



**V E R M O N T**

**AGENCY OF HUMAN SERVICES  
DEPARTMENT OF VERMONT HEALTH ACCESS**



**BUDGET DOCUMENT**  
**STATE FISCAL YEAR 2018**

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I am honored to be presenting the Department of Vermont Health Access (DVHA) budget book on behalf of the Governor and our entire staff. Our commitment is to serve both Vermonters enrolled in our programs and Vermont taxpayers who fund our programs. Quite simply, our job is to make sure our members have access to the services they need in the most efficient and cost effective manner possible, and our collective eye is focused on continuous improvement. As a department within the Agency of Human Services, we hold common core values of integrity, transparency and service to guide our work and decision making.

The time I have spent in the world of health care policy representing the interests of payers and providers has shown me the value of collaboration with public and private stakeholders (legislature, advocates, healthcare practitioners, and all our state and federal partners). Many good people are working hard to make our health care system better and we at DVHA recognize that we need to work with all to achieve a common goal: preserve our high-quality healthcare system while making Vermont more affordable..

This budget book is designed to clearly depict the functional areas of responsibility within the DVHA, to provide the public with the status of the initiatives which the teams are working to accomplish, and ultimately portray our budgetary needs for the coming year. We offer trends in national and regional health care delivery and how Vermont's Green Mountain Care programs compare.

Two of the most important trends to be explored are caseload and utilization. The Department of Vermont Health Access began the effort of re-determining Medicaid eligibility for large sections of the populations in SFY 2016 and continues to do so. At a very high level, we have found that Medicaid members with higher levels of health care needs remain eligible while those with less per member costs were found non-eligible. While numbers are trending down, the needs of our members are trending upward.

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.

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[GreenMountainCare.org](http://GreenMountainCare.org)  
[HCR.Vermont.gov](http://HCR.Vermont.gov)

FAST FACTS

Category	Description	Data Point
<b>Coverage</b>	Number of covered lives in Vermont’s public health insurance coverage programs (SFY2016)	220,556
	Number of children included in the above (SFY2016)	71,870
	Percent of Vermont children covered by Green Mountain Care	55%
	Percent of Vermonters enrolled in a public health insurance coverage program	35%
	Average number of covered lives in Vermont Health Connect Qualified Health Plans (SFY 2016)	27,006
<b>Providers</b>	Number of providers enrolled in Green Mountain Care (January 2016)	14,096
	Number of Vermont Medicaid Electronic Health Record Incentive Program eligible providers that have received payment for using Certified EHR systems (SFY 2011-2016)	988
	Number of Blueprint Patient Centered Medical Home practices (SFY 2016)	128
<b>Claims</b>	Number of claims processed annually (SFY2016)	7,643,349
	Percent of claims received electronically (SFY2016)	93%
	Percent of claims processed within 30 days (SFY2016)	95%
	Average number of days from claim receipt to adjudication (SFY2016)	3.75
<b>Customer Support</b>	Average number of VHC calls to Member Services per month (SFY2016)	30,775
	Average number of GMC calls to Member Services per month (SFY2016)	16,192

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AGENCIES

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

**Agency of Administration (AOA)**

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

**Agency of Human Services (AHS)**

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

**Agency of Agriculture, Food & Market (AAFMM)**

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

**Agency of Commerce & Community Development (ACCD)**

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

**Agency of Education (AOE)**

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

**Agency of Natural Resources (ANR)**

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

**Agency of Transportation (AOT)**

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

**Department of Labor (DOL)**

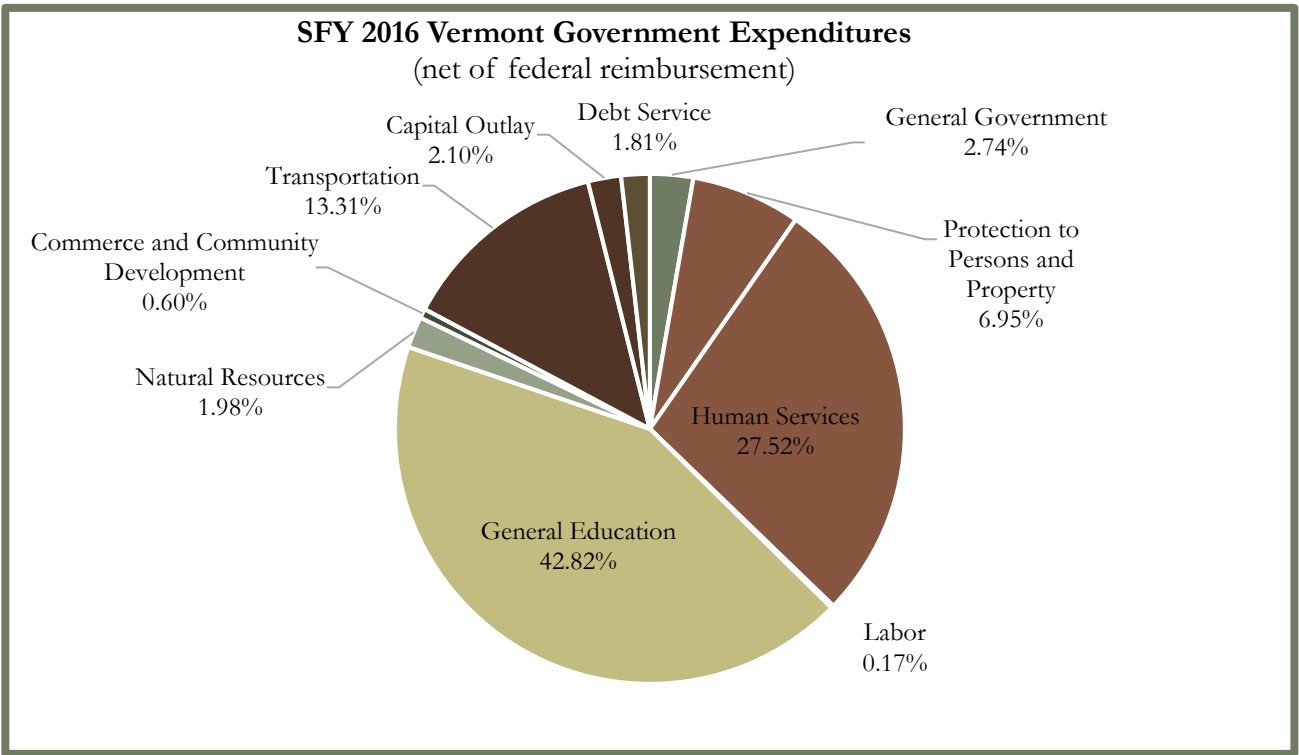
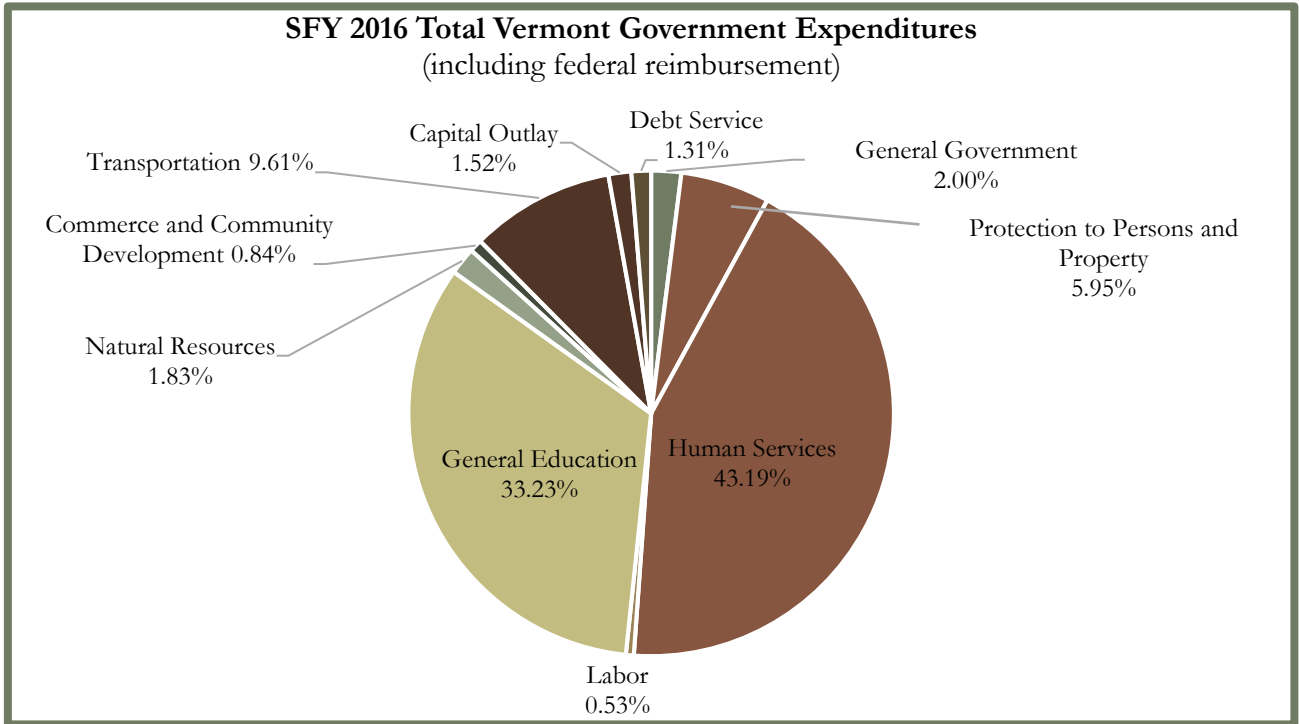
- **Mission:** To promote Vermont’s economic strength by assisting employers with job creation, retention and recruitment; coordinating the education and training of our workforce for Vermont’s current and future job opportunities; ensuring that Vermont workers have well-paying jobs in safe work environments;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

**Department of Public Safety (DPS)**

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

## AGENCIES' SPEND

The first chart below depicts the AHS total expenses as a percentage of the total State expenditures. The next chart shows the State fund portion of those expenditures. While AHS is the Agency with the largest expenses, it uses a smaller fraction of state funds than Education.



### AGENCY OF HUMAN SERVICES

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 the AHS indirect rate;
- Updates federal cost allocation plans; and
- Updates the State plan.

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

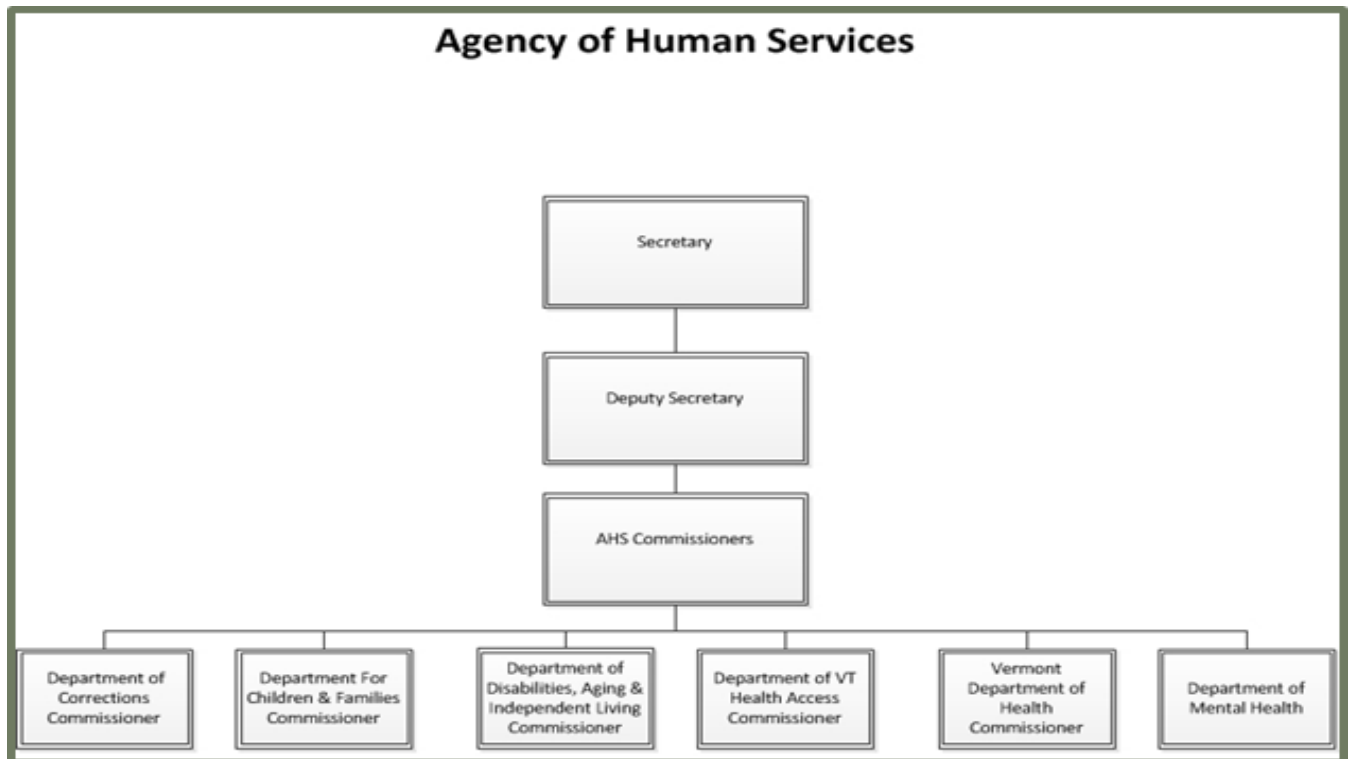
The AHS Healthcare Operations, Compliance, and Improvement Unit manages activities pertaining to Medicaid and associated healthcare operations. It is responsible for integrated planning, policy development, regulatory compliance and funding. These initiatives require cross-departmental (and intra-governmental) 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.

	VT Population Estimate <sup>1</sup>	Green Mountain Care Enrollment	Percent of Population Enrolled
SFY2016	624,594	220,556	35.31%
SFY2015	626,562	209,395	33.42%
SFY2014	626,855	178,650	28.50%
SFY2013	626,138	173,849	27.77%
SFY2012	626,450	171,610	27.39%
SFY2011	625,792	169,179	27.03%

1. *Annual estimates of the Resident Population: April 1, 2010 to July 1, 2016*, U.S. Census Bureau, Population Division, Release Date: December 2016

## AHS ORGANIZATIONAL CHART



## DEPARTMENTAL APPROACHES TO MEDICAID

The Agency of Human Services (AHS), its Departments, and the Agency of Education (AOE) oversee and operate numerous programs designed to address the health and wellness needs of Vermont. The AHS’ Department of Vermont Health Access (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:

<b>Department</b>	<b>Division/Programs/Services</b>
Department of Vermont Health Access (DVHA)	Traditional Healthcare Services Blueprint for Health Coordination of Benefits (COB) Mental Health and Substance Abuse Program Integrity (PI) Vermont Chronic Care Initiative (VCCI) Quality Reporting 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) Developmental Disabilities Services (DDS) Program Traumatic Brain Injury Services (TBI) Program Long Term Care (LTC or CFC) Program
Department for Children and Families (DCF)	Child Development Division (CDD) Children’s Integrated Services (CIS) Program Family Services Division (FSD) Contracted Treatment Service Programs
Department of Corrections (DOC)	Medicaid for Incarcerated Individuals Admitted to Hospital or Other Facility
Department of Mental Health (DMH)	Adult Mental Health Division (AMH) Children’s Mental Health Division (CMH)
Vermont Department of Health (VDH)	Alcohol and Drug Abuse Program (ADAP) Ladies First Program HIV/AIDS Program

### **GLOBAL COMMITMENT TO HEALTH WAIVER**

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 abuse 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.

## DEPARTMENT FOR CHILDREN AND FAMILIES (DCF)

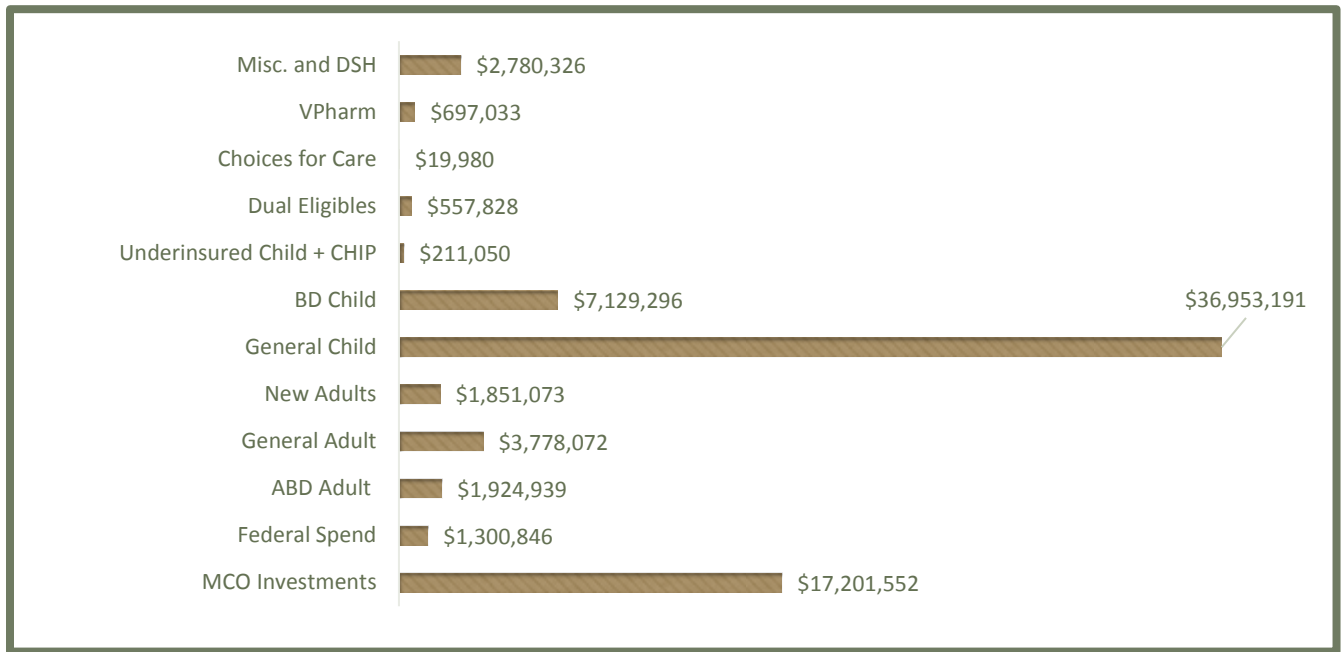
**Mission Statement:** To foster the healthy development, safety, well-being, and self-sufficiency of Vermonters.

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

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

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

## DCF SFY 2016 Medicaid Spend



### DEPARTMENT OF CORRECTIONS (DOC)

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

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

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

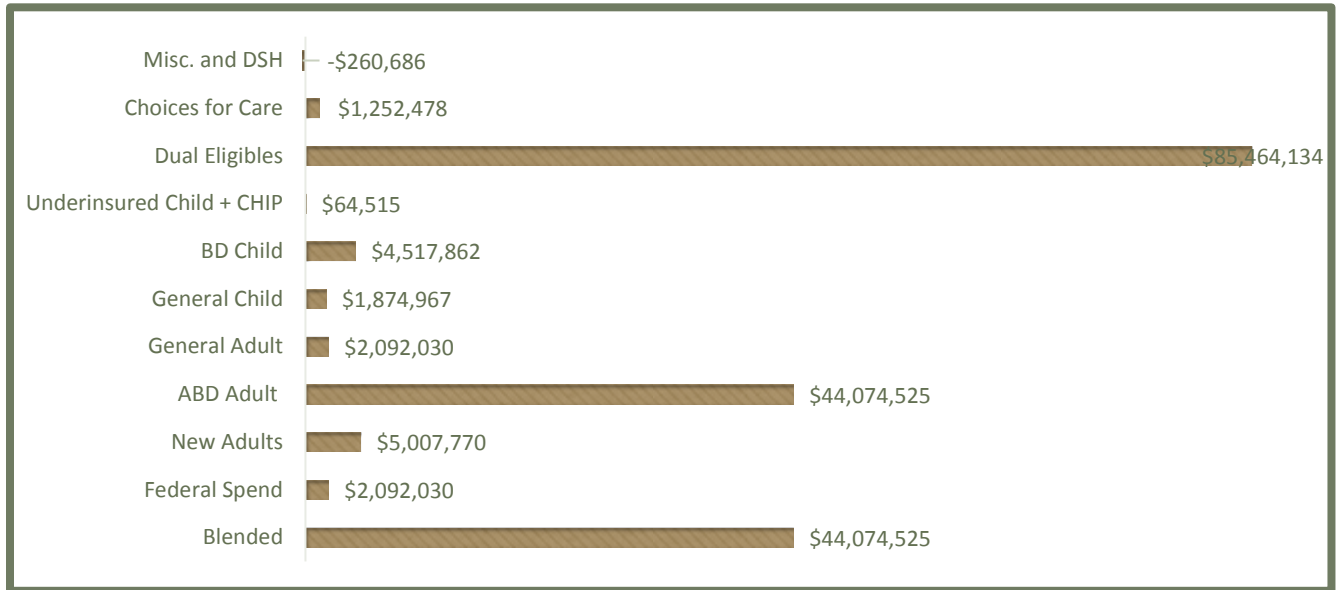
### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING (DAIL)

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

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

- Division for the Blind and Visually Impaired
- Office of Child Support
- Division of Licensing and Protection
- Office of Disability Determinations

### DAIL SFY 2016 Medicaid Spend



## DEPARTMENT OF MENTAL HEALTH (DMH)

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

**Vision:** Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion improving the conditions and well-being of Vermonters and protect those who cannot protect themselves. A determination to respond effectively and respectfully to the mental health needs of all citizens. Vermonters will have access to effective prevention, early intervention and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities.

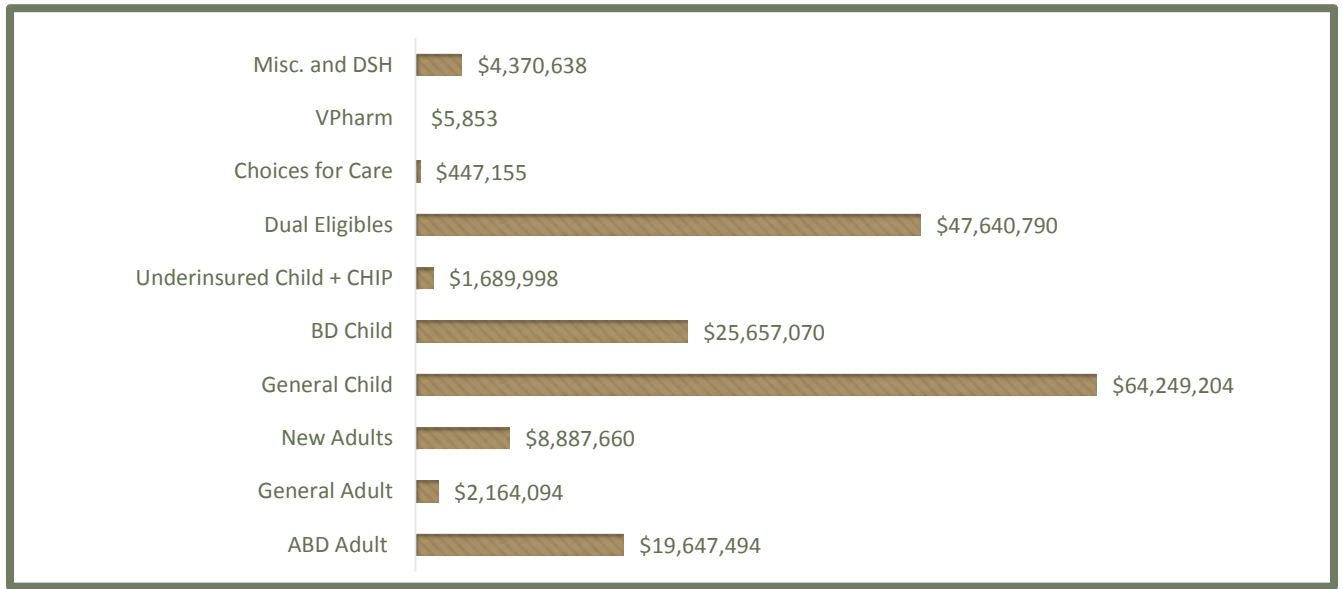
The Department of Mental Health (DMH) consists of three programmatic divisions:

- Adult
- Child, Adolescent, & Family
- Vermont Psychiatric Care Hospital

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



## DMH SFY 2016 Medicaid Spend



### DEPARTMENT OF HEALTH (VDH)

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

**Vision:** Healthy Vermonters living in healthy communities.

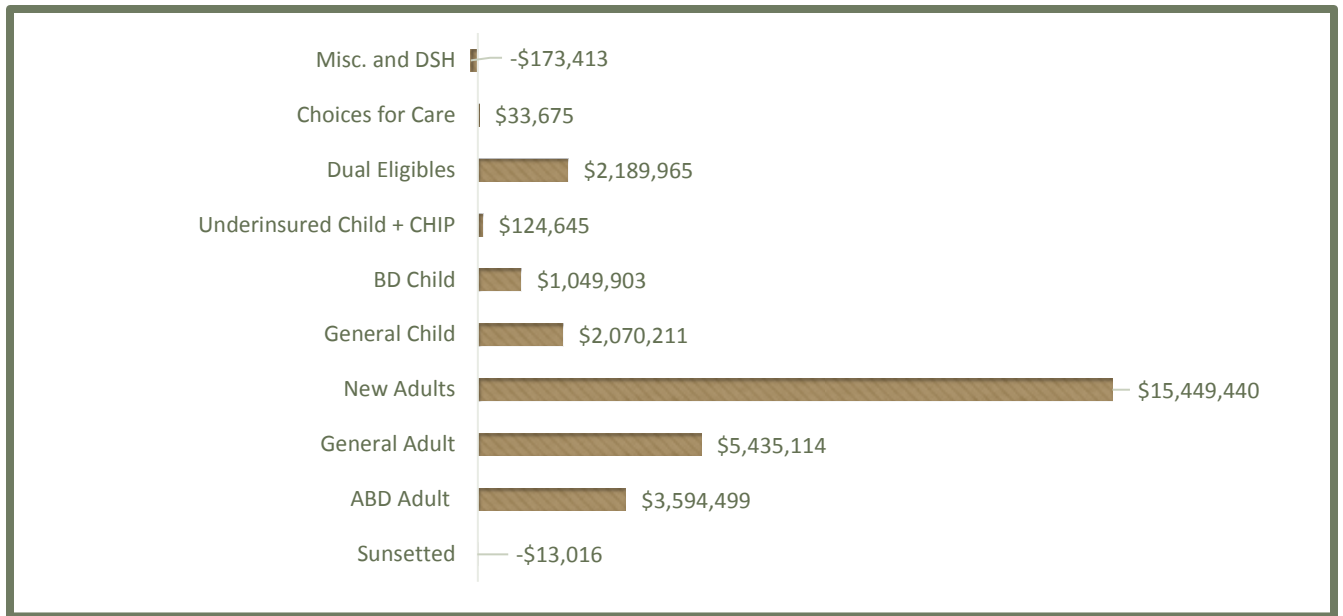
VDH is divided into individual divisions, each with the goal of promoting safety and health throughout the state. Those divisions are as follows:

- The Environmental Health Division
- Health Surveillance Division
- Office of Public Health Preparedness and Emergency Medical Services,
- The Board of Medical Practice
- Health Promotion and Disease Prevention Division
- The Office of Local Health, Maternal and Child Health Division
- The Alcohol & Drug Abuse Programs Division (ADAP)

ADAP helps Vermonters prevent, reduce, and/or eliminate alcohol and other drug related problems. ADAP manages and evaluates a comprehensive system of substance abuse treatment, prevention, and recovery services throughout Vermont. The substance abuse Care Alliance (termed “Hub and Spoke”) is a joint effort administered by both VDH and the DVHA’s Blueprint for Health program.

The Ladies First program is administered by VDH and provides women with breast, cervical, and heart health screenings. VDH also provides several specific programs for persons living with HIV and AIDS. These care programs are federally funded through the HRSA Ryan White Act and the CDC HIV Surveillance System.

## VDH SFY 2016 Medicaid Spend



### AGENCY OF EDUCATION (AOE)

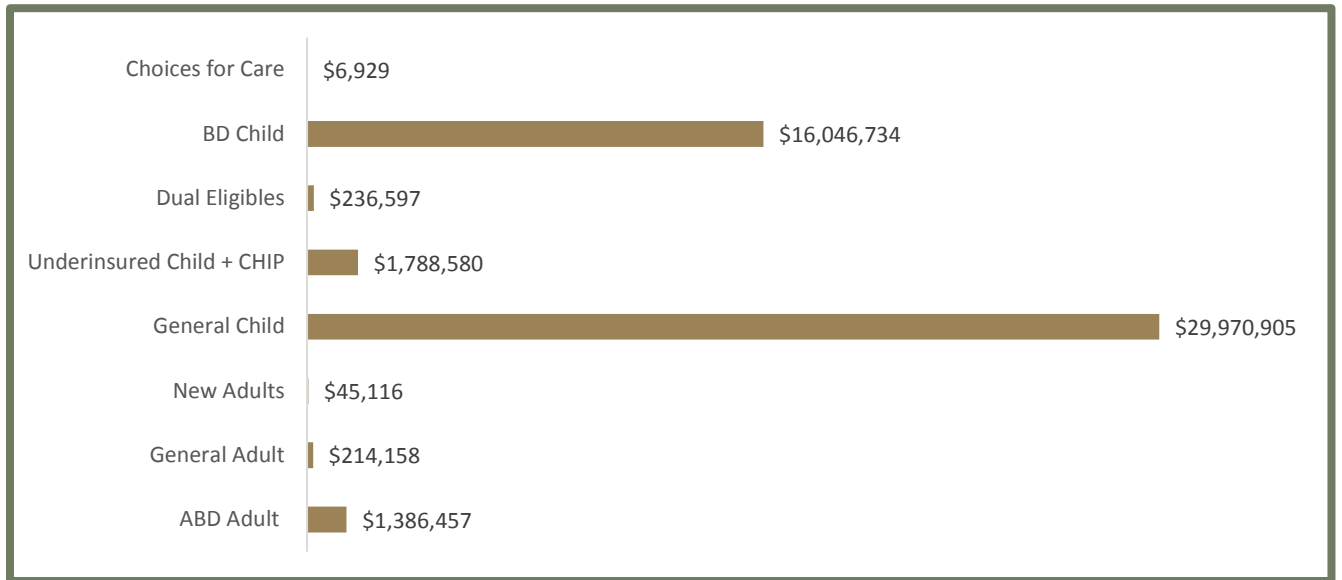
**Mission Statement:** The State Board of Education and Agency of Education provide leadership, support, and oversight to ensure that the Vermont public education system enables all students to be successful.

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

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

Vermont's adult education and literacy system offers essential services at locations throughout the state with trained professionals. Personalized instruction is offered in mathematics, reading and writing, essential workplace skills and English for speakers of other languages (ESOL and civics education for immigrants). All educational services are informed and guided by the Equipped for the Future (EFF) Standards and the College and Career Readiness Standards (CCRS) for Adult Education.

## AOE SFY 2016 Medicaid Spend



### DEPARTMENT OF VERMONT HEALTH ACCESS (DVHA)

The Department of Vermont Health Access (DVHA) is responsible for the oversight, implementation, and management of Vermont’s publicly funded health coverage programs.

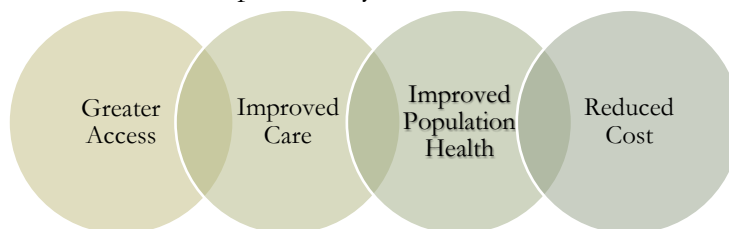
These programs include Medicaid and the Children’s Health Insurance Program, collectively branded Green Mountain Care (GMC); as well as the State’s health insurance marketplace.

DVHA oversees many of Vermont's expansive Healthcare Reform initiatives. These initiatives are designed to increase access, improve quality, and contain the cost of healthcare for all Vermonters, and include the federally funded Vermont Healthcare Innovation Project (VHCIP), Vermont’s Blueprint for Health, and Health Information Technology strategic planning, coordination and oversight.

Under the current terms and conditions of the Global Commitment to Healthcare waiver, DVHA acts as a non-risk pre-paid inpatient health plan (PIHP).

DVHA’s Commissioner is a member of the Governor’s healthcare leadership team. He is responsible for DVHA’s operations as well as leading state and federal healthcare reform implementations. The department has a total of 366 budgeted, classified staff positions who work serves the State of Vermont’s high level health reform goals.

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



In support of the objectives outlined above, DVHA's successful Blueprint for Health and the Vermont Chronic Care Initiative (VCCI) have been working hand-in-hand with the federally-funded State Innovation Model (SIM) project, labeled the Vermont Healthcare Innovation Project (VHCIP).

The Blueprint for Health team oversees the statewide multi-insurer program designed to coordinate a system of healthcare for patients, improve the health of the overall population, and improve control over healthcare costs by promoting health maintenance, prevention, care coordination, and management at the provider level.

The specific goals for the Vermont Healthcare Innovation Project (VHCIP) are: to increase the level of accountability for cost and quality outcomes among provider organizations; to create a health information network that supports the best possible care management and assessment of cost and quality outcomes and informs opportunities to improve care; to establish payment methodologies across all payers that encourage the best cost and quality outcomes; to ensure accountability for outcomes from both the public and private sectors; and to create commitment to change and synergy between public and private cultures, policies and behaviors.

To address the project aims and goals described above, the VHCIP has three main focus areas: Payment models—implementing provider payments that move away from straight fee-for-service and incorporate value measurement, care models; creating a more integrated system of care management and care coordination for Vermonters; and health information technology/health information exchange (HIT/HIE) building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.

The Vermont Chronic Care Initiative continues to partner with the pilot Medicaid Accountable Care Organization (ACO) delivery model to assure integrated, non-duplicative service delivery for VCCI-eligible, high risk members. VCCI is a healthcare reform strategy which supports Medicaid members with chronic health conditions and/or high utilization of medical services in accessing clinically appropriate healthcare information and services; coordinates the efficient delivery of healthcare to these members by addressing barriers to care, gaps in evidence-based treatment, and reducing duplication of services; and educates and empowers members to eventually self-manage their conditions.

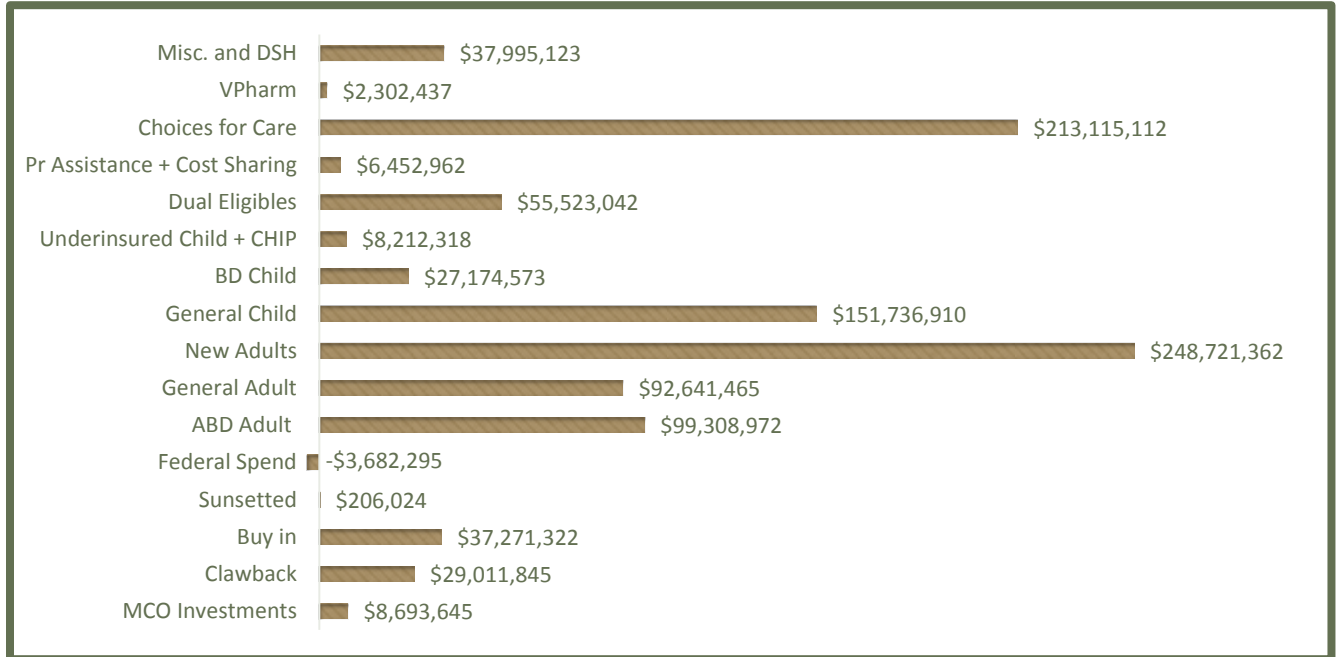
VCCI case managers/care coordinators are field based and embedded in AHS district offices and high volume hospital and provider practice sites to support communication, referrals, and transitions in care. They partner with providers and ACO clinical teams, are members of the Blueprint for Health community health teams (CHT), and work with partners across AHS to facilitate a holistic approach for addressing the socioeconomic barriers to health for at risk members.

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

Vermont and DHVA have long been leaders in healthcare coverage expansion and maintenance. Two of DVHA's most successful coverage expansion programs – the Vermont Health Access Plan (VHAP) and

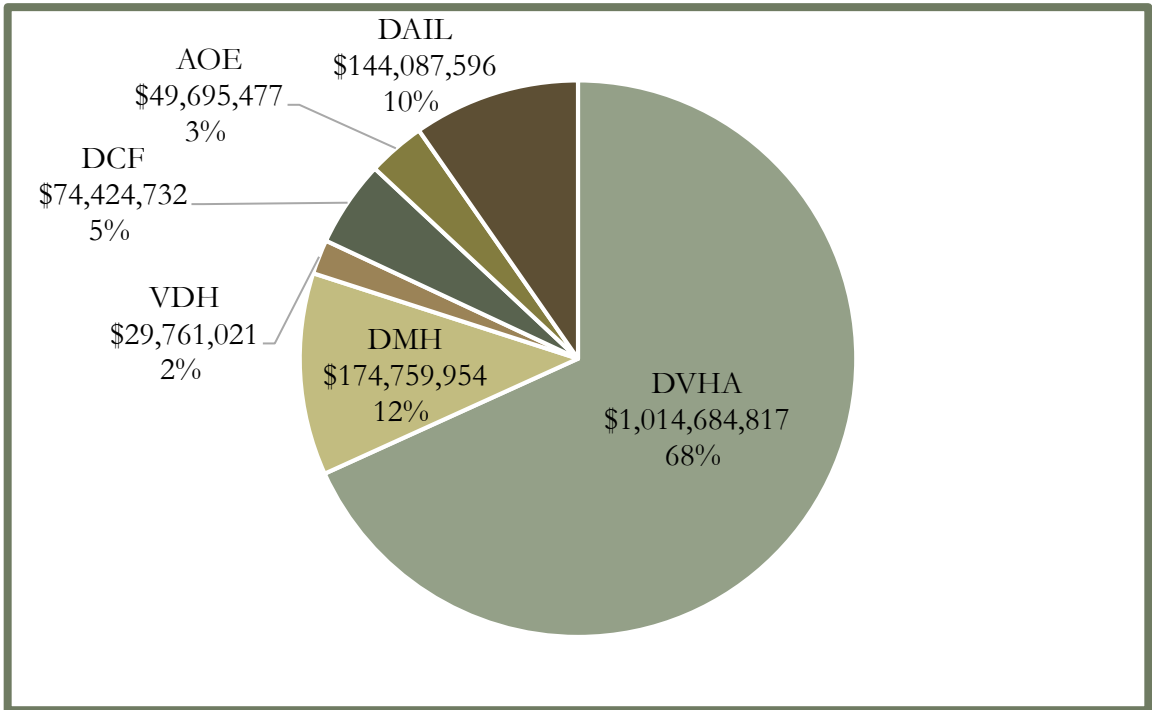
Catamount – came to an end in 2014, and eligible individuals were moved into the expanded Medicaid program or onto a new Qualified Health Plans (QHPs) in Vermont Health Connect. In 2016, DVHA served 220,556 Vermonters clinically and/or financially, and an additional 12,028 Vermonters (individuals and families) are enrolled in Vermont Health Connect Qualified Health Plans with no financial subsidy.

### DVHA SFY 2016 Medicaid Spend

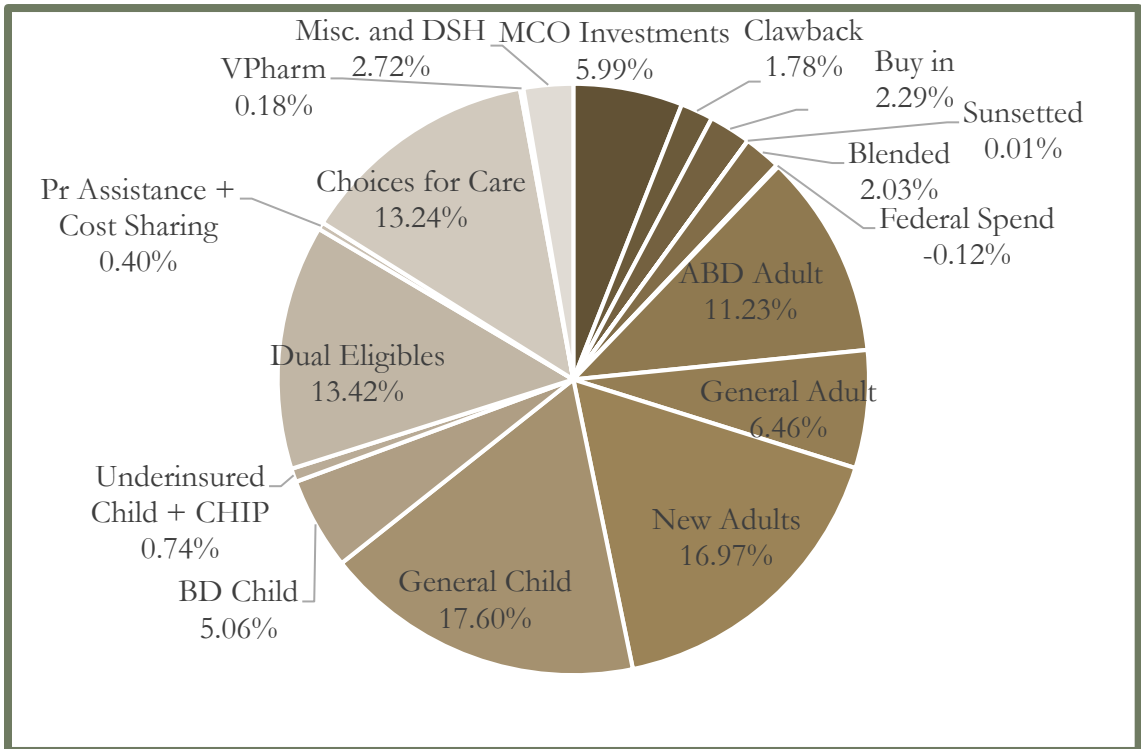


**CROSS-DEPARTMENTAL MEDICAID/CHIP COMPARISON**

**Total SFY 2016 Medicaid/CHIP Spend by Department - \$1,487,413,598**



**Total SFY 2016 Medicaid/CHIP Spend by Eligibility Group**



## Departmental Spend by Category of Service

SFY 2016 Medicaid Spend - Global Commitment, CHIP, & CFC - BY CATEGORY OF SERVICE							
Category of Service	DVHA	DMH	VDH	DCF	AOE	DAIL	Total AHS
Inpatient	\$ 142,551,542	\$ 4,276,698	\$ -	\$ -	\$ -	\$ -	\$ 146,828,240
Outpatient	\$ 143,456,449	\$ 611	\$ -	\$ 10,373	\$ -	\$ -	\$ 143,467,433
Physician	\$ 123,330,113	\$ 3,730	\$ -	\$ 216,749	\$ 245,434	\$ -	\$ 123,796,026
Pharmacy	\$ 208,281,067	\$ -	\$ -	\$ 13,370	\$ -	\$ -	\$ 208,294,437
Nursing Home	\$ 121,227,892	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 121,227,892
ICF/MR Private	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 777,843	\$ 777,843
Mental Health Facility	\$ 645,746	\$ 14,805	\$ -	\$ -	\$ -	\$ -	\$ 660,551
Dental	\$ 29,229,900	\$ -	\$ -	\$ 168,178	\$ -	\$ -	\$ 29,398,078
MH Clinic	\$ 194,888	\$ 104,993,212	\$ -	\$ -	\$ -	\$ 394,723	\$ 105,582,824
Independent Lab/Xray	\$ 11,705,155	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 11,705,155
Home Health	\$ 6,789,547	\$ -	\$ -	\$ 311,606	\$ 250	\$ -	\$ 7,101,403
Hospice	\$ 4,058,563	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,058,563
FQHC & RHC	\$ 36,121,371	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 36,121,371
Chiropractor	\$ 1,365,792	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,365,792
Nurse Practitioner	\$ 1,038,466	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,038,466
Skilled Nursing	\$ 2,633,311	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,633,311
Podiatrist	\$ 236,072	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 236,072
Psychologist	\$ 27,906,070	\$ 6,203	\$ -	\$ 5,918	\$ -	\$ -	\$ 27,918,191
Optometrist/Optician	\$ 2,534,042	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,534,042
Transportation	\$ 12,682,079	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 12,682,079
Therapy Services	\$ 5,887,648	\$ -	\$ -	\$ 1,381,940	\$ -	\$ -	\$ 7,269,589
Prosthetic/Ortho	\$ 3,507,216	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,507,216
Medical Supplies & DME	\$ 11,556,374	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 11,556,374
H&CB Services	\$ 59,240,530	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 59,240,530
H&CB Services Mental Service	\$ 697,455	\$ 1,570,670	\$ -	\$ -	\$ -	\$ -	\$ 2,268,126
H&CB Services Development Services	\$ (650)	\$ -	\$ -	\$ -	\$ -	\$ 129,148,935	\$ 129,148,285
TBI Services	\$ -	\$ 176,834	\$ -	\$ -	\$ -	\$ 3,282,469	\$ 3,459,303
Enhanced Resident Care	\$ 9,054,265	\$ -	\$ -	\$ -	\$ -	\$ 183	\$ 9,054,448
Personal Care Services	\$ 13,216,268	\$ -	\$ -	\$ -	\$ -	\$ 1,091,613	\$ 14,307,882
Targeted Case Management (Drug)	\$ 45,453	\$ 4,935,586	\$ -	\$ -	\$ -	\$ 357,894	\$ 5,338,933
Assistive Community Care	\$ 14,036,662	\$ 4,756,090	\$ -	\$ 12,367,911	\$ -	\$ -	\$ 31,160,663
Day Treatment MHS	\$ 169	\$ 53,389,672	\$ -	\$ -	\$ -	\$ 1,653,611	\$ 55,043,452
OADAP Families in Recovery	\$ 3,088,695	\$ -	\$ 27,352,443	\$ -	\$ -	\$ 6,773,539	\$ 37,214,678
Rehabilitation	\$ 778,552	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 778,552
D & P Dept of Health	\$ 306,463	\$ 638,684	\$ 2,420,764	\$ 40,127,598	\$ 49,449,793	\$ 718,875	\$ 93,662,177
PcPlus Case Mgmt and Special Program Payments	\$ 1,542,550	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,542,550
Blue Print & CHT Payments	\$ 14,762,160	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 14,762,160
PDP Premiums	\$ 1,503,221	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,503,221
VPA Premiums	\$ 5,266,242	\$ -	\$ -	\$ 356,753	\$ -	\$ -	\$ 5,622,995
Ambulance	\$ 4,448,037	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,448,037
Dialysis	\$ 1,456,654	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,456,654
ASC	\$ 61,095	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 61,095
Other Expenditures	\$ 113,467,538	\$ -	\$ -	\$ 19,464,336	\$ -	\$ (101,517)	\$ 132,830,357
Total Offsets	\$ (125,225,848)	\$ (2,841)	\$ (12,186)	\$ -	\$ -	\$ (10,574)	\$ (125,251,448)
<b>Total All Program Expenditures</b>	<b>\$ 1,014,684,817</b>	<b>\$ 174,759,954</b>	<b>\$ 29,761,021</b>	<b>\$ 74,424,732</b>	<b>\$ 49,695,477</b>	<b>\$ 144,087,596</b>	<b>\$ 1,487,413,598</b>

DVHA MISSION STATEMENT

**Assist Medicaid beneficiaries in accessing clinically appropriate health services.**

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

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

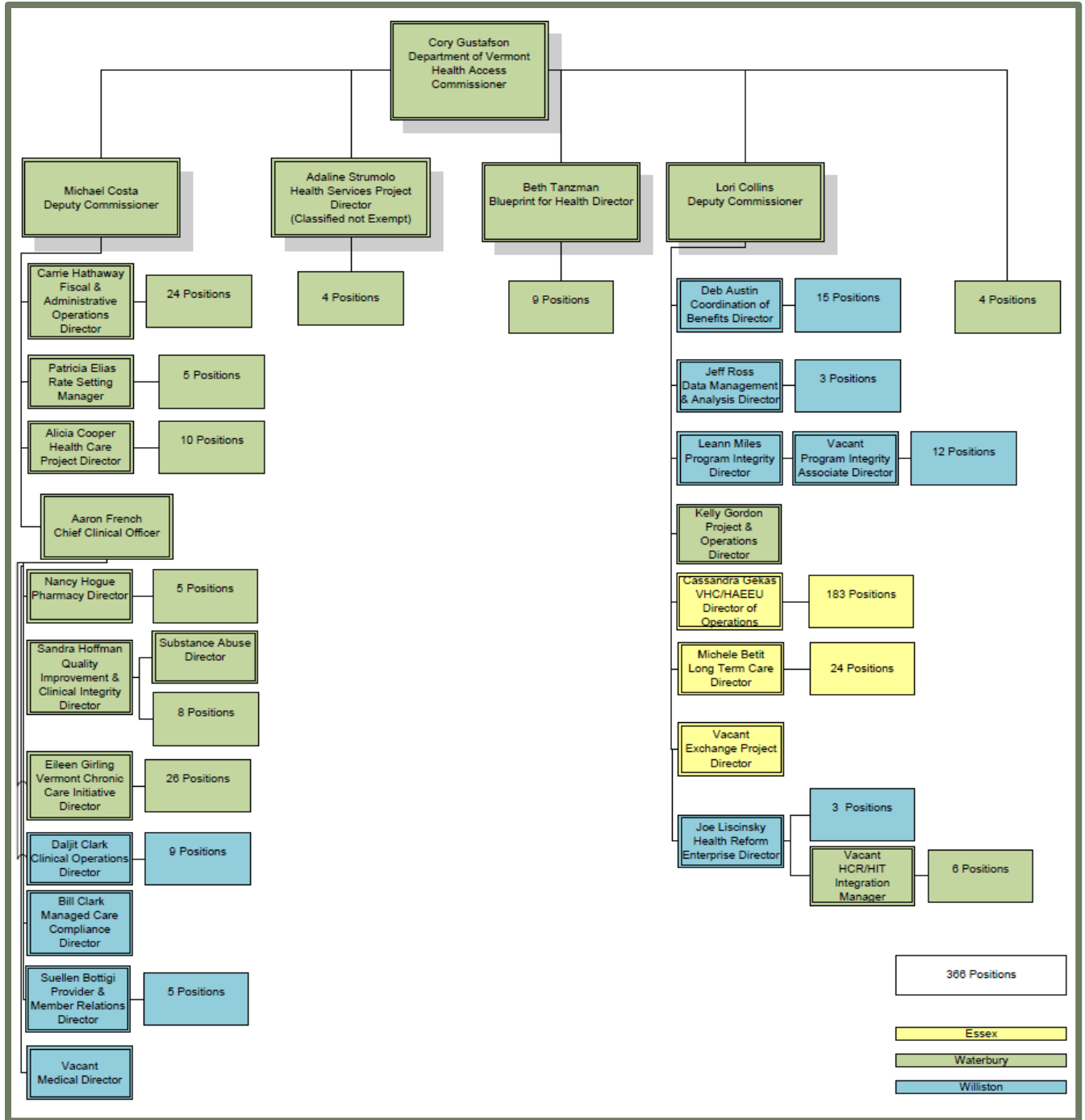
**Provide leadership for Vermont stakeholders to improve access, quality and cost-effectiveness of healthcare.**

DVHA ORGANIZATIONAL CHANGES OVERVIEW

As will be noted in the budget testimony, DVHA has eliminated two Deputy Commissioner positions in order to streamline roles and responsibilities and distribute unit oversight more equitably. Lori Collins, Deputy Commissioner, will oversee Coordination of Benefits, Data, Program Integrity, Eligibility, and Special Projects. Michael Costa, Deputy Commissioner, will be supporting the Business Office, Reimbursement, Payment Reform, and Health Services & Managed Care.



# DVHA ORGANIZATIONAL CHART



## FUNCTIONAL AREAS OF RESPONSIBILITY

The Department of Vermont Health Access (DVHA) has five key areas which are the department's administrative focus. These are:

- **General Administration**
- **Claims Services**
- **Eligibility**
- **Quality**
- **Project**

	SFY 2018 Governor's Recommendation			
	# FTEs	Total \$	% of Admin Budget	% of Total Budget
<b>General Administration</b>	<b>87</b>	<b>\$ 9,960,991</b>	<b>5.26%</b>	<b>0.82%</b>
<b>Claims Services</b>	<b>29</b>	<b>\$ 18,273,537</b>	<b>9.65%</b>	<b>1.51%</b>
<b>Eligibility</b>	<b>145</b>	<b>\$ 48,272,806</b>	<b>25.48%</b>	<b>3.98%</b>
<b>Quality</b>	<b>90</b>	<b>\$ 21,733,978</b>	<b>11.47%</b>	<b>1.79%</b>
<b>Project</b>	<b>15</b>	<b>\$ 91,198,799</b>	<b>48.14%</b>	<b>7.52%</b>
<b>TOTAL ADMINISTRATIVE COSTS</b>	<b>366</b>	<b>\$ 189,440,111</b>	<b>100.00%</b>	<b>15.62%</b>

## GENERAL ADMINISTRATION

The following units comprise this division:

- **General Administration**
  - Business Office
  - Commissioner's Office
  - Data
  - Outreach/Education
  - Operational Support
  - Medicaid Support

	SFY 2018 Governor's Recommendation			
	# FTEs	Total \$	% of Admin Budget	% of Total Budget
<b>General Administration</b>	<b>87</b>	<b>\$ 9,960,991</b>	<b>5.26%</b>	<b>0.82%</b>
Business Office	25	\$ 2,665,428	1.41%	0.22%
Commissioner's Office	13	\$ 1,908,652	1.01%	0.16%
Data	4	\$ 485,612	0.26%	0.04%
Outreach/Education	7	\$ 801,079	0.42%	0.07%
Operational Support	31	\$ 3,136,991	1.66%	0.26%
Medicaid Support	7	\$ 963,229	0.51%	0.08%

## 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 health care 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 unit includes Accounts Payable/Accounts Receivable (AP/AR), Grants and Contracts, Business Administration, Fiscal Analytics, and Subrecipient Monitoring.

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

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 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. 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 in adherence with state and federal financial reporting requirements, responds to audit requests, and manages agreement closeout.

The Business Administration and Operations team 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. This team manages building related issues, telephone, and IT equipment and oversees the departmental purchasing card, fleet vehicles. They work with stakeholders on the process and procedures needed for purchases and HR requirements.

The Fiscal Analytics unit 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.

The Sub-Recipient Compliance Monitoring unit is responsible for researching, developing and implementing relevant administrative processes, procedures and internal controls. This includes the establishment of the in-direct cost rates as applicable. The unit also manages the Business Office’s audit process.

## **DATA**

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 3 last HEDIS seasons. The unit continues to support the AHS Central Office monitoring of the Designated Agencies (DAs) by running the annual DA Master Grant Performance Measures and providing AHS with a multi-year span of results for nine measures to track progress and monitor continued improvements. The unit is actively engaged in Performance Improvements Projects (PIP) aimed at improving three HEDIS measures: Breast Cancer Screening (BCS), Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET), and Follow-Up After Hospitalization for Mental Illness (FUH). Analysts working on these projects analyze claims records while designing, developing, and implementing change processes to encourage beneficiary and provider coordination and cooperation.

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

## **OUTREACH/EDUCATION**

This unit is responsible for the development of a broad-based public outreach and education campaign, stakeholder partnerships to support public education around health reform and tie those partnerships to a coordinated and comprehensive outreach strategy, including members of the advocacy and business communities in the partnership development strategy. This unit oversees the development of customer facing communication, including notices, as well as the Navigator/Broker Program.

## **OPERATIONAL SUPPORT**

The DVHA Operations Support team provides hands-on training, reporting, workflow, administrative support, and business process support for the Health Care 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 health care assistance programs and enroll them in the correct coverage. The Operations Support team provides support for enrollment functions, including invoicing, premium processing, and 834 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.

## **MEDICAID SUPPORT**

The Medicaid Support unit is responsible for operationalizing select new program initiatives and ongoing projects, particularly requiring cross-functional involvement. Responsibilities include the MMIS Care Management project which is part of the Agency of Human Services' Health and Human Services Enterprise (HSE), the Graduate Medical Education (GME) Program, the CMS mitigation plan for Vermont Health Connect (VHC), various VHC development projects, the Automated Asset Verification project for eligibility determinations, and monitoring implementation of the Medicaid part of the All Payer Model.

Key accomplishments for this unit during the past year include: ensuring quarterly GME payments and fulfillment of quality reporting requirements; determining 2017 GME funding and enhanced reporting requirements for UVM Medical Center; implementing Phase 1 of the MMIS care management project with the Vermont Chronic Care Initiative; initiating Phase 2 system development and onboarding with Children's Integrated Services in DCF and Children with Special Health Needs in VDH; developing and obtaining approval from CMS of the VHC mitigation plan; and completing various VHC development and enhancement projects.

## CLAIMS SERVICES

- **Claims Services**
  - Clinical Operations
  - MMIS - Claims Processor
  - MMIS - Misc. Contracts
  - Provider and Member Relations
  - Reimbursement Unit

	SFY 2018 Governor's Recommendation			
	# FTEs	Total \$	% of Admin Budget	% of Total Budget
<b>Claims Services</b>	<b>29</b>	<b>\$ 18,273,537</b>	<b>9.65%</b>	<b>1.51%</b>
Clinical Operations	14	\$ 1,460,637	0.77%	0.12%
MMIS - Claims Processor		\$ 12,740,897	6.73%	1.05%
MMIS - Misc. Contracts		\$ 2,729,905	1.44%	0.23%
Provider and Member Relations	8	\$ 713,156	0.38%	0.06%
Reimbursement Unit	7	\$ 628,943	0.33%	0.05%

## **CLINICAL OPERATIONS**

The Clinical Operations Unit (COU) monitors the quality, appropriateness, and effectiveness of healthcare services requested by providers for members. The unit ensures that requests for services are reviewed and processed efficiently and within timeframes outlined in Medicaid Rule; identifies over- and under-utilization of healthcare services through the prior authorization (PA) review process and case tracking; develops and/or adopts clinical criteria for certain established clinical services, new technologies and medical treatments; assures correct coding for medical benefits; reviews provider appeals; offers provider education related to specific Medicaid policies and procedures; and performs quality improvement activities to enhance medical benefits for members.

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

The DVHA successfully implemented the ICD-10 code set on October 1, 2015. The Conversion Project Team was comprised of members from various units in DVHA, who were chosen specifically for their expertise.

The ICD-10 conversion included a full MMIS system remediation, coupled with outreach to agency departments and providers. The team provided testing of each step, from impact studies for budgeting to the assessment of new software for processing and reporting. The success of this very complex ICD-10 conversion project is a direct reflection of the extensive work the project team conducted to ensure that the MMIS claim processing adjudication system was fully remediated, tested and ICD-10 ready.

The DVHA ICD-10 Conversion Project team's expertise and oversight also ensured that all VT Medicaid ICD-10 identified impacts were addressed, tested and verified. The process included an extensive amount of internal code review and verifying code mapping, policy remediation, internal process and system workflow adjustments, user acceptance testing and MMIS system testing by the COU. We continue to perform post deployment monitoring and tracking.

## **VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM CLAIMS PROCESSOR**

Enterprise Services (ES), formerly known as Hewlett Packard Enterprise Services, provides the Department of Vermont Health Access (DVHA) with Medicaid Fiscal Agent Services that include claims processing and payment, financial services, provider enrollment, and system maintenance and operation. ES processes over 7.6 million claims a year for the State.



ES has provided Medicaid fiscal agent services to the 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, and answers help desk calls from providers, performs coordination of benefit services, and supports data analytics activities.

MMIS activities:

- Member identification card production and distribution
- Claims processing and payment
- Management and reporting
- Provider education and relations
- Provider enrollment
- Financial Services
- Coordination of benefits
- Data analytics
- Security
- System maintenance and operation
- System modification and enhancement

DVHA awarded ES a contract to implement a new client/server MMIS in July 1992 and has maintained it ever since. ES operates a client MMIS server certified by Centers for Medicare & Medicaid Services (CMS) that facilitates real-time claims processing and updating capabilities, and gives users flexible reporting options.

In 2017 the primary focus is on continued MMIS enhancements to support the All Payer Model (APM).

In SFY 2016,

- System is used to process over 7.6 million claims for services provided to 220,556 members by over 14,096 Medicaid providers
- System supports approximately 120 state staff at multiple locations throughout the state as well as 85 ES employees
- Processes over 1 billion in expenditures paid out to providers, carriers and beneficiaries.
- 95% of all claims are processed within 30 days with an average turnaround of 5 days

## **PROVIDER AND MEMBER RELATIONS**

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

Unit responsibilities relating to providers include provider enrollment, screening, and revalidation. Credentialing of providers and monitoring of the network helps prevent Medicaid fraud and abuse. In

conjunction with the State's fiscal agent, PMR currently has 14,096 providers enrolled in the Vermont Medicaid program.

In exceptional circumstances, PMR pursues the enrollment of providers for members prior authorized for out-of-state medical needs. PMR also pursues claim information if members receive emergency healthcare services while out of state.

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

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

## **REIMBURSEMENT UNIT**

The DVHA 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.

The unit is involved with addressing the individual and special circumstantial needs of members by working closely with clinical staff from within DVHA and partner agencies to ensure that needed services are provided in an efficient and timely manner. The Reimbursement unit works closely and collaboratively on reimbursement policies for specialized programs with AHS sister departments, including the Department of Disabilities, Aging, and Independent Living (DAAIL), the Vermont Department of Health (VDH), the Vermont Department of Mental Health (DMH), Integrated Family Services (IFS), and Children's Integrated Services (CIS).

In calendar year 2016, the Reimbursement unit had many accomplishments including: allocating \$2.3 million appropriated under V.S.A. 33 Section E.306.12 to Ambulance Agencies in the form of increased

reimbursements effective July 1, 2016; and per Section E.306.13 V.S.A. 33, the reallocation of \$4 million, through an adjustment of inpatient rates at Academic Medical Centers to participating primary care providers of Evaluation & Management and vaccine administration services in the form of enhanced payments. Additionally, the Reimbursement unit continues to work with FQHCs and RHCs as well as Home Health Agencies in developing new Value Based Prospective Payment Systems.

## ELIGIBILITY

- **Eligibility**
  - Assistant Operations (AOps)
  - Call Center (Maximus)
  - Eligibility - Misc. Contracts
  - Health Access Eligibility & Enrollment
  - Long-Term Care
  - Premium Processing (Wex)
  - Vermont Health Connect

	SFY 2018 Governor's Recommendation			
	# FTEs	Total \$	% of Admin Budget	% of Total Budget
<b>Eligibility</b>	<b>145</b>	<b>\$ 48,272,806</b>	<b>25.48%</b>	<b>3.98%</b>
Assistant Operations (AOps)	16	\$ 1,806,214	0.95%	0.15%
Call Center (Maximus)		\$ 7,504,006	3.96%	0.62%
Eligibility - Misc. Contracts		\$ 1,595,526	0.84%	0.13%
Health Access Eligibility & Enrollment	104	\$ 9,132,124	4.82%	0.75%
Long-Term Care	25	\$ 2,858,990	1.51%	0.24%
Premium Processing (Wex)		\$ 3,940,926	2.08%	0.32%
Vermont Health Connect		\$ 21,435,020	11.31%	1.77%

## ASSISTANT OPERATIONS (AOPS)

This unit 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 subject matter expertise to the training department.

## CALL CENTER (MAXIMUS)

Maximus operates the Customer Support Center (CSC) which handles the incoming calls for Vermont Health Connect, Green Mountain Care (GMC), and the Medicaid Bus Program. Open Monday through Friday from 8am to 8pm, the CSC is the first line of contact for customers who call for assistance with these DVHA programs. Maximus handles roughly 90% of the QHP and GMC calls themselves by either resolving the customer's inquiry or escalating via Service Request to the appropriate department, and transfers the balance to the Healthcare Eligibility & Enrollment Unit when more in-depth eligibility support is required. Maximus is responsible for achieving service level targets such as percentage of calls answered within 24 seconds and abandon rate to ensure that acceptable customer service standards are met consistently.

Maximus also supports other DVHA programs such as the Primary Care Plus Program where their responsibilities include enrollments, dis-enrollments, managed care benefit outreach, tracking dental provider information for the Dental Home initiative, and mailing of initial enrollment packets and notices. They also process outgoing and incoming mail including VHC and GMC applications, forms, and notices, as well as Program Handbooks. Other administrative support tasks include Third Party Liability activities such as creating, closing, and correcting new insurance panels.

In addition to taking incoming calls for the Medicaid Bus Program, Maximus also administers the other aspects of this voucher program. Medicaid Bus Program clerks enter data for all registered appointments and make verification calls to validate the appointments. They mail single use or 10-ride bus tickets to eligible individuals and provide them to walk-in clients.

## HEALTH ACCESS ELIGIBILITY & ENROLLMENT UNIT (HAEEU)

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 units:

**Tier 2 Call Center** - Health care eligibility and customer service representatives determine applicant eligibility for health care programs and provide ongoing customer service to Vermonters enrolled in these programs.

**Tier 3 Call Center** - The Tier 3 call center handles complex case resolution including extensive interaction with customers and ongoing customer service.

**Fair Hearing** - The Fair Hearing Unit provides investigative research and support of eligibility appeals.

**Enrollment** - The enrollment unit monitors the integrity, accuracy, and timeliness of transactions between the State's Case Management System, billing system, QHP issuers, and ACCESS. This unit includes premium processing which researches and addresses customer and reconciliation issues related to premiums and the processing of payments.

**Training/Business Processes** - The training team is responsible for facilitating the learning and professional development of the organization's workforce through proper training. The Business Process team is responsible for the creation and maintenance of business processes and job aids to support day to day operations of Health Care Eligibility and Enrollment Unit.

**Workflow** - The unit 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.

## LONG-TERM CARE

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); and
2. Financial eligibility performed by the workers in the Department for Vermont Health Access (DVHA).

The most current 2015 data for the LTC Program indicates an average LTC Medicaid customer's age is 72 years old. The Vermont LTC average monthly caseload is 6,335. In 2015, approximately 1,210 LTC applications were approved and approximately 571 applications were denied.

The LTC application is usually submitted to DVHA 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.

DVHA workers must evaluate income and resources and review financial statements for the five year "Look Back" period. Transfers made in 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.

The DVHA LTC staff work closely with clients, families, case managers and authorized representatives to help ensure eligible Vermonters can access needed LTC services in a timely manner. Periodic meetings, frequent communications and effective coordination with nursing facility staff, Vermont's Area Agencies on Aging (AAA) staff, DAIL management, Legal Aid, and other parties has helped the LTC Medicaid program to improve the 2016 processing times for LTC applications. Another positive impact on the LTC application

processing times was the January 11, 2016, Health Benefits Eligibility and Enrollment (HBEE) rule change which reduced the verification period back to ten days for the first verification and another ten days for the second verification. The efforts of DVHA LTC staff and the 2016 HBEE rule change have had a direct and positive impact on the 2016 LTC application processing times.

## **VERMONT HEALTH CONNECT (VHC)**

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 Medicaid for Children and Adults (MCA) or private health insurance with financial help, such as federal Advanced Premium Tax Credits (APTCs), Vermont Premium Assistance (VPA), and state and federal cost-sharing reductions (CSR). Vermonters can find information they need online, and those who are uncomfortable with the internet or who want personal assistance selecting a health plan can call the toll-free Customer Support Center or contact a local Assister for in-person assistance.

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

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

## **PREMIUM PROCESSING (WEX)**

Wex Health (previously known as Benaissance) perform payment services administration associated with QHP carrier insurance and Green Mountain Care premiums, state premium subsidy, state cost sharing reduction, and associated terminations and refunds. Additionally, they are responsible for invoicing and noticing required for the QHP and Medicaid populations.

## QUALITY

- **Quality**
  - Blueprint
  - Care Management
  - Coordination of Benefits
  - Managed Care and Compliance
  - Payment Reform
  - Pharmacy
  - Pharmacy Benefits Manager
  - Program Integrity
  - Quality Improvement
  - Vermont Chronic Care Initiative

	SFY 2018 Governor's Recommendation			
	# FTEs	Total \$	% of Admin Budget	% of Total Budget
<b>Quality</b>	<b>90</b>	<b>\$ 21,733,978</b>	<b>11.47%</b>	<b>1.79%</b>
Blueprint	9	\$ 6,031,337	3.18%	0.50%
Care Management		\$ 2,484,577	1.31%	0.20%
Coordination of Benefits	17	\$ 1,698,944	0.90%	0.14%
Managed Care and Compliance	1	\$ 159,433	0.08%	0.01%
Payment Reform	9	\$ 972,958	0.51%	0.08%
Pharmacy	6	\$ 832,417	0.44%	0.07%
Pharmacy Benefits Manager		\$ 3,750,535	1.98%	0.31%
Program Integrity	14	\$ 1,684,307	0.89%	0.14%
Quality Improvement	10	\$ 1,195,956	0.63%	0.10%
Vermont Chronic Care Initiative	24	\$ 2,923,514	1.54%	0.24%



## BLUEPRINT FOR HEALTH

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative transforming Vermont healthcare into an Integrated Health System. The foundation of this transformation is quality improvement inside healthcare organizations and coordination across healthcare and community health services. Participating organizations are incentivized to work together with other health and human services organizations to achieve common goals. The result is comprehensive health services with a focus on population health and prevention.

The Blueprint model includes coaching and support for primary care practices becoming Patient Centered Medical Homes (PCMHs), locally directed community health teams (CHTs) that provide multi-disciplinary support services and connect primary care to community based services, health information systems infrastructure including a statewide clinical registry and analytics that together enable comparative reporting to inform continuous improvement activities, and Community Collaboratives that guide accountable health systems operations.

### *Patient Centered Medical Homes (PCMH)*

Vermont's primary care practices are supported by the Blueprint in the process of achieving and maintaining recognition at Patient Centered Medical Homes (PCMHs) under the National Committee for Quality Assurance (NCQA) standards. Through Community Collaboratives, PCMHs are connected to broader community goals and initiatives.

### *Community Health Teams (CHT)*

Local community partners plan and develop CHTs that provide multidisciplinary support and link primary care to the broader integrated health system. CHT members are functionally integrated with the practices in proportion to the number of patients served by each practice. CHTs include members such as nurse coordinators, health educators, and counselors who provide support and work closely with practices and community-based service providers at the local level. Services include: outreach and population management, cross organization care coordination, brief counseling and close integration with other social and economic support services in the community. In addition to core CHT services, CHT extenders provide targeted services including Support and Services at Home (SASH) for at-risk Medicare members, the Vermont Chronic Care Initiative (VCCI) for high utilizing Medicaid beneficiaries, and the Care Alliance for Opioid Addiction for patients receiving medication assisted therapy for opioid addiction. Extender-type activities build upon, and take advantage of, the existing CHT infrastructure locally.

## CARE MANAGEMENT

In December 2015, DVHA acquired a new Care Management platform. The technology purchased (eQ Health) will continue to allow the VCCI program within the healthcare reform strategy to support Medicaid members with chronic health conditions and/or high utilization of medical services to access clinical appropriate healthcare services. The eQ Care Management platform will be implemented throughout AHS to promote and integrate services, decreasing duplication while allowing a full understanding of the

comprehensive needs of the member across the programs within AHS. This will ensure members have access to services while promoting independent decision making.

## **COORDINATION OF BENEFITS**

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.

## **MANAGED CARE COMPLIANCE**

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

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

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

## **PAYMENT REFORM**

The Payment Reform Team 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 team supports an array of payment reform and integration activities; ensures consistency across multiple program areas; develops fiscal analysis, data analysis, and reimbursement models; engages providers in testing models; and ensures the models encourage higher quality of care and are supported by robust monitoring and evaluation plans. Members of the payment reform team are also responsible for staffing VHCIP multi-stakeholder work groups to facilitate overall program decision-making.

In 2016, Vermont has maintained implementation of commercial and Medicaid ACO Shared Savings Programs. The Vermont Medicaid Shared Savings Program currently boasts over 85,000 members attributed through two participating ACOs (OneCare Vermont and Community Health Accountable Care).

There has also been a focus on planning for implementation of an ACO-based All-Inclusive Population-Based Payment model for Medicaid members expected to begin in 2017. During the next year, the Medicaid payment reform team will continue to support VHCIP activities, focusing on ongoing implementation and evaluation of the ACO SSPs, along with the launch of additional payment reform models to complement initiatives that are already underway.

## PHARMACY

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

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

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

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

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

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

## **PHARMACY BENEFITS MANAGER (CHANGE HEALTH CARE)**

DVHA contracts with Change Healthcare for Pharmacy Benefit Management (PBM) services. Change Healthcare expertise includes clinical management, account management, analytics, pharmacy cost management strategies, claims processing, formulary management, and rebate processing.

Pharmacy Benefit Management (PBM) services support DVHA's drug benefit programs in the following areas:

- Claims processing platform and operational support
- E-prescribing support
- Drug benefit management
- Drug utilization review activities
- Preferred Drug List management
- Drug Prior Authorization programs (manual and automated PA)
- Drug Utilization Review Board coordination
- Federal, State, and Supplemental Rebate management
- Analysis and reporting
- Provider Portal (SFY 2017)
- Pharmacy and Provider Call Center
- High cost/high risk drug management program

The Change Healthcare Helpdesk is staffed and operated out of their South Burlington office location. Staff include Vermont pharmacists and pharmacy technicians and supports all pharmacies and prescribers enrolled in Vermont's pharmacy benefits programs. They are the first point of contact for pharmacy and medical providers with questions, concerns and complaints.

During SFY2016, Change Healthcare processed a total of 2.2 million claims for all of DVHA's pharmacy benefit programs, totaling \$208 million dollars. They also processed over forty thousand prior authorization requests for non-preferred drugs on our Preferred Drug List, of which over nine-thousand were denied. The call center fielded over 50,000 phone calls from pharmacies and prescribers.

In SFY 2017, DVHA and Change Healthcare are working on implementing rolling out a new provider portal that will give pharmacists and prescribers access to a secure, web-based application that offers functionality

tailored to the individual needs of Vermont prescribers and pharmacists, depending on their practice. Features include:

- Pharmacy and member history look-up capabilities
- Electronic PA submission including upload of clinical documentation
- Status updates for submitted PA request

## PROGRAM INTEGRITY

The Program Integrity unit 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 MACU team works with other Medicaid program units to facilitate changes in policies, procedures and program logic to ensure the integrity of the programs. In addition, the MACU team provides education to the Medicaid providers when deficiencies and incorrect billing practices are identified. Cases with credible allegations of Provider fraud are referred to the Office of the Attorney General's Medicaid Fraud and Residential Abuse Unit (MFRAU).

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 O&M team facilitates communication and collaboration between State staff, leadership, Federal and State Auditors and independent auditors including but not limited to CMS, OIG, GAO, and the IRS. This facilitated communication helps ensure accurate, consistent and appropriate communication made in a succinct, informative and professional manner.

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. All other aspects of State assisted program investigations remain the responsibility of the Department for Children and Families (DCF). The Beneficiary Healthcare Fraud team works with DCF to evaluate and investigate allegations received.

## QUALITY IMPROVEMENT

The Quality Improvement unit collaborates with AHS partners to develop a culture of continuous quality improvement. The unit maintains the Vermont Medicaid Quality Plan and Work Plan, that:

- Coordinates quality initiatives throughout DVHA in collaboration with AHS partners, including formal performance improvement projects as required by the Global Commitment to Health Waiver;
- Coordinates the production of standard performance measure sets including *Global Commitment to Health* measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS Adult and

Children’s Core Quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures;

- Is the DVHA lead unit for the Results Based Accountability (RBA) methodology for performance improvement; and produces the DVHA RBA Scorecards.

The unit is working in collaboration with the Vermont Department of Health on cancer screening improvement projects and on a new formal substance use disorder Performance Improvement Project (PIP). The Quality unit staff also led and participated in the medical record review (MRR) process in 2016 that allows us to produce more accurate performance data for measures requiring a hybrid of data collection methodologies making use of both claim and medical records. The DVHA Quality unit leads the Agency Improvement Model (AIM) and supports DVHA staff with process improvement.

The unit contains the Clinical Utilization Review (UR) team 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.

In SFY 2016, the UR team authorized and performed concurrent reviews for 417 child/adolescent psychiatric inpatient admissions, 681 withdrawal management inpatient admissions, 1,220 adult psychiatric inpatient admissions and 2,331 residential treatment admissions. In addition, the Autism Specialist within the Quality Unit prior authorized applied behavior analysis services for 56 members. The team continues to work closely with the Department of Mental Health, the Vermont Department of Health’s Division of Alcohol and Drug Abuse Program, the Care Alliance for Opioid Addiction (also referred to as “Hub and Spoke”), the Vermont Chronic Care Initiative, and the DVHA Pharmacy and Clinical Operations units.

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

## **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; 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.

Management of behavioral health conditions including depression and substance use/abuse 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 (historically, the top 5%). Helping members to manage their depression is indicated prior to addressing any other chronic healthcare conditions.

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

A major initiative of the VCCI and within AHS over the past year has been the work supporting the launch of the new Enterprise MMIS/Care Management system. This Medicaid resource is supported through funding made available under the Affordable Care Act (ACA) with the goal of the system certified by CMS with resulting 75/25 funding.

The VCCI is the first unit within DVHA to go live in the new Enterprise Care Management system, with additional features being added throughout SFY 2017, concurrent with the addition of programs in AHS sister Departments (Children's Integrated Services within DCF; and Children with Special Health Needs, within VDH). Functionality will be expanded to include consumer and provider portals for secure data sharing based on permissions. The goal is for a single, evidence based, shared plan of care (POC) to be available for Medicaid members in case management at the AHS and community level; and to track service delivery toward clinical improvement and cost benefit across the system of care.

VCCI's extensive collaboration with the legacy and new vendor toward launching this effort included data transition from the legacy system to the new Enterprise Care Management system; as well as operational restructuring within the VCCI to assure the Enterprise was staffed by VCCI 'subject matter experts'; and that VCCI clinical field staff were assigned to 'user acceptance testing'. Concurrently, the VCCI had a reduction in caseload which is attributable to the loss of six FTE nurse case managers from the legacy vendor, and to the reduced caseload associated with requisite staff training and the learning curve of our team for successful onboarding of the new technology solution.

In SFY 2017, VCCI anticipates the benefits derived from a planned bio-medical data feed into the Enterprise Care Management system from the VITL/HIE for all Medicaid members, which will significantly enhance the ability to effectively case manage members with consideration of their clinical profile and adherence to evidence based treatment.

An additional opportunity for the Enterprise is the capacity to evaluate the return on investment (ROI) not only of the VCCI, but for anticipated 'next generation ACOs', as the Enterprise system utilizes an evidence based predictive modeling application (Johns Hopkins predictive model) that looks at predictive and actual costs over time. The system affords the State the opportunity to eventually profile ACO providers and members predicted versus actual costs, thus informing ACO performance as well as the actuarial base for future capitated payments.

## PROJECT

AHS' 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 (currently performed in VHC and in ACCESS but will transition to our new enterprise) and claims processing (currently performed by a vendor though certain functions may transition to our new enterprise in the future).

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: Integrated Eligibility and Enrollment (IE) program, Medicaid Management Information System (MMIS) program and the Health Information Exchange/Health Information Technology (HIE/HIT) program.

It is important to note that while these projects represent a significant portion of the DVHA administrative budget, these investments to infrastructure are predominately funded with either 90% or 100% federal funding.

- **Project**
  - EHRIP
  - HIT/HIE
  - MMIS
  - MMIS/HSE/HIT Staff
  - HSE Platform
  - IE: Healthcare Projects

	SFY 2018 Governor's Recommendation			
	# FTEs	Total \$	% of Admin Budget	% of Total Budget
<b>Project</b>	<b>15</b>	<b>\$ 91,198,799</b>	<b>48.14%</b>	<b>7.52%</b>
EHRIP		\$ 10,300,000	5.44%	0.85%
HIT/HIE		\$ 10,552,176	5.57%	0.87%
MMIS		\$ 44,206,081	23.34%	3.65%
MMIS/HSE/HIT Staff	15	\$ 1,728,628	0.91%	0.14%
IE: Healthcare Projects		\$ 24,411,914	12.89%	2.01%



## **ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM (EHRIP)**

The Electronic Health Record Incentive Payment 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 electronic health records (EHRs). The funds used to support the incentive payment are 100% federal.

The Medicaid 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 potential benefits of EHRs depend on how they are used. Meaningful Use is the set of standards defined by CMS that governs the use of EHRs by setting specific criteria for eligible providers and hospitals.

Program Progress:

- The Vermont Medicaid EHRIP has paid over \$49 million since the program began in October 2010.
- 1,030 individual clinicians and 16 individual hospitals have received at least one payment from the VT Medicaid EHRIP.
- Vermont Medicaid EHRIP payments are scheduled to be issued through Program Year 2021.
- Audits of incentive payments are a required element of the program. Approximately 10% of clinicians and 50% of hospitals receiving an EHR incentive payment each program year are selected for audit.

## **HEALTH INFORMATION TECHNOLOGY/ HEALTH INFORMATION EXCHANGE**

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 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, 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.

## **VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM**

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. DVHA has started transformation of the MMIS environment with the implementation of Pharmacy Benefit Management and

Care Management modules. Staff continue to work with CMS on the planning of future modules (claims processing, program integrity, provider management, etc.) in conjunction with HSE work to optimize capabilities across the Agency. This maximizes our investments and continues to assist the Agency transformation towards that person-centric and data-driven environment.

## **INTEGRATED ELIGIBILITY HEALTHCARE PROJECTS**

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.

**All Payer Model (APM):**

In an agreement with the Center for Medicare and Medicaid Innovation (CMMI), the State of Vermont seeks to transform Vermont's healthcare system under the All Payer Model from one that rewards fee-for-service, quantity-driven care to one that rewards quality-based care; focusing on keeping Vermonters healthy. An All-Payer Model will build on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that shift risk on to health care providers and that are aligned across all payers encourage collaboration across the care continuum and can result in better health outcomes for Vermonters. Through the legal authority of the Green Mountain Care Board (GMCB) and facilitated by an All-Payer Accountable Care Organization (ACO) Model Agreement with CMMI, the State can enable the alignment of commercial payers, Medicaid, and Medicare in an Advanced Alternative Payment Model. Specifically, the State will apply the Next Generation ACO payment model, with modifications, and subsequently, a Vermont Medicare ACO Initiative model across all payers. The GMCB will set participating ACO rates on an all-payer basis to enable the model. The focus on the ACO and existing CMS ACO programming, along with Vermont's strong stakeholder network, SIM investments, and the current SSP program, is a timely and realistic evolution of Vermont's multi-payer reform. Eventually, an integrated ACO and All-Payer Model in Vermont could attract and involve the vast majority of people, payers, and providers.

After a period of negotiation and public process, agreement on terms was reached in September 2016 between the State of Vermont and CMMI. Vermont distributed the draft agreement and companion documents to a broad group of stakeholders on September 28th and held a series of GMCB meetings and joint public forums with the Administration to explain the draft agreement and gather public comment in October. The agreement was signed on October 27, 2016. Staff and federal partners also worked together to ensure alignment between the All-Payer Model and Vermont's 1115 Medicaid waiver renewal, also finalized in late October. The heart of the agreement is to keep healthcare costs below the growth of the general economy. Along with spending targets are quality targets designed to ensure Vermonters not only spend less but see better health outcomes. The three goals included in this proposal are: increasing access to primary care, reducing the prevalence of and improving the management of chronic diseases, and addressing the substance abuse epidemic. Under the All Payer Model, Vermonters will continue to see the doctor or health care provider of their choice. Vermonters on Medicare and Medicaid will see no change to their benefits.

**Premium assistance for Medicare supplemental insurance for dual eligible members:**

The legislative request to research the use of State or Global Commitment funds to purchase Medicare supplemental insurance plans for individuals eligible for both Medicare and Medicaid was concluded by the determination that Medicaid payments for Medicare supplemental insurance would exceed any savings. The BCBSVT Monthly Rate for individuals is \$157.48, with a projected savings of only \$124.91 per month.

### **Ambulance Rate Increase:**

Prior to July 2016, ambulance rates were unchanged since 2008. Originally, the fixed fee schedule for ambulance services was set at 46% percent of Medicare rates. Medicaid rates remained unchanged as Medicare rates increased by 3%. Low rates made it difficult for providers to cover costs, particularly if Medicaid members were a large segment of an ambulance providers' customer base. Medicaid is dependent on ambulance providers to deliver critical services to its members.

In SFY 2017, DVHA increased mileage and base ambulance services to 80% of Medicare's rate and implemented a provider tax on in-state ambulance services per legislative intent. Reimbursement for supplies was not covered in the rate increase as these are typically included within the Medicare payment and Medicaid does reimburse these separately.

### **Ambulance HCPCS Codes with Rate Increase:**

A0425 - Ground mileage, per statute mile

A0426 - Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)

A0427 - Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 – emergency)

A0428 - Ambulance service, basic life support, nonemergency transport, (BLS)

A0429 - Ambulance service, basic life support, emergency transport (BLS, emergency)

A0434 - Specialty care transport (SCT)

### **Data Sharing for Enhanced Coordination of Benefits:**

The Deficit Reduction Act (DRA) strengthened the States' ability to identify third party resources that are legally required to pay claims as primary. DVHA has, in the past year, amended a Vermont State Statute requiring health insurers to provide data to Vermont Medicaid regarding enrollees in private coverage, dates of coverage, and covered benefits. This brings health insurance carriers offering coverage in the state of Vermont into compliance with current federal law.

The contents of these data files will allow DVHA to determine whether members have private insurance that should pay for medical claims instead of Medicaid and allow for updates to our database so that Medicaid will remain the payer of last resort.

DVHA's Coordination of Benefits unit had been working with Tricare and UnitedHealthcare's data before this strengthened statute was passed. DVHA and Enterprise Services, have been engaged with three additional carriers, including BCBS of Vermont to begin data matching.

## MEASUREMENTS AND OUTCOMES

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

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

## BLUEPRINT FOR HEALTH REPORT CARD

### Program Statement:

The Vermont Blueprint for Health is transforming the healthcare and integrated health systems delivery and payment model, consisting of:

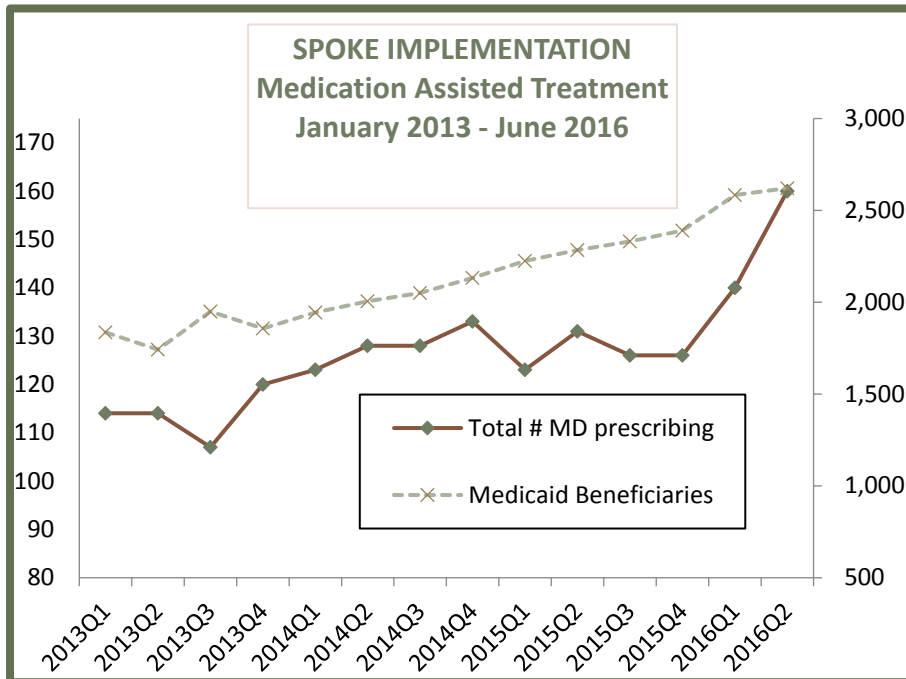
- A steady increase of primary care practices throughout the state that are recognized as Patient Centered Medical Homes (PCMHs) by the National Committee for Quality Assurance (NCQA) currently totaling 128 practices
- Comprehensive evidence-based self-management programs
- Multi-disciplinary core Community Health Teams (CHTs) in each of the state's 14 health service areas, additional specialized care coordinators to support the PCMHs and their patients
- All-insurer payment reforms that support PCMHs and CHTs
- Implementation of health information systems, analytics and a multi-faceted evaluation system to appraise the program's impact
- A Learning Health System that supports quality improvement

### Outcomes:

- The Blueprint for Health's intensive program evaluation includes results published in peer-reviewed journals including Population Health Management. The article "Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care" demonstrates that patients participating in the Blueprint, by receiving care at one of Vermont's PCMHs, incur less healthcare spending than non-participants.
- At the same time that their healthcare expenditures decreased, Medicaid patients receiving the majority of their care at a Blueprint PCMH saw a corresponding increase in expenditures for dental, social, and community-based support services, suggesting that PCMHs – likely through their Community Health Teams – are better at connecting patients with non-medical community and social supports.




























### What's Next?

- Blueprint and ACO workgroups come together with homecare, mental health, and other service providers in Community Collaboratives that deliver shared governance aimed at improving population health, healthcare utilization, and quality.
- Continued advancement of analytics and reporting in collaboration with ACOs to provide comparative information that can guide improvement in Vermont's health system. A key component is the Statewide Clinical Registry and analytics where claims and clinical data are combined and used to produce profiles that span insurers and health systems, offering community-level outcomes reporting in order to spur community-based solutions.
- Performance payments to Blueprint PCMHs based on community level outcomes on ACO quality measures. Performance payments are adjusted to incentivize communities to work together to improve utilization, care quality, and population health.
- Women's Health Initiative introducing women's health providers – OB/GYN and Family Planning – to the Blueprint.



Healthcare expenditures for patients receiving the majority of their care at Blueprint PCMHs continue to diverge. By year three, expenditures for patients in PCMHs are \$492 less per person than for those receiving care in non-PCMHs, primarily because of fewer hospital visits.

# BLUEPRINT FOR HEALTH SCORECARD

 <b>Improve Access to Quality Healthcare for all Vermonters</b>		Time Period	Actual Value	Current Trend	Baseline % Change
 <b>Blueprint for Health</b>		Time Period	Actual Value	Current Trend	Baseline % Change
<b>Budget Information</b>					
<b>Total DVHA Program Budget SFY 2018: \$897,820</b>					
<b>What We Do</b>					
<p>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.</p> <p>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.</p>					
<b>Who We Serve</b>					
The Vermont Blueprint for Health serves all Vermonters.					
<b>How We Impact</b>					
<p>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.</p> <p>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.</p>					
	# of Patient Centered Medical Homes	2015	126	 6	1700% 
	Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)	2014	1:2.9	 0	0% 
	Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)	2014	1:0.9	 0	0% 
	Blueprint Return on Investment (ROI) - All Payers	2014	1:5.8	 0	0% 
 <b>Blueprint for Health</b>		Time Period	Actual Value	Current Trend	Baseline % Change
	# of Patient Centered Medical Homes	2015	126	 6	1700% 
	Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)	2014	1:2.9	 0	0% 
	Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)	2014	1:0.9	 0	0% 
	Blueprint Return on Investment (ROI) - All Payers	2014	1:5.8	 0	0% 

## COORDINATION OF BENEFITS (COB) REPORT CARD

### Program Statement:

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

### Outcomes:

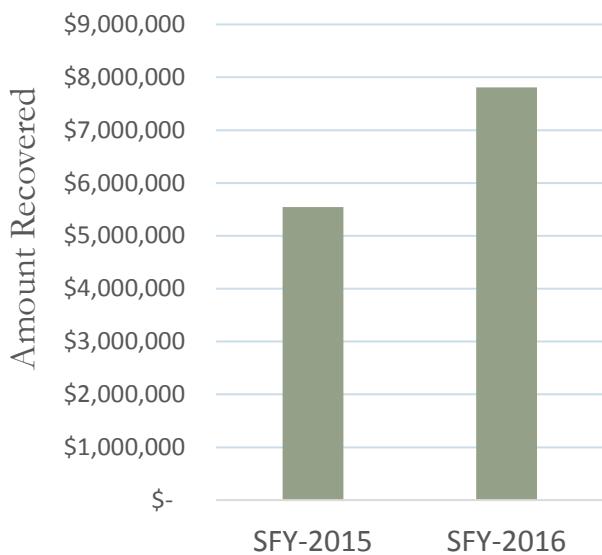
COB Medicaid Recovery totaled \$7,808,500 in SFY 2016, the result of various recovery and recoupment practices.

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

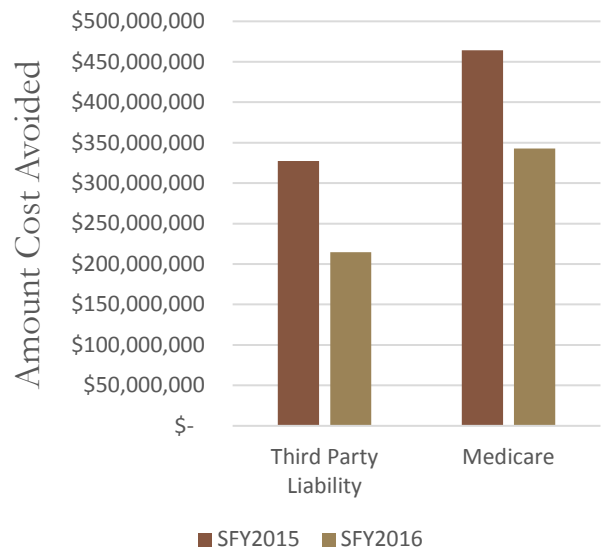
### What's Next?

1. The COB unit has strengthened Medicaid statutes and rules to data-match with health insurance companies. This will allow COB to start the process of data matching with the 3 largest insurance companies in Vermont in SFY 2018
2. COB will also continue to work with CMS regarding Medicare Dual Eligible beneficiaries.
3. These efforts will help increase cost avoidance and recoveries to ensure that Medicaid is the payer of last resort.

### COB MEDICAID RECOVERY



### COST AVOIDANCE





## PROGRAM INTEGRITY (PI) REPORT CARD

### Program Statement:

The Program Integrity Unit's Medicaid Audit & Compliance Unit (MACU) staff work to ensure Medicaid services are medically necessary, coded, billed, and paid in accordance with federal and state Medicaid rules, regulations, and statutes. Oversight & Monitoring (O&M) staff help ensure the effectiveness and efficiency of departmental controls, operational processes, regulatory compliance, and financial and performance reporting are in line with applicable laws and regulations. Medicaid Beneficiary Fraud staff investigate, detect, and prevent Healthcare eligibility and enrollment fraud in Vermont's Medicaid Program.

### Outcomes:

MACU made significant strides in detecting, investigating, and preventing fraud, waste and abuse in the Vermont Medicaid program, including the implementation of case triage in order to most effectively utilize staffing resources. A close collaborative relationship with the Medicaid Fraud and Residential Abuse Unit (MFRAU) resulted in successful civil settlements under the State's False Claims Act, and a provider being placed under a Corporate Integrity Agreement to ensure ongoing compliance and submission of correct claims. To date, the majority of the MACU staff have achieved the Medicaid Integrity Institute's (MII) national certification for the Certified Program Integrity Professional (CPIP).

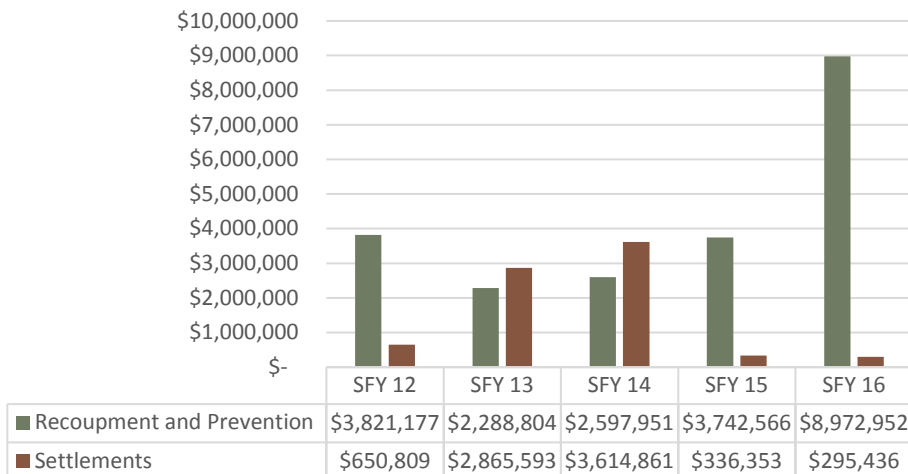
O&M made significant strides in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. O&M is also working to collaborate on the audit response process with our partners at AHS and our sister Departments.

Beneficiary Healthcare Eligibility and Enrollment Fraud has joined DVHA as of July 2016, as a result of the DVHA/HAEU merger and includes Medicaid as well as the state-based health exchange. This unit is in the early stages of forming and will work collaboratively with the Department for Children and Families (DCF), as DCF remains responsible for all non-healthcare eligibility fraud investigations.

### What's Next?

1. Continued collaboration with the Medicaid Fraud Residential & Abuse Unit (MFRAU), to identify and refer appropriate cases for potential civil or criminal prosecution.
2. Evaluation of Vermont Medicaid rules, state plan and coverage criteria, including how those rules are managed within the MMIS, to identify and correct any potential vulnerabilities and deficiencies.
3. Establish and refine business processes and procedures for the Beneficiary Healthcare Eligibility and Enrollment Fraud group within PI Unit.

### Program Integrity Recovery and Cost Prevention



Global settlements are typically national lawsuits which may involve medical or product liability.

## VERMONT CHRONIC CARE INITIATIVE (VCCI) REPORT CARD

### Program Statement:

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

**Outcomes:** VCCI has transitioned from the legacy care management provider into the new Enterprise Care Management system in mid SFY 2016. Resultantly, VCCI is in the process of resetting the 'baseline' and methodology for clinical and financial benchmarks.

The new system utilizes the evidence based Johns Hopkins predictive modeling software that will be utilized for population selection and for predicted vs actual cost and resulting cost savings (ROI); along with clinical and performance measures for individual and population based approached utilized by the VCCI for care management. Data for SFY 2016 are therefore not yet available.

In SFY 2014 (the last year financial data is available due to the sun-setting of our vendor prior to the six-month claim run out) the VCCI documented \$30.5 million in net savings over anticipated cost among the eligible top 5% utilizers, who account for roughly 39% of Medicaid expenditures. VCCI/DVHA anticipates continued tracking of adherence to evidence-based clinical guidelines as well as ambulatory care sensitive hospital utilization on a go forward basis (i.e. ED, IP and 30-day admission rates). Data from SFY 2015 demonstrates a reduction in ambulatory care sensitive (ACS) hospital inpatient visit rate (IP) of 16% and 30-day IP readmission rate of 44% for VCCI eligible members, as compared to 2014. In this same time-frame however, there was an increase in ACS Emergency Department admissions (ED) of 25% which is likely attributable to PCP shortages and related delay in access for Medicaid member, including practices closed to Medicaid.

### What's Next?

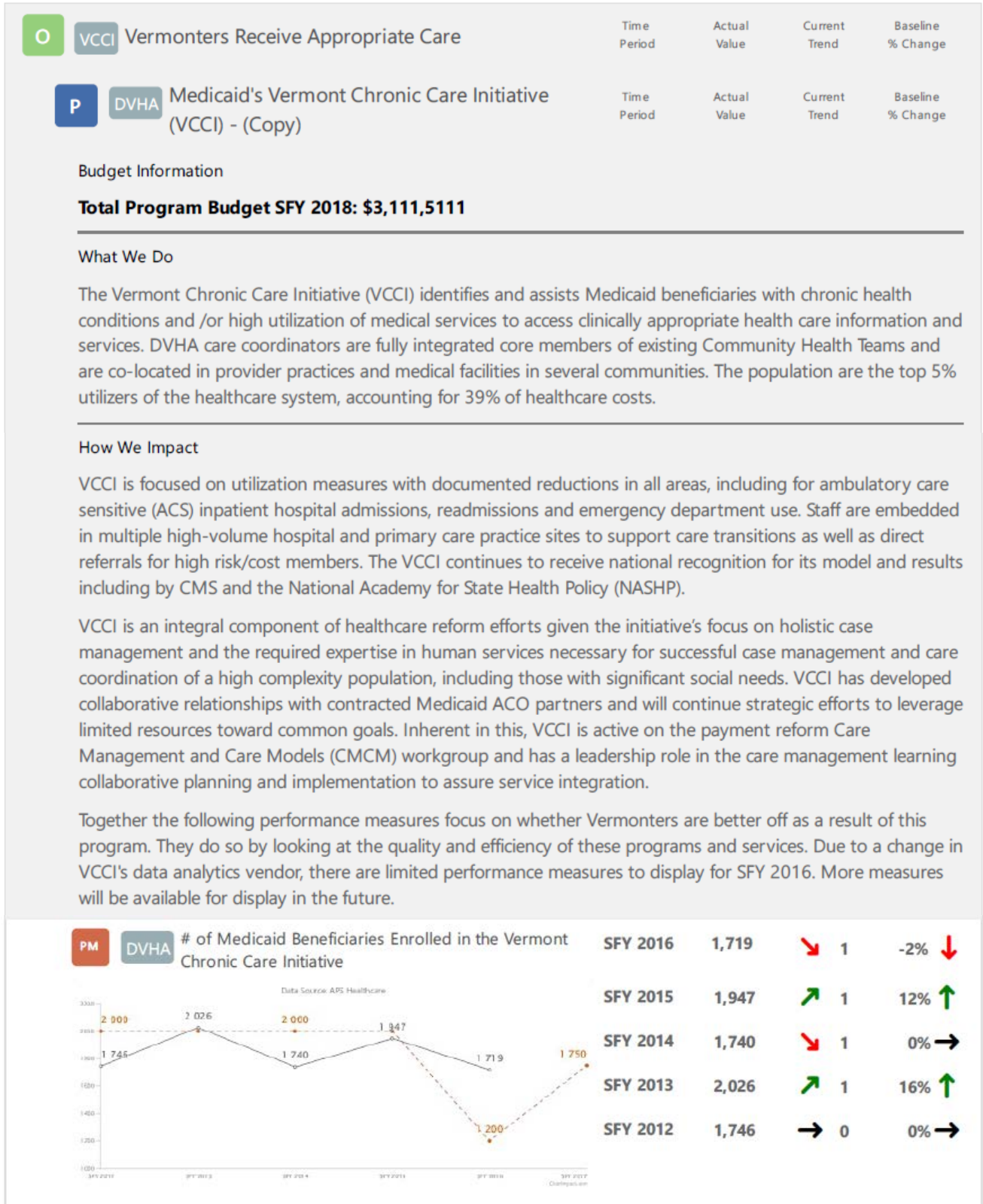
1. VCCI continues to be an integral component of healthcare reform efforts given the initiative's focus on holistic case management and the required expertise in human services necessary for successful case management and care coordination of a high complexity population, including those with significant social support needs and associated cost reduction/containment efforts.
2. The Unit has taken a leadership role in the enterprise level MMIS/Care Management system design and development and went live in the new environment December 2015. Additional features and sister Department programs will continue to be added in 2017 and 2018.
3. An interface with the VITL HIE is anticipated for all Medicaid members in SFY 2017, which will significantly enhance system capacity for case management.
4. VCCI staff collaborate with community and provider partners, Medicaid ACOs and Community Health Team (CHT) members to a single 'lead' case manager; and are active in the community learning collaboratives supported by the VHCIP efforts.

### VCCI Utilization & Percentage Change, 2014-2015



## VERMONT CHRONIC CARE INITIATIVE (VCCI) SCORECARD

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



### Program Statement:

DVHA Quality Improvement Unit (QI) strives to improve the quality of care to Medicaid members by identifying and monitoring quality measures and performance improvement projects, performing utilization management and improving internal processes.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on dimensions of care and service.

Under the terms of the Global Commitment to Health Waiver, DVHA reports on a core set of HEDIS measures. These measures represent a wide range of health conditions that DVHA and the Agency of Human Services have determined are important to Vermonters.

### What's Next?

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

### Outcomes:

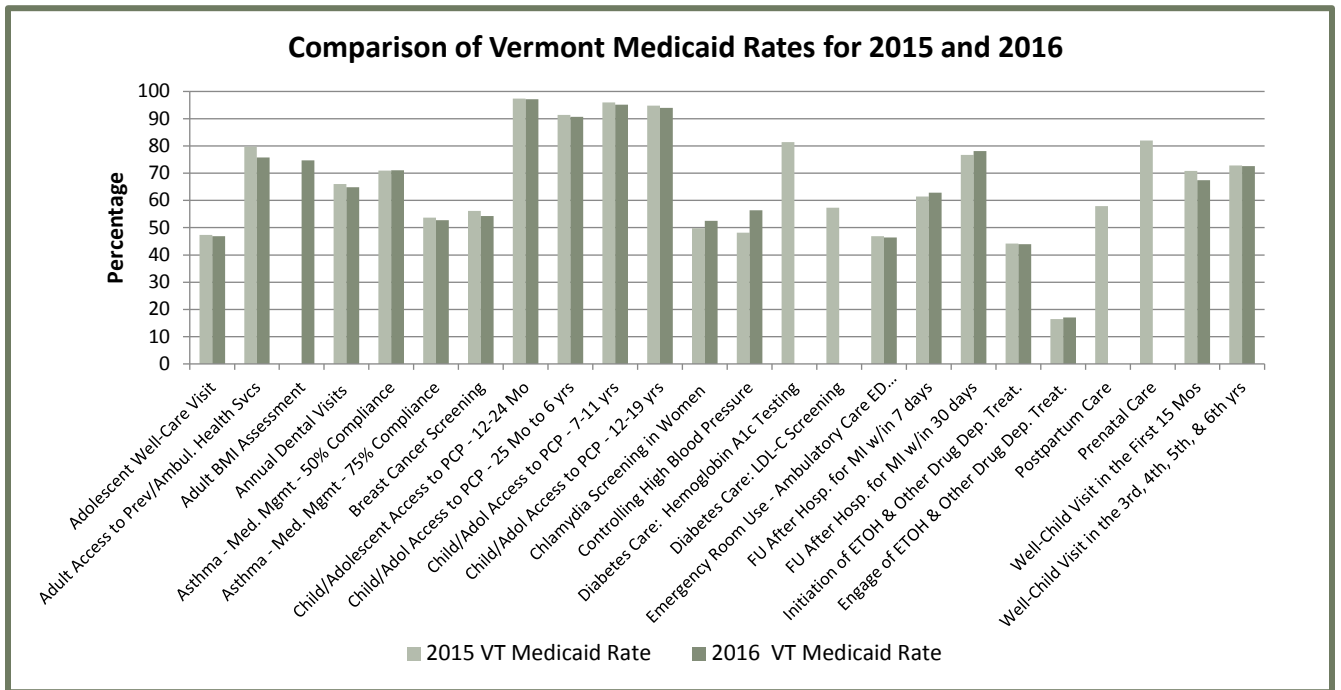
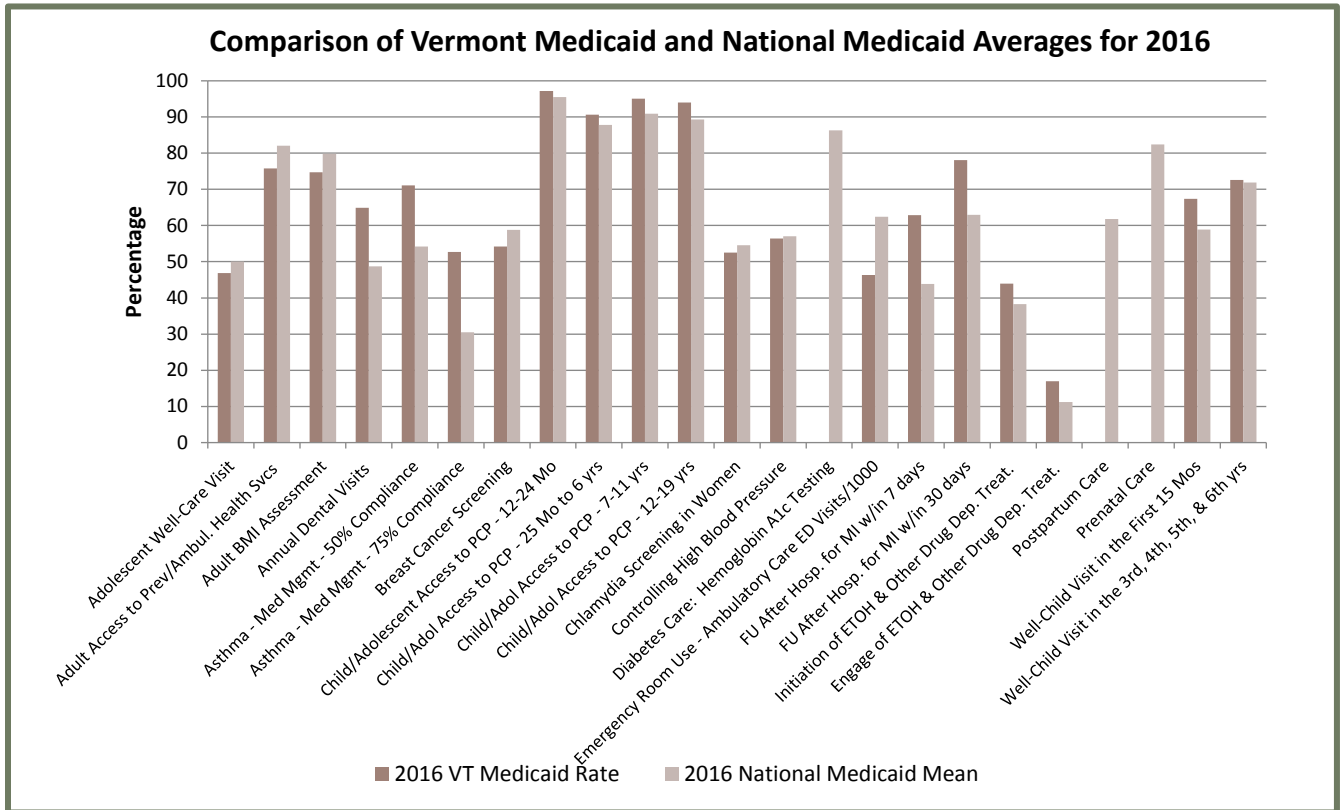
The QI Unit works closely with the Data Unit to ensure the internal capacity to produce valid performance measure results. DVHA then uses a vendor certified by the National Committee for Quality Assurance (NCQA) to calculate the measures annually.

The first chart, (Comparison of Vermont Medicaid and National Medicaid Averages for 2016), compares Vermont Medicaid's performance on this core set of Global Commitment to Health measures against the national mean for other state Medicaid plans for 2016. It shows that Vermont's rates are higher than or comparable to the national mean on most measures. This means, as an example: of Vermont Medicaid enrollees who are recommended to receive an Adolescent Well-Care visit, approximately 47% actually do, which is comparable to the national average.

The *Initiation and Engagement in Alcohol and Other Substance Dependent Treatment* measure is one of the lowest performing measures in the set, both for Vermont and nationally. Based on this data along with Vermont's growing and well documented opioid addiction problem, DVHA is involved in multi-faceted improvement initiatives. The Hub and Spoke, is one such initiative. DVHA is also currently working on a performance improvement project related to the treatment of substance use disorders.

The next chart (Comparison of Vermont Medicaid Rates for 2015 and 2016), shows Vermont Medicaid's performance on these measures in 2015 compared against performance in 2016. It displays steady performance across most of these measures. An area of improvement worth noting can be seen in the Controlling High Blood Pressure measure. This is a hybrid measure, meaning that the rate is calculated using information from both claims and medical record review. We see an increase of more than eight percentage points between 2015 and 2016. This has been an area of focus for care management teams such as the DVHA's Vermont Chronic Care initiative, as high blood pressure contributes to many chronic conditions.

# QUALITY IMPROVEMENT REPORT CARD



Note: Some measures do not have data reported for both years. This may be due to measures being retired from year to year or to lack of reliable data. For example, the DVHA was able to perform the medical record review required to report on Diabetes and Prenatal/Postpartum Care in 2015, but not in 2016.

## MENTAL HEALTH AND SUBSTANCE USE DISORDER REPORT CARD

### Program Statement:

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

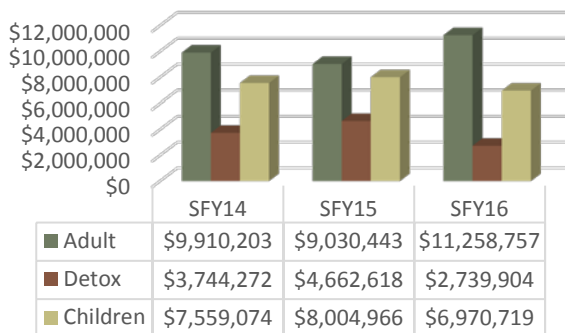
### Outcomes:

The State continues to experience a number of challenges that impact the ability of the Vermont Medicaid utilization management program to successfully bend the cost curve for inpatient mental health and substance use disorder costs. The ongoing problem of opiate addiction and resulting need for services has led to inpatient level of care being used in place of medically necessary lower levels of care, when these services are not available when a Medicaid member seeks out treatment. In addition, the need for mental health treatment and services in the community outpaces the availability of those services and again leads to an over-reliance on inpatient hospitalization. However, without the utilization management program, history has indicated that costs and average lengths of stay would have grown even more exponentially.

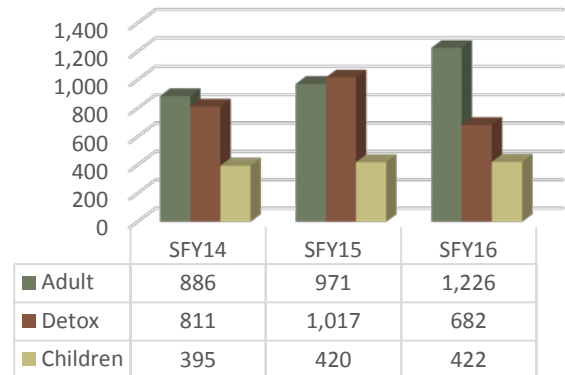
### What's Next?

1. The Quality unit will continue to perform utilization review activities on all inpatient stays on psychiatric floors to ensure Medicaid is only paying for medically necessary services.
2. The Quality unit is working with HPE staff to improve the edits and PA process in the MMIS system to ensure that only inpatient services on psychiatric floors require PA and that claims are paid correctly and timely according to what was authorized.

**SFY 14-16 DVHA Total Claims Paid for Inpatient Hospitalizations as of 01/04/17**



**SFY 14-16 DVHA Total # Inpatient Hospitalizations**



## VERMONT MENTAL HEALTH AND SUBSTANCE USE DISORDER SCORECARD

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

			Time Period	Actual Value	Current Trend	Baseline % Change
<span style="color: green; font-weight: bold;">O</span>	DVHA	<b>Vermonters Receive Appropriate Care</b>				
<span style="color: blue; font-weight: bold;">P</span>	DVHA	<b>Medicaid Inpatient Psychiatric and Detoxification Utilization</b>				
<b>Budget Information</b>						
<b>Total DVHA Program Budget SFY 2018: \$987,810</b>						
<span style="color: red; font-weight: bold;">PM</span>	DVHA	# of Children's Mental Health Inpatient Admissions/1000 members	SFY 2016	6.16	↘ 1	-1% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	# of Adult Mental Health Inpatient Admissions/1000 members	SFY 2016	9.98	↗ 1	5% ↑
<span style="color: red; font-weight: bold;">PM</span>	DVHA	# of Detoxification Admissions/1000 members	SFY 2016	5.55	↘ 1	-36% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Average Length of Stay - Children's Mental Health Inpatient Admissions	SFY 2016	13.40days	↘ 2	-12% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Average Length of Stay - Adult Mental Health Inpatient Admissions	SFY 2016	6.90days	↘ 2	-12% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Average Length of Stay - Detox. Admissions	SFY 2016	4.60days	↘ 2	-4% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Paid Claims - Children's Mental Health Inpatient Admissions	SFY 2016	\$5.80Mil	↘ 1	-23% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Paid Claims - Adult Mental Health Inpatient Admissions	SFY 2016	\$9.48Mil	↗ 1	-4% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Paid Claims - Detox. Admissions	SFY 2016	\$2.44Mil	↘ 1	-35% ↓
<span style="color: blue; font-weight: bold;">P</span>	DVHA	<b>Medicaid Inpatient Psychiatric and Detoxification Utilization</b>				
<span style="color: red; font-weight: bold;">PM</span>	DVHA	# of Children's Mental Health Inpatient Admissions/1000 members	SFY 2016	6.16	↘ 1	-1% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	# of Adult Mental Health Inpatient Admissions/1000 members	SFY 2016	9.98	↗ 1	5% ↑
<span style="color: red; font-weight: bold;">PM</span>	DVHA	# of Detoxification Admissions/1000 members	SFY 2016	5.55	↘ 1	-36% ↓
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<span style="color: red; font-weight: bold;">PM</span>	DVHA	Average Length of Stay - Adult Mental Health Inpatient Admissions	SFY 2016	6.90days	↘ 2	-12% ↓
<span style="color: red; font-weight: bold;">PM</span>	DVHA	Average Length of Stay - Detox. Admissions	SFY 2016	4.60days	↘ 2	-4% ↓

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 and projections for these different programs.

# Green Mountain Care

<b>Adult Medicaid</b> <ul style="list-style-type: none"> <li>• Low-cost or free health coverage for adults</li> </ul>	<b>Dr Dynasaur</b> <ul style="list-style-type: none"> <li>• Provides low-cost or free health coverage for children, teenagers under age 19 and pregnant women.</li> <li>• Medicaid &amp; CHIP populations</li> </ul>	<b>Long-Term Care</b> <ul style="list-style-type: none"> <li>• Vermont's Long-Term Care Medicaid program helps eligible Vermonters pay for long-term care services in the setting of their choice.</li> </ul>	<b>Prescription Assistance</b> <ul style="list-style-type: none"> <li>• Vermont offers prescription assistance to uninsured Vermonters and those enrolled in Medicare. Eligibility is based on income, disability status and age.</li> </ul>	<b>Healthy Vermonters</b> <ul style="list-style-type: none"> <li>• This program provides a pharmacy discount to eligible Vermonters, helping members purchase prescription drugs necessary to maintain their health and prevent unnecessary health problems.</li> </ul>	<b>Premium Assistance &amp; Cost Sharing Reductions</b> <ul style="list-style-type: none"> <li>• Financial subsidies towards premiums and cost sharing for members whose income is &lt; 300%.</li> </ul>
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**Adult Programs**

Medicaid programs for adults provide low-cost or free coverage for low-income parents, childless adults, pregnant individuals, caretaker relatives, people who are blind or disabled, and those ages 65 or older. Eligibility is based on various factors including income, and - in certain cases - resources (e.g., cash, bank accounts, etc.).

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



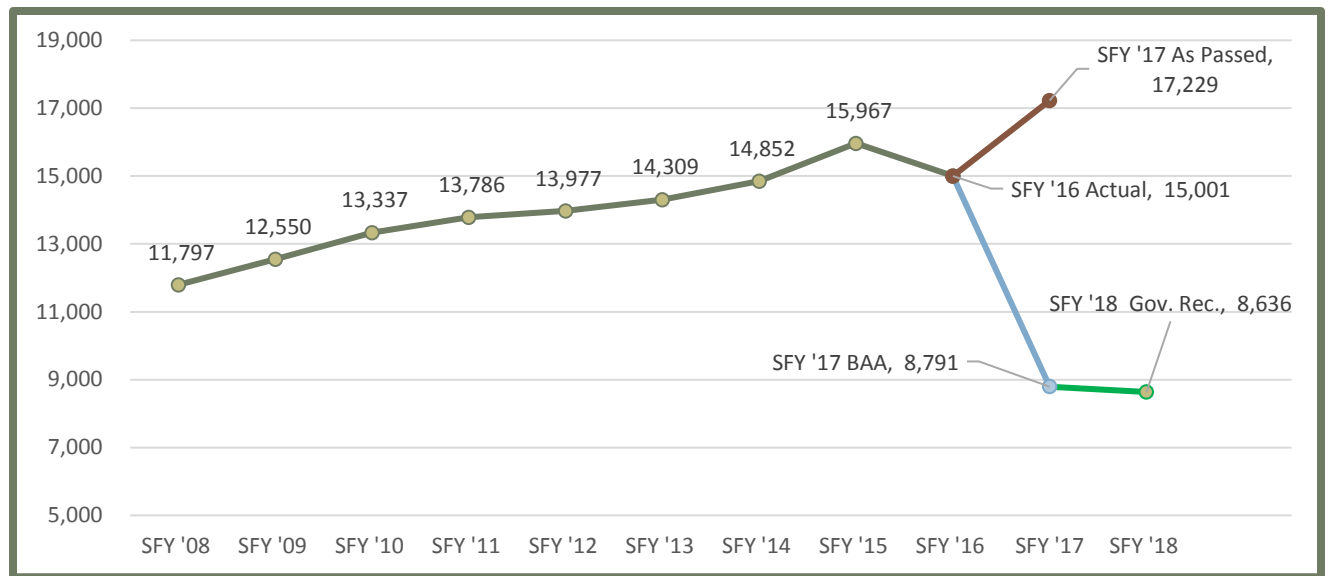
## Aged, Blind, or Disabled (ABD) and/or Medically Needy Adults

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

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

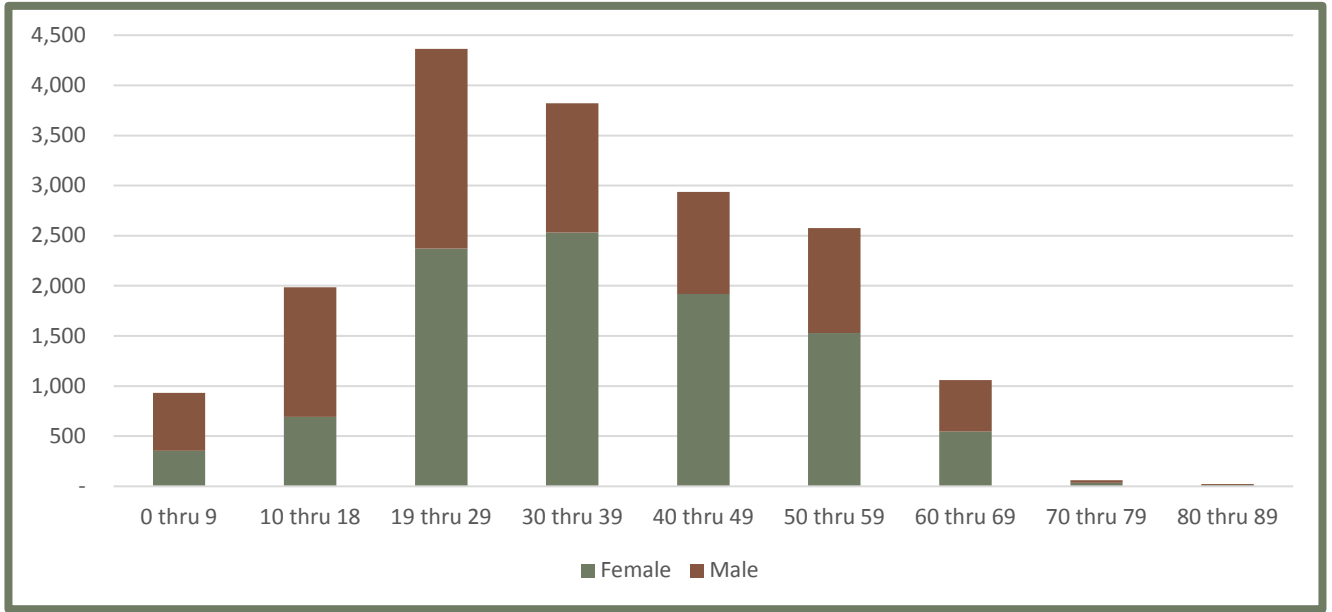
Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	14,852	\$108,329,783	\$ 607.82	\$ 188,835,438	\$ 1,059.52
SFY '15 Actual	15,967	\$102,508,327	\$ 535.01	\$ 185,718,082	\$ 969.31
SFY '16 Actual	15,001	\$ 99,308,972	\$ 551.69	\$ 182,970,086	\$ 1,016.46
SFY '17 As Passed	17,229	\$105,981,420	\$ 512.62	\$ 186,952,635	\$ 904.26
SFY '17 BAA	8,791	\$ 70,363,336	\$ 666.98	\$ 158,618,312	\$ 1,503.56
SFY '18 Gov. Rec.	8,636	\$ 74,195,101	\$ 715.91	\$ 163,972,304	\$ 1,582.17

### ABD Caseload Comparison by State Budget Cycle

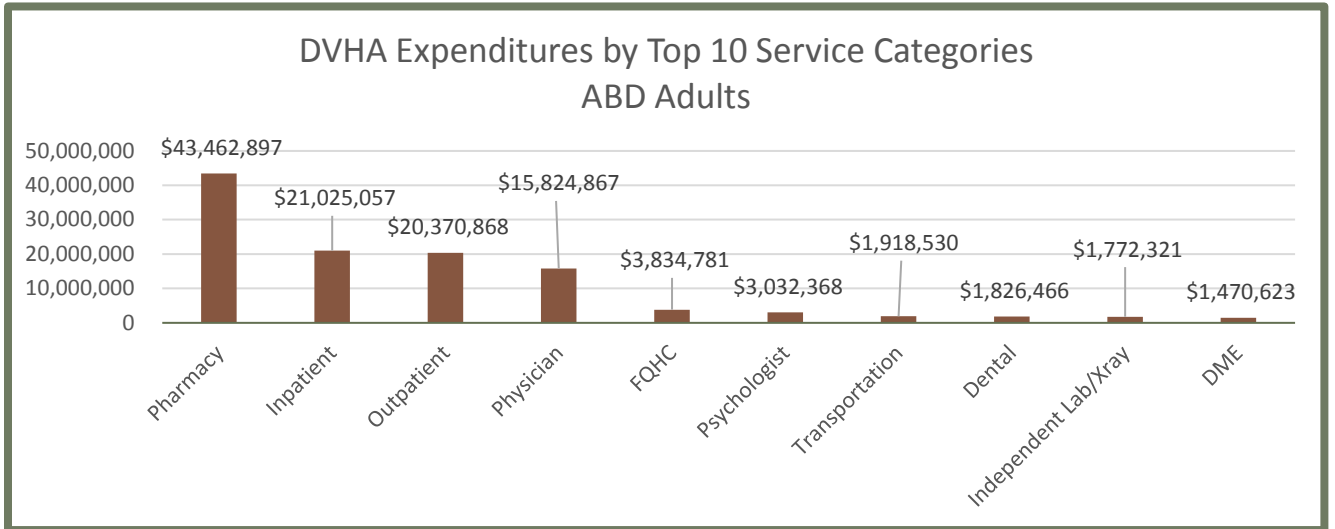


The eligibility and enrollment redetermination activities have resulted in higher PMPM expectations for SFY 2018 as the remaining population tends to have more health care needs.

### ABD Adult SFY 2016 Average Enrollment Breakout by Age and Gender



For adults with disabilities, pharmacy, outpatient, inpatient, and professional services accounted for the majority of the \$99,308,972 total expenditure for ABD Adults.



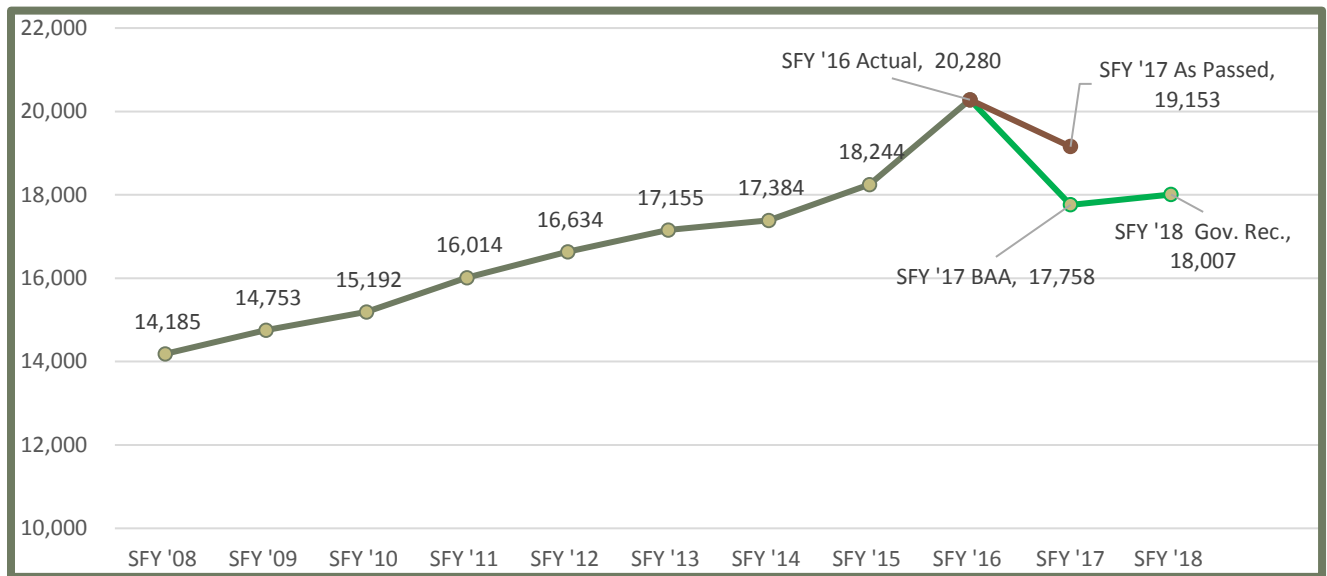
## Dual Eligible

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

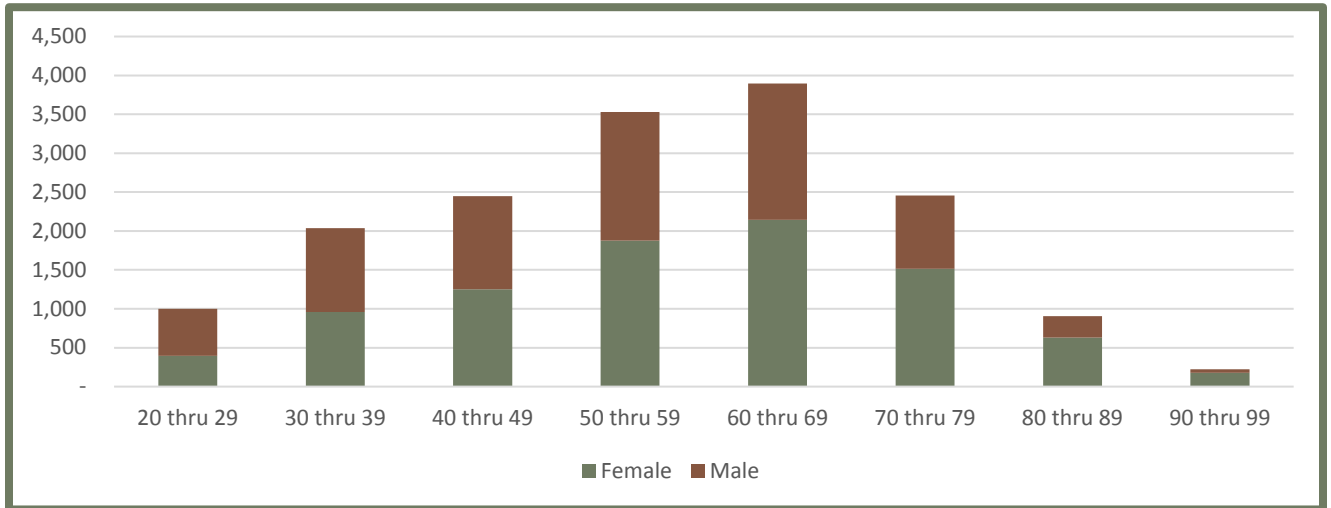
### Dual Eligible Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Dual Eligibles					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	17,384	\$ 49,143,760	\$ 235.58	\$ 201,968,814	\$ 968.19
SFY '15 Actual	18,244	\$ 53,518,538	\$ 244.46	\$ 216,083,619	\$ 987.00
SFY '16 Actual	20,280	\$ 55,523,042	\$ 228.15	\$ 243,884,642	\$ 1,002.14
SFY '17 As Passed	19,153	\$ 55,272,017	\$ 240.48	\$ 249,193,065	\$ 1,084.20
SFY '17 BAA	17,758	\$ 57,665,231	\$ 270.61	\$ 229,776,003	\$ 1,078.28
SFY '18 Gov. Rec.	18,007	\$ 59,567,044	\$ 275.66	\$ 234,646,394	\$ 1,085.88

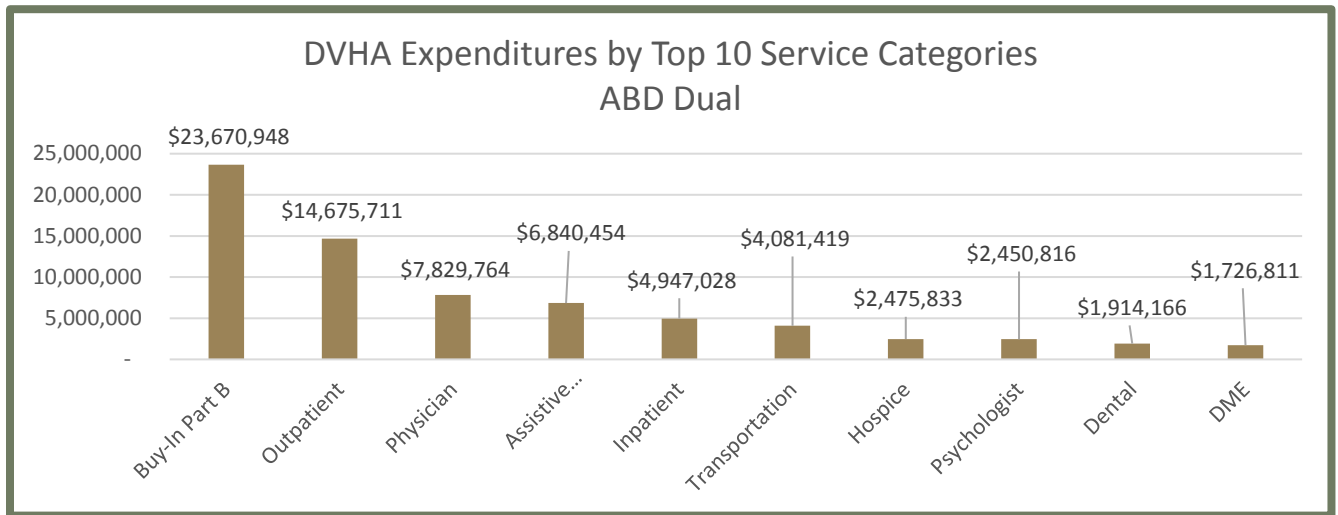
### Dual Eligible Caseload comparison by State Budget Cycle



### Dual Eligible SFY 2016 Average Enrollment Breakout by Age and Gender



For the Dual Eligible population, outpatient, assistive community supports, inpatient, and professional services accounted for the majority of the \$55,523,042 spend in SFY 2016. This population is covered by Medicare as the primary insurer, and Medicaid pays for co-insurance and deductibles, as well wrapping certain services not covered by Medicare.



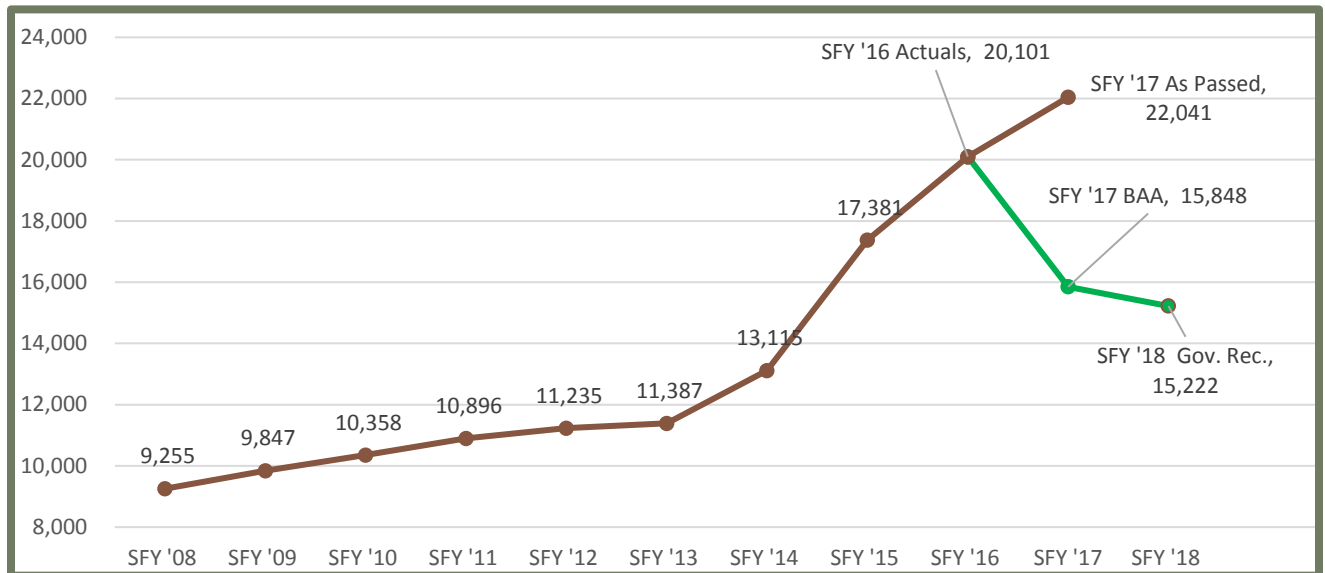
## General Adults

The general eligibility requirements for General Adults are: parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance, whose income is below the protected income level (PIL).

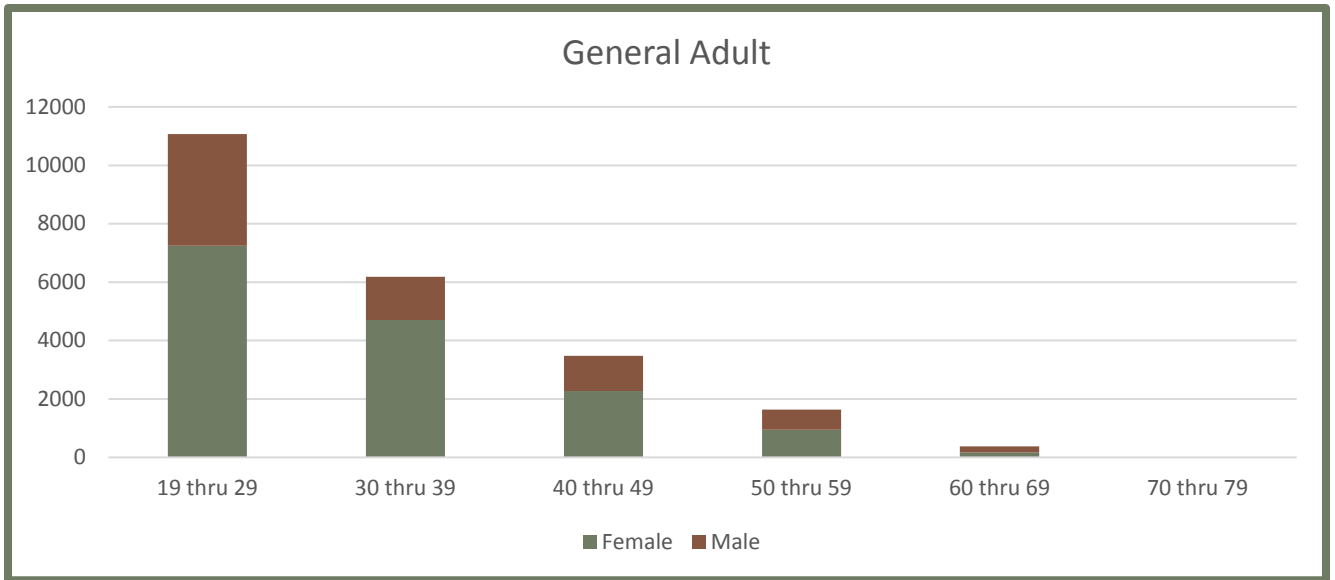
### General Adults Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

General Adults					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	13,115	\$ 76,094,174	\$ 483.51	\$ 84,532,839	\$ 537.13
SFY '15 Actual	17,381	\$ 88,383,933	\$ 423.75	\$ 98,968,224	\$ 474.49
SFY '16 Actual	20,101	\$ 92,641,465	\$ 384.07	\$ 105,326,128	\$ 436.66
SFY '17 As Passed	22,041	\$100,815,869	\$ 381.17	\$ 107,618,669	\$ 406.89
SFY '17 BAA	15,848	\$ 82,715,184	\$ 434.93	\$ 95,900,502	\$ 504.26
SFY '18 Gov. Rec.	15,222	\$ 85,433,739	\$ 467.72	\$ 98,846,478	\$ 541.15

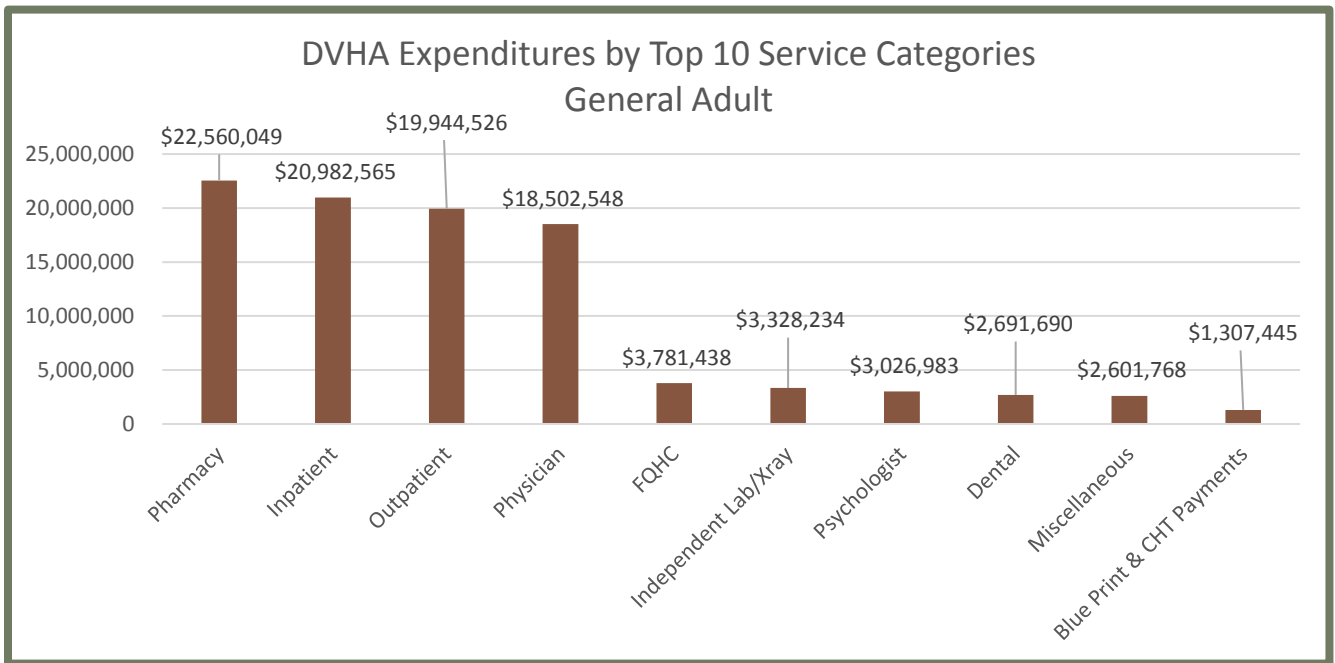
### General Adults Caseload Comparison by State Budget Cycle



**General Adults SFY 2016 Average Enrollment Breakout by Age and Gender**



Inpatient, physician, outpatient, and pharmacy accounted for the majority of the \$92,641,465 SFY 2016 spend.



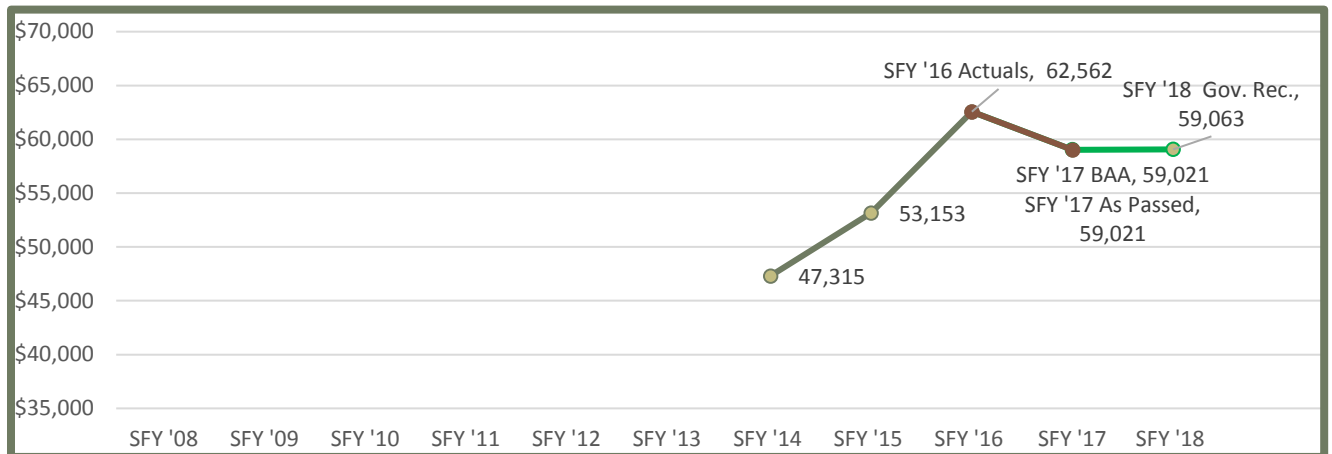
## New Adult

Due to Affordable Care Act changes that expanded Medicaid eligibility, adults who are at or below 138% of the federal poverty level will now qualify for traditional Medicaid. This population includes members who both have children and are childless. The federal government reimburses services for childless new adults at a higher percentage rate.

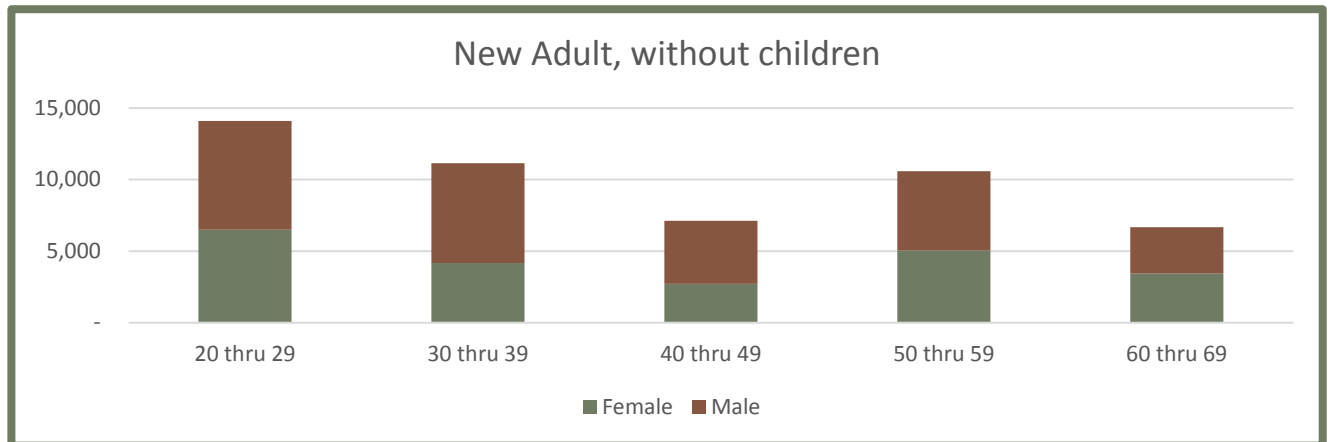
### New Adult Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

New Adult					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	47,315	\$ 72,982,243	\$ 321.41	\$ 80,536,031	\$ 350.28
SFY '15 Actual	53,153	\$224,311,542	\$ 351.68	\$ 246,954,265	\$ 387.18
SFY '16 Actual	62,562	\$248,721,362	\$ 331.30	\$ 276,465,556	\$ 368.25
SFY '17 As Passed	59,021	\$231,146,862	\$ 326.36	\$ 282,483,139	\$ 398.85
SFY '17 BAA	59,021	\$255,945,079	\$ 361.38	\$ 285,093,609	\$ 402.53
SFY '18 Gov. Rec.	59,063	\$275,478,837	\$ 388.68	\$ 305,130,122	\$ 430.52

### New Adults Caseload Comparison by State Budget Cycle

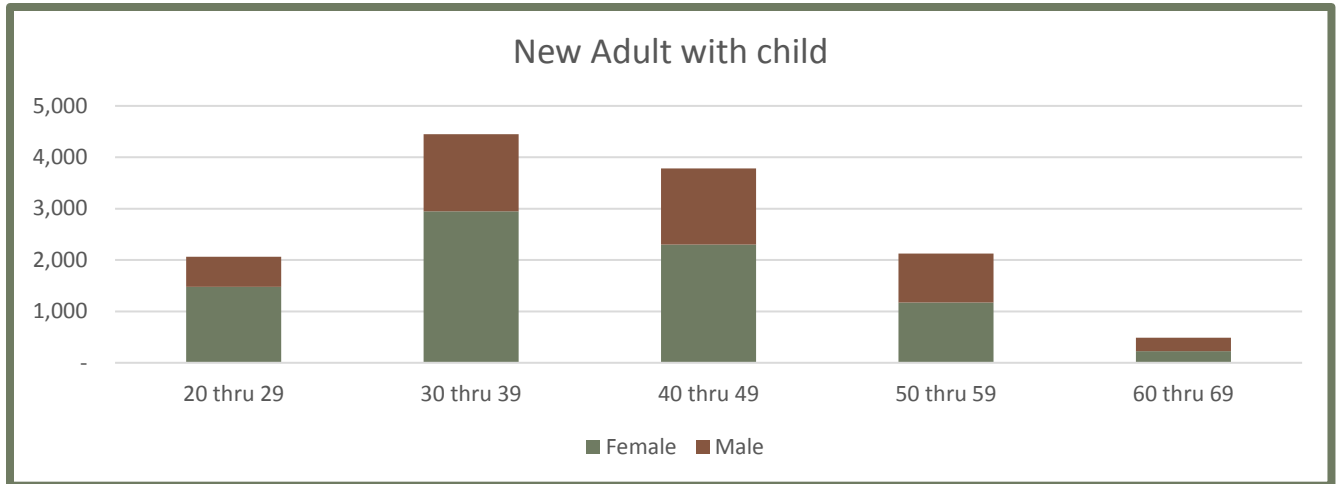


### New Adults SFY 2016 Average Enrollment Breakout by Age and Gender

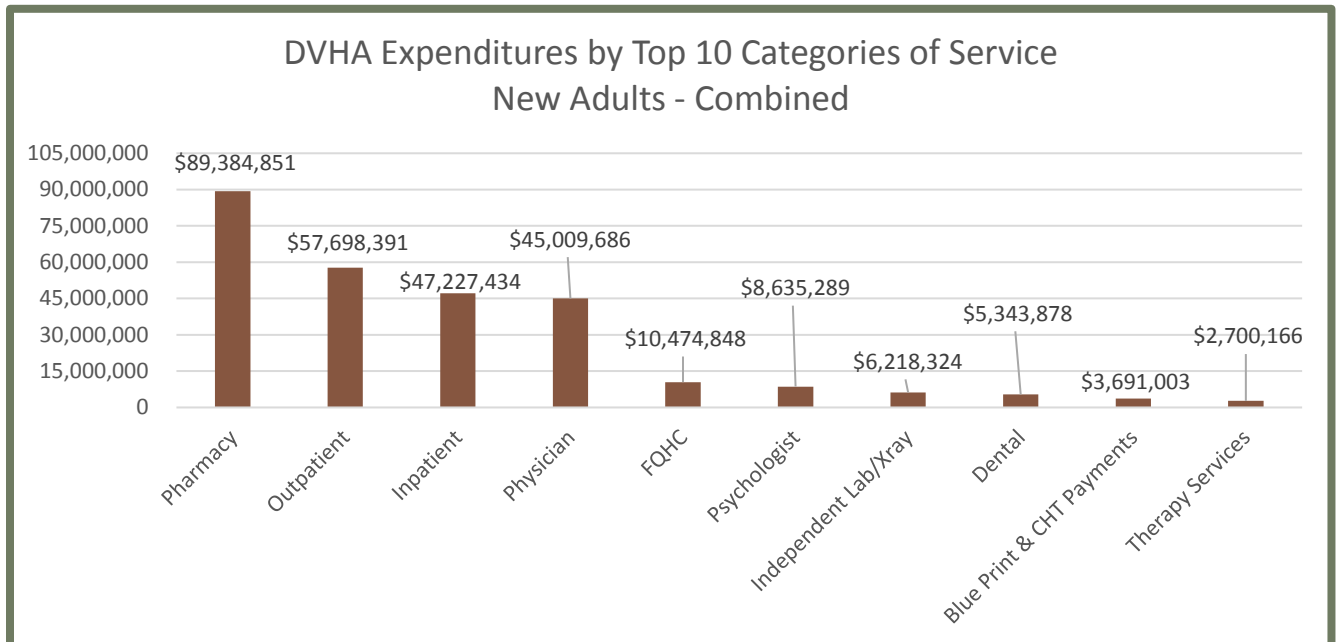


As is depicted in the FMAP table at the end of this chapter, the DVHA is able to claim enhanced federal participation for the new adult population without children.

Many of the enrollees in the New Adults categories were previously covered through other Green Mountain Care Programs such as Employer Sponsored Insurance Assistance (ESIA), VHAP, or Catamount Premium Assistance. Some, however, are brand new to any program.



Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the \$248,721,362. New Adult utilization for lab services is partially due to the opioid dependency prevalence within this population.





## Prescription Assistance Pharmacy Only Programs

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

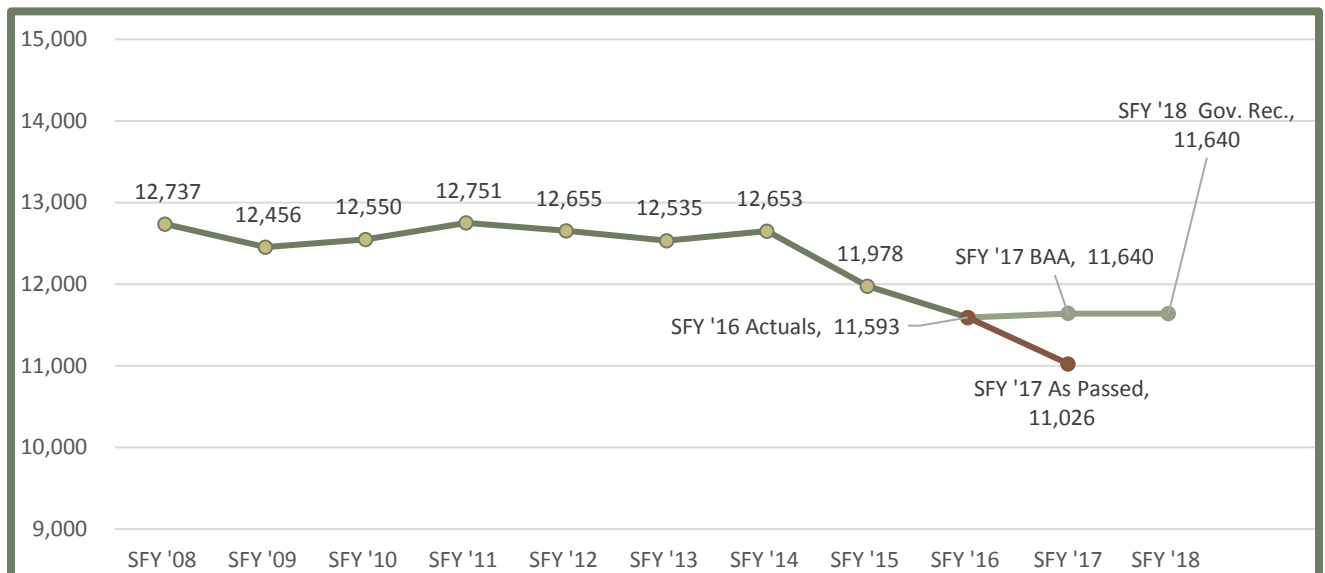
VPharm assists Vermonters enrolled in Medicare Part D with paying for prescription medicines. Those eligible include people age 65 and older, and Vermonters of all ages with disabilities with household incomes up to 225% FPL.

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

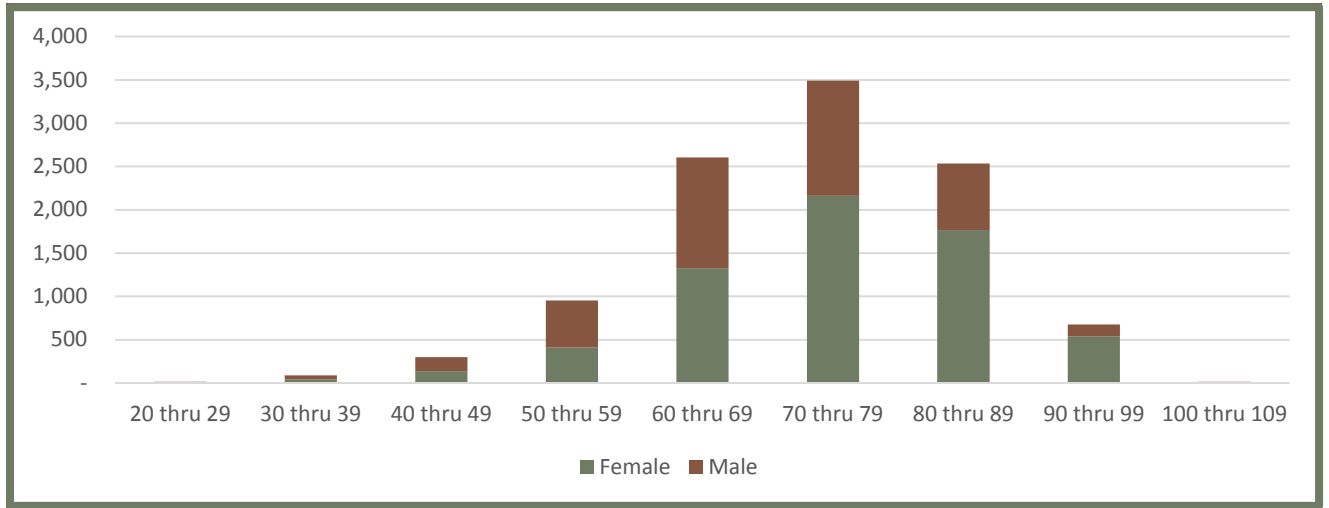
### Pharmacy Only Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Pharmacy Only Programs					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	12,653	\$ 4,485,706	\$ 29.54	\$ 4,485,706	\$ 29.54
SFY '15 Actual	11,978	\$ 4,914,695	\$ 34.19	\$ 4,914,695	\$ 34.19
SFY '16 Actual	11,593	\$ 2,302,437	\$ 16.55	\$ 2,302,437	\$ 16.55
SFY '17 As Passed	11,026	\$ 5,020,813	\$ 37.95	\$ 5,020,813	\$ 37.95
SFY '17 BAA	11,640	\$ 6,266,029	\$ 44.86	\$ 6,266,029	\$ 44.86
SFY '18 Gov. Rec.	11,640	\$ 6,385,921	\$ 45.72	\$ 6,385,921	\$ 45.72

### Pharmacy Only Caseload Comparison by State Budget Cycle



### SFY 2016 Average Enrollment Breakout by Age and Gender

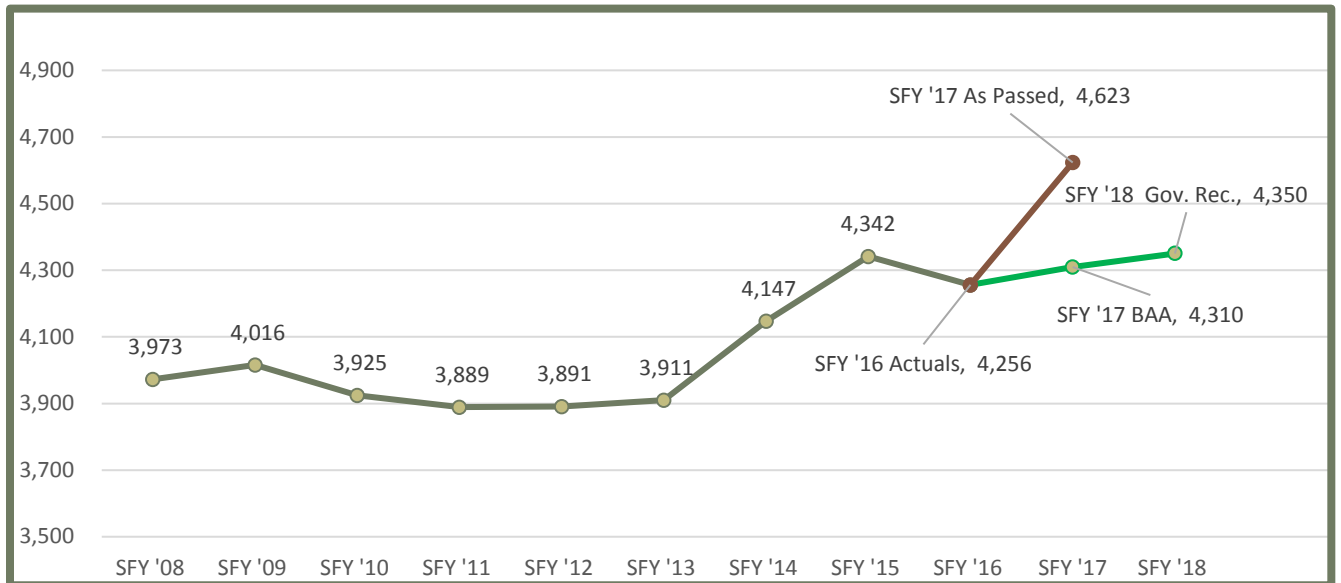


The general eligibility requirements for this subset are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, and enhanced residential care (ERC).

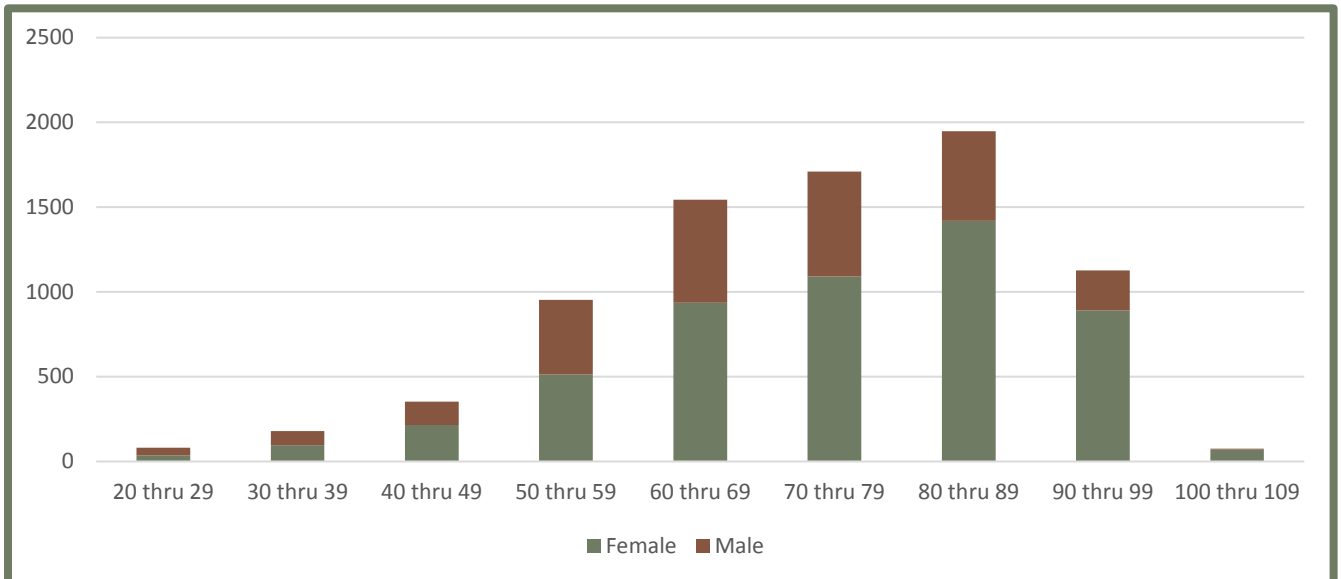
## Choices for Care Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Choices for Care					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	4,147	\$202,593,610	\$ 4,071.09	\$ 202,593,610	\$ 4,071.09
SFY '15 Actual	4,342	\$208,149,276	\$ 4,045.92	\$ 208,149,276	\$ 3,995.26
SFY '16 Actual	4,256	\$213,115,112	\$ 4,228.78	\$ 218,544,540	\$ 4,278.89
SFY '17 As Passed	4,623	\$209,154,497	\$ 3,827.62	\$ 219,966,581	\$ 3,964.77
SFY '17 BAA	4,310	\$220,308,324	\$ 4,315.94	\$ 225,786,465	\$ 4,365.92
SFY '18 Gov. Rec.	4,350	\$224,510,158	\$ 4,360.07	\$ 230,231,515	\$ 4,410.43

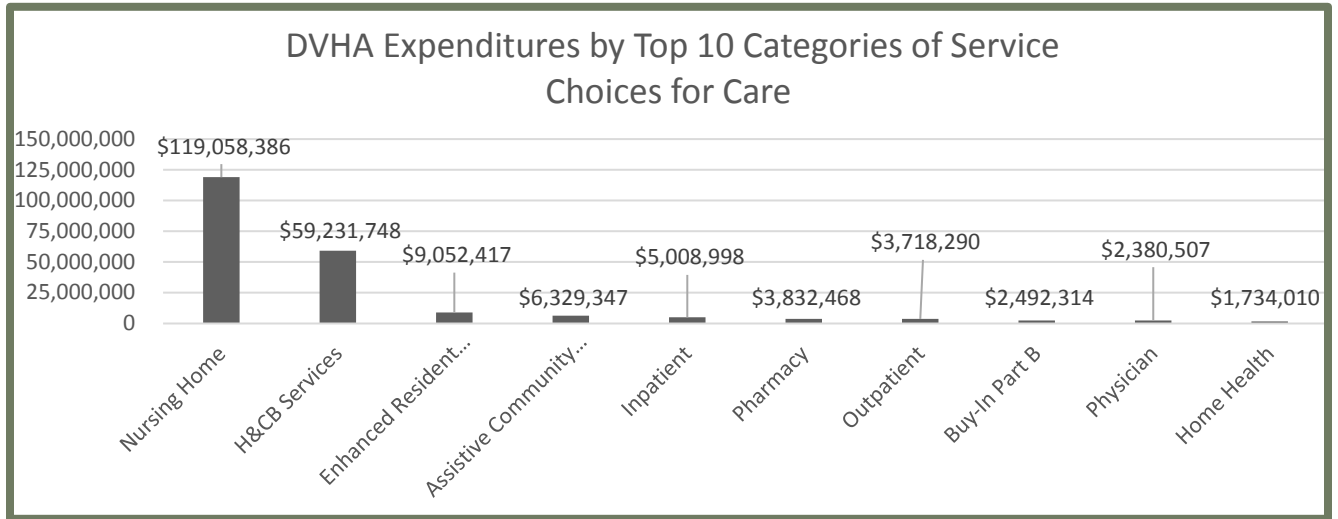
### Choices for Care Caseload Comparison by State Budget Cycle



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



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



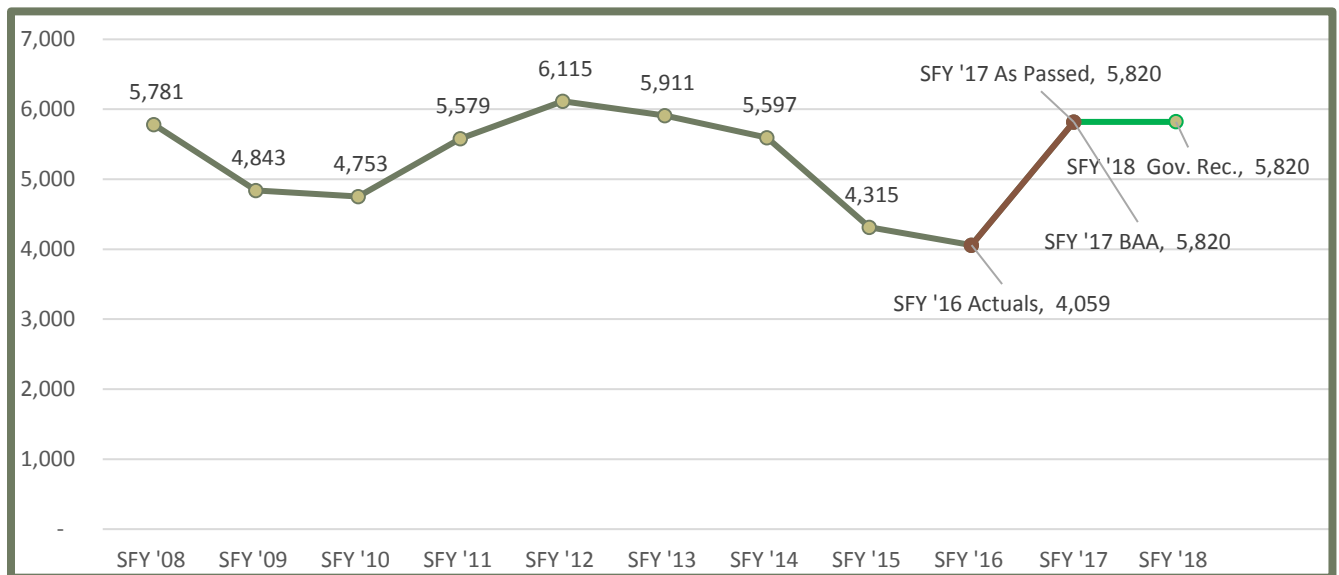
## Healthy Vermonters

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

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

Healthy Vermonters Program					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	5,597	\$ -	n/a	\$ -	n/a
SFY '15 Actual	4,315	\$ -	n/a	\$ -	n/a
SFY '16 Actual	4,059	\$ -	n/a	\$ -	n/a
SFY '17 As Passed	5,820	\$ -	n/a	\$ -	n/a
SFY '17 BAA	5,820	\$ -	n/a	\$ -	n/a
SFY '18 Gov. Rec.	5,820	\$ -	n/a	\$ -	n/a

### Healthy Vermonters Caseload Comparison by State Budget Cycle



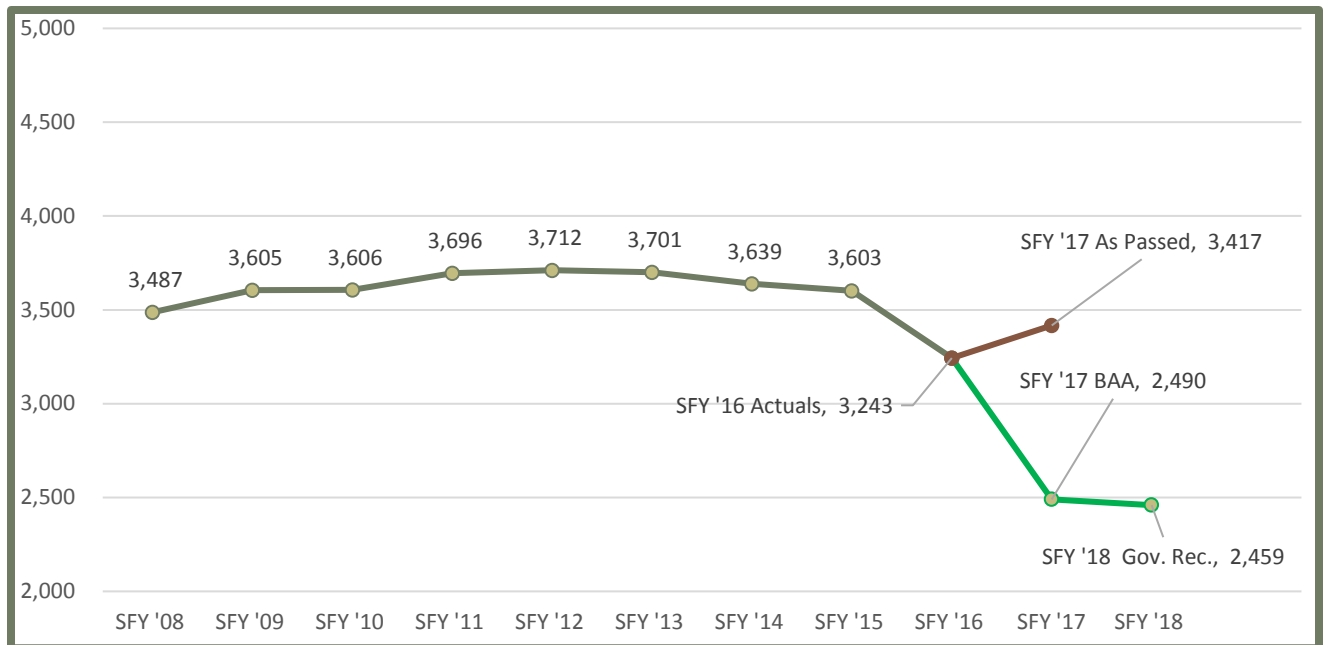
## Blind or Disabled (BD) and/or Medically Needy Children

The general eligibility requirements for BD and/or Medically Needy Children are: under age 21; categorized as blind or disabled; generally, includes Supplemental Security Income (SSI) cash assistance recipients; hospice patients; those eligible under “Katie Beckett” rules; and medically needy Vermonters [i.e., eligible because their income is greater than the cash assistance level but less than the protected income level (PII)]. Medically needy children may or may not be blind or disabled.

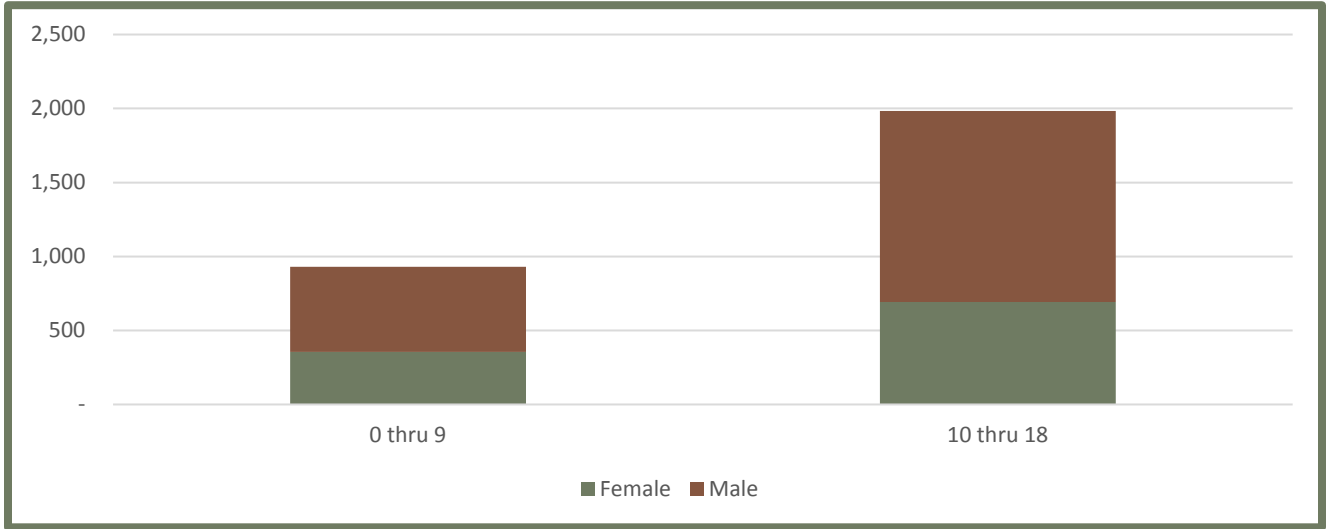
### Blind or Disabled and/or Medically Needy Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Blind or Disabled and/or Medically Needy Children					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	3,639	\$ 36,486,052	\$ 835.48	\$ 91,503,344	\$ 2,095.29
SFY '15 Actual	3,603	\$ 30,889,676	\$ 714.53	\$ 87,051,488	\$ 2,013.64
SFY '16 Actual	3,243	\$ 27,174,573	\$ 698.22	\$ 82,411,072	\$ 2,117.45
SFY '17 As Passed	3,417	\$ 28,773,934	\$ 701.72	\$ 84,204,841	\$ 2,053.53
SFY '17 BAA	2,490	\$ 24,874,655	\$ 832.43	\$ 83,165,401	\$ 2,783.14
SFY '18 Gov. Rec.	2,459	\$ 24,989,822	\$ 846.72	\$ 84,285,971	\$ 2,855.84

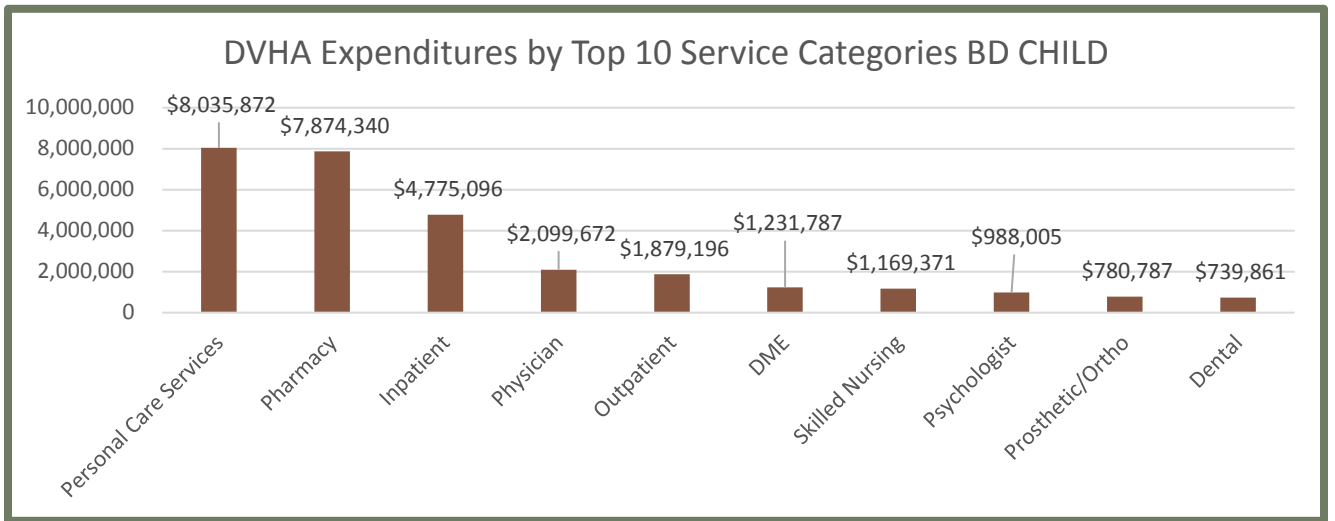
### Blind or Disabled Children Caseload Comparison by State Budget Cycle



### BD Child SFY 2016 Average Enrollment Breakout by Age and Gender



Personal Care Services, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the \$27,174,573.



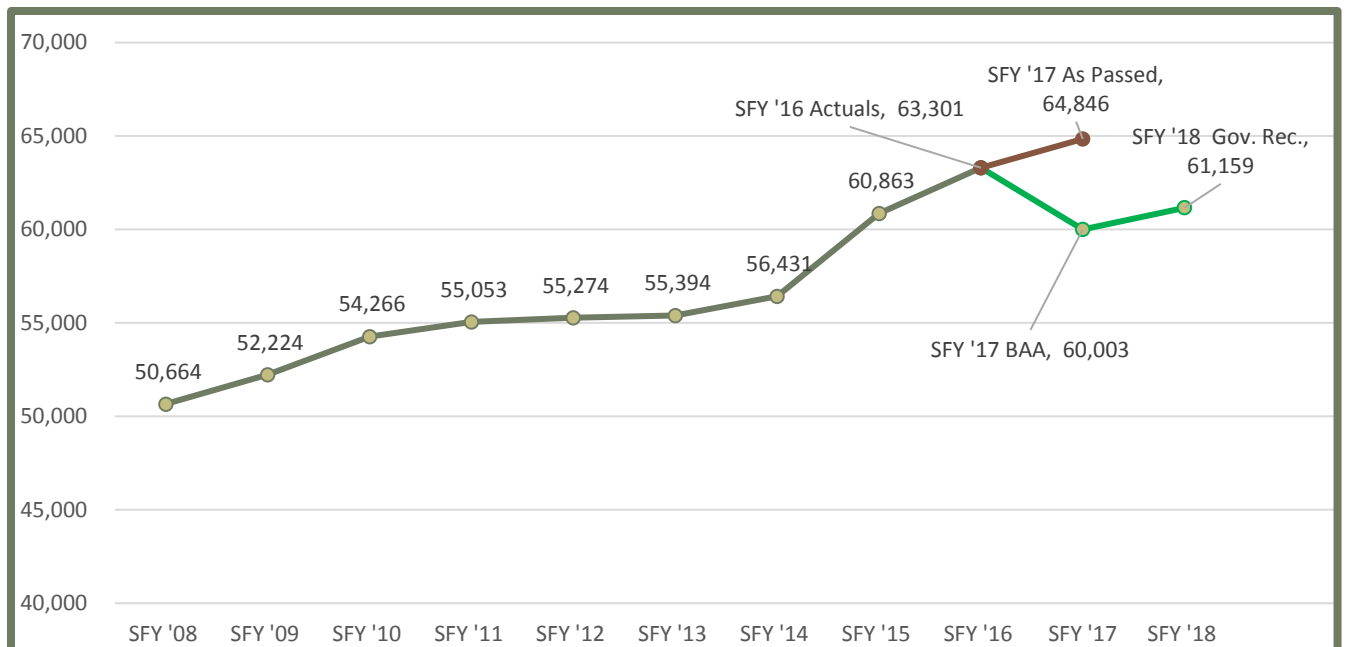
## General Children

The general eligibility requirements for General Children are: under age 19 and below the protected income level (PIL), categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E).

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

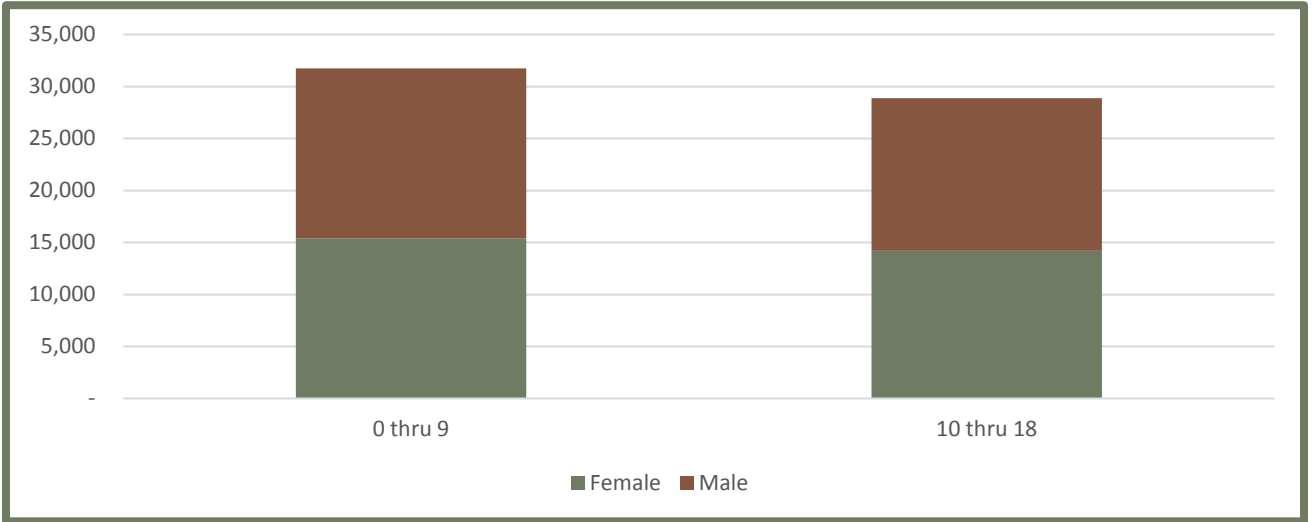
General Children					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	56,431	\$130,940,851	\$ 193.36	\$ 236,587,894	\$ 349.38
SFY '15 Actual	60,863	\$144,338,098	\$ 197.63	\$ 267,623,445	\$ 366.43
SFY '16 Actual	63,301	\$151,736,910	\$ 199.75	\$ 286,746,415	\$ 377.49
SFY '17 As Passed	64,846	\$149,777,097	\$ 192.48	\$ 292,987,771	\$ 376.52
SFY '17 BAA	60,003	\$153,506,519	\$ 213.19	\$ 295,934,148	\$ 411.00
SFY '18 Gov. Rec.	61,159	\$156,718,714	\$ 213.54	\$ 301,602,945	\$ 410.95

### General Children Caseload Comparison by State Budget Cycle

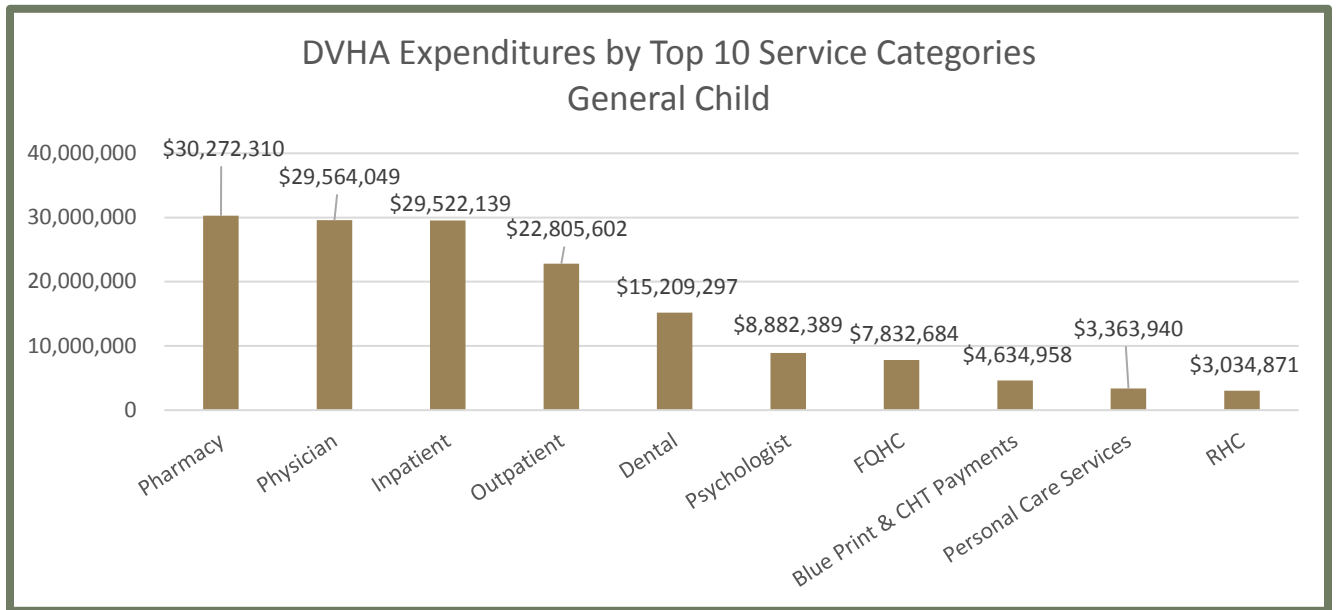




### General Child SFY 2016 Average Enrollment Breakout by Age and Gender



Professional services, inpatient, outpatient, and pharmacy (net drug rebate) accounted for the majority of the \$151,736,910.



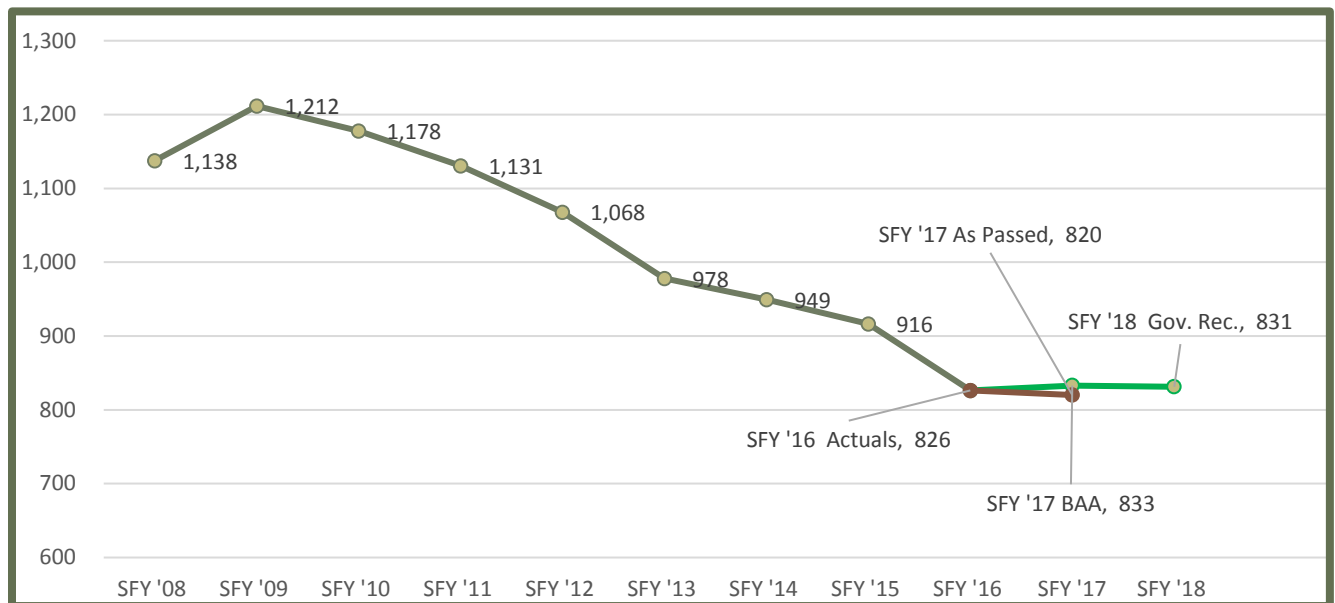
## Optional Benefit Children

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

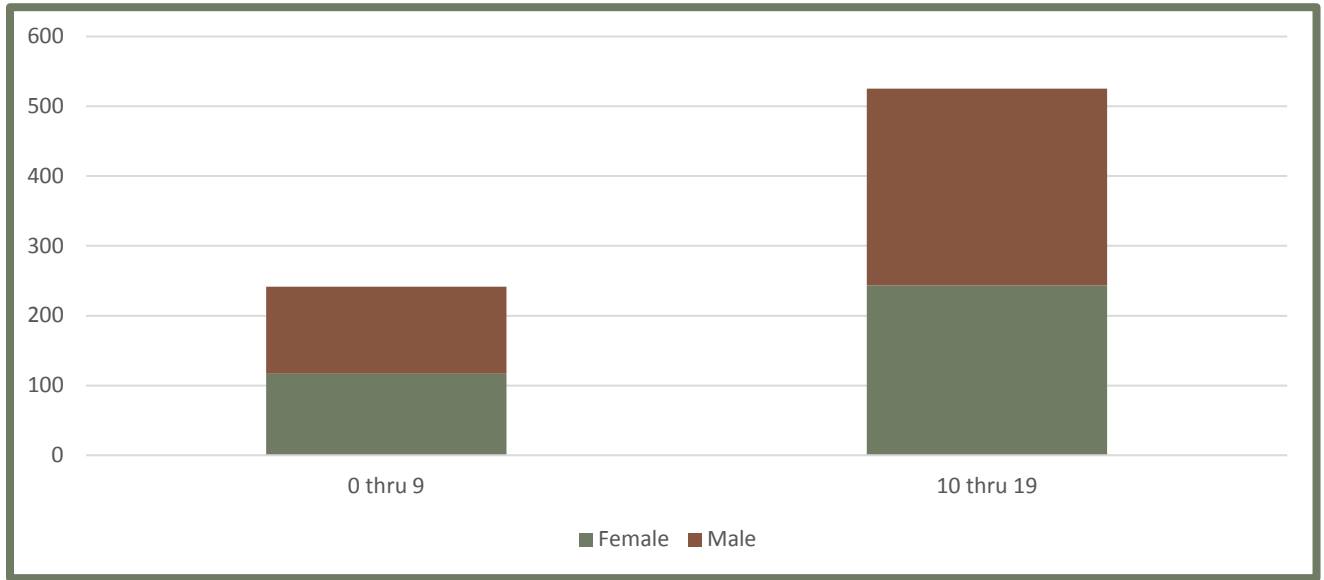
### Optional Benefit Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

Optional Benefit Children					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	949	\$ 1,072,657	\$ 94.15	\$ 2,521,774	\$ 221.34
SFY '15 Actual	916	\$ 1,253,421	\$ 113.98	\$ 2,962,429	\$ 269.39
SFY '16 Actual	826	\$ 1,186,527	\$ 119.66	\$ 2,329,302	\$ 234.90
SFY '17 As Passed	820	\$ 1,207,158	\$ 122.66	\$ 2,380,002	\$ 241.83
SFY '17 BAA	833	\$ 1,210,126	\$ 121.09	\$ 2,415,745	\$ 241.72
SFY '18 Gov. Rec.	831	\$ 1,230,043	\$ 123.31	\$ 2,456,457	\$ 246.25

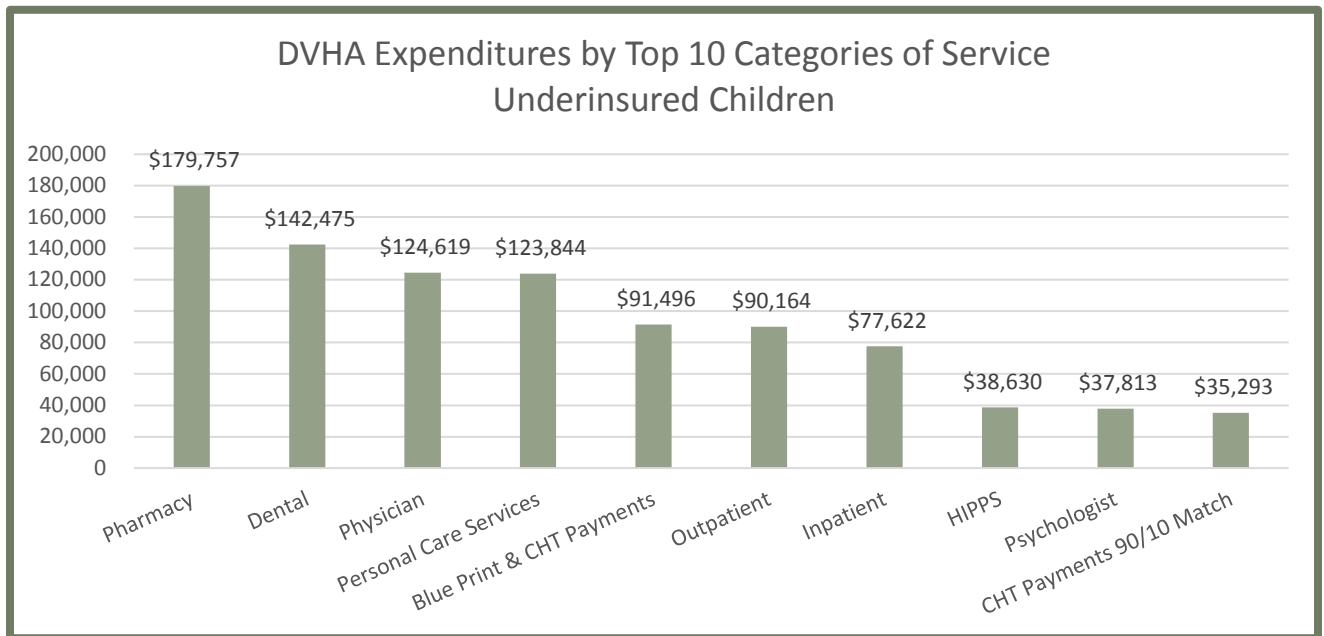
### Optional Benefit Children Caseload Comparison by State Budget Cycle



### Optional Benefit Children SFY 2016 Average Enrollment Breakout by Age and Gender



Inpatient, dental, personal care services, and professional services accounted for the majority of the \$1,186,527.



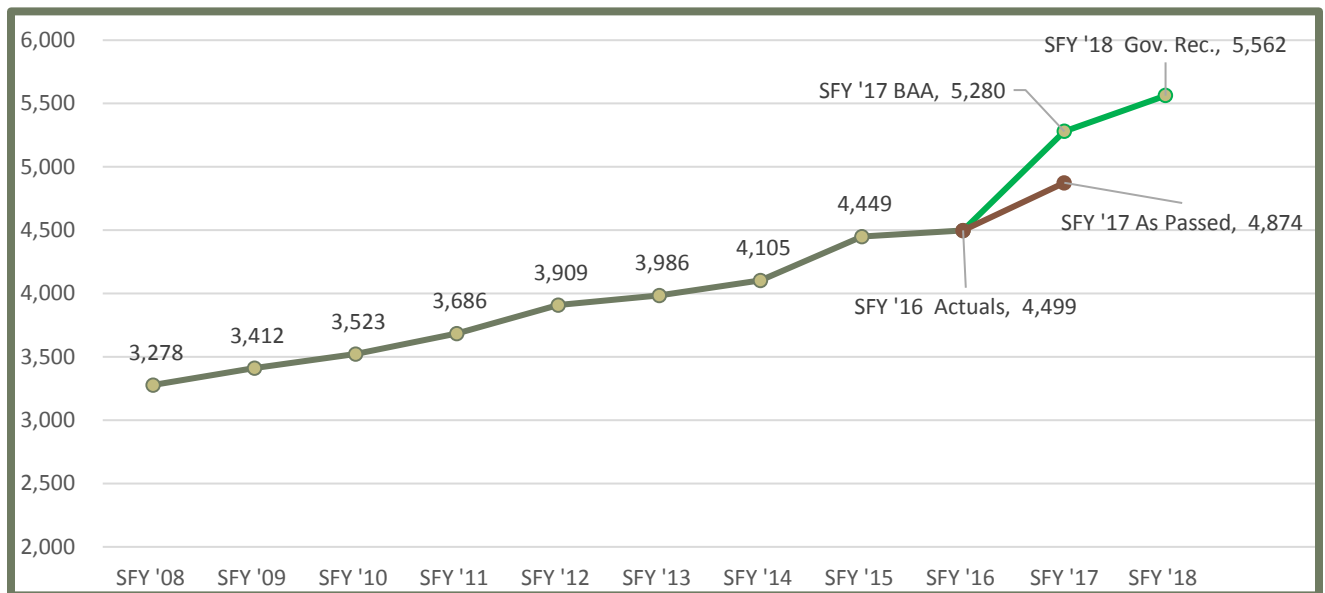
## Children’s Health Insurance Program (CHIP)

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

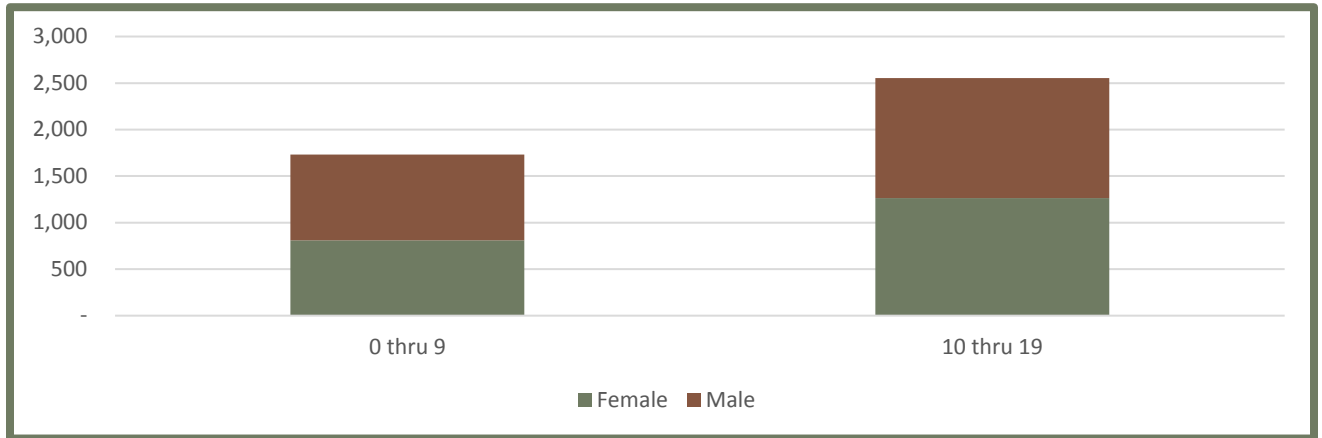
### CHIP Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

CHIP (Uninsured)					
SFY	Caseload	DVHA Only		All AHS and AOE	
		Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	4,105	\$ 7,465,861	\$ 151.57	\$ 10,218,851	\$ 207.46
SFY '15 Actual	4,449	\$ 7,471,592	\$ 139.43	\$ 8,775,083	\$ 164.36
SFY '16 Actual	4,499	\$ 7,025,792	\$ 130.15	\$ 9,755,883	\$ 180.72
SFY '17 As Passed	4,874	\$ 8,400,371	\$ 143.61	\$ 11,130,462	\$ 190.29
SFY '17 BAA	5,280	\$ 9,400,484	\$ 148.37	\$ 12,130,576	\$ 191.45
SFY '18 Gov. Rec.	5,562	\$ 9,286,093	\$ 139.13	\$ 12,016,184	\$ 180.03

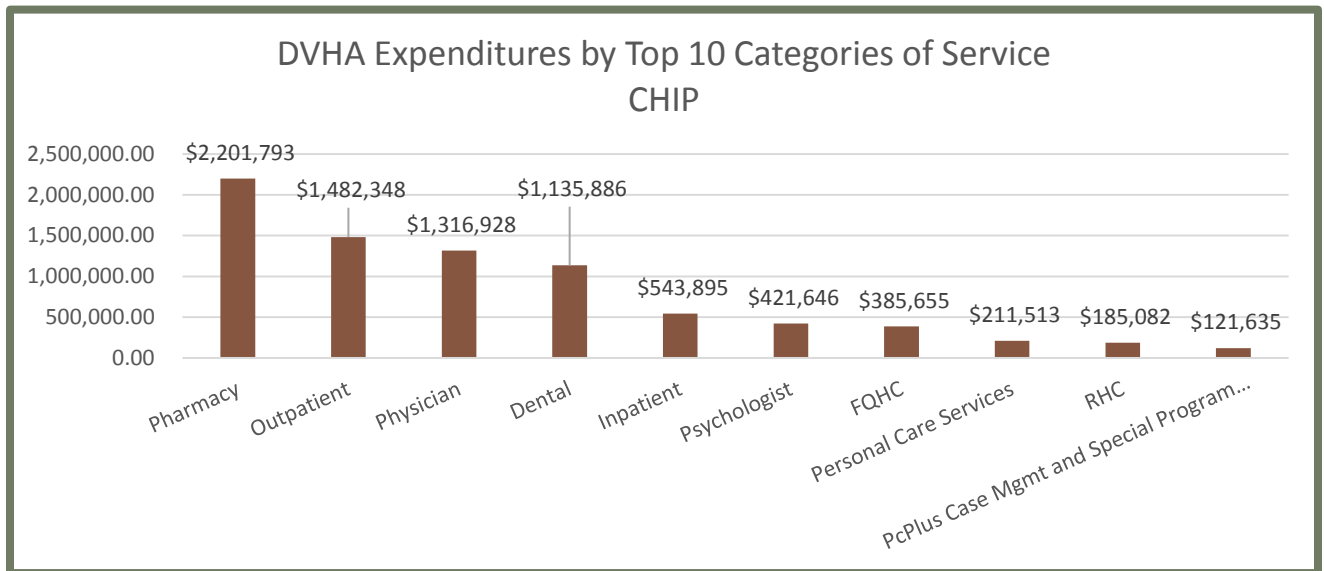
### CHIP Caseload Comparison by State Budget Cycle



### CHIP SFY 2016 Average Enrollment Breakout by Age and Gender



Professional services, outpatient, inpatient, and dental accounted for the majority of the \$7,025,792.

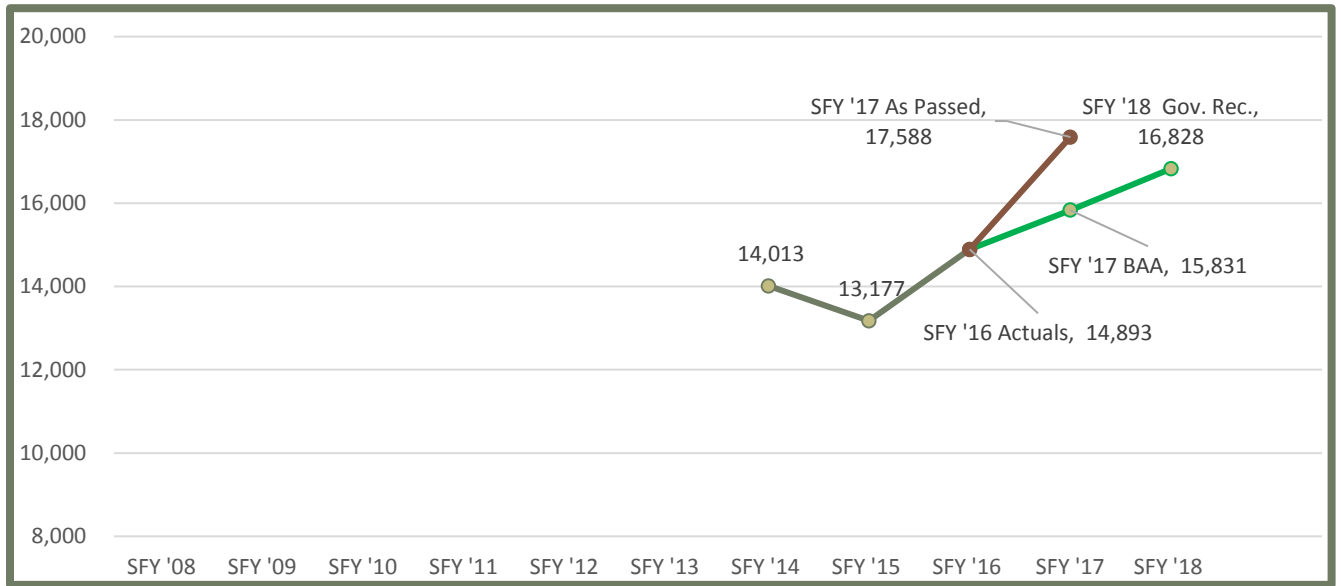


## Premium Assistance and Cost Sharing

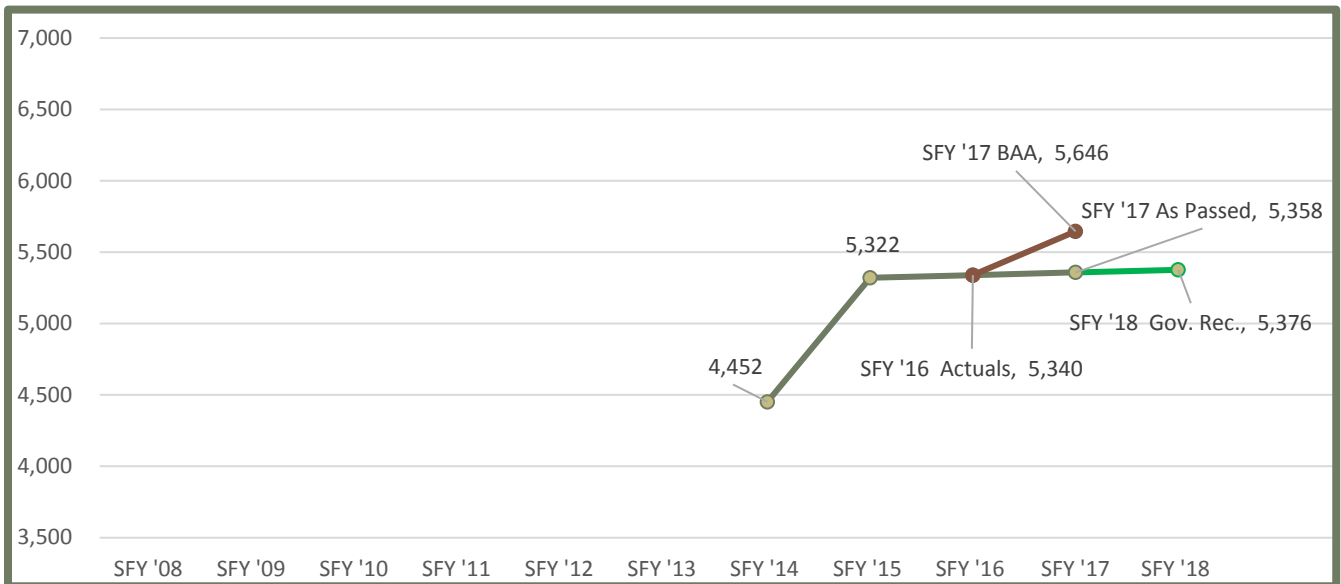
Individuals with household income over 138% of FPL can choose to enroll in qualified health plans purchased on Vermont Health Connect, Vermont’s health benefit exchange. These plans have varying cost sharing and premium levels. There are federal tax credits to make premiums more affordable for people 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 qualified health plans (QHP) will be less affordable than Vermonters had previously experienced under VHAP and Catamount. To address this affordability challenge, the State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300% of FPL. The following tables depict the caseload and expenditure information by SFY, including the Governor’s Recommend for SFY 2018 for additional Cost Sharing supports.

Premium Assistance For Exchange Enrollees < 300%					
		DVHA Only		All AHS and AOE	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	14,013	\$ 2,571,477	\$ 36.91	\$ 2,571,477	\$ 36.91
SFY '15 Actual	13,177	\$ 5,611,465	\$ 27.66	\$ 5,611,465	\$ 35.49
SFY '16 Actual	14,893	\$ 5,266,242	\$ 29.47	\$ 5,266,242	\$ 29.47
SFY '17 As Passed	17,588	\$ 5,954,932	\$ 28.21	\$ 5,954,932	\$ 28.21
SFY '17 BAA	15,831	\$ 6,065,475	\$ 31.93	\$ 6,065,475	\$ 31.93
SFY '18 Gov. Rec.	16,828	\$ 5,706,135	\$ 28.26	\$ 5,706,135	\$ 28.26
Cost Sharing For Exchange Enrollees < 300%					
		DVHA Only		All AHS and AOE	
SFY	Caseload	Expenditures	P.M.P.M.	Expenditures	P.M.P.M.
SFY '14 Actual	4,452	\$ 332,623	\$ 19.52	\$ 332,623	\$ 19.52
SFY '15 Actual	5,322	\$ 1,138,775	\$ 17.83	\$ 1,138,775	\$ 17.83
SFY '16 Actual	5,340	\$ 1,186,720	\$ 18.52	\$ 1,186,720	\$ 18.52
SFY '17 As Passed	5,646	\$ 1,232,289	\$ 18.19	\$ 1,232,289	\$ 18.19
SFY '17 BAA	5,358	\$ 1,232,289	\$ 19.17	\$ 1,232,289	\$ 19.17
SFY '18 Gov. Rec.	5,376	\$ 1,232,289	\$ 19.10	\$ 1,232,289	\$ 19.10

### Premium Assistance Caseload Comparison by State Budget Cycle

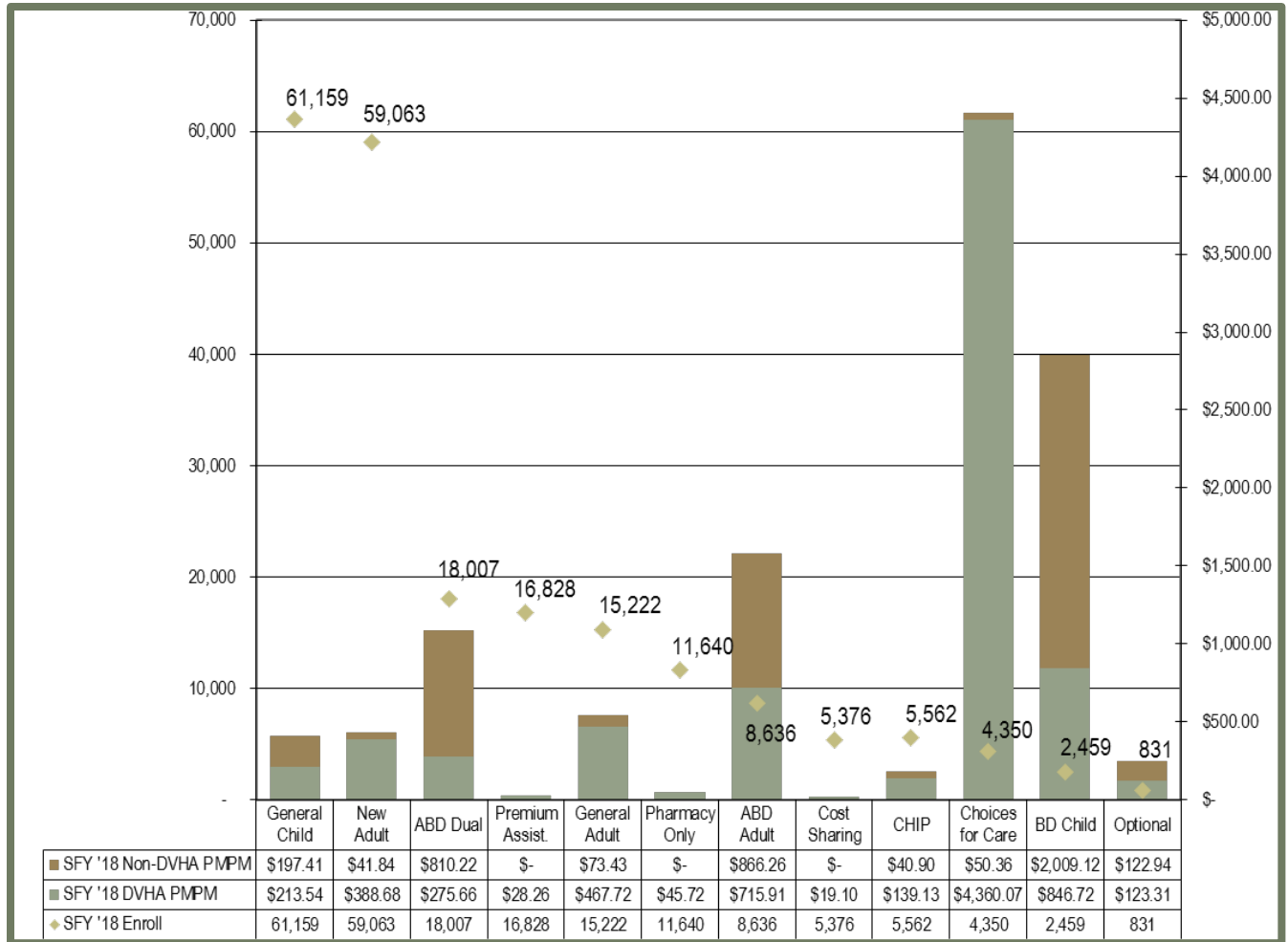


### Cost Sharing Reduction Caseload Comparison by State Budget Cycle



The summary below displays the distribution of Vermont Medicaid programs by population served with DVHA and non-DVHA PMPMs. Spending per member per month is highly variable. For example, the large number of children in the General Child category have a much lower per person cost than enrollees in Choices for Care.

### DVHA and Non-DVHA PMPM and Enrollment



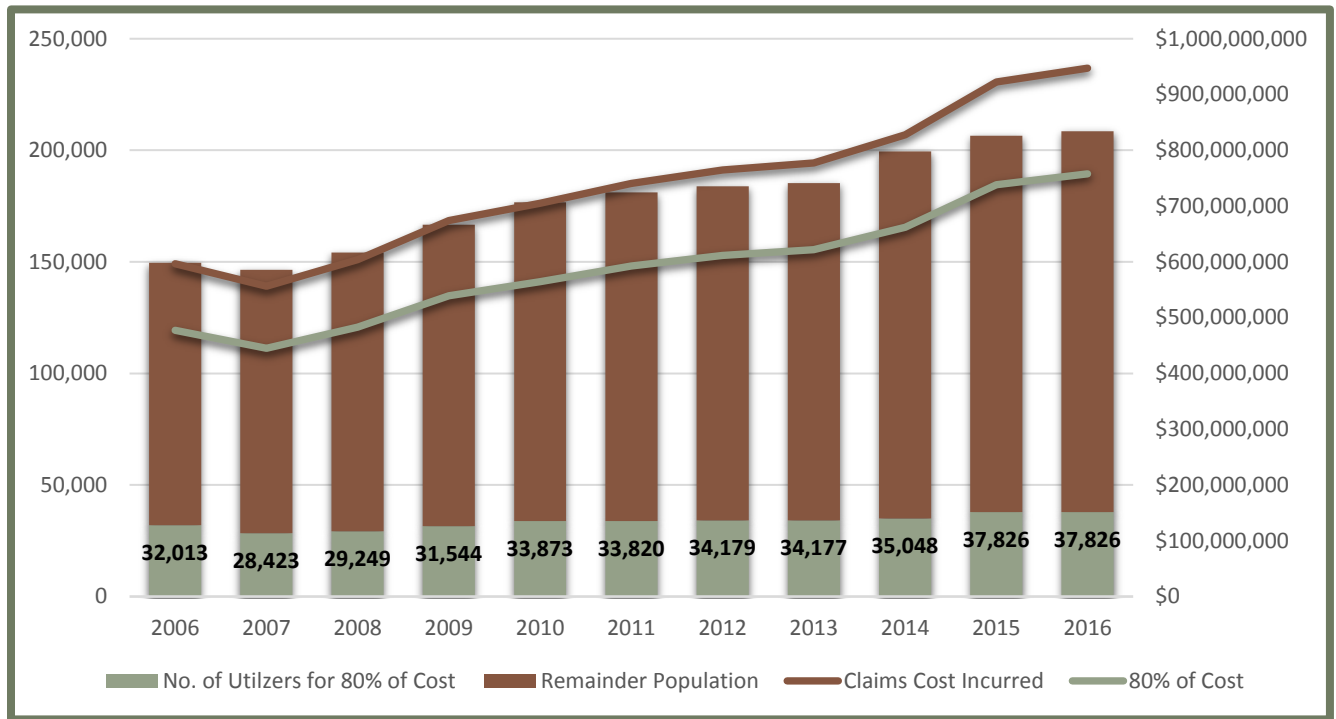
Note: The Pharmacy Only FMAP used is a blend of the Global Commitment Waiver fund matching, and State Only funds, and the New Adult FMAP used is that of the New Adult childless population, while the population and spend are both New Adults with children, and childless.



## VERMONT MEDICAID TRENDS – A NATIONAL & REGIONAL COMPARISON

Vermont did not originally anticipate higher spend as much of the expansion populations were already eligible for some level of coverage; VHAP, VPharm, Catamount Premium Assistance, and Employer-Sponsored Insurance assistance. The reality of 2015 and 2016, however, showed a much higher than anticipated Medicaid roster. This was due in part to the lack of eligibility re-determinations as DVHA struggled with the implementation of the VHC. This resulted in high member rosters but a decrease in the per member per month cost.

### Population with 80% of Medicaid Spend – Compared to Total Population



The chart above demonstrates the historical trend of the highest cost utilizers. The population in green accounts for 80% of all claim based spend. In-depth analysis indicated that most costs are either born in the first three months of gaining Medicaid eligibility or attributed to members with chronic needs that retained eligibility after re-determination. This hypothesis was then confirmed with the actuarial firm engaged in assisting DVHA with case load projections.

### Aged Population Trend Comparison

As portrayed in the CMS’s National Health Expenditure Projections 2015 – 2025, post-ACA implementation, national growth is expected to continue as a result of an aging population as well as higher cost in delivery of services. Nationally, the aging population will exert a considerable force from 2020 through 2025. During this time, there is a projected average growth of 6.1% in Medicaid spend, driven primarily by the changing profile of that program’s population as an increasingly higher share of members are comprised of expensive aged and disabled individuals. After 2016, Medicaid spending growth is projected to average 6.0 % per year

through 2025, as aged and disabled members, who typically require more care, represent an increasingly larger share of the Medicaid population.

Regarding the national concern that Medicaid spending will grow based on the aged and disabled population, Vermont in comparison to the nation has been more aged for a number years. Vermont Medicaid growth rate of the aged in 2015 was 3.3% (national projections, 10.7%) and 3.98% (national projection, 5.3%) in SFY 2016. While this population will contribute to some increased costs in future, DVHA does not foresee the same rate of increases as seen in other parts of the nation in the next few budget cycles. This chart below depicts states in the highest percentage of elderly.

### 2015 – States with the Highest Population Percent of Over 65

State	Children 0-18	Adults 19-25	Adults 26-34	Adults 35-54	Adults 55-64	65+
Maine	20%	7%	11%	29%	14%	21%
West Virginia	23%	8%	10%	25%	14%	19%
Florida	22%	9%	11%	26%	13%	19%
Montana	24%	10%	12%	23%	14%	18%
Vermont	22%	9%	11%	26%	16%	17%
Michigan	23%	11%	10%	26%	14%	17%
Pennsylvania	23%	10%	11%	25%	14%	17%
Hawaii	24%	9%	14%	24%	13%	17%
South Carolina	24%	8%	12%	26%	13%	17%
New Mexico	26%	10%	11%	24%	12%	17%

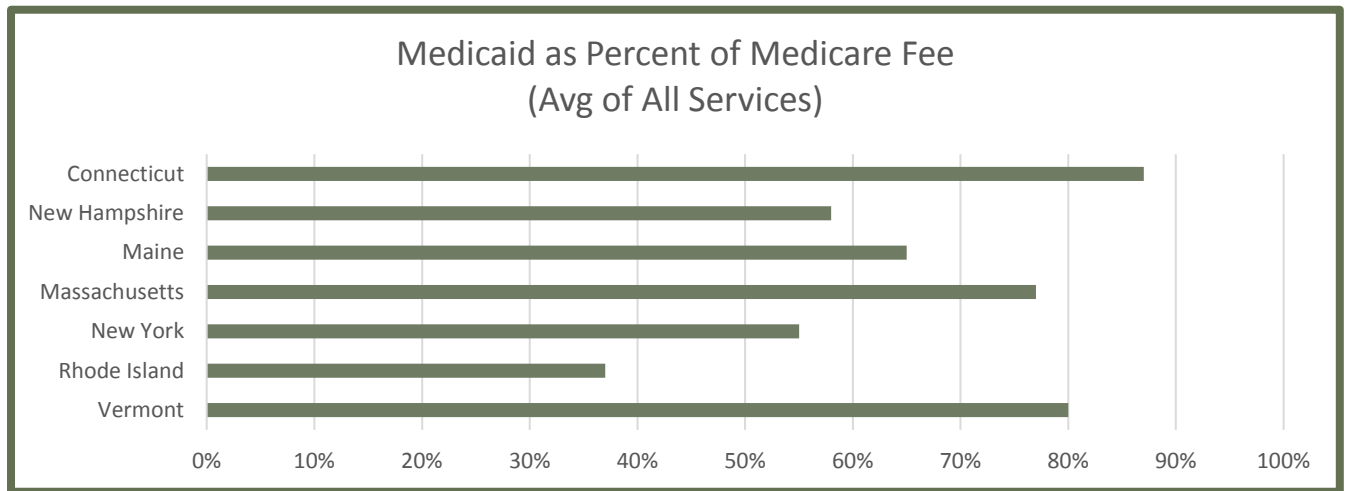
AARP Public Policy Institute predicts the over-85 Vermont population will nearly triple between 2015 and 2050 (2.3% to 6.5%). This growth is exactly in line with the nation and the region. LTC health supports are expensive with Home and Community Based Services being more affordable than institutional based services. The DAIL manages these programs, although the appropriations and the acute care service delivery resides within DVHA’s responsibilities. Nationally Medicaid is the primary payer for long term support services; incurring cost sharing expenses for dually eligible members including paying as primary when Medicare benefits are exhausted, and premium assistance through Part A and Part B buy-in. DVHA also provides low-income premium assistance subsidies for Part D for VPharm members that meet income guidelines<sup>1</sup>.

Vermont will need to continue innovative delivery reform, focused on addressing community-based providers, challenges in housing, and ensuring access to community-based care that supports independence and enhances quality of life as our Medicaid elderly population continues to grow.

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<sup>1</sup> <http://www.aarp.org/ppi/info-2016/share-of-the-population-85-in%202015-and-2050-by-state.html>

In addition to the State’s decisions concerning services available to Medicaid enrollees, Medicaid reimbursement rates have an obvious impact to the spending level. The table below illustrates how Vermont compares to the region based on the 2012 Medicaid rate as a percentage of the 2012 Medicare rate.<sup>2 3</sup>



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

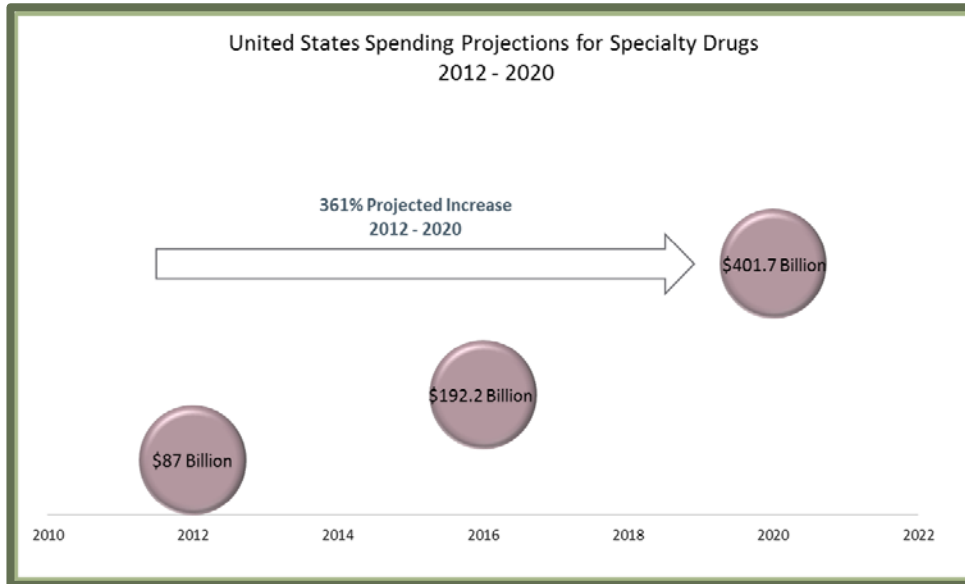
<sup>2</sup> <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>

<sup>3</sup> MACStats: Medicaid and CHIP Data Book, December 2015 & <http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/>

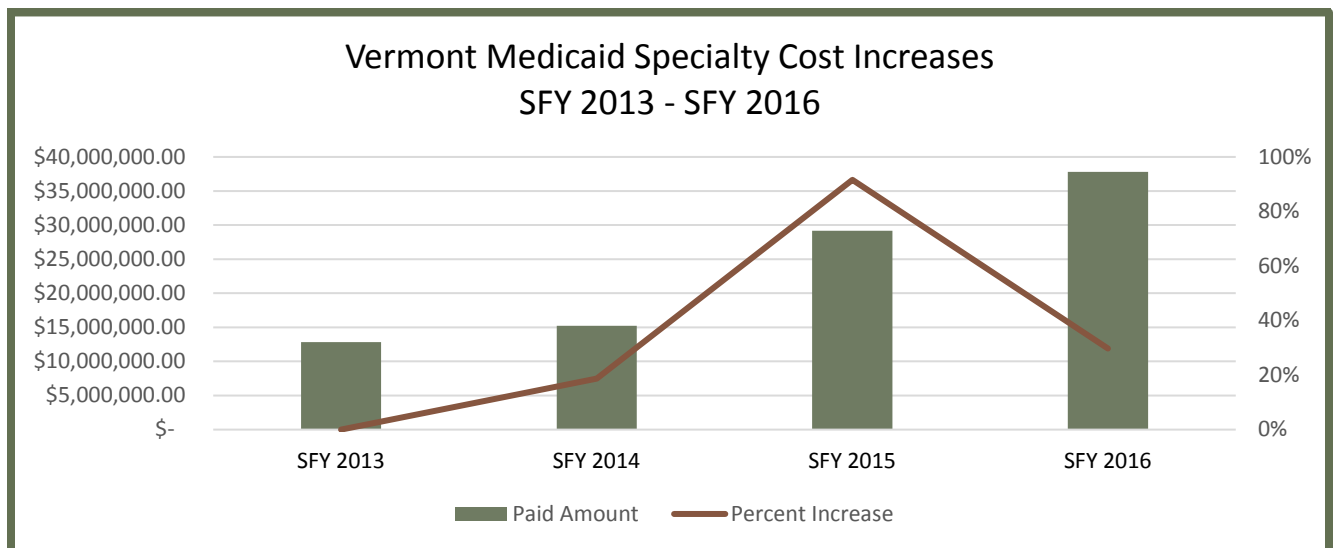
## Category of Service Trends Comparison

Prescription drug spend is an increasing pressure especially in the specialty drug market as this is the most rapidly growing component of health care costs. Vermont is experiencing a slower rate of growth in SFY 2017 in comparison to 2016, yet the specialty drug growth greatly exceeds the Consumer Price Index (CPI) for medical services.

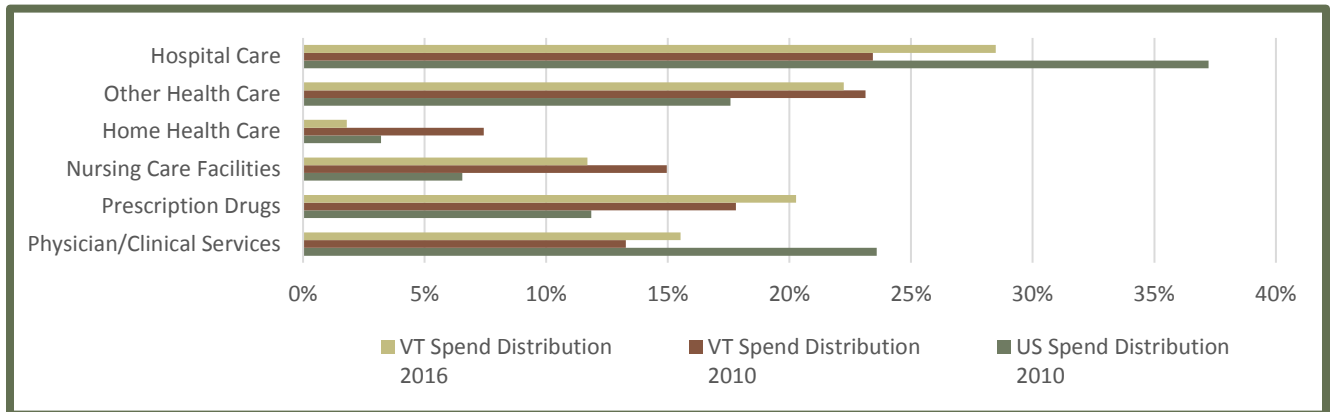
Some studies have found that up to 50% of all spending on prescription medication by 2018 will be for specialty drugs, which are complex pharmaceuticals that require special handling, administration, and monitoring by healthcare providers as well as being generally more expensive.



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

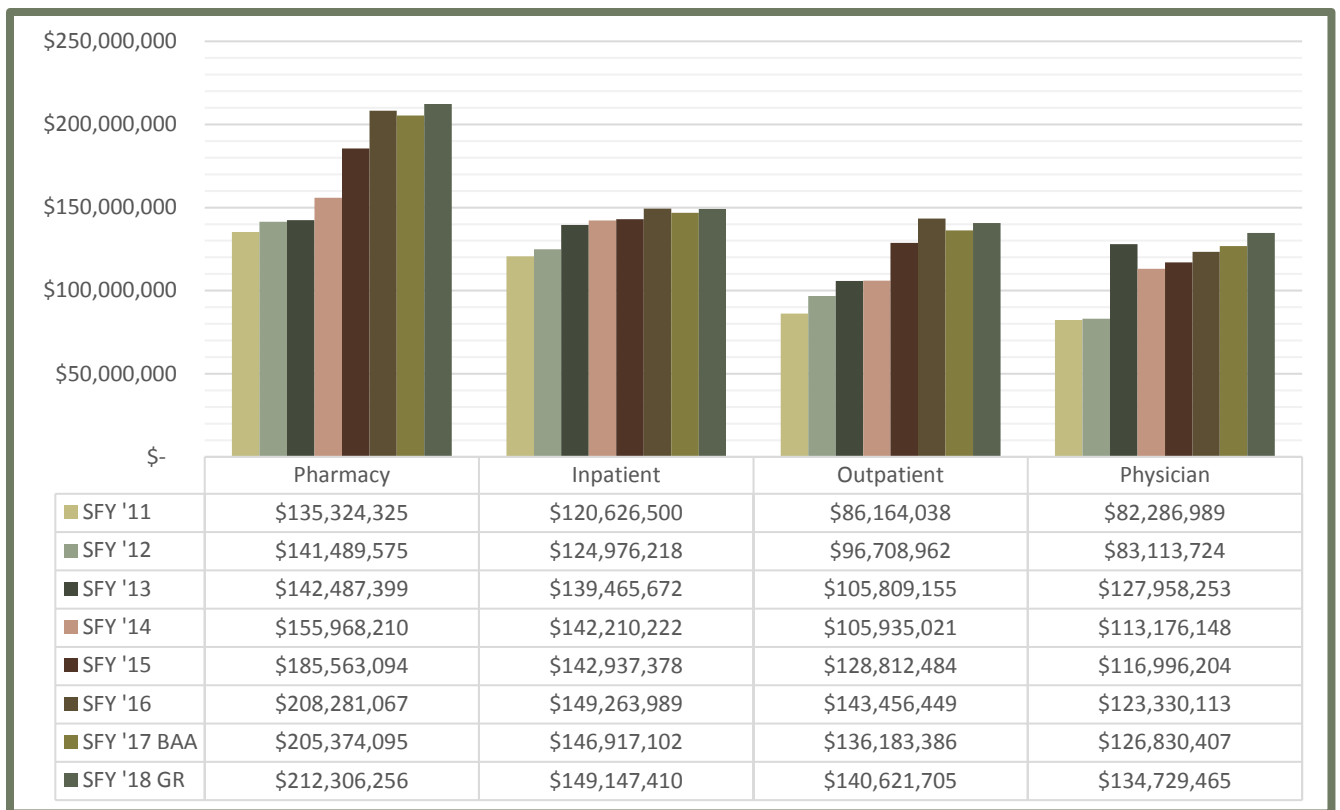


Beyond the prescription drug concerns, the healthcare delivery system in a fee-for-service model has proven to be unsustainable for Vermont and the nation. The chart below demonstrates the changes in spend distribution over the last ten years.



Note: Other Health Care includes dental, mental health providers, durable medical equipment, etc. Physician/Clinical Services includes FQHC and RHC sites of service.

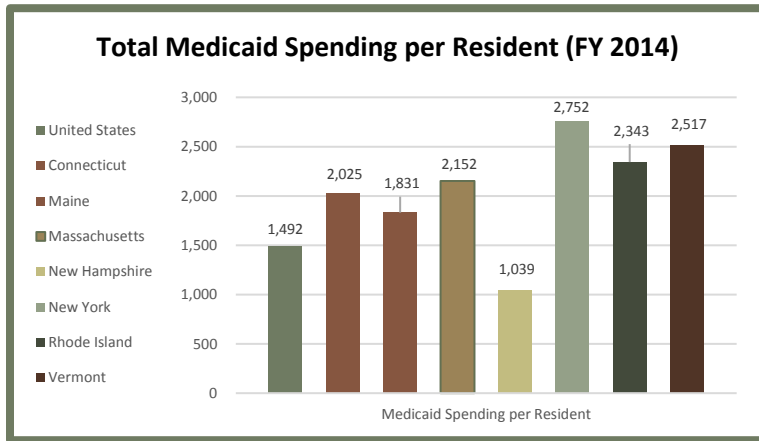
### Highest Areas of DVHA Spend SFY 2011 - SFY 2018 (projected)



As depicted in the chart above, expenses in the four key categories of service continue overall to exert pressure on the DVHA budget.

## Medicaid/CHIP Population Comparison

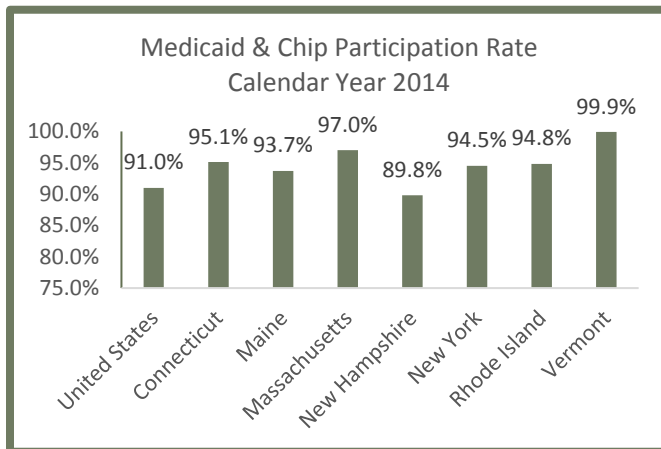
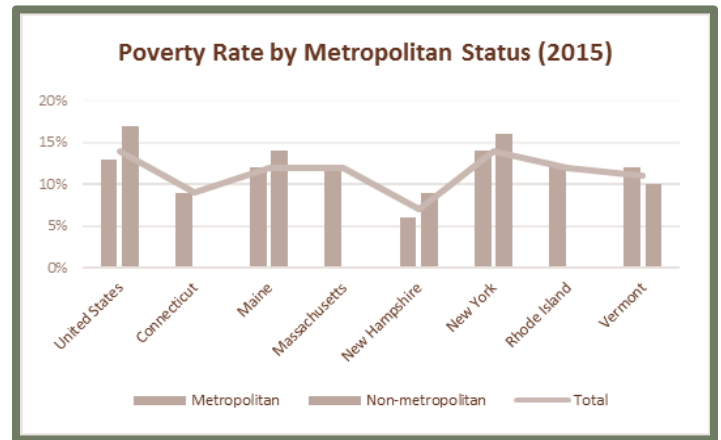
This section explores the relationship between poverty and mental health spending, nationally and regionally.



Medicaid expenditures presented here do not include administrative costs, accounting adjustments, or data for the U.S. territories. <sup>4</sup>

The Department of Health and Human Services (HHS) produces poverty thresholds called "poverty guidelines" that are used to assess eligibility for income-based programs such as Medicaid.

Non-Metropolitan includes both respondents living in non-metropolitan areas and areas not classified in either category. Metropolitan Statistical Area must include at least one city with 50,000 or more inhabitants, or a Census-Bureau defined urbanized area of at least 50,000 inhabitants and a total metropolitan population of 100,000 or more (75,000 in New England).



The Medicaid/CHIP child participation rates (the percentage of children enrolled in Medicaid or CHIP as compared to the population eligible for enrollment). <sup>5</sup>

<sup>4</sup> Source: Urban Institute analysis of CM Form 64 data as of June 2015.

<sup>5</sup> Sources: Urban Institute tabulations of 2013/2014 American Community Survey (ACS) data from the Integrated Public Use Micro-data Series (IPUMS) from: Kenney, Genevieve, Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens. [Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA.] (<http://www.urban.org/research/publication/childrens-coverage-climb-continues-uninsurance-and-medicicaidchip-eligibility-and-participation-under-aca>), The Urban Institute, Washington, DC, May 10, 2016.

## 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
<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Outpatient hospital services</li> <li>• EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services</li> <li>• Nursing Facility Services</li> <li>• Home Health Services</li> <li>• Physician Services</li> <li>• Rural health clinic services</li> <li>• Federally qualified health center services</li> <li>• Laboratory and X-ray services</li> <li>• Family Planning Services</li> <li>• Nurse Midwife services</li> <li>• Certified Pediatric and Family Nurse Practitioner services</li> <li>• Freestanding Birth Center Services (when licensed or otherwise recognized by the state)</li> <li>• Transportation to medical care</li> <li>• Tobacco cessation counseling for pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription Drugs</li> <li>• Clinic Services</li> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech, hearing and language disorder services</li> <li>• Respiratory care services</li> <li>• Other diagnostic, screening, preventative and rehabilitative services</li> <li>• Podiatry services</li> <li>• Optometry services</li> <li>• Dental services</li> <li>• Dentures</li> <li>• Prosthetics</li> <li>• Eyeglasses</li> <li>• Chiropractic services</li> <li>• Other practitioner services</li> <li>• Private duty nursing services</li> <li>• Personal care</li> <li>• Hospice</li> <li>• Case Management</li> <li>• Service for Individuals Age 65 or Older in an Institute for Mental Disease (IMD)</li> <li>• Services in an intermediate care facility for individuals with intellectual Disability</li> <li>• State Plan Home and Community Based Services-1915(i)</li> <li>• Self-Directed Personal Assistance Services-1915 (j)</li> <li>• Community First Choice Option-1915 (k)</li> <li>• TB Related Services</li> <li>• Inpatient psychiatric services for individuals under age 21</li> <li>• Other services approved by the Secretary</li> <li>• Health home for Enrollees with Chronic Conditions-Section 1945</li> </ul>

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<sup>6</sup>.

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	<i>Data not available</i>	No
Tuberculosis (TB) Related Services	No	No	No	No	No	<i>Data not available</i>	Yes
Health Homes for Enrollees with Chronic Conditions – Nursing services, home health aides and medical supplies/equipment	Yes	No	No	Yes	No	Yes	Yes

<sup>6</sup> <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>  
Budget Document—State Fiscal Year 2018



## Mental Health & Substance Use Disorder

Vermont spent \$365 million in SFY 2016 on 74,520 unique Medicaid/CHIP enrollees for members with mental health related diagnoses. This is up \$23 million from SFY 2015. Nationally, the spending for all Medicaid enrollees with mental health diagnoses in 2011 was \$131.18 billion. The 20% of enrollees with mental health diagnoses accounted for 48% of Medicaid costs. In Vermont individuals diagnosed with mental health disorders account for 50% of the total Medicaid costs and accounts for 30% of the population. However, it should be noted mental health issues may be contributing factors to other medical conditions and simply not captured in claims data.

Including addiction treatment into the spend increases Vermont spend to \$440 million. \$22 million of which is spent on medication assisted treatment for alcohol and drug dependencies inclusive of all locations and provider types. Other covered addiction treatment includes inpatient, detox, outpatient, as well as, individual and group psychotherapy.

Act 58 of the 2015 Legislative session directs the Agency of Human Services (AHS), through the Departments of Vermont Health Access (DVHA) and Mental Health (DMH), to create an implementation plan for a unified service and financial allocation for funded mental health services as parts of an integrated health care system.

The goal of the plan is to integrate public funding for direct mental health care services within the Department of Vermont Health Access while maintaining oversight function and the data necessary to perform those functions within the department of appropriate jurisdiction.

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

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

Priorities for the public mental health system include:

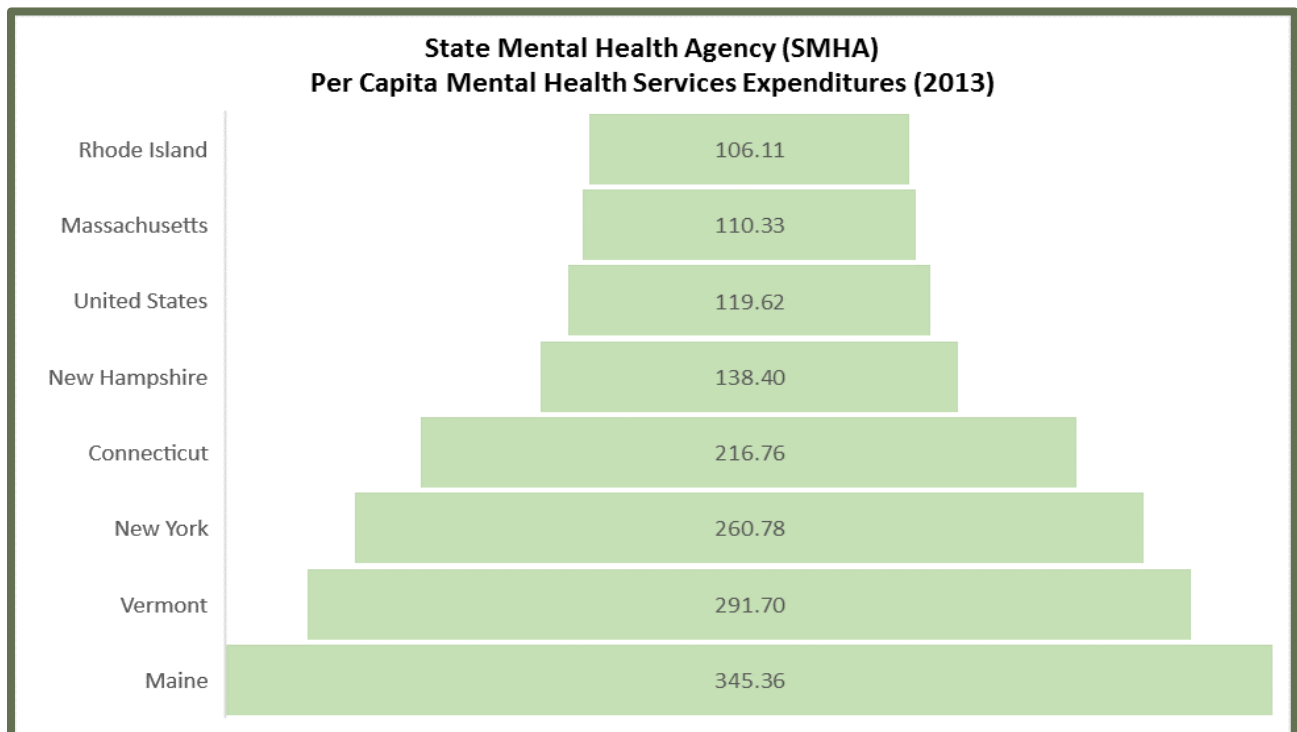
- Promotion – Promotion of mental health and wellness for all Vermonters
- Prevention – Protect all Vermonters from the risk for mental disorders
- Treatment – Intervene early to treat mental health problems
- Re-Claiming – Provide support and treatment to achieve recovery and resiliency

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

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

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

DMH manages all admissions for persons affiliated with DA/SSA programs; Level I clinical designations; Emergency Evaluations and Level I hospital cost settlements as well as the Vermont Psychiatric Care Hospital. DMH monitors overall capacity within DA/SSA Mental Health System of Care and supports continuity of care planning between multiple levels and providers of care (e.g. outpatient, inpatient, hospital diversion, step down and other community beds).



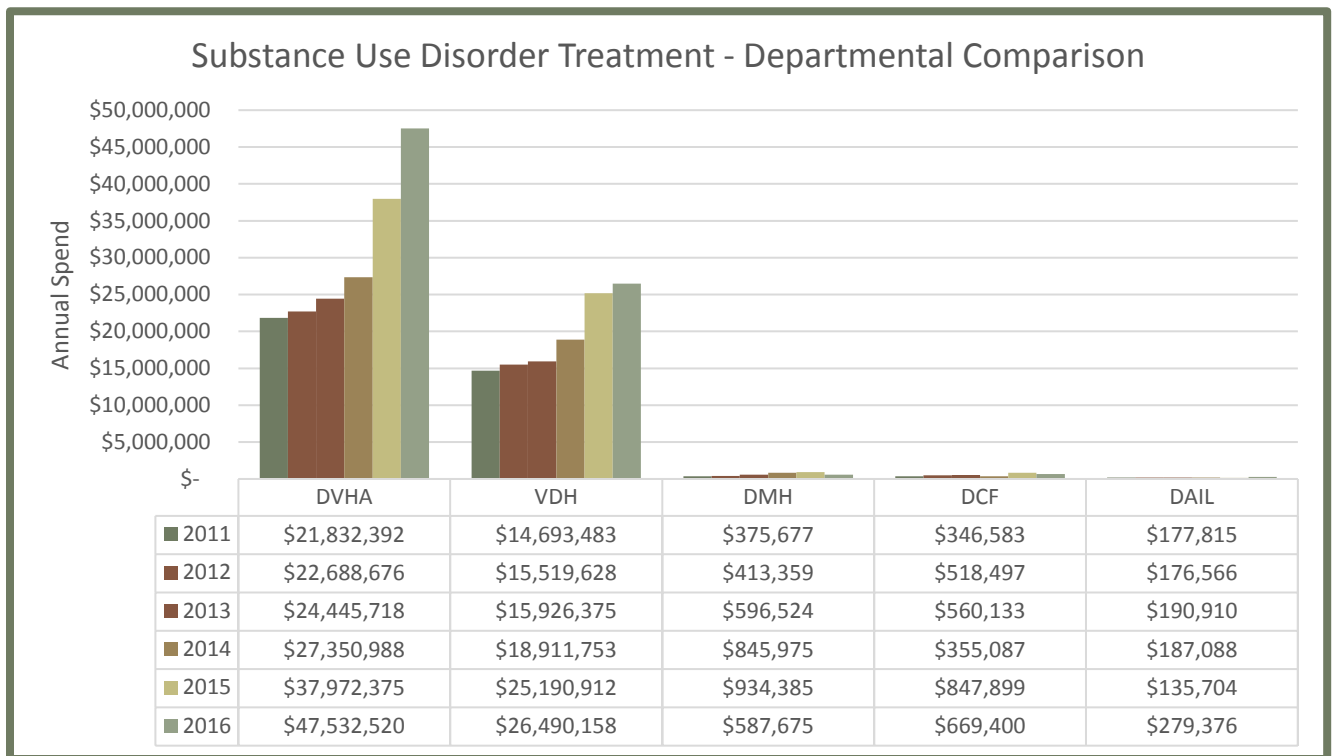
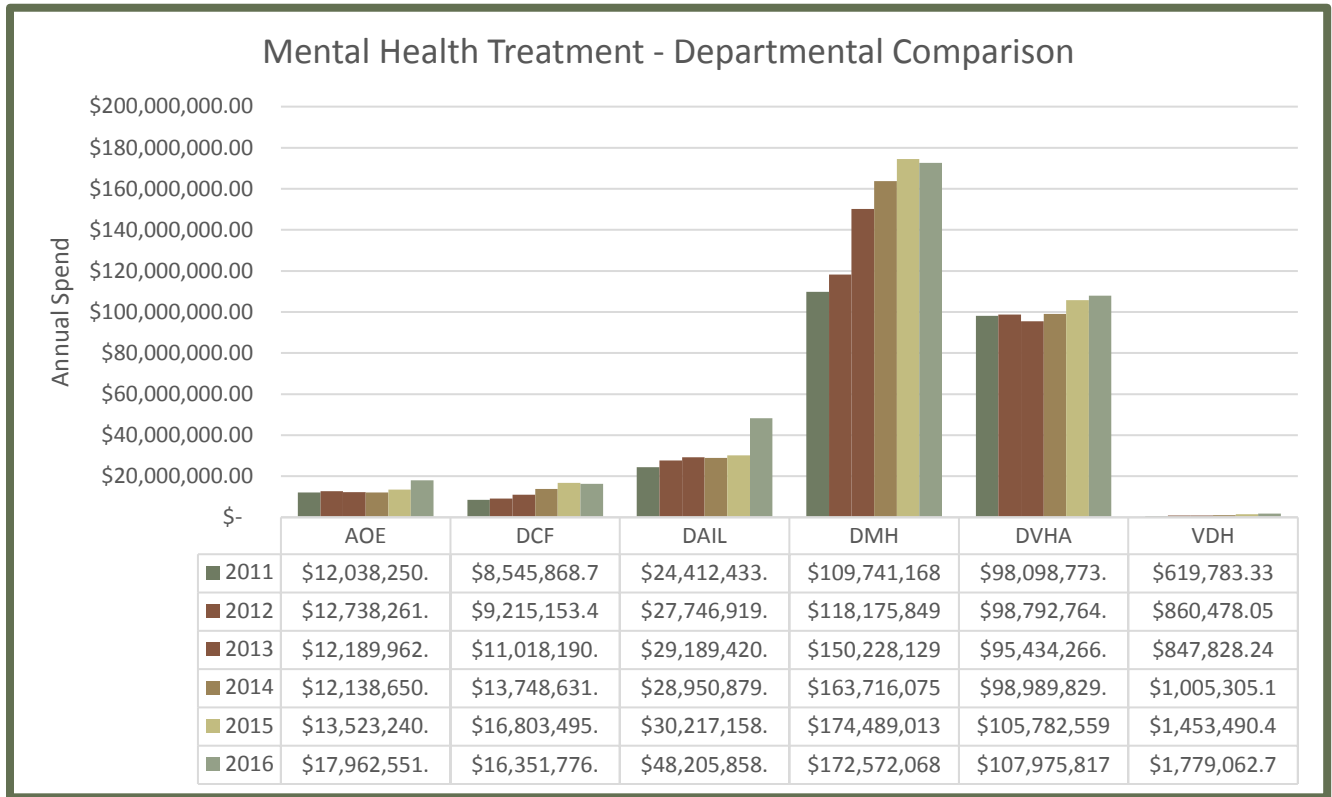
DVHA manages episodes of care for all non-DA/SSA and non-court involved adult admissions and all children’s admissions. DVHA ensures discharge planning is timely and coordinated. DVHA also provides general provider oversight through traditional fee for service Medicaid provider enrollment and program integrity process.

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

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

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

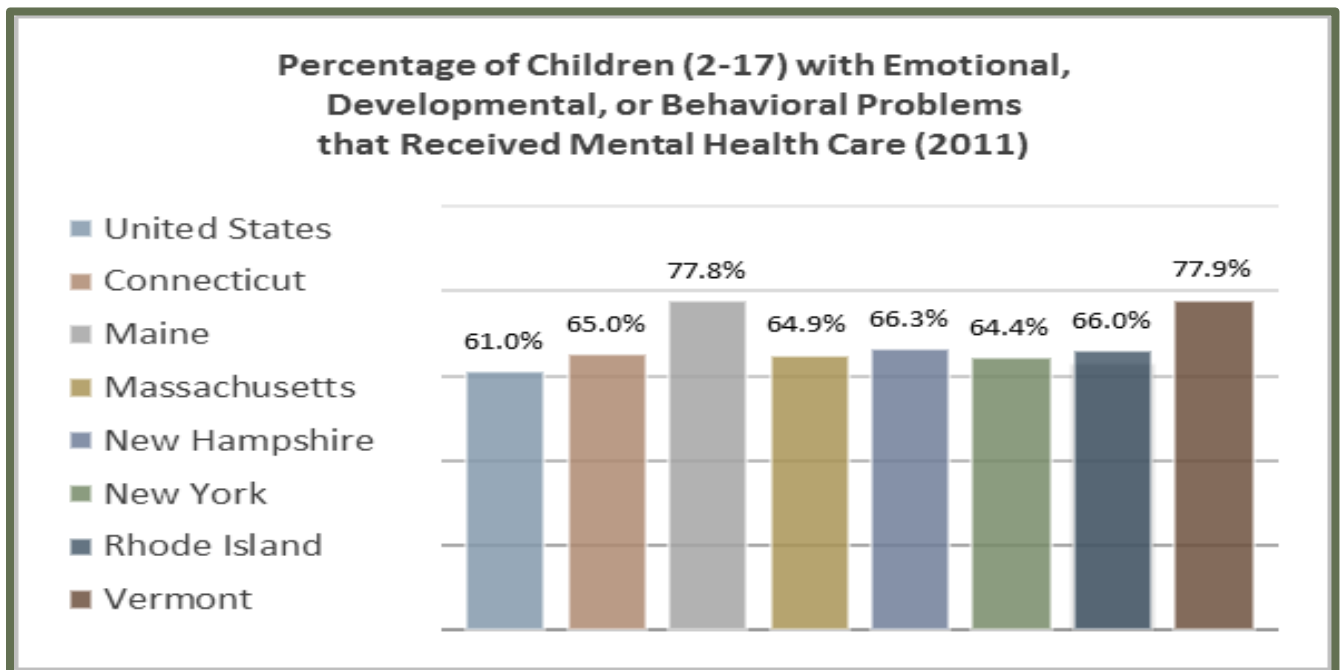
The following two charts depict the annual claims spend for Mental Health and Substance Use Disorder Treatment by the department of financial responsibility.



**Children’s Mental Health**

Mental health in childhood is characterized by the achievement of development and emotional milestones, healthy social development, and effective coping skills, such that mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. Children’s mental health is an important public health issue in the United States because of prevalence, early onset, and impact on the child, family, community, and long term health outcomes.

In comparing national trends, mental disorders among children are described as: serious deviations from expected cognitive, social, and emotional development. As you can see below, Vermont ranked the highest nationally in 2011.<sup>7</sup> It is important to note that Vermont has a well-developed community mental health system and better access. Additionally, Vermont has a long history of focusing on prevention and early intervention and have developed a system that includes those efforts. It is estimated that one out of eight U.S. children has experienced an emotional or behavioral health disorder in the past year. Based on combined data, prevalence of diagnosable mental disorders with severe impairment was 11.3% for children aged 8 to 15, and ADHD was the most common specific disorder.



**The following are the most common children’s mental health problems within the Vermont Medicaid population for SFY 2016:**

<sup>7</sup> These are the estimated percentages after applying the sampling weights.

Data based on The National Survey of Children’s Health, sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration, U.S. Department of Health and Human Services.<sup>7</sup>

Data for 2011.

- 1) ADHD - Attention-Deficit/Hyperactivity Disorder (6.8%) was the most prevalent current diagnosis among children aged 3–17 years;
- 2) Behavioral or Conduct Problems (3.5%);
- 3) Anxiety (3.0%);
- 4) Depression (2.1%);
- 5) ASD - Autism Spectrum Disorders (1.1%);
- 6) Tourette Syndrome (0.2% among children aged 6–17 years).

The most recent national statistics for these mental disorders are in the chart below.

Percentage of persons (8-15) with a past year mental disorder with or without severe impairment, U.S. (2001-2004) by level of severity and selected characteristics, U.S. (2009)										
DSM-IV (defined disorder)	Disorder without severe impairment					Disorder with severe impairment*				
	Total	Male	Female	Age 8-11	Age 12-15	Total	Male	Female	Age 8-11	Age 12-15
<b>ADHD</b>	8.6%	11.6%	5.4%	9.9%	7.4%	7.8%	10.8%	4.7%	9.1%	6.7%
<b>Conduct Disorder</b>	2.1%	2.3%	1.9%	1.5%	2.7%	1.7%	2.0%	1.4%	1.2%	2.2%
<b>Anxiety Disorder</b>	0.7%	0.4%	0.9%	0.4%	0.8%	0.4%	0.4%	0.4%	0.3%	0.5%
<b>Generalized anxiety</b>	0.3%	0.3%	0.4%	0.1%	0.7%	0.2%	0.3%	0.1%	0.0%	0.4%
<b>Panic Disorder</b>	0.4%	0.2%	0.6%	0.4%	0.4%	0.3%	0.2%	0.4%	0.3%	0.2%
<b>Eating Disorder</b>	0.1%	0.1%	0.2%	0.1%	0.2%	0.0%	0.0%	0.1%	0.0%	0.1%
<b>Mood Disorder</b>	3.7%	2.5%	4.9%	2.5%	4.8%	2.9%	1.7%	4.1%	1.8%	3.9%
<b>Major Depression</b>	2.7%	1.8%	3.7%	1.6%	3.8%	2.4%	1.6%	3.2%	1.4%	3.2%
<b>Dysthymia</b>	1.0%	0.7%	1.2%	0.8%	1.1%	0.5%	0.1%	0.9%	0.4%	0.7%
<b>Any of above</b>	13.1%	14.5%	11.6%	12.8%	13.4%	11.3%	13.0%	9.4%	11.0%	11.5%

A nationally representative study which used data on principal diagnoses for hospital stays in the United States from the Healthcare Cost and Utilization Project reported that in 2010, mood disorders were among the most common principal diagnoses for all hospital stays among children in the United States, and the rate of hospital stays among children for mood disorders increased 80% during 1997-2010, from 10 to 17 stays per 10,000 population.

Children with mental disorders also more often have other chronic health conditions (e.g., asthma, diabetes, and epilepsy) than children without a mental health diagnosis. Vermont focused on Adverse Family/Childhood Experiences and the impact of trauma on health including mental health. We know that because of trauma and adverse experiences, there is an associated increased risk for mental disorders including in adulthood. The combination of these is also associated with decreased productivity, increased substance use and injury, and substantial costs to the individual and society. There is heightened concern in Vermont and nationally regarding the substance use co-occurrence in children and adolescents. The use of alcohol and illicit drugs such as marijuana and inhalants among children has social, financial, and health consequences. Substance use among adolescents can lead to poor academic performance, mental disorders, accidents and injuries, overdose, addiction, and unintended pregnancy. Substance use affects approximately 20 million persons in the United States each year, including 1.7 million adolescents aged 12–17 years.

**Vermont Medicaid Adolescent Mental Health and Substance Abuse Costs  
SFY 2015**

**Children Ages 12 - 17**

**Primary Diagnosis Mental Health or Substance Abuse**

	Total Cost	Mental Health	Alcohol Abuse	Drug Abuse	Smoking Cessation
<b>All AHS</b>	\$82,059,497	\$80,117,247	\$655,215	\$1,280,083	\$6,950
<b>DVHA</b>	\$20,379,830	\$20,139,772	\$63,555	\$169,847	\$6,654

**GREEN MOUNTAIN CARE INFORMATION**

PROGRAM	WHO IS ELIGIBLE	COVERED SERVICES	COST-SHARING
<p><b>MABD Medicaid</b></p> <p><b>Katie Beckett Medicaid</b></p> <p><b>Medicaid Working Disabled</b></p> <p><b>MCA (Expanded Medicaid – New Adults)</b></p>	<ul style="list-style-type: none"> <li>• Age ≥ 65, blind, disabled</li> <li>• At or below the PIL</li> <li>• <b>Katie Beckett:</b> <ul style="list-style-type: none"> <li>○ Only disabled child’s income/resources used to meet MABD limits</li> </ul> </li> <li>• <b>Medicaid Working Disabled:</b> <ul style="list-style-type: none"> <li>○ ≥ 250% FPL</li> <li>○ Meet working criteria</li> </ul> </li> <li>• <b>MCA</b> <ul style="list-style-type: none"> <li>○ ≥ 138% of FPL</li> <li>○ Not eligible for Medicare</li> </ul>                     And either: Parent or caretaker relative of a dependent child; or ≤ 21 years of age, ≥ 65 years of age                 </li> </ul>	<ul style="list-style-type: none"> <li>• Physical and mental health</li> <li>• Dental (\$510 cap/yr, no dentures)</li> <li>• Prescriptions</li> <li>• Chiropractic (limited)</li> <li>• Transportation (limited)</li> <li>• Excluded classes of Medicare Part D drugs with Medicare eligibility</li> <li>• Katie Beckett Medicaid covers 100% of recipient’s costs</li> <li>• Additional benefits for youth ages 19-20, and Katie Beckett recipients (see Dr. Dynasaur below)</li> </ul>	<ul style="list-style-type: none"> <li>• No monthly premium</li> <li>• \$1/\$2/\$3 prescription co-pay if no Medicare Part D coverage</li> <li>• \$1.20 -\$6.60 co-pays with Medicare Part D coverage</li> <li>• \$3 dental co-pay</li> <li>• \$3 outpatient hospital visit co-pay (over 21 yrs of age)</li> <li>• No co-pay for pregnant or post-partum persons, or persons in LTC facility</li> </ul>
<p><b>Dr. Dynasaur</b></p>	<ul style="list-style-type: none"> <li>• Children under age 19 at or below 317% FPL</li> <li>• Pregnant persons at or below 213% FPL</li> </ul>	<ul style="list-style-type: none"> <li>• Same as Medicaid plus:                             <ul style="list-style-type: none"> <li>○ Eyeglasses</li> <li>○ Dental</li> <li>○ Additional benefits</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Up to 195% FPL: no premium</li> <li>• Up to 237% FPL: \$15/family/month</li> <li>• Up to 317% FPL: \$20/family/month (\$60/family/mo. w/out other insurance)</li> <li>• No prescription co-pays</li> </ul>
<p><b>VPharm1, 2, &amp; 3</b></p>	<ul style="list-style-type: none"> <li>• ≥ age 65, blind, or disabled</li> <li>• eligible and enrolled in Medicare PDP or MAPD</li> <li>• VPharm1:                             <ul style="list-style-type: none"> <li>○ ≤ 150% FPL</li> <li>○ Must apply for LIS</li> </ul> </li> <li>• VPharm2:                             <ul style="list-style-type: none"> <li>○ 150.01% - 175% FPL</li> </ul> </li> <li>• VPharm3:                             <ul style="list-style-type: none"> <li>○ 175.01% - 225% FPL</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• VPharm1 (after primary LIS reductions):                             <ul style="list-style-type: none"> <li>○ Medicare Part D cost-sharing</li> <li>○ Excluded classes of Part D meds</li> <li>○ Diabetic supplies</li> <li>○ Eye exams</li> </ul> </li> <li>• VPharm 2&amp;3:                             <ul style="list-style-type: none"> <li>○ Maintenance meds</li> <li>○ Diabetic supplies</li> </ul> </li> <li>• No retroactive payments</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly premium per person:                             <ul style="list-style-type: none"> <li>○ VPharm1: \$15</li> <li>○ VPharm2: \$20</li> <li>○ VPharm3: \$50</li> </ul> </li> <li>• \$1/\$2 prescription co-pays</li> </ul>
<p><b>Medicare Savings Programs</b></p>	<ul style="list-style-type: none"> <li>• ≥ age 65, blind, or disabled</li> <li>• Active Medicare beneficiaries</li> <li>• QMB: ≤ 100% FPL</li> </ul>	<ul style="list-style-type: none"> <li>• QMB covers Medicare Part B (and A if not free) premiums; Medicare A &amp; B cost-sharing</li> </ul>	<ul style="list-style-type: none"> <li>• No monthly premium</li> <li>• QMB may still have to pay Medicare co-pay, and not eligible for retroactive payments</li> </ul>



	<ul style="list-style-type: none"> <li>• SLMB 100.01 - 120% FPL</li> <li>• QI-1 120.01 - 135% FPL</li> <li>• QI-1 Not eligible for Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• SLMB and QI-1 cover Medicare Part B premiums only</li> </ul>	<ul style="list-style-type: none"> <li>• 3 months retroactive payments are possible for SLMB and QI-1</li> </ul>
<b>Healthy Vermonters Program</b>	<ul style="list-style-type: none"> <li>• 350% FPL if uninsured</li> <li>• 400% FPL if <math>\geq</math> age 65, blind, or disabled</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid prescription pricing</li> <li>• If enrolled in Medicare Part D, excluded classes of prescriptions are priced at Medicaid rate</li> <li>• No retroactive payments</li> </ul>	<ul style="list-style-type: none"> <li>• No monthly premium</li> </ul>
<b>Qualified Health Plan (QHP)</b>	<ul style="list-style-type: none"> <li>• Vermont Residents who do not have Medicare/Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Choice of Eligible QHPs on (VHC)</li> </ul>	<ul style="list-style-type: none"> <li>• Full QHP cost sharing unless reduced by tax credits, or employer share</li> </ul>
<b>Federal Advance Premium Tax Credits (APTC)</b>	<ul style="list-style-type: none"> <li>• 100-400% FPL</li> <li>• No Medicaid</li> <li>• Enrolled in Silver Plan QHP</li> </ul>	<ul style="list-style-type: none"> <li>• Tax credit received yearly as a lump sum, or monthly toward QHP premium</li> </ul>	<ul style="list-style-type: none"> <li>• Full QHP cost sharing minus tax credit</li> </ul>
<b>Federal Cost-Sharing Reduction (CSR)</b>	<ul style="list-style-type: none"> <li>• <math>\geq</math> 250% FPL</li> <li>• No affordable Minimum Essential Coverage (MEC)</li> <li>• Meets APTC</li> </ul>	<ul style="list-style-type: none"> <li>• Reduces co-pays, co-insurance, deductibles, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc.</li> </ul>
<b>Vermont Premium Assistance (VPA)</b>	<ul style="list-style-type: none"> <li>• <math>\geq</math> 300% FPL</li> <li>• No affordable MEC</li> <li>• Meets APTC</li> </ul>	<ul style="list-style-type: none"> <li>• Covers all or part of QHP premium</li> </ul>	<ul style="list-style-type: none"> <li>• Covers all or part of QHP premium</li> </ul>
<b>Vermont Cost Sharing Reductions (VCSR)</b>	<ul style="list-style-type: none"> <li>• <math>\geq</math> 300% FPL</li> <li>• No affordable MEC</li> <li>• Meets APTC</li> </ul>	<ul style="list-style-type: none"> <li>• Reduces co-pays, co-insurance, deductibles, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc.</li> </ul>

## 2017 Federal Poverty Levels – Annual Household Income

Income calculations are based on Gross Monthly Income minus some deductions. QHP, APTC, CSR, VPA, and VCSR income is determined using Modified Adjusted Gross Income (MAGI).

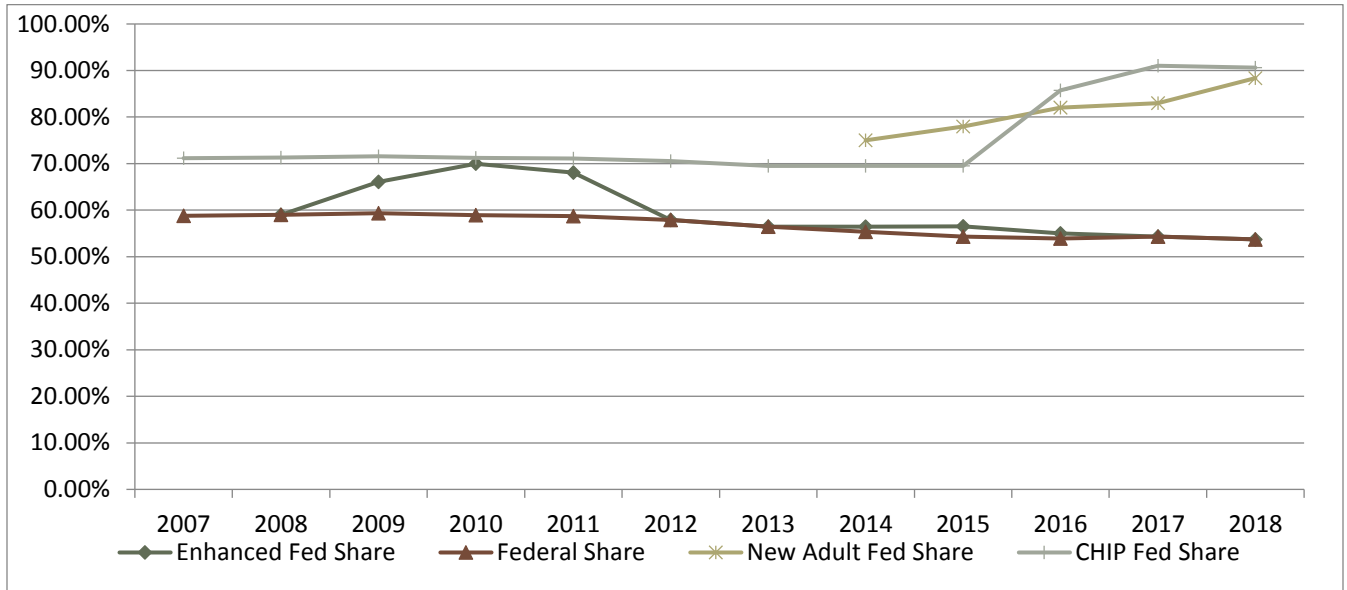
HH Size	100% FPL	120% FPL	135% FPL	150% FPL	175% FPL	200% FPL	225% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	11,880	14,256	16,044	17,820	20,796	23,760	26,736	29,700	35,640	41,580	47,520
2	16,020	19,224	21,636	24,036	28,044	32,040	36,048	40,050	48,060	56,076	64,080
3	20,160	24,192	27,216	30,240	35,280	40,320	45,360	50,400	60,480	70,560	80,640
4	24,300	29,160	32,805	36,456	42,528	48,600	54,684	60,750	72,900	85,056	97,200
5	28,440	34,128	38,394	42,660	49,776	56,880	63,996	71,100	85,320	99,540	113,760
6	32,580	39,096	43,983	48,876	57,024	65,160	73,308	81,450	97,740	114,036	130,320
7	36,730	44,076	49,586	55,104	64,284	73,460	82,644	91,825	110,190	128,556	146,928
8	40,890	49,068	55,202	61,344	71,568	81,780	92,004	102,225	122,670	143,124	163,560
9	45,050	54,060	60,818	67,584	78,840	90,100	101,364	112,625	135,150	157,680	180,204
10	49,210	59,052	66,434	73,824	86,124	98,420	110,724	123,025	147,630	172,236	196,848
11	53,370	64,044	72,050	80,064	93,408	106,740	120,084	133,425	160,110	186,804	213,480
12	57,530	69,036	77,666	86,304	100,680	115,060	129,444	143,825	172,590	201,360	230,124
13	61,690	74,028	83,282	92,544	107,964	123,380	138,804	154,225	185,070	215,916	246,768
14	65,850	79,020	88,898	98,784	115,248	131,700	148,164	164,625	197,550	230,484	263,400
15	70,010	84,012	94,514	105,024	122,520	140,020	157,524	175,025	210,030	245,040	280,044

## 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 2007 - 2018



#### FEDERAL MATCH RATES

FFIS projs + JFO/Admin consensus - rev September 30, 2016  
Fiscal Years 2010 to 2018 [Prior years are in hidden rows]

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

Federal Fiscal Year						State Fiscal Year							
FFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share	SFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share
2016	10/01/15	09/30/16	53.90%	n/a	53.90%	46.10%	2016	7/1/2015	6/30/2016	53.93%	n/a	53.93%	46.07%
	ACA Expansion State e-FMAP		53.90%	0.55%	54.45%	45.55%		ACA Expansion State e-FMAP		53.93%	1.10%	55.03%	44.97%
2017	10/01/16	09/30/17	54.46%		54.46%	45.54%	2017	7/1/2016	6/30/2017	54.32%		54.32%	45.68%
2018	10/01/17	09/30/18	53.47%		53.47%	46.53%	2018	7/1/2017	6/30/2018	53.72%		53.72%	46.28%

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

Federal Fiscal Year						State Fiscal Year							
FFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share	SFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share
2016	10/01/15	09/30/16	67.57%	0.55%	67.57%	32.43%	2016	7/1/2015	6/30/2016	67.42%	1.10%	67.42%	32.58%
	Expanded CHIP FMAP		67.57%	23.55%	91.12%	8.88%		Expanded CHIP FMAP		67.42%	18.35%	85.77%	14.23%
2017	10/01/16	09/30/17	68.12%	n/a	68.12%	31.88%	2017	7/1/2016	6/30/2017	68.02%	n/a	68.02%	31.98%
	Expanded CHIP FMAP		68.12%	23.00%	91.12%	8.88%		Expanded CHIP FMAP		68.02%	23.00%	91.02%	8.98%
2018	10/1/2017	09/30/18	67.43%	n/a	67.43%	32.57%	2018	7/1/2017	6/30/2018	67.60%	n/a	67.60%	32.40%
	Expanded CHIP FMAP		67.43%	23.00%	90.43%	9.57%		Expanded CHIP FMAP		67.60%	23.00%	90.60%	9.40%

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

10/1/2008-12/31/2010: Base Federal share + 6.2% ARRA

1/1/2011-3/31/2011: Base Federal share + 3.2% ARRA

4/1/2011-6/30/2011: Base Federal share + 1.2% ARRA

Title IV-E does not receive ACA Expansion State Enhanced FMAP.

CHAPTER FIVE: BUDGET ASK

BUDGET SUMMARY ADMINISTRATION

	GF	SF	IdptT	FF	VHC	Medicaid GCF	Invmnt GCF	Total
DVHA Administration - As Passed FY17	6,551,086	799,894	10,604,077	99,758,443		62,996,293	8,804,256	189,514,049
<b>other changes:</b>								
<b>Personal Services:</b>								
S.243 - Opioid Abuse - Acupuncture (Evidence-Based Education and Advertising Fund)		200,000						200,000
<b>FY17 after other changes</b>	<b>0</b>	<b>200,000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>200,000</b>
<b>Total after FY17 other changes</b>	<b>6,551,086</b>	<b>999,894</b>	<b>10,604,077</b>	<b>99,758,443</b>	<b>0</b>	<b>62,996,293</b>	<b>8,804,256</b>	<b>189,714,049</b>
<b>FY17 after other changes</b>								
<b>Personal Services:</b>								
Salary Increase	548,885		31,709	803,866	2,816			1,387,276
Fringe Increase	138,885		8,023	203,402	713			351,023
Deputy Commissioner Workforce Reduction - 2 FTE	(97,741)			(156,344)	(8,198)			(262,283)
2 PG Bump for 104 BPS	108,232			332,636	30,950			471,818
52 Health Access Eligibility & Enrollment Unit (HAEEU Positions)	971,375			2,985,397	277,777			4,234,549
Vacancy Savings from HAEEU	(203,655)			(396,739)	(32,666)			(633,060)
Internal Service Fund (ISF) increase	97,902		6,492	97,902				202,295
<b>Grants:</b>								
Temp Staff Contracts	175,820			175,820	24,671			376,310
VHC Contract Increases (Optum, Speridian)	331,590			994,771	93,056			1,419,417
Base Contract Increases (MMIS, Blueprint)	1,445,078	(200,000)		1,445,078				2,690,157
Decrease in IAPD Revenue	(540,116)			(4,861,047)				(5,401,164)
LTC-AAA Senior Eligibility grants transfer from DCF (AHS net neutral)	74,952			74,952				149,904
Ombudsman moving to AHS Central Office (net neutral)	(356,993)			(356,993)	(19,667)			(733,653)
VHC Contract savings for improved efficiencies	(455,895)			(804,223)	(2,402,105)			(3,662,223)
Misc Admin Contract Reductions	(400,000)			(464,304)				(864,304)
GC Admin to Medicaid Admin swap 50/50	13,473,907	2,288,181		15,762,087		(31,524,174)		0
GC Admin to Medicaid Admin swap SPMP 75/25	178,392			535,176		(713,568)		0
GC Admin to Medicaid Admin swap MMIS Legacy, Care and PBM 75/25	5,698,453			17,095,358		(22,793,810)		0
Convert VITL Investment Funding		569,912		317,751			(887,663)	0
Additional Operational Advanced Planning Document (OAPD) Revenue	1,991,185			5,973,555		(7,964,741)		0
Funding Shifts due to Cost Allocation Impacts	1,483,866	(80,049)	1,521,606	(267,922)	(2,656,644)		(857)	0
Swaps SHCRF for Exchange, replaced with IDT			(4,689,297)		4,689,297			0
<b>FY18 Changes</b>	<b>24,664,120</b>	<b>2,578,044</b>	<b>(3,121,467)</b>	<b>39,490,179</b>	<b>0</b>	<b>(62,996,293)</b>	<b>(888,520)</b>	<b>(273,938)</b>
<b>FY18 Gov Recommended</b>	<b>31,215,206</b>	<b>3,577,938</b>	<b>7,482,610</b>	<b>139,248,622</b>	<b>0</b>	<b>0</b>	<b>7,915,736</b>	<b>189,440,111</b>
<b>FY18 Legislative Changes</b>								
<b>FY18 Subtotal of Legislative Changes</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>FY18 As Passed - Dept ID 3410010000</b>	<b>31,215,206</b>	<b>3,577,938</b>	<b>7,482,610</b>	<b>139,248,622</b>	<b>0</b>	<b>0</b>	<b>7,915,736</b>	<b>189,440,111</b>

# BUDGET SUMMARY PROGRAM

<b>DVHA Program - As Passed FY17</b>	<b>55,813,197</b>	<b>0</b>	<b>0</b>	<b>29,453,975</b>	<b>0</b>	<b>942,009,237</b>	<b>7,922,526</b>	<b>1,035,198,935</b>
<b>other changes:</b>								
<b>Grants:</b>								
H.620 - LARC Reimbursement						34,864		34,864
<b>FY17 after other changes</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34,864</b>	<b>0</b>	<b>34,864</b>
<b>Total after FY17 other changes</b>	<b>55,813,197</b>	<b>0</b>	<b>0</b>	<b>29,453,975</b>	<b>0</b>	<b>942,044,101</b>	<b>7,922,526</b>	<b>1,035,233,799</b>
<b>FY17 after other changes</b>								
<b>Grants:</b>								
53rd week base funding rescission						(13,027,475)		(13,027,475)
Caseload and Utilization	877,821			569,665		11,981,737	1,745,502	15,174,725
Caseload and Utilization Reserve						(21,607,606)		(21,607,606)
Buy-in Adjustment				198,764		1,214,814		1,413,578
Clawback increase	2,457,530							2,457,530
Disproportionate Share (DSH) 10% Reduction	(1,712,360)			(1,987,640)				(3,700,000)
Change in FMAP	400,110			(400,110)				0
Statutory Nursing Home inflationary rate increase (from Rate Setting)						3,315,308		3,315,308
Statutory Nursing Home Nurse Rebase						1,390,064		1,390,064
Nursing Home Medicaid Bed Day decrease in utilization 1.67% - 10,390 days @ \$196.54 per day						(2,042,050)		(2,042,050)
Moderate Needs Group - AAA flex funds funded by reinvestment for a couple years - need to base budget						178,740		178,740
Home and Community Based caseload pressure 43 x \$30,100						1,294,300		1,294,300
Base budget H&CB caseload pressure built in SFY17 that was funded by anticipated carryforward funds						445,000		445,000
Money Follows the Person pressure on GC due to loss of federal funds for 1/2 year, no transfer of GF as the base budget for MFP is half of recent year actuals.						1,700,000		1,700,000
2% Transfer from AHS-CO for CFC H&CB (AHS net neutral)						1,091,216		1,091,216
<b>FY18 Changes</b>	<b>2,023,101</b>	<b>0</b>	<b>0</b>	<b>(1,619,321)</b>	<b>0</b>	<b>(14,065,951)</b>	<b>1,745,502</b>	<b>(11,916,670)</b>
<b>FY18 Gov Recommended</b>	<b>57,836,298</b>	<b>0</b>	<b>0</b>	<b>27,834,654</b>	<b>0</b>	<b>927,978,150</b>	<b>9,668,028</b>	<b>1,023,317,129</b>
<b>FY18 Legislative Changes</b>								
<b>FY18 Subtotal of Legislative Changes</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>FY18 As Passed - Dept ID 3410018000</b>	<b>57,836,298</b>	<b>0</b>	<b>0</b>	<b>27,834,654</b>	<b>0</b>	<b>927,978,150</b>	<b>9,668,028</b>	<b>1,023,317,129</b>
<b>TOTAL FY17 DVHA Big Bill As Passed</b>	<b>62,364,283</b>	<b>799,894</b>	<b>10,604,077</b>	<b>129,212,418</b>	<b>0</b>	<b>1,005,005,530</b>	<b>16,726,782</b>	<b>1,224,712,984</b>
<b>TOTAL FY17 DVHA Reductions &amp; other changes</b>	<b>0</b>	<b>200,000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>34,864</b>	<b>0</b>	<b>234,864</b>
<b>TOTAL FY18 DVHA Starting Point</b>	<b>62,364,283</b>	<b>999,894</b>	<b>10,604,077</b>	<b>129,212,418</b>	<b>0</b>	<b>1,005,040,394</b>	<b>16,726,782</b>	<b>1,224,947,848</b>
<b>TOTAL FY18 DVHA ups &amp; downs</b>	<b>26,687,221</b>	<b>2,578,044</b>	<b>(3,121,467)</b>	<b>37,870,858</b>	<b>0</b>	<b>(77,062,244)</b>	<b>856,982</b>	<b>(12,190,606)</b>
<b>TOTAL FY18 DVHA Gov Recommended</b>	<b>89,051,504</b>	<b>3,577,938</b>	<b>7,482,610</b>	<b>167,083,276</b>	<b>0</b>	<b>927,978,150</b>	<b>17,583,764</b>	<b>1,212,757,242</b>
<b>TOTAL FY18 DVHA Legislative Changes</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>TOTAL FY18 DVHA As Passed</b>	<b>89,051,504</b>	<b>3,577,938</b>	<b>7,482,610</b>	<b>167,083,276</b>	<b>0</b>	<b>927,978,150</b>	<b>17,583,764</b>	<b>1,212,757,242</b>

## BUDGET CONSIDERATIONS

The Department of Vermont Health Access (DVHA) budget request includes a decrease in administration of \$273,938 and a decrease in program of \$11,916,670, for a total of \$12,190,606 in reduced appropriations as compared to our SFY 2017 appropriated spending authority.

The programmatic changes in DVHA's budget are 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 populations so we are consolidating these items for the purposes of testimony and have provided a spreadsheet at the beginning of this narrative that consolidates the official state budget ups and downs to track with our testimony. It is also worth noting that while Choices for Care is still handled independently of the Global Commitment appropriation, the expenditures are now allocated at the same rates and using the same funds.

Within the administrative section, the re-negotiated terms and conditions has an impact on the general fund appropriation. While there will be continued access to Investment funds for Blueprint projects, the State will not have access to Global Commitment funding for traditional Medicaid administrative services. The traditional Medicaid match rate is 50% federal. However, DVHA will be able to claim an enhanced match rate of 75% federal for the operation and maintenance of the certified MMIS, currently under contract with Enterprise Services, and certain state staff.

**PROGRAM**

The Department of Vermont Health Access requests a decrease of **\$11,916,670 gross/ \$3,679,111 state** to support the programmatic budget.

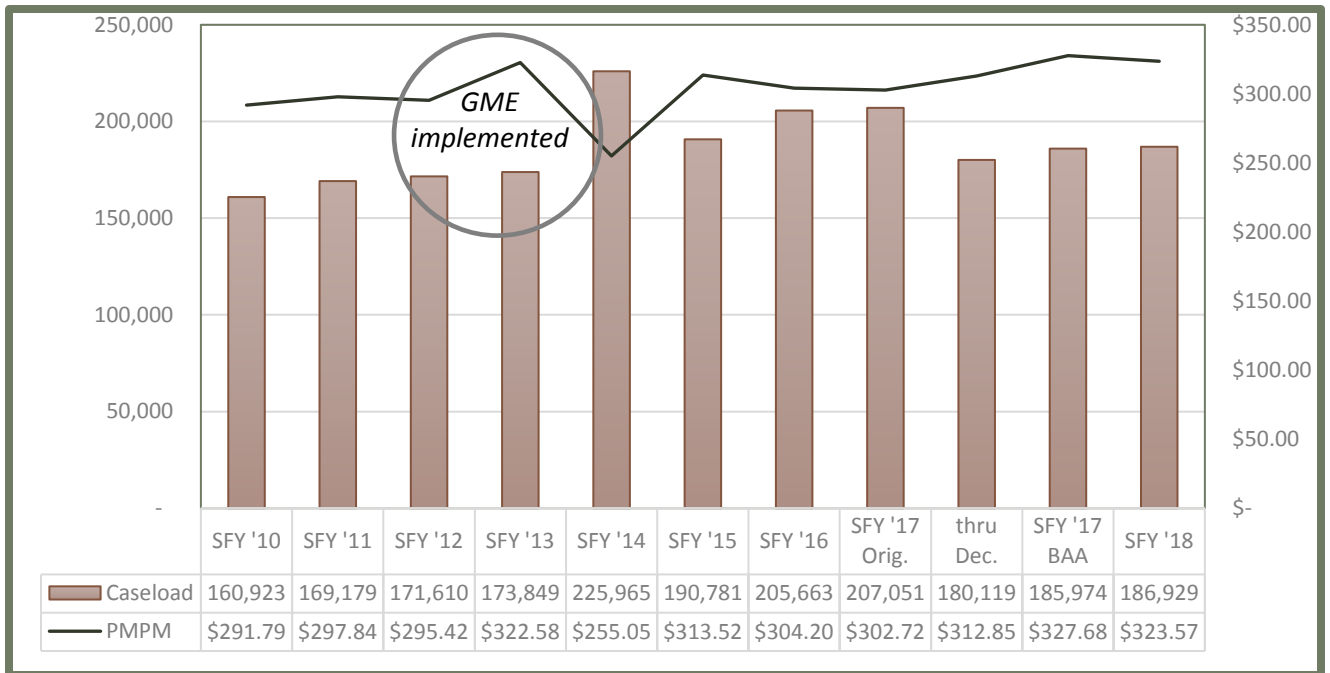
**53<sup>rd</sup> Week Base Funding Rescission . . . . . (\$13,027,475)**  
*(\$6,029,441) state*

The 53rd week was paid for in SFY 2016 using base funds appropriated to the Agency of Human Services. Since this was a one-time expenditure in SFY 2016, these funds will not be needed to cover base costs in SFY 2018. Therefore, appropriations can be reduced accordingly without impacting programs.

**Caseload and Utilization Changes . . . . . \$15,174,725**  
*\$6,422,969 state*

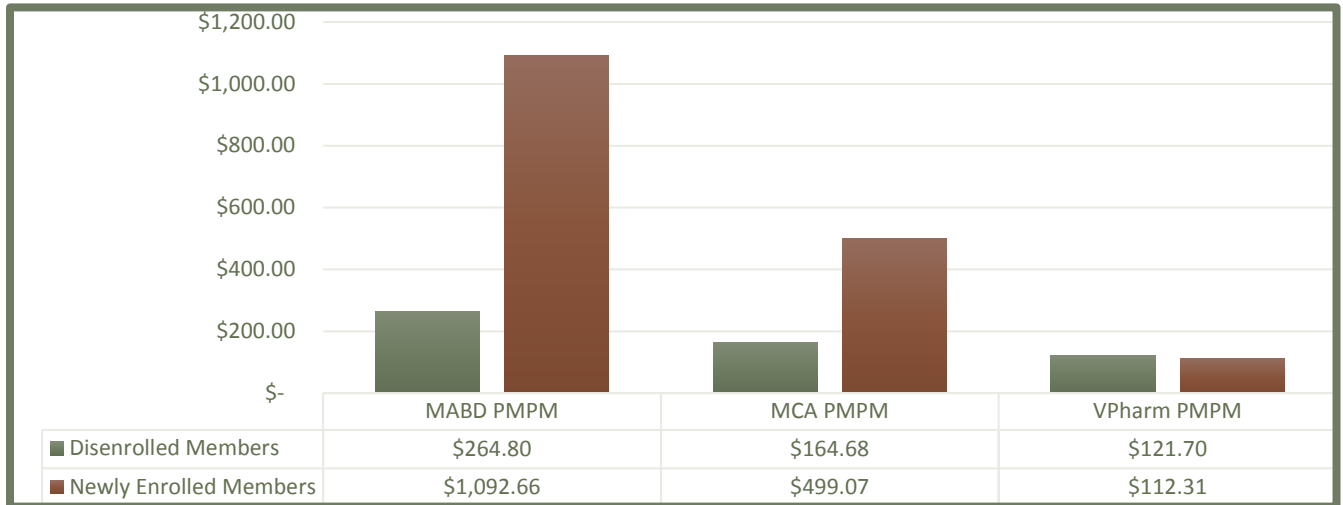
DVHA engages in a consensus caseload and utilization estimate process with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services when projecting caseload and utilization changes. States are required to re-determine eligibility for Medicaid enrollees every year. However, since the inception of the Affordable Care Act, DVHA had a waiver from having to do so. DVHA entered into a mitigation plan with the Centers for Medicare and Medicaid Services (CMS) to bring the re-enrollments current and have been processing approximately 9,000 applications a month. This resulted in a sub-set of individuals remaining on Medicaid for two years demonstrating a disproportionate growth in enrollment trends. Due to the dramatic effect on enrollment driven by redeterminations, the State chose to also engage the expertise of an independent firm to evaluate the drop in caseload as compared to the impacts on per-member per-month (PMPM) costs.

Year-Over-Year Caseload and Utilization Comparison



One of the things we are seeing, however, is that though caseload is declining, there is not an equal parallel to expenditures. Individuals dropping off Medicaid were utilizing services at a disproportionately lower rate than new individuals enrolling for coverage:

**Per Member Per Month Costs of Members Utilizing Healthcare Services**



**Caseload and Utilization Reserve . . . . . (\$21,607,606)**

*\$(10,000,000) state*

Though consensus was garnered through the traditional annual process, DVHA continues to have expenses come in under budget expectations due to the collections of drug rebates. Since it is essential that general fund dollars be appropriated to ensure all critical state government functions can continue, the funds were transferred to the Human Services Caseload reserve to protect against future risk and/or caseload uncertainties.

**Buy-In Adjustment . . . . . \$1,413,578**

*\$562,246 state*

The federal government allows for states to use Medicaid dollars to “buy-in” to Medicare on behalf of eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload and member month costs vary from year to year.

**Clawback Increase . . . . . \$2,457,530**

*\$2,457,530 state*

Currently, all beneficiaries of Vermont’s publicly funded pharmacy programs who are also covered by Medicare, should receive their primary pharmacy benefit from Medicare. Medicare Part D design calls for states to annually pay a portion of what they would have paid in Medicaid “state share” in that year for those enrollees who are or would be eligible for Medicaid drug coverage. This is referred to as “Clawback” or “state phase down”.



**Disproportionate Share Reduction** ..... **(\$3,700,000)**  
*\$(1,712,360) state*

Hospitals currently receive supplemental income called Disproportionate Share Hospital (DSH) payments. Due to the success of the Affordable Care Act, Vermont reduced its rate of uninsured by half. As such, DVHA is proposing a reduction in these types of payments.

**Change in Federal Match** ..... **\$0**  
*\$400,110 state*

The federal receipts the State receives is dependent upon a funding formula used by the federal government (Federal Medical Assistance Percentage – FMAP) and which is based on economic need for each state across the country. This general fund impact is due to a reduction in the traditional match rate.

**DAIL Managed Policy Decisions** ..... **\$7,372,578**  
*\$3,412,213 state*

DVHA pays for the Choices for Care (CFC) expenditures, but DAIL is responsible for managing the long-term care components. 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 Rate Changes & Bed-Day Decreases - \$2,663,322
- Moderate Need Rate Change - \$178,740
- Home and Community Based Caseload - \$1,739,300
- Money Follows the Person Funding Changes - \$1,700,000
- 2% Transfer from AHS-CO for CFC HCBS - \$1,091,216

**ADMINISTRATIVE**

The Department of Vermont Health Access requests a decrease of **\$273,938 gross/ (\$5,446,792) state** to support the programmatic budget.

**Personal Services** ..... **\$5,549,323**  
*\$1,777,105 state*

- Pay Act and Fringe ..... \$1,738,299 gross / \$731,030 state
- Elimination of Two Deputy Commissioners ..... (\$262,283) gross / (\$105,939) state
- 2 Paygrade Increase for Benefits Program Specialists ..... \$471,818 gross / \$139,182 state
- 52 Health Access Eligibility & Enrollment Positions ..... \$4,234,549 gross / \$1,249,153 state
- Vacancy Savings Increase due to HAEEU Positions ..... (\$633,060) gross / (\$236,321) state
- 

**Operating** ..... **\$202,295**  
*\$104,394 state*

DVHA receives allocations from the Department of Buildings and General Services (BGS) to cover our share of the Vision system and fee-for-space, the Department of Information and Innovation (DII) costs,

and the Department of Human Resources (DHR). Departments are notified every year of increases or decreases in their relative share in order to incorporate these changes into budget requests.

**Grants and Contracts . . . . . (\$6,025,556)**  
*(\$7,328,290) state*

- Eligibility Unit Temporary Support . . . . . \$376,310 gross / \$200,490 state  
 The Health Access Eligibility and Enrollment Unit has relied upon temporary staff to help support the ongoing operations within their division. While it is expected that the core contract used to staff the 30 full-time equivalent (FTE) temporary positions will no longer be utilized in SFY 2018, there is one contract that staffs 5 FTEs that will be needed into this fiscal year.
  
- Vermont Health Connect Contract Increases . . . . . \$1,419,417 gross / \$424,646 state  
 Through a competitive bid process, Vermont engaged OptumHealth to continue to perform enhanced maintenance and operation (M&O) including increased scope of services previously delivered by OneGate and additional Medicaid enrollment populations. This request annualizes the value previously asked for during budget adjustment.
  
- Base Contract Increases . . . . . \$2,690,157 gross / 1,245,078 state  
 DVHA contracts with Enterprise Services Inc, previously known as Hewlett Packard Enterprises (HPE), to run our Medicaid Management Information System and provide fiscal agent services in order to effectively manage much of our \$1 billion programmatic expenditures. This contract needed to be extended resulting in an increase in the contract value. Additionally, the Blueprint program has administrative contracts supporting the Community Health Team construct. To continue to advance the work of the Women’s Health Initiative, increases were required in these contracts. This request annualizes the value previously asked for during budget adjustment.
  
- Decrease in Project Contracts . . . . . (\$5,401,164) gross / (\$540,116) state  
 DVHA has been engaged in multiple design, development, and implementation (DDI) contracts through the build-out of the Vermont Health Connect. As the system continues to mature, less funding is needed to support the build of the project.
  
- Transfer of LTC – AAA Senior Eligibility Grants . . . . . \$149,904 gross / \$74,952 state  
 The Long-Term Care Eligibility Unit was transferred to DVHA at the inception of SFY 2017. These individuals are responsible for managing Senior Eligibility Grants. The cost for these agreements remained in DCF’s budget during SFY 2017. This is a cost-neutral transfer from DCF to DVHA so the money aligns with the individuals who manage them.
  
- Movement of Ombudsman Contract to AHS . . . . . (\$733,653) gross / (\$376,660) state  
 There are multiple contracts with Vermont Legal Aid across the various AHS departments. It was decided that these services could be more effectively managed by combining the

agreements into one and have it managed out of the AHS Central Office. This is a cost-neutral shift of funding from DVHA to AHS.

- VHC Contract Savings for Improved Efficiencies . . . . . (\$3,662,223) gross / (\$2,858,000) state  
There are many individuals who enroll through Vermont Health Connect that do not receive any sort of federal or state subsidies. By encouraging these people to enroll directly with the carriers, DVHA can garner administrative efficiencies. The predominance of the savings comes from a cost allocation shift to Medicaid (as a smaller percentage of the population now allocate to state only). There are additional savings to be achieved through less utilization of the call center, the premium processor, the Ombudsman, and mailings. We also are going to push to level fund contracts to SFY 2017 amounts and reduce the amount spent on outreach, education, advertising, and navigators.
  
- Miscellaneous Administrative Contract Reductions . . . . . (\$864,304) gross / (\$400,000) state  
DVHA has a strong reliance on outsourced contractors. It is this Administration's commitment to evaluate all of these agreements and find a way to reduce the overall appropriation through found efficiencies.
  
- Changes in Funding . . . . . \$0 gross / (\$5,098,680) state  
Prior year Global Commitment administrative expenditures were funded at the program match rate. The most recent GC negotiations has the State reverting to drawing in 50% federal/50% state for traditional admin and 75% federal/25% state for Skilled Professional Medical Personal and MMIS and Eligibility systems and staff costs. Though this shift does not produce a gross change to DVHA's budget, there is a general fund savings due to these adjustments. Additionally, we are able to garner enhanced federal receipts through an Operational Advanced Planning Document with CMS regarding eligibility determination. Other revenue adjustments include shifts due to cost allocation impacts and a movement of funding for VTTL from federal to other state sources.

## Category of Service (COS) Spend

Category of Service	Actual	BAA	Gov. Rec.	2017 BAA -	5-Yr. Avg. Growth % Chg.	5-Yr. Total Change	10-Yr. Avg. Growth % Chg.	10-Yr. Total Change
	SFY '16	SFY '17	SFY '18	2018 Rec. %				
Inpatient	149,263,989	146,917,102	149,147,410	1.52%	1.18%	4,706,880	5.98%	62,911,572
Outpatient	143,456,449	136,183,386	140,621,705	3.26%	5.65%	30,248,365	7.03%	67,048,824
Physician	123,330,113	126,830,407	134,729,465	6.23%	0.24%	13,654,258	6.82%	56,845,668
Pharmacy	208,281,067	205,374,095	212,306,256	3.38%	7.98%	49,405,885	5.63%	86,596,439
Nursing Home	120,190,810	120,694,103	125,371,604	3.88%	0.75%	(301,847)	0.53%	6,010,025
Mental Health Facility	645,746	611,730	670,650	9.63%	22.19%	(85,144)	27.16%	532,658
Dental	29,229,900	30,445,273	31,251,506	2.65%	8.81%	8,118,006	5.18%	11,932,105
MH Clinic	194,888	196,267	202,540	3.20%	554.84%	354	364.44%	187,787
Independent Lab/Xray	11,705,155	12,012,366	12,883,150	7.25%	26.58%	5,722,372	14.36%	6,937,365
Home Health	6,789,547	6,659,214	6,827,348	2.52%	0.67%	(245,412)	0.47%	250,913
RHC	7,554,078	6,901,604	7,589,355	9.97%	7.80%	1,624,072	2.97%	1,488,183
Hospice	4,058,563	3,933,640	4,213,488	7.11%	30.33%	1,309,219	17.58%	2,883,452
FQHC	28,567,293	25,974,780	26,608,796	2.44%	7.32%	5,790,415	10.78%	16,328,588
Chiropractor	1,365,792	1,314,004	1,365,098	3.89%	10.58%	346,447	4.18%	400,971
Nurse Practitioner	1,038,466	1,019,930	1,041,360	2.10%	1.21%	129,967	8.18%	532,106
Skilled Nursing	2,633,311	2,660,554	2,657,180	-0.13%	-1.57%	(440,123)	-1.68%	(573,167)
Podiatrist	236,072	234,619	244,848	4.36%	-4.05%	(65,922)	2.38%	(1,800)
Psychologist	27,906,070	25,431,417	27,115,471	6.62%	6.73%	3,773,481	6.30%	12,036,612
Optometrist	2,327,892	2,259,193	2,334,046	3.31%	10.77%	587,533	9.73%	1,363,352
Optician	206,150	210,291	215,673	2.56%	2.72%	22,354	-1.72%	(47,232)
Transportation	12,682,079	12,984,916	13,049,002	0.49%	4.81%	2,517,962	1.54%	1,354,429
Therapy Services/ PT OT	5,887,648	5,691,813	5,902,579	3.70%	13.98%	1,504,368	10.41%	3,580,253
Prosthetic/Ortho	3,507,216	3,613,923	3,670,072	1.55%	5.24%	916,509	7.29%	1,789,037
Medical Supplies	1,467,899	1,446,406	1,477,652	2.16%	12.55%	460,645	5.75%	587,375
DME	10,088,474	9,871,310	10,096,953	2.29%	4.63%	1,254,214	3.76%	2,978,054
H&CB Services	59,240,530	59,526,677	61,864,468	3.93%	4.88%	8,179,994	3.12%	15,569,137
H&CB Services Mental Service	697,455	711,359	730,260	2.66%	7.60%	131,088	3.90%	155,106
H&CB Services Mental Retardation	(650)	-	-	0.00%	-158.52%	(1,274)	0.00%	-
Enhanced Resident Care	9,054,265	9,097,934	9,455,220	3.93%	6.49%	1,370,581	5.84%	3,723,737
Personal Care Services	13,216,268	10,262,423	10,165,450	-0.94%	-8.99%	(8,258,423)	-3.72%	(9,111,059)
Targeted Case Management (Drug)	45,453	45,957	47,311	2.95%	-5.99%	(27,193)	268.97%	5,731
Assistive Community Care	14,036,662	14,078,408	14,984,948	6.44%	1.34%	600,311	2.57%	3,293,013
Day Treatment MHS	169	0	0	0.00%	0.00%	19	0.00%	(86,780)
ADAP Families in Recovery	3,088,695	3,101,857	3,212,111	3.55%	139.54%	1,963,206	105.78%	3,192,686
Rehabilitation	778,552	745,735	775,116	3.94%	2040.47%	(5,288)	1015.45%	754,342
D & P Dept of Health	306,463	314,512	320,405	1.87%	47.66%	(48,665)	13.73%	(3,509,762)
PC+Case Mgmt Fees	1,542,550	1,555,972	1,609,533	3.44%	3.63%	(1,421,630)	1.28%	(3,716,778)
Blueprint & CHT	14,762,160	14,938,312	15,415,997	3.20%	35.58%	7,361,083	0.00%	15,415,997
Other Premiums (CSR)	1,186,720	1,232,289	1,232,289	0.00%	0.00%	899,666	0.00%	1,232,289
Catamount, ESI, & VHAP ESI Premiums	5,262,182	6,065,475	5,706,135	-5.92%	-17.82%	(46,159,226)	-2.80%	(26,504,635)
Ambulance	4,448,037	5,583,554	6,180,655	10.69%	10.30%	1,548,845	8.62%	3,036,423
Dialysis	1,456,654	1,454,751	1,510,347	3.82%	7.79%	5,381	-3.13%	(1,502,141)
ASC	61,095	59,241	63,303	6.86%	3.54%	5,044	53.01%	54,740
Miscellaneous	1,846,121	1,802,073	(19,803,915)	-1198.95%	176.52%	1,547,578	-21.20%	(19,898,358)
Clawback	29,011,845	33,750,064	36,207,593	7.28%	5.62%	7,916,750	7.59%	15,428,500
DSH	37,448,781	37,448,781	33,748,781	-9.88%	0.00%	0	-0.48%	(1,900,000)
HIV Insurance Fund F	8,484	9,038	9,695	7.27%	-18.74%	(17,502)	-9.72%	(35,281)
Legal Aid	547,983	547,983	-	-100.00%	2.23%	(45,665)	-9.72%	(547,983)
Buy-In	37,271,322	39,320,072	41,411,125	5.32%	3.97%	5,658,176	4.74%	14,753,948
PDP Premium	1,503,221	1,577,321	1,656,187	5.00%	0.12%	62,669	-0.17%	(173,538)
HIPPS	474,979	484,848	479,389	-1.13%	4.46%	95,709	26.75%	326,725
Drug Rebates	(111,015,837)	(106,275,214)	(110,399,949)	3.88%	11.71%	(43,115,748)	13.29%	(72,849,220)
ACA Rebate	(3,793,338)	(3,937,084)	(3,937,084)	0.00%	-1.60%	(573,881)	-1.64%	(3,937,084)
Drug Rebate Interest	(5,699)	(5,945)	(6,162)	3.65%	215.01%	(2,318)	130.36%	(6,162)
Supplemental Drug Rebates	(9,882,281)	(10,240,735)	(10,630,988)	3.81%	5.50%	(214,423)	6.74%	(4,141,277)
Cost Settlements	4,070,870	4,113,134	4,241,548	3.12%	26.87%	(33,839)	-1.35%	7,298,753
TPL - All	(4,599,564)	(4,423,586)	(4,525,842)	2.31%	4.54%	(1,011,001)	1.69%	526,375
<b>Grand Total of All Expenditures</b>	<b>1,014,684,817</b>	<b>1,012,417,548</b>	<b>1,023,317,131</b>	<b>1.08%</b>	<b>1.95%</b>	<b>67,788,249</b>	<b>1.85%</b>	<b>47,493,728</b>

**DEPARTMENT OF VERMONT HEALTH ACCESS BUDGET BY MEDICAID ELIGIBILITY GROUP**

PROGRAM EXPENDITURES																					
Adults	SFY '13 Actuals			SFY '14 Actuals			SFY '15 Actuals			SFY '16 Actuals			SFY '17 As Passed			SFY '17 BAA			SFY '18 Gov. Rec		
	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM	Enrollment	total correctly	PMPM	Enrollment	Expenses	PMPM	Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)	14,309	\$ 104,236,243	\$ 607.05	14,852	\$ 108,329,783	\$ 607.82	15,967	\$ 102,508,327	\$ 535.01	15,001	\$ 99,308,972	\$ 551.69	17,229	\$ 105,981,420	\$ 512.62	8,791	\$ 70,363,336	\$ 666.98	8,636	\$ 74,195,101	\$ 715.91
Dual Eligibles	17,155	\$ 48,224,153	\$ 234.25	17,384	\$ 49,143,760	\$ 235.58	18,244	\$ 53,518,538	\$ 244.46	20,280	\$ 55,523,042	\$ 228.15	19,153	\$ 55,272,017	\$ 240.48	17,758	\$ 57,665,231	\$ 270.61	18,007	\$ 59,567,044	\$ 275.66
General	11,387	\$ 73,079,701	\$ 534.83	13,115	\$ 76,094,174	\$ 483.51	17,381	\$ 88,383,933	\$ 423.75	20,101	\$ 92,641,465	\$ 384.07	22,041	\$ 100,815,869	\$ 381.17	15,848	\$ 82,715,184	\$ 434.93	15,222	\$ 85,433,739	\$ 467.72
VHAP	37,475	\$ 165,952,625	\$ 369.03	36,637	\$ 97,932,892	\$ 423.90		\$ (292,634)			\$ 208,896										
VHAP ESI	793	\$ 936,724	\$ 98.48	720	\$ 849,213	\$ 158.08		\$ (8,048)			\$ (425)										
Calamount	11,484	\$ 53,960,735	\$ 391.56	13,329	\$ 48,356,058	\$ 387.41		\$ (9,233)			\$ (2,525)										
ESIA	742	\$ 699,507	\$ 78.54	689	\$ 638,510	\$ 117.75		\$ (15,969)			\$ 78										
New Adult				47,315	\$ 72,982,243	\$ -	53,153	\$ 224,311,542	\$ 351.68	62,562	\$ 248,721,362	\$ 331.30	59,021	\$ 231,146,862	\$ 326.36	59,021	\$ 255,945,079	\$ 361.38	59,063	\$ 275,478,837	\$ 388.68
Premium Assistance				14,013	\$ 2,571,477	\$ 36.91	13,177	\$ 5,611,465	\$ 35.49	14,893	\$ 5,266,242	\$ 29.47	17,588	\$ 5,954,932	\$ 28.21	15,831	\$ 6,065,475	\$ 31.93	16,828	\$ 5,706,135	\$ 28.26
Cost Sharing				4,452	\$ 332,623	\$ 19.52	5,322	\$ 1,138,775	\$ 17.83	5,340	\$ 1,186,720	\$ 18.52	5,646	\$ 1,232,289	\$ 18.19	5,358	\$ 1,232,289	\$ 19.17	5,376	\$ 1,232,289	\$ 19.10
<b>Subtotal Adults</b>	<b>93,345</b>	<b>\$ 447,089,687</b>	<b>\$ 399.14</b>	<b>96,726</b>	<b>\$ 457,230,732</b>	<b>\$ 393.92</b>	<b>123,244</b>	<b>\$ 475,146,697</b>	<b>\$ 321.28</b>	<b>132,837</b>	<b>\$ 502,853,828</b>	<b>\$ 315.46</b>	<b>135,033</b>	<b>\$ 500,403,389</b>	<b>\$ 314.64</b>	<b>117,249</b>	<b>\$ 473,986,595</b>	<b>\$ 336.88</b>	<b>117,756</b>	<b>\$ 501,613,144</b>	<b>\$ 354.98</b>
<b>Children</b>																					
Blind or Disabled (BD)	3,701	\$ 32,794,574	\$ 738.42	3,639	\$ 36,486,052	\$ 835.48	3,603	\$ 30,889,676	\$ 714.53	3,243	\$ 27,174,573	\$ 698.22	3,417	\$ 28,773,934	\$ 701.72	2,490	\$ 24,874,655	\$ 832.43	2,459	\$ 24,989,822	\$ 846.72
General	55,394	\$ 131,289,464	\$ 197.51	56,431	\$ 130,940,851	\$ 193.36	60,863	\$ 144,338,098	\$ 197.63	63,301	\$ 151,736,910	\$ 199.75	64,846	\$ 149,777,097	\$ 192.48	60,003	\$ 153,506,519	\$ 213.19	61,159	\$ 156,718,714	\$ 213.54
Underinsured	978	\$ 791,009	\$ 67.40	949	\$ 1,072,657	\$ 94.15	916	\$ 1,253,421	\$ 113.98	826	\$ 1,186,527	\$ 119.66	820	\$ 1,207,158	\$ 122.66	833	\$ 1,210,126	\$ 121.09	831	\$ 1,230,043	\$ 123.31
SCHIP (Uninsured)	3,986	\$ 7,279,703	\$ 152.21	4,105	\$ 7,465,861	\$ 151.57	4,449	\$ 7,471,592	\$ 139.95	4,499	\$ 7,025,792	\$ 130.15	4,874	\$ 8,400,371	\$ 143.61	5,280	\$ 9,400,484	\$ 148.37	5,562	\$ 9,286,093	\$ 139.13
<b>Subtotal Children</b>	<b>64,058</b>	<b>\$ 172,154,749</b>	<b>\$ 223.96</b>	<b>65,124</b>	<b>\$ 175,965,422</b>	<b>\$ 225.17</b>	<b>69,831</b>	<b>\$ 183,952,788</b>	<b>\$ 219.52</b>	<b>71,870</b>	<b>\$ 187,123,801</b>	<b>\$ 216.97</b>	<b>73,957</b>	<b>\$ 188,158,559</b>	<b>\$ 212</b>	<b>68,606</b>	<b>\$ 188,991,784</b>	<b>\$ 229.56</b>	<b>70,012</b>	<b>\$ 192,224,672</b>	<b>\$ 228.80</b>
Pharmacy Only Programs	12,535	\$ 1,813,724	\$ 12.06	12,653	\$ 4,485,706	\$ 29.54	11,978	\$ 4,914,695	\$ 34.19	11,593	\$ 2,302,437	\$ 16.55	11,026	\$ 5,020,813	\$ 37.95	11,640	\$ 6,266,029	\$ 44.86	11,640	\$ 6,385,921	\$ 45.72
<b>Choices for Care</b>																					
Nursing Home, Home & Community Based, ERC	3,911	\$ 173,842,505	\$ 3,704.61	4,147	\$ 178,448,959	\$ 3,585.90	4,342	\$ 183,700,087	\$ 3,525.98	4,256	\$ 186,796,297.91	\$ 3,657.29	4,623	\$ 187,699,781	\$ 3,383.18	4,310	\$ 191,664,880	\$ 3,706.12	4,350	\$ 195,072,359	\$ 3,736.91
Acute-Care Services - DVHA	3,911	\$ 21,145,391	\$ 450.61	4,147	\$ 22,448,822	\$ 451.11	4,342	\$ 22,938,346	\$ 440.28	4,256	\$ 26,318,814	\$ 515.30	4,623	\$ 21,454,716	\$ 386.71	4,310	\$ 28,643,444	\$ 553.86	4,350	\$ 29,437,799	\$ 563.93
Acute-Care Services - Other Depts.	3,911	\$ 1,471,934	\$ 31.37	4,147	\$ 1,695,828	\$ 34.08	4,342	\$ 1,510,843	\$ 29.00	4,256	\$ -	\$ -	4,623	\$ -	\$ -	4,310	\$ -	\$ -	4,350	\$ -	\$ -
Buy-In		\$ 2,573,180			\$ 2,630,639			\$ 2,639,101			\$ 2,869,715			\$ 3,202,586			\$ 2,893,610			\$ 3,092,248	
<b>Subtotal Choices for Care*</b>	<b>3,911</b>	<b>\$ 199,033,009</b>	<b>\$ 4,241.42</b>	<b>4,147</b>	<b>\$ 205,224,249</b>	<b>\$ 4,123.95</b>	<b>4,342</b>	<b>\$ 210,788,377</b>	<b>\$ 4,045.92</b>	<b>4,256</b>	<b>\$ 215,984,826</b>	<b>\$ 4,228.78</b>	<b>4,623</b>	<b>\$ 212,357,083</b>	<b>\$ 3,827.62</b>	<b>4,310</b>	<b>\$ 223,201,934</b>	<b>\$ 4,315.94</b>	<b>4,350</b>	<b>\$ 227,602,406</b>	<b>\$ 4,360.07</b>
<b>Subtotal Direct Services</b>	<b>173,849</b>	<b>\$ 820,091,169</b>	<b>\$ 393.11</b>	<b>178,650</b>	<b>\$ 842,906,108</b>	<b>\$ 393.18</b>	<b>209,395</b>	<b>\$ 874,802,557</b>	<b>\$ 348.15</b>	<b>220,556</b>	<b>\$ 908,264,892</b>	<b>\$ 343.17</b>	<b>224,640</b>	<b>\$ 905,939,845</b>	<b>\$ 339.53</b>	<b>201,805</b>	<b>\$ 892,446,342</b>	<b>\$ 368.53</b>	<b>203,758</b>	<b>\$ 927,826,143</b>	<b>\$ 379.46</b>
<b>Miscellaneous Program</b>																					
GC to CFC Funding Reallocation		\$ (1,471,934)			\$ (1,696,912)			\$ (1,509,760)						\$ -			\$ -			\$ -	
Refugee	66	\$ 308,395	\$ 390.37	22	\$ 96,121	\$ 358.66	1	\$ 15,884	\$ 1,588.36	1	\$ 111,042	\$ 9,253.54	-	\$ (1,321)		-	\$ (7,984)		1	\$ 14,009	
ACA Rebates		\$ (4,453,259)			\$ (3,363,203)			\$ (3,654,840)			\$ (3,793,338)			\$ (3,683,010)			\$ (3,683,010)			\$ (3,937,084)	
HIV	96	\$ 39,881	\$ 34.62	103	\$ 26,540	\$ 21.51	118	\$ 10,072	\$ 7.12	120	\$ 8,484	\$ 5.90	142	\$ 12,143	\$ 7.12	132	\$ 11,862	\$ 7.50	141	\$ 9,657	\$ 5.69
Civil Unions	344	\$ 1,288,895	\$ 311.93		\$ 1,099,414			\$ 285,335			\$ 601,912			\$ -			\$ -			\$ -	
Underinsured		\$ 10,155,454			\$ 10,671,650			\$ 10,539,574			\$ 8,112,696			\$ 7,846,572			\$ 8,843,860			\$ 9,597,071	
DSH		\$ 37,448,781			\$ 37,448,781			\$ 37,448,781			\$ 37,448,781			\$ 37,448,781			\$ 37,448,781			\$ 37,448,781	
Clawback		\$ 25,971,679			\$ 25,833,314			\$ 25,888,658			\$ 29,011,845			\$ 33,750,064			\$ 33,750,064			\$ 36,207,593	
Buy-In - GC		\$ 26,705,032			\$ 27,471,919			\$ 27,792,073			\$ 30,475,367			\$ 35,122,032			\$ 34,403,631			\$ 36,447,184	
Buy-In - State Only		\$ 17,878			\$ 17,728			\$ 27,169			\$ (64,963)			\$ 63,812			\$ 64,206			\$ 68,613	
Buy-In - Federal Only		\$ 3,499,264			\$ 3,541,610			\$ 3,593,474			\$ 3,961,756			\$ 4,197,412			\$ 4,113,776			\$ 4,396,176	
Legal Aid		\$ 502,318			\$ 593,648			\$ 593,648			\$ 547,983			\$ 593,648			\$ 593,648			\$ 547,983	
Misc. Pymts.		\$ (9,566)			\$ (17,420)			\$ (9,223)			\$ (1,641)			\$ 916,347			\$ 4,432,372			\$ (21,608,996)	
Healthy Vermonters Program	5,911	\$ -	n/a	5,597	\$ -	n/a	4,315	\$ -	n/a	4,059	\$ -	n/a	5,820	\$ -	n/a	5,820	\$ -	n/a	5,820	\$ -	n/a
<b>Subtotal Miscellaneous Program</b>	<b>6,417</b>	<b>\$ 100,002,818</b>		<b>5,722</b>	<b>\$ 101,723,191</b>		<b>4,434</b>	<b>\$ 101,020,847</b>		<b>4,180</b>	<b>\$ 106,419,926</b>		<b>5,962</b>	<b>\$ 116,266,479</b>		<b>5,952</b>	<b>\$ 119,971,206</b>		<b>5,962</b>	<b>\$ 95,490,988</b>	
<b>TOTAL PROGRAM EXPENDITURES</b>	<b>180,265</b>	<b>\$ 920,093,987</b>		<b>184,372</b>	<b>\$ 944,629,299</b>		<b>213,829</b>	<b>\$ 975,823,404</b>		<b>224,736</b>	<b>\$ 1,014,684,817</b>		<b>230,602</b>	<b>\$ 1,022,206,324</b>		<b>207,757</b>	<b>\$ 1,012,417,548</b>		<b>209,720</b>	<b>\$ 1,023,317,131</b>	
<b>ADMINISTRATIVE EXPENDITURES</b>																					
		SFY '13 Actuals		SFY '14 Actuals		SFY '15 Actuals		SFY '16 Actuals		SFY '17 As Passed		SFY '17 BAA		SFY '18 Gov. Rec							
		Expenses		Expenses		Expenses		Expenses		Expenses		Expenses		Expenses							
General		\$ 4,654,800		\$ 5,988,274		\$ 6,997,923		\$ 6,851,198		\$ 10,039,437		\$ 10,268,266		\$ 9,960,991							
Claims Services		\$ 17,309,387		\$ 18,725,612		\$ 13,853,767		\$ 14,084,854		\$ 17,602,116		\$ 18,764,856		\$ 18,273,537							
Eligibility		\$ 2,819,787		\$ 8,538,622		\$ 4,507,624		\$ 297,794		\$ 45,247,377		\$ 54,882,312		\$ 48,272,806							
Quality		\$ 13,306,170		\$ 16,740,595		\$ 17,354,914		\$ 16,127,593		\$ 20,308,736		\$ 21,190,088		\$ 21,733,978							
Project		\$ 53,608,733		\$ 103,140,066		\$ 91,518,391		\$ 112,633,897		\$ 96,516,383		\$ 95,723,587		\$ 91,198,799							
<b>Total Administrative Expenses</b>		<b>\$</b>																			

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

PROGRAM EXPENDITURES								
	SFY '17 As Passed		SFY '17 BAA		SFY '18 Gov. Rec		SFY '18 Funding Description	
	Expenses	State Funds	Expenses	State Funds	Expenses	State Funds		
<b>Adults</b>								
Aged, Blind, or Disabled (ABD)	\$ 105,981,420	\$ 48,412,313	\$ 70,363,336	\$ 32,141,972	\$ 74,195,101	\$ 34,337,493	Global Commitment funded (GC) - g.f. @ 46.28%	
Dual Eligibles	\$ 55,272,017	\$ 25,248,258	\$ 57,665,231	\$ 26,341,478	\$ 59,567,044	\$ 27,567,628		
General	\$ 100,815,869	\$ 46,052,689	\$ 82,715,184	\$ 37,784,296	\$ 85,433,739	\$ 39,538,734		
New Adult	\$ 231,146,862	\$ 45,946,449	\$ 255,945,079	\$ 55,003,237	\$ 275,478,837	\$ 55,901,543		g.f. @ 13.43% for childless new adults; with children = 46.28%
Premium Assistance	\$ 5,954,932	\$ 2,720,213	\$ 6,065,475	\$ 2,770,709	\$ 5,706,135	\$ 2,640,799		GC funded as detailed above
Cost Sharing	\$ 1,232,289	\$ 1,232,289	\$ 1,232,289	\$ 1,232,289	\$ 1,232,289	\$ 1,232,288.62		100% general fund
<b>Subtotal Adults</b>	\$ 500,403,389	\$ 169,612,209	\$ 473,986,595	\$ 155,273,981	\$ 501,613,144	\$ 161,218,486		
<b>Children</b>								
Blind or Disabled (BD)	\$ 28,773,934	\$ 13,143,933	\$ 24,874,655	\$ 11,362,742	\$ 24,989,822	\$ 11,565,290	Global Commitment funded (GC) - g.f. @ 46.28%	
General	\$ 149,777,097	\$ 68,418,178	\$ 153,506,519	\$ 70,121,778	\$ 156,718,714	\$ 72,529,421		
Underinsured	\$ 1,207,158	\$ 551,430	\$ 1,210,126	\$ 552,786	\$ 1,230,043	\$ 569,264		
SCHIP (Uninsured)	\$ 8,400,371	\$ 856,838	\$ 9,400,484	\$ 844,163	\$ 9,286,093	\$ 872,893		Title XXI - g.f. @ 9.40% and federal @ 90.60%
<b>Subtotal Children</b>	\$ 188,158,559	\$ 82,970,378	\$ 188,991,784	\$ 82,881,469	\$ 192,224,672	\$ 85,536,867		
<b>Pharmacy Only Programs</b>	\$ 5,020,813	\$ 4,535,362	\$ 6,266,029	\$ 5,660,180	\$ 6,385,921	\$ 5,836,756	Predominantly state only	
<b>Choices for Care</b>								
Nursing Home, Home & Community Based, ERC	\$ 187,699,781	\$ 85,741,260	\$ 191,664,880	\$ 87,552,517	\$ 195,072,359	\$ 90,279,488	Global Commitment funded (GC) - g.f. @ 46.28%	
Acute-Care Services - DVHA	\$ 21,454,716	\$ 9,800,514	\$ 28,643,444	\$ 13,084,325	\$ 29,437,799	\$ 13,623,813		
Buy-In	\$ 3,202,586	\$ 1,462,941	\$ 2,893,610	\$ 1,321,801	\$ 3,092,248	\$ 1,431,093		
<b>Subtotal Choices for Care*</b>	\$ 212,357,083	\$ 97,004,716	\$ 223,201,934	\$ 101,958,643	\$ 227,602,406	\$ 105,334,393		
<b>Subtotal Direct Services</b>	\$ 905,939,845	\$ 354,122,665	\$ 892,446,342	\$ 345,774,274	\$ 927,826,143	\$ 357,926,503		
<b>Miscellaneous Program</b>								
Refugee	\$ (1,321)	\$ -	\$ (7,984)	\$ -	\$ 14,009	\$ -	100% federally reimbursed	
ACA Rebates	\$ (3,683,010)	\$ -	\$ (3,683,010)	\$ -	\$ (3,937,084)	\$ -	100% federally reimbursed	
HIV	\$ 12,143	\$ 5,547	\$ 11,862	\$ 5,419	\$ 9,657	\$ 4,469	MCO Investments - matched like GC above	
Underinsured	\$ 7,846,572	\$ 3,584,314	\$ 8,843,860	\$ 4,039,875	\$ 9,597,071	\$ 4,441,524	MCO Investments - matched like GC above	
DSH	\$ 37,448,781	\$ 17,106,603	\$ 37,448,781	\$ 17,106,603	\$ 33,748,781	\$ 15,618,936	GC funded as detailed above	
Clawback	\$ 33,750,064	\$ 33,750,064	\$ 33,750,064	\$ 33,750,064	\$ 36,207,593	\$ 36,207,593	100% general fund	
Buy-In - GC	\$ 35,122,032	\$ 16,043,744	\$ 34,403,631	\$ 15,715,579	\$ 36,447,184	\$ 16,867,757	GC funded as detailed above	
Buy-In - State Only	\$ 63,812	\$ 29,149	\$ 64,206	\$ 29,329	\$ 68,613	\$ 31,754	MCO Investments - matched like GC above	
Buy-In - Federal Only	\$ 4,197,412	\$ -	\$ 4,113,776	\$ -	\$ 4,396,176	\$ -	100% federally reimbursed	
Legal Aid	\$ 593,648	\$ 271,179	\$ 593,648	\$ 271,179	\$ 547,983	\$ 253,607	GC funded as detailed above	
Misc. Pymts.	\$ 916,347	\$ 418,587	\$ 4,432,372	\$ 2,024,707	\$ (21,608,996)	\$ (10,000,643)	GC funded as detailed above	
Healthy Vermonters Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
<b>Subtotal Miscellaneous Program</b>	\$ 116,266,479	\$ 71,209,187	\$ 119,971,206	\$ 72,942,755	\$ 95,490,988	\$ 63,424,997		
<b>TOTAL PROGRAM EXPENDITURES</b>	\$ 1,022,206,324	\$ 425,331,852	\$ 1,012,417,548	\$ 418,717,029	\$ 1,023,317,131	\$ 421,351,500		

ADMINISTRATIVE EXPENDITURES							
ADMINISTRATIVE EXPENDITURES	SFY '17 As Passed		SFY '17 BAA		SFY '18 Gov. Rec		SFY '18 Funding Description
	Expenses	State Funds	Expenses	State Funds	Expenses	State Funds	
General	\$ 10,039,437	\$ 3,926,053	\$ 10,268,266	\$ 4,747,234	\$ 9,960,991	\$ 4,560,371	Blended based on federal programs - match GF, SF, IDT
Claims Services	\$ 17,602,116	\$ 9,284,521	\$ 18,764,856	\$ 6,809,018	\$ 18,273,537	\$ 5,211,781	Blended based on federal programs - match GF, SF, IDT
Eligibility	\$ 45,247,377	\$ 18,918,040	\$ 54,882,312	\$ 21,226,008	\$ 48,272,806	\$ 16,095,332	Eligible for both traditional and enhanced match
Quality	\$ 20,308,736	\$ 8,093,445	\$ 21,190,088	\$ 8,891,982	\$ 21,733,978	\$ 8,183,168	Blended based on federal programs - match GF, SF, IDT
Project	\$ 96,516,383	\$ 9,931,594	\$ 95,723,587	\$ 10,206,857	\$ 91,198,799	\$ 10,873,774	Blended based on federal programs - match GF, SF, IDT, Enhanced
<b>Total Administrative Expenses</b>	\$ 189,714,049	\$ 50,153,654	\$ 200,829,110	\$ 51,881,100	\$ 189,440,111	\$ 44,924,426	
<b>TOTAL ALL EXPENDITURES</b>	\$ 1,211,920,373	\$ 475,485,505	\$ 1,213,246,658	\$ 470,598,128	\$ 1,212,757,242	\$ 466,275,926	

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**MANDATORY/OPTIONAL GROUPS**

State Plan Groups			
Mandatory			
Population Description	Green Mountain Care Group	Standards and Methodologies	Benefit Package
Section 1931 low-income families with children (Parents and caretaker relatives)	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)	AFDC standard and MAGI-based methodologies	<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Outpatient hospital services</li> <li>• Rural health clinic services</li> <li>• Federally qualified health center services</li> <li>• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services</li> <li>• Laboratory and X-ray services</li> <li>• Family planning services</li> <li>• Physician services and Medical and Surgical Services of a Dentist</li> <li>• Home health services</li> <li>• Nurse Midwife services</li> <li>• Nursing facility services Certified Pediatric and Family Nurse Practitioner Services</li> <li>• Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, licensed social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife)</li> <li>• Clinical Services</li> <li>• Prescription drugs</li> <li>• Diagnostic, Screening, Preventive and Rehabilitative Services</li> <li>• Private duty nursing services</li> <li>• Other Aids to Vision</li> <li>• Dental Services</li> <li>• Prosthetic Devices</li> <li>• Physical and Occupational therapies, and services for Individuals with Speech, hearing and language disorder services</li> <li>• Inpatient Hospital/Nursing Facility/ICF Services for Individuals 65 and Older in IMD</li> <li>• ICF/MR Services</li> <li>• Inpatient Psychiatric Services for Individuals Under 21</li> <li>• Personal Care Services</li> <li>• Case Management</li> <li>• Respiratory Care for Ventilator Dependent Individuals</li> <li>• Primary Care Case Management</li> <li>• Hospice</li> <li>• Transportation Services</li> <li>• Nursing Facility Services for Individuals Under Age 21</li> <li>• Emergency Hospital Services</li> <li>• Critical Access Hospital</li> <li>• Traumatic Brain Injury; HCBS waiver –like services</li> <li>• Mental Illness Under 22; HCBS waiver-like services</li> <li>• Community Rehabilitation and Treatment; HCBS waiver-like services</li> <li>• Developmental Services; HCBS waiver-like services</li> <li>• Services for individuals with persistent mental illness up to 150 FPL</li> <li>• Community and nursing home services for individuals eligible for long-term care supports</li> <li>• Community based services for individuals with moderate needs as identified through long-term care eligibility</li> </ul>
Children receiving IV-E payments (IV-E foster care or adoption assistance)		No income or resource tests	
Individuals who lose eligibility under §1931 due to employment		AFDC standard and MAGI-based methodologies	
Individuals who lose eligibility under §1931 because of spousal support		AFDC standard and MAGI-based methodologies	
Individuals participating in a work supplementation program who would otherwise be eligible under §1931		AFDC standard and MAGI-based methodologies	
Individuals receiving SSI cash benefits		SSI standard and methodologies	
Disabled children no longer eligible for SSI benefits because of a change in definition of disability		SSI standard and methodologies	
Qualified severely impaired individuals (as defined in §1905(q))		SSI standard and methodologies	
Individuals under age 21 eligible for Medicaid in the month they apply for SSI		SSI standard and methodologies	
Pregnant women		≤ 208% of the FPL and MAGI-based methodologies	
Children under age 19		≤ 312% of the FPL and MAGI-based methodologies	
Individuals age 19 or older and under 65		≤ 133% FPL and MAGI-based methodologies	
Blind and disabled individuals eligible in December 1973		SSI standard and methodologies	
Disabled individuals whose earnings exceed SSI substantial gainful activity level		SSI standard and methodologies	
Disabled individuals whose earnings are too high to receive SSI cash benefits		SSI standard and methodologies	
Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (§503 of Public Law 94-566)		SSI standard and methodologies	
Disabled widows and widowers		SSI standard and methodologies	
Disabled adult children		SSI standard and methodologies	
Early widows/widowers		SSI standard and methodologies	
Individuals receiving mandatory State supplements		SSI standard and methodologies	
Individuals eligible as essential spouses in December 1973	SSI standard and methodologies		
Institutionalized individuals who were eligible in December 1973	SSI standard and methodologies		
Blind and disabled individuals eligible in December 1973	SSI standard and methodologies		
Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336	SSI standard and methodologies		
Newborns deemed eligible for one year	Automatically eligible		
Pregnant women eligible on their last day of pregnancy receive 60 days coverage	Automatically eligible		
Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay	Automatically eligible	Inpatient hospital services	
Qualified Medicare Beneficiaries	Commonly referred to as QMBs	Medicare beneficiaries with income at or below 100% of the FPL	Payment of Medicare premiums, coinsurance, deductibles, and copayment except Part D copayment
Qualified Disabled and Working Individuals	Commonly referred to as QDWIs	Medicare beneficiaries with income at or below 200% of the FPL and not eligible for Medicaid	Payment of Medicare Part A premiums
Specified Low-Income Medicare Beneficiaries	Commonly referred to as SLMBs	Medicare beneficiaries with income between 100 and 120% of the FPL	Payment of Medicare Part B premiums
Qualifying Individuals	Commonly referred to as QI-1s	Medicare beneficiaries with income between 120% and 135% of the FPL and not eligible for Medicaid	Payment of Medicare Part B premiums

**MANDATORY/OPTIONAL GROUPS**

Optional			
Population Description	Green Mountain Care Group	Standards and Methodologies	Benefit Package
Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance	Commonly referred to as Medicaid (for adults) and Dr. Dynasaur (for children)		Same comprehensive benefit package as Global Commitment Demonstration Population 1
Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution			
<i>Special income level group:</i> individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard			
Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care			
Children under 21 (or at State option 20, 19, or 18) who are under State adoption			
Breast & Cervical Cancer Treatment			
BBA Working Disabled with income < 250%			
Individuals receiving only a State supplementary payment with agreement under 1634 of the Act			
Katie Beckett children			
Medically Needy Individuals under 21 who would be mandatorily categorically eligible except for income			
Medically Needy Specified relatives of dependent children who are ineligible as categorically needy			
Medically Needy Aged individuals who are ineligible as categorically needy			
Medically Needy Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness			
Medically Needy Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of disabled			
Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; individuals who were previously covered under a separate 1915(c) Demonstration. <ol style="list-style-type: none"> <li>1. TBI (traumatic brain injury)</li> <li>2. MI under 22 (Children’s Mental Health)</li> <li>3. MR/DD (Mental Retardation/Developmental Disabilities)</li> </ol>			
Medically Needy Pregnant women who would be categorically eligible except for income and resources			

**APPENDIX A: INVESTMENTS**

**Global Commitment Investment Expenditures**

<u>Department</u>	<u>Investment Description</u>	<u>SFY10 Actuals</u>	<u>SFY11 Actuals</u>	<u>SFY12 Actuals</u>	<u>SFY13 Actuals</u>	<u>SFY14 Actuals</u>	<u>SFY15 Actuals</u>	<u>SFY16 Actuals</u>
AHSCO	Designated Agency Underinsured Services		\$2,510,099	\$5,401,947	\$6,232,517	\$7,184,084	\$6,894,205	\$5,632,253
AHSCO	2-1-1 Grant	\$415,000	\$415,000	\$415,000	\$415,000	\$499,792	\$499,667	\$453,000
AOA	Blueprint Director	\$179,284						
AOA	Green Mountain Care						\$639,239	
AOE	School Health Services	\$8,956,247	\$4,478,124	\$11,027,579	\$9,741,252	\$10,454,116	\$10,029,809	\$10,472,205
DCF	Family Infant Toddler Program	\$81,086	\$624					
DCF	Medical Services	\$45,216	\$64,496	\$47,720	\$37,164	\$33,514	\$32,299	\$55,400
DCF	Residential Care for Youth/Substitute Care	\$8,033,068	\$7,853,100	\$9,629,269	\$10,131,790	\$11,137,225	\$10,405,184	\$10,238,115
DCF	AABD Admin							\$135,517
DCF	AABD							
DCF	Aid to the Aged, Blind and Disabled CCL Level III	\$2,827,617	\$2,661,246	\$2,563,226	\$2,621,786	\$2,611,499	\$2,864,727	\$2,753,853
DCF	Aid to the Aged, Blind and Disabled Res Care Level III	\$137,356	\$136,466	\$137,833	\$124,731	\$89,159	\$77,196	\$80,830
DCF	Aid to the Aged, Blind and Disabled Res Care Level IV	\$299,488	\$265,812	\$273,662	\$269,121	\$183,025	\$160,963	\$190,066
DCF	Essential Person Program	\$485,536	\$736,479	\$775,278	\$783,860	\$801,658	\$707,316	\$667,102
DCF	GA Medical Expenses	\$583,080	\$492,079	\$352,451	\$275,187	\$253,939	\$211,973	\$181,835
DCF	CUPS/Early Childhood Mental Health	\$166,429	\$112,619	\$165,016	\$45,491			
DCF	Children's Integrated Services Early Intervention					\$200,484		\$371,836
DCF	Therapeutic Child Care	\$577,259	\$570,493	\$596,406	\$557,599	\$543,196	\$605,419	\$712,884
DCF	Lund Home	\$175,378	\$196,159	\$354,528	\$181,243	\$237,387	\$405,034	\$261,081
DCF	GA Community Action		\$199,762	\$338,275	\$420,359	\$25,181		
DCF	Prevent Child Abuse Vermont: Shaken Baby		\$44,119	\$74,250	\$86,969	\$111,094	\$54,125	\$54,125
DCF	Prevent Child Abuse Vermont: Nurturing Parent			\$107,184	\$186,916	\$54,231	\$195,124	\$126,365
DCF	Challenges for Change: DCF		\$50,622	\$196,378	\$197,426	\$207,286	\$189,378	\$202,488
DCF	Strengthening Families			\$465,343	\$429,154	\$399,841	\$370,003	\$426,417
DCF	Lamoille Valley Community Justice Project			\$162,000	\$216,000	\$402,685	\$83,315	\$216,000
DCF	Building Bright Futures				\$398,201	\$594,070	\$514,225	\$531,283

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## Global Commitment Investment Expenditures

Department	Investment Description	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	SFY16 Actuals
DAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired	\$245,000	\$245,000	\$245,000	\$245,000	\$245,000	\$245,000	\$270,171
DAIL	DS Special Payments for Medical Services	\$469,770	\$757,070	\$1,498,083	\$1,299,613	\$1,277,148	\$385,896	\$1,904,880
DAIL	Flexible Family/Respite Funding	\$1,114,898	\$1,103,748	\$1,103,749	\$1,088,889	\$2,868,218	\$1,400,997	\$1,919,377
DAIL	Quality Review of Home Health Agencies	\$90,227	\$103,598	\$128,399	\$84,139	\$51,697	\$44,682	\$35,203
DAIL	Support and Services at Home (SASH)			\$773,192	\$773,192	\$1,013,671	\$1,026,155	\$1,013,283
DAIL	Home-Sharing				\$310,000	\$317,312	\$327,163	\$339,966
DAIL	Self-Neglect Initiative				\$150,000	\$200,000	\$265,000	\$276,830
DAIL	Seriously Functionally Impaired: DAIL				\$1,270,247	\$859,371	\$333,331	\$120,997
DFR	Health Care Administration	\$1,713,959	\$1,898,342	\$1,897,997	\$659,544	\$165,946		
DMH	Special Payments for Treatment Plan Services	\$149,068	\$134,791	\$132,021	\$180,773	\$168,492	\$152,047	\$158,316
DMH	MH Outpatient Services for Adults	\$864,815	\$522,595	\$974,854	\$1,454,379	\$2,661,510	\$3,074,989	\$4,446,379
DMH	Mental Health Consumer Support Programs	\$802,579	\$582,397	\$67,285	\$1,649,340	\$2,178,825	\$1,132,931	\$470,222
DMH	Mental Health CRT Community Support Services		\$1,935,344	\$1,886,140	\$6,047,450	\$11,331,235	\$282,071	\$5,866,297
DMH	Mental Health Children's Community Services	\$2,569,759	\$1,775,120	\$2,785,090	\$3,088,773	\$3,377,546	\$3,706,864	\$4,379,820
DMH	Emergency Mental Health for Children and Adults	\$1,797,605	\$2,309,810	\$4,395,885	\$8,719,824	\$6,662,850	\$4,148,197	\$2,528,751
DMH	Respite Services for Youth with SED and their Families	\$516,677	\$543,635	\$541,707	\$823,819	\$749,943	\$931,962	\$1,286,154
DMH	Recovery Housing	\$332,635	\$512,307	\$562,921	\$874,194	\$985,098	\$463,708	\$914,858
DMH	Vermont State Hospital Records	\$19,590						
DMH	Challenges for Change: DMH		\$229,512	\$945,051	\$819,069			
DMH	Seriously Functionally Impaired: DMH		\$68,713	\$160,560	\$1,151,615	\$721,727	\$392,593	\$246,049
DMH	Acute Psychiatric Inpatient Services			\$12,603,067	\$5,268,556	\$3,011,307	\$2,423,577	\$3,145,476
DMH	Institution for Mental Disease Services: DMH				\$10,443,654	\$7,194,964	\$25,371,245	\$22,335,938
DOC	Intensive Substance Abuse Program (ISAP)	\$591,004	\$591,000	\$458,485	\$400,910	\$547,550	\$58,280	

**This table extends to the next page.**

## Global Commitment Investment Expenditures

Department	Investment Description	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	SFY16 Actuals
DOC	Intensive Sexual Abuse Program	\$68,350	\$70,002	\$60,585	\$69,311	\$19,322	\$15,532	\$6,375
DOC	Intensive Domestic Violence Program	\$173,938	\$174,000	\$164,218	\$86,814	\$64,970	\$169,043	\$88,152
DOC	Community Rehabilitative Care	\$2,190,924	\$2,221,448	\$2,242,871	\$2,500,085	\$2,388,327	\$2,539,161	\$2,639,580
DOC	Return House				\$399,999	\$399,999	\$343,592	\$342,084
DOC	Northern Lights	\$40,000	\$40,000		\$393,750	\$335,587	\$354,909	\$768,289
DOC	Challenges for Change: DOC			\$687,166	\$524,594	\$433,910	\$539,727	
DOC	Northeast Kingdom Community Action				\$548,825	\$287,662	\$267,025	\$220,436
DOC	Pathways to Housing				\$802,488	\$830,936	\$830,336	\$1,018,229
DVHA	Vermont Information Technology Leaders/HIT/HIE/HCR	\$339,500	\$646,220	\$1,425,017	\$1,517,044	\$1,549,214	\$2,915,149	\$1,887,543
DVHA	Vermont Blueprint for Health		\$2,616,211	\$1,841,690	\$2,002,798	\$2,490,206	\$1,987,056	\$2,594,329
DVHA	Buy-In	\$200,868	\$50,605	\$24,000	\$17,878	\$17,728	\$27,169	\$29,447
DVHA	HIV Drug Coverage	\$38,904	\$39,176	\$37,452	\$39,881	\$26,540	\$10,072	\$8,484
DVHA	Civil Union	\$627,976	\$999,084	\$1,215,109	\$1,112,119	\$760,819	\$(50,085)	\$(585)
DVHA	Vpharm	\$210,796						
DVHA	Patient Safety Net Services		\$36,112	\$73,487	\$2,394	\$363,489	\$335,420	\$573,050
DVHA	Institution for Mental Disease Services: DVHA				\$6,214,805	\$6,948,129	\$7,792,709	\$7,839,519
DVHA	Family Supports				\$4,015,491	\$3,723,521	\$2,982,388	\$273,177
GMCB	Green Mountain Care Board			\$789,437	\$1,450,717	\$2,360,462	\$2,517,516	\$2,188,901
UVM	Vermont Physician Training	\$4,006,152	\$4,006,156	\$4,006,156	\$4,006,156	\$4,006,156	\$4,046,217	\$4,046,217
VAAFM	Agriculture Public Health Initiatives			\$90,278	\$90,278	\$90,278	\$90,278	\$90,278
VDH	DMH Investment Cost in CAP		\$752	\$140				
VDH	Renal Disease	\$2,053	\$13,689	\$1,752	\$28,500	\$3,375	\$10,125	\$13,500
VDH	TB Medical Services	\$41,313	\$36,284	\$39,173	\$34,046	\$59,872	\$28,571	\$9,738
VDH	Immunization	\$ -	\$ -	\$23,903	\$457,757	\$165,770	\$253,245	\$109,373
VDH	Emergency Medical Services	\$425,870	\$333,488	\$274,417	\$378,168	\$498,338	\$480,027	\$442,538
VDH	Family Planning	\$300,876	\$275,803	\$420,823	\$1,574,550	\$1,556,025	\$1,390,410	\$1,193,215
VDH	WIC Coverage	\$ -	\$36,959	\$ -	\$77,743	\$317,775	\$1,824,848	\$1,201,498
VDH	Substance Abuse Treatment	\$3,000,335	\$1,693,198	\$2,928,773	\$2,435,796	\$2,363,671	\$2,913,591	\$2,169,074
VDH	Health Laboratory	\$1,875,487	\$1,912,034	\$1,293,671	\$2,885,451	\$2,494,516	\$3,405,659	\$3,294,240
VDH	Fluoride Treatment	\$ -	\$ -	\$43,483	\$75,081	\$59,362	\$55,209	\$75,916
VDH	Health Research and Statistics	\$254,828	\$289,420	\$439,742	\$497,700	\$576,920	\$715,513	\$1,195,231

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

## MCO Investment Expenditures Continued

Department	Investment Description	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	SFY16 Actuals
VDH	Epidemiology	\$241,932	\$315,135	\$329,380	\$766,053	\$623,363	\$872,449	\$750,539
VDH	Statewide Tobacco Cessation	\$484,998	\$507,543	\$450,804	\$487,214	\$1,073,244	\$1,148,535	\$257,507
VDH	Community Clinics	\$468,154	\$640,000	\$600,000	\$640,000	\$688,000		
VDH	Patient Safety - Adverse Events	\$44,573	\$16,829	\$25,081	\$42,169	\$38,731	\$34,988	\$35,033
VDH	FQHC Lookalike	\$81,500	\$87,900	\$102,545	\$382,800	\$160,200	\$97,000	\$6,000
VDH	Poison Control	\$176,340	\$115,710	\$213,150	\$152,250	\$152,433	\$105,586	\$85,586
VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	\$412,043	\$290,661	\$318,806	\$345,930	\$326,184	\$395,229	\$(26,262)
VDH	Healthy Homes and Lead Poisoning Prevention Program				\$101,127	\$479,936	\$421,302	\$187,784
VDH	Challenges for Change: VDH			\$309,645	\$353,625	\$288,691	\$426,000	\$784,155
VDH	Area Health Education Centers (AHEC)	\$725,000	\$500,000	\$540,094	\$496,176	\$547,500	\$543,995	\$562,000
VDH	CHIP Vaccines			\$196,868	\$482,454	\$707,788	\$557,784	\$578,183
VDH	Tobacco Cessation: Community Coalitions	\$535,573	\$94,089	\$371,646	\$498,275	\$632,848	\$702,544	
VDH	Vermont Blueprint for Health	\$1,417,770	\$752,375	\$454,813	\$875,851	\$713,216	\$703,123	\$757,576
VDH	Physician/Dentist Loan Repayment Program	\$970,000	\$900,000	\$970,000	\$970,105	\$1,040,000	\$900,000	\$770,000
VDH	Recovery Centers	\$ 716,000	\$648,350	\$771,100	\$864,526	\$1,009,176	\$1,299,604	\$1,354,104
VSC	Health Professional Training	\$405,407	\$405,407	\$405,407	\$405,407	\$405,407	\$409,461	\$629,462
VVH	Vermont Veterans Home	\$837,225	\$1,410,956	\$1,410,956	\$1,410,956	\$410,986	\$410,986	\$410,986
<b>TOTALS</b>		<b>\$55,554,314</b>	<b>\$56,275,877</b>	<b>\$9,836,470</b>	<b>\$123,669,882</b>	<b>\$127,103,459</b>	<b>\$128,924,888</b>	<b>\$126,882,102</b>

This section is in response to the legislature’s request in Act 172, Section E.307.1, that the Department of Vermont Health Access (DVHA) explore the use of State or Global Commitment funds to purchase Medicare supplemental insurance plans for individuals eligible for both Medicare and Medicaid.

**Medicare Supplemental Cost vs. Benefit Analysis**

**Conclusion:** Payment for Medicare Supplemental Insurance would exceed any savings received by Medicaid. The BCBSVT monthly rate for individuals is \$157.48, with a projected saving of only \$124.91 per month.

Medicare Supplement insurance does not cover long-term care (care in a nursing home), vision or dental care, hearing aids, eyeglasses and private-duty nursing.

Plan Choice Recommendation: Plan Choice C (Part A & B Deductibles are covered on first day)

Hospitalization Benefit: Part A Co-insurance + 365 additional days

Medical Benefit: Part B Co-Insurance

Hospice: Part A Co-Insurance

BCBSVT Monthly Rate for Individual: \$157.48

BCBSVT Monthly Rate for Vermonters with Disabilities: \$281.36

Approximately 2,259 ABD Duals have an Advantage Plan (HMO replacement for Medicare part A & B). This population cannot use Medigap to pay coinsurance, deductibles or co-pay, as it is against federal law to knowingly sell a Medigap plan to someone that has a Medicare advantage plan. As a result, these individuals are not included in this analysis. The targeted population will also exclude 3,582 duals who already have an active Medigap policy.

Potential population:	15,431
Total Medicaid spend for potential population:	\$177,218,632
*Cost for non-Medicare covered services:	\$154,089,449
Potential \$ to be cost avoided:	\$23,129,183
PMPM:	\$124.91

\* Includes transportation, Pharmacy, Blueprint, Optometry, Dental, Case Management, HCBS, non- Medicare covered Home Health, services delivered by a non-Medicare eligible provider (such naturopaths or clinical social workers who have not met Medicare guidelines), and benefits beyond Medicare supplemental limits.

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## APPENDIX C: QUALIFIED HEALTH PLANS

**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 2017 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				
		Platinum	Gold	Silver	Bronze	Silver HDHP		Bronze HDHP		Gold	Silver	Gold CDHP Can pair with HSA	Bronze CDHP	Gold	Silver	Bronze	Gold HDHP Can pair with HSA	
						BCBSVT	MVP	BCBSVT	MVP									
		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		
<b>Deductible (Ded.)</b>	Integrated Ded.?	N	N	N	N	Y - \$1,550/\$3,100 <sup>7</sup>	Y - \$1,600/\$3,200 <sup>7</sup>	Y - \$5,050/\$10,100	Y - \$5,300/\$10,600	Y - \$1,250/\$2,500	Y - \$2,300/\$4,600 <sup>7</sup>	Y - \$2,500/\$5,000	Y - \$7,150/\$14,300	N	N	N	Y - \$2,500/\$5,000	
	Medical Ded.	\$250/\$500	\$850/\$1,700	\$2,150/\$4,300 <sup>7</sup>	\$4,600/\$9,200	See above	See above	See above	See above	See above	See above	See above	See above	\$950/\$1,900	\$1,800/\$3,600 <sup>7</sup>	\$5,500/\$11,000	See above	
	Waived <sup>1</sup> for: (see Services below)	Prev, OV, UC, Amb, ER, Den1	Prev, OV, UC, Amb, ER, Den1	Prev, OV, UC, Amb, Den1	Prev, Den1	Prev	Prev	Prev	Prev	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev	Prev	Prev, OV, UC, Den1	Prev, PCP/MH, Den1	Prev, Den1	Prev	
	Prescription (Rx) Ded.	\$0	\$100 <sup>8</sup>	\$150 <sup>7,8</sup>	\$700 <sup>8</sup>	See above	See above	See above	See above	See above	See above	See above	See above	\$250/\$500	\$500/\$1,000 <sup>7</sup>	\$300/\$600	See above	
	Waived for:	N/A (\$0 Ded)	Rx Generic	Rx Generic	Not Waived	Rx Wellness	Rx Wellness	Rx Wellness	Rx Wellness	Not Waived	Not Waived	Rx Wellness	Rx Wellness	VBID, Rx Generic	VBID	VBID	Rx Wellness	
<b>Max. Out-of-Pocket (MOOP)</b>	Integrated?	N	N	Y-\$6,000/\$12,000 <sup>7</sup>	Y-\$7,150/\$14,300	Y-\$6,400/\$12,800	Y-\$6,400/\$12,800	Y-\$6,550/\$13,100	Y-\$6,550/\$13,100	Y-\$4,250/\$8,500	Y-\$7,150/\$14,300 <sup>7</sup>	Y - \$2,500/\$5,000	Y - \$7,150/\$14,300	N	N	Y-\$7,150/\$14,300	Y-\$2,500/\$5,000	
	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	\$5,850/\$11,700	\$5,850/\$11,700 <sup>7</sup>	See above	See above	
	Prescription (Rx)	\$1,300/\$2,600	\$1,300/\$2,600	\$1,300/\$2,600 <sup>7</sup>	\$1,300/\$2,600	\$1,300/\$2,600 <sup>7</sup>	\$1,300/\$2,600 <sup>7</sup>	\$1,300/\$2,600	\$1,300/\$2,600	\$1,300/\$2,600	\$1,300/\$2,600 <sup>7</sup>	\$1,300/\$2,600	\$1,300/\$2,600	\$1,300/\$2,600	\$1,300/\$2,600 <sup>7</sup>	\$1,300/\$2,600	\$1,300/\$2,600	
Stacked or Aggregate? <sup>5,6</sup>	Stacked <sup>5</sup>	Stacked <sup>5</sup>	Stacked <sup>5</sup>	Stacked <sup>5</sup>	Aggregate Embedded <sup>6,10</sup>	Agg Ded/ Stack MOOP <sup>5</sup>	Aggregate Embedded <sup>6,10</sup>	Agg Ded/ Stack MOOP <sup>5</sup>	Aggregate Embedded <sup>6,10</sup>	Aggregate Embedded <sup>6,10</sup>	Aggregate <sup>6</sup>	Aggregate Embedded <sup>6,10</sup>	Stacked <sup>5</sup>	Stacked <sup>5</sup>	Stacked <sup>5</sup>	Aggregate <sup>6</sup>		
<b>Service Category (Examples)</b>		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 (\$)	
Office Visit (OV)	Preventive (Prev)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
	PCP or Mental Health (PCP/MH)	\$10	\$15	\$25	Ded., then \$35	Ded., then 10%	Ded., then 10%	Ded., then 50%	Ded., then 50%	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of \$20 (Gold) or \$30 (Silver)	Ded., then \$0	Ded., then \$0	\$15	\$25	Ded., then \$40	Ded., then \$0		
	Specialist <sup>2</sup>	\$30	\$30	\$65	Ded., then \$90	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then \$30	Ded., then \$50	Ded., then \$0	Ded., then \$0	\$30	Ded., then \$60	Ded., then \$100	Ded., then \$0	
	Urgent Care (UC)	\$40	\$45	\$60	Ded., then \$100	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then \$30	Ded., then \$50	Ded., then \$0	Ded., then \$0	\$45	Ded., then \$60	Ded., then \$100	Ded., then \$0	
	Ambulance (Amb)	\$50	\$50	\$100	Ded., then \$100	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then \$30	Ded., then \$50	Ded., then \$0	Ded., then \$0	Ded., then \$50	Ded., then \$100	Ded., then \$100	Ded., then \$0	
	Emergency Room (ER) <sup>3</sup>	\$100	\$150	Ded., then \$250	Ded., then 50%	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then \$250	Ded., then \$400	Ded., then \$0	Ded., then \$0	Ded., then \$250	Ded., then \$250	Ded., then 50%	Ded., then \$0	
Hospital Services <sup>4</sup>	Inpatient	Ded., then 10%	Ded., then 20%	Ded., then 40%	Ded., then 50%	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then \$500	Ded., then \$1,500	Ded., then \$0	Ded., then \$0	Ded., then 20%	Ded., then 50%	Ded., then 50%	Ded., then \$0	
	Outpatient	Ded., then 10%	Ded., then 20%	Ded., then 40%	Ded., then 50%	Ded., then 25%	Ded., then 25%	Ded., then 50%	Ded., then 50%	Ded., then \$500	Ded., then \$1,500	Ded., then \$0	Ded., then \$0	Varies by service	Varies by service	Ded., then 50%	Ded., then \$0	
<b>Prescription (Rx) Drug Coverage</b>		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 <sup>5</sup>	\$5	\$5	\$15	Ded., then \$20	Ded., then \$10	Ded., then \$10	Ded., then \$12	Ded., then \$12	Ded., then \$5	Ded., then \$5	Ded., then \$0	Ded., then \$25	\$5	Ded., then \$15	Ded., then \$20	Ded., then \$0	
	Rx Preferred Brand <sup>5</sup>	\$50	Ded., then \$50	Ded., then \$60	Ded., then \$85	Ded., then \$40	Ded., then \$40	Ded., then 40%	Ded., then 40%	Ded., then 40%	Ded., then 40%	Ded., then \$0	Ded., then 40%	Ded., then \$40	Ded., then 50%	Ded., then \$90	Ded., then \$0	
	Rx Non-Preferred Brand <sup>5</sup>	50%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then \$0	Ded., then 60%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then \$0	
<b>Additional Benefits</b>																		
<b>Wellness Benefits</b>		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				Up to \$50/adult
<b>Premiums by Tier<sup>6</sup></b>		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	\$686.76	\$603.29	\$520.92	\$440.84	\$515.81		\$442.96		\$582.30	\$507.01	\$553.14	\$438.18					
	MVP	\$673.21	\$602.52	\$521.73	\$408.10		\$491.74		\$412.52					\$586.08	\$470.40	\$406.28	\$530.99	
Couple	BCBSVT	\$1,373.52	\$1,206.58	\$1,041.84	\$881.68	\$1,031.62		\$885.92		\$1,164.60	\$1,014.02	\$1,106.28	\$876.36					
	MVP	\$1,346.42	\$1,205.04	\$1,043.46	\$816.20		\$983.48		\$825.04					\$1,172.16	\$940.80	\$812.56	\$1,061.98	
Parent and Child(ren)	BCBSVT	\$1,325.45	\$1,164.35	\$1,005.38	\$850.82	\$995.51		\$854.91		\$1,123.84	\$978.53	\$1,067.56	\$845.69					
	MVP	\$1,299.30	\$1,162.86	\$1,006.94	\$787.63		\$949.06		\$796.16					\$1,131.13	\$907.87	\$784.12	\$1,024.81	
Family	BCBSVT	\$1,929.80	\$1,695.24	\$1,463.79	\$1,238.76	\$1,449.43		\$1,244.72		\$1,636.26	\$1,424.70	\$1,554.32	\$1,231.29					
	MVP	\$1,891.72	\$1,693.08	\$1,466.06	\$1,146.76		\$1,381.79		\$1,159.18					\$1,646.88	\$1,321.82	\$1,141.65	\$1,492.08	

**Footnotes**

1 Medical Deductible waived for: Preventive, Office Visit, Urgent Care, Ambulance, Emergency Room, Pediatric Dental Class 1 Series (as indicated by plan).  
 2 Specialist co-pay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.  
 3 ER co-pay is waived if admitted.  
 4 Hospital Services are Inpatient (including surgery, ICU/NICU, maternity, SNF and MH/SA); Outpatient (including ambulatory surgery centers); and Radiology (MRI, CT, PET). This cost-sharing will also include physician and anesthesia costs, as appropriate.  
 5 Each insurance carrier classifies drugs according to its own formulary. To see if a specific drug qualifies for the Generic or Preferred co-pay, view the formularies at <http://info.healthconnect.vermont.gov/healthplans> or contact BCBSVT (800-247-2583) or MVP (800-TALK-MVP). <http://info.healthconnect.vermont.gov/glossary>.  
 6 With an aggregate family deductible, your family must meet the family deductible before the plan pays benefits. With a stacked deductible, the plan pays benefits once you meet either your individual deductible or your family deductible.  
 7 If you purchase a silver plan and your income qualifies for cost-sharing reductions (for example, up to \$72,900 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](http://www.VermontHealthConnect.gov) and click on "Health Plans."  
 8 BCBSVT Standard Gold/Silver/Bronze plans have a \$100/\$150/\$700 Rx Deductible per person, while MVP Standard Gold/Silver/Bronze plans have an Rx Deductible of \$100/\$150/\$700 for a Single plan or \$200/\$300/\$1,400 for all other tiers.  
 9 With High Deductible Health Plans (HDHP), you do not have to pay the deductible for Wellness prescriptions. See the BCBSVT and MVP lists of Wellness drugs at <http://info.healthconnect.vermont.gov/healthplans>.  
 10 Some aggregate family deductibles have an embedded individual maximum out-of-pocket of \$7,150 to prevent one individual from paying the full family maximum out-of-pocket when it exceeds the federal maximum out-of-pocket of \$7,150 for an individual.

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

Updated 11/2/16

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# DVHA Programmatic Performance Budget SFY '18 - Medicaid Inpatient Psychiatric and Detox Utilization

**O** DVHA Vermonters Receive Appropriate Care

Time Period      Actual Value      Current Trend      Baseline % Change

**P** DVHA Medicaid Inpatient Psychiatric and Detoxification Utilization

Time Period      Actual Value      Current Trend      Baseline % Change

## Budget Information

**Total DVHA Program Budget SFY 2018: \$987,810**

## What We Do

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

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

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

## Partners

- Department of Mental Health Adult and Children and Families Units,
- Department of Disabilities, Aging and Independent Living,
- Department for Children and Families,
- Integrated Family Services,
- Designated Hospitals,
- Designated Agencies,
- Special Service Agencies,
- Vermont Chronic Care Initiative

## How We Impact

Historically, as a part of an acute care management program that was developed in response to the 1115b Waiver, children's inpatient admissions at the Brattleboro Retreat were managed through a concurrent review process, however this oversight ended in late 2006 and during this "unmanaged" period the average length of stay and inpatient costs grew substantially. In 2010 the Department of Vermont Health Access began a utilization management (UM) system for children and adolescents, adults ages 18-22 admitted to the Brattleboro Retreat, and all adults admitted to out of state facilities. In 2011, the DVHA added inpatient detoxification admissions and adult psychiatric admissions (excluding CRT and Involuntary) to the UM program. In 2012 the Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) collaborated to create a unified utilization management system for all Medicaid funded inpatient psychiatric and detoxification services. The goals for the utilization management system are as follows:

- Clinical care is provided only as long as necessary for safety and/or other acute needs.
- There are standardized criteria for admission, continued stay and discharge throughout the system of care.

- Care is continuous between the ongoing community treatment teams and episodes of inpatient or residential care. Ideally the hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and their family, beginning within 24 hours of admission.
- Resources of the public system are effectively and efficiently used.
- The system of care will ensure access to effective, appropriate, recovery-based services that promote an individual's health, wellness and resiliency and will support successful integration into the community.

Collaboration between VCCI and DVHA utilization review staff helps ensure timely communication with inpatient facilities and supports beneficiaries being able to successfully re-integrate with outpatient supports and services. Collaboration between DVHA and DMH UR staff and DCF, DAIL and DMH adult Care Managers and DMH CAFU Care Managers helps to ensure that active and appropriate aftercare planning is facilitated between the Designated Hospitals and the outpatient providers, this allows for aftercare services to be in place and ready to receive beneficiaries as soon as they are ready to be discharged and return to their communities. Our Agency partners are also invaluable in holding their preferred providers accountable to the tenets of the "Triple AIM".

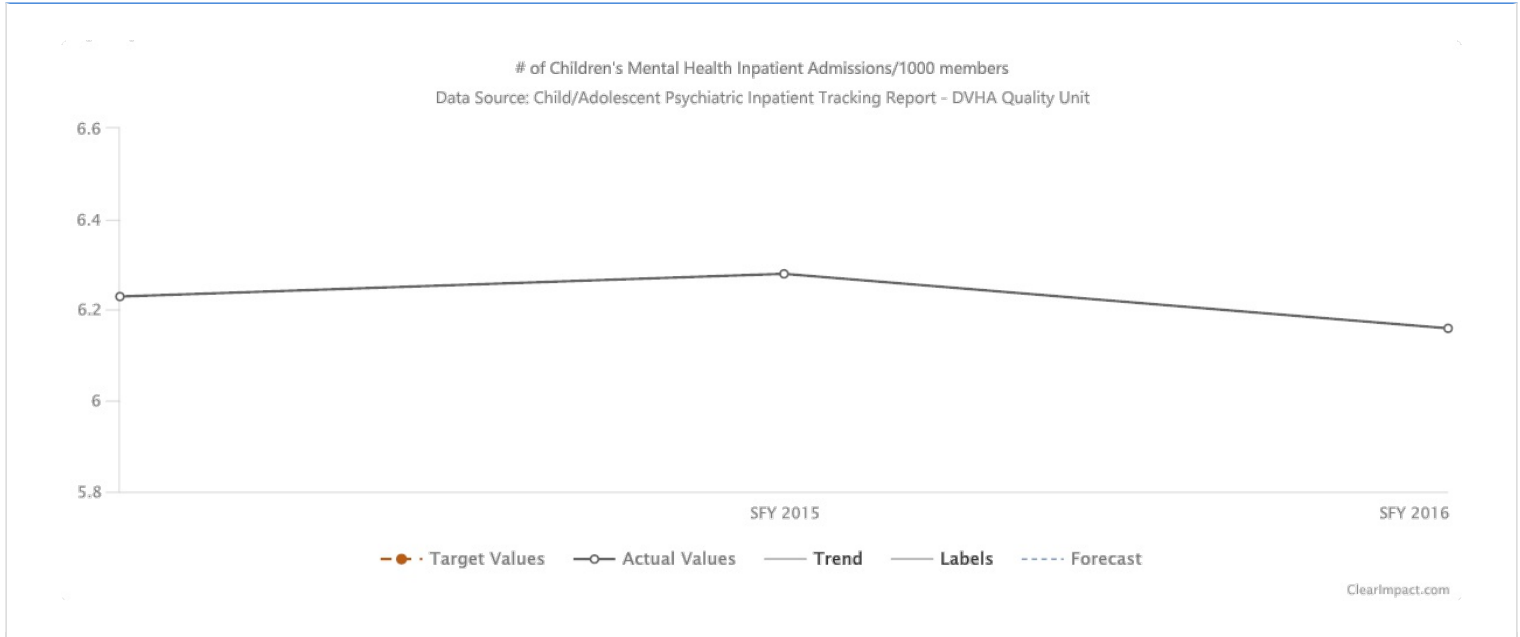
Together the following performance measures focus on whether Vermonters are better off as a result of this program. They do so by looking at the quality and efficiency of these programs and services.

PM	DVHA	# of Children's Mental Health Inpatient Admissions/1000 members	SFY 2016	6.16	↓ 1	-1%	↓
PM	DVHA	# of Adult Mental Health Inpatient Admissions/1000 members	SFY 2016	9.98	↑ 1	5%	↑
PM	DVHA	# of Detoxification Admissions/1000 members	SFY 2016	5.55	↓ 1	-36%	↓
PM	DVHA	Average Length of Stay - Children's Mental Health Inpatient Admissions	SFY 2016	13.40days	↓ 2	-12%	↓
PM	DVHA	Average Length of Stay - Adult Mental Health Inpatient Admissions	SFY 2016	6.90days	↓ 2	-12%	↓
PM	DVHA	Average Length of Stay - Detox. Admissions	SFY 2016	4.60days	↓ 2	-4%	↓
PM	DVHA	Paid Claims - Children's Mental Health Inpatient Admissions	SFY 2016	\$5.80Mil	↓ 1	-23%	↓
PM	DVHA	Paid Claims - Adult Mental Health Inpatient Admissions	SFY 2016	\$9.48Mil	↑ 1	-4%	↓
PM	DVHA	Paid Claims - Detox. Admissions	SFY 2016	\$2.44Mil	↓ 1	-35%	↓
P	DVHA	Medicaid Inpatient Psychiatric and Detoxification Utilization	Time Period	Actual Value	Current Trend	Baseline % Change	
PM	DVHA	# of Children's Mental Health Inpatient Admissions/1000 members	SFY 2016	6.16	↓ 1	-1%	↓
PM	DVHA	# of Adult Mental Health Inpatient Admissions/1000 members	SFY 2016	9.98	↑ 1	5%	↑
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# P Medicaid Inpatient Psychiatric and Detoxification Utilization

PM DVHA # of Children's Mental Health Inpatient Admissions/1000 members

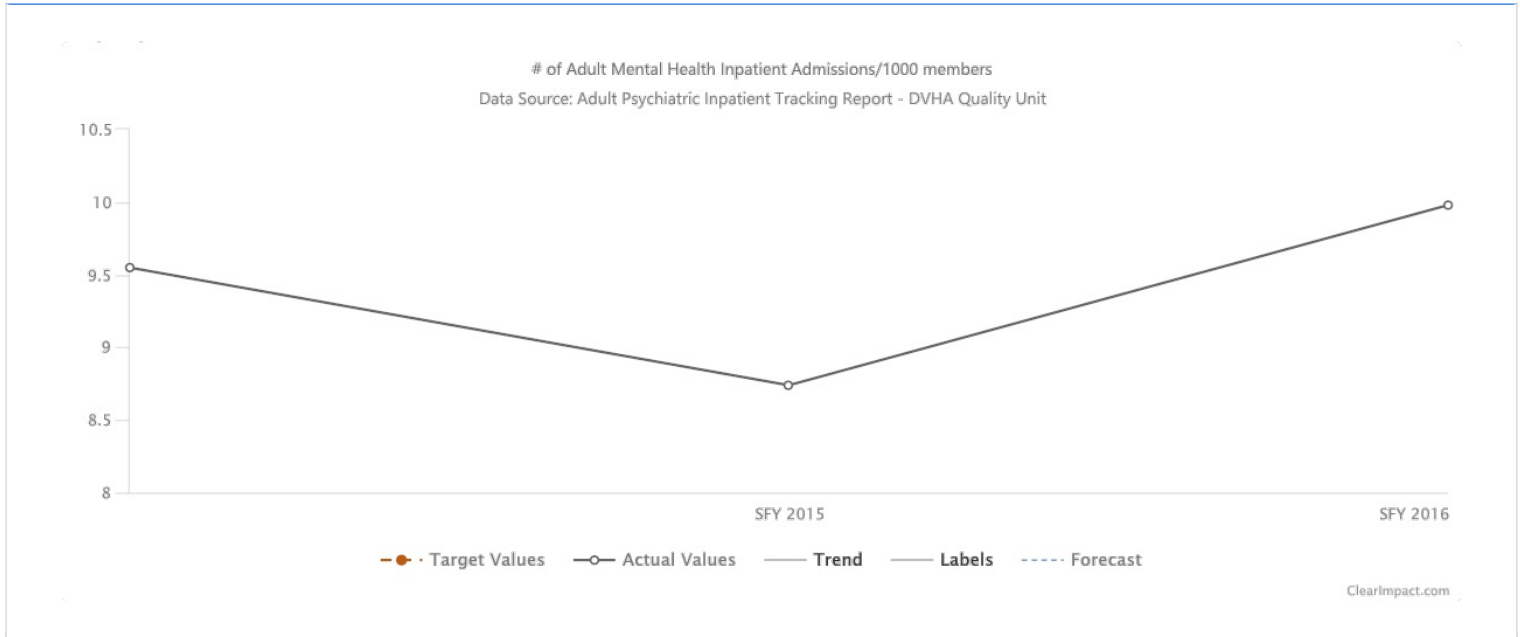


## Story Behind the Curve

This performance measure is important because it measures HOW MUCH the program is doing; it measure quantity of program effort.

# P Medicaid Inpatient Psychiatric and Detoxification Utilization

PM DVHA # of Adult Mental Health Inpatient Admissions/1000 members



## Story Behind the Curve

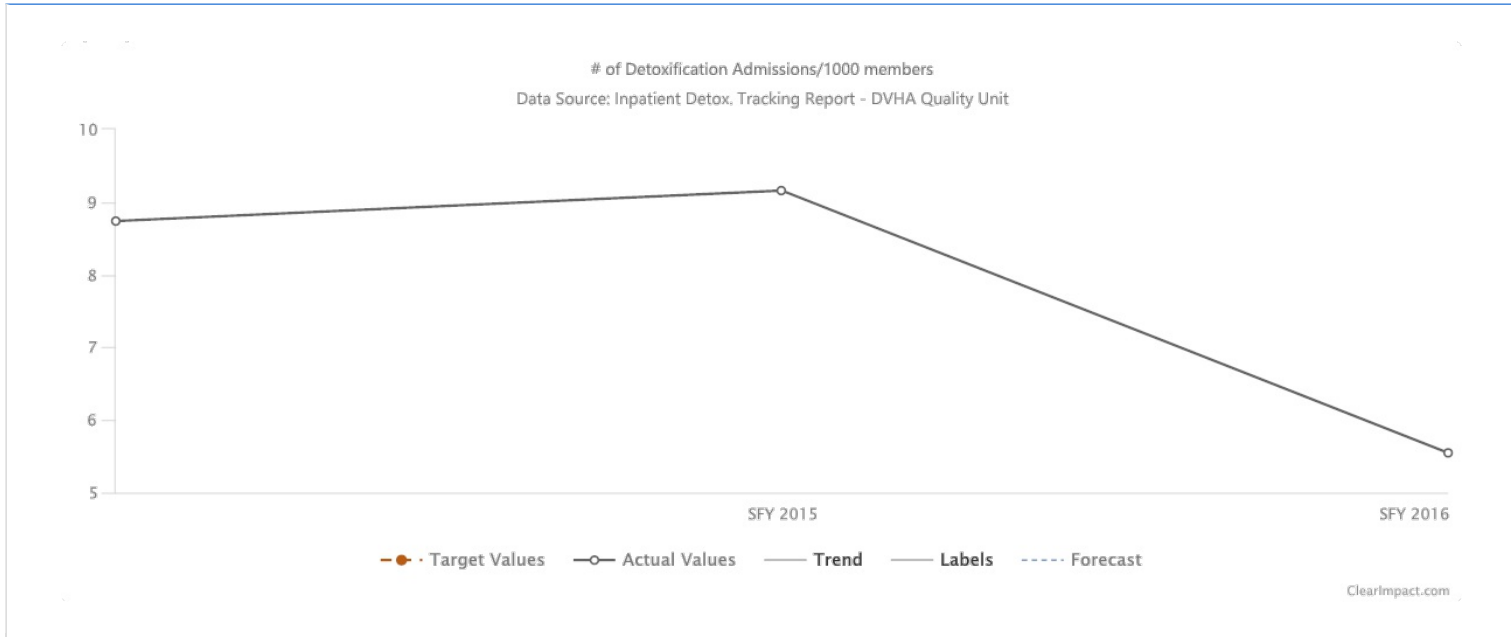
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The DVHA Quality Unit's behavioral health team is looking into any possible correlation between the decline in SFY '16 detox admissions and the increase in adult psychiatric admissions.



# P Medicaid Inpatient Psychiatric and Detoxification Utilization

PM DVHA # of Detoxification Admissions/1000 members



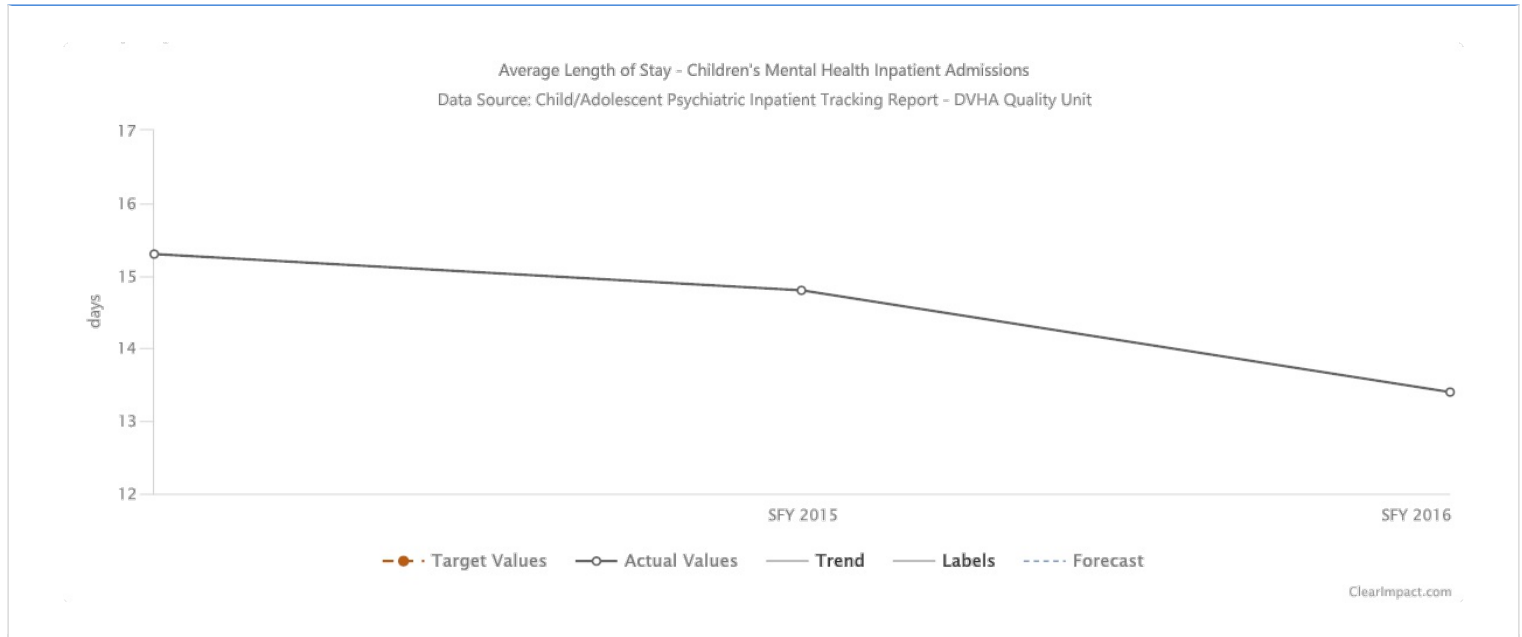
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# P Medicaid Inpatient Psychiatric and Detoxification Utilization

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



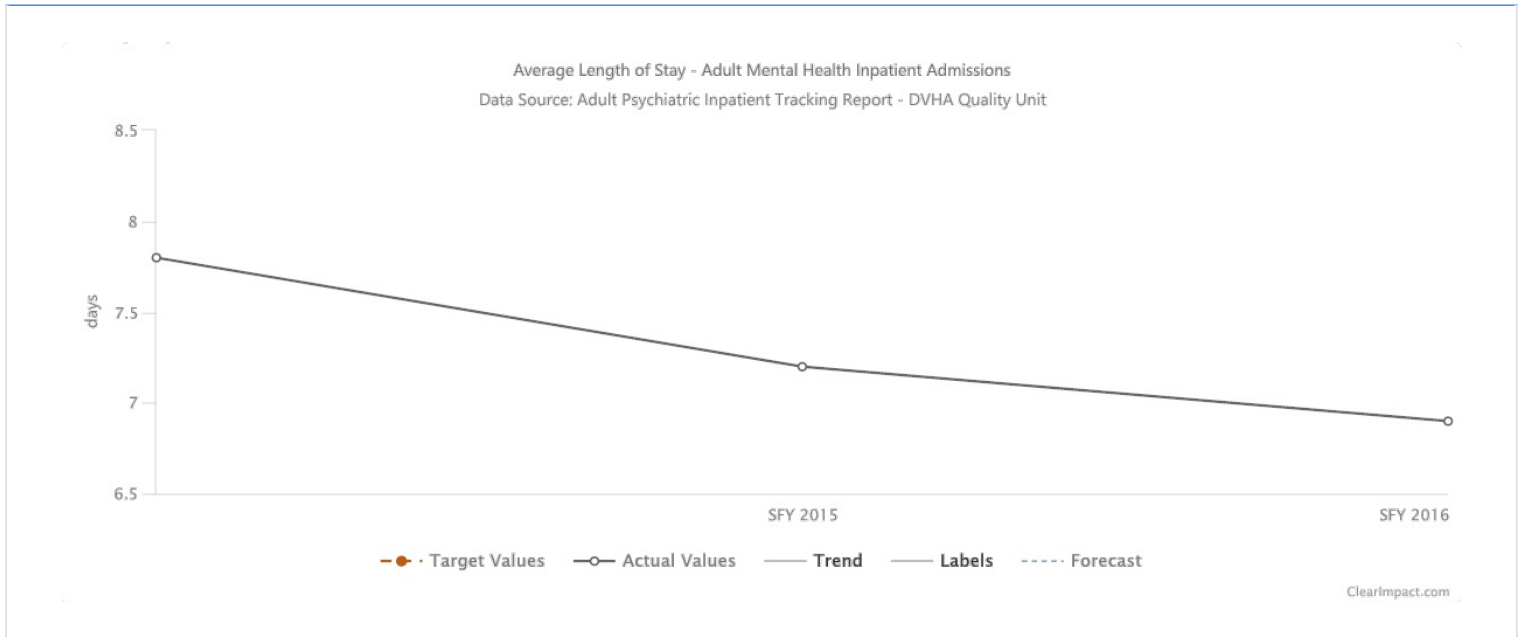
### Story Behind the Curve

This performance measure is important because it measures HOW WELL the program is doing; it measures quality of program effort.

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

# P Medicaid Inpatient Psychiatric and Detoxification Utilization

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



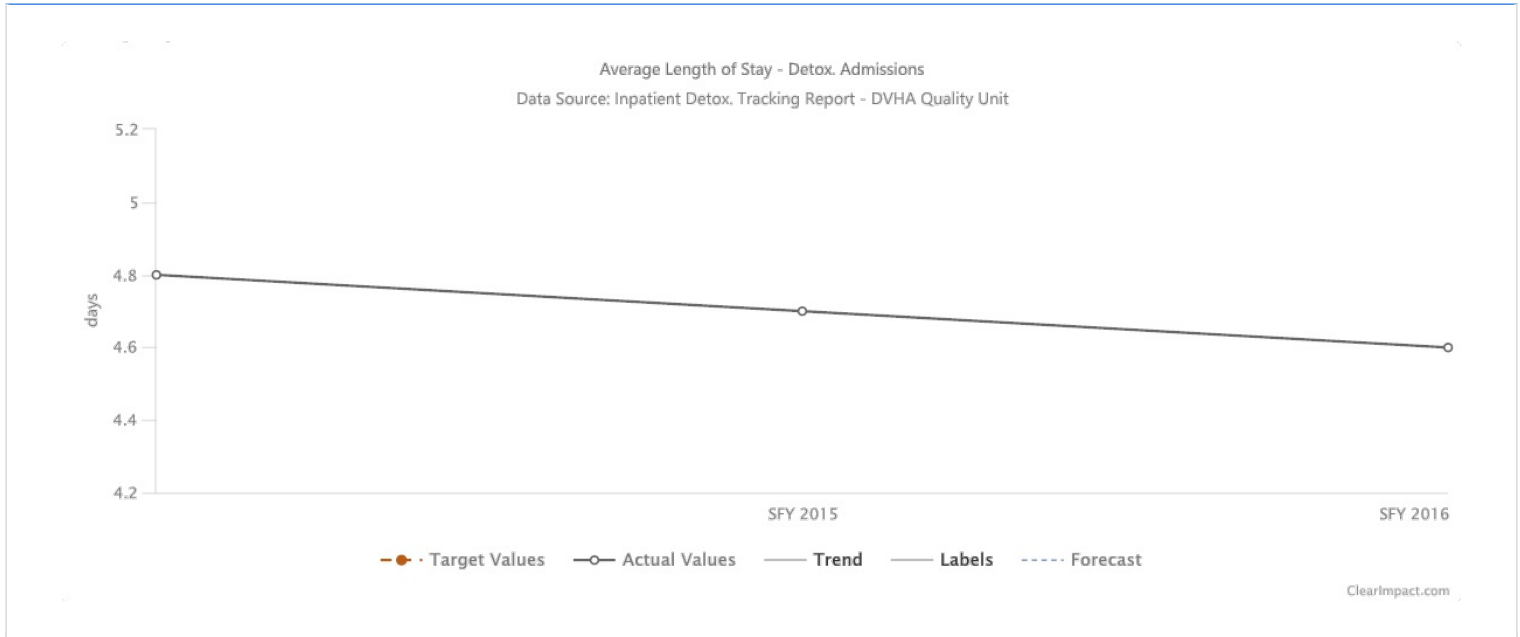
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# P Medicaid Inpatient Psychiatric and Detoxification Utilization

## PM DVHA Average Length of Stay - Detox. Admissions



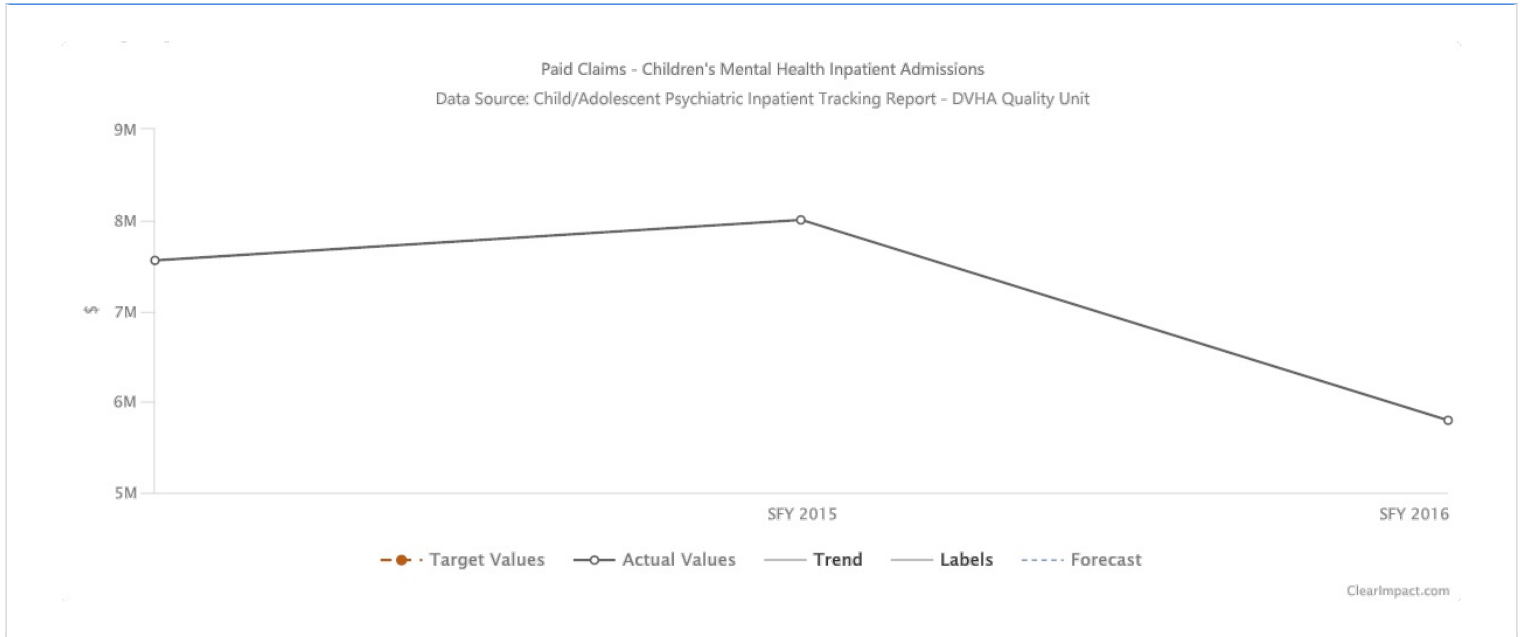
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# P Medicaid Inpatient Psychiatric and Detoxification Utilization

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

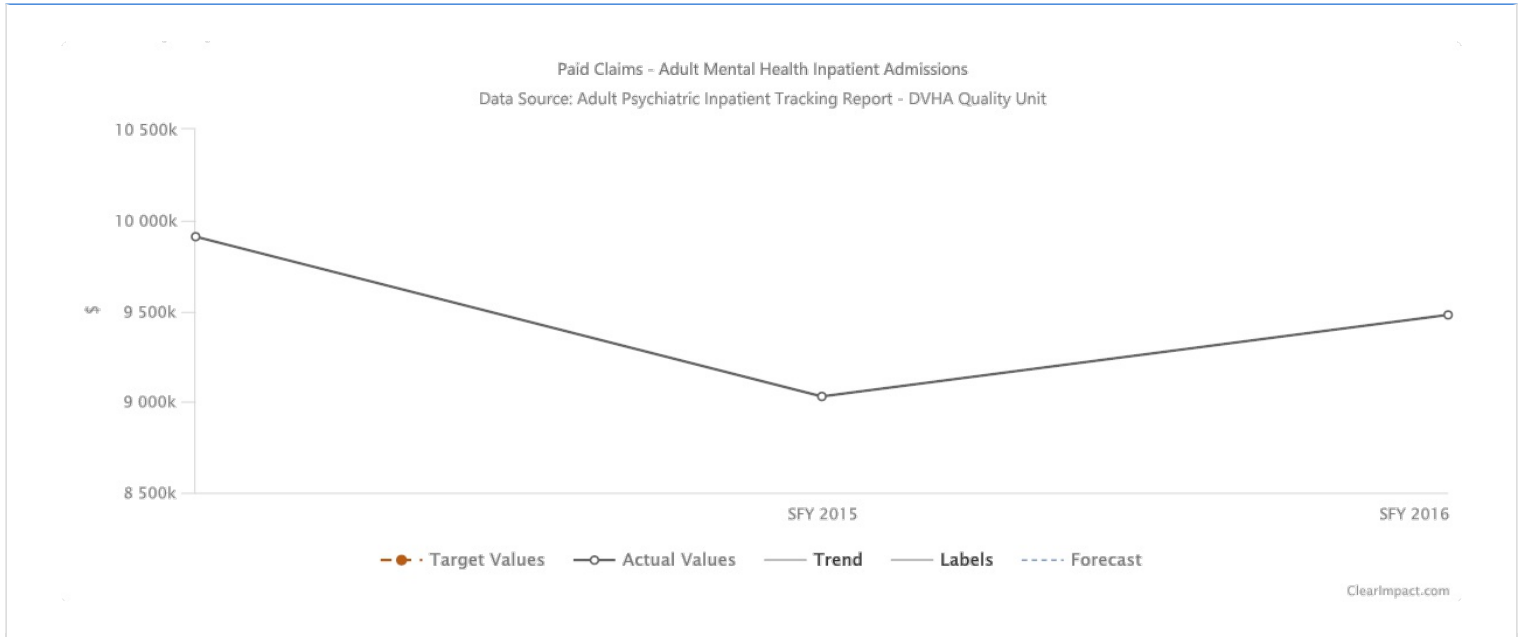


### Story Behind the Curve

This performance measure is important because it measures how much the program is doing; it measures quantity of program effort. The DVHA Quality Unit reviews paid claims and tracks the costs of inpatient hospitalization for specific populations.

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

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



### Story Behind the Curve

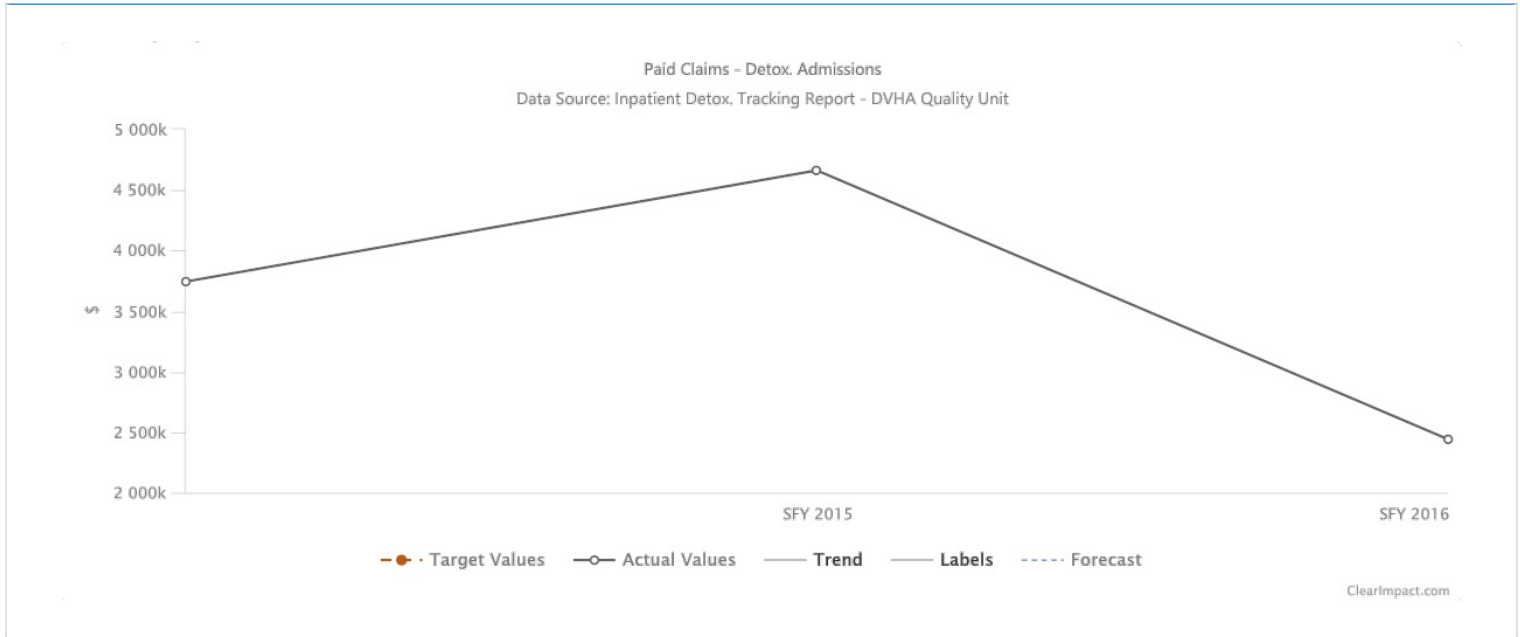
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## ACRONYMS

| [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/I/U** ..... Adoption/ Implementation/  
Upgrade

**A/R**.....Accounts Receivable

**A2A** ..... Application To Application

**AA** .....Alcoholics Anonymous

**AAA** ..... Area Agency on Aging

**AAA** ..... Vermont’s Area Agencies on Aging

**AABD**.....Aid to the Aged, Blind or Disabled

**AAC** ..... Average Acquisition Cost

**AAG** .....Assistant Attorney General

**AAP**.....American Academy of Pediatrics

**ABAWD**.....Able-Bodied Adults without  
Dependents

**ABD**.....Aged Blind and Disabled

**ACA** .....Affordable Care Act

**ACCESS** .....Legacy Eligibility System

**ACD**..... Automatic Call Distributor

**ACF**.....Administration for Children and  
Families

**ACH** .....Automated Clearing House

**ACL** .....Access Control List

**ACO**..... Accountable Care Organization

**ACT 248**.....Supervision of people with  
developmental disabilities

**AD** .....Active Directory

**ADA**.....American Dental Association

**ADABAS**.....Adaptable Data Base System

**ADAP** .....Alcohol and Drug Abuse Programs

**ADD** .....Attention Deficit Disorder

**ADL** .....Activities of Daily Living

**ADO**.....St. Albans District Office

**ADPC** .....Application and Document  
Processing Center

**ADRC**.....Aging and Disability Resource  
Center

**ADS**.....Adult Day Services

**ADTM**.....Adjusted Downtime Minutes

**ADUR**.....Annual Drug Utilization Review

**ADURS** .....American Drug Utilization Review  
Society

**AdvaMed** .....Advances Medical Technology  
Association

**AEP**.....Annual Enrollment Period

**AG** .....Attorney General

**AGA**.....Adult General Assessment

**AGO**.....Office of the Attorney General

**AHCA**.....American Healthcare Association

**AHCPR**.....Agency for Healthcare and Policy  
Research

**AHEC**.....Are Health Education Center

**AHFS**.....American Hospital Formulary  
Service

**AHHS**.....(Vermont) Association of  
Hospitals and health Systems (see  
VAHHS)

**AHIMA**.....American Health Information  
Management Association

**AHIP** .....American’s Health Insurance Plans

**AHRF** .....Area Heath Recourse File



<b>AHRQ</b> .....Agency for Healthcare Research and Quality	<b>APDU</b> .....Advance Planning Document Update
<b>AHS</b> .....Agency of Human Services	<b>APG</b> .....Ambulatory Patient Group
<b>AIDS</b> .....Acquired Immune Deficiency Syndrome	<b>APhA</b> .....American Pharmaceutical Association
<b>AIM</b> .....Agency Improvement Model	<b>APHA</b> .....American Public Health Associations
<b>AIM</b> .....Advanced Information Management System (see MMIS)	<b>APHSA</b> .....American Public Human Services Association
<b>AIPBP</b> .....All-Inclusive Population-Based Payment	<b>API</b> .....Application Program Interface
<b>AIRS</b> .....Automated Information and Referral System	<b>APM</b> .....All Payer Model
<b>ALS</b> .....Advanced Life Support	<b>APMH</b> .....Advanced Practice Medical Homes
<b>AMA</b> .....American Medical Association	<b>APS</b> .....Adult Protective Services
<b>AMAP</b> .....Aids Medication Assistance Program	<b>APS</b> .....APS Healthcare
<b>AMP</b> .....Average Manufacturer Price	<b>APSE</b> .....Association for Persons in Supported Employment
<b>ANFC</b> .....Aid to Needy Families with Children	<b>APT</b> .....Admissions Per Thousand
<b>ANHA</b> .....American Nursing Home Association	<b>APTC</b> .....Advanced Premium Tax Credit
<b>ANSI</b> .....American National Standards Institute	<b>AR</b> .....ACCESS Remediation
<b>AOA</b> .....Agency Of Administration	<b>ARC</b> .....Advocacy Organization for People with Developmental Disabilities
<b>AOE</b> .....Agency Of Education	<b>ARIS</b> .....Area Resources for Individualized Services
<b>AOEP</b> .....Annual Open Enrollment Period	<b>ARRA</b> .....American Recovery and Reinvestment Act of 2009
<b>AOPS</b> .....Assistant Operations	<b>AS1</b> .....Applicability Statement 1
<b>APA</b> .....Administrative Procedures Act	<b>AS2</b> .....Applicability Statement 2
<b>APC</b> .....Ambulatory Payment Classification	<b>ASD</b> .....Adult Services Division
<b>APCP</b> .....Advanced Primary Care Practice	<b>ASD</b> .....Administrative Services Division
<b>APD</b> .....Advanced Planning Document	<b>ASFA</b> .....Adoption and Safe Families Act
<b>AP-DRG</b> ..... All Patient Diagnosis Related Groups	<b>ASHHRA</b> .....American Society of Healthcare Human Resources Administration
	<b>ASHP</b> .....American Society of Heal-System Pharmacists

<b>ASHRM</b> .....	American Society for Hospital Risk Management	<b>BHIE</b> .....	Bi-directional Health Information Exchange
<b>ASP</b> .....	Attendant Services Program	<b>BHP</b> .....	Basic Health Plan
<b>ASPA</b> .....	American Society for Personnel Administration	<b>BI</b> .....	Business Intelligence
<b>ASTHO</b> .....	Association of State and Territorial Health Officials	<b>BIAVT</b> .....	Brain Injury Association of Vermont
<b>AT</b> .....	Access Transformation	<b>BIN</b> .....	Bank Identification Number
<b>AT</b> .....	Assistive Technology	<b>BISCHA</b> .....	Banking and Insurance, Securities and healthcare Administration
<b>ATD</b> .....	ACCESS Transformation and Decommissioning	<b>BISHCA</b> .....	Banking, Insurance, Securities, and Healthcare Administration (Department of)
<b>ATNA</b> .....	Audit Trails and Node Authentication	<b>BizObj</b> .....	Business Objects
<b>AUR</b> .....	Ambulatory Utilization Review	<b>BJS</b> .....	Bureau of Justice Statistics
<b>AVR</b> .....	Automated Voice Response	<b>BLA</b> .....	Bureau of Labor Statistics
<b>AWP</b> .....	Average Wholesale Price	<b>BMI</b> .....	Body Mass Index
<b>B</b>		<b>BO</b> .....	Business Office
<b>B2B</b> .....	Business To Business	<b>BOBI</b> .....	Business Objects Business Intelligence
<b>BA</b> .....	Business Analyst	<b>BOD</b> .....	Business Office Division
<b>BAA</b> .....	Budget Adjustment Act	<b>BP</b> .....	Blueprint
<b>BAFO</b> .....	Best And Final Offer	<b>BPA</b> .....	Business Process Analysis
<b>BASU</b> .....	Business Applications Support Unit	<b>BPAA</b> .....	Benefit Program Assistant Administrator
<b>BBF</b> .....	Building Bright Futures	<b>BPEL</b> .....	Business Process Execution Language
<b>BC/BS</b> .....	Blue Cross/Blue Shield	<b>BPFH</b> .....	Blueprint for Health
<b>BCBSVT</b> .....	Blue Cross/Blue Shield of Vermont	<b>BPHC</b> .....	Bureau of Primary Healthcare
<b>BCCH</b> .....	Bipartisan Commission on Comprehensive Healthcare	<b>BPM</b> .....	Business Process Management
<b>BCCT</b>	Breast and Cervical Cancer Treatment	<b>BPM</b> .....	Business Process Model/Modeling
<b>BD</b> .....	Blind and Disabled	<b>BPMN</b> .....	Business Process modeling Notation
<b>BDO</b> .....	Burlington District office	<b>BPMS</b> .....	Business Process Management Software
<b>BENDEX</b> .....	Beneficiary Benefits Eligibility Screening Tool	<b>BPS</b> .....	Benefits Programs Specialist
<b>BEST</b> .....	Social Security Benefits Eligibility Screening Tool	<b>BPT</b> .....	Business Process Template
<b>BGS</b> .....	Building and General Services	<b>BR</b> .....	Business Rule
		<b>BRE</b> .....	Business Rule Engine
		<b>BRFSS</b> .....	Behavioral Risk Factor Surveillance System
		<b>BRMS</b> .....	Business Rule Management System

**BROC**.....Bennington-Rutland Opportunity Council

**BSV**.....Biosurveillance

**C**

**CA**.....Community Associates

**CAC**.....Child Advocacy Center

**CACFP**.....Child and Adult Care Food Program

**CAD**.....Coronary Artery Disease

**CAFU**.....Child, Adolescent and Family Unit

**CAH**.....Critical Access Hospital

**CAHPS**.....Consumer Assessment of Health Plans Survey

**CALT**.....Collaborative Application Lifecycle Tool

**CAN**.....Child Abuse and Neglect

**CAP**.....Community Action Program

**CAP**.....Corrective Action Plan

**CAP**.....Center Accreditation Project

**CAPTA**.....Child Abuse Protection and Treatment Act

**CARF**.....Commission on Accreditation of Rehabilitation Facilities

**CARU**.....Child Abuse Registry Unit

**CASSP**.....Child Adolescent Services System Program

**CBA**.....Cost Benefit Analysis

**CBO**.....Congressional Budget Office

**CBU**.....Child Benefits Unit

**CC**.....Committed Child

**CC**.....Chronic Care

**CC**.....Contact Center

**CCB**.....Change Control Board

**CCCSA**.....Community Child Care Support Agencies

**CCD**.....Child Development Division of DCF

**CCD**.....Continuity of Care Documents

**CCDBG**.....Child Care Development Block Grant

**CCFS**.....Child Care Subsidy Program

**CCHIT**.....Certification Commission for Healthcare Information Technology

**CCIO**.....Center for Consumer Information and Insurance Oversight (CMS)

**CCIS**.....Chronic Care Information System

**CCM**.....Clinical Criteria Manual

**CCMP**.....Chronic Care Management Program

**CCO**.....Community Corrections Officer

**CCP**.....Care Coordination Program

**CCPA**.....Consumer Credit Protection Act

**CCR**.....Continuity of Care Record

**CCRRP**.....Child Care Resource and Referral Programs

**CCRS**.....College and Career Readiness Standards

**CCSC**.....Community Correctional Services Center

**CCTA**.....Chittenden County Transportation Authority

**CCU**.....Coronary Care Unit

**CCV**.....Community College of Vermont

**CCWC**.....Caledonia Community Work Camp

**CD**.....Compact Disk

**CD/SD**.....Consumer Directed/Surrogate Directed

**CDC**.....Center for Disease Control and Prevention

**CDD**.....Child Development Division of DCF

**CDISC**.....Clinical Data Interchange Standards Consortium

**CDR**.....Continuing Disability Review

**CDS**.....Clinical Decisions Support

**CDS**.....Community Developmental Services

**CDT**.....Current Dental Terminology

**CEJ**.....Continuing Exclusive Jurisdiction

**CERT**.....Corrections Emergency Response Team

**CET**.....Cost Effective Test

<b>CF</b> .....	Crisis Fuel	<b>CHT</b> .....	Community Health Team
<b>CFC</b> .....	Choices For Care	<b>CI</b> .....	Configuration Item
<b>CFCCP</b> .....	Children and Family Council for Prevention Programs	<b>CIA</b> .....	Confidentiality, Integrity, and Availability
<b>CFIS</b> .....	Clinical Financial Information Systems	<b>CIO</b> .....	Chief Information Officer
<b>CFR</b> .....	Code of Federal Regulations	<b>CIS</b> .....	Children’s Integrated Services
<b>CFSR</b> .....	Child and Family State Review	<b>CLD</b> .....	Claim Level Detail
<b>CFSS</b> .....	Correctional Facility Shift Supervisor	<b>CLIA</b> .....	Clinical Laboratory Improvement Amendments
<b>CGMP</b> .....	Current Good Manufacturing Price/Practice	<b>CM</b> .....	Case Management
<b>CHAC</b> .....	Community Health Accountability Care	<b>CM</b> .....	Change Management
<b>CHAMPUS</b> ...	Civilian Health and Medical Program of the Uniformed Services	<b>CM</b> .....	Configuration Management
<b>CHAMPVA</b> ...	Civilian Health and Medical Program of the Department of Veterans Affairs	<b>CMC</b> .....	Case Manager Conference
<b>CHAP</b> .....	Catamount Health Assistance Premium	<b>CMCM</b> .....	Care Management and Care Models
<b>CHC</b> .....	Community Health Centers	<b>CMHC</b> .....	Community Mental Health Center
<b>CHC</b> .....	Comprehensive Health Centers	<b>CMHS</b> .....	Center for Mental Health Services
<b>CHI</b> .....	Consolidated Health Informatics	<b>CMIA</b> .....	Cash Management Improvement Act
<b>CHIP</b> .....	Children’s Health Insurance Program	<b>CMMI</b> .....	Center for Medicare and Medicaid Innovation
<b>CHIPRA</b> .....	Children’s Health Insurance Program Re-Authorization Act	<b>CMN</b> .....	Certification of Medical Necessity
<b>CHF</b> .....	Congestive Heart Failure	<b>CMS</b> .....	Centers for Medicare and Medicaid Services
<b>CHO</b> .....	Comprehensive Health Centers	<b>CMSO</b> .....	Center for Medicaid and State Operations
<b>CHP</b> .....	Certified Health Plan	<b>CNM</b> .....	Certified Nurse Midwife
<b>CHPA</b> .....	Community Health Purchasing Alliance	<b>CO I</b> .....	Correctional Officer One
<b>CHPR</b> .....	Center for Health Policy and Research	<b>CO II</b> .....	Correctional Officer Two
<b>CHS</b> .....	Community High School of Vermont	<b>COA</b> .....	Council On Aging
<b>CHSO</b> .....	Comprehensive Health Services Organization	<b>COB</b> .....	Coordination Of Benefits
<b>CHSVT</b> .....	Community High School of Vermont	<b>COB</b> .....	Certificate of Benefit
		<b>COB</b> .....	Close Of Business
		<b>COB-MAT</b> .....	Coordination of Office Based Medication Assisted Therapy
		<b>COBRA</b> .....	Consolidated Omnibus Reconciliation Act of 1986 (health coverage)
		<b>COC</b> .....	Change Of Circumstance
		<b>COC</b> .....	Certificate Of Coverage
		<b>CODTP</b> .....	Co-Occurring Disorders Treatment Program

<b>COLA</b> .....	Cost Of Living Adjustment	<b>CRM</b> .....	Customer Relationship Management
<b>COLST</b> .....	Clinician Orders for Life-Sustaining Treatment	<b>CRT</b> .....	Community Rehabilitation and Treatment
<b>CON</b> .....	Certificate Of Need	<b>CSAC</b> .....	Counseling Services of Addison County
<b>ConOps</b> .....	Concept of Operations	<b>CSAP</b> .....	Center for Substance Abuse Prevention
<b>COPC</b> .....	Community Oriented Primary Care	<b>CSAT</b> .....	Center for Substance Abuse Treatment
<b>COPD</b> .....	Chronic Obstructive Pulmonary Disease	<b>CSBG</b> .....	Community Services Block Grant
<b>COPS</b> .....	Computer Operations and Problem Solving	<b>CSC</b> .....	Customer Support Center
<b>CORF</b> .....	Comprehensive Outpatient Rehabilitation Facility	<b>CSD</b> .....	Computer Services Division (OCS)
<b>COS</b> .....	Category Of Service	<b>CSE</b> .....	Child Support Enforcement
<b>COS</b> .....	Cost Of Service	<b>CSFP</b> .....	Commodity Supplemental Food Program
<b>COTS</b> .....	Commercial/Common Off-The-Shelf	<b>CSHN</b> .....	Children with Special Health Needs
<b>COU</b> .....	Clinical Operations Unit	<b>CSME</b> .....	Coverage and Services Management Enhancement
<b>COVE</b> .....	Community Of Vermont Elders	<b>CSME</b> .....	Central Source for Measurements and Evaluation
<b>CP</b> .....	Custodial Parent (recipient of the support)	<b>CSP</b> .....	Child Support Problems
<b>CP (2)</b> .....	Certified Provider (or Cerebral Palsy)	<b>CSP</b> .....	Community Support Program
<b>CPC</b> .....	Certified Professional Coder	<b>CSR</b> .....	Cost Sharing Reductions
<b>CPH</b> .....	Community Public Health (of the VDH)	<b>CSR</b> .....	Customer Service Request
<b>CPI</b> .....	Center for Program Integrity	<b>CSR</b> .....	Change System Request
<b>CPI</b> .....	Consumer Price Index	<b>CSR</b> .....	Customer Support/Service Representative
<b>CPR</b> .....	Comparative Performance Reports	<b>CSS</b> .....	Child Support Specialist
<b>CPRC</b> .....	Customary, Prevailing and Reasonable Charge	<b>CSS</b> .....	Corrections Service Specialist
<b>CPRS</b> .....	Computerized Patient Record System	<b>CSTL</b> .....	Community Services Team Leader
<b>CPS</b> .....	Child Protective Services	<b>CUPS</b> .....	Children’s Upstream Services Grant
<b>CPT</b> .....	Common Procedural Terminology	<b>CURB</b> .....	Clinical Utilization Review Board
<b>CPTOD</b> .....	Capitated Program for the Treatment of Opiate Dependency	<b>CVCA</b> .....	Central Vermont Council on Aging
<b>CQI</b> .....	Continuous Quality Improvement	<b>CVCAC</b> .....	Central Vermont Community Action Council
<b>CR</b> .....	Conditional Reentry	<b>CVH</b> .....	Central Vermont Hospital
<b>CRC</b> .....	Community Rating by Class	<b>CVOEO</b> .....	Champlain Valley Office of Economic Opportunity
<b>CRCF</b> .....	Chittenden Regional Correctional Facility	<b>CVP</b> .....	Controlled Vendor Payment

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

<b>DSA</b> .....	Digital Signature Algorithm	<b>ED</b> .....	Emotionally Disturbed
<b>DSCF</b> .....	Dale State Correctional Facility	<b>ED</b> .....	Emergency Department
<b>DSH</b> .....	Disproportionate Share Hospital	<b>EDA</b> .....	Event Driven Architecture
<b>DSHP</b> .....	Designated State Health Plan	<b>EDI</b> .....	Electronic Data Interchange
<b>DSM IV</b> .....	Diagnostic and Statistical Manual of Mental Disorders (4th Edition Revised)	<b>EDMS</b> .....	Electronic Documentation Management System
<b>DSM V</b> .....	Diagnostic and Statistical Manual of Mental Disorders Version V	<b>EDS</b> .....	Electronic Data Systems Corporation
<b>DSM 5</b> .....	Diagnostic and Statistical Manual of Mental Disorders Version V	<b>EEG</b> .....	Electroencephalogram
<b>DSS</b> .....	Decision Support System	<b>EFF</b> .....	Equipped For the Future
<b>DUR</b> .....	Drug Utilization Review (Board)	<b>EFT</b> .....	Electronic Funds Transfer
<b>DURSA</b> .....	Data Use and Reciprocal Support Agreement	<b>EGA</b> .....	Estimated Gestational Age
<b>DVHA</b> .....	Department of Vermont Health Access	<b>EHB</b> .....	Essential Health Benefits
<b>DVR</b> .....	Vermont Division of Vocational Rehabilitation	<b>EHR</b> .....	Electronic Health Record
<b>DW</b> .....	Data Warehouse	<b>EHRIP</b> .....	Electronic Health Record Incentive Program
<b>E</b>		<b>EIA</b> .....	Enterprise Information Architecture
<b>E&amp;E</b> .....	Eligibility & Enrollment (Funding for more than IE)	<b>EITC</b> .....	Earned Income Tax Credit
<b>EA</b> .....	Emergency Assistance	<b>ELC</b> .....	Enterprise Life Cycle
<b>EA</b> .....	Enterprise Architecture	<b>EMPI</b> .....	Enterprise Master Patient Index
<b>EA</b> .....	Economic Assistance	<b>EMR</b> .....	Electronic Medical Record
<b>EAC</b> .....	Estimated Acquisition Cost	<b>EMS</b> .....	Emergency Medical Services
<b>EAC</b> .....	Estimate At Completion (Estimate to Complete)	<b>EOB</b> .....	Explanation Of Benefits
<b>EAI</b> .....	Enterprise Application Integration	<b>EOMB</b> .....	Explanation Of Medicare (or Medicaid) Benefits
<b>EAP</b> .....	Employee Assistance Program	<b>EP</b> .....	Essential Person
<b>EBC</b> .....	Enterprise Business Capabilities	<b>EP</b> .....	Emergency Preparedness
<b>E-bed</b> .....	Emergency Bed	<b>EPMO</b> .....	Enterprise Project Management Office
<b>EBPM</b> .....	Enterprise Business Process Management	<b>EPO</b> .....	Exclusive Provider Organization
<b>EBPO</b> .....	Enterprise Business Process Owner	<b>EPSDT</b> .....	Early and Periodic Screening, Diagnosis and Treatment
<b>EBT</b> .....	Electronic Benefit Transfer	<b>EQR</b> .....	External Quality Review
<b>ECM</b> .....	Enterprise Content Management	<b>EQRO</b> .....	External Quality Review Organization
<b>ECR</b> .....	Engineer Change Request	<b>ER</b> .....	Emergency Room
<b>ECS</b> .....	Electronic Claims Submission	<b>ERA</b> .....	Electronic Remittance Advice
<b>ECT</b> .....	Electro-Convulsive Therapy	<b>ERC</b> .....	Enhanced Residential Care
		<b>ESB</b> .....	Enterprise Service Bus
		<b>ESD</b> .....	Economic Services Division (part of DCF)

**ESDT** ..... Early Periodic Screening, Diagnosis and Treatment

**ESGP** ..... Emergency Shelter Grants Program

**ESI** ..... Employer Sponsored Insurance

**ESIA** ..... Employer Sponsored Insurance Assistance

**ESOL** ..... English for Speakers of Other Languages

**ESRD** ..... End Stage Renal Disease

**EST** ..... Eastern Standard Time

**ETL** ..... Extract, Transform, Load

**EVAH** ..... Enhanced VT Ad Hoc (query and reporting system)

**EVS** ..... Eligibility Verification System

**F**

**FA** ..... Fiscal Agent

**FAC** ..... Freestanding Ambulatory Center

**FACA** ..... Federal Advisory Committee Act

**FADS** ..... Fraud, Abuse and Detection System

**FAQ** ..... Frequently Asked Questions

**FAST** ..... Federal Adoption of Standards for Health IT

**FAT** ..... Formal Acceptance Test (after UAT)

**FBR** ..... Fiscal Budget Report

**FC** ..... Foster Care

**FCR** ..... Federal Case Registry

**FDA** ..... Food and Drug Administration

**FDP** ..... Family Development Plan

**FDSH** ..... Federal Data Services Hub

**FEA** ..... Federal Enterprise Architecture

**FED** ..... Front End Deductible

**FEIN** ..... Federal Employer’s Identification Number

**FEMA** ..... Federal Emergency Management Administration

**FF** ..... Families First

**FFF** ..... Flexible Family Funding

**FFP** ..... Federal Financial Participation

**FFS** ..... Fee for Service

**FFY** ..... Federal Fiscal Year

**FH** ..... Fair Hearing

**FHA** ..... Federal Health Architecture

**FHIPR** ..... Federal Health Information Planning and Reporting

**FHU** ..... Fair Hearing Unit

**FI** ..... Fiscal Intermediary

**FICA** ..... Federal Insurance Contribution Act

**FIDM** ..... Financial Institution Data Match

**FIPS** ..... Federal Information Processing Standards

**FISMA** ..... Federal Information Security Management Act

**FITP** ..... Family, Infant and Toddler Program

**FMAP** ..... Federal Medical Assistance Percentage

**FMB** ..... Financial Measurement Baseline

**FMP** ..... Financial Management Plan

**FNS** ..... Food and Nutrition Service

**FOA** ..... Funding Opportunity Announcement

**FP** ..... Foster Parent

**FP** ..... For Profit

**FPL** ..... Federal Poverty Level

**FPLS** ..... Federal Parent Locator Service

**FPO** ..... Family Planning Option

**FQHC** ..... Federally Qualified Health Center

**FSA** ..... Flexible Spending Account

**FSD** ..... Family Services Division

**FSP** ..... Food Stamp Program

**FSS** ..... Federal Security Strategy

**FTE** ..... Full Time Equivalent

**FTI** ..... Federal Tax Information

**FTP** ..... File Transfer Protocol

**FTR** ..... Failure To Reconcile

**FUL** ..... Federal Upper Limit (for pricing and payment of drug claims)

**FVI** ..... Family Violence Indicator

**FYE** ..... Fiscal Year End

**G**



<b>G/L</b> .....	General Ledger	<b>HB</b> .....	Home-based
<b>G2B</b> .....	Government To Business	<b>HBE</b> .....	Health Benefit Exchange
<b>G2C</b> .....	Government To Consumer	<b>HBE or VHC</b>	Health Benefits Exchange
<b>G2E</b> .....	Government To Employee	<b>HBEE Rule</b> ...	Health Benefits Eligibility and Enrollment Rule
<b>G2G</b> .....	Government To Government	<b>HBKF</b> .....	Healthy Babies, Kids and Families
<b>GA</b> .....	General Assistance	<b>HCBS</b> .....	Home and Community Based Services
<b>GA/EA</b> .....	General Assistance/Emergency Assistance	<b>HCERA</b> .....	Healthcare and Education Reconciliation Act of 2010
<b>GAAP</b> .....	Generally Accepted Accounting Principles	<b>HCFA</b> .....	Healthcare Finance Administration (now CMS)
<b>GAO</b> .....	General Accounting Office	<b>HCPCS</b> .....	Healthcare Common Procedure Coding System
<b>GAO</b> .....	Government Accounting Office	<b>HCQIA</b> .....	Healthcare Quality Improvement Act
<b>GC</b> .....	Global Commitment	<b>HCR</b> .....	Healthcare Reform
<b>GCR</b> .....	Global Clinical Record (application of the MMIS)	<b>HDO</b> .....	Hartford District Office
<b>GDEA</b> .....	Generic Drug Enforcement Act	<b>HEASB</b> .....	Health Standard Board
<b>GEP</b> .....	General Enrollment Period	<b>HEDIS</b> .....	Health Plan Employer Data and Information Set
<b>GF</b> .....	General Fund	<b>HEDIS</b> .....	Healthcare Effectiveness Data and Information Set
<b>GH</b> .....	Group Home	<b>HFMA</b> .....	Healthcare Financial Management Association
<b>GHRI</b> .....	General Health Rating Index	<b>HHA</b> .....	Home Health Agency
<b>GHS</b> .....	Goold Health Systems	<b>HHS</b> .....	Health and Human Services (U.S. Department of)
<b>GMC</b> .....	Green Mountain Care	<b>HI</b> .....	Home Intervention
<b>GMCB</b> .....	Green Mountain Care Board	<b>HIAA</b> .....	Health Insurance Association of America
<b>GME</b> .....	Graduate Medical Education	<b>HIB</b> .....	Health Insurance Benefits
<b>GMP</b> .....	Good Manufacturing Practice	<b>HIB</b> .....	Hospital Insurance Benefit
<b>GMSA</b> .....	Green Mountain Self-Advocates	<b>HICN</b> .....	Health Insurance Claim Number
<b>GOVNET</b> .....	State of Vermont Government Wide Area Network (WAN)	<b>HIE</b> .....	Health Information Exchange
<b>GPCI</b> .....	Geographic Practice Cost Index	<b>HIE/HIX</b> .....	Health Information Exchange
<b>GPI</b> .....	Generic Product Identifier	<b>HIFA</b> .....	Health Insurance Flexibility and Accountability
<b>GS</b> .....	Guardianship services	<b>HIM</b> .....	Health Insurance Marketplace
<b>GSD</b> .....	General Systems Design	<b>HIMSS</b> .....	Healthcare Information Management Systems Society
<b>GSS</b> .....	Guardian Services Specialist	<b>HIN</b> .....	Health Information Network
<b>GUI</b> .....	Graphical User Interface		
<b>H</b>			
<b>HAEEU</b> .....	Health Access Eligibility and Enrollment Unit		
<b>HSA</b> .....	Health Savings Account		
<b>HSA</b> .....	Health Services Area		
<b>HSA</b> .....	Health Systems Agency		
<b>HASS</b> .....	Housing and Supportive Services		
<b>HATF</b> .....	Health Access Trust Fund		

<b>HIPAA</b> .....	Health Insurance Portability and Accountability Act	<b>HSB</b> .....	Human Services Board
<b>HIPP</b> .....	Health Insurance Premium Program	<b>HSE</b> .....	Health and Human Services Enterprise
<b>HIR</b> .....	Hire Into Range	<b>HSE</b> .....	Health Services Enterprise
<b>HISP</b> .....	Health Information Service Provider	<b>HSE ESC</b> .....	Health Services Enterprise Executive Steering Committee
<b>HISPC</b> .....	Health Information Security and Privacy Collaboration	<b>HSE OSC</b> .....	Health Services Enterprise Operational Steering Committee
<b>HIT</b> .....	Health Information Technology	<b>HSEP</b> .....	Health Services Enterprise Platform - “the Platform”; the shared services and infrastructure that will be shared across solutions.
<b>HITECH</b> .....	HIT for Economic and Clinical Health	<b>HSS</b> .....	Health Care Service Specialist
<b>HITPC</b> .....	Health Information Technology Policy Committee	<b>HTHC</b> .....	Adult High Technology Home Care
<b>HITSP</b> .....	Health Information Technology Standards Panel	<b>HTML</b> .....	Hypertext Markup Language
<b>HIV</b> .....	Human Immunodeficiency Virus	<b>HTTP</b> .....	Hypertext Transfer Protocol
<b>HIX</b> .....	Health Insurance Exchange	<b>HUD</b> .....	United States Department of Housing and Urban
<b>HJR</b> .....	House Joint Resolution	<b>HVP</b> .....	Healthy Vermonters Program
<b>HMO</b> .....	Health Maintenance Organization	<b>I</b>	
<b>HMSA</b> .....	Health Manpower Shortage Area	<b>I&amp;R</b> .....	Information and Referral
<b>HN Team</b> .....	Hostage Negotiations Team	<b>IA</b> .....	Information Architecture
<b>HOS</b> .....	Health Outcomes Survey	<b>IAM</b> .....	Identity and Access Management
<b>HP</b> .....	Hewlett Packard	<b>IAPD</b> .....	Implementation Advance Planning Document
<b>HPA</b> .....	Health Policy Agenda	<b>IAPDU</b> .....	Implementation Advanced Planning Document Update
<b>HPID</b> .....	Health Plan Identifier	<b>IBM</b> .....	Intensive Benefits Management
<b>HPO</b> .....	Hospital Physician Organization	<b>IBNE</b> .....	Incurred But Not Enough
<b>HPES</b> .....	Hewlett-Packard Enterprise Services	<b>IBNR</b> .....	Incurred But Not Reported
<b>HPIU</b> .....	Health Programs Integration Unit	<b>IC</b> .....	Individual Consideration
<b>HR</b> .....	Health Reform	<b>ICD</b> .....	International Classification of Diseases (diagnosis codes and surgical codes)
<b>HRA</b> .....	Health Reimbursement Account	<b>ICD-9</b> .....	ICD 9 <sup>th</sup> Edition (prior version)-clinical modification
<b>HRA</b> .....	Health Risk Assessment	<b>ICD-10</b> .....	ICD 10 <sup>th</sup> Edition (current version)-clinical modification
<b>HRAP</b> .....	Health Resource Allocation Plan	<b>ICEHR</b> .....	Integrated Care Electronic Health Record
<b>HRD</b> .....	Human Resource Development	<b>ICF</b> .....	Intermediate Care Facility
<b>HRP</b> .....	High Risk Pregnancy Program		
<b>HRQoL</b> .....	Health Related Quality of Life Scale		
<b>HRSA</b> .....	Health Resources and Services Administration		
<b>HSA</b> .....	Health Savings Account		
<b>HSA</b> .....	Health Services Area		

<b>ICF/DD</b> .....	Intermediate Care Facility for people with Developmental Disabilities	<b>INS</b> .....	Immigration and Naturalization Service
<b>ICF/MR</b> .....	Intermediate Care Facilities for Mentally Retarded	<b>INS</b> .....	Initial Needs Survey
<b>ICM</b> .....	Integrated Care Management	<b>IP</b> .....	Internet Protocol
<b>ICN</b> .....	Internal Control Number	<b>IPPS</b> .....	Inpatient Prospective Payment System
<b>ICN</b> .....	Incident Command Structure	<b>IPR</b> .....	Independent Review
<b>ICP</b> .....	Interim Change Process	<b>IPS</b> .....	Integrated Practice System
<b>ICS</b> .....	Information and Computer Services	<b>IPS</b> .....	Individual Placement and Support
<b>ICS</b> .....	Incident Command Structure	<b>IPSec</b> .....	Internet Protocol Security
<b>ICU</b> .....	Intensive Care Unit	<b>IR</b> .....	Independent Review
<b>ICU/ICS</b> .....	Intensive Care Unit	<b>IRB</b> .....	Institutional Review Board
<b>ID</b> .....	Identification	<b>IRS</b> .....	Internal Revenue Service
<b>IDA</b> .....	Individual Development Account	<b>ISA</b> .....	Individual Support Agreement
<b>IDAP</b> .....	Intensive Domestic Abuse Program	<b>ISAP</b> .....	Intensive Substance Abuse Program
<b>IDN</b> .....	Integrated Delivery Network	<b>ISB</b> .....	Individualized Services Budget
<b>IDS</b> .....	Integrated Delivery System	<b>ISC</b> .....	Integrated Systems of Care
<b>IDS</b> .....	Intrusion Detection System	<b>ISD</b> .....	Information Services Division
<b>IDT</b> .....	Interdepartmental Transfer	<b>ISN</b> .....	Integrated Services Network
<b>IE</b> .....	Integrated Eligibility (DCF)	<b>ISO</b> .....	Intermediary Service Organization
<b>IEP</b> .....	Individual Education Plan	<b>ISR</b> .....	Intermediate Sanction Report
<b>IEP</b> .....	Initial Enrollment Period	<b>ISRA</b> .....	Information Security Risk Assessment
<b>IEVS</b> .....	Income Eligibility Verification System	<b>IT</b> .....	Information Technology
<b>IFBS</b> .....	Intensive Family Based Services	<b>ITF</b> .....	Integrated Test Facility
<b>IFC/DD</b> .....	Intermediate Care Facility for People with Developmental Disabilities	<b>ITIL v3</b> .....	Information Technology Infrastructure Library Version 3
<b>IFS</b> .....	Integrating Family Services	<b>IV A</b> .....	Title of the Social Security Act governing TANF programs (Temporary Assistance to Needy Families)
<b>IFSP</b> .....	Individual Family Services Plan	<b>IV D</b> .....	Title of the Social Security Act (governing child support programs)
<b>IG</b> .....	Inspector General	<b>IV E</b> .....	Title of the Social Security Act governing foster care
<b>IGA</b> .....	Inter Governmental Agreements	<b>IV&amp;V</b> .....	Internal Validation & Verification
<b>IHI</b> .....	Institute for Healthcare Improvement	<b>IV&amp;V</b> .....	Independent Verification & Validation
<b>IIOB</b> .....	Internet Inter-ORB Protocol	<b>IV-A</b> .....	Title IV-A of the Social Security Act governing TANF programs
<b>IOPT</b> .....	Integrated Operations and Policy Team		
<b>IL</b> .....	Independent Living		
<b>ILA</b> .....	Independent Living Assessment		

(Temporary Assistance to Needy Families)

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

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

**IVR** .....Interactive Voice Response

**IVRS** .....Interactive Voice Response System

**IVS** .....Intervention Services

**J**

**JAD** .....Joint Application Development

**JAD** .....Joint Application Design

**JAIBG**.....Juvenile Accountability Incentive Block Grant

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

**JCA**.....Java Connector Architecture

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

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

**JCL**.....Job Control Language

**JDBC**.....Java Database Connectivity

**JDO**.....St. Johnsbury District Office

**JFO** .....Joint Fiscal Office

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

**JL**.....Consent Decree Governing Involuntary Medication

**JR**.....Judicial Review

**JVM**.....Java Virtual Machine

**K**

**KPI**.....Key Performance Indicator

**KPI's**.....Key Performance Indicators

**L**

**LAMP**.....Legal Aid Medicaid Project

**LAN**.....Local Area Network

**LBT** .....Look Back Period

**LC** .....Legislative Council

**LDAP** .....Lightweight Directory Access Protocol

**LDO**.....Brattleboro District Office

**LEA**.....Local Education Agency

**LECC**.....Legally Exempt Child Care

**LECP** .....Licensed Early Childhood Programs

**LEIE**.....Excluded Individuals/Entities

**LERT** .....Local Emergency Response Team

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

**LIS**.....Low-Income Subsidy

**LIT** .....Local Interagency Team

**LOC** .....Level Of Care

**LOE** .....Level Of Effort

**LOS**.....Length Of Stay

**LSI**.....Level of Services Inventory

**LTC**.....Long-Term Care

**LUPA**.....Low Utilization Payment Adjustment

**M**

**M&O** .....Maintenance & Operations

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

**MA**.....Medical Assistance

**MAA**.....Medical Assistance for the Aged

**MAB**.....Medicaid Advisory Board

**MAC**.....Maximum Acquisition Cost

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

**MAF**.....Medical Assistance Facility

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

**MAP**.....Medical Audit Program

**MAPIR**.....Medicaid Assistance Provider Incentive Repository

**MARS** .....Management and Administrative Reporting System

**MARx** .....Medicare Advantage and Part D Inquiry System

**MAT**.....Medication Assisted Therapy

**MBES** .....Medicaid Budget and Expenditure System

**MCA**.....Medicaid for Children and Adults

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

**MVRCF** ..... Marble Valley Regional Correctional Facility

**N**

**NAEYC** ..... National Association for the Education of Young Children

**NAMI**..... National Association for Mental Illness

**NAPPI** ..... Non-Abusive Physical and Psychological Intervention

**NAPPI Non** .. Abusive Physical and Psychological Intervention

**NASW** ..... National Association of Social Workers

**NCBD** ..... National CAHPS Benchmarking Database

**NCCI**..... National Correct Coding Initiative

**NCE** ..... No Cost Extension

**NCIC** ..... National Criminal Information

**NCP**..... Non-Custodial Parent (obligated for the support)

**NCSEA**..... National Child Support Enforcement Association

**NCQA**..... National Committee for Quality Assurance

**NDC**..... National Drug Code

**NDO** ..... Newport District Office

**NEDD** ..... Northeast Delta Dental

**NEKCA** ..... North East Kingdom Community Action

**NEMT** ..... Non-Emergency Medical Transportation

**NERCF** ..... Northeast Regional Correctional Facility

**NEW** ..... National Eligibility Worker

**NF** ..... Nursing Facility

**NFR**..... Non-Functional Requirements

**NGA** ..... National Governors Association

**NHR** ..... New Hire Reporting

**NIMH**..... National Institute of Mental Health

**NLP**..... Natural

**NLP**..... Neuro-Linguistic Programming

**NLUOF**..... Non-Lethal Use Of Force

**NNH** .....Number Needed to Harm

**NNT** .....Number Needed to Treat

**NOD**.....Notice Of Decision

**NP** .....Naturopathic Physician

**NP** .....Nurse Practitioner

**NPA** .....Non-Public Assistance

**NPF** .....National Provider File

**NPI** .....National Provider Identifier

**NPRM**.....Notice of Proposed Rulemaking

**NSF**.....Non-Sufficient Funds

**NWSCF**.....Northwest State Correctional Facility

**O**

**OAA** .....Older Americans Act

**OAAM**.....Oracle Adaptive Access Manager

**OADAP**.....Office of Alcohol and Drug Abuse Programs

**OAM**.....Oracle Access Manager

**OASDHI**.....Old Age Survivors, Disability and Health Insurance Program

**OASDI**.....Old Age, Survivors, Disability Insurance

**OASIS**.....Outcomes Assessment and Information Set

**OBIEE**.....Oracle Business Intelligence Suite Enterprise Edition

**OBRA '90** .....Omnibus Reconciliation Act of 1990

**OC**.....Oleoresin Capsicum

**OCHIO** .....Office of Consumer Information and Insurance Oversight (CMS) (Former name for CCIIO)

**OCM**.....Organizational Change Management

**OCRB**.....Operational Change Review Board

**OCS**.....Office of Child Support

**OCSE**.....Office of Child Support Enforcement (Federal agency)

**ODBC** .....Open Database Connectivity

**ODS** .....Operational Data Store

**ODS** .....Organized Delivery System

**OEM**.....Oracle Enterprise Manager

<b>OEP</b> .....	Open Enrollment Period	<b>PA</b> .....	Payment Authorization
<b>O&amp;E</b> .....	Outreach and Education	<b>PA</b> .....	Physician Assistant
<b>OEO</b> .....	Office of Economic Opportunity	<b>PA</b> .....	Prior Authorization
<b>OH</b> .....	Order of Hospitalization	<b>PA</b> .....	Public Assistance
<b>OHA</b> .....	Office of Hearings and Appeals	<b>PACE</b> .....	Program for All-Inclusive Care for the Elderly
<b>OHITA</b> .....	Office of Health Information Technology Adoption	<b>PADSS</b> .....	Prior Authorization Decision Support System
<b>OHM</b> .....	Oracle HTTP Server	<b>PAF</b> .....	Pre-Approved Furlough
<b>OHRA</b> .....	Oral Health Risk Assessment	<b>PAL</b> .....	Parents' Assistance Line
<b>OIG</b> .....	Office of the Inspector General	<b>PAPD</b> .....	Planning Advanced Planning Document (CMS)
<b>OIM</b> .....	Oracle Identity Manager	<b>PAR</b> .....	Personnel Action Request
<b>OIS</b> .....	Office of Interoperability and Standards	<b>PARIS</b> .....	Public Assistance Reporting Information System
<b>OJJDP</b> .....	Office of Juvenile Justice and Delinquency Prevention	<b>PASRR</b> .....	Preadmission, Screening and Annual Resident Review
<b>OJP</b> .....	Office of Justice Programs	<b>PATH</b> .....	Program to Assist in the Transition from Homelessness (federal)
<b>OLAP</b> .....	Online Analytical Processing	<b>PATH</b> .....	Prevention, Assistance, Transition and Health Access
<b>OLTP</b> .....	Online Transaction Processing	<b>PBA</b> .....	Pharmacy Benefit Administrator
<b>OMS</b> .....	Offender Management System	<b>PBA/PBM</b> .....	Pharmacy Benefits Administrator/Pharmacy Benefits Manager
<b>ONC</b> .....	Office of National Coordinator for Health Information Technology	<b>PBM</b> .....	Pharmacy Benefit Management
<b>ONH</b> .....	Order of Non-Hospitalization	<b>PBMS</b> .....	Pharmacy Benefits Management System
<b>OPG</b> .....	Office of Public Guardian	<b>PBSA</b> .....	Pharmacy Benefits Services Administration
<b>OPM</b> .....	Oversight Project Management	<b>PC</b> .....	Personal Computer
<b>OPPS</b> .....	Outpatient Prospective Payment System	<b>PC Plus</b> .....	Primary Care Plus (VT program)
<b>OPS</b> .....	Operations	<b>PCA</b> .....	Personal Care Attendant
<b>ORP</b> .....	Offender Responsibility Plan	<b>PCA</b> .....	Primary Care Association
<b>OSA</b> .....	Other State Agency	<b>PCC</b> .....	Parent Child Centers
<b>OSHA</b> .....	Occupational Safety and Health Administration	<b>PCCM</b> .....	Primary Care Case Management
<b>OTC</b> .....	Over The Counter	<b>PCIP</b> .....	Pre-existing Condition Insurance Plan
<b>OUD</b> .....	Oracle Unified Directory	<b>PCMH</b> .....	Patient-Centered Medical Home
<b>OVD</b> .....	Oracle Virtual Directory	<b>PCMH</b> .....	Program in Community Mental Health
<b>OVHA</b> .....	Office of Vermont Health Access (now DVHA)	<b>PCN</b> .....	Primary Care Network
<b>P</b>			
<b>P&amp;T</b> .....	Pharmacy and Therapeutics Committee		
<b>P&amp;A</b> .....	Protection and Advocacy		
<b>P&amp;P</b> .....	Probation and Parole or Policies and Procedures		

<b>PCN</b> .....	Processor Control Number	<b>PIRL</b> .....	Plan Information Request Letter
<b>PCO</b> .....	Primary Care Office	<b>PKI</b> .....	Public Key Infrastructure
<b>PCP</b> .....	Primary Care Provider	<b>PM</b> .....	Project Manager
<b>PCPlus</b> .....	Primary Care Plus	<b>PMBOK</b> .....	Project Management Body Of Knowledge
<b>PCS</b> .....	Procedure Coding System	<b>PMI</b> .....	Project Management Institute
<b>PDC</b> .....	Primary Data Center	<b>PMIS</b> .....	Provider Management Information System
<b>PDD</b> .....	Pervasive developmental disorder	<b>PMNI</b> .....	Private Non-Medical Institution (treatment group home)
<b>PDF</b> .....	Portable Document File	<b>PMO</b> .....	Project Management Office
<b>PDL</b> .....	Preferred Drug List	<b>PMP</b> .....	Project Management Plan
<b>PDL</b> .....	Project Document Library	<b>PMP</b> .....	Project Management Professional
<b>PDP</b> .....	Prescription Drug Plan	<b>PMPM</b> .....	Per Member Per Month
<b>PDP</b> .....	Pharmacy Drug Plan	<b>PMPY</b> .....	Per Member Per Year
<b>PDP</b> .....	Medicare Part D Prescription Drug Plan	<b>PNA</b> .....	Personal Needs Allowance
<b>PDP</b> .....	Pharmacy Discount Program	<b>PNI</b> .....	Personal Needs Issuance
<b>PDSA</b> .....	Plan, Do, Study, Act	<b>PNMI</b> .....	Private Non-Medical Institution
<b>PEAKS</b> .....	Performance Enhancement and Knowledge System	<b>POC</b> .....	Plan Of Care
<b>PEP</b> .....	Principal Earner Parent	<b>POC</b> .....	Public Oversight Committee
<b>PEP</b> .....	Proposal Evaluation Plan	<b>POLST</b> .....	Physician Orders for Life- Sustaining Treatment
<b>PERM</b> .....	Payment Error Rate Measurement	<b>POS</b> .....	Place Of Service
<b>PERS</b> .....	Personal Emergency Response System	<b>POS</b> .....	Point Of Sale
<b>PES</b> .....	Provider Electronic Solutions	<b>POS</b> .....	Point Of Service
<b>PHC</b> .....	Personalized Healthcare	<b>POX</b> .....	Plain Old XML
<b>PHI</b> .....	Protected Health Information	<b>PP&amp;D</b> .....	Policy & Procedure Directive
<b>PHO</b> .....	Physician Hospital Organization	<b>PP&amp;D</b> .....	Policy, Procedures & Development (Interpretive Rule Memo)
<b>PHR</b> .....	Personal Health Record	<b>PPA</b> .....	Project Process Agreement
<b>PI</b> .....	Program Integrity	<b>PPA</b> .....	Prior Period Adjustment
<b>PIA</b> .....	Privacy Impact Assessment	<b>PPACA</b> .....	Patient Protection and Affordable Care Act
<b>PIC</b> .....	Parent Information Center	<b>PPC</b> .....	Program Participation Credit
<b>PIDL</b> .....	Physician Injectable Drug List	<b>PPCP</b> .....	Pediatric Palliative Care Program
<b>PIHP</b> .....	Pre-Paid Inpatient Health Plan	<b>PPO</b> .....	Preferred Provider Organization
<b>PII</b> .....	Personally Identifiable Information	<b>PPPM</b> .....	Per Patient Per Month
<b>PIL</b> .....	Protected Income Level (Poverty Income Guidelines)	<b>PPR</b> .....	Planning, Policy and Regulation
<b>PIL</b> .....	Project Information Library (also known as Project Document Library)	<b>PPS</b> .....	Prospective Payment System
<b>PIP</b> .....	Performance Indicator Project	<b>PPS</b> .....	Production Problem Solving
<b>PIP</b> .....	Performance Improvement Project	<b>PQA</b> .....	Prior Quarter Adjustment
<b>PIP</b> .....	Periodic Interim Payment		



**PQAS**.....Prior Quarter Adjustment Statement  
**PQRS**.....Physician Quality Reporting System  
**PREA**.....Prison Rape Elimination Act  
**PRO**.....Peer Review Organization  
**ProDUR**.....Prospective Drug Utilization Review  
**PROS**.....Pediatric Research in Office Settings  
**PRT**.....Proposal Review Team  
**PRWORA**.....Personal Responsibility and Work Opportunity Reconciliation Act  
**PSE**.....Post-Secondary Education  
**PSI**.....Pre-Sentence Investigation  
**PSTG**.....Private Sector Technology Group  
**PSU**.....Payment Services Unit  
**PVRP**.....Physician Voluntary Reporting Program

**Q**

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

**R**

**R&C**.....Reasonable and Customary  
**R&R**.....Resource and Referral  
**R&T**.....Research and Training Centers  
**RA**.....Remittance Advice  
**RAC**.....Recovery Audit Contractor  
**RACI**.....Responsible, Accountable, Consulted, Informed  
**RAI**.....Residential Assessment Instrument  
**RAID**.....Risks Actions Issues Decisions  
**RAM**.....Responsibility Assignment Matrix  
**RAM/RACI**.....Responsibility Assignment Matrix  
**RAN**.....Rural Area Computer Network  
**RBA**.....Results Based Accountability  
**RBAC**.....Role Based Access Control  
**RBC**.....Risk Based Capital  
**RRVS**.....Resource-Based Relative Value Scale  
**RBUC**.....Reported But Unpaid Claims  
**RC**.....Restraint Chair  
**RCH**.....Residential Care Home  
**RDBMS**.....Relational Database Management System  
**RDO**.....Rutland District Office  
**REMS**.....Risk Evaluation and Mitigation Strategies  
**REOMB**.....Recipient Explanation of Medicaid Benefits  
**REST**.....Representational State Transfer  
**RetroDUR**.....Retrospective Drug Utilization Review  
**REV/ONH**.....Revocation of an Order of Non-Hospitalization  
**REVS**.....Recipient Eligibility Verification System  
**RFB**.....Request for Bid  
**RFCCH**.....Registered Family Child Care Homes  
**RFI**.....Request For Information  
**RFPP**.....Request For Proposals  
**RFQ**.....Request For Quote  
**RFR**.....Request For Classification Review

<b>RFR</b> .....	Request For Reclassification	<b>SAML</b> .....	Security Assertion Market Language
<b>RHC</b> .....	Rural Health Clinic	<b>SAMS</b> .....	Social Assistance Management System
<b>RHFP</b> .....	Rural Hospital Flexibility Program	<b>SAS</b> .....	Statement on Auditing Standards
<b>RHIO</b> .....	Regional Health Information Organization	<b>SASH</b> .....	Support And Services at Home
<b>RIA</b> .....	Rich Internet Application	<b>SBC</b> .....	Summary of Benefits and Coverage
<b>RICW</b> .....	Risk, Issue, Contingency, Workaround	<b>SBE</b> .....	State Health Benefit Exchange
<b>RLU</b> .....	Residential Licensing Unit	<b>SBM</b> .....	State-Based Marketplace
<b>RMP</b> .....	Requirements Management Plan	<b>SBS</b> .....	Success Beyond Six
<b>RMP</b> .....	Risk Management Plan	<b>SCBA</b> .....	Self Contained Breathing Apparatus
<b>RN</b> .....	Registered Nurse	<b>SCC</b> .....	Specialized Community Care
<b>RO</b> .....	Regional Office	<b>SCHIP</b> .....	States Children’s Health Insurance Program (Plan)
<b>ROA</b> .....	Return On Assets	<b>SCORE</b> .....	Service Corps Of Retired Executives
<b>ROB</b> .....	Rules Of Behavior	<b>SCP</b> .....	Senior Companion Program
<b>ROE</b> .....	Return On Equity	<b>SCS</b> .....	Supervised Community Sentence
<b>ROI</b> .....	Return On Investment	<b>SCSEP</b> .....	Senior Community Service Employment Program
<b>ROP</b> .....	Reasonable Opportunity Period	<b>SD</b> .....	Self-Determination
<b>ROSI</b> .....	Reconciliation Of State Invoice	<b>SDFSC</b> .....	Safe and Drug Free Schools and Communities
<b>ROX</b> .....	Report Object Executable	<b>SDK</b> .....	Software Development Kit
<b>RPMS</b> .....	Resource and Patient Management System	<b>SDLC</b> .....	Software Development Lifecycle
<b>RPO</b> .....	Recovery Point Objective	<b>SDLC</b> .....	Systems Development Life Cycle
<b>RPU</b> .....	Rebate Price per Unit	<b>SDMP</b> .....	System Development Management Plan
<b>RR</b> .....	Railroad Retirement	<b>SDO</b> .....	Standards Development Organization
<b>RTM</b> .....	Requirements Traceability Matrix	<b>SDO</b> .....	Springfield District Office
<b>RTO</b> .....	Recovery Time Objective	<b>SDP</b> .....	Self-Determination Project
<b>RU</b> .....	Reach Up program	<b>SDU</b> .....	State Disbursement Unit
<b>RUCM</b> .....	Reach Up Case Manager	<b>SDX</b> .....	State Data Exchange System
<b>RVU</b> .....	Relative Value Units	<b>SE</b> .....	Systems Engineer
<b>RWJ</b> .....	Robert Wood Johnson Foundation	<b>SECCA</b> .....	State Employee Combined Charitable Appeal
<b>S</b>		<b>SED</b> .....	Severe Emotional Disturbance
<b>S/MMIE</b> .....	Secure/Multipurpose Internet Mail Extensions	<b>SEI</b> .....	Software Engineering Institute
<b>SA</b> .....	Solution Architecture	<b>SEI</b> .....	Systems Engineer
<b>SaaS</b> .....	Software as a Service	<b>SEP</b> .....	Special Enrollment Periods
<b>SAD</b> .....	Screening, Application and Determination		
<b>SAI</b> .....	Shared Analytics Infrastructure		
<b>SAMHSA</b> .....	Substance Abuse and Mental Health Services Administration		

<b>SESCF</b> .....	Southeast State Correctional Facility	<b>SMHRCY</b> .....	State Mental Health Representatives for Children and Youth
<b>SEVCA</b> .....	Southeastern Vermont Community Action	<b>SMI</b> .....	Supplementary Medical Insurance
<b>SF</b> .....	Supplemental Fuel	<b>SMM</b> .....	State Medicaid Manual
<b>SFTP</b> .....	Secure File Transfer Protocol	<b>SMOKE TEST</b>	Preliminary testing to reveal simple failures severe enough to reject a release
<b>SFY</b> .....	State Fiscal Year	<b>SNAP</b> .....	State Nutritional Assistance Program
<b>SGF</b> .....	State General Fund	<b>SNF</b> .....	Skilled Nursing Facility
<b>SGO</b> .....	Surgeon General’s Office	<b>SNOMED</b> .....	Systematized Nomenclature Of Medicine
<b>SHCRF</b> .....	State Healthcare Resource Fund	<b>SNTP</b> .....	Simple Network Time Protocol
<b>SHIP</b> .....	State Health Insurance (and Assistance) Program	<b>SO</b> .....	State Office
<b>SHIP(s)</b> .....	State Health Insurance Assistance Program(s)	<b>SOA</b> .....	Service Oriented Architecture
<b>SHMO</b> .....	Social Health Maintenance Organization	<b>SOAP</b> .....	Simple Object Access Protocol
<b>SHOP</b> .....	Small business Health Options Program	<b>SOP</b> .....	Standard Operating Procedure
<b>SHP</b> .....	Supportive Housing Program	<b>SOR</b> .....	System Of Records
<b>SHRF</b> .....	State Healthcare Resources Fund	<b>SORN</b> .....	System Of Record Notice
<b>SI</b> .....	Systems Integration	<b>SOS</b> .....	Security and Operations Supervisor
<b>SI</b> .....	Systems Integrator	<b>SOV</b> .....	State Of Vermont
<b>SIDS</b> .....	Sudden Infant Death Syndrome	<b>SOW</b> .....	Statement Of Work
<b>SILC</b> .....	Statewide Independent Living Council	<b>SP</b> .....	Service Plan
<b>SIM</b> .....	State Innovation Model	<b>SPA</b> .....	State Plan Amendment
<b>SIT</b> .....	State Interagency Team	<b>SPAP</b> .....	State Pharmacy Assistance Program
<b>SIT</b> .....	System Integration Test	<b>SPAP</b> .....	State Pharmaceutical Assistance Program
<b>SIU</b> .....	Special Investigation Unit	<b>SPAP</b> .....	State Prescription Drug Assistance Program
<b>SLA</b> .....	Service Level Agreement	<b>SPLS</b> .....	State Parent Locator Service
<b>SLHIE</b> .....	State Level HIE Consensus Project	<b>SPM</b> .....	Service Portfolio Management
<b>SLMB</b> .....	Specified Low-income Medicare Beneficiary	<b>SPP</b> .....	Specialized Programs Project (under the MMIS program)
<b>SLP (2)</b> .....	Shared living provider (or speech language pathologist)	<b>SPR</b> .....	Safeguard Procedures Report
<b>SLR</b> .....	System/Service Level Requirement	<b>SQL</b> .....	Structured Query Language
<b>SMA</b> .....	State Medicaid Agency	<b>SR</b> .....	Supplemental Rebate
<b>SMA</b> .....	System Modification Authorization	<b>SRA</b> .....	Supplemental Rebate Agreement
<b>SMAC</b> .....	State Maximum Acceptable Cost	<b>SRF</b> .....	Siebel Repository File
<b>SMDL</b> .....	State Medicaid Directors Letter	<b>SRS</b> .....	Social and Rehabilitative Services (Department of)
<b>SME</b> .....	Subject Matter Expert		
<b>SMHP</b> .....	State Medicaid HIT Plan		

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

**T**

**T4T** .....Training For Trainers  
**TA** .....Technology Architecture  
**TAD**.....Turn Around Documents

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

**U**

**UAP**.....University Affiliated Program for  
 Developmental Disabilities  
**UAT** .....User Acceptance Test  
**UB** .....Uniform Billing/Uniform Bill  
**UBP** .....Uniform Benefit Package  
**UC** .....Unemployment Compensation

<b>UC</b> .....	Unmanageable in Custody	<b>VAHHA</b> .....	Vermont Assembly of Home Health Agencies
<b>UCF</b> .....	Universal Claim Format	<b>VAHHS</b> .....	VT Association of Hospital and Health Systems
<b>UCM</b> .....	Universal Customer Master	<b>VAMH</b> .....	Vermont Association for Mental Health
<b>UCR</b> .....	Usual and Customary Rate	<b>VAR</b> .....	Value Added Reseller
<b>UCS</b> .....	United Counseling Services	<b>VARC</b> .....	Resources and Community Opportunities for Vermonters w/ Developmental Disabilities
<b>UCUM</b> .....	Unified Code for Units of Measure	<b>VC</b> .....	Voluntary Care
<b>UDDI</b> .....	Universal Description, Discovery and Integration	<b>VCA</b> .....	Vermont Correctional Academy
<b>UI</b> .....	Unemployment Insurance	<b>VCCI</b> .....	Vermont Chronic Care Initiative
<b>UI</b> .....	User Interface	<b>VCDMHS</b> .....	Vermont Council of Developmental and Mental Health Services
<b>UIB</b> .....	Unemployment Insurance Benefits	<b>VCDR</b> .....	Vermont Coalition for Disability Rights
<b>UID</b> .....	Unique Identification Number	<b>VCF</b> .....	Vermont Children’s Forum
<b>UIFSA</b> .....	Uniform Interstate Family Support Act (governs interstate child support cases)	<b>VCHIP</b> .....	Vermont Child Health Improvement Program
<b>UIR</b> .....	Unusual Incident Report	<b>VHCIP</b> .....	Vermont Healthcare Innovation Project
<b>UM</b> .....	Utilization Management	<b>VCI</b> .....	Vermont Correctional Industries
<b>UML</b> .....	Unified Modeling Language	<b>VCIL</b> .....	Vermont Center for Independent Living
<b>UMLS</b> .....	Unified Medical Language System	<b>VCORP</b> .....	Vermont Coalition Of Residential Providers
<b>UR</b> .....	Utilization Review	<b>VCRP</b> .....	Vermont Coalition of Runaway Programs
<b>URA</b> .....	Unreimbursed Public Assistance	<b>VCSA</b> .....	Vermont Cost Sharing Assistance
<b>URA</b> .....	Unit Rebate Amount	<b>VCSR</b> .....	Vermont Cost Sharing Reduction
<b>URAC</b> .....	Utilization Review Accreditation Commission	<b>VCTF</b> .....	Vermont Children’s Trust Fund
<b>URC</b> .....	Utilization Review Committee	<b>VDH</b> .....	VT Department of Health
<b>URESA</b> .....	Uniform Reciprocal Enforcement of Support Act	<b>VDO</b> .....	Morrisville District Office
<b>URO</b> .....	Utilization Review Organization	<b>VEAF</b> .....	Vermont Enterprise Architecture Framework
<b>USC</b> .....	United States Code	<b>VET</b> .....	Vetting is a process of examination and evaluation
<b>USDA</b> .....	United States Department of Agriculture	<b>VFAPA</b> .....	Vermont Foster and Adoptive Family Association
<b>USPHS</b> .....	U.S. Public Health Service	<b>VHAP</b> .....	Vermont Health Access Plan
<b>UT</b> .....	Unit Test		
<b>UVM</b> .....	University of Vermont		
<b>V</b>			
<b>VA</b> .....	Veterans Administration		
<b>VAB</b> .....	VT Association for the Blind		
<b>VABIR</b> .....	Vermont Association of Business, Industry and Rehabilitation		
<b>VABVI</b> .....	Vermont Association for the Blind and Visually Impaired		
<b>VAC</b> .....	Vermont Achievement Center		

<b>VHAP-Rx</b> .....	Vermont Health Access Plan Pharmacy Program	<b>VP&amp;A</b> .....	Vermont Protection and Advocacy
<b>VHAT</b> .....	VT Health Access Team	<b>VPCCN</b> .....	Vermont Parent Child Center Network
<b>VHBE</b> .....	Vermont Health benefit Exchange	<b>VPharm</b> .....	VT Pharmacy Program
<b>VHC</b> .....	Vermont Health Connect	<b>VPIC</b> .....	Vermont Parent Information Center
<b>VHCA</b> .....	Vermont Healthcare Association	<b>VPN</b> .....	Virtual Private Network
<b>VHCURES</b> ....	Vermont Healthcare Claims Uniform Reporting and Evaluation System	<b>VPQHC</b> .....	Vermont Program for Quality in Healthcare
<b>VHITP</b> .....	Vermont Health Information Technology Plan	<b>VPR</b> .....	Vermont Premium Reduction (see VPA)
<b>VHPSI</b> .....	Vermont Hospital Preventative Services Initiative	<b>VPS</b> .....	Vermont Psychiatric Survivors
<b>VIEWS</b> .....	Vermont’s Integrated Eligibility Workflow System	<b>VPTA</b> .....	Vermont Public Transportation Agency
<b>VIP</b> .....	VT Independence Project	<b>VR</b> .....	Vocational Rehabilitation
<b>VISION</b> .....	VT’s Integrated Solution for Information and Organizational Needs (the statewide accounting system)	<b>VRS</b> .....	Voice Response System
<b>VISTA</b> .....	Volunteers in Service to America	<b>VRU</b> .....	Voice Response Unit
<b>VIT</b> .....	VT Interactive Television	<b>VSA</b> .....	Vermont Statutes Annotated
<b>VIT</b> .....	Vermont Interactive Technologies	<b>VScript</b> .....	VT Pharmacy Assistance Program
<b>VITL</b> .....	Vermont Information Technology Leaders	<b>VSDS</b> .....	VT State Dental Society
<b>VITN</b> .....	Vermont Interactive Television Network	<b>VSEA</b> .....	Vermont State Employees Association
<b>VLA</b> .....	Vermont Legal Aid	<b>VSECU</b> .....	Vermont State Employees Credit Union
<b>VMAP</b> .....	Vermont Medication Assistance Program	<b>VSH</b> .....	Vermont State Hospital
<b>VMS</b> .....	VT Medical Society	<b>VSHA</b> .....	Vermont State Housing Authority
<b>VNA</b> .....	Visiting Nurses Association	<b>VTCECH</b> .....	Vermont Campaign to End Childhood Hunger
<b>VOIP</b> .....	Voice Over Internet Protocol	<b>VTDDC</b> .....	Vermont Developmental Disabilities Council
<b>VPA</b> .....	Vermont Premium Assistance	<b>VTHR</b> .....	Vermont Human Resources
		<b>VTL</b> .....	Vermont Technology Leaders
		<b>VTPSA</b> .....	Vermont Treatment Program for Sexual Aggressives

## W

<b>WAC</b>	Wholesale Acquisition Cost
<b>WAM</b>	Welfare Administration Manual
<b>WAN</b>	Wide-Area Network
<b>WAP/WX</b>	Weatherization Assistance Program
<b>WBS</b>	Work Breakdown Structure
<b>WC</b>	Worker's Compensation
<b>WC</b>	Web Center
<b>WIA</b>	Workforce Investment Act
<b>WIC</b>	Supplemental Food Program for Women, Infants and Children
<b>WJRC</b>	Woodside Juvenile Rehabilitation Center
<b>WRAT</b>	Wide Range Achievement Test
<b>WRP</b>	Welfare Restructuring Project
<b>WS</b>	Web Services
<b>WSDL</b>	Web Services Description Language
<b>WSFL</b>	Web Services Flow Language
<b>WS-I</b>	Web Services Interoperability
<b>WTF</b>	Weatherization Trust Fund
<b>WWW</b>	Waiver While Waiting

## X

<b>XCA</b>	Cross-Community Access
<b>XDEA</b>	X-DEA Number
<b>XDS</b>	Cross-Enterprise Document Sharing
<b>XHTML</b>	Extensible Hyper Text Markup Language
<b>XML</b>	Extensible Markup Language
<b>XPDL</b>	XML Process Definition Language
<b>XSLT</b>	Extensible Style Sheet Language Transformations

## Y

<b>YDO</b>	Middlebury District Office
<b>YRBS</b>	Youth Risk Behavior Survey

## Z

<b>ZDO</b>	State Office/Central Office
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