FY2019 Proposed Budget – Agency of Human Services

Agency of Human Services – Grant Reduction

Reduce Grants Across AHS	$2,000,000 General Fund

Per the FY2017 AHS Grants Inventory, in FY2017 AHS issued 686 discrete grants totally $198M across all fund sources. Of this amount, $30.5M was GF, $100M was GC (roughly $47M state funds), $57M was federal, and the balance was from other funds. This data reflects grants issued in FY2017 and cover a wide range of AHS programs.

Over the next three months, AHS will conduct a systematic review of grants and contracts and identify areas for savings. The analysis will include an assessment of outcomes through performance measures, efficacy of services, impact on Vermont residents and community partners, redundancy and statutory guidelines. $2M which is a roughly 2.59% reduction to the state share (GF and state share of GC) of the total grants issued in FY2017.

AHS is pursuing enhancing its grant and contract management systems. This assessment and review will be part of these efforts and lay the foundation for enhanced management. Impacts will vary depending on reduction decision. However, AHS will focus on minimizing impacts to Vermont's most vulnerable.

FY2019 Proposed Budget – Agency of Human Services

Agency of Human Services – Secretary's Office - Reduce Direct Service Funding

Reduce Direct Service Funding	$43,000 General Fund

The AHS Field Directors maintain a small pool of flexible dollars in the districts to address immediate and concrete needs for the individuals and families in those areas. The proposed $43,000 reduction would leave a balance of $20,000 for use by field directors. This program was chosen for reduction because there are no program rules that govern the use of these funds and it is implemented at the discretion of the field directors. In addition, there are programs at DCF (GA emergency assistance) that overlap this program.

The savings will be achieved by reducing the amount of flexible spending available to the district field directors. Some AHS clients may not be eligible to receive immediate, emergency assistance from the field directors. These individuals will be referred to other programs at AHS.

FY2019 Proposed Budget – Agency of Human Services

Vermont Department of Health – Eliminate Loan Repayment Program for Health Professionals

Eliminate Loan Repayment Program for Health Professionals	$667,000 Global Commitment	$308,220 General Fund

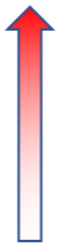
The loan repayment program for health professionals is administered by the UVM Area Health Education Centers (AHEC). The program provides direct financial incentives to health care professionals who agree to practice in Vermont for specified periods. Under this proposal, the program will be ended effective on June 30, 2018.

VDH has concluded that there are insufficient data in Vermont and in the medical literature to assess the effectiveness of this intervention in recruiting medical professionals who might have gone elsewhere or retaining these medical practitioners in Vermont once the obligated time of service has ended.

In addition, most financial awards in this program are not going to providers in health shortage areas.

Educational Loan Repayment Program primary care awards 2012-2016:

Higher need



Lower need

Population per FTE	Total Providers	MD	Nursing
>3500	5	2	3
3-3,500	2	2	0
2,400-3,000	6	1	5
1,500-2,400	143	41	102
<1500	277	105	172
Total	433	151	282

Population per FTE ratios form the basis of HRSA's Health Professional Shortage Areas (HPSA), which in turn form the basis of the work in the Office of Rural Health. Only four MD's out of 151 have been placed in two tiers of pop to FTE ratio that would actually qualify as HPAs, over the last 5 years.

The immediate impact is the end of financial incentive awards. The current program makes about 65 awards per year. Average awards to nurses is $5,500, for physician and dentist awards average $10,500 which will have some individual impact. However, most providers receiving awards do not practice in underserved areas, so the impact on access to primary care services for Vermonter's is expected to be minor.

FY2019 Proposed Budget – Agency of Human Services

Department of Disabilities, Aging and Independent Living – Eliminate Attendant Services General Fund-Only Program

Eliminate Attendant Services GF-Only Program	$1,389,547 General Fund

The Attendant Services Program (ASP) General Funds option serves people with "permanent and severe" disabilities who need attendant care services to complete at least two activities of daily living (bathing, dressing, meal preparation) but are not eligible for Medicaid. Approximately 67% of current ASP GF participants are 60 or older. ASP participants are awarded an average of 6 hours per day of attendant care with actual amounts varying by person based on their assessed need. Diagnoses include: quadriplegia, paraplegia, multiple sclerosis, severe arthritis, muscular dystrophy and others. The program has been frozen since SFY 2015 and slowly seeing participants decrease over time.

To achieve the full savings, the program would be eliminated and current participants would be moved into other services. If we are successful in transitioning individuals to other programs with some level of federal participation, there may still be costs associated with these individuals. People would also be eligible to apply for Choices for Care Moderate Needs funding and may also be eligible for other community services such as SASH and insurance covered home health services. DAIL will work with the affected individuals to transition to alternative programs. If alternative programs cannot be identified, there may still be general fund costs to this program.

Since the program was frozen in SFY2015, the enrollment has been slowly decreasing, and there are now approximately 42 individuals in the program. We chose to look to eliminate this program because it is pure state general fund for individuals not eligible for Medicaid. Due to the relatively small number of enrollees, we will be able to work 1:1 with the enrollees to find other services.

This program was created in Vermont to address the gap in needs for those individuals who are working and trying to be self-sufficient, therefore not eligible for Medicaid but striving to be self-sufficient. Stakeholders see this as a step away from Vermont values and our focus on enabling people with disabilities to be self-sufficient without having to be driven into poverty and eligibility for Medicaid.

If funding were eliminated for the General Funds option, the potential impact would require that 42 people be dis-enrolled from state-funded attendant care services, but they would migrate to other programs.

FY2019 Proposed Budget – Agency of Human Services

Department of Disabilities, Aging and Independent Living – Development Services Waiver Reduction

Development Services Waiver Reduction	$4.3M Gross	$2.0M General Fund

The Developmental Services Waiver program services individuals across the state who are diagnosed with a developmental disability and who meet a system of care funding priority. These waiver services include residential supports, supports to access the community, case management, support for families caring for individuals, respite, and supported employment. They are provided in Vermont as a community-based alternative to institutional care and support individuals to live robust lives, in their own home communities and in concert with every other Vermonter, with rights, responsibilities and civil liberties. Services packages are developed individually based on assessed needs.

The Developmental Services system is one of our largest budget/caseload pressures. In order to fund the new caseload dollars required to support individuals new to the system or significant changes in need for existing individuals, we needed to identify some reductions in the DAIL budget. Because the Developmental Services System of Care already articulates a process for rescission should new caseload dollars prove insufficient to meet the need, this seemed like a logical reduction to fund that need.

Savings would be achieved by an approximately 2% reduction in funding to the all of the existing, current service plans asking each individual or family to work with the agency provider to reduce existing services by a 2% margin. Agencies would receive an administrative reduction based on the service reductions. If a reduction in funding is necessary in SFY 19, we will follow the reduction process outlined in the DS System of Care Plan and which has been followed in past years. This does not require statutory, regulatory changes. The process allows for agencies to exercise some flexibility in how to effect reductions while at the same time setting clear expectations for consumer/family involvement in decision making.

If the proposed reductions are implemented across the board as suggested, this will impact 3,070 currently in services. Direct supports to consumers, including employment supports, community supports, respite and residential supports will be reduced and/or eliminated.

FY2019 Proposed Budget – Agency of Human Services

Department for Children and Families – Reduce Reach Up Grants

Reduction in Grants related to Reach Up	$1,159,485 General Fund

A reduction in in grants and contracts to community partners for the following services: support to Reach Up participants seeking and obtaining employment, including case management, housing and transportation supports, employment/job coaching and work site activities. Reach Up provides financial assistance to meet parents' basic needs and case management to help parents gain job skills, overcome barriers, and find employment.

The Reach Up caseload has dropped approximately 33%, from a high of over 6,500 cases in 2013 to approximately 4,400 cases now. With the large caseload decrease, the amount of outsourced services is no longer necessary to support the needs of the caseload. The total of Reach Up grants in FY2017 was approximately $9,796,000.

DCF/ESD believes these reductions will not have an impact on the services needed by Reach Up Program participants to become successfully employed. It may impact community partners.

FY2019 Proposed Budget – Agency of Human Services

Department of Corrections – Reduce Contracts

Reduction in Department of Corrections Contracts	$500,000 General Fund

DOC is reviewing an array of contracts, which include administrative, programmatic, and operational agreements. These agreements are being reviewed for underutilization and opportunities to reduce administrative costs without impacting capacity. Any agreements considered for reduction are being examined for program effectiveness, overall need, and utilization.

While the focus is on reducing contract costs, DOC is looking to minimize the overall impact from any contract reductions. The goal is to reduce costs without impacting capacity, though there are agreements that may be underutilized and could be reduced appropriately.

Department of Corrections – Reduce Grants

Reduction in Department of Corrections Grants	$149,500 General Fund

To achieve these savings, one approach is to reduce each grant agreement by approximately 2%. Alternatively, it is possible to reduce administrative and/or operating expenses in certain areas where resources may be able to be shared, which could impact 1 or 2 grants, as opposed to more than 50.

DOC is reviewing all existing grants and is considering the program effectiveness, overall need, and utilization of each.

The impact will vary by grant and will require discussions with each grantee. There are currently DOC grants for Transitional Housing, Community Justice Centers and CoSA's (Circles of Support and Accountability), and community-based programs. These GF grant reductions would range from $300 to $9,095, with the average reduction being approximately $3,000.

FY2019 Proposed Budget – Agency of Human Services

Department of Vermont Health Access – Vermont Cost Sharing Reduction (VCSR) Program

Vermont Cost Sharing Reduction (VSCR) Program	$827,175 General Fund (for 6 months in FY2019)

DVHA administers Vermont's cost sharing reduction (VCSR) benefit for individuals and families enrolled in qualified health plans (QHPs) through the exchange. The benefit is only available to Vermonters who:

a) Select a silver plan, and
b) Have a household income between 200-300% of federal poverty level (FPL). For an individual, this is an annual income $24,120-$36,180.

The benefit reduces potential out-of-pocket costs by lowering the plan's deductible, maximum out-of-pocket limit, and/or co-pays. This increases a plan's actuarial value (AV), which is the average percentage that a plan will pay for covered services. The benefit enhances the federal cost sharing reduction (CSR) benefit.

- Those in the 200-250% FPL income group have their AV bumped from 73% to 77% (i.e. Silver 77 Plan).
- Those in the 250-300% FPL income group have their AV bumped from 70% to 73% (i.e. Silver 73 Plan).

Approximately 6,100 Vermonters are currently enrolled in VCSR plans. Vermont pays approximately $1.6 million annually, all state funds, to VT QHP issuers to fund VCSRs. The impact identified in the DVHA budget submission of $827,175 is for 6 months of savings in FY2019. Vermont is prohibited from ending VCSR payments in the middle of the plan year by federal statute.

Vermonters Currently Enrolled in VSCR Plans & Cost	
3,900 Silver 77	$1.2M – Silver 77
2,200 Silver 73	$400,000 – Silver 73

The VCSR payments are funded entirely through State general funds. The reduction was designed to preserve state dollars for the Medicaid program since other program reductions would have resulted in a greater gross cut in order to achieve the same general fund savings. These alternative program reductions may have effected program access and effectiveness.

The VCSR payments are managed by WEX Health. One of the other DVHA proposals is to eliminate that contract. If we were to eliminate the contract and not cut this payment, DVHA would have to develop a process with carriers to continue payments in a different manner and complete annual reconciliations of the VCSR payment. This may require additional staff to complete.

The following table shows the household income ranges for Vermonters between 200-300% FPL.

FY2019 Proposed Budget – Agency of Human Services

Vermont Household Income Thresholds for Advanced Premium Tax Credits (APTC), Vermont Premium Assistance (VPA), and Cost Sharing Reductions (CSR)

Eligibility for 2018 Benefits Determined Based on 2017 Federal Poverty Level (FPL)

Upper FPL% and ***annual*** income limits for:		Silver 94 (94% AV) CSR Tier I	Silver 87 (87% AV) CSR Tier II	Silver 77 (77% AV) CSR Tier III	VPA & Silver 73 (73% AV) CSR Tier IV	APTC only
Household Size*	**100% (for reference)**	**150%**	**200%**	**250%**	**300%**	**400%**
1	$12,060	$18,090	$24,120	$30,150	$36,180	$48,240
2	$16,240	$24,360	$32,480	$40,600	$48,720	$64,960
3	$20,420	$30,630	$40,840	$51,050	$61,260	$81,680
4	$24,600	$36,900	$49,200	$61,500	$73,800	$98,400
5	$28,780	$43,170	$57,560	$71,950	$86,340	$115,120
6	$32,960	$49,440	$65,920	$82,400	$98,880	$131,840
7	$37,140	$55,710	$74,280	$92,850	$111,420	$148,560
8	$41,320	$61,980	$82,640	$103,300	$123,960	$165,280
For each additional person add	$4,180	$6,270	$8,360	$10,450	$12,540	$16,720

*Household size = tax filer + spouse (even if they live apart) + tax filer's dependents. Married couples must file jointly to be eligible for APTC and CSR.

The following tables show the deductibles and maximum out-of-pocket limits of unsubsidized (Silver 70) plans as well as Enhanced Silver (Silver 73 and Silver 77) plans. Without VCSR, Vermonters who previously received Silver 77 would be enrolled in Silver 73, while Vermonters who previously received Silver 73 would be enrolled in Silver 70.

Deductible of Plans with and without VCSR

Deductible (either integrated or medical)			
Enhanced Silver Plan Design	**Silver 77**	**Silver 73**	**Silver 70**
Standard Silver	$2,000	$2,550	$2,600
Standard Silver HDHP	$1,300	$1,550	$1,550
BCBSVT Blue Rewards Silver	$1,000	$2,100	$2,750
MVP Non-Standard Silver	$300	$1,100	$2,000

Maximum Out of Pocket with and without VCSR

Maximum Out-of-Pocket (either integrated or medical)			
Enhanced Silver Plan Design	**Silver 77**	**Silver 73**	**Silver 70**
Standard Silver	$4,500	$5,700	$6,800
Standard Silver HDHP	$3,000	$4,100	$6,400
BCBSVT Blue Rewards Silver	$5,200	$5,700	$7,350
MVP Non-Standard Silver	$4,500	$4,550	$6,050

FY2019 Proposed Budget – Agency of Human Services

Department of Vermont Health Access – Primary Care Case Management (PCCM) Fee Elimination

Primary Care Case Management (PCCM) Fee Elimination	$3,327,479 Gross	$1,490,870 General Fund

The PCCM framework was intended to incentivize primary care coordination of health services by compensating providers for any extra support needed for complex Medicaid cases through a $2.50 per member per month (PMPM) payment. The $2.50 PMPM payment is made to either: 1) the primary care practitioner that the member sees most often for preventative care or, if the member does not receive preventative care services, 2) the Primary Care Physician (PCP) assigned by DVHA as the Member's Primary Care Physician. The payment is made whether the member receives any coordinated care or other services.

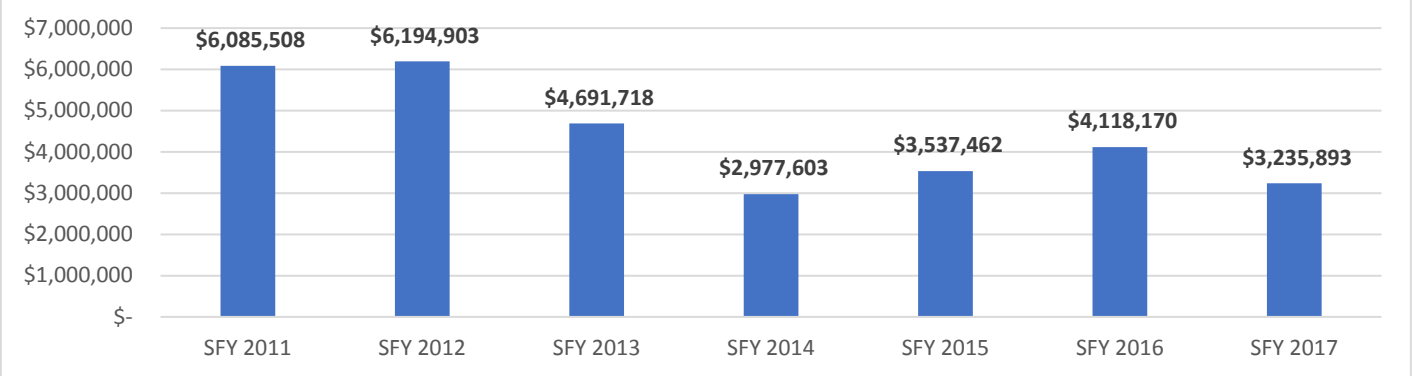
In FY2017, DVHA paid $3,235,893 out to 181 practices (857 primary care practitioners) on behalf of 107,863 members. The impact to provider by type is listed in the table below based on the member distribution in SFY 2017.

Table 5: PCCM by Provider Type

Provider Type	SFY 2019 Estimated Impact
FQHC & RHCs	($1,397,541)
Other Physician Group	($1,929,938)
Total Impact	($3,327,479)

DVHA proposes eliminating this payment effective July 1, 2018 with the submission of a State Plan Amendment to CMS. Overall state spending on the PCCM has fallen over time since payments were reduced from $5.00 per month to $2.50 per month per member effective January 1, 2014 (FY2013).

Total PCCM Payment, SFY 2011 – SFY 2017



Vermont put PCCM in place under the original Vermont Health Access Plan (VHAP) demonstration; however, as Medicaid has evolved, the payment is no longer aligned with DVHA's healthcare reform goals and focus on value-based payments. The payment is not tied to a specific program or activity; therefore, impact cannot be assessed, and it is not complementary to other DVHA care coordination efforts underway.

There is nothing in federal or state statute requiring the monthly $2.50 PCCM payment. There are no current Standard Terms and Conditions (STCs) of the Global Commitment to Health (GC) Waiver that would require/obligate the PCCM payment to continue. This change would require a State Plan Amendment.

Despite this reduction, health centers will see their reimbursement from DVHA increase by $2.4 million in the aggregate in FY2019 due to other rate changes made during a recent re-basing of DVHA's reimbursement schedule for health centers.

Primary care fee-for-service payments, set to 100% of the Medicare rate, will not change under this plan. Additionally, practices will continue to receive additional payments for participation in the Blueprint for Health and the Vermont Medicaid Next Generation (VMNG) ACO Programs. Of the 181 practices, 45 are within the Vermont Next Generation (VMNG) ACO Program as of January 1, 2018 and 113 practices also receive Blueprint Medical Home Payments. Total Blueprint investments are expected to be approximately $39.2 million in SFY 18, of which the State of Vermont pays $25.2 million. The VMNG provides a $6.50 Per Member Per Month (PMPM) administrative fee to the ACO, and the ACO pays $3.25 of each PMPM to the primary care provider that is responsible for those attributed lives. Those payments would be approximately $1.6 million in calendar year 2018 given the current ACO population.

FY2019 Proposed Budget – Agency of Human Services

Department of Vermont Health Access – Turning Premium Processing from DVHA to Insurance Carriers

Turning Premium Processing from DVHA to Insurance Carriers	$2,136,305 Gross	$1,106,606 State Funds

DVHA currently processes qualified health plan (QHP) premium payments for the health insurance exchange's carrier partners, while the carriers are responsible for late payment notices and terminations. DVHA contracts with WEX Health to provide premium processing functionality.

This proposal removes DVHA as intermediary and turns premium processing directly over to the insurance carriers, thereby consolidating the payment, noticing, and termination functions. The change achieves savings by allowing DVHA to eliminate its contract with WEX Health.

Key Considerations:

1. **Opportunity to Reduce Errors and Escalations**
   The exchange's operational metrics have improved dramatically over the last two years, especially those areas that involve collaboration between two partners' systems (e.g. the State and an insurance carrier). Payment processing has continued to be a problem area, however, as the current structure divides responsibilities and requires coordination across a third system. Billing-related issues account for at least two-thirds of the exchange's integration errors and two-thirds of phone calls that are escalated to DVHA.

2. **Change in Information Source for 1095 Tax Forms**
   DVHA mails 1095 tax forms to QHP and Medicaid members every January to use as proof of health coverage when filing federal taxes. DVHA mails approximately 120,000 1095-B forms to Medicaid members; this process would not be impacted since it doesn't rely on payments to carriers. DVHA will, however, need to modify some processes in order to continue to send approximately 25,000 1095-A forms to QHP members. Currently, the exchange's payment processor communicates the months of coverage for which it has received a member's payments; DVHA then populates the 1095-A forms accordingly. Starting next year, DVHA will rely on the carriers for this information.

3. **Process for Collecting Dr. Dynasaur Premiums**
   Approximately 6,000 households pay premiums for their children's Dr. Dynasaur health coverage. The State will need a solution for sending invoices and collecting premiums for these members. The simplest option would be to temporarily revert to the process that was used for these payments prior to the exchange. Specifically, the State could process Dr. Dynasaur premium payments through the legacy ACCESS system until ACCESS is sunsetted and a new premium solution is implemented as part of the Integrated Enrollment & Eligibility (IE&E) Program. The functionality needed for this process still exists; therefore, the State would need to build a bridge to have the exchange communicate the amount of the premium to ACCESS and have ACCESS communicate back whether or not the premium was collected. Work is needed to ensure seamless transition.

4. **Vermont Cost-Sharing Reductions (VCSR) to Sunset before Go-Live**
   The Governor's budget sunsets the VCSR program at the end of calendar year 2018, so VCSR payments will not be an issue.

5. **A Simpler Reconciliation Process**
   Carriers will need to communicate info on non-pay terminations back to the exchange so that DVHA can update enrollment files. The reconciliation process will presumably be able to focus simply on whether members are active or inactive, thereby saving staff and financial resources on both sides.

6. **Decommissioning**
   DVHA will need to work with its Maintenance and Operations (M&O) vendor to decommission its premium processing system for QHPs at some cost to the State. This decommissioning work will include system changes to decouple enrollment and payment information, redirect customers to carriers for payments/invoices, and make changes to integration triggers for enrollment and payment confirmation.

The FY2019 savings target is for a half year based on a go-live of January 2019. The schedule is aggressive and depends on the carriers' ability to collect the premiums from all members and apply Vermont Premium Assistance (VPA) appropriately. DVHA would retain responsibility for collecting Dr. Dynasaur premiums using the legacy Access system.

DVHA had planned to re-evaluate the cost benefit analysis of having a third-party vendor pass through VPA, VCSR, and premium collections, largely due to the reconciliation challenges experienced in the last few years and the on-going maintenance and operation costs of the WEX Health system. The fiscal pressure escalated these preliminary plans.

DVHA and its carrier partners have considerable work to do in the coming months in order to start development in July 2018 and implement changes for January 2019. The partners kicked off a series of meetings this month and are working through the above considerations as well as related details, from how to ensure adherence to rolling grace period rules, the refund process, electronic payments, and a variety of payment-related notices. As long as they stay on track and replicate the collaboration from recent open enrollment preparations, they have the opportunity to save financial resources and improve the customer experience through the consolidation of payment processing.

FY2019 Proposed Budget – Agency of Human Services

Department of Vermont Health Access – Vermont Chronic Care Initiative (VCCI) and Blueprint Alignment

Vermont Chronic Care Initiative (VCCI) and Blueprint Alignment	$1,826,928 Gross	$650,000 General Fund

DVHA's goal is to better align its care coordination activities and ensure its operations are in sync with current health care reform goals. DVHA believes that aligning the work of VCCI and Blueprint is the best way to achieve that in the short-term. DVHA is developing a plan to implement this change collaboratively with VCCI and Blueprint staff. This effort is being led by DVHA's Chief Medical Officer and the Director of the Blueprint for Health, who have thus far visited prepared a team for this project, conducted research and interviews, made preliminary recommendations, and are gaining feedback from DVHA senior leadership in order to build a more detailed plan. The effort placed a premium on collaboration, using the following steps to gain evidence:

- Interview 5 community teams and a large FQHC
- Project Managers and or CHT leader identify and convened the local team, which included broad representation
- Interview 6 VCCI staff
- Develop a summary report of the interview

That plan will focus on removing program barriers to further integrate VCCI into Community Health Teams. DVHA believes it can absorb this savings target while maintaining the strong performance of both programs.

DVHA's objective in creating to plan to align Blueprint and VCCI is to achieve budget goals, while maintaining existing services to beneficiaries. DVHA has recognized that aligning care coordination efforts could potentially improve performance, generate budget savings, and provide opportunity for improved service delivery. Fiscal pressures accelerated this planning.

FY2019 Proposed Budget – Agency of Human Services

Department of Vermont Health Access – Coordination of Benefits/Program Integrity Savings

Coordination of Benefits/Program Integrity	$1,959,716 Gross	$905,585 General Fund

This proposal projects cost reductions associated with increased Coordination of Benefits (COB) and Program Integrity cost avoidance and recovery activities. Increased focus on recovering taxpayer funds through COB and Program Integrity activities, coupled with enhanced data matching capabilities, will result in Medicaid savings.

COB activities are divided into two areas of work to ensure that Medicaid is the payer of last resort: Cost Avoidance and Benefit Recovery. The most effective strategy is to avoid paying claims (Cost Avoidance) when there is a primary insurance, rather than engaging with payers to recovery funds (Benefit Recovery). Locating sources of correct health insurance information on behalf of Medicaid members is a time-consuming activity and often does not provide actionable results. DVHA has engaged in a multi-year healthcare IT project to streamline the identification process through electronic data matching. Additional work is needed to complete this project but DVHA proposes fast tracking this as much as possible to meet the savings target.

In July 2015, DVHA became responsible for the Medicaid Health Access Eligibility & Enrollment Unit (HAEEU). Because of this, member healthcare eligibility and enrollment fraud also became the responsibility of DVHA. In April 2017, new staff were hired, and the Beneficiary Healthcare Fraud Investigative Unit (BFIU) was formed. The responsibility of this team is to investigate, detect and prevent Vermont Medicaid beneficiary healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. It is DVHA's position that the new BFIU lead by Program Integrity will lead to increased recoveries.

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

DVHA does not foresee any impact to the Medicaid member for the COB activities. Program Integrity's new focus on Beneficiary Healthcare fraud will impact members who have committing eligibility and enrollment fraud.