VERMONT

State of Vermont
Department of Vermont Health Access
280 State Street, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

M E M O R A N D U M

To: Representative Catherine Toll, Chair, House Committee on Appropriations

From: Cory Gustafson, Commissioner, Department of Vermont Health Access

Cc: Al Gobeille, Secretary, Agency of Human Services

Date: January 24, 2017

Re: Department of Vermont Health Access SFY 2017 Budget Adjustment

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On behalf of the Department of Vermont Health Access (DVHA), this memorandum is in response to questions raised during testimony on the state fiscal year (SFY) 2017 budget adjustment in the House Committee on Appropriations and in meetings with Representative David Yacovone.

Why were costs for the Blueprint Women's Health Initiative not budgeted for? Why are they contracted costs vs. state costs?

DVHA implemented a women's health initiative in SFY 2016 which incentivized the use of long-acting reversible contraceptives (LARCs) immediately following delivery. The Blueprint unit has been working with independent physicians' practices to enhance access to family planning counseling and LARC, implementation of psychosocial screening and brief intervention, and follow-up for mental health, substance abuse, inter-partner violence, housing stability and food security with a goal of reducing unintended pregnancy and improving the health of families. Supplemental payments to practices and community health teams were initiated.

What portion of DVHA is limited service vs. permanent (vs. contracts)?

DVHA has a total of 387 positions, not including temporary positions. Out of that total, 177 are limited service (46%). HAEEU specifically has 104 employees, of which 68 are limited service (65%). In addition to state staff, DVHA has 30 temporary positions on contract to assist with Medicaid redeterminations. These temporary positions are set to expire on July 1, 2017 and are not included in the FY18 budget.

Why weren't ACO savings or BCBSVT settlement costs budgeted for?

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Both the ACO savings values and the BCBSVT settlement agreement require getting to the end of a contract period in order to quantify the value associated with these payouts. The dollar amounts needed to satisfy these arrangements are unknown at the time of the budget build. Since there can be significant variances between fiscal years (e.g. the ACO savings in SFY '16 were $6.5 million as compared to $445,000 in SFY '17), this decision has been made to request the budget for these during BAA.

What are the details behind the $6.6 million miscellaneous contracting needs?

Description	Gross Change
The Vermont Health Connect must rely upon a contractor to support the production of federally required tax forms (1095s) which includes complex data migration and manipulation. The State is working to replace this contract work with existing state employees, though support from this organization is needed until staff can be fully trained to take over this complex workload.	$ 2,797,412
Contracted temporary staff are needed to ensure the success of open enrollment and Medicaid redetermination processing. (Desai: $936,500, Temps: $800K)	$ 1,736,500
DVHA contracts with 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. ($1.2 million)	$ 1,162,741
The Blueprint program has myriad administrative contracts that support the Community Health Team construct. To continue to advance the work of the Women's Health Initiative, increases were required in these contracts.	$ 881,352
VHC Contract Increases (Optum)	$ 776,366
DDI Contract Changes	$ (792,796)

Why was there an increase in VHC systems costs of $776,366 and a decrease in DDI contracts of $792,796?

Through a competitive bid process, Vermont engaged Optum to continue to perform enhanced maintenance and operation (M&O) including increased scope of services previously delivered by OneGate and expanding Medicaid enrollment.

The total DDI forecasted amount is based on projects planned for the SFY and aligns to the CMS approved IAPD's for E&E, MMIS and Platform related development activities.

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In aggregate, the funding need shifted away from the HSE platform development activities to more focus on E&E. This down reflects the DDI budget re-alignment based on the updated IAPDs and project plans.

What are the details on behind the hepatitis C coverage increase (e.g., number of people to receive the service and cost of service)?

Approximately 70-100 patients will benefit from this change, and the cost per patient can vary between $150,000.00 to $200,000.00. Not all patients will seek treatment or due to other conditions may wait out progression of disease to determine if treatment is necessary.

How does LARC reimbursement in Act 120 align with the women's health initiative in Blueprint?

Act 120 allowed for an increase for Medicaid reimbursement of LARC in the outpatient setting. This rate increase of 20% increase on the device when into effect on October 1, 2016. Providers who participate in Medicaid's 340B drug discount program may not realize the full increase in reimbursement due to their unique 340B agreements with DVHA, and compliance with federal law. 340B entities are required (by CMS and HRSA) to bill Medicaid agencies their 340B acquisition cost, which in most cases is far lower than the fee schedule. This federal policy is in place so that Medicaid agencies can maintain cost neutrality because 340B claims cannot be submitted for federal rebate.