State of Vermont *Agency of Human Services*
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M E M O R A N D U M

To: Senator Jane Kitchel, Chair, Senate Committee on Appropriations

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

Cc: Al Gobeille, Secretary, Agency of Human Services

Date: February 23, 2017

Re: Department of Vermont Health Access SFY 2018 Budget Testimony

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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) 2018 Governor's proposed budget in the Senate Committee on Appropriations on February 16, 2017.

Was there a reduction to the budget when the initial wave of individuals opted to direct enroll?

There was not an itemized reduction specific to direct enrollment in the SFY 2017 budget. The SFY 2017 initial budget submission assumed full system functionality; therefore, the budget had been reduced to reflect such. (SFY '16 BAA = $51.8 million; SFY '17 as passed = $47.2 million.) Due to the need to continue to have manual workarounds, the SFY 2017 BAA request was for $50.5 million. However, the general fund need associated with the increase over as passed was nominal. This was predominantly due to the cost allocation shift from individuals opting to direct enroll. An additional $2.3 million general fund would have been needed had those individuals opted to enroll through VHC. Based on what we are seeing by way of scalability in workload, there is roughly $22.50 PMPM spent associated with caseload service variability including customer service calls, premium processing, and mailings. If that statistic were applied to the 2016 plan year direct-enroll population (4,500 individuals), this would equate to $1.2 million in gross service dollars not spent.

How many additional staff would we have needed if there was no direct enrollment?

In addition to state staff, DVHA has been handling the workload associated with eligibility and enrollment through temp contracts. In SFY 2017 BAA, we requested $1.7 million in support of these contracts. In SFY 2018 DVHA's budget reflects a need of $376,310. The reduction in

need is due to both the expectation that more individuals would direct enroll and that system functionality would continue to improve, thus requiring less administrative support from DVHA.

What are the numbers associated with the metrics in the VHC dashboard?

The Health Care Eligibility and Enrollment Unit tracks a set of 75 metrics to monitor operational performance. These metrics roll up into the Key Performance Indicator dashboard presented in the DHVA budget book. Operations leadership is happy to present the details behind the numbers to the Committee or to meet with interested Committee members individually to answer questions.

What is the system fix associated with the Phase One work?

The AHS and the Health and Human Services Enterprise Project Director will be meeting with the Joint Fiscal Office in order to provide the Committee with a detailed description as to the work associated with Phase One.

Could you provide more specificity regarding what "estimated acquisition cost" means?

Estimated Acquisition Cost is the estimated cost for which a pharmacy can purchase a drug, and it is what Medicaid is to reimburse pharmacies (in addition to a reasonable cost of dispensing). Currently for Medicaid, this reimbursement is based on the lower of Average Wholesale Cost (AWP)-14.2%, the Pharmacy's Usual and Customary charge, and for generics the Maximum Allowable Cost and Federal Upper Limit. CMS has recognized that the AWP is an artificial benchmark that bears little relationship to the actual acquisition cost; therefore on April 1, 2017 CMS will be requiring states to reimburse pharmacies based on their "Actual Acquisition Cost (AAC)" plus a professional dispensing fee. The AAC will be based on a CMS published benchmark called the NADAC (National Average Drug Acquisition Cost). The NADAC is created by surveying pharmacies around the country who report their actual acquisition cost. As a result, Vermont will be moving to a more reliable benchmark that will better reflect a pharmacy's cost of acquisition. If there are additional questions, DVHA is happy to meet with the Committee to provide additional information.

Could you provide more information on the ACO? Who are the Medicaid enrollees attributed? What are the associated services?

Enclosed please find two documents with information pertaining to the Vermont Medicaid Next Generation ACO arrangement.

What is the cost to DVHA for having individuals in emergency rooms with a mental health diagnosis who are awaiting placement?

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Based on the diagnosis, in SFY 2017 DVHA spent $1,512,554 in mental health emergency room usage. DMH spent $10,465. Medicaid funds can only be spent on services that meet medical necessity requirements. DVHA reimburses only emergent and urgent ED visits, opting to deny non-emergency or "elective" ED visits based on the hospital's determination of what is considered emergent or urgent. This response will pertain only to instances where a Medicaid patient is admitted to and subsequently discharged from the ED. Additionally, it can be assumed that if the patient is admitted, then the reason for the ED visit could not have been avoided. If a patient is admitted to an inpatient setting, the ED is not paid separately and is considered part of the inpatient claim. If an individual is in an inpatient setting but awaiting placement, the rate of reimbursement is lower than an active inpatient stay.

Emergency: The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.

Urgent: The patient required immediate attention for the care and treatment of a physical or mental disorder.

Elective: The patient's condition permitted adequate time to schedule the availability of suitable accommodations.