VERMONT
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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Category	Description	Data Point
Coverage	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
Providers	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
Claims	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
Customer Support	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 (AAFM)

- **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 the 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.

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.

SFY 2016 Total Vermont Government Expenditures
(including federal reimbursement)

Capital Outlay 1.52%
Debt Service 1.31%
General Government 2.00%
Transportation 9.61%
Commerce and Community Development 0.84%
Protection to Persons and Property 5.95%
Natural Resources 1.83%
General Education 33.23%
Human Services 43.19%
Labor 0.53%

SFY 2016 Vermont Government Expenditures
(net of federal reimbursement)

Capital Outlay 2.10%
Debt Service 1.81%
General Government 2.74%
Transportation 13.31%
Commerce and Community Development 0.60%
Protection to Persons and Property 6.95%
Natural Resources 1.98%
Human Services 27.52%
General Education 42.82%
Labor 0.17%

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[1]	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
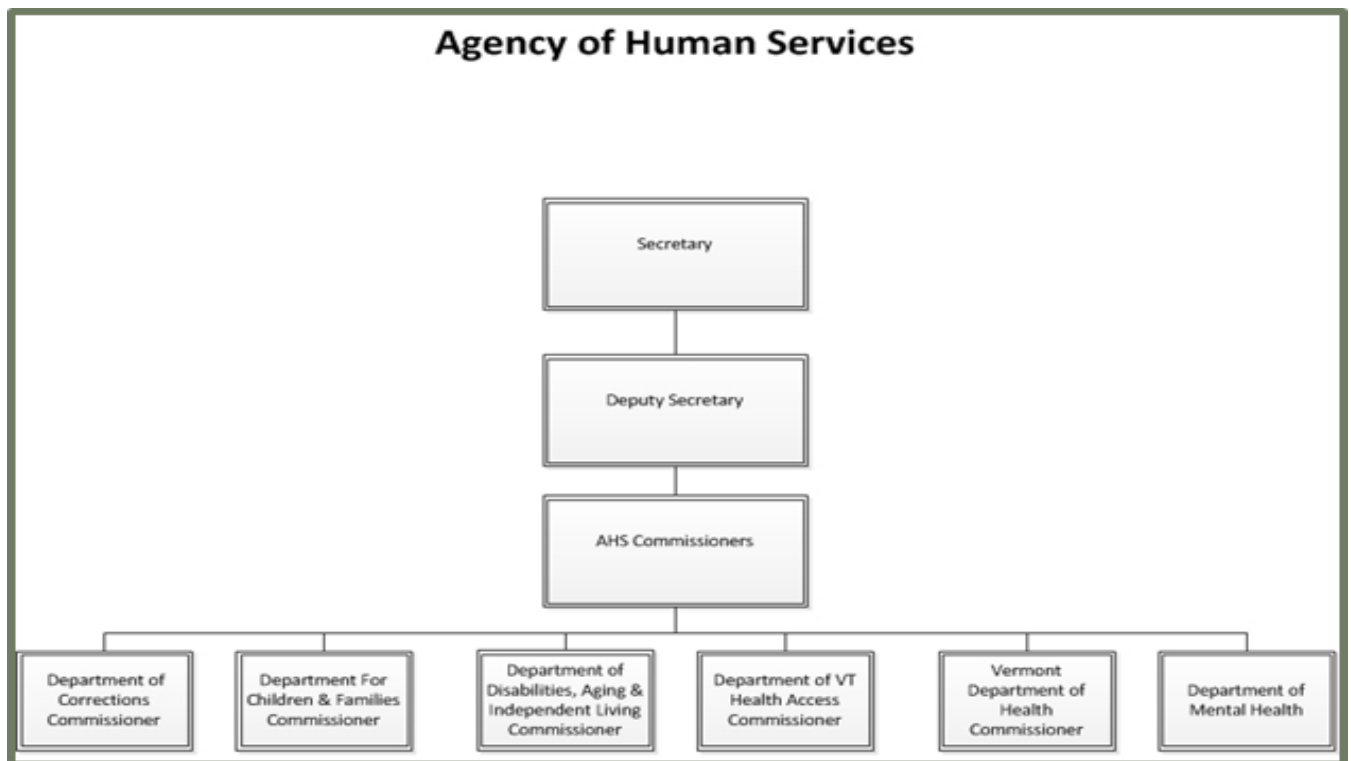
DEPARTMENTAL APPROACHES TO MEDICAID

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:

Department	Division/Programs/Services
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

Category	Amount
Misc. and DSH	$2,780,326
VPharm	$697,033
Choices for Care	$19,980
Dual Eligibles	$557,828
Underinsured Child + CHIP	$211,050
BD Child	$7,129,296
General Child	$36,953,191
New Adults	$1,851,073
General Adult	$3,778,072
ABD Adult	$1,924,939
Federal Spend	$1,300,846
MCO Investments	$17,201,552
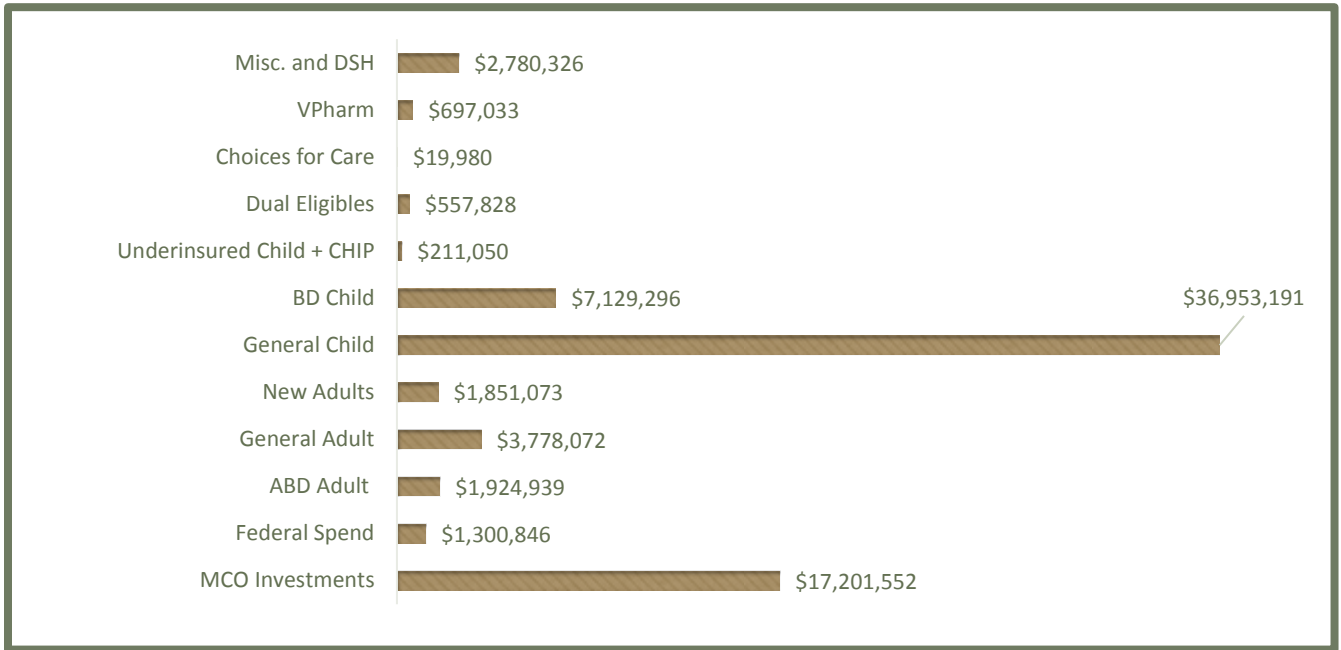
DEPARTMENT OF CORRECTIONS (DOC)

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
- Division of Licensing and Protection
- Office of Child Support
- Office of Disability Determinations

DAIL SFY 2016 Medicaid Spend

Misc. and DSH	-$260,686
Choices for Care	$1,252,478
Dual Eligibles	$85,464,134
Underinsured Child + CHIP	$64,515
BD Child	$4,517,862
General Child	$1,874,967
General Adult	$2,092,030
ABD Adult	$44,074,525
New Adults	$5,007,770
Federal Spend	$2,092,030
Blended	$44,074,525
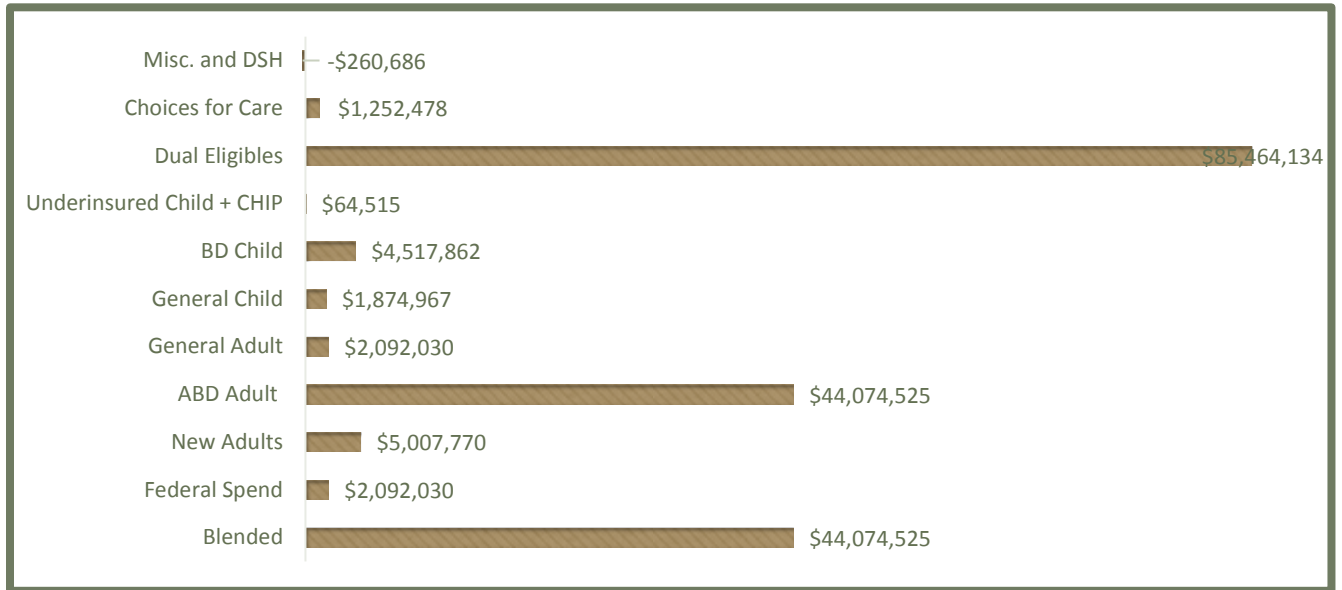
DEPARTMENT OF MENTAL HEALTH (DMH)

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

Category	Amount
Misc. and DSH	$4,370,638
VPharm	$5,853
Choices for Care	$447,155
Dual Eligibles	$47,640,790
Underinsured Child + CHIP	$1,689,998
BD Child	$25,657,070
General Child	$64,249,204
New Adults	$8,887,660
General Adult	$2,164,094
ABD Adult	$19,647,494
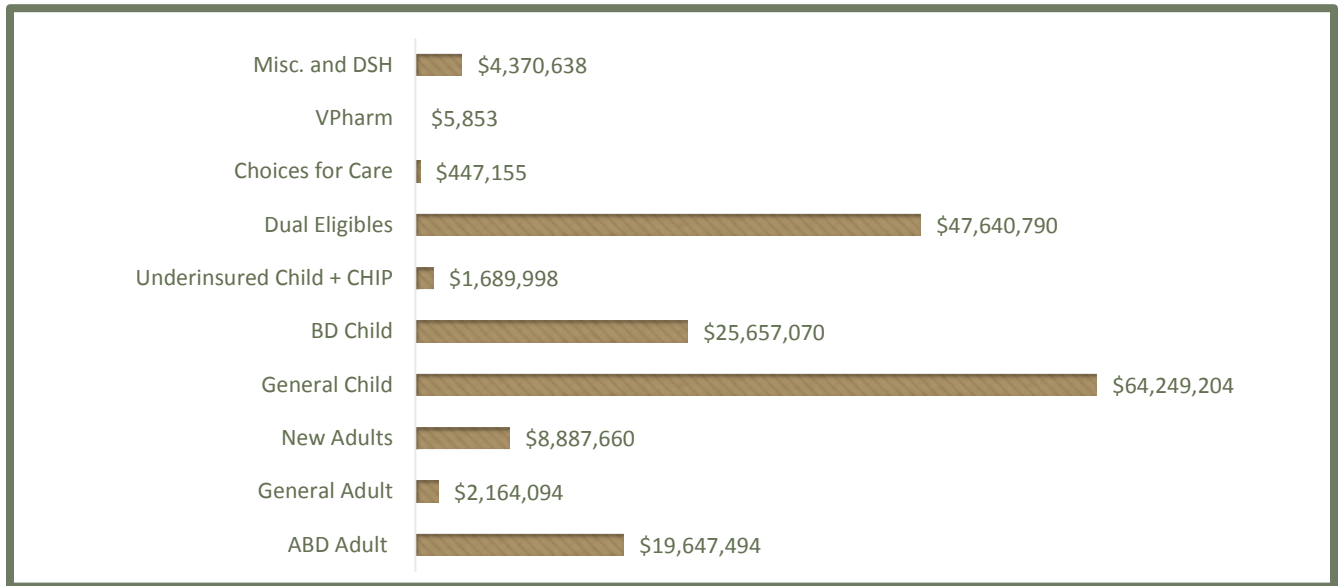
DEPARTMENT OF HEALTH (VDH)

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

Category	Amount
Misc. and DSH	-$173,413
Choices for Care	$33,675
Dual Eligibles	$2,189,965
Underinsured Child + CHIP	$124,645
BD Child	$1,049,903
General Child	$2,070,211
New Adults	$15,449,440
General Adult	$5,435,114
ABD Adult	$3,594,499
Sunsetted	-$13,016
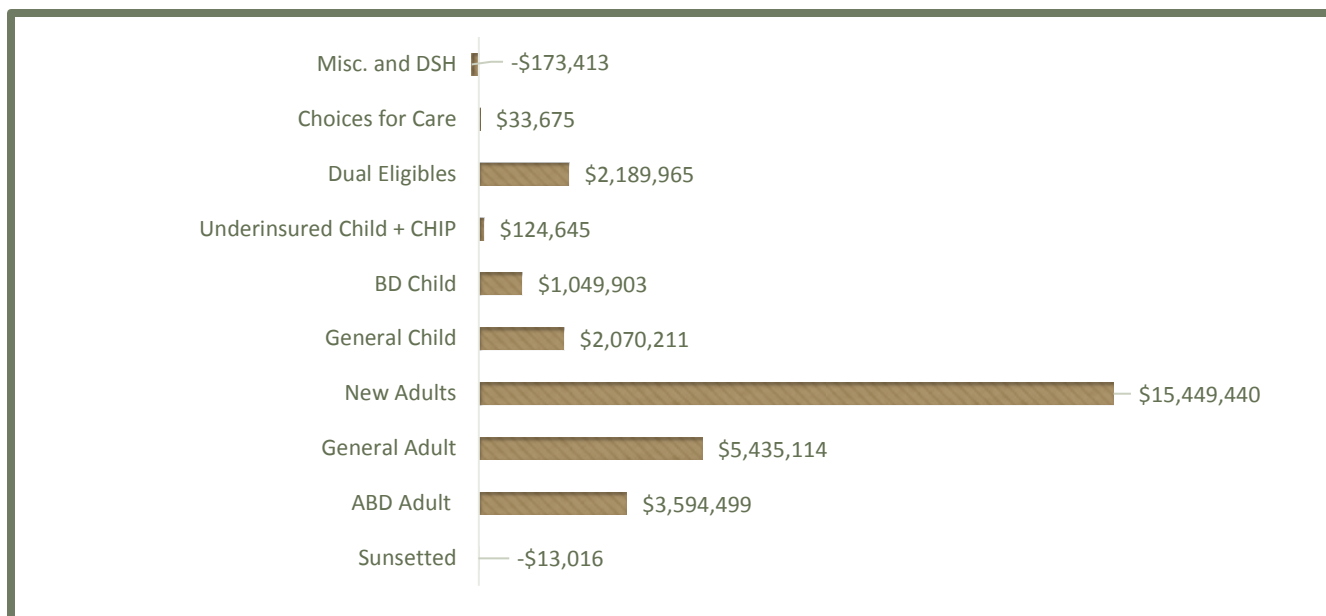
AGENCY OF EDUCATION (AOE)

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

Category	Amount
Choices for Care	$6,929
BD Child	$16,046,734
Dual Eligibles	$236,597
Underinsured Child + CHIP	$1,788,580
General Child	$29,970,905
New Adults	$45,116
General Adult	$214,158
ABD Adult	$1,386,457
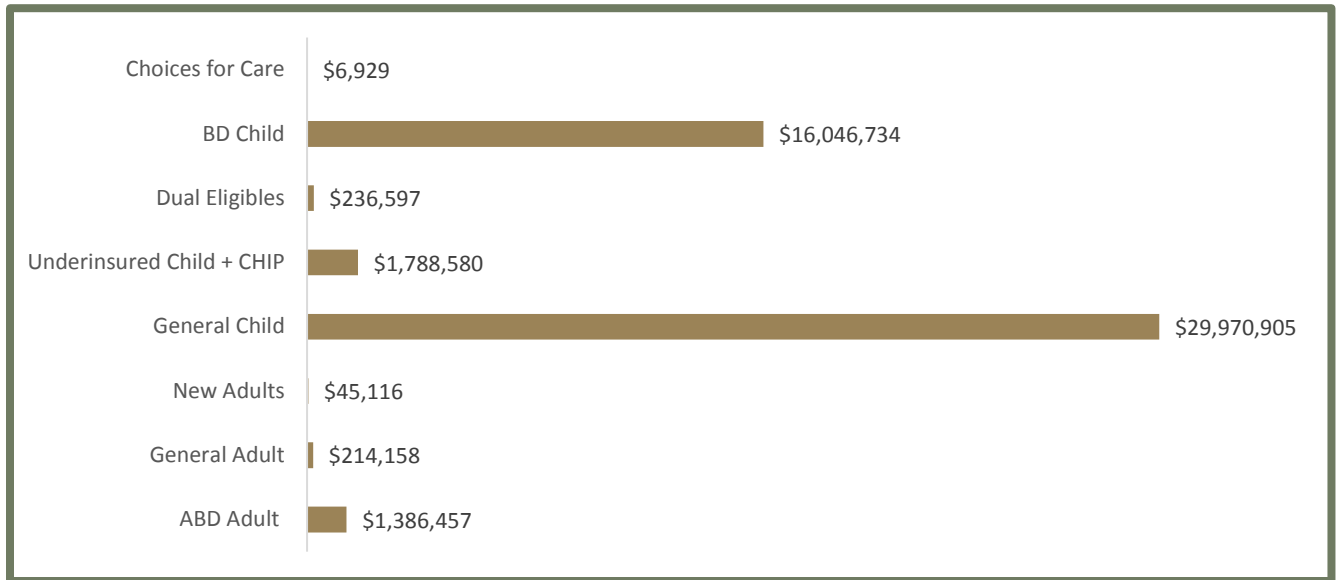
DEPARTMENT OF VERMONT HEALTH ACCESS (DVHA)

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:

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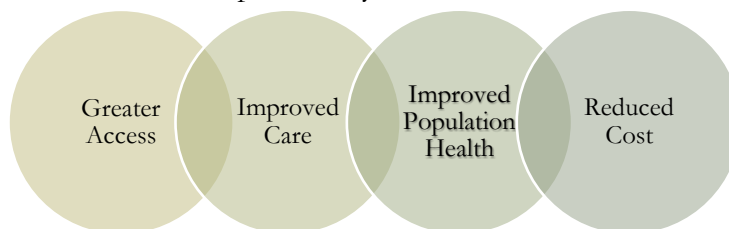
In support of the objectives outlined above, DVHA's successful Blueprint for Health and the Vermont Chronic Care Initiative (VCCI) have been working hand-in-hand with the federally-funded State Innovation Model (SIM) project, labeled the Vermont Healthcare Innovation Project (VHCIP).

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

Category	Amount
Misc. and DSH	$37,995,123
VPharm	$2,302,437
Choices for Care	$213,115,112
Pr Assistance + Cost Sharing	$6,452,962
Dual Eligibles	$55,523,042
Underinsured Child + CHIP	$8,212,318
BD Child	$27,174,573
General Child	$151,736,910
New Adults	$248,721,362
General Adult	$92,641,465
ABD Adult	$99,308,972
Federal Spend	-$3,682,295
Sunsetted	$206,024
Buy in	$37,271,322
Clawback	$29,011,845
MCO Investments	$8,693,645
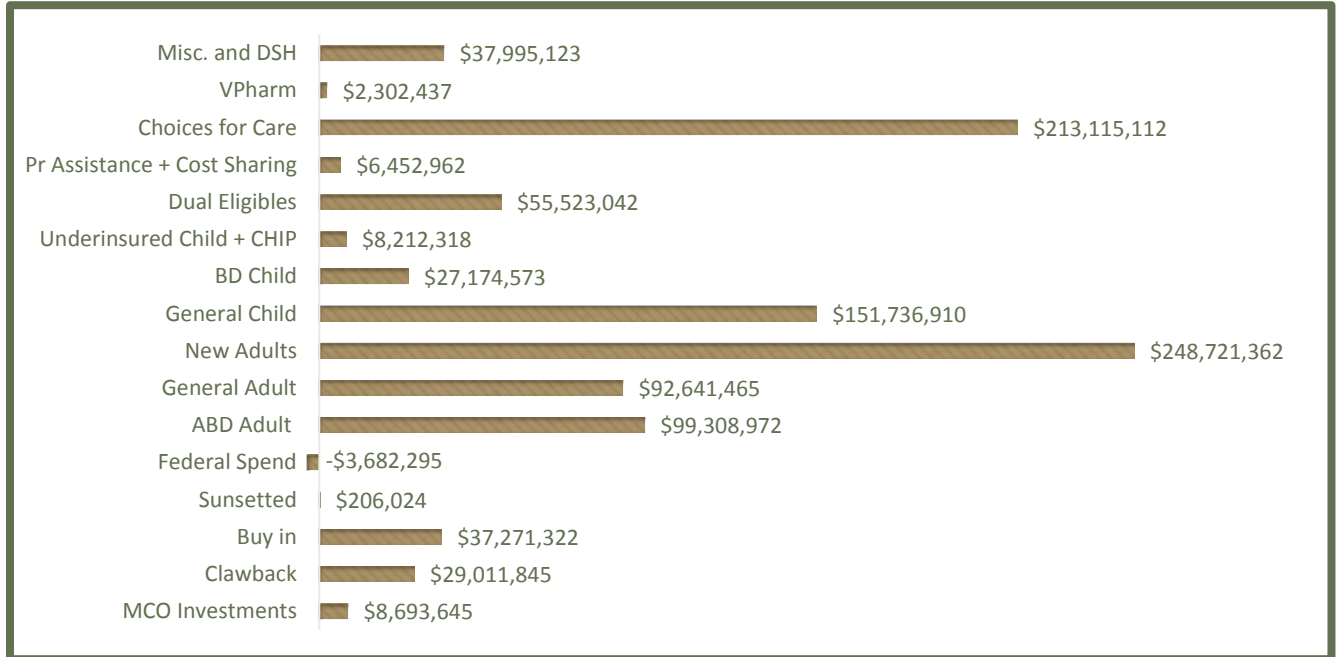
Total SFY 2016 Medicaid/CHIP Spend by Department - $1,487,413,598

- DAIL $144,087,596 10%
- AOE $49,695,477 3%
- DCF $74,424,732 5%
- VDH $29,761,021 2%
- DMH $174,759,954 12%
- DVHA $1,014,684,817 68%
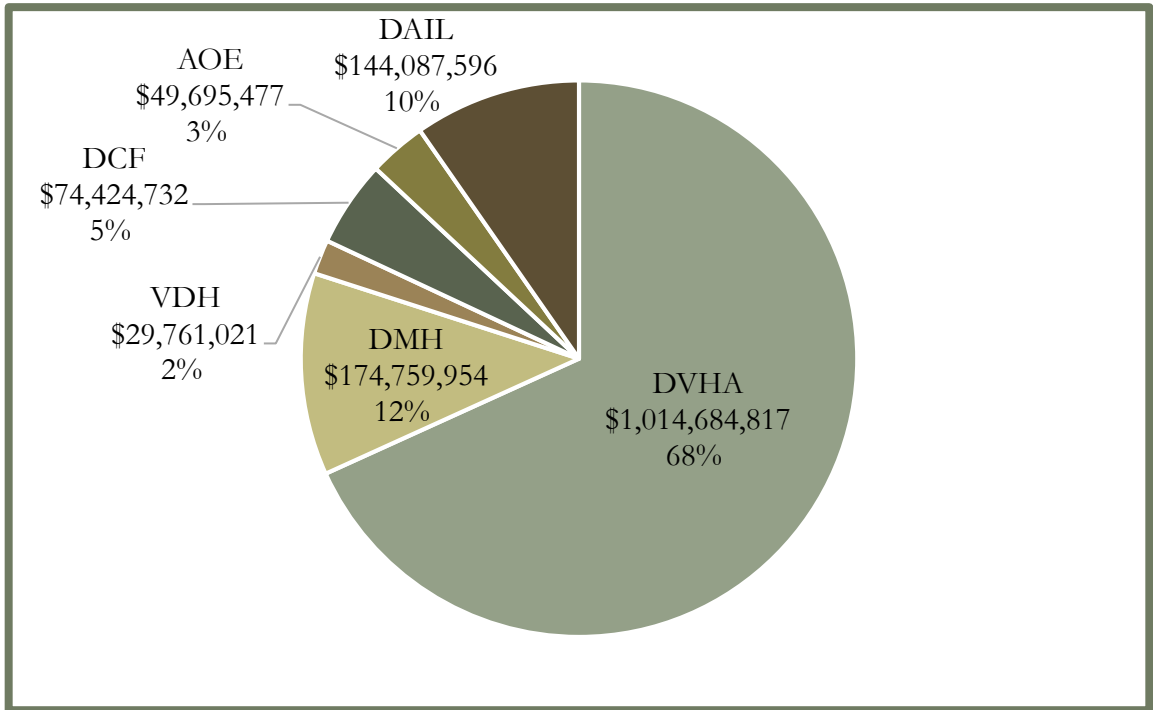
Total SFY 2016 Medicaid/CHIP Spend by Eligibility Group

- Misc. and DSH 2.72%
- VPharm 0.18%
- MCO Investments 5.99%
- Clawback 1.78%
- Buy in 2.29%
- Sunsetted 0.01%
- Blended 2.03%
- Federal Spend -0.12%
- Pr Assistance + Cost Sharing 0.40%
- Choices for Care 13.24%
- ABD Adult 11.23%
- Dual Eligibles 13.42%
- General Adult 6.46%
- Underinsured Child + CHIP 0.74%
- New Adults 16.97%
- BD Child 5.06%
- General Child 17.60%
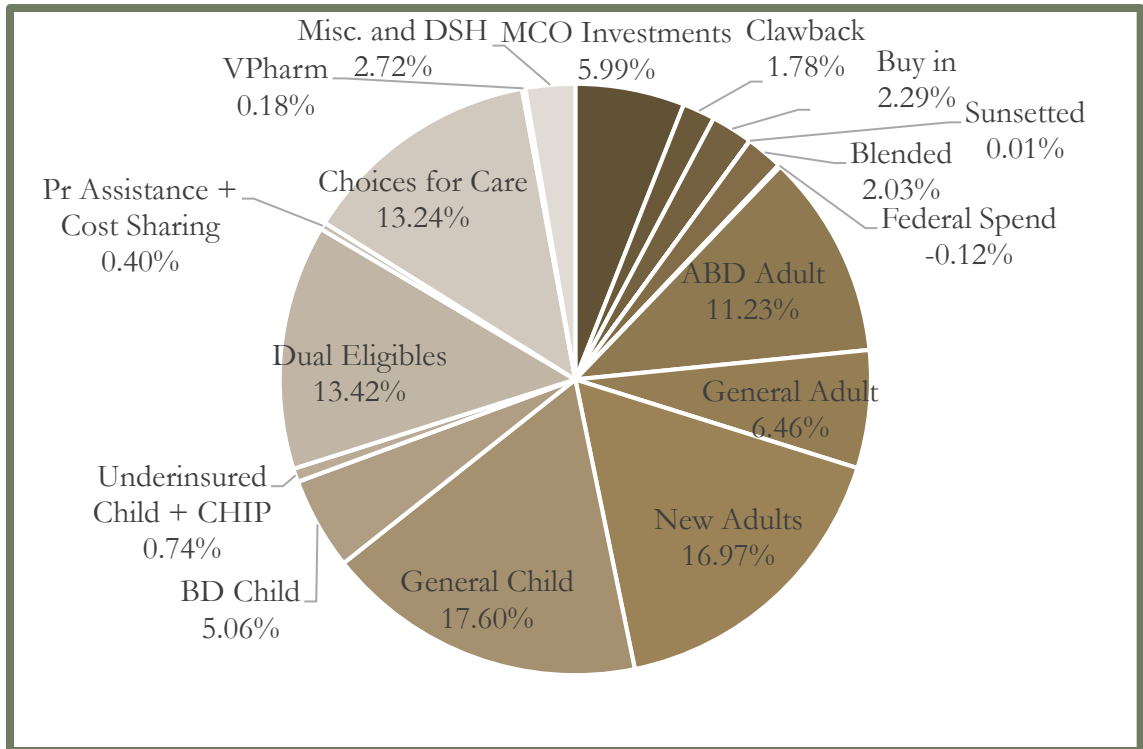
Departmental Spend by Category of Service

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)
Total All Program Expenditures	$ 1,014,684,817	$ 174,759,954	$ 29,761,021	$ 74,424,732	$ 49,695,477	$ 144,087,596	$ 1,487,413,598

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

Cory Gustafson
Department of Vermont
Health Access
Commissioner

Michael Costa
Deputy Commissioner

Adaline Strumolo
Health Services Project
Director
(Classified not Exempt)

Beth Tanzman
Blueprint for Health Director

Lori Collins
Deputy Commissioner

Carrie Hathaway
Fiscal &
Administrative
Operations
Director — 24 Positions

4 Positions

9 Positions

Deb Austin
Coordination of
Benefits Director — 15 Positions

4 Positions

Patricia Elias
Rate Setting
Manager — 5 Positions

Jeff Ross
Data Management
& Analysis Director — 3 Positions

Alicia Cooper
Health Care
Project Director — 10 Positions

Leann Miles
Program Integrity
Director

Vacant
Program Integrity
Associate Director — 12 Positions

Aaron French
Chief Clinical Officer

Kelly Gordon
Project &
Operations
Director

Nancy Hogue
Pharmacy Director — 5 Positions

Cassandra Gekas
VHC/HAEEU
Director of
Operations — 183 Positions

Sandra Hoffman
Quality
Improvement &
Clinical Integrity
Director

Substance Abuse
Director

8 Positions

Michele Betit
Long Term Care
Director — 24 Positions

Eileen Girling
Vermont Chronic
Care Initiative
Director — 26 Positions

Vacant
Exchange Project
Director

Daljit Clark
Clinical Operations
Director — 9 Positions

Joe Liscinsky
Health Reform
Enterprise Director

3 Positions

Vacant
HCR/HIT
Integration
Manager — 6 Positions

Bill Clark
Managed Care
Compliance
Director

Suellen Bottigi
Provider &
Member Relations
Director — 5 Positions

366 Positions

Vacant
Medical Director

Essex

Waterbury

Williston

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
General Administration	87	$ 9,960,991	*5.26%*	*0.82%*
Claims Services	29	$ 18,273,537	*9.65%*	*1.51%*
Eligibility	145	$ 48,272,806	*25.48%*	*3.98%*
Quality	90	$ 21,733,978	*11.47%*	*1.79%*
Project	15	$ 91,198,799	*48.14%*	*7.52%*
TOTAL ADMINISTRATIVE COSTS	366	$ 189,440,111	*100.00%*	*15.62%*

The following units comprise this division:

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

	# FTEs	Total $	% of Admin Budget	% of Total Budget
		SFY 2018 Governor's Recommendation		
General Administration	**87**	**$ 9,960,991**	**5.26%**	**0.82%**
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**
  - Clinical Operations
  - MMIS - Claims Processor
  - MMIS - Misc. Contracts
  - Provider and Member Relations
  - Reimbursement Unit

	# FTEs	SFY 2018 Governor's Recommendation		
		Total $	% of Admin Budget	% of Total Budget
Claims Services	**29**	**$ 18,273,537**	**9.65%**	**1.51%**
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 (DAIL), 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**
  - Assistant Operations (AOps)
  - Call Center (Maximus)
  - Eligibility - Misc. Contracts
  - Health Access Eligibility & Enrollment
  - Long-Term Care
  - Premium Processing (Wex)
  - Vermont Health Connect

	# FTEs	Total $	% of Admin Budget	% of Total Budget
		SFY 2018 Governor's Recommendation		
Eligibility	**145**	**$ 48,272,806**	**25.48%**	**3.98%**
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 Bennaissance) 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**
  - Blueprint
  - Care Management
  - Coordination of Benefits
  - Managed Care and Compliance
  - Payment Reform
  - Pharmacy
  - Pharmacy Benefits Manager
  - Program Integrity
  - Quality Improvement
  - Vermont Chronic Care Initiative

	# FTEs	Total $	% of Admin Budget	% of Total Budget
		SFY 2018 Governor's Recommendation		
Quality	**90**	**$ 21,733,978**	**11.47%**	**1.79%**
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

	# FTEs	Total $	% of Admin Budget	% of Total Budget
		SFY 2018 Governor's Recommendation		
Project	**15**	**$ 91,198,799**	**48.14%**	**7.52%**
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 heath 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.

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

Program Statement:

The Vermont Blueprint for Health is transforming the healthcare and integrated health systems delivery and payment model, consisting of:
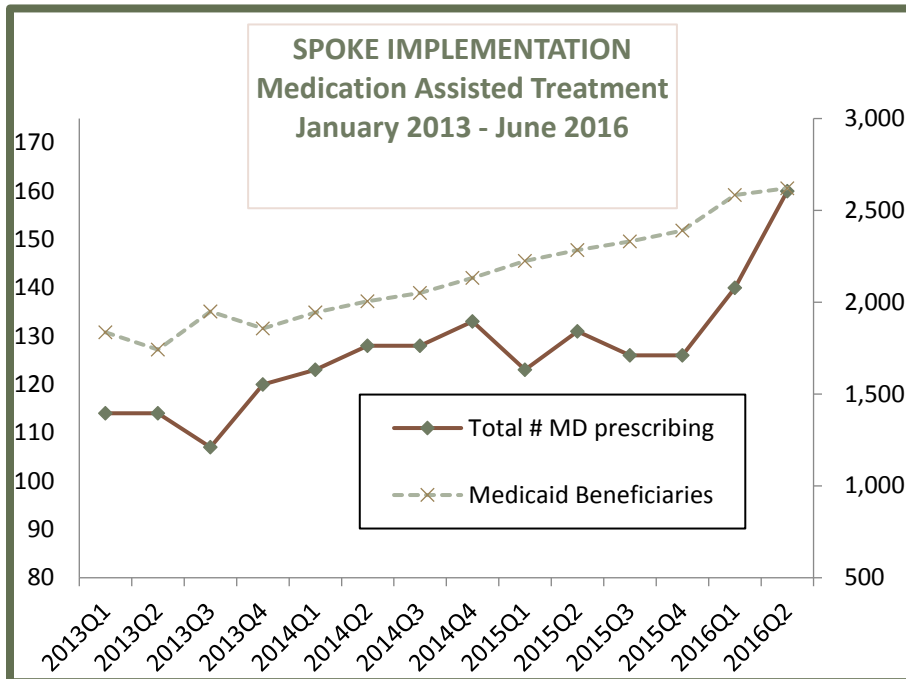
- A steady increase of primary care practices throughout the state that are recognized as Patient Centered Medical Homes (PCMHs) by the National Committee for Quality Assurance (NCQA) currently totaling 128 practices
- Comprehensive evidence-based self-management programs
- Multi-disciplinary core Community 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.

SPOKE IMPLEMENTATION
Medication Assisted Treatment
January 2013 - June 2016

Legend: Total # MD prescribing; Medicaid Beneficiaries

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.

O DVHA Improve Access to Quality Healthcare for all Vermonters	Time Period	Actual Value	Current Trend	Baseline % Change

P BP Blueprint for Health	Time Period	Actual Value	Current Trend	Baseline % Change

Budget Information

Total DVHA Program Budget SFY 2018: $897,820

What We Do

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes and community health teams.

Who We Serve

The Vermont Blueprint for Health serves all Vermonters.

How We Impact

The activities of the Blueprint serve as the foundation for strengthening primary care and expanding the ACO programs. This initiative is especially focused on building the links between community and medical services, so that patients have better coordinated care across the spectrum of services.

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

	Time Period	Actual Value	Current Trend	Baseline % Change
PM BP # of Patient Centered Medical Homes	2015	126	↗ 6	1700% ↑
PM BP Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)	2014	1:2.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)	2014	1:0.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) - All Payers	2014	1:5.8	→ 0	0% →

P BP Blueprint for Health	Time Period	Actual Value	Current Trend	Baseline % Change
PM BP # of Patient Centered Medical Homes	2015	126	↗ 6	1700% ↑
PM BP Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)	2014	1:2.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)	2014	1:0.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) - All Payers	2014	1:5.8	→ 0	0% →

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
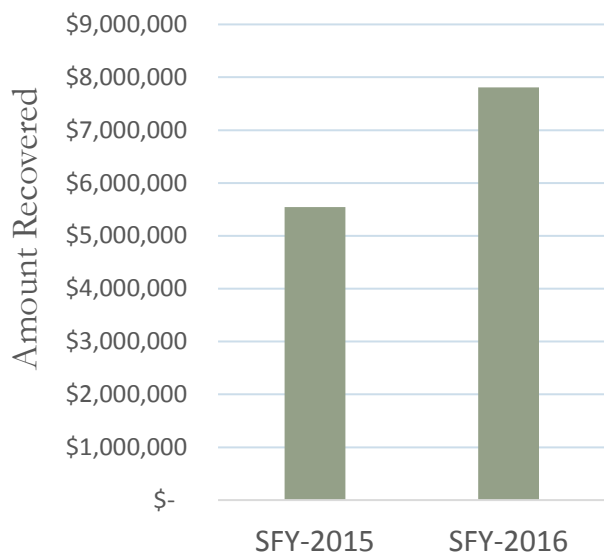
COST AVOIDANCE
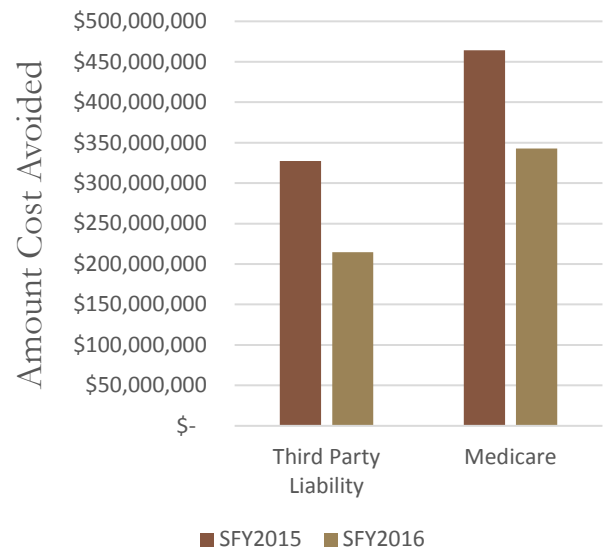
Program Statement:

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

	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16
Recoupment and Prevention	$3,821,177	$2,288,804	$2,597,951	$3,742,566	$8,972,952
Settlements	$650,809	$2,865,593	$3,614,861	$336,353	$295,436
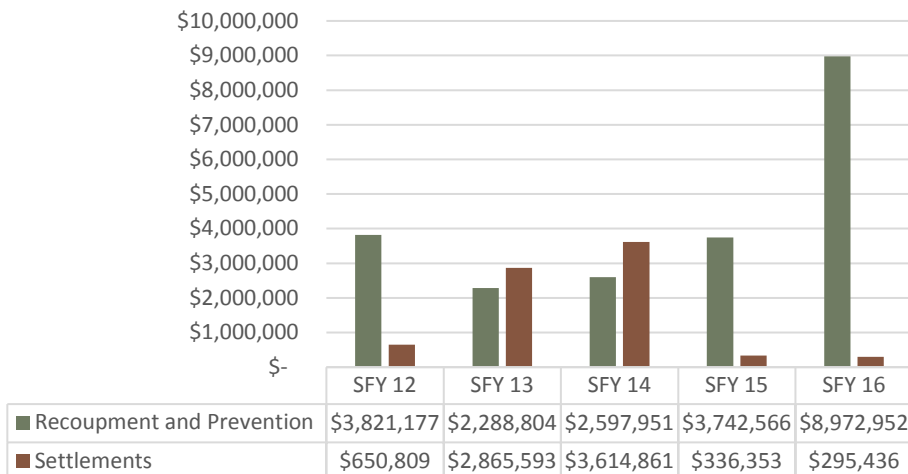
Global settlements are typically national lawsuits which may involve medical or product liability.

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 approaches 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

Legend: ■ FY14 Rate ■ FY15 Rate

Categories: Inpatient Admissions, Readmissions, Emergency Room Visits

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.

O	VCCI	Vermonters Receive Appropriate Care	Time Period	Actual Value	Current Trend	Baseline % Change
P	DVHA	Medicaid's Vermont Chronic Care Initiative (VCCI) - (Copy)	Time Period	Actual Value	Current Trend	Baseline % Change

Budget Information

Total Program Budget SFY 2018: $3,111,5111

What We Do

The Vermont Chronic Care Initiative (VCCI) identifies and assists Medicaid beneficiaries with chronic health conditions and /or high utilization of medical services to access clinically appropriate health care information and services. DVHA care coordinators are fully integrated core members of existing Community Health Teams and are co-located in provider practices and medical facilities in several communities. The population are the top 5% utilizers of the healthcare system, accounting for 39% of healthcare costs.

How We Impact

VCCI is focused on utilization measures with documented reductions in all areas, including for ambulatory care sensitive (ACS) inpatient hospital admissions, readmissions and emergency department use. Staff are embedded in multiple high-volume hospital and primary care practice sites to support care transitions as well as direct referrals for high risk/cost members. The VCCI continues to receive national recognition for its model and results including by CMS and the National Academy for State Health Policy (NASHP).

VCCI is 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 needs. VCCI has developed collaborative relationships with contracted Medicaid ACO partners and will continue strategic efforts to leverage limited resources toward common goals. Inherent in this, VCCI is active on the payment reform Care Management and Care Models (CMCM) workgroup and has a leadership role in the care management learning collaborative planning and implementation to assure service integration.

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. Due to a change in VCCI's data analytics vendor, there are limited performance measures to display for SFY 2016. More measures will be available for display in the future.

PM	DVHA	# of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative				
			SFY 2016	1,719	↘ 1	-2% ↓
			SFY 2015	1,947	↗ 1	12% ↑
			SFY 2014	1,740	↘ 1	0% →
			SFY 2013	2,026	↗ 1	16% ↑
			SFY 2012	1,746	→ 0	0% →

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.

Comparison of Vermont Medicaid and National Medicaid Averages for 2016

Legend: 2016 VT Medicaid Rate, 2016 National Medicaid Mean

Comparison of Vermont Medicaid Rates for 2015 and 2016

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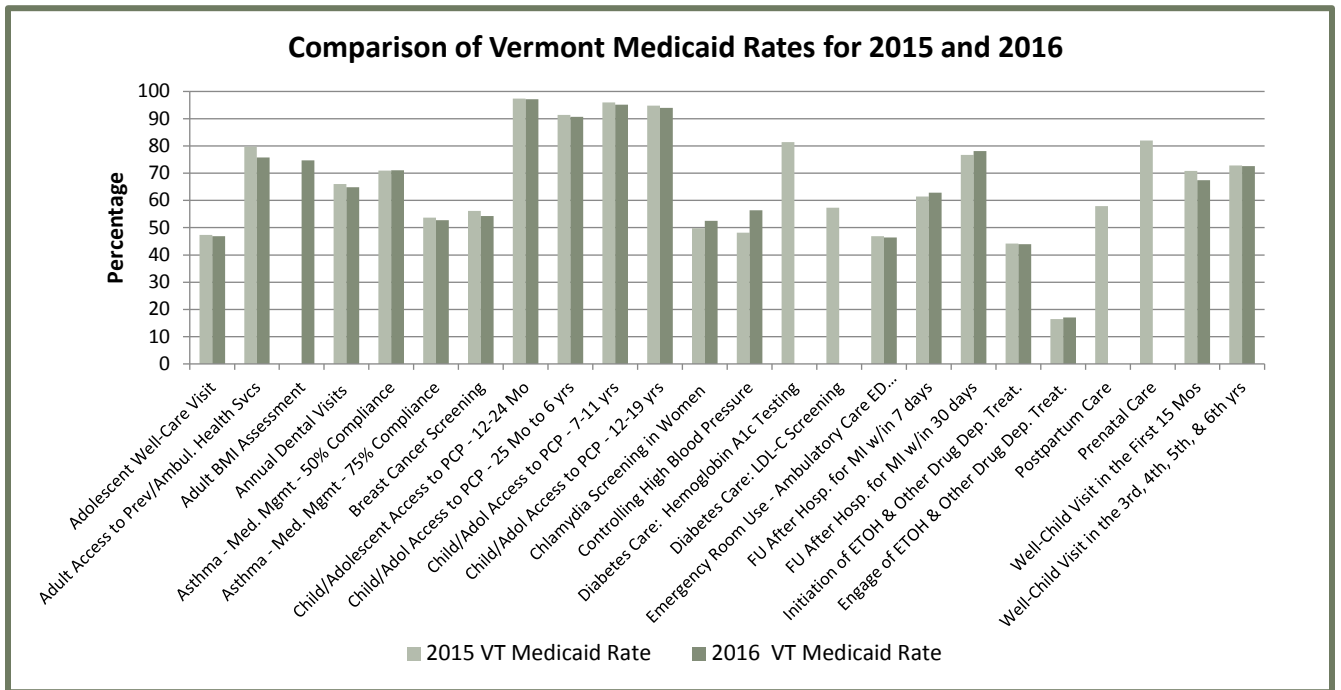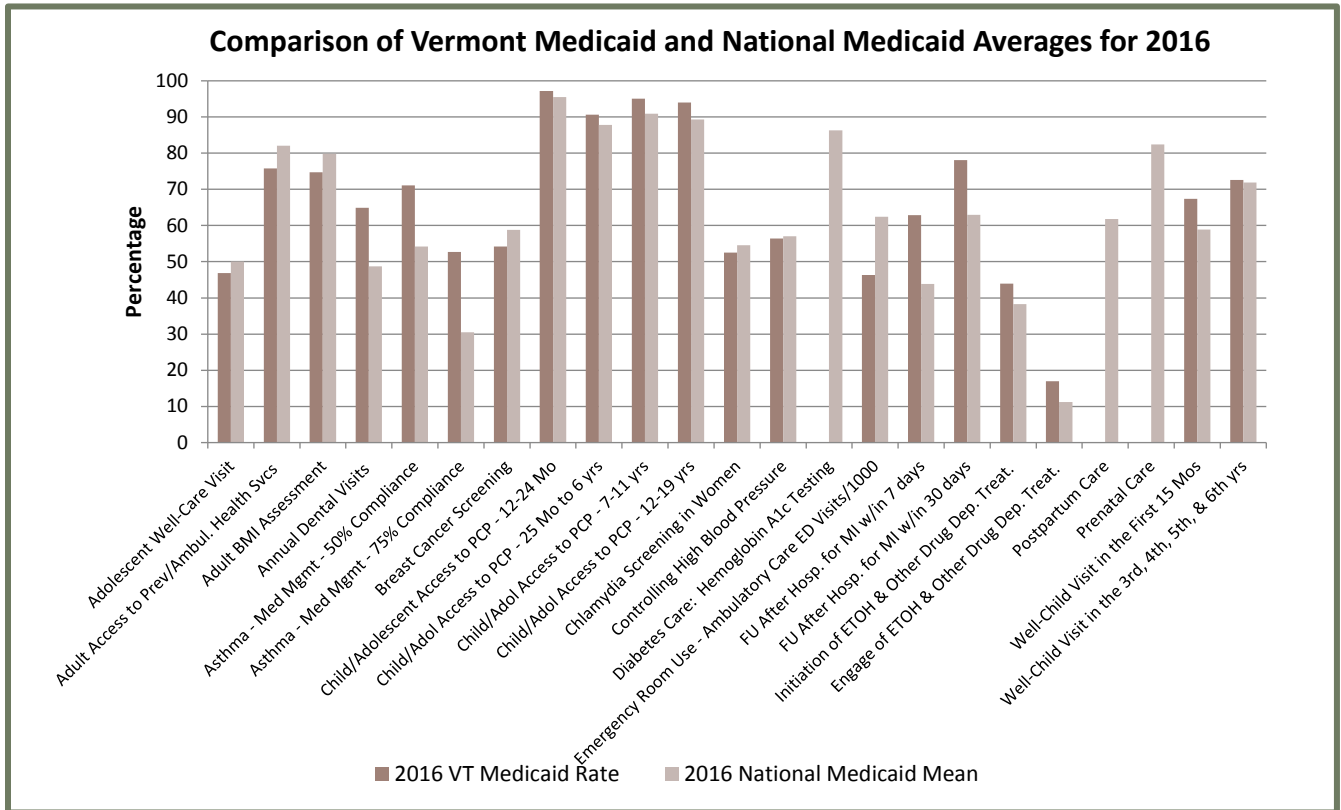
Note: Some measures do not have data reported for both years. This may be due to measures being retired from year to year or to lack of reliable data. For example, the DVHA was able to perform the medical record review required to report on Diabetes and Prenatal/Postpartum Care in 2015, but not in 2016.

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

	SFY14	SFY15	SFY16
Adult	$9,910,203	$9,030,443	$11,258,757
Detox	$3,744,272	$4,662,618	$2,739,904
Children	$7,559,074	$8,004,966	$6,970,719
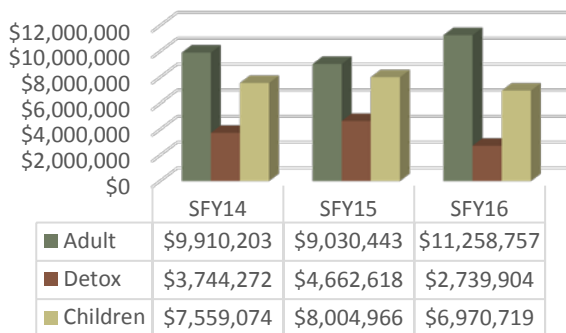
SFY 14-16 DVHA Total # Inpatient Hospitalizations

	SFY14	SFY15	SFY16
Adult	886	971	1,226
Detox	811	1,017	682
Children	395	420	422
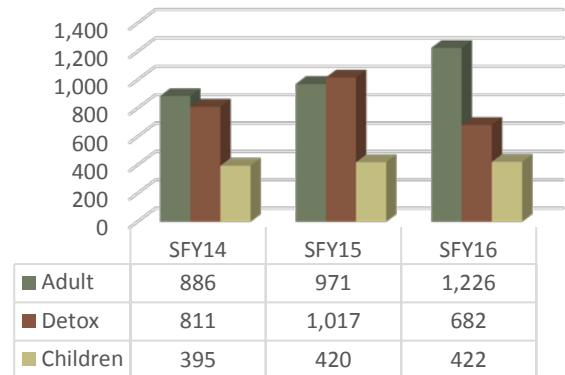
Below is an overview of the Mental Health and Substance Abuse Scorecard, as required of this Budget Document. See the full contents of the Mental Health and Substance Abuse Scorecard in Appendix D.

			Time Period	Actual Value	Current Trend		Baseline % Change	
O	DVHA	Vermonters Receive Appropriate Care						
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

			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%	↑
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%	↓

			Time Period	Actual Value	Current Trend		Baseline % Change	
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%	↑
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%	↓

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

Adult Medicaid	Dr Dynasaur	Long-Term Care	Prescription Assistance	Healthy Vermonters	Premium Assistance & Cost Sharing Reductions
• Low-cost or free health coverage for adults	• Provides low-cost or free health coverage for children, teenagers under age 19 and pregnant women. • Medicaid & CHIP populations	• Vermont's Long-Term Care Medicaid program helps eligible Vermonters pay for long-term care services in the setting of their choice.	• Vermont offers prescription assistance to uninsured Vermonters and those enrolled in Medicare. Eligibility is based on income, disability status and age.	• This program provides a pharmacy discount to eligible Vermonters, helping members purchase prescription drugs necessary to maintain their health and prevent unnecessary health problems.	• Financial subsidies towards premiums and cost sharing for members whose income is < 300%.

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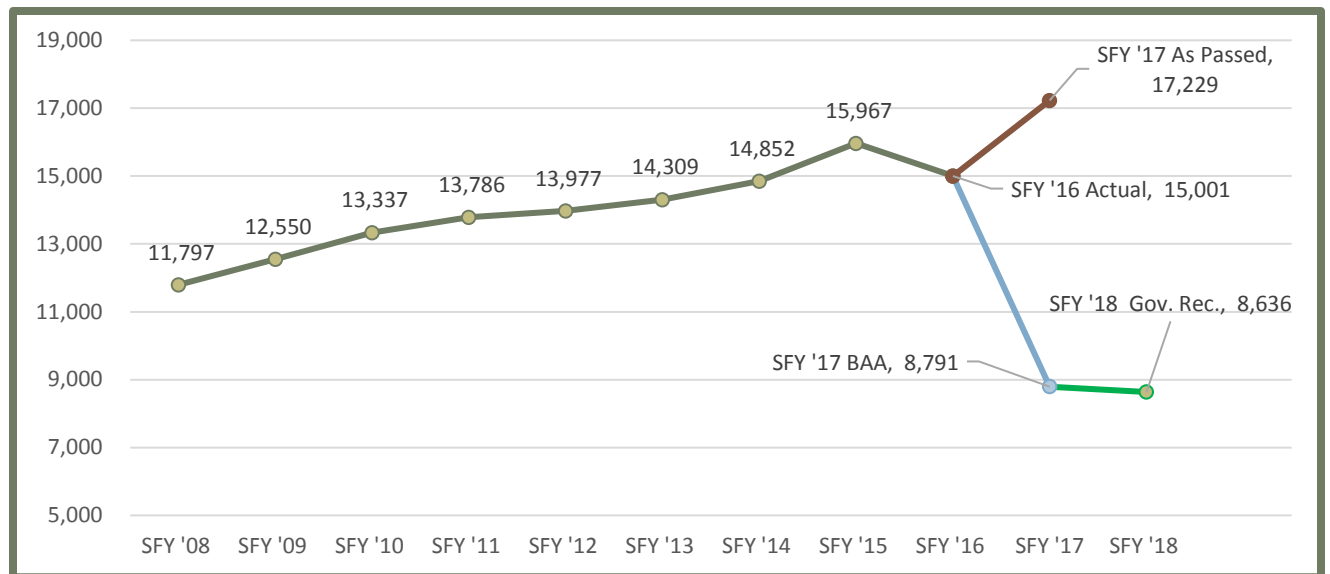
The eligibility and enrollment redetermination activities have resulted in higher PMPM expectations for SFY 2018 as the remaining population tends to have more health care needs.

ABD Adult SFY 2016 Average Enrollment Breakout by Age and Gender
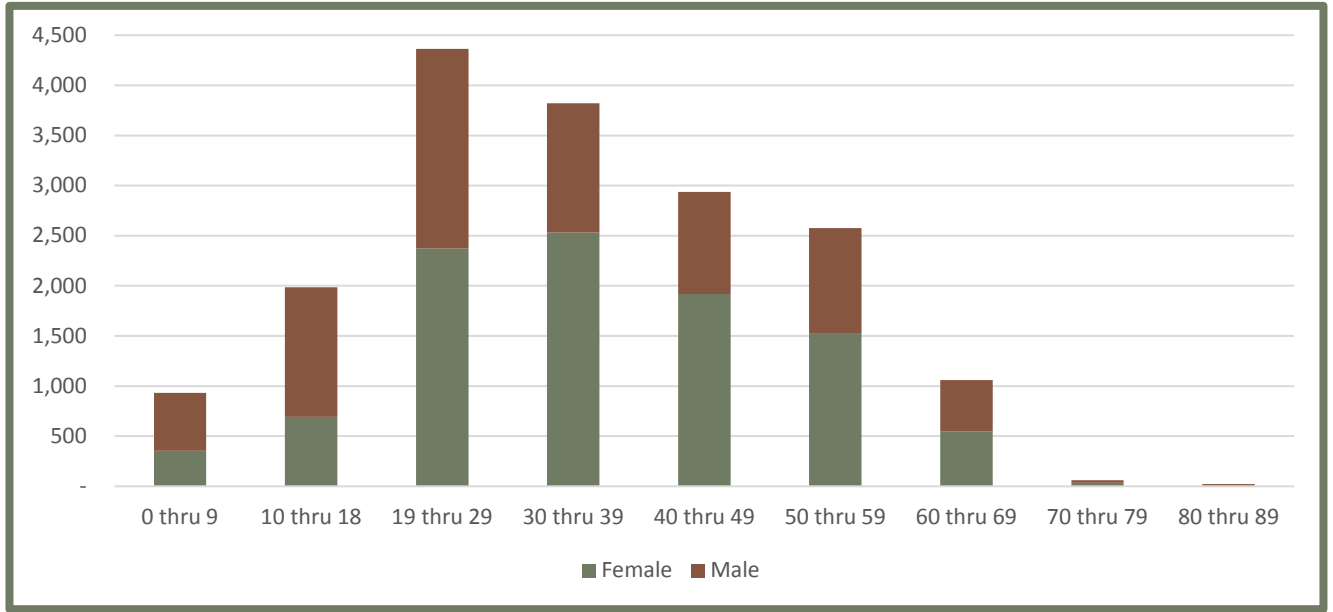
For adults with disabilities, pharmacy, outpatient, inpatient, and professional services accounted for the majority of the $99,308,972 total expenditure for ABD Adults.

DVHA Expenditures by Top 10 Service Categories
ABD Adults
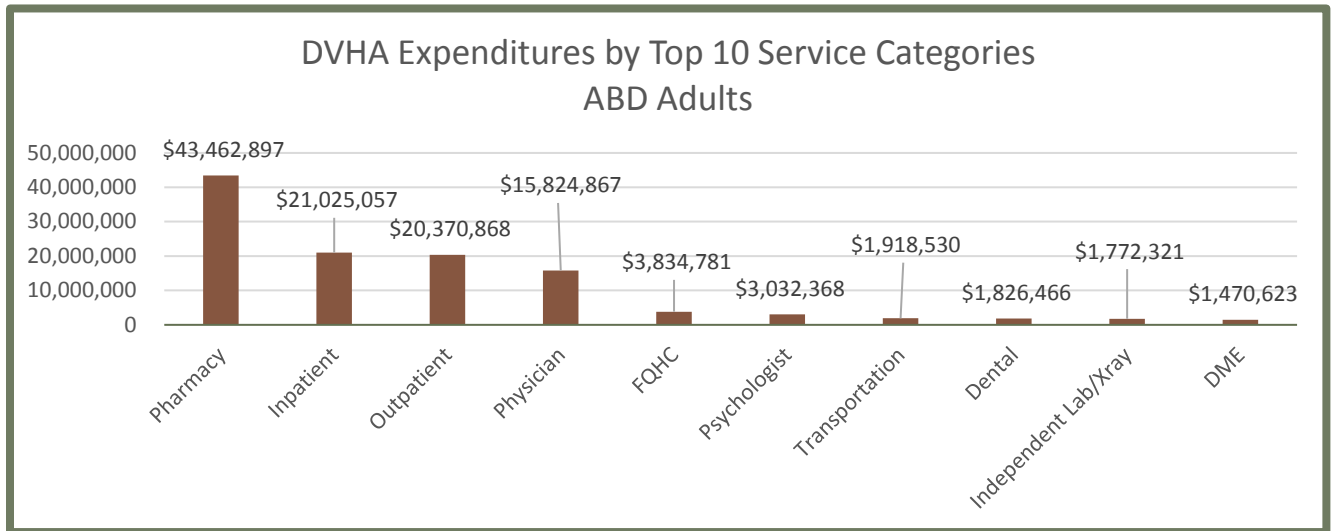
Dual Eligible

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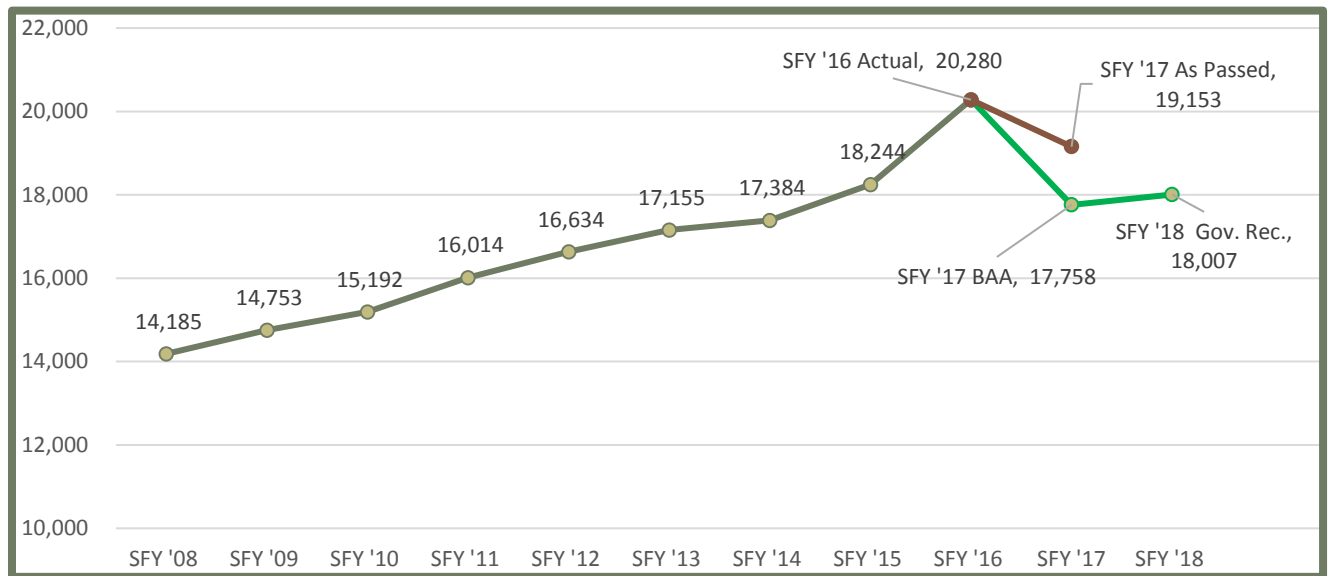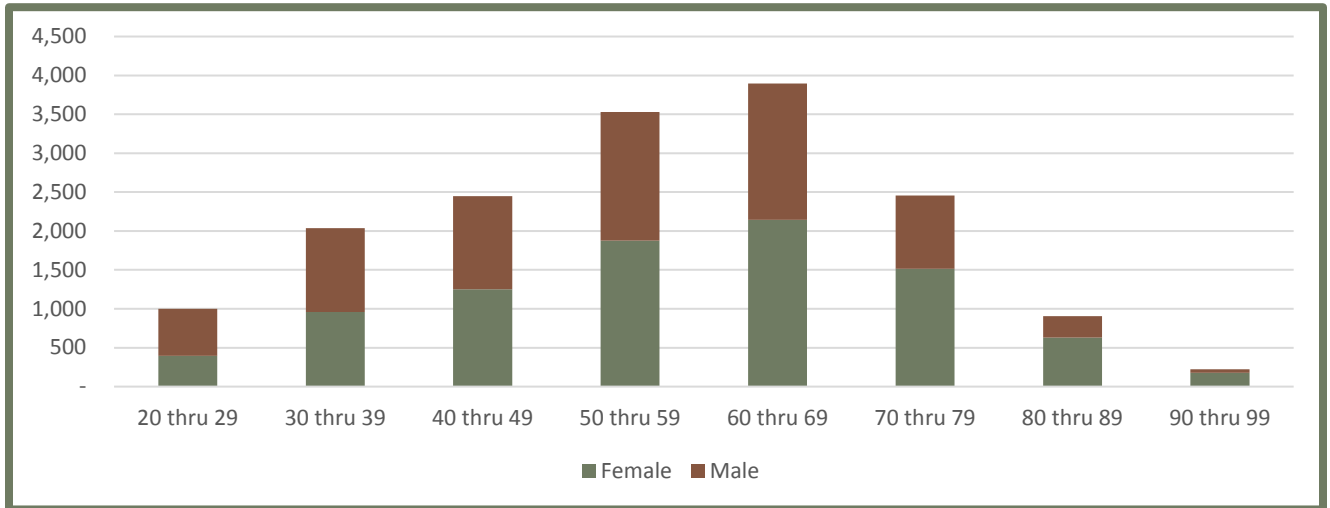
For the Dual Eligible population, outpatient, assistive community supports, inpatient, and professional services accounted for the majority of the $55,523,042 spend in SFY 2016. This population is covered by Medicare as the primary insurer, and Medicaid pays for co-insurance and deductibles, as well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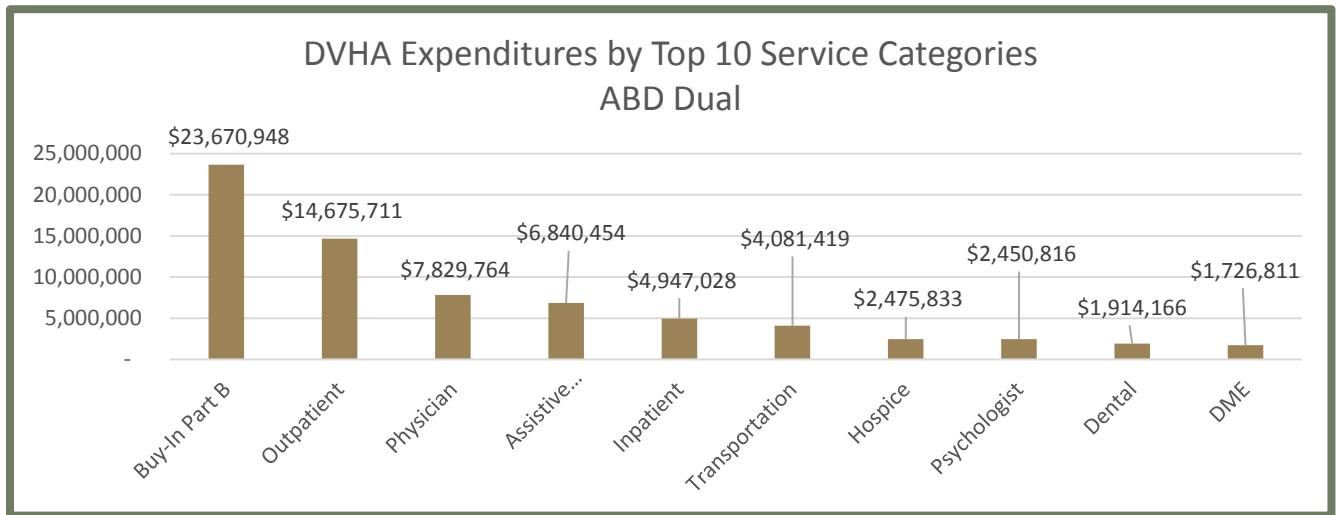
General Adults

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					
		DVHA Only		All AHS and AOE	
SFY	Caseload	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 Adult

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

DVHA Expenditures by Top 10 Service Categories
General Adult
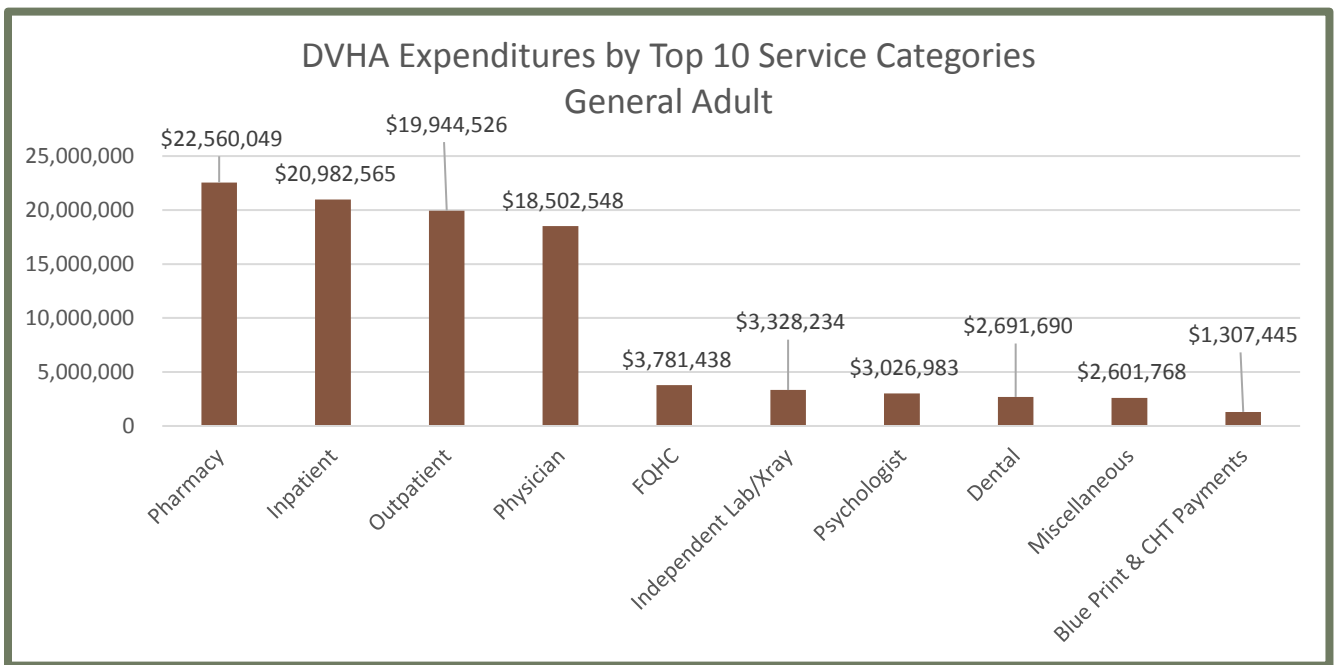
New Adult

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					
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
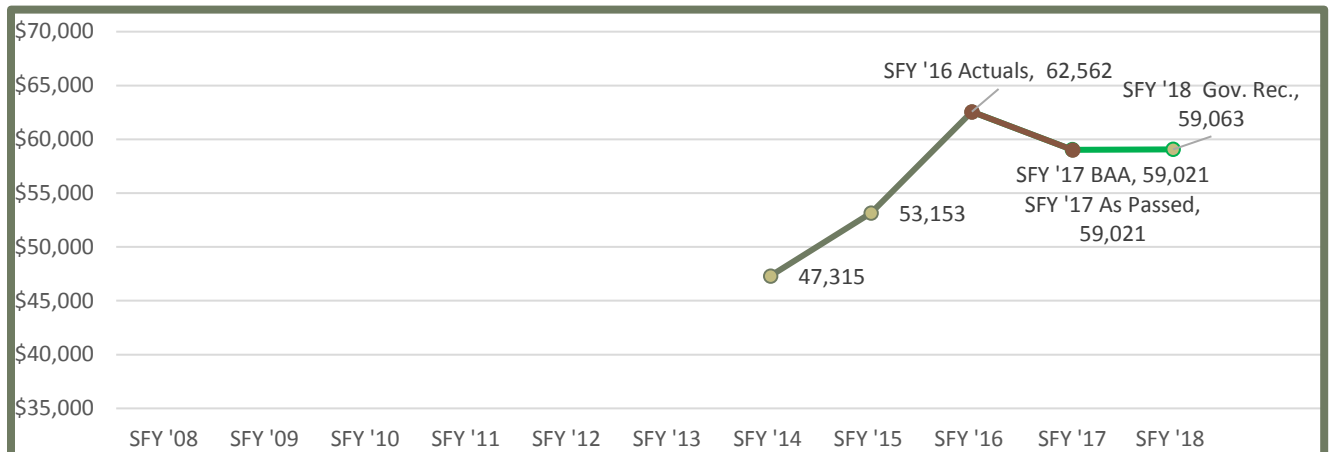
New Adults SFY 2016 Average Enrollment Breakout by Age and Gender
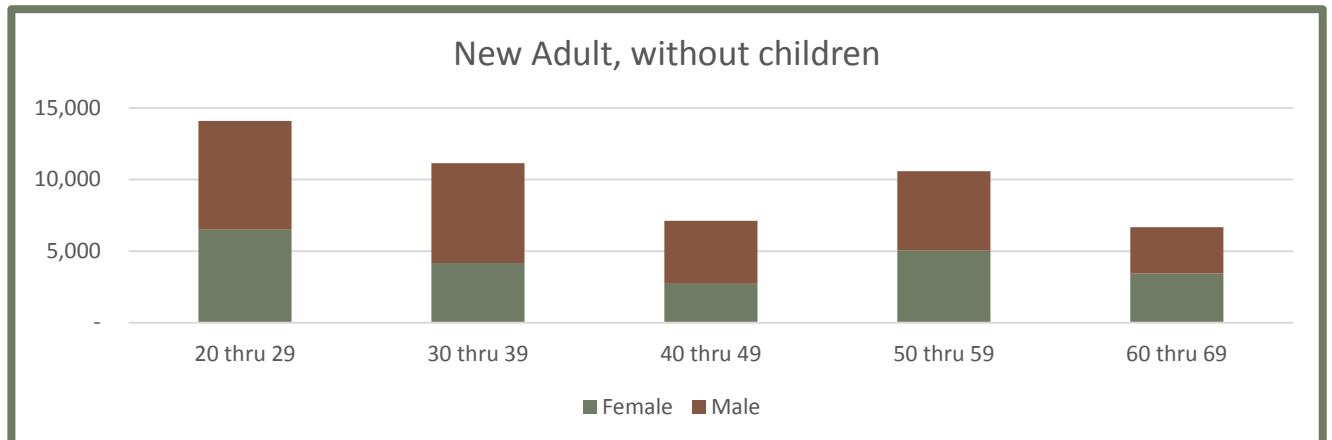
As is depicted in the FMAP table at the end of this chapter, the DVHA is able to claim enhanced federal participation for the new adult population without children.

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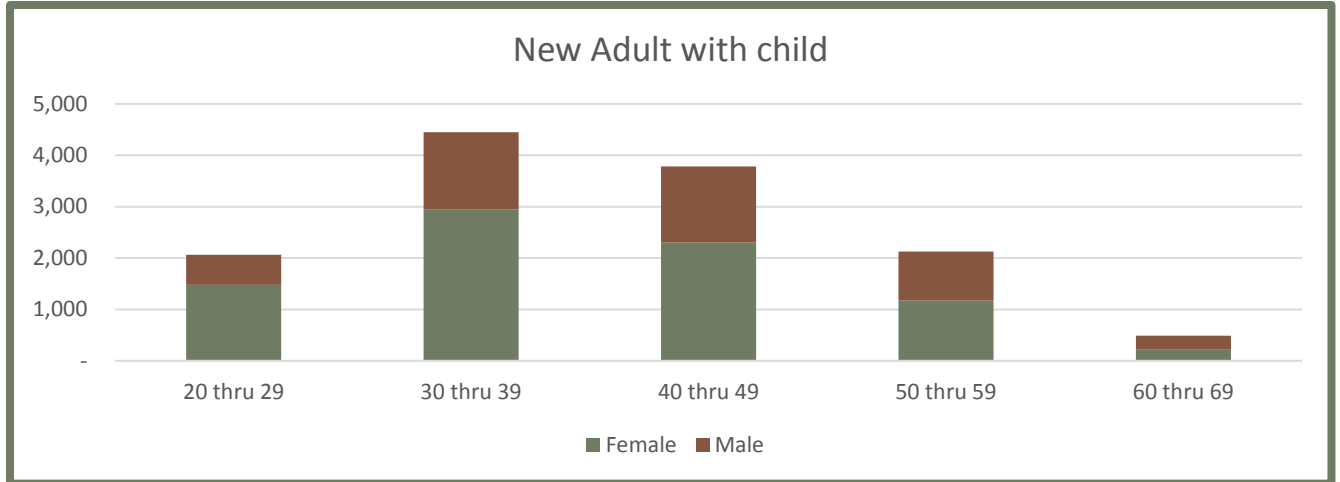
Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $248,721,362. New Adult utilization for lab services is partially due to the opioid dependency prevalence within this population.
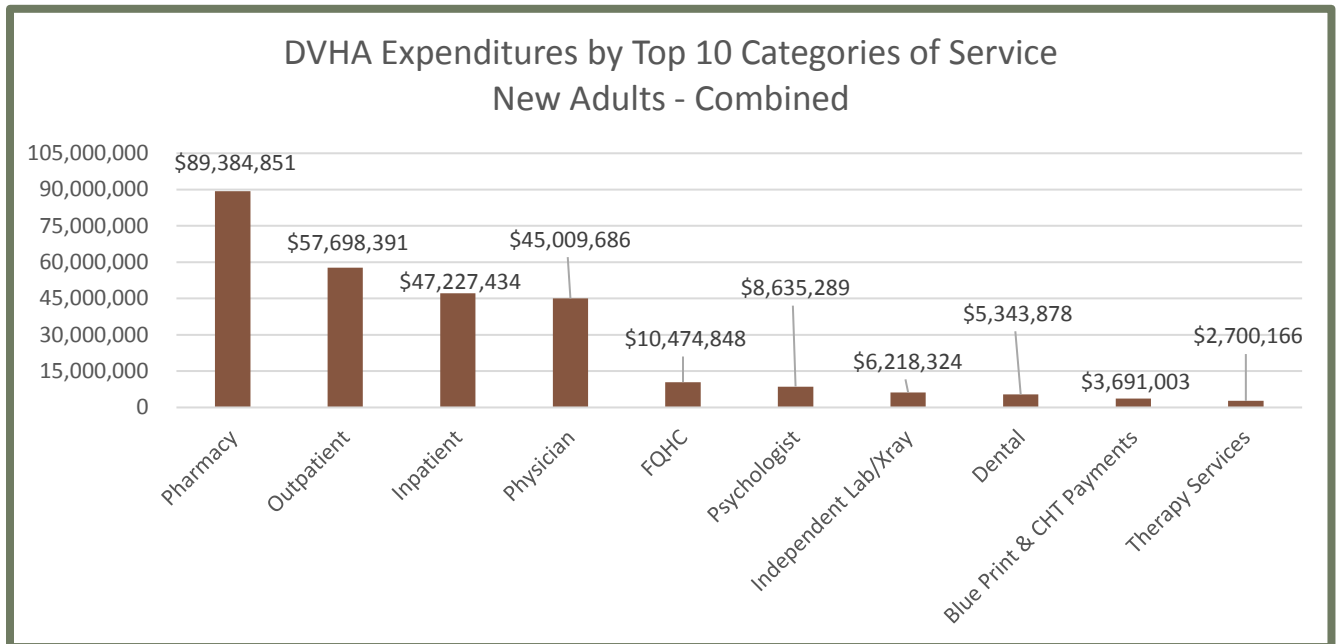
Prescription Assistance Pharmacy Only Programs

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			
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
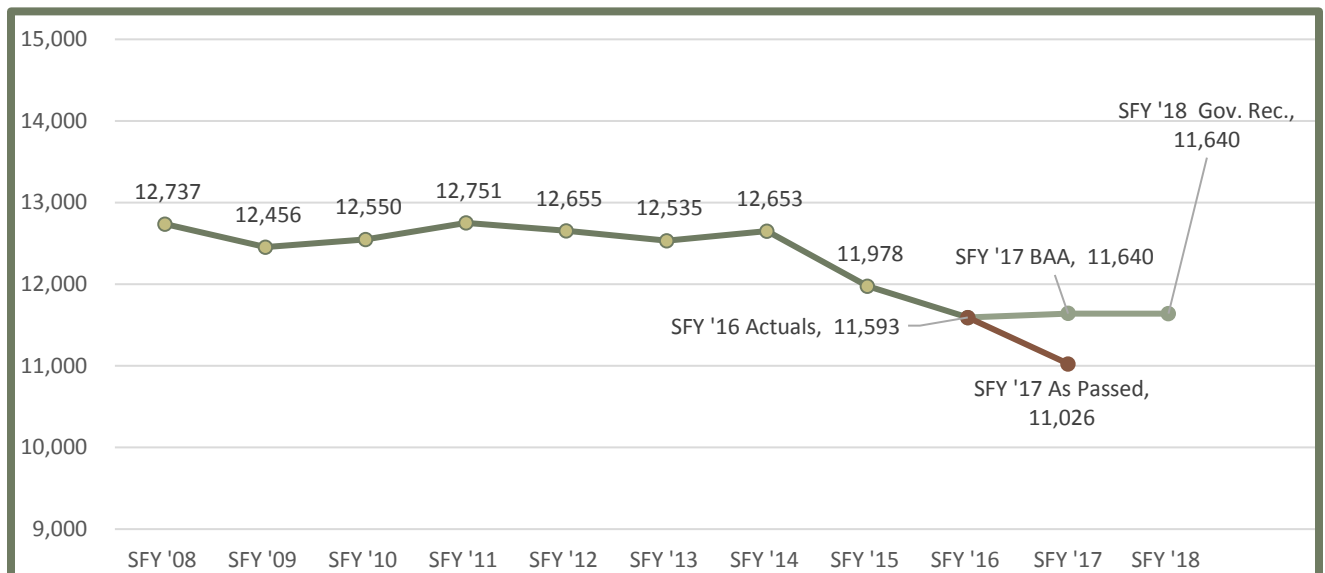
SFY 2016 Average Enrollment Breakout by Age and Gender
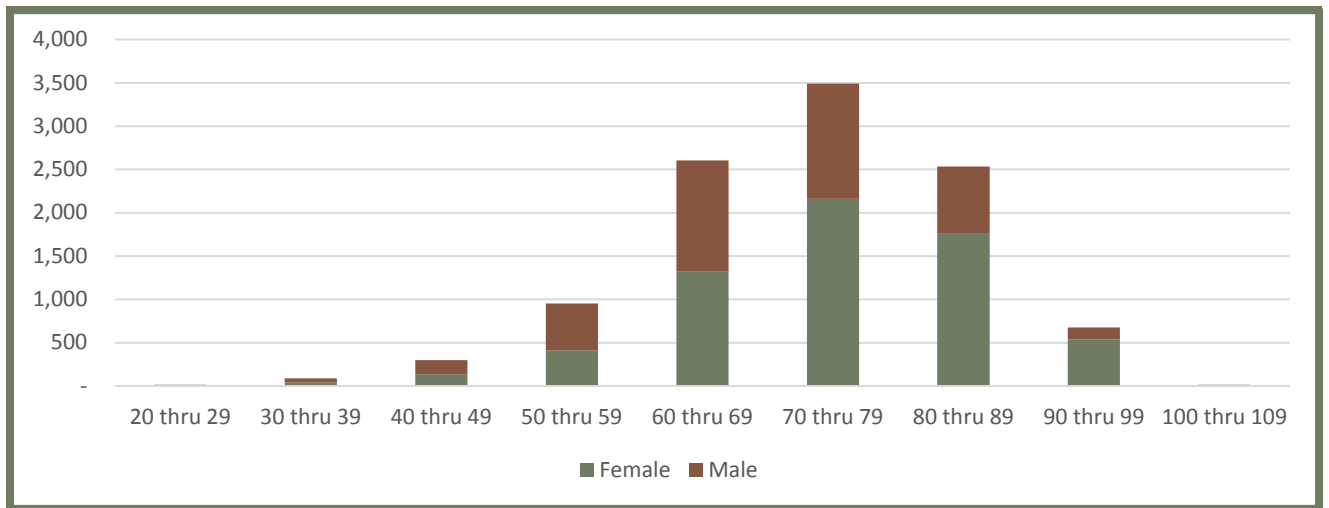
The general eligibility requirements for this subset are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, and enhanced residential care (ERC).

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

		DVHA Only		All AHS and AOE	
	Choices for Care				
SFY	Caseload	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
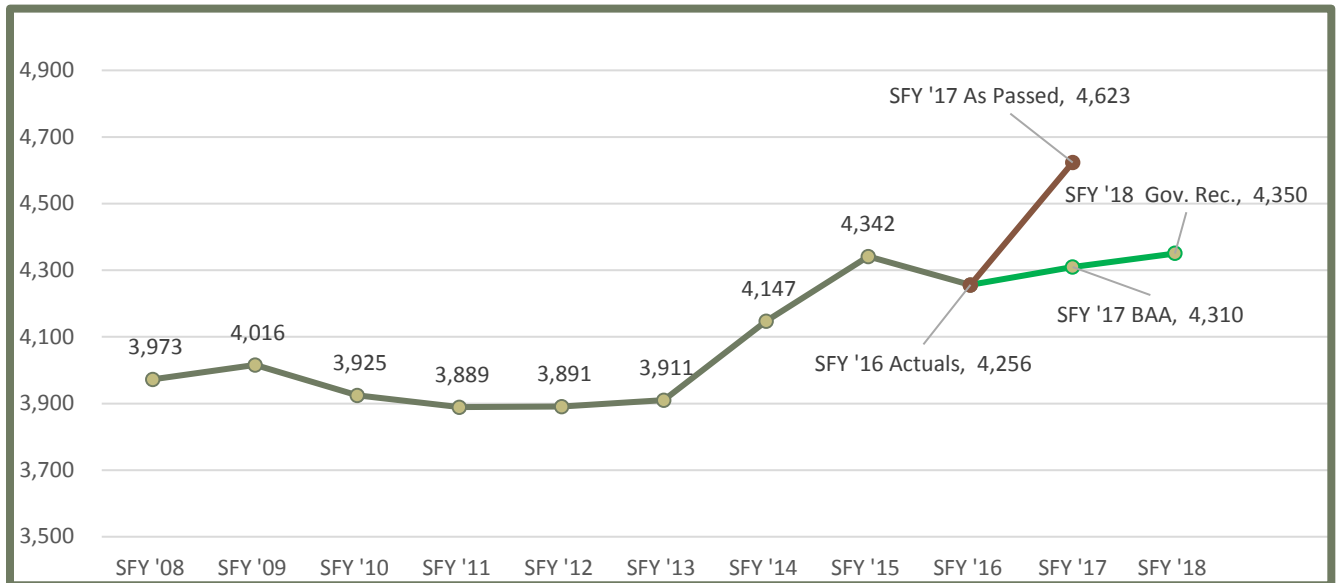
Choices for Care SFY 2015 Average Enrollment Breakout by Age and Gender
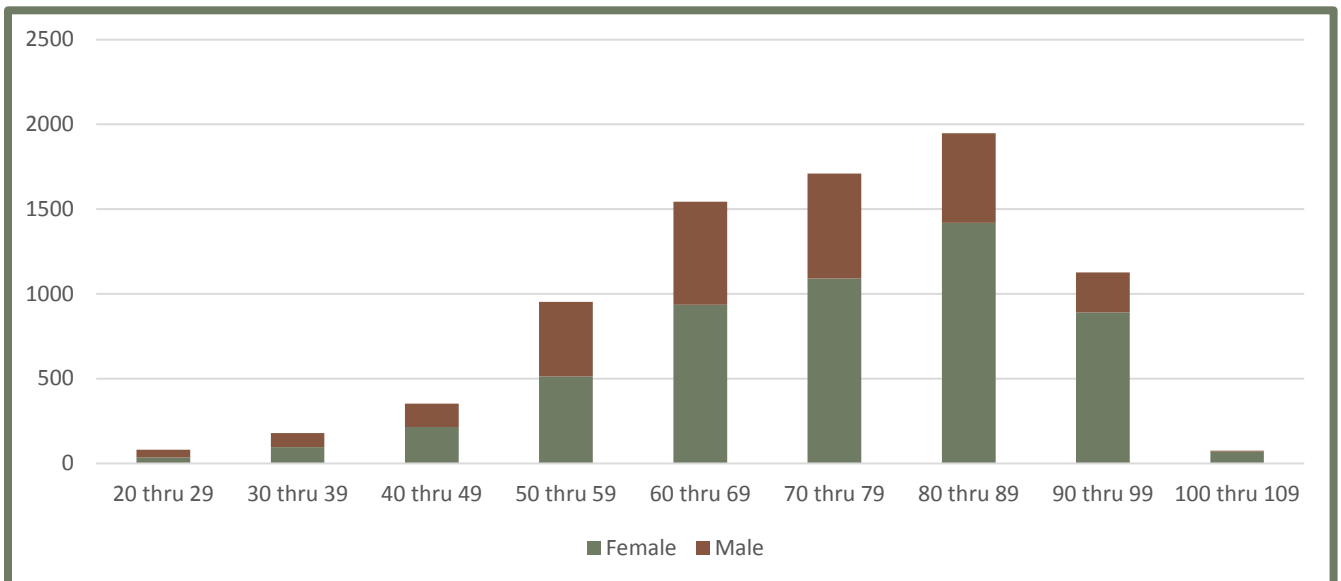
A high percentage of the Choices for Care costs relate to nursing home services. This highlights the need to promote Home and Community Based Services over the more costly option of nursing home services.

DVHA Expenditures by Top 10 Categories of Service
Choices for Care

Category	Amount
Nursing Home	$119,058,386
H&CB Services	$59,231,748
Enhanced Resident...	$9,052,417
Assistive Community...	$6,329,347
Inpatient	$5,008,998
Pharmacy	$3,832,468
Outpatient	$3,718,290
Buy-In Part B	$2,492,314
Physician	$2,380,507
Home Health	$1,734,010
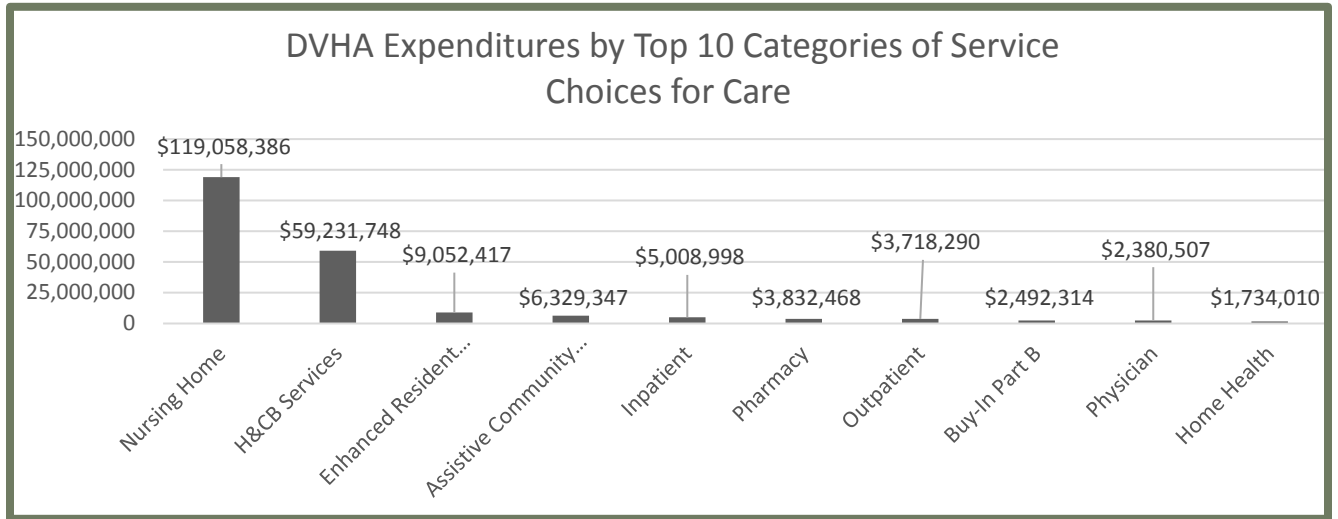
Healthy Vermonters

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			
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
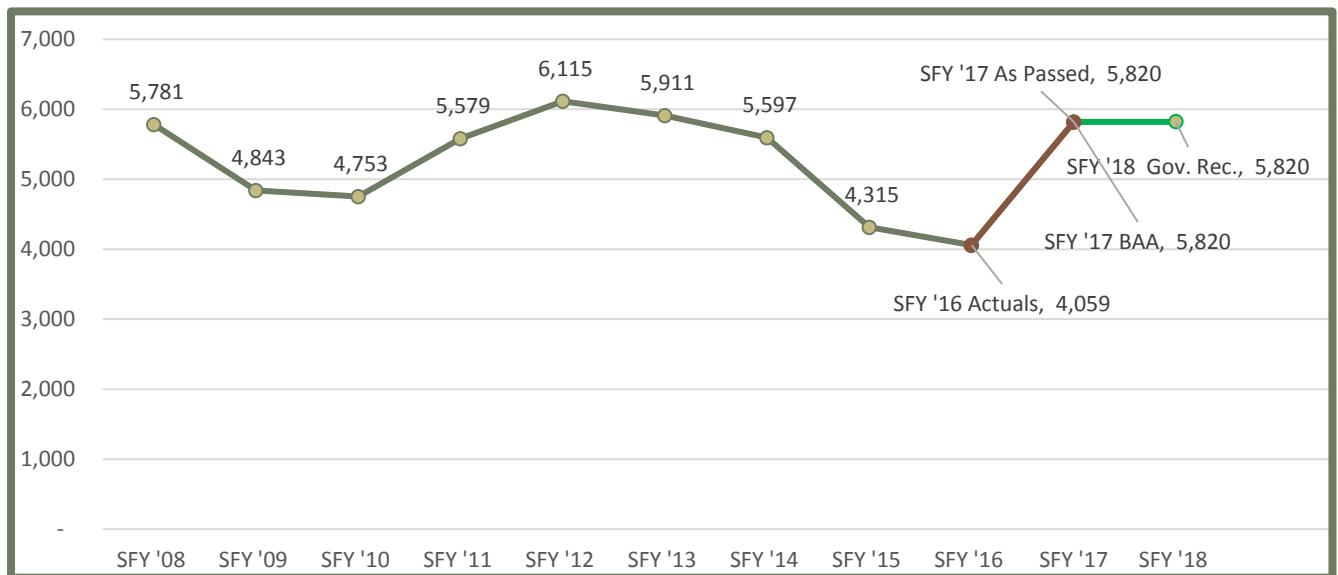
Blind or Disabled (BD) and/or Medically Needy Children

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 (PIL)]. 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					
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
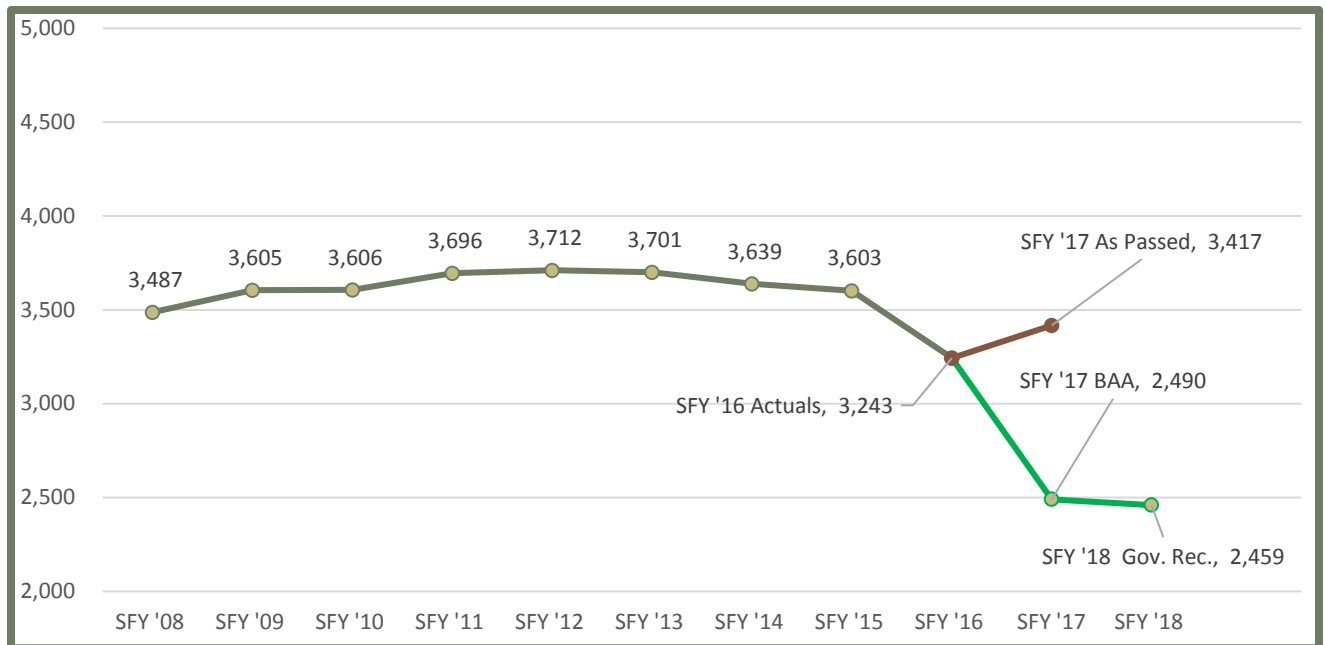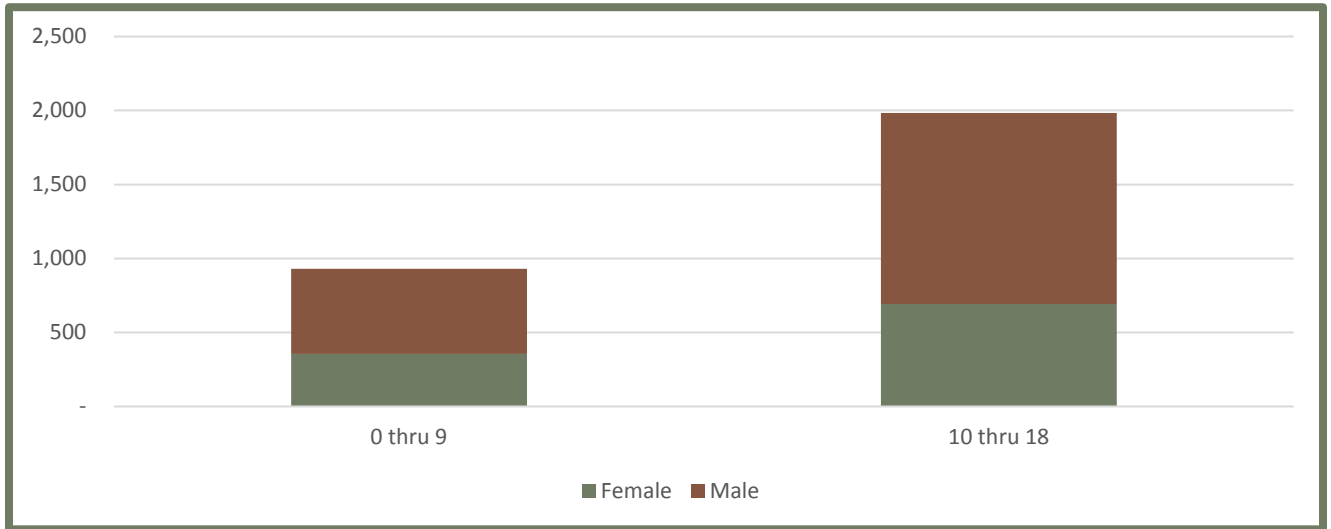
Personal Care Services, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $27,174,573.
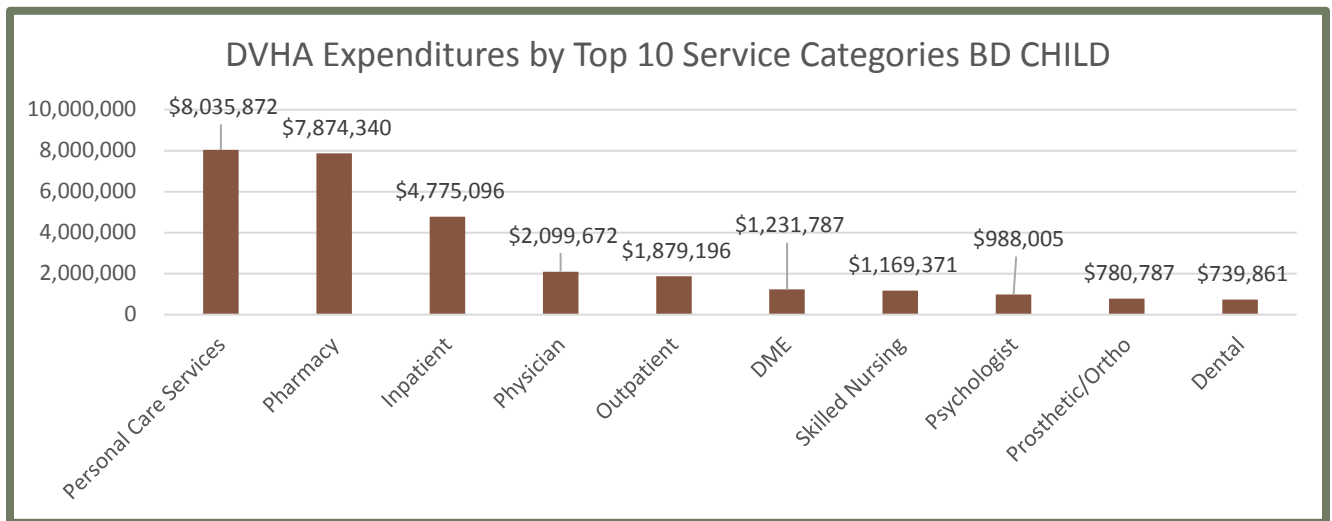
General Children

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			
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
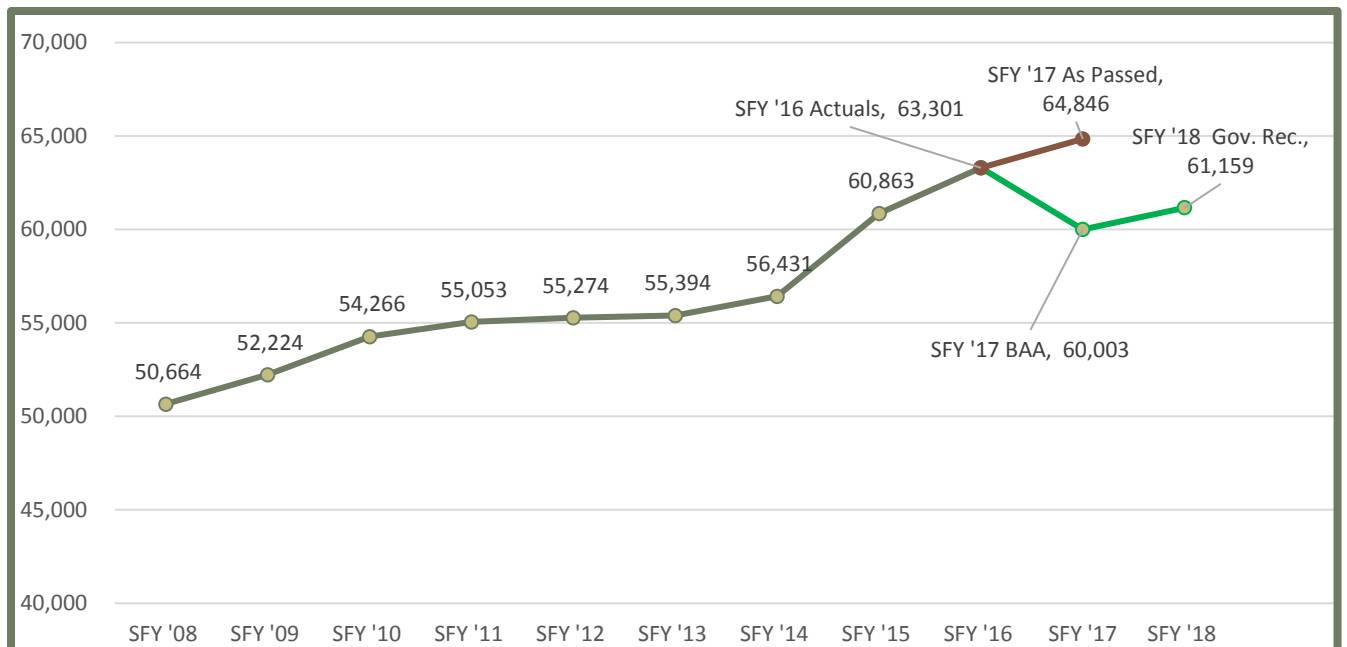
General Child SFY 2016 Average Enrollment Breakout by Age and Gender
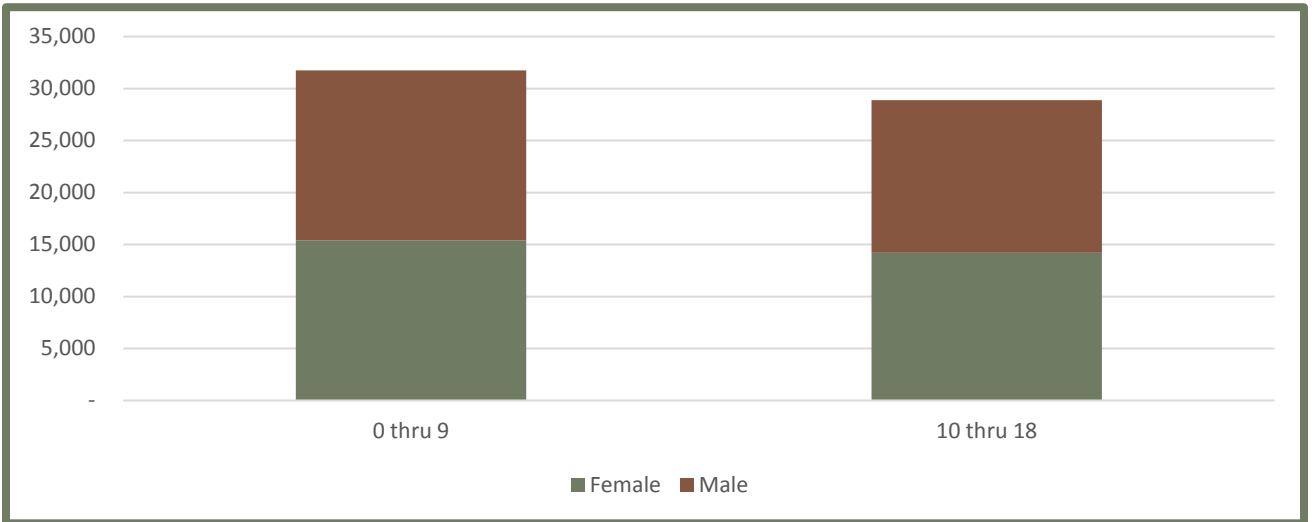
Professional services, inpatient, outpatient, and pharmacy (net drug rebate) accounted for the majority of the $151,736,910.

DVHA Expenditures by Top 10 Service Categories
General Child

Service Category	Expenditure
Pharmacy	$30,272,310
Physician	$29,564,049
Inpatient	$29,522,139
Outpatient	$22,805,602
Dental	$15,209,297
Psychologist	$8,882,389
FQHC	$7,832,684
Blue Print & CHT Payments	$4,634,958
Personal Care Services	$3,363,940
RHC	$3,034,871
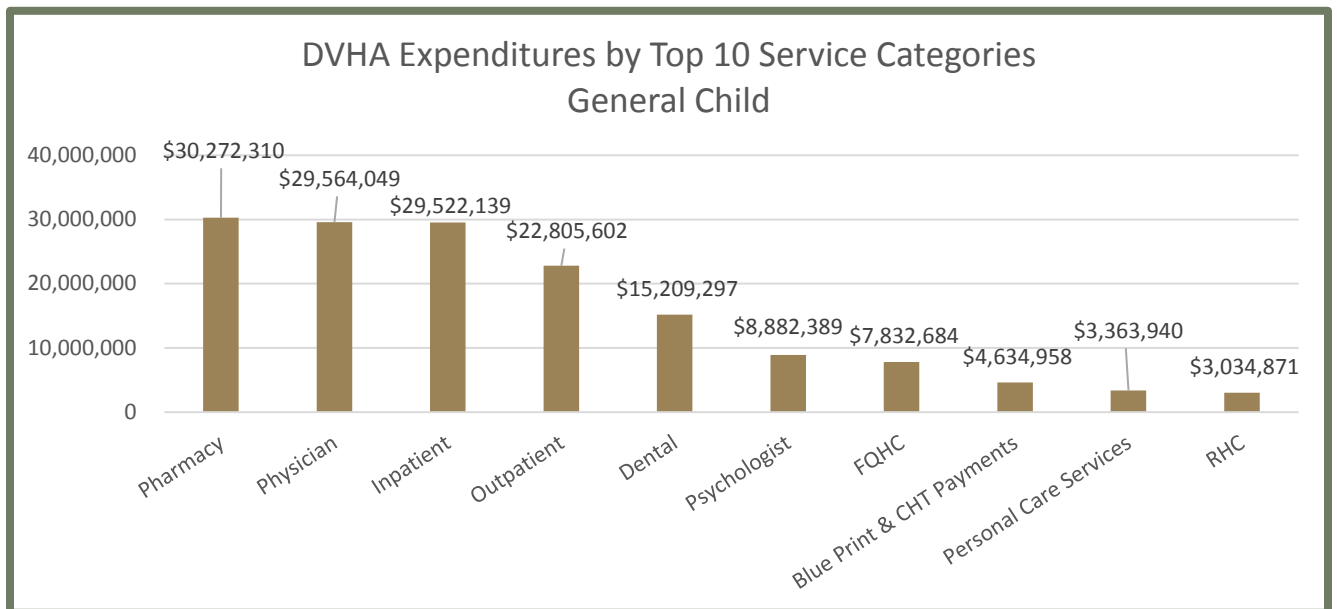
Optional Benefit Children

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					
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
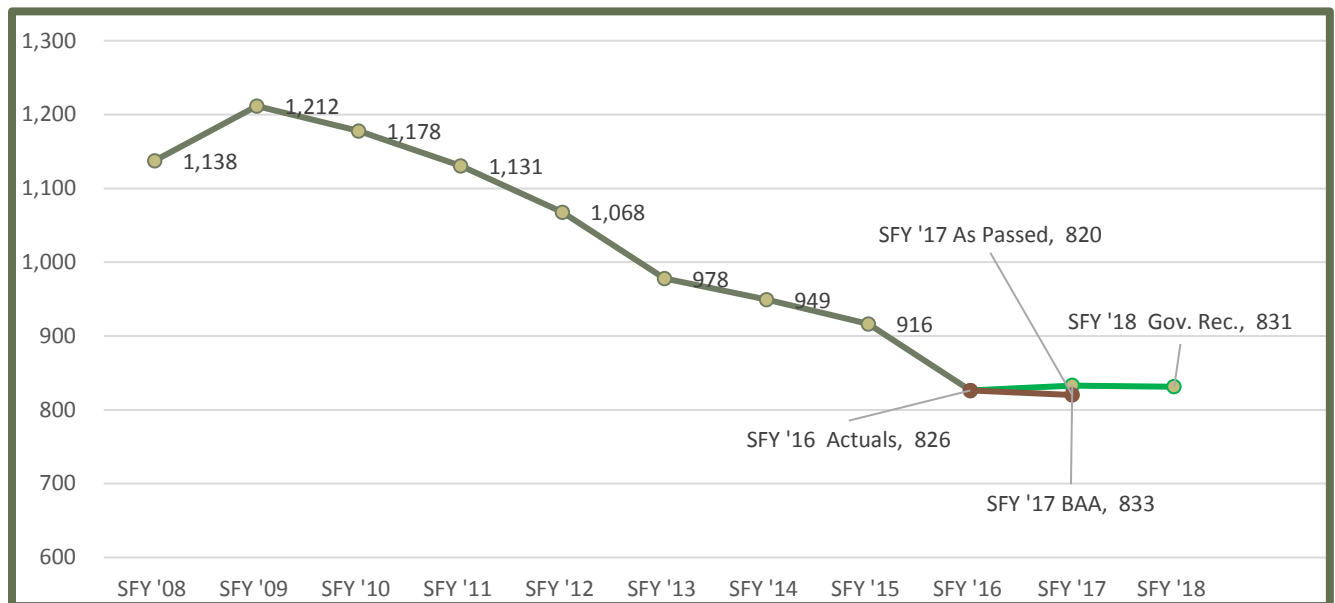
Optional Benefit Children SFY 2016 Average Enrollment Breakout by Age and Gender
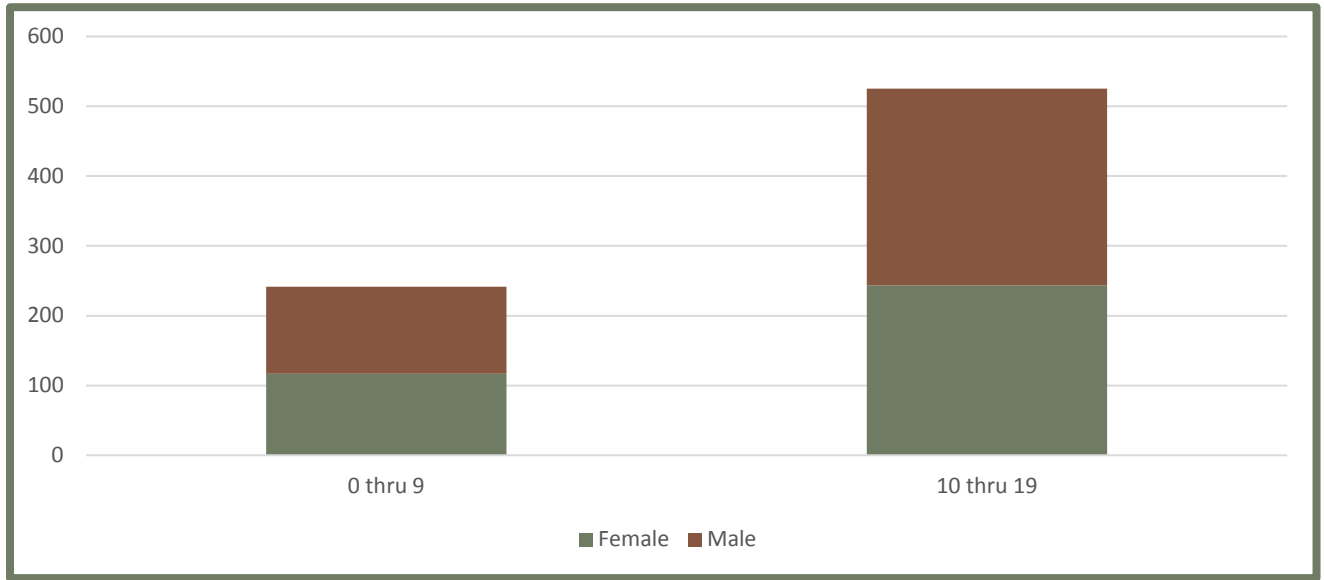
Inpatient, dental, personal care services, and professional services accounted for the majority of the $1,186,527.
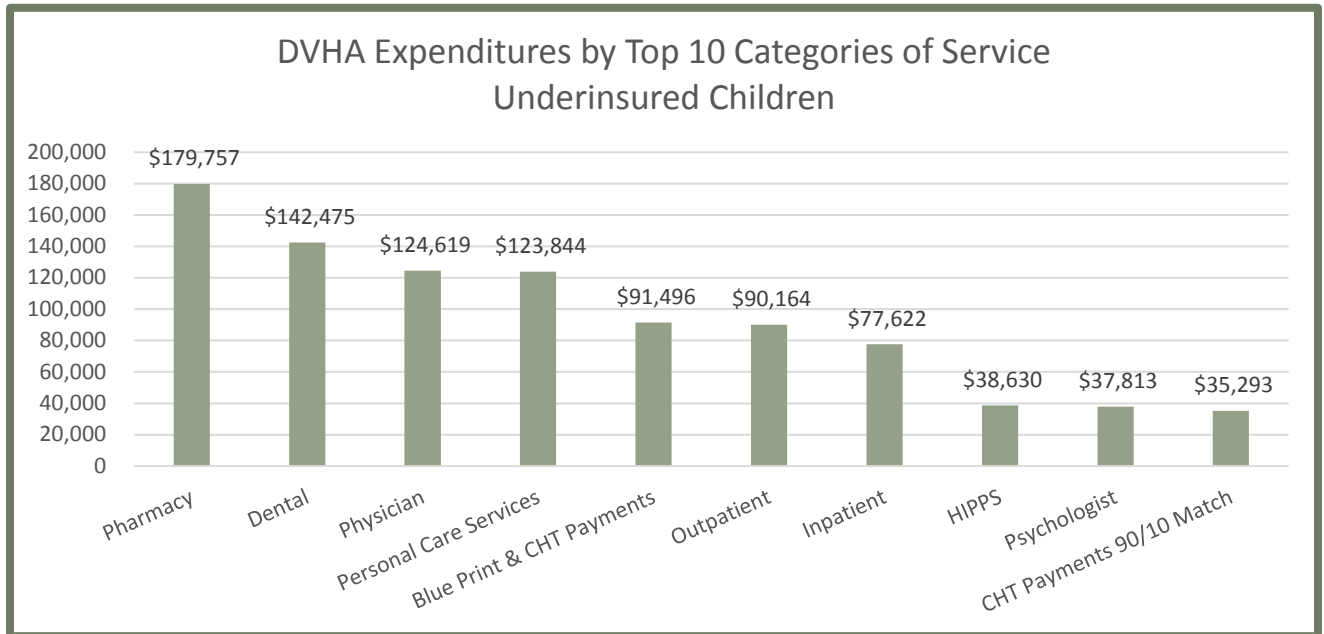
Children's Health Insurance Program (CHIP)

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)					
		DVHA Only		All AHS and AOE	
SFY	Caseload	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
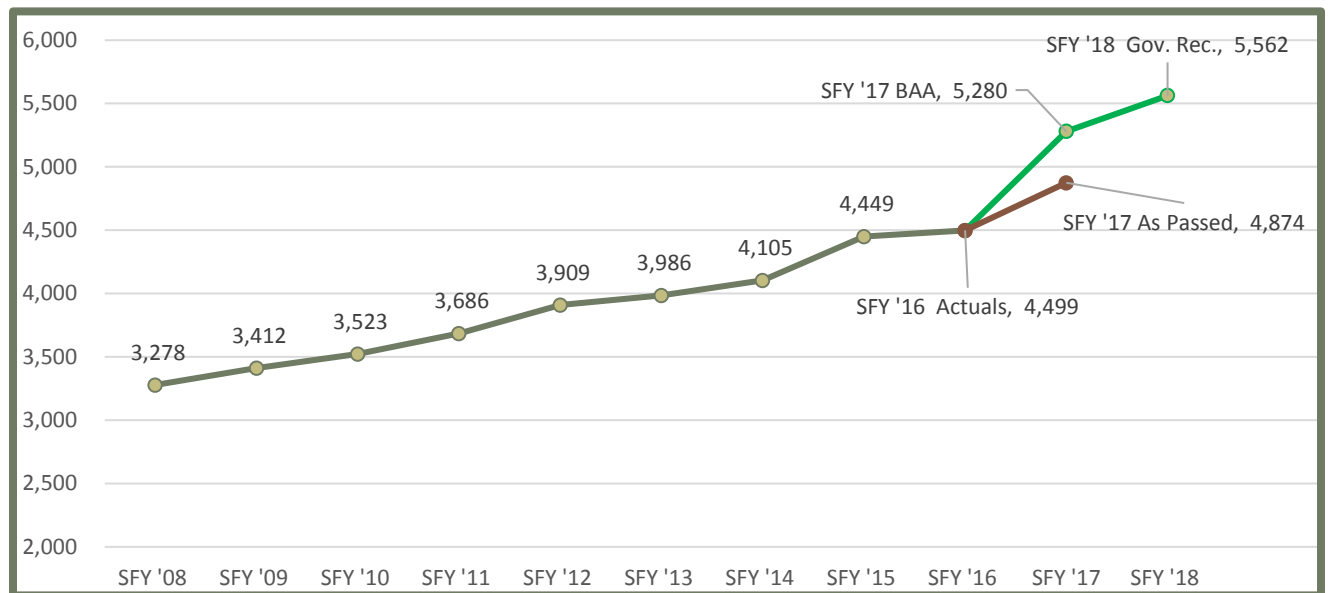
CHIP SFY 2016 Average Enrollment Breakout by Age and Gender
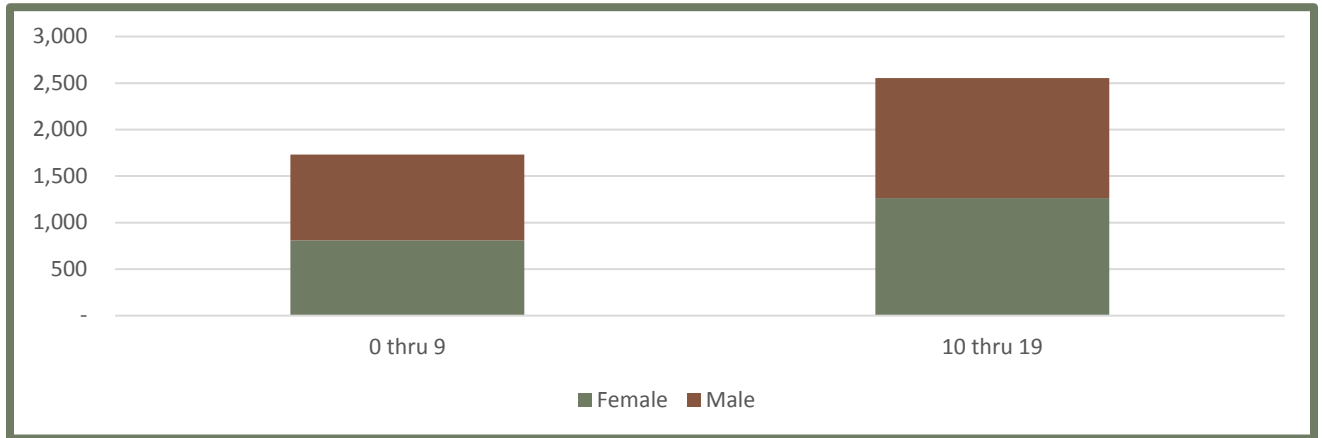
Professional services, outpatient, inpatient, and dental accounted for the majority of the $7,025,792.

DVHA Expenditures by Top 10 Categories of Service
CHIP

- Pharmacy: $2,201,793
- Outpatient: $1,482,348
- Physician: $1,316,928
- Dental: $1,135,886
- Inpatient: $543,895
- Psychologist: $421,646
- FQHC: $385,655
- Personal Care Services: $211,513
- RHC: $185,082
- PcPlus Case Mgmt and Special Program...: $121,635
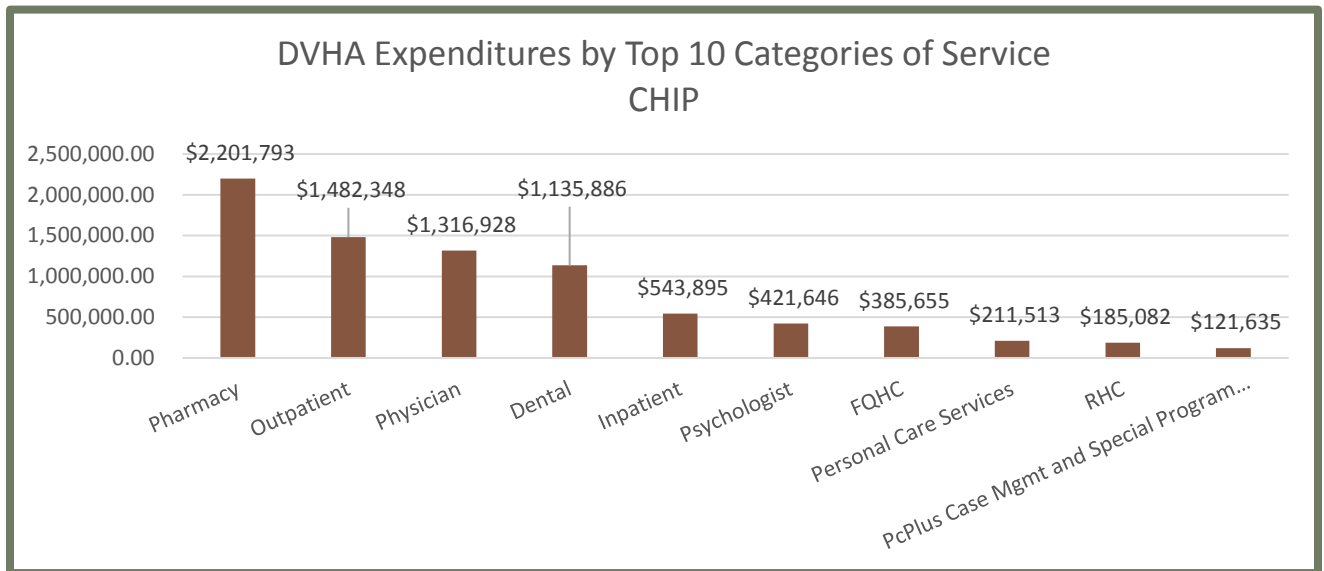
Premium Assistance and Cost Sharing

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

Premium Assistance Caseload Comparison by State Budget Cycle

- SFY '17 As Passed, 17,588
- SFY '18 Gov. Rec., 16,828
- 14,013
- 13,177
- SFY '17 BAA, 15,831
- SFY '16 Actuals, 14,893

Cost Sharing Reduction Caseload Comparison by State Budget Cycle

Cost Sharing Reduction Caseload Comparison by State Budget Cycle

- SFY '17 BAA, 5,646
- SFY '17 As Passed, 5,358
- 5,322
- SFY '16 Actuals, 5,340
- SFY '18 Gov. Rec., 5,376
- 4,452
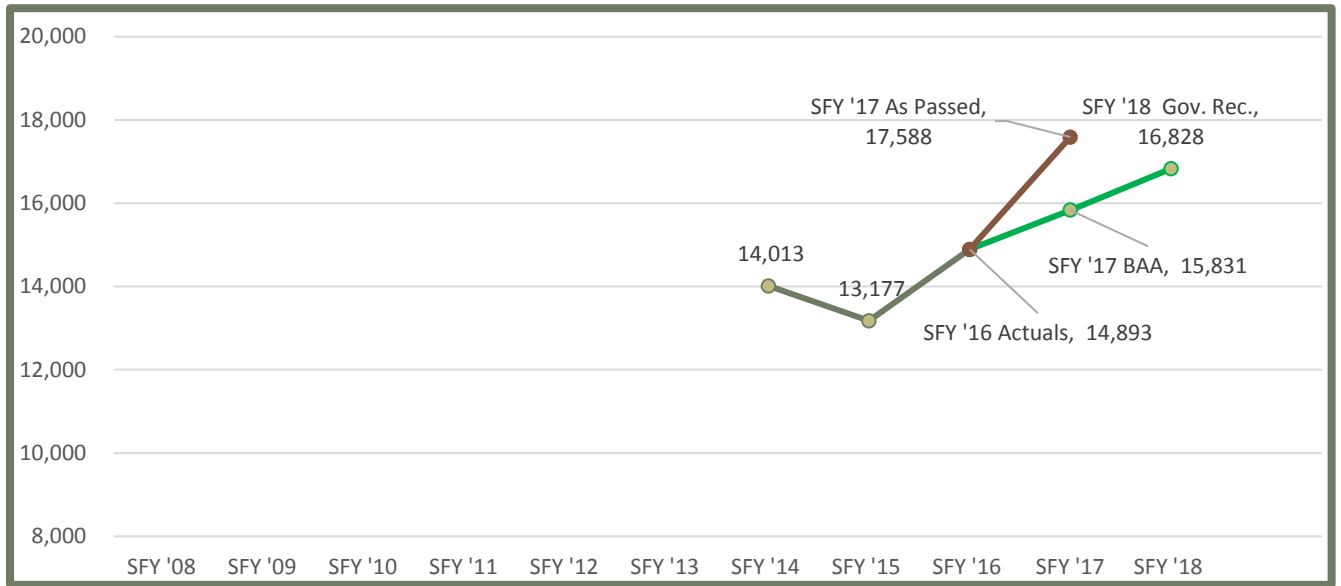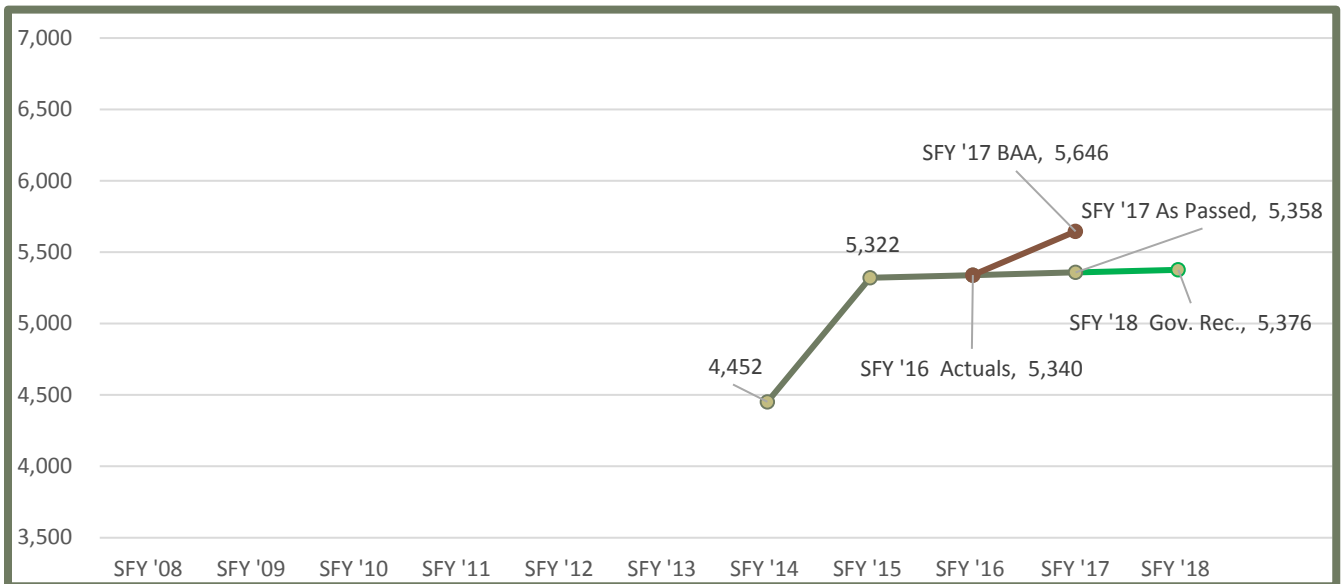
The summary below displays the distribution of Vermont Medicaid programs by population served with DVHA and non-DVHA PMPMs. Spending per member per month is highly variable. For example, the large number of children in the General Child category have a much lower per person cost then enrollees in Choices for Care.

DVHA and Non-DVHA PMPM and Enrollment

	General Child	New Adult	ABD Dual	Premium Assist.	General Adult	Pharmacy Only	ABD Adult	Cost Sharing	CHIP	Choices for Care	BD Child	Optional
SFY '18 Non-DVHA PMPM	$197.41	$41.84	$810.22	$-	$73.43	$-	$866.26	$-	$40.90	$50.36	$2,009.12	$122.94
SFY '18 DVHA PMPM	$213.54	$388.68	$275.66	$28.26	$467.72	$45.72	$715.91	$19.10	$139.13	$4,360.07	$846.72	$123.31
SFY '18 Enroll	61,159	59,063	18,007	16,828	15,222	11,640	8,636	5,376	5,562	4,350	2,459	831

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 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
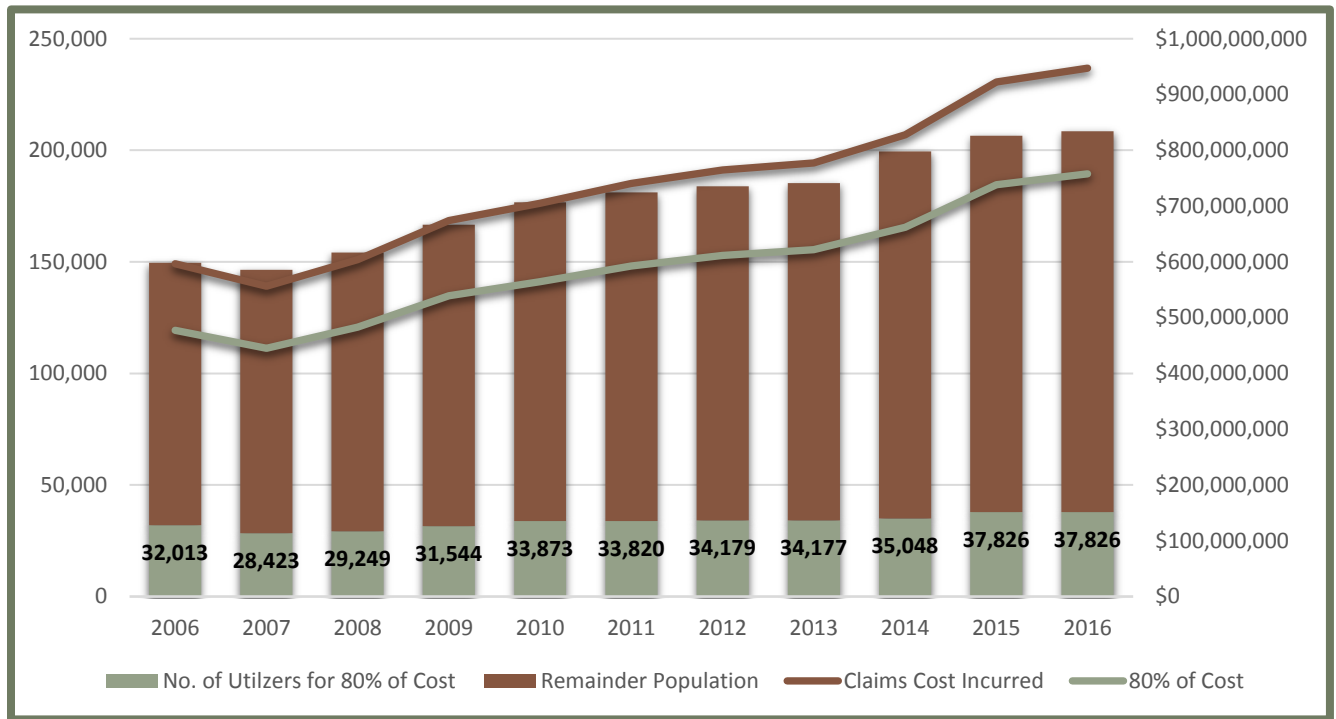
The chart above demonstrates the historical trend of the highest cost utilizers. The population in green accounts for 80% of all claim based spend. In-depth analysis indicated that most costs are either born in the first three months of gaining Medicaid eligibility or attributed to members with chronic 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[1].

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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[1] 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. [2] [3]

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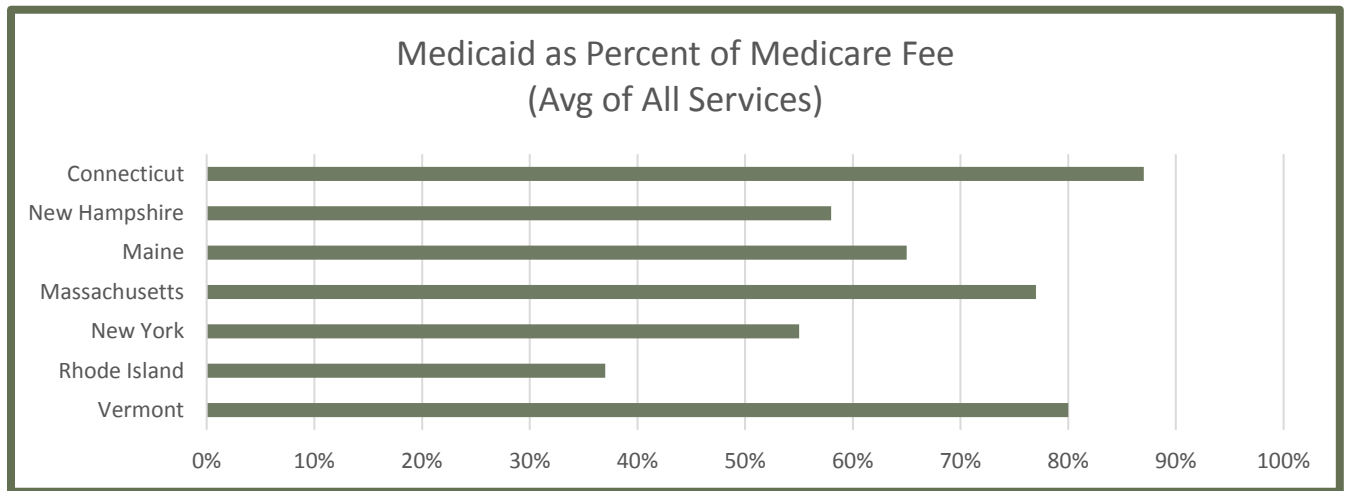
State	Number of Medicaid & CHIP enrollees July 2014	Acute Care	PMPY Acute Care Estimate	Long-Term Care	PMPY LTC Estimate	DSH Payments	Total	Total PMPY
Connecticut	753,927	$4,194,040,934	$5,563	$2,888,126,680	$3,831	$149,024,544	$7,231,192,158	$9,591.37
Maine	280,241	$1,590,280,368	$5,675	$827,567,260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

[2] http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

[3] 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.

United States Spending Projections for Specialty Drugs 2012 - 2020
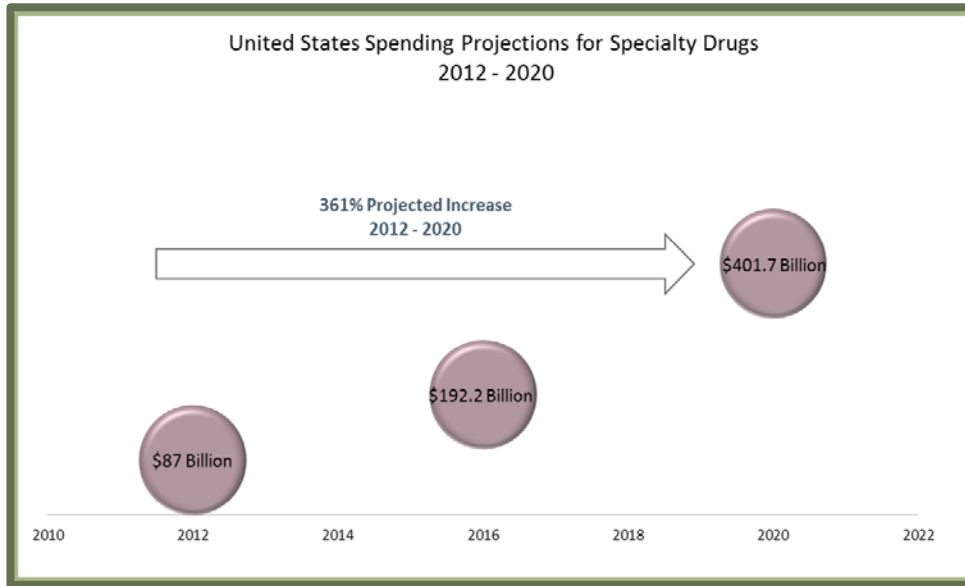
National spending on specialty medications increased in 2015, due almost entirely to increases in unit cost. Although generic availability in some of these classes exist, changes to drug formulation are needed to address mutations in virus strains that cause resistance to drugs. Additionally, some medications which have generic versions available, older HIV drugs for example, must be used in combination with other, newer and more expensive, medications.

Vermont Medicaid Specialty Cost Increases SFY 2013 - SFY 2016
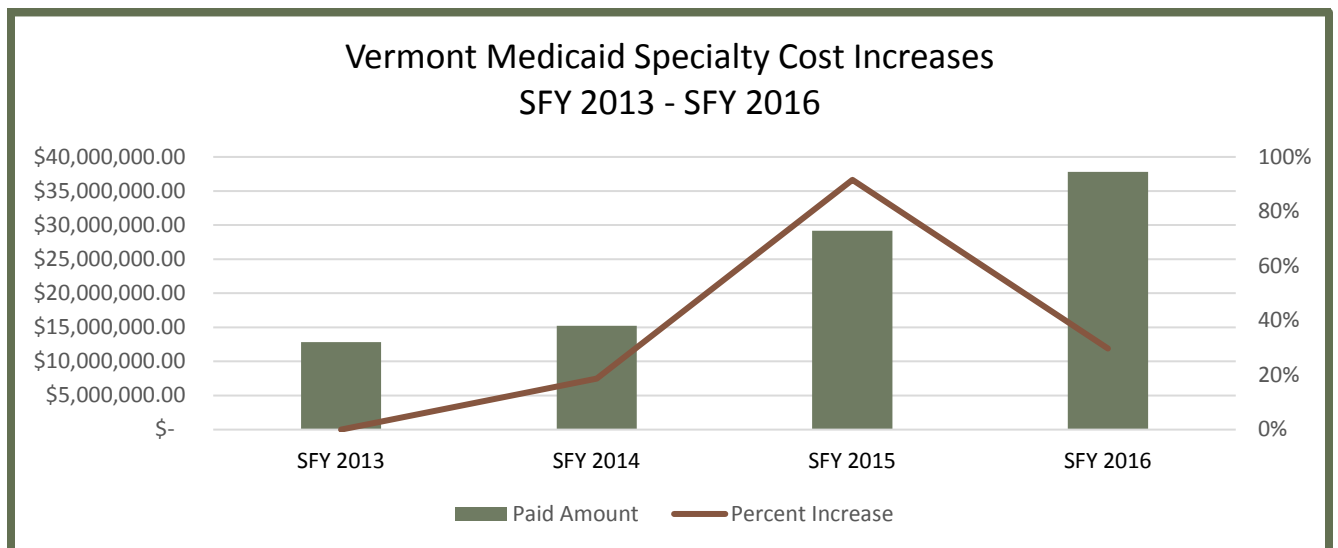
Beyond the prescription drug concerns, the healthcare delivery system in a fee-for-service model has proven to be unsustainable for Vermont and the nation. The chart below demonstrates the changes in spend distribution over the last ten years.
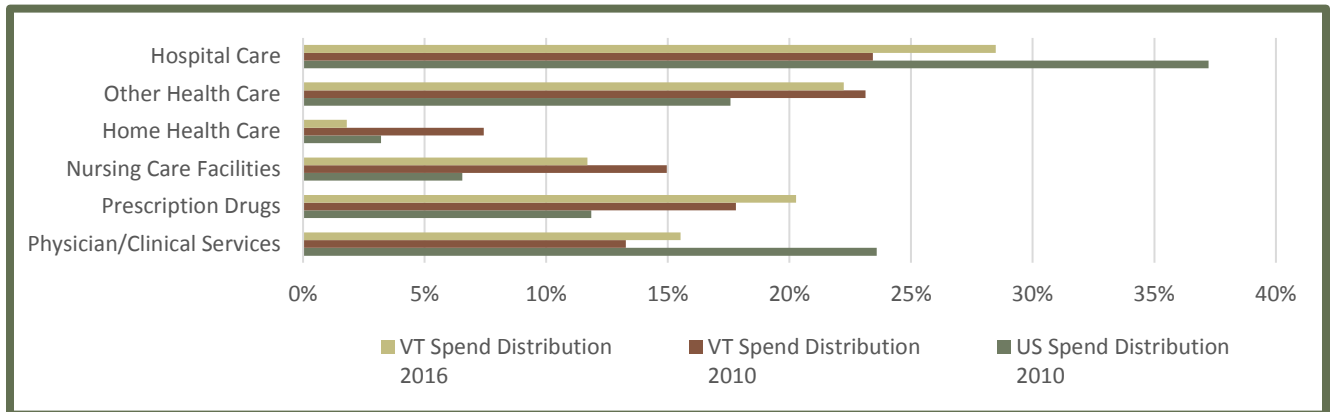
Note: Other Health Care includes dental, mental health providers, durable medical equipment, etc. Physician/Clinical Services includes FQHC and RHC sites of service.

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

	Pharmacy	Inpatient	Outpatient	Physician
SFY '11	$135,324,325	$120,626,500	$86,164,038	$82,286,989
SFY '12	$141,489,575	$124,976,218	$96,708,962	$83,113,724
SFY '13	$142,487,399	$139,465,672	$105,809,155	$127,958,253
SFY '14	$155,968,210	$142,210,222	$105,935,021	$113,176,148
SFY '15	$185,563,094	$142,937,378	$128,812,484	$116,996,204
SFY '16	$208,281,067	$149,263,989	$143,456,449	$123,330,113
SFY '17 BAA	$205,374,095	$146,917,102	$136,183,386	$126,830,407
SFY '18 GR	$212,306,256	$149,147,410	$140,621,705	$134,729,465

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.

Total Medicaid Spending per Resident (FY 2014)

Legend:
- United States
- Connecticut
- Maine
- Massachusetts
- New Hampshire
- New York
- Rhode Island
- Vermont

Values: 1,492 · 2,025 · 1,831 · 2,152 · 1,039 · 2,752 · 2,343 · 2,517

Medicaid Spending per Resident
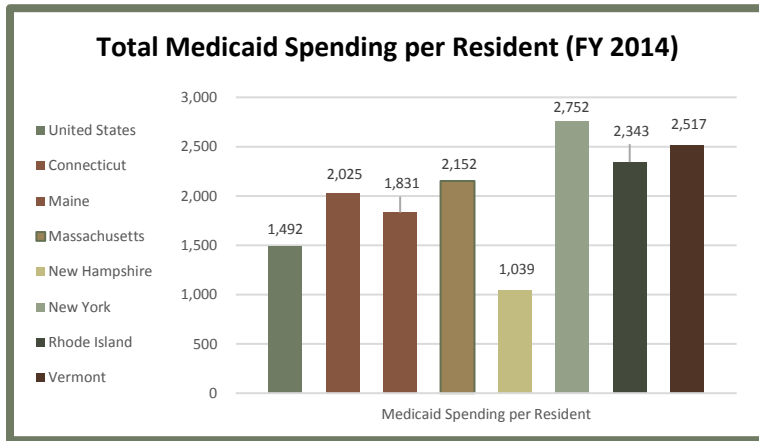
Medicaid expenditures presented here do not include administrative costs, accounting adjustments, or data for the U.S. territories. [4]

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).

Poverty Rate by Metropolitan Status (2015)

Legend: Metropolitan · Non-metropolitan · Total

(Categories: United States, Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont)

Medicaid & Chip Participation Rate Calendar Year 2014

United States 91.0%, Connecticut 95.1%, Maine 93.7%, Massachusetts 97.0%, New Hampshire 89.8%, New York 94.5%, Rhode Island 94.8%, Vermont 99.9%

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

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[4] Source: Urban Institute analysis of CM Form 64 data as of June 2015.

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

Under EPSDT, children up to age 21 are entitled to all medically necessary Medicaid services, including optional services, even if the state does not cover them for adults. The following table depicts the differences across states on providing optional services to their Medicaid populations[6].

Medicaid Optional Services New England + NY	VT	CT	MA	ME	NH	NY	RI
Physical Therapy	Yes	Yes	Yes	Yes	Yes	Yes	No
Occupational Therapy	Yes	No	Yes	Yes	Yes	Yes	No
Speech, hearing and language disorder services	Yes	Yes	Yes	Yes	Yes	Yes	No
Podiatry services	Yes	Yes	Yes	Yes	Yes	No	Yes
Dentures	No	Yes	Yes	Yes	No	Yes	Yes
Eyeglasses	No	Yes	Yes	Yes	Yes	Yes	Yes
Chiropractic Services	Yes	Yes	Yes	Yes	No	No	No
Private duty nursing services	Yes	No	Yes	Yes	Yes	Yes	No
Personal Care	Yes	No	Yes	Yes	Yes	Yes	Yes
Hospice	Yes	No	No	Yes	No	No	No
Self-Directed Personal Assistance Services- 1915(j)	Yes	No	No	No	No	*Data not available*	No
Tuberculosis (TB) Related Services	No	No	No	No	No	*Data not available*	Yes
Health Homes for Enrollees with Chronic Conditions – Nursing services, home health aides and medical supplies/equipment	Yes	No	No	Yes	No	Yes	Yes

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

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 addition 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.

DMH/DVHA Mental Health Providers			
	Oversight Reasonability		
Provider Networks/Program	**Policy**	**Funding**	**Provider**
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).

State Mental Health Agency (SMHA)
Per Capita Mental Health Services Expenditures (2013)

Rhode Island	106.11
Massachusetts	110.33
United States	119.62
New Hampshire	138.40
Connecticut	216.76
New York	260.78
Vermont	291.70
Maine	345.36
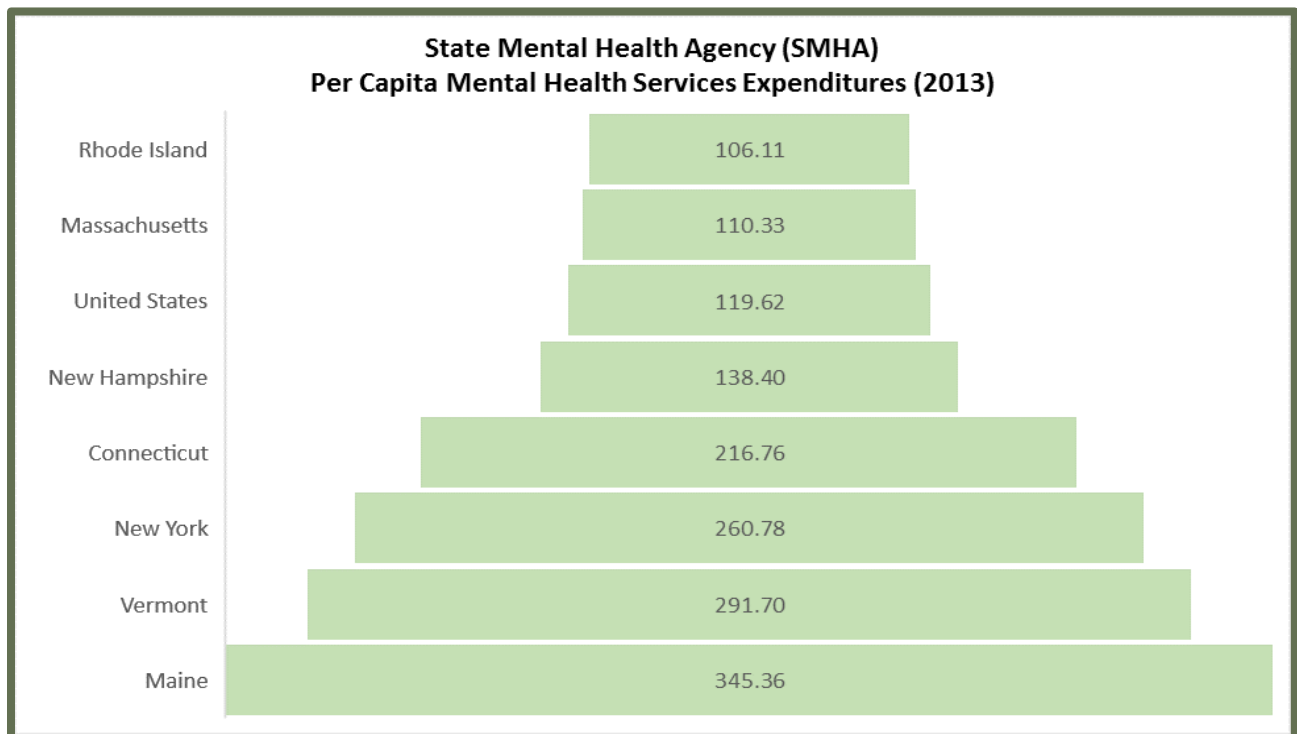
DVHA manages episodes of care for all non-DA/SSA and non-court involved adult admissions and all children's admissions. DVHA ensures discharge planning is timely and coordinated. DVHA also provides general provider oversight through traditional fee for service Medicaid provider enrollment and program 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.

Publicly Funded Mental Health Services Across AHS & AOE	
Behavioral and Mental Health Program	**Brief Description**
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.

Mental Health Treatment - Departmental Comparison

Annual Spend

	AOE	DCF	DAIL	DMH	DVHA	VDH
2011	$12,038,250.	$8,545,868.7	$24,412,433.	$109,741,168	$98,098,773.	$619,783.33
2012	$12,738,261.	$9,215,153.4	$27,746,919.	$118,175,849	$98,792,764.	$860,478.05
2013	$12,189,962.	$11,018,190.	$29,189,420.	$150,228,129	$95,434,266.	$847,828.24
2014	$12,138,650.	$13,748,631.	$28,950,879.	$163,716,075	$98,989,829.	$1,005,305.1
2015	$13,523,240.	$16,803,495.	$30,217,158.	$174,489,013	$105,782,559	$1,453,490.4
2016	$17,962,551.	$16,351,776.	$48,205,858.	$172,572,068	$107,975,817	$1,779,062.7

Substance Use Disorder Treatment - Departmental Comparison

Annual Spend

	DVHA	VDH	DMH	DCF	DAIL
2011	$21,832,392	$14,693,483	$375,677	$346,583	$177,815
2012	$22,688,676	$15,519,628	$413,359	$518,497	$176,566
2013	$24,445,718	$15,926,375	$596,524	$560,133	$190,910
2014	$27,350,988	$18,911,753	$845,975	$355,087	$187,088
2015	$37,972,375	$25,190,912	$934,385	$847,899	$135,704
2016	$47,532,520	$26,490,158	$587,675	$669,400	$279,376

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.[7] 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.

Percentage of Children (2-17) with Emotional, Developmental, or Behavioral Problems that Received Mental Health Care (2011)

- United States — 61.0%
- Connecticut — 65.0%
- Maine — 77.8%
- Massachusetts — 64.9%
- New Hampshire — 66.3%
- New York — 64.4%
- Rhode Island — 66.0%
- Vermont — 77.9%
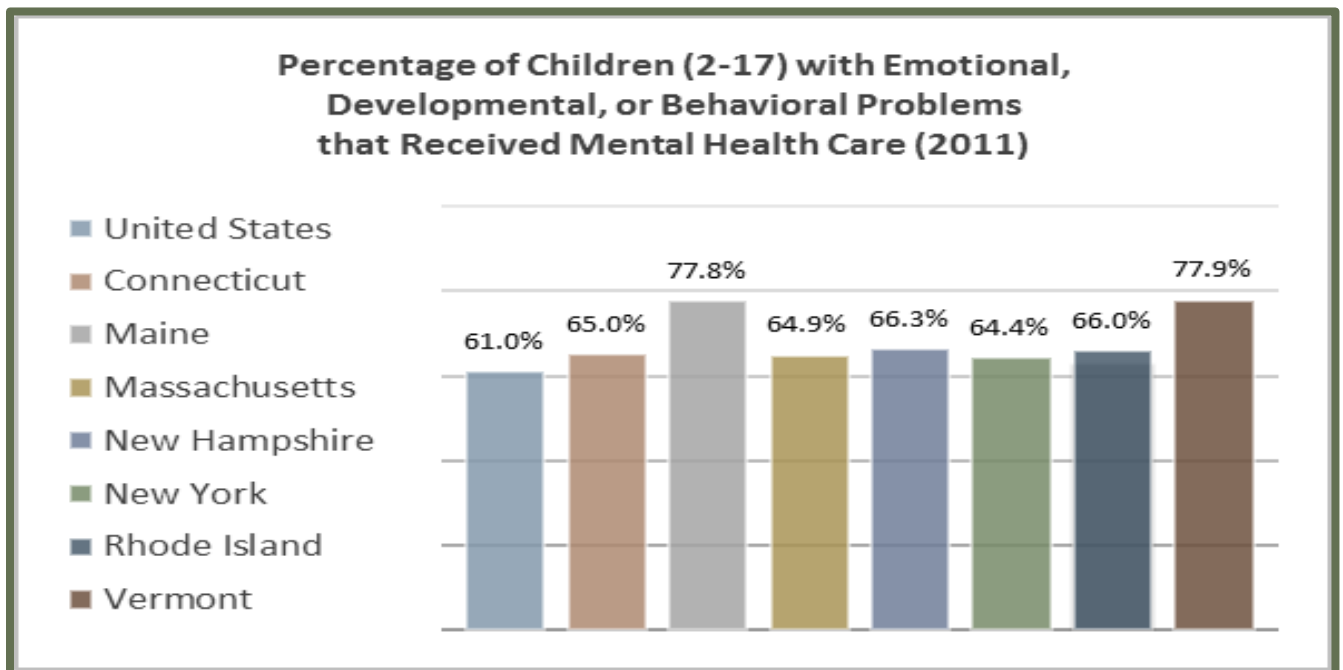
The following are the most common children's mental health problems within the Vermont Medicaid population for SFY 2016:

[7] 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.[7]

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
ADHD	8.6%	11.6%	5.4%	9.9%	7.4%	7.8%	10.8%	4.7%	9.1%	6.7%
Conduct Disorder	2.1%	2.3%	1.9%	1.5%	2.7%	1.7%	2.0%	1.4%	1.2%	2.2%
Anxiety Disorder	0.7%	0.4%	0.9%	0.4%	0.8%	0.4%	0.4%	0.4%	0.3%	0.5%
Generalized anxiety	0.3%	0.3%	0.4%	0.1%	0.7%	0.2%	0.3%	0.1%	0.0%	0.4%
Panic Disorder	0.4%	0.2%	0.6%	0.4%	0.4%	0.3%	0.2%	0.4%	0.3%	0.2%
Eating Disorder	0.1%	0.1%	0.2%	0.1%	0.2%	0.0%	0.0%	0.1%	0.0%	0.1%
Mood Disorder	3.7%	2.5%	4.9%	2.5%	4.8%	2.9%	1.7%	4.1%	1.8%	3.9%
Major Depression	2.7%	1.8%	3.7%	1.6%	3.8%	2.4%	1.6%	3.2%	1.4%	3.2%
Dysthymia	1.0%	0.7%	1.2%	0.8%	1.1%	0.5%	0.1%	0.9%	0.4%	0.7%
Any of above	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.

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

**Vermont Medicaid Adolescent Mental Health and Substance Abuse Costs
SFY 2015
Children Ages 12 - 17
Primary Diagnosis Mental Health or Substance Abuse**

PROGRAM	WHO IS ELIGIBLE	COVERED SERVICES	COST-SHARING
MABD Medicaid **Katie Beckett Medicaid** **Medicaid Working Disabled** **MCA (Expanded Medicaid – New Adults)**	• Age ≥ 65, blind, disabled • At or below the PIL • **Katie Beckett:** o Only disabled child's income/resources used to meet MABD limits • **Medicaid Working Disabled**: o ≥ 250% FPL o Meet working criteria • **MCA** o ≥ 138% of FPL o Not eligible for Medicare And either: Parent or caretaker relative of a dependent child; or ≤ 21 years of age, ≥ 65 years of age	• Physical and mental health • Dental ($510 cap/yr, no dentures) • Prescriptions • Chiropractic (limited) • Transportation (limited) • Excluded classes of Medicare Part D drugs with Medicare eligibility • Katie Beckett Medicaid covers 100% of recipient's costs • Additional benefits for youth ages 19-20, and Katie Beckett recipients (see Dr. Dynasaur below)	• No monthly premium • $1/$2/$3 prescription co-pay if no Medicare Part D coverage • $1.20 -$6.60 co-pays with Medicare Part D coverage • $3 dental co-pay • $3 outpatient hospital visit co-pay (over 21 yrs of age) • No co-pay for pregnant or post-partum persons, or persons in LTC facility
Dr. Dynasaur	• Children under age 19 at or below 317% FPL • Pregnant persons at or below 213% FPL	• Same as Medicaid plus: o Eyeglasses o Dental o Additional benefits	• Up to 195% FPL: no premium • Up to 237% FPL: $15/family/month • Up to 317% FPL: $20/family/month ($60/family/mo. w/out other insurance) • No prescription co-pays
VPharm1, 2, & 3	• ≥ age 65, blind, or disabled • eligible and enrolled in Medicare PDP or MAPD •VPharm1: o ≤ 150% FPL o Must apply for LIS •VPharm2: o 150.01% - 175% FPL •VPharm3: o 175.01% - 225% FPL	• VPharm1 (after primary LIS reductions): o Medicare Part D cost-sharing o Excluded classes of Part D meds o Diabetic supplies o Eye exams • VPharm 2&3: o Maintenance meds o Diabetic supplies • No retroactive payments	• Monthly premium per person: o VPharm1: $15 o VPharm2: $20 o VPharm3: $50 • $1/$2 prescription co-pays
Medicare Savings Programs	• ≥ age 65, blind, or disabled • Active Medicare beneficiaries • QMB: ≤ 100% FPL	• QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing	• No monthly premium • QMB may still have to pay Medicare co-pay, and not eligible for retroactive payments

	• SLMB 100.01 - 120% FPL • QI-1 120.01 - 135% FPL • QI-1 Not eligible for Medicaid	• SLMB and QI-1 cover Medicare Part B premiums only	• 3 months retroactive payments are possible for SLMB and QI-1
Healthy Vermonters Program	• 350% FPL if uninsured • 400% FPL if ≥ age 65, blind, or disabled	• Medicaid prescription pricing • If enrolled in Medicare Part D, excluded classes of prescriptions are priced at Medicaid rate • No retroactive payments	• No monthly premium
Qualified Health Plan (QHP)	• Vermont Residents who do not have Medicare/Medicaid	• Choice of Eligible QHPs on (VHC)	• Full QHP cost sharing unless reduced by tax credits, or employer share
Federal Advance Premium Tax Credits (APTC)	• 100-400% FPL • No Medicaid • Enrolled in Silver Plan QHP	• Tax credit received yearly as a lump sum, or monthly toward QHP premium	• Full QHP cost sharing minus tax credit
Federal Cost-Sharing Reduction (CSR)	• ≥ 250% FPL • No affordable Minimum Essential Coverage (MEC) • Meets APTC	• Reduces co-pays, co-insurance, deductibles, etc.	• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc.
Vermont Premium Assistance (VPA)	• ≥ 300% FPL • No affordable MEC • Meets APTC	• Covers all or part of QHP premium	• Covers all or part of QHP premium
Vermont Cost Sharing Reductions (VCSR)	• ≥ 300% FPL • No affordable MEC • Meets APTC	• Reduces co-pays, co-insurance, deductibles, etc.	• Full QHP cost sharing with reduction in co-pays, co-insurance, deductibles, etc.

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

Legend: —— Enhanced Fed Share   —— Federal Share   —×— New Adult Fed Share   —— CHIP Fed Share
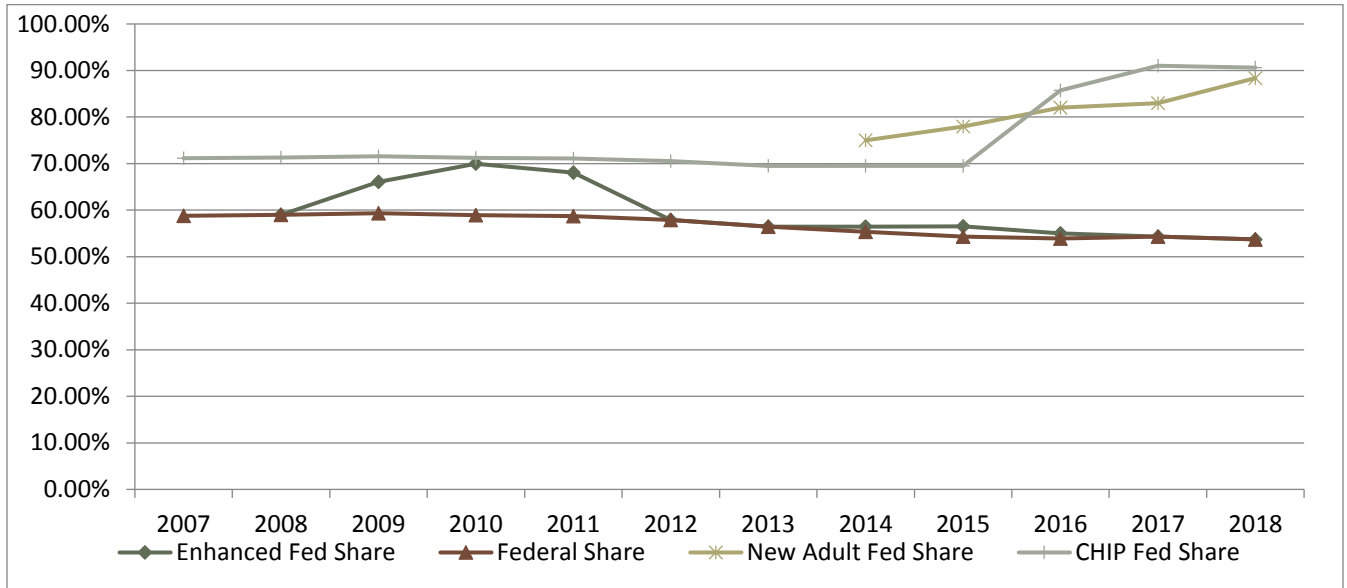
FEDERAL MATCH RATES
FFIS projs + JFO/Admin consensus - rev September 30, 2016
Fiscal Years 2010 to 2018 [Prior years are in hidden rows]

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

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
			Federal Fiscal Year								**State Fiscal Year**			
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:

FFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share		SFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share
			Federal Fiscal Year								**State Fiscal Year**			
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.

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
other changes:								
Personal Services:								
S.243 - Opioid Abuse - Acupuncture (Evidence-Based Education and Advertising Fund)		200,000						200,000
FY17 after other changes	0	200,000	0	0	0	0	0	200,000
Total after FY17 other changes	6,551,086	999,894	10,604,077	99,758,443	0	62,996,293	8,804,256	189,714,049
FY17 after other changes								
Personal Services:								
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
Grants:								
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
FY18 Changes	24,664,120	2,578,044	(3,121,467)	39,490,179	0	(62,996,293)	(888,520)	(273,938)
FY18 Gov Recommended	31,215,206	3,577,938	7,482,610	139,248,622	0	0	7,915,736	189,440,111
FY18 Legislative Changes								
FY18 Subtotal of Legislative Changes	0	0	0	0	0	0	0	0
FY18 As Passed - Dept ID 3410010000	31,215,206	3,577,938	7,482,610	139,248,622	0	0	7,915,736	189,440,111

DVHA Program - As Passed FY17	55,813,197	0	0	29,453,975	0	942,009,237	7,922,526	1,035,198,935
other changes:								
Grants:								
H.620 - LARC Reimbursement						34,864		34,864
FY17 after other changes	0	0	0	0	0	34,864	0	34,864
Total after FY17 other changes	55,813,197	0	0	29,453,975	0	942,044,101	7,922,526	1,035,233,799
FY17 after other changes								
Grants:								
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
FY18 Changes	2,023,101	0	0	(1,619,321)	0	(14,065,951)	1,745,502	(11,916,670)
FY18 Gov Recommended	57,836,298	0	0	27,834,654	0	927,978,150	9,668,028	1,023,317,129
FY18 Legislative Changes								
FY18 Subtotal of Legislative Changes	0	0	0	0	0	0	0	0
FY18 As Passed - Dept ID 3410018000	57,836,298	0	0	27,834,654	0	927,978,150	9,668,028	1,023,317,129
TOTAL FY17 DVHA Big Bill As Passed	62,364,283	799,894	10,604,077	129,212,418	0	1,005,005,530	16,726,782	1,224,712,984
TOTAL FY17 DVHA Reductions & other changes	0	200,000	0	0	0	34,864	0	234,864
TOTAL FY18 DVHA Starting Point	62,364,283	999,894	10,604,077	129,212,418	0	1,005,040,394	16,726,782	1,224,947,848
TOTAL FY18 DVHA ups & downs	26,687,221	2,578,044	(3,121,467)	37,870,858	0	(77,062,244)	856,982	(12,190,606)
TOTAL FY18 DVHA Gov Recommended	89,051,504	3,577,938	7,482,610	167,083,276	0	927,978,150	17,583,764	1,212,757,242
TOTAL FY18 DVHA Legislative Changes	0	0	0	0	0	0	0	0
TOTAL FY18 DVHA As Passed	89,051,504	3,577,938	7,482,610	167,083,276	0	927,978,150	17,583,764	1,212,757,242

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.

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

53rd 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

	SFY '10	SFY '11	SFY '12	SFY '13	SFY '14	SFY '15	SFY '16	SFY '17 Orig.	thru Dec.	SFY '17 BAA	SFY '18
Caseload	160,923	169,179	171,610	173,849	225,965	190,781	205,663	207,051	180,119	185,974	186,929
PMPM	$291.79	$297.84	$295.42	$322.58	$255.05	$313.52	$304.20	$302.72	$312.85	$327.68	$323.57
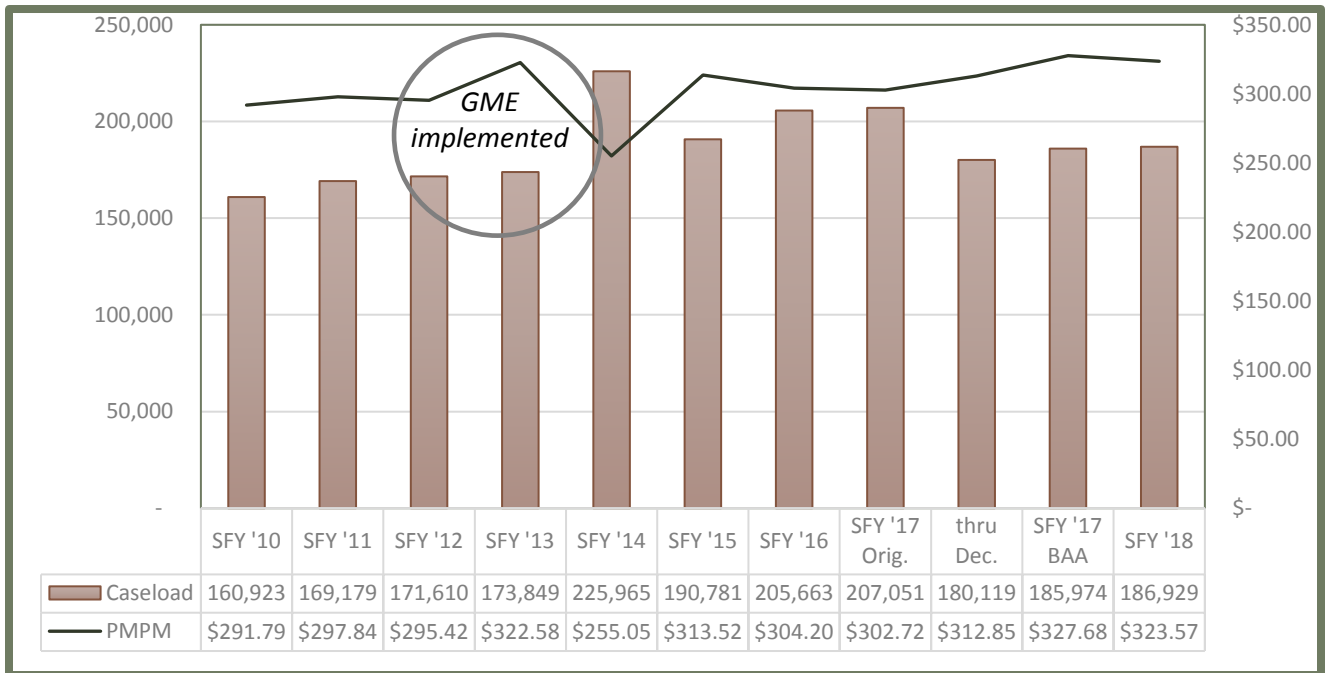
One of the things we are seeing, however, is that though caseload is declining, there is not an equal parallel to expenditures. Individuals dropping off Medicaid were utilizing services at a disproportionately lower rate than new individuals enrolling for coverage:

Per Member Per Month Costs of Members Utilizing Healthcare Services

	MABD PMPM	MCA PMPM	VPharm PMPM
■ Disenrolled Members	$264.80	$164.68	$121.70
■ Newly Enrolled Members	$1,092.66	$499.07	$112.31
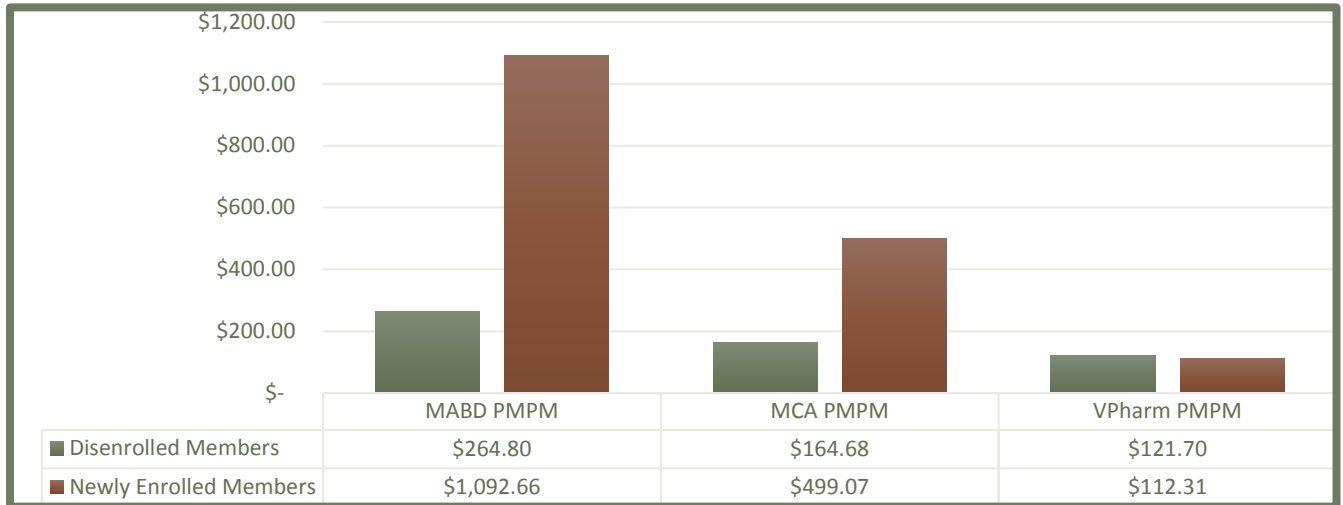
Caseload and Utilization Reserve . . . . **($21,607,606)**

$(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 VITL from federal to other state sources.

Category of Service (COS) Spend

Category of Service	Actual SFY '16	BAA SFY '17	Gov. Rec. SFY '18	2017 BAA - 2018 Rec. %	5-Yr. Avg. Growth % Chg.	5-Yr. Total Change	10-Yr. Avg. Growth % Chg.	10-Yr. Total Change
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
Grand Total of All Expenditures	**1,014,684,817**	**1,012,417,548**	**1,023,317,131**	**1.08%**	**1.95%**	**67,788,249**	**1.85%**	**47,493,728**

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)										
Catamount	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
Subtotal Adults	93,345	447,089,687	399.14	96,726	457,230,732	393.92	123,244	475,146,697	321.28	132,837	502,853,828	315.46	135,033	500,403,389	314.64	117,249	473,986,595	336.88	117,756	501,613,144	354.98
Children																					
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
Subtotal Children	64,058	172,154,749	223.96	65,124	175,965,422	225.17	69,831	183,952,788	219.52	71,870	187,123,801	216.97	73,957	188,158,559	212	68,606	188,991,784	229.56	70,012	192,224,672	228.80
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
Choices for Care																					
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	
Subtotal Choices for Care*	3,911	199,033,009	4,241.42	4,147	205,224,249	4,123.95	4,342	210,788,377	4,045.92	4,256	215,984,826	4,228.78	4,623	212,357,083	3,827.62	4,310	223,201,934	4,315.94	4,350	227,602,406	4,360.07
Subtotal Direct Services	173,849	820,091,169	393.11	178,650	842,906,108	393.18	209,395	874,802,557	348.15	220,556	908,264,892	343.17	224,640	905,939,845	339.53	201,805	892,446,342	368.53	203,758	927,826,143	379.46
Miscellaneous Program																					
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			$ 33,748,781	
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	593,648	$ 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
Subtotal Miscellaneous Program	6,417	100,002,818		5,722	101,723,191		4,434	101,020,847		4,180	106,419,926		5,962	116,266,479		5,952	119,971,206		5,962	95,490,988	
TOTAL PROGRAM EXPENDITURES	180,265	$ 920,093,987		184,372	$ 944,629,299		213,829	$ 975,823,404		224,736	$ 1,014,684,817		230,602	$ 1,022,206,324		207,757	$ 1,012,417,548		209,720	$ 1,023,317,131	

ADMINISTRATIVE EXPENDITURES	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
Total Administrative Expenses	$ 91,698,877	$ 153,133,170	$ 134,232,620	$ 149,995,336	$ 189,714,049	$ 200,829,110	$ 189,440,111
TOTAL ALL EXPENDITURES	180,265 $ 1,011,792,864	184,372 $ 1,097,762,469	212,255 $ 1,110,056,024	224,736 $ 1,164,680,153	230,602 $ 1,211,920,373	207,757 $ 1,213,246,658	209,720 $ 1,212,757,242

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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	
Adults							
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
Subtotal Adults	$ 500,403,389	$ 169,612,209	$ 473,986,595	$ 155,273,981	$ 501,613,144	$ 161,218,486	
Children							
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%
Subtotal Children	$ 188,158,559	$ 82,970,378	$ 188,991,784	$ 82,881,469	$ 192,224,672	$ 85,536,867	
Pharmacy Only Programs	$ 5,020,813	$ 4,535,362	$ 6,266,029	$ 5,660,180	$ 6,385,921	$ 5,836,756	Predominantly state only
Choices for Care							
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	
Subtotal Choices for Care*	$ 212,357,083	$ 97,004,716	$ 223,201,934	$ 101,958,643	$ 227,602,406	$ 105,334,393	
Subtotal Direct Services	$ 905,939,845	$ 354,122,665	$ 892,446,342	$ 345,774,274	$ 927,826,143	$ 357,926,503	
Miscellaneous Program							
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	$ -	$ -	$ -	$ -	$ -	$ -	
Subtotal Miscellaneous Program	$ 116,266,479	$ 71,209,187	$ 119,971,206	$ 72,942,755	$ 95,490,988	$ 63,424,997	
TOTAL PROGRAM EXPENDITURES	$1,022,206,324	$ 425,331,852	$1,012,417,548	$ 418,717,029	$1,023,317,131	$ 421,351,500	

ADMINISTRATIVE EXPENDITURES

	SFY '17 As Passed		SFY '17 BAA		SFY '18 Gov. Rec		SFY '18 Funding Description
ADMINISTRATIVE EXPENDITURES	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
Total Administrative Expenses	$ 189,714,049	$ 50,153,654	$ 200,829,110	$ 51,881,100	$ 189,440,111	$ 44,924,426	
TOTAL ALL EXPENDITURES	$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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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	• Inpatient hospital services • Outpatient hospital services • Rural health clinic services • Federally qualified health center services • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services • Laboratory and X-ray services • Family planning services • Physician services and Medical and Surgical Services of a Dentist • Home health services • Nurse Midwife services • Nursing facility services Certified Pediatric and Family Nurse Practitioner Services • 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) • Clinical Services • Prescription drugs • Diagnostic, Screening, Preventive and Rehabilitative Services • Private duty nursing services • Other Aids to Vision • Dental Services • Prosthetic Devices • Physical and Occupational therapies, and services for Individuals with Speech, hearing and language disorder services • Inpatient Hospital/Nursing Facility/ICF Services for Individuals 65 and Older in IMD • ICF/MR Services • Inpatient Psychiatric Services for Individuals Under 21 • Personal Care Services • Case Management • Respiratory Care for Ventilator Dependent Individuals • Primary Care Case Management • Hospice • Transportation Services • Nursing Facility Services for Individuals Under Age 21 • Emergency Hospital Services • Critical Access Hospital • Traumatic Brain Injury; HCBS waiver –like services • Mental Illness Under 22; HCBS waiver-like services • Community Rehabilitation and Treatment; HCBS waiver-like services • Developmental Services; HCBS waiver-like services • Services for individuals with persistent mental illness up to 150 FPL • Community and nursing home services for individuals eligible for long-term care supports • Community based services for individuals with moderate needs as identified through long-term care eligibility
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			
Special income level group: 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. 1. TBI (traumatic brain injury) 2. MI under 22 (Children's Mental Health) 3. MR/DD (Mental Retardation/Developmental Disabilities)			
Medically Needy Pregnant women who would be categorically eligible except for income and resources			

Global Commitment Investment Expenditures

Department	Investment Description	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	SFY16 Actuals
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	

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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
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

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Global Commitment 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
TOTALS		**$55,554,314**	**$56,275,877**	**$9,836,470**	**$123,669,882**	**$127,103,459**	**$128,924,888**	**$126,882,102**

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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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.

		Standard Plans				**Standard High Deductible Health Plans (HDHP)**				**Blue Rewards**				**MVP VT Plus Non-Standard**			
		BCBSVT & MVP				**Can Pair with Health Savings Account (HSA)**				**BCBSVT only**				**MVP only**			
						Silver HDHP		**Bronze HDHP**									
		Platinum	Gold	Silver	Bronze	BCBSVT	MVP	BCBSVT	MVP	Gold	Silver	Gold CDHP Can pair with HSA	Bronze CDHP	Gold	Silver	Bronze	Gold HDHP Can pair with HSA
		Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.)	Integrated Ded.?	N	N	N	N	Y - $1,550/$3,100[7]	Y - $1,600/$3,200[7]	Y - $5,050/$10,100	Y - $5,300/$10,600	Y - $1,250/$2,500	Y - $2,300/$4,600[7]	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[7]	$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[7]	$5,500/$11,000	See above
	Waived[1] 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[8]	$150[78]	$700[8]	See above	See above	See above	See above	See above	See above	See above	See above	$250/$500	$500/$1,000[7]	$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
Max. Out-of-Pocket (MOOP)	Integrated?	N	N	Y-$6,000/$12,000[7]	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[7]	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[7]	See above	See above
	Prescription (Rx)	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600[7]	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	$1,300/$2,600
Stacked or Aggregate?[6]		Stacked[6]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate Embedded[610]	Agg Ded/ Stack MOOP[6]	Aggregate Embedded[610]	Agg Ded/ Stack MOOP[6]	Aggregate Embedded[610]	Aggregate Embedded[610]	Aggregate[6]	Aggregate Embedded[610]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate[6]
Service Category (Examples)		Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)	Co-insurance (%) / Co-pay ($)
	Preventive (Prev)	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
Office Visit (OV)	PCP or Mental Health (PCP/MH)	$10	$15	$25	Ded., then $35	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[2]	$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)[3]	$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[4]	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
Prescription (Rx) Drug Coverage		30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
	Rx Generic	$5	$5	$15	Ded., then $20	Ded.[9], then $10	Ded.[9], then $10	Ded.[9], then $12	Ded.[9], then $12	Ded., then $5	Ded., then $5	Ded.[9], then $0	Ded.[9], then $25	$5	Ded., then $15	Ded., then $20	Ded.[9], then $0
	Rx Preferred Brand[5]	$50	Ded., then $50	Ded., then $60	Ded., then $85	Ded.[9], then $40	Ded.[9], then $40	Ded.[9], then 40%	Ded.[9], then 40%	Ded., then 40%	Ded., then 40%	Ded.[9], then $0	Ded.[9], then 40%	Ded., then $40	Ded., then 50%	Ded., then $90	Ded.[9], then $0
	Rx Non-Preferred Brand[5]	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
Additional Benefits																	
	Wellness Benefits	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
Premiums by Tier[6]		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 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 DentalClass 1 Series, ER: Emergency Room
Glossary-- Find definitions for VBID, Stacked, Aggregated, Integrated, and other terms at http://info.healthconnect.vermont.gov/glossary.
Plan details -- Different plans cover specific drugs and services in different ways. For specifics, contact BCBSVT (800-247-2583) or MVP (800-TALK-MVP).

Updated 11/2/16

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

				Time Period	Actual Value	Current Trend	Baseline % Change
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.

			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%	↑
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%	↑
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 Medicaid Inpatient Psychiatric and Detoxification Utilization

PM **DVHA** # of Children's Mental Health Inpatient Admissions/1000 members
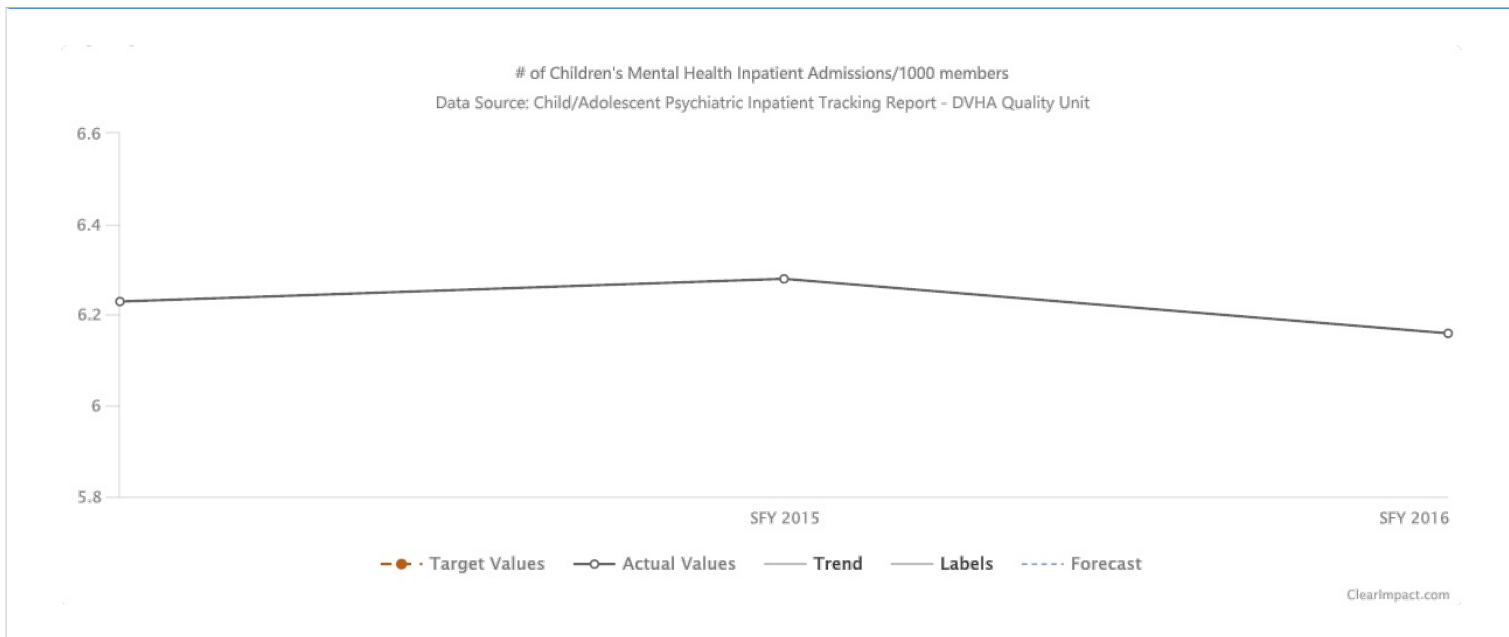
# of Children's Mental Health Inpatient Admissions/1000 members
Data Source: Child/Adolescent Psychiatric Inpatient Tracking Report - DVHA Quality Unit

Story Behind the Curve

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

Medicaid Inpatient Psychiatric and Detoxification Utilization

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

# of Adult Mental Health Inpatient Admissions/1000 members
Data Source: Adult Psychiatric Inpatient Tracking Report - DVHA Quality Unit

Legend: Target Values, Actual Values, Trend, Labels, Forecast

ClearImpact.com

Story Behind the Curve

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

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.

# of Detoxification Admissions/1000 members
Data Source: Inpatient Detox. Tracking Report - DVHA Quality Unit

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

Average Length of Stay - Children's Mental Health Inpatient Admissions
Data Source: Child/Adolescent Psychiatric Inpatient Tracking Report - DVHA Quality Unit

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

Average Length of Stay - Adult Mental Health Inpatient Admissions
Data Source: Adult Psychiatric Inpatient Tracking Report - DVHA Quality Unit

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.

PM **DVHA** Average Length of Stay - Detox. 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.

Paid Claims - Children's Mental Health Inpatient Admissions
Data Source: Child/Adolescent Psychiatric Inpatient Tracking Report - DVHA Quality Unit

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.

Paid Claims - Adult Mental Health Inpatient Admissions
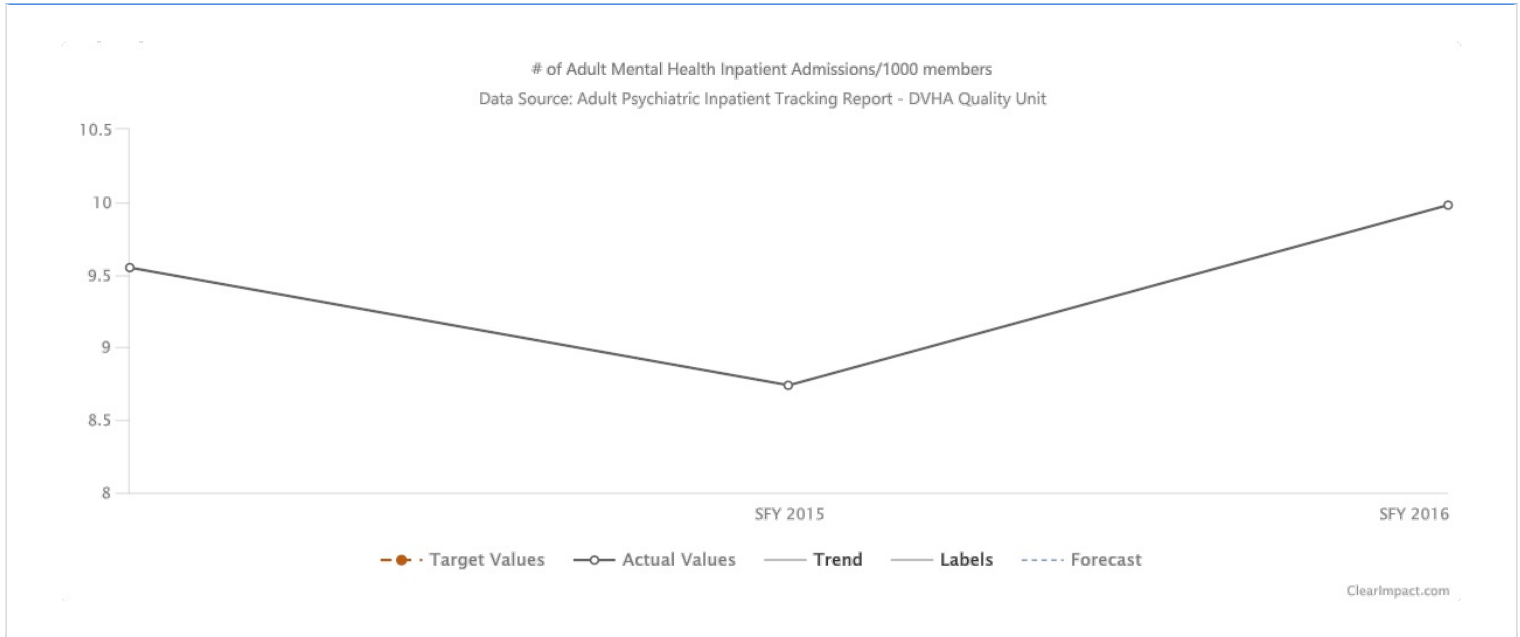Data Source: Adult Psychiatric Inpatient Tracking Report - DVHA Quality Unit
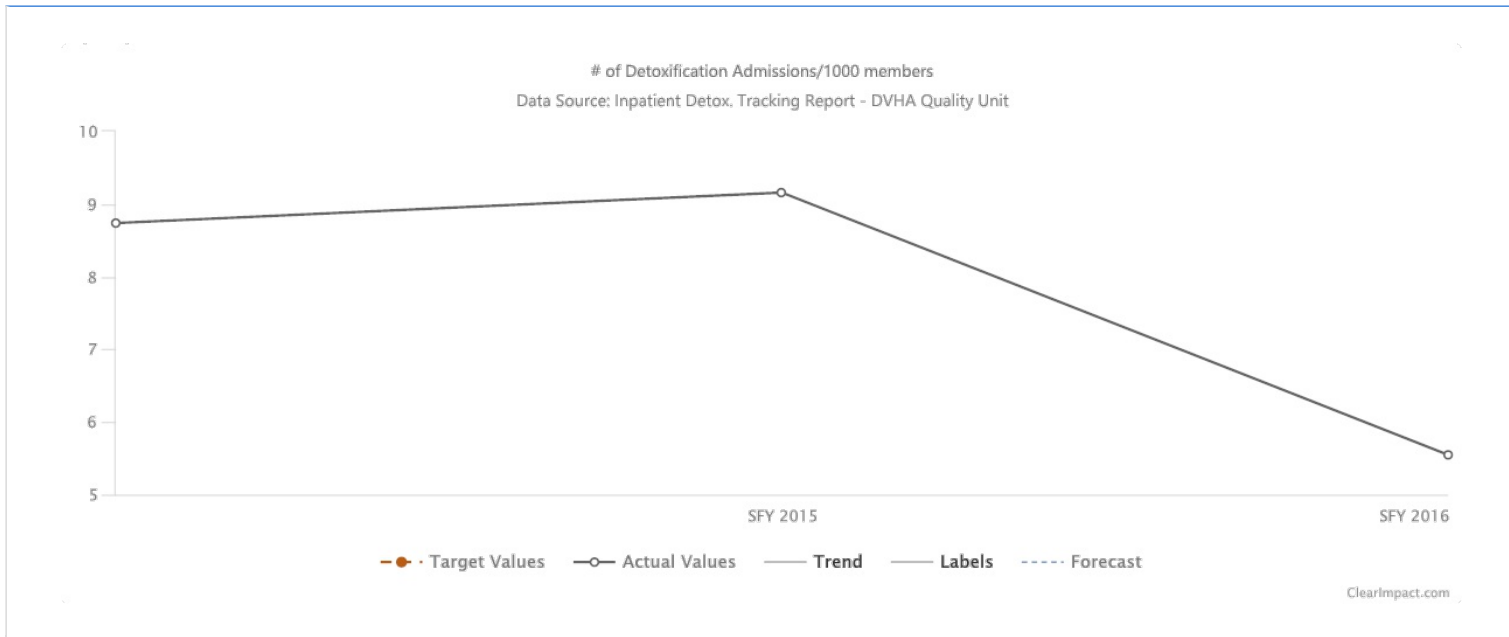
Story Behind the Curve

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.

PM **DVHA** Paid Claims - Detox. Admissions

Paid Claims - Detox. Admissions
Data Source: Inpatient Detox. Tracking Report - DVHA Quality Unit

Legend: — ● · Target Values — ○ — Actual Values —— Trend —— Labels ----- Forecast
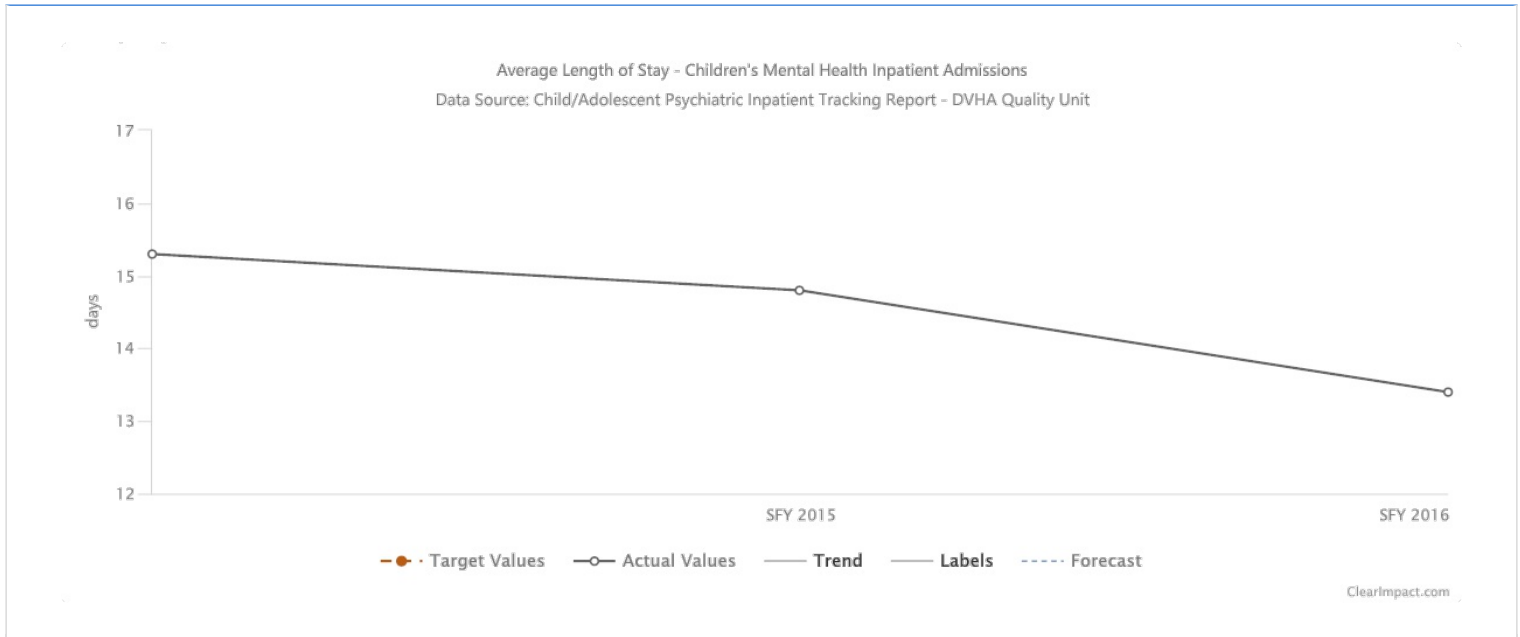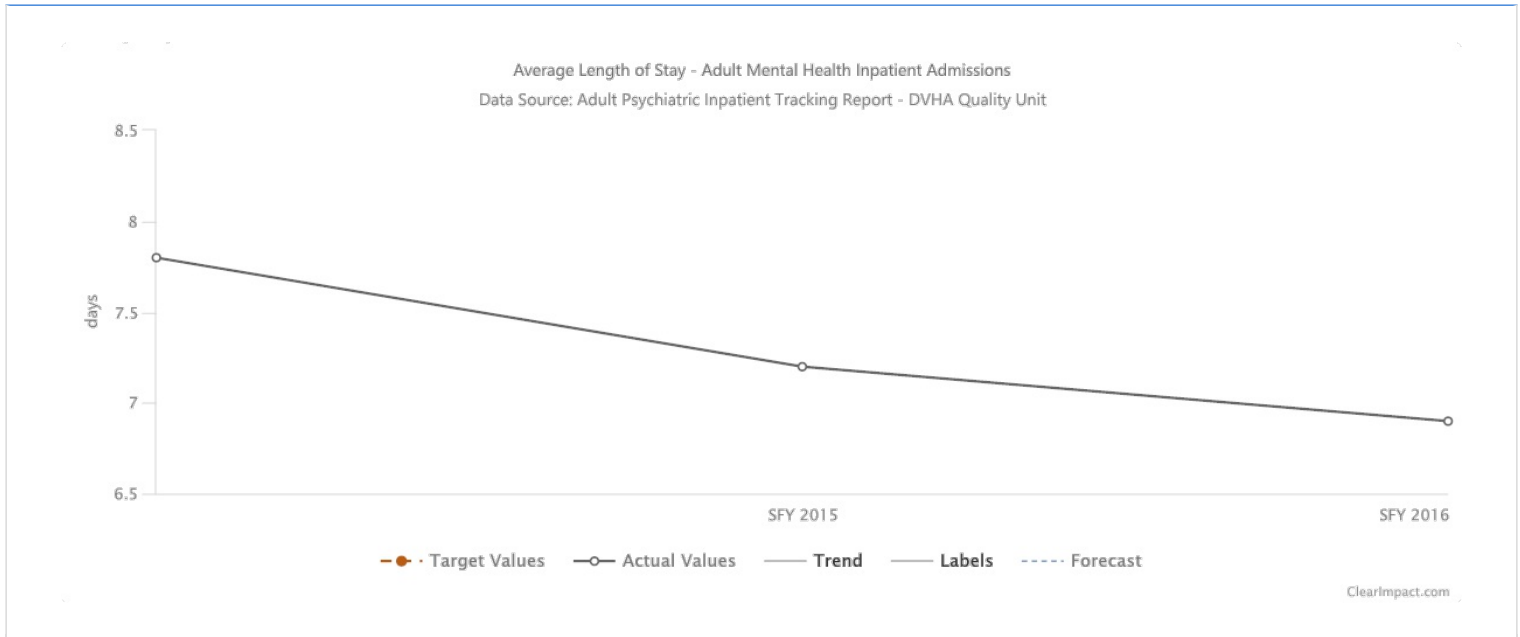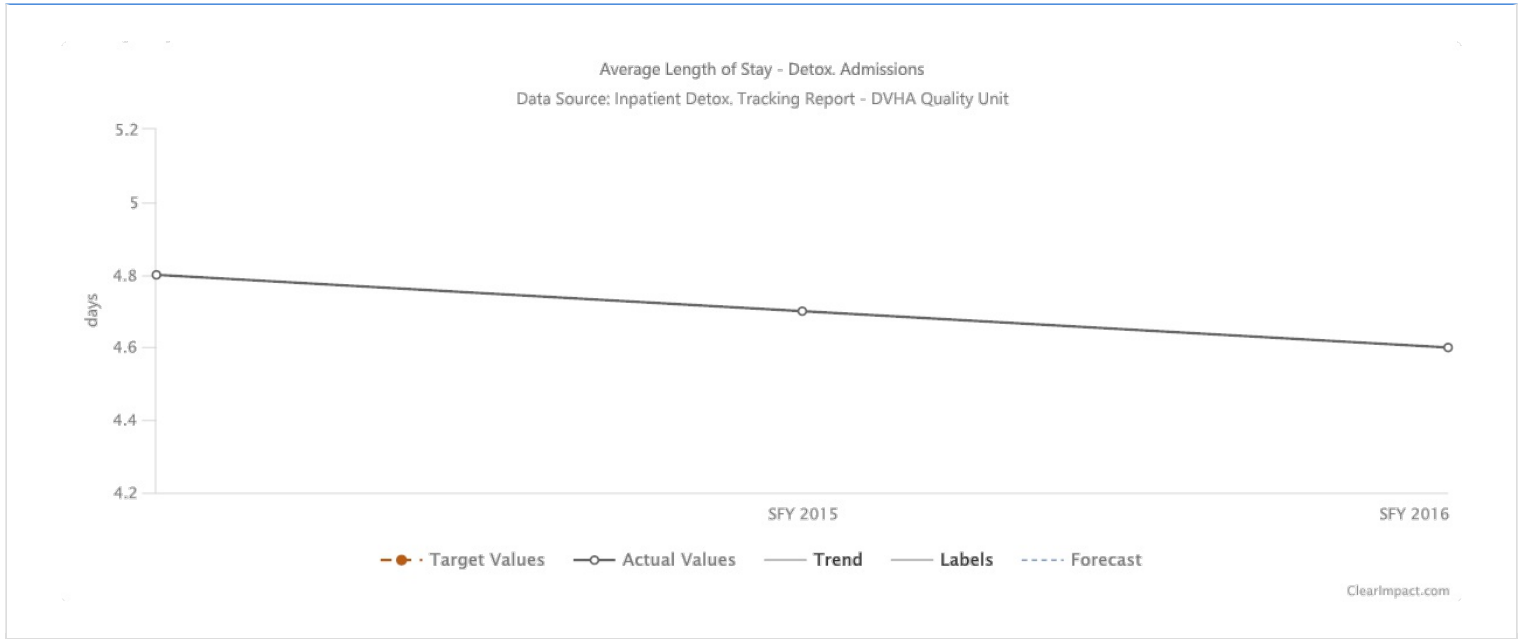
ClearImpact.com

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DVHA Programmatic Performance Budget SFY '18 – Blueprint for Health

O DVHA Improve Access to Quality Healthcare for all Vermonters	Time Period	Actual Value	Current Trend	Baseline % Change

P BP Blueprint for Health	Time Period	Actual Value	Current Trend	Baseline % Change

Budget Information

Total DVHA Program Budget SFY 2018: $897,820

What We Do

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes and community health teams.

Who We Serve

The Vermont Blueprint for Health serves all Vermonters.

How We Impact

The activities of the Blueprint serve as the foundation for strengthening primary care and expanding the ACO programs. This initiative is especially focused on building the links between community and medical services, so that patients have better coordinated care across the spectrum of services.

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

PM BP Measure	Time Period	Actual Value	Current Trend	Baseline % Change
PM BP # of Patient Centered Medical Homes	2015	126	↗ 6	1700% ↑
PM BP Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)	2014	1:2.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)	2014	1:0.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) - All Payers	2014	1:5.8	→ 0	0% →

P BP Blueprint for Health	Time Period	Actual Value	Current Trend	Baseline % Change
PM BP # of Patient Centered Medical Homes	2015	126	↗ 6	1700% ↑
PM BP Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)	2014	1:2.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)	2014	1:0.9	→ 0	0% →
PM BP Blueprint Return on Investment (ROI) - All Payers	2014	1:5.8	→ 0	0% →

P Blueprint for Health

PM BP Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)

Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)
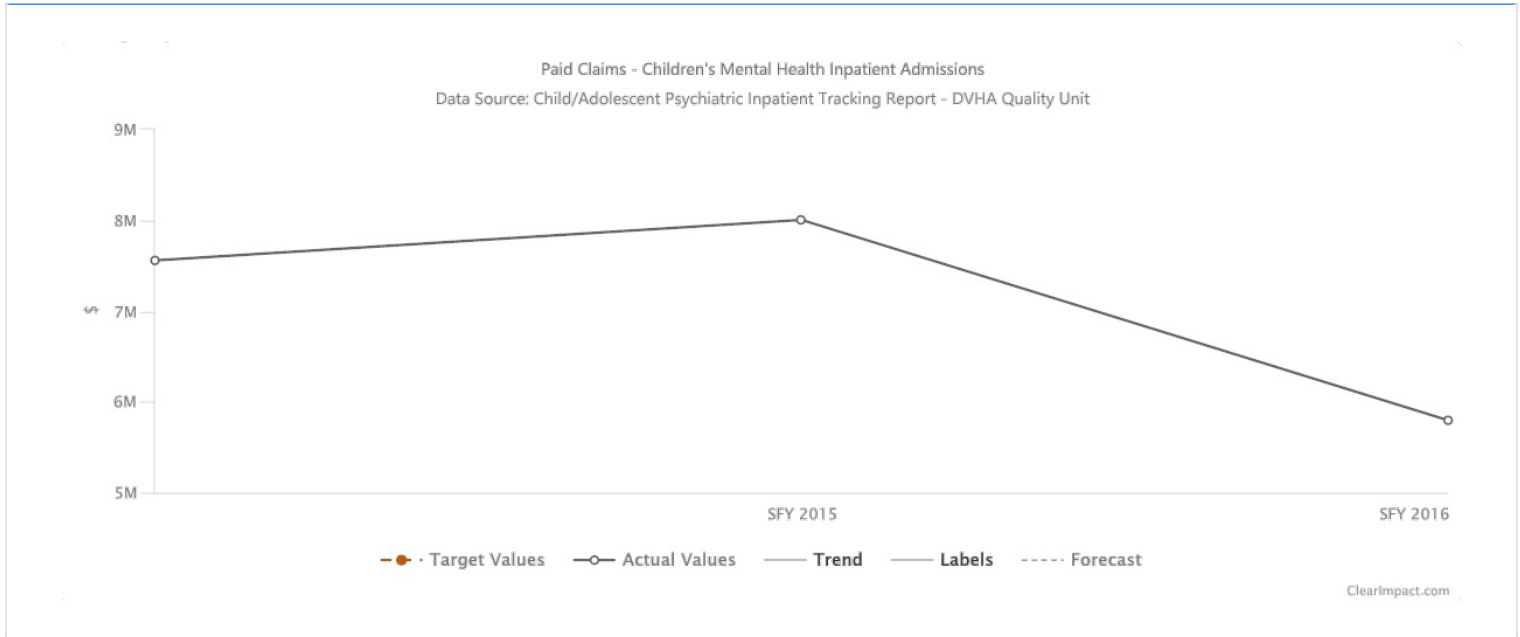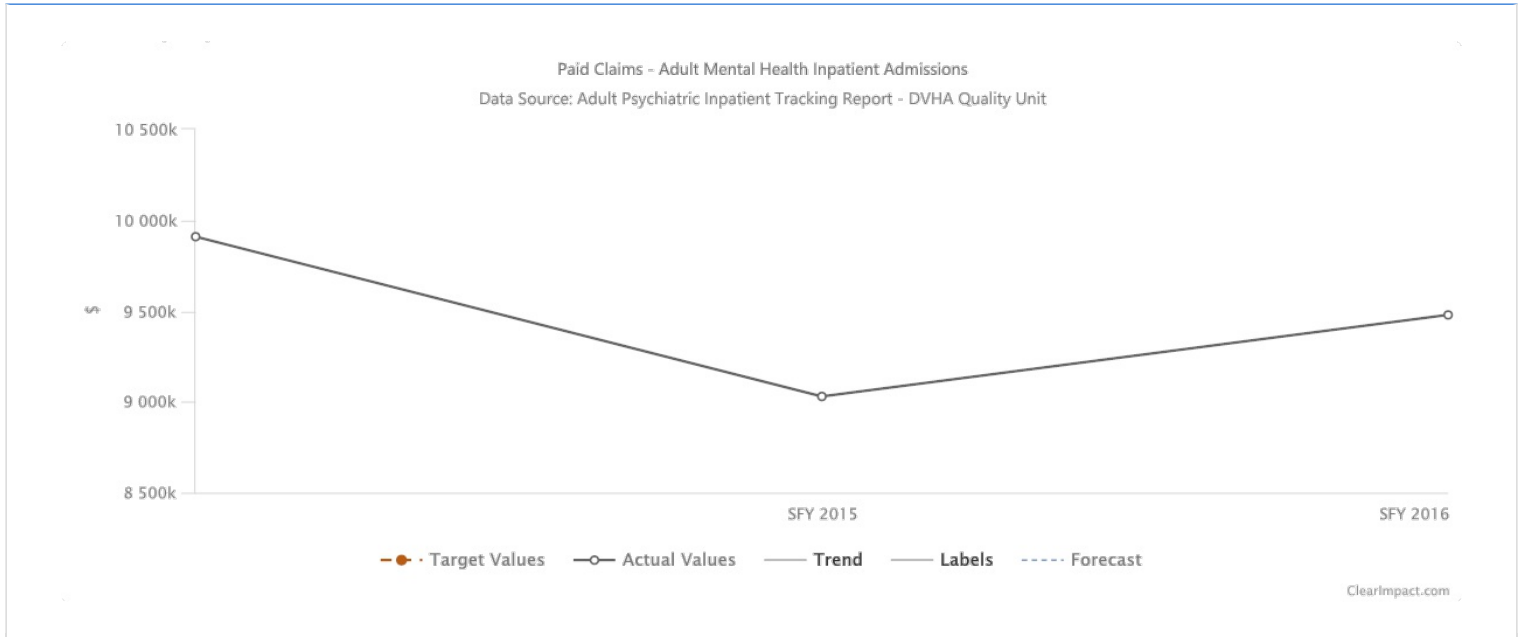Data Source: Onpoint

Story Behind the Curve
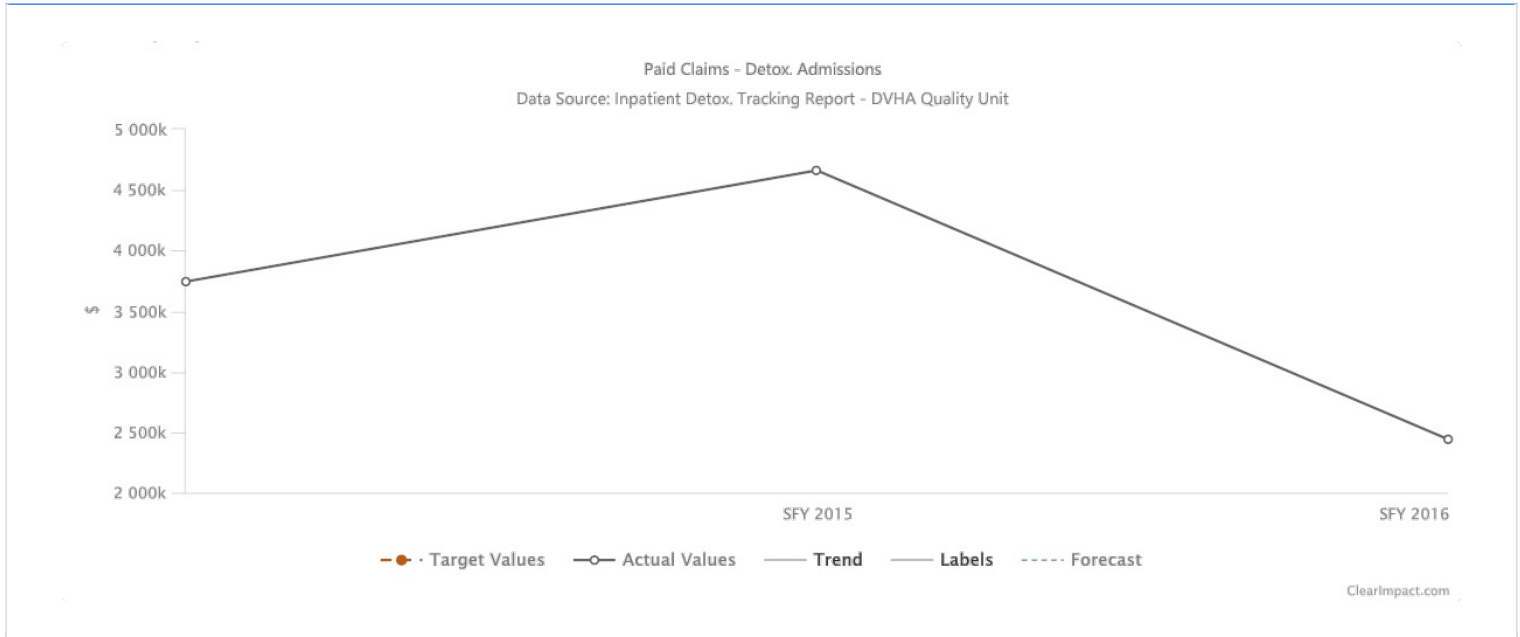
This performance measure is important because it measures how well the program is doing; it measures quality of program effort.

In general, return on investment (ROI) is the benefit (return) of an investment divided by the cost of an investment, and then expressed as a percentage or a ratio. In this case, the benefit of our investment is a reduction in healthcare expenditures. The cost of the investment is the total amount of money invested by the federal government through the Global Commitment to Health Section 1115 waiver and by the State through the General Fund.

The Blueprint's ROI calculation takes in to consideration payments to medical home and Community Health Teams and the program budget. Overall, return on investment (ROI) in the Blueprint across all payers is strongly positive, except for Medicaid when including Special Medicaid Services (SMS), which cover social supports for better health - like transportation to appointments. When these other services are included, the reduction in expenditures does not fully offset investments. This indicates a better balance in utilization of medical and social services, and greater investment in prevention versus treatment.

PM **BP** Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)

Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)
Data Source: Onpoint

Story Behind the Curve

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

In general, return on investment (ROI) is the benefit (return) of an investment divided by the cost of an investment, and then expressed as a percentage or a ratio. In this case, the benefit of our investment is a reduction in healthcare expenditures. The cost of the investment is the total amount of money invested by the federal government through the Global Commitment to Health Section 1115 waiver and by the State through the General Fund.

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Blueprint Return on Investment (ROI) - All Payers
Data Source: Onpoint

Story Behind the Curve

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

In general, return on investment (ROI) is the benefit (return) of an investment divided by the cost of an investment, and then expressed as a percentage or a ratio. In this case, the benefit of our investment is a reduction in healthcare expenditures. The cost of the investment is the total amount of money invested by the federal government through the Global Commitment to Health Section 1115 waiver and by the State through the General Fund.

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PM **BP** # of Patient Centered Medical Homes

# of Patient Centered Medical Homes
Data Source: DVHA/Blueprint Practice Database

Story Behind the Curve

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

The Patient Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform primary care into what patients want it to be. Research confirms medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. The # of patient centered medical homes in Vermont has risen steadily since 2008.

O VCCI Vermonters Receive Appropriate Care	Time Period	Actual Value	Current Trend	Baseline % Change

P DVHA Medicaid's Vermont Chronic Care Initiative (VCCI) - (Copy)	Time Period	Actual Value	Current Trend	Baseline % Change

Budget Information

Total Program Budget SFY 2018: $3,111,5111

What We Do

The Vermont Chronic Care Initiative (VCCI) identifies and assists Medicaid beneficiaries with chronic health conditions and /or high utilization of medical services to access clinically appropriate health care information and services. DVHA care coordinators are fully integrated core members of existing Community Health Teams and are co-located in provider practices and medical facilities in several communities. The population are the top 5% utilizers of the healthcare system, accounting for 39% of healthcare costs.

How We Impact

VCCI is focused on utilization measures with documented reductions in all areas, including for ambulatory care sensitive (ACS) inpatient hospital admissions, readmissions and emergency department use. Staff are embedded in multiple high-volume hospital and primary care practice sites to support care transitions as well as direct referrals for high risk/cost members. The VCCI continues to receive national recognition for its model and results including by CMS and the National Academy for State Health Policy (NASHP).

VCCI is 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 needs. VCCI has developed collaborative relationships with contracted Medicaid ACO partners and will continue strategic efforts to leverage limited resources toward common goals. Inherent in this, VCCI is active on the payment reform Care Management and Care Models (CMCM) workgroup and has a leadership role in the care management learning collaborative planning and implementation to assure service integration.

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. Due to a change in VCCI's data analytics vendor, there are limited performance measures to display for SFY 2016. More measures will be available for display in the future.

PM DVHA # of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative				
	SFY 2016	1,719	↘ 1	-2% ↓
	SFY 2015	1,947	↗ 1	12% ↑
	SFY 2014	1,740	↘ 1	0% →
	SFY 2013	2,026	↗ 1	16% ↑
	SFY 2012	1,746	→ 0	0% →

Data Source: APS Healthcare

Medicaid's Vermont Chronic Care Initiative (VCCI) - (Copy)

PM **DVHA** # of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative
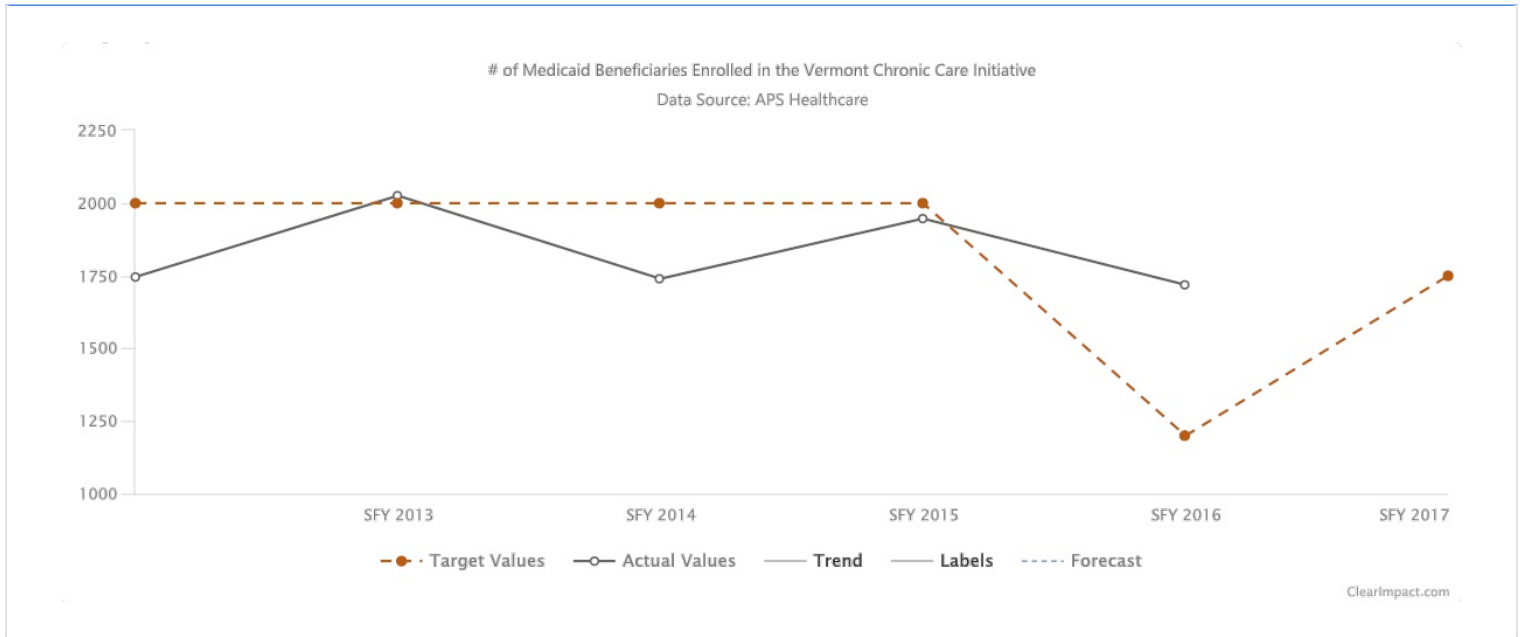
# of Medicaid Beneficiaries Enrolled in the Vermont Chronic Care Initiative
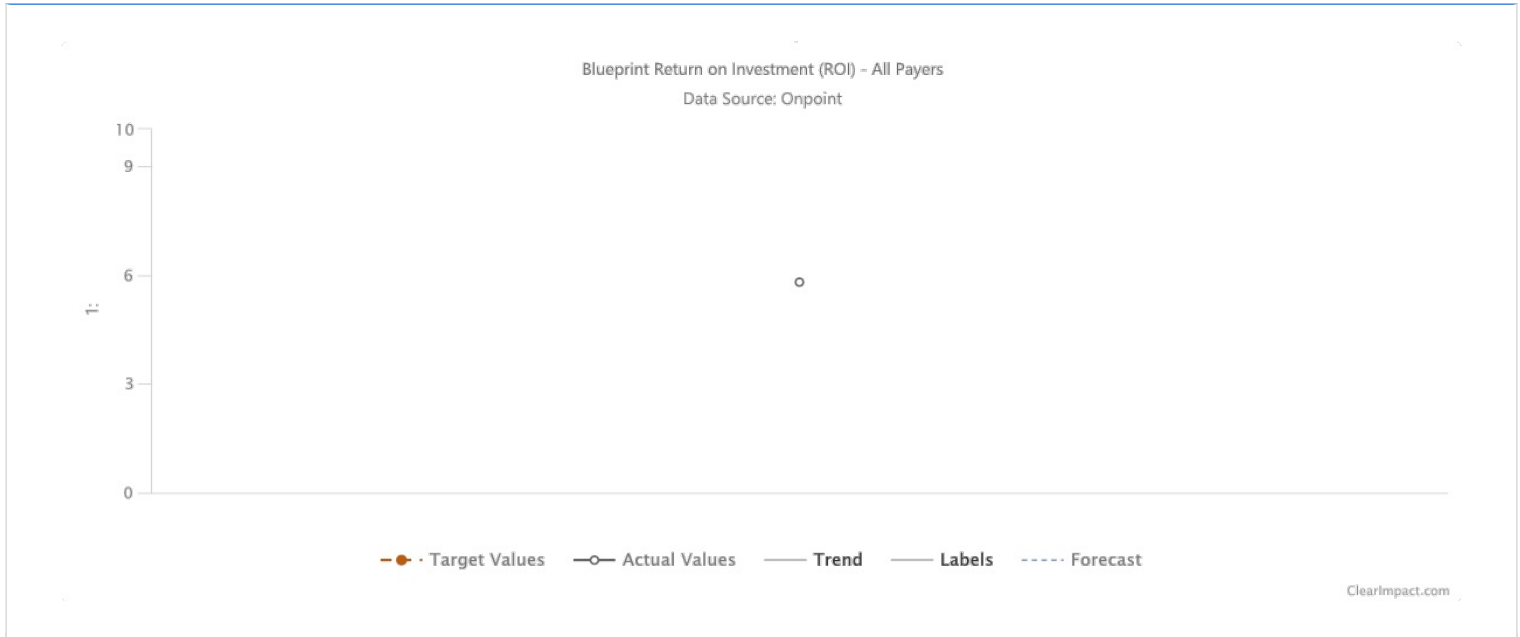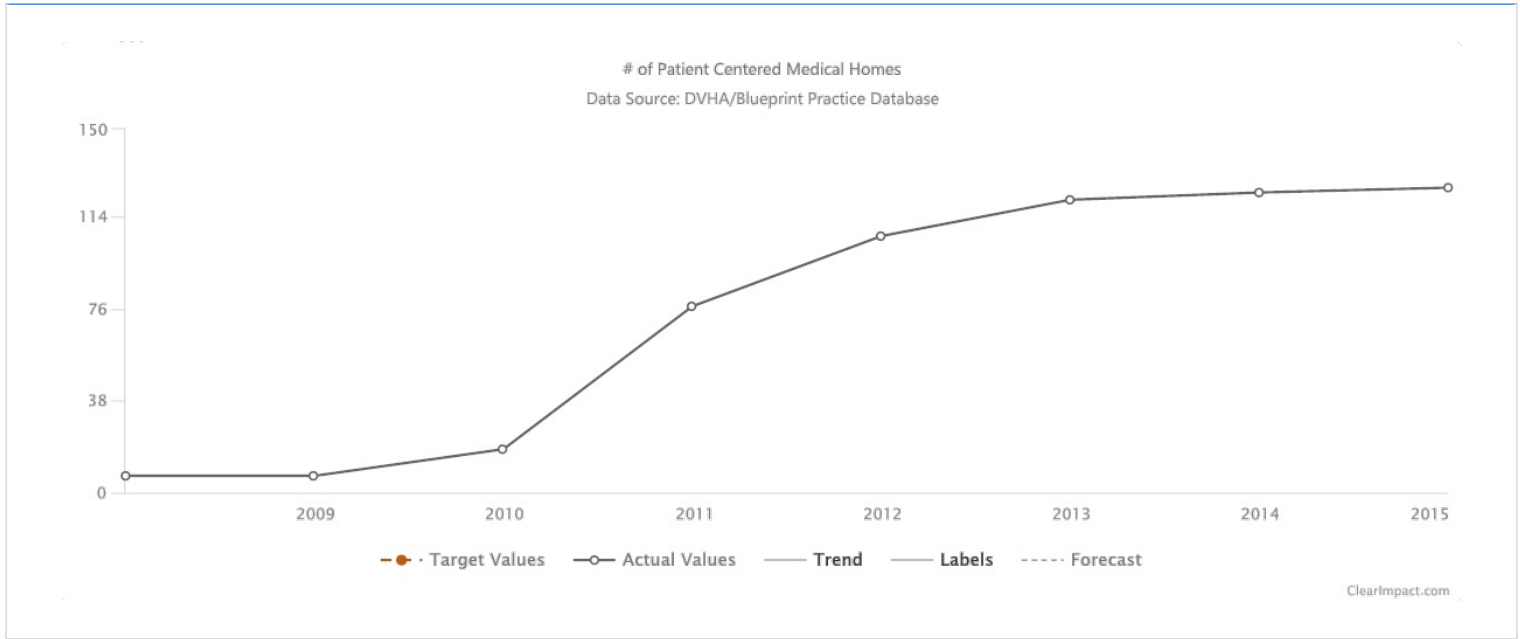Data Source: APS Healthcare

Story Behind the Curve

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

The DVHA/VCCI enrollment for top 5% high cost/high risk members may continue to decrease in the short run, but we do anticipate a leveling off toward the end of the 2nd half of SFY 2017. Reasons behind this are:

- Continued effects of the loss of vendor staff in SFY 2016; 6 FTE nursing and 2 FTE social work positions concurrent with the sun- setting of our contract with APS Healthcare in SFY 2016.These 8 clinical positions were not replaced through the SOV budget/recruitment process and so our VCCI cannot expect to realistically absorb the caseload of these clinicians. Loss of contract staff also included 4 FTE data/reporting positions which has also adversely impacted our program ability to report out.

- The VCCI continues to transition into our new enterprise Care Management system eQHealth and are not up to full functionality in the system. Ongoing bugs/defects in system which include incorrect identification of high risk/high cost members being assigned to VCCI staff; slow system performance is absorbing key clinical time and affects day to day operations. Clinical staff have been pulled, and continue to be pulled from core job duties to support testing in the eQ Training environment – both for testing fixes with current defects in the production site and for testing anticipated future release of functionality/features. Five VCCI clinical staff are identified as testers and are intermittently pulled away from clinical core duties of case management.

- Decrease in direct community referrals from Medicaid funded BP CHTs; this is being addressed at the DVHA senior management level.

- Unknown population details with APM contract with projected start in January 2017; still awaiting attribution from ACO/VCO which will affect VCCI eligible population.

- The variability of VCCI Staff turnover due to uncertainty and unknown in healthcare and healthcare reform landscape based on state and national election results.

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DVHA-HAEEU KPI Dashboard - January 2017

G — Meeting key goals.	⬆ Better than prior period.
Y — Attention needed.	⬌ Same as prior period.
R — Action needed.	⬇ Worse than prior period.

Goal 1: Promptly answer members' calls — Y

Primary Metric	Dec-16	Jan-17	Status	Trend	Green	Yellow
Tier 1 Calls Answered <24 seconds	82%	71%	Y	⬇	>=75%	60-74%
Secondary Metrics						
Tier 1 Answer Rate	97%	95%	G	⬇	>=95%	90-94%
Tier 1 Internal Transfer Rate	19%	17%	Y	⬆	<=10%	11-20%
Tier 1 Internal Transfer ASA (s)	74	133	Y	⬇	<=90	91-180
Transfer Rate (to Tier 2)	8%	10%	Y	⬇	<=7%	8-10%
Tier 2 Calls Answered <300 seconds	44%	39%	R	⬇	>=75%	60-74%

Goal 2: Process member requests timely — Y

Primary Metric	Dec-16	Jan-17	Status	Trend	Green	Yellow
Customer requests resolved in 10 days	92%	90%	G	⬇	>=85%	75-84%
Secondary Metric						
Customer requests resolved in 60 days	97%	97%	Y	⬌	>=99%	95-98%

Goal 3: Transmit data files timely and accurately — Y

Primary Metric	Dec-16	Jan-17	Status	Trend	Green	Yellow
VHC-Carrier errors >10 days old	25	17	G	⬆	<=20	21-50
Secondary Metrics						
VHC-WEX errors >10 days old	82	226	R	⬇	<=20	21-50
VHC-Carrier total error inventory	33	46	G	⬇	<=100	101-200
VHC-WEX total error inventory	105	322	R	⬇	<=100	101-200
VHC-Carrier error rate	1%	1%	G	⬌	<=3%	4-6%
VHC-WEX error rate	6%	7%	R	⬇	<=3%	4-6%
In-Flight Over 4 Days	54	17	G	⬆	<250	250-500

Goal 4: Resolve discrepancies expediently (monthly reconciliation) — Y

Primary Metric	Jan-17	Status	Trend	Green	Yellow
% discrepancies resolved in 30 days	64%	◇		<=90%	81-89%
Secondary Metrics					
Total potential discrepancies identified	4,260	R		<=1000	1001-2000
Discrepancy work inventory	1,536	R		<=750	751-1500
% 1-month carryover (of total potential)	N/A	◇		<=5%	6-10%
% 2-month carryover (of total potential)	N/A	◇		<=3%	4-6%

Goal 5: Facilitate use of self-service functionality

To be added in March 2017

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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

AHRQ............Agency for Healthcare Research and Quality

AHS................Agency of Human Services

AIDS...............Acquired Immune Deficiency Syndrome

AIM................Agency Improvement Model

AIM................Advanced Information Management System (see MMIS)

AIPBP.............All-Inclusive Population-Based Payment

AIRS...............Automated Information and Referral System

ALS.................Advanced Life Support

AMA...............American Medical Association

AMAP.............Aids Medication Assistance Program

AMP...............Average Manufacturer Price

ANFC.............Aid to Needy Families with Children

ANHA.............American Nursing Home Association

ANSI...............American National Standards Institute

AOA................Agency Of Administration

AOE................Agency Of Education

AOEP.............Annual Open Enrollment Period

AOPS..............Assistant Operations

APA................Administrative Procedures Act

APC................Ambulatory Payment Classification

APCP.............Advanced Primary Care Practice

APD................Advanced Planning Document

AP-DRG........All Patient Diagnosis Related Groups

APDU.............Advance Planning Document Update

APG................Ambulatory Patient Group

APhA..............American Pharmaceutical Association

APHA.............American Public Health Associations

APHSA...........American Public Human Services Association

API.................Application Program Interface

APM...............All Payer Model

APMH.............Advanced Practice Medical Homes

APS................Adult Protective Services

APS................APS Healthcare

APSE.............Association for Persons in Supported Employment

APT................Admissions Per Thousand

APTC.............Advanced Premium Tax Credit

AR...................ACCESS Remediation

ARC................Advocacy Organization for People with Developmental Disabilities

ARIS...............Area Resources for Individualized Services

ARRA.............American Recovery and Reinvestment Act of 2009

AS1.................Applicability Statement 1

AS2.................Applicability Statement 2

ASD................Adult Services Division

ASD................Administrative Services Division

ASFA..............Adoption and Safe Families Act

ASHHRA.......American Society of Healthcare Human Resources Administration

ASHP.............American Society of Heal-System Pharmacists

ASHRM .... American Society for Hospital Risk Management

ASP .... Attendant Services Program

ASPA .... American Society for Personnel Administration

ASTHO .... Association of State and Territorial Health Officials

AT .... Access Transformation

AT .... Assistive Technology

ATD .... ACCESS Transformation and Decommissioning

ATNA .... Audit Trails and Node Authentication

AUR .... Ambulatory Utilization Review

AVR .... Automated Voice Response

AWP .... Average Wholesale Price

B

B2B .... Business To Business

BA .... Business Analyst

BAA .... Budget Adjustment Act

BAFO .... Best And Final Offer

BASU .... Business Applications Support Unit

BBF .... Building Bright Futures

BC/BS .... Blue Cross/Blue Shield

BCBSVT .... Blue Cross/Blue Shield of Vermont

BCCH .... Bipartisan Commission on Comprehensive Healthcare

BCCT .... Breast and Cervical Cancer Treatment

BD .... Blind and Disabled

BDO .... Burlington District office

BENDEX ...... Beneficiary Benefits Eligibility Screening Tool

BEST .... Social Security Benefits Eligibility Screening Tool

BGS .... Building and General Services

BHIE .... Bi-directional Health Information Exchange

BHP .... Basic Health Plan

BI .... Business Intelligence

BIAVT .... Brain Injury Association of Vermont

BIN .... Bank Identification Number

BISCHA .... Banking and Insurance, Securities and healthcare Administration

BISHCA .... Banking, Insurance, Securities, and Healthcare Administration (Department of)

BizObj .... Business Objects

BJS .... Bureau of Justice Statistics

BLA .... Bureau of Labor Statistics

BMI .... Body Mass Index

BO .... Business Office

BOBI .... Business Objects Business Intelligence

BOD .... Business Office Division

BP .... Blueprint

BPA .... Business Process Analysis

BPAA .... Benefit Program Assistant Administrator

BPEL .... Business Process Execution Language

BPFH .... Blueprint for Health

BPHC .... Bureau of Primary Healthcare

BPM .... Business Process Management

BPM .... Business Process Model/Modeling

BPMN .... Business Process modeling Notation

BPMS .... Business Process Management Software

BPS .... Benefits Programs Specialist

BPT .... Business Process Template

BR .... Business Rule

BRE .... Business Rule Engine

BRFSS .... Behavioral Risk Factor Surveillance System

BRMS .... Business Rile 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

CCIIO.............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

CF.....................Crisis Fuel
CFC ....Choices For Care
CFCCP............Children and Family Council for Prevention Programs
CFIS ....Clinical Financial Information Systems
CFR ....Code of Federal Regulations
CFSR ....Child and Family State Review
CFSS................Correctional Facility Shift Supervisor
CGMP.............Current Good Manufacturing Price/Practice
CHAC ....Community Health Accountability Care
CHAMPUS....Civilian Health and Medical Program of the Uniformed Services
CHAMPVA ...Civilian Health and Medical Program of the Department of Veterans Affairs
CHAP..............Catamount Health Assistance Premium
CHC ....Community Health Centers
CHC ....Comprehensive Health Centers
CHI..................Consolidated Health Informatics
CHIP...............Children's Health Insurance Program
CHIPRA.........Children's Health Insurance Program Re-Authorization Act
CHF.................Congestive Heart Failure
CHO................Comprehensive Health Centers
CHP.................Certified Health Plan
CHPA...............Community Health Purchasing Alliance
CHPR ....Center for Health Policy and Research
CHS ....Community High School of Vermont
CHSO..............Comprehensive Health Services Organization
CHSVT...........Community High School of Vermont

CHT.................Community Health Team
CI......................Configuration Item
CIA..................Confidentiality, Integrity, and Availability
CIO ....Chief Information Officer
CIS....................Children's Integrated Services
CLD ....Claim Level Detail
CLIA................Clinical Laboratory Improvement Amendments
CM...................Case Management
CM...................Change Management
CM...................Configuration Management
CMC ....Case Manager Conference
CMCM ....Care Management and Care Models
CMHC.............Community Mental Health Center
CMHS ....Center for Mental Health Services
CMIA...............Cash Management Improvement Act
CMMI..............Center for Medicare and Medicaid Innovation
CMN................Certification of Medical Necessity
CMS ....Centers for Medicare and Medicaid Services
CMSO..............Center for Medicaid and State Operations
CNM................Certified Nurse Midwife
CO I ....Correctional Officer One
CO II ....Correctional Officer Two
COA.................Council On Aging
COB ....Coordination Of Benefits
COB ....Certificate of Benefit
COB ....Close Of Business
COB-MAT .....Coordination of Office Based Medication Assisted Therapy
COBRA...........Consolidated Omnibus Reconciliation Act of 1986 (health coverage)
COC.................Change Of Circumstance
COC.................Certificate Of Coverage
CODTP...........Co-Occurring Disorders Treatment Program

COLA .... Cost Of Living Adjustment

COLST .... Clinician Orders for Life-Sustaining Treatment

CON .... Certificate Of Need

ConOps .... Concept of Operations

COPC .... Community Oriented Primary Care

COPD .... Chronic Obstructive Pulmonary Disease

COPS .... Computer Operations and Problem Solving

CORF .... Comprehensive Outpatient Rehabilitation Facility

COS .... Category Of Service

COS .... Cost Of Service

COTS .... Commercial/Common Off-The-Shelf

COU .... Clinical Operations Unit

COVE .... Community Of Vermont Elders

CP .... Custodial Parent (recipient of the support)

CP (2) .... Certified Provider (or Cerebral Palsy)

CPC .... Certified Professional Coder

CPH .... Community Public Health (of the VDH)

CPI .... Center for Program Integrity

CPI .... Consumer Price Index

CPR .... Comparative Performance Reports

CPRC .... Customary, Prevailing and Reasonable Charge

CPRS .... Computerized Patient Record System

CPS .... Child Protective Services

CPT .... Common Procedural Terminology

CPTOD .... Capitated Program for the Treatment of Opiate Dependency

CQI .... Continuous Quality Improvement

CR .... Conditional Reentry

CRC .... Community Rating by Class

CRCF .... Chittenden Regional Correctional Facility

CRM .... Customer Relationship Management

CRT .... Community Rehabilitation and Treatment

CSAC .... Counseling Services of Addison County

CSAP .... Center for Substance Abuse Prevention

CSAT .... Center for Substance Abuse Treatment

CSBG .... Community Services Block Grant

CSC .... Customer Support Center

CSD .... Computer Services Division (OCS)

CSE .... Child Support Enforcement

CSFP .... Commodity Supplemental Food Program

CSHN .... Children with Special Health Needs

CSME .... Coverage and Services Management Enhancement

CSME .... Central Source for Measurements and Evaluation

CSP .... Child Support Problems

CSP .... Community Support Program

CSR .... Cost Sharing Reductions

CSR .... Customer Service Request

CSR .... Change System Request

CSR .... Customer Support/Service Representative

CSS .... Child Support Specialist

CSS .... Corrections Service Specialist

CSTL .... Community Services Team Leader

CUPS .... Children's Upstream Services Grant

CURB .... Clinical Utilization Review Board

CVCA .... Central Vermont Council on Aging

CVCAC .... Central Vermont Community Action Council

CVH .... Central Vermont Hospital

CVOEO .... Champlain Valley Office of Economic Opportunity

CVP .... Controlled Vendor Payment

CVSAS	Central Vermont Substance Abuse Service
CW&YJ	Child Welfare and Youth Justice
CY	Calendar Year

D

DA	Designated Agency
DAD	Deliverable Acceptance Document
DAIL	Department of Disabilities, Aging and Independent Living
DAW	Dispense As Written
DAWN	Drug Abuse Warning Network
DBA	Database Administration
DBMS	Database Management System/Services
DBVI	Division for the Blind and Visually Impaired
DC	Delinquent in Custody
DCA	Department of Cost Allocation (federal)
DCF	Department for Children and Families
DCF BO	Department for Children and Families Business Office
DCG	Diagnostic Cost Group
DD	Developmental Disabilities
DDC	Developmental Disabilities Council
DDI	Design, Development and Implementation
DDR	Drug Data Reporting for Medicaid
DDS	Disability Determination Services (part of DCF)
DDS	Division of Developmental Services
DDS	Developmental Disability Services
DDSD	Developmental Disabilities Services Division
DEA	Drug Enforcement Administration
DED	Deliverable Expectations Document
DEL	Deliverable
DESI	Drug Efficacy Study Implementation

DHHS	Department of Health and Human Services (federal)
DHHS/HHS	United States Department of Health and Human Services
DHMC	Dartmouth Hitchcock Medical Center
DHRS	Day Health Rehabilitation Services
DII	Department of Information and Innovation
DIS	Detailed Implementation Schedule
DLP	Division of Licensing and Protection
DLP	Disability Law Project
DMC	Disease Management Coordinators
DME	Durable Medical Equipment
DMH	Department of Mental Health
DO	District Office
DOA	Date Of Application
DOB	Date Of Birth
DOC	Department Of Corrections
DOE	Department of Education (United States or State.)
DOE	United States Department of Energy
DOH	Department Of Health (now VDH)
DOJ	Department Of Justice
DOL	Department Of Labor
DOS	Date Of Service
DOT	Dictionary of Occupational Titles
DP	Delinquent on Probation
DR	Disciplinary Report
DR	Desk Review
DR	Disaster Recovery
DR. D	Dr. Dynasaur Program
DR.D	Doctor Dynasaur
DRA	Deficit Reduction Act
DRAMS	Drug Rebate Analysis and Management System
DRG	Diagnosis Related Grouping
DS	Developmental Services
DS	Day Supply

DSA	Digital Signature Algorithm
DSCF	Dale State Correctional Facility
DSH	Disproportionate Share Hospital
DSHP	Designated State Health Plan
DSM IV	Diagnostic and Statistical Manual of Mental Disorders (4th Edition Revised)
DSM V	Diagnostic and Statistical Manual of Mental Disorders Version V
DSM 5	Diagnostic and Statistical Manual of Mental Disorders Version V
DSS	Decision Support System
DUR	Drug Utilization Review (Board)
DURSA	Data Use and Reciprocal Support Agreement
DVHA	Department of Vermont Health Access
DVR	Vermont Division of Vocational Rehabilitation
DW	Data Warehouse

E

E&E	Eligibility & Enrollment (Funding for more than IE)
EA	Emergency Assistance
EA	Enterprise Architecture
EA	Economic Assistance
EAC	Estimated Acquisition Cost
EAC	Estimate At Completion (Estimate to Complete)
EAI	Enterprise Application Integration
EAP	Employee Assistance Program
EBC	Enterprise Business Capabilities
E-bed	Emergency Bed
EBPM	Enterprise Business Process Management
EBPO	Enterprise Business Process Owner
EBT	Electronic Benefit Transfer
ECM	Enterprise Content Management
ECR	Engineer Change Request
ECS	Electronic Claims Submission
ECT	Electro-Convulsive Therapy

ED	Emotionally Disturbed
ED	Emergency Department
EDA	Event Driven Architecture
EDI	Electronic Data Interchange
EDMS	Electronic Documentation Management System
EDS	Electronic Data Systems Corporation
EEG	Electroencephalogram
EFF	Equipped For the Future
EFT	Electronic Funds Transfer
EGA	Estimated Gestational Age
EHB	Essential Health Benefits
EHR	Electronic Health Record
EHRIP	Electronic Health Record Incentive Program
EIA	Enterprise Information Architecture
EITC	Earned Income Tax Credit
ELC	Enterprise Life Cycle
EMPI	Enterprise Master Patient Index
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EOB	Explanation Of Benefits
EOMB	Explanation Of Medicare (or Medicaid) Benefits
EP	Essential Person
EP	Emergency Preparedness
EPMO	Enterprise Project Management Office
EPO	Exclusive Provider Organization
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
ERA	Electronic Remittance Advice
ERC	Enhanced Residential Care
ESB	Enterprise Service Bus
ESD	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

G/L .... General Ledger
G2B .... Government To Business
G2C .... Government To Consumer
G2E .... Government To Employee
G2G .... Government To Government
GA .... General Assistance
GA/EA .... General Assistance/Emergency Assistance
GAAP .... Generally Accepted Accounting Principles
GAO .... General Accounting Office
GAO .... Government Accounting Office
GC .... Global Commitment
GCR .... Global Clinical Record (application of the MMIS)
GDEA .... Generic Drug Enforcement Act
GEP .... General Enrollment Period
GF .... General Fund
GH .... Group Home
GHRI .... General Health Rating Index
GHS .... Goold Health Systems
GMC .... Green Mountain Care
GMCB .... Green Mountain Care Board
GME .... Graduate Medical Education
GMP .... Good Manufacturing Practice
GMSA .... Green Mountain Self-Advocates
GOVNET ...... State of Vermont Government Wide Area Network (WAN)
GPCI .... Geographic Practice Cost Index
GPI .... Generic Product Identifier
GS .... Guardianship services
GSD .... General Systems Design
GSS .... Guardian Services Specialist
GUI .... Graphical User Interface

H

HAEEU .... Health Access Eligibility and Enrollment Unit
HSA .... Health Savings Account
HSA .... Health Services Area
HSA .... Health Systems Agency
HASS .... Housing and Supportive Services
HATF .... Health Access Trust Fund

HB .... Home-based
HBE .... Health Benefit Exchange
HBE or VHC Health Benefits Exchange
HBEE Rule ... Health Benefits Eligibility and Enrollment Rule
HBKF .... Healthy Babies, Kids and Families
HCBS .... Home and Community Based Services
HCERA .... Healthcare and Education Reconciliation Act of 2010
HCFA .... Healthcare Finance Administration (now CMS)
HCPCS .... Healthcare Common Procedure Coding System
HCQIA .... Healthcare Quality Improvement Act
HCR .... Healthcare Reform
HDO .... Hartford District Office
HEASB .... Health Standard Board
HEDIS .... Health Plan Employer Data and Information Set
HEDIS .... Healthcare Effectiveness Data and Information Set
HFMA .... Healthcare Financial Management Association
HHA .... Home Health Agency
HHS .... Health and Human Services (U.S. Department of)
HI .... Home Intervention
HIAA .... Health Insurance Association of America
HIB .... Health Insurance Benefits
HIB .... Hospital Insurance Benefit
HICN .... Health Insurance Claim Number
HIE .... Health Information Exchange
HIE/HIX ...... Health Information Exchange
HIFA .... Health Insurance Flexibility and Accountability
HIM .... Health Insurance Marketplace
HIMSS .... Healthcare Information Management Systems Society
HIN .... Health Information Network

HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Program
HIR	Hire Into Range
HISP	Health Information Service Provider
HISPC	Health Information Security and Privacy Collaboration
HIT	Health Information Technology
HITECH	HIT for Economic and Clinical Health
HITPC	Health Information Technology Policy Committee
HITSP	Health Information Technology Standards Panel
HIV	Human Immunodeficiency Virus
HIX	Health Insurance Exchange
HJR	House Joint Resolution
HMO	Health Maintenance Organization
HMSA	Health Manpower Shortage Area
HN Team	Hostage Negotiations Team
HOS	Health Outcomes Survey
HP	Hewlett Packard
HPA	Health Policy Agenda
HPID	Health Plan Identifier
HPO	Hospital Physician Organization
HPES	Hewlett-Packard Enterprise Services
HPIU	Health Programs Integration Unit
HR	Health Reform
HRA	Health Reimbursement Account
HRA	Health Risk Assessment
HRAP	Health Resource Allocation Plan
HRD	Human Resource Development
HRP	High Risk Pregnancy Program
HRQoL	Health Related Quality of Life Scale
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
HSA	Health Services Area

HSB	Human Services Board
HSE	Health and Human Services Enterprise
HSE	Health Services Enterprise
HSE ESC	Health Services Enterprise Executive Steering Committee
HSE OSC	Health Services Enterprise Operational Steering Committee
HSEP	Health Services Enterprise Platform - "the Platform"; the shared services and infrastructure that will be shared across solutions.
HSS	Health Care Service Specialist
HTHC	Adult High Technology Home Care
HTML	Hypertext Markup Language
HTTP	Hypertext Transfer Protocol
HUD	United States Department of Housing and Urban
HVP	Healthy Vermonters Program

I

I&R	Information and Referral
IA	Information Architecture
IAM	Identity and Access Management
IAPD	Implementation Advance Planning Document
IAPDU	Implementation Advanced Planning Document Update
IBM	Intensive Benefits Management
IBNE	Incurred But Not Enough
IBNR	Incurred But Not Reported
IC	Individual Consideration
ICD	International Classification of Diseases (diagnosis codes and surgical codes)
ICD-9	ICD 9th Edition (prior version)-clinical modification
ICD-10	ICD 10th Edition (current version)-clinical modification
ICEHR	Integrated Care Electronic Health Record
ICF	Intermediate Care Facility

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

MCE	Managed Care Entity
MCH	Maternal and Child Health
MCI	Master Client Index
MCIS	Managed Care Information System
MCMC	Managed Care Medical Committee
MCO	Managed Care Organization
MCP	Managed Care Plan
MCPI	Medical Care Price Index
MCR	Modified Community Rating
MDB	Medicare DataBase
MDC	Major Diagnostic Category
MDM	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
MDO	Barre District Office
MDS	Minimum Data Set
MEAB	Medicaid and Exchange Advisory Board
MEC	Minimum Essential Coverage
MECT	Medicaid Enterprise Certification Toolkit
MEG	Medicaid Eligibility Group
MED	Mental or Emotional Disturbance (or Disorder.)
MEQC	Medicaid Eligibility Quality Control
MES	Medicaid Enterprise Solution
MFCN	Military Family Community Network
MFCU	Medicaid Fraud and Control Unit
MFP	Money Follows the Person
MFRAU	Medicaid Fraud and Residential Abuse Unit
MFS	Medical Fee Schedule
MFT	Managed File Transfer
MH	Mental Health
MHSA	Mental Health and Substance Abuse
MI	Mental Illness
MIC	Medicaid Integrity Contractor

MID	Medicaid Identification Number (for member, see UID)
MIG	Medicaid Integrity Group
MIG	Medicare Insured Groups
MIP	Medicaid Integrity Program
MIS	Management Information System
MITA	Medicaid Information Technology Architecture
MMA	Medicare Modernization Act
MMIS	Medicaid Management Information System
MMM	Medicaid Information Technology Architecture Maturity Model
MMP	Mixed Model Plan
MNF	Medical Necessity Form
MOE	Maintenance Of Effort
MOE	Maintenance Of Eligibility
MOM	Message-Oriented Middleware
MOS	Medicaid Operations Services
MOU	Memorandum Of Understanding
MOW	Meals On Wheels
MOVE	Modernization Of VT's Enterprise
MPI	Master Provider Index
MPR	Medication Possession Ratio
MPU	Medicaid Policy Unit
MR	Mental Retardation
MRP	Management Reporting System
MSA	Medical Savings Account
MSA	Metropolitan Statistical Areas
MSIS	Medicaid Statistical Information System
MSP	Medicare Savings Programs
MSR	Monthly Service Report
MSW	Master's degree in Social Work
MTM	Medication Therapy Management
MTMP	Medication Therapy Management Program
MU	Meaningful Use
MUA	Medically Underserved Areas
MVP	Mohawk Valley Physicians
MVP	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
OCIIO ....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

OEP................Open Enrollment Period
O&E................Outreach and Education
OEO................Office of Economic Opportunity
OH................Order of Hospitalization
OHA................Office of Hearings and Appeals
OHITA..........Office of Health Information Technology Adoption
OHM................Oracle HTTP Server
OHRA..............Oral Health Risk Assessment
OIG................Office of the Inspector General
OIM................Oracle Identity Manager
OIS................Office of Interoperability and Standards
OJJDP.............Office of Juvenile Justice and Delinquency Prevention
OJP................Office of Justice Programs
OLAP..............Online Analytical Processing
OLTP..............Online Transaction Processing
OMS................Offender Management System
ONC................Office of National Coordinator for Health Information Technology
ONH................Order of Non-Hospitalization
OPG................Office of Public Guardian
OPM................Oversight Project Management
OPPS..............Outpatient Prospective Payment System
OPS................Operations
ORP................Offender Responsibility Plan
OSA................Other State Agency
OSHA..............Occupational Safety and Health Administration
OTC................Over The Counter
OUD................Oracle Unified Directory
OVD................Oracle Virtual Directory
OVHA..............Office of Vermont Health Access (now DVHA)

P

P&T................Pharmacy and Therapeutics Committee
P&A................Protection and Advocacy
P&P................Probation and Parole or Policies and Procedures

PA................Payment Authorization
PA................Physician Assistant
PA................Prior Authorization
PA................Public Assistance
PACE..............Program for All-Inclusive Care for the Elderly
PADSS.............Prior Authorization Decision Support System
PAF................Pre-Approved Furlough
PAL................Parents' Assistance Line
PAPD..............Planning Advanced Planning Document (CMS)
PAR................Personnel Action Request
PARIS..............Public Assistance Reporting Information System
PASRR............Preadmission, Screening and Annual Resident Review
PATH.............Program to Assist in the Transition from Homelessness (federal)
PATH..............Prevention, Assistance, Transition and Health Access
PBA................Pharmacy Benefit Administrator
PBA/PBM.....Pharmacy Benefits Administrator/Pharmacy Benefits Manager
PBM................Pharmacy Benefit Management
PBMS..............Pharmacy Benefits Management System
PBSA..............Pharmacy Benefits Services Administration
PC................Personal Computer
PC Plus..........Primary Care Plus (VT program)
PCA................Personal Care Attendant
PCA................Primary Care Association
PCC................Parent Child Centers
PCCM..............Primary Care Case Management
PCIP................Pre-existing Condition Insurance Plan
PCMH.............Patient-Centered Medical Home
PCMH.............Program in Community Mental Health
PCN................Primary Care Network

PCN	....	Processor Control Number
PCO	....	Primary Care Office
PCP	....	Primary Care Provider
PCPlus	....	Primary Care Plus
PCS	....	Procedure Coding System
PDC	....	Primary Data Center
PDD	....	Pervasive developmental disorder
PDF	....	Portable Document File
PDL	....	Preferred Drug List
PDL	....	Project Document Library
PDP	....	Prescription Drug Plan
PDP	....	Pharmacy Drug Plan
PDP	....	Medicare Part D Prescription Drug Plan
PDP	....	Pharmacy Discount Program
PDSA	....	Plan, Do, Study, Act
PEAKS	....	Performance Enhancement and Knowledge System
PEP	....	Principal Earner Parent
PEP	....	Proposal Evaluation Plan
PERM	....	Payment Error Rate Measurement
PERS	....	Personal Emergency Response System
PES	....	Provider Electronic Solutions
PHC	....	Personalized Healthcare
PHI	....	Protected Health Information
PHO	....	Physician Hospital Organization
PHR	....	Personal Health Record
PI	....	Program Integrity
PIA	....	Privacy Impact Assessment
PIC	....	Parent Information Center
PIDL	....	Physician Injectable Drug List
PIHP	....	Pre-Paid Inpatient Health Plan
PII	....	Personally Identifiable Information
PIL	....	Protected Income Level (Poverty Income Guidelines)
PIL	....	Project Information Library (also known as Project Document Library)
PIP	....	Performance Indicator Project
PIP	....	Performance Improvement Project
PIP	....	Periodic Interim Payment

PIRL	....	Plan Information Request Letter
PKI	....	Public Key Infrastructure
PM	....	Project Manager
PMBOK	....	Project Management Body Of Knowledge
PMI	....	Project Management Institute
PMIS	....	Provider Management Information System
PMNI	....	Private Non-Medical Institution (treatment group home)
PMO	....	Project Management Office
PMP	....	Project Management Plan
PMP	....	Project Management Professional
PMPM	....	Per Member Per Month
PMPY	....	Per Member Per Year
PNA	....	Personal Needs Allowance
PNI	....	Personal Needs Issuance
PNMI	....	Private Non-Medical Institution
POC	....	Plan Of Care
POC	....	Public Oversight Committee
POLST	....	Physician Orders for Life-Sustaining Treatment
POS	....	Place Of Service
POS	....	Point Of Sale
POS	....	Point Of Service
POX	....	Plain Old XML
PP&D	....	Policy & Procedure Directive
PP&D	....	Policy, Procedures & Development (Interpretive Rule Memo)
PPA	....	Project Process Agreement
PPA	....	Prior Period Adjustment
PPACA	....	Patient Protection and Affordable Care Act
PPC	....	Program Participation Credit
PPCP	....	Pediatric Palliative Care Program
PPO	....	Preferred Provider Organization
PPPM	....	Per Patient Per Month
PPR	....	Planning, Policy and Regulation
PPS	....	Prospective Payment System
PPS	....	Production Problem Solving
PQA	....	Prior Quarter Adjustment

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
RBRVS...........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
RFP.................Request For Proposals
RFQ.................Request For Quote
RFR..................Request For Classification Review

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

SESCF............Southeast State Correctional Facility

SEVCA............Southeastern Vermont Community Action

SF ....Supplemental Fuel

SFTP ....Secure File Transfer Protocol

SFY ....State Fiscal Year

SGF ....State General Fund

SGO ....Surgeon General's Office

SHCRF ....State Healthcare Resource Fund

SHIP................State Health Insurance (and Assistance) Program

SHIP(s) ....State Health Insurance Assistance Program(s)

SHMO ....Social Health Maintenance Organization

SHOP..............Small business Health Options Program

SHP ....Supportive Housing Program

SHRF ....State Healthcare Resources Fund

SI ....Systems Integration

SI ....Systems Integrator

SIDS ....Sudden Infant Death Syndrome

SILC ....Statewide Independent Living Council

SIM ....State Innovation Model

SIT ....State Interagency Team

SIT ....System Integration Test

SIU ....Special Investigation Unit

SLA ....Service Level Agreement

SLHIE ....State Level HIE Consensus Project

SLMB..............Specified Low-income Medicare Beneficiary

SLP (2) ....Shared living provider (or speech language pathologist)

SLR ....System/Service Level Requirement

SMA.................State Medicaid Agency

SMA.................System Modification Authorization

SMAC..............State Maximum Acceptable Cost

SMDL..............State Medicaid Directors Letter

SME.................Subject Matter Expert

SMHP ....State Medicaid HIT Plan

SMHRCY ....State Mental Health Representatives for Children and Youth

SMI...................Supplementary Medical Insurance

SMM ....State Medicaid Manual

SMOKE TEST Preliminary testing to reveal simple failures severe enough to reject a release

SNAP...............State Nutritional Assistance Program

SNF..................Skilled Nursing Facility

SNOMED ......Systematized Nomenclature Of Medicine

SNTP...............Simple Network Time Protocol

SO....................State Office

SOA.................Service Oriented Architecture

SOAP..............Simple Object Access Protocol

SOP.................Standard Operating Procedure

SOR.................System Of Records

SORN..............System Of Record Notice

SOS..................Security and Operations Supervisor

SOV.................State Of Vermont

SOW................Statement Of Work

SP....................Service Plan

SPA..................State Plan Amendment

SPAP...............State Pharmacy Assistance Program

SPAP...............State Pharmaceutical Assistance Program

SPAP...............State Prescription Drug Assistance Program

SPLS ....State Parent Locator Service

SPM.................Service Portfolio Management

SPP..................Specialized Programs Project (under the MMIS program)

SPR..................Safeguard Procedures Report

SQL..................Structured Query Language

SR ....Supplemental Rebate

SRA ....Supplemental Rebate Agreement

SRF..................Siebel Repository File

SRS...................Social and Rehabilitative Services (Department of)

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

UC ....Unmanageable in Custody	
UCF................Universal Claim Format	
UCM................Universal Customer Master	
UCR................Usual and Customary Rate	
UCS................United Counseling Services	
UCUM ....Unified Code for Units of Measure	
UDDI ....Universal Description, Discovery and Integration	
UI ....Unemployment Insurance	
UI ....User Interface	
UIB ....Unemployment Insurance Benefits	
UID................Unique Identification Number	
UIFSA ....Uniform Interstate Family Support Act (governs interstate child support cases)	
UIR................Unusual Incident Report	
UM................Utilization Management	
UML................Unified Modeling Language	
UMLS..............Unified Medical Language System	
UR................Utilization Review	
URA................Unreimbursed Public Assistance	
URA................Unit Rebate Amount	
URAC..............Utilization Review Accreditation Commission	
URC................Utilization Review Committee	
URESA ....Uniform Reciprocal Enforcement of Support Act	
URO ....Utilization Review Organization	
USC................United States Code	
USDA..............United States Department of Agriculture	
USPHS...........U.S. Public Health Service	
UT................Unit Test	
UVM...............University of Vermont	

V

VA ....Veterans Administration
VAB ....VT Association for the Blind
VABIR ....Vermont Association of Business, Industry and Rehabilitation
VABVI.............Vermont Association for the Blind and Visually Impaired
VAC ....Vermont Achievement Center

VAHHA.........Vermont Assembly of Home Health Agencies
VAHHS..........VT Association of Hospital and Health Systems
VAMH.............Vermont Association for Mental Health
VAR.................Value Added Reseller
VARC..............Resources and Community Opportunities for Vermonters w/ Developmental Disabilities
VC ....Voluntary Care
VCA................Vermont Correctional Academy
VCCI...............Vermont Chronic Care Initiative
VCDMHS.......Vermont Council of Developmental and Mental Health Services
VCDR.............Vermont Coalition for Disability Rights
VCF.................Vermont Children's Forum
VCHIP ....Vermont Child Health Improvement Program
VHCIP ....Vermont Healthcare Innovation Project
VCI ....Vermont Correctional Industries
VCIL...............Vermont Center for Independent Living
VCORP..........Vermont Coalition Of Residential Providers
VCRP ....Vermont Coalition of Runaway Programs
VCSA ....Vermont Cost Sharing Assistance
VCSR ....Vermont Cost Sharing Reduction
VCTF...............Vermont Children's Trust Fund
VDH ....VT Department of Health
VDO................Morrisville District Office
VEAF..............Vermont Enterprise Architecture Framework
VET ....Vetting is a process of examination and evaluation
VFAFA ....Vermont Foster and Adoptive Family Association
VHAP ....Vermont Health Access Plan

VHAP-Rx.......Vermont Health Access Plan Pharmacy Program

VHAT ....VT Health Access Team

VHBE ....Vermont Health benefit Exchange

VHC ....Vermont Health Connect

VHCA ....Vermont Healthcare Association

VHCURES ....Vermont Healthcare Claims Uniform Reporting and Evaluation System

VHITP............Vermont Health Information Technology Plan

VHPSI.............Vermont Hospital Preventative Services Initiative

VIEWS............Vermont's Integrated Eligibility Workflow System

VIP..................VT Independence Project

VISION..........VT's Integrated Solution for Information and Organizational Needs (the statewide accounting system)

VISTA.............Volunteers in Service to America

VIT ....VT Interactive Television

VIT ....Vermont Interactive Technologies

VITL................Vermont Information Technology Leaders

VITN...............Vermont Interactive Television Network

VLA..................Vermont Legal Aid

VMAP ....Vermont Medication Assistance Program

VMS................VT Medical Society

VNA................Visiting Nurses Association

VOIP ....Voice Over Internet Protocol

VPA..................Vermont Premium Assistance

VP&A ....Vermont Protection and Advocacy

VPCCN..........Vermont Parent Child Center Network

VPharm..........VT Pharmacy Program

VPIC...............Vermont Parent Information Center

VPN ....Virtual Private Network

VPQHC ....Vermont Program for Quality in Healthcare

VPR.................Vermont Premium Reduction (see VPA)

VPS ....Vermont Psychiatric Survivors

VPTA...............Vermont Public Transportation Agency

VR....................Vocational Rehabilitation

VRS ....Voice Response System

VRU ....Voice Response Unit

VSA ....Vermont Statutes Annotated

VScript.............VT Pharmacy Assistance Program

VSDS................VT State Dental Society

VSEA ....Vermont State Employees Association

VSECU............Vermont State Employees Credit Union

VSH..................Vermont State Hospital

VSHA...............Vermont State Housing Authority

VTCECH ....Vermont Campaign to End Childhood Hunger

VTDDC ....Vermont Developmental Disabilities Council

VTHR..............Vermont Human Resources

VTL..................Vermont Technology Leaders

VTPSA.............Vermont Treatment Program for Sexual Aggressives

W

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

X

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

Y

YDO................Middlebury District Office
YRBS ....Youth Risk Behavior Survey

Z

ZDO................State Office/Central Office