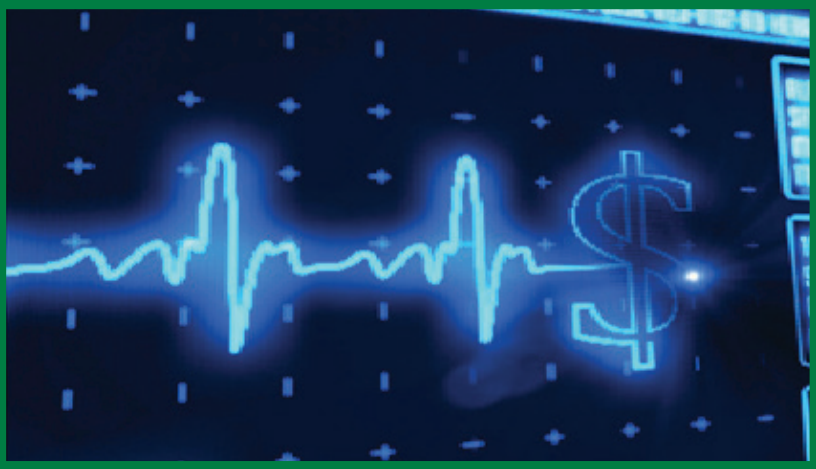
VERMONT

Department of Vermont Health Access
Annual Report and SFY 2020 Budget Recommendation



Special Thanks to:

- **Heather Batalion**
- **Christie Omodeo**
- **Stacy DeSisto**
- **All DVHA Staff who submitted photos**

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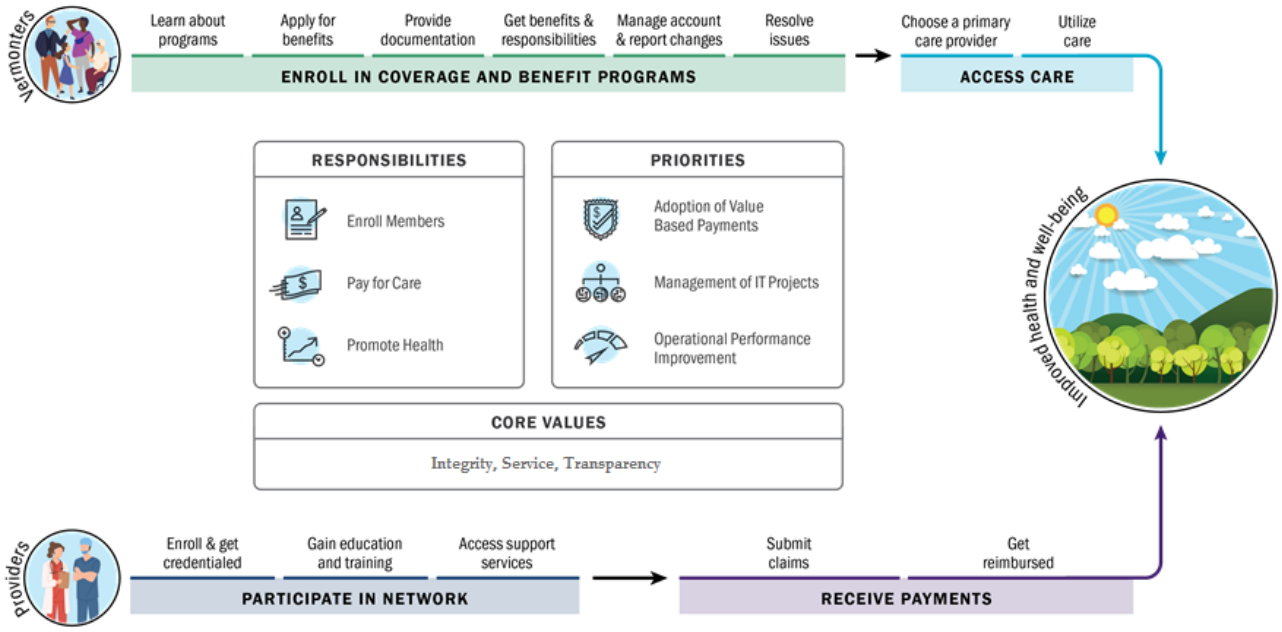
Chapter One: Introduction to DVHA

DVHA Commissioner's Message

<u>Our Mission:</u> Improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively.



Story Behind the Mission

When we say our mission is "to improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively," we are really saying that we are striving to do multiple things. First, we are saying *what* we're trying to do: to improve the health and well-being of Vermonters. Second, we're saying *how* we're trying to do it: by providing access to quality healthcare. But that's not all. We're *committing* to meeting our first two mission objectives cost-effectively. In other words, we are conscious that we are accountable to both our members and to taxpayers.

To achieve this mission, our work revolves around three core responsibilities:

- Assisting Vermonters in need to enroll as members in appropriate programs. Follow the "Vermonters" path in the diagram above and read on to Chapter 2 to see this process described in greater detail.
- Paying for care. Follow the "Providers" path in the diagram above and read on to Chapter 3 and 4 to hear about our work building and collaborating with a robust network of healthcare providers, pharmacies, and others.
- Improving health outcomes. We recognize that simply signing people up will not achieve optimal outcomes at the most efficient cost, so we strategically invest in

programs that improve health. Read on to Chapter 5 to hear about our commitment to quality and improvement.

Our Priorities

Our commitment to continual improvement is not limited to health outcomes. When we look for opportunities to improve internally – in the way we carry out our responsibilities – three priorities emerge *adoption of value-based payments, management of information technology projects*, *and operational performance improvement*. If we successfully execute these priorities, we will be well positioned to deliver on the triple aim of improving patient experience of care, improving population health, and reducing per capita cost growth.

Our department has 20 functional units, each works on one or more of our responsibilities and contributes to one or more of our priorities. The graphic at the start of Chapter 9 maps which units work on which priorities, while the Scorecard in Appendix C tracks their key performance indicators.

Our Values

Our department commits to executing our responsibilities and priorities while adhering to three core values:

Transparency	We trust that we will achieve our collective goals most efficiently if we communicate the good, the bad, and the ugly with our partners and stakeholders.
Integrity	In the words of psychologist Brené Brown, we commit to "choosing courage over comfort…. choosing what is right over what is fun, fast, or easy…. choosing to practice [our] values rather than simply professing them."
Service	Everything we do is funded by taxpayers to serve Vermonters. Therefore, we must ensure that our processes and policies are person-centered. We aim to model, drive, and support the integration of person-centered principles throughout our organizational culture.

These values guide all our work, including the development of this annual report and budget request. We strive to empower policymakers with more predictable Medicaid forecasting and continually reach for better health outcomes for Vermonters. We seek to determine what drives success in our business and measure performance in these functions over time.

We appreciate that you are taking the time to read our annual report and we welcome your participation in the dialogue.

Accomplishments

DVHA strives to fulfill its responsibilities to members and taxpayers while making progress on its three priorities: adoption of value-based payments, management of information technology projects, and operational performance improvement. This section offers highlights of some of the past year's accomplishments.

Adoption of Value-based Payments

DVHA has continued to advance value-based payments, successfully completing and evaluating the first full year of the Accountable Care Organization (ACO) program and initiating the second year; expanding payment reforms out across an array of services; and, through the Medicaid Pathways Work, developing an outline of payment reform processes to help guide future reforms.

Refined and Continued Medicaid Pathways Work

Section 12 of Act 113 of 2016 requires the Secretary of the Agency of Human Services to embark upon a multi-year process of payment and delivery system reform for Medicaid providers aligned with the Vermont All-Payer ACO Model and other existing payment and delivery system reform initiatives. DVHA published the Medicaid Pathways report on 1/1/19, which attempts to demystify payment and delivery system reform by describing the process and daily work that occurs within AHS and with our stakeholders. Specifically, the report consisted of two basic elements. First, a description of the payment reform process, which is typically facilitated by the Payment Reform team at DVHA. Second, the report provides an update on completed and in-progress payment reform activities, using the enumerated statutory criteria:

- Medicaid payments to affected providers;
- changes to reimbursement methodology and the services impacted;
- efforts to integrate affected providers into the APM and with other payment and delivery system reform initiatives;
- changes to quality measure collection and identifying alignment efforts and analyses, if any; and
- the interrelationship of results-based accountability initiatives with the quality measures referenced above.

The following payment and delivery system reform initiatives were either completed or in-progress in 2018:

- Vermont Medicaid Next Generation (VMNG) ACO program
- Applied Behavior Analysis (ABA)
- Children's and Adult's Mental Health
- Residential Substance Use Disorder (SUD) Program
- Developmental Disabilities Services
- Pediatric Palliative Care

The report serves as an excellent primer on reform, and some of these programs are described in greater length below.

Completed the First Full Year of the Vermont Medicaid Next Generation (VMNG) ACO Program

The calendar year 2017 was the first full year of the VMNG ACO program. DVHA reported five distinct results:

1. DVHA and One Care launched the program successfully.
2. The program is growing.
3. The ACO program spent less than expected on healthcare in 2017.
4. The ACO met most of its quality targets. Specifically, the ACO's quality score was 85% on 10 pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to diabetes control and engagement with alcohol and drug dependence treatment. Examining quality trends over time will be important to understand the impact of changing provider payment on quality of care.
5. DVHA is seeing more use of primary care among ACO-attributed Medicaid members. Based on preliminary analyses of utilization, the cohort of attributed members has had higher utilization of primary care office visits than the cohort of members who are eligible for attribution but not attributed. As further information about utilization becomes available, DVHA will conduct more robust analyses to determine whether differences between cohorts are statistically significant, and to understand the impact of the program on utilization patterns over time.

Nearly Tripled the Number of Members Covered by Value-Based Payments Rather than Fee-for-service

Additional providers and communities have joined the ACO network to participate in the VMNG program for the 2019 performance year. The table below depicts program growth from 2017 – 2019, a key milestone for provider-led health reform.

	2017 Performance Year	2018 Performance Year	2019 Performance Year
Hospital Service Areas	4	10	13
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs
Unique Medicaid Providers	~2,000	~3,400	~4,300
Attributed Medicaid Members	~29,000	~42,000	~79,000

Partnered on Mental Health Payment Reform

The Department of Mental Health (DMH) and DVHA are collaborating on a payment reform project that transitioned Vermont Medicaid payments to all Designated Agencies (DA) and Pathways Vermont (a Specialized Services Agency or SSA), from traditional reimbursement mechanisms (a combination of program-specific budgets and fee for service) to a monthly case rate. Although the scope of services is narrow, the new payment model relies heavily on prior experience through the Integrating Family Services (IFS) pilot and expands the case rate approach to child and adult populations statewide. Each child and adult case rate are unique to the individual agency's child and adult population, comprised of their mental health allocation from DMH and their historical DVHA

fee for service expenditure. Under the new model, agencies are paid a fixed amount prospectively at the beginning of each month and are expected to meet established caseload targets by delivering at least one qualifying service to an individual in each month. Value-based payments are made through a separate quality payment. During each measurement year, DMH will withhold a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model uses three types of performance metrics to assess the quality and value of services: monitoring; reporting; and performance. The payment change went into effect for all mental health services delivered on or after January 1, 2019, for Medicaid beneficiaries receiving treatment at all Vermont DAs and one SSA (Pathways).

Reformed Residential Substance Use Disorder Payments

The Vermont Department of Health (VDH) and DVHA are collaborating on a payment reform project transitioning Vermont Medicaid payment to residential substance use disorder (SUD) treatment providers from a per diem rate to an episodic payment. An episodic payment was selected as it would: provide a framework to pay for outcomes rather than discrete services; incentivize innovation and cost-containment through increased provider flexibility; and ensure financial stability through the delivery of more predictable payments. The change went into effect for all episodes of care beginning on/after January 1, 2019, for Medicaid beneficiaries at all residential treatment providers in Vermont (Valley Vista: Vergennes, Valley Vista: Bradford, and Serenity House). VDH and DVHA will begin work on the second phase of this payment reform, implementing the value-based component, at the end of January 2019.

Launched Developmental Disabilities Services Payment Reform

The Department of Disabilities, Aging and Independent Living (DAIL) and DVHA are working in partnership on a payment reform project to transition from the current Developmental Disabilities Services (DDS) home- and community-based services (HCBS) daily rates to a new form of payment for individuals with intellectual and developmental disabilities.

AHS has initiated this project to meet several objectives:

- Comply with the State's APM Agreement with the federal Centers for Medicare & Medicaid Services, which obligates the Agency of Human Services to develop a plan to coordinate payment and delivery of Medicaid Home and Community-based Services with the State's delivery reform efforts for healthcare;
- Increase the transparency and accountability of developmental disabilities services, consistent with recommendations in the 2014 State Auditor's Report;
- Improve the validity and reliability of needs assessments;
- Improve equity and consistency in funding of individual services;
- Increase flexibility in addressing individual needs, services and outcomes, within the limits of available funding; and
- Support a sustainable provider network.

Representatives from the State, provider network, consumers, family members, and other stakeholders have begun work on the project scope and planning. This tentatively scheduled for January 1, 2020.

Improved Payment Model for Applied Behavior Analysis Services

DVHA partnered with providers to identify barriers to service provision of applied behavioral analysis. Based on stakeholder feedback it was determined that providers needed more flexibility in administering their programs. Therefore, a new payment model was designed, which offers more flexibility, tailored to specific member needs. The team also developed new clinical guidelines to ensure providers have guidance in best practices for service delivery. Additionally, DVHA onboarded two agencies, with multiple ABA practitioners, to further expand the network of providers allowing for an increase in services for our members.

Gained Federal Approval for Alternative Payments

CMS approved all eight of Vermont Medicaid's Alternative Payment Methodologies through at least CY 2020, marking the first time any of these methodologies were approved beyond a single calendar year. The following programs operate under Alternative Payment Methodologies that requires prospective CMS approval every calendar year: Children's Integrated Services; Integrating Family Services; OneCare Accountable Care Organization; Blueprint Women's Health Initiative; Blueprint Community Health Teams; Blueprint Patient-Centered Medical Homes; Dental Incentive; and Mental Health.

Clarified Roles and Responsibilities of Program Integrity (PI) in Payment Reform Initiatives

The roles of and mechanism Program Integrity unit uses to detect fraud, waste and abuse were established based on standard fee for service payment models. The Payment Reform and Program Integrity units continue to work to define how PI works in prospective payment, episodic payment and bundled payment constructs wherein providers have more flexibility in how and what services are delivered, and payment is not linked to a specific service

Management of Information Technology Projects

DVHA and the Agency of Human Services (AHS) continue to collaborate with the Agency of Digital Services (ADS) to overhaul the way the State implements and manages information technology projects. Major focal points from the past year include Integrated Eligibility and Enrollment and the Medicaid Management Information System (described in greater detail in Chapter 9) initiatives to meet federal requirements and advance financial integrity, efforts to efficiently deliver care that improves the health of Vermonters and achieving Health Information Exchange goals including developing the Health Information Exchange Plan.

Implemented Payer Initiated Eligibility Matching

DVHA's Coordination of Benefits (COB) ensures that Medicaid is always the payer of last resort, recovering funds from other insurers when appropriate. COB launched a Payer Initiated Eligibility electronic data matching process with Blue Cross Blue Shield of Vermont to better identify and collect payment from liable third parties. This effort resulted in COB billing an additional $3.2M in SFY 2019. COB will continue to roll out data matching with additional insurance carriers and explore options to automate the data matching results in the future.

Achieved Federal Compliance with Social Security Removal Initiative

The federal government changed Medicare ID's from Social Security Numbers to a unique ID. DVHA completed this federally mandated process which allows for continued data matching with Medicare and the ability to accept claims directly for Medicare.

Implementing the Provider Management Module

DVHA continually seeks opportunities to reduce provider administrative burden. Enrolling providers into DVHA's network was taking over 120 days, affecting provider payments. DVHA prioritized the creation of a new Provider Management Module to enroll providers in less than 30 days. The procurement was successful, and the new module will launch by April 1st, 2019.

Launched the Clinical Imaging Project

This project converted 166,000 active Medicaid member Prior Authorization (PA) requests from paper to electronic images retrievable through OnBase Document Control an electronic document manager. In addition, an operational plan was developed to handle new PA requests. The project launched July 15th and went live November 19th, 2018.

Used Statewide Data to Inform Blueprint for Health Programming

In 2018, the Blueprint began reporting on all Vermonters, not just those in Blueprint practices. This change supports a better understanding of the health of Vermonters and the care they access.

Significant Improvements were made within the Health Information Exchange (HIE) Program

- DVHA established the Health Information Exchange (HIE) Steering Committee, with representatives from across the continuum of care. The Committee focused on supporting the State in developing a statewide Health Information Exchange Plan. In 2019, the HIE Steering Committee will oversee execution of the Plan and update the Plan for the 2020 calendar year.
- DVHA, with support from the HIE Steering Committee, developed a state-wide strategic Health Information Exchange Plan. The State is obligated to create a Health Information Exchange plan each year; however, a plan had not been approved since 2010. The Green Mountain Care Board approved the Plan in late November 2018.
- DVHA and VITL, the operator of the State's Health Information Exchange, completed all legislative obligations outlined in Act 187 of 2018. This included consistent reporting on progress made to address the recommendations from the HIE Evaluation of 2017, procuring a third-party evaluation (which concluded that work is on track), and procuring a contingency plan to be used if VITL could not address known issues.

Implemented Interface to Prescribe Medication Securely and Efficiently

Surescripts is a service that supports standard electronic prescription transactions to allow clinicians to securely and easily e-prescribe. DVHA worked with its Provider Benefit Manager, Change Healthcare, to establish a connection with Surescripts to provide electronic health records (EHR) for Medicaid members. Providers who e-prescribe now have access to Vermont Medicaid data to assist them in managing prescriptions for Medicaid members more efficiently. The initiative enables providers to access members' outpatient pharmacy claims history, Medicaid eligibility status, and the

status of prescribed drugs on the Medicaid Preferred Drug List. Surescripts currently processes approximately 240,000 EHR transaction requests monthly for DVHA members.

Launched a Pharmacy Benefits Program Provider Portal

In 2018, DVHA launched the eWEBS Pharmacy Benefits Provider Portal developed by Change Healthcare designed for use by registered prescribers and pharmacies to simplify access to member and drug information securely. Prescribers are guided through preferred and non-preferred drug selections, and potential step therapy, dose limits or other coverage restrictions, giving them the ability to make informed drug choices. Additionally, prescribers and pharmacists can look-up member demographic information, eligibility, current and historical pharmacy claims, pharmacy location and telephone number, the Preferred Drug List (PDL), PA criteria and diagnosis code definitions. Most importantly, providers can electronically submit Prior Authorization (PA) requests, track the progress of a request, and view PA determination results.

Improve Operational Performance

DVHA is committed to continual improvement. The Department's core values of transparency, integrity, and service call upon all staff to identify opportunities within their sphere of influence to improve the way DVHA serves Medicaid members and Vermont taxpayers. In addition to striving for business efficiencies, DVHA has implemented results-based accountability (RBA) principles and tools to provide structure to the organization's commitment. Along with other departments in the Agency of Human Services, DVHA uses Clear Impact Scorecard, RBA-based strategy management and collaboration support software that facilitates data charting, project management, and public communication of results.

Each of DVHA's units now tracks performance metrics with an emphasis on the core responsibilities of enrolling members, paying for care, and promoting health. The results can be seen across all three areas of responsibility as well as in general operations.

Enroll Members

✓ Met Federal Requirements on Asset Verification

The federal Social Security Act requires states to implement an asset verification system. Under a mitigation plan between the Centers for Medicare and Medicaid Services (CMS) and DVHA, Vermont agreed to implement an electronic asset verification system (eAVS) by December 31, 2017. The system was approved for deployment on December 29, 2017 and used throughout 2018 to verify assets of Vermonters who were applying to relevant programs, specifically Choices for Care and Medicaid for the Aged, Blind, and Disabled.

✓ Designed and Piloted Self-Service Document Uploader

To make it easier for Vermonters to submit pay stubs and other personal documents to verify their eligibility for benefits the Integrated Eligibility and Enrollment (IE&E) program designed a technical solution that utilizes mobile and online technology to submit documents. The tool also eases staff burden by automating the classification of documents. This solution will improve the efficiency of the eligibility determination process and result in better customer experience for Vermonters. A fall 2018 pilot found that the tool enabled 55% of pilot users to submit documents on the same day of their request, compared to 11% of non-pilot users. IE&E also found that the average time from document

request to submission was nearly cut in half, from nine days to five. The program aims to roll out the Uploader statewide in fall 2019.

✓ Automatically Renewed Nearly All Qualified Health Plan Members

The first step in the renewal effort involves determining eligibility for the coming year's state and federal subsidies and enrolling members in new comparable versions of their health and/or dental plans. In October 2018, this step was operated with a single, clean, automated run that took care of 99.3% of eligible cases, up from 97.8% the prior year and 91.5% two years prior. The small number of remaining cases were processed by staff the following day. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they wanted to do so.

✓ Minimized Errors between Insurance Carriers and Exchange

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more than a 1.5% error rate and achieved this goal in all 12 months of 2018. Ten months had error rates less than 1.0%. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. With more than 31,000 subscriber cases across the three carriers, that equated to an inventory of 15 or fewer errors open more than ten days. DVHA met this new target in 11 out of 12 months in 2018, finishing seven months with zero cases in error status for more than ten days.

✓ Use of Plan Comparison Tool Increased 62%.

Due to complex policy changes that led to shifts in qualified health plan premiums and subsidies, DVHA strongly encouraged members to comparison shop rather than electing to be automatically renewed into their previous health plan. Vermonters heeded the call, using the online Plan Comparison Tool more than 38,000 times between October 15th and December 15th, a 62% increase over the previous year. They also spent more time researching options, staying on the site 22% longer.

✓ Promptly Answered Escalated Calls

When members call with questions about eligibility or other issues that cannot be addressed by DVHA's contracted call center, the calls are transferred to DVHA's Eligibility and Enrollment Unit. DVHA set a goal of answering 90% of these escalated calls within five minutes. As of spring 2017, the team had never responded to more than 68% of these escalated calls within that timeframe. In 2018, they exceeded the target in all twelve months, never falling short of 94%.

✓ Processed 98% of Vermont Health Connect Member Requests within Ten Days

Vermonters deserve to have their requests addressed promptly. During the first few years of Vermont's health insurance marketplace, many requests took several weeks or months to complete. For 2018, DVHA set a target to complete 95% of requests within ten days and met this goal for members managed in the Vermont Health Connect system. In fact, in the last quarter of 2018, 98% of requests were completed within ten days – an especially impressive accomplishment given that the remaining two percent include requests that are not allowed to be processed immediately (such as post-partum cases).

✓ Executed Monthly Reconciliation of Health Insurance Marketplace Systems

Multiple enrollment systems (Vermont Health Connect, payment processing vendor WEX, and the three insurance carriers) create the risk of discrepancies Medicaid and qualified health plan members across systems. In 2018, DVHA set a target of addressing 100% of potential discrepancies each month and, starting in February, met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD). In June 2018, MVP Healthcare completed the system work needed to support the monthly reconciliation process that DVHA was already operating with BCBSVT and NEDD and operationalized it in the fall.

✓ Executed Monthly Reconciliation of Medicaid Systems.

Multiple enrollment systems (Vermont Health Connect and the State's legacy ACCESS system) create the risk of discrepancies across systems, especially during months with large renewal caseloads. In 2018, DVHA honed its Medicaid reconciliation process. The reconciliation team cut the number of Medicaid cases with open discrepancies from more than 8,000 in April 2018 to fewer than 2,000 in July 2018, then consistently worked new discrepancies for the rest of the year. As of December 2018, there were fewer than 2,000 discrepancies and fewer than 150 that had been open for two months.

✓ Maintained In-Person Assistance across Vermont

DVHA ended 2018 with 279 DVHA-trained and certified Assisters working in hospitals, clinics, and community-based organizations in all of Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace. In addition, each of Vermont's five Area Agencies on Aging offices has certified State Health Insurance Program (SHIP) staff who provide counseling to Medicare beneficiaries and those about to become eligible for Medicare, and to help Vermonters over 60 years old apply for Choices for Care and Green Mountain Care programs. These partners' outreach efforts, along with other stakeholders and individuals, helped drive the state's uninsured rate to the lowest level ever seen in the Vermont Household Health Insurance Survey.

Pay for Care

✓ Conducted Training with Hospitals on Medicaid Eligibility

In 2018, Provider Member Relations (PMR) conducted training seminars to four Hospitals on Presumptive Eligibility (PE). As of January 1, 2018, Vermont Medicaid enrolled hospitals can immediately determine Medicaid Eligibility for certain individuals who are likely to be eligible for traditional Medicaid based on preliminary information. Eligibility under PE is short-term but allows immediate access to coverage for eligible individuals and ensures the hospital will be reimbursed for services provided, just as if the individual was enrolled in traditional Medicaid.

✓ Implemented Change in Scope Process for Health Centers

DVHA continued its commitment to professionalize reimbursement fee schedules generally and improve health center reimbursement specifically. DVHA, in collaboration with Bi-State Primary Care and health centers, implemented the federally mandated change of scope process that adjusts rates due to a change in the type, intensity, duration and /or amount of services.

✓ Better Aligned Health Center Reimbursements with Health Care Reform

DVHA continued to align health center rates with reform by phasing down site-specific alternative payment models. DVHA collaborated with health centers, considered their feedback, and implemented a three-year phase down to give health centers more time to adjust to changing reimbursement rates.

✓ Modified Durable Medical Equipment (DME) Fee Schedule Based on Provider Feedback

In early 2018, DVHA changed the DME fee schedule for the first time in decades. DVHA partnered with DME providers and their representatives to address serious concerns that arose during implementation. This included further analysis of Medicare, New England states, and New York state reimbursement rates that led to creating a Provisional Access to Care Adjustment (PACA) designed to raise certain rates to ensure access to services.

✓ Optimized Reimbursement Arrangements Based on Provider Feedback

DVHA continues to incorporate the helpful feedback of healthcare providers in improving its fee schedules and payment arrangements. Examples include: (1) created a uniform and sufficient reimbursement for Long Acting Reversible Contraceptive for both inpatient and outpatient providers, (2) eliminated burdensome administrative process related to certain 340B program claims, and (3) ensured full and proper payment by only applying the Nurse Practitioner/Physician's Assistant reduction to their services rather than the full claim.

✓ Gained Federal Approval to Improve Substance Use Disorder (SUD) Treatments

The Centers for Medicare and Medicaid Services (CMS) approved an amendment to Vermont's Global Commitment to Health 1115 Demonstration waiver that authorizes the State to receive federal Medicaid funding for treatment services offered in residential and inpatient facilities provided to Medicaid enrollees to treat addictions to opioids and other substances. The approval of this amendment allows Medicaid to pay for inpatient and residential treatment for addiction in institutions for mental disease (IMDs), which is not permitted currently under federal law and removes the mandatory sunset of Vermont's current financial arrangement. Absent this amendment approval, Vermont would be required to phase down federal Medicaid participation for substance use disorders (SUD) treatment in a residential or inpatient setting, beginning in 2021 and phase out completely at the end of 2025.

✓ Continue to Support Providers through Electronic Health Record Payments

Vermont successfully executes the Medicaid Promoting Interoperability Program (formerly the Electronic Health Record Incentive Payment Program), connecting Vermont's provider community with incentive payments to offset the cost of Electronic Health Record (EHR) systems. As of 2018, the program has distributed $54.4 million in 100% federal dollars to eligible professionals and hospitals. Every hospital in Vermont has an EHR system and has taken advantage of the program.

Promote Health

✓ Continued the Blueprint for Health's Statewide Reach

Almost all of Vermont's primary care practices participate in the Blueprint for Health at the end of 2018, including 137 of Vermont's estimated 149 primary care practices. These Patient-Centered Medical Homes provide evidence-based care consistent with national standards focused on care access, team-based care, patient/population health management, care management and support, care coordination and care transitions, and performance measurement and quality improvement.

✓ Continued to Work on a Common Model of Care

In 2018 the Blueprint for Health worked with Community Health Team Leaders and staff to implement a common community-based care model adopted by both the Blueprint and OneCare Vermont.

✓ **Grew the Women's Health Initiative**

Participation in the Women's Health Initiative continued to grow adding three new women's health specialty practices and four new Patient-Centered Medical Homes between the third quarter of 2017 and the third quarter of 2018.

✓ **Expanded Hub & Spoke**

The Hub & Spoke program continued to add new medication-assisted treatment (MAT) prescribers in Spokes in 2018, expanding local capacity for opioid use disorder treatment.

✓ **Promoted Chronic Disease Management via the Blueprint for Health**

The Self-Management Programs had 1011 graduates in 2018. The participants learned skills to manage their chronic conditions including diabetes, chronic pain, and more.

✓ **Aligned the Vermont Chronic Care Initiative (VCCI) with Health Care Reform**

Developed a new way to identify and engage patients that reflects the presence of both the ACO and VCCI in Medicaid's network. First, VCCI allied its risk stratification with the ACO's risk methodology. Next, VCCI focused on new Medicaid members to engage members, reflecting the fact the ACO does not add members after the first of the year. Preliminary results are promising. Recent reports show that we were able to help half of the members that needed help finding a PCP get one. Third, creating a needs-based methodology that allows medical practices to identify high-risk people including duals. Despite these changes, analysis by eQHealth continues to demonstrate a decrease in health care utilization.

✓ **Provide Options for Children with Autism Spectrum Disorder to Get Services in Vermont**

DVHA collaborated with two hospitals, addressing their concerns and resulting providing acute mental health stabilization services for children with Autism Spectrum disorder (a service that is not available in Vermont). Both the new providers offer extensive aftercare planning and training for families in the what to do once their child is released from the hospital. Additionally, one of the providers offers inpatient stabilization services for children without a diagnosis of ASD. Previously there was only one hospital in Vermont providing mental health stabilization for children.

✓ **Collaborated Across AHS to Reduce Mental Health Stabilization Wait Times**

DVHA worked with the Department of Mental Health and Department of Children and Families to facilitate more rapid placement for individuals awaiting mental health stabilization services. In addition, this cross-agency planning team conducted weekly meetings to jointly review cases with the Brattleboro Retreat to Address disposition challenges. In the coming year, the team will track progress toward their goals of 1) reducing the number of days individuals wait in hospital emergency rooms for placement, and 2) ensuring individuals who are inpatient can transition back into the community at the appropriate time, potentially reducing the total number of inpatient days and improving access for services to others.

✓ **Updated Lock-In Program to Serve Members and Taxpayers Better**

This year, the Lock-in program shifted from simply a mechanism to prevent fraud, waste, and abuse to providing wrap-around supports for recovery. The program, which implemented Team Care, now aims to do more than impose federally mandated restrictions. Vermont's Team Care is ***a care-management program*** for members who may need additional support to focus their healthcare services in a way that could be most beneficial to them. The program intends to identify and help to address unmet healthcare and substance use disorder treatment needs, support access to well-coordinated primary and specialty care, and prevent misuse and abuse of regulated medications. Clear

criteria were established and adopted for members enrolling in Team Care and a protocol for disenrollment once stabilization is achieved. For members in recovery from addictions, the Team Care Program may be a valuable tool in supporting those members' recovery efforts. Each member's case is now evaluated on a case-by-case basis. Members needs are assessed, and referrals are made to the Vermont Chronic Care Initiative to support individuals in accessing services necessary supports for stabilization and recovery.

✓ Improved Access to Substance Use Disorder (SUD) treatments

DVHA modified the PA criteria for Suboxone Film for the Spokes by eliminating prior authorization for doses 16mg or lower to improve access to treatment and lower provider burden for PA submissions. This resulted in an average reduction of 2500 PA's per month, overall a 17% reduction in PA volume. In addition, DVHA aligned Hub and Spoke coverage by adding Buprenorphine/Naloxone tablets, and buprenorphine depot injection (Sublocade®) to the available collection of resources for all authorized prescribers in the Hubs and aligned the PA criteria between Hubs and Spokes for those drugs.

✓ Improved Access to Hepatitis C Treatments

In January 2018, DVHA removed the requirement that patients must have a certain level of liver disease (by determining a patient's liver fibrosis score) to be eligible for Direct Acting Antiviral (DAA) drugs. In addition, the requirement for six months of sobriety was removed. These changes opened the door for broader access to treatment for Hepatitis C infected patients. For most patients, DAA's represent a cure for Hepatitis C. These drugs are a focus of pharmacy medication management services to facilitate adherence and follow up to enable the best clinical outcomes. The average number of patients treated per month increased from 33 in 2017 to 63 through September of 2018.

✓ Expanded Prenatal and Post-Partum Coverage for New Mothers

DVHA made the following changes to Vermont's Medicaid program to ensure Medicaid mothers had access to the same breastfeeding and parenting services and benefits afforded to Vermont women with commercial coverage, specifically:

- Medicaid expanded its coverage of electric breast pumps to include personal use double electric breast pumps for new mothers who anticipate being separated from their infant on a regular basis. Previously, Medicaid coverage was limited to hospital grade electric breast pump rentals when medically necessary.
- Medicaid expanded its coverage of lactation services to include in-home lactation consulting services. Previously, Medicaid coverage was limited to lactation services provided only in an office setting.
- Medicaid increased reimbursement for childbirth education classes to address access issues Medicaid parents were experiencing.

Improve Operations

✓ Expanded Use of Key Performance Indicator Scorecards

DVHA continued to refine each unit's performance measures to quantify the culture of continual improvement and track progress over time. Units report goals and monthly metrics related to key performance indicators, share the information in public scorecards, and increasingly use data to assess performance and make business decisions. Scorecards can be found in Appendix C.

✓ **Streamlined Administration**

DVHA created an Administrative Services Unit to streamline and improve operations. First steps focused on documenting business processes and identifying best practices to support program staff and management efficiency. The unit has implemented these practices along with organizational development efforts, activities to improve DVHA's culture, and launched a new DVHA intranet to improve communication across the department.

✓ **Fostered Business Cohesion through Co-location**

DVHA brought three large units to the Waterbury State Office Complex, Program Integrity, Oversight and Monitoring, and the Division of Rate Setting. More units are set to move from Williston to Waterbury in February. DVHA will continue to seek opportunities to move staff to Waterbury and those within the Waterbury State Office Complex closer to DVHA's main office space.

✓ **Created Structure to Align Authority and Accountability**

Understanding that clear lines of authority and accountability are necessary to promote performance and innovation, DVHA developed a Change Management Operations Structure. Three Change Management positions were transferred to DVHA to continue their work in Integrated Eligibility project and Medicaid Management Information System, and DVHA developed an organizational structure and identified roles and responsibilities.

✓ **Promoted Additional Transparency and Performance in Claims Processing with DXC**

DXC and DVHA developed a service level dashboard that is reported on monthly. There are currently 45 SLAs that are monitored and reported on monthly. Examples of service levels measured are the following: (1) notify the state within two business days of the discovery of overpayment, duplicates, or incorrect payments. (2) Adjudicate 90% of clean claims within 90 days of receipt, excluding drug claims. (3) Maintain 1% or less error rate on all reference file updates applied. DXC is meeting more than 90% of these SLAs.

✓ **Promoted Transparency and Performance in Transportation Services**

In 2018, Provider Member Relations (PMR) worked with the Vermont Public Transit Authority (VPTA) to come into compliance with the reporting guidelines of the contract for Nonemergency Transportation Services (NEMT). PMR collaborated with VPTA and its members, conducting "Road Shows" with the VPTA subcontractors to outline expectations of working with DVHA and the requirements of reports needed. Over the last six months of 2018, VPTA has shown vast improvement in meeting the expectation of DVHA and servicing our members.

✓ **Designed New Timely Filing Guidelines**

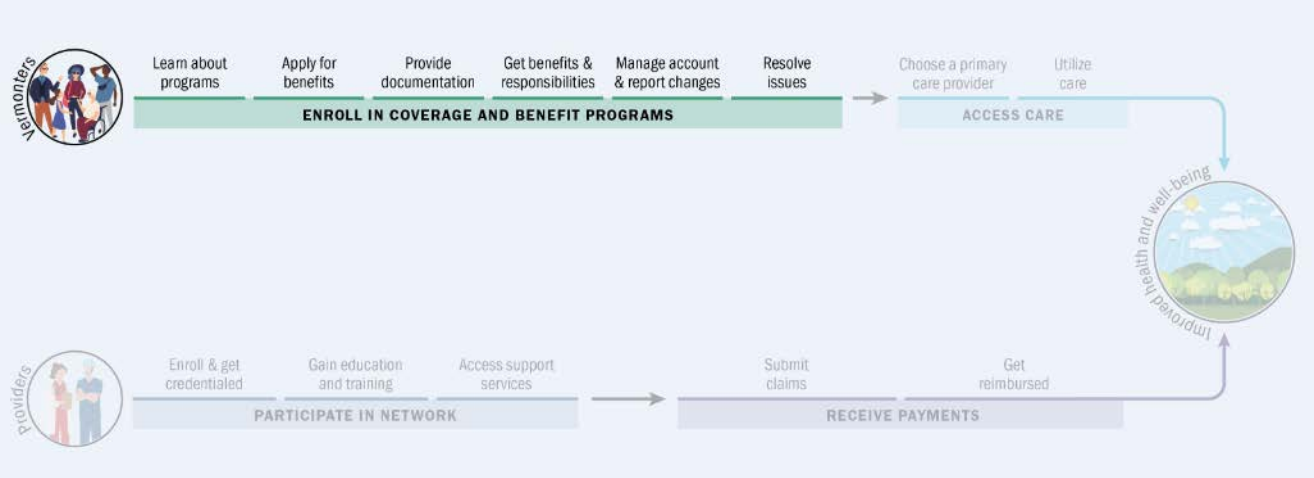
The Reimbursement Unit, in partnership with other units, created new guidelines to assure compliance with federal timely filing requirements. Developed an internal review process to identify claims outside the filing limits that couldn't be paid with Medicaid funds. Worked with DXC to ensure this could be implemented and identified within their system. Caught up outstanding timely filing reconsideration packets and completed the review of timely filing reconsideration requests within our metric of 80 % completed within 15 business days of receipt. The change in timing filing requirements will be rolled out to providers in early 2019.

✓ **Reduced Administrative Burden for Mental Health Inpatient Stabilization**

When a member is experiencing a mental health crisis, it can often be difficult for a provider to get a full clinical assessment and generate a plan of that that anticipates an appropriate length of stay within

24 hours of admission, the requirement for prior authorization. Recognizing this challenge and the potential role it plays in determining the length of inpatient stays, DVHA piloted with Brattleboro Retreat an automatic authorization for mental health inpatient stays of five days for all members meeting the acute level of care criteria. The new process focuses on helping the provider and member determine a length of treatment that will most benefit the member's health and allows time to assess and formulate an individualized plan of care and discharge plan for each member admitted. As a result of the pilot, data indicate that the average number of days for an inpatient psychiatric stay for adults dropped from seven in 2017 to six in July of 2018, for child psychiatric admits it dropped from 16 to 13, and for detoxification admissions, it dropped from five to four.

Chapter Two: Member Experience



Learn About Program

DVHA's Health Access Eligibility and Enrollment Unit (HAEEU) serves as the doorway for Vermonters to access the Department's programs and services. HAEEU's Outreach and Education team has two broad consumers:

- Vermonters who need health coverage
- Members enrolled in one of DVHA's health plans

Connecting with Vermonters who lack health coverage

DVHA engages with community partners, including hospitals, clinics, agricultural organizations, libraries, pharmacies, and other stakeholders to participate in public events and conduct targeted outreach. This outreach seeks to help Vermonters understand health insurance terms and how to interact with the state's health insurance marketplace, Vermont Health Connect (VHC). Targeted outreach focuses on groups of Vermonters likely to lack access to health insurance, including farmers, justice-involved individuals, new Vermont residents, and those in the 26-34 age group.

- ❖ Vermont maintained one of the lowest uninsured rates in the nation.[1]
- ❖ In 2008, one in eight (13%) lower-income Vermonters (<139% FPL) were uninsured; in 2018, one in 50 (2%) were uninsured. [2]
- ❖ From 2014 to 2018, the uninsured rate for the lowest income Vermonters improved more than any other income group. [2]

[1] September 2018 report from U.S Census
[2] 2018 Vermont Household Health Insurance Survey

Several studies point to Vermont's success in enrolling its citizens and improving health access. The Vermont Household Health Insurance Survey (VHHIS) reports that Vermont cut its uninsured rate

by more than half from 2012 to 2018, resulting in a 3.2% rate or fewer than 20,000 uninsured Vermonters for the first time since the survey began being fielded in 2000. Of those uninsured Vermonters who reported the length of time they haven't had insurance, more than half said they had coverage at some point in the last twelve months and nearly two-thirds said within the last two years. Reports from the U.S. Census, National Center for Health Statistics, and the State Health Access Data Assistance Center (SHADAC) praise Vermont for having one of the lowest overall uninsured rates in the country as well as the lowest childhood uninsured rate in the nation.

In seeking to protect the most vulnerable, Vermont has been particularly successful when it comes to engaging and enrolling the lowest income Vermonters. The 2018 VHHIS shows that the lowest income Vermonters (under 139% of federal poverty level) were at least as likely to have coverage as any other income group. In 2008, one in eight (13%) of the lowest income Vermonters were uninsured; in 2018, one in 50 (2%) were uninsured. From 2014 to 2018, the uninsured rate for this group fell more than the rate for any income group, an achievement that stands out even more considering the State resumed annual Medicaid redeterminations in 2016 and thus did a better job that Vermonters don't continue to receive Medicaid when they become ineligible. In fact, the number of Vermonters who were uninsured because they "lost eligibility/not eligible for state health insurance" increased from 4,900 in 2014 to 6,700 in 2018, while the number who said they were uninsured for any other reason (i.e., affordability, job loss, employer stopped offering insurance) all fell over the same period. For more information on the VHHIS report, please visit www.healthvermont.gov/stats/surveys/household-health-insurance-survey.

National studies have made similar observations about Vermont's most vulnerable children. Notably, a Vermont family's income no longer determines whether their child has health coverage, as a 2015 SHADAC report noted low, middle, and high-income children in Vermont all have less than a two percent uninsured rate.

Vermont continues to chip away at the remaining uninsured population. During the 2019 Open Enrollment period, DVHA's public communication sought to ensure that young people and other Vermonters were aware of federal subsidy changes that made health insurance more affordable for most uninsured Vermonters in 2019 than at any point in the past five years. Social media and other outreach focused on the fact that most uninsured Vermonters had income levels that would qualify for enough financial help that they could buy a zero-premium plan – meaning that their monthly subsidy would cover the entire premium for the lowest premium plans in the marketplace. Higher premium plans may result in lower total costs, depending on how much out-of-pocket costs the member occurs, but someone trying to decide between getting an insurance plan with no net premium and going uninsured, the choice should be clear.

Vermont ranked in the top three states in the nation in terms of health access and affordability in 2018.[3]

[3] Commonwealth Fund

While the VHHIS found that young people (25-34) were again more than twice as likely as any other age group to be uninsured, this group now enrolls in health coverage at a higher rate. In 2018, nearly one in four (23%) new enrollees in a QHP through VHC were in this age group, compared to one in eight (13%) renewing members.

Helping members maintain the best coverage for their needs and budget

HAEEU's outreach with existing members focuses on helping them get the most out of their health plans, reminding them to respond to Medicaid renewal notices, and offering information.

- The uninsured rate for Vermonters age 25-34 fell from 2014 to 2018 but remained higher than that of any other age group. [4]
- In 2018, nearly one in four (23%) new enrollees in a Qualified Health Plan (QHP) through VHC were in this age group, compared to one in eight (13%) renewing members.[5]

[4]Vermont Household Health Insurance Survey
[5]Vermont Health Connect data

In SFY 2017, DVHA offered "Health Insurance 101" events and webinars. These events were promoted to existing members and primarily focused on VHC's online Plan Comparison Tool. The tool is a resource for helping Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs. The Tool was created by the non-profit Consumers' Checkbook and was named the country's best plan selection tool by the Robert Wood Johnson Foundation[6]. The Tool was used nearly 60,000 times in SFY 2018 and was praised as a key resource for QHP members, especially those transitioning out of Medicaid, or those new to healthcare plan comparison.

[6] https://www.rwjf.org/en/library/articles-and-news/2015/03/apps-to-use-when-shopping-for-health-insurance-win-national-comp.html

Apply for Benefits

Applying for Health Coverage

Once Vermonters decide that they want to apply for health coverage, they can generally take one of four possible paths to enrollment:

- Apply online at VermontHealthConnect.gov,
- Call the Customer Support Center and apply by phone,
- Apply by paper, or
- Meet with an Assister who will help them fill out the application in-person.

Vermonters on Medicare because of age (65 or older), blindness, or disability must fill out a paper application but can access help doing so through the Customer Support Center or local help. The State offers other forms of healthcare assistance in addition to Medicaid, CHIP, and QHP. Currently, some of those other programs may require additional application steps. The process for applying for Long-Term Care assistance is outlined in the Long-Term Care section later in this chapter.

Regardless of the path the applicant takes, DVHA aims to promptly process the application and verify information so that the applicant can be enrolled in appropriate programs. This section covers each of the four ways to apply and then explains the details of application processing and verification.

How to Apply	
Online	http://VermontHealthConnect.gov/
By Phone	1-855-899-9600 (Toll-Free)
By Paper	http://info.healthconnect.vermont.gov/paper
With an In-Person Assister	http://info.healthconnect.vermont.gov/find

Applying Online

Two years ago, DVHA set a goal for a continual 10% year-over-year increase in the adoption of self-service functionalities. Since that time, the actual growth in online applications has far exceeded the goal. The percentage of Vermonters applying for coverage online has more than tripled over the last two years, increasing from 16% of VHC applications in June 2016 to 51% in June 2018. Applying online can lead to improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow state staff to spend less time processing applications and more time delivering on other priorities for Vermonters.

Vermonters applying for coverage online jumped from 16% in June 2016 to 51% in June 2018.

Self-service application uptake has exceeded DVHA's goal of 10% growth year-over-year.

Applying by Phone

Callers to VHC's contracted Customer Support Center experienced prompt service throughout the first three quarters of calendar year 2018. Call volume for each of the first nine months was down from the corresponding month in 2017, likely due to both downward enrollment trends as well as improved operational performance. This low volume combined with ample spring and summer staffing levels at call center contractor Maximus to result in short wait times for callers. More than four out of five calls were answered within 24 seconds nearly every month. Maximus met its contracted service level agreements and earned a bonus during every month from February through October.

This experience changed in November 2018 as Maximus struggled to retain the staff needed to meet staffing level targets and was unable to hire enough new staff to keep up with attrition. Combined with DVHA's success in encouraging members to comparison shop and Open Enrollment's call volumes, the result was long waits and missed service levels in November and December. Per the contract, Maximus paid a penalty both months.

On the positive side, there was a decrease in the percentage of calls that Maximus needed to escalate to DVHA. Maximus only transferred 5% of December 2018 calls to DVHA's Eligibility and Enrollment staff, down from 6% in both November 2018 and December 2017. This figure would

have been even lower if its transfers were limited to calls that Maximus was unable to resolve. Instead DVHA took additional calls during high volume times in order to alleviate Vermonters' wait times.

DVHA worked closely with Maximus management to monitor performance and adopt a mitigation plan which included opening a satellite support center in Virginia and committing to maintain it until they can hire enough Vermont staff to meet contracted service level agreements.

Applying by Paper

The paper application is a federally required option but is the least utilized of the four application options as increasing numbers of applicants move to the online and phone applications. There are a couple of notable exceptions, however. First, as noted earlier, Vermonters on Medicare because of age, blindness, or disability do not yet have the option of an online application; they must fill out a paper application. In addition, applicants whose identities cannot be confirmed have the option of either filling out a paper application or meeting with a local Assister who can validate their identity and help them apply for coverage.

Applying with an In-Person Assister

The In-Person Assister (IPA) Program serves as a cornerstone of DVHA's ongoing effort to help Vermonters understand and enroll in the health coverage that best meets their families' needs and budget. The program fosters collaboration between the State's health insurance marketplace, hospitals, clinics, and community organizations, helping Vermont dramatically reduce its uninsured rate. Paired with the Customer Support Center and online tools, the IPA Program provides an additional option of support to Vermonters who may have encountered barriers to enrollment in healthcare coverage.

The IPA Program has changed significantly since it was launched in 2013. Initially, Vermont was awarded federal grants that served as initial funding with twin goals of helping tens of thousands of individuals transition to the new marketplace and helping DVHA lay the building blocks for a sustainable consumer assistance program. DVHA dispersed grants to healthcare and community-based institutions to assign staff to become Navigators who then engage in education, outreach, and enrollment activities. The program met its key goals:

- Vermonters learned how to compare and select health coverage.
- Hospitals and other providers saw value in assigning staff to be trained and certified as Assisters.
- Vermont drove down its uninsured rate from 6.8% in 2012 to 3.7% in 2014.

The federal navigator grants ended after SFY 2015. DVHA then charted goals of expanding the overall IPA Program by focusing on specialized training, troubleshooting, and support for Certified Application Counselors (CACs). Assisters who are funded by hospitals, clinics, and organizations who see enrollment assistance as both a valuable service to their clients and beneficial to their organization as covered clients are more likely to result in paid claims.

By the start of SFY 2018, the IPA Program had achieved these goals and a network of 138 CACs, 15 Navigators, and 78 certified brokers – more Assisters than the program had during the federal grant era in SFY 2015!

The IPA program continues to grow throughout SFY 2018. With 196 CACs and Navigators by the end of SFY 2018, Vermont had nearly 30% more Assisters providing free in-person assistance than at the end of SFY 2017 – and 80% more than at the height of the federal grant period in SFY 2015. The program also added a few certified brokers, ending the year with 81.

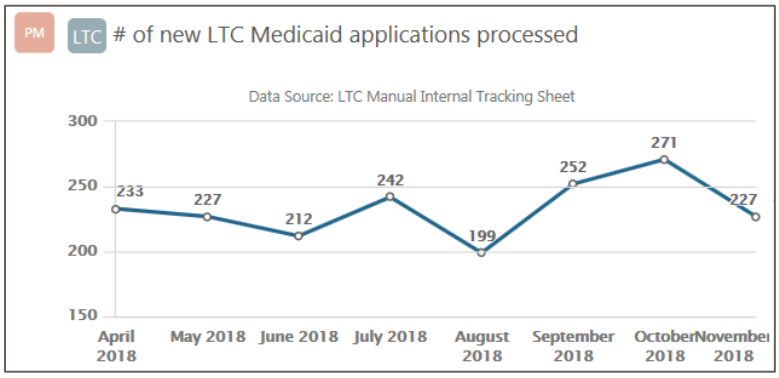
In addition, collaboration with other healthcare stakeholders will provide an array of options for those seeking assistance. HAEEU worked with DCF's Economic Services Division (ESD) to develop a back-up option for MABD applicants who wanted in-person assistance. In addition, the Area Agencies on Aging (AAA) and Senior Health Insurance Program (SHIP) offices continue to assist Vermonters who are submitting paper applications, or who may need assistance with Medicare.

Applying for Long-Term Care Programs

Vermont's Long-Term Care (LTC) Medicaid Program includes Choices for Care (CFC), Developmental Disability Services (DDS), Developmental Disability Home and Community Based Services (DD HCBS), Traumatic Brain Injury (TBI), and Enhanced Family Treatment (EFT). 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:

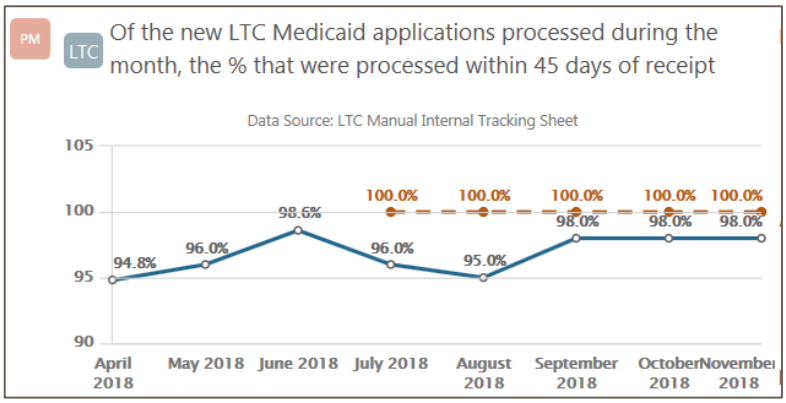
1) Clinical eligibility, most of which is performed by the Department of Disabilities, Aging and Independent Living (DAIL); and
2) Financial eligibility performed by the Department for Vermont Health Access (DVHA).



The LTC application is submitted to DVHA and a copy is forwarded to DAIL for the CFC clinical assessment. DD HCBS, TBI, and EFT have the clinical assessment completed before applying for LTC Medicaid. Upon receipt of the LTC application, DVHA begins 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.

Federal rules require that LTC staff evaluate income and resources, as well as review financial statements for a five-year "look-back" period. In addition, they must carefully review transfers of income and/or resources made within the 60 months prior to the month of application to determine if a penalty period must be applied. There are complicated rules which address client assets and what types of transfers are allowed.

LTC staff work closely with clients, families, nursing facilities, case managers, and authorized representatives to ensure eligible Vermonters can access needed LTC services promptly. One of the challenges for the LTC program is the client's ability to gather and submit verification documents promptly. LTC works collaboratively with applicants who are trying to provide needed documentation, while also ensuring applications are processed within the 45-day Federal timeliness standard. Unlike many other states, Vermont does not deny applicants who are trying to provide verification documents but cannot do so within the initial verification period. Instead of denying those applicants, they are given additional verification deadlines and extensions for extenuating circumstances as Federal audit rules allow. In late 2017 and through 2018, the LTC Team has focused on business process improvements necessary to ensure that applications are processed within the 45-day federal timeliness standard. Vermont Medicaid implemented the CMS-mandated electronic Asset Verification System (e-AVS) on January 1, 2018. Due to the rural nature of Vermont, DVHA is less successful in retrieving information from financial institutions when compared to other states. This results in an increased manual effort for Vermont's LTC staff. Despite the increasing complexity of Vermont LTC applications, recent data shows that 98% of LTC applications were processed within the 45-day timeliness standard.



Enrollment Integration

DVHA's eligibility system is the system of record for QHP and dental plan enrollment, while the insurance carriers' systems (along with DVHA's MMIS on the Medicaid side) ensure that providers and pharmacies can see coverage and bill for services. To deliver a smooth customer experience, changes that are made to customers' accounts must promptly be integrated across all the applicable systems and errors that occur must be resolved promptly.

DVHA has made significant progress in improving performance, processing requests in an increasingly timely manner, and resolving errors for customers. By the start of SFY 2018 errors had fallen 80% from March 2016 levels. Integration errors were also cut 80%. This improvement continued throughout SFY 2018.

Calendar year 2018, HAEEU set a primary goal of having less than one-twentieth of one percent of cases sit in error status between the VHC and carrier systems for more than ten days. With more than 31,000 subscriber cases across all three carriers, that goal would leave 15 or fewer error statuses open beyond ten days. The idea behind this goal was that while error rate and total error inventories are important, the length of time that errors are open is a more accurate indicator of potential member impact. The goal marked a ratcheting up of the 2017 goal of one-tenth of one percent, or 31 cases.

HAEEU 2018 GOAL

Have less than 0.05% of cases remain in error status for more than 10 days.

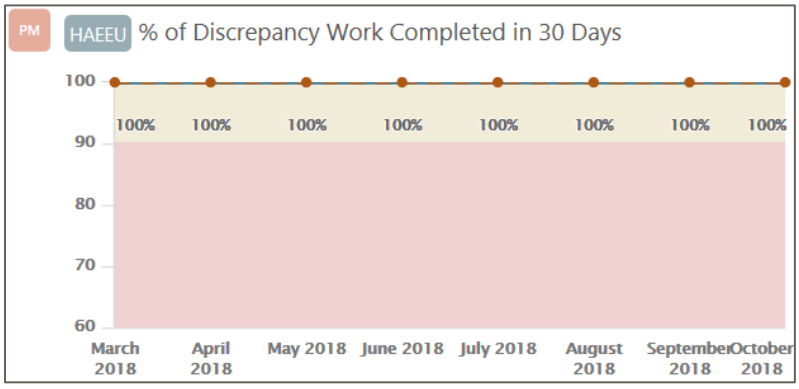
At the end of SFY 2018, there were no cases in error status over 10 days.

DVHA met this new target in 11 out of 12 months in 2018, finishing seven months (March through December) with zero cases in error status for more than ten days.

HAEEU also set six secondary goals related to the error rates, the overall number of open errors, and the length of time it takes cases to be confirmed across systems. As of the end of SFY 2018, five of the six metrics were meeting their targets, with a 2.1% error rate between the marketplace and payment processor WEX being the lone exception. All six metrics beat their levels from a year earlier.

Enrollment Reconciliation

The ability to perform ongoing monthly reconciliation between DVHA's eligibility system and those of the three insurance carriers is essential to maintaining data integrity, ensuring positive customer experience, and limiting financial liabilities. If discrepancies can be identified and most of those discrepancies addressed within the month, HAEEU will be in a strong position to avoid the various issues caused by cases left in error status.



Effective January 2017, DVHA and the three insurance carriers established a new process for conducting monthly reconciliation and set a primary goal of addressing at least 90% of those discrepancies within the month. The reconciliation team met this goal in each of the following months in SFY 2017. The team continued to improve in SFY 2018, completing 100% of the work in every month.

DVHA also utilized control reports and an ongoing reconciliation process to resolve discrepancies between VHC's case management system and the legacy ACCESS system. In 2018, DVHA aligned the Medicaid and QHP reconciliation processes to report on standardized measures.

Provide Documentation

Completing verification requirements can be challenging and time-consuming for Vermonters. For staff, verifying Vermonters' income (and other requirements) routinely involves delays, stressful

conversations, and duplicative work. Mail and paper slow the entire process from initial notification, to mailing documents, to scanning and indexing. Internal staff wait for Vermonters' submission of required documentation such as pay stubs, employment forms, or attestations to process applications or changes, which lengthens the eligibility determination process.

To make it easier for Vermonters in the future, DVHA is working to implement a technical solution which allows Vermonters to utilize mobile and online technology to submit verification documents and to automate the classification of these documents. This solution will improve the efficiency of the eligibility determination process and result in a better customer experience for Vermonters.

Obtain Benefits and Responsibilities

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 MCA or private health insurance with financial help, such as federal Advanced Premium Tax Credits (APTC), Vermont Premium Assistance (VPA), and state and federal cost-sharing reductions (VCSR and CSR). Vermonters can find the 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.

Vermont Medicaid Programs

Medicaid programs provide low-cost or free coverage for low-income parents, children, 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).

Medicaid programs cover most physical and mental health care services such as doctor's visits, hospital care, prescription medications, vision care, 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.

Vermont provides prescription assistance programs to help Vermonters pay for prescription medications 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.

Vermont Pharmacy Program (VPharm) assists Vermonters enrolled in Medicare Part D with paying for prescription medications. Those eligible include people age 65 and older, and Vermonters of all ages with disabilities with household incomes up to 225% Federal Poverty Level (FPL).

Healthy Vermonters provides a discount on prescription medications 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.

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 Vermont Health Access Plan (VHAP) and Catamount. The State of Vermont further subsidizes premiums and cost-sharing for enrollees whose income is < 300% of FPL to address this affordability challenge.

Income calculation is based on gross monthly income minus deductions. The following programs are determined using Modified Adjusted Gross Income (MAGI): QHP, APTC, CSR, MCA, VPA, and VCSR. The following table provides the January 2018 FPL information as an example of household income levels.

2018 Federal Poverty Levels (FPLs)

Monthly

Household Size	100%	133%	138%	150%	200%	225%	250%	275%	300%	400%
1	$1,012	$1,346	$1,396	$1,518	$2,023	$2,276	$2,529	$2,782	$3,035	$4,047
2	$1,372	$1,824	$1,893	$2,058	$2,743	$3,086	$3,429	$3,772	$4,115	$5,487
3	$1,732	$2,303	$2,390	$2,598	$3,463	$3,896	$4,329	$4,762	$5,195	$6,927
4	$2,092	$2,782	$2,887	$3,138	$4,183	$4,706	$5,229	$5,752	$6,275	$8,367
5	$2,452	$3,261	$3,383	$3,678	$4,903	$5,516	$6,129	$6,742	$7,355	$9,807
6	$2,812	$3,740	$3,880	$4,218	$5,623	$6,326	$7,029	$7,732	$8,435	$11,247
7	$3,172	$4,218	$4,377	$4,758	$6,343	$7,136	$7,929	$8,722	$9,515	$12,687
8	$3,532	$4,697	$4,874	$5,298	$7,063	$7,946	$8,829	$9,712	$10,595	$14,127

Annually

Household Size	100%	133%	138%	150%	200%	225%	250%	275%	300%	400%
1	$12,140	$16,146	$16,753	$18,210	$24,280	$27,315	$30,350	$33,385	$36,420	$48,560
2	$16,460	$21,892	$22,715	$24,690	$32,920	$37,035	$41,150	$45,265	$49,380	$65,840
3	$20,780	$27,637	$28,676	$31,170	$41,560	$46,755	$51,950	$57,145	$62,340	$83,120
4	$25,100	$33,383	$34,638	$37,650	$50,200	$56,475	$62,750	$69,025	$75,300	$100,400
5	$29,420	$39,129	$40,600	$44,130	$58,840	$66,195	$73,550	$80,905	$88,260	$117,680
6	$33,740	$44,874	$46,561	$50,610	$67,480	$75,915	$84,350	$92,785	$101,220	$134,960
7	$38,060	$50,620	$52,523	$57,090	$76,120	$85,635	$95,150	$104,665	$114,180	$152,240
8	$42,380	$56,365	$58,484	$63,570	$84,760	$95,355	$105,950	$116,545	$127,140	$169,520

https://www.gpo.gov/fdsys/pkg/FR-2018-01-18/pdf/2018-00814.pdf

Medicaid 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

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 persons	• 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. [7]

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

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 N/A*	**No**
Tuberculosis (TB) Related Services	**No**	**No**	**No**	**No**	**No**	*Data N/A*	**Yes**
Health Homes for Enrollees with Chronic Conditions – Nursing services, Home health aides and medical supplies/equipment	**Yes**	**No**	**No**	**Yes**	**No**	**Yes**	**Yes**

Premiums and Co-Pays

States can impose copayments on most Medicaid-covered benefits, both inpatient and outpatient services and States can assess premium requirements for eligibility.

Co-pays cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. Because Medicaid covers particularly low-income and often very sick patients, services cannot be withheld for failure to pay, but members may be held liable for unpaid copayments. The total cost-sharing (out-of-pocket) cost may not exceed 5 percent of the family's household income.

If a Vermonter is determined eligible for a program that has a monthly premium, they pay that premium to effectuate coverage and must continue to pay their bill on a timely basis to maintain their benefits. HAEEU's enrollment team monitors the integrity, accuracy, and timeliness of transactions between the VHC case management system, our billing system with Wex Health, as well as the Medicaid ACCESS and private insurance carriers' systems. The team works closely with Wex, the

systems integrator Optum, the Business Office, and each of the insurance carriers, to ensure sound performance in both system integration and reconciliation.

The table below illustrates the benefit programs and any cost-sharing requirements that may exist.

Program	Who is Eligible?	Benefits & Cost-sharing
MABD Medicaid	Age ≥ 65, blind, disabled At or below the PIL Resource limits: Individual: $2000 Couple: $3000	• Physical and mental health • Chiropractic (limited) • Transportation (limited) • Dental ($510 cap/yr., no dentures) • Prescriptions • $1/$2/$3 prescription co-pay if no Medicare Part D coverage • Up to $8.50 co-pays with Medicare Part D coverage • $3 dental co-pay • $3 outpatient hospital visit co-pay (over 21 yrs. of age)
Katie Beckett Medicaid	Up to age 19 Only disabled child's income/resources used to meet MABD limits	• No monthly premium • No co-pays • Same benefits as Dr. Dynasaur
Medicaid Working Disabled	< 250% FPL Meet working criteria Resource Limits: Individual: $10,000 Couple: $15,000	• Physical and mental health • Chiropractic (limited) • Transportation (limited) • Dental ($510 cap/yr., no dentures) • Prescriptions • $1/$2/$3 prescription co-pay if no Medicare Part D coverage • Up to $8.50 co-pays with Medicare Part D coverage • $3 dental co-pay • $3 outpatient hospital visit co-pay (over 21 yrs. of age)
Non-MABD and MCA (Expanded) Medicaid	≤ 138% of FPL Not eligible for Medicare And either: Parent or caretaker relative of a dependent child (Non-MABD); or adult under 65 years of age (Expanded)	• Physical and mental health • Chiropractic (limited) • Transportation (limited) • Dental ($510 cap/yr., no dentures) • Prescriptions • $1/$2/$3 prescription co-pay • $3 dental co-pay • $3 outpatient hospital visit co-pay (over 21 yrs. of age)
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 Full Dental 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 co-pays
VPharm 1, 2, & 3	Eligible and enrolled in Medicare PDP or MAPD VPharm 1: ≤ 150% FPL Must apply for LIS VPharm 2: 150.01% - 175% FPL	• VPharm 1 (after primary LIS reductions): o Medicare Part D cost-sharing for meds o Excluded classes of Part D meds o Diabetic supplies o Some Part D Premiums o Eye exams • VPharm 2 & 3:

	VPharm 3: 175.01% - 225% FPL	o Medicare Part D cost-sharing for maintenance meds only o Diabetic supplies o Some Part D Premiums • Monthly premium per person: o VPharm 1: $15 o VPharm 2: $20 o VPharm 3: $50 • $1/$2 prescription co-pays • No retroactive payments
Medicare Savings Programs	≥ age 65, blind, or disabled Active Medicare beneficiaries QMB: ≤ 100% FPL SLMB 100.01 - 120% FPL QI-1 120.01 - 135% FPL QI-1 Not eligible for Medicaid	• QMB covers Medicare Part B (and A if not free) premiums; Medicare A & B cost-sharing • SLMB and QI-1 cover Medicare Part B premiums only • No monthly premium • 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 the Medicaid rate • No monthly premium • No retroactive payments
Qualified Health Plan (QHP)	Vermont Residents who do not have Medicare	• 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 any level (Bronze, Silver, Gold) QHP	• Tax credit received yearly as a lump sum, or monthly toward QHP premium • Full QHP cost-sharing minus the tax credit
Federally Required Cost-Sharing Reduction (CSR)	≤ 250% FPL No affordable Minimum Essential Coverage (MEC) Meets APTC criteria Enrolled in Silver Plan QHP	• Reduces co-pays, co-insurance, & deductibles. • Full QHP cost-sharing with the reduction in co-pays, co-insurance, deductibles.
Vermont Premium Assistance (VPA)	≤ 300% FPL No affordable MEC Meets APTC criteria	• Covers all or part of QHP premium
Vermont Cost Sharing Reductions (VCSR)	200-300% FPL Enrolled in Silver Plan QHP	• Reduces co-pays, co-insurance, & deductibles. • It should be noted that Silver plans may not be the best option in 2019, as Vermonters who qualify for VCSR will typically find gold plans that have lower premiums and out-of-pocket costs than the VCSR silver plans.

Manage Account and Report Changes

Once Vermonters are enrolled in benefit programs, DVHA aims to ensure both that they can get the maximum health benefits available to them and that they adhere to program rules. Members are required to promptly report changes to their household or income so that DVHA can determine whether they still qualify for the same benefits. Medicaid members are required to report changes within ten days, while QHP members have 30 days to report. In addition to these ongoing changes, most benefit programs require members to go through an annual redetermination process. This process for QHP members takes place during VHC Open Enrollment, which in SFY 2019 ran from November 1, 2018, through December 15, 2018. Redetermination for Medicaid benefits is on a rolling basis throughout the year, twelve months after a household's prior renewal.

This section will provide greater detail on:

- Enrollment in Primary Care (PC Plus)
- Ongoing Changes
- Medicaid Renewals
- QHP Renewals

Enrollment in Primary Care

Having a health insurance card doesn't necessarily produce better health outcomes. Connecting with a primary care provider is a key step in the right direction. DVHA's Customer Support Center, managed by Maximus, provides enrollment functions for the State's primary care case management program for Medicaid members, Primary Care Plus (PC Plus). These functions include outreach to eligible enrollees identified by the State, entering enrollments received via phone or mail, sending enrollment reminder and confirmation notices, and providing unbiased information to educate members of their enrollment options and program benefits. In addition, the Customer Support Center solicits the choice of a dental provider for PC Plus enrollees between age one and seventeen.

Enrollment forms that contain complete and accurate information are entered into the State's enrollment system within two business days of receipt. When the form received is incomplete, the Customer Support Center calls members to obtain the missing information. If they are unable to reach the consumer by telephone, the original enrollment form is mailed to the member along with a detailed description of the additional information required to complete the transaction. In SFY 2017, the Customer Support Center mailed more than 72,000 PC Plus enrollment notices and more than 43,000 handbooks.

Ongoing Changes

In a typical month, HAEEU receives more than 10,000 member requests, over half of which involve reported changes. Most of these requests are made by phone to the Customer Support Center.

HAEEU receives more than 10,000 member requests per month.

All Vermonters who are served by HAEEU should expect that their requests will be addressed promptly. However, during the first few years of VHC, many requests took several weeks or months to complete. In the first quarter of 2016, fewer than 60% of requests were completed within ten business days. After years of

continual improvement, HAEEU now consistently completes more than 90% of member requests within ten business days and set a goal of completing 95% in 2018.

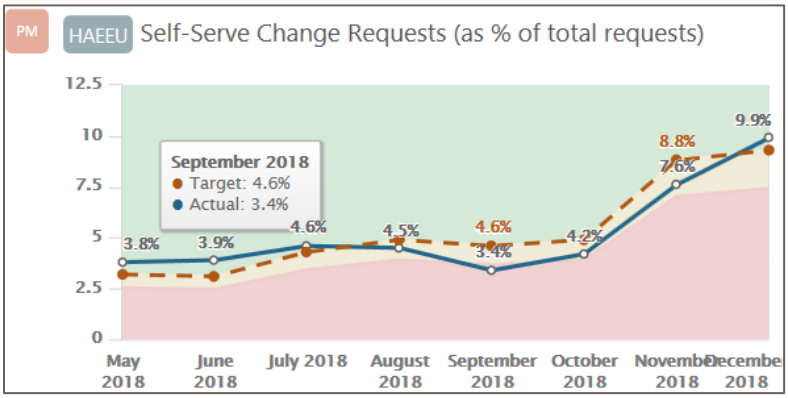
Green Mountain Care (GMC) requests through the State's legacy ACCESS system didn't have the same level of consistently strong performance as VHC requests, yet the combined average exceeded 90% for 20 of the first 26 months of 2018. Early in SFY 2017, DVHA opened self-service functionality on the VHC system; allowing Vermonters to report changes online, as well as, pay bills, access tax documents, and other actions. Self-service can lead to improved customer experience as Vermonters can log in at their convenience. It also has the potential to save the State money through automation. As of the end of SFY 2017 (June 2017), 2.8% of change requests were submitted online. By June 2018, that metric had increased to 3.9% -- meeting DVHA's goal for 10% year-over-year increases in self-service adoption but far behind the number of initial applications (51%) – are submitted online. Stated in another way, making changes on the web lags the use of the web for submitting initial applications. HAEEU promotes the self-service option using bill stuffers, call center staff and partner organizations, and social media.

HAEEU 2018 Goal:

Complete 95% of member requests within 10 business days.

Members who receive MABD and other non-MAGI benefit programs are served by the State's legacy ACCESS system and are unable to utilize self-service options at this time.

Medicaid Renewals



Annual Medicaid redeterminations are an important piece of DVHA's work to ensure that members maintain eligibility for the programs in which they are enrolled. Redeterminations for Medicaid for Children and Adults (MCA) continued their normal cycle throughout 2018 and into 2019. The auto-renewal process, known as "ex parte," consistently confirmed the continuing eligibility of more than 40% of renewing members through electronic sources in the first half of SFY 2019. As a result, fewer than 60% of members were required to fill out a renewal application and provide documentation. Redeterminations for MABD also continued their normal annual cycle but do not utilize the ex parte process.

QHP Renewals

DVHA kicks off a series of preparatory meetings at the beginning of every summer for the coming Open Enrollment with its insurance carrier partners and the Health Care Advocate to prepare for system testing, business, and transactional planning activities. QHP renewals presented major challenges for the marketplace in its early years VHC in past years, including the 2016 Open Enrollment which was the first year with automated renewal functionality and was complicated by a significant contractor going out of business at the start of Open Enrollment. In SFY 2017 and SFY

2018, the State of Vermont and its partners successfully completed three major steps on, or ahead of, schedule to ensure a successful renewal effort.

In October 2018, 99.3% of eligible QHP renewals were handled through a single, clean automated process (up from 97.8% the prior year and 91.5% two years prior).

The first step in the renewal effort involves determining eligibility for the coming year's State and Federal subsidies and enrolling members in new comparable versions of their health and/or dental plans. In SFY 2018, this step was operated with a single, clean, automated run that took care of 99.3% of eligible cases, up from 97.8% the prior year and 91.5% two years prior. The 0.7% failure rate meant that only 312 cases needed to be renewed by staff the following day; allowing all members to have updated accounts and 2019 information before the start of Open Enrollment. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, select a new plan if they wanted to do so. This year, due to changes in premiums and subsidies, DVHA strongly encourage members to comparison shop rather than simply accepting their auto-renewal plan. Members also had the option to call the Customer Support Center or meet with an In-Person Assister and go through the same steps if they didn't want or were unable to use the online option.

The second step involves sending these files to the payment and premium processor, Wex Health, and the insurance carriers to ensure appropriate billing and effectuation. In SFY 2019, this initial integration run was completed with 99% accuracy in mid-November. DVHA and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consists of a year-end business process that allows changes to be made on cases if the member reports changes in household or income information. In SFY 2018 this process ran with nearly a 100% success rate and all cases were ready to accept change requests in early January.

Altogether, performance on these three steps made the 2018 QHP renewal experience markedly different than the early years of the marketplace and left DVHA staff both optimistic and well-positioned to tackle other challenges.

Resolve Issues

Vermonters have a right to file grievances and fair hearing requests – two forms of validation and contestation for eligibility or coverage determinations with which they disagree. That disagreement can come in the form of concern a mistake was made or a disagreement with the relevant policy as written. When dealing with multiple systems, complex State and Federal policies, over three hundred staff, and more than 200,000 members, it is inevitable that there will be mistakes, disagreements, and other problems. DVHA aims to both minimize the occurrence of these problems and to provide clear, formal, and informal paths for members to seek resolution.

Health Care Appeals 2018 Goal:

Resolve more than half of appealed cases without going to the Human Services Board.

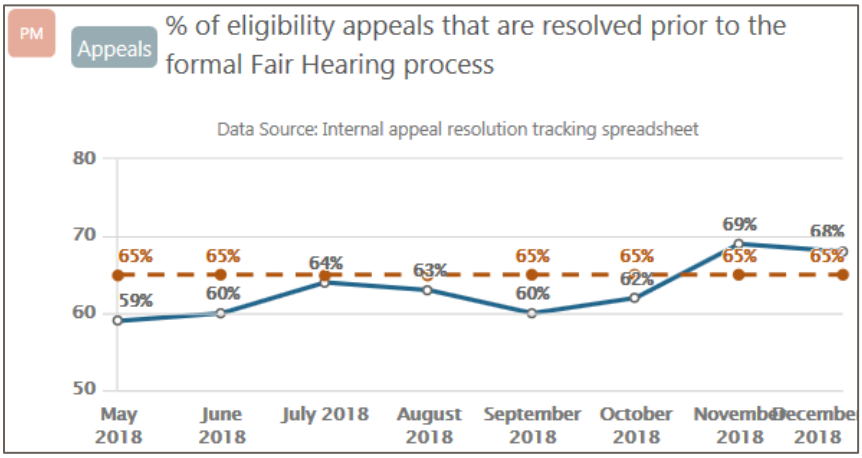
More than 6 out of 10 appealed cases were resolved without HSB involvement.

Staff at DVHA's Customer Support Center are permitted to work on member cases up until the point that a formal grievance or appeal is filed. Once a member files a formal grievance or appeal, appeals staff from DVHA's Health Care Appeals Team will work with the member.

If the case is referred from the Health Care Appeals Team (HCAT) to the Human Services Board (HSB), only the Assistant Attorney General (AAG) will communicate directly with the member – although appeals staff will testify at the HSB hearing.

To provide strong customer service and to save the State's resources, the appeals staff work to identify cases that can be resolved in the customer's favor prior to referring cases to the HSB and engaging in the resource-intensive formal Fair Hearing process. If a mistake was made in the case, they work to correct it. If, on the other hand, the system worked properly, and procedures were followed, then the case moves into the Fair Hearing process. Informal resolution benefits Vermonters by providing expeditious and favorable resolution to their appeals wherever possible.

In SFY 2018, HCAT set a goal of resolving more than half of appealed eligibility cases in this manner per month. The unit exceeded this goal in all twelve months. For the year, more than six out of ten appealed cases were resolved without having to go to the HSB.

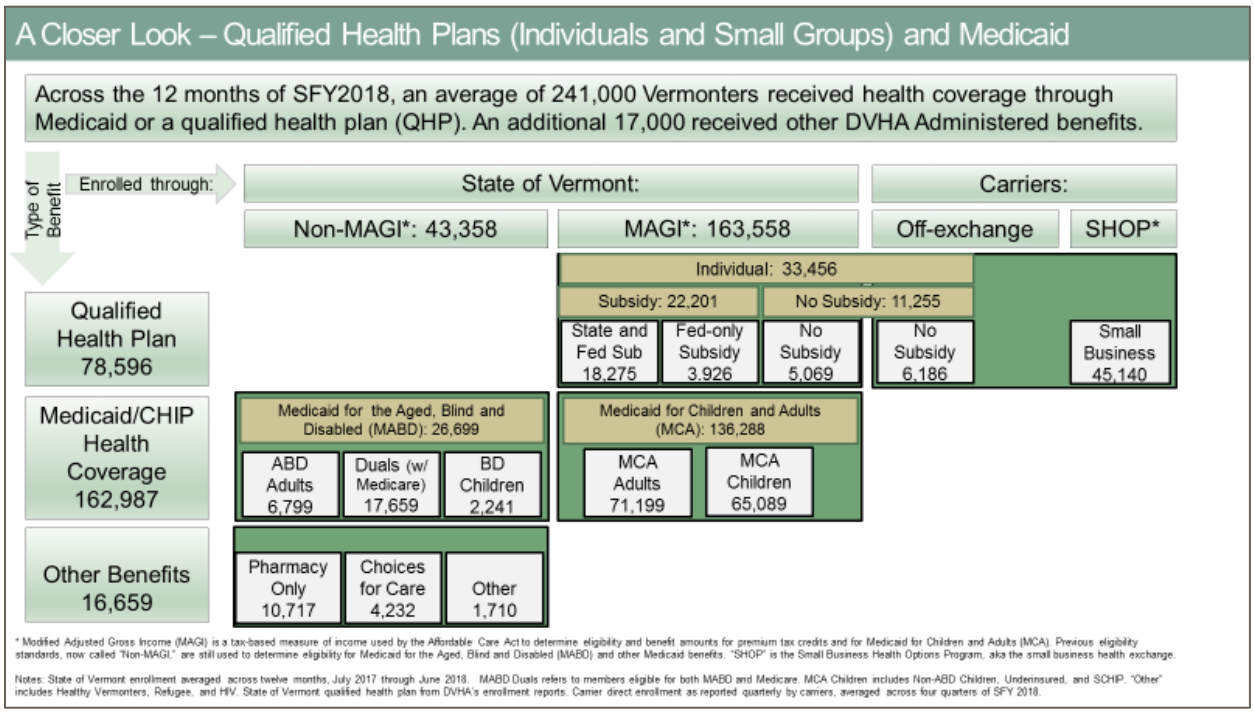


This performance measure has been helpful in tracking how many cases HCAT can resolve informally; however, the story behind this curve is more complex. Now that the eligibility system is stable, fewer mistakes are made, and fewer appeals can be resolved informally. HCAT will revisit this metric in the next year to ensure it is still striving for the right goal.

Chapter Three: Caseload and Utilization

This section details the historical and projected caseload and utilization of Medicaid Services. By statute, Vermont uses a consensus process to forecast Medicaid caseload and utilization. Program spending is a function of caseload, utilization and cost for services. Generally, DVHA is experiencing declining enrollment, increased utilization and increased cost of services. Specific cost pressures are seen in Inpatient Psychiatric services at the Brattleboro Retreat and non-emergency transportation.

Caseload declines are being experienced in both Children and Adults as compared to SFY 2018. The graphic below provides a snapshot of the Vermonters who access health care coverage through Medicaid, CHIP, DVHA-managed limited health care benefit, or the QHP.



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

The eligibility requirements for the aged, blind, or disabled (ABD) and/or Medically Needy Adults are:

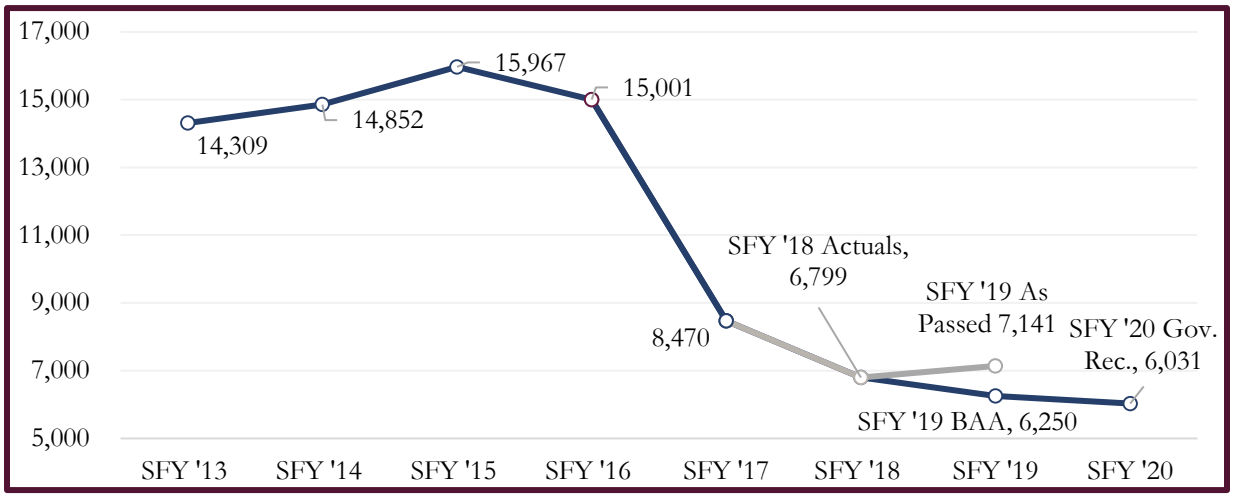
- Age 19 and older
- Determined ABD but ineligible for Medicare includes:
  - Supplemental Security Income (SSI) cash assistance recipients
  - Working disabled
  - Hospice patients
  - Breast and Cervical Cancer Treatment (BCCT) participants
  - Medicaid/Qualified Medicare Beneficiaries (QMB)
  - Medically needy – eligible because their income is greater than the cash assistance level but less than the protected income level (PIL) – may be ABD or the parents/caretaker relatives of minor children.

ABD Caseload, Expenditure, and PMPM Comparison by SFY

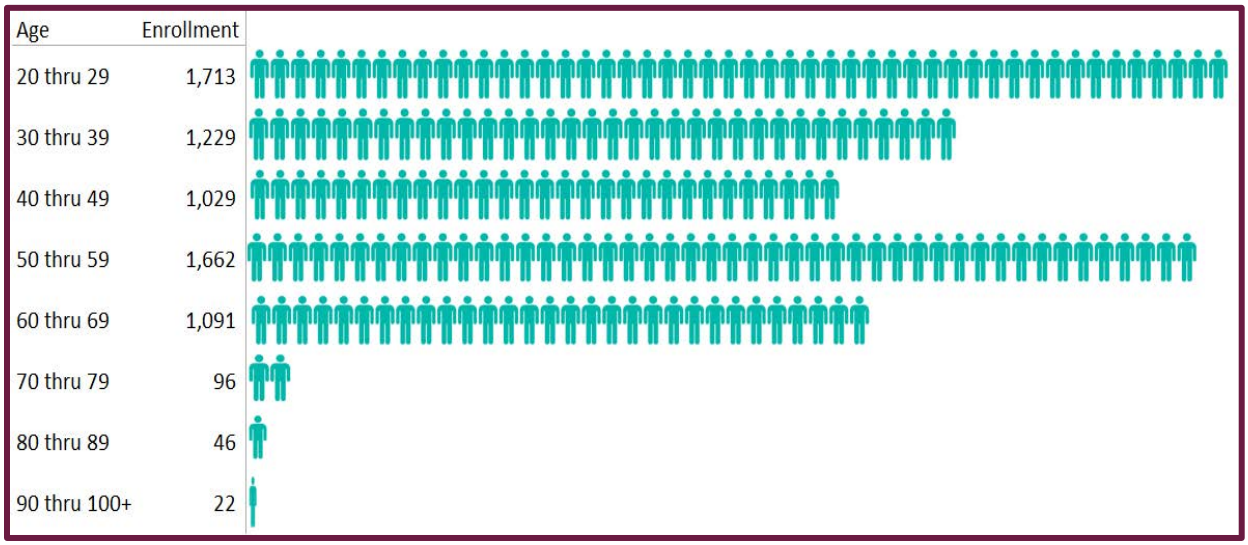
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	15,001	$ 99,308,972	$ 551.69	$ 182,970,086	$ 1,016.46
SFY '17 Actual	8,470	$ 68,865,433	$ 677.58	$ 150,586,971	$ 1,481.66
SFY '18 Actual	6,799	$ 54,818,596	$ 671.90	$ 136,589,693	$ 1,674.14
SFY '19 As Passed	7,141	$ 65,793,951	$ 767.80	$ 147,609,888	$ 1,722.56
SFY '19 BAA	6,250	$ 57,191,818	$ 762.56	$ 150,089,250	$ 2,001.19
SFY '20 Gov. Rec.	6,031	$ 55,637,661	$ 768.78	$ 150,836,222	$ 2,084.19

ABD Caseload Comparison by SFY

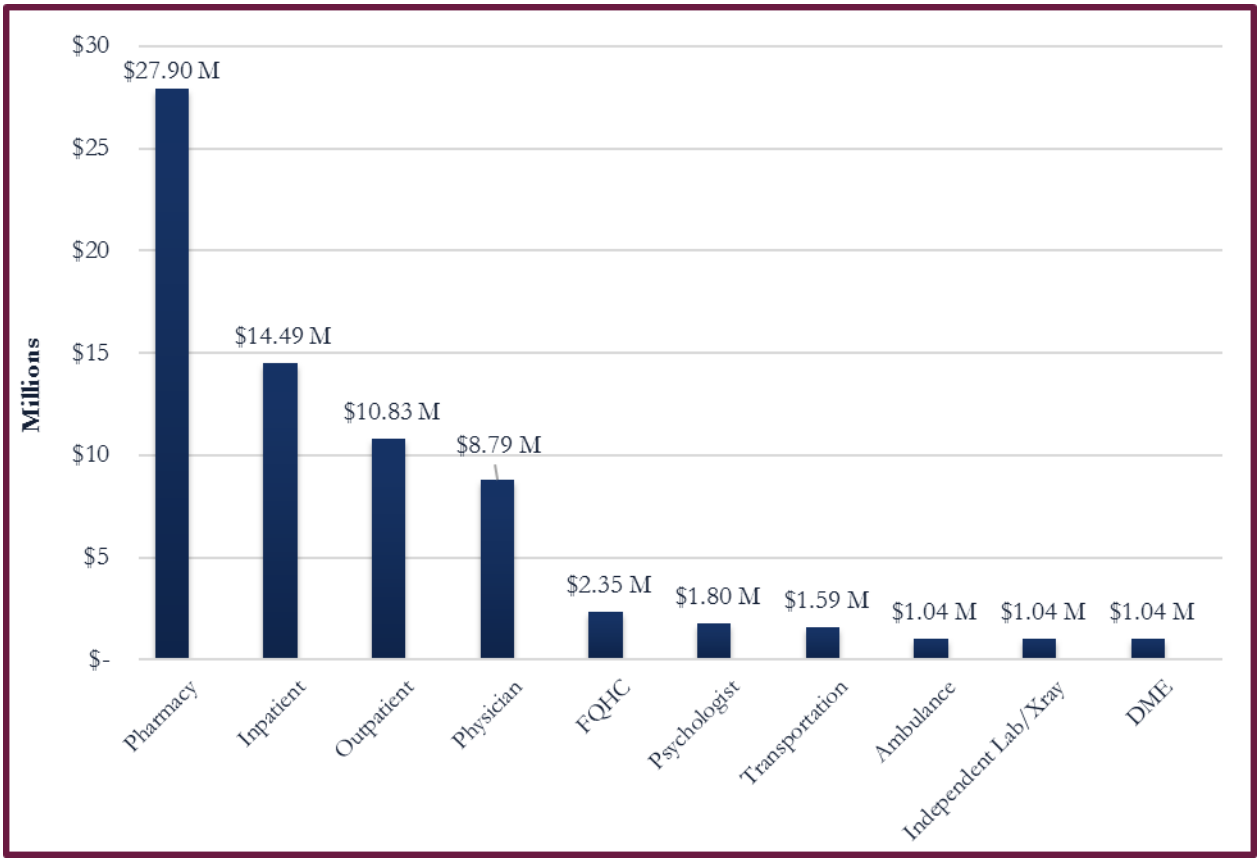


ABD Adult SFY 2018 Average Enrollment Breakout by Age



ABD DVHA Expenditures by Top 10 Service Categories

For adults with disabilities, pharmacy, outpatient, inpatient, and professional services accounted for the majority of the $54,818,596 DVHA expenditure for ABD Adults.



Dual Eligible

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

Medicaid is responsible for:

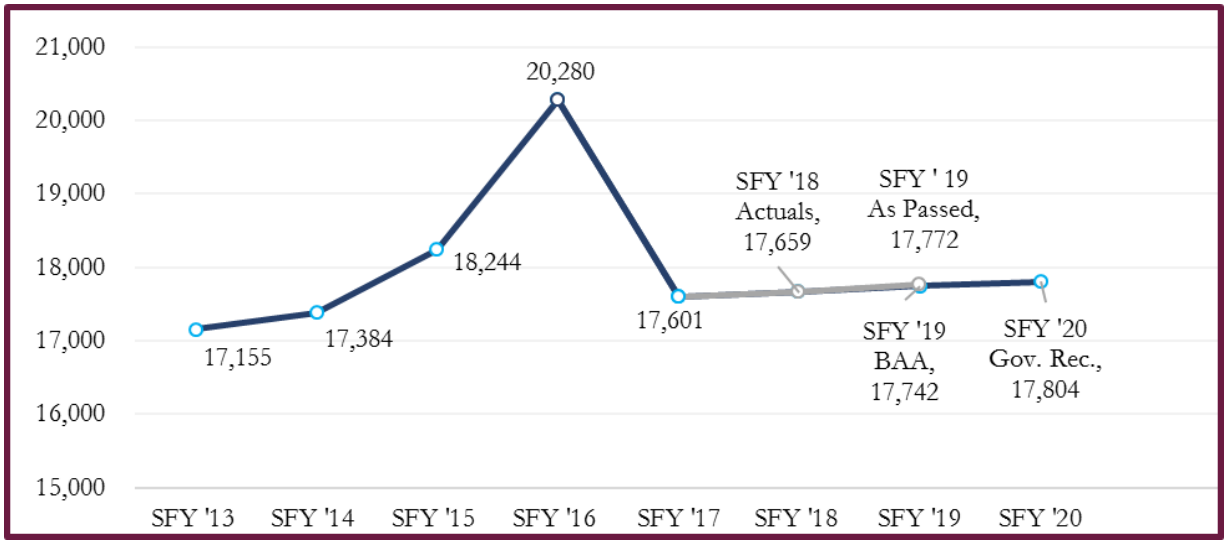
- Medicare:
  - Co-payments
  - Co-insurance
  - Deductibles
- Non-Medicare routine services:
  - Hearing
  - Dental
  - Transportation

Dual Eligible Caseload, Expenditure, and PMPM Comparison by SFY

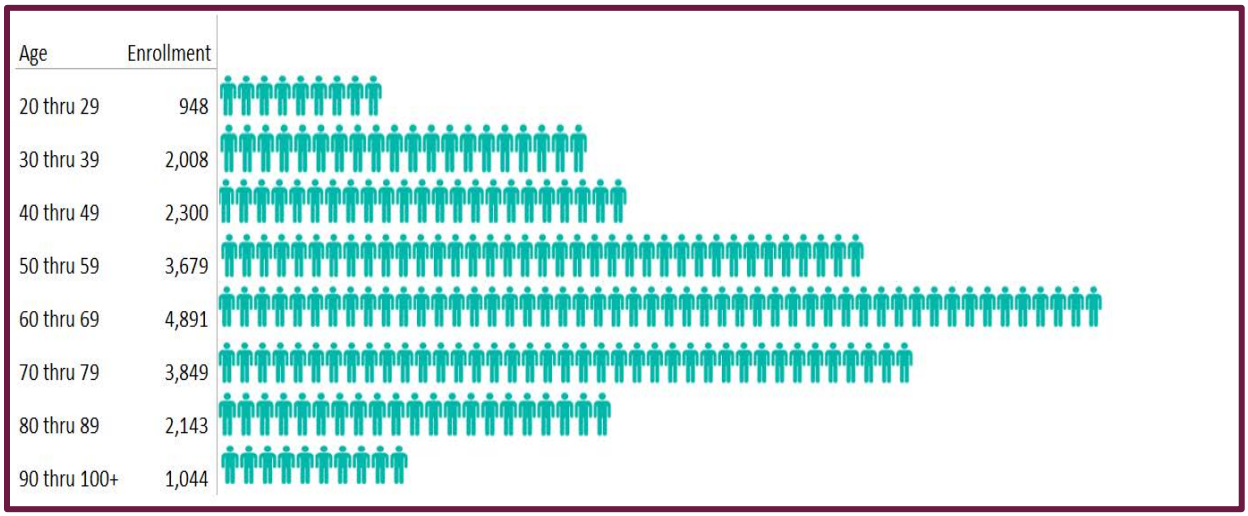
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	20,280	$ 55,523,042	$ 228.15	$ 243,884,642	$ 1,002.14
SFY '17 Actual	17,601	$ 52,597,445	$ 249.02	$ 214,721,288	$ 1,016.60
SFY '18 Actual	17,659	$ 53,612,503	$ 253.00	$ 222,809,638	$ 1,051.45
SFY '19 As Passed	17,772	$ 53,627,621	$ 251.46	$ 222,906,616	$ 1,045.21
SFY '19 BAA	17,742	$ 57,507,834	$ 270.11	$ 249,796,005	$ 1,173.28
SFY '20 Gov. Rec.	17,804	$ 58,409,743	$ 273.39	$ 254,764,558	$ 1,192.45

Dual Eligible Caseload Comparison by SFY

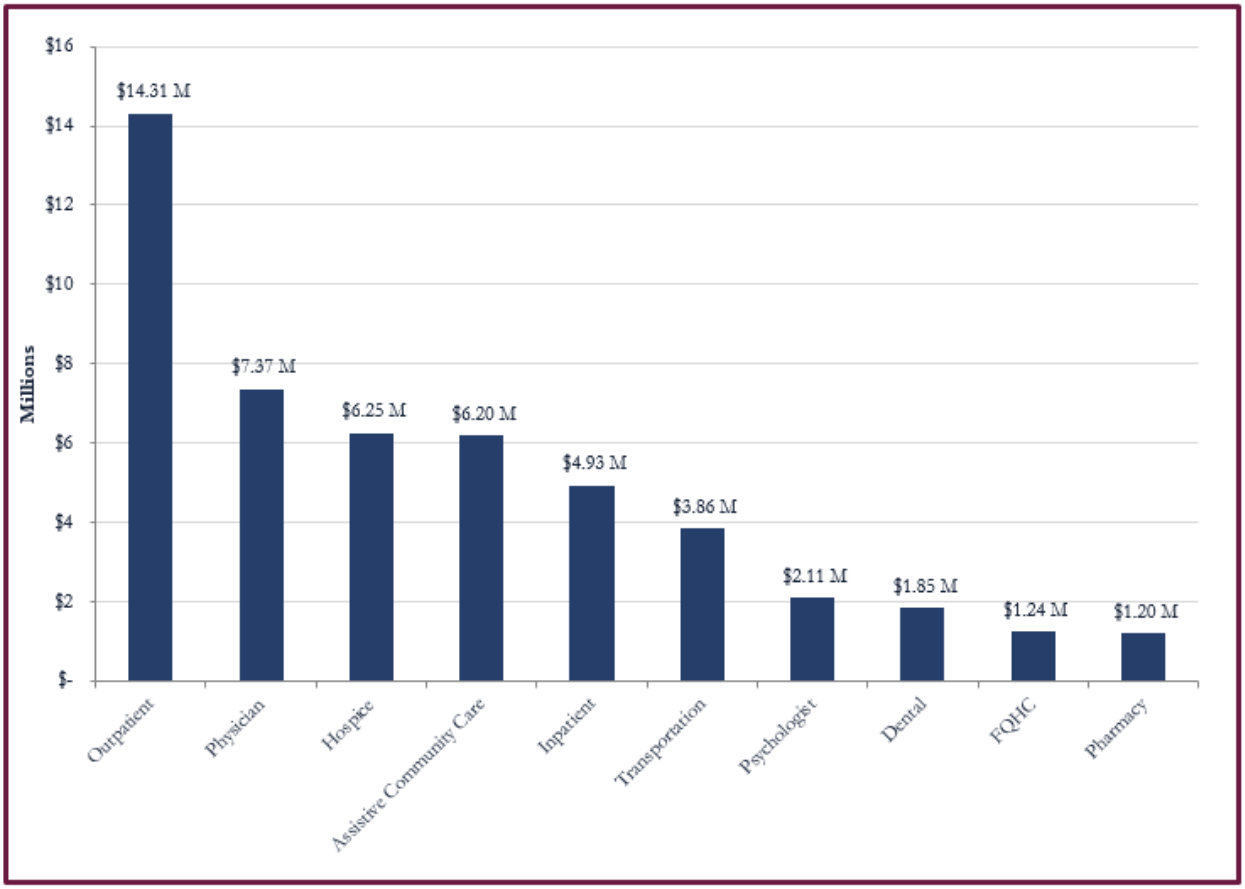


Dual Eligible SFY 2018 Average Enrollment Breakout by Age



Dual Eligible DVHA Expenditures by Top 10 Service Categories

For the Dual Eligible population, outpatient, assistive community supports, inpatient, and professional services accounted for the majority of the $53,612,503 DVHA spend in SFY 2018. This population is covered by Medicare as the primary insurer, and Medicaid pays for co-insurance and deductibles, as well as wrapping certain services not covered by Medicare.



General Adults

The eligibility requirements for General Adults are:

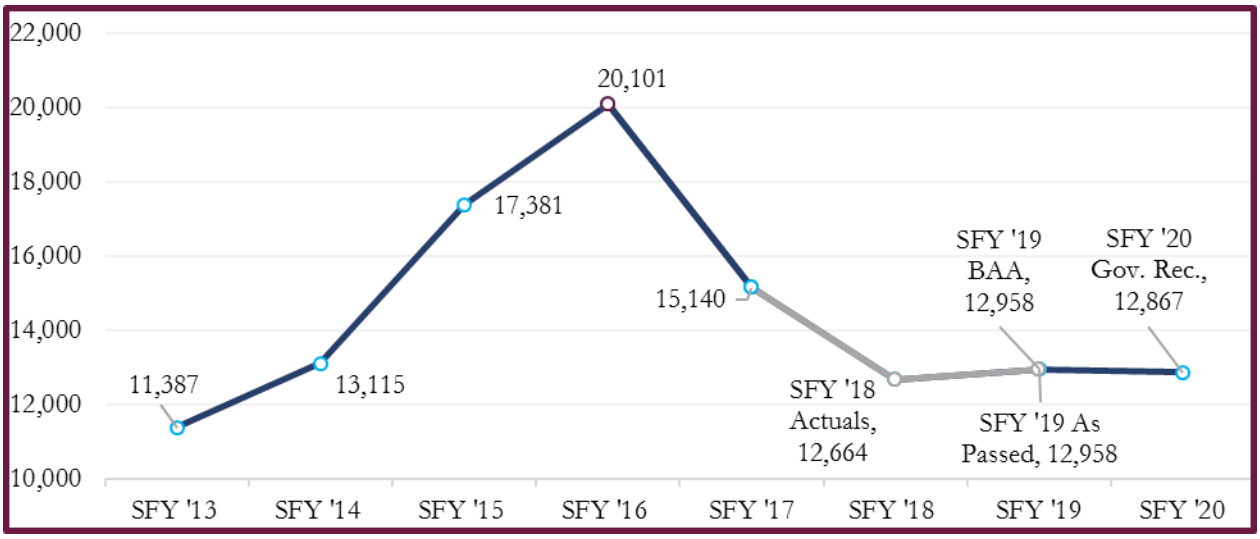
- Age 19 and older
- Parent(s), caretaker(s), or relative(s) of minor children (including cash assistance recipients)
- Those receiving transitional Medicaid after the receipt of cash assistance
- Income below the PIL

General Adults Caseload, Expenditure, and PMPM Comparison by SFY

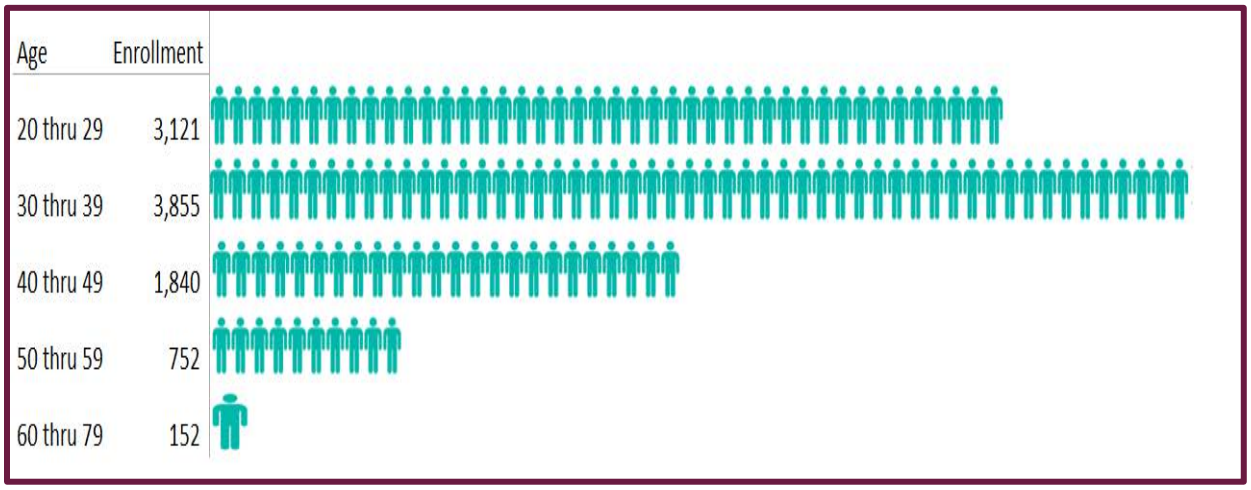
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	20,101	$ 92,641,465	$ 384.07	$ 105,326,128	$ 436.66
SFY '17 Actual	15,140	$ 77,460,396	$ 426.37	$ 89,853,697	$ 494.58
SFY '18 Actual	12,664	$ 71,486,396	$ 470.40	$ 83,434,709	$ 549.03
SFY '19 As Passed	12,958	$ 72,192,004	$ 464.27	$ 84,168,242	$ 541.29
SFY '19 BAA	12,958	$ 75,554,021	$ 485.89	$ 90,344,731	$ 581.01
SFY '20 Gov. Rec.	12,867	$ 75,690,117	$ 490.21	$ 90,845,137	$ 588.36

General Adults Caseload Comparison by SFY

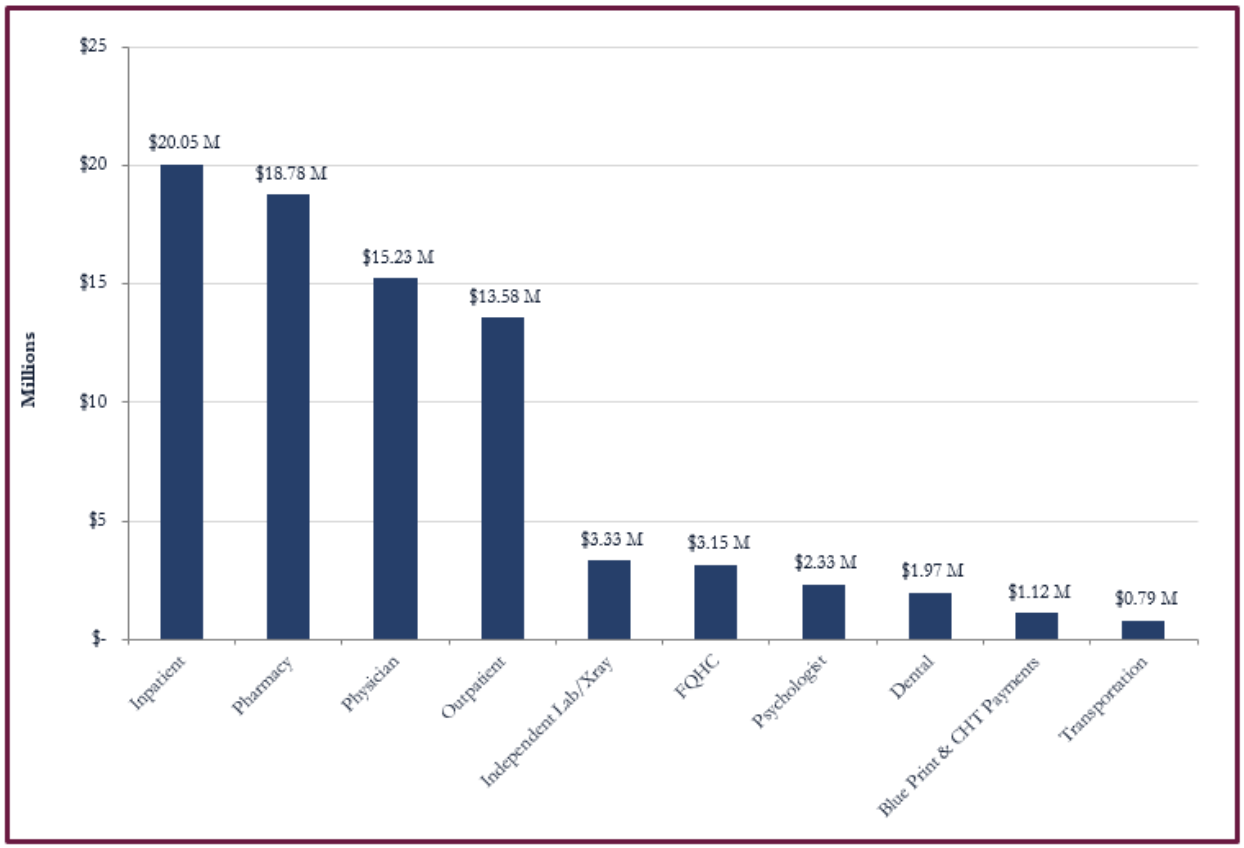


General Adults SFY 2018 Average Enrollment Breakout by Age



General Adults DVHA Expenditures by Top 10 Service Categories

Inpatient, physician, outpatient, and pharmacy accounted for the majority of the $71,486,396 SFY 2018 DVHA spend.



New Adults without Children

The eligibility requirements for New Adults are:

- Age 19 and older
- Income below the designated FPL
- No children in the household

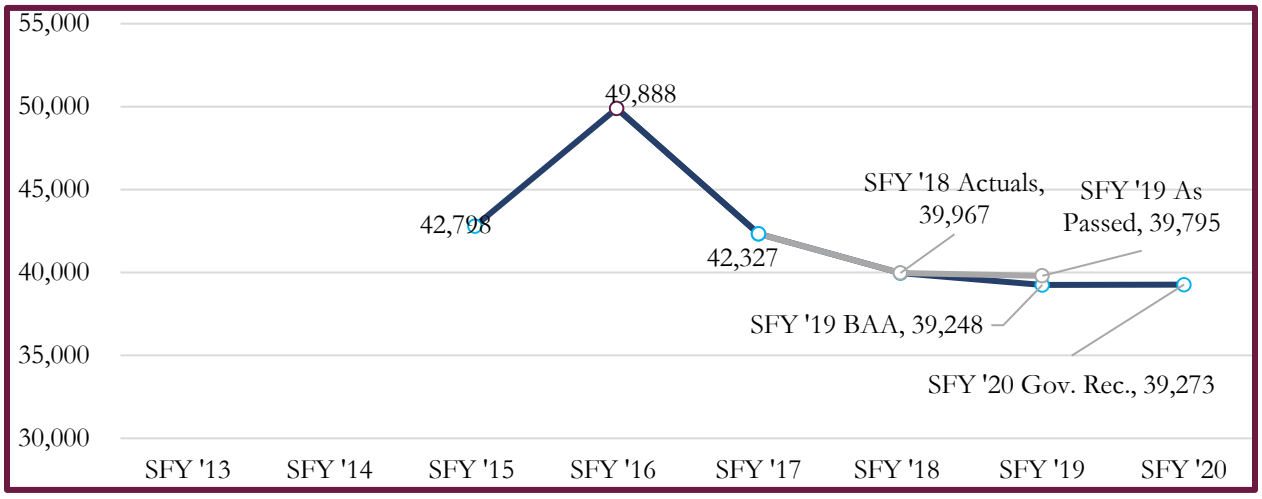
The Federal government reimburses services for New Adults without Children in the household at a higher percentage rate.

New Adults – Without Children Caseload, Expenditure, and PMPM Comparison by SFY

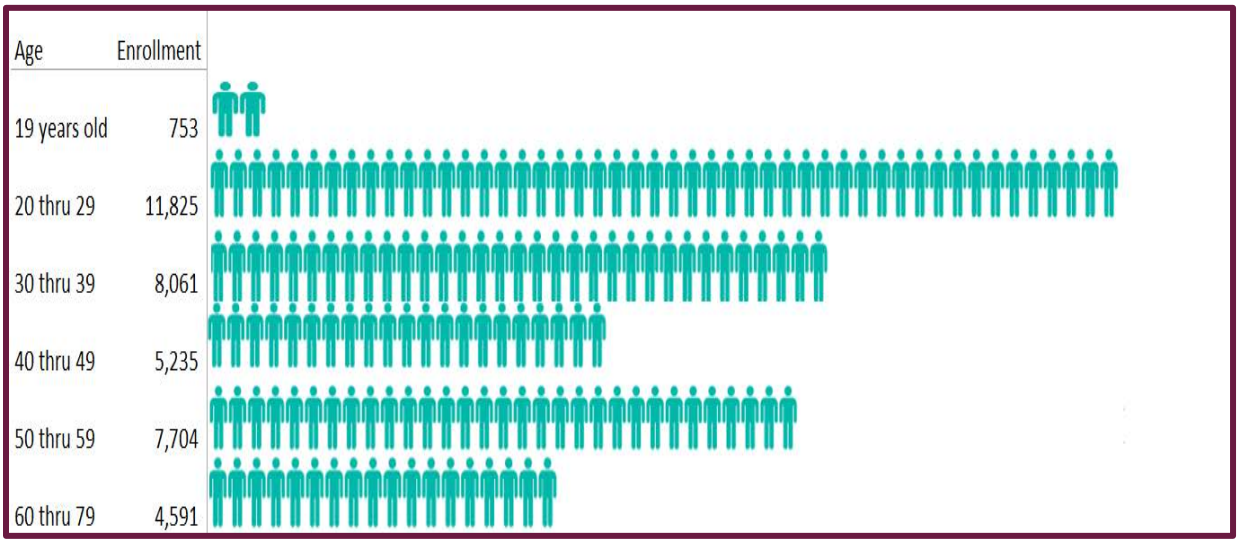
The following tables illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	49,888	$ 210,571,136	$ 351.74	$ 234,059,775	$ 390.98
SFY '17 Actual	42,327	$ 194,062,032	$ 382.07	$ 215,734,379	$ 424.74
SFY '18 Actual	39,967	$ 189,970,050	$ 396.10	$ 213,244,422	$ 444.63
SFY '19 As Passed	39,795	$ 195,593,587	$ 409.59	$ 218,903,188	$ 458.40
SFY '19 BAA	39,248	$ 202,267,933	$ 429.47	$ 231,376,380	$ 491.27
SFY '20 Gov. Rec.	39,273	$ 204,022,998	$ 432.92	$ 233,856,577	$ 496.22

New Adults – Without Children Caseload Comparison by SFY

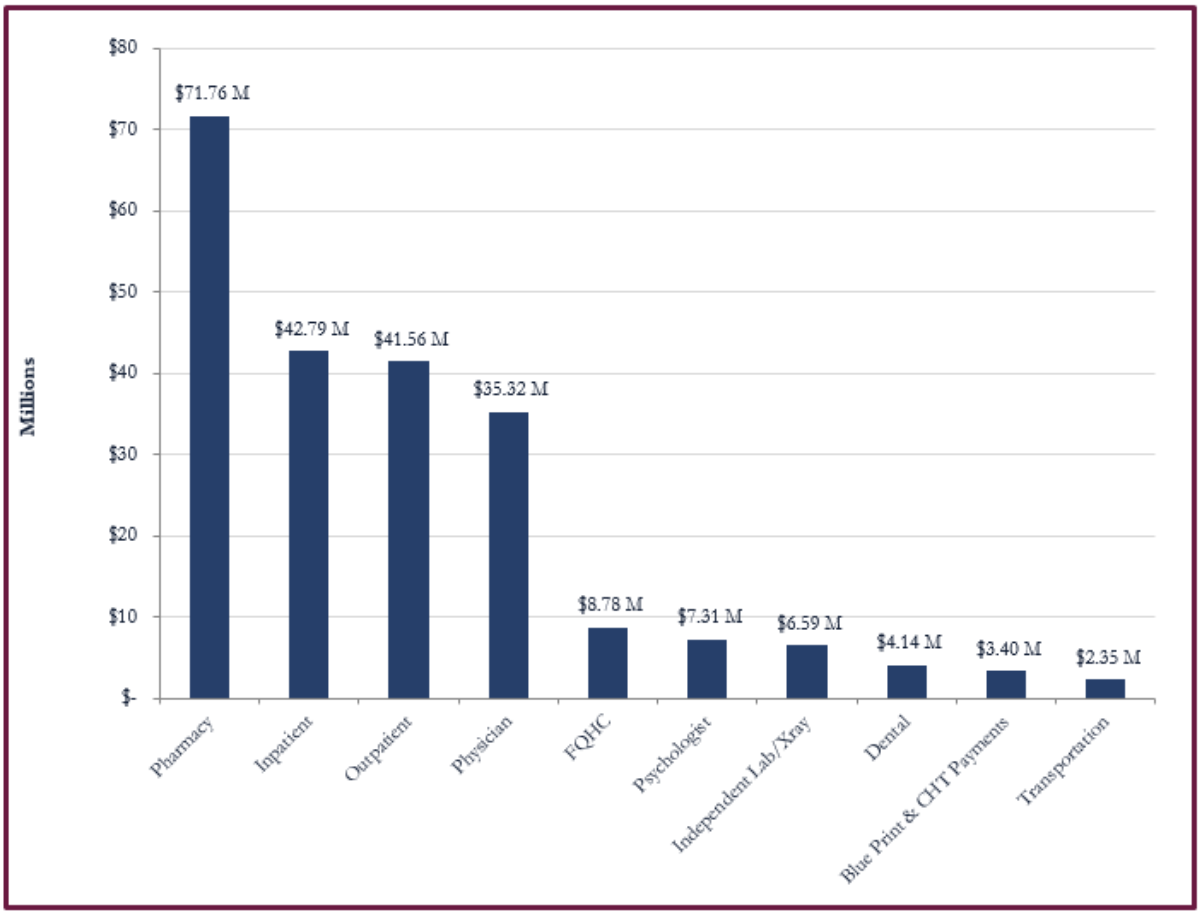


New Adults – Without Children SFY 2018 Average Enrollment Breakout by Age



New Adults – Without Children DVHA Expenditures by Top 10 Service Categories

Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $189,970,050 New Adult – Without Children DVHA spend.



New Adults with Children

The eligibility requirements for New Adults are:

- Age 19 and older
- Income below the designated FPL
- With children in the household under the age of 19

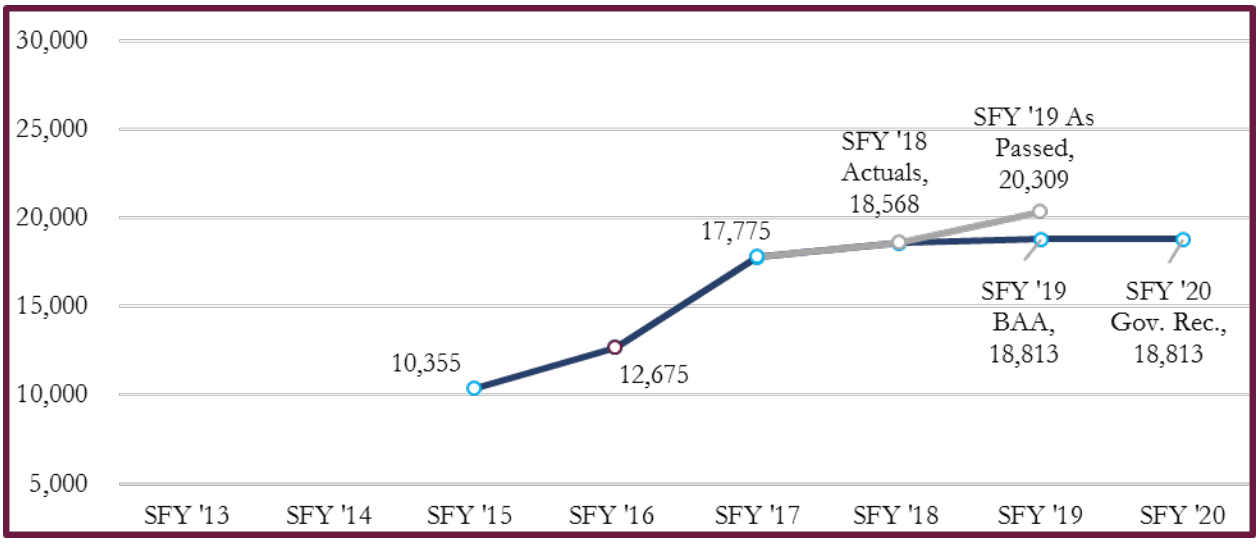
Unlike New Adults without children, for this population, the Federal government reimburses services for New Adults without Children in the household at the unenhanced Global Commitment rate.

New Adults – With Child Caseload, Expenditure, and PMPM Comparison by SFY

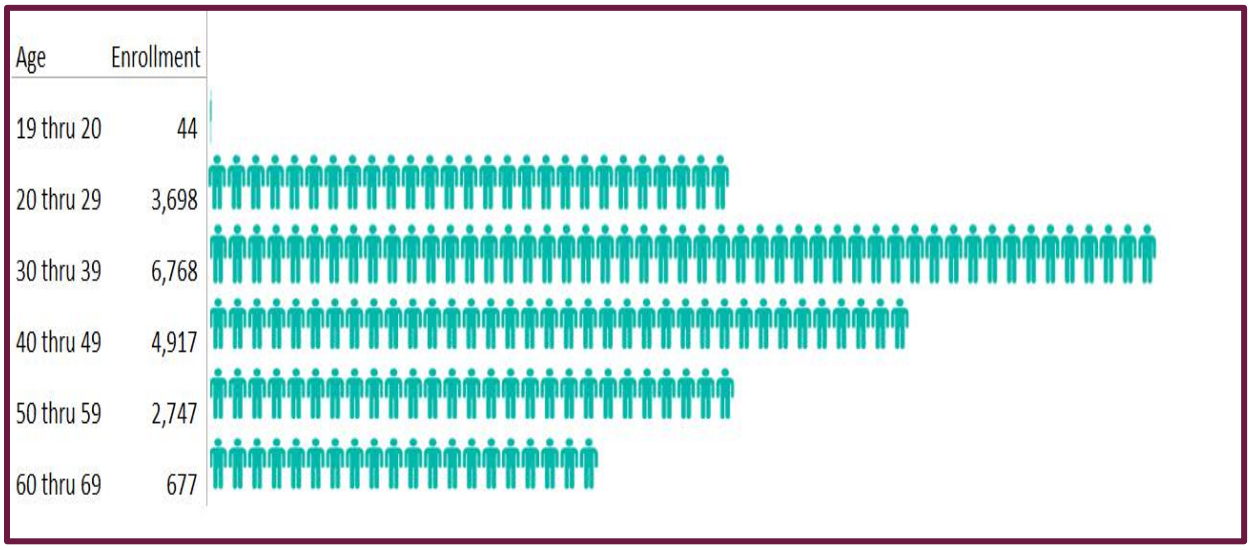
The following tables illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	Caseload	Expenditures	PMPM	Expenditures	PMPM
SFY '16 Actual	12,675	$ 38,150,227	$ 250.83	$ 42,405,781	$ 278.81
SFY '17 Actual	17,775	$ 70,043,265	$ 328.38	$ 77,865,517	$ 365.05
SFY '18 Actual	18,568	$ 74,119,966	$ 332.65	$ 80,482,778	$ 361.21
SFY '19 As Passed	20,309	$ 84,329,765	$ 346.03	$ 90,719,087	$ 372.25
SFY '19 BAA	18,813	$ 81,007,952	$ 358.83	$ 88,871,107	$ 393.66
SFY '20 Gov. Rec.	18,813	$ 81,593,448	$ 361.42	$ 89,652,223	$ 397.12

New Adults – With Child Caseload Comparison by SFY

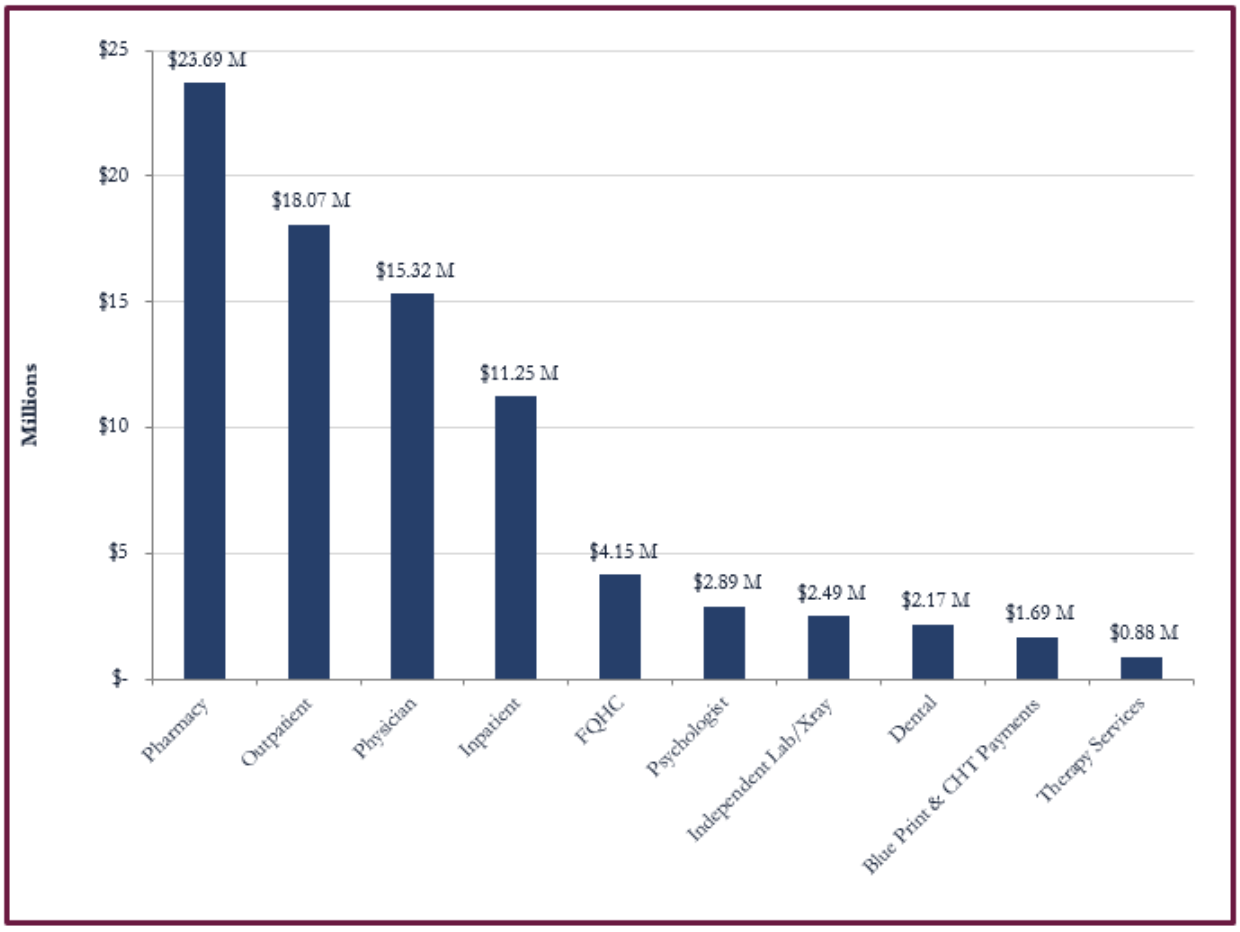


New Adults – With Child SFY 2018 Average Enrollment Breakout by Age



New Adults – With Child DVHA Expenditures by Top 10 Service Categories

Outpatient, inpatient, pharmacy (net drug rebate), and professional services accounted for the majority of the $74,119,966 New Adult – with Child DVHA spend.



Pharmacy Only Programs – Prescription Assistance

Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status, and age. There are monthly premiums 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 as well as their Medicare Part D premiums.

The eligibility requirements for VPharm are:

- Age 65 and older
- Any age with disability
- Current Medicare Part D eligibility
- Income below the designated FPL

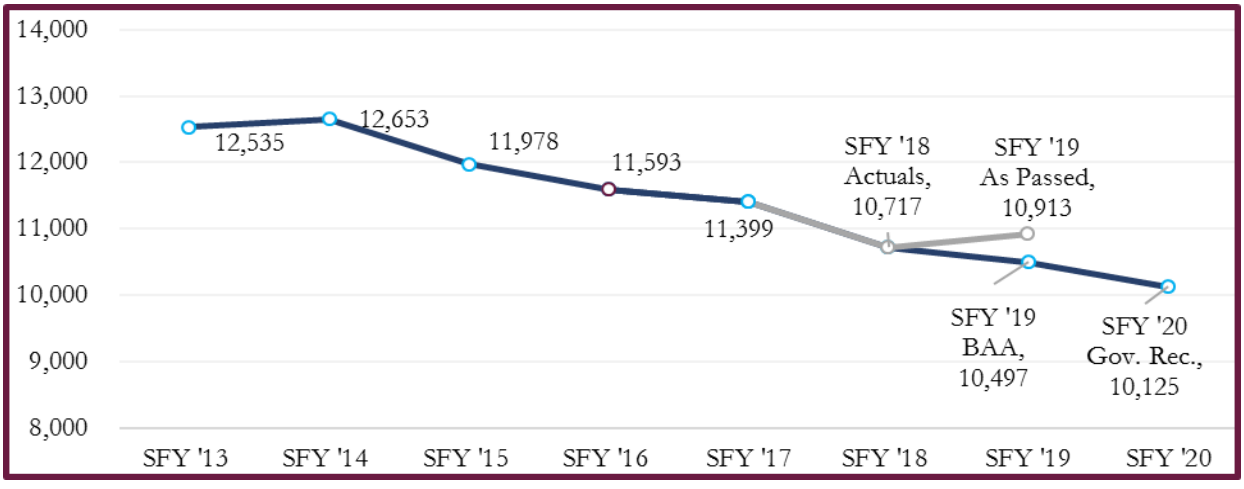
VPharm Caseload, Expenditure, and PMPM Comparison by SFY

The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	11,593	$ 2,302,437	$ 16.55	$ 2,302,437	$ 16.55
SFY '17 Actual	11,399	$ 3,155,724	$ 23.07	$ 3,155,724	$ 23.07
SFY '18 Actual	10,717	$ 4,588,899	$ 35.68	$ 4,588,899	$ 35.68
SFY '19 As Passed	10,913	$ 6,134,624	$ 46.84	$ 6,134,624	$ 46.84
SFY '19 BAA*	10,497	$ 11,278,883	$ 89.54	$ 11,278,817	$ 89.54
SFY '20 Gov. Rec.	10,125	$ 7,614,529	$ 62.67	$ 7,614,405	$ 62.67

*The PMPM for SFY 2019 includes anticipated refund of $3.5M for VPharm rebate credit balances.

VPharm Caseload Comparison by SFY



Choices for Care

The eligibility requirements for Choices for Care are:

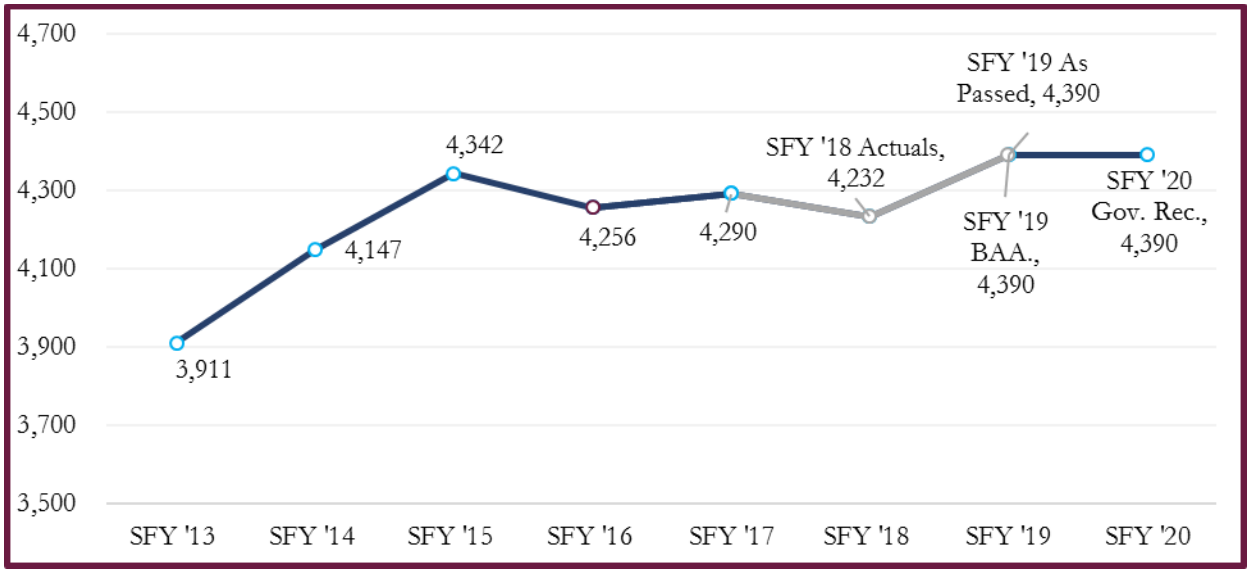
- Vermonters in nursing homes
- Home-based settings under home and community-based services (HCBS) waiver programs
- Enhanced residential care (ERC)

Choices for Care Caseload, Expenditure, and PMPM Comparison by SFY

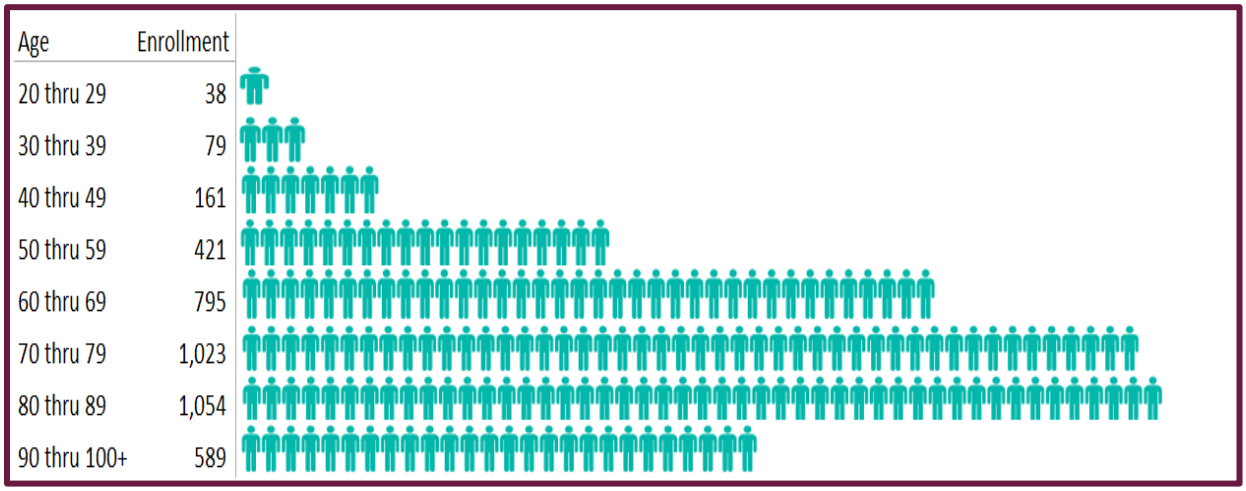
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	4,256	$ 213,115,112	$ 4,172.59	$ 218,544,540	$ 4,278.89
SFY '17 Actual	4,290	$ 222,772,830	$ 4,327.20	$ 225,042,484	$ 4,371.28
SFY '18 Actual	4,232	$ 225,076,899	$ 4,432.04	$ 231,145,293	$ 4,551.54
SFY '19 As Passed	4,390	$ 232,625,508	$ 4,415.82	$ 235,548,100	$ 4,471.30
SFY '19 BAA	4,390	$ 237,381,325	$ 4,506.10	$ 243,378,966	$ 4,619.95
SFY '20 Gov. Rec.	4,390	$ 240,156,067	$ 4,558.77	$ 246,750,486	$ 4,683.95

Choices for Care Caseload Comparison by SFY

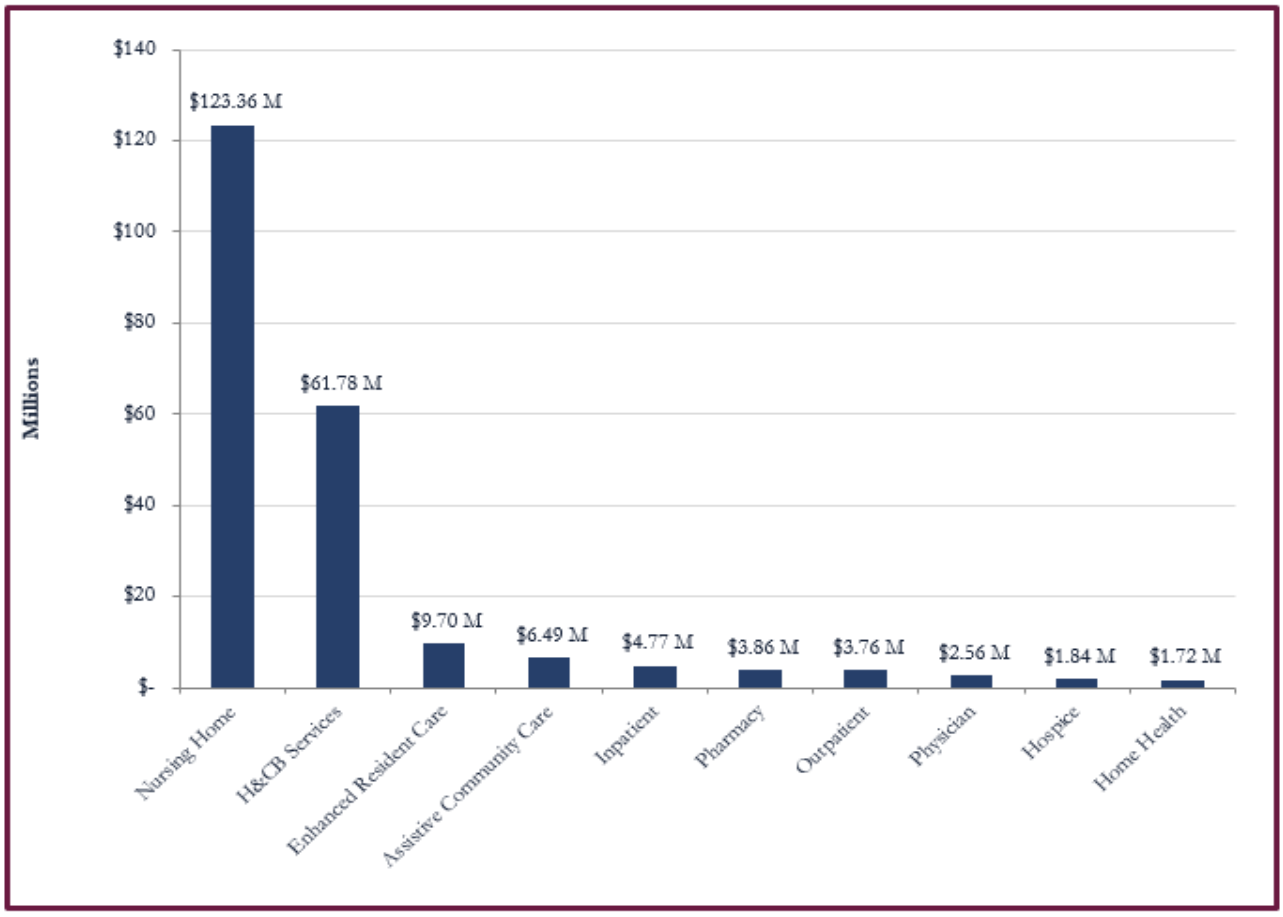


Choices for Care SFY 2018 Average Enrollment Breakout by Age



DVHA Expenditures by Top 10 Service Categories: Choices for Care

This population receives Choices for Care Services – Nursing Home, Enhanced Residential Care, and Home and Community Based Services – as well as acute services such as Inpatient, Pharmacy, and Outpatient Services. The Department of Disabilities, Aging, and Independent Living (DAIL) manages the Choices for Care (CFC) Program Benefit while DVHA manages the CFC appropriation and the acute services.



Healthy Vermonters

Healthy Vermonters provides a discount on prescription medicines for individuals not eligible for other pharmacy assistance programs. There is no cost to the state for this program.

The eligibility requirements for Healthy Vermonters are:

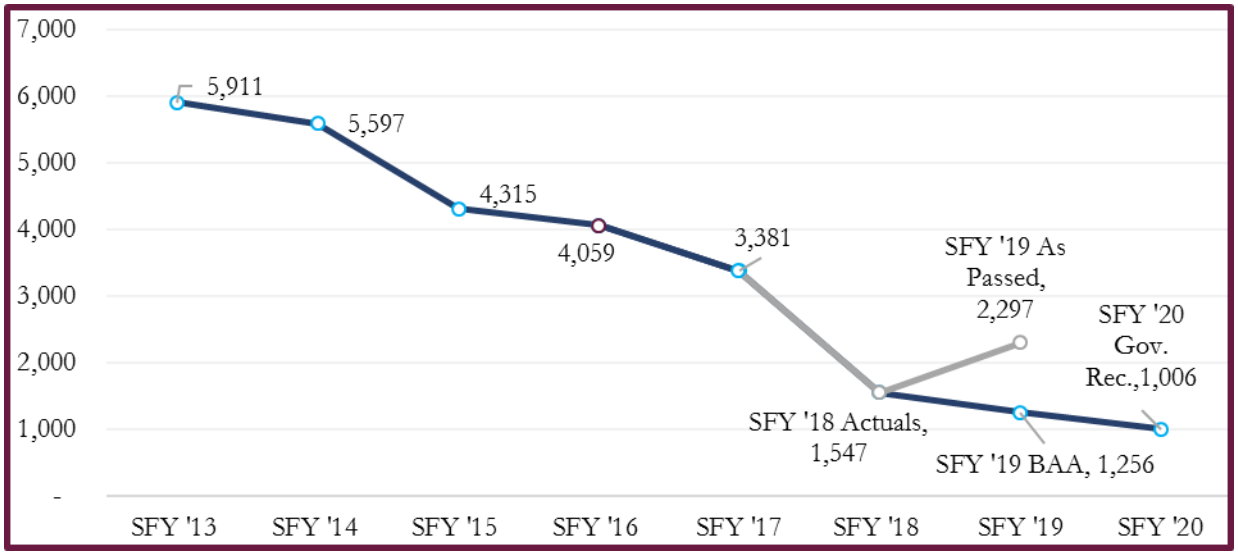
- Household incomes up to 350% and 400% FPL if they are aged or disabled.

Healthy Vermonters Caseload, Expenditure, and PMPM Comparison by SFY

The following table illustrates the actual and anticipated caseload for this population.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	4,059	$ -	n/a	$ -	n/a
SFY '17 Actual	3,381	$ -	n/a	$ -	n/a
SFY '18 Actual	1,547	$ -	n/a	$ -	n/a
SFY '19 As Passed	2,297	$ -	n/a	$ -	n/a
SFY '19 BAA	1,256	$ -	n/a	$ -	n/a
SFY '20 Gov. Rec.	1,006	$ -	n/a	$ -	n/a

Healthy Vermonters Caseload Comparison by SFY



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

The eligibility requirements for Blind or Disabled (BD) and/or Medically Needy Children are:

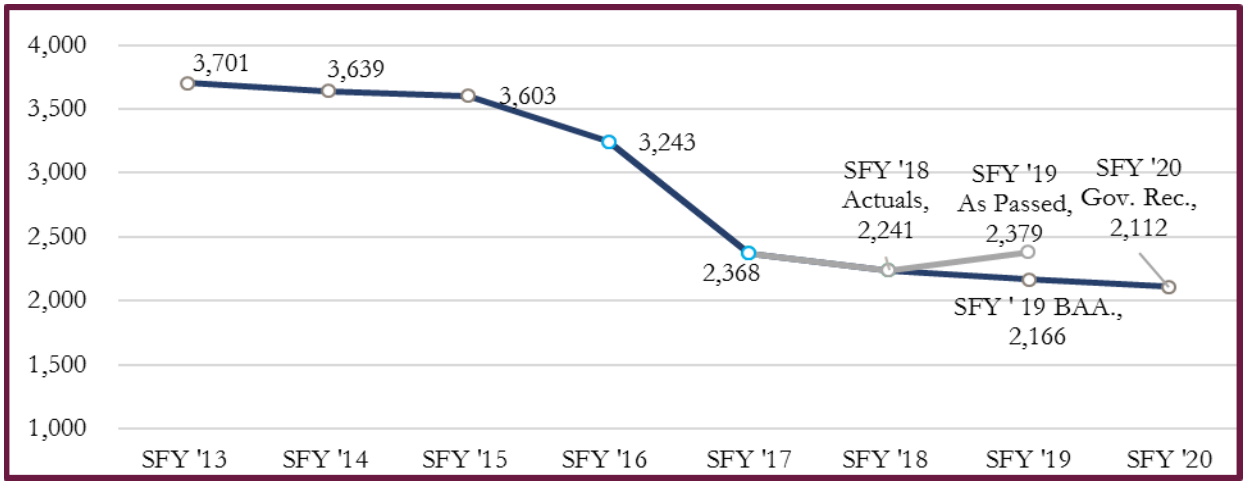
- Age cap of 19 years, unless eligible for a special exception
- Blind or disabled status as determined by the federal Social Security Administration, or the State
- Supplemental Security Income (SSI) cash assistance recipients
- Hospice patients
- Those eligible under "Katie Beckett" rules
- Medically needy Vermonters:
    - Children whose household income is greater than the cash assistance level but less than the 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 SFY

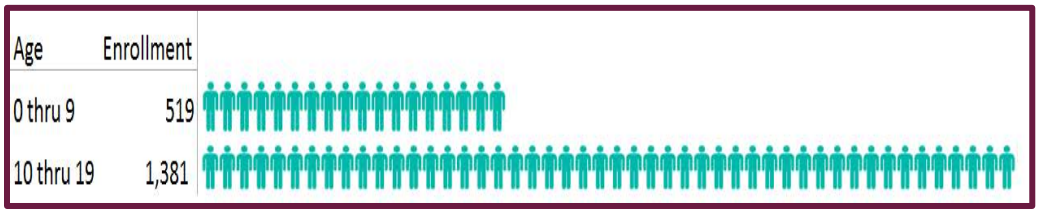
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	3,243	$ 27,174,573	$ 698.22	$ 82,411,072	$ 2,117.45
SFY '17 Actual	2,368	$ 23,032,607	$ 810.47	$ 71,540,812	$ 2,517.36
SFY '18 Actual	2,241	$ 20,174,102	$ 750.19	$ 60,785,052	$ 2,260.34
SFY '19 As Passed	2,379	$ 24,411,851	$ 855.12	$ 65,040,119	$ 2,278.27
SFY '19 BAA	2,166	$ 20,395,140	$ 784.67	$ 57,048,281	$ 2,194.84
SFY '20 Gov. Rec.	2,112	$ 20,144,940	$ 794.86	$ 57,428,744	$ 2,265.97

Blind or Disabled Children Caseload Comparison by SFY

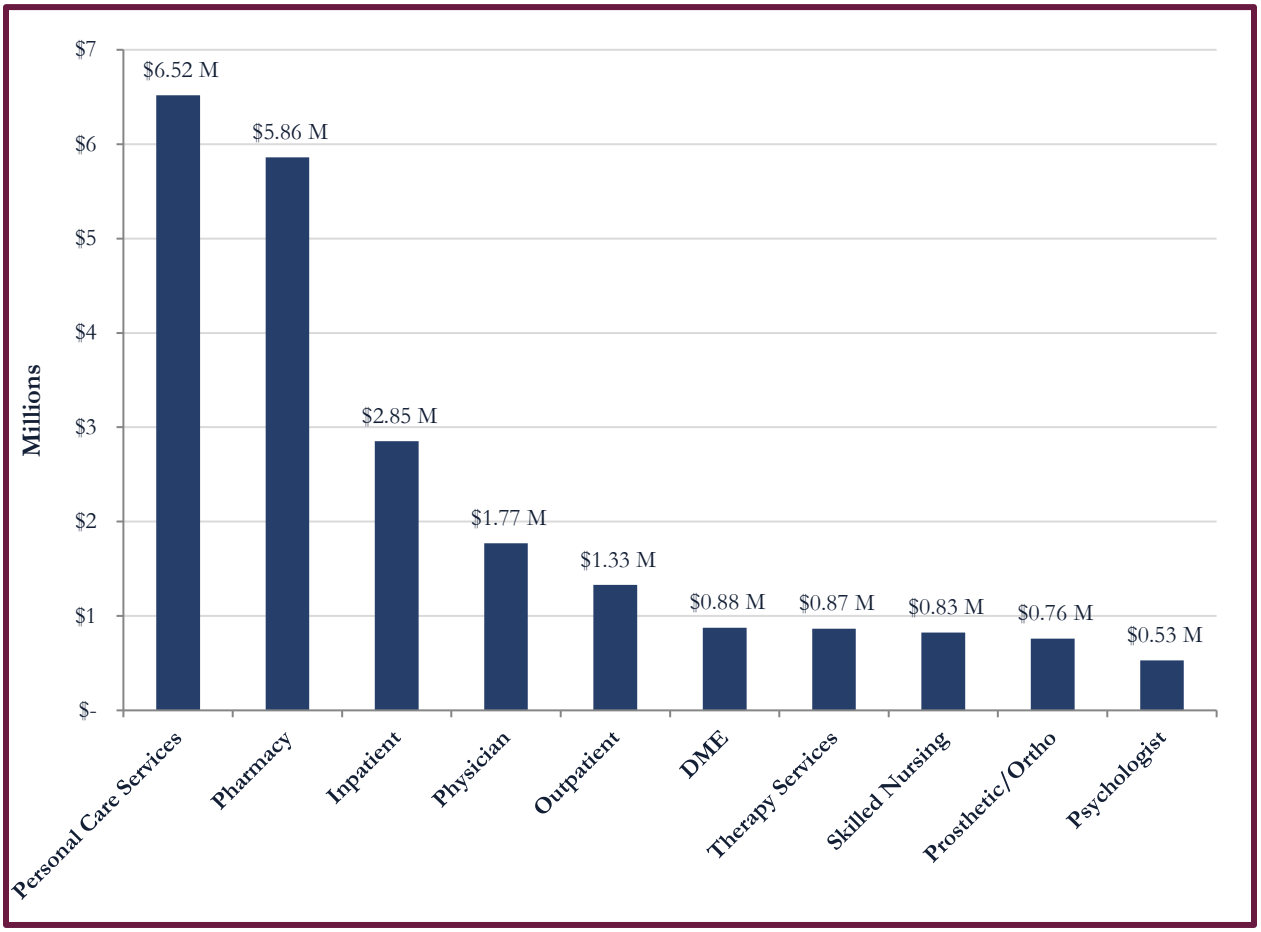


BD Child SFY 2018 Average Enrollment Breakout by Age



DVHA Expenditures by Top 10 Service Categories: BD Child

Personal Care Services, inpatient, pharmacy, and professional services accounted for the majority of the $20,174,102 SFY 2018 DVHA spend.



General Children

The eligibility requirements for General Children are:

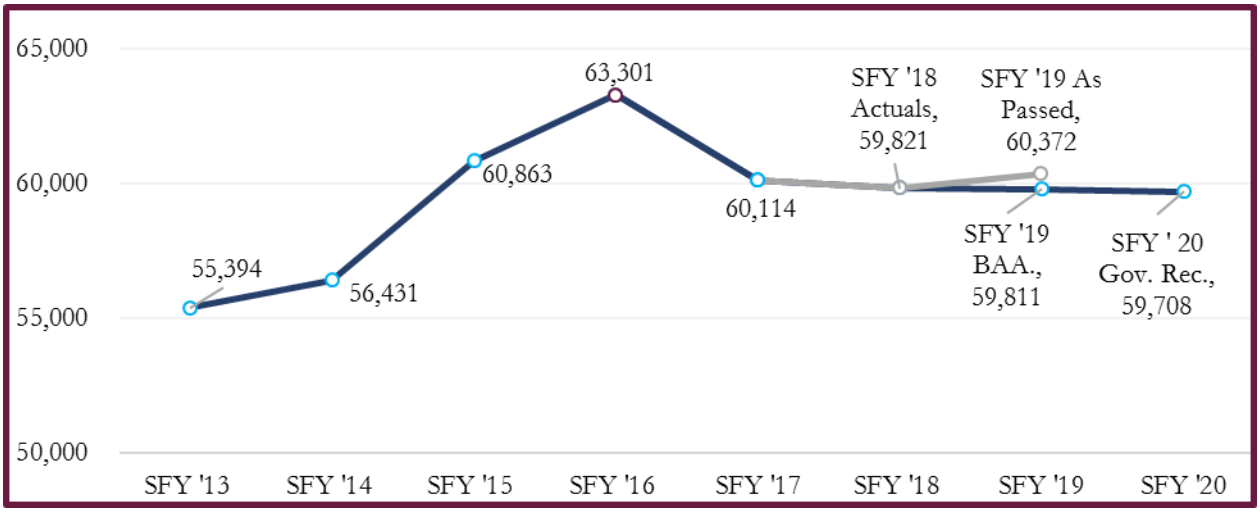
- Age 18 and younger
- Income below the PIL
- Categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

General Children Caseload, Expenditure, and PMPM Comparison by SFY

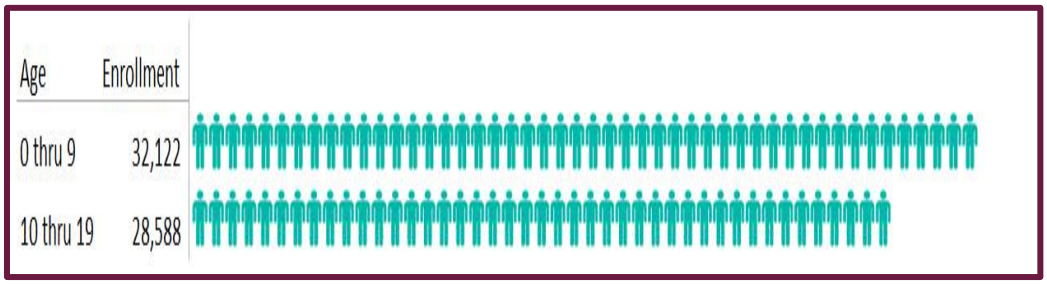
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	63,301	$ 151,736,910	$ 199.75	$ 286,746,415	$ 377.49
SFY '17 Actual	60,114	$ 153,917,906	$ 213.37	$ 295,676,075	$ 409.88
SFY '18 Actual	59,821	$ 156,825,223	$ 218.46	$ 318,447,021	$ 443.61
SFY '19 As Passed	60,372	$ 155,075,053	$ 214.05	$ 316,799,483	$ 437.29
SFY '19 BAA	59,811	$ 155,918,142	$ 217.24	$ 326,388,627	$ 454.75
SFY '20 Gov. Rec.	59,708	$ 156,718,655	$ 218.73	$ 330,634,244	$ 461.46

General Children Caseload Comparison by SFY

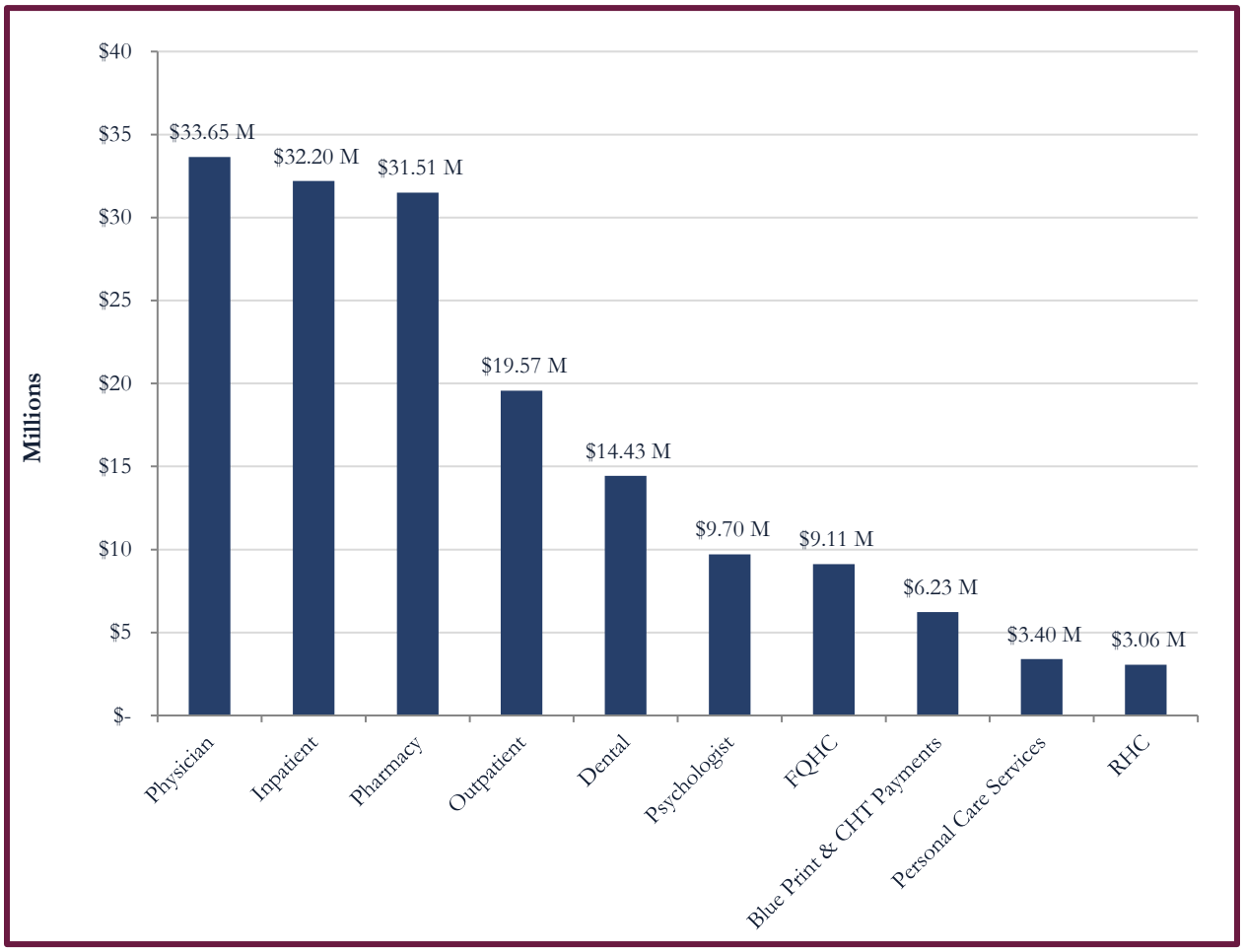


General Child SFY 2018 Average Enrollment Breakout by Age



DVHA Expenditures by Top 10 Service Categories: General Child

Professional services, inpatient, outpatient, and pharmacy accounted for the majority of the $156,825,223 in the SFY 2018 DVHA spend.



Optional Benefit (Underinsured) Children

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.

The general eligibility requirements for Underinsured Children are:

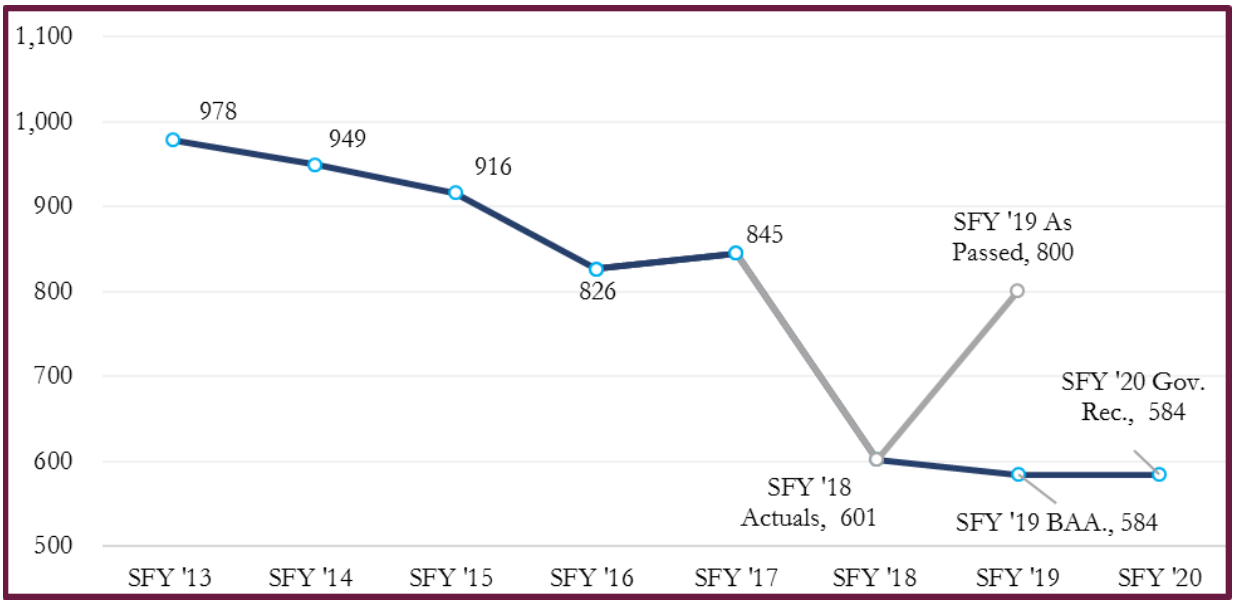
- Age 18 and younger
- Income up to 312% FPL

Optional Benefit Children Caseload, Expenditure, and PMPM Comparison by SFY

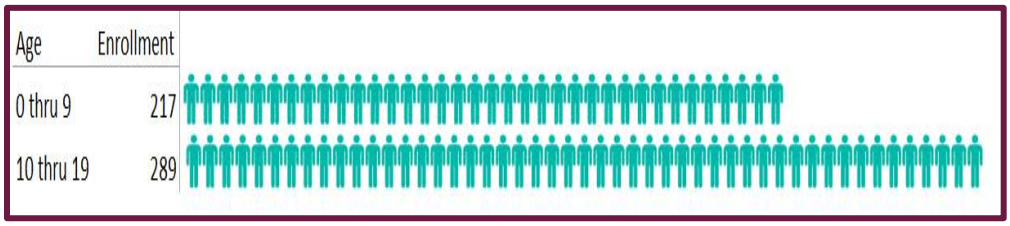
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	826	$ 1,186,527	$ 119.66	$ 2,329,302	$ 234.90
SFY '17 Actual	845	$ 1,095,901	$ 108.14	$ 2,440,929	$ 240.87
SFY '18 Actual	601	$ 515,180	$ 71.43	$ 1,398,663	$ 193.94
SFY '19 As Passed	800	$ 1,130,829	$ 117.79	$ 2,014,699	$ 209.86
SFY '19 BAA	584	$ 502,278	$ 71.67	$ 931,433	$ 132.91
SFY '20 Gov. Rec.	584	$ 509,190	$ 72.66	$ 961,848	$ 137.25

Optional Benefit Children Caseload Comparison by SFY

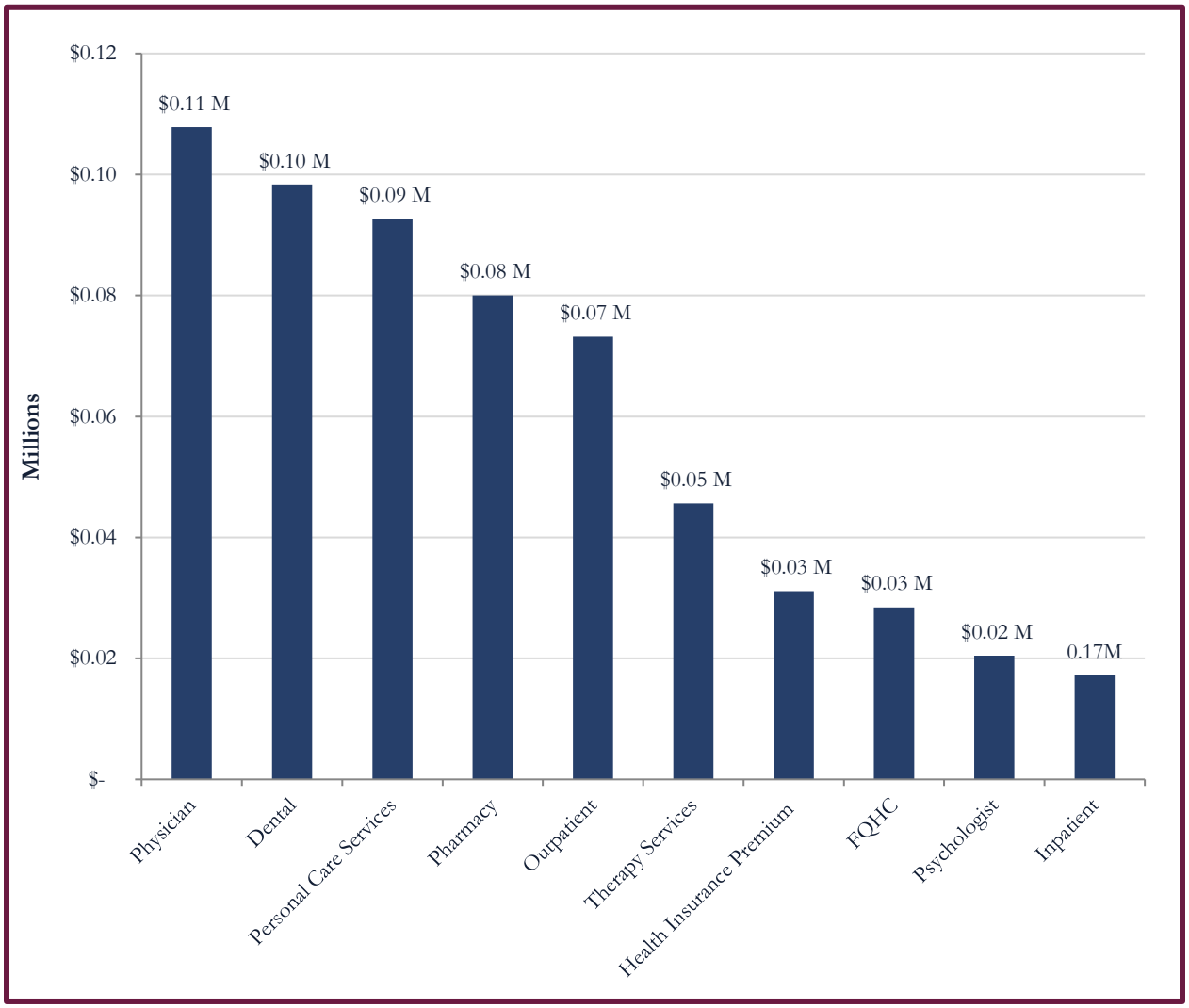


Optional Benefit Children SFY 2018 Average Enrollment Breakout by Age



DVHA Expenditures by Top 10 Service Categories: Optional Benefit Child

Inpatient, dental, personal care services, and professional services accounted for the majority of the $515,180 SFY 2018 DVHA spend.



Children's Health Insurance Program (CHIP)

As of January 1, 2014, CHIP is operated as a Medicaid Expansion with enhanced federal funding from Title XXI of the Social Security Act.

The general eligibility requirements for the CHIP are:

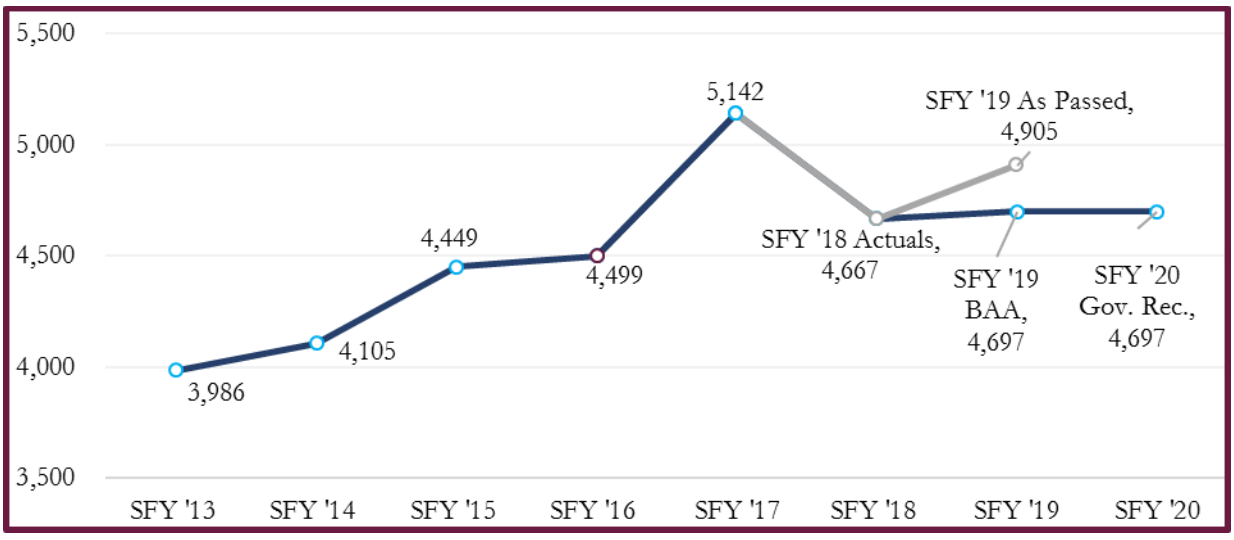
- Age 18 and younger
- Income up to 312% FPL
- Uninsured

CHIP Caseload, Expenditure, and PMPM Comparison by SFY

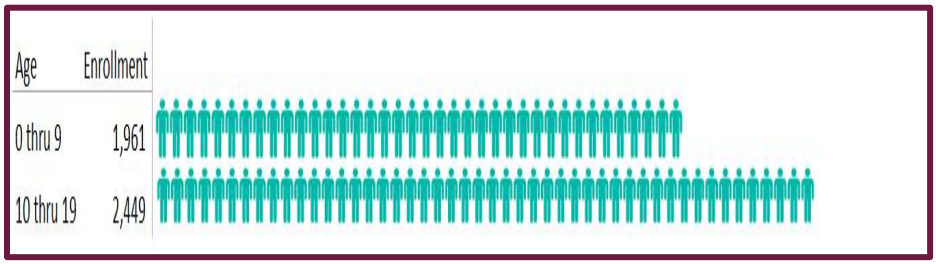
The following table illustrates the caseload and expenditure actual and estimated information.

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	4,499	$ 7,025,792	$ 130.15	$ 9,755,883	$ 180.72
SFY '17 Actual	5,142	$ 7,893,710	$ 127.94	$ 11,615,325	$ 188.25
SFY '18 Actual	4,667	$ 8,323,354	$ 148.62	$ 12,511,519	$ 223.40
SFY '19 As Passed	4,905	$ 8,295,782	$ 140.94	$ 12,483,947	$ 212.10
SFY '19 BAA	4,697	$ 8,362,970	$ 148.37	$ 11,544,474	$ 204.82
SFY '20 Gov. Rec.	4,697	$ 8,433,289	$ 149.62	$ 11,656,075	$ 206.80

CHIP Caseload Comparison by SFY

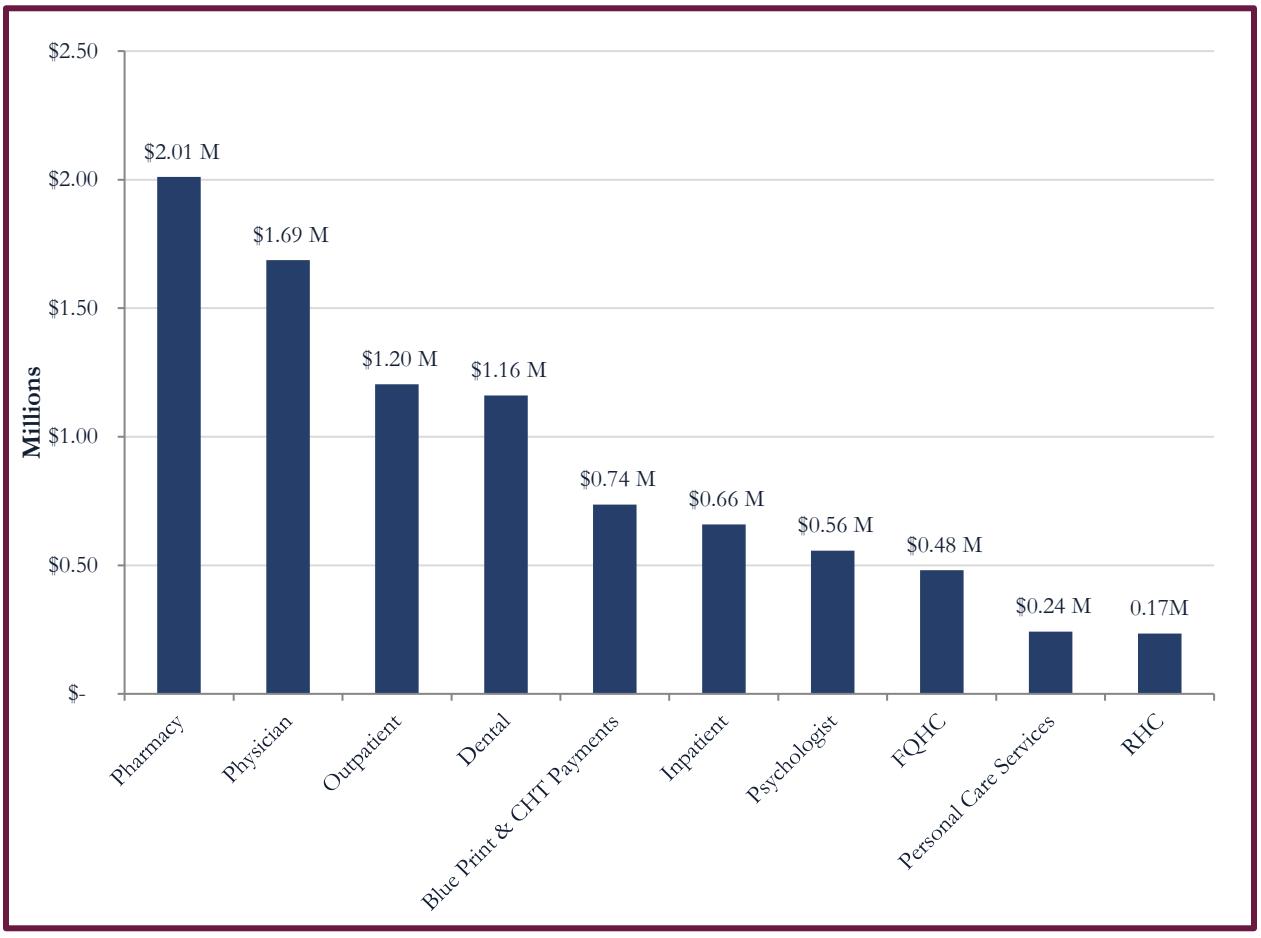


CHIP SFY 2018 Average Enrollment Breakout by Age



DVHA Expenditures by Top 10 Service Categories: CHIP

Professional services, outpatient, inpatient, and dental accounted for the majority of the $8,323,354 SFY 2018 DVHA spend.



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 QHP will be less affordable than Vermonters had previously experienced under VHAP and Catamount. The State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300% of FPL to address this affordability challenge. The following tables depict the caseload and expenditure information by SFY, including the Governor's Recommendation for SFY 2019, for the elimination of Vermont CSR effective January 1, 2019.

The following tables illustrates the caseload and expenditure actual and estimated information.

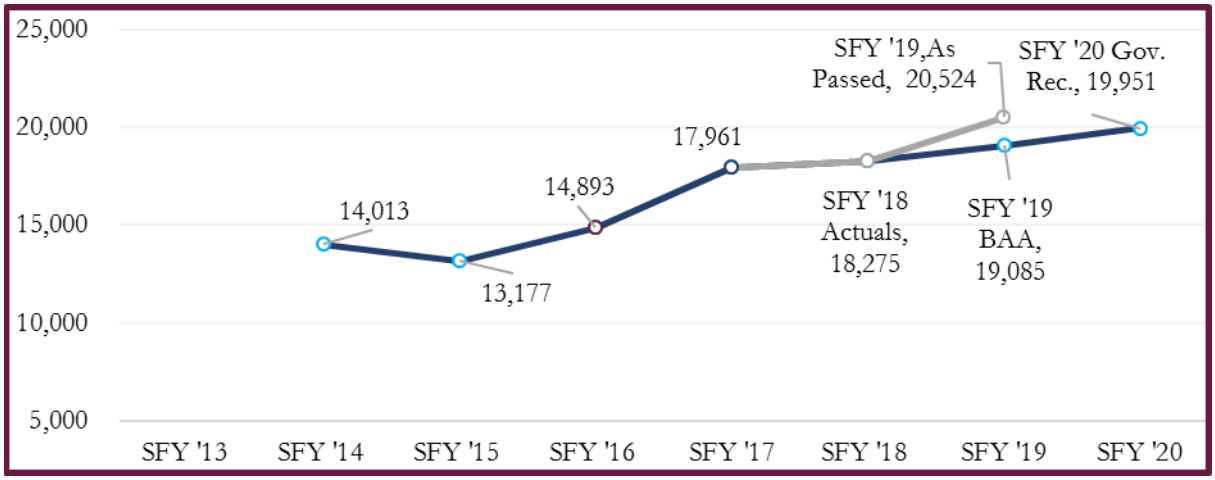
Premium Assistance for Exchange Enrollees

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	14,893	$ 5,266,242	$ 29.47	$ 5,266,242	$ 29.47
SFY '17 Actual	17,961	$ 6,100,378	$ 28.30	$ 6,100,378	$ 28.30
SFY '18 Actual	18,275	$ 6,334,440	$ 28.88	$ 6,334,440	$ 28.88
SFY '19 As Passed	20,524	$ 7,112,797	$ 28.88	$ 7,112,797	$ 28.88
SFY '19 BAA	19,085	$ 6,614,098	$ 28.88	$ 6,614,098	$ 28.88
SFY '20 Gov. Rec.	19,951	$ 6,914,219	$ 28.88	$ 6,914,219	$ 28.88

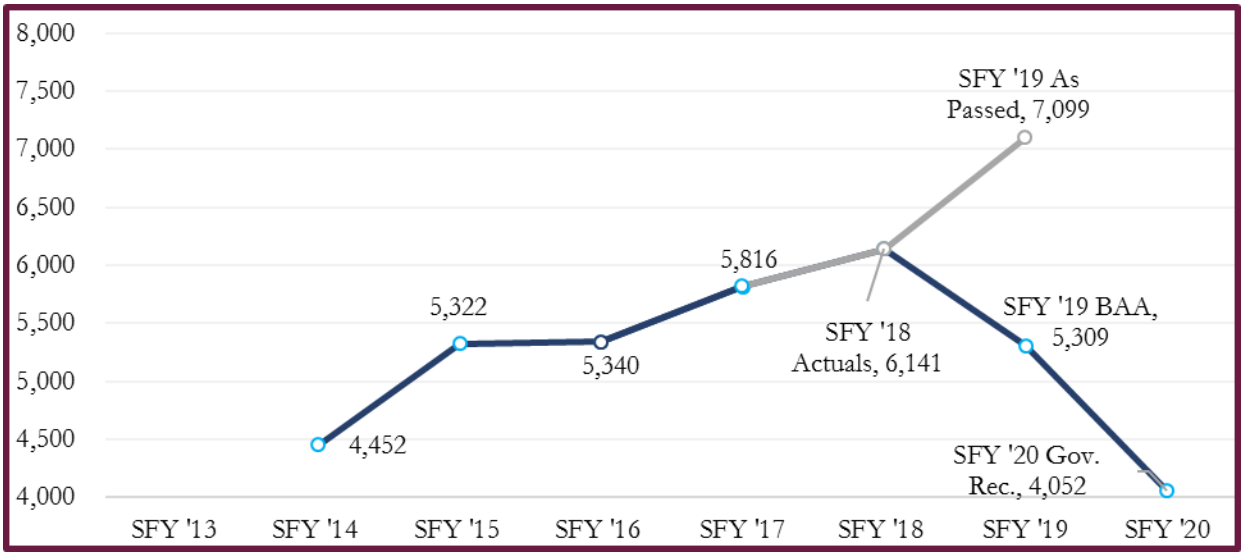
Cost Sharing for Exchange Enrollees

		DVHA Only		All AHS and AOE	
SFY	**Caseload**	**Expenditures**	**PMPM**	**Expenditures**	**PMPM**
SFY '16 Actual	5,340	$ 1,186,720	$ 18.52	$ 1,186,720	$ 18.52
SFY '17 Actual	5,816	$ 1,355,318	$ 19.42	$ 1,355,318	$ 19.42
SFY '18 Actual	6,141	$ 1,570,896	$ 21.32	$ 1,570,896	$ 21.32
SFY '19 As Passed	7,099	$ 1,427,176	$ 16.75	$ 1,427,176	$ 16.75
SFY '19 BAA	5,309	$ 1,520,434	$ 23.87	$ 1520,434	$ 23.87
SFY '20 Gov. Rec.	4,052	$ 1,314,872	$ 27.04	$ 1,314,872	$ 27.04

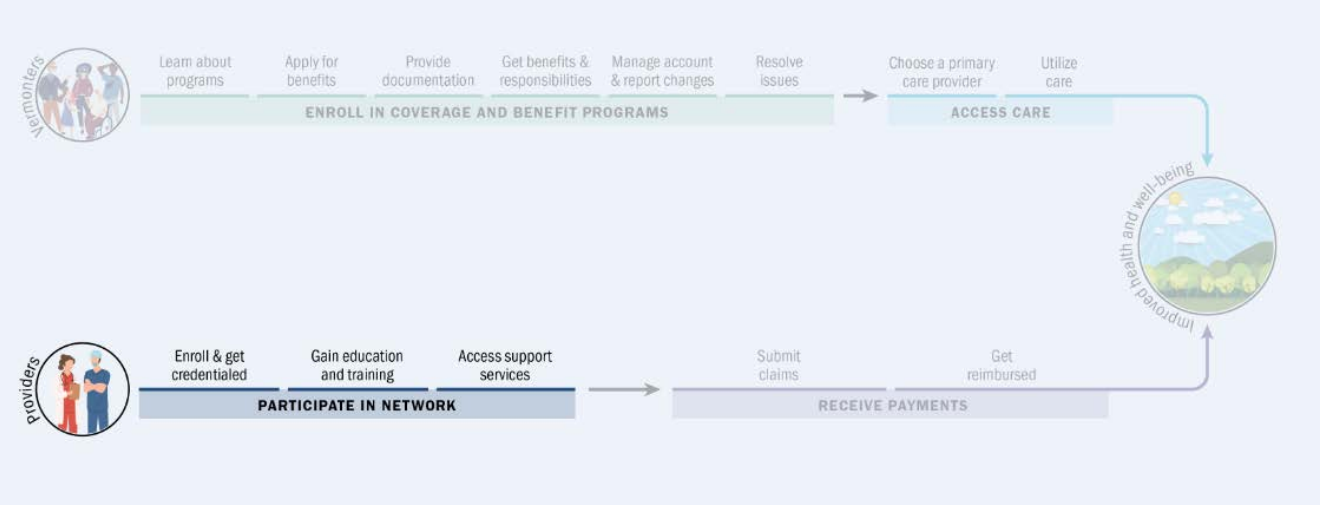
Premium Assistance Caseload Comparison by SFY



Cost Sharing Reduction Caseload Comparison by SFY



Chapter Four: Provider Network Management



Provider Network

DVHA strives to ensure that the provider network is adequate to deliver the right care; at the right time to prevent Vermonters from traveling too far and to maximize member choice of provider. This is true for members within the Accountable Care Organization, and the remaining managed Medicaid population. Vermonters have a variety of health care needs and require a network of providers that can address all those needs and deliver all the covered services.

DVHA recognizes that regularly visiting a primary care provider (PCP) is beneficial for health and wellness, management of chronic disease and the reduction of overall health care costs.

Beyond ensuring that the provider network meets State and Federal requirements, DVHA must act as a gatekeeper to safeguard vulnerable Vermonters and mitigate the financial risk of fraud and abuse. DVHA conducts training and outreach to help providers understand how to properly bill so that they can get paid promptly. Training and outreach efforts also help both members and providers stay up-to-date with changes to programs. The Provider and Member Relations (PMR) unit conducts these crucial functions and oversees a vendor responsible for provider enrollment, credentialing and phone support.

There are 17,189 providers enrolled in DVHA's network. The following table lists the number of providers by type.

Number of Enrolled Providers by Type

PHYSICIAN	8,919	RURAL HEALTH CLINIC	21
NURSE PRACTITIONER	1,649	LICENSED MIDWIFE	16
MASTERS LEVEL PSYCHOLOGIST	1,628	INTELLECTUAL DISABILITIES CLINIC	16
PHYSICIAN ASSISTANT	748	VOCATIONAL REHABILITATION AGENCY	16
PHYSICAL, OCCUPATIONAL, & SPEECH THERAPISTS	643	INDEPENDENT AGING WAIVER	16

DENTIST	522	CHILD/FAMILY WAIVER CLINIC	15
GENERAL HOSPITAL	410	NON-EMERGENCY TRANSPORTATION	15
PHARMACY	325	FAMILY SUPPORT MANAGEMENT	13
PSYCHOLOGIST - DOCTORATE	313	ADULT DAY FACILITY	13
DME SUPPLIER	206	DIALYSIS FACILITY	12
CHIROPRACTOR	190	PERSONAL CARE SERVICES	12
LICENSED ALCOHOL DRUG COUNSELOR	168	HOSPICE	11
NON-MEDICAL RESIDENTIAL FACILITY	159	DA CLINIC	10
OPTOMETRIST	145	LICENSED NURSE	9
RESIDENTIAL CARE WAIVER	131	NURSING HOME - NON-MEDICARE PARTICIPATING	9
AMBULANCE	123	FREESTANDING PSYCHIATRIC HOSPITAL	8
INDEPENDENT LAB	105	PSYCHIATRIC RESIDENTIAL FACILITY	8
NATUROPATHIC PHYSICIAN	80	CASE MANAGER	6
DEPT OF EDUCATION	66	AMBULATORY SURGICAL CENTER	4
AUDIOLOGIST	59	CLINIC	4
FEDERALLY QUALIFIED HEALTH CENTER	57	PROSTHETICS/ORTHOTICS	4
NURSING HOME - MEDICARE PARTICIPATING	54	CASE RATE AGENCY	3
PODIATRIST	46	ICF/INTELLECTUAL DISABILITY FACILITY	1
OTHER PRACTITIONERS	41	WAIVER CASE MANAGER-AGING AND ADULT	1
STATE-DESIGNATED MENTAL HEALTH CLINIC	40	SOLE SOURCE EYEGLASS LAB	1
ADAP FACILITY	33	DOH INTELLECTUAL FACILITY	1
INDEPENDENT HIGH-TECH NURSES	28	INDEPENDENT RADIOLOGY	1
STATE-DESIGNATED CHILDRENS MED SVCS	27	TARGETED CASE MGMT	1
HOME HEALTH AGENCY	26	OPTICIAN	1

Enroll and Get Credentialed

As stated in the introduction to this section, the DVHA 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.

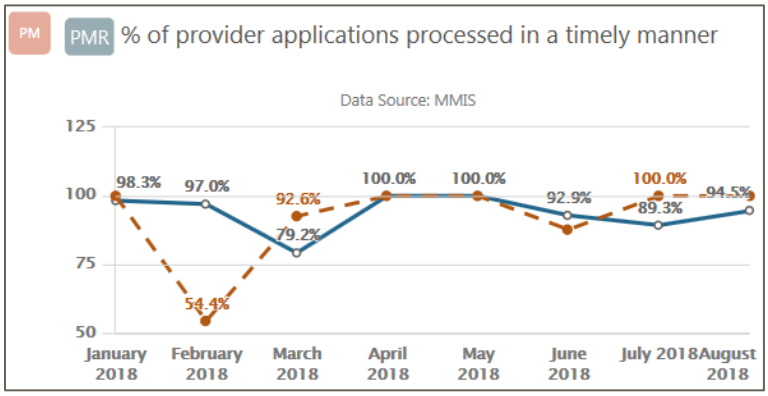
The PMR unit, beyond other responsibilities as set forth above, has obligations relating to providers including provider enrollment, screening, revalidation screening and monitoring of the network to help prevent Medicaid fraud and abuse. Federal rules, specifically Title 42 Code of Federal Regulations (CFR) §§455.410 and §455.450 require all participating providers to be screened upon initial enrollment and revalidation of enrollment. Health care providers are categorized by screening levels

established by the CMS and utilized by DVHA. The defined risk levels of limited, moderate and high are based on an assessment of potential fraud, waste and abuse for each provider/supplier type. DVHA then screens providers according to their risk level. DVHA may increase risk level assignments at any time, and the new risk level will apply to all enrollment-related activities.

Number of Active Providers Enrolled in Vermont Medicaid:

17,189

PMR works closely with its fiscal agent, DXC, to screen and enroll providers. There are 17,189 providers actively enrolled with Vermont Medicaid at this time. These providers are not solely practicing in Vermont as some members received care out-of-state. On average, DVHA enrolls about 300 new providers a month and terminates about 15 a month from participation with Vermont Medicaid. Providers terminate with Vermont Medicaid for various reasons including, but not limited to not wanting to accept Medicaid rates, not submitting claims in the past 36 months, moving or retirement. Due to access issues with certain provider types, such as dental providers, the PMR team often contacts the provider when they indicate that they wish to no longer participate with Vermont Medicaid.



Vermont Medicaid's current enrollment process is paper-based, manual, and cumbersome for DVHA and its providers. First, providers must submit a 10 to 50-page paper application. Then DXC manually screens the provider, frequently taking up to 120 days to complete. DVHA is committed to improving this process and is working collaboratively with providers and DXC to develop short-term and long-term solutions. The PMR unit has worked closely with DVHA management to solicit an online tool to assist providers in enrolling with Vermont Medicaid. A new tool has been identified and the PMR unit along with DXC and a dedicated DVHA staff have been working to implement a new Provider Management Module (PMM). The new PMM is set to go live in the spring of 2019 and will allow providers to enroll, make changes to their files, and receive notices electronically. The PMM is expected to significantly decrease the turnaround time of enrolling providers from 120 days to an average of 45 days. This will help improve our members access to care as they will be able to find services or be seen by new providers quicker.

PMR conducts site visits for a subset of providers upon enrollment and every five years thereafter. This subset of providers includes: ambulance service suppliers, community mental health centers (CMHC), comprehensive outpatient rehabilitation facilities (CORF), hospice organizations, independent clinical laboratories, independent diagnostic testing facilities (IDTF), physical therapists enrolling as individuals or group practices, portable x-ray suppliers (PXRS), revalidating home health agencies (HHA) and revalidating DMEPOS suppliers. In addition, newly-enrolling DMEPOS and newly-enrolling HHAs must have a site visit performed to comply with 42 CFR §455.432.

Network Adequacy of the GMC Network evaluation is completed every six months. The PMR unit works with a variety of associations and societies to solicit providers to participate with Vermont Medicaid to meet the needs of its members.

Gain Education and Training

The PMR unit is responsible for outreach and communication to both members and providers, as well as ensuring members have access to care. This is done twice a year, through a report on members access to care and how far they must travel.

PMR oversees the publishing of a member newsletter annually. This newsletter is a collaborative effort with many units within DVHA. PMR also has oversight of the DVHA website and updates the Green Mount Care Website to ensure the most accurate and informative information is available.

PMR's goal is to ensure members and provider are always informed. The Green Mountain Care Member Support Center contractor is the point of initial contact for members' questions and concerns. If questions or concerns exist after talking with Member Support, the call may come to PMR for additional education on programs. PMR is working to engage with member services to identify educational needs for the member community and proactively offer resources to our members.

Providers are assisted by DXC's Provider Services Unit. Education is given to the provider community in collaboration with the DXC's Provider Representatives and PMR. PMR strives to ensure that providers have the most up to date information by overseeing and consistently updating the provider manuals. In SFY 2019, the provider manuals and DVHA Rules will be in alignment so that all providers are aware of not only the procedural information in the manuals but the policy behind the rules.

The provider community is offered training opportunities throughout the year on varying topics via in-person visits by both DXC staff and PMR staff as well as Webinars on varying topics.

In SFY 2019, Statewide town hall forums will be offered to the provider community to train them on the new Provider Management Module.

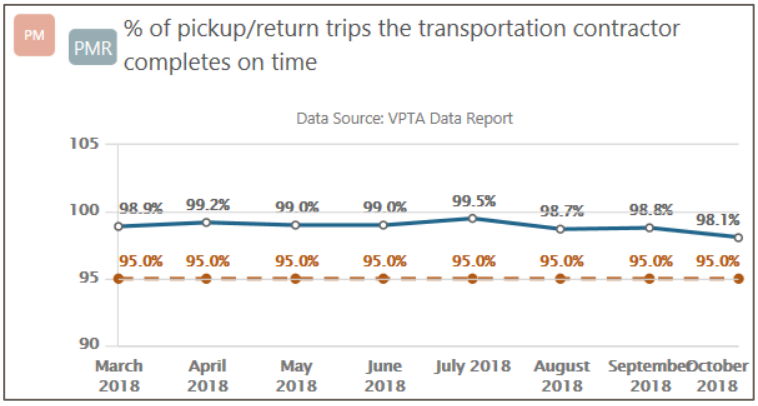
Access Support Services

The goal within the PMR unit is to address member issues promptly and ensure the member is satisfied with the answers received. Member issues come from many different avenues, including but not limited to the Governor's office, Legislators, Vermont Legal Aid, and the provider community. The PMR unit always strives to ensure all parties are informed of the outcome of the issue.

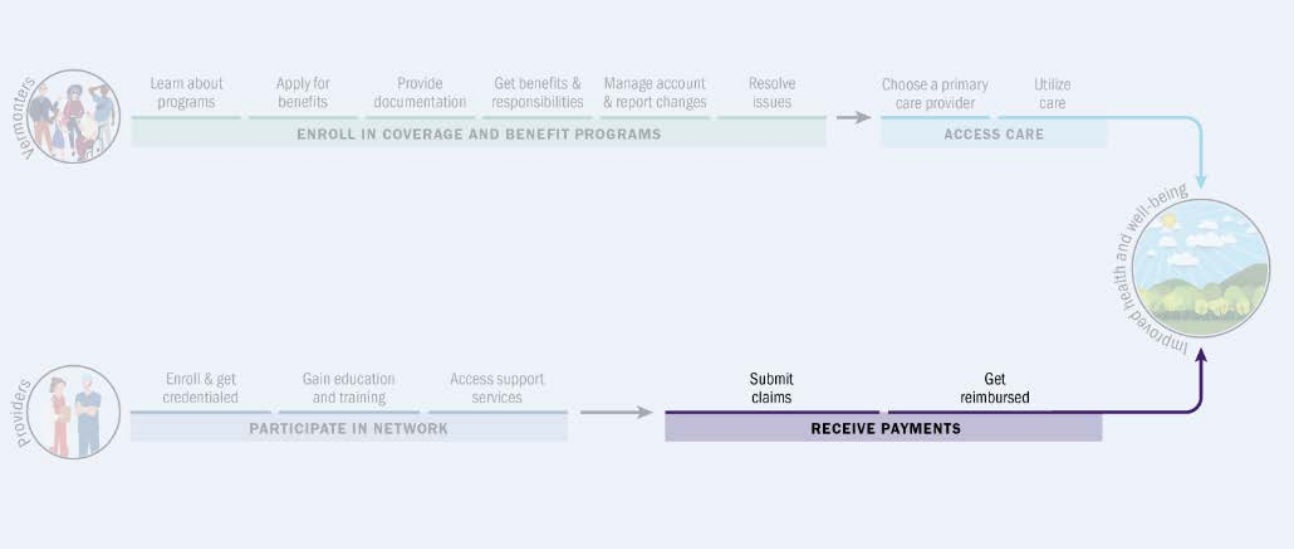
PMR works with many organizations, such as the Vermont Medical Society, Vermont Hospital Association, Dental Society and Vermont Legal to provide support and guidance on a variety of issues, such as timely processing of claims and understanding how the Non-Emergency Transportation program works as well as many other topics.

The PMR staff strive to resolve members' out-of-network emergency care billing issues while remaining mindful of enrollment and claims processing rules and regulations. The team works to ensure that members are not held responsible for emergency or post-stabilization medical services when out-of-network.

There are times when members need medical services that are not available in Vermont. These services are provided by out-of-state providers after receiving authorization by DVHA's clinical staff. PMR staff, in conjunction with DXC's enrollment and claims processing staff, utilize a process that streamlines one-time enrollment requirements through timely and detailed outreach resulting in greater out-of-network provider participation and claims submission. Vermont Medicaid, through the work of dedicated PMR staff, has received praise from CMS staff for continuing to focus on such needs.

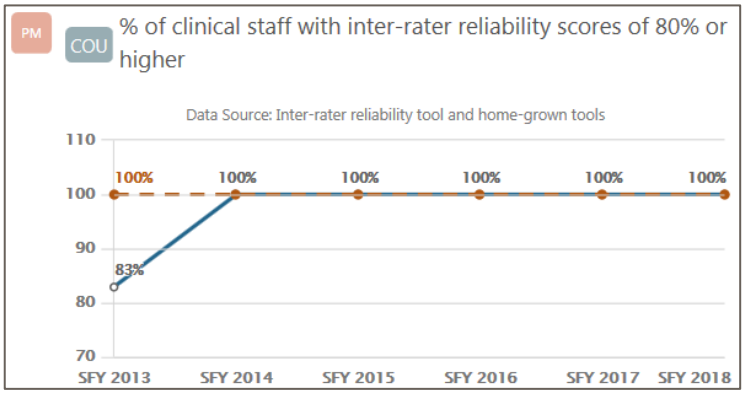


PMR oversees and monitors Non-Emergency Transportation (NEMT), issuing policies and procedures to coincide with changing circumstances and federal and state directives. PMR is also responsible for approving various trips and exceptions, including authorizing trips outside of a 60-mile radius from a member's home and out- of-state trips. As the contracted Vermont NEMT administrator, VPTA subcontracts with a network of public transportation providers to ensure statewide access to transportation services for eligible members. VPTA must ensure that these subcontractors screen for eligibility, schedule the least-costly mode of transportation to medical appointments/services, and submit claims to DXC for processing.



Submit Claims and Reimbursements

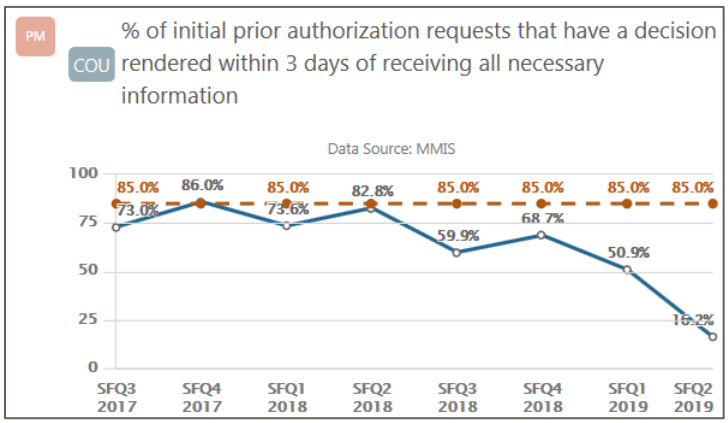
Clinical Review and Operations



The Clinical Operations Unit (COU) is a vital link between providers, DVHA, Agency of Human Services (AHS) and community partners. The clinical perspective ensures that the decisions made by the department and the agency are based on solid, evidence-based medical information. Providers are supported by the COU to provide collaborative, outcome driven, comprehensive member-focused care. It is also a priority that the clinical decisions being made by the COU are consistent and medically appropriate. We can monitor this by chart reviews as well as multiple inter-rater reliability tests throughout the year for the COU staff.

The COU provides guidance via telephonic support, meetings with provider groups and community partners, on-site in-services, and listening sessions. Clinical guidelines purchased as well as ones created by the COU, are reviewed and updated annually. The COU also creates new criteria based on emerging technology as well as driven by provider requests. The COU has over 50 criteria that we created and maintain. The criteria, as well as other information related to prior authorization (PA), is posted on the DVHA website for providers to access.

Timely Reviews



The COU performs timely, thorough, and consistent reviews of medical necessity. The COU staff determines the medical necessity of a service or product provided to our members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and Federal regulations. The COU has a three-day goal for decisions to be rendered based on these regulations. Reaching this goal is heavily dependent on having adequate staffing, made challenging by vacancies. Due to the small size of the COU, even one vacancy is a hardship. The COU processes over 1,500 PA requests each month.

The COU provides post-provision oversight of services, to ensure that fair, efficacious, outcomes-driven services have been provided. This can include outcomes comparisons between payment methodologies. The COU is also creating and implementing a new medical audit review program. This will help the COU and DVHA move forward as the way healthcare is being delivered is changing.

Benefit Rules Management

According to the CMS National Correct Coding Initiative, providers must use the appropriate and correct codes for services that are provided to members. The use of correct codes allows for appropriate reimbursement for services provided to members. All CPT, HCPCS, and ICD-10 PCS codes released each year are updated in the Medicaid Management Information System (MMIS) by specific deadlines so that providers may submit claims for reimbursement timely. The bulk of the codes are released at the end of each year, with some new codes released quarterly. Intensive review is performed by the COU for each code before implementation in the MMIS to determine:

- Coverage, if service is permissible under state plan/rule,
- the effectiveness of service,
- FDA approval,
- the number of units allowed, and
- necessary edits and audits.

Other COU Functions

- ACO Oversight:
  - Review utilization claims reports,
  - collaboration on managing the disconnect between a PA waiver and the limitations within the MMIS as well as with members who need to go out of network for care not available in network,
  - reviewing a defined group of PA requests for "imminent harm", and
  - medical audit for the quality of care.

- Work with the Chief Medical Officer and DVHA senior management regarding specific highly complex unique cases.
- Develops service requests log for advanced planning documents for fiscal agent services within the areas of clinical expertise.
- Collaboration on Agency-wide initiatives, such as Early Periodic Screening Diagnosis & Treatment (EPSDT) review of services, and program integrity case reviews, tobacco, asthma, and high-tech nursing.

Successes

The COU had three significant achievements in SFY 2018, including:

✓ Providing Clinical Expertise to the Policy Unit

The COU continues to work closely with the Policy Unit to ensure that all policy updates are grounded in the most current medical research and perspectives. This process improvement initiative will ensure that policy changes do not have unexpected consequences for our members, our providers, and for our stakeholders.

✓ Completion of the Rent to Purchase project

Medicare and many regional State Medicaid programs utilize a Rent to Purchase or a capped rental payment system for specific durable medical equipment (DME). Medicare's capped rental program is designed to pay for a piece of DME for 13 months. After 13 months of rental the beneficiary owns the DME item. Medicare pays for reasonable and necessary maintenance and servicing of the item, i.e., parts and labor not covered by a supplier's or manufacturer's warranty.

The COU partnered with the Reimbursement and Program Integrity Units to implement a Rent to Purchase payment system for Vermont Medicaid. The Vermont Rent to Purchase program will pay for specific DME for ten months, and the item will then be considered fully purchased. This payment method will save VT Medicaid money because the rental payments will be included in the purchase price, which is not the current practice. The rental reimbursement for the item is based on the maximum allowed for the DME. Charges beyond the ten-month rental will be denied. The multi-unit team is working with DXC to implement necessary systems enhancements before the start of the program. DME vendors were informed of the Rent to Purchase payment policy at a meeting held at DVHA in November 2017. The start date for this program was January 1, 2018. Unlike Medicare's program, DVHA remains the owner of all purchased DME. This allows DVHA to recycle equipment, resulting in additional savings.

This process has been implemented, however, there have been challenges. The DVHA Reimbursement Team is the one who is sorting out those challenges and working closely with the COU and Provider and Member Relations to make sure our DME providers are aware of any changes.

✓ Healthcare Advancements

The COU constantly seeks out research regarding the ongoing changes in medical technology and procedures that are changing the landscape of the healthcare industry. Completing this activity helps COU ensure that decisions made by DVHA are based on the most current, well supported, peer-reviewed medical literature at least annually. COU also uses data analysis to create initiatives and to

track progress. The unit utilizes targeted data pulls to ensure that Medicaid funds are spent wisely and fairly.

Future State

The Clinical Operations Unit has identified four increasingly important areas of future work, including:

1. Clinical Criteria Development for Genetic Tests and Procedures

Genetic testing is a relatively new science and can be used to confirm a suspected diagnosis, predict future illness, detect when an individual might pass a genetic mutation to his or her children, screen newborns, and predict response to therapy. Many of the laboratories developing new genetic tests, and many of the existing tests, are not regulated by the Food and Drug Administration or any other entity. The scientists developing this new field of medicine are focused on its expansion and not necessarily the costs. The cost of a single test can range into hundreds of dollars.

To make clinically sound, medically appropriate, and cost-effective decisions, we need evidence-based guidelines. Due to limited staff resources and the time it takes to develop credible guidelines, the COU has only developed about a dozen guidelines. Commercial genetic test guidelines do not clearly demonstrate the clinical utility for most genetic tests to support our decisions; therefore, we have not purchased a product to help us with this work. We will continue to work with our providers and leverage their clinical expertise to help users navigate this realm of work.

2. Incontinence Supplies

Unfortunately, due to competing priorities, this priority did not get any momentum in 2017. It remains a priority and will be reviewed again for the 2018/2019 project. Our goal is to establish a single source contract with a company that can provide high-quality incontinence products and related supplies to Vermont Medicaid members in a cost-effective and customer-friendly manner, utilizing economies of scale. The goal is to:

- increase member access to special size and types of incontinence supplies
- increase product quality
- reduce the cost of Medicaid incontinence supplies

3. Out-of-Network Outpatient Services:

COU would like to focus on ensuring that outpatient services are **only** being provided Out-of-Network when the services are not available In-Network. With no increase in staff, but reallocating time for planning and implementation for the development of this project. This will require working with DXC on possible MMIS changes as well as with Provider Member Services to help outreach and educate providers.

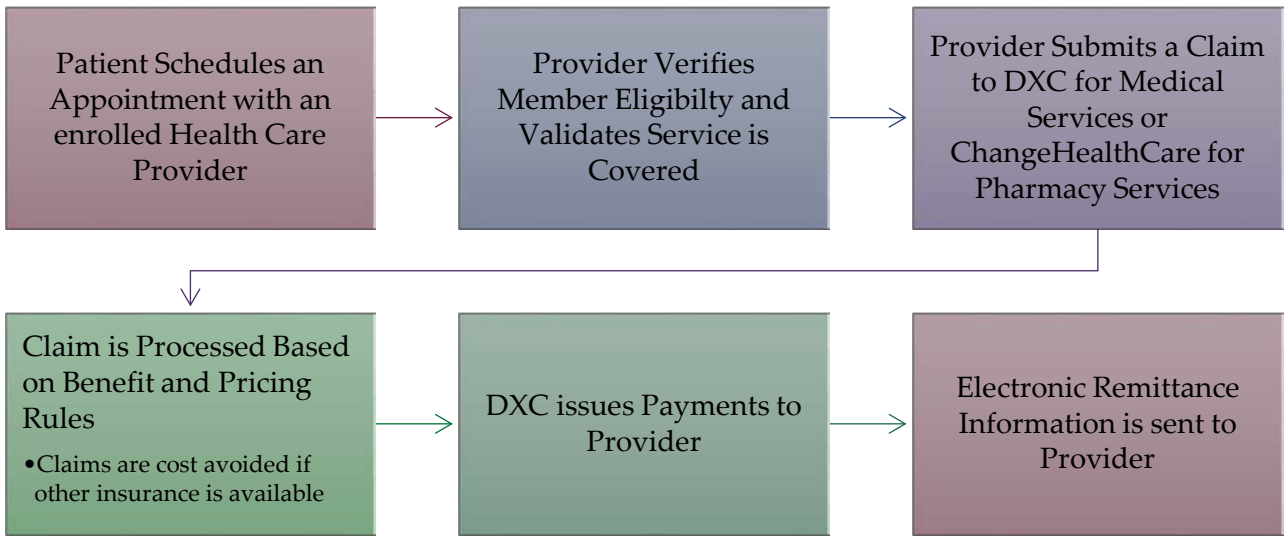
4. Post-Payment Reviews of Inpatient Admissions:

The COU plans to implement, as part of our Medical Review Audit program, the following studies to obtain a thorough understanding of providing the most effective care for Medicaid members:

- Review a percentage of cases from each facility to verify the medical necessity of admission, the intensity of services, an appropriate level of care, length of stay, and effective discharge planning.

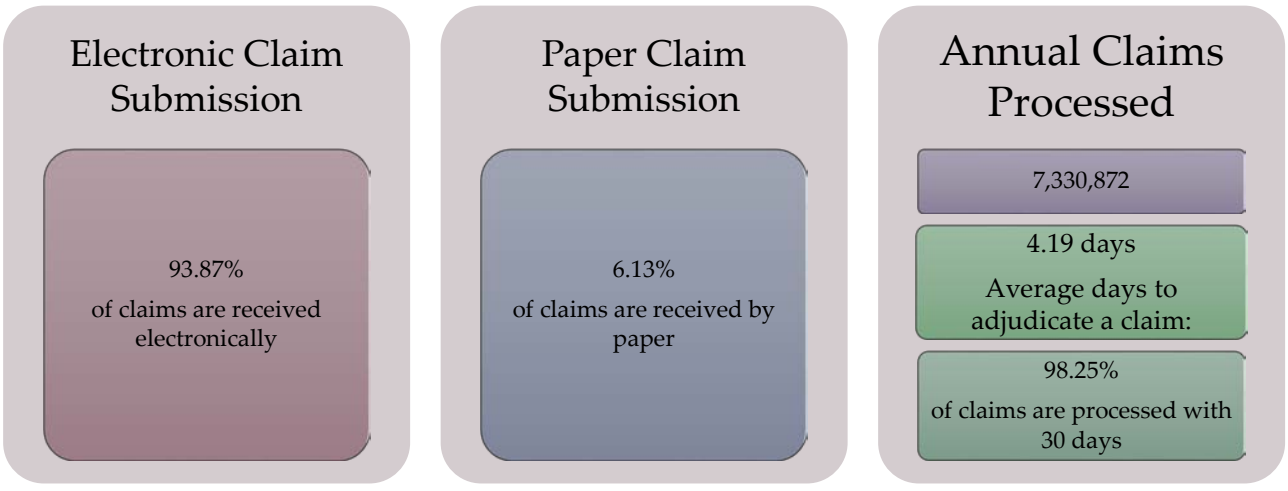
- Review rehospitalization rates, including the issues that have led to rehospitalization. This study includes the rehospitalization diagnosis, the length of time post-discharge for admission by a home health agency, and the length of time before medically necessary equipment is received, for individuals who are re-hospitalized.

Medical Claims Processing



DXC Technology, formerly known as Hewlett Packard Enterprise (HPE), provides DVHA with Medicaid fiscal agent services that include claims processing and payment, financial services, provider enrollment, and system maintenance and operation. This system is referred to as the fiscal agent/claims processing component of the MMIS.

DXC processed over 7.3 million claims in SFY 2018 for more than 30 distinct health care programs supporting all Departments within in the Agency of Human Service and the Agency of Education resulting in $1.68 billion in payments to providers.



DXC has provided Medicaid fiscal agent services to the State of Vermont since 1981, and over the past 37 years, they have continued to evolve the system to support multiple programs. DVHA obtains 75% federal funds for the CMS certified for the operation and maintenance of this system.

DXC performs the following services:

Claims Processing activities including claims input, resolutions, claim adjustment processing, utilization review and reference file maintenance to ensure compliance with Federal and State policy.	**Data Analytics** including advanced programming using data science tools to extract, prepare, and analyze MMIS information in support of AHS departments and operations.
Provider Services function including education and publications; Provider Call Center, provider screening and enrollment	**Financial Services** including reporting, accounts receivable, Federal tax form generation, post-payment analysis and collections, cash receipt processing, bank reconciliation and payment to providers, members, and carriers
Quality Management services to include Audit support and coordination; reporting on quality metrics; Service Level Requirements monitoring and reporting and process improvement projects.	**Coordination of Benefits** services including billing and collection from other third-party liabilities; screening and identification of Casualty cases, issuance of premium payments
Application Services for support and enhancements for several DXC and commercial software applications used by Providers, hundreds of AHS staff, and by DXC fiscal agent staff.	**Platform Services** providing IT infrastructure, data center facilities, security services, and systems administration within private DXC data centers as well as for software services hosted in commercial cloud environments.

Performance Highlights

- On average, 92% of all claims processed are finalized within 15 days of receipt.
- The Provider Services Call Center received over 57,791 calls, and when comparing ASA (Average Speed of Answer), DXC is responding to calls out of the queue 32.5 seconds faster than the prior year.
- Enrolled 1,423 new providers into the VT Medicaid program network while significantly reducing the turnaround time to 60 days or less for most providers.
- Focus this year on reviewing cost avoidance criteria and automating the data match process with other insurance carriers, has resulted in just over $1.2M in additional recoveries when compared to prior year results.
- Improvements to the existing Provider website for online fee schedules and advanced member lookups that assist members with finding providers participating and accepting patients in the Medicaid program.

Upcoming Projects in SFY 2019

- Implementation of a new Provider Management Module which will significantly improve the turnaround times associated with the processing of the provider enrollment application and recertification processes.
- Continue to enable Vermont's payment reform initiatives, via enhancements to claims and financial processing systems.
- Support of federally required initiatives such as new Medicare IDs, TMSIS reporting and Electronic Visit Verification (EVV) mandate.

Pharmacy Claims Processing

The Pharmacy Services Unit is responsible for seeing that DVHA members receive high-quality, clinically appropriate, evidence-based medications in the most efficiently and cost-effectively. The unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program and overseeing the prescription benefits management (PBM) contract with Change Healthcare®. Some of the major responsibilities of the Pharmacy team and PBM include:

- processing pharmacy claims; making drug coverage determinations
- assisting with drug appeals and exception requests
- overseeing federal, state and supplemental drug rebate programs and the manufacturer fee program
- resolving drug-related pharmacy and medical provider issues
- overseeing and managing the Drug Utilization Review (DUR) Board
- managing of the Preferred Drug List (PDL)
- assuring compliance with state and federal pharmacy and pharmacy benefits regulations

In addition, the unit focuses on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations and other efforts related to administrative simplification for DVHA and its providers. Change Healthcare (CHC) employs physicians who provide additional support to DVHA and the drug benefit program by attending and presenting clinical drug information at our Drug Utilization Review Board Meeting. They act as a clinical resource to the pharmacy team, providing peer to peer consults and supporting DVHA's medical director as needed, and supporting DVHA's drug appeals and fair hearings. This helps us provide an ongoing high level of clinical support and credibility to our programs.

Pharmacy Benefit Programs Summary

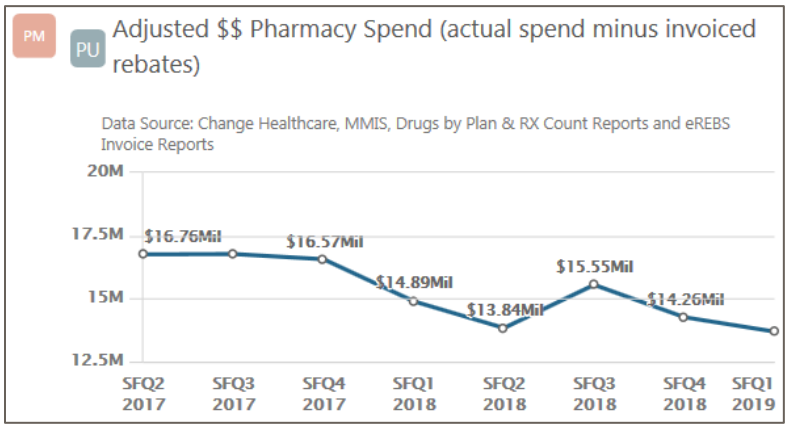
Benefit Plans	Pharmacy Coverage	Co-Pays
Medicaid **Dr. Dynasaur (no copay)**	Coverage of all CMS-covered outpatient drug, rebate participating manufacturers. Also, a limited list of OTC, Rx, Vitamins, cough and cold preparations.	$1 $2 $3
General Assistance (GA)	Coverage of all CMS covered outpatient drug, rebate participating manufacturers. Also, a limited list of OTC, Rx, Vitamins, cough and cold preparations	No Co-Pay
Healthy Vermonters	Passes through to the patient the Medicaid Pharmacy Reimbursement rate. DVHA does not reimburse for services.	100% Co-Pay
VPharm	SPAP "wrap-around" Medicare drug benefit, pays Part C/D cost-share	$1 $2
VMAP (managed at VDH)	HIV/AIDS and related medications	$1, $2, $3
Dual Eligible (including CFC)	Non-Part C/D covered drugs only	$1, $2, $3

Successes

The Pharmacy Unit was focused on four areas of achievement this past fiscal year:

✓ Effective Clinical and Cost Management

The Pharmacy Unit processed 2,064,317 million claims through the State's contracted PBM, Change Healthcare®, and managed $196.5 million in gross drug spending in SFY 2018. Gross drug spending reflects what DVHA paid to both in-state and out-of-state pharmacies enrolled in our network.



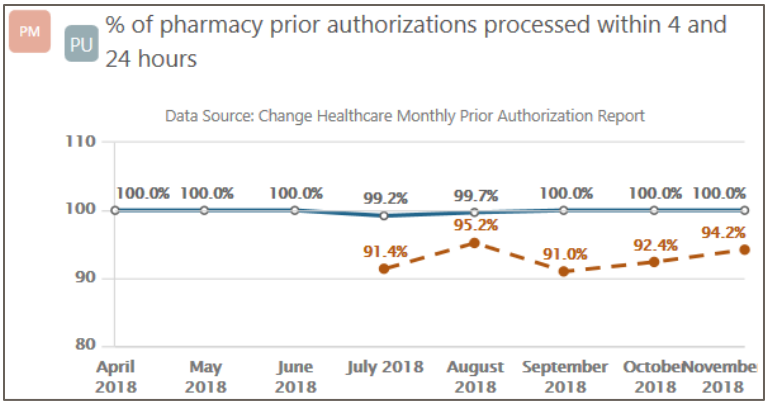
In the Medicaid-only population, including dual-eligible members, DVHA processed 1,731,253 pharmacy claims with a gross spend of $190,682,710. This represents a decrease of 1.4% in the number of Medicaid claims processed a 1.6% increase in gross spending over SFY 2017.

✓ Improved Customer Service

Beginning in January 2015, pharmacies and prescribers have access to a Vermont-based Help Desk in South Burlington servicing DVHA providers and staffed by Vermont pharmacists and pharmacy technicians. This call center assists pharmacies with drug coverage questions, claims processing issues, and processes all the prior authorization requests from prescribers for Medicaid members. The Help Desk is the first point of contact for pharmacy and medical providers with questions, concerns, and complaints. The Help Desk software tracks contacts and problem resolution through a technical call management application, to facilitate logging, tracking, and resolution of all calls and issues in addition to performance monitoring. Surveys and anecdotal reports have demonstrated that Vermont Medicaid operates one of the most responsive and helpful PBM call centers among all health plans in Vermont.

✓ Improved Automation and Administrative Simplification for Providers

Automated Prior Authorizations: The Pharmacy Unit continues to make strides toward reducing the administrative burden of providers in submitting manual prior authorization requests and other drug coverage determination documentation. One notable achievement has been the recent launch of an automated prior authorization (PA) program. This program has allowed the automation of many edits in the system that alleviate the need for a prescriber to fax a paper form to DVHA. As a



result, less than 5% of all paid claims now require a manual clinical PA. Of all claims requiring a PA or override, nearly 80% were automatically processed without prescriber intervention or the need for a manual PA form.

eWEBS Provider Portal: A new provider portal called eWEBS was launched in SFY 2018. The portal was developed in collaboration with our Pharmacy Benefits Manager, Change Healthcare®, and is designed for use by prescribers, pharmacies, and program administrators. It provides a secure way for registered users to look up member eligibility, member drug history, and PDL information. In addition, providers can electronically submit PA requests and track the progress of PA requests online. Prescribers are guided through preferred or non-preferred selections, as well as potential step therapy, dose limits or other PDL criteria giving them the ability to make informed drug choices.

SureScripts ePrescribing Interface: In April 2018, DVHA implemented an e-prescribing interface which enables Medicaid-enrolled prescribers with EHR systems to utilize the Surescripts® network and system platform to view Vermont Medicaid members' drug history and the State's preferred drug list to make informed prescribing decisions. In our first full month of providing this service (May 2018), we received 278,563 transactions including eligibility inquiries, drug history and PDL information related to e-prescribing.

Pharmacy Cost Management (PCM) Program: The PCM program focuses on Medicaid's highest-cost drugs. A clinical pharmacist interacts with the dispensing pharmacy, prescribing physician and patient to assure adherence and compliance, minimize adverse drug events and maximize the clinical outcome of therapy. In 2017, its first year of operation, the PCM program saved the State $634,164 and is anticipated to grow as the program matures.

✓ CMS Certification of the Pharmacy Benefit Management System (PBMS)

In SFY 2018, DVHA received CMS certification of the PBM system. This certification effort evaluated the entire solution and associated documentation to ensure adherence to federal regulations and industry standards. By achieving certification, DVHA can claim 75% federal financial participation (FFP) for maintenance and operations (M&O) costs; until a solution is certified, a state is only eligible for 50%.

Challenges and the Future

The Pharmacy Unit has identified two significant future challenges and opportunities:

1. Clinical and Fiscal Strategy: Specialty Drugs as a Percent of Total Drug Cost

Although there is no standard industry definition, a specialty drug is generally defined as:

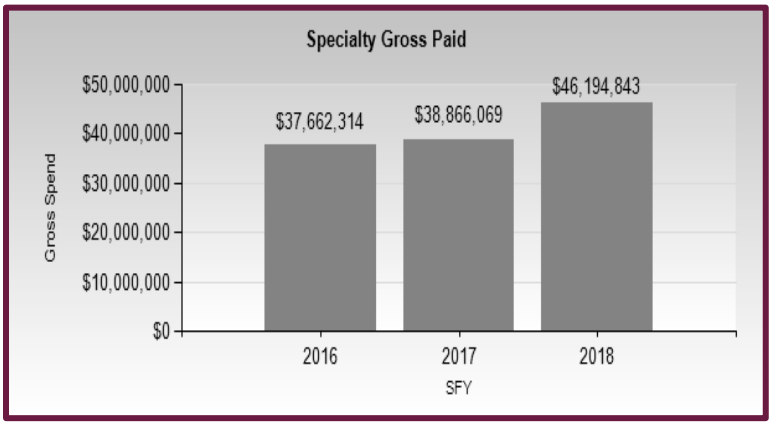
- The cost of the medication exceeds $5,000 per month.
- The medication is used in the treatment of a complex, chronic condition. This may include but is not limited to drugs which require administration, infusion, or injection by a health care professional.
- The manufacturer or FDA requires exclusive, restricted, or limited distribution. This includes medications which have Risk Evaluation and Mitigation Strategies (REMS)

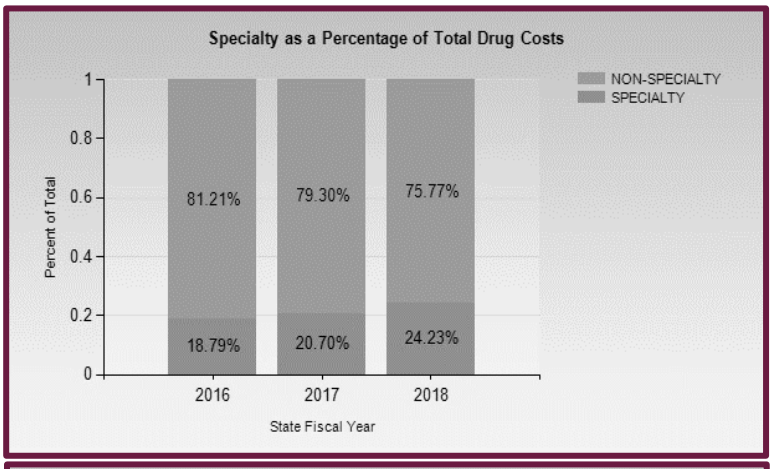
requirements requiring training, certifications, or ongoing monitoring for the drug to be distributed.

- The medication requires specialized handling, storage, or inventory reporting requirements.

In SFY 2018, the proportion of drug spend attributed to specialty drugs increased 3.5% from 20.7% to 24.23%. This represented an overall increase in specialty drug costs of 18.9% over SFY 2017. Between SFY 2017 and SFY 2018:

- The total gross amount spent on specialty drugs increased by 18.9%.
- The gross amount paid per specialty prescription decreased by 2.4%.





Specialty medications include, but are not limited to, drugs used in the treatment of the following conditions: Cancer, Cystic Fibrosis, Endocrine Disorders, Enzyme Deficiencies, Hemophilia, Hepatitis C, Hereditary Angioedema, Immune Deficiency, Inflammatory Conditions such as Crohn's Disease, Ulcerative Colitis, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, and Psoriasis, Multiple Sclerosis, Pulmonary Arterial Hypertension, and Respiratory Syncytial Virus (RSV).

In SFY 2018, the average cost per prescription for all drugs was approximately **$110**, while the average cost per specialty prescription drug was more than **$7,000**

New gene therapies represent a breakthrough in the treatment of disease. Gene therapy is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms: replacing a disease-causing gene with a healthy copy of the gene; inactivating a disease-causing gene that is not functioning properly; or introducing a new or modified gene into the body to help treat a disease. Gene therapy products are being studied to treat diseases including cancer, genetic diseases, and infectious diseases. In SFY2018, the FDA approved three new gene therapies; one for an inherited cause of retinal blindness, one for a type of acute lymphoblastic leukemia, and one for a type of B-cell lymphoma. While side effects can be severe, the effectiveness of gene therapies can be remarkable. It is expected that dozens of new gene therapies will reach the market over the next few years, and DVHA is closely monitoring their development. The cost of gene therapies can be extremely high, ranging from $250,000 to nearly $1 million per course of therapy.

Specialty drugs including gene therapies will continue to put financial strain on the Medicaid program. DVHA's Pharmacy Unit is laser-focused on monitoring the pipeline of new drugs, the prevalence of the diseases they treat in Vermont and analyzing the potential overall impact on DVHA's budget.

Value-Based Contracting as it Impacts Specialty Drugs

During the past decade, payment models for the delivery of health care have undergone a dramatic shift from focusing on volume to focusing on value. This shift began with the Affordable Care Act and was reinforced by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which increased the emphasis on payment for delivery of quality care. Today, value-based care is a primary strategy for improving patient care while managing costs.

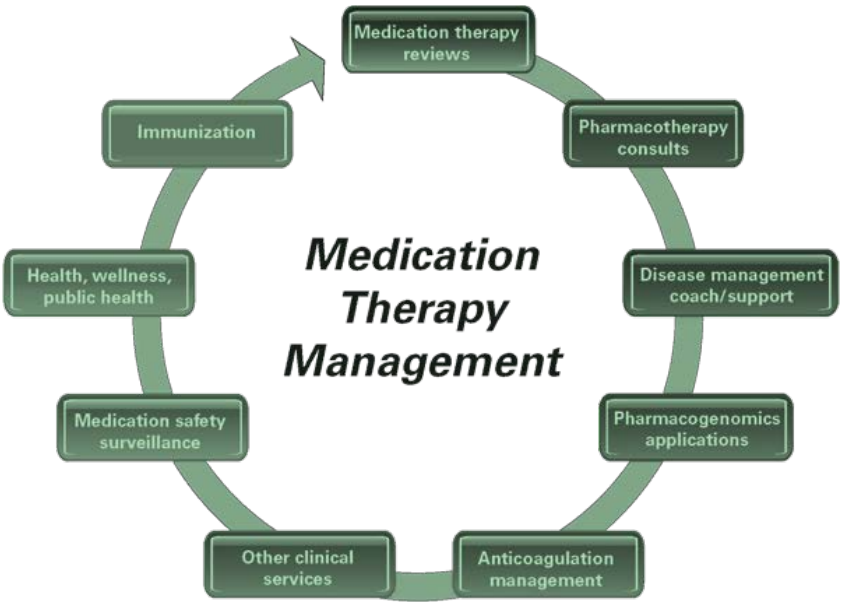
Pharmaceutical value-based contracts (VBC) have emerged as a mechanism that payers may use to better align their contracting structures with broader changes in the healthcare system. Pharmaceuticals are one of the fastest-growing segments of the healthcare marketplace and increasing drug costs necessitate the flexibility to contract in new ways based on the value of these products. Increasingly, reimbursement decisions for drugs will be based on their demonstrated impact on patient outcomes.

Although not all drugs are appropriate for these types of contracts, VBC could be a part of the solution to address increasing drug prices and overall drug spending. Under value-based pricing agreements, payers and pharmaceutical companies agree to link payment for medicine to value achieved, rather than volume. DVHA is carefully monitoring opportunities to participate in VBC's through its membership in the Sovereign States Drug Consortium (SSDC), which is now the largest and only

independent state-owned rebate pool in the country. Vermont was one of the three founding members of the SSDC, which now boasts twelve member-states.

2. Pharmacist-Based Medication Management Services

As we move toward a healthcare system focused less on "fee-for-service" payments and more focused on payments for improved health outcomes, DVHA's Pharmacy Unit is exploring pharmacist payments for improved medication management. Medication management services performed by pharmacists are distinct from medication dispensing and focus on a patient-centered, rather than an individual product-centered process of care. The key goals of a medication management program include providing quality services to patients, enhancing therapeutic outcomes, and maximizing cost-effectiveness. Medication management services encompass the assessment and evaluation of the patient's complete medication therapy regimen, rather than focusing on an individual medication product. The type of care provided through medication management may include the pharmacist checking in regularly with the patient to ensure he or she is taking medications as prescribed, verify the patient is following health and wellness guidelines, and checking into any related problems such as adverse reactions to medications. Various medication management programs are demonstrating positive clinical, economic and health outcomes.



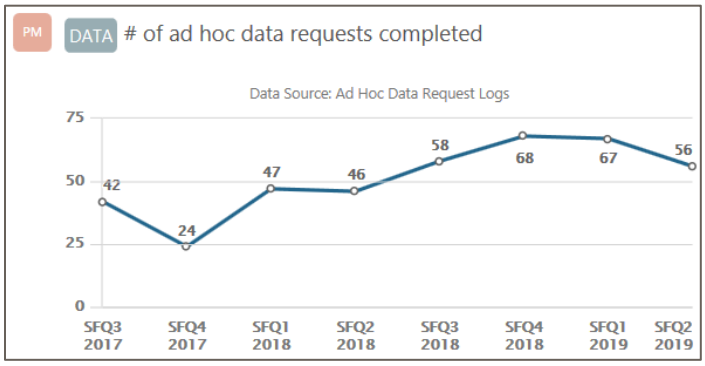
Data Management and Analysis

The Data Management and Analysis unit provides data analysis, distribution of Medicaid data extracts, and reporting to regulatory agencies, the legislature, and other stakeholders and vendors. The unit delivers mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), delivers routine Vermont Healthcare Claims Uniform Reporting and Evaluations System (VHCURES) data feeds. We develop the annual Healthcare Effectiveness Data and Information Sets (HEDIS) data extracts for reporting, deliver weekly medical and pharmacy claims files and monthly eligibility records to support Care Coordination for the Vermont Chronic Care Initiative (VCCI), and provide ad hoc data analysis for internal DVHA divisions and other AHS departments and state agencies.

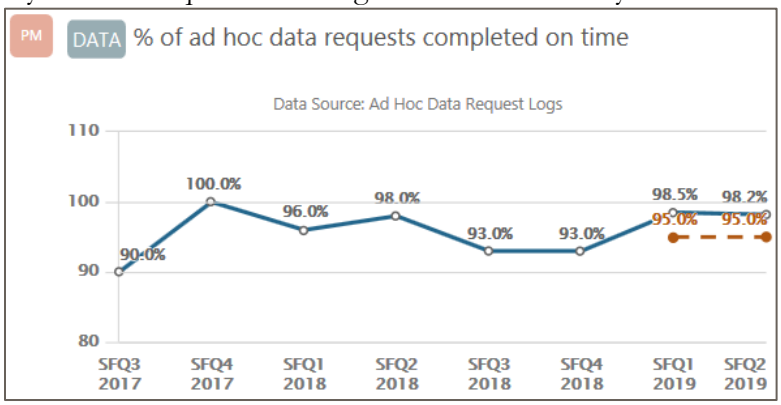
The Data unit supports AHS and DVHA initiatives around performance measures, performance improvement projects, and pay-for-performance initiatives. We are actively engaged in Performance Improvements Projects (PIPs) aimed at improving several HEDIS measures: Chlamydia Screening in Women (CHL); Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

(IET); and, Adults' Access to Preventative/Ambulatory Health Services (AAP). Analysts working on these projects analyze eligibility and claims records while collaboratively designing, developing, and implementing change processes to encourage beneficiary and provider coordination and cooperation. The unit continues to support the AHS Central Office with the annual Designated Agencies (DA) Master Grant Performance Measures; and participates in leadership roles in the AHS Community Profiles project, and AHS Data Governance Initiation project.

In collaboration with the Payment Reform Team, the unit provides weekly claims and monthly eligibility/enrollment extracts to OneCare Vermont, provides quarterly legislative reporting, and ongoing services and support with the implementation of the Vermont Medicaid Next Generation Pilot Project - OneCare, a risk-based program between the DVHA and OneCare Vermont an accountable care organization.



As a support entity within the department responsible for the development of information resources required for effective policy-making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide on-demand, ad hoc data analysis to support ongoing policy development and implementation of Medicaid programs. Requests come into the Data unit from various program staff in DVHA and sister departments in the Agency on any given day and are assigned a priority; High priority- As-Soon-as-Possible (ASAP), and Regular priority. ASAP requests are assigned a 2-business day turnaround time. As an example, if an ASAP request comes in on Monday, it is assigned a due date of Wednesday. Regular priority requests are assigned a 10-business day turnaround time. During SFY 2018, the Data Unit performed over 200 data requests and achieved an average rating of 95% for delivering this information on time.



Health Information Exchange

The Health Information Exchange (HIE) Program is focused on the aggregation and exchange of health data to ensure providers and patients have access to complete health records to inform quality care decisions and to enable analysis and reporting that supports continuous, quality improvement in the health care system. Fundamentally, automating the exchange of clinical data is essential to:

- Improving health care quality
- Making care more efficient

- Reducing administrative burden
- Emboldening policy-making and program development
- Engaging patients in their care, and
- Supporting the health and well-being of the Vermont community

The HIE Program at DVHA was previously called Health-IT/HIE and located under the Blueprint for Health Program.

The HIE Program is responsible for:

- Coordinating state-wide HIE planning to further the State's health system goals
- Operating the Medicaid Promoting Interoperability Program (formerly the Electronic Health Record Incentive Program) to incentivize the adoption and meaningful use of electronic health record systems
- Managing state and federal funding sources to further HIE initiatives
- Contracting with vendors such as the operator of Vermont's Health Information Exchange, VITL, to support the aggregation, exchange and use of health data
- Responding to state and federal mandates related to HIE

There has been a significant investment of funds, time and energy in HIE at the state and federal levels since the early 2000s. In this past year, the HIE Program's progress can be described as follows.

Coordinating state-wide HIE planning to further the State's health system goals

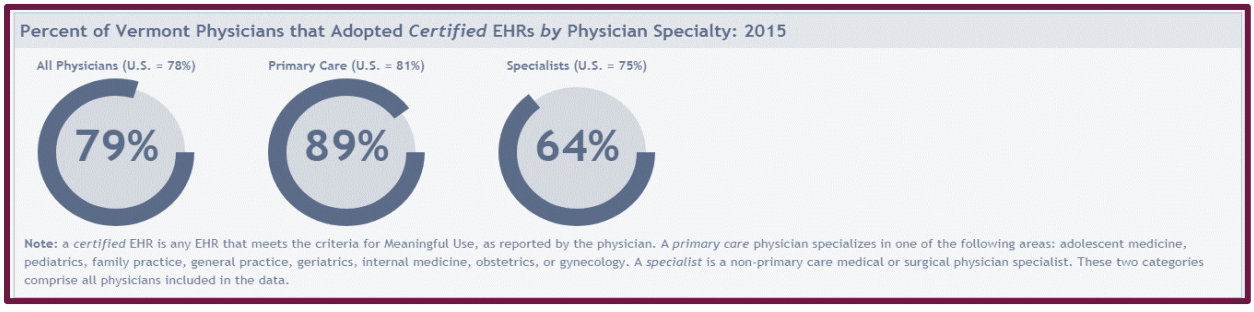
In Act 73 of 2017, the Vermont General Assembly called for a comprehensive evaluation of how HIE is funded, managed and governed. One of the central findings from the 2017 evaluation was Vermont's lack of a strategic plan and a unified, accountable HIE governance body.

In late 2017, DVHA established the HIE Steering Committee, a group of stakeholders charged with developing a state-wide strategic HIE plan, including a proposed permanent HIE governance model. The HIE Plan will be delivered to the Green Mountain Care Board (GMCB) for review and approval no later than November 1, 2018, per 18 V.S.A. § 9351.

Operating the Medicaid Promoting Interoperability Program (PIP)

The Medicaid PIP is focused on using federal dollars to incentivize the adoption and meaningful use of electronic health record (EHR) systems, as defined by the Center for Medicare and Medicaid Services. Since its start in 2011, the Vermont program has distributed close to $55M in 100% federal dollars to eligible professionals and hospitals. Every hospital in Vermont has an EHR system and has taken advantage of the program.

Over 80% of primary care providers in Vermont use an EHR.[8]



[8]The Office of the National Coordinator for Health Information Technology, Health IT Data Summaries: https://dashboard.healthit.gov/apps/health-information-technology-data-summaries.php?state=Vermont&cat9=all+data#summary-data

Managing the state and federal funding sources used to further HIE initiatives

Per 32 V.S.A. § 10301, the HIT Fund supports electronic health systems, the health information exchange network (operated by VITL), and the Blueprint for Health and like initiatives in their use of information technology (IT). The HIT Fund is supported by revenue collected through a portion of the Health Care Claims Tax - .0199% paid by insurers on each private health insurance claim. As legislated, the tax revenue that supports the Fund sunsets annually; the current sunset date is July 1, 2019. Annual HIT Fund reports are posted on the Vermont General Assembly website.

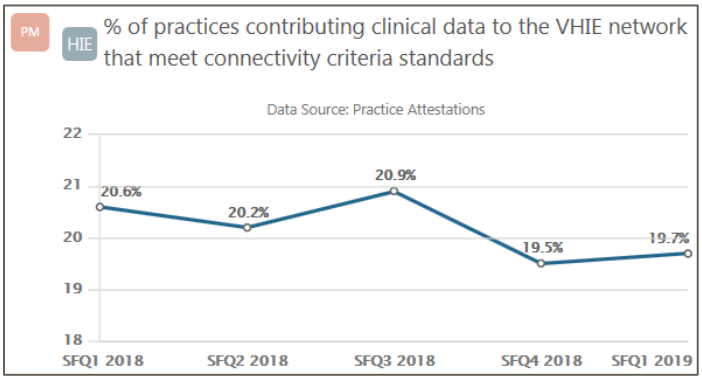
HIT Funds combined with investments under the federal HITECH Act have provided the State with significant financial support for HIE initiatives. Examples of these investments include the development of Vermont's Health Information Exchange, development of the Vermont Clinical Registry (operated by the Blueprint for Health), and expansion of public health registries (managed by the Department of Health).

Contract with vendors to support the aggregation, exchange and use of health data

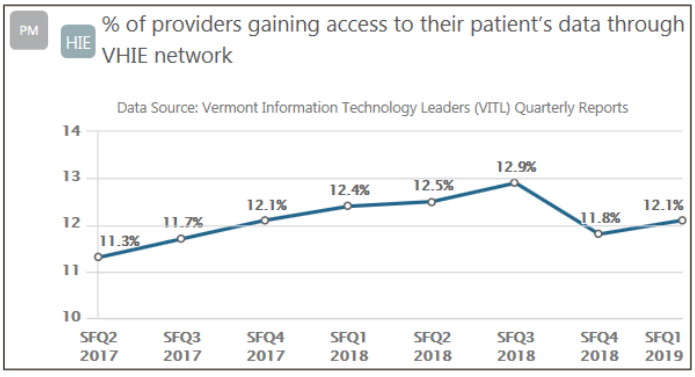
DVHA contracts with vendors such as VITL, Bi-State Primary Care Association, OneCare Vermont, Capitol Health Associates and others to further the State's HIE goals to aggregate, exchange and use health data to support the health care delivery system.

These contracts have driven the current state:

- VITL has established over 1,000 data connections between EHR systems and the central repository, the Vermont Health Information Exchange (VHIE).
- Annually, VITL develops Connectivity Criteria to ensure that EHR connections to the VHIE are supporting good patient/record matching and quality data exchange. To date, close to 20% of providers contributing to the VHIE are meeting the Criteria standards.



- Vermont policy dictates that Vermonter's must consent to share their health information via the VHIE. Currently, over 30% of patient records are available in the VHIE, up from 19% in 2017.
- Vermont's providers can access health records from other care settings via a provider portal called, VITLAccess. In July of 2018, 154 provider organizations were using the VITLAccess system.



- Health data can be used in many ways from informing quality improvement efforts within healthcare practices to driving population health management. In SFY17, a small number (3) of the quality measures supporting Vermont's All-Payer Model used data from the VHIE as a primary source.
- Bi-State Primary Care Associate aggregates clinical and claims data to develop data models that inform quality improvement activities within Federally Qualified Health Centers (FQHCs). The FQHCs are instructed on how to apply learnings from the data and use an analytics tool to monitor progress continually.

Responding to state and federal mandates related to HIE

In 2018, the General Assembly passed Act 187, which calls for continued oversight and monitoring of DVHA and VITL's work in executing the recommendations from the 2017 Evaluation.[9] Specifically, Act 187 of 2018 requires:

- A **Work Plan** with timelines and objectives to assist the General Assembly in evaluating the success or failure of DVHA and VITL's work. *To be delivered: by May 1, 2018*.
- Written **Progress Updates** from DVHA and VITL to the General Assembly and the GMCB on implementing the recommendations from the Act 73 evaluation report. *To be delivered: by May 1, July 1, September 1, November 1, 2018, January 1, 2019*.
- A **Contingency Plan** triggered if DVHA and VITL are unable to implement the recommendations from report. *To be delivered: by September 1, 2018*.
- A **Third-Party Evaluation** of DVHA's and VITL's progress toward implementing the recommendations from the report. *To be delivered: by October 15, 2018*.
- Submission of the **Health Information Technology Plan** to the GMCB *by November 1, 2018*.
- A **recommendation on Vermont's consent policy.** *To be delivered: by January 15, 2019*.
- A **recommendation on how to improve the utility and interoperability of EHRs and HIE.** *To be delivered: by January 15, 2019*.

[9] Health Information Technology Report per Act 73 of 2017, Sec. 15: https://legislature.vermont.gov/assets/Legislative-Reports/VT-Evaluation-of-HIT-Activities-FinalReport-Secretary-Signature.pdf

Beginning in May of 2018, DVHA and VITL provided the legislature and GMCB with bi-monthly updates on progress made toward executing the recommendations from the evaluation report. Updates to a joint work plan are included in each progress update. DVHA and VITL have also provided verbal testimony on progress directly to the GMCB.

The Contingency Plan was developed by a third-party, Capitol Health Associates, and delivered to the legislature and the GMCB as required.

HealthTech Solutions, the third party that conducted the evaluation called for in Act 73 of 2017, conducted an additional evaluation of VITL and DVHA's progress in addressing the recommendations from the 2017 Evaluation Report. HealthTech concluded that both parties were making enough progress and on track.

In November of 2018, DVHA, with support from the HIE Steering Committee, submitted the HIE (HIT) statewide strategic plan to the GMCB. The plan, including an annual update to the State's Connectivity Criteria, was approved later that month.

In mid-January, DVHA also submitted recommendations on the State's consent policy and interoperability.

Reimbursement

The DVHA Medicaid Reimbursement Unit oversees rate setting, pricing, implementation of the National Correct Coding Initiative Program, quarterly code changes, provider payments, and reimbursement methodologies for a large array of services provided under Vermont Medicaid. The unit works with Medicaid providers and other stakeholders to support equitable, transparent, and predictable payment policy 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. This work is crucial because outpatient, inpatient and professional services combine to account for most total payments overseen by Medicaid Reimbursement.

Medicaid Reimbursement 2018 Goals:

Increase payments to border teaching hospitals for inpatient services to achieve alignment between payment methodologies for in-state and border teaching hospitals. This was undertaken to ensure continued access to high quality and timely inpatient services for Vermont residents

In addition, the Reimbursement Unit oversees a complementary set of specialty fee schedules including, but not limited to: durable medical equipment, ambulance and transportation, clinical laboratory, blood, physician-administered drugs, dental, and home health. The unit also manages the FQHC and RHC payment process as well as supplemental payment administration such as the 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 Disabilities, Aging and Independent Living (DAIL), the Vermont Department of Health (VDH), the Vermont Department of Mental Health (DMH), and the Department for Children and Families (DCF).

Each year, the Reimbursement Unit updates prospective payment systems and fee schedules for inpatient, outpatient, professional and durable medical equipment services.

To continue Vermonters access to high quality and timely inpatient services and to achieve ongoing parity in payments for inpatient services provided by border and in-state teaching hospitals the unit made changes to the Inpatient Prospective Payment System (IPPS). In 2018, to accomplish this the following changes to the existing methodologies were made: 1) An increase to the base IPPS rate paid to border teaching hospitals to align with the IPPS base rate paid to in-state teaching hospitals 2) An increase to the Rehabilitation Add-On Payment made to border teaching hospitals to align with the rate paid to in-state teaching hospitals 3) Alignment in payments for psychiatric diagnosis-related

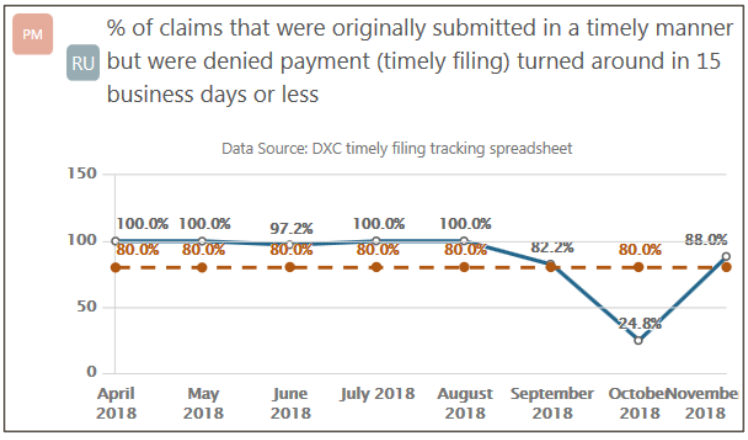
groups (DRG's) between border teaching hospitals and in-state teaching hospitals. A move from an acuity-based per case rate to an acuity-based per diem rate was required to accomplish this and 4) Alignment in payments for extraordinary high-cost outlier cases between border teaching hospitals and in-state teaching hospitals.

Reimbursement was also able to increase reimbursement rates for Physician-Administered Drugs (PAD) and move closer to reimbursing at 100% of Medicare pricing. The unit updates the PAD fee schedule on a semi-annual basis, January 1st, and July 1st each year. The methodology used to reimburse for physician-administered drugs is based on reimbursing at a percent of the latest version of Medicare pricing in effect at the time of update. In its January 2018, update an additional investment of $87K allowed PAD reimbursement rates to increase from 93% to 96% of Medicare. In a subsequent update for July 1, 2018, an additional investment of $24K allowed the rates to move upwards to 97% of Medicare rate.

As of January 1, 2018, a new payment methodology for the pricing of the DMEPOS fee schedule was adopted. DVHA will reimburse at a percentage of Medicare rates on file. For 2018, rates were set at 100% of Medicare rates.

The Reimbursement unit began working with supplier representatives and their association to update the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule in August 2017. Due to the complex nature of the DMEPOS fee schedule with its numerous classes of equipment and services, rental and/or purchase options and policies, and varying arrays of supply items, the full update is expected to extend over a multi-year period and is being implemented in a phased approach. The first of those phases was implemented on January 1, 2018 as part of DVHA's ongoing strategy to modernize the way it pays for healthcare services and to more align with Medicare pricing methodologies and policies.

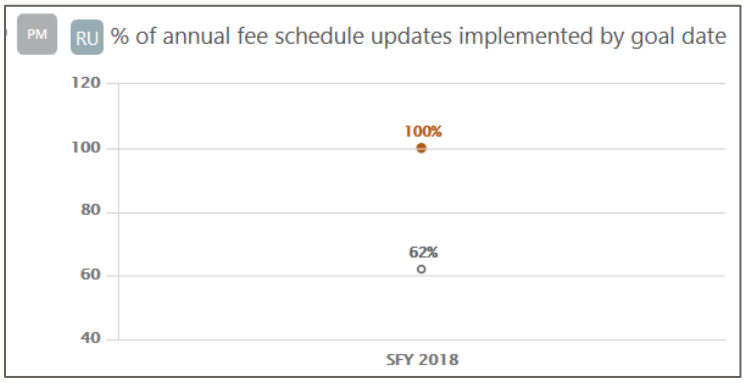
During the past year, DVHA Reimbursement had measured their performance based on three separate measures. All measures were implemented a little over a year ago with a full year of data now available for each of the measures. PM 1 measures the percentage of timely filing claims turned around with a final determination within 15 days of receipt in the unit. This measure was implemented to serve our provider community with more consistent and timely decisions on previously denied claims. This measure is measured monthly. The unit set a goal of reaching the 15-business day turnaround of at least 80% of the time. While the unit got off to a rocky start in the first few months of the revised timely filing process while we ironed out glitches in the process, since that time, the trend has changed. We have consistently met or surpassed our goal since January 2018, and this is a trend we hope to continue going forward.



The units second measures (PM2) tracks our performance in the percentage of annual fee schedule updates that are posted to the Global Commitment Register (GCR) for public comment 30 days prior to the effective date of the rate change. This measure is important to stakeholders as a 30-day

comment period is important to them for many reasons. It allows them time to review, analyze and provide feedback to proposed changes before implementation. It gives them time to educate themselves and their partners/employees on potential process changes needed to comply with updated policies.

The unit has been able to track our performance in this area over the past two years. For 2017, the unit was compliant with the 30-day target 50% of the time while for 2018 that dropped to 30%. When we choose this performance measure, we knew that there would be many challenges to meeting our goal as we work with many partners during the process. Many factors contributed to the unit not meeting their target including the delayed release of Medicare fee schedules or guidelines, which are the basis for many of our rate updates. Other factors included an extended legislative session for the past two sessions, obtaining stakeholder or others consensus promptly and in some instances obtaining signatures needed in the PBR process. We believe this is a good measure and will continue in our efforts to meet our target in the future.



For our third measure, we are trying to implement consistent dates for when our fee schedules and prospective payment rates are updated on an annual basis. During 2017, we chose annual target dates, and our goal is to implement new rates by the identified target date each year. For SFY 2018, we met out target date 63% of the time. Many of the same factors that contributed to our failure to meet PM2 also were a factor in us not meeting of PM3 goal.

Rate Setting

The Division of Rate Setting audits costs and establishes Medicaid payment rates for 35 nursing homes (also referred to as nursing facilities) for the Department of Vermont Health Access and in consultation with the Department of Disabilities, Aging and Independent Living (DAIL). Vermont Medicaid nursing home rates are set according to rules adopted in accordance with the Vermont Administrative Procedures Act (3 V.S.A. §836), Methods, Standards, and Principles for Establishing Payment Rates for Long-Term Care Facilities. In addition to the rules, the Division has implemented certain practices and procedures for the application of the rules.

The Medicaid payment rates for privately owned homes are set prospectively for each quarter, based on the historical costs of providing service in a base year, with certain limits on the amount of costs recognized in each category. The Nursing Care category is adjusted by the home's average Medicaid case-mix score. An annual inflation factor is added to the base year costs to trend the rates forward to the current rate period. Costs are rebased periodically. Property and related costs and ancillary costs are updated annually based on the home's settled cost report.

The Division also sets rates for Private Nonmedical Institutions (PNMI) for Residential Child Care, part of the State's Medicaid program. This is a network of treatment facilities for children and

adolescents with emotional, behavior and other challenges. The facilities provide treatment for children and adolescents and families. The Division establishes annual rates for 16 PNMIs for the Department for Children and Families, the Department of Mental Health (DMH), the Alcohol and Drug Abuse Program. These rates usually have an education component; as such, staff of the Agency of Education is also involved in the rate setting process. The rules governing PNMI rate setting are titled Methods, Standards, and Principles for Establishing Payment Rates for Private Nonmedical Institutions Providing Residential Child Care Services and referred to as V.P.N.M.I.R.

The rate for the State's Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID) is set by the Division for DAIL.

Through the application of its rules, the Division evaluates the reasonableness and allowability of program costs. The rules prescribe in detail how the Medicaid rates for nursing homes and PNMI facilities are to be set. The Division's staff consists primarily of professional accountants who examine the expenditures of the providers to determine allowable costs for use in the calculation of the Medicaid rates.

Nursing homes and PNMI providers may request a special review and a rate adjustment due to a change in circumstances. There are also provisions in the Division's rules that allow a provider to request Extraordinary Financial Relief if they are in danger of closing due to financial challenges. These provisions give the State the opportunity to examine these situations and decide on the appropriate course of action.

The Division's nursing home rules allow for the development of individual rates for nursing home residents who have special, atypical needs due to medical conditions or challenging behaviors. Special individual medical needs are addressed pursuant to V.D.R.S.R. §14.1. Individual rates for current or prospective nursing home residents with severe behavioral issues are set pursuant to V.D.R.S.R. §14.2. In the quarter starting on October 1, 2018, there were 40 individual rates for residents with extremely challenging behaviors and 14 rates for individuals with atypical medical needs. Requests for all special rates are reviewed by staff of the Adult Services Division (ADS) of DAIL. Staff of the ADS work with the Division to evaluate applications and establish rates. DMH is involved in the requests for special rates for severe challenging behaviors. Persons with extremely challenging behaviors can be stranded in hospitals, emergency rooms or psychiatric facilities. This is avoided by a special individualized rate. This individualized rate setting work requires considerable staff time to evaluate the complexities of care needs and requires extensive cooperation with other departments within the Agency of Human Services.

In Vermont, there are two specialty units within Nursing Home for which the Division has established unit-specific specialized rates. One Vermont nursing home will provide care for residents on ventilators. Before this unit was established, residents on ventilators who needed nursing home care had to go out-of-state. A second specialized unit was developed for residents with a condition called Huntington's Chorea. There have been many severe conditions where special individual rates were set to ensure that care could be provided in nursing homes. The availability of these special rates allows for the placement in the proper milieu, with specialized care, and prevents these residents from having to go out-of-state for care or have extended stays in hospitals.

To accomplish the work of the Division of Rate Setting, extensive collaboration with many different departments and many different providers is essential. Staff have high-level expertise in accounting

and finance as well as the ability to work closely and effectively with staff of other departments. The Division engages in continuous process evaluation and improvement to achieve the desired outcomes. Division staff strive to communicate clearly and respectfully with all who are affected by the processes of the Division.

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; 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 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; and supporting members in depression management is indicated prior to addressing other chronic healthcare conditions; and supporting at-risk pregnant women, including those with substance use and mental health disorders.

VCCI has had success caring for Vermonters, however, DVHA is seeking to align its healthcare reform vision, goals, and resources. Accordingly, DVHA will re-evaluate VCCI's work to determine the best use of these resources, including how VCCI coordinates with partners like the Blueprint for Health. The rest of this section will discuss current practice.

The VCCI works with the most vulnerable Medicaid members (those with highest risk, cost, and utilization of services) to support timely and appropriate access to health care services, health education and coaching on their chronic health conditions to improve health literacy, and the advocacy and tools required to support effective and ongoing self-management of their chronic health conditions.

Individuals with complex health care needs account for 5% of the population, but 50% of medical expenses.

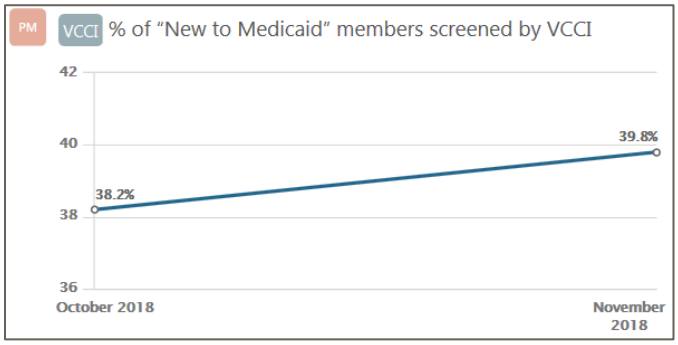
A core component of VCCI case management and care coordination of complex Medicaid members is concurrently addressing the medical, behavioral, and psychosocial needs of these high risk/high-cost members to help them make sustainable change that improves not only their health but reduces health care costs. National research indicates that individuals with complex health needs account for 5% of the overall population and these individuals account for 50% of medical expenses. A significant percent of the complex need population has high frequency of emergency department (ED) visits (47%) and stress related to insecurity in food, housing, transportation (62%), as compared to those without complex health needs. The attributes of the VCCI target population are similar.

Member Identification and Outreach

A typical VCCI member has multiple chronic medical and/or behavioral health conditions, complex pharmacy needs, and patterns of high use of hospital emergency and inpatient resources; indicating poor management of their health condition. Members enrolled by the VCCI are often overweight, obese, or morbidly obese, and thus at increased risk for multiple chronic conditions and their sequela, including diabetes, heart disease, hypertension, and hyperlipidemia. Targeted members may have gaps in or poor adherence to evidence-based treatment including pharmacy, either due to limited health

literacy or other socio-economic barriers to care such as insecurity in finances, housing, food, and/or transportation for preventive or urgent health care needs.

For member identification, the VCCI utilizes the component MMIS Care Management system, eQHealth, to trend the high risk and the 'rising risk' members who will benefit most from case management. The vendor applies the Johns Hopkins predictive analytical tool to member claims history for identification of eligible members in the top 10% who are anticipated to remain high-cost in the future. In addition, the VCCI receives direct referrals from medical and behavioral health providers, hospital case managers, community health team (CHT) colleagues, AHS field directors and sister departments, and internal DVHA units performing concurrent hospital review for substance use and mental health care, and the DVHA Pharmacy Unit/Benefits Manager for those members on high-cost medications. These referrals support the real time need of members at a point when they may be most ready to engage in supportive services.



The VCCI staff outreach and engage members using the predictive modeling outputs for the target population and direct collaboration with their primary care provider. Staff are embedded in some high-risk practices, and function as liaisons to other high-volume Medicaid practices to meet with members at the time of the primary care appointment, or more ideally, in advance of their needed/scheduled visit to prepare for the visit and maximize the provider-patient interaction. Staff also function as liaisons to hospitals, work with case management staff for identification of VCCI currently enrolled members or those eligible for services, support the post hospitalization transition in care, including medication reconciliation, health education and coaching, and the post discharge primary care or behavioral health provider follow-up.

VCCI CORE PROGAM GOAL

Secure access to a medical home and formation of a trusting relationship between the member and their primary care provider for improved health management and decreased acute care service utilization.

The member's readiness to change is a significant factor in the VCCI case manager-member relationship and the staff employ motivational interviewing skills to engage members, starting with the member identified need, while concurrently providing supportive education and coaching on linkages between assessed behavior and health, and future health and life goals. Using a holistic and strength-based approach, the VCCI case manager, member, and provider jointly develop the Plan of Care goals for short term, intensive case management, and care coordination support.

Intervention Services

The statewide, licensed VCCI staff perform outreach and case management services for members in the target population. They carry a case load of roughly 20-25 members at a time, performing short term, intensive case management services of high-risk members with complex medical and psycho-social needs. Staff are co-located within AHS district offices, hospitals and/or provider locations to meet and support members where they may already engage with local service providers for assistance.

The team works directly with members to perform general and disease specific health assessments which include socio-economic gaps and barriers to care, knowledge of their medical condition(s), evidence-based care goals, and pharmaceutical treatment; which informs the holistic and member centric care plan.

Face-to-face interactions with members occur in state offices or provider practices and at the member's home to best assess health risks or barriers, assess medication knowledge, perform medication reconciliation and coach on treatment adherence. Members set goals and generate a self-management plan and a disease specific action plan. The action plan informs proactive primary care engagement versus emergency department utilization. A goal of the program is to secure access to a medical home and formation of a trusting relationship between the member and their primary care provider, as a requisite for improved health management and decreased acute care service utilization.

Research (Commonwealth Fund) indicates that individuals with complex health care needs, multiple providers, hospital admissions and polypharmacy have less confidence in their providers, and more errors in care management, including medication prescribing that may be complicated, duplicative and/or contraindicated. Subsequently, the VCCI team focuses on the members medication knowledge, reconciliation, adherence, and communication among service providers and prescribers, to promote medication management in an environment of specialists. The VCCI clinical team works with members to coordinate care among their service providers and recommend and refer to specialty services as appropriate. The team prepares members for appointments and difficult discussions with the medical team; and accompany them to medical appointments to help create an environment of safety and personal empowerment for the individual member and their treatment team.

Cases are typically open for 3-6 months for 'intensive' case management, based on progressive improvement toward plan of care goals, followed by a transition back to the medical home care team, in support of sustainable change over time.

Successes

The VCCI works at both the individual and population level to implement change and monitor improvement.

Impact to Inpatient Hospitalization/1000, Emergency Department (ED) visits per 1000 and Readmissions in 30 days/1000: An analysis of the VCCI cohort (those enrolled into Case Management services between January 1, 2017 and June 30, 2017 was done comparing claims 6 months before enrollment and 6 months after enrollment. The analysis demonstrates a decline in usage compared to a Control group.

Services Impacted	Cohort Pre	Cohort Post	% Cohort Reduction	Control Pre	Control Post	% Control Reduction
Inpatient Hospitalization/1000	1409	873	38%	1142	1165	-2%
Emergency Department visits/1000	3117	2743	12%	3330	3361	-1%
Readmissions in 30 days/1000	364	171	53%	286	222	22%

Impacts to Vermonters: Case Studies

Below are two examples of how VCCI's efforts directly impact vulnerable Vermonters.

Case Highlight: 25 y/o female with a history of Addison's Disease, uncontrolled asthma, anxiety, domestic abuse, alcohol abuse (in remission), chronic homelessness, and a high-risk pregnancy. Issues included: recurrent ED and inpatient visits, poor medication adherence, homelessness, poor follow up of health needs, lack of resources. VCCI Case Management services provided: medication reconciliation and set up to assist with adherence connection to local resources to maintain nutrition, sanitation and optimize asthma control by reducing/eliminating exposure to environmental triggers; advocated/connected her to long term housing resources. Outcomes include: no unplanned admissions/readmissions or ED visits; improved medication adherence, stable high-risk pregnancy with no complications or issues; case involved collaboration with the PCP office, the OB office, local housing authority, Pathways, shelter, local hospital facility, Economic Services and the member.

Case Highlight: 54 y/o male with two recent inpatient admissions for respiratory failure. Member with: hypertension, Chronic Obstructive Pulmonary Disease, Post-Traumatic Stress Disorder (PTSD), untreated sleep apnea, polysubstance abuse, anxiety, homeless/living in a tent. Issues included: no primary care follow up from the inpatient stay, poor medication compliance, poor education regarding health issues and managing conditions. VCCI Case Management Services: PCP appointment made, collaboration with PCP on medications, schedule and evidence-based medications; education regarding hypertension, medications, substance abuse treatment and care of COPD; Outcomes include no inpatient admissions, adherence to medications, blood pressure controlled, following up with substance use treatment. Case involved collaboration with: PCP, specialist providers, Economic Services, substance use treatment center, local housing resource, and smoking cessation program coordinator.

Blueprint

The Vermont Blueprint for Health is a state-based, nationally-recognized initiative that designs community-led strategies for improving health and well-being. It is based in the Department of Vermont Health Access. The Blueprint supports a network of Project Managers and Quality Improvement Facilitators who work with local Patient-Centered Medical Homes (PCMHs), Community Health Teams (CHTs), and health and human services leaders across Vermont. This network allows for rapid response to Vermont's health priorities through statewide implementation of new initiatives.

The Blueprint performs comprehensive evaluations of health care quality and outcomes at the practice-, community-, and state-level. As the care delivery system and payment models evolve, the Blueprint's aim is constant: connecting Vermonters with whole-person health care that is evidence-based, patient- and family-centered, and cost-effective.

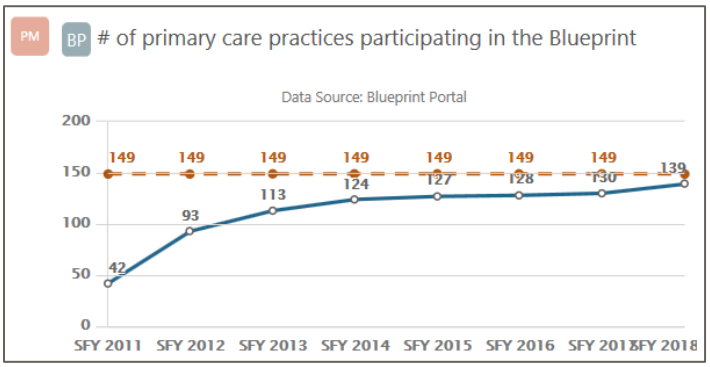
Supporting Primary Care Practices and Providers

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for

Quality Assurance (NCQA)-certified PCMHs. Project Managers, who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Most of Vermont's primary care practices are now Blueprint-participating PCMHs. The Blueprint supports each participating practice with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators bring Blueprint generated all-payer data about practice performance (Blueprint Practice Profiles, Blueprint Community Health Profiles) and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). They initially help launch patient-centered practices and secure NCQA-PCMH recognition, then return regularly to help with quality improvement efforts related to:

- Ongoing practice transformation (e.g. integrating mental health into primary care, electronic medical record optimization)
- State quality and payment reform efforts (e.g. focusing improvement activities on All Payer Model agreement and Accountable Care Organization quality measures, integration of the care model)
- Implementation of new initiatives (e.g. Spoke program, Women's Health Initiative)
- Focus on special populations (e.g. improved opioid prescribing patterns, chronic condition – such as diabetes and hypertension-prevention and management)

Providers and practice teams value Quality Improvement Facilitators' knowledge, expertise, and support in making meaningful change accessible to busy primary care offices.



At the end of the 2nd Quarter of 2018, 139 Vermont practices were operating as PCMHs, thanks to the commitment of providers and staff, the technical assistance of Quality Improvement Facilitators, and the support of Project Managers. The number of practices participating the Blueprint is a key measure in the Blueprint's DVHA Scorecard. The Blueprint currently estimates that there are about 151 total primary care practices that employ more than one provider operating in the state.

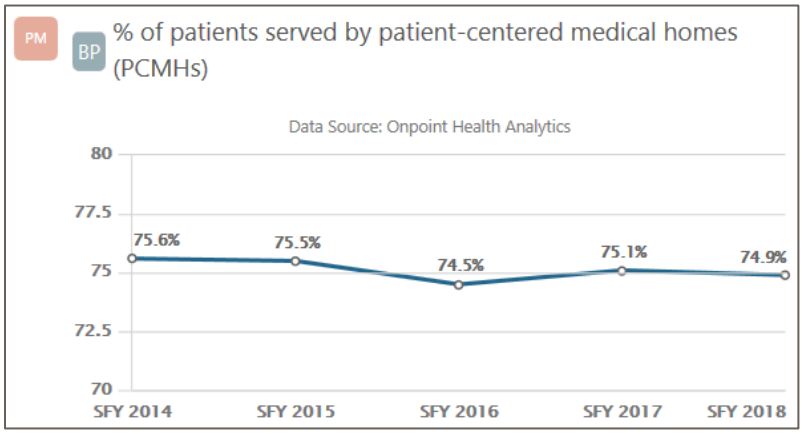
Supporting Primary Care Patients

What difference does a PCMH designation make to patients? When a practice first achieves recognition as a PCMH, its patients may notice certain improvements in accessibility, outreach, and information sharing.

- Patients may notice that their provider's office is open outside of the traditional 9-5 Monday-Friday hours, making it easier to balance work and wellbeing, or they may be surprised to get a sick-appointment right away when they or their loved one needs care, or get connected to a nurse on-call when an urgent concern arises in the middle of the night.

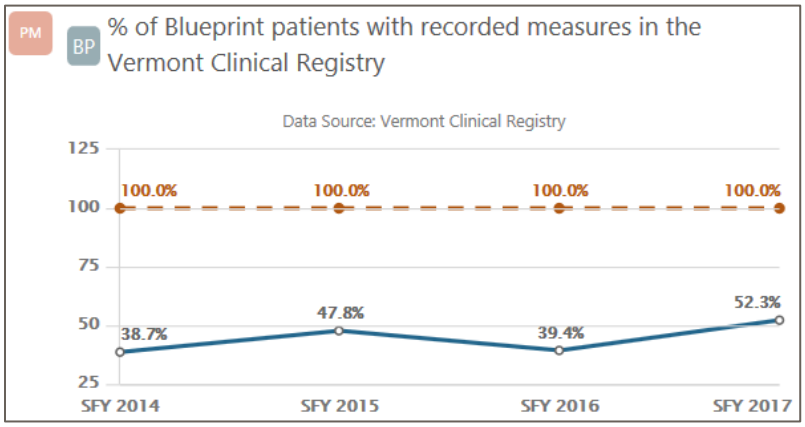
- Patients with a chronic condition, like diabetes or hypertension, may receive a check - in call if they haven't been in to the office recently, encouraging them to make an appointment to have critical health indicators (like HbA1c for diabetes, or blood pressure for hypertension) tested and their ongoing management plan updated as needed according to the findings.
- Providers can offer patients resources for improving their wellbeing, like referrals to the CHT for condition specific education, health coaching, care coordination, brief counseling and connections with longer-term treatment and support options.
- Patients may also receive referrals from their primary care provider to an evidence-based Blueprint self-management workshop, such as Tobacco Cessation, Diabetes Prevention, Diabetes Management, Chronic Pain Management, Wellness Recovery Action Plan (WRAP) for self-designed prevention and wellness planning, or general Chronic Disease Management.
- PCMHs build in evidence-based care, age and gender appropriate prevention services, chronic condition management, and patient- and family-friendly access and communication, and work over time to maintain and continuously improve quality.

Community Health Teams Connect Providers, Patients, and Community Services



The Blueprint CHTs are comprised of multi-disciplinary health and human services providers that work as a team to supplement the services available in PCMHs and link patients with the social and economic services that make healthy living possible for all Vermonters. These teams are funded by Medicare, Medicaid, and Vermont's major commercial insurers, and operate in all areas of the state. Having a CHT, including members embedded within the practices or linked through mutually agreed-upon workflows, gives primary care providers the confidence and support to work alongside patients to identify the cause of health problems, including those that may have a psychosocial component, and connect patients with effective interventions upon identification, manage chronic conditions, or simply provide additional opportunities to support improved well-being. Providers are more confident completing screenings because they have a team of professionals ready to jump in and help the patient move from screening to brief interventions and then connect them with treatment, either through the CHT itself or with community partners.

CHTs provide patients with referrals and warm hand-offs to a wide range of services, including longer-term mental health and substance use disorder treatment services, financial support to afford prescriptions and healthy food, or any other support the patient might need to stay well. For patients, this is often the difference between their physician not asking about depression (for example) or asking and then providing the patient a list of names and phone numbers of counselors to call (many of whom may not be accepting new patients). Instead, with a CHT in place, the patient relates to a trained staff member (possibly even located in the same office and available the same day) who can help the patient further explore their risk factors, needs, and personal goals and then make a referral to counselor with availability for longer term treatment.



In addition to these brief intervention, brief treatment, and referral services, CHT providers can complete additional evidence-based interventions in-house. These interventions include condition specific education (i.e., helping a patient newly-diagnosed with diabetes understand their condition and how to manage it day-to-day), health coaching for a patient who is looking for support in reducing behavioral risk factors for improved health and well-being (i.e., eating more fruits and vegetables, exercising more, or stopping tobacco use) and patient-centered care coordination.

Community Health Teams Partner for Complex Care

The CHTs support patients at all levels of acuity, whether they need a little information and coaching to maximize their wellness, or wraparound health and social services to maintain safety and basic functioning. Regardless of the level of need, the CHTs help put patient motivations first. The Blueprint CHTs participate in OneCare's ACO care model, described in more detail in the "Care Model Implementation" section below.

Self-Management Workshops Help People with Chronic Conditions Thrive

For people living with one or more of the most common chronic health conditions, and for Vermonters who appreciate learning alongside their peers, the Blueprint offers a series of Self-Management Workshops. In 2017, 1,263 Vermonters completed one of these six types of workshops, which focus on the topics of Tobacco Cessation, Diabetes Management, Diabetes Prevention, general Chronic Disease Management, Chronic Pain, and WRAP for self-designed prevention and wellness planning. Self-management workshops are offered in all parts of the state, free of charge to participants, and in various community locations to reduce barriers that may prevent Vermonters from accessing this resource. Some participants say the experience is life-changing and that even small improvements in habits can make a big difference in their health over the long term (a national study showed the Diabetes Prevention workshop model that is also used in Vermont helped participants exercise more, track their food intake, and lose weight, with a resulting $2,650 estimated reduction in Medicare spending per participant over a 15-month period).

Collaborative Efforts – Partnerships with ACOs, other AHS Departments, and Quality Improvement Organizations

Accountable Communities for Health

In partnership with the Vermont Department of Health (VDH) and OneCare Vermont, the Blueprint supports local Community Collaboratives and their ongoing transformation into Accountable Communities for Health a model of community organization that engages community partners in health prevention efforts that was introduced in the state under SIM grant funding. These groups work in partnership to attend local meetings, provide coaching, assess developmental needs, and design and provide training, resources, and state-wide learning opportunities.

All Field Team Development

In partnership with OneCare Vermont, Bi-State Primary Care Association, and Vermont Program for Quality in Health Care, the Blueprint identifies needs of the shared transformation network (Project Managers, Quality Improvement Facilitators, CHT Leaders, Clinical Consultants, and other local stakeholders). By hosting a monthly meeting focused on leadership vision, performance and context-setting data, expert resources, and networking sessions, this group helps to further All Payer Model progress and other important initiatives within the State.

Learning Collaboratives

In partnership with OneCare Vermont, Bi-State Primary Care, New England Quality Innovation Network-Quality Improvement Organizations, VDH, and Support and Services at Home (SASH), the Blueprint hosts quality improvement learning collaboratives that support PCMHs and communities in reducing the prevalence and burden of chronic disease in Vermont. The Learning Collaboratives are 8-12 months long and include in-person and web-based sessions. The sessions include experts to discuss current evidence-based guidelines and uses quality improvement methodology to inform improvement efforts. Learning Collaborative focus areas align with current system priorities and new project launches. In the year ahead, they will include series on opioid prescribing, Hub & Spoke activities, chronic disease prevention and management, and more.

Care Model Implementation (Care Coordination and Management)

The ACO's care model represents the primary method by which it aims to realize savings in the health system. This care model includes identifying patients at the highest levels of acuity and risk for major health problems and resource utilization. Identified patients are offered wraparound supports from health care providers and human services professionals, working together in a care team. The patient-centered care management approach used here is an evolution of the Integrated Communities Care Management model, introduced under the SIM grant by partners including the Blueprint for Health. OneCare offers trainings on the tools (like shared care plans) and methods (like patient-centered multi-disciplinary care conferences) to leaders and staff around the state. Blueprint Project Managers, CHT leaders, CHT staff, and others attend these trainings and lead and/or participate in the care teams that are helping high-risk patients manage their health conditions and achieve their goals.

The Hub & Spoke System of Care Helps Providers Effectively Treat Opioid Use Disorder

Medication Assisted Treatment (MAT) for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient"

approach to the treatment of opioid use disorder. The Hub & Spoke system of care in Vermont provides medication assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (OTPs, Hubs), which provide higher intensity treatment and office-based opioid treatment (OBOT) in community-based medical practice settings (Spokes). The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established medication assisted treatment as an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission and increased social functioning and retention in treatment.

Many of these outcomes were supported by the recent evaluation of Vermont's Hub and Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS), established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (one registered nurse and one licensed mental health clinician per every 100 Medicaid patients receiving medication assisted treatment) into Spoke practices for a patient-centered, team- and evidenced-based approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the "significant impact" demonstrated by the Hub & Spoke system, Vermont is working towards gaining All Payer participation in the Opioid Use Disorder Health Home model.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer Learning Collaboratives with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in Spoke settings. For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. Capacity for receiving medication assisted treatment in Spoke settings has continued to increase, with 2,866 Vermonters with Medicaid insurance receiving medication assisted treatment for opioid use disorder from 224 prescribers and 57.20 full-time equivalent Spoke staff, working as teams, across more than 85 different Spoke settings as of June 2018.

Women's Health Initiative offers Enhanced Preventative Care

Like Hub & Spoke, the Women's Health Initiative began as a challenge from state leadership to address unintended pregnancies and improve the health of women and families. Initially, the initiative was a design project for the Blueprint, in partnership with the VDH and other policy-makers, providers, and experts, and then developed into statewide intervention that helps the people of Vermont access the most current evidence-based care.

The Women's Health Initiative offers participating providers and practices new training, staffing, payments, and community connections. With these supports practices offer women enhanced preventative care, screenings and follow-up to address health and social risks, comprehensive family planning counseling, and timely access to the most effective forms of contraception, including Long

Acting Reversible Contraceptives (LARC). Women who visit a Women's Health Initiative participating women's health practices (OB-GYN offices, midwifery practices, and family planning clinics) and primary care practices engage in enhanced screening to assess mental health, substance use disorder, trauma, intimate partner violence, and access to food and housing.

Women identified as at-risk are immediately connected to a licensed, master-prepared mental health clinician for brief intervention, counseling, and referral to more intensive treatment as needed. The clinicians connect women with their local network of health, social, economic and community services.

Women also engage in comprehensive family planning counseling at participating practices and community-based organizations. Those who indicate they do not want to have a baby in the coming year have access to the full spectrum of contraception options including immediate access to LARC. Women who wish to become pregnant receive pre-conception counseling and services.

The payments associated with participating in the Women's Health Initiative, support women's health and primary care practices in designing workflows to support the enhance screening, family planning counseling, and same-day LARC insertion.

A key aspect of the initiative is the collaboration between participating practices and community-based organizations. Communities that have practices participating in the Women's Health Initiative have developed coalitions that including the participating medical practices, and community organizations. The communities developed these coalition to develop bi-directional referrals pathways to get clients/patient quicker access to necessary services.

Challenges

The Blueprint's PCMHs and CHTs each support providers and patients through the funding of all Vermont insurers: Medicare, Medicaid, and the major commercial insurers. This all-payer participation is part of what makes these programs effective and sustainable. The newer Blueprint service models of Hub & Spoke and the Women's Health Initiative do not currently have all-payer support. Hub & Spoke staffing and the Women's Health Initiative are all funded by Medicaid only. In both cases, the reality of service provision is that providers do not limit their offerings to only those patients with the appropriate insurance, but rather spread the resources they are provided by any insurer over all patients. This may result in fewer resources (usually in the form of staff time) being devoted to any given patient within the target population of the intervention. Additionally, while underfunding an initiative may not prevent a provider from extending services to everybody, it may limit the services they can offer. For instance, a Women's Health Initiative – funded CHT member may be able to offer health coaching and brief counseling, but not complex care management (or vice versa) because resources meant to provide all those services for a select population are being stretched to cover the full practice population regardless of insurer.

In the year ahead, the Blueprint will continue working with the federal government to plan Medicare support for Hub & Spoke and will work with Vermont's major commercial insurers on pilot programs testing models of their participation. Likewise, the Blueprint will continue working closely with Vermont's major commercial insurers to demonstrate the value of the Women's Health Initiative through the wellbeing of Vermonters and their families, improved care quality, and immediate or modeled impacts on health care expenditures, to encourage their participation in fully funding the Women's Health Initiative.

Coordination of Benefits

The Coordination of Benefits (COB) Unit works with providers, members, 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. States are mandated to have a system to identify medical services that are the legal obligation of third parties, such as private health or accident insurers. Third-party resources should be exhausted before paying claims with program funds. If a liable third-party is established after a claim is paid, reimbursement from that third party should be sought. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency.

Correct information from members 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 (TPL) 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 members. COB Medicaid Recovery totaled over $9.1 Million dollars in SFY 2018, the result of various recovery and recoupment practices.

COB Medicaid Recoveries Collected in SFY 2018: $9,178,131

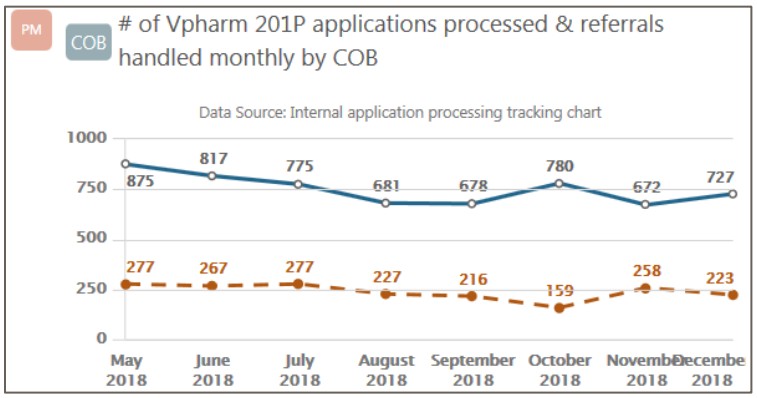
The State has various types of TPL sources, with the most common being other insurance, casualty, and estate. Examples of third parties which may be liable to pay for services:

- Self-insured plans
- Managed care organizations
- Pharmacy benefit managers
- Medicare
- Group Health Plans
- Court-ordered health coverage
- Settlements from a liability insurer
- Workers' compensation
- Long-Term Care (LTC) insurance
- Other State or Federal coverage programs (unless specifically excluded by law)

Coordination of Benefits (COB)

- Dedicated team specializing in the coordination of Medicare/Medicaid pharmacy issues.
- Accesses Federal systems to verify Medicare, Medicare Hospice, Buy-in, Low Income Subsidy, and cost saving programs.
- Specializes in billing issues between Medicaid and all other insurers.
- Responsible for ensuring that Medicaid is the "Payer of Last Resort". The unit is responsible for identifying and recovering payments made by Medicaid as the primary payer, when Medicaid should have been the secondary payer.
- Responsible for systems and process changes that will increase efficiencies and decrease incorrect Medicaid payments.

Medicare and the Medicare Prescription Drug Program (PDP)



The PDP team responds to daily inquiries from member services, the Health Care Advocates office, pharmacists, providers, and other state agencies, and works to resolve the benefits or access to care issues presented by those community partners on behalf of members covered by both Medicare and a Vermont secondary program.

The team also works to resolve issues with the Medicare Part A and/or Part B enrollment as enrollment in these programs is a requirement for enrollment in a Medicare Part C or Part D prescription drug plan. The PDP Team will take in an average of 298 referrals a month to assist with enrollment (Medicare/Medicaid), premium cost, and pharmacy/medical cost share.

Casualty Recovery Process

As a condition of eligibility, applicants are required to assign their rights to medical support and payments for medical care from any third-party payer. Applicants/beneficiaries are also required to cooperate with the State in the pursuit of any third-party payer, including the establishment of paternity for dependent children. Failure to cooperate may lead to termination of their benefits, unless good cause can be established.

Casualty Recoveries Collected in SFY 2018:

$2,579,367

Medicaid providers are required (except as noted below under cost avoidance methods) to apply third party payment resources prior to billing Medicaid. Third party resources include Medicare, private health insurance, accident insurance, or worker's compensation. If Medicaid providers fail to apply third party payment resources before billing Medicaid, this could result in a recoupment of amounts paid to the provider (a reduction of the next payment for services rendered).

The Medicaid State Plan (section 4.22-B), requires the State to investigate all casualty cases with a medical expense of $200 or more that have trauma related diagnosis codes within the MMIS system. To determine if these specified codes are related to an injury, a monthly Accident/Trauma Report is generated by DXC, and insurance/accident questionnaires are sent to members requesting additional information. All cases with no response remain on the Accident/Trauma report until the proper documentation is received or cases are closed. All returned questionnaires are reviewed to determine the possibility of third-party liability; whether it is an insurer or a potential legal recovery. If a settlement is obtained by the member, the State would be entitled to recover the amount Medicaid paid for services.

If an injury is motor vehicle related, the COB Unit may access the crash file, as well as obtain the accident report through the Department of Motor Vehicles. Workers Compensation information may be obtained from the employer, if it is a work-related injury claim. The COB Unit also has the authority to review homeowner's insurance policies for potential medical coverage.

State statutes mandate that attorneys and insurance companies consult with the COB unit to determine if a claimant is a Medicaid beneficiary and whether claims were paid by the Medicaid program. If the claimant is/was a Medicaid beneficiary and claims were paid by the Medicaid program, the Medicaid program must settle the case before the claimant and the attorney receive their portion of the settlement. If claims are potentially recoverable, DVHA places a lien against any possible settlement.

Estate Recovery

The State has the authority to recover all amounts paid for Long Term Care Services by the Medicaid program from a beneficiary's estate at the time of death, if the beneficiary was 55 or older and was receiving Long Term Care Medicaid. The State has an agreement with Probate Courts/State Tax Department whereby the State is notified of all estate cases filed.

Estate Recoveries Collected in SFY 2018:

$910,579

Each estate case is researched to determine if the deceased was a Medicaid beneficiary 55 or older and had received LTC services. If the case is found to qualify for Estate Recovery, a claim for LTC service is sent to the Executor/Administrator of the estate, and a copy is sent to the Probate Court petitioning a claim to be paid from the estate. Once the estate case comes to settlement and payment is received, the case is closed by the staff. Estate recovery staff annually review outstanding estate cases and request up-dates from the executors/executrix, administrators, or attorneys.

Over Resource

When a beneficiary has been found LTC eligible and exceeds the income and resource limits set by the program, the excesses are payable to Medicaid and processed by COB staff.

Over Resource Recoveries Collected in SFY 2018:

$510,614

Patient Share/ Credit Balance

An LTC patient's share is determined by Economic Services Division and is payable directly to the LTC provider/facility monthly by the beneficiary, family or administrator.

Patient Share Recoveries Collected in SFY 2018:

$1,029,058

- When LTC claims are received at DVHA, the patient share amount for the month is deducted prior to Medicaid's payment to the LTC provider.
- A Medicaid Credit Balance exists with the LTC provider when the monthly patient share has not been deducted from a claim.
- Patient share/credit balance collections have increased by roughly $500,000 during SFY 2018 due to more people entering hospice care while in the nursing home. This situation requires that COB collect the patient share manually versus collecting the patient share from claims.

A report is generated monthly showing balance due from the LTC provider and provides the basis for COB to seek recovery.

Trust & Annuity Accounts

Trusts and annuities are legal accounts into which a person can transfer their assets to be held, managed, and administered by an appointed trustee for the benefit of the individual. Certain trusts are allowed by Medicaid to be excluded when considering an applicant's resources for their eligibility.

Any money remaining in a trust or annuity after the death of the beneficiary must be sent to DVHA as Medicaid recovery.

Trust & Annuity Recoveries Collected in SFY 2018:

$858,607

TPL & Medicare Cost Avoidance

Cost avoidance is COB's main goal. Once other insurance or Medicare information is known to the MMIS or the PBM, the system will begin cost avoiding claims. If the provider sends in a claim without the other insurers payment or an explanation of why there is no payment, the system denies and sends the claim back to the provider with a message that the beneficiary had other insurance or Medicare on the date of service and that claims should be filed with the other insurance first.

TPL Cost Avoided in SFY 2018:

$173,502,191

Medicare Cost Avoided in SFY 2018:

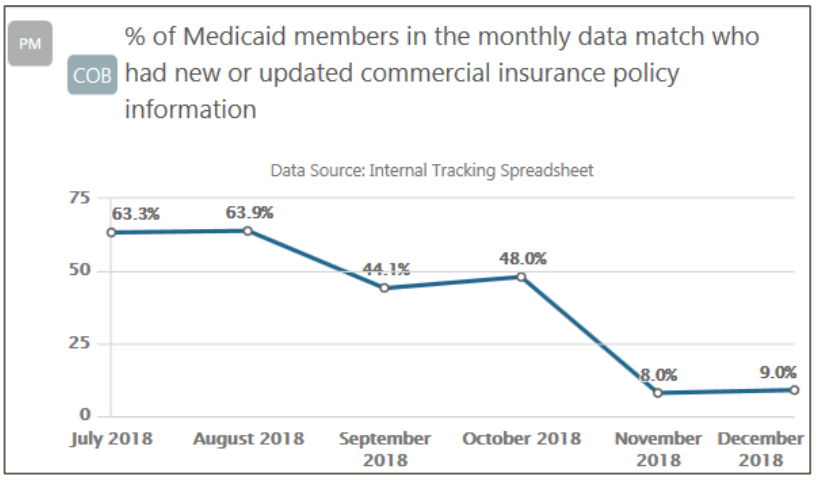
$372,794,834

Medicare cost avoidance has decreased and begun to plateau due to many years of provider education, improved system edits, audits and updates, timely systematic coding updates, medical claim reversals/recoupments/voids, and rigorous PDP Team efforts regarding correct VPHARM eligibility, member buy-in eligibility and member access to prescription medications.

Data Matching with Health Insurers

As required by Federal Law, Medicaid is the "payer of last resort," meaning that Medicaid only pays for as the primary insurance for a service if there are no other liable third-party payers. What this means is if a member has a primary insurance and Medicaid is the secondary insurance, providers are required to bill the primary insurance for all the member's services and then bill Medicaid as the secondary insurance.

Information about applicants and members is collected when an applicant completes an application for Medicaid determination, or a member completes review paperwork at Medicaid redetermination. If the applicant or the member forgets, is unaware or fails to provide information about another health insurance, Medicaid is considered the primary payer of healthcare claims until the department is aware of another health insurer.



In 2005, the Federal Government required health insurers to provide a file of their health care eligible members with specific information in a legally required format to all State Medicaid Agencies. Unfortunately, not all states have been successful in getting health insurers to comply with this Federal Requirement.

Vermont has been receiving a file of eligible members from United Health Care since approximately 2010 and just began receiving a file of eligible members in the specified DRA format from Blue Cross and Blue Shield of Vermont in mid-2018.

Health Insurance Premium Program (HIPP)

When an individual is eligible for both Medicaid and a private health insurance, and in danger of losing their private health insurance due to affordability, the case is referred to COB. The case is reviewed by COB staff and a cost-effective determination is performed.

If the private health insurance is found to be cost-effective, Medicaid, through DVHA will reimburse the household for part or the entirety of the private health insurance premium. The retention of the private insurance makes Medicaid the second payer of services for the eligible member, which is a cost savings for the Medicaid program.

COB Successes

- Strengthened State Statutes to enforce data matching with Insurance providers.
- Received data-matching files from BCBSVT beginning in June 2018 and worked through the last 3 years (2015, 2016, 2017) of data.
- Improving the data-matching process from the MMIS perspective and starting to automate the data-matching process from the Eligibility System perspective.
- Submitted a legislative statute amendment to enforce and assist in Estate recoveries, by requiring probate courts to submit lists of probate cases to the COB unit monthly.

COB Challenges

COB's Casualty and Estate recovery teams are burdened with extensive paper case files and a limited TPL data system that provides billed and collected amounts for transactions. An automated system that would allow electronic storage of scanned documents, produce necessary letters, lien notices, and

monthly reports would increase worker efficiencies, collections, and provide an audit trail for these collection processes. COB is currently participating in an analysis of its business processes and the needs that result from those business processes to determine if there is a solution available on the market that could meet the need for automation and increased collections.

Future State

After data matching is automated in both the MMIS and the Access Eligibility System, COB will work towards implementing a similar process with MVP and CIGNA. Increased data matching will increase DVHA's ability to cost avoid – the goal of COB.

Program Integrity

The Program Integrity Unit (PIU) is responsible for DVHA programmatic compliance with federal and state Medicaid regulations and has the responsibility to monitor, detect, prevent, and investigate inappropriate use of resources, fraud, waste, and abuse.

The team works with providers, beneficiaries, fiscal agents, contractors, the Centers for Medicare & Medicaid (CMS), AHS, DVHA, and many other various partners to ensure that federal and state regulatory requirements are met, and that compliance and integrity are fundamental in all aspects of the Vermont Medicaid Program.

By ensuring compliance, reducing fraud, waste & abuse and supporting the appropriate spend of federal and state tax dollars, Vermonters will continue to have access to excellent healthcare by our enrolled Providers.

The following business areas within the PIU work to meet federal and state obligations to ensure compliance and to reduce risk to the Medicaid program.

Provider Audit & Compliance Unit (PACU)	• Prevent, detect, and investigate Provider fraud, waste and abuse. • Investigate allegations of provider fraud. • Identify aberrant billing patterns amongst Medicaid providers. • Assist providers through education as necessary.

The Provider Audit & Compliance Unit (PACU) works to establish and maintain the integrity of the Medicaid Program by engaging in activities to prevent, detect and investigate Medicaid provider fraud, waste and abuse. PACU receives referral(s) from all sources and uses data mining and analytics to investigate allegations of fraud, waste and abuse. PACU works with our Vermont Medicaid providers and the various AHS departments to identify payment integrity issues. PACU works with medical professionals to develop appropriate resolutions to the many issues confronting Medicaid. PACU assists other Medicaid program units to facilitate changes in policies, procedures and program logic to ensure the integrity of the programs. In addition, PACU provides education to 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's General's Medicaid Fraud and Residential Abuse Unit (MFRAU).

Beneficiary Healthcare Fraud Investigative Unit (BFIU)	• Prevent, detect, and investigate Beneficiary healthcare eligibility and enrollment fraud. • Manage the Public Assistance Reporting Information System (PARIS) matches for dual enrollment amongst other states. • Propose program recommendations for the prevention of Medicaid enrollment fraud.

In July 2015, DVHA became responsible for the Medicaid Health Access Eligibility & Enrollment Unit (HAEEU). As a result of this, member healthcare eligibility and enrollment fraud also became the responsibility of DVHA. In April 2017, new staff were hired, and the Beneficiary Healthcare Fraud Investigative Unit (BFIU) was formed. The responsibility of this team is to investigate, detect and prevent member healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. All other programs such as TANF, 3SQUARESVT, Fuel Assistance, and Reach Up investigations remain the responsibility of the Department for Children and Families (DCF). Collectively, the BFIU team works with DCF to evaluate and investigate allegations received. BFIU works regularly and in collaboration with the Drug Enforcement Agency (DEA), the Office of the Inspector General (OIG) and other state and federal agencies.

Oversight & Monitoring (O&M)	• Faciliatate audit discussions and work product between DVHA and external regulators and auditors. • Monitor audit findings and follow up on any corrective action plans. • Collaborate with DVHA staff for standardized policies and procedures.

The Oversight & Monitoring (O&M) Unit 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. O&M facilitates communication and collaboration between state staff, leadership, federal and state auditors and independent auditors including but not limited to CMS, OIG, Government Accounting Office (GAO), Internal Revenue Service (IRS). This facilitation helps ensure accurate, consistent, and appropriate communication is made in a succinct, informative, and professional manner. The goal is standardization of efforts across all DVHA resulting in satisfactory audit results and proactive determination of audit issues and their timely resolution through collaboration of the appropriate course of action with program management. O&M oversees the tracking, reporting and escalation of DVHA Medicaid Program findings to DVHA Senior Leadership until properly resolved therefore reducing regulatory exam findings potentially resulting in costly monetary penalties.

HealthCare Quality Control (HCQC)	• Reduce errors in beneficiary enrollment and eligibility determinations through a systemmatic approach. • Conduct and assist with the Payment Error Rate Measurement (PERM) audit . • Facilitate Medicaid Eligibility Quality Control (MEQC) examinations.

The HealthCare Quality Control Unit (HCQC) joined Program Integrity in September 2017, in line with the Vermont State Plan, which stipulates the implementation of a quality control system designed to reduce erroneous expenditures by conducting a random sample of eligibility determinations. HCQC focuses on identifying quality issues, based on adherence to State and Federal Rules. HCQC manages the DVHA Quality Control Program which includes internal and external quality control audit efforts. Additional responsibilities include the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) exams to ensure Rule compliance when determinations are made regarding Medicaid Member eligibility and enrollment determinations.

HCQC staff maintain strong, professional relationships with regulators, examiners, auditors and leadership in support of creating an environment of compliance with state and federal regulations and laws governing Health Care assistance programs. The HCQC unit oversees the tracking and reporting of eligibility and enrollment findings to DVHA leadership until properly resolved therefore reducing regulatory exam findings.

PACU Case Settlements/Recovered and Cost-Avoided:

$4,433,183

BFIU Case Settlements/Recovered and Cost-Avoided:

$560,124

The DVHA Medicaid Compliance Officer (CO) is responsible for ensuring DVHA's adherence to all state and federal Medicaid requirements. The CO manages DVHA's Intra-Governmental Agreements (IGA) with other AHS departments and coordinates internal reviews and consultation opportunities aimed at evaluating the compliance and quality of Medicaid activities and programs. If a compliance issue is identified, the Compliance Officer, alone, or in collaboration with the AHS Compliance Committee, will create, manage and monitor any corrective action plan.

The Compliance Officer guides and assists DVHA and AHS units as they address complicated audit findings or new compliance requirements related to Medicaid programs.

Each year, the Compliance Officer coordinates a compliance audit, which is conducted by an External Quality Review Organization (EQRO), designated by CMS. 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 Officer works closely with units within DVHA and across AHS to maintain continuity between compliance, education and quality improvement activities.

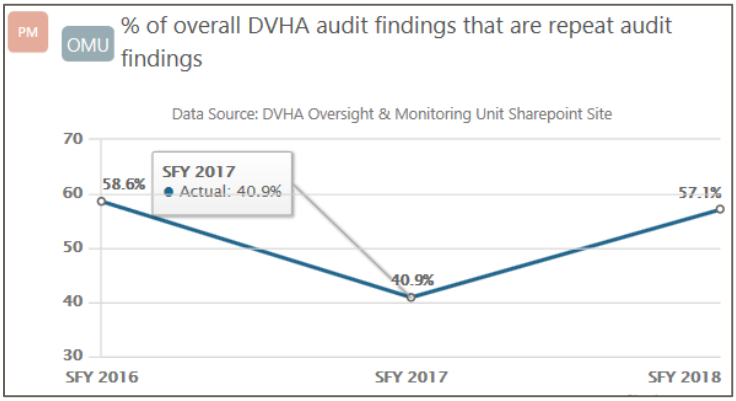
Successes

The Vermont PIU is regularly regarded, by CMS, as well as other federal and state partners, as a leading and strong unit. The PIU takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars, which further allows for more flexibility in the budget to consider increased coverage options, increased budgetary appropriations, and potential increased rates.

In SFY 2018, the Provider Audit & Compliance Unit (PACU) worked more than 300 provider fraud, waste and abuse allegation cases. Of these cases, PACU successfully settled, recovered and cost-avoided a collective $4,433,183. Case settlements and recoveries totaled $4,221,551 and the unit projected a cost avoidance savings of $211,632.

In SFY 2018, the Member Fraud Investigative Unit (BFIU) successfully cost-avoided and settled a collective $560,124. The cost avoidance amount of $544,809 was achieved by working the Public Assistance Reporting Information System (PARIS) Interstate Match Report. This report identifies beneficiaries that are active in two or more State Medicaid programs. BFIU was able to identify, investigate and determine the beneficiaries correct State Medicaid Program. BFIU also recouped $15,315 in a case settlement.

The Oversight & Monitoring Unit has a goal to reduce repeat findings from DVHA audits and has dramatically reduced findings and repeat audit findings across the board in each of the audits that have been conducted thus far. This is the result of direct communication and collaboration between the DVHA units, as well as Federal and State regulators. Adherence to, and completion of corrective actions has further strengthened the program.



Challenges

Each year, new legislation for programmatic and policy changes come with tight timeframes for compliance, systematic changes, and defined coverage and funding requirements. These new requirements can sometimes create challenges where conflicts between other existing policies and regulations exist.

It is increasingly difficult to proactively ensure system changes can accurately enroll and re-determine member and provider eligibility, process claims and make correct payments when the Medicaid enrollment, eligibility, and claims engine systems are outdated. It is becoming apparent and concerning that providers and members are expected to bill and submit appropriate documentation to support accurate results since the system is less able to utilize edits and audits and business intelligence software to guide our work.

Federal and state regulations continue to be introduced and evolve. Existing staff are used to evaluate, implement, monitor and enforce these new and changing policies, all while also ensuring that daily work continues.

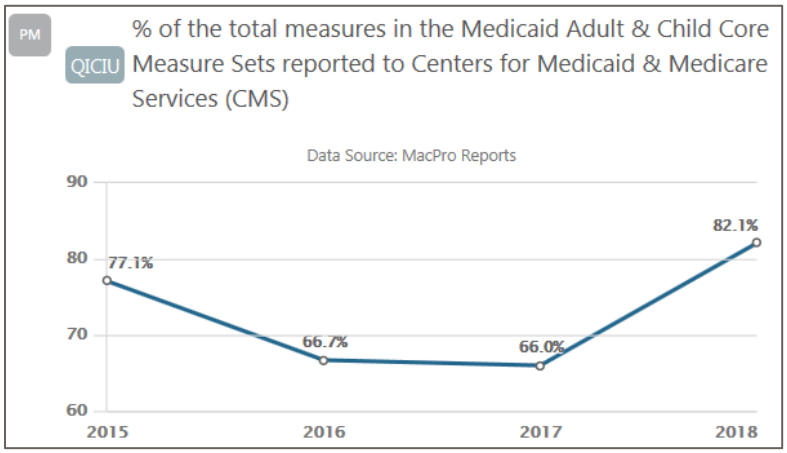
Future State

DVHA just introduced a new asset verification tool that will support the work in PACU, BFIU, and HCQC. BFIU and PACU are looking into new tools for enhanced fraud investigations, to support better case tracking and to provide stronger business intelligence.

Quality Improvement & Clinical Integrity Unit

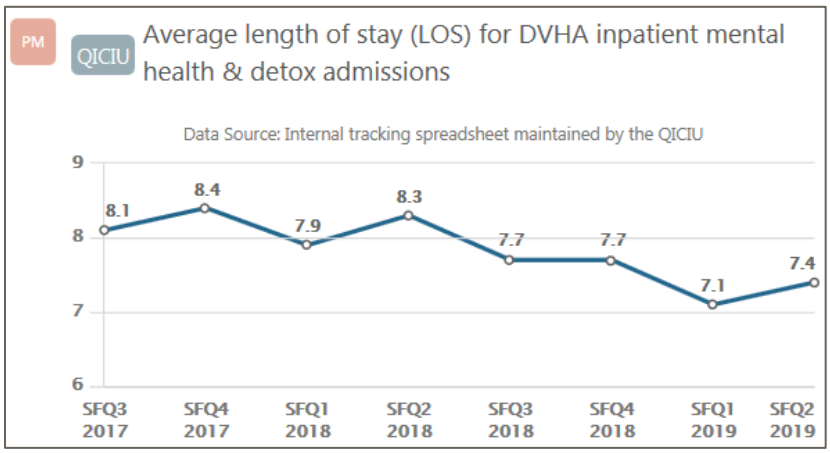
The Quality Improvement & Clinical Integrity Unit monitors, evaluates, and improves the quality of care for Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects, and performing utilization management. Efforts are aligned across the Agency of Human Services and community providers. The unit is responsible for instilling the principles of quality throughout DVHA and helping everyone in the organization to achieve excellence. The unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

One step in developing that culture is being able to communicate with each other about our performance on the areas of work that are important to running a high-quality health plan. A tool that we use to communicate our Department's goals and the work that goes into achieving those goals is our Results Based Accountability (RBA) Scorecard. Quality Unit staff have taken the lead on developing DVHA's scorecards – some of which are posted on the DVHA website; others are used for internal performance management.



The Quality Unit also annually reports out on Vermont Medicaid's performance on national standard measure sets. These measure sets include both clinical indicators, as well as experience of care, or customer satisfaction, measures. Quality Unit staff lead committees within DVHA that analyze performance on these measures each year. Knowing how Vermont performs compared to other state Medicaid programs (and against ourselves from year to year) helps identify opportunities for improvement.

The Clinical Utilization Review (UR) team is responsible for the utilization management of mental health and substance use disorder services. These services include both promoting the integration of, and coordination of services for, Vermont Medicaid members with substance use disorder and mental health needs. The team works to ensure that members get the right level of care for the appropriate length of time. All reviewers are licensed clinicians dedicated to increased access and positive outcomes for our members. The team performs utilization management activities including concurrent review and authorization of mental health and substance use disorder services.



In SFY 2018, the UR team authorized and performed concurrent reviews for 391 child/adolescent psychiatric inpatient admissions, 340 withdrawal management inpatient admissions, 1,256 adult psychiatric inpatient admissions and 1,759 residential treatment admissions. Single case agreements were authorized to support members in receiving services not available in state.

The UR team has collaborated with the Department of Mental Health, the Department for Children and Families and the Department of Aging and Independent Living to identify and enhance our provider network to allow for timely discharge from inpatient hospitalization. The team has onboarded providers to increase the network. Our partners have also enhanced the community service provider network. We team with sister departments to support discharge through case consultation. This practice has greatly reducing the need for Administrative Authorizations. Administrative Authorizations are approvals at the acute rate that are authorized when the member is ready for discharge but there are discharge barriers attributable to other departments within the state, or forces beyond the control of the provider. Weekly case consultations allow for transparency, a greater understanding of barriers, and exploration of available services. The team has strengthened relationships with external partners through participation in site visits, training, case consultations, and frequent inter- rater reliability checks.

The UR team has continued to partner with the Department of Mental Health, the Department for Children and Families, the Department of Corrections and the Vermont Department of Health's Division of Alcohol and Drug Abuse Program to participate in case consultations and management to support members in receiving needed care while being fiscally responsible. The team has developed a system to refer members to the Vermont Chronic Care Initiative (VCCI).

The Behavioral Health Team also manages the Team Care program (the lock-in program). The team completed a comprehensive review of clinical documentation and data to support ongoing member inclusion in the program. Members no longer requiring inclusion were notified of disenrollment. The team then initiated a review and revision of Team Care protocol. Standards for inclusion and disenrollment were defined and are being operationalized by the Team. A new manual was developed, and staff have been trained. The practice of referring Team Care program members to VCCI when appropriate has been incorporated in the protocol. New methods for identification of potential members in being explored as there have been no new referrals this quarter. The lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS. The team is also developing a method to more accurately assess cost savings attributable to inclusion in the Team Care program.

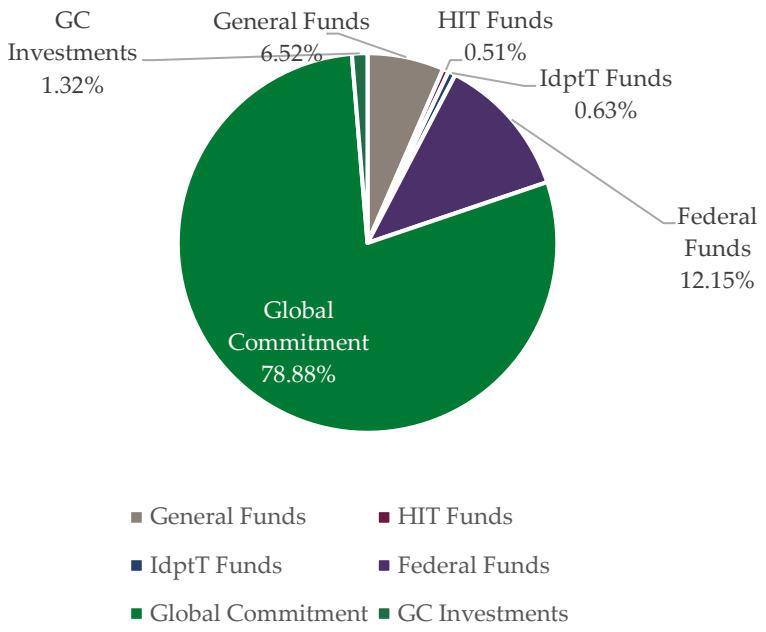
The Unit also manages the Applied Behavior Analysis (ABA) benefit. The Autism Specialist, a member of the Behavioral Health Team, has worked collaboratively with the Policy Unit and sister

Departments to evaluate and improve the program. DVHA is currently working on development of a new payment model that would continue to support members and providers, as well as attract new ABA providers to serve members. The Autism Specialist participates in the Autism Workgroup, which happens on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist. Ongoing collaboration with sister departments has allowed for coordination of services and increasing supports to Medicaid members. We also continue to identify and onboard providers specializing in services for children with Autism.

Agency of Human Services,
Department of Vermont Health Access
FY 2020 Governor's Recommend Budget

MISSION

Improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively.



FY 2020 SUMMARY & HIGHLIGHTS

DVHA is comprised of 379 positions: 16 Exempt and 363 Classified.

This proposal represents an 1.43% increase in general funds.

DVHA continues to focus on three priorities; adoption of value-based payments, management of information technology projects, and operational performance improvement.

We invite you to review Chapter 1 of this Annual Report for a full list of DVHA Accomplishments in the last year.

In Chapter 9, we provide readers with an overview of specific items that we are focused on in the coming year.

DVHA Budget Recommendation Changes from As Passed

Changes	Program	Administration	Total DVHA	State Funds Estimate*
SFY 2019 As Passed	**$1,014,205,305**	**$163,194,019**	**$1,177,399,324**	**$520,286,600**
2020 Changes	$14,078,471	$8,630,369	$22,708,840	$9,379,624
SFY 2020 Recommendation	**$1,028,283,776**	**$171,824,388**	**$1,200,108,164**	**$529,666,224**

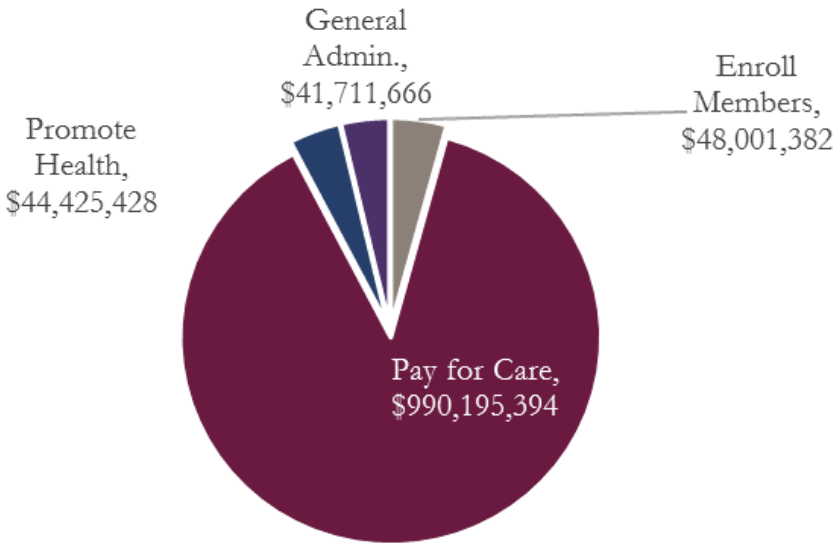
* This estimate converts Global Commitment which is handled at AHS Central Office using a blended Federal Medical Assistance Percentage (FMAP) which may not fully reflect the actual mix of caseload for the New Adults.

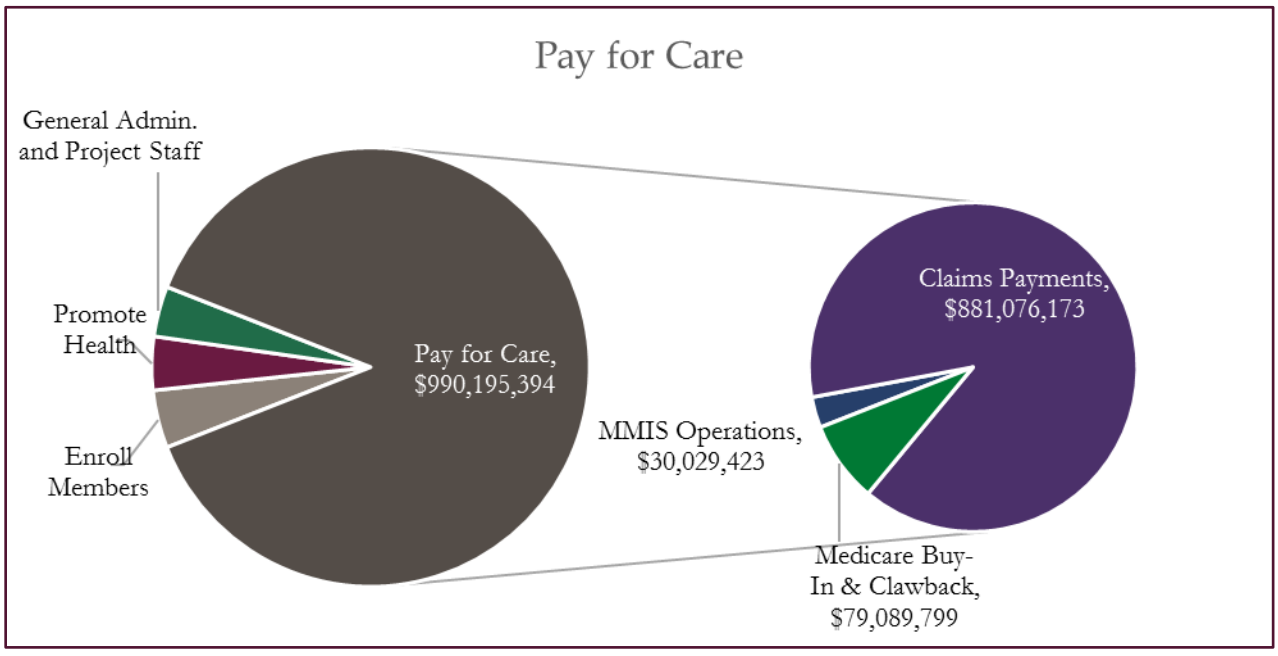
SFY 2018 Spend

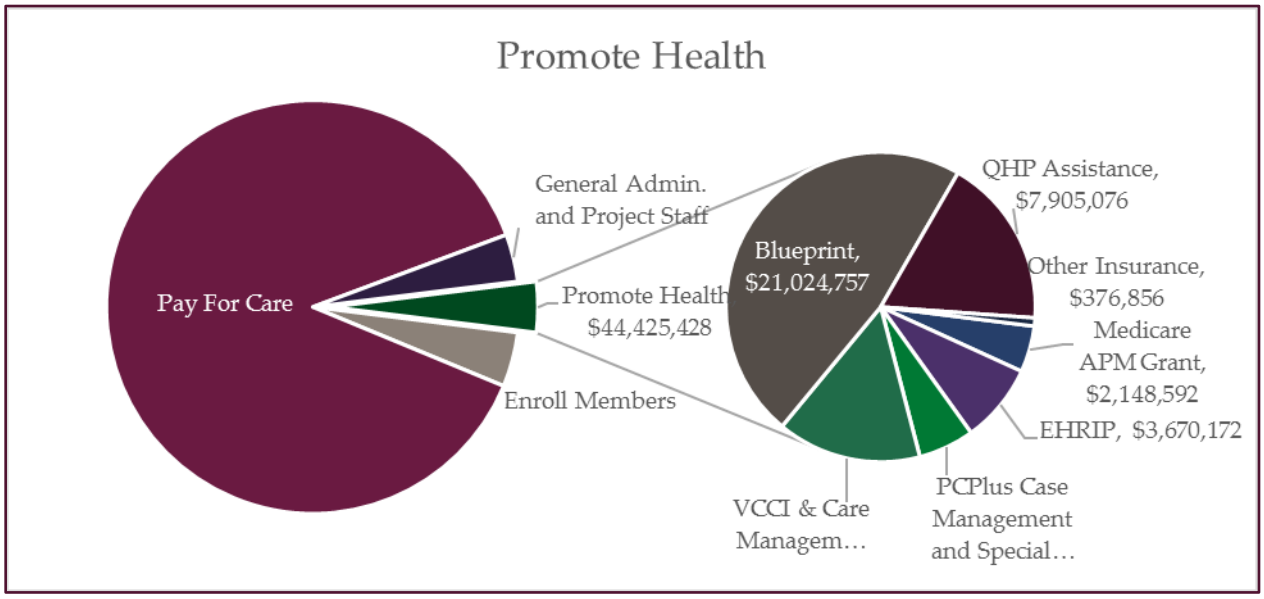
The work of DVHA revolves around three core responsibilities:

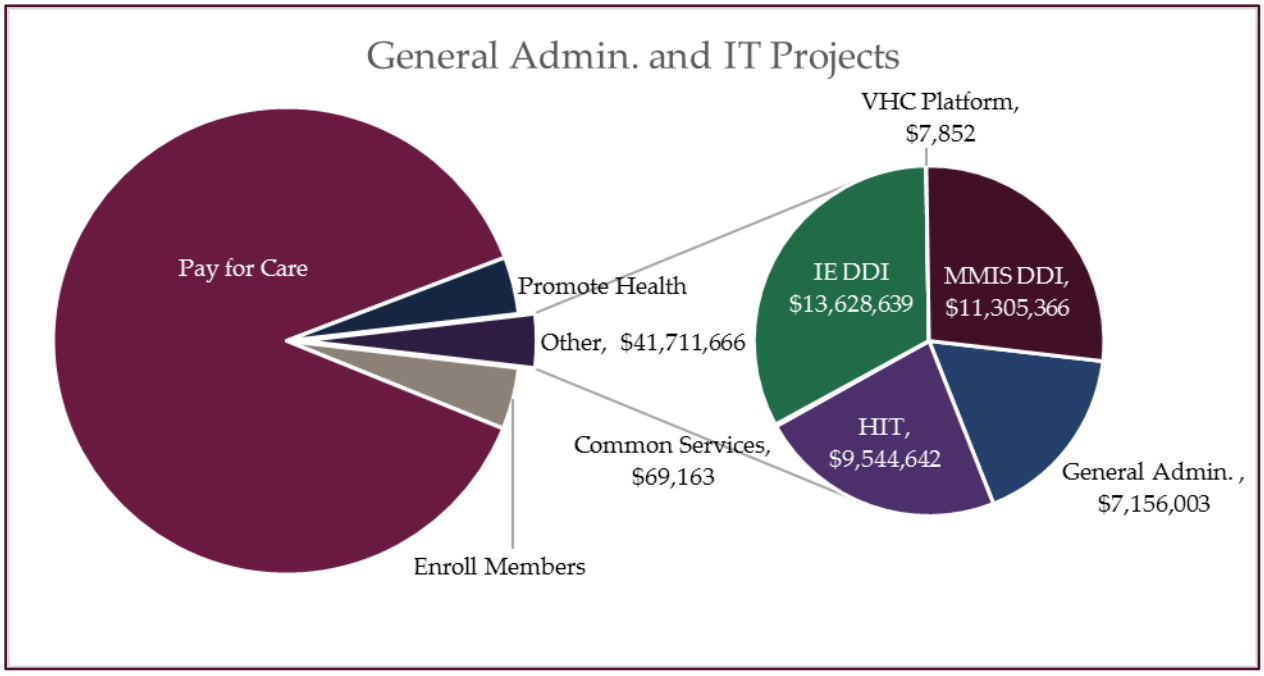
- Assisting Vermonters in need to enroll as members in appropriate programs.
- Paying for care. This work consists of building and collaborating with a robust network of healthcare providers, pharmacies, and others.
- Improving health outcomes. We recognize that simply signing people up will not achieve optimal outcomes at the most efficient cost, so we strategically invest in programs that improve health.

The charts below reflect DVHA's SFY 2018 of $1,124,333,871 spend as it falls into our priority categories.






Promote Health
Pay For Care
General Admin. and Project Staff
Promote Health $44,425,428
Enroll Members
Blueprint, $21,024,757
QHP Assistance, $7,905,076
Other Insurance, $376,856
Medicare APM Grant, $2,148,592
EHRIP, $3,670,172
PCPlus Case Management and Special…
VCCI & Care Managem…


General Admin. and IT Projects
Pay for Care
Promote Health
Other, $41,711,666
Enroll Members
VHC Platform, $7,852
IE DDI $13,628,639
MMIS DDI, $11,305,366
HIT, $9,544,642
General Admin. , $7,156,003
Common Services, $69,163

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Budget Summary Administration

	GF	SF	State Health Care Res	IdptT	FF	VT Health Connect (Portion Funded By SHCRF)	Medicaid GCF	Invmnt GCF	Total
DVHA Administration - As Passed FY19	**26,674,061**	**3,522,585**		**7,246,989**	**118,955,295**			**6,795,089**	**163,194,019**
Total after FY19 other changes	**26,674,061**	**3,522,585**	**0**	**7,246,989**	**118,955,295**	**0**	**0**	**6,795,089**	**163,194,019**
FY19 after other changes									
Personal Services:									
1. Salary	(38,370)	(8,029)			682,384	(157,101)		(64,759)	**414,125**
2. Retirement Increases	12,960	85		173	32,465	700		1,054	**47,437**
3.Other Fringe Increases	11,762	80		164	30,555	658		992	**44,211**
4. Eliminate 6 Positions	(300,000)				(300,000)				**(600,000)**
5. Transfer Change Management Staff and Admin from AHS to DVHA (AHS net-neutral)				43,422	390,792				**434,214**
6. Transfer Rate Setting from AHS to DVHA (AHS Net Neutral) Salary Fringe	436,834				436,834				**873,668**
6. Transfer Rate Setting from AHS to DVHA (AHS Net Neutral) Contracts	21,500				21,500				**43,000**
7. Wex Premium Processing for SFY 2020 (renegotiated contract)	948,300				948,300				**1,896,600**
8. E&E M&O Contract Increase	690,812				2,122,177	168,261			**2,981,250**
9. MMIS M&O Contract Increases (non-certified modules)	490,201				490,201				**980,402**
10. Reduction of SFY2019 OneCare Vermont Accountable Care Organization Quality and Health Management Measurement Improvement Investment								(1,875,000)	**(1,875,000)**
11. VHC swap				12,518		(12,518)			**0**
12. Final Phasedown of HIT Investments		643,180						(643,180)	**0**
13. HIT Fair Share FMAP change impact		1,925,242			(1,925,242)				**0**
									0
Operating Expenses:									**0**
6. Transfer Rate Setting from AHS to DVHA (AHS Net Neutral)	48,372				48,372				**96,744**
14. ADS true-up from AHSCO (AHS net-neutral)	186,473	12,965		239,336	2,776,120				**3,214,894**
15. Internal Service Fund Increases	39,412				39,412				**78,824**
Grants:									**0**
FY20 Changes	**2,548,256**	**2,573,523**	**0**	**295,613**	**5,793,870**	**0**	**0**	**(2,580,893)**	**8,630,369**
FY20 Gov Recommended	**29,222,317**	**6,096,108**	**0**	**7,542,602**	**124,749,165**	**0**	**0**	**4,214,196**	**171,824,388**
FY20 Legislative Changes									
FY20 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY20 As Passed - Dept ID 3410010000	**29,222,317**	**6,096,108**	**0**	**7,542,602**	**124,749,165**	**0**	**0**	**4,214,196**	**171,824,388**

	GF	SF	State Health Care Res	IdptT	FF	VT Health Connect (Portion Funded By SHCRF)	Medicaid GCF	Invmnt GCF	Total
DVHA Global Commitment - As Passed FY19							730,388,202		730,388,202
Total after FY19 other changes	0	0	0	0	0	0	730,388,202	0	730,388,202
FY19 after other changes									
Grants:									
16. Medicaid Consensus October 2018							4,075,981		4,075,981
16. Medicaid Consensus December 2018							1,206,717		1,206,717
17. Buy In							2,741,069		2,741,069
18. Transfer from DMH to support ABA Payment Model (AHS Net Neutral)							1,394,200		1,394,200
19. CIS from DCF (AHS Net Neutral)							262,508		262,508
19. Transfer to DCF for services moved into CIS bundle (AHS Net Neutral)							(203,709)		(203,709)
18. Tranfer to DMH to support DA Payment Reform (AHS Net Neutral)							(5,480,209)		(5,480,209)
20. ASFCME - Collective Bargaining Agreement - Year 1 (BAA item)							229,826		229,826
20. ASFCME - Collective Bargaining Agreement - Year 2							240,041		240,041
20. Other Insurance - Commercial Policy WC reduction							(106,011)		(106,011)
									0
FY20 Changes	0	0	0	0	0	0	4,360,413	0	4,360,413
FY20 Gov Recommended	0	0	0	0	0	0	734,748,615	0	734,748,615
FY20 Legislative Changes									
FY20 Subtotal of Legislative Changes	0	0	0	0	0	0	0	0	0
FY20 As Passed - Dept ID 3410015000	0	0	0	0	0	0	734,748,615	0	734,748,615
DVHA - Med Prog - LTC Waiver-As Passed FY19							204,515,915		204,515,915
Total after FY19 other changes	0	0	0	0	0	0	204,515,915	0	204,515,915
FY19 after other changes									
Traditional:									0
21. Statutory Nursing Home rebase and inflationary rate increase (from Ratesetting)							5,831,086		5,831,086
22. Nursing Home Medicaid Bed Day decrease in utilization - 23,759 days @ $210 per day							(4,989,295)		(4,989,295)
23. Home and Community Based caseload pressure 56 x $31,958							1,789,648		1,789,648
24. ASFCME - Collective Bargaining Agreement - Year 1 (BAA item)							533,145		533,145
25. ASFCME - Collective Bargaining Agreement - Year 2							556,841		556,841
26. VVH rate increase - statewide budget neutral							3,779,395		3,779,395
27. Other Insurance - Commercial Policy WC reduction							(128,206)		(128,206)
									0
FY20 Changes	0	0	0	0	0	0	7,372,614	0	7,372,614
FY20 Gov Recommended	0	0	0	0	0	0	211,888,529	0	211,888,529
FY20 Legislative Changes									
FY20 Subtotal of Legislative Changes	0	0	0	0	0	0	0	0	0
FY20 As Passed - Dept ID 3410016000	0	0	0	0	0	0	211,888,529	0	211,888,529

	GF	SF	State Health Care Res	IdptT	FF	VT Health Connect (Portion Funded By SHCRF)	Medicaid GCF	Invmnt GCF	Total
DVHA - Medicaid Program - State Only - As Passed FY19	**39,074,163**							**8,881,777**	**47,955,940**
Total after FY19 other changes	**39,074,163**	**0**	**0**	**0**	**0**	**0**	**0**	**8,881,777**	**47,955,940**
FY19 after other changes									
Grants:									
16. Medicaid Consensus October 2018	285,820							2,737,350	**3,023,170**
16. Medicaid Consensus December 2018	(6,104)								**(6,104)**
17. Buy In								(13,489)	**(13,489)**
28. Clawback	(1,747,959)								**(1,747,959)**
									0
FY20 Changes	**(1,468,243)**	**0**	**0**	**0**	**0**	**0**	**0**	**2,723,861**	**1,255,618**
FY20 Gov Recommended	**37,605,920**	**0**	**0**	**0**	**0**	**0**	**0**	**11,605,638**	**49,211,558**
FY20 Legislative Changes									
FY20 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY20 As Passed - Dept ID 3410017000	**37,605,920**	**0**	**0**	**0**	**0**	**0**	**0**	**11,605,638**	**49,211,558**
DVHA - Medicaid Matched NON Waiver Expenses - As Passed FY19	**11,400,406**				**19,944,842**				**31,345,248**
Total after FY19 other changes	**11,400,406**	**0**	**0**	**0**	**19,944,842**	**0**	**0**	**0**	**31,345,248**
FY19 after other changes									
Grants:									
16. Medicaid Consensus October 2018	33,256				152,323				**185,579**
16. Medicaid Consensus December 2018	11,427				52,342				**63,769**
17. Buy In					952,319				**952,319**
18. Transfer to DMH to support DA Payment Reform (AHS Net Neutral)	(20,042)				(91,799)				**(111,841)**
									0
FY20 Changes	**24,641**	**0**	**0**	**0**	**1,065,185**	**0**	**0**	**0**	**1,089,826**
FY20 Gov Recommended	**11,425,047**	**0**	**0**	**0**	**21,010,027**	**0**	**0**	**0**	**32,435,074**
FY20 Legislative Changes									
FY20 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY20 As Passed - Dept ID 3410018000	**11,425,047**	**0**	**0**	**0**	**21,010,027**	**0**	**0**	**0**	**32,435,074**

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Budget Considerations Administration

Salary and Fringe

DVHA is comprised of 379 positions. The three items below provide the annual increases related to these positions for Payact, retirement, and other fringe benefits.

1. Payact	$414,125 gross *($233,373) state*
2. Retirement Increases	$47,437 gross *$14,403 state*
3. Fringe Increases	$44,211 gross *$13,122state*

4. Elimination of 6 Positions	($600,000)gross *($300,000) state*

DVHA shall assess its operations for efficiencies, considering both combining and/or modifying job functions to eliminate positions thru attrition and/or vacancies.

5. Change Management & IE Admin Transfer	$434,214 gross *$43,422 state*

This AHS transfer is net-neutral. DVHA received four change management and admin positions from AHS. These positions support the two major CMS funded technology projects managed by DVHA – MMIS and IE&E. Moving these positions allows for alignment between budgeting and oversight. This request annualizes the ask in Budget Adjustment.

6. Rate Setting Unit Transfer	$1,013,412 gross *$506,706 state*

This AHS transfer is net-neutral. DVHA received eight positions transferred from AHS. The Agency of Human Services (AHS) needs the capacity to take a professional and systematic approach to setting rates and making Medicaid payments across the full continuum of health care providers and services. Medicaid Rate Setting currently exists in at least three places – DVHA's Payment Reform unit, DVHA's Reimbursement unit, and the Division of Rate Setting. The merger of the three division/units in which Medicaid rates are set would improve the odds of success in pursuing the twin goals of creating more value-based payments and creating an integrated health system. Additionally, this transfer should be beneficial for staff over the long-term. Rate setting is highly specialized, and DVHA envisions opportunities for increased professional development, cross-training, collaboration, and a career ladder for rate setting professionals. Also, the move unites the setting of nursing home rates with that spending in DVHA's budget, linking authority and accountability. This transfer includes salary and fringe, contracts, and operating expenses. This request annualizes the ask in Budget Adjustment.

7. Premium Processing Contract	$1,896,600 gross *$948,300 state*

This line item is an extension of the SFY 2019 BAA request and is one-time funding to support DVHA's plan to transition the responsibility for qualified health plan premium billing from Vermont Health Connect to insurance carriers. WEX is the State's current Maintenance and Operations (M&O) premium processing vendor for Vermont Heath Connect. The State is working collaboratively with carriers to craft a plan to transition successfully. The current target for this transition is calendar

year/plan year 2021. The decision to continue contracting with WEX in the interim will be both operationally and financially advantageous to the State. It ensures stability as the State plans for the larger premium billing transition and avoids gaps in services. In addition, the State, through renegotiation, will save money through reduced Per Member Per Month (PMPM) pricing and a reduced fixed monthly cost.

- 2018 and 2019 PMPM $3.17
- 2020 PMPM $2.50
- 2018 Base Services Fee $222,000 per month
- 2019 Base Services Fee $200,000 per month
- 2020 Base Services Fee $180,000 per month

8. E& E Maintenance and Operation Contracts

$2,981,250 gross *$859,073 state*

DVHA engages with Optum Health and other vendors to perform hosting and enhanced Maintenance and Operations (M&O) services. This request annualizes the value previously asked for during budget adjustment. As IE matures, it is anticipated that we will see decreased reliance on singular vendors.

9. MMIS Maintenance and Operation Contracts

$980,402 gross *$490,201 state*

DVHA contracts with DXC to operate our Medicaid Management Information System and provide fiscal agent services. This request annualizes the Provider Management Module enhancement previously asked for during budget adjustment. In addition, this adds $171,594 for a six month increase to the operating costs associated with the Electronic Visit Verification (EVV) system and the negotiated annual increase to the base contract. Section 12006 of the 21st Century CURES Act requires states to implement an EVV system for (1) Personal Care Services (PCS) by January 1, 2020 and (2) Home Health Care Services (HHCS) by January 1, 2023. The EVVS enables home care workers to digitally record information about the visit—specific care or services rendered—and to report changes in patient condition for follow-up. EVV work will be both less expensive than anticipated and begin later than anticipated.

10. Delivery System Reform (DSR) Investment Reduction to Base Budget

($1,875,000) gross *($937,500) state*

Vermont's ACO program runs on a calendar year to align with federal ACO programs. Each year, DVHA negotiates a set price for the care of members attributed to the ACO. The contract makes some of this price dependent on quality benchmarks and places the ACO at financial risk if overspending occurs. Also, each year thus far, DVHA has funded a limited number of DSR investments within the ACO contract, which are designed to accelerate the progress of reform as permitted by Vermont's Global Commitment to Health 1115 Medicaid Waiver. Thus far, investments included in the budget have focused on technology tools. Given the temporary nature of these investments, DVHA proposes removing the investment funding from its base budget and addressing them, if at all, on an ad hoc basis at the conclusion of the annual contracting process and, if needed, in a future Budget Adjustment Act.

11. VHC Swap

$0 gross *$0 state*

This item swaps SHCRF funding, $12,518, for the VHC, with an interdepartmental transfer (IDT).

12. Final Phasedown of the HIT Investment

$0 gross *$346,481 state*

The 2017 Global Commitment to Health Waiver renewal required the State to begin to phase down Investments to ensure that they are time-limited. DVHA began this process in January 2018, as required, and replaced 50% of the HIT Investments with HIT funds for calendar year 2018. This final phasedown replaces the final 50% of HIT Investments with HIT funds effective January 2019.

13. HIT Fair Share FMAP Change

$0 gross *$1,925,242 state*

Health Information Technology match rates are reduced when the technology is used by non-Medicaid populations. This Fair Share calculation is required by CMS and is based on the proportion of insurer coverage as compared to Medicaid coverage in Vermont. The HIT Fair Share FMAP calculation changed from ~78% federal to ~65% federal effective 10/1/2018, effectively making the HIT Fair Share contracts within the HIT fund more expensive for the State. This request annualizes the ask in Budget Adjustment.

14. ADS True-up from AHSCO (AHS net-neutral)

$3,214,894 gross *$438,774 state*

There is a transition of ADS technical staff for the Enterprise Project Management Office (EPMO)for healthcare project and operations (IE, MMIS, E&E Operations, & HIE) from AHS to DVHA. This transfer moves the spending authority to support that transition. This request annualizes the ask in Budget Adjustment.

15. Internal Service Fund Increase

$78,824 gross *$39,412 state*

DVHA receives allocations from Department of Buildings and General Services (BGS) to cover our share of VISION system and fee-for-space, Agency of Digital Services (ADS) costs, and Department of Human Resources (DHR) costs. Departments are notified annually of increases or decreases and the department's relative share to incorporate into the budget request. The amount above reflects the net change to the DVHA operations budget for these costs.

16. Medicaid Caseload & Utilization Changes

$8,549,112 gross *$4,024,047 state*

By statute, Vermont uses a consensus process to forecast Medicaid caseload and spending. This program spending is based on projected enrollment, utilization of services, and the price of those services. The consensus forecast proceeded in two steps this year. The forecast group made enrollment adjustments in October 2018 and PMPM cost adjustments in December 2018. These two adjustments are shown as two distinct rows in the ups/downs document. Generally, as compared to SFY 2018 actuals, caseload is down and utilization and price pressures are up, increasing our PMPM.

Overall, program costs are changing due to multiple factors:

- Declining enrollment: 0.91% reduction in Adults as compared to SFY 2018 actuals and 0.34% reduction in children.
- Changes to MEG enrollment: Individuals that were previously ABD with a higher PMPM are now classified as New or General Adults.
- Increases to utilization of healthcare services: 1.4% increase in utilization per member as compared to SFY 2018. This increase in utilization is offsetting the decline in enrollment.
- Hepatitis C utilization
- Brattleboro Retreat Rate Increase: $3.5M rate increase
- Non-Emergency Transportation increase: $2.175M rate increase
- Professionalize DME fee schedule
- Reset VPharm Rebate expectations ongoing: $3M less in State Only rebates per year
- Federally mandated increases for FQHCs/RHCs $2.2M more in reimbursements for SFY 2019.

17. Buy-In Adjustment

$3,679,899 gross *$1,258,233 state*

The federal government allows for states to use Medicaid dollars to "buy-in" to Medicare on behalf of dually eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload and member month costs vary from year to year. This change incorporates a rate increase and trend in member months. DVHA experienced an increase to Buy-In enrollment as a result of progress correcting and updating the eligibility files exchanged between CMS and DVHA.

The Medicare Buy-in Programs help people with a low income pay their Medicare premium. There are three distinct Buy-in programs and each has different eligibility requirements:

- *Qualified Medicare Beneficiary* (QMB)– Individuals who qualify for QMB are eligible to have Medicaid pay for Medicare Premiums for Parts A and B, Medicare deductibles, and Medicare coinsurance within the prescribed limits.

- *Special Low-Income Medicare Beneficiary* (SLMB)-Individuals who are eligible for SLMB are eligible to have Medicaid pay Medicare directly for Medicare premiums for Part B.

- *Qualified Individuals* (QI-1)-Individuals who are eligible for QI1 are eligible to have Medicaid pay Medicare directly for Medicare premiums for Part B. The income limits are higher than SLMB and payment is only guaranteed through the end of the year the application was made. This is the only Medicaid benefit.

This request is an annualization of the Budget Adjustment request.

18. DMH Interdepartmental Transfer ($4,197,850) gross *($1,904,918) state*

DVHA is engaged in a variety of payment reform projects. This transfer supports two initiatives, DA Payment Reform and Applied Behavior Analysis Payment Reform. Overall, payment reform is intended to pursue the twin goals of making more value- based payments and creating a more integrated system of care across the care continuum. Both items are an annualization of the Budget Adjustment request.

The Applied Behavioral Analysis (ABA) Payment Reform project seeks to create bundled payments that incentivize appropriate clinical treatment and accessibility to services for autism supports. It is scheduled for implementation in January 2019. This transfer effectively reverses the previous transfers from DVHA to DMH that included ABA services in NCSS's IFS case rate.

ABA Transfer from DMH: $1,394,200 gross

In addition to the ABA payment report project, DVHA and DMH have implemented a payment reform project for Designated Agencies in January 2019. This is in the form of a prospective alternative payment and effectively combines DVHA and DMH spending for similar services.

Designated Agency Transfer to DMH: ($5,592,050) gross

19. DCF Interdepartmental Transfer $58,799 gross *$27,124 state*

This item relates to a transfer into DVHA from DCF and a transfer to DCF from DVHA. These items are an annualization of items previously requested in Budget Adjustment.

DCF eliminated two contracts because the autism and deaf child services they were covering are Medicaid eligible and can be direct billed by the provider. $262,508 gross

Washington County Youth Services Bureau will be a bundled CIS provider effective 01/01/2019. DVHA is transferring fund for formerly direct billed services to DCF. **($203,710)** gross

20. Collective Bargaining Agreement Changes $363,856 gross *$167,847 state*

In 2013 the Vermont Legislature passed Act 48, authorizing collective bargaining agreements (CBA) between independent direct support providers and the State of Vermont. The DVHA funded Children's personal care attendant providers are included in the CBA. The amounts referenced above are for CY Year 1 & 2 increases as determined by the agreement.

- ASFCME – Collective Bargaining Agreement Yr. 1 $229,826 gross
- ASFCME – Collective Bargaining Agreement Yr. 2 $240,041 gross
- Commercial Policy Worker's Compensation Reduction ($106,011) gross

Choices for Care Changes Decision Items $7,372,614 gross *$3,400,987 state*

DVHA reimburses providers for the Choices for Care (CFC) services, but DAIL is responsible for managing the long-term care component. DAIL is implementing the following changes and DVHA defers to DAIL for an explanation of each of the changes:

21. Statutory Nursing Home rebase and inflationary rate increase (from Rate Setting)
22. Nursing Home Medicaid Bed Day decrease in utilization - 23,759 days @ $210 per day
23. Home and Community Based caseload pressure 56 x $31,958
24. ASFCME - Collective Bargaining Agreement - Year 1 (BAA item)
25. ASFCME - Collective Bargaining Agreement - Year 2
26. VVH rate increase - statewide budget neutral
27. Other Insurance - Commercial Policy WC reduction

28. "Clawback" Enrollment Decrease ($1,747,959) gross *($1,747,959) state*

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which established the Medicare Part D prescription drug program, eliminated Medicaid prescription drug coverage for people dually eligible for Medicare and Medicaid (duals), and required all duals to receive their drug coverage through a Medicare Part D plan. This reduced state costs; however, MMA also required states to reimburse the federal government for costs associated with the transfer of prescription drug coverage for this population from state Medicaid programs to Medicare.

Since the implementation of the Affordable Care Act, DVHA has seen a marked decline in the number of VPharm Enrollees. Part D members who have high prescription drug expenses currently must pay more once the total cost of their medicines reaches a certain threshold. That's due to an aspect of Part D called the coverage gap, also known as the "donut hole".

The donut hole has been narrowing each year since the Affordable Care Act (ACA) was passed in 2010. Beginning in 2019, Part D enrollees will pay 25 percent of the cost of all their prescription drugs from the time they enter the gap until they reach catastrophic coverage. The narrowing of the donut hole, results in fewer members needing the wrapped benefit of VPharm. DVHA's Clawback enrollment has dropped 7% from a high of 21,347 (Oct 2015) to a current (June 2018) 19,825.
This item is an annualization of the Budget Adjustment request.

Categories of Service

COS	Actual SFY '18	BAA SFY '19	2019 AP-2019 BAA % Change	Gov. Rec. SFY '20	2019 GR-2019 BAA % Change	5-Yr. Avg. Growth % Chg.	5-Yr. Total Change	10-Yr. Avg. Growth % Chg.	10-Yr. Total Change
Inpatient	127,383,519	124,819,395	-13.56%	118,747,290	-4.86%	-1.73%	(12,082,152)	7.72%	62,748,256
Outpatient	103,305,241	86,077,539	-31.24%	79,128,023	-8.07%	0.58%	(2,503,914)	5.01%	35,486,087
Physician	107,441,393	100,341,117	-17.74%	94,835,316	-5.49%	-3.20%	(20,516,860)	5.81%	38,730,988
Pharmacy	192,560,973	195,070,893	-3.27%	193,606,581	-0.75%	6.64%	50,073,574	5.81%	80,154,748
Nursing Home	123,548,028	131,879,402	2.23%	133,239,635	1.03%	1.22%	7,097,401	0.69%	7,905,193
Mental Health Facility	483,992	530,455	51.36%	537,511	1.33%	10.84%	52,829	16.21%	241,534
Dental	27,362,187	31,233,996	9.92%	31,631,624	1.27%	6.67%	7,166,626	5.94%	11,381,716
MH Clinic	860,488	1,015,198	350.96%	880,450	-13.27%	85.79%	766,560	122.27%	805,326
Independent Lab/Xray	13,797,691	15,339,388	21.28%	15,014,176	-2.12%	27.20%	7,998,895	21.09%	10,330,079
Home Health	6,940,779	7,630,714	8.17%	7,669,859	0.51%	1.53%	483,218	1.06%	627,708
RHC	6,398,735	5,045,357	-32.68%	4,474,526	-11.31%	6.30%	1,505,816	2.46%	967,574
Hospice	8,760,170	9,275,575	61.39%	9,375,572	1.08%	48.00%	7,403,779	25.77%	7,438,214
FQHC	30,145,922	35,280,302	22.42%	35,672,717	1.11%	9.98%	11,097,850	13.29%	21,142,546
Chiropractor	1,243,186	1,492,307	15.80%	1,512,226	1.33%	9.48%	423,508	184.70%	1,192,829
Nurse Practitioner	802,194	885,240	6.91%	884,603	-0.07%	-3.06%	(170,671)	5.86%	294,510
Skilled Nursing	2,973,334	2,941,246	27.42%	2,938,166	-0.10%	0.74%	66,892	0.61%	69,776
Podiatrist	212,071	243,740	6.74%	245,913	0.89%	-8.82%	(136,787)	-0.08%	(25,994)
Psychologist	27,626,234	30,035,669	12.66%	28,191,830	-6.14%	8.35%	8,895,917	7.49%	13,975,455
Optometrist	2,202,913	2,565,238	9.83%	2,596,345	1.21%	10.01%	800,897	10.13%	1,329,170
Optician	195,144	218,534	12.35%	221,344	1.29%	1.28%	10,972	-1.61%	(42,161)
Transportation	12,278,749	16,031,838	26.28%	16,139,491	0.67%	3.25%	1,659,475	1.67%	1,615,453
Therapy Services	7,383,176	8,672,412	32.19%	8,655,279	-0.20%	19.35%	4,290,233	16.97%	5,752,694
Prosthetic/Ortho	3,718,505	4,216,312	12.84%	4,226,444	0.24%	5.81%	879,988	7.96%	1,934,364
Medical Supplies	2,730,341	2,630,489	48.17%	2,645,219	0.56%	27.93%	1,908,087	15.66%	2,014,644
DME	7,228,239	7,945,891	10.13%	7,938,646	-0.09%	-1.14%	(707,152)	2.30%	1,116,418
H&CB Services	64,394,582	67,682,694	1.80%	69,229,834	2.29%	6.33%	16,938,509	4.00%	20,540,982
H&CB Services Mental Service	1,148,788	1,282,135	69.98%	1,298,151	1.25%	19.53%	650,617	9.28%	554,397
Enhanced Resident Care	9,700,162	9,706,685	1.03%	9,605,556	-1.04%	6.51%	2,606,114	3.77%	2,803,821
Personal Care Services	11,389,927	11,841,585	-3.08%	11,945,034	0.87%	-11.06%	(9,328,962)	-3.21%	(5,449,282)
Targeted Case Management (Drug)	146,809	128,448	67.57%	118,879	-7.45%	21.04%	61,563	489.41%	144,895
Assistive Community Care	13,475,129	14,113,902	3.16%	14,198,823	0.60%	0.40%	240,744	2.04%	2,428,754
Day Treatment MHS	40,600	45,325	0.00%	45,924	1.32%	-60.76%	40,108	-44.86%	(17,522)
OADAP Families in Recovery	3,798,193	4,526,634	30.02%	4,579,142	1.16%	143.92%	3,622,048	100.05%	3,718,429
Rehabilitation	371,270	388,609	-27.81%	388,111	-0.13%	2028.58%	363,975	1003.97%	328,601
D & P Dept of Health	271,258	306,833	13.87%	310,496	1.19%	-15.79%	(797,498)	-17.74%	(3,399,987)
PcPlus Case Mgmt and Special Program Pa	2,597,178	1,095,510	-49.62%	121	-99.99%	3.15%	(2,094,540)	1.17%	(2,487,413)
Blue Print & CHT Payments	16,178,009	17,374,107	30.07%	18,703,112	7.65%	36.81%	12,183,157	154.86%	16,178,009
ACO Capitation	67,972,230	95,240,425	345.18%	118,148,213	24.05%	-13.39%	63,464,458	19.09%	67,056,742
Other Premiums (CSR)	1,570,896	1,520,434	6.53%	1,314,872	-13.52%	55.34%	1,570,896	17.67%	1,570,896
Cat, ESI, &VHAP ESI Premiums (VPA)	6,334,180	6,613,796	-7.02%	6,913,914	4.54%	-16.87%	(49,532,611)	25.75%	(2,259,749)
Ambulance	7,049,332	8,084,212	24.00%	7,789,708	-3.64%	13.19%	3,083,728	11.50%	4,534,930
Dialysis	1,139,557	1,009,973	-29.62%	947,856	-6.15%	2.40%	52,091	36.68%	569,872
ASC	76,714	83,581	33.73%	84,560	1.17%	8.86%	24,032	59.03%	70,617
Miscellaneous and Gearwar	6,722,404	260,881	-61.86%	264,066	1.22%	549.12%	6,515,256	276.74%	6,179,758
Provider Non Classified	(1,360,980)	(1,654,227)	80.83%	(1,674,529)	1.23%	24.42%	(626,126)	129.95%	(1,113,308)
Clawback	33,888,772	34,565,706	-5.71%	34,912,199	1.00%	5.58%	7,917,094	7.06%	13,549,518
DSH	27,448,780	22,704,471	0.00%	22,704,471	0.00%	-5.34%	(10,000,001)	-4.89%	(21,555,118)
HIV Insurance Fund F	4,085	8,421	0.00%	8,421	0.00%	-34.08%	(35,795)	-17.87%	(39,828)
Legal Aid	547,983	547,983	0.00%	547,983	0.00%	2.10%	45,665	1.71%	71,151
Buy-In	43,834,747	43,834,259	8.15%	44,210,300	0.86%	6.05%	11,039,393	5.18%	17,000,068
PDP Premium	1,366,280	2,211,757	-23.51%	2,160,837	-2.30%	-2.72%	(208,333)	-2.40%	(521,888)
HIPPS	372,770	402,529	1.50%	403,616	0.27%	-0.76%	(28,197)	-37.90%	402,043
Drug Rebates	(130,896,504)	(118,211,859)	-0.20%	(122,466,714)	3.60%	15.03%	(62,200,604)	16.87%	(100,399,605)
ACA Rebates	(3,620,344)	(2,819,171)	0.00%	(2,819,171)	0.00%	-3.32%	832,915	-2.17%	(3,620,344)
Drug Rebate Interest	(51,483)	(56,446)	324.09%	(58,064)	2.87%	188.34%	(45,521)	90.59%	(51,483)
Supplemental Drug Rebates	(14,300,412)	(16,834,084)	64.26%	(15,006,426)	-10.86%	13.57%	(6,123,255)	12.60%	(8,981,969)
Cost Settlements	3,314,750	3,350,433	-44.19%	3,376,344	0.77%	26.29%	1,512,794	23.26%	4,182,833
TPL - All	(5,297,895)	(4,869,445)	53.63%	(4,910,649)	0.85%	6.64%	(1,092,042)	1.27%	464,053
Grand Total of All Expenditures	**987,210,970**	**1,025,904,341**	**1.15%**	**1,028,283,776**	**0.23%**	**1.45%**	**67,116,984**	**4.05%**	**318,384,407**

Budget by Eligibility Group Pullout

PROGRAM EXPENDITURES

Adults	SFY '16 Actuals Enrollment	SFY '16 Actuals Expenses	SFY '16 Actuals PMPM	SFY '17 Actuals Enrollment	SFY '17 Actuals Expenses	SFY '17 Actuals PMPM	SFY '18 Actuals Enrollment	SFY '18 Actuals Expenses	SFY '18 Actuals PMPM	SFY '19 BAA Enrollment	SFY '19 BAA Expenses	SFY '19 BAA PMPM	SFY '20 Gov. Rec. Enrollment	SFY '20 Gov. Rec. Expenses	SFY '20 Gov. Rec. PMPM
Aged, Blind, or Disabled (ABD)	15,001	$ 99,308,972	$ 551.69	8,470	$ 68,865,433	$ 677.58	6,799	$ 54,818,596	$ 671.90	6,250	$ 57,191,818	$ 762.56	6,031	$ 55,637,661	$ 768.78
Dual Eligibles	20,280	$ 55,523,042	$ 228.15	17,601	$ 52,597,445	$ 249.02	17,659	$ 53,612,503	$ 253.00	17,742	$ 57,507,834	$ 270.11	17,804	$ 58,409,743	$ 273.39
General	20,101	$ 92,641,465	$ 384.07	15,140	$ 77,460,396	$ 426.37	12,664	$ 71,486,396	$ 470.40	12,958	$ 75,554,021	$ 485.89	12,867	$ 75,690,117	$ 490.21
New Adult Childless	49,888	$ 210,571,136	$ 351.74	42,327	$ 194,062,032	$ 382.07	39,967	$ 189,970,050	$ 396.10	39,248	$ 202,267,933	$ 429.47	39,273	$ 204,022,998	$ 432.92
New Adult W/Child	12,675	$ 38,150,227	$ 250.83	17,775	$ 70,043,265	$ 328.38	18,568	$ 74,119,966	$ 332.65	18,813	$ 81,007,952	$ 358.83	18,813	$ 81,593,448	$ 361.42
Subtotal Adults	117,944	$ 496,194,841	$ 350.59	101,312	$ 463,028,572	$ 380.86	95,657	$ 444,007,511	$ 386.81	95,011	$ 473,529,558	$ 415.33	94,788	$ 475,353,967	$ 417.91
Sunsetted Programs		$ 206,024			$ 186,985			$ 627,043							
Children															
Blind or Disabled (BD)	3,243	$ 27,174,573	$ 698.22	2,368	$ 23,032,607	$ 810.47	2,241	$ 20,174,102	$ 750.19	2,166	$ 20,395,140	$ 784.67	2,112	$ 20,144,940	$ 794.86
General	63,301	$ 151,736,910	$ 199.75	60,114	$ 153,917,906	$ 213.37	59,821	$ 156,825,223	$ 218.46	59,811	$ 155,918,142	$ 217.24	59,708	$ 156,718,655	$ 218.73
Underinsured	826	$ 1,186,527	$ 119.66	845	$ 1,095,901	$ 108.14	601	$ 515,180	$ 71.43	584	$ 502,278	$ 71.67	584	$ 509,190	$ 72.66
SCHIP (Uninsured)	4,499	$ 7,025,792	$ 130.15	5,142	$ 7,893,710	$ 127.94	4,667	$ 8,323,354	$ 148.62	4,697	$ 8,362,970	$ 148.37	4,697	$ 8,433,289	$ 149.62
Subtotal Children	71,870	$ 187,123,801	$ 216.97	68,468	$ 185,940,124	$ 226.31	67,330	$ 185,837,860	$ 230.01	67,258	$ 185,178,529	$ 229.44	67,101	$ 185,806,074	$ 230.75
Pharmacy Only Programs	11,593	$ 2,302,437	$ 16.55	11,399	$ 3,155,724	$ 23.07	10,717	$ 4,588,899	$ 35.68	10,497	$ 11,278,883	$ 89.54	10,125	$ 7,614,529	$ 62.67
Choices for Care															
Nursing Home, Home & Community Based, E	4,256	$ 186,796,298	$ 3,657.29	4,290	$ 194,689,010	$ 3,781.69	4,232	$ 197,448,652	$ 3,888.01	4,390	$ 209,074,560	$ 3,968.77	4,390	$ 211,888,529	$ 4,022.18
Acute-Care Services ~ DVHA	4,256	$ 26,318,814	$ 515.30	4,290	$ 28,083,820	$ 545.51	4,232	$ 27,628,248	$ 544.03	4,390	$ 28,306,765	$ 537.33	4,390	$ 28,267,538	$ 536.59
Acute-Care Services ~ Other Depts.	4,256	$ -	$ -	4,290	$ -	$ -	4,232	$ -	$ -	4,390	$ -	$ -	4,390	$ -	$ -
Buy-In		$ 2,869,715			$ 3,379,492			$ 3,562,365			$ 3,457,915			$ 3,886,884	
Subtotal Choices for Care*	4,256	$ 215,984,826	$ 4,228.78	4,290	$ 226,152,323	$ 4,392.84	4,232	$ 228,639,264	$ 4,502.19	4,390	$ 240,839,240	$ 4,571.74	4,390	$ 244,042,951	$ 4,632.55
QHP Assistance															
Premium Assistance	14,893	$ 5,266,242	$ 29.47	17,961	$ 6,100,378	$ 28.30	18,275	$ 6,334,440	$ 28.88	19,085	$ 6,614,098	$ 28.88	19,951	$ 6,914,219	$ 28.88
Cost Sharing	5,340	$ 1,186,720	$ 18.52	5,816	$ 1,355,318	$ 19.42	6,141	$ 1,570,896	$ 21.32	5,309	$ 1,520,434	$ 23.87	4,052	$ 1,314,872	$ 27.04
Subtotal QHP Assistance	$ 14,893	$ 6,452,962	$ 36.11	$ 17,961	$ 7,455,696	$ 34.59	$ 18,275	$ 7,905,336	$ 36.05	$ 19,085	$ 8,134,532	$ 35.52	$ 19,951	$ 8,229,091	$ 34.37
Subtotal Direct Services	**220,556**	**$ 908,264,892**	**$ 4,118.07**	**203,430**	**$ 885,919,423**	**$ 4,354.90**	**196,211**	**$ 871,605,912**	**$ 4,442.19**	**196,241**	**$ 918,960,743**	**$ 4,682.82**	**196,355**	**$ 921,046,612**	**$ 4,690.72**
Miscellaneous Program															
Medicare ACO		$ -			$ 3,148,191			$ 2,203,217							
Refugee	1	$ 111,042	$ 9,253.54	1	$ 8,380	$ 523.74	2	$ 4,135	$ 172.30	1	$ 6,285	$ 523.73	1	$ 6,285	$ 523.73
ACA Rebates		$ (3,793,338)			$ (3,758,894)			$ (3,620,344)			$ (2,819,171)			$ (2,819,171)	
HIV	120	$ 8,484	$ 5.90	143	$ 7,001	$ 4.08	161	$ 4,085	$ 2.11	172	$ 8,421	$ 4.08	188	$ 8,421	$ 3.73
Civil Unions		$ 601,912			$ -			$ -			$ -			$ -	
Underinsured		$ 8,112,696			$ 8,682,104			$ 7,933,373			$ 11,553,560			$ 11,553,560	
DSH		$ 37,448,781			$ 37,448,780			$ 27,448,780			$ 22,704,471			$ 22,704,471	
Clawback		$ 29,011,845			$ 31,738,186			$ 33,888,772			$ 34,565,706			$ 34,912,199	
Buy-In ~ GC		$ 30,475,367			$ 33,855,164			$ 35,999,728			$ 36,149,997			$ 36,168,170	
Buy-In ~ Investments/State Only		$ (64,963)			$ 53,552			$ 30,686			$ 40,525			$ 50,969	
Buy-In ~ Federal Only		$ 3,961,756			$ 4,202,611			$ 4,241,969			$ 4,185,822			$ 4,104,278	
Legal Aid		$ 547,983			$ 547,983			$ 547,983			$ 547,983			$ 547,983	
Misc. Pymts.		$ (1,641)			$ 3,499,372			$ 6,922,674			$ -			$ -	
Healthy Vermonters Program	4,059	$ -	n/a	3,381	$ -	n/a	1,547	$ -	n/a	1,256	$ -	n/a	1,006	$ -	n/a
Subtotal Miscellaneous Program	**4,180**	**$ 106,419,926**		**3,525**	**$ 119,432,429**		**1,710**	**$ 115,605,058**		**1,429**	**$ 106,943,598**		**1,195**	**$ 107,237,164**	
TOTAL PROGRAM EXPENDITURES	**224,736**	**$ 1,014,684,817**		**206,955**	**$ 1,005,351,851**		**197,921**	**$ 987,210,970**		**197,670**	**$ 1,025,904,341**		**197,550**	**$ 1,028,283,776**	

ADMINISTRATIVE EXPENDITURES	SFY '16 Actuals Enrollment	SFY '16 Actuals Expenses	SFY '17 Actuals Enrollment	SFY '17 Actuals Expenses	SFY '18 Actuals Enrollment	SFY '18 Actuals Expenses	SFY '19 BAA Enrollment	SFY '19 BAA Expenses	SFY '20 Gov. Rec. Enrollment	SFY '20 Gov. Rec. Expenses
General		**$ 4,867,436**		**$ 5,606,638**		**$ 5,268,226**		**$ 5,426,272**		**$ 5,410,869**
Medicaid Operations		**$ 28,373,173**		**$ 30,344,422**		**$ 30,041,542**		**$ 35,747,554**		**$ 35,970,944**
Eligibility & Enrollment Ops.		**$ 21,196,356**		**$ 55,641,885**		**$ 48,001,382**		**$ 53,879,232**		**$ 53,879,232**
Blueprint & Care Management		**$ 9,787,515**		**$ 9,134,415**		**$ 11,549,545**		**$ 11,283,581**		**$ 11,283,581**
IT Projects		**$ 130,196,551**		**$ 49,130,591**		**$ 42,262,205**		**$ 65,791,335**		**$ 65,279,761**
Total Administrative Expenses		**$ 194,421,031**		**$ 149,857,951**		**$ 137,122,901**		**$ 172,127,975**		**$ 171,824,388**
TOTAL ALL EXPENDITURES	**224,736**	**$ 1,209,105,848**	**206,955**	**$ 1,155,209,802**	**197,921**	**$ 1,124,333,871**	**197,670**	**$ 1,198,032,316**	**197,550**	**$ 1,200,108,164**

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Budget by Eligibility Group Funding Pullout

PROGRAM EXPENDITURES

	SFY '19 As Passed		SFY '19 BAA		SFY '20 Gov. Rec.		Funding Description
Adults	Expenses	General Funds	Expenses	General Funds	Expenses	General Funds	
Aged, Blind, or Disabled (ABD)	$ 65,793,951	$ 30,403,385	$ 57,191,818	$ 26,428,339	$ 55,637,661	$ 25,665,653	Global Commitment Funded (GC)
Dual Eligibles	$ 53,627,621	$ 24,781,324	$ 57,507,834	$ 26,574,370	$ 58,409,743	$ 26,944,415	Global Commitment Funded (GC)
General	$ 72,192,004	$ 33,359,925	$ 75,554,021	$ 34,913,513	$ 75,690,117	$ 34,915,851	Global Commitment Funded (GC)
New Adult Childless	$ 195,593,587	$ 18,151,085	$ 202,267,933	$ 18,770,464	$ 204,022,998	$ 17,341,955	Enhanced for Childless New Adults ~ General Funds
New Adult W/Child	$ 84,329,765	$ 38,968,784	$ 81,007,952	$ 37,433,775	$ 81,593,448	$ 37,639,058	Global Commitment Funded (GC) ~ General Funds
Subtotal Adults	$ 471,536,928	$ 145,664,502	$ 473,529,558	$ 144,120,461	$ 475,353,967	$ 142,506,931	
Sunsetted Programs							
Children							
Blind or Disabled (BD)	$ 24,411,851	$ 11,280,716	$ 20,395,140	$ 9,424,594	$ 20,144,940	$ 9,292,861	Global Commitment Funded (GC)
General	$ 155,075,053	$ 71,660,182	$ 155,918,142	$ 72,049,773	$ 156,718,655	$ 72,294,316	Global Commitment Funded (GC)
Underinsured	$ 1,130,829	$ 522,556	$ 502,278	$ 232,103	$ 509,190	$ 234,889	Global Commitment Funded (GC)
SCHIP (Uninsured)	$ 8,295,782	$ 775,656	$ 8,362,970	$ 781,938	$ 8,433,289	$ 1,510,402	Title XXI Enhanced
Subtotal Children	$ 188,913,515	$ 84,239,110	$ 185,178,529	$ 82,488,408	$ 185,806,074	$ 83,332,468	
Pharmacy Only Programs	$ 6,134,624	$ 6,134,624	$ 11,278,883	$ 7,103,494	$ 7,614,529	$ 3,520,619	Mixture of Global Commitment Funding (GC) and General Funds
Choices for Care							
Nursing Home, Home & Community Based, ERC	$ 204,515,915	$ 94,506,804	$ 209,074,560	$ 96,613,354	$ 211,888,529	$ 97,744,178	Global Commitment Funded (GC)
Acute-Care Services ~ DVHA	$ 28,109,593	$ 12,989,443	$ 28,306,765	$ 13,080,556	$ 28,267,538	$ 13,039,815	Global Commitment Funded (GC)
Acute-Care Services ~ Other Depts.	$ -	$ -	$ -	$ -	$ -	$ -	Global Commitment Funded (GC)
Buy-In	$ 3,457,915	$ 1,597,903	$ 3,457,915	$ 1,597,903	$ 3,886,884	$ 1,793,019	Global Commitment Funded (GC)
Subtotal Choices for Care*	$ 236,083,423	$ 109,094,150	$ 240,839,240	$ 111,291,813	$ 244,042,951	$ 112,577,013	
Premium Assistance	$ 7,112,797	$ 3,286,824	$ 6,614,098	$ 3,056,375	$ 6,914,219	$ 3,189,529	Global Commitment Funded (GC)
Cost Sharing	$ 1,427,176	$ 1,427,176	$ 1,520,434	$ 1,520,434	$ 1,314,872	$ 1,314,872	General Funds @ 100%
Subtotal Adults	$ 8,539,973	$ 4,714,000	$ 8,134,532	$ 4,576,809	$ 8,229,091	$ 4,504,401	
Subtotal Direct Services	**$ 911,208,462**	**$ 349,846,385**	**$ 918,960,743**	**$ 349,580,985**	**$ 921,046,612**	**$ 346,441,433**	
Miscellaneous Program							
Medicare ACO							Federally Funded @ 100%
Refugee	$ 6,285	$ -	$ 6,285	$ -	$ 6,285	$ -	Federally Funded @ 100%
ACA Rebates	$ (2,819,171)	$ -	$ (2,819,171)	$ -	$ (2,819,171)	$ -	Federally Funded @ 100%
HIV	$ 8,421	$ 3,891	$ 8,421	$ 3,891	$ 8,421	$ 3,885	Investments: Global Commitment Funded (GC)
Civil Unions	$ -	$ -	$ -	$ -	$ -	$ -	N/A
Underinsured	$ 8,816,210	$ 4,073,971	$ 11,553,560	$ 5,338,900	$ 11,553,560	$ 5,329,657	Investments: Global Commitment Funded (GC)
DSH	$ 22,704,471	$ 10,491,736	$ 22,704,471	$ 10,491,736	$ 22,704,471	$ 10,473,572	Global Commitment Funded (GC)
Clawback	$ 36,660,158	$ 36,660,158	$ 34,565,706	$ 34,565,706	$ 34,912,199	$ 34,912,199	General Funds @ 100%
Buy-In ~ GC	$ 33,856,070	$ 15,644,890	$ 36,149,997	$ 16,704,914	$ 36,168,170	$ 16,684,377	Global Commitment Funded (GC)
Buy-In ~ Investments/State Only	$ 64,458	$ 29,786	$ 40,525	$ 18,726	$ 50,969	$ 23,512	Investments: Global Commitment Funded (GC)
Buy-In ~ Federal Only	$ 3,151,959	$ -	$ 4,185,822	$ -	$ 4,104,278	$ -	Federally Funded @ 100%
Legal Aid	$ 547,983	$ 253,223	$ 547,983	$ 253,223	$ 547,983	$ 252,785	Global Commitment Funded (GC)
Misc. Pymts.	$ -	$ -	$ -	$ -	$ -	$ -	Global Commitment Funded (GC)
Healthy Vermonters Program	$ -	$ -	$ -	$ -	$ -	$ -	
Subtotal Miscellaneous Program	**$ 102,996,843**	**$ 67,157,654.44**	**$ 106,943,598**	**$ 67,377,096.34**	**$ 107,237,164**	**$ 67,679,986.34**	
TOTAL PROGRAM EXPENDITURES	**$ 1,014,205,305**	**$ 417,004,040**	**$ 1,025,904,341**	**$ 416,958,081**	**$ 1,028,283,776**	**$ 414,121,419**	

	SFY '19 As Passed		SFY '19 BAA		SFY '20 Gov. Rec.		Funding Description
ADMINISTRATIVE EXPENDITURES	Expenses	State Funds	Expenses	State Funds	Expenses	State Funds	
General	$ 5,426,272	$ 2,653,281	$ 5,426,272	$ 2,653,281	$ 5,410,869	$ 2,176,362	Federally Funded @ 50%
Medicaid Operations	$ 33,977,130	$ 10,744,616	$ 35,747,554	$ 11,908,828	$ 35,970,944	$ 11,780,935	Federally Funded @ 75% for certified systems - @ 50% for non-certified systems and staffing
Eligibility & Enrollment Ops.	$ 49,001,382	$ 15,080,168	$ 53,879,232	$ 16,887,541	$ 53,879,232	$ 16,899,607	Most is Federally Funded @ 75% for systems and staffing
Blueprint & Care Management	$ 11,283,581	$ 4,440,788	$ 11,283,581	$ 4,440,788	$ 11,283,581	$ 4,440,788	Most is Federally Funded @ 50%
IT Projects	$ 63,505,653	$ 7,922,327	$ 65,791,335	$ 7,671,238	$ 65,279,761	$ 9,670,433	Most is Federally Funded @ 90%
Total Administrative Expenses	**$ 163,194,019**	**$ 40,841,180**	**$ 172,127,975**	**$ 43,561,676**	**$ 171,824,388**	**$ 44,968,125**	
TOTAL ALL EXPENDITURES	**$ 1,177,399,324**	**$ 457,845,220**	**$ 1,198,032,316**	**$ 460,519,757**	**$ 1,200,108,164**	**$ 459,089,544**	

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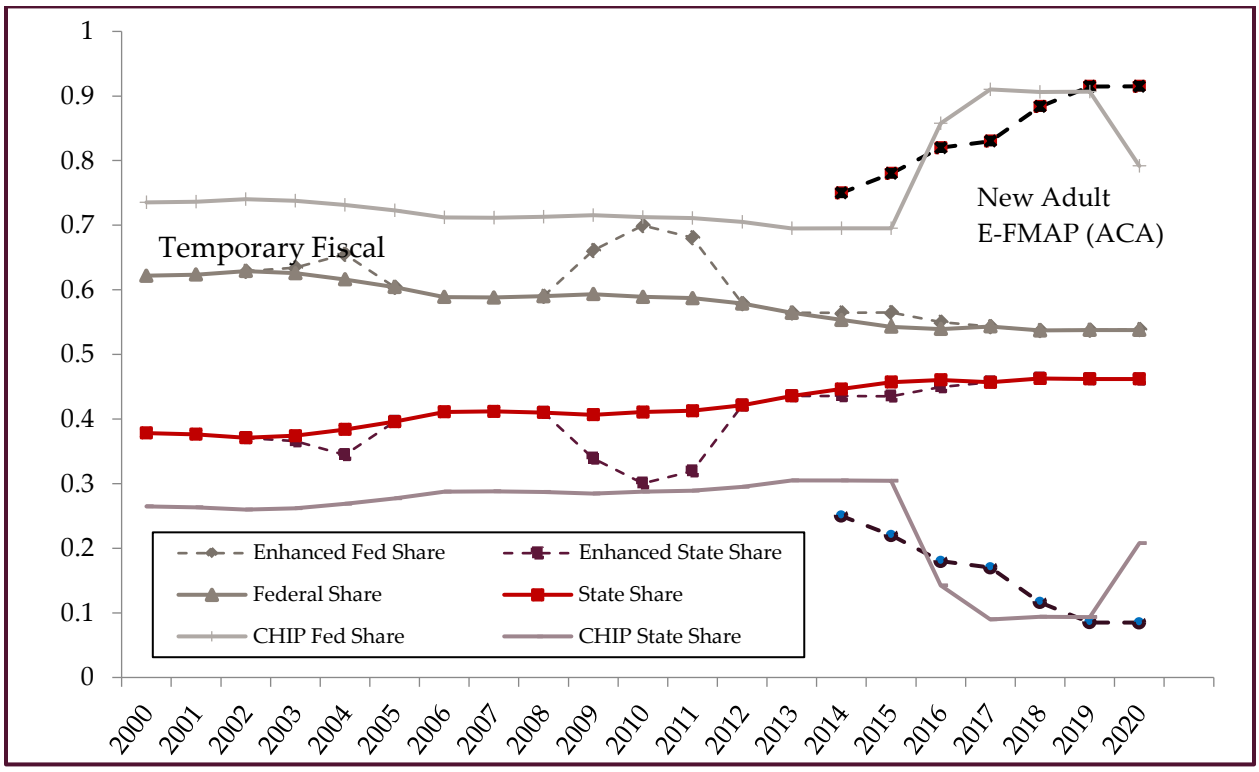
Federal Medical Assistance Percentage (FMAP)

The FMAP is the share of state Medicaid benefit costs paid by the federal government. 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. States can't receive less than 50% or more than 83% federal match, except for "enhanced FMAPs" for expansion populations under the ACA and for the Children's Health Insurance Program (CHIP).

Vermont Medicaid & CHIP, SFY 2000 - 2019



Vermont Medicaid & CHIP Detail, SFY 2018 – 2020

FEDERAL MATCH RATES
Fiscal Years 2018 to 2020

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

Federal Fiscal Year							State Fiscal Year						
FFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share	SFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share
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%
2019	10/01/18	09/30/19	53.89%		53.89%	46.11%	2019	7/1/2018	6/30/2019	53.79%		53.79%	46.21%
2020	10/01/19	09/30/20	53.86%		53.86%	46.14%	2020	7/1/2019	6/30/2020	53.87%		53.87%	46.13%

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

Federal Fiscal Year							State Fiscal Year						
FFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share	SFY	From	To	Federal Share	e-FMAP	Total Federal Share	Share
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%**
2019	10/1/2018	09/30/19	67.72%	n/a	67.72%	32.28%	2019	7/1/2018	6/30/2019	67.65%	n/a	67.65%	32.35%
	Expanded CHIP FMAP		**67.72%**	**23.00%**	**90.72%**	**9.28%**		**Expanded CHIP FMAP**		**67.65%**	**23.00%**	**90.65%**	**9.35%**
2020	10/1/2019	09/30/20	67.70%	n/a	67.70%	32.30%	2020	7/1/2019	6/30/2020	67.71%	n/a	67.71%	32.29%
	Expanded CHIP FMAP		**67.70%**	**11.50%**	**79.20%**	**20.80%**		**Expanded CHIP FMAP**		**67.71%**	**14.38%**	**82.08%**	**17.92%**

Chapter Eight: Administrative

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 healthcare 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 Business Office includes the Accounts Payable/Accounts Receivable (AP/AR), Grants and Contracts, and Fiscal Analytics units.

Accounts Payable/Accounts Receivable (AP/AR)

The AP/AR Unit is tasked with processing vendor payments, reimbursement of employee travel expenses, billing and receipt of provider assessments, collection of pharmacy assessments, drug rebate receipts, and other miscellaneous receivables. This unit is also responsible for reconciliations, financial reporting, tracking of department assets, and assisting with audits.

In the past few years, some providers have struggled with making timely assessment payments. The AP/AR Unit worked with the Legal Unit and Deputy Commissioner, Michael Costa to formalize a process to work with providers to collect these past due balances. With regular communication and payment plans, most providers are now currently paid to date. The amount past due at the beginning of SFY18 was $2,333,779, in comparison, the amount past due at the beginning of SFY19 is $1,535,295. We continue to work with providers and have developed relations resulting in effective communication and payments in a timelier manner.

Grants and Contracts

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 Proposal (RFP) through agreement closeout. 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 125 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 to ensure adherence with State and Federal financial reporting requirements, responds to audit requests, and manages agreement closeout.

The Grants and Contracts unit is currently engaged in three process improvement projects to introduce Lean-agile procurement techniques to contracting, grant issuance and monitoring, and Integrated Eligibility & Enrollment procurement. This approach stresses collaboration between people as a key success factor. The goals are to:

- Reduce preparation efforts and rework (reduce waste)
- Eliminate variation so that creation and comparison of multiple proposals/contracts becomes as easy as possible
- Reduce time to execution which will allow for quicker implementations

This team engages in a quality improvement project for the contracting process, which began in Fall 2017, with the purpose of reducing the amount of time taken to execute a contract from the time drafting begins to a final signature. To execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution promptly. For contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. The focus has been on streamlining the process while also ensuring that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review. The project is currently in phase three of a six phase process and is expected to be fully implemented by January 2019.

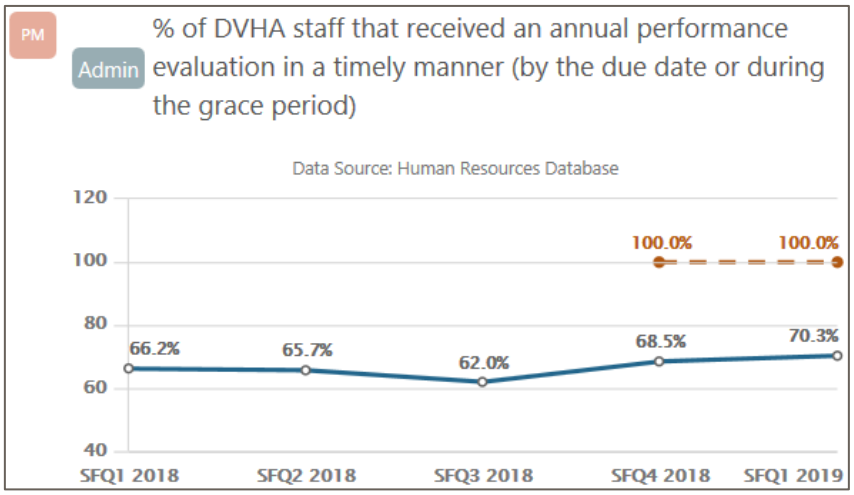
Fiscal Analytics

The Fiscal Analytics unit formulates and performs analysis of the budget, periodic financial reporting, and ad-hoc research requests providing analytic support for DVHA leadership. This team monitors changes in Medicaid spending and Medicaid Policy, Budget, and Reimbursement (PBR) forms to determine financial impact, assists with programmatic and administration budget preparation, and ensures financial reporting alignment with federal and state regulations. A main task of the analytics team is the preparation and completion of the annual report and budget recommendation for the upcoming state fiscal year.

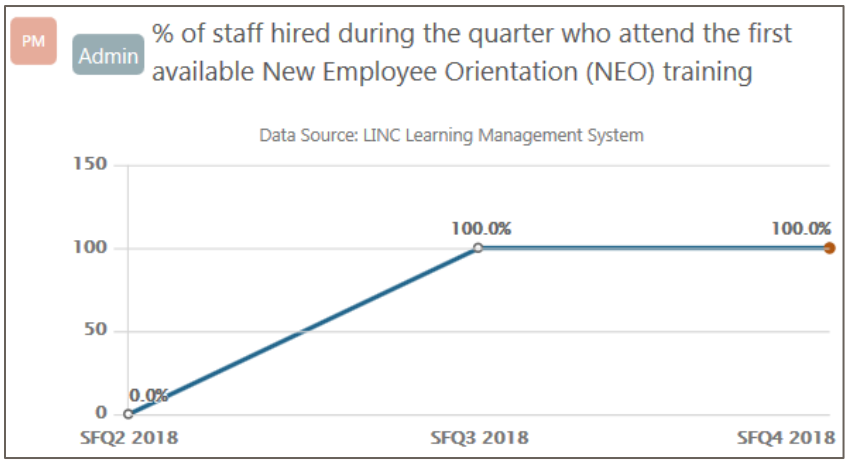
Administrative Services

The Administrative Services Unit works to help achieve consistency in our operational and administrative processes and procedures across the department. Our unit is focused on moving the departments objectives of performance management and transparency forward. We accomplish this through our initiatives on improving the onboarding process, position management and performance evaluations. The work that DVHA is responsible for within the agency and the state is critical to

serving the needs of Vermonters. Through the work of the Administrative Services Unit, we can focus on strengthening and improving the development and wellbeing of DVHA employees. By doing so, we have a direct impact on employee engagement thus improving the output of their performance and work they do for the department.



One area of challenge for our unit is the completion of probation and annual evaluations. Historically, across the agency, and our department, engagement in the evaluation process has been significantly low. The Administrative Services Unit, along with the support of leadership, has communicated to managers and supervisors the importance of evaluations and how they help promote employee engagement, productivity, and motivation for our staff. Our expectation is that DVHA's completion rate will continue to significantly increase over time.



An area of notable success has been our New Employee Orientation. Research indicates that a successful onboarding process improves employee engagement and leads to retaining top talent. DVHA's New Employee Orientation provides an opportunity for new staff to meet with the Senior Leadership Team. This face-to-face interaction helps staff to feel welcome and that they are valued. The orientation is held quarterly, and the goal is to provide an opportunity for new employees to make a real connection between the work that they do in their unit and how that relates to the work of the department, agency, and the lives of Vermonters. We have been successful in ensuring that 100% of staff hired during the quarter attend the first available orientation so that the information they receive is relevant to their experience as a new employee.

Policy Unit

The Medicaid Policy Unit (MPU) consists of 8 positions – Director of Healthcare Policy and Planning, Health Policy and Planning Chief, 3 Health Benefit Assistant Administrators, 1 Program Consultant, and 2 Staff Attorneys.

The MPU works to ensure that DVHA and other AHS departments administer the Medicaid program in alignment with Federal and State regulations. Additionally, the MPU works with AHS staff and other public and private partners to develop and implement effective Medicaid policy initiatives aimed at advancing the agency's goals of improving access and quality while reducing overall costs. Primary functions of the MPU include: 1) Policy Development and Implementation, 2) Medicaid Legislative Coordination, 3) Medicaid Administrative Rulemaking, 4) Policy Research and Analysis, and 5) Administration and planning of the Medicaid State Plan and Global Commitment 1115 Waiver.

Successes

1. In June 2018, Vermont secured approval from the Centers for Medicare and Medicaid Services (CMS) an amendment to Vermont's Global Commitment to Health 1115 Demonstration Waiver that authorizes the State to receive federal Medicaid funding for treatment services offered at institutions for mental disease (IMDs) provided to Medicaid enrollees to treat addictions to opioids and other substances.

   The approval of this amendment allows Medicaid to pay for inpatient residential treatment for addiction, which is not allowed currently under federal law, and removes the mandatory sunset of Vermont's current financial arrangement. Absent this amendment approval, Vermont would be required to begin phasing down federal Medicaid participation for substance use disorders treatment in a residential setting, in 2021 and phase out completely at the end of 2025.

2. In the summer of 2018, MPU spearheaded several notable changes to Medicaid services available to new moms. These changes reflect a commitment to increase support for new families, enabling them to make healthy choices for their children.
   - In-Home Lactation Consultation Services (Effective 6/1/2018):
     - Medicaid now covers in-home lactation consultation services for new mothers.
       - Historically this service was covered by commercial insurance, but not available for moms receiving Medicaid.
     - Ensures new mothers will be able to access breastfeeding guidance and support needed to succeed.
   - Breast Pumps (effective 8/1/2018):
     - Medicaid will cover breast pumps for mothers who will be away from their newborns for extended periods of time, such as for work or school.
       - The ACA required all commercial insurance plans to cover personal use breast pumps for new moms, but it was not a requirement for Medicaid.
     - Ensures that mothers will be able to continue feeding their newborn breast milk.
   - Childbirth Education Reimbursement Increase (effective 8/1/2018):
     - Medicaid will be increasing reimbursement rates for childbirth education classes.

        - Providers of these education classes expressed that low Medicaid rates resulted in limiting class space for Medicaid parents to make room for commercially insured Vermonters with more generous child education benefits.
    - Ensures women have access to educational tools to gain knowledge and skills that may be helpful to them during delivery.

3. MPU continues to undergo a 5 - 7-year project to rewrite all of Vermont's Medicaid administrative rules under one centralized framework. The existing Medicaid rules, many untouched for 30 years, are structured under individual departments and are at best redundant, at worst in conflict with each other, and are mostly not in alignment with existing operations.

   With more time and/or resources, Medicaid's administrative rules could be updated far faster. Updated and consolidated Medicaid rules promotes transparency, reduces provider/member confusion, and better protects AHS in the event of law suits.

Challenges

1. IT projects
    - DVHA has been actively engaged in IT procurement activities for years. Providing policy expertise to the procurement effort is essential to ensuring that the potential solution fits the policy need, however this procurement support is not built into the capacity of the Policy Unit and creates significant conflict between performing current policy activities and working towards a future IE solution.
2. Audits of the Medicaid Program
    - The annual state audit and periodic State Auditor audits require significant effort to organize around and respond promptly. Of late, audits have placed a substantial burden on policy staff to coordinate with federal partners and negotiate on written communication that is satisfactory to the auditors.
3. Legislative Reports
    - As of 2018, DVHA is directed to author 33 distinct reports for the Vermont Legislature, some required multiple times annually. The number of new reports grows every year (up from 23 reports in 2017), but the legislature never conducts a review of old reports to see if they are still relevant or helpful. The growing number of legislative reports adds significant pressure to the existing resources available to facilitate, draft, and review reports.
4. New Federal/State Requirements
    - Capacity to manage a routine amount of federal and/or state policy changes is built into the MPU. However, there are occasions when new requirements are so numerous, or a change so sweeping, that capacity is overwhelmed (e.g. implementation of the ACA).

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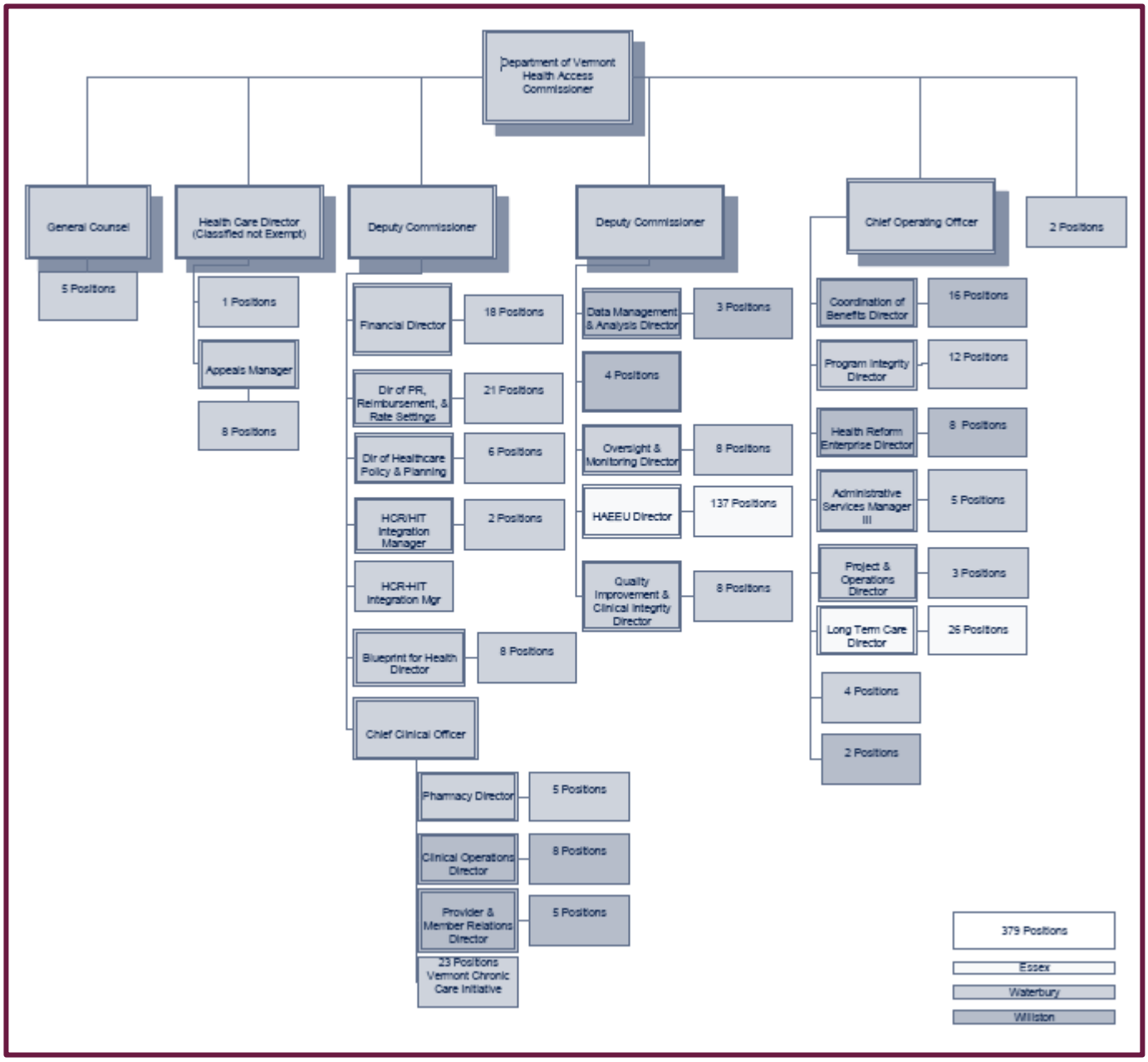
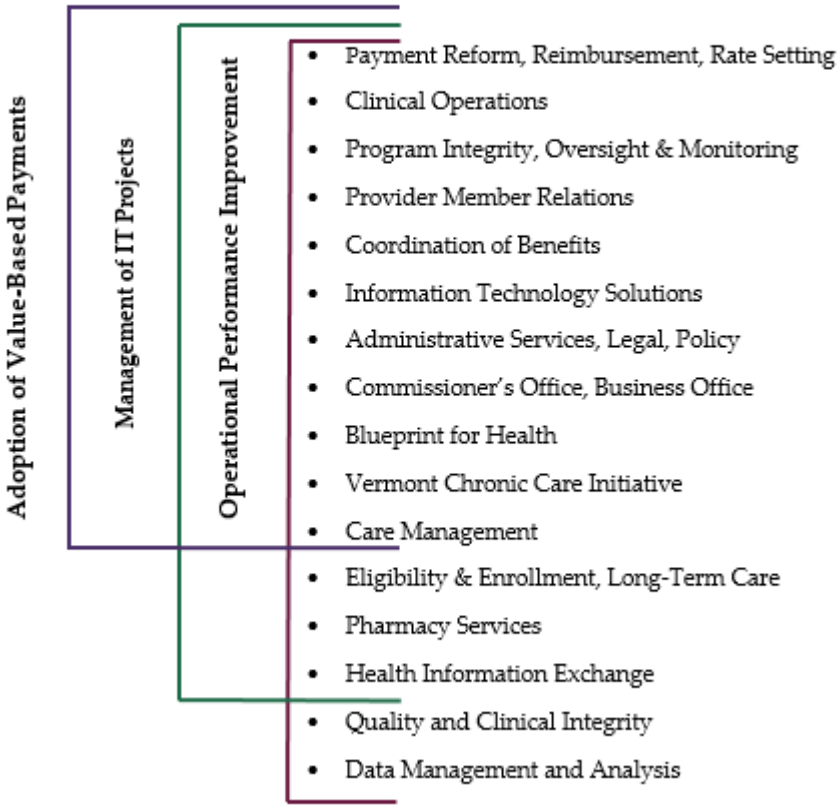
DVHA Organizational Chart



Organizational Priorities by Unit



Adoption of Value-Based Payments

The Payment Reform Unit seeks to transition Vermont Medicaid's healthcare revenue model from fee-for-service payments to value-based payments. In support of this goal, the Payment Reform Unit partners with internal and external stakeholders in taking incremental steps toward the integrated healthcare system envisioned by the Vermont All-Payer Accountable Care Organization (ACO) Model agreement with CMS. The Payment Reform Unit also works with providers and provider organizations in testing models, ensuring the models encourage higher quality of care, and are supported by robust monitoring and evaluation plans.

The Payment Reform Unit is available as a resource to DVHA and to other departments within AHS in the consideration of potential payment reform options. The unit is also responsible for the implementation and oversight of the Vermont Medicaid Next Generation (VMNG) ACO program, a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health and lower costs.

During the next year, the Medicaid Payment Reform team will continue to oversee the implementation, evaluation, and evolution of the VMNG program; and will provide support to department and agency leadership in the consideration of and planning for any additional value-based payment reform models to support continued advancement toward an integrated healthcare system in Vermont.

Accountable Care

In 2017, DVHA began to test a voluntary pilot program, the VMNG ACO program, which prioritizes paying for the quality of care for each Vermonter rather than the quantity of services delivered. The model is focused on prevention, empowering primary care providers, and coordinating care. It does so through ACOs, which are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care. The goal of the pilot is to improve health while moderating healthcare costs; which are a barrier to affordability. The VMNG ACO program pursues this goal by taking the next step in transitioning the healthcare revenue model from Fee-for-Service payments to Value-Based payments. One ACO, OneCare Vermont, is currently working with the State to participate in this model. In its first year (2017), OneCare's Medicaid pilot included four hospital communities made up of approximately 2,000 providers and around 29,000 attributed Medicaid members. In calendar year 2018, ten communities participated, including more than 5,000 unique providers and approximately 42,000 attributed Medicaid members. In calendar year 2019, thirteen communities are participating, and the number of attributed Medicaid members is approximately 79,000.

In OneCare Vermont's 2018 Medicaid pilot there were ten hospital communities with approximately 5,000 providers and 42,000 Medicaid members.

Through the VMNG, DVHA (through DXC Technologies) pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) participating with the ACO. This is a monthly, per member payment made in advance of the services being performed. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. As OneCare providers are still required to submit claims for all services, zero-paid "shadow claims" are used to calculate the cost of services delivered (according to the Medicaid fee-for-service fee schedule) that were covered by the prospective payment from DVHA to OneCare. In addition, OneCare has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the performance year, it is liable for expenses up to 103% of the target (104% in 2019); if the ACO spends less than its target, it may retain savings to 97% of the target (96% in 2019). This arrangement provides an incentive to use resources efficiently. Because the ACO is responsible for both the cost and quality of care for each attributed member, OneCare will also withhold some of the payment to providers up front—0.5% in 2017, 1.5% in 2018, and 2% in 2019 —to support a quality incentive program. The providers in the ACO can earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care and is expected to grow over time.

In September of 2018, DVHA published the results of the 2017 performance year.[10] The 2017 program results indicate enough, incremental progress that warrants cautious optimism and a continued commitment to the program. A summary of these results is presented below.

Result 1: DVHA and One Care launched the program successfully.

- In 2016, DVHA issued a Request for Proposals (RFP) for a new ACO program based on Medicare's "Next Generation" ACO Program. OneCare Vermont was selected as the Apparently Successful Bidder.
- DVHA conducted a readiness review before the launch of the 2017 program year. OneCare Vermont satisfied most requirements before January 1, 2017 and completed all outstanding Readiness Review items prior to the end of the first quarter of 2017.

- DVHA worked with DXC Technologies to change Medicaid payment systems to make fixed prospective payments to OneCare Vermont.
- Processes for ongoing data exchange between DVHA and OneCare have been implemented and are regularly evaluated for potential improvements.
- DVHA and OneCare prepare and maintain an operational timeline to ensure contractually required data sharing and reporting occurs promptly.
- OneCare and DVHA have established a forum for convening operational teams on a weekly basis, and for convening subject matter experts monthly. These forums have allowed the teams to identify, discuss, and resolve multiple operational challenges, and have resulted in several process improvements to date.
- DVHA and OneCare have worked together to monitor and report on program performance on a quarterly basis.

[10]https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-2017-Report-FINAL-09-20-18.pdf

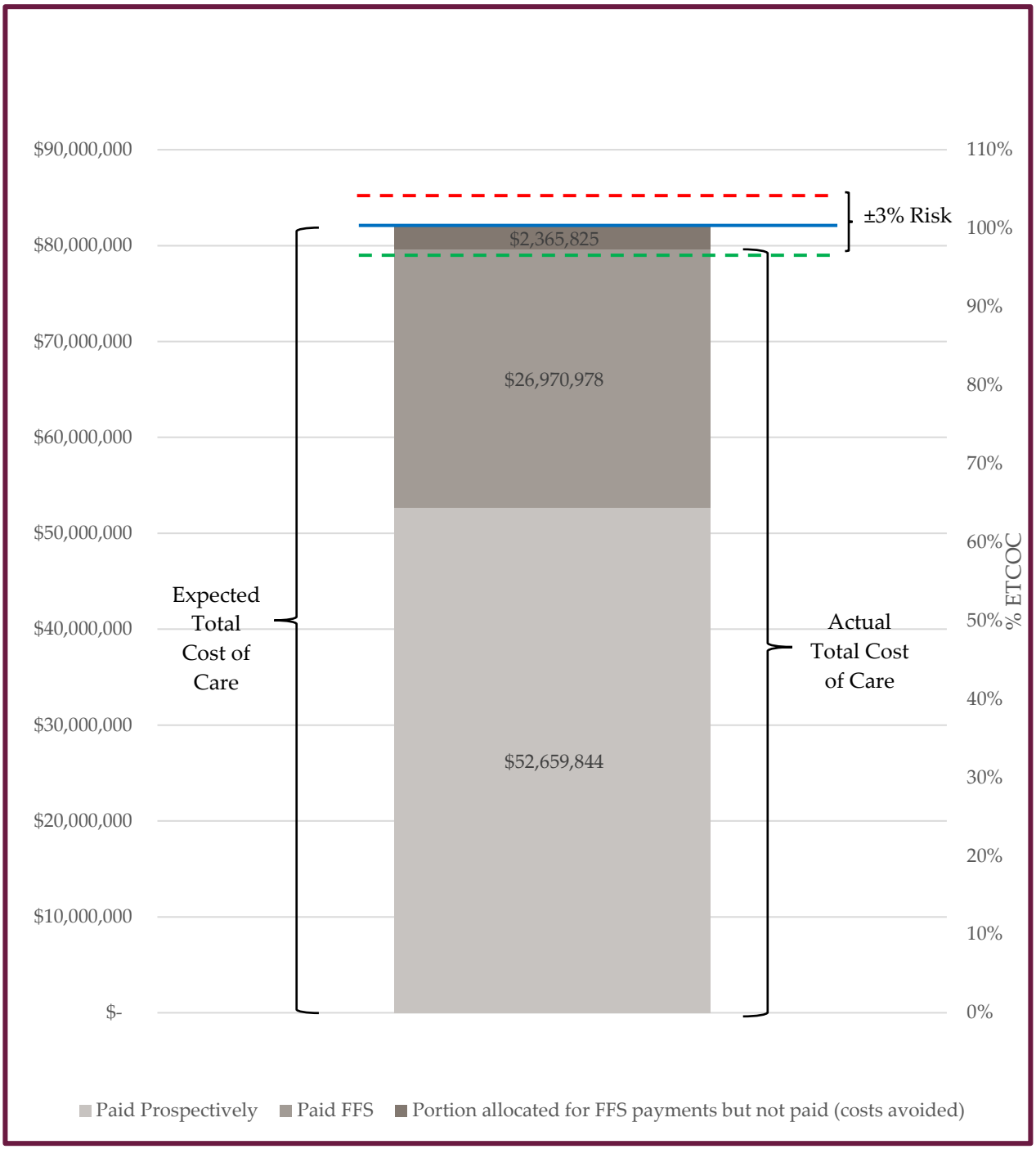
Result 2: The program is growing.

Additional providers and communities have joined the ACO network to participate in the program for the 2018 performance year, and more are expected to do so for the 2019 performance year.

Result 3: The ACO program spent less than expected on health care in 2017.

DVHA and the ACO agreed on the price of health care upfront, and the ACO spent approximately $2.4 million less than the expected price (see chart below). Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members are entitled to save those dollars.

2017 VMNG Financial Performance within Expected Total Cost of Care



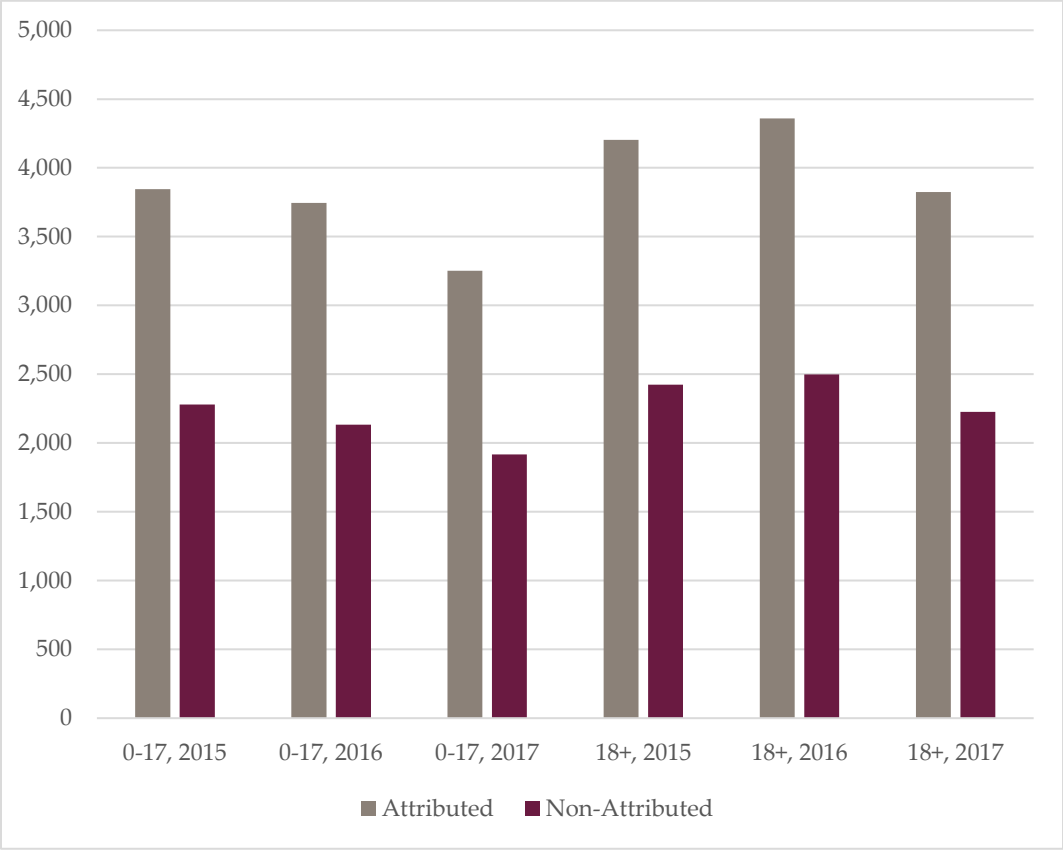
Result 4: The ACO met most of its quality targets.

The ACO's quality score was 85% on ten pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to diabetes control and engagement with alcohol and drug dependence treatment. Examining quality trends over time will be important to understand the impact of changing provider payment on quality of care.

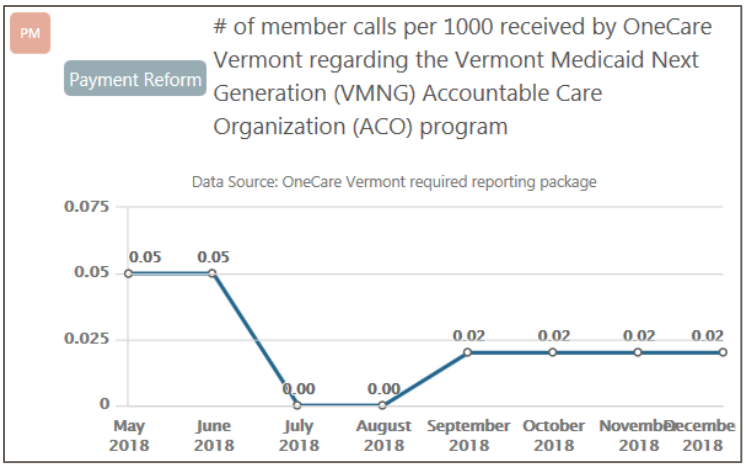
Result 5: DVHA is seeing more use of primary care among ACO-attributed Medicaid members.

Based on preliminary analyses of utilization, the cohort of attributed members has had higher utilization of primary care office-visits than the cohort of members who are eligible for attribution but not attributed (see chart below). As further information about utilization becomes available, DVHA will conduct more robust analyses to determine whether differences between cohorts are statistically significant, and to understand the impact of the program on utilization patterns over time.

Primary Care Visits Per 1,000 Member Years by Age and Year



The 2017 and 2018 pilot years have served as a valuable learning experience both internally at DVHA, and externally in its partnership with OneCare. Though the Payment Reform Unit is the designated contract monitor for the ACO program, coordination across the department in several functional areas is crucial to the program's success. Subject matter experts throughout DVHA review required reports from the ACO which monitor its quality improvement, clinical, financial, provider/member communications, and care management data, to ensure alignment with the department's goals of high-quality care for its members. Externally, DVHA and OneCare have developed a collaborative partnership in support of program implementation and oversight. Regular meetings between DVHA and OneCare operational teams have ensured that a continuous feedback mechanism is in place, giving staff the ability to

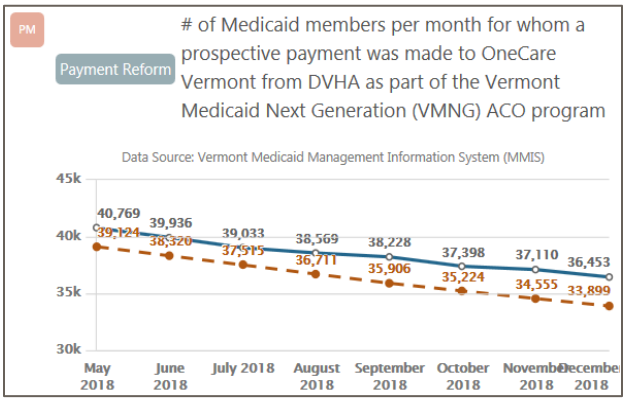


performance of the program to evaluate its efficacy and to determine whether the ACO program generally, and the fixed prospective payments to hospitals specifically, are contributing to an overall moderation in DVHA healthcare spending.

The table below shows monthly changes in attribution of Medicaid members in the 2018 VMNG Program. Attributed Medicaid members are defined as number of individuals for whom a monthly prospective payment was made.

make operational adjustments as needed. As a result, VMNG program operations have become further streamlined over the course of the year. Ongoing coordination between DVHA and OneCare will be required to maintain and optimize operations in a second performance year.

As the program continues into a third performance year, more data will be available to support meaningful evaluation of both quality and financial performance. DVHA will continue to analyze the financial, clinical, and quality



Medicaid Members Attributed to OneCare for the 2018 VMNG Program

*Attributed Medicaid Members**	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% of 42,342	100%	99.20%	98.12%	97.23%	96.29%	94.32%	92.19%	91.09%	90.28%	88.32%	87.64%	86.09%
Total	42,342	42,005	41,545	41,169	40,769	39,936	39,033	38,569	38,228	37,398	37,110	36,453
Aged, Blind, Disabled	2,757	2,705	2,686	2,632	2,613	2,607	2,587	2,578	2,571	2,562	2,547	2,560
General Adult	18,097	18,006	17,769	17,609	17,422	16,929	16,431	16,168	15,972	15,411	15,286	14,900
General Child	21,488	21,294	21,090	20,928	20,734	20,400	20,015	19,823	19,685	19,425	19,277	18,993

Attribution of Medicaid members to the ACO occurs prospectively, at the start of the program year. In this way, the ACO is aware of the full population for which it is accountable at the program's outset and can use that information to identify and engage members most effectively. Although no members can be added during a program year, some of the prospectively attributed members may become ineligible for attribution during the program year. Members may become ineligible for attribution due to:

- Becoming ineligible for Medicaid coverage[11]
- Switching to a limited Medicaid benefits package (e.g. pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g. commercial or Medicare)
- Death

[11]If a member has lost Medicaid coverage but later becomes eligible for Medicaid again during the performance year, they may also become eligible for attribution again at the time.

Cross-Agency Payment Reform Projects

During the term of the Vermont All-Payer ACO Model agreement, the State will evolve and expand ACO-based reform and develop payment reform projects that impact other Medicaid-covered services (including, but not limited to, mental health services, substance use disorder treatment services, and long-term services and supports) through partnerships between departments within AHS. The State will place emphasis on program evolution or development that ensures State compliance with the provisions of the All-Payer ACO Model related to achieving scale targets and on planning for the expansion of value-based payment arrangements to include providers and suppliers of additional Medicaid services beyond 2020.

In addition to the Vermont All-Payer ACO Model agreement, Vermont's Global Commitment to Health 1115 Waiver further supports the development of alternative payments for Medicaid providers and services. One of Vermont's key strategies for improving the health status of all Vermonters through implementation of the waiver is "promoting delivery system reform through value-based payment models and alignment across public payers."[12] Within the last year, the Payment Reform unit has begun working with several departments within AHS to contemplate new payment reform projects that would align with Vermont's All-Payer ACO Model agreement and would advance implementation of Vermont's Global Commitment to Health waiver. Models under consideration for future implementation are described in the below table.

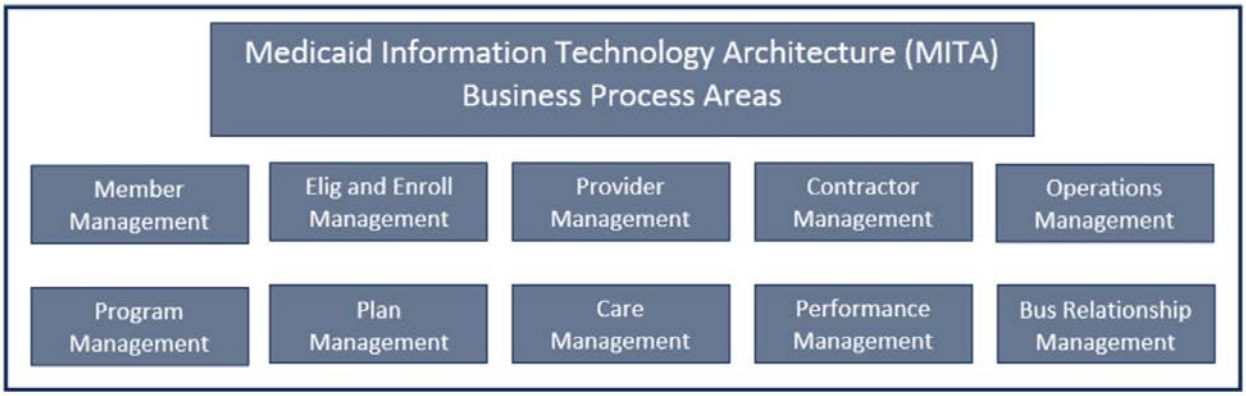
[12]http://dvha.vermont.gov/global-commitment-to-health/vt-1115-extension-waivers-exp-author-stcs-techncial-corrections-no-track-changes06212017.pdf

Project	Model Under Discussion	Potential Impact
Applied Behavior Analysis [Department of Vermont Health Access]	-Prospective monthly bundled payment -Flexibility in payment levels based on total hours in an individual's care plan -Adoption of standardized assessment (begin measurement of progress toward outcomes) -DVHA staff conducting site visits & record review	-Moves away from fee-for-service reimbursement -Gives providers payment predictability and flexibility in service delivery -Establishes monitoring framework that could be used to pay for outcomes in future
Children's and Adult Mental Health [Department of Mental Health]	-Monthly per person case rate -Based on average monthly case load, not attribution of fixed population -Introduction of quality performance incentive payments (pay for reporting, pay for performance)	-Consolidation of historically program-specific funding streams paid to designated mental health agencies for adult mental health services -Gives providers payment predictability and flexibility in service delivery -Develops a multi-year framework for paying providers based on quality
Residential Substance Use Disorder Programs [Division of Alcohol and Drug Abuse Programs]	-Bundled payment per residential stay -Variation in payment based on primary SUD diagnosis on admission -Introduction of quality performance measures -ADAP staff conducting site visits & record review	-Moves away from fee-for-service (per diem) reimbursement -Gives providers payment predictability and flexibility in service delivery -Develops a multi-year framework for paying providers based on quality
Developmental Disability Services [Department of Disabilities, Aging, and Independent Living]	-Payment model options under discussion; to be informed by rate study currently in process	-Develops a revised service delivery and payment model for disability services that is based on data, easy to understand, and transparent regarding the services for which payments are made -Ensures accountability between DAIL and providers without destabilizing the developmental disabilities system of care
Pediatric Palliative Care [Vermont Department of Health]	-Payment model options under discussion	-Moves away from fee-for-service reimbursement -Gives providers payment predictability and flexibility in service delivery -Establishes monitoring framework that could be used to pay for outcomes in future

MMIS Program

The Medicaid Management Information System (MMIS Program) is one of several programs in the Agency of Human Services (AHS) Information Technology (IT) Portfolio involved with upgrading the State's technological infrastructure for Medicaid and other benefit programs. The MMIS Program consists of projects to respond to Federal and State mandates and Agency goals and to modernize Vermont's Medicaid systems that deliver health care provider solutions and payment capabilities.

Vermont's MMIS Program is leveraging innovative technologies to help AHS administer the Medicaid program and serve Vermonters in the most time efficient, secure and integrated manner. Projects are executed using IT Project Management best practices and are evaluated for alignment with scope, schedule and budget. The Centers for Medicare and Medicaid Services (CMS), Vermont's Federal Medicaid partner, has established a Medicaid Information Technology Architecture (MITA) framework of Business Process Areas with capabilities and services that support business needs. All these areas are potential opportunities for IT system improvements.



The enhanced MMIS will efficiently and securely share appropriate data with Vermont agencies, providers, and other stakeholders involved in a member's case and care. Guiding principles are to:

- Align with the Triple Aim
  - Improve patient experience of care (including quality and satisfaction)
  - Improve the health of populations
  - Reduce the per capita cost of health care
- Improve the customer service experience for health and human services providers and all Vermonters
- Improve the efficiency and effectiveness of Medicaid operations

Early significant initiatives in transforming Vermont's MMIS include:

- The PBM System was completed and has been certified by CMS, which allows DVHA to receive enhanced funding for Maintenance & Operations expenses. This system provides drug claims adjudication, call center operations, utilization management, drug utilization review, benefit design, clinical support, rebate management, reporting and analytics for over 180,000 Medicaid beneficiaries who have pharmacy benefits.

- The Care Management (CM) System is operational for the Vermont Chronic Care Initiative (VCCI) and will be seeking CMS certification in early 2019. This system evaluates the Vermont Medicaid population to identify members most in need of intensive case management and care coordination services. It provides automated support to VCCI staff in all aspects of providing care management services to the most vulnerable Medicaid members.
- The Provider Management Module (PMM) is in the design and development phase, with implementation planned for the first half of 2019. This system will replace the current manually intensive provider eligibility determination, credentialing, and enrollment processes by automating steps in the business process and allowing providers to enter enrollment information online.
- Electronic Visit Verification (EVV) is being developed in response to a CMS mandate, first for Personal Care Services and then for Home Health Care Services. This system will enable home care workers to digitally record information about their visits, including the specific care or services rendered, and to electronically report changes in a patient's condition for follow-up.
- Payer Initiated Eligibility (PIE) is being executed to support sharing eligibility and coverage data that enables identification and collection of payments from liable third parties. The new system will create efficiencies in ensuring Medicaid is the payer of last resort.
- The Electronic Imaging project is underway to digitize large volumes of paper records, beginning with DVHA's Clinical Operations Unit, which is almost complete. Records for the Program Integrity Unit and the Coordination of Benefits Unit will be digitized during the next phases.

MMIS System enhancements are being developed to support Vermont's Payment and Delivery System (PADS) reform initiatives. Enhancements and replacement of additional MMIS modules are being explored and prioritized. Potential projects on the horizon likely will focus on MMIS Operations Management (OM), System Integration (SI), Coordination of Benefits (COB) and Program Integrity (PI). The MMIS Program currently is establishing a Maintenance & Operations (M&O) Unit that will be responsible for successfully transitioning IT projects from design, development and implementation (DDI) to M&O, providing support to the business units that manage the systems, and monitoring vendor compliance during operations.

MMIS Maintenance & Operations

The Medicaid Management Information System (MMIS) Maintenance & Operations (M&O) Unit is being formed to provide support and oversight for MMIS IT modules that are transitioning or have transitioned from system design, development, and implementation into ongoing operations. The team's primary objectives are to develop consistent internal M&O practices and procedures, create a standardized operational compliance structure for MMIS vendors, and support the business units that rely on these systems to provide services to Vermonters.

While the MMIS M&O team is still being developed, it already is engaged with active modules and vendors. Work is underway to identify consistent practices that will help ensure the successful transition of projects to M&O. Best practices for developing service level requirements are being determined and opportunities for applying the same service level requirements and vendor compliance standards across modules are being identified. Ultimately, the unit will recommend best practice performance standards to include in future MMIS module procurements and vendor contracts. The M&O Unit also will serve as a central point for staff access to information about MMIS system operations.

Introducing consistent operational best practices across MMIS modules will help address one of DVHA's key focus areas: to improve management of Information Technology projects. Monitoring MMIS vendors for

compliance and service standards helps protect the significant State and Federal investments made in developing these IT systems and ensures the appropriate spend of tax dollars to maintain them. These systems are key tools for providing Vermonters with continued access to excellent healthcare services and supports, as well as supporting staff, providers, and other stakeholders in efficiently and effectively serving Vermonters.

MMIS Compliance work previously initiated within the Program Integrity Unit will now be performed through the MMIS M&O Unit. The M&O team will ensure the State receives the appropriate financial credit when vendors fail to meet a Service Level Requirement (SLR) and will follow up with the vendors to ensure improvements are in place to prevent future failures. The team will work with vendors to identify and address root causes for ongoing performance challenges and develop process improvements for state requested MMIS changes. These activities ensure that Vermont Medicaid receives quality customer service from its MMIS vendors and prevents unnecessary spending on system changes or solutions that may be accomplished in a more efficient or less costly manner.

Challenges

As additional MMIS modules are enhanced or replaced and the number of MMIS vendors increases, inconsistent operational practices create unnecessary complexity and inefficiencies in managing vendor performance and conducting compliance oversight. Divergent performance standards and operating expectations contribute to siloed and disconnected MMIS components. Implementing consistent best practices across MMIS operations will contribute to achieving the goal of building an integrated and interoperable MMIS modular system. The transition by active modules toward greater consistency will require changes to existing business processes and therefore may be more gradual than for new modules; consistent operational expectations and standards for new modules ultimately will begin at the procurement stage.

Scorecard measures will be developed concurrent with developing the MMIS M&O Unit and therefore have not yet been identified.

Integrated Eligibility & Enrollment Projects

The Integrated Eligibility & Enrollment (IE&E Program) is a central program in the Agency of Human Services (AHS) Information Technology (IT) Portfolio involved with upgrading the State's technological infrastructure for member enrollment in both Medicaid and other healthcare benefit programs as well as the State's economic services administered by the Department of Children and Families.

The program envisions a world in which eligible Vermonters have a simple and easy way to apply for, access, and maintain healthcare and financial benefits, without coverage gaps. To achieve this vision, the State must deliver services efficiently and sustainably, using innovative ways of working and modern technology.

The Challenge

Enrolling members is one of DVHA's three central responsibilities, yet the current enrollment system and processes are problematic for Vermonters, staff, and the State.

Vermonters who apply for benefits also must submit the same information multiple times and deal with different call centers. They can see that there is little to no coordination across programs. The result is wasted time and missed opportunities. They don't always understand what information they need to provide and can't submit personal documentation easily. They face lengthy approval timelines, complex instructions, and have no way to apply for all benefits at once.

State staff also face challenges as they deliver these services. Staff processes tend to be very manual and labor intensive. Staff must memorize complex rules and processes. They also waste time dealing with multiple systems that don't talk to each other.

Finally, the State bears financial risk due to the current systems. First and foremost, the federal government, through the Centers for Medicare and Medicaid Services (CMS), and Vermont have identified areas where the State is out of compliance along with a mitigation plan to bring the State into compliance. Failure to meet CMS's mitigation plan could result in financial penalties and impact Medicaid funding.

In addition, lack of quality data makes it difficult to ensure that the right people are in the right programs, a situation that could lead to extra expense. Hard-to-maintain systems are also expensive to update, vendor-lock reduces the State's negotiating power, and the size and scale of IT contracts make them unlikely to succeed.

Goals

The IE&E Program aims to improve the customer experience in the following ways:

- Provide a united application, determination, and enrollment experience that allows the customer to engage with the State through the channel of their choosing
- Facilitate a simple, user-friendly experience that allows the customer to maintain continuous benefits, services, or health coverage, especially during critical life transitions
- Ensure accurate and timely determination and notification of eligibility
- Deliver clear and concise information throughout the eligibility and enrollment process through the customer's chosen method and language

An integrated IE&E technology system will also ensure:

- Staff can serve Vermonters efficiently and effectively by maximizing focus on case management and customer service.
- Vermont can meet federal and state mandates and requirements.
- Improved data integrity and robust access to data for analysis, reporting and modeling.
- Financial integrity in the administration of benefit programs.

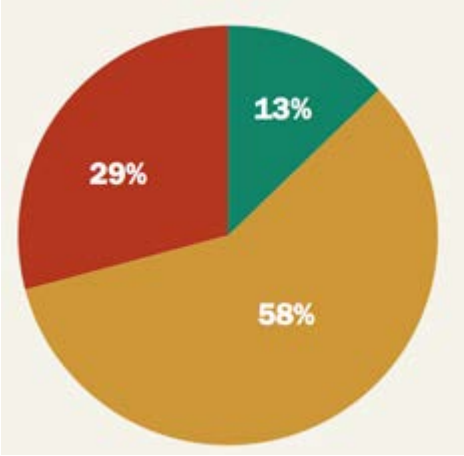
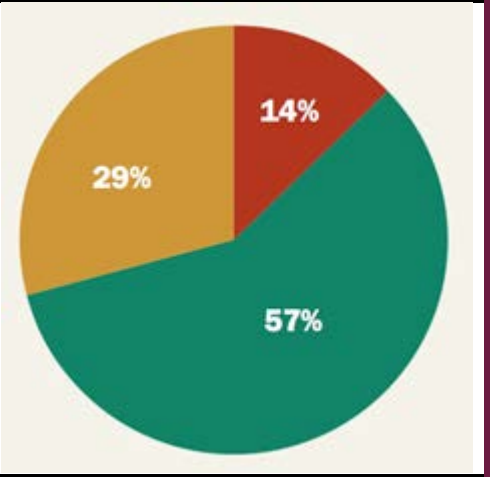
The IE&E Program Approach

The IE&E Program is committed to putting the needs of the user first. This means taking the time to engage the Vermonters who use services, letting program staff lead, and ensuring that developers understand the problems that need to be solved before building a solution.

The IE&E Program also commits to taking smaller financial risks by breaking up large technology projects into small, manageable chunks that deliver clear value to the end user. This approach allows the IE&E Program to find the best vendor to fill a specific need without getting locked into big, ongoing contracts.

The table below provides evidence for the success of this approach by comparing large government projects versus smaller government projects.

Smaller IT Projects Have a Much Higher Success Rate

Large Government Projects	Small Government Projects
	

Source: The Standish Group's CHAOS database. Large is defined as labor cost >5 million euros or $6 million. Small is defined as labor costs less than $1 million (or euros). Successful (green) projects are on time, on budget, and on target. Challenged (yellow) projects are late, over budget, and/or have an unsatisfactory target. Failed (red) projects were either canceled before completion or not used after implementation.

Finally, the IE&E Program utilizes an Agile development methodology, which enables us to be nimbler as we make decisions and to course-correct as we go, resulting in a greater opportunity to achieve our desired outcomes. This incremental approach to delivering value to users, with their needs driving decisions, is a bottom-up instead of top-down mindset.

New Ways of Working

"New ways of working" does not just refer to updating systems built long ago. It means that we are rethinking every aspect of our work and looking for opportunities to improve. This includes product management, risk mitigation, staffing, procurement, development methods, technology choices, oversight response, design, user engagement, vendor management, and more.

The IE&E Program has already benefited from these new ways of working efforts in terms of meeting delivery schedule, budgets, and quality of results. The Agency of Human Services and Agency of Digital Services seek to share these lessons throughout the rest of their work, and the rest of state government, wherever possible.

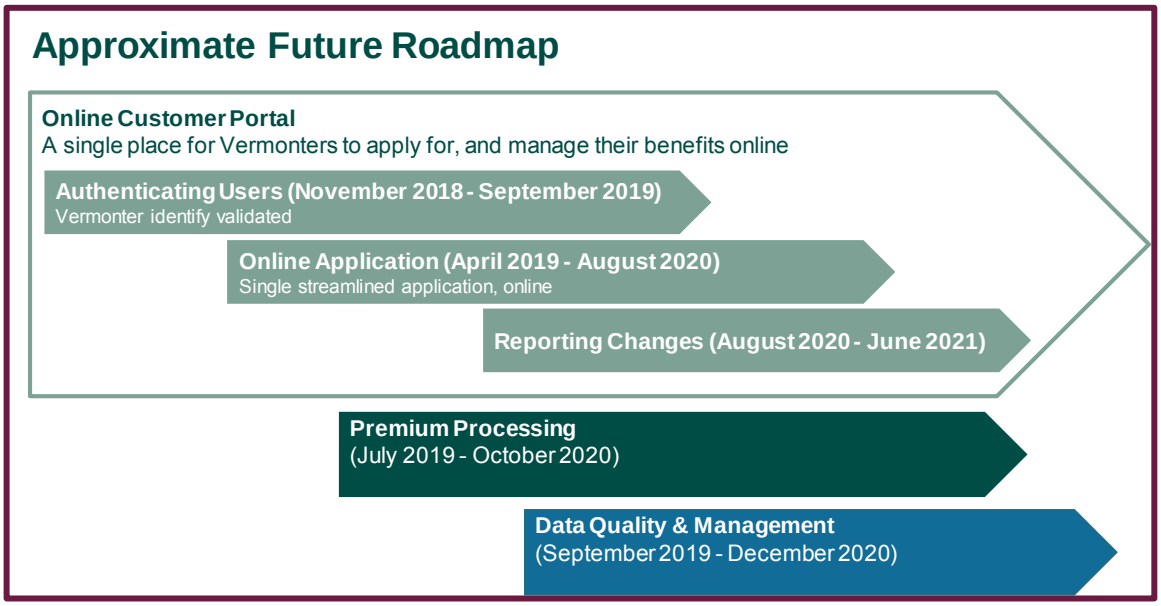
Technical Principles

The IE&E Program follows nine technical principles:

- Build using Agile and iterative practices to deliver value frequently and incrementally
- Default to Open
- Default to Cloud

- Default to open standards and formats to maximize extensibility and interoperability
- Own and manage our data and business rules
- Choose emergent architecture over 'big up-front design'
- Favor small components and loosely-coupled parts
- Automate testing and deployments
- Value experimentation and innovation

Product Roadmap

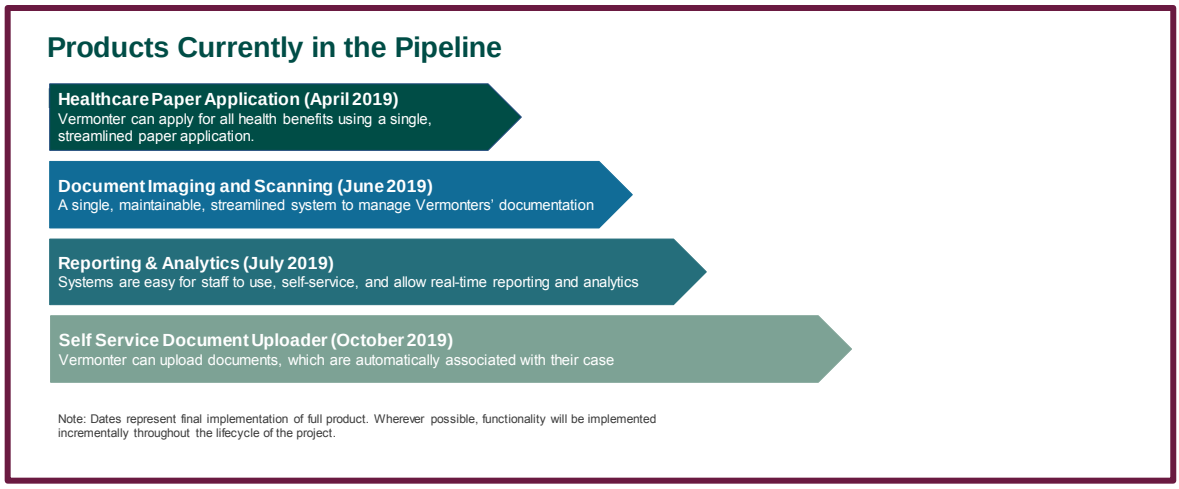


The IE&E Program's delivery plan uses each individual product development to move the program forward in achieving its high-level goals while also providing incremental benefits. The products are developed, tested, and launched with a focus on value proposition, key stakeholders, program promises, and key performance indicators (KPIs).

It is important to understand that the State's roadmap will evolve over time as new information/experience is gained and the marketplace evolves. The products evolve as the users provide feedback and the long-range roadmap evolves as new technologies and other opportunities unfold and the needs of members and staff are clarified.

Products Currently in the Pipeline

The IE&E Program currently has four products in development and scheduled for release in late SFY 2019 and early SFY 2020.



Healthcare Paper Application

- Problem: Healthcare paper applications contain essential information needed for staff to process health benefit eligibility determinations decisions. Currently, paper application forms are out of compliance with the Federal mandate to have a single application for all MAGI and non-MAGI healthcare programs. Additionally, the forms do not comply with plain language requirements, making it harder for applicants to complete the application correctly, often leading to requests for additional information which in turn causes processing delays.

- Vision: A newly designed paper application, branded with Vermont logo and colors, that is easy for applicants to complete, enables full healthcare screening for both MAGI and non-MAGI based eligibility determinations, collects information needed for efficient and accurate eligibility decisions, and reduces data entry and processing time for staff.

Document Imaging and Scanning

- Problem: Currently, Vermont eligibility and enrollment staff utilize two enterprise content management (ECM) systems for scanning, indexing, workflow and viewing Vermonters' documentation and notices. This leads to operational inefficiencies, unnecessary maintenance & operations costs, and difficulty coordinating enrollee documentation across programs.

- Vision: To utilize one system to scan, index, manage workflow, and view Vermonters' documentation and notices. By utilizing only one system, ECM will create a streamlined experience and process for staff that is user-friendly and more efficient for the State to maintain. Training, documentation, and processes will be easier and faster resulting in less waste and improved quality.

Reporting and Analytics

- Problem: The current reporting system used by Vermont Health Connect (VHC) is expensive, complicated, and does not perform to our standards. It requires outside contractor expertise to support and is manually intensive and time consuming for State staff to maintain. It also means that VHC data is housed separately from the rest of IE&E Program data, which is in Microsoft SQL Server.

- Vision: To align data storage and reporting for MAGI health coverage programs with the other in-scope benefit programs for IE&E, by migrating the data from the OBIEE data warehouse to Microsoft SQL Server. The new system will be easier for staff to use, enable self-service, and allow for real-time reporting and analytics. It will also be more affordable and enable in-house State of Vermont expertise to sustain support and maintenance of the solution.

Self Service Document Uploader

- Problem: Vermonters find satisfying verification requirements to be a challenging, time-consuming, and frustrating experience. For staff, verifying Vermonters' income (and other requirements) routinely involves delays, stressful conversations, and duplicative work. Mail and paper slow the entire process from initial notification, to mailing documents, to scanning and indexing. Internal staff wait for Vermonters' submission of required documentation such as pay stubs, employment forms, or attestations to process applications or changes, which lengthens the eligibility determination process.
- Vision: To make it easier for Vermonters to submit- and staff to process- manual verification documentation. We will implement a technical solution which allows Vermonters to utilize mobile and online technology to submit verification documents and to automate the classification of these documents. This solution will improve the efficiency of the eligibility determination process and result in a better customer experience for Vermonters.

Operational Performance Improvement

Results-based Accountability

DVHA's third priority, operational performance improvement, relates to every unit and every staff member. In addition to striving for business efficiencies, DVHA has implemented results-based accountability (RBA) principles and tools to provide structure to the organization's commitment. Along with other departments in the Agency of Human Services, DVHA uses Clear Impact Scorecard, an RBA-based strategy management and collaboration support software that facilitates data charting, project management, and public communication of results.

Each of DVHA's units identified key performance indicators (KPI) with an emphasis on their aspect of DVHA's work to enroll members, pay for care, and promote health. Over the last year, DVHA continued to refine each unit's goals and metrics to chart progress over time and find opportunities for improvement. Units report goals and monthly metrics related to KPIs, share the information in public scorecards, and increasingly use data to assess performance and make business decisions. Scorecards can be found in Appendix C.

Appendix A: Global Commitment Investments

Department	Investment Description	SFY14	SFY15	SFY16	SFY17	SFY18
AHSCO	Investments (STC-79) - 2-1-1 Grant (41)	$ 499,792	$ 499,667	$ 453,000	$ 453,000	$ 453,000
AHSCO	Investments (STC-79) - Designated Agency Underinsured Services (54)	$ 7,184,084	$ 6,894,205	$ 5,632,253	$ 7,652,462	$ 7,316,517
AOA	Green Mountain Care	$ -	$ 639,239	$ -	$ -	$ -
AOE	Non-state plan Related Education Fund Investments (School Health Services)	$ 10,454,116	$ 10,029,809	$ 10,472,205	$ -	$ -
DCF	Investments (STC-79) - Medical Services (55)	$ 33,514	$ 32,299	$ 55,400	$ 85,151	$ 71,382
DCF	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	$ 11,137,225	$ 10,405,184	$ 10,238,115	$ 11,329,080	$ 9,017,098
DCF	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	$ 2,611,499	$ 2,864,727	$ 2,753,853	$ 2,710,931	$ 2,809,148
DCF	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	$ 89,159	$ 77,196	$ 80,830	$ 61,678	$ 43,529

DCF	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	$ 183,025	$ 160,963	$ 190,066	$ 172,218	$ 105,594
DCF	Investments (STC-79) - Essential Person Program (59)	$ 801,658	$ 707,316	$ 802,619	$ 1,022,339	$ 942,059
DCF	Investments (STC-79) - GA Medical Expenses (60)	$ 253,939	$ 211,973	$ 181,835	$ 221,199	$ 236,643
DCF	Investments (STC-79) - Children's Integrated Services Early Intervention	$ 200,484	$ -	$ 371,836	$ 371,870	$ -
DCF	Investments (STC-79) - Therapeutic Child Care (61)	$ 543,196	$ 605,419	$ 712,884	$ 612,052	$ 1,279,496
DCF	Investments (STC-79) - Lund Home (2)	$ 237,387	$ 405,034	$ 261,081	$ 1,769,128	$ 2,349,849
DCF	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	$ 111,094	$ 54,125	$ 54,125	$ 38,795	$ -
DCF	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	$ 54,231	$ 195,124	$ 126,365	$ 113,832	$ 102,582
DCF	Investments (STC-79) - Challenges for Change: DCF (9)	$ 207,286	$ 189,378	$ 202,488	$ 210,624	$ 202,488
DCF	Investments (STC-79) - Strengthening Families (26)	$ 399,841	$ 370,003	$ 426,417	$ 439,420	$ 921,322

DCF	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	$ 402,685	$ 83,315	$ 216,000	$ 216,000	$ 219,000
DCF	Investments (STC-79) - Building Bright Futures (35)	$ 594,070	$ 514,225	$ 531,283	$ 625,562	$ 543,611
DCF	CUPS/Early Childhood Mental Health	$ -	$ -	$ -	$ -	$ -
DCF	GA Community Action	$ 25,181	$ -	$ -	$ -	$ -
DCF	AABD Admin	$ -	$ -	$ -	$ -	$ -
DDAIL	Investments (STC-79) - Mobility Training/Other Svcs. - Elderly Visually Impaired (63)	$ 245,000	$ 245,000	$ 270,170	$ 295,403	$ 268,670
DDAIL	Investments (STC-79) - DS Special Payments for Medical Services (64)	$ 1,277,148	$ 385,896	$ 1,904,880	$ 2,736,796	$ 1,847,505
DDAIL	Investments (STC-79) - Flexible Family/Respite Funding (27)	$ 2,868,218	$ 1,400,997	$ 1,919,377	$ 1,877,363	$ 1,591,743
DDAIL	Investments (STC-79) - Quality Review of Home Health Agencies (42)	$ 51,697	$ 44,682	$ 35,203	$ 21,928	$ 70
DDAIL	Investments (STC-79) - Support and Services at Home (SASH) (43)	$ 1,013,671	$ 1,026,155	$ 1,013,283	$ 1,022,170	$ 1,039,818
DDAIL	Investments (STC-79) - HomeSharing (77)	$ 317,312	$ 327,163	$ 339,966	$ 340,882	$ 349,318
DDAIL	Investments (STC-79) - Self-Neglect Initiative (78)	$ 200,000	$ 265,000	$ 276,830	$ 277,257	$ 281,738

DDAIL	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	$ 859,371	$ 333,331	$ 120,997	$ 74,041	$ 73,806
DFR	Health Care Administratio n	$ 165,946	$ -	$ -	$ -	$ -
DMH	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	$ 168,492	$ 152,047	$ 158,316	$ 155,800	$ 144,810
DMH	Investments (STC-79) - MH Outpatient Services for Adults (66)	$ 2,661,510	$ 3,074,989	$ 4,446,379	$ 2,702,991	$ 2,897,020
DMH	Investments (STC-79) - Mental Health Consumer Support Programs (79)	$ 2,178,825	$ 1,132,931	$ 470,222	$ 464,525	$ 396,237
DMH	Investments (STC-79) - Mental Health CRT Community Support Services (16)	$ 11,331,235	$ 282,071	$ 5,866,297	$ 7,446,247	$ 8,592,779
DMH	Investments (STC-79) - Mental Health Children's Community Services (12)	$ 3,377,546	$ 3,706,864	$ 4,379,820	$ 4,511,388	$ 4,689,320
DMH	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	$ 6,662,850	$ 4,148,197	$ 2,528,751	$ 7,989,001	$ 9,281,100
DMH	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	$ 749,943	$ 931,962	$ 1,286,154	$ 1,209,076	$ 1,213,442
DMH	Investments (STC-79) - Emergency Support Fund (22)	$ 985,098	$ 463,708	$ 914,858	$ 995,193	$ 1,020,523

DMH	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	$ -	$ -	$ -	$ 21,804,310	$ 22,438,553
DMH	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	$ 7,194,964	$ 25,371,245	$ 22,335,938	$ 4,786,816	$ 5,882,299
DMH	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	$ 721,727	$ 392,593	$ 246,049	$ 114,942	$ 109,731
DMH	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	$ 3,011,307	$ 2,423,577	$ 3,145,476	$ 4,287,792	$ 3,148,571
DMH	Challenges for Change: DMH	$ -	$ -	$ -	$ -	$ -
DOC	Return House	$ 399,999	$ 343,592	$ 342,084	$ 437,023	$ 457,139
DOC	Northern Lights	$ 335,587	$ 354,909	$ 768,289	$ 370,155	$ 414,183
DOC	Pathways to Housing - Transitional Housing	$ 830,936	$ 830,336	$ 1,018,229	$ 910,936	$ 937,864
DOC	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	$ 433,910	$ 539,727	$ -	$ 667,967	$ 460,741
DOC	Northeast Kingdom Community Action	$ 287,662	$ 267,025	$ 220,436	$ 201,744	$ 45,293
DOC	Intensive Substance Abuse Program (ISAP)	$ 547,550	$ 58,280	$ -	$ -	$ -
DOC	Intensive Domestic Violence Program	$ 64,970	$ 169,043	$ 88,152	$ -	$ -

DOC	Community Rehabilitative Care	$ 2,388,327	$ 2,539,161	$ 2,639,580	$ 2,690,514	$ 2,840,036
DOC	Intensive Sexual Abuse Program	$ 19,322	$ 15,532	$ 6,375	$ 9,530	$ 10,795
DVHA	Investments (STC-79) - Vermont Information Technology Leaders/HIT /HIE/HCR (8)	$ 1,549,214	$ 2,915,149	$ 1,887,543	$ 3,694,675	$ 2,131,044
DVHA	Investments (STC-79) - Vermont Blueprint for Health (51)	$ 2,490,206	$ 1,987,056	$ 2,594,329	$ 2,474,551	$ 3,290,433
DVHA	Investments (STC-79) - Buy-In (52)	$ 17,728	$ 27,169	$ 29,447	$ 53,552	$ 30,686
DVHA	Investments (STC-79) - HIV Drug Coverage (53)	$ 26,540	$ 10,072	$ 8,484	$ 7,000	$ 4,085
DVHA	Investments (STC-79) - Patient Safety Net Services (18)	$ 363,489	$ 335,420	$ 573,050	$ 647,696	$ 29,050
DVHA	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	$ 6,948,129	$ 7,792,709	$ 7,839,519	$ 8,034,408	$ 7,897,961
DVHA	Investments (STC-79) - Family Supports (72)	$ 3,723,521	$ 2,982,388	$ 273,177	$ -	$ 6,362
DVHA	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	$ -	$ -	$ -	$ -	$ 614,250
DVHA	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care	$ -	$ -	$ -	$ -	$ 1,173,125

	Coordination (82)					
DVHA	Civil Union	$ 760,819	$ (50,085)	$ (585)	$ -	$ -
GMCB	Green Mountain Care Board	$ 2,360,462	$ 2,517,516	$ 2,188,901	$ 2,795,198	$ 1,920,142
UVM	Vermont Physician Training	$ 4,006,156	$ 4,046,217	$ 4,046,217	$ 4,046,217	$ 4,046,217
VAAFM	Agriculture Public Health Initiatives	$ 90,278	$ 90,278	$ 90,278	$ 90,278	$ -
VDH	Investments (STC-79) - Emergency Medical Services (19)	$ 498,338	$ 480,027	$ 442,538	$ 547,703	$ 763,945
VDH	Investments (STC-79) - TB Medical Services (74)	$ 59,872	$ 28,571	$ 9,738	$ 139,946	$ 132,445
VDH	Investments (STC-79) - Epidemiology (40)	$ 623,363	$ 872,449	$ 750,539	$ 876,737	$ 1,146,645
VDH	Investments (STC-79) - Health Research and Statistics (39)	$ 576,920	$ 715,513	$ 1,195,231	$ 1,304,587	$ 1,579,988
VDH	Investments (STC-79) - Health Laboratory (31)	$ 2,494,516	$ 3,405,659	$ 3,294,240	$ 3,227,611	$ 3,245,097
VDH	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	$ 632,848	$ 702,544	$ -	$ -	$ 1,351,459
VDH	Investments (STC-79) - Statewide Tobacco Cessation (76)	$ 1,073,244	$ 1,148,535	$ 257,507	$ 257,507	$ -
VDH	Investments (STC-79) - Family Planning (75)	$ 1,556,025	$ 1,390,410	$ 1,193,215	$ 1,473,280	$ 1,349,711

VDH	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	$ 1,040,000	$ 900,000	$ 770,000	$ 834,222	$ 767,111
VDH	Investments (STC-79) - Renal Disease (73)	$ 3,375	$ 10,125	$ 13,500	$ 11,625	$ -
VDH	Investments (STC-79) - WIC Coverage (37)	$ 317,775	$ 1,824,848	$ 1,201,498	$ 1,592,077	$ 3,881,689
VDH	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	$ 547,500	$ 543,995	$ 562,000	$ 463,000	$ 556,100
VDH	Investments (STC-79) - Patient Safety - Adverse Events (47)	$ 38,731	$ 34,988	$ 35,033	$ 39,465	$ 36,700
VDH	Investments (STC-79) - Substance Use Disorder Treatment (30)	$ 2,363,671	$ 2,913,591	$ 2,169,074	$ 4,483,334	$ 9,078,817
VDH	Investments (STC-79) - Recovery Centers (17)	$ 1,009,176	$ 1,299,604	$ 1,354,104	$ 1,505,120	$ 1,486,634
VDH	Investments (STC-79) - Enhanced Immunization (46)	$ 165,770	$ 253,245	$ 109,373	$ 251,577	$ 166,046
VDH	Investments (STC-79) - Poison Control (48)	$ 152,433	$ 105,586	$ 85,586	$ 136,390	$ 84,756
VDH	Investments (STC-79) - Public Inebriate Services, C for C (23)	$ 288,691	$ 426,000	$ 784,155	$ 1,229,572	$ 819,027
VDH	Investments (STC-79) - Fluoride Treatment (38)	$ 59,362	$ 55,209	$ 75,916	$ 62,341	$ 57,644
VDH	Investments (STC-79) - Medicaid Vaccines (24)	$ 707,788	$ 557,784	$ 578,183	$ -	$ -

VDH	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	$ 479,936	$ 421,302	$ 187,784	$ 258,563	$ 257,121
VDH	Investments (STC-79) - VT Blueprint for Health (44)	$ 713,216	$ 703,123	$ 757,576	$ 874,534	$ 1,466,561
VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$ 326,184	$ 395,229	$ (26,262)	$ -	$ -
VDH	Community Clinics	$ 688,000	$ -	$ -	$ -	$ -
VDH	FQHC Lookalike	$ 160,200	$ 97,000	$ 6,000	$ -	$ -
VSC	Health Professional Training	$ 405,407	$ 409,461	$ 629,462	$ 409,461	$ 409,461
VVH	Vermont Veterans Home	$ 410,986	$ 410,986	$ 410,986	$ 410,986	$ 410,986
Total		**$ 127,103,459**	**$ 128,924,888**	**$ 126,882,102**	**$ 138,740,345**	**$ 147,237,720**

Appendix B: Quality Health Plan Pullout

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
2019 Plan Designs & Monthly Premiums (before subsidy)

Interested in the cost *after* subsidy?
Most Vermonters who use Vermont Health Connect qualify for financial help to reduce their costs. To see if you qualify, visit the Plan Comparison Tool at https://vt.checkbookhealth.org or call 1-855-899-9600.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

		Standard Plans					Standard High Deductible Health Plans (HDHP)		Blue Rewards						MVP VT Plus Non-Standard					
		BCBSVT & MVP					Can Pair with Health Savings Account (HSA)		BCBSVT only						MVP only					
		Platinum	Gold	Silver	Bronze	Bronze without Rx MOOP	Silver HDHP	Bronze HDHP	Gold	Silver	Bronze without Rx MOOP	Gold CDHP (HDHP) Can pair with HSA	Silver CDHP (HDHP) Can pair with HSA (NEW in 2019)	Bronze CDHP (HDHP) without Rx MOOP (Can pair with HSA)	Gold	Silver	Bronze	Gold HDHP Can pair with HSA	Silver HDHP Can pair with HSA (NEW in 2019)	Bronze without Rx MOOP
		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	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.)	Integrated Ded.?	N	N	N	N	Y - $7,600/$15,200	Y - $1,550/$3,100	Y - $5,250/$10,500	Y - $1,550/$3,100	Y - $2,850/$5,700	Y - $7,900/$15,800	Y - $3,000/$6,000	Y - $4,100/$8,200	Y - $6,650/$13,300	N	N	N	Y - $2,700/$5,400	Y - $4,100/$8,200	Y - $7,600/$15,200
	Medical Ded.	$350/$700	$850/$1,700	$2,800/$5,600	$5,500/$11,000	See above	See above	See above	See above	See above	See above	See above	See above	See above	$850/$1,700	$1,400/$2,800	$6,750/$13,500	See above	See above	See above
	Waived[1] for: (see Services below)	Prev, OV, UC, Amb, Den1[11]	Prev, OV, UC, Amb, Den1[11]	Prev, OV, UC, Amb, Den1[11]	Prev, Den1	Prev, OV, Den 1	Prev	Prev	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev	Prev	Prev	Prev, UC, OV, Den1[11]	Prev, 3 PCP/MH, Den1	Prev	Prev	Prev	Prev, 3 PCP/MH OV, Den1
	Prescription (Rx) Ded.	$0	$100/$200	$300/$600	$900/$1,800	See above	See above	See above	See above	See above	See above	See above	See above	See above	$225/$450	$400/$800	$550/$1,100	See above	See above	See above
	Waived for:	N/A ($0 Ded.)	Rx Generic	Rx Generic	Not waived	Rx Generic	Rx Wellness	Rx Wellness	Not waived	Not waived	Not waived	Rx Wellness	Rx Wellness	Rx Wellness	Rx VBID, Rx Generic to age 10	Rx VBID, Rx Generic to age 10	Rx VBID, Rx Generic to age 10	Rx Wellness	Rx Wellness	Rx VBID, Rx Generic
Max. Out-of-Pocket (MOOP)	Integrated?	N	N	Y-$7,500/$15,000[7]	Y - $7,900/$15,800	Y - $7,600/$15,200	Y-$6,650/$13,300	Y-$6,650/$13,300	Y-$5,150/$10,300	Y-$7,900/$15,800[7]	Y - $7,900/$15,800	Y - $3,000/$6,000	Y - $4,100/$8,200	Y - $6,650/$13,300	N	N	Y - $7,900/$15,800	Y - $2,700/$5,400	Y - $4,100/$8,200	Y - $7,600/$15,200
	Medical	$1,350/$2,700	$4,700/$9,400	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	See above	$6,050/$12,100	$6,050/$12,100	See above	See above	See above	See above
	Prescription (Rx)	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	See above	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	See above	$1,350/$2,700	$1,350/$2,700	See above	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	$1,350/$2,700	See above
Stacked, Embedded or Aggregate?[6]		Stacked[6]	Stacked[6]	Stacked[6]	Stacked[6]	Stacked[6]	Aggregate Embedded[8,10]	Aggregate Embedded[8,10]	Aggregate Embedded[8,10]	Aggregate Embedded[8,10]	Aggregate Embedded[8,10]	Aggregate[6]	Aggregate Embedded[8,10]	Aggregate Embedded[8,10]	Embedded[6]	Embedded[6]	Embedded[6]	Aggregate[6]	Embedded[6]	Embedded[6]
Service Category (Examples)		Co-insurance (%) / Co-pay ($)	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 ($)	Co-insurance (%) / Co-pay ($)	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	$0	$0	$0	$0
Office Visit (OV)	PCP or Mental Health (PCP/MH)	$10	$15	$30	Ded., then $35	$40	Ded., then 10%	Ded., then 50%	3 visits/person (9/family) with no cost-share; then deductible applies + co-pay: $20 (Gold), $30 (Silver), $0 (Bronze)			Ded., then $0	Ded., then $0	Ded., then $0	$15	$30 x3, then ded., then $30	Ded., then $40	Ded., then $0	Ded., then $0	0% x3, then ded., then 0%
	Specialist[2]	$30	$30	$75	Ded., then $90	$100	Ded., then 30%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $0	$40	Ded., then $60	Ded., then $100	Ded., then 0%	Ded., then 0%	Ded., then 0%
Urgent Care (UC)		$40	$40	$85	Ded., then $100	Ded., then $0	Ded., then 30%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $0	$30	Ded., then $60	Ded., then $100	Ded., then 0%	Ded., then 0%	Ded., then 0%
Ambulance (Amb)		$50	$50	$100	Ded., then $100	Ded., then $0	Ded., then 30%	Ded., then 50%	Ded., then $30	Ded., then $50	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $50	Ded., then $100	Ded., then $100	Ded., then 0%	Ded., then 0%	Ded., then 0%
Emergency Room (ER)[3]		Ded, then $100	Ded, then $150	Ded., then $250	Ded., then 50%	Ded., then $0	Ded., then 30%	Ded., then 50%	Ded., then $250	Ded., then $450	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $250	Ded., then $400	Ded., then 50%	Ded., then 0%	Ded., then 0%	Ded., then 0%
Hospital Services[4]	Inpatient	Ded., then 10%	Ded., then 30%	Ded., then 40%	Ded., then 50%	Ded., then $0	Ded., then 30%	Ded., then 50%	Ded., then $750	Ded., then $1,750	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then 20%	Ded., then 50%	Ded., then 50%	Ded., then 0%	Ded., then 0%	Ded., then 0%
	Outpatient	Ded., then 10%	Ded., then 30%	Ded., then 40%	Ded., then 50%	Ded., then $0	Ded., then 30%	Ded., then 50%	Ded., then $750	Ded., then $1,750	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then $0	Ded., then 20%	Ded., then $1,400	Ded., then 50%	Ded., then 0%	Ded., then 0%	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	30-day supply	30-day supply	30-day supply
Rx Generic[5]		$5	$10	$15	Ded., then $20	$25	Ded.[9], then $10	Ded.[9], then $12	Ded., then $5	Ded., then $5	Ded.[9], then $0	Ded., then $5	Ded., then $15	Ded., then $25	$5	Ded., then $5	Ded.[9], then $20	Ded., then 0%	Ded., then 0%	$30
Rx Preferred Brand[5]		$50	Ded., then $50	Ded., then $60	Ded., then $85	Ded.[9], then $0	Ded.[9], then $40	Ded.[9], then 40%	Ded., then 40%	Ded., then 40%	Ded.[9], then $0	Ded., then 40%	Ded., then 40%	Ded., then 40%	Ded., then $40	Ded., then 50%	Ded.[9], then $90	Ded., then 0%	Ded., then 0%	Ded.[9], then 0%
Rx Non-Preferred Brand[5]		50%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then $0	Ded., then 50%	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then $0	Ded., then 60%	Ded., then 60%	Ded., then 60%	Ded., then 50%	Ded., then 50%	Ded., then 60%	Ded., then 0%	Ded., then 0%	Ded., then 0%
Additional Benefits																				
Wellness Benefits		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, up to $50 in wellness rewards			Up to $50 in wellness rewards	Up to $50 in wellness rewards	VBID Rx co-pay of $3, up to $50 in wellness rewards
Premiums by Tier[8]		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	Cost before subsidy	Cost before subsidy	Cost before subsidy
Single	BCBSVT	$786.86	$674.23	$645.34	$496.39	$512.57	$650.23	$507.44	$657.64	$651.71	$499.40	$625.62	$639.80	$504.10						
	MVP	$716.54	$608.39	$638.82	$426.12	$485.37	$621.74	$436.34							$623.64	$597.79	$428.16	$583.79	$623.72	$441.18
Couple	BCBSVT	$1,573.72	$1,348.46	$1,290.68	$992.78	$1,025.14	$1,300.46	$1,014.88	$1,315.28	$1,303.42	$998.80	$1,251.24	$1,279.60	$1,008.20						
	MVP	$1,433.08	$1,216.78	$1,277.64	$852.24	$970.74	$1,243.48	$872.68							$1,247.28	$1,195.58	$856.32	$1,167.58	$1,247.44	$882.36
Parent and Child(ren)	BCBSVT	$1,518.64	$1,301.26	$1,245.51	$958.03	$989.26	$1,254.94	$979.36	$1,269.25	$1,257.80	$963.84	$1,207.45	$1,234.81	$972.91						
	MVP	$1,382.92	$1,174.19	$1,232.92	$822.41	$936.76	$1,199.96	$842.14							$1,203.63	$1,153.73	$826.35	$1,126.71	$1,203.78	$851.48
Family	BCBSVT	$2,211.08	$1,894.59	$1,813.41	$1,394.86	$1,440.32	$1,827.15	$1,425.91	$1,847.97	$1,831.31	$1,403.31	$1,757.99	$1,797.84	$1,416.52						
	MVP	$2,013.48	$1,709.58	$1,795.08	$1,197.40	$1,363.89	$1,747.09	$1,226.12							$1,752.43	$1,679.79	$1,203.13	$1,640.45	$1,752.65	$1,239.72

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 (844-865-0250).
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/$300/$900 Rx Deductible per person, while MVP Standard Gold/Silver/Bronze plans have an Rx Deductible of $100/$300/$900 for a Single plan or a maximum of $200/$600/$1,800 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 $7,900 to prevent one individual from paying the full family maximum out-of-pocket when it exceeds the federal maximum out-of-pocket of $7,900 for an individual.
11 This plan includes deductible-waived vision care for qualifying children. See Summary of Benefits and Coverage for details: http://info.healthconnect.vermont.gov/healthplans#SBCs

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 (844-865-0250).

Updated 10/08/18

[11] https://info.healthconnect.vermont.gov/sites/hcexchange/files/2019%20Plan%20Designs%20with%20Final%20Rates_final.pdf

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DVHA Performance Accountability Scorecard

Transparency is essential to good public management. DVHA operates a public health plan that serves approximately a third of all Vermonters. This Scorecard is designed to let Vermonters know what strategic goals are important in operating our health plan and how DVHA is doing in striving for success. DVHA is committed to continually reviewing these priorities with our partners and stakeholders to ensure that we are delivering the best service possible for Vermonters.

Healthcare Access, Eligibility & Enrollment Unit (HAEEU)

What We Do

The Health Access Eligibility and Enrollment Unit (HAEEU)consists of five teams that each fulfill a specific function in helping Vermonters down the path from learning about health programs to applying, enrolling, and understanding their rights and responsibilities.

Eligibility & Enrollment Team works directly with members and is responsible for managing documents sent in by applicants, determining eligibility, assisting in enrollment, providing customer support through the call center, and resolving escalated cases.

Maintenance & Operations Team ensures that the Unit's systems are well maintained and tested. They monitor the integrity, accuracy, and timeliness of transactions and are accountable for the overall success and delivery of Open Enrollment. They document policies and procedures, streamline business processes, and provide member facing staff with the training and knowledge needed to be operationally ready.

Data Team reconciles file transactions between Vermont Health Connect's case management system, billing system, health insurance issuers, and the State's legacy ACCESS system. They maintain the Unit's data and provide operational reports and dashboards.

Assistant Operations Team serves as the policy liaison for HAEEU, providing guidance, direction, and interpretation on federal regulations and state rules and how those policies are implemented technically and operationally.

Customer Experience Team works to ensure that current members understand their benefits and responsibilities and that potential applicants understand health care programs and the application process. They manage member notices, a contracted call center, and a network of nearly 300 In-person Assisters. They manage health insurance literacy efforts – helping Vermonters understand health insurance terms, compare options, and get the most out of their health coverage – and focus on groups of Vermonters likely to lack access to health insurance, including farmers, justice- involved individuals, new Vermont residents, and those in the 26-34 age group. They collaborate with community partners, including hospitals, clinics, agricultural organizations, libraries, pharmacies, and other stakeholders.

Who We Serve

HAEEU serves the more than 200,000 Vermonters who receive health benefits through Medicaid programs and/or the State's health insurance marketplace. Medicaid program members include those Vermonters who receive health coverage through Medicaid for Children and Adults (MCA), Dr. Dynasaur, Medicaid for the Aged, Blind and Disabled, VPharm, and the Medicare Savings Programs. The health insurance marketplace enrolls members in qualified health plans (QHP) and administers federal and state-based financial assistance, while also providing resources to Vermonters who buy unsubsidized health coverage on their own or through a small business.

How We Impact

Quality health coverage is a key ingredient of health and well-being. Vermont has one of the lowest uninsured rates in the nation and its health care system is consistently ranked one of the best, with one of the narrowest gaps in access between rich and poor residents. For many Vermonters, HAEEU is the doorway into this healthcare system.

Action Plan

Implement Total Quality Management, building a climate in which:

Each staff member is responsible for continuous improvement of their knowledge and management of the programs and systems;

The team communicates effectively with members, partners, and stakeholders;

The team provides members, partners, and stakeholders with an exceptional customer experience by continuing to improve the speed and quality of eligibility determinations for applications, verifications, and change requests.

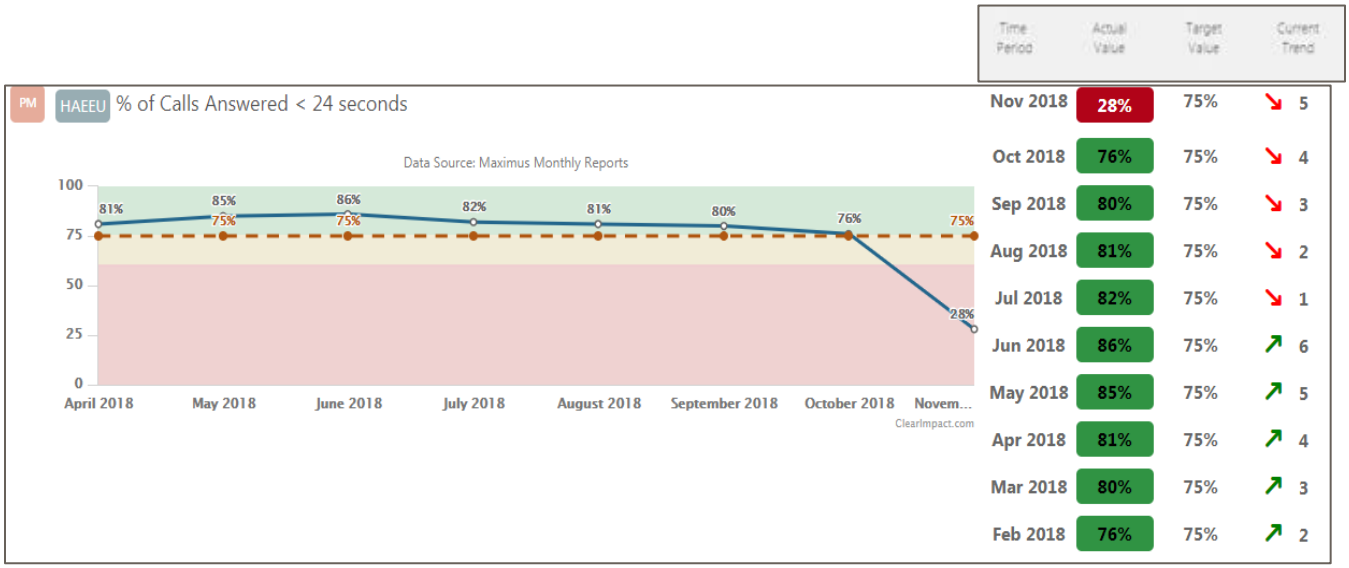
Implement several Integrated Eligibility and Enrollment products, including:

Health Care Application Usability (HCAU) – A single streamlined application will provide the opportunity for an applicant to request a full health care screening for all healthcare benefit programs, including both Modified Adjusted Gross Income (MAGI) and non-MAGI programs.

Customer Portal Phase 1 (CPPH1) -- A technical solution will allow Vermonters to submit verification documentation electronically, with the benefits of both making it easier for Vermonters to submit documentation and streamlining staff's intake and processing work.

Enterprise Content Management (ECM) Migration Project -- One system, OnBase, will be used for all healthcare benefit programs, including both MAGI and non-MAGI programs.

Business Intelligence (BI) Migration Project - Microsoft SQL Server, which is broadly used throughout AHS, will replace HAEEU's current Oracle-based reporting system.



Partners

DVHA-HAEEU's Tier 1 Customer Support Center is contracted through Maximus. Vermonters who need to apply for health benefits can call the Customer Support Center, as can members who need to ask questions or report changes to their accounts. A Service Level Agreement (SLA) in the contract between DVHA and Maximus calls for Maximus to receive a performance bonus for any months in which they answer at least 75% of calls within 24 seconds and have an abandoned rate of no more than 5.0%. It also calls for a financial penalty if fewer than 60% of calls are answered within 24 seconds. Tier 2 Customer Support is run directly by DVHA, handling eligibility-related questions and other escalations.

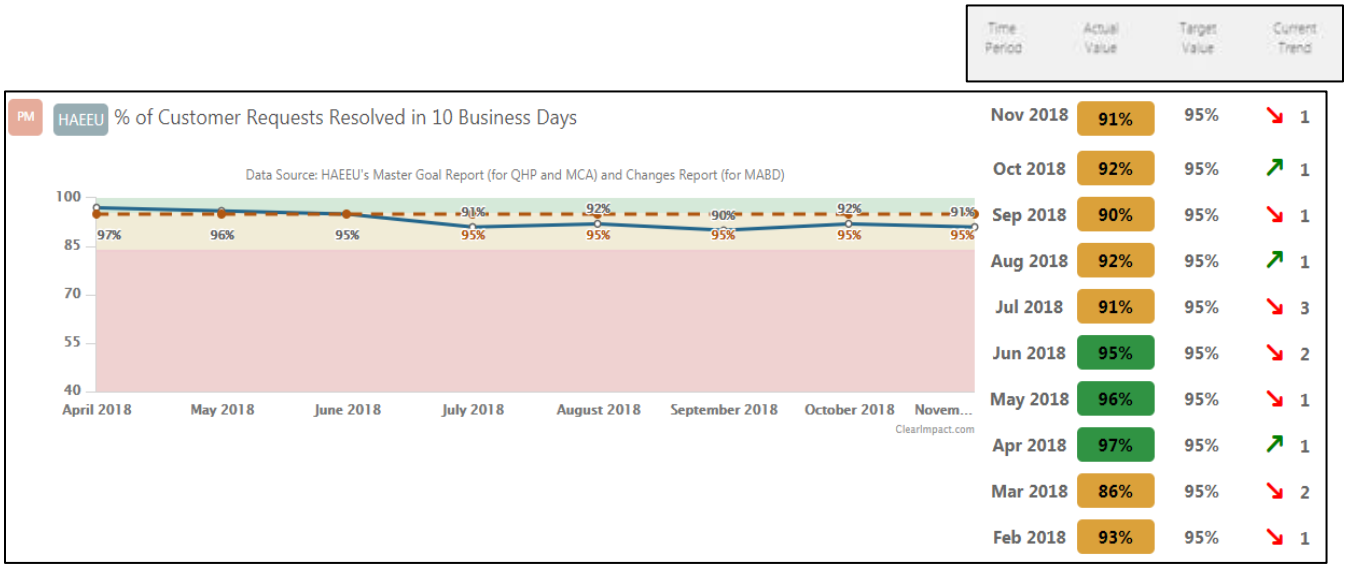
Story Behind the Curve

Call volume for each of the first three months of 2018 was down more than 30% from the corresponding month in 2017. February 2018 was the lowest of any month since the launch of the exchange, likely due in part to the earlier open enrollment period, in part to 1095 forms being mailed earlier this year, and in part to fewer problems in general.

Call volume for the second quarter was even lower, with first May and then June surpassing February's record for lowest monthly call volume. This low volume combined with ample staffing levels at Maximus result in prompt answer times for callers.

The experience for callers has been strong throughout 2018 and was even largely positive during the newly compressed 2018 Open Enrollment period (November 1 - December 15, 2017). In anticipation of heavy volumes as the deadline approached, customer support implemented a new triage process that allowed callers to decide whether to request a callback or stay on the line during times of high volume. DVHA credits this process with the fact that there were minimal customer complaints even though the Customer Support Center fell short of its target of answering 75% of calls in 24 seconds (actuals were 73% for November 65% for December). Notably, the proportion of callers who responded to a survey saying that they were satisfied with their overall service on the call was 96.0% in November and 96.3% in December.

The customer experience was also improved by a decrease in escalations. Only 6% of November-December 2017 calls had to be transferred to DVHA's Eligibility and Enrollment staff, down from 8% in November-December 2016. Just as importantly, DVHA promptly answered the calls that were transferred; 92% of those November-December 2017 transfers were answered in five minutes, up from 46% in November-December 2016. This trend continued into 2018, with at least 94% of transferred calls answered in five minutes in each of the first six months of the year.



Story Behind the Curve

This metric measures the speed at which customer requests are processed. It includes requests related to Qualified Health Plan (QHP) and MAGI-Medicaid members in the Vermont Health Connect (VHC) system as well as those related to Medicaid for the Aged, Blind and Disabled (MABD) members in Green Mountain Care (GMC) programs in the State's legacy ACCESS system.

The goal for 2018 is to complete at least 95% of customer requests within ten business days.

All Vermonters who are served by DVHA-HAEEU should expect that their requests will be addressed promptly. And yet, for the first few years of VHC, many requests took several weeks or months to complete. In the first quarter of 2016, fewer than 60% of requests were completed within ten business days. That spring HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017.

In March 2016, the State of Vermont and VHC Systems Integrator Optum deployed their final major release to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March 2016 and continued into the summer of 2016.

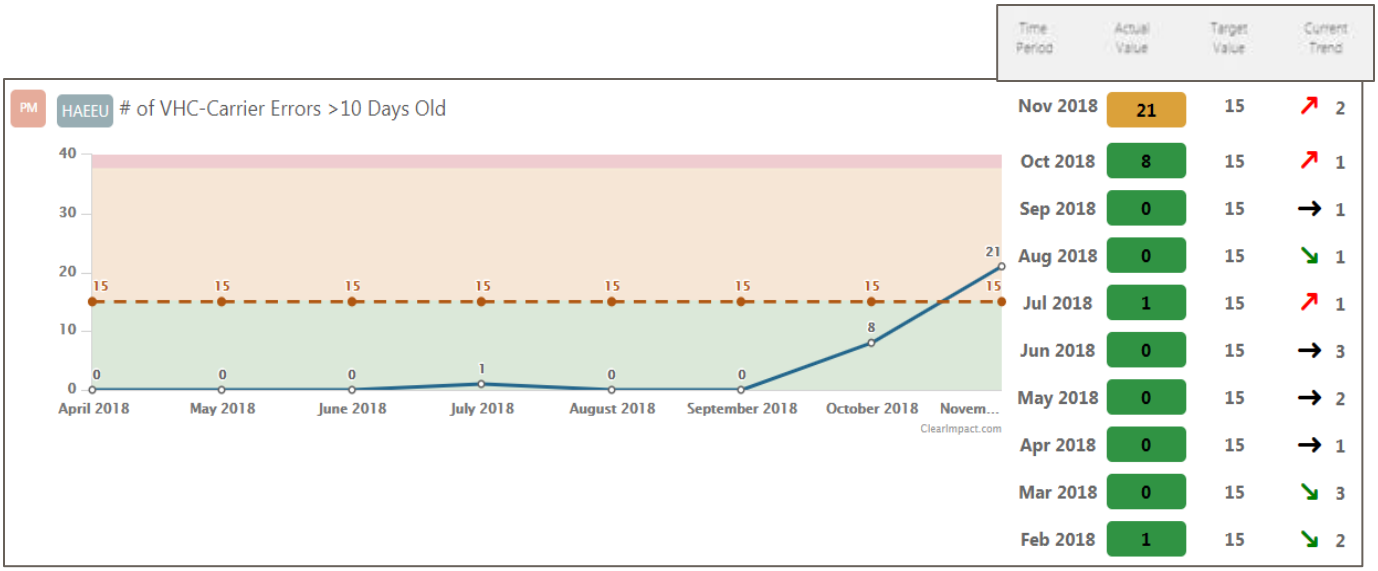
The results of the M&O Surge were clearly visible by late spring 2016. Escalated case inventories fell 80% from March levels. Integration errors were also cut 80%. Customer requests were processed in an increasingly timely manner.

In June 2016, HAEEU surpassed its October goal of completing 75% of requests in ten business days. In October 2016, they surpassed their June 2017 goal of 85%. Over the following months, performance continued to improve. With the 2017 QHP Open Enrollment and Renewal Period's successful completion, system integration improved over prior years and errors fell. As a result, customer requests were promptly completed on a more consistent basis.

The second week of March 2017 marked the first time that 95% of VHC requests were completed in ten days. Since that time, VHC requests have consistently met this threshold. For 22 straight weeks, from the beginning of February 2018 through early July 2018, there wasn't a single week that didn't exceed the 95% threshold. It's also important to note that the 5%delta includes cases that can’t be worked for a couple months by rule, such as post-partum cases.

GMC requests have not had quite the same level of consistently strong performance as VHC requests over that time, typically resulting in the combined result for HAEEU requests (i.e. this metric) being lower than the results for VHC requests.

DVHA-HAEEU partners with its three carrier partners (BlueCross BlueShield of Vermont, MVP Healthcare, and Northeast Delta Dental) as well as the State's systems integrator (Optum) to send new customer cases and changes to cases from the State's system to the partners' systems. Integration teams at DVHA-HAEEU and the partners work together to clean up errors, identify the root cause of defects that cause errors, and deploy fixes to defects to reduce the occurrence of errors in the future.


PM
HAEEU
# of VHC-Carrier Errors >10 Days Old
40
30
20
10
0
15
0
April 2018
May 2018
June 2018
July 2018
August 2018
September 2018
October 2018
Novem...
ClearImpact.com
Time Period
Actual Value
Target Value
Current Trend
Nov 2018 21 15 2
Oct 2018 8 15 1
Sep 2018 0 15 1
Aug 2018 0 15 1
Jul 2018 1 15 1
Jun 2018 0 15 3
May 2018 0 15 2
Apr 2018 0 15 1
Mar 2018 0 15 3
Feb 2018 1 15 2

Story Behind the Curve

This metric measures the inventory of integration errors between the State of Vermont's system and the insurance carriers' systems that have been open more than ten days as of the last Thursday of every month.

The State's system is the system of record for Qualified Health Plans (QHPs) and dental plans, while the insurance carriers' systems ensure that providers and pharmacies can see coverage and bill for service. In order to deliver a smooth customer experience, changes that are made to customers' accounts must promptly be integrated across systems, and errors that do occur must be resolved in a timely manner in order to avoid customer impact.

And yet, for the first few years of the Vermont's health insurance exchange, DVHA-HAEEU lacked the ability to resolve many errors through the system. Hundreds of cases lingered in error status for weeks at a time, resulting in billing problems, customer confusion, and Access-to-Care escalations.

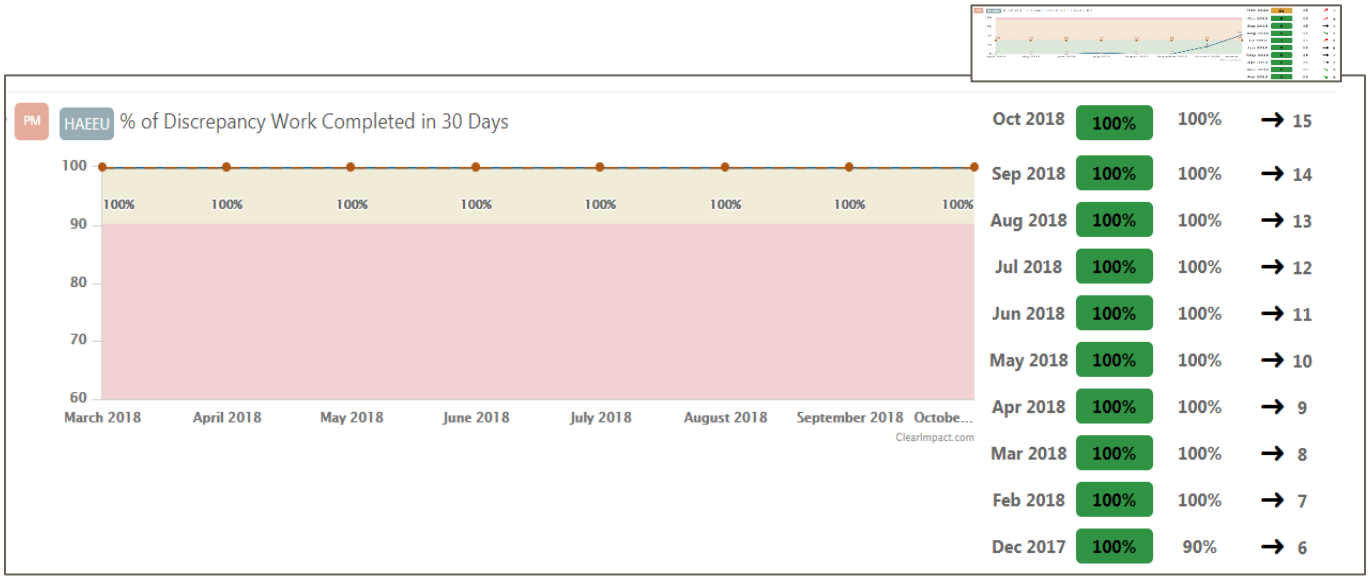
In March 2016, the State and VHC Systems Integrator Optum deployed their final major release to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March 2016 and continued into the summer of 2016.

The results of the M&O Surge were clearly visible by late spring 2016. Escalated case inventories fell 80% from March levels. Integration errors were also cut 80%. Progress continued into the fall.

For 2017, DVHA-HAEEU set a goal of having less than one-tenth of one percent of cases sit in error status for more than ten days. With more than 31,000 subscriber cases across the three carriers, that equates to an inventory of 31 or fewer errors open more than ten days.

After just missing the target in February and March 2017, DVHA-HAEEU exceeded the goal in each of the last nine months of the year, then started off 2018 on a strong note.

In the spirit of continual improvement, DVHA has adopted a more ambitious target for 2018 by aiming to have less than one- twentieth of one percent of cases sit in error status for more than ten days. This equates to an inventory of 15 or fewer errors open more than ten days. DVHA met this new target in each of the first eight months of 2018, finishing March, April, May, June, and August with zero cases in error status for more than ten days.



Partners

DVHA-HAEEU partners with its three carrier partners (BlueCross BlueShield of Vermont, MVP Healthcare, and Northeast Delta Dental) as well as its premium processing contractor (Wex Health).

Story Behind the Curve

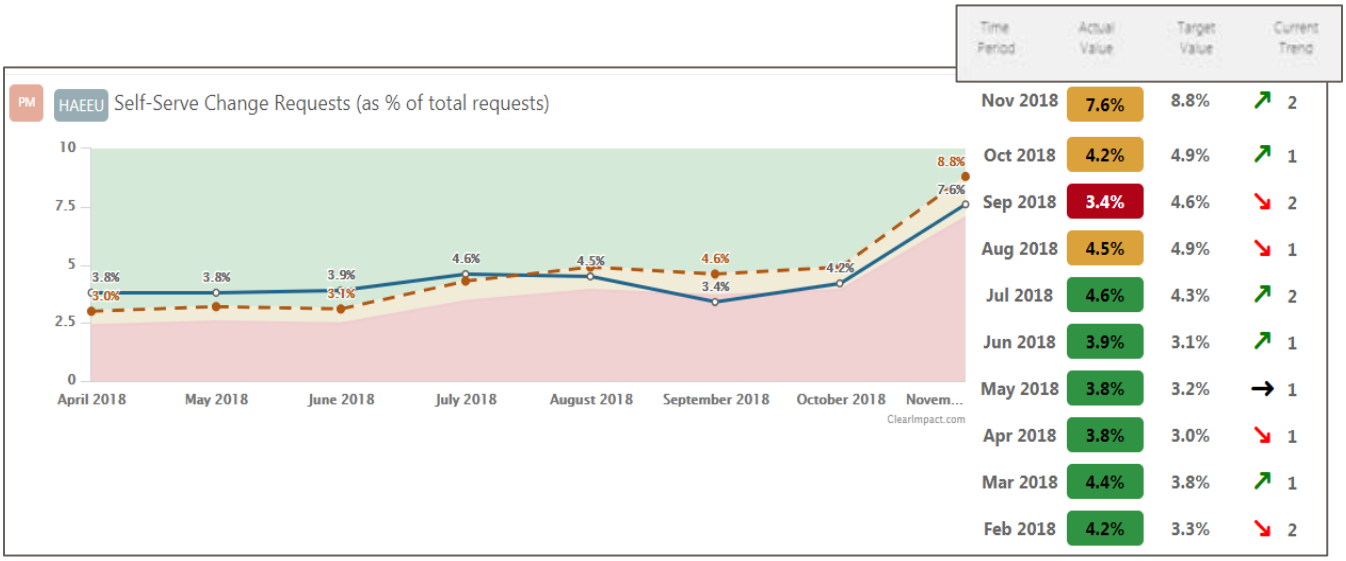
This metric looks at the number of discrepancies between the State's system and the systems of its carrier partners that are identified and should be worked within 30 days, then evaluates how many of those items are worked within the month.

The ability to perform ongoing monthly reconciliation between the State's system and the systems of its carrier partners is essential to maintaining data integrity, ensuring a positive customer experience, and limiting financial liabilities. If the State and its partners can identify discrepancies that arise and address most of those discrepancies within the month, they will be in a strong position to avoid lingering inventories and the accompanying risks.

False positives and items related to the timing of reports are screened out. MVP Health Care needs to improve the quality of its reports in order to enable reconciliation, which is a priority for 2018 now that MVP has a new integration vendor in place as of the end of2017. In June 2018, MVP completed the system work needed to support this reconciliation. DVHA and its reporting vendor then turned to develop the ability to consume this data, with a goal of operationalizing the process by fall.

In December 2017, the reconciliation team reported that it had completed 100% of November discrepancy work -- all with the Blue Cross Blue Shield of Vermont and Northeast Delta Dental systems -- within 30 days, surpassing the 90% goal for the tenth straight month.

Due to the way the monthly reconciliation process works within the annual process, there were no figures for January 2018. Metrics for 2018 monthly reconciliation are reported from February through December. The target for 2018 was increased to the goal of completing 100% of discrepancy work each month. This target has been met every month since February 2018.



Partners

DVHA-HAEEU works with partners across the state, including libraries, clinics, and community organizations in HAEEU's Assister Program to encourage Vermonters to set-up online accounts with Vermont Health Connect and then use those accounts to access their documents and report changes.

Story Behind the Curve

This metric measures the percentage of Vermont Health Connect (VHC) change requests that members make online themselves, as opposed to calling and talking to a Customer Support Representative.

The VHC system offers self-service options for Vermonters to pay their bills, report changes, and access tax documents and other forms. Self-service can lead to an improved customer experience as Vermonters can log in at their convenience. It can also save the State money through automation. The goal is for a continual increase in self-service adoption at a rate of at least 10% growth year-over-year.

The percentage of change requests made via the self-serve option nearly doubled, from 4.6% in December 2016 to 8.5% in December 2017. Significantly more members utilize this option during open enrollment, however, and the proportion dropped to 4.5% in January 2018 (which was still 50% higher than the first month after open enrollment last year, though lower than January 2017 which was during open enrollment).

While it has shown improvement, change request uptake lags some other self-service areas. For example, in December 2017 over half (52%) of new VHC applications were submitted via the online self-serve option during in December 2017, and nearly half (46%) of all electronic payments were made via the recurring payments option.

With most change requests continuing to be made over the phone, more work needs to be done to

increase the uptake of self-serve as an alternative to the call center for reporting changes to income and other household information. In 2017, DVHA promoted self-serve using bill stuffers, call center staff and partner organizations, and social media. During 2018 Open Enrollment, DVHA promoted the self-serve option in email, postcards, and other direct outreach, as well as on social media, press releases, and in notices. In 2018, DVHA-HAEEU's customer experience team will evaluate input from members and work with partners to promote uptake. Members who receive Medicaid for the Aged, Blind and Disabled and other non-MAGI benefit programs are served by the State's legacy ACCESS system and cannot currently utilize self-service options.

Long Term Care (LTC) Unit

What we do

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:

Clinical eligibility which is performed by the Department of Disabilities, Aging and Independent Living (DAIL)

Financial eligibility performed by the **Long-Term Care Unit** in the Department for Vermont Health Access (DVHA)

The LTC application is usually submitted to the DVHA Long Term Care Unit 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.

Who We Serve

LTC Medicaid serves eligible Vermonters who are over 65, blind or disabled and who need access to long term supports and services at home, in an enhanced residential treatment center (ERC) or nursing facility. When Vermont Medicaid covers services for these Vermonters, the families of those Vermonters experience relief from concerns about their family member's long-term care needs.

How We Impact

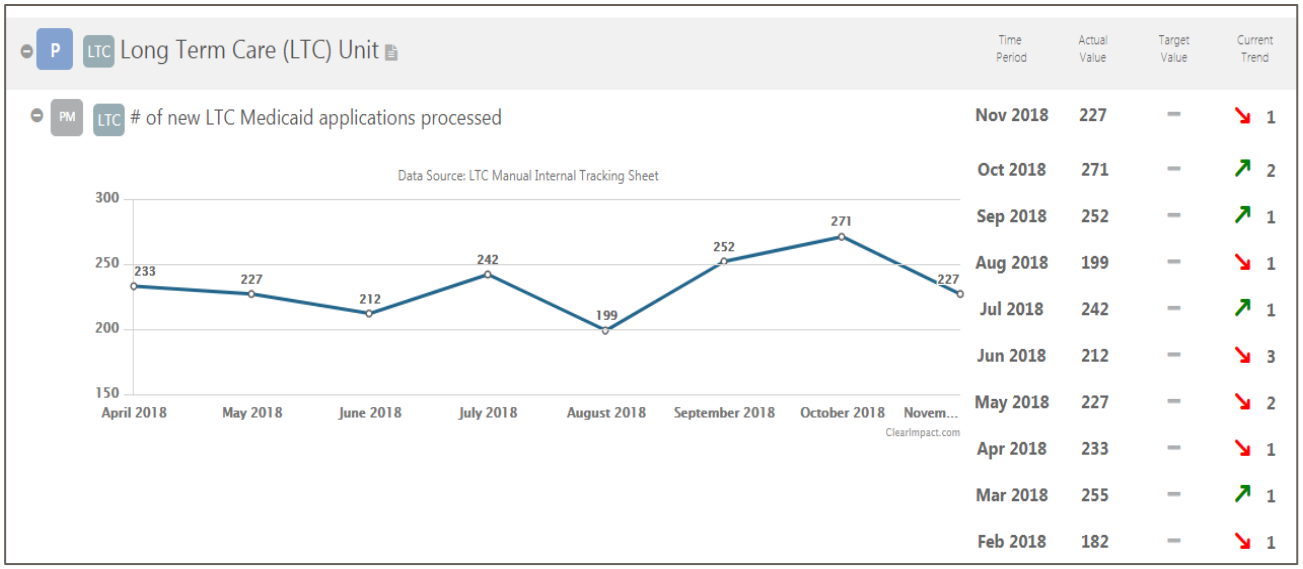
Many Vermonters cannot afford to self-pay for their long-term care (LTC) supports and services and depend upon Vermont Medicaid to enable eligible Vermonters to access necessary LTC services. Often when family members apply for Vermont LTC Medicaid for their relative, family caregivers are struggling to meet the needs of the applicant while maintaining all their other work and family responsibilities. LTC staff often hear from family members who are relieved when Vermont Medicaid begins providing LTC services for the applicant.

Action Plan

The 2 top priorities/initiatives for the LTC Unit in SFY19 are:

Process LTC Applications within the 45-day federal timeliness standard

Improve worker OnBase efficiencies via LEAN Project with ESD



Partners

The Long-Term Care (LTC) Unit has many internal & external partners. The five most frequently contacted are: LTC Applicant

Family members of applicant

Department of Disabilities, Aging and Independent Living (DAIL) staff

DVHA Staff Attorney for LTC

Area Agencies on Aging case managers

Story Behind the Curve

This performance measure reflects the total number of Long-Term Care (LTC) Medicaid applications which received an eligibility determination during the month.

LTC applications require a two-part eligibility determination: DAIL nurses perform a clinical determination and DVHA workers perform the financial eligibility determination.

The LTC Unit is responsible for the financial eligibility determination necessary to ensure that eligible Vermonters can access high quality long term supports and services. The LTC financial eligibility rules are complex. Many Vermonters hire elder law attorneys to help them with the LTC planning and application process. The LTC applications have gotten increasingly detailed and complex over time. LTC financial eligibility rules require a five year look back period of the applicant's financial documents.

The above trend line reflects the number of LTC applications that are processed in each month. An application is considered "processed" after both the DAIL LTC clinical eligibility and the DVHA LTC financial eligibility determinations are completed. The number includes both LTC application approvals and denials.

The new electronic asset verification system (eAVS) was launched in January 2018. While we get many of the eAVS financial results within the Vermont standard of 10 days, we continue to get many later than that. For all applications where we do not get eAVS results for known bank accounts within10 days, the LTC staff must send paper forms to banks requesting copies of the applicant's bank statements. In many cases, the staff will get ultimately get responses from both eAVS and copies of bank statements from the banks. This process creates more work for eligibility staff.

Last updated: 12/15/18

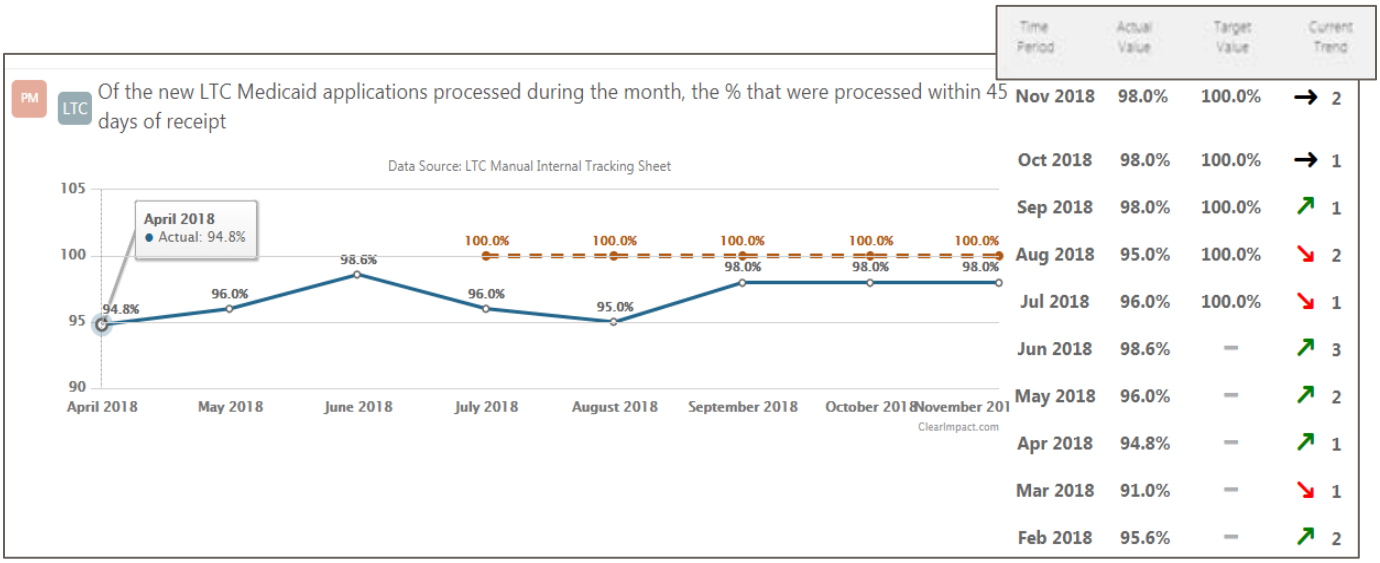
Strategy

The LTC strategies are focused on making accurate eligibility determinations in a more efficient timeframe with the following methods:

Continue training staff to increase foundational knowledge of LTC rules and policies to ensure staff have knowledge necessary to efficiently process cases without supervisor or AOPs guidance. Staff response to trainings have been positive. They have conveyed that the trainings make their work more efficient as they must do less research or consult their supervisor less as their breadth and depth of knowledge improves.

Continue working with PCG to increase percentage of eAVS results received within the 10-day standard. Expectations are that the contracted eAVS solution will give increasingly more results within the 10-day Vermont standard. When that happens, the duplicative work associated with requests for paper bank statements will diminish. That will reduce work burden for staff and concomitantly increase worker efficiencies which will have a positive effect on this trend line.

Identify and improve efficiencies of the business environment for LTC workers. An area where staff chronically complain their time is wasted is in the use of OnBase. Because LTC workers have an extraordinary number of documents in their OnBase queues and because far too many of those documents have the exact same name (rather than the more granular names LTC has repeatedly requested), the LTC staff find themselves repetitively clicking and viewing numerous documents unnecessarily before finding the document they need to review. We have started a LEAN Project where we have defined the problem as inefficiencies associated with LTC workers having to locate needed documents when in OnBase.



Partners

The Long-Term Care (LTC) Unit has many internal & external partners. The five most frequently contacted are:

- LTC Applicant
- Family members of applicant
- Department of Disabilities, Aging and Independent Living (DAIL) staff DVHA Staff Attorney for LTC
- Area Agencies on Aging case managers

Story Behind the Curve

This is a measure of how well staff are processing applications relative to the current timeliness standard.

Long Term Care (LTC) Medicaid applications must be processed within the 45-day federal timeliness standard. Some clients cannot access long term supports and services until their LTC application has been processed. Other clients are admitted to nursing facilities (NF) prior to submission of their LTC application. The NF's depend upon timely processing as they need to know if the client is LTC Medicaid eligible. Additionally, delays in payments for Medicaid eligible LTC services can create revenue issues for the facilities.

Sometimes applications are delayed because the Department of Aging & Independent Living (DAIL) cannot find a clinical placement for the applicant. Sometimes clients do not submit all verification documents within their initial verification due date which requires the worker to send a second verification request. Other delays are the result of the client needing additional time to submit verification documents for the five year look back period (LBP). Finally, since launching the electronic asset verification system (eAVS), LTC workers have experienced higher workloads as explained above.

Applications exceeding 45 days processing time which can be directly attributed to one of these types of delays are not included in this performance measure because the financial eligibility worker has no control over those delays.

The percentage of applications processed within the 45-day federal timeliness standard reflects Vermont's level of compliance with that federal rule. The higher the level of compliance, the lower the risk of financial penalties related to payment errors for exceeding the federal timeliness standard. This

measure receives extensive focus from the LTC Unit, as staff seek to continuously improve in this error through business process efficiencies, worker training and review of casework. Staff workload levels make it very difficult to achieve a 45-day timeliness standard on all LTC cases due to the complex work associated with these cases.

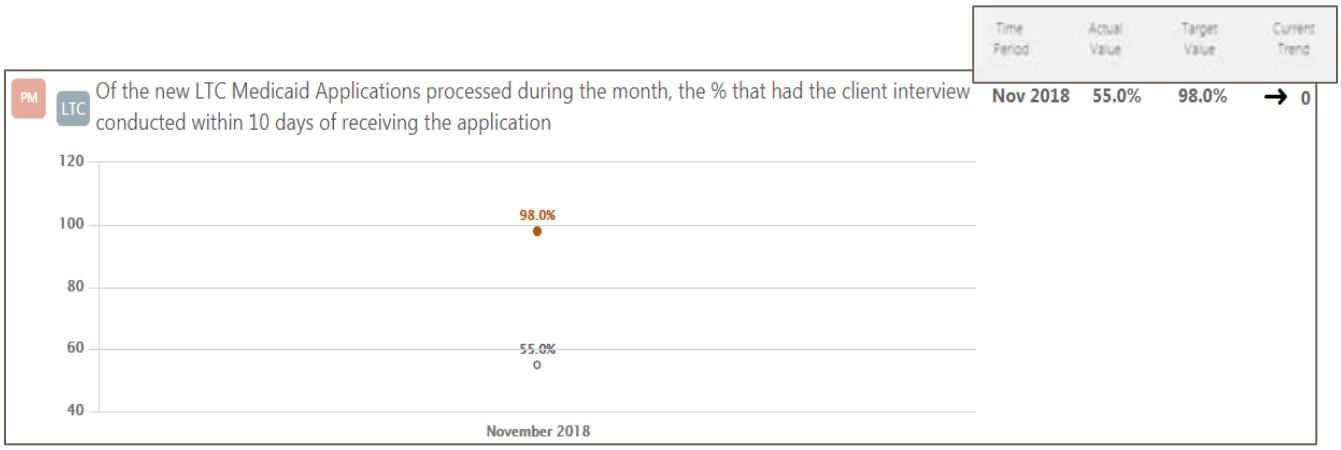
A goal of 100% was established in July 2018 for this performance measure.

Last updated: 12/15/18

Strategy

The LTC strategies are focused on making accurate eligibility determinations in a more efficient timeframe with the following methods:

- Continue training staff to increase foundational knowledge of LTC rules and policies to ensure staff have knowledge necessary to efficiently process cases without supervisor or AOPs guidance. Staff response to trainings have been positive. They have conveyed that the trainings make their work more efficient as they must do less research or consult their supervisor less as their breadth and depth of knowledge improves.
- Continue working with PCG to increase percentage of eAVS results received within the ten-day standard. Expectations are that the contracted eAVS solution will give increasingly more results within the ten-day Vermont standard. When that happens, the duplicative work associated with paper requests for bank statements will diminish. That will reduce work burden for staff and concomitantly increase worker efficiencies which will have a positive effect on this trend line.
- Identify and improve efficiencies of the business environment for LTC workers. An area where staff chronically complain their time is wasted is in the use of OnBase. Because LTC workers have an extraordinary number of documents in their OnBase queues and because far too many of those documents have the exact same name (rather than the more granular names LTC has repeatedly requested), the LTC staff find themselves repetitively clicking and viewing numerous documents unnecessarily before finding the document they need to review. We have started a LEAN Project where we have defined the problem as inefficiencies associated with LTC workers having to locate needed documents when in OnBase.



Notes on Methodology

- This is a new performance measure in December 2018.

Partners

- Economic Services Division's (ESD) Applications and Documents Processing Center (ADPC)
- LTC applicants, family members, case managers or authorized representatives responsible for participating in interview

Story Behind the Curve

Processing new LTC applications requires many steps to ensure that the eligibility determination is done in a compliant manner. Federal rule requires that the financial eligibility determination be completed within 45 days of the application receipt date.

One of the early steps of processing an LTC Medicaid application is the applicant interview. Best practice is for the interview to be conducted within ten days of the application being received in the LTC worker's OnBase queue. The applications are first received by ESD's ADPC Unit prior to being routed to the LTC worker (which normally takes two business days).

Ideally, the interview would be conducted following receipt of the electronic asset verification system (eAVS) responses about bank accounts found for the applicant. However, 77% of the eAVS responses are received later than Vermont's established standard of ten days from the date of the eAVS request. Therefore, workers often do not have eAVS results prior to the interview. These eAVS delays can negatively impact the effectiveness of the client interview. In December 2018, LTC had an all staff face to face meeting to discuss our objectives around interviews and best practices for meeting the ten-day interview goal. During that discussion, workers explained that they have been waiting for eAVS results before conducting the interview which has pushed the average LTC interview times out beyond our goal of ten days. The LTC Team continues to discuss these issues with staff as we strategize how to meet our goal despite some current hurdles with the eAVS timeframes.

Last updated: 12/19/18

Strategy

As we gather and analyze data for this measure, the LTC Management Team will be able to determine if interview times are acceptable or need improvement. If we identify any problematic trends, we will identify the root cause of the problems and develop strategies for improvement.

Provider Member Relations Unit

What We Do

The Provider and Member Relations Unit (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. PMR oversees the Non-Emergency Medical Transportation (NEMT) for covered service for members enrolled in Medicaid and Dr. Dynasaur programs. PMR oversees and monitors NEMT, issuing policies and procedures to coincide with changing circumstances and federal and state directives. NEMT is a statewide service for providing transports for eligible people to and from necessary, non-emergency medical services. It is provided through a Personal Services Contract between the State of Vermont, Department of Vermont Health Access (DVHA) and the Vermont Public Transportation Association (VPTA).

Who We Serve

The Provider and Member Relations Unit (PMR) serves members enrolled in Medicaid and Dr. Dynasaur programs as well as all Providers enrolled with Vermont Medicaid.

How We Impact

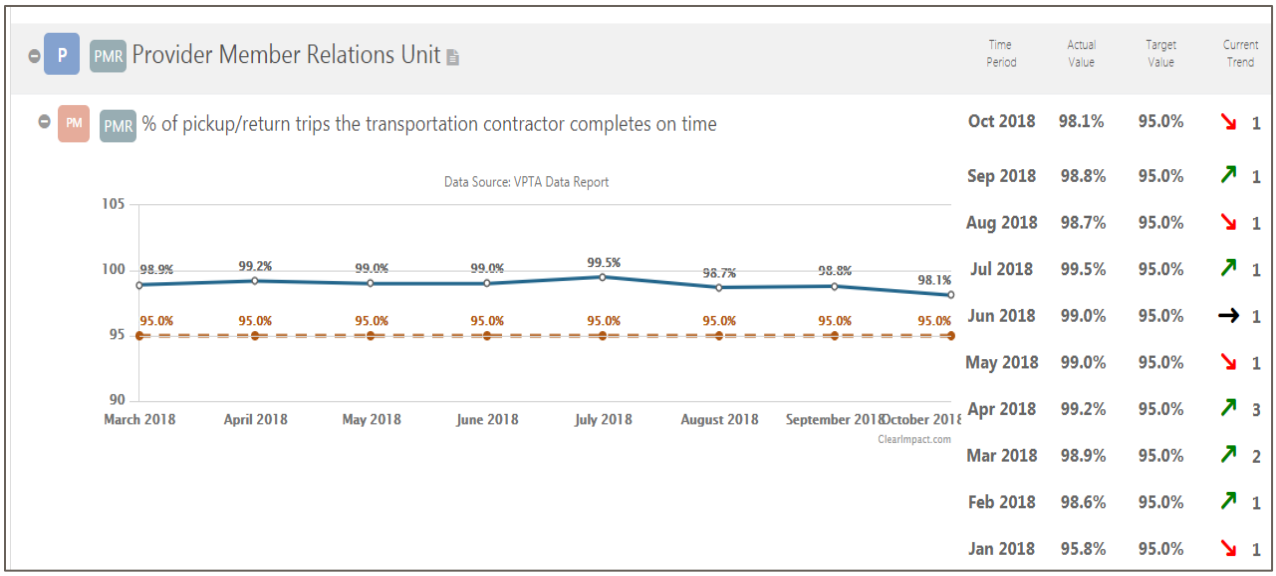
The Provider and Member Relations Unit (PMR) works with all members of Vermont Medicaid to ensure that they have access to covered services as well as ensuring that the provider community is actively engaged with DVHA.

Action Plan

The 2 top priorities/initiatives for the PMR Unit in SFY19 are:

PMR is actively working on a Provider Management Module to ensure providers are enrolled or re-validated with Vermont Medicaid within 60 days.

PMR is actively working with the NEMT to ensure members are receiving all services afforded to them under the program by performing Audits and collaborating with VPTA.



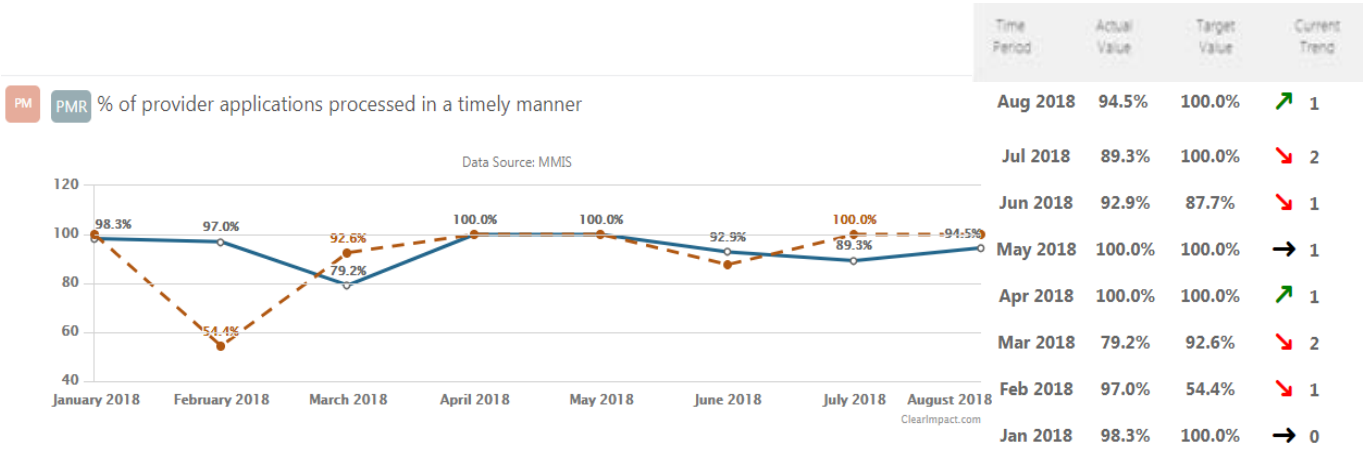
Notes on Methodology

% of pickup/return trips the contractor completes on time														
	SFY18										SFY19			
	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
# member rides	34,345	45,119	47,061	46,413	47,414	42,463	47,492	47,097	49,609	45,676	43,855	46,281	44,309	48,609
# member rides on time	32,115	43,456	45,343	45,073	45,409	41,850	46,958	46,709	49,102	45,221	43,631	45,669	43,794	47,697
% member rides on time	93.5%	96.3%	96.3%	97.1%	95.8%	98.6%	98.9%	99.2%	99.0%	99.0%	99.5%	98.7%	98.8%	98.1%

Story Behind the Curve

This measure captures the non-emergency transportation (NEMT) timely pick up and drop off Medicaid members to medical appointments. The measure is important to the Provider Member Relations (PMR) Unit because it looks at whether Medicaid members are receiving NEMT services within the designated timeframes as defined in the NEMT manual. The PMR Unit is monitoring this measure because significant complaints have been received from members not getting to appointments and not getting picked up in a timely manner.

Prior to August 2017, NEMT was operating as 8 separate entities. As of 8/1/2017, the Vermont Public Transportation Association (VPTA)holds the sole contract for non-emergency transportation. Therefore, the measure data will begin at the start of the VPTA contract. VPTA reporting is due to the PMR Unit within 30 days of the end of the month.



Notes on Methodology

Please note in the chart above:

The solid trend line in the chart above shows the % of VT & border provider applications processed in 60 days or less

The dotted trend line shows the % of out-of-state provider applications processed in 120 days or less

# of days it took to process all VT & border provider applications and out-of-state (OOS) applications that came in during the month																
Report Period	SFY18															
	Jan-18		Feb-18		Mar-18		Apr-18		May-18		Jun-18		Jul-18		Aug-18	
Type of Provider	VT & Border	OOS	VT & Border	OOS	VT & Border	OOS	VT & Border	OOS	VT & Border	OOS	VT & Border	OOS	VT & Border	OOS	VT & Border	OOS
1-30 days	90	0	103	0	50	0	81	3	11	4	17	41	9	44	19	23
31-60 days	26	0	58	0	72	19	89	21	107	10	166	14	166	11	152	11
61-90 days	0	192	3	67	23	6	0	5	0	8	13	17	18	14	9	14
91-120 days	2	0	2	26	7	87	0	11	0	3	1	21	3	5	1	6
121+ days	0	0	0	78	2	9	0	0	0	0	0	13	0	0	0	0
Total # Apps	**118**	**192**	**166**	**171**	**154**	**121**	**170**	**40**	**118**	**25**	**197**	**106**	**196**	**74**	**181**	**54**
% w/in 60 days	**98.3%**	*N/A*	**97.0%**	*N/A*	**79.2%**	*N/A*	**100.0%**	*N/A*	**100.0%**	*N/A*	**92.9%**	*N/A*	**89.3%**	*N/A*	**94.5%**	*N/A*
% w/in 120 days	*N/A*	**100.0%**	*N/A*	**54.4%**	*N/A*	**92.6%**	*N/A*	**100.0%**	*N/A*	**100.0%**	*N/A*	**87.7%**	*N/A*	**100.0%**	*N/A*	**100.0%**
# applications timeframe waived due to PMR review	0	*N/A*	0	*N/A*	0	*N/A*	6	*N/A*	0	*N/A*	14	*N/A*	18	*N/A*	0	*N/A*
Deferred applications (no required timeframe)	*N/A*	0	*N/A*	0	*N/A*	0	*N/A*	1889	*N/A*	2017	*N/A*	2146	*N/A*	2001	*N/A*	1957

Partners

- Medicaid Providers
- DXC

Story Behind the Curve

The Provider Member Relations (PMR) Unit ensures that providers are enrolled in Medicaid in a timely manner to ensure access to services for members.

This measure is important to the PMR Unit because their goal is to ensure Medicaid members can see enrolled providers for their medical needs as well as to ensure Medicaid providers can bill and be paid for the services they deliver.

DXC processes enrollment applications on the behalf of VT Medicaid. It was noted in late December 2017 that the reporting mechanism used to track provider enrollment timeliness was not working at

100% due to clerks not inputting applications correctly when they may have been returned to the provider and resubmitted. DXC and DVHA worked collaboratively to address this error during November & December of 2017; data points are not available for those 2 months.

In the last session, the legislature passed S282, mandating that by July 1, 2019, all provider applications will be processed in 60 days or less. As an interim step, DVHA Senior Management set the following 2 internal targets that by April 1, 2018:

100% of Vermont & border state providers applications will be processed in 60 days or less

100% of all other out-of-state provider applications (with claims or patients) will be processed in 120 days or less

Last updated: 12/18/18

Reimbursement Unit

What We Do

The DVHA Medicaid Reimbursement Unit oversees rate setting, pricing, implementation of the National Correct Coding Initiative Program, quarterly code changes, provider payments, and reimbursement methodologies for a large array of services provided under Vermont Medicaid. 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.

In addition, the Reimbursement Unit oversees a complementary set of specialty fee schedules including, but not limited to: durable medical equipment, ambulance and transportation, clinical laboratory, blood, physician administered drugs, dental, and home health. The unit also manages the FQHC and RHC payment process as well as supplemental payment administration such as the DSH program.

Who We Serve

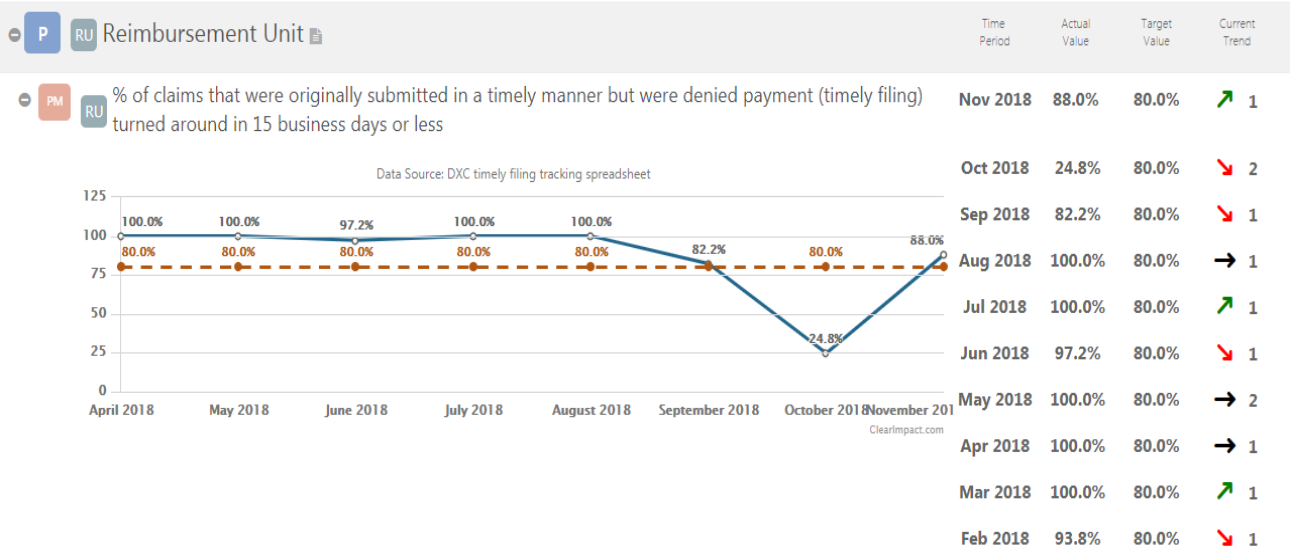
Through our work with Medicaid providers and their stakeholders in implementing payment pricing and policy DVHA Reimbursement has an impact on and serve all Vermont Medicaid recipients.

How We Impact

The unit works with Medicaid providers and other stakeholders to support equitable, transparent, and predictable payment policy to ensure efficient and appropriate use of Medicaid resources. 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. We work closely and collaboratively on reimbursement policies for specialized programs with AHS sister departments, including Disabilities, Aging and Independent Living (DAIL), the Vermont Department of Health (VDH), the Vermont Department of Mental Health (DMH), and the Department for Children and Families (DCF).

Action Plan

The top 2 priorities/initiatives for the Reimbursement Unit in SFY19 are to continue working with suppliers and stakeholders on the update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule.



Partners

Medicaid Providers DXC

Department of Mental Health

Department of Aging & Independent Living Department for Children & Families

Story Behind the Curve

Medicaid has regulations on how long providers have to submit claims for reimbursement, this is called timely filling. For claims originally submitted in a timely manner but denied payment, the DVHA Reimbursement Unit will review for payment. This performance measure will track how long the Reimbursement Unit takes to review denied claims and make a final decision on whether to pay them.

This measure is important to ensure that provider reviews of timely filings are processed in a consistent and timely manner. Providers will appreciate having a decision sooner rather than later.

The jump in % of claims turned around in 15 days or less jumped to 95.1% in January 2018 due to the unit being fully staffed for the first time since a staff member retired in September 2017.

In October 2018 the trendline dropped due to one employee on maternity leave and another new employee being trained.

In November 2018 the trendline jumped to 88% due to the new staff on board. However, that staff left DVHA in early December.

Last updated 12/15/18

Strategy

The Reimbursement Unit recently worked with DXC to update the Timely Filing process. Prior to the update, the process was entirely manual with claims handed off in person from DXC to DVHA Reimbursement staff to work the timely filing request and then return to DXC for MMIS processing, if approved for payment. No tracking system was in place, so it was difficult and time consuming to determine where a claim was in the process when a provider called for a status update. With the Reimbursement Unit's move to the Waterbury complex the process became even more difficult and lengthier. Claims now had to be transported between Williston and Waterbury by currier, adding an additional 3 to 6 days on each end to the time it took to determine whether to pay the claim(s) or not.

The Reimbursement Unit, recognizing the process was inefficient and cumbersome, started working with DXC staff to update and streamline the process. Starting in June 2017, scanned documentation replaced the need for a currier and a tracking spreadsheet is now available in SharePoint that is continually updated and viewable by both DXC and Reimbursement. The electronic process tracks the timely filing request from the day it arrives at DXC to the day a final determination is made by Reimbursement and communicated to DXC.

Now that a tracking system is in place, the Reimbursement Unit has set a goal to review and make a payment determination on 80% of timely filing requests within 15 business days of being received in the unit. There are various challenges to achieving this goal such as:

The free flow of requests in a timely manner to the unit

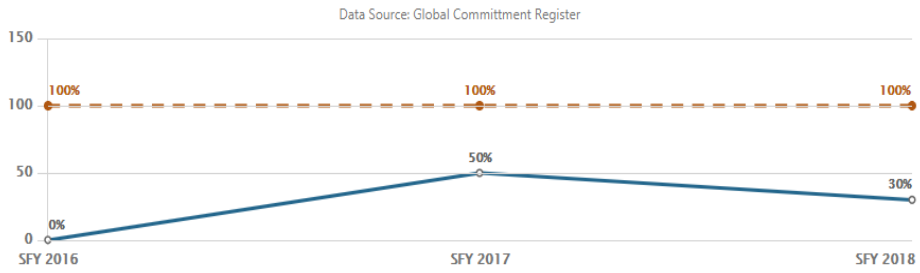
The appropriateness of documentation included in the request (i.e. does it support the providers claim or is additional support needed to make a determination)

Complexity of the case

For timely filing requests received that require a determination by a sister department, receiving the determination in a timely manner

Obtaining management approval, when appropriate Working out the "bugs" of a new process.

PM RU % of annual fee schedule updates that are posted for public comment 30 days prior to the effective date of the rate change



Time Period	Actual Value	Target Value	Current Trend
SFY 2018	30%	100%	↘ 1
SFY 2017	50%	100%	↗ 1
SFY 2016	0%	100%	→ 0

Partners

Burns and Associates Inc. (consultants) Medicaid Providers

Trade associations such as Vermont Association of Hospitals and Health Systems (VAHHS), VNA's of Vermont and Bi-State, etc.

DXC

DVHA Policy Unit DVHA Business Office

DVHA Program Integrity Unit Legislature

DVHA/AHS Management

Medicare – Release of fee schedules and guidelines

Story Behind the Curve

During the 2016 legislative session the Reimbursement Unit received a lot of push back from hospitals related to its proposed policy to eliminate Provider Based Billing (PBB), with specific complaints on the length of the public comment period. In this case, public comment was posted to the Global Commitment Register on February 13, 2016 and slated to run until February 29th (Leap Year), a total of 17 days. The new policy was to have been implemented on March 1, 2016.

While Vermont Medicaid does not have a specific policy related to the length of a public comment period, it has followed Medicare guidelines which states public comment should be posted for a "reasonable" length of time. As a result, the Reimbursement Unit has established the goal that 100% of annual fee schedule/policy change updates will be posted for public comment 30 days prior to the effective date of the rate or policy change.

It is important to stakeholders to be able to analyze and review proposed changes prior to their implementation so that they can familiarize themselves with the changes and analyze how it effects their operations. It also gives stakeholders the opportunity to be engaged in the process and provide feedback to the State. Medicaid Reimbursement appreciates the benefits of being able to work collaboratively with partners and stakeholders so that we can all work together effectively to provide the best health care possible at a reasonable cost to Vermont residents.

Last updated: 08/22/18

Strategy

There are many challenges to the Reimbursement Unit meeting the goal of posting public comment 30 days prior to the effective date for a fee schedule/policy/PPS change update. Some of those barriers are as follows:

Obtaining timely feedback and consensus from stakeholders on proposed changes

Due to competing projects, the availability of contractor to pull data, model new rates and provide fiscal impact for PBR completion

Having clear and concise language in legislative directives

Having enough time to review and model rate/policy changes prior to legislatively directed implementation dates

Extended legislative sessions

Length of time needed to make system changes to MMIS Complexity of proposed changes

One of the strategies being used by Medicaid Reimbursement to meet our goal is to engage with stakeholders earlier in the update process. As an example, starting in August 2017 we engaged with stakeholders on the update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule for a proposed January 1, 2018 implementation date. Parties engaged in the conversations included the Home Medical Equipment and Services Association of New England (HOMES), representatives from the provider community, state employees representing various DVHA units and consultants engaged by the State. During the August meeting DVHA informed stakeholders of their intent to update the VT Medicaid DMEPOS fee schedule to more align with Medicare policies and rates and invited their input in the process including feedback on proposals.

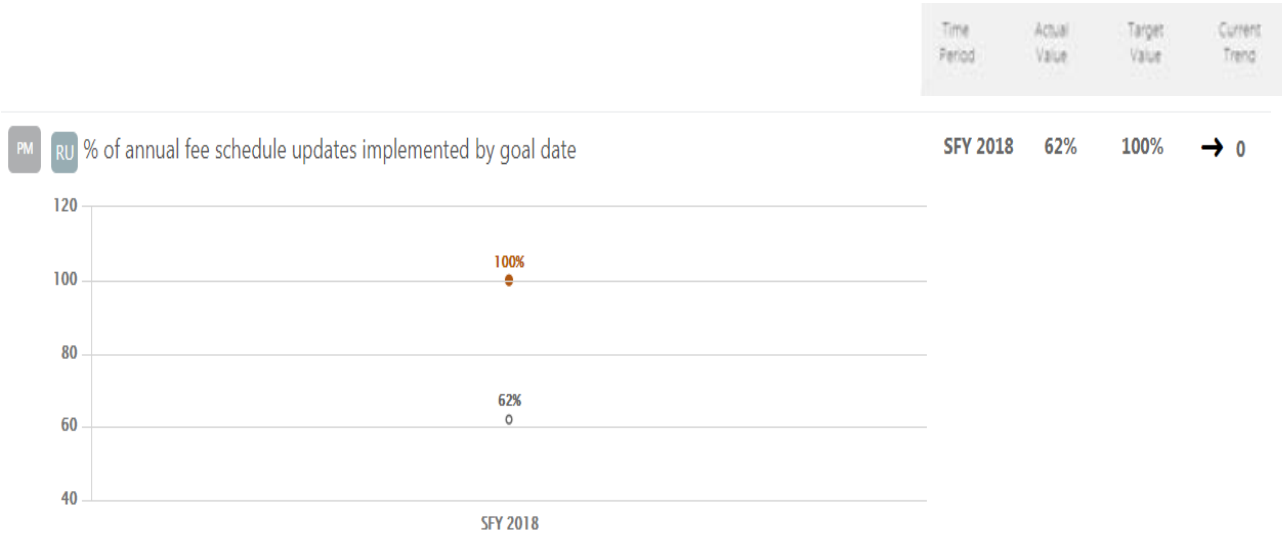
Since the fee schedule had not been updated in about 10 years and includes numerous distinct classes of items, DVHA/Consultants laid out and shared a plan to update in a phased approach. Phase 1 of the update was scheduled for January 1, 2018 with additional classes of items to follow in a subsequent Phase 2 update. Over the ensuing months data was gathered and analyzed and preliminary models created and shared. Since DVHA's new methodology is to benchmark to Medicare rates, the model could not be finalized and shared with stakeholders until late December because Medicare issued guidelines to States using their DMEPOS fee schedule around the second week of December.

Other strategies being used are:

Gathering all units/individuals involved in the PBR process to attend an informational session with the intent of explaining the changes (e.g. policy, methodology) included in the update including fiscal impact. Fiscal impact and other appropriate information are shared prior to meeting so that individuals can come prepared with any questions they may have. The intent is to have all PBR signers well informed on the details of the update by the time their signature is required.

Informing our DXC partners as soon as MMIS system changes are identified and working with them to make sure that any system changes needed can be completed by the effective date of the change.

For updates to payment methodologies that are complex in nature such as those that include major policy and/or system changes completing the update in different phases over a pre-determined period instead of a one-time update.



Partners

Burns and Associates Inc. (consultants) Medicaid Providers

Trade associations such as Vermont Association of Hospitals and Health Systems (VAHHS), VNA's of Vermont and Bi-State, etc.

DXC

DVHA Policy Unit DVHA Business Office

DVHA Program Integrity Unit

Legislature

DVHA/AHS Management

Medicare – Release of fee schedules

Story Behind the Curve

For the most part, Vermont Medicaid has no written policy outlining the frequency of Medicaid fee schedule or other payment methodology updates. Over the years, as payment methodologies were re-vamped or new ones created to more align with Medicare payment methodologies, Medicaid Reimbursement has sought to update the rates on a more consistent basis, either annually or semi-annually or as prescribed in the State Plan.

A few years ago, Medicaid Reimbursement sought approval to update the last of the major fee schedules. The fee schedule for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) had not been updated in almost a decade.

Approval was granted in 2017 and a new methodology was implemented January 1, 2018.

To better serve our provider community and as a result our clients through greater access, Medicaid Reimbursement is committed to consistently updating fee schedules on a consistent and predictable basis. The goal of the unit going forward is to work towards greater consistency in updates to all fee schedules and other payment methodologies that the unit oversees.

Last updated: 08/22/18

Author: Reimbursement Unit

Strategy

To accomplish this goal, starting in SFY 2018 Medicaid Reimbursement set a target date (i.e. month and day) for when each fee schedule or other payment methodology rate would be updated. After the end of each SFY a review will be completed to see if the updates were completed by the target date. The goal is to meet the target implementation date 100% of the time. The same strategies used in the second performance measure will be used to meet this goal.

Pharmacy Unit

What We Do

The DVHA Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits programs. The pharmacy unit oversees the contract with DVHA's pharmacy benefits manager (PBM) Change Healthcare. Together with its PBM, the Pharmacy Unit is responsible for: working with pharmacies, prescribers and members and resolving all drug-related issues; processing over 2 million pharmacy claims annually, facilitating appeals related to prescription drug coverage within the pharmacy benefit; making drug coverage determinations for pharmacy claims and physician-administered drugs; assisting with drug appeals and exception requests; overseeing federal, state, and supplemental drug rebate programs and the manufacturer fee program; overseeing and managing the Drug Utilization Review Board; managing DVHA's preferred drug list (PDL); and conducting pharmacy utilization management programs and drug utilization review activities focused on promoting rational prescribing practices and alignment with evidence-based clinical guidelines. The Pharmacy Unit enforces coverage rules in compliance with federal and state laws and implements legislative and operational changes to the pharmacy benefit programs as needed.

Who We Serve

The Pharmacy Unit's primary stakeholders are Vermont Medicaid enrolled members, prescribers, and pharmacies. The unit also interacts with many other internal and external stakeholders such as other units within DVHA, other departments within the Agency of Human Services, various legislative committees, pharmaceutical manufacturers, and many others.

How We Impact

The Pharmacy Unit established and actively manages a pharmacy best practice and cost control program designed to ensure that members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible.

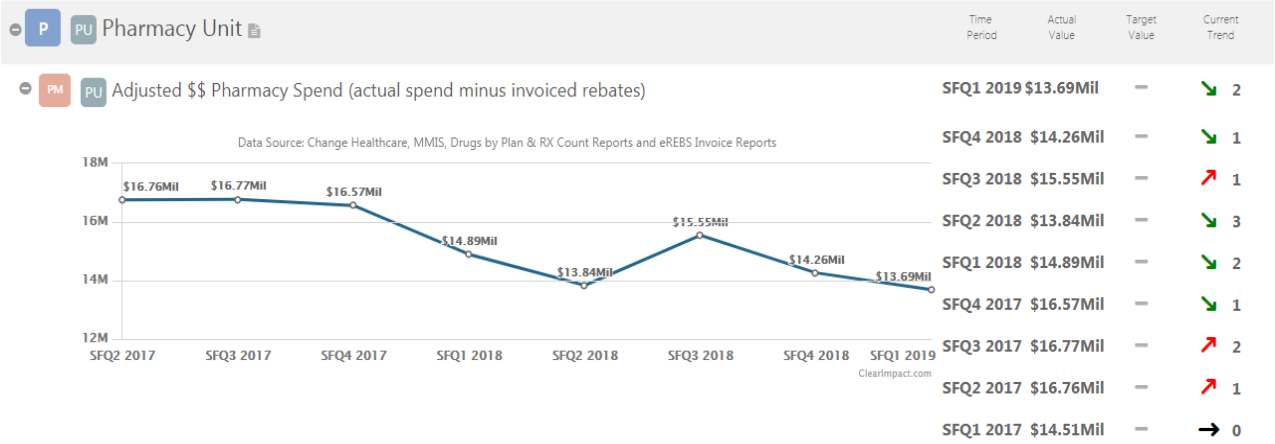
Action Plan

The Pharmacy Unit's top priorities/initiatives in SFY19 are:

Continue to manage high cost medications

Launch a medication management pilot with several FQHC's

Based on a legislative reporting requirement, evaluate the drug supply chain for cost savings opportunities



Notes on Methodology

Adjusted $$ Pharmacy Spend (actual spend minus invoiced rebates)									
	SFY17				SFY18				SFY19
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Total Spend	$47,963,613	$47,495,762	$49,338,141	$50,412,440	$47,469,475	$47,977,688	$51,260,572	$50,939,914	$48,822,914
Total Rebate	$33,457,103	$30,737,867	$32,565,210	$33,846,070	$32,574,510	$34,142,521	$35,711,136	$36,676,109	$35,131,870
Estimated Net Spend	$14,506,510	$16,757,895	$16,772,930	$16,566,370	$14,894,965	$13,835,167	$15,549,436	$14,263,805	$13,691,044

Partners

Change Healthcare Pharmaceutical Manufacturers

Story Behind the Curve

The Pharmacy Unit oversees the rebate programs. DVHA's Pharmacy Benefit Manager, Change Healthcare, manages the rebate processes. Rebates are invoiced every quarter. The measure shows an estimated net spend because it is based on rebates invoiced, not rebates collected.

The rebate program is vitally important to DVHA's overall healthcare spending. DVHA receives approximately 60-65% of its drug spend back in the form of federal, state and supplemental rebates.

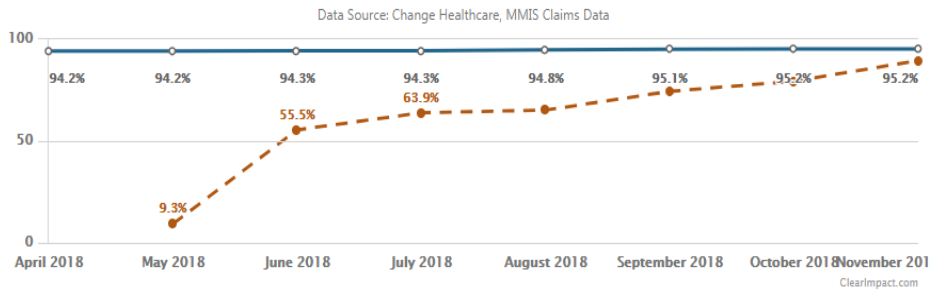
Optimally, we manage drug spend by maximizing rebate opportunities and preferring drugs that have the lowest net cost to DVHA and meet the clinical needs of our members.

Last updated: 12/15/18

Strategy

DVHA's strategies for managing the lowest net cost possible is primarily driven by successful management of our Preferred Drug List (PDL). Through support from our PBM, Change Healthcare, and our Drug Utilization Review Board, DVHA makes informed drug coverage decisions based on clinical appropriateness and the lowest net cost possible. We take into consideration factors such as drug acquisition cost, federal and supplemental rebates, and manage non-preferred products through effective strategies such as prior authorization, quantity limits, and step therapy.

PM PU % of manufacturers' fees collected



Time Period	Actual Value	Target Value	Current Trend
Nov 2018	95.2%	89.5%	→ 1
Oct 2018	95.2%	79.4%	↗ 3
Sep 2018	95.1%	74.4%	↗ 2
Aug 2018	94.8%	65.2%	↗ 1
Jul 2018	94.3%	63.9%	→ 1
Jun 2018	94.3%	55.5%	↗ 1
May 2018	94.2%	9.3%	→ 1
Apr 2018	94.2%	–	↗ 5
Mar 2018	87.4%	–	↗ 4
Feb 2018	69.2%	–	↗ 3

Notes on Methodology

% of manufacturer's fees collected for CY 2016													
	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Aug-18	Sep-18	Oct-18	Nov-18
Total $ Amount Invoiced	$3,235,138	$3,235,138	no update	$3,235,138	$3,235,138	$3,235,138	$3,235,138	$3,235,138	$3,235,138	$3,235,138	$3,235,138	$3,235,138	$3,235,138
Total $ Amount Collected	$1,796,892	$2,113,156	no update	$2,113,311	$2,124,427	$2,140,758	$2,240,081	$2,827,098	$3,047,930	$3,067,086	$3,075,627	$3,078,675	$3,078,675
% Collected	55.5%	65.3%	no update	65.3%	65.7%	66.2%	69.2%	87.4%	94.2%	94.8%	95.1%	95.2%	95.2%
% of manufacturer's fees collected for CY 2017													
	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Jun-19	Jul-19	Aug-19	Sep-19
Total Amt Invoiced	$3,154,826	$3,154,826	$3,154,826	$3,154,826	$3,154,826	$3,154,826	$3,154,826						
Total Amount Collected	$292,677	$1,750,514	$2,015,967	$2,056,073	$2,345,733	$2,506,413	$2,824,313						
% Collected	9.3%	55.5%	63.9%	65.2%	74.4%	79.4%	89.5%						

The solid trend line represents CY2016 & the dotted trend line represents CY2017 in the chart above

Please note that invoices are billed in April for the previous calendar year.

Partners

Change Healthcare Pharmaceutical Manufacturers

Story Behind the Curve

The Pharmacy Unit, in collaboration with its pharmacy benefit manager Change Healthcare, annually invoices a fee to each pharmaceutical manufacturer paid by the Department of Vermont Health Access for prescriptions for individuals participating in Medicaid, Dr. Dynasaur or VPharm. The fee is 1.5 percent of the previous calendar year's prescription drug spend by the Department of Vermont Health Access.

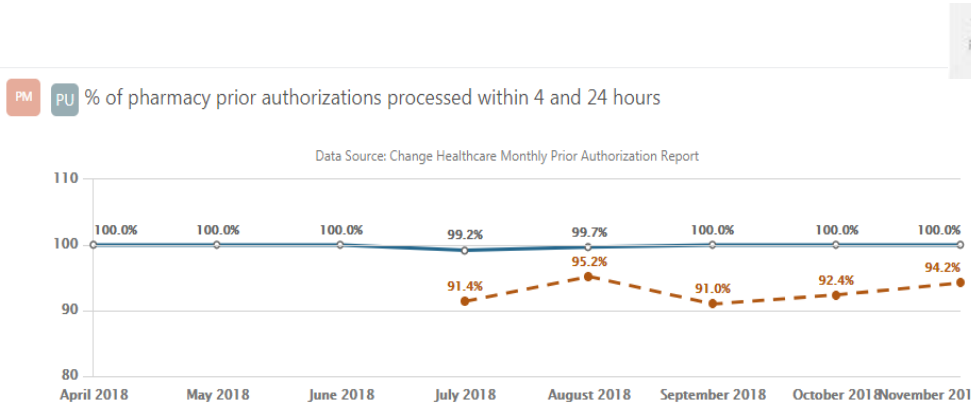
The manufacturer fee funds the collection and analysis of information on pharmaceutical marketing activities, analysis of prescription drug data needed by the attorney general's office for enforcement activities, and the evidence-based education program established in subchapter 2 of chapter 91 of Title 18.

The Pharmacy Unit will provide further analysis as more data becomes available, with the goal of increasing the percentage of collections.

Last updated: 12/15/18

Strategy

DVHA works with its PBM, Change Healthcare to invoice delinquent manufacturers, send late notices, and follow-up with phone calls to maximize collections of the fee. DVHA will be transitioning the collection of the fee to VDH in 2019, since the funds are primarily used by VDH in the administration of its programs



Time Period	Actual Value	Target Value	Current Trend
Nov 2018	100.0%	94.2%	→ 2
Oct 2018	100.0%	92.4%	→ 1
Sep 2018	100.0%	91.0%	↗ 2
Aug 2018	99.7%	95.2%	↗ 1
Jul 2018	99.2%	91.4%	↘ 1
Jun 2018	100.0%	–	→ 2
May 2018	100.0%	–	→ 1
Apr 2018	100.0%	–	↗ 1
Mar 2018	99.9%	–	↘ 1
Feb 2018	100.0%	–	↗ 1

Please note that in the chart above:

The dotted trendline represents the % of PA processed in 4 hours or less

The solid trendline represents the % of PA processed in 24 hours or less

# & % of pharmacy PAs processed										
SFY19										
	Jul-18		Aug-18		Sep-18		Oct-18		Nov-18	
	08/15/18		09/15/18		10/15/18		11/15/18		12/15/18	
	#	%	#	%	#	%	#	%	#	%
Total PA Processed	2817	100.00%	3006	100.00%	3482	100.00%	3087	100.00%	2669	100.00%
PA Processed in 24 hours	2794	99.20%	2997	99.70%	3482	100.00%	3087	100.00%	2668	99.96%
PA Processed in 4 hours	2575	91.41%	2863	95.24%	3168	90.98%	2853	92.42%	2514	94.19%

Partners

Change Healthcare

Story Behind the Curve

This performance measure allows the Pharmacy Unit to monitor prior authorization (PA) processing turnaround times. PA turn- around time is important to ensure that DVHA's Service Level Agreements are met by our vendor, Change Healthcare, in servicing our prescribers.

Last updated: 12/15/18

Strategy

DVHA monitors weekly, the turnaround times for PA's conducted by the CHC Help Desk. We also monitor staffing levels and asks for adjustments as need, such as vacation coverage, and anticipate changes that could impact call volumes such as operational claims processing changes. In addition, we work to reduce the number of PA's needed through improving automated PA processing, and monitoring approval and denials rates for possible changes.

We serve a variety of internal DVHA units, partnering AHS departments, additional state agencies, and external contractors/vendors working on behalf of DVHA with access to and an understanding of information regarding the implementation of Medicaid policies and programs.

How We Impact

We serve as experts on researching and mining data, statistical analysis, and reporting on mandated state and federal requirements. We are accountable for producing and understandable display of quantitative information to colleagues and decision makers using modern databases and sophisticated statistical, mapping and reporting software. We are responsible for recording, preserving, validating and updating the methodologies, syntax, queries and directives for each analysis, extract and final product.

Data Management, Analysis & Integrity Unit

What We Do

The Data Management and Integrity Unit provides data analysis, distribution of Medicaid data extracts to contractors, reporting to regulatory agencies, the legislature, and other stakeholders. We deliver: mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS); routine Vermont Healthcare Claims Uniform Reporting and Evaluations System (VHCURES) data feeds; the annual Healthcare Effectiveness Data and Information Sets (HEDIS) data extracts for performance measurement reporting; weekly medical and pharmacy claims files and monthly eligibility records to support Care Coordination for the Vermont Chronic Care Initiative (VCCI) and the Vermont Medicaid Next Generation Pilot Project - a risk-based program between the DVHA and OneCare Vermont an accountable care organization. In addition, we provide ad hoc data analysis for internal DVHA divisions and other AHS departments and state agencies. These requests include Public Record Requests (PRR) which are managed by the Legal Unit and are forwarded to the Data Unit as deemed necessary.

Who We Serve

We serve a variety of internal DVHA units, partnering AHS departments, additional state agencies, and external contractors/vendors working on behalf of DVHA with access to and an understanding of information regarding the implementation of Medicaid policies and programs.

How We Impact

We serve as experts on researching and mining data, statistical analysis, and reporting on mandated state and federal requirements. We are accountable for producing and understandable display of quantitative information to colleagues and decision makers using modern databases and sophisticated statistical, mapping and reporting software. We are responsible for recording, preserving, validating

and updating the methodologies, syntax, queries and directives for each analysis, extract and final product.

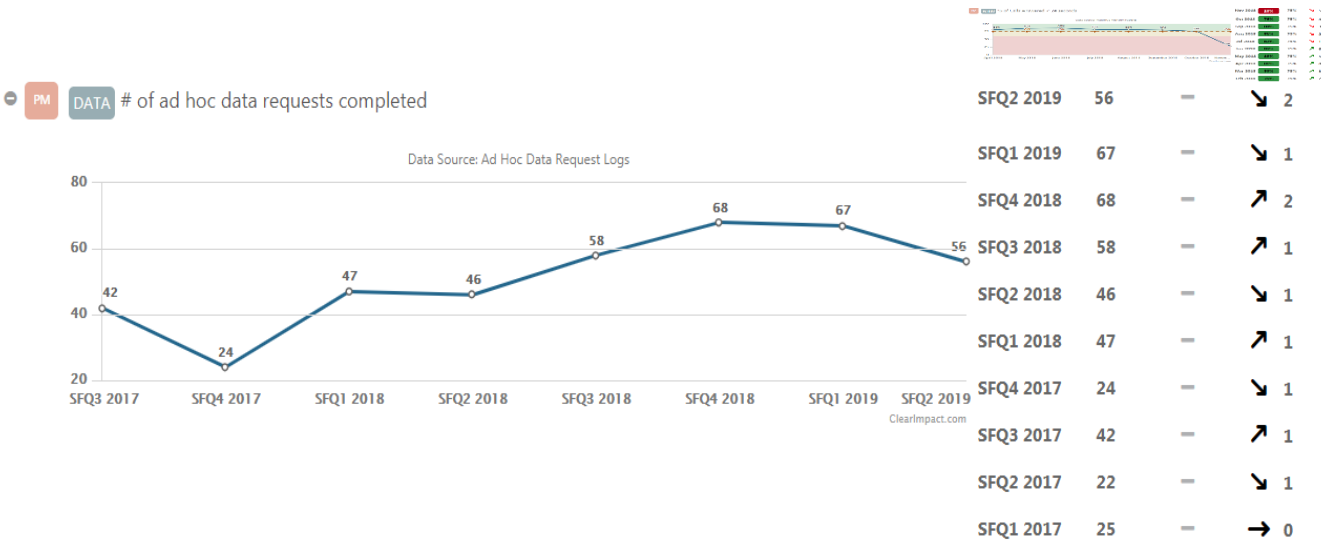
Action Plan

The top 2 priorities/initiatives for the Data Unit in SFY19 are:

Continue to provide Burns and Associates and OneCare Vermont regular data extracts as well as routine reporting to OneCare Vermont and the Legislature to support the continued implementation of the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program.

Supporting the Agency of Human Services Central Office with required reporting to support the Global Commitment to Health Section 1115 Medicaid Demonstration Evaluation and the Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration Monitoring Protocol.

Collaborate with Clinical Operations Unit and Mental Health Clinical Utilization Review team in developing a snapshot dashboard.



Partners

Agency of Human Services Central Office Departments within the Agency of Human Services DVHA Division Program Units

Story Behind the Curve

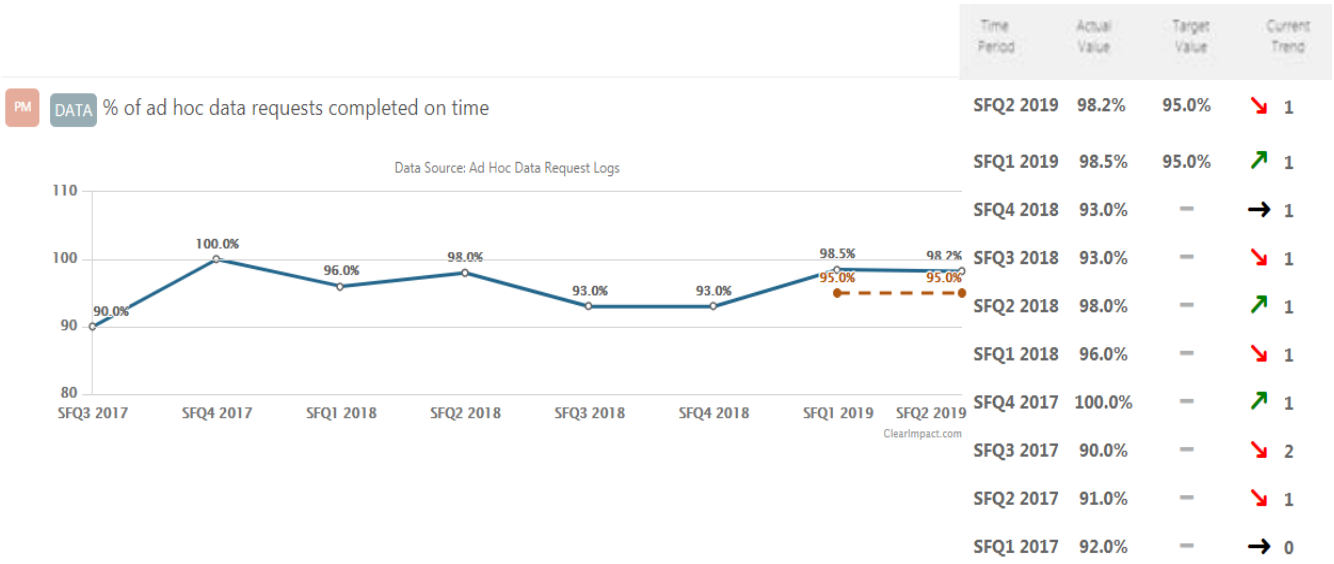
Number of ad hoc data requests completed by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs. Requests come into the Data Unit from various program staff in DVHA and sister departments in the Agency on any given day.

Last updated: 01/14/19

Strategy

Collaboration with program staff to facilitate learning opportunities for collective ownership of their respective data. Engage in detailed conversations to determine informational needs versus wants.



Time Period	Actual Value	Target Value	Current Trend
SFQ2 2019	98.2%	95.0%	↘ 1
SFQ1 2019	98.5%	95.0%	↗ 1
SFQ4 2018	93.0%	–	→ 1
SFQ3 2018	93.0%	–	↘ 1
SFQ2 2018	98.0%	–	↗ 1
SFQ1 2018	96.0%	–	↘ 1
SFQ4 2017	100.0%	–	↗ 1
SFQ3 2017	90.0%	–	↘ 2
SFQ2 2017	91.0%	–	↘ 1
SFQ1 2017	92.0%	–	→ 0

Partners

DVHA Clinical Operations Unit DVHA Coordination of Benefits Unit DVHA Payments Reform Unit

DVHA Policy Unit

DVHA Quality Improvement and Clinical Integrity Unit

Story Behind the Curve

Percent of ad hoc data requests completed on time by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data analysis to support ongoing policy development and implementation of Medicaid programs.

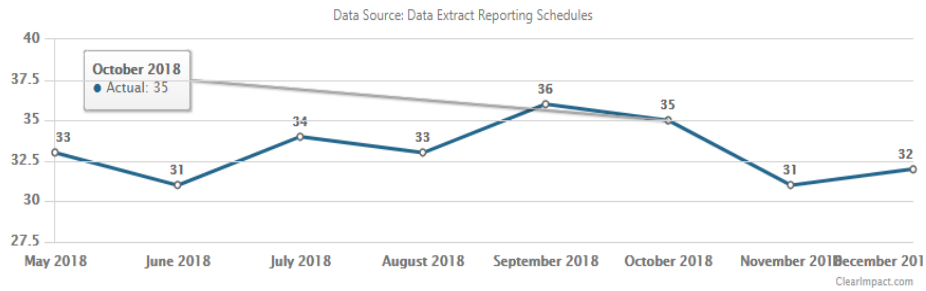
A goal of 95% was established in September 2018 for this measure.

Last updated: 01/14/19

Strategy

Requests come in from various program staff in DVHA and sister departments in the Agency on any given day. ASAP requests are assigned a 2-business day turnaround time. As an example, if an ASAP request comes in on Monday, it is assigned a due date of Wednesday. Other requests that are not ASAP are assigned a10-businessday turnaround time.

PM DATA # of required federal and state reporting initiatives completed



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	32	–	↗ 1
Nov 2018	31	–	↘ 2
Oct 2018	35	–	↘ 1
Sep 2018	36	–	↗ 1
Aug 2018	33	–	↘ 1
Jul 2018	34	–	↗ 1
Jun 2018	31	–	↘ 1
May 2018	33	–	↗ 2
Apr 2018	32	–	↗ 1
Mar 2018	31	–	↘ 1

Partners

Burns & Associates / Reimbursement Unit

Centers for Medicare & Medicaid Services / Policy Unit

eQHealth Systems / Vermont Chronic Care Initiative (VCCI) OneCare Vermont / Payment Reform Unit

Onpoint Health / Blueprint for Health

Story Behind the Curve

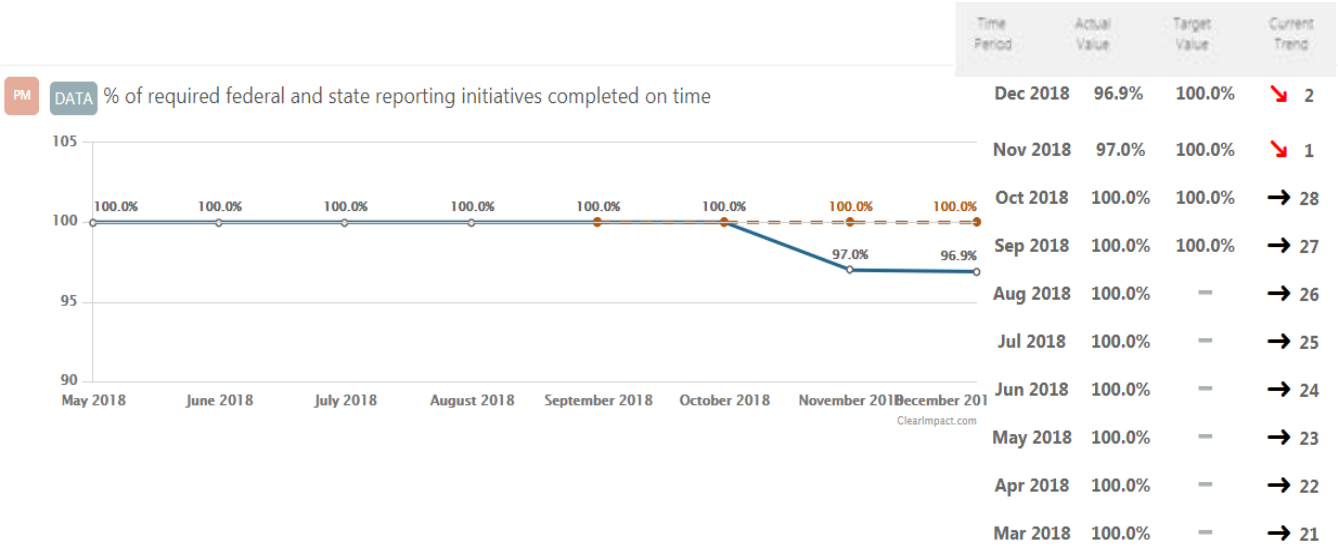
Number of data extracts and required reporting deliverables completed by the Data Unit.

As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data extracts to contractors and vendors working on behalf of the department and provide required reporting to federal and state partners to support ongoing policy development and implementation of Medicaid programs.

Last updated: 01/14/19

Strategy

Provide data extracts (files) to contracted business partners to support complementary data systems and department initiatives, as well as mandated reporting to state and federal entities.



Partners

Burns & Associates / Reimbursement Unit

Centers for Medicare & Medicaid Services / Policy Unit

eQHealth Systems / Vermont Chronic Care Initiative (VCCI) OneCare Vermont / Payment Reform Unit

Onpoint Health / Blueprint for Health

Story Behind the Curve

Percent of data extracts (files) and required reporting deliverables completed by the Data Unit prior to or on the due date. As a support entity within the department responsible for the development of information resources required for effective policy making, planning, regulation and evaluation for the state's Medicaid program it is important to know how often the Data Unit is asked and relied on to provide data extracts to contractors and vendors working on behalf of the department and provide required reporting to federal and state partners to support ongoing policy development and implementation of Medicaid programs.

A goal of 100% was established in September 2018 for this measure.

Last updated: 01/14/19

Strategy

Provide data extracts (files) to contracted business partners to support complementary data systems and department initiatives, as well as mandated reporting to state and federal entities.

Vermont Chronic Care Initiative (VCCI)

What We Do

The Vermont Chronic Care Initiative (VCCI) is a healthcare reform strategy that provides complex care management to Vermont's highest cost/highest need members. A holistic approach is utilized –

as case managers screen for social determinants of health as part of the initial member assessment; recognizing that gaps in care for substance abuse/mental health; housing and food insecurity impact one's health and quality of life.

The VCCI supports 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.

Who We Serve

VCCI serves Medicaid members (except members who are receiving CMS funded case management through DAIL or DMH).

How We Impact

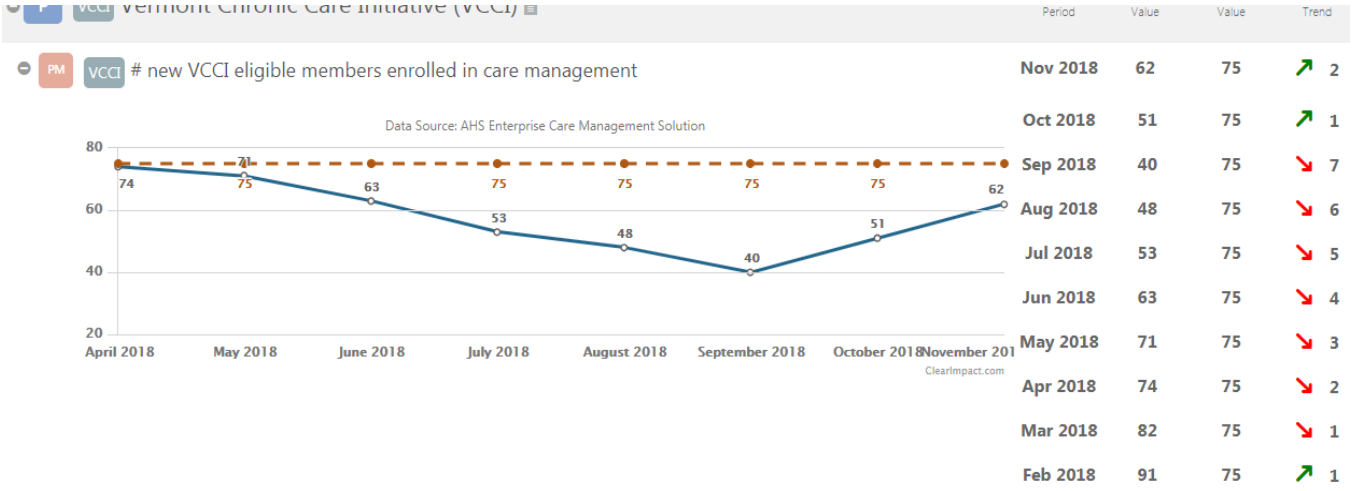
The VCCI case managers are community based and are stationed within the communities they live in. They work closely with their community health care and social service providers; collaboratively working with each other and the member on the member identified priorities. The case managers are closely linked with their AHS Field Directors – which has proven vital when working with members that may be involved with DCF, DOC, DMH, DAIL, and VDH. VCCI case managers meet with members in varied locations- homes, PCP offices, homeless camps, hospitals, shelters- successfully engaging members that have been historically 'hard to find'.

Action Plan

In SFY19, the VCCI's is working on expanding the population served:

Needs based eligibility as identified by community providers; not only the highest cost/highest need.

Align with health care reform efforts: Outreaching Members new to Medicaid; goal of orienting members to the health system, facilitating access to primary care and engaging in self-management programs, and providing complex care management for those members that meet high risk criteria.



Partners

Community Health Teams Healthcare Providers Community Service Providers

State Partners to include AHS Field Directors, DCF, DOC DVHA Colleagues to include QIU, Pharmacy, COU

Chief Medical officer; DVHA

MMIS & Care Management vendors

Story Behind the Curve

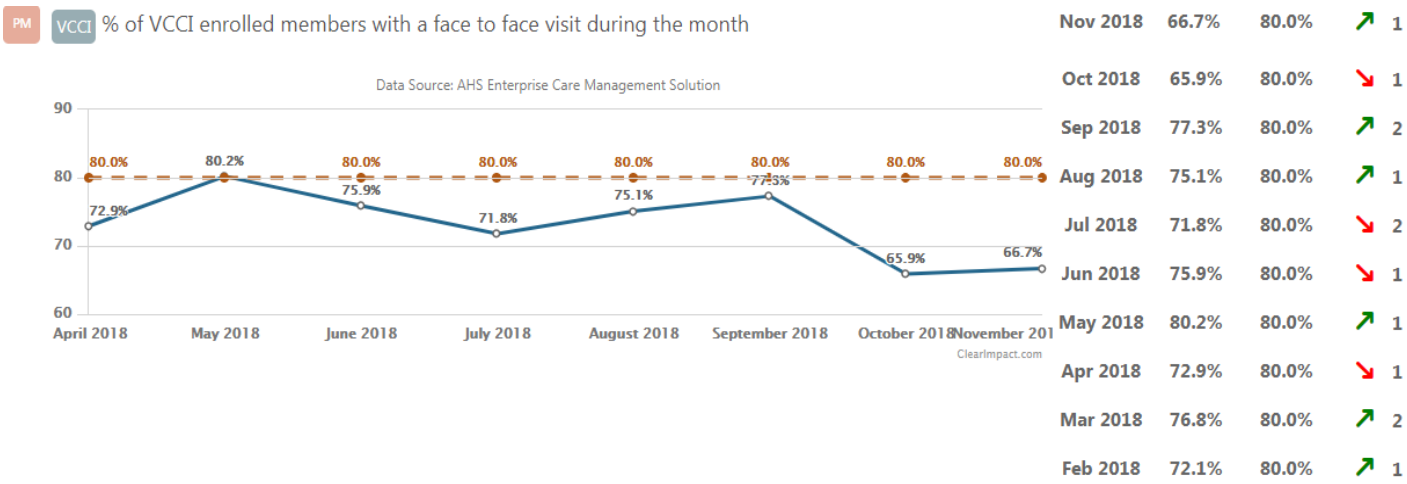
The VCCI eligible population has gradually decreased over past couple of years, based on ACO attribution, with CY 2019 yielding ~29K less eligible members. This coupled with community feedback asking the VCCI to explore other populations that could be served by VCCI brought about enhancements to the VCCI eligible population. In addition to the traditional claims- based methodology, focused on our high cost/high risk population, health care providers and community partners may send over needs-based referrals on non-ACO attributed individuals whom, using their clinical judgment, need complex care management; now includes those dually insured. VCCI also welcomes new member to Medicaid by outreaching asking questions about primary care provider, health conditions and other supports that would assist them in maintain or improve their health (housing, food, safety). This measure captures new enrollments/cases only – it does not reflect the total VCCI caseload. Recent fluctuations in this measure may certainly be impacted by ongoing training of VCCI in the new to Medicaid workflow/use of screening tool; in tandem with community and state providers/partners also learning of VCCI program enhancements. Communities have also commented that their learning curve with ACO and the system of care, has been an area of focus for them, with referrals to VCCI a lower priority. VCCI staffing resources may also have impacted this measure as one staff with reduced hours; one staff returning from FMLA; one in orientation.

Last updated: 12/15/18

Strategy

Outreach and Support Coordinator started at end of October 2018 and received training on our New to Medicaid outreach through November. This staff member is primary lead for outreach and screening of those individuals New to Medicaid, and assignment to VCCI care managers as appropriate based on member risk level

The PBR requesting expansion of the population served by VCCI was approved. Communication with our community healthcare and service providers, which supplements formal letter signed by DVHA leadership, is ongoing at the local level. Attendance at local community partner meetings around complex members.



Partners

Medicaid Beneficiaries

Community Health Teams Healthcare Providers Community Service Providers

State Partners to include AHS Field Directors, DCF, DOC DVHA Colleagues to include QIU, Pharmacy, COU

Chief Medical officer; DVHA

MMIS & Care Management vendors

Story Behind the Curve

One of the important and differentiating elements of the Vermont Chronic Care Initiative (VCCI) model is member face to face meetings as a measure of member engagement and trust, to support effective self-management and sustainable change. This measure is calculated as the percent of all members enrolled during the reporting month that received at least one face to face visit. Face to face visits are a component of short term, intensive case management and a factor in overall assessment of need and relationship building. Both are required to generate effective self-management and sustainable change.

The VCCI continues to work on staffing goals and standardized documentation and reporting in the new MMIS/Care Management system. Measurement is based on the month activity and only includes Face-to-Face visits with members that were enrolled during the entire month in the calculation as well as excluding members in an "on-hold" status. This is impacted by members lost to contact. This may also be impacted by the New to Medicaid focus which is done telephonically.

Members lost to contact (phone/home address change), member 'no shows' and/or case closures during the enrollment month, thus impacting face to face visit calculation in the measurement period.

Weather/winter road conditions may also impact member ability to get to office visit; VCCI staff ability to complete home visit.

Last updated 12/15/18

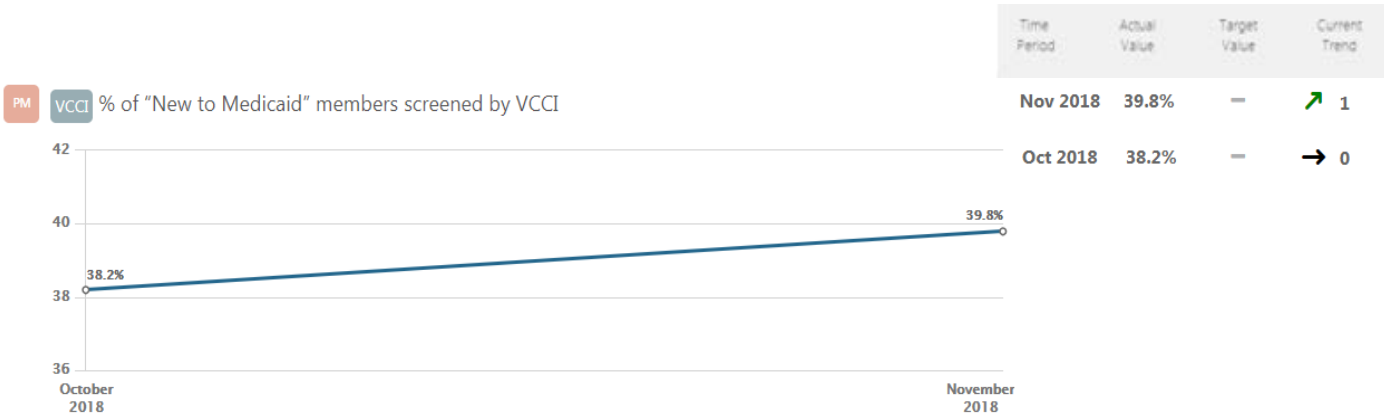
What Works

Face to face visits offer an opportunity for further member assessment and establishing meaningful relationship/engagement and trust required for health coaching/education on behavioral changes required for improved health. Home visits support assessment of the home environment, precipitating factors in their health/chronic health conditions (i.e. mold exposure for asthmatics with recurrent ED usage) and offer the chance to perform medication reconciliation and assess adherence to pharmacy treatment. The literature does support the effectiveness of face to face case management vs. telephonic as regards results and sustainable change.

Strategy

A few staff are over booking daily visits with the experiential knowledge that some members may cancel the visits during the week.

Other staff offer members consistent time/day of visits; before leaving a visit, staff are scheduling the next follow up visit.



Notes on Methodology

This is a new performance measure beginning in October 2018.

% of "New to Medicaid" members screened			
	SFY19 Monthly		
	Oct-18	Nov-18	Dec-18
# of new to Medicaid members	435	402	
# of new to Medicaid members reached	199	208	
# of new to Medicaid members screened	166	160	
% of new to Medicaid members screened	38.2%	39.8%	

Partners

New to Medicaid (NTM) members MMIS/Data Unit

Vermont Health Connect (VHC)

Story Behind the Curve

In effort to align with healthcare reform efforts and the system of care, the VCCI will be outreaching members new to Medicaid, screening for access to primary care, health conditions and social determinants of health.

The goals are to:

Orient the members to the system of care, including navigation of services to health-related needs such as housing, food security

Onboard the members ahead of their anticipated future ACO attribution to include facilitation of access to primary care Connect the members to community supports and resources

Full VCCI team started this outreach in October; starting with New to Medicaid population of 18 years of age and over, to allow for us to assess for team capacity.

Some influences on measure outcomes include:

Members without valid phone numbers due to disconnected services; phones without voice messaging set up. Members not returning phone calls; nor responding to mailed screenings.

Members declining to engage in screening.

Ensuring new to Medicaid screening completion and system of care issues (PCP, etc.) even if members indicate they will be dropping off Medicaid soon.

Last updated: 12/15/18

Strategy

Ongoing training/coaching of VCCI team to inform system of care issues such as PCP establishment, connection to local community resources (community action, self-management programs, transportation options).

VCCI has hired an Outreach Support and Coordinator staff member whose primary role is to outreach to the new to Medicaid population with goal that one dedicated staff member will support increase in members successfully screened.

Blueprint
for Health

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 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.

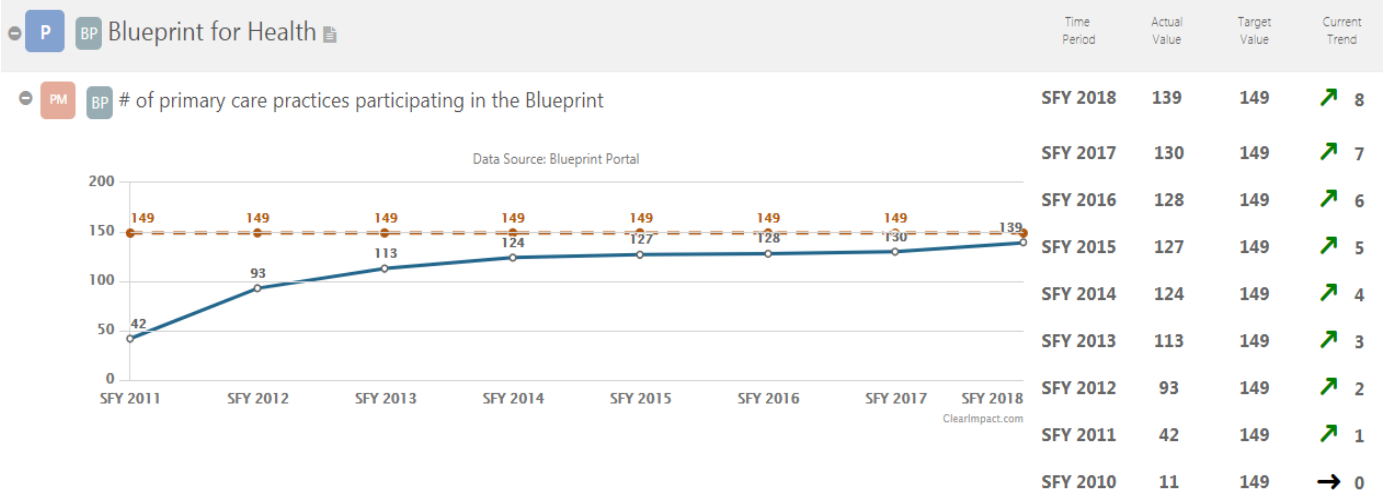
Action Plan

The top 3 priorities/initiatives for the Blueprint in SFY19 are:

Pending availability of funds, implement SBINS program and Chronic Pain Pilots

Enhance the Vermont Clinical Registry and develop data linkage & reporting with Department of Corrections (DOC) and Department of Labor (DOL)

Support the community health teams and program field staff with leadership training and consistent deployment of care models



Notes on Methodology

The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://blueprintforhealthport...). The Blueprint Data Analyst manages information stored in the Blueprint portal.

The goal figure for this measure was obtained by identifying all primary care practices in the AHEC survey database and immunization registry database, validating these primary care practices with our Blueprint project managers, and eliminating from the count practices with 1 FTE or less of a provider.

Partners

The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Story Behind the Curve

These are practices who meet the NCQA standard of a patient-centered medical home (PCMH) and participate in Blueprint initiatives. This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices are qualified as PCMHs and supported by Blueprint payments, increasing numbers of Vermonters should have access to high quality primary care.

The trend line above clearly highlights the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient- Centered Medical Homes (PCMHs) in 2011. This rapid increase is the

result of a coordinated effort by the Blueprint team to comply with the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandated the statewide expansion of the Blueprint, including practice recognition as PCMHs. Evidence of this expansion required a minimum of two primary care practices in each health service area (HSA) becoming PCMHs by July 2011. The Act additionally required the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread). A significant achievement in 2010 that paved the way towards compliance with Act 128 was the Blueprint's successful application for the Centers for Medicare & Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In mid-July, Medicare joined all other major insurers in Vermont in contributing to the financial payments to PCMHs.

Since the mandate that all willing primary care providers in Vermont be involved as a PCMH in the Blueprint by October 2013, Blueprint practice facilitators have continued to engage providers across the State to encourage and inspire participation.

Practice facilitators, highly skilled and intensively trained clinical and process coaches, work with primary care practices throughout the state and guide them as they make quality improvement changes on the path towards becoming PCMHs. When practices achieve NCQA certification as a PCMH with the assistance of the Blueprint practice facilitators, they demonstrate adherence with important characteristics of high-quality healthcare and well-coordinated health services. The practices find the NCQA PCMH standards and Blueprint program as value-adds to their practice, as since the inception of the Blueprint program, only one PCMH has dropped out of the Blueprint (pending an upcoming move out of state).

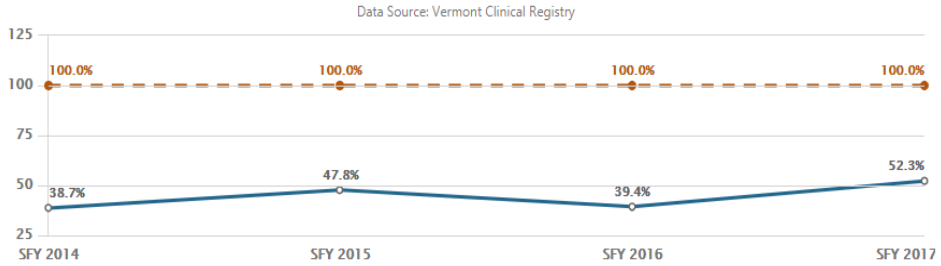
The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. Program expansion is continuing due to the outreach efforts of the Blueprint practice facilitators, who are making a coordinated effort to reach primary care practices in their communities that have not participated in the Blueprint as a patient-centered medical home in the past. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

Last updated: 09/17/18 Author: Blueprint for Health

Strategy

Include expectation to outreach to all area primary care practices in Blueprint Implementation Manual
Add as agenda item to regular check-ins with Blueprint Assistant Directors

PM BP % of Blueprint patients with recorded measures in the Vermont Clinical Registry



Time Period	Actual Value	Target Value	Current Trend
SFY 2017	52.3%	100.0%	↗ 1
SFY 2016	39.4%	100.0%	↘ 1
SFY 2015	47.8%	100.0%	↗ 1
SFY 2014	38.7%	100.0%	→ 0

Notes on Methodology

The denominator is the number of Blueprint patients in the Vermont Clinical Registry who could be linked to claims data in VHCURES.

The statewide average percentage of linked Blueprint patients with recorded measures in the Clinical Registry is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset (APCD). Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this percentage every six months, accounting for the next 6-month time period.

The goal figure for this measure is 100%, as the Blueprint is aiming to have all Blueprint patients in the Vermont Clinical Registry who could be linked to claims data in VHCURES to also have at least one recorded measure within the Vermont Clinical Registry.

Partners

Vermont Information Technology Leaders (VITL) Capitol Health Associates

Electronic Health Record (EHR) vendors Patient-Centered Medical Homes (PCMHs) HIE/HIT Unit

Story Behind the Curve

This is a measure of the percentage of Blueprint patients that have been identified in claims and linked to the Clinical Registry, who also have key clinical measures recorded in the Clinical Registry.

This measure is an indicator of the effectiveness of the HIE to aggregate data and the effectiveness of the Clinical Registry to populate clinical measures. This measure also reflects the ability of EHR systems to send structured data in Clinical Continuity Documents (CCDs). These data can be used to enhance patient care and inform improvements throughout the system.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. Blueprint practices across the state have been populating the Clinical Registry for over 7 years. The Registry, previously referred to as DocSite, was purchased from Covisint under a perpetual software license and is now managed by Capitol Health Associates, LLC. After analysis of the data in the Clinical Registry for quality and completeness, the data are de-identified and linked at the person

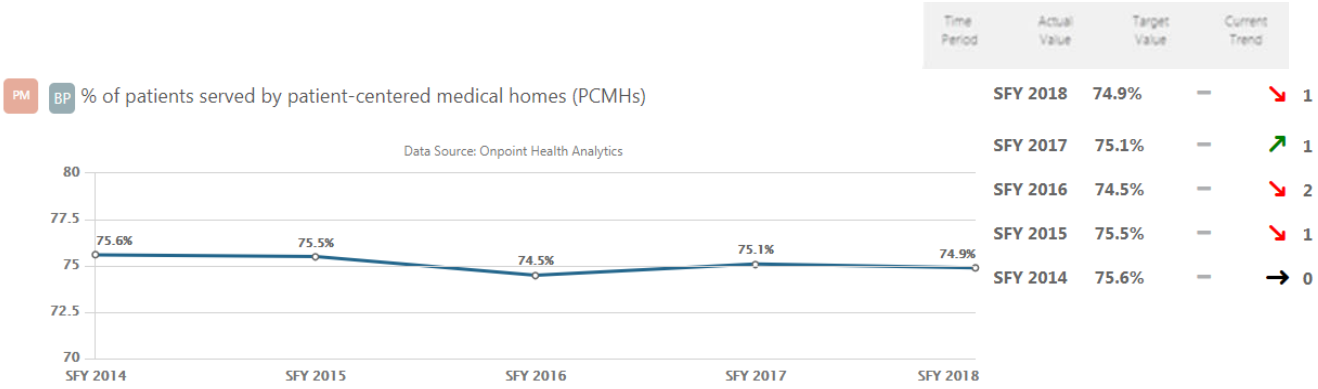
level with the corresponding individual's claims records in VHCURES. This linkage is conducted by the Blueprint's analytics vendor, Onpoint Health Analytics, who determines the portion of the population in VHCURES for which clinical data can be associated with claims, and of that population, the percentage that have recorded clinical measures.

In July 2015, several practices experienced interruptions in, or terminations to, their clinical data feeds to the VHIE as a result of upgrades made to their EHRs, including: switching to a cloud-based system, EHR vendors releasing updated software, and practices switching EHR vendors.

Last updated: 09/17/18 Author: Blueprint for Health

Strategy

Develop the capacity of the Vermont Clinical Registry to accept flat files and other forms of direct data transfer. In progress in draft RFP for enhanced Registry functions. Continue work with VITL to develop interface standards.



Notes on Methodology

The percentage of Blueprint patients from the population of VHCURES members with a primary care visit is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this percentage every six months, accounting for the next 6-month time period.

The trend line for this measure should increase as additional practices join the Blueprint.

Partners

The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Staff at Blueprint Patient-Centered Medical Homes (PCMHs) Onpoint Health Analytics

Story Behind the Curve

This is a measure of the percentage of Vermonters who receive their primary care from a Blueprint PCMH from the population of VHCURES members with a primary care visit. This is an access to care measure.

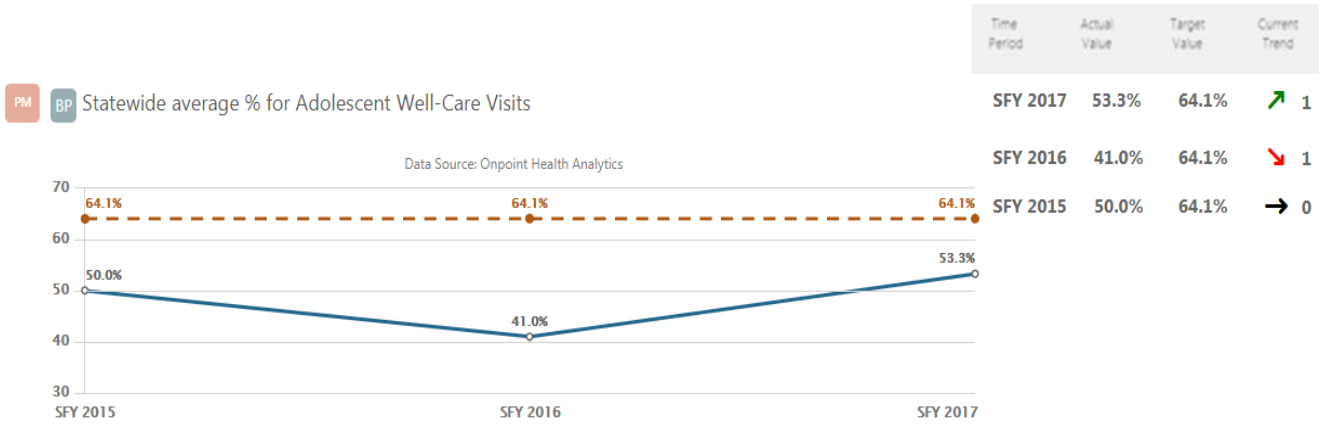
PCMHs provide top-quality primary care centered on several key evidence-based standards. By increasing the percentage of Vermonters who receive their primary care through PCMHs, we are increasing access to high quality care and the opportunity for improved health outcomes.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. Data points from 2013 to 2014 clearly highlight the effects of the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in due to the mandate that all willing primary care providers in Vermont by involved as a PCMH in the Blueprint by October 2013. Data points in 2015 show a decrease in the percentage of the Blueprint patients from the population of VHCURES members with a primary care visit due to either improvements in the accuracy of attributing individuals to PCMHs at Onpoint Health Analytics or access to care issues. The small increase between SFY 2016 and SFY 2017 can be attributed to a continued engagement of providers across the State by Blueprint practice facilitators to encourage and inspire participation in the Blueprint. It should be noted that the SFY 2018 figure is not adjusted to account for the loss of data in VHCURES due to the Gobeille v. Liberty Mutual decision.

Last updated: 11/26/18 Author: Blueprint for Health

Strategy

Access to primary care is also an All Payer Model Population Health goal. Work with the Green Mountain Care Board and partners to design strategies to increase access.



Notes on Methodology

The statewide average percentage of the Adolescent Well-Child Visit performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Adolescent Well-Child Visit performance measure is listed in every Health Service Area Pediatric profile, which can be found here (http://blueprintforhealth.verm...).

The statewide average percentage of the Adolescent Well-Child Visit performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received

most of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.

The goal figure for this measure represents the weighted average of the HEDIS national Medicaid 90th percentile benchmark for 2016 and the HEDIS national Commercial 90th percentile benchmark for 2016.

Partners

The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Staff at Blueprint Patient-Centered Medical Homes

Onpoint Health Analytic

Story Behind the Curve

The Adolescent Well Care (AWC) measure is the first of the four key indicators of quality health care. This measure assesses the statewide average percentage of members, ages 12–21 years, who had at least one well-care visit with a primary care practitioner or OB/GYN during the measurement year.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

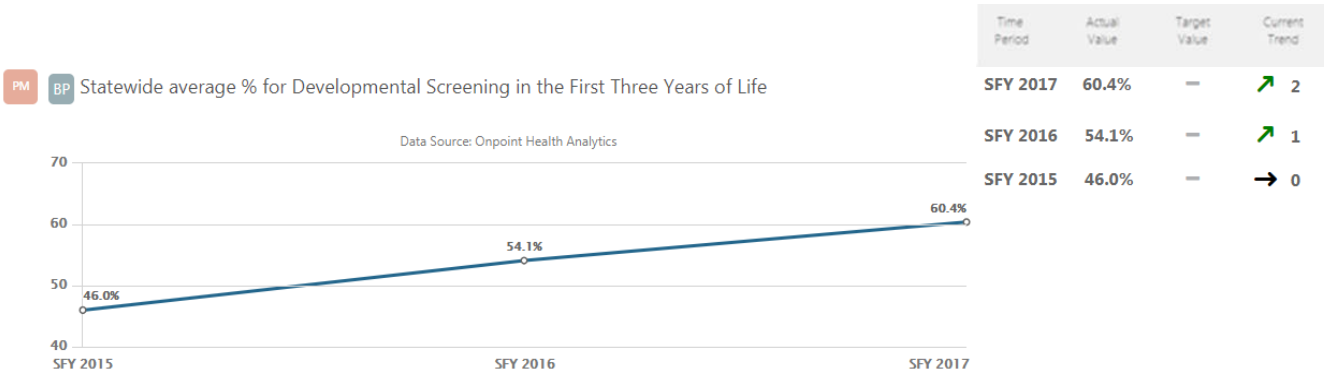
The trend line above, while moving towards the right direction, suggests an opportunity for improvement. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, several Health Service Areas have developed quality improvement policies on this measure, including Barre, Bennington, Burlington, Randolph, St. Albans, and Middlebury.

Middlebury has been working on follow-up processes for patients that are overdue for adolescent well child visits (2016, 2017). Practice staff have been developing reports for the number of active 11-23 year old patients who have not had an adolescent well child visit in the past year, developing outreach materials and outreach processes for those patients that have not had a visit in the past year, and implemented a policy of ensuring that the next adolescent well child visit is scheduled when the patient visits the office for any reason. In addition, a reminder is sent to patients when the adolescent well child visit nears to avoid increased cancelations. Within the last year, there was an improvement in the rate of patients who had an adolescent well child visit.

Last updated: 09/17/18 Author: Blueprint for Health

Strategy

Continue use as a performance payment measure



Notes on Methodology

The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is listed in every Health Service Area Pediatric profile, which can be found here (http://blueprintforhealth.verm...).

The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received most of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.

Since HEDIS does not produce national benchmarks on this measure, the goal has been identified as the Blueprint's metric of improvement in the Blueprint performance payment methodology, which is an increase of 5% change each study period. The Blueprint performance payment methodology can be found here (http://blueprintforhealth.verm...)

Partners

The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Staff at Blueprint Patient-Centered Medical Homes (PCMHs) Onpoint Health Analytics

Vermont Department of Health

Vermont Child Health Improvement Program

Story Behind the Curve

The Developmental Screening in the First Three Years of life (DEV)measure is the second of the four key indicators of quality health care. This measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

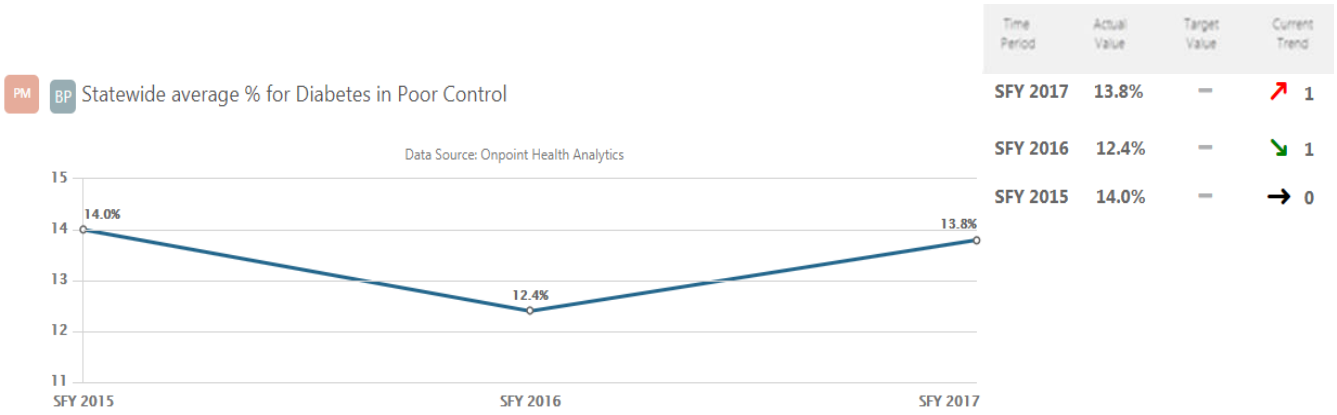
The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above shows that there has been significant improvement on this measure due to the coordinated efforts of internal and external partners. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non- medical providers. Following this measure's implementation as a payment measure in July 2015, practices showed renewed interest in developmental screening with almost fifty practices participating in the University of Vermont College of Medicine's Child Health Advances Measured in Practice (CHAMP) initiative funded by the Vermont Department of Health (VDH). The Blueprint worked collaboratively with VCHIP to provide each practice with their practice-level results for this measure in Fall 2016 (rather than Health Service Area results) and is happy to announce that practice-level results for this measure will be reported on all Blueprint practice profiles starting with Calendar Year 2016 data, set to be released in November 2017.

Last updated: 09/17/18 Author: Blueprint for Health

Strategy

Continue use as a performance payment measure



Notes on Methodology

The statewide average percentage of the Diabetes in Poor Control performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Diabetes in Poor Control performance measure is listed in every Health Service Area Adult profile, which can be found here (http://blueprintforhealth.verm...). The statewide average percentage of the Diabetes in Poor Control performance measure relies on data from the Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non- random sampling variability is not accounted for in the measure.

It is important to note that the weighted average of the HEDIS national Medicaid 90th percentile benchmark for 2016 and the HEDIS national Commercial 90th percentile benchmark for 2016 is **28%**. Given that Vermont is performing significantly better than the national 90th percentile benchmark, the Blueprint has elected to not include a goal for this measure.

Partners

The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Staff at Blueprint Patient-Centered Medical Home Onpoint Health Analytics

Story Behind the Curve

The Diabetes in Poor Control (i.e., Hemoglobin A1c>9%) measure is the third of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the Clinical Registry was in poor control (>9%). This is a mixed methods measure relying both on claims and clinical data.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, several Health Service Areas have developed quality improvement policies on this measure, most notably, Morrisville.

Morrisville has been working on follow-up appointment processes and referrals to self-management services for patients with diabetes (2016, 2017). With regard to quality improvement work directed towards diabetes, practice staff conducted outreach to patients that were overdue for follow-up appointments, reminded patients of the importance of regular appointments with their PCP, and new staff members were trained on how to review physician follow-up recommendations and complete appropriate scheduling for patients for the next visit prior to the patients leaving the office. An improvement in the rate of patients with diabetes who were overdue for an appointment was observed. In addition, the care coordinator nurse was provided with a list of patients with diabetes who were determined to have an A1C greater than 9%, chart review was completed to determine current status of self-management activities, and depending on patient needs, assistance and referrals were completed. There was an improvement in the rate of patients who are engaged with a form of self-management within the last year.

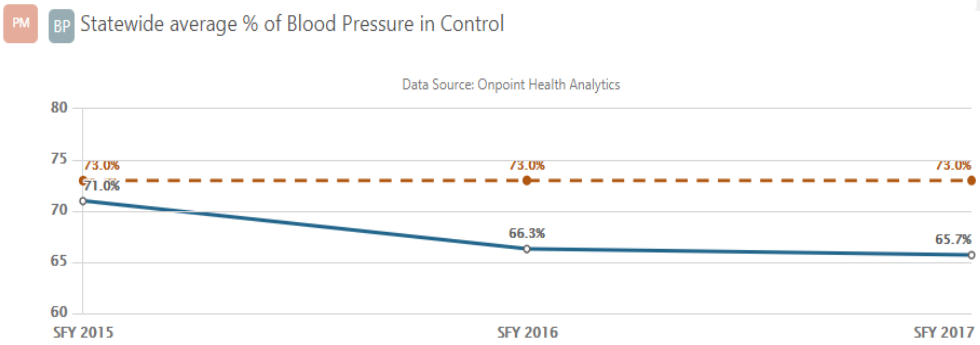
Last updated: 09/17/18 Author: Blueprint for Health

Strategy

Continue as a performance payment measure

Support dissemination and use of the VDH toolkit on Diabetes care Offer Learning Collaborative to improve care at participating practices

Deploy practice facilitators to practices interested in working on QI for diabetes care



Time Period	Actual Value	Target Value	Current Trend
SFY 2017	65.7%	73.0%	↘ 2
SFY 2016	66.3%	73.0%	↘ 1
SFY 2015	71.0%	73.0%	→ 0

Notes on Methodology

The statewide average% for the Blood Pressure in Control performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Hypertension in Control performance measure is listed in every Health Service Area Adult profile, which can be found here (http://blueprintforhealth.verm...). The statewide average percentage of the Hypertension in Control performance measure relies on data from the Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims

data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.

The goal figure for this measure represents a weighted average of the HEDIS national Medicaid 90th percentile benchmark for 2016 and the HEDIS national Commercial 90th percentile benchmark for 2016.

Partners

The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Staff at Blueprint Patient-Centered Medical Homes Onpoint Health Analytics

Vermont Department of Health OneCare Vermont

Support and Services at Home

New England Quality Innovation Network-Quality Improvement Organization Community Health Accountable Care, LLC

Vermont Program for Quality in Health Care, Inc.

Story Behind the Curve

The Blood Pressure in Control measure is the fourth of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with hypertension, ages 18-85 years, whose last recorded systolic blood pressure was less than 140 mm/Hg and whose last recorded diastolic blood pressure was less than 90 mm/Hg.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. The Blueprint for Health, in conjunction with the Vermont Department of Health, OneCare VT, SASH, New England QIN-QIO, CHAC, and VPQHC, has launched a 6-month long peer-learning community to support practices in implementing key strategies to improve blood pressure control in patients with hypertension. In the peer-learning community, we have brought together expert faculty to provide a dynamic learning environment and provided practices the opportunity to learn from peers and have quality improvement.

Last updated: 09/17/18 Author: Blueprint

Strategy

Continue as a performance measure

Support dissemination and use of the OneCare VT toolkit on Hypertension care

Offer Learning Collaborative to improve care at participating practices

Deploy practice facilitators to practices interested in working on QI for hypertension management

Health Information Exchange (HIE) Unit

What We Do

The Health Information Exchange (HIE) Program is focused on the aggregation and exchange of health data for two main purposes:

To ensure providers and patients have access to complete health records to inform quality care decisions and

To enable analysis and reporting that supports continuous, quality improvement in the health care system.

Fundamentally, automating the exchange of health data is essential to improving health care quality, making care more efficient, reducing administrative burden, engaging patients in their care, and supporting the health and well-being of the Vermont community. The Department of Vermont Health Access (DVHA) leverages federal funding under the HITECH Act and the State HIT- Fund to progress health information exchange activities on behalf of Vermont's patients and providers.

Vermont's Health Information Exchange (VHIE), operated by VITL, is a central system that aggregates data from electronic health records for use by providers and health care programs state-wide. DVHA contracts with VITL for operations and development of the VHIE system.

Who We Serve

HIE is intended to serve the health care system and those who use it.

How We Impact

The Department of Vermont Health Access (DVHA) leverages federal funding under the HITECH Act and through the State HIT-Fund to ensure that HIE activities continually meet the needs of the health care system.

As an example, Vermont's Health Information Exchange (VHIE), operated by VITL, is a central system that aggregates data from electronic health records for use by providers and health care programs state-wide. It is one system in the States' health information exchange network. DVHA contracts with VITL for operations and development of the VHIE system.

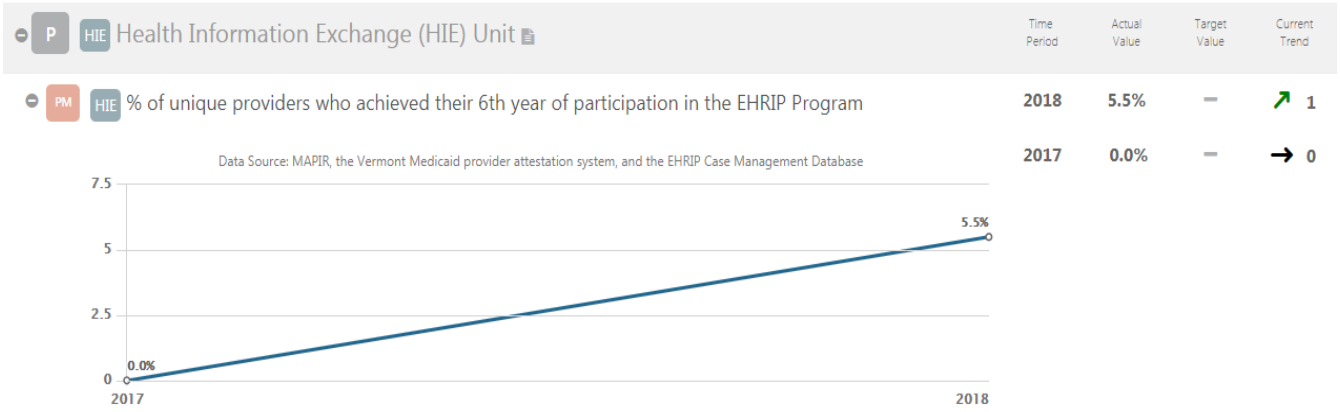
DVHA also supports the HIE Steering Committee in their work developing, executing and evaluating the state-wide strategic HIE Plan.

Action Plan

The top priorities for the HIE Unit in SFY19 are:

Partnering with the HIE Steering Committee to develop a strategic HIE Plan to coordinate state-wide HIE investment, governance and oversight.

Meeting the requirements of Vermont Act 187 of 2018 to address the recommendations from the Act 73 of 2017 Health Information Exchange Evaluation and prepare for future endeavors.



Partners

The MAPIR 14-state Collaborative: System design and development; HITECH policy consultation; technical support

DXC: Vendor technical partner for system integration with MMIS, system deployment and technical support

Vermont Information Technology Leaders (VITL): Education and outreach support

Story Behind the Curve

This measure is used to determine the percent of providers who achieve their maximum six years of eligibility for payment in the EHR Incentive Program.

The Electronic Health Record Incentive program (now called Promoting Interoperability) 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 improve the quality, safety and efficiency of patient health care using electronic health record (EHR) systems.

The EHRIP provides incentive payments to Eligible Hospitals and to clinicians who are designated by the Center for Medicare & Medicaid Services as Eligible Professionals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Vermont started issuing payments to providers for EHRIP Program Year 2011 and will be issuing payments through Program Year 2021. Eligible Hospitals can receive one payment per year for up to three years. Eligible Professionals (EPs) can receive one payment per year for up to 6 years. Not every provider can meet program requirements each year. EPs may skip a year of participation and resume in subsequent years.

One measure of the program's success is evidence that providers return for all 6 years of eligibility. This demonstrates that the program is perceived as useful and the incentive payments make an impact on a provider's ability to adopt an EHR system.

Therefore, this measure focuses on the % of participating providers who received a final program payment. Since providers can continue to access payments through the end of the program in 2021, the State expects to see a successive increase until that time.

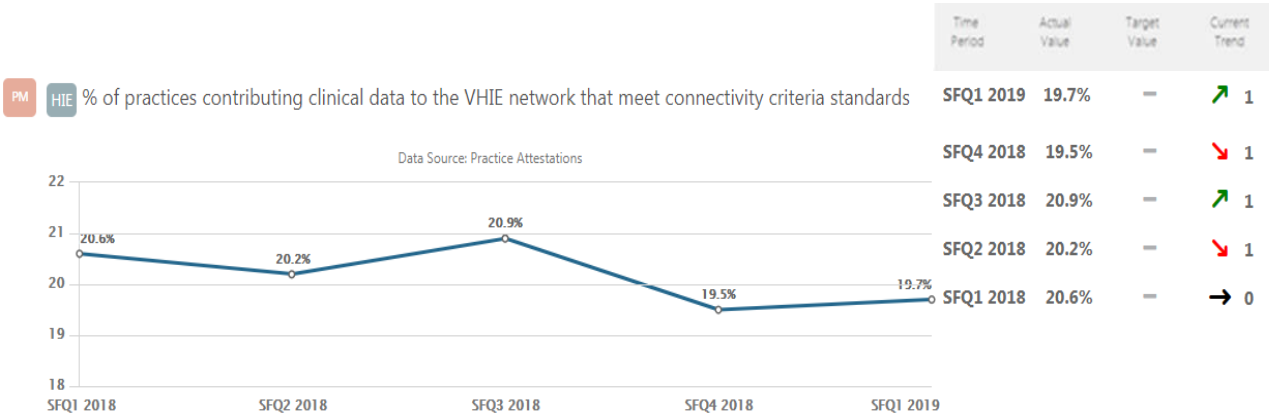
Last updated: 09/17/18

Strategy

Develop strategy for maximizing program participation through 2021.

Perform analysis on all program participation and determine providers who have 1 or more years (maximum 6 years) of eligibility in the program.

Devote additional staff hours to provide targeted outreach to providers most likely to participate in the program. Carefully monitor outreach activity and gauge level of interest.



Time Period	Actual Value	Target Value	Current Trend
SFQ1 2019	19.7%	–	↗ 1
SFQ4 2018	19.5%	–	↘ 1
SFQ3 2018	20.9%	–	↗ 1
SFQ2 2018	20.2%	–	↘ 1
SFQ1 2018	20.6%	–	→ 0

Partners

Vermont Information Technology Leaders (VITL) Vermont Providers

Story Behind the Curve

The Green Mountain Care Board (GMCB) and DVHA require annual updates to Connectivity Criteria to impact the quality of data and patient matching occurring in data connections (interfaces) between electronic health record (EHR) systems and the Vermont Health Information Exchange (VHIE). DVHA contracts with VITL to maintain and establish interfaces.

The Vermont Health Information Exchange (VHIE) exists to aggregate clinical data to support providers at the point of care and those measuring the population's health and the cost of health care. The mechanism for obtaining the clinical data for aggregation is an interface (technical connection) between an electronic health record system and the VHIE.

Since 2009, the State has funded VITL to develop these interfaces and the VHIE to aggregate the clinical data documented in medical records because exchange of clinical data is essential to improving health care quality, making care more efficient, reducing administrative burden, engaging patients in their care, and supporting the health and well-being of the Vermont community.

In addition to funding an increase in interfaces, the State also works with VITL to continually improve data quality and patient matching ability of interfaces. Data connection standards are documented in "Connectivity Criteria" which includes the minimum qualifications a health care organization's EHR system must meet before an interface is established. The usefulness of the data aggregated and exchanged through the VHIE increases as more practices meet the Connectivity Criteria standards.

The Connectivity Criteria is updated annually.

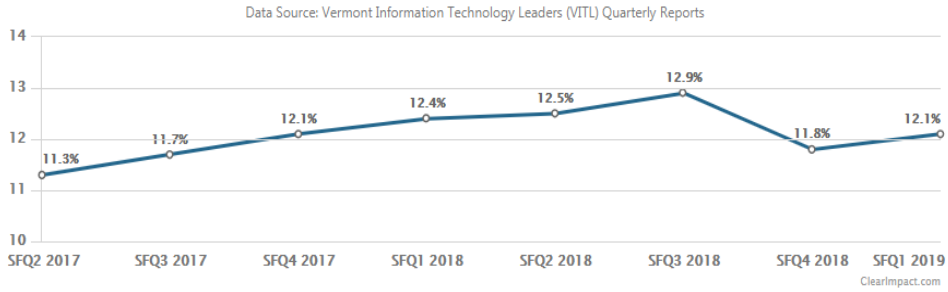
Last updated: 09/17/18

Strategy

Focus state investment on new and replacement interface connections that meet revised connectivity criteria.

Work with the HIE Steering Committee to identify priority candidates for interface development in calendar year 2019.

PM HIE % of providers gaining access to their patient's data through VHIE network



Time Period	Actual Value	Target Value	Current Trend
SFQ1 2019	12.1%	–	↗ 1
SFQ4 2018	11.8%	–	↘ 1
SFQ3 2018	12.9%	–	↗ 6
SFQ2 2018	12.5%	–	↗ 5
SFQ1 2018	12.4%	–	↗ 4
SFQ4 2017	12.1%	–	↗ 3
SFQ3 2017	11.7%	–	↗ 2
SFQ2 2017	11.3%	–	↗ 1
SFQ1 2017	10.7%	–	→ 0

Notes on Methodology

The goal for this measure is to increase the total health care locations (providers) that have gained access to their patient's clinical data via the VHIE by the end of Q2 of SFY19.

Partners

Vermont Information Technology Leaders (VITL) Vermont Providers

Story Behind the Curve

This measure quantifies the percent of providers gaining access to their patients' clinical data via the Vermont Health Information Exchange (VHIE). VITLAccess is a secure online provider portal supplied by Vermont's Health Information Exchange. The VITLAccess portal allows providers to access clinical data for their patients, which is not stored within their practice's electronic health record.

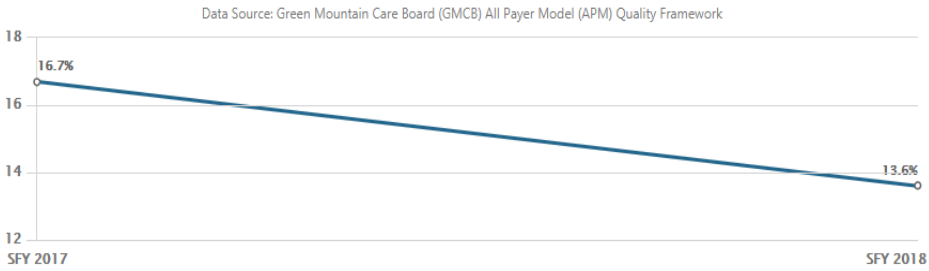
Last updated: 09/17/18

Strategy

Support the VHIE in developing data access methods that consumers demand, such as direct feeds into existing Electronic Health Record systems.

PM HIE % All-Payer Model quality measures currently using Vermont Health Information Exchange (VHIE) data as a primary or secondary source

Time Period	Actual Value	Target Value	Current Trend
SFY 2018	13.6%	–	↘ 1
SFY 2017	16.7%	–	→ 0



Partners

Green Mountain Care Board

Story Behind the Curve

Vermont's Health Information Exchange (HIE) exists to provide clinical data to support providers at the point of care and to be used as a primary data source to assess population-level clinical outcomes and costs of care. The availability of clinical data from the HIE, paired with claims data, helps AHS and our partners quantify the impact of Vermont's health reform initiatives.

Vermont's All-Payer Model has a total of 18 measures supporting 3 overarching goals. The measures that currently rely on clinical data include:

Multi-Payer ACO Screening for Clinical Depression and Follow-Up Plan

Medicare ACO chronic disease composite (specifically two sub-measures: Diabetes HbA1c Poor Control and Controlling High Blood Pressure)

Multi-Payer ACO tobacco use assessment and cessation intervention

To fully understand how clinical data is used to assess population health and the costs of care, other measure-based programs should be evaluated including the Blueprint for Health and the Shared Savings Program.

If clinical data from the VHIE is valued, the HIE-HIT Unit expects to see an annual increase in this figure.

Last updated: 09/17/18

Strategy

Focus state investment on foundational HIE services that increase the usability and quantity of aggregate clinical data. The greater the quality of the data managed by the VHIE, the greater the likelihood that it will be used to meet data analytics and direct care needs.

Coordination of Benefits (COB) Unit

What We Do

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.

Who We Serve

The COB Unit works with providers, beneficiaries, probate courts, attorneys, estate executors, health insurers, liability insurance companies, employers, third party administrators (TPA) and Medicare A, B, C & D plans to ensure that Medicaid is the payer of last resort and that all possible types of recovery are pursued as required by federal law.

How We Impact

The COB Unit recovers monies that Medicaid has paid as the primary insurer in error, that Medicaid has paid for the care of a beneficiary 55 years of age of older, who received long term care services or that Medicaid has paid for care for a beneficiary with another liable third party. The collections from the recovery processes are utilized to offset program costs in the yearly Medicaid budget.

The COB Unit assists Medicare beneficiaries with state health/pharmacy assistance obtain their prescription medications at the pharmacy, eligibility for pharmacy assistance, premium assistance, Low Income Subsidy (LIS), Medicare buy-in, and Medicare Open Enrollment. The assistance given by this unit saves beneficiaries monies and allows them to access necessary pharmacy medications at a reasonable cost, while at the same time it saves the State of Vermont millions. Ensuring that beneficiaries are receiving all the federal programs (Medicare Buy-in, LIS PART D Coverage) for which they are eligible, means the State of Vermont will not be responsible for the costs of the services/items in the Medicaid budget.

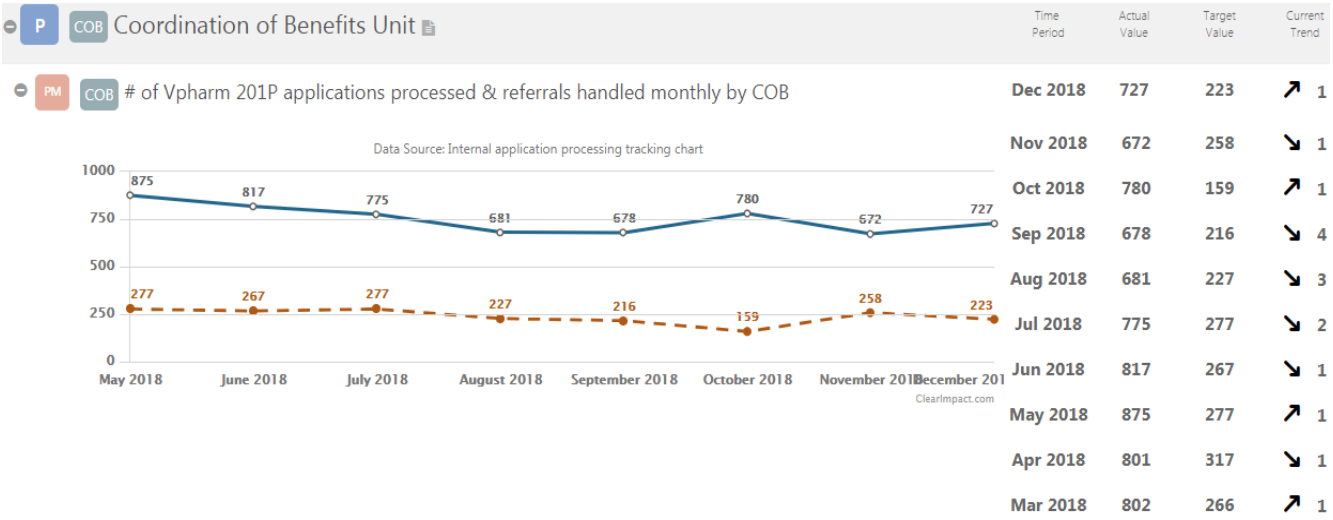
The updates done to systems to ensure correct claims processing properly, prevents Medicaid from being the primary payer in error, saving the program hundreds of millions of dollars annually.

Action Plan

The top 2 priorities/initiatives for the COB Unit in SFY19 are:

To increase collections by improving and automating the data matching process with insurers

To procure a tracking system that streamlines and manages COB business processes through automation, workflow management, document management and by performing the end of month process



Notes on Methodology

Please note in the above chart that:

The solid trend line shows the total # of applications process. The dotted trend line shows the total # of referrals handled.

# of Vpharm 201P applications processed & referrals handled by COB Unit													
	SFY18							SFY19					
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
# app completed	716	775	762	774	783	852	795	755	662	654	759	647	691
# app pended	26	35	29	28	18	23	22	20	19	24	21	25	36
Total # app	742	810	791	802	801	875	817	775	681	678	780	672	727
Total # referrals	346	253	247	266	317	277	267	277	227	216	159	258	223

The PDP Team is divided into two groups. The first group handles VPharm and Medicare Savings Program eligibility and this is what has been previously measured below by the number of applications processed per month. The second group handles billing related referrals and the new field below gives an indication on the number of case referrals that group handles per month and gives a more accurate picture of the duties of the entire PDP Team.

Partners

Health Access Eligibility & Enrollment Unit (HAEEU) OnBase (document processing)

AHS Policy Unit

Centers for Medicare & Medicaid Services (CMS) Social Security Administration (SSA)

Story Behind the Curve

This measure will show how many 201P applications are processed on a monthly basis by the COB Unit, and whether they are completed or pended due to incomplete information.

VPharm eligibility is determined by members completing either the 1) VPharm application (201P) or 2) Medicaid application (202MED).

If only the 201P VPharm application is received, the Coordination of Benefit (COB)staff process it.

If both the 201P VPharm mixed household application and 202MED applications are received, HAEEU staff process them.

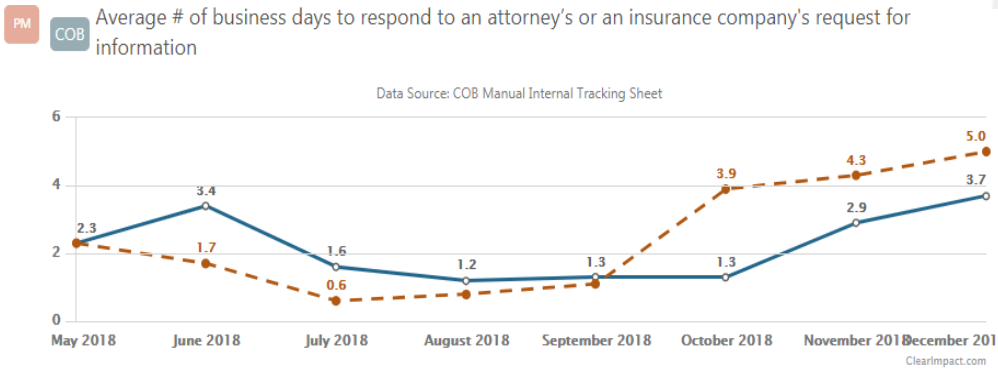
This measure looks at **201P VPharm** applications put into the Coordination of Benefit (COB) Unit's working que in OnBase by the Application Data Processing Center (ADPC). The COB Unit has 3 employees with access to OnBase and who can work these applications. Counts are systematically tracked in OnBase, a reporting tool and calculated monthly.

If an application is found to be incomplete (not worked) due to missing information, a notice is sent to the applicant requesting information and an extra 30 days is given to respond. Members that are given this extra time to follow up with requested information are tracked manually for measure purposes but there are system edits to either complete or close the application.

Last updated: 01/14/19

Strategy

The PDP Team is divided into two groups. The first group handles VPharm and Medicare Savings Program eligibility and this is what has been previously measured below by the number of applications processed per month. The second group handles billing related referrals and the new field below gives an indication on the number of case referrals that group handles per month and gives a more accurate picture of the duties of the entire PDP Team.



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	3.7	5.0	↗ 2
Nov 2018	2.9	4.3	↗ 1
Oct 2018	1.3	3.9	→ 1
Sep 2018	1.3	1.1	↗ 1
Aug 2018	1.2	0.8	↘ 2
Jul 2018	1.6	0.6	↘ 1
Jun 2018	3.4	1.7	↗ 3
May 2018	2.3	2.3	↗ 2
Apr 2018	1.6	2.2	↗ 1
Mar 2018	1.2	1.0	↘ 1

Notes on Methodology

Please note in the above chart that:

The solid trend line shows the average # of business days to respond to an attorney's request

The dotted trend line shows the average # of business days to respond to an insurance company's request

Average # of business days to respond to an attorney's or an insurance company's request for information													
	SFY18							SFY19					
	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Avg # attorney	1.2	0.7	1.4	1.2	1.6	2.3	3.4	1.6	1.2	1.3	1.3	2.9	3.7
Avg # insurance company	1.4	1.1	0.4	1.0	2.2	2.3	1.7	0.6	0.8	1.1	3.9	4.3	5.0
Total avg # days	1.3	0.9	1.0	1.1	1.7	2.3	2.7	1.1	1.1	1.2	2.2	3.4	4.2

Partners

Medicaid Beneficiaries Attorneys

Insurance Companies

Story Behind the Curve

State of Vermont Legislation passed Title 33 VSA 1910 (amended) which enhances the ability to collect from third party payers by establishing procedures which third party payers must adhere to in the State of Vermont. Attorneys representing clients that are Vermont Medicaid members must follow Vermont Statute 33 V.S.A. § 1910: Liability of third parties; liens: "(c) A recipient who has applied for or has received medical assistance under this subchapter and the recipient's attorney, if any, shall cooperate with the agency by informing the agency in writing within a reasonable period of time after learning that the agency has paid medical expenses for the recipient. The recipient's attorney shall take reasonable steps to discover the existence of the agency's medical assistance."

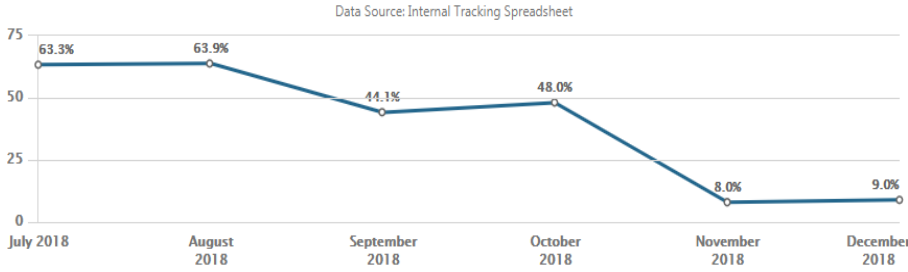
Attorneys outreach our Coordination of Benefits (COB) Casualty Recovery Team via phone, fax, email and snail mail to verify Medicaid coverage of their client and vice versa. This can begin with the client informing their attorney that they are covered by Medicaid, or by a returned Accident/Questionnaire, which states that the member has retained an attorney after a trauma related injury. Once the COB Unit receives an attorney's request for information, it has 45 days to respond. However, the goal has always been a timely and accurate response to all requests.

July 2017 results were a bit higher due to a couple of cases that had increased turn-around times. Sometime there are difficulties connecting with attorneys. Also, COB will not release information until a copy of an Authorization to Release Information form is received. This can increase the time to case closure. *Last updated: 01/14/19*

Strategy

The Coordination of Benefits (COB) Casualty Recovery Team will work requests for both attorney's and insurances in chronological order as the requests come into the unit. Prior to 10/01/2018 attorney requests were prioritized before insurance company requests.

PM COB % of Medicaid members in the monthly data match who had new or updated commercial insurance policy information



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	9.0%	–	↗ 1
Nov 2018	8.0%	–	↘ 1
Oct 2018	48.0%	–	↗ 1
Sep 2018	44.1%	–	↘ 1
Aug 2018	63.9%	–	↗ 1
Jul 2018	63.3%	–	→ 0

Notes on Methodology

Partners

United Health Care (UHC)

Blue Cross Blue Shield of Vermont (BCBSVT)

% of Medicaid members in the monthly data match who had new or updated commercial insurance policy information																		
	SFY19																	
	Jul-18			Aug-18			Sep-18			Oct-18			Nov-18			Dec-18		
	UHC	BCBSVT	Total	UHC	BCBSVT	Total	UHC	BCBSVT	Total	UHC	BCBSVT	Total	UHC	BCBSVT	Total	UHC	BCBSVT	Total
Total # members in data match	1020	4503	5523	822	2987	3809	767	2,888	3,655	804	4,803	5,607	873	1,585	2,458	1,008	1583	2591
# members w/ new or updated commercial insurance info	453	3041	3494	185	2248	2433	225	1,386	1,611	209	2,481	2,690	84	113	197	97	128	225
% members w/ new or updated commercial insurance info	44.4%	67.5%	63.3%	22.5%	75.3%	63.9%	29.3%	48.0%	44.1%	26.0%	51.7%	48.0%	9.6%	7.1%	8.0%	10.0%	8.0%	9.0%
For each member in the data match, panels are:																		
# members with new insurance information	449	2717	3166	175	2165	2340	224	1,315	1,539	207	2,253	2,460	84	108	192	97	56	153
# members with updated insurance information	4	324	328	10	83	93	1	71	72	2	228	230	0	5	5	0	72	72
# members w/ name/DOB/SSN discrepancy (untouched)	567	1462	2029	637	739	1376	542	1,502	2,044	595	2,322	2,917	789	1,472	2,261	911	1455	2366
# members not worked (roll over to next month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total # (should match total # members in data match)	1020	4503	5523	822	2987	3809	767	2888	3655	804	4,803	5,607	873	1,585	2,458	1,008	1583	2591

Story Behind the Curve

Data matching uses data files required by State of Vermont Statute: 33 V.S.A. § 1908 Medicaid; payer of rights and shall not charge the Agency or any of its authorized agents fees for the processing of claims or eligibility requests. *Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information* that will enable the Agency to determine the existence of third-party coverage for Medicaid recipients, the period during which Medicaid recipients may have been covered by the insurer, and the nature of the coverage provided, including information such as the name, address, and identifying number of the plan.

These data files are "matched" with the insurance panels captured in the DVHA's ACCESS system. ACCESS is the repository of a member's insurance data and is transferred to the payment systems. An "insurance panel" is a screen within the systems that contains the member's policy and group numbers, for their primary insurance. This includes policy holder and family members covered. By matching the ACCESS system's information against data received from an insurer, DVHA can capture missing or incorrect information. When ACCESS is missing "other" insurance info, a provider's claim will be paid by Medicaid incorrectly. The correct information once added to ACCESS will re-direct a request for payment to the other insurer, and Cost Avoid any future claims. Currently, all updates to insurance screens "panels" in ACCESS resulting from data matching are manually done.

The Coordination of Benefits (COB) Unit currently receive between 2500 to 5000, sometimes more lines of data per month from United Health Care and BCBS of Vermont. The file's come in monthly, the data is then reviewed by Coordination of Benefit Program Consultants for appropriate entry and updating.

Correcting and adding new beneficiary's "other insurance" information, in part through 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, and maintains Medicaid as "payer of last resort". This is identified as Medicaid Cost Avoidance. The Medicaid Third Party Liability Cost Avoidance in 2017 was more than $130 Million, as stated data matching plays a part in this savings.

In November 2018, the trend line dropped because the BCBS data match is current. In previous months, the data point included old data that COB was processing. Now that they are current, they are only getting new and/or updated data.

Last updated: 01/14/19

Strategy

COB Recovery unit that reviews data matching is a team of 4 employees. 1 of the employees is the lead during the initial review who then disperses the report to the other employees. We have found that by using staff talents within the group typically works best. Longer term employee may offer additional assistance to the other staff which then leads to better group discussion. This group works well as a team, they offer to help others who may have fallen behind due to other job duties and staff being out of the office. Our main goal as a team is to get all data entered by month end, to reach this goal we all pitch in, and work together while taking all our other duties into consideration.

Oversight & Monitoring Unit

What We Do

The Oversight & Monitoring Unit (OMU) consists of two teams; Audit & Internal Control and Healthcare Quality Control. The OMU 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.

Who We Serve

The OMU serves DVHA Senior Leadership and all DVHA departments and units.

How We Impact

Establishment and maintenance of an Oversight and Monitoring Program in line with the strategic direction of DVHA and Agency Leadership to ensure the effectiveness and efficiency of departmental control environments, operational processes, financial and performance reporting; and alignment with applicable laws and regulations.

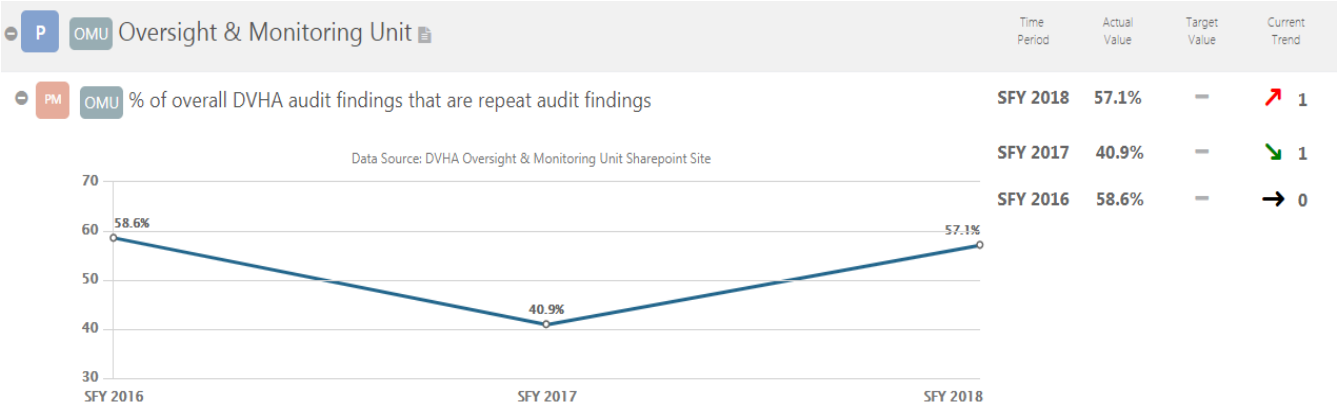
The OMU facilitates and consults on numerous exams, reviews and audits to establish professional working relationships between the DVHA units, examiners, regulators and auditors resulting in a better understanding of what is truly an issue versus a miscommunication, which results in reduced of findings.

Action Plan

The top two priorities/initiatives for the OMU in SFY19 are:

The total number of audit findings in audits that closed during a state fiscal year (SFY) and the total number that are repeat findings from previous audits.

The OMU will be developing a KPI for HCQC



Notes on Methodology

% of overall audit findings that are repeat audit findings									
	SFY16			SFY17			SFY18		
	Total #	Repeat #	Repeat %	Total #	Repeat #	Repeat %	Total #	Repeat #	Repeat %
45 CFR VHC	10	0	0.0%	4	1	25.0%	3	0	0.0%
CAFR	5	5	100.0%	4	4	100.0%	1	1	100.0%
A133	14	12	85.7%	6	3	50.0%	3	3	100.0%
CMS PI	N/A	N/A		8	1	12.5%	N/A	N/A	N/A
Total	29	17	58.6%	22	9	40.9%	7	4	57.1%

Goal: The goal for this measure is no repeat findings. However, it is understandable if there are repeat findings related to known or discovered system problems that require ADS project assessment.

45 CFR is an annual audit of the Vermont State Exchange "VHC" by an independent qualified auditing entity which, follows generally accepted governmental auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review by CMS/CCIIO/HHS. The Centers for Medicare & Medicaid Services (CMS) is part of the Department of Health and Human Services (HHS). CMS administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. The Center for Consumer Information and Insurance Oversight (CCIIO) has direct enforcement authority over non-Federal governmental health plans and is charged with ensuring adequate implementation of the provisions of the Affordable Care Act.

The Comprehensive Annual Financial Report (CAFR) is a thorough and detailed annual presentation of the state's financial condition. It reports on the state's activities and balances for each fiscal year. The State's external accounting firm works with the State of Vermont to review prepared modified accrual financial statements for compliance with GAAS and GAAP guidelines.

The A133 Single Audit is an annual review by the State's external audit firm to ensure a recipient of federal funds is in compliance with the federal program's requirements for how the money can be used. Each federal agency that gives out grants outlines specific items it feels are important for recipients to meet to ensure the successful management of the program and alignment with the legislative intent of the program. These items are laid out in the A-133 Compliance Supplement.

CMS PI Review - Every 3 or 4 years, the Centers for Medicare & Medicaid Services (CMS) conduct a focused review to determine the extent of program integrity oversight of the managed care program at the state level.

Partners

DVHA staff

DVHA Unit Directors

DVHA Leadership

Story Behind the Curve

This measure shows the total number of audit findings in audits that closed during a state fiscal year (SFY) and the % that are repeat findings from previous audits.

It is the expectation by regulators, auditors and examiners that their findings and recommendations are resolved before the next exam/audit. The State provides corrective action plans to these entities and periodic progress reports. Findings and recommendations not adequately addressed before the next audit are reported as repeat findings and the criticality of these findings increases the longer the finding remains open. Special consideration is given by auditors, regulator and examiners for findings and recommendations that are system related that may need project planning and resolution that cannot be completed in a one-year period.

DVHA is required to be compliant with all Federal and State policies regarding the administration of the Medicaid Program and the Qualified Health Plans. When DVHA is audited by an external auditor or regulator, and findings are identified, DVHA will correct the issue, in the approved time frames to ensure there are no repeat findings when that auditor or regulator returns.

Federal and State policies define the regulations for which DVHA must follow to be compliant with the administration of the Medicaid Program, including the Qualified Health Plans. When repeat findings exist, it brings to light that deficiencies and/or material weaknesses remain and that the programs are not compliant with the requirements. A compliant program will help to strengthen the economy, make Vermont more affordable and protect the most vulnerable.

Tracking of this data is limited, historically, as the Oversight & Monitoring unit has only been in existence for a few years. Historical data is captured, as current audits present, where repeat findings may be brought forward. At present, approximately 2 years of data has been captured so for any audit that happens more than every 2 years (CMS IAG Review is every 3-4 years), the data may need to be captured for the first time, as the beginning of the next review time frame.

The 45 CFR VHC audit that closed in SFY 2016 was the first audit of VHC and resulted in an Adverse Opinion due to the lack of documented Standard Operating Procedures (SOPs). A tremendous undertaking was made by DVHA HAEEU with assistance from Oversight & Monitoring to complete numerous SOPs before the next year's review. As noted in the above table, there was only one repeat finding and an Unqualified Opinion was issued.

In 2016, the Oversight & Monitoring unit was established within Program Integrity to formalize an Oversight & Monitoring Program for the Medicaid Program, including the Vermont Health Connect, in line with the strategic direction of DVHA and Agency Leadership to ensure the effectiveness and efficiency of departmental control environments and operational processes in alignment with applicable laws and regulations. Working closely with DVHA departments, corrective action plans were

put in place and actively pursued to ensure a reduction in repeat findings. The result was a reduction from 12 to 3 repeat findings reduction for SFY 2017 Single audit.

Adverse Opinion – the State did not comply in all material respects with the federal compliance requirements that could have a direct and material effect on major federal programs.

Unqualified Opinion – The State compiled in all material respects with federal requirements that could have a direct and material effect on major federal programs.

Last updated: 12/04/18

Strategy

Continue to work with DVHA departments to strengthen documented Standard Operations Procedures "SOPs". Through the 2018 SOP project, DVHA departments learned how to capture the risks and controls in each area and to have documentation for leadership and the regulators to support our self-assessment that we have a strong control environment. Being able to document a strong control environment that stands up to audit testing results in reduced testing and findings.

Continue to work with DVHA departments to assess and prepare for audits, exams and reviews to ensure consistent messaging and accurate exchange of requested documentation and answers from one exam/audit to the next.

Program Integrity Unit

What We Do

The Program Integrity Unit (PIU) works to establish and maintain integrity within the Medicaid Program and engages in activities to prevent, detect and investigate Medicaid provider and beneficiary fraud, waste and abuse. Data mining and analytics, along with referrals received, are used to identify and support the appropriate resolution.

Who We Serve

The PIU serves the Medicaid recipients of Vermont. We protect the integrity of Vermont tax dollars and ensure they are spent on the health and welfare of the recipients that need it.

How We Impact

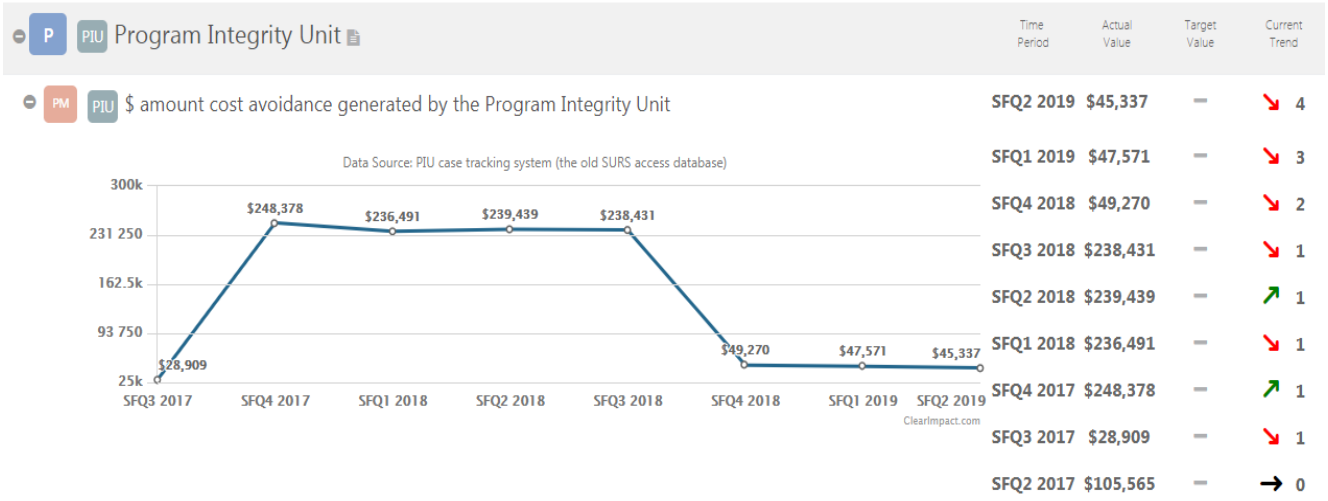
By identifying and preventing fraud and abuse from providers and beneficiaries which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients. The more fraud and abuse we detect and prevent means there are more funds available for the recipients that really need it. We ensure services are provided as billed, are medically necessary, and at the proper cost.

Action Plan

The 2 top priorities/initiatives for the PIU in SFY19 are:

To collaborate with the ACO to develop and implement educational and training needs to effectively deliver quality health care at an accurate cost.

To develop and monitor all PIU initiatives defined in the ACO contract with the ACO that will establish a strong compliance program.



Notes on Methodology

Please note while there is no specific target for this measure, the goal is to increased quarterly cost avoidance as we move

into more Value Based Payment models

	$ amount cost avoidance generated by the Program Integrity Medicaid Audit & Compliance Unit					
	SFY18				SFY19	
	Q1	Q2	Q3	Q4	Q1	Q2
Provider	$236,491	$239,439	$238,431	$49,270	$47,571	$45,337
Member	$468,029	$294,514	$115,193	not yet available		
Total	**$704,520**	**$533,953**	**$353,624**	**$49,270**	**$47,571**	**$45,337**

We intend to combine provider and member cost avoidance amounts in the display above.

The provider cost avoidance amount becomes available 45 days after the end of the quarter.

The timing of incoming member cost avoidance data and resulting cost avoidance amounts shown here is still being worked through.

Ultimately, individual & combined $ amounts will be updated as new data becomes available.

Partners

Other DVHA Units (such as Clinical or Policy) whom assist the PIU in policy development or systems change in support of DVHA PI initiatives for payment integrity and eliminating waste across all programs though edits and future "cost avoidance".

Story Behind the Curve

The Program Integrity Unit (formerly PACU & BFIU) records cost avoidance, when a case is final, and the actions stop the historical claim pattern. PI records cost avoidance which we remove people from Vermont Medicaid roles when beneficiaries live out of state. Cost avoidance is recorded in the SURS system and on excel spreadsheets, when it refers to a projected reduction in future Medicaid

expenditures caused by a change in billing patterns by a provider triggered by an investigation or when we correct people eligibility.

The chart shows the quarterly impact of our cost avoidance spread over the future impacted period. Cost avoidance calculation covers only projected annual saving (one year). This is spread across future months using an accrual method to show the financial impact received from our closed case.

The goal of the PIU is to increase payment integrity across the board by recommending changes to DVHA policies/procedures or change edits/audits based on case work and consulting with other units across AHS. When these questions are answered, the projected cost avoidance is recorded which represents future dollars which remain available to be reallocated for other purposes. Cost avoidance doesn't exist with each case opened in PIU.

Cost Avoidance chart shows an increase in quarterly cost avoidance starting in Q$ SFY 2017 and continues in SFY 2018. This represent several cases closed in late SFY2017 and early SFY 2018. These projected saving are spread over 12 months following the closure of the case. The Goal of the PIU is to continue to increase the quarterly cost avoidance dollar amount over time.

Last updated: 01/14/19

Strategy

There is no direct strategy for cost avoidance. Cost Avoidance can only be achieved by all of us working together to remove and/or place edits in our systems in order to achieve payment integrity.

Clinical Operations Unit

What We Do

The Clinical Operations Unit (COU) monitors the quality, appropriateness, and effectiveness of healthcare services requested by providers for members.

The COU ensures that:

Requests for services are reviewed and processed efficiently and within the time frames outlined in Medicaid Rule;

Over-and-under utilization of healthcare services is identified through the prior authorization (PA) review process and case tracking;

Clinical criteria for certain established clinical services, new technologies and medical treatments are developed and/or adopted; Medical benefits are correctly coded;

Provider appeals are reviewed;

Provider education is offered related to specific Medicaid policies and procedures; quality Improvement activities are performed to enhance medical benefits for members.

Who We Serve

One of the main roles of the COU is reviewing prior authorization requests for medical necessity. These requests are for services or goods (examples: durable medical equipment, elective inpatient admissions, out of network office visits) for our beneficiaries.

The COU also serves our provider community, as we help support them by providing education around our processes, so we can better serve our beneficiaries.

How We Impact

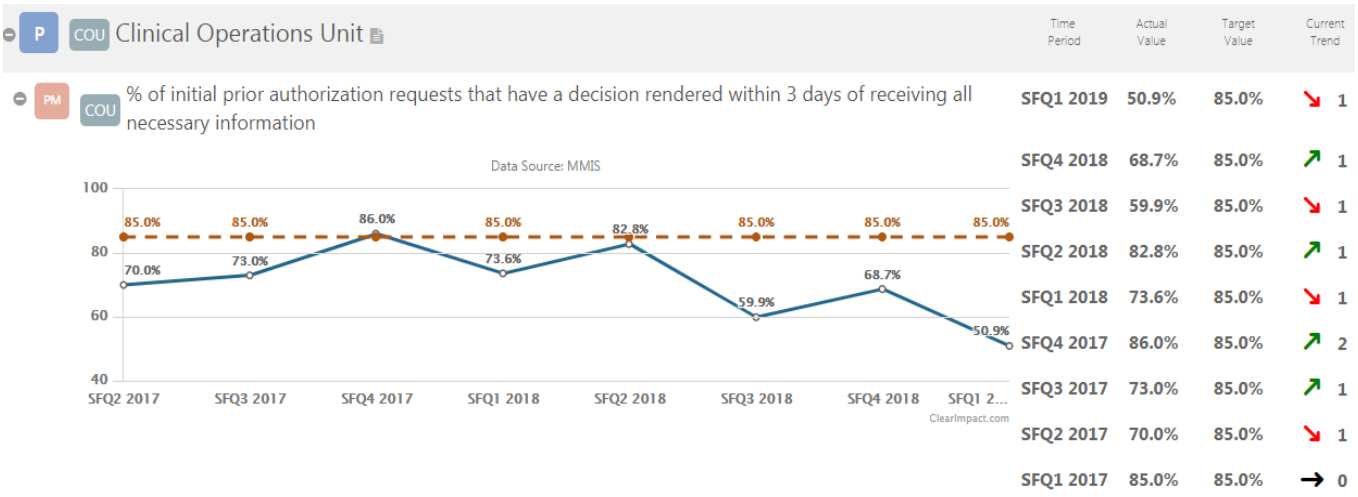
The COU processed almost 20,000 prior authorization requests in calendar year 2017. Decisions are based on Vermont Medicaid Rule 7102 – this in brief is medical necessity and least expensive, appropriate health service. COU's priority is that our beneficiaries get what is medically appropriate while being fiscally responsible.

Action Plan

The 2 top priorities/initiatives for the COU in SFY19 are:

Collaboration with the ACO: Due to the limitations of our MMIS, the COU is working closely with the Payment Reform Unit to utilize everyone's strengths to help improve the transition for our providers and beneficiaries into the ACO model.

Medical Audits: In the past, the COU did concurrent reviews on in-network inpatient admissions after 13 days. It was determined that the hospital understood the correct process for billing inpatient stays, so we decided to focus one staff's time to develop a Medical Audit program.



Partners

Chief Medical Officer (CMO)

Story Behind the Curve

The Clinical Operations Unit (COU) staff determine the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations.

The 3-day goal for a decision to be rendered is based on CMS rule. Reaching this goal is heavily dependent on having adequate staffing. The COU has had extended review time due to vacancies. During SFY18 Q3, the COU (a unit of 9 FTEs) saw a drop in our rate due to the following staffing vacancies: 1 Nursing Operations Director, 1 Program Tech, 1 nurse for 1 month, and 1 another nurse for 1 month. This is almost a third of our FTEs that our unit was short during this quarter.

The COU experienced extended review time in September due to:

Increased Prior Authorization requests within Q4: July and August 2017=3035/July and August 2018=3536

Several staffing shifts w/in the COU: short 1 & ½ staff every day, onboarding of NOD, RN Administrator work redistributed

Collaboration and implementation of ACO transitional processes: determination of PA requirements, development of forms, and provider education

Preparing and transitioning to a new electronic system: receipt of electronic faxes began 8/21/18, examples: # of PA requests 8/21=122, 8/24=203, 9/11=496

Increased volume of reconsideration requests from DXC requiring clinical determinations **This performance measure is important because it shows:**

Timely access to treatment/services for members Compliance with State and Federal Regulations

The PA turnaround times are reported to the External Quality Review Organization (EQRO) and to KPMG, an auditing service that monitors the COU's regulatory compliance

Last updated: 10/15/18

Strategy

Examination of high-volume Prior Authorization request trends

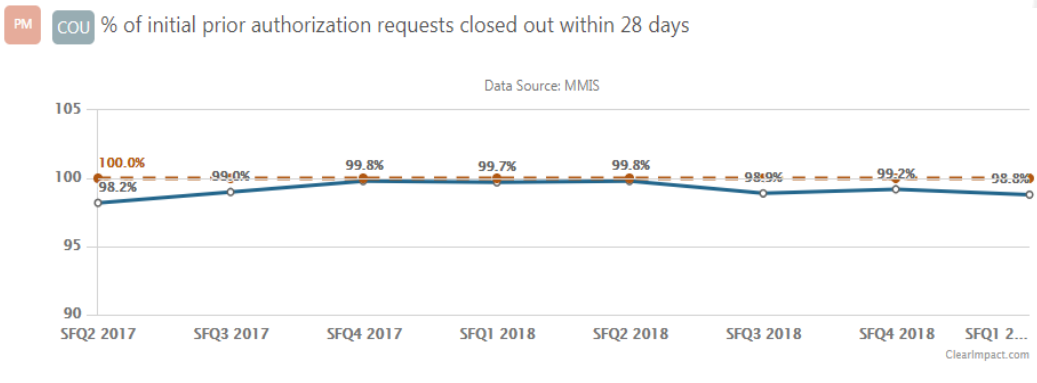
Retention of administrative staff to support clinical staff reviewing PA requests

Continued efforts and communication with the Business Office to allow for overtime Recognize COU staff accepting overtime

ACO PA requirements, forms, and communications forwarded to ACO providers New temp hired to support electronic record transition October 2018

New temp hired to support administrative needs of clinical staff October 2018

Refinement of documents and processes between DXC and COU to increase reconsideration response efficiencies



Time Period	Actual Value	Target Value	Current Trend
SFQ1 2019	98.8%	100.0%	↘ 1
SFQ4 2018	99.2%	100.0%	↗ 1
SFQ3 2018	98.9%	100.0%	↘ 1
SFQ2 2018	99.8%	100.0%	↗ 1
SFQ1 2018	99.7%	100.0%	↘ 1
SFQ4 2017	99.8%	100.0%	↗ 2
SFQ3 2017	99.0%	100.0%	↗ 1
SFQ2 2017	98.2%	100.0%	↘ 1
SFQ1 2017	98.6%	100.0%	→ 0

Partners

Part time MD support - Dental & MS Chief Medical Officer (CMO)

DXC contract staff-Physical Therapy DXC Provider Relations

DVHA Provider Member Relations Unit DVHA Data Unit

Story Behind the Curve

The Clinical Operations Unit (COU) staff determine the medical necessity of a service or product provided to its members using the prior authorization (PA) process. Medical necessity determinations are made using evidence-based clinical guidelines. PA decisions must be made within time frames specified in the Medicaid Rules and in Federal regulations.

There is variation in this data that is out of the control of the COU. This data heavily relies on Medicaid providers sending enough clinical information so a complete clinical review and decision can be rendered.

The COU has had extended review time due to:

Electronic Fax new process 8/2018 and increase in volume/trouble shooting COU transition to OnBase technology for processing PA requests Completion of paper files to scanned documentation

Increase in PA requests from August 2018-October 2018 Addition of ACO technical PA requests to COU workload

This performance measure is important because it shows:

Timely access to treatment/services for members Compliance with State and Federal Regulations

The PA turnaround times are reported to the External Quality Review Board (EQRO) and to KPMG, an auditing service that monitors the COU's regulatory compliance.

Last updated: 11/15/18

Strategy

Increase administrative support for COU

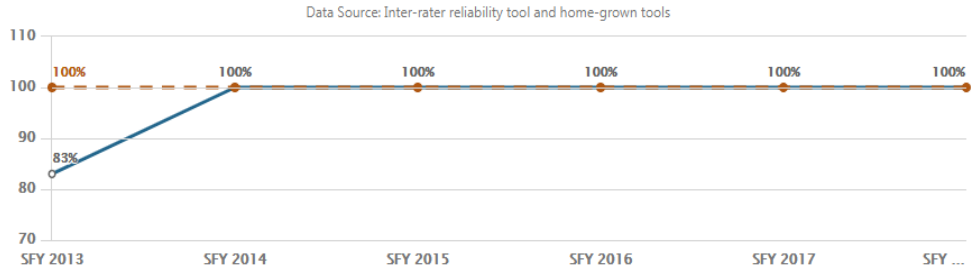
PA work process redistributed to respond to increased PA requests

Banner page sent to out to inform of new electronic process and transition occurring within COU Website address added to COU voicemail to provide additional resource to providers

ACO and COU developed PA request form for technical ACO PA requests Overtime opportunity provided for COU staff

Collaboration with IT to support technical transitions w/I COU

PM COU % of clinical staff with inter-rater reliability scores of 80% or higher



Time Period	Actual Value	Target Value	Current Trend
SFY 2018	100%	100%	→ 4
SFY 2017	100%	100%	→ 3
SFY 2016	100%	100%	→ 2
SFY 2015	100%	100%	→ 1
SFY 2014	100%	100%	↗ 1
SFY 2013	83%	100%	→ 0

Partners

Change Healthcare

Story Behind the Curve

Inter-rater reliability (IRR) assessments are conducted on each of the clinical content areas, on an annual basis. They are performed to determine the uniform application of review criteria, confirm consistent clinical determinations are made by review staff and to ensure that the COU is in compliance with Federal and State Regulations.

The COU utilizes IRR tests created by Change Healthcare for the following: Durable Medical Equipment (DME)

Acute Care – Adults Acute Care – Pediatric

Outpatient Rehabilitation and Chiropractic Procedures

The COU has created IRR tests for administrative staff and for dental staff as these are not available from Change Healthcare.

The low score in 2013 was based on the subpar performance of one staff member. This staff had an extraordinary amount of one on one training, which still not help them become successful. This staff is no longer part of the COU.

This measure is important to:

Determine the uniform application of review criteria

Confirm that consistent clinical determinations are made by review staff

Ensure that the COU is in compliance with the Code of Federal Regulations (CFR): §438.210 Coverage and authorization of services (b)(2)(i) "Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;"

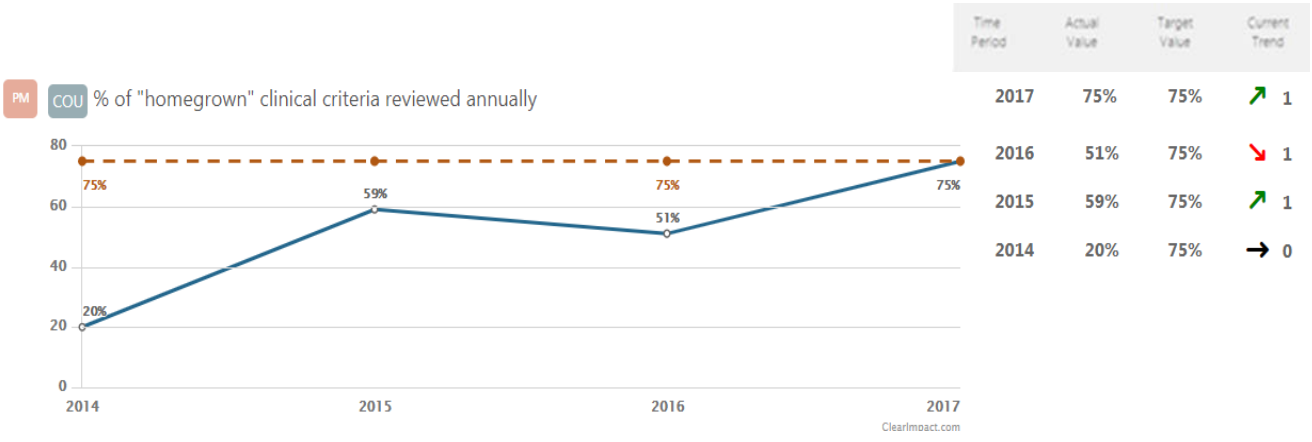
§438.236 Practice guidelines (d) *Application of guidelines.* "Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines."

Last updated: 07/16/18

Strategy

Staff receive training once a year from Change HealthCare on how to utilize this system.

After each IRR, staff review all incorrect answers individually and the COU reviews common errors as a team.



Time Period	Actual Value	Target Value	Current Trend
2017	75%	75%	↗ 1
2016	51%	75%	↘ 1
2015	59%	75%	↗ 1
2014	20%	75%	→ 0

Partners

Part time physician support

Chief Medical Officer (CMO)

DXC contract staff

Story Behind the Curve

DVHA Clinical Operations Unit (COU) purchases clinical criteria from Change Healthcare. The purchased criteria do not contain criteria for all the procedures that Medicaid covers, therefore COU staff research and develop "homegrown" criteria. Staff utilize Vermont State Medicaid Rules; Hayes and Cochrane (Peer review journal libraries); and other nationally recognized evidence-based criteria). Also, some of the purchased criteria is not strong enough to support state policies. In these cases, staff create supplemental criteria that are used in conjunction with the purchased criteria.

It is important to know that the COU does not have dedicated staff to research and develop these criteria. This is an additional task added to the Utilization Review Nurses role. When a criterion is completed, it is then reviewed by the Nurse Administrator II, the Nursing Operations Director, and then reviewed and approved by the Chief Medical Officer.

The data is not strong for several reasons:

The COU does not have dedicated staff to do this work Staff vacancies which has included the following:

- In 2014, the COU had 2 nurses retire which significantly decreased work efficiency and therefore the ability to work on clinical criteria
- In 2017, the COU experienced the following vacancies:
  - Administrative staff (which requires the nursing staff to help in this role to keep the COU work flow going) Nurse out for 6 weeks due to injuries
  - Vacant nurse position
  - Chief Medical Officer position being vacant with only part time coverage in 2018, the COU Nursing Operations Director position since January.

Last updated: 05/30/18

Strategy

Spread the reviews out as evenly as possible amongst the staff as well as throughout the year.

Quality Improvement & Clinical Integrity Unit

What We Do

The Quality Improvement & Clinical Integrity Unit (QICIU) includes the Quality Team and the Clinical Utilization Review Team. The Quality Team collaborates with AHS partners to develop a culture of continuous quality improvement, maintains the Vermont Medicaid Quality Plan and Work Plan, coordinates quality initiatives including formal performance improvement projects, coordinates the production of standard performance measures, and is the DVHA lead unit for the Results Based Accountability (RBA) methodology & produces the DVHA RBA Scorecards.

The Clinical Utilization Review Team (UR) is 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 disorders and mental health needs. The team performs utilization management activities including concurrent review and authorization of mental health and substance use disorder services. The UR Team also administers the Team Care program, which locks a member to a single prescriber and a single pharmacy. In addition, the Autism Specialist prior authorizes applied behavior analysis (ABA) services for children.

Who We Serve

The QICIU serves Vermonters enrolled in Medicaid who require behavioral health inpatient, residential, and ABA services.

How We Impact

The Quality Team supports the Department in creating a culture of quality improvement; supporting units to strive for and demonstrate improvement.

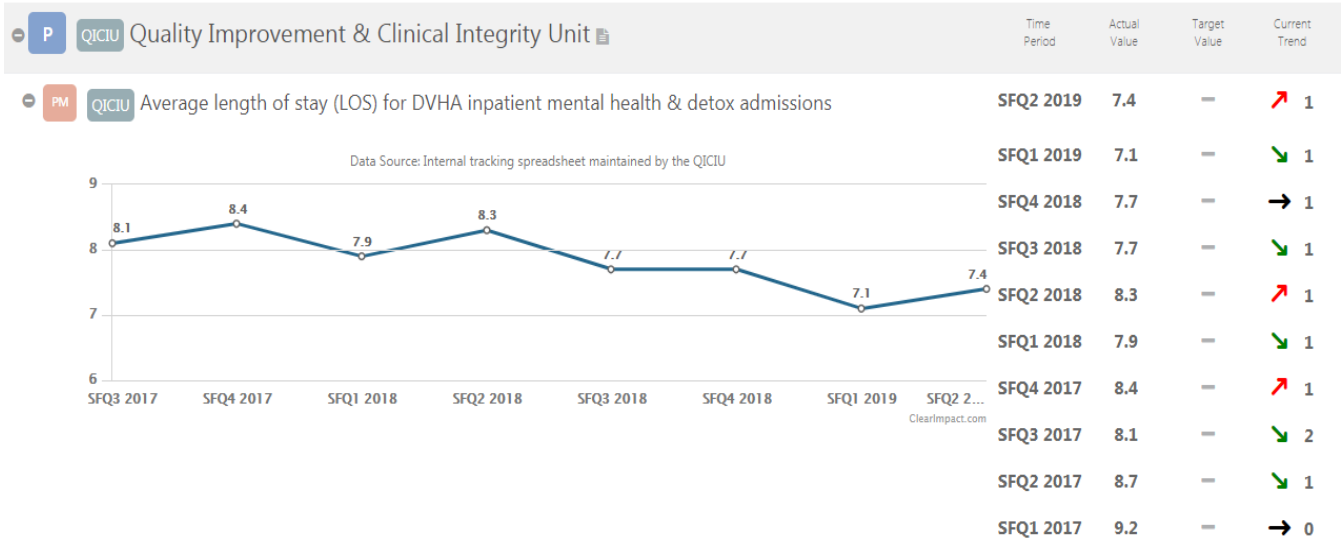
The Clinical Utilization Review Team ensures that our members get the services needed for the appropriate length of time.

Action Plan

Thetop3 priorities/initiatives for the QICIU in SFY19 are: Revitalizing the Team Care Program

Revamping the procedure for ABA services authorizations

Strengthening our provider network to eliminate the need for administrative authorizations



Notes on Methodology

Average Length of Stay for DVHA Inpatient Mental Health & Detox Admissions														
		SFY17					SFY 18					SFY 19 (as of 01/14/19)		
		Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD	Q1	Q2	YTD
Adult	# admits	281	278	313	289	1161	338	312	276	340	1266	297	268	565
	# days auth	2351	2065	2090	2206	8712	2510	2337	1874	2259	8980	2085	2006	4091
	Avg LOS	8.4	7.4	6.7	7.6	7.5	7.4	7.5	6.8	6.6	7.1	7.0	7.5	7.2
Detox	# admits	156	97	109	106	468	77	110	79	72	338	72	63	135
	# days auth	853	472	597	545	2467	367	549	339	293	1548	389	279	668
	Avg LOS	5.5	4.9	5.5	5.1	5.3	4.8	5.0	4.3	4.1	4.6	5.4	4.4	4.9
Children	# admits	79	77	101	92	349	100	111	102	80	393	66	84	150
	# days auth	1567	1383	1557	1345	5852	1196	1534	1323	1224	5277	631	767	1398
	Avg LOS	19.8	18.0	15.4	14.6	16.8	12.0	13.8	13.0	15.3	13.4	9.6	9.1	9.3
Total	# admits	516	452	523	487	1978	515	533	457	492	1997	435	415	850
	# days auth	4771	3920	4244	4096	17031	4073	4420	3536	3776	15805	3105	3052	6157
	Avg LOS	9.2	8.7	8.1	8.4	8.6	7.9	8.3	7.7	7.7	7.9	7.1	7.4	7.2

Partners

Vermont Medicaid Inpatient Providers Department of Children & Families Department of Mental Health

Story Behind the Curve

As a part of DVHA's utilization management program, the Quality Unit impacts and tracks the average length of inpatient psychiatric and detox stays for Vermont Medicaid members over time.

The Utilization Review (UR) Clinicians conduct numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally- recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. The UR Clinicians utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence.

The data in the above trend lines show relatively consistent average lengths of stay for the psychiatric adult and detox populations. In January of 2017, UR Clinicians began participation in weekly status calls for all children placed in the Brattleboro Retreat. In doing so, some disposition issues were addressed. This may have contributed to the decrease in the average length of stay for children.

A pilot project with one of our providers was initiated in SFY18 Q1. We anticipate this pilot to influence the average lengths of stay.

Last updated: 01/15/19

Strategy

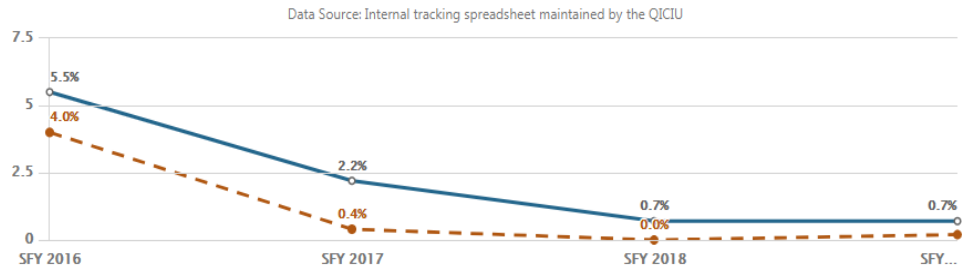
The UR Team regularly shares data with providers that may impact the average lengths of stay. Recently a trend to avoid discharges (especially for children) on weekends was noticed and shared with those providers. Both have reported investigating and one has suggested there might be an internal shift to support daily discharges.

The UR Team has worked closely with providers to provide information on admission criteria. Site visits, presentations, and consultations have shown to improve under

Time Period	Actual Value	Target Value	Current Trend

process has also strengthened our partnerships.

PM QICIU % of DVHA inpatient mental health and detox admissions with a reconsideration review request



SFY 2019	0.7%	0.2%	→ 1
SFY 2018	0.7%	0.0%	↘ 2
SFY 2017	2.2%	0.4%	↘ 1
SFY 2016	5.5%	4.0%	→ 0

Notes on Methodology

Please note in the chart above that:

the solid trend line represents the % of total admits for which a secondary review was requested and

the dotted target trend line represents the % of total admits for which a doc to doc review was requested and the SFY19 data point represent discharged admissions for Q1 & Q2 as of 01/14/19

% of DVHA inpatient mental health & detox admissions with a reconsideration review request																				
	SFY16					SFY17					SFY18					Q1 & Q2 SFY19 (as of 01/14/19)				
	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews
Adult	1228	36	2.9%	25	2.0%	1161	23	2.0%	2	0.2%	1266	9	0.7%	0	0.0%	565	3	0.5%	1	0.2%
Detox	682	16	2.3%	10	1.5%	468	2	0.4%	1	0.2%	338	1	0.3%	0	0.0%	1	0	0.0%	0	0.0%
Child	422	76	18.0%	58	13.7%	349	19	5.4%	4	1.1%	393	4	1.0%	0	0.0%	4	1	24.9%	0	0.0%
Total	2332	128	5.5%	93	4.0%	1978	44	2.2%	7	0.4%	1997	14	0.7%	0	0.0%	570	4	0.7%	1	0.2%

Partners

Brattleboro Retreat

University of Vermont Medical Center Central Vermont Medical Center Rutland Regional Medical Center

Valley Vista

Serenity House

Department of Mental Health Vermont Department of Health, ADAP Department for Children and Families Department of Corrections

Story Behind the Curve

There has been a significant decrease in the number of requests for reconsideration. This shows that there is agreement with the authorization decisions. Significant outreach and collaboration with providers likely contributed to the decline in reconsideration requests. Team members conducted site visits and educated clinicians about documentation requirements. Review of data shows that there was not an increase in average number of days authorized or length of stay.

Last updated: 01/14/19

Strategy

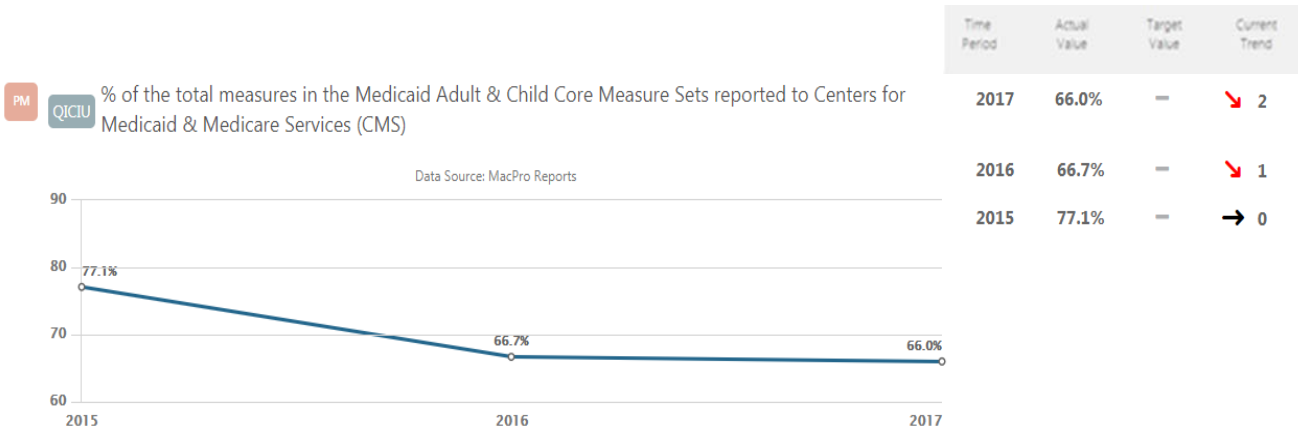
UR Team members have conducted:

Site visits and educated clinicians about documentation requirements

Significant amounts of outreach with sister departments to ensure that members are referred to the appropriate agencies for discharge services

Weekly phone consultations with DCF to address discharge issues

The QICIU Director has developed a protocol with one of the major providers to analyze discrepancies prior to submitting reconsideration requests.



Notes on Methodology

% of the total measures reported to CMS				
		2015	2016	2017
Adult Core Set	Total #	25	26	27
	# Reported	19	16	16
	% Reported	76.0%	61.5%	59.3%
Child Core Set	Total #	23	25	26
	# Reported	18	18	19
	% Reported	78.3%	72.0%	73.1%
Total Perf Measures Reported	Total #	48	51	53
	# Reported	37	34	35
	% Reported	77.1%	66.7%	66.0%

Partners

DVHA Data Unit

Contractor to produce the performance measures

Story Behind the Curve

Medicaid provides coverage to low-income adults, children, elderly persons, pregnant women, and people with disabilities. In short, Medicaid covers some of the most high-need populations in the country.

Accordingly, federal legislation called for the creation of core sets of healthcare quality measures to assess the quality of care for adults and children enrolled in Medicaid. The U.S. Department of Health & Human Services established the Adult and Child Core Sets to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.

The Adult and Child Core Sets are often used to provide a snapshot of quality within Medicaid. They are not comprehensive, but prior to their creation and implementation, performance measurement varied greatly by state, and it was not possible to glean an overall picture of quality. Statute requires

CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information.

The DVHA was awarded Adult Medicaid Quality Grant funding starting in CY 2013 through CY 2015. A portion of this funding was used to facilitate quality improvement projects, as well as to assist in collecting and reporting on these core measures. The DVHA focused some of the funding on producing measures that require medical record review for results to be accurate and complete. This funding was no longer available to the State starting in 2016, so the Department was not able to produce the measures that require record review, thus the drop in the trend line above. We strive to build this funding back into our budget in years to come, as the production of measures that require record review will be key to the state's ability to keep pace with other state Medicaid plans and to evaluate the effectiveness of our payment reform models. These models are required to report out on key health indicators (hypertension for example) for their attributed populations. In order to achieve alignment and a comparison cohort, we need to produce these same measures for the general Medicaid population.

Last updated: 02/08/18

Author: Quality Improvement & Clinical Integrity Unit

Strategy

As we strive to report on all performance measures within the CMS Adult and Child Medicaid Quality Core measure sets, the Quality Improvement team:

Continues to partner with the Data Unit in order to maintain an already high level of accurate and complete reporting;

Fosters new partnerships with staff who work closely with the Vermont Clinical Registry so that we can think creatively about the best use of our resources moving forward;

Actively engages in annual budgetary conversations related to performance measure set reporting.

Payment Reform Unit

What We Do

The Payment Reform Unit seeks to transition Vermont Medicaid's health care revenue model from Fee-for-Service payments to value-based payments with the goal of providing better, more efficient, coordinated care for Vermonters. In support of this goal, the Payment Reform Unit partners with internal and external stakeholders in taking incremental steps toward the integrated healthcare system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services. The Payment Reform Unit also works with providers and provider organizations in testing models, and ensures the models encourage higher quality of care and are supported by robust monitoring and evaluation plans.

Who We Serve

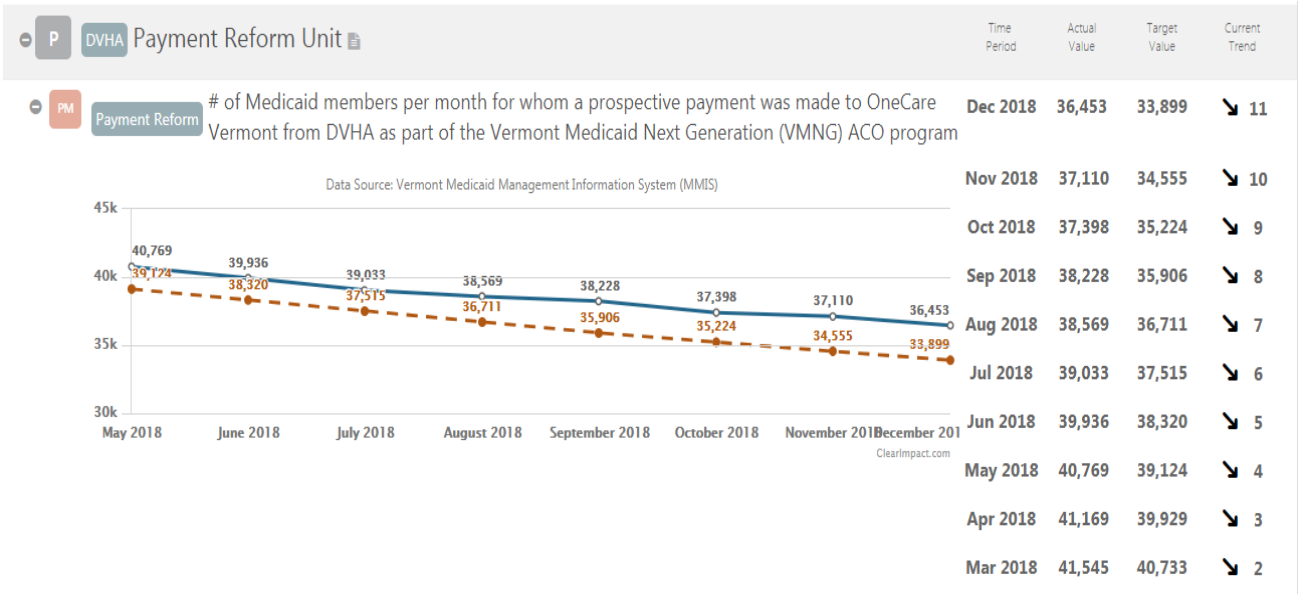
The Payment Reform Unit is available as a resource to DVHA and to other departments within the Agency of Human Services in the consideration of potential payment reform options. The unit is also responsible for the implementation and oversight of the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program, a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health and lower costs.

How We Impact

By designing and testing new payment models both for DVHA and other departments within the Agency of Human Services, the Payment Reform unit plays a crucial role in support of DVHA's goal of transitioning to more value-based payment structures which in turn supports Vermont's overall health reform efforts. All models being developed ultimately support the Triple Aim in healthcare, which will ensure better care, better health, and lower costs for Vermonters.

Action Plan

During the next year, the Medicaid Payment Reform team will continue to oversee the implementation, evaluation and evolution of the VMNG program, and will provide support to Departmental and Agency leadership in the consideration of and planning for any additional value-based payment reform models to support continued advancement toward an integrated healthcare system in Vermont.



Notes on Methodology

In the chart above, please note that:

The solid trendline represents the actual # of members. The dotted trendline represents the target # of members.

PMPM Payment Information by Medicaid Eligibility Group (MEG) by Month												
Report Period	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**
% of 29,102 (2017) % of 42,342 (2018)	**100.0%**	**99.2%**	**98.1%**	**97.2%**	**96.2%**	**94.3%**	**92.1%**	**91.0%**	**90.2%**	**88.3%**	**87.6%**	**86.1%**
Target #	**42,342**	**41,538**	**40,733**	**39,929**	**39,124**	**38,320**	**37,515**	**36,711**	**35,906**	**35,224**	**34,555**	**33,899**
Total #	**42,342**	**42,005**	**41,545**	**41,169**	**40,769**	**39,936**	**39,033**	**38,569**	**38,228**	**37,398**	**37,110**	**36,453**
ABD #	2,757	2,702	2,686	2,632	2,613	2,607	2,587	2,578	2,571	2,562	2,547	2,560
ABD %	6.5%	6.4%	6.5%	6.3%	6.4%	6.5%	6.6%	6.7%	6.7%	6.9%	6.9%	7.0%
Gen Adult #	18,097	18,006	17,769	17,609	17,422	16,929	16,431	16,168	15,972	15,411	15,286	14,900
Gen Adult %	42.7%	42.8%	42.8%	42.8%	42.7%	42.4%	42.1%	41.9%	41.8%	41.2%	41.2%	40.9%
Gen Child #	21,488	21,294	21,090	20,928	20,734	20,400	20,015	19,823	19,685	19,425	19,277	18,993
Gen Child %	50.7%	50.1%	50.7%	50.8%	50.8%	51.1%	51.3%	51.4%	51.5%	51.9%	51.9%	52.1%

Partners

DXC Technology

OneCare Vermont

Story Behind the Curve

This measure shows ACO Attribution. It is broken down by Medicaid Eligibility Group (MEG) and shows what percentage of each MEG makes up the reported total.

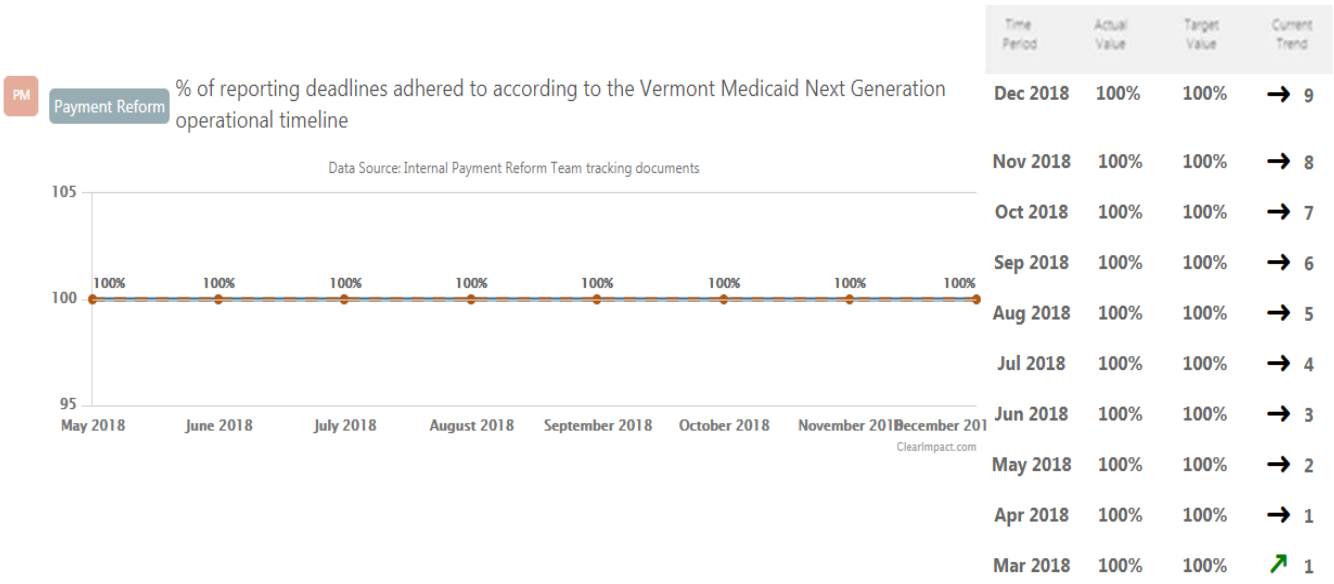
This measure is a useful indicator of:

How many actively attributed members the ACO has in each month (which helps quantify the program's scale)

Any fluctuation in attribution on a month-to-month basis, overall and by MEG (which helps quantify population dynamism and the effects of changing Medicaid eligibility on prospective ACO attribution).

Member attribution to the VMNG ACO program is set prospectively (at the beginning of a performance year), and no new members are added to the population during a performance year. However, prospectively attributed members may be considered ineligible for attribution in a given month due to a number of factors, including eligibility changes (e.g. loss of Medicaid coverage); evidence of an additional source of insurance coverage or ageing into Medicare eligibility; death; or termination of a contractual relationship between an attributing provider practice and the ACO (at which time all members that had been attributed through that practice are no longer considered attributed to the ACO). Some members may subsequently become eligible for attribution again after losing eligibility in an earlier point in the year, but a 1-1.5% decrease in the number of PMPM payments made is expected month-to-month in a given program year. The more significant decrease (4%) in the number of members for whom payments were made between April and May highlights an instance in which an entire practice's membership was removed from the ACO-attributed population due to termination of a contractual relationship between that practice and the ACO (OneCare Vermont).

% of reporting deadlines adhered to according to the VMNG operational timeline											
Report Period	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**
% met	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% met after extension	5%	5%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% not met	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%



Notes on Methodology

Partners

DVHA Payment Reform Unit DVHA Data Unit

OneCare Vermont

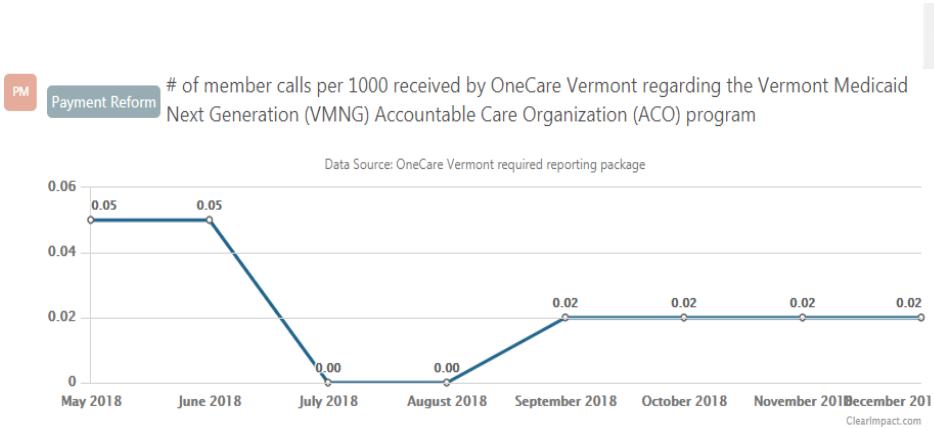
Story Behind the Curve

Reporting requirements for the ACO program began in January 2017. Reporting considered for this measure includes ACO reports on performance (for example, member helpline reports, care management reports, and utilization reports) as well as DVHA data reports to the ACO (claims extracts for ACO attributed population). In general, close to 100% of reporting requirements have been met on time. To date, OneCare has submitted all required reports to DVHA, and DVHA has transferred all required data files to OneCare, either on time or by mutually agreed-upon adjusted deadlines (to allow other necessary processes to occur). For example, DVHA and OneCare agreed to extend the deadlines for OneCare's submission of four reports in March because OneCare would require claims-data to complete those reports, and DVHA's initial claims-sharing in that month could not occur until members had been notified of their initial opportunity to opt-out of having DVHA share their claims data with OneCare. As program operations continue and processes are streamlined to account for adjustments made to reporting templates and data elements, the Payment Reform team anticipates that 100% of reporting deadlines will be met on time month-to-month.

Last updated: 12/15/18

Strategy

Payment Reform's goal for this measure is to ensure that 100% of reporting requirements are met in a timely fashion (by their deadline). Consistently, one report is received by the Payment Reform team after its deadline, either due to human or technological error. Strategies for ensuring on time receipt have included reaching out to the responsible party ahead of time or on the day of the deadline to remind them of the deadline, as well as working with the responsible party to make changes to reporting requirements for that report that better align with the ACO's internal reporting processes.



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	0.02	–	→ 3
Nov 2018	0.02	–	→ 2
Oct 2018	0.02	–	→ 1
Sep 2018	0.02	–	↗ 1
Aug 2018	0.00	–	→ 1
Jul 2018	0.00	–	↘ 1
Jun 2018	0.05	–	→ 1
May 2018	0.05	–	↘ 4
Apr 2018	0.09	–	↘ 3
Mar 2018	0.16	–	↘ 2

Notes on Methodology

# of member calls per 1000 members											
Report Period	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**
# Inquires	62	20	7	4	2	2	0	0	1	1	1
# Complaints	0	0	0	1	0	0	0	0	0	0	0
# Grievances	0	0	0	0	0	0	0	0	0	0	0
# Appeals	0	0	0	0	0	0	0	0	0	0	0
Total # Calls	62	20	7	0	0	0	0	0	0	0	0
Calls/1000 att mem	1.46	0.47	0.16	0.09	0.05	0.05	0.00	0.00	0.02	0.02	0.02

Partners

OneCare Vermont

Story Behind the Curve

This measure shows the number of member calls per 1000 members per month, broken out into the 4 categories of communication below:

Inquiry: routine communication from an ACO member or provider requesting information that is within the general scope of the ACO, or requesting a routine action be taken

Complaint: a routine communication from an ACO member or provider that requires the ACO to take an action to resolve issues

Grievance: a complaint that is not readily resolved through discussion with the ACO when first presented, and is elevated to senior leadership of the ACO, the DVHA payment reform team, and the Health Care Advocate as appropriate

Appeal: a grievance that has not been resolved to the satisfaction of the member or provider. The member or provider can bring their grievance through an appeals process that will include continued support from DVHA, the ACO and the Health Care Advocate as appropriate.

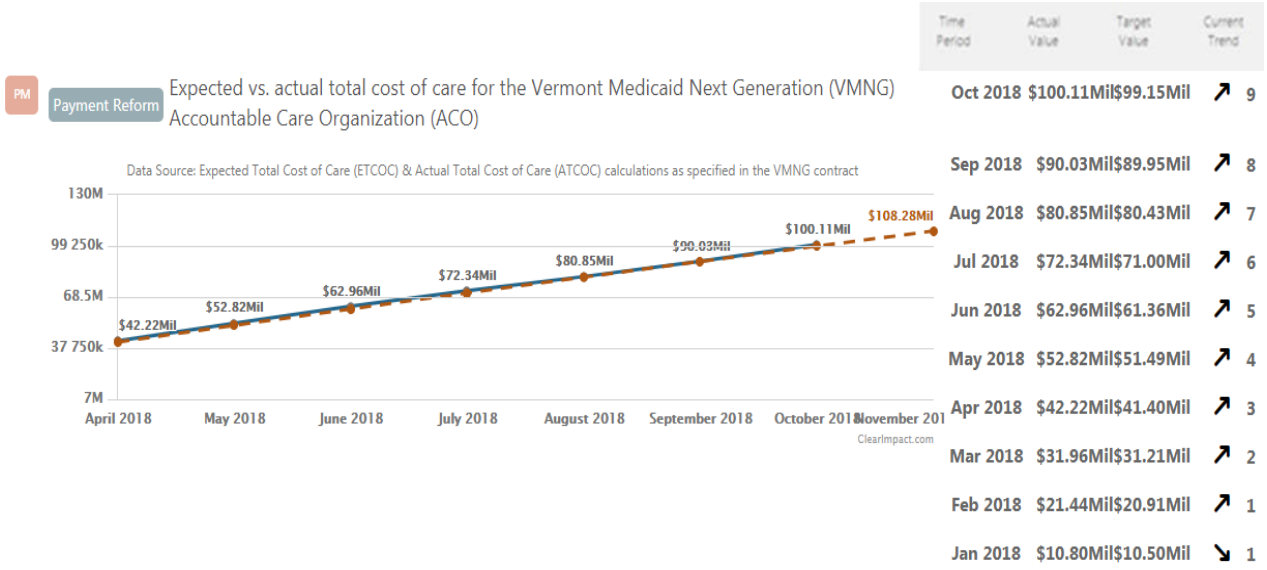
Reporting requirements for the VMNG ACO program's member helpline began in February 2017, and the ACO is required to report monthly the number of member inquiries, complaints, grievances, and appeals received via their member/provider helpline.

Since the beginning of the VMNG pilot, Medicaid members' primary reason for contacting OneCare pertained to opting out of having their Medicaid claims data shared with OneCare. Letters were mailed to Medicaid members attributed to OneCare in the middle of February; these letters explained what ACOs are, notified members that their primary care provider was participating in the ACO, and gave members the option of not having DVHA share their claims data with OneCare. The higher volume of member

inquiries for February and March was in response to this initial mailing.

As the program continues, it is expected that the monthly number of member inquiries will remain steadily low, unless other targeted or widespread communication activities occur. Monitoring trends for these types of member contact will remain important as key indicators of program performance from the perspective of the member. Any increases in complaints, grievances, or appeals will be treated as priority areas for expedient investigation and resolution by both OneCare and DVHA.

Last updated: 12/15/18



Notes on Methodology

Please note in the chart above that the $ amounts are cumulative; the solid trend line shows the actual total cost of care (ATCOC)

The dotted trend line shows the expected total cost of care (ETCOC).

Cumulative ETCOC & ATCOC:

Cumulative ETCOC & ATCOC for the Vermont Medicaid Next Generation Accountable Care Organization											
Report Period	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
ETCOC	$10,500,008	$20,914,319	$31,210,244	$41,398,426	$51,487,044	$61,359,983	$71,001,210	$80,433,148	$89,954,230	$99,152,909	$108,281,574
ATCOC*	$10,804,348	$21,440,811	$31,958,610	$42,223,304	$52,820,742	$62,955,217	$72,336,872	$80,853,430	$90,033,633	$100,107,624	
Over/(Under)*	$328,462	$526,492	$748,366	$824,878	$1,333,698	$1,595,234	$1,335,662	$1,400,980	$1,080,578	$954,715	

Month-to-Month ETCOC & ATCOC:

Month-to-Month ETCOC & ATCOC for the Vermont Medicaid Next Generation Accountable Care Organization											
Report Period	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
ETCOC	$10,500,008	$10,414,310	$10,295,925	$10,188,183	$10,088,618	$9,872,939	$9,641,227	$9,521,082	$9,431,938	$9,198,680	$9,128,665
ATCOC*	$10,828,470	$10,612,341	$10,517,799	$10,264,694	$10,597,438	$10,134,475	$9,381,655	$9,586,400	$9,111,536	$9,072,816	
Over/(Under)*	$328,462	$198,031	$221,874	$76,511	$508,820	$261,536	($259,572)	$65,318	($320,402)	($125,864)	

Partners

DVHA Business Office

DXC Technologies

OneCare Vermont

Story Behind the Curve

The Accountable Care Organization's (ACO's) expected total cost of care (ETCOC) is derived based on actuarial projections of the cost of care in 2017 for the population of prospectively attributed Medicaid members, using 2015 claims for the attributed members as a baseline and trending it forward to 2017.

The ACO's actual total cost of care (ATCOC) is the sum of the Fixed Prospective Payment (FPP) paid to the ACO and the total actual Fee-For-Service expenditures paid by DVHA on behalf of the ACO to its providers for services not covered by the FPP.

The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. If the ETCOC and ATCOC are equal, then the ACO's actual spending is on consistent with its projected spending for the performance year, and a minimal amount of financial reconciliation will occur between the ACO and DVHA during the final financial reconciliation. If the ETCOC is greater than the ATCOC, the ACO's spending has been less than the financial target, and the ACO would be eligible to retain a portion of the dollars saved relative to the target. Conversely, if the ATCOC is higher than the ETCOC, the ACO's spending has exceeded its financial target, and the ACO would be liable for a portion of the dollars spent in excess of the target.

Caution should be exercised when using this information to evaluate financial performance during the performance year, as claims lag has a significant impact on financial data, and the data does not factor in claims or payments that will need to be reconciled after the program year. Currently, the ACO's overall expenditure for January through June of 2017 is higher than the expected total cost of care for the corresponding months.

Last updated: 12/15/18

Appeals Unit

What We Do

The health care appeals team (HCAT) is responsible for both covered services and eligibility appeals and fair hearing processes. It coordinates the internal covered services appeal process on standard and expedited timeframes. It also processes and, where possible, resolves requests for fair hearings on eligibility determinations.

Who We Serve

The health care appeals team (HCAT) serves all Medicaid members as well as QHP.

How We Impact

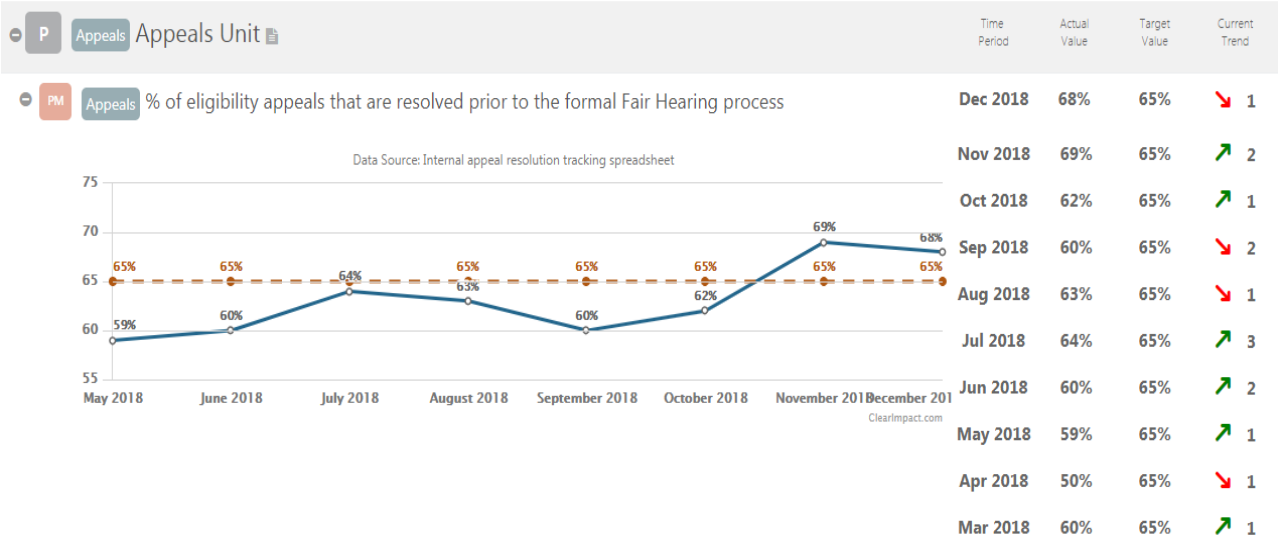
The health care appeals team (HCAT) facilitates the process for members to address issues with their coverage or eligibility. This not only benefits individual members, but it enables system-wide improvements by identifying patterns and working with other units to prevent issues from arising again.

Action Plan

The top two priorities/initiatives for the HCAT in SFY19 are:

Meeting established SLA timelines

Continuing to resolve as many appeals informally as possible



Partners

Office of the Attorney General

DVHA Health Access Eligibility & Enrollment Unit

Story Behind the Curve

This metric tracks the percentage of eligibility appeal requests received during a month that are resolved prior to a formal fair hearing. Because internal resolution may take longer than one month, the data points for previous months may be updated retrospectively.

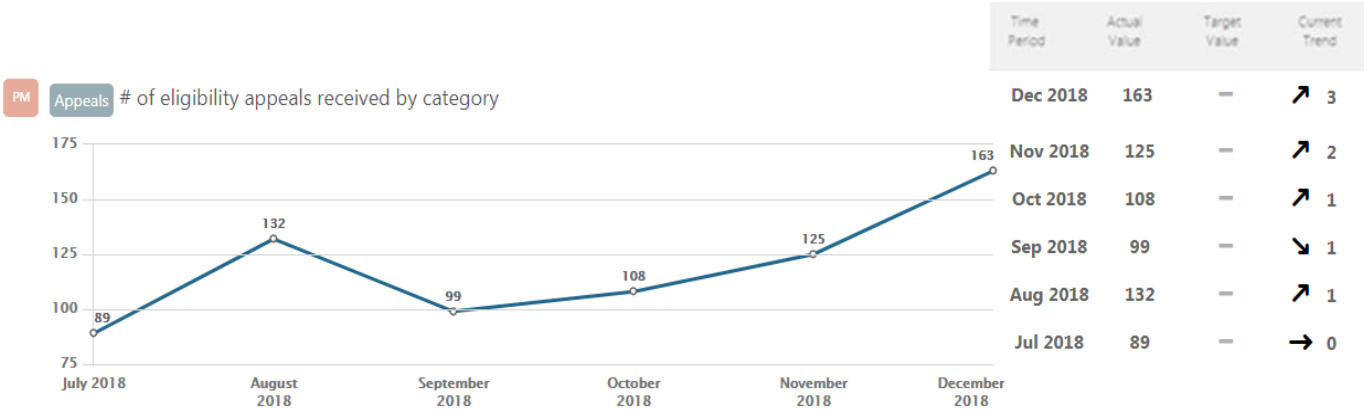
This process benefits Vermonters by providing expeditious and favorable resolution to their eligibility appeals wherever possible. The appeals staff work to identify cases that can be resolved in the customer's favor prior to expending resources on the formal Fair Hearing process before the Human Services Board. The goal has been to resolve more than 50% in this manner. Given that the unit consistently surpassed this goal in CY 2017, DVHA increased the goal to 65% for CY 2018.

For CY 2019, we are reducing the target back to 50%. The rationale is that having fewer cases that can be resolved internally actually represents system improvement (there are fewer cases where something went wrong that the appeals team can fix). While we still want to address as many cases internally as we can, we do not necessarily want to increase the volume.

Last updated: 01/14/19

Strategy

The HCAT will adhere to standard operating procedures for handling appeal requests and review cases for resolution within fifteen days of receipt.



Notes on Methodology

# of eligibility appeals received by category				
	SFY19			
	Sep-18	Oct-18	Nov-18	Dec-18
MAGI Medicaid	32	47	47	69
Non-MAGI Medicaid	9	11	11	5
QHP - Premium Processing	17	18	55	76
QHP - No SEP	19	13	3	1
Other QHP	22	19	9	12
Total	99	108	125	163

Partners

Office of the Attorney General

DVHA Health Access Eligibility & Enrollment Unit

Story Behind the Curve

This metric tracks the number of eligibility appeal requests received during a month by category. We have identified the five most common categories of appeals. This metric is for tracking/monitoring purposes. The volume of appeals is beyond the health care appeals team (HCAT)'s control since appeals requests come from members. However, it is important to track the overall volume in order to identify program-wide trends through appeals.

Last updated: 01/14/19

Strategy

N/A since this is a tracking metric. HCAT will adhere to standard operating procedures for handling appeal requests and meeting established SLA timelines.

Business Office

What We Do

The Business Office (BO) 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, & Fiscal Analytics.

The AP/AR Unit is tasked with processing vendor payments, reimbursement of employee travel expenses, billing and receipt of provider assessments, collection of pharmacy assessments, drug rebate receipts, and other miscellaneous receivables. This unit is also responsible for reconciliations, financial reporting, tracking of department assets, and assisting with audits. In the past two years, some providers have struggled with making timely assessment payments. The AP/AR unit worked with the Legal unit and deputy commissioner Michael Costa to formalize a process to work with providers to collect these past due balances. With regular communication and payment plans put in place, most providers are now currently paid to date.

The Grants and Contracts Team 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. The team 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 Fiscal Analytics Team 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.

Who We Serve

Department of Finance & Management

State of Vermont Treasurers Office DVHA Vendors

DVHA Contractors DVHA Grantees

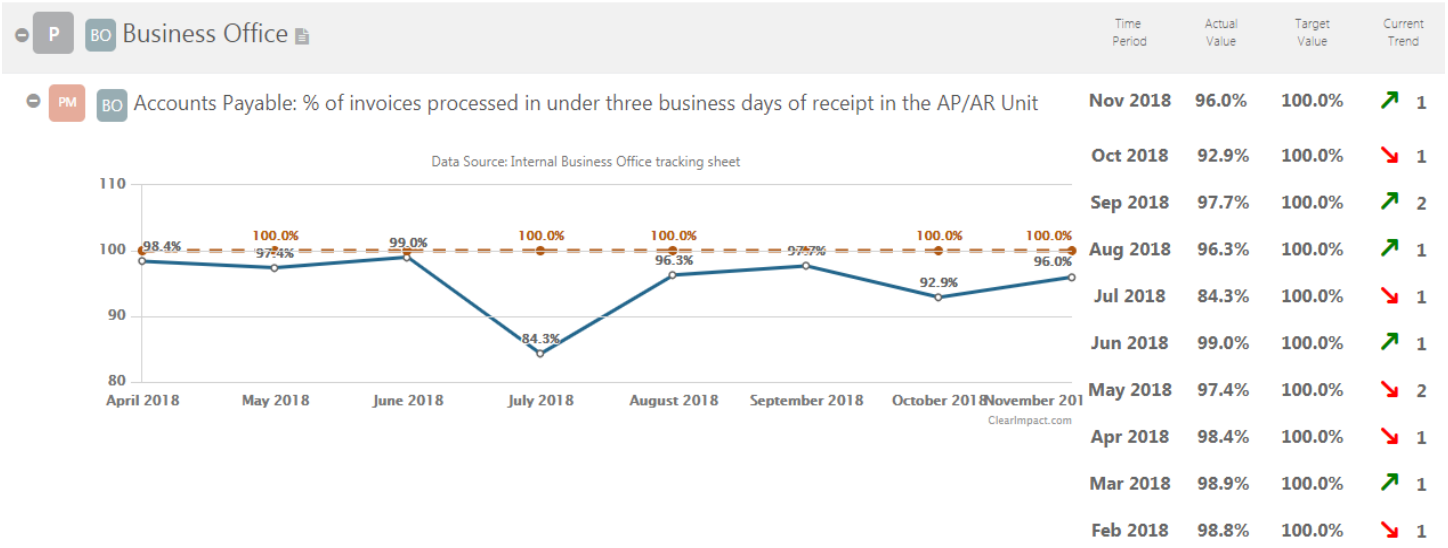
Agency of Human Services Agency of Digital Services Office of the Attorney General AHS CO

State of Vermont Legislature – Joint Fiscal Committee

Action Plan

Continue to develop in-depth work instructions for all areas of Business Office responsibility and fully train back-ups in those tasks. This will ensure that services and reporting are delivered consistently. This will further allow us to develop target ranges for our KPIs and make assessments of individual and team performance. Employees who work in compliance with SOPs know exactly what is expected of them, and they plan their work schedules to meet their goals with efficiency. When all employees follow the same processes, it's an easy matter to measure them against the same standards. Performance can be appraised fairly. Documentation of job processes survives employee attrition due to retirement and resignation and allows DVHA to carry on as usual.

Develop and implement a standardized procedure to sub-recipient monitoring; outlining the business activities to be executed. Subrecipient monitoring is essential at all stages of the granting process from proposal to award closeout.



Partners

Department of Finance & Management State of Vermont Treasurers Office DVHA Vendors

DVHA Contractors DVHA Grantees

Story Behind the Curve

This performance measure informs management and employees about how efficiently the unit is managing the financial and business aspects.

The Business Office utilizes KPIs to locate barriers to successful operations and design strategies that will lead to better performance.

Internal influences: Properly trained AP staff, and having trained backup staff to fill in when key AP positions are out of the office or vacant.

External influences: Ensuring that invoices are correct and ready to pay when received in AP. This may involve training other DVHA staff and reaching out to vendors.

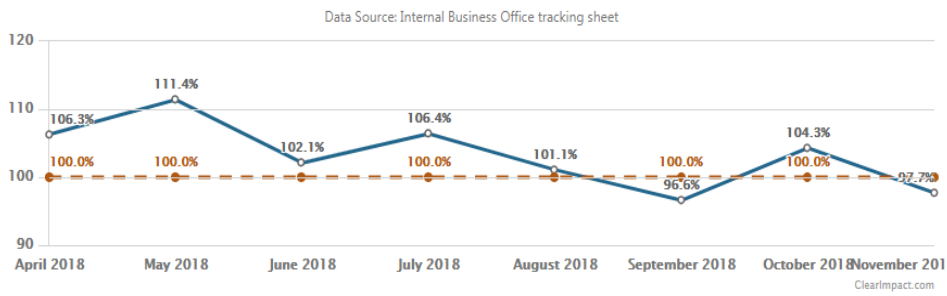
June/July period - Contract invoices received mid to end of June cannot be processed until July due to Department of Finance & Management guidelines for year-end closeout. Because of this, the percentage of invoices processed more than three days after receipt greatly increases.

Strategy

AP Unit Training and Backup – Current AP staff have been trained and have procedures and coding spreadsheets to assist with entering invoice vouchers. There are two other positions in the business office that have been trained and can fill in as backup if needed.

When invoices are not able to be processed, education is provided to other DVHA staff, vendors, etc. to ensure a better process going forward.

PM BO Accounts Receivable: % of provider taxes ($) collected by DVHA vs. invoiced/estimated



Time Period	Actual Value	Target Value	Current Trend
Nov 2018	97.7%	100.0%	↘ 1
Oct 2018	104.3%	100.0%	↗ 1
Sep 2018	96.6%	100.0%	↘ 2
Aug 2018	101.1%	100.0%	↘ 1
Jul 2018	106.4%	100.0%	↗ 1
Jun 2018	102.1%	100.0%	↘ 1
May 2018	111.4%	100.0%	↗ 2
Apr 2018	106.3%	100.0%	↗ 1
Mar 2018	104.0%	100.0%	↘ 1
Feb 2018	140.6%	100.0%	↗ 2

Partners

Department of Finance & Management Agency of Human Resources Central Office State of Vermont Treasurer's Office

Providers, including Hospitals, Home Health Agencies, Nursing Home Facilities, Independent Care Facilities, and Pharmacies

Story Behind the Curve

This performance measure shows how efficiently the DVHA Business Office is managing the financial and business aspects. Measure components include Provider Tax by type: Nursing Home Facilities, Hospitals, ICF (Independent Care Facilities), Home Health Agencies, and Pharmacies.

This excludes Ambulance Assessments, as they are only billed annually. Pharmacies self-report each month, so some taxes are estimates.

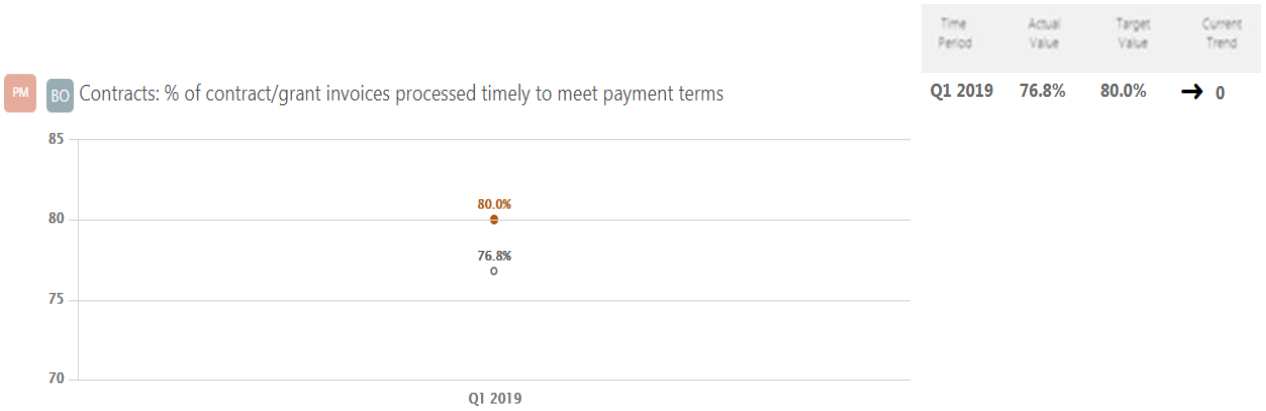
DVHA has some providers that owe past due taxes. More aggressive collection processes were developed and implemented in the first half of 2017, accompanied by updated standard operating procedure (SOP) documents. This resulted in several providers making additional payments; which is reflected in the July statistics, as more taxes were collected than billed.

Accounts Receivable continues to collect past due payments.

Last updated: 12/15/18

Strategy

A formal process has been instituted to collect provider taxes, including regular communication with providers when payments are not received on time. As a last resort, Medicaid payments are garnished to collect these taxes.



Partners

Department of Finance & Management DVHA Vendors

Story Behind the Curve

This performance measure informs management and employees about how efficiently the unit is managing the financial aspects of its agreements.

Approximately 21% of DVHA agreements have Net 15 or Net 00 terms rather than the State standard Net 30. The majority of those are grant agreements, requiring more detailed backup support from vendors before payment is fully approved by the State. This often results in invoices initially being rejected or DVHA requiring and waiting for additional information from vendors, thereby delaying the process.

Additionally, the VISION system determines payment due date based on the date of the vendor's invoice. DVHA's agreements, however, are based on State language, stating that payment terms are based on the date the State receives an error-free invoice and complete supporting documentation, not on the date of the invoice. DVHA is working to initially review invoices quickly in order to promptly identify issues and inform vendors of needed corrections, including invoice dates that match submission dates.

DVHA will use this first reporting period as a baseline in its work towards improving timely invoice processing. The unit is starting with a target value of 80%, which will be reevaluated in March.

Last updated 01/14/19

Strategy

Invoice status is reviewed at weekly unit meetings and will be emailed to the group with a weekly agreement status check. Team members will seek assistance within the group if workload demands or scheduling conflicts are expected to create unusual challenges. There will be a push toward negotiating Net 30 payment terms for all agreements whenever possible. Invoice processing KPIs are used to locate barriers to successful operations and design strategies that will lead to better performance. Unit staff will work to ensure funds are properly encumbered through POs so that invoice can be processed in a timely manner.

Notes on Methodology

In December 2018, a goal of 30 business days was set as a target for this measure.

Partners

Agency of Human Services Agency of Digital Services Agency of Administration Office of the Attorney General

Department of Finance & Management DVHA Vendors

Story Behind the Curve

In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. For contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. Department program staff would like to see this process shortened, while Business Office staff must ensure that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review.

Many of the contracts that the unit manages expire and need to be renewed or replaced by the end of calendar and State fiscal years. Due to the volume of agreements and the nature of the work, development often takes longer as shown in the KPIs for Dec 2017/Jan 2018 and Jun/July 2018.

In Feb/March 2018, we had 5 long-term care contracts (AAA) were in development for longer than usual due to extended negotiations with vendors.

Last updated: 01/14/19

Strategy

The Grants and Contracts unit is currently engaged in three process improvement projects to introduce Lean-agile procurement techniques to contracting, grant issuance and monitoring, and IE&E procurement. This approach stresses collaboration between people as a key success factor.

The goals are to:

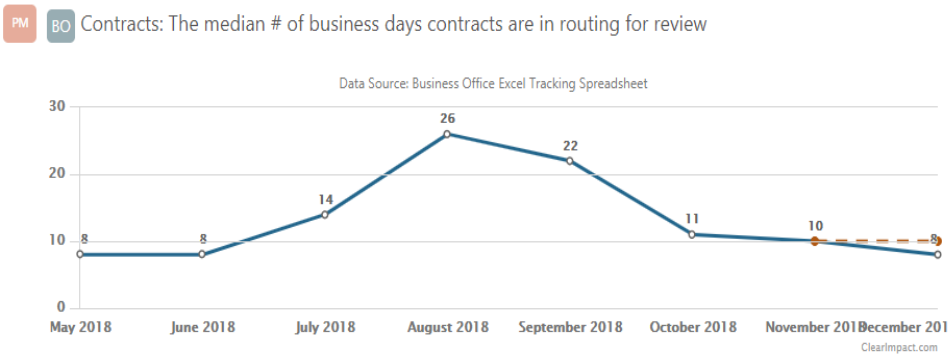
Reduce preparation efforts and rework as much as possible (reduce waste);

Eliminate variation so that creation and comparison of multiple proposals/contracts becomes as easy as possible; and

Reduce time to execution which will allow for quicker implementations.

Of note is the quality improvement project for the contracting process, which began in Fall 2017, with the purpose of reducing the amount of time taken to execute a contract from the time drafting begins to a final signature. In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. For contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. The focus has been on streamlining the process while also ensuring that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review. The project is currently in Phase 3 of a six-phase process and is expected to be fully implemented by January 2019.

KPIs were developed to measure the amount of time taken in the drafting, routing, and final execution phases of the contracting process. These KPIs present a more useful story once able to be compared with measurements taken after final implementation of the contract improvement project.



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	8	10	↘ 4
Nov 2018	10	10	↘ 3
Oct 2018	11	–	↘ 2
Sep 2018	22	–	↘ 1
Aug 2018	26	–	↗ 2
Jul 2018	14	–	↗ 1
Jun 2018	8	–	→ 1
May 2018	8	–	↘ 1
Apr 2018	12	–	→ 1
Mar 2018	12	–	↘ 1

Notes on Methodology

In December 2018, a goal of 10 business days was set as a target for this measure

Partners

Agency of Human Services Agency of Digital Services Agency of Administration Office of the Attorney General

Department of Finance and Management DVHA Vendors

Story Behind the Curve

In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. For contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate,

and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. Department program staff would like to see this process shortened, while Business Office staff must ensure that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review.

Many of the contracts that the unit manages expire and need to be renewed or replaced by the end of calendar and State fiscal years. Due to the volume of agreements and the nature of the work, internal State review often takes longer as shown in the KPIs for Jan 2018 and July 2018.

In Feb/March 2018, there were two agreements that spent over 30 days with State reviewers which is reflected in the KPI increase.

Last updated: 01/14/19

Strategy

The Grants and Contracts unit is currently engaged in three process improvement projects to introduce Lean-agile procurement techniques to contracting, grant issuance and monitoring, and IE&E procurement. This approach stresses collaboration between people as a key success factor.

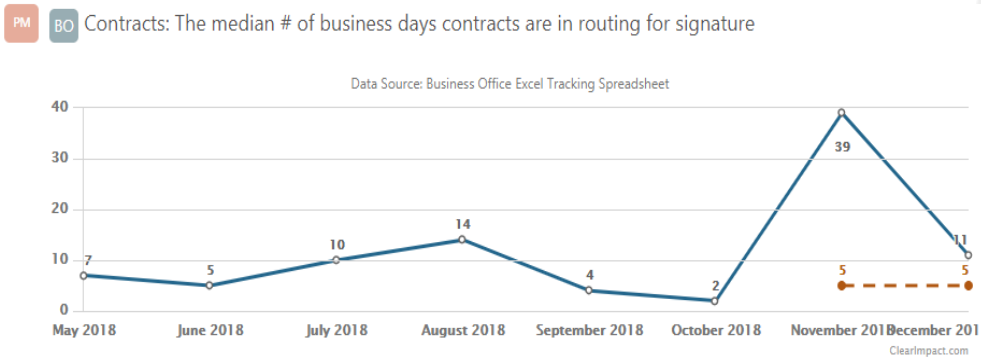
The goals are to:

Reduce preparation efforts and rework as much as possible (reduce waste);

Eliminate variation so that creation and comparison of multiple proposals/contracts becomes as easy as possible; and

Reduce time to execution which will allow for quicker implementations.

Of note is the quality improvement project for the contracting process, which began in Fall 2017, with the purpose of reducing the amount of time taken to execute a contract from the time drafting begins to a final signature. In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. For contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. The focus has been on streamlining the process while also ensuring that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review. The project is currently in Phase 3 of a six-phase process and is expected to be fully implemented by January 2019.



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	11	5	↘ 1
Nov 2018	39	5	↗ 1
Oct 2018	2	–	↘ 2
Sep 2018	4	–	↘ 1
Aug 2018	14	–	↗ 2
Jul 2018	10	–	↗ 1
Jun 2018	5	–	↘ 2
May 2018	7	–	↘ 1
Apr 2018	13	–	↗ 1

Notes on Methodology

In December 2018, a goal of 5 business days was set as a target for this measure

Partners

Agency of Human Services Agency of Digital Services Agency of Administration Office of the Attorney General

Department of Finance & Management (AOA) DVHA Vendors

Story Behind the Curve

In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. For contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. Department program staff would like to see this process shortened, while Business Office staff must ensure that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review.

Many of the contracts that the unit manages expire and need to be renewed or replaced by the end of calendar and State fiscal years. Due to the volume of agreements and the nature of the work, collecting signatures from internal State reviewers, the Commissioner, and vendors can often takes longer as shown in the KPIs for Jan 2018 and July 2018.

In November 2018, there was only one agreement amendment to execute for the month. The higher than normal # of days it waited for signature is due to the vendor taking 3 weeks to sign the agreement.

We had 4 agreements executed in December 2018, 3 of which were high priority so review and signature times were expedited, reflected by lower-than-average KPI values.

Last updated: 01/14/19

Strategy

The Grants and Contracts unit is currently engaged in three process improvement projects to introduce Lean-agile procurement techniques to contracting, grant issuance and monitoring, and IE&E procurement. This approach stresses collaboration between people as a key success factor.

The goals are to:

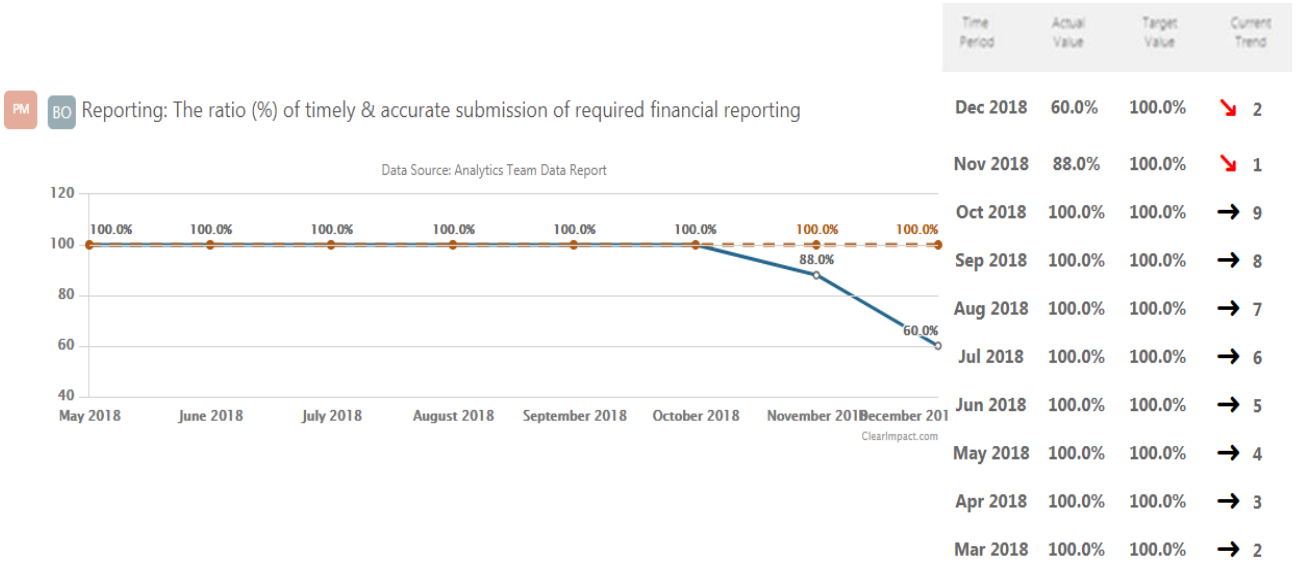
Reduce preparation efforts and rework as much as possible (reduce waste);

Eliminate variation so that creation and comparison of multiple proposals/contracts becomes as easy as possible; and

Reduce time to execution which will allow for quicker implementations.

Of note is the quality improvement project for the contracting process, which began in Fall 2017, with the purpose of reducing the amount of time taken to execute a contract from the time drafting begins to a final signature. In order to execute agreements that enable work to happen on schedule and within budget, contracts need to be drafted, routed, and signed for execution in a timely manner. For

contracts to guide the delivery of results, contract language related to business need and expectations must be clear, accurate, and understood by all parties. The current process related to drafting, routing, and executing contracts involves many required reviewers and signatories per the Agency of Administration's Bulletin 3.5 requirements. The focus has been on streamlining the process while also ensuring that all requirements of Bulletin 3.5 are adhered to and that reviewers have adequate time to perform their review. The project is currently in Phase 3 of a six-phase process and is expected to be fully implemented by January 2019.



Partners

DXC

Change Health Care AHS Central Office

Department of Finance & Management Legislature

Story Behind the Curve

This performance measure shows how efficiently the Business Office (BO) is managing the financial and business aspects. The BO utilizes Key Performance Indicators (KPIs) to locate barriers to successful operations and design strategies that will lead to better performance. This measure is all encompassing of the DVHA business office including items delivered by the Deputy Commissioner.

November was a difficult month because in addition to changing the format of the report, the Enrollment and Expenditures legislative report was completed by different Business Office staff due to key staff absence. The team is now keenly aware of the requirement to have fully trained back-ups in all required reporting and that this will impact the November KPIs for reporting timely and accurately.

In addition to the legislative report which would have only dropped the KPI by 8% from 100%, the 52 points of light were submitted to AHS and JFO either late, or not at all, reducing the percentage of success by an additional 25%. While this KPI requires that this report is sent out on a weekly basis by upper management, the internal process proved successful during November as it left the Business Office review on time throughout the entire month.

Last updated: 01/14/19

Strategy

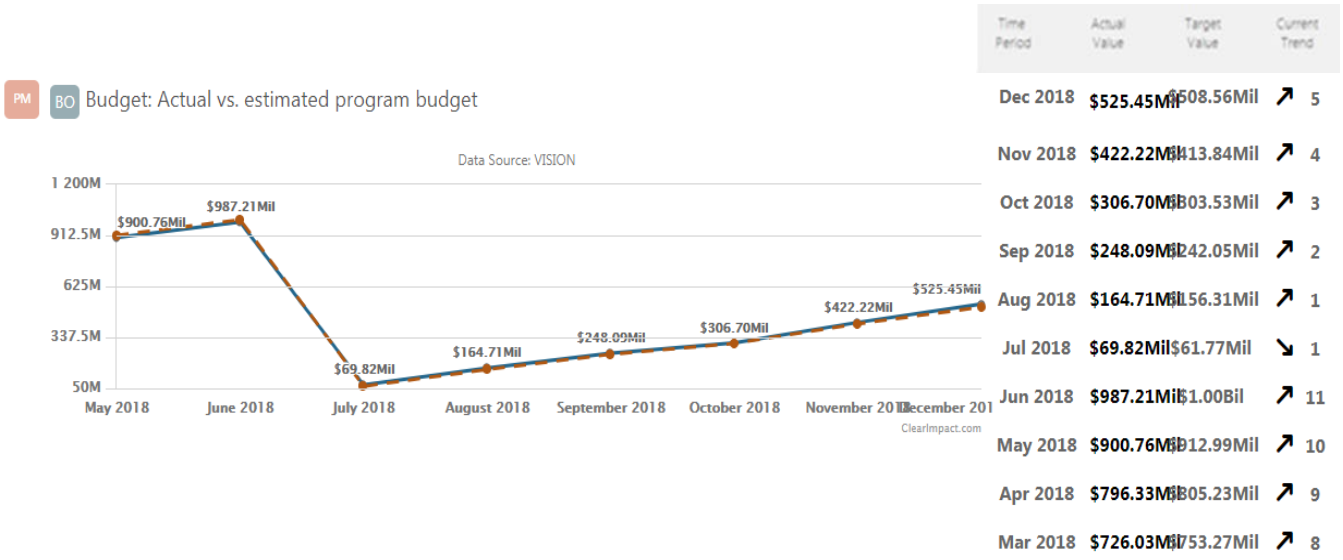
DVHA's commissioner and deputies have stressed financial transparency and mitigation of errors. In order to meet our goal of 100% for this measure, the following strategies must be followed:

Financial Transparency

In order to make thoughtful and informed decisions by DVHA's leadership, it is imperative that the Business Office is being honest and open about our performance, even when sub-par. In order to do so, we are committed to meeting both internal and external reporting requirements in the most accurate manner possible. This means adapting methodology that will allow all necessary reviewers appropriate time to approve any and all reports.

Mitigate Errors

DVHA Business Office is committed to only reporting accurate information to the best of its ability. It continually improves internal processes to adapt to both the requirements of its partners, and the accuracy of its reporting. Additional internal reviews are regularly evaluated, added, and improved upon so that errors are avoided whenever possible



Notes on Methodology

Please note in the chart above that the $ amounts are cumulative; The solid trend line shows the actual total cost of care (ATCOC)

The dotted trend line shows the expected total cost of care (ETCOC)

Cumulative ETCOC & ATCOC for DVHA Program Budget

	SFY18												SFY19					
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Estimated	$59,406,582	$159,623,409	$235,816,660	$303,581,175	$419,353,686	$511,713,792	$567,750,078	$647,309,868	$758,272,280	$805,225,920	$912,991,488	$1,001,639,845	$ 61,767,960	$ 156,307,695	$ 242,049,402	$ 303,525,830	$ 413,844,671	$ 508,560,941
Actual	$58,589,271	$150,012,142	$232,251,627	$290,067,563	$395,219,126	$482,107,265	$552,907,488	$632,302,900	$726,031,807	$796,325,693	$900,758,209	$987,211,338	$ 69,819,472	$ 164,706,378	$ 248,092,686	$ 306,695,845	$ 422,218,321	$ 525,448,019
Over/(Under)	$817,311	$9,611,267	$3,565,033	$13,513,612	$24,134,560	$29,606,527	$14,842,590	$15,006,968	$27,240,473	$8,900,227	$12,233,279	$14,428,507	$ (8,051,512)	$ (8,398,683)	$ (6,043,284)	$ (3,170,015)	$ (8,373,650)	$ (16,887,078)

Month-to-Month ETCOC & ATCOC for DVHA Program Budget

	SFY18												SFY19					
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Estimated	$59,406,582	$100,216,827	$76,193,251	$67,764,515	$115,772,511	$92,360,106	$56,036,286	$79,559,790	$105,962,412	$51,953,640	$107,765,568	$88,648,357	$ 61,421,029	$ 95,743,535	$ 86,363,802	$ 61,478,428	$ 110,318,841	$94,716,271
Actual	$58,589,271	$91,422,871	$82,239,485	$57,815,936	$105,151,563	$86,888,139	$70,800,223	$79,395,412	$93,728,907	$70,293,886	$104,432,516	$86,453,129	$ 69,819,472	$ 94,886,906	$ 83,386,308	$ 58,603,159	$ 115,522,476	$103,219,698
Over/(Under)	$817,311	$8,793,956	($6,046,234)	$9,948,579	$10,620,948	$5,471,967	($14,763,937)	$164,378	$12,233,505	($18,340,246)	$3,333,052	$2,195,228	$ (8,398,443)	$ 858,629	$ 2,977,493	$ 2,873,269	$ (5,203,635)	($8,513,428)

Partners

AHS CO

Dept. of Finance and Management

State of Vermont Legislature – Joint Fiscal Committee

Story Behind the Curve

The Business Office (BO) tracks spending and enrollment trends by Medicaid Eligibility Group (MEG) and Category of Service (COS) as well as anticipated one-time costs, coordinates with the partners listed above, and creates a budget estimate for the fiscal year. Then, applying the historical spending trends that most closely resemble current experience, break down that annual amount into weekly spending estimates to create the 52 Points of Light dashboards.

The current overall trend for enrollment is up in some major MEGs, while spending is expected to reduce in some of the non- MEG based costs such as Buy in and Disproportionate Hospital Share (DSH). These factors combined create an overall up for both enrollment and spending budget each fiscal year.

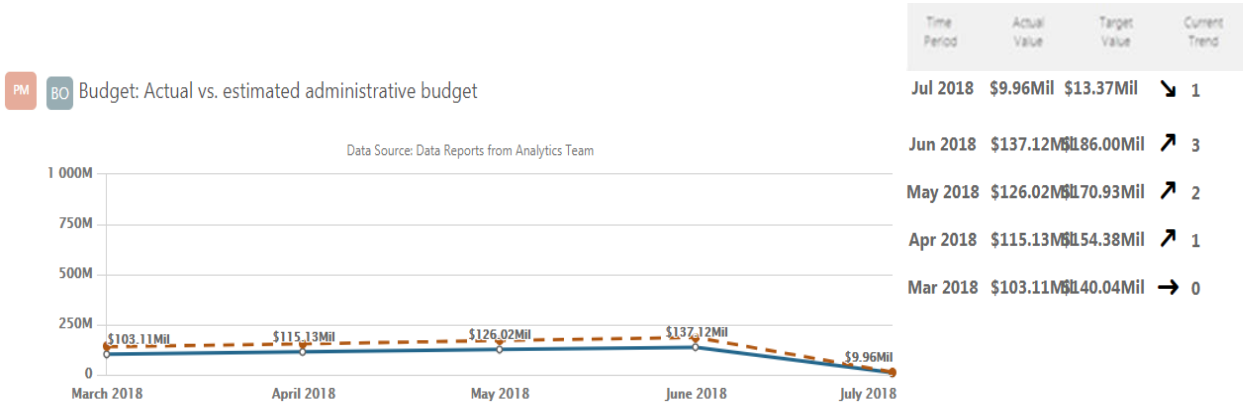
DVHA aims for programmatic spending to be within 1% of appropriation. This KPI is informational only. The complexity of healthcare spending is largely outside of the scope of control of finance.

Last updated: 01/14/19

Strategy

The strategy behind the creation of the budget each fiscal year is to engage in the most rigorous analysis of the actual spending experience as possible, and then combine the knowledge gained from that with additional known factors such as one-time liabilities, expected price changes, expected population shifts, revenue requirements and limitations, and administrative and legislative initiatives.

Research trends in utilization and spend, engage with appropriate contacts.



Notes on Methodology

Please note in the chart above that the:

solid trend line represents the actual spend to date dotted trend line represents the estimated spend to date

DVHA Admin Budget

As of July 31st, 2018

Category	Budget for '18	Expected Spend to Date	Actual Spend to Date	Surplus (Deficit)	% Spent	Notes:
General Admin	$ 5,439,284	$ 418,406	$ 394,202	$ 24,204	7%	
BLUEPRINT	$ 7,349,851	$ 605,255	$ 393,346	$ 211,909	5%	Some Vendors haven't been invoiced for July yet.
VCCI & Care Management	$ 6,201,897	$ 493,746	$ 566,209	$ (72,464)	9%	
E&E Operations	$ 52,179,069	$ 4,250,355	$ 2,970,037	$ 1,280,318	6%	ADS hasn't invoiced us this year
EHRIP	$ 8,899,451	$ 741,621	$ 470,930	$ 270,691	5%	
HIT	$ 10,172,156	$ 843,527	$ 834,385	$ 9,142	8%	
Common Services	$ -	$ -	$ 9,450	$ (9,450)		
IE	$ 17,840,690	$ 1,486,724	$ 749,407	$ 737,317	4%	Projects have not ramped up yet.
MISSING	$ -	$ -	$ -	$ -	0%	
MMIS DDI	$ 22,452,052	$ 1,869,824	$ 1,397,004	$ 472,820	6%	
MMIS M&O	$ 32,659,569	$ 2,662,352	$ 2,178,752	$ 483,599	7%	
	$ 163,194,019	$ 13,371,810	$ 9,963,723	$ 3,408,086	6%	

By Budget Object	18 BAA incl. carryforward	Expected Spend to Date	Actual Spend to Date	Surplus (Deficit)	% Spent	
Salary & Fringe	$ 30,711,605.61	$ 2,762,432	$ 2,462,857	$ 299,576	8%	DVHA is experiening higher cost in staffing than anticipated.
Operations	$ 4,859,987.11	$ 373,845	$ 187,147	$ 186,698	4%	
Grants	$ 7,199,531.28	$ 553,810	$ 126,358	$ 427,452	2%	Under spending in Grants because of Blue Print.
Contracts	$ 120,422,895.20	$ 9,681,722.63	$ 7,187,360	$ 2,494,362	6%	
	$ 163,194,019	$ 13,371,810	$ 9,963,723	$ 3,408,087	6%	

Fund	Appropriation	Actual Earnings	% of Spend	Contractual Encumbrances & Remaining Payroll and Operational Costs	Projected Ending Balance	Notes:
General Fund	$ 26,674,061	$ 2,537,685	10%	$ 1,288,638	$ 24,136,376	
Investments	$ 6,795,089	$ 299,925	4%	$ 524,931	$ 6,495,164	
Interdepartmental Transfers	$ 7,246,989	$ 392,066	5%	$ 516,985	$ 6,854,923	
Special Funds	$ 0	$ -	0%	$ -	$ 0	
HIT Funds	$ 3,522,585	$ 420,672	12%	$ 518,638	$ 3,101,913	
Federal Funds	$ 118,955,295	$ 6,313,374	5%	$ 9,679,898	$ 112,641,921	
	$ 163,194,019	$ 9,963,723	6%	$ 12,529,091	$ 153,230,297	

Partners

AHS CO

Dept. of Finance and Management

State of Vermont Legislature – Joint Fiscal Committee

Story Behind the Curve

The Business Office (BO) tracks spending and enrollment trends by Medicaid Eligibility Group (MEG) and Category of Service (COS) as well as anticipated one-time costs, coordinates with the partners listed above, and creates a budget estimate for the fiscal year. Then, applying the historical spending trends that most closely resemble current experience, break down that annual amount into weekly spending estimates to create the 52 Points of Light dashboards.

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Last updated: 12/15/18

Strategy

The strategy behind the creation of the budget each fiscal year is to engage in the most rigorous analysis of the actual spending experience as possible, and then combine the knowledge gained from that with additional known factors such as one-time liabilities, expected price changes, expected population shifts, revenue requirements and limitations, and administrative and legislative initiatives.

Research trends in utilization and spend, engage with appropriate contacts.

Administrative Services Unit

What We Do

The Administrative Services Unit works to help achieve consistency in our operational and administrative processes and procedures across the department. Our unit is focused on moving the departments objectives of performance management and transparency forward. We accomplish this through our initiatives on improving the onboarding process, position management and performance evaluations. The work that DVHA is responsible for within the agency and the state is critical to serving the needs of Vermonters.

Through the work of the Administrative Services Unit, we can focus on strengthening and improving the development and wellbeing of DVHA employees. By doing so, we have a direct impact on employee engagement thus improving the output of their performance and work they do for the department.

Who We Serve

The Administrative Services Unit serves the entire department. We work directly and indirectly with staff at all levels.

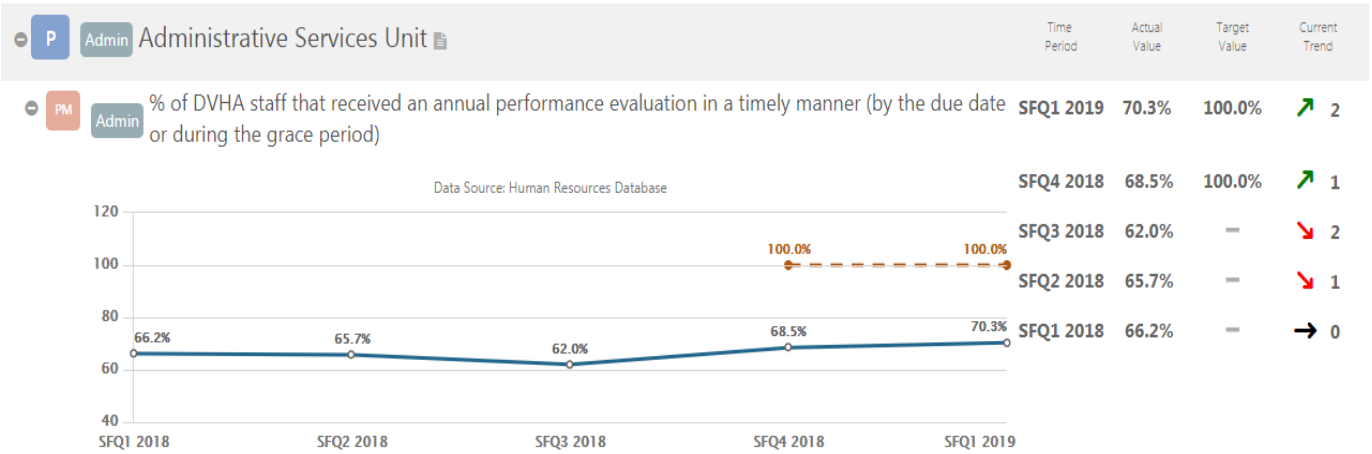
How We Impact

The Administrative Services Unit impacts the department through the development and usage of Administrative policies, procedures and protocols. The Administrative functions that our unit is

responsible for is vast. How we interact with DVHA employees and our capacity to help support them directly impacts their ability to do their work. Our improvements to recruitment, onboarding and evaluations helps to improve the culture of DVHA.

Action Plan

One area of challenge for the Administrative Services Unit is the completion of probation and annual evaluations. Historically, across the agency, and our department, engagement in the evaluation process has been significantly low. The Administrative Services Unit, along with the support of leadership, has communicated to Managers and supervisors the importance of evaluations and how they help promote employee engagement, productivity and motivation for our staff. Our expectation is that DVHA's completion rate will continue to significantly increase over time.



Staffing: % of DVHA staff that received an annual performance evaluation in a timely manner (by the due date or during the grace period)					
	SFY18				SFY19
	Q1	Q2	Q3	Q4	Q1
Total # evals due	71	70	71	111	74
# evals completed timely	47	46	44	76	52
% evals completed timely	66.2%	65.7%	62.0%	68.5%	70.3%

Partners

DVHA Senior Management Team DVHA Management Team

DVHA Business Office Managers/Supervisors Administrative Staff

Story Behind the Curve

Performance management is an effective supervisory tool that can enhance the productivity and motivation of employees. Clear job responsibilities and expectations are established in relation to organizational goals and objectives. Continuous feedback is provided to improve communication between employees and supervisors. Formal performance reviews document and evaluate performance in relation to established expectations.

Historically, across the agency, and our department, engagement in the evaluation process has been significantly low. The Administrative Services Unit, along with the support of leadership, has communicated to Managers and supervisors the importance of evaluations and how they help promote employee engagement, productivity and motivation for our staff. Our expectation is that DVHA's completion rate will continue to significantly increase over time.

Note on SFY19 Q1: DVHA has9 evaluations that are still pending as the grace period just ended or is ending soon and there is a two-pay period turn-around time for HR to add these to the database. Of the pending 2 are Exempt Positions; They do not have to follow a due date listed/grace period and can submit an evaluation any time during the year. Also, to note, one of these exempt positions is in the AAGs office and they have their own evaluation process and don't submit them to AHS HR.

Last updated: 12/15/18

Strategy

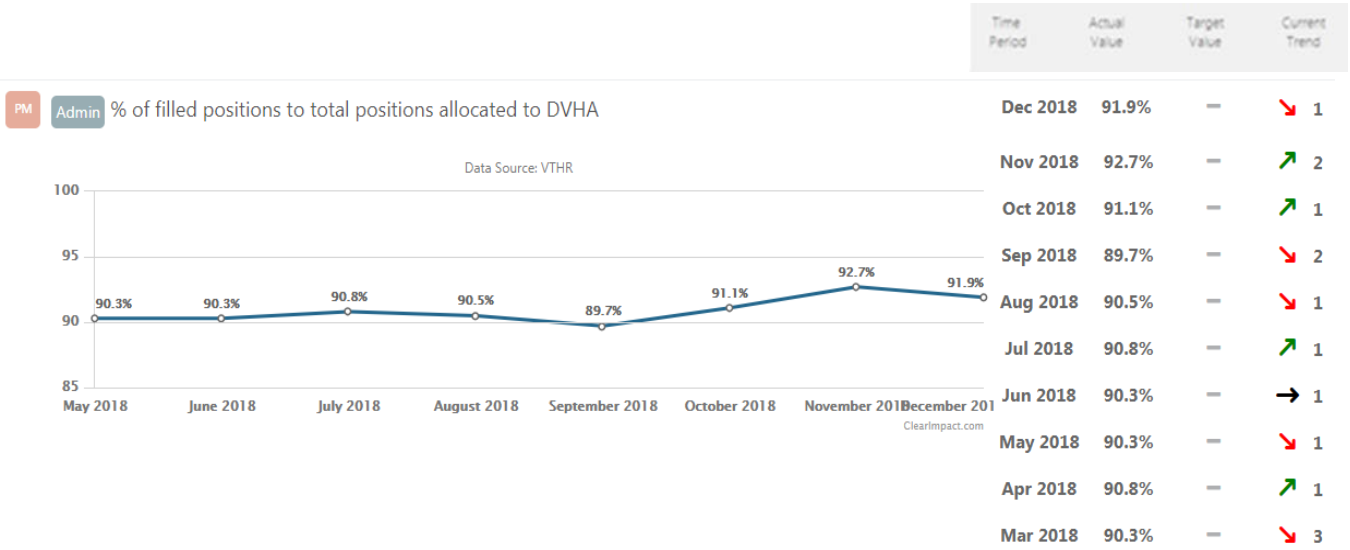
Send monthly email reminders to managers/supervisors alerting them of any upcoming evaluations that are due for their staff.

Ensure that new managers/supervisors receive a list of their staff evaluation due dates.

Administrative staff can create reminders and block out time on a quarterly basis for working on evaluations for managers/supervisors. They can start the evaluation for the manager/supervisor by filling in position information, current job duties, and copy past evaluation goals over.

In order to create more of a culture around this and to express the importance, timely evaluations should be mentioned at all Senior Management Team, Management Team, and one-on-one check-ins with managers/supervisors.

All managers/supervisors should have documented in their own evaluations the timely completion of evaluations for each of their staff. This should be a requirement across the board and needs to be instituted from the top down organizationally.



Notes on Methodology

Staffing: % of filled positions to total positions allocated to DVHA																		
	SFY18												SFY19					
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Total #	X	X	X	X	370	367	367	368	370	370	370	370	368	368	370	371	371	371
# Filled	X	X	X	X	338	349	339	336	334	336	334	334	334	333	332	338	344	341
% Filled	89.4%	88.4%	88.7%	89.5%	91.4%	95.1%	92.4%	91.3%	90.3%	90.8%	90.3%	90.3%	90.8%	90.5%	89.7%	91.1%	92.7%	91.9%

Partners

Senior Leadership DVHA Managers

Story Behind the Curve

Adequate staffing resources is an important component in the success of the Department's initiatives. The Department of Vermont Health Access (DVHA) must have a focus on recruitment and on professional development in order to recruit and retain talent. DVHA needs to ensure that adequate resources are allocated in order to continue to meet our deadlines for important projects and initiatives.

This key performance indicator shows how well DVHA is managing and filling position vacancies.

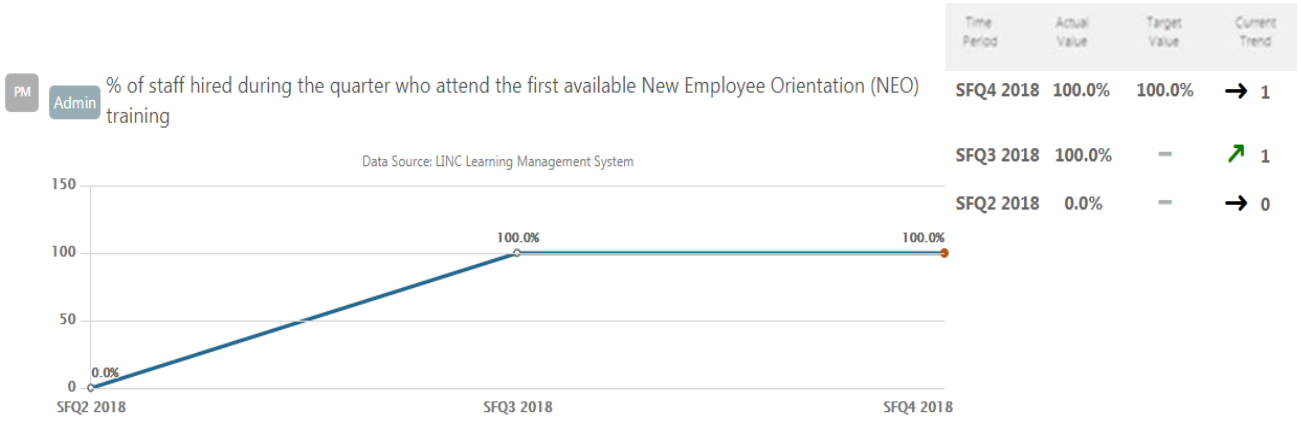
Last updated: 01/14/19

Strategy

Managers identify & report resource deficiencies and needs to Senior Leadership.

As positions become vacant, Senior Leadership reviews the needs of the unit as well as the needs of the department.

A decision is made to recruit for the position as is or to reclassify the position to better suit the needs of the unit or the department.



Partners

Senior Leadership

Story Behind the Curve

Research indicates that a successful onboarding process improves employee engagement and leads to retaining top talent. The Department of Vermont Health Access (DVHA) New Employee Orientation provides an opportunity for new staff to make the connection between the work that they do in their position and how that rolls up to our overall department and agency mission.

Going forward, all new employees will be assigned the DVHA New Employee Orientation in LINC as they are onboarded. There is a reporting feature in LINC that will allows the Admin Unit to track completion and develop this key performance indicator. The completion reports in LINC will be compared to reports in people soft (VTHR) for new hires/transfers into the department.

Last updated: 01/14/19

Strategy

DVHA's New Employee orientation is presented by Senior Leadership. They will continue to prioritize orientation as an opportunity to engage with new staff and provide insight into the important work that DVHA does.

The Administrative Services Unit will continue to work with Managers and Supervisors to ensure they are allowing and encouraging new staff to take time to attend orientation training in person at the Waterbury complex.

Operations

What We Do

The Operations staff manages the day to day operational items for DVHA, this includes addressing building related issues such as moves, space planning and floor plans, VOIP phones, and IT equipment. We oversee the departmental purchasing cards to include setting those up, canceling cards, signing off on monthly charges and audits. We sign off on prior approvals for all Department purchases and approve commodity invoices. Staff also manage fleet vehicles and act as lead on Continuity of Operations plan and Public Records Staff work with stakeholders on the process and procedures needed for purchases to ensure audit requirements are met. This unit leads the TAP project for Public Records Retention for DVHA. They coordinate all ergonomic assessments and work with district staff and internal staff to resolve building issues. They work with AHS, BGS, ADS, vendors and staff to keep all operational responsibilities running. They are part of the AHS safety committee team.

Who We Serve

The Operations staff serve the entire department, we work directly and indirectly with staff at all levels.

How We Impact

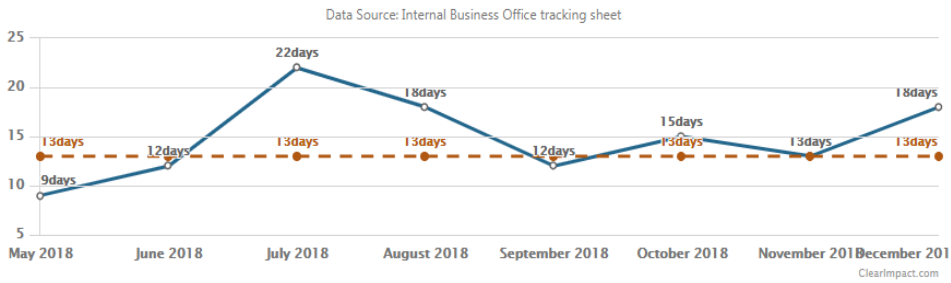
The Operations staff impacts the department by addressing daily issues that come up within the buildings for staff. We educate and support staff. We offer consistent guidelines and procedures for the daily operational items needed in order to perform their job, as well as ensuring any discomforts or work place safety concerns are addressed.

Action Plan

One of the Operations staff top priorities in SFY19 is to complete an electronic manual so it's available for clear instructions to staff for all the operational needs. This will include the instructions and expectations of having all expenses pre-approved before an expense is incurred. It will also include when and how an ergonomic assessment is performed.

P Operations Operations

PM Operations Average # of business days to Agency of Digital Services (ADS) ticket fulfillment



Time Period	Actual Value	Target Value	Current Trend
Dec 2018	18days	13days	↗ 1
Nov 2018	13days	13days	↘ 1
Oct 2018	15days	13days	↗ 1
Sep 2018	12days	13days	↘ 2
Aug 2018	18days	13days	↘ 1
Jul 2018	22days	13days	↗ 2
Jun 2018	12days	13days	↗ 1
May 2018	9days	13days	→ 1
Apr 2018	9days	13days	↘ 1
Mar 2018	11days	13days	↗ 1

Notes on Methodology

The goal is to bring ADS tickets to fulfillment in ≤13business days

Partners

DVHA Staff

DVHA Managers & Directors DVHA IT Support

The Agency of Digital Services (ADS)

Story Behind the Curve

If DVHA staff have a need for computer software or hardware, they submit an Agency of Digital Services (ADS)deployment request to their supervisor for approval. The ticket is then reviewed and approved by the DVHA Business Office, DVHA IT Support & the ADS. The total ticket turnaround time is 13 business days; the Business Office has a turnaround time of 3 business days & ADS has a turnaround time of10 business days.

This measure is important because it shows that the Business Office is ensuring that DVHA employees have equipment ordered and available for their use in a timely manner in order to deliver quality service to Vermonters.

A variety of challenges may be faced in bringing a ticket to closure (including but not limited to):

ADS do not have some items in stock, and they need to be ordered

Some items require installation which must be coordinated with the end user

Staff vacation and sick time can influence ticket closure time

ADS may not recommend or support a purchase; the ticket may take some time to negotiate

Some of the delays in August for the deployment of hardware/software were because of:

ADS is holding some deployment requests until MS 10 can be rolled out.

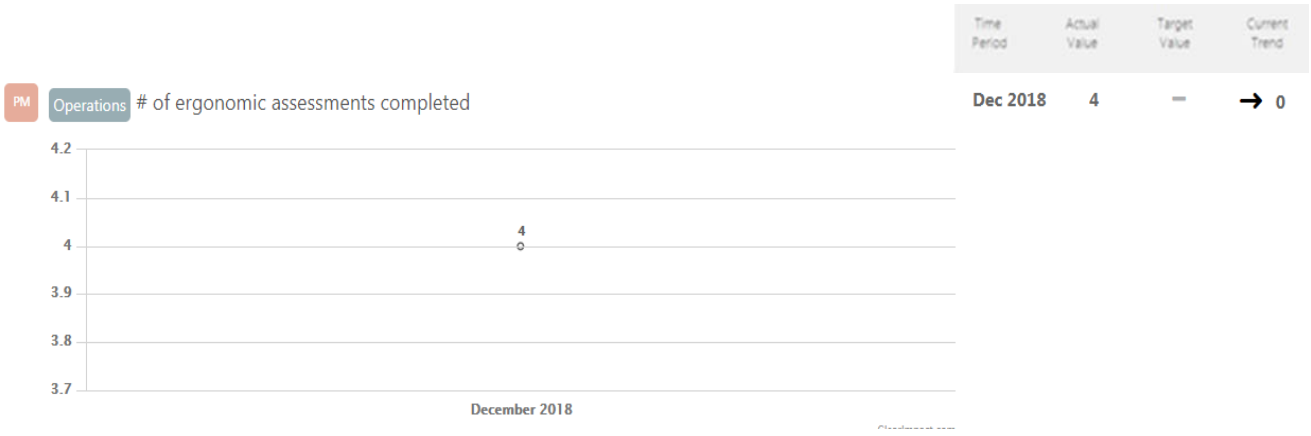
User requested specific software not approved, discussion of replacement software to use needed to occur.

ADS trouble shooting possible repair multiple times vs. approving new laptop request.

Last updated: 01/11/19

Strategy

It's the Operations Unit goal to have a three day turn around for us to review, code, sign off on the form and submit it to AHS – IT support for the purchase. They will then have 10 days on their end to meet the 13-day goal.



Notes on Methodology

We track this performance measure to monitor and understand what the department is spending on ergonomic assessments monthly.

# ergononomic assessments completed & associated cost			
	SFY19		
	Nov-18	Dec-18	Jan-19
# completed	N/A	4	
associated $ cost	N/A	$1,037	

Partners

State ergonomic assessment contracted vendor

DVHA managers

Commodity vendor

DVHA staff

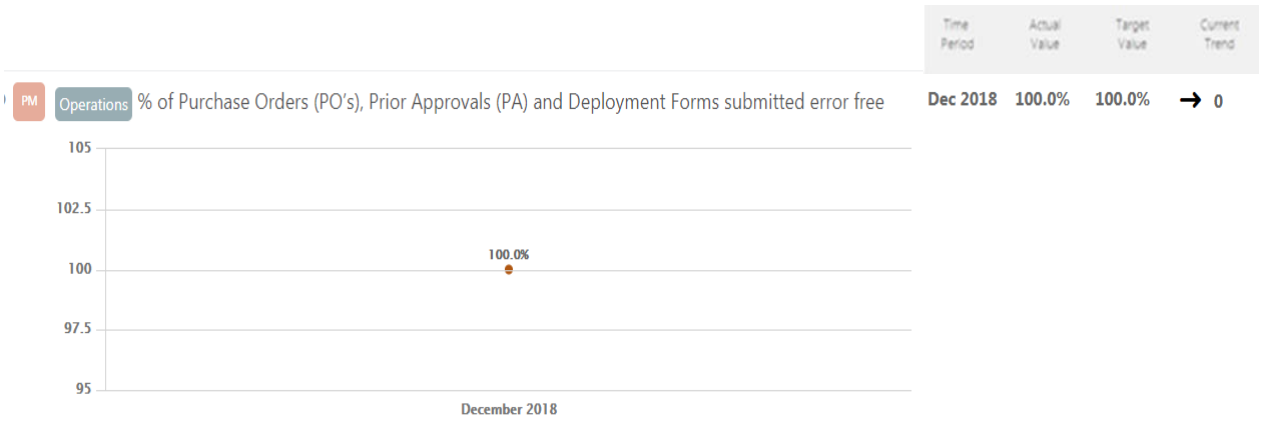
Story Behind the Curve

Ergonomic assessments occur when an employee notifies us of a discomfort or an injury or if we have a move of workstations or buildings. The employee provides us with the details of any injury or discomfort and the Operations Unit shares this information with the contracted vendor. The vendor visits the employee's location and recommends employees work station heights and recommend equipment. The Operations Unit then works with the vendors to achieve the recommendations of the assessment.

Depending on the amount of moves internally and externally and the amount of staff turnover DVHA has, this will affect the count and the amount we spend on these assessments. We will move approximately 120 staff in to the Weeks building in February with sit/stand work stations. We would expect to see a drop in the assessment being requested because of this.

Strategy

Our strategy of this monitoring is to have a better understanding of the cost. Our goal is to provide the employees with what is needed to make their workstations comfortable.



% of purchase orders (PO), prior approvals (PA) and deployment forms submitted error free			
	SFY19		
	Nov-18	Dec-18	Jan-19
Total # forms submitted	N/A	25	
# forms error free	N/A	25	
% forms error free	N/A	100.0%	

Partners

DVHA Staff

DVHA Operations staff

DVHA managers

Story Behind the Curve

The forms are required for all purchases made within DVHA prior to any expense being incurred. This is to prevent fraud and abuse and to ensure DVHA is following all BGS, AHS and AOA purchasing policies. The employee must request the item and a manager signature completed on the form. All purchases are to include three individuals in the process. By submitting the forms timely and accurately it ensures the department agrees with the expense and the purchase being made.

We tend to see inaccuracies occur when we have new staff involved or when there has been a formed or policy updated, and staff are not using the correct version of the document/form.

Last updated: 01/11/19

Strategy

We try to identify the incorrect form issues we are having and edit the forms to be clear of the expectations. We also have this posted on the DVHA intranet with instructions and try to do individual out-reach as needed. We are also continuing to work on an Operations manual which will include additional, clear directions.

Policy Unit

What We Do

Primary Functions of the Medicaid Policy Unit

Oversight and Coordination of Vermont's Global Commitment to Health 1115 Demonstration Waiver Policy Development and Implementation

Medicaid Legislative Coordination Medicaid Administrative Rulemaking

Policy Research and Analysis

Administration of:

1115 Global Commitment to Health Waiver Medicaid State Plan

Global Commitment Register

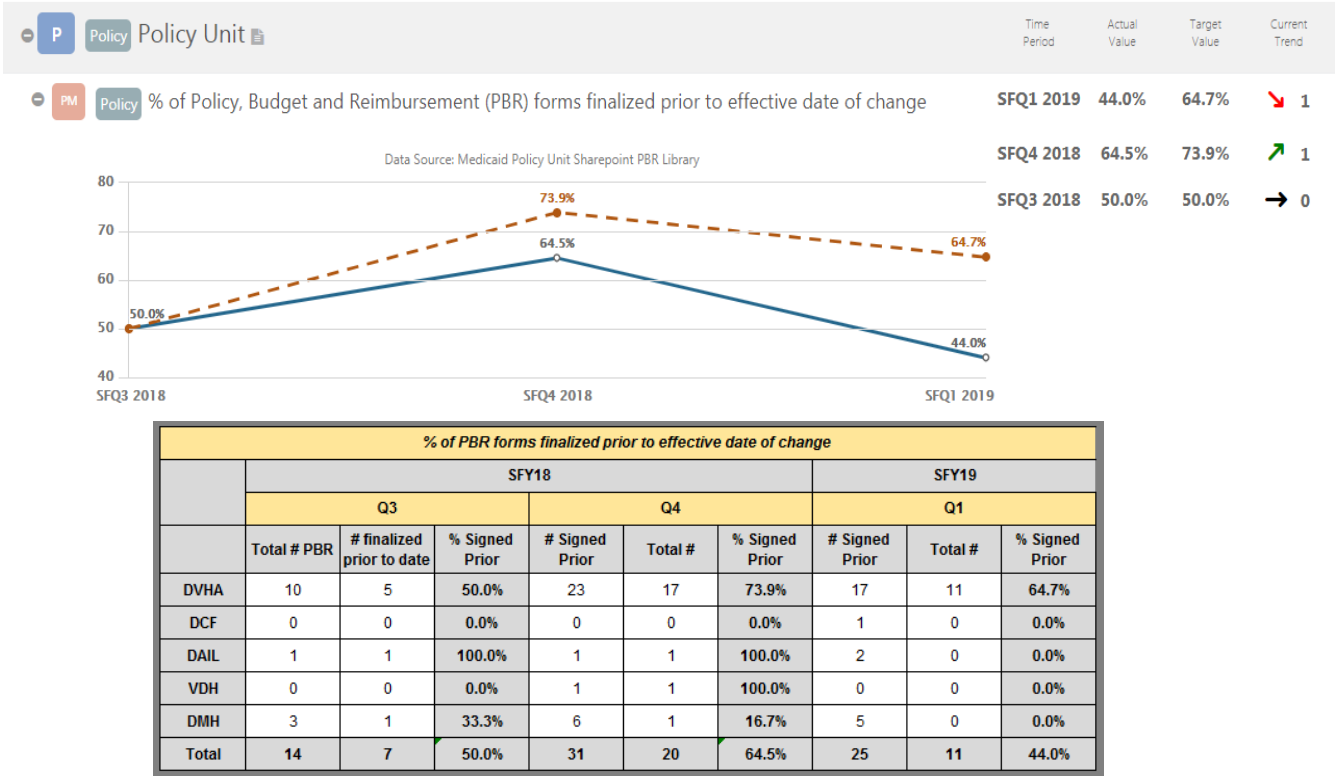
PBR (Policy, Budget, Reimbursement) Process

Who We Serve

The Medicaid Policy unit serves all of AHS in the policy development and implementation of the Vermont Medicaid program. Additionally, the Unit serves broader external stakeholders including the Vermont Legislature, Vermont Legal Aid, Vermont's Congressional Delegation, the Medicaid and Exchange Advisory Board, Vermont's Medical Society, and the Vermont Hospitals Association to both navigate and improve on Medicaid policy statewide.

How We Impact

The Medicaid Policy Unit works to ensure that DVHA and other AHS departments administer the Medicaid program in compliance with federal and state regulations. Additionally, the Policy Unit works with AHS staff and other public and private partners to develop and implement effective Medicaid policy aimed at advancing the agency's goals of improving access and quality while reducing overall costs.



% of PBR forms finalized prior to effective date of change									
	SFY18						SFY19		
	Q3			Q4			Q1		
	Total # PBR	# finalized prior to date	% Signed Prior	# Signed Prior	Total #	% Signed Prior	# Signed Prior	Total #	% Signed Prior
DVHA	10	5	50.0%	23	17	73.9%	17	11	64.7%
DCF	0	0	0.0%	0	0	0.0%	1	0	0.0%
DAIL	1	1	100.0%	1	1	100.0%	2	0	0.0%
VDH	0	0	0.0%	1	1	100.0%	0	0	0.0%
DMH	3	1	33.3%	6	1	16.7%	5	0	0.0%
Total	14	7	50.0%	31	20	64.5%	25	11	44.0%

Partners

Contact for Change (varies)

Lead Department Business Office Program Integrity Unit

AHS Finance

DXC

Story Behind the Curve

Changes to Medicaid programs, services, and policies require a coordinated review to ensure alignment with federal and state regulations as well as Vermont Medicaid policies and practices. The Policy, Budget and Reimbursement (PBR) form provides a tool to support the systematic coordination of AHS departments and units and provides essential documentation regarding the change. The routine use of the PBR form creates a process that serves as an internal safeguard against any unintended consequences of proposed changes.

Policy, Budget & Reimbursement (PBR) forms require review and approval from the lead department business office, DVHA Reimbursement Unit, DVHA Program Integrity Unit, Medicaid Policy Unit, AHS Finance, and the DXC Contract Lead. The goal is to have approval from all before the change is effective and to issue public notice, if required.

The Medicaid Policy Unit manages the PBR process for changes to Medicaid. Having a PBR signed by all reviewers prior to effective date indicates the health and proper utilization of the PBR process. It strengthens the change to have had fiscal, policy, reimbursement, and program integrity review it and allows time for public notice (if required).

If we are not finalizing PBRs prior to their effective dates, we are at risk for the following:

Poor budgeting: Adding new coverage for services or making other Medicaid changes without understanding the fiscal impact ahead of time inhibits DVHA's and the Agency's ability to manage the Medicaid budget.

Loss of, or inability to, receive federal match: Changes to the Medicaid program can require federal approval, or at a minimum, federally required public notice. Without a system that ensures we check for these needs prior to implementation, the chance that we miss a federal approval or public notice requirement increases.

Non-compliance with state and federal policies: We cannot ensure accuracy of Medicaid changes without a coordinated review by subject matter, financial, coding, reimbursement, and policy experts.

Public engagement: Public notice and other public engagement has the most value when conducted prior implementation. By ensuring have internally engaged each other prior to a Medicaid change, we can increase our ability to also engage externally as well.

Cost of mistakes: It can be costly to implement a Medicaid change (in MMIS or otherwise) that then needs to revised after implementation because certain considerations or connections were not made. By maximizing accuracy via the PBR Process, we increase the likelihood that it is done correctly the first time.

Last updated: 11/15/18

Strategy

Variables impacting the performance measure:

Staff awareness of PBR process and requirements

Quality of work put into PBR completion

Agency business processes for planning, budgeting, contracting, etc.

Hashing out MMIS or other necessary IT requirements

Policy Unit's ability to expeditiously route PBRs

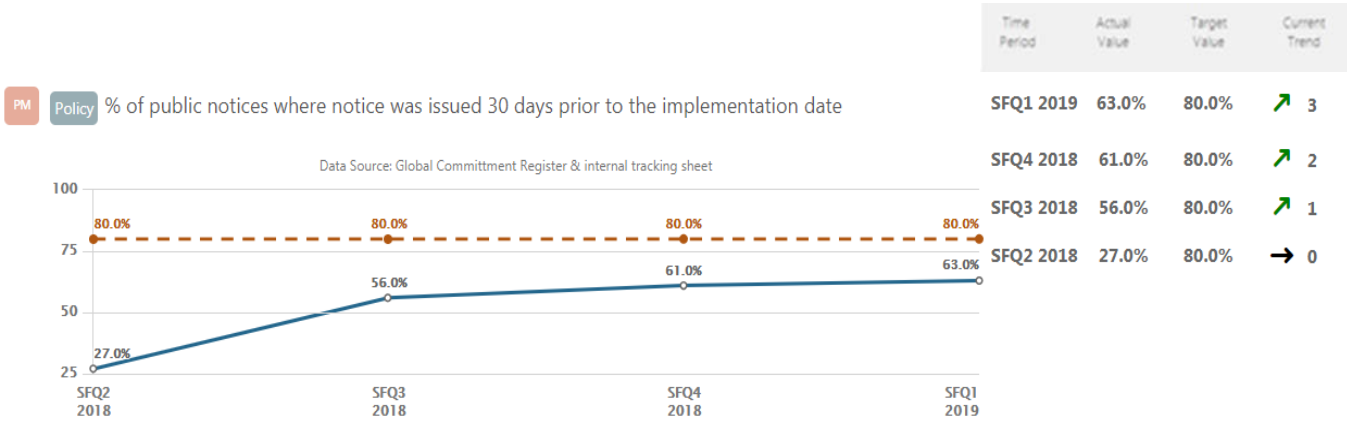
Reviewers' ability to expeditiously review PBRs

Ways to improve:

Continue to work with units and departments to: Ensure awareness of PBR requirements

Discuss ways in which the PBR can work with their business processes and/or their business process can be modified to allow for more PBR pre-planning

Work with departments to think about ways to have more of an ongoing methodology to their annual rate updates rather than have it be driven by one-off changes that are not formula-driven (i.e. any additional dollars they get from the legislature divided by the number of clients providers say they will serve that year).



Notes on Methodology

% of public notices where notice was given 30 days prior to the implementation date				
	SFY18			SFY19
	Q2	Q3	Q4	Q1
# Notices	11	9	23	8
# Met	3	5	14	5
% Met	27%	56%	61%	63%

Partners

Lead for the change (if applicable)

Story Behind the Curve

Public notice is required for certain changes to Medicaid and must be published before the effective date of the change being made.

Public Notice is required for the following:

Any change that eliminates or restricts eligibility or benefits for beneficiaries.

Any change to establish or substantially modify existing premiums or cost sharing or change the consequences for non- payment.

Applications for a demonstration project, or an extension of an existing demonstration project.

Any significant change in methods and standards for setting payment rates for services, except when:

The change is being made to conform to Medicare methods or levels of reimbursement;

The change is required by court order; or

The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.

Any change to the Alternative Benefit Plan.

Public Notices must be published before the effective date of change being made. Waiver renewals and amendments and some SPAs (i.e. ABP amendments) will require longer public comment periods, as stated in CFR (30 days for waivers/demonstrations) and/or specified by CMS (SPAs).

The Policy Unit strives to issue public notice 30 days prior to the effective date of implementation for all changes requiring public notice.

Last updated: 11/15/18

Strategy

Continue to work with units and departments to ensure awareness of PBR and public notice requirements Work with Legislature around feasible effective dates

Cycles of change

Appendix D: AHS Overview

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 following 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 and coordinates agency budget submission
- Updates federal cost allocation plans
- Works with the Medicaid Policy Unit to update the State plan
- Coordinates the master grant negotiations with Designated Agencies (DAs) and Specialized Service Agencies (SSAs)

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.

State Fiscal Year	VT Population Estimate[7]	Green Mountain Care Enrollment	Percent of Population Enrolled
SFY 2018	626,299	197,921	31.60%
SFY 2017	623,657	206,955	33.18%
SFY 2016	624,594	220,556	35.31%
SFY 2015	626,562	209,395	33.42%
SFY 2014	626,855	178,650	28.50%
SFY 2013	626,138	173,849	27.77%
SFY 2012	626,450	171,610	27.39%
SFY 2011	625,792	169,179	27.03%

[7]Annual estimates of the Resident Population: April 1, 2010 to July 1, 2018, U.S. Census Bureau, Population Division, Release Date: July 2018

Medicaid within AHS

AHS, its Departments, and the Agency of Education (AOE) oversee and operate numerous programs designed to address the health and wellness needs of Vermont. AHS' 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 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 Use 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

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
- 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".

DVHA 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 use disorder 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.

SFY 2018 Medicaid Spend - Global Commitment, CHIP, & CFC by Category of Service							
Category of Service	**DVHA**	**DMH**	**VDH**	**DCF**	**DAIL**	**AOE**	**Total AHS**
Inpatient	$127,383,519	$9,075,249	$0	$30,871	$0	$0	$136,489,639
Outpatient	$103,305,241	$0	$27,149	$50,593	$0	$0	$103,382,984
Physician	$107,441,393	-$82	$32,781	$244,848	$0	$224,046	$107,942,986
Pharmacy	$192,560,973	$0	$494,504	$3,719	$0	$0	$193,059,197
Nursing Home	$123,548,028	$0	$0	$0	$0	$0	$123,548,028
ICF/MR Private	$0	$0	$0	$0	$1,367,477	$0	$1,367,477
Mental Health Facility	$483,992	$76,825	$0	$0	$0	$0	$560,817
Dental	$27,362,187	$0	$0	$185,456	$0	$0	$27,547,642
MH Clinic	$860,488	$150,342,548	$0	$0	$870,454	$0	$152,073,490
Independent Lab/X-ray	$13,797,691	$0	$1,124	$0	$0	$0	$13,798,816
Home Health	$6,940,779	$0	$0	$391,546	$0	$0	$7,332,325
Hospice	$8,760,170	$0	$0	$0	$0	$0	$8,760,170
FQHC & RHC	$36,544,657	$0	$0	$0	$0	$0	$30,145,922
Chiropractor	$1,243,186	$0	$0	$0	$0	$0	$1,243,186
Nurse Practitioner	$802,194	$0	$159	$0	$0	$31	$802,384
Skilled Nursing	$2,973,334	$0	$0	$0	$0	$0	$2,973,334
Podiatrist	$212,071	$0	$0	$0	$0	$0	$212,071
Psychologist	$27,626,234	-$374	-$237	$0	$0	$0	$27,625,623
Optometrist & Optician	$2,398,057	$0	$0	$0	$0	$0	$2,202,913
Transportation	$12,278,749	$0	$0	$0	$0	$0	$12,278,749
Therapy Services	$7,383,176	$0	$0	$1,184,270	$0	$0	$8,567,445
Prosthetic/Ortho	$3,718,505	$0	$0	$0	$0	$0	$3,718,505
Medical Supplies & DME	$9,958,579	$0	$0	$0	$0	$0	$2,730,341
H&CB Services	$64,421,474	$0	$0	$0	$655,098	$0	$65,076,572
H&CB Services Mental Service	$1,148,788	$2,704,184	$0	$44,800	$0	$0	$3,897,772
H&CB Services Development Services	$0	$0	$0	$0	$194,817,608	$0	$194,817,608
TBI Services	$0	$386,259	$0	$0	$5,532,191	$0	$5,918,450
Enhanced Resident Care	$9,700,162	$0	$0	$0	$0	$0	$9,700,162
Personal Care Services	$11,389,927	$0	$0	$0	$1,280,589	$0	$12,670,517
Targeted Case Management (Drug)	$146,809	$669	$0	$0	$422,721	$0	$570,199
Assistive Community Care	$13,475,129	$6,320,833	$0	$13,567,993	$0	$0	$33,363,955
Day Treatment MHS	$40,600	$62,819,006	$0	$0	$2,197,838	$0	$65,057,444
OADAP Families in Recovery	$3,798,193	$0	$30,022,624	$0	$0	$0	$33,820,817
Rehabilitation	$371,270	$0	$0	$0	$0	$0	$371,270
D & P Dept of Health	$271,258	$665,417	$1,457,891	$36,090,898	$0	$53,446,127	$91,931,591
PCCM Payments	$2,597,178	$0	$0	$0	$0	$0	$2,597,178
Blue Print & CHT Payments	$18,630,819	$0	$0	$0	$0	$0	$18,630,819
ACO Capitation	$66,799,105	$0	$0	$0	$0	$0	$66,799,105
PDP Premiums	$1,366,280	$0	$2,538	$0	$0	$0	$1,368,818
VPA Premiums	$6,334,440						
Ambulance	$7,049,332	$0	$0	$0	$0	$0	$7,049,332
Dialysis	$1,139,557	$0	$0	$0	$0	$0	$1,139,557
ASC	$76,714	$0	$0	$0	$0	$0	$76,714
Other Expenditures	$117,763,739	$41,707,167	$21,004,346	$19,045,199	$4,623,833	$0	$211,244,338
Offsets	-$150,851,888	-$251,487	-$37,467	-$8,267	-$4,600	-$19,552	-$151,173,262
Total All Program Expenditures	**$993,252,089**	**$273,846,213**	**$53,069,122**	**$71,375,341**	**$211,763,209**	**$53,650,651**	**$1,678,439,332**

Appendix E: Vantage Reports

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Report ID: VTPB-11-BUDRLLUP
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State of Vermont

FY2020 Governor's Recommended Budget: Rollup Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Salaries and Wages	21,674,446	22,579,249	23,279,914	22,800,515	221,266	1.0%
Fringe Benefits	10,211,387	11,710,000	11,710,000	12,697,473	987,473	8.4%
Contracted and 3rd Party Service	86,900,703	115,702,534	120,648,096	99,091,828	(16,610,706)	-14.4%
PerDiem and Other Personal Services	10,272	9,075	9,075	13,990	4,915	54.2%
Budget Object Group Total: 1. PERSONAL SERVICES	**118,796,808**	**150,000,858**	**155,647,085**	**134,603,806**	**(15,397,052)**	**-10.3%**

Budget Object Group: 2. OPERATING

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Equipment	111,025	120,157	120,157	114,800	(5,357)	-4.5%
IT/Telecom Services and Equipment	1,373,038	1,488,161	4,703,055	1,126,506	(361,655)	-24.3%
Travel	109,780	116,577	116,577	119,750	3,173	2.7%
Supplies	148,798	244,166	244,166	161,750	(82,416)	-33.8%
Other Purchased Services	7,190,508	1,512,469	1,512,469	26,045,459	24,532,990	1,622.0%
Other Operating Expenses	23	37,383	37,383	40,250	2,867	7.7%
Rental Other	35,309	47,011	47,011	40,000	(7,011)	-14.9%
Rental Property	1,462,387	1,825,879	1,898,717	2,208,476	382,597	21.0%
Property and Maintenance	47,703	37,268	37,268	48,868	11,600	31.1%
Repair and Maintenance Services	0	449,348	449,348	0	(449,348)	-100.0%
Rentals	53,218	0	0	0	0	0.0%
Budget Object Group Total: 2. OPERATING	**10,531,788**	**5,878,419**	**9,166,151**	**29,905,859**	**24,027,440**	**408.7%**

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State of Vermont

FY2020 Governor's Recommended Budget: Rollup Report

Organization: 3410010000 - Department of Vermont health access - administration
Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Grants Rollup	7,794,305	7,314,742	7,314,742	7,314,723	(19)	0.0%
Budget Object Group Total: 3. GRANTS	**7,794,305**	**7,314,742**	**7,314,742**	**7,314,723**	**(19)**	**0.0%**
Total Expenses	**137,122,901**	**163,194,019**	**172,127,978**	**171,824,388**	**8,630,369**	**5.3%**

Fund Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
General Funds	32,499,745	26,674,061	29,303,802	29,222,317	2,548,256	9.6%
Special Fund	2,377,402	3,522,585	4,180,049	6,096,108	2,573,523	73.1%
State Health Care Resources Fund	0	0	0	0	0	0.0%
Federal Funds	92,215,446	118,955,295	122,595,258	124,749,165	5,793,870	4.9%
ARRA Funds	0	0	0	0	0	0.0%
Global Commitment	5,909,406	6,795,089	8,420,089	4,214,196	(2,580,893)	-38.0%
IDT Funds	4,120,902	7,246,989	7,628,780	7,542,602	295,613	4.1%
Funds Total	**137,122,901**	**163,194,019**	**172,127,978**	**171,824,388**	**8,630,369**	**5.3%**

Position Count				380		
FTE Total				376.23		

State of Vermont

FY2020 Governor's Recommended Budget: Rollup Report

Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Contracted and 3rd Party Service	547,983	0	0	547,983	547,983	0.0%
Budget Object Group Total: 1. PERSONAL SERVICES	**547,983**	**0**	**0**	**547,983**	**547,983**	**0.0%**

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Grants Rollup	700,499,445	730,388,202	731,836,651	734,200,632	3,812,430	0.5%
Budget Object Group Total: 3. GRANTS	**700,499,445**	**730,388,202**	**731,836,651**	**734,200,632**	**3,812,430**	**0.5%**

Total Expenses	**701,047,428**	**730,388,202**	**731,836,651**	**734,748,615**	**4,360,413**	**0.6%**

Fund Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Global Commitment	701,047,428	730,388,202	731,836,651	734,748,615	4,360,413	0.6%
Funds Total	**701,047,428**	**730,388,202**	**731,836,651**	**734,748,615**	**4,360,413**	**0.6%**

Position Count						
FTE Total						

State of Vermont

FY2020 Governor's Recommended Budget: Rollup Report

Organization: 3410016000 - DVHA-Medicaid/long term care waiver

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Grants Rollup	196,563,497	204,515,915	209,074,560	211,888,529	7,372,614	3.6%
Budget Object Group Total: 3. GRANTS	**196,563,497**	**204,515,915**	**209,074,560**	**211,888,529**	**7,372,614**	**3.6%**
Total Expenses	**196,563,497**	**204,515,915**	**209,074,560**	**211,888,529**	**7,372,614**	**3.6%**

Fund Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
General Funds	603,428	0	0	0	0	0.0%
Federal Funds	2,003,722	0	0	0	0	0.0%
Global Commitment	193,956,348	204,515,915	209,074,560	211,888,529	7,372,614	3.6%
Funds Total	**196,563,497**	**204,515,915**	**209,074,560**	**211,888,529**	**7,372,614**	**3.6%**

Position Count						
FTE Total						

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State of Vermont

FY2020 Governor's Recommended Budget: Rollup Report

Organization: 3410017000 - DVHA- Medicaid/state only programs

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Grants Rollup	48,999,381	47,955,940	52,546,833	49,211,558	1,255,618	2.6%
Budget Object Group Total: 3. GRANTS	**48,999,381**	**47,955,940**	**52,546,833**	**49,211,558**	**1,255,618**	**2.6%**
Total Expenses	**48,999,381**	**47,955,940**	**52,546,833**	**49,211,558**	**1,255,618**	**2.6%**

Fund Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
General Funds	40,794,096	39,074,163	40,951,636	37,605,920	(1,468,243)	-3.8%
Global Commitment	8,205,285	8,881,777	11,595,197	11,605,638	2,723,861	30.7%
Funds Total	**48,999,381**	**47,955,940**	**52,546,833**	**49,211,558**	**1,255,618**	**2.6%**

Position Count						
FTE Total						

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State of Vermont

FY2020 Governor's Recommended Budget: Rollup Report

Organization: 3410018000 - DVHA-Medicaid/non-waiver matched programs

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2018 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
Contracted and 3rd Party Service	1,999,549	0	0	0	0	0.0%
Budget Object Group Total: 1. PERSONAL SERVICES	**1,999,549**	**0**	**0**	**0**	**0**	**0.0%**

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Grants Rollup	38,601,115	31,345,248	32,446,297	32,435,074	1,089,826	3.5%
Budget Object Group Total: 3. GRANTS	**38,601,115**	**31,345,248**	**32,446,297**	**32,435,074**	**1,089,826**	**3.5%**

Total Expenses	**40,600,664**	**31,345,248**	**32,446,297**	**32,435,074**	**1,089,826**	**3.5%**

Fund Name	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
General Funds	13,594,534	11,400,406	11,406,688	11,425,047	24,641	0.2%
Federal Funds	27,006,130	19,944,842	21,039,609	21,010,027	1,065,185	5.3%
Funds Total	**40,600,664**	**31,345,248**	**32,446,297**	**32,435,074**	**1,089,826**	**3.5%**

Position Count						
FTE Total						

State of Vermont
FY2020 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 1. PERSONAL SERVICES

Salaries and Wages		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Classified Employees	500000	21,286,909	21,879,687	22,580,352	22,803,026	923,339	4.2%
Exempt	500010	0	1,474,368	1,474,368	1,439,137	(35,231)	-2.4%
Overtime	500060	387,537	0	0	0	0	0.0%
Market Factor - Classified	500899	0	643,399	643,399	606,639	(36,760)	-5.7%
Vacancy Turnover Savings	508000	0	(1,418,205)	(1,418,205)	(2,048,287)	(630,082)	44.4%
Total: Salaries and Wages		**21,674,446**	**22,579,249**	**23,279,914**	**22,800,515**	**221,266**	**1.0%**

Fringe Benefits		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
FICA - Classified Employees	501000	1,586,156	1,722,688	1,722,688	1,790,752	68,064	4.0%
FICA - Exempt	501010	0	106,346	106,346	107,246	900	0.8%
Health Ins - Classified Empl	501500	4,482,454	4,904,651	4,904,651	5,001,894	97,243	2.0%
Health Ins - Exempt	501510	0	231,389	231,389	249,395	18,006	7.8%
Retirement - Classified Empl	502000	3,708,801	3,926,193	3,926,193	4,747,501	821,308	20.9%
Retirement - Exempt	502010	0	218,282	218,282	257,812	39,530	18.1%
Dental - Classified Employees	502500	240,242	279,291	279,291	310,420	31,129	11.1%
Dental - Exempt	502510	0	11,358	11,358	13,660	2,302	20.3%

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Fringe Benefits		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Life Ins - Classified Empl	503000	73,161	78,289	78,289	98,802	20,513	26.2%
Life Ins - Exempt	503010	0	5,966	5,966	6,078	112	1.9%
LTD - Classified Employees	503500	4,515	2,914	2,914	2,771	(143)	-4.9%
LTD - Exempt	503510	0	3,389	3,389	3,312	(77)	-2.3%
EAP - Classified Empl	504000	9,873	10,650	10,650	11,363	713	6.7%
EAP - Exempt	504010	0	450	450	509	59	13.1%
Employee Tuition Costs	504530	2,414	2,444	2,444	2,494	50	2.0%
Workers Comp - Other	505030	0	205,700	205,700	0	(205,700)	-100.0%
Workers Comp - Ins Premium	505200	0	0	0	85,250	85,250	0.0%
Unemployment Compensation	505500	95,556	0	0	0	0	0.0%
Catamount Health Assessment	505700	8,214	0	0	8,214	8,214	0.0%
Total: Fringe Benefits		**10,211,387**	**11,710,000**	**11,710,000**	**12,697,473**	**987,473**	**8.4%**

Contracted and 3rd Party Service		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
IT Contracts - IT Finance & Administration	507105	0	0	0	0	0	0.0%
Contr&3Rd Pty-Educ & Training	507350	716	198	198	198	0	0.0%
IT Contracts - Project Managment	507542	9,636,032	8,307,500	8,307,500	0	(8,307,500)	-100.0%
IT Contracts - Storage	507544	2,589,491	873,870	873,870	873,869	(1)	0.0%
IT Contracts - Application Development	507565	7,066,759	42,500,765	42,500,765	26,522,675	(15,978,090)	-37.6%
IT Contracts - Application Support	507566	33,942,972	33,467,637	38,313,199	33,337,925	(129,712)	-0.4%
Other Contr and 3Rd Pty Serv	507600	33,659,404	30,511,494	30,611,494	38,346,541	7,835,047	25.7%

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Organization: 3410010000 - Department of Vermont health access - administration

Contracted and 3rd Party Service		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Interpreters	507615	4,777	40,900	40,900	10,020	(30,880)	-75.5%
Custodial	507670	553	170	170	600	430	252.9%
Total: Contracted and 3rd Party Service		**86,900,703**	**115,702,534**	**120,648,096**	**99,091,828**	**(16,610,706)**	**-14.4%**

PerDiem and Other Personal Services		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Per Diem	506000	5,359	7,925	7,925	7,926	1	0.0%
Other Pers Serv	506200	4,913	0	0	4,914	4,914	0.0%
Sheriffs	506230	0	1,150	1,150	1,150	0	0.0%
Total: PerDiem and Other Personal Services		**10,272**	**9,075**	**9,075**	**13,990**	**4,915**	**54.2%**

Total: 1. PERSONAL SERVICES		**118,796,808**	**150,000,858**	**155,647,085**	**134,603,806**	**(15,397,052)**	**-10.3%**

Budget Object Group: 2. OPERATING

Equipment		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Hardware - Desktop & Laptop Pc	522216	58,923	57,803	57,803	60,000	2,197	3.8%

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Organization: 3410010000 - Department of Vermont health access - administration

Equipment		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Hw - Printers,Copiers,Scanners	522217	5,397	18,303	18,303	6,000	(12,303)	-67.2%
Hardware - Data Network	522273	840	0	0	1,000	1,000	0.0%
Software-Application Development	522283	3,080	2,640	2,640	3,000	360	13.6%
Software - Application Support	522284	11,234	9,184	9,184	11,500	2,316	25.2%
Software - Desktop	522286	5,524	6,689	6,689	5,500	(1,189)	-17.8%
Software-Security	522288	1,424	578	578	1,500	922	159.5%
Software - Server	522289	2,145	0	0	2,200	2,200	0.0%
Office Equipment	522410	61	0	0	100	100	0.0%
Furniture & Fixtures	522700	22,396	24,960	24,960	24,000	(960)	-3.8%
Total: Equipment		**111,025**	**120,157**	**120,157**	**114,800**	**(5,357)**	**-4.5%**

IT/Telecom Services and Equipment		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Communications	516600	3,233	0	0	4,000	4,000	0.0%
Telecom-Data Telecom Services	516651	0	0	0	0	0	0.0%
Telecom-Video Conf Services	516653	0	0	0	0	0	0.0%
Telecom-Conf Calling Services	516658	15,108	31,156	31,156	15,000	(16,156)	-51.9%
ADS Enterp App Supp SOV Emp Exp	516660	431,961	0	0	0	0	0.0%
ADS App Support SOV Emp Exp	516661	0	0	3,214,894	0	0	0.0%
It Intsvccost-Vision/Isdassess	516671	505,364	636,348	636,348	639,024	2,676	0.4%
ADS Centrex Exp.	516672	7,497	489,307	489,307	0	(489,307)	-100.0%
It Intsvccos-Dii Data Telecomm	516673	0	0	0	0	0	0.0%

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Organization: 3410010000 - Department of Vermont health access - administration

IT/Telecom Services and Equipment		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
It Inter Svc Cost User Support	516678	0	0	0	0	0	0.0%
ADS Allocation Exp.	516685	409,875	331,350	331,350	468,482	137,132	41.4%
Hw - Other Info Tech	522200	0	0	0	0	0	0.0%
Software - Other	522220	0	0	0	0	0	0.0%
Total: IT/Telecom Services and Equipment		**1,373,038**	**1,488,161**	**4,703,055**	**1,126,506**	**(361,655)**	**-24.3%**

Other Operating Expenses		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Single Audit Allocation	523620	23	37,100	37,100	40,000	2,900	7.8%
Bank Service Charges	524000	0	283	283	250	(33)	-11.7%
Total: Other Operating Expenses		**23**	**37,383**	**37,383**	**40,250**	**2,867**	**7.7%**

Other Purchased Services		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Insurance Other Than Empl Bene	516000	68,305	0	0	2,988	2,988	0.0%
Insurance - General Liability	516010	0	121,541	121,541	59,806	(61,735)	-50.8%
Dues	516500	48,256	48,919	48,919	49,000	81	0.2%
Licenses	516550	440	37,254	37,254	800	(36,454)	-97.9%

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Organization: 3410010000 - Department of Vermont health access - administration

Other Purchased Services		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Telecom-Mobile Wireless Data	516623	0	0	0	0	0	0.0%
Telecom-Telephone Services	516652	81,156	85,018	85,018	83,000	(2,018)	-2.4%
ADS PM SOV Employee Expense	516683	0	247,192	247,192	0	(247,192)	-100.0%
Advertising	516800	0	0	0	0	0	0.0%
Advertising-Other	516815	1,679	6,574	6,574	10,000	3,426	52.1%
Advertising - Job Vacancies	516820	4,697	10,488	10,488	10,000	(488)	-4.7%
Printing and Binding	517000	229,612	358,790	358,790	240,000	(118,790)	-33.1%
Photocopying	517020	0	70	70	0	(70)	-100.0%
Registration For Meetings&Conf	517100	524	5,728	5,728	2,000	(3,728)	-65.1%
Training - Info Tech	517110	0	3,500	3,500	2,000	(1,500)	-42.9%
Empl Train & Background Checks	517120	751	479	479	1,000	521	108.8%
Postage	517200	257,421	353,184	353,184	275,000	(78,184)	-22.1%
Freight & Express Mail	517300	22,513	24,237	24,237	25,000	763	3.1%
Instate Conf, Meetings, Etc	517400	9,893	25,873	25,873	25,000	(873)	-3.4%
Catering-Meals-Cost	517410	637	0	0	1,000	1,000	0.0%
Outside Conf, Meetings, Etc	517500	10,165	16,147	16,147	0	(16,147)	-100.0%
Other Purchased Services	519000	55,297	32,785	32,785	58,000	25,215	76.9%
Human Resources Services	519006	195,775	118,776	118,776	240,582	121,806	102.6%
Administrative Service Charge	519010	28,167	15,914	15,914	30,000	14,086	88.5%
Security Services	519025	2	0	0	0	0	0.0%
Infrastructure as a Service	519081	6,175,218	0	0	24,930,283	24,930,283	0.0%
Total: Other Purchased Services		**7,190,508**	**1,512,469**	**1,512,469**	**26,045,459**	**24,532,990**	**1,622.0%**

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FY2020 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Property and Maintenance		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Water/Sewer	510000	33	68	68	68	0	0.0%
Disposal	510200	1,119	940	940	1,200	260	27.7%
Repair & Maint - Buildings	512000	549	4,064	4,064	600	(3,464)	-85.2%
Repair & Maint - Office Tech	513010	39,100	29,620	29,620	40,000	10,380	35.0%
Other Repair & Maint Serv	513200	1,796	16	16	2,000	1,984	12,400.0%
Repair&Maint-Property/Grounds	513210	5,107	2,560	2,560	5,000	2,440	95.3%
Total: Property and Maintenance		**47,703**	**37,268**	**37,268**	**48,868**	**11,600**	**31.1%**

Rental Other		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Rental - Auto	514550	16,462	20,594	20,594	20,000	(594)	-2.9%
Rental - Office Equipment	514650	18,847	26,417	26,417	20,000	(6,417)	-24.3%
Total: Rental Other		**35,309**	**47,011**	**47,011**	**40,000**	**(7,011)**	**-14.9%**

Rental Property		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Rent Land & Bldgs-Office Space	514000	1,245,908	1,461,768	1,534,606	1,500,000	38,232	2.6%
Rent Land&Bldgs-Non-Office	514010	66	0	0	0	0	0.0%

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Organization: 3410010000 - Department of Vermont health access - administration

Rental Property		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Fee-For-Space Charge	515010	216,413	364,111	364,111	708,476	344,365	94.6%
Total: Rental Property		**1,462,387**	**1,825,879**	**1,898,717**	**2,208,476**	**382,597**	**21.0%**

Supplies		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Office Supplies	520000	42,379	64,820	64,820	50,000	(14,820)	-22.9%
Gasoline	520110	129	305	305	200	(105)	-34.4%
Other General Supplies	520500	2,940	0	0	3,000	3,000	0.0%
Recognition/Awards	520600	0	0	0	0	0	0.0%
Food	520700	3,032	4,425	4,425	3,000	(1,425)	-32.2%
Water	520712	724	1,160	1,160	800	(360)	-31.0%
Electricity	521100	712	855	855	800	(55)	-6.4%
Heating Oil #2	521220	353	0	0	400	400	0.0%
Propane Gas	521320	111	400	400	150	(250)	-62.5%
Books&Periodicals-Library/Educ	521500	521	936	936	600	(336)	-35.9%
Subscriptions	521510	95,020	169,915	169,915	100,000	(69,915)	-41.1%
Other Books & Periodicals	521520	1,455	0	0	1,500	1,500	0.0%
Household, Facility&Lab Suppl	521800	304	304	304	300	(4)	-1.3%
Paper Products	521820	1,118	1,046	1,046	1,000	(46)	-4.4%
Total: Supplies		**148,798**	**244,166**	**244,166**	**161,750**	**(82,416)**	**-33.8%**

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Organization: 3410010000 - Department of Vermont health access - administration

Travel		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Travel-Inst-Auto Mileage-Emp	518000	48,397	55,899	55,899	50,000	(5,899)	-10.6%
Travel-Inst-Other Transp-Emp	518010	4,139	4,866	4,866	5,000	134	2.8%
Travel-Inst-Meals-Emp	518020	24	599	599	600	1	0.2%
Travel-Inst-Lodging-Emp	518030	258	0	0	0	0	0.0%
Travel-Inst-Incidentals-Emp	518040	762	274	274	800	526	192.0%
Travl-Inst-Auto Mileage-Nonemp	518300	3,196	3,928	3,928	3,500	(428)	-10.9%
Travel-Inst-Other Trans-Nonemp	518310	130	0	0	150	150	0.0%
Travel-Outst-Auto Mileage-Emp	518500	1,573	717	717	1,700	983	137.1%
Travel-Outst-Other Trans-Emp	518510	19,897	20,865	20,865	25,000	4,135	19.8%
Travel-Outst-Meals-Emp	518520	4,235	3,213	3,213	5,000	1,787	55.6%
Travel-Outst-Lodging-Emp	518530	24,487	24,470	24,470	25,000	530	2.2%
Travel-Outst-Incidentals-Emp	518540	2,684	1,746	1,746	3,000	1,254	71.8%
Total: Travel		**109,780**	**116,577**	**116,577**	**119,750**	**3,173**	**2.7%**

Repair and Maintenance Services			FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Software-Rep&Maint-ApplicaSupp	513050	0	449,348	449,348	0	(449,348)	-100.0%
Total: Repair and Maintenance Services		**0**	**449,348**	**449,348**	**0**	**(449,348)**	**-100.0%**

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Organization: 3410010000 - Department of Vermont health access - administration

Rentals		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Software-License-ApplicaSupprt	516551	53,218	0	0	0	0	0.0%
Software-License-ApplicaDevel	516552	0	0	0	0	0	0.0%
Software-License-Security	516554	0	0	0	0	0	0.0%
Software-License-DeskLaptop PC	516559	0	0	0	0	0	0.0%
Total: Rentals		**53,218**	**0**	**0**	**0**	**0**	**0.0%**
Total: 2. OPERATING		**10,531,788**	**5,878,419**	**9,166,151**	**29,905,859**	**24,027,440**	**408.7%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Grants	550220	0	3,900,028	3,900,028	0	(3,900,028)	-100.0%
Other Grants	550500	3,238,382	3,414,714	3,414,714	3,192,301	(222,413)	-6.5%
Medical Services Grants	604250	4,555,922	0	0	4,122,422	4,122,422	0.0%
Ahs Cost Allocation Exp. Acct.	799090	0	0	0	0	0	0.0%
Total: Grants Rollup		**7,794,305**	**7,314,742**	**7,314,742**	**7,314,723**	**(19)**	**0.0%**
Total: 3. GRANTS		**7,794,305**	**7,314,742**	**7,314,742**	**7,314,723**	**(19)**	**0.0%**
Total Expenses:		**137,122,901**	**163,194,019**	**172,127,978**	**171,824,388**	**8,630,369**	**5.3%**

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Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Object Group: 1. PERSONAL SERVICES

Contracted and 3rd Party Service		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Other Contr and 3Rd Pty Serv	507600	547,983	0	0	547,983	547,983	0.0%
Total: Contracted and 3rd Party Service		**547,983**	**0**	**0**	**547,983**	**547,983**	**0.0%**
Total: 1. PERSONAL SERVICES		**547,983**	**0**	**0**	**547,983**	**547,983**	**0.0%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Grants	550220	0	0	0	0	0	0.0%
Medical Services Grants	604250	700,888,344	730,388,202	731,836,651	734,200,632	3,812,430	0.5%
Ahs Cost Allocation Exp. Acct.	799090	(388,899)	0	0	0	0	0.0%
Total: Grants Rollup		**700,499,445**	**730,388,202**	**731,836,651**	**734,200,632**	**3,812,430**	**0.5%**
Total: 3. GRANTS		**700,499,445**	**730,388,202**	**731,836,651**	**734,200,632**	**3,812,430**	**0.5%**
Total Expenses:		**701,047,428**	**730,388,202**	**731,836,651**	**734,748,615**	**4,360,413**	**0.6%**

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Organization: 3410016000 - DVHA-Medicaid/long term care waiver

Budget Object Group: 3. GRANTS

Grants Rollup		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Medical Services Grants	604250	196,488,162	204,515,915	209,074,560	211,888,529	7,372,614	3.6%
Ahs Cost Allocation Exp. Acct.	799090	75,335	0	0	0	0	0.0%
Total: Grants Rollup		**196,563,497**	**204,515,915**	**209,074,560**	**211,888,529**	**7,372,614**	**3.6%**
Total: 3. GRANTS		**196,563,497**	**204,515,915**	**209,074,560**	**211,888,529**	**7,372,614**	**3.6%**
Total Expenses:		**196,563,497**	**204,515,915**	**209,074,560**	**211,888,529**	**7,372,614**	**3.6%**

State of Vermont
FY2020 Governor's Recommended Budget: Detail Report

Organization: 3410017000 - DVHA- Medicaid/state only programs

Budget Object Group: 3. GRANTS

Grants Rollup		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Medical Services Grants	604250	48,543,535	47,955,940	52,546,833	49,211,558	1,255,618	2.6%
Ahs Cost Allocation Exp. Acct.	799090	455,847	0	0	0	0	0.0%
Total: Grants Rollup		**48,999,381**	**47,955,940**	**52,546,833**	**49,211,558**	**1,255,618**	**2.6%**
Total: 3. GRANTS		**48,999,381**	**47,955,940**	**52,546,833**	**49,211,558**	**1,255,618**	**2.6%**
Total Expenses:		**48,999,381**	**47,955,940**	**52,546,833**	**49,211,558**	**1,255,618**	**2.6%**

State of Vermont
FY2020 Governor's Recommended Budget: Detail Report

Organization: 3410018000 - DVHA-Medicaid/non-waiver matched programs

Budget Object Group: 1. PERSONAL SERVICES

Contracted and 3rd Party Service		FY2018 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
Description	**Code**						
Other Contr and 3Rd Pty Serv	507600	1,999,549	0	0	0	0	0.0%
Total: Contracted and 3rd Party Service		**1,999,549**	**0**	**0**	**0**	**0**	**0.0%**
Total: 1. PERSONAL SERVICES		**1,999,549**	**0**	**0**	**0**	**0**	**0.0%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Description	**Code**						
Medical Services Grants	604250	38,743,398	31,345,248	32,446,297	32,435,074	1,089,826	3.5%
Ahs Cost Allocation Exp. Acct.	799090	(142,282)	0	0	0	0	0.0%
Total: Grants Rollup		**38,601,115**	**31,345,248**	**32,446,297**	**32,435,074**	**1,089,826**	**3.5%**
Total: 3. GRANTS		**38,601,115**	**31,345,248**	**32,446,297**	**32,435,074**	**1,089,826**	**3.5%**
Total Expenses:		**40,600,664**	**31,345,248**	**32,446,297**	**32,435,074**	**1,089,826**	**3.5%**

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FY2020 Governor's Recommended Budget: Detail Report

Fund Name	Fund Code	FY2018 Actuals	FY2019 Original As Passed Budget	FY2019 Governor's BAA Recommended Budget	FY2020 Governor's Recommended Budget	Difference Between FY2020 Governor's Recommend and FY2019 As Passed	Percent Change FY2020 Governor's Recommend and FY2019 As Passed
Default Fund	0	0	0	0	0	0	0.0%
General Fund	10000	87,491,802	77,148,630	81,662,126	78,253,284	1,104,654	1.4%
Global Commitment Fund	20405	909,118,467	950,580,983	960,926,497	962,456,978	11,875,995	1.2%
Insurance Regulatory & Suprv	21075	0	0	0	0	0	0.0%
Inter-Unit Transfers Fund	21500	4,120,902	7,246,989	7,628,780	7,542,602	295,613	4.1%
Evidence-Based Educ & Advertis	21912	12,000	0	100,000	0	0	0.0%
Vermont Health IT Fund	21916	2,365,402	3,522,585	4,080,049	6,096,108	2,573,523	73.1%
State Health Care Resources Fd	21990	0	0	0	0	0	0.0%
Federal Revenue Fund	22005	121,225,298	138,900,137	143,634,867	145,759,192	6,859,055	4.9%
ARRA Federal Fund	22040	0	0	0	0	0	0.0%
Funds Total:		**1,124,333,871**	**1,177,399,324**	**1,198,032,319**	**1,200,108,164**	**22,708,840**	**1.9%**

Position Count					380		
FTE Total					376.23		

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State of Vermont

FY2020 Governor's Recommended Budget
Position Summary Report

3410010000-Department of Vermont health access - administration

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
720010	514900 - Rate Setting Office & Data Mgr	1	1	51,458	28,222	3,936	83,616
720027	510000 - Director of Rate Setting	1	1	101,082	30,384	7,734	139,200
720028	032901 - Medicaid Residentl Prgm Audito	1	1	63,686	22,410	4,872	90,968
720031	510010 - Rate Setting Manager	1	1	92,060	28,284	7,042	127,386
720032	509800 - Rate Setting Audit Supervisor	1	1	81,646	34,470	6,246	122,362
720033	032950 - Health Facility Auditor II	1	1	65,414	14,428	5,004	84,846
720174	033900 - Hlth Fac Sr Audit & Rate Spec	1	1	88,412	39,122	6,764	134,298
727014	95868E - Staff Attorney III	1	1	74,236	39,360	5,678	119,274
730001	501100 - DVHA Program Consultant	1	1	54,937	35,193	4,203	94,333
730002	501100 - DVHA Program Consultant	1	1	49,792	27,873	3,809	81,474
730003	499800 - DVHA COB Director	1	1	89,846	27,824	6,874	124,544
730005	459400 - DVHA Medicaid Compliance Off	1	1	98,257	44,161	7,517	149,935

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730006	495100 - Pharmacy Project Administrator	1	1	74,268	32,940	5,682	112,890
730007	495900 - Med Hlthcare Data & Stat Anal	1	1	74,268	16,259	5,681	96,208
730009	460500 - Program Integrity Director	1	1	78,231	34,622	5,986	118,839
730011	460560 - Oversight&Monitor Security Aud	1	1	83,522	41,112	6,390	131,024
730012	000070 - Nurse Case Manager / URN I	1	1	80,169	25,822	6,134	112,124
730013	004700 - Program Technician I	1	1	44,533	33,039	3,406	80,978
730014	499700 - Medicaid Operations Adm	1	1	67,332	37,759	5,151	110,242
730018	089130 - Financial Director I	1	1	73,720	39,084	5,638	118,442
730020	495600 - Associate Prog Integrity Dir	1	1	73,720	32,827	5,640	112,187
730021	459800 - Health Program Administrator	1	1	69,988	38,312	5,354	113,654
730023	501100 - DVHA Program Consultant	1	1	51,458	19,876	3,937	75,271
730024	089240 - Administrative Srvcs Cord III	1	1	58,078	29,592	4,442	92,112
730025	501100 - DVHA Program Consultant	1	1	62,230	22,107	4,760	89,097
730027	459500 - Provider Relations Specialist	1	1	62,146	13,749	4,754	80,649

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730028	469900 - Provider & Member Serv Dir	1	1	81,351	40,661	6,224	128,236
730029	459800 - Health Program Administrator	1	1	68,070	23,318	5,208	96,596
730030	514400 - Dir Data Mgn Analysis & Integ	1	1	89,847	42,420	6,873	139,140
730031	498800 - Medicaid Fiscal Analyst	1	1	61,704	13,660	4,720	80,084
730032	089120 - Financial Manager III	1	1	67,184	23,136	5,140	95,460
730034	000070 - Nurse Case Manager / URN I	1	1	100,261	21,640	7,669	129,570
730035	000078 - Nurse Auditor	1	1	85,641	41,549	6,551	133,741
730036	000070 - Nurse Case Manager / URN I	1	1	77,209	25,208	5,906	108,323
730037	501100 - DVHA Program Consultant	1	1	51,458	34,473	3,936	89,867
730047	000086 - Nurse Administrator II	1	1	88,059	36,658	6,736	131,453
730049	089140 - Financial Director II	1	1	86,896	41,810	6,648	135,354
730050	000090 - Nursing Operations Director	1	1	134,403	29,018	10,187	173,607
730051	089210 - Administrative Srvcs Tech IV	1	1	48,043	19,169	3,675	70,887
730053	089120 - Financial Manager III	1	1	88,918	35,976	6,802	131,696

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730054	089060 - Financial Administrator II	1	1	52,850	34,764	4,042	91,656
730056	459500 - Provider Relations Specialist	1	1	60,038	13,313	4,593	77,944
730059	089141 - Financial Director IV	1	1	98,954	44,536	7,570	151,060
730060	495900 - Med Hlthcare Data & Stat Anal	1	1	67,627	37,821	5,173	110,621
730061	480200 - DVHA Quality Improvement Dir	1	1	86,726	41,774	6,635	135,135
730067	501100 - DVHA Program Consultant	1	1	56,708	35,559	4,338	96,605
730068	533500 - Coord of Benefits Supervisor	1	1	69,567	38,222	5,322	113,111
730069	000075 - Nurse Case Manager / URN II	1	1	106,551	45,878	8,151	160,579
730070	422000 - Clinical Informatics Analyst	1	1	69,967	32,049	5,352	107,368
730073	000070 - Nurse Case Manager / URN I	1	1	91,297	19,784	6,984	118,065
730074	000075 - Nurse Case Manager / URN II	1	1	115,999	24,898	8,874	149,771
730075	000075 - Nurse Case Manager / URN II	1	1	82,019	35,406	6,274	123,699
730076	000070 - Nurse Case Manager / URN I	1	1	97,529	29,414	7,461	134,404
730081	089040 - Financial Specialist III	1	1	45,450	10,296	3,478	59,224

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730082	486400 - Project & Operations Dir	1	1	78,230	34,626	5,984	118,840
730084	464900 - DVHA Program & Oper Auditor	1	1	53,967	29,600	4,128	87,695
730086	486400 - Project & Operations Dir	1	1	92,671	36,750	7,090	136,511
730087	735500 - Healthcare Assistant Admin II	1	1	74,268	24,599	5,681	104,548
730088	501100 - DVHA Program Consultant	1	1	60,481	30,085	4,626	95,192
730089	501100 - DVHA Program Consultant	1	1	60,481	13,405	4,627	78,513
730090	533500 - Coord of Benefits Supervisor	1	1	78,927	33,906	6,038	118,871
730091	000070 - Nurse Case Manager / URN I	1	1	77,209	34,411	5,907	117,527
730093	000070 - Nurse Case Manager / URN I	1	1	80,169	34,161	6,132	120,463
730094	000075 - Nurse Case Manager / URN II	1	1	100,261	38,321	7,670	146,253
730097	498800 - Medicaid Fiscal Analyst	1	1	55,928	35,400	4,278	95,606
730098	000070 - Nurse Case Manager / URN I	1	1	77,210	39,804	5,906	122,919
730102	498000 - Health Enterprise Director II	1	1	112,002	47,265	8,568	167,835
730103	458902 - Health Services Researcher	1	1	98,954	44,305	7,568	150,827

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730105	089210 - Administrative Srvcs Tech IV	0.65	1	21,829	28,339	1,670	51,838
730105	089210 - Administrative Srvcs Tech IV	0.65	1	24,791	28,951	1,897	55,639
730107	501100 - DVHA Program Consultant	1	1	54,937	20,597	4,202	79,736
730108	536900 - VHC Support Services Spec	1	1	53,123	20,219	4,064	77,406
730109	460600 - Coordination of Benefit Spec	1	1	57,108	29,387	4,369	90,864
730110	478100 - Business Process Manager	1	1	79,095	40,193	6,051	125,339
730112	536900 - VHC Support Services Spec	1	1	53,123	34,816	4,064	92,003
730113	536900 - VHC Support Services Spec	1	1	54,937	20,595	4,202	79,734
730114	536900 - VHC Support Services Spec	1	1	53,123	20,219	4,064	77,406
730115	499700 - Medicaid Operations Adm	1	1	65,161	37,309	4,985	107,455
730123	434100 - Public Health Dentist	0.63	1	50,172	31,202	3,839	85,213
730123	434100 - Public Health Dentist	0.44	1	25,087	6,077	1,920	33,084
730123	434100 - Public Health Dentist	0.44	1	24,375	5,930	1,864	32,169
730124	464900 - DVHA Program & Oper Auditor	1	1	53,967	20,397	4,128	78,492

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Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730125	459450 - MMIS Compliance Specialist	1	1	73,993	16,201	5,661	95,855
730126	498800 - Medicaid Fiscal Analyst	1	1	68,070	23,316	5,207	96,593
730127	499400 - Medicaid Transptation QC Chief	1	1	74,268	32,940	5,681	112,889
730129	089090 - Financial Manager II	1	1	71,844	24,100	5,496	101,440
730130	034550 - HCR-HIT Integration Manager	1	1	95,749	29,266	7,326	132,341
730131	000070 - Nurse Case Manager / URN I	1	1	91,297	36,466	6,985	134,747
730132	000070 - Nurse Case Manager / URN I	1	1	80,169	25,820	6,133	112,121
730133	000070 - Nurse Case Manager / URN I	1	1	100,261	44,576	7,670	152,507
730134	000070 - Nurse Case Manager / URN I	1	1	80,169	40,416	6,132	126,718
730135	482800 - Clinical Social Worker	1	1	72,244	38,775	5,527	116,546
730136	482800 - Clinical Social Worker	1	1	67,627	23,224	5,174	96,025
730137	089260 - Administrative Srvcs Mngr I	1	1	61,302	36,512	4,688	102,502
730138	068510 - Blueprint Data Analyst	1	1	57,193	12,725	4,374	74,292
730139	034550 - HCR-HIT Integration Manager	1	1	95,749	43,862	7,326	146,937

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730140	458902 - Health Services Researcher	1	1	86,727	41,775	6,634	135,136
730141	501100 - DVHA Program Consultant	1	1	56,708	35,559	4,339	96,606
730142	464900 - DVHA Program & Oper Auditor	1	1	63,685	37,005	4,872	105,562
730143	464900 - DVHA Program & Oper Auditor	1	1	55,927	29,144	4,279	89,350
730144	495600 - Associate Prog Integrity Dir	1	1	73,720	39,082	5,640	118,442
730145	486300 - Clinical Util Rev Data Analyst	1	1	63,390	22,346	4,849	90,585
730146	486200 - Asst Dir of Blueprint for Hlth	1	1	73,720	16,145	5,639	95,504
730147	486200 - Asst Dir of Blueprint for Hlth	0.87	1	57,121	35,644	4,370	97,135
730170	550200 - Contracts & Grants Administrat	1	1	53,966	39,464	4,128	97,558
730171	464900 - DVHA Program & Oper Auditor	1	1	61,704	21,999	4,720	88,423
730172	480210 - DVHA Quality Assurance Mgr	1	1	65,414	22,766	5,004	93,184
730174	464900 - DVHA Program & Oper Auditor	1	1	68,070	31,657	5,207	104,934
730175	499700 - Medicaid Operations Adm	1	1	69,567	38,221	5,322	113,110
730176	498800 - Medicaid Fiscal Analyst	1	1	61,704	22,000	4,720	88,424

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730177	499700 - Medicaid Operations Adm	1	1	78,927	40,160	6,037	125,124
730178	004900 - Program Technician III	1	1	49,794	34,128	3,809	87,731
730180	735700 - Healthcare Eligib & Enorll Dir	1	1	86,726	41,973	6,635	135,334
730181	334100 - Audit Liaison/Int Control	1	1	57,192	30,270	4,376	91,838
730182	536900 - VHC Support Services Spec	1	1	53,124	20,221	4,064	77,409
730183	494000 - Exchange Project Director	1	1	97,498	44,002	7,460	148,960
730184	089080 - Financial Manager I	1	1	57,192	35,662	4,376	97,230
730185	464910 - DVHA Healthcare QC Auditor	1	1	57,761	35,777	4,418	97,956
730186	550200 - Contracts & Grants Administrat	1	1	55,928	12,464	4,278	72,670
730187	089240 - Administrative Srvcs Cord III	1	1	52,850	11,828	4,042	68,720
730188	089080 - Financial Manager I	1	1	59,384	36,116	4,544	100,044
730189	089090 - Financial Manager II	1	1	63,116	13,951	4,828	81,895
730190	536900 - VHC Support Services Spec	1	1	51,458	19,877	3,937	75,272
730192	000070 - Nurse Case Manager / URN I	1	1	77,210	25,208	5,907	108,324

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730193	000075 - Nurse Case Manager / URN II	1	1	100,261	38,321	7,669	146,251
730194	089230 - Administrative Srvcs Cord II	1	1	54,937	35,193	4,202	94,332
730195	503801 - Data Analytics & Info Admin	1	1	89,446	19,400	6,842	115,688
730197	090000 - Dir. of Integrated Health Care	1	1	91,427	19,811	6,995	118,233
730198	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	61,303	13,575	4,689	79,567
730199	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	74,268	39,195	5,681	119,144
730200	000086 - Nurse Administrator II	1	1	121,299	48,931	9,280	179,511
730201	000086 - Nurse Administrator II	1	1	107,816	46,140	8,247	162,202
730202	053100 - DVHA Data Anlyst and Info Chie	1	1	78,737	17,184	6,023	101,944
730204	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	69,967	38,306	5,353	113,626
730205	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	67,627	23,224	5,174	96,025
730206	499700 - Medicaid Operations Adm	1	1	60,755	31,005	4,648	96,408
730207	499700 - Medicaid Operations Adm	1	1	67,332	14,823	5,151	87,306
730208	454300 - DVHA Rate Setting Mang	1	1	92,060	36,623	7,043	135,726

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FY2020 Governor's Recommended Budget
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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730210	000070 - Nurse Case Manager / URN I	1	1	80,169	17,481	6,133	103,784
730211	501100 - DVHA Program Consultant	1	1	48,044	28,374	3,675	80,093
730212	464900 - DVHA Program & Oper Auditor	1	1	53,967	29,600	4,128	87,695
730213	501100 - DVHA Program Consultant	1	1	53,124	28,563	4,064	85,751
730214	089230 - Administrative Srvcs Cord II	1	1	53,124	20,224	4,064	77,412
730215	000070 - Nurse Case Manager / URN I	1	1	100,261	38,321	7,670	146,252
730216	000070 - Nurse Case Manager / URN I	1	1	97,530	37,756	7,460	142,744
730218	000070 - Nurse Case Manager / URN I	1	1	80,170	40,417	6,133	126,720
730219	537300 - DVHA Quality Improvement Admin	0.87	1	61,029	13,518	4,669	79,216
730222	089120 - Financial Manager III	1	1	67,184	23,136	5,140	95,460
730226	735800 - Healthcare Deputy Dir of Ops	1	1	73,382	33,619	5,614	112,615
730227	089130 - Financial Director I	1	1	97,498	31,035	7,459	135,992
730229	410300 - Workforce Management Coord II	1	1	57,761	35,778	4,419	97,958
730230	330310 - VHC Business Process Coord	1	1	63,116	13,950	4,829	81,895

State of Vermont

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Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730232	590200 - VHC Educ & Outreach Coord	1	1	61,303	23,540	4,689	89,532
730233	735800 - Healthcare Deputy Dir of Ops	1	1	106,985	45,968	8,184	161,137
730234	464910 - DVHA Healthcare QC Auditor	1	1	55,928	35,397	4,278	95,603
730235	089270 - Administrative Srvcs Mngr II	1	1	67,332	34,753	5,151	107,236
730236	087800 - Dir. VHC Customer Srv Center	1	1	71,400	24,003	5,462	100,865
730238	459800 - Health Program Administrator	1	1	61,703	36,592	4,720	103,015
730239	459800 - Health Program Administrator	1	1	55,927	20,802	4,279	81,008
730240	857200 - Communications & Outreach Coor	1	1	52,146	20,019	3,989	76,154
730241	463100 - Health Care Project Director	1	1	81,350	40,664	6,224	128,238
730242	977000 - Director of Payment Reform	1	1	98,954	31,566	7,570	138,090
730243	089090 - Financial Manager II	1	1	63,116	22,292	4,830	90,238
730244	442100 - Project Administrator Bluepri	1	1	65,413	31,111	5,005	101,529
730245	098300 - Quality Oversight Analyst II	1	1	78,736	17,186	6,024	101,946
730248	854000 - Senior Policy Advisor	1	1	57,192	29,408	4,376	90,976

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FY2020 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730249	854000 - Senior Policy Advisor	1	1	63,390	22,350	4,850	90,590
730251	464950 - Dir of Ops for ACO Programs	1	1	71,400	15,668	5,462	92,530
730252	533900 - Medicaid Provider Rel Oper Chf	1	1	72,244	38,776	5,526	116,546
730253	049601 - Grants Management Specialist	1	1	60,038	21,656	4,592	86,286
730254	048000 - Health Senior Policy Analyst	1	1	53,966	29,602	4,128	87,696
730255	735750 - Business Reporting Admin	1	1	65,160	22,713	4,985	92,858
730256	496600 - Grant Programs Manager	1	1	65,414	31,110	5,004	101,528
730257	857300 - Communications & Notices Mgr	1	1	63,116	36,886	4,829	104,831
730260	089090 - Financial Manager II	1	1	60,755	31,005	4,648	96,408
730261	208800 - Business Analyst	1	1	67,627	23,223	5,175	96,025
730263	089230 - Administrative Srvcs Cord II	1	1	49,792	34,130	3,810	87,732
730265	410300 - Workforce Management Coord II	1	1	61,703	36,592	4,720	103,015
730266	460550 - Oversight & Monitoring Dir	1	1	86,896	41,810	6,648	135,354
730267	089290 - Administrative Srvcs Dir I	1	1	81,372	40,664	6,224	128,260

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730268	089270 - Administrative Srvcs Mngr II	1	1	63,116	22,290	4,829	90,235
730271	089280 - Administrative Srvcs Mngr III	1	1	73,994	32,882	5,661	112,537
730272	501100 - DVHA Program Consultant	1	1	54,936	20,600	4,202	79,738
730273	513410 - Health Care Train/Commun Mngr	1	1	76,524	33,406	5,854	115,784
730275	089220 - Administrative Srvcs Cord I	1	1	45,450	33,232	3,478	82,160
730276	089280 - Administrative Srvcs Mngr III	1	1	73,994	39,140	5,660	118,794
730277	499700 - Medicaid Operations Adm	1	1	60,755	30,143	4,648	95,546
730278	501100 - DVHA Program Consultant	1	1	49,793	19,534	3,810	73,137
730279	501100 - DVHA Program Consultant	1	1	51,458	11,540	3,936	66,934
730280	501100 - DVHA Program Consultant	1	1	48,043	28,372	3,676	80,091
730281	501100 - DVHA Program Consultant	1	1	48,043	28,373	3,675	80,091
730282	464920 - DVHA Quality Control Manager	1	1	65,160	37,310	4,984	107,454
730283	501100 - DVHA Program Consultant	1	1	58,604	35,952	4,482	99,038
730284	148400 - Senior Autism Specialist	1	1	74,268	24,598	5,682	104,548

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730286	499700 - Medicaid Operations Adm	0.89	1	63,222	36,908	4,837	104,967
730287	442100 - Project Administrator Bluepri	1	1	59,384	33,112	4,543	97,039
730288	463150 - Health Care Director	1	1	89,656	27,992	6,858	124,506
730289	735200 - Benefits Program Mentor	1	1	54,473	35,097	4,169	93,739
730290	735100 - VT Healthcare Service Spec II	1	1	53,124	11,880	4,064	69,068
730291	735100 - VT Healthcare Service Spec II	1	1	49,793	34,126	3,809	87,728
730292	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730293	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730294	735110 - VT Healthcare Service Spec III	1	1	54,473	20,501	4,169	79,143
730295	735100 - VT Healthcare Service Spec II	1	1	53,124	21,847	4,064	79,035
730296	735100 - VT Healthcare Service Spec II	1	1	49,793	27,871	3,809	81,473
730297	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730298	735000 - VT Healthcare Service Spec I	1	1	45,451	27,836	3,476	76,763
730299	735000 - VT Healthcare Service Spec I	1	1	48,591	19,282	3,718	71,591

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730300	480210 - DVHA Quality Assurance Mgr	1	1	59,384	29,858	4,542	93,784
730301	460570 - Program Integrity Analyst	1	1	57,192	30,267	4,375	91,834
730302	735100 - VT Healthcare Service Spec II	1	1	53,124	34,816	4,064	92,004
730303	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730304	735000 - VT Healthcare Service Spec I	1	1	47,073	10,628	3,601	61,302
730305	735000 - VT Healthcare Service Spec I	1	1	48,591	27,623	3,718	79,932
730306	735100 - VT Healthcare Service Spec II	1	1	49,793	19,530	3,809	73,132
730307	735100 - VT Healthcare Service Spec II	1	1	49,793	19,530	3,809	73,132
730308	735000 - VT Healthcare Service Spec I	1	1	47,073	33,564	3,601	84,238
730309	735100 - VT Healthcare Service Spec II	1	1	49,793	11,190	3,809	64,792
730310	735000 - VT Healthcare Service Spec I	1	1	45,451	18,633	3,476	67,560
730311	208800 - Business Analyst	1	1	59,384	36,113	4,542	100,039
730312	330320 - Knowledge Management Sys Admin	1	1	53,967	29,598	4,128	87,693
730313	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730314	735100 - VT Healthcare Service Spec II	1	1	49,793	19,530	3,809	73,132
730315	735000 - VT Healthcare Service Spec I	1	1	49,130	19,394	3,758	72,282
730316	735000 - VT Healthcare Service Spec I	1	1	45,451	27,836	3,476	76,763
730317	735000 - VT Healthcare Service Spec I	1	1	47,073	10,628	3,601	61,302
730318	735110 - VT Healthcare Service Spec III	1	1	54,473	12,161	4,169	70,803
730319	735000 - VT Healthcare Service Spec I	1	1	45,451	20,260	3,476	69,187
730320	735000 - VT Healthcare Service Spec I	1	1	47,073	18,968	3,601	69,642
730321	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730322	735100 - VT Healthcare Service Spec II	1	1	51,458	19,877	3,937	75,272
730323	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730324	735000 - VT Healthcare Service Spec I	1	1	48,591	27,623	3,718	79,932
730325	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730326	735110 - VT Healthcare Service Spec III	1	1	54,473	35,097	4,169	93,739
730327	735110 - VT Healthcare Service Spec III	1	1	50,847	28,952	3,888	83,687

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730328	735200 - Benefits Program Mentor	1	1	52,849	34,761	4,043	91,653
730329	735200 - Benefits Program Mentor	1	1	56,265	20,870	4,305	81,440
730330	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730331	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730332	735200 - Benefits Program Mentor	1	1	52,849	28,506	4,043	85,398
730333	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730334	735000 - VT Healthcare Service Spec I	1	1	45,451	18,633	3,476	67,560
730335	735100 - VT Healthcare Service Spec II	1	1	53,124	28,561	4,064	85,749
730336	735110 - VT Healthcare Service Spec III	1	1	52,849	20,165	4,043	77,057
730337	735200 - Benefits Program Mentor	1	1	54,473	12,161	4,169	70,803
730338	735100 - VT Healthcare Service Spec II	1	1	51,458	28,218	3,937	83,613
730339	735110 - VT Healthcare Service Spec III	1	1	54,473	20,501	4,169	79,143
730340	536900 - VHC Support Services Spec	1	1	49,793	19,530	3,809	73,132
730341	459800 - Health Program Administrator	1	1	57,761	21,182	4,419	83,362

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730342	735300 - Fair Hearing Specialist	1	1	50,847	28,952	3,888	83,687
730343	536900 - VHC Support Services Spec	1	1	51,458	21,504	3,937	76,899
730344	004700 - Program Technician I	1	1	38,682	17,232	2,958	58,872
730345	735000 - VT Healthcare Service Spec I	1	1	47,073	10,628	3,601	61,302
730346	536900 - VHC Support Services Spec	1	1	51,458	11,537	3,937	66,932
730347	735000 - VT Healthcare Service Spec I	1	1	49,130	27,735	3,758	80,623
730348	536900 - VHC Support Services Spec	1	1	51,458	11,537	3,937	66,932
730349	735100 - VT Healthcare Service Spec II	1	1	49,793	11,190	3,809	64,792
730350	089220 - Administrative Srvcs Cord I	1	1	45,451	18,633	3,476	67,560
730352	735200 - Benefits Program Mentor	1	1	62,146	36,688	4,756	103,590
730353	513700 - Benefits Programs Specialist	1	1	65,836	31,198	5,036	102,070
730354	735100 - VT Healthcare Service Spec II	0.9	1	42,498	9,684	3,250	55,432
730355	503400 - Benefits Progrms Administrator	1	1	94,611	37,151	7,238	139,000
730356	513700 - Benefits Programs Specialist	1	1	56,708	35,562	4,338	96,608

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730357	513700 - Benefits Programs Specialist	1	1	53,124	20,224	4,064	77,412
730358	513700 - Benefits Programs Specialist	1	1	53,124	34,820	4,064	92,008
730359	459900 - ESD Health Care Elig Dir	1	1	92,672	28,626	7,090	128,388
730360	735500 - Healthcare Assistant Admin II	1	1	69,567	38,221	5,321	113,109
730361	464920 - DVHA Quality Control Manager	1	1	71,844	38,692	5,496	116,032
730362	513700 - Benefits Programs Specialist	1	1	62,231	22,107	4,760	89,098
730363	513700 - Benefits Programs Specialist	1	1	60,480	36,344	4,626	101,450
730364	735200 - Benefits Program Mentor	1	1	69,694	38,250	5,330	113,274
730365	503400 - Benefits Progrms Administrator	1	1	81,372	40,664	6,224	128,260
730366	503400 - Benefits Progrms Administrator	1	1	92,060	19,942	7,043	119,045
730367	513700 - Benefits Programs Specialist	1	1	56,708	29,308	4,338	90,354
730368	513700 - Benefits Programs Specialist	1	1	69,608	31,978	5,326	106,912
730369	513700 - Benefits Programs Specialist	1	1	54,936	35,196	4,202	94,334
730370	735510 - Healthcare Assistant Admin I	1	1	65,878	22,861	5,039	93,778

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730371	513700 - Benefits Programs Specialist	1	1	56,708	12,626	4,338	73,672
730372	513700 - Benefits Programs Specialist	1	1	48,044	28,376	3,674	80,094
730373	513700 - Benefits Programs Specialist	1	1	53,124	11,884	4,064	69,072
730374	513700 - Benefits Programs Specialist	1	1	54,936	28,942	4,202	88,080
730375	735510 - Healthcare Assistant Admin I	1	1	63,685	37,004	4,873	105,562
730377	735500 - Healthcare Assistant Admin II	1	1	74,268	39,198	5,680	119,146
730378	501200 - Economic Services Supervisor	1	1	65,414	22,768	5,004	93,186
730379	735500 - Healthcare Assistant Admin II	1	1	69,567	15,285	5,321	90,173
730380	050200 - Administrative Assistant B	1	1	42,288	9,640	3,236	55,164
730381	464910 - DVHA Healthcare QC Auditor	1	1	57,761	21,180	4,418	83,359
730382	735500 - Healthcare Assistant Admin II	1	1	69,566	38,224	5,322	113,112
730383	513700 - Benefits Programs Specialist	1	1	53,124	34,820	4,064	92,008
730384	513700 - Benefits Programs Specialist	1	1	53,124	20,224	4,064	77,412
730385	501200 - Economic Services Supervisor	1	1	72,244	32,524	5,528	110,296

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730386	513400 - Healthcare Training/Curr Coord	1	1	52,849	20,165	4,043	77,057
730387	735710 - Eligib & Enorll Data Director	1	1	84,049	28,249	6,430	118,728
730388	503400 - Benefits Progrms Administrator	1	1	92,060	28,284	7,042	127,386
730389	735500 - Healthcare Assistant Admin II	1	1	65,160	22,713	4,985	92,858
730390	735500 - Healthcare Assistant Admin II	1	1	63,116	22,290	4,829	90,235
730391	735510 - Healthcare Assistant Admin I	1	1	60,485	13,405	4,628	78,518
730392	735510 - Healthcare Assistant Admin I	1	1	57,761	12,842	4,419	75,022
730393	735510 - Healthcare Assistant Admin I	1	1	53,967	29,598	4,128	87,693
730394	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730395	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730396	735100 - VT Healthcare Service Spec II	1	1	53,124	34,816	4,064	92,004
730397	089280 - Administrative Srvcs Mngr III	1	1	64,633	31,807	4,943	101,383
730398	735110 - VT Healthcare Service Spec III	1	1	54,473	12,161	4,169	70,803
730399	735100 - VT Healthcare Service Spec II	1	1	53,124	28,561	4,064	85,749

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730400	459800 - Health Program Administrator	1	1	57,761	40,247	4,419	102,427
730401	735200 - Benefits Program Mentor	1	1	56,265	20,870	4,305	81,440
730402	735400 - VT Healthcare Srvc Supervisor	1	1	61,303	30,254	4,689	96,246
730403	735200 - Benefits Program Mentor	1	1	65,961	37,474	5,047	108,482
730404	735200 - Benefits Program Mentor	1	1	60,039	36,249	4,592	100,880
730405	735000 - VT Healthcare Service Spec I	1	1	50,215	34,215	3,841	88,271
730406	735400 - VT Healthcare Srvc Supervisor	1	1	63,391	14,006	4,849	82,246
730407	735400 - VT Healthcare Srvc Supervisor	1	1	63,391	14,006	4,849	82,246
730408	735400 - VT Healthcare Srvc Supervisor	1	1	57,192	30,267	4,375	91,834
730409	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730410	735110 - VT Healthcare Service Spec III	1	1	54,473	28,842	4,169	87,484
730411	735200 - Benefits Program Mentor	1	1	64,043	22,481	4,899	91,423
730412	735100 - VT Healthcare Service Spec II	1	1	62,230	22,107	4,760	89,097
730413	735110 - VT Healthcare Service Spec III	1	1	54,473	20,501	4,169	79,143

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730414	735100 - VT Healthcare Service Spec II	1	1	51,458	34,473	3,937	89,868
730415	735600 - Healthcare Call Center Dir	1	1	73,719	32,826	5,639	112,184
730416	735000 - VT Healthcare Service Spec I	1	1	54,205	20,444	4,145	78,794
730417	735100 - VT Healthcare Service Spec II	1	1	54,936	20,597	4,203	79,736
730419	089420 - Administrative Srvcs Dir IV	1	1	105,889	39,730	8,101	153,720
730420	735100 - VT Healthcare Service Spec II	1	1	49,792	19,534	3,810	73,136
730421	735400 - VT Healthcare Srvc Supervisor	1	1	65,415	31,107	5,004	101,526
730422	735400 - VT Healthcare Srvc Supervisor	1	1	69,967	38,303	5,354	113,624
730423	735100 - VT Healthcare Service Spec II	1	1	53,124	11,880	4,064	69,068
730424	089230 - Administrative Srvcs Cord II	1	1	54,936	28,938	4,203	88,077
730425	735200 - Benefits Program Mentor	1	1	58,078	35,842	4,444	98,364
730426	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730427	735100 - VT Healthcare Service Spec II	1	1	54,936	35,193	4,203	94,332
730428	735400 - VT Healthcare Srvc Supervisor	1	1	63,391	22,346	4,849	90,586

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730429	735100 - VT Healthcare Service Spec II	1	1	53,124	20,220	4,064	77,408
730430	735100 - VT Healthcare Service Spec II	1	1	53,124	34,816	4,064	92,004
730431	735100 - VT Healthcare Service Spec II	1	1	49,793	19,530	3,809	73,132
730432	208800 - Business Analyst	1	1	59,384	21,517	4,542	85,443
730433	735400 - VT Healthcare Srvc Supervisor	1	1	61,303	36,509	4,689	102,501
730434	735100 - VT Healthcare Service Spec II	1	1	49,793	19,530	3,809	73,132
730435	735100 - VT Healthcare Service Spec II	1	1	48,043	28,372	3,676	80,091
730436	536900 - VHC Support Services Spec	1	1	49,793	11,190	3,809	64,792
730437	735300 - Fair Hearing Specialist	1	1	52,849	21,792	4,043	78,684
730438	735100 - VT Healthcare Service Spec II	1	1	49,793	27,871	3,809	81,473
730439	536900 - VHC Support Services Spec	1	1	51,458	19,877	3,937	75,272
730440	735100 - VT Healthcare Service Spec II	1	1	49,793	19,530	3,809	73,132
730441	735110 - VT Healthcare Service Spec III	1	1	54,473	12,161	4,169	70,803
730442	735200 - Benefits Program Mentor	1	1	50,847	28,952	3,888	83,687

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730443	735300 - Fair Hearing Specialist	1	1	54,473	20,501	4,169	79,143
730444	735300 - Fair Hearing Specialist	1	1	54,473	20,501	4,169	79,143
730445	513400 - Healthcare Training/Curr Coord	1	1	56,265	20,870	4,305	81,440
730446	735300 - Fair Hearing Specialist	1	1	50,847	19,749	3,888	74,484
730447	735300 - Fair Hearing Specialist	1	1	64,043	37,077	4,899	106,019
730448	464900 - DVHA Program & Oper Auditor	1	1	57,761	21,181	4,418	83,360
730449	048500 - Hlth AccessPolicy & Plng Chief	1	1	69,355	38,177	5,306	112,838
730450	454200 - Dir Healthcare Policy&Planning	1	1	92,692	43,222	7,091	143,005
730451	735500 - Healthcare Assistant Admin II	1	1	83,523	34,855	6,390	124,768
730452	501100 - DVHA Program Consultant	1	1	53,124	34,817	4,064	92,005
730453	081550 - Appeals Manager	1	1	71,843	38,692	5,496	116,031
730454	735500 - Healthcare Assistant Admin II	1	1	63,116	30,632	4,828	98,576
730455	735500 - Healthcare Assistant Admin II	1	1	71,843	38,694	5,496	116,033
730487	098400 - Quality Oversight Analyst I	1	1	64,633	31,807	4,945	101,385

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730488	018100 - Change Management Director	1	1	73,382	33,619	5,614	112,615
730489	497901 - Health Reform Portfo Dir II	1	1	78,231	34,623	5,984	118,838
730490	089250 - Administrative Srvcs Cord IV	1	1	53,967	29,599	4,128	87,694
737001	95010E - Executive Director	1	1	137,862	52,678	10,239	200,779
737002	90120A - Commissioner	1	1	128,752	50,772	9,848	189,372
737003	90570D - Deputy Commissioner	1	1	104,000	45,591	7,956	157,547
737004	90570D - Deputy Commissioner	1	1	102,254	45,226	7,822	155,302
737006	91590E - Private Secretary	1	1	173,826	53,954	10,760	238,540
737008	95867E - Staff Attorney II	1	1	63,960	16,872	4,894	85,726
737014	95866E - Staff Attorney I	1	1	53,394	24,812	4,084	82,290
737015	95866E - Staff Attorney I	1	1	53,830	35,090	4,118	93,038
737016	95870E - General Counsel I	1	1	90,002	11,644	6,886	108,532
737017	95360E - Principal Assistant	1	1	125,008	27,054	9,562	161,624
737028	95868E - Staff Attorney III	1	1	0	18,430	0	18,430

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
737036	95867E - Staff Attorney II	1	1	61,798	18,238	4,728	84,764
737037	95868E - Staff Attorney III	1	1	80,122	25,995	6,129	112,246
737038	95868E - Staff Attorney III	1	1	80,122	34,336	6,129	120,587
737100	96700E - Director Blueprint for Health	1	1	109,971	30,714	8,413	149,098
Total		**377.33**	**380**	**24,848,807**	**10,703,517**	**1,897,998**	**37,450,317**

Fund Code	Fund Name	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
10000	General Fund	141.47	8	9,228,608	3,970,989	703,045	13,902,643
20405	Global Commitment Fund	6.12	9	492,251	189,831	37,657	719,739
21500	Inter-Unit Transfers Fund	6.79		389,659	176,735	29,824	596,218
21916	Vermont Health IT Fund	0.5		37,554	17,620	2,873	58,047
22005	Federal Revenue Fund	222.45	363	14,700,735	6,348,342	1,124,599	22,173,670
Total		**377.33**	**380**	**24,848,807**	**10,703,517**	**1,897,998**	**37,450,317**

Note: Numbers may not sum to total due to rounding.

Report ID:	VTPB-24 EST_FED_RECEIPTS

State of Vermont
FY2020 Governor's Recommended Budget
Federal - Receipts Detail Report

Department: 3410010000 - Department of Vermont health access - administration

Budget Request Code	Fund	Justification	Est Amount
8929	22005	CFDA 93.778	$124,749,165
		Total	**$124,749,165**

State of Vermont
FY2020 Governor's Recommended Budget
Federal - Receipts Detail Report

Department: 3410018000 - DVHA-Medicaid/non-waiver matched programs

Budget Request Code	Fund	Justification	Est Amount
8930	22005	CFDA 93-767	$7,632,785
8930	22005	CFDA 93-778	$13,377,242
		Total	**$21,010,027**

Report ID:	VTPB-23 IDT_RECEIPTS

State of Vermont
FY2020 Governor's Recommended Budget
Interdepartmental Transfers Inventory Report

Department: 3410010000 - Department of Vermont health access - administration

Budget Request Code	Fund	Justification	Est Amount
8928	21500	ADAP 3420060000	$441,500
8928	21500	IE 3400991601	$4,198,227
8928	21500	VHC Sust. 3400004000	$2,902,875
		Total	**7,542,602**

Report ID:	VTPB-28 GRANTS_INVENTOR`

State of Vermont
FY2020 Governor's Recommended Budget
Grants Out Inventory Report

Department: 3410016000 - DVHA-Medicaid/long term care waiver

Budget Request Code	Fund	Justification	Est Amount
9163	20405	Choices For Care	$211,888,529
		Total	**211,888,529**

State of Vermont
FY2020 Governor's Recommended Budget
Grants Out Inventory Report

Department: 3410017000 - DVHA- Medicaid/state only programs

Budget Request Code	Fund	Justification	Est Amount
9162	10000	G.F. State Only	$37,605,920
9162	20405	GC Investments	$11,605,638
		Total	**49,211,558**

Report ID:	VTPB-28 GRANTS_INVENTOR`

State of Vermont
FY2020 Governor's Recommended Budget
Grants Out Inventory Report

Department: 3410018000 - DVHA-Medicaid/non-waiver matched programs

Budget Request Code	Fund	Justification	Est Amount
9161	10000	G.F. Non-Waiver	$11,425,047
9161	22005	Federal Non-Waiver	$21,010,027
		Total	**32,435,074**

Report ID:	VTPB-28 GRANTS_INVENTOR`

State of Vermont
FY2020 Governor's Recommended Budget
Grants Out Inventory Report

Department: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Request Code	Fund	Justification	Est Amount
9160	20405	GC Program	$734,200,632
		Total	**734,200,632**

Report ID:	VTPB-28 GRANTS_INVENTOR

State of Vermont
FY2020 Governor's Recommended Budget
Grants Out Inventory Report

Department: 3410010000 - Department of Vermont health access - administration

Budget Request Code	Fund	Justification	Est Amount
8927	10000	Blueprint Grants	$25,099
8927	10000	Navigator Grant	$22,101
8927	20405	Blueprint Grants	$1,822,192
8927	21500	Blueprint Grants	$441,500
8927	21500	Navigator Grant	$348,796
8927	21916	HIT Grant	$169,515
8927	22005	Blueprint Grants	$410,099
8927	22005	EHRIP	$3,979,872
8927	22005	HIT Grant	$35,485
8927	22005	Navigator Grant	$60,064
		Total	**7,314,723**

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Acronyms

| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z |

A

A/R..... Accounts Receivable

AAA ..... Area Agencies on Aging

AAG..... Assistant Attorney General

AAP ..... Adults' Access to Preventative/Ambulatory Health Services

ABA..... Applied Behavior Analysis

ABD..... Aged Blind and Disabled

ACA..... Affordable Care Act

ACCESS..... Legacy Eligibility System

ACH ..... Automated Clearing House

ACO..... Accountable Care Organization

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

AD..... Active Directory

ADAP..... Alcohol and Drug Abuse Programs

ADD ..... Attention deficit disorder

ADS ..... Agency of Digital Services

AEP ..... Annual Enrollment Period

AG..... Attorney General

AGO ..... Office of the Attorney General

AHS..... Agency of Human Services

AHSCO ..... Agency of Human Services Central Office

AIDS..... Acquired Immune Deficiency Syndrome

ALS..... Advanced Life Support

AMA..... American Medical Association

AMH ..... Adult Mental Health Division

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

AOA..... Agency of Administration

AOE ..... Agency of Education

AOEP.....Annual Open Enrollment Period

AOPS.....Assistant Operations Unit

APA .....Administrative Procedures Act

AP/AR.....Accounts Payable/Accounts Receivable

APD.....Advanced Planning Document

APDU .....Advance Planning Document Update

APM .....All Payer Model

APTC.....Advanced Premium Tax Credit

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

ASA.....Average Speed of Answer

ASAP.....As-Soon-As-Possible

B

BA.....Business Analyst
BAA.....Budget Adjustment Act
BAFO.....Best and Final Offer
BC/BS.....Blue Cross/Blue Shield
BCBSVT.....Blue Cross/Blue Shield of Vermont
BCCT Breast & Cervical Cancer Treatment
BCS.....Breast Cancer Screening
BD.....Blind & Disabled
BFIU.....Member Healthcare Fraud Investigative Unit
BGS.....Building and General Services
BIPA.....Benefits Improvement and Protection Act
BO.....Business Office
BP .....Blueprint
BPFH.....Blueprint for Health

C

CAC.....Certified Application Counselors
CAFR.....Comprehensive Annual Financial Report
CAH.....Critical Access Hospital
CAP.....Corrective Action Plan
CC.....Chronic Care
CFC.....Choices for Care
CFR.....Code of Federal Regulations
CHAC.....Community Health Accountability Care
CHC.....Change Healthcare
CHIP.....Children's Health Insurance Program
CHL.....Chlamydia Screening in Women
CHT.....Community Health Team

CIS.....Children's Integrated Services
CLD.....Claim Level Detail
CMC.....Case Manager Conference
CMH.....Children's Mental Health Division
CMHC.....Community Mental Health Center
CMMI.....Center for Medicare and Medicaid Innovation
CMS.....Centers for Medicare & Medicaid Services
CO.....Compliance officer
COB.....Coordination of Benefits
COBRA.....Consolidated Omnibus Reconciliation Act of 1986 (health coverage)
COLA.....Cost of Living Adjustment
CON.....Certificate of Need
COPD.....Chronic Obstructive Pulmonary Disease
CORF.....Comprehensive Outpatient Rehabilitation Facilities
COS.....Category of Service
COS.....Cost of Service
COU.....Clinical Operations Unit
CPAP.....Continuous Positive Airway Pressure
CPT.....Common Procedural Terminology
CR.....Capped Rental
CSHN.....Children with Special Health Needs
CSR.....Cost Sharing Reductions
CVH.....Central Vermont Hospital
CY.....Calendar Year

D

DA.....Designated Agency
DAIL.....Department of Disabilities, Aging & Independent Living
DCF.....Department for Children & Families
DCF BO.....Department for Children and Families Business Office
DD.....Developmental Disabilities
DD HCBS.....Developmental Disability Home and Community Based Services
DDI.....Design, Development & Implementation
DDS.....Developmental Disability Services
DEA.....Drug Enforcement Administration
DFCU.....DVHA Fiscal Compliance Unit
DHHS.....Department of Health & 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 & Innovation
DME.....Durable Medical Equipment
DMEPOS.....Durable Medical Equipment Prosthetics, Orthotics, and Supplies
DMH.....Department of Mental Health
DOB.....Date of Birth

DOC.....Department of Corrections
DOS.....Date of Service
DRA.....Deficit Reduction Act
DR. D.....Dr. Dynasaur Program
DRG.....Diagnosis Related Grouping
DS.....Developmental Services
DS.....Day Supply
DSH.....Disproportionate Share Hospital
DSHP.....Designated State Health Plan
DSR.....Delivery System Reform
DUR.....Drug Utilization Review (Board)
DVHA.....Department of Vermont Health Access

E

E&E.....Eligibility & Enrollment (Funding for more than IE)
EA.....Emergency Assistance
EA.....Enterprise Architecture
EA.....Economic Assistance
eAVS.....Electronic Asset Verification System
ECS.....Electronic Claims Submission
ED.....Emergency Department
EDI.....Electronic Data Interchange
EFT.....Electronic Funds Transfer
EFT.....Enhanced Family Treatment
EHR.....Electronic Health Record
EHRIP.....Electronic Health Record Incentive Program
EMS.....Emergency Medical Services
EOB.....Explanation of Benefits
EOMB.....Explanation of Medicare (or Medicaid) Benefits
EPCP.....Enhanced Primary Care Payment
EPMO.....Enterprise Project Management Office
EPSDT.....Early & Periodic Screening, Diagnosis & Treatment
EQR.....External Quality Review
EQRO.....External Quality Review Organization
ER.....Emergency Room
ERA.....Electronic Remittance Advice
ERC.....Enhanced Residential Care
ESD.....Economic Services Division (part of DCF)
ESI.....Employer Sponsored Insurance
ESIA.....Employer Sponsored Insurance Assistance
ESRD.....End Stage Renal Disease
EVAH.....Enhanced Vermont Ad Hoc (query & reporting system)
EVS.....Eligibility Verification System
EVV.....Electronic Visit Verification

F

FA ..... Fiscal Agent
FADS..... Fraud, Abuse & Detection System
FAQ..... Frequently Asked Questions
FBR ..... Fiscal Budget Report
FCR ..... Federal Case Registry
FDA..... Food & Drug Administration
FED..... Front End Deductible
FEIN..... Federal Employer's Identification Number
FEMA..... Federal Emergency Management Administration
FFP..... Federal Financial Participation
FFS ..... Fee for Service
FFY..... Federal Fiscal Year
FH..... Fair Hearing
FHU ..... Fair Hearing Unit
FI..... Fiscal Intermediary
FICA..... Federal Insurance Contribution Act
FITP..... Family, Infant and Toddler Program
FMAP..... Federal Medical Assistance Percentage
FOA..... Funding Opportunity Announcement
FPL..... Federal Poverty Level
FPP..... Fixed Prospective Payment
FQHC..... Federally Qualified Health Center
FSA ..... Flexible Spending Account
FSD..... Family Services Division
FTE ..... Full Time Equivalent
FUL ..... Federal Upper Limit (for pricing & payment of drug claims)
FYE ..... Fiscal Year End

G

G/L..... General Ledger
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
GCH..... Global Commitment to Health
GCR..... Global Commitment Register
GEP..... General Enrollment Period
GF ..... General Fund
GMC..... Green Mountain Care
GMCB..... Green Mountain Care Board
GME..... Graduate Medical Education

H

HAEEU ..... Health Access Eligibility and Enrollment Unit

HB ..... Home-based
HBE ..... Health Benefit Exchange
HBEE Rule ... Health Benefits Eligibility and Enrollment Rule
HBKF ..... Healthy Babies, Kids and Families
HCAT ..... Health Care Appeals Team
HCBS ..... Home & Community Based Services
HCPCS ..... Healthcare Common Procedure Coding System
HCQC ..... HealthCare Quality Control Unit
HCR ..... Healthcare Reform
HEDIS ..... Health Plan Employer Data and Information Set
HEDIS ..... Healthcare Effectiveness Data & Information Set
HEPO ..... Healthcare Eligibility Policy and Operations
HHA ..... Home Health Agency
HHS ..... Health & Human Services (U.S. Department of)
HIE ..... Health Information Exchange
HIM ..... Health Insurance Marketplace
HIMSS ..... Healthcare Information Management Systems Society
HIN ..... Health Information Network
HIPAA ..... Health Insurance Portability & Accountability Act
HIPP ..... Health Insurance Premium Program
HIT ..... Health Information Technology
HITECH ..... HIT for Economic & Clinical Health
HIV ..... Human Immunodeficiency Virus
HPE ..... Hewlett-Packard Enterprise Services
HR ..... Health Reform
HRA ..... Health Reimbursement Account
HRA ..... Health Risk Assessment
HSB ..... Human Services Board
HVP ..... Healthy Vermonters Program

I

IAPD ..... Implementation Advance Planning Document
IAPDU ..... Implementation Advanced Planning Document Update
IBNR ..... Incurred but Not Reported
ICD ..... International Classification of Diseases (diagnosis codes & surgical codes)
ICD-9 ..... ICD 9th Edition (prior version)-clinical modification
ICD-10 ..... ICD 10th Edition (current version)-clinical modification
ICF ..... Intermediate Care Facility
ICF/DD ..... Intermediate Care Facility for people with Developmental Disabilities
ICF/MR ..... Intermediate Care Facilities for Mentally Retarded
ICN ..... Internal Control Number
ICU ..... Intensive Care Unit
ID ..... Identification
IDT ..... Interdepartmental Transfer
IDTF ..... Independent Diagnostic Testing Facilities

IE&E ..... Integrated Eligibility and Enrollment
IEP ..... Initial Enrollment Period
IET ..... Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IFS ..... Integrating Family Services
IFSP..... Individual Family Services Plan
IG ..... Inspector General
IL..... Independent Living
ILA..... Independent Living Assessment
IMD..... Institute for Mental Disease
INS ..... Immigration and Naturalization Service
IP..... Internet Protocol
IPA..... In-Person Assister
IPPS..... Inpatient Prospective Payment System
IRS..... Internal Revenue Service
ISAP ..... Intense Substance Abuse Program
IT ..... Information Technology
IV-A..... Title IV-A of the Social Security Act governing TANF programs (Temporary Assistance to Needy Families)
IV-D ..... Title IV-D of the Social Security Act governing child support program
IV E..... Title of the Social Security Act governing foster care
IV&V..... Independent Verification and Validation

J

JFO ..... Joint Fiscal Office
JR ..... Judicial Review

K

KPI..... Key Performance Indicator

L

LAMP ..... Legal Aid Medicaid Project
LARC..... Long Acting Reversible Contraception
LOC..... Level of Care
LOS ..... Length of Stay
LTC..... Long-Term Care

M

M&O..... Maintenance and Operations
MA..... Medicare Advantage (Medicare Part C in Vermont)
MA..... Medical Assistance
MAB..... Medicaid Advisory Board
MABD ..... Medicaid for the Aged, Blind, and Disabled
MACRA..... Medicare Access and CHIP Reauthorization Act
MACU..... Medicaid Audit & Compliance Unit
MAGI..... Modified Adjusted Gross Income (expanded Medicaid)
MAP ..... Medical Audit Program
MAPIR ..... Medicaid Assistance Provider Incentive Repository

MARS.....Management & Administrative Reporting System
MAT.....Medication Assisted Therapy
MCA.....Medicaid for Children and Adults
MCO.....Managed Care Organization
MCP.....Managed Care Plan
MEAB.....Medicaid & Exchange Advisory Board
MEC.....Minimum Essential Coverage
MECT.....Medicaid Enterprise Certification Toolkit
MEG.....Medicaid Eligibility Group
MED.....Mental or emotional disturbance (or disorder)
MEI.....Medicare Economic Index
MEQC.....Medicaid Eligibility Quality Control
MES.....Medicaid Enterprise Solution
MFCU.....Medicaid Fraud & Control Unit
MFP.....Money Follows the Person (DAIL)
MFRAU.....Medicaid Fraud & Residential Abuse Unit
MFS.....Medical Fee Schedule
MFT.....Managed File Transfer
MH.....Mental Health
MHSA.....Mental Health and Substance Abuse
MI.....Mental Illness
MID.....Medicaid Identification Number (for member, see UID)
MIS.....Management Information System
MITA.....Medicaid Information Technology Architecture
MMA.....Medicare Modernization Act
MMIS.....Medicaid Management Information System
MOMS.....Medicaid Obstetrical and Maternal Supports
MOU.....Memorandum of Understanding
MPU.....Medicaid Policy Unit
MSIS.....Medicaid Statistical Information System
MSP.....Medicare Savings Programs
MSRP.....Manufacturer's Suggested Retail Price
MU.....Meaningful Use
MUA.....Medically Underserved Areas
MVP.....MVP Health Care

N

NCCI.....National Correct Coding Initiative
NCQA.....National Committee for Quality Assurance
NDC.....National Drug Code
NEDD.....Northeast Delta Dental
NEMT.....Non-Emergency Medical Transportation
NESCSO.....New England States Consortium Systems Organization
NF.....Nursing Facility
NH.....Nursing Home

NICU ..... Neonatal Intensive Care Unit
NIMH ..... National Institute of Mental Health
NOD ..... Notice of Decision
NP ..... Naturopathic Physician
NP ..... Nurse Practitioner
NPF ..... National Provider File
NPI ..... National Provider Identifier
NPRM ..... Notice of Proposed Rulemaking
NQF ..... National Quality Forum
NSF ..... Non-Sufficient Funds

O

OADAP ..... Office of Alcohol & Drug Abuse Programs
OBOT ..... Office-Based Opioid Treatment
OEP ..... Open Enrollment Period
O&E ..... Outreach and Education
OIG ..... Office of the Inspector General
O&M ..... Oversight and Monitoring
OPPS ..... Outpatient Prospective Payment System
OPS ..... Operations
OS ..... Ostomy, Tracheostomy, and Urological Items
OSHA ..... Occupational Safety & Health Administration
OTC ..... Over the Counter
OTP ..... Opioid Treatment Programs
OUD ..... Opioid Use Disorder

P

PA ..... Payment Authorization
PA ..... Physician Assistant
PA ..... Prior Authorization
PA ..... Public Assistance
PAC ..... Procedure Action Code
PACU ..... Provider Audit & Compliance Unit
PAD ..... Physician-Administered Drug
PAPD ..... Planning Advanced Planning Document (CMS)
PARIS ..... Public Assistance Reporting Information System
PATH ..... Prevention, Assistance, Transition and Health Access
PBM ..... Pharmacy Benefit Management
PBMS ..... Pharmacy Benefits Management System
PBR ..... Medicaid Policy, Budget, and Reimbursement
PC Plus ..... Primary Care Plus (Vermont Program)
PCA ..... Personal Care Attendant
PCA ..... Primary Care Association
PCCM ..... Primary Care Case Management
PCMH ..... Patient-Centered Medical Home
PCM ..... Pharmacy Cost Management

PCN.....Primary Care Network
PCP.....Primary Care Provider
PCS.....Procedure Coding System
PDL.....Preferred Drug List
PDP.....Prescription Drug Plan
PDP.....Pharmacy Drug Plan
PDP.....Medicare Part D Prescription Drug Plan
PDP.....Pharmacy Discount Program
PDSA.....Plan-Do-Study-Act
PE.....Presumptive Eligibility
PERM.....Payment Error Rate Measurement
PES.....Provider Electronic Solutions
PHC.....Personalized Healthcare
PHI.....Protected Health Information
PHR.....Personal Health Record
PI.....Program Integrity
PIDL.....Physician Injectable Drug List
PIE.....Payer Initiated Eligibility
PIHP.....Prepaid Inpatient Hospital Plan
PII.....Personally Identifiable Information
PIL.....Protected Income Level (Poverty Income Guidelines)
PIP.....Performance Improvement Project
PIRL.....Plan Information Request Letter
PIU.....Program Integrity Unit
PM.....Performance Measure
PM.....Project Manager
PMM.....Provider Management Module
PMPM.....Per Member Per Month
PMPY.....Per Member Per Year
PMR.....Provider and Member Relations
PN.....Parenteral and Enteral Nutrition
POC.....Plan of Care
POLST.....Physician Orders for Life-Sustaining Treatment
POS.....Place of Service
POS.....Point of Sale
POS.....Point of Service
PPA.....Prior Period Adjustment
PPACA.....Patient Protection & Affordable Care Act
PPO.....Preferred Provider Organization
PPS.....Prospective Payment System
PQA.....Prior Quarter Adjustment
PQAS.....Prior Quarter Adjustment Statement
ProDUR.....Prospective Drug Utilization Review
PSU.....Provider Services Unit
PT.....Physical Therapy

PXRS.....Portable X-rays Suppliers

Q

QA.....Quality Assurance
QC.....Quality Control
QHP.....Qualified Health Plans
QI.....Qualified Individual
QI.....Quality Improvement
QMB.....Qualified Medicare Member

R

RA.....Remittance Advice
RBA.....Results Based Accountability
RBRVS.....Resource-Based Relative Value Scale
RCH.....Residential Care Home
REMS.....Risk Evaluation and Mitigation Strategies
REOMB.....Recipient Explanation of Medicaid Benefits
RetroDUR.....Retrospective Drug Utilization Review
REVS.....Recipient Eligibility Verification System
RFB.....Request for Bid
RFI.....Request for Information
RFP.....Request for Proposals
RFQ.....Request for Quote
RHC.....Rural Health Clinic
RMP.....Risk Management Plan
RN.....Registered Nurse
ROP.....Reasonable Opportunity Period
ROSI.....Reconciliation of State Invoice
RPMS.....Resource and Patient Management System
RPU.....Rebate Price per Unit
RSV.....Respiratory Syncytial Virus
RVU.....Relative Value Units
RWJ.....Robert Wood Johnson Foundation

S

SAD.....Screening, Application and Determination
SAMHSA.....Substance Abuse & Mental Health Services Administration
SAS.....Statement on Auditing Standards
SASH.....Support and Services at Home
SBC.....Summary of Benefits & Coverage
SBM.....State-Based Marketplace
SDX.....State Data Exchange System
SE.....Systems Engineer
SEP.....Special Enrollment Periods
SEVCA.....Southeastern Vermont Community Action
SFY.....State Fiscal Year
SGF.....State General Fund

SGO ..... Surgeon General's Office
SHADAC ..... State Health Access Data Assistance Center
SHIP ..... State Health Insurance (and Assistance) Program
SHIP ..... Senior Health Insurance Program
SI ..... Systems Integration
SI ..... Systems Integrator
SIDS ..... Sudden Infant Death Syndrome
SIM ..... State Innovation Model
SIT ..... System Integration Test
SLA ..... Service Level Agreement
SLC ..... Service Level Credits
SLMB ..... Specified Low-income Medicare Member
SLR ..... System/Service Level Requirement
SMA ..... State Medicaid Agency
SMDL ..... State Medicaid Directors Letter
SME ..... Subject Matter Expert
SNF ..... Skilled Nursing Facility
SO ..... State Office
SOP ..... Standard Operating Procedure
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
SPP ..... Specialized Programs Project (under the MMIS program)
SR ..... Supplemental Rebate
SRA ..... Supplemental Rebate Agreement
SSA ..... Specialized Service Agency
SSDC ..... Sovereign States Drug Consortium
SSI ..... Supplemental Security Income
SSN ..... Social Security Number
STD ..... Sexually Transmitted Disease
SUR ..... Surveillance & Utilization Review
SURS ..... Surveillance and Utilization Review Subsystem

T

TB ..... Tuberculosis
TBD ..... To Be Determined
TBI ..... Traumatic Brain Injury
TCR ..... Therapeutic Class Review
TCS ..... Therapeutic Classification
TDOC ..... Total Days of Care
TM ..... Transitional Medicaid

TMSIS.....Transformed Medicaid Statistical Information System
TPA.....Third Party Administrator
TPCM.....Third Party Claim Management
TPL.....Third Party Liability
TRS.....Treatment and Recovery Services
TXIX.....Title XIX

U

UB.....Uniform Billing/Uniform Bill
UID.....Unique Identification Number
UM.....Utilization Management
UR.....Utilization Review
URA.....Unit Rebate Amount
UVM.....University of Vermont

V

VA.....Vaccine Administration
VBC.....Value-Based Contracts
VCCI.....Vermont Chronic Care Initiative
VCHIP.....Vermont Child Health Improvement Program
VCSA.....Vermont Cost Sharing Assistance
VCSR.....Vermont Cost Sharing Reduction
VDH.....Vermont Department of Health
VHAP.....Vermont Health Access Plan
VHC.....Vermont Health Connect
VHCURES....Vermont Healthcare Claims Uniform Reporting and Evaluation System
VHHIS.....Vermont Household Health Insurance Survey
VHIE.....Vermont Health Information Exchange
VHITP.....Vermont Health Information Technology Plan
VISION.....Vermont's Integrated Solution for Information and Organizational Needs – the statewide accounting system
VITL.....Vermont Information Technology Leaders
VLA.....Vermont Legal Aid
VMAP.....Vermont Medication Assistance Program
VMNG.....Vermont Medicaid Next Generation
VNA.....Visiting Nurses Association
VPA.....Vermont Premium Assistance
VPharm.....Vermont Pharmacy Program
VPMS.....Vermont Prescription Monitoring System

VPTA.....Vermont Public Transportation Agency

VRU.....Voice Response Unit

VScript.....Vermont Pharmacy Assistance Program

VSEA.....Vermont State Employees Association

VTHR.....Vermont Human Resources

W

WC.....Worker's Compensation

WRAP.....Wellness Recovery Action Plan

X

Y

Z