ANNUAL REPORT FOR STATE FISCAL YEAR 2020 & GOVERNOR'S RECOMMENDED BUDGET FOR STATE FISCAL YEAR 2022

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

MESSAGE FROM THE COMMISSIONER OF VERMONT HEALTH ACCESS

It will not surprise anyone that this year's Annual Report begins a bit differently than reports for previous years. The unprecedented public health crisis produced by the novel coronavirus (SARS-CoV-2) resulted in an emergency response requiring swift action by the Vermont Medicaid program to facilitate health care coverage (enrollment into initial or preservation of continuous), assure access to health care services for Vermont Medicaid members, and provide immediate financial assistance for providers experiencing financial hardship as a result of the public health emergency.

The Department of Vermont Health Access (DVHA) responded to the emergency immediately following the President of the United States declaring a National Emergency, the Secretary of the United States Department of Health and Human Services declaration of a Public Health Emergency (PHE), and the Governor of Vermont declaring a State of Emergency in Vermont. We felt fortunate to have strong partners in state departments and our legislative leadership, who acted quickly to implement as many flexibilities as possible at the state level to ensure the State of Vermont could mount an effective response to the virus.

While March onwards has been filled with uncertainty as we watched the effects of the virus on communities, states, and our Nation, the staff at the Department of Vermont Health Access exhibited exemplary service for Vermonters. Their dedication, willingness to go above and beyond the job responsibilities for which they had been hired, and continued service to protect the most vulnerable allowed the Vermont Medicaid program to respond effectively to the public health emergency. It must be explicitly acknowledged that the leadership and response of the Department of Health, as well as the actions of the other state departments, allowed the State of Vermont to lead the nation time and time again in controlling the impact of COVID-19 in Vermont communities.

However, there were challenges experienced, and the response to the COVID-19 public health emergency demanded a great deal of resources from the Department of Vermont Health Access. Staff were deployed to support the State's response to the Emergency, develop and administer new financial relief programs, and design new systems for coverage and reimbursement of necessary services. At times, this required the Department to adjust its previously established priority projects. Despite the challenges, DVHA's staff were successful in continuing to make progress in our Department's priority areas (detailed in the Accomplishments section), and in supporting each other to alleviate job-related stress. As we embark upon the next year, there is much to be grateful for and I continue to be appreciative of the people who choose to serve Vermont Medicaid members and providers with compassion and respect every day.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

TABLE OF CONTENTS

Facilitating Health Care Coverage during a Public Health Emergency

The public health emergency produced by COVID-19 demonstrated the importance of having health coverage. Effective March 20, 2020, Vermont Medicaid began:

- Temporarily waiving financial verifications required for those seeking to enroll in health insurance;
- Extending out coverage periods until after the Emergency ends (meaning that the State of Vermont is not processing annual "reviews" that could result in loss of Medicaid);
- Suspending certain terminations of health insurance (meaning that the State will generally not end Medicaid coverage during the Emergency unless the member requests it);
- Offering a Special Enrollment period for Vermonters who did not currently have health insurance so Vermonters could enroll in a qualified health plan and receive premium and cost-sharing assistance if eligible. This Special Enrollment Period was open from March 20 through August 14, 2020. **Importantly, for Medicaid, eligible Vermonters could continue to apply for and enroll in Medicaid at any time** and this has always been in effect;
- Medicaid eligibility appeals may not be resolved until after the Emergency provided the appealing member has continuing benefits. [1,2]

Vermont Medicaid also began temporarily accepting self-attestations for applicants for Long-Term Care Medicaid and suspending transfer of asset rules (through October 4, 2020).[3] Additionally, Vermont Medicaid began temporarily waiving Dr. Dynasaur premium obligations to further facilitate initial and continuous coverage, beginning with the bills that were mailed in April 2020 for premiums due for May 2020.

Ensuring No Copayments Apply to COVID-19 Testing, Diagnosis, Treatment or Vaccination Services for Vermont Medicaid Members

Vermont Medicaid's co-payment requirements prior to the public health emergency were limited to outpatient hospital services, dental services, and prescription medications unless Medicaid members were exempt (section 6.100.3 of the Rule). Thus, to ensure no co-payments apply to COVID-19 testing, diagnosis, treatment, or vaccination services for Vermont Medicaid members during the public health emergency, Vermont Medicaid eliminated co-payments for outpatient hospital services and certain prescription medications (i.e., used to treat the symptoms of COVID-19).[4]

---

[1] https://dvha.vermont.gov/covid-19

[2] Announcement: Postponement of Pending Cases Involving Termination or Reduction in Existing Benefits.

[3] For LTC applications received on/after October 5, 2020, normal processes apply, including verification of income, resources, and a review of the transfer of assets during the 60-month look back period. However, sufficient time will be allowed to provide requested verification in recognition of delays associated with the COVID-19 public health emergency.

[4] https://dvha.vermont.gov/covid-19

Assuring Access to Health Care Services for Vermont Medicaid Members: Telemedicine, Audio-only, and Technology-based Triage Consultations

Vermont Medicaid's continuing coverage for telemedicine and temporary new coverage for medically necessary and clinically appropriate services delivered by audio-only telehealth (i.e., by telephone) during the Emergency provided another mechanism to support providers in delivering, and being reimbursed for, health care services during the unprecedented public health crisis produced by COVID-19.[5] Vermont Medicaid-participating providers were encouraged to continue to use telemedicine to care for their Medicaid members; however, it was identified that telemedicine (defined as 2-way, real-time audio and video/visual interactive communication) may not be possible for all Medicaid members due to a number of factors. As such, Vermont Medicaid began providing temporary coverage and reimbursement for medically necessary and clinically appropriate services delivered by audio-only telehealth (i.e., services delivered by telephone) at the same rate as the rate currently established for Medicaid-covered services provided through telemedicine/face-to-face.

By April of 2020, Vermont Medicaid-participating providers had delivered 58,110 health care services through telemedicine and 15,858 services by audio-only telehealth. In contrast, the highest number of telemedicine services delivered in any month of the year prior to the Emergency was 1,753 services. Vermont's Medicaid-participating providers quickly adapted their ways of delivering health care to effectively meet the needs of Vermont Medicaid members.

Vermont Medicaid also began providing coverage and reimbursement for brief technology-based triage consultations to allow providers to receive payment for brief virtual communication services used to determine whether an office visit or other service is needed. These changes were implemented in order to assure access to care for Vermont Medicaid members, support Medicaid-participating providers in responding effectively to the Emergency, and enable Vermont Medicaid providers to receive reimbursement for services provided for their patients during the public health emergency without requiring patients to travel to a health care facility or use telemedicine when patients were not equipped, or comfortable with, the technology.

[5] https://dvha.vermont.gov/covid-19

Assuring Access to Health Care Services for Vermont Medicaid Members: Provider Financial Relief

Vermont Medicaid implemented crucial strategies to respond swiftly to the State of Emergency produced by COVID-19 in order to assure access to health care services for Vermont Medicaid members and enable Medicaid-enrolled providers to effectively respond to the State of Emergency produced by COVID-19, including establishing a process for providing immediate financial assistance for providers experiencing financial hardship as a result of the Emergency as of March 27, 2020,[6,7] and by having fixed, prospective payments established (implemented under ongoing health care payment and delivery system reform efforts) for entities participating with the Accountable Care Organization, OneCare Vermont, and for designated agencies/specialized service agencies providing adult and children's mental health services through the Agency of Human Services that provide a secure source of funds during this time.[8] In accordance with Act 136 (H.965) of 2020, the Agency of Human Services and Department of Vermont Health Access also administered the Health Care Provider Stabilization Grant Program. [9]

The Agency of Human Services and the Department of Vermont Health Access distributed $87,007,181.66 in grant awards during the first application cycle of the Health Care Provider Stabilization Grant Program. The first application cycle resulted in 351 applications received from eligible providers, with 78% of those providers having not received any prior financial relief from the Agency of Human Services.

Of the applications received in the first application cycle, a broad array of provider types were represented; the provider type with the largest percentage was dental providers at 22.7%. The second application cycle opened in October of 2020; information regarding the total payments from that cycle is not yet available.

[6] https://dvha.vermont.gov/covid-19; Phase I opened 3/27/2020 and closed 4/21/2020; Phase II opened 4/27/2020.
[7] The Department also waived late payment assessments for provider taxes when provider entities requested assistance (in writing) due to COVID-19.
[8] In order to address provider administrative burden during the Emergency, the Department's Program Integrity unit has suspended requests for documentation in case reviews and the Department's Oversight and Monitoring unit is acting in alignment with notification from the Centers for Medicare and Medicaid Services (CMS) regarding the Payment Error Rate Measurement (PERM) program, including that CMS is suspending all improper payment-related engagement/communication or data requests to providers and state agencies until further notice (e.g. calls and communications regarding existing PERM correction action plans).
[9] Progress Report on the Health Care Provider Stabilization Grant Program (October 2020).

In addition, by March 30, 2020, the Blueprint for Health program had confirmed for all health service areas that payments for Blueprint for Health programs funded through alternative payment models (i.e., non-fee-for service), including the Patient Centered Medical Home, Community Health Team, and Spoke programs, would continue and that Patient Centered Medical Home recertification was being postponed in order to reduce provider administrative burden during the COVID-19 public health emergency.

Assuring Access to Health Care Services for Vermont Medicaid Members: Provider Enrollment

Vermont Medicaid instituted the following flexibilities to ensure a sufficient number of providers were available to serve Medicaid members:

- Temporarily waiving certain provider enrollment requirements, including the payment of application fees, criminal background checks, or site visits;
- Temporarily ceasing the revalidation of providers who are located in-state or otherwise directly impacted by the disaster;
- Temporarily waiving requirements that physicians and other health care professionals be licensed, certified, or registered in Vermont, so long as they have equivalent authorization in another state, and the provider's services are offered to a patient located in Vermont using telehealth or as part of the staff of a licensed facility.

Assuring Access to Health Care Services for Vermont Medicaid Members: Clinical and Pharmacy

To support Vermont Medicaid-enrolled providers in providing health care services for Vermont Medicaid members, Vermont Medicaid instituted the following flexibilities:

- Removing clinical prior authorization requirements for imaging services, durable medical equipment and supplies, and dental services, excepting services with the potential to cause imminent harm; and
- Extending pre-existing prior authorizations for certain clinical services set to exhaust in April for an additional six months.
- Permitting members to request early refills of prescription medications (up to a 90-day supply, as needed);
- Extending the day supply limit for Suboxone, Buprenorphine, and Buprenorphine/Naloxone prescriptions (up to 30-days);
- Extending existing pharmacy prior authorizations for an additional 6 months, as needed, except for those medications for which it is not clinically appropriate to extend;
- Permitting pharmacies to override the existing 90-day supply requirement for select medications to better manage inventory and avoid drug shortages; and
- Waiving requirement for pharmacists to obtain a signature for prescription receipt/delivery.

Submitting the Required Regulatory Request to CMS for Section 1135 Waiver Approval of Flexibilities to Address Health Care System Delivery in All Counties of Vermont[10]

The Section 1135 Waiver Checklist[11] provided the federal authority to enact many of the efforts listed above, including:

1). Temporarily suspending Medicaid fee-for-service prior authorization requirements for imaging, DME Supplies (except imminent harm codes), Dental, and Orthodontia;

2). Extending pre-existing authorizations for certain clinical services for which a Medicaid member has previously received prior authorization, but expiring in April, for an additional six months;

3). Suspending pre-admission screening and annual resident review Level 1 and Level II assessments for 30 days (e.g., all new admissions can be treated like exempted hospital discharges with new admissions for mental illness or intellectual disability receiving a resident review as soon as resources are made available after the 30 days);

4). Temporarily delaying scheduling of Medicaid fair hearings and issuing fair hearing decisions during the Emergency (CMS approved enrollees to have more than 90 days, up to an additional 120 days, for an eligibility or fee for service appeal, to request a fair hearing and modification of the timeline for resolving appeals).

5). Providing Services in Alternative Settings: allows facilities, such as nursing facilities, intermediate care facilities for individuals with intellectual and developmental disabilities, psychiatric residential treatment facilities, etc. to be fully reimbursed for services rendered to an unlicensed facility during the Emergency due to an emergency evacuation or other need to relocate residents where the placing facility continues to render services.

6.) Reporting and Oversight:

- Modify deadlines for OASIS and Minimum Data Sets (MDS) assessments and transmission.
- Suspend 2-week aide supervision requirements by a registered nurse for home health agencies.
- Suspend supervision of hospice aides by a registered nurse ever 14 days' requirement for hospice agencies.

The federal public health emergency was renewed throughout 2020 and remains in effect through early 2021 as of the date this report was finalized.[12] As the United States addresses the impacts of the second surge of the virus and prepares for approval and distribution of the COVID-19 vaccines, state Medicaid programs will continue to serve an essential role in the COVID-19 emergency response. Vermont Medicaid will continue its commitment to ensuring that Vermonters have access to the health care services they need to remain healthy.

---

[10] Submitted March 23, 2020

[11] When the President declares a major disaster or emergency under the Stafford Act, or an emergency under the National Emergency Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to take certain actions. In March 2020, CMS created an 1135 Medicaid and CHIP Checklist to assist states during the COVID-19 public health emergency.

[12] https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

THE DEPARTMENT OF VERMONT HEALTH ACCESS

The Department of Vermont Health Access (DVHA) strives to fulfill its responsibilities to Medicaid members, Medicaid providers, and Vermont taxpayers while making progress on its three priorities: adoption of value-based payments, management of information technology projects, and operational performance improvement. This summary provides a high-level overview of the Department's work over the last year and describes the ongoing work that supports attainment of the Department's priorities and strategic goals.

Adoption of Value-Based Payments

The Department continues to advance value-based payments through its participation in the All-Payer Accountable Care Organization Model agreement (Vermont Medicaid Next Generation ACO program) and payment reform for Medicaid providers through Applied Behavioral Analysis, Children's and Adult's Mental Health, Residential Substance Use Disorder Treatment, Developmental Disabilities Services, and Children's Integrated Services work. The goal of this work is to control both the rate of growth and variability in health care costs over time by incentivizing quality over quantity and ensuring that providers are connected to the total cost of care.

Management of Information Technology Projects

The Department is working with the Agency of Digital Services to transform the way the Agency of Human Services plans for, implements, and manages large scale Medicaid information technology projects. These new approaches are designed to improve outcomes and efficiency, achieve compliance with federal regulations, reduce financial risk to the State of Vermont, reduce vendor lock-in, and build systems that are flexible and responsive in the face of changing customer expectations, a shifting federal landscape, and advancements in the marketplace. This report highlights recent accomplishments including the ability of Vermonters to utilize mobile and online technology to submit applications and verification documentation (MABD Online Application pilot; Document Uploader), migration to a single document management system (Enterprise Content Management), security-related work that allowed for an expanded use of the Document Uploader (Medicaid and Qualified Health Plan customers), and the completion of an eligibility and enrollment system upgrade including transition of the business reporting application to an upgraded environment for reliable and secure use going forward (Business Intelligence).

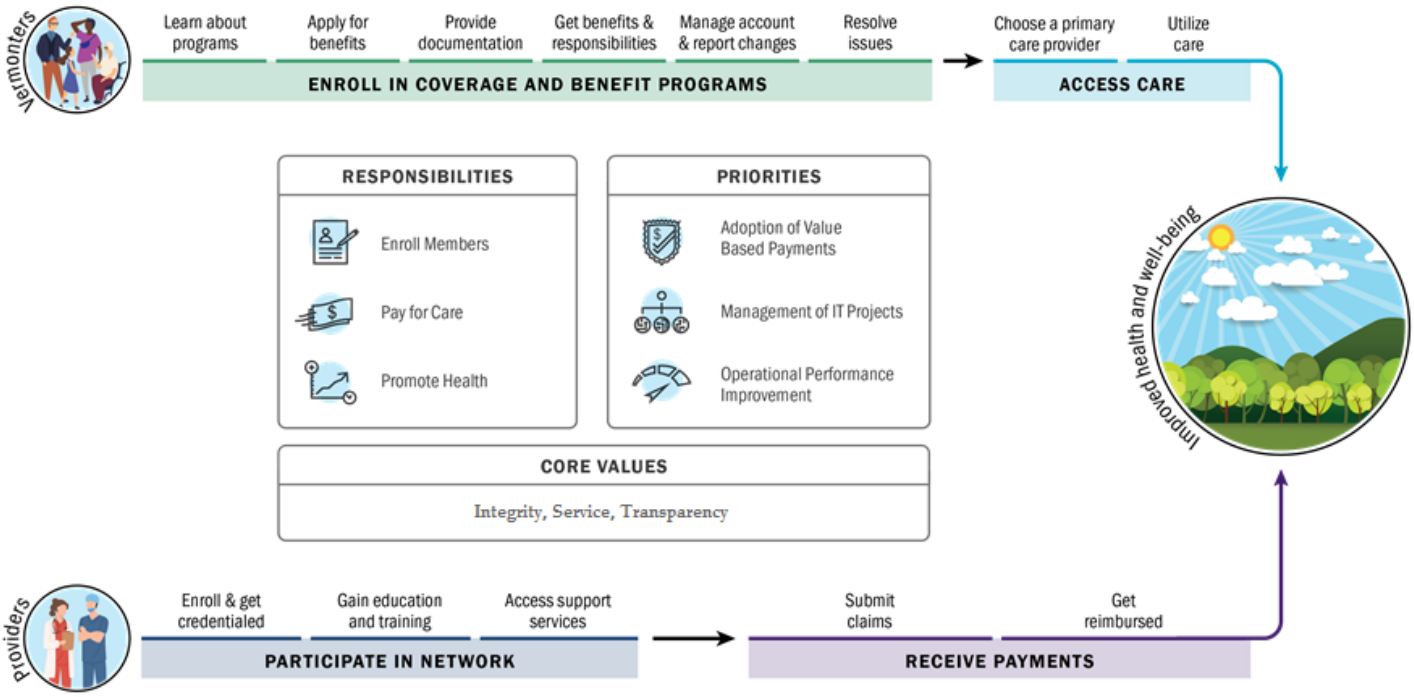
Operational Performance Improvement

The Department has focused on business efficiencies for improving the way Medicaid members and providers are served and has implemented Scorecards for performance metric tracking as part of its system for strategic management. Each of the Department's units are responsible for assessing performance on identified measures that are aligned with the core responsibilities of enrolling members, paying for care, and promoting health. The performance measures are used to drive clinical initiatives, decision making and the pursuit of better customer service, a higher quality of care, and operational efficiencies. Targeted performance improvement projects have resulted in numerous operational and financial efficiencies; for example, reduced call center contract costs (in the 2021 Governor's Recommended budget) and a one-time

reduction in DVHA's contract with its Medicaid fiscal agent resulting from reduced system specification order hours (in the 2021 Budget Restatement), improvements in contract and grant management resulting in reduced retroactive agreements and electronic invoice processing, improved processes for provider enrollment, changing the Assister program to continue to meet Vermonters' needs, evolving the Vermont Chronic Care Initiative and Blueprint for Health programs, effectively managing the pharmacy benefit and pharmaceutical spend, and a reduction in audit findings.

INTRODUCTION TO DVHA

OUR MISSION: IMPROVE THE HEALTH AND WELL-BEING OF VERMONTERS BY PROVIDING ACCESS TO QUALITY HEALTH CARE COST EFFECTIVELY.



About Us

The Department of Vermont Health Access (DVHA), within the State of Vermont's Agency of Human Services, is responsible for administering the Vermont Medicaid health insurance program and Vermont's state-based exchange for health insurance. Vermont's state-based health insurance exchange is also referred to as the health insurance marketplace. The Health Access Eligibility and Enrollment team integrates eligibility and enrollment for Medicaid and commercial health insurance plans for many of Vermont's individuals and families.

The Department coordinates a range of health insurance plan options and offers online, telephone, paper and in-person assistance for Vermonters who are applying for health insurance. It is important to know that:

- **Medicaid** was designed to provide a government-funded health insurance plan for income-eligible people and people who are categorically eligible. The federal government establishes requirements for all states to follow but each state administers their own Medicaid program differently. Thus, Medicaid is sometimes referred to as "government insurance."
- **Commercial** health insurance plans are offered by private insurance companies like BlueCross BlueShield of Vermont and MVP® Health Care. Qualified Health Plans offered by BlueCross BlueShield and MVP® in Vermont are certified by the Department of Vermont Health Access. An insurance plan that is certified provides essential health benefits, follows established limits on deductibles, co-payments and out-of-pocket maximum amounts, and meets other requirements of the Affordable Care Act.

The State of Vermont's health insurance marketplace, also known as the "Exchange," is integrated. This means that Vermonters can come through one "door" and be screened for eligibility for health coverage through Medicaid and also for financial help and health coverage through Qualified Health Plans.

Our Mission and Responsibilities

When we say our mission is "to improve the health and well-being of Vermonters by providing access to quality health care 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 health care. But that's not all. We're committing to do so cost-effectively. In other words, we are conscious that we are accountable to our members, providers and to taxpayers.

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

1) We engage Vermonters in need to **enroll as members** in appropriate programs. This work is represented by the "Vermonters" path in the diagram above.
2) We **pay for their care**. This work of building, and collaborating with, a robust network of health care providers, pharmacies, and other partners is represented in the "Providers" path above.
3) We recognize that simply signing up thousands of people and paying thousands of invoices will not achieve optimal outcomes at the most efficient cost, so we strategically invest in programs that **promote health**. This work is central to our commitment to quality and improvement.

Our Priorities

Our commitment to continual improvement is not limited to external 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 is comprised of 20 functional units, every one of which works on one or more of our responsibilities and contributes to one or more of our priorities.

Our Values

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

1) **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.
2) **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."
3) **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 our pursuit of the above responsibilities, priorities, and mission. We are committed to innovation and collaboration. We are not tied to any one way of carrying out our charges. We approach opportunities to manage Medicaid costs differently with an open mind and a commitment to do right by Medicaid members, providers and Vermont taxpayers. We recognize that the success of our initiatives is dependent on strong working relationships with other state agencies, federal and local governments, and community partners.

ACCOMPLISHMENTS

The Department of Vermont Health Access (DVHA) strives to fulfill its responsibilities to members, providers 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 through implementing payment reform processes to guide future reforms through the Medicaid Delivery System Reform Work, successfully completing and evaluating the third full year of the Vermont Medicaid Next Generation Accountable Care Organization (ACO) program and initiating the fourth year and expanding payment reforms across an array of services.

Implementing Medicaid Delivery System Reform 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. In 2020, DVHA published the most recent Medicaid Delivery System Reform (2019) report to provide a written update on payment and delivery system reform efforts, describing the process and ongoing efforts occurring within the Agency of Human Services, Department of Vermont Health Access and with stakeholders.[13] 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 the Department of Vermont Health Access. 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 All-Payer Model 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 implemented or in-progress:

- Vermont Medicaid Next Generation (VMNG) ACO program

[13] Medicaid Delivery System Reform Report (Submitted January 15, 2020).

- Applied Behavior Analysis (ABA)
- Children's and Adult's Mental Health
- Developmental Disabilities Services
- Residential Substance Use Disorder (SUD) Program
- Children's Integrated Services

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

Completing and Evaluating the Third Full Year of the Vermont Medicaid Next Generation Accountable Care Organization Program

Calendar year 2019 was the third full year of the Vermont Medicaid Next Generation Accountable Care Organization (ACO) program. During 2020, the Department completed its evaluation of the Vermont Medicaid Next Generation (VMNG) program's third year, and results indicated the program: [14]

1. **Continues to Grow and the Number of Medicaid Members Attributed to the ACO Increased to 88% of Medicaid Members**[15]

   The table below depicts the number of hospital service areas, provider entities, unique Medicaid providers, and attributed Medicaid members from 2017 – 2020.

	2017 Performance Year	2018 Performance Year	2019 Performance Year	2020 Performance Year
Hospital Service Areas	4	10	13	14
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	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000
Attributed Medicaid Members	~29,000	~42,000	~79,000	~114,000

[14] Vermont Medicaid Next Generation ACO Program 2019 Performance (Published October 12, 2020).

[15] In 2020, the number of prospectively attributed Medicaid members increased to approximately 114,000, representing approximately 88% of members for whom Medicaid was the primary payer.

Indicative of programmatic growth, there continues to be more providers and communities participating in the Program demonstrating the Vermont Medicaid Next Generation program's contribution to the State's overall progress towards the scale targets in the All-Payer ACO Model agreement. However, as most Vermont communities are now participating in the Vermont Medicaid Next Generation program, it is likely that the 2021 performance year will observe only modest additional provider participation.

2. **Promoted Shared Financial Accountability for Health Care between ACO Participating Providers and Medicaid in 2019**

The Department and OneCare Vermont agreed on the price of health care for attributed Medicaid members upfront and spending for ACO-attributed Medicaid members was approximately $13.5 million more than the expected price. OneCare Vermont is liable for financial performance within the 4% risk corridor, meaning that after application of other necessary adjustments, OneCare Vermont will repay $6.7 million dollars to the Department of Vermont Health Access.[16]

Providers participating with OneCare Vermont who were paid prospectively (instead of fee-for-service) spent $8.2 million less than expected on the services within their control. Conversely, providers who were paid fee-for-service (both within and outside of OneCare's network) spent $13.5 million more than expected.

3. **The ACO Met or Exceeded Most of its Quality Targets**

The overall quality score was 95% for 10 pre-selected measures; notably, OneCare Vermont's performance exceeded the national 90th percentile on measures relating to diabetes mellitus hemoglobin A1c control and 30-day follow-up after discharge from emergency departments for mental health and substance use. OneCare's performance exceeded the national 75th percentile on measures relating to developmental screening in the first 3 years of life and engagement of substance treatment. Finally, OneCare demonstrated improvement over prior year performance on other measures, such as adolescent well care visits and screening for clinical depression with follow-up plan.

[16] Paid in January of 2021.

4. **Expanded the Advanced Community Care Coordination Model in all Participating Communities**

   The Advanced Community Care Coordination (A3C) Model continued to grow in 2019 and expanded in all participating health service areas. During the 2019 performance period, OneCare Vermont distributed approximately $5.2 million in advanced community care coordination model payments to 84 community partner organizations – including primary care practices, designated mental health agencies, Area Agencies on Aging, and Visiting Nurse Associations. Care Coordination Core Teams were active in all 13 participating communities and OneCare came very close (14.5%) to reaching its target of 15% of high and very-high risk members being care managed (i.e., having a lead care coordinator and creating a shared care plan that is comprised of at least 2 goals and 2 tasks). OneCare also began to implement the Developmental Understanding and Legal Collaboration for Everyone (DULCE) model in 4 pediatric practices. This intervention takes place within a pediatric office to address social determinants of health infants, newborn to 6 months of age, and provides support for parents.

5. **The Department and OneCare made Incremental Programmatic Improvements**

   During the 2019 performance year, the Department and OneCare implemented several programmatic changes that represented opportunities for incremental improvement. One notable change was a pilot in the St. Johnsbury health service area to study an alternative attribution methodology based on a Medicaid member's residence rather than their primary care utilization. The pilot sought to focus on provider accountability for the entire community of Medicaid members, rather than just those who had historically accessed primary care. Additionally, it tested whether alternative attribution methodologies could be operationalized and built upon in future years of the program. The lessons learned from this pilot were incorporated into the Vermont Medicaid Next Generation's expanded attribution methodology for the 2020 performance year.

Implementing and Analyzing Applied Behavior Analysis Payment Reform

The Applied Behavior Analysis tiered rate payment methodology became effective on July 1st, 2019 for members with Vermont Medicaid as their primary insurance. Providers are no longer required to complete prior authorization requests, nor must they wait for approvals of changes to treatment plans. The tiered rate structure allows providers to determine the appropriate treatment type and to respond immediately to changes in their patients' medically necessary service needs. Utilization and clinical services are monitored by the Department's Quality Improvement and Clinical Integrity unit using claims data, chart audits, site visits, and standardized tools/reporting to ensure that utilization and payments are closely aligned. The program includes an annual financial reconciliation after allowing the providers adequate time to submit encounter data.

Partnering on Children's and Adult's Mental Health Payment Reform

The Department of Mental Health and the Department of Vermont Health Access continued to collaborate on transitioning Vermont Medicaid payments for a wide array of mental health services for children and adult populations statewide from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service reimbursement) to a monthly case rate. The payment model went into effect for all covered health services delivered on/after January 1, 2019 for Medicaid members receiving treatment at all Vermont designated agencies and Pathways, a specialized services agency. Under the new model, agency-specific case rates are calculated for each agency's unique child and adult populations, based on their mental health allocation from the Department of Mental Health and their historical fee-for-service expenditures from the Department of Vermont Health Access. 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 a given month as monitored through service encounter data submissions.

For this project, value-based payments are made through a separate quality payment. During each measurement year, the Department of Mental Health will withhold a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model uses 3 types of performance metrics to assess the quality and value of services. In the next phase of work, the Departments will continue to work with providers and members to evolve aspects of the payment model and rate setting methodologies for further increases in accountability, transparency, and equity in payments.

Designing and Developing Developmental Disabilities Services Payment Model Options

The Payment Reform unit within the Department of Vermont Health Access has been working with the Department of Disabilities, Aging, and Independent Living to transition from the current developmental disabilities services home- and community-based services daily rates to a new form of payment for individuals with intellectual and developmental disabilities. The payment and delivery system reform project is complex and seeks to improve data on services provided and ensure consistent assessment of individual needs. The goal of this project is to create a transparent, effective, and operationally feasible payment model for developmental disabilities services that aligns with the Agency's broader health care reform goals. The identified objectives are:

- Comply with the State's All-Payer Model 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 health care;
- 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 through use of a standardized assessment tool;

- Ensure submission of encounter data to support continued tracking of approved services;
- Provide equity and predictability, including similar budgets and services for individuals with similar needs, and consistent funding streams for providers;
- Provide flexibility in response to changes in individual needs and choices; and
- Support a sustainable provider network.

Importantly, this work has involved representatives from the State, provider network, consumers, individuals & family members, and other interested stakeholders since 2018. The State engaged Burns and Associates, a consulting firm, to conduct a provider rate study to evaluate the actual cost to providers of delivering services. The study results will inform the new payment model and assist in the development of provider reimbursement rates. Initial rate study results were presented for public comment; more information may be found in the report submitted by the Department of Disabilities, Aging and Independent Living.[17]

MANAGEMENT OF INFORMATION TECHNOLOGY PROJECTS

Effective, secure, and reliable technology is required for the Agency of Human Services (AHS) to administer Vermont's Medicaid program efficiently, with financial integrity, and in compliance with federal and state law. This work inherently involves multiple entities – the Agency of Digital Services, Agency of Human Services – Secretary's Office, Department of Vermont Health Access, and Department for Children and Families – in order to implement technology that meets these objectives on time and on budget. Successful implementation of information technology projects has been a challenge in Vermont, with the most public example being "Vermont Health Connect." The Department and State learned difficult lessons from that experience and these learnings have been applied to improve the chances of success on future information technology projects.

The Department of Vermont Health Access is currently engaged with two large scale information technology projects, the Medicaid Management Information System (MMIS) and the Integrated Eligibility & Enrollment (IE&E) program, both of which are designed to replace outdated and poorly performing technology and improve the experience of applicants/enrollees, staff, and providers. The Department is taking a modular approach to these projects, which means improvements will be delivered incrementally over time. Breaking these projects up into smaller pieces and parts reduces financial risk to the State, allows for more frequent project completion, and will result in the implementation of a system that is more flexible and able to adapt to regulatory changes, technological innovation, and consumer expectations.

[17] Department of Disabilities, Aging and Independent Living: Developmental Disabilities Service Payment Reform Update (Submitted January 15, 2020).

Receiving CMS Certification for the Care Management System

The Department received certification for its care management system in October of 2019 – marking the first care management solution ever certified by CMS. The Centers for Medicare and Medicaid Services (CMS) completed its final certification review in August of 2019 for the Department's care management system, EQHealth. EQHealth is a care management system that is designed to provide both network population management and individual member management and facilitates the Vermont Chronic Care Initiative's coordination of care for Medicaid members to ensure effective management for physical and mental health needs and health-related social needs. [18]

Evolving Systems for Document Imaging and Scanning to Improve Staff and Customer Experiences - Enterprise Content Management

The Enterprise Content Management project was completed in May of 2020. Under the Integrated Eligibility and Enrollment program, DVHA had been working on the Enterprise Content Management project to sunset the Oracle solution and transition to the State of Vermont's OnBase Electronic Content Management solution.[19] Vermont's eligibility and enrollment staff were utilizing two different systems for scanning, indexing, and viewing Vermonters' documentation and notices. This led to operational inefficiencies, unnecessary maintenance and operations costs, and difficulty coordinating enrollee documentation across programs. In addition, Oracle WebCenter, the content management system previously utilized, was expensive to maintain and difficult to build on. By contrast, OnBase, the solution leveraged for the aged, blind, and disabled Medicaid population and economic services programs, is an existing technological asset owned and maintained by the State and is working reasonably well for the programs it supports. This change creates a streamlined experience for staff, reduces operating expenses, and allows for simplified training and documentation, improving quality and reducing the time needed to onboard new staff. Finally, when the staff experience is improved, the customer experience is positively impacted.

Implemented and Expanded Use of the Document Uploader, Launched MABD Application Pilot

Vermont's work on the Document Uploader project, under the Integrated Eligibility and Enrollment program, launched a new technical solution statewide to allow Vermonters to utilize mobile and online technology to submit verification documentation (November 2019).[20] The project improved the efficiency of the eligibility determination process and resulted in a better customer experience. The next customer portal-related project focused on authentication and allowed the

---

[18] Certification results in enhanced federal financial participation for ongoing maintenance and operation costs, increasing federal financial participation to 75/25 federal/state (from 50/50 federal/state).

[19] Integrated Eligibility and Enrollment Program Update to the Joint Information Technology Oversight Committee (November 2020).

[20] Integrated Eligibility and Enrollment Program Update to the Joint Information Technology Oversight Committee (November 2020).

State to consolidate two log-ins for Vermonters into a single log-in. The Authentication work was completed in September 2020 and made it easier for customers to access the systems. In addition, adding authentication to the Document Uploader brought the State into compliance with federal security standards, allowing Medicaid and Qualified Health Plan customers to submit verification electronically. Also in September 2020, the Medicaid for the Aged, Blind, and Disabled Application pilot was launched, allowing customers to have their application completed while they are on the phone with the State's Customer Support Center. Importantly, this project addresses a Medicaid compliance issue and provides the foundation for additional improvements.

Launched and Completed Eligibility and Enrollment System Upgrade Including Business Intelligence Transition under the Integrated Eligibility and Enrollment Program

This year, components of the Department's eligibility and enrollment system had to be upgraded to address security concerns. This upgrade is referred to as the "OFE Cutover" project. The OFE Cutover project's primary goal was to move existing eligibility and enrollment applications onto new servers in the Optum-hosted data centers to resolve outstanding Plan of Action & Milestones security concerns by upgrading operating systems. As part of that move, Optum also upgraded Oracle and Portal component versions. As a prerequisite to the full cutover, the Department engaged in a Business Intelligence project to transfer the Eligibility and Enrollment business reporting application (i.e., OBIEE) to the upgraded environment (i.e., OFE) to ensure its continued use. Much of the Department's eligibility and enrollment work depends on reporting. The goal of this project was to ensure reliable and secure use of the reporting application going forward. It also lays the groundwork for additional reporting system improvements. The reporting project deliverables were complete in July of 2020 and the OFE cutover project was complete in September 2020.

Encouraging Consumer Choice and Comparison Shopping for Qualified Health Plans through the Plan Comparison Tool

The Department encouraged Vermonters to comparison shop to choose the best health insurance plan for themselves and determine if they qualify for financial help by using the Plan Comparison Tool. The Tool compares qualified health plans on both plan design and total cost (including premium and out-of-pocket costs) to help Vermonters make informed decisions. Vermonters heard the message and visited the online Plan Comparison Tool 15,600 times between the first day of Open Enrollment (November 1) and December 15th, 2020 when Open Enrollment closed. It should be noted that overall use of the Plan Comparison Tool was decreased during this year's Open Enrollment period; this decrease is likely attributable to the Department's response efforts to the COVID-19 public health emergency. The Department maintained continuous health coverage through Medicaid and opened a COVID-19 Special Enrollment Period so that Vermonters who were currently uninsured could enroll into health coverage. As a result, uninsured Vermonters did not need to wait until the annual Open Enrollment period to obtain health coverage.

Coordination of Benefits, Ensuring Medicaid is the Payer of Last Resort, and Utilizing an Electronic Payer Initiated Eligibility Data Matching Process

DVHA's Coordination of Benefits unit merged with Provider Member Relations in March of 2020, forming Member and Provider Services as part of an ongoing initiative to improve operational processes. By providing assistance for Vermonters who are Medicare-eligible to support enrollment into appropriate programs, coordinating benefits, and working with providers, members, and other insurance companies, Member and Provider Services ensures that Vermont Medicaid is always the payer of last resort. This work also involves recovering funds from third parties when appropriate, including estate, casualty, trust and Medicare recovery. In state fiscal year 2020, the Department collected $7,240,289.78 related to Coordination of Benefits. Importantly, the Member and Provider Services and Data teams implemented utilization of an electronic Payer Initiated Eligibility data matching process to better identify and collect payment from liable third parties. This resulted in the recovery of nearly $1,455,986 dollars in state fiscal year 2020.

Preparing for Vermont's Consent to Share Health Records Policy Change

In order to improve patient outcomes by allowing providers to make better informed decisions at the point of care, a higher volume of patient records needed to be available to be exchanged in the Vermont Health Information Exchange. Act 53 of 2019 changed Vermont's consent to share health records policy from an opt-in to an opt-out policy, effective March 1, 2020; this policy change was intended to increase the volume of patient records within the Vermont Health Information Exchange. In preparation for the policy change, the Department of Vermont Health Access engaged stakeholders in the process of developing a consensus-based implementation strategy for the consent policy change and the Department submitted its final report on the stakeholder engagement process and consent policy implementation strategy on January 15, 2020.[21] The final reported highlighted:

- DVHA, in partnership with Vermont Information Technology Leaders, the Health Information Exchange Steering Committee, advocacy organizations and community partners, had assessed, developed and launched a significant public input effort and subsequent stakeholder engagement. The work aimed to embolden advocacy organizations, including the Office of the Health Care Advocate, to support constituents in meaningful decision-making about the availability of their health information and produce broad awareness of the change to the consent policy.
- Patient education mechanisms and multi-sector communication strategies were being implemented and would live on through public messaging, trained advocates, a

[21] Final Report on the Stakeholder Engagement Process and Consent Policy Implementation Strategy (January 2020). https://legislature.vermont.gov/assets/Legislative-Reports/Act-53-Consent-Policy-15-January-2020_DVHA-Final-Report.pdf

communications toolkit, a website with continually updated content, and telephone hotlines at Vermont Information Technology Leaders and the Office of the Health Care Advocate.

- Technical mechanisms were in place at Vermont Information Technology Leaders to capture consent. Vermonters who wished to opt-out on March 1, 2020 when the new policy became effective were able to call the Vermont Information Technology Leaders hotline or go online to record their consent preference.
- The Health Information Exchange (HIE) Plan was updated as required by Act 187 and included the provisions specified in Act 53 (2019). Vermont Information Technology leaders had updated protocols for consent management, data access, and auditing, and summaries were included in an addendum to the Plan.

The Health Information Exchange Strategic Plan, as called for in Vermont Title 18, provided an overview of the consent policy change evaluation results when it was submitted in the fall of 2020.[22]

OPERATIONAL PERFORMANCE IMPROVEMENT

The Department of Vermont Health Access 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 Medicaid members and Vermont taxpayers are served. In addition to striving for business efficiencies, the Department 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, the Department of Vermont Health Access uses RBA-based strategy management, the Clear Impact Scorecard, and collaboration support software to facilitate project management, data charting and public communication of results. These tools inform our continuous quality improvement work, inclusive of clinical initiatives.

Identifying Efficiencies in Maximus Contract Management

The Health Access Eligibility and Enrollment unit began a focused initiative for continuous improvement in its vendor management of Maximus call processes (the vendor for Vermont Health Connect for member questions about eligibility or other issues). The initiative was designed to help the vendor efficiently respond to Vermonters, as evidenced by a reduction in the length of calls without compromising the quality of the call. For June of 2019, Maximus' talk minutes were 22% below budget and were 17% below last year's actuals. Through efficient contract management, Health Access Eligibility and Enrollment was able to demonstrate cost savings through reduced call

[22] Vermont's Health Information Exchange Strategic Plan (2020 Update).

length without a reduction in the quality of the calls and the reduced call center contract costs were included in the 2021 Governor's Recommended budget.

Improving Departmental Contract and Grant Management

The Department carefully studied its contract and grant management procedures to improve vendor relations whilst still ensuring compliance with federal and state requirements. This effort included reviewing current practices and policies, researching procedures used by other states and Vermont state departments, and obtaining feedback from vendors. The first phase of this project was completed in May 2019, and the electronic invoicing process was subsequently streamlined to address vendor concerns while still maintaining compliance requirements. Key performance indicators showed that the Contract and Grants team became successful at processing invoices on-time in accordance with agreement payment terms after moving solely to electronic agreement development, routing, and invoice processing in April of 2020. The median number of business days to develop an agreement, along with the median number of days agreements were routing as part of the internal state review process, declined until staffing challenges were experienced due to the COVID-19 public health emergency and many agreements ending on the same date (June 30), requiring new agreement execution for July 1. Despite these challenges, the Department was able to get the required approvals for all agreements ending on June 30, avoiding the need for retroactive agreements.

Receiving CMS Certification for the Provider Management Module and Reduced Time to Enroll

The Department received CMS certification for its Provider Management Module in February of 2020 and the certification was retroactive to May 1, 2019.[23] In order to increase the number of providers participating in the Vermont Medicaid Program and improve the provider experience, the Department needed to develop the capacity to complete the screening and enrollment process within 60 calendar days. Under the Medicaid Management Information System, the new online Provider Management Module was implemented on May 1st, 2019 on schedule, ahead of the date required by Act 116 (2018) and continues to demonstrate significant efficiencies for enrolling providers to participate with Vermont Medicaid.[24] The online Provider Management Module significantly reduced the average time to enroll providers, continues to receive positive feedback from providers and other Medicaid programs have requested technical assistance from Vermont to learn from Vermont's implementation. The most recent data indicates that 6,878 providers have enrolled through the module, with an average requirement of 21 minutes of provider time to

[23] Certification results in enhanced federal financial participation for ongoing maintenance and operation costs, increasing federal financial participation to 75/25 federal/state (from 50/50 federal/state).
[24] https://legislature.vermont.gov/Documents/2018/Docs/ACTS/ACT116/ACT116%20As%20Enacted.pdf

complete their part of the process and less than 10 days for Vermont Medicaid to screen/approve the application.

Supporting the Assister Program to Deliver Services in New Ways for Vermonters

The Assister Program is the Department's program for in-person assistance and provides a cornerstone of support for Vermonters seeking enrollment assistance when applying for health insurance plans. In 2020, the Assisters continued their work both in-person and virtually, as COVID-19 circumstances allowed, and the Program introduced a new suite of online tools for the Assisters to utilize in the context of COVID-19. These tools included a Resource Center, which serves as an information source and a wholly virtual training platform. The Program held its first virtual conference in October of 2020, with participation from 79 Assisters representing 13 counties in Vermont, Agency of Human Services and Department of Vermont Health Access staff, representatives from BlueCross BlueShield of Vermont, MVP Health Care, and community stakeholders, to prepare for Open Enrollment. The Assister Program will continue to change its training and support for Assisters to ensure safety while still meeting the needs of Vermonters.

Evolving the Vermont Chronic Care Initiative Model

In the All-Payer ACO Model, an Accountable Care Organization (ACO) consisting of a network of hospitals and community providers assumes responsibility for the care, health, quality and health care costs of their population. Through the Vermont Medicaid Next Generation (VMNG) program, DVHA and OneCare are piloting a financial and delivery system model that is intended to improve the health of Vermonters and moderate health care spending growth in the future. As the VMNG and OneCare's role grows, some of the functions and structures within the Department of Vermont Health Access and Agency of Human Services will necessarily evolve. Under the ACO model, OneCare assumes responsibility for complex care management for attributed Medicaid members which was traditionally a role assumed by the DVHA under the Vermont Chronic Care Initiative (VCCI). Using lean process improvement methodology and stakeholder engagement, DVHA identified opportunities to reorient the VCCI model. As a result, VCCI staff began outreach to individuals who are new to Medicaid and thus not attributable to the OneCare with the goal to connect these Medicaid members with local care providers and assist in aligning their care with the OneCare Care Model during the last state fiscal year.

In state fiscal year 2020, the VCCI program continued to align its work with the efforts of OneCare Vermont; VCCI worked with ACO and community partners on complex care model training and implementation of the care model as well as training and access of Care Navigator (OneCare Vermont's care coordination platform). Access to Care Navigator has allowed VCCI staff to coordinate care planning and communication with other care team members and monitor goal progression for complex members. Finally, two additional activities of the VCCI team this year are important to note:

- VCCI worked with the Quality Improvement team at DVHA to develop and implement a new pediatric screening tool for New to Medicaid outreach to improve consistency of assessment practices. The initial pilot data indicated the outreach and screenings were well-received by members and families; and
- VCCI worked with the Vermont Department of Health and the Department of Disabilities, Aging, and Independent Living to assess the role of VCCI in reviewing complex cases in the High-Technology Nursing Services population and working with families to coordinate services within households.

Data Management & Analysis to Support Advancing Care Coordination

The Data Management and Analysis unit provides data analysis, distribution of Medicaid data extracts, and reporting to regulatory agencies, the Vermont General Assembly, 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, and develops the annual Healthcare Effectiveness Data and Information Sets (HEDIS) data extracts for reporting. The unit also delivers weekly medical and pharmacy claims files and monthly eligibility records to support Care Coordination for the Vermont Chronic Care Initiative (VCCI), and provides ad hoc data analysis for internal DVHA divisions and other Agency of Human Services (AHS) departments and state agencies. Through the Vermont Medicaid Next Generation program with OneCare Vermont, DVHA has been consistently sending claims extracts and demographic files for active Accountable Care Organization (ACO) attributed members to advance the way care is coordinated and provided. The unit's Director monitors the percentage of required federal and state reporting initiatives that are completed on time; performance data indicates 100% of required federal and state reporting has been completed on time, with the exception of the first month of the COVID-19 public health emergency.

Reducing Audit Findings

The Oversight and Monitoring unit within DVHA ensures effectiveness and efficiency of departmental operational processes, reporting, controls, and alignment with applicable laws and regulations. In order to support the strategic direction of the Department, this unit was created to proactively evaluate departmental units for audit readiness and to facilitate and consult on reviews and audits to improve the Department's operational performance and establish professional relationships with regulators and auditors for better understanding and communication. The Oversight and Monitoring unit has focused on maintaining the reduction in the total number of audit findings in audits that closed during the previous state fiscal year and reducing the total number of repeat findings from previous audits. As part of that process, all departmental units have been a part of the Standard Operating Procedures project to ensure documentation of risks/controls and demonstrate a strong control environment for reducing audit testing and findings.

For state fiscal year 2019 end, there were 3 total audit findings for the A133 Single Audit, as compared to 1 finding in 2018.[25] The goal remains no repeat audit findings. The 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. The Comprehensive Annual Financial Report (CAFR) audit completed for state fiscal year end 2019 resulted in 0 audit findings for the second year in a row; the high from previous state fiscal years (prior to 2018) for this audit was 5 findings. The CAFR audit is a thorough and detailed annual presentation of the State's financial condition where the State's external accounting firm reviews prepared modified accrual financial statements for compliance with Generally Accepted Auditing Standards (GAAS) and Generally Accepted Accounting Principles (GAAP) guidelines. The audit reports for state fiscal year 2020 end will not be available until March of 2021.

Successful CMS Review of Vermont's State-Based Health Insurance Exchange

The Health Access Eligibility and Enrollment unit's commitment to improvement has resulted in continuous progress being made to achieve compliance with certain federal regulatory requirements for Vermont's state-based health insurance exchange. As required under the Affordable Care Act, DVHA's Health Access Eligibility and Enrollment unit administers Vermont's state-based health insurance exchange. In October of 2020, the Department received formal notification from the Centers for Medicare and Medicaid Services (CMS) that CMS had no observations regarding the 2019 State-based Marketplace Annual Reporting Tool nor any outstanding action items from prior submissions. Annually, the Department is required by CMS and CMS' Center for Consumer Information and Insurance Oversight (CCIIO) to provide financial and operational documents via the State-based Marketplace Annual Reporting Tool (SMART). CMS uses the SMART submission, in conjunction with ongoing monitoring activities and readiness reviews, to document the compliance of Vermont's state-based exchange with regulatory requirements and to identify observations and potential action items.

Automatically Renewing 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 2020, this step was operated with a single, clean, automated run that took care of 99% of eligible cases for the third year in a row, up from 97.8% in 2017 and 91.5% in 2016. The small number of remaining cases were processed by staff the following day. For Vermonters, this means that Vermonters can log into their online accounts on the very first day of Open Enrollment,

[25] It should be noted that in previous fiscal years (prior to 2018), there was a total high of 12 or more A133 Single Audit findings.

see their benefits and net premiums for the coming year, and select a new plan if they choose to do so.

Promoting National Standards in Primary Care and Access to Medication Assisted Treatment for Vermonters with Opioid Use Disorder

The Blueprint for Health has continued its work to promote the health and well-being of Vermonters and to attain alignment with OneCare Vermont, ensuring coordination in community-based strategies. The Blueprint for Health utilizes national standards to support improvements in primary care delivery and payment system reform. The program provides practice facilitation to help providers and practices achieve and maintain National Committee for Quality Assurance (NCQA) Patient Centered Medical Home certification. Patient Centered Medical Homes provide care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. Patient Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each health service area of the State that provide supplemental services, allowing Blueprint-participating primary care practices to focus on promotion of prevention, wellness, and coordinated care.

The majority of Vermont's primary care practices are Blueprint-participating Patient Centered Medical Homes, as evidenced by the fact that 134 of Vermont's primary care practices are Blueprint-participating (out of an estimated 169 total primary care practices). Blueprint-participating Patient Centered Medical Homes currently serve 302,548 insurer-attributed patients, of which 100,829 are Medicaid members, and are supported by approximately 168 full-time equivalents of Community Health Team staff. The Blueprint for Health also administers the Spoke program for office-based opioid treatment in community-based medical practice settings. In fact, most of the Spoke practices are also Blueprint-participating Patient Centered Medical Homes, providing medication assisted treatment for opioid use disorder. By September of 2020, there were 3,675 Vermont Medicaid members receiving medication-assisted treatment for opioid use disorder from 273 prescribers, supported by 77.53 full-time equivalents of Spoke staff (licensed registered nurses and licensed mental health clinicians).[26,27]

Effectively Managing the Pharmacy Benefit and Pharmaceutical Spend

The Pharmacy unit managed $200.4 million in gross drug spend in state fiscal year 2020 (July 1, 2019, through June 30, 2020) and invoiced approximately $132.5 million dollars in federal and supplemental rebates, representing 66.1% of the total gross drug spend. Gross drug spend reflects what DVHA paid

---

[26] https://humanservices.vermont.gov/sites/ahsnew/files/QE092020_GC_Quarterly_%20CMS%20Submission_December%203%202020_Final.pdf

[27] https://legislature.vermont.gov/assets/Legislative-Reports/Blueprint-for-Health-Annual-Report-2019-FINAL_1.31.2020.pdf

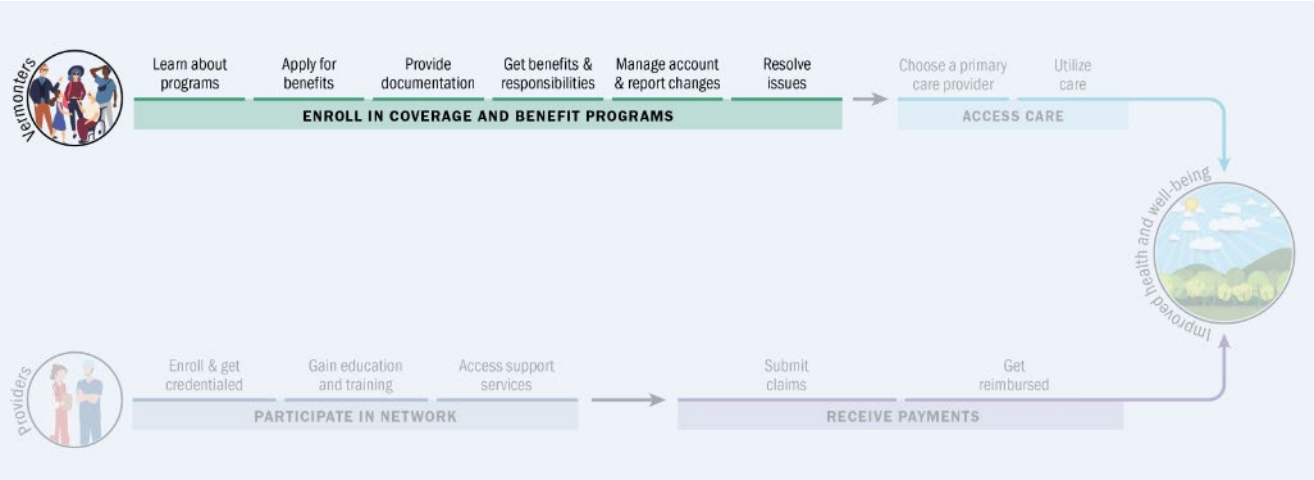
to both in-state and out-of-state pharmacies enrolled in the network. This amount represents a modest increase in gross expenditures of approximately $1.6 million dollars or a 0.82% increase over the previous fiscal year. Approximately 37% of adults and 19% of children utilize the drug benefit programs each month. In state fiscal year 2020, $5.3 million was spent on the Vermont pharmaceutical assistance program (VPharm), reflecting a 4.7% decrease in VPharm spending for the second year in a row.

Strategically Managing Departmental Activities

Each of the Department's units 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. For each of the units mentioned above, and for all units within the Department, additional information regarding performance measures by unit may be found in the Performance Accountability Scorecard.

MEMBER EXPERIENCE

HOW WE SERVE VERMONTERS



In state fiscal year 2020 (July 1, 2019 – June 30, 2020), more than 240,000 Vermonters received health coverage through Vermont's state-based exchange for health insurance (Medicaid or Qualified Health Plans), or a qualified or reflective health plan directly from Vermont's health insurance carriers. In fact, 151,839 Vermonters received health insurance through Medicaid (full health benefits), 9,988 Vermonters received pharmacy assistance through Vermont Medicaid to help pay for prescription medications and 4,515 were enrolled in Vermont Medicaid's Choices for Care (long-term care for Vermonters in nursing homes, home-based settings, and/or enhanced residential care).[28] As of June 2020, there were 24,802 Vermonters enrolled in Qualified Health Plans through DVHA, with 21,108 of them (approximately 85%) receiving subsidies to help make health insurance more affordable.[29]

The 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 insurance; and
- Members enrolled in one of the Department's health insurance plans (i.e. Medicaid or Qualified Health Plans offered through Vermont's state-based health insurance exchange).

[28] Medicaid Program Enrollment and Expenditures Quarterly Report (June 2020).
[29] Health Coverage in Vermont (June 2020).

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

<table>
<tr><th colspan="4">Total Medicaid: 166,342[1]</th><th colspan="3">Total Commercial: 73,859</th></tr>
<tr><th colspan="3">Medicaid Health Coverage</th><th>Other Medicaid Benefits</th><th colspan="2">Vermont Health Connect Qualified Health Plans[2]</th><th>Direct from Carriers[3] QHP & Reflective</th></tr>
<tr><td colspan="3">Total: 151,839</td><td>Total: 14,503</td><td colspan="2">Total: 24,802</td><td>Total: 49,057</td></tr>
<tr><td colspan="3">Medicaid for the Aged, Blind & Disabled[4]: 25,577</td><td rowspan="2">Pharmacy Assistance (Only): 9,988</td><td colspan="2">Total w/ Subsidy[5]: 21,108</td><td>Individuals: 7,525</td></tr>
<tr><td>Aged, Blind & Disabled Adults: 6,298</td><td>Duals (Medicare & Medicaid): 17,521</td><td>Blind, Disabled Children: 1,758</td><td>State & Federal Subsidy: 16,039</td><td>Federal Only Subsidy: 5,069</td><td>Qualified Health Plan (QHP): 4,921</td><td>Reflective: 2,604</td></tr>
<tr><td colspan="3">Medicaid for Children and Adults[5]: 126,262</td><td rowspan="2">Choices for Care: 4,515</td><td colspan="2" rowspan="2">No Subsidy[6]: 3,694</td><td>Small Businesses: 41,532</td></tr>
<tr><td colspan="2">Adults: 63,474</td><td>Children: 62,788</td><td>QHP: 31,168</td><td>Reflective: 10,364</td></tr>
</table>

As of June 2020

1 Medicaid enrollment is from the quarterly DVHA Enrollment and Expenditure report and is for the state fiscal year-to-date, and reports caseload representative of an average monthly member enrollment.

2 Vermont Health Connect qualified health plan data is from June effectuated coverage from DVHA enrollment reports.

3 Carrier direct enrollment is June effectuated coverage as reported by the Carriers to DVHA.

4 Medicaid for the Aged, Blind, and Disabled, Pharmacy Assistance, and Choices for Care use the previous eligibility standards (Non-MAGI) to determine eligibility.

5 Vermont uses the tax-based measure of income, Modified Adjusted Gross Income (MAGI), to determine eligibility and benefit amounts for Medicaid for Children and Adults and premium tax credits in accordance with the Affordable Care Act.

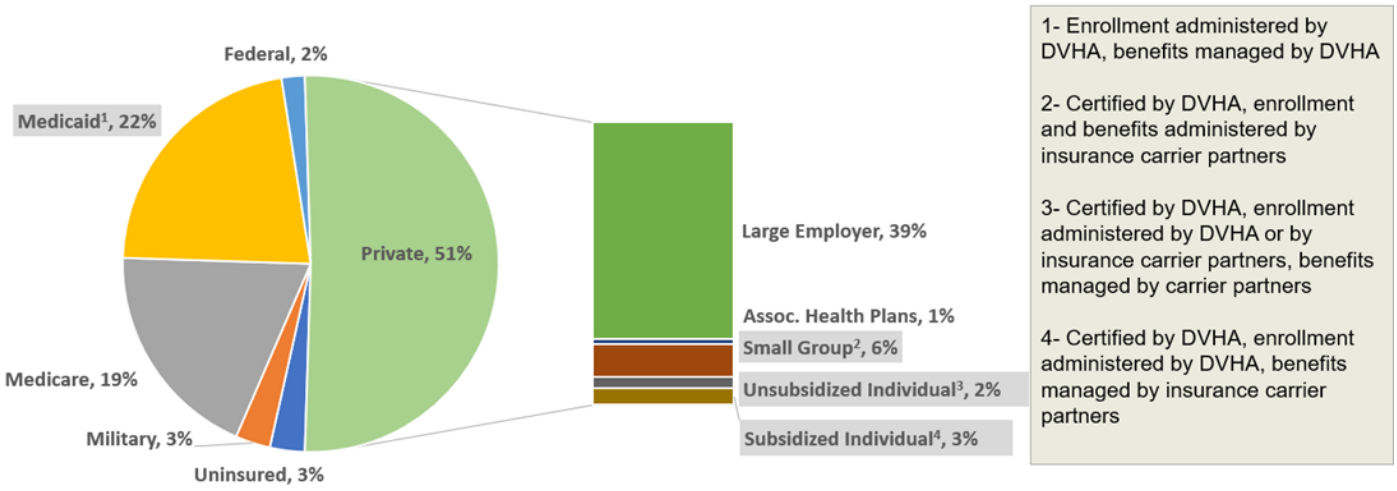
6 The no subsidy category includes those who did not qualify for a subsidy but chose to enroll through the Exchange anyway & those who did not apply for a subsidy.

The Health Insurance Landscape in Vermont

The Affordable Care Act increased access to affordable coverage for Vermonters. Overall, the number of individuals with insurance has increased. In Vermont, the number of covered individuals increased from 583,674 in 2012 to 604,800 in 2018, according to the 2018 Vermont Household Health Insurance Survey

(VHHIS).[30] Over the same period, the number of uninsured Vermonters was more than cut in half, dropping from 42,800 in 2012 to 19,800 in 2018. This correlates to an uninsured rate of 6.8% in 2012 and 3.2% in 2018. This compares to a national uninsured rate of 9.4% as reported by the 2018 CDC National Health Interview Survey.[31] Vermont has done especially well ensuring coverage for our most vulnerable children. Notably, a 2016 State Health Access Data Assistance Center report indicated Vermont children have a 1% uninsured rate, with 2.1% uninsured for 0-138% of Federal Poverty Guidelines, 0.7% uninsured for 139-400% Federal Poverty Guidelines, and 0.9% for children above 400% Federal Poverty Guidelines.[32]

The Affordable Care Act (ACA) expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges, like Vermont's state-based exchange, for those individuals with moderate incomes. Also, largely due to the ACA's provision that adult children can be covered by their parents' health plan until age 26, the number of uninsured young Vermonters decreased significantly. Overall, more Vermonters have access to preventative health services such as immunizations for children, cancer screenings, and birth control as well as other essential health benefits (e.g. substance use disorder treatment) through enrollment in qualified health plans.



One out of three Vermonters are covered by a health plan that is administered and/or certified by the Department of Vermont Health Access (DVHA).

* Estimates of primary insurance type have been compiled from multiple sources, including the 2018 Vermont Household Health Insurance Survey, and should be viewed as an example of relative scale, not absolute values.

[30] https://www.healthvermont.gov/stats/surveys/household-health-insurance-survey
[31] https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf
[32] https://www.shadac.org/sites/default/files/state_pdf/VT_Kids18.pdf

For the 19,800 Vermonters who remain uninsured there are a handful of reasons reported on the 2018 Vermont Household Health Insurance Survey.[33] Cost is still the primary barrier to health insurance coverage for Vermonters. More than half (51%) of the uninsured surveyed identify cost as the only reason they do not have insurance. An additional quarter say cost is one of the main reasons and 11% say it is one reason among many for being uninsured. Relatively few, one in ten, say cost is not much of a factor in their not having health insurance coverage.

When asked about other reasons for not having health insurance coverage:

- A third (34%) say they became ineligible for Medicaid or Dr. Dynasaur.
- About a quarter (23%) are not interested in insurance.
- One in five (20%) report a family member losing their job.
- One in ten say their family is no longer eligible for insurance through an employer because of a reduction in hours worked (11%) or that an employer stopped offering health insurance coverage (10%).

The State of Vermont is in the process of planning for the next iteration of the Vermont Household Health Insurance Survey. More recent data will be essential to understand the impact of the COVID-19 public health emergency on the uninsured population.

Medicaid and Exchange Advisory Committee

The Department of Vermont Health Access (DVHA) is informed by member experience in part though the Medicaid and Exchange Advisory Committee. This advisory committee raises issues for DVHA to consider and provides feedback on policy development and program administration. The Medicaid and Exchange Advisory Committee is comprised of stakeholders who represent a variety of groups, including consumers of both Medicaid and Exchange health plans, businesses and health care providers.[34] Advisory Committee members are appointed by the Commissioner of DVHA. Importantly, the meetings of the advisory committee are open to anyone to attend and the Committee welcomes community members, especially consumers, to share their interest in being considered for open positions.

LEARN ABOUT PROGRAMS

Vermont Medicaid Programs

Medicaid programs provide low-cost or free health coverage for eligible 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) depending on the program. Medicaid programs cover most physical and mental health care services

[33] https://www.healthvermont.gov/sites/default/files/documents/pdf/VHHIS_Report_2018.pdf
[34] https://legislature.vermont.gov/statutes/section/33/004/00402

such as doctor's visits, hospital care, emergency care, laboratory and X-ray services, family planning services, tobacco cessation counseling for pregnant persons, and transportation to non-emergency medical appointments and more. States are required to cover mandatory benefits under federal law and may cover optional benefits if they choose.[35,36] Importantly, health care services must be medically necessary in order to be covered. In general, benefits must be equivalent in amount, duration and scope for all members and covered services must be uniform across the state. Members must have freedom of choice among health care providers participating in Medicaid. States can assess premium requirements for eligibility and can impose co-payments on most Medicaid-covered benefits, including inpatient and outpatient services. Co-payments cannot be imposed for emergency, family planning, and pregnancy-related services or preventive services for children.

Importantly, Medicaid provides health insurance for income-eligible and often very ill individuals; as such, services cannot be withheld for failure to pay, but Medicaid members may be held liable for unpaid co-payments. The total cost-sharing (out-of-pocket) cost may not exceed 5 percent of the family's household income. Children under the age of 21 are covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit which requires all states to provide all services described in the Medicaid statute necessary for physical or mental health conditions, regardless of whether the services are part of states' traditional Medicaid benefit packages. This includes treatment for any vision and hearing problems, as well as eyeglasses and hearing aids. It also includes regular preventive dental care and treatment to relieve pain and infection, restore teeth, maintain dental health and some orthodontia. Said another way, under EPSDT, children up to age 21 are entitled to all medically necessary Medicaid services, including optional services, even if a state does not cover the services for adults.[37]

Vermont has chosen to cover the following Medicaid optional services:

- Physical therapy;
- Occupational therapy;
- Speech, hearing, and language disorder services;
- Podiatry;
- Chiropractic services;
- Private duty nursing services;
- Personal care;
- Hospice; and

[35] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
[36] Mandatory benefits include: inpatient and outpatient hospital, EPSDT, nursing facility, home health, physician, rural health clinic, federally qualified health center, laboratory/X-ray, family planning, nurse midwife, certified pediatric and family nurse practitioner, transportation to medical care, tobacco cessation counseling for pregnant women and freestanding birth center services.
[37] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html

- Health Homes for chronic conditions.[38]

The Vermont Medicaid Program continues to receive positive feedback from members with 86% of those surveyed through the Consumer Assessment of Healthcare Providers & Systems survey giving the plan a high rating (2019 results; 2020 results will be ready in early 2021).

Qualified Health Plans

Individuals may choose to enroll in qualified health plans purchased on Vermont's state-based health insurance exchange. Qualified Health Plans (QHPs) cover the 10 essential health benefits and enrolling through the state-based exchange allows Vermonters to receive financial help if they are eligible. [39,40,41] Financial help is available through federal Advanced Premium Tax Credits (APTC), federal and state Cost-Sharing Reductions (CSR), and Vermont Premium Assistance (VPA). Federal tax credits make premiums more affordable for people with incomes at and less than 400% of the federal poverty guidelines who are not eligible for other coverage and additional federal subsidies make out of pocket expenses more affordable for people with incomes at/below 250% of the federal poverty guidelines. 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. As a result, the State of Vermont further subsidizes premiums and cost-sharing for enrollees whose income is at/less than 300% of federal poverty guidelines to address this affordability challenge. A reference chart depicting the household income thresholds may be found on the top of the next page.

CMS 2020 Quality Rating System for Qualified Health Plans

Under the Affordable Care Act, the federal government is required to rate qualified health plans based on quality and price in order to assist customers with selecting health plans. The Centers for Medicare and Medicaid Services (CMS) is the federal governmental entity responsible for the qualified health plan ratings. The Department of Vermont Health Access is required to publicly post the results of the Quality Rating System on its website; the 2020 Quality Rating System results may be found here: https://info.healthconnect.vermont.gov/_QRS

---

[38] Vermont does not cover the following optional benefits: dentures, eyeglasses, tuberculosis-related services.
[39] 'The federal poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.' https://aspe.hhs.gov/poverty-guidelines
[40] Ambulatory care (outpatient), emergency, hospitalization (inpatient), pregnancy/maternity/newborn care, mental health/substance use disorder, prescription medication, rehabilitative/habilitative, laboratory, prevention/wellness/chronic disease management and pediatric, including oral/vision, services.
[41] Vermont's state-based exchange for health insurance was created because of the federal Affordable Care Act and Act 48 of 2011.
https://legislature.vermont.gov/Documents/2012/Docs/ACTS/ACT048/ACT048%20As%20Enacted.pdf

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

Eligibility for 2020 Benefits Determined Based on 2019 Federal Poverty Level (FPL)

Upper FPL% and ***annual*** income limits for:		Silver 94 (94% AV) CSR Tier I	Silver 87 (87% AV) CSR Tier II	Silver 77 (77% AV) CSR Tier III	VPA & Silver 73 (73% AV) CSR Tier IV	APTC only
Household Size*	**100% (for reference)**	**150%**	**200%**	**250%**	**300%**	**400%**
1	$12,490	$18,735	$24,980	$31,225	$37,470	$49,960
2	$16,910	$25,365	$33,820	$42,275	$50,730	$67,640
3	$21,330	$31,995	$42,660	$53,325	$63,990	$85,320
4	$25,750	$38,625	$51,500	$64,375	$77,250	$103,000
5	$30,170	$45,255	$60,340	$75,425	$90,510	$120,680
6	$34,590	$51,885	$69,180	$86,475	$103,770	$138,360
7	$39,010	$58,515	$78,020	$97,525	$117,030	$156,040
8	$43,430	$65,145	$86,860	$108,575	$130,290	$173,720
For each additional person add	$4,420	$6,630	$8,840	$11,050	$13,260	$17,680

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

Prescription Assistance Programs

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-payments are based on the cost of the prescription. The Vermont Pharmaceutical Assistance Program (VPharm) assists Vermont residents with paying for prescription medications by providing supplemental pharmaceutical coverage to Medicare members. Vermont residents with income no greater than 225% of the federal poverty guidelines and participating in Medicare Part D, having secured the low income subsidy if the individual is eligible and meeting the general eligibility requirements for the program, are eligible for VPharm.[42,43] Healthy Vermonters provides a discount on prescription medications for individuals not eligible for other pharmacy

[42] https://legislature.vermont.gov/statutes/section/33/019/02073

[43] Act 140 of 2020 (H.960), Section 7, directs the Agency of Human Services to request approval from the Centers for Medicare and Medicaid Services when Vermont next seeks changes to its Global Commitment to Health Section 1115 Medicaid demonstration waiver for an expansion of VPharm coverage so that for Vermont Medicare beneficiaries with income between 150 and 225 percent of the federal poverty level, the coverage would be the same as the pharmaceutical coverage under the Medicaid program.

assistance programs with household incomes up to 350% (if uninsured) and 400% (if aged 65 or older, blind or disabled) of the federal poverty guidelines. There is no cost to the State for this program.

Medicare Cost-Sharing

There are three Medicare Savings Programs that help individuals (who are aged 65 years of age or older, blind, or disabled) afford their Medicare premiums, deductibles, and/ or coinsurance depending on their income eligibility. This cost sharing is funded with Medicaid dollars.

Eligibility & Cost-sharing of Programs

Income calculations are based on gross monthly income minus certain qualifying deductions. Qualified Health Plans, advanced premium tax credits, cost-sharing reductions, and Vermont premium assistance all use Modified Adjusted Gross Income (MAGI) for eligibility determination, as is used for Medicaid for Children and Adults. If a Vermonter is determined to be eligible for a program that requires a monthly premium, the Vermonter must pay that premium to effectuate, or put into effect, coverage. The Vermonter must also continue to pay their bill on a timely basis as required to maintain their coverage.

Visit the State's website for the eligibility guidelines currently in effect for income based programs for 2021: https://info.healthconnect.vermont.gov/elig_2021.

Program	Who is Eligible?	Benefits & Cost-sharing[44]
Medicaid		
Medicaid for the Aged, Blind & Disabled (MABD)	Age ≥ 65, blind, disabled At or below the Protected Income Level Resource limits: Individual: $2,000 Couple: $3,000	Physical and mental health Chiropractic (limited) Transportation Dental ($1,000 cap/year[45], no dentures) Prescriptions ▪ $1/$2/$3 co-payment if the member does not have Medicare coverage

[44] To ensure no co-payments apply to COVID-19 testing, diagnosis, treatment, or vaccination services for Vermont Medicaid members during the public health emergency, Vermont Medicaid eliminated co-payments for outpatient hospital services and certain prescription medications (i.e., used to treat the symptoms of COVID-19). Additionally, Vermont Medicaid began temporarily waiving Dr. Dynasaur premium obligations to further facilitate initial and continuous coverage, beginning with the bills that were mailed in April 2020 for premiums due for May 2020.

[45] Effective 1/1/20, the Medicaid adult dental benefit annual limit was increased to $1,000 per Medicaid member per calendar year.

		▪ $1/$2/$3 co-payment for over-the-counter medications ▪ Up to $8.95 co-payment with Medicare coverage for prescriptions if the member has Low Income Subsidy responsibility. Other Co-payments: ▪ $3 co-payment per Dental visit ▪ $3 co-payment per Outpatient Hospital visit (over 21 years of age)
Disabled Child in Home Care (commonly referred to as "Katie Beckett Medicaid")	Up to age 19, disabled child(ren) qualifying for an institutional level of care; eligibility based only on child's income and resources to meet MABD limits	Same health care benefits as Dr. Dynasaur, no premiums, no co-payments.
Medicaid Working Disabled	Determined disabled by Social Security or State of VT and income less than 250% of federal poverty guidelines, meets working criteria, & resource limits ($10,000 individual, $15,000 couple)	Physical and mental health Chiropractic (limited) Transportation Dental ($1,000 cap/yr.,[29] no dentures) Prescriptions ▪ $1/$2/$3 co-payment if the member does not have Medicare coverage ▪ $1/$2/$3 co-payment for over-the-counter medications ▪ Up to $8.95 co-payment with Medicare coverage for prescriptions if the member has Low Income Subsidy responsibility Other Co-payments: ▪ $3 co-payment per Dental visit ▪ $3 co-payment per Outpatient Hospital visit (over 21 years of age)
Medicaid for Adults	≤ 138% of federal poverty guidelines Not eligible for Medicare and either a parent or caretaker relative of a	Physical and mental health Chiropractic (limited) Transportation Dental ($1,000 cap/yr.,[29] no dentures) Prescriptions

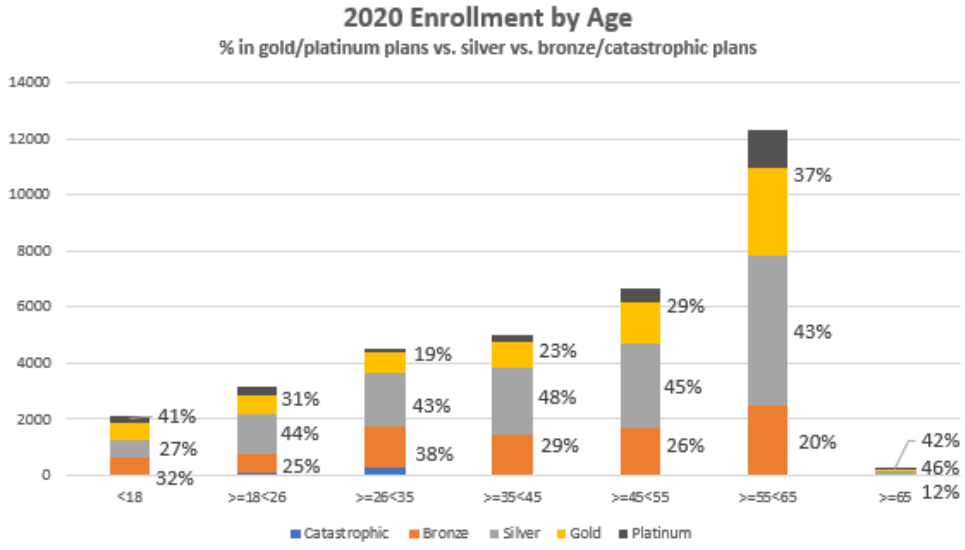
	dependent child (non-MABD) or adult under 65 years of age (expanded)	▪ $1/$2/$3 co-payment for prescriptions if member does not have Medicare coverage ▪ $1/$2/$3 co-payment for over-the-counter medications ▪ Up to $8.95 co-payment with Medicare coverage for prescriptions if the member has Low Income Subsidy responsibility. Other Co-payments: ▪ $3 co-payment per Dental visit ▪ $3 co-payment per Outpatient Hospital visit (over 21 years of age)
Dr. Dynasaur	Children under age 19 at or below 317% federal poverty guidelines	Same as Medicaid benefits and includes: Eyeglasses Full Dental Benefits No co-payments for: ▪ Prescriptions, over-the-counter medications, dental visits or outpatient hospital visits. Monthly household premiums: • No premium for up to 195% federal poverty guidelines • $15 premium for up to 237% federal poverty guidelines per family per month • $20 premium for incomes over 237% up to 317% federal poverty guidelines per family per month if other insurance. • $60 premium for incomes over 237% up to 317% federal poverty guidelines per family per month without other insurance.
	Pregnant persons at or below 213% federal poverty guidelines	Same as Medicaid benefits and includes: Eyeglasses Full Dental Benefits No premium for pregnant women No co-payments for: ▪ Prescriptions, over-the-counter medications, dental visits or outpatient hospital visits.
Qualified Health Plans		
Qualified Health Plans (QHP)	No income restrictions	Choice of QHPs on Vermont's state-based exchange All plan designs include cost-sharing

Federal Advanced Premium Tax Credits (APTC)	100-400% federal poverty guidelines, no other Minimum Essential Coverage (MEC), e.g. Medicaid	Tax credit received in advance monthly to reduce QHP premium or yearly as a lump sum
Federally Required Cost-Sharing Reduction (CSR)	Up to 250% federal poverty guidelines, eligible for advanced premium tax credit, enrolled in silver QHP	Reduces co-payments, co-insurance, & deductibles, etc.
Vermont Premium Assistance (VPA)	Up to 300% federal poverty guidelines, eligible for advanced premium tax credit.	Reduces QHP premium
Vermont Cost Sharing Reductions (VCSR)	200-300% federal poverty guidelines, eligible for advanced premium tax credit / Vermont premium assistance, enrolled in silver QHP	Reduces co-payments, co-insurance, & deductibles, etc.
Pharmacy Assistance Programs		
VPharm 1, 2, & 3	Eligible & enrolled in Medicare PDP or MAPD **VPharm 1**: ≤150% FPG and must apply for LIS **VPharm 2**: 150.01% - 175% FPG **VPharm 3**: 175.01 – 225% FPG	VPharm 1 (after primary LIS reductions): ▪ Cost-sharing for medications and diabetic supplies covered by Medicare; ▪ Full coverage for some over-the-counter medications and excluded Medicare drug classes; ▪ Part D premiums (dependent on LIS Level), and eye examinations. VPharm 2 & 3 ▪ Cost-sharing for maintenance medications and diabetic supplies ▪ Coverage for some maintenance over-the counter medications and excluded maintenance Medicare drug classes; ▪ Part D premiums (dependent on LIS Level).

		Monthly premium per person: o VPharm 1: $15 o VPharm 2: $20 o VPharm 3: $50 $1/$2 prescription co-payments No retroactive coverage
Healthy Vermonters Program	350% FPG if uninsured 400% FPG if ≥ age 65, blind, or disabled	Not a funded benefit, offers Medicaid prescription pricing If enrolled in Medicare Part D, excluded classes of prescriptions are priced at the Medicaid rate No monthly premium No retroactive coverage
Medicare Cost-Sharing		
Medicare Savings Programs	**Qualified Medicare Beneficiary (QMB)** ≥ age 65, blind, or disabled Active Medicare beneficiary ≤100% federal poverty guidelines	Eligible for Medicaid payment of their Medicare part A and part B premiums, deductibles, and co-insurance. No retroactive coverage. Coverage starts the first of the month after the initial QMB benefit is granted.
	Specified Low-Income Medicare Beneficiary (SLMB) ≥ age 65, blind, or disabled Active Medicare beneficiary <120% federal poverty guidelines	Eligible for Medicaid payment of their Medicare part B premiums Up to 3 months retroactive eligibility possible Coverage starts first of the month of application or all eligibility met
	Qualifying Individual (QI-1) ≥ age 65, blind, or disabled Active Medicare beneficiary ≤ 135% federal poverty guidelines	Eligible for Medicaid payment of their Medicare part B premiums Up to 3 months retroactive eligibility possible Coverage starts first of the month of application or all eligibility met

REACHING VERMONTERS – INCREASING ENROLLMENT

DVHA engages with community partners, including hospitals, clinics, agricultural organizations, libraries, pharmacies, and other stakeholders to participate in public events and conduct targeted outreach in addition to utilizing social and other forms of media. This broad outreach seeks to help Vermonters understand the health insurance options available to them and the purpose of the state's health insurance marketplace. Targeted outreach focuses on groups of Vermonters likely to still lack access to health insurance, including farmers, justice-system involved individuals, new Vermont residents, residents of rural areas, and those in the 25-34 age group. While the Vermont Household Health Insurance Survey 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 indicating that this age group may be receiving the message about their insurance options.



The Health Access Eligibility and Enrollment unit's outreach with existing members focuses on helping them get the most out of their health plans, reminding them to respond to Medicaid and Qualified Health Plan (QHP) renewal notices, and offering information. As Vermont's state-based health insurance exchange is an integrated marketplace providing both Medicaid and qualified health plan coverage, DVHA serves households with eligibility for either. For households with both Medicaid and QHP enrollees, the QHP renewal notice includes language reminding customers that eligibility for the entire household will be updated as a result of a reported change, if applicable. Medicaid members in households where other members are enrolled in QHPs are renewed through a separate process and receive Medicaid specific renewal notices.

DVHA offers "Health Insurance 101" events and webinars. These events were promoted to existing members and primarily focused on increasing awareness and understanding of the online Plan Comparison Tool. The Plan Comparison Tool is a resource to help Vermonters better understand the subsidies they qualify for and how various plan designs and out-of-pocket costs could impact their total health care costs. Vermonters' use of the Plan Comparison Tool has demonstrated its value for Vermonters; the Tool was praised as a key resource for Qualified Health Plan members, especially those transitioning out of Medicaid, or those new to health care plan comparison. These resources will be especially useful in clearly outlining changes to premiums and the cost sharing under each plan for new enrollment.

APPLY FOR BENEFITS

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.

It is important to note that until this state fiscal year (2020), Vermonters enrolling in Medicaid because of age (65 or older), blindness, or disability had to fill out a paper application (but could still access help to complete the paper application through the Customer Support Center or with a local Assister). In early 2020, the Department launched a Medicaid for the Aged, Blind, and Disabled application supplement that could be completed online as a PDF and submitted using the Document Uploader. In September 2020, the Medicaid for the Aged, Blind, and Disabled application pilot launched under the Integrated Eligibility and Enrollment program allowing customers to have their application completed while they are on the phone with the State's Customer Support Center. This addresses a Medicaid compliance issue and provides the foundation for additional improvements.[46]

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

[46] Integrated Eligibility and Enrollment Program Updates (August 2020 and November 2020).

Applying Online

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. Four years ago, the Department established a goal to increase the percentage of Vermonters applying for coverage online. From June 2016 to June 2019, the percentage of Vermonters applying for coverage online more than tripled, increasing from 16% of applications in 2016 to 57% in June 2019. After 3 years of monitoring the increase, the Department is planning to focus on better understanding the changes Vermonters make online themselves during Open Enrollment, as compared to calling and talking to a representative in the Customer Support Center, to guide future improvement efforts (e.g., customer portal improvements).

Applying by Phone

Callers to the Department's contracted Customer Support Center continue to experience prompt service overall. However, call volume is the highest during Open Enrollment. As a result, the Department has established the percentage of calls answered within 25 seconds during Open Enrollment as the new measure to assess performance (implemented in 2020). In the first month of Open Enrollment (November 1-30, 2020), 74% of calls were answered within 25 seconds in accordance with new contract provisions and nearly meeting the target of 75% despite the increased questions about health coverage from customers attributable to the ongoing COVID-19 public health emergency. DVHA continues to work with the contracted call center vendor, Maximus, to increase trained staff and staffing coverage to avoid the long wait times that occurred in the past.

Scorecard: The Percentage of Calls Answered within 25 Seconds During Open Enrollment

Target: 75%	Current Performance (November 2020): 74%

Data Review: A review of the data illustrated that Maximus met the goal for virtually every day of the Open Enrollment period except for Mondays. High call volume on Mondays has historically been observed due to both Open Enrollment and general Medicaid eligibility questions.

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 online and phone applications. There are a couple of notable exceptions, however. First, 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. As noted earlier, the Medicaid for the Aged, Blind, and Disabled application process has traditionally been paper-based, but the pilot launched under the Integrated Eligibility and Enrollment program in September of 2020 allows customers to have their application completed while they are on the phone with the State's Customer Support Center.

Applying with an In-person Assister

The In-person Assister 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 and maintain its low uninsured rate. Paired with the Customer Support Center and online tools, the In-person Assister Program provides an additional option of support to Vermonters who may have encountered barriers to enrollment in health care coverage. Vermont's Assister Network consists of more than 110 Certified Application Counselors, Navigators, and Brokers. These Assisters provide in-person enrollment assistance in all 14 counties of the state. As federal grant funding for Assister positions went away, organizations took on having their own staff trained to provide this support. Assisters who are funded by hospitals, clinics, and organizations 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. Assisters work in organizations where providers are hospital-based or community-based and within service organizations.

Assisters are able to meet Vermonters where they are whether it be a senior center or when they are admitted to the hospital. A large part of what Assisters do through their work results in alleviated stress and reassurance for Vermonters that they can in fact afford health insurance and the health care that they need. As stated by one long-time Assister, "meeting with someone face to face, and understanding their fear, often means more to people than anyone knows." In-person assistance is especially important for those Vermonters who become ineligible for Medicaid, often due to an increase in income when they start a new job. On their own, they often do not know that they still qualify for health coverage at an affordable premium through financial help for a Qualified Health Plan.

> **Story:** An older Vermonter living in a remote part of the State had been covered through Medicaid for a long time but became ineligible due to a change in income. He was too scared to look for other coverage because he was sure he could not afford the premiums. Without insurance to cover the cost, he stopped filling his diabetes medications and ended up hospitalized. While in the hospital, a locally-based Assister came to meet with him in-person

and helped him to understand his options. He realized that he could afford the premiums. He was then able to get back on track managing his diabetes.

The In-person Assister Directory can be found on the Vermont Health Connect website: https://info.healthconnect.vermont.gov/find.

Applying for Long-Term Care Programs

There are two parts to determining Vermont Long-Term Care (LTC) Program 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 Choices for Care clinical assessment. Developmental Disabilities Home & Community Based Services, Traumatic Brain Injury, and Enhanced Family Treatment programs 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.

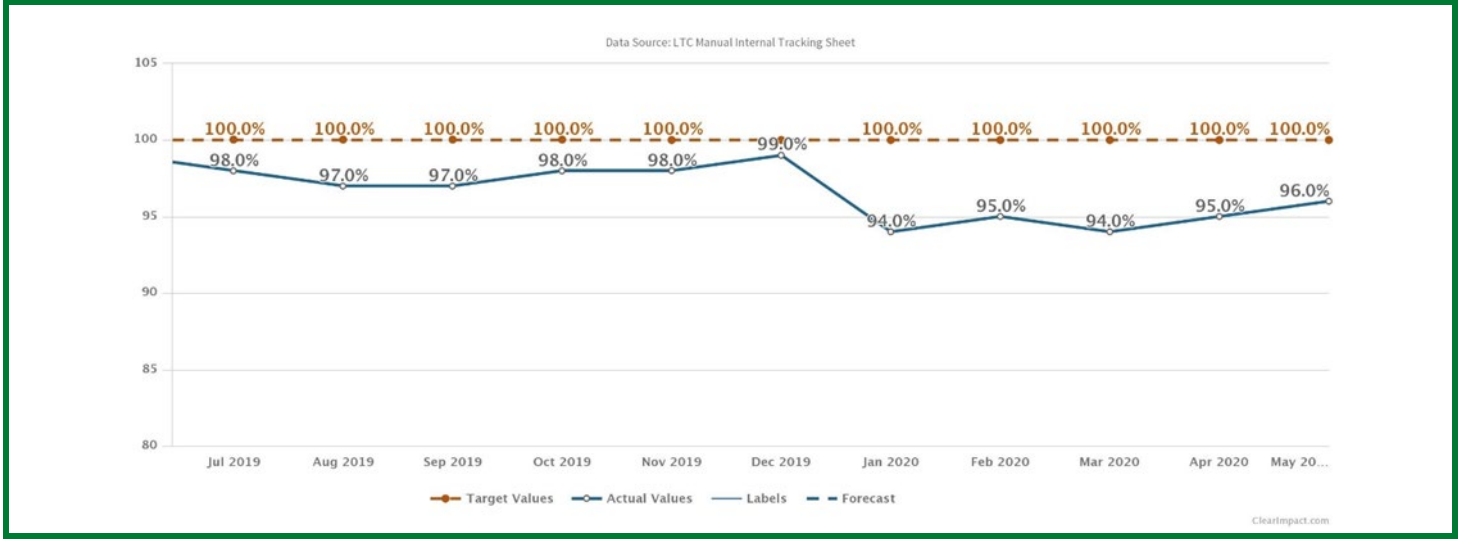
Federal rules require that Long-Term Care program staff evaluate income and resources, as well as review financial statements for a five-year "look-back" period. In addition, they must carefully review transfers of income and/or resources made within the 60 months prior to the month of application to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

Long-Term Care (LTC) program staff work closely with clients, families, nursing facilities, case managers, and authorized representatives to ensure eligible Vermonters can access needed long-term care services promptly and in their chosen setting – their home, an approved residential care home, an assisted living facility, or an approved nursing home. However, the ability of the client to gather and submit verification documents in a timely manner often presents a challenge. Staff work 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 focused on business process improvements necessary to ensure that applications are processed within the 45-day federal timeliness standard. Vermont Medicaid implemented the Center for Medicare and Medicaid Services (CMS)-mandated electronic Asset Verification System (e-AVS) on January 1, 2018. Due to a number of reasons, Vermont can be less successful in retrieving information from financial institutions when compared to other states and this can result in an associated increase in the amount of manual effort required by Vermont's Long-Term Care staff. However, as a result of the process improvement work in 2017-2018, and despite the increasing number and complexity of Vermont LTC applications observed, data demonstrated that, on average, approximately 96.6% of new LTC applications were processed within the 45-day timeliness standard in 2020 prior to the onset of the COVID-19 public health emergency.

Scorecard: The Percentage of New Long-Term Care Applications Processed (within 45-day standard)	
Target: 100%	**Performance Range (July 2019 – March 2020): 94% - 99%**
Trend: The average percentage processed within the 45-day standard was 96.6% for the July 2019 – March 2020 time period.	



Providing Documentation

Regardless of how Vermonters apply for programs, completing verification requirements can be challenging and time-consuming. Vermonters often asked internal staff if they can "just email" their

documents. For staff, verifying Vermonters' income (and other requirements) routinely involved delays, stressful conversations, and duplicative work. Mail and paper slowed the entire process from initial notification, to mailing documents, to scanning and indexing. Internal staff waited for Vermonters' submission of required documentation such as pay stubs, employment forms, or attestations to process applications or changes, which lengthened the eligibility determination process.

To make it easier for Vermonters, DVHA has worked to implement a technical solution, the Document Uploader, to allow Vermonters to utilize mobile and online technology to submit verification documents and to automate the classification of these documents. This solution improves the efficiency of the eligibility determination process and results in a better customer experience for Vermonters. The Document Uploader launched in November of 2019 and closed in September 2020 following completion of authentication work that allowed for consolidation of two log-ins into a single log-in. In addition, the authentication work was essential for coming into compliance with federal security standards. As a result, Medicaid and Qualified Health Plan customers are able to submit verification documentation electronically.

Enrollment Integration & Reconciliation

There are multiple systems of record involved in the range of health plans within DVHA.[47] To ensure that members receive prompt care and that providers and pharmacies can bill for services, it is essential that the systems display up-to-date information about coverage. This requires that changes 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.

Monthly **reconciliation** between the Department's eligibility system and those of the insurance carriers is essential for maintaining positive customer experiences, data integrity and for limiting financial liability. If discrepancies can be identified and most of those discrepancies addressed within the month, the Health Access Eligibility and Enrollment Unit is in a strong position to avoid 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. After months of continually

Scorecard: % of Discrepancy Work Completed in 30 Days	
Target:	**100%**
Current Performance:	**100%**

[47] For example, the system of record for qualified health plans and dental plans purchased on the Exchange is one eligibility system, the insurance carriers also have their systems, and there is a separate enrollment and eligibility system for Medicaid for the Aged, Blind and Disabled.

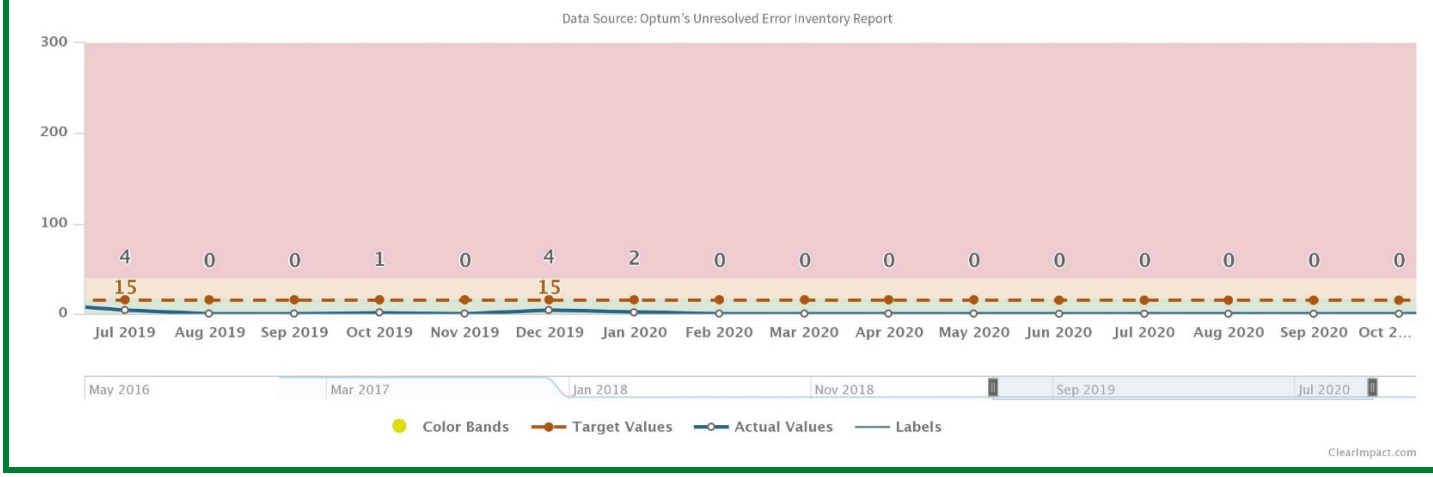
surpassing that goal, **the target was raised to 100% in 2018, which the unit has continued to meet as of November 2020**.

The Department also utilized control reports and an ongoing reconciliation process to resolve discrepancies between the State's case management systems, aligning Medicaid and qualified health plan reconciliation processes to report on standardized measures.

Scorecard: The Number of Enrollment Integration Errors Greater than 10 days old

Target: Below 15	Current Performance (October 2020): 0

Trend: Enrollment integration errors are corrected in a timely manner and are below the target for the year. In months where there was a higher volume of cases being processed, the errors tend to increase.



GET BENEFITS & RESPONSIBILITIES

Reporting Changes

In a typical month, and outside of the COVID-19 public health emergency, the Health Access Eligibility and Enrollment Unit (HAEEU) **receives more than 10,000 member requests**, over half of which involve reported changes.[48] Most of these requests are made by phone to the Customer Support Center.

[48] Outside of the context of the COVID-19 public health emergency: Members are required to report changes to their household or income; Medicaid members are required to report changes within 10 days, while Qualified Health Plan members have 30 days to report changes. In addition, most programs require an annual redetermination process. For Medicaid members, this occurs on a rolling basis through the year; for Qualified Health Plan members, this occurs during Open Enrollment.

All Vermonters who are served by the Department's Eligibility and Enrollment unit should expect that their requests will be addressed promptly. However, during the first few years of implementing Vermont's state-based exchange for health insurance, 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, the Eligibility and Enrollment unit now consistently completes more than 90% of member requests within ten business days. **In fact, before the onset of the COVID-19 public health emergency, 98% of customer requests were resolved within 10 business days.**

Scorecard: % of Customer Requests Resolved in 10 Business Days	
Target:	**95%**
Current Performance:	**90%**

Enrollment in Primary Care

Having a health insurance card does not 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, and DVHA's Health Access Enrollment and Eligibility, Provider and Member Relations, Vermont Chronic Care Initiative, Blueprint for Health, Clinical and Quality units all provide support for Vermonters enrolling in Medicaid or qualified health plans through Vermont's state-based exchange to assure access to care.

Removing Barriers to Care

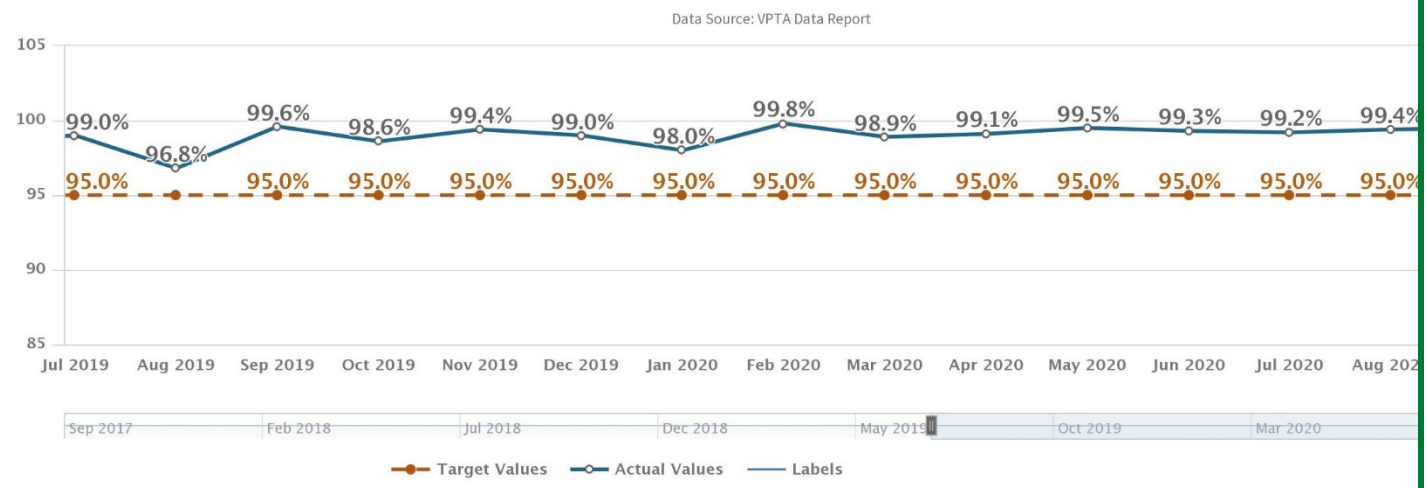
Transportation - In order to respond to the transportation challenges experienced by Vermont Medicaid members, the Department of Vermont Health Access (DVHA) contracts with the Vermont Public Transportation Association (VPTA).[49] The Vermont Public Transportation Association is comprised of a regional network of public transit providers who transport Medicaid and Dr. Dynasaur members to and from medically necessary, non-emergency medical services. Non-Emergency Medical Transportation is a covered service for members enrolled in Medicaid and Dr. Dynasaur programs. As an example, Medicaid members receiving medication assisted treatment for opioid use disorder that want to place a request for transportation are able to contact their regional public transportation provider directly.[50] The regional public transportation provider will review eligibility criteria and make trip arrangements for the Medicaid member. Medicaid members may find more information about transportation on the VPTA website. Providers may find more information about Non-Emergency Medical Transportation (NEMT) on DVHA's website.[51]

The Department's Provider and Member Relations unit has established a reporting process with the Vermont Public Transportation Association to ensure that Medicaid members are getting to and from

[49] http://www.vpta.net/medicaid-transportation/
[50] http://www.vpta.net/medicaid-transportation/
[51] Medicaid Non-Emergency Transportation Manual.

their appointments on time. Reporting indicates that the service has exceeded the target of 95% of rides completed on time. The Non-Emergency Medical Transportation program uses a per member per week methodology to calculate weekly payments based on the total number of unduplicated individuals served. While this reimbursement methodology allows for more predictable payments to the Contractor, the length of the time period (based on the prior 395 days, with the past 30-day period excluded) helps safeguard against sudden and drastic decreases in utilization.[52]

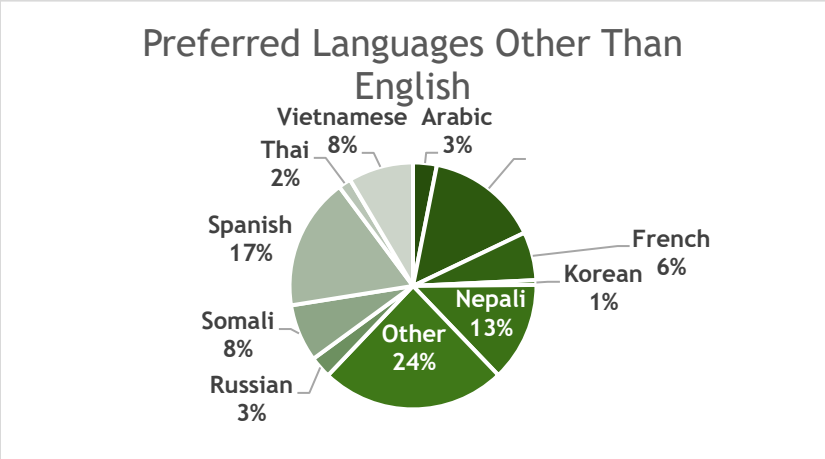
Scorecard: Percentage of Pick-up/Return Trips the Transportation Contractor Completes On Time	
Target: 95%	**Current Performance (September 2020): 99.5%**
Trend: Performance has remained above the target for the entire year, resulting in timeliness of rides for members.	



Language Assistance – DVHA works to ensure meaningful access to all programs and services for all Vermonters including those with limited English proficiency. The Department provides language assistance so that persons seeking services may understand which services and benefits are available to them. Vermonters who need translation services should call the Customer Support Center at 1-855-899-9600.

The below chart shows an example of the languages other than English indicated by Vermonters as their preferred language when they complete their health coverage application. This illustrates a variety of languages in which language assistance may be supportive.

[52] As a result, changes in utilization do not produce cost savings for the Department.



It is also important for members to have meaningful access to care at a provider's office. When care is delivered in a language other than the patient's preferred language, there can be significant barriers to the patient understating a diagnosis, the care they are consenting to, or if important follow up is needed. As well as sharing what is important to the individual and their family, providers are required under federal and State law to provide interpreters for patients with limited English proficiency and those who are deaf or hard of hearing. DVHA's network of providers are able to bill for reimbursement of interpreter services for Vermont Medicaid members.[53] The Department's Member and Provider Services unit works to ensure that providers know the resources available to them to provide language assistance.

Resolving 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 that 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 over 200,000 members, it is inevitable that there will be mistakes, disagreements, and other problems. The Department of Vermont Health Access aims to both minimize the occurrence of these problems and to provide clear, formal, and informal paths for members to seek resolution.

Staff at the 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 the Department's Health Care Appeals Team will work with the member.

[53] Section 4.8.4: Limited English Proficiency, Section 4.8.5 Deaf and Hard of Hearing.

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 Human Services Board hearing.

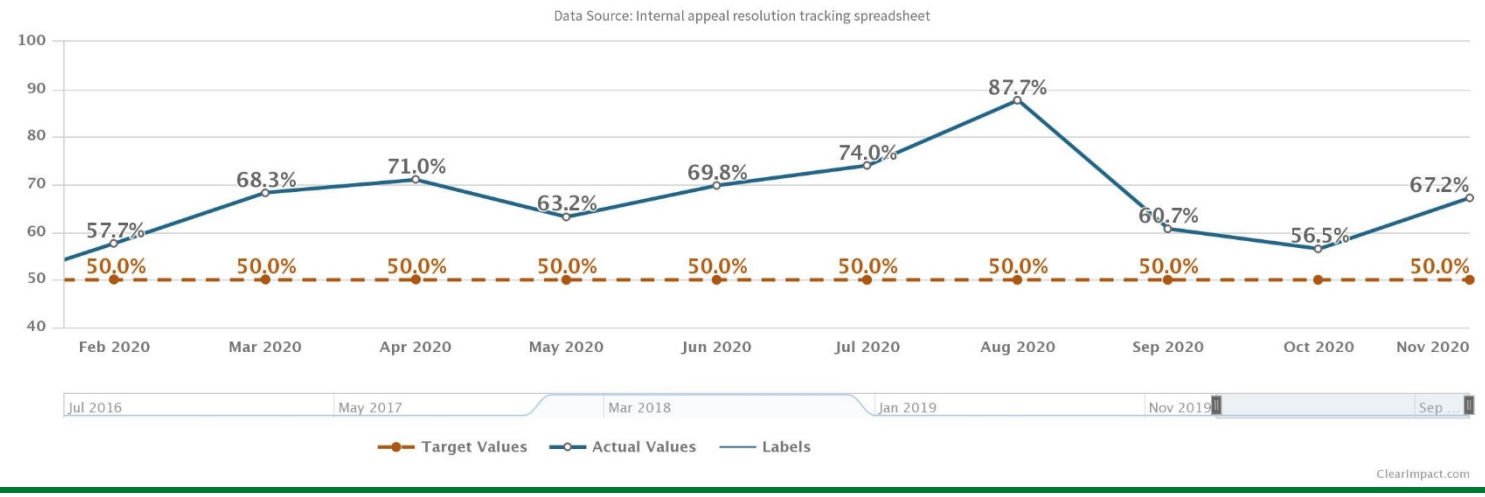
To provide strong customer service and to save the State's resources, the Appeals staff work to identify cases that can be resolved in the customer's favor prior to referring cases to the Human Services Board and engaging in the resource-intensive formal Fair Hearing process. If a mistake was made in 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.

The Health Care Appeals Team has been tracking a performance metric in the form of the percentage of eligibility appeals that are resolved prior to the formal Fair Hearing process. The target for this metric was reset to 50% in January 2019 to more accurately represent the ideal performance that would sustain the reduced number of mistakes made as well as continuing to resolve any mistakes that do happen more efficiently. 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 Appeals staff still want to address as many cases internally as possible, staff do not necessarily want to increase the volume. Why? If the percentage rises significantly higher than 50%, this could mean that too many mistakes are being made by the Customer Support Center team or eligibility system.

Scorecard: Percentage of Eligibility Appeals that are Resolved Prior to the Formal Fair Hearing Process

Target: 50%	**Current Performance (November 2020): 67.2%**

Trend: Performance has consistently trended higher than the target of 50%.



Member and Provider Services – Navigating Member Needs and Issues for Resolution

The Department's Member and Provider Services unit assures members have access to appropriate health care for their physical health, mental health and dental health needs. The goal within the Member and Provider Services unit is to ensure members are informed, member issues are addressed promptly, and members are satisfied with the answers received. The Customer Support Center is the point of initial contact for members' questions and concerns. If questions or concerns exist after talking with Customer Support, the call may come to Member and Provider Services staff for additional information/review. Member and Provider Services staff are currently working to identify educational needs for the member community and proactively offer resources for members.

Member issues come from many different avenues, including but not limited to, members, the Governor's Office, the Secretary of the Agency of Human Services' Office, members of the Vermont Legislature, Vermont Legal Aid, and the provider community. Frequently, Member and Provider Services staff are working on issues such as resolving members' out-of-network emergency care billing issues (while remaining mindful of enrollment and claims processing rules and regulations). The Member and Provider Services team works to ensure that members are not held responsible for emergency or post-stabilization medical services when out-of-network. Life is unpredictable and the Member and Provider Services team is there to help when unpredictable events manifest. For example, when a member is out-of-state and finds themselves in the emergency department instead of where they intended to be, staff are there to serve as a link between the member and the billing service provider(s). Member and Provider Services has served as the primary outreach and education arm of Vermont Medicaid for out-of-network emergency medical service billing matters since 2011. Staff address and resolve cases that range anywhere from stitches to major cardiovascular events and the team addresses each case with the same level of urgency and need. Member and Provider Services strives towards a resolution where Vermont Medicaid acts as the responsible payer and the member is not held accountable for any financial responsibility. The process typically begins when a member reports an out-of-network emergency related bill to the Customer Support Center (Maximus). Customer Support staff upload this information to Siebel, a customer relationship management software tool, and the case is then assigned to a unit staff member in the form of a service request.

From there, outreach materials are generated and sent to each service provider. These materials explain how Vermont Medicaid is required under federal law (42 CFR 438.114) to serve as the responsible payer for such services regardless of whether the provider that furnishes the services is contracted with Vermont Medicaid. Providers may utilize Vermont Medicaid's online Provider Management Module (PMM) in order to enroll as a Vermont Medicaid provider, thus enabling them to submit claims and be paid at Vermont Medicaid rates. If providers are unwilling or unable to do so, they may also submit a paper claim directly to Member and Provider Services staff. Member and Provider Services staff will then work with Gainwell Technologies[54]

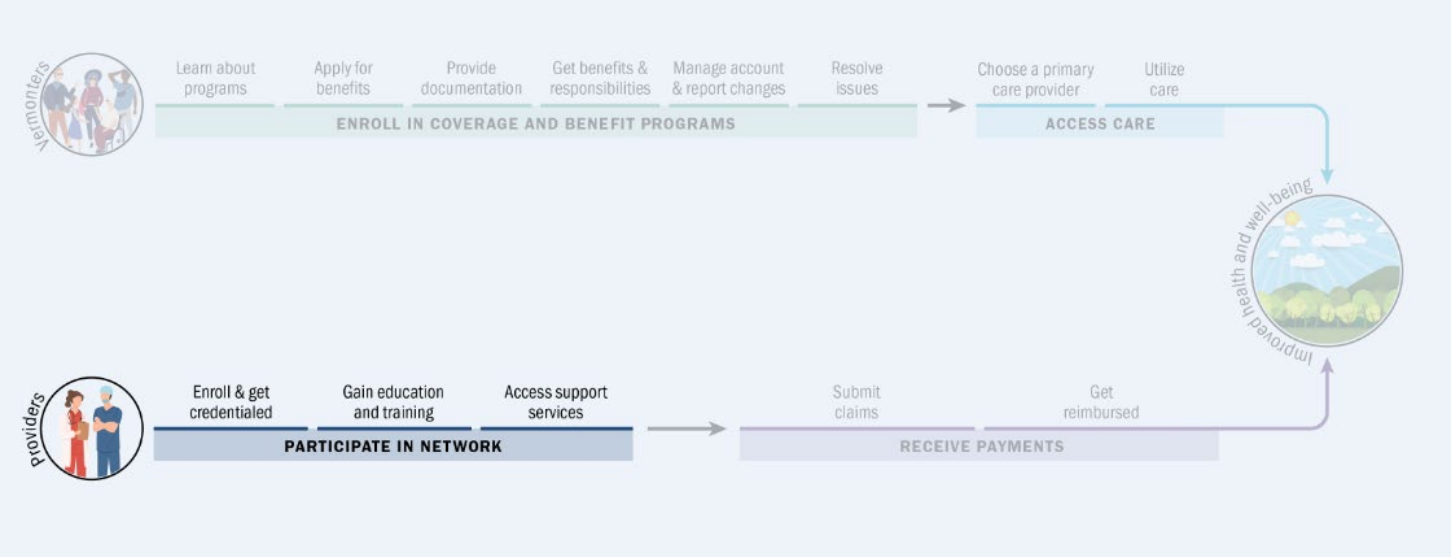
[54] Gainwell Technologies, formerly DXC Technology, is the contracted fiscal agent for enrollment/re-enrollment of Vermont Medicaid providers, management of a provider call center, management of the Medicaid Management

enrollment specialists and claims reviewers throughout the enrollment and claims adjudication process. Staff make it clear to providers that Vermont Medicaid payments should be considered as payment in full and that billing any balance to the member is strictly prohibited.

Members are kept informed of the progress made by having direct phone access to Member and Provider Services staff, opting to have copies of outreach materials mailed to them for their records, as well as having service request notes attached to each step of the process in the customer relationship management software (Siebel). Members are also encouraged to remain in touch with Member and Provider Services staff during the process for questions and updates related to their specific case. Staff aim to serve members needs and keep them well informed of how Vermont Medicaid is able to address such billing needs throughout the enrollment and payment process.

PROVIDER EXPERIENCE

HOW WE SUPPORT PROVIDERS



With a focus on providing access to quality care for Vermonters, the Department of Vermont Health Access supports an extensive network of providers. Vermonters have a variety of health care needs and require a network of providers that can address those needs and deliver medically necessary, covered services. The Member and Provider Services unit works to support providers through training and outreach on enrolling, getting credentialed, billing, program changes, and state and federal requirements.

Information System, processing of Vermont Medicaid claims, and payments to Vermont Medicaid-enrolled providers.

Despite the challenges of the COVID-19 public health emergency, the Department observed an increase in the number of providers participating with the Vermont Medicaid program during state fiscal year 2020. In state fiscal year 2020, there were 26,636 providers enrolled in DVHA's network (23,089 individual providers, 1,586 group providers, and 1,961 facilities).[55] The table below lists the number of providers by type.[56]

Provider Type Code	Provider Type Code Description	№ of Individual Providers	№ of Group Providers	№ of Facilities	Total Number
1	GENERAL HOSPITAL			536	536
3	CLINIC CENTER URGENT CARE		9	1	10
4	DENTIST	462	142		604
5	PHYSICIAN	14511	551		15062
6	PODIATRIST	50	4		54
7	OPTOMETRIST	126	38		164
8	OPTICIAN		1		1
9	PHARMACY	1	11	350	362
10	HOME HEALTH AGENCY			12	12
11	INDEPENDENT RADIOLOGY		2	6	8
12	INDEPENDENT LAB		6	158	164
13	AMBULANCE			144	144
14	DME SUPPLIER		21	244	265
17	PT-OT-ST	689	124		813
18	CHIROPRACTOR	148	63		211
19	MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT	1930	134		2064
20	NURSING HOME - MEDICARE PARTICIPATI			59	59
21	NURSING HOME - NON-MEDICARE PARTICI			7	7
23	ANESTHESIA ASSISTANT	61			61
27	HOSPICE			12	12
29	ICF/INTELLECTUAL DISABILITY FAC			1	1
30	PSYCHOLOGIST - DOCTORATE	393	29		422
31	RURAL HEALTH CLINIC		16		16

[55] In state fiscal year 2019, there were 24,035 providers enrolled in DVHA's network (21,152 individual providers, 1,327 group providers, and 1,452 facilities).
[56] No. refers to "number of."

35	AUDIOLOGIST	77	6		83
36	OTHER INTERNAL USE ONLY		16		16
37	STATE DESIGNATED MH CLINIC		53	2	55
38	STATE DEF. INTELLECTUAL DIS CLINIC		15	2	17
39	STATE DEF. CHILD - FMLY WVR CLINIC		3	1	4
40	MH/DS CLINIC - VHAP		7	2	9
42	STATE DEFINED IND AGING WAIVER		7	10	17
43	NATUROPATHIC PHYSICIAN	81	18		99
44	PHARMACIST	114			114
T01	PTF PSYCH RESIDENTIAL FACILITY			16	16
T02	DIALYSIS FACILITIES			12	12
T03	AMBULATORY SURGICAL CENTER			6	6
T04	PERSONAL CARE SERVICES		12		12
T06	NURSE PRACTITIONER	2685	24		2709
T07	LICENSED NURSE	10	10		20
T11	FEDERALLY QUALIFIED HEALTH CENTER		58		58
T13	NON-EMERGENCY TRANSPORTATION SVCS		6	9	15
T14	STATE DEF RESIDENTIAL CARE WAIVER		44	93	137
T16	STATE DEFINED TARGETED CASE MGMT			1	1
T17	STATE DEFINED IND CASE MANAGER	2	1	1	4
T18	STATE DEFINED DOH INTELLECTUAL FAC			1	1
T19	STATE DEFINED VOC REHAB AGENCY		5	11	16
T20	FAMILY SUPPORT MANAGEMENT		7	9	16
T21	STATE DESIGNATED CHILDRENS MED SVCS		6	30	36
T23	STATE DEFINED NON-MED RESID FAC		49	127	176
T25	STATE DEFINED ADAP FACILITY			34	34
T26	STATE DEFINED ADULT DAY FACILITY		2	11	13
T27	STATE DEFINED DEPT OF EDUCATION		30	41	71
T31	SOLE SOURCE EYEGLASS LAB			1	1
T34	STATE DEFINED CASE RATE AGENCY	5		7	12
T36	INDEPEND. BILLING HIGH TECH NURSES	44			44
T37	PHYSICIAN ASSISTANT	1218			1218
T38	LICENSED ALCOHOL DRUG COUNSELOR	193	12		205
T39	LICENSED MIDWIFE	29	4		33
T41	LICENSED PHYSICAL THERAPY ASSISTANT	2			2
T42	ACO		1		1
T44	NUTRITIONAL EDUCATORS	135	11		146
T45	SLEEP STUDY CENTER		2		2

T46	BEHAVIORAL ANALYST	123	21		144
T47	FAMILY SUPPORTIVE HOUSING		5	4	9

Member and Provider Services monitors the adequacy of Vermont Medicaid's network of enrolled providers and ensures that members are served in accordance with managed care requirements.[57] The Unit strives to make certain that Vermonters do not have to travel too far to receive the care they need, maximize members' choices for providers, and facilitate connection with primary care providers for improved health and wellness and management of chronic disease for members.

Member and Provider Services also works with many organizations, such as the Vermont Medical Society, Vermont Association of Hospitals and Health Systems, Vermont State Dental Society and Vermont Legal Aid, to provide support and guidance to providers 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.

ENROLL AND GET CREDENTIALED

The Member and Provider Services unit also has obligations relating to providers including provider enrollment, screening, revalidation screening and monitoring of the network to help prevent Medicaid fraud, waste and abuse. Federal regulations, specifically 42 CFR § 455.410 and § 455.450, require all participating providers to be screened upon initial enrollment and revalidation of enrollment.[58] Health care providers are categorized by screening levels established by the Centers for Medicare & Medicaid Services and utilized by the Department of Vermont Health Access. 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. The Department then screens providers according to their risk level. The Department may increase risk level assignments at any time, and the new risk level will apply to all enrollment-related activities. The Member and Provider Services unit works closely with its fiscal agent, Gainwell Technologies, to screen and enroll providers.[59,60] On average, the Department 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 Member and Provider Services team often contacts providers when they indicate that they wish to no longer participate

[57] Evaluation of network adequacy is completed every six months. Member and Provider Services works with a variety of associations and societies to encourage providers to participate with Vermont Medicaid & meet the needs of its members.
[58] CFR is the Code of Federal Regulations.
[59] http://www.vtmedicaid.com/assets/provEnroll/VT_PMM_ProviderEnrollmentOnlineApplicationInstructions.pdf; Provider Services Telephone Number: 1-802-878-7871.
[60] In late 2020, DXC Technology completed its sale of U.S. state and local health and human services business to Veritas Capital, thereby forming Gainwell Technologies.

with Vermont Medicaid to identify if there were challenges that could be addressed that would support continued participation with Vermont Medicaid.

Member and Provider Services conducts site visits for a subset of providers upon enrollment and every 5 years thereafter. This subset of providers includes:

- Ambulance service suppliers;
- Community mental health centers;
- Comprehensive outpatient rehabilitation facilities;
- Hospice organizations;
- Independent clinical laboratories;
- Independent diagnostic testing facilities;
- Physical therapists enrolling as individuals or group practices;
- Portable X-ray suppliers;
- Revalidating Home Health agencies;[61]
- Revalidating Durable Medical Equipment, Prosthetics/Orthotics & Supplies suppliers.[62]

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 the Department's clinical staff. Member and Provider Services staff, in conjunction with Gainwell Technologies 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 staff, has received praise from staff at the Centers for Medicare and Medicaid Services for continuing to focus on such needs.

One of the top ways that the Member and Provider Services unit worked to serve providers more effectively was to launch the Provider Management Module (PMM) in state fiscal year 2019. Historically, Vermont Medicaid's enrollment process has been paper-based, manual, and cumbersome for the Department and its providers. Providers were required to submit a lengthy paper application and then Gainwell Technologies (formerly DXC) manually screened the provider (frequently taking up to 120 days to complete). The new online Provider Management Module went live in May of 2019 and allows providers to enroll, make changes, and receive notices electronically. The Provider Management Module has met expectations for significantly decreasing the turnaround time for enrolling providers and thus, improving member access to care. Performance measure monitoring has demonstrated success of the new module with 100% of provider applications processed within 60 days (see chart below). On February 19, 2020, CMS approved the State's request for Certification retroactive to the implementation on May 1, 2019. The module's implementation and approval for Certification would not have possible without a remarkable team of people from Member and

[61] Newly enrolling Home Health agencies must have a site visit to comply with 42 CFR § 455.432.
[62] Newly enrolling suppliers must have a site visit to comply with 42 CFR § 455.432.

Provider Services, MMIS Program, Quality Control team, Gainwell Technologies (formerly DXC), and the Certification team.

The chart below demonstrates that the new system quickly reduced processing time well below the 60-day target with most applications being processed in fewer than 30 days.

% of VT, border, and out of state (OOS) provider applications processed within 60 days																		
Report Period	SFY20												SFY21					
	Jan-20		Feb-20		Mar-20		Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20	
Type of Provider	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps
# submitted during month	369	32	182	22	325	10	239	8	252	11	363	11	226	23	216	8	252	10
# within 15 days	246	0	174	22	309	0	239	7	252	9	363	8	226	22	215	6	242	0
# within 30 days	102	32	7	0	10	10	0	1	0	2	0	3	0	1	1	2	7	10
# within 45 days	11	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	3	0
# within 60 days	10	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
# over 60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
# not completed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal # within 60 days	369	32	182	22	325	10	239	8	252	11	363	11	226	23	216	8	252	10
% within 60 days	100.00%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
# applications timeframe waived due to PMR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

GAIN EDUCATION AND TRAINING & ACCESSING SUPPORT SERVICES

The Member and Provider Services unit is responsible for ensuring members have access to care, as well as for engagement, outreach and communication with both members and providers.[63] The goal is to ensure members and providers are always informed. Providers are assisted by Gainwell's Provider Services unit. Gainwell's services in support of providers include management of a Provider Services Call Center.[64] Educational opportunities are offered to the provider community through collaboration between Gainwell Technologies and Member and Provider Services. Together, Gainwell and Member and Provider Services strive to ensure that providers have the most up to date information by overseeing and consistently updating the provider manuals. Available Provider Manuals and Supplements include:

- Applied Behavior Analysis;
- Mental Health Services;
- Federally Qualified Health Centers and Rural Health Clinics;
- General Provider;
- General Billing and Forms;
- Home Health Agency, Assistive Community Care and Enhanced Residential Care;
- Primary Care;
- Physical Therapy, Occupational Therapy, and Speech Language Therapy; and

[63] This is done twice a year, through a report on members access to care and how far they must travel.
[64] Gainwell Technologies Provider Services: Toll-Free, Out-of-State: 1-800-925-1706, Local and In-State: 1-802-878-7871.

- Non-Emergency Medical Transportation.[65]

Additional supplements are also available to provide more information on dental, durable medical equipment, and vision. Education/training was provided to enhance provider awareness of the procedural information in the manuals. In addition, associated rules are being revised as the Agency of Human Services undertakes a comprehensive revision of the Medicaid rules. During this multi-year process, the Medicaid rules are being amended and adopted under the title of Health Care Administrative Rules (a collection of Medicaid rules). The provider community is offered training opportunities throughout the year on varying topics via in-person visits by both Member and Provider Services and Gainwell Technologies staff, as well as webinars, on varying topics. Finally, information is shared with providers through both banners and advisories as topics arise that require awareness or additional information.[66]

Clinical Operations, Clinical Integrity & Quality Improvement

The Clinical Operations, Clinical Integrity and Quality Improvement teams are vital links with providers, other units within DVHA, the Agency of Human Services (AHS) and community partners as the Department strives to provide access to high quality health care services and support for Vermont's health care providers. The clinical perspective provided by Clinical Operations, Clinical Integrity and Quality Improvement staff ensure that the decisions made by the Department and the Agency are evidence-based and of high clinical integrity. Providers indicate that they feel supported by the collaborative staffing model, resulting in providers being better able to provide comprehensive, member-focused, and evidence-based care. Clinical decisions are medically appropriate and consistent, as evidenced by chart reviews and inter-rater reliability tests performed throughout the year. Guidance for providers and professionals is offered through telephonic support, meetings with provider groups and community partners, on-site services, and listening sessions. Clinical guidelines are reviewed and updated annually, reviews of medical literature and emerging technology completed, and provider requests for programmatic improvements are evaluated from the lens of creating a culture of continuous quality improvement within Vermont Medicaid. The teams also work on integrating and coordinating services provided for Vermont Medicaid members with mental health and substance use disorder needs through initiatives such as the Team Care Program.[67]

Oversight of services occurs post-provision to help ensure that services are equitable, efficacious and outcome driven. This may include comparisons between payment methodologies to assess effects on health outcomes. Measures indicative of health care effectiveness are collected and reported to external entities, including federal partners, and data is reviewed to determine member satisfaction, quality of care, and cost efficiency.

[65] http://www.vtmedicaid.com/#/manuals
[66] Banners: http://www.vtmedicaid.com/#/bannerMain, Advisories: http://www.vtmedicaid.com/#/advisory
[67] https://dvha.vermont.gov/providers/team-care

Finally, health care reform is constantly changing the way health care is delivered, requiring new practices, review of literature and evaluation to ensure Vermont Medicaid members receive quality services.

Benefit Rules Management

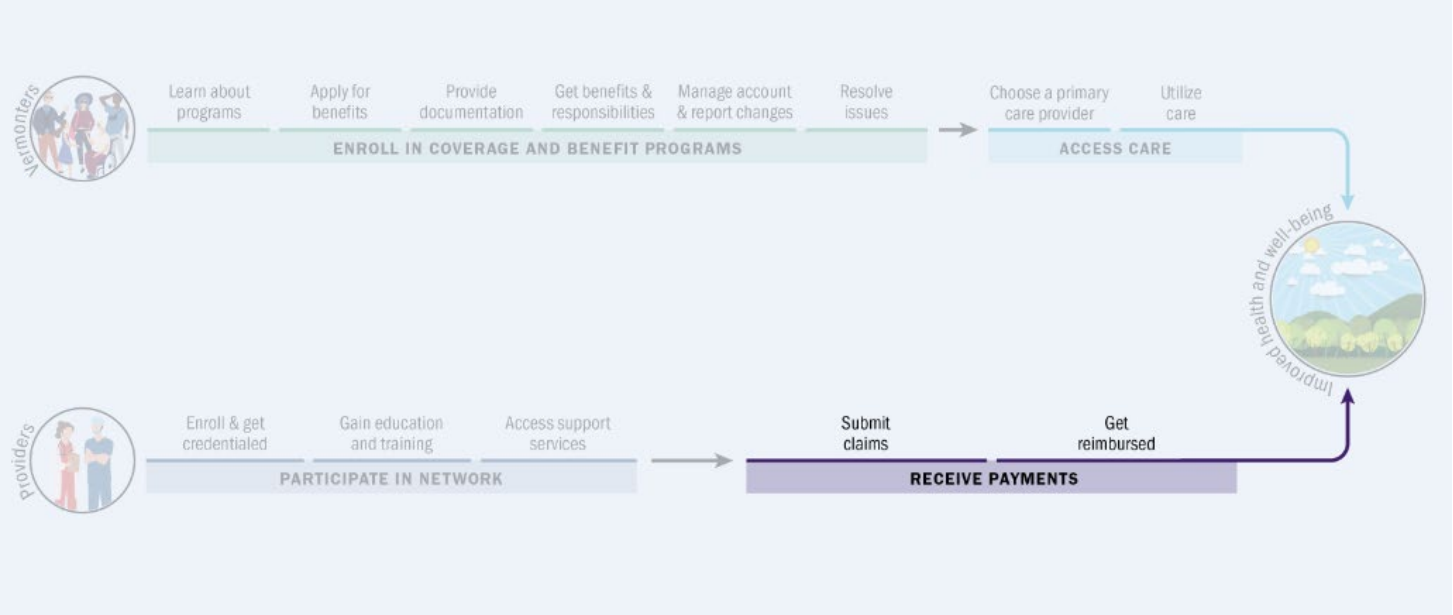
According to the Centers for Medicare and Medicaid Services National Correct Coding Initiative, providers must use the appropriate and correct codes for services that are provided to members. The use of correct codes allows for appropriate reimbursement for services provided to members. All codes (e.g.,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

- Coverage, if the service is permissible under state plan/rule,
- Effectiveness of service,
- FDA approval,
- Number of units allowed, and
- Necessary edits and audits.

Other functions include:

- Reviewing utilization and claims reports (including for mental health and substance use disorders),
- Managing the prior authorization waiver under the Vermont Medicaid Next Generation Program and the limitations within the MMIS, as well managing when members need to go out-of-network for care not available in-network,
- Reviewing prior authorization requests for services with risk for "imminent harm,"
- Clinical audits to assess quality of care,
- Collaboration on Agency-wide initiatives, such as Early Periodic Screening Diagnosis & Treatment (EPSDT) review of services, Applied Behavior Analysis utilization review and reconciliation, and clinical case reviews.

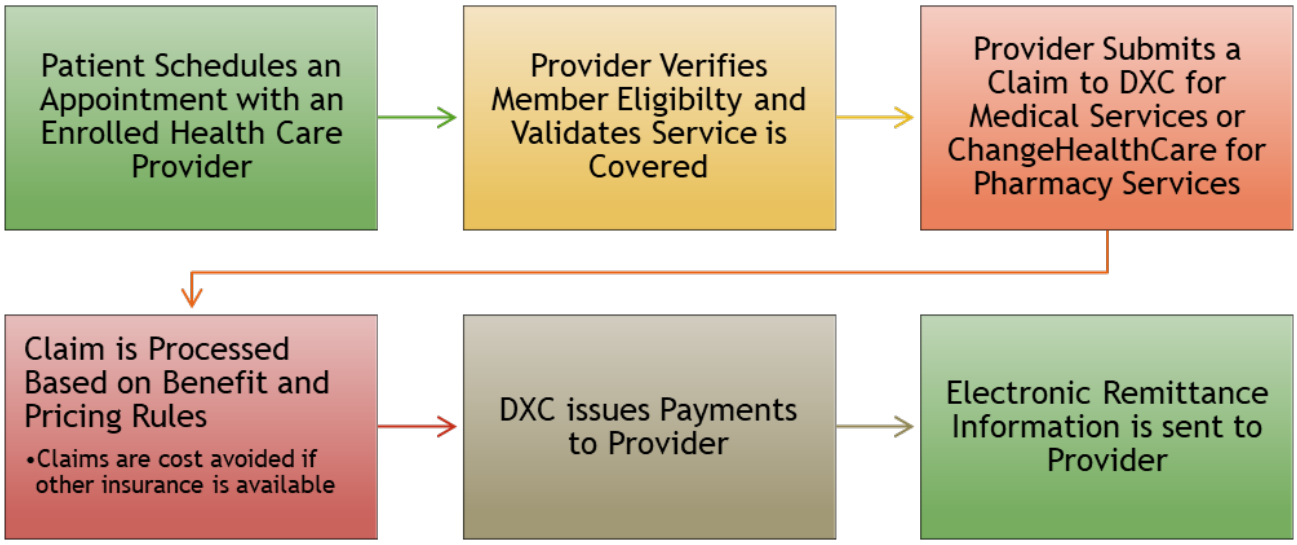
SUBMIT CLAIMS AND REIMBURSEMENT



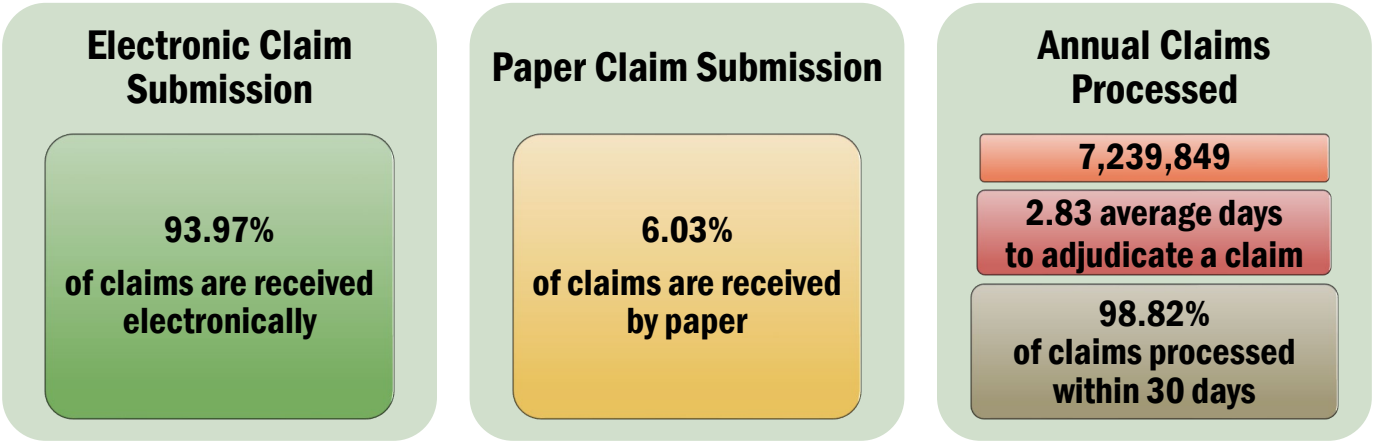
Medical Claims Processing

Since 1981, Gainwell Technologies (formerly DXC Technology) has provided Medicaid fiscal agent services to the State of Vermont.[68] Medical claims processing is one of the services Gainwell provides and this involves claims input, resolutions, claim adjustment processing, utilization review, and reference file maintenance to ensure compliance with federal and state requirements. The diagram below shows a high-level overview of the process of paying a provider; this process actually begins when a patient first schedules an appointment to access care and continues through payment being sent.

[68] Gainwell Technologies, formerly DXC Technology (formerly known as Hewlett Packard Enterprise), 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 Medicaid Management Information System.



DXC, now Gainwell Technologies, processed over 7 million claims in state fiscal year 2020 for more than 30 distinct programs supporting all departments within the Agency of Human Services and the Agency of Education resulting in more than $1.3 billion in payments for processed claims to providers.



Over the past 39 years, Gainwell (formerly DXC) has continued to evolve the system to support multiple programs. DVHA obtains 75% federal funds for the CMS-certified operation and maintenance of this system. Gainwell Technologies performs the following services:

- **Provider Services** including education and publications, Provider Services Call Center, provider screening and enrollment.

- **Application Services** for support and enhancements for several Gainwell and commercial software applications used by Providers, hundreds of AHS staff, and by Gainwell fiscal agent staff.
- **Quality Management Services** to include audit support and coordination, reporting on quality metrics, Service Level Agreement monitoring and reporting, and process improvement projects.
- **Data Analytics Services** including advanced programming using data science tools to extract, prepare, and analyze MMIS information in support of AHS departments and operations.
- **Coordination of Benefits Services** including billing and collection from other third-party liabilities, screening and identification of Casualty cases, issuance of premium payments.
- **Claims Processing Services** including claims input, resolutions, claim adjustment processing, utilization review and reference file maintenance to ensure compliance with federal and state policy.
- **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.
- **Platform Services** providing IT infrastructure, data center facilities, security services, and systems administration within private Gainwell data centers, as well as for software services hosted in commercial cloud environments.

Pharmacy Claims Processing

Change Healthcare, DVHA's prescription benefit management vendor, processed over **1.9 million claims** in state fiscal year 2020 resulting in approximately **$200.4 million in payments** to DVHA-enrolled pharmacies. Change Healthcare adjudicates pharmacy claims, which are then sent to Gainwell Technologies for payments to the pharmacies. In addition to claims processing, Change Healthcare also operates a provider call center in South Burlington. This provider call center processes all drug-related prior authorizations and provides claims processing support for pharmacies. **In state fiscal year 2020, Change Healthcare processed approximately 25,259 drug-related prior authorizations, with 18,511 of those approved.**

The Pharmacy Services unit within DVHA is responsible for assuring that Medicaid members receive high-quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner possible. The Pharmacy Services unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefit program and for overseeing the prescription benefit management (PBM) contract with Change Healthcare.

Some of the major responsibilities of the Pharmacy Services team and its prescription benefit management vendor include:

- processing pharmacy claims and making drug coverage determinations
- assisting with drug appeals and exception requests

- overseeing federal, state and supplemental drug rebate programs
- resolving drug-related pharmacy and medical provider issues
- overseeing and managing the Drug Utilization Review Board (DURB)
- managing the Preferred Drug List (PDL)
- assuring compliance with state and federal pharmacy benefit regulations
- assuring correct drug pricing and coordination of benefits
- operating a provider-focused clinical call center
- performing both prospective and retrospective drug utilization review analyses and procedures
- operating a software suite that supports clinical, operational and financial reporting
- managing all pharmacy communications.

In addition, the Pharmacy Services unit focuses on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations, a web-based pharmacy portal and other efforts related to administrative simplification for the Department and Vermont Medicaid-participating providers. Change Healthcare (CHC) provides operational and clinical services for the Department, its providers, and members. Change Healthcare employs physicians and pharmacists to provide additional support for the Department and the drug benefit program by attending and presenting clinical drug information at meetings of the federally required Drug Utilization Review Board. These physicians and pharmacists are a valuable clinical resource for the Department's pharmacy team by providing peer to peer consults, supporting the Department's Medical Director and Pharmacy Services Director and drug appeals and fair hearings as needed, and ensures continuous clinical support and associated credibility for the Department's management of its pharmacy benefit program.

Reimbursement

The Department's Reimbursement unit oversees rate setting, pricing, 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.[69] This work is crucial because outpatient, inpatient and professional services combine to account for a large portion of the total payments overseen by Reimbursement.

[69] The Department has continued its efforts to achieve parity with Medicare rates. During fiscal year 2019, the Department invested additional funds to bring Physician Administered Drugs to 100% of Medicare rates; primary care rates for Vermont Medicaid were previously increased to 100% of Medicare rates and that continues to be maintained.

In addition, the Reimbursement unit oversees a complementary set of specialty fee schedules including, but not limited to, durable medical equipment, ambulance, clinical laboratory, physician-administered drugs, dental, and home health and hospice. The Unit also manages the Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) payment process as well as supplemental payment administration (e.g., the Disproportionate Share Hospital (DSH) payment program). In state fiscal year 2020, the Reimbursement unit was in the initial stages of planning for annual updates to various Fee Schedules and Prospective Payment Methodologies when the COVID-19 public health emergency began. These updates were scheduled to take effect July - October 2020; however, in order to support provider financial stability during an unprecedented crisis and an effective emergency response, Reimbursement's priorities were temporarily redirected during the initial months of the Emergency. Although delayed due to the pandemic, the updates to the Fee Schedules and Prospective Payment Methodologies were successfully implemented November 1, 2020 in alignment with the Unit's commitment to providers that Fee Schedules and Methodologies will be updated on a consistent basis. Reimbursement rate updates during 2020 also included FQHC/RHC payment rates, Clinical Laboratory Services, Home Health Services and **as of October 1, 2020, Vermont Medicaid has aligned its Hospice Service rates to those of Medicare** (this required an additional investment of approximately $49,000 into hospice service rates).

The Reimbursement unit works closely and collaboratively on reimbursement policies for specialized programs with other departments of the Agency of Human Services, including Disabilities, Aging and Independent Living (DAIL), the Vermont Department of Health (VDH), the Department of Mental Health (DMH), and the Department for Children and Families (DCF). The Reimbursement unit is involved with addressing the individual and special circumstantial needs of members by working closely with clinical staff from within the Department of Vermont Health Access and partner departments to ensure that needed services are provided in an efficient and timely manner.

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 the Department's ongoing strategy to modernize the way it pays for health care services and to align with Medicare pricing methodologies and policies. Phase two of this project was implemented in January of 2020. During phase two, the rates on file for the **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule were updated to 100% of Medicare rates**, capped rental polices were revised and an updated payment methodology for manually priced DMEPOS codes was introduced. The new manual pricing payment methodology was planned as a two-step project, with the first step implemented in January of 2020 and the second step planned for July 2020. Due to the pandemic, step

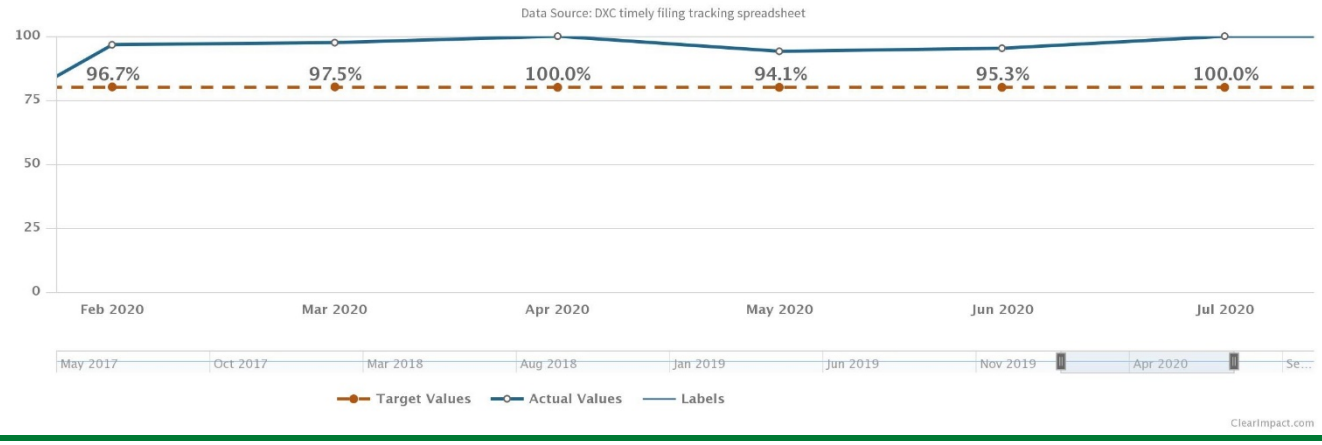
2 implementation was delayed until January 2021. The DMEPOS fee schedule will continue to be updated on an annual basis going forward.

During the past year, the Reimbursement unit has measured its performance on 3 separate measures. The first performance measure, displayed below for reference, provides the percentage of timely filing claims turned around with a final determination within 15 days of receipt by the Unit. This measure was implemented to assess the Unit's service to the provider community and with the goal of ensuring consistent and timely decisions on previously denied claims. This measure is reported on a monthly basis. The Unit established a realistic goal of reaching the 15-business day turnaround at least 80% of the time. Overall, for state fiscal year 2020, the Unit's performance on this metric consistently exceeded the target that was established.

Scorecard: The Percentage of Claims that were Originally Submitted in a Timely Manner but were Denied Payment (timely filing) Turned Around in 15 Business Days or Less

Target: 80% | **Current Performance (June 2020): 95.3%**

Trend: Overall, the Unit is meeting or exceeding its target of 80%.



Rate Setting

The Division of Rate Setting audits costs and establishes Medicaid payment rates for 34 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 and the Nursing Care category has historically been adjusted by the home's average Medicaid case-mix score (see more information below regarding the transition to adjust the nursing component of the Medicaid nursing facility rate). Additionally, inflation factors specific to each cost category are applied to the base year allowable costs, which are subject to caps and a minimum occupancy penalty, 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.

In 2019, Rate Setting initiated a process to work with the Department of Disabilities, Aging and Independent Living, the nursing home industry, provider representatives, and the Centers for Medicare and Medicaid Services (CMS) to develop an understanding of the acuity data that will be available to Rate Setting under the new CMS Patient Driven Payment Model and to prepare for the transition away from the current acuity measure use for which CMS has announced it will discontinue support on an undetermined date in the future. The new Patient Driven Payment Model was implemented to determine Medicare reimbursement rates as of October 1, 2019 but the Centers for Medicare and Medicaid Services continued to support the current RUG-IV case-mix system used to set Vermont's nursing home rates, giving states more time to implement changes to their Medicaid reimbursement systems. The Division contracted with a vendor to support the transition to the Patient Driven Payment Model.

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, behavioral and other challenges. The facilities provide treatment for children and adolescents and families. The Division establishes annual rates for 15 PNMIs for the Department for Children and Families, the Department of Mental Health (DMH), and the Division of Alcohol and Drug Abuse Programs of the Vermont Department of Health. These rates usually have an education component; as such, staff of the Agency of Education are 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. Although the State's Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID) closed on October 6, 2020, Rate Setting will have 2 years of retrospective rate setting to complete so the work will continue for the Division.

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 consist 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. Requests for all special rates are reviewed by staff of the Adult Services Division (ADS) of the Department of Disabilities, Aging and Independent Living (DAIL). Staff of DAIL's Adult Services Division work with the Division to evaluate applications and establish rates. The Department of Mental Health 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 may be avoided by a special individualized rate, but it must be noted that 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 Homes 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.

Finally, it is important to note that there remain nursing homes with years of significant financial losses. Financial instability could affect nursing facility providers' willingness or ability to continue to provide these services and/or result in potential quality issues stemming from inadequate financial resources. The Division of Rate Setting continues to monitor the financial health of nursing facilities and collects data on the percentage of nursing homes enrolled in Medicaid that have losses over $100,000 in a calendar year to highlight the importance of continued work to reduce the number of Vermont nursing facilities experiencing these annual losses and ensure sufficient capacity continues exist to meet Vermonters' needs. The data below indicates the fragility of the nursing facility industry and it is anticipated that facilities in danger of financial failure will apply for extraordinary financial relief in the coming year.

Scorecard: The Percentage of Nursing Homes Enrolled with Medicaid that have Annual Losses over $100,000 in a State Fiscal Year

% of nursing homes enrolled in Medicaid that have losses over $100,000 in a SFY							
	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019
Total # NH enrolled in Medicaid	37	36	36	36	36	35	35
# Medicaid NH w/ losses over $100K	11	12	14	15	19	13	15
% Medicaid NH w/ losses over $100K	29.7%	33.3%	38.9%	41.7%	52.8%	37.1%	42.9%

The second performance measure, the percentage of utilization based on capacity of Vermont nursing homes, looks at occupancy levels as an indicator of the financial health of a facility. That is, low occupancy levels indicate less revenue being earned by nursing facilities, which can in turn result in financial difficulties. Financial difficulties and financial distress can impact quality of care, as facilities may not be able to pay vendors for essential services (e.g., food, utilities, or therapy). The current minimum occupancy level (90%) means that when facilities with base year occupancies are below 90%, they are penalized in their Medicaid rates. Even before the COVID-19 public health emergency, the average occupancy was 83-84%; during the COVID-19 public health emergency, the average occupancy has decreased to 75%. This has the potential to result in large financial penalties for facilities if action isn't taken.

Strategically Managing Departmental Activities

Each of the Department's units 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. For each of the units mentioned above, and for all units within the Department, additional information regarding performance measures by unit may be found in the Performance Accountability Scorecard and examples are provided for reference in Appendix A.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

GOVERNOR'S BUDGET RECOMMENDATION: STATE FISCAL YEAR 2022

Department's Mission: Improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively.

SFY2022 Summary: The Department of Vermont Health Access (DVHA) state fiscal year 2022 budget request includes a decrease in Administration of $1,562,420 (gross) and an increase in Program of $20,069,161 (gross) for a total of $18,506,741 (gross) in new appropriations; additional information for explanatory purposes is provided under the Administration and Program sections below.

Appropriation	GROSS	STATE FUNDS
B.306 DVHA Administration	($1,562,420)	$472,950
B.307 Global Commitment Program	$30,773,366	$13,540,281
B.309 State Only Program	($10,450,210)	($3,730,094)
B.310 Non-Waiver Program	($253,995)	$500,514
Total Change	$18,506,741	$10,783,651

The programmatic changes in DVHA's budget are spread across three different covered populations: Global Commitment, State Only, and Medicaid Matched Non-Waiver; the descriptions of the changes are similar across these populations, so these items have been consolidated for purposes of discussion within this narrative. However, the items are repeated appropriately in the Ups/Downs document. DVHA has numerically cross walked the changes listed below to the Ups/Downs and included an appropriation level breakdown table whenever an item is referenced more than once in the Ups/Downs document.

B.306 ADMINISTRATION ($1,562,420) GROSS / $472,950 STATE

1. **Salary & Fringe Changes** . . . . . $177,426 / $246,850 state

DVHA consists of 375 employees. This change reflects annual salary, fringe and Federal Financial Participation rates.

2. **Restoration of One-Time Savings**. . . . . $125,000 / $125,000 state

This item restores a one-time reduction to the Gainwell Technologies LLC (formerly known as DXC) contract enacted in the fiscal year 2021 budget restatement. DVHA had requested vendors to review potential areas of spending reductions in SFY 2021.

3. **Internal Service Fund Changes** . . . . . ($111,874) / ($22,414) 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.

4. ADS Service Level Agreement Changes. . . . . $247,028 / $123,514 state

This item is the DVHA allocated portion of the fiscal year 2022 ADS Service Level Agreement between the Agency of Digital Services (ADS) and the Agency of Human Services.

5. Discontinuation of EHR Incentive Payment Federal Program. . . . . ($2,000,000) / $0 state

The Federal EHR Incentive Program, authorized under the HITECH Act of 2009, provided incentive payments for certain health care providers to use EHR technology in ways that can positively impact patient care. Through this program, DVHA passed through 100% federal funds to eligible providers. This program sunsets at the end of calendar year 2021.

PROGRAM $20,069,161 GROSS / $10,310,701 STATE

6. Caseload & Utilization Changes . . . . . $16,979,709 / $6,587,503 state

DVHA engaged in an updated Medicaid Consensus Forecast (i.e., a collaborative process for estimating caseload and utilization) with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services.

The Coronavirus pandemic is the primary factor in caseload and utilization expectations for fiscal year 2022. Vermont experienced growth in Medicaid enrollment throughout 2020 due to the pandemic as federal requirements to maintain continuous health care benefits were enacted and as individuals experienced economic challenges related to the pandemic.

The Medicaid Consensus Forecast assumed a gradual decline of Medicaid enrollment in fiscal year 2022 as the public health emergency improves and assumed an increase in the per member per month costs as we return to pre-pandemic utilization levels and deferred health care is obtained. As stated in the 2021 Budget Adjustment, Vermont is required to maintain continuous health care benefits for Medicaid and CHIP enrollees during the period of the federal COVID-19 public health emergency in order to continue to receive the 6.2% enhancement in Federal Medical Assistance Percentage (FMAP) as authorized in the CARES Act. To ensure continuous health care coverage during the COVID-19 public health emergency, DVHA is facilitating continuous health coverage by:

- Extending Medicaid coverage periods (meaning the Department is not processing the redeterminations that could result in loss of Medicaid) until after the emergency ends.
- Suspending certain termination of health insurance (meaning the Department is generally not ending Medicaid coverage during the Emergency unless the customer requests it).
- Temporarily waiving financial verifications required for those seeking to enroll in health insurance.

The Department's Budget request combines the gradual decline in caseload and expected increases to utilization per member.

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$18,994,719	$8,357,676
B.309 State Only	($1,761,015)	($1,692,941)
B.310 Non-Waiver	($253,995)	($77,232)

7. SMI & SUD Waivers; moves IMD cost to GC . . . . . $0 / $56,000 state

As presented in the 2021 Budget Adjustment request, this technical adjustment moves the spending authority for costs for Institutions for Mental Disease (IMD) from Global Commitment Investments within the State-Only Appropriation to Global Commitment Program as a result of the Serious Mental Illness (SMI) and Substance Use Disorder (SUD) Global Commitment 1115 Waiver changes. As Vermont is required to phasedown the Investment authority for IMD services, this allows for the continuation of adult inpatient psychiatry services at IMD hospitals.

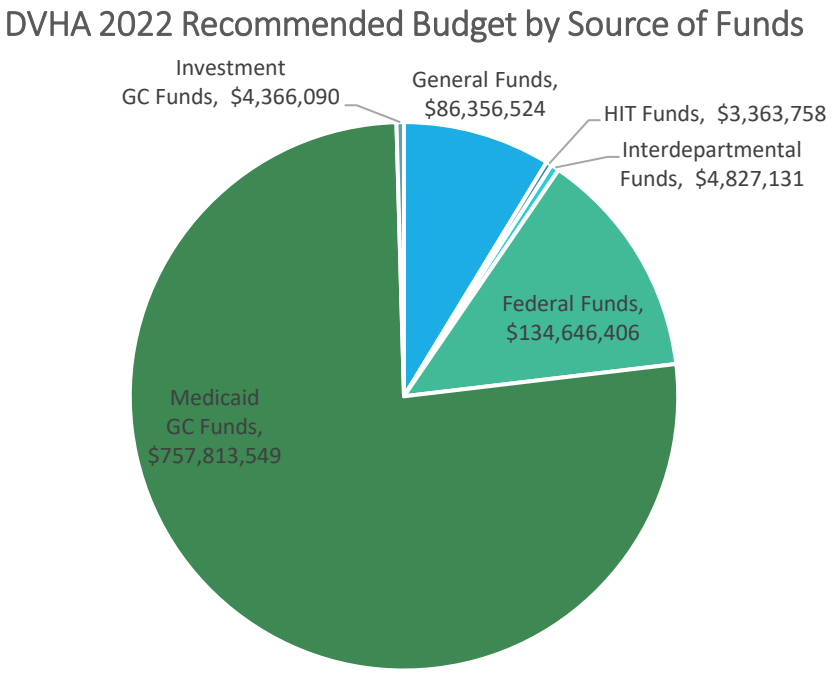
Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$11,778,647	$5,182,605
B.309 State Only	($11,778,647)	($5,126,605)
B.310 Non-Waiver	$0	$0

8. DVHA Program FMAP Changes . . . . $3,089,452 / $3,667,198 state

This item depicts the anticipated changes to Federal Medical Assistance Percentage (FMAP) in fiscal year 2022. Specifically, this removes the fiscal year 2021 base budget reduction associated with the 6.2% FMAP reimbursement rate for the Medicare Clawback program and the Children's Health Insurance Program (CHIP) as authorized in the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act. In addition, this item accounts for the changes in base FMAP to the CHIP program.

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$0	$0
B.309 State Only	$3,089,452	$3,089,452
B.310 Non-Waiver	$0	$577,746

Additional Information on Source of Funds:



Year Over Year Changes	Program (Gross)	Admin (Gross)	Total DVHA	State Funds Estimate
2020 Actuals	$805,095,705	$142,118,762	$947,214,467	$414,421,731
2021 BAA	$813,793,130	$164,143,664	$977,936,794	$421,073,387
2022 Governor's Recommended Budget	$831,623,309	$159,750,149	$991,373,458	$430,165,297

* This estimate converts Global Commitment funds which are 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.

SFY2022 GOVERNOR'S RECOMMENDED BUDGET

The pullouts may be found on the following pages.

	FY22 Department Request - DVHA									
		GF	SF	State Health Care Res	IdptT	FF	Coronavirus Relief Fund	Medicaid GCF	Invmnt GCF	Total
Sec. B.306	**Approp #3410010000 - DVHA Administration As Passed FY21**	**32,314,433**	**3,378,509**		**4,792,881**	**116,496,036**			**4,330,710**	**161,312,569**
	Other Changes:									
	FY21 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY21 Other Changes	**32,314,433**	**3,378,509**	**0**	**4,792,881**	**116,496,036**	**0**	**0**	**4,330,710**	**161,312,569**
	FY21 After Other Changes									
	Personal Services:									
	1. Salary & Fringe	160,913	(7,006)		(10,934)	6,952		0	27,501	**177,426**
	1. Vacancy Savings Adjustments related to changes in FFP	73,509	(7,343)		45,184	(68,902)		0	(42,448)	**0**
	2. Restoration of DXC savings (FY21 one-time)	125,000								**125,000**
										0
	Operating Expenses:									**0**
	3. Internal Service Fund (ISF) Changes	(21,150)	(402)			(88,598)			(1,724)	**(111,874)**
	4. ADS SLA Changes	123,514				123,514				**247,028**
										0
	Grants:									**0**
	5. Discontinuation of federal HITECH funding for Electronic Health Record Incentive Payments (EHRIP)					(2,000,000)				**(2,000,000)**
										0
	FY22 Subtotal of Increases/Decreases	**461,786**	**(14,751)**	**0**	**34,250**	**(2,027,034)**	**0**	**0**	**(16,671)**	**(1,562,420)**
	FY22 Gov Recommended	**32,776,219**	**3,363,758**	**0**	**4,827,131**	**114,469,002**	**0**	**0**	**4,314,039**	**159,750,149**
	FY22 Legislative Changes									
	FY22 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY22 As Passed - Dept ID 3410010000	**32,776,219**	**3,363,758**	**0**	**4,827,131**	**114,469,002**	**0**	**0**	**4,314,039**	**159,750,149**

THIS PAGE LEFT INTENTIONALLY BLANK

	FY22 Department Request - DVHA	GF	SF	State Health Care Res	IdptT	FF	Coronavirus Relief Fund	Medicaid GCF	Invmnt GCF	Total
Sec. B.307	**Approp #3410015000 - DVHA Global Commitment As Passed FY21**							**727,040,183**		**727,040,183**
	Other Changes:									
	FY21 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY21 Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**727,040,183**	**0**	**727,040,183**
	FY21 After Other Changes									
	Grants:									
	6. Caseload & Utilization Changes							18,994,719		**18,994,719**
	7. Technical Adjustment: SMI & SUD Waivers; moves IMD cost to GC Program (BAA item)							11,778,647		**11,778,647**
	FY22 Subtotal of Increases/Decreases	**0**	**0**	**0**	**0**	**0**	**0**	**30,773,366**	**0**	**30,773,366**
	FY22 Gov Recommended	**0**	**0**	**0**	**0**	**0**	**0**	**757,813,549**	**0**	**757,813,549**
	FY22 Legislative Changes									
	FY22 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY22 As Passed - Dept ID 3410015000	**0**	**0**	**0**	**0**	**0**	**0**	**757,813,549**	**0**	**757,813,549**
Sec. B.309	**Approp #3410017000 - DVHA - Medicaid Program - State Only As Passed FY21**	**39,365,706**							**12,052,258**	**51,417,964**
	Other Changes:									
	FY21 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY21 Other Changes	**39,365,706**	**0**	**0**	**0**	**0**	**0**	**0**	**12,052,258**	**51,417,964**
	FY21 After Other Changes									
	Grants:									
	6. Caseload & Utilization Changes	(1,639,455)							(121,560)	**(1,761,015)**
	item)	100,000							(11,878,647)	**(11,778,647)**
	8. Backfill of base fmap for Clawback (FY21 one-time)	3,089,452								**3,089,452**
	FY22 Subtotal of Increases/Decreases	**1,549,997**	**0**	**0**	**0**	**0**	**0**	**0**	**(12,000,207)**	**(10,450,210)**
	FY22 Gov Recommended	**40,915,703**	**0**	**0**	**0**	**0**	**0**	**0**	**52,051**	**40,967,754**
	FY22 Legislative Changes									
	FY22 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY22 As Passed - Dept ID 3410017000	**40,915,703**	**0**	**0**	**0**	**0**	**0**	**0**	**52,051**	**40,967,754**
Sec. B.310	**Approp #3410018000 - DVHA - Medicaid Matched NON Waiver Expenses As Passed FY21**	**12,164,088**				**20,931,913**				**33,096,001**
	Other Changes:									
	FY21 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY21 Other Changes	**12,164,088**	**0**	**0**	**0**	**20,931,913**	**0**	**0**	**0**	**33,096,001**
	FY21 After Other Changes									
	Grants:									
	6. Caseload & Utilization Changes	(77,232)				(176,763)				**(253,995)**
	8. FY'22 CHIP & DSH base fmap Changes	(264,580)				264,580				**0**
	8. Backfill of fmap for DSH (FY21 one-time)	703,839				(703,839)				**0**
	8. Backfill of fmap for CHIP (FY21 one-time)	138,487				(138,487)				**0**
	FY22 Subtotal of Increases/Decreases	**500,514**	**0**	**0**	**0**	**(754,509)**	**0**	**0**	**0**	**(253,995)**
	FY22 Gov Recommended	**12,664,602**	**0**	**0**	**0**	**20,177,404**	**0**	**0**	**0**	**32,842,006**
	FY22 Legislative Changes									
	FY22 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY22 As Passed - Dept ID 3410018000	**12,664,602**	**0**	**0**	**0**	**20,177,404**	**0**	**0**	**0**	**32,842,006**

THIS PAGE LEFT INTENTIONALLY BLANK

	GF	SF	State Health Care Res	IdptT	FF	Coronavirus Relief Fund	Medicaid GCF	Invmnt GCF	Total
DVHA FY22 Governor Recommend	83,844,227	3,378,509	0	4,792,881	137,427,949	0	727,040,183	16,382,968	972,866,717
DVHA FY22 Reductions and Other Changes	0	0	0	0	0	0	0	0	0
DVHA FY22 GovRec Total After Reductions and Other Changes	83,844,227	3,378,509	0	4,792,881	137,427,949	0	727,040,183	16,382,968	972,866,717
DVHA FY22 Total Increases/Decreases	2,512,297	(14,751)	0	34,250	(2,781,543)	0	30,773,366	(12,016,878)	18,506,741
DVHA FY22 Governor Recommend Addendum	86,356,524	3,363,758	0	4,827,131	134,646,406	0	757,813,549	4,366,090	991,373,458
DVHA FY22 Total Legislative Changes	0	0	0	0	0	0	0	0	0
DVHA FY22 Total As Passed	86,356,524	3,363,758	0	4,827,131	134,646,406	0	757,813,549	4,366,090	991,373,458

THIS PAGE LEFT INTENTIONALLY BLANK

BUDGET BY ELIGIBILITY GROUP & BUDGET BY ELIGIBILITY GROUP FUNDING

The pullouts may be found on the following pages.

PROGRAM EXPENDITURES	SFY '20 Actuals			SFY '21 Gov. Rec. Restated			SFY '21 BAA				SFY '22 Gov Rec			Funding Description
Adults	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Total Member Months	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	
Aged, Blind, or Disabled (ABD)	6,298	$ 57,489,532	$ 760.67	6,475	$ 61,811,034	$ 795.51	6,475	77,700	$ 59,467,740	$ 765.35	6,475	$ 59,334,492	$ 763.64	Global Commitment Funded (GC)
CFC Acute-Care Services	4,326	$ 36,665,867	$ 706.27	4,329	$ 36,642,934	$ 705.38	4,477	49,974	$ 46,175,225	$ 859.49	4,596	$ 40,076,740	$ 726.66	Global Commitment Funded (GC)
Dual Eligibles	17,522	$ 53,812,435	$ 255.93	17,439	$ 57,644,404	$ 275.46	17,678	214,565	$ 48,359,639	$ 227.97	17,649	$ 54,523,872	$ 257.45	Global Commitment Funded (GC)
General	8,287	$ 51,559,566	$ 518.51	8,114	$ 50,275,041	$ 516.34	10,043	94,783	$ 60,812,047	$ 504.60	10,049	$ 60,549,753	$ 502.12	Global Commitment Funded (GC)
New Adult Childless	35,009	$ 192,985,152	$ 459.36	35,000	$ 187,427,978	$ 446.26	37,550	406,013	$ 204,362,854	$ 453.53	35,802	$ 201,827,686	$ 469.78	Enhanced for Childless New Adults ~ General Funds
New Adult W/Child	20,177	$ 98,886,805	$ 408.42	19,988	$ 94,734,165	$ 394.96	22,473	239,858	$ 102,062,482	$ 378.46	22,258	$ 108,032,753	$ 404.47	Global Commitment Funded (GC)
Subtotal Adults	91,619	$ 491,399,357	$ 446.96	91,345	$ 488,535,556	$ 451.14	98,696	1,082,893	$ 521,239,986	$ 481.34	96,829	$ 524,345,296	$ 451.26	
Sunsetted Direct Programs														
Sunsetted/Transferred CFC Programs		$ 223,970,679												
Subtotal Sunsetted														
Children														
Blind or Disabled (BD)	1,758	$ 22,103,589	$ 1,047.61	1,604	$ 20,361,380	$ 1,057.84	1,634	25,800	$ 21,562,729	$ 1,099.69	1,594	$ 20,412,365	$ 1,067.15	Global Commitment Funded (GC)
General	57,691	$ 161,637,128	$ 233.48	57,698	$ 164,653,910	$ 237.81	59,540	688,719	$ 146,388,328	$ 204.89	59,588	$ 160,340,868	$ 224.24	Global Commitment Funded (GC)
Underinsured	561	$ 468,699	$ 69.62	509	$ 431,984	$ 70.72	549	6,112	$ 527,572	$ 80.08	530	$ 433,316	$ 68.13	Global Commitment Funded (GC)
SCHIP (Uninsured)	4,535	$ 9,136,532	$ 167.88	4,450	$ 8,934,633	$ 167.32	4,450	51,293	$ 8,852,317	$ 165.77	4,374	$ 8,683,881	$ 165.45	Title XXI Enhanced
Subtotal Children	64,546	$ 193,345,948	$ 249.62	64,261	$ 194,381,907	$ 251.81	66,173	771,924	$ 177,330,945	$ 229.73	66,086	$ 189,870,430	$ 239.42	
Pharmacy														
Pharmacy Only - GC	9,988	$ 2,243,323	$ 18.72	9,664	$ 3,050,321	$ 26.30	9,889	115,971	$ 2,556,826	$ 21.55	9,568	$ 2,478,347	$ 21.59	Global Commitment Funded (GC)
Pharmacy Only - State Only	9,988	$ 1,208,067	$ 10.08	9,664	$ 4,527,614	$ 39.04	9,889	115,971	$ 3,073,535	$ 25.90	9,568	$ 2,973,767	$ 25.90	General Funds @ 100%
Pharmacy Only Programs	9,988	$ 3,451,390	$ 28.80	9,664	$ 7,577,935	$ 65.34	9,889	115,971	$ 5,630,360	$ 48.55	9,568	$ 5,452,114	$ 47.49	
QHP Assistance														
Premium Assistance	16,237	$ 5,732,382	$ 29.42	16,515	$ 5,819,526	$ 29.36	15,935		$ 5,625,792	$ 29.42	15,937	$ 5,615,851	$ 29.36	Global Commitment Funded (GC)
Cost Sharing	3,518	$ 1,170,612	$ 27.73	3,481	$ 1,216,331	$ 29.12	3,235		$ 1,076,393	$ 27.73	3,236	$ 1,130,724	$ 29.12	General Funds @ 100%
Subtotal QHP Assistance	16,237	$ 6,902,994	$ 35.43	16,515	$ 7,035,857	$ 35.50	15,935		$ 6,702,185	$ 35.05	15,937	$ 6,746,574	$ 35.28	
Subtotal Direct Services	**182,389**	**$ 695,099,689**	**$ 317.59**	**181,785**	**$ 697,531,255**	**$ 319.76**	**190,693**		**$ 710,903,477**	**$ 310.67**	**188,420**	**$ 726,414,415**	**$ 321.27**	
Miscellaneous Program														
Refugee	1	$ 2,478	$ 225.31	1	$ 499	$ 41.60	1		$ 499	$ 41.60	1	$ 499	$ 41.60	Federally Funded @ 100%
HIV	181	$ 3,181	$ 1.47	198	$ 3,244	$ 1.37	191		$ 3,129	$ 1.37	204	$ 3,440	$ 1.41	Investments: Global Commitment Funded (GC)
Underinsured		$ 8,334,423		-	$ 12,003,647				$ 100,000			$ 100,000		Investments: Global Commitment Funded (GC)
DSH		$ 22,704,470		-	$ 22,704,471				$ 22,704,471			$ 22,704,471		Global Commitment Funded (GC)
Clawback		$ 35,532,471		-	$ 33,621,761				$ 33,621,761			$ 36,711,213		General Funds @ 100%
Buy-In ~ GC		$ 37,665,327		-	$ 39,164,716				$ 39,730,058			$ 39,164,716		Global Commitment Funded (GC)
Buy-In ~ CFC		$ 4,194,263		-	$ 4,474,808				$ 4,682,228			$ 4,474,808		Global Commitment Funded (GC)
Buy-In ~ Investments/State Only		$ 43,219		-	$ 48,610				$ 56,661			$ 48,610		Investments: Global Commitment Funded (GC)
Buy-In ~ Federal Only		$ 4,336,552		-	$ 4,489,813				$ 4,479,521			$ 4,489,813		Federally Funded @ 100%
Legal Aid		$ 547,983		-	$ 547,983				$ 547,983			$ 547,983		Global Commitment Funded (GC)
Misc. Pymts.		$ 408,764		-	$ -				$ -			$ -		Global Commitment Funded (GC)
Healthy Vermonters Program	1,229	$ -	$ -	1,358	$ -	$ -	1,072		$ -	$ -	934	$ -	$ -	N/A
Subtotal Miscellaneous Program	**1,411**	**$ 109,996,016**		**1,557**	**$ 114,022,893**		**1,264**		**$ 102,889,654**		**1,139**	**$ 105,208,894**		
TOTAL PROGRAM EXPENDITURES	**183,801**	**$ 805,095,705**		**183,342**	**$ 811,554,148**		**191,957**		**$ 813,793,130**		**189,559**	**$ 831,623,309**		
Total Program Expenditure with CFC Traditional		**$ 1,029,066,384**												

THIS PAGE LEFT INTENTIONALLY BLANK

PROGRAM EXPENDITURES	SFY '18 Actuals			SFY '19 Actuals			SFY '20 Actuals			SFY '21 Gov. Rec. Restated			SFY '21 BAA			SFY '22 Gov Rec		
Adults	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM
Aged, Blind, or Disabled (ABD)	6,799	$ 54,818,596	$671.90	6,485	$ 61,197,266	$786.40	6,298	$ 57,489,532	$ 760.67	6,475	$ 61,811,034	$ 795.51	6,475	$ 59,467,740	$ 765.35	6,475	$ 59,334,492	$ 763.64
CFC Acute-Care Services	4,232	$ 27,628,248	$544.03	4,275	$ 31,156,672	$607.34	4,326	$ 36,665,867	$ 706.27	4,329	$ 36,642,934	$ 705.38	4,477	$ 46,175,225	$ 859.49	4,596	$ 40,076,740	$ 726.66
Dual Eligibles	17,659	$ 53,612,503	$253.00	17,651	$ 58,079,913	$274.21	17,522	$ 53,812,435	$ 255.93	17,439	$ 57,644,404	$ 275.46	17,678	$ 48,359,639	$ 227.97	17,649	$ 54,523,872	$ 257.45
General	12,664	$ 71,486,396	$470.40	10,148	$ 62,828,505	$515.94	8,287	$ 51,559,566	$ 518.51	8,114	$ 50,275,041	$ 516.34	10,043	$ 60,812,047	$ 504.60	10,049	$ 60,549,753	$ 502.12
New Adult Childless	39,967	$ 189,970,050	$396.10	37,432	$ 204,022,529	$454.21	35,009	$ 192,985,152	$ 459.36	35,000	$ 187,427,978	$ 446.26	37,550	$ 204,362,854	$ 453.53	35,802	$ 201,827,686	$ 469.78
New Adult W/Child	18,568	$ 74,119,966	$332.65	19,101	$ 88,370,003	$385.54	20,177	$ 98,886,805	$ 408.42	19,988	$ 94,734,165	$ 394.96	22,473	$ 102,062,482	$ 378.46	22,258	$ 108,032,753	$ 404.47
Subtotal Adults	99,889	$ 471,635,758	$393.47	95,092	$ 505,654,888	$443.13	91,619	$ 491,399,357	$ 446.96	91,345	$ 488,535,556	$ 451.14	98,696	$ 521,239,986	$ 481.34	96,829	$ 524,345,296	$ 451.26
Sunsetted Direct Programs	-	$ 2,830,260		-	$ 1,118,192													
Sunsetted/Transferred CFC Programs		$ 199,651,869			$ 206,971,637			$ 223,970,679										
Subtotal Sunsetted	-	$ 202,482,129	$ -	-	$ 208,089,830	$ -												
Children																		
Blind or Disabled (BD)	2,241	$ 20,174,102	$750.19	2,093	$ 21,234,113	$845.44	1,758	$ 22,103,589	$1,047.61	1,604	$ 20,361,380	$ 1,057.84	1,634	$ 21,562,729	$ 1,099.69	1,594	$ 20,412,365	$ 1,067.15
General	59,821	$ 156,825,223	$218.46	58,779	$ 165,815,234	$235.08	57,691	$ 161,637,128	$ 233.48	57,698	$ 164,653,910	$ 237.81	59,540	$ 146,388,328	$ 204.89	59,588	$ 160,340,868	$ 224.24
Underinsured	601	$ 515,180	$ 71.43	563	$ 472,464	$ 69.93	561	$ 468,699	$ 69.62	509	$ 431,984	$ 70.72	549	$ 527,572	$ 80.08	530	$ 433,316	$ 68.13
SCHIP (Uninsured)	4,667	$ 8,323,354	$148.62	4,479	$ 9,234,963	$171.82	4,535	$ 9,136,532	$ 167.88	4,450	$ 8,934,633	$ 167.32	4,450	$ 8,852,317	$ 165.77	4,374	$ 8,683,881	$ 165.45
Subtotal Children	67,330	$ 185,837,860	$230.01	65,914	$ 196,756,774	$248.75	64,546	$ 193,345,948	$ 249.62	64,261	$ 194,381,907	$ 251.81	66,173	$ 177,330,945	$ 229.73	66,086	$ 189,870,430	$ 239.42
Pharmacy																		
Pharmacy Only - GC	10,717	$ 8,472,905	$ 65.88	10,382	$ 3,690,759	$ 29.62	9,988	$ 2,243,323	$ 18.72	9,664	$ 3,050,321	$ 26.30	9,889	$ 2,556,826	$ 21.55	9,568	$ 2,478,347	$ 21.59
Pharmacy Only - State Only	10,717	$ (3,884,006)	$ (30.20)	10,382	$ 4,784,346	$ 38.40	9,988	$ 1,208,067	$ 10.08	9,664	$ 4,527,614	$ 39.04	9,889	$ 3,073,535	$ 25.90	9,568	$ 2,973,767	$ 25.90
Pharmacy Only Programs	10,717	$ 4,588,899	$ 35.68	10,382	$ 8,475,105	$ 68.03	9,988	$ 3,451,390	$ 28.80	9,664	$ 7,577,935	$ 65.34	9,889	$ 5,630,360	$ 48.55	9,568	$ 5,452,114	$ 47.49
QHP Assistance																		
Premium Assistance	18,275	$ 6,334,440	$ 28.88	17,163	$ 5,941,367	$ 28.85	16,237	$ 5,732,382	$ 29.42	16,515	$ 5,819,526	$ 29.36	15,935	$ 5,625,792	$ 29.42	15,937	$ 5,615,851	$ 29.36
Cost Sharing	6,141	$ 1,570,896	$ 21.32	4,919	$ 1,482,370	$ 25.11	3,518	$ 1,170,612	$ 27.73	3,481	$ 1,216,331	$ 29.12	3,235	$ 1,076,393	$ 27.73	3,236	$ 1,130,724	$ 29.12
Subtotal QHP Assistance	18,275	$ 7,905,336	$ 36.05	17,163	$ 7,423,737	$ 36.05	16,237	$ 6,902,994	$ 35.43	16,515	$ 7,035,857	$ 35.50	15,935	$ 6,702,185	$ 35.05	15,937	$ 6,746,574	$ 35.28
Subtotal Direct Services	**196,211**	**$ 672,798,113**	**$285.75**	**188,551**	**$ 719,428,695**	**$317.96**	**182,389**	**$ 695,099,689**	**$ 317.59**	**181,785**	**$ 697,531,255**	**$ 319.76**	**190,693**	**$ 710,903,477**	**$ 310.67**	**188,420**	**$ 726,414,415**	**$ 321.27**
Miscellaneous Program																		
Refugee	2	$ 4,135	$172.30	1	$ 499	$ 41.60	1	$ 2,478	$ 225.31	1	$ 499	$ 41.60	1	$ 499	$ 41.60	1	$ 499	$ 41.60
HIV	161	$ 4,085	$ 2.11	165	$ 2,703	$ 1.37	181	$ 3,181	$ 1.47	198	$ 3,244	$ 1.37	191	$ 3,129	$ 1.37	204	$ 3,440	$ 1.41
Underinsured		$ 7,933,373			$ 10,620,552			$ 8,334,423		-	$ 12,003,647			$ 100,000			$ 100,000	
DSH		$ 27,448,780			$ 22,704,470			$ 22,704,470		-	$ 22,704,471			$ 22,704,471			$ 22,704,471	
Clawback		$ 33,888,772			$ 34,453,902			$ 35,532,471		-	$ 33,621,761			$ 33,621,761			$ 36,711,213	
Buy-In ~ GC		$ 35,999,728			$ 36,384,457			$ 37,665,327		-	$ 39,164,716			$ 39,730,058			$ 39,164,716	
Buy-In ~ CFC		$ 3,562,365			$ 3,872,527			$ 4,194,263		-	$ 4,474,808			$ 4,682,228			$ 4,474,808	
Buy-In ~ Investments/State Only		$ 30,686			$ 49,581			$ 43,219		-	$ 48,610			$ 56,661			$ 48,610	
Buy-In ~ Federal Only		$ 4,241,969			$ 4,172,939			$ 4,336,552		-	$ 4,489,813			$ 4,479,521			$ 4,489,813	
Legal Aid		$ 547,983			$ 547,983			$ 547,983		-	$ 547,983			$ 547,983			$ 547,983	
Misc. Pymts.		$ 6,922,674			$ 990,667			$ 408,764		-	$ -			$ -			$ -	
Healthy Vermonters Program	1,547	$ -	$ -	1,389	$ -	$ -	1,229	$ -	$ -	1,358	$ -	$ -	1,072	$ -	$ -	934	$ -	$ -
Subtotal Miscellaneous Program	**1,710**	**$ 116,964,206**		**1,555**	**$ 110,603,362**		**1,411**	**$ 109,996,016**		**1,557**	**$ 114,022,893**		**1,264**	**$ 102,889,654**		**1,139**	**$ 105,208,894**	
TOTAL PROGRAM EXPENDITURES	**197,921**	**$ 789,762,319**		**190,106**	**$ 830,032,057**		**183,801**	**$ 805,095,705**		**183,342**	**$ 811,554,148**		**191,957**	**$ 813,793,130**		**189,559**	**$ 831,623,309**	
Total Program Expenditure with CFC Traditional		**$ 989,414,187**			**$ 1,037,003,694**			**$ 1,029,066,384**										

CATEGORIES OF SERVICE

DVHA Medicaid Spend by Category of Service			
Category of Service	**SFY 2020 Actual Spend**	**SFY 2021 BAA**	**SFY 2022 Gov. Rec.**
Inpatient	$ 119,367,212	$ 110,807,891	$ 113,979,504
Outpatient	$ 69,212,422	$ 69,011,648	$ 70,988,727
Physician	$ 60,560,976	$ 60,385,298	$ 62,115,245
Pharmacy	$ 194,253,523	$ 193,690,025	$ 199,238,949
Nursing Home	$ 747,141	$ 744,974	$ 766,316
Mental Health Facility	$ 162,596	$ 162,124	$ 166,769
Dental	$ 21,988,362	$ 21,924,577	$ 22,552,683
MH Clinic	$ 253,177	$ 252,443	$ 259,675
Independent Lab/Xray	$ 7,086,837	$ 7,066,279	$ 7,268,717
Home Health	$ 6,313,828	$ 6,295,512	$ 6,475,869
RHC	$ 3,236,341	$ 3,226,953	$ 3,319,400
Hospice	$ 10,940,010	$ 10,908,275	$ 11,220,781
FQHC	$ 29,848,061	$ 29,761,477	$ 30,614,098
Chiropractor	$ 1,251,794	$ 1,248,163	$ 1,283,921
Nurse Practitioner	$ 924,032	$ 921,351	$ 947,747
Skilled Nursing	$ 2,432,910	$ 2,425,852	$ 2,495,349
Podiatrist	$ 151,079	$ 150,641	$ 154,957
Psychologist	$ 24,034,637	$ 23,964,916	$ 24,651,475
Optometrist	$ 1,965,262	$ 1,959,561	$ 2,015,700
Optician	$ 182,585	$ 182,055	$ 187,271
Transportation	$ 14,692,589	$ 14,649,968	$ 15,069,668
Therapy Services	$ 9,506,404	$ 9,478,827	$ 9,750,381
Prosthetic/Ortho	$ 3,187,101	$ 3,177,856	$ 3,268,897
Medical Supplies	$ 4,556,661	$ 4,543,443	$ 4,673,605
DME	$ 8,564,534	$ 8,539,690	$ 8,784,339
H&CB Services	$ 11,203	$ 11,171	$ 11,491
H&CB Services Mental Service	$ 1,335,564	$ 1,331,689	$ 1,369,840
Enhanced Resident Care	$ (69)	$ (69)	$ (70)
Personal Care Services	$ 11,079,720	$ 11,047,579	$ 11,364,076
Targeted Case Management (Drug)	$ 165,551	$ 165,071	$ 169,800
Assistive Community Care	$ 15,210,933	$ 15,166,809	$ 15,601,315
Day Treatment MHS	$ (55)	$ (55)	$ (57)
OADAP Families in Recovery	$ 2,825,675	$ 2,817,478	$ 2,898,195
Rehabilitation	$ 319,350	$ 318,424	$ 327,546
D & P Dept of Health	$ 17,471	$ 17,420	$ 17,919
PcPlus Case Mgmt and Special Program Payments	$ -	$ -	$ -
Blue Print & CHT Payments	$ 16,286,600	$ 16,239,355	$ 16,704,588
ACO Capitation	$ 154,806,296	$ 166,652,684	$ 166,652,684
PDP Premiums	$ 1,266,496	$ 1,262,822	$ 1,299,000
HIPPS	$ 519,621	$ 518,114	$ 532,957
ESIA/CHAP Premium Assistance	$ -	$ -	$ -
Ambulance	$ 7,244,216	$ 7,223,202	$ 7,430,135
Dialysis	$ 1,129,539	$ 1,126,262	$ 1,158,528
ASC	$ 68,281	$ 68,083	$ 70,034
Unknown	$ 608	$ 606	$ 624
Miscellaneous	$ 715,873	$ 713,796	$ 734,245
Non Classified	$ (1,382,211)	$ (1,378,201)	$ (1,417,685)
Other Expenditures	$ 141,978,456	$ 142,575,853	$ 142,621,827
Offsets	$ (143,923,489)	$ (137,564,767)	$ (138,173,725)
Total DVHA Program Expenditures	**$ 805,095,705**	**$ 813,793,130**	**$ 831,623,309**

CASELOAD AND UTILIZATION

This section details the historical and projected caseload and utilization of Medicaid services. In accordance with state statute, Vermont uses a consensus process to forecast Medicaid caseload and utilization. Program spending is a function of caseload, utilization, and cost for services.

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

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

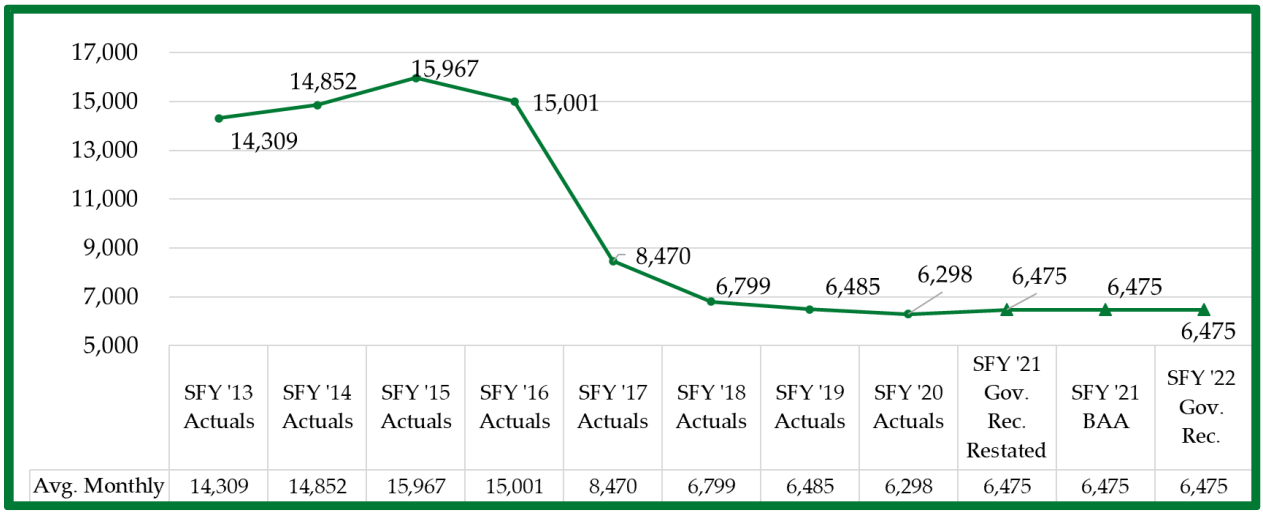
- Age 19 and older
- Determined ABD but ineligible for Medicare includes:
  - Supplemental Security Income (SSI) cash assistance recipients
  - Working disabled
  - Hospice patients
  - Breast and Cervical Cancer Treatment (BCCT) participants
  - Medicaid/Qualified Medicare Beneficiaries (QMB)
  - Medically 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 disabled or medically needy minor children

ABD Adult Caseload, Expenditures, and PMPM by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	6,799	$ 54,818,596	$ 671.90
SFY 2019	6,485	$ 61,197,266	$ 786.40
SFY 2020	6,298	$ 57,489,532	$ 760.67
SFY 2021 Gov. Rec. Restated	6,475	$ 61,811,034	$ 795.51
SFY 2021 BAA	6,475	$ 59,467,740	$ 765.35
SFY 2022 Gov. Rec.	6,475	$ 59,334,492	$ 763.64

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

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	14,309	14,852	15,967	15,001	8,470	6,799	6,485	6,298	6,475	6,475	6,475

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.

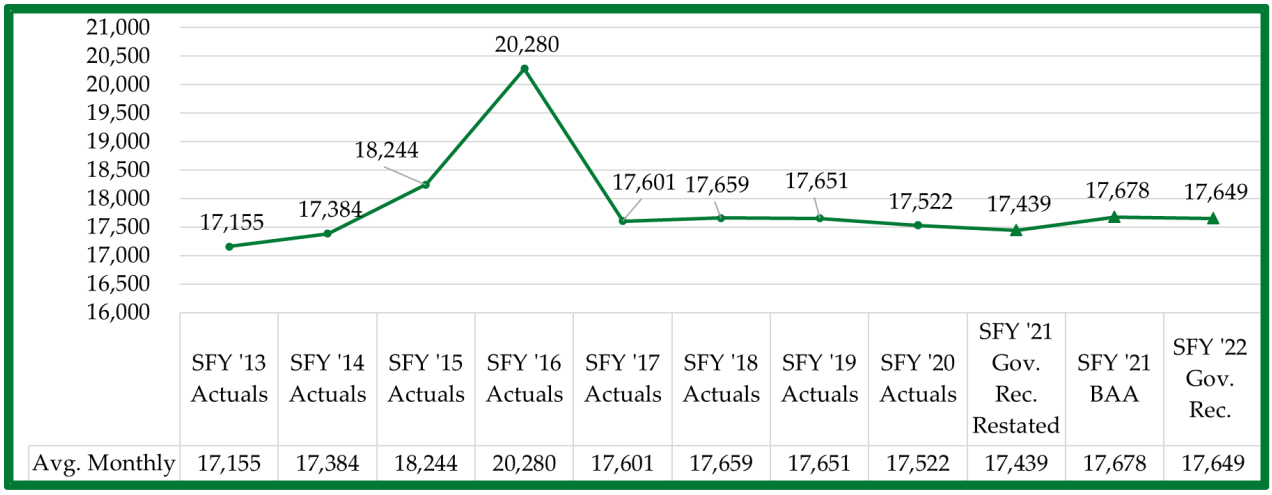
Medicaid assists with:

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

Dual Eligible Caseload, Expenditures, and PMPM by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	17,659	$ 53,612,503	$ 253.00
SFY 2019	17,651	$ 58,079,913	$ 274.21
SFY 2020	17,522	$ 53,812,435	$ 255.93
SFY 2021 Gov. Rec. Restated	17,439	$ 57,644,404	$ 275.46
SFY 2021 BAA	17,678	$ 48,359,639	$ 227.97
SFY 2022 Gov. Rec.	17,649	$ 54,523,872	$ 257.45

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	17,155	17,384	18,244	20,280	17,601	17,659	17,651	17,522	17,439	17,678	17,649

General Adults

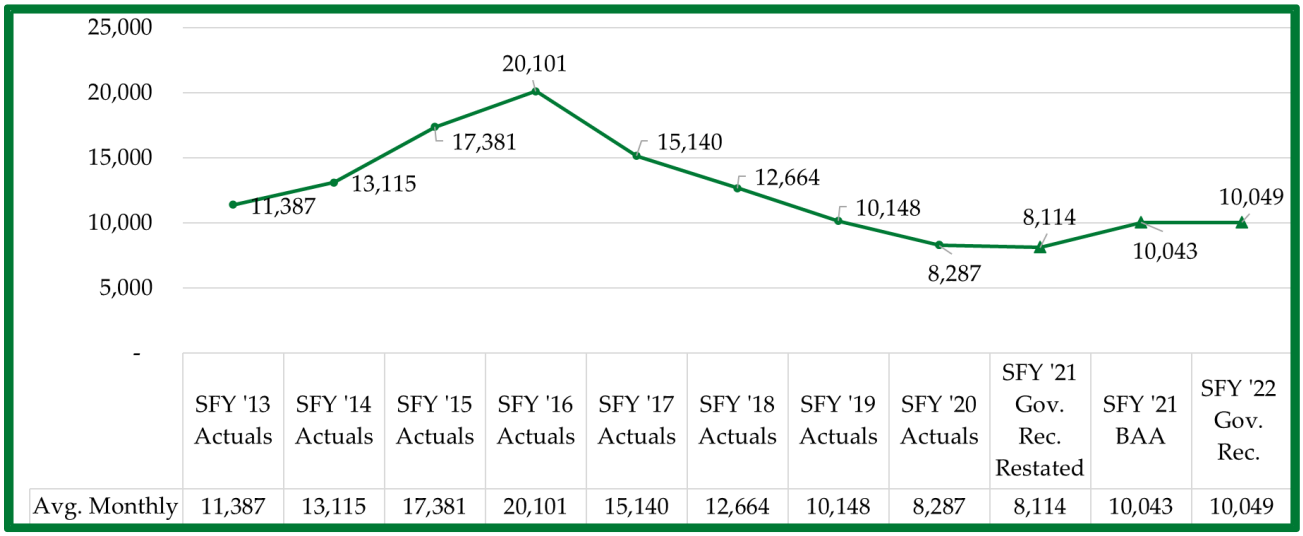
The eligibility requirements for General Adults are as follows:

- 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 protected income level (PIL)

General Adults Caseload, Expenditures, and PMPM by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	12,664	$ 71,486,396	$ 470.40
SFY 2019	10,148	$ 62,828,505	$ 515.94
SFY 2020 As Passed	8,287	$ 51,559,566	$ 518.51
SFY 2021 Gov. Rec. Restated	8,114	$ 50,275,041	$ 516.34
SFY 2021 BAA	10,043	$ 60,812,047	$ 504.60
SFY 2022 Gov. Rec.	10,049	$ 60,549,753	$ 502.12

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	11,387	13,115	17,381	20,101	15,140	12,664	10,148	8,287	8,114	10,043	10,049

New Adults without Children

The eligibility requirements for New Adults without Children are as follows:

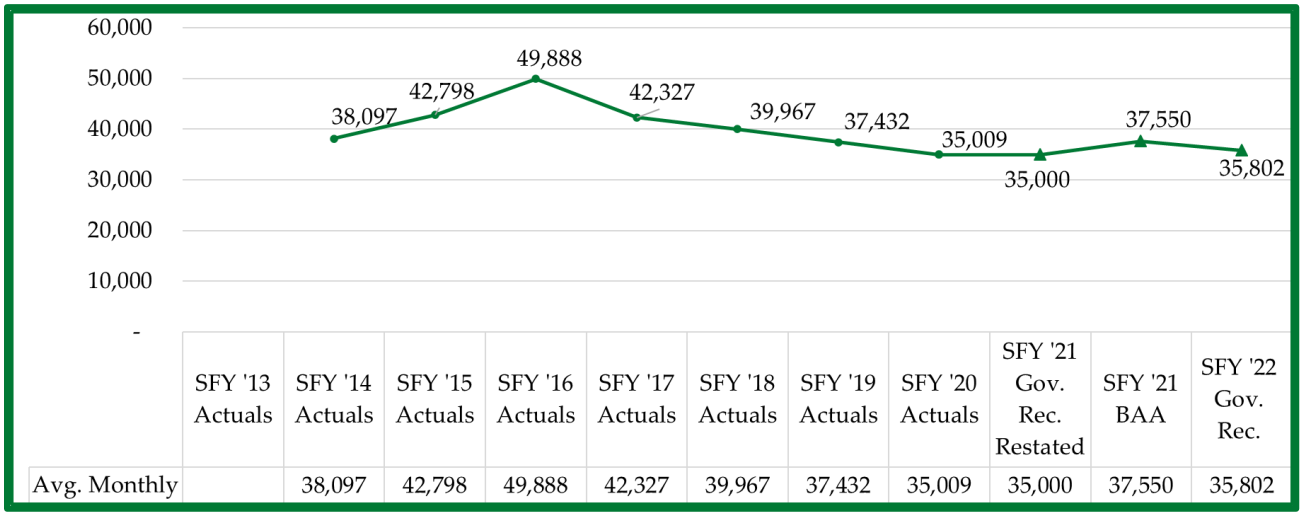
- Age 19 and older
- Income below the designated federal poverty guidelines
- No children in the household

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

New Adults Without Children Caseload, Expenditures, and PMPM by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	39,967	$ 189,970,050	$ 396.10
SFY 2019	37,432	$ 204,022,529	$ 454.21
SFY 2020 As Passed	35,009	$ 192,985,152	$ 459.36
SFY 2021 Gov. Rec. Restated	35,000	$ 187,427,978	$ 446.26
SFY 2021 BAA	37,550	$ 204,362,854	$ 453.53
SFY 2022 Gov. Rec.	35,802	$ 201,827,686	$ 469.78

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly		38,097	42,798	49,888	42,327	39,967	37,432	35,009	35,000	37,550	35,802

New Adults with Children

The eligibility requirements for New Adults with Children are as follows:

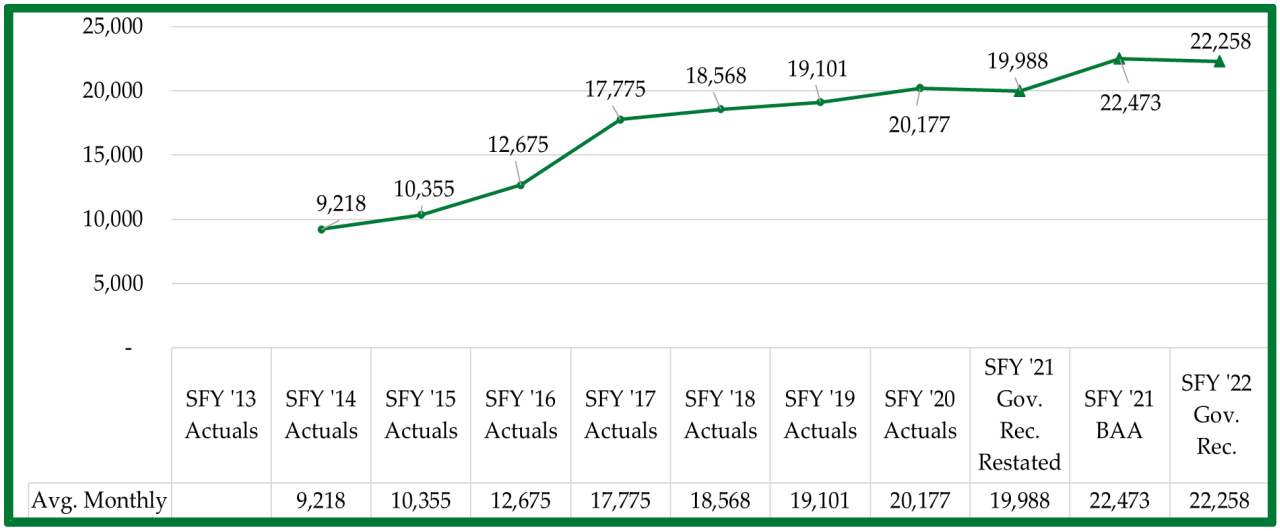
- Age 19 and older
- Income below the designated federal poverty guidelines
- With children in the household under the age of 19

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

New Adults with Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	18,568	$ 74,119,966	$332.65
SFY 2019	19,101	$ 88,370,003	$385.54
SFY 2020 As Passed	20,177	$ 98,886,805	$408.42
SFY 2021 Gov. Rec. Restated	19,988	$ 94,734,165	$394.96
SFY 2021 BAA	22,473	$ 102,062,482	$378.46
SFY 2022 Gov. Rec.	22,258	$ 108,032,753	$404.47

Average Monthly Caseload Actuals Comparison by SFY



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

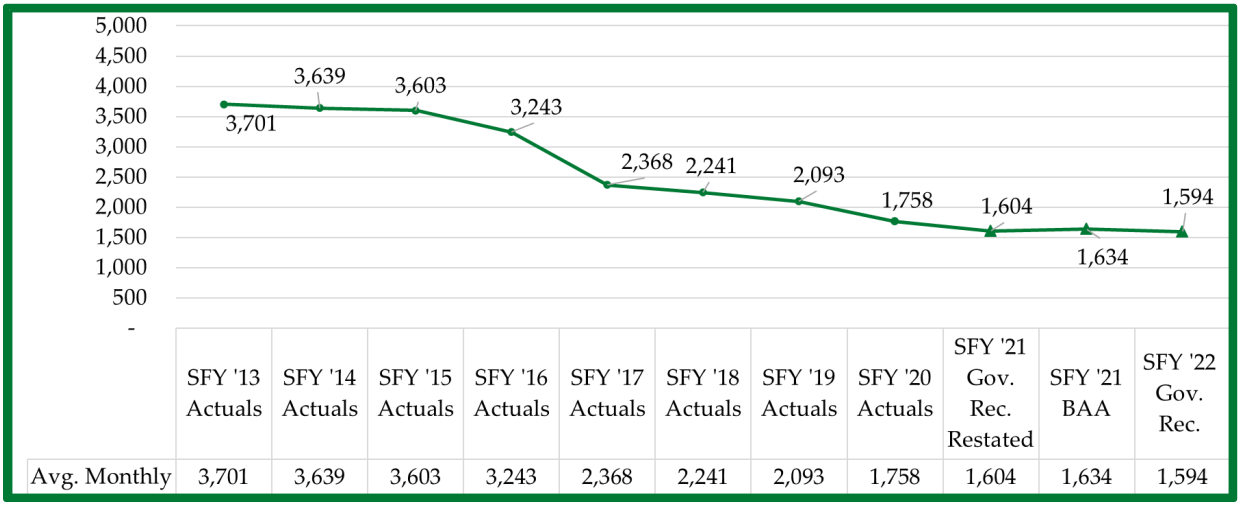
The eligibility requirements for Blind or Disabled (BD) and/or Medically Needy Children are as follows:

- 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:
    - o Children whose household income is greater than the cash assistance level but less than the Protected Income Level (PIL)
    - o Medically needy children may or may not be blind or disabled

BD Child Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	2,241	$ 20,174,102	$ 750.19
SFY 2019	2,093	$ 21,234,113	$ 845.44
SFY 2020 As Passed	1,758	$ 22,103,589	$1,047.61
SFY 2021 Gov. Rec. Restated	1,604	$ 20,361,380	$1,057.84
SFY 2021 BAA	1,634	$ 21,562,729	$1,099.69
SFY 2022 Gov. Rec.	1,594	$ 20,412,365	$1,067.15

BD Child Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	3,701	3,639	3,603	3,243	2,368	2,241	2,093	1,758	1,604	1,634	1,594

General Children

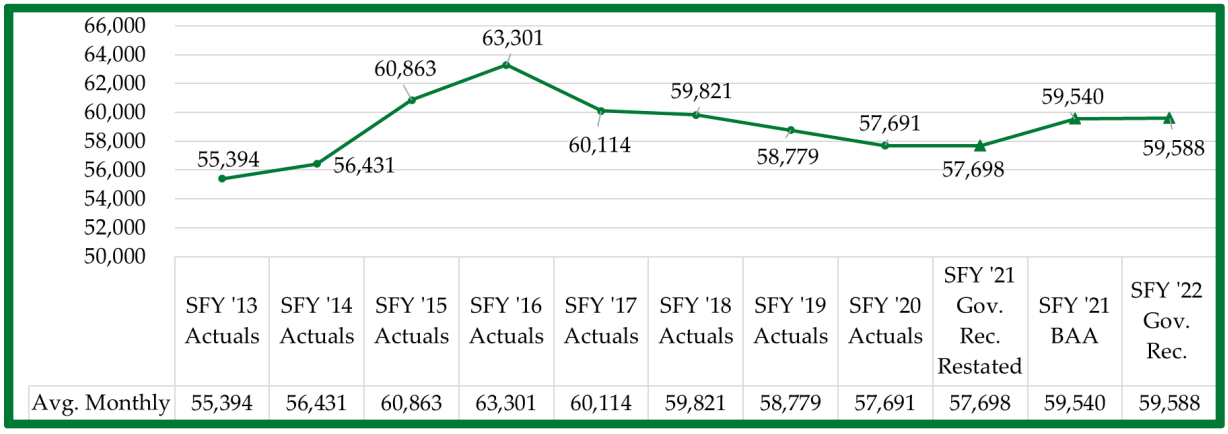
The eligibility requirements for General Children are as follows:

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

General Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	59,821	$156,825,223	$ 218.46
SFY 2019	58,779	$165,815,234	$ 235.08
SFY 2020 As Passed	57,691	$161,637,128	$ 233.48
SFY 2021 Gov. Rec. Restated	57,698	$164,653,910	$ 237.81
SFY 2021 BAA	59,540	$146,388,328	$ 204.89
SFY 2022 Gov. Rec.	59,588	$160,340,868	$ 224.24

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	55,394	56,431	60,863	63,301	60,114	59,821	58,779	57,691	57,698	59,540	59,588

Optional Benefit (Underinsured) Children

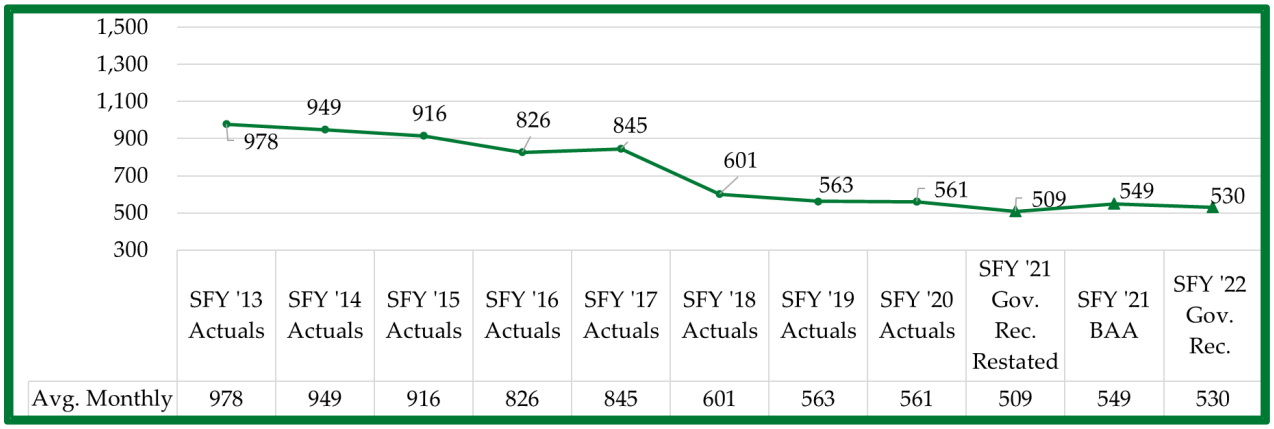
This program was designed as part of the original 1115 Waiver to Title XIX of the Social Security Act to provide health care coverage for children who would otherwise be underinsured. The general eligibility requirements for Underinsured Children are as follows:

- Age 18 and younger
- Income up to 312% federal poverty guidelines

Optional Benefit Children Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	601	$ 515,180	$ 71.43
SFY 2019	563	$ 472,464	$ 69.93
SFY 2020 As Passed	561	$ 468,699	$ 69.62
SFY 2021 Gov. Rec. Restated	509	$ 431,984	$ 70.72
SFY 2021 BAA	549	$ 527,572	$ 80.08
SFY 2022 Gov. Rec.	530	$ 433,316	$ 68.13

Average Monthly Caseload Actuals Comparison by SFY



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.

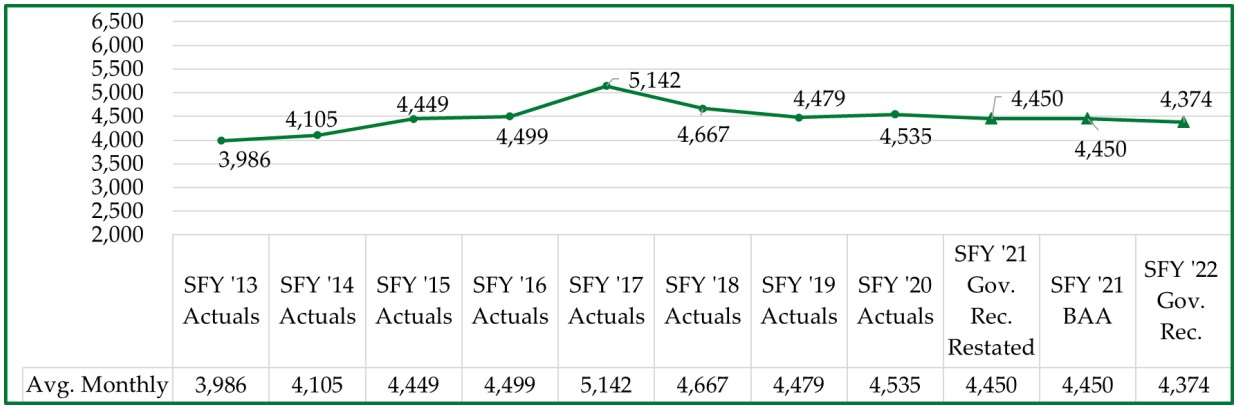
The general eligibility requirements for the CHIP are:

- Age 18 and younger
- Income up to 312% federal poverty guidelines
- Uninsured

CHIP Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	4,667	$ 8,323,354	$148.62
SFY 2019	4,479	$ 9,234,963	$171.82
SFY 2020 As Passed	4,535	$ 9,136,532	$167.88
SFY 2021 Gov. Rec. Restated	4,450	$ 8,934,633	$167.32
SFY 2021 BAA	4,450	$ 8,852,317	$165.77
SFY 2022 Gov. Rec.	4,374	$ 8,683,881	$165.45

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	3,986	4,105	4,449	4,499	5,142	4,667	4,479	4,535	4,450	4,450	4,374

Choices for Care - Acute

The Choices for Care program is managed and funded by the Disabilities, Aging, and Independent Living. The eligibility requirements for Choices for Care are:

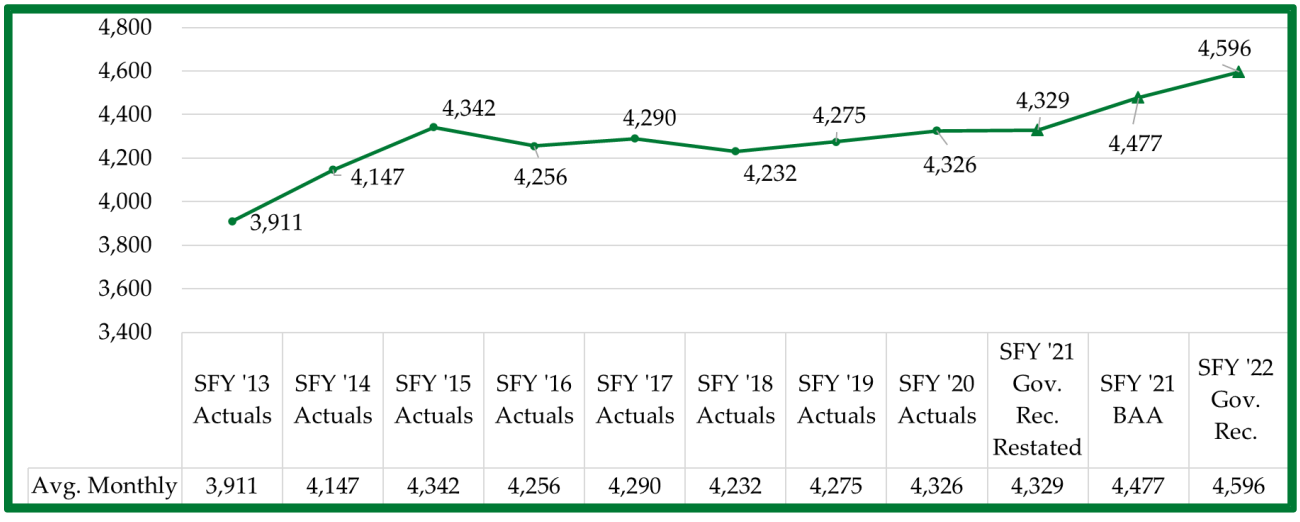
- Vermonters in nursing homes
- Home-based settings under home and community-based services (HCBS) waiver programs
- Enhanced residential care (ERC)

DVHA is responsible for other Medicaid state plan benefits for this population.

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

SFY	Caseload	Expenditures	PMPM
SFY 2018	4,232	$ 27,628,248	$544.03
SFY 2019	4,275	$ 31,156,672	$607.34
SFY 2020 As Passed	4,326	$ 36,665,867	$706.27
SFY 2021 Gov. Rec. Restated	4,329	$ 36,642,934	$705.38
SFY 2021 BAA	4,477	$ 46,175,225	$859.49
SFY 2022 Gov. Rec.	4,596	$ 40,076,740	$726.66

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	3,911	4,147	4,342	4,256	4,290	4,232	4,275	4,326	4,329	4,477	4,596

Pharmacy Only Programs – Prescription Assistance

Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status, and age under the name VPharm. There are monthly premiums based on income and co-pays based on the cost of the prescription.

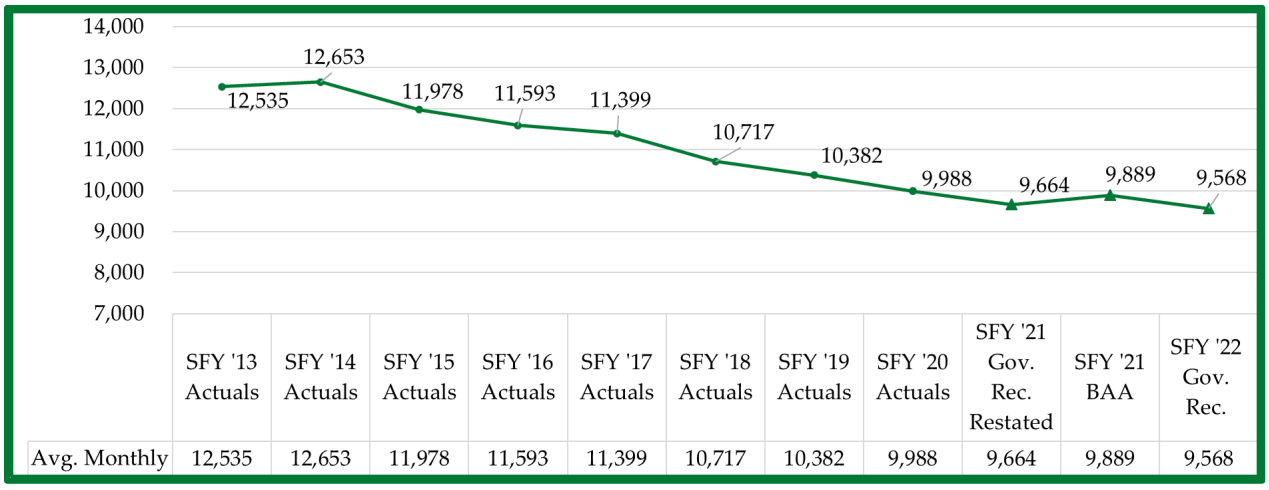
VPharm assists Vermonters enrolled in Medicare Part D with paying for prescription medicines as well as their Medicare Part D premiums. The eligibility requirements for VPharm are as follows:

- 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 State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2018	10,717	$ 4,588,899	$ 35.68
SFY 2019	10,382	$ 8,475,105	$ 68.03
SFY 2020 As Passed	9,988	$ 3,451,390	$ 28.80
SFY 2021 Gov. Rec. Restated	9,664	$ 7,577,935	$ 65.34
SFY 2021 BAA	9,889	$ 5,630,360	$ 48.55
SFY 2022 Gov. Rec.	9,568	$ 5,452,114	$ 47.49

Average Monthly Caseload Actuals Comparison by SFY



Healthy Vermonters

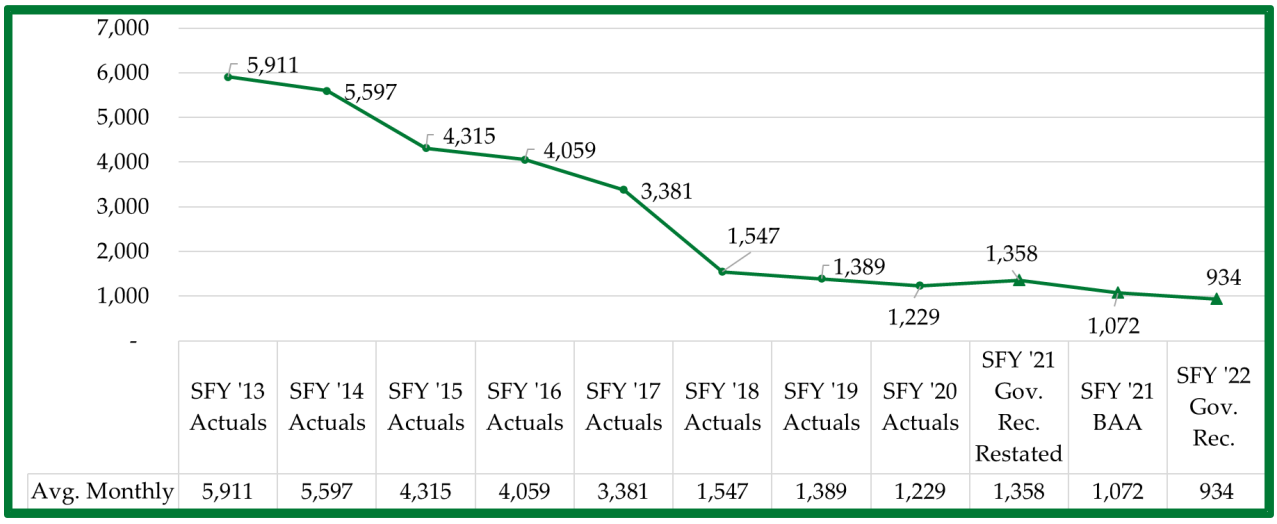
Healthy Vermonters provides a discount on prescription medicines for individuals not eligible for other pharmacy assistance programs. There are no programmatic costs to the State for this program. The eligibility requirements for Healthy Vermonters are:

- household incomes up to 350% of the federal poverty guidelines if uninsured; or
- household incomes up to 400% of the federal poverty guidelines if ≥ age 65, blind, or disabled.

Healthy Vermonters Caseload Comparison by State Fiscal Year
(There is no programmatic cost to the State for this program)

SFY	Caseload
SFY 2018	1,547
SFY 2019	1,389
SFY 2020 As Passed	1,229
SFY 2021 Gov. Rec. Restated	1,358
SFY 2021 BAA	1,072
SFY 2022 Gov. Rec.	934

Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly	5,911	5,597	4,315	4,059	3,381	1,547	1,389	1,229	1,358	1,072	934

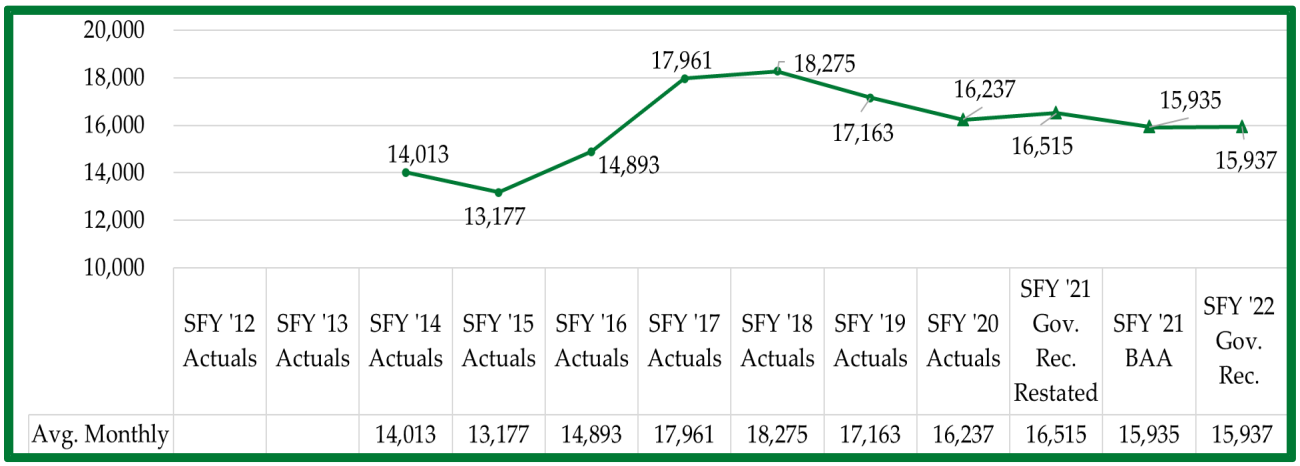
Premium Assistance and Cost Sharing

Individuals can choose to enroll in qualified health plans purchased on 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.

Premium Assistance Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2017	17,961	$ 6,100,378	$ 28.30
SFY 2018	18,275	$ 6,334,440	$ 28.88
SFY 2019	17,163	$ 5,941,367	$ 28.85
SFY 2020 As Passed	16,237	$ 5,732,382	$ 29.42
SFY 2021 Gov. Rec. Restated	16,515	$ 5,819,526	$ 29.36
SFY 2021 BAA	15,935	$ 5,625,792	$ 29.42
SFY 2022 Gov. Rec.	15,937	$ 5,615,851	$ 29.36

Premium Assistance Average Monthly Caseload Actuals Comparison by SFY

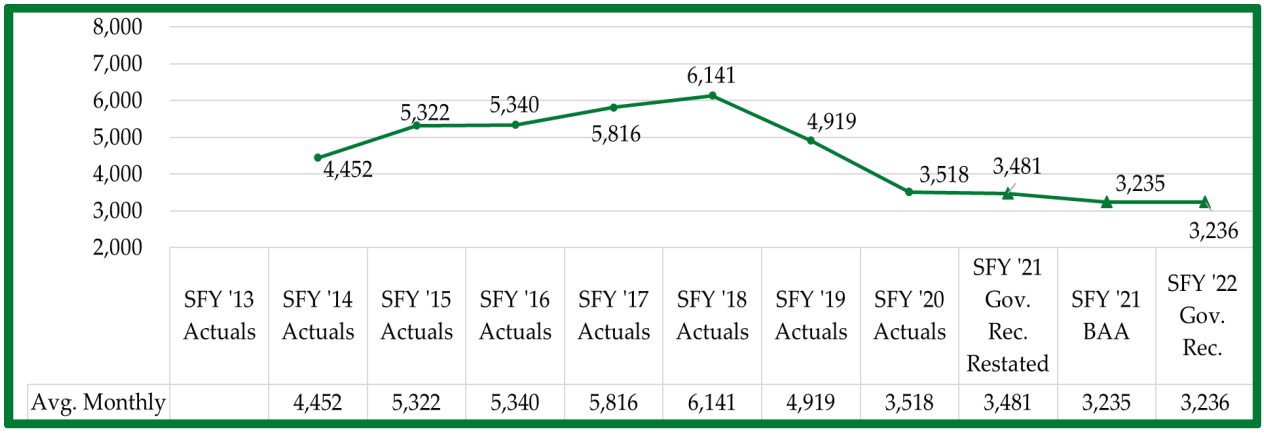


Premium Assistance and Cost Sharing Cont.

Cost Sharing Caseload, Expenditure, and PMPM Comparison by State Fiscal Year

SFY	Caseload	Expenditures	PMPM
SFY 2017	5,340	$ 1,186,720	$ 18.52
SFY 2018	5,816	$ 1,355,318	$ 19.42
SFY 2018	6,141	$ 1,570,896	$ 21.32
SFY 2019	4,919	$ 1,482,370	$ 25.11
SFY 2020 As Passed	3,518	$ 1,170,612	$ 27.73
SFY 2021 Gov. Rec. Restated	3,481	$ 1,216,331	$ 29.12
SFY 2021 BAA	3,235	$ 1,076,393	$ 27.73

Cost Sharing Average Monthly Caseload Actuals Comparison by SFY



	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Gov. Rec. Restated	SFY '21 BAA	SFY '22 Gov. Rec.
Avg. Monthly		4,452	5,322	5,340	5,816	6,141	4,919	3,518	3,481	3,235	3,236

APPENDIX A: EXAMPLES OF PERFORMANCE ACCOUNTABILITY SCORECARDS

1. ENROLL MEMBERS

Health Access Eligibility & Enrollment Unit

The Health Access Eligibility & Enrollment Unit (HAEEU) serves Vermont individuals and families through coordinating a range of health insurance plan options and offering online, telephone, paper and in-person assistance for Vermonters who are applying for health insurance.

THE TOP PRIORITIES/INITIATIVES FOR HAEEU IN SFY20 WERE:

1) Provide members, partners, and stakeholders with exceptional customer experience by continuing to improve the speed and quality of eligibility determinations for applications, verifications, and change requests.

2) Advance several Integrated Eligibility and Enrollment projects, including:
   - Launching an integrated Health Care Application (July 2019);
   - Launching the electronic Document Uploader tool (November 2019);
   - Completing Enterprise Content Management migration (May 2020);
   - Completing Enterprise Content Management encryption (May 2020).

3) Planning and preparation for additional Integrated Eligibility and Enrollment efforts for customer portal improvements and case management preparation, including the Business Rules Management source policy update (to prepare for a new case management system), launching Business Intelligence (i.e., reporting application to support case management preparation), Authentication for Document Uploader, the Medicaid for the Aged, Blind, and Disabled online application pilot, and reconfiguring and developing existing systems to return premium billing to the carriers for January 1, 2022.

To read more about these initiatives as well as who we serve, how we impact, and our performance measures, see HAEEU's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

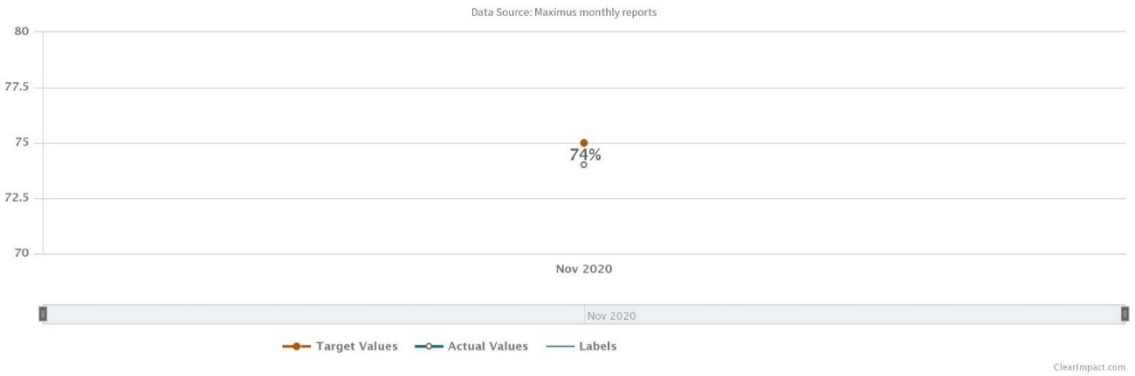
A commitment to continuous quality improvement has been adopted and the tracking of performance metrics has helped the Unit identify necessary process and system improvements. This commitment, monitoring of performance, and collaboration across all teams in the Unit has resulted in improvement in customer service (e.g., answering

calls quickly & resolving the majority of customer requests within 10 business days) and operational processes (e.g., reducing the number of integration errors between Vermont's state-based exchange and its commercial insurance carrier partners). In addition, the Unit has been contributing to performance measurement on IE&E information technology projects to monitor whether the projects remain on schedule.

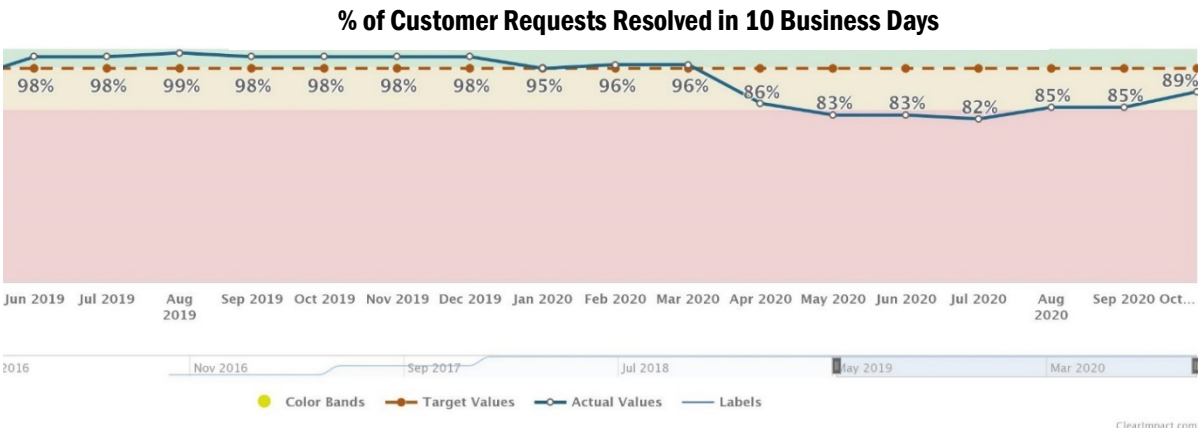
Accomplishments

The Unit completed several Integrated Eligibility and Enrollment projects and successfully renewed 99% of qualified health plan enrollees ahead of Open Enrollment for the third year in a row (2020, 2019, and 2018).

74% of Calls Answered within 25 Seconds During November's Open Enrollment Period



Callers to the State's Customer Support Center continue to experience prompt service overall. During the first month of Open Enrollment (November 1 – 30, 2020), 74% of calls were answered within 25 seconds, nearly meeting the target of 75%. DVHA continues to work with the contracted call center, Maximus, to increase trained staff and staffing coverage to avoid the long wait times that occurred during calendar year 2018 Open Enrollment.



After years of continuous quality improvement, the Health Access Eligibility and Enrollment unit was consistently completing more than 90% of customer requests within ten business days. In fact, at the close of the 2019 state fiscal year, this measure was at 98%.

In state fiscal year 2020, the COVID-19 public health emergency impacted performance on this measure related to federal requirements (i.e., Vermont Medicaid was unable to complete most requests that would result in termination of Medicaid coverage during the public health emergency due to conditions for receiving the increased Federal Medical Assistance Percentage (FMAP) funding). The Unit continues to assess delayed cases with regularity to identify root causes and improve the processes.

Long-Term Care Unit

Vermont's Long-Term Care program includes Choices for Care, Developmental Disability Services, Developmental Disability Home- and Community-based Services, Traumatic Brain Injury, and Enhanced Family Treatment. The Long-Term Care unit assists eligible Vermonters with accessing services in their chosen setting; the Program requires two types of eligibility determination. The first, clinical eligibility, is performed by the Department of Disabilities, Aging and Independent Living. The second, financial eligibility, is the portion performed by DVHA's Long-Term Care unit.

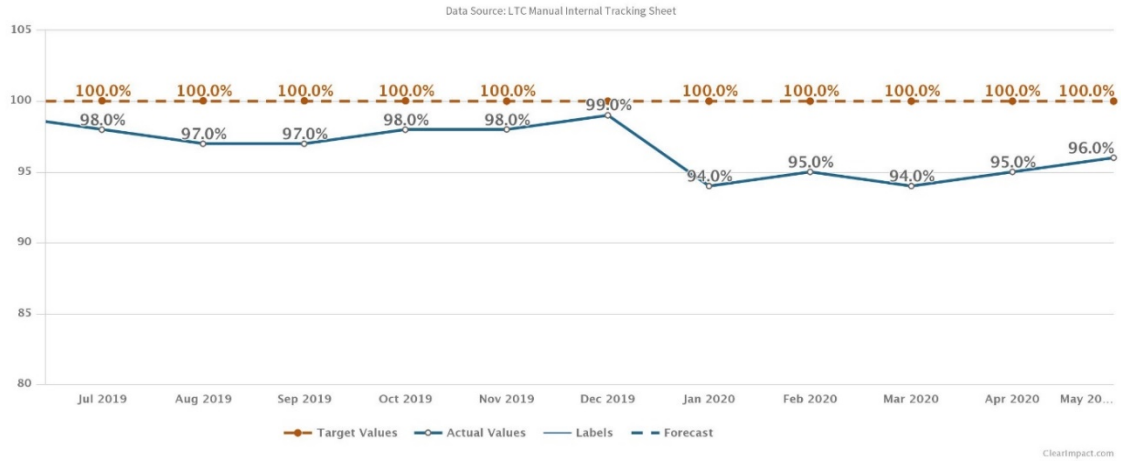
THE TOP PRIORITIES/INITIATIVES FOR LTC IN SFY20 WERE:

1) Process new Long-Term Care applications within the 45-day federal standard for timeliness.

2) Focus on operational performance improvement (e.g., fill full-time positions to support existing staff, update LTC Training Manual and Procedures, deliver updated training on rules, policies, and business processes to all LTC staff and begin to explore information technology for statistical reporting, forms, and annual ex parte review).

To see what we do, who we serve, how we impact, and our performance measures, see LTC's Section of the DVHA Performance Accountability Scorecard.

Of the New LTC Applications Processed, % Processed in 45 Days



Of the New LTC Medicaid Applications, % that had the Client Interview Conducted within 10 Days of Receiving the Application

BUSINESS INSIGHTS FOR SFY20:

Federal requirements establish a timeliness standard for processing long-term care applications (within 45-days) and staff must evaluate the income, resources, financial statements, and transfers of income/resources within the 60 months prior to the month of application for each applicant. Best practices involve the interview being conducted within 10 days of the application being received by LTC staff in to remain compliant with the timeliness standard. Due to the COVID-19 public health emergency, the 45-day requirement for processing applications, as well as the interview requirement, was suspended as of March 2020.

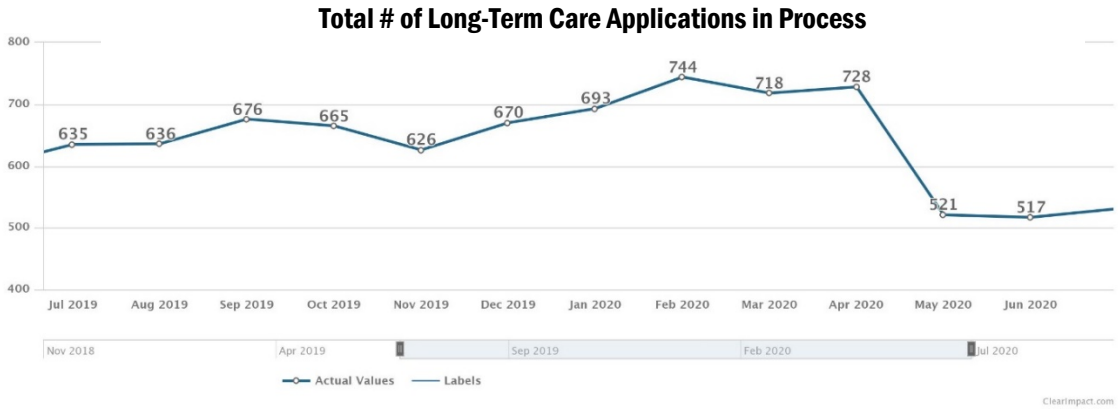
The LTC management team spent significant time analyzing collected performance data. Review of results from collected performance measures led to changes in business processes to appropriately adjust workload for staff without diminishing program integrity. However, these changes were introduced just prior to the public health emergency produced by COVID-19; as a result, the impact of implementing these changes cannot be assessed.

Accomplishments

Despite the increased number of applications in process prior to the public health emergency and complexity of administering the Long-Term Care program particularly during a public health emergency, staff remained responsive and helpful to clients, providers, colleagues in the Department of Disabilities, Aging, and Independent Living, and other parties who needed assistance consistently during the last state fiscal year.

Challenges

The following table shows the observed trend of the increasing number of LTC applications worked on by DVHA's staff in the last state fiscal year. As the Vermont population ages, this increased workload is expected to continue. In addition, the number of applications in process is impacted by the complexity of the cases; staff have observed that individual cases are also generally more complicated, requiring additional staff time to process. In addition, addressing the backlog of applications once the public health emergency ends is expected to be a challenge for the next state fiscal year.



2. PAY FOR CARE

Clinical Operations Unit

The Clinical Operations unit monitors the quality, appropriateness and effectiveness of health care services for Medicaid members. Prior authorization is a process used to assure appropriate use of health care services and that services are medically necessary and effective for the medical needs of the member. Clinical Operations staff must issue a notice of decision within 3 days of receipt of a prior authorization request containing all necessary information and the longest time allowable for a decision is 28 days (if the 14-day extension is employed).[1]

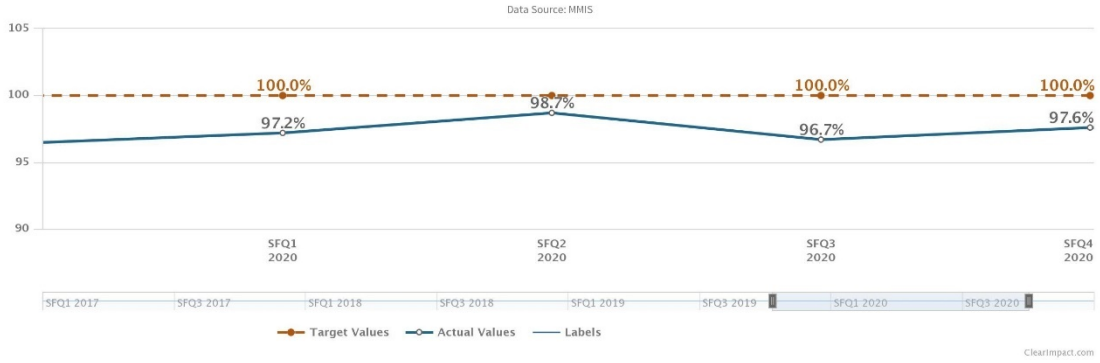
THE TOP PRIORITIES/INITIATIVES FOR THE CLINICAL UNIT IN SFY20 WERE:

1) Improving the transition for Medicaid providers and beneficiaries into the ACO model (determination of PA requirements, development of forms, provider education) to support adoption of value-based care and payment models while assuring appropriate use, medical necessity, and effectiveness of health care services for Medicaid members in a timely manner.
2) Utilization of information technology resources and data analysis to support clinical decision making, assessment of service and claims utilization and support collaborative clinical determinations to ensure Medicaid members have access to quality health care.

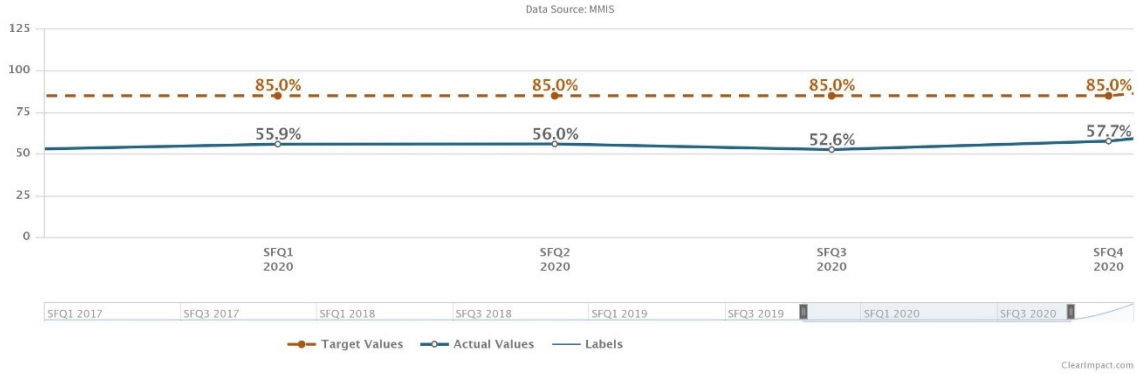
To see what we do, who we serve, how we impact, and our performance measures, see Clinical's Section of the DVHA Performance Accountability Scorecard.

[1] Medicaid Covered Services Rule 7102 & 42 CFR § 438.210

% of Initial Prior Authorization Requests Closed Out within 28 Days



% of Initial Prior Authorization Requests that Have a Decision Rendered within 3 Days of Receiving all Necessary Information



BUSINESS INSIGHTS FOR SFY20:

In state fiscal year 2019, the Unit implemented a new, fully electronic process on the OnBase system. The new system enhances efficiency in the processing prior authorizations. Additionally, planned utilization management changes, elimination of certain prior authorization requirements and accountable care organization attribution changes were factors impacting these performance measures. Since implementation of the new system, the trend for the initial prior authorization requests closed out within 28 days has remained consistently high and near the target of 100%. An in-depth review of the data for the measure of "initial prior authorization requests that have a decision rendered within 3 days of receiving all necessary information" indicated a need to change how the data is captured/calculated with current Medicaid Management Information System specifications; a new methodology will be implemented for State Fiscal Year 2021 (SFY21) in order to improve accuracy of measurement as this measure is

intended to capture a decision following receipt of all required information. Receipt of clinical documentation from the requesting provider is crucial for clinical decision-making but can have delays associated with this factor that previously impacted the performance measure.

Accomplishments

The Unit's strategic goals and priorities were redefined and integrated with the work of the Agency and Department. This allowed for engagement with mutually identified health outcome priorities, advancement of clinical measures aligned with those priorities, and expansion of urine drug testing guidelines for appropriate testing, provider education and best practices for risk stratification/utilization of results in collaboration with other payers.

Challenges

Expansion of access to electronic health records at medical facilities is necessary to support utilization management efforts and quality improvement activities. Prior authorization requirements must be reviewed to reduce administrative burden on providers to the extent possible whilst ensuring that appropriate requirements are in place to protect Medicaid members from imminent harm; in order to accomplish this review, staff must identify imminent harm codes of service and complete review of the code set. Finally, the COVID-19 public health emergency required the Unit to adapt its staff and structure to remain responsive to the needs produced by the public health emergency.

MMIS Program Maintenance & Operations (M&O)

The Medicaid Management Information System (MMIS) Program Maintenance & Operations (M&O) unit supports MMIS projects as they transition from Design, Development, and Implementation (DDI) to operations, establishes consistent operational practices and standards to monitor MMIS modules, and provides compliance oversight and support for managing vendor performance as well as adherence to national correct coding standards.

THE TOP PRIORITIES/INITIATIVES FOR THE MMIS PROGRAM IN SFY20 WERE:

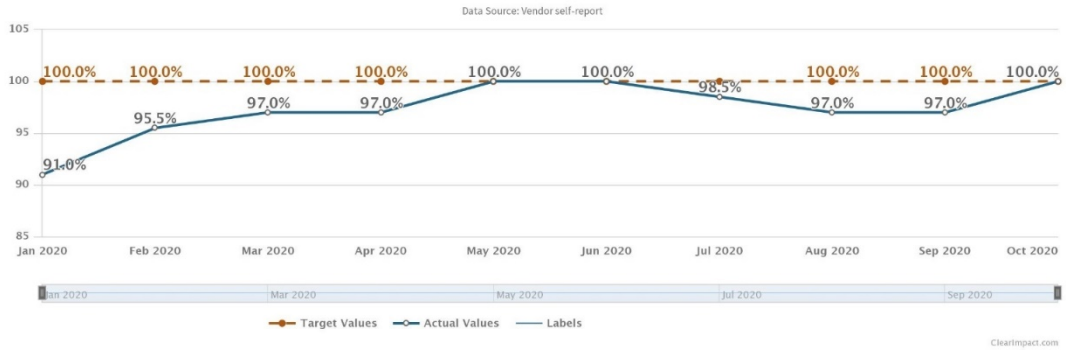
1) Procure Technical Assistance (TA) vendor to provide procurement support for the program;
2) DXC contract extension to allow runway to procure Operations Management Module (OMM);

3) Receive Final CMS Certification approval for Care Management and Provider Management;
4) Issue RFP for Medicaid Data Warehouse (MDW) and data analytic tools;
5) Continued implementation activities associated with Electronic Visit Verification (EVV);
6) Continue MMIS system modifications to support payment reform initiatives.

To see what we do, who we serve, how we impact, and our performance measures, see MMIS' section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

The MMIS team developed a new performance measure to show how MMIS technology/services contractors are performing on their contractual Service Level Agreements. Service Level Agreements are the minimum levels established for a contractor to meet, so the goal for the measure was set at 100%. While the business unit leaders who provide oversight for each contract monitor the SLAs and address any issues/failures (including a potential monetary Service Level Credit and/or implementation of a corrective action plan), new this year was working with each contractor that provides support for the MMIS to establish monthly reporting for a single performance measurement.



Once the measurement was established, it became clear that the trendline shows that MMIS contractors frequently, but not always, meet their monthly Service Level Agreements. Going forward, root causes and corrective actions will be documented.

Accomplishments

DXC's, now Gainwell Technologies, current contract term ends on December 31, 2021. Thus, planning for the five-year contract restatement needed to begin in 2020 to ensure sufficient time to meet the goals and objectives of the restatement, i.e., to prepare for procuring, implementing and transitioning to a new claims processing system. The

restatement will include requirements to maintain and improve existing operations while limiting the expense/time of developing new system functionality for a short lifespan, documenting the current state DXC processes, defining and documenting transition requirements to support a smooth transition, and support effective request for proposals issuance. The Restatement team held their first official project kickoff on June 18, 2020 with a discussion of the goals and objectives indicated above, as well as identifying that new contract language will need to include the deliverables the State of Vermont needs from DXC during the restatement period. Importantly, the work needed to develop the restatement will be performed as a project using 90/10 funding.

Provider Management Module

The Provider Management Module required documented processes and procedures to facilitate transition to operations inclusive of continued monitoring of the new module.

Coding Guidance & Adherence to National Correct Coding Standards

For state fiscal year 2020, identified coding issues began to be escalated to the newly established DVHA Coding Team for review. While coding review processes and roles/responsibilities (including integration with those of the Clinical and Reimbursement units) continue to evolve, the Coding Team has demonstrated its value in supporting other DVHA units. The DVHA Coding Team, Clinical, Reimbursement, Member and Provider Services, Policy, and Pharmacy units are all working together to reevaluate the process for putting new and changed codes on file during quarterly and annual code updates. This was the first year the Coding Team was asked to be involved in facilitating the process and ensuring deadlines are met.

Challenges

During the past three years, a top priority has been developing system changes that support payment reform initiatives in the MMIS (e.g., the Vermont Medicaid Next Generation program). However, this requires the same finite resources are for this work as the resources to correct system defects and perform system enhancements. This has resulted in many M&O items remaining in the backlog. Thus, an effort is underway to identify the full scope of backlog items so better prioritization can occur. This information will be essential for senior management to make informed decisions about prioritizing all work needed from Gainwell – both M&O and payment reform changes.

Payment Reform Unit

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.

THE TOP PRIORITIES/INITIATIVES FOR PAYMENT REFORM IN SFY20 WERE:

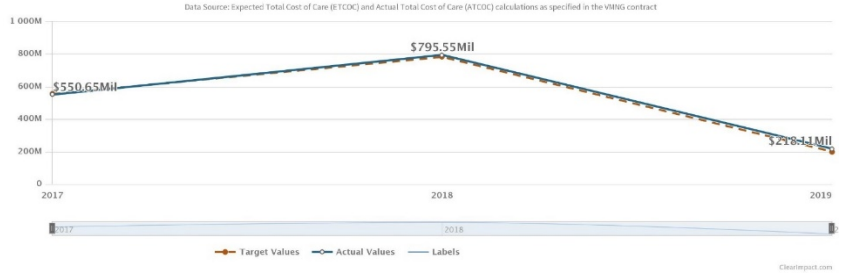
1) Continue to oversee the implementation, evaluation and evolution of the VMNG program, as well as the other payment reform initiatives that are in process.
2) Provide support to Department and Agency leadership in the consideration of, and planning for, any additional value-based payment reform models to support continued advancement toward an integrated health care system in Vermont.
3) Understand and engage in the unique internal and external stakeholder landscape for each Payment Reform initiative, emphasizing respectful, transparent, and collaborative interactions.

To see what we do, who we serve, how we impact, and our performance measures, see Payment Reform's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

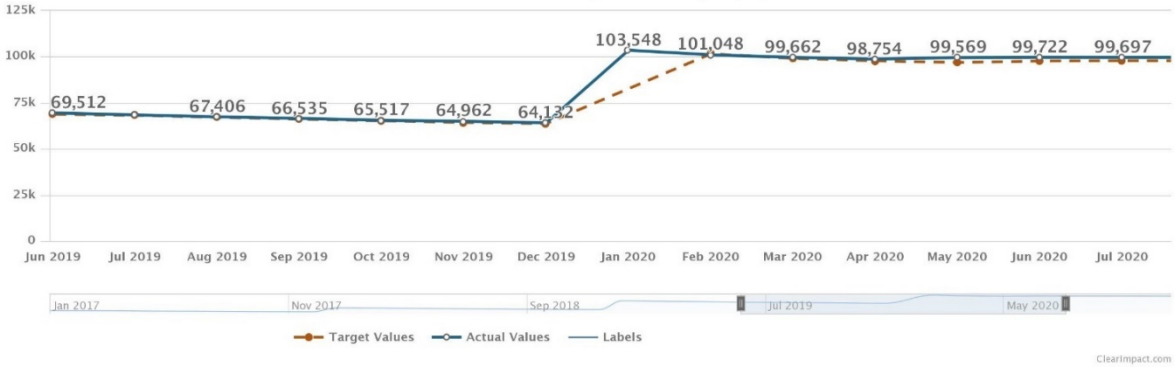
The Payment Reform unit's measures in the DVHA Performance Accountability Scorecard mostly relate to the Vermont Medicaid Next Generation program. The first performance measure, looking at the ACO's actual total cost of care – shows that the actual total cost of care exceeded the expected total cost of care for the Vermont Medicaid Next Generation Program for the second year in a row. This indicates that cost containment continues to be a challenge. The shared risk built into the Program mitigates the impact on Vermont Medicaid to some extent, but it impacts providers and OneCare Vermont.

Expected vs. Actual Total Cost of Care for the Vermont Medicaid Next Generation (VMNG)



The Program's most recent results indicate that the Program continues to grow (i.e., provider participation and member attribution in Vermont Medicaid Next Generation program has continued to increase since the Program's start). The performance measure for attribution of Medicaid members to the Vermont Medicaid Next Generation Program conveys the impact of the innovative approach employed for expanded attribution based on the Medicaid member's location of residence for those who could not be traditionally attributed.

Number of Medicaid Members per month for whom a Prospective Payment was made to OneCare Vermont



The team continues to gain experience in planning, designing, implementing, and evaluating innovative value-based payment models. Previous learnings are used to improve approaches and support alignment across models as the cross-departmental collaboration on payment reform initiatives continues.

Accomplishments: Team members demonstrated extraordinary dedication, flexibility, and creativity in responding to the pandemic. While some payment reform projects were initially paused as the team prioritized the Emergency response to financially stabilize Vermont's health care providers, other projects were able to maintain momentum, and the Unit observed an increase in interest in payment reform initiatives as providers and other departments observed the stability that alternative payment models can provide during a time of extreme utilization volatility.

Challenges: Resource constraints (i.e., due to the increased interest in payment reform initiatives and the Team's dedication to stabilization efforts, like the Health Care Provider Stabilization Grant Program), and continued volatility in containing health care costs.

Pharmacy Unit

The Pharmacy unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefit programs. The Pharmacy unit oversees the contract with DVHA's pharmacy benefits administrator, Change Healthcare. 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.

THE TOP PRIORITIES/INITIATIVES FOR THE PHARMACY UNIT IN SFY20 WERE:

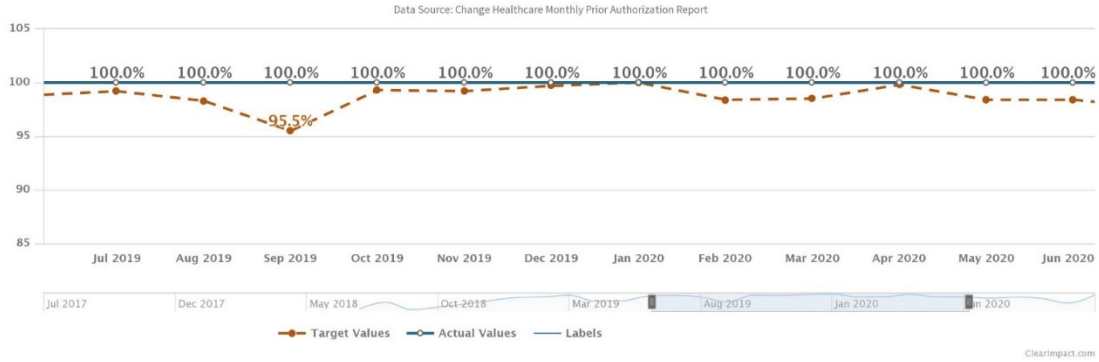
1. Continue to effectively manage DVHA's Preferred Drug List and coverage criteria by promoting clinically appropriate medications with the lowest net cost to DVHA;
2. Manage very high-cost drugs (over $5000 per month or treatment) through specialized cost management programs;
3. Coordinate and align with other clinical units to optimally manage ultra-high cost (over $100,000) drugs;
4. Launch a medication management program pilot;
5. Minimize PA burden on providers using new tools and technology; and
6. Evaluate cost benefits of value-based purchasing agreements from pharmaceutical manufacturers.

To see what we do, who we serve, how we impact, and our performance measures, see Pharmacy's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

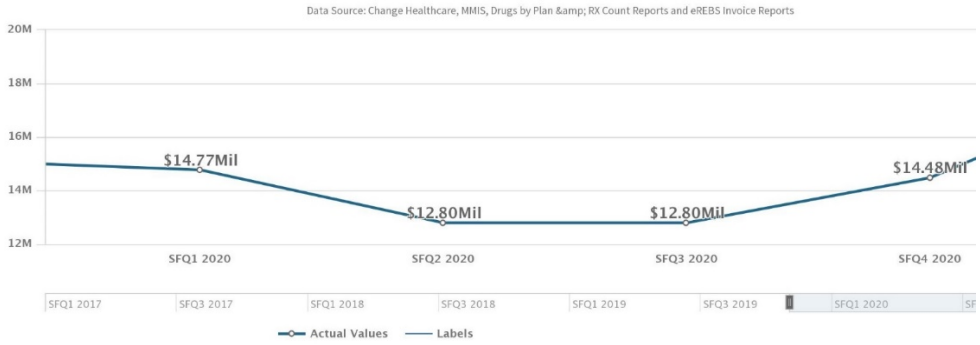
The Pharmacy unit has been successful in managing net drug spend through comprehensive preferred drug list management, rebate negotiations, and maximizing the utilization of drugs that have clinical and economic value for members. The Unit will be challenged over the next several years with very high-cost drugs and the advent of many "extremely high cost" drugs (in excess of $500,000 per treatment) including gene and cell therapies. The Unit continues to effectively manage the pharmacy benefit for Vermont Medicaid.

% of Pharmacy Prior Authorizations Processed within 4 and 24 Hours



The data collected and represented in the graph above demonstrated that the Unit remains within the federal and state requirements for processing drug prior authorization requests for members and is doing so efficiently. It also confirmed that the State's vendor is meeting its contractual service level agreements. **The Pharmacy unit has now started to monitor the percent completed within 4 hours, represented by the dotted red line, since the 24-hour requirement was being met 100% of the time (within 24 hours is represented by the solid, blue line**).

Adjusted Pharmacy Spend (actual spend minus invoiced rebates)



The Unit uses this measure to monitor the net pharmacy spend and identify any concern changes in the trend to assure maximization of rebate opportunities and utilization management programs. The Department receives approximately 60-65% of its drug spend back in the form of federal, state and supplemental rebates. If this trend line showed a significant deviation, drug details for the quarter would need to be evaluated to better understand what is driving such a change. While some fluctuation in the trend is always present due to drug mix and seasonal variations, the trend has been relatively stable overall. (There were declines observed in the net spend for the 2nd and 3rd quarter of state fiscal year 2020 attributable to fewer prescriptions being filled due to the

COVID-19 public health emergency.) The Pharmacy unit continues to monitor very high cost drugs as these drugs can move the trend line very quickly.

Member and Provider Services

The Member and Provider Services unit assures members have access to appropriate health care for their physical, mental, dental, and vision health needs. Member and Provider Services strives to:

- maximize Vermont Medicaid members' choices for providers,
- facilitate connection for Vermont Medicaid members with primary care providers for improved health and wellness and management of chronic disease,
- make certain that Vermont Medicaid members do not have to travel too far to receive the care they need, and
- support providers in participating with Vermont Medicaid.

Additionally, the Coordination of Benefits team of Member and Provider Services offers assistance for Vermonters who are Medicare-eligible in enrolling in appropriate programs. Through coordinating benefits and working with providers, members and other insurance companies, this team works to ensure that Medicaid is the 'payer of last resort.' Coordination of Benefits also works to recover funds from third parties, including estate, casualty, trust and Medicare recovery.

THE TOP PRIORITIES/INITIATIVES FOR THE UNIT IN SFY20 WERE:

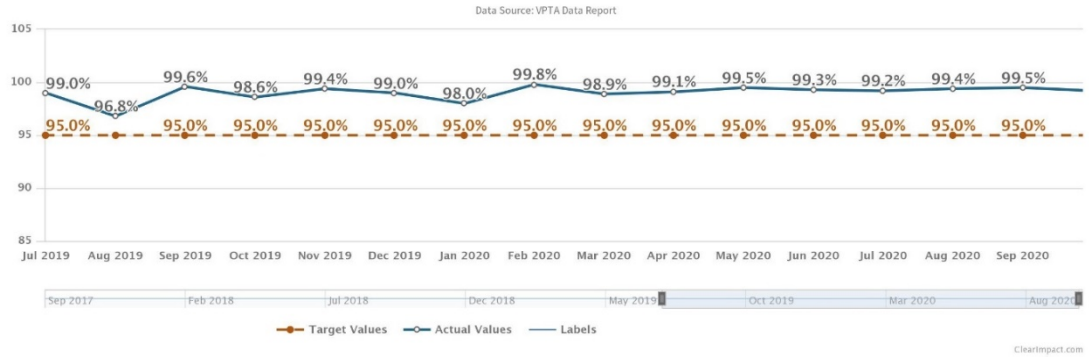
1). Ensuring members are receiving all federal programs they are eligible for, including pharmaceutical assistance, and staff are trained in applicable processes.
2). Improving the data matching process with insurers, resulting in increased collections as appropriate.
3). Engaging with Vermont Medicaid members and providers to ensure members understand the Medicaid program and providers participate with the Medicaid program.
4). Actively working with the NEMT program to ensure members are receiving all services afforded to them under the Program by performing audits and collaborating with VPTA. The Unit will also issue an RFP for the NEMT program.

To see what we do, who we serve, how we impact, and our performance measures, see the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

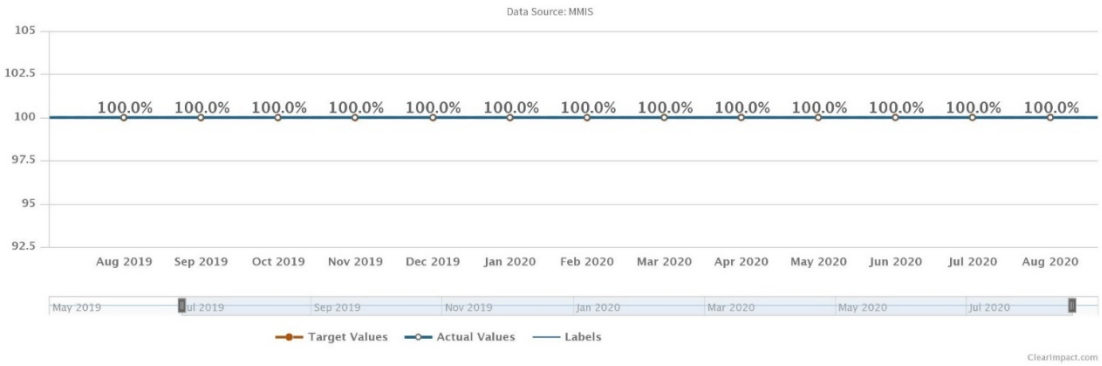
The Unit began monitoring this measure because complaints were being received from Vermont Medicaid members. The Unit receives reports from the transportation contractor, Vermont Public Transportation Association on a monthly basis and monitors

the on-time pick up and drop off times. If at any given time the rate drops below 95%, the contractor must provide a corrective action plan to the Department. Member and Provider Services also completes record audits twice a year and completes randomized Vermont Medicaid member outreach to members who have received rides through the Non-Emergency Medical Transportation program to assess whether their rides were on time. Since implementation, the trendline has maintained a fairly steady rate.



Since the Provider Management Module was launched, the trend demonstrates that provider applications are consistently being processed within 60 days.

Percentage of Provider Applications Processed within 60 Days



Rate Setting

The Division of Rate Setting (DRS) establishes and certifies Medicaid rates for residential services provided to Vermonters by 34 Vermont nursing homes enrolled with Medicaid, out-of-state nursing homes, 15 residential facilities for youth called Private Non-Medical Institutions (PNMIs), the Intermediate Care Facility for the Developmentally Disabled (ICF/DD), and hospital swing bed rates. The Division's rules govern the processes for setting the Medicaid rates of each different type of facility.

THE TOP PRIORITIES/INITIATIVES FOR THE RATE SETTING UNIT IN SFY20 WERE:

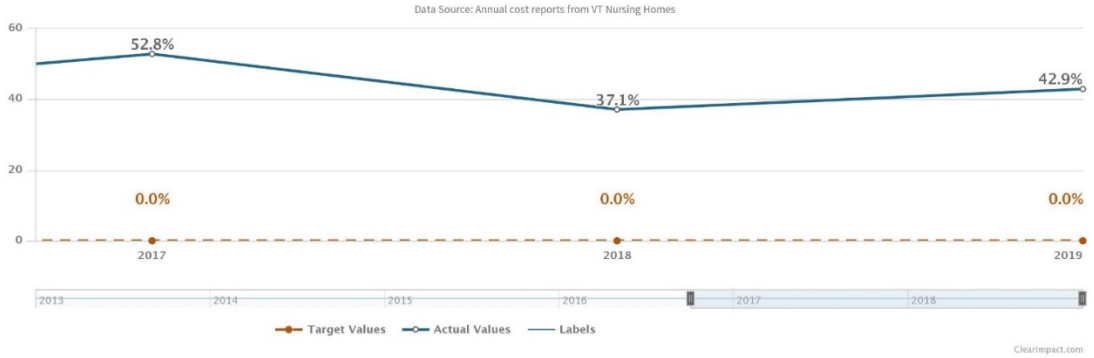
1) Nursing home and PNMI rulemaking.
2) Plan and prepare for a transition away from the current acuity measure used quarterly to adjust the nursing component of the Medicaid nursing facility rate.
3) Participate in the development of the new transfer of ownership financial review while continuing to participate in the interim review process.
4) Continue to focus on setting accurate nursing home rates, including many resident specific rates, in a timely manner.
5) Continue to focus on setting accurate rates for Private Non-Medical Institutions in a timely manner.

To see what we do, who we serve, how we impact, and our performance measures, see Rate Setting's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

There remain nursing homes with years of significant financial losses. Financial instability could affect nursing facility providers' willingness or ability to continue to provide these services and/or result in potential quality issues stemming from inadequate financial resources. The Division of Rate Setting continues to monitor the financial health of nursing facilities and collects data on the percentage of nursing homes enrolled in Medicaid that have losses over $100,000 in a calendar year to highlight the importance of continued work to reduce the number of Vermont nursing facilities experiencing these annual losses and ensure sufficient capacity continues exist to meet Vermonters' needs.

% of Nursing Homes Enrolled in Medicaid that have Losses over $100,000 in a Calendar Year



Reimbursement Unit

The Department's Reimbursement unit oversees rate setting, pricing, 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 a large portion of the total payments overseen by Reimbursement.

THE TOP PRIORITIES/INITIATIVES FOR THE REIMBURSEMENT UNIT IN SFY20 WERE:

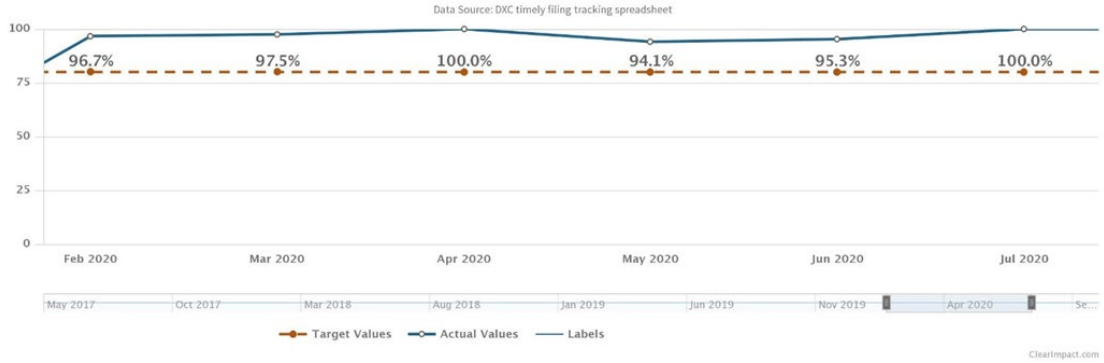
1) Continue working with suppliers and stakeholders on the update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule.
2) Continue efforts to work with stakeholders to support equitable, transparent, and predictable payment policy to ensure efficient and appropriate use of Medicaid resources.
3) Continued focus on resolution of timely filing requests.

To see what we do, who we serve, how we impact, and our performance measures, see Reimbursement's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

This measure was implemented to assess the Unit's service to the provider community and with the goal of ensuring consistent and timely decisions on previously denied claims. This measure is reported on a monthly basis. The Unit established a realistic goal of reaching the 15-business day turnaround at least 80% of the time. Overall, for state fiscal year 2020, the Unit's performance on this metric consistently exceeded the target that was established.

Percentage of Claims that were Originally Submitted in a Timely Manner but were Denied Payment Turned Around in 15 Business Days or Less



3. IMPROVE HEALTH

Blueprint for Health

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, community health teams, the Spoke program and Women's Health Initiative.

THE TOP PRIORITIES/INITIATIVES FOR THE BLUEPRINT UNIT IN SFY20 WERE:

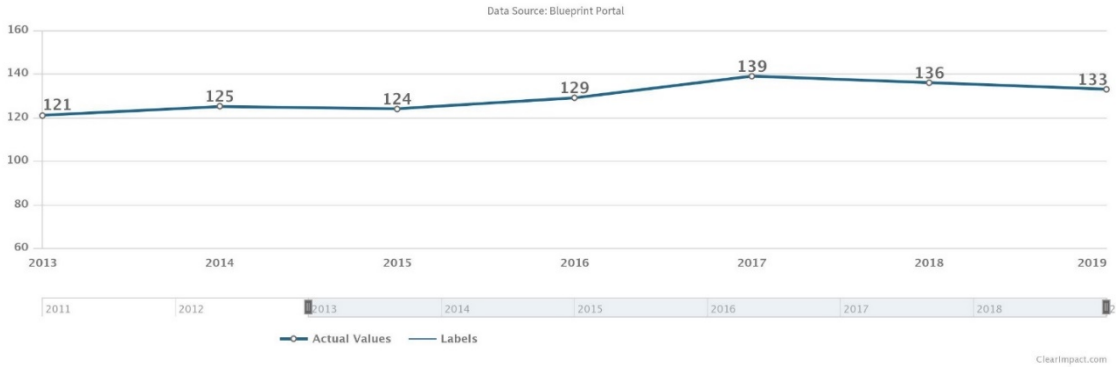
1) Strategic planning to align with the State's priorities for health care reform and the All-Payer ACO Model Agreement;
2) Full implementation of the Women's Health Initiative; and
3) Supporting the community health teams and program field staff in consistent deployment of care models.

To see what we do, who we serve, how we impact, and our performance measures, see Blueprint's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY20:

The Blueprint has approached a saturation point where the Program has recruited most of the available primary care practices in the State of Vermont, and the rate of onboarding new practices has generally plateaued.

Number of Primary Care Practices Participating with the Blueprint for Health



Quality Improvement and Clinical Integrity

The Quality Improvement & Clinical Integrity teams collaborate with Agency partners to develop a culture of continuous quality improvement, maintain the Vermont Medicaid Quality Plan and Work Plan, coordinate quality initiatives including formal performance improvement projects, coordinate the production of standard performance measures, and manage utilization of mental health and substance use disorder services. The team works toward the integration and coordination of services provided for 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 and administers the Team Care program.

THE TOP PRIORITIES/INITIATIVES FOR THE QUALITY IMPROVEMENT & CLINICAL INTEGRITY UNIT IN SFY20 WERE:

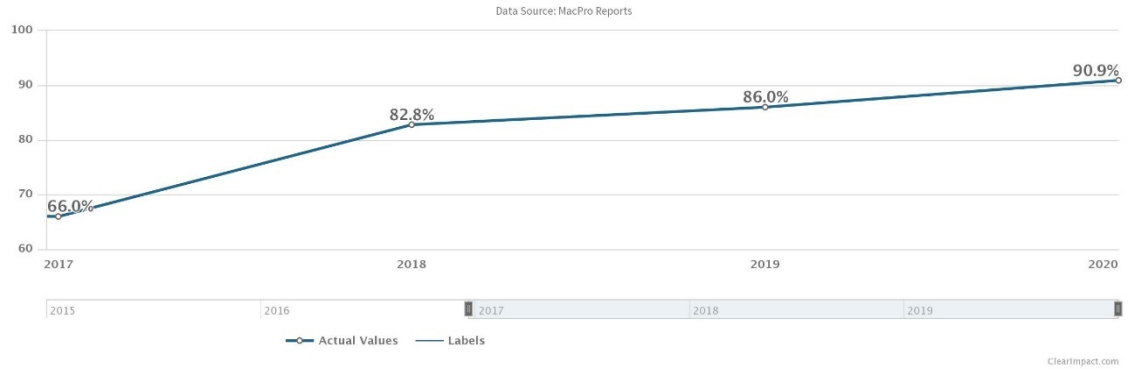
1) Strengthen and increase the provider network;
2) Modify utilization management activities to align with payment reform initiatives;
3) Support addressment of social determinants of health through housing and recovery services post-discharge;
4) Continue coordination for performance improvement projects and increase the total measures in the Medicaid Adult and Child Core Measure Sets reported to CMS; and
5) Collaborate with other units and departments to reduce duplication of efforts and promote a culture of continuous quality improvement.

To see what we do, who we serve, how we impact, and our performance measures, see Quality & Clinical Integrity's Section of the DVHA Performance Accountability Scorecard.

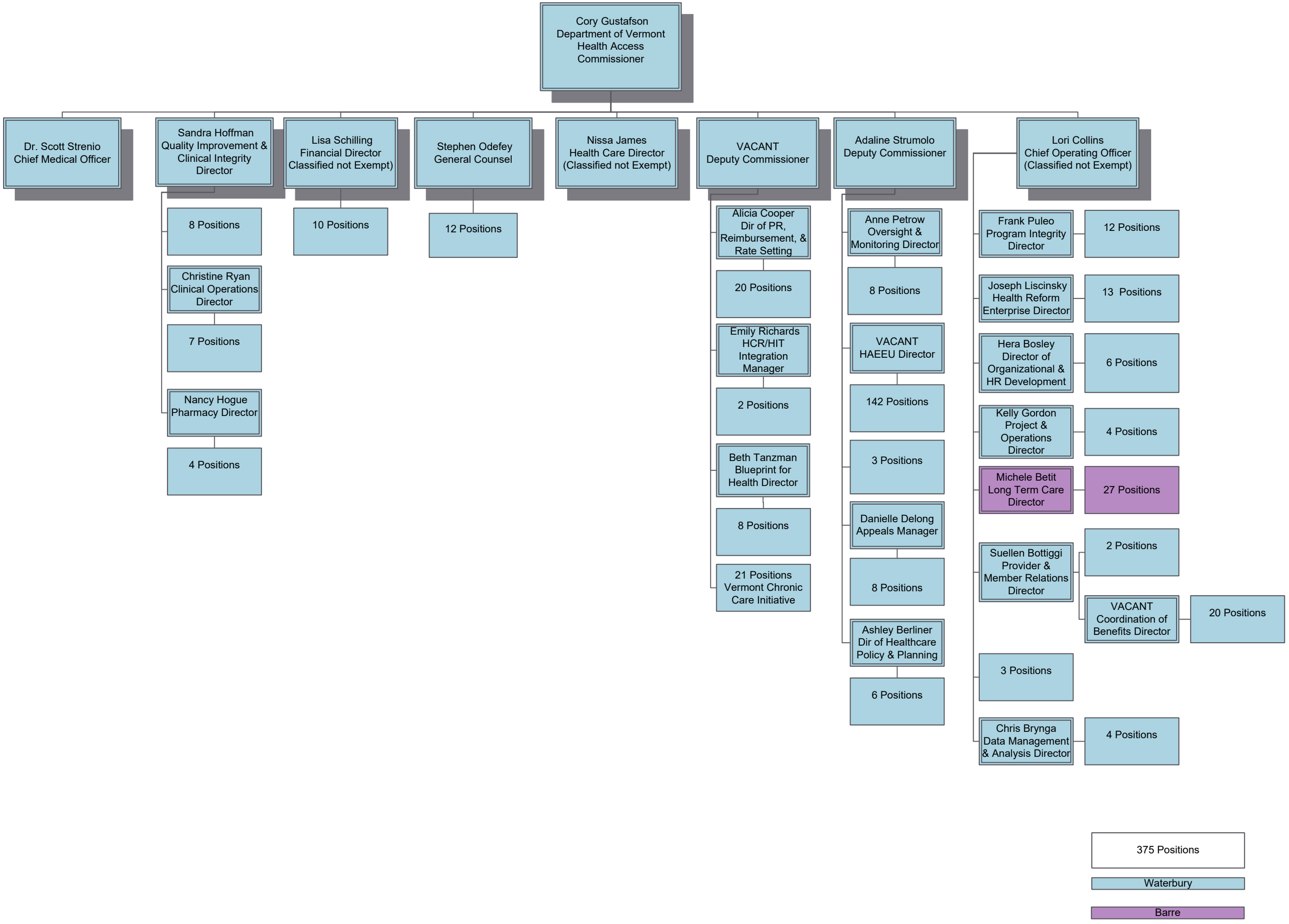
BUSINESS INSIGHTS FOR SFY20:

The efforts in recent years by the Quality Improvement and Clinical Integrity teams have resulted in Vermont Medicaid reaching over 90% of all CMS Core Measures being reported; the goal of 100% is expected to be reached by 2024. To attain that goal, the Unit has been strategic about how it plans for measure production each year and has continued to collaborate with internal and external stakeholders. For example, DVHA has worked with VITL staff to run comparison hybrid measure results and has worked with other DVHA units on the new HEDIS/Quality Measure Production Request for Proposals to ensure alignment and coordination. Finally, the Quality Improvement and Clinical Integrity teams completed a 3-year cycle of a formal CMS performance improvement project focused on a telehealth intervention.

Percentage of the Total Measures in the Medicaid Adult & Child Core Measure Sets Reported to the Centers for Medicare and Medicaid Services



APPENDIX B: ORGANIZATIONAL CHART (JUNE 2020)


Cory Gustafson
Department of Vermont Health Access Commissioner
Dr. Scott Strenio
Chief Medical Officer
Sandra Hoffman
Quality Improvement & Clinical Integrity Director
8 Positions
Christine Ryan
Clinical Operations Director
7 Positions
Nancy Hogue
Pharmacy Director
4 Positions
Lisa Schilling
Financial Director
Classified not Exempt)
10 Positions
Stephen Odefey
General Counsel
12 Positions
Nissa James
Health Care Director
(Classified not Exempt)
VACANT
Deputy Commissioner
Alicia Cooper
Dir of PR, Reimbursement, & Rate Setting
20 Positions
Emily Richards
HCR/HIT Integration Manager
2 Positions
Beth Tanzman
Blueprint for Health Director
8 Positions
21 Positions
Vermont Chronic Care Initiative
Adaline Strumolo
Deputy Commissioner
Anne Petrow
Oversight & Monitoring Director
8 Positions
VACANT
HAEEU Director
142 Positions
3 Positions
Danielle Delong
Appeals Manager
8 Positions
Ashley Berliner
Dir of Healthcare Policy & Planning
6 Positions
Lori Collins
Chief Operating Officer
(Classified not Exempt)
Frank Puleo
Program Integrity Director
12 Positions
Joseph Liscinsky
Health Reform Enterprise Director
13 Positions
Hera Bosley
Director of Organizational & HR Development
6 Positions
Kelly Gordon
Project & Operations Director
4 Positions
Michele Betit
Long Term Care Director
27 Positions
Suellen Bottiggi
Provider & Member Relations Director
2 Positions
VACANT
Coordination of Benefits Director
20 Positions
3 Positions
Chris Brynga
Data Management & Analysis Director
4 Positions
375 Positions
Waterbury
Barre

APPENDIX C: VANTAGE REPORTS

State of Vermont
FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 1. PERSONAL SERVICES

Salaries and Wages		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Classified Employees	500000	23,244,705	23,197,822	23,528,917	23,464,040	266,218	1.1%
Exempt	500010	0	1,525,968	1,525,968	1,486,151	(39,817)	-2.6%
Overtime	500060	354,036	0	0	0	0	0.0%
Market Factor - Classified	500899	0	588,917	588,917	575,685	(13,232)	-2.2%
Vacancy Turnover Savings	508000	0	(2,575,781)	(2,575,781)	(2,818,744)	(242,963)	9.4%
Total: Salaries and Wages		**23,598,741**	**22,736,926**	**23,068,021**	**22,707,132**	**(29,794)**	**-0.1%**

Fringe Benefits		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
FICA - Classified Employees	501000	1,723,915	1,819,692	1,819,692	1,839,020	19,328	1.1%
FICA - Exempt	501010	0	112,757	112,757	110,175	(2,582)	-2.3%
Health Ins - Classified Empl	501500	4,949,119	5,166,689	5,166,689	5,244,792	78,103	1.5%
Health Ins - Exempt	501510	0	246,905	246,905	234,395	(12,510)	-5.1%
Retirement - Classified Empl	502000	4,846,946	4,995,221	4,995,221	5,155,374	160,153	3.2%
Retirement - Exempt	502010	0	300,057	300,057	278,393	(21,664)	-7.2%
Dental - Classified Employees	502500	281,035	294,270	294,270	295,105	835	0.3%
Dental - Exempt	502510	0	12,540	12,540	11,704	(836)	-6.7%

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Fringe Benefits		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Life Ins - Classified Empl	503000	83,199	100,368	100,368	87,165	(13,203)	-13.2%
Life Ins - Exempt	503010	0	6,439	6,439	6,056	(383)	-5.9%
LTD - Classified Employees	503500	5,556	2,966	2,966	3,158	192	6.5%
LTD - Exempt	503510	0	3,509	3,509	3,299	(210)	-6.0%
EAP - Classified Empl	504000	10,908	11,510	11,510	11,541	31	0.3%
EAP - Exempt	504010	0	479	479	447	(32)	-6.7%
Employee Tuition Costs	504530	2,003	10,000	10,000	10,000	0	0.0%
Workers Comp - Ins Premium	505200	0	156,062	156,062	182,446	26,384	16.9%
Unemployment Compensation	505500	19,489	0	0	0	0	0.0%
Catamount Health Assessment	505700	2,571	8,400	8,400	8,400	0	0.0%
Total: Fringe Benefits		**11,924,741**	**13,247,864**	**13,247,864**	**13,481,470**	**233,606**	**1.8%**

Contracted and 3rd Party Service		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Contr&3Rd Pty-Educ & Training	507350	3,129	0	0	0	0	0.0%
IT Contracts - Storage	507544	0	2,892,179	2,892,179	2,892,179	0	0.0%
IT Contracts - Application Development	507565	9,496,051	14,457,417	14,457,417	14,457,417	0	0.0%
IT Contracts - Application Support	507566	45,013,859	42,624,158	42,624,158	42,624,158	0	0.0%
Other Contr and 3Rd Pty Serv	507600	25,517,143	33,816,593	36,316,593	33,941,593	125,000	0.4%
Interpreters	507615	35,963	43,000	43,000	43,000	0	0.0%
Custodial	507670	0	1,000	1,000	1,000	0	0.0%
Total: Contracted and 3rd Party Service		**80,066,145**	**93,834,347**	**96,334,347**	**93,959,347**	**125,000**	**0.1%**

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

PerDiem and Other Personal Services		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Per Diem	506000	5,850	8,126	8,126	8,126	0	0.0%
Other Pers Serv	506200	0	6,200	6,200	6,200	0	0.0%
Transcripts	506220	83	0	0	0	0	0.0%
Sheriffs	506230	0	1,150	1,150	1,150	0	0.0%
Total: PerDiem and Other Personal Service		**5,933**	**15,476**	**15,476**	**15,476**	**0**	**0.0%**
Total: 1. PERSONAL SERVICES		**115,595,560**	**129,834,613**	**132,665,708**	**130,163,425**	**328,812**	**0.3%**

Budget Object Group: 2. OPERATING

Equipment		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Hardware - Desktop & Laptop Pc	522216	252,840	115,000	115,000	115,000	0	0.0%
Hw - Printers,Copiers,Scanners	522217	1,480	18,000	18,000	18,000	0	0.0%
Hardware - Data Network	522273	0	1,000	1,000	1,000	0	0.0%
Software-Application Development	522283	440	3,000	3,000	3,000	0	0.0%
Software - Application Support	522284	14,889	42,000	42,000	42,000	0	0.0%
Software - Desktop	522286	69,950	85,000	85,000	85,000	0	0.0%
Software-Security	522288	0	1,500	1,500	1,500	0	0.0%
Software - Server	522289	0	2,200	2,200	2,200	0	0.0%
Other Equipment	522400	12,050	0	0	0	0	0.0%

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Equipment		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Office Equipment	522410	0	100	100	100	0	0.0%
Furniture & Fixtures	522700	43,928	83,300	83,300	83,300	0	0.0%
Total: Equipment		**395,577**	**351,100**	**351,100**	**351,100**	**0**	**0.0%**

IT/Telecom Services and Equipment		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Communications	516600	0	8,500	8,500	8,500	0	0.0%
ADS VOIP Expense	516605	2,371	0	0	0	0	0.0%
Telecom-Conf Calling Services	516658	0	30,000	30,000	30,000	0	0.0%
ADS Enterp App Supp SOV Emp Exp	516660	899,480	603,961	603,961	850,989	247,028	40.9%
It Intsvccost-Vision/Isdassess	516671	639,024	644,165	644,165	546,428	(97,737)	-15.2%
ADS Centrex Exp.	516672	34,921	172,100	172,100	172,100	0	0.0%
ADS Allocation Exp.	516685	468,482	483,856	483,856	459,093	(24,763)	-5.1%
Software as a Service	519085	102,002	0	0	0	0	0.0%
Hw - Computer Peripherals	522201	129	0	0	0	0	0.0%
Total: IT/Telecom Services and Equipment		**2,146,409**	**1,942,582**	**1,942,582**	**2,067,110**	**124,528**	**6.4%**

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Other Operating Expenses			FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Single Audit Allocation	523620	0	40,000	40,000	40,000	0	0.0%
Bank Service Charges	524000	0	250	250	250	0	0.0%
Total: Other Operating Expenses		**0**	**40,250**	**40,250**	**40,250**	**0**	**0.0%**

Other Purchased Services		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Insurance Other Than Empl Bene	516000	145,633	8,236	8,236	7,628	(608)	-7.4%
Insurance - General Liability	516010	0	92,195	92,195	99,475	7,280	7.9%
Dues	516500	60,863	55,000	55,000	55,000	0	0.0%
Licenses	516550	47,832	79,000	79,000	79,000	0	0.0%
Telecom-Mobile Wireless Data	516623	0	2,400	2,400	2,400	0	0.0%
Telecom-Telephone Services	516652	80,747	166,000	166,000	166,000	0	0.0%
Advertising-Print	516813	65,323	0	0	0	0	0.0%
Advertising-Other	516815	2,785	10,000	10,000	10,000	0	0.0%
Advertising - Job Vacancies	516820	1,773	10,000	10,000	10,000	0	0.0%
Printing and Binding	517000	188,126	267,000	267,000	267,000	0	0.0%
Printing-Promotional	517010	258	0	0	0	0	0.0%
Photocopying	517020	0	100	100	100	0	0.0%
Registration For Meetings&Conf	517100	0	2,000	2,000	2,000	0	0.0%
Training - Info Tech	517110	0	20,000	20,000	20,000	0	0.0%
Empl Train & Background Checks	517120	295	1,000	1,000	1,000	0	0.0%
Postage	517200	228,350	307,500	307,500	307,500	0	0.0%

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Other Purchased Services		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Freight & Express Mail	517300	8,555	25,200	25,200	25,200	0	0.0%
Instate Conf, Meetings, Etc	517400	11,970	25,000	25,000	25,000	0	0.0%
Catering-Meals-Cost	517410	1,575	1,000	1,000	1,000	0	0.0%
Outside Conf, Meetings, Etc	517500	19,762	28,000	28,000	28,000	0	0.0%
Other Purchased Services	519000	43,814	61,250	61,250	61,250	0	0.0%
Human Resources Services	519006	240,581	246,265	246,265	268,804	22,539	9.2%
Administrative Service Charge	519010	20,323	30,000	30,000	30,000	0	0.0%
Security Services	519025	211	0	0	0	0	0.0%
Moving State Agencies	519040	14,224	0	0	0	0	0.0%
Infrastructure as a Service	519081	18,413,700	19,422,819	19,422,819	19,422,819	0	0.0%
Total: Other Purchased Services		**19,596,700**	**20,859,965**	**20,859,965**	**20,889,176**	**29,211**	**0.1%**

Property and Maintenance		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Water/Sewer	510000	49	68	68	68	0	0.0%
Disposal	510200	489	1,200	1,200	1,200	0	0.0%
Recycling	510220	3,483	0	0	0	0	0.0%
Custodial	510400	3,312	0	0	0	0	0.0%
Repair & Maint - Buildings	512000	750	1,100	1,100	1,100	0	0.0%
Repairs Maint To Elec System	512020	1,500	0	0	0	0	0.0%
Repair & Maint - Office Tech	513010	36,114	41,000	41,000	41,000	0	0.0%
Other Repair & Maint Serv	513200	18,096	23,000	23,000	23,000	0	0.0%

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Property and Maintenance		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Repair&Maint-Property/Grounds	513210	24,893	34,000	34,000	34,000	0	0.0%
Total: Property and Maintenance		**88,686**	**100,368**	**100,368**	**100,368**	**0**	**0.0%**

Rental Other		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Rental - Auto	514550	14,842	23,020	23,020	23,020	0	0.0%
Rental - Office Equipment	514650	26,399	32,000	32,000	32,000	0	0.0%
Total: Rental Other		**41,241**	**55,020**	**55,020**	**55,020**	**0**	**0.0%**

Rental Property		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Rent Land & Bldgs-Office Space	514000	839,969	1,610,956	1,610,956	1,610,956	0	0.0%
Rent Land&Bldgs-Non-Office	514010	18	60	60	60	0	0.0%
Fee-For-Space Charge	515010	708,478	699,004	699,004	654,033	(44,971)	-6.4%
Total: Rental Property		**1,548,465**	**2,310,020**	**2,310,020**	**2,265,049**	**(44,971)**	**-1.9%**

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Supplies		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Office Supplies	520000	35,669	51,000	51,000	51,000	0	0.0%
Gasoline	520110	104	500	500	500	0	0.0%
Other General Supplies	520500	587	3,000	3,000	3,000	0	0.0%
Educational Supplies	520540	200	0	0	0	0	0.0%
Recognition/Awards	520600	0	600	600	600	0	0.0%
Food	520700	4,230	9,000	9,000	9,000	0	0.0%
Water	520712	754	2,000	2,000	2,000	0	0.0%
Electricity	521100	745	1,000	1,000	1,000	0	0.0%
Heating Oil #2 - Uncut	521220	0	400	400	400	0	0.0%
Propane Gas	521320	366	400	400	400	0	0.0%
Books&Periodicals-Library/Educ	521500	13,549	11,700	11,700	11,700	0	0.0%
Subscriptions	521510	18,851	100,100	100,100	100,100	0	0.0%
Other Books & Periodicals	521520	107	1,500	1,500	1,500	0	0.0%
Household, Facility&Lab Suppl	521800	305	400	400	400	0	0.0%
Medical and Lab Supplies	521810	464	0	0	0	0	0.0%
Paper Products	521820	676	1,200	1,200	1,200	0	0.0%
Total: Supplies		**76,607**	**182,800**	**182,800**	**182,800**	**0**	**0.0%**

Travel		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Travel-Inst-Auto Mileage-Emp	518000	21,593	210,000	210,000	210,000	0	0.0%
Travel-Inst-Other Transp-Emp	518010	6,452	21,000	21,000	21,000	0	0.0%

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Travel		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Travel-Inst-Meals-Emp	518020	67	1,800	1,800	1,800	0	0.0%
Travel-Inst-Incidentals-Emp	518040	272	2,400	2,400	2,400	0	0.0%
Travl-Inst-Auto Mileage-Nonemp	518300	2,690	4,500	4,500	4,500	0	0.0%
Travel-Inst-Other Trans-Nonemp	518310	0	450	450	450	0	0.0%
Travel-Inst-Lodging-Nonemp	518330	198	0	0	0	0	0.0%
Travel-Outst-Auto Mileage-Emp	518500	430	5,100	5,100	5,100	0	0.0%
Travel-Outst-Other Trans-Emp	518510	21,899	90,300	90,300	90,300	0	0.0%
Travel-Outst-Meals-Emp	518520	2,684	21,000	21,000	21,000	0	0.0%
Travel-Outst-Lodging-Emp	518530	28,049	75,000	75,000	75,000	0	0.0%
Travel-Outst-Incidentals-Emp	518540	2,458	12,000	12,000	12,000	0	0.0%
Total: Travel		**86,792**	**443,550**	**443,550**	**443,550**	**0**	**0.0%**

Rentals		FY2020 Actuals			FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and As Passed	Percent Change FY2022 Governor's Recommend and As Passed
Description	**Code**						
Software-License-ApplicaSupprt	516551	10,558	0	0	0	0	0.0%
Software-License-ApplicaDevel	516552	283	0	0	0	0	0.0%
Software-License-DeskLaptop PC	516559	36,344	0	0	0	0	0.0%
Total: Rentals		**47,185**	**0**	**0**	**0**	**0**	**0.0%**

State of Vermont
FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Property Management Services		FY2020 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
Description	**Code**						
Accreditation/Certification	516575	(275)	0	0	0	0	0.0%
Total: Property Management Services		**(275)**	**0**	**0**	**0**	**0**	**0.0%**
Total: 2. OPERATING		**24,027,387**	**26,285,655**	**26,285,655**	**26,394,423**	**108,768**	**0.4%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Other Grants	550500	1,618,130	3,192,301	3,192,301	3,192,301	0	0.0%
Other Grants-Service Agreemnt	550501	670,651	0	0	0	0	0.0%
Cooperative Agreement Payment	550510	3,000	0	0	0	0	0.0%
Medical Services Grants	604250	1,595,167	2,000,000	2,000,000	0	(2,000,000)	-100.0%
AHS Cost Allocation Exp. Acct.	799090	(367,831)	0	0	0	0	0.0%
Total: Grants Rollup		**3,519,117**	**5,192,301**	**5,192,301**	**3,192,301**	**(2,000,000)**	**-38.5%**
Total: 3. GRANTS		**3,519,117**	**5,192,301**	**5,192,301**	**3,192,301**	**(2,000,000)**	**-38.5%**
Total Expenses:		**143,142,065**	**161,312,569**	**164,143,664**	**159,750,149**	**(1,562,420)**	**-1.0%**

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Object Group: 1. PERSONAL SERVICES

Contracted and 3rd Party Service		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Other Contr and 3Rd Pty Serv	507600	547,983	547,983	547,983	547,983	0	0.0%
Total: Contracted and 3rd Party Service		**547,983**	**547,983**	**547,983**	**547,983**	**0**	**0.0%**
Total: 1. PERSONAL SERVICES		**547,983**	**547,983**	**547,983**	**547,983**	**0**	**0.0%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Medical Services Grants	604250	717,123,543	726,492,200	742,313,519	757,265,566	30,773,366	4.2%
AHS Cost Allocation Exp. Acct.	799090	8,820,285	0	0	0	0	0.0%
Total: Grants Rollup		**725,943,828**	**726,492,200**	**742,313,519**	**757,265,566**	**30,773,366**	**4.2%**
Total: 3. GRANTS		**725,943,828**	**726,492,200**	**742,313,519**	**757,265,566**	**30,773,366**	**4.2%**
Total Expenses:		**726,491,811**	**727,040,183**	**742,861,502**	**757,813,549**	**30,773,366**	**4.2%**

State of Vermont
FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410016000 - DVHA-Medicaid/long term care waiver

Budget Object Group: 3. GRANTS

Grants Rollup		FY2020 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
Description	**Code**						
Medical Services Grants	604250	230,846,693	0	0	0	0	0.0%
AHS Cost Allocation Exp. Acct.	799090	(6,876,014)	0	0	0	0	0.0%
Total: Grants Rollup		**223,970,679**	**0**	**0**	**0**	**0**	**0.0%**
Total: 3. GRANTS		**223,970,679**	**0**	**0**	**0**	**0**	**0.0%**
Total Expenses:		**223,970,679**	**0**	**0**	**0**		**0.0%**

State of Vermont
FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410017000 - DVHA- Medicaid/state only programs

Budget Object Group: 3. GRANTS

Grants Rollup		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Other Grants	550500	47,995	0	0	0	0	0.0%
Medical Services Grants	604250	47,720,837	51,417,964	37,928,235	40,967,754	(10,450,210)	-20.3%
AHS Cost Allocation Exp. Acct.	799090	(1,567,856)	0	0	0	0	0.0%
Total: Grants Rollup		**46,200,977**	**51,417,964**	**37,928,235**	**40,967,754**	**(10,450,210)**	**-20.3%**
Total: 3. GRANTS		**46,200,977**	**51,417,964**	**37,928,235**	**40,967,754**	**(10,450,210)**	**-20.3%**
Total Expenses:		**46,200,977**	**51,417,964**	**37,928,235**	**40,967,754**	**(10,450,210)**	**-20.3%**

State of Vermont

FY2022 Governor's Recommended Budget: Detail Report

Organization: 3410018000 - DVHA-Medicaid/non-waiver matched programs

Budget Object Group: 3. GRANTS

Grants Rollup		FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Description	**Code**						
Medical Services Grants	604250	61,433,537	33,096,001	33,003,393	32,842,006	(253,995)	-0.8%
AHS Cost Allocation Exp. Acct.	799090	(8,585)	0	0	0	0	0.0%
Total: Grants Rollup		**61,424,953**	**33,096,001**	**33,003,393**	**32,842,006**	**(253,995)**	**-0.8%**
Total: 3. GRANTS		**61,424,953**	**33,096,001**	**33,003,393**	**32,842,006**	**(253,995)**	**-0.8%**
Total Expenses:		**61,424,953**	**33,096,001**	**33,003,393**	**32,842,006**	**(253,995)**	**-0.8%**

Fund Name	Fund Code	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
General Fund	10000	82,941,892	83,844,227	82,558,700	86,356,524	2,512,297	3.0%
Global Commitment Fund	20405	739,699,220	743,423,151	749,848,759	762,179,639	18,756,488	2.5%
Inter-Unit Transfers Fund	21500	227,212,521	4,792,881	4,792,881	4,827,131	34,250	0.7%
Vermont Health IT Fund	21916	4,151,198	3,378,509	3,378,509	3,363,758	(14,751)	-0.4%
Federal Revenue Fund	22005	117,180,314	137,427,949	137,357,945	134,646,406	(2,781,543)	-2.0%
Coronavirus Relief Fund	22045	30,045,339	0	0	0	0	0.0%
Funds Total:		**1,201,230,485**	**972,866,717**	**977,936,794**	**991,373,458**	**18,506,741**	**1.9%**
Position Count					375		
FTE Total					371.01		

State of Vermont

FY2022 Governor's Recommended Budget: Rollup Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Salaries and Wages	23,598,741	22,736,926	23,068,021	22,707,132	(29,794)	-0.1%
Fringe Benefits	11,924,741	13,247,864	13,247,864	13,481,470	233,606	1.8%
Contracted and 3rd Party Service	80,066,145	93,834,347	96,334,347	93,959,347	125,000	0.1%
PerDiem and Other Personal Services	5,933	15,476	15,476	15,476	0	0.0%
Budget Object Group Total: 1. PERSONAL SERVICES	**115,595,560**	**129,834,613**	**132,665,708**	**130,163,425**	**328,812**	**0.3%**

Budget Object Group: 2. OPERATING

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Equipment	395,577	351,100	351,100	351,100	0	0.0%
IT/Telecom Services and Equipment	2,146,409	1,942,582	1,942,582	2,067,110	124,528	6.4%
Travel	86,792	443,550	443,550	443,550	0	0.0%
Supplies	76,607	182,800	182,800	182,800	0	0.0%
Other Purchased Services	19,596,700	20,859,965	20,859,965	20,889,176	29,211	0.1%
Other Operating Expenses	0	40,250	40,250	40,250	0	0.0%
Rental Other	41,241	55,020	55,020	55,020	0	0.0%
Rental Property	1,548,465	2,310,020	2,310,020	2,265,049	(44,971)	-1.9%
Property and Maintenance	88,686	100,368	100,368	100,368	0	0.0%
Rentals	47,185	0	0	0	0	0.0%
Property Management Services	(275)	0	0	0	0	0.0%
Budget Object Group Total: 2. OPERATING	**24,027,387**	**26,285,655**	**26,285,655**	**26,394,423**	**108,768**	**0.4%**

Report ID: VTPB-11-BUDRLLUP
Run Date: 01/28/2021
Run Time: 12:12 PM

State of Vermont

FY2022 Governor's Recommended Budget: Rollup Report

Organization: 3410010000 - Department of Vermont health access - administration
Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Grants Rollup	3,519,117	5,192,301	5,192,301	3,192,301	(2,000,000)	-38.5%
Budget Object Group Total: 3. GRANTS	**3,519,117**	**5,192,301**	**5,192,301**	**3,192,301**	**(2,000,000)**	**-38.5%**
Total Expenses	**143,142,065**	**161,312,569**	**164,143,664**	**159,750,149**	**(1,562,420)**	**-1.0%**

Fund Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
General Funds	33,224,749	32,314,433	32,645,528	32,776,219	461,786	1.4%
Special Fund	4,151,198	3,378,509	3,378,509	3,363,758	(14,751)	-0.4%
Coronavirus Relief Fund	1,023,303	0	0	0	0	0.0%
Federal Funds	96,674,387	116,496,036	116,496,036	114,469,002	(2,027,034)	-1.7%
Global Commitment	4,826,585	4,330,710	6,830,710	4,314,039	(16,671)	-0.4%
IDT Funds	3,241,842	4,792,881	4,792,881	4,827,131	34,250	0.7%
Funds Total	**143,142,065**	**161,312,569**	**164,143,664**	**159,750,149**	**(1,562,420)**	**-1.0%**

Position Count				375		
FTE Total				371.01		

State of Vermont

FY2022 Governor's Recommended Budget: Rollup Report

Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Contracted and 3rd Party Service	547,983	547,983	547,983	547,983	0	0.0%
Budget Object Group Total: 1. PERSONAL SERVICES	**547,983**	**547,983**	**547,983**	**547,983**		**0.0%**

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Grants Rollup	725,943,828	726,492,200	742,313,519	757,265,566	30,773,366	4.2%
Budget Object Group Total: 3. GRANTS	**725,943,828**	**726,492,200**	**742,313,519**	**757,265,566**	**30,773,366**	**4.2%**

Total Expenses	**726,491,811**	**727,040,183**	**742,861,502**	**757,813,549**	**30,773,366**	**4.2%**

Fund Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Global Commitment	726,491,811	727,040,183	742,861,502	757,813,549	30,773,366	4.2%
Funds Total	**726,491,811**	**727,040,183**	**742,861,502**	**757,813,549**	**30,773,366**	**4.2%**

Position Count						
FTE Total						

Report ID: VTPB-11-BUDRLLUP
Run Date: 01/28/2021
Run Time: 12:12 PM

State of Vermont

FY2022 Governor's Recommended Budget: Rollup Report

Organization: 3410016000 - DVHA-Medicaid/long term care waiver

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2020 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
Grants Rollup	223,970,679	0	0	0	0	0.0%
Budget Object Group Total: 3. GRANTS	**223,970,679**	**0**	**0**	**0**		**0.0%**
Total Expenses	**223,970,679**	**0**	**0**	**0**	**0**	**0.0%**

Fund Name	FY2020 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
IDT Funds	223,970,679	0	0	0	0	0.0%
Funds Total	**223,970,679**	**0**	**0**	**0**		**0.0%**

Position Count						
FTE Total						

Report ID: VTPB-11-BUDRLLUP
Run Date: 01/28/2021
Run Time: 12:12 PM

State of Vermont

FY2022 Governor's Recommended Budget: Rollup Report

Organization: 3410017000 - DVHA- Medicaid/state only programs

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Grants Rollup	46,200,977	51,417,964	37,928,235	40,967,754	(10,450,210)	-20.3%
Budget Object Group Total: 3. GRANTS	**46,200,977**	**51,417,964**	**37,928,235**	**40,967,754**	**(10,450,210)**	**-20.3%**
Total Expenses	**46,200,977**	**51,417,964**	**37,928,235**	**40,967,754**	**(10,450,210)**	**-20.3%**

Fund Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
General Funds	37,820,154	39,365,706	37,771,688	40,915,703	1,549,997	3.9%
Global Commitment	8,380,823	12,052,258	156,547	52,051	(12,000,207)	-99.6%
Funds Total	**46,200,977**	**51,417,964**	**37,928,235**	**40,967,754**	**(10,450,210)**	**-20.3%**

Position Count						
FTE Total						

Report ID: VTPB-11-BUDRLLUP
Run Date: 01/28/2021
Run Time: 12:12 PM

State of Vermont

FY2022 Governor's Recommended Budget: Rollup Report

Organization: 3410018000 - DVHA-Medicaid/non-waiver matched programs

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
Grants Rollup	61,424,953	33,096,001	33,003,393	32,842,006	(253,995)	-0.8%
Budget Object Group Total: 3. GRANTS	**61,424,953**	**33,096,001**	**33,003,393**	**32,842,006**	**(253,995)**	**-0.8%**
Total Expenses	**61,424,953**	**33,096,001**	**33,003,393**	**32,842,006**	**(253,995)**	**-0.8%**

Fund Name	FY2020 Actuals	FY2021 Original As Passed Budget	FY2021 Governor's BAA Recommended Budget	FY2022 Governor's Recommended Budget	Difference Between FY2022 Governor's Recommend and FY2021 As Passed	Percent Change FY2022 Governor's Recommend and FY2021 As Passed
General Funds	11,896,989	12,164,088	12,141,484	12,664,602	500,514	4.1%
Coronavirus Relief Fund	29,022,036	0	0	0	0	0.0%
Federal Funds	20,505,927	20,931,913	20,861,909	20,177,404	(754,509)	-3.6%
Funds Total	**61,424,953**	**33,096,001**	**33,003,393**	**32,842,006**	**(253,995)**	**-0.8%**

Position Count						
FTE Total						

Report ID : VTPB - 14
Run Date : 01/28/2021
Run Time : 12:14 PM

State of Vermont

FY2022 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
730001	501100 - DVHA Program Consultant	1	1	57,470	36,345	4,397	98,212
730002	501100 - DVHA Program Consultant	1	1	53,830	29,295	4,119	87,244
730003	499800 - DVHA COB Director	1	1	74,380	34,643	5,689	114,712
730005	459400 - DVHA Medicaid Compliance Off	1	1	102,461	46,160	7,839	156,460
730006	459800 - Health Program Administrator	1	1	60,508	22,412	4,630	87,550
730007	495900 - Med Hlthcare Data & Stat Anal	1	1	82,389	41,782	6,302	130,473
730009	460500 - Program Integrity Director	1	1	100,277	22,980	7,671	130,928
730011	460560 - Oversight&Monitor Security Aud	1	1	87,090	42,805	6,663	136,558
730012	089080 - Financial Manager I	1	1	62,130	37,362	4,752	104,244
730013	004700 - Program Technician I	1	1	40,581	18,063	3,104	61,748
730014	499700 - Medicaid Operations Adm	1	1	70,512	39,192	5,394	115,098
730018	089080 - Financial Manager I	1	1	60,196	22,344	4,604	87,144

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730020	495600 - Associate Prog Integrity Dir	1	1	79,789	34,961	6,104	120,854
730021	459800 - Health Program Administrator	1	1	72,924	39,718	5,580	118,222
730023	501100 - DVHA Program Consultant	1	1	61,298	37,180	4,689	103,167
730024	089230 - Administrative Srvcs Cord II	1	1	61,298	30,926	4,689	96,913
730025	501100 - DVHA Program Consultant	1	1	64,771	23,343	4,955	93,069
730027	459500 - Provider Relations Specialist	1	1	64,917	15,034	4,966	84,917
730028	469900 - Provider & Member Serv Dir	1	1	85,197	42,395	6,517	134,109
730029	459800 - Health Program Administrator	1	1	70,928	24,686	5,426	101,040
730030	514400 - Dir Data Mgn Analysis & Integ	1	1	85,196	42,036	6,517	133,749
730031	498800 - Medicaid Fiscal Analyst	1	1	64,542	14,952	4,938	84,432
730032	089120 - Financial Manager III	1	1	72,655	25,062	5,558	103,275
730034	000075 - Nurse Case Manager / URN II	1	1	107,996	41,116	8,262	157,374
730035	000078 - Nurse Auditor	1	1	89,692	43,376	6,861	139,929
730036	000075 - Nurse Case Manager / URN II	1	1	89,154	28,663	6,821	124,638

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730037	501100 - DVHA Program Consultant	1	1	55,682	35,955	4,260	95,897
730047	000086 - Nurse Administrator II	1	1	130,117	52,198	9,953	192,268
730049	089140 - Financial Director II	1	1	79,768	26,615	6,102	112,485
730050	000090 - Nursing Operations Director	1	1	109,025	52,314	8,340	169,680
730051	089210 - Administrative Srvcs Tech IV	1	1	50,253	28,516	3,845	82,614
730053	089230 - Administrative Srvcs Cord II	1	1	50,461	28,560	3,861	82,882
730054	089080 - Financial Manager I	1	1	64,252	37,824	4,916	106,992
730056	459500 - Provider Relations Specialist	1	1	62,982	14,611	4,818	82,411
730059	089141 - Financial Director IV	1	1	103,729	46,674	7,935	158,338
730060	495900 - Med Hlthcare Data & Stat Anal	1	1	75,275	40,231	5,759	121,265
730061	480200 - DVHA Clinical Chief	1	1	90,480	38,156	6,921	135,557
730067	501100 - DVHA Program Consultant	1	1	59,405	36,767	4,544	100,716
730068	533500 - Coord of Benefits Supervisor	1	1	72,821	39,387	5,571	117,779
730069	000075 - Nurse Case Manager / URN II	1	1	111,225	48,077	8,508	167,810

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730073	000070 - Nurse Case Manager / URN I	1	1	95,725	38,034	7,323	141,082
730074	000075 - Nurse Case Manager / URN II	1	1	89,154	43,259	6,821	139,234
730075	000070 - Nurse Case Manager / URN I	1	1	78,259	35,489	5,986	119,734
730076	000070 - Nurse Case Manager / URN I	1	1	101,621	30,955	7,773	140,349
730081	089040 - Financial Specialist III	1	1	47,714	27,962	3,651	79,327
730082	004900 - Program Technician III	1	1	52,146	39,653	3,990	95,789
730084	464901 - DVHA Programs & Ops Auditor II	1	1	60,196	36,940	4,605	101,741
730086	486400 - Project & Operations Dir	1	1	106,163	40,268	8,121	154,552
730087	735500 - Healthcare Assistant Admin II	1	1	77,771	26,180	5,948	109,899
730088	501100 - DVHA Program Consultant	1	1	63,065	37,566	4,825	105,456
730089	501100 - DVHA Program Consultant	1	1	63,065	22,970	4,825	90,860
730090	533500 - Coord of Benefits Supervisor	1	1	82,389	35,527	6,303	124,219
730091	508560 - VCCI Outreach & Support Coord	1	1	55,682	29,700	4,261	89,643
730093	735510 - Healthcare Assistant Admin I	1	1	68,994	15,923	5,277	90,194

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730094	000075 - Nurse Case Manager / URN II	1	1	104,991	40,460	8,033	153,484
730097	089080 - Financial Manager I	1	1	51,542	29,658	3,943	85,143
730098	000070 - Nurse Case Manager / URN I	1	1	83,874	35,852	6,416	126,144
730102	498000 - Health Enterprise Director II	1	1	116,896	49,582	8,942	175,420
730103	458902 - Health Services Researcher	1	1	103,730	46,439	7,936	158,105
730105	089210 - Administrative Srvcs Tech IV	1	1	47,196	34,104	3,610	84,910
730107	735000 - VT Healthcare Service Spec I	1	1	64,771	31,683	4,955	101,409
730108	735110 - VT Healthcare Service Spec III	1	1	58,864	22,054	4,503	85,421
730109	501100 - DVHA Program Consultant	1	1	63,066	31,311	4,825	99,202
730110	478100 - Business Process Manager	1	1	82,742	35,605	6,330	124,677
730112	536900 - VHC Support Services Spec	1	1	52,146	12,247	3,989	68,382
730113	536900 - VHC Support Services Spec	1	1	57,471	21,748	4,396	83,615
730114	536900 - VHC Support Services Spec	1	1	50,461	20,219	3,860	74,540
730115	499700 - Medicaid Operations Adm	1	1	70,512	39,192	5,394	115,098

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730123	434100 - Public Health Dentist	0.5	1	52,323	32,216	4,002	88,541
730123	434100 - Public Health Dentist	0.25	1	26,161	5,742	2,002	33,905
730123	434100 - Public Health Dentist	0.25	1	24,700	6,257	1,889	32,846
730124	464900 - DVHA Program & Oper Auditor	1	1	62,545	22,857	4,785	90,187
730125	459450 - MMIS Compliance Manager	1	1	79,788	41,216	6,104	127,108
730126	498800 - Medicaid Fiscal Analyst	1	1	73,216	39,781	5,600	118,597
730127	499400 - Medicaid Transptation QC Chief	1	1	77,500	34,461	5,929	117,890
730131	000070 - Nurse Case Manager / URN I	1	1	95,725	44,693	7,323	147,740
730132	508560 - VCCI Outreach & Support Coord	1	1	50,460	28,560	3,860	82,880
730133	000070 - Nurse Case Manager / URN I	1	1	104,627	46,635	8,004	159,265
730134	000070 - Nurse Case Manager / URN I	1	1	86,740	42,732	6,636	136,107
730135	482800 - Clinical Social Worker	1	1	60,196	14,004	4,605	78,805
730136	000070 - Nurse Case Manager / URN I	1	1	78,259	26,285	5,987	110,530
730137	089270 - Administrative Srvcs Mngr II	1	1	70,512	24,596	5,393	100,501

Report ID : VTPB - 14
Run Date : 01/28/2021
Run Time : 12:14 PM

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730138	068520 - Blueprint Payment Ops Admin	1	1	85,218	42,398	6,519	134,135
730140	503801 - Data Analytics & Info Admin	1	1	79,789	28,244	6,105	114,138
730141	501100 - DVHA Program Consultant	1	1	59,405	36,767	4,544	100,716
730142	460570 - Program Integrity Analyst	1	1	68,536	38,471	5,243	112,250
730143	464901 - DVHA Programs & Ops Auditor II	1	1	62,129	31,107	4,752	97,988
730144	495600 - Associate Prog Integrity Dir	1	1	79,789	41,216	6,104	127,109
730145	495900 - Med Hlthcare Data & Stat Anal	1	1	63,960	23,166	4,892	92,018
730146	486200 - Asst Dir of Blueprint for Hlth	1	1	82,472	27,203	6,308	115,983
730147	486200 - Asst Dir of Blueprint for Hlth	0.8	1	61,867	37,303	4,734	103,904
730170	089080 - Financial Manager I	1	1	62,130	41,830	4,752	108,712
730171	464900 - DVHA Program & Oper Auditor	1	1	64,543	23,292	4,938	92,773
730172	480210 - DVHA Quality Assurance Mgr	0.8	1	54,829	20,941	4,195	79,965
730174	334100 - Audit Liaison/Int Control	1	1	64,252	22,957	4,916	92,125
730175	499700 - Medicaid Operations Adm	1	1	63,960	37,762	4,894	106,616

State of Vermont

FY2022 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	61,568	22,384	4,709	88,661
730178	464910 - DVHA Healthcare QC Auditor	1	1	56,680	29,917	4,335	90,932
730181	334100 - Audit Liaison/Int Control	1	1	62,130	22,766	4,752	89,648
730182	536900 - VHC Support Services Spec	1	1	55,681	21,124	4,260	81,065
730185	464910 - DVHA Healthcare QC Auditor	1	1	62,546	37,453	4,784	104,783
730186	459800 - Health Program Administrator	1	1	56,680	21,576	4,336	82,592
730187	550200 - Contracts & Grants Administrat	1	1	60,507	22,412	4,630	87,549
730188	089120 - Financial Manager III	1	1	100,278	40,292	7,670	148,240
730189	550200 - Contracts & Grants Administrat	1	1	54,704	29,487	4,186	88,377
730190	536900 - VHC Support Services Spec	1	1	55,681	21,124	4,260	81,065
730192	000070 - Nurse Case Manager / URN I	1	1	83,875	42,107	6,416	132,397
730193	000075 - Nurse Case Manager / URN II	1	1	104,992	40,460	8,032	153,483
730194	089230 - Administrative Srvcs Cord II	1	1	57,470	36,345	4,396	98,211
730195	503801 - Data Analytics & Info Admin	1	1	93,308	20,394	7,137	120,839

Report ID : VTPB - 14
Run Date : 01/28/2021
Run Time : 12:14 PM

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730197	067400 - Mgr Qlty Imprvmt and Care Mgm	1	1	82,472	35,198	6,309	123,979
730198	533200 - Senior Behav Hlth CRC Mg	1	1	70,512	15,958	5,394	91,864
730199	089240 - Administrative Srvcs Cord III	1	1	58,864	36,400	4,502	99,766
730200	000086 - Nurse Administrator II	1	1	126,597	51,430	9,685	187,712
730201	000086 - Nurse Administrator II	1	1	112,819	42,168	8,631	163,619
730202	053100 - DVHA Data Anlyst and Info Chie	1	1	82,472	41,801	6,309	130,582
730204	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	57,970	31,062	4,435	93,467
730205	485400 - DVHA Clinical Therapist	1	1	57,970	31,062	4,435	93,467
730206	499700 - Medicaid Operations Adm	0.8	1	52,832	35,333	4,042	92,207
730207	499700 - Medicaid Operations Adm	1	1	70,512	16,256	5,394	92,162
730208	454300 - DVHA Rate Setting Mang	1	1	95,888	38,473	7,335	141,696
730210	000070 - Nurse Case Manager / URN I	1	1	86,740	19,796	6,636	113,171
730211	464980 - DVHA Program Liaison	1	1	69,618	33,602	5,327	108,547
730212	000078 - Nurse Auditor	1	1	71,115	33,930	5,440	110,485

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730213	501100 - DVHA Program Consultant	1	1	55,681	29,699	4,260	89,640
730215	000070 - Nurse Case Manager / URN I	1	1	104,626	40,380	8,003	153,009
730216	000070 - Nurse Case Manager / URN I	1	1	78,259	40,882	5,987	125,129
730218	000070 - Nurse Case Manager / URN I	1	1	83,875	42,107	6,417	132,399
730219	537300 - DVHA Director of Quality Mgmt	1	1	91,063	43,676	6,965	141,704
730227	480210 - DVHA Quality Assurance Mgr	1	1	57,970	31,058	4,434	93,462
730232	590200 - VHC Educ & Outreach Coord	1	1	66,290	25,300	5,071	96,661
730234	464910 - DVHA Healthcare QC Auditor	1	1	60,507	37,008	4,629	102,144
730235	483010 - Assister Program Manager	1	1	74,984	37,162	5,736	117,882
730236	330310 - VHC Business Process Coord	1	1	63,960	23,166	4,894	92,020
730238	459800 - Health Program Administrator	1	1	64,542	37,889	4,938	107,369
730239	459800 - Health Program Administrator	1	1	60,507	37,008	4,629	102,144
730240	857200 - Communications & Outreach Coor	1	1	55,681	21,359	4,260	81,300
730241	463100 - Health Care Project Director	1	1	85,197	42,395	6,517	134,109

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730244	442100 - Project Administrator Bluepri	1	1	57,970	31,060	4,435	93,465
730245	098500 - Admin HC Pymnt Refrm Analytics	1	1	82,472	18,517	6,309	107,298
730248	854000 - Senior Policy Advisor	1	1	62,130	31,107	4,754	97,991
730249	977020 - Payment Reform Spec Proj Lead	1	1	72,363	24,998	5,535	102,896
730251	464950 - Dir of Ops for ACO Programs	1	1	77,335	34,098	5,915	117,348
730252	533900 - Medicaid Provider Rel Oper Chf	1	1	75,275	40,231	5,759	121,265
730253	049601 - Grants Management Specialist	1	1	51,542	29,659	3,943	85,144
730254	977010 - Deputy Dir of Payment Reform	1	1	118,061	43,312	9,032	170,405
730256	496600 - Grant Programs Manager	1	1	68,536	32,506	5,243	106,285
730260	497800 - Health Reform Enterprise Dir I	1	1	70,512	32,937	5,394	108,843
730272	501100 - DVHA Program Consultant	1	1	55,682	21,358	4,260	81,300
730273	513410 - Health Care Train/Commun Mngr	1	1	80,163	41,297	6,132	127,592
730275	501100 - DVHA Program Consultant	1	1	52,146	35,183	3,990	91,319
730277	486400 - Project & Operations Dir	1	1	103,230	31,735	7,897	142,862

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730278	501100 - DVHA Program Consultant	1	1	52,146	20,587	3,990	76,723
730279	497800 - Health Reform Enterprise Dir I	1	1	63,960	14,826	4,894	83,680
730280	501100 - DVHA Program Consultant	1	1	48,693	29,037	3,725	81,455
730281	501100 - DVHA Program Consultant	0.5	1	27,841	29,880	2,130	59,851
730282	464920 - DVHA Quality Control Manager	1	1	70,512	39,192	5,395	115,099
730283	501100 - DVHA Program Consultant	1	1	52,146	35,183	3,989	91,318
730284	148400 - Autism Specialist	1	1	68,536	15,534	5,242	89,312
730286	499700 - Medicaid Operations Adm	0.81	1	60,973	37,110	4,664	102,747
730287	442100 - Project Administrator Bluepri	1	1	60,195	30,684	4,603	95,482
730288	463150 - Health Care Director	1	1	85,052	42,557	6,506	134,115
730289	735200 - Benefits Program Mentor	1	1	58,864	36,649	4,503	100,016
730290	735100 - VT Healthcare Service Spec II	1	1	48,692	29,037	3,725	81,454
730291	735100 - VT Healthcare Service Spec II	1	1	48,692	11,494	3,725	63,911
730292	735100 - VT Healthcare Service Spec II	1	1	55,681	21,359	4,260	81,300

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730293	735100 - VT Healthcare Service Spec II	1	1	55,681	21,359	4,260	81,300
730294	735110 - VT Healthcare Service Spec III	1	1	58,864	22,053	4,503	85,420
730295	735100 - VT Healthcare Service Spec II	1	1	55,681	22,750	4,260	82,691
730296	735100 - VT Healthcare Service Spec II	1	1	52,145	35,183	3,989	91,317
730297	735100 - VT Healthcare Service Spec II	1	1	48,692	29,037	3,725	81,454
730298	735000 - VT Healthcare Service Spec I	1	1	49,255	28,298	3,767	81,320
730299	735000 - VT Healthcare Service Spec I	1	1	52,562	29,020	4,021	85,603
730300	459800 - Health Program Administrator	1	1	56,680	29,917	4,335	90,932
730301	460570 - Program Integrity Analyst	1	1	66,290	23,394	5,071	94,755
730302	735100 - VT Healthcare Service Spec II	1	1	55,681	21,359	4,260	81,300
730303	735100 - VT Healthcare Service Spec II	1	1	55,681	21,359	4,260	81,300
730304	735000 - VT Healthcare Service Spec I	1	1	47,715	11,280	3,650	62,645
730305	735000 - VT Healthcare Service Spec I	1	1	47,715	10,445	3,651	61,811
730306	735100 - VT Healthcare Service Spec II	1	1	50,461	11,880	3,859	66,200

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730307	735100 - VT Healthcare Service Spec II	1	1	48,692	34,430	3,725	86,847
730308	735000 - VT Healthcare Service Spec I	1	1	50,897	34,910	3,894	89,701
730309	735100 - VT Healthcare Service Spec II	1	1	53,830	20,955	4,118	78,903
730310	735000 - VT Healthcare Service Spec I	1	1	46,051	10,917	3,522	60,490
730313	735100 - VT Healthcare Service Spec II	1	1	48,692	29,037	3,725	81,454
730314	735100 - VT Healthcare Service Spec II	1	1	48,692	19,834	3,725	72,251
730315	735000 - VT Healthcare Service Spec I	1	1	52,561	20,678	4,021	77,260
730316	735000 - VT Healthcare Service Spec I	1	1	47,715	19,620	3,650	70,985
730317	735000 - VT Healthcare Service Spec I	1	1	47,715	11,280	3,650	62,645
730318	735110 - VT Healthcare Service Spec III	1	1	58,864	36,649	4,503	100,016
730319	735000 - VT Healthcare Service Spec I	1	1	49,255	28,298	3,767	81,320
730320	735000 - VT Healthcare Service Spec I	1	1	50,898	20,315	3,894	75,107
730321	735100 - VT Healthcare Service Spec II	1	1	55,681	21,359	4,260	81,300
730322	735100 - VT Healthcare Service Spec II	1	1	48,692	29,037	3,725	81,454

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730323	512100 - Long Term Care Specialist I	1	1	48,692	29,038	3,724	81,454
730324	735000 - VT Healthcare Service Spec I	1	1	52,561	29,019	4,021	85,601
730325	735500 - Healthcare Assistant Admin II	1	1	66,040	23,341	5,052	94,433
730326	735110 - VT Healthcare Service Spec III	1	1	58,864	36,401	4,503	99,768
730327	208800 - Business Analyst	1	1	66,290	23,394	5,071	94,755
730328	735000 - VT Healthcare Service Spec I	1	1	46,051	19,257	3,522	68,830
730329	735200 - Benefits Program Mentor	1	1	58,864	22,053	4,503	85,420
730330	735500 - Healthcare Assistant Admin II	1	1	61,568	31,846	4,710	98,124
730331	735100 - VT Healthcare Service Spec II	1	1	50,461	20,220	3,859	74,540
730332	735200 - Benefits Program Mentor	1	1	57,034	29,995	4,363	91,392
730333	735100 - VT Healthcare Service Spec II	1	1	50,461	20,220	3,859	74,540
730334	735000 - VT Healthcare Service Spec I	1	1	46,051	27,598	3,522	77,171
730335	735100 - VT Healthcare Service Spec II	1	1	55,681	29,700	4,260	89,641
730336	735110 - VT Healthcare Service Spec III	1	1	55,203	12,915	4,222	72,340

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730337	735200 - Benefits Program Mentor	1	1	58,864	13,465	4,503	76,832
730338	735100 - VT Healthcare Service Spec II	1	1	48,692	29,037	3,725	81,454
730339	735110 - VT Healthcare Service Spec III	1	1	58,864	30,394	4,503	93,761
730340	536900 - VHC Support Services Spec	1	1	53,831	20,954	4,118	78,903
730341	459800 - Health Program Administrator	1	1	64,251	22,958	4,914	92,123
730342	735300 - Fair Hearing Specialist	1	1	51,542	29,658	3,944	85,144
730343	208800 - Business Analyst	1	1	66,289	23,394	5,071	94,754
730344	004700 - Program Technician I	1	1	43,306	33,254	3,313	79,873
730345	735000 - VT Healthcare Service Spec I	1	1	46,051	28,460	3,522	78,033
730346	536900 - VHC Support Services Spec	1	1	48,693	29,038	3,725	81,456
730347	735000 - VT Healthcare Service Spec I	1	1	46,051	19,257	3,522	68,830
730348	536900 - VHC Support Services Spec	1	1	55,681	12,784	4,260	72,725
730349	735100 - VT Healthcare Service Spec II	1	1	48,692	29,037	3,725	81,454
730352	512300 - Long Term Care Specialist III	1	1	72,924	25,122	5,580	103,626

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730353	512200 - Long Term Care Specialist II	1	1	72,716	25,076	5,562	103,354
730354	512200 - Long Term Care Specialist II	0.8	1	47,092	19,484	3,602	70,178
730355	503400 - Benefits Progrms Administrator	1	1	82,472	26,857	6,308	115,637
730356	512200 - Long Term Care Specialist II	1	1	62,982	31,294	4,818	99,094
730357	512200 - Long Term Care Specialist II	1	1	58,864	22,052	4,504	85,420
730358	512200 - Long Term Care Specialist II	1	1	58,864	36,400	4,504	99,768
730359	459900 - ESD Health Care Elig Dir	1	1	97,032	30,606	7,422	135,060
730360	735500 - Healthcare Assistant Admin II	1	1	72,821	33,133	5,571	111,525
730361	464920 - DVHA Quality Control Manager	1	1	75,275	33,658	5,759	114,692
730362	512200 - Long Term Care Specialist II	1	1	53,560	35,492	4,096	93,148
730363	512200 - Long Term Care Specialist II	1	1	66,852	23,796	5,114	95,762
730364	512300 - Long Term Care Specialist III	1	1	62,546	22,856	4,784	90,186
730365	503405 - Healthcare Programs Director	1	1	91,063	37,421	6,965	135,449
730366	459800 - Health Program Administrator	1	1	56,680	21,577	4,336	82,593

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730367	512200 - Long Term Care Specialist II	1	1	62,982	31,294	4,818	99,094
730368	512200 - Long Term Care Specialist II	1	1	53,560	35,492	4,096	93,148
730369	512200 - Long Term Care Specialist II	1	1	60,840	13,308	4,654	78,802
730370	735510 - Healthcare Assistant Admin I	1	1	62,545	22,593	4,785	89,923
730371	512200 - Long Term Care Specialist II	1	1	60,840	22,484	4,654	87,978
730372	501200 - Economic Services Supervisor	1	1	68,536	24,164	5,244	97,944
730373	512200 - Long Term Care Specialist II	1	1	58,864	30,394	4,504	93,762
730374	512200 - Long Term Care Specialist II	1	1	58,864	36,648	4,504	100,016
730375	735510 - Healthcare Assistant Admin I	1	1	66,768	38,092	5,107	109,967
730377	503400 - Benefits Progrms Administrator	1	1	79,789	41,218	6,104	127,111
730378	735500 - Healthcare Assistant Admin II	1	1	72,820	33,442	5,570	111,832
730379	735500 - Healthcare Assistant Admin II	1	1	72,821	15,924	5,571	94,316
730381	464910 - DVHA Healthcare QC Auditor	1	1	60,507	22,412	4,629	87,548
730382	512100 - Long Term Care Specialist I	1	1	48,692	19,834	3,724	72,250

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730383	512200 - Long Term Care Specialist II	1	1	57,034	29,756	4,362	91,152
730384	512200 - Long Term Care Specialist II	1	1	53,560	35,492	4,096	93,148
730385	501200 - Economic Services Supervisor	1	1	75,276	33,976	5,760	115,012
730388	512100 - Long Term Care Specialist I	1	1	48,692	28,175	3,725	80,592
730389	735510 - Healthcare Assistant Admin I	1	1	64,543	37,616	4,938	107,097
730390	735500 - Healthcare Assistant Admin II	1	1	66,040	38,216	5,051	109,307
730391	735500 - Healthcare Assistant Admin II	1	1	70,512	26,222	5,394	102,128
730392	735510 - Healthcare Assistant Admin I	1	1	58,531	12,805	4,478	75,814
730393	735510 - Healthcare Assistant Admin I	1	1	58,531	23,606	4,477	86,614
730394	735100 - VT Healthcare Service Spec II	1	1	55,681	21,359	4,260	81,300
730395	735100 - VT Healthcare Service Spec II	1	1	55,681	29,700	4,260	89,641
730396	735100 - VT Healthcare Service Spec II	1	1	52,145	20,587	3,989	76,721
730397	089280 - Administrative Srvcs Mngr III	1	1	98,155	38,968	7,509	144,632
730398	735110 - VT Healthcare Service Spec III	1	1	58,864	13,713	4,503	77,080

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730399	735100 - VT Healthcare Service Spec II	1	1	48,692	11,494	3,725	63,911
730400	459800 - Health Program Administrator	1	1	62,545	34,184	4,784	101,513
730401	735200 - Benefits Program Mentor	1	1	58,864	21,805	4,503	85,172
730402	735400 - VT Healthcare Srvc Supervisor	1	1	66,289	37,990	5,071	109,350
730403	735500 - Healthcare Assistant Admin II	1	1	70,512	24,297	5,394	100,203
730404	735400 - VT Healthcare Srvc Supervisor	1	1	60,195	22,343	4,606	87,144
730405	735200 - Benefits Program Mentor	1	1	57,034	36,250	4,363	97,647
730406	735400 - VT Healthcare Srvc Supervisor	1	1	66,289	15,334	5,071	86,694
730407	735500 - Healthcare Assistant Admin II	1	1	70,512	38,893	5,394	114,799
730408	459800 - Health Program Administrator	1	1	62,545	37,189	4,784	104,518
730409	735200 - Benefits Program Mentor	1	1	68,703	38,796	5,256	112,755
730410	735110 - VT Healthcare Service Spec III	1	1	58,864	30,394	4,503	93,761
730411	735200 - Benefits Program Mentor	1	1	66,851	23,797	5,114	95,762
730412	735100 - VT Healthcare Service Spec II	1	1	64,772	23,342	4,955	93,069

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730413	735110 - VT Healthcare Service Spec III	1	1	58,864	36,649	4,503	100,016
730414	735100 - VT Healthcare Service Spec II	1	1	55,681	35,955	4,260	95,896
730415	735600 - HAEEU Operations Director	1	1	85,051	36,109	6,506	127,666
730416	735000 - VT Healthcare Service Spec I	1	1	57,886	21,840	4,428	84,154
730417	735100 - VT Healthcare Service Spec II	1	1	57,470	21,749	4,396	83,615
730419	089420 - Administrative Srvcs Dir IV	1	1	111,009	42,030	8,492	161,531
730420	735500 - Healthcare Assistant Admin II	1	1	72,820	39,696	5,570	118,086
730421	735400 - VT Healthcare Srvc Supervisor	1	1	68,536	32,505	5,244	106,285
730422	735400 - VT Healthcare Srvc Supervisor	1	1	62,130	37,361	4,753	104,244
730423	735100 - VT Healthcare Service Spec II	1	1	55,681	13,019	4,260	72,960
730424	089230 - Administrative Srvcs Cord II	1	1	48,692	29,037	3,725	81,454
730425	735200 - Benefits Program Mentor	1	1	60,840	37,080	4,655	102,575
730426	735000 - VT Healthcare Service Spec I	1	1	53,560	35,492	4,097	93,149
730427	735100 - VT Healthcare Service Spec II	1	1	57,470	36,103	4,396	97,969

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730428	735400 - VT Healthcare Srvc Supervisor	1	1	66,290	23,673	5,071	95,034
730429	735100 - VT Healthcare Service Spec II	1	1	52,145	20,587	3,989	76,721
730430	735100 - VT Healthcare Service Spec II	1	1	53,830	35,551	4,118	93,499
730431	735300 - Fair Hearing Specialist	1	1	66,851	38,393	5,114	110,358
730433	735500 - Healthcare Assistant Admin II	1	1	70,512	32,935	5,394	108,841
730434	735100 - VT Healthcare Service Spec II	1	1	53,830	20,955	4,118	78,903
730435	735100 - VT Healthcare Service Spec II	1	1	48,692	11,494	3,725	63,911
730436	735200 - Benefits Program Mentor	1	1	55,203	29,596	4,222	89,021
730437	735300 - Fair Hearing Specialist	1	1	57,033	21,654	4,363	83,050
730438	735100 - VT Healthcare Service Spec II	1	1	50,461	20,220	3,859	74,540
730439	536900 - VHC Support Services Spec	1	1	48,693	29,038	3,725	81,456
730440	735100 - VT Healthcare Service Spec II	1	1	53,830	12,615	4,118	70,563
730441	735110 - VT Healthcare Service Spec III	1	1	55,203	21,255	4,222	80,680
730442	735200 - Benefits Program Mentor	1	1	57,034	21,654	4,363	83,051

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730443	735300 - Fair Hearing Specialist	1	1	58,864	21,805	4,504	85,173
730444	735300 - Fair Hearing Specialist	1	1	58,864	22,053	4,504	85,421
730446	735300 - Fair Hearing Specialist	1	1	53,560	20,896	4,098	78,554
730447	735100 - VT Healthcare Service Spec II	1	1	53,831	29,295	4,118	87,244
730448	464900 - DVHA Program & Oper Auditor	1	1	62,545	22,857	4,785	90,187
730449	499105 - Senior Policy & Implementation	1	1	65,500	32,707	5,010	103,217
730450	454200 - Dir Healthcare Policy&Planning	1	1	100,380	45,517	7,680	153,577
730451	735500 - Healthcare Assistant Admin II	1	1	87,089	36,186	6,663	129,938
730452	735500 - Healthcare Assistant Admin II	1	1	66,040	38,215	5,052	109,307
730453	081550 - Appeals Manager	1	1	75,275	33,975	5,759	115,009
730454	735500 - Healthcare Assistant Admin II	1	1	68,245	32,441	5,221	105,907
730455	735500 - Healthcare Assistant Admin II	1	1	75,275	40,230	5,759	121,264
730456	089120 - Financial Manager III	1	1	77,564	25,806	5,932	109,302
730457	034550 - HCR-HIT Integration Manager	0.5	1	50,139	34,861	3,836	88,836

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730458	498800 - Medicaid Fiscal Analyst	1	1	64,542	23,020	4,938	92,500
730459	735700 - Healthcare Eligib & Enorll Dir	1	1	103,730	23,743	7,935	135,408
730460	494000 - Exchange Project Director	1	1	101,691	45,995	7,779	155,465
730461	498800 - Medicaid Fiscal Analyst	1	1	56,680	21,576	4,335	82,591
730462	089230 - Administrative Srvcs Cord II	1	1	55,682	21,124	4,261	81,067
730463	459500 - Provider Relations Specialist	1	1	57,033	36,250	4,363	97,646
730464	410300 - Workforce Management Coord II	1	1	62,546	37,453	4,784	104,783
730465	330310 - VHC Business Process Coord	1	1	66,040	31,960	5,052	103,052
730466	735800 - Healthcare Deputy Dir of Ops	1	1	88,067	43,023	6,737	137,827
730467	977000 - Dir Paymnt Refrm Reimbrse Rate	1	1	103,729	33,708	7,935	145,372
730468	089090 - Financial Manager II	1	1	61,569	31,845	4,710	98,124
730469	735750 - Business Reporting Admin	1	1	72,820	33,439	5,571	111,830
730470	857300 - Communications & Notices Mgr	1	1	68,245	38,696	5,221	112,162
730471	208800 - Business Analyst	1	1	57,969	31,060	4,435	93,464

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730472	089230 - Administrative Srvcs Cord II	1	1	55,682	35,955	4,261	95,898
730473	410300 - Workforce Management Coord II	1	1	64,542	37,889	4,938	107,369
730474	459800 - Health Program Administrator	1	1	64,542	31,361	4,938	100,841
730475	735500 - Healthcare Assistant Admin II	1	1	61,568	31,846	4,709	98,123
730476	089280 - Administrative Srvcs Mngr III	1	1	74,984	25,570	5,736	106,290
730477	066730 - DVHA Org & HR Development Dir	1	1	82,472	41,991	6,308	130,771
730478	208800 - Business Analyst	1	1	64,251	37,825	4,914	106,990
730479	330320 - Knowledge Management Sys Admin	1	1	58,531	30,074	4,477	93,082
730480	410300 - Workforce Management Coord II	1	1	56,680	21,577	4,336	82,593
730481	089230 - Administrative Srvcs Cord II	1	1	50,461	20,218	3,861	74,540
730482	513400 - Healthcare Training/Curr Coord	1	1	53,560	20,896	4,098	78,554
730483	406705 - Program Improvement Manager	1	1	65,499	32,704	5,011	103,214
730484	208800 - Business Analyst	1	1	86,778	36,485	6,639	129,902
730485	513400 - Healthcare Training/Curr Coord	1	1	58,864	30,146	4,504	93,514

Report ID : VTPB - 14
Run Date : 01/28/2021
Run Time : 12:14 PM

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730486	460550 - Oversight & Monitoring Dir	1	1	91,062	43,677	6,966	141,705
730487	018100 - Director of Change Management	1	1	93,308	44,166	7,140	144,614
730488	018000 - Change Management Practitioner	1	1	66,039	15,281	5,051	86,371
730489	018000 - Change Management Practitioner	1	1	68,245	38,696	5,221	112,162
730490	089260 - Administrative Srvcs Mngr I	1	1	68,536	32,506	5,243	106,285
730491	510000 - Director of Rate Setting	1	1	105,498	32,472	8,070	146,040
730492	032950 - Health Facility Auditor II	1	1	68,536	14,988	5,244	88,768
730493	514900 - Rate Support Specialist	1	1	54,704	35,740	4,186	94,630
730494	033900 - Hlth Fac Sr Audit & Rate Spec	1	1	92,248	30,966	7,058	130,272
730495	510010 - Rate Setting Manager	1	1	79,788	41,214	6,102	127,104
730496	032950 - Health Facility Auditor II	1	1	84,282	35,942	6,448	126,672
730497	032901 - Medicaid Residentl Prgm Audito	1	1	66,768	23,778	5,108	95,654
737001	95010E - Executive Director	1	1	147,035	49,972	10,669	207,676
737002	90120A - Commissioner	1	1	137,051	54,026	10,486	201,563

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
737003	90570D - Deputy Commissioner	1	1	106,683	41,074	8,161	155,918
737004	480200 - DVHA Clinical Chief	1	0.51	52,923	11,687	4,048	68,658
737004	90570D - Deputy Commissioner		0.49	50,848	11,228	3,890	65,966
737006	91590E - Private Secretary	1	1	185,058	58,358	11,221	254,637
737008	95866E - Staff Attorney I	1	1	61,859	22,849	4,733	89,441
737015	95867E - Staff Attorney II	1	1	60,861	37,225	4,656	102,742
737016	95869E - Staff Attorney IV	1	0.49	39,739	16,414	3,040	59,193
737016	95870E - General Counsel I		0.51	41,361	17,083	3,165	61,609
737017	95360E - Principal Assistant	1	1	133,078	53,151	10,181	196,410
737018	95869E - Staff Attorney IV	1	1	86,362	28,732	6,606	121,700
737028	95868E - Staff Attorney III	1	1	71,178	24,904	5,444	101,526
737036	95867E - Staff Attorney II	1	1	74,630	34,006	5,709	114,345
737037	95868E - Staff Attorney III	1	1	85,467	28,056	6,537	120,060
737038	95868E - Staff Attorney III	1	1	87,651	36,877	6,705	131,233

Report ID : VTPB - 14
Run Date : 01/28/2021
Run Time : 12:14 PM

State of Vermont

FY2022 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
737100	96700E - Director Blueprint for Health	1	1	117,290	31,567	8,972	157,829
Total		**371.01**	**375**	**25,525,878**	**11,331,429**	**1,949,195**	**38,806,500**

Fund Code	Fund Name	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
10000	General Fund		149.38	10,115,727	4,485,727	770,676	15,372,133
20405	Global Commitment Fund	9.8	6.94	577,770	234,255	44,084	856,109
21500	Inter-Unit Transfers Fund		2.6	207,686	87,694	15,660	311,040
21916	Vermont Health IT Fund		0.4	23,664	13,215	1,811	38,690
22005	Federal Revenue Fund	361.21	215.68	14,601,031	6,510,538	1,116,964	22,228,528
Total		**371.01**	**375**	**25,525,878**	**11,331,429**	**1,949,195**	**38,806,500**

Note: Numbers may not sum to total due to rounding.