Department of Vermont Health Access

ANNUAL REPORT FOR STATE FISCAL YEAR 2021 & GOVERNOR'S RECOMMENDED BUDGET FOR STATE FISCAL YEAR 2023

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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MESSAGE FROM THE COMMISSIONER OF VERMONT HEALTH ACCESS

As we enter a new calendar year, we remain entangled in the worst public health crisis in a century. We are fortunate to live in Vermont, which has had one of the most successful COVID-19 vaccination and testing rollouts in the country, as well as one of the highest COVID-19 vaccination rates and one of the lowest death rates per capita. We still have much work to do to move to the endemic phase, but I am grateful to be a Vermonter and to have the opportunity to lead the Department of Vermont Health Access (DVHA).

As one of six departments within the Agency of Human Services, DVHA continues to play a critical role in the pandemic response. A few priorities for the Department include the design and implementation of payment reform solutions that allow Vermont Medicaid to be a more predictable and reliable partner, and offering participating providers the ability to determine revenue and support long-term sustainability more accurately. We are very appreciative of the services and quality health care participating providers offer to Vermonters. Vermont Medicaid has also offered continuous health care coverage to Vermonters during the federally declared public health emergency. This is significant as almost one third of Vermonters are now enrolled.

Additionally, as the administrator of the health insurance marketplace, DVHA has valued partnerships with other health and dental insurers in Vermont. For example, this year's Open Enrollment period was extended to allow more folks to take advantage of federal subsidies and achieve significant tax credit savings via the American Rescue Plan Act (ARPA). DVHA has proposed a policy for the 2022 legislative session to offer a year-round, special enrollment period for income-eligible Vermonters to enroll in Qualified Health Plans. We are very encouraged by the support of Governor Scott and many Vermont lawmakers.

It is easy to be distracted during this time of uncertainty, but the DVHA staff remains focused on furthering the mission of the Department and the Agency of Human Services in service to Vermonters. We are committed to continuous improvement in each of our 20 units within the Department. I am confident that staying true to our values of transparency, integrity, and service, will be the foundation for us to achieve our goals and continue to innovate and collaborate with other State agencies, local and federal governments, as well as community partners. We will continue to be responsive, and 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.

Andrea De La Bruere

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. **As of November 2021, Vermont Medicaid resumed the process of asking new Medicaid applicants for financial documentation when needed. This does not impact existing Medicaid members**;
- 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 or moves out of state). **As of January 2021, Vermont is processing transitions between Medicaid coverage groups as required by the federal government**;
- 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 through September 30, 2021**. Importantly, for Medicaid, eligible Vermonters could continue to apply for and enroll in Medicaid at any time and this has always been in effect;
- 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). **For applications received on and after October 5, 2020, normal processes apply, including verification of income, resources, and review of the transfer of assets during the 60-month look back period. More time may be allowed to provide the requested verification.** The review period for Long-Term Care Medicaid members who had a review scheduled during the Emergency period will be extended.[1,2]

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. **Dr. Dynasaur premiums will remain waived through the first quarter following the end of the federal COVID-19 public health emergency.** While the State of Vermont collects approximately $2 million dollars (gross, based on 2019 data) from Dr. Dynasaur premiums from households with incomes between 195 – 312% of the federal poverty guidelines, the majority of those funds

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

[2] Several of these steps were required under federal law. Continuous Medicaid coverage is a condition of receiving the 6.2% enhancement in Federal Medical Assistance Percentage (FMAP) as authorized in the Families First Coronavirus Response Act (FFCRA). The federal government is providing this increased FMAP to support states and promote stability of health care coverage during the pandemic.

($1,700,000) is returned to the federal government with the State of Vermont retaining $300,000 that goes into the general fund. However, it is important to note that in order to collect and process the premiums, the State of Vermont maintains a contract with a billing vendor (WEX) in the amount of $664,920 (gross) or approximately $196,000 of general fund for calendar year 2022 and the State must utilize state staff to manage the contract, complete the accounting, and other administrative tasks associated with the premium collection.

Ensuring No Copayments Apply to COVID-19 Testing, Diagnosis, Treatment or Vaccination Services for Vermont Medicaid Members & Participating Providers are Reimbursed for Medicaid-Covered Services

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 receiving services from Vermont Medicaid-participating providers 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).[3] The Department also provided frequently updated guidance for providers related to billing for testing, diagnosis, treatment, and vaccination services (including booster doses) to support providers in being reimbursed for these services when caring for Vermont Medicaid members.[4]

Early Findings for the Impact of the 2021 COVID-19 Special Enrollment Period for Vermont's Health Insurance Marketplace

Vermont's 2021 COVID-19 Special Enrollment Period ran from February 15 through September 30, 2021. During the 2021 COVID-19 Special Enrollment Period, approximately 3,200 Vermont households signed up for health insurance through Vermont's health insurance marketplace, Vermont Health Connect. This number does not include households who transferred a direct enroll plan into the Marketplace. About one-quarter – 800 households or just over 1,000 Vermonters – enrolled in a qualified health plan using the COVID-19 Special Enrollment Period flexibility. The other three-quarters enrolled using another qualifying event, such as losing health insurance or moving to the state. The 3,200 household enrollment is only slightly higher than the same time period in 2020, when 3,100 households enrolled in health plans. However, the pattern was different as in 2021, more people enrolled in the summer (presumably drawn by the expanded American Rescue Plan subsidies) while the April, May, and October enrollments during 2020 outpaced those in 2021.

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

Vermont Medicaid Expansion of Coverage for At-Home COVID-19 Antigen Tests through Vermont Medicaid-Participating Pharmacies

Vermont Medicaid expanded its coverage for at-home COVID-19 antigen tests without any cost to Vermont Medicaid members through Vermont Medicaid-participating pharmacies when prescribed by a Medicaid-enrolled provider working within their scope of practice. Vermont Medicaid-enrolled pharmacists can be the prescribing provider on the pharmacy claim in accordance with the provisions of the federal Public Readiness and Emergency Preparedness (PREP) Act. Tests may also be obtained through pharmacies in one of the following ways:

a. through the use of the Commissioner of Health's standing order;
b. through the pharmacy's own standing order (most chains have these); or
c. the pharmacist can write the prescription if they are enrolled as a Medicaid provider.

These tests are to be used by Medicaid members in the home setting. Copayments do not apply to COVID-19 tests including tests for at-home use; the pharmacy claims system processes the claim at the point of service to ensure cost isn't a barrier for Vermont Medicaid members accessing at-home COVID-19 antigen tests. COVID-19 testing must be in accordance with guidance from the Centers for Disease Control and Prevention and Vermont Department of Health on when testing is appropriate.[5]

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

In March of 2021, Vermont Medicaid-participating providers had delivered 55,325 health care services through telemedicine and 9,481 services by an audio-only modality. In contrast, the highest number of telemedicine services delivered in any month of the year prior to the Public Health Emergency beginning 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.

[5] For more information on the proposed policy, visit the public notice on Pharmacy COVID-19 Antigen Test Coverage. Pharmacies and pharmacists can access: Pharmacy COVID-19 Antigen Test Coverage.

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.[6] 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.

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.

In state fiscal year 2021, the Department analyzed the Medicare Physician Fee Schedule final rule from the Centers for Medicare and Medicaid Services to understand the policy provisions specific to telehealth coverage and reimbursement for Medicare. After engagement within departments of the Agency of Human Services, with the Department's Medicaid and Exchange Advisory Committee and other stakeholders, and consultation with Medicare and Medicaid policy teams, the Department began its revision of the existing Health Care Administrative Rule on Telehealth in preparation for the period following the end of the federal COVID-19 public health emergency. The revised rule will include audio-only as a covered/reimbursable telehealth modality for delivering health care services that are medically necessary and clinically appropriate (based on Medicare's Telehealth Services list).

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

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 by having fixed, prospective payments established (implemented under ongoing health care payment and delivery system reform efforts) for entities participating with the Accountable Care

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

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.[7] Any providers who received the COVID-19-specific Medicaid Retainer (April 2020), COVID-19 Sustained Monthly Retainer (in effect for the months of May, June, and July 2020), and COVID-19 Extraordinary Financial Relief for Nursing Homes and Private Non-Medical Institutions payment received retroactive grant agreements following an initial memo from the Secretary of the Agency of Human Services on November 3, 2020. Grant agreements were subsequently sent to providers, beginning in the last week of November and throughout the first couple of weeks in December.

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**.[8] Of the 351 applications received in the first application cycle from eligible providers, 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 and 272 applications were received from a broad array of provider types and organizations, including primary care, mental health, specialists, dental, chiropractic, physical therapy, family centers, hospitals, and designated/specialized service agencies.

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. During the second application cycle, $58,695,286 was awarded to a broad array of eligible providers from the 272 applications received. Payments were issued as one lump sum grant payment on December 21, 2020.

[7] In order to address provider administrative burden during the Emergency, the Department's Program Integrity unit suspended requests for documentation in case reviews and the Department's Oversight and Monitoring unit, in alignment with notification from the Centers for Medicare and Medicaid Services (CMS) regarding the Payment Error Rate Measurement (PERM) program, suspended 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).

[8] Final Report on the Health Care Provider Stabilization Grant Program (January 2021).

Utilizing the Completed, Required Regulatory Request to CMS for Section 1135 Waiver Approval of Flexibilities to Continue to Address Health Care System Delivery in All Counties of Vermont[9]

The Section 1135 Waiver Checklist[10] provided the federal authority to enact many flexibilities already discussed and 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 COVID-19 public health emergency was renewed throughout 2020 and 2021 and remained in effect as of the date this report was finalized.[11] As the United States addresses the impacts of the next surge of variants (delta and omicron) of the virus and continues distribution of the COVID-19 vaccines and booster doses, state Medicaid programs will continue to serve an essential role in the COVID-19 emergency response.

[9] Submitted March 23, 2020.

[10] 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.

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

Vermont Medicaid will continue its commitment to ensuring that Vermonters have access to the health care services they need to remain healthy.

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

In response to the COVID-19 public health emergency, 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.

As of September 2021, the Department re-started provider enrollment and revalidation processes, allowing providers the flexibility to continue to waive these requirements if a provider indicates they need flexibility in order to continue to offer timely access to care for Medicaid members. This approach has been well-received by providers to date, with many understanding that Vermont Medicaid could experience a significant backlog of provider enrollments once the public health emergency ends and the impact could adversely affect the level of service they are accustomed to receiving.[12]

Assuring Access to Health Care Services for Vermont Medicaid Members: Changes in Clinical and Pharmacy Prior Authorizations Following the State of Emergency Ending in Vermont

To support Vermont Medicaid-enrolled providers in providing health care services for Vermont Medicaid members in a safe and timely way, and to ensure Vermonters have access to necessary care, Vermont Medicaid instituted the following changes in 2021, and communicated the following in response to requests from providers for additional guidance:

- Although the State of Emergency was lifted for Vermont, the federal COVID-19 public health emergency and associated waivers are still in place. Prior authorizations that are currently waived continue to be waived under the federal public health emergency.
- In addition, and effective June 1, 2021, prior authorizations will no longer be required for imaging services, most durable medical equipment and supplies through the medical benefit, and most

[12] More information on provider enrollment flexibilities may be found in authorizing legislation, including Act 6 (S.117) of 2021, An act relating to extending health care regulatory flexibility during and after the COVID-19 pandemic and to coverage of health care services delivered by audio-only telephone.

dental services.

- Prior authorizations are still required for services with the potential to cause imminent harm[13], services found on the Fee Schedule indicating a prior authorization is required,[14] and for items not found on the Waived Prior Authorization List (updated October 28, 2021).[15]
- For pharmacy prior authorization requirements, refer to the Preferred Drug List and Clinical Criteria.[16]
    - Beginning January 1, 2021, the Department ceased extending existing pharmacy prior authorizations beyond their normal expiration date.[17]

Act 140 of 2020, An act relating to miscellaneous health care provisions, required the Department of Vermont Health Access to review requirements for clinical prior authorizations in the Vermont Medicaid program outside of the flexibilities implemented in response to the public health emergency and report the findings and recommendations resulting from that review to the House Committee on Health Care, Senate Committees on Health and Welfare and Finance, and Green Mountain Care Board on/before September 30, 2021.[18] The work group utilized data from the temporary waiver of prior authorization requirements during the COVID-19 public health emergency to inform the recommendations within the report.

The recommendations were presented to clinical representatives of OneCare Vermont on September 10, 2021, with no concerns raised regarding the recommendations as proposed. The recommendations were next summarized and presented to the Medicaid and Exchange Advisory Committee on September 27, 2021 with several Committee members indicating strong support for the recommendations as proposed. For prior authorization requirements that would remain, one Vermont Medicaid member advised that the Medicaid member's rationale for requesting a service should be considered alongside the rationale provided by the provider. The Department will continue to take any feedback received into account as it moves forward in the approval and implementation process. Finally, it is the policy of the Agency of Human Services and Department of Vermont Health Access to issue public notice on these types of proposed changes. Public notice will occur 30 days prior to the implementation of any changes related to these recommendations, at which time additional feedback from stakeholders and the public will be gathered and considered. In some cases, changes to the Medicaid benefit or coverage policies require federal approval and/or modification to the State's rules for the Medicaid program.

[13] Imminent Harm List
[14] Vermont Medicaid Fee Schedule
[15] Waived Prior Authorization List
[16] Preferred Drug List and Clinical Criteria
[17] Pharmacy Prior Authorization Extensions Ending: Communication to Pharmacies and Prescribers.
[18] DVHA Clinical Prior Authorization Requirements: Findings and Recommendations.

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 is committed to transitioning Vermont's Medicaid's health care revenue model from Fee-For-Service payments to value-based payments. As a result, 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). 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. The Department has also prioritized payment models for Medicaid providers through past and present projects for Applied Behavioral Analysis, Children's and Adult Mental Health, Residential Substance Use Disorder Treatment, Developmental Disabilities Services, Children's Integrated Services, and High-Technology Nursing Services.

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 reporting and business process improvements that allow certain Medicaid-eligible Vermonters to be renewed automatically (MABD Automatic Renewals), implementation of the expanded subsidies for Vermonters enrolling in Qualified Health Plans through the State's health insurance marketplace as a result of the federal American Rescue Plan Act, the transfer of premium billing and collection of payments for Qualified Health Plan customers to the commercial insurers (Premium Processing project), and roadmap planning for the Integrated Eligibility and Enrollment (IE&E) system development.

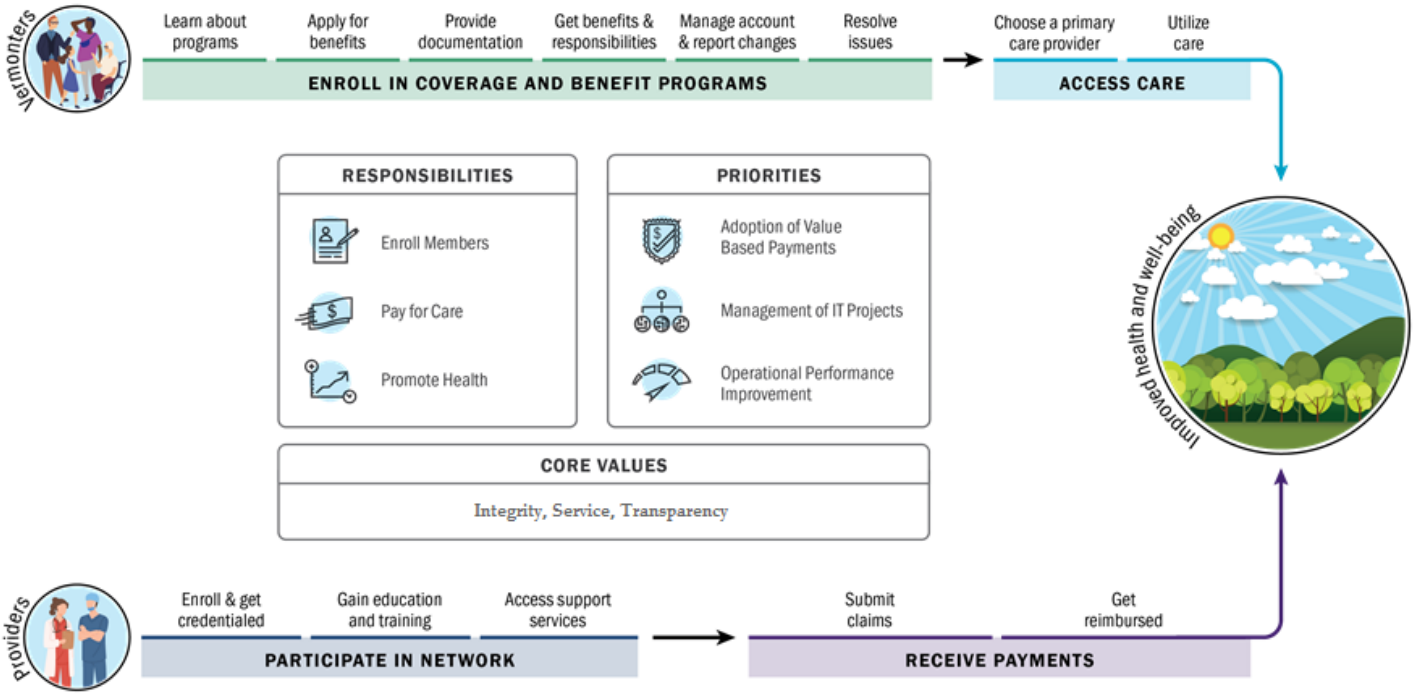
Operational Performance Improvement

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, closely monitored customer support center and claims processor contract service level agreements, improvements in contract and grant processes resulting in reduced retroactive agreements and effective electronic invoice processing, improved processes for provider enrollment, ensuring Medicaid members are able to access non-emergency medical transportation in a timely manner, dynamically changing the Assister program to continue to meet Vermonters' needs, 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 Vermont's state-based exchange for health insurance and the Vermont Medicaid health insurance program. Vermont's state-based health insurance exchange is also referred to as the health insurance marketplace. The State of Vermont's health insurance marketplace is integrated. This means

that Vermonters can come through one "door" and be screened for eligibility for health insurance through Medicaid and also for financial help and health insurance through Qualified Health Plans. 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 Blue Cross and Blue Shield of Vermont and MVP Health Care®. Qualified Health Plans offered by Blue Cross and Blue Shield 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.

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 fourth full year of the Vermont Medicaid Next Generation Accountable Care Organization (ACO) program and initiating the fifth 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 2021, DVHA published the most recent Medicaid Delivery System Reform (2020) 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.[19]

Overall, the Agency of Human Services and Department of Vermont Health Access continued to make steady progress on payment and delivery system reform. That progress could not have occurred without the commitment and collaborative efforts of health care providers, people who receive services, advocates, regulators, and policymakers. The goal remains the same: to create an integrated system of care that spans the entire care continuum.

Specifically, the report summarized a renewed focus by the Centers for Medicare and Medicaid Services on value-based care, and shows the extent to which Vermont's Medicaid payment and delivery system reform results exceed the national average. The report then provides a description of the payment reform process, which is typically facilitated by the Payment Reform team at the Department of Vermont Health Access. Finally, the report provides an update on completed and in-progress payment reform activities, using the enumerated statutory criteria:

[19] Medicaid Delivery System Reform Report (Submitted January 15, 2021).

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

The report serves as an excellent primer on reform, and some of these programs are described in greater length below.[20]

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

Calendar year 2020 was the fourth full year of the Vermont Medicaid Next Generation Accountable Care Organization (ACO) program. During 2021, the Department completed its evaluation of the Vermont Medicaid Next Generation (VMNG) program's fourth year, and results indicated: [21]

1. **Participation in the Vermont Medicaid Next Generation ACO program is Stable.**

   Additional providers and communities joined the ACO network to participate in the program for the 2020 performance year. Provider participation has remained fairly constant in 2021 and 2022, though attribution remained stable or continued to increase. The table below depicts the number of hospital service areas, provider entities, unique Medicaid providers, and attributed Medicaid members from 2017 – 2022.

[20] Medicaid Delivery System Reform Report (Submitted January 15, 2021).
[21] Vermont Medicaid Next Generation ACO Program 2020 Results (December 2021) & Vermont Medicaid Next Generation ACO Program 2020 Performance report.

Performance Year	2017	2018	2019	2020	2021	2022
Health Service Areas	4	10	13	14	14	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	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	~4,800	~5,000
Attributed Medicaid Members	~29,000	~42,000	~79,000	~114,000	~111,000	~126,000

The findings above are consistent with the predictions from the last report that "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. **The Program Promoted Shared Financial Accountability for Health Care between ACO Participating Providers and Medicaid & Spending on Health Care Services was less than Expected in 2020.**

For 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 was liable for financial performance within the 4% risk corridor, meaning that after application of other necessary adjustments, OneCare Vermont was contractually obligated to pay $6.7 million dollars to the Department of Vermont Health Access.[22] In contrast, for the 2020 performance year, the spending for ACO-attributed Medicaid members was approximately $11.6 million less than expected for the traditional attribution cohort group and approximately $5.2 million less than expected for the expanded attribution cohort group. In addition, 2020 was the first year that OneCare Vermont assumed accountability for the expanded attribution cohort; as a result, each cohort had a distinct risk arrangement and was reconciled separately. For the 2020 performance year, OneCare Vermont

[22] Paid in January of 2021; financial results reflected in the 2019 VMNG performance report.

is entitled to the full amount of funding below the agreed-upon price and within the risk corridors. After application of other necessary adjustments, the Department of Vermont Health Access is contractually obligated to issue OneCare Vermont a reconciliation payment of approximately $15.4 million dollars. The Department will present these results in its state fiscal year 2022 budget adjustment request.

3. **The Vermont Medicaid Next Generation ACO Program Played a Significant Role in Stabilizing Health Care Providers and Hospitals During the COVID-19 Public Health Emergency.**

The Vermont Medicaid Next Generation ACO program, and Vermont's other innovative health care models, played a significant role stabilizing health care providers and hospitals facing the catastrophic public health emergency. As providers saw revenue decrease for elective visits and procedures that were on hold during the COVID-19 pandemic, those who received fixed prospective payments in the VMNG program were better able to withstand the loss of fee-for-service revenue for non-Medicaid lines of business. Additionally, funding distributed to OneCare as a result of spending under its 2020 financial target will direct additional resources to the health care system as COVID-19-related pressures continue.

4. **The Program's Assessment of 2020 Quality Results Aligned with the Approach of the Federal Government.**

Vermont followed the lead of the Federal government in determining how to assess 2020 quality results. The Center for Medicare and Medicaid Innovation (CMMI) decided to link payment to reporting rather than performance in 2020, in recognition that care was delayed or forgone during the pandemic. Vermont aligned its approach with CMMI and described the planned approach as part of public testimony before the Vermont Legislature and with relevant advisory committees given the pandemic produced circumstances not previously encountered during the Vermont Medicaid Next Generation program. Prior to 2020, quality results in the Vermont Medicaid Next Generation program were very encouraging. In 2019, OneCare was evaluated on the same 10 measures as in 2020. There were national Medicaid benchmarks for 8 of those measures. One Care provider performance exceeded national averages for 7 of the 8 measures.

For the two measures in 2019 with no national benchmarks, OneCare's 2019 performance was compared to its 2018 performance. For both measures, performance improved in 2019. Perhaps most encouraging, for 5 of the 10 total measures there was statistically significant improvement from 2018 to 2019.

The Department is hopeful that as the public health emergency abates, and as providers are able to return their focus to preventive care and chronic disease management, and as Vermonters feel more comfortable accessing important care, quality results will return to previous levels. The Department will continue to assess OneCare's performance carefully in the coming years and will resume linking quality performance to financial performance.

Collaborating on Residential Substance Use Disorder Treatment Episodic Payments

The Vermont Department of Health and DVHA are collaborating on a payment reform project that transitioned Vermont Medicaid payments to residential substance use disorder (SUD) treatment providers from a per diem rate to an episodic payment).[23] An episodic payment was selected as it would:

- provide a framework to pay for outcomes rather than discrete services;
- incentivize innovation and cost-containment through increased provider flexibility; and
- ensure financial stability through the delivery of more predictable payments.

The episodic payment covers the entire episode of care, which includes both the residential detoxification and the residential treatment, with pharmaceutical benefits continuing to be billed separately. The payment covers the full length of stay, from pre-admission through discharge, and all providers and services utilized for treatments at the facility. The payment model includes eight potential episodic payment rates. The amount of the payment is determined by two factors: the primary diagnosis and a co-morbidity. This multifactored episodic rate was designed to incentivize providers to admit only those patients that need the full resources of residential care and only for a medically necessary length of stay, thereby promoting the good stewardship of public resources and ensuring people receive appropriate types and levels of care.

Prior to January 1, 2019, Vermont Medicaid reimbursed SUD residential providers based on rates separately negotiated by each provider, resulting in three different per diem rates for the same services. Through payment reform change, Vermont Medicaid now accounts for variations in populations and acuity in a way that is consistent throughout the state and across providers and better aligns with federal requirements that State Medicaid agencies pursue payment structures in which all payment rates are "consistent with efficiency, economy, and quality of care" (42 CFR § 447.200, Payments for Services, Payment Methods: General Provisions) and that the payment is (a) based on the utilization and delivery of services, and (b) directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract (42 CFR § 438.6(c)(2)).

Because this payment reform initiative was implemented in January 2019, the public health emergency did not impact the project start date. However, it resulted in a delay in the implementation of the value-based payment component of the project as providers prioritized delivering residential services safely during the pandemic. Providers reduced admissions and maintained lower census during the pandemic along with incurring additional costs. These factors have contributed to challenges with gathering comparable data in order to effectively adjust rates and set outcome measures.

[23] Medicaid Delivery System Reform Report (Submitted January 15, 2021).

Residential SUD payment reform program implementation continued as expected in 2020, with monitoring of results on key program indicators underway. **An analysis of data since the start of the program indicates that length of stay is declining. Since the baseline year of 2018, the residential treatment program has seen a 23.8% reduction in the average length of stay** (see Table 3 below for provider-level and statewide results).

Table 3: Average Length of Stay by Calendar Year (CY) and Provider

	CY2018	CY2019	CY2020 (as of December 21st)
Provider	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*
Recovery House	14.51	12.39	12.49
Valley Vista: Vergennes	19.56	16.01	14.07
Valley Vista: Bradford	18.12	16.03	14.70
Statewide	17.97	15.03	13.69

The Department of Vermont Health Access and the Department of Health believe that this result can be at least partially attributed to the introduction of the new payment model, reduction in administrative burden (e.g., removal of the requirement for concurrent review) allowing more time for direct care by clinical staff, improved discharge planning at the facilities, and better access to outpatient services, including medication assisted treatment. It is important to note that results during the COVID-19 public health emergency should be interpreted with caution; it is possible that COVID-19 changed the way people decided to access services, in terms of timing, type of service, duration of service and/or whether they chose to access services or not. The COVID-19 public health emergency also impacted staffing at residential treatment programs.

The Department of Health and DVHA paused efforts to refine and implement a value-based payment component due to the COVID-19 public health emergency, as noted above. In future years, the intent is to create an opportunity for residential treatment providers to earn value-based payments by demonstrating improved outcomes in certain areas. Measures under consideration include:

- Clients initiating outpatient treatment within seven days of discharge;
- Reducing readmissions (90- and 180-day); and
- Clients visiting a Primary Care Physician within 30 days of discharge.

Summary Overview: SUD Residential Treatment Payment Reform	
Program:	SUD Residential Treatment
Impacted Providers:	• Valley Vista: Vergennes • Valley Vista: Bradford • Serenity House
Impacted Beneficiaries (CY2020)	~1050
Funds allocated for new payment model (CY2020)	~$4,060,000
Type of Payment Reform:	Per diem rate to episodic payment
Implementation Date:	January 1, 2019

Partnering on Children and Adult Mental Health Payment Reform

The Department of Mental Health (DMH) and DVHA have partnered during the past three years on a payment reform project that has changed the Medicaid payment model for the state's Designated Agencies (DAs) and Pathways Vermont (a Specialized Services Agency or SSA) for a wide array of mental health services.[24] In January 2019, after extensive planning and design work, the payment model for children and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service) to a monthly case rate.

Performance year 2020 saw a continuation of the case rate model under which agency-specific case rates are calculated for each agency's unique child and adult populations, based on the agency's mental health allocation from DMH and its historical DVHA fee-for-service expenditure. **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 during the month, as monitored through encounter data submissions.**

Value-based payments for this program are made through a separate quality payment. During each measurement year, DMH withholds a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model uses three types of performance metrics to assess the quality and value of services:

- **Monitoring Measures** to assess health and access to care of populations and/or catchment areas. Monitoring measures do not impact the distribution of value-based payments.

[24] Medicaid Delivery System Reform Report (Submitted January 15, 2021).

- **Reporting Measures** to establish a baseline and/or gather data. Reporting measures do impact the distribution of value-based payments according to an agency's ability to meet specific reporting criteria.
- **Performance Measures** to assess an agency's work and/or outcomes of work. Performance measures do impact the distribution of value-based payments according to the agency's ability to meet specific targets and/or outcomes.

The key goals of mental health payment reform, including increasing provider flexibility to meet the needs of Vermonters and increasing predictability and stability of payment, remain unchanged. As DMH and DVHA close out 2020 and move into the third year of the case rate model, the experience of both the Agency of Human Services and providers in operating the model continues to grow and program operations continue to be routinized. Initial implementation of the case rate model represented a significant shift in operational protocols for DMH. Impacts to core business functions (ranging from the merging of multiple discrete program and policy manuals into a single unified mental health provider manual, to the marrying of paid and encounter claims in a single claims processing system, to shifts in historical accounting and reconciliation practices) affected staff across nearly every unit within DMH. While these changes require hard work and dedication from all involved, they also represent opportunities for strategic improvements to long term program and payment operations.

The COVID-19 pandemic, beginning in early 2020 and continuing through 2021, introduced additional and novel challenges for advancing the mental health system of care. Vermont's mental health care system has adapted to changing utilization patterns, economic shifts, service delivery guidelines, and workforce capacity fluctuations as it has become necessary to ensure a public-health-informed response for all Vermonters. While some COVID-19 impacts are short term in nature, others may persist over the longer term. Factors such as changes in caseload, the intensity of individual needs and the cost of delivering mental health services are evolving and have the potential to influence future iterations of the payment model.

In the next phase of work on the mental health payment model, DMH and DVHA will continue to collaborate with providers and member recipients to evolve aspects of the payment model and rate setting methodologies, with an eye toward further increasing accountability, transparency, and equity. Finally, an important program accomplishment is that providers are now successfully submitting encounter claims to the Medicaid Management Information System (MMIS), which allows the State to monitor service delivery and other aspects of performance.

Summary Overview: Children's and Adult's Mental Health Payment Reform	
Program:	Children's and Adult's Mental Health
Impacted Providers:	• Designated Agencies • Pathways (Specialized Services Agency)
Impacted Beneficiaries:	~13,700 (~6,500 in child program and ~7,200 in adult program)
Funds allocated for new payment model (CY2020)	~$97,100,000 (~$40,300,000 for child case rates and ~$56,800,000 adult case rates)
Type of Payment Reform:	Fee-for-service to a monthly case rate
Implementation Date:	January 1, 2019

Designing and Developing Developmental Disabilities Services Payment Model Options

The Department of Disabilities, Aging, and Independent Living (DAIL) and DVHA have been working on a complex and comprehensive payment and delivery system reform project to improve data on services provided, ensure consistent assessment of individuals' needs, and transition from the current Developmental Disabilities Services (DDS) home- and community-based services (HCBS) payment model to a new form of payment for individuals with intellectual and developmental disabilities.[25] The goal 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. This project has several objectives:

- Align with and inform a potential 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 State Auditor's Report to improve the State's oversight of Designated Agencies;
- Improve the validity and reliability of needs assessments through use of a standardized assessment tool;
- Ensure submission of encounter data to the Medicaid Management Information System (MMIS) 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.

[25] Medicaid Delivery System Reform Report (Submitted January 15, 2021).

Representatives from the State, provider network, individuals, family members, and other stakeholders have been working together on this project since 2018 within a structure that consists of three work groups and an advisory committee.

The COVID-19 public health emergency has had a significant impact on this project. The COVID-19 response effort was DAIL's most critical priority during most of 2020, and that prioritization persisted into 2021. Work on the project was paused for about six months. Nonetheless, progress was been made on the standardized assessment and encounter data workstreams during the latter half of 2020 and into 2021; more detailed information on that progress is available in the Medicaid Delivery System Reform report. [26]

High-Technology Nursing Program Payment Reform Project Implements a New Payment Model to Address Individual Needs and Access to Services

The Vermont Department of Health and the Department of Disabilities, Aging, and Independent Living (DAIL) each manage high-technology nursing programs: The Department of Health for children and DAIL for recipients over the age of 21. These programs offer in-home nursing care for individuals with complex medical needs in support of their choice to remain in their homes and communities. Vermont's home health agencies and visiting nurse associations are the high-technology nursing providers at the focus of this payment reform project. High-technology nursing services represent critical supports for the individuals and families that need these services. The Social Security Act requires state Medicaid programs to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to all Medicaid eligible individuals under age 21, which includes medically necessary high-technology nursing services. Adults also rely on the high-technology nursing program to remain at home. Nursing shortages and the complexity of the services can make it challenging for home health agencies to provide staffing for all of the authorized hours. In response to these challenges, the Department of Health and DAIL have engaged with providers, advocates, individuals receiving services, and families to develop a multi-faceted approach to address individuals' needs for and access to high-technology nursing services. In March of 2020, the high-technology nursing services payment reform project, a collaborative effort between the Department of Health, DAIL, and DVHA, was initiated as one component of the broader approach. High-technology nursing payment reform efforts are focused on the development of a new payment model as one mechanism to help achieve the overarching goal of ensuring access to authorized services. A new payment model should:

- Support improved access to services;
- Be developed in collaboration with stakeholders;
- Be based on accurate, verifiable, and reliable data; and

[26] Medicaid Delivery System Reform Report (Submitted January 15, 2021).

- Include relevant monitoring and performance measures.

Payment model design is expected to be complete in 2021; detailed information on the project's progress is available in the Medicaid Delivery System Reform report.[27]

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.

Implementing MABD Automatic Renewals: Pilots Renew Approximately 850 Vermonters in the First Three Months, Saving Vermonters From Completing a New Application Annually

Under the Integrated Eligibility and Enrollment program, a Medicaid for the Aged, Blind, and Disabled (MABD) compliance project has pilots in progress; 850 Vermonters were automatically renewed in the first 3 months. Automatic renewals save Vermonters from filling out a new application every year and save application processing time for State of Vermont staff. This project focused on implementing an "ex parte" renewal process for MABD enrollees and on streamlining the renewal process for those who can't renew "ex parte." In an ex parte redetermination, the State of Vermont performs an eligibility redetermination based on available electronic information so that the State can complete the redetermination to the maximum extent possible from available

[27] Medicaid Delivery System Reform Report (Submitted January 15, 2021).

information to ease the burden on enrollees. The project team has been working with the ACCESS IT staff to build a report to facilitate the ex parte renewal process. The only Medicaid renewals the Department is processing during the federal COVID-19 public health emergency are those that are considered "ex parte."

Implementing the Federal American Rescue Plan Act's Expanded Subsidies and Outreach Efforts to Ensure Vermonters were Aware and Acted on the New, Lower Costs for Health Insurance

The American Rescue Plan became law on March 11, 2021, and significantly expanded eligibility for the Premium Tax Credit. The expanded subsidy provisions of the American Rescue Plan Act will make health coverage more affordable for Vermonters enrolled through the State's marketplace for health insurance in 2021 and 2022.

These changes are effective through the end of calendar year 2022 only, absent further federal legislation:

- **Increased Premium Tax Credit**: This reduces the percentage of household income that customers are expected to pay toward health insurance premiums, i.e., the federal tax credit amount available is increased. For example, the new contribution limits make certain qualified health insurance fully subsidized for households with income up to 150% of the Federal Poverty Level (FPL), caps payments on the benchmark plan premium at 2% of household income for those up to 200% FPL, and 8.5% for those at 400% FPL (the Affordable Care Act's upper limit for Premium Tax Credit eligibility).
- **Cliff removal**: It removes the premium subsidy "cliff" of 400% FPL by making the Premium Tax Credit available for households of any income, calculated based on an 8.5% contribution limit for the benchmark plan premium.

The expanded subsidies available through the federal American Rescue Plan Act for customers enrolling in qualified health plans through the Marketplace required process changes, system changes, and robust communication plan development to support a successful implementation (see Toolkit, Press Release, 12 Facts to Know, Plan Comparison Tool, Frequently Asked Questions, previous press coverage).[28]

[28] Vermont Communications Toolkit for the American Rescue Plan Act.

Vermont's system changes were complete in the summer of 2021. As in the past, Vermonters can take the subsidy as an advance payment in the form of a discount on their monthly health insurance premium, or they can take some or all of it when they file their federal taxes. Vermonters took action, as captured in the 2021 Final Marketplace Special Enrollment Period report.[29,30]

Tens of thousands of Vermonters can pay less for health insurance purchased through Vermont's health insurance marketplace than they did previously. In fact, a new national report shows that Vermont marketplace customers are saving, on average, $186 per consumer per month – making Vermont's savings the L A R G E S T in the nation and nearly T R I P L E the national average.

It represents a 62% reduction in those Vermonters' monthly payment, though we note that the change in Vermonters' net payments will be slightly different since the federal report evaluates the change in net premiums after federal subsidies but before state subsidies. In any event, many Vermonters who took advantage of the new subsidies to pay lower premiums are paying less than half what they were paying a few months ago. That's a significant infusion of funds for Vermont families during these difficult times.

For 2022, Vermonters who sign up through Vermont's health insurance marketplace may qualify for subsidies if they are in a single plan with income up to $105,000. If they are in a family plan, they may qualify with income up to $297,000. DVHA's annual renewal notice tells members the maximum subsidy they can take as a discount on their bill. The letter also tells them how they can apply the expanded subsidy (through online self-service or by phone). In addition, the Customer Support Center is open 8am to 5pm Monday to Friday throughout Open Enrollment to help explain the options to members.

[29] https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf
[30] The American Rescue Plan Act waives excess Advance Premium Tax Credit repayment for 2020. While people who under-estimate annual income normally have to repay the excess tax credit when they file their taxes, the Federal government has recognized that there was a high degree of economic uncertainty in 2020. Therefore, they granted a "repayment holiday" for 2020. More information will presumably be coming from the IRS regarding how they will refund taxpayers who already filed their 2020 taxes and reconciled their premium tax credit overpayment at that time. Concerned members are encouraged to ask their tax preparer or call the IRS directly.

Successfully Transitioning Health and Dental Plan Premium Responsibilities to the Commercial Insurance Issuers – A Payment Change for 2022 Based on Customer Feedback

Customers of Vermont's health insurance marketplace experienced a change in who they pay for their 2022 health and dental insurance.[31] Previously, customers paid one monthly bill to Vermont Health Connect. Beginning with 2022 health and dental plans, customers will send separate payments directly to their insurance companies. This transition – referred to as the Premium Processing project, under the Integrated Eligibility and Enrollment program – was a result of customer requests to pay their insurance company directly, removing the State of Vermont from the financial relationship between a Vermonter and their insurance company. This project involved significant information technology work to change our current system and development of a robust communication plan.

The Premium Processing project's communication campaign asked customers to stop paying Vermont Health Connect. The campaign had over a 98% success rate, meaning that only 284 customers attempted to send payments to Vermont Health Connect for their 2022 health and dental insurance.

Communications materials were developed collaboratively with Blue Cross and Blue Shield of Vermont, MVP Health Care®, Northeast Delta Dental, the State's Chief Marketing Office, the Office of the Health Care Advocate, and in consultation with the Medicaid and Exchange Advisory Committee. Two sets of communications – one for awareness of the change in the initial communications phase, and one for immediate attention to encourage action – were developed and distributed as notice stuffers, postcards, posters, and social media graphics.

[31] https://info.healthconnect.vermont.gov/premiums

Awareness:

Immediate Attention:

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 2022 Plan Comparison Tool 20,724 times between the first day of Open Enrollment, November 1, and December 15th, 2021 when Open Enrollment reached its first deadline this year. This year, Open Enrollment was extended, with December 15, 2021 being the first deadline for customers to enroll in health and dental plans for coverage that begins January 1, 2022; from December 16, 2021 – January 15, 2022, customers can enroll in health and dental plans for coverage that begins February 1, 2022. It should be noted that overall use of the 2022 Plan Comparison Tool increased during this year's Open Enrollment period when compared to the same time period as last year. In fact, between October 15, 2021 (when the 2022 Plan Comparison Tool went live) and the end of December 2021, Vermonters visited the Plan Comparison Tool 29,122 times (an 11% increase over last year). As a reminder, the Department maintained continuous health coverage through Medicaid and opened a COVID-19 Special Enrollment Period again in 2021 so that Vermonters who were currently uninsured could enroll into health insurance. As a result, uninsured Vermonters did not need to wait until the annual Open Enrollment period to obtain health insurance.

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 integrating the teams responsible for providing assistance for Vermonters who are seeking to enroll 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 casualty, estate, trust, and Medicare recovery. 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. In state fiscal year 2021, the Department's coordination of benefits activities resulted in nearly $984,707 dollars from casualty recovery and $352,297 from estate recovery.[32]

[32] Estate recovery was impacted by the backlog in probate courts in 2020 and 2021; state fiscal year 2022 recovery is already at nearly $557,308.

Pursuing CMS Certification for the Health Information Exchange

The Department began the process of pursuing certification for its health information exchange; certification is important as it generally results in enhanced federal financial participation for ongoing maintenance and operation costs, e.g., increasing federal financial participation to 75/25 federal/state (from 50/50 federal/state). The Centers for Medicare and Medicaid Services (CMS) completed its final certification review of the health information exchange in November 2021 and indicated that the State of Vermont "outshined the other states" during the review process.

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.

Verification of Individuals Indicating Receipt of Unemployment During 2021, Eligibility for the Highest Tax Credit under the American Rescue Plan Act

The Department collaborated with the Department of Labor to verify receipt of unemployment for approximately 1,400 Vermonters; these Vermonters are eligible to receive the highest tax credit under the American Rescue Plan Act. The Department mailed notices to 411 Vermonters whose receipt of unemployment could not be verified with the Department of Labor. Customers were asked to respond to the notice by September 23, 2021, with proof that unemployment was received. If proof was received, the customer continued to receive the unemployment-specific tax credit for their health insurance through the end of 2021. If proof could not be provided and/or a response wasn't received, customers lost the unemployment-specific tax credit but could still receive a tax credit based on their actual income to help pay for health insurance.

Departmental Contract and Grant Management for Improved Vendor Relations

The Department has carefully studied its contract and grant management procedures in recent years to improve vendor relations whilst still ensuring compliance with federal and state requirements. Key performance indicators showed that the Contract and Grants unit has remained successful at processing invoices on-time and in accordance with agreement payment terms after moving solely to electronic agreement development, routing, and invoice processing in April of

2020. In state fiscal year 2021, the median number of business days to develop an agreement was, on average, 34 days. Additionally, the median number of days agreements were routing as part of the internal state review process and the median number of days an agreement is routing for reviewer signature both remained under, on average, 10 days. These averages fall in line with performance expectations for the Department. The Department was able to get required prior State and federal approvals for all agreements ending on June 30. During state fiscal year 2021, the Department continued to support the COVID-19 response efforts by executing and amending COVID-19 related 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.[33] 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.[34] 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 7,587 providers have newly enrolled or revalidated through the module in 2021, with an average requirement of 21 minutes of provider time to 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 tailored, one-on-one assistance and provides a cornerstone of support for Vermonters seeking enrollment help when applying for health insurance plans. In 2021, the Assisters continued their work both in-person and virtually, and the Program continued to utilize a new suite of online tools launched in response to the COVID-19 public health emergency. These tools included a Resource Center, which serves as an information source, and a virtual training platform.

The annual Assister conference was convened virtually for the second year in a row. In addition to key information and updates delivered by Department of Vermont Health Access staff, guest speakers

[33] 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).
[34] https://legislature.vermont.gov/Documents/2018/Docs/ACTS/ACT116/ACT116%20As%20Enacted.pdf

focused on advancing health equity. Attendees had opportunities for interaction, questions, and dialogue. Conference attendance and engagement continued to be very high with the majority of certified Assisters in attendance. Assisters have continued to support Vermonters throughout the pandemic to help navigate changes to policies, payments, and opportunities to save money on their health insurance.

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 department 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 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.

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, the Department's Health Access Eligibility and Enrollment unit administers Vermont's state-based health insurance exchange. On September 29, 2021, the Department received formal notification from the Centers for Medicare and Medicaid Services (CMS) that CMS had completed their review, had no observations regarding the 2020 State-based Marketplace Annual Reporting Tool nor any outstanding action items from prior submissions (meaning Vermont is in good standing). 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 2021, this step was operated with a single, clean, automated run that took care of 99% of eligible cases for the **fourth 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 during the next week. For Vermonters, this means that Vermonters can log into their online accounts on the very first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they choose to do so.

Completing the Federal Open Enrollment Readiness Review of Vermont's Health Insurance Marketplace

The Department's planning for Open Enrollment begins well ahead of Open Enrollment beginning on November 1 each year. This year, along with the traditional Open Enrollment planning activities, activities for Open Enrollment also included the Premium Processing transition (in effect for January of 2022). The Department delivered its annual presentation to CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on September 13, 2021 as part of the federal government's Open Enrollment Readiness Review for state-based marketplaces. The Department answered all of CCIIO's questions and received a letter confirming that the federal government deems Vermont ready for Open Enrollment. Nationally, the unusually large number of amended tax returns for Tax Year 2020 is expected to result in an increase in income verification work for health insurance marketplaces in 2022. The Department is working with its federal partners, other marketplaces, and system integrator Optum to assess the situation and prepare for

the work. Both CMS and the IRS have indicated that they will support flexible approaches that will work for marketplace operations and provide a positive customer experience.

2022 Qualified Health Plans Certified by DVHA, Completing Final Step in Annual Certification Process

Once the Green Mountain Care Board releases its final decision on rate requests submitted by the commercial insurance companies and rates are finalized, the Department of Vermont Health Access reviews Qualified Health Plans for certification. No new plans were offered for 2022; as a result, DVHA re-certified all of the existing plans. The Department completed the final step in the annual certification process for 2022 Qualified Health Plans in August 2021. Certification letters were sent to the 3 issuers on August 30, 2021.

Effectively Managing the Pharmacy Benefit and Pharmaceutical Spend

The Pharmacy unit managed $231.2 million in total gross drug spend in state fiscal year 2021 (July 1, 2020, through June 30, 2021). Of that total, $225.8 million was spent on Medicaid members, including those dually eligible for Medicaid and Medicare, and $5.4 million was spent in the Vermont pharmaceutical assistance program, VPharm. The Department reimbursed pharmacies $225.8 million for all prescriptions for Medicaid members (including dual eligible members) in state fiscal year 2021 compared to $195 million in state fiscal year 2020. This represents a significant increase in gross expenditures of approximately $31 million dollars, representing a 15.7% increase over the previous fiscal year. The Department invoiced approximately $144.7 million dollars in federal and supplemental rebates, representing 62.6% of the total gross drug spend. Gross drug spend reflects what the Department of Vermont Health Access paid to both in-state and out-of-state pharmacies enrolled in the network. Approximately 36% of adults and 17% of children utilize the drug benefit programs each month.[35]

CMS Certification Review of Electronic Visit Verification: Exploring Options for Claims with Missing Data Elements

The Department of Vermont Health Access, in partnership with the Department of Disabilities Aging and Independent Living (DAIL) and Department of Health, has been in the process of implementing Electronic Visit Verification (EVV) for in-home services funded by Vermont Medicaid to comply with federal requirements set forth in the 21st Century Cures Act (Cures Act).[36] In order to implement an Electronic Visit Verification system, Vermont Medicaid has been working with Sandata Technologies to provide a state-sponsored Electronic Visit Verification solution. In partnership with Gainwell Technologies, the Vermont Medicaid system will capture the required data.[37] For reference, Electronic

[35] Pharmacy Best Practices and Cost Control Program Report (October 30, 2021)
[36] https://dvha.vermont.gov/initiatives/electronic-visit-verification
[37] https://dvha.vermont.gov/initiatives/electronic-visit-verification/what-vermont-doing-implement-evv-system

Visit Verification for personal care services was required to be in place by January 1, 2021 and for home health agencies by January 1, 2023. Vermont requested a one-year extension for personal care services.

The Centers for Medicare and Medicaid Services (CMS) reviewed the Electronic Visit Verification solution for certification on October 14, 2021. In preparation for the review, the Electronic Visit Verification (EVV) team prepared by focusing on ensuring a high adoption rate among users, particularly in client-directed services programs (managed by ARIS). Following the certification review, CMS requested additional information regarding the process and date by which Vermont Medicaid will begin enforcing claim recoupments for claims with missing data. The Department's Program Integrity unit has been working to finalize the business processes for resolution and recoupment, with the EVV team working closely with the home health agencies to ensure the best possible outcomes.

Improving Access to Hepatitis C Medications

Following guideline changes issued by the American Association for the Study of Liver Diseases (AASLD) and Infectious Disease Society of America (IDSA) for simplified Hepatitis C Virus (HCV) treatment for naïve adults without cirrhosis and to support expanded access to Hepatitis C Direct Acting Antivirals, the Department will no longer require dispensing by an accredited specialty pharmacy for Direct Acting Antivirals medications. Effective July 9, 2021, prescriptions for these medications can be filled at any Vermont Medicaid-enrolled pharmacy. This will improve access to these medications and simplify prescription ordering for providers. A new simplified regimen prior authorization form has been posted on the DVHA Pharmacy website and a communication will be sent to pharmacies and providers this week.

Other Activities to Support Access to Health Insurance and Health Care Services

Coordination of Health Insurance for Afghan Evacuees

The Department of Vermont Health Access has been coordinating with other state and community partners to prepare for the arrival of up to 125 Afghan Evacuees. As part of the State's preparation, the Department has been working on processes and communication materials to clearly communicate several key points about health insurance for this population:

- **Most Evacuees can get Medicaid.**
  If approved, Medicaid starts on the first day of the month the application was received.
  Do they have unpaid medical bills? Medicaid can sometimes go back for up to 3 months.
  But they must meet the rules, including living in Vermont.

- **What if they can't get Medicaid?** If they meet the rules, they may get:
  Refugee Medicaid Assistance -- covers the same health care services as Medicaid. It starts the month they have immigration status and lasts for 8 months.

A Qualified Health Plan -- this is private health insurance through Vermont Health Connect. They may also get help paying for their health insurance.

A one-page communication document was developed for community partners inclusive of additional information on "How to Apply for Health Insurance" and contact information for a state staff person who can support inquiries related to the application process for Afghan Evacuees.

Supporting Vermont's Essential Health Benefits Benchmark Plan Analysis Funded by Grant to, and Work Led by, the Department of Financial Regulation

Last winter, the Department supported the Department of Financial Regulation in applying for a market stabilization grant from the Centers for Medicare and Medicaid Services (CMS) to conduct a study and analysis of Vermont's essential health benefits benchmark plan. On September 15, 2021, CMS announced that Vermont had received an award of $663,538 with a 24-month budget period. This will support the analysis work in process that the Department of Financial Regulation, Department of Vermont Health Access, and many other stakeholders are doing to comply with Act 74 (2021).

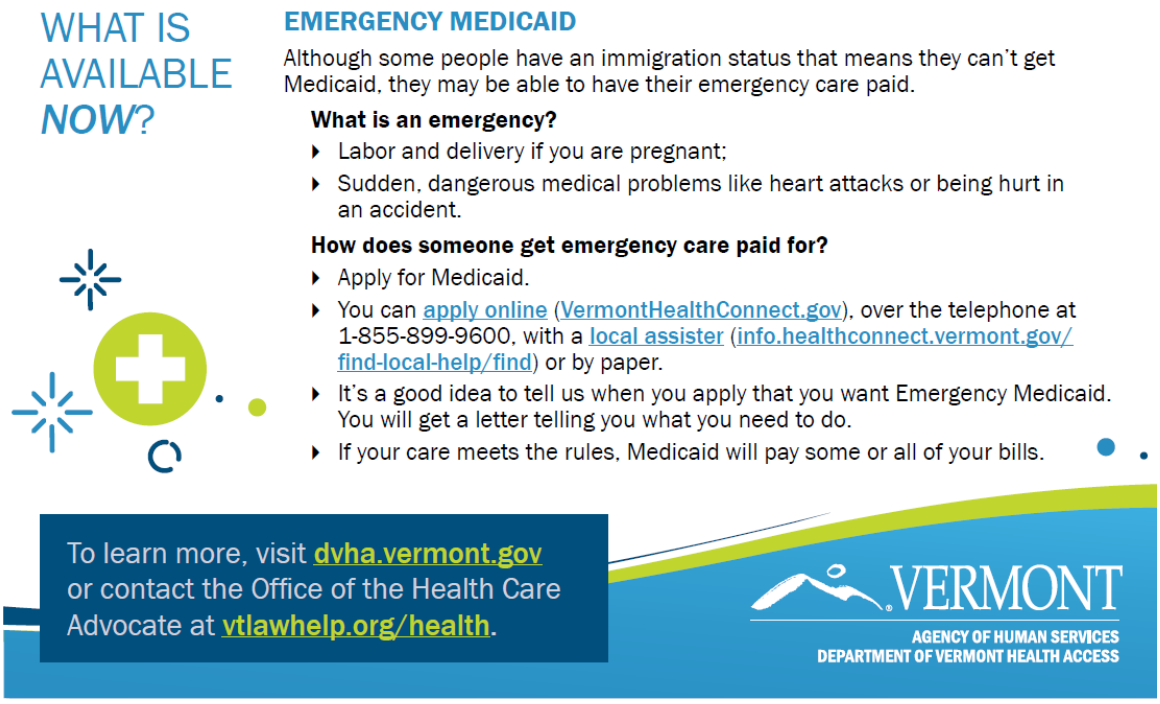
Implementing the State Fiscal Year 2022 Provider Funding Opportunity for Health Care Providers Delivering Health Care Services to Pregnant Individuals and Children who are Eligible for Medicaid EXCEPT for their Immigration Status (Act 48 of 2021)

As the Department worked through the process for implementing the provider funding opportunity for state fiscal year 2022 in accordance with the requirements of Act 48 of 2021, it became apparent that opportunity would need to be administered through a grant opportunity for providers and would need to be implemented in phases.[38] As a result, the Department worked with stakeholders and the State's Chief Marketing Office to develop a communication informing providers that the opportunity would be coming soon given the amount of time required to operationalize. Health care services delivered for dates of service on/after July 1, 2021 are eligible for funding through both Phase I and Phase II of the grant opportunity. The grant funding provides a bridge to the state-funded program (the Immigrant Health Insurance Plan) that will begin during the summer of 2022 (if funding is appropriated for that purpose).

Providers/Practices are strongly encouraged to read the Frequently Asked Questions document.[39]

[38] Act 48 of 2021
[39] Frequently Asked Questions.

The communication also emphasized the existing availability of Medicaid to pay for emergency medical conditions/services to build awareness amongst stakeholders and community partners.



The State of Vermont released Phase I of the grant opportunity for providers to receive funding for delivering health care services to pregnant individuals and children who would be eligible for Vermont Medicaid EXCEPT for their immigration status in accordance with Act 48 (H.430) of 2021. **Phase I involved collaboration with the State's Blueprint for Health program and its Administrative Entities across the State; this partnership was essential for attempting to reduce provider administrative burden associated with the grant funding opportunity**.[40]

Grant agreements were and are available for Blueprint for Health Administrative Entities to finalize details of their participation with the State to flow this funding to health care providers.
More specific information about the community arrangements in each health service area are listed below and the Act 48: Provider Funding Opportunity website is updated as additional grant agreements are executed.[41]

Grant Agreements Executed to Date:

Gifford Health Care – Covering all Gifford Health Care providers.
North Country Hospital – Covering all North Country Hospital providers.
Northeastern Vermont Regional Hospital – Covering all Northeastern Vermont Regional Hospital providers as well as Northern Counties Health Care primary care and dental providers.
Northwestern Medical Center – Covering all providers in the Health Service Area, including the hospital, primary care, pediatric, and OB-GYN.
Southwestern Vermont Health Care – Covering Southwestern Vermont Health Care providers.
University of Vermont Health Network – Grant execution in process; more information soon.

If the provider is employed by, or has executed a contract with, a Blueprint for Health program Administrative Entity, the funding may be distributed to the provider under a grant agreement between the Department of Vermont Health Access and the Blueprint Administrative Entity if all requirements of Act 48 (2021) and the grant agreement are met. Providers are encouraged to contact their local Blueprint for Health Program Manager if they are uncertain if they are covered under an agreement executed between the Department of Vermont Health Access and the Blueprint Administrative Entity.[42]

Once Phase I was operationalized, the State released Phase II of the grant opportunity for providers not covered by Blueprint for Health Administrative Entities. **For providers who are not covered by their Blueprint Administrative Entity, they may apply for funding directly (Phase II). This will require the provider to execute a separate agreement with the Department of Vermont Health**

[40] https://blueprintforhealth.vermont.gov/contact-us
[41] https://dvha.vermont.gov/information-for-non-citizens/act-48-funding-providers
[42] https://blueprintforhealth.vermont.gov/contact-us

Access. Providers may find this Grant agreement and associated documents at the Vermont Business Registry.[43]

Finally, all Act 48 Provider Funding Opportunity communications continue to promote the availability of Medicaid to pay for emergency care, if eligible, following testimony during the 2021 legislative session that this was not known broadly (short version below).

> "**Emergency Medicaid is Still Available:**
> Although some people have an immigration status that means they can't get Medicaid, they may be able to have their emergency care paid.
>
> **What is an emergency?**
> Labor and delivery if you are pregnant;
> Sudden, dangerous medical problems like heart attacks or being hurt in an accident.
>
> **How does someone get emergency care paid for?**
> Apply for Medicaid.
> If your care meets the rules, Medicaid will pay some or all of the bills."

Scheduled Development Workload for Department's Systems Confirmed to Have Little Capacity for Additional Changes for the Next Year

As part of its testimony related to Act 48 (2021) that established the Dr. Dynasaur-like program for July 1, 2022, the Department testified to the limited capacity for changes to its systems (e.g., eligibility and enrollment, claims processing) resulting in the recommendation that the Program not be effective until July 1, 2022. Based on the currently scheduled development workload over the next 9 months, including the addition of the Act 48 (2021) Dr. Dynasaur-like program, there continues to be very limited capacity to complete any additional, substantial changes to the Department's systems for the next year or more without potentially and negatively impacting the timing of priority initiatives underway. However, the State must also plan for, and be prepared to, accommodate any federal changes necessitating system updates, such as revisions to federal subsidies or Centers for Medicare and Medicaid Services (CMS) direction to move funding from Medicaid investments to the Medicaid program related to the 1115 waiver renewal currently being negotiated.

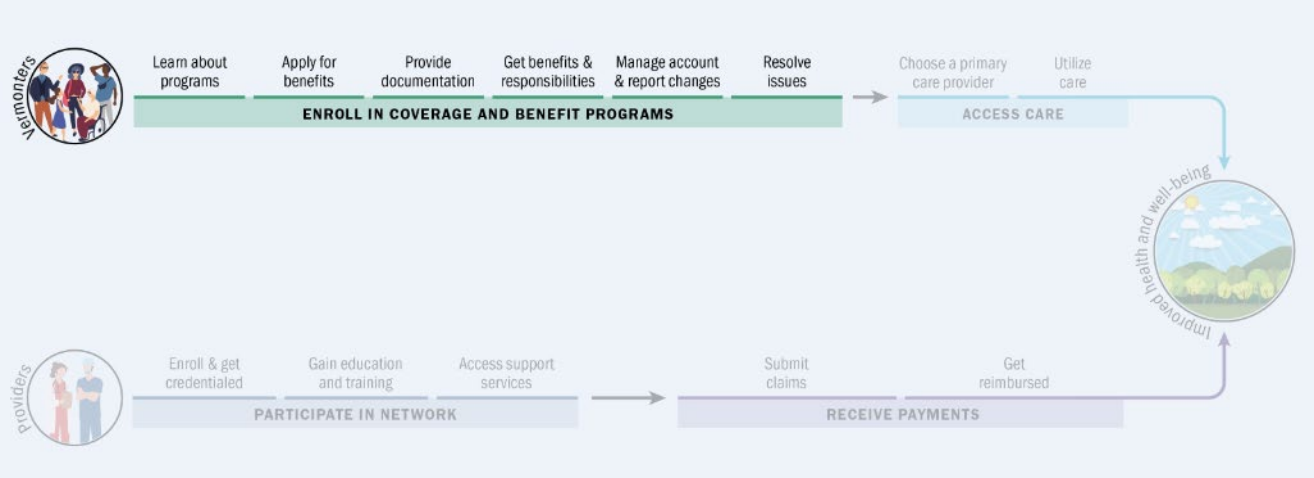
[43] 2021 Act 48 Provider Funding Opportunity

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 2021 (July 1, 2020 – June 30, 2021), more than 250,000 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, 168,983 Vermonters received health insurance through Medicaid (full health benefits), 9,980 Vermonters received pharmacy assistance through Vermont Medicaid to help pay for prescription medications and 4,590 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).[44] As of June 2021, there were 24,124 Vermonters enrolled in Qualified Health Plans through DVHA, with 19,728 of them (approximately 82%) receiving subsidies to help make health insurance more affordable.[45]

[44] Medicaid Program Enrollment and Expenditures Quarterly Report (through June 2021).
[45] Health Coverage in Vermont (as of June 2021).

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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).

<table>
<tr><th colspan="4">Total Medicaid: 183,553[1]</th><th colspan="3">Total Commercial: 71,211</th></tr>
<tr><td colspan="3">Medicaid Health Coverage</td><td>Other Medicaid Benefits</td><td>Vermont Health Connect Qualified Health Plans[2]</td><td colspan="2">Direct from Insurance Companies[3] QHP & Reflective</td></tr>
<tr><td colspan="3">Total: 168,983</td><td>Total: 14,570</td><td>Total: 24,124</td><td colspan="2">Total: 47,087</td></tr>
<tr><td colspan="3">Medicaid for the Aged, Blind & Disabled[4]: 25,786</td><td rowspan="2">Pharmacy Assistance (Only): 9,980</td><td>Total w/ Subsidy[5]: 19,728</td><td colspan="2">Small Businesses: 40,491</td></tr>
<tr><td>Aged, Blind & Disabled Adults: 6,241</td><td>Duals (Medicare & Medicaid): 17,921</td><td>Blind, Disabled Children: 1,624</td><td>State & Federal Subsidy: 14,646</td><td>Federal Only Subsidy: 5,082</td><td>QHP: 30,058</td><td>Reflective: 10,433</td></tr>
<tr><td colspan="3">Medicaid for Children and Adults[5]: 143,197</td><td rowspan="2">Choices for Care: 4,590</td><td rowspan="2">No Subsidy[6]: 4,396</td><td colspan="2">Individuals: 6,596</td></tr>
<tr><td colspan="2">Adults: 77,671</td><td>Children: 65,526</td><td>QHP: 4,153</td><td>Reflective: 2,443</td></tr>
</table>

As of June 2021

1 Medicaid enrollment is from the quarterly Medicaid Enrollment and Expenditure report, is for the state fiscal year-to-date, and reports "ending enrollment," i.e., actual caseload.

2 Health Insurance Marketplace ("Vermont Health Connect") qualified health plan data is from June effectuated coverage from DVHA enrollment reports.

3 Direct from insurance companies enrollment is June effectuated coverage as reported by the insurance companies 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.

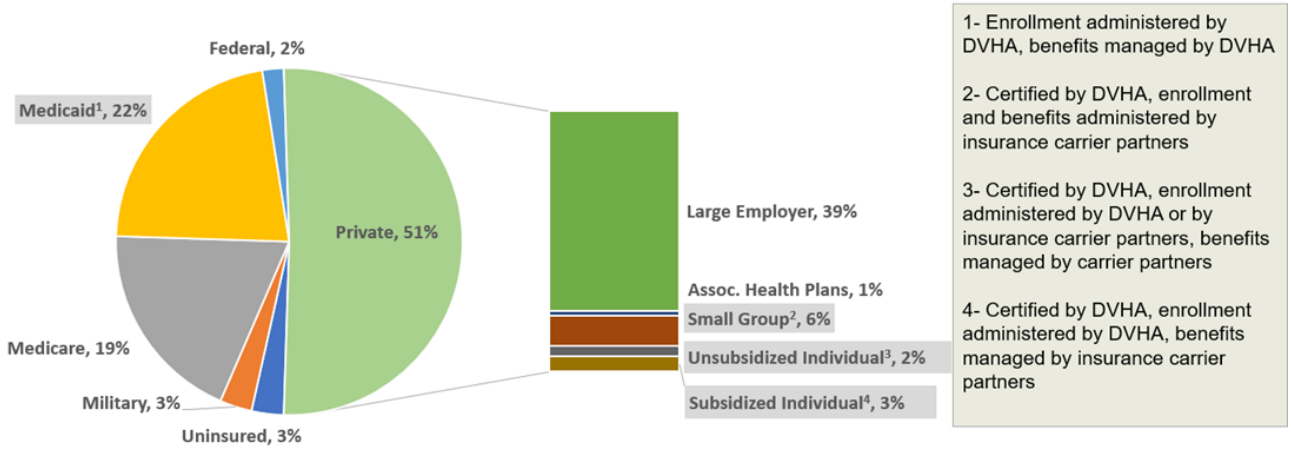
The Health Insurance Landscape in Vermont

In 2021, the next iteration of the Vermont Household Health Insurance Survey was in the field. The results of the new Vermont Household Health Insurance Survey are expected to be released in early 2022. This information will provide a great deal of insight into how the health insurance landscape may have changed and help policymakers to understand the impact of the COVID-19 public health emergency on the insured and uninsured populations.

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).[46] 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.[47] 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.[48]

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.

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



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.

For the 19,800 Vermonters who remain uninsured there are a handful of reasons reported on the 2018 Vermont Household Health Insurance Survey.[49] 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%).

Medicaid and Exchange Advisory Committee

The Department of Vermont Health Access (DVHA) is informed by member and provider 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

[49] https://www.healthvermont.gov/sites/default/files/documents/pdf/VHHIS_Report_2018.pdf

consumers of both Medicaid and Qualified Health Plans, businesses and health care providers.[50] Advisory Committee members are appointed by the Commissioner of DVHA. Importantly, the meetings of the advisory committee are open to anyone to attend. That is, meetings of the Medicaid and Exchange Advisory Committee are open to the public and required to follow Open Meeting law in Vermont. The Committee welcomes community members, especially Medicaid members, Qualified Health Plan members, and Providers participating with the Medicaid program, to share their interest in being considered for open positions.

LEARN ABOUT PROGRAMS

Vermont Medicaid Programs

Medicaid programs provide low-cost or free health insurance 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 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.[51,52] Importantly, health care services must be medically necessary 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 with Vermont Medicaid. State Medicaid programs can assess premium requirements for eligibility and can also 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'

[50] https://legislature.vermont.gov/statutes/section/33/004/00402
[51] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
[52] 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.

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.[53]

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
- Health Homes for chronic conditions.[54]

The voice of Medicaid members is essential for evaluating the impact of the Department's administration of Vermont Medicaid. Hearing from Medicaid members provides the Department with useful information on our members' experience of care related to matters such as: how quickly care can be obtained, whether members perceive they are able to get needed care, how effective the customer service support is perceived to be, and how members rate their Medicaid health insurance overall.[55] It also lets the Department know what could be improved.

Medicaid is required to report out on the results from the experience of care survey the Department administers to collect this information. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey looks at health care performance from the Medicaid member's point of view.The Vermont Medicaid program continues to receive positive feedback from adult members with 85% of those surveyed through the Consumer Assessment of Healthcare Providers & Systems survey giving the plan a high rating (2020 results).[56]

[53] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
[54] Vermont does not cover the following optional benefits: dentures, eyeglasses, tuberculosis-related services.
[55] https://dvha.vermont.gov/quality/experience-care
[56] Vermont Medicaid's Experience of Care scorecard.

In 2020, 91% of surveyed Medicaid members rated Vermont Medicaid's customer service highly for adults and children covered by Vermont Medicaid, indicating that they "usually" or "always" received the information they needed and were treated well by customer service staff. When Medicaid members were asked about their overall rating for their Medicaid health insurance for children, 95% rated their health plan highly.

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. [57,58,59] Financial help is available through federal Advanced Premium Tax Credits (APTC), federal and state Cost-Sharing Reductions (CSR), and Vermont Premium Assistance (VPA). Before the federal American Rescue Plan Act became effective in 2021, federal premium tax credits made premiums more affordable for people with incomes at and less than 400% of the federal poverty guidelines, who were not eligible for other coverage, and additional federal subsidies made 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.

[57] '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

[58] 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.

[59] Vermont's state-based exchange for health insurance was created because of the federal Affordable Care Act and Act 48 of 2011.

In 2021, the American Rescue Plan Act significantly expanded eligibility for the Premium Tax Credit. The expanded subsidy provisions of the American Rescue Plan Act will make health coverage more affordable for Vermonters enrolled through the State's marketplace for health insurance for 2021 and 2022 (throughout each calendar year).[60]

The American Rescue Plan Act's expanded eligibility for the Premium Tax Credit is effective through the end of calendar year 2022 absent further federal legislation. The changes reduce the percentage of household income that customers are expected to pay toward health insurance premiums because the amount of the federal premium tax credit is increased. In addition, the new contribution limits make certain qualified health insurance plans fully subsidized for households with incomes up to 150% of the Federal Poverty Level, places a limitation on the benchmark plan premium at 2% of household income for those up to 200% of the Federal Poverty Level, and at 8.5% for those at 400%.

CMS 2021 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. For the 2021 plan year, there are no Quality Rating System star ratings as the program was temporarily suspended in response to the COVID-19 public health emergency.[61]

[60] More information on the subsidy expansion and Vermont's implementation of the changes under the American Rescue Plan Act may be found in the earlier sub-section entitled, **"Implementing the Federal American Rescue Plan Act's Expanded Subsidies and Outreach Efforts"** under the **"Management of Information Technology Projects"** section of this annual report.

[61] https://info.healthconnect.vermont.gov/compare-plans/qualified-health-plans/2021-quality-rating-scores

Income Eligibility for Financial Help for Qualified Health Plans through Vermont's Health Insurance Marketplace

Vermonters with qualifying incomes may be able to get financial help paying for their health insurance when they enroll through the health insurance marketplace. The health insurance marketplace provides tables on the website to show the type of financial help available. For 2021, there were 2 eligibility tables provided – one for before the American Rescue Plan Act was effective, and another table for after the American Rescue Plan Act.

For more information on 2021 income thresholds for financial help for qualified health plans through the State's health insurance marketplace, visit:

https://info.healthconnect.vermont.gov/compare-plans/eligibility-tables/2021-eligibility-tables

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.[62,63] Healthy Vermonters provides a discount on prescription medications for individuals not eligible for other pharmacy 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.

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

[63] Act 140 of 2020 (H.960), Section 7, directed 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. This expansion would mean that Vermont Medicare beneficiaries with income between 150 and 225 percent of the federal poverty level would have the same pharmaceutical coverage as is provided under the Medicaid program.

Eligibility & Cost-sharing of Programs

Income calculations are based on gross monthly income minus certain qualifying deductions. Qualified Health Plans, advance 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, their insurance coverage. The Vermonter must also continue to pay their bill on a timely basis as required to maintain their health insurance.

Visit the State's website for the eligibility guidelines in effect for income based programs for 2021 to learn more.[64]

Program	Who is Eligible?	Benefits & Cost-sharing[65]
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[66], 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 $9.85 co-payment with Medicare coverage for prescriptions if the member has Low Income Subsidy responsibility.

[64] https://info.healthconnect.vermont.gov/compare-plans/eligibility-tables/2021-eligibility-tables

[65] 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., those 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.

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

		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 $9.85 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 dependent child (non-MABD) or adult under 65 years of age (expanded)	Physical and mental health Chiropractic (limited) Transportation Dental ($1,000 cap/yr.,[29] no dentures) Prescriptions ▪ $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 $9.85 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: 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 Advance Premium Tax Credit (APTC)	Historically, 100-400% federal poverty guidelines, but expanded for 2021 & 2022 (see note to the right), no other Minimum	Premium Tax Credit received in advance monthly to reduce QHP premium or yearly as a lump sum. **For calendar years 2021 and 2022, the federal American Rescue Plan Act expanded eligibility for the premium tax credit to households with an income above 400% of the federal poverty guidelines by lowering the upper**

	Essential Coverage (MEC), e.g., Medicaid	**premium contribution limit to 8.5% of household income for the benchmark plan.**
Federally Required Cost-Sharing Reduction (CSR)	Up to 250% federal poverty guidelines, eligible for advance 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 advance premium tax credit.	Reduces QHP premium
Vermont Cost Sharing Reductions (VCSR)	200-300% federal poverty guidelines, eligible for advance 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

The Department of Vermont Health Access engages with community partners, including hospitals, clinics, agricultural organizations, libraries, pharmacies, and other stakeholders to participate in public events and

conduct outreach in addition to utilizing social and other forms of media. Broad outreach seeks to help Vermonters understand the health insurance options available to them and the purpose of the state's health insurance marketplace. Outreach efforts also focus 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.

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 insurance options through both Medicaid and Qualified Health Plans, the Department of Vermont Health Access serves households with eligibility for either. For households with both Medicaid and Qualified Health Plans, the Qualified Health Plan 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 Qualified Health Plans are renewed through a separate process and receive Medicaid-specific renewal notices.

In state fiscal year 2021, the Department offered multiple virtual health insurance "Town Halls" to provide "Health Insurance 101" opportunities, information on the expanded subsidies under the American Rescue Plan Act, information on Open Enrollment, answer general questions and hear feedback from experiences interacting with Vermont's health insurance marketplace.[67] These events were promoted to existing members and the public through press releases and social media, as well as through partner communication networks, in order to build broad awareness of the new, lower costs for health insurance through the State's health insurance marketplace for calendar years 2021 and 2022.

Finally, 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 at a time and place that works for Vermonters. 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. This resource is especially useful in clearly outlining changes to premiums and the cost sharing under each plan for new enrollments.

APPLY FOR BENEFITS

Once Vermonters decide that they want to apply for health insurance through Vermont's integrated health insurance marketplace, they generally take one of four possible paths to enrollment:

- Apply online at VermontHealthConnect.gov,

[67] Recordings of past Town Halls may be viewed here: https://info.healthconnect.vermont.gov/OE_Communications_Toolkit

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

It is important to note that until 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 of 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. Importantly, this project addresses a Medicaid compliance issue and provides the foundation for additional improvements. The next phase of this effort has started to make this available as a self-serve option for members.

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 Assister	http://info.healthconnect.vermont.gov/find

Applying Online

Applying online can lead to improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow staff to spend less time processing applications and more time delivering on other priorities for Vermonters. Five 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. The Department retired this performance measure after 3 years of monitoring and is now working to understand 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).

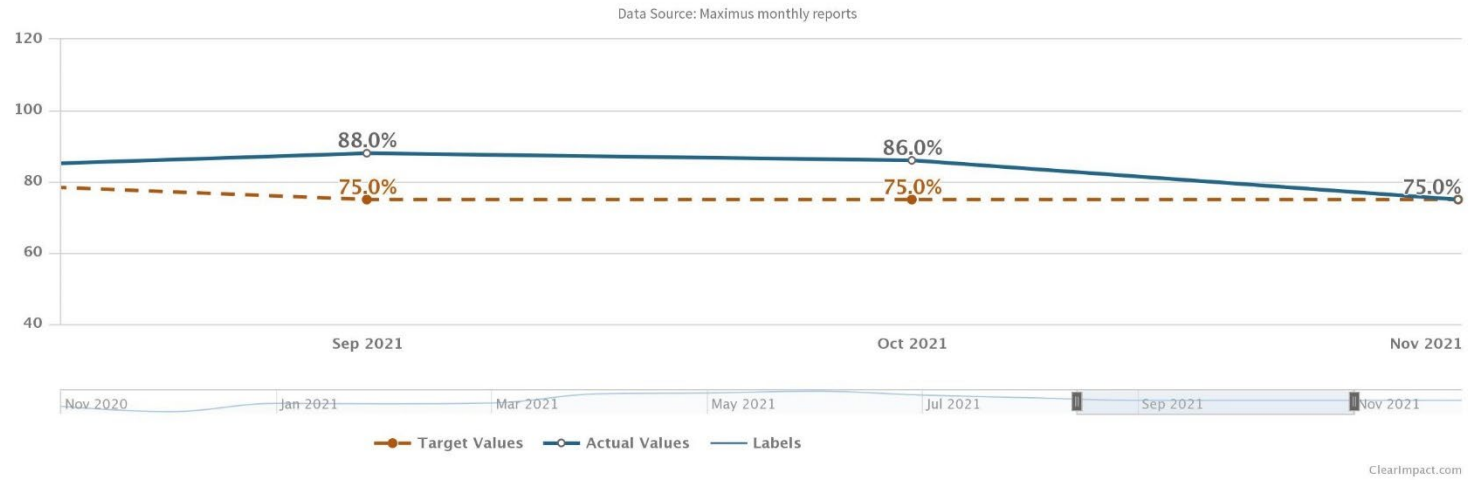
Applying by Phone

Callers to the Department's contracted Customer Support Center continue to experience prompt service overall. However, call volume is the highest during the Open Enrollment period. 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, 2021), 75% of calls were answered within 25 seconds in accordance with contract and despite the increased questions about health insurance subsidy expansion from customers attributable to the American Rescue Plan Act. The Department 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 2021): 75%

Review of the data indicated several factors affecting this measure including: high call volume on Mondays (this has historically been observed due to both Open Enrollment and general Medicaid eligibility questions), staffing recruitment and retention challenges experienced nationwide and locally, and an increased number of questions related to the expansion of the premium tax credit.



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 health insurance. 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 and the next phase of this effort begins to make this available as a self-serve option for members.

Applying with an Assister

The Assister program serves as a cornerstone of the Department's ongoing effort to help Vermonters understand and enroll in the health insurance that best meets their families' needs and budget. The Program fosters collaboration between the State's health insurance marketplace, hospitals, clinics, and community organizations, having helped Vermont dramatically reduce and continue to maintain its low uninsured rate. Paired with the Customer Support Center and online tools, the Assister program provides an additional option of tailored, one-on-one support for Vermonters who may have encountered barriers to enrollment in health insurance.

Vermont's Assister Network consists of more than 110 Certified Application Counselors, Navigators, and Brokers. These Assisters provide in-person and virtual enrollment assistance in all 14 counties of the State of Vermont. 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.

With consideration for the impact of the COVID-19 public health emergency and changing community conditions, when available, in-person Assisters meet Vermonters where they are whether it be a senior center or when they are admitted to the hospital. The Assisters also offer options for meeting virtually, with many individuals preferring to consult with an Assister without even leaving their home. **A large part of what Assisters do through their work results in alleviated stress and reassurance for Vermonters that Vermonters can 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." One-on-one 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 insurance 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 Assister Directory is located on the website for the State's health insurance marketplace: https://info.healthconnect.vermont.gov/find-local-help/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 of Vermont Health Access (DVHA).

Vermont LTC applications are processed simultaneously by the Department of Vermont Health Access (financial eligibility) and the Department of Disabilities, Aging, and Independent Living (the clinical eligibility). Upon receipt of the LTC application, the Department of Vermont Health Access begins the financial eligibility determination process while the Department of Disabilities, Aging, and Independent Living begins the clinical assessment process.

The Department of Disabilities, Aging, and Independent Living performs the clinical eligibility assessment for the Choices for Care, Developmental Disabilities Services, Home- & Community-Based Services, and Traumatic Brain Injury programs and communicates with the Department of Vermont Health Access when the clinical eligibility determination is complete, and a placement has been found. The Department of Vermont Health Access is responsible for issuing the Notice of Decision; the Notice of Decision advises the applicant of approval or denial of their application. If an individual is not clinically eligible, the Department of Disabilities, Aging, and Independent Living sends a Notice of Decision directly to the individual and a copy to the Department of Vermont Health Access.

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. Many applicants have complex financial histories and have hired elder law attorneys to assist them with planning and sheltering their assets. There are complicated rules that address client assets and what types of transfers are allowed. The more complicated applications take a significant amount of staff time to analyze before making a final financial eligibility determination.

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.[68]

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. This can impact the length of time it takes to process an application and also increases the number of applications in process on any given month.

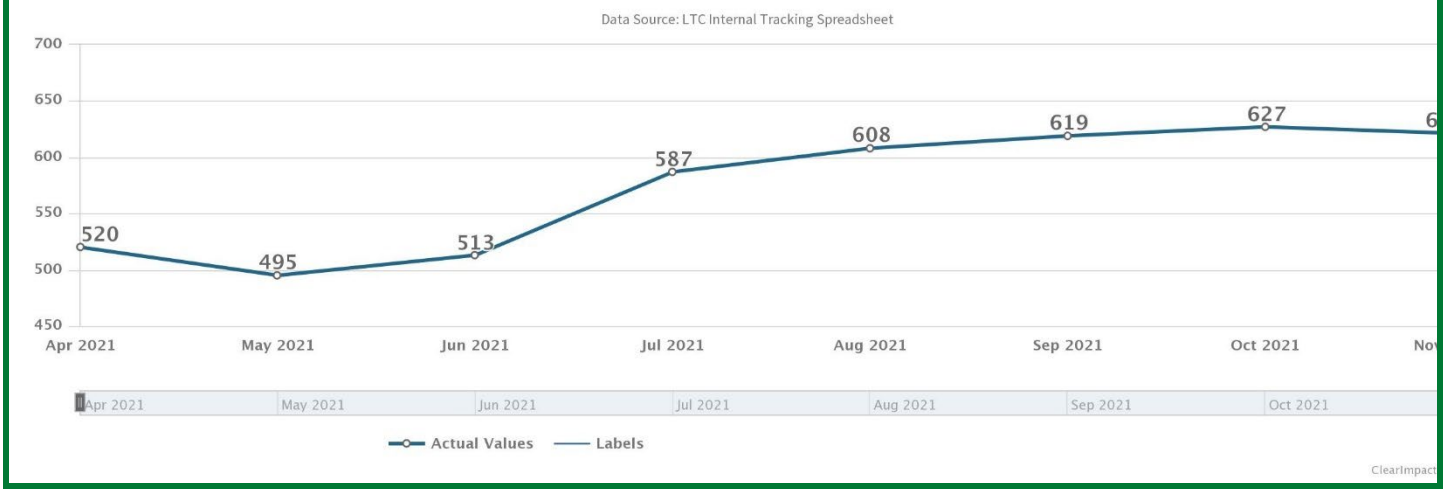
[68] During the federal COVID-19 Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) recognizes that applications may take longer than usual to process. Because of this, CMS advised states that they will not assign an error to Medicaid applications that take longer than 45 days to process during the PHE. States must provide a brief explanation about the PHE delay in the case notes.

Scorecard: The Number of Long-Term Care Applications in Process Per Month

Primary Indicator: Number of Vermonters seeking access to Long Term Care supports and services.

Performance Range (April 2021 – October 2021): 520 – 627 applications in process per month.

Trend: The number of applications in process continues to increase.



Providing Documentation

Regardless of how Vermonters apply for programs, completing verification requirements was historically very challenging and time-consuming. Vermonters often asked internal staff if they could "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, the Integrated Eligibility and Enrollment program implemented a technical solution, the AHS 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 project launched in November of 2019 and successfully 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.[69] 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 in a timely manner. The Department has made significant progress in improving performance, processing requests promptly, 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 surpassing that goal, the target was then raised to 100% in 2018, which the unit continued to meet through November 2020.[70] The results of the performance monitoring indicated successful performance improvement; this measure was subsequently retired from the Unit's performance accountability scorecard.

Scorecard: % of Discrepancy Work Completed in 30 Days (November 2020)	
Target:	**100%**
Current Performance:	**100%**

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.[71] Most of these requests are made by phone to the Customer Support Center. All Vermonters who

[69] 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.

[70] 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.

[71] 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

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 Health Access Eligibility and Enrollment unit now consistently completes more than 95% 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; currently, 99% of customer requests are resolved in 10 business days.

Scorecard: % of Customer Requests Resolved in 10 Business Days (November 2021)	
Target:	95%
Current Performance:	99%

Connecting with 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, Member and Provider Services, and Clinical Services units all provide support for Vermonters enrolling in Medicaid or Qualified Health Plans through Vermont's state-based health insurance marketplace to find providers who participate with Vermont Medicaid.

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).[72] 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.[73] The regional public transportation provider will review eligibility criteria and make trip arrangements for the Medicaid member. Medicaid members may find more information about

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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.

[72] http://www.vpta.net/medicaid-transportation/

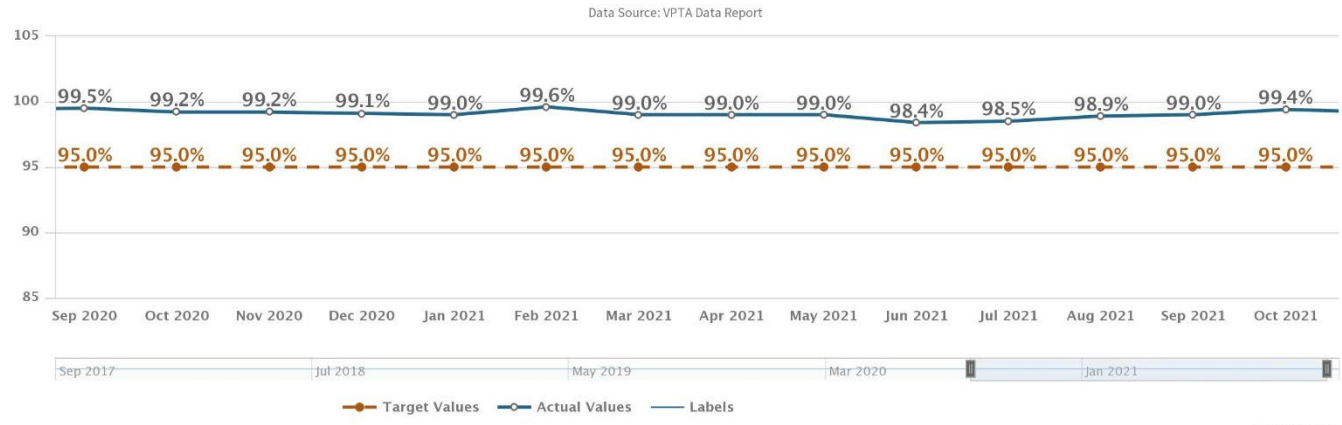
[73] http://www.vpta.net/medicaid-transportation/

transportation on the VPTA website. Providers may find more information about Non-Emergency Medical Transportation (NEMT) on DVHA's website.[19]

The Department's Member and Provider Services unit has established a reporting process with the Vermont Public Transportation Association to ensure that Medicaid members are getting to and from their appointments on time. Reporting indicates that the service has consistently 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.[20]

Scorecard: Percentage of Pick-up/Return Trips the Transportation Contractor Completes On Time	
Target: 95%	**Current Performance (October 2021): 99.4%**

Trend: For state fiscal year 2021, the performance remained above the target of 95% for the entire state fiscal year (as depicted by the graph below), resulting in timeliness of rides for Medicaid members. As of October 2021, the percentage is 99.4%.

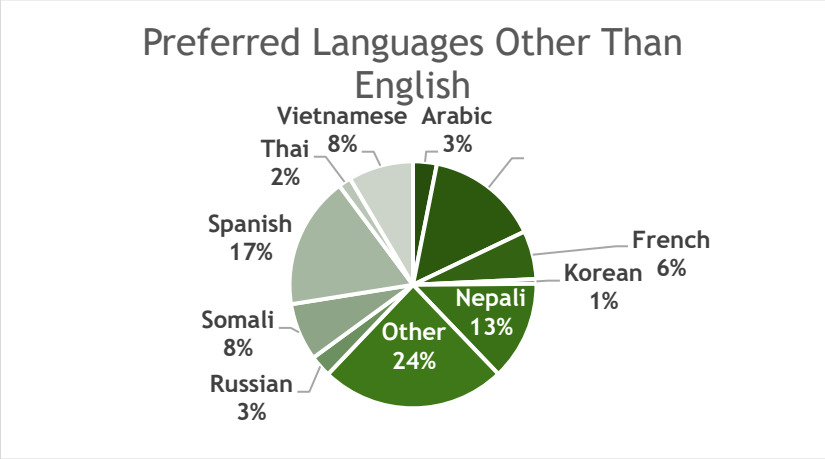


Language Assistance – DVHA works to ensure meaningful access to all programs and services for all Vermonters including those with limited English proficiency. The Department provides language assistance so that persons seeking services may understand which services and benefits are available to

[19] Medicaid Non-Emergency Transportation Manual.
[20] As a result, changes in utilization do not produce cost savings for the Department.

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.



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.[76] 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.

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

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. 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.

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, the Department's 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 system, 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 to serve as the responsible payer for such services regardless of whether the provider that furnishes the services is contracted with Vermont Medicaid.[77] Providers are encouraged to 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[78] enrollment specialists and claims processing team 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.**

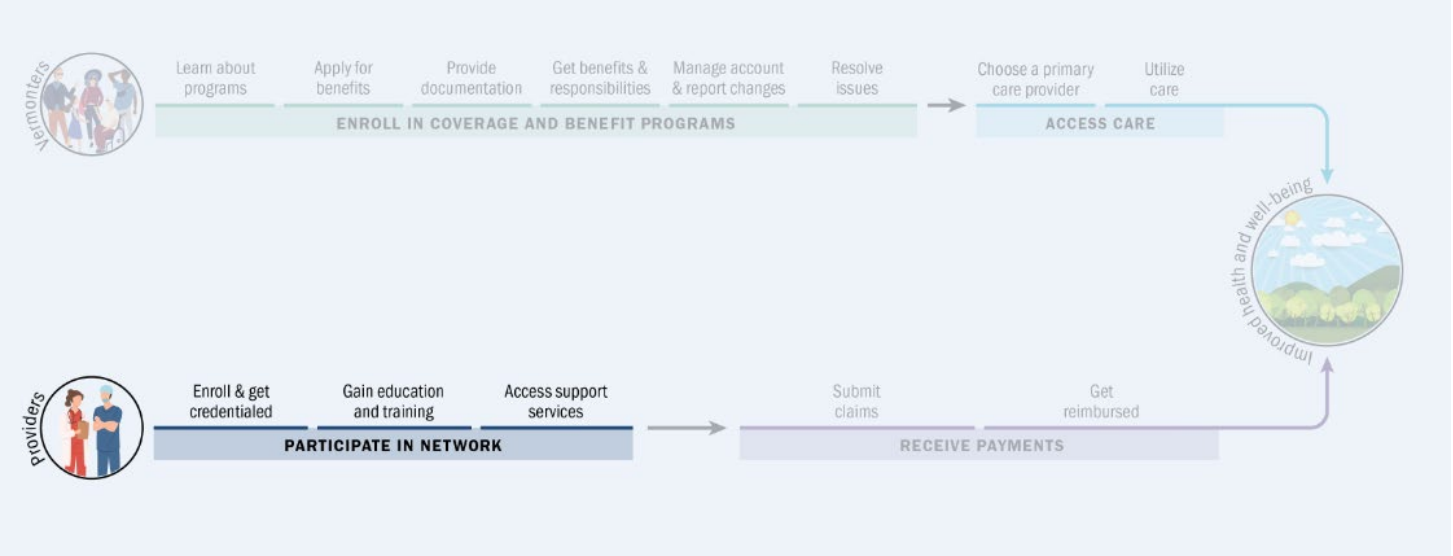
Members are kept informed of the progress made by having direct phone access to Member and Provider Services staff, opting to have copies of outreach materials mailed to them for their records, as well as having service request notes attached to each step of the process in the customer relationship management 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.

[77] 42 CFR § 438.114 and 42 CFR § 422.14

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

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 in-state and out-of-state 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, outreach, and support on screening, enrolling, revalidating, and billing processes as well as program changes and state and federal requirements.

Despite the challenges of the COVID-19 public health emergency, the Department observed an increase in providers overall for state fiscal year 2021 when compared to the number enrolled in state fiscal year 2019. In state fiscal year 2021, more providers were enrolled under the "group" type when compared to state fiscal year 2020; however, the Department observed a decrease in the number of providers enrolling under the "individual" and "facility" types. This resulted in a slight overall decrease in the total number of providers participating with the Vermont Medicaid program during state fiscal year 2021 when compared to state fiscal year 2020. In state fiscal year 2021, there were 26,017 providers enrolled in DVHA's network (22,499 individual providers, 1,664 group providers, and 1,854 facilities).[79] The table below lists the number of providers by type.[80]

[79] 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). 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).
[80] No. refers to "number of."

Provider Type Code	Provider Type Code Description	№ of Individual Providers	№ of Group Providers	№ of Facilities	Total Number
1	GENERAL HOSPITAL			492	492
3	CLINIC CENTER URGENT CARE		11	2	13
4	DENTIST	388	137		525
5	PHYSICIAN	13831	535		14366
6	PODIATRIST	51	8		59
7	OPTOMETRIST	133	40		173
8	OPTICIAN		1		1
9	PHARMACY	1	11	346	358
10	HOME HEALTH AGENCY			11	11
11	INDEPENDENT RADIOLOGY		2	7	9
12	INDEPENDENT LAB		5	166	171
13	AMBULANCE			137	137
14	DME SUPPLIER		19	254	273
17	PT-OT-ST	631	124		755
18	CHIROPRACTOR	145	61		206
19	MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT	1907	161		2068
20	NURSING HOME - MEDICARE PARTICIPATI			59	59
21	NURSING HOME - NON-MEDICARE PARTICI			7	7
23	ANESTHESIA ASSISTANT	70			70
27	HOSPICE			12	12
29	ICF/INTELLECTUAL DISABILITY FAC			1	1
30	PSYCHOLOGIST - DOCTORATE	404	28		432
31	RURAL HEALTH CLINIC		16		16
35	AUDIOLOGIST	76	6		82
36	INTERNAL STATE PROGRAMS		16		16
37	STATE DESIGNATED MH CLINIC		52	2	54
38	STATE DEF. INTELLECTUAL DIS CLINIC		16	1	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		11	10	21
43	NATUROPATHIC PHYSICIAN	75	20		95
44	PHARMACIST	322			322
T01	PTF PSYCH RESIDENTIAL FACILITY			23	23
T02	DIALYSIS FACILITIES			12	12
T03	AMBULATORY SURGICAL CENTER			5	5

T04	PERSONAL CARE SERVICES		14		14
T06	NURSE PRACTITIONER	2723	27		2750
T07	LICENSED NURSE	11	10		21
T11	FEDERALLY QUALIFIED HEALTH CENTER		59		59
T13	NON-EMERGENCY TRANSPORTATION SVCS		7	7	14
T14	STATE DEF RESIDENTIAL CARE WAIVER		64	74	138
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		7	9	16
T20	FAMILY SUPPORT MANAGEMENT		7	7	14
T21	STATE DESIGNATED CHILDRENS MED SVCS		6	29	35
T23	STATE DEFINED NON-MED RESID FAC		67	103	170
T25	STATE DEFINED ADAP FACILITY			35	35
T26	STATE DEFINED ADULT DAY FACILITY		2	11	13
T27	STATE DEFINED DEPT OF EDUCATION		44	18	62
T31	SOLE SOURCE EYEGLASS LAB			1	1
T34	STATE DEFINED CASE RATE AGENCY	2		3	5
T36	INDEPEND. BILLING HIGH TECH NURSES	46			46
T37	PHYSICIAN ASSISTANT	1197			1197
T38	LICENSED ALCOHOL DRUG COUNSELOR	187	12		199
T39	LICENSED MIDWIFE	29	5		34
T41	LICENSED PHYSICAL THERAPY ASSISTANT	3			3
T42	ACCOUNTABLE CARE ORGANIZATION		1		1
T44	NUTRITIONAL EDUCATORS	136	11		147
T45	SLEEP STUDY CENTER		3		3
T46	BEHAVIORAL ANALYST	129	21		150
T47	FAMILY SUPPORTIVE HOUSING		6	4	10

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.[81] The Unit strives to make certain that Vermonters do not have to travel too far to receive the care they need, maximize members'

[81] 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.

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.

ENROLMENT & REVALIDATION WITH VERMONT MEDICAID

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.[82] 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.[83,84] 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 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;

[82] CFR is the Code of Federal Regulations.
[83] http://www.vtmedicaid.com/assets/provEnroll/VT_PMM_ProviderEnrollmentOnlineApplicationInstructions.pdf; Provider Services Telephone Number: 1-800-925-1706.
[84] 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.

- 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;[85]
- Revalidating Durable Medical Equipment, Prosthetics/Orthotics & Supplies suppliers.[86]

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 for certain services 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.

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

The Provider Management Module has continued to meet 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 and typically, providers are enrolled in less than 15 business days (see the Provider Management Module's Performance Accountability Scorecard).

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

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.[87] 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.[88] 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;
- Physical Therapy, Occupational Therapy, and Speech Language Therapy; and
- Non-Emergency Medical Transportation.[89]

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.[90]

Clinical Operations, Clinical Integrity & Quality Improvement – Together with Pharmacy, Comprise DVHA's Clinical Services Team

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

[87] This is done twice a year, through a report on members access to care and how far they must travel.
[88] Provider Services Telephone Number: 1-800-925-1706
[89] http://www.vtmedicaid.com/#/manuals
[90] Banners: http://www.vtmedicaid.com/#/bannerMain, Advisories: http://www.vtmedicaid.com/#/advisory

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.[91]

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. 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:

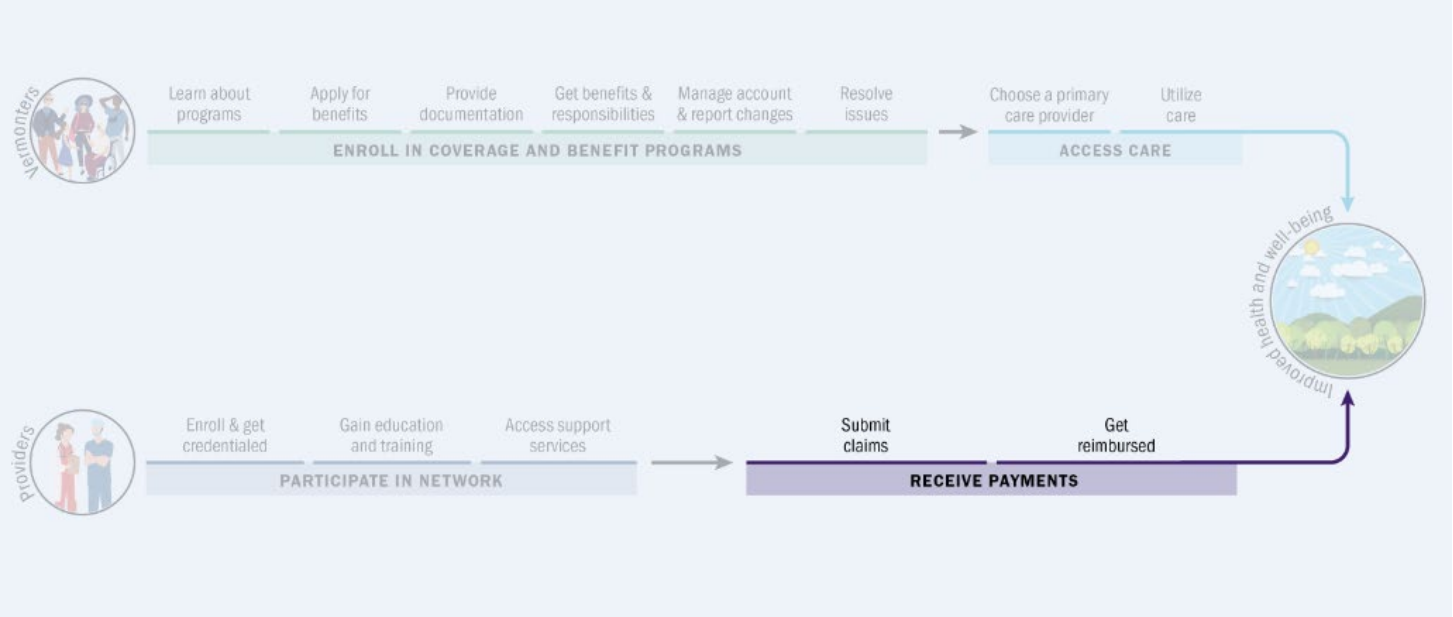
- Coverage, if the service is permissible under state plan/rule,
- Effectiveness of service,
- FDA approval,
- Number of units allowed, and
- Necessary edits and audits.

[91] https://dvha.vermont.gov/providers/team-care

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 ensure medical necessity and appropriate utilization of services, and
- 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

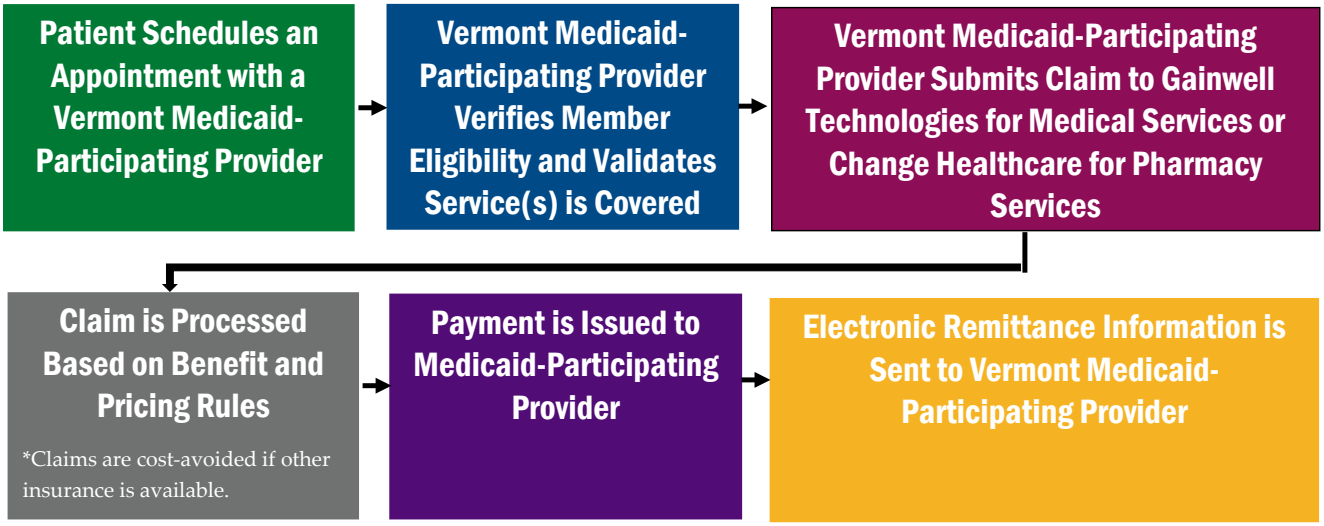


Medical Claims Processing

Since 1981, Gainwell Technologies has provided Medicaid fiscal agent services to the State of Vermont.[92] Medical claims processing is one of the services Gainwell provides, which involves claims

[92] Gainwell Technologies (formerly DXC Technology), provides the State of Vermont 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 (MMIS).

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 begins when a Vermont Medicaid member first schedules an appointment to access care and continues through payment being sent to the provider.



Gainwell Technologies processed over 7 million claims in state fiscal year 2021 for more than 30 distinct programs supporting all departments within the Agency of Human Services and the Agency of Education. These claims resulted in almost $1.3 billion in payments to providers.
Despite the ongoing federal COVID-19 public health emergency, and an increase in claims volume, the time to adjudicate claims was reduced to less than 1 day on average. In addition, providers were paid more quickly than ever, with 99.8% of claims paid within 30 days. [93]

Over the past 40 years, Gainwell Technologies has continued to evolve the system to support multiple programs. The Department of Vermont Health Access obtains 75% federal funds for the operation and maintenance of this CMS-certified system. Gainwell Technologies performs the following services:

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

[93] In state fiscal year 2020, 93.97% of claims were received electronically; 6.03% of claims were received by paper; 7,239,849 claims were processed in state fiscal year 2020, with 2.83 average days to adjudicate a claim and 98.82% of claims processed within 30 days.

- **Application Services** for support and enhancements for several Gainwell and commercial software applications used by Providers, hundreds of Agency of Human Services 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 Medicaid Management Information System (MMIS) information in support of Agency of Human Services departments and operations.
- **Coordination of Benefits Services** including billing and collection from other third-party liabilities, screening and identification of Casualty cases, and 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 analyses 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 **2 million claims in state fiscal year 2021 resulting in approximately $231.2 million in payments to Vermont Medicaid-enrolled pharmacies**.[94] 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 2021, Change Healthcare processed approximately 24,503 drug-related prior authorizations, with 18,245 of those approved.**[95]

The Pharmacy Services unit within the Department of Vermont Health Access 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.

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[94] Pharmacy Best Practices and Cost Control Program Report (2021).
[95] Pharmacy Best Practices and Cost Control Program Report (2021).

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; and
- 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 ensuring 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.[96] This work is crucial because outpatient, inpatient and professional services combine to account for a large portion of the total payments overseen by Reimbursement. In addition, the Reimbursement unit oversees a complementary set of specialty fee schedules including, but not limited to:

- Durable Medical Equipment, Prosthetics, Orthotics, & Supplies,
- Ambulance;
- Clinical Laboratory;
- Physician-Administered Drugs;
- Dental; and
- Home Health and Hospice.

The Reimbursement unit also manages the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) payment process as well as supplemental payment administration (e.g., the Disproportionate Share Hospital (DSH) payment program).

The Reimbursement unit works closely and collaboratively on reimbursement policies for specialized programs with other departments of the Agency of Human Services, including the Department of Disabilities, Aging, and Independent Living (DAIL), the Vermont Department of Health, 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.

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. In the last state fiscal year, this performance measure was impacted by staff capacity but monitoring this measure consistently has allowed the Unit to meet or exceed the target in recent months.

[96] The Department has continued its efforts to achieve parity with Medicare rates. Primary care rates for Vermont Medicaid were previously increased to 100% of Medicare rates and that continues to be maintained. In January of 2020, the DMEPOS fee schedule was updated to 100% of Medicare.

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 (October 2021): 100%**
Trend: The Unit is currently exceeding its target of 80%.	
Performance Accountability Scorecard	

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 13 PNMIs for the Department for Children and Families, the Department of Mental Health (DMH), and, periodically, 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 1 year 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.

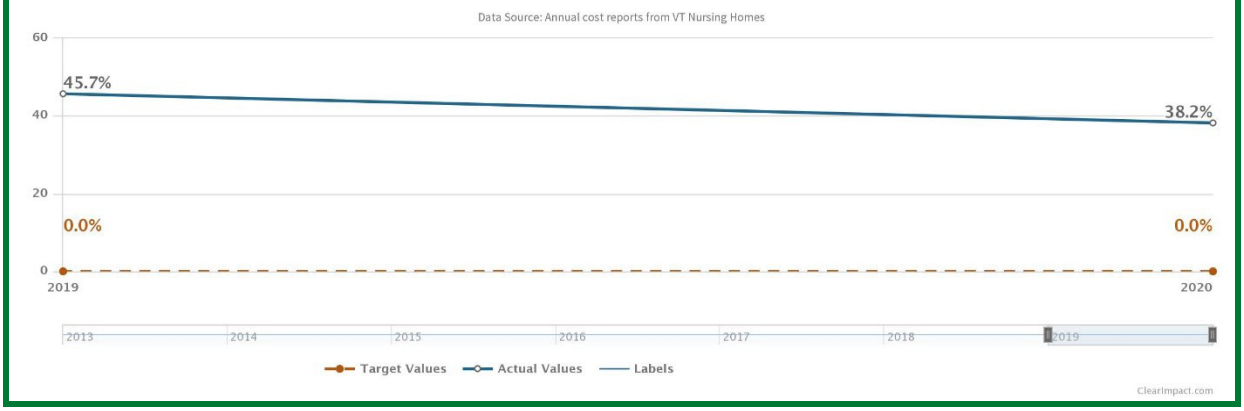
The Division's nursing home rules allow for the development of individual rates for nursing home residents who have special, atypical needs due to medical conditions or challenging behaviors. Special individual medical needs are addressed pursuant to V.D.R.S.R. § 14.1. Individual rates for current or 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. The Division also sets rates for out-of-state nursing and rehabilitation facilities for adults and children whose needs cannot be met by Vermont facilities.

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.

The Division of Rate Setting calculates Vermont Medicaid payment rates for services provided in Vermont licensed nursing facilities participating in the Medicaid program based on submission of an annual cost report by the nursing facility. The rates are determined based on each nursing facility's allowable costs for providing services (with certain limits on the amount of costs recognized in each category). These costs are annually reviewed by the Division's auditors for allowability. There are a variety of reasons that nursing facilities may show financial losses, including that certain costs are not allowable for Medicaid reimbursement. For example, some nursing facility financial losses can be attributed to owner and management decisions that include paying high property rents to real estate investment trusts ("REITs") and paying high management fees to owners and related parties, both of which are largely not reimbursed in the Medicaid rate. The most recent data received by the Division of Rate Setting appears to indicate that the industry was significantly more profitable in fiscal year 2020 than in fiscal year 2019, largely due to the various streams of COVID-19 relief funding. In aggregate, profit/loss data collected by the Division of Rate Setting indicates that nursing homes made $5 million in fiscal year 2020, while they lost $8 million in fiscal year 2019. Sixteen homes had losses over $100k in fiscal year 2019 while only thirteen did in fiscal year 2020 (see data table on next page).

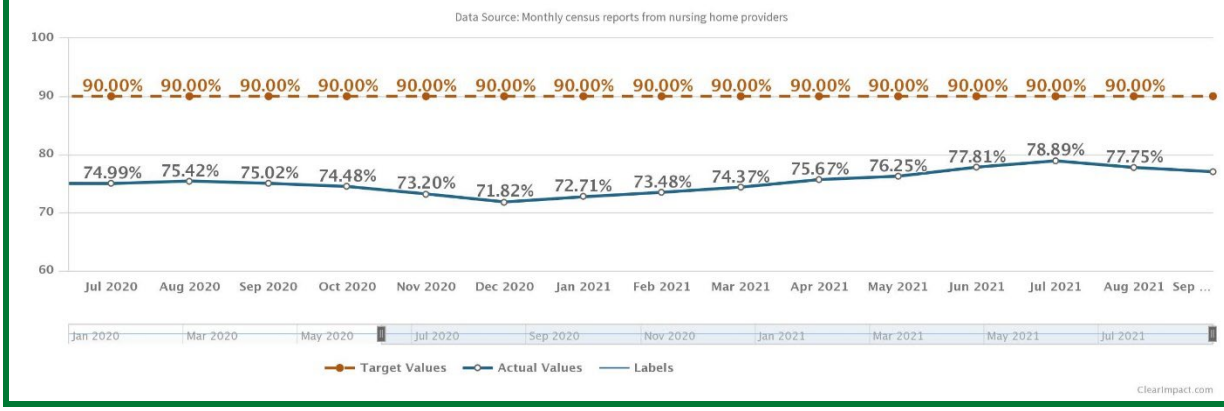
It is important to note that there remain nursing homes with years of significant financial losses. Financial instability could affect nursing facility providers' willingness or ability to continue to provide these services and/or result in potential quality issues stemming from inadequate financial 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 on the next page 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



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 (see table below). This has the potential to result in large financial penalties for facilities if action isn't taken.

Scorecard: The Percentage of Utilization Based on Capacity of Vermont Medicaid-Participating Nursing Homes



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.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

GOVERNOR'S BUDGET RECOMMENDATION: STATE FISCAL YEAR 2023

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

State Fiscal Year 2023 Summary: The Department of Vermont Health Access' (DVHA's) state fiscal year 2023 budget request includes an increase in Administration of $3,471,152 (gross) and an increase in Program of $91,326,980 (gross) for a total of $94,798,132 (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	$3,471,152	$3,126,023
B.307 Global Commitment Program	$77,306,957	$34,032,522
B.309 State Only Program	$11,736,437	$6,408,106
B.310 Non-Waiver Program	$2,283,586	$72,097
Total	$94,798,132	$43,636,739

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 $3,471,152 GROSS / $3,126,023 STATE

1. B.306 - Annual Salary & Fringe Changes. . . . . .$2,657,927 / $1,286,715 state

Assuming no changes from SFY2022, DVHA will have 373 positions in SFY2023. These costs reflect annual salary, fringe and Federal Financial Participation (FFP) rates, reclassifications and an increase to retiree pension and health care cost accruals:

Expense	GROSS	STATE FUNDS
Annual Salary and Fringe	$810,025	$421,513
Increased Retirement Cost	$1,236,137	$605,707
Incremental Fringe	$611,765	$259,495
Total Changes	$2,657,927	$1,286,715

2. B.306 - Vermont Health Information Exchange (VHIE) reduced FMAP earnings . . . .$0 / $1,480,821 state

This reflects two unfavorable changes to the Vermont Health Information Exchange (VHIE) cost allocation following the expiration of HITECH funding, and the corresponding need to cover VHIE maintenance and operations (M&O) costs via a Centers for Medicare and Medicaid Services (CMS) approved cost allocation

plan. First, it is anticipated that only 65% of VHIE activities will be eligible for FFP, corresponding to the percentage of transactions for Medicaid members, and second, enhanced FFP for M&O costs is only 75%.

Expense	GROSS	STATE FUNDS
Contracts	$0	$1,065,383
Operating Expenses	$0	$415,518
Total Changes	$0	$1,480,821

3. B.306 - Patient Access to Healthcare Information Contract (Interoperability) . $840,000 / $420,000 state

This project is being undertaken to comply with the Centers for Medicare and Medicaid (CMS) Interoperability and Patient Access final rule CMS-9115-F and the Office of the National Coordinator (ONC) for Health Information Technology 21st Century CURES Act, which aims to empower Americans with their health data by delivering it conveniently through computers, cell phones, and mobile applications.

In SFY 2022, DVHA is implementing these requirements and this line item is for the increase to the VITL contract in support of supplying clinical information and for the contract with Gainwell Technologies to for make the data available to Medicaid member. The Gainwell contract will be maintained by the Agency of Digital Services; therefore, this line item is represented twice on the ups/downs.

VITL Contract Increase	$400,000/year (begins 4/1/2022)
ADS MOU Increase for Gainwell M&O	$440,000 (begins 4/1/2022)

The FFP for this project is a 50% share pending CMS deeming the project eligible for retroactive enhanced funding at a 75% share.

4. B.306 - Internal Service Fund Changes. . . . . $253,225 / $52,312 state

DVHA receives allocations from Department of Buildings and General Services (BGS) to cover its 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.

5. B.306 - Reduction in Health Information Technology Grants (Bi-State) . . . . ($280,000) / ($113,825) state

This grant with the Bi-State Primary Care Association is not being renewed as the work is being subsumed under the VITL contract.

PROGRAM $91,326,980 GROSS / $40,510,725 STATE

6. B.307, B.309, B.310 - Caseload & Utilization Changes. . . . . .$48,694,954 / $20,428,393 state

DVHA updates the 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 twice each year as part of the State's Consensus Revenue Forecasting process.

The COVID-19 pandemic continues to be the primary factor driving caseload and utilization expectations for the balance of fiscal year 2022. After several years of steady decline, since the start of the pandemic in March 2020 Vermont's Medicaid enrollment has grown. This is a result of individuals experiencing pandemic-related economic challenges as well as federal requirements to maintain continuous health care benefits during the federal COVID-19 Public Health Emergency (PHE). Continuous Medicaid coverage is a condition of receiving the 6.2% enhancement in Federal Medical Assistance Percentage (FMAP) as authorized in the Families First Coronavirus Response Act (FFCRA). The federal government is providing this increased FMAP to support states and promote stability of health care coverage during the pandemic.

DVHA has taken many steps facilitate access to health care and comply with the continuous coverage requirement during the COVID-19 PHE including:

- 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 most recent Medicaid Consensus Forecast completed in August projects that the federal COVID-19 PHE will continue through January 2022, but that resuming processing of redeterminations and corresponding terminations will not result in a gradual decline of Medicaid enrollment until at least May 2022. The federal government is allowing states twelve months following the end of the PHE to process the backlog of redeterminations, so elevated enrollment is expected to continue for the duration of fiscal year 2023. An increase in the per member per month costs is also anticipated as the State returns to pre-pandemic utilization levels and deferred health care is obtained. 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	$48,850,908	$21,504,170
B.309 State Only	($1,469,024)	($1,468,779)
B.310 Non-Waiver	$1,313,070	$393,002
Total	$48,694,954	$20,428,393

7. B.307, B.309 - Transfer from DMH for Brattleboro Retreat (AHS net-neutral) . . . . . $13,000,000 / $5,722,600 state

The Department of Mental Health (DMH) is transferring funds to DVHA in support of the Alternative Payment Model (APM) contract between DVHA and Brattleboro Retreat, whereby the Retreat receives monthly fixed prospective payments (FFP) in exchange for providing 24/7 psychiatric services and maintaining 26 Level I beds and capacity for a fixed number of inpatient days for Medicaid members.

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$3,436,758	$1,512,861
B.309 State Only	$9,563,242	$4,209,739
Total	$13,000,000	$5,722,600

8. B.307 - Transfer from DMH for NFI Vermont (AHS net-neutral) . . . . . $209,170 / $92,077 state

DMH is transferring funds to DVHA to align the Northeast Family Institute (NFI) Vermont's hospital diversion program (HDP) Medicaid reimbursement rates with a more reliable and predictable process that relies on the Inpatient Prospective Payment System (IPPS) methodology.

9. B.307, B.310 - Annual Medicaid Rate Adjustments. . . . . $12,576,731 / $5,519,896 state

DVHA has established reimbursement goals to be a reliable and predictable payer for Vermont Medicaid-participating providers; this is important because Medicaid-participating providers often furnish services to underserved and underrepresented communities. Professionalizing provider reimbursement includes aligning with established rate methodologies (e.g., following Medicare for annual updates to the Resource-Based Relative Value Scale (RBRVS) for physician services, Outpatient Prospective Payment System (OPPS) for hospital outpatient services, etc.), and including requests for rate updates as part of the State's annual budget development process to support maintenance of provider network adequacy and maximize transparency of the annual rate changes. Because of continued pressure on DVHA's budget resulting from increased caseload, DVHA will not be able to continue to support rate increases aligned with established methodologies unless funding is appropriated for this purpose.

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$12,460,471	$5,485,099
B.310 Non-Waiver	$116,260	$34,797
Total	$12,576,731	$5,519,896

10. B.307, B.310 - Access to Care – Emergency Department per diem rates. . . . .$500,000 / $219,448 state

The objective of this proposal is to compensate Emergency Departments (ED) for those beds being occupied by members awaiting placement at an inpatient psychiatric facility. The per diem rate will require payment authorization and have clinical oversight by the Department.

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$495,378	$218,065
B.310 Non-Waiver	$4,622	$1,383
Total	$500,000	$219,448

11. B.307, B.309, B.310 - Annual Medicare Buy-In & Caseload Changes. . . . .$9,628,233 / $3,864,339 state

The federal government allows for states to use Medicaid dollars to "buy-in" to Medicare on behalf of dually eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload and member month costs vary from year to year. This change incorporates a rate increase and trend in member months. DVHA experienced an increase to Buy-In enrollment as a result of progress correcting and updating the eligibility files exchanged between CMS and DVHA, and CMS announced a significantly larger-than-expected 14.5% increase to Medicare Part B premiums on November 12.

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$8,823,127	$3,883,941
B.309 State Only	($44,528)	($19,601)
B.310 Non-Waiver	$849,634	$0
Total	$9,628,233	$3,864,339

12. B.307 - High-Technology Nursing Payment Reform. . . . . .$304,478 / $134,031 state

This initiative creates a fee-for-service (FFS) hybrid payment model for the High-Technology Nursing program services delivered by home health agencies. The High-Technology Nursing program is an intensive home care program operating as an authorized Vermont Medicaid benefit for eligible individuals dependent upon medical technology or whose condition requires regular individual and continuous care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and requires greater skill than a Home Health Aide or Personal Care Assistant can provide.

13. B.307 - Medicaid Expense Transfer from DCF (AHS net-neutral) . . . . . .$60,000 / $26,412 state

The Department for Children and Families is transferring funds to DVHA to move the Family Service Division (FSD) Medical Service payments to DVHA, primarily for the cost of emergency medical services for children in out-of-state custody.

14. B.307 - Assistive Community Care Services (ACCS) rate increase. . . . . .$506,667 / $223,035 state

This funding provides a 3% rate increase for ACCS providers, and aligns with similar increases from both the Department of Aging and Independent Living (DAIL) and DMH for Designated Agencies (DAs) and Specialized Service Agencies (SSAs).

15.B.307 - Post-partum Coverage Expansion to 12 months. . . . . $2,160,000 / $950,832 state

This funding is to pursue an option under the American Rescue Plan Act (ARPA) that expands Medicaid post-partum coverage from the current 60 days from the end of a pregnancy to 12 months.

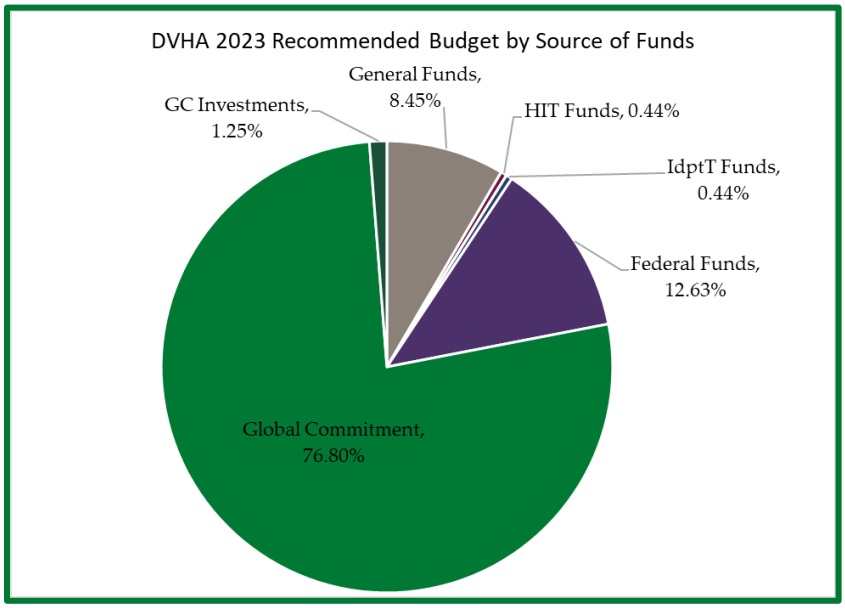
16. B.309 - Annual Medicare Clawback Changes. . . . . $3,686,747 / $3,686,747 state

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

This cost increase is driven primarily by the anticipated end of the federal COVID-19 PHE and loss of the corresponding 6.2% enhanced Federal Medical Assistance Percentage (FMAP) rate that was applied to, and reduced, Clawback payments.

17.B.310 - CHIP FMAP Changes. . . . . ($0) / ($357,085) state

This item depicts the anticipated changes to Federal Medical Assistance Percentage (FMAP) in fiscal year 2023. 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.



Year Over Year Changes	Program (Gross)	Admin (Gross)	Total DVHA	State Funds Estimate*
2021 Actuals	$839,884,105	$132,169,792	$972,053,898	$388,995,694
2022 Budget Adjustment Act	$940,709,827	$159,527,171	$1,100,236,998	$477,712,322
2023 Governor's Recommended	$924,856,956	$163,221,301	$1,088,078,257	$475,318,674

* 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.

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

GOVERNOR'S RECOMMENDED BUDGET: STATE FISCAL YEAR 2023 PULLOUTS

The following pages contain state fiscal year 2023 budget pullouts.

FY23 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 FY22**	**32,776,219**	**3,363,758**		**4,827,131**	**114,469,002**			**4,314,039**	**159,750,149**
	FY22 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY22 Other Changes	**32,776,219**	**3,363,758**	**0**	**4,827,131**	**114,469,002**	**0**	**0**	**4,314,039**	**159,750,149**
	FY22 After Other Changes									
	Personal Services:									
	1. Annual Salary and Fringe Increases (excluding Retirement)	563,436	6,514			577,278			(337,203)	**810,025**
	1. Retirement Increases	605,707				630,430				**1,236,137**
	1. Incremental Fringe	248,495	929		5,898	346,963			9,480	**611,765**
	2. HIE reduction in FMAP earnings for contracts		1,065,303			(1,065,303)				**0**
	3. Patient Access to Healthcare Information (Interoperability) (BAA item)	200,000				200,000				**400,000**
	Operating Expenses:									
	2. HIE reduction in FMAP earnings for operating expenses		415,518			(415,518)				**0**
	3. Patient Access to Healthcare Information (Interoperability)	220,000				220,000				**440,000**
	4. Internal Service Fund Increases	52,312				200,913				**253,225**
	Grants:									
	5. HIE Related Grants Changes (BAA item)		(113,825)			(166,175)				**(280,000)**
	FY23 Subtotal of Increases/Decreases	**1,889,950**	**1,374,439**	**0**	**5,898**	**528,588**	**0**	**0**	**(327,723)**	**3,471,152**
	FY23 Gov Recommended	**34,666,169**	**4,738,197**	**0**	**4,833,029**	**114,997,590**	**0**	**0**	**3,986,316**	**163,221,301**
	FY23 Legislative Changes									
	FY23 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY23 As Passed - Dept ID 3410010000	**34,666,169**	**4,738,197**	**0**	**4,833,029**	**114,997,590**	**0**	**0**	**3,986,316**	**163,221,301**

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	FY23 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 FY22							**758,320,216**		**758,320,216**
	FY22 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY22 Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**758,320,216**	**0**	**758,320,216**
	FY22 After Other Changes									
	Grants:									
	6. Caseload & Utilization Annual Changes							48,850,908		**48,850,908**
	7. DMH Transfer to Support Brattleboro Retreat Alternative Payment Model (BAA item; AHS net-neutral)							3,436,758		**3,436,758**
	8. DMH Transfer for NFI Hospital Diversion (BAA item; AHS net-neutral)							209,170		**209,170**
	9. Annual Rate Adjustments (BAA item)							12,460,471		**12,460,471**
	10. Access to Care - Increase ED per diem rates (BAA item)							495,378		**495,378**
	11. Annual Medicare Buy-In Rate and Caseload Changes							8,823,127		**8,823,127**
	12. High-Tech Nursing (BAA item)							304,478		**304,478**
	13. Medicaid Expense transfer from DCF (BAA item; AHS net-neutral)							60,000		**60,000**
	14. ACCS rate increase							506,667		**506,667**
	15. Postpartum expanded coverage to 12 months							2,160,000		**2,160,000**
	FY23 Subtotal of Increases/Decreases	**0**	**0**	**0**	**0**	**0**	**0**	**77,306,957**	**0**	**77,306,957**
	FY23 Gov Recommended	**0**	**0**	**0**	**0**	**0**	**0**	**835,627,173**	**0**	**835,627,173**
	FY23 Legislative Changes									
	FY23 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY23 As Passed - Dept ID 3410015000	**0**	**0**	**0**	**0**	**0**	**0**	**835,627,173**	**0**	**835,627,173**
Sec. B.309	**Approp #3410017000 - DVHA - Medicaid Program - State Only**									
	As Passed FY22	**42,315,703**							**52,051**	**42,367,754**
	FY22 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY22 Other Changes	**42,315,703**	**0**	**0**	**0**	**0**	**0**	**0**	**52,051**	**42,367,754**
	FY22 After Other Changes									
	Grants: 0									
	6. Caseload & Utilization Annual Changes	(1,468,586)							(438)	**(1,469,024)**
	7. DMH Transfer to Support Brattleboro Retreat Alternative Payment Model (BAA item; AHS net-neutral)								9,563,242	**9,563,242**
	11. Annual Medicare Buy-In Rate and Caseload Changes								(44,528)	**(44,528)**
	16. Annual Medicare Clawback Changes (reversion to normal FMAP)	3,686,747								**3,686,747**
	FY23 Subtotal of Increases/Decreases	**2,218,161**	**0**	**0**	**0**	**0**	**0**	**0**	**9,518,276**	**11,736,437**
	FY23 Gov Recommended	**44,533,864**	**0**	**0**	**0**	**0**	**0**	**0**	**9,570,327**	**54,104,191**
	FY23 Legislative Changes									
	FY23 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY23 As Passed - Dept ID 3410017000	**44,533,864**	**0**	**0**	**0**	**0**	**0**	**0**	**9,570,327**	**54,104,191**
Sec. B.310	**Approp #3410018000 - DVHA - Medicaid Matched NON Waiver Expenses**									
	As Passed FY22	**12,664,602**				**20,177,404**				**32,842,006**
	FY22 After Other Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total After FY22 Other Changes	**12,664,602**	**0**	**0**	**0**	**20,177,404**	**0**	**0**	**0**	**32,842,006**
	FY22 After Other Changes									
	Grants: 0									
	6. Caseload & Utilization Annual Changes	393,002				920,068				**1,313,070**
	9. Annual Rate Adjustments (BAA item)	34,797				81,463				**116,260**
	10. Access to Care - Increase ED per diem rates (BAA item)	1,383				3,239				**4,622**
	11. Annual Medicare Buy-In Rate and Caseload Changes					849,634				**849,634**
	17. CHIP FMAP Adjustment	(357,085)				357,085				**0**
	FY23 Subtotal of Increases/Decreases	**72,097**	**0**	**0**	**0**	**2,211,489**	**0**	**0**	**0**	**2,283,586**
	FY23 Gov Recommended	**12,736,699**	**0**	**0**	**0**	**22,388,893**	**0**	**0**	**0**	**35,125,592**
	FY23 Legislative Changes									
	FY23 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	FY23 As Passed - Dept ID 3410018000	**12,736,699**	**0**	**0**	**0**	**22,388,893**	**0**	**0**	**0**	**35,125,592**

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FY23 Department Request - DVHA

	GF	SF	State Health Care Res	IdptT	FF	Coronavirus Relief Fund	Medicaid GCF	Invmnt GCF	Total
DVHA FY23 Governor Recommend	87,756,524	3,363,758	0	4,827,131	134,646,406	0	758,320,216	4,366,090	993,280,125
DVHA FY23 Reductions and Other Changes	0	0	0	0	0	0	0	0	0
DVHA FY23 GovRec Total After Reductions and Other Changes	87,756,524	3,363,758	0	4,827,131	134,646,406	0	758,320,216	4,366,090	993,280,125
DVHA FY23 Total Increases/Decreases	4,180,208	1,374,439	0	5,898	2,740,077	0	77,306,957	9,190,553	94,798,132
DVHA FY23 Governor Recommend Addendum	91,936,732	4,738,197	0	4,833,029	137,386,483	0	835,627,173	13,556,643	1,088,078,257
DVHA FY23 Total Legislative Changes	0	0	0	0	0	0	0	0	0
DVHA FY23 Total As Passed	91,936,732	4,738,197	0	4,833,029	137,386,483	0	835,627,173	13,556,643	1,088,078,257

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PROGRAM EXPENDITURES	SFY '21 Actuals			SFY '22 As Passed			SFY '22 BAA			SFY '23 GR				
Adults	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Dept. ID	Funding Description
Aged, Blind, or Disabled (ABD)	6,233	$ 55,539,766	$ 742.59	6,475	$ 59,377,463	$ 764.19	6,227	$ 52,883,649	$ 707.72	6,218	$ 52,753,147	$ 707.00	15000	Global Commitment Funded (GC)
CFC Acute-Care Services	4,472	$ 41,518,829	$ 773.75	4,596	$ 40,104,146	$ 727.16	4,366	$ 41,284,482	$ 787.99	4,409	$ 42,896,466	$ 810.77	15000	Global Commitment Funded (GC)
Dual Eligibles	17,951	$ 45,495,222	$ 211.21	17,649	$ 54,564,094	$ 257.64	18,233	$ 46,071,349	$ 210.57	18,340	$ 49,147,490	$ 223.32	15000	Global Commitment Funded (GC)
General	11,165	$ 58,810,030	$ 438.95	10,049	$ 60,588,292	$ 502.44	14,291	$ 77,272,967	$ 450.59	12,965	$ 70,631,417	$ 453.99	15000	Global Commitment Funded (GC)
New Adult Childless	42,088	$ 219,469,261	$ 434.54	35,802	$ 201,971,935	$ 470.11	49,215	$ 265,799,315	$ 450.06	45,289	$ 248,036,891	$ 456.40	15000	Enhanced for Childless New Adults ~ General Funds
New Adult W/Child	24,524	$ 114,487,987	$ 389.03	22,258	$ 108,106,667	$ 404.75	26,643	$ 129,587,428	$ 405.32	25,192	$ 123,224,166	$ 407.62	15000	Global Commitment Funded (GC)
Dr. D Expansion - State Only				22	$ 252,420	$ 956.14	22	$ 216,354	$ 819.52	22	$ 252,420	$ 956.14	17000	General Funds @ 100%
Subtotal Adults	106,432	$ 535,321,094	$ 419.14	96,851	$ 524,965,017	$ 451.69	118,997	$ 613,115,544	$ 429.36	112,435	$ 586,941,998	$ 435.02		
Sunsetted Direct Programs														
Sunsetted/Transferred CFC Programs														
Subtotal Sunsetted														
Children														
Blind or Disabled (BD)	1,633	$ 19,998,435	$ 1,020.33	1,594	$ 20,428,886	$ 1,068.01	1,553	$ 19,252,179	$ 1,033.06	1,477	$ 18,565,073	$ 1,047.45	15000	Global Commitment Funded (GC)
General	60,652	$ 155,451,561	$ 213.59	59,588	$ 160,461,685	$ 224.40	61,573	$ 164,447,651	$ 222.56	62,082	$ 167,462,753	$ 224.79	15000	Global Commitment Funded (GC)
Underinsured	566	$ 542,218	$ 79.78	530	$ 433,667	$ 68.19	548	$ 557,058	$ 84.71	537	$ 560,098	$ 86.92	15000	Global Commitment Funded (GC)
SCHIP (Uninsured)	4,363	$ 9,417,889	$ 179.87	4,374	$ 8,683,881	$ 165.45	4,535	$ 10,095,316	$ 185.51	4,523	$ 10,117,833	$ 186.41	18000	Title XXI Enhanced
Dr. D Expansion - State Only				100	$ 1,147,580	$ 956.32	100	$ 983,646	$ 819.70	100	$ 1,147,580	$ 956.32	17000	General Funds @ 100%
Subtotal Children	67,215	$ 185,410,102	$ 229.87	66,186	$ 191,155,699	$ 240.68	68,309	$ 195,335,849	$ 238.30	68,719	$ 197,853,338	$ 239.93		
Pharmacy														
Pharmacy Only - GC	9,966	$ 3,447,891	$ 28.83	9,568	$ 2,480,024	$ 21.60	9,853	$ 3,550,040	$ 30.03	9,762	$ 3,723,187	$ 31.78	15000	Global Commitment Funded (GC)
Pharmacy Only - State Only	9,966	$ 1,444,819	$ 12.08	9,568	$ 2,973,767	$ 25.90	9,853	$ 1,489,423	$ 12.60	9,762	$ 1,505,181	$ 12.85	17000	General Funds @ 100%
Pharmacy Only Programs	9,966	$ 4,892,710	$ 40.91	9,568	$ 5,453,791	$ 47.50	9,853	$ 5,039,463	$ 42.62	9,762	$ 5,228,367	$ 44.63		
QHP Assistance														
Premium Assistance	15,187	$ 5,591,697	$ 30.68	15,937	$ 5,615,851	$ 29.36	15,937	$ 5,615,851	$ 29.36	15,937	$ 5,615,851	$ 29.36	15000	Global Commitment Funded (GC)
Cost Sharing	3,044	$ 1,176,262	$ 32.20	3,236	$ 1,130,724	$ 29.12	3,236	$ 1,130,724	$ 29.12	3,236	$ 1,130,724	$ 29.12	17000	General Funds @ 100%
Subtotal QHP Assistance	15,187	$ 6,767,959	$ 37.14	15,937	$ 6,746,574	$ 35.28	15,937	$ 6,746,574	$ 35.28	15,937	$ 6,746,574	$ 35.28		
Subtotal Direct Services	**198,800**	**$ 732,391,866**	**$ 307.01**	**188,542**	**$ 728,321,082**	**$ 321.91**	**213,096**	**$ 820,237,431**	**$ 320.76**	**206,853**	**$ 796,770,277**	**$ 320.99**		
Miscellaneous Program														
Refugee	-	$ -	$ -	1	$ 499	$ 41.60	1	$ 499	$ 41.60	1	$ 499	$ 41.60	18000	Federally Funded @ 100%
ACA Rebates		$ (3,864,124)			$ (3,036,658)			$ (3,036,658)			$ (3,036,658)		18000	Federally Funded @ 100%
HIV	170	$ 4,537	$ 2.22	204	$ 3,440	$ 1.41	172	$ 2,904	$ 1.41	178	$ 3,002	$ 1.41	17000	Investments: Global Commitment Funded (GC)
IMD and Underinsured		$ 2,078,349			$ 100,000			$ 9,288,294			$ 9,663,242		17000	Investments: Global Commitment Funded (GC)
DSH		$ 22,704,470			$ 22,704,471			$ 22,704,471			$ 22,704,471		18000	Global Commitment Funded (GC)
Clawback		$ 30,355,530			$ 36,711,213			$ 36,539,706			$ 40,397,960		17000	General Funds @ 100%
Buy-In ~ GC		$ 40,643,414			$ 39,164,716			$ 44,406,211			$ 47,165,892		15000	Global Commitment Funded (GC)
Buy-In ~ CFC		$ 4,674,988			$ 4,474,808			$ 5,010,186			$ 5,296,758		15000	Global Commitment Funded (GC)
Buy-In ~ Investments/State Only		$ 54,058			$ 48,610			$ 3,823			$ 4,082		17000	Investments: Global Commitment Funded (GC)
Buy-In ~ Federal Only		$ 4,557,709			$ 4,489,813			$ 5,004,976			$ 5,339,447		18000	Federally Funded @ 100%
Legal Aid		$ 547,983			$ 547,983			$ 547,983			$ 547,983		15000	Global Commitment Funded (GC)
Misc. Pymts.		$ 13,991			$ -			$ -			$ -		17000	General Funds @ 100%
Healthy Vermonters Program	1,084	$ -	$ -	934	$ -	$ -	1,062	$ -	$ -	1,040	$ -	$ -		N/A
Subtotal Miscellaneous Program	**1,254**	**$ 101,770,905**		**1,139**	**$ 105,208,894**		**1,235**	**$ 120,472,395**		**1,219**	**$ 128,086,679**			
TOTAL PROGRAM EXPENDITURES	**200,054**	**$ 834,162,770**		**189,681**	**$ 833,529,976**		**214,331**	**$ 940,709,825**		**208,072**	**$ 924,856,956**			

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PROGRAM EXPENDITURES	SFY '19 Actuals			SFY '20 Actuals			SFY '21 Actuals			SFY '22 As Passed			SFY '22 BAA			SFY '23 GR		
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)	6,485	$ 61,197,266	$ 786.40	6,298	$ 57,489,532	$ 760.67	6,233	$ 55,539,766	$ 742.59	6,475	$ 59,377,463	$ 764.19	6,227	$ 52,883,649	$ 707.72	6,218	$ 52,753,147	$ 707.00
CFC Acute-Care Services	4,275	$ 31,156,672	$ 607.34	4,326	$ 36,665,867	$ 706.27	4,472	$ 41,518,829	$ 773.75	4,596	$ 40,104,146	$ 727.16	4,366	$ 41,284,482	$ 787.99	4,409	$ 42,896,466	$ 810.77
Dual Eligibles	17,651	$ 58,079,913	$ 274.21	17,522	$ 53,812,435	$ 255.93	17,951	$ 45,495,222	$ 211.21	17,649	$ 54,564,094	$ 257.64	18,233	$ 46,071,349	$ 210.57	18,340	$ 49,147,490	$ 223.32
General	10,148	$ 62,828,505	$ 515.94	8,287	$ 51,559,566	$ 518.51	11,165	$ 58,810,030	$ 438.95	10,049	$ 60,588,292	$ 502.44	14,291	$ 77,272,967	$ 450.59	12,965	$ 70,631,417	$ 453.99
New Adult Childless	37,432	$ 204,022,529	$ 454.21	35,009	$ 192,985,152	$ 459.36	42,088	$ 219,469,261	$ 434.54	35,802	$ 201,971,935	$ 470.11	49,215	$ 265,799,315	$ 450.06	45,289	$ 248,036,891	$ 456.40
New Adult W/Child	19,101	$ 88,370,003	$ 385.54	20,177	$ 98,886,805	$ 408.42	24,524	$ 114,487,987	$ 389.03	22,258	$ 108,106,667	$ 404.75	26,643	$ 129,587,428	$ 405.32	25,192	$ 123,224,166	$ 407.62
Dr. D Expansion - State Only										22	$ 252,420	$ 956.14	22	$ 216,354	$ 819.52	22	$ 252,420	$ 956.14
Subtotal Adults	95,092	$ 505,654,888	$ 443.13	91,619	$ 491,399,357	$ 446.96	106,432	$ 535,321,094	$ 419.14	96,851	$ 524,965,017	$ 451.69	118,997	$ 613,115,544	$ 429.36	112,435	$ 586,941,998	$ 435.02
Sunsetted Direct Programs	-	$ 1,118,192																
Sunsetted/Transferred CFC Programs		$ 206,971,637			$ 223,970,679													
Subtotal Sunsetted	-	$ 208,089,830	$ -															
Children																		
Blind or Disabled (BD)	2,093	$ 21,234,113	$ 845.44	1,758	$ 22,103,589	$ 1,047.61	1,633	$ 19,998,435	$ 1,020.33	1,594	$ 20,428,886	$ 1,068.01	1,553	$ 19,252,179	$ 1,033.06	1,477	$ 18,565,073	$ 1,047.45
General	58,779	$ 165,815,234	$ 235.08	57,691	$ 161,637,128	$ 233.48	60,652	$ 155,451,561	$ 213.59	59,588	$ 160,461,685	$ 224.40	61,573	$ 164,447,651	$ 222.56	62,082	$ 167,462,753	$ 224.79
Underinsured	563	$ 472,464	$ 69.93	561	$ 468,699	$ 69.62	566	$ 542,218	$ 79.78	530	$ 433,667	$ 68.19	548	$ 557,058	$ 84.71	537	$ 560,098	$ 86.92
SCHIP (Uninsured)	4,479	$ 9,234,963	$ 171.82	4,535	$ 9,136,532	$ 167.88	4,363	$ 9,417,889	$ 179.87	4,374	$ 8,683,881	$ 165.45	4,535	$ 10,095,316	$ 185.51	4,523	$ 10,117,833	$ 186.41
Dr. D Expansion - State Only										100	$ 1,147,580	$ 956.32	100	$ 983,646	$ 819.70	100	$ 1,147,580	$ 956.32
Subtotal Children	65,914	$ 196,756,774	$ 248.75	64,546	$ 193,345,948	$ 249.62	67,215	$ 185,410,102	$ 229.87	66,186	$ 191,155,699	$ 240.68	68,309	$ 195,335,849	$ 238.30	68,719	$ 197,853,338	$ 239.93
Pharmacy																		
Pharmacy Only - GC	10,382	$ 3,690,759	$ 29.62	9,988	$ 2,243,323	$ 18.72	9,966	$ 3,447,891	$ 28.83	9,568	$ 2,480,024	$ 21.60	9,853	$ 3,550,040	$ 30.03	9,762	$ 3,723,187	$ 31.78
Pharmacy Only - State Only	10,382	$ 4,784,346	$ 38.40	9,988	$ 1,208,067	$ 10.08	9,966	$ 1,444,819	$ 12.08	9,568	$ 2,973,767	$ 25.90	9,853	$ 1,489,423	$ 12.60	9,762	$ 1,505,181	$ 12.85
Pharmacy Only Programs	10,382	$ 8,475,105	$ 68.03	9,988	$ 3,451,390	$ 28.80	9,966	$ 4,892,710	$ 40.91	9,568	$ 5,453,791	$ 47.50	9,853	$ 5,039,463	$ 42.62	9,762	$ 5,228,367	$ 44.63
QHP Assistance																		
Premium Assistance	17,163	$ 5,941,367	$ 28.85	16,237	$ 5,732,382	$ 29.42	15,187	$ 5,591,697	$ 30.68	15,937	$ 5,615,851	$ 29.36	15,937	$ 5,615,851	$ 29.36	15,937	$ 5,615,851	$ 29.36
Cost Sharing	4,919	$ 1,482,370	$ 25.11	3,518	$ 1,170,612	$ 27.73	3,044	$ 1,176,262	$ 32.20	3,236	$ 1,130,724	$ 29.12	3,236	$ 1,130,724	$ 29.12	3,236	$ 1,130,724	$ 29.12
Subtotal QHP Assistance	17,163	$ 7,423,737	$ 36.05	16,237	$ 6,902,994	$ 35.43	15,187	$ 6,767,959	$ 37.14	15,937	$ 6,746,574	$ 35.28	15,937	$ 6,746,574	$ 35.28	15,937	$ 6,746,574	$ 35.28
Subtotal Direct Services	**188,551**	**$ 719,428,695**	**$ 317.96**	**182,389**	**$ 695,099,689**	**$ 317.59**	**198,800**	**$ 732,391,866**	**$ 307.01**	**188,542**	**$ 728,321,082**	**$ 321.91**	**213,096**	**$ 820,237,431**	**$ 320.76**	**206,853**	**$ 796,770,277**	**$ 320.99**
Miscellaneous Program																		
Refugee	1	$ 499	$ 41.60	1	$ 2,478	$ 225.31	-	$ -	$ -	1	$ 499	$ 41.60	1	$ 499	$ 41.60	1	$ 499	$ 41.60
ACA Rebates		$ (3,196,918)			$ (3,777,116)			$ (3,864,124)			$ (3,036,658)			$ (3,036,658)			$ (3,036,658)	
HIV	165	$ 2,703	$ 1.37	181	$ 3,181	$ 1.47	170	$ 4,537	$ 2.22	204	$ 3,440	$ 1.41	172	$ 2,904	$ 1.41	178	$ 3,002	$ 1.41
IMD and Underinsured		$ 10,620,552			$ 8,334,423			$ 2,078,349			$ 100,000			$ 9,288,294			$ 9,663,242	
DSH		$ 22,704,470			$ 22,704,470			$ 22,704,470			$ 22,704,471			$ 22,704,471			$ 22,704,471	
Clawback		$ 34,453,902			$ 35,532,471			$ 30,355,530			$ 36,711,213			$ 36,539,706			$ 40,397,960	
Buy-In ~ GC		$ 36,384,457			$ 37,665,327			$ 40,643,414			$ 39,164,716			$ 44,406,211			$ 47,165,892	
Buy-In ~ CFC		$ 3,872,527			$ 4,194,263			$ 4,674,988			$ 4,474,808			$ 5,010,186			$ 5,296,758	
Buy-In ~ Investments/State Only		$ 49,581			$ 43,219			$ 54,058			$ 48,610			$ 3,823			$ 4,082	
Buy-In ~ Federal Only		$ 4,172,939			$ 4,336,552			$ 4,557,709			$ 4,489,813			$ 5,004,976			$ 5,339,447	
Legal Aid		$ 547,983			$ 547,983			$ 547,983			$ 547,983			$ 547,983			$ 547,983	
Misc. Pymts.		$ 990,667			$ 408,764			$ 13,991			$ -			$ -			$ -	
Healthy Vermonters Program	1,389	$ -	$ -	1,229	$ -	$ -	1,084	$ -	$ -	934	$ -	$ -	1,062	$ -	$ -	1,040	$ -	$ -
Subtotal Miscellaneous Program	**1,555**	**$ 110,603,362**		**1,411**	**$ 109,996,016**		**1,254**	**$ 101,770,905**		**1,139**	**$ 105,208,894**		**1,235**	**$ 120,472,395**		**1,219**	**$ 128,086,679**	
TOTAL PROGRAM EXPENDITURES	**190,106**	**$ 830,032,057**		**183,801**	**$ 805,095,705**		**200,054**	**$ 834,162,770**		**189,681**	**$ 833,529,976**		**214,331**	**$ 940,709,825**		**208,072**	**$ 924,856,956**	
Total Program Expenditure with CFC Traditional		**$ 1,037,003,694**			**$ 1,029,066,384**													

CATEGORIES OF SERVICE

CATEGORIES OF SERVICE

DVHA Medicaid Spend by Category of Service			
Category of Service	**SFY 2021 Actual Spend**	**SFY 2022 BAA**	**SFY 2023 Gov. Rec.**
Inpatient	$ 105,062,447	$ 142,239,547	$ 140,833,556
Outpatient	$ 66,917,125	$ 75,060,579	$ 73,006,948
Physician	$ 59,475,655	$ 69,510,725	$ 72,482,312
Pharmacy	$ 222,427,004	$ 247,402,779	$ 226,449,448
Nursing Home	$ 772,521	$ 859,265	$ 823,095
Mental Health Facility	$ 541,949	$ 602,803	$ 577,428
Dental	$ 27,117,661	$ 30,568,818	$ 29,995,689
MH Clinic	$ 589,162	$ 655,318	$ 627,733
Independent Lab/Xray	$ 7,626,399	$ 8,372,246	$ 7,825,672
Home Health	$ 6,074,687	$ 6,918,132	$ 6,910,375
RHC	$ 3,082,532	$ 3,428,661	$ 3,284,334
Hospice	$ 10,195,134	$ 11,352,075	$ 10,895,572
FQHC	$ 32,847,445	$ 34,748,487	$ 33,478,849
Chiropractor	$ 1,568,039	$ 1,744,110	$ 1,670,692
Nurse Practitioner	$ 986,921	$ 1,097,740	$ 1,051,531
Skilled Nursing	$ 2,077,629	$ 2,460,457	$ 2,518,122
Podiatrist	$ 148,720	$ 165,420	$ 158,457
Psychologist	$ 28,524,600	$ 31,727,556	$ 30,392,002
Optometrist	$ 2,472,714	$ 2,750,368	$ 2,634,593
Optician	$ 188,413	$ 209,570	$ 200,748
Transportation	$ 11,931,013	$ 13,302,394	$ 12,808,844
Therapy Services	$ 11,093,425	$ 11,847,956	$ 10,919,672
Prosthetic/Ortho	$ 3,237,447	$ 3,600,972	$ 3,449,391
Medical Supplies	$ 4,498,946	$ 5,004,122	$ 4,498,946
DME	$ 8,238,080	$ 9,163,114	$ 8,238,080
H&CB Services	$ 118,777	$ 132,114	$ 126,553
H&CB Services Mental Service	$ 1,489,767	$ 1,861,144	$ 1,796,467
Enhanced Resident Care	$ -	$ 0	$ -
Personal Care Services	$ 12,175,104	$ 12,559,972	$ 12,175,104
Targeted Case Management (Drug)	$ (80,687)	$ 176,804	$ 165,551
Assistive Community Care	$ 14,481,427	$ 16,107,511	$ 15,936,141
Day Treatment MHS	$ -	$ 0	$ -
OADAP Families in Recovery	$ 1,129,927	$ 2,946,732	$ 2,800,000
Rehabilitation	$ 200,335	$ 321,055	$ 319,350
D & P Dept of Health	$ 34,647	$ 49,112	$ 36,915
PcPlus Case Mgmt and Special Program Payments	$ -	$ -	$ -
Blue Print & CHT Payments	$ 17,492,714	$ 18,474,684	$ 17,492,714
ACO Capitation	$ 159,741,399	$ 169,445,308	$ 168,504,615
PDP Premiums	$ 1,192,523	$ 1,326,428	$ 1,270,593
HIPPS	$ 495,882	$ 551,563	$ 528,345
ESIA/CHAP Premium Assistance	$ -	$ -	$ -
Ambulance	$ 7,477,442	$ 8,317,066	$ 7,966,964
Dialysis	$ 1,088,939	$ 1,211,213	$ 1,160,227
ASC	$ 244,970	$ 272,477	$ 261,007
Unknown	$ 44,796	$ (261,388)	$ 47,728
Miscellaneous	$ 495,553	$ 556,960	$ 527,995
Non Classified	$ (707,753)	$ (787,224)	$ (754,087)
Other Expenditures	$ 110,310,647	$ 120,966,834	$ 128,206,170
Offsets	$ (140,959,309)	$ (158,311,754)	$ (147,075,704)
Total DVHA Program Expenditures	**$ 834,162,770**	**$ 940,709,825**	**$ 927,224,741**

CASELOAD AND UTILIZATION

Caseload and Utilization

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

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

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

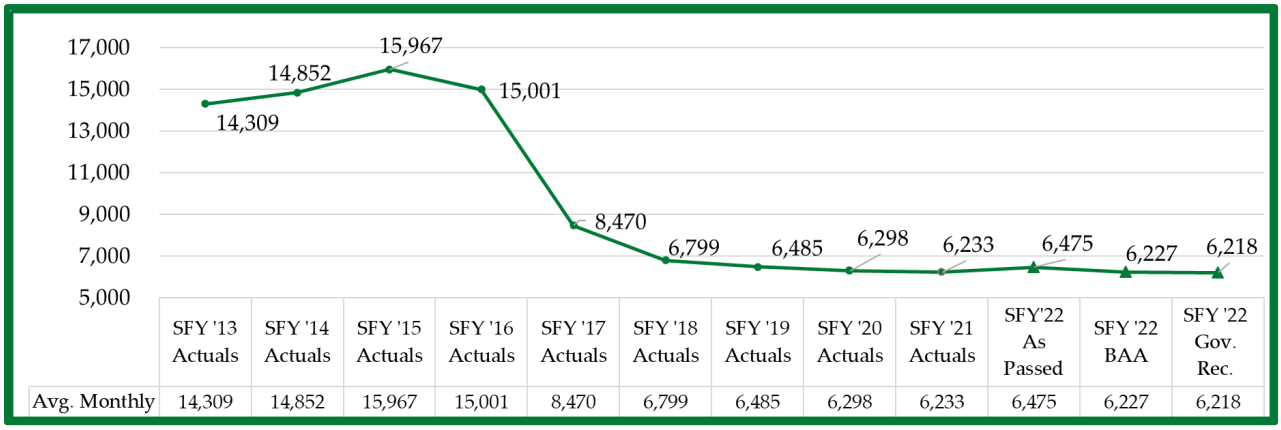
- Age 19 and older
- Determined ABD but ineligible for Medicare includes:
  - Supplemental Security Income (SSI) cash assistance recipients
  - Working disabled
  - Hospice patients
  - Breast and Cervical Cancer Treatment (BCCT) participants
  - Medicaid/Qualified Medicare Beneficiaries (QMB)
  - Medically 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	6,233	$ 55,539,766	$ 742.59
SFY 2022 As Passed	6,475	$ 59,377,463	$ 764.19
SFY 2022 BAA	6,227	$ 52,883,649	$ 707.72
SFY 2023 Gov. Rec.	6,218	$ 52,753,147	$ 707.00

Aged, Blind, or 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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	14,309	14,852	15,967	15,001	8,470	6,799	6,485	6,298	6,233	6,475	6,227	6,218

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.

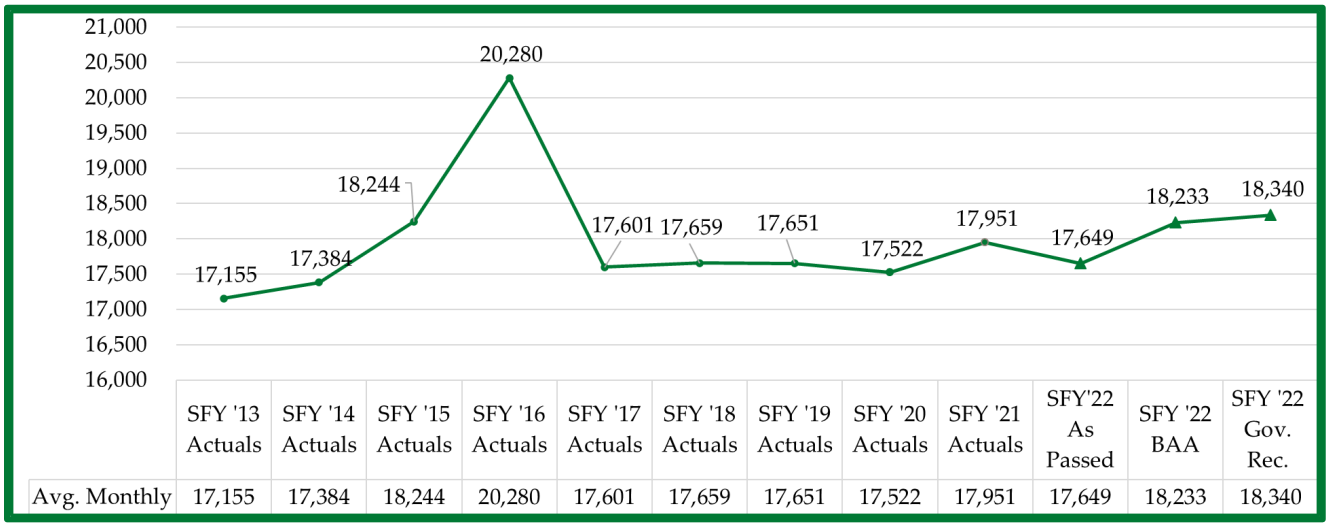
Medicaid assists with:

- 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	17,951	$ 45,495,222	$ 211.21
SFY 2022 As Passed	17,649	$ 54,564,094	$ 257.64
SFY 2022 BAA	18,233	$ 46,071,349	$ 210.57
SFY 2023 Gov. Rec.	18,340	$ 49,147,490	$ 223.32

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	17,155	17,384	18,244	20,280	17,601	17,659	17,651	17,522	17,951	17,649	18,233	18,340

General Adults

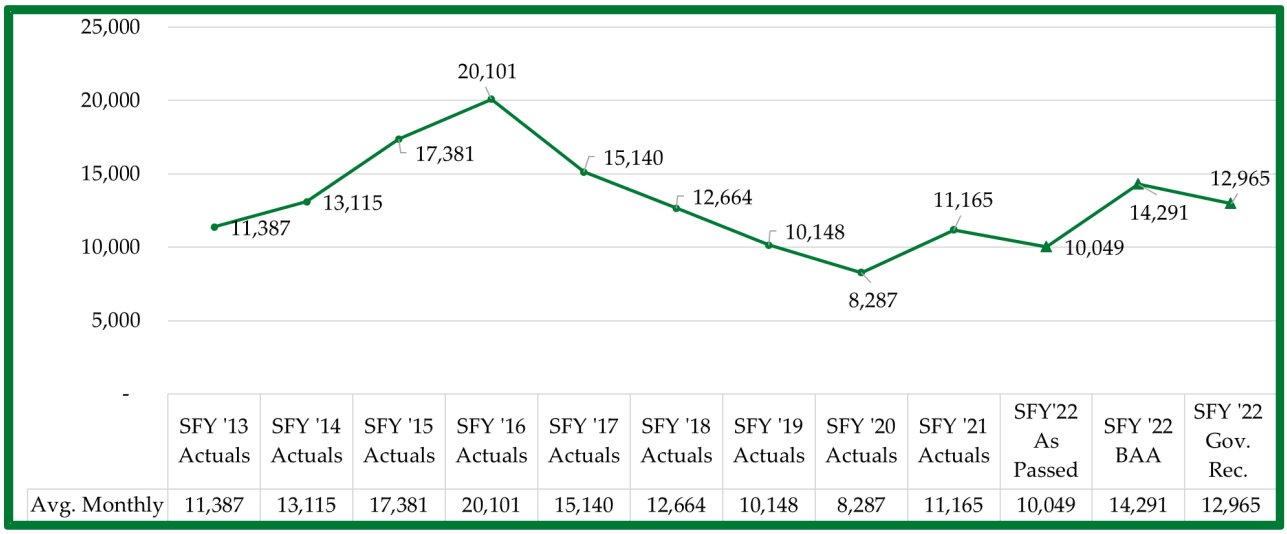
The eligibility requirements for General Adults are as follows:

- 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 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	8,287	$ 51,559,566	$ 518.51
SFY 2021	11,165	$ 58,810,030	$ 438.95
SFY 2022 As Passed	10,049	$ 60,588,292	$ 502.44
SFY 2022 BAA	14,291	$ 77,272,967	$ 450.59
SFY 2023 Gov. Rec.	12,965	$ 70,631,417	$ 453.99

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	11,387	13,115	17,381	20,101	15,140	12,664	10,148	8,287	11,165	10,049	14,291	12,965

New Adults without Children

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

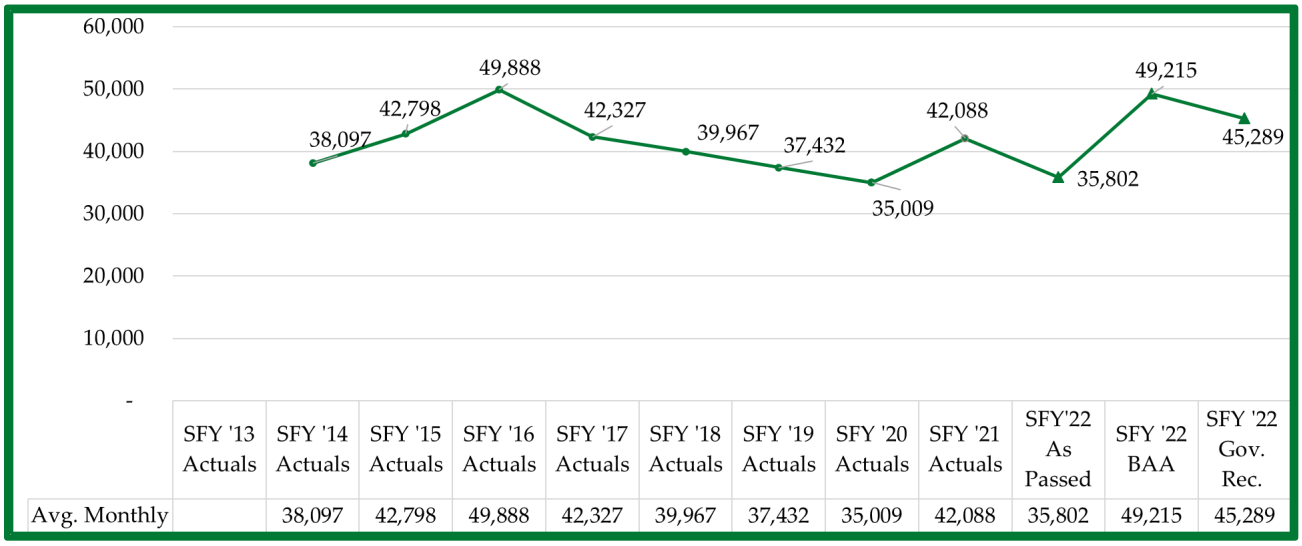
- Age 19 and older
- Income below the designated FPL
- No children in the household

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

New Adults Without Children Caseload, 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	35,009	$ 192,985,152	$ 459.36
SFY 2021	42,088	$ 219,469,261	$ 434.54
SFY 2022 As Passed	35,802	$ 201,971,935	$ 470.11
SFY 2022 BAA	49,215	$ 265,799,315	$ 450.06
SFY 2023 Gov. Rec.	45,289	$ 248,036,891	$ 456.40

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly		38,097	42,798	49,888	42,327	39,967	37,432	35,009	42,088	35,802	49,215	45,289

New Adults with Children

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

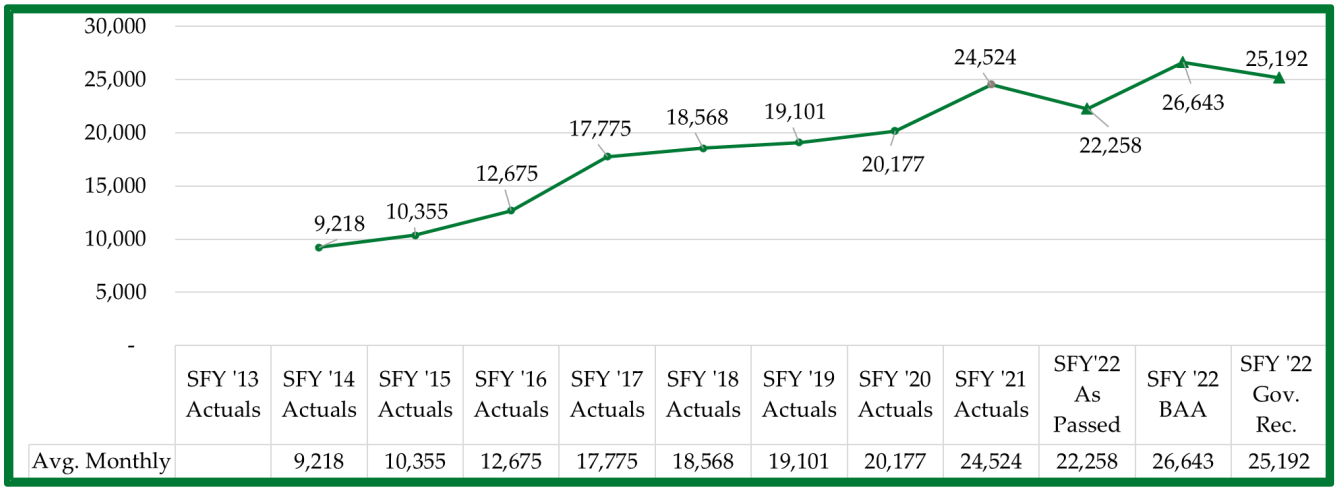
- Age 19 and older
- Income below the designated FPL
- With children in the household under the age of 19

Unlike New Adults without children, for this population, the Federal government reimburses services for New Adults 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	20,177	$ 98,886,805	$ 408.42
SFY 2021	24,524	$ 114,487,987	$ 389.03
SFY 2022 As Passed	22,258	$ 108,106,667	$ 404.75
SFY 2022 BAA	26,643	$ 129,587,428	$ 405.32
SFY 2023 Gov. Rec.	25,192	$ 123,224,166	$ 407.62

Average Monthly Caseload Actuals Comparison by SFY



Pharmacy Only Programs – Prescription Assistance

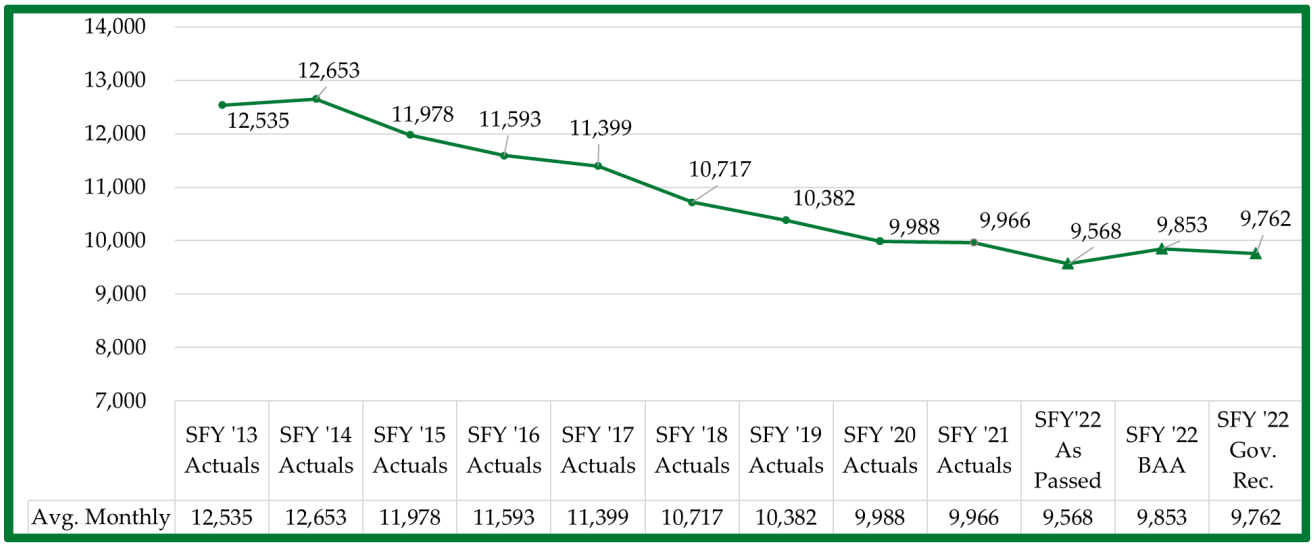
Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status, and age under the name VPharm. There are monthly premiums based on income and co-pays based on the cost of the prescription.
VPharm assists Vermonters enrolled in Medicare 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	9,988	$ 3,451,390	$ 28.80
SFY 2021	9,966	$ 4,892,710	$ 40.91
SFY 2022 As Passed	9,568	$ 5,453,791	$ 47.50
SFY 2022 BAA	9,853	$ 5,039,463	$ 42.62
SFY 2023 Gov. Rec.	9,762	$ 5,228,367	$ 44.63

Average Monthly Caseload Actuals Comparison by SFY



Choices for Care Acute

The eligibility requirements for Choices for Care Acute are as follows:

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

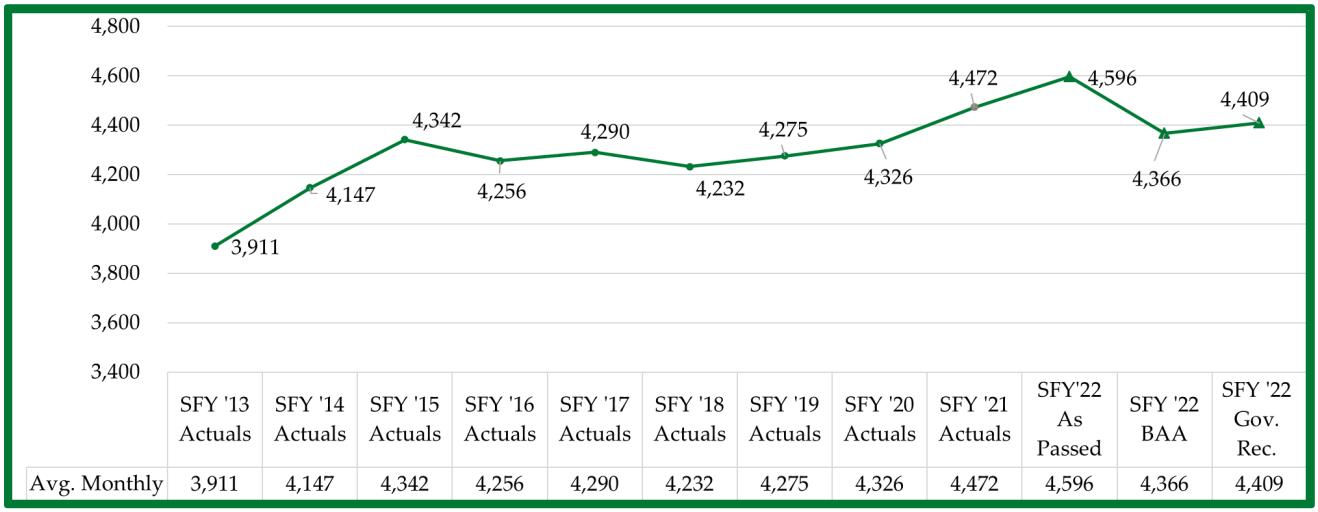
- Vermonters in nursing homes
- Home-based settings under home and community-based services (HCBS) waiver programs
- Enhanced residential care (ERC)

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	4,326	$ 36,665,867	$ 706.27
SFY 2021	4,472	$ 41,518,829	$ 773.75
SFY 2022 As Passed	4,596	$ 40,104,146	$ 727.16
SFY 2022 BAA	4,366	$ 41,284,482	$ 787.99
SFY 2023 Gov. Rec.	4,409	$ 42,896,466	$ 810.77

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	3,911	4,147	4,342	4,256	4,290	4,232	4,275	4,326	4,472	4,596	4,366	4,409

Healthy Vermonters

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

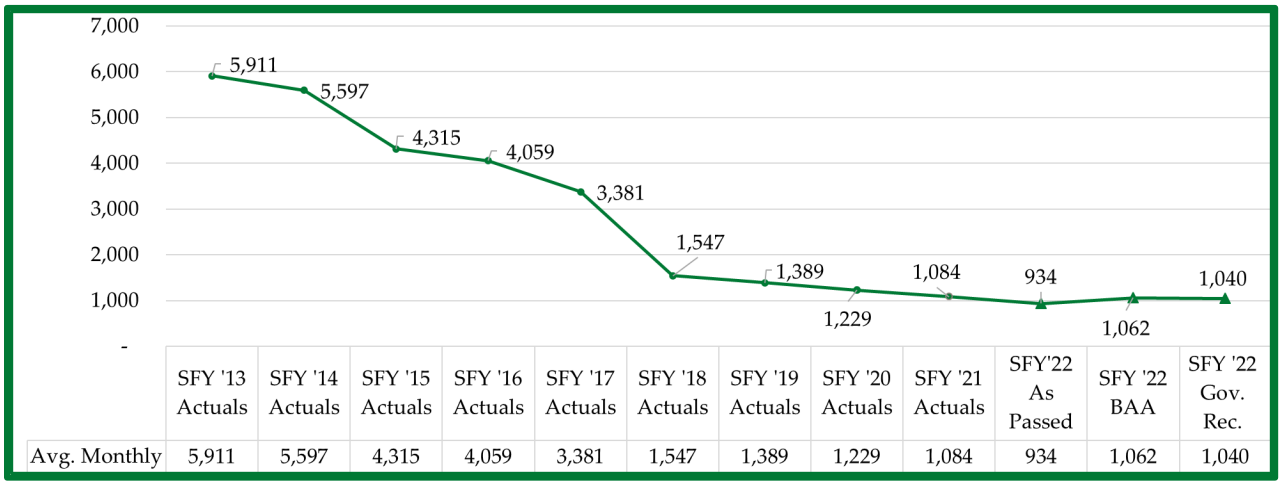
The eligibility requirements for Healthy Vermonters are:

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

Healthy Vermonters Caseload 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	1,229
SFY 2021	1,084
SFY 2022 As Passed	934
SFY 2022 BAA	1,062
SFY 2023 Gov. Rec.	1,040

Average Monthly Caseload Actuals Comparison by SFY



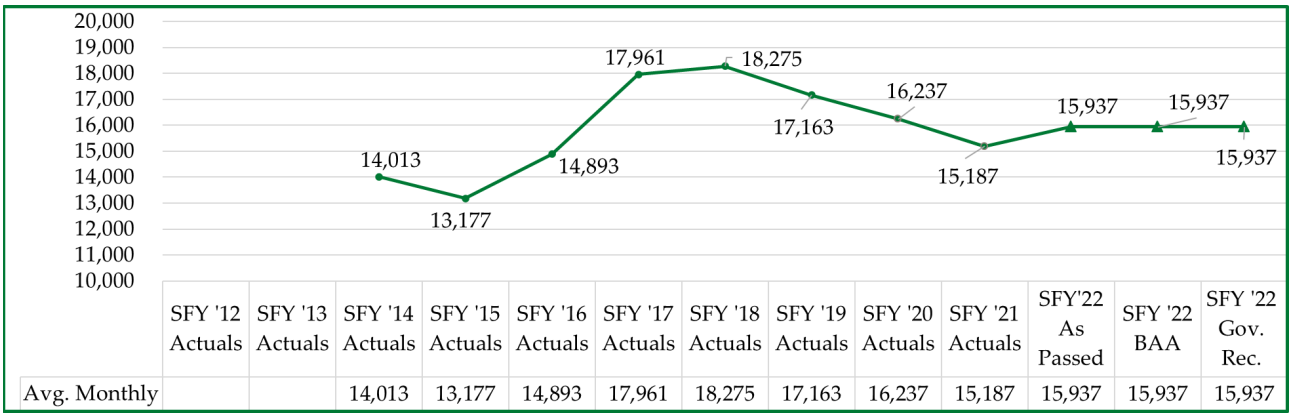
Premium Assistance and Cost Sharing

Individuals with household income over 138% of FPL can choose to enroll in qualified health plans purchased on Vermont Health Connect, Vermont's health benefit exchange. These plans have varying cost sharing and premium levels. There are Federal tax credits to make premiums more affordable for people with incomes less than 400% of FPL and Federal subsidies to make out of pocket expenses more affordable for people with incomes below 250% FPL. Despite these Federal tax credits and cost sharing subsidies provided by the Affordable Care Act, coverage through these QHP will be less affordable than Vermonters had previously experienced under VHAP and Catamount. The State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300% of FPL to address this affordability challenge.

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	16,237	$ 5,732,382	$ 29.42
SFY 2021	15,187	$ 5,591,697	$ 30.68
SFY 2022 As Passed	15,937	$ 5,615,851	$ 29.36
SFY 2022 BAA	15,937	$ 5,615,851	$ 29.36
SFY 2023 Gov. Rec.	15,937	$ 5,615,851	$ 29.36

Premium Assistance Average Monthly Caseload Actuals Comparison by SFY



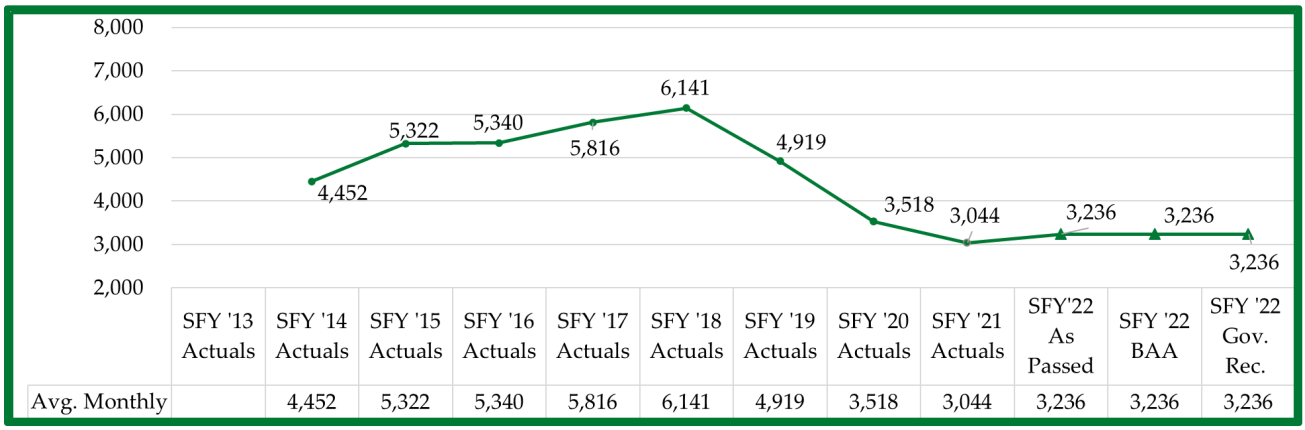
	SFY '12 Actuals	SFY '13 Actuals	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 Actuals	SFY '21 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly			14,013	13,177	14,893	17,961	18,275	17,163	16,237	15,187	15,937	15,937	15,937

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	3,518	$ 1,170,612	$ 27.73
SFY 2021	3,044	$ 1,176,262	$ 32.20
SFY 2022 As Passed	3,236	$ 1,130,724	$ 29.12
SFY 2022 BAA	3,236	$ 1,130,724	$ 29.12

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly		4,452	5,322	5,340	5,816	6,141	4,919	3,518	3,044	3,236	3,236	3,236

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

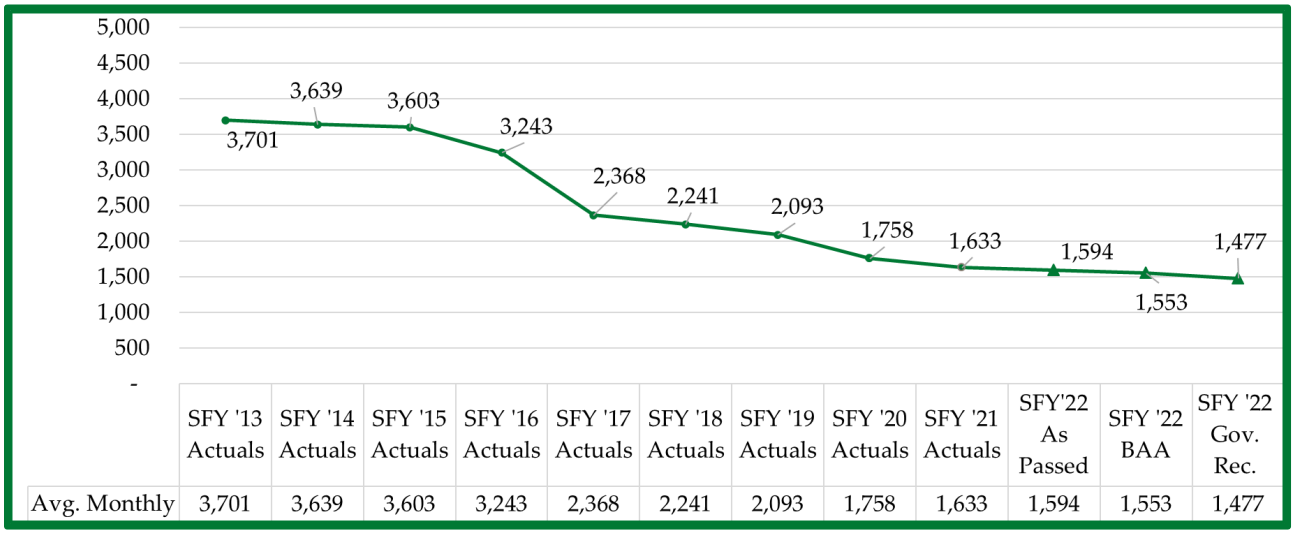
The eligibility requirements for Blind or Disabled (BD) and/or Medically Needy Children are as follows:

- 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 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	1,758	$ 22,103,589	$ 1,047.61
SFY 2021	1,633	$ 19,998,435	$ 1,020.33
SFY 2022 As Passed	1,594	$ 20,428,886	$ 1,068.01
SFY 2022 BAA	1,553	$ 19,252,179	$ 1,033.06
SFY 2023 Gov. Rec.	1,477	$ 18,565,073	$ 1,047.45

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	3,701	3,639	3,603	3,243	2,368	2,241	2,093	1,758	1,633	1,594	1,553	1,477

General Children

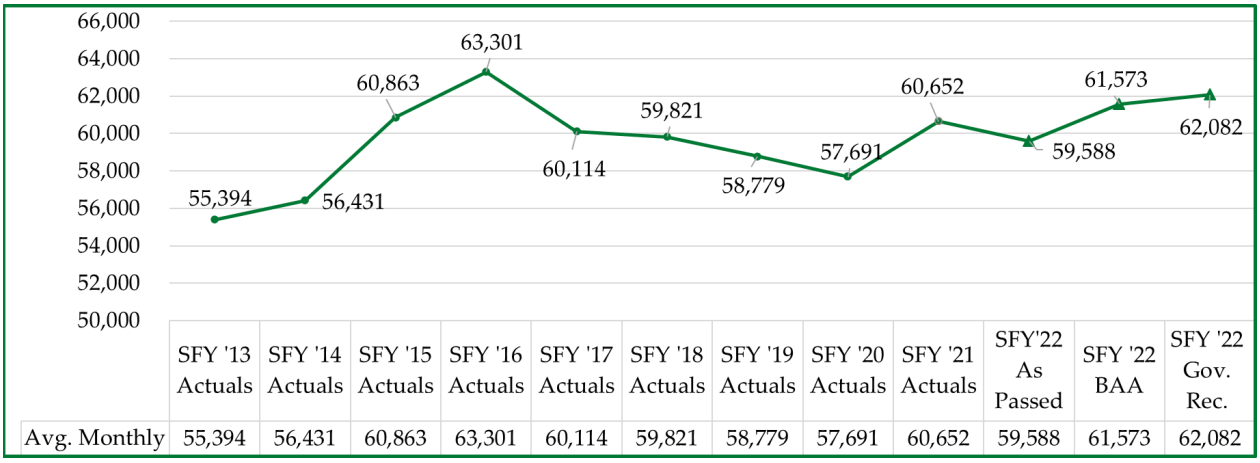
The eligibility requirements for General Children are as follows:

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

General Children Caseload, Expenditure, and PMPM Comparison by 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	57,691	$ 161,637,128	$ 233.48
SFY 2021	60,652	$ 155,451,561	$ 213.59
SFY 2022 As Passed	59,588	$ 160,461,685	$ 224.40
SFY 2022 BAA	61,573	$ 164,447,651	$ 222.56
SFY 2023 Gov. Rec.	62,082	$ 167,462,753	$ 224.79

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	55,394	56,431	60,863	63,301	60,114	59,821	58,779	57,691	60,652	59,588	61,573	62,082

Optional Benefit (Underinsured) Children

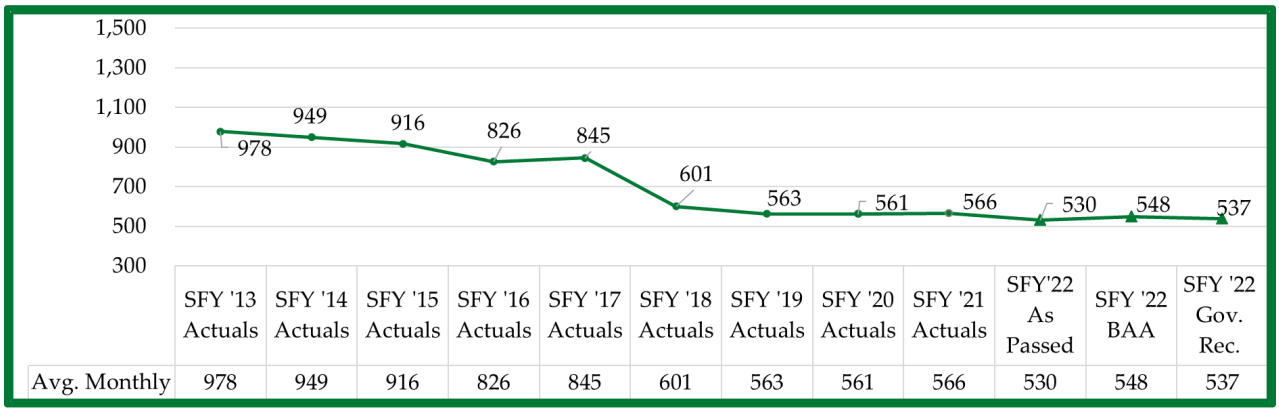
This program was designed as part of the original 1115 Waiver to Title XIX of the Social Security Act to provide healthcare coverage for children who would otherwise be underinsured.
The general eligibility requirements for Underinsured Children are as follows:

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

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	561	$ 468,699	$ 69.62
SFY 2021	566	$ 542,218	$ 79.78
SFY 2022 As Passed	530	$ 433,667	$ 68.19
SFY 2022 BAA	548	$ 557,058	$ 84.71
SFY 2023 Gov. Rec.	537	$ 560,098	$ 86.92

Average Monthly Caseload Actuals Comparison by SFY



Children's Health Insurance Program (CHIP)

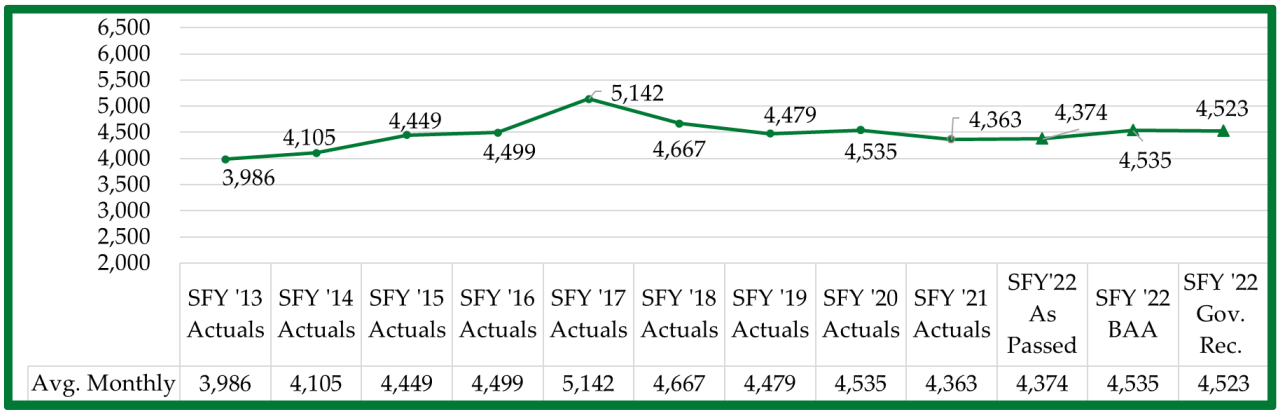
As of January 1, 2014, CHIP is operated as a Medicaid Expansion with enhanced federal funding from Title XXI of the Social Security Act.
The general eligibility requirements for the CHIP are:

- Age 18 and younger
- Income up to 312% FPL
- 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	4,535	$ 9,136,532	$ 167.88
SFY 2021	4,363	$ 9,417,889	$ 179.87
SFY 2022 As Passed	4,374	$ 8,683,881	$ 165.45
SFY 2022 BAA	4,535	$ 10,095,316	$ 185.51
SFY 2023 Gov. Rec.	4,523	$ 10,117,833	$ 186.41

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 Actuals	SFY'22 As Passed	SFY '22 BAA	SFY '22 Gov. Rec.
Avg. Monthly	3,986	4,105	4,449	4,499	5,142	4,667	4,479	4,535	4,363	4,374	4,535	4,523

APPENDIX A: VANTAGE REPORTS