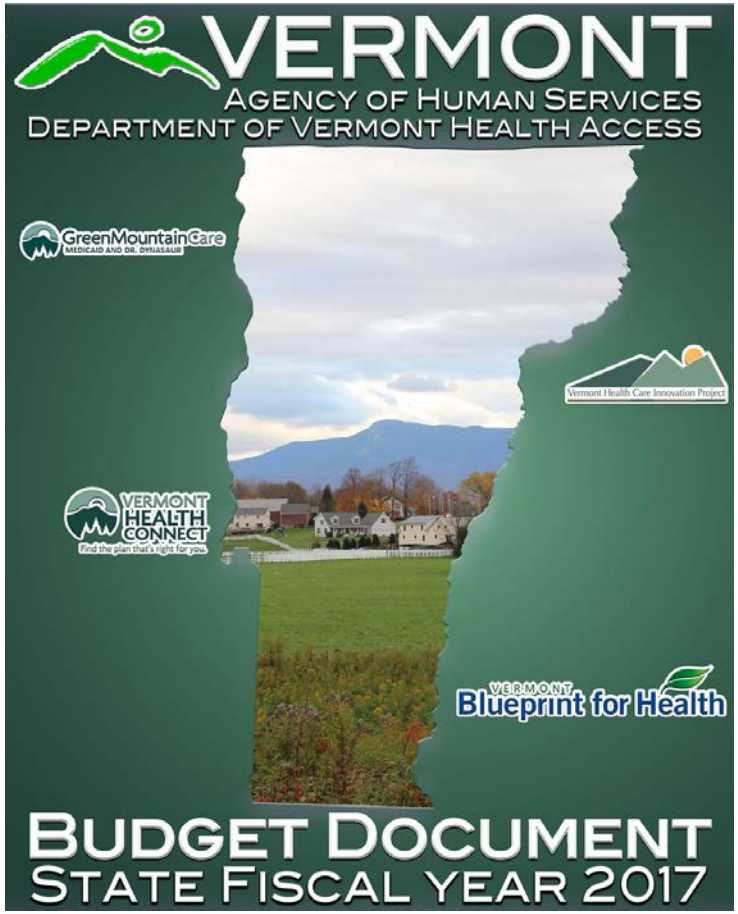
DEPARTMENT OF VERMONT HEALTH ACCESS

State Fiscal year 2017

Budget Presentation



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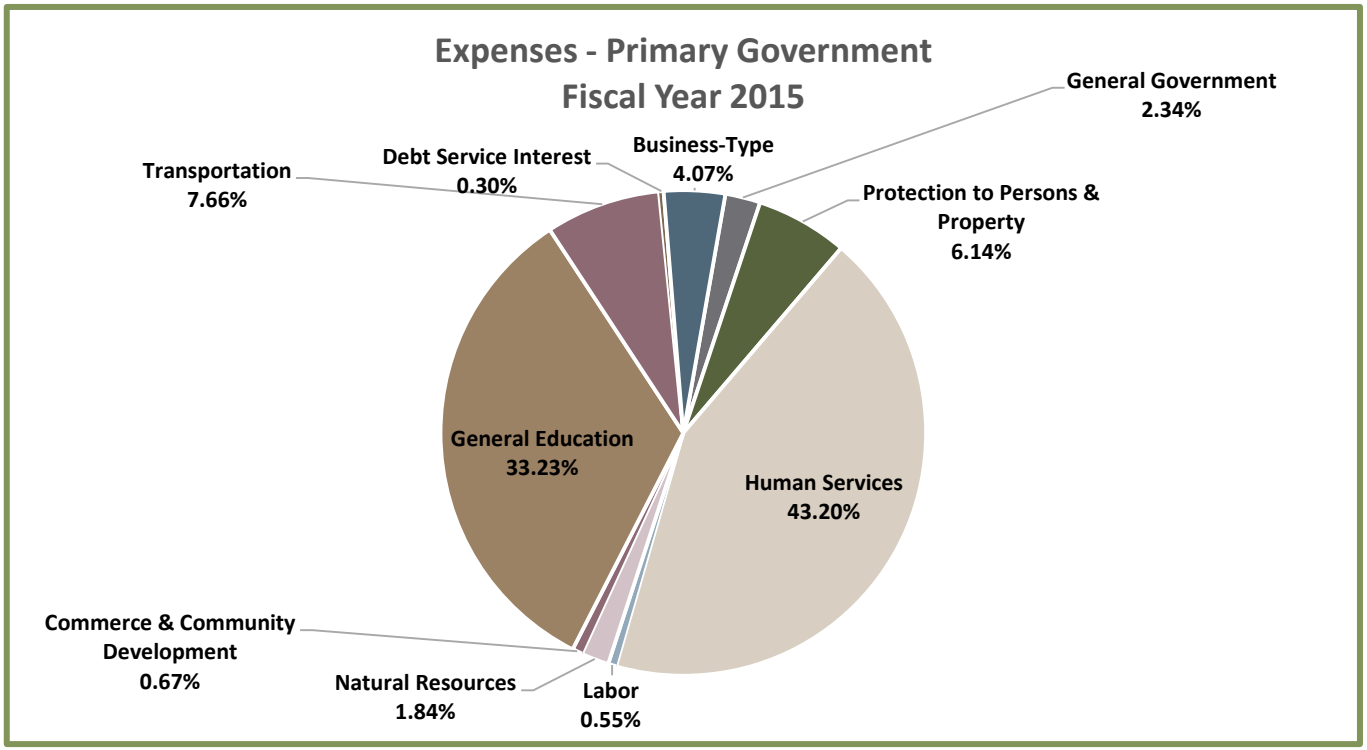
Chapter 1: All State Spending

see page 7 of the DVHA Budget Document

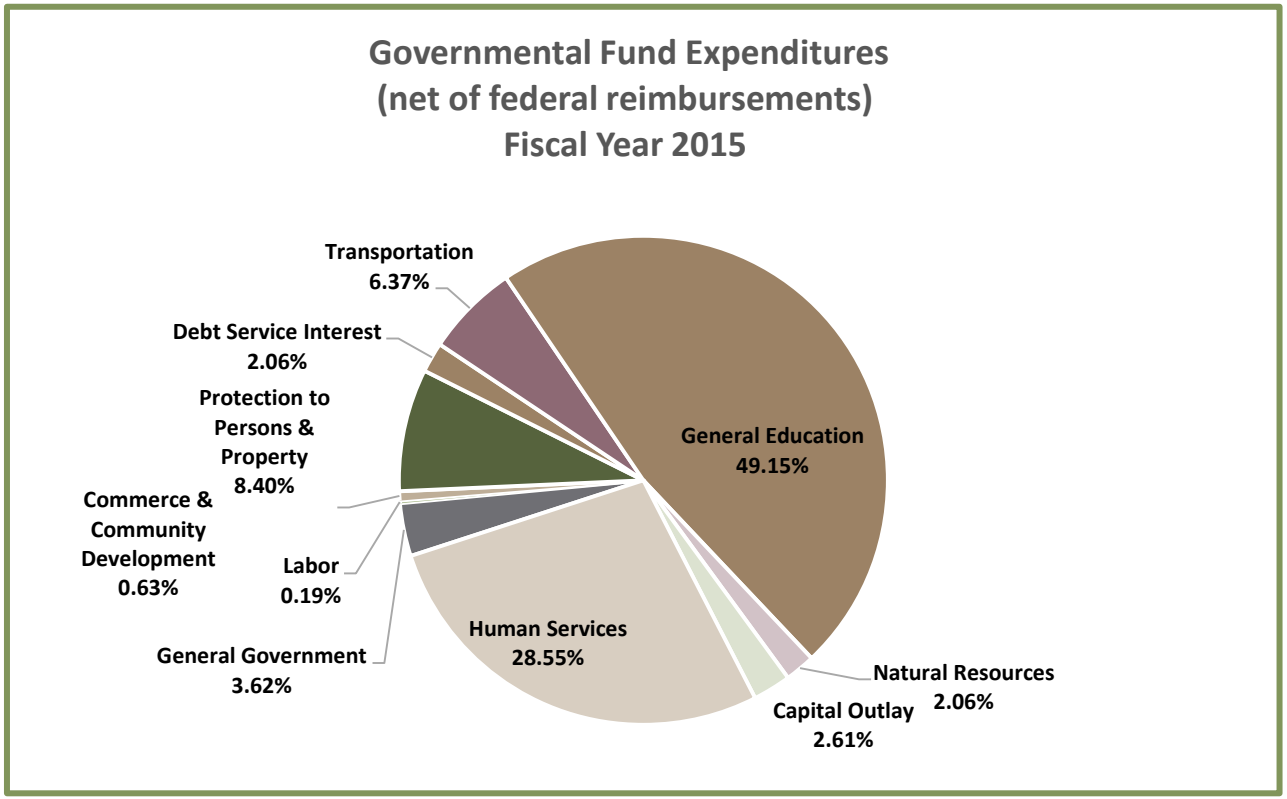
Total All Funds Statewide Spending

One of the Governor's top priorities is to support Vermonters' health through prevention and universal, affordable, and quality healthcare for all. To that end, the Agency of Human Services accounts for 43% of gross spending. see page 8 of the DVHA Budget Document



Total State Funds Spending

While AHS overall spend is 43% of the total budget, due to the ability to earn federal receipts, only 28.5% of state spending goes to support the Agency – second to the Agency of Education. see page 8 of the DVHA Budget Document

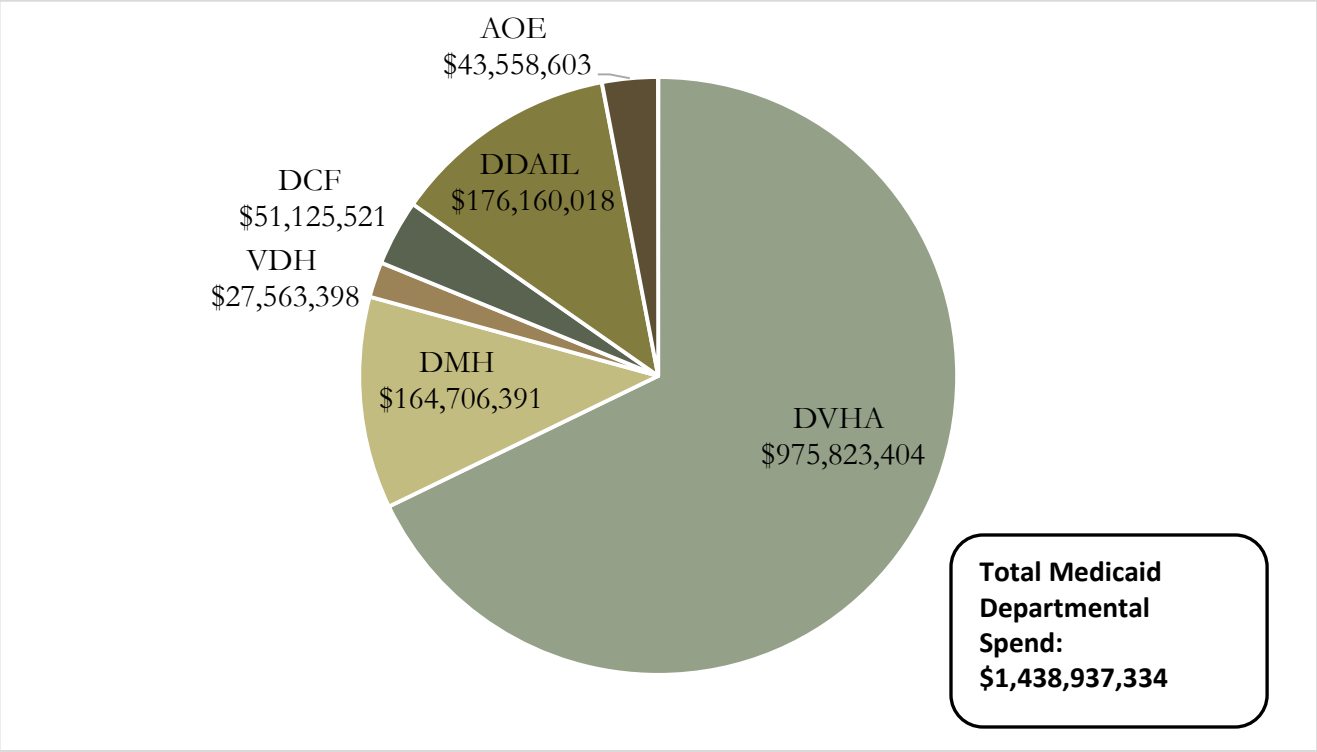


Chapter 2: Total AHS Medicaid Spending

see page 9 of the DVHA Budget Document

Total AHS Medicaid Spending

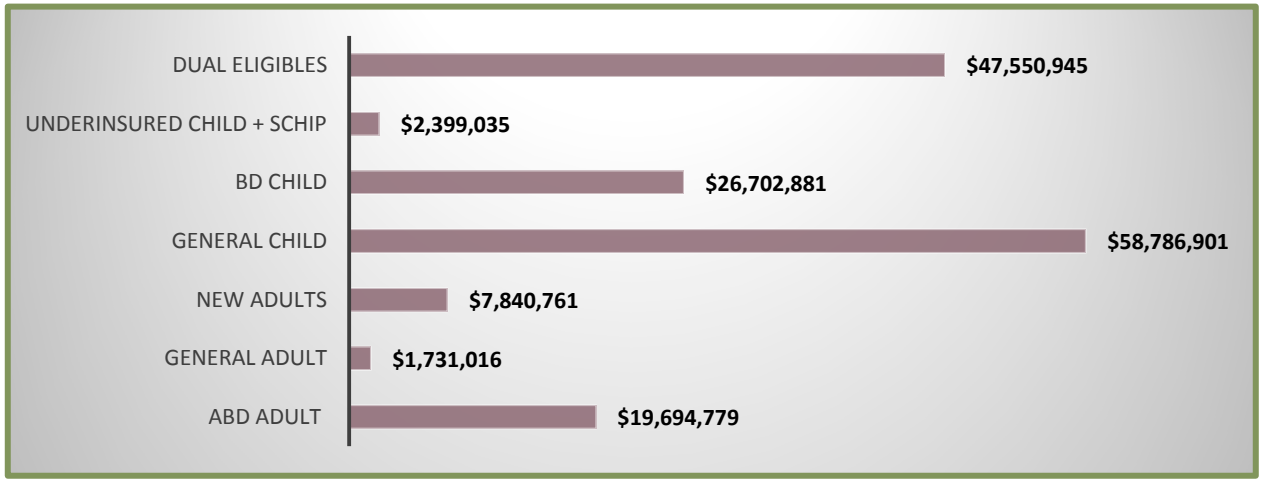
Within the Agency of Human Services, DVHA accounted for nearly two-thirds of the Medicaid expenses of $1.4 billion in SFY 2015.



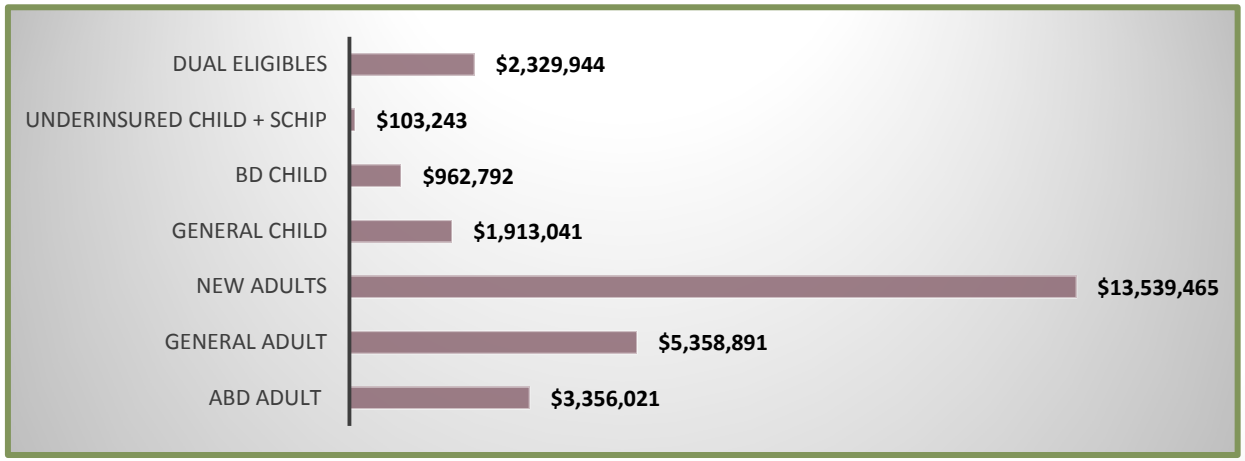
For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

Total Spending by Department

SFY 2015 DMH Medicaid & CHIP Spend: $164,706,391



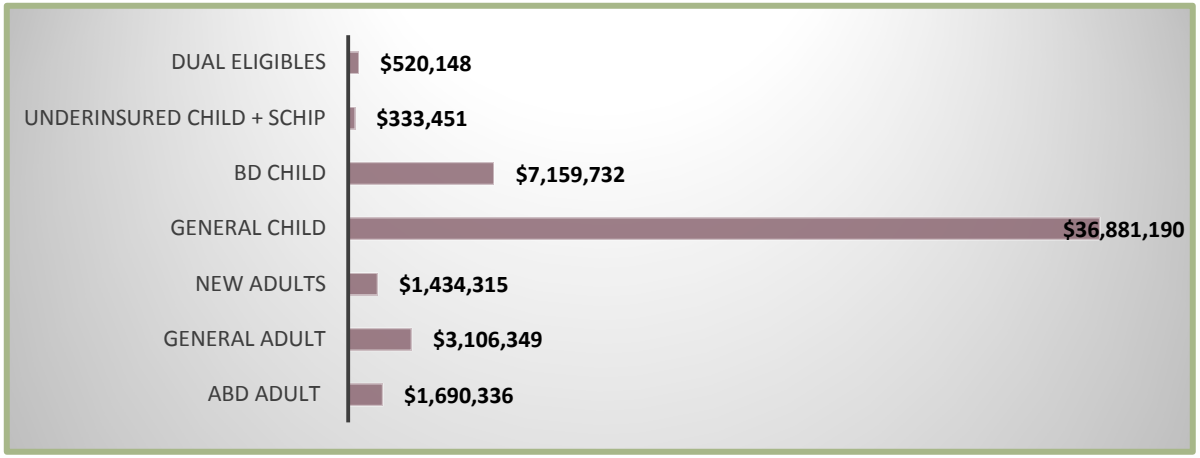
SFY 2015 VDH Medicaid & CHIP Spend: $27,563,398



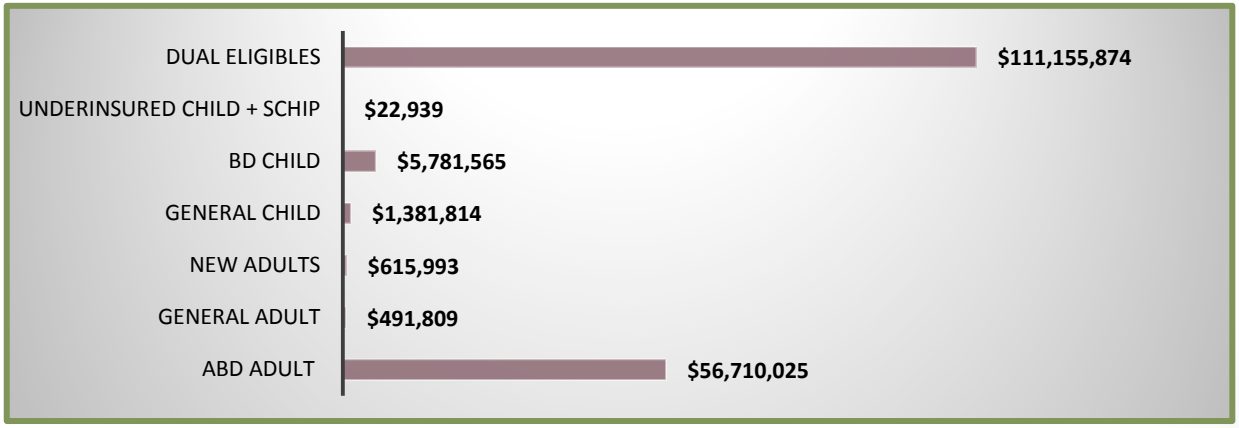
For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

Total Spending by Department

SFY 2015 DCF Medicaid & CHIP Spend: $51,125,521



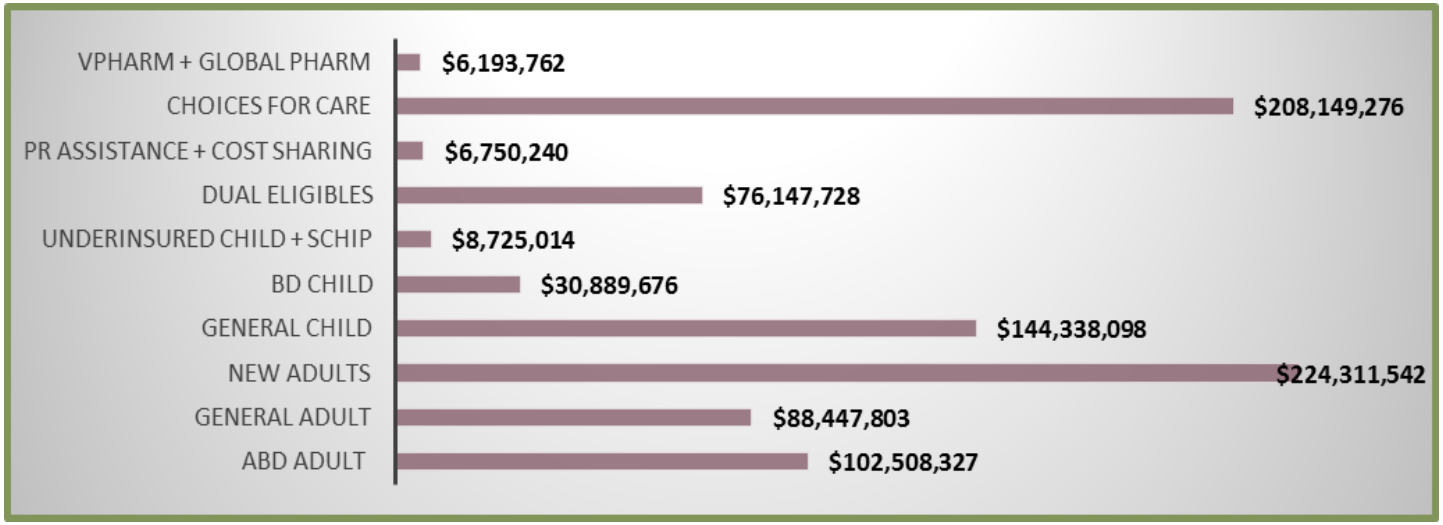
SFY 2015 DDAIL Medicaid & CHIP Spend: $176,160,018



For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

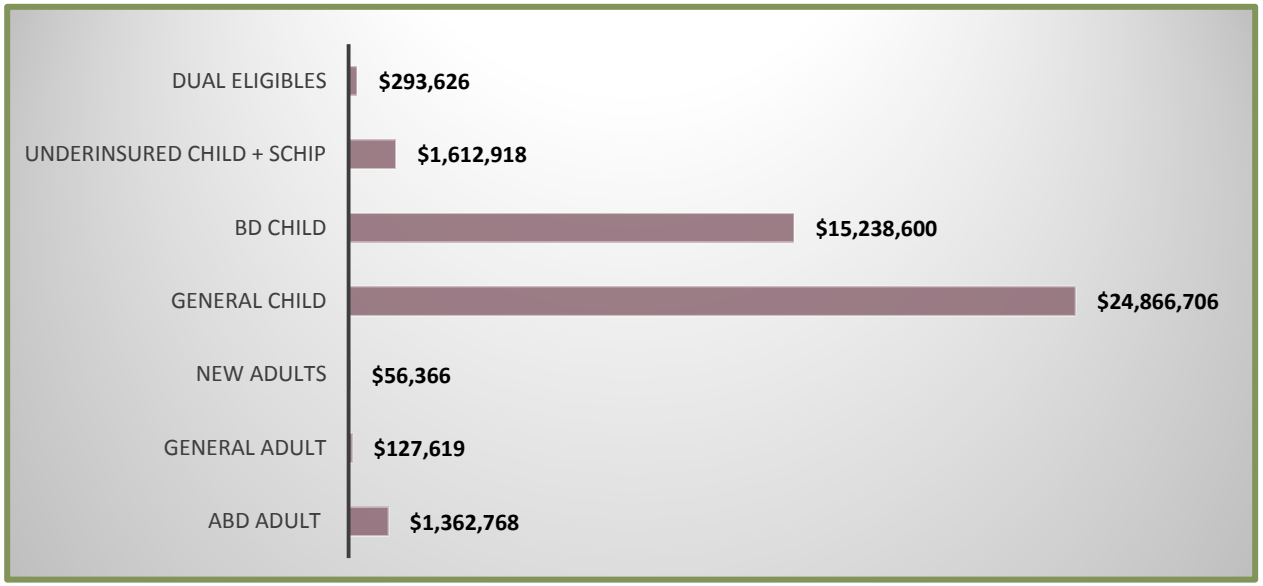
Total Spending by Department

SFY 2015 DVHA Program Spend: $975,823,404



For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

Total Spending by Agency of Education: $43,558,603

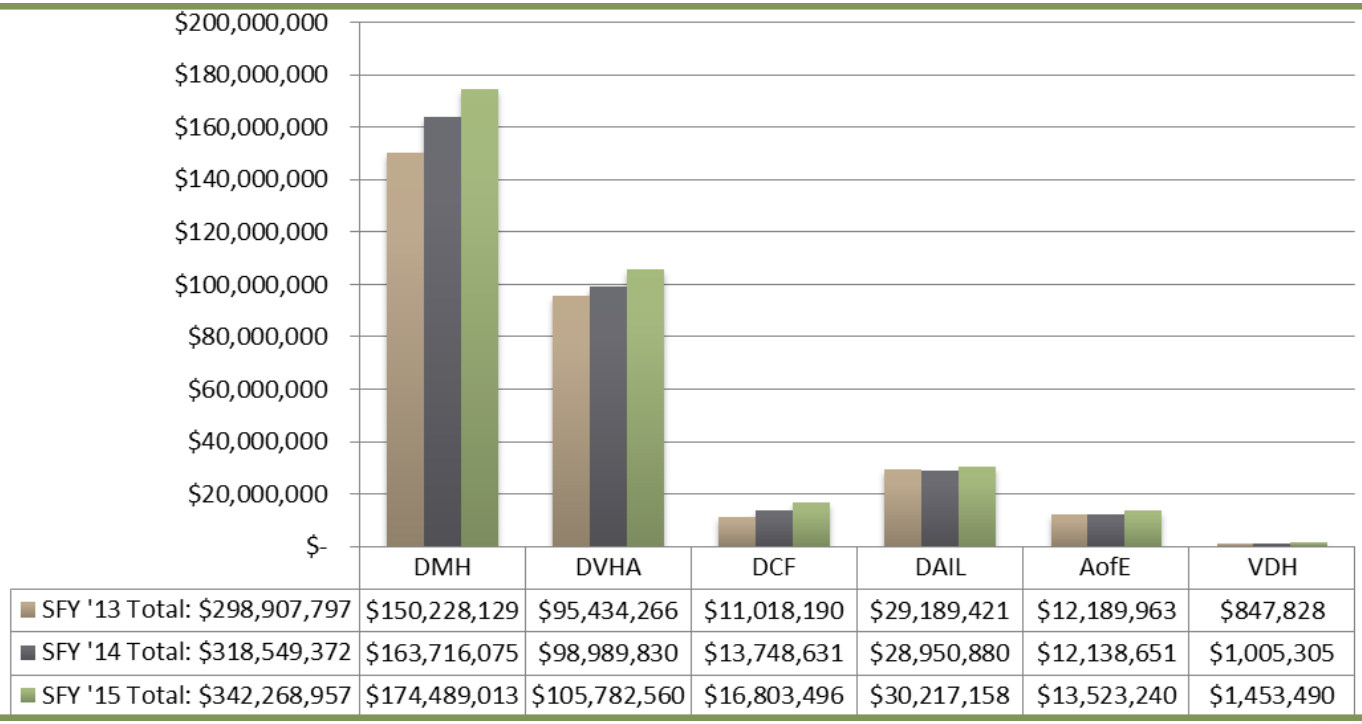


For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

Mental Health Expenditures by Department

The DMH and DVHA have developed a plan for unified service and financial allocation for publicly funded mental health services as part of an integrated healthcare system. Details on this plan can be found in Appendix C.

Today, mental health services are managed throughout the Agency, each focusing on the individual goals of their respective programs.



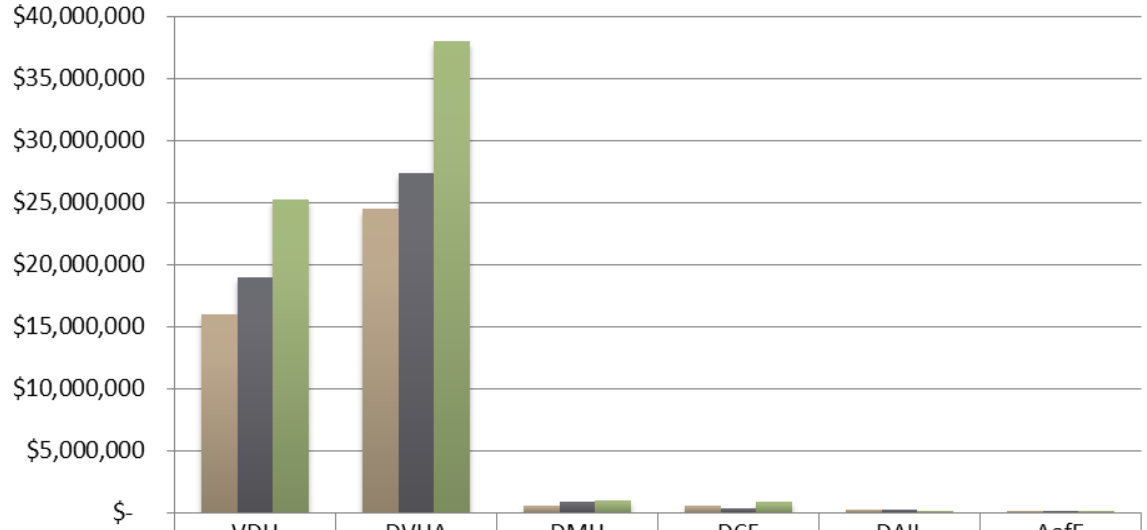
	DMH	DVHA	DCF	DAIL	AofE	VDH
SFY '13 Total: $298,907,797	$150,228,129	$95,434,266	$11,018,190	$29,189,421	$12,189,963	$847,828
SFY '14 Total: $318,549,372	$163,716,075	$98,989,830	$13,748,631	$28,950,880	$12,138,651	$1,005,305
SFY '15 Total: $342,268,957	$174,489,013	$105,782,560	$16,803,496	$30,217,158	$13,523,240	$1,453,490

For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

Substance Abuse Expenditures by Department

ADAP manages a Preferred Provider Network in which Medicaid members can obtain preventative, intervention, treatment, and recovery services.

DVHA in accordance with the Medicaid State Plan manages the Medicaid Provider Network. Providers within this network can provide crisis, preventative, intervention, treatment, & recovery services to eligible members in accordance with the Provider's licensure.



	VDH	DVHA	DMH	DCF	DAIL	AofE
SFY '13 Total: $41,683,304	$15,926,375	$24,445,718	$560,133	$560,133	$190,910	$34
SFY '14 Total: $47,650,925	$18,911,753	$27,350,988	$845,975	$355,087	$187,088	$34
SFY '15 Total: $65,081,309	$25,190,912	$37,972,375	$934,385	$847,899	$135,704	$34

For more information regarding the Agency's Medicaid distribution please see Chapter 2 of the DVHA Budget Document.

How Vermont Compares

Modified Adjusted Gross Income or MAGI

see page 26 of the DVHA Budget Document

Some of the changes in eligibility guidelines are:

No longer requiring a 12 month uninsured period for those Vermonters who lost previous insurance voluntarily;

No requirement for students to take school insurance;

No premiums;

Eligibility granted retroactively to the first of the application month;
No resource test;

Expanded income considerations such as depreciation, worker's compensation payments, child support, and expanded tax deductions.

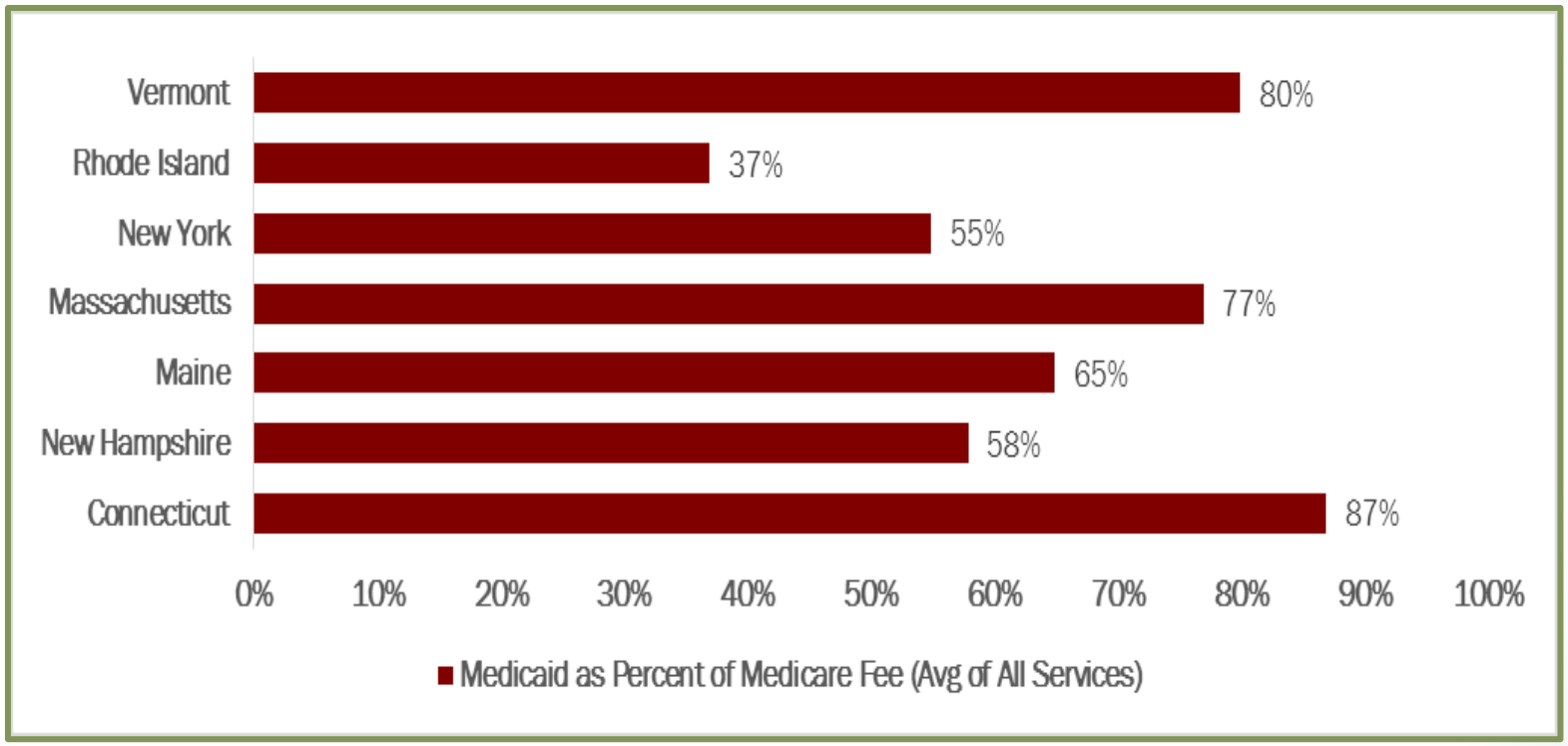
How Vermont Compares

Many variables drive Medicaid costs making multi-state comparisons difficult:

- Varying Reimbursement Strategies
- Optional vs. Mandatory Benefits
- Demographics
- Service Limitations

Varying Reimbursement Strategies

- Medicaid reimbursement rates vary dramatically state by state. see page 31 of the DVHA Budget Document



Optional vs. Mandatory Benefits

States can also opt to provide optional benefits. see pages 30-32 of the DVHA budget document

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

Demographics

Age and income are factors that drive Medicaid spend. see page 35 of the DVHA budget document

Population Distribution by Age CY 2014							
Location	Children 0-18	Adults 19-25	Adults 26-34	Adults 35-44	Adults 45-54	Adults 55-64	65+
Connecticut	24%	9%	12%	12%	16%	15%	14%
Maine	21%	7%	9%	13%	16%	15%	19%
Massachusetts	23%	10%	13%	12%	13%	14%	16%
New Hampshire	21%	10%	10%	12%	16%	15%	16%
New York	23%	10%	13%	12%	14%	13%	15%
Rhode Island	22%	11%	11%	12%	15%	15%	15%
Vermont	20%	8%	13%	12%	14%	16%	16%

Distribution of Total Population by Federal Poverty Level CY 2014				
Location	Under 100%	100-199%	200-399%	400%+
Connecticut	9%	13%	26%	52%
Maine	15%	16%	32%	37%
Massachusetts	13%	15%	21%	51%
New Hampshire	8%	13%	26%	53%
New York	14%	20%	26%	40%
Rhode Island	12%	16%	29%	43%
Vermont	10%	14%	32%	44%

Service Limitations

States also have the ability to limit services provided. The chart below provides examples of these limitations. see page 33 of the DVHA budget document

Location	Service Limitation
Connecticut	10 days/occurrence in approved Alcohol Abuse Treatment Center for acute and evaluation phase of treatment
Maine	Substance abuse services limited to 30 weeks
Massachusetts	Substance abuse counseling limited to 24 sessions per recipient per calendar year. MassHealth does not reimburse for nonmedical MH services such as community outreach services and voc rehab.
New Hampshire	Community mental health care limited to $1,800/year unless specified criteria met, low service utilizer with severe or persistent mental illness limited to $4,000/year; ambulatory detox services for substance abuse are not covered
New York	Beneficiary Specific Utilization Thresholds apply to mental health services
Rhode Island	MH/SA limits of 30 outpatient counseling sessions, 60 days treatment, and 60 consecutive days of residential treatment per calendar year. Beyond this requires prior authorization.
Vermont	1 group psychotherapy per day and three per week; Limit of 12 family psychotherapy sessions per year without patient; No psychiatric inpatient limitation

Cross State Comparison

see page 31 of the DVHA budget document

State	Number of Medicaid & CHIP enrollees July 2014	Acute Care	Acute Care PMPY	Long-Term Care	LTC PMPY	DSH Payments	Total	Total PMPY
Connecticut	753,927	$4,194,040,934	$5,563	$2,888,126,680	$3,831	$149,024,544	$7,231,192,158	$9,591.37
Maine	280,241	$1,590,280,368	$5,675	$827,567,260	$2,953	$39,328,950	$2,457,176,578	$8,768.08
Massachusetts	1,639,259	$10,333,520,762	$6,304	$4,269,201,576	$2,604	$0	$14,602,722,338	$8,908.12
New Hampshire	181,182	$555,436,277	$3,066	$678,967,270	$3,747	$109,314,773	$1,343,718,320	$7,416.40
New York	6,452,876	$35,605,322,810	$5,518	$15,232,267,682	$2,361	$3,366,485,105	$54,204,075,597	$8,399.99
Rhode Island	276,028	$2,069,517,652	$7,497	$240,416,400	$871	$138,322,435	$2,448,256,487	$8,869.59
Vermont	185,242	$1,369,634,401	$7,394	$127,690,959	$689	$37,448,781	$1,534,774,141	$8,285.24

Chapter 3: DVHA Internal

see page 37 of the DVHA Budget Document

DVHA Internal

see page 37 of the DVHA budget document

Mission Statement

Provide leadership for Vermont stakeholders to improve access, quality and cost-effectiveness of healthcare.

Assist Medicaid beneficiaries in accessing clinically appropriate health services.

Administer Vermont's public health insurance system efficiently and effectively.

Collaborate with other healthcare system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

DVHA is Comprised of the Following Divisions

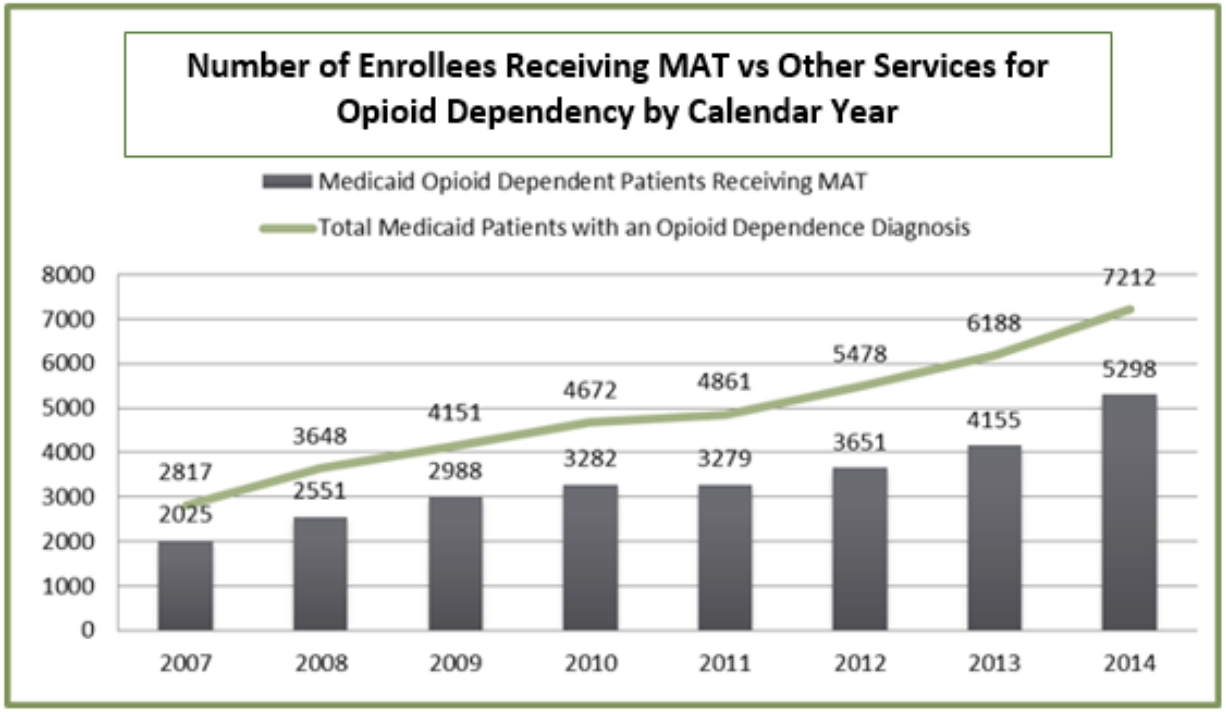
see page 40 of the DVHA budget document

- *Medicaid Health Services and Managed Care*
- *Medicaid Policy, Fiscal, and Support Services*
- *Medicaid Payment Reform and Reimbursement*
- *Blueprint for Health*
- *Vermont Health Connect*

Status of SFY '16 Initiatives

see page 63 of the DVHA budget document

There were several initiatives undertaken in SFY '16, and starting on page 61 in the DVHA budget book, you can read about the successful implementation of such. Of particular note, specific to Opioid Treatment, 73% of Medicaid requests with an Opioid dependency diagnosis received MAT (Hub & Spoke).



Measurements and Outcomes

see page 64 of the DVHA budget document

DVHA programs and staff strive toward excellence and value in serving Vermonters effectively. Asking the questions – *how much did we do, how well did we do it, is anyone better off* – DVHA works toward the most powerful results possible. Pages 64-73 highlight some of these initiatives and units. Each provides the program statement, annual outcomes with data, and plans to ensure continued success. Added to this section this year are sample score cards for two of the programs. (The full scorecards can be found in appendix b.)

- *Blueprint for Health*
- *Coordination of Benefits*
- *Program Integrity*
- *Vermont Chronic Care Initiative*
- *Quality Reporting*
- *Mental Health and Substance Abuse*

Caseload and Utilization

see pages 74-102 of the DVHA budget document

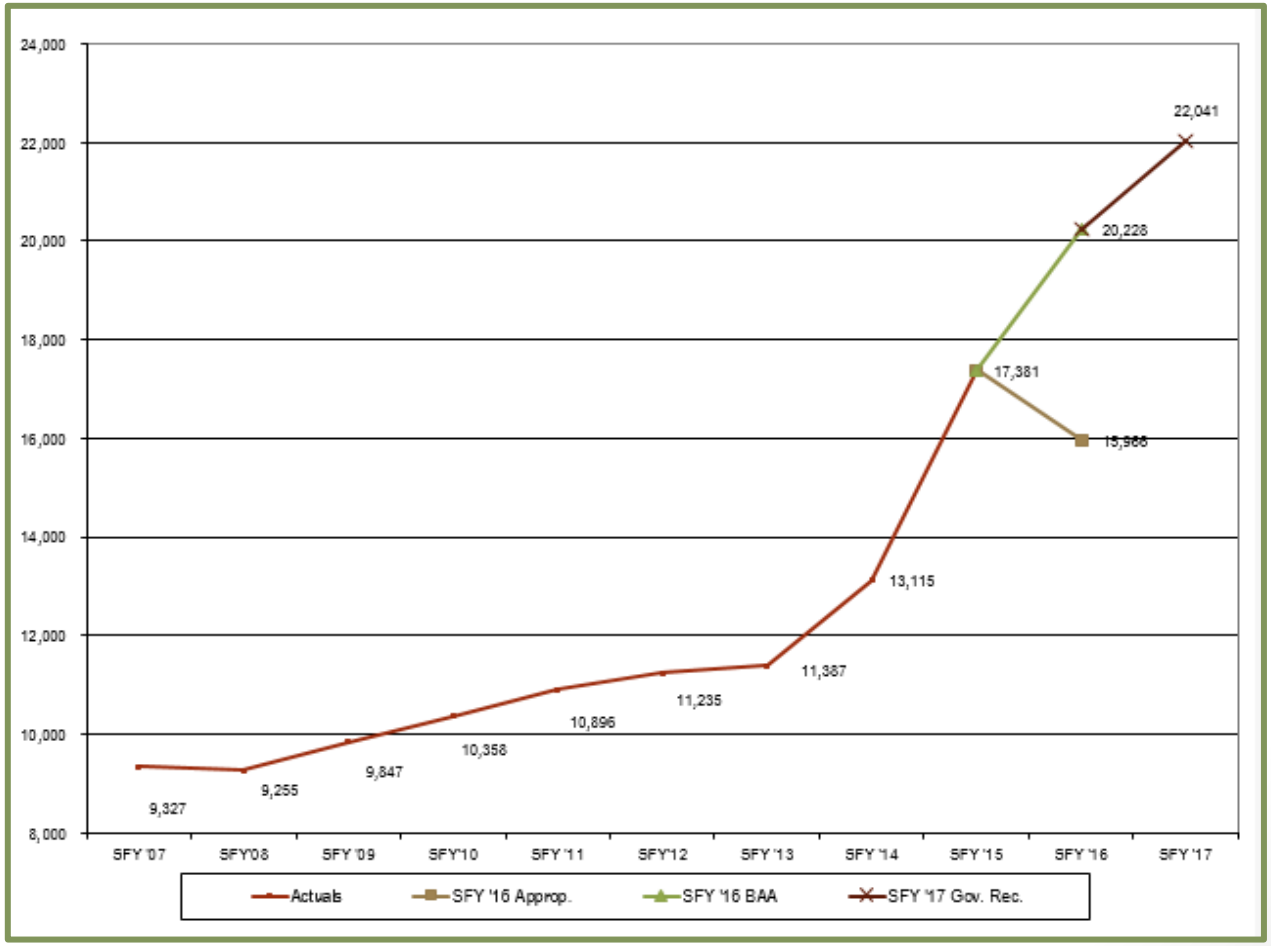
Green Mountain Care is the umbrella name for the state-sponsored family of low-cost and free health coverage programs for uninsured Vermonters. Offered by the State of Vermont and its partners, **Green Mountain Care** programs offer access to quality, comprehensive healthcare coverage at a reasonable cost. Plans with either low co-payments and premiums or no co-payments or premiums keep out-of-pocket costs reasonable.

This section of the budget book describes the populations covered by Vermont Medicaid. New this year is demographic information for each of the Medicaid Eligibility Groups (MEGs).

General Adults

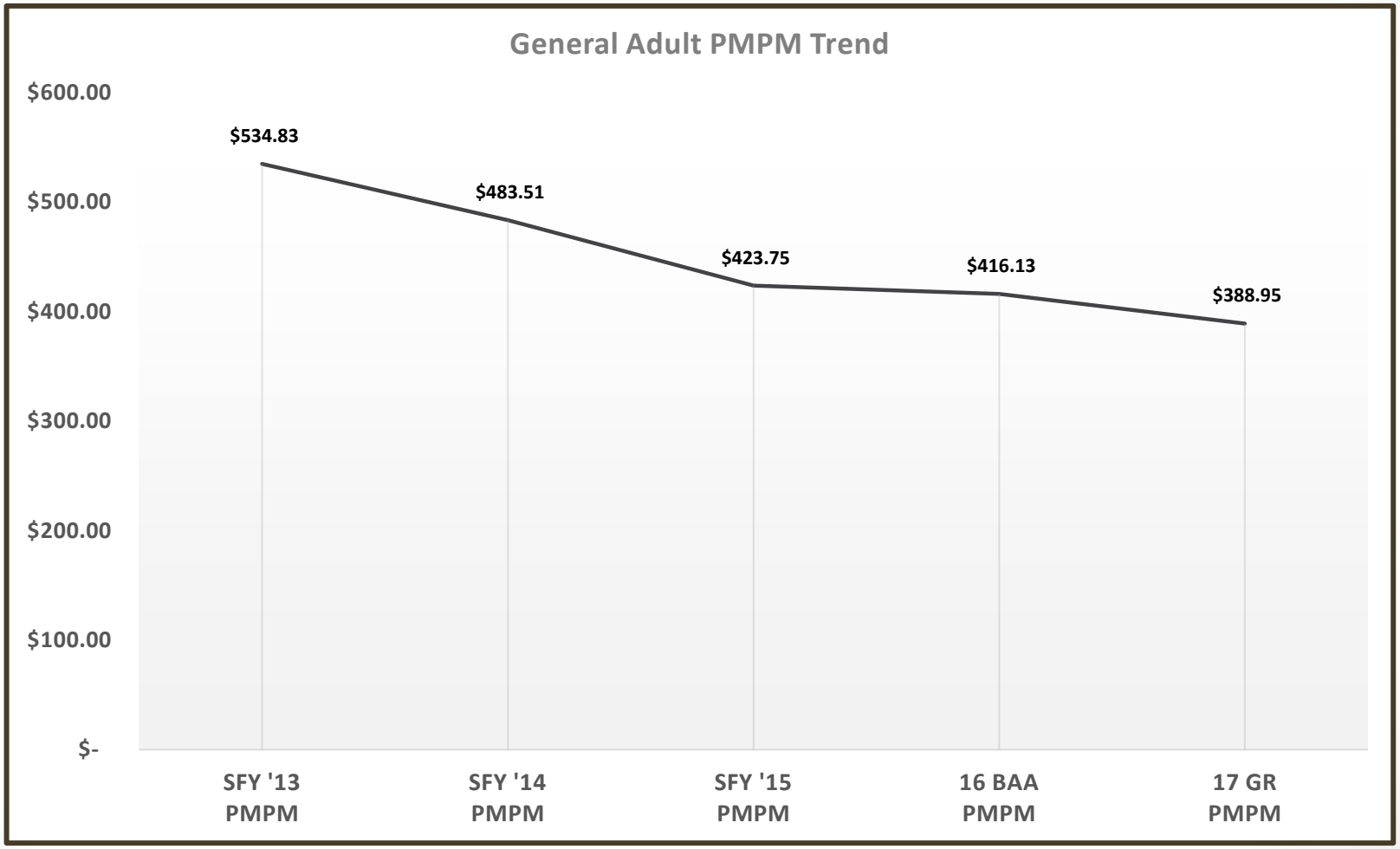
see pages 74-102 of the DVHA budget document

With the Affordable Care Act and conversion to MAGI eligibility, DVHA has seen an increase in caseload. However, in many instances, the cost of care has been dropping. Depicted below is one population group.



General Adults

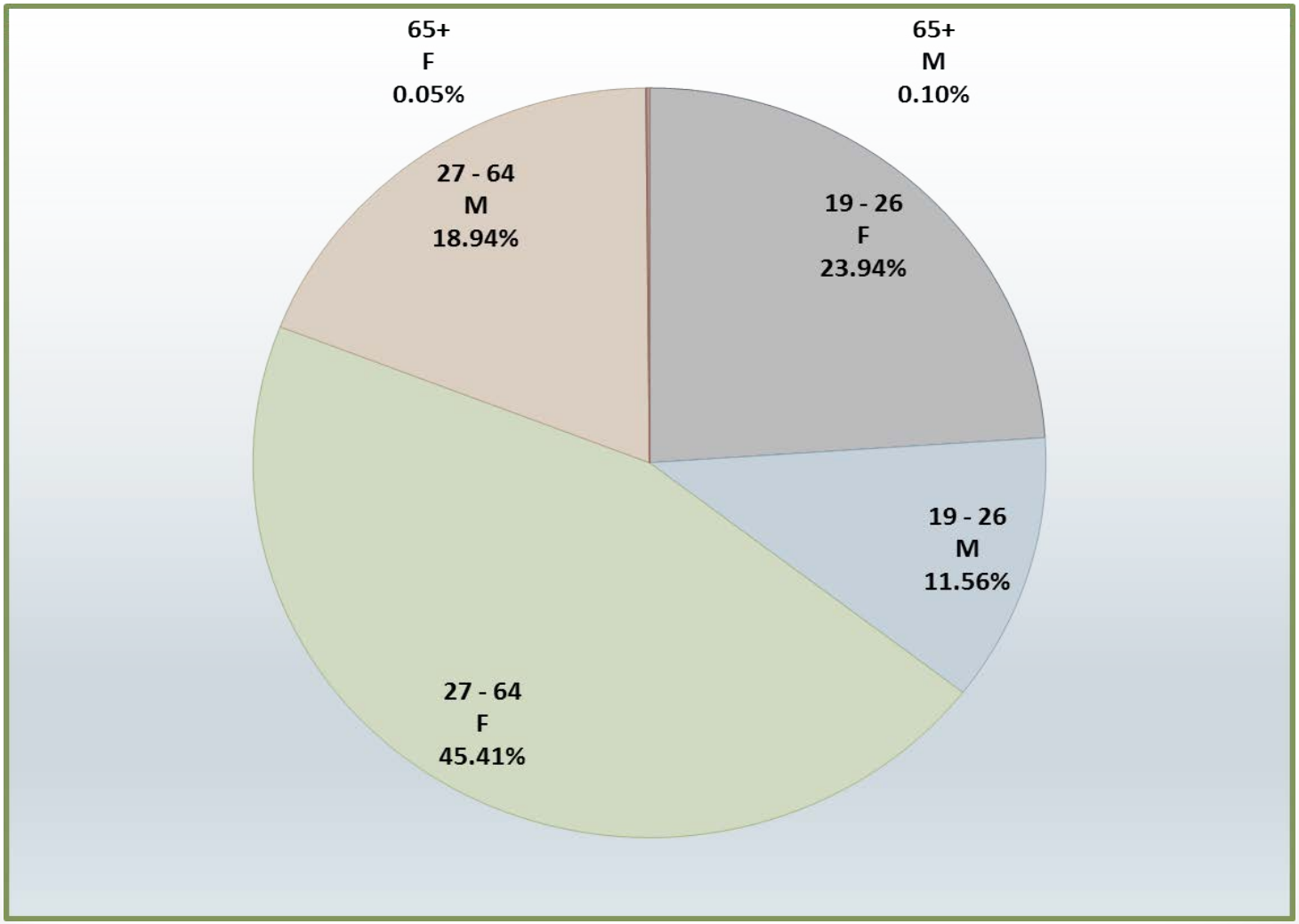
see pages 74-102 of the DVHA budget document



General Adults

see pages 74-102 of the DVHA budget document

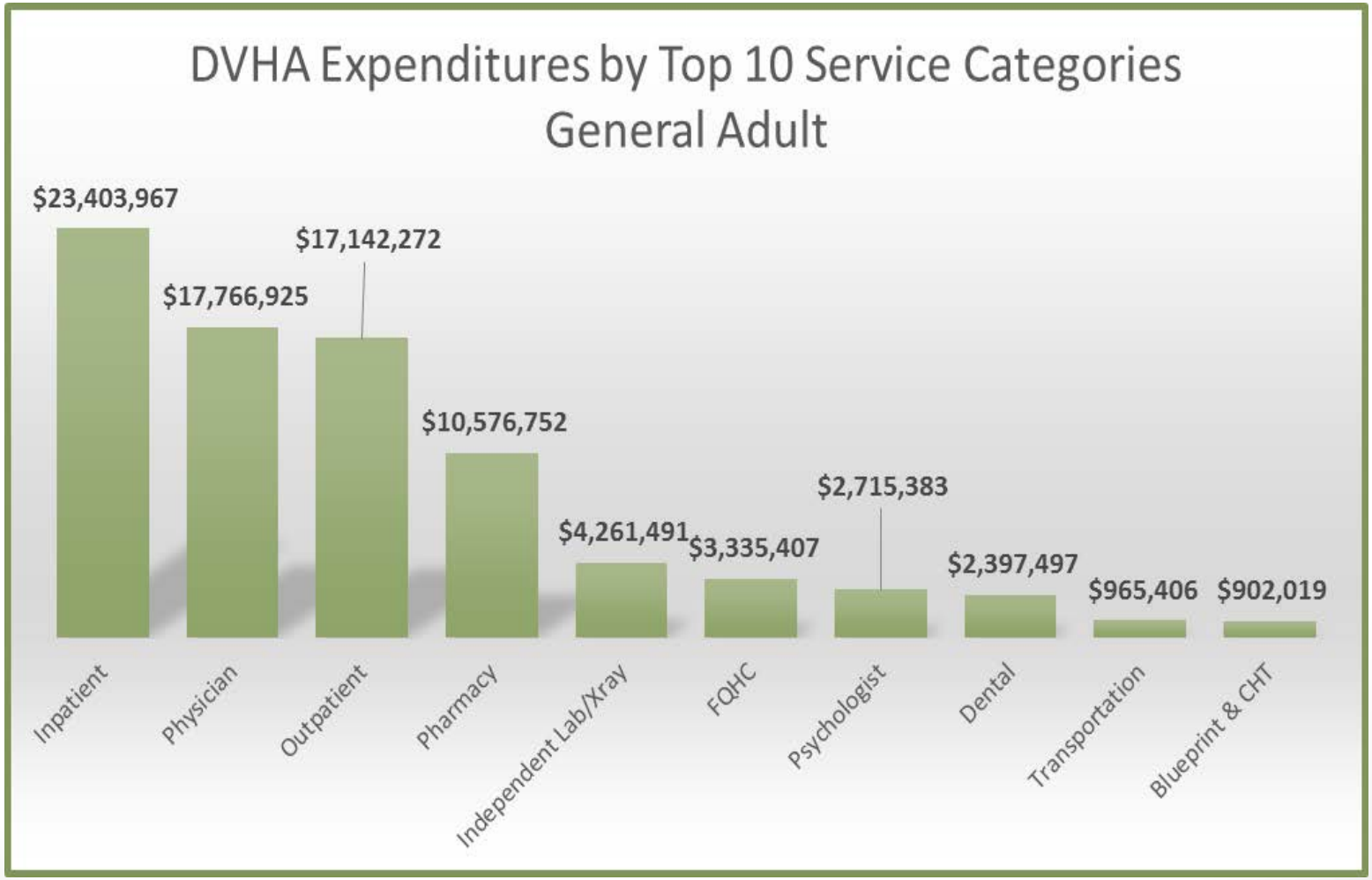
New to the book is population composition of each of the MEGs.



General Adults

see pages 74-102 of the DVHA budget document

… and information regarding expenditure information.



General Adults

see pages 74-102 of the DVHA budget document

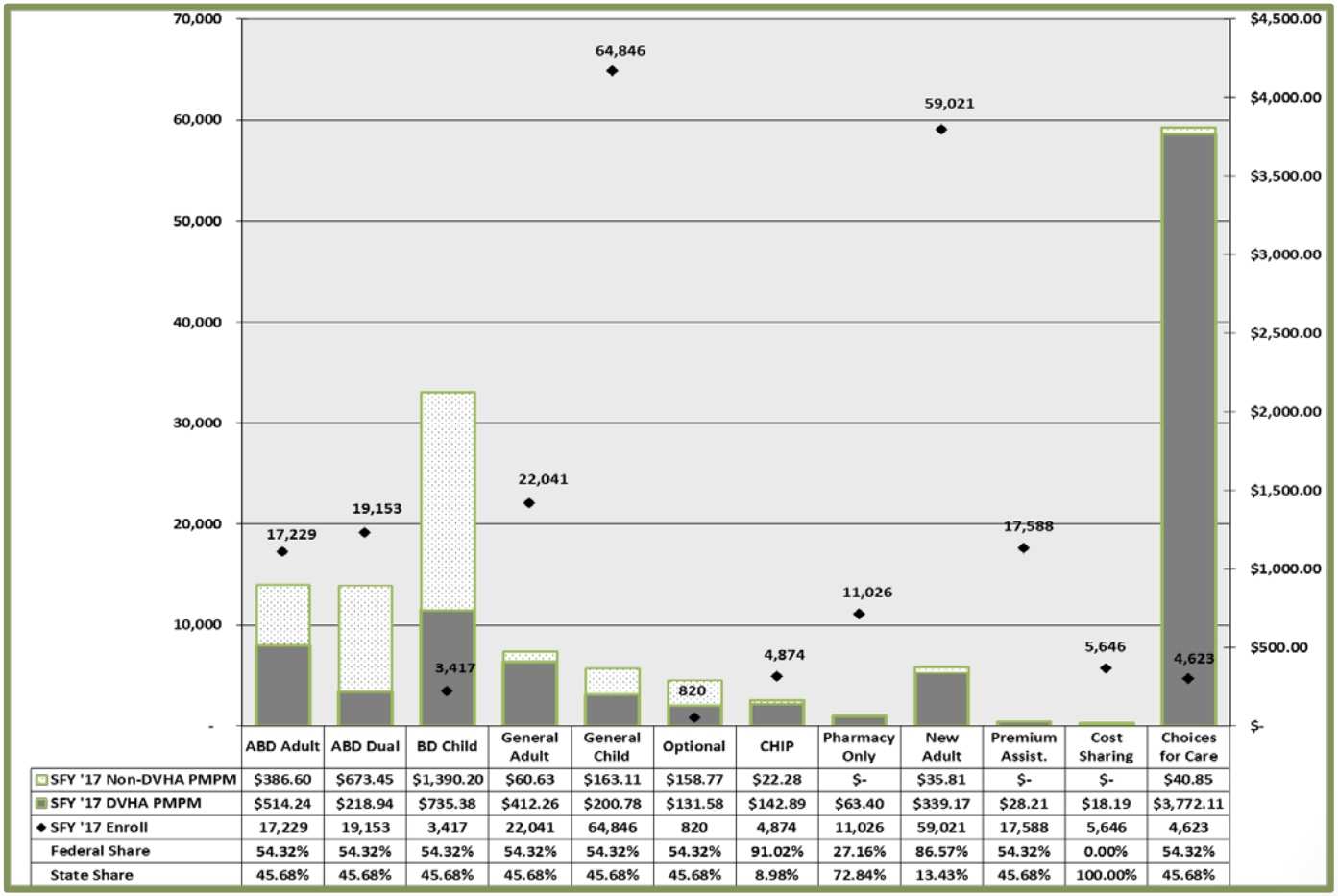
As mentioned above, MAGI was one of the drivers of increased caseload. The General Adult MEG saw 3,545 new individuals who have never been enrolled in Medicaid. (The New Adult MEG had 19,300 new enrollees.)

		New Enrollees - General Adults									
Category	Demographic	QE Mar 2014	QE Jun 2014	QE Sept 2014	QE Dec 2014	QE Mar 2015	QE June 2015	QE Sept 2015	QE Dec 2015	Medicaid Expansion New Enrollees	New Enrollees Trendline
General Adult	Female 19 - 26	120	109	101	111	102	49	32	56	680	
General Adult	Female 27 - 64	437	189	231	212	251	129	143	148	1,740	
General Adult	Male 19 - 26	25	16	10	13	17	6	8	14	109	
General Adult	Male 27 - 64	346	123	107	147	130	67	43	53	1,016	
General Adult		928	437	449	483	500	251	226	271	3,545	

DVHA Program Efficiency

see page 101 of the DVHA budget document

The summary below displays the efficiency of Vermont Medicaid programs by comparing population served with DVHA and non-DVHA PMPMs.



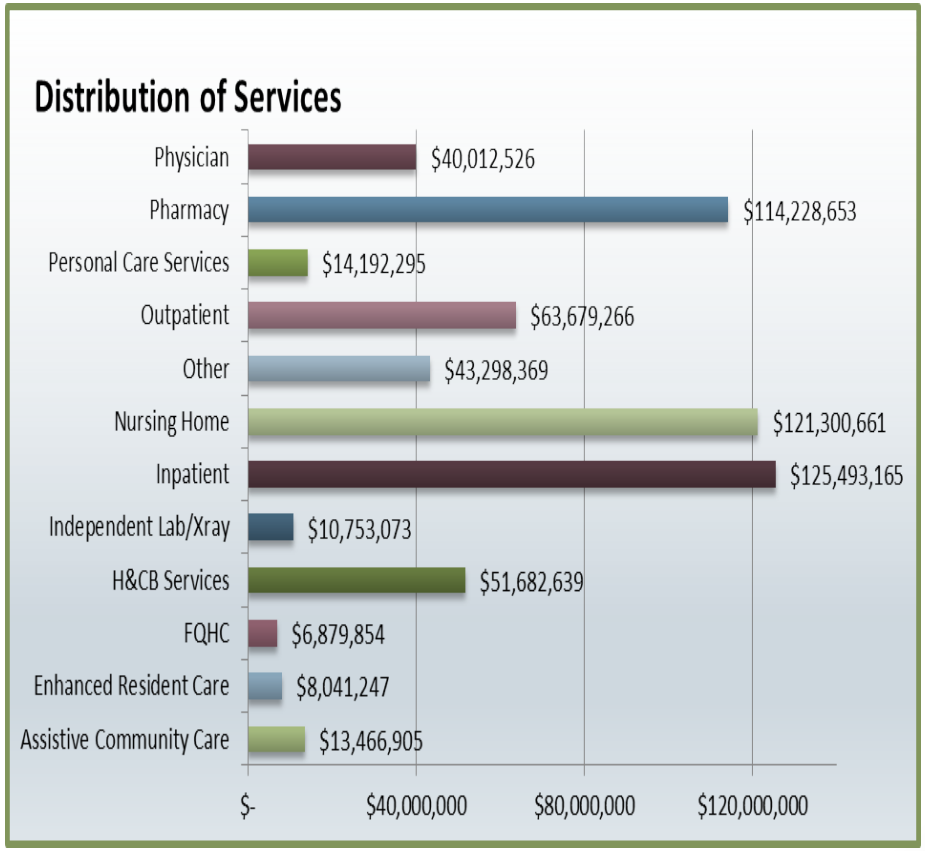
	ABD Adult	ABD Dual	BD Child	General Adult	General Child	Optional	CHIP	Pharmacy Only	New Adult	Premium Assist.	Cost Sharing	Choices for Care
SFY '17 Non-DVHA PMPM	$386.60	$673.45	$1,390.20	$60.63	$163.11	$158.77	$22.28	$-	$35.81	$-	$-	$40.85
SFY '17 DVHA PMPM	$514.24	$218.94	$735.38	$412.26	$200.78	$131.58	$142.89	$63.40	$339.17	$28.21	$18.19	$3,772.11
SFY '17 Enroll	17,229	19,153	3,417	22,041	64,846	820	4,874	11,026	59,021	17,588	5,646	4,623
Federal Share	54.32%	54.32%	54.32%	54.32%	54.32%	54.32%	91.02%	27.16%	86.57%	54.32%	0.00%	54.32%
State Share	45.68%	45.68%	45.68%	45.68%	45.68%	45.68%	8.98%	72.84%	13.43%	45.68%	100.00%	45.68%

It should be noted that in the above graph, the Pharmacy Only FMAP used is a blend of the Global Commitment Waiver fund matching, and State Only funds; and the New Adult FMAP used is that of the New Adult childless population, while the population and spend are both New Adults with children and childless.

High Cost Utilizers

see page 102 of the DVHA budget document

DVHA Medicaid claim expenditures are highly concentrated; the top 10% of users account for 67.53% of claim expenditures. The median SFY 2015 PMPY claim cost for the top 10% of users was $28,882. The following graph depicts the costs of the high cost users. The non-DVHA Medicaid claim spend – not depicted – for this population in SFY 2015 was $111,719,800. DVHA's Medicaid claim spend was $614,324,165.



DVHA Budget Considerations and Challenges

see page 110 of the DVHA budget document

Budget Considerations and Challenges

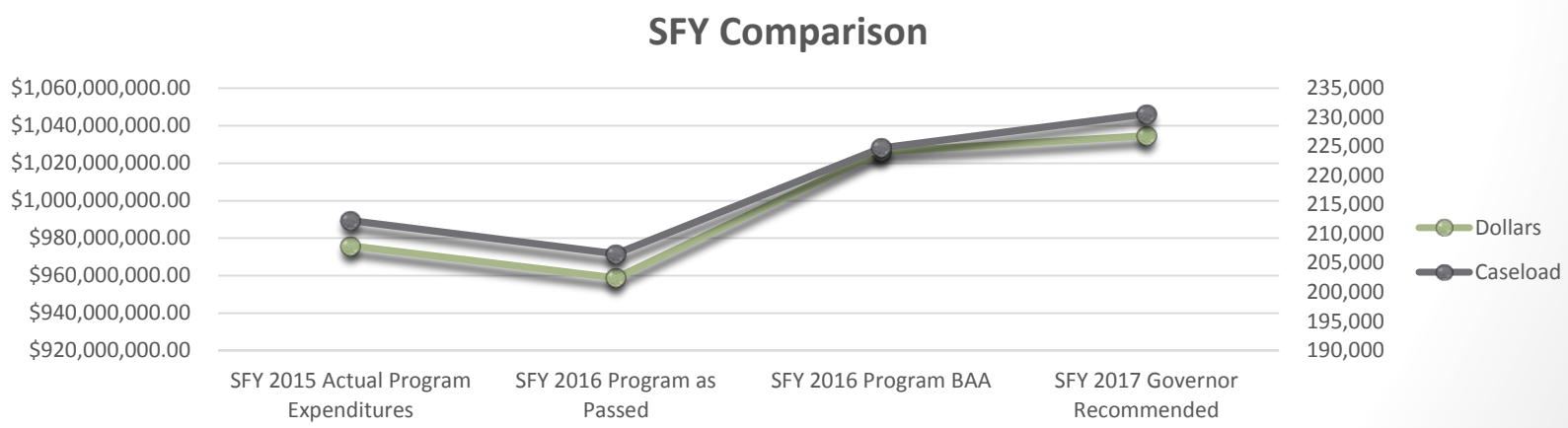
- DVHA continues to face increased budgetary pressures as the caseload increases. SFY 2015's caseload increased 18% over SFY 2014 and SFY 2016 is anticipated to end 6% higher than SFY 2015. Caseload increases are due primarily to economic conditions within the state, Medicaid Expansion including the new modified adjusted gross income (MAGI) calculations, and enrollees finding they are eligible for Medicaid when signing up for a QHP. see page 26 of the DVHA Budget Document

- Generally, Per Member Per Month (PMPM) trends are downward as there is an overall decrease in utilization especially in inpatient hospital. see pages 74, 75, & 91 of the DVHA Budget Document

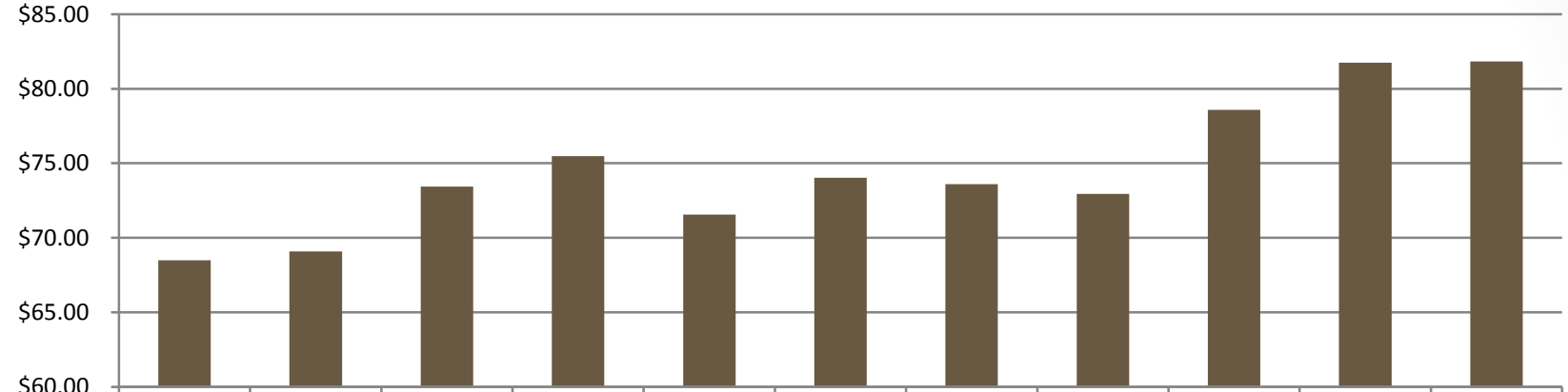
- Pharmacy costs have increased over 18% between SFY 2014 and 2015. Specialty drug pricing is of critical concern to DVHA. see page 28 & 29 of the DVHA Budget Document

SFY Comparison

- SFY 2015 Actual Program Expenditures: $975,823,404
  - Caseload: 212,255
- SFY 2016 Program as Passed: $958,698,640
  - Caseload: 206,582
- SFY 2016 Program BAA : $1,026,055,097
  - Consensus Caseload: 224,750
- SFY 2017 Governor Recommended: $1,034,560,733
  - Consensus Caseload: 230,602

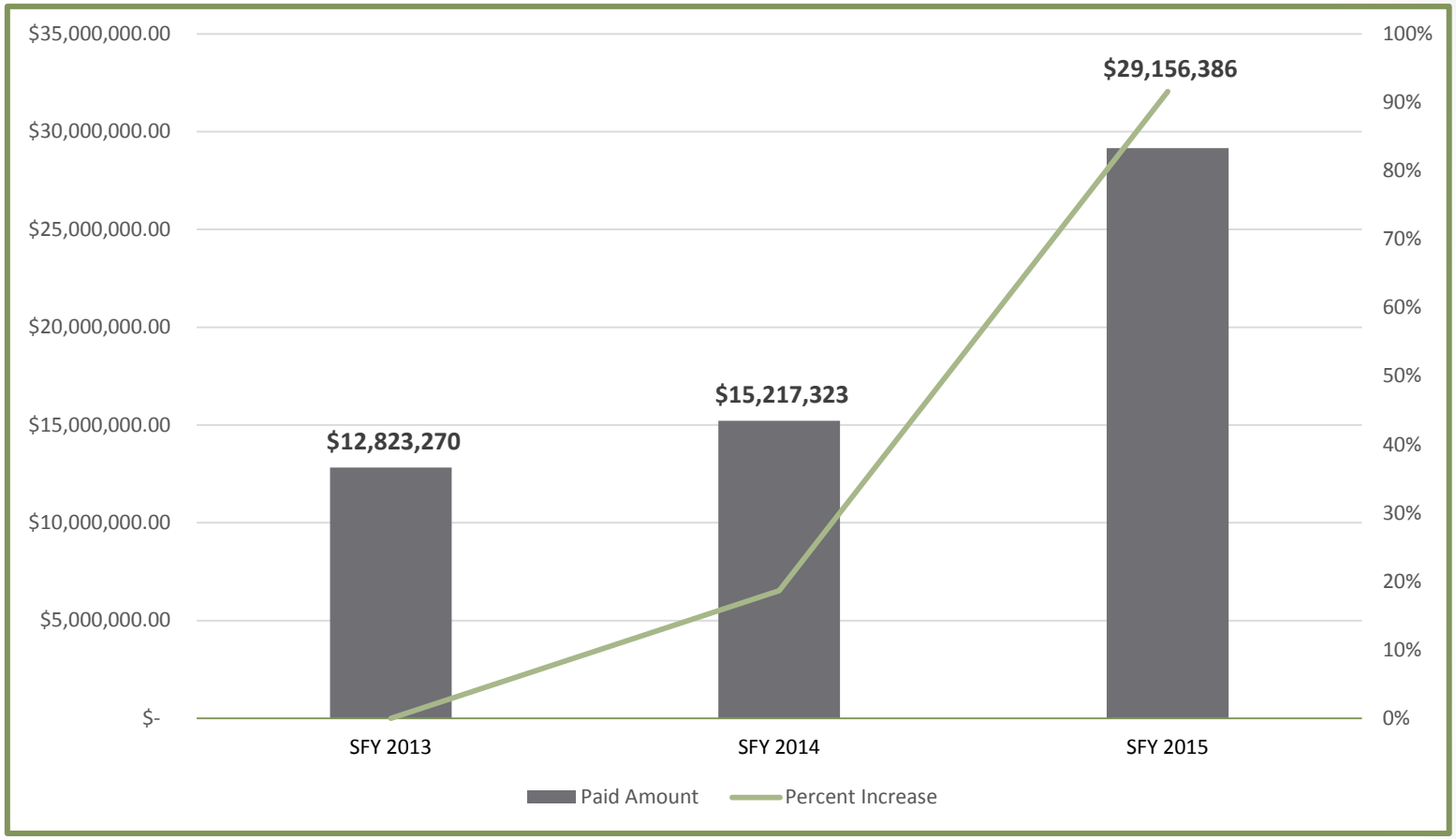


Pharmacy costs are an issue for Vermont,



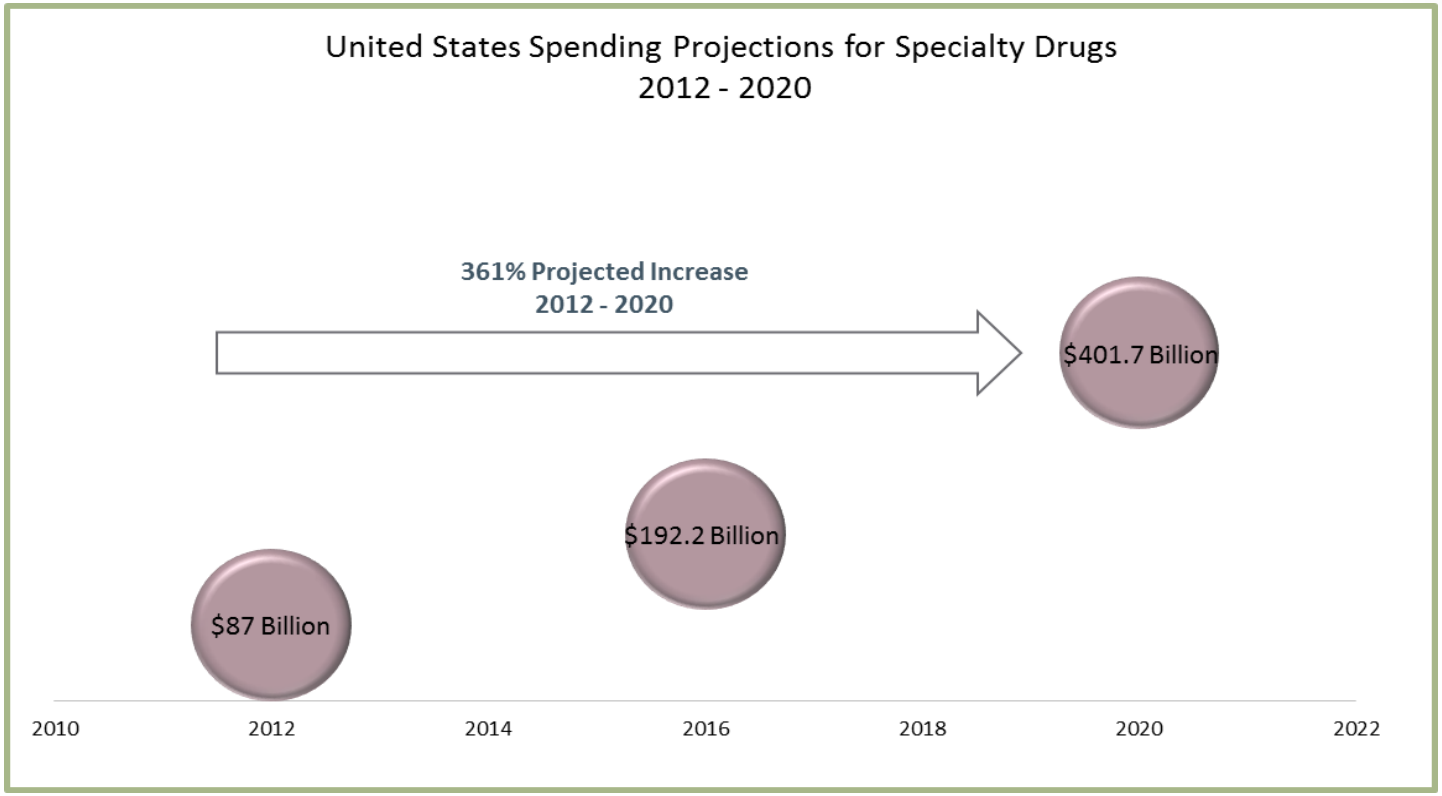
	SFY '07	SFY '08	SFY '09	SFY '10	SFY '11	SFY '12	SFY '13	SFY '14	SFY 15	SFY '16 BAA	SFY 17 Gov. Rec.
Pharmacy	$68.48	$69.08	$73.43	$75.49	$71.57	$74.02	$73.60	$72.94	$78.59	$81.75	$81.84

especially specialty drugs



In SFY 2015, DVHA spent $29,156,386 on specialty drugs. This is a 92% increase over SFY 2014, when specialty drug costs were $15,217,323.

… and nationwide

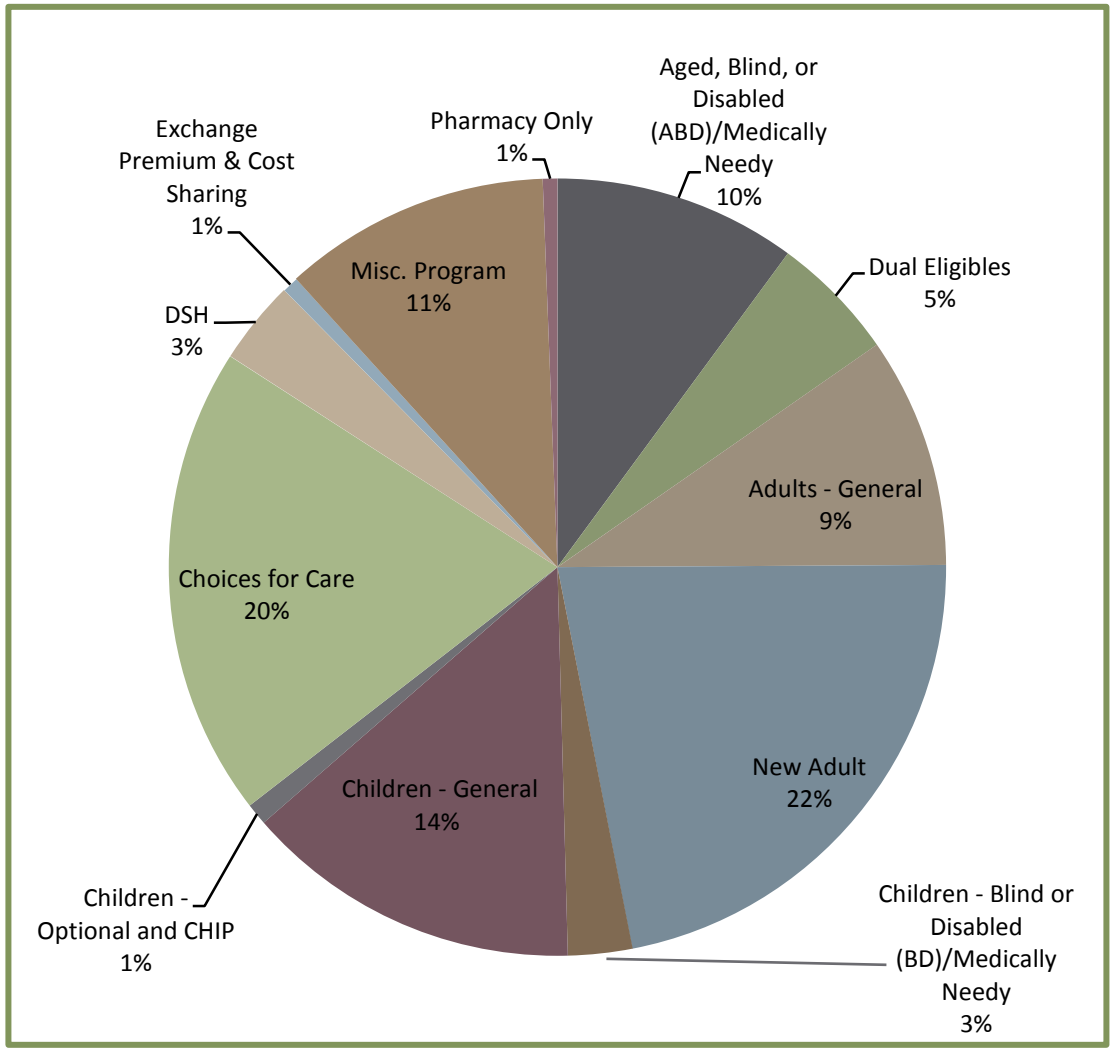


Chapter 4: DVHA Budget Ask

see page 107 of the DVHA Budget Document

Program Considerations

$75,191,096 Gross/ $32,863,582 State



see page 109 of the DVHA Budget Document

Caseload & Utilization

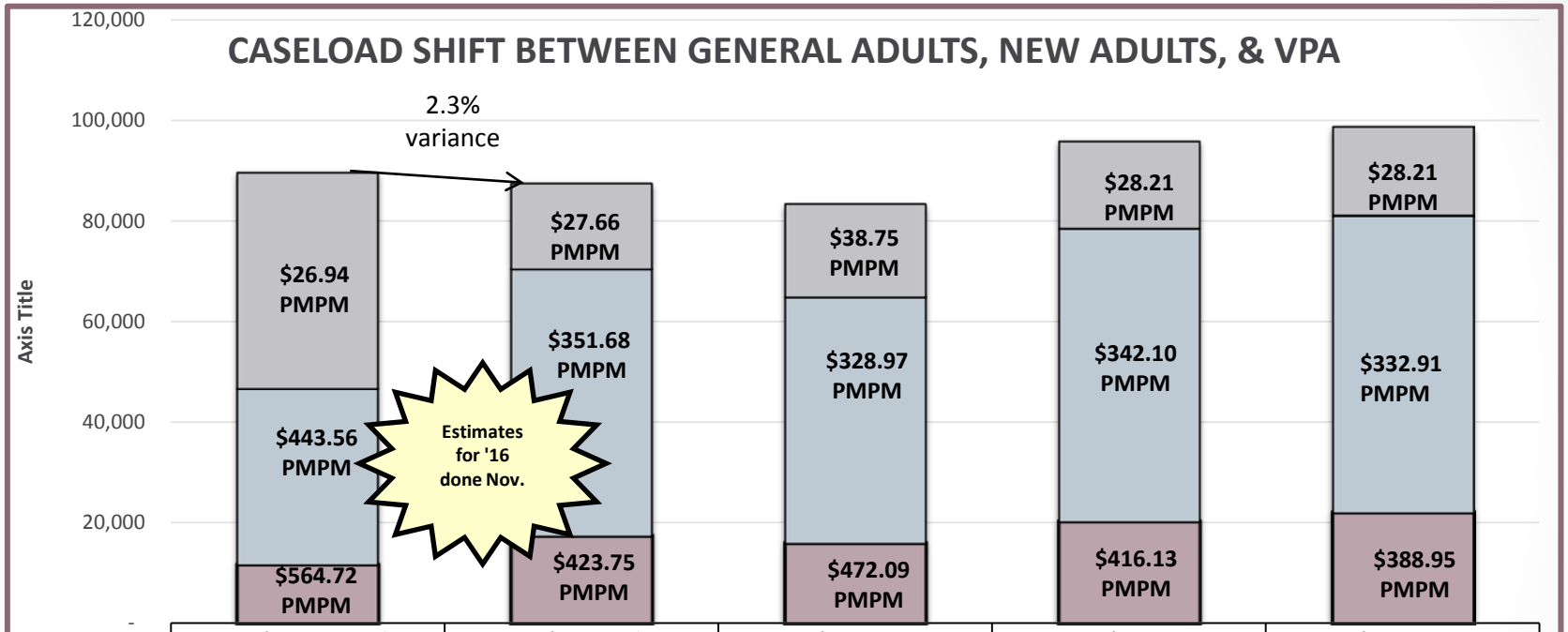
see page 110 of the DVHA Budget Document

Caseload and Utilization Changes $68,424,824

$26,415,651 state

DVHA engages in a consensus caseload estimate process with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services when projecting caseload and utilization growth. The success of Vermont's Medicaid expansion means a growth in the caseload seen primarily in the New Adults category. The original predictions, made after the VHAP and Catamount programs ended in 2014, estimated the majority of enrollees would move into one of the QHP cost assistance programs. After reviewing the SFY 2015 actuals, it was evident that while caseload numbers were projected well, the migration analysis proved incorrect. This can be seen in the chart below. The expanded eligibility guidelines allowed for a significant number of those previously enrolled in a Catamount program to transition to the more costly New Adults program and SFY 2017 estimates must accommodate this connection. The utilization changes included in this request are based not only on increases predicted by the same consensus process as the caseload estimates, but also changes to the prescription drug formulary that include new and expensive medications which offer much needed treatments where less effective options existed. For more information on the fiscal pressures associated with the increased medication costs, see the *Vermont Medicaid Trends – A National & Regional Comparison* section of the DVHA Budget Document.

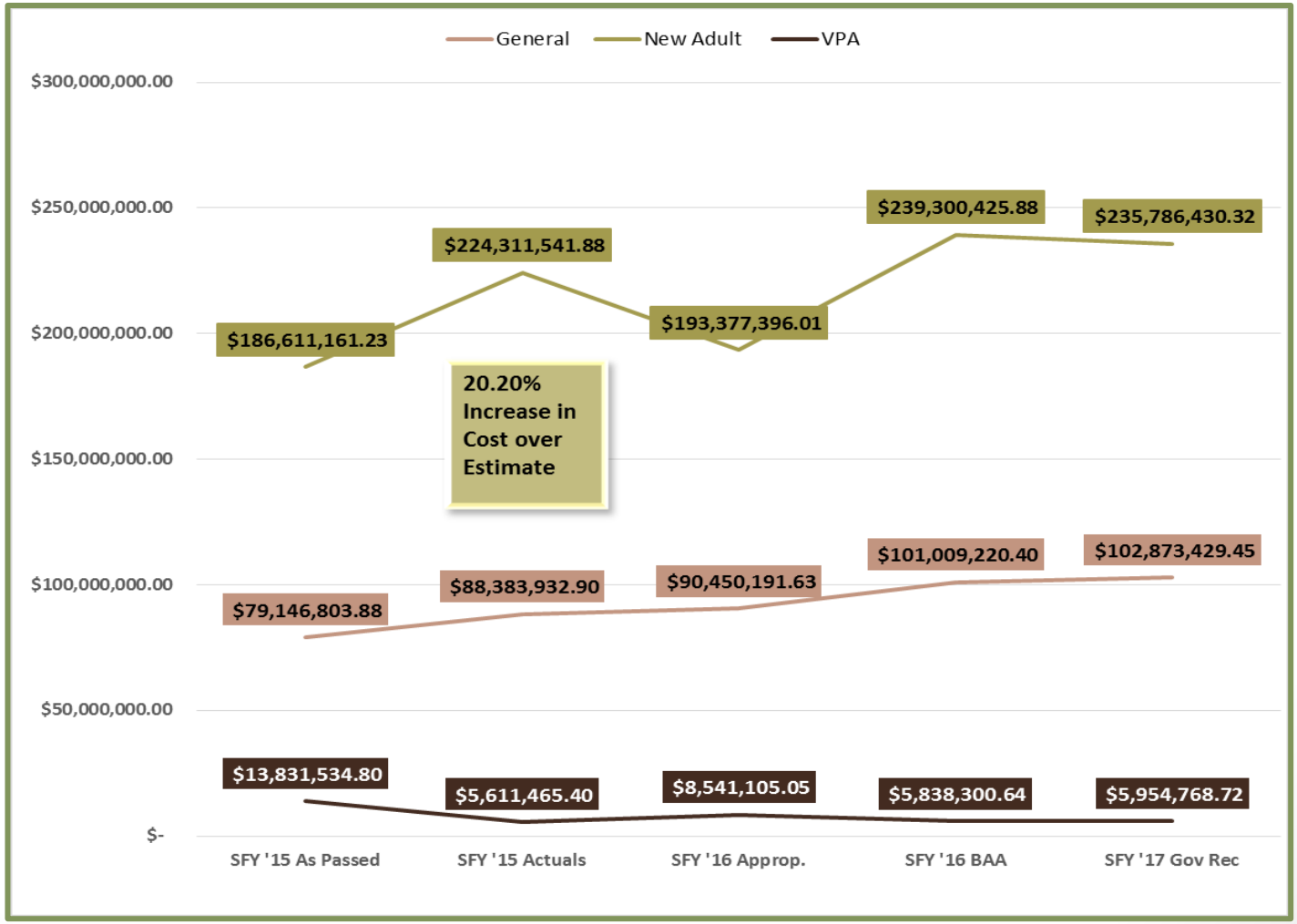
Caseload & Utilization



	SFY '15 As Passed	SFY '15 Actuals	SFY '16 Approp.	SFY '16 BAA	SFY '17 Gov. Rec.
VPA	42,785	16,906	18,368	17,244	17,588
New Adult	35,059	53,153	48,985	58,292	59,021
General	11,679	17,381	15,966	20,228	22,041

Caseload & Utilization

Based on the case shift above, the total costs changed dramatically from SFY2015 As Passed to SFY 2015 Actuals.



Additional Changes

see page 112 of the DVHA Budget Document

GC and CFC Waiver consolidation appropriation adjustments . . . . . $(0)

$1,480,185 state

Buy-In Adjustment $572,758

$261,636 state

The federal government allows for states to use Medicaid dollars to "buy-in" to Medicare on behalf of eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload and member month costs vary from year to year.

Buy-in Medicare Part B premium increase $4,979,191

$2,047,045 state

As of January 1, 2016, CMS has increased Medicare Part B premiums by nearly 14% for those who have assistance in paying their premiums. The structure of this increase puts the burden of additional cost on the individual states. The above request is reflective of that cost increase.

Additional Changes, cont'd.

Applied Behavioral Analysis (ABA) $4,870,901

$2,225,028 state

DVHA garnered state plan approval to offer applied behavior analysis services to individuals with autism in order to address a service delivery gap. This adds funding to support the new service costs ~ $2,800,000, increases rates due to feedback received through the public notice process that established rates were not sufficient ~ $2,500,000, and transfers funding to DMH to support ABA expansion in the NCSS IFS bundle ~ ($429,099).

Change in Federal Participation Match Rate $0

$(1,137,087) state

The federal receipts the State receives is dependent upon a funding formula used by the federal government (Federal Medical Assistance Percentage - FMAP) and which is based on economic need for each state across the country. This general fund impact is due to a reduction in the traditional match rate, a significant increase in the CHIP match rate, and the elimination of the 2.2% as of January 1, 2016.

Increase in Clawback $5,967,321

$5,967,321 state

Currently, all beneficiaries of Vermont's publicly funded pharmacy programs, who are also covered by Medicare, should receive their primary pharmacy benefit from Medicare. Medicare Part D design calls for states to annually pay a portion of what they would have paid in Medicaid "state share" in that year for those enrollees who are or would be eligible for Medicaid drug coverage. This is referred to as "Clawback" or "state phase down."

Additional Changes, cont'd.

Licensed Alcohol and Drug Abuse Counselors $160,000

$73,088 state

In a DVHA net-neutral shift, DVHA has removed the cost of this specific group of providers from the Special Projects grant, and moved it into the standard Program budget.

Long Acting Reversible Contraceptives . . . . . $(4,750,000)

$(2,169,800) state

Long-acting reversible contraception (LARC) methods include the intrauterine device (IUD) and the birth control implant. Both methods are highly effective in preventing pregnancy, last for several years, are easy to use, and are reversible. Inpatient setting after delivery is a critical time to promote contraceptive use. Too often after hospital discharge, individuals do not follow up with outpatient providers for birth control, while they're at higher risk for future unintended pregnancies. 46% of Vermont pregnancies are unintended. The immediate postpartum period – prior to hospital discharge— can be an opportune time to offer contraception. Increasing the post-partum inpatient Diagnosis Related Grouping (DRG) with an add-on payment will promote post-partum contraceptive intervention. While a benefit to all individuals in the postpartum period, this is an especially important strategy for more vulnerable persons who face social and economic barriers. These individuals' life circumstances may be encumbered by substance abuse, mental health issues, and/or poverty. As such they are at risk of not returning for a postpartum visit. Preliminary 2012 Vermont data show that of the 6,007 births, only 50.3% were intended pregnancies. 74% of unplanned births are publicly funded in Vermont and more than $30 million is spent each year on unintended pregnancies in the state.

Additional Changes, cont'd.

Group Psychotherapy Reimbursement Adjustment . . . . . $(2,000,000)

$(913,600) state

As previously requested in the SFY 2016 BAA, DVHA is revising the reimbursement methodology for group psychotherapy billed under Current Procedural Terminology (CPT®) Code 90853, to the Resource Based Relative Value System (RBRVS) payment methodology DVHA uses for professional services. This is needed to comply with federal requirements. The Medicaid State Plan requires professional services to follow RBRVS, and this is the methodology used by DVHA for the payment of all other psychotherapy CPT® codes. This change went into effect January 1, 2016 and no additional changes to payment methodology are being requested at this time.

Nursing Home Changes and Carryforward $4,786,983

$2,186,694 state

Changes to Nursing home costs include: utilization, the statutory Nursing Home rate increase, a backfilling of one-time SFY2016 funds, caseload pressure from the Home and Community Based population, and the anticipated carryforward from SFY2016 into SFY2017.

Additional Changes, cont'd.

Technical Rate Adjustments to Align with Best Practices . . . . . $(7,820,882)

$(3,572,579) state

DVHA has committed to making changes in the areas of payment methodologies to align with best practices. These changes include:

Align Inpatient Detox Reimbursement with Best Practice ~ ($1,489,882) gross: Beginning July 1, 2015, admissions to an inpatient hospital for opioid detoxification must meet medical necessity criteria in order to be reimbursable through Vermont Medicaid. The Department of Vermont Heath Access (DVHA) utilizes the McKesson InterQual ® Level of Care Criteria. These nationally recognized, evidence-based criteria will be used to determine the medical necessity of any inpatient admission submitted to the DVHA for reimbursement.

Prior Authorize Outpatient Psychotherapy > 24 Visits per Calendar Year ~ ($2,200,000) gross: The Clinical Utilization Review Board (CURB) reviewed utilization of the outpatient psychotherapy services for adults and children. The number of outpatient psychotherapy services per person has been increasing. After reviewing the utilization data, on July 15, 2015 the CURB voted unanimously in favor of requiring outpatient psychotherapy providers. Recommendation from CURB: Require Prior Authorization for outpatient psychotherapy visits one standard deviation beyond median. This equates to after 24 visits per calendar year, a prior authorization is needed for additional visits.

Technical Adjustments, cont'd.

Adopt Medicare's Reimbursement Practice for Oxygen ~ ($70,000) gross: Medicare limits the reimbursement for Oxygen to a 36 month rental cap. After the 36 months, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment. Medicare will pay for maintenance and service no more often than every 6 months beginning 6 months after the 36 month rental cap.

Revise Psychiatric Inpatient Reimbursement Methodology to Only Apply When a Patient is Cared for on a Psychiatric Unit ~ ($1,500,000) gross: Currently any inpatient claim grouped into a psych DRG is paid using the inpatient psychiatric reimbursement methodology, including inpatient stays on medical floors. This change proposes to adjust the current inpatient psych reimbursement methodology to only apply to inpatient stays on psychiatric floors and have any inpatient stay on a medical floor be paid as other inpatient stays on medical floors, according to the DRG, without the psychiatric per diem. This would ensure that only stays receiving the full complement of psychiatric services expected to be provided on a psychiatric unit are paid with the psychiatric reimbursement methodology.

Cardiology High-Tech Imaging Prior Authorization ~ ($711,000) gross: Currently cardiology services are not prior authorized. Adopting this proposal will allow the current vendor performing prior authorizations for other hi-tech imaging services, will also perform prior authorizations and monitor inappropriate utilization for cardiac imaging.

Technical Adjustments, cont'd.

Add-ons for Newborn DRGs ~ ($1,000,000) gross: Currently, DRG weights take into account the mean length of stay (LoS) in their development, and add-on claims do not. This proposal would adjust the add-on claim allowances to take these LoS' into consideration by limiting the number of claims, or the number of days of a stay allowed.

Add-on Code Reimbursement ~ ($175,000) gross: Medicare requires that an add-on code be reimbursed only in conjunction with a primary service (also known as a parent code). This adjustment brings Medicaid payment methodologies in line with Medicare rule.

Endoscopy Reimbursement Policy ~ ($200,000) gross: Medicare has special payment rules for multiple endoscopies performed on the same day. When two endoscopies in the same family are performed, the endoscopy with the highest fee schedule amount is allowed at 100%. The additional related endoscopies are priced by subtracting the base endoscopy price. This adjustment brings Medicaid payment methodologies in line with Medicare rule.

Generic Drug Rebate Expansion ~ ($475,000) gross: Currently, we are allowed to set a State Maximum Allowable Cost (SMAC) on all generic drugs. This has always been a pricing service contracted service through the PBM. Our new vendor GHS, who has a more robust SMAC program, is recommending new SMAC's on a number of generics which could save the state $475,000 SFY 2017. We have already implemented some new SMAC's totaling $1.5 million in savings for SFY'16, which we submitted for SFY'16 BAA.

Governor's Initiatives

$670,997 Gross/$306,511 State

All Payer Model (APM)

The Governor, his senior healthcare advisors, and Green Mountain Care seek to transform Vermont's healthcare system under the All Payer Model from one that rewards fee-for-service, quantity-driven care to one that rewards quality-based care; focusing on keeping Vermonters healthy. This work will enable Vermont to address rising healthcare costs that are squeezing the budgets of families, businesses, and state government.

The fee-for-service healthcare model is over 50 years old and was designed to treat acute medical conditions that required a single visit. Today, treating people with chronic diseases account for 86 percent of healthcare costs, according to the Centers for Disease Control. The disconnect means that doctors are governed by a payment system that does not address the needs of patients, a situation that results in Vermonters receiving care that is expensive, fragmented, and disorganized. The All Payer Model seeks to change that by enabling the three main payers of healthcare in Vermont - Medicaid, Medicare, and private insurance - to pay doctors and hospitals in a different way than they do today. Instead of paying for each test or procedure, doctors and hospitals will receive a set payment for each patient attributed to them, shifting the financial incentive from running tests and procedures to keeping patients healthy.

see page 111 of the DVHA Budget Document

Governor's Initiatives, cont'd.

All Payer Model (APM), cont'd.

The heart of the proposal is to keep healthcare costs below the growth of the general economy. The terms outlined today propose a statewide healthcare spending target for all payers in the healthcare system of 3.5 percent with a maximum allowable spending growth of 4.3 percent for the next five years. The financial cap is set approximately 1 percent higher than Vermont's economic growth as measured by gross state product over the past 15 years. Along with spending targets will be quality ones that ensure Vermonters not only spend less but see better health outcomes. The three goals included in this proposal are: increasing access to primary care, reducing the prevalence of and improving the management of chronic diseases, and addressing the substance abuse epidemic.

Under the All Payer Model, Vermonters will continue to see the doctor or heath care provider of their choice. Vermonters on Medicare and Medicaid will see no change to their benefits. In fact, Vermont proposes to expand Medicare benefits to seniors, including services at home for seniors in through the successful Services and Supports at Home (SASH) program by expanding the program statewide and addiction treatment services through the Hub and Spoke program.

Governor's Initiatives, cont'd.

Involuntary Inpatient Mental Health Treatment Best Practice . . . . . $(5,000,000)

$(2,284,000) state

Under current practices found only in Vermont, a patient deemed in need of involuntary inpatient mental health services waits for their due process for a median of 60 days in a facility before beginning treatment. This practice is no longer viewed by the medical and psychiatric communities as an effective or *ethical* approach to helping these patients and results in several important unintended consequences. In all other states, when persons with serious mental illness are involuntarily hospitalized and refuse treatment, the due process underlying the decision to require involuntary treatment is carried out in approximately two weeks or less. Clinical, ethical, and economic issues that are unique to Vermont would be remedied by implementing the use of an administrative model of due process that is common in other states. By reducing the 60 day waiting period to the currently accepted best practice of two weeks, Vermont reduces the cost of the stay and brings its approach to mental healthcare up to current standards.

Eligibility for Special Enrollment Period for Pregnant Persons and their Families .. $0

$0 state

New policy will allow for pregnant persons above 138% of the FPL, along with their entire family, to enroll in any QHP, and be screened for all available premium and cost sharing assistance – APTCs, VPA, and/or CSR subsidies.

Governor's Initiatives, cont'd.

Eligibility for Pregnant Persons Between 138% and 213% of the FPL . . . $(4,929,003)

$(2,251,569) state

DVHA currently offers additional eligibility to pregnant persons above the FPL guideline used for the non-pregnant population. By removing this additional eligibility window, pregnant persons will be subject to the same income guidelines as their non-pregnant counterparts. It ensures that all pregnant individuals with household income at or below 133 percent of federal poverty level with a 5 percent disregard shall receive Medicaid coverage. All others in the individual or small group market will be able to enroll in a qualified health plan through Vermont Health Connect. This eligibility alignment will be accompanied by a change in the enrollment policy for QHPs.

Dental Rate Increase $2,200,000

$1,004,960 state

When VHAP was eliminated, 50,000 former private pay patients converted to adult Medicaid. A number of dental offices found that they could no longer survive financially and needed to significantly reduce the number of Medicaid patients they were able to accept in their practices. This created an access to care issue. The cost of delivery of care from every aspect: taxes, staffing, disposable materials, and capital investment for hard goods, has continued to rise without fee increases. In order to have the infrastructure to provide the care for the general welfare of enrollees, additional funding must be made available. An increase in reimbursement of 18% is recommended for preventive services including routine care such as restorations, fluoride treatment and cleanings.

Governor's Initiatives, cont'd.

Primary Care Rate Increase $8,400,000

$3,837,120 state

Primary Care is critical to Vermont's healthcare system. Medicaid expansion has led to more pressure on Primary Care physicians patients due to the increased patient volume. Current reimbursement for Primary Care is approximately 80% of Medicare. The provider community has expressed concerns that the current level of reimbursement is impacting access to care. This budget initiative proposes to fully restore the enhanced primary care payments as defined by the Affordable Care Act (ACA). These rates were in place from 1/1/13 to 12/31/14 and were fully funded by Federal dollars. It is DVHA's recommendation to fully restore the EPCP rates.

Improved Data Matching for Coordination of Benefits Activities . . . . . $(0)

$(0) state

DVHA needs private insurer data files in a Medicaid format that CMS now uses in order to perform mandated Coordination of Benefits activities. DVHA will use the results of the data files to determine whether members have private insurance that should pay for medical claims before DVHA, in compliance with Medicaid as the payer of last resort. Further, federal law requires that the state shall provide assurances to the Secretary that it has laws in effect requiring health insurers to provide data regarding who is enrolled in private coverage and dates of coverage and benefits.

Provider Assessment Expansion

$(17,000,000) State Health Care Resources Fund

A proposed 2.35% provider assessment on independent physicians practices and dentists will raise $17 million in state funds. This will offset the increased funding to primary care services and preventative dental care services by $5 million.

Subject to 2.35% tax:	Not included:
Independent entities made up of one or more: • Dentists • Dental Hygienists • Dental Assistants • Dental Therapists if S.20 passes • Primary care physicians • Physician assistants • Specialists • Osteopaths • Psychiatrists • Ophthalmologists • Naturopaths	• Chiropractors • Radiologists • Podiatrists • Optometrists • Psychologists • Drug and Alcohol Counselors • Physical Therapists • Occupational Therapists • Speech Therapists • Acupuncturists • Dieticians • Midwives • Nursing Homes • Hospitals • Home Health Agency • Ambulatory surgical center • Free-standing lab • Free-standing x-ray facility

Please see page 119 of the DVHA Budget Book for further information.

Provider Tax Overview

Provider taxes must follow federal law including:

- Must be broad based
- Must be uniformly imposed
- Cannot violate hold harmless provisions– tax paid is not returned to providers to make them whole
  - There is a presumption of meeting this requirement if the tax is less than or equal to 6% of net patient revenue

Monies from provider taxes are deposited into the State Health Care Resources Fund

Revenue from Current Provider Taxes

Class of Provider	FY16 (Gov Rec for e-board BAA Jan. 2016)	FY17 (Gov Rec for e-board January 2016)
Hospital 6% of net patient revenue	$ 129,647,755	$ 133,570,285
Nursing Home per bed assessment	$ 15,644,925	$ 15,245,623
Home Health Agencies 19.3% of net operating revenue	$ 4,487,950	$ 4,521,602
Intermediate Care Facilities 5.9% of total annual and indirect expenses	$ 73,308	$ 73,308
Pharmacy $0.10/script	$ 780,000	$ 780,000
TOTAL	**$ 150,633,938**	**$ 154,191,218**

Administration's Proposal

- The Administration is proposing a 2.35% provider tax on independent physician practices and practicing dentists

Proposed Tax at 2.35%	Calendar Year 2016, Collected 2017
Physicians	$10,944,023
Dentists	$6,074,214
Total Revenue	**$17,018,237**

- Numbers based on 2014 UMass update of 2012 Pacific Health Policy Group Report for DVHA: "Health Care Related Tax Study"
- Adjusted for: trend and calendar year as applied to state fiscal year

Administration's Proposal: Revenue

Initiative Focus	Description	Financial Impact
Medicaid Support	Support deficit in Medicaid program in order to provide affordable quality health care to Vermonters.	State share: $12M Fed. match: $14.3M Total: $26.3M
Primary Care	Restore Medicaid primary care provider rates to Medicare levels as required under the ACA in 2013-2014 to ensure retention of primary care providers	State share: $3.9M Fed. match: $4.5M Total: $8.4M
Dental Services	Increase Medicaid reimbursement by 18% for preventive dental services including routine care such as restorations, fluoride treatment and cleanings to improve access to dental care	State share: $1.0M Fed. match: $1.2M Total: $2.2M

Provider Tax Cap

- Federal law prohibits getting federal match for provider tax revenue that exceeds 25% of State Medicaid expenditures
- Proposal brings Vermont close to the cap

Provider Tax Cap	$175,481,723
Provider Tax Current Law	$154,191,218
FY 17 Budget Proposal	$17,018,237
Provider Tax w/Proposal	$171,209,455
Remaining Cap Space	**$4,272,269**
% to Cap	**97.565%**

Administrative Considerations

$8,785,888 Gross/$218,653 State

Personal Services $8,483,298

$3,046,980 state

- Payact and Fringe . . . . . .$501,002 *$178,847 state*
- Position and Management Change . . . . . $8,335,486 *$2,951,300 state*
  - DCF is transferring the Health Access Eligibility unit (HAEU), as well as its Assisted Operations (AOPs) positions to DVHA. This transfer is a total of 108 positions, and is an AHS net-neutral shift ~ $7,934,996 gross.
  - DVHA is also transitioning one Full Time Employee position to AHS Central Office ~ ($130,381) gross.
  - In order to oversee and maintain a proposed expansion of Vermont's provider tax to include Doctors and Dentists, DVHA is requesting 3 new Full Time Employees. Currently, those two provider populations are excluded from the standard provider tax and including them is expected to increase tax revenue significantly. This expansion requires oversight and management, additional Accounts Receivable staff, and auditing in order to be handled properly ~ $530,871 gross.
- VHC Personal Services budget realignment . . . . . $(353,190) *$(83,167) state*

Administrative Considerations, cont'd.

Operating . . . . . $(279,948)

$(82,071) state

- General Operating . . . . . $(377,730) *$(154,627) state*

  In response to budget pressures, DVHA continues to evaluate the efficacy of current operating expenses, enacting changes where savings can be found. This amount includes lease negotiations and changes, and reflects costs associated with facility changes made in SFY 2016.

- Other Department Allocated Costs . . . . . $249,053 *$99,073 state*

  DVHA receives allocations from the Department of Buildings and General Services (BGS) to cover our share of the Vision system and fee-for-space, the Department of Information and Innovation (DII) costs, and the Department of Human Resources (DHR). Departments are notified every year of increases or decreases in their relative share in order to incorporate these changes into budget requests.

- HAEU and AOPs related operational costs . . . . . $860,850 *$349,981 state*

  This is an AHS net-neutral shift to accompany the transition of HAEU and AOPs staff from DCF to DVHA.

- VHC Overhead budget realignment . . . . . $(1,012,121) *$(376,498) state*

  At the end of the legislative session, there was a reduction to DVHA's VHC operating budget of $6.8 million. We were able to realign expenses in order to meet this reduction value.

Administrative Considerations, cont'd.

Grants and Contracts $582,538

$(2,746,256) state

- Blueprint Contract . . . . . $(300,000) *$(137,040) state*

  The University of Vermont Child Health Improvement Program conducts a third party on-site review and submits materials to the National Commission on Quality Assurance (NCQA) on behalf of primary care practices in Vermont who are seeking Patient Centered Medical Home (PCMH) recognition and participation in the Blueprint for Health. PCMH recognition triggers multi-payer per patient medical home payments to the practices and community health team payments to the communities. In light of the current budget climate, Blueprint agreed to eliminate this arrangement.

- Licensed Alcohol and Drug Abuse Counselors . . . . . .$(160,000) *$(73,088) state*

  DVHA had special projects money in a UVM grant to support certain analytical and programmatic needs. Again, due to the known budget pressures and the need to increase services to individuals in need of alcohol or drug abuse treatment, a decision was made to eliminate these administrative supports.

- VHC Contracts budget realignment . . . . . .$1,042,538 *$(2,536,128) state*

  As mentioned above, DVHA was able to adjust budget changes made by the legislature in order to meet legislative expectations. Additionally, an Operations Advanced Planning Document (OAPD) was approved by CMS allowing us to draw down 75%/25% funding on systems and direct eligibility staff costs.

Supplemental

Category of Service (COS) Spend ~ page 122

DVHA Budget by Medicaid Eligibility Group ~ page 123

DVHA Budget with Funding Descriptions ~ page 125

Mandatory/Optional Groups/Services ~ page 127

Appendix A: MCO Investments ~ page 129

Appendix B: Scorecards ~ page 132

Appendix C: Mental Health Plan ~ page 147

Appendix D: Qualified Health Plans ~ page 169

Appendix E: Involuntary Inpatient Mental Health ~ page 171

Glossary ~ page 173

Acronyms ~ page 177