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### Budget Adjustment Factors Impacting the SFY '12 Budget

**SFY '12 BUDGET ADJUSTMENT ..... (8,325,775) (gross) / (4,323,008) (state)**

The Department of Vermont Health Access (DVHA) budget adjustment request includes a decrease in program related expenditures of \$4,034,304 and in Administration of \$4,291,471.

**Program ..... (\$4,034,304) (gross)**  
*(\$3,980,723) (state)*

**There are a myriad of programmatic issues that comprise the \$4,034,304 decrease requested in our program budget. It should be noted, however, that there is a \$30 million increase for a Graduate Medical Education initiative at Fletcher Allen for which the state match is being provided by UVM (in the amount of \$12,726,000). The balance of the budget adjustment request reflects a reduction in programmatic expenditures of (\$34,034,304) gross / (\$16,706,724) state. The details are as follows:**

**Caseload Revisions ..... (\$16,883,960) (gross)**  
*(\$7,294,709) (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 growth. Caseload appears to be leveling off more dramatically than anticipated resulting in a need for less funding than originally projected.

Medicaid Eligibility Group	Approp	BAA	Chg. In Caseload	Caseload Dollar Impact
ABD/Medically Needy Adults	14,772	14,101	(671)	\$ (4,703,753)
Dual Eligibles	16,270	16,532	262	\$ 779,146
General Adults	11,127	11,260	133	\$ 822,582
VHAP	41,240	38,799	(2,441)	\$ (10,147,868)
VHAP ESI	866	845	(21)	\$ (59,866)
BD Children	3,707	3,657	(50)	\$ (478,283)
General Children	55,985	55,244	(741)	\$ (1,657,266)
Underinsured Children	1,236	1,041	(195)	\$ (148,492)
SCHIP	3,710	3,863	153	\$ 306,380
Pharmacy Only	13,113	12,828	(285)	\$ (233,278)
Refugee	53	57	3	\$ 13,099
HIV Beneficiaries	158	91	(67)	\$ (23,705)
Civil Union Beneficiaries	252	251	(1)	\$ (2,178)
Choices for Care Beneficiaries	4,010	3,825	(185)	\$ (1,350,477)
<b>Total</b>	<b>166,500</b>	<b>162,394</b>	<b>(4,106)</b>	<b>\$ (16,883,960)</b>

**Utilization** ..... **(\$21,928,011) (gross)**  
 (\$9,146,491) (state)

Three of our largest category of service expenditures ~ outpatient, physician, and pharmacy ~ have a 6-year average growth rate of 9.1%, 8.7%, and .3% respectively. In state fiscal year '11, our costs in all three categories were less than that spent in SFY '10. Had predictable growth trends carried through into SFY '11, our overall costs would have been \$22 million higher. This reduction in expenditures reflects the lower growth rate.

**Buy-In Adjustment** ..... **\$1,174,869 (gross)**  
 \$600,042 (state)

The federal government allows states to use Medicaid dollars to “buy-in” to Medicare on behalf of eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Much work was performed in SFY '11 to ensure the components of this program comported with proper eligibility rules. The result was more people becoming eligible for buy-in which should, in turn, reduce our programmatic expenditures.

**Graduate Medical Education** ..... **\$30,000,000 (gross)**  
 \$12,726,000 (state)

DVHA has worked closely with UVM and Fletcher Allen partners to develop a new mechanism for reimbursing Fletcher Allen for quality deliverables associated with their graduate medical education programs. The source of the state match will be provided by UVM and does not represent an increase in state expenditures.

**Choices for Care General Fund Transfer for Caseload Needs** ..... **\$2,160,686 (gross)**  
 (559,556) (state)

The SFY '11 Choices for Care budget was built on the increased ARRA receipts from the January to March quarter. This allowed for less g.f. need in SFY '11 and subsequently carrying the g.f. from SFY '11 to SFY '12. These funds are being moved to the Global Commitment appropriation in AHS. Additionally, though general fund was carried forward, the associated federal receipts were not. This request includes that additional need for federal authority.

**Clawback Increase** ..... **\$126,982 (gross)**  
 \$126,982 (state)

States are required to reimburse the federal government for full-benefit dual beneficiaries enrolled in the part D program. Revised caseload estimates (17,310) are coming in slightly higher than expected (budgeted: 16,972).

**State-Only Appropriation General Fund Carry-forward Use** ..... **(\$477,636) (gross)**  
 (\$477,636) (state)

DVHA carried forward general fund dollars from SFY '12 in anticipation of need around the state-only pharmacy initiative. Due to the continued collections of rebates on retroactive billings, this general fund is not needed.

**ACA Federal Reimbursement . . . . . \$1,792,766 (federal only)**  
 \$0 (state)

In SFY '11 the Affordable Care Act required that we return 100% of enhanced rebate collections to the federal government. Our original estimate of the impact to Vermont for this requirement was slightly overstated. We therefore need \$1.7 million in additional federal expenditure authority. There is no general fund impact associated with this request.

**Cost Neutral Adjustments Between DVHA Appropriations . . . . . \$0**  
 \$44,645 (state)

During the budget development process, often times the dollars associated with policy decisions are added to or subtracted from the DVHA Global Commitment appropriation. However, these decisions typically impact all DVHA appropriations; therefore, funds are being redistributed from the Global Commitment appropriation to the other three DVHA program areas.

**Administration . . . . . (\$4,291,471) (gross)**  
 (\$342,285) (state)

**Staffing Resources Needed . . . . . \$408,144 (gross)**  
 \$171,992 (state)

The Department of Vermont Health Access has undergone significant change over the past six years. DVHA began as the Office of Vermont Health Access (OVHA), acting primarily as a Medicaid claims processing engine. There was one appropriation comprised of both administrative costs (charged at 50% state / 50% federal) and program costs (charged at 40% state / 60% federal).

In SFY '07, the number of appropriations grew from one to five. The funding streams changed from the traditional match as identified above to multiple approaches depending upon the waiver applied for and approved through CMS. OVHA moved toward operating as a Managed Care Entity for the Global Commitment to Health Waiver population. The *Vermont Chronic Care Initiative* also was launched, and Program Integrity was identified as a necessary resource to combat fraud, waste, and abuse in the Medicaid program.

In SFY '10, Healthcare Reform, Health Information Technology and Health Information Exchange responsibilities were transferred to OVHA. Additionally, the MITA/MOVE initiative was launched.

In SFY '11, the Vermont *Blueprint for Health* joined the organization, responsibility for the Evidence-Based Practices and the Health Information Technology Funds was assigned to OVHA, Program Integrity activities were expanded, Payment Reform was initiated, and OVHA became DVHA.

In SFY '12, DVHA became responsible for developing and implementing the Health Benefits Exchange, billing and collecting for the new Healthcare Claims Assessment, and studying the feasibility of expanding the Provider Tax option.

**Resources to Sustain Core Functions**

Many changes detailed above occurred during a time of scarce state staff resources. The administration and legislature were very supportive of staff increases that directly linked to program savings or healthcare reform goals, such as in Program Integrity, Chronic Care Coordination, and Healthcare Reform. However, workloads also increased in areas of the Department for which positions were either not considered or position reductions occurred. In order for DVHA to continue to effectively manage its expanding core functions and

responsibilities while simultaneously preparing for comprehensive health care reform, the following resources were identified to address SFY '12 unmet shortages (3 months of expenditures are reflected):

4 FTE - Fiscal & Data Needs for VHCURES, DSH, HIT, Assessments Healthcare/Payment Reform	\$82,204
1 FTE - Blueprint Statewide Expansion	\$18,048
1 FTE - Pharmacy Health Services	\$17,039
<b>Subtotal - Positions Needed to Support Current Operations:</b>	<b>\$117,291</b>

**4 FTE - DVHA Data and Reimbursement Unit.** Implementation of Healthcare Reform, Payment Reform, and the *Blueprint for Health* has resulted in substantial increases in data support services and reimbursement requests from within DVHA as well as from the Agency of Human Services (AHS). Three of these requested positions will enable enhanced support for these initiatives, aid in the integration of Medicaid into the VHCURES multi-payer database, and augment the continued ability to provide weekly, monthly, quarterly, and annual analyses for State and Federal reporting requirements, as well as daily ad-hoc requests from DVHA and AHS. Additional resources also are needed for calculating DSH and Provider Assessments.

**1 FTE - DVHA Blueprint Division.** Act 128 mandated statewide expansion of the *Blueprint Integrated Health System* on an aggressive timeline, calling for successful participation of every willing primary care provider in the state by October 2013. As the program successfully expands and additional content areas are increasingly prominent, the general management of activity at the local health service area level continues to increase in scale and scope.

**1 FTE - DVHA Pharmacy Unit.** This position will address activities that require pharmacist participation in the *Blueprint for Health*, implementing a Medication Therapy Management (MTM) program through the Vermont Chronic Care Initiative (VCCI), and developing a single formulary to support statewide universal health care. Incrementally implementing a single formulary with additional covered lives (e.g., duals project) requires the pharmacy unit to assume expanding responsibilities in areas such as rebate management and pharmacy and therapeutics oversight. Additionally, the unit has assumed increased responsibilities for improved monitoring and oversight of the pharmacy rebate programs, implementation of a statewide Medicaid 340B drug discount program, the upcoming transition to a new specialty pharmacy vendor, and improved coordination of clinical management of biologics, biosimilars, and drugs in the medical benefit.

#### **Resources for Health Care System Transformation and Cost Containment**

As both the Public Managed Care Entity (MCE) and the largest insurer in Vermont, DVHA is a catalyst for comprehensive health care system reform. System transformation to achieve universal health care coverage and improved healthcare for all Vermonters requires an unprecedented commitment on the part of State government and its workforce.

As the MCE, DVHA is collaborating with the other AHS departments to eliminate service fragmentation and establish a seamless system of care that integrates physical, mental health and substance abuse services within the *Blueprint for Health* medical home model. In one large initiative supporting these goals, DVHA including the *Blueprint for Health* and VDH-ADAP are collaborating with community substance abuse treatment providers and organizations to create *Hub and Spoke* style health care systems for patients who require medication assisted treatment (buprenorphine and methadone) for opiate dependency. These *Hub and Spoke* health systems will adhere to consistent evidence-based guidelines for outpatient medication assisted treatment, including standardized intake assessments, regular counseling, random drug screening, routine medication management, active physician oversight and regular reevaluations. The model includes close collaboration with the *Blueprint for Health* advanced primary care practices, and the ultimate goal is to improve the capacity of patient-centered medical homes to provide behavioral health care to individuals with opiate addiction who seek medication assisted substance abuse treatment. DVHA and VDH-ADAP will share oversight of quality and clinical standards. Savings are anticipated through improved coordination and system

integration. DVHA currently is engaged in discussions with CMS to determine whether Section 2703 of the Affordable Care Act, *State Option to Provide Health Homes for Enrollees with Chronic Conditions*, provides an opportunity to receive additional federal support (90/10 match) for enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for people across the lifespan.

The following positions were identified as necessary for continued advancement toward system transformation and all are projected to result in cost savings:

3 FTE - Substance Abuse Director & Lock-in Administrators	\$59,759
5 FTE - Vermont Chronic Care Initiative (VCCI) Expansion	\$134,955
1 FTE - Concurrent Review Health Services	\$20,105
<u>2 FTE – Mental Health Utilization Review Care Managers</u>	<u>\$37,210</u>
<b><i>Subtotal</i> - Positions for Transformation Resulting in Program Savings:</b>	<b>\$252,029</b>

3 FTE - DVHA Substance Abuse. A Substance Abuse Director is needed to assure current and planned approaches at the community and provider levels, including the *Hub and Spoke* model, supporting a holistic health care delivery system. Just as the VCCI successfully addresses traditional healthcare service coordination, the need for similar improvements in substance abuse and mental health service coordination has become apparent. The Director also will supervise the two (2) *Team Care* program administrators. This *Team Care* (formally called the lock-in program) limits a beneficiary to designated Medicaid service providers, typically one pharmacy and one primary care provider, to improve coordination of care, decrease over-utilization and misuse of services, and monitor regulated medication use and non-emergency health care services. The *Team Care* program must expand in both size and scope to support a comprehensive approach to substance abuse care, with dedicated clinicians and audit personnel identifying and managing additional cases. These staff also will work with the Medicaid Medical Director on reconsiderations and appeals for all controlled substances, and collaborate with DVHA's Pharmacy unit and the Vermont Chronic Care Initiative (VCCI) to provide beneficiary oversight and outreach to providers to assure adherence to established medical practice guidelines. Savings are estimated in SFY '13 using the *Blueprint/VCCI* financial model and evidence that well-coordinated prescription management will result in savings from reduced unnecessary emergency room use, inpatient detoxification, and duplicative pharmacy payments.

5 FTE - DVHA VCCI. Using 2010 Medicaid claims data and the *Blueprint for Health* financial model, DVHA identified savings opportunities among high risk/high cost beneficiaries from better coordinated care in areas such as ER, inpatient admissions, and pharmacy use. Potential net decreases for SFY '13 are estimated in hospital inpatient (7%), physician inpatient (6%), and ER charges (7%).

These additional program staff will continue VCCI's successful efforts to address traditional healthcare service coordination and support its planned expansion and ongoing integration with other statewide healthcare reform initiatives. Staff will be co-located in high volume primary care offices, specialty practices, and hospitals to assure high quality, integrated, and cost effective health care coordination and transition planning.

1 FTE - DVHA Clinical Operations Unit Concurrent Review. This position is needed to implement concurrent reviews of all Medical Surgical Lengths of Stay (LOS), as well as post payment reviews. In SFY '11, costs fell outside the DRG payment for a total of 703 admissions for 573 unique beneficiaries. A retrospective review on a small sample of these beneficiaries (15) revealed that in every case the benchmark LOS (using nationally recognized criteria) had been exceeded, in extreme cases by 100 days or more. DVHA estimates that concurrent review and discharge planning could result in avoiding at least 10% of the inpatient costs and subsequent admissions for these outlier cases.

2 FTE - DVHA Mental Health Utilization Review Care Managers. Savings for these positions are expected in SFY '13 and estimated by a projected reduction of 2-3 days in the average length of stay (LOS) for adult (non-CRT) inpatient psychiatric services exceeding 10 days. DVHA identified a total of 672 days that could be avoided by implementing concurrent review and discharge planning. These days were multiplied by the average per diem to arrive at the estimated savings.

DVHA has already successfully decreased the average LOS for children's inpatient psychiatric admissions by 4 days through concurrent review of medical necessity and adherence to placement criteria, thereby ensuring appropriate resource use that does not increase state expenditures. The two (2) additional licensed clinical professionals will perform concurrent review and discharge planning for adult admissions, assist with discharge planning, and track utilization trends in existing programs and in two new partial hospitalization programs. These staff will work closely with the DVHA Substance Abuse Director (requested above), *Blueprint for Health* Community Health Teams (CHTs), AHS Field Services Directors, DVHA's VCCI Care Coordinators, AHS Integrated Family Services staff, Department of Mental Health and VDH/ADAP to develop a more coordinated and cohesive system of care for individuals with co-occurring diagnoses.

The above-referenced costs represent the salary and fringe costs only. In addition, \$38,825 is needed to provide the individuals with sufficient operating supports.

**Retirement Savings for Non-GF Positions ..... (\$75,715) (gross)**  
 (\$31,350) (state)

The FY 2012 Appropriation Reductions Act (2011 Act 63 Sec. B.1101) reduced the state's contribution to the pension plan from 17.34% (budgeted) to 16.13%. This reflects the cost-saving impact to DVHA.

**Cost Neutral Transfer of IT Position to AHS ..... (\$42,400) (gross)**  
 (\$17,867) (state)

As part of the centralization of IT functions, DVHA is transferring one IT position to AHS.

**Cost Neutral Transfer to the Department of Mental Health ..... (\$21,500) (gross)**  
 (\$9,060) (state)

Historically DVHA has granted funds to the Community Health Center of Burlington. Due to its historical nature, performance-based deliverables were not inherent in the agreement. Since the Department of Mental Health has much more involvement with this organization, the funding was transferred to DMH in order to establish better programmatic controls.

**Reduction in MMIS Anticipated Expenditures ..... (\$4,560,000) (gross)**  
 (\$456,000) state

Due to the cancellation of the MMIS RFP and restart of the MMIS project, DVHA will not need to use \$456,000 of GF and the associated federal receipts for this project during SFY'12. This project is expected to be fully engaged during SFY'13.

FOR FY 2012 DVHA BAA	GF	SF	IdptT	FF	ARRA Fed	Medicaid GCF	Invmnt GCF	Total
<b>Administration - As Passed FY12</b>	945,014	1,579,123	4,077,117	43,169,600	2,505,044	37,872,530	6,043,568	96,191,996
Retirement rate reduction GF savings	(558)							(558)
Benefit Rate Reduction	(2,009)							(2,009)
Voluntary Furlough	(610)							(610)
<b>FY12 BAA Subtotal Challenges:</b>	<b>(3,177)</b>							<b>(3,177)</b>
<b>FY12 Post Challenges</b>	<b>941,837</b>	<b>1,579,123</b>	<b>4,077,117</b>	<b>43,169,600</b>	<b>2,505,044</b>	<b>37,872,530</b>	<b>6,043,568</b>	<b>96,188,819</b>
<b>Personal Services:</b>								
Retirement rate Reduction Savings (non-GF)				(1,321)		(74,394)		(75,715)
4 FTE - Reimbursement and Data needs for VHCURES, DSH, HIT, Assessments, and Health Care/Payment Reform						82,204		82,204
1 FTE - Blueprint statewide expansion						18,048		18,048
1 FTE - Pharmacy						17,039		17,039
3 FTE - Sub Abuse Director & Lock-in Administrators (Program Savings)						59,759		59,759
5 FTE - VCCI Expansion (Program savings)						134,955		134,955
1 FTE - Concurrent Reviews (program savings)						20,105		20,105
2 FTE - MH Case management and reviews (Program savings)						37,210		37,210
Transfer Development Position to AHS IT eff. 1/6/11 (net neutral)						(42,400)		(42,400)
<b>Operating Expenses:</b>								
Operating for 17 FTE( 1 qtr = 5 VCCI @ \$3,025, 12 FTE @ \$1,975)				(4,104,000)		38,825		38,825
Admin Approp has \$676,640 GF for MMIS projects - not needed SFY'12	(456,000)							(4,560,000)
<b>Grants:</b>								
Transfer to DMH grant for ChCB (net zero)						(21,500)		(21,500)
<b>FY12 BAA Changes</b>	<b>(456,000)</b>			<b>(4,105,321)</b>		<b>269,850</b>		<b>(4,291,471)</b>
<b>FY12 BAA Request</b>	<b>485,837</b>	<b>1,579,123</b>	<b>4,077,117</b>	<b>39,064,279</b>	<b>2,505,044</b>	<b>38,142,380</b>	<b>6,043,568</b>	<b>91,897,348</b>
<b>FY12 BAA Changes</b>								
<b>FY12 BAA Subtotal of Legislative Changes</b>								
<b>FY12 BAA As Passed - Dept ID 3410010000</b>	<b>485,837</b>	<b>1,579,123</b>	<b>4,077,117</b>	<b>39,064,279</b>	<b>2,505,044</b>	<b>38,142,380</b>	<b>6,043,568</b>	<b>91,897,348</b>

FOR FY 2012 DVHA BAA	GF	SF	ldptT	FF	ARRA Fed	Medicaid GCF	Invmt GCF	Total
<b>Program Appropriations - As Passed FY12</b>	130,421,780	-	-	143,519,012	-	640,777,596	1,083,465	915,801,853
<b>FY12 Challenges for Change:</b>								
<b>FY12 BAA Subtotal Challenges:</b>	130,421,780	-	-	143,519,012	-	640,777,596	1,083,465	915,801,853
<b>Grants:</b>								
GC Caseload						(15,592,839)		(15,592,839)
CFC Acute Caseload	(569,091)			(781,386)		(1,350,477)		(2,341,468)
State-Only Pharmacy Caseload	(234,240)							(234,240)
Civil Union Caseload							(2,178)	(2,178)
HIV Caseload							(23,705)	(23,705)
SCHIP Caseload	90,359			216,021				306,380
Refugee Caseload				13,099				13,099
Subtotal Caseload	(712,972)	-	-	(552,266)	-	(15,592,839)	(25,883)	(16,883,960)
GC Utilization								
CFC Acute Utilization	(1,650,229)			(2,265,834)		(17,717,358)		(19,633,421)
State-Only Pharmacy Utilization	82,245							82,245
Civil Union Utilization								
HIV Utilization								
SCHIP Utilization	(184,027)			(439,951)				(623,978)
Refugee Utilization				77,235				77,235
Subtotal Utilization	(1,752,011)	-	-	(2,628,550)	-	(17,717,358)	169,907	(21,928,011)
GC Buy-In Caseload								
Change in CFC Buy-In Caseload	56,044			76,951		1,366,467		1,399,462
Change in State Only Buy-In Caseload								
Change in Federal Only Buy-In Caseload								
Subtotal Buy-In	56,044	-	-	(172,104)	-	1,366,467	(75,538)	1,174,869
Implementation of GME Initiative								
CFC FY11 carryover; Increased SFY '11 ARRA receipts transfer to CO (DVHA portion of CO GC \$3.6M carryover) - (net neutral); Fed. receipt on carryforward	(559,556)			2,720,242		30,000,000		2,160,686
Change in Clawback	126,982							126,982
State Only GF carryforward from SFY '11	(477,636)							(477,636)
ACA Rebate				1,792,766				1,792,766
<b>Technical Adj. to GC Due to Conf. Committee Chgs.</b>						136,470		136,470
<b>Technical Adj. to Choices for Care Due to Conf. Committee Chgs.</b>	(84,910)			(116,586)				(201,496)
<b>Technical Adj. to State Only Due to Conf. Committee Chgs.</b>	72,848						(1,902)	70,946
<b>Technical Adj. to Non Waiver Due to Conf. Committee Chgs.</b>				(5,920)				(5,920)
<b>Subtotal Technical Adj. Due to Conf. Committee Chgs.</b>	(12,062)	-	-	(122,505)	-	136,470	(1,902)	0
<b>FY12 BAA Changes</b>	(3,331,210)	-	-	1,037,582	-	(1,807,261)	66,584	(4,034,304)
<b>FY12 BAA Request</b>	127,090,570	-	-	144,556,594	-	638,970,335	1,150,049	911,767,549
<b>Grants:</b>								
<b>FY12 BAA Subtotal of Legislative Changes</b>	127,090,570	-	-	144,556,594	-	638,970,335	1,150,049	911,767,549
<b>FY12 BAA As Passed - Program Appropriations</b>	131,366,794	1,579,123	4,077,117	186,688,612	2,505,044	678,650,126	7,127,033	1,011,993,849
<b>TOTAL FY12 DVHA Big Bill As Passed</b>	(3,177)	-	-	-	-	-	-	(3,177)
<b>TOTAL FY12 DVHA Challenges for Change</b>	131,363,617	1,579,123	4,077,117	186,688,612	2,505,044	678,650,126	7,127,033	1,011,990,672
<b>TOTAL FY12 BAA DVHA Starting Point</b>	(3,787,210)	-	-	(3,067,739)	-	(1,537,411)	66,584	(8,325,775)
<b>TOTAL FY12 BAA DVHA Ups &amp; Downs</b>	127,576,407	1,579,123	4,077,117	183,620,873	2,505,044	677,112,715	7,193,617	1,003,664,897
<b>TOTAL FY12 BAA DVHA Gov Recommended</b>	127,576,407	1,579,123	4,077,117	183,620,873	2,505,044	677,112,715	7,193,617	1,003,664,897
<b>TOTAL FY12 BAA DVHA Legislative Changes</b>	127,576,407	1,579,123	4,077,117	183,620,873	2,505,044	677,112,715	7,193,617	1,003,664,897