DEPARTMENT OF VERMONT HEALTH ACCESS

ANNUAL REPORT FOR STATE FISCAL YEAR 2019 & BUDGET RECOMMENDATION FOR STATE FISCAL YEAR 2021

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MESSAGE FROM THE COMMISSIONER

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

Adoption of Value-Based Payments

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

Management of Information Technology Projects

The Department is working with the Agency of Digital Services to transform the way the Agency of Human Services plans for, implements, and manages large scale Medicaid information technology projects. These new approaches are designed to improve outcomes and efficiency, reduce financial risk to the State of Vermont, reduce vendor lock-in, and to build systems that are nimble and responsive in the face of changing customer expectations, a shifting federal landscape, and advancements in the marketplace. This report highlights recent accomplishments including the new online provider management module for enrolling providers in Vermont Medicaid, the new fully electronic process for prior authorization requests, and the ability of Vermonters to upload application and verification documents through their mobile device.

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 decision making and the pursuit of better customer service, a higher quality of care, and operational efficiencies. Targeted performance improvement projects have resulted in numerous operational and financial efficiencies; for example, reduced call center contract costs, improvements in subrecipient grant monitoring, a lean procurement process (Rapid Agile Procurement), improved processes for Early and Periodic Screening, Diagnostic, and Treatment services, Vermont Chronic Care Initiative model evolution, and a reduction in audit findings.

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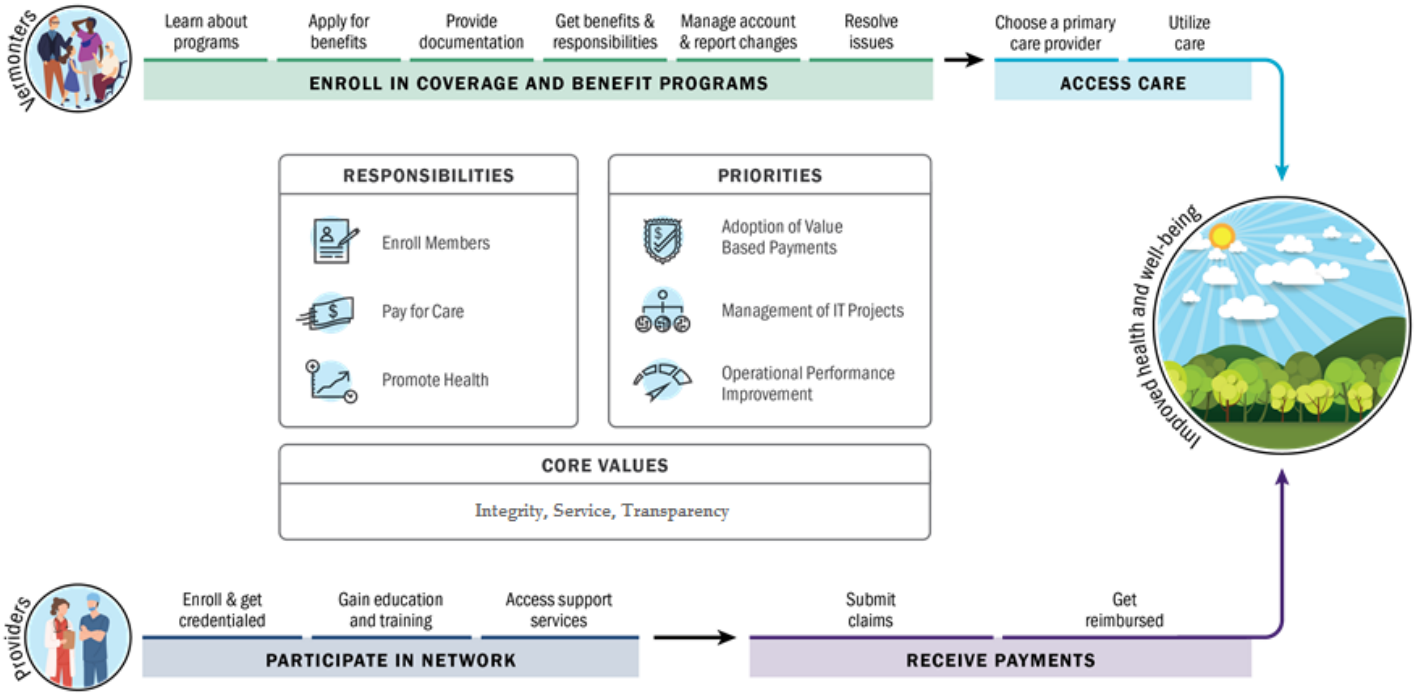
INTRODUCTION TO DVHA

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



About Us

The Department of Vermont Health Access (DVHA), within the State of Vermont's Agency of Human Services, is responsible for administering the Vermont Medicaid health insurance program and Vermont's state-based exchange for health insurance. Vermont's state-based health insurance exchange is also referred to as the health insurance marketplace. The Health Access Eligibility and Enrollment team integrates eligibility and enrollment for Medicaid and commercial health insurance plans for many of Vermont's individuals and families. The Department coordinates a range of health insurance plan options and offers online, telephone, paper and in-person assistance for Vermonters who are applying for health insurance. It is important to know that:

- **Medicaid** was designed to provide a government-funded health insurance plan for income-eligible people and people who are categorically eligible. The federal government establishes requirements for all states to follow but each state administers their own Medicaid program differently. Thus, Medicaid is sometimes referred to as "government insurance."

- **Commercial** health insurance plans are offered by private insurance companies like BlueCross BlueShield of Vermont and MVP® Health Care. Qualified Health Plans offered by BlueCross BlueShield and MVP® in Vermont are certified by the Department of Vermont Health Access. An insurance plan that is certified provides essential health benefits, follows established limits on deductibles, copayments 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 healthcare cost effectively," we are really saying that we are striving to do multiple things. First, we are saying what we're trying to do: to improve the health and well-being of Vermonters. Second, we're saying how we're trying to do it: by providing access to quality 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.

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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 second full year of the Accountable Care Organization (ACO) program and initiating the third 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 2019, DVHA published the Medicaid Delivery System Reform (2018) report to demystify payment and delivery system reform by describing the process and ongoing efforts that occur within AHS and with

stakeholders.[1] Specifically, the report consisted of two basic elements. First, a description of the payment reform process, which is typically facilitated by the Payment Reform team at DVHA. Second, the report provides an update on completed and in-progress payment reform activities, using the enumerated statutory criteria:

- Medicaid payments to affected providers;
- changes to reimbursement methodology and the services impacted;
- efforts to integrate affected providers into the 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 completed or in-progress in 2019:

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

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

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

Calendar year 2018 was the second full year of the Vermont Medicaid Next Generation Accountable Care Organization program. During 2019, the Department completed its evaluation of the Vermont Medicaid Next Generation (VMNG) second year, and results indicated the program:[2]

1. **Nearly Tripled the Number of Members Covered by Value-Based Payments Rather than Fee-For-Service**

   The table below depicts the number of hospital service areas, provider entities, unique Medicaid providers, and attributed Medicaid members from 2017 – 2019.

[1] https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Report-2019.pdf
[2] https://dvha.vermont.gov/administration/1final-vmng-2018-report-09-20-19.pdf

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

Indicative of programmatic growth, there continues to be more providers and communities participating in the Program and this remains a key milestone for provider-led reform.

2. **Reduced Provider Administrative Burden**

   During the 2018 performance year, the Department and OneCare Vermont implemented several programmatic changes that represented opportunities for incremental improvement. One notable change was the expansion of the waiver of prior authorization in the program to all providers in the Vermont Medicaid network, decreasing administrative burden for providers.

3. **Promoted Shared Financial Accountability for Health Care between Participating Providers and Medicaid**

   The Department and OneCare Vermont agreed on the price of health care upfront and OneCare Vermont spent approximately $1.5 million more than the expected price. Financial performance was within the risk corridor, meaning that OneCare Vermont and its members will repay these dollars to the State.

4. **Demonstrated a Focus on High Quality of Care**

   The overall quality score was 85% for 10 pre-selected measures; notably, OneCare Vermont's performance exceeded the national 75th percentile on measures relating to developmental screening in the first 3 years of life and 30-day follow-up after discharge from Emergency Departments for mental health and substance use.

5. **Expanded the Advanced Community Care Coordination Model**

   The Advanced Community Care Coordination (A3C) Model expanded from the initial 4 pilot communities to include eligible community partners in the 10 participating hospital service areas in 2018. During the 2018 performance year, OneCare Vermont distributed approximately $2.7 million in advanced community care coordination model payments to 65 community partner organizations – including primary care practices, designated mental health agencies, Area Agencies on Aging, and Visiting Nurse Associations. Nearly 700 community care team members trained in care coordination and Care Coordination Core Teams were active in all 10 participating communities.

Implementing and Analyzing Applied Behavior Analysis Payment Reform

The Applied Behavior Analysis case rate payment methodology became effective on July 1st, 2019. As of the effective date, providers successfully received 3 months of prospective payments to support increased access to, and utilization of, Applied Behavior Analysis services by Medicaid members. Following the new payment methodology implementation, 31 new Medicaid members began to receive Applied Behavior Analysis services. Next, an analysis of treatment hour data will be completed to determine if the number of treatment hours for Medicaid members receiving Applied Behavior Analysis services have increased following the implementation of the case rate.

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

Vermont Medicaid payments to all designated agencies and Pathways Vermont (a specialized services agency) for mental health services were previously through traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service reimbursement). The Department of Vermont Health Access began collaborative work with the Department of Mental Health in 2018 to transition Vermont Medicaid payments for these agencies to a monthly case rate for children and adult populations statewide. Under the new payment model, the agencies are paid a prospective, fixed amount at the beginning of each month and are expected to meet established caseload targets by delivering at least one qualifying service to an individual in each month. The payment model went into effect for all mental health services delivered on/after January 1, 2019 for Medicaid members receiving treatment at all Vermont designated agencies and Pathways, a specialized services agency.

Work is underway to develop the quality framework to implement the value-based payment component of the model. During each measurement year, the Department of Mental Health will withhold a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model will use 3 types of performance metrics to assess quality and value of services: monitoring, reporting and performance.

Designing and Developing Developmental Disabilities Services Payment Model Options

The Department of Vermont Health Access has been working with the Department of Disabilities, Aging, and Independent Living to transition from the current developmental disabilities services home- and community-based services daily rates to a new form of payment for individuals with intellectual and developmental disabilities. Importantly, this work has involved representatives from the provider network, of consumers & family members, from the State and other interested stakeholders to meet the following objectives:

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

This project has involved the establishment of multiple workstreams to produce progress in the collaborative endeavor to pay for developmental disabilities services through a different payment model that supports coordination with existing delivery system and payment reform efforts while increasing transparency and accountability, and improving validity, reliability and equity for individuals with intellectual and developmental disabilities. As a result, four payment model options have been developed and are under consideration. The Payment Model Work Group recently received clarifications regarding the details of a provider-led payment model proposal (which is one of the four options). A multi-stakeholder Advisory Committee reviewed the payment model options and provided feedback on the decisions that need to be made. The Needs Assessment Work Group has been meeting to discuss potential supplemental questions for a standardized assessment tool. The Encounter Data Work Group continues to make progress towards initiating data collection through the Medicaid Management Information System. Public forums have been convened throughout the state related to the identified issue of conflict of interest in case management for people with developmental disabilities. It is anticipated that another round of public forums will be convened in November 2019 to gather feedback on the proposed payment models following feedback received from the Advisory Committee and work groups.

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. Implementing technology that meets these objectives and does so on time and on budget has been a challenge in Vermont, with the most public example being Vermont Health Connect. DVHA learned difficult lessons from that experience and has worked over the past two years to apply these learnings in a manner that will improve the chances of success on future projects.

DVHA is currently engaged in two large scale IT 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. DVHA 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 the delivery of more frequent business value, 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 the Provider Management Module

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 team, the new online Provider Management Module was implemented on May 1st, 2019 on schedule, ahead of the date required by Act 116 of 2018 and continues to demonstrate significant efficiencies for enrolling providers to participate with Vermont Medicaid.[3] The launch of the new online Provider Management Module has significantly reduced the average time to enroll providers. Between May 1st and June 30th, 2019, Vermont Medicaid enrolled 987 providers as compared to the same time frame in 2018 during which 433 providers were enrolled. The average time to enroll a provider in May and June 2019 was 15 days, as compared to 63 days for the same period in 2018. In 2018, there were 9 DXC Enterprise Services (DVHA's fiscal agent) staff and 2 State of Vermont staff completing provider enrollments. For the same time period in 2019, Provider Management Module implementation resulted in an average of 7 DXC staff completing provider enrollments. A survey was conducted in early August 2019 to gauge satisfaction of the provider

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

community. The Provider Management Module has been reviewed by CMS and the team is awaiting CMS certification. Transitioning to this online system is showing potential for cost savings across additional DVHA units; Provider Member Relations is currently working with DXC and the Blueprint for Health to determine feasibility of replacing the Blueprint's Provider Registry with the Provider Management Module.

Receiving CMS Certification for the Care Management System

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

Migrating to an Electronic Prior Authorization Process

In 2018, the Department received 20,752 paper prior authorization requests into its Clinical Operations unit, with prior authorization request facsimiles comprised of anywhere from 1 page to over 100 pages per request. The volume of paper required large file rooms for storage, which were stored in rooms away from where unit staff worked. If a provider called and a staff member needed to review the file with the prior authorization request, time was required to end the call, walk to the storage room, locate the file and return to call the provider back. The inherent inefficiency of the established process was addressed by transitioning to a new, fully electronic process on the OnBase system, where facsimiles are now imported into OnBase. By removing the need for paper storage, the Clinical Operations unit has been able to move from the building in Williston, Vermont to the Waterbury State Office Complex. If a provider calls, staff can now access the file with the prior authorization request immediately, while the provider is on the call. Less time is required to transfer the file to the next person in line to review the prior authorization request and the very manual process of re-filing the paper prior authorization requests once the review was completed can now be accomplished virtually. Paper prior authorization requests also need to be retained – which required storage offsite. This is no longer needed due to the fully electronic process for prior authorization requests being implemented as of November 19th, 2018.

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

Under the Integrated Eligibility and Enrollment program, DVHA has been working on the Enterprise Content Management project to sunset the Oracle solution and transition to OnBase for

Vermont Health Connect programs by October 1st, 2019.[4] Vermont's eligibility and enrollment staff currently utilize two different systems for scanning, indexing, and viewing Vermonters' documentation and notices. This leads to operational inefficiencies, unnecessary maintenance and operations costs, and difficulty coordinating enrollee documentation across programs. In addition, Oracle WebCenter, the content management system currently utilized by Vermont Health Connect (VHC), is expensive to maintain, difficult to build on, and is incompatible with IE&E's technical principles. By contrast, OnBase, the solution leveraged for the aged, blind, and disabled Medicaid population and economic services programs, is an existing technological asset owned and maintained by the State and is working reasonably well for the programs it supports. This change will create a streamlined experience for staff, reduce operating expenses, and allow for simplified training and documentation, improving quality and reducing the time needed to onboard new staff.

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

The Department encouraged Vermonters to comparison shop to choose the best health insurance plan for themselves and determine if they qualify for financial help by using the Plan Comparison Tool. The Tool compares qualified health plans on both plan design and total cost (including premium and out-of-pocket costs) to help Vermonters make informed decisions. Vermonters heard the message and visited the online Plan Comparison Tool 62% more during October 15th when it debuted to December 15th, 2018 when Open Enrollment closed when compared to the previous year (38,319 sessions versus 23,683).

Implementing an Integrated Health Care Paper Application

The Integrated Eligibility and Enrollment program's Health Care Paper Application project involved the design of a new user-friendly paper application that allows Vermonters to apply for all health coverage programs at once (excepting long-term care). The new integrated application consolidated 3 applications into 1, was submitted to the Centers for Medicare and Medicaid Services for approval on May 17th after piloting the application with Vermont Legal Aid and several district offices and is federally approved. The new paper application enables full health care screening for both Modified Adjusted Gross Income (MAGI) and non-MAGI based eligibility determinations and collects information needed for efficient and accurate eligibility decisions with reduced data entry and processing time for staff. Successful project completion has improved the

[4] https://legislature.vermont.gov/assets/Legislative-Reports/Act-42-IEE-1-November-2019-Progress-Report_DVHA_FINAL.pdf

experiences of Vermonters in applying for health care coverage and improved the percentage of applications submitted with all information complete.[5]

Launching the Customer Portal Phase 1 (Document Uploader)

Vermont's work to date on the Document Uploader project, under the Integrated Eligibility and Enrollment program, has been in preparation to launch a new technical solution statewide that allows Vermonters to utilize mobile and online technology to submit verification documentation electronically and to automate classification of such documentation by October 1st, 2019.[6] When the State cannot verify an applicant's information using electronic data sources, it must ask for additional documentation. Currently the applicant must either send copies of their documentation in the mail or must present that information in person at one of the State's district offices. The result is a manual verification process that is challenging, time-consuming, and frustrating for both staff and customers. For internal staff, verifying Vermonter's income routinely involves delays, stressful conversations, and duplicative work. Mail and paper slow the entire process from initial notification, to mailing documents, to scanning and indexing. Internal staff wait for Vermonters submission of pay stubs, employment forms, or attestations to process applications or changes.

Phone calls become stressful when Vermonters don't understand what to do and end up being required to mail additional forms before they run out of time, or in extreme cases hand deliver documents to avoid losing benefits due to missed deadlines. Internal staff in the district offices try to help Vermonters by calling employers multiple times to verify information, while health care workers often need to search multiple systems to track down the right document. Vermonters' data isn't well shared across agencies within state systems. The Customer Portal Phase 1 (Document Uploader) solution will improve the efficiency of the eligibility determination process and result in a better customer experience for Vermonters. This product is currently being piloted in district offices and with several key hospitals across the State. Initial pilot result data is showing that:

- By giving Vermonters an online option to submit verification documents, they can progress through the same application stages 40.4% faster.
- 55% of uploader users were able to submit documents within one day or less, compared to just 11% of the baseline group.
- 30% of uploader users submitted documents outside of business hours and 50% submitted them using a mobile device.

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[5] https://legislature.vermont.gov/assets/Legislative-Reports/Act-42-IEE-1-Sept-2019-Progress-Report_FINAL.pdf
[6] https://legislature.vermont.gov/assets/Legislative-Reports/Act-42-IEE-1-November-2019-Progress-Report_DVHA_FINAL.pdf

Launching an Electronic Payer Initiated Eligibility Matching Process

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

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

In order to improve patient outcomes by allowing providers to make better informed decisions at the point of care, a higher volume of patient records needs to be available to be exchanged in the Vermont Health Information Exchange. Act 53 of 2019 changes Vermont's consent to share health records policy from an opt-in to an opt-out policy, effective March 1, 2020; this policy change is intended to increase the volume of patient records within the Vermont Health Information Exchange. In preparation for the policy change, the Department of Vermont Health Access engaged stakeholders in the process of developing a consensus-based implementation strategy for the consent policy change and the Department submitted progress reports on/before August 1, 2019 and November 1, 2019 indicating specifics for stakeholder engagement and project status.[7,8] The implementation strategy was required to include:

- substantial opportunities for public input;
- focus on the creation of patient education mechanisms and processes that combine new information with existing patient education obligations, addresses diverse needs, abilities and learning styles, and clearly explains the purpose of the health information exchange, the way information is collected, how and with whom health information may be shared, the purposes of sharing health information, how to opt-out of health information sharing and how to change their participation status in the future;
- identification of mechanisms that Vermonters can use to easily opt-out of having their health information shared through the Vermont Health Information Exchange.

Key stakeholders were identified by the Health Information Exchange (HIE) Steering Committee in order to ensure a multi-party process inclusive of diverse audiences and engagement is ongoing. In

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[7] https://legislature.vermont.gov/assets/Legislative-Reports/Act-53-Consent-Policy-Implementation-1-August-2019-Progress-Report_DVHA_FINAL.pdf
[8] https://legislature.vermont.gov/assets/Legislative-Reports/Act-53-Consent-Policy-1-November-2019-Progress-Report_DVHA_FINAL.pdf

addition, DVHA hired national experts, Lantana and Velatura, to support the HIE Steering Committee in developing a Technical Roadmap to define strategy for near- and medium-term investments that align the HIE network and support achievement of statewide HIE goals. Lantana & Velatura are also participating in the stakeholder engagement activities in order to comprehensively assess Vermont's current HIE landscape. Lantana executed a subcontract with an Office of the National Coordinator of Health Information Technology (ONC) consultant to assist the Steering Committee with operations and execution of the identified changes to the HIE Strategic Plan, including updating the HIE Plan with the Technical Roadmap. The Health Information Exchange Plan was updated as required by Act 187 and the updated Plan includes the provisions as specified in Act 53 of 2019. The updated 2019-2020 Plan was submitted to the Green Mountain Care Board in November of 2019.[9] Approval of the plan was with the condition that "DVHA shall return to the Board prior to March 1, 2020, to propose an addendum to the 2019-2020 HIE Plan (eff. 3/1/2020) to reflect opt-out consent and document how opt-out consent will be managed."

Returning Premium Processing to Insurance Carriers

Premium billing continues to be a pain point for Vermont Health Connect customers. Vermonters do not always understand what they need to pay, by when, and how it will impact their coverage. Customers do not always know who to call when there is a problem. Data inconsistencies, transaction errors, and premium allocation issues make it difficult for staff to understand the information they are seeing and accurately communicate case status to customers. As a result of these issues, the Vermont General Assembly indicated in Sec. C.102(a)(3) of Act 11 of 2018 (Special Session) that "it is anticipated that premium processing functions will be performed by insurance carriers;" the State is preparing to return Qualified Health Plan (QHP) premium processing to insurance carriers for plan year 2021.[10]

The State of Vermont is leading the premium processing project as a part of its overall Integrated Eligibility & Enrollment (IE&E) program. The State will transition responsibility for Qualified Health Plan premium processing to insurance carriers for coverage starting 1/1/2021. The resulting product will ensure a better experience for customers and reduced operating expenses, and a compliant billing process.

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[9] https://healthdata.vermont.gov/sites/healthdata/files/DVHA_HIE%20Plan_10.31.19_FINAL%20%28003%29.pdf

[10] https://legislature.vermont.gov/Documents/2018.1/Docs/ACTS/ACT011/ACT011%20As%20Enacted.pdf

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.

Identifying Efficiencies in Maximus Contract Management

The Health Access Eligibility and Enrollment unit began a focused initiative for continuous improvement in its vendor management of Maximus call processes (the vendor for Vermont Health Connect for member questions about eligibility or other issues). The initiative was designed to help the vendor efficiently respond to Vermonters, as evidenced by a reduction in the length of calls without compromising the quality of the call. For June of 2019, Maximus' talk minutes were 22% below budget and were 17% below last year's actuals. Through efficient contract management, Health Access Eligibility and Enrollment was able to demonstrate cost savings through reduced call length without a reduction in the quality of the calls. For SFY19, the budget for the Maximus contract was $8,075,332, with actuals at $7,290,327 resulting in a $785,005 budgetary savings (nearly 10%).

Improving Subrecipient Grant Monitoring

The Department carefully studied its subrecipient grant monitoring procedures to improve vendor relations and best ensure compliance with federal and state requirements. This year-long effort included reviewing current practices and policies, researching procedures used by other states and Vermont state departments, consulting with the Agency of Human Services Central Office, and obtaining feedback from vendors prior to rolling out the final changes. The first phase of this project was completed in May 2019, and positive impacts have already been reported by vendors both in person and through survey responses. The grant invoicing process has been streamlined to address vendor concerns while still maintaining compliance requirements, and a new Frequently Asked Questions page is in development to post on DVHA's external website. The second phase, currently in progress, involves a careful review of DVHA's vendor risk assessment process. As a continuous improvement project, the resulting new DVHA policy guidelines will be periodically updated as areas for improvement are identified.

Transitioning to a Lean Procurement Process - Rapid Agile Procurement

The Rapid Agile Procurement process was developed with two goals in mind: 1) to step away from waterfall contracting practices and begin an agile procurement effort, and 2) to streamline the State's procurement process through well-defined processes and procedures. The year-plus effort began with a week-long lean event focused on best future practices. A team was then formed, headed by the Agency's General Counsel, to document guidelines, roles and responsibilities, procedures, templates, and realistic timelines. A unique aspect of this effort was having an interdepartmental team, to include members from the Agency of Human Services (AHS), Department of Vermont Health Access, Agency of Digital Services (ADS), and our federal partner 18F. The group effort met with success in working through a pilot study and into a procurement process that is now used by both AHS (DVHA) and ADS. The focus of this project has been to devote more attention to increased communication and collaboration at the beginning of the procurement process, such as creating strong requests for proposals, in order to streamline later contract development and negotiations. As this project only recently reached completion, measurement of its success has been limited. The Rapid Agile Procurement team views the work as a continuing process and meets monthly to consider any processes that may need additional definition or refinement and reviews After Action Reports to determine future areas of improvement. Rapid Agile Procurement processes are being explored on how best to incorporate with all contracts, and DVHA Legal has started developing a key performance indicator to measure the impacts on efficiencies in DVHA's contract routing process. This is expected to be put into place in the fall of 2019.

Establishing Processes for Early and Periodic Screening, Diagnostic, and Treatment Services

The federal Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) law requires states to cover all medically necessary services for Medicaid children under 21 that could possibly be covered under the Social Security Act, regardless of whether that service is listed as covered in Medicaid rule or State Plan. In 2019, the Department worked on operational process improvements to ensure EPSDT services that are not listed as covered services under Vermont Medicaid are reviewed for medical necessity and, if appropriate, covered on an individual basis. Examples of services that may be reviewed for medical necessity but are not covered under Vermont Medicaid are certain genetic tests, dental implants, and specialized durable medical equipment. This operational process improvement work supports the Department's mission as Vermont Medicaid-enrolled children under 21, and their providers, are now able to receive a decision on EPSDT coverage faster. The new process has requests reviewed as part of the established prior authorization process, rather than going through a separate, prolonged, and administratively arduous exception request process.

Evolving the Vermont Chronic Care Initiative Model

In the All-Payer Model, an Accountable Care Organization (ACO) consisting of a network of hospitals and community providers assumes responsibility for the care, health, quality and health care costs of their population. Through the Vermont Medicaid Next Generation (VMNG) program, DVHA and OneCare are piloting a financial and delivery system model that is intended to improve the health of Vermonters and moderate health care spending growth in the future. As the VMNG and OneCare's role grows, some of the functions and structures within the Department of Vermont Health Access need to evolve. Under the ACO model, OneCare assumes responsibility for complex care management for attributed Medicaid members which was traditionally a role assumed by the DVHA under the Vermont Chronic Care Initiative (VCCI). Using lean process improvement methodology and stakeholder engagement, DVHA identified opportunities to reorient the VCCI model. In 2018, VCCI staff began outreach to individuals who are new to Medicaid and thus not attributable to the OneCare. The goal is to connect these Medicaid members with local care providers and assist in aligning their care with the OneCare Care Model. As the VMNG program prepares for state fiscal year 2021, VCCI is working with the community in the geographic attribution pilot to clarify and define a role that further supports the growth of the VMNG value-based payment model.

Data Management & Analysis to Support Advancing Care Coordination

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

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. Over the last year, the Oversight and Monitoring unit has been focused on reducing the total number of audit findings in audits that closed during the previous state fiscal year and reducing the total number of repeat findings from previous audits. As part of that process, all departmental units have been a part of the Standard Operating Procedures project to ensure documentation of risks/controls and demonstrate a strong control environment for reducing audit testing and findings.

For state fiscal year 2018 end, there was 1 total audit finding for the A133 Single Audit, as compared to a high of 14 total A133 Single Audit findings in previous fiscal years. The finding was a repeat finding; previous A133 Single Audits had a high of 12 repeat findings. The goal remains no repeat audit findings. The A133 Single Audit is an annual review by the State's external audit firm to ensure a recipient of federal funds is in compliance with the federal program's requirements for how the money can be used. The Comprehensive Annual Financial Report (CAFR) audit completed for state fiscal year end 2018 resulted in 0 audit findings; the high from previous state fiscal years for this audit was 5 findings. The CAFR audit is a thorough and detailed annual presentation of the State's financial condition where the State's external accounting firm reviews prepared modified accrual financial statements for compliance with Generally Accepted Auditing Standards (GAAS) and Generally Accepted Accounting Principles (GAAP) guidelines. The audit reports for state fiscal year 2019 end will not be available until January of 2020.

Achieving Compliance with Federal Regulatory Requirements for 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 federal regulatory requirements for Vermont's state-based health insurance exchange. On July 1st, 2019, the Department of Vermont Health Access received notification that the Center for Consumer Information and Insurance Oversight had agreed to close the final item on the mitigation plan based on this quarter's showing of compliance with verification rules for Qualified Health Plan eligibility. As required under the Affordable Care Act, DVHA's Health Access Eligibility and Enrollment unit administers Vermont's state-based health insurance exchange. CMS' Center for Consumer Information and Insurance Oversight (CCIIO) provides federal regulatory oversight of state-based exchanges. Since early 2016, DVHA has been in a mitigation agreement with CCIIO due to lack of compliance with federal requirements for verification of Qualified Health Plan eligibility.

Additionally, in October of 2019, the Department of received formal notification from the Centers for Medicare and Medicaid Services (CMS) that CMS had no observations regarding the 2018 State-based Marketplace Annual Reporting Tool nor any outstanding action items from prior

submissions. A notification of no outstanding action items demonstrates the Department's commitment to compliance with regulatory requirements for operation of Vermont Health Connect. 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 2019, this step was operated with a single, clean, automated run that took care of 99% of eligible cases for the second year in a row, up from 97.8% in 2017 and 91.5% in 2016. The small number of remaining cases were processed by staff the following day. For Vermonters, this means that they are able to 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.

Supporting the Assister Program to Improve Service Provided to Vermonters

The Assister Program is the Department's program for in-person assistance and provides a cornerstone of support for Vermonters seeking enrollment assistance when applying for health insurance plans. The Department convened the second annual Assister Program conference in October of 2019 to bring together 72 Assisters, representing 13 counties in Vermont, Agency of Human Services and Department of Vermont Health Access staff, representatives from BlueCross BlueShield of Vermont, MVP Health Care, and Northeast Delta Dental, and community stakeholders to prepare for Open Enrollment. The all-day event focused on "Getting Underserved Vermonters to Coverage," and increasing accessibility to supportive services.

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

The Blueprint for Health has continued its work to promote the health and well-being of Vermonters and has started the process of strategic planning to attain alignment with OneCare Vermont and ensure coordination in community-based strategies. The Blueprint for Health utilizes national standards to support improvements in primary care delivery and payment system reform. The program provides practice facilitation to help providers and practices achieve and maintain National Committee for Quality Assurance (NCQA) Patient Centered Medical Home recognition. Patient Centered Medical Homes provide care that is patient-centered, team-based, comprehensive,

coordinated, accessible, and focused on quality and safety. Patient Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each health service area of the State that provide supplemental services, allowing Blueprint-participating primary care practices to focus on promotion of prevention, wellness, and coordinated care.

The majority of Vermont's primary care practices are now Blueprint-participating Patient Centered Medical Homes, as evidenced by the fact that 137 of Vermont's primary care practices are Blueprint-participating (out of an estimated 169 total primary care practices). Blueprint-participating Patient Centered Medical Homes currently serve 294,108 insurer-attributed patients, of which 100,585 are Medicaid members, and are supported by approximately 165 full-time equivalents of Community Health Team staff. The Blueprint for Health also administers the Spoke program for office-based opioid treatment in community-based medical practice settings. In fact, most of the Spoke practices are also Blueprint-participating Patient Centered Medical Homes, providing medication assisted treatment for opioid use disorder. By June of 2019, there were 3,057 Vermonters receiving medication-assisted treatment for opioid use disorder from 259 prescribers, supported by 70.7 full-time equivalents of Spoke staff (licensed registered nurses and licensed mental health clinicians).[11,12]

Effectively Managing the Pharmacy Benefit and Pharmaceutical Spend

The Pharmacy unit managed $198.8 million in gross drug spend in state fiscal year 2019 (July 1, 2018, through June 30, 2019) and invoiced approximately $127 million dollars in federal and supplemental rebates, representing 63.8% of the total gross drug spend. Gross drug spend reflects what DVHA paid to both in-state and out-of-state pharmacies enrolled in the network. This amount represents a modest increase in gross expenditures of approximately $1.6 million dollars or a 0.82% increase over the previous fiscal year. Approximately 37% of adults and 21% of children utilize the drug benefit programs each month. In state fiscal year 2019, $5.59 million was spent on the Vermont pharmaceutical assistance program (VPharm), reflecting a 4.7% decrease in VPharm spending from the prior year.

Medications used to treat various inflammatory conditions, such as ulcerative colitis, Crohn's disease and arthritis, are projected to increase by approximately 10 percent. This is due to an increase in overall prescribing and increased utilization of new higher cost interleukin agents. Net spend for oncology drugs is projected to increase about 11% each year as utilization of newer products with expanded indications continues to increase. The projected increase is also in part due to increased overall

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[11] https://dvha.vermont.gov/global-commitment-to-health/vt-ahs-qe0619-gc-quarterly-report-final-w-attachments.pdf

[12] https://legislature.vermont.gov/assets/Legislative-Reports/2018_Blueprint_for_Health_Annual_Report_final.pdf

utilization as cancer becomes more of a chronic disease and more people live with cancer. Net spend on HIV-related drugs is expected to increase by almost 10% per year as utilization shifts away from older multiple-tablet regimens to newer single-tablet regimens. Finally, an increase in net spend for diabetes, of about 8% in state fiscal year 2020, is expected due to a shift to new higher cost drugs often used in combination for both type 1 and type 2 diabetes.[13]

Strategically Managing Departmental Activities

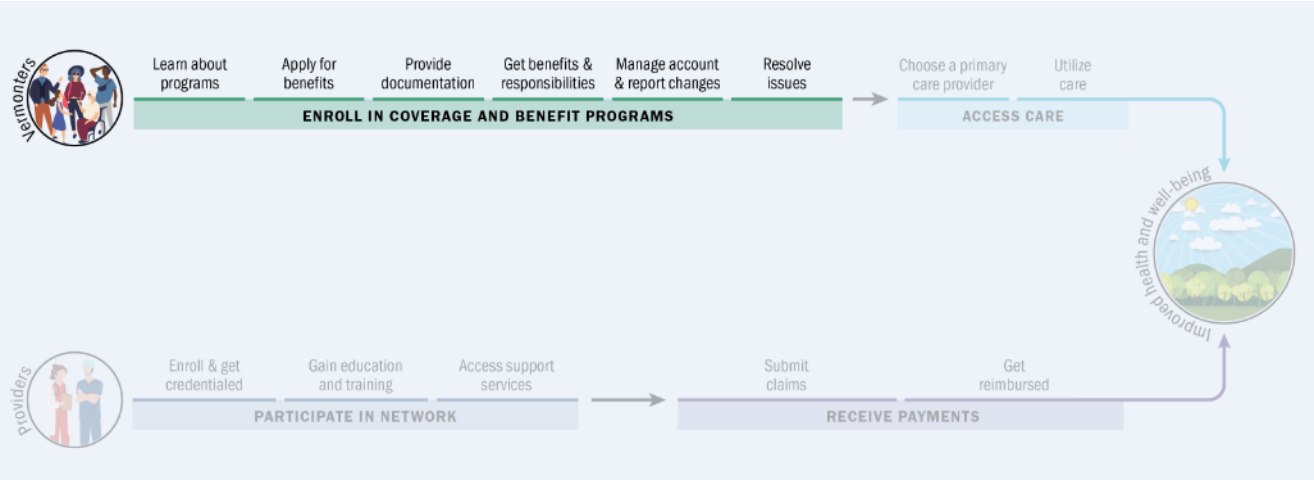
Each of the Department's units tracks performance metrics with an emphasis on the core responsibilities of enrolling members, paying for care, and promoting health. The results can be seen across all three areas of responsibility as well as in general operations. For each of the units mentioned above, and for all units within the Department, additional information regarding performance measures by unit may be found in the Performance Accountability Scorecard.

[13] https://legislature.vermont.gov/assets/Legislative-Reports/Pharmacy-Best-Practices-Cost-Control-Report-30-October-2019_DVHA_FINAL.pdf

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

MEMBER EXPERIENCE

HOW WE SERVE VERMONTERS



In state fiscal year 2019 (July 1, 2018 – June 30, 2019), more than 230,000 Vermonters received health insurance through Medicaid or a Qualified Health Plan. In fact, 156,731 Vermonters received health insurance through Medicaid (full health benefits), 10,382 Vermonters received pharmacy assistance through Vermont Medicaid to help pay for prescription medications and 4,275 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).[14] The Department of Vermont Health Access enrolled 26,119 Vermonters in Qualified Health Plans, with 22,370 Vermonters (85.6%) receiving subsidies to help make health insurance more affordable.[15]

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).

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[14] Medicaid Program Enrollment and Expenditure Quarterly Report, SFY19

[15] As of June 2018, 27,123 Vermonters obtained health insurance through Vermont's state-based exchange & 22,128 (81.6%) received subsidies.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

<table>
<tr><th colspan="5">Total Medicaid: 171,388[1]</th><th colspan="4">Total Commercial: 73,701</th></tr>
<tr><td colspan="4">Medicaid Health Coverage</td><td>Other Medicaid Benefits</td><td colspan="2">Vermont Health Connect Qualified Health Plans[2]</td><td colspan="2">Direct from Carriers[3] QHP & Reflective</td></tr>
<tr><td colspan="4">Total: 156,731</td><td>Total: 14,657</td><td colspan="2">Total: 26,119</td><td colspan="2">Total: 47,582</td></tr>
<tr><td colspan="4">Medicaid for the Aged, Blind & Disabled[4]: 26,229</td><td rowspan="2">Pharmacy Assistance (Only): 10,382</td><td colspan="2">Total w/ Subsidy[5]: 22,370</td><td colspan="2">Individuals: 7,249</td></tr>
<tr><td>Aged, Blind & Disabled Adults: 6,485</td><td colspan="2">Duals (Medicare & Medicaid): 17,651</td><td>Blind, Disabled Children: 2,093</td><td>State & Federal Subsidy: 16,912</td><td>Federal Only Subsidy: 5,458</td><td>Qualified Health Plan (QHP): 4,471</td><td>Reflective: 2,778</td></tr>
<tr><td colspan="4">Medicaid for Children and Adults[5]: 130,502</td><td rowspan="2">Choices for Care: 4,275</td><td colspan="2" rowspan="2">No Subsidy[6]: 3,749</td><td colspan="2">Small Businesses: 40,333</td></tr>
<tr><td colspan="2">Adults: 66,681</td><td colspan="2">Children: 63,821</td><td>QHP: 30,103</td><td>Reflective: 10,230</td></tr>
</table>

As of June 2019

1 Medicaid enrollment is from the quarterly DVHA Enrollment and Expenditure report and is for the state fiscal year-to-date.

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

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

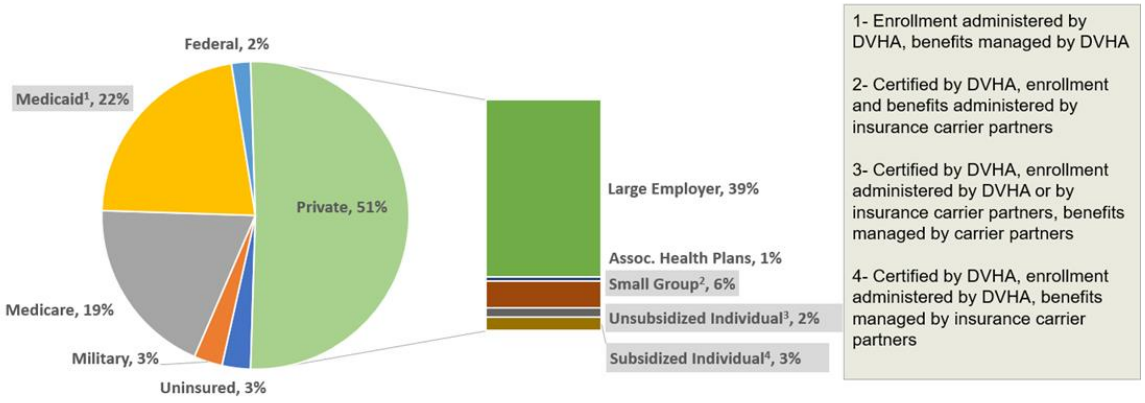
4 Medicaid for the Aged, Blind, and Disabled, Pharmacy Assistance, and Choices for Care use the previous eligibility standards (Non-MAGI) to determine eligibility.

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

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

The Health Insurance Landscape in Vermont

The Affordable Care Act increased access to affordable coverage for Vermonters. Overall, the number of individuals with insurance has increased. In Vermont, the number of covered individuals increased from 583,674 in 2012 to 604,800 in 2018, according to the 2018 Vermont Household Health Insurance Survey (VHHIS).[16] 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.[17] 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.[18] The Affordable Care Act (ACA) expanded coverage through two key mechanisms: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance exchanges, like Vermont's state-based exchange, for those individuals with moderate incomes. Also, largely due to the ACA's provision that adult children can be covered by their parents' health plan until age 26, the number of uninsured young Vermonters decreased significantly. Overall, more Vermonters have access to preventative health services such as immunizations for children, cancer screenings, and birth control as well as other essential health benefits (e.g. substance use disorder treatment) through enrollment in qualified health plans.



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

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

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

For the 19,800 Vermonters who remain uninsured there are a handful of reasons reported on the 2018 Vermont Household Health Insurance Survey.[19] 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 experience in part though the Medicaid and Exchange Advisory Committee. This advisory committee raises issues for DVHA to consider and provides feedback on policy development and program administration. The Medicaid and Exchange Advisory Committee is comprised of stakeholders who represent a variety of groups, including consumers of both Medicaid and Exchange health plans, businesses and health care providers.[20] Advisory Committee members are appointed by the Commissioner of DVHA. Importantly, the meetings of the advisory committee are open to anyone to attend and the Committee welcomes community members, especially consumers, to share their interest in being considered for open positions.

LEARN ABOUT PROGRAMS

Vermont Medicaid Programs

Medicaid programs provide low-cost or free health coverage for eligible parents, children, childless adults, pregnant individuals, caretaker relatives, people who are blind or disabled, and those ages 65 or older. Eligibility is based on various factors including income and, in certain cases, resources (e.g., cash, bank accounts) depending on the program. Medicaid programs cover most physical and mental health care services 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

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

appointments and more. States are required to cover mandatory benefits under federal law and may cover optional benefits if they choose.[21,22] Importantly, health care services must be medically necessary in order to be covered. In general, benefits must be equivalent in amount, duration and scope for all members and covered services must be uniform across the state. Members must have freedom of choice among health care providers participating in Medicaid. States can assess premium requirements for eligibility and can impose co-payments on most Medicaid-covered benefits, including inpatient and outpatient services. Co-payments cannot be imposed for emergency, family planning, and pregnancy-related services or preventive services for children. Medicaid provides health insurance for income-eligible and often very ill individuals; as such, services cannot be withheld for failure to pay, but Medicaid members may be held liable for unpaid co-payments. The total cost-sharing (out-of-pocket) cost may not exceed 5 percent of the family's household income. Children under the age of 21 are covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit which requires all states to provide all services described in the Medicaid statute necessary for physical or mental health conditions, regardless of whether the services are part of states' traditional Medicaid benefit packages. This includes treatment for any vision and hearing problems, as well as eyeglasses and hearing aids. It also includes regular preventive dental care and treatment to relieve pain and infection, restore teeth, maintain dental health and some orthodontia. Said another way, under EPSDT, children up to age 21 are entitled to all medically necessary Medicaid services, including optional services, even if a state does not cover the services for adults.[23]

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.[24]

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[21] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
[22] 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.
[23] https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html
[24] Vermont does not cover the following optional benefits: dentures, eyeglasses, tuberculosis-related services.

The Vermont Medicaid Program continues to receive positive feedback from members with 84% of those surveyed through the Consumer Assessment of Healthcare Providers & Systems survey giving the plan a high rating.

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. [25,26,27] Financial help is available through federal Advanced Premium Tax Credits (APTC), federal and state Cost-Sharing Reductions (CSR), and Vermont Premium Assistance (VPA). Federal tax credits make premiums more affordable for people with incomes at and less than 400% of the federal poverty guidelines who are not eligible for other coverage and additional federal subsidies make out of pocket expenses more affordable for people with incomes at/below 250% of the federal poverty guidelines. Despite these federal tax credits and cost-sharing subsidies provided by the Affordable Care Act, coverage through these Qualified Health Plans (QHP) will be less affordable than Vermonters had previously experienced under Vermont Health Access Plan (VHAP) and Catamount. As a result, the State of Vermont further subsidizes premiums and cost-sharing for enrollees whose income is at/less than 300% of federal poverty guidelines to address this affordability challenge.

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[25] '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

[26] 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.

[27] Vermont's state-based exchange for health insurance was created because of the federal Affordable Care Act and Act 48 of 2011. https://legislature.vermont.gov/Documents/2012/Docs/ACTS/ACT048/ACT048%20As%20Enacted.pdf

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

Eligibility for 2019 Benefits Determined Based on 2018 Federal Poverty Level (FPL)

Upper FPL% and ***annual*** income limits for:		Silver 94 (94% AV) CSR Tier I	Silver 87 (87% AV) CSR Tier II	Silver 77 (77% AV) CSR Tier III	VPA & Silver 73 (73% AV) CSR Tier IV	APTC only
Household Size*	**100% (for reference)**	**150%**	**200%**	**250%**	**300%**	**400%**
1	$12,140	$18,210	$24,280	$30,350	$36,420	$48,560
2	$16,460	$24,690	$32,920	$41,150	$49,380	$65,840
3	$20,780	$31,170	$41,560	$51,950	$62,340	$83,120
4	$25,100	$37,650	$50,200	$62,750	$75,300	$100,400
5	$29,420	$44,130	$58,840	$73,550	$88,260	$117,680
6	$33,740	$50,610	$67,480	$84,350	$101,220	$134,960
7	$38,060	$57,090	$76,120	$95,150	$114,180	$152,240
8	$42,380	$63,570	$84,760	$105,950	$127,140	$169,520
For each additional person add	$4,320	$6,480	$8,640	$10,800	$12,960	$17,280

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

Prescription Assistance Programs

Vermont provides prescription assistance programs to help Vermonters pay for prescription medications based on income, disability status, and age. There is a monthly premium based on income and co-payments are based on the cost of the prescription. The Vermont Pharmaceutical Assistance Program (VPharm) assists Vermont residents with paying for prescription medications by providing supplemental pharmaceutical coverage to Medicare members. Vermont residents with income no greater than 225% of the federal poverty guidelines and participating in Medicare Part D, having secured the low income subsidy if the individual is eligible and meeting the general eligibility requirements for the program, are eligible for VPharm.[28] 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.

Eligibility & Cost-sharing of Programs

Income calculations are based on gross monthly income minus certain qualifying deductions. Qualified Health Plans, advanced premium tax credits, cost-sharing reductions, and Vermont premium assistance all use Modified Adjusted Gross Income (MAGI) for eligibility determination, just as the Medicaid for Children and

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

Adults does. If a Vermonter is determined to be eligible for a program that requires a monthly premium, the Vermonter must pay that premium to effectuate, or put into effect, coverage. The Vermonter must also continue to pay their bill on a timely basis as required to maintain their coverage.

Visit the State's website for the eligibility guidelines currently in effect for income based programs for 2020: https://info.healthconnect.vermont.gov/thresholds2020.

Program	Who is Eligible?	Benefits & Cost-sharing
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 (limited) • Dental ($510 cap/year[29], no dentures) • Prescriptions ▪ $1/$2/$3 prescription co-payment if no Medicare Part D coverage ▪ Up to $8.50 co-payments with Medicare Part D coverage • $3 Dental co-payment • $3 Outpatient hospital visit co-payment (over 21 yrs. of age)
Katie Beckett Medicaid	Up to age 19 Only disabled child's income/resources used to meet MABD limits	• No monthly premium • No co-payments • Same benefits as Dr. Dynasaur

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

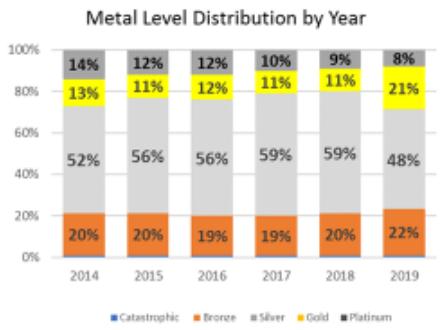
Medicaid Working Disabled	Determined disabled by Social Security or State of VT and income less than 250% of federal poverty guidelines, meets working criteria, & resource limits ($10,000 individual, $15,000 couple)	• Physical and mental health • Chiropractic (limited) • Transportation (limited) • Dental ($510 cap/yr., [29] no dentures) • Prescriptions ▪ $1/$2/$3 prescription co-payments if no Medicare Part D coverage ▪ Up to $8.50 co-payment with Medicare Part D coverage • $3 Dental co-payment • $3 Outpatient hospital visit co-payment (over 21 yrs. 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 (limited) • Dental ($510 cap/yr.,[29] no dentures) • Prescriptions ▪ $1/$2/$3 prescription co-pay • $3 dental co-pay • $3 outpatient hospital visit co-pay (over 21 yrs. of age)
Dr. Dynasaur	Children under age 19 at or below 317% federal poverty guidelines	Same as Medicaid Plus: • Eyeglasses • Full Dental Benefits • 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 up to 317% federal poverty guidelines per family per month ($60/family/month without other insurance) • No co-payments
	Pregnant persons at or below 213% federal poverty guidelines	Same as Medicaid Plus: • Eyeglasses • Full Dental Benefits • No premium for pregnant women • No co-payments

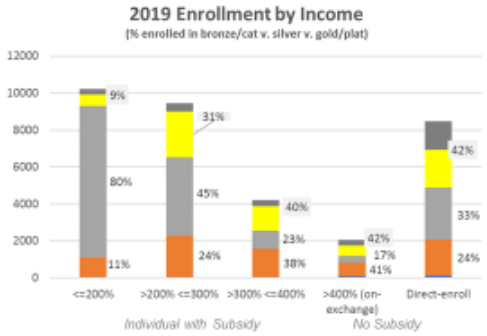
Qualified Health Plans		
Qualified Health Plans (QHP)	No income restrictions	• Choice of QHPs on Vermont's state-based exchange • All plan designs include cost-sharing
Federal Advanced Premium Tax Credits (APTC)	100-400% federal poverty guidelines, no other Minimum Essential Coverage (MEC), e.g. Medicaid	• Tax credit received in advance monthly to reduce QHP premium or yearly as a lump sum
Federally Required Cost-Sharing Reduction (CSR)	Up to 250% federal poverty guidelines, eligible for advanced premium tax credit, enrolled in silver QHP	• Reduces co-payments, co-insurance, & deductibles, etc.
Vermont Premium Assistance (VPA)	Up to 300% federal poverty guidelines, eligible for advanced premium tax credit.	• Reduces QHP premium
Vermont Cost Sharing Reductions (VCSR)	200-300% federal poverty guidelines, eligible for advanced premium tax credit / Vermont premium assistance, enrolled in silver QHP	• Reduces co-payments, co-insurance, & deductibles, etc.
Pharmacy Assistance Programs		
VPharm 1, 2, & 3	Eligible & enrolled in Medicare PDP or MAPD **VPharm 1**: ≤150% FPG and must apply for LIS **VPharm 2**: 150.01% - 175% FPG	• VPharm 1 (after primary LIS reductions): Medicare Part D cost-sharing for medications, excluded classes of Part D medications, diabetic supplies, some Part D premiums, and eye examinations • VPharm 2 & 3 Medicare Part D cost-sharing for maintenance medications only, diabetic supplies, and some Part D premiums

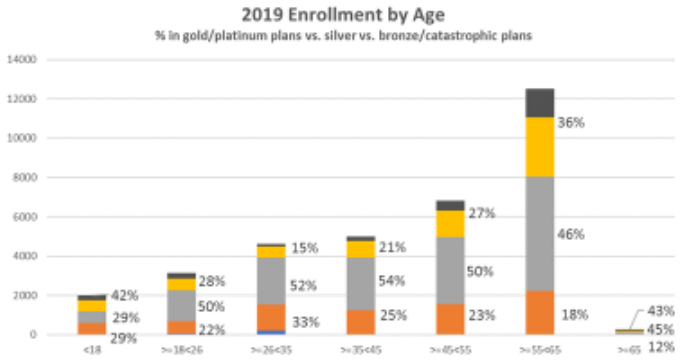
	VPharm 3: 175.01 – 225% FPG	• Monthly premium per person: o VPharm 1: $15 o VPharm 2: $20 o VPharm 3: $50 • $1/$2 prescription co-payments • No retroactive payments
Healthy Vermonters Program	350% FPG if uninsured 400% FPG if ≥ age 65, blind, or disabled	• Medicaid prescription pricing • If enrolled in Medicare Part D, excluded classes of prescriptions are priced at the Medicaid rate • No monthly premium • No retroactive payments
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.
	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 found eligible

REACHING VERMONTERS – INCREASING ENROLLMENT

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







- From 2014 to 2018, enrollment in the individual market slowly shifted from gold and platinum to silver, as members increasingly learned the benefits of enhanced silver plans with cost-sharing reductions.
- In 2019, with silver-loading, far more members changed plans than ever before and enrollment in gold plans nearly doubled.
- Eight in ten individuals with income under 200% FPL enroll in a silver plan to take advantage of significant cost-sharing reductions, while members with incomes over 300% FPL who don't qualify for enhanced silver plans tend to enroll in other metal levels.
- Nearly three times as many older Vermonters (55-64) are covered by individual qualified health plans as younger Vermonters (26-34). More than one in three (36%) older members are in a gold or platinum plan, compared to one in seven (15%) younger members.

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

result of a reported change, if applicable. Medicaid members in households where other members are enrolled in QHPs will be renewed through a separate process and will receive Medicaid specific renewal notices.

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

APPLY FOR BENEFITS

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

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

It is important to note that Vermonters enrolling in Medicaid because of age (65 or older), blindness, or disability must fill out a paper application but can access help doing so through the Customer Support Center or with a local Assister. An online application option is currently in development under the Integrated Eligibility and Enrollment program.[30]

[30] https://legislature.vermont.gov/assets/Legislative-Reports/Act-42-IEE-1-November-2019-Progress-Report_DVHA_FINAL.pdf

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

Applying Online

Three years ago, the Department established a goal to increase the percentage of Vermonters applying for coverage online. From June 2016 to June 2018, the percentage of Vermonters applying for coverage online more than tripled, increasing from 16% of applications in 2016 to 51% in June 2018, and by June of 2019 it was 57%. Applying online can lead to improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow state staff to spend less time processing applications and more time delivering on other priorities for Vermonters.

Applying by Phone

Callers to the Department's contracted Customer Support Center continue to experience prompt service overall. At the beginning of calendar year 2019 call wait times improved back to previous levels such that **84% of calls are answered within 24 seconds, well above the target of 75%.** DVHA has been working with the contracted call center, Maximus, to increase staff to avoid the long wait times that occurred during calendar year 2018 Open Enrollment.

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, as noted earlier, Vermonters enrolling in Medicaid because of age, blindness, or disability do not yet have the option of an online application; they must fill out a paper application. In addition, applicants whose identities cannot be confirmed have the option of either filling out a paper application or meeting with a local Assister who can validate their identity and help them apply for coverage.

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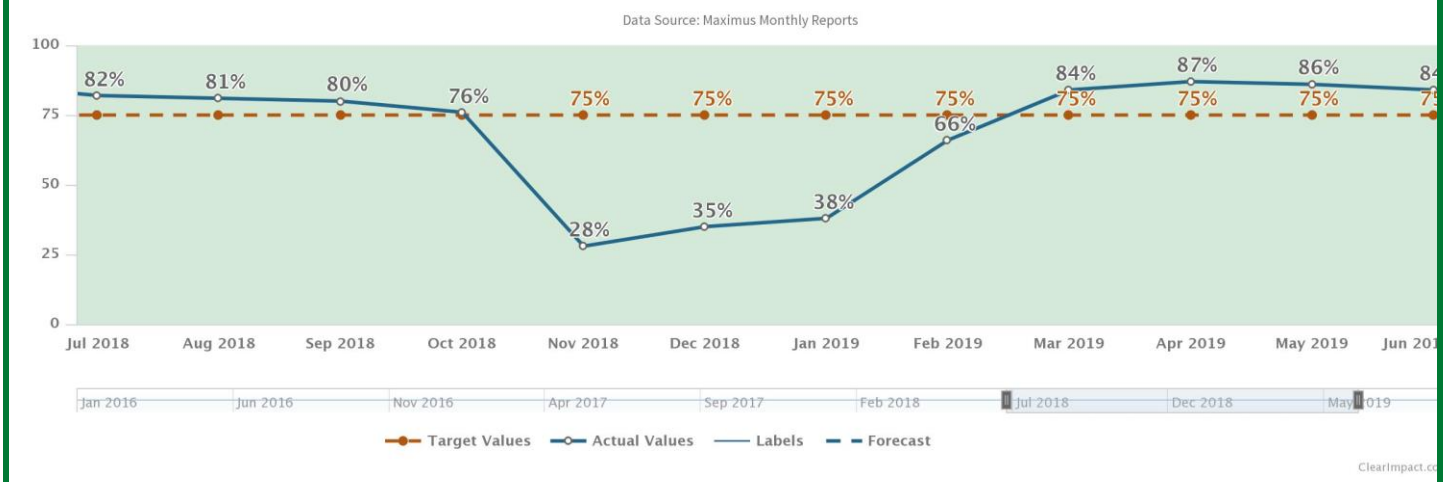
Scorecard: The Percentage of Calls Answered within 24 Seconds	
Target: 75%	**Current Performance (June 2019): 84%**

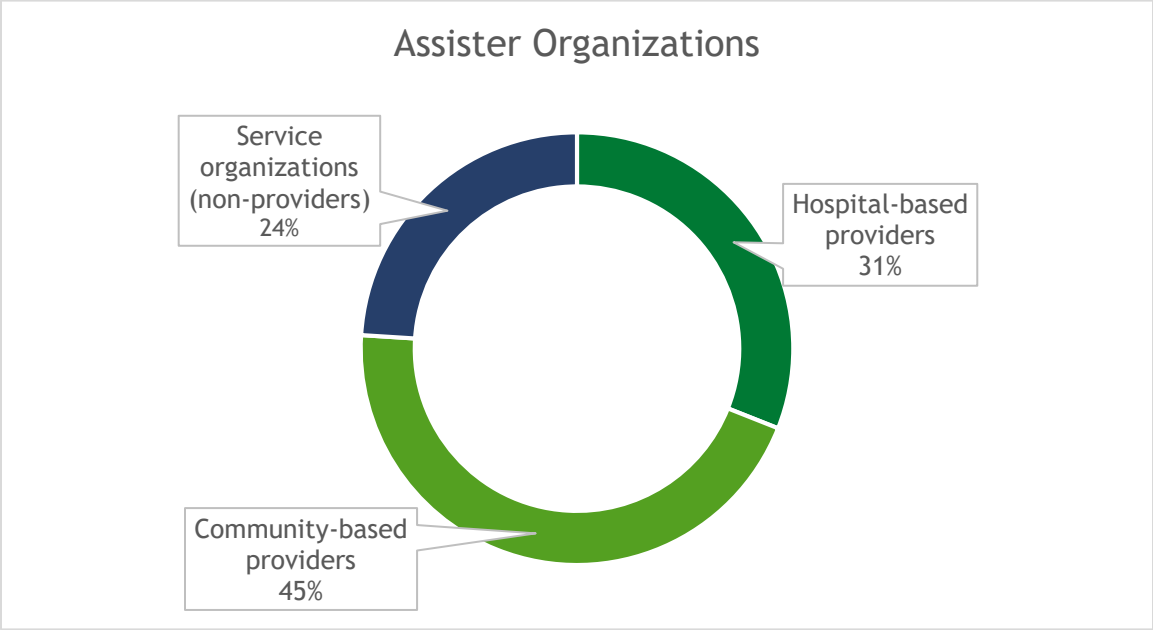
Trend: Timeliness of calls resumed above target after open enrollment.



Applying with an In-person Assister

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

Vermont's Assister Network consists of more than 192 Navigators, Brokers, and Certified Application Counselors. These Assisters provide in-person enrollment assistance in all 14 counties of the state. As federal grant funding for Assister positions went away, organizations took on having their own staff trained to provide this support. Assisters who are funded by hospitals, clinics, and organizations see enrollment assistance as both a valuable service to their clients and beneficial to their organization as covered clients are more likely to result in paid claims. Assisters work in organizations where providers are hospital-based or community-based and in-service organizations.



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

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

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

Applying for Long-Term Care Programs

There are two parts to determining Vermont Long-Term Care (LTC) Program eligibility:

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

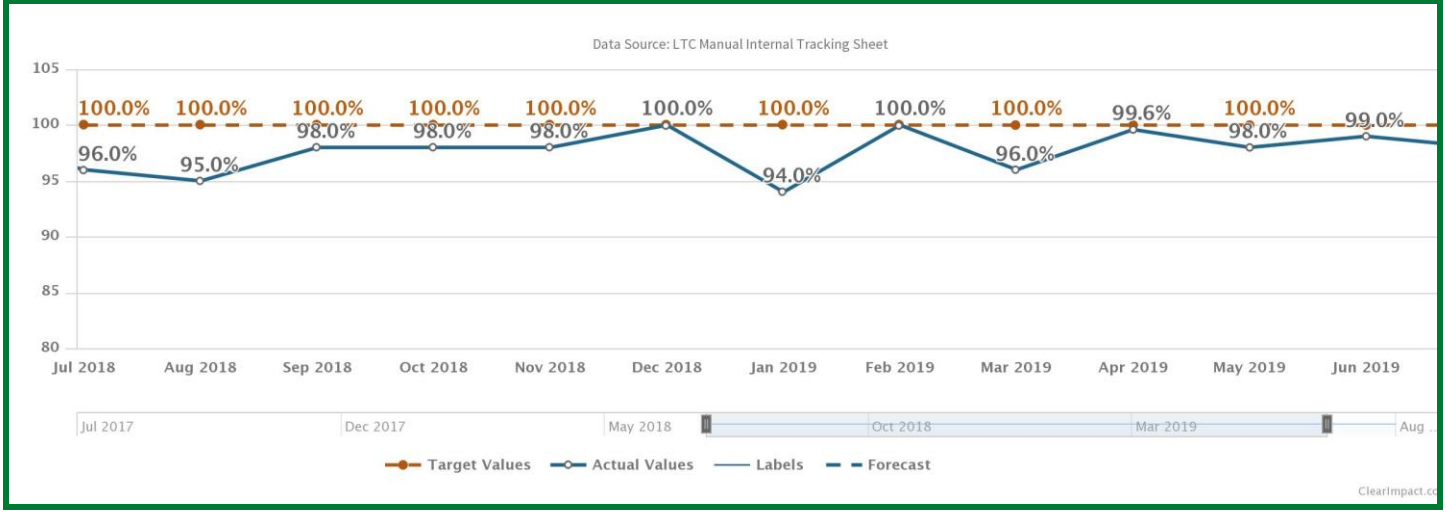
The LTC application is submitted to DVHA and a copy is forwarded to DAIL for the Choices for Care clinical assessment. Developmental Disabilities Home & Community Based Services, Traumatic Brain Injury, and Enhanced Family Treatment have the clinical assessment completed before applying for LTC Medicaid. Upon receipt of the LTC application, DVHA begins the financial eligibility determination process. Many applicants have complex financial histories and have hired elder law attorneys to assist them with planning and sheltering their assets. The more complicated applications take a significant amount of staff time to analyze before making a final financial eligibility determination.

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

Long-Term Care (LTC) program staff work closely with clients, families, nursing facilities, case managers, and authorized representatives to ensure eligible Vermonters can access needed long-term care services promptly and in their chosen setting – their home, an approved residential care home, an assisted living facility, or an approved nursing home. However, the ability of the client to gather and submit verification documents in a timely manner often presents a challenge. Staff work collaboratively with applicants who are trying to provide needed documentation, while also ensuring applications are processed within the 45-day federal timeliness standard. Unlike many other states, Vermont does not deny applicants who are trying to provide verification documents but cannot do so within the initial verification period. Instead of denying those applicants, they are given additional verification deadlines and extensions for extenuating circumstances as federal audit rules allow. In late 2017 and through 2018, the LTC team focused on business process improvements necessary to ensure that applications are processed within

the 45-day federal timeliness standard. Vermont Medicaid implemented the Center for Medicare and Medicaid Services (CMS)-mandated electronic Asset Verification System (e-AVS) on January 1, 2018. Due to the rural nature of Vermont, DVHA is less successful in retrieving information from financial institutions when compared to other states. This continued to be a challenge experienced this year and resulted in an associated increase in the manual effort required by Vermont's long-term care staff. However, as a result of the process improvement work in 2017-2018, and despite the increasing number and complexity of Vermont LTC applications observed in 2019, recent data demonstrated that **99% of LTC applications were processed within the 45-day timeliness standard**.

Scorecard: The Percentage of New Long-Term Care Applications Processed (within 45-day standard)	
Target: 100%	**Current Performance (June 2019): 99%**
Trend: The percentage processed within the 45-day standard remained above 98% for April – June 2019.	



Providing Documentation

Regardless of how Vermonters apply for programs, completing verification requirements can be challenging and time-consuming. Vermonters often ask internal staff if they can email their documents. For staff, verifying Vermonters' income (and other requirements) routinely involves delays, stressful conversations, and duplicative work. Mail and paper slow the entire process from initial notification, to mailing documents, to scanning and indexing. Internal staff wait for Vermonters' submission of required documentation such as pay stubs, employment forms, or attestations to process applications or changes, which lengthens the eligibility determination process.

To make it easier for Vermonters in the future, DVHA is working to implement a technical solution, the Document Uploader, which allows Vermonters to utilize mobile and online technology to submit verification documents and to automate the classification of these documents. This solution will

improve the efficiency of the eligibility determination process and result in a better customer experience for Vermonters. The Document Uploader is currently in a phased rollout, with the launch for the statewide Medicaid Aged, Blind and Disabled & Long-Term Care populations and Economic Services Division district offices in September 2019. The project will be fully implemented in early calendar year 2020 after the close of open enrollment.

Enrollment Integration & Reconciliation

There are multiple systems of record involved in the range of health plans within DVHA.[31] To ensure that members receive prompt care and that providers and pharmacies can bill for services, it is essential that the systems display up-to-date information about coverage. This requires that changes made to customers' accounts must promptly be **integrated** across all the applicable systems and errors that occur must be resolved promptly. DVHA has made significant progress in improving performance, processing requests in an increasingly timely manner, and resolving errors for customers.

Monthly **reconciliation** between the Department's eligibility system and those of the insurance carriers is essential for maintaining positive customer experiences, data integrity and for limiting financial liability. If discrepancies can be identified and most of those discrepancies addressed within the month, the Health Access Eligibility and Enrollment Unit is in a strong position to avoid various issues caused by cases left in error status. Effective January 2017, DVHA and the three insurance carriers established a new process for conducting monthly reconciliation and set a primary goal of addressing at least 90% of those discrepancies within the month. After months of continually surpassing that goal, **the target was raised to 100% in 2018, which the unit has continued to meet**.

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

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.

[31] For example, the system of record for qualified health plans and dental plans purchased on the Exchange is DVHA's eligibility system, the insurance carriers also have their systems, and there is the Medicaid Management Information System for Medicaid.

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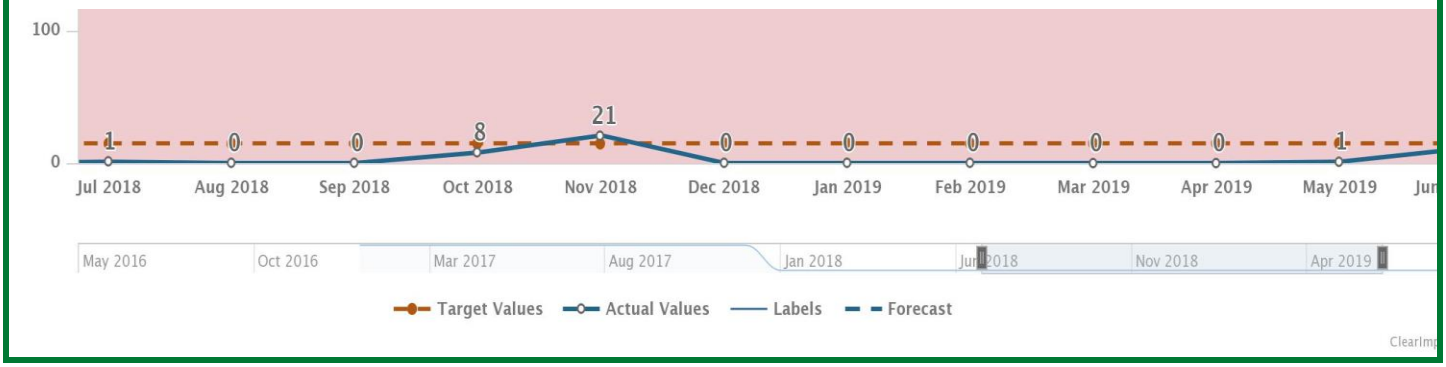
Scorecard: The Number of Enrollment Errors 10 days old	
Target: Below 15	**Current Performance (June 2019): 11**

Trend: Enrollment errors are corrected in a timely manner and are below the target for the year. There was a slight increase during Open Enrollment (November '18), when there was a higher volume of cases being processed.



GET BENEFITS & RESPONSIBILITIES

Reporting Changes

In a typical month, the Health Access Eligibility and Enrollment Unit (HAEEU) **receives more than 10,000 member requests**, over half of which involve reported changes.[32] Most of these requests are made by phone to the Customer Support Center. All Vermonters who are served by the Department's Eligibility and Enrollment unit should expect that their requests will be addressed promptly. However, during the first few years of implementing Vermont's state-based exchange for health insurance, many requests took several weeks or months to complete. In the first quarter of 2016, fewer than 60% of requests were completed within ten business days.

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

After years of continual improvement, the Eligibility and Enrollment unit now consistently completes more than 90% of member requests within ten business days. **In fact, at the close of the state fiscal year, 98% of customer requests were resolved within 10 business days.**

Scorecard: % of Customer Requests Resolved in 10 Business Days	
Target:	95%
Current Performance:	98%

In 2017, DVHA opened self-service functionality on Vermont's state-based exchange system, allowing Vermonters to report changes online, as well as pay bills, access tax documents, and other actions. Self-service can often lead to an improved customer experience as Vermonters can log in at their convenience. It also has the potential to save the State money through automation. As of the end of June 30th, 2017, 2.8% of change requests were submitted online. By June 30th, 2018, that metric had increased to 3.9% and by **June 30th, 2019 there was another increase to 4.3%.** This increase supported DVHA in attaining its goal of 10% year-over-year increases in self-service adoption but is far behind the number of initial applications (57%) that are submitted online. Stated in another way, making changes to one's account through self-service is still far less commonly used than submitting applications online.[33] The Health Access Eligibility and Enrollment unit promotes the self-service option using bill stuffers, call center staff and partner organizations, and social media in an effort to increase its use. Members who receive Medicaid for the Aged, Blind and Disabled, pharmacy assistance programs and Choices for Care are served by the State's legacy ACCESS system and are unable to utilize self-service options at this time.

[33] It has been observed that more members utilize the self-service option for change requests during the period of Open Enrollment; however, the percentage then decreases after Open Enrollment as Medicaid change requests are less likely to be made via self-service.

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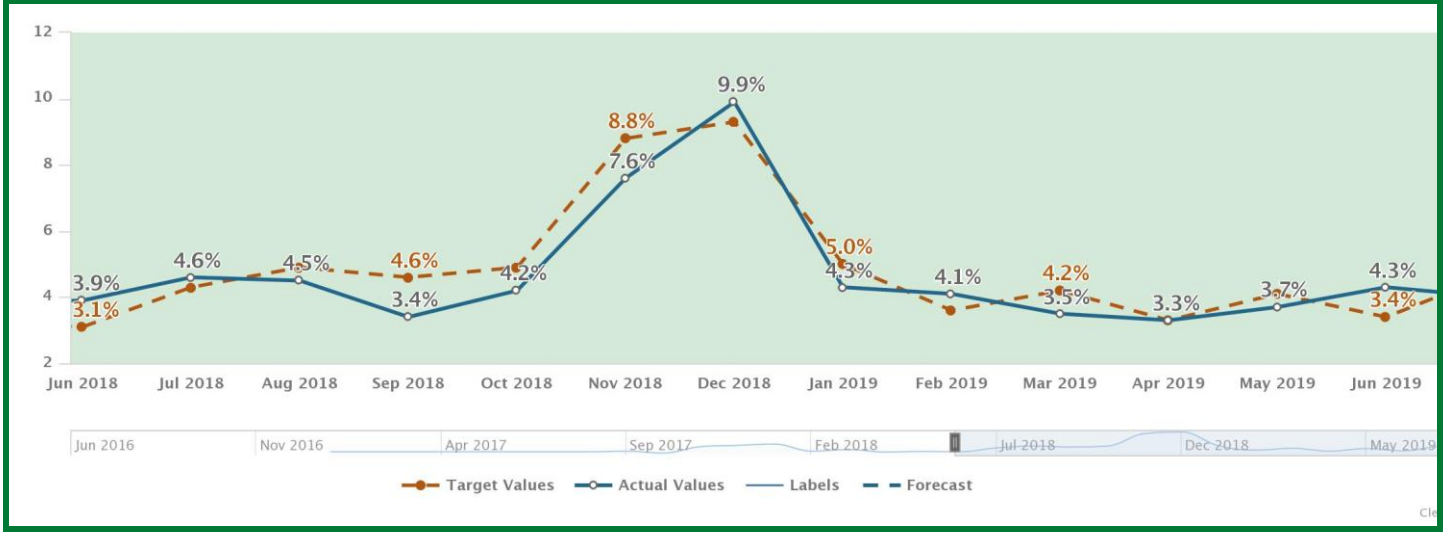
Scorecard: Self-Serve Change Requests (as % of total requests)	
Target: 3.4%	**Current Performance (June 2019): 4.3%**
Trend: Performance follows the target over the course of the year including an increase during open enrollment.	



Enrollment in Primary Care

Having a health insurance card does not necessarily produce better health outcomes; connecting with a primary care provider is a key step in the right direction. DVHA's Health Access Enrollment and Eligibility, Provider and Member Relations, Vermont Chronic Care Initiative, Blueprint for Health, Clinical and Quality units alongside DVHA's Customer Support Center, managed by Maximus, all provide support for Vermonters enrolling in Medicaid or qualified health plans through Vermont's state-based health insurance exchange to assure access to care.

Removing Barriers to Care

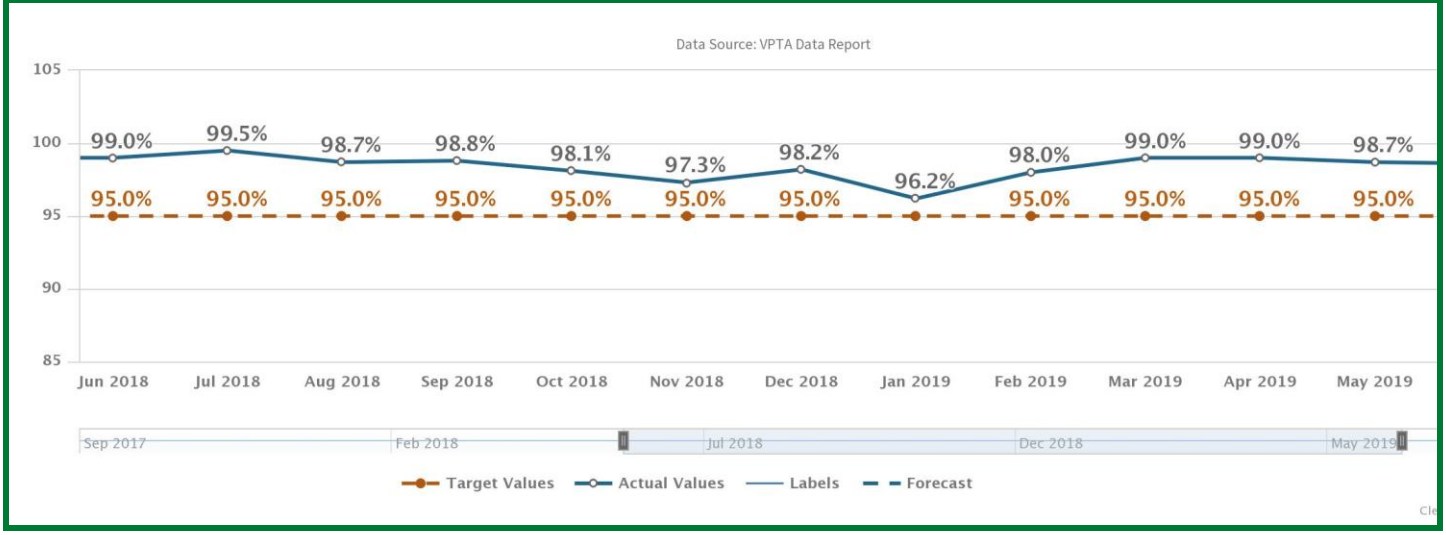
Transportation - In order to respond to the transportation challenges experienced by Vermont Medicaid members, the Department of Vermont Health Access (DVHA) contracts with the Vermont Public Transportation Association (VPTA).[34] The Vermont Public Transportation Association is comprised of a regional 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

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

provider directly.[35] The regional public transportation provider will review eligibility criteria and make trip arrangements for the Medicaid member. Medicaid members may find more information about transportation on the VPTA website. Providers may find more information about Non-Emergency Medical Transportation (NEMT) on DVHA's website.[36]

The Department's Provider and Member Relations unit has established a reporting process with the Vermont Public Transportation Association to ensure that Medicaid members are getting to and from their appointments on time. Reporting indicates that the service has exceeded the target of 95% of rides completed on time. For state fiscal year 2019, the Non-Emergency Medical Transportation program expenditure was $14,406,522.

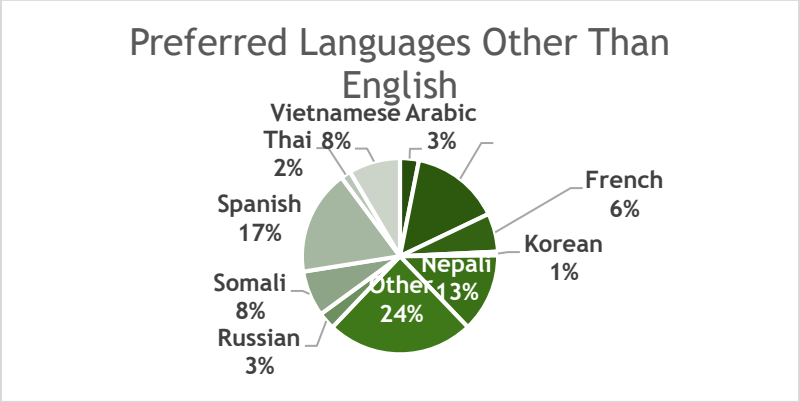
Scorecard: Percentage of Pick-up/Return Trips the Transportation Contractor Completes on Time	
Target: 95%	**Current Performance (June 2019): 98.6%**
Trend: Performance has remained above the target for the entire year, resulting in timeliness of rides for members.	



[35] http://www.vpta.net/scheduled-public-transportation-services/
[36] https://dvha.vermont.gov/for-providers/transportation/

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 communicate effectively with program providers and are able to understand which services and benefits are available to them.

The below chart shows 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.



The Agency of Human Services maintains 3 forms of interpretive and translation services to support communication. Those services are:

- **In-person Interpretive Services**: The Agency maintains contracts to provide in-person interpretive services throughout the state.
- **Written Translation Services**: The State, through the Department of Information & Innovation, maintains a contract to provide translation of documents, brochures, application forms and any other needed written materials for all State agencies and departments.
- **Telephonic Services**: The State, through the Department of Information & Innovation, maintains a contract to allow all State agencies and departments to access interpretive and translation services telephonically.

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. The Department's Provider and

Member Relations unit works to ensure that providers know the resources available to them to provide language assistance. In state fiscal year 2019, **providers billed DVHA for over 9,000 interpretation appointments.**

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 nearly 200,000 members, it is inevitable that there will be mistakes, disagreements, and other problems. DVHA aims to both minimize the occurrence of these problems and to provide clear, formal, and informal paths for members to seek resolution.

Staff at DVHA's Customer Support Center are permitted to work on member cases up until the point that a formal grievance or appeal is filed. Once a member files a formal grievance or appeal, Appeals staff from DVHA's Health Care Appeals Team will work with the member. If the case is referred from the Health Care Appeals Team (HCAT) to the Human Services Board (HSB), only the Assistant Attorney General (AAG) will communicate directly with the member – although Appeals staff will testify at the Human Services Board hearing.

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

The Health Care Appeals Team has been tracking a performance metric in the form of the percentage of eligibility appeals that are resolved prior to the formal Fair Hearing process. The target for this metric was reset to 50% in January 2019 to more accurately represent the ideal performance that would sustain the reduced number of mistakes made as well as continuing to resolve any mistakes that do happen more efficiently. The rationale is that having fewer cases that can be resolved internally actually represents system improvement (there are fewer cases where something went wrong that the Appeals team can fix). While Appeals staff still want to address as many cases internally as possible, staff do not necessarily want to increase the volume. Why? If the percentage rises significantly higher than 50%, this could mean that too many mistakes are being made that the Customer Support Center team could control to begin with.

VERMONT
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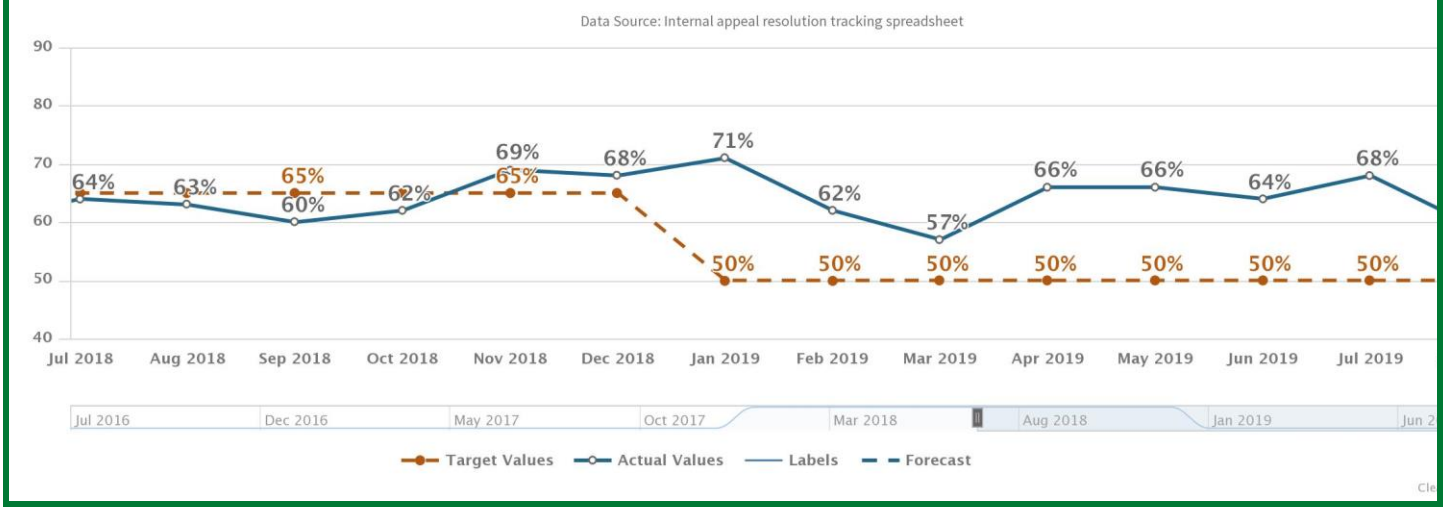
DEPARTMENT OF VERMONT HEALTH ACCESS

Scorecard: Percentage of Eligibility Appeals that are Resolved Prior to the Formal Fair Hearing Process	
Target: 50%	**Current Performance (June 2019): 64%**
Trend: Performance is slightly higher than the new reduced target of 50% though recent data indicates a decrease.	



Provider and Member Relations – Navigating Member Needs and Issues

The Department's Provider and Member Relations unit assures members have access to appropriate health care for their physical health, mental health and dental health needs. The goal within the Provider and Member Relations (PMR) 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 PMR staff for additional information/review. Provider and Member Relations 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, Legislators, Vermont Legal Aid, and the provider community. Frequently, Provider and Member Relations (PMR) 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 PMR 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 PMR 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, Provider and

Member Relations staff are there to serve as a link between the member and the billing service provider(s). PMR has served as the primary outreach and education arm of Vermont Medicaid for out-of-network emergency medical service billing matters since 2011. PMR staff address and resolve cases that range anywhere from stitches to major cardiovascular events. PMR addresses each case with the same level of urgency and need and strives towards a resolution where Vermont Medicaid acts as the responsible payer and the member is not held accountable for any financial responsibility. The process typically begins when a member reports an out-of-network emergency related bill to the Customer Support Center (Maximus). Customer Support staff upload this information to Siebel, a customer relationship management software tool, and the case is then assigned to a PMR unit staff member in the form of a service request.

From there, outreach materials are generated and sent to each service provider. These materials explain how Vermont Medicaid is required under federal law (42 CFR 438.114) to serve as the responsible payer for such services regardless of whether the provider that furnishes the services is contracted with Vermont Medicaid. Providers may utilize Vermont Medicaid's online Provider Management Module (PMM) in order to enroll as a Vermont Medicaid provider, thus enabling them to submit claims and be paid at Vermont Medicaid rates. If providers are unwilling or unable to do so, they may also submit a paper claim directly to PMR staff. PMR will then work with DXC[37] enrollment specialists and claims reviewers throughout the enrollment and claims adjudication process. PMR 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 Provider and Member Relations 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 PMR staff during the process for questions and updates related to their specific case. PMR 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.

[37] DXC Technology, or DXC, 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.

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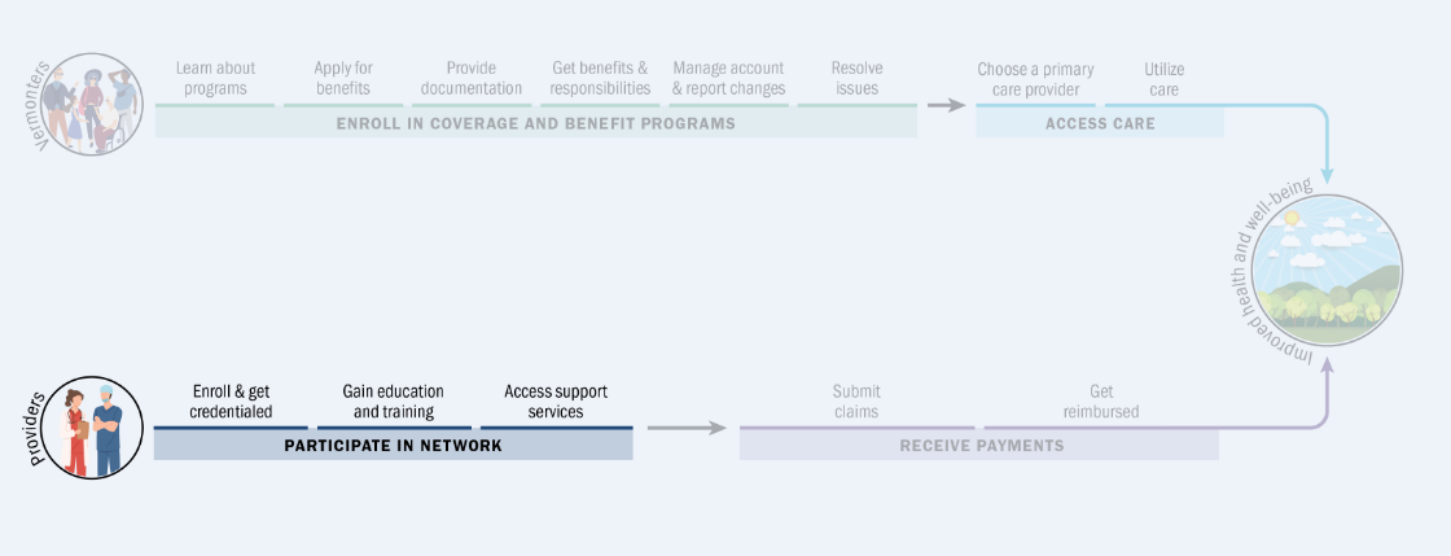
PROVIDER EXPERIENCE

HOW WE SUPPORT PROVIDERS



With a focus on providing access to quality care for Vermonters, DVHA supports an extensive network of providers. Vermonters have a variety of health care needs and require a network of providers that can address those needs and deliver medically necessary, covered services. The Provider and Member Relations unit works to support providers through training and outreach on enrolling, getting credentialed, billing, program changes, and state and federal requirements. There are 24,035 providers enrolled in DVHA's network (21,152 individual providers, 1,327 group providers, and 1,452 facilities). The following table lists the number of providers by type.[38]

Provider Type Code	Provider Type Code Description	№ of Individual Providers	№ of Group Providers	№ of Facilities	Total Number
001	GENERAL HOSPITAL			490	490
003	CLINIC CENTER URGENT CARE			7	7
004	DENTIST	440	137		577
005	PHYSICIAN	13090	503	1	13594
006	PODIATRIST	47	4		51
007	OPTOMETRIST	117	35		152

[38] № refers to "number of."

008	OPTICIAN		1		1
009	PHARMACY			350	350
010	HOME HEALTH AGENCY			26	26
011	INDEPENDENT RADIOLOGY	1	2		3
012	INDEPENDENT LAB			131	131
013	AMBULANCE			138	138
014	DME SUPPLIER	1	2	219	221
017	PT-OT-SLP	632	113		745
018	CHIROPRACTOR	145	59		204
019	MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT	1769	114		1883
020	NURSING HOME - MEDICARE PARTICIPATING			59	59
021	NURSING HOME - NON-MEDICARE PARTICIPATING			10	10
023	ANESTHESIA ASSISTANT	33			33
027	HOSPICE			12	12
029	ICF/INTELLECTUAL DISABILITY FACILITY			1	1
030	PSYCHOLOGIST - DOCTORATE	366	28		394
031	RURAL HEALTH CLINIC		21		21
035	AUDIOLOGIST	68	5		73
037	STATE DESIGNATED MH CLINIC		50	4	54
038	STATE DESIGNATED INTELLECTUAL DISABILITY CLINIC		14	3	17
039	STATE DEFINED CHILDREN AND FAMILY WAIVER CLINIC	1	13	2	16
042	STATE DEFINED INDEPENDENT AGING AND LIVING WAIVER		1	16	17
043	NATUROPATHIC PHYSICIAN	75	16		91
T01	PTF PSYCH RESIDENTIAL FACILITY			13	13
T02	DIALYSIS FACILITIES			12	12
T03	AMBULATORY SURGICAL CENTER			5	5
T04	PERSONAL CARE SERVICES		12		12
T06	NURSE PRACTITIONER	2384	18		2403

T07	LICENSED NURSE	11	10		21
T11	FEDERALLY QUALIFIED HEALTH CENTER			57	57
T13	NON-EMERGENCY TRANSPORTATION SERVICES			15	15
T14	STATE DEFINED RESIDENTIAL CARE WAIVER		4	131	135
T16	STATE DEFINED TARGETED CASE MANAGEMENT			1	1
T17	STATE DEFINED INDIVIDUAL CASE MANAGER	5		1	6
T18	STATE DEFINED DOH INTELLECTUAL FACILITY			1	1
T19	STATE DEFINED VOCATIONAL REHAB AGENCY			16	16
T20	DCF STATE DEFINED DESIGNATED CASE MANAGEMENT	1		16	17
T21	STATE DESIGNATED CHILDRENS MEDICAL SERVICES			37	37
T23	STATE DEFINED NON-MEDICAL RESIDENTIAL FACILITY		7	166	173
T25	STATE DEFINED ADAP FACILITY		35		35
T26	STATE DEFINED ADULT DAY FACILITY		14		14
T27	STATE DEFINED DEPARTMENT OF EDUCATION		71		71
T31	SOLE SOURCE EYEGLASS LAB			1	1
T34	STATE DEFINED CASE RATE AGENCY	4		8	12
T36	INDEPEND. BILLING HIGH TECH NURSES	39			39
T37	PHYSICIAN ASSISTANT	1103			1103
T38	LICENSED ALCOHOL DRUG COUNSELOR	180	10		190
T39	LICENSED MIDWIFE	23	4		31
T41	LICENSED PHYSICAL THERAPY ASSISTANT	1			1
T44	NUTRITIONAL EDUCATORS	116	9		125
T45	SLEEP STUDY CENTER		1		1

T46	BEHAVIORAL ANALYST	103	7		110
T47	FAMILY SUPPORTIVE HOUSING		7		7

Provider and Member Relations monitors the adequacy of Vermont Medicaid's network of enrolled providers and ensures that members are served in accordance with managed care requirements.[39] The Unit strives to make certain that Vermonters do not have to travel too far to receive the care they need, maximize members' choices for providers, and facilitate connection with primary care providers for improved health and wellness and management of chronic disease for members. Provider and Member Relations also works with many organizations, such as the Vermont Medical Society, Vermont Association of Hospitals and Health Systems, Vermont State Dental Society and Vermont Legal Aid, to provide support and guidance to providers on a variety of issues, such as timely processing of claims and understanding how the Non-Emergency Transportation program works, as well as many other topics.

ENROLL AND GET CREDENTIALED

The Provider and Member Relations 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.[40] Health care providers are categorized by screening levels established by the Centers for Medicare & Medicaid Services and utilized by DVHA. The defined risk levels of limited, moderate and high are based on an assessment of potential fraud, waste and abuse for each provider/supplier type. DVHA then screens providers according to their risk level. DVHA may increase risk level assignments at any time, and the new risk level will apply to all enrollment-related activities. The Provider and Member Relations unit works closely with its fiscal agent, DXC, to screen and enroll providers.[41] On average, DVHA enrolls about 300 new providers a month and terminates about 15 a month from participation with Vermont Medicaid. Providers terminate with Vermont Medicaid for various reasons including, but not limited to not wanting to accept Medicaid rates, not submitting claims in the past 36 months, moving or retirement. Due to access issues with certain provider types, such as dental providers, the Provider and Member Relations team often contacts providers when they indicate that they wish to no longer

[39] Evaluation of network adequacy is completed every six months. PMR works with a variety of associations and societies to encourage providers to participate with Vermont Medicaid & meet the needs of its members.

[40] CFR is the Code of Federal Regulations.

[41] http://www.vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf & DXC Technology Provider Enrollment Unit 802.879.4450, option 4, Email: vtproviderenrollment@dxc.com.

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

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

- Ambulance service suppliers;
- Community mental health centers;
- Comprehensive outpatient rehabilitation facilities;
- Hospice organizations;
- Independent clinical laboratories;
- Independent diagnostic testing facilities;
- Physical therapists enrolling as individuals or group practices;
- Portable X-ray suppliers;
- Revalidating Home Health agencies;[42]
- Revalidating Durable Medical Equipment, Prosthetics/Orthotics & Supplies suppliers.[43]

There are times when members need medical services that are not available in Vermont. These services are provided by out-of-state providers after receiving authorization by DVHA's clinical staff. PMR staff, in conjunction with DXC's enrollment and claims processing staff, utilize a process that streamlines one-time enrollment requirements through timely and detailed outreach resulting in greater out-of-network provider participation and claims submission. Vermont Medicaid, through the work of dedicated Provider and Member Relations 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 Provider and Member Relations unit worked to serve providers in state fiscal year 2019 was to launch the Provider Management Module (PMM). Historically, Vermont Medicaid's enrollment process has been paper-based, manual, and cumbersome for DVHA and its providers. Providers were required to submit a lengthy paper application and then DXC manually screened the provider (frequently taking up to 120 days to complete). The new online Provider Management Module went live in May of 2019 and allows providers to enroll, make changes, and receive notices electronically. The Provider Management Module is meeting expectations for significantly decreasing the turnaround time for enrolling providers and thus, improving member access to care. Performance measure monitoring for the first four months following implementation of the Provider Management Module is demonstrating success of the new module.

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

The chart below demonstrates:

- Early adoption of the online application process by providers;
- There was a back log of providers waiting to enroll, as evidenced by the high volume in May that then tapered off by September of 2019;
- The new system quickly reduced processing time well below the 60-day target to within 30 days.

% of VT, border, and out of state (OOS) provider applications processed within 60 days								
Report Period	SFY20							
	May-19		Jun-19		Jul-19		Sep-19	
Type of Provider	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps	On-line Apps	Paper Apps
# submitted during month	542	84	501	63	375	37	175	35
# within 15 days	97	15	207	35	203	20	169	35
# within 30 days	303	69	284	28	172	17	1	0
# within 45 days	117	0	1	0	0	0	0	0
# within 60 days	23	0	0	0	0	0	0	0
# over 60 days	0	0	0	0	0	0	0	0
% within 60 days	100.0%	100.0%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%
# applications timeframe waived due to PMR review	2	0	0	0	0	0	5	*0*

GAIN EDUCATION AND TRAINING & ACCESSING SUPPORT SERVICES

The Provider and Member Relations (PMR) unit is responsible for ensuring members have access to care, as well as for engagement, outreach and communication with both members and providers.[44] PMR's goal is to ensure members and providers are always informed. Providers are assisted by DXC's Provider Services Unit. DXC's Provider Services include management of a Provider Call Center.[45] Educational opportunities are offered to the provider community through collaboration between DXC and PMR. Provider and Member Relations strives to ensure that providers have the most up to date information by overseeing and consistently updating the provider manuals.

[44] This is done twice a year, through a report on members access to care and how far they must travel.
[45] DXC Technology Provider Call Center: Toll-Free Out-of-State: 800.925.1706, Local and in-State: 802.878.7871.

In state fiscal year 2019, the Department updated its provider manuals, with manuals now available for:

- Applied Behavior Analysis and Mental Health Services;
- Federally Qualified Health Centers and Rural Health Clinics;
- General Provider;
- Home Health Agency, Assistive Community Care and Enhanced Residential Care;
- Primary Care;
- Physical Therapy, Occupational Therapy, and Speech Language Therapy; and
- Non-Emergency Medical Transportation.[46]

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 DXC and PMR 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.

Clinical Operations & Quality Improvement

The Clinical Operations and Quality Improvement units are vital links with providers, other units within DVHA, the Agency of Human Services (AHS) and community partners as the Department strives to provide access to high quality health care services and support for Vermont's health care providers. The clinical perspective provided by Clinical Operations and Quality Improvement staff ensures 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 approach staff 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 multiple 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 improvements evaluated as a culture of continuous quality improvement within Vermont Medicaid is enhanced. The teams also work on integrating and coordinating services provided for Vermont Medicaid members with substance use disorders and mental health needs.

[46] https://dvha.vermont.gov/for-providers/manual?portal_status_message=Changes%20saved.

Oversight of services occurs post-provision to help ensure that services are equitable, efficacious and outcome-driven and this may include comparisons between payment methodologies to assess effects on outcomes. Measures indicative of health care effectiveness are collected and reported to external entities, including federal partners, as appropriate. Finally, health care reform is changing the way health care is delivered, which requires development of new practices for review and evaluation. As a result, a new medical review program is in development to help the Department move its practices forward.

Benefit Rules Management

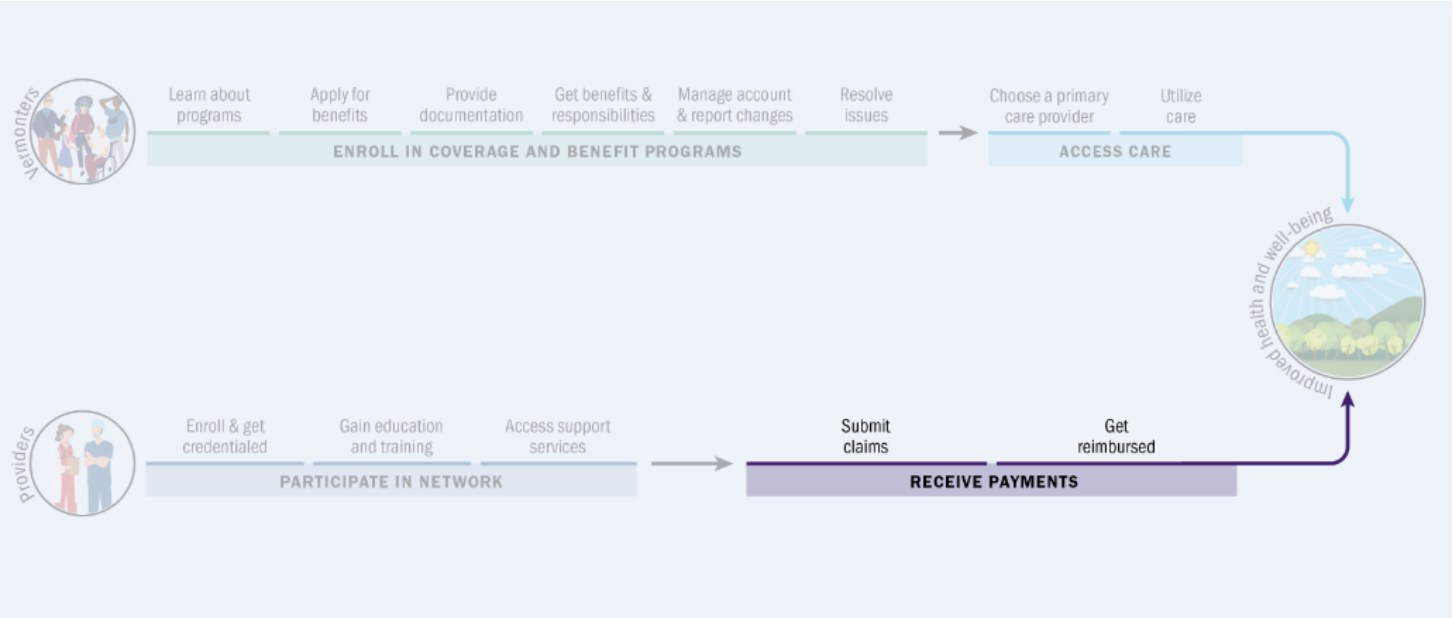
According to the Centers for Medicare and Medicaid Services National Correct Coding Initiative, providers must use the appropriate and correct codes for services that are provided to members. The use of correct codes allows for appropriate reimbursement for services provided to members. All codes (CPT, HCPCS, and ICD-10 PCS) released each year are updated in the Medicaid Management Information System (MMIS) 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. Intensive review is performed by Clinical Operations for each code before implementation in the Medicaid Management Information System to determine:

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

Other Functions

- Reviewing utilization, medical claims reports,
- Managing the disconnect between a PA waiver and the limitations within the MMIS as well as with members who need to go out of network for care not available in network,
- Reviewing a defined group of PA requests for "imminent harm", and
- Medical audit for quality of care,
- Collaboration on Agency-wide initiatives, such as Early Periodic Screening Diagnosis & Treatment (EPSDT) review of services, and program integrity case reviews, tobacco, asthma, and high-tech nursing.

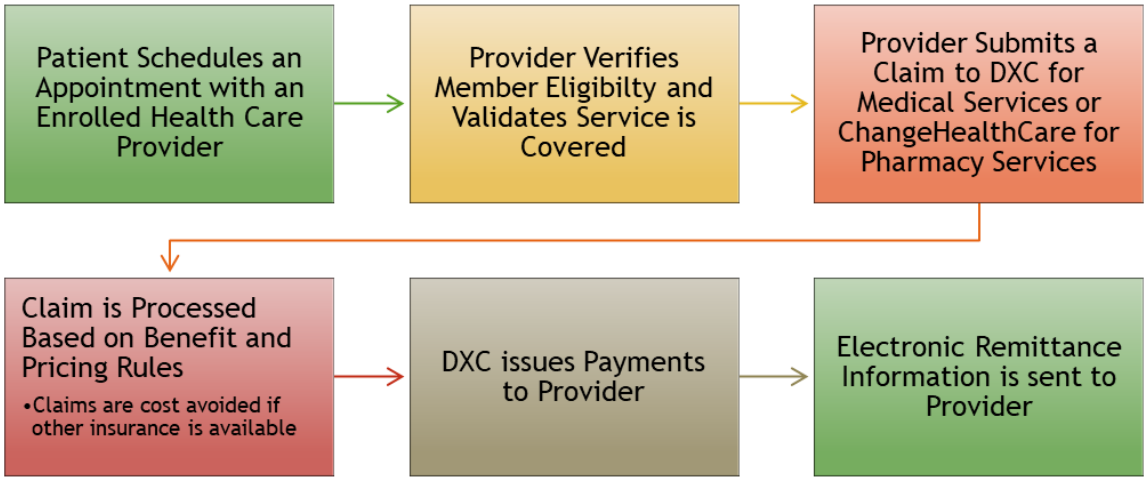
SUBMIT CLAIMS AND REIMBURSEMENT



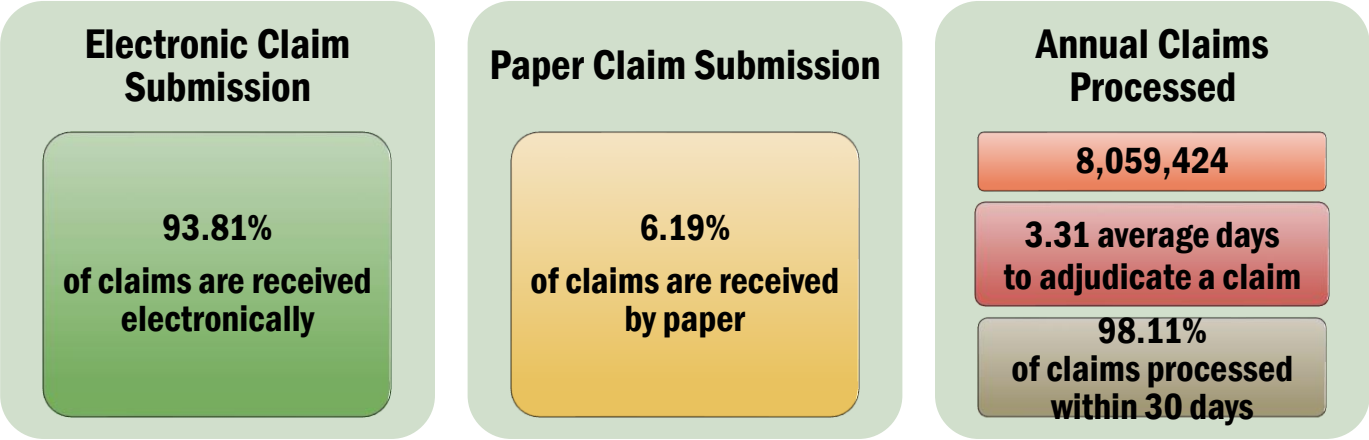
Medical Claims Processing

Since 1981, DXC Technology has provided Medicaid fiscal agent services to the State of Vermont.[47] Medical claims processing is one of the services DXC provides and this involves claims input, resolutions, claim adjustment processing, utilization review, and reference file maintenance to ensure compliance with federal and state requirements. The diagram below shows a high-level overview of the process of paying a provider – beginning when a patient first schedules an appointment through payment being sent.

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



DXC processed over 8 million claims in state fiscal year 2019 for more than 30 distinct health care programs supporting all departments within the Agency of Human Services and the Agency of Education resulting in $1.53 billion in payments to providers.



Over the past 38 years, DXC has continued to evolve the system to support multiple programs. DVHA obtains 75% federal funds for the CMS-certified operation and maintenance of this system. DXC performs the following services:

- **Provider Services** including education and publications, Provider Call Center, provider screening and enrollment.
- **Application Services** for support and enhancements for several DXC and commercial software applications used by Providers, hundreds of AHS staff, and by DXC fiscal agent staff.

- **Quality Management Services** to include audit support and coordination, reporting on quality metrics, Service Level Agreement monitoring and reporting, and process improvement projects.
- **Data Analytics Services** including advanced programming using data science tools to extract, prepare, and analyze MMIS information in support of AHS departments and operations.
- **Coordination of Benefits Services** including billing and collection from other third-party liabilities, screening and identification of Casualty cases, issuance of premium payments.
- **Claims Processing Services** including claims input, resolutions, claim adjustment processing, utilization review and reference file maintenance to ensure compliance with federal and state policy.
- **Financial Services** including reporting, accounts receivable, federal tax form generation, post-payment analysis and collections, cash receipt processing, bank reconciliation and payment to providers, members, and carriers.
- **Platform Services** providing IT infrastructure, data center facilities, security services, and systems administration within private DXC 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 **2.1 million claims** in state fiscal year 2019 resulting in approximately **$198 million in payments** to DVHA-enrolled pharmacies. Change Healthcare adjudicates pharmacy claims, which are then sent to DXC 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 2019, Change Healthcare processed approximately 27,000 drug-related prior authorizations, representing about 4% of all claims processed.

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

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

- processing pharmacy claims and making drug coverage determinations
- assisting with drug appeals and exception requests
- overseeing federal, state and supplemental drug rebate programs
- resolving drug-related pharmacy and medical provider issues

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

In addition, the Pharmacy Services unit focuses on improving health information exchange and reducing provider burden through e-prescribing, automating prior authorizations, a web-based pharmacy portal and other efforts related to administrative simplification for DVHA and its providers. Change Healthcare (CHC) provides operational and clinical services to DVHA, its providers, and members. CHC employs physicians and pharmacists to provide additional support for DVHA 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 DVHA's Medical Director and drug appeals and fair hearings as needed, and ensure continuous clinical support and associated credibility for the Department's management of its pharmacy benefit program.

Reimbursement

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

In addition, the Reimbursement Unit oversees a complementary set of specialty fee schedules including, but not limited to, durable medical equipment, ambulance and transportation, clinical laboratory, blood, physician-administered drugs, dental, and home health. The Unit also manages the Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) payment process as well as

supplemental payment administration (e.g. the Disproportionate Share Hospital (DSH) payment program).

In 2019, the Reimbursement unit continued its efforts in achieving parity with Medicare rates for Physician-Administered Drugs (PAD) by investing additional funds ($29,000) and in July of 2019, this goal was successfully met when Vermont Medicaid rates were increased from 97% to 100% of Medicare rates. The Physician-Administered Drug fee schedule will be updated on an annual basis. In addition to increased investments in the Physician-Administered Drug fee schedule, the Unit managed other increases to Medicaid rates during the year, including for outpatient (OPPS), physician and other professional services (RBRVS), ambulance, home health services and Assistive Community Care services (ACCS). **The Medicaid reimbursement rates for primary care physicians and other professionals providing specialty care received a combined average rate increase of 3.4% with an investment of $3.6 million**. Outpatient and home health service rates were increased by an average of 2% with $2.3 million and $300,000 in investments, respectively. Assistive Community Care Service providers received an increase of about 13% to their per diem rates through additional funding totaling approximately $2 million and ambulance services also received increased funding (approximately $243,000).

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

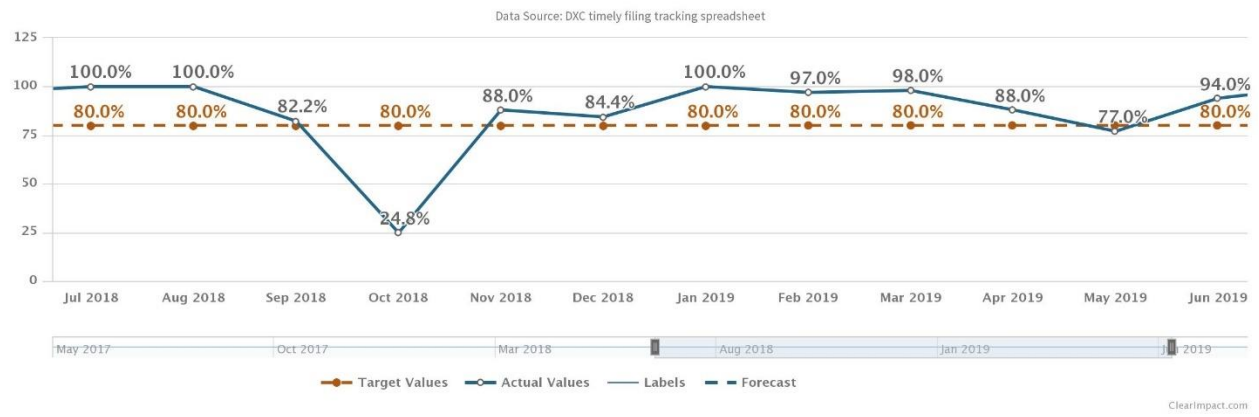
The Reimbursement unit began working with supplier representatives and their association to update the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule in August 2017. Due to the complex nature of the DMEPOS fee schedule with its numerous classes of equipment and services, rental and/or purchase options and policies, and varying arrays of supply items, the full update is expected to extend over a multi-year period and is being implemented in a phased approach. The first of those phases was implemented on January 1, 2018 as part of the Department's ongoing strategy to modernize the way it pays for healthcare services and to align with Medicare pricing methodologies and policies. The next phase of this project is expected to be implemented in January 2020 with stakeholder engagement and additional work occurring throughout 2019. It will include alignment between Vermont Medicaid and Medicare policy for oxygen and an update to the most recent Medicare rates on file at the time the work was completed.

During the past year, the Reimbursement unit has measured its performance on 3 separate measures. The first performance measure, displayed below for reference, provides the percentage of timely filing claims turned around with a final determination within 15 days of receipt by the Unit. This measure was implemented to assess the Unit's service to the provider community and with the goal of ensuring consistent and timely decisions on previously denied claims. This measure is reported on a monthly basis. The Unit established a realistic goal of reaching the 15-business day turnaround at least 80% of the time. Overall, for state fiscal year 2019, the Unit's performance on this metric was well above the target that was established. However, in October of 2018, the Unit had an employee begin family medical leave & the Unit was also in the process of training a new employee. These factors impacted the Unit's performance on this measure for a brief period of time, as illustrated in the graph below.

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

Target: 80%	Current Performance (June 2019): 94%

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



Rate Setting

The Division of Rate Setting audits costs and establishes Medicaid payment rates for 35 nursing homes (also referred to as nursing facilities) for the Department of Vermont Health Access and in consultation with the Department of Disabilities, Aging and Independent Living (DAIL). Vermont Medicaid nursing home rates are set according to rules adopted in accordance with the Vermont Administrative Procedures Act (3 V.S.A. § 836), Methods, Standards, and Principles for Establishing Payment Rates for Long-Term Care Facilities. In addition to the rules, the Division has implemented certain practices and procedures for the application of the rules. Currently, 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 is adjusted by the home's average Medicaid case-mix score. Additionally, an annual inflation factor is added to the base year costs to trend the rates forward to the current rate period. Costs are rebased periodically. Property and related costs and ancillary costs are updated annually based on the home's settled cost report.

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. The new Patient Driven Payment Model will be used to determine Medicare reimbursement rates beginning October 1, 2019. The Centers for Medicare and Medicaid Services will continue to support the current RUG-IV case-mix system used to set Vermont's nursing home rates until September 30, 2020.

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 16 PNMIs for the Department for Children and Families, the Department of Mental Health (DMH), and the Division of Alcohol and Drug Abuse Programs of the Vermont Department of Health. These rates usually have an education component; as such, staff of the Agency of Education are also involved in the rate setting process. The rules governing PNMI rate setting are titled Methods, Standards, and Principles for Establishing Payment Rates for Private Nonmedical Institutions Providing Residential Child Care Services and referred to as V.P.N.M.I.R. The rate for the State's Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID) is set by the Division for DAIL.

Through the application of its rules, the Division evaluates the reasonableness and allowability of program costs. The rules prescribe in detail how the Medicaid rates for nursing homes and PNMI facilities are to be set. The Division's staff consist primarily of professional accountants who examine the expenditures of the providers to determine allowable costs for use in the calculation of the Medicaid rates. Nursing homes and PNMI providers may request a special review and a rate adjustment due to a change in circumstances. There are also provisions in the Division's rules that allow a provider to request Extraordinary Financial Relief if they are in danger of closing due to financial challenges. These provisions give the State the opportunity to examine these situations and decide on the appropriate course of action.

The Division's nursing home rules allow for the development of individual rates for nursing home residents who have special, atypical needs due to medical conditions or challenging behaviors. Special individual medical needs are addressed pursuant to V.D.R.S.R. §14.1. Individual rates for current or prospective nursing home residents with severe behavioral issues are set pursuant to V.D.R.S.R. §14.2. Requests for all special rates are reviewed by staff of the Adult Services Division (ADS) of the Department of Disabilities, Aging and Independent Living (DAIL). Staff of DAIL's Adult Services Division work with the Division to evaluate applications and establish rates. The Department of Mental Health is involved in the requests for special rates for severe challenging behaviors. Persons with extremely challenging behaviors can be stranded in hospitals, emergency rooms or psychiatric facilities. This may be avoided by a special individualized rate, but it must be noted that this individualized rate setting work requires considerable staff time to evaluate the complexities of care needs and requires extensive cooperation with other departments within the Agency of Human Services.

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

Strategically Managing Departmental Activities

Each of the Department's units tracks performance metrics with an emphasis on the core responsibilities of enrolling members, paying for care, and promoting health. The results can be seen across all three areas of responsibility as well as in general operations. For each of the units mentioned above, and for all units within the Department, additional information regarding performance measures by unit may be found in the Performance Accountability Scorecard and a summary of results is provided for reference in Appendix A.

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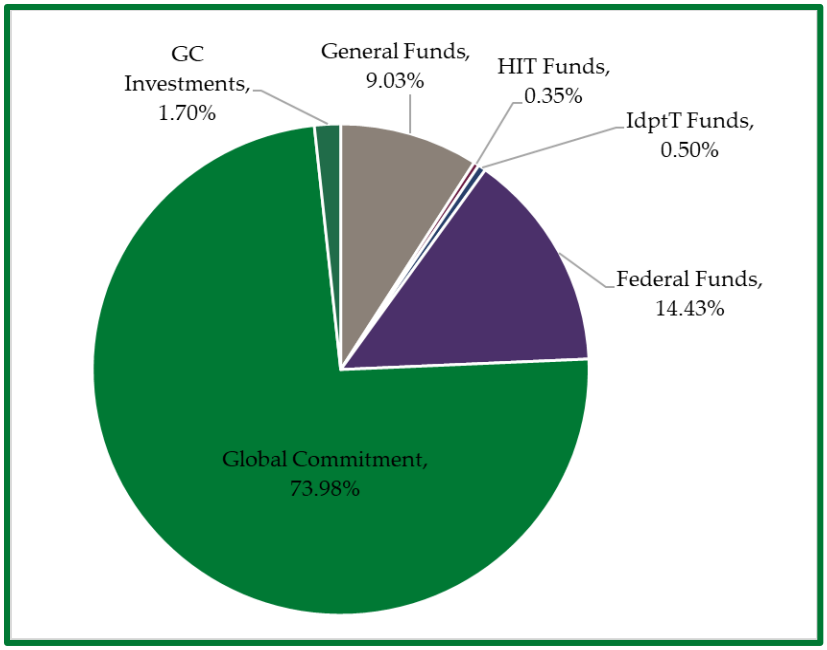
SFY 2021 Governor's Budget Recommendation

Agency of Human Services,
Department of Vermont Health Access

MISSION:

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



SFY 2021 SUMMARY & HIGHLIGHTS

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

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

DVHA BUDGET RECOMMENDATION CHANGES FROM AS PASSED

Changes	Program	Administration	Total DVHA	State Funds Estimate*
SFY 2020 As Passed	**$1,033,707,774**	**$ 171,824,388**	**$1,205,532,162**	**$533,527,510**
Proposed Changes	($234,785,794)	($8,977,845)	($243,763,639)	($106,278,594)
SFY 2021 Recommendation	**$ 798,921,980**	**$ 162,846,543**	**$ 961,768,523**	**$427,248,916**

* 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.

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Budget Summary Administration

	GF	SF	State Health Care Res	IdptT	FF	Medicaid GCF	Invmnt GCF	Total
DVHA Administration - As Passed FY20	**29,222,317**	**6,096,108**		**7,542,602**	**124,749,165**		**4,214,196**	**171,824,388**
Total after FY20 other changes	**29,222,317**	**6,096,108**	**0**	**7,542,602**	**124,749,165**	**0**	**4,214,196**	**171,824,388**
Personal Services:								
1. Salary and Fringe Increases	525,846	(12,566)		308,845	(116,847)		105,646	**810,924**
2. Retirement Rate Increase	66,551	219			107,277		3,325	**177,372**
3. Maximus Contract Savings	(245,198)				(572,129)			**(817,327)**
4. Rebase HIT Budget to reflect Revenue Expectation	(765,801)	(2,705,360)			(845,419)			**(4,316,580)**
5. Contract Savings - align the Prior Authorization requirements for Medicaid FFS with the ACO Population	(250,000)				(25,000)			**(275,000)**
6. Position elimination through attrition - align the Prior Authorization requirements for Medicaid FFS with the ACO Population	(58,436)				(58,436)			**(116,872)**
7. Reduction of the Wex Contract after QHP Premium processing transition	(577,500)				(522,500)			**(1,100,000)**
8. Transfer of VHC Sustainability Funds from AHS to DVHA (BAA item; AHS GF net-neutral)	2,586,929			(2,586,929)				**0**
9. Federal Funds Technical Adjustment					(2,069,737)			**(2,069,737)**
Operating Expenses:								**0**
8. Transfer of VHC Sustainability Funds from AHS to DVHA (BAA item; AHS GF net-neutral)	430,883			(430,883)				**0**
10. ADS Service Level Agreement	301,981				301,980			**603,961**
11. ISFs increase	109,048	1,078		1,401	134,094		2,215	**247,836**
Grants:								**0**
8. Transfer of VHC Sustainability Funds from AHS to DVHA (BAA item; AHS GF net-neutral)	2,400			(2,400)				**0**
12. 1/2 year reduction of Federal Electronic Health Record Incentive Payments (EHRIP)					(2,122,422)			**(2,122,422)**
FY21 Changes	**2,126,703**	**(2,716,629)**	**0**	**(2,709,966)**	**(5,789,139)**	**0**	**111,186**	**(8,977,845)**
FY21 Gov Recommended	**31,349,020**	**3,379,479**	**0**	**4,832,636**	**118,960,026**	**0**	**4,325,382**	**162,846,543**
FY21 Subtotal of Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY21 As Passed - Dept ID 3410010000	**31,349,020**	**3,379,479**	**0**	**4,832,636**	**118,960,026**	**0**	**4,325,382**	**162,846,543**

Budget Summary Program

	GF	SF	State Health Care Res	IdptT	FF	Medicaid GCF	Invmnt GCF	Total
DVHA Global Commitment - As Passed FY20						**738,348,508**		**738,348,508**
Total after FY20 other changes	**0**	**0**	**0**	**0**	**0**	**738,348,508**	**0**	**738,348,508**
Grants:								
13. Caseload and Utilization Changes						(29,911,922)		**(29,911,922)**
14. Preferred Drug List (PDL) Management for HIV						(1,140,000)		**(1,140,000)**
15. Medicare Buy-In and Clawback Price Increases						3,584,469		**3,584,469**
16. Brattleboro Retreat Rate Increase (BAA item)						650,819		**650,819**
FY21 Changes	**0**	**0**	**0**	**0**	**0**	**(26,816,634)**	**0**	**(26,816,634)**
FY21 Gov Recommended	**0**	**0**	**0**	**0**	**0**	**711,531,874**	**0**	**711,531,874**
FY21 Legislative Changes								
FY21 As Passed - Dept ID 3410015000	**0**	**0**	**0**	**0**	**0**	**711,531,874**	**0**	**711,531,874**
DVHA - Med Prog - LTC Waiver-As Passed FY20						**213,712,634**		**213,712,634**
Total after FY20 other changes	**0**	**0**	**0**	**0**	**0**	**213,712,634**	**0**	**213,712,634**
Traditional:								
17. Pursuant to Act 72 Sec. E.308 - Transfer Long Term Care appropriation to DAIL (BAA item, AHS net-neutral)						(213,712,634)		**(213,712,634)**
FY20 BAA Changes	**0**	**0**	**0**	**0**	**0**	**(213,712,634)**	**0**	**(213,712,634)**
FY20 BAA Gov Recommended	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY20 BAA Legislative Changes								
FY20 BAA As Passed - Dept ID 3410016000	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
DVHA - Medicaid Program - State Only - As Passed FY20	**37,605,920**						**11,605,638**	**49,211,558**
Total after FY20 other changes	**37,605,920**	**0**	**0**	**0**	**0**	**0**	**11,605,638**	**49,211,558**
Grants:								
13. Caseload and Utilization Changes	3,213,400						(1,109)	**3,212,291**
14. Preferred Drug List (PDL) Management for HIV	(24,000)							**(24,000)**
15. Medicare Buy-In and Clawback Price Increases	1,799,014						(2,359)	**1,796,655**
16. Brattleboro Retreat Rate Increase (BAA item)							450,088	**450,088**
FY21 Changes	**4,988,414**	**0**	**0**	**0**	**0**	**0**	**446,620**	**5,435,034**
FY21 Gov Recommended	**42,594,334**	**0**	**0**	**0**	**0**	**0**	**12,052,258**	**54,646,592**
FY21 Legislative Changes								
FY21 As Passed - Dept ID 3410017000	**42,594,334**	**0**	**0**	**0**	**0**	**0**	**12,052,258**	**54,646,592**
DVHA - Medicaid Matched NON Waiver Expenses - As Passed FY20	**11,425,047**				**21,010,027**			**32,435,074**
other changes:								
FY20 after other changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total after FY20 other changes	**11,425,047**	**0**	**0**	**0**	**21,010,027**	**0**	**0**	**32,435,074**
Grants:								
13. Caseload, Utilization & FMAP Changes for CHIP Population	1,486,019				(1,538,909)			**(52,890)**
14. Preferred Drug List (PDL) Management for HIV	(10,458)				(25,542)			**(36,000)**
15. Medicare Buy-In and Clawback Price Increases					385,536			**385,536**
16. Brattleboro Retreat Rate Increase (BAA item)	3,426				8,368			**11,794**
FY21 Changes	**1,478,987**	**0**	**0**	**0**	**(1,170,547)**	**0**	**0**	**308,440**
FY21 Gov Recommended	**12,904,034**	**0**	**0**	**0**	**19,839,480**	**0**	**0**	**32,743,514**
FY21 Legislative Changes								
FY21 As Passed - Dept ID 3410018000	**12,904,034**	**0**	**0**	**0**	**19,839,480**	**0**	**0**	**32,743,514**

Budget Summary Total

	GF	SF	State Health Care Res	IdptT	FF	Medicaid GCF	Invmnt GCF	Total
TOTAL FY20 DVHA Big Bill As Passed	78,253,284	6,096,108	0	7,542,602	145,759,192	952,061,142	15,819,834	1,205,532,162
TOTAL FY20 DVHA Reductions & other changes	0	0	0	0	0	0	0	0
TOTAL FY21 DVHA Starting Point	78,253,284	6,096,108	0	7,542,602	145,759,192	952,061,142	15,819,834	1,205,532,162
TOTAL FY21 DVHA ups & downs	8,594,104	(2,716,629)	0	(2,709,966)	(6,959,686)	(240,529,268)	557,806	(243,763,639)
TOTAL FY21 DVHA Gov Recommended	86,847,388	3,379,479	0	4,832,636	138,799,506	711,531,874	16,377,640	961,768,523
TOTAL FY21 DVHA Legislative Changes	0	0	0	0	0	0	0	0
TOTAL FY21 DVHA As Passed	86,847,388	3,379,479	0	4,832,636	138,799,506	711,531,874	16,377,640	961,768,523

CATEGORIES OF SERVICE

DVHA Medicaid Spend by Category of Service			
Category of Service	**SFY 2019 Actual Spend**	**SFY 2020 BAA**	**SFY 2021 Gov. Rec.**
Inpatient	$ 133,646,741	$ 122,092,366	$ 111,503,017
Outpatient	$ 90,133,446	$ 75,653,522	$ 63,818,220
Physician	$ 100,468,342	$ 66,392,419	$ 58,614,489
Pharmacy	$ 194,941,931	$ 193,393,812	$ 184,079,035
Nursing Home	$ 810,939	$ 772,577	$ 739,958
Mental Health Facility	$ 337,394	$ 303,147	$ 290,348
Dental	$ 27,377,567	$ 26,911,445	$ 25,775,194
MH Clinic	$ 1,083,707	$ 326,276	$ 312,500
Independent Lab/Xray	$ 11,365,014	$ 10,322,565	$ 9,886,727
Home Health	$ 6,742,372	$ 6,367,937	$ 6,099,071
RHC	$ 4,635,911	$ 3,845,461	$ 3,107,166
Hospice	$ 9,850,657	$ 11,688,598	$ 11,195,083
FQHC	$ 32,827,030	$ 31,693,062	$ 30,352,835
Chiropractor	$ 1,266,162	$ 1,179,340	$ 1,129,546
Nurse Practitioner	$ 944,593	$ 920,434	$ 864,878
Skilled Nursing	$ 2,785,844	$ 2,688,652	$ 2,575,132
Podiatrist	$ 198,602	$ 169,974	$ 162,797
Psychologist	$ 25,822,671	$ 23,271,476	$ 22,288,911
Optometrist	$ 2,283,111	$ 2,249,407	$ 2,154,433
Optician	$ 185,298	$ 196,701	$ 188,396
Transportation	$ 14,406,522	$ 14,742,299	$ 14,119,852
Therapy Services	$ 9,101,188	$ 11,670,719	$ 11,161,266
Prosthetic/Ortho	$ 3,488,154	$ 3,643,594	$ 3,483,495
Medical Supplies	$ 3,672,439	$ 4,400,000	$ 4,214,224
DME	$ 7,057,128	$ 9,359,852	$ 8,952,142
H&CB Services Mental Service	$ 1,523,563	$ 1,257,498	$ 1,204,404
Enhanced Resident Care	$ 2,241	$ 2,000	$ 1,916
Personal Care Services	$ 11,268,981	$ 11,119,509	$ 10,650,023
Targeted Case Management (Drug)	$ 88,131	$ 70,699	$ 59,367
Assistive Community Care	$ 13,493,878	$ 15,206,211	$ 14,564,176
OADAP Families in Recovery	$ 3,510,001	$ 4,149,074	$ 3,973,892
Rehabilitation	$ 593,357	$ 493,588	$ 453,968
D & P Dept of Health	$ 561,018	$ 12,113	$ 11,601
PcPlus Case Mgmt and Special Program Payments	$ 1,035,964	$ -	$ -
Blue Print & CHT Payments	$ 14,990,068	$ 16,409,003	$ 15,716,185
ACO Capitation	$ 102,504,879	$ 153,397,877	$ 175,184,875
PDP Premiums	$ 1,346,771	$ 1,318,498	$ 1,262,829
HIPPS	$ 419,456	$ 517,999	$ 496,128
Ambulance	$ 7,204,058	$ 7,535,598	$ 7,217,431
Dialysis	$ 1,229,779	$ 1,201,337	$ 1,056,713
ASC	$ 59,161	$ 51,093	$ 48,936
Unknown	$ 32,800	$ 1,000	$ 958
Miscellaneous	$ 261,315	$ 52,648	$ 386,943
Provider Non Classified	$ (2,092,605)	$ (491,361)	$ (470,615)
Other Expenditures	$ 109,641,713	$ 112,634,492	$ 115,331,806
Offsets	$ (123,998,362)	$ (165,692,949)	$ (155,298,271)
Total DVHA Program Expenditures	**$ 829,108,931**	**$ 813,501,561**	**$ 798,921,981**

BUDGET CONSIDERATIONS: ADMINISTRATION B.306

The SFY 2021 Governor's Budget recommends $162,846,543 for the administration of the Department's Medicaid and CHIP program. This is a reduction of $8,977,845 gross and $3,244,299 state funds as compared to SFY 2020 As Passed.

Administration	Gross	State Funds
2020 As Passed	**$171,824,388**	**$44,968,125**
Changes	**($8,977,845)**	**($3,244,299)**
2021 Governor's Recommended	**$162,846,543**	**$41,723,826**

Salary & Fringe Increases	$988,296	$943,380

DVHA is comprised of 375 positions, representing a decrease of 5 positions as compared to 2019. Positions included in the decrease include a staff attorney, a clinical informatics analyst, an integration manager, and two support positions.

The three items below provide the annual increases related to these positions for salary, retirement, and other fringe benefits. There is a disproportionate general fund increase as some positions previously funded through enhanced federal participation revert to Medicaid administrative match.

1. Salary Increases	$428,163 gross / $502,476 state
2. Retirement Increases	$177,372 gross / $68,432 state
1. Fringe Increases	$382,761 gross / $372,472 state

Eligibility & Enrollment Operations Contract Decreases	($1,917,327)	($822,698)

DVHA engages with vendors to perform Maintenance and Operations (M&O) services and systems to support Eligibility and Enrollment functions. The Department expects to realize contract savings in two areas; operational improvement under the member contact center contract, Maximus, and a reduction in the scope of premium services in the contract with Wex Health.

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. The Departmental 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 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 and reduced call center contract costs as we improve the call scripting and call escalation process which has led to a gradual, yet sustained, decrease in call times. The anticipated spend for SFY 2020 is approximate $7M as compared to SFY 2017, $9M.

The Wex Health contract reductions are anticipated as DVHA completes the transition of Qualified Health Plan premium collection responsibility from DVHA to the QHP carriers. The SFY 2020 contract cost is $3.6M.

3. Member Call Center Efficiencies ($817,327) gross / ($245,198) g.f.
7. Premium Processing Scope Reduction ($1,100,000) gross / ($577,500) g.f.

Health Information Exchange Contract Reductions ($4,316,580) ($3,471,161)

DVHA is committed to aligning annual HIT Fund revenues with annual expenditures while maintaining and improving services. Thus far, this has been accomplished by reviewing current investments and advancements in technology to look for opportunities for efficiency and assessing whether current match rates are appropriate by the program area. This reduction eliminates the duplication of analytics and data repositories.

In 2019, the Department of Vermont Health Access (DVHA) was presented with the need to fund the purchase of new tools for several organizations. Seeing an opportunity to collaborate and realize savings, DVHA conceptualized the Collaborative Services Project (CSP). The intention of this project is to take an innovative approach to the exchange of healthcare information, providing service as efficiently and effectively as possible, while maintaining the highest level of patient privacy. In 2020, DVHA memorialized the CSP in a contract with the Vermont Information Technology Leaders (VITL), the operator of Vermont's Health Information Exchange. This contract now represents the development of several services that previously lived in other agreements, resulting in overall savings and the same, or improved health data services. DVHA also pursued an opportunity to gain 50% FFP on maintenance and operations activities which were previously covered almost entirely by state funds. Through a certification process, the Center for Medicare and Medicaid Services may retroactively increase that match rate to 75% if Vermont can certify its Health Information Exchange system.

4. Rebase HIT Budget ($4,316,580) gross / ($3,471,161) state

Alignment of Prior Authorization Requirements	($391,872)	($308,436)

DVHA has been engaged in efforts to align clinical activities and the prior authorization requirements for Medicaid members; attributed and un-attributed to the ACO. This clinical alignment will result in administrative efficiencies at the provider level and at DVHA. A result is the elimination of a position in the clinical team (through attrition) and reduction in contracts that support prior authorization decision making.

5. Elimination of a position through attrition ($116,872) gross / ($58,436) g.f.
6. Reductions in Prior Authorization Contracts. ($275,000) gross / ($250,000) g.f.

ADS Service Level & Internal Service Fund Increases	$851,797	$414,616

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

10. ADS Service Level Agreements $603,961 gross / $301,981 g.f.
11. ISF Increases $247,836 gross / $112,635 g.f.

Transfer Management of Funds from AHS (Agency Net Neutral)

Historically the VHC Sustainability Fund was managed by AHS, and DVHA was appropriated interdepartmental funds in order to fund the operations of the Health Access Eligibility and Enrollment unit for the Qualified Health Plan population. This change removes a step and allows for a direct appropriation of general funds to DVHA.

8. Personal Services: $2,586,929 from Interdepartmental Transfer to G.F.
8. Operating: $430,883 from Interdepartmental Transfer to G.F
8. Grants: $2,400 from Interdepartmental Transfer to G.F

Reduction in Federal Spending Authority	($4,192,159)	$0

These two items remove federal fund spending authority in contracts related to changes in federal participation and in the Electronic Health Record Incentive Program.

In 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability programs) to encourage clinicians, eligible hospitals, and critical access hospitals to adopt, implement, upgrade, and demonstrate meaningful use of electronic health records. This payment is made through the states but is a pass-through of 100% federal dollars. This change reduces the federal spending authority to our 2021 spending expectations.

9. Federal Funds Technical Adjustment ($2,069,737) gross / $0 g.f.
12. ½ Year Reduction of the Federal Electronic Health Record Incentive Payment ($2,122,422) gross / $0 g.f.

BUDGET CONSIDERATIONS: PROGRAM

The SFY 2021 Governor's Budget recommends $798,921,980 for the payment of healthcare services and supplies related to the DVHA administered Medicaid and CHIP program.

Program	Gross	General Funds
2020 As Passed	**$1,033,707,774**	**$488,559,385**
Changes	**($234,785,794)**	**($103,034,294)**
2021 Governor's Recommended	**$798,821,980**	**$385,525,091**

17. Choices for Care Appropriation Moves to DAIL (Agency Net Neutral) ($213,712,634) ($98,585,638)

Pursuant to Act 72 Sec. E.308 - Transfer Long Term Care appropriation to DAIL. This BAA item moves the spending authority to the Department of administration.

B.308 Long Term Care Waiver: Choices for Care $213,712,634 transfer to DAIL

13. Medicaid Caseload and Utilization ($26,752,521) ($8,943,914)

By statute, Vermont uses a consensus process to forecast Medicaid caseload and spending. This program spending is based on projected enrollment, utilization of services, and the price of those services. Overall, Medicaid enrollment is expected to continue to decline which is offset by increases to utilization. Factors likely contributing to the decline in enrollment are low unemployment rates, low birth rates, aging into Medicare, and improved technology & business processes for eligibility and enrollment.

Overall, program costs are changing due to the following factors:

- Declining enrollment, 5.2% adults and 2.4% for children, as compared to SFY 2019. For MEG level information, please see page 20 of this budget presentation.
- Increases in utilization including inpatient hospital services, hospice, hepatitis C treatment, and primary care/ preventative services amounting to 3.15% in adults in 0.32% in children as compared to SFY 2019.
- Annual price updates including physician, FQHCs/RHCs, home health and outpatient rates, and physician-administered drug prices.
    - The table below reflects the percent rate increase:

Physician (RBRVS)	FQHC/RHC	OPPS	PAD	Home Health
3.4%	1.5%	2%	0.5%	2%

- FMAP decrease within the CHIP program this increases the general fund by $1,870,724.
- Reset VPharm Rebate expectations ongoing: $3M less in State Only rebates per year.

B.307 Global Commitment:	($29,911,922) gross / ($13,642,828) g.f.
B.309 State Only Appropriation:	$3,212,291 gross / $3,212,895 g.f.
B.310 Non-Waiver Appropriation:	($52,890) gross / $1,486,019 g.f.

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14. PDL Management of HIV/AIDS Medications	($1,200,000)	($554,412)

The Pharmacy Best Practices and Cost Control Program is well-established with the appropriate amount of oversight and consumer protection through the Vermont Legislature, federal partners and the Drug Utilization Review Board, allowing the Department of Vermont Health Access to manage over 200 therapeutic classes of medications on its Preferred Drug List.[1] The Program was designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies for Vermont Medicaid members. Established processes under this Program allow for clinical efficacy and safety review and consideration of the net cost to the State by a Board of multi-disciplinary professionals (pharmacists, medical doctors, and allied health professionals). However, HIV- and AIDS-related medications remain one of the few major therapeutic classes left unmanaged by the Department because the current statute restricts the Department's ability to manage HIV- and AIDS-related medications. The current statute prohibits the Department of Vermont Health Access from managing HIV- and AIDS-related medications any more strictly than the Vermont Medication Assistance Program (VMAP) administered by the Vermont Department of Health.[2] The Ryan White HIV program and the VMAP program do not appear to have established processes for management of this class of medications that are consistent with the established processes utilized by the Department of Vermont Health Access to effectively manage all other therapeutic classes of medications.

In-state fiscal year 2019, the Department of Vermont Health Access' efficient management of its net drug spending, which was largely through preferred drug list management by the Drug Utilization Review Board, as evidenced by the Department invoicing approximately $127 million dollars in federal and supplemental rebates, representing 63.8% of the total gross drug spend ($198.8 million). At the request of the Administration, the Department of Vermont Health Access identified the potential for significant cost savings if the current statute was amended to allow the Department of Vermont Health Access to manage this therapeutic class of medications in accordance with the Pharmacy Best Practices and Cost Control Program. This change would allow Vermont Medicaid, through its Drug Utilization Review Board, to establish a Preferred

[1] https://legislature.vermont.gov/statutes/section/33/019/01998
[2] https://legislature.vermont.gov/statutes/section/33/019/01999

Drug List (PDL) for HIV- and AIDS-related medications, generating approximately $1.2 million in savings, and reducing utilization of clinically inferior products, by:

A. Taking advantage of supplemental drug rebates for HIV- and AIDS-related medications (supplemental drug rebates are not available absent a Preferred Drug List and are thus not currently being collected by the State of Vermont for this therapeutic class of medications).
B. Preferring lower-cost drugs over high cost, non-preferred drugs with equal clinical efficacy, no effect on the frequency of dosing for patients, and minimal impact on "pill burden."

Importantly, guidelines for the use of antiretroviral agents in adults and adolescents with HIV are available, well-respected, and recommend regimens (not specific medications); these guidelines inform the proposal for the establishment of a preferred drug list for antiretroviral therapy.[3] Additionally, a guiding principle in the establishment of a preferred drug list for antiretroviral therapy is that "grandfathering" is recommended to occur in order to ensure existing patients do not have changes to their regimens thus minimizing the impact to individuals; the definition of "grandfathering" will require stakeholder engagement to assure creation of an operational definition that meets the expectations of Vermont Medicaid members, prescribers and stakeholders. Finally, a key guiding principle is that all Medicaid-covered medications, even if placed in non-preferred status, are still available with prior authorization.

Unlike the early days of HIV/AIDS treatment, there are now many medication treatment options available that have brought clinical improvement and significant market competition to this therapeutic class of medications. The State could expect to save approximately $1.2 million by managing this therapeutic class with minimal impact for Vermont Medicaid members and prescribers.

B.307 Global Commitment:	($1,140,000) gross / ($519,954) g.f.
B. 309 State Only Appropriation:	($24,000) gross / ($24,000) g.f.
B. 310 Non-Waiver Appropriation:	($36,000) gross / ($10,458) g.f.

[3] https://aidsinfo.nih.gov/guidelines/brief-html/1/adult-and-adolescent-arv/0

15. Medicare Buy-In Increase $3,967,646 $1,633,800

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

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

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

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

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

- The table below reflects the per member, month price change mandated by CMS:

	CY 2019 Per Member Premium	CY 2020 Per Member Premium	% Change
Medicare Part A	$437.00	$458.00	4.81%
Medicare Part B	$135.50	$144.60	6.72%

Medicare Part A includes coverage for inpatient services, limited home health visits, skilled nursing facility and hospice care. Medicare Part B covers outpatient medical services and supplies, including physician service, ambulance and durable medical equipment.

Additionally, DVHA is seeing a decline in the enrollment of the investment buy-in population hence the decrease in the state only appropriate below.

B.307 Global Commitment: $3,584,469 gross / $1,634,876 g.f.
B.309 State Only Appropriation: ($2,359) gross / ($1,076) g.f.
B.310 Non-Waiver Appropriation: $385,536 gross / $0 g.f.

16. Brattleboro Retreat Rate Increase $1,112,701 $505,550

This is the annualization of the 2020 BAA line item for the Brattleboro Retreat rate increase. This increase reflects a rate increase to their base inpatient rate for adults and children served at the Brattleboro Retreat. This change increases the base per diem rate from $1,425 to $1,493 (4.8% increase), effective November 1st, 2019.

B.307 Global Commitment: $650,819 gross / $296,839 g.f.
B.309 State Only Appropriation: $450,088 gross / $205,285 g.f.
B.310 Non-Waiver Appropriation: $11,794 gross / $3,426 g.f.

15. Clawback Rate Increase $1,799,014 $1,799,014

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which established the Medicare Part D prescription drug program, eliminated Medicaid prescription drug coverage for people dually eligible for Medicare and Medicaid (duals) and required all duals to receive their drug coverage through a Medicare Part D plan. This reduced state costs; however, MMA also required states to reimburse the federal government for costs associated with the transfer of prescription drug coverage for this population from state Medicaid programs to Medicare. Effective January 1st, 2020, the amount DVHA pays per member is increasing.

- The table below reflects the per member per member month price change mandated by CMS:

	CY 2019 Per Member	CY 2020 Per Member	% Change
Clawback	$145.28	$152.85	5.21%

B.309 State Only Appropriation: $1,799,014 gross / $1,799,014 g.f.

Budget by Eligibility Group Pullout

PROGRAM EXPENDITURES	SFY '17 Actuals			SFY '18 Actuals			SFY '19 Actuals			SFY '20 As Passed			SFY '20 BAA				SFY '21 Gov. Rec.			
Adults	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Total Member Months	Expenses	PMPM	Avg. Enrollment	Total Member Months	Expenses	PMPM
Aged, Blind, or Disabled (ABD)	8,470	$ 66,094,888	$ 650.28	6,799	$ 52,603,422	$ 644.74	6,485	$ 58,975,376	$ 757.84	6,031	$ 53,364,028	$ 737.36	6,475	77,353	$ 58,682,577	$ 758.63	6,475	77,700	$ 58,910,637	$ 750.69
CFC Acute-Care Services	4,290	$ 27,403,064	$ 532.31	4,232	$ 26,947,522	$ 530.63	4,275	$ 30,423,279	$ 593.05	4,390	$ 28,269,908	$ 536.63	4,135	49,669	$ 29,451,020	$ 592.94	4,135	49,974	$ 29,703,413	$ 592.70
Dual Eligibles	17,601	$ 50,725,226	$ 240.16	17,659	$ 51,521,525	$ 243.13	17,651	$ 55,741,782	$ 263.17	17,804	$ 56,831,305	$ 266.00	17,828	213,420	$ 56,031,023	$ 262.54	17,898	214,565	$ 56,370,156	$ 262.59
General	15,140	$ 73,390,102	$ 403.95	12,664	$ 67,656,322	$ 445.20	10,148	$ 59,269,233	$ 486.71	12,867	$ 72,488,541	$ 469.47	9,657	114,411	$ 49,488,338	$ 432.55	7,899	94,783	$ 41,369,996	$ 432.45
New Adult Childless	42,327	$ 185,089,356	$ 364.40	39,967	$ 181,065,107	$ 377.53	37,432	$ 194,636,266	$ 433.31	39,273	$ 195,378,448	$ 414.57	35,559	430,828	$ 182,723,389	$ 424.12	33,834	406,013	$ 172,999,367	$ 422.38
New Adult W/Child	17,775	$ 66,689,083	$ 312.65	18,568	$ 70,327,528	$ 315.63	19,101	$ 84,103,541	$ 366.92	18,813	$ 78,136,341	$ 346.11	19,550	234,464	$ 88,628,779	$ 378.01	19,988	239,858	$ 90,346,416	$ 374.47
Subtotal Adults	105,603	$ 469,391,718	$ 370.41	99,889	$ 450,121,426	$ 375.52	95,092	$ 483,149,478	$ 423.41	99,178	$ 484,468,571	$ 407.07	93,204	1,120,146	$ 465,005,125	$ 415.13	90,229	1,082,893	$ 449,699,985	$ 412.40
Sunsetted Direct Programs	-	$ 3,326,296		-	$ 2,814,595		-	$ 1,090,676		-	$ -									
Sunsetted/Transferred CFC Programs		$ 194,689,010			$ 197,448,652			$ 206,971,637			$ 213,712,634									
Subtotal Sunsetted	-	$ 198,015,306	$ -	-	$ 200,263,247	$ -	-	$ 208,062,313	$ -	-	$ 213,712,634	$ -								
Children																				
Blind or Disabled (BD)	2,368	$ 22,608,139	$ 795.61	2,241	$ 19,728,813	$ 733.63	2,093	$ 20,956,833	$ 834.40	2,112	$ 19,287,093	$ 761.01	2,138	24,923	$ 21,511,798	$ 863.15	2,150	25,800	$ 22,188,693	$ 855.50
General	60,114	$ 146,114,183	$ 202.55	59,821	$ 148,830,755	$ 207.33	58,779	$ 158,649,068	$ 224.92	59,708	$ 150,490,908	$ 210.04	58,256	695,522	$ 157,862,953	$ 226.97	57,393	688,719	$ 156,312,500	$ 226.00
Underinsured	845	$ 1,053,645	$ 103.91	601	$ 484,934	$ 67.24	563	$ 448,836	$ 66.44	584	$ 490,900	$ 70.05	540	6,460	$ 436,196	$ 67.52	509	6,112	$ 412,421	$ 67.23
SCHIP (Uninsured)	5,142	$ 7,893,710	$ 127.93	4,667	$ 8,323,354	$ 148.62	4,479	$ 9,234,963	$ 171.82	4,697	$ 8,439,212	$ 149.73	4,399	52,445	$ 9,304,698	$ 177.42	4,274	51,293	$ 8,582,146	$ 167.32
Subtotal Children	68,469	$ 177,669,678	$ 216.24	67,330	$ 177,367,857	$ 219.53	65,914	$ 189,289,700	$ 239.31	67,101	$ 178,708,112	$ 221.94	65,333	779,350	$ 189,115,644	$ 242.66	64,326	771,924	$ 187,495,759	$ 241.88
Pharmacy																				
Pharmacy Only - GC	11,399	$ 3,310,386	$ 24.20	10,717	$ 3,403,278	$ 26.46	10,382	$ 3,690,759	$ 29.62	10,125	$ 6,086,469	$ 50.09	10,050	120,546	$ 2,883,672	$ 23.92	9,664	115,971	$ 2,911,244	$ 25.03
Pharmacy Only - State Only	11,399	$ (258,671)	$ (1.89)	10,717	$ 1,054,658	$ 8.20	10,382	$ 4,784,346	$ 38.40	10,125	$ 1,378,849	$ 11.35	10,050	120,546	$ 5,152,255	$ 42.74	9,664	115,971	$ 4,527,721	$ 39.04
Pharmacy Only Programs	11,399	$ 3,155,724	$ 23.07	10,717	$ 4,588,899	$ 35.68	10,382	$ 8,475,105	$ 68.03	10,125	$ 7,465,318	$ 61.44	10,050	120,546	$ 8,035,927	$ 66.66	9,664	115,971	$ 7,438,965	$ 64.07
QHP Assistance																				
Premium Assistance	17,961	$ 6,100,378	$ 28.30	18,275	$ 6,334,440	$ 28.88	17,163	$ 5,941,367	$ 28.85	19,951	$ 6,914,219	$ 28.88	16,988	-	$ 5,986,200	$ 29.36	16,515		$ 5,819,526	$ 29.36
Cost Sharing	5,816	$ 1,355,318	$ 19.42	6,141	$ 1,570,896	$ 21.32	4,919	$ 1,482,370	$ 25.11	4,052	$ 1,314,872	$ 27.04	3,879	-	$ 1,355,401	$ 29.12	3,879		$ 1,355,401	$ 29.12
Subtotal QHP Assistance	17,961	$ 7,455,696	$ 34.59	18,275	$ 7,905,336	$ 36.05	17,163	$ 7,423,737	$ 36.05	19,951	$ 8,229,091	$ 34.37	16,988		$ 7,341,601	$ 36.01	16,515		$ 7,174,926	$ 36.20
Subtotal Direct Services	**203,432**	**$ 660,999,112**	**$ 270.77**	**196,211**	**$ 642,798,113**	**$ 273.00**	**188,551**	**$ 689,428,696**	**$ 304.70**	**196,355**	**$ 678,871,092**	**$ 288.11**	**185,575**		**$ 669,498,297**	**$ 300.64**	**180,734**		**$ 651,809,635**	**$ 298.74**
Miscellaneous Program																				
GME		$ 30,000,000			$ 30,000,000			$ 30,000,000			$ 30,000,000				$ 30,000,000				$ 30,000,000	
ACA Rebates	-	$ (3,758,894)			$ (3,620,344)			$ (3,196,918)			$ (2,819,171)				$ (2,819,171)				$ (3,036,658)	
HIV	143	$ 7,001	$ 4.08	161	$ 4,085	$ 2.11	165	$ 2,703	$ 1.37	188	$ 8,421	$ 3.73	184		$ 3,015	$ 1.37	198		$ 3,244	$ 1.37
Underinsured	-	$ 8,682,104			$ 7,933,373			$ 9,697,426			$ 11,553,560				$ 11,778,985				$ 12,003,647	
DSH	-	$ 37,448,780			$ 27,448,780			$ 22,704,470			$ 22,704,471				$ 22,704,471				$ 22,704,471	
Clawback	-	$ 31,738,186			$ 33,888,772			$ 34,453,902			$ 34,912,199				$ 35,764,577				$ 36,711,213	
Buy-In ~ GC	-	$ 33,855,164			$ 35,999,728			$ 36,384,457			$ 36,168,170				$ 38,218,162				$ 39,164,716	
Buy-In ~ CFC		$ 3,379,492			$ 3,562,365			$ 3,872,527			$ 3,886,884				$ 3,886,884				$ 4,474,808	
Buy-In ~ Investments/State Only	-	$ 53,552			$ 30,686			$ 91,601			$ 50,969				$ 50,969				$ 48,610	
Buy-In ~ Federal Only	-	$ 4,202,611			$ 4,241,969			$ 4,172,939			$ 4,104,278				$ 4,104,278				$ 4,489,813	
Legal Aid	-	$ 547,983			$ 547,983			$ 547,983			$ 547,983				$ 547,983				$ 547,983	
Misc. Pymts.	-	$ 3,499,372			$ 6,922,674			$ 948,647			$ -				$ (237,387)				$ -	
Healthy Vermonters Program	3,381	$ -	$ -	1,547	$ -	$ -	1,389	$ -	$ -	1,006	$ -	$ -	1,357		$ -	$ -	1,358		$ -	$ -
Subtotal Miscellaneous Program	**3,525**	**$ 149,663,730**		**1,710**	**$ 146,964,206**		**1,555**	**$ 139,680,236**		**1,195**	**$ 141,124,048**		**1,542**		**$ 144,003,264**		**1,557**		**$ 147,112,345**	
TOTAL PROGRAM EXPENDITURES	**206,957**	**$ 810,662,841**		**197,921**	**$ 789,762,319**		**190,106**	**$ 829,108,931**		**197,550**	**$ 819,995,140**		**187,117**		**$ 813,501,561**		**182,291**		**$ 798,921,981**	
Total Program Expenditure with CFC Traditional		**$ 1,005,351,851**			**$ 987,210,971**			**$ 1,036,080,569**			**$ 1,033,707,774**									

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Budget by Eligibility Group Funding Pullout

PROGRAM EXPENDITURES	SFY '19 Actuals			SFY '20 As Passed			SFY '20 BAA				SFY '21 Gov. Rec.				Funding Description
Adults	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Expenses	PMPM	Avg. Enrollment	Total Member Months	Expenses	PMPM	Avg. Enrollment	Total Member Months	Expenses	PMPM	
Aged, Blind, or Disabled (ABD)	6,485	$ 58,975,376	$ 757.84	6,031	$ 53,364,028	$ 737.36	6,475	77,353	$ 59,264,272	$ 766.15	6,475	77,700	$ 58,910,637	$ 758.18	Global Commitment Funded (GC)
CFC Acute-Care Services	17,651	$ 55,741,782	$ 263.17	17,804	$ 56,831,305	$ 266.00	17,828	213,420	$ 56,057,878	$ 262.66	17,898	214,565	$ 29,703,413	$ 138.44	Global Commitment Funded (GC)
Dual Eligibles	4,275	$ 30,423,279	$ 593.05	4,390	$ 28,269,908	$ 536.63	4,135	49,669	$ 29,534,792	$ 594.63	4,135	49,974	$ 56,370,156	$ 594.37	Global Commitment Funded (GC)
General	10,148	$ 59,269,233	$ 486.71	12,867	$ 72,488,541	$ 469.47	9,657	114,411	$ 49,869,376	$ 435.88	7,899	94,783	$ 41,369,996	$ 436.47	Global Commitment Funded (GC)
New Adult Childless	37,432	$ 194,636,266	$ 433.31	39,273	$ 195,378,448	$ 414.57	35,559	430,828	$ 184,233,168	$ 427.63	33,834	406,013	$ 172,999,367	$ 426.09	Global Commitment Funded (GC)
New Adult W/Child	19,101	$ 84,103,541	$ 366.92	18,813	$ 78,136,341	$ 346.11	19,550	234,464	$ 89,155,509	$ 380.25	19,988	239,858	$ 90,346,416	$ 376.67	Global Commitment Funded (GC)
Subtotal Adults	95,092	$ 483,149,478	$ 423.41	99,178	$ 484,468,571	$ 407.07	93,204	1,120,146	$ 468,114,995	$ 417.91	90,229	1,082,893	$ 449,699,985	$ 415.28	
Sunsetted Direct Programs	-	$ 1,090,676		-	$ -										Global Commitment Funded (GC)
Sunsetted/Transferred CFC Programs		$ 206,971,637			$ 213,712,634										Global Commitment Funded (GC)
Subtotal Sunsetted															
Children															
Blind or Disabled (BD)	2,093	$ 20,956,833	$ 834.40	2,112	$ 19,287,093	$ 761.01	2,138	24,923	$ 21,628,625	$ 867.83	2,150	25,800	$ 22,188,693	$ 860.03	Global Commitment Funded (GC)
General	58,779	$ 158,649,068	$ 224.92	59,708	$ 150,490,908	$ 210.04	58,256	695,522	$ 158,526,471	$ 227.92	57,393	688,719	$ 156,312,500	$ 226.96	Global Commitment Funded (GC)
Underinsured	563	$ 448,836	$ 66.44	584	$ 490,900	$ 70.05	540	6,460	$ 437,714	$ 67.76	509	6,112	$ 412,421	$ 67.48	Global Commitment Funded (GC)
SCHIP (Uninsured)	4,479	$ 9,234,963	$ 171.82	4,697	$ 8,439,212	$ 149.73	4,399	52,445	$ 9,304,698	$ 177.42	4,274	51,293	$ 8,582,146	$ 167.32	Title XXI Enhanced
Subtotal Children	65,914	$ 189,289,700	$ 239.31	67,101	$ 178,708,112	$ 221.94	65,333	779,350	$ 189,897,507	$ 243.66	64,326	771,924	$ 187,495,759	$ 242.89	
Pharmacy															
Pharmacy Only - GC	10,382	$ 3,690,759	$ 29.62	10,125	$ 6,086,469	$ 50.09	10,050	120,546	$ 2,891,938	$ 23.99	9,664	115,971	$ 2,911,244	$ 25.10	Global Commitment Funded (GC)
Pharmacy Only - State Only	10,382	$ 4,784,346	$ 38.40	10,125	$ 1,378,849	$ 11.35	10,050	120,546	$ 5,152,255	$ 42.74	9,664	115,971	$ 4,527,721	$ 39.04	General Funds (GF) @ 100%
Pharmacy Only Programs	10,382	$ 8,475,105	$ 68.03	10,125	$ 7,465,318	$ 61.44	10,050	120,546	$ 8,044,193	$ 66.73	9,664	115,971	$ 7,438,965	$ 64.15	
QHP Assistance															
Premium Assistance	17,163	$ 5,941,367	$ 28.85	19,951	$ 6,914,219	$ 28.88	16,988		$ 5,986,200	$ 29.36	16,515		$ 5,819,526	$ 29.36	Global Commitment Funded (GC)
Cost Sharing	4,919	$ 1,482,370	$ 25.11	4,052	$ 1,314,872	$ 27.04	3,879		$ 1,355,401	$ 29.12	3,879		$ 1,355,401	$ 29.12	General Funds (GF) @ 100%
Subtotal QHP Assistance	17,163	$ 7,423,737	$ 36.05	19,951	$ 8,229,091	$ 34.37	16,988		$ 7,341,601	$ 36.01	16,515		$ 7,174,926	$ 36.20	
Subtotal Direct Services	**188,551**	**$ 896,400,333**	**$ 396.18**	**196,355**	**$ 892,583,726**	**$ 378.81**	**185,575**		**$ 673,398,297**	**$ 302.39**	**180,734**		**$ 651,809,635**	**$ 300.54**	
Miscellaneous Program															
GME		$ 30,000,000			$ 30,000,000				$ 30,000,000				$ 30,000,000		Global Commitment Funded (GC)
Refugee	1	$ 499	$ 41.60	1	$ 6,285	$ 523.73	1		$ 499	$ 41.60	1		$ 499	$ 41.60	Federally Funded @ 100%
ACA Rebates		$ (3,196,918)			$ (2,819,171)				$ (2,819,171)				$ (3,036,658)		Federally Funded @ 100%
HIV	165	$ 2,703	$ 1.37	188	$ 8,421	$ 3.73	184		$ 3,015	$ 1.37	198		$ 3,244	$ 1.37	Investments: Global Commitment Funded (GC)
Underinsured		$ 9,697,426			$ 11,553,560				$ 11,778,985				$ 12,003,647		Investments: Global Commitment Funded (GC)
DSH		$ 22,704,470			$ 22,704,471				$ 22,704,471				$ 22,704,471		Global Commitment Funded (GC)
Clawback		$ 34,453,902			$ 34,912,199				$ 34,912,199				$ 36,711,213		General Funds (GF) @ 100%
Buy-In ~ GC		$ 36,384,457			$ 36,168,170				$ 36,168,170				$ 39,164,716		Global Commitment Funded (GC)
Buy-In ~ CFC		$ 3,872,527			$ 3,886,884				$ 3,886,884				$ 4,474,808		Global Commitment Funded (GC)
Buy-In ~ Investments/State Only		$ 91,601			$ 50,969				$ 50,969				$ 48,610		Investments: Global Commitment Funded (GC)
Buy-In ~ Federal Only		$ 4,172,939			$ 4,104,278				$ 4,104,278				$ 4,489,813		Federally Funded @ 100%
Legal Aid		$ 547,983			$ 547,983				$ 547,983				$ 547,983		Global Commitment Funded (GC)
Misc. Pymts.		$ 948,647			$ -				$ (237,387)				$ -		Global Commitment Funded (GC)
Healthy Vermonters Program	1,389	$ -	$ -	1,006	$ -	$ -	1,357		$ -	$ -	1,358		$ -	$ -	No Programmatic Cost
Subtotal Miscellaneous Program	**1,555**	**$ 139,680,236**		**1,195**	**$ 141,124,048**		**1,542**		**$ 141,100,894**		**1,557**		**$ 147,112,345**		
TOTAL PROGRAM EXPENDITURES	**190,106**	**$ 829,108,931**		**197,550**	**$ 819,995,140**		**187,117**		**$ 814,499,191**		**182,291**		**$ 798,921,981**		
Total Program Expenditure with CFC Traditional		**$ 1,036,080,569**			**$ 1,033,707,774**										

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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:

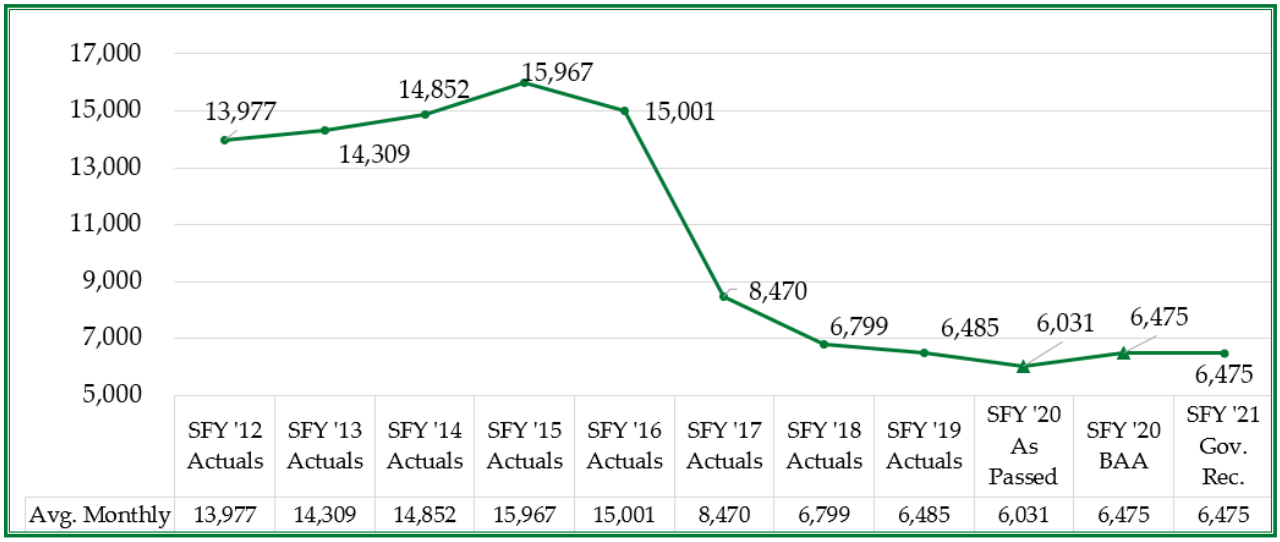
- Age 19 and older
- Determined ABD but ineligible for Medicare include:
  - Supplemental Security Income (SSI) cash assistance recipients
  - Working disabled
  - Hospice patients
  - Breast and Cervical Cancer Treatment (BCCT) participants
  - Medicaid/Qualified Medicare Beneficiaries (QMB)
  - Medically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

Aged, Blind, & Disabled (ABD) and/or Medically Needy Adults			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	13,977	$ 95,212,717	$567.67
SFY 2013	14,309	$ 94,040,772	$547.68
SFY 2014	14,852	$ 103,081,677	$578.38
SFY 2015	15,967	$ 98,124,603	$512.12
SFY 2016	15,001	$ 95,383,227	$529.87
SFY 2017	8,470	$ 66,094,888	$650.28
SFY 2018	6,799	$ 52,603,422	$644.74
SFY 2019	6,485	$ 58,975,376	$757.84
SFY 2020 As Passed	6,031	$ 53,364,028	$737.36
SFY 2020 BAA	6,475	$ 58,682,577	$758.63
SFY 2021 Gov. Rec.	6,475	$ 58,910,637	$750.69

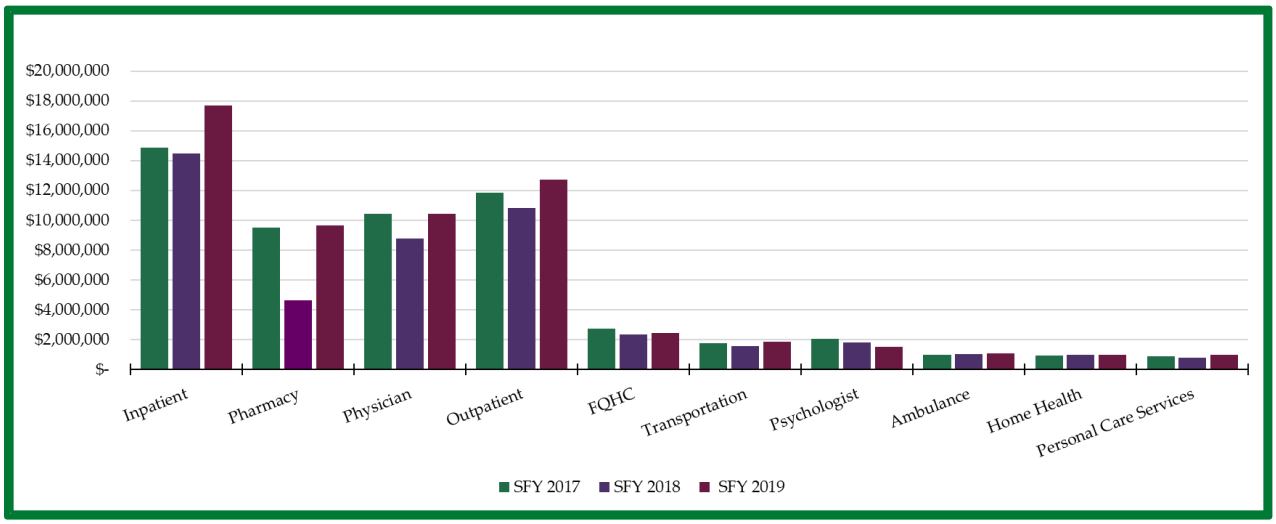
Aged, Blind, or Disabled (ABD) and/or Medically Needy Adults Cont.

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	13,977	14,309	14,852	15,967	15,001	8,470	6,799	6,485	6,031	6,475	6,475

Top 10 Actual Expenditures by Category of Service



The decrease in pharmacy spend in SFY 2018 is due to high drug rebate collections offset expenditures. The Brattleboro Retreat and Dartmouth rate increases contributed to the increase in inpatient spend in SFY 2020.

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:

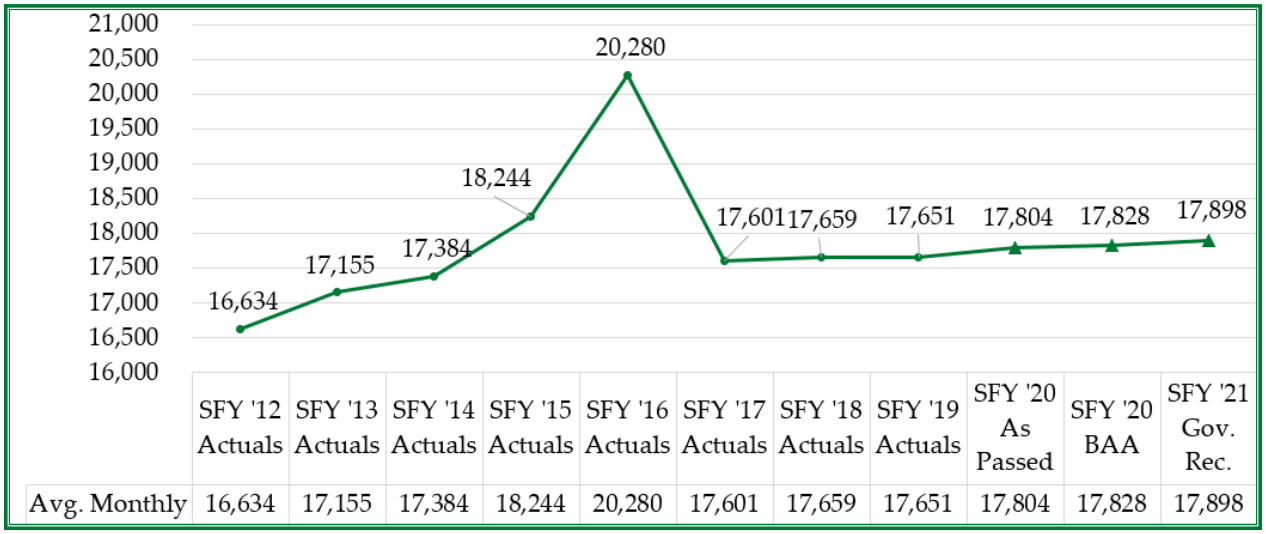
- Medicare:
  - o Co-payments
  - o Co-insurance
  - o Deductibles
- Non-Medicare routine services:
  - o Hearing
  - o Dental
  - o Transportation

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

Aged, Blind, & Disabled (ABD) Dual Eligibles			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	16,634	$ 43,120,000	$216.02
SFY 2013	17,155	$ 43,653,408	$212.05
SFY 2014	17,384	$ 46,837,084	$224.52
SFY 2015	18,244	$ 51,628,212	$235.82
SFY 2016	20,280	$ 53,629,774	$220.37
SFY 2017	17,601	$ 50,725,226	$240.16
SFY 2018	17,659	$ 51,521,525	$243.13
SFY 2019	17,651	$ 55,741,782	$263.17
SFY 2020 As Passed	17,804	$ 56,831,305	$266.00
SFY 2020 BAA	17,828	$ 56,031,023	$262.54
SFY 2021 Gov. Rec.	17,898	$ 56,370,156	$262.59

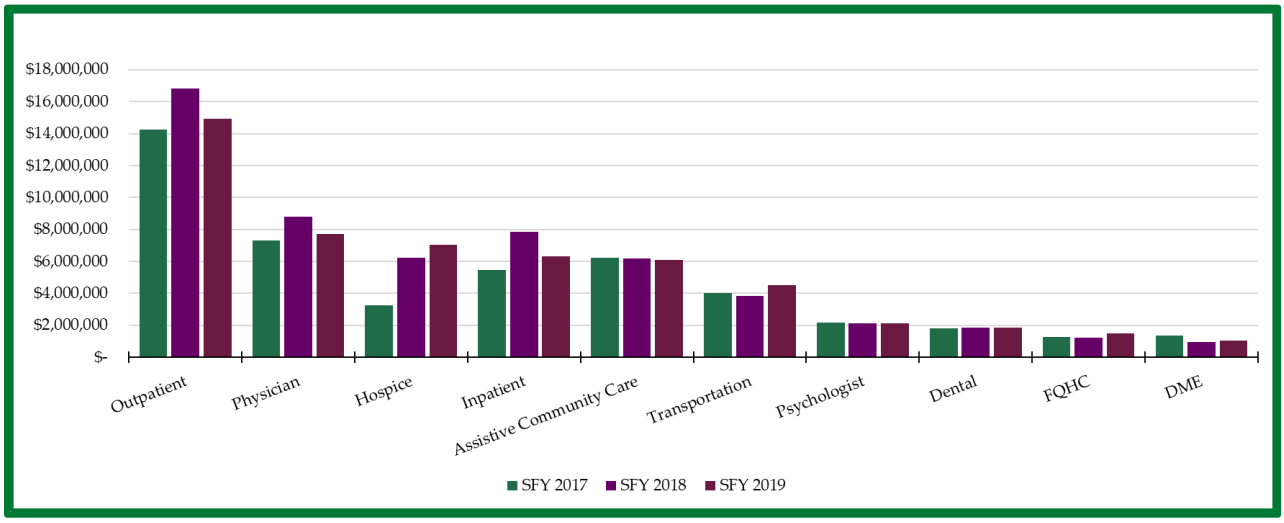
Dual Eligible Cont.

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	16,634	17,155	17,384	18,244	20,280	17,601	17,659	17,651	17,804	17,828	17,898

Top 10 Actual Expenditures by Category of Service



Members electing hospice services increased sharply between 2017 and 2018. This trend continues although at a lesser rate.

General Adults

The eligibility requirements for General Adults are as follows:

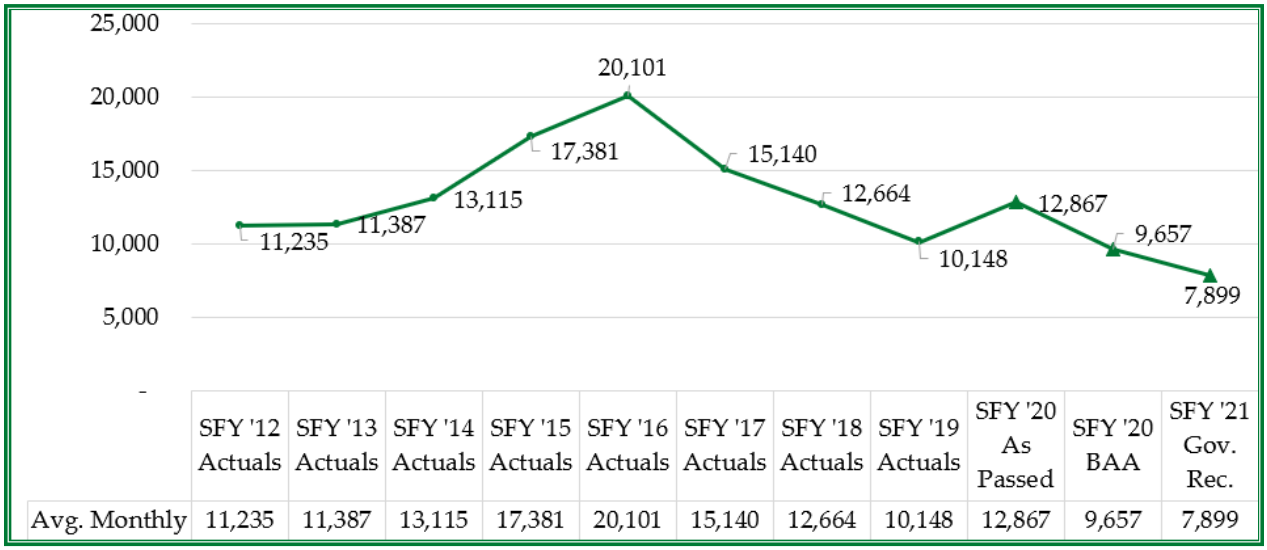
- Age 19 and older
- Parent(s), caretaker(s), or relative(s) of minor children (including cash assistance recipients)
- Those receiving transitional Medicaid after the receipt of cash assistance
- Income below the PIL

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

General Adults			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	11,235	$ 61,521,695	$456.32
SFY 2013	11,387	$ 66,153,118	$484.13
SFY 2014	13,115	$ 72,522,519	$460.81
SFY 2015	17,381	$ 83,697,172	$401.29
SFY 2016	20,101	$ 88,167,474	$365.52
SFY 2017	15,140	$ 73,390,102	$403.95
SFY 2018	12,664	$ 67,656,322	$445.20
SFY 2019	10,148	$ 59,269,233	$486.71
SFY 2020 As Passed	12,867	$ 72,488,541	$469.47
SFY 2020 BAA	9,657	$ 49,488,338	$432.55
SFY 2021 Gov. Rec.	7,899	$ 41,369,996	$432.45

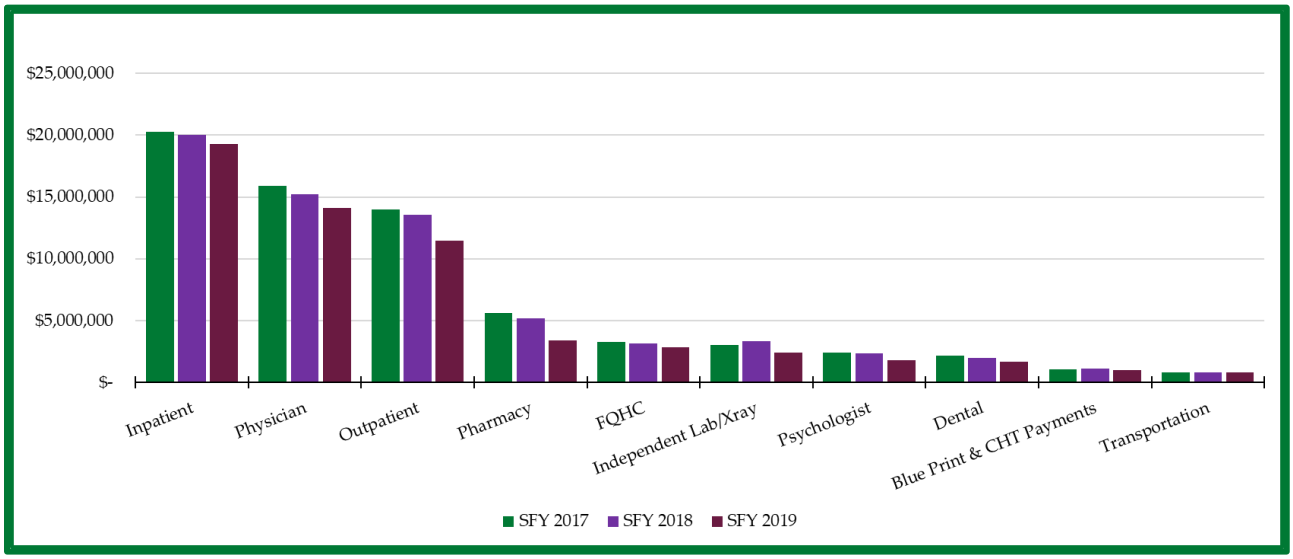
General Adults Cont.

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	11,235	11,387	13,115	17,381	20,101	15,140	12,664	10,148	12,867	9,657	7,899

Top 10 Actual Expenditures by Category of Service



New Adults without Children

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

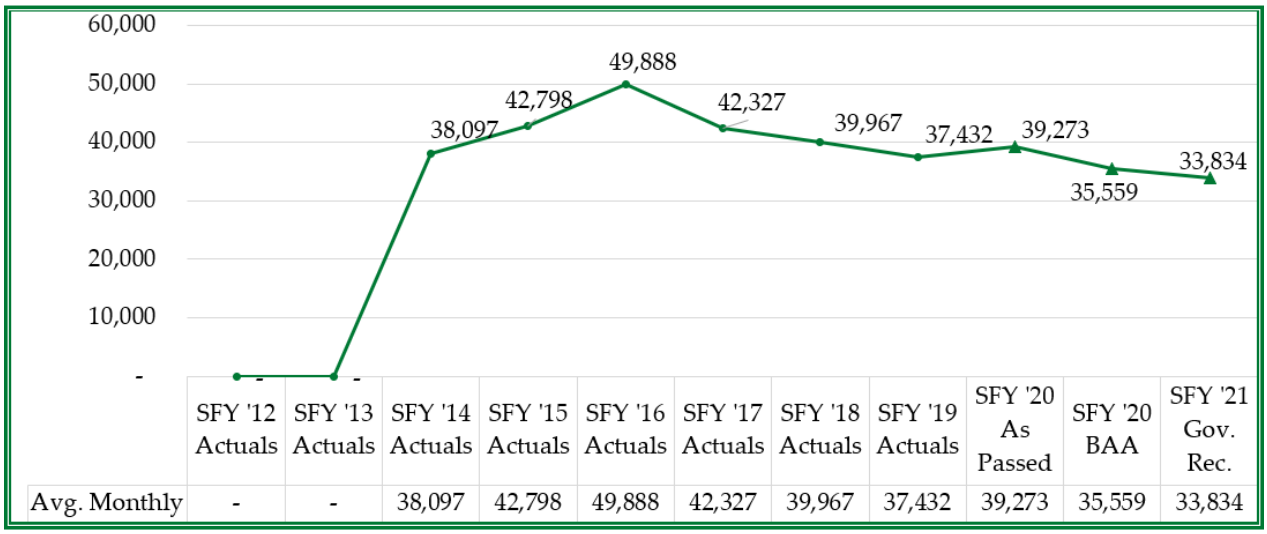
- Age 19 and older
- Income below the designated FPL
- No children in the household

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

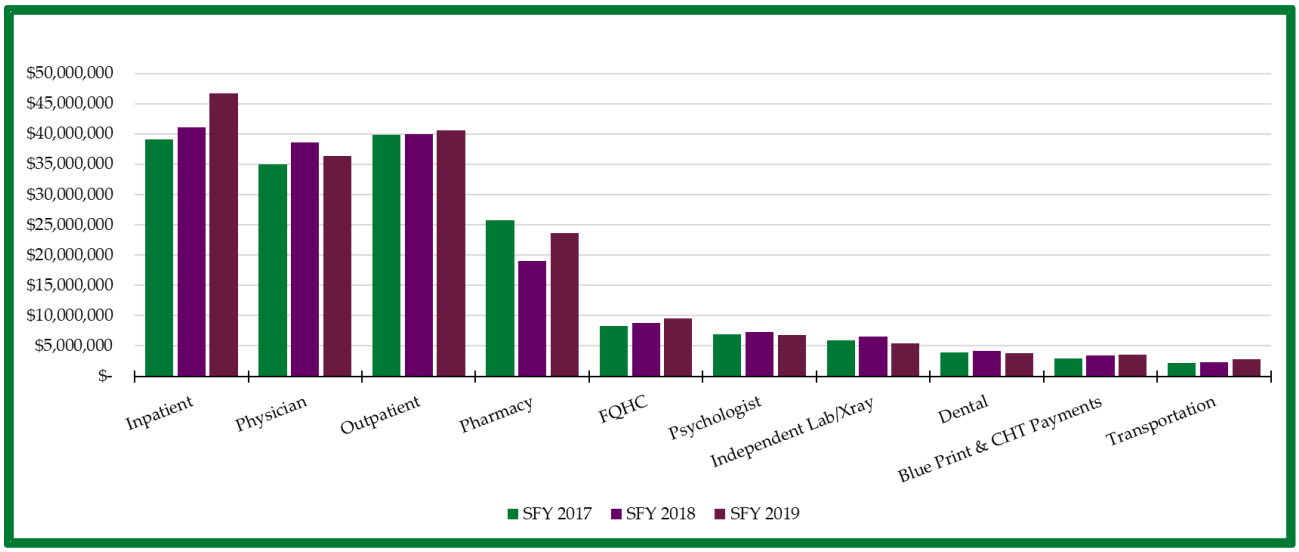
New Adult Childless			
SFY	Caseload	Expenditures	PMPM
SFY 2012	-	$ -	$ -
SFY 2013	-	$ -	$ -
SFY 2014	38,097	$ 63,320,749	$138.51
SFY 2015	42,798	$ 183,204,215	$356.72
SFY 2016	49,888	$ 201,487,803	$336.57
SFY 2017	42,327	$ 185,089,356	$364.40
SFY 2018	39,967	$ 181,065,107	$377.53
SFY 2019	37,432	$ 194,636,266	$433.31
SFY 2020 As Passed	39,273	$ 195,378,448	$414.57
SFY 2020 BAA	35,559	$ 182,723,389	$424.12
SFY 2021 Gov. Rec.	33,834	$ 172,999,367	$422.38

Average Monthly Caseload Actuals Comparison by SFY



New Adults without Children Cont.

Top 10 Actual Expenditures by Category of Service



The decrease in pharmacy spend in SFY 2018 is due to high drug rebate collections offsetting expenditures.

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

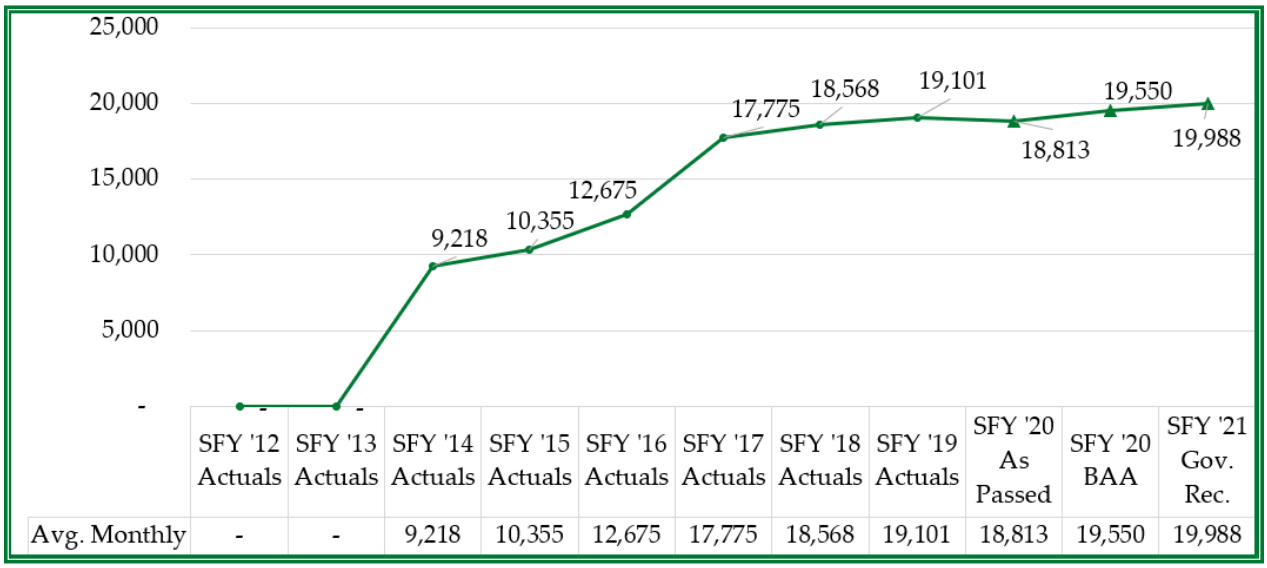
Unlike New Adults without children, for this population, the Federal government reimburses services for New Adults with Children in the household at the unenhanced Global Commitment rate.

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

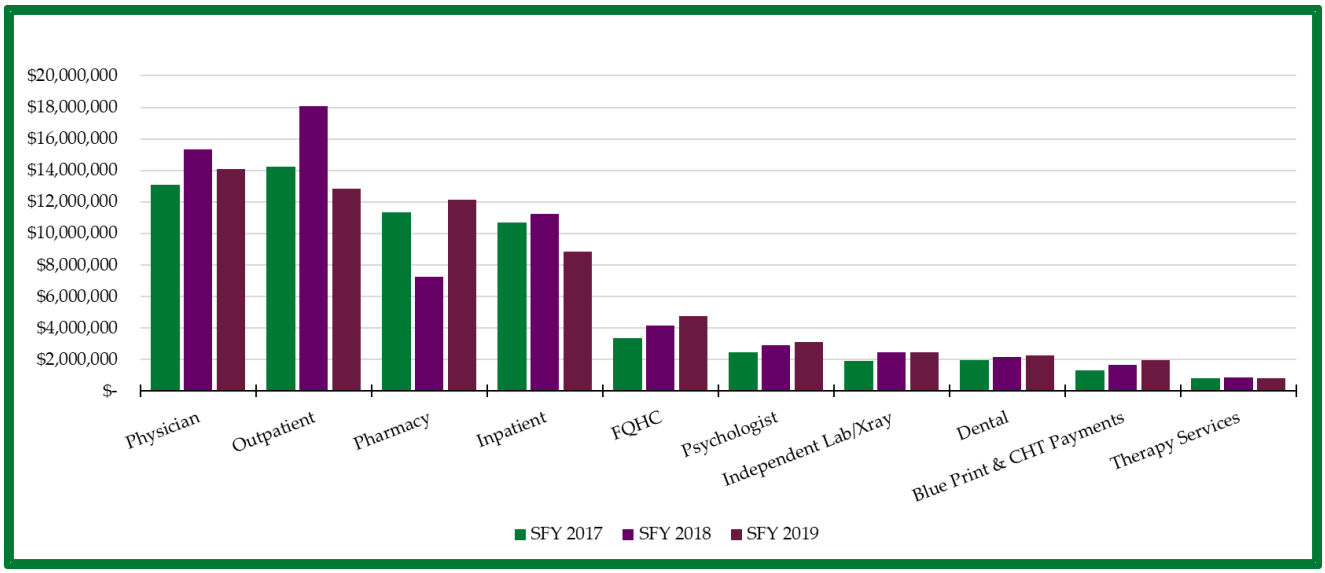
New Adult with Child			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	-	$ -	$ -
SFY 2013	-	$ -	$ -
SFY 2014	9,218	$ 6,235,905	$ 56.37
SFY 2015	10,355	$ 30,538,909	$ 245.77
SFY 2016	12,675	$ 36,350,037	$ 238.99
SFY 2017	17,775	$ 66,689,083	$ 312.65
SFY 2018	18,568	$ 70,327,528	$ 315.63
SFY 2019	19,101	$ 84,103,541	$ 366.92
SFY 2020 As Passed	18,813	$ 78,136,341	$ 346.11
SFY 2020 BAA	19,550	$ 88,628,779	$ 378.01
SFY 2021 Gov. Rec.	19,988	$ 90,346,416	$ 374.47

New Adults with Children Cont.

Average Monthly Caseload Actuals Comparison by SFY



Top 10 Actual Expenditures by Category of Service



The decrease in pharmacy spend in SFY 2018 is due to high drug rebate collections offsetting expenditures.

Pharmacy Only Programs – Prescription Assistance

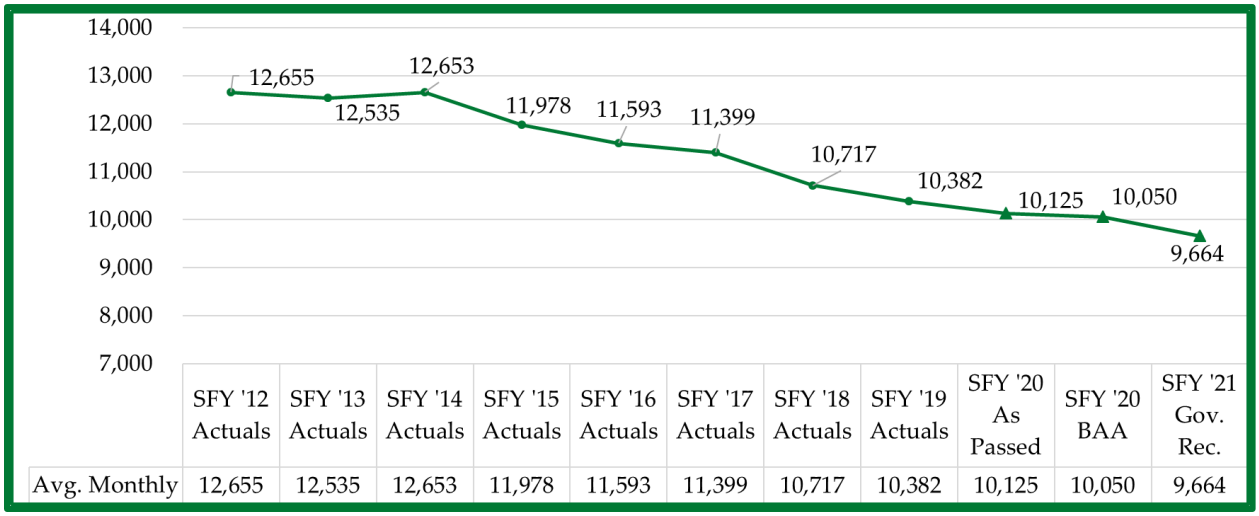
Vermont provides prescription assistance programs to help Vermonters pay for prescription medicines based on income, disability status, and age under the name VPharm. There are monthly premiums based on income and co-pays based on the cost of the prescription.
VPharm assists Vermonters enrolled in Medicare 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 a disability
- Current Medicare Part D eligibility
- Income below the designated FPL

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

Pharmacy Only Programs			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	12,655	$ (1,421,868)	$ (9.36)
SFY 2013	12,535	$ 1,813,724	$ 12.06
SFY 2014	12,653	$ 4,485,706	$ 29.54
SFY 2015	11,978	$ 4,914,695	$ 34.19
SFY 2016	11,593	$ 2,302,437	$ 16.55
SFY 2017	11,399	$ 3,155,724	$ 23.07
SFY 2018	10,717	$ 4,588,899	$ 35.68
SFY 2019	10,382	$ 8,475,105	$ 68.03
SFY 2020 As Passed	10,125	$ 7,465,318	$ 61.44
SFY 2020 BAA	10,050	$ 8,035,927	$ 66.66
SFY 2021 Gov. Rec.	9,664	$ 7,438,965	$ 64.07

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	12,655	12,535	12,653	11,978	11,593	11,399	10,717	10,382	10,125	10,050	9,664

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)

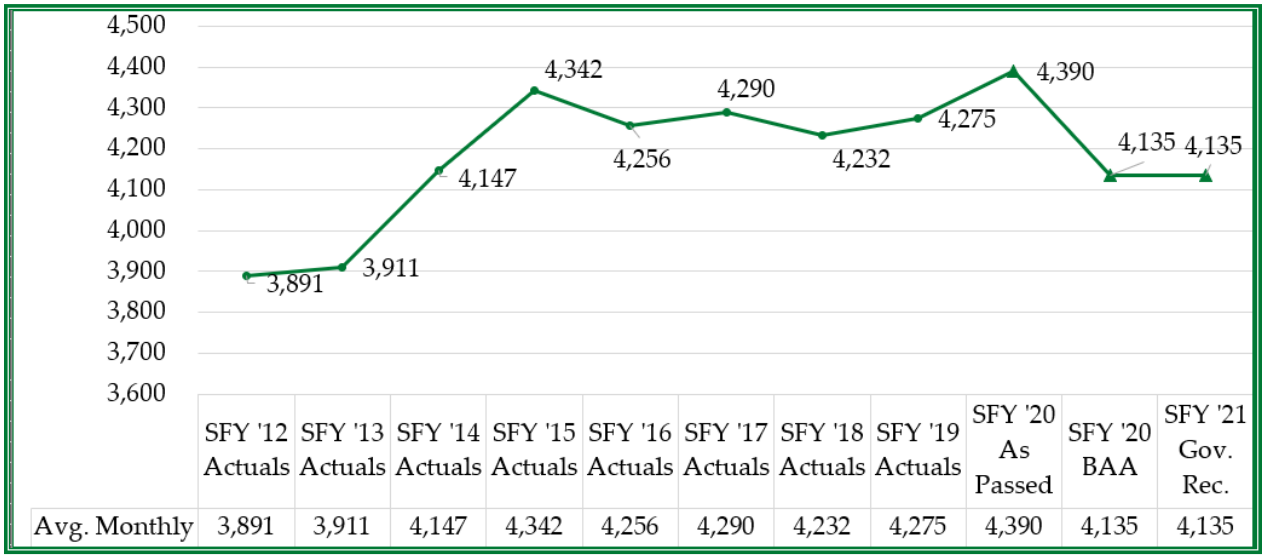
DVHA is responsible for other Medicaid state plan benefits for this population.

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

Choices for Care - Acute			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	3,891	$ 21,310,228	$456.40
SFY 2013	3,911	$ 19,141,205	$407.85
SFY 2014	4,147	$ 21,395,135	$429.93
SFY 2015	4,342	$ 22,938,346	$440.24
SFY 2016	4,256	$ 25,743,198	$504.06
SFY 2017	4,290	$ 27,403,064	$532.31
SFY 2018	4,232	$ 26,947,522	$530.63
SFY 2019	4,275	$ 30,423,279	$593.05
SFY 2020 As Passed	4,390	$ 28,269,908	$536.63
SFY 2020 BAA	4,135	$ 29,451,020	$592.94
SFY 2021 Gov. Rec.	4,135	$ 29,703,413	$592.70

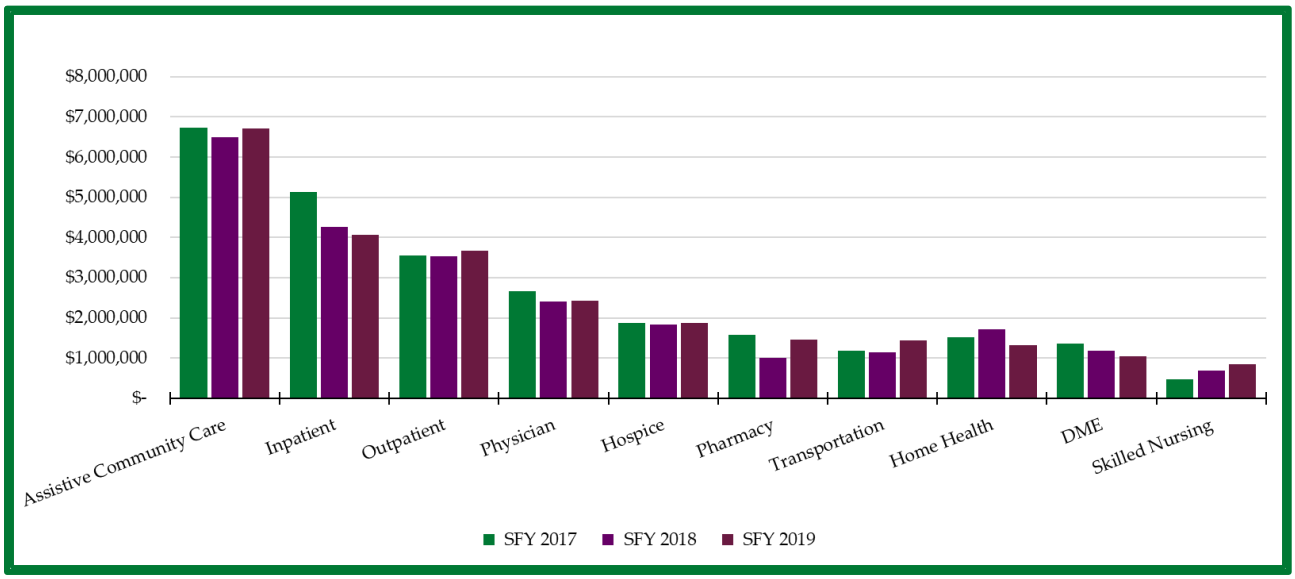
Choices for Care Acute Cont.

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	3,891	3,911	4,147	4,342	4,256	4,290	4,232	4,275	4,390	4,135	4,135

Top 10 Actual Expenditures by Category of Service



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:

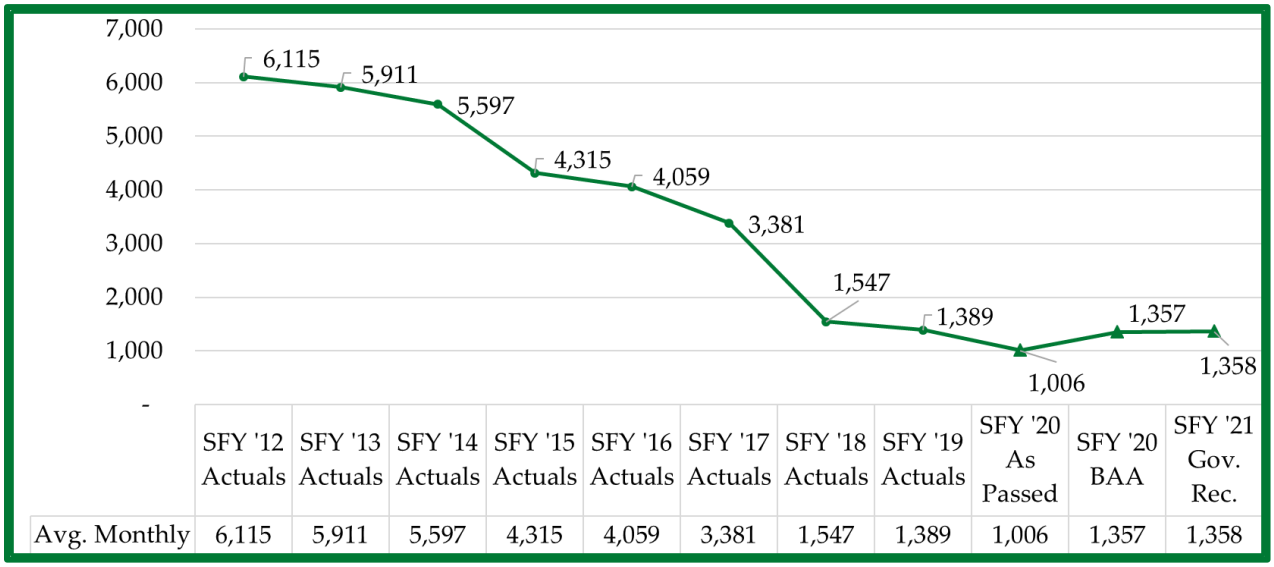
- Household incomes up to 350% and 400% FPL if they are aged or disabled.

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

Healthy Vermonters Program	
SFY	**Caseload**
SFY 2012	6,115
SFY 2013	5,911
SFY 2014	5,597
SFY 2015	4,315
SFY 2016	4,059
SFY 2017	3,381
SFY 2018	1,547
SFY 2019	1,389
SFY 2020 As Passed	1,006
SFY 2020 BAA	1,357
SFY 2021 Gov. Rec.	1,358

Healthy Vermonters Cont.

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	6,115	5,911	5,597	4,315	4,059	3,381	1,547	1,389	1,006	1,357	1,358

Premium Assistance and Cost-Sharing

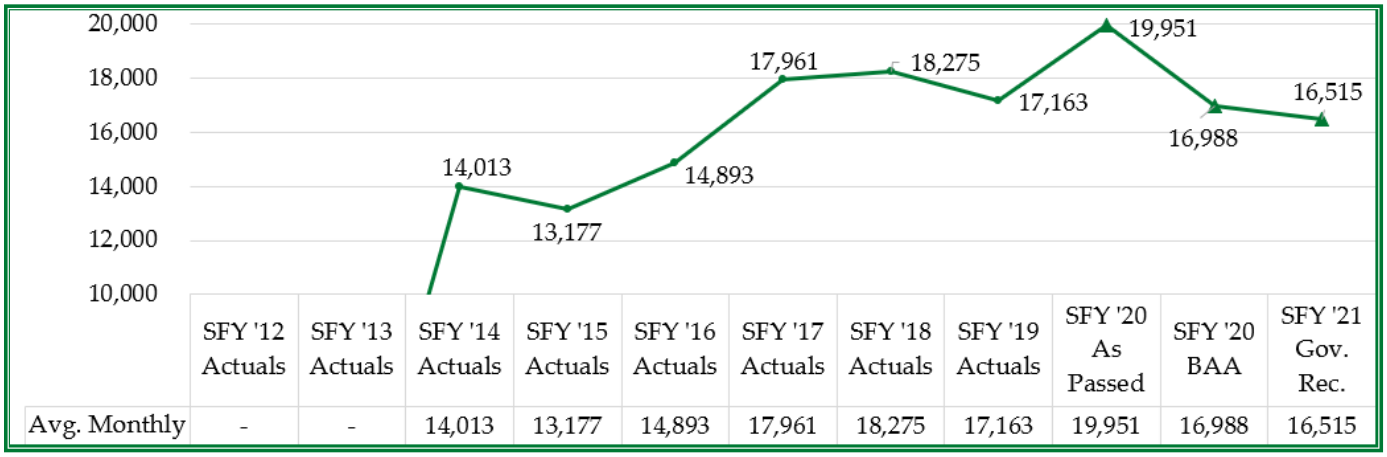
Individuals may choose to enroll in qualified health plans purchased on Vermont's state-based health insurance exchange. These plans have varying cost-sharing and premium levels. Federal tax credits make premiums more affordable for people with incomes at and less than 400% of FPG who are not eligible for other coverage and additional federal subsidies make out of pocket expenses more affordable for people with incomes at/below 250% FPG. Despite these federal tax credits and cost-sharing subsidies provided by the Affordable Care Act, coverage through these QHPs will be less affordable than Vermonters had previously experienced under 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 FPG to address this affordability challenge.

Premium Assistance and Cost-Sharing Cont.

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

Premium Assistance for Exchange Enrollees < 300%			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	-	$ -	$ -
SFY 2013	-	$ -	$ -
SFY 2014	14,013	$ 2,571,477	$ 15.29
SFY 2015	13,177	$ 5,611,465	$ 35.49
SFY 2016	14,893	$ 5,266,242	$ 29.47
SFY 2017	17,961	$ 6,100,378	$ 28.30
SFY 2018	18,275	$ 6,334,440	$ 28.88
SFY 2019	17,163	$ 5,941,367	$ 28.85
SFY 2020 As Passed	19,951	$ 6,914,219	$ 28.88
SFY 2020 BAA	16,988	$ 5,986,200	$ 29.36
SFY 2021 Gov. Rec.	16,515	$ 5,819,526	$ 29.36

Premium Assistance Average Monthly Caseload Actuals Comparison by SFY

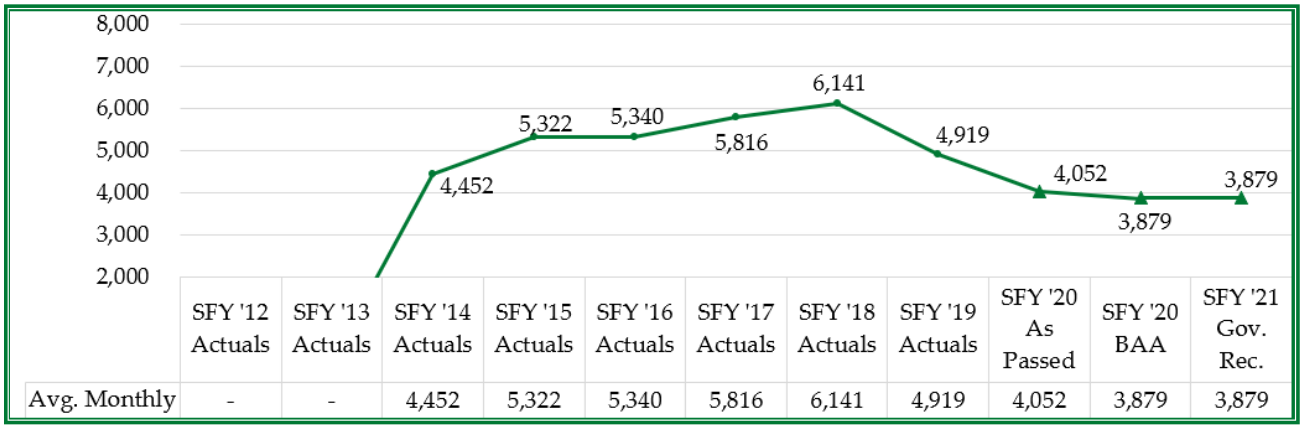


Premium Assistance and Cost-Sharing Cont.

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

Cost Sharing for Exchange Enrollees < 300%			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	-	$ -	$ -
SFY 2013	-	$ -	$ -
SFY 2014	4,452	$ 332,623	$ 6.23
SFY 2015	5,322	$ 1,138,775	$ 17.83
SFY 2016	5,340	$ 1,186,720	$ 18.52
SFY 2017	5,816	$ 1,355,318	$ 19.42
SFY 2018	6,141	$ 1,570,896	$ 21.32
SFY 2019	4,919	$ 1,482,370	$ 25.11
SFY 2020 As Passed	4,052	$ 1,314,872	$ 27.04
SFY 2020 BAA	3,879	$ 1,355,401	$ 29.12
SFY 2021 Gov. Rec.	3,879	$ 1,355,401	$ 29.12

Cost-Sharing Average Monthly Caseload Actuals Comparison by SFY



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

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

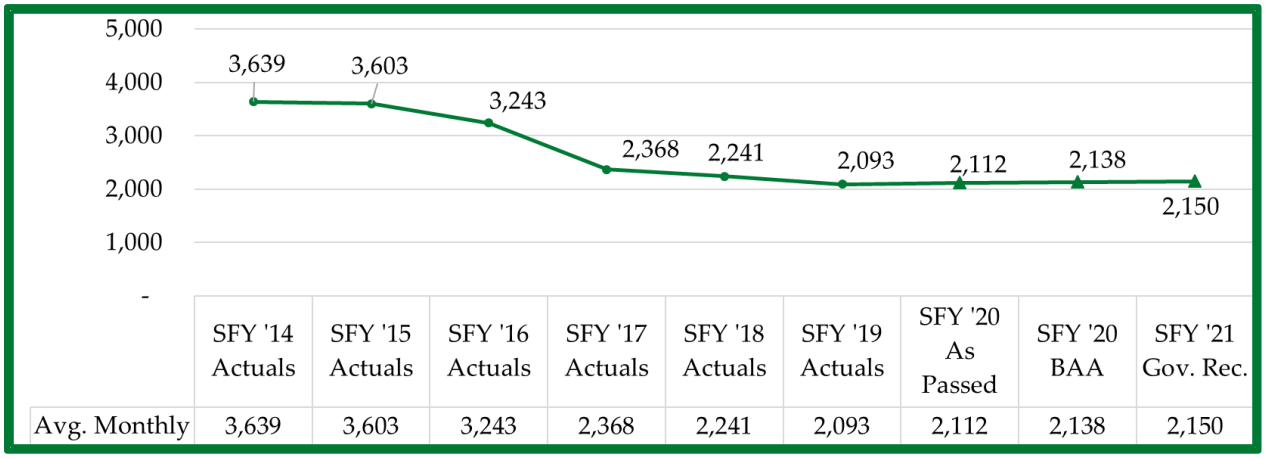
- Age cap of 19 years, unless eligible for a special exception
- Blind or disabled status as determined by the Federal Social Security Administration, or the State
- Supplemental Security Income (SSI) cash assistance recipients
- Hospice patients
- Those eligible under "Katie Beckett" rules
- Medically needy Vermonters:
    - o Children whose household income is greater than the cash assistance level but less than the PIL
    - o Medically needy children may or may not be blind or disabled

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

Blind or Disabled (ABD) and/or Medically Needy			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	3,712	$ 33,805,689	$758.93
SFY 2013	3,701	$ 29,686,264	$668.43
SFY 2014	3,639	$ 34,773,495	$796.32
SFY 2015	3,603	$ 30,213,622	$698.81
SFY 2016	3,243	$ 26,666,864	$685.24
SFY 2017	2,368	$ 22,608,139	$795.61
SFY 2018	2,241	$ 19,728,813	$733.63
SFY 2019	2,093	$ 20,956,833	$834.40
SFY 2020 As Passed	2,112	$ 19,287,093	$761.01
SFY 2020 BAA	2,138	$ 21,511,798	$863.15
SFY 2021 Gov. Rec.	2,150	$ 22,188,693	$855.50

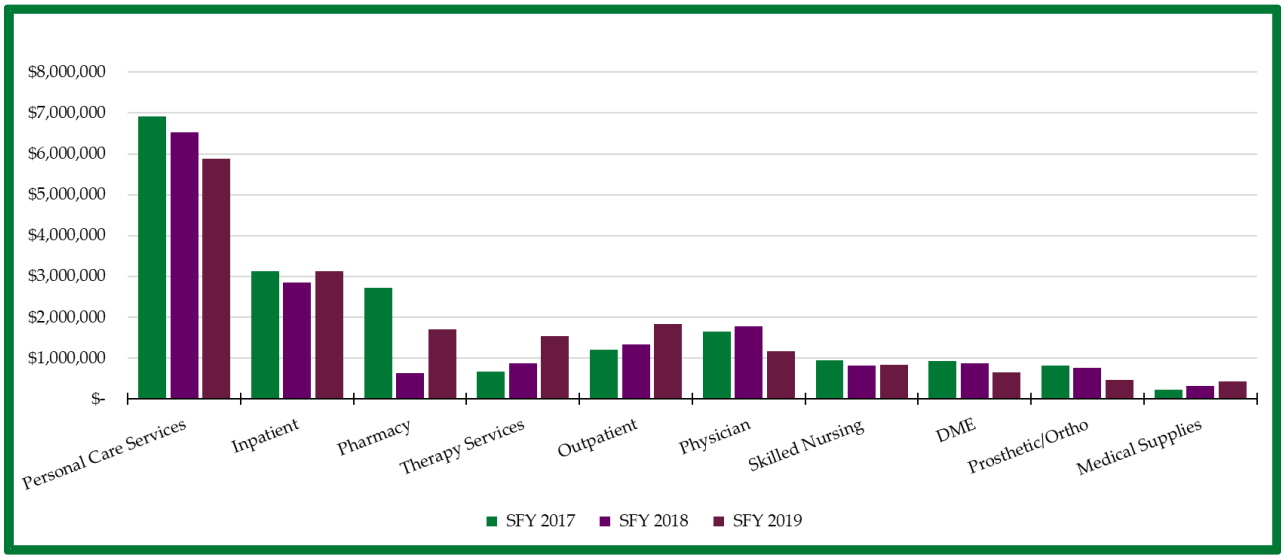
Blind or Disabled (BD) and/or Medically Needy Children Cont.

BD Child Average Monthly Caseload Actuals Comparison by SFY



	SFY '14 Actuals	SFY '15 Actuals	SFY '16 Actuals	SFY '17 Actuals	SFY '18 Actuals	SFY '19 Actuals	SFY '20 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	3,639	3,603	3,243	2,368	2,241	2,093	2,112	2,138	2,150

Top 10 Actual Expenditures by Category of Service



General Children

The eligibility requirements for General Children are as follows:

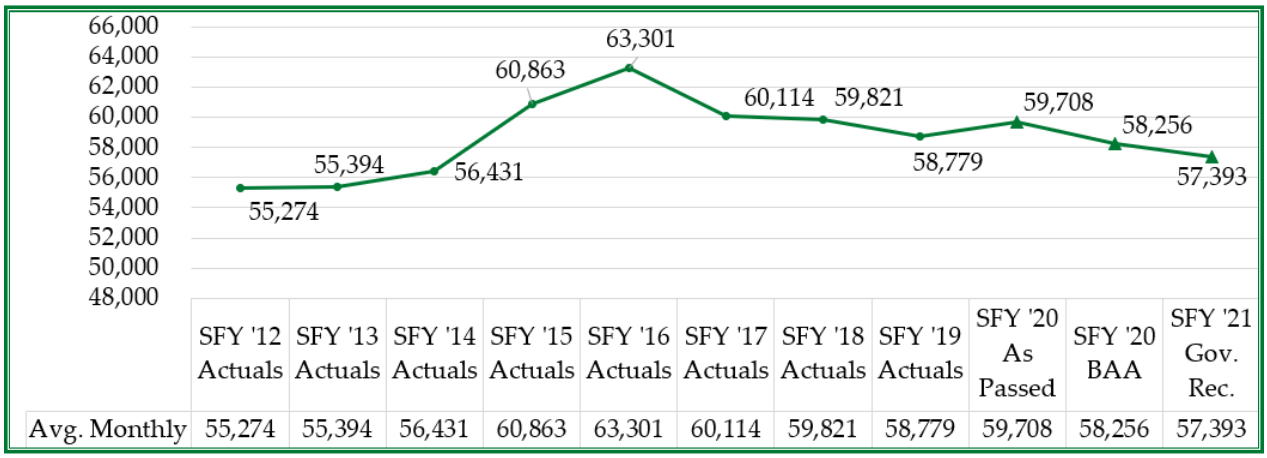
- Age 18 and younger
- Income below the PIL
- Categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

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

General Children			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	55,274	$117,381,607	$176.97
SFY 2013	55,394	$ 118,845,688	$178.79
SFY 2014	56,431	$124,794,841	$184.29
SFY 2015	60,863	$ 136,620,315	$187.06
SFY 2016	63,301	$ 144,588,204	$190.34
SFY 2017	60,114	$ 146,114,183	$202.55
SFY 2018	59,821	$ 148,830,755	$207.33
SFY 2019	58,779	$ 158,649,068	$224.92
SFY 2020 As Passed	59,708	$ 150,490,908	$210.04
SFY 2020 BAA	58,256	$ 157,862,953	$226.97
SFY 2021 Gov. Rec.	57,393	$ 156,312,500	$226.00

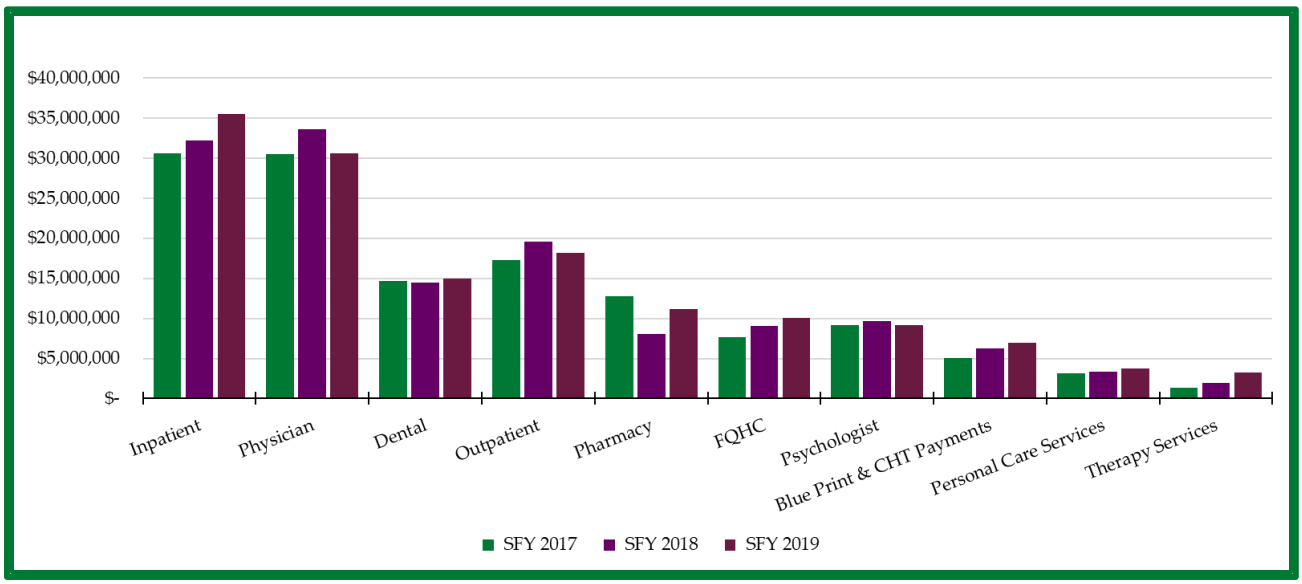
General Children Cont.

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 As Passed	SFY '20 BAA	SFY '21 Gov. Rec.
Avg. Monthly	55,274	55,394	56,431	60,863	63,301	60,114	59,821	58,779	59,708	58,256	57,393

Top 10 Actual Expenditures by Category of Service



Optional Benefit (Underinsured) Children

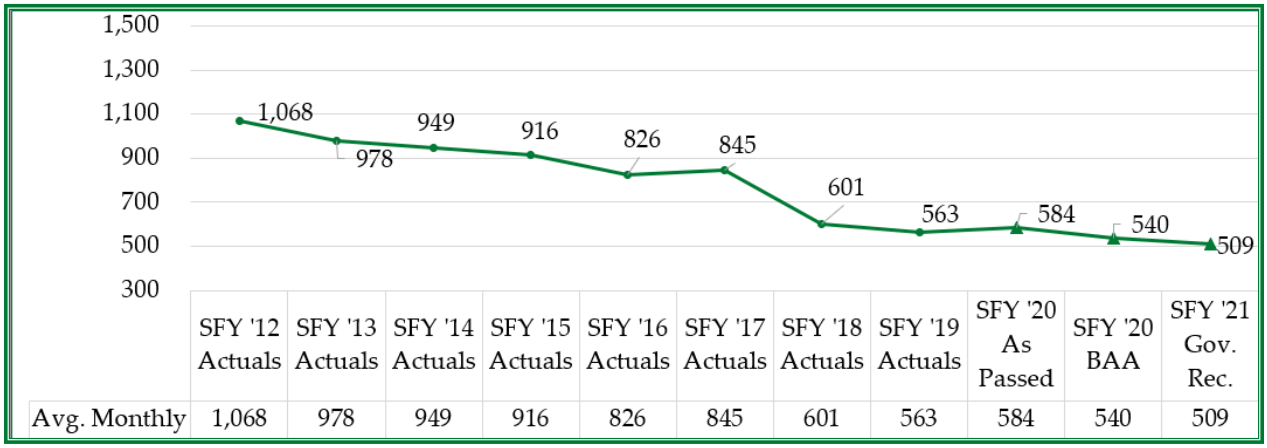
This program was designed as part of the original 1115 Waiver to Title XIX of the Social Security Act to provide healthcare coverage for children who would otherwise be underinsured.
The general eligibility requirements for Underinsured Children are as follows:

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

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

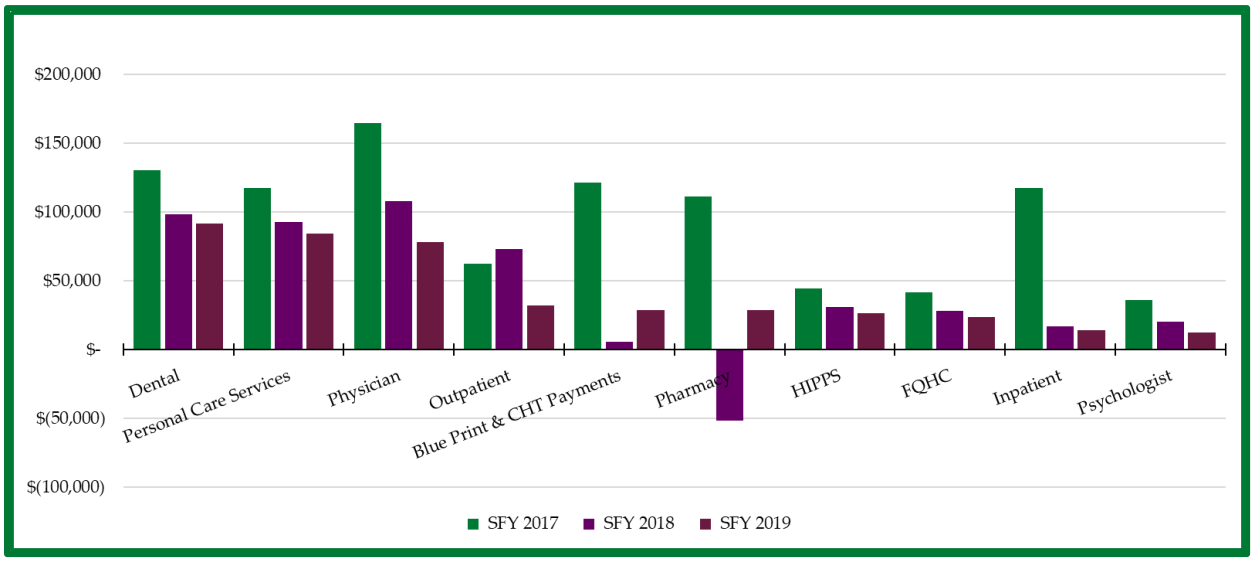
Optional Benefit Children			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	1,068	$ 766,013	$ 59.77
SFY 2013	978	$ 716,036	$ 61.01
SFY 2014	949	$ 1,022,310	$ 89.77
SFY 2015	916	$ 1,216,320	$ 110.66
SFY 2016	826	$ 1,156,393	$ 116.67
SFY 2017	845	$ 1,053,645	$ 103.91
SFY 2018	601	$ 484,934	$ 67.24
SFY 2019	563	$ 448,836	$ 66.44
SFY 2020 As Passed	584	$ 490,900	$ 70.05
SFY 2020 BAA	540	$ 436,196	$ 67.52
SFY 2021 Gov. Rec.	509	$ 412,421	$ 67.23

Average Monthly Caseload Actuals Comparison by SFY



Optional Benefit (Underinsured) Children Cont.

Top 10 Actual Expenditures by Category of Service



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:

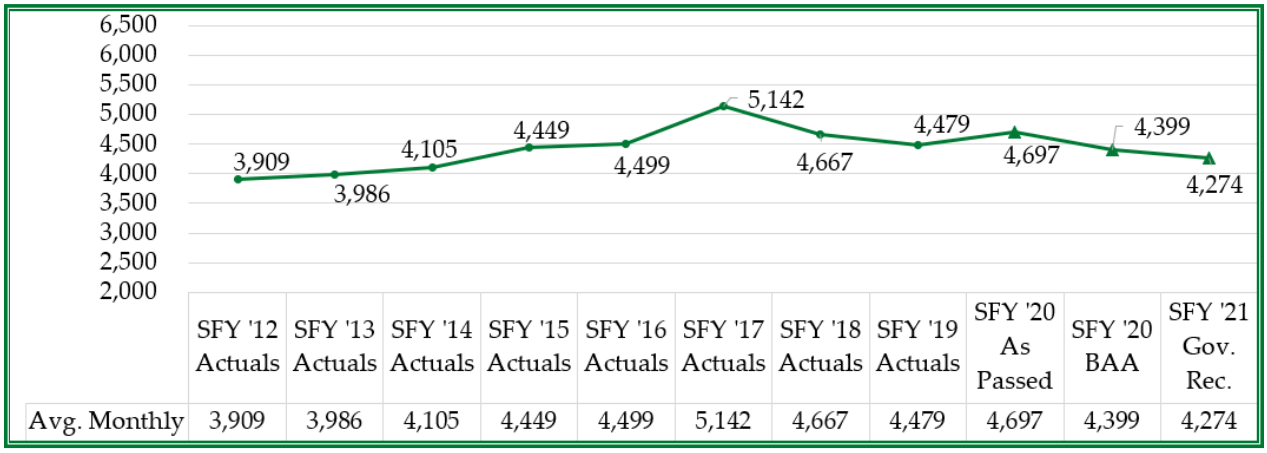
- Age 18 and younger
- Income up to 312% FPL
- Uninsured

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

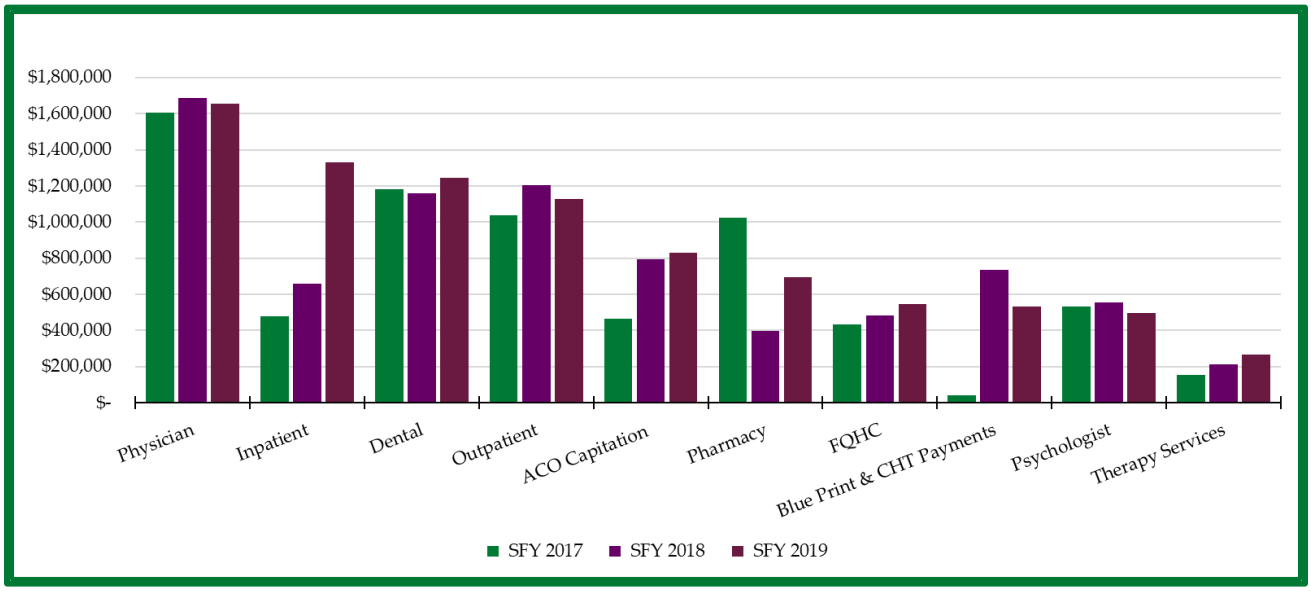
CHIP (Uninsured)			
SFY	**Caseload**	**Expenditures**	**PMPM**
SFY 2012	3,909	$ 6,873,629	$146.53
SFY 2013	3,986	$ 7,279,703	$152.19
SFY 2014	4,105	$ 7,465,861	$151.56
SFY 2015	4,449	$ 7,471,592	$139.95
SFY 2016	4,499	$ 7,025,792	$130.14
SFY 2017	5,142	$ 7,893,710	$127.93
SFY 2018	4,667	$ 8,323,354	$148.62
SFY 2019	4,479	$ 9,234,963	$171.82
SFY 2020 As Passed	4,697	$ 8,439,212	$149.73
SFY 2020 BAA	4,399	$ 9,304,698	$177.42
SFY 2021 Gov. Rec.	4,274	$ 8,582,146	$167.32

Children's Health Insurance Program (CHIP) Cont.

Average Monthly Caseload Actuals Comparison by SFY



Top 10 Actual Expenditures by Category of Service

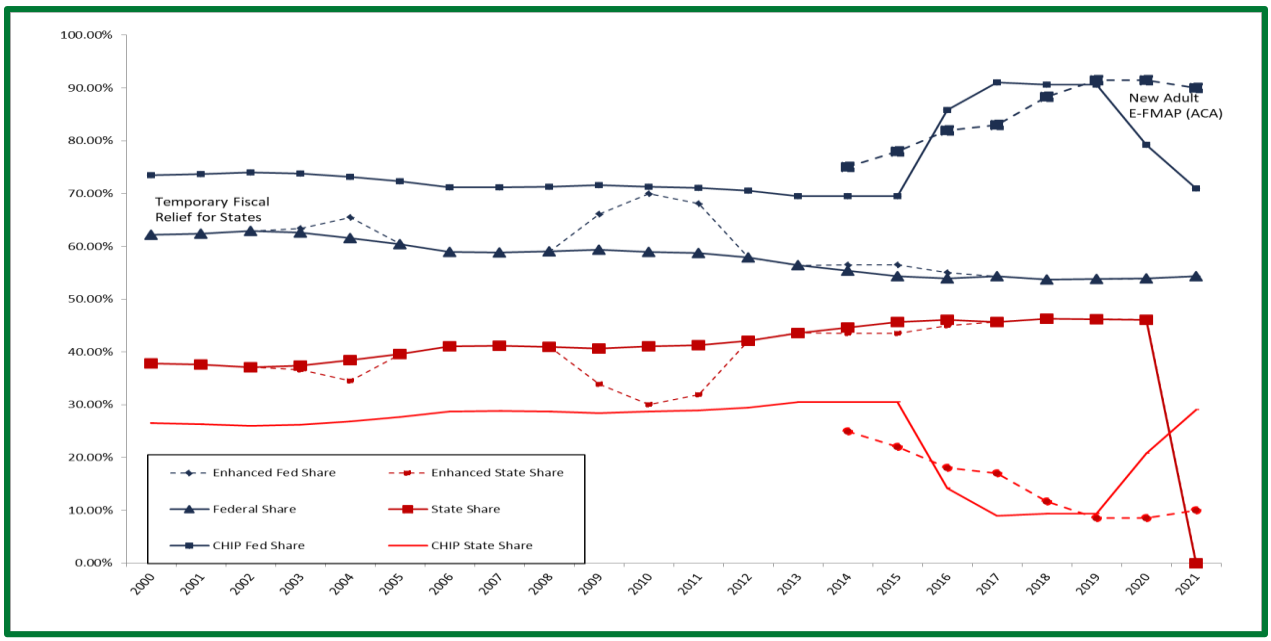


Inpatient costs grew disportionate to enrollment changes primarily driven by a small number of newborn intensive care cases.

Federal Medicaid Assistance Percentage (FMAP)

The FMAP is the share of state Medicaid benefit costs paid by the federal government. The U.S. Dept. of Health and Human Services calculates the FMAPs each year, based on a three-year average of state per capita personal income compared to the national average. States can't receive less than 50% or more than 83% federal match, except for "enhanced FMAPs" for expansion populations under the ACA and for the Children's Health Insurance Program (CHIP).

Vermont Medicaid & CHIP, SFY 2000 - 2021



Vermont Medicaid & CHIP Detail, SFY 2019 – 2021

FEDERAL MATCH RATES
Fiscal Years 2019 to 2021

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

Federal Fiscal Year							State Fiscal Year						
FFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share	SFY	From	To	Federal Share w/o hold harmless	e-FMAP	Total Federal Share	State Share
2019	10/01/18	09/30/19	53.89%		53.89%	46.11%	2019	7/1/2018	6/30/2019	53.79%		53.79%	46.21%
2020	10/01/19	09/30/20	53.86%		53.86%	46.14%	2020	7/1/2019	6/30/2020	53.87%		53.87%	46.13%
2021	10/01/20	09/30/21	54.57%		54.57%	45.43%	2021	7/1/2020	6/30/2021	54.39%		54.39%	45.61%

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

Federal Fiscal Year							State Fiscal Year						
FFY	From	To	Federal Share	e-FMAP	Total Federal Share	State Share	SFY	From	To	Federal Share	e-FMAP	Total Federal Share	Share
2019	10/1/2018	09/30/19	67.72%	23.00%	90.72%	9.28%	2019	7/1/2018	6/30/2019	67.65%	23.00%	90.65%	9.35%
2020	10/1/2019	09/30/20	67.70%	11.50%	79.20%	20.80%	2020	7/1/2019	6/30/2020	67.71%	14.38%	82.08%	17.92%
2021	10/1/2020	09/30/21	68.20%	0.00%	68.20%	31.80%	2021	7/1/2020	6/30/2021	68.08%	2.88%	70.95%	29.05%

The Affordable Care Act allowed for a 23% enhanced FMAP for the CHIP population through September 2019. That enhancement tapers to 11.50% through September 2020, and then ends as of October 1, 2020.

Program Profile Reporting A1

Department of Vermont Health Access		Financial Info					
Programs	**Financial Category**	**GF $$**	**Spec F (incl tobacco) $$**	**Fed F $$**	**All other funds $$**	**Total funds $$**	**Authorized Positions (if available)**
Adoption of Value Based Payments: Promote an Integrated System of Care							
Promote an Integrated System of Care by: - Measuring provider participation level in the ACO network by provider type. - Number of unduplicated ACO attributed members receiving out of network care. - Measure the coordination of care within the network	FY 2019 Actual expenditures	$ 331,865.62	$ 140,000.00	$ 1,331,865.62	$ 3,800,000.00	$ 5,603,731.24	8
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 338,502.93	$ 140,000.00	$ 1,598,502.93	$ 5,705,019.00	$ 7,782,024.86	8
	FY 2021 Budget Request for Governor's Recommendation	$ 345,272.99	$ 140,000.00	$ 1,605,272.99	$ -	$ 2,090,545.98	8
Management of Information Technology Projects: Deliver On Schedule and On Budget							
Delivery on Schedule and On Budget: - % DVHA priority IT project on schedule. - % of DVHA priority IT projects re-baselined during the quarter. - Expected vs. actuals total cost of DVHA priority IT projects	FY 2019 Actual expenditures	$ 6,888,084.91	$ 376,043.21	$ 41,163,392.67	$ -	$ 48,427,520.79	28
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 7,934,069.01	$ 376,043.21	$ 47,090,635.94	$ -	$ 55,400,748.17	28
	FY 2021 Budget Request for Governor's Recommendation	$ 6,362,867.34	$ 376,043.21	$ 38,187,159.80	$ 4,382,636.00	$ 49,308,706.35	28

Program Profile Reporting A1 Cont.

Department of Vermont Health Access		Financial Info					
Programs	**Financial Category**	**GF $$**	**Spec F (incl tobacco) $$**	**Fed F $$**	**All other funds $$**	**Total funds $$**	**Authorized Positions (if available)**
Medicaid Inpatient Psychiatric and Detoxification Utilization							
- Average length of stay (LOS) for DVHA inpatient mental health & detox admissions. - % of DVHA inpatient mental health and detox admission with a reconsideration review request	FY 2019 Actual expenditures	$ 456,046.23		$ 436,079.77	$ 18,455,703.60	$ 19,347,829.60	9
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 483,250.93		$ 505,377.18	$ 8,622,880.00	$ 9,611,508.11	9
	FY 2021 Budget Request for Governor's Recommendation	$ 494,365.32		$ 472,721.19	$ 8,622,880.00	$ 9,589,966.51	9
Blueprint for Health							
- # of primary care practices participating in the Blueprint. - of patients served by patient-centered medical homes (PCMHs)	FY 2019 Actual expenditures	$ 701,341.26		$ 701,341.26	$ 17,688,796.34	$ 19,091,478.85	9
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 1,050,614.39		$ 1,050,614.39	$ 18,298,818.88	$ 20,400,047.66	9
	FY 2021 Budget Request for Governor's Recommendation	$ 1,001,401.65		$ 1,001,401.65	$ 17,787,698.12	$ 19,790,501.41	9
Medicaid's Vermont Chronic Care Initiative (VCCI)							
- # new VCCI eligible members enrolled in care management - % of VCCI enrolled members with a face to face visit during the month - % "New to Medicaid" members who accepted help with PCP establishment and who successfully established care with practice/medical home	FY 2019 Actual expenditures	$ 431,074.06	$ -	$ 444,558.80	$ -	$ 875,632.86	25
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 3,161,915.82	$ -	$ 3,260,826.05	$ -	$ 6,422,741.87	25
	FY 2021 Budget Request for Governor's Recommendation	$ 2,824,866.03	$ -	$ 2,913,232.75	$ -	$ 5,738,098.78	25

Program Profile Reporting A1 Cont.

Department of Vermont Health Access		Financial Info					
Programs	**Financial Category**	**GF $$**	**Spec F (incl tobacco) $$**	**Fed F $$**	**All other funds $$**	**Total funds $$**	**Authorized Positions (if available)**
All Other Medicaid Admin							
Medicaid Administration	FY 2019 Actual expenditures	$ 22,038,357.93	$ 3,692,318.79	$ 37,052,569.88	$ 1,833,870.55	$ 64,617,117.15	311
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 26,012,638.74	$ 5,580,064.79	$ 74,591,711.44	$ -	$ 106,184,414.96	306
	FY 2021 Budget Request for Governor's Recommendation	$ 20,320,246.67	$ 2,863,435.79	$ 74,780,237.62	$ -	$ 97,963,920.08	306
All Other Medicaid Program							
Medicaid & CHIP Other Program, including Global Commitment Medicaid Investments VPHARM CHIP and other Non-Waiver Services	FY 2019 Actual expenditures	$ 52,358,324.00	$ -	$ 21,583,851.00	$926,602,748.51	$1,000,544,923.51	0
	FY 2020 estimated expenditures (including requested budget adjustments)	$ 49,746,894.00	$ -	$ 21,156,815.00	$ 936,256,847.12	$1,007,160,556.12	0
	FY 2021 Budget Request for Governor's Recommendation	$ 55,498,368.00	$ -	$ 19,839,480.00	$ 701,948,935.88	$ 777,286,783.88	0
	FY 2019 Actuals	**$ 83,205,094.00**	**$ 4,208,362.00**	**$ 102,713,659.00**	**$ 968,381,119.00**	**$1,158,508,234.00**	**390**
	FY 2020 Estimated	**$ 88,727,885.82**	**$ 6,096,108.00**	**$ 149,254,482.93**	**$ 968,883,565.00**	**$1,212,962,041.75**	**385**
	FY 2021 Budget Request	**$ 86,847,388.00**	**$ 3,379,479.00**	**$ 138,799,506.00**	**$ 732,742,150.00**	**$ 961,768,523.00**	**385**
	FY21 Targets	$ 86,847,388.00	$ 3,379,479.00	$ 138,799,506.00	$ 732,742,150.00	$ 961,768,523.00	**385**
	Difference	$ -	$ -	$ -	$ -	$ -	**0**

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Program Profile Reporting A2

DVHA is submitting Scorecards in leu of Program Profile Reporting A2.

APPENDIX A: PERFORMANCE ACCOUNTABILITY SCORECARDS

1. ENROLL MEMBERS

Health Access Eligibility & Enrollment Unit

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

THE TOP PRIORITIES/INITIATIVES FOR HAEEU IN SFY19 WERE:

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

2) Advance several Integrated Eligibility and Enrollment projects, including an online application, a customer portal that will allow Vermonters to apply online for benefits electronically, and reconfiguring and developing existing systems to return premium billing to the carriers.

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

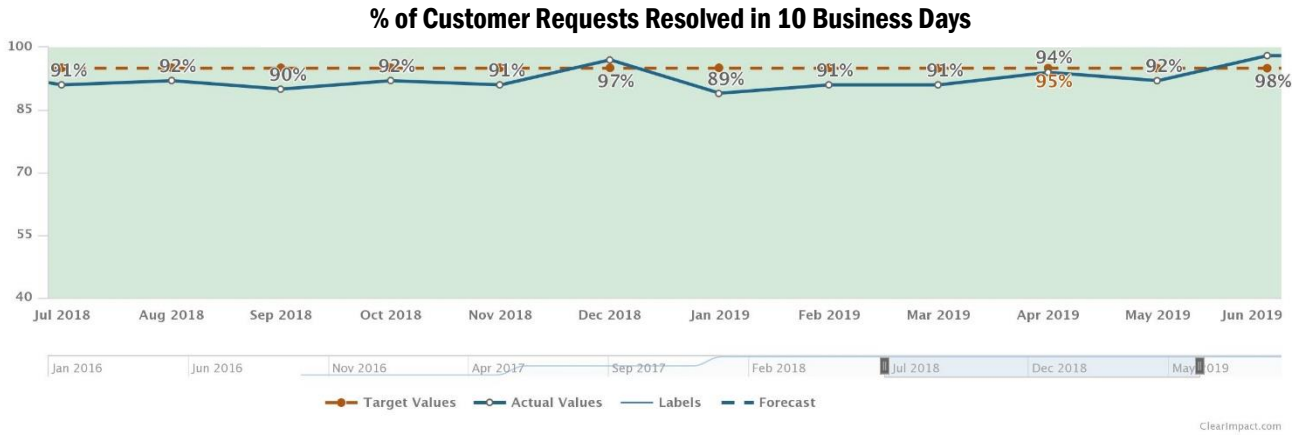
BUSINESS INSIGHTS FOR SFY19:

A commitment to continuous quality improvement has been adopted and the tracking of performance metrics has helped the Unit identify necessary process and system improvements. This commitment, monitoring of performance, and collaboration across all teams in the Unit has resulted in improvement in customer service (the percent of calls answered within 24 seconds & the percentage of customer requests resolved in 10 business days) and operational processes (e.g. reducing the number of integration errors between Vermont's state-based exchange and its commercial insurance carrier partners). In addition, the Unit has been contributing to the Priority Scorecard for its IE&E information technology projects to monitor whether the projects remain on schedule. For state fiscal year 2020, the Unit will remain focused on operational excellence.

Accomplishments

The Unit completed its first and second Integrated Eligibility and Enrollment projects, the health care paper application and Enterprise Content Management in 2019, and successfully renewed 99% of qualified health plan enrollees ahead of Open Enrollment.

Callers to the State's Customer Support Center continue to experience prompt service overall. At the beginning of calendar year 2019, call wait times improved back to previous levels such that **84% of calls are answered within 24 seconds, well above the target of 75%.** DVHA has been working with the contracted call center, Maximus, to increase staff to avoid the long wait times that occurred during calendar year 2018 Open Enrollment, which is the notable decrease observed in the graph above.



After years of continuous quality improvement, the Health Access Eligibility and Enrollment unit now consistently completes more than 90% of customer requests within ten business days. In fact, at the close of the state fiscal year, this measure was at 98%. The Unit also assesses delayed cases with regularity to identify root causes and improve the processes.

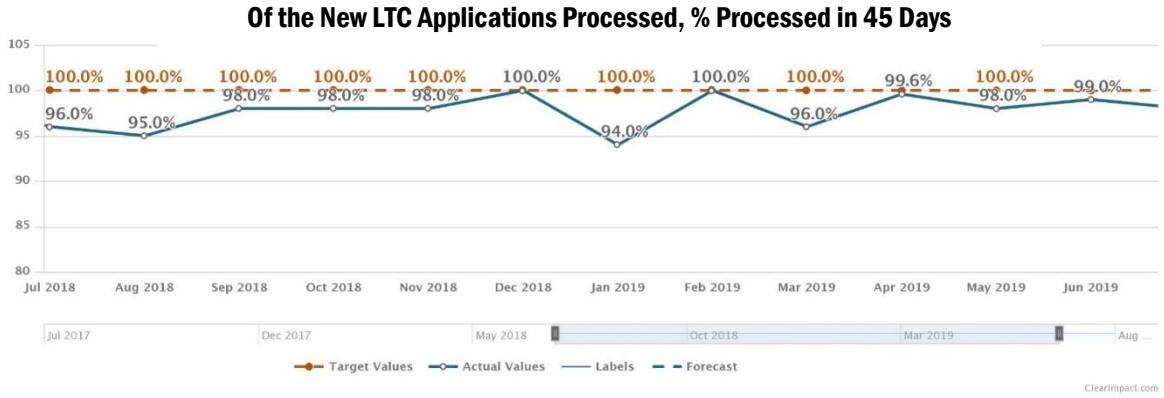
Long-Term Care Unit

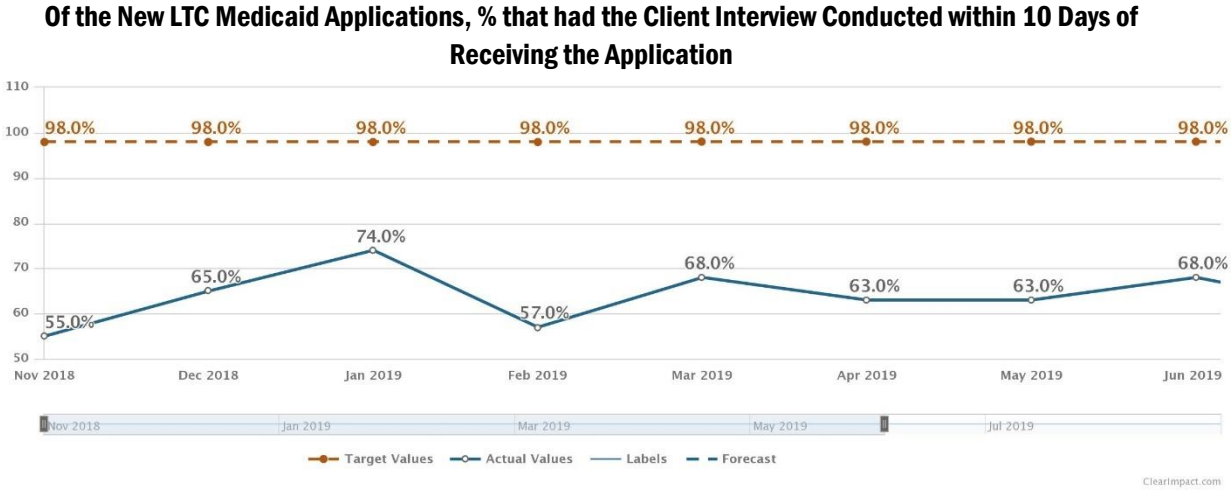
Vermont's Long-Term Care program includes Choices for Care, Developmental Disability Services, Developmental Disability Home- and Community-based Services, Traumatic Brain Injury, and Enhanced Family Treatment. The Long-Term Care unit assists eligible Vermonters with accessing services in their chosen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

THE TOP PRIORITIES/INITIATIVES FOR LTC IN SFY19 WERE:

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

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





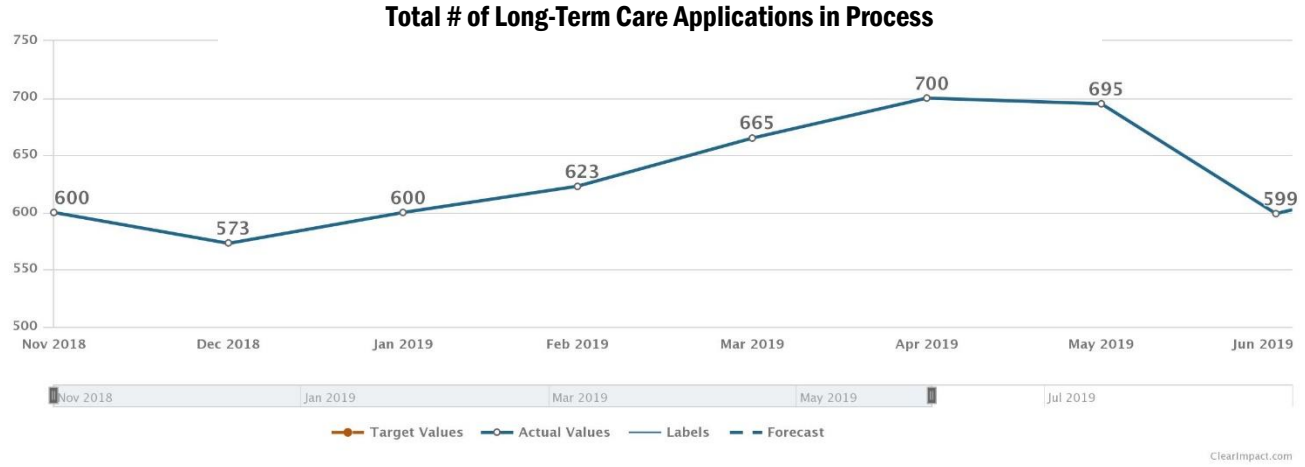
BUSINESS INSIGHTS FOR SFY19:

Accomplishments

Federal requirements establish a timeliness standard for processing long-term care applications (within 45-days) and staff must evaluate the income, resources, financial statements, and transfers of income/resources within the 60 months prior to the month of application for each applicant. Despite vacancies, medical leaves, temporary staffing and other under-staffing issues, the Long-Term Care unit performed relatively well on key performance indicators for state fiscal year 2019.

Challenges

The following table shows the observed trend of the increasing number of LTC applications worked on by DVHA's staff in recent months. As the Vermont population ages, this increased workload is expected to continue. In addition, the number of applications in process is impacted by the complexity of the cases; staff have observed that individual cases are also generally more complicated, requiring additional staff time to process.



2. PAY FOR CARE

Clinical Operations Unit

The Clinical Operations unit monitors the quality, appropriateness and effectiveness of health care services for Medicaid members. Prior authorization is a process used to assure appropriate use of health care services and that services are medically necessary and effective for the medical needs of the member. Clinical Operations staff must issue a notice of decision within 3 days of receipt of a prior authorization

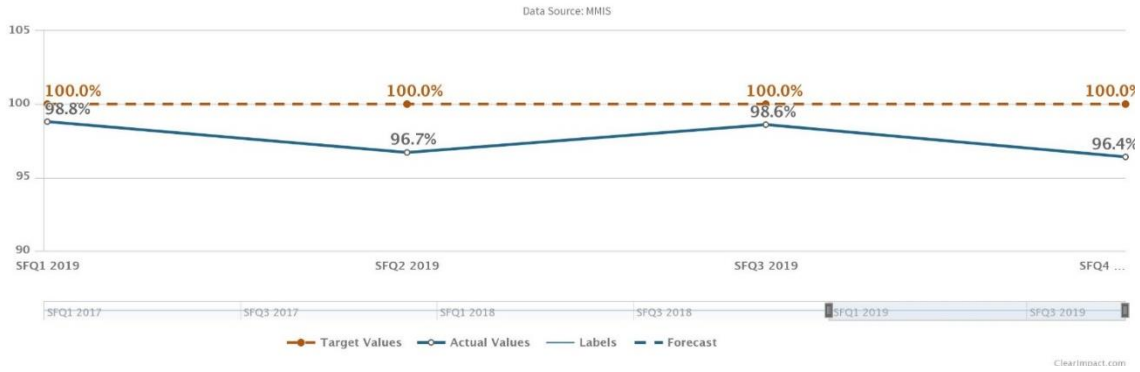
request containing all necessary information and the longest time allowable for a decision is 28 days (if the 14-day extension is employed).[1]

THE TOP PRIORITIES/INITIATIVES FOR THE CLINICAL UNIT IN SFY19 WERE:

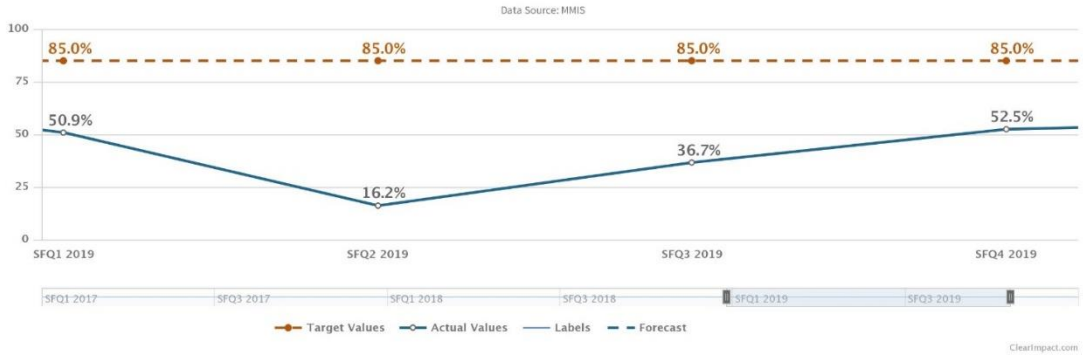
1) Improving the transition for Medicaid providers and beneficiaries into the ACO model (determination of PA requirements, development of forms, provider education) and assuring appropriate use, medical necessity, and effectiveness of health care services for Medicaid members in a timely manner.

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

% of Initial Prior Authorization Requests Closed Out within 28 Days



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



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

BUSINESS INSIGHTS FOR SFY19:

In state fiscal year 2019, the Unit implemented a new, fully electronic process on the OnBase system. The new system enhances efficiency in the processing prior authorizations.

Accomplishments

Payer clinical collaboration is a new focus for the Clinical Operations unit. The Unit is leading a dialogue with OneCare Vermont and Blue Cross Blue Shield to support the clinical intersection of payers within an ACO care model. Additionally, in the past, the Unit did concurrent reviews on in-network inpatient admissions after 13 days. It was determined that the hospital understood the correct process for billing inpatient stays, so one staff member's time will now be focused on developing a Medical Record Review program.

Challenges

Responding to, and redefining, the Unit's work and developing clinical workflows that address both current and future state.

Coordination of Benefits Unit

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

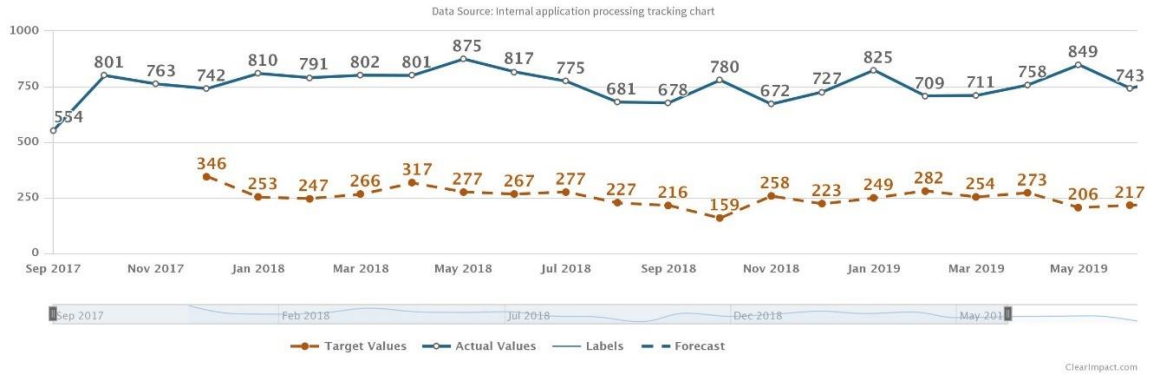
THE TOP PRIORITIES/INITIATIVES FOR THE COB UNIT IN SFY19 WERE:

1). Ensuring members are receiving all federal programs they are eligible for, including pharmaceutical assistance.

2). Improving the data matching process with insurers, resulting in increased collections as appropriate.

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

Number of VPharm Applications Processed & Referrals Handled Monthly by COB



BUSINESS INSIGHTS FOR SFY19:

The total number of VPharm applications (i.e., the 201P application) processed on a monthly basis by Coordination of Benefits unit staff captures information pertaining to eligibility for Vermont's pharmaceutical assistance program, VPharm, and is represented in the graph above by the solid, blue line. The number of case referrals addressed by the Coordination of Benefits unit provides additional information regarding the depth of responsibilities of staff related to prescription drug plans and is represented by the dotted, red line.

Additionally, foundational work was required throughout state fiscal year 2019 to ensure the success of automated data matching. The Coordination of Benefits unit is exploring options for a new system that establishes a data-matching relationship with the insurers and streamlines business processes through automation, workflow management, and document management. For state fiscal year 2020, the Unit will be cross-training staff to ensure all processes can be managed, onboarding two insurers, and assessing performance through an associated measure.

Accomplishments

The Coordination of Benefits unit collected $1,690,000 million dollars in state fiscal year 2019 by data-matching with BlueCross BlueShield of Vermont and collected $1,400,000 million dollars over the estimated collection projections.

MMIS Program Maintenance & Operations (M&O)

The Medicaid Management Information System (MMIS) Program Maintenance & Operations (M&O) Unit supports MMIS projects as they transition from Design, Development, and Implementation (DDI) to operations, establishes consistent operational standards across the MMIS Program, and provides compliance oversight and support for managing vendor performance.

THE TOP PRIORITIES/INITIATIVES FOR THE MMIS PROGRAM IN SFY19 WERE:

1. Completion of Care Management Implementation and Certification
2. Provider Management Module (PMM) Implementation
3. Business Objects Replacement
4. Payment and Delivery System (PADS) Implementations
5. Clinical Records Imaging (CRI) Conversion

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

Care Management Project

The Care Management project team focused on preparing for the CMS final certification review during state fiscal year 2019. The VITL-eQSuite® interface was successfully implemented and will be included in the software demonstration for CMS/MITRE. VCCI clinical staff were trained on how to use the new functionality in their care management workflow.

Provider Management Module

Data for the performance of the Provider Management Module was provided on page 54 of the Department's annual report (state fiscal year 2019), demonstrating the effectiveness of the Module for improving provider enrollment with the Vermont Medicaid program.

Coding Guidance

Discussions regarding coding review processes, roles and responsibilities are occurring with the Reimbursement and Clinical Operations units; respective roles in the reconsideration process have been determined. For state fiscal year 2020, the number of coding issues escalated to the MMIS coding team for review will be monitored.

Payment Reform Unit

The Payment Reform unit seeks to transition Vermont Medicaid's health care revenue model from fee-for-service payments to value-based payments with the goal of providing better, more efficient, coordinated care for Vermonters. In support of this goal, the Payment Reform unit partners with internal and external stakeholders in taking incremental steps toward the integrated healthcare system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services. The Payment Reform unit also works with providers and provider organizations in testing models, and ensures the models encourage higher quality of care and are supported by robust monitoring and evaluation plans.

THE TOP PRIORITIES/INITIATIVES FOR PAYMENT REFORM IN SFY19 WERE:

1) Continue to oversee the implementation, evaluation and evolution of the VMNG program.
2) Provide support to Department and Agency leadership in the consideration of, and planning for, any additional value-based payment reform models to support continued advancement toward an integrated healthcare system in Vermont.

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

BUSINESS INSIGHTS FOR SFY19:

The Payment Reform unit's measures in the DVHA Performance Accountability Scorecard relate to the Vermont Medicaid Next Generation program. The results indicate that provider participation and member attribution in Vermont Medicaid Next Generation program increased significantly from 2018 to 2019, the program's reporting deadlines were almost always met, the Accountable Care Organization (ACO) appears to see an increase in calls during the first month of the performance year (when new attribution takes effect), and financial targets appear to be stabilizing costs for the services included in Total Cost of Care calculations.

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

# of Medicaid Members per Month-prospective Payment Made to OneCare VT from DVHA

Although member attribution has increased significantly, DVHA leadership, the Payment Reform unit, and the Vermont Chronic Care Initiative are collaborating with the Accountable Care Organization (ACO) and the St. Johnsbury community to pilot a "geographic attribution" model, in which Medicaid members would be attributed to the ACO according to their place of residence rather than whether they have primary care claims. DVHA and the ACO are exploring the potential to expand this model statewide. The goal is to increase scale in the Medicaid component of the Vermont All-Payer ACO Model, and to provide an innovative model that the other major payers might also use to increase scale.

In addition to ongoing and successful operation of the VMNG program, the Payment Reform unit also facilitated successful design and implementation of three additional payment reform initiatives: the Mental Health Payment Reform Project with the Department of Mental Health, the Residential Substance Use Disorder Payment Reform Project with the Vermont Department of Health, and the

Applied Behavior Analysis Payment Reform Project with DVHA's Quality Improvement and Clinical Integrity Unit.

Pharmacy Unit

The Pharmacy unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefit programs. The Pharmacy unit oversees the contract with DVHA's pharmacy benefits administrator, Change Healthcare. The Pharmacy unit enforces coverage rules in compliance with federal and state laws and implements legislative and operational changes to the pharmacy benefit programs as needed.

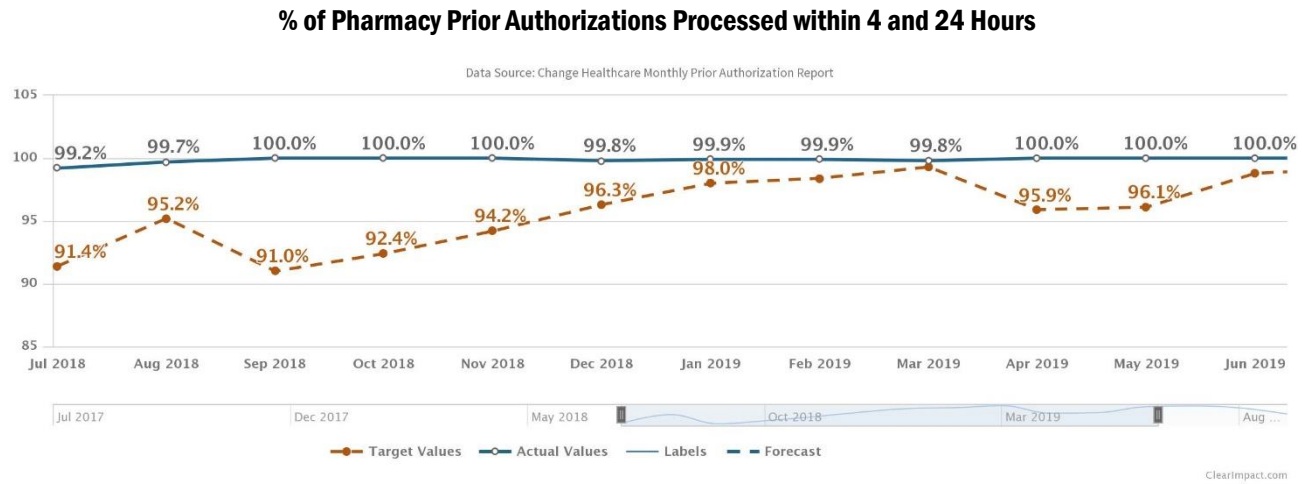
THE TOP PRIORITIES/INITIATIVES FOR THE PHARMACY UNIT IN SFY19 WERE:

1) Continue to manage high cost medications to encourage use of the most clinically appropriate drugs with the highest value for DVHA in the most efficient manner possible.
2) Promote value-based pharmacy programs such as Vermont pharmacists providing medication management services to DVHA members.
3) Based on a legislative reporting requirement, evaluate the drug supply chain for cost savings opportunities.

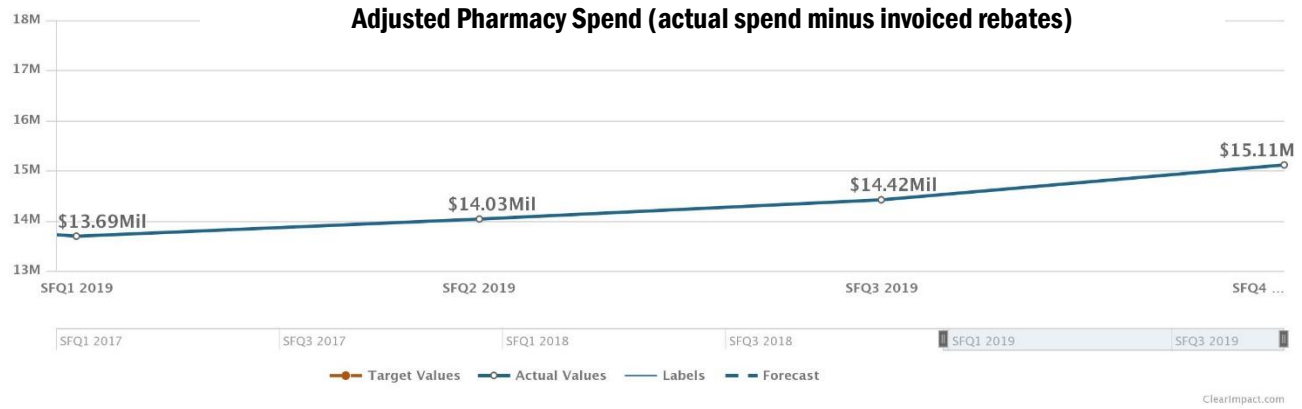
To see what we do, who we serve, how we impact, and our performance measures, see Pharmacy's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY19:

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



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



This measure tells the Unit that it is "on track" for net pharmacy drug spend. The Department receives approximately 60-65% of its drug spend back in the form of federal, state and supplemental rebates. If this trend line showed a significant deviation, drug details for the quarter would need to be evaluated to better understand what is driving such a change. The Pharmacy unit continues to monitor very high cost drugs which can move the trend line very quickly.

Provider Member Relations

The Provider and Member Relations unit assures members have access to appropriate health care for their physical health, mental health and dental health needs. Provider and Member Relations (PMR) strives to maximize members' choices for providers, facilitate connection with primary care providers for improved health and wellness and management of chronic disease for members, make certain that Vermonters do not have to travel too far to receive the care they need, and support providers in participating with Vermont Medicaid.

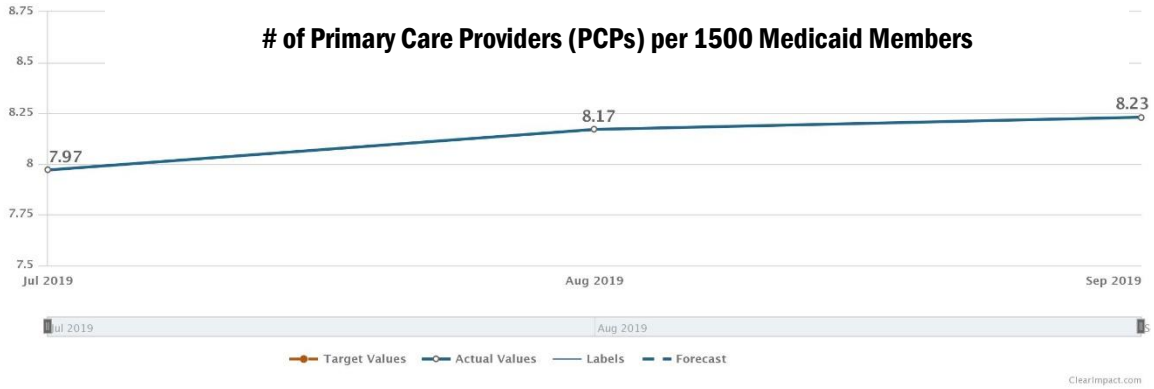
THE TOP PRIORITIES/INITIATIVES FOR THE PMR UNIT IN SFY19 WERE:

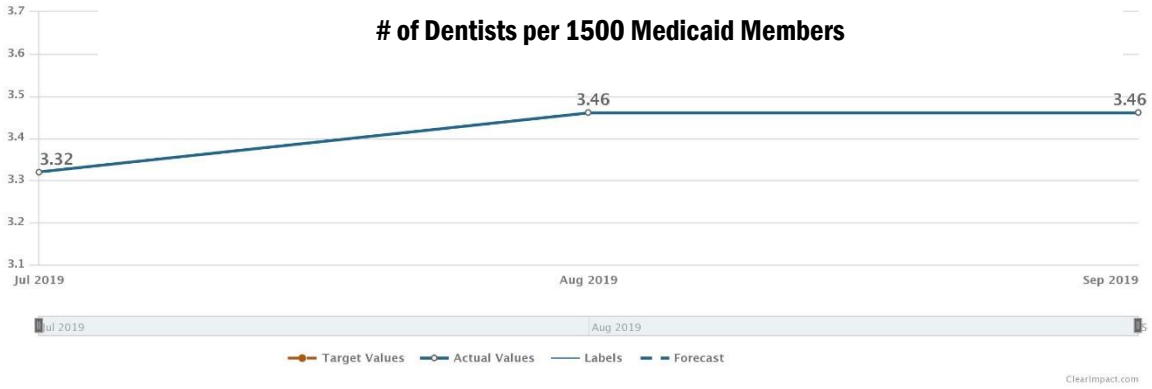
1) PMR is actively working on a Provider Management Module to ensure providers are enrolled or re-validated with Vermont Medicaid within 60 days.
2) PMR is actively working with the NEMT to ensure members are receiving all services afforded to them under the program by performing audits and collaborating with VPTA.

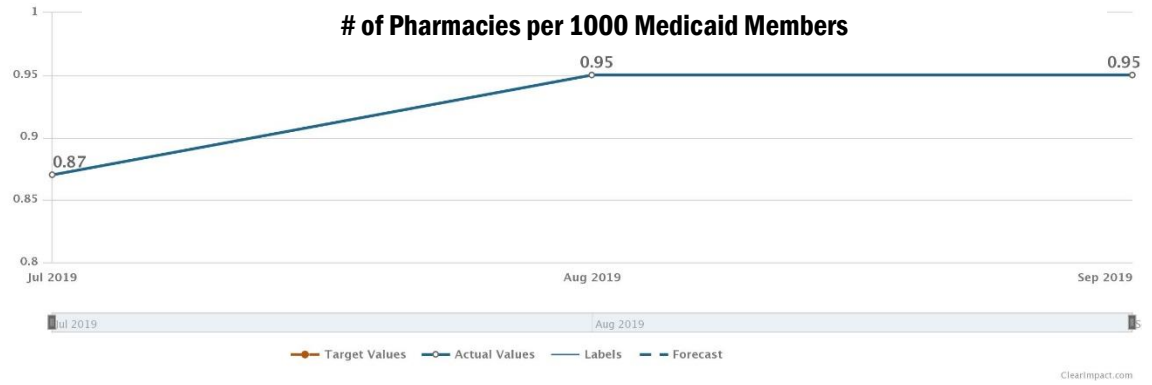
To see what we do, who we serve, how we impact, and our performance measures, see PMR's Section of the DVHA Performance Accountability Scorecard.

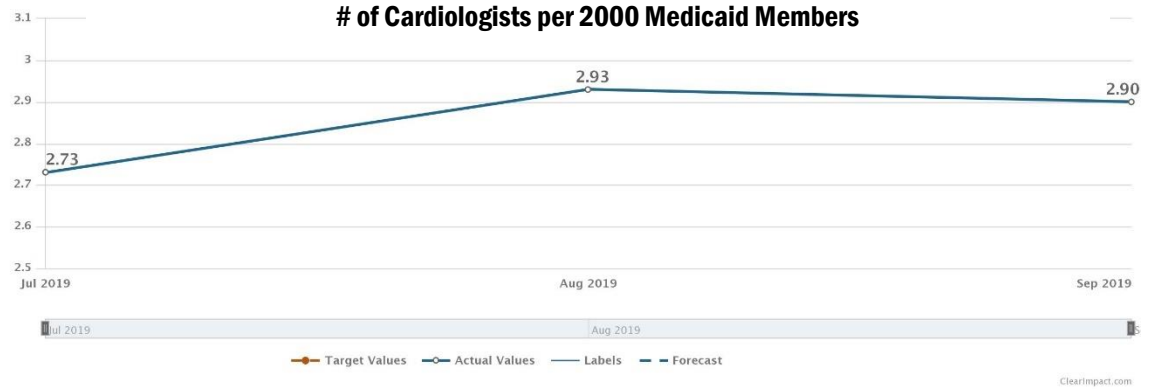
BUSINESS INSIGHTS FOR SFY19:

The Provider Management Module was launched in May of 2019 and the provider community has commented on how easy and fast the module is to enroll with Vermont Medicaid. Prior to the Provider Management Module being implemented, there were challenges with enrolling providers in a timely manner, resulting in fewer providers participating with Vermont Medicaid. Since the Provider Management Module was launched, the number of providers participating with Vermont Medicaid has been rising steadily across all provider types as shown in the graphs below.









Rate Setting

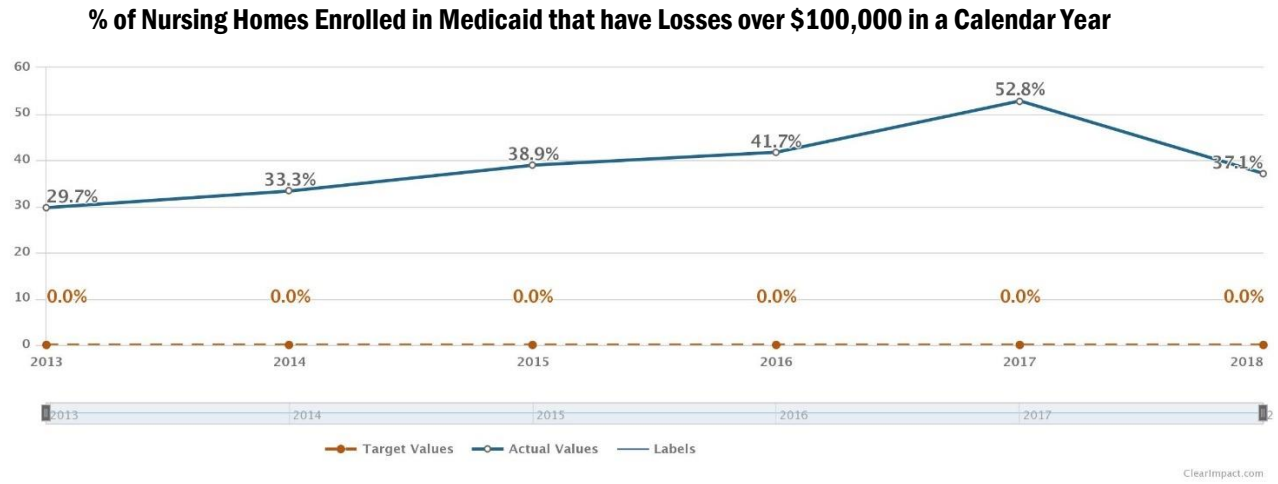
The Division of Rate Setting (DRS) establishes and certifies Medicaid rates for residential services provided to Vermonters by 35 Vermont nursing homes, out-of-state nursing homes, 15 residential facilities for youth called Private Non-Medical Institutions (PNMIs), the Intermediate Care Facility for the Developmentally Disabled (ICF/DD), and hospital swing bed rates. The Division's rules govern the processes for setting the Medicaid rates of each different type of facility.

THE TOP PRIORITIES/INITIATIVES FOR THE RATE SETTING UNIT IN SFY19 WERE:

1) Nursing home and PNMI rulemaking.
2) Prepare for the full nursing home rebase (that occurs every four years) which will be in effect as of 7/1/19.
3) Plan and prepare for a transition away from the current acuity measure used quarterly to adjust the nursing component of the Medicaid nursing facility rate to a new measure of acuity based on data that will be available in the future.
4) Participate in the development of the new transfer of ownership financial review while continuing to participate in the interim review process.

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

BUSINESS INSIGHTS FOR SFY19:



There are many nursing homes with years of significant losses which could affect their willingness tor ability to continue to provide services; ensuring the financial health of these facilities will be ongoing challenge. In 2019, Rate Setting assessed ventilator rates for The Pines at Rutland as these rates had not been updated/revised since 2011. This nursing home operates the only unit which accepts residents on ventilators in Vermont. The respiratory therapy is provided through a collaboration between the Rutland Regional Medical Center and the nursing home.

Additionally, during 2019, Rate Setting initiated a process to work with DAIL, the nursing home industry, provider representatives and CMS to develop an understanding of the acuity data that will be available under the new CMS Patient Driven Payment Model (PDPM). PDPM will be used to

determine Medicare reimbursement rates starting on 10/1/19. After an initial meeting with DAIL, a smaller focus group has been developed and this will meet to continue the conversations about this change. Rate Setting has also been in contact with rate setters in a few other states, some experts with the Genesis organization and has asked CMS to include Vermont in their lists of interested parties. As this change is implemented, new performance measures may be designed for state fiscal year 2020.

Reimbursement Unit

The DVHA Medicaid Reimbursement unit oversees rate setting, pricing, implementation of the National Correct Coding Initiative Program, quarterly code changes, provider payments, and reimbursement methodologies for a large array of services provided under Vermont Medicaid. The Reimbursement unit is primarily responsible for implementing and managing prospective payment reimbursement methodologies developed to align with CMS Medicare methodologies for outpatient, inpatient and professional fee services.

THE TOP PRIORITIES/INITIATIVES FOR THE REIMBURSEMENT UNIT IN SFY19 WERE:

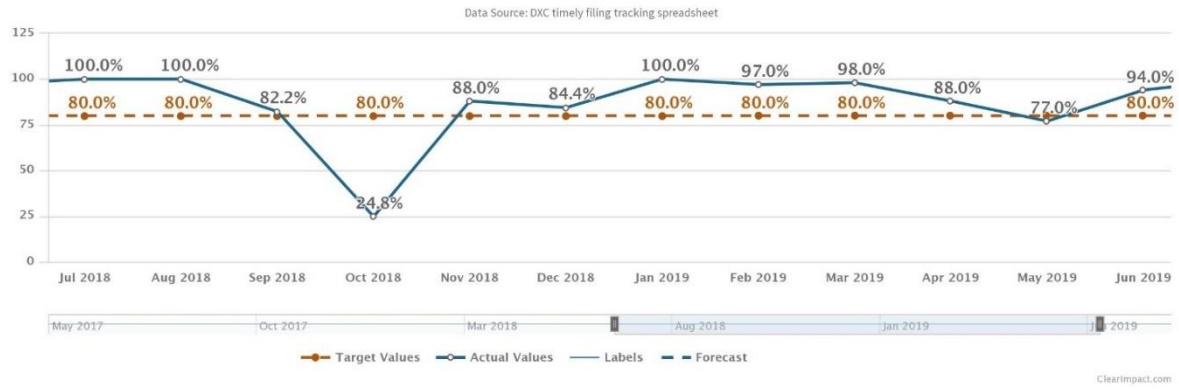
1) Continue working with suppliers and stakeholders on the update to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule.
2) Continue efforts to work with stakeholders to support equitable, transparent, and predictable payment policy to ensure efficient and appropriate use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

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

BUSINESS INSIGHTS FOR SFY19:

Over the past year, the Unit has undergone a review of its timely filing compliance including a review of system changes that would benefit the current timely filing process. New timely filing guidelines were issued with outreach to inform and educate stakeholders and other partners of the changes. This project will continue with system changes planned for state fiscal year 2020 with continued efforts to keep the Department's partners up to date on planned changes and to help inform the goal of reaching the targeted timely filing completion rate each month. In state fiscal year 2019, the timely filing measure showed continued improvement in meeting or exceeding the goal.

% of Claims that were Originally Submitted in a Timely Manner but were Denied Payment Turned Around



In state fiscal year 2019, performance on the measure "Percentage of Annual Fee Schedule Updates that are Posted for Public Comment 30 Days Prior to the Effective Date of the Rate Change" also improved due to new strategies being employed. Earlier engagement with stakeholders and renewed focus on explaining and educating State partners on the scope of annual updates helped to improve performance. However, many obstacles remain for fully achieving this goal and are outside of the control of the unit, including 1) legislatively mandated updates to rates with a July 1 implementation date, 2) the timing of Medicare releases of updated fee schedules and policy updates allowing sufficient time for implementation, and 3) the length of time needed for system changes prior to implementation.

Although these obstacles create challenges for attaining improvement on this performance measure, the Unit significantly increased its compliance in posting proposed changes for public comment 30 days prior to making fee schedule or prospective payment rate updates. The Unit went from a 30% compliance rate in state fiscal year 2018 to a 62.5% compliance rate in state fiscal year 2019.

% of Annual Fee Schedule Updates that are Posted for Public Comment 30 Days Prior to the Effective Date of the Rate Change

3. IMPROVE HEALTH

Blueprint for Health

The Vermont Blueprint for Health is a state-led, nationally recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes, community health teams, the Spoke program and Women's Health Initiative.

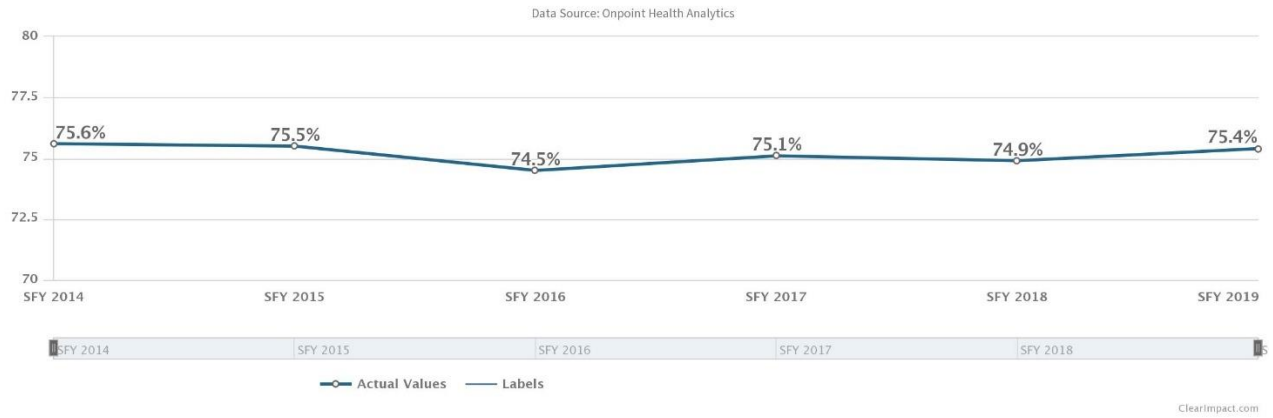
THE TOP PRIORITIES/INITIATIVES FOR THE BLUEPRINT UNIT IN SFY19 WERE:

1) Pending availability of funds, implement SBINS program and Chronic Pain Pilots
2) Enhance the Vermont Clinical Registry and develop data linkage & reporting with Department of Corrections (DOC) and Department of Labor (DOL)
3) Support the community health teams and program field staff with leadership training and consistent deployment of care models

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

BUSINESS INSIGHTS FOR SFY19:

% of Patients Served by Patient-Centered Medical Homes



Quality and Clinical Integrity Unit

The Quality Improvement & Clinical Integrity unit includes the Quality team and the Clinical Utilization Review team. The Quality team collaborates with Agency partners to develop a culture of continuous quality improvement, maintains the Vermont Medicaid Quality Plan and Work Plan, coordinates quality initiatives including formal performance improvement projects, coordinates the production of standard performance measures, and is the Department's lead unit for Results Based Accountability (RBA) methodology & production of the Department's Performance Accountability Scorecards.

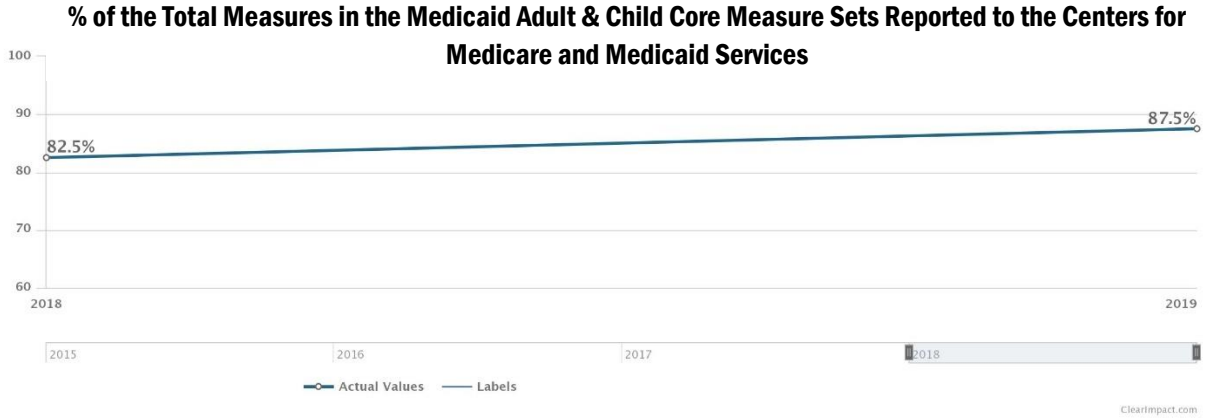
The Clinical Utilization Review team is responsible for the utilization management of mental health and substance use disorder services. The team works toward the integration and coordination of services provided to Vermont Medicaid members with substance use disorders and mental health needs. The team performs utilization management activities including concurrent review and authorization of mental health and substance use disorder services. The Utilization Review team also administers the Team Care Program, which links a member to a single prescriber and a single pharmacy. In addition, the team has an Autism Specialist who provides prior authorization review for applied behavior analysis (ABA) services for children.

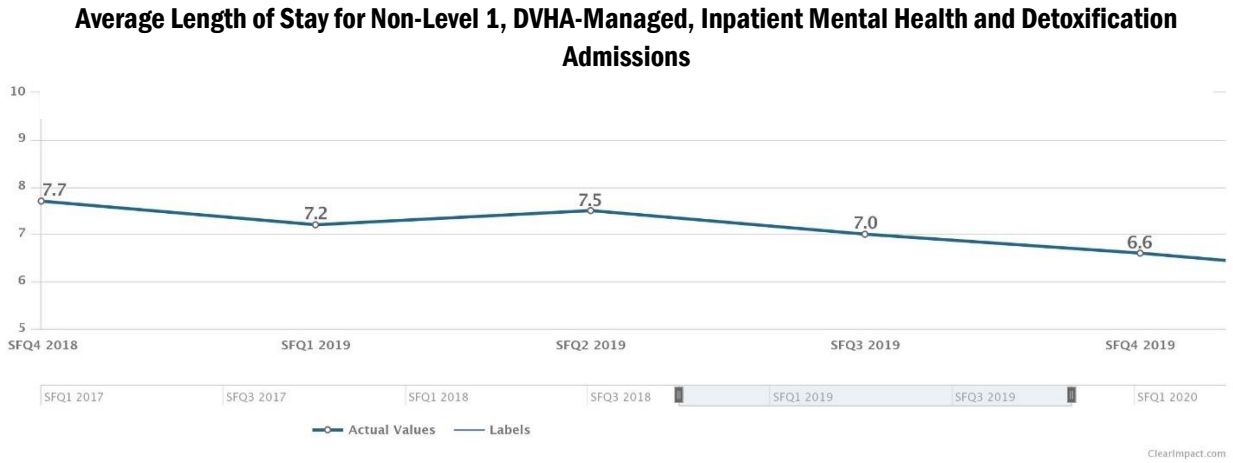
THE TOP PRIORITIES/INITIATIVES FOR THE QUALITY & CLINICAL INTEGRITY UNIT IN SFY19 WERE:

1) Revitalizing the Team Care Program
2) Revamping the procedure for applied behavior analysis (ABA) service authorizations
3) Strengthening our provider network to eliminate the need for administrative authorizations

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

BUSINESS INSIGHTS FOR SFY19:





Additionally, in state fiscal year 2019, the Unit focused on revitalizing the Team Care program. Based on review of the lack of referrals and an inability to show meaningful results, there was a complete overhaul of the Team Care program. The goal was to create a more meaningful program that supports members in receiving appropriate care. A Standard Operating Procedure was developed, and staff were trained on the new procedure. External communications were modified to be more accessible. The practice of referring Team Care program members to the Vermont Chronic Care Initiative when appropriate was incorporated. New methods for data-driven identification of potential members were identified and monthly review has begun.

The Unit also worked to revamp the procedure for Applied Behavior Analysis (ABA) service authorization following ABA-provider feedback regarding the Vermont Medicaid ABA benefit. The team reviewed data, including the number of members currently receiving applied behavior analysis services funded through Vermont Medicaid and average number of hours of ABA services, what ABA

CPT codes were being billed and the amounts, etc. The data review showed that the benefit was not being used to its fullest potential. The Unit collaborated with the Payment Reform unit to explore opportunities for changing the current payment method for ABA. A tiered rate was developed and implemented on 7/1/19. Prior to implementation, the team met individually with providers to discuss the tiered case rate and how it would work for their agencies as well as for the members receiving the benefit. Thus far, feedback from providers has been overall positive.

Finally, the Unit worked to strengthen Vermont Medicaid's provider network & eliminate the need for administrative authorizations. The Clinical and Quality team collaborated with other departments within the Agency of Human Services (specifically DMH, DCF, and DAIL) to identify gaps in the system of care. The Unit has been actively working to onboard new Vermont Medicaid providers and have been working to build upon existing relationships with current providers. Over the past year, the team has onboarded specialty hospitals in Maine and New Hampshire, and an Eating Disorder residential facility in New York.

Vermont Chronic Care Initiative

The Vermont Chronic Care Initiative (VCCI) provides holistic, intensive and short-term case management services to Vermont residents enrolled in Medicaid, including dually eligible members. VCCI works with non-ACO members identified using claims-based methodology and members identified by health care providers and community partners in need of complex care management. VCCI case managers are also welcoming new members to Medicaid, by outreaching and asking questions about having a primary care provider, health conditions and other supports that would assist them in maintaining or improving their health as well as housing, food and safety. The VCCI team works to connect members with medical homes, community-based self-management programs, and local care management teams.

THE TOP PRIORITIES/INITIATIVES FOR THE VCCI UNIT IN SFY19 WERE:

1) Align with health care reform efforts and formal adoption of the complex care model and team-based care & utilization of common tools.
2) Population enhancement to include outreach to members new to Medicaid, accepting referrals based on need from community providers and those dually insured, facilitating access to primary care and providing complex case management to those meeting high risk criteria with the goal of facilitating member integration and connectedness with the health care system.

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

BUSINESS INSIGHTS FOR SFY19:

The collected data on VCCI's results-based accountability measures of 1) the percentage of new to Medicaid members screened by VCCI and 2) the percentage of new to Medicaid members who accepted help with establishment of a primary care provider continue to show the challenges staff experience in trying to contact members (e.g. due to the member not having a valid, working phone number) and that access to a primary care provider remains an issue for members. Vermont Chronic Care Initiative continues to work on identifying barriers that prevent members from accessing primary care services, e.g. working with organizations to amend existing workflows that allow for the first appointment to be scheduled without waiting until the member's medical records are received. The Unit has identified a need to develop a strategy for following up with members with whom a connection to a primary care provider was facilitated but review of medical claims does not demonstrate a primary care visit.

% of "New to Medicaid" Members Screened by VCCI

% "New to Medicaid" Members who Accepted Help with PCP Establishment

4. SUPPORT

Business Office

THE TOP PRIORITIES/INITIATIVES FOR THE BUSINESS OFFICE IN SFY19 WERE:

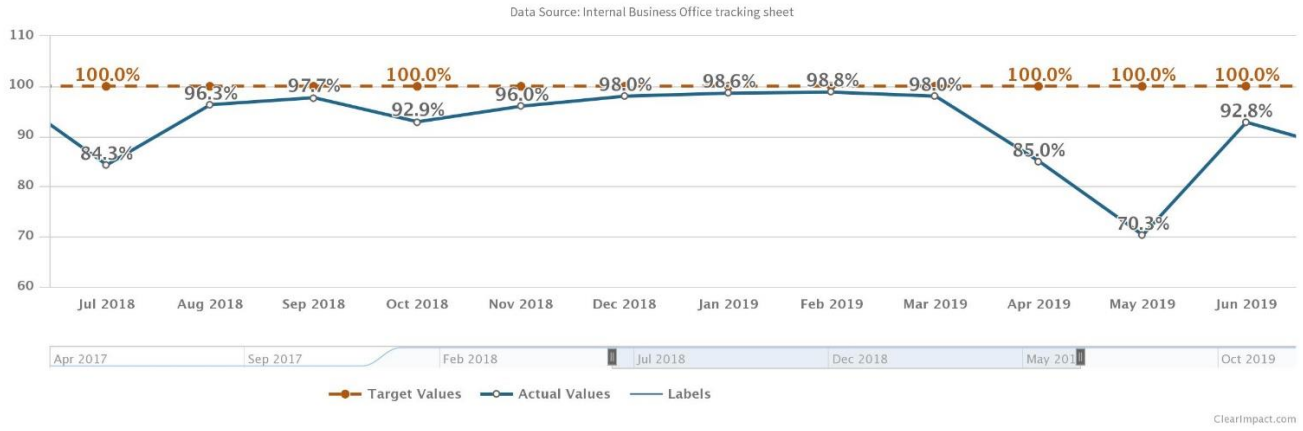
The Business Office supports, monitors, manages and reports on all aspects of fiscal planning and responsibility. The Business Office includes the work of the Accounts Payable/Accounts Receivable, Grants and Contracts, and Fiscal Analytics teams.

1) Continue to develop in-depth work instructions for all areas of Business Office responsibility and fully train back-ups in those tasks, ensuring that services and reporting are delivered consistently.
2) Develop and implement a standardized procedure to sub-recipient monitoring; outlining the business activities to be executed. Subrecipient monitoring is essential at all stages of the granting process from proposal to award closeout.

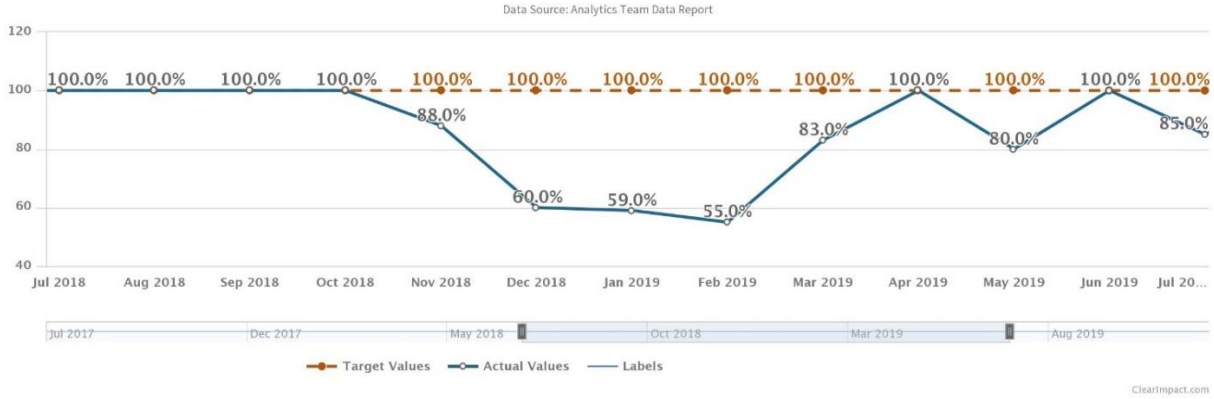
To see what we do, who we serve, how we impact, and our performance measures, see Business Office's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY19:

% of Invoices Processed in Under 3 Business Days of Receipt by AP/AR



The Ratio of Timely and Accurate Submission of Required Financial Reporting



Data Management and Analysis Unit

The Data Management and Analysis unit is responsible for reporting Medicaid data to the Federal Government, the Vermont Legislature, and other stakeholders. The Unit provides mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), routine Vermont Healthcare Claims Uniform Reporting and Evaluations System (VHCURES) data feeds, the annual Healthcare Effectiveness Data and Information Sets (HEDIS) data extracts for performance measurement reporting, weekly medical and pharmacy claims files and monthly eligibility records to support Care Coordination for the Vermont Chronic Care Initiative (VCCI) and the Vermont Medicaid Next Generation Pilot program.

THE TOP PRIORITIES/INITIATIVES FOR THE DATA UNIT IN SFY19 WERE:

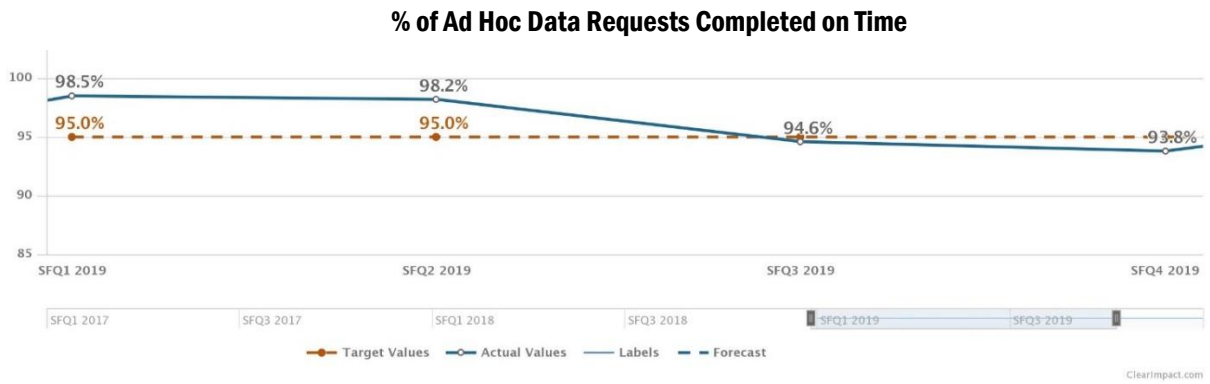
1) Continue to provide regular data extracts as well as routine reporting to OneCare Vermont and the Legislature to support the continued implementation of the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program.
2) Supporting the Agency of Human Services Central Office with required reporting for the Global Commitment to Health Section 1115 Medicaid Demonstration Evaluation and the Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration Monitoring Protocol.

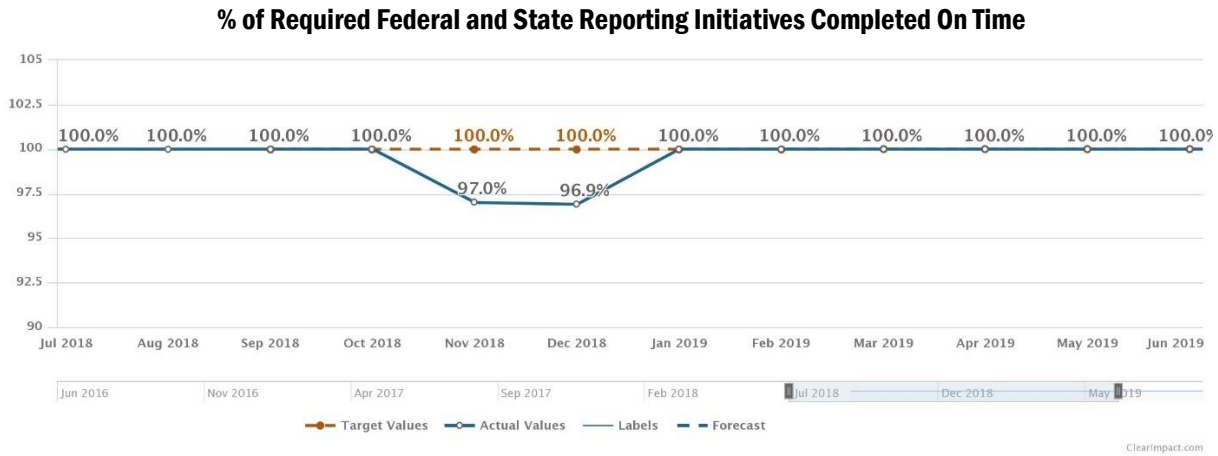
To see what we do, who we serve, how we impact, and our performance measures, see Data's Section of the DVHA Performance Accountability Scorecard.

BUSINESS INSIGHTS FOR SFY19:

The Data unit continued to serve its partners in a consistent manner. The number of ad-hoc requests and required federal and state reporting initiatives continue to grow in an upward trend and the Unit's

percentages for completing these tasks were at, or near, established goals. The Data unit has a continuous quality improvement approach embedded within its analytical business processes.





Health Information Exchange (HIE) UNIT

The Health Information Exchange (HIE) unit is focused on the aggregation and exchange of health data for two main purposes:

1. To ensure providers and patients have access to complete health records to inform quality care decisions; and
2. To enable analysis and reporting that supports continuous, quality improvement in the health care system.

Fundamentally, automating the exchange of health data is essential to improving health care quality, making care more efficient, reducing administrative burden, engaging patients in their care, and supporting the health and well-being of the Vermont community. Vermont's Health Information Exchange (VHIE), operated by VITL, is a central system that aggregates data from electronic health records for use by

providers and health care programs statewide. DVHA contracts with VITL for operations and development of the VHIE system.

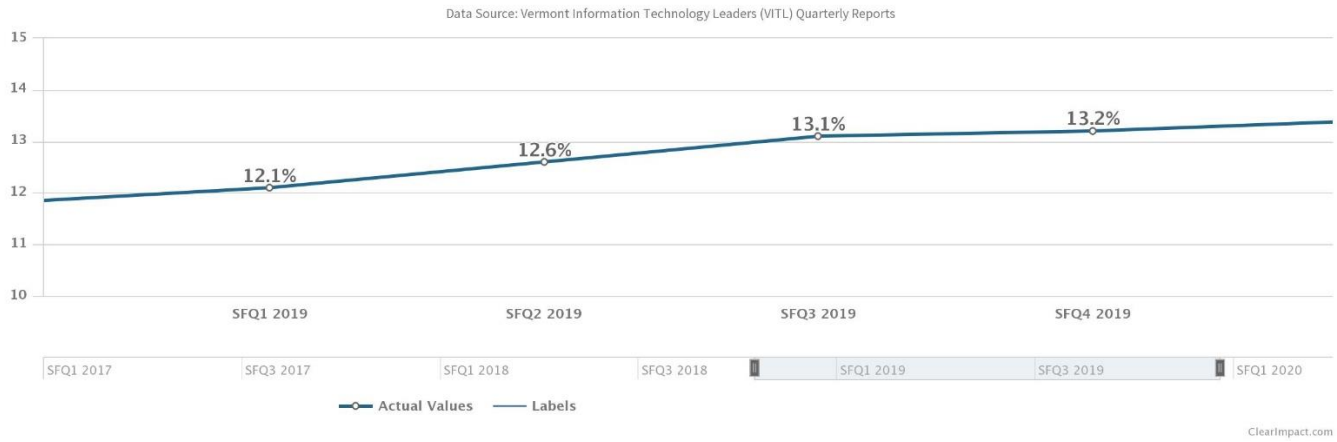
THE TOP PRIORITIES/INITIATIVES FOR THE HIT UNIT IN SFY19 WERE:

1) Partnering with the HIE Steering Committee to develop a strategic HIE Plan to coordinate state-wide HIE investment, governance and oversight.
2) Meeting the requirements of Vermont Act 187 of 2018 to address the recommendations from the Act 73 of 2017 Health Information Exchange Evaluation and prepare for future endeavors.

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

BUSINESS INSIGHTS FOR SFY19:

% of Providers Gaining Access to their Patient's Data Through the VHIE Network



Oversight & Monitoring

The Oversight & Monitoring unit consists of two teams: Audit & Internal Control and Health Care Quality Control. The Unit is responsible for ensuring the effectiveness and efficiency of departmental control environments, operational processes, regulatory compliance, and financial and performance reporting in line with applicable laws and regulations.

THE TOP PRIORITIES/INITIATIVES FOR THE OVERSIGHT & MONITORING UNIT IN SFY19 WERE:

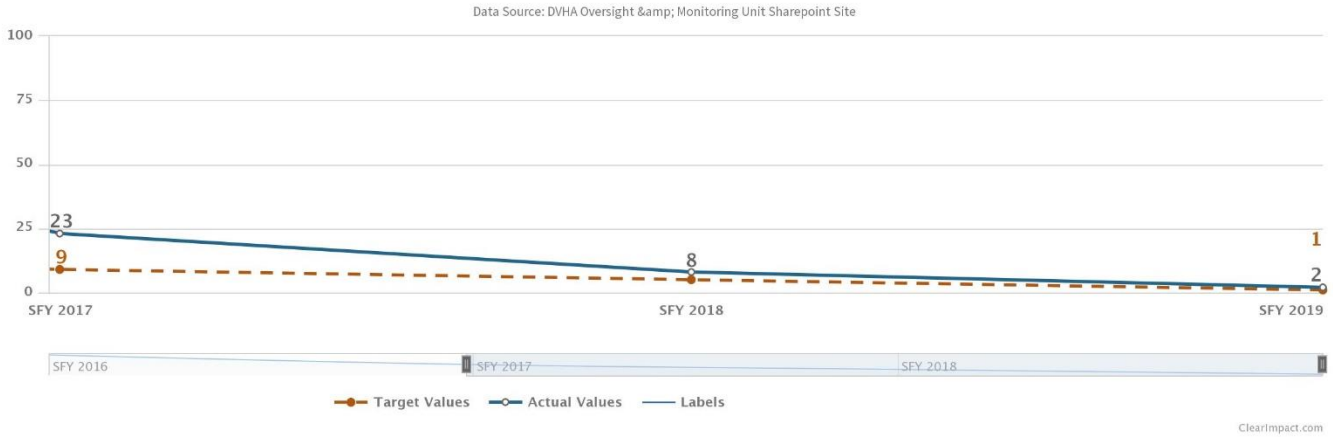
1) Reducing the total number of audit findings in audits that closed during the state fiscal year and the total number of findings that are repeat findings from previous audits.

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

BUSINESS INSIGHTS FOR SFY19:

The Oversight & Monitoring unit worked closely with departmental units to put in place corrective action plans and timely completion of the plans, resulting in a reduction in repeat findings. The Unit proactively evaluated units for audit readiness and provided consultation regarding auditor/regulator communications, proper response, follow up, escalation and reporting. All DVHA units were a part of the Standard Operating Procedure project this year; being able to document a strong control environment (that stands up to audit testing) resulted in reduced testing and findings. In the graph below, the solid line represents the total number of audit findings and the dotted line represents the number of repeat findings.

# of Overall DVHA Audit Findings that are Repeat Audit Findings



Policy Unit

The primary functions of the Medicaid Policy unit include administration of Vermont's Global Commitment to Health 1115 Demonstration Waiver, Medicaid State Plan, Global Commitment Register, Policy, Budget & Reimbursement process, policy research, development and implementation, and administrative rulemaking.

THE TOP PRIORITIES/INITIATIVES FOR THE POLICY/LEGAL UNIT IN SFY19 WERE:

1) 1115 Waiver Administration and Planning
    a. Planning for new waiver in 2022 and administration of existing waiver.
2) Administrative Rulemaking

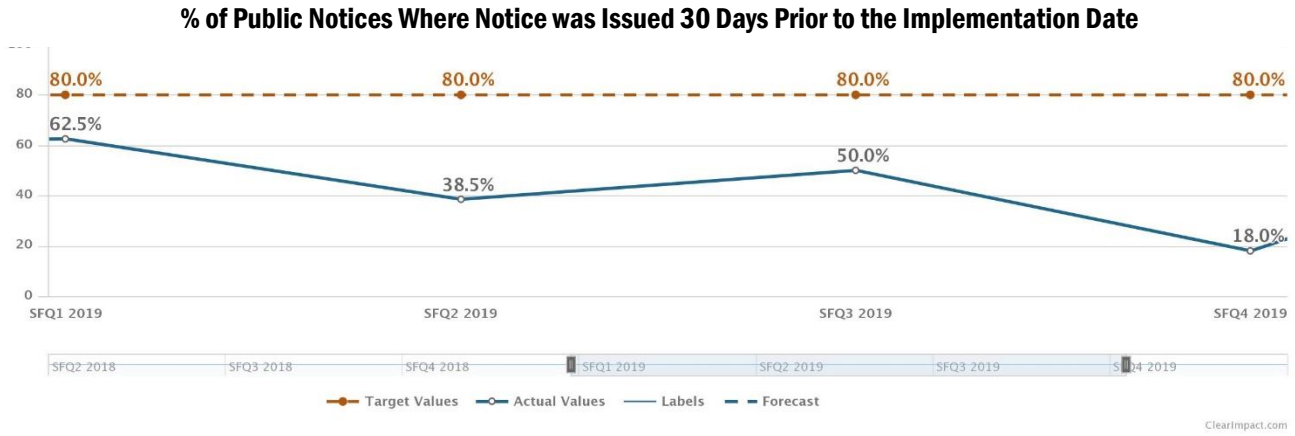
a. The Medicaid Policy unit is currently undergoing a 5-7-year project to rewrite all of Vermont's Medicaid administrative rules under one centralized framework for transparency and reduced provider/beneficiary confusion.

3) Medicaid Policy Development and Implementation at AHS.

To see what we do, who we serve, how we impact, and our performance measures, see Policy's Section of the DVHA Performance Accountability Scorecard (also available from the DVHA Intranet).

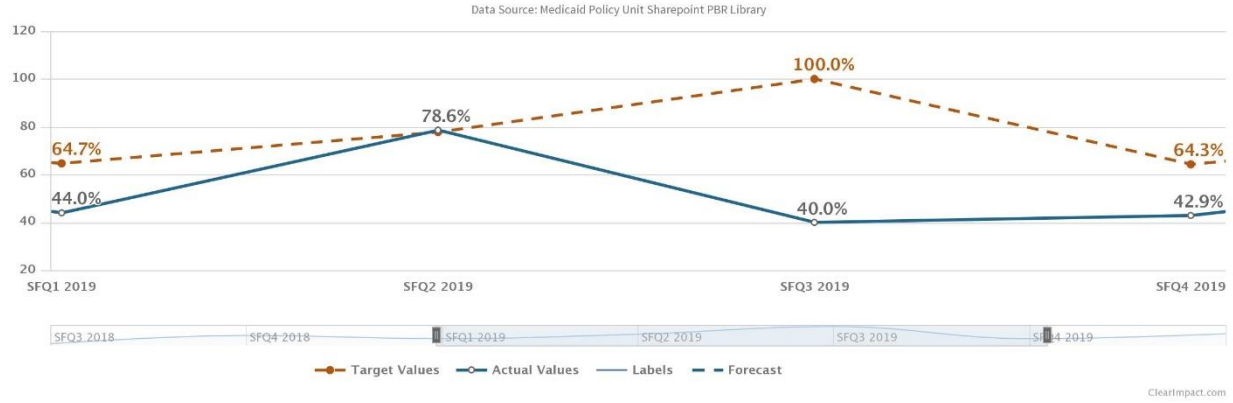
BUSINESS INSIGHTS FOR SFY19:

The Medicaid Policy unit engaged with a contractor to update select Medicaid notices and other written materials to applicants and beneficiaries to ensure the use of plain language. Plain language is language that is readily understood by individuals with limited reading skills, individuals whose primary language is not English, and individuals with disabilities. Federal Medicaid law requires that all Medicaid notices and other communications to Medicaid applicants and beneficiaries be written in plain language.[2] The contractor was chosen based on the breadth of skills and experience they have around communicating in plain language and conveying complex concepts at a 4th grade reading level. In addition to updating notices and written materials, the Policy unit is working with the contractor to develop a training for AHS staff on plain language skills that will be unveiled later this year.



[2] 42 CFR § 438.10

% of Policy, Budget and Reimbursement (PBR) Forms Finalized Prior to Effective Date of Change*



*Please note: In the PBR graph above, the solid line represents the total percentage (for all departments); the dotted line represents DVHA's percentage.

Program Integrity Unit

The Program Integrity unit works to establish and maintain integrity within the Medicaid Program and engages in activities to prevent, detect and investigate Medicaid provider and beneficiary fraud, waste and abuse.

THE TOP PRIORITIES/INITIATIVES FOR PI IN SFY19 WERE:

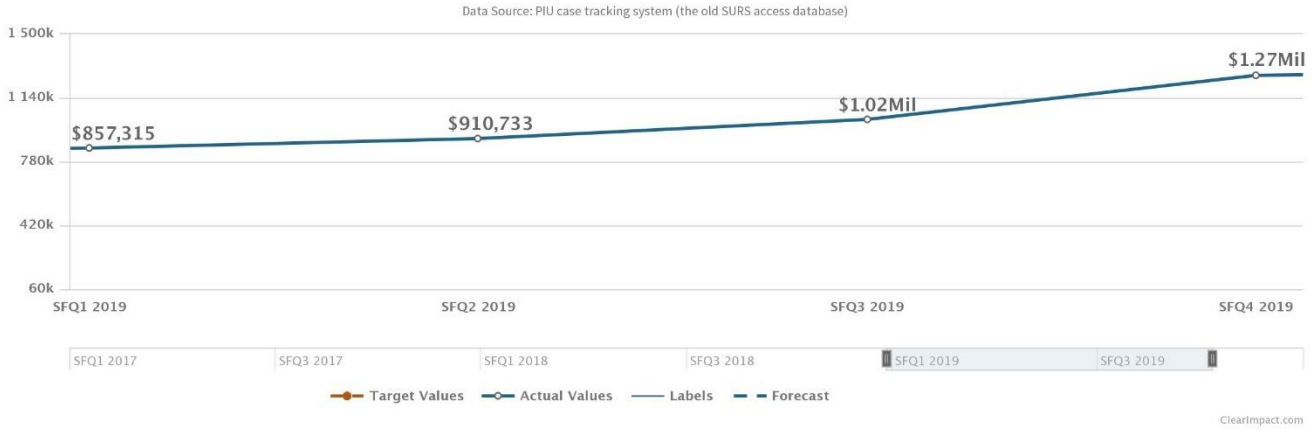
1) To collaborate with the ACO to develop and implement educational and training needs to effectively deliver quality health care at an accurate cost.
2) To develop and monitor all PIU initiatives defined in the ACO contract with the ACO that will establish a strong compliance program.

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

BUSINESS INSIGHTS FOR SFY19:

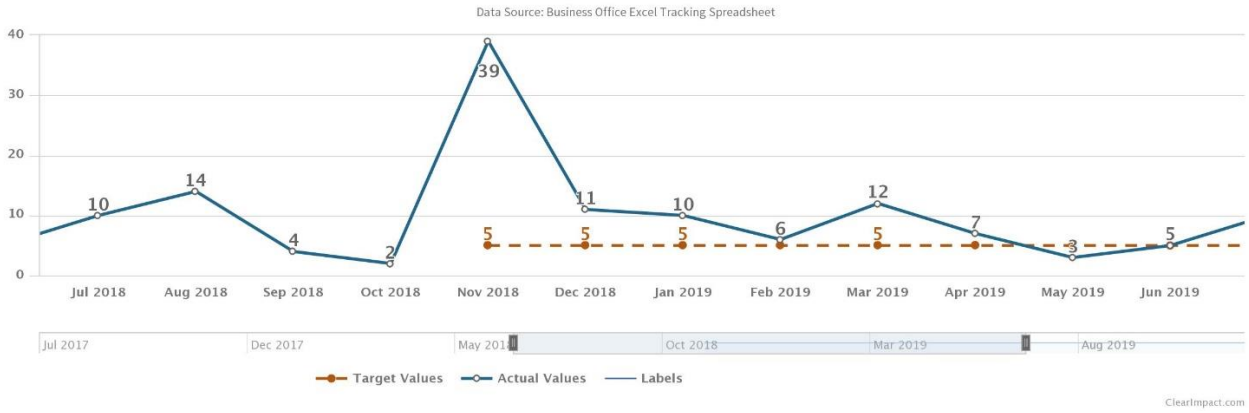
The performance data indicates there is actual cost avoidance achieved with Program Integrity involvement. Program Integrity is beginning a proactive provider audit project and will develop a new performance measure for state fiscal year 2020 to monitor this planned activity. Data analysis will assist in the identification of providers to audit. The goal of the audits is to educate providers when necessary, recover funds as appropriate, and measure cost avoidance achieved.

$ Amount Cost Avoidance Generated by the Program Integrity Unit



Legal & Administrative Units

The Median Number of Business Days Contracts are Routing for Signature



Of the Annual Performance Evaluations Submitted During the Quarter, the Percentage Submitted on or before the End of the Grace Period

In state fiscal year 2019, the Department focused on improving its contracting processes and ensuring that annual performance evaluations for staff are completed on time. This work will continue into state fiscal year 2020. While some of the performance measures for the Department's units may be revised as new priorities are established for the upcoming fiscal year, the culture of continuous quality improvement will continue into state fiscal year 2020 and beyond.

APPENDIX B: STATE FISCAL YEAR 2019 BUDGET – AS PASSED

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State Fiscal Year 2019 As Passed, Excerpt from State Fiscal Year 2020 Budget Recommendation

Agency of Human Services,
Department of Vermont Health Access

MISSION

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

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

DVHA State Fiscal Year 2019 Budget As Passed and State Fiscal Year 2020 Budget Recommendation Changes from As Passed[1]

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

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

[1] https://dvha.vermont.gov/budget-legislative/2dvha-annual-report-and-sfy-2020-budget-recommendation.pdf

APPENDIX C: ORGANIZATIONAL CHART – SEPTEMBER 2019

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September 1, 2019
Executive

390 Total
---
379 Positions
11 Temps

Senior Management Team
Management Team*
Managers & Supervisors*

**Does not represent bargaining unit classification*

- Cory Gustafson, Department of Vermont Health Access Commissioner, 34100010000
  - 3 Positions
  - Lisa Schilling, Financial Dir IV
    - 3 Managers/ Supervisors
      - 6 Positions
  - Scott Strenio, Chief Clinical Officer, 3410010200
    - Christine Ryan, DVHA Clinical Operations Dir.
      - 1 Manager/ Supervisor
        - 7 Positions
    - Nancy Hogue, Pharmacy Executive Director
      - 5 Positions
  - Jenney Samuelson, Deputy Commissioner, 3410010300
    - Dawn Weening, VCCI Nurse Administrator II
      - 10 Positions
    - Heather Bollman, VCCI Nurse Administrator II
      - 11 Positions
    - Alicia Cooper, Dir of Payment Reform, Reimbursement, & Rate Settings
      - Lindsay Gillette, Director of Rate Setting
        - 1 Manager/ Supervisor
          - 5 Positions, 1 Temp
      - Pat Jones, Deputy Director Payment Reform
        - 1 Managers/ Supervisors
          - 5 Positions
      - Patricia Elias, DVHA Rate Settings Manager
        - 4 Positions
    - Emily Richards, HCR/HIT Integration Mngr
      - 2 Positions
    - Beth Tanzman, Blueprint for Health Director, 3410010500
      - 8 Positions
  - Lori Collins, Administrative Services Director IV
    - Suellen Bottigi, Director Provider & Member Relations
      - 1 Manager/ Supervisor
        - 5 Positions
    - Joe Liscinsky, Health Enterprise Dir II
      - 2 Manager/ Supervisor
        - 6 Positions, 1 Temp
    - Deb Austin, Coordination of Benefits Director
      - 3 Managers/ Supervisors
        - 13 Positions
    - Michele Betit, Long term Care
      - 2 Managers/ Supervisors
        - 24 Positions, 7 Temps
    - Kelly Gordon, Project and Operations Director
      - 4 Positions
    - Hera Bosley, Director of Organizational & HR Development
      - 5 Positions
    - Frank Puleo, Program Integrity Director
      - 1 Managers/ Supervisors
        - 11 Positions
    - Devon Downing, Change Manager
      - 2 Positions
    - 1 Managers/ Supervisors
      - 1 Positions
  - Cassandra Madison, Deputy Commissioner, 3410010400
    - Sandra Hoffman, Director, Quality Improvement & Clinical Integrity
      - 2 Manager/ Supervisor
        - 6 Positions
    - Anne Petrow, Oversight & Monitoring Director
      - 1 Managers/ Supervisors
        - 7 Positions
    - Athanasia Boskalio, HAEEU Director
      - 19 Manager/ Supervisor
        - 122 Positions, 1 temp
    - Jeff Ross, Director Data Mgmt & Integrity
      - 4 Positions
      - 4 Positions
  - Adaline Strumolo, Health Care Director
    - Ashley Berliner, Director of Healthcare Policy & Planning
      - 6 Positions
    - Dani Delong, Appeals Manager
      - 1 Manager/ Supervisor
        - 7 Positions
    - 1 Positions
  - Stephen Odefey, General Counsel
    - 2 Positions
    - 2 Managers/ Supervisors
      - 5 Positions
      - Zoe Newman, Staff Attorney II
      - Patrick Lamb, Staff Attorney III
      - David Weigel, Staff Attorney II

APPENDIX D: PPMB SCORECARDS

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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Blueprint for Health

P BP DVHA PPMB

What We Do

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes and community health teams.

Who We Serve

The Vermont Blueprint for Health serves all Vermonters.

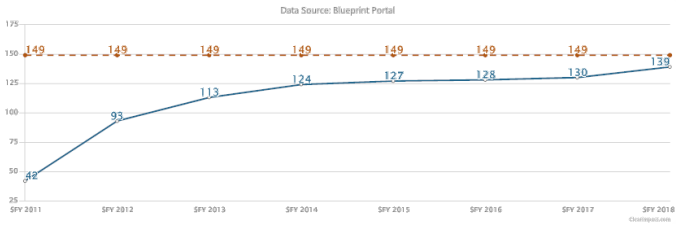
How We Impact

The activities of the Blueprint serve as the foundation for strengthening primary care and expanding the ACO programs. This initiative is especially focused on building the links between community and medical services, so that patients have better coordinated care across the spectrum of services.

Together the following performance measures focus on whether Vermonters are better off as a result of this program. They do so by looking at the quality and efficiency of these programs and services.

Performance Measures

PM BP # of primary care practices participating in the Blueprint



Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend		Baseline % Change
SFY 2018	139	149	–	↗	8	1164% ↑
SFY 2017	130	149		↗	7	1082% ↑
SFY 2016	128	149		↗	6	1064% ↑
SFY 2015	127	149		↗	5	1055% ↑
SFY 2014	124	149		↗	4	1027% ↑
SFY 2013	113	149		↗	3	927% ↑
SFY 2012	93	149		↗	2	745% ↑
SFY 2011	42	149		↗	1	282% ↑

Notes on Methodology

- The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://blueprintforhealthport...). The Blueprint Data Analyst manages information stored in the Blueprint portal.
- The goal figure for this measure was obtained by identifying all primary care practices in the AHEC survey database and immunization registry database, validating these primary care practices with our Blueprint project managers, and eliminating from the count practices with 1 FTE or less of a provider.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Story Behind the Curve

These are practices who meet the NCQA standard of a patient-centered medical home (PCMH) and participate in Blueprint initiatives. This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices are qualified as PCMHs and supported by Blueprint payments, increasing numbers of Vermonters should have access to high quality primary care.

The trend line above clearly highlights the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in 2011. This rapid increase is the result of a coordinated effort by the Blueprint team to comply with the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandated the statewide expansion of the Blueprint, including practice recognition as PCMHs. Evidence of this expansion required a minimum of two primary care practices in each health service area (HSA) becoming PCMHs by July 2011. The Act additionally required the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread). A significant achievement in 2010 that paved the way towards compliance with Act 128 was the Blueprint's successful application for the Centers for Medicare & Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In mid-July, Medicare joined all other major insurers in Vermont in contributing to the financial payments to PCMHs.

Since the mandate that all willing primary care providers in Vermont be involved as a PCMH in the Blueprint by October 2013, Blueprint practice facilitators have continued to engage providers across the State to encourage and inspire participation. Practice facilitators, highly skilled and intensively trained clinical and process coaches, work with primary care practices throughout the state and guide them as they make quality improvement changes on the path towards becoming PCMHs. When practices achieve NCQA certification as a PCMH with the assistance of the Blueprint practice facilitators, they demonstrate adherence with important characteristics of high quality healthcare and well-coordinated health services. The practices find the NCQA PCMH standards and Blueprint program as value-adds to their practice, as since the inception of the Blueprint program, only one PCMH has dropped out of the Blueprint (pending an upcoming move out of state).

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. Program expansion is continuing due to the outreach efforts of the Blueprint practice facilitators, who are making a coordinated effort to reach primary care practices in their communities that have not participated in the Blueprint as a patient-centered medical home in the past. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

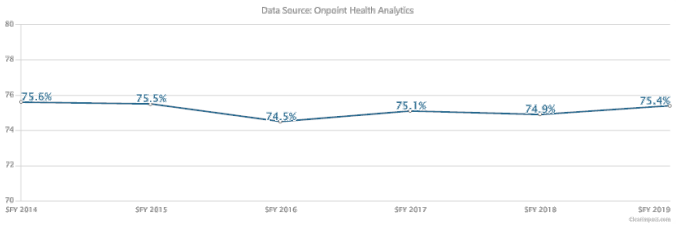
Last updated: 08/15/19

Author: Blueprint for Health

Strategy

- Include expectation to outreach to all area primary care practices in Blueprint Implementation Manual
- Add as agenda item to regular check-ins with Blueprint Assistant Directors

PM BP % of patients served by patient-centered medical homes (PCMHs)



SFY 2019	75.4%	–	–	↗	1	0% →
SFY 2018	74.9%	–		↘	1	-1% ↓
SFY 2017	75.1%	–		↗	1	-1% ↓
SFY 2016	74.5%	–		↘	2	-1% ↓
SFY 2015	75.5%	–		↘	1	0% →
SFY 2014	75.6%	–		→	0	0% →

Notes on Methodology

- The percentage of Blueprint patients from the population of VHCURES members with a primary care visit is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this percentage every six months, accounting for the next 6 month time period.
- The trend line for this measure should increase as additional practices join the Blueprint.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Onpoint Health Analytics

Story Behind the Curve

This is a measure of the percentage of Vermonters who receive their primary care from a Blueprint PCMH from the population of VHCURES members with a primary care visit. This is an access to care measure.

PCMHs provide top-quality primary care centered on several key evidence-based standards. By increasing the percentage of Vermonters who receive their primary care through PCMHs, we are increasing access to high quality care and the opportunity for improved health outcomes.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. Data points from 2013 to 2014 clearly highlight the effects of the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in due to the mandate that all willing primary care providers in Vermont by involved as a PCMH in the Blueprint by October 2013. Data points in 2015 show a decrease in the percentage of the Blueprint patients from the population of VHCURES members with a primary care visit due to either improvements in the accuracy of attributing individuals to PCMHs at Onpoint Health Analytics or access to care issues. The small increase between SFY 2016 and SFY 2017 can be attributed to a continued engagement of providers across the State by Blueprint practice facilitators to encourage and inspire participation in the Blueprint. It should be noted that the SFY 2018 figure is not adjusted to account for the loss of data in VHCURES due to the Gobeille v. Liberty Mutual decision.

Last updated: 08/15/19

Author: Blueprint for Health

Strategy

- Access to primary care is also an All Payer Model Population Health goal. Work with the Green Mountain Care Board and partners to design strategies to increase access.

Actions

Name	Assigned To	Status	Due Date	Progress

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

P Medicaid Inpatient Psychiatric and Detoxification Utilization

DVHA

Budget Information

What We Do

The DVHA strives towards the Institute for Healthcare Improvement's "Triple AIM":

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

One of the strategies the DVHA has adopted to move towards the "Triple AIM" is **utilization management** of our most intensive and high-cost services, which include inpatient psychiatric hospitalization. Inpatient psychiatric services, which include detoxification, are paid on a per day basis, unlike hospitalization on traditional medical inpatient units. This per day payment methodology has the potential to create a dis-incentive for providers to make efficient use of this high cost, most restrictive level of care. While CRT members' hospital costs are included in their case rate payment to the Designated Agencies (DAs), which creates an incentive for the DAs to work efficiently with the inpatient units to transition their members back to their existing community services and supports, no such incentives exists for children or non-CRT enrolled adults.

Partners

- Department of Mental Health Adult and Children and Families Units,
- Department of Disabilities, Aging and Independent Living,
- Department for Children and Families,
- Integrated Family Services,
- Designated Hospitals,
- Designated Agencies,
- Special Service Agencies,

- Vermont Chronic Care Initiative

How We Impact

Historically, as a part of an acute care management program that was developed in response to the 1115b Waiver, children's inpatient admissions at the Brattleboro Retreat were managed through a concurrent review process, however this oversight ended in late 2006 and during this "unmanaged" period the average length of stay and inpatient costs grew substantially. In 2010 the Department of Vermont Health Access began a utilization management (UM) system for children and adolescents, adults ages 18-22 admitted to the Brattleboro Retreat, and all adults admitted to out of state facilities. In 2011, the DVHA added inpatient detoxification admissions and adult psychiatric admissions (excluding CRT and Involuntary) to the UM program. In 2012 the Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) collaborated to create a unified utilization management system for all Medicaid funded inpatient psychiatric and detoxification services. The goals for the utilization management system are as follows:

- Clinical care is provided only as long as necessary for safety and/or other acute needs.

- There are standardized criteria for admission, continued stay and discharge throughout the system of care.

- Care is continuous between the ongoing community treatment teams and episodes of inpatient or residential care. Ideally the hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and their family, beginning within 24 hours of admission.

- Resources of the public system are effectively and efficiently used.

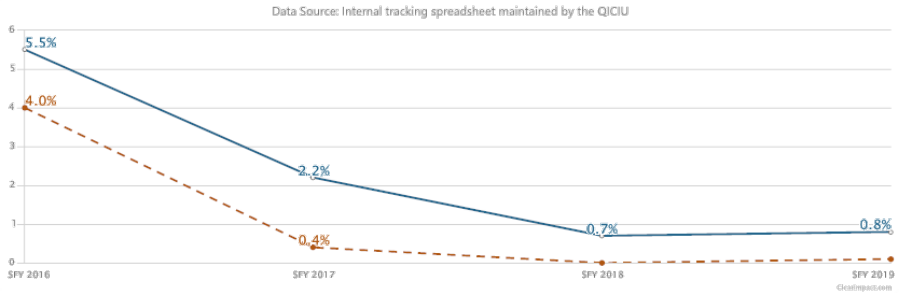
- The system of care will ensure access to effective, appropriate, recovery-based services that promote an individual's health, wellness and resiliency and will support successful integration into the community.

Collaboration between VCCI and DVHA utilization review staff helps ensure timely communication with inpatient facilities and supports beneficiaries being able to successfully re-integrate with outpatient supports and services.Collaboration between DVHA and DMH UR staff and DCF, DAIL and DMH adult Care Managers and DMH CAFU Care Managers helps to ensure that active and appropriate aftercare planning is facilitated between the Designated Hospitals and the outpatient providers, this allows for aftercare services to be in place and ready to receive beneficiaries as soon as they are ready to be discharged and return to their communities. Our Agency partners are also invaluable in holding their preferred providers accountable to the tenets of the "Triple AIM".

Together the following performance measures focus on whether Vermonters are better off as a result of this program. They do so by looking at the quality and efficiency of these programs and services.

Performance Measures

	Most Recent Period	Current Actual Value
PM QICIU % of DVHA inpatient mental health and detox admissions with a reconsideration review request	SFY 2019	0.8%
	SFY 2018	0.7%
	SFY 2017	2.2%
	SFY 2016	5.5%



Notes on Methodology

Please note in the chart above that:

- the solid trend line represents the % of total admits for which a secondary review was requested and
- the dotted target trend line represents the % of total admits for which a doc to doc review was requested and
- the SFY19 data point represent discharged admissions for Q1 & Q2 as of 01/14/19

% of DVHA inpatient mental health & detox admissions with a reconsideration review request

	SFY16					SFY17					SFY18					YTD SFY19 (as of 07/08/19)				
	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews	total # admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews	total # d/c admits	# 2ndary reviews	% total admits w/ 2ndary reviews	# D2D reviews	% total admits w/ D2D reviews
Adult	1228	36	2.9%	25	2.0%	1161	23	2.0%	2	0.2%	1266	9	0.7%	0	0.0%	936	6	0.6%	1	0.1%
Detox	682	16	2.3%	10	1.5%	468	2	0.4%	1	0.2%	338	1	0.3%	0	0.0%	236	0	0.0%	0	0.0%
Child	422	76	18.0%	58	13.7%	349	19	5.4%	4	1.1%	393	4	1.0%	0	0.0%	214	5	2.3%	0	0.0%
Total	2332	128	5.5%	93	4.0%	1978	44	2.2%	7	0.4%	1997	14	0.7%	0	0.0%	1386	11	0.8%	1	0.1%

Partners

- Brattleboro Retreat
- University of Vermont Medical Center
- Central Vermont Medical Center
- Rutland Regional Medical Center
- Valley Vista

- Serenity House
- Department of Mental Health
- Vermont Department of Health, ADAP
- Department for Children and Families
- Department of Corrections

Story Behind the Curve

There has been a significant decrease in the number of requests for reconsideration. This shows that there is agreement with the authorization decisions. Significant outreach and collaboration with providers likely contributed to the decline in reconsideration requests. Team members conducted site visits and educated clinicians about documentation requirements. Review of data shows that there was not an increase in average number of days authorized or length of stay.

Last updated: 07/15/19

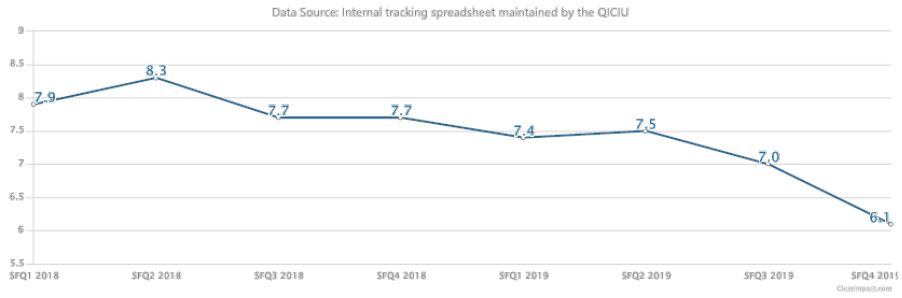
Strategy

UR Team members have conducted:

- site visits and educated clinicians about documentation requirements
- a significant amount of outreach with sister departments to ensure that members are referred to the appropriate agencies for discharge services
- weekly phone consultations with DCF to address discharge issues

The QICIU Director has developed a protocol with one of the major providers to analyze discrepancies prior to submitting reconsideration requests.

PM QICIU Average length of stay (LOS) for DVHA inpatient mental health & detox admissions



SFQ4 2019	6.1
SFQ3 2019	7.0
SFQ2 2019	7.5
SFQ1 2019	7.4
SFQ4 2018	7.7
SFQ3 2018	7.7
SFQ2 2018	8.3
SFQ1 2018	7.9

Notes on Methodology

Average Length of Stay for DVHA Inpatient Mental Health & Detox Admissions																	
		SFY17					SFY 18					SFY 19 (as of 07/08/19)				
		Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD
Adult	# admits	281	278	313	289	1161	338	312	276	340	1266	298	276	188	174	936
	# days auth	2351	2065	2090	2206	8712	2510	2337	1874	2259	8980	2141	2103	1359	1075	6678
	Avg LOS	8.4	7.4	6.7	7.6	7.5	7.4	7.5	6.8	6.6	7.1	7.2	7.6	7.2	6.2	7.1
Detox	# admits	156	97	109	106	468	77	110	79	72	338	74	64	44	54	236
	# days auth	853	472	597	545	2467	367	549	339	293	1548	398	284	170	275	1127
	Avg LOS	5.5	4.9	5.5	5.1	5.3	4.8	5.0	4.3	4.1	4.6	5.4	4.4	3.9	5.1	4.8
Children	# admits	79	77	101	92	349	100	111	102	80	393	69	86	42	17	214
	# days auth	1567	1383	1557	1345	5852	1196	1534	1323	1224	5277	731	807	378	156	2072
	Avg LOS	19.8	18.0	15.4	14.6	16.8	12.0	13.8	13.0	15.3	13.4	10.6	9.4	9.0	9.2	9.7
Total	# admits	516	452	523	487	1978	515	533	457	492	1997	441	426	274	245	1386
	# days auth	4771	3920	4244	4096	17031	4073	4420	3536	3776	15805	3270	3194	1907	1506	9877
	Avg LOS	9.2	8.7	8.1	8.4	8.6	7.9	8.3	7.7	7.7	7.9	7.4	7.5	7.0	6.1	7.1

Partners

- Vermont Medicaid Inpatient Providers
- Department of Children & Families
- Department of Mental Health

Story Behind the Curve

As a part of DVHA's utilization management program, the Quality Unit impacts and tracks the average length of inpatient psychiatric and detox stays for Vermont Medicaid members over time.

The Utilization Review (UR) Clinicians conduct numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally-recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. The UR Clinicians utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence.

The data in the above trend lines show relatively consistent average lengths of stay for the non-Level 1 DVHA-managed psychiatric adult and detox populations. In January of 2017, UR Clinicians began participation in weekly status calls for all children placed in the Brattleboro Retreat. In doing so, some disposition issues were addressed. This may have contributed to the decrease in the average length of stay for children.

A pilot project with one of our providers was initiated in SFY18 Q1. We anticipate this pilot to have an effect on the average lengths of stay.

Last updated: 07/15/19

Strategy

The UR Team regularly shares data with providers that may impact the average lengths of stay. Recently a trend to avoid discharges (especially for children) on weekends was noticed and shared with those providers. Both have reported investigating and one has suggested there might be an internal shift to support daily discharges.

The UR Team has worked closely with providers to provide information on admission criteria. Site visits, presentations, and consultations have shown to improve understanding of requirements. The process has also strengthened our partnerships.

Actions

Name	Assigned To	Status	Due Date	Progress

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

P Management of Information Technology Projects: Deliver on Schedule and On Budget

PPMB

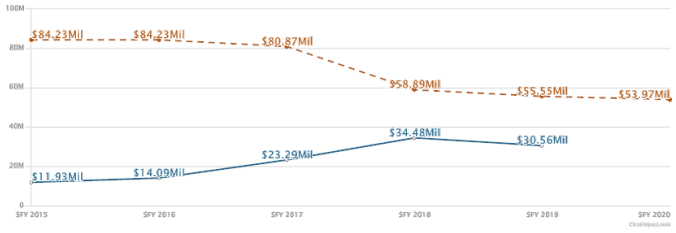
Budget Information

How We Impact

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, reduce financial risk to the State of Vermont, reduce vendor lock-in, and to build systems that are nimble and responsive in the face of changing customer expectations, a shifting federal landscape, and advancements in the marketplace.

Performance Measures

PM IT Expected vs actual total cost of DVHA priority IT projects



Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
SFY 2019	$30.56Mil	$55.55Mil	–	↘ 1	156% ↑
SFY 2018	$34.48Mil	$58.89Mil		↗ 3	189% ↑
SFY 2017	$23.29Mil	$80.87Mil		↗ 2	95% ↑
SFY 2016	$14.09Mil	$84.23Mil		↗ 1	18% ↑
SFY 2015	$11.93Mil	$84.23Mil		→ 0	0% →

Notes on Methodology

DVHA IT Budget to Actuals								
	SFY17		SFY18		SFY19		SFY20	
	Budget	Actuals	Budget	Actuals	Budget	Actuals	Budget (Gov Rec)	Actuals
HIT (excludes SIM funding)	$ 11,721,817	$ 9,328,564	$ 11,721,817	$ 9,544,642	$ 12,707,687	$ 9,282,673	$ 14,867,577	
IE (excludes Establishment Grants $199M)	$ 47,504,263	$ 5,204,919	$ 20,648,363	$ 13,628,639	$ 22,070,246	$ 9,538,379	$ 18,328,375	
MMIS	$ 21,648,734	$ 8,753,628	$ 26,515,445	$ 11,305,366	$ 20,775,699	$ 11,741,791	$ 20,775,699	
Total	$ 80,874,814	$ 23,287,111	$ 58,885,624	$ 34,478,648	$ 55,553,632	$ 30,562,843	$ 53,971,651	$ -
*excludes costs incurred outside of DVHA								

Story Behind the Curve

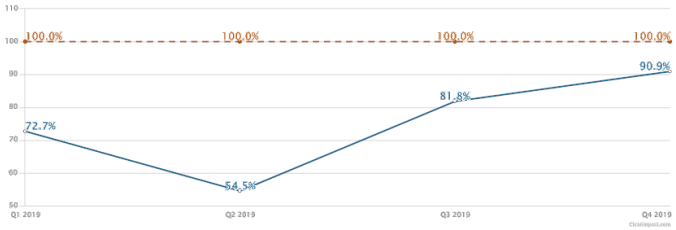
Program commentary on data points and/or trend lines:

- HIE has been in the process of assessing how to best use resources efficiently and has been working with the operator of the health information exchange to find technical solutions that meet multiple user needs and offer shared infrastructure.
- IE&E has worked hard over the last 18 months to build a realistic delivery roadmap and budget that more closely reflects anticipated spending. This is closely linked to our transition from a big bang, monolithic approach to one that focus on agile, modular delivery. Our goal is to reduce the size of individual projects/procurements, lower risk, and deliver more frequent business value. We expect that the accuracy of our budget estimates will increase over time as we gain additional experience delivering in this way

- MMIS: The MMIS Program has leveraged the project and portfolio management (PPM) tool CA Clarity to more effectively and efficiently manage projects by better forecasting/allocating resources over the lifecycle of projects. In accordance with CMS guidance, the Program has also began to implement earned value management (EVM) practices to monitor program performance. EVM takes into consideration the schedule variances (from baseline estimates) and speaks to those projects that may exceed original timeframes. Timelines can extend due to project complexities and/or additional CMS requirements such as Certification activities. These practices, in concert with developing a long-term MMIS modernization strategy, will enable accurate estimates to actuals for projects scope, schedule and cost.

Last updated 10/09/19

PM IT % DVHA priority IT projects on schedule



Q4 2019	90.9%	100.0%	–	↗	2	25% ↑
Q3 2019	81.8%	100.0%		↗	1	13% ↑
Q2 2019	54.5%	100.0%		↘	1	-25% ↓
Q1 2019	72.7%	100.0%		→	0	0% →

Notes on Methodology

Priority IT projects included in the denominator of this measure		
HIE	**IE&E**	**MMIS**
Collaborative Services (formerly VT Clinical Registry)	Enterprise Content Management	Provider Management Module
VT HIE Performance Improvement	Business Intelligence	Care Management Module
VT HIE Connectivity	Health Care Paper Application	TMSIS Module
	Customer Portal Phase 1: Document Uploader	EVVS Module

% priority IT projects on schedule												
	SFY19											
	Q1			Q2			Q3			Q4		
	# projects	# projects on schedule	% projects on schedule	# projects	# projects on schedule	% projects on schedule	# projects	# projects on schedule	% projects on schedule	# projects	# projects on schedule	% projects on schedule
HIE	3	2	66.7%	3	2	66.7%	3	3	100.0%	3	3	100.0%
IE&E	4	3	75.0%	4	2	50.0%	4	3	75.0%	4	3	75.0%
MMIS	4	3	75.0%	4	2	50.0%	4	3	75.0%	4	4	100.0%
Total	11	8	72.7%	11	6	54.5%	11	9	81.8%	11	10	90.9%

Partners

- Agency of Digital Services
- Agency of Human Services
- Vendor partners
- Product owners

Story Behind the Curve

This measure examines the number and percentage of IT projects within each one of DVHA's core programs (IE&E, MMIS, and HIE) that are "on schedule". For this measure, a project is "on schedule" if its projected end date is within 3 months of the end date stated in the project charter.

There are several factors critical to the successful delivery of a project, including whether the project is on schedule. This is important, not only from a budget perspective, but a critical indicator of the State's ability to build a plan and then deliver according to that plan.

SFY19 Q1 Comments:

IE&E: During this quarter, most IE&E IT projects remained on schedule. The exception to this was the Enterprise Content Management project, whose schedule slipped due to the unanticipated need to do a full system boundary security assessment on the OnBase solution/environment and the number of findings that were identified as needing remediation prior to go-live.

MMIS: The MMIS Program has 4 projects going on in this quarter, Care Management Certification, Provider Management Module (PMM), Electronic Visit Verification (EVV) and Business Objects (BobJ) upgrade. EVV was behind schedule due to needed clarity from Centers for Medicare and Medicaid Services (CMS) requirements.

HIE: The VT HIE Performance Improvement project and the VT HIE Connectivity project are on schedule. Each of these projects has multiple components that are all tracking according to the agreed upon project plans and contract deliverables. The VT Clinical Registry project has been paused to assess (1) the most effective strategy for technical facets deemed "shared services" or services that will benefit HIE users more broadly and (2) the most effective strategy for meeting the needs of the Blueprint program and DVHA as it relates to the use of aggregate clinical data for measure, analysis, and reporting.

SFY19 Q2 Comments:

IE&E: During this quarter, the Health Care Paper Application and Document Uploader projects stayed on schedule. Enterprise Content Management continued to stay behind schedule due to the need to remediate security findings. The State is working to rebaseline the project schedule for the upcoming quarter. Business Intelligence also fell behind due to technical challenges in building the connection between the new reporting environment and Optum's environment for Vermont Health Connect. The State is working with Optum to continue to triage this issue in order to secure the delivery timeline going forward.

MMIS: The MMIS Program has 4 projects going on in this quarter, Care Management Certification, Provider Management Module (PMM), Electronic Visit Verification (EVV) and Business Objects (BobJ) upgrade. EVV continued to be behind schedule due to needed clarity from Centers for Medicare and Medicaid Services (CMS) requirements. Care Management was behind schedule with regard to its Certification efforts which resulted from clarify from CMS on Certification requirements.

HIE: The VT HIE Performance Improvement project and the VT HIE Connectivity project are on schedule. Each of these projects has multiple components that are all tracking according to the agreed upon project plans and contract deliverables. The VT Clinical Registry project has been paused to assess (1) the most effective strategy for technical facets deemed "shared services" or services that will benefit HIE users more broadly and (2) the most effective strategy for meeting the needs of the Blueprint program and DVHA as it relates to the use of aggregate clinical data for measure, analysis, and reporting.

SFY19 Q3 Comments:

IE&E: During this quarter, the Health Care Paper Application, Document Uploader, and Enterprise Content Management projects stayed on schedule with Enterprise Content Management remediating all high priority security findings. The Business Intelligence project experienced network connectivity issues that have slowed progress.

MMIS: The MMIS Program has 4 projects going on in this quarter, Care Management Certification, Provider Management Module (PMM), Electronic Visit Verification (EVV) and Business Objects (BobJ) upgrade. PMM go-live date was scheduled for May 1, 2019. EVV continued to be behind schedule due to needed clarity from Centers for Medicare and Medicaid Services (CMS) requirements for its Certification efforts.

HIE: The VT HIE Performance Improvement project and the VT HIE Connectivity project are on schedule. Each of these projects has multiple components that are all tracking according to the agreed upon project plans and contract deliverables. The VT Clinical Registry project has been paused to assess (1) the most effective strategy for technical facets deemed "shared services" or services that will benefit HIE users more broadly and (2) the most effective strategy for meeting the needs of the Blueprint program and DVHA as it relates to the use of aggregate clinical data for measure, analysis, and reporting.

SFY19 Q4 Comments:

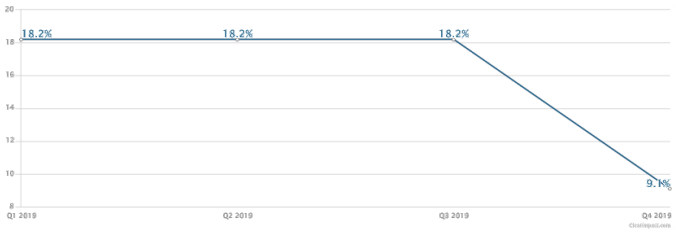
IE&E: During this quarter, the Health Care Paper Application, Document Uploader, and Enterprise Content Management projects remained on schedule. The Business Intelligence project experienced significant and persistent network connectivity issues that resulted in major performance issues and delayed implementation.

MMIS: The MMIS Program has 4 projects going on in this quarter, Care Management Certification, Provider Management Module (PMM), Electronic Visit Verification (EVV) and Business Objects (BobJ) upgrade. PMM had a successful go-live on May 1, 2019. CMS released its Certification requirements fo EVV. Care Management had a tentative date set for Milestone Review (R3) for Certification. Business Objects (BobJ) was completed and the project closed out.

HIE: The VT HIE Performance Improvement project and the VT HIE Connectivity project are on schedule. Each of these projects has multiple components that are all tracking according to the agreed upon project plans and contract deliverables. The project previously entitled Vermont Clinical Registry has been modified to serve a broader audience and use resources more efficiently. The HIE operator, VITL, has proposed a technical solution that offers shared infrastructure (Master Patient Index, Terminology Services, Integration Engine, Data Storage) to meet the needs of both the Clinical Registry and all consumers of health data from the HIE (see Q3 numbers).

Last updated 10/07/19

PM IT % of DVHA priority IT projects re-baselined during the quarter



Q4 2019	9.1%	–	–	↘ 1	-50% ↓
Q3 2019	18.2%	–		→ 2	0% →
Q2 2019	18.2%	–		→ 1	0% →
Q1 2019	18.2%	–		→ 0	0% →

Notes on Methodology

Priority IT projects included in the denominator of this measure		
HIE	**IE&E**	**MMIS**
Collaborative Services (formerly VT Clinical Registry)	Enterprise Content Management	Provider Management Module
VT HIE Performance Improvement	Business Intelligence	Care Management Module
VT HIE Connectivity	Health Care Paper Application	TMSIS Module
	Customer Portal Phase 1: Document Uploader	EVVS Module

Note: The HIE project previously entitled Vermont Clinical Registry has been modified to serve a broader audience and use resources more efficiently. The HIE operator, VITL, has proposed a technical solution that offers shared infrastructure (Master Patient Index, Terminology Services, Integration Engine, Clinical Warehouse) to meet the needs of Blueprint and all consumers of health data from the HIE.

% of priority IT projects re-baselined during the quarter												
	SFY19											
	Q1			Q2			Q3			Q4		
	# projects	# projects re-baselined	% projects re-baselined	# projects	# projects re-baselined	% projects re-baselined	# projects	# projects re-baselined	% projects re-baselined	# projects	# projects on schedule	% projects on schedule
HIE	3	1	33.3%	3	1	33.3%	3	0	0.0%	3	0	0.0%
IE&E	4	1	25.0%	4	1	25.0%	4	2	50.0%	4	1	25.0%
MMIS	4	0	0.0%	4	0	0.0%	4	0	0.0%	4	0	0.0%
Total	11	2	18.2%	11	2	18.2%	11	2	18.2%	11	1	9.1%

Partners

- Agency of Digital Services
- Centers for Medicare and Medicaid Services
- Agency of Human Services - Central Office
- Vermont General Assembly
- Economic Services Division, Department for Children and Families (Agency of Human Services)

Story Behind the Curve

Re-baselined is defined as the schedule being bumped by 3 or more months (so moving it from one quarter to the next).

SFY19 Q1 Comments:
IE&E: Health Care Paper Application schedule was adjusted due to additional time needed to work with vendor on design.
MMIS: No MMIS IT projects were re-baselined during the quarter.
HIE: Out of 3 projects one, VT Clinical Registry (now Collaborative Services), was re-baselined to better meet the needs of both Blueprint and all consumers of health data from the HIE.

SFY19 Q2 Comments:
IE&E: Document Uploader launch moved from August to October 2019.
MMIS: No MMIS IT projects were re-baselined during the quarter.
HIE: Out of 3 projects one, VT Clinical Registry (now Collaborative Services), was re-baselined to better meet the needs of both Blueprint and all consumers of health data from the HIE.

SFY19 Q3 Comments:
IE&E: Business Intelligence project delivery date was pushed from July to September 2019 due to network connectivity issues. Enterprise Content Management project delivery was pushed to September 2019 due to volume of security findings to be remediated following assessment.
MMIS: No MMIS IT projects were re-baselined during the quarter
HIE: No HIE IT projects were re-baselined during Q3.

SFY19 Q4 Comments:
IE&E: Business Intelligence project delivery was pushed from September to February due to network connectivity issues.
MMIS: No MMIS IT projects were re-baselined during the quarter
HIE: No HIE IT projects were re-baselined during Q4.

Last updated: 10/07/19

Actions

Name	Assigned To	Status	Due Date	Progress

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

P Adoption of Value Based Payments: Promote an Integrated System of Care

PPMB

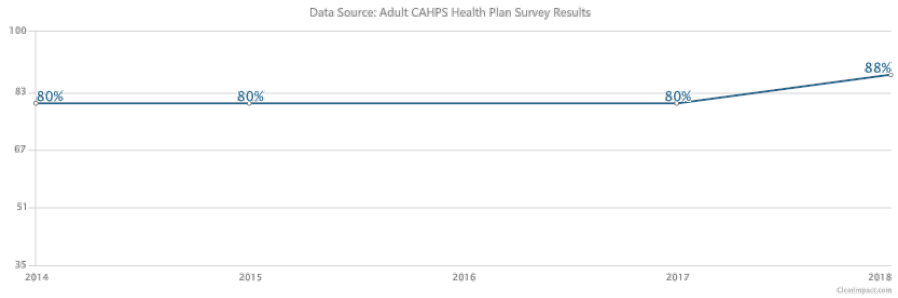
Budget Information

How We Impact

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

Performance Measures

	Most Recent Period	Current Actual Value
PM DVHA Coordination of Care - % of surveyed adult Medicaid beneficiaries who responded "usually" or "always" when asked about their perception of whether their doctor is up-to-date about the care he/she received from other doctors or health providers	2018	88%
	2017	80%
	2015	80%
	2014	80%



Notes on Methodology

This measure comes from the annual Adult Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey, which is a questionnaire developed jointly by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance.

The survey draws as potential respondents the adult members of Vermont Medicaid who were continuously enrolled in the plan for at least 6 months, with no more than one enrollment gap of 45 days or less. From this sample frame, a random sample of 1,650 cases is drawn.

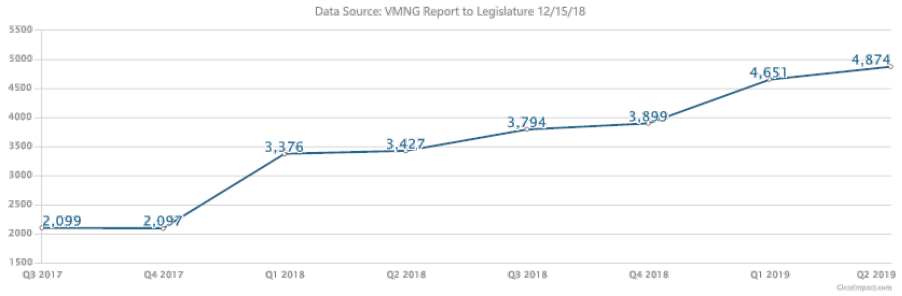
Story Behind the Curve

This measure displays the percentage of adult Medicaid beneficiaries who answered "usually" or "always" when asked about their perception of whether their personal doctor is up-to-date about the care he/she has received from other doctors or health providers.

Vermont Medicaid's performance on this measure stayed the same at 80% from 2014 - 2017. With the many healthcare reform efforts underway in Vermont, like patient-centered medical homes, community health teams and value based payment models, we hoped to see our performance on this measure improve, which it did in 2018 (by eight percentage points).

Last updated: 10/09/19

PM VBP Provider participation level in the ACO network by provider type



Q2 2019	4,874
Q1 2019	4,651
Q4 2018	3,899
Q3 2018	3,794
Q2 2018	3,427
Q1 2018	3,376
Q4 2017	2,097
Q3 2017	2,099
Q2 2017	2,026

Notes on Methodology

Provider participation level in the ACO network by provider type										
	CY2017				CY2018				CY2019	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Primary Care Providers	529	518	533	542	732	737	861	880	1110	1126
Specialists	1521	1508	1566	1555	2644	2690	2933	3019	3541	3748
Total	2050	2026	2099	2097	3376	3427	3794	3899	4651	4874

Partners

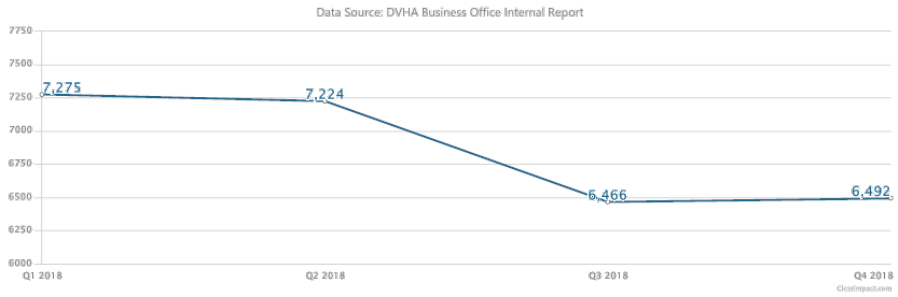
- OneCare

Story Behind the Curve

OneCare supplies DVHA with Network Composition reports on a quarterly basis. The grid above summarizes the counts of primary care and specialist providers participating in the Vermont Medicaid Next Generation program network for all Quarters in 2017, 2018, and for Quarters 1 and 2 of 2019. Provider participation remained fairly constant throughout each performance year and has significantly increased at the beginning of each subsequent year as OneCare expands its provider network.

Last updated: 09/16/19

PM VBP # of unduplicated ACO attributed members receiving out of network care



Q4 2018	6,492
Q3 2018	6,466
Q2 2018	7,224
Q1 2018	7,275

Partners

- OneCare

Story Behind the Curve

ACO-attributed members may seek care with any Medicaid provider. The ACO is accountable for the Total Cost of Care for these attributed members whether a provider is participating in the ACO network or not. Providers that are not participating in the ACO network are considered “Out of Network” providers.

Last updated: 10/09/19

Actions

Name	Assigned To	Status	Due Date	Progress

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

P Medicaid's Vermont Chronic Care Initiative (VCCI)

DVHA

What We Do

The Vermont Chronic Care Initiative (VCCI) provides holistic, intensive and short-term case management services to Vermont residents enrolled in Medicaid, including dually eligible members. VCCI works with non- ACO members identified using claims-based methodology and members identified by health care providers and community partners in need of complex care management. VCCI case managers are also welcoming new members to Medicaid, by outreaching and asking questions about primary care provider, health conditions and other supports that would assist them in maintaining or improving their health as well as housing, food and safety. The VCCI team works to connect members with medical homes, community-based self- management programs, and local care management teams.

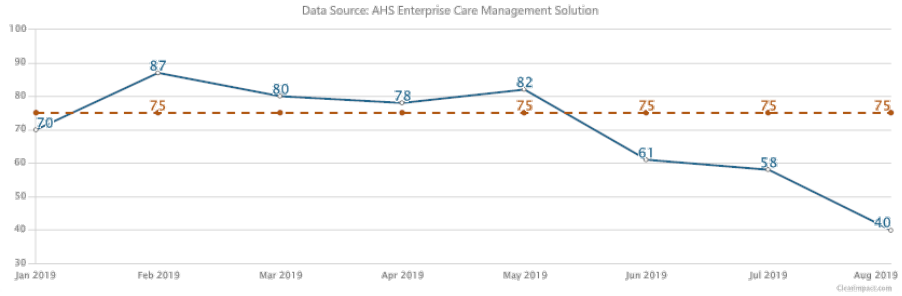
The VCCI utilizes common tools and processes adopted by the local community care teams as part of the complex care model to include eco mapping, identification of lead care coordinator, facilitating care teams, and shared care plan development.

Licensed case managers trained in the complex care model, deliver services in communities throughout the state.

How We Impact

The VCCI case managers are community based; and are stationed within the communities they live in. They work closely with their community health care and social service providers; collaboratively working with each other and the member on the member identified priorities. The case managers are closely linked with their AHS Field Directors – which has proven vital when working with members that may be involved with DCF, DOC, DMH, DAIL, and VDH. VCCI case managers meet with members in varied locations- homes, PCP offices, homeless camps, hospitals, shelters- successfully engaging members that have been historically 'hard to find'.

Performance Measures	Most Recent Period	Current Actual Value
PM VCCI # new VCCI eligible members enrolled in care management	Aug 2019	40



Jul 2019	**58**
Jun 2019	**61**
May 2019	**82**
Apr 2019	**78**
Mar 2019	**80**
Feb 2019	**87**
Jan 2019	**70**
Dec 2018	**35**

Partners

- Community Health Teams
- Healthcare Providers
- Community Service Providers
- State Partners to include AHS Field Directors, DCF, DOC
- DVHA Colleagues to include QIU, Pharmacy, COU
- Chief Medical officer; DVHA
- MMIS & Care Management vendors

Story Behind the Curve

The VCCI eligible population has gradually decreased over past couple of years, based on ACO attribution, with CY 2019 yielding ~29K less eligible members. This coupled with community feedback asking the VCCI to explore other populations that could be served by VCCI brought about enhancements to the VCCI eligible population. In addition to the traditional claims-based methodology, focused on our high cost/high risk population, health care providers and community partners may send over needs-based referrals on non-ACO attributed individuals whom, using their clinical judgment, need complex care management; now includes those dually insured. VCCI also welcomes new member to Medicaid by outreaching asking questions about primary care provider, health conditions and other supports that would assist them in maintain or improve their health (housing, food, safety).

This measure captures new enrollments/cases only – it does not reflect the total VCCI caseload. Recent fluctuations in this measure may certainly be impacted by ongoing training of VCCI in the new to Medicaid workflow/use of screening tool; in tandem with community and state providers/partners also learning of VCCI program enhancements. Communities have also commented that their learning curve with ACO and the system of care, has been an area of focus for them, with referrals to VCCI a lower priority. This number may still be impacted by staffing as there is 1 position vacant, one position has a nurse just beginning to enroll members, and we are waiting for a position to be approved for conversion to an outreach and support position.

Communities have also commented that their learning curve with ACO and the system of care, has been an area of focus for them, with referrals to VCCI a lower priority. This number may still be impacted by staffing as there is 1 RN position vacant, and our second outreach and support staff will start on June 10th.

There may be indirect correlation to our population enhancement to include outreach to New to Medicaid, needs based eligibility and dually insured. Other factors may include having one staff member dedicated to the outreach/screening and stratification of those new to Medicaid; coupled with the VCCI team commitment to service. This number may be impacted over the next few months as staff achieve target caseloads and will not be enrolling as many members.

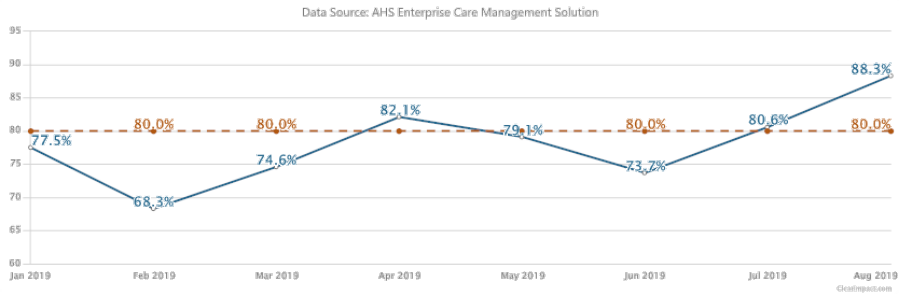
Last updated: 09/18/19

Strategy

- Continue to focus on increasing enrollments to achieve caseload expectations.
- Collaborate with local care teams and Providers to help identify high risk VCCI eligible members for enrollment

- Continue to work on ADT messaging from VITL into the eQ system to real time information on members admitted to facilities to enroll at time of service.

PM VCCI % of VCCI enrolled members with a face to face visit during the month



Aug 2019	88.3%
Jul 2019	80.6%
Jun 2019	73.7%
May 2019	79.1%
Apr 2019	82.1%
Mar 2019	74.6%
Feb 2019	68.3%
Jan 2019	77.5%
Dec 2018	65.6%

Partners

- Medicaid Beneficiaries
- Community Health Teams
- Healthcare Providers
- Community Service Providers
- State Partners to include AHS Field Directors, DCF, DOC
- DVHA Colleagues to include QIU, Pharmacy, COU
- Chief Medical officer; DVHA
- MMIS & Care Management vendors

Story Behind the Curve

One of the important and differentiating elements of the Vermont Chronic Care Initiative (VCCI) model is member face to face meetings as a measure of member engagement and trust, to support effective self-management and sustainable change. This measure is calculated as the percent of all members enrolled during the reporting month that received at least one face to face visit. Face to face visits are a component of short term, intensive case management and a factor in overall assessment of need and relationship building. Both are required to generate effective self-management and sustainable change.

The VCCI continues to work on staffing goals and standardized documentation and reporting in the new MMIS/Care Management system. Measurement is based on the month activity and only includes Face-to-Face visits with members that were enrolled during the entire month in the calculation as well as excluding members in an "on-hold" status. This is impacted by members lost to contact. This may also be impacted by the New to Medicaid focus which is done telephonically.

Members lost to contact (phone/home address change), member 'no shows' and/or case closures during the enrollment month, thus impacting face to face visit calculation in the measurement period.

Staffing resources impact this number as we have one staff member vacancy.

This number is up, possibly related to increase in enrollments and staff caseloads

Last updated: 09/18/19

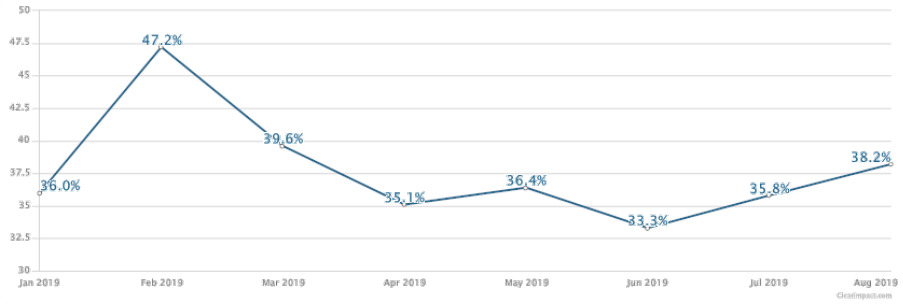
What Works

Face to face visits offer an opportunity for further member assessment and establishing meaningful relationship/engagement and trust required for health coaching/education on behavioral changes required for improved health. Home visits support assessment of the home environment, precipitating factors in their health/chronic health conditions (i.e. mold exposure for asthmatics with recurrent ED usage) and also offer the chance to perform medication reconciliation and assess adherence to pharmacy treatment. The literature does support the effectiveness of face to face case management vs. telephonic as regards results and sustainable change.

Strategy

- A few staff are over booking daily visits with the experiential knowledge that some members may cancel the visits during the week.
- Other staff offer members consistent time/day of visits; before leaving a visit, staff are scheduling the next follow up visit.
- Provide information to member that face to face visits are expected part of their participation in the VCCI program.

PM VCCI % of "New to Medicaid" members screened by VCCI



Aug 2019	38.2%
Jul 2019	35.8%
Jun 2019	33.3%
May 2019	36.4%
Apr 2019	35.1%
Mar 2019	39.6%
Feb 2019	47.2%
Jan 2019	36.0%
Dec 2018	20.8%

Notes on Methodology

% of "New to Medicaid" members screened								
	SFY19 Monthly						SFY20 Monthly	
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
# of new to Medicaid members	567	551	356	276	428	309	307	419
# of new to Medicaid members reached	230	310	175	99	168	117	129	185
# of new to Medicaid members screened	204	260	141	97	156	103	110	160
% of new to Medicaid members screened	**36.0%**	**47.2%**	**39.6%**	**35.1%**	**36.4%**	**33.3%**	**35.8%**	**38.2%**

Partners

- New to Medicaid (NTM) members
- MMIS/Data Unit
- Vermont Health Connect (VHC)

Story Behind the Curve

In effort to align with healthcare reform efforts and the system of care, the VCCI will be outreaching members new to Medicaid, screening for access to primary care, health conditions and social determinants of health.

The goals are to:

- Orient the members to the system of care, including navigation of services to health-related needs such as housing, food security

- Onboard the members ahead of their anticipated future ACO attribution to include facilitation of access to primary care
- Connect the members to community supports and resources

Full VCCI team started this outreach in October; starting with New to Medicaid population of 18 years of age and over, to allow for us to assess for team capacity.

Some influences on measure outcomes include:

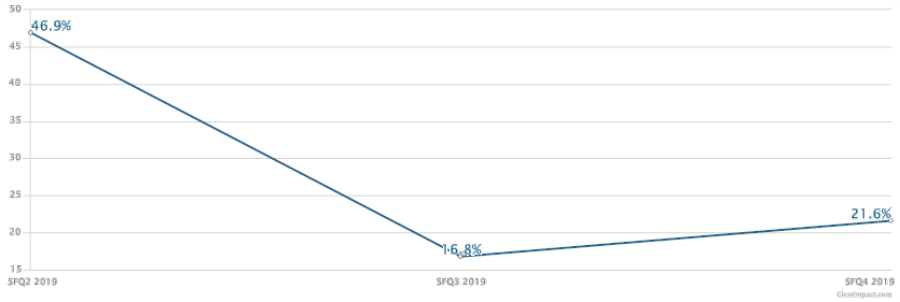
- Gap in feed of member phone numbers from VHC due to warehouse issues with December new to Medicaid population. We did not have phone numbers for ~50% population; in prior month, the gap was only ~14%.
- Members without valid phone numbers due to disconnected services; phones without voice messaging set up.
- Members not returning phone calls; nor responding to mailed screenings.
- Members declining to engage in screening.
- Ensuring new to Medicaid screening completion and system of care issues (PCP, etc) even if members indicate they will be dropping off of Medicaid soon.

Last updated: 09/18/19

Strategy

- Receive follow up training on Motivational Interviewing and providing brief interventions telephonically, in early 2019.
- Ongoing training/coaching of VCCI team to inform system of care issues such as PCP establishment, connection to local community resources (community action, self-management programs, transportation options).
- We have hired a second Outreach and Support Specialist to start June 10th to assist with outreach to the new to Medicaid population with goal that having dedicated staff members will support increase in members successfully screened.
- Provide regular training to staff to ensure documentation is standard in order to capture data.

PM VCCI % "New to Medicaid" members who accepted help with PCP establishment and who successfully established care with practice/medical home **SFQ4 2019** **21.6%**



SFQ3 2019	**16.8%**
SFQ2 2019	**46.9%**

Notes on Methodology

% of "New to Medicaid" members who accepted help with PCP establishment and who successfully established care with practice/medical home			
	SFY19		
	Q2	**Q3**	**Q4**
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	297	458	289
# members who didn't have a PCP and declined help	53	70	21
# members who didn't have a PCP and accepted help	81	95	51
# members who successfully established care	38	16	11
% members who successfully established care	**46.9%**	**16.8%**	**21.6%**

Partners

- Members
- Healthcare practices
- Blueprint Community Health Teams
- Medicaid Member Services
- Bi-State

Story Behind the Curve

In an effort to align with healthcare reform efforts and the system of care, the VCCI is outreaching members new to Medicaid; screening for access to primary care, health conditions and social determinants of health. One of the goals of this effort is to onboard members ahead of their anticipated future ACO attribution to include facilitation of access to primary care. Our new to Medicaid screening begins with asking each member if they have established primary care. If member answers 'no', they are then asked if they would accept help in facilitating primary care. VCCI staff then offer a 3-way phone call to actively connect member to primary care office/medical home; provide number to Medicaid Member Services to update primary care provider.

Some influences on measure outcomes include:

- Primary care offices continue to decline to schedule a new patient appointment, without receipt of medical records from previous provider. Recently, one practice provided an appointment date, but then called member back to cancel the appointment, pending records.
- Members preferring to independently call provider practice to establish care versus accepting VCCI offer of 3-way phone call, and perhaps not following through on own.
- Despite coaching on importance of primary care, members may still decline offer of primary care contact options; decline 3-way phone call to provider practices.
- Primary care offices not accepting any new patients.
- Members not able to be outreached by phone, are mailed new to Medicaid screening; and may not return the screening. Note - Business reply envelopes are included with screening.
- VCCI staff not updating plan of care with reflection of issue of lack of primary care resolved and therefore, data cannot be pulled for reporting purposes. Staff have shared that they are waiting to resolve this issue until member has attended appointment versus resolving when providing an appointment date as they feel that an appointment scheduled is separate than attending the appointment. Our eQ care management system will be amended to have an additional goal added to our primary care issue, so that staff can resolve PCP appointment scheduling as a separate issue from PCP appointment attendance.

Last updated: 07/15/19

APPENDIX E: VANTAGE REPORTS

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State of Vermont
FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 1. PERSONAL SERVICES

Salaries and Wages		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Classified Employees	500000	22,092,730	22,803,026	22,803,026	23,197,822	394,796	1.7%
Exempt	500010	0	1,439,137	1,439,137	1,525,968	86,831	6.0%
Overtime	500060	342,063	0	0	0	0	0.0%
Market Factor - Classified	500899	0	606,639	606,639	588,917	(17,722)	-2.9%
Vacancy Turnover Savings	508000	0	(2,048,287)	(2,048,287)	(2,200,901)	(152,614)	7.5%
Total: Salaries and Wages		**22,434,793**	**22,800,515**	**22,800,515**	**23,111,806**	**311,291**	**1.4%**

Fringe Benefits		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
FICA - Classified Employees	501000	1,636,978	1,790,752	1,790,752	1,819,692	28,940	1.6%
FICA - Exempt	501010	0	107,246	107,246	112,757	5,511	5.1%
Health Ins - Classified Empl	501500	4,819,590	5,001,894	5,001,894	5,166,689	164,795	3.3%
Health Ins - Exempt	501510	0	249,395	249,395	246,905	(2,490)	-1.0%
Retirement - Classified Empl	502000	4,056,187	4,747,501	4,747,501	4,995,221	247,720	5.2%
Retirement - Exempt	502010	0	257,812	257,812	300,057	42,245	16.4%
Dental - Classified Employees	502500	267,560	310,420	310,420	294,270	(16,150)	-5.2%
Dental - Exempt	502510	0	13,660	13,660	12,540	(1,120)	-8.2%

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Fringe Benefits		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Life Ins - Classified Empl	503000	78,122	98,802	98,802	100,368	1,566	1.6%
Life Ins - Exempt	503010	0	6,078	6,078	6,439	361	5.9%
LTD - Classified Employees	503500	5,048	2,771	2,771	2,966	195	7.0%
LTD - Exempt	503510	0	3,312	3,312	3,509	197	5.9%
EAP - Classified Empl	504000	10,363	11,363	11,363	11,510	147	1.3%
EAP - Exempt	504010	0	509	509	479	(30)	-5.9%
Employee Tuition Costs	504530	4,508	2,494	2,494	10,000	7,506	301.0%
Workers Comp - Other	505030	0	0	0	0	0	0.0%
Workers Comp - Ins Premium	505200	0	85,250	85,250	164,318	79,068	92.7%
Unemployment Compensation	505500	9,585	0	0	0	0	0.0%
Catamount Health Assessment	505700	1,333	8,214	8,214	8,400	186	2.3%
Total: Fringe Benefits		**10,889,273**	**12,697,473**	**12,697,473**	**13,256,120**	**558,647**	**4.4%**

Contracted and 3rd Party Service		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
IT Contracts - IT Finance & Administration	507105	0	0	0	0	0	0.0%
Contr&3Rd Pty-Educ & Training	507350	1,745	198	198	0	(198)	-100.0%
IT Contracts - Project Managment	507542	7,289,397	0	0	0	0	0.0%
IT Contracts - Storage	507544	295,200	873,869	873,869	2,892,179	2,018,310	231.0%
IT Contracts - Application Development	507565	4,239,334	26,522,675	26,522,675	14,457,417	(12,065,258)	-45.5%
IT Contracts - Application Support	507566	37,431,329	33,337,925	33,337,925	42,624,158	9,286,233	27.9%
Other Contr and 3Rd Pty Serv	507600	24,424,659	38,346,541	44,051,560	30,495,430	(7,851,111)	-20.5%

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Contracted and 3rd Party Service		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Interpreters	507615	41,572	10,020	10,020	43,000	32,980	329.1%
Custodial	507670	808	600	600	1,000	400	66.7%
Total: Contracted and 3rd Party Service		**73,724,044**	**99,091,828**	**104,796,847**	**90,513,184**	**(8,578,644)**	**-8.7%**

PerDiem and Other Personal Services		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Per Diem	506000	5,950	7,926	7,926	8,126	200	2.5%
Other Pers Serv	506200	6,012	4,914	4,914	6,200	1,286	26.2%
Transcripts	506220	36	0	0	0	0	0.0%
Sheriffs	506230	0	1,150	1,150	1,150	0	0.0%
Total: PerDiem and Other Personal Services		**11,998**	**13,990**	**13,990**	**15,476**	**1,486**	**10.6%**

Total: 1. PERSONAL SERVICES	**107,060,108**	**134,603,806**	**140,308,825**	**126,896,586**	**(7,707,220)**	**-5.7%**

Budget Object Group: 2. OPERATING

Equipment		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						

State of Vermont
FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Equipment		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Hardware - Desktop & Laptop Pc	522216	109,472	60,000	60,000	115,000	55,000	91.7%
Hw - Printers,Copiers,Scanners	522217	15,129	6,000	6,000	18,000	12,000	200.0%
Hardware - Data Network	522273	605	1,000	1,000	1,000	0	0.0%
Server Connectivity	522282	220	0	0	0	0	0.0%
Software-Application Development	522283	2,420	3,000	3,000	3,000	0	0.0%
Software - Application Support	522284	47,335	11,500	11,500	42,000	30,500	265.2%
Software - Desktop	522286	80,657	5,500	5,500	85,000	79,500	1,445.5%
Software-Security	522288	0	1,500	1,500	1,500	0	0.0%
Software - Server	522289	0	2,200	2,200	2,200	0	0.0%
Software - Storage	522290	9,740	0	0	0	0	0.0%
Office Equipment	522410	66	100	100	100	0	0.0%
Safety Supplies & Equipment	522440	133	0	0	0	0	0.0%
Furniture & Fixtures	522700	82,573	24,000	24,000	83,300	59,300	247.1%
Total: Equipment		**348,349**	**114,800**	**114,800**	**351,100**	**236,300**	**205.8%**

IT/Telecom Services and Equipment		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Communications	516600	8,589	4,000	4,000	8,500	4,500	112.5%
ADS VOIP Expense	516605	45,662	0	0	0	0	0.0%
Internet	516620	16	0	0	0	0	0.0%
Telecom-Data Telecom Services	516651	0	0	0	0	0	0.0%
Telecom-Video Conf Services	516653	0	0	0	0	0	0.0%

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

IT/Telecom Services and Equipment		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Telecom-Conf Calling Services	516658	0	15,000	15,000	30,000	15,000	100.0%
Telecom-Wireless Phone Service	516659	471	0	0	0	0	0.0%
ADS Enterp App Supp SOV Emp Exp	516660	739,378	0	0	603,961	603,961	100.0%
It Intsvccost-Vision/Isdassess	516671	629,241	639,024	639,024	678,068	39,044	6.1%
ADS Centrex Exp.	516672	170,986	0	0	172,100	172,100	100.0%
It Intsvccos-Dii Data Telecomm	516673	0	0	0	0	0	0.0%
It Inter Svc Cost User Support	516678	0	0	0	0	0	0.0%
ADS Allocation Exp.	516685	323,127	468,482	468,482	509,322	40,840	8.7%
Hw - Other Info Tech	522200	0	0	0	0	0	0.0%
Hw - Computer Peripherals	522201	140	0	0	0	0	0.0%
Software - Other	522220	0	0	0	0	0	0.0%
Total: IT/Telecom Services and Equipment		**1,917,610**	**1,126,506**	**1,126,506**	**2,001,951**	**875,445**	**77.7%**

Other Operating Expenses		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Single Audit Allocation	523620	0	40,000	40,000	40,000	0	0.0%
Bank Service Charges	524000	74	250	250	250	0	0.0%
Total: Other Operating Expenses		**74**	**40,250**	**40,250**	**40,250**	**0**	**0.0%**

State of Vermont

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Organization: 3410010000 - Department of Vermont health access - administration

Other Purchased Services		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Insurance Other Than Empl Bene	516000	94,547	2,988	2,988	8,669	5,681	190.1%
Insurance - General Liability	516010	0	59,806	59,806	97,047	37,241	62.3%
Dues	516500	51,800	49,000	49,000	55,000	6,000	12.2%
Licenses	516550	77,924	800	800	79,000	78,200	9,775.0%
Telecom-Mobile Wireless Data	516623	2,170	0	0	2,400	2,400	100.0%
Telecom-Telephone Services	516652	78,423	83,000	83,000	166,000	83,000	100.0%
ADS PM SOV Employee Expense	516683	0	0	0	0	0	0.0%
Advertising	516800	0	0	0	0	0	0.0%
Advertising-Other	516815	1,873	10,000	10,000	10,000	0	0.0%
Advertising - Job Vacancies	516820	4,577	10,000	10,000	10,000	0	0.0%
Printing and Binding	517000	243,294	240,000	240,000	267,000	27,000	11.3%
Photocopying	517020	24	0	0	100	100	100.0%
Registration For Meetings&Conf	517100	0	2,000	2,000	2,000	0	0.0%
Training - Info Tech	517110	0	2,000	2,000	20,000	18,000	900.0%
Empl Train & Background Checks	517120	285	1,000	1,000	1,000	0	0.0%
Postage	517200	284,432	275,000	275,000	307,500	32,500	11.8%
Postage - Bgs Postal Svcs Only	517205	74	0	0	0	0	0.0%
Freight & Express Mail	517300	13,111	25,000	25,000	25,200	200	0.8%
Instate Conf, Meetings, Etc	517400	18,502	25,000	25,000	25,000	0	0.0%
Catering-Meals-Cost	517410	543	1,000	1,000	1,000	0	0.0%
Outside Conf, Meetings, Etc	517500	29,204	0	0	28,000	28,000	100.0%
Other Purchased Services	519000	59,685	58,000	58,000	61,250	3,250	5.6%
Human Resources Services	519006	215,951	240,582	240,582	259,226	18,644	7.7%
Administrative Service Charge	519010	23,395	30,000	30,000	30,000	0	0.0%
Security Services	519025	203	0	0	0	0	0.0%
Moving State Agencies	519040	2,972	0	0	0	0	0.0%

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Other Purchased Services		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Infrastructure as a Service	519081	8,436,682	24,930,283	24,930,283	23,780,415	(1,149,868)	-4.6%
Total: Other Purchased Services		**9,639,671**	**26,045,459**	**26,045,459**	**25,235,807**	**(809,652)**	**-3.1%**

Property and Maintenance		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Water/Sewer	510000	35	68	68	68	0	0.0%
Disposal	510200	760	1,200	1,200	1,200	0	0.0%
Recycling	510220	1,210	0	0	0	0	0.0%
Custodial	510400	1,388	0	0	0	0	0.0%
Exterminators	510510	171	0	0	0	0	0.0%
Repair & Maint - Buildings	512000	754	600	600	1,100	500	83.3%
Rep&Maint-Telecom&Ntwrkhw	513006	3,000	0	0	0	0	0.0%
Repair & Maint - Office Tech	513010	38,166	40,000	40,000	41,000	1,000	2.5%
Other Repair & Maint Serv	513200	22,766	2,000	2,000	23,000	21,000	1,050.0%
Repair&Maint-Property/Grounds	513210	32,642	5,000	5,000	34,000	29,000	580.0%
Total: Property and Maintenance		**100,892**	**48,868**	**48,868**	**100,368**	**51,500**	**105.4%**

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Rental Other		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Rental - Auto	514550	21,061	20,000	20,000	23,020	3,020	15.1%
Rental - Office Equipment	514650	32,100	20,000	20,000	32,000	12,000	60.0%
Total: Rental Other		**53,161**	**40,000**	**40,000**	**55,020**	**15,020**	**37.6%**

Rental Property		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Rent Land & Bldgs-Office Space	514000	1,389,919	1,500,000	1,500,000	1,610,956	110,956	7.4%
Rent Land&Bldgs-Non-Office	514010	39	0	0	60	60	100.0%
Fee-For-Space Charge	515010	275,198	708,476	708,476	735,794	27,318	3.9%
Total: Rental Property		**1,665,157**	**2,208,476**	**2,208,476**	**2,346,810**	**138,334**	**6.3%**

Supplies		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Office Supplies	520000	38,566	50,000	50,000	51,000	1,000	2.0%
Gasoline	520110	316	200	200	500	300	150.0%
Other General Supplies	520500	7	3,000	3,000	3,000	0	0.0%
Recognition/Awards	520600	415	0	0	600	600	100.0%
Public Service Recog Wk Food	520601	1,618	0	0	0	0	0.0%

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Supplies		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Food	520700	8,396	3,000	3,000	9,000	6,000	200.0%
Water	520712	1,888	800	800	2,000	1,200	150.0%
Electricity	521100	836	800	800	1,000	200	25.0%
Heating Oil #2 - Uncut	521220	117	400	400	400	0	0.0%
Propane Gas	521320	312	150	150	400	250	166.7%
Books&Periodicals-Library/Educ	521500	10,962	600	600	11,700	11,100	1,850.0%
Subscriptions	521510	18,647	100,000	100,000	100,100	100	0.1%
Other Books & Periodicals	521520	0	1,500	1,500	1,500	0	0.0%
Household, Facility&Lab Suppl	521800	304	300	300	400	100	33.3%
Paper Products	521820	1,173	1,000	1,000	1,200	200	20.0%
Total: Supplies		**83,557**	**161,750**	**161,750**	**182,800**	**21,050**	**13.0%**

Travel		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Travel-Inst-Auto Mileage-Emp	518000	43,358	50,000	50,000	210,000	160,000	320.0%
Travel-Inst-Other Transp-Emp	518010	6,948	5,000	5,000	21,000	16,000	320.0%
Travel-Inst-Meals-Emp	518020	0	600	600	1,800	1,200	200.0%
Travel-Inst-Incidentals-Emp	518040	328	800	800	2,400	1,600	200.0%
Travl-Inst-Auto Mileage-Nonemp	518300	4,500	3,500	3,500	4,500	1,000	28.6%
Travel-Inst-Other Trans-Nonemp	518310	0	150	150	450	300	200.0%
Travel-Outst-Auto Mileage-Emp	518500	796	1,700	1,700	5,100	3,400	200.0%
Travel-Outst-Other Trans-Emp	518510	18,706	25,000	25,000	90,300	65,300	261.2%

State of Vermont
FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Travel		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Travel-Outst-Meals-Emp	518520	4,108	5,000	5,000	21,000	16,000	320.0%
Travel-Outst-Lodging-Emp	518530	20,759	25,000	25,000	75,000	50,000	200.0%
Travel-Outst-Incidentals-Emp	518540	2,587	3,000	3,000	12,000	9,000	300.0%
Total: Travel		**102,091**	**119,750**	**119,750**	**443,550**	**323,800**	**270.4%**

Repair and Maintenance Services			FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Software-Rep&Maint-ApplicaSupp	513050	0	0	0	0	0	0.0%
Total: Repair and Maintenance Services		**0**	**0**	**0**	**0**	**0**	**0.0%**

Rentals		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Software-License-ApplicaSupprt	516551	62,692	0	0	0	0	0.0%
Software-License-ApplicaDevel	516552	0	0	0	0	0	0.0%
Software-License-Security	516554	0	0	0	0	0	0.0%
Software-License-DeskLaptop PC	516559	0	0	0	0	0	0.0%
Total: Rentals		**62,692**	**0**	**0**	**0**	**0**	**0.0%**

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410010000 - Department of Vermont health access - administration

Property Management Services		FY2019 Actuals				Difference Between Recommend and As Passed	Percent Change Recommend and As Passed
Description	**Code**						
Accreditation/Certification	516575	275	0	0	0	0	0.0%
Total: Property Management Services		**275**	**0**	**0**	**0**	**0**	**0.0%**
Total: 2. OPERATING		**13,973,527**	**29,905,859**	**29,905,859**	**30,757,656**	**851,797**	**2.8%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Grants	550220	0	0	0	0	0	0.0%
Other Grants	550500	2,490,227	3,192,301	3,192,301	3,192,301	0	0.0%
Medical Services Grants	604250	2,949,549	4,122,422	4,122,422	2,000,000	(2,122,422)	-51.5%
AHS Cost Allocation Exp. Acct.	799090	(261,007)	0	0	0	0	0.0%
Total: Grants Rollup		**5,178,770**	**7,314,723**	**7,314,723**	**5,192,301**	**(2,122,422)**	**-29.0%**
Total: 3. GRANTS		**5,178,770**	**7,314,723**	**7,314,723**	**5,192,301**	**(2,122,422)**	**-29.0%**
Total Expenses:		**126,212,405**	**171,824,388**	**177,529,407**	**162,846,543**	**(8,977,845)**	**-5.2%**

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Object Group: 1. PERSONAL SERVICES

Contracted and 3rd Party Service		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Other Contr and 3Rd Pty Serv	507600	547,983	547,983	547,983	547,983	0	0.0%
Total: Contracted and 3rd Party Service		**547,983**	**547,983**	**547,983**	**547,983**	**0**	**0.0%**
Total: 1. PERSONAL SERVICES		**547,983**	**547,983**	**547,983**	**547,983**	**0**	**0.0%**

Budget Object Group: 3. GRANTS

Grants Rollup		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Grants	550220	0	0	0	0	0	0.0%
Medical Services Grants	604250	744,635,569	737,800,525	727,640,997	710,983,891	(26,816,634)	-3.6%
AHS Cost Allocation Exp. Acct.	799090	4	0	0	0	0	0.0%
Total: Grants Rollup		**744,635,573**	**737,800,525**	**727,640,997**	**710,983,891**	**(26,816,634)**	**-3.6%**
Total: 3. GRANTS		**744,635,573**	**737,800,525**	**727,640,997**	**710,983,891**	**(26,816,634)**	**-3.6%**
Total Expenses:		**745,183,556**	**738,348,508**	**728,188,980**	**711,531,874**	**(26,816,634)**	**-3.6%**

State of Vermont
FY2021 Governor's Recommended Budget: Detail Report

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

Budget Object Group: 3. GRANTS

Grants Rollup		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Medical Services Grants	604250	206,971,637	213,712,634	220,695,415	0	(213,712,634)	-100.0%
Total: Grants Rollup		**206,971,637**	**213,712,634**	**220,695,415**	**0**	**(213,712,634)**	**-100.0%**
Total: 3. GRANTS		**206,971,637**	**213,712,634**	**220,695,415**	**0**	**(213,712,634)**	**-100.0%**
Total Expenses:		**206,971,637**	**213,712,634**	**220,695,415**	**0**	**(213,712,634)**	**-100.0%**

State of Vermont

FY2021 Governor's Recommended Budget: Detail Report

Organization: 3410017000 - DVHA- Medicaid/state only programs

Budget Object Group: 3. GRANTS

Grants Rollup		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Medical Services Grants	604250	53,310,523	49,211,558	53,012,422	54,646,592	5,435,034	11.0%
AHS Cost Allocation Exp. Acct.	799090	(237,391)	0	0	0	0	0.0%
Total: Grants Rollup		**53,073,132**	**49,211,558**	**53,012,422**	**54,646,592**	**5,435,034**	**11.0%**
Total: 3. GRANTS		**53,073,132**	**49,211,558**	**53,012,422**	**54,646,592**	**5,435,034**	**11.0%**
Total Expenses:		**53,073,132**	**49,211,558**	**53,012,422**	**54,646,592**	**5,435,034**	**11.0%**

State of Vermont
FY2021 Governor's Recommended Budget: Detail Report

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

Budget Object Group: 3. GRANTS

Grants Rollup		FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Description	**Code**						
Medical Services Grants	604250	32,492,145	32,435,074	33,297,789	32,743,514	308,440	1.0%
AHS Cost Allocation Exp. Acct.	799090	498,394	0	0	0	0	0.0%
Total: Grants Rollup		**32,990,539**	**32,435,074**	**33,297,789**	**32,743,514**	**308,440**	**1.0%**
Total: 3. GRANTS		**32,990,539**	**32,435,074**	**33,297,789**	**32,743,514**	**308,440**	**1.0%**
Total Expenses:		**32,990,539**	**32,435,074**	**33,297,789**	**32,743,514**	**308,440**	**1.0%**

Fund Name	Fund Code	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
General Fund	10000	83,205,094	78,253,284	85,565,970	86,847,388	8,594,104	11.0%
Global Commitment Fund	20405	968,381,119	967,880,976	968,883,565	727,909,514	(239,971,462)	-24.8%
Insurance Regulatory & Suprv	21075	0	0	0	0	0	0.0%
Inter-Unit Transfers Fund	21500	5,923,036	7,542,602	4,522,390	4,832,636	(2,709,966)	-35.9%
Evidence-Based Educ & Advertis	21912	0	0	0	0	0	0.0%
Vermont Health IT Fund	21916	4,208,362	6,096,108	6,096,108	3,379,479	(2,716,629)	-44.6%
State Health Care Resources Fd	21990	0	0	0	0	0	0.0%
Federal Revenue Fund	22005	102,713,659	145,759,192	147,655,980	138,799,506	(6,959,686)	-4.8%
ARRA Federal Fund	22040	0	0	0	0	0	0.0%
Funds Total:		**1,164,431,269**	**1,205,532,162**	**1,212,724,013**	**961,768,523**	**(243,763,639)**	**-20.2%**

Position Count					375		
FTE Total					371.46		

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State of Vermont

FY2021 Governor's Recommended Budget: Rollup Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Salaries and Wages	22,434,793	22,800,515	22,800,515	23,111,806	311,291	1.4%
Fringe Benefits	10,889,273	12,697,473	12,697,473	13,256,120	558,647	4.4%
Contracted and 3rd Party Service	73,724,044	99,091,828	104,796,847	90,513,184	(8,578,644)	-8.7%
PerDiem and Other Personal Services	11,998	13,990	13,990	15,476	1,486	10.6%
Budget Object Group Total: 1. PERSONAL SERVICES	**107,060,108**	**134,603,806**	**140,308,825**	**126,896,586**	**(7,707,220)**	**-5.7%**

Budget Object Group: 2. OPERATING

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Equipment	348,349	114,800	114,800	351,100	236,300	205.8%
IT/Telecom Services and Equipment	1,917,610	1,126,506	1,126,506	2,001,951	875,445	77.7%
Travel	102,091	119,750	119,750	443,550	323,800	270.4%
Supplies	83,557	161,750	161,750	182,800	21,050	13.0%
Other Purchased Services	9,639,671	26,045,459	26,045,459	25,235,807	(809,652)	-3.1%
Other Operating Expenses	74	40,250	40,250	40,250	0	0.0%
Rental Other	53,161	40,000	40,000	55,020	15,020	37.6%
Rental Property	1,665,157	2,208,476	2,208,476	2,346,810	138,334	6.3%
Property and Maintenance	100,892	48,868	48,868	100,368	51,500	105.4%
Repair and Maintenance Services	0	0	0	0	0	0.0%
Rentals	62,692	0	0	0	0	0.0%
Property Management Services	275	0	0	0	0	0.0%
Budget Object Group Total: 2. OPERATING	**13,973,527**	**29,905,859**	**29,905,859**	**30,757,656**	**851,797**	**2.8%**

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State of Vermont

FY2021 Governor's Recommended Budget: Rollup Report

Organization: 3410010000 - Department of Vermont health access - administration

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Grants Rollup	5,178,770	7,314,723	7,314,723	5,192,301	(2,122,422)	-29.0%
Budget Object Group Total: 3. GRANTS	**5,178,770**	**7,314,723**	**7,314,723**	**5,192,301**	**(2,122,422)**	**-29.0%**
Total Expenses	**126,212,405**	**171,824,388**	**177,529,407**	**162,846,543**	**(8,977,845)**	**-5.2%**

Fund Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
General Funds	30,906,692	29,222,317	32,242,529	31,349,020	2,126,703	7.3%
Special Fund	4,208,362	6,096,108	6,096,108	3,379,479	(2,716,629)	-44.6%
State Health Care Resources Fund	0	0	0	0	0	0.0%
Federal Funds	80,540,445	124,749,165	124,749,165	118,960,026	(5,789,139)	-4.6%
ARRA Funds	0	0	0	0	0	0.0%
Global Commitment	5,633,870	4,214,196	9,919,215	4,325,382	111,186	2.6%
IDT Funds	4,923,036	7,542,602	4,522,390	4,832,636	(2,709,966)	-35.9%
Funds Total	**126,212,405**	**171,824,388**	**177,529,407**	**162,846,543**	**(8,977,845)**	**-5.2%**

Position Count				375		
FTE Total				371.46		

State of Vermont

FY2021 Governor's Recommended Budget: Rollup Report

Organization: 3410015000 - DVHA- Medicaid Program/Global Commitment

Budget Object Group: 1. PERSONAL SERVICES

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Contracted and 3rd Party Service	547,983	547,983	547,983	547,983	0	0.0%
Budget Object Group Total: 1. PERSONAL SERVICES	**547,983**	**547,983**	**547,983**	**547,983**		**0.0%**

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Grants Rollup	744,635,573	737,800,525	727,640,997	710,983,891	(26,816,634)	-3.6%
Budget Object Group Total: 3. GRANTS	**744,635,573**	**737,800,525**	**727,640,997**	**710,983,891**	**(26,816,634)**	**-3.6%**

Total Expenses	**745,183,556**	**738,348,508**	**728,188,980**	**711,531,874**	**(26,816,634)**	**-3.6%**

Fund Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Global Commitment	745,183,556	738,348,508	728,188,980	711,531,874	(26,816,634)	-3.6%
Funds Total	**745,183,556**	**738,348,508**	**728,188,980**	**711,531,874**	**(26,816,634)**	**-3.6%**

Position Count						
FTE Total						

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State of Vermont

FY2021 Governor's Recommended Budget: Rollup Report

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

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Grants Rollup	206,971,637	213,712,634	220,695,415	0	(213,712,634)	-100.0%
Budget Object Group Total: 3. GRANTS	**206,971,637**	**213,712,634**	**220,695,415**	**0**	**(213,712,634)**	**-100.0%**
Total Expenses	**206,971,637**	**213,712,634**	**220,695,415**	**0**	**(213,712,634)**	**-100.0%**

Fund Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
General Funds	177,465	0	0	0	0	0.0%
Federal Funds	589,363	0	1,750,000	0	0	0.0%
Global Commitment	206,204,809	213,712,634	218,945,415	0	(213,712,634)	-100.0%
Funds Total	**206,971,637**	**213,712,634**	**220,695,415**	**0**	**(213,712,634)**	**-100.0%**

Position Count						
FTE Total						

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State of Vermont

FY2021 Governor's Recommended Budget: Rollup Report

Organization: 3410017000 - DVHA- Medicaid/state only programs

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Grants Rollup	53,073,132	49,211,558	53,012,422	54,646,592	5,435,034	11.0%
Budget Object Group Total: 3. GRANTS	**53,073,132**	**49,211,558**	**53,012,422**	**54,646,592**	**5,435,034**	**11.0%**
Total Expenses	**53,073,132**	**49,211,558**	**53,012,422**	**54,646,592**	**5,435,034**	**11.0%**

Fund Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
General Funds	40,714,249	37,605,920	41,182,467	42,594,334	4,988,414	13.3%
Global Commitment	11,358,883	11,605,638	11,829,955	12,052,258	446,620	3.8%
IDT Funds	1,000,000	0	0	0	0	0.0%
Funds Total	**53,073,132**	**49,211,558**	**53,012,422**	**54,646,592**	**5,435,034**	**11.0%**

Position Count						
FTE Total						

Report ID: VTPB-11-BUDRLLUP
Run Date: 01/30/2020
Run Time: 03:57 PM

State of Vermont

FY2021 Governor's Recommended Budget: Rollup Report

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

Budget Object Group: 3. GRANTS

Budget Object Rollup Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
Grants Rollup	32,990,539	32,435,074	33,297,789	32,743,514	308,440	1.0%
Budget Object Group Total: 3. GRANTS	**32,990,539**	**32,435,074**	**33,297,789**	**32,743,514**	**308,440**	**1.0%**
Total Expenses	**32,990,539**	**32,435,074**	**33,297,789**	**32,743,514**	**308,440**	**1.0%**

Fund Name	FY2019 Actuals	FY2020 Original As Passed Budget	FY2020 Governor's BAA Recommended Budget	FY2021 Governor's Recommended Budget	Difference Between FY2021 Governor's Recommend and FY2020 As Passed	Percent Change FY2021 Governor's Recommend and FY2020 As Passed
General Funds	11,406,688	11,425,047	12,140,974	12,904,034	1,478,987	12.9%
Federal Funds	21,583,851	21,010,027	21,156,815	19,839,480	(1,170,547)	-5.6%
Funds Total	**32,990,539**	**32,435,074**	**33,297,789**	**32,743,514**	**308,440**	**1.0%**

Position Count						
FTE Total						

State of Vermont
FY2021 Governor's Recommended Budget
Federal - Receipts Detail Report

Department: 3410010000 - Department of Vermont health access - administration

Budget Request Code	Fund	Justification	Est Amount
10032	22005		$118,960,026
		Total	**$118,960,026**

State of Vermont
FY2021 Governor's Recommended Budget
Grants Out Inventory Report

VERMONT

Department: 3410010000 - Department of Vermont health access - administration

Budget Request Code	Fund	Justification	Est Amount
9603	10000	Navigator Grant	$24,000
9603	20405	Blueprint Grants	$2,659,301
9603	21916	HIE Funded Grants	$402,477
9603	22005	EHRIP Grants	$2,000,000
9603	22005	HIE Funded Grants	$82,523
9603	22005	Navigator Grant	$24,000
		Total	**5,192,301**

Report ID:	VTPB-23 IDT_RECEIPTS

State of Vermont
FY2021 Governor's Recommended Budget
Interdepartmental Transfers Inventory Report

Department: 3410010000 - Department of Vermont health access - administration

Budget Request Code	Fund	Justification	Est Amount
10034	21500	03400 AHS	$4,382,636
10034	21500	03420 VDH	$450,000
		Total	**4,832,636**

Report ID : VTPB - 14
Run Date : 01/24/2020
Run Time : 02:52 PM

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

3410010000-Department of Vermont health access - administration

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730001	501100 - DVHA Program Consultant	1	1	57,466	36,115	4,397	97,978
730002	501100 - DVHA Program Consultant	1	1	52,154	28,721	3,989	84,864
730003	499800 - DVHA COB Director	1	1	91,069	28,716	6,966	126,751
730005	459400 - DVHA Medicaid Compliance Off	1	1	102,453	45,748	7,838	156,039
730006	459800 - Health Program Administrator	1	1	54,704	30,130	4,186	89,020
730007	495900 - Med Hlthcare Data & Stat Anal	1	1	80,002	18,005	6,120	104,127
730009	460500 - Program Integrity Director	1	1	97,035	21,877	7,424	126,336
730011	460560 - Oversight&Monitor Security Aud	1	1	87,085	42,456	6,663	136,204
730012	000070 - Nurse Case Manager / URN I	1	1	83,869	27,175	6,416	117,461
730013	004700 - Program Technician I	1	1	39,210	9,267	3,000	51,477
730014	499700 - Medicaid Operations Adm	1	1	70,515	38,910	5,394	114,819
730018	089130 - Financial Director I	1	1	77,323	40,368	5,915	123,606

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730020	495600 - Associate Prog Integrity Dir	1	1	77,324	34,113	5,915	117,352
730021	459800 - Health Program Administrator	1	1	72,918	39,424	5,578	117,920
730023	501100 - DVHA Program Consultant	1	1	61,303	36,935	4,689	102,927
730024	089230 - Administrative Srvcs Cord II	1	1	59,406	30,276	4,544	94,226
730025	501100 - DVHA Program Consultant	1	1	63,074	22,720	4,826	90,620
730027	459500 - Provider Relations Specialist	1	1	64,908	14,773	4,965	84,646
730028	469900 - Provider & Member Serv Dir	1	1	85,188	42,052	6,517	133,757
730029	459800 - Health Program Administrator	1	1	68,998	23,990	5,278	98,266
730030	514400 - Dir Data Mgn Analysis & Integ	1	1	74,373	34,344	5,690	114,407
730031	498800 - Medicaid Fiscal Analyst	1	1	64,549	14,696	4,938	84,183
730032	089120 - Financial Manager III	1	1	70,284	24,264	5,377	99,925
730034	000075 - Nurse Case Manager / URN II	1	1	104,986	40,039	8,031	153,055
730035	000078 - Nurse Auditor	1	1	89,696	43,019	6,861	139,578
730036	000070 - Nurse Case Manager / URN I	1	1	81,250	26,614	6,216	114,081

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FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730037	501100 - DVHA Program Consultant	1	1	53,840	35,338	4,118	93,296
730047	000086 - Nurse Administrator II	1	1	126,586	27,985	9,684	164,255
730049	089140 - Financial Director II	1	1	77,240	25,754	5,910	108,904
730050	000090 - Nursing Operations Director	1	1	105,489	51,113	8,070	164,670
730051	089210 - Administrative Srvcs Tech IV	1	1	50,257	28,314	3,845	82,416
730053	089120 - Financial Manager III	1	1	90,120	36,856	6,894	133,870
730054	089060 - Financial Administrator II	1	1	55,210	35,631	4,222	95,063
730056	459500 - Provider Relations Specialist	1	1	62,989	14,361	4,818	82,168
730059	089141 - Financial Director IV	1	1	103,738	46,266	7,936	157,940
730060	495900 - Med Hlthcare Data & Stat Anal	1	1	72,813	39,402	5,569	117,784
730061	480200 - DVHA Quality Improvement Dir	1	1	90,858	43,267	6,950	141,075
730067	501100 - DVHA Program Consultant	1	1	59,406	36,529	4,544	100,479
730068	533500 - Coord of Benefits Supervisor	1	1	72,813	39,402	5,571	117,786
730069	000075 - Nurse Case Manager / URN II	1	1	108,003	46,941	8,262	163,204

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FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730073	000070 - Nurse Case Manager / URN I	1	1	95,737	38,057	7,324	141,118
730074	000075 - Nurse Case Manager / URN II	1	1	86,345	42,300	6,605	135,251
730075	000070 - Nurse Case Manager / URN I	1	1	78,263	40,569	5,986	124,817
730076	000070 - Nurse Case Manager / URN I	1	1	101,627	30,978	7,774	140,379
730081	089040 - Financial Specialist III	1	1	46,062	27,417	3,524	77,003
730082	004900 - Program Technician III	1	1	50,468	39,085	3,861	93,414
730084	464900 - DVHA Program & Oper Auditor	1	1	56,686	13,011	4,337	74,034
730086	486400 - Project & Operations Dir	1	1	103,232	39,664	7,897	150,793
730087	735500 - Healthcare Assistant Admin II	1	1	77,767	25,868	5,948	109,583
730088	501100 - DVHA Program Consultant	1	1	63,073	37,316	4,825	105,214
730089	501100 - DVHA Program Consultant	1	1	61,303	30,681	4,689	96,673
730090	533500 - Coord of Benefits Supervisor	1	1	82,384	35,196	6,303	123,883
730091	508560 - VCCI Outreach & Support Coord	1	1	55,674	29,476	4,259	89,409
730093	000070 - Nurse Case Manager / URN I	1	1	78,263	25,974	5,987	110,224

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730094	000075 - Nurse Case Manager / URN II	1	1	101,627	39,320	7,775	148,722
730097	498800 - Medicaid Fiscal Analyst	1	1	58,541	30,091	4,477	93,109
730098	000070 - Nurse Case Manager / URN I	1	1	81,250	34,954	6,216	122,420
730102	498000 - Health Enterprise Director II	1	1	113,520	48,383	8,684	170,587
730103	458902 - Health Services Researcher	1	1	103,739	46,024	7,936	157,699
730105	089210 - Administrative Srvcs Tech IV	0.5	1	22,124	28,545	1,693	52,362
730107	501100 - DVHA Program Consultant	1	1	55,674	11,959	4,259	71,892
730108	735110 - VT Healthcare Service Spec III	1	1	58,857	21,817	4,503	85,177
730109	501100 - DVHA Program Consultant	1	1	61,303	30,682	4,689	96,674
730110	478100 - Business Process Manager	1	1	82,742	35,274	6,330	124,346
730112	536900 - VHC Support Services Spec	1	1	50,467	11,679	3,861	66,007
730113	536900 - VHC Support Services Spec	1	1	57,466	21,518	4,396	83,380
730114	536900 - VHC Support Services Spec	1	1	48,696	19,641	3,725	72,062
730115	499700 - Medicaid Operations Adm	1	1	68,239	38,422	5,221	111,882

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FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730123	434100 - Public Health Dentist	0.5	1	50,847	31,692	3,891	86,430
730123	434100 - Public Health Dentist	0.25	1	25,423	5,478	1,945	32,846
730123	434100 - Public Health Dentist	0.25	1	24,701	6,160	1,889	32,750
730124	464900 - DVHA Program & Oper Auditor	1	1	62,547	22,607	4,785	89,939
730125	459450 - MMIS Compliance Specialist	1	1	74,984	39,867	5,736	120,587
730126	498800 - Medicaid Fiscal Analyst	1	1	70,937	24,404	5,427	100,768
730127	499400 - Medicaid Transptation QC Chief	1	1	75,280	33,675	5,759	114,714
730131	000070 - Nurse Case Manager / URN I	1	1	95,737	44,312	7,324	147,373
730132	508560 - VCCI Outreach & Support Coord	1	1	48,697	27,981	3,726	80,404
730133	000070 - Nurse Case Manager / URN I	1	1	101,627	45,574	7,774	154,975
730134	000070 - Nurse Case Manager / URN I	1	1	83,869	41,770	6,416	132,055
730135	482800 - Clinical Social Worker	1	1	57,972	30,831	4,435	93,238
730136	000070 - Nurse Case Manager / URN I	1	1	78,263	35,177	5,987	119,426
730137	089260 - Administrative Srvcs Mngr I	1	1	64,255	22,973	4,916	92,144

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730138	068520 - Blueprint Payment Ops Admin	1	1	82,469	41,469	6,308	130,246
730140	503801 - Data Analytics & Info Admin	1	1	77,324	27,395	5,916	110,635
730141	501100 - DVHA Program Consultant	1	1	57,467	36,115	4,396	97,978
730142	464900 - DVHA Program & Oper Auditor	1	1	64,549	37,631	4,938	107,118
730143	464900 - DVHA Program & Oper Auditor	1	1	58,542	30,090	4,477	93,109
730144	495600 - Associate Prog Integrity Dir	1	1	77,324	40,368	5,915	123,607
730145	495900 - Med Hlthcare Data & Stat Anal	1	1	61,577	31,602	4,711	97,890
730146	486200 - Asst Dir of Blueprint for Hlth	1	1	69,608	33,321	5,326	108,255
730147	486200 - Asst Dir of Blueprint for Hlth	0.8	1	59,769	36,607	4,572	100,948
730170	550200 - Contracts & Grants Administrat	1	1	56,686	40,415	4,336	101,437
730171	464900 - DVHA Program & Oper Auditor	1	1	62,547	22,607	4,785	89,939
730172	480210 - DVHA Quality Assurance Mgr	1	1	68,534	23,889	5,243	97,666
730174	334100 - Audit Liaison/Int Control	1	1	62,125	22,516	4,752	89,393
730175	499700 - Medicaid Operations Adm	1	1	61,577	22,399	4,711	88,687

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730177	499700 - Medicaid Operations Adm	1	1	80,001	40,942	6,120	127,063
730178	004900 - Program Technician III	1	1	52,154	28,721	3,989	84,864
730181	334100 - Audit Liaison/Int Control	1	1	60,186	22,100	4,604	86,890
730182	536900 - VHC Support Services Spec	1	1	55,675	21,135	4,259	81,069
730185	464910 - DVHA Healthcare QC Auditor	1	1	60,502	36,766	4,629	101,897
730186	459800 - Health Program Administrator	1	1	54,704	30,129	4,186	89,019
730187	089240 - Administrative Srvcs Cord III	1	1	55,210	12,695	4,222	72,127
730188	089080 - Financial Manager I	1	1	62,125	37,112	4,752	103,989
730189	089090 - Financial Manager II	1	1	61,578	31,602	4,712	97,892
730190	536900 - VHC Support Services Spec	1	1	53,840	20,741	4,119	78,700
730192	000070 - Nurse Case Manager / URN I	1	1	81,251	41,209	6,216	128,676
730193	000075 - Nurse Case Manager / URN II	1	1	101,628	39,320	7,775	148,721
730194	089230 - Administrative Srvcs Cord II	1	1	57,466	36,115	4,396	97,977
730195	503801 - Data Analytics & Info Admin	1	1	90,647	19,449	6,932	117,028

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730197	067400 - Mgr Qlty Imprvmt and Care Mgm	1	1	79,791	26,301	6,104	112,196
730198	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	64,254	14,633	4,915	83,802
730199	089240 - Administrative Srvcs Cord III	1	1	58,857	36,413	4,502	99,772
730200	000086 - Nurse Administrator II	1	1	126,586	50,921	9,684	187,192
730201	000086 - Nurse Administrator II	1	1	112,824	41,718	8,631	163,174
730202	053100 - DVHA Data Anlyst and Info Chie	1	1	82,468	41,470	6,309	130,247
730204	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	70,916	38,996	5,425	115,337
730205	334000 - DVHA Bhav Hlth Cnrnt RvwCre Mg	1	1	68,533	23,891	5,243	97,667
730206	499700 - Medicaid Operations Adm	0.8	1	51,167	34,765	3,914	89,846
730207	499700 - Medicaid Operations Adm	1	1	70,515	15,974	5,394	91,883
730208	454300 - DVHA Rate Setting Mang	1	1	95,896	38,092	7,335	141,323
730210	000070 - Nurse Case Manager / URN I	1	1	83,869	18,834	6,416	109,119
730211	501100 - DVHA Program Consultant	1	1	48,697	28,844	3,725	81,266
730212	464900 - DVHA Program & Oper Auditor	1	1	58,542	21,749	4,477	84,768

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730213	501100 - DVHA Program Consultant	1	1	55,674	29,474	4,260	89,408
730215	000070 - Nurse Case Manager / URN I	1	1	101,627	39,319	7,775	148,721
730216	000070 - Nurse Case Manager / URN I	1	1	78,262	35,176	5,987	119,425
730218	000070 - Nurse Case Manager / URN I	1	1	81,250	41,210	6,216	128,677
730219	537300 - DVHA Quality Improvement Admin	0.88	1	74,984	39,867	5,737	120,588
730227	089130 - Financial Director I	1	1	69,609	33,319	5,326	108,254
730232	590200 - VHC Educ & Outreach Coord	1	1	64,255	24,599	4,916	93,770
730234	464910 - DVHA Healthcare QC Auditor	1	1	58,542	36,345	4,477	99,364
730235	483010 - Assister Program Manager	1	1	74,985	36,862	5,736	117,583
730236	087800 - Dir. VHC Customer Srv Center	1	1	69,609	33,321	5,325	108,255
730238	459800 - Health Program Administrator	1	1	64,550	37,633	4,938	107,121
730239	459800 - Health Program Administrator	1	1	58,542	36,345	4,477	99,364
730240	857200 - Communications & Outreach Coor	1	1	55,675	21,135	4,259	81,069
730241	463100 - Health Care Project Director	1	1	85,188	42,052	6,517	133,757

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730244	442100 - Project Administrator Bluepri	1	1	66,299	31,752	5,071	103,122
730245	098300 - Quality Oversight Analyst II	1	1	82,468	18,535	6,309	107,312
730248	854000 - Senior Policy Advisor	1	1	60,185	30,442	4,604	95,231
730249	854000 - Senior Policy Advisor	1	1	66,299	23,411	5,072	94,782
730251	464950 - Dir of Ops for ACO Programs	1	1	74,710	33,553	5,715	113,978
730252	533900 - Medicaid Provider Rel Oper Chf	1	1	73,214	39,488	5,600	118,302
730253	049601 - Grants Management Specialist	1	1	62,990	13,526	4,820	81,336
730254	977010 - Deputy Dir of Payment Reform	1	1	116,480	42,502	8,910	167,892
730256	496600 - Grant Programs Manager	1	1	68,534	32,230	5,243	106,007
730260	497800 - Health Reform Enterprise Dir I	1	1	68,682	32,262	5,254	106,198
730272	501100 - DVHA Program Consultant	1	1	55,674	21,134	4,260	81,068
730273	513410 - Health Care Train/Commun Mngr	1	1	77,556	40,418	5,933	123,907
730275	501100 - DVHA Program Consultant	1	1	50,468	34,615	3,861	88,944
730277	486400 - Project & Operations Dir	1	1	103,233	40,525	7,897	151,655

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730278	501100 - DVHA Program Consultant	1	1	50,467	20,020	3,862	74,349
730279	501100 - DVHA Program Consultant	1	1	55,674	12,793	4,260	72,727
730280	501100 - DVHA Program Consultant	1	1	50,468	20,019	3,861	74,348
730281	501100 - DVHA Program Consultant	1	1	53,840	35,338	4,119	93,297
730282	464920 - DVHA Quality Control Manager	1	1	68,239	38,422	5,221	111,882
730283	501100 - DVHA Program Consultant	1	1	50,467	28,360	3,861	82,688
730284	148400 - Autism Specialist	1	1	66,299	15,070	5,071	86,440
730286	499700 - Medicaid Operations Adm	0.88	1	64,076	37,530	4,901	106,507
730287	442100 - Project Administrator Bluepri	0.8	1	46,377	19,142	3,548	69,067
730288	463150 - Health Care Director	1	1	90,859	28,879	6,951	126,689
730289	735200 - Benefits Program Mentor	1	1	57,023	36,020	4,363	97,406
730290	735100 - VT Healthcare Service Spec II	1	1	55,675	12,795	4,260	72,730
730291	735100 - VT Healthcare Service Spec II	1	1	52,153	34,976	3,989	91,118
730292	735100 - VT Healthcare Service Spec II	1	1	55,675	21,135	4,260	81,070

State of Vermont

FY2021 Governor's Recommended Budget
Position Summary Report

Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730293	735100 - VT Healthcare Service Spec II	1	1	55,675	21,135	4,260	81,070
730294	735110 - VT Healthcare Service Spec III	1	1	57,023	21,424	4,363	82,810
730295	735100 - VT Healthcare Service Spec II	1	1	55,675	22,761	4,260	82,696
730296	735100 - VT Healthcare Service Spec II	1	1	50,467	34,615	3,860	88,942
730297	735100 - VT Healthcare Service Spec II	1	1	50,467	20,019	3,860	74,346
730298	735000 - VT Healthcare Service Spec I	1	1	47,706	27,769	3,650	79,125
730299	735000 - VT Healthcare Service Spec I	1	1	50,889	28,451	3,893	83,233
730300	480210 - DVHA Quality Assurance Mgr	1	1	62,125	30,857	4,752	97,734
730301	460570 - Program Integrity Analyst	1	1	66,300	23,411	5,071	94,782
730302	735100 - VT Healthcare Service Spec II	1	1	55,675	29,476	4,260	89,411
730303	735100 - VT Healthcare Service Spec II	1	1	55,675	21,135	4,260	81,070
730304	735000 - VT Healthcare Service Spec I	1	1	46,061	10,735	3,523	60,319
730305	735000 - VT Healthcare Service Spec I	1	1	46,061	10,735	3,523	60,319
730306	735100 - VT Healthcare Service Spec II	1	1	48,697	28,843	3,725	81,265

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730307	735100 - VT Healthcare Service Spec II	1	1	50,467	11,679	3,860	66,006
730308	735000 - VT Healthcare Service Spec I	1	1	49,245	34,353	3,767	87,365
730309	735100 - VT Healthcare Service Spec II	1	1	50,467	20,019	3,860	74,346
730310	735000 - VT Healthcare Service Spec I	1	1	47,706	19,428	3,650	70,784
730313	735100 - VT Healthcare Service Spec II	1	1	64,781	31,426	4,956	101,163
730314	735100 - VT Healthcare Service Spec II	1	1	52,153	20,380	3,989	76,522
730315	735000 - VT Healthcare Service Spec I	1	1	52,555	20,466	4,020	77,041
730316	735000 - VT Healthcare Service Spec I	1	1	46,061	19,075	3,523	68,659
730317	735000 - VT Healthcare Service Spec I	1	1	46,061	28,278	3,523	77,862
730318	735110 - VT Healthcare Service Spec III	1	1	51,542	29,452	3,942	84,936
730319	735000 - VT Healthcare Service Spec I	1	1	47,706	21,054	3,650	72,410
730320	735000 - VT Healthcare Service Spec I	1	1	49,244	19,758	3,768	72,770
730321	735100 - VT Healthcare Service Spec II	1	1	55,675	21,135	4,260	81,070
730322	735100 - VT Healthcare Service Spec II	1	1	48,697	28,843	3,725	81,265

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730323	735100 - VT Healthcare Service Spec II	1	1	48,696	11,300	3,726	63,722
730324	735000 - VT Healthcare Service Spec I	1	1	50,889	28,449	3,893	83,231
730325	410200 - Workforce Manangement Coord I	1	1	57,023	21,424	4,362	82,809
730326	735110 - VT Healthcare Service Spec III	1	1	57,023	36,020	4,363	97,406
730327	208800 - Business Analyst	1	1	64,254	22,972	4,915	92,141
730328	735200 - Benefits Program Mentor	1	1	51,542	29,452	3,942	84,936
730329	735200 - Benefits Program Mentor	1	1	58,858	21,816	4,502	85,176
730330	410200 - Workforce Manangement Coord I	1	1	60,839	36,838	4,654	102,331
730331	735100 - VT Healthcare Service Spec II	1	1	48,697	28,843	3,725	81,265
730332	735200 - Benefits Program Mentor	1	1	55,211	29,376	4,223	88,810
730333	735100 - VT Healthcare Service Spec II	1	1	48,697	28,843	3,725	81,265
730334	735000 - VT Healthcare Service Spec I	1	1	47,706	19,428	3,650	70,784
730335	735100 - VT Healthcare Service Spec II	1	1	55,675	29,476	4,260	89,411
730336	735110 - VT Healthcare Service Spec III	1	1	53,566	12,343	4,099	70,008

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730337	735200 - Benefits Program Mentor	1	1	57,023	13,084	4,363	74,470
730338	735100 - VT Healthcare Service Spec II	1	1	53,841	20,741	4,119	78,701
730339	735110 - VT Healthcare Service Spec III	1	1	57,023	29,765	4,363	91,151
730340	536900 - VHC Support Services Spec	1	1	52,154	20,380	3,989	76,523
730341	459800 - Health Program Administrator	1	1	63,398	22,789	4,850	91,037
730342	735300 - Fair Hearing Specialist	1	1	53,566	20,683	4,098	78,347
730343	208800 - Business Analyst	1	1	62,125	22,517	4,751	89,393
730344	004700 - Program Technician I	1	1	41,950	32,791	3,208	77,949
730345	735000 - VT Healthcare Service Spec I	1	1	49,245	34,353	3,767	87,365
730346	536900 - VHC Support Services Spec	1	1	50,467	20,019	3,861	74,347
730347	735000 - VT Healthcare Service Spec I	1	1	52,555	28,807	4,020	85,382
730348	536900 - VHC Support Services Spec	1	1	53,840	12,401	4,119	70,360
730349	735100 - VT Healthcare Service Spec II	1	1	52,153	20,380	3,989	76,522
730352	735200 - Benefits Program Mentor	1	1	64,908	37,708	4,966	107,582

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730353	513700 - Benefits Programs Specialist	1	1	68,596	32,246	5,248	106,090
730354	735100 - VT Healthcare Service Spec II	0.8	1	44,540	18,750	3,408	66,698
730355	503400 - Benefits Progrms Administrator	1	1	79,791	26,301	6,104	112,196
730356	513700 - Benefits Programs Specialist	1	1	59,406	30,276	4,546	94,228
730357	513700 - Benefits Programs Specialist	1	1	55,674	21,134	4,260	81,068
730358	513700 - Benefits Programs Specialist	1	1	55,674	35,730	4,260	95,664
730359	459900 - ESD Health Care Elig Dir	1	1	97,034	30,220	7,424	134,678
730360	735500 - Healthcare Assistant Admin II	1	1	70,515	32,655	5,394	108,564
730361	464920 - DVHA Quality Control Manager	1	1	75,279	33,675	5,759	114,713
730362	513700 - Benefits Programs Specialist	1	1	64,782	23,086	4,956	92,824
730363	513700 - Benefits Programs Specialist	1	1	63,074	22,720	4,824	90,618
730364	735200 - Benefits Program Mentor	1	1	72,708	39,378	5,562	117,648
730365	503400 - Benefits Progrms Administrator	1	1	82,468	35,215	6,309	123,992
730366	503400 - Benefits Progrms Administrator	1	1	93,303	37,535	7,137	137,975

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730367	513700 - Benefits Programs Specialist	1	1	59,406	30,276	4,546	94,228
730368	513700 - Benefits Programs Specialist	1	1	50,468	34,614	3,860	88,942
730369	513700 - Benefits Programs Specialist	1	1	57,466	36,114	4,396	97,976
730370	735510 - Healthcare Assistant Admin I	1	1	60,502	22,169	4,628	87,299
730371	513700 - Benefits Programs Specialist	1	1	59,406	13,594	4,546	77,546
730372	513700 - Benefits Programs Specialist	1	1	57,466	21,518	4,396	83,380
730373	513700 - Benefits Programs Specialist	1	1	55,674	29,476	4,260	89,410
730374	513700 - Benefits Programs Specialist	1	1	55,674	35,730	4,260	95,664
730375	735510 - Healthcare Assistant Admin I	1	1	64,549	37,631	4,938	107,118
730377	735500 - Healthcare Assistant Admin II	1	1	75,280	39,933	5,759	120,972
730378	501200 - Economic Services Supervisor	1	1	68,534	23,890	5,244	97,668
730379	735500 - Healthcare Assistant Admin II	1	1	72,813	15,630	5,569	94,012
730381	464910 - DVHA Healthcare QC Auditor	1	1	58,542	21,749	4,477	84,768
730382	735500 - Healthcare Assistant Admin II	1	1	72,814	33,148	5,570	111,532

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730383	513700 - Benefits Programs Specialist	1	1	52,154	20,380	3,990	76,524
730384	513700 - Benefits Programs Specialist	1	1	55,674	21,134	4,260	81,068
730385	501200 - Economic Services Supervisor	1	1	75,280	33,676	5,760	114,716
730388	503400 - Benefits Progrms Administrator	1	1	69,608	33,323	5,326	108,257
730389	735500 - Healthcare Assistant Admin II	1	1	68,239	23,826	5,221	97,286
730390	735500 - Healthcare Assistant Admin II	1	1	63,959	14,569	4,892	83,420
730391	735500 - Healthcare Assistant Admin II	1	1	70,515	15,138	5,395	91,048
730392	735510 - Healthcare Assistant Admin I	1	1	56,686	12,175	4,336	73,197
730393	735510 - Healthcare Assistant Admin I	1	1	56,686	22,977	4,337	84,000
730394	735100 - VT Healthcare Service Spec II	1	1	55,675	21,135	4,260	81,070
730395	735100 - VT Healthcare Service Spec II	1	1	55,675	29,476	4,260	89,411
730396	735100 - VT Healthcare Service Spec II	1	1	55,675	35,731	4,260	95,666
730397	089280 - Administrative Srvcs Mngr III	1	1	98,152	38,575	7,509	144,236
730398	735110 - VT Healthcare Service Spec III	1	1	57,023	13,084	4,363	74,470

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730399	735100 - VT Healthcare Service Spec II	1	1	55,675	29,476	4,260	89,411
730400	459800 - Health Program Administrator	1	1	60,502	33,759	4,628	98,889
730401	735200 - Benefits Program Mentor	1	1	58,858	21,816	4,502	85,176
730402	735400 - VT Healthcare Srvc Supervisor	1	1	64,255	37,570	4,915	106,740
730403	735200 - Benefits Program Mentor	1	1	68,702	38,522	5,256	112,480
730404	735400 - VT Healthcare Srvc Supervisor	1	1	57,972	30,830	4,435	93,237
730405	735000 - VT Healthcare Service Spec I	1	1	52,555	35,062	4,020	91,637
730406	735400 - VT Healthcare Srvc Supervisor	1	1	66,299	15,071	5,072	86,442
730407	735400 - VT Healthcare Srvc Supervisor	1	1	66,299	38,007	5,072	109,378
730408	459800 - Health Program Administrator	1	1	58,541	21,749	4,479	84,769
730409	735200 - Benefits Program Mentor	1	1	51,542	29,452	3,942	84,936
730410	735110 - VT Healthcare Service Spec III	1	1	57,023	29,765	4,363	91,151
730411	735200 - Benefits Program Mentor	1	1	66,847	23,529	5,113	95,489
730412	735100 - VT Healthcare Service Spec II	1	1	64,781	23,085	4,956	92,822

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730413	735110 - VT Healthcare Service Spec III	1	1	57,023	36,020	4,363	97,406
730414	735100 - VT Healthcare Service Spec II	1	1	53,841	35,337	4,119	93,297
730415	735600 - HAEEU Operations Director	1	1	82,320	35,183	6,297	123,800
730416	735000 - VT Healthcare Service Spec I	1	1	56,053	21,216	4,288	81,557
730417	735100 - VT Healthcare Service Spec II	1	1	57,466	21,517	4,396	83,379
730419	089420 - Administrative Srvcs Dir IV	1	1	111,011	41,585	8,492	161,088
730420	735100 - VT Healthcare Service Spec II	1	1	48,696	28,844	3,726	81,266
730421	735400 - VT Healthcare Srvc Supervisor	1	1	66,299	31,752	5,072	103,123
730422	735400 - VT Healthcare Srvc Supervisor	1	1	60,186	36,697	4,604	101,487
730423	735100 - VT Healthcare Service Spec II	1	1	55,675	12,795	4,260	72,730
730424	089230 - Administrative Srvcs Cord II	1	1	55,675	29,476	4,260	89,411
730425	735200 - Benefits Program Mentor	1	1	58,858	36,412	4,502	99,772
730426	735000 - VT Healthcare Service Spec I	1	1	52,853	35,126	4,043	92,022
730427	735100 - VT Healthcare Service Spec II	1	1	57,466	36,113	4,396	97,975

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730428	735400 - VT Healthcare Srvc Supervisor	1	1	66,300	23,410	5,071	94,781
730429	735100 - VT Healthcare Service Spec II	1	1	52,153	28,721	3,989	84,863
730430	735100 - VT Healthcare Service Spec II	1	1	48,697	28,843	3,725	81,265
730431	735100 - VT Healthcare Service Spec II	1	1	52,153	28,721	3,989	84,863
730433	735400 - VT Healthcare Srvc Supervisor	1	1	64,255	37,570	4,915	106,740
730434	735100 - VT Healthcare Service Spec II	1	1	52,153	20,380	3,989	76,522
730435	735100 - VT Healthcare Service Spec II	1	1	50,467	28,360	3,860	82,687
730436	735200 - Benefits Program Mentor	1	1	53,566	29,024	4,099	86,689
730437	735300 - Fair Hearing Specialist	1	1	55,211	21,035	4,223	80,469
730438	735100 - VT Healthcare Service Spec II	1	1	48,697	19,640	3,725	72,062
730439	536900 - VHC Support Services Spec	1	1	53,840	20,741	4,119	78,700
730440	735100 - VT Healthcare Service Spec II	1	1	52,153	12,040	3,989	68,182
730441	735110 - VT Healthcare Service Spec III	1	1	57,023	29,765	4,363	91,151
730442	735200 - Benefits Program Mentor	1	1	57,023	29,765	4,363	91,151

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
730443	735300 - Fair Hearing Specialist	1	1	57,023	21,424	4,362	82,809
730444	735300 - Fair Hearing Specialist	1	1	57,023	21,424	4,362	82,809
730446	735300 - Fair Hearing Specialist	1	1	51,542	20,248	3,944	75,734
730447	735300 - Fair Hearing Specialist	1	1	66,848	38,124	5,113	110,085
730448	464900 - DVHA Program & Oper Auditor	1	1	60,502	22,169	4,628	87,299
730449	551850 - Dir of Comm & Leg Affairs DVHA	1	1	77,323	40,372	5,915	123,610
730450	454200 - Dir Healthcare Policy&Planning	1	1	97,056	44,818	7,425	149,299
730451	735500 - Healthcare Assistant Admin II	1	1	87,085	36,205	6,662	129,952
730452	735500 - Healthcare Assistant Admin II	1	1	63,959	37,506	4,894	106,359
730453	081550 - Appeals Manager	1	1	75,279	33,675	5,759	114,713
730454	735500 - Healthcare Assistant Admin II	1	1	66,047	31,698	5,051	102,796
730455	735500 - Healthcare Assistant Admin II	1	1	75,279	39,930	5,759	120,968
730456	089090 - Financial Manager II	1	1	75,280	25,333	5,760	106,373
730457	034550 - HCR-HIT Integration Manager	1	1	97,034	30,219	7,424	134,677

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730458	498800 - Medicaid Fiscal Analyst	1	1	64,549	23,036	4,938	92,523
730459	735700 - Healthcare Eligib & Enorll Dir	1	1	90,859	43,477	6,952	141,288
730460	494000 - Exchange Project Director	1	1	101,694	45,588	7,779	155,061
730461	498800 - Medicaid Fiscal Analyst	1	1	54,704	20,927	4,186	79,817
730462	089230 - Administrative Srvcs Cord II	1	1	55,674	21,135	4,259	81,068
730463	459500 - Provider Relations Specialist	1	1	55,210	35,631	4,222	95,063
730464	410300 - Workforce Management Coord II	1	1	60,502	36,766	4,629	101,897
730465	330310 - VHC Business Process Coord	1	1	66,046	15,017	5,053	86,116
730466	735800 - Healthcare Deputy Dir of Ops	1	1	88,076	42,672	6,738	137,486
730467	977000 - Dir Paymnt Refrm Reimbrse Rate	1	1	103,738	33,295	7,935	144,968
730468	089090 - Financial Manager II	1	1	66,046	23,356	5,053	94,455
730469	735750 - Business Reporting Admin	1	1	70,515	24,314	5,394	100,223
730470	857300 - Communications & Notices Mgr	1	1	66,046	37,952	5,053	109,051
730471	208800 - Business Analyst	1	1	68,533	23,889	5,242	97,664

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730472	089230 - Administrative Srvcs Cord II	1	1	53,840	35,337	4,120	93,297
730473	410300 - Workforce Management Coord II	1	1	62,546	37,203	4,785	104,534
730474	089290 - Administrative Srvcs Dir I	1	1	69,609	33,322	5,324	108,255
730475	735500 - Healthcare Assistant Admin II	1	1	70,516	24,313	5,394	100,223
730476	089280 - Administrative Srvcs Mngr III	1	1	65,498	32,443	5,011	102,952
730477	066730 - DVHA Org & HR Development Dir	1	1	79,792	41,081	6,104	126,977
730478	208800 - Business Analyst	1	1	62,125	37,112	4,753	103,990
730479	330320 - Knowledge Management Sys Admin	1	1	56,686	29,692	4,337	90,715
730480	089220 - Administrative Srvcs Cord I	1	1	47,706	19,428	3,650	70,784
730481	089230 - Administrative Srvcs Cord II	1	1	50,467	28,360	3,861	82,688
730482	513400 - Healthcare Training/Curr Coord	1	1	51,542	29,451	3,944	84,937
730483	735710 - Eligib & Enorll Data Director	1	1	88,076	29,701	6,738	124,515
730484	208800 - Business Analyst	1	1	84,281	35,603	6,447	126,331
730485	513400 - Healthcare Training/Curr Coord	1	1	58,858	30,157	4,504	93,519

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730486	460550 - Oversight & Monitoring Dir	1	1	88,077	42,672	6,739	137,488
730487	018100 - Change Manager	1	1	90,647	43,222	6,935	140,804
730488	018000 - Change Management Practitioner	1	1	63,960	14,570	4,893	83,423
730489	018000 - Change Management Practitioner	1	1	66,046	37,953	5,051	109,050
730490	089250 - Administrative Srvcs Cord IV	1	1	64,549	37,631	4,938	107,118
730491	510000 - Director of Rate Setting	1	1	102,452	31,392	7,838	141,682
730492	032950 - Health Facility Auditor II	1	1	66,300	14,234	5,072	85,606
730493	514900 - Rate Setting Office & Data Mgr	1	1	53,840	35,338	4,118	93,296
730494	033900 - Hlth Fac Sr Audit & Rate Spec	1	1	92,250	30,596	7,058	129,904
730495	510010 - Rate Setting Manager	1	1	79,790	40,896	6,104	126,790
730496	032950 - Health Facility Auditor II	1	1	84,282	35,606	6,448	126,336
730497	032901 - Medicaid Residentl Prgm Audito	1	1	66,762	23,510	5,108	95,380
737001	95010E - Executive Director	1	1	145,080	55,217	10,343	210,640
737002	90120A - Commissioner	1	1	135,220	53,081	10,201	198,502

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Position Number	Classification	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
737003	90570D - Deputy Commissioner	1	1	109,450	47,501	8,373	165,324
737004	90570D - Deputy Commissioner	1	1	107,307	47,039	8,210	162,556
737006	91590E - Private Secretary	1	1	182,583	57,081	10,886	250,550
737008	95866E - Staff Attorney I	1	1	57,574	21,674	4,404	83,652
737015	95866E - Staff Attorney I	1	1	56,659	36,072	4,333	97,064
737016	95870E - General Counsel I	1	1	94,536	12,166	7,232	113,934
737017	95360E - Principal Assistant	1	1	131,310	52,235	10,045	193,590
737018	95868E - Staff Attorney III	1	1	80,018	35,738	6,122	121,878
737028	95868E - Staff Attorney III	1	1	70,220	24,412	5,372	100,004
737036	95867E - Staff Attorney II	1	1	69,472	32,594	5,315	107,381
737037	95868E - Staff Attorney III	1	1	84,323	27,466	6,451	118,240
737038	95868E - Staff Attorney III	1	1	86,486	36,274	6,616	129,376
737100	96700E - Director Blueprint for Health	1	1	115,730	31,379	8,854	155,963
Total		**371.46**	**375**	**25,312,708**	**11,140,953**	**1,932,449**	**38,386,109**

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Fund Code	Fund Name	FTE	Count	Gross Salary	Benefits Total	Statutory Total	Total
10000	General Fund		149.41	9,995,417	4,388,178	761,159	15,144,750
20405	Global Commitment Fund	9.6	6.93	556,185	227,873	42,437	826,495
21500	Inter-Unit Transfers Fund		2.59	209,932	91,931	15,688	317,551
21916	Vermont Health IT Fund		0.4	30,269	13,111	2,316	45,696
22005	Federal Revenue Fund	361.86	215.67	14,520,905	6,419,860	1,110,849	22,051,617
Total		**371.46**	**375**	**25,312,708**	**11,140,953**	**1,932,449**	**38,386,109**

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