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GENERAL ASSEMBLY
STATE OF VERMONT
LEGISLATIVE JOINT FISCAL COMMITTEE

Thursday, January 26, 2017

Agenda

Room 5, State House

8:15 a.m. Convene Meeting and Elect Officers
Stephen Klein, Chief Fiscal Officer, Joint Fiscal Office

8:20 a.m. Re-adoption Committee Rules

8:25 a.m. Other Business

8:30 a.m. Adjourn

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STATE OF VERMONT
LEGISLATIVE JOINT FISCAL COMMITTEE

Thursday, January 26, 2017

Minutes

Room 5, State House

Members present: Representatives Ancel, Donovan, Fagan, Lippert, and Toll, and Senators Ayer, Cummings, Kitchel, Sears, and Westman.

Other Attendees: Administration, Joint Fiscal Office, and various lobbyists, and advocacy groups.

Stephen Klein, Chief Fiscal Officer, Legislative Joint Fiscal Office, called the meeting to order at 8:15 a.m. and asked for nominations for Chair of the Committee. One nomination was cast for Representative Ancel by Senator Cummings that was adopted by the Committee.

Representative Ancel, Chair, cast the only nomination for vice chair of the Committee for Senator Cummings that was adopted by the Committee. Senator Sears cast the only nomination for clerk of the Committee for Representative Fagan that was adopted by the Committee.

The proposed rules of the Committee were presented by Mr. Klein. Senator Sears moved to adopt them and Senator Ayer seconded the motion with a follow-up question on the Committee's sexual harassment policy. Mr. Klein responded that the Committee had followed the State employees' policy from the Department of Human Resources but the Office would review it to ensure it was the most current language. The Committee adopted the rules presented.

Mr. Klein reviewed other business that included staff updates.

The Committee adjourned at 9:30 a.m.

Respectfully Submitted,

Theresa Utton-Jerman
Joint Fiscal Office

VERMONT

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Agency of Human Services

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MEMORANDUM

To: Health Reform Oversight Committee

From: Frank Reed, Commissioner, Department of Mental Health

Date: November 22, 2016

RE: Follow up response to questions related to DMH's testimony on November 14, 2016

Below is information responding to questions posed about how travel nurse salaries compare to full-time staff nurses salaries, and what was spent in FY'15, FY'16, and YTD through October 2016 on travel nurse costs at the Vermont Psychiatric Care Hospital (VPCH).

Q1: Can you tell us how traveling nurse salaries compare to staff nurses for comparison?

The travelling nurse salaries, based on full-time annual hours are:

Nightingale Nurses	$122,720.00
Worldwide Travel Staffing	$141,440.00
Supplemental Health Care	$141,440.00
Cross Country TravCorps	$162,240.00

The average DMH nurse salary including fringe benefits is $118,848.00.

Q2: Can you tell us how much has been spent on traveling nurses in FY'15, FY'16 and YTD'17 if available)?

Travel Nurse Annual Costs:
FY15 Travel Nurse Total: $1,349,238.96
FY16 Travel Nurse Total: $2,102,299.34
FY17 YTD (through Oct 2016) total: $887,837.01

VERMONT

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Andrew Pallito, Commissioner

MEMORANDUM

TO: Joint Fiscal Committee
FROM: Andrew Pallito, Commissioner of Finance & Management
DATE: January 15, 2017
RE: Excess Receipts Report – 32 VSA Sec 511

In accordance with 32 VSA Sec 511, please find attached the report on Excess Receipts approved for expenditure through the first quarter of FY 2017 (7/1/2016 through 12/31/16). The full text of the governing statute is provided at the end of this memo.

Review Process

The Administration goes through an extensive application and approval process for allowing expenditure of excess receipts. The form required of departments can be found at: http://finance.vermont.gov/sites/finance/files/pdf/forms/budget/Excess_Receipts_Form.doc (at http://finance.vermont.gov/forms under the "Budget" category). The form requires information to ensure that the approval does not overstep statutory guidelines. Requests that overstep the statutory guidelines are denied, and/or where appropriate are held for the legislative budget process.

Departments are required to provide written answers to the following questions (although only the response to the first question is entered into the VISION database):

- Reason funds are available?
- Do you anticipate additional funds from the same source available in this fiscal year and above current appropriation?
- Is this increase one-time or at an ongoing level?
- Why were funds not fully budgeted during budget development?
    - What is the current year appropriation or grant amount approved by the Joint Fiscal Committee for this fiscal year, from this source of funds for this purpose?
- If these are ongoing funds, will funds from this source be fully budgeted and appropriated next fiscal year?
- Were excess receipts requested from this source in the preceding two fiscal years? If so, explain why they were not budgeted?
- Are these excess receipts being received from another department (i.e., interdepartmental transfers)? If so, are they appropriated in that department or will excess receipts be required there as well?

- Relationship, if any, to the Budget Adjustment Act?
- Can excess receipts be used to reduce the expenditure of State funds?
- **Will excess receipts establish or increase the scope of a program, committing the State at any time to expend State funds?** [The form notes that in such instances, legislative approval is required.]
- What specifically will excess receipts be used for? What is the impact on programs if this excess receipt request is not approved?
- Are any of the excess receipts to be used for your department's administrative, staff or operating expenses? If so, explain.
- Is there any matching fund requirement due to excess receipts? If so, where is the match found in your budget?
- If excess receipts are earned federal receipts, is excess receipt being spent in the same (federal) program where the excess receipts are earned? If not, explain.
- Has the excess receipt been received and deposited? If no, what date are funds expected?
- If approved, when will the expenditure of this excess receipt first occur?

The VISION entry normally includes only the response to the first question – why are additional receipts available? However, for any individual Excess Receipt Request, we can provide the full paper copy of the form, listing all the department's responses.

Broad Categories of Excess Receipt Requests

Requests for expenditure of excess receipts generally fall into several broad categories:

Interdepartmental Transfers: It is not uncommon for one State department ("Department A") to purchase services from another State department ("Department B"). In that instance, Department A budgets these expenditures just as they would any other type of expenditure: by type of expenditure and by the source of revenue that will fund these expenditures. Department B also budgets these expenditures, and identifies the source of revenue as "interdepartmental transfers." This process results in a small amount of "double-booking" of spending authority but ensures that both departments have the necessary spending authority. In many cases, at the time of budget development, Department A has not yet decided from where to purchase the services in question, so Department B does not budget the interdepartmental transfer revenues. When Department A moves forward to contract for services with Department B after the budget has closed, then Department B must request an Excess Receipts approval for the additional spending authority to perform the services.

Federal Funds: Departments estimate their likely federal receipts in the fall for the upcoming budget year, meaning the estimate is as much as nine-months old at the start of the budget year, and another 12 months older by the end of the budgeted fiscal year. As a result, more recent developments may mean that the budgeted federal spending authority is insufficient, either because the current federal award for an existing grant has been increased, or there is spending authority from grants from earlier federal fiscal years that can be used in the current year. Additionally, extraordinary events – such as the federal American Recovery and Reinvestment Act (ARRA) or federal aid to Vermont due to Tropical Storm Irene – may cause large – and unanticipated -- spikes in federal receipts.

Other: There are over 200 different special funds created under State law, in which are deposited fees, user charges, penalties, specified taxes, etc. Departments estimate how much they will collect each year for each of these special funds, and base their spending plans accordingly. However, for the same reasons noted above, the actual collections for these revenues may be higher than the original budget. Excess receipts may also be used in an instance where prior-year special fund spending authority was not utilized and needs to be created again in the subsequent year (similar to a carry-forward). It should be noted that in addition to the restrictions in the excess receipts statute, each special fund has its own statutory restrictions that prevent the funds being used for other than their intended purposes and programs.

Attached Report:

The attached report is a cumulative list of approved excess receipt requests for the current fiscal year. It includes ALL the data entered in VISION for that transaction, including:

- Agency/Department name
- Appropriation name and "DeptID"
- Transaction date
- Fund source – name and fund number
- Amount
- Comments in response to question: "Why are funds available?" (VISION allows for a limited number of characters per cell entry.)

The data are sorted into the three broad categories of requests discussed above.

Governing Statute:

32 V.S.A. § 511. EXCESS RECEIPTS

If any receipts including federal receipts exceed the appropriated amounts, the receipts may be allocated and expended on the approval of the commissioner of finance and management. If, however, the expenditure of those receipts will establish or increase the scope of the program, which establishment or increase will at any time commit the state to the expenditure of state funds, they may only be expended upon the approval of the legislature. Excess federal receipts, whenever possible, shall be utilized to reduce the expenditure of state funds. The commissioner of finance and management shall report to the joint fiscal committee quarterly with a cumulative list and explanation of the allocation and expenditure of such excess receipts.

FY 2017 Excess Receipts Report - Q2 Cumulative - Run 1-15-2017

Agency/Dept Name	Appropriation Name	Deptid	Date	Fund	Fund Name	Amount	Comments
Federal Funds (including "Regular" ARRA) Excess Receipts:							
Military	MIL Vet Affairs Office	2150050000	7/19/2016	22005	Federal Revenue Fund	2,328,130.27	Re-establishment of federal funds alloted to VT for multi-year federally funded Veterans Cemetary Expansion.
Women's Commission	Commission on Women	3310000000	7/28/2016	22005	Federal Revenue Fund	173,784.00	Federal grant from US Dept of Labor to conduct a comprehensive Paid Family & Medical Leave Feasibility Study for the State of VT.
Human Services Agency	Secretary's Office Admin Costs	3400001000	9/14/2016	22005	Federal Revenue Fund	2,650,000.00	AA-1 JFC# 2668 dated 3/24/14 approved during SFY14 in March for the Race to the Top Early Learning Challenge Grant
Human Services Agency	Secretary's Office Admin Costs	3400001000	9/14/2016	22005	Federal Revenue Fund	4,250,000.00	AA-1 JFC #2622 dated 5/9/2013 approved during SFY13 for the State Innovation Model grant.
Corrections	Correc-Correctional Services	3480004000	12/7/2016	22005	Federal Revenue Fund	550,000.00	The Dept of Justice awarded a 1MM federal grant to DOC, which was approved by JFO #2726.
Forests, Parks & Recreation	Lands Administration	6130040000	8/2/2016	22005	Federal Revenue Fund	1,300,000.00	Federal funds from Forest Legacy program for the acquisition of the Backus and Bullard properties
Environmental Conservation	Management & Support Services	6140020000	10/31/2016	22005	Federal Revenue Fund	300,000.00	New federal grant that was not known at the time of budgeting
Environmental Conservation	Water Programs Appropriaion	6140040000	12/9/2016	22005	Federal Revenue Fund	550,000.00	Increased use of federal grant that was no anticipated at the time of budgeting. PFOA expenses were not known during budgeting.
Economic Development	Economic Development	7120010000	11/16/2016	22005	Federal Revenue Fund	112,228.00	CFDA 59.061 State Trade & Export Promotion (STEP) federal award exceeds FY17 spending authority
Public Service Department	Regulation & Energy Efficiency	2240000000	10/21/2016	22040	ARRA Federal Fund	387,881.62	ARRA funds left available at the end of FY2016.
Subtotal Federal Funds (Including "Regular" ARRA) Excess						12,602,033.89	
Interdepartmental Transfer Excess Receipts:							
Joint Fiscal Office	Joint Fiscal Committee/Office	1220000000	8/24/2016	21500	Inter-Unit Transfers Fund	173,437.50	Act 26 of 2015, Sec. 36(d): Funds moved to 21500 by F&M in FY16 and additional funds to 21500 by AHS in FY17
Sergeant at Arms' Office	Sergeant at Arms	1230001000	8/5/2016	21500	Inter-Unit Transfers Fund	10,000.00	Room rentals
Attorney General's Office	Attorney General's Office	2100001000	9/22/2016	21500	Inter-Unit Transfers Fund	100,000.00	Funds available per Emergency Board meeting on 7/21/16 and 2016 Act 172, Sec. B.139
State's Attorneys and Sheriffs	Sheriffs	2130200000	11/14/2016	21500	Inter-Unit Transfers Fund	20,000.00	DOC will provide oversight and funding of the electronic monitoring system pilot program during the first ninety day of FY17
Agriculture, Food&Mrkts Agency	Plant Industry, Labs & CA Div	2200040000	9/27/2016	21500	Inter-Unit Transfers Fund	26,664.00	Funding from the CDC provided through Vt Dept of Health in support of arbovirus surveillance.
Human Services Agency	Administrative Management Fund	3400020000	12/16/2016	21500	Inter-Unit Transfers Fund	5,500,000.00	Funds will be used to process the annual DII SLA invoice which now includes mainframe changes. AHS will pay the entire invoice and bill back the AHS Depts.
Children and Families	DCFS - LIHEAP	3440090000	12/8/2016	21500	Inter-Unit Transfers Fund	252,339.00	Funds available due to refunds received from vendors for unspent state funds made available through a contingent appropriation in SFY2016.
Forests, Parks & Recreation	Administration	6130010000	8/2/2016	21500	Inter-Unit Transfers Fund	300,000.00	Funds from FEMA disaster assistance received through VTrans.
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21500	Inter-Unit Transfers Fund	40,000.00	IDT funds from DEC and PSD

FY 2017 Excess Receipts Report - Q2 Cumulative - Run 1-15-2017

Agency/Dept Name	Appropriation Name	Deptid	Date	Fund	Fund Name	Amount	Comments
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21500	Inter-Unit Transfers Fund	15,000.00	IDT funds from DEC and PSD
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21500	Inter-Unit Transfers Fund	22,000.00	IDT funds from DEC and PSD
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21500	Inter-Unit Transfers Fund	29,445.00	IDT funds from DEC and PSD
Forests, Parks & Recreation	Lands Administration	6130040000	8/2/2016	21500	Inter-Unit Transfers Fund	50,000.00	Funds from VHCB for long-range management projects.
Commerce & Community Dev Agency	Administration Division	7100000000	9/13/2016	21500	Inter-Unit Transfers Fund	205,442.29	FY13 and FY15 Capital Bill for Orthophoto program appropriated to tax dept, program moved under ACCD/VCGI admin in FY16.
Tourism & Marketing	Dept. of Tourism & Marketing	7130000000	9/15/2016	21500	Inter-Unit Transfers Fund	135,107.00	FY16 Remaining Cash Balance of: Act 51, 2015 session Sec.G.10.(a)(3) Economic Marketing Development Fund
Transportation Agency	Department of Motor Vehicles	8100002100	10/24/2016	21500	Inter-Unit Transfers Fund	9,000.00	Funds from grant #NH16402-667, 2016 Equipment Grant
Transportation Agency	Department of Motor Vehicles	8100002100	9/13/2016	21500	Inter-Unit Transfers Fund	50,000.00	Funds available from Grant #NH16405C-710, 2016 E-Citation Printers.
Transportation Agency	Policy and Planning	8100002200	8/11/2016	21500	Inter-Unit Transfers Fund	232,994.00	Fund from Grant #02140-34000-118B, State Hazard Mitigation Plan Update.
Subtotal Interdepartmental Transfer Excess Receipts						**7,171,428.79**	
Special Fund Excess Receipts:							
Transportation Agency	Policy and Planning	8100002200	9/13/2016	20155	Transportation-FRA Fund	20,000.00	Funds from a MOA betweeen Vt Agency of Transportation and Mass Dept of Transportation
Transportation Agency	Rail	8100002300	8/24/2016	20165	Transportation Other Fed Funds	163,717.25	Funds are the FY16 remaining balance from a Northern Border Regional Commission Grant
Education Agency	Ed - Flexible Pathways	5100210000	11/9/2016	20205	Education Fund	(1,397,950.00)	To reverse original ER-402 dated 10/10/16 per memo from Andy Pallito dated 11/9/16.
Education Agency	Ed - Flexible Pathways	5100210000	10/10/2016	20205	Education Fund	1,397,950.00	Funds approved in carry forward plan
Treasurer's Office	Office of the Treasurer	1260010000	7/12/2016	21003	Financial Literacy Commission	12,000.00	Pursuant to 9 V.S.A. Chapter 151 Section 6004 Financial Literacy Commission Fund
Human Resources-Gov'tal	DHR - VTHR Operations	1120080000	9/27/2016	21005	FMS System Development Fund	307,903.00	Funds in the FMS Development fund to support the requirements gathering and documentation of a contract with KPMG.
Children and Families	DCFS - LIHEAP	3440090000	12/8/2016	21235	Home Weatherization Assist	1,037,512.00	Funds available due to remaining state funds from LIHEAP/Weatherization federal fund for stat/special fund swap in FFY2016.
Environmental Conservation	Air & Waste Management Approp	6140030000	12/9/2016	21275	Environmental Contingency Fund	1,000,000.00	Increased use of federal grant that was no anticipated at the time of budgeting. PFOA expenses were not known during budgeting.
Environmental Conservation	Water Programs Appropriaion	6140040000	8/3/2016	21313	Ecosystem Rest & Water Quality	175,000.00	New fund created by statute
Commerce & Community Dev Agency	Administration Division	7100000000	9/13/2016	21330	Municipal & Regional Planning	85,787.47	Several significant multi-agency projects are in the planning and requirements gathering phases for Property Parcel Mapping Program.

FY 2017 Excess Receipts Report - Q2 Cumulative - Run 1-15-2017

Agency/Dept Name	Appropriation Name	Deptid	Date	Fund	Fund Name	Amount	Comments
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21475	Natural Resources Mgmnt	4,233.57	Reestablish spending authority from JFO 2734 to accept grant funds from The Nature Conservancy to create the Forster I limited service position.
Agriculture, Food&Mrkts Agency	Ag Development Division	2200030000	9/27/2016	21493	VT Working Lands Enterprise	175,000.00	Donations made in FY2016 and approved via JFO's 2807-2809
Forests, Parks & Recreation	Administration	6130010000	8/2/2016	21525	Conference Fees & Donations	5,000.00	Funds available from Waterbury Area Trail Alliance, American Forest Foundation, and anticipated from Urban & Community Forestry workshop fees.
Forests, Parks & Recreation	Administration	6130010000	8/2/2016	21525	Conference Fees & Donations	14,869.00	Funds available from Waterbury Area Trail Alliance, American Forest Foundation, and anticipated from Urban & Community Forestry workshop fees.
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21525	Conference Fees & Donations	8,000.00	Funds available from Waterbury Area Trail Alliance, American Forest Foundation, and anticipated from Urban & Community Forestry workshop fees.
Buildings & Gen Serv-Gov'tal	BGS-Administrative Services	1150100000	8/9/2016	21526	Governor's Portrait & Frame	20,000.00	Funds for Governor's Portrait & Frame Fund
Forests, Parks & Recreation	Administration	6130010000	8/2/2016	21550	Lands and Facilities Trust Fd	150,000.00	Funds from the receipts in the lands and facilities trust funds that FPR has authority to use per statute.
Public Safety	DPS-Emergency Management	2140030000	8/4/2016	21555	Emergency Relief & Assist Fd	173,324.00	This funding is granted to locals for completing Public Assistance projects.
Transportation Agency	Public Assistance Program	8100005500	9/22/2016	21555	Emergency Relief & Assist Fd	1,500,000.00	FEMA disaster declaration FEMA-4022-DR-VT. ERAF funds provide state match for the FEMA funds.
Transportation Agency	Public Assistance Program	8100005500	9/13/2016	21555	Emergency Relief & Assist Fd	400,000.00	FEMA disaster declaration FEMA-4022-DR-VT.
Attorney General's Office	Attorney General's Office	2100001000	8/29/2016	21584	Surplus Property	2,659.31	Proceeds from the sale of vehicle at AOT spring auction
Public Safety	DPS-Fire Safety	2140040000	10/18/2016	21584	Surplus Property	31,987.47	Funds available from the sale of vehicles sold at auction
Military	MIL BLDG Maint&Armory Caretkr	2150040000	8/24/2016	21584	Surplus Property	24,212.13	Proceeds from the sale of vehicles
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21584	Surplus Property	(10,452.00)	Payor mix change during the year
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21584	Surplus Property	10,452.00	Payor mix change during the year
Forests, Parks & Recreation	Forestry	6130020000	8/2/2016	21584	Surplus Property	3,662.72	Funds were received from the sale of assets
Buildings & Gen Serv-Gov'tal	BGS-Information Centers	1150400000	8/5/2016	21603	Motorist Aid Refreshment Prog	130,000.00	Funds from donations made by motorists at Info Centers.
Buildings & Gen Serv-Gov'tal	BGS- Recycling Efforts	1150060000	10/6/2016	21604	BGS-Recycling Efforts	20,000.00	Funds collected from the disposition of recycling materials.
Buildings & Gen Serv-Capital	BGS-Various Property Sales	0904300250	8/2/2016	21613	BGS-Sale of State Land	9,403.51	Replenish spending authority as of 6/30/16
Agriculture, Food&Mrkts Agency	VT Ag & Environmental Lab	2200150000	7/19/2016	21667	AF&M-Laboratory Testing	50,415.57	To reestablish funding originally approved on ER255 on 4/12/16. Funding to cover PO from FY16 was not able to be rolled to FY17.

FY 2017 Excess Receipts Report - Q2 Cumulative - Run 1-15-2017

Agency/Dept Name	Appropriation Name	Dept Id	Date	Fund	Fund Name	Amount	Comments
Buildings & Gen Serv-Capital	VT Expo major Maint 51/14(a)	1305100141	8/2/2016	21682	AF&M-Eastern States Building	46,628.04	Replenish spending authority as of 6/30/16
Education Agency	Administration	5100010000	10/10/2016	21764	ED-Medicaid Reimb-Admin	750,000.00	Funds approved in carry forward plan
Education Agency	Education Services	5100070000	10/10/2016	21764	ED-Medicaid Reimb-Admin	99,999.75	Funds approved in carry forward plan
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21767	Vets Home-Private Pay	(907,320.00)	Payor mix change during the year
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21767	Vets Home-Private Pay	907,320.00	Payor mix change during the year
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21768	Vets Home-Dom Applied Income	(104,788.00)	Payor mix change during the year
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21768	Vets Home-Dom Applied Income	104,788.00	Payor mix change during the year
Forests, Parks & Recreation	Vt Youth Conservation Corps	6130080000	8/2/2016	21779	FPR-Youth Conservation Corps	300,000.00	Funds from a cash assistance MOA between FPR and VYCC.
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21785	New York Medicaid	(870,389.00)	Payor mix change during the year
Veterans' Home	VERMONT VETERANS' HOME	3300010000	7/8/2016	21785	New York Medicaid	870,389.00	Payor mix change during the year
Buildings & Gen Serv-Gov'tal	BGS-Information Centers	1150400000	11/7/2016	21822	ACCD\Tourism & Marketing Broch	225,000.00	Annual fees that vendors pay BGS to display their business brochures at the State Info Centers.
Education Agency	Education Services	5100070000	10/31/2016	21848	ED-Private Sector Grants	150,000.00	This is a new award approved by JFO before the end of FY16, but were not known at FY17 budget development time.
Education Agency	Education Services	5100070000	8/24/2016	21848	ED-Private Sector Grants	30,300.00	Carryover funds and new awards approved by JFO before the end of FY16, but were not known at FY17 budget development time.
Education Agency	Education Services	5100070000	8/24/2016	21848	ED-Private Sector Grants	27,372.00	Carryover funds and new awards approved by JFO before the end of FY16, but were not known at FY17 budget development time.
Education Agency	Education Services	5100070000	8/24/2016	21848	ED-Private Sector Grants	90,000.00	Carryover funds and new awards approved by JFO before the end of FY16, but were not known at FY17 budget development time.
Libraries	Department of Libraries	1130030000	9/29/2016	21870	Misc Special Revenue	6,000.00	Funds from billings to CCV for their portion of Learning Express Library Database
Sergeant at Arms' Office	Sergeant at Arms	1230001000	8/5/2016	21870	Misc Special Revenue	10,000.00	Room rentals
Public Safety	DPS-Fire Safety	2140040000	10/18/2016	21870	Misc Special Revenue	1,166.31	MOU between Clean Energy States Alliance and DPS-Division of Fire Safety to facilitate the instruction training for "Solar Photovoltaic Safety for Fire Fighters course, reference 32 VSA, 603.
Libraries	Department of Libraries	1130030000	10/6/2016	21883	Gates Foundation Grants	7,500.86	Funds from the Opportunity ONline Broadband Grant from the Bill & Melinda Gates Foundation
Agriculture, Food&Mrkts Agency	Ag Development Division	2200030000	8/5/2016	21889	Risk Manage Ag Producers	59,964.00	Grant from VT Low Income Trust for electricity accepted through JFO via #2688
Public Service Department	Regulation & Energy Efficiency	2240000000	7/28/2016	21899	Connectivity Fund	2,552,153.36	VT Telecommunications Authority

FY 2017 Excess Receipts Report - Q2 Cumulative - Run 1-15-2017

Agency/Dept Name	Appropriation Name	Deptid	Date	Fund	Fund Name	Amount	Comments
Administration Agency	Secretary of Administration	1100010000	7/28/2016	21908	Misc Grants Fund	194,723.16	Grant award from the Permanent Fund for VT's Children. To provide staff and consulting support of the Blue Ribbon Commission on Child Care.
Agriculture, Food&Mrkts Agency	Ag Development Division	2200030000	7/19/2016	21908	Misc Grants Fund	9,750.00	Grant from Agricultural Safety & Health Council of America: JFO #2825 approved 6/20/16
Military	MIL Vet Affairs Office	2150050000	9/1/2016	21924	Vermont Veterans Fund	71,500.00	Proceeds from tax return donations
Agriculture, Food&Mrkts Agency	Water Quality Programs	2200891602	7/19/2016	21933	Agricultural Water Quality	873,384.33	Remaining funds from 2015 Act 64 Section 42
Buildings & Gen Serv-Gov'tal	BGS-Information Centers	1150400000	10/4/2016	21936	Information Center Revenues	5,000.00	Receipts from advertising panels placed in Info Centers around the state.
Buildings & Gen Serv-Gov'tal	BGS-Information Centers	1150400000	8/10/2016	21936	Information Center Revenues	102.72	Receipts come from advertisement marketing panels placed in Info Centers around the state
Treasurer's Office	Office of the Treasurer	1260010000	10/21/2016	21980	Indemnification Fund	509,338.01	Pursuant to 10 V.S.A. Chapter 12, Subchapter 2 Section 223 Mortgage Insurance Fund and Act 157 signed June 2, 2016.
Agriculture, Food&Mrkts Agency	Lg Animal Vet Loan Forgive	2200891601	7/19/2016	21992	Next Generation Initiative Fnd	18,593.02	Remaining one-time appropriation - grant agreement exists fully obligating funds
Economic Development	STEM Incentive	7120891502	8/5/2016	21992	Next Generation Initiative Fnd	63,600.00	One-time appropriations for FY2016 carry forward
Economic Development	STEM Incentive	7120891602	8/5/2016	21992	Next Generation Initiative Fnd	129,000.00	One-time appropriations for FY2016 carry forward
Transportation Agency-Prop	Central Garage	8110000200	8/24/2016	57100	Highway Garage Fund	70,692.17	Funds are the unexpended balance in the equipment replacement account at the end of FY16. Funds will be used for equipment purchases per Title 19, Sec. 13 (c)
Buildings & Gen Serv-Prop	State Energy Management Prog	1160700000	10/24/2016	59700	Energy Revolving Fund	600,000.00	Per 2014 Act 178 Sec 41 that established Energy Revolving Fund under section 29 VSA Sec. 168 for the purpose of facilitating energy projects in State facilities.
Subtotal Special Fund Excess Receipts						**12,426,454.73**	
TOTAL:						**32,199,917.41**	

VERMONT

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[phone] 802-828-2376
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Agency of Administration

MEMORANDUM

TO: Joint Fiscal Committee
FROM: Trey Martin, Secretary of Administration
RE: 2016 Act 172 Sec. B.1106 – Fiscal Year 2017 Exempt Position Savings
DATE: November 15, 2016

Pursuant to 2016 Act 172 Sec.B.1106, the Administration was directed to reduce exempt salaries and positions to a level of $550,000 General Fund. As reported to the Joint Fiscal Committee by Commissioner Pallito on November 14, 2016, we are requesting an extension to January 15, 2017, to fulfill this request. This will allow the Shumlin Administration to work with the incoming Administration to identify the positions for elimination.

In order to give the next Governor the flexibility to staff the next administration, this administration will be working with the transition team to identify the remaining positions to be eliminated.

Thank you very much. If you have any questions about this request, please direct them to Commissioner Pallito or myself.

VERMONT

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Office of the Commissioner
120 State Street - 5th Floor
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Agency of Administration

TO: **Joint Fiscal Committee**
Government Accountability Committee
House Committee on Government Operations
Senate Committee on Government Operations

FROM: **Thomas S. Cheney, Commissioner** TC

DATE: **November 21, 2016**

SUBJECT: **Department of Environmental Conservation Position Pilot Program**

In accordance with Act 179, Sec. E.100(d) as amended by 2015 Acts and Resolves No. 4, Sec. 74 and Acts and Resolves No. 172, Sec. E.100.2, Secretary of Administration Trey Martin has approved the attached position pilot request from the Department of Environmental Conservation (DEC).

The written description required by Act 179, Sec. E.100(d)(4), including the method for evaluating the cost-effectiveness of the positions, as provided by DEC, is attached for your information.

The Department of Human Resources fully supports the request to create three positions with the Position Pilot Program. We believe the request is an appropriate use of the Position Pilot. Department of Human Resources has reviewed vacancies at the DEC and has determined all vacancies are under active recruitment. Each position will increase the Department's effectiveness and level of service provided to Vermonters.

Summary of Department of Environmental Conservation's Position Pilot Request

DEC proposes creating two positions (one 18-month limited services position and one three-year limited services position) funded within existing departmental appropriations. The positions will be paid for out of existing fees and revenues. An Environmental Analyst V positon will be responsible for permitting, inspecting and technical assistance surrounding the Residual Waste Program and the Environmental Analyst IV positon will provide additional technical assistance to the development community around sites that qualify for siting of renewables. The position may assist with recommended policies or guidance documents.

Any questions should be directed to Molly Paulger at 828-3517.

c: Secretary Martin
Secretary Markowitz
M. Paulger

VERMONT

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Agency of Administration

TO: ~~Trey Martin, Secretary of Administration~~
FROM: Thomas S. Cheney, Commissioner of DHR
RE: DEC Position Pilot Program Proposal Recommendation
DATE: November 16, 2016

On October 28, 2016, I received a Position Pilot Proposal from Department of Environmental Conservation. The written description required by Act 179, Sec. E.100(d)(4), including the method for evaluating the cost-effectiveness of the positions, as provided by DEC, is attached for your information. Below is our recommendation and summary of our analysis.

The Department of Human Resources fully supports the request to create two positions with the Position Pilot Program. We believe the request is an appropriate use of the Position Pilot. Department of Human Resources has reviewed vacancies at the DEC and has determined all vacancies are under active recruitment. Each position will increase the Department's effectiveness and level of service provided to Vermonters.

Summary of Department of Environmental Conservation's Position Pilot Request

DEC proposes creating two positions (one 18-month limited services position and one three-year limited services position) funded within existing departmental appropriations. The positions will be paid for out of existing fees and revenues. An Environmental Analyst V positon will be responsible for permitting, inspecting and technical assistance surrounding the Residual Waste Program and the Environmental Analyst IV positon will provide additional technical assistance to the development community around sites that qualify for siting of renewables. The position may assist with recommended policies or guidance documents.

Any questions should be directed to Molly Paulger at 828-3517.

c: M. Paulger

VERMONT

Vermont Department of Environmental Conservation
Watershed Management Division
1 National Life Drive, 2 Main
Montpelier, VT 05620-3522

Agency of Natural Resources

[phone] 802-828-1535
[fax] 802-828-1544

MEMORANDUM

TO: Trey Martin, Secretary, Agency of Administration
Michael Clasen, Deputy Secretary, Agency of Administration

THRU: Deborah Markowitz, Secretary, Agency of Natural Resources

FROM: Alyssa B. Schuren, Commissioner, Department of Environmental Conservation

DATE: October 28, 2016

RE: Position Pilot Proposal

New Position (2 Positions):

1) DEC proposes one new three-year limited service position to work within our Residual Waste Program in the Waste Management & Prevention Division (WMPD). This position will be fully funded by a combination of our new annual septage hauler fees (authorized in the 2016 DEC fee bill year) and available solid waste certification permit fee funds. This position is needed to fill a critical gap in this program. The Residuals Program was relocated from our Watershed Management Division to WMPD in May 2016. However, this move included one FTE not the 2.5 FTEs which are deemed needed to manage this program and growing demands in the face of emerging contaminants. The position requested would include the duties of permitting, inspection, and technical assistance support. These duties are needed to help ensure this program continues to be effective at managing residuals in a manner which is protective of public health and the environment. This need has become even more urgent with the discovery of perfluoroalkyl substances (PFAS) throughout VT and the associated new duties needed to address emerging contaminants.

Environmental Analyst V – The Residuals Program is charged with the regulatory oversight of bio-solids and septage that is generated in the treatment of domestic wastewater either from private home septic systems or municipally operated wastewater treatment facilities (WWTF), the regulatory oversight of sludges produced by the biological treatment of dairy wastes, and the regulatory oversight of the uses of wood ash and short paper fiber. It is important to ensure that bio-solids are free of pathogens and hazardous contaminants and that vector attraction has been controlled if they are to be applied to the land under a site specific solid waste facility certification or prepared to a quality where the bio-solids can be marketed and distributed to the general public as a commodity, rather than being disposed as a solid waste.

Every public and private WWTF treating domestic wastes must have either a Sludge Management Plan (78 facilities) which must be revised and reapproved whenever facility operations or control personnel changes, or a Solid Waste Facility Certification (41 facilities) which must be renewed every 10 years. There are 18 permittees operating land application

programs on 62 different sites. Facility inspections are conducted on the non-land applying facilities under permits (12 facilities) every other year, and each of the facilities that land apply or produce marketable bio-solids (29 facilities) receive annual inspections. There are also 12 wood ash and three short paper fiber generators that need to be managed by the program under two "Procedures". The Residuals Program also provides considerable technical support to these facilities and it conducts enforcement activities when required. There are quarterly reports from 113 municipal and private WWTFs and 120 transporters permitted for hauling residual wastes that need to be logged, and scanned to the Wastewater Inventory, and even more importantly reviewed for compliance issues. There is also the work associated with collection and receipt of Residual Program fees which require logging and tracking of the septage fees collected from the 120~ transporters that pump septic tanks on a quarterly basis (projected $300k-$400k annually). This new position, along with aiding in the duties outlined above, will conduct inspections and audits to determine if there are septage haulers that are not paying the required fees.

Measures of success:

- Percentage of required facility inspections (out of 29) completed each year.
- Percentage of quarterly management and monitoring reports reviewed within 30 days of receipt.
- Tracking and verification of quarterly septage fee payments from transporters received on time and for the proper amount (Year 1 Goal: 75%).

2) DEC proposes one new 18-month limited service position for our Waste Management & Prevention Division's (WMPD) Sites Management Program to support implementation of Vermont's new Net Metering Rule and Standard Offer Program. Both the new Public Service Board (PSB) rule for net metered energy facilities (Rule 5.100) and the Standard Offer Program for, larger, utility scale facilities (Act 174), now provide incentives for projects to be sited at 'preferred locations'. The preferred locations include, but are not limited to, sanitary landfills, brownfields and Superfund sites.

Environmental Analyst IV – There are a number of benefits to siting renewables at these preferred sites: it provides a viable and economically positive use for land that may otherwise be challenging to develop, it may result in an energy project assuming some of the maintenance costs at these sites during the life of the energy project, and it helps the state advance our greenhouse gas reductions goals while taking pressure of 'green field' development for energy projects, where the potential for natural resource impacts is often greater. Since the prioritization of these locations is a new aspect of the state's energy policy, the development community may need additional technical assistance from the Agency of Natural Resources (ANR), and more specifically DEC's Brownfields Program, to determine which sites qualify as preferred locations and how to deploy renewables at those locations without exacerbating the existing site conditions.

Specifically, both the new Net Metering Rule and the Standard Offer require applicants to obtain 'certification' from the Secretary of ANR that a given site is in fact a sanitary landfill as defined in 10 V.S.A. § 6602, a brownfield site as defined in 10 V.S.A. § 6642, or a superfund site listed on the National Priority List to qualify as a preferred location. The WMPD Sites Management Program would need to advise the Secretary on making these certifications, and we also recommend developing a policy or guidance document that sets out the steps for that certification so that the development community is aware of how to proceed. With this additional workload there is a critical need to build a dedicated capacity to this effort within the

Sites Management Program. With an allocation of Section 248 fee revenue collected by ANR and a small amount of available solid waste funds we could support this dedicated capacity to assist with the review and certification of these sites. Given the short term nature of the funding and the likely short term nature of this related role/workload to get the Program implemented we are requesting an 18-month limited service Environmental Analyst IV.

Measures of success:

- Creation and implementation of a program to certify the preferred location for renewable energy projects at sanitary landfills, brownfield and Superfund sites, including development of fact sheets and guidance for energy developers.
- Number of facilities developed for renewable energy on brownfields, landfills and Superfund sites.
- Number of workshops, presentations and other direct technical assistance deliverables used to increase understanding of best practices amongst renewable energy development community developing facilities at landfills, brownfields and Superfund sites.

Each of these positions is extremely critical to the specific efforts detailed above and our ability to implement such efforts successfully. Should you have any questions or require any additional information please do not hesitate to contact us directly. Thank you.

Attachment

Dept. of Environmental Conservation - Position Pilot - DHR Job Title Requests

new position number	Position Job Title Requested	Job Code	Position Type	Department ID	Workstation Zip Code	Supervisor's Position Number	Supervisor's Name
[redacted]	Environmental Analyst V: General	145308	3 year Ltd. Service	6140030260	05602	660068	Ernest Kelley
[redacted]	Environmental Analyst IV: General	145208	1.5 year Ltd. Service	6140030245	05602	660370	Patricia Coppolino

State of Vermont
Agency of Administration
Health Care Reform
109 State Street
Montpelier, Vermont 05609

REPORT TO THE VERMONT LEGISLATURE

Report on Universal Primary Care

In accordance with Act 172 of 2016, Section E.100.10

Submitted to
Health Reform Oversight Committee
Joint Fiscal Committee
House Committee on Appropriations
House Committee on Health Care
House Committee on Ways and Means
Senate Committee on Appropriations
Senate Committee on Finance
Senate Committee on Health and Welfare

Submitted by
Director of Health Care Reform
Agency of Administration

November 23, 2016

Table of Contents

Executive Summary

In order to further advance health care reform, the Vermont Legislature passed Act 54 of 2015, which required the Agency of Administration to report the costs of a system of universal primary care (UPC) for all Vermonters. In 2015, the Agency of Administration reported the following costs for the following primary care services:

Figure 1: Universal Primary Care Service Categories and Specialty Types

Universal Primary Care Service Categories	Universal Primary Care Specialty Types
•New or Established Patient Office or Other Outpatient Visit •Initial New or Established Patient Preventive Medicine Evaluation •Other Preventive Services •Patient Office Consultation •Administration of Vaccine •Prolonged Patient Service or Office or Other Outpatient Service •Prolonged Physician Service •Initial or Subsequent Nursing Facility Visit •Other Nursing Facility •New or Established Patient Home Visit •New or Established Patient Assited Living Visit •Other Home or Assisted Living Facility •Alcohol, Smoking , or Substance Abuse Screening or Counseling •All-Inclusive Clinic Visit (FQHCs/RHCs) •Behavioral Health	•Family Medicine MD •Registered Nurse •Internal Medicine MD •Pediatrician MD •Physician Assistant/Nurse Practitioner •Psychiatrist •OB/GYN MD •Naturopath •Geriatric •Registered Nurse - Psychiatric/Mental Health •Social Worker •Psychologist •Counselor •Counselor - Addiction

Table 1a. Summary of Claim Cost Estimates for Universal Primary Care in 2017, With and Without Cost-Sharing[1]

Claim Costs	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
Total Claim Costs	$221,747,000	$220,236,000	$281,929,000
Paid by Medicaid[2]	($107,371,000)	($107,371,000)	($107,371,000)
Net Claim Costs	$114,376,000	$112,865,000	$174,558,000
% Covered by the payer, on average	87%	87%	100%

In 2016, the Legislature passed Act 172, which required the Agency of Administration report on:

- A literature review of any savings realized by universal health care programs over time that are attributable to the availability to the access to primary care.

[1] This methodology results in a cost estimate range for the legislature from status quo to 100% coverage.

[2] Actuarial firm Wakely Consulting assumed a payment rate trend of 1.7% for Medicaid estimates and trended forward three years from 2014 to 2017. If Medicaid grows more slowly the total cost estimate will increase.

- Analysis of the primary care payment models created through the development of the all-payer model.
- A potential implementation timeline for universal primary care.

Part 1. Investigating Cost Savings Attributable to Universal Primary Care: A Literature Review

The Agency reviewed 49 sources from the academic and policy literature. A summary of key articles reviewed and full list of sources is included in Appendix B. Key findings include:

- No studies directly exploring the cost savings attributable to universal access to primary care were found in the literature.
- Many studies demonstrated elements of primary care that produced cost savings and improved health outcomes. Four of these studies demonstrated cost savings attributable to Vermont Blueprint for Health, a primary care intervention based in the patient-centered medical home model that contributed to primary care payment and delivery reform in Vermont since 2003.
- Other studies from around the US further demonstrated the evidence of primary care interventions to reduce costs through continuity of care, access to care, utilization of care, alternative payment models, and electronic health records. Around the world, countries with higher investment in primary care and social service spending had better health outcomes and lower health care costs. Policymakers should consider whether and how this would apply to UPC.

Part 2. Primary Care Models Created in All-Payer Model

After Act 172 was passed, the State of Vermont finalized the Vermont All-Payer Accountable Care Organization Agreement, commonly referred to as the all-payer model.[3] The final agreement, executed on October 27, 2016, set 2017 as a planning year and 2018 as the first year that requires Vermont to have aligned accountable care organization (ACO) programs across Medicare, Medicaid, and commercial insurers. Accordingly, it is not yet possible to describe and evaluate primary care models created for the all-payer model and their impact on the UPC concept. The study would need to be updated as ACOs and their constituent providers develop and implement primary care models in 2017 and future years.

Part 3. Draft Implementation Timeline

An implementation timeline consists of several phases. In the first phase, the Legislature must refine elements of the universal primary care program and provide direction to the Agency of Human Services in order to complete the cost analyses and financing plan. During Phase 2, the Agency of Administration will perform cost analyses and developing financing plans. In phase 3, the Legislature must pass a financing plan. And in the final phase, the State of Vermont will apply for federal waivers and implement the program. These tasks may be spread out over a five-year period with the State of Vermont starting implementation in Year 3 or Year 4.

[3] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.

Part 1. Investigating Cost Savings Attributable to Universal Primary Care: A Literature Review

Introduction

Vermont has a long tradition of leadership in health care reform through Dr. Dynasaur, Catamount Health and Vermont Access Programs (VHAP), Act 48, and other initiatives. In 2011, Act 48 established a framework for an integrated health care delivery system to steer Vermont towards the following goals:

1. Reducing health care costs and cost growth
2. Assuring that all Vermonters have access to and coverage for high quality care
3. Assuring greater fairness and equity in how we pay for health care
4. Improving the health of Vermont's population [1]

In 2015, universal primary care (UPC) was proposed by members of the General Assembly as an intervention to potentially decrease costs over time, improve health equity, and ensure universal coverage through a publicly financed program for these services as a step towards a larger universal coverage program. The Legislature approved what would become Act 875 of 2016, Sec. E.100.10, requiring the Agency of Administration to produce a literature review on the cost savings attributable to universal access to primary care.

Act 875 Sec. E.100.10 UNIVERSAL PRIMARY CARE; REPORT reads,

> "(a) Regardless of any future developments in payment and delivery system reform, Vermont is likely to continue to have uninsured or underinsured residents. As expanding access to primary care services is a proven method for improving population health, the General Assembly intends to move forward with implementation of universal primary care for all Vermonters.
> (b) In order to determine a path forward toward implementing universal primary care in Vermont, the Secretary of Administration or designee shall:
> (1) conduct a literature review of any savings realized by universal health care programs over time that are attributable to the availability of universal access to primary care." [2]

This is the second report produced by the Agency of Administration on the topic of UPC. In December of 2015, a report was released comparing the estimated costs of implementing UPC with costs of maintaining the status quo. The claims cost estimates for UPC in 2017 were projected to be $221,747,000 for the status quo, $220,236,000 with cost sharing, and $281,929,000 without cost sharing (Figure 2)[4]. To put these numbers in context, total health care spending in Vermont in 2014 was $5.5 billion [3].

[4] These figures do not include administrative costs or transition costs.

Figure 2: Costs Scenarios for Primary Care [4]

Claim Costs	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
Total Claim Costs	$221,747,000	$220,236,000	$281,929,000
Paid by Medicaid[9]	($107,371,000)	($107,371,000)	($107,371,000)
Net Claim Costs	$114,376,000	$112,865,000	$174,558,000
% Covered by the payer, on average	87%	87%	100%

The purpose of this literature review is to investigate studies on cost savings attributable to universal access to primary care. A comprehensive literature review using three different research databases did not yield any results directly applicable to studies on universal primary care. In the US, there is no precedent for universal primary care and Vermont would be the first state to implement UPC, which may explain the gap in the literature. Other studies did show cost savings attributable to primary care in non-universal programs in the United States and in universal health care programs in other countries. In the absence of studies directly related to universal access to primary care, this literature review examines the evidence on the best use of primary care with key findings and considerations for Vermont.

The literature also includes information on cost sharing, as cost sharing was studied in the 2015 Cost Estimates for Universal Primary Care Report. This study was limited to analyzing the claims costs and provider reimbursement increases for UPC, and did not include the full costs associated with administration or costs related to a public financing plan, economic analysis of the financing plan, legal and waiver analysis, operational plan, or benefit design [4].

Defining primary care

Act 54 of 2015 authorizes a cost estimate report on UPC and defines UPC as,

> "A publicly financed program that would provide primary care services to all Vermonters, regardless of insurance coverage, ensuring that all Vermonters have access to primary care." [5]

The Legislature defines primary care as,

> "Health services provided by health care professionals who are specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and includes pediatrics, internal and family medicine, gynecology, primary mental health services, and other health services commonly provided at federally qualified health centers. Primary care does not include dental services" [5].

This literature review precedes an outline of a defined UPC program established by the General Assembly, which necessarily leaves outstanding issues and questions as to the program design.

Methods

The search terms *universal primary care, cost savings, health outcomes, population health, primary care*, and *return on investment* were used separately and in combination in Medline, CINAHL, and Proquest. A secondary search using the terms *cost savings, primary care utilization, emergency department use*, and *hospitalization rates* was also performed. A "snowballing" strategy was used to include studies referenced in the articles that were found via search. Academic peer-reviewed articles, white papers, and reports by leading health organizations were also included for study.

Literature on cost-sharing was found in Medline using the following search terms: *cost sharing, cost sharing and primary care, deductibles, coinsurance, and primary care*, and *cost sharing and chronic disease*. In total 125 studies and articles were reviewed and fifty, including six systematic literature reviews, were included in this report.[5]

Key Findings

For each key finding, a summary of the literature is presented followed by a discussion of considerations for policy makers. A review of the literature produced the following findings:

1. No peer-reviewed studies showed cost savings directly attributable to universal access to primary care.
2. Many studies showed cost savings attributable to access to primary care in non-universal settings, including in Vermont.
3. Many studies showed countries with a foundation in strong primary care systems had lower costs, greater health equity, and better population health than the US.
4. Many studies showed cost sharing can decrease healthcare utilization and disproportionately impact the poor.

Key Finding 1: No peer-reviewed studies showed cost savings directly attributable to universal access to primary care.

Summary of Findings

Studies on universal access to primary care were not explicitly available through any of the database searches.

Considerations for Vermont

Vermont would be the first place where data on universal access to primary care could be collected.

[5] The Joint Fiscal Office and Dr. Deb Richter also contributed studies to this review.

Key Finding 2: Many studies showed cost savings attributable to access to primary care in non-universal settings, including in Vermont.

Summary of Findings

A total of thirteen studies investigated the cost savings from a primary care intervention in the US (Tables 2-4). This section provides definitions for key terms, tables of the thirteen cost savings studies, a Vermont case study, and other elements of primary care that were shown to affect cost, quality, and/or health outcomes.

Definitions

This section provides definitions relevant to the discussion of the studies on cost savings.

Patient-Centered Medical Home (PCMH): The patient-centered medical home is an alternative care model certified by the National Committee for Quality Assurance (NCQA) using evidence-based practices for quality, cost reduction, and population health management to achieve the following standards [6]:

- To improve prevention and management of chronic disease and ambulatory care sensitive conditions;
- To create multi-specialist, team-based care, including linkage with social workers, nutritionists, and other social service professionals outside the scope of traditional primary care; and
- To reduce unnecessary medical expenditures.

High-intensity primary care: According to the Bailit Health Purchasing report, "High-Intensity Primary Care provides patient-centered, team-based care to those patients with the most significant health care needs (e.g., multiple chronic conditions). The patient's team of medical professionals (which may include a primary care physician, specialist, a behavioral health clinician, a nurse manager, a health educator, and a community health worker) work together with the patient to support him or her in developing and following his or her individualized care plan. This model of care often includes a significant level of patient-provider interaction (potentially daily) using in-person visits, telephone calls, and e-mail" [7].

Ambulatory care sensitive conditions (ACSCs): According to Purdy, et al. (2009), "Ambulatory or primary care sensitive conditions (ACSCs) are those conditions for which hospital admission could be prevented by interventions in primary care," and include at least thirty-six identified conditions such as asthma, hypertension, congestive heart failure, chronic obstructive pulmonary disease, common infections, and others [8].

Studies of Cost Savings Attributable to Primary Care Interventions

Of the thirteen studies of cost savings attributable to primary care interventions, six studies focused on primary care interventions for Medicare and/or Medicaid beneficiaries [9-13], three studies focused on primary care interventions for private sector and non-profits [7, 14, 15], and

four studies focused on five statewide programs. Of the five statewide programs, four of the studies occurred in Vermont[6] [6, 10, 16, 17].

In terms of primary care interventions, three of the studies focused on high-intensity primary care, eight focused on patient-centered medical homes, two focused on home-based primary care, and one focused on insuring previously uninsured patients and providing access to a community primary care clinic.

Tables 2 – 4 on pages 9-10 provide summaries of the studies described above.

[6] These were studies assessing Vermont Blueprint for Health: two studies focused on PCMHs, one focused on SASH, and one on the Vermont Chronic Care Initiative.

Table 2. Primary Care Programs with Return on Investment: Medicare/Medicaid Specific

Program	Cost savings	Focus	Size of Study	Timeframe
Priority Access Primary Care (PAPC) Pilot in East Baltimore, MD Study conducted internally by PAPC team with results published in John Hopkins Medicine BestPractice News	2-to-1 ROI [30% decrease in ED use, 41% decrease in hospital admissions]	High intensity primary care	70 patients enrolled in Medicaid	1.5 years
Virginia Commonwealth University Medical Center program Study by Bradley, et al. (2012) and published in the journal *Health Affairs*	Costs went from $8,899 to $4,569 per patient per year, almost 50% reduction in costs	Insuring previously uninsured patients and providing access to a community primary care clinic	26,284 patients enrolled in Medicaid	7 years
Community Care of North Carolina[7] Study by Steiner, et al (2008) published in the journal *Annals of Family Medicine*	$160 million annual savings 2008 $336 million annual savings in 2014	PCMH	750,000 patients enrolled in Medicaid in 2008, 1.44 million in 2014	N/A, but program began in 1998
Home Based Primary Care practice, Washington D.C. Study by de Jonge, et al. (2014) published in *Journal of the American Geriatrics Society*	$8,477 per patient (17% lower than projected Medicare costs) over two years	Home based primary care	722 patients enrolled in Medicare	2 years
Hennepin Health, a Medicaid ACO pilot program in Minnesota's Coordinated Care Clinic Evaluated by the Center for Medicaid and CHIP Services (CMCS)	$24,170 per patient over first year	PCMH	232 Medicaid patients	30 months

[7] This was also a statewide study. Updated 2014 information found in North Carolina Community Care Networks, Inc. Clinical Program Analysis, May 2015 at https://www.communitycarenc.org/media/files/roi-document-may-2015.pdf

Table 3. Primary Care Programs with Return on Investment: Private Sector and Non-Profit

Program	Cost savings	Focus	Size of Study	Timeframe
Intensive Outpatient Care Program by Boeing Study published by Bailit Health Purchasing, LLC in collaboration with the Robert Wood Johnson Foundation	A 20% decrease in spending per patient	High intensity primary care	740 Boeing employees	1 year
Proven Heath Navigator (PHN), a PCMH developed by Geisinger Health System Study by Maeng et al. (2012) in the *American Journal of Managed Care*	1.7 ROI	PCMH	Over 26,000 enrollees in a Medicare advantage plan	4 years
Group Health Medical Home Study by Reid, et al (2010) in *Health Affairs*	$10.30 per patient per month (est.)	PCMH	N/A	21 months

Table 4. Primary Care Programs with Return on Investment: Statewide Programs

Program	Cost savings	Focus	Size of Study	Timeframe
Pennsylvania Chronic Care Initiative Study by Friedberg, et al. (2015) published in *JAMA Internal Medicine*	N/A. Decreased use of services associated with higher costs was found (emergency care, specialty, and hospital use) while PC utilization and quality increased.	PCMH	17,386 in pilot and control groups	3 years
Vermont Blueprint for Health (case study page 7) Study by Jones, et al. (2015) in the journal *Population Health Management*	$482 per patient per year, $104.4 million in total	PCMH	123 participating practices, plus an unspecified number of control groups	6 years
Vermont Blueprint for Health (See Case Study, pg. 7) Study by Thompson, et al. (2015) in the journal *Population Health Management*	Costs increased while health care utilization decreased	PCMH	Samples of claims data taken from 104,160-150,846 people per year	5 years (2007-2011)
Support and Services at Home (SASH) Evaluated by the Assistant Secretary for Planning and Evaluation Office of Disability	$1,536 per beneficiary for those enrolled before April 2012	Home-based primary care, elements of PCMH	3,385 SASH enrollees plus controls	3 years
Vermont Chronic Care Initiative Evaluated by the Center for Medicaid and CHIP Services (CMCS)	$11 million in FY 2012	High-intensity primary care	N/A	2 years

Because the majority of the studies on statewide programs focused on Vermont's primary care interventions, we have included a brief case study to summarize the findings below.

Case Study: Vermont PCMHs

Jones, et al. (2015) compared costs, health care utilization, and quality outcomes for PCMHs in Vermont to non-PCMH primary care practices annually over six years. It was found that costs were reduced by $482 per patient (using a different-in-differences change methodology) for PCMHs compared to the non-PCMH group while achieving higher scores on 9 of 11 quality measures. If the cost savings are applied per patient, the total savings amounts to $104.4 million over six years. While 123 primary care practices participated as PCMHs, the article did not specify how many practices were included in the non-PCMH group.

Thompson, et al. (2015) arrived at different results using a different study design. This study analyzed claims data for all Vermonters with commercial insurance and Medicaid from 2007-2011, a period where PCMHs were growing and expanding across Vermont. The study analyzed inpatient costs, costs per discharge, and cost per inpatient day and found that *costs* increased despite a decrease in health care utilization due to external cost drivers.

The primary care interventions discussed above that produced cost savings used evidence-based methods relating to the following elements:

- Continuity of care
- Access to care
- Utilization of care
- Alternative payment models
- Electronic health records

Each element is discussed in greater detail below in order to provide a summary of how this element impacted the care of patients and why it might be associated with cost savings. Because more than one element may be present in an existing system or may be introduced as a new intervention, it is difficult to assess which interventions are successful over time. This is due to the methodological challenges of assessing more than one variable interacting in a complex system. In a randomized controlled trial, known as the gold standard of research design, often a single variable is introduced to two otherwise very similar groups. The studies in this topical area are observational studies in communities and health institutions. The likelihood for confounding factors, or unaccounted for factors that influence the study results, is much greater in observational studies such as these.

Continuity of Care

Continuity of care was generally defined as a longitudinal relationship between patients and their PCP's, but one study expanded the definition to include "informational continuity of care" which included having a patient's medical records easily transferable between providers [18]. A

2010 systematic literature review of primary care found that continuity of care was associated with improved preventative services, higher quality of care, decreased hospitalizations, and improved early diagnosis in four separate literature reviews [18]. Better-coordinated care has also been shown to be cost-effective in most circumstances [15, 18, 19].

Access to Care

A 2010 literature review of primary care found seven dimensions of access to primary care based on six separate, previous literature reviews. The results showed access to primary care was defined by availability (type and amount of services), geographic accessibility, accommodation (i.e. home visits, appointment hours), affordability, acceptability (patient satisfaction), utilization, and equality in access [18]. The evidence overwhelmingly showed that access to care was associated with fewer hospitalizations for ACSC's and better population health.

Bradley, et al. (2012) found cost savings associated with insuring a previously uninsured population of low-income adults in Virginia and providing them access to a community based primary care system. The results showed a 17% reduction in health care costs over a three-year period with a savings of $4,330 per patient as a result of decreased ER visits and inpatient hospitalizations [11].

Utilization of Care

Access to primary care and primary care utilization were analyzed separately in the literature, with the exception of one literature review that analyzed utilization under the umbrella of access to care. Findings in the US showed that an increase in primary care utilization was consistently correlated to positive health outcomes pertaining to blood pressure and glycemic index control, colorectal cancer, and lung cancer [20-22]. In other words, using more primary care services resulted in better control or early detection of certain conditions.

Alternative Financing Models

Two studies were found on how different financing models influence clinical decision-making. These studies do not offer conclusive evidence as to what kind of payment model is best, but they do highlight the important role that payment models make in influencing costs. One study found that there was no significant difference in clinical-decision making for life-saving care under fee-for-service (FFS) or capitated payments, but there was a difference in discretionary care [23]. The authors of this study, Shen et al. (2004) found that, "Physicians on average tended to conserve discretionary resources under capitated arrangements compared with traditional FFS" (p. 4). However, a 2013 academic review recommended a revised FFS model over capitated payments, arguing that capitated payments can lead to the underuse of necessary diagnostic testing and treatment [24].

Alternative Care Models

Patient-centered medical homes were the most widely cited alternative care models in the literature. This care model addresses patient-centered care, access to care, continuity of care,

electronic health records and other quality issues. The cost savings of PCMHs are documented under this key finding section (Tables 2-4) and in the case studies. Some studies showed less concrete success from PCMHs. Kern, et al. (2016) found that changes in utilization and quality for the PCMH were modest [25].

Electronic Health Records

The use of electronic health records has shown cost savings, however, results are inconclusive as health IT studies vary widely by study design and locale [26]. A systemic review of studies demonstrated an improvement in costs, quality, and efficiency attributable to electronic health records, citing an improvement in care delivery, a reduction in medical errors, better preventative health delivery, and a reduction in redundant care [27].

Evidence of Cost Increase

One article showed that primary care was associated with increased health care spending growth. Chernew, et al. (2009) analyzed ten years of Medicare data and found that regions with a ten percent higher than average number of primary care physicians also had a 1.8% higher health care growth spending rate. This study also found that higher numbers of primary care physicians was correlated with lower health care costs overall, consistent with many previous studies [28].

Considerations for Vermont

Cost Savings from Delivery and Payment Reforms

Since 2003, primary care in Vermont has been transforming under a state initiative called the Vermont Blueprint for Health. This program within the Department of Vermont Health Access (DVHA) focuses on delivery reform, as well as some payment reform efforts. The goal of the Blueprint is to improve quality, reduce costs, and improve population health through a series of primary care innovations. These innovations are centered on PCMH certification, community health teams, payment reforms, and community-led programs to improve health. The Blueprint started with two a two-practice pilot in 2008, grew to 18 sites in 2010, and then to 123 sites in 2013 [6]. Today, over 126 of Vermont's 140 primary care practices are enrolled in Blueprint [29]. The Blueprint also includes the Vermont Chronic Care Initiative, SASH, and Hub & Spoke programs.

Because Vermont has implemented a PCMH model with community health teams, the most relevant studies on cost savings related to these models are those about the Blueprint. This is important to note, as some cost savings related to care delivery may already be realized in Vermont.

Cost Savings from Access

A small but noteworthy percentage of Vermont's population remains uninsured. The National Center for Health Statistics estimated Vermont's uninsured rate at 2.7% for 2015 based on the results of the National Health Interview Survey. According to the 2014 Vermont Household Health Insurance survey, 3.7% Vermonters are uninsured, representing 23,231 people,

including 1,300 children. In addition, the Vermont Department of Health (VDH) estimates there to be approximately 5,000 people of foreign citizenship without legal documentation in Vermont lacking health insurance. Vermont also has a sizeable population of underinsured residents. According to the survey, the underinsured population includes 27% of people with private health insurance under the age of 65. Young adults represent the largest group within this demographic with 63% of people ages 18-24 underinsured. "Underinsurance" was defined in the survey as having a deductible that exceeds a family's income by 5% and/ or having medical expenses that amount to over 5% or 10% of a family's income depending if they've earned under or over 200% of the Federal Poverty Level (FPL).

One study indicated there would likely be a cost savings for insuring uninsured, low-income adults. Of the remaining 23,231 Vermonters without health insurance, 45% of the uninsured are within 1-199% FPL. The literature shows that cost savings from insuring people who were previously uninsured has cost savings, but the exact amount and time frame to realize cost savings are unclear. Furthermore, findings from other states may not be directly applicable to Vermont if uninsured and underinsured Vermonters currently have better access to primary care through federally qualified health centers, rural health clinics, free clinics, and other safety net providers throughout the state. If this were true, then cost savings attributable to primary care for UPC would likely be lower than in other states.

Cost was self-reported as the number one barrier to health insurance in the 2014 Vermont Household Health Insurance Survey. According to the survey, uninsured Vermonters were more likely to forgo preventative services, mental health services, and treating an illness due to the cost of care than insured Vermonters. Depending on how the program were funded, UPC could remove the cost barrier standing between the uninsured and access to routine and preventative care, ultimately improving health and saving costs. However, the transferability of these findings to Vermont hinges on several factors, including to what degree Vermont's uninsured population currently receives free or low-cost care and if they would increase primary care utilization with UPC.

A further consideration for UPC, health disparities, and costs, is whether or not UPC would cover the estimated 5,000 people in Vermont without US citizenship or immigration documents [30]. No studies were found on the cost savings or health outcomes of providing health insurance to this population.

It may be reasonable to expect a modest reduction in overall trend in health care spending from expanding the Vermont Blueprint for Health to include currently uninsured Vermonters. Studies from other states indicate success with similar interventions, but should be applied with caution given state-to-state differences. It is impossible to say if UPC would further promote these cost savings as decisions are yet to be made as to how the UPC program would be structured.

The exception was a Vermont study showing costs increasing over time in PCMHs despite decreased health care utilization rates. This study highlighted the influence of factors outside of

the control of primary care to influence costs including labor costs, medical innovations (including prescription drug costs), cultural norms, macroeconomic conditions, population health, contracting with commercial insurance, and government rate setting among other cost drivers [16].

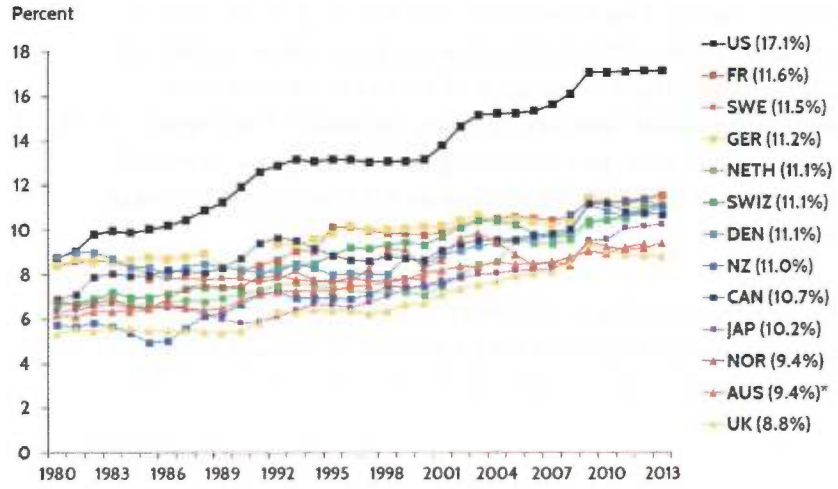
Overall, assuming that UPC is designed to increase access to health care for the uninsured, the studies attributable to increase access support cost savings for this population. In addition, expanding Blueprint for Health medical homes to the now uninsured could provide overall health care cost trend reductions as opposed to other types of delivery system interventions.

Key Finding 3: Many studies showed countries with a foundation in strong primary care systems had lower costs, greater health equity, and better population health than the US.

Summary of Findings

Despite spending significantly more than any other country on health care, the US ranks low compared to other wealthy countries when it comes to access to health care, health equity, and many leading health indicators[8] [31]. The US spends approximately 17.1% of GDP on health care compared among the second highest spenders, the Netherlands and Switzerland (Figure 3).

Figure 3: Health Care Spending as a Percentage of the GDP, 1980-2013 [32]



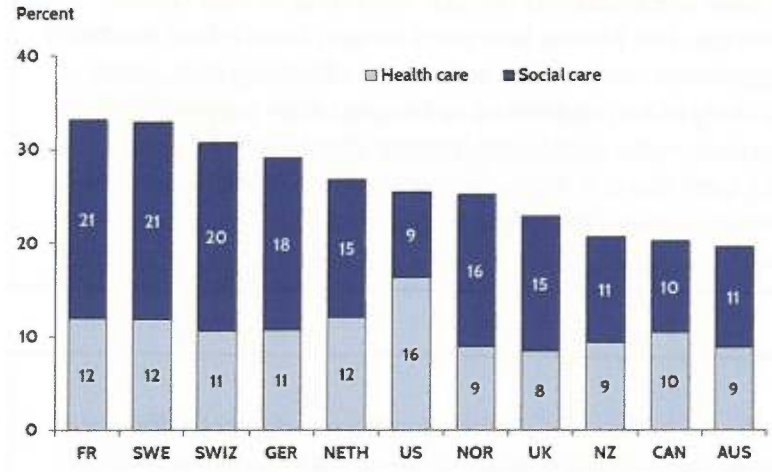
* 2012
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers
Source: OECD Health Data 2015

In many countries with universal health care, including Canada, Spain, and United Kingdom, strong universal primary care systems serve as a foundation for universal health care. These countries define primary care as an "orientation of systems" where primary care is a robust

[8] http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

form of health care delivery for a region, and also as a specialty within medicine [33]. These countries also spend more on social services than the US [31] (Figure 4).

Figure 4: Percentage of GDP spent on health care and social care by country [32]



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.

Reasons for how strong primary care systems can lead to lower health care spending:

- By reducing the number of services performed by specialists [33-36].
- By decreasing inpatient and outpatient hospital expenditures [6, 10, 11, 37, 38].
- By decreasing emergency department care, especially for ambulatory care sensitive conditions (ACSCs)[9] [9-11, 39].

Proposed explanations for why universal health care systems may lead to lower health care spending:

- By improving health equity and social cohesion [40].[10]
- By increasing earnings and tax revenues for healthier adults [11].
- By Improving modifiable risk behaviors that can lead to poor health outcomes [41, 42].

The following case studies are provided to give context to other countries systems.

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[10] The WHO emphasizes social cohesion as an attribute of universal health care, framing the issue as building equity when many communities are feeling the adverse effects of income inequality and globalization. The WHO supports the notion that UPC could help improve well-being and health by strengthening the foundation of health necessary to engage in civic life and by building the equity necessary to establish trust and social support within communities.

Case Study: United Kingdom

The National Health Service, the publicly funded universal health care system in the UK, is built on Primary Care Trusts (PCT's). PCT's are entities that integrate health care services similar to the aims of Accountable Care Organizations (ACOs). According to Rice (2010), "U.K. residents enjoy universal coverage, live almost two years longer, have infant mortality rates that are 25% lower, rarely experience cost-related barriers to obtaining care, have lower medical-error rates, are less likely to be readmitted to hospital after surgery, and, based on surveys of patients and primary-care physicians, ranked second out of seven selected countries in overall quality, with the U.S. finishing last—and all of this at less than half of the cost per capita" (p.1). PCT's control 75% of the National Health Service's Budget, establishing a link between resources devoted to primary care and lower overall costs [43].

Case Study: Canada

Canada and the United States are similar in size and culture, but have a distinct difference when it comes to health care: Canada has publicly funded universal health care system and the US does not. According to the National Bureau of Economic Research, Canada spent only 10.4% of its GDP on healthcare while the United States spent 16% in 2013. Canada's health care spending per capita at that time was $4,569, compared to $9,086 in the US [32]. Despite spending less, Canadians have a more regular primary care doctor, fewer unmet health needs, and a smaller range of health outcomes between the poor and the wealthy [44].

Canada has a lower primary care-specialist ratio than the US. According to Shi (2012), there are only 10% more physicians are specialists than primary care physicians in Canada, while the US has over 50% more physicians are specialists.

Case Study: Spain

Beginning in 1978, Spain moved from a privatized health care system to universal health care, relying heavily on primary care teams strategically focusing on prevention, health promotion, treatment, and community care. As a result, health outcomes improved. In 2010, Spain spent 8.5% of its GDP on health care, compared to 16% in the United States [45]. Despite spending almost half of what the US does, life expectancy is higher in Spain and infant mortality rates are lower than in the US. Even with a strong emphasis on primary care, Spain faces challenges to its health care system due to immigration, population growth, an aging population, and insufficient primary care workforce. Even though universal health care exists, approximately 15% of Spaniards purchase secondary insurance [46].

Considerations for Vermont

Countries with strong primary care systems as a foundation for their universal health care system and higher spending on social services achieve better health outcomes and lower costs than the US. Implementing UPC would shift Vermont's practices closer to those practices showing results over time in other countries, but there is no evidence to show that universal primary care *alone* can achieve cost savings without universal health care or greater spending on social services. Furthermore, applying studies capturing trends in health outcomes and costs in other countries to Vermont due to structural and cultural differences and should be approached with caution.

The literature shows that health disparities may be influenced by universal health care policy. In Vermont, adults of racial or ethnic minority groups are more likely to be uninsured and 45% of the uninsured are within 1-199% FPL [30]. Of the uninsured, there is an unequal distribution of the population uninsured by county. The two counties with the highest uninsured rates were Essex (at 10%) and Caledonia (at 6.6%). Chittenden County had the highest number of uninsured overall at 3,868 persons. UPC would eliminate the disparity of being insured based on socioeconomic status or race/ethnicity, but other health disparities would likely persist due to access issues (i.e. transportation) and other social determinants of health[11].

Key Finding 4: Many studies showed cost sharing can decrease healthcare utilization and disproportionately impact the poor.

Summary of Findings

Cost sharing has been used selectively since the 1980s as a way to reduce health care costs. The theory behind cost sharing is that if health care consumers shoulder some of the costs through copays, deductibles, coinsurance, or a combination of methods, then they will forgo unnecessary care in favor of utilizing higher value care [47].

The landmark RAND Health Insurance Experiment (see case study) found that copayments decreased health care utilization without influencing health outcomes for the average consumer. For people who were poor and/or sick, however, copays were found to lead to less health care utilization and worse health outcomes. These findings have been replicated by more recent studies [47-49]. Trivedi, et al. (2010) conducted a study from 2001-2006 study on 899,060 Medicare beneficiaries and found that a rise in copayment costs was associated with a decrease in outpatient care and an increase in inpatient care. According to the authors, "The effects of increases in copayments for ambulatory care were magnified among enrollees living in areas of lower income and education and among enrollees who had hypertension, diabetes, or a history of myocardial infarction" (p. 1). This shows that cost sharing may save money in the short run on outpatient costs, but costs will be higher in the long-term due to greater use of inpatient services.

[11] According the World Health Organization, social determinants of health are defined as, "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels." http://www.who.int/social_determinants/sdh_definition/en/

The 2015 literature review that incorporated five previous literature reviews built a more nuanced theory of cost sharing for people of low-incomes. Key findings from the review are summarized below:

1. Cost sharing was a disincentive for new treatments and reduced the utilization of treatments for chronic diseases.
2. Cost sharing caused low-income families to choose between health care services and "other household necessities."
3. Study participants lacked understanding of how costs vary in different treatment scenarios (limiting their ability to discern between costs of services).
4. Many study participants lacked the knowledge to make informed decisions on the best type of care for their long-term benefit [48].

These findings further highlight the vulnerability of low-income persons to cost sharing and also highlights the role health literacy plays in health care utilization. Powell, et al. (2015) defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (p. 16).

To further complicate the efficacy of cost sharing, a study by Nilay et al. (2011) found that the removal of cost sharing had no influence on primary care utilization in a study of an unspecified number of Mayo Clinic employees over a six-year period. However, specialty care decreased amongst Mayo Clinic employees with the addition of $25 copays [47].

Case Study: RAND Health Insurance Experiment

The RAND Health Insurance Experiment randomly assigned approximately 5,800 people across the US to health insurance plans with different cost sharing scenarios: no cost-sharing (free care), 25% co-insurance, 50% co-insurance, 95% co-insurance, and a $600/individual and $1800 per family deductible (in 2005 dollars) and followed them for the course of years. The results showed *a decrease in healthcare utilization without a change in health outcomes for the average consumer, with exceptions for two demographics: people with low-incomes and poor health.* Looking at the average consumer, cost-sharing was a win for cost savings as it decreased care utilization without impacting quality, even though necessary care was foregone in equal amounts as unnecessary care. Looking at low-income consumers and those in poor health, cost sharing presented a barrier to care that was associated with a larger decrease in effective and necessary care and poorer health outcomes, including the risk of premature death. The risk increased for those consumers who were both low-income and in poorer health. The results also showed a decline in preventative services like immunizations for children and pap smears. Although the RAND Health Insurance Experiment is considered a landmark study for its comprehensiveness and rigor around measuring cost sharing, a major limitation is that the study was conducted in the mid-seventies in a very different health care environment from today.

Considerations for Vermont

Currently, there is an outstanding policy question of whether there would be cost sharing in a UPC program. This section provides considerations that may be useful to policymakers in deciding this question.

The evidence points to cost sharing as being beneficial to cost reduction at little cost to the health care consumer, unless the consumer is of a low-income demographic group or has health issues. All of the studies included in this cost-sharing portion of the literature review stated that cost sharing is an understudied field, comprised mostly of short-term studies that may not show the full effect of a decrease in necessary care on a patient's health over time. This inherently limits the applicability of cost sharing studies in the context of UPC. It is clear that cost sharing will likely harm vulnerable groups in terms of decreased health care utilization and health outcomes, but to what extent and under what threshold is uncertain.

Limitations

This literature review has several limitations. First, there are methodological issues and limitations inherent in all studies included in this report. Biases, confounding factors, and other methodological issues were not critically analyzed beyond a preliminary "pass/fail" assessment for inclusion. Second, studies comparing data across countries should be interpreted with caution, as they rely on aggregate data that may obscure more particular trends and patterns within a country. The potential for confounding factors is higher in observational studies like these and in observational studies where a single intervention is measured within the context of a complex system. Third, there was an absence of qualitative data to understand the monetary and other costs for individuals and families to be without access to primary care through a microeconomic lens. And fourth, this literature review was comprehensive and inclusive of all relevant articles yielded by the search methods, but was not systematic in the way of a peer-reviewed published literature review.

Conclusion

No studies directly exploring the cost savings attributable to universal access to primary care were found in the literature.

Many studies did demonstrate elements of primary care that produced cost savings and improved health outcomes. Four of these studies demonstrated cost savings attributable to Vermont Blueprint for Health, a primary care intervention that contributed to primary care payment and delivery reform in Vermont since 2003.

Other studies from around the US further demonstrated the evidence of primary care interventions to reduce costs through continuity of care, access to care, utilization of care, alternative payment models, and electronic health records. Around the world, countries with higher investment in primary care and social service spending had better health outcomes and lower health care costs. Policymakers should consider whether and how this would apply to UPC.

In addition, cost sharing was found to decrease health care utilization without adverse impacts on people's health, with the exception for the poor and the sick. This information should be considered when defining a cost sharing approach for UPC.

Part 2. Primary Care Models Created in All-Payer Model

Act 172 requires the Secretary of Administration to analyze the primary care payment models created through the development of the All-Payer Model in order to enable legislators to estimate appropriate reimbursement amounts for health care providers delivering primary services.

At the end of October, Vermont came to agreement with the federal government on the Vermont All-Payer Accountable Care Organization Model Agreement, commonly referred to as the All-Payer Model. Within this agreement, 2017 is designed to be a planning year for payers, providers, and the Green Mountain Care Board to ensure readiness and prepare for implementation. Although a specific primary care model is not available at the time of this report, primary care models will be developed as a requirement of ACO certification under Act 113. Legislators may have the opportunity to review these models prior to ACO certification.

Preliminary work on developing a capitated payment to primary care was provided in the *Cost Estimates for Universal Primary Care* report, submitted on December 16, 2015: http://hcr.vermont.gov/sites/hcr/files/pdfs/Universal%20Primary%20Care%20Study%20Act%2054%20Sec%2016-19%20Dec%2016%202015%20FINAL.pdf.

In addition, the Green Mountain Care Board's Accountable Care Organization work group developed a straw model for a capitated payment to primary care, which should form the basis of next steps on developing a new payment model:[12] http://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/Primary-Care-Payment-Work-GroupReport.pdf.

[12] It is important to note that the ACO may develop and deploy multiple primary care payment models depending on the needs of their provider network, particularly the ability of practices to take on quality measurement and risk.

Part 3. Draft Implementation Timeline

Act 172 requires the Secretary of Administration to provide a potential implementation timeline for universal primary care, including the recommended timing for conducting cost analyses; developing financing options; projecting impacts on insurance markets, individuals, households, businesses, and others; and estimating one-time and ongoing administrative costs. The five-year detailed implementation timeline, provided as Appendix A, is structured around legislative sessions and provides a detailed roadmap for the implementation of the program. It includes both policy and operations development.

In order to implement universal primary care, the Legislature will need to provide guidance at two points in time: (1) immediately prior to starting the cost analyses to provide further details on eligibility, benefit design, invalidation of Health Savings Accounts, and provider reimbursements; and (2) selecting and passing a finance plan prior to the start of implementation.

More information about outstanding issues needing analysis was provided in the **Recommended Future Analysis** section of the *Cost Estimates for Universal Primary Care* report from December 2015: http://hcr.vermont.gov/sites/hcr/files/pdfs/Universal%20Primary%20Care%20Study%20Act%2054%20Sec%2016-19%20Dec%2016%202015%20FINAL.pdf. The study assumed that the Legislature would provide further details regarding eligibility, benefit design, invalidation of Health Savings Accounts[13], and provider reimbursements in Year 1.

Two fundamental choices for the Legislature are (a) whether to pass the financing plan in Year 2 or 3 and (b) whether to begin operations in Year 3 or Year 4. Figure 5 presents a broad overview of the two possible timelines.

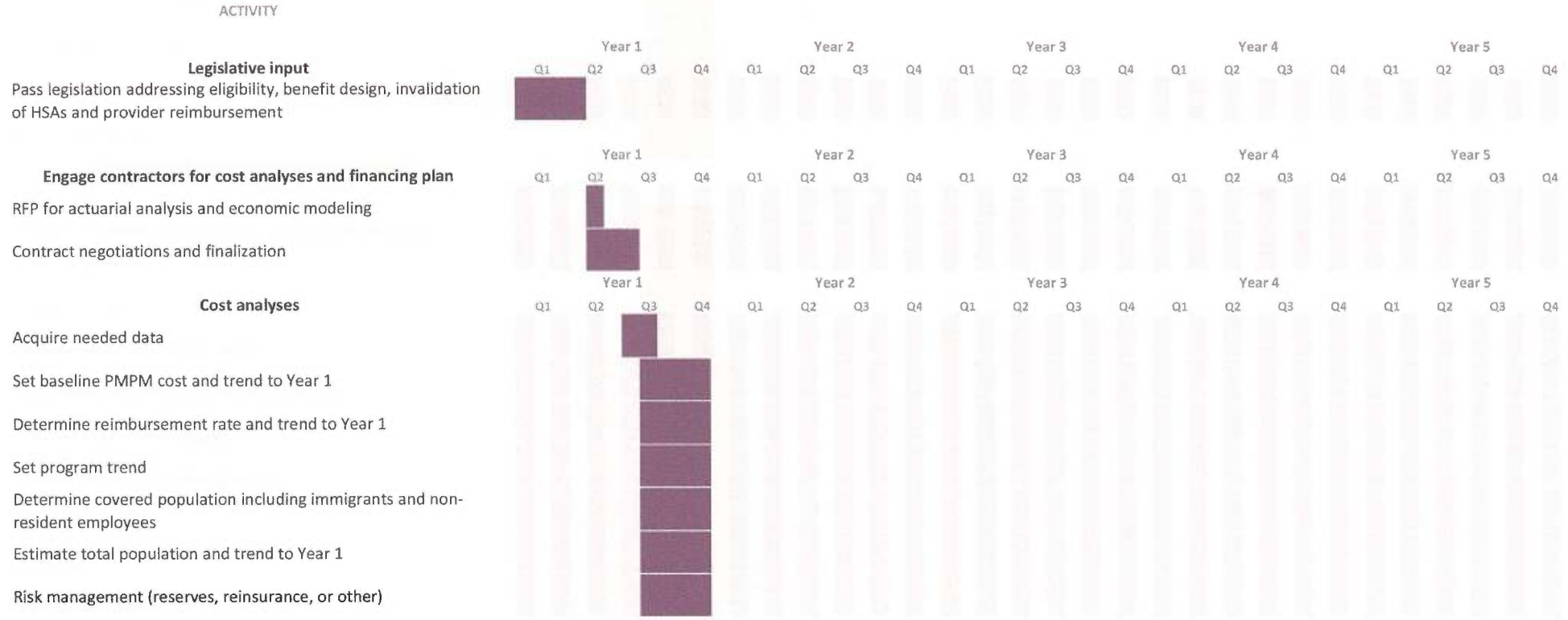
[13] Page 31 of the *Cost Estimates* report discusses the Health Savings Account issue: "It should be noted that coverage by UPC will make Vermonters ineligible for Health Savings Accounts (HSAs). In order to be eligible for an HSA, federal law requires that the individual have a high deductible health plan and prohibits coverage under any additional health plan...Without further action from Congress or Treasury, however, Vermont's UPC program would likely make Vermonters ineligible for an HSA."

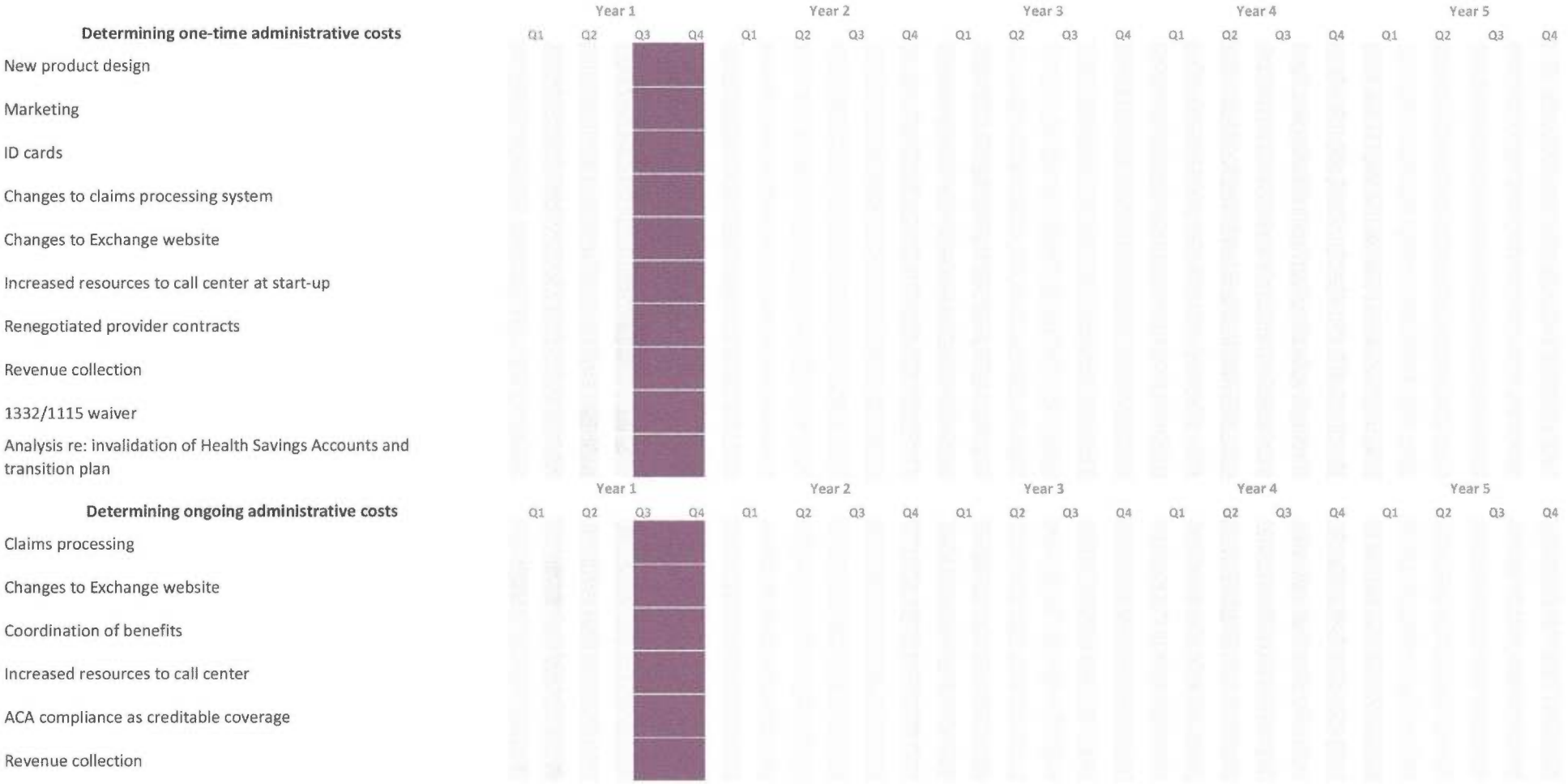
Figure 5: High-Level Timeline Options

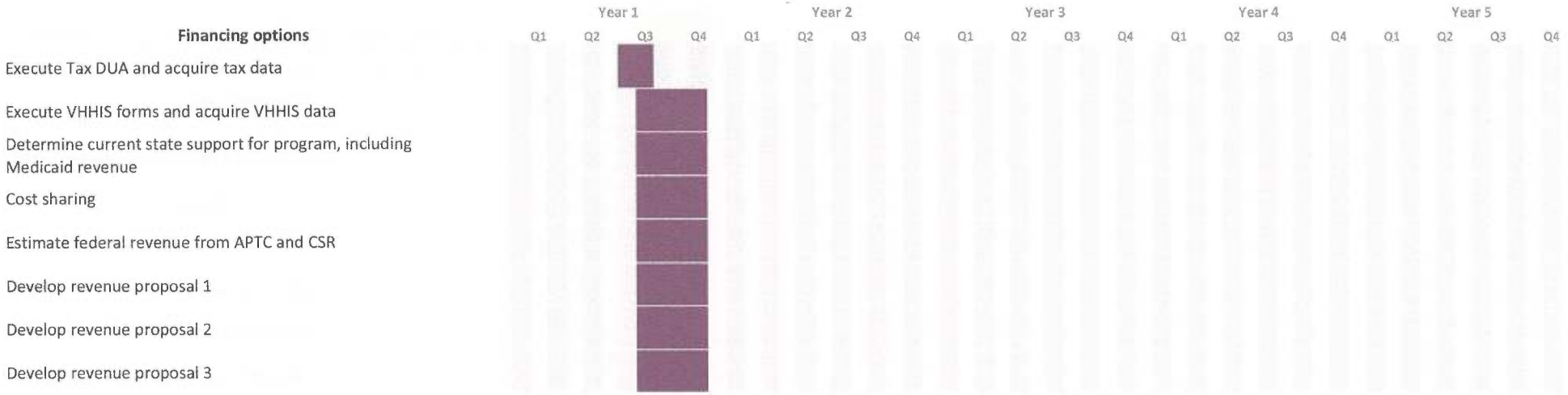
A key factor in making this timing decision will be whether the Legislature has its preferred level of information prior to passing a financing plan or whether additional study or consulting resources are needed. Another factor will be capacity of the legislature and a new administration to fully consider passage of this type of program in Year 1 or whether two years are needed. In addition, consideration should be given to allowing for sufficient time for implementation in order to ensure a smooth coverage transition of Vermont's population to this program. Since this program would shift the entire population, consideration should be given to a longer, phased-in approach, which argues for a longer implementation period.

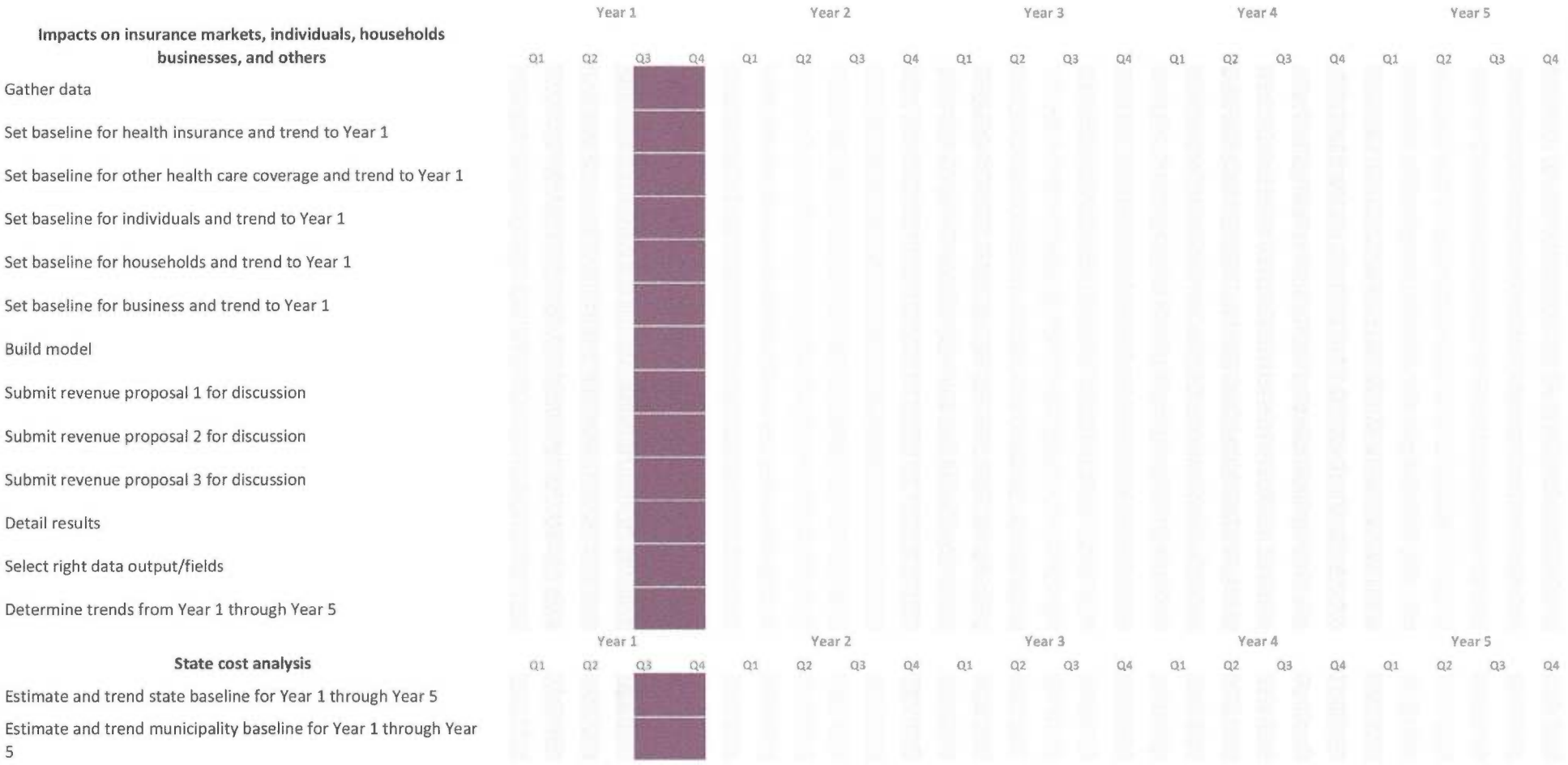
Appendix A: Detailed, Five-Year Implementation Timeline

Universal Primary Care Implementation Timeline




Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Determining one-time administrative costs
New product design
Marketing
ID cards
Changes to claims processing system
Changes to Exchange website
Increased resources to call center at start-up
Renegotiated provider contracts
Revenue collection
1332/1115 waiver
Analysis re: invalidation of Health Savings Accounts and transition plan
Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Determining ongoing administrative costs
Claims processing
Changes to Exchange website
Coordination of benefits
Increased resources to call center
ACA compliance as creditable coverage
Revenue collection


Financing options
Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Execute Tax DUA and acquire tax data
Execute VHHIS forms and acquire VHHIS data
Determine current state support for program, including Medicaid revenue
Cost sharing
Estimate federal revenue from APTC and CSR
Develop revenue proposal 1
Develop revenue proposal 2
Develop revenue proposal 3


Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Impacts on insurance markets, individuals, households businesses, and others
Gather data
Set baseline for health insurance and trend to Year 1
Set baseline for other health care coverage and trend to Year 1
Set baseline for individuals and trend to Year 1
Set baseline for households and trend to Year 1
Set baseline for business and trend to Year 1
Build model
Submit revenue proposal 1 for discussion
Submit revenue proposal 2 for discussion
Submit revenue proposal 3 for discussion
Detail results
Select right data output/fields
Determine trends from Year 1 through Year 5
Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
State cost analysis
Estimate and trend state baseline for Year 1 through Year 5
Estimate and trend municipality baseline for Year 1 through Year 5

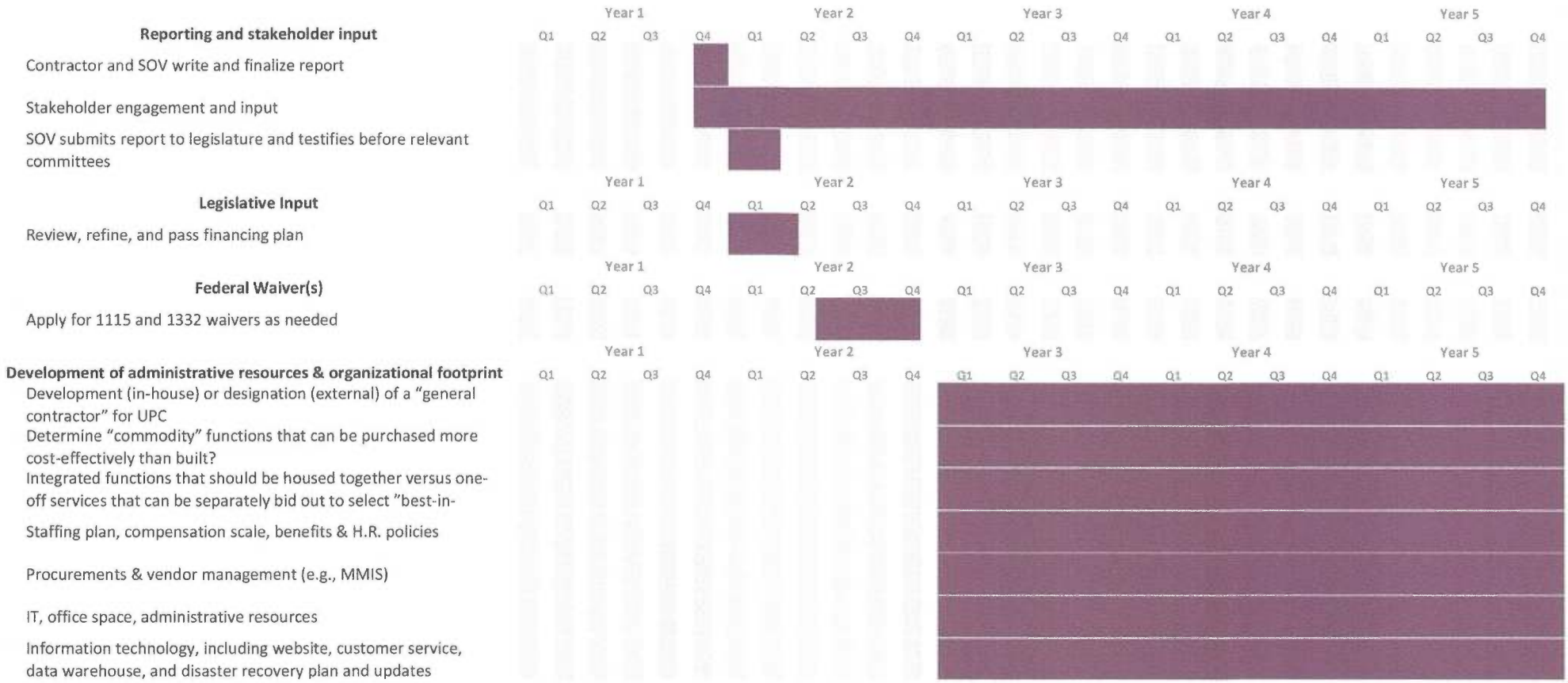
Estimate and trend schools baseline for Year 1 through Year 5

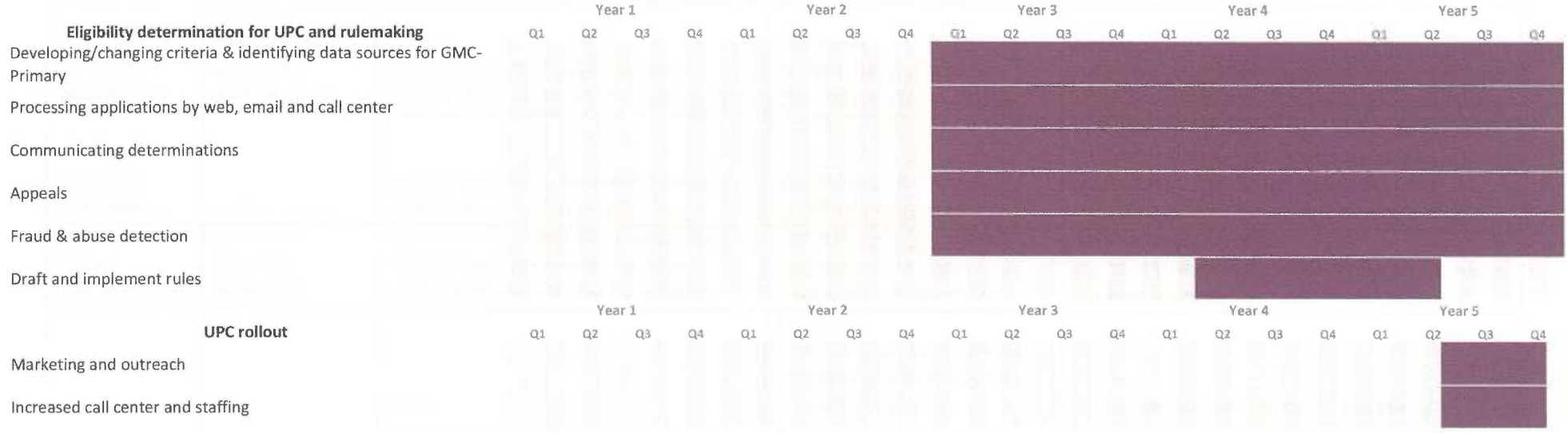
Develop and trend SOV employer spending baseline for Year 1 through Year 5

Tax revenue or deficit from wage pass back assumptions

Impact of new taxes and insurance market changes

Estimate impact on OPEB liability


Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Reporting and stakeholder input
Contractor and SOV write and finalize report
Stakeholder engagement and input
SOV submits report to legislature and testifies before relevant committees
Legislative Input
Review, refine, and pass financing plan
Federal Waiver(s)
Apply for 1115 and 1332 waivers as needed
Development of administrative resources & organizational footprint
Development (in-house) or designation (external) of a "general contractor" for UPC
Determine "commodity" functions that can be purchased more cost-effectively than built?
Integrated functions that should be housed together versus one-off services that can be separately bid out to select "best-in-
Staffing plan, compensation scale, benefits & H.R. policies
Procurements & vendor management (e.g., MMIS)
IT, office space, administrative resources
Information technology, including website, customer service, data warehouse, and disaster recovery plan and updates


Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Eligibility determination for UPC and rulemaking
Developing/changing criteria & identifying data sources for GMC-Primary
Processing applications by web, email and call center
Communicating determinations
Appeals
Fraud & abuse detection
Draft and implement rules
Year 1
Year 2
Year 3
Year 4
Year 5
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
UPC rollout
Marketing and outreach
Increased call center and staffing

Appendix B: Summary of Articles in Literature Review

Summary: Key Literature Review Findings

Author(s)	Journal	*Title*	Methodology	Findings
Bertakis & Azari (2011)	Journal of the American Board of Family Medicine	*Patient-centered care is associated with decreased health care utilization*	509 patients were randomly assigned care by family physicians or general internists and a patient center practice style was measured. Outcomes were measured over one year and analyzed using multivariate analysis.	Health care utilization has been shown to decrease with patient-centered care.
Bradley, et al. (2012)	Health Affairs	*Lessons for coverage expansion: a Virginia primary care program for the uninsured reduced utilization and cut costs*	Cross-sectional study measuring costs and care for previously uninsured, low-income adults at a community-based primary care program after receiving insurance	ER utilization and inpatient hospitalizations decreased for this population after gaining insurance, primary care use and outpatient care increased; overall costs decreased
Chaudry, et al. (2006)	Annals of Internal Medicine	*Systematic review: impact of health information technology on quality, efficiency, and costs of medical care*	Systematic review of the literature from 1995-2005 that included 257 articles	HIT was shown to improve quality and efficiency, however, there was limited financial data surrounding costs.
Chernew et al. (2009)	Health Affairs	*Would having more primary care doctors cut health spending growth?*	Cross sectional study of Medicare over 10 years	Higher PCP prevalence was associated with lower health care costs. Unlike previous studies, higher PCP prevalence was also associated with higher spending growth rates
de Jonge, et al. (2014)	Journal of the American Geriatrics Society	*Effects of home-based primary care on Medicare costs in high-risk elders*	Case control study of HBPC vs. non-HBPC Medicare recipients	HBPC recipients had 17% lower Medicare costs than non-HBPC recipients over a two-year time period
Ferrante et al. (2013)	Annals of Internal Medicine	*Primary care utilization and colorectal cancer incidence and mortality among Medicare beneficiaries: a population-based, case-control study*	Case control study comparing the incidence of CRC for Medicare recipients based on number of primary care visits	Higher rates of primary care utilization correlated to reduced rates of colorectal cancer in Medicare recipients

Friedberg, et al. (2015)	JAMA Internal Medicine	*Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care*	Cross-sectional analysis of medical claims for 17, 363 patients for PCMH and non-PCMHs from 2007-2012	PCMHs had better performance for diabetes care and breast cancer screening, fewer hospitalizations & ED visits, fewer ACSC visits to specialists, higher rates of ACSC visits to primary care
Jones & Doebbeling (2007)	Journal of Clinical Oncology	*Beyond the traditional prognostic indicators: the impact of primary care utilization on cancer survival*	Prospective cohort study using of 323 male veterans with lung cancer	The risk of death was lower for patients who had one, two, or three PC visits within 6 months of cancer diagnosis
Jones, et al. (2015)	Population Health Management	*Vermont's community-oriented all-payer medical home model reduces expenditures and utilization while delivering high-quality care*	Sequential, cross-sectional review of annual cost, utilization, and quality outcomes over 6 years	Patients who used a PCMH had reduced costs of $482 compared to patients of non-PCMH PC practices
Kern (2016)	Annals of Internal Medicine	*The patient-centered medical home and associations with health care quality and utilization: a 5-years cohort study*	Prospective cohort study of claims outcomes for 136,480 patients from 2008-2012	Quality and utilization patterns were similar across PCMHs and control groups, except in the final year of the study.
Kringos, D.S., et al. (2010)	BMC Health Serv Res	*The breadth of primary care: a systematic literature review of its core dimensions*	Systematic review of primary care literature between 2003-2008	Primary care is a multidimensional system with structures (governance, economic conditions, and PC workforce development) and processes that can greatly impact public health.
Lake, et al (2013)	Journal of Comparative Effectiveness Research	*Paying more wisely: effects of payment reforms on evidence-based case clinical decision-making*	literature review of several payment reform options	The authors recommended a recalibrated fee FFS schedule
Maeng, et al. (2012)	The American Journal of Managed Care	*Reducing long-term cost by transforming primary care: evidence from Geisinger's medical home model*	Analysis of claims data from 43 PCP sites that were converted into PCMHs from 2006-2010	Longer periods of time as a PCMH were associated with lower costs.
Purdy, et al. (2010)	Public Health	*Ambulatory care sensitive conditions: terminology and disease coding need to be more specific to aid policy makers and clinicians*	Literature review	36 ACSCs were identified in the UK's NHS, ACSCs are used to evaluate primary care efficacy
Reid, et al. (2010)	Health Affairs	*The Group Health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers*	Compared patient experience, provider burnout, quality of care, and costs for PCMH vs. controls over 24 months	PCMH patients had 29% fewer ED visits & 6% fewer hospitalizations than control group. Total savings were estimated at $10.30 per patient per month, 21 months into the pilot

Shen, et al (2004)	Medical Care	*The effects of payment method on clinical decision-making: physician responses to clinical scenarios.*	Survey of clinical scenarios and "bother scores" for 601 physicians throughout US	Different clinical decisions were made on discretionary care, but not life-saving care based on fee for service or capitated payments; physicians were more bothered by capitated payments.
Smith, et al. (2015)	Journal of the American Board of Family Medicine	*The effect of regular primary care utilization on long-term glycemic and blood pressure control in adults with diabetes*	Case control study analyzing medical records of 2,138 adults in a ten-year time span	Regular primary care utilization correlated to better blood pressure and glycemic control for adults with diabetes.
Steiner, et al. (2008)	Annals of Family Medicine	*Community Care of North Carolina: improving care through community health networks*	N/A	Higher primary care utilization rates correlated with a 23% lower than projected rate of ER utilization and a 3-to-1 cost savings overall
Thompson, et al. (2015)	Population Health Management	*Evaluating Health Care Delivery Reform Initiatives in the Face of 'Cost Disease'*	Vermont All-Payer Claims data was analyzed between 2007-2011 for PCMH's	A decrease in utilization did not always demonstrate a decrease in costs and many factors driving cost are outside the control of providers,
Wang, et al. (2003)	American Journal of Medicine	*A cost-benefit analysis of electronic medical records in primary care*	Data was collected from their institution to measure the cost savings of electronic medical records for primary care physicians over a 5-year period	The cost-benefit model estimated a savings of $86,400 per provider. Savings came from drug expenditures, decreased radiology utilization, decreased billing errors, and improvement in charge capture. Benefits decrease over time.

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Appendix C: Universal Primary Care Study Presentation

Universal Primary Care Study
Act 54 of 2015, Sections 16-19

Robin Lunge, Director of Health Care Reform
Marisa Melamed, Health Care Reform Policy and Planning Coordinator
Agency of Administration
January 21, 2016

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HEALTH CARE REFORM

Statutory Charge

- **Examine the cost of providing primary care to all Vermont residents starting January 1, 2017**
  - Provide cost estimates of primary care without universal primary care reform, i.e. **status quo**
  - Provide cost estimates of universal primary care, **with cost-sharing**
  - Provide cost estimates of universal primary care, with **no cost-sharing**

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What is Universal Primary Care?

- Definition of primary care
- Coverage Assumptions
- Payment Assumptions

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First Step – Define Primary Care

- Primary care definition in Act 54, Section 17 (statutory language found on resource slide #19)
- Translate statutory language into an operational definition
  - Current Procedural Terminology (CPT) codes
  - Provider types
- Consulted with:
  - Wakely Consulting, actuarial analysis
  - Policy Integrity, health care data analyst
  - GMCB primary care payment work group, providers, Blueprint, Bi-State, carriers, Dr. Richter

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Definition of Primary Care (CPT categories)

Universal Primary Care Service Categories

- New or Established Patient Office or Other Outpatient Visit
- Initial New or Established Patient Preventive Medicine Evaluation
- Other Preventive Services
- Patient Office Consultation
- Administration of Vaccine
- Prolonged Patient Service or Office or Other Outpatient Service
- Prolonged Physician Service
- Initial or Subsequent Nursing Facility Visit
- Other Nursing Facility
- New or Established Patient Home Visit
- New or Established Patient Assited Living Visit
- Other Home or Assisted Living Facility
- Alcohol, Smoking , or Substance Abuse Screening or Counseling
- All-Inclusive Clinic Visit (FQHCs/RHCs)
- Behavioral Health

Universal Primary Care Specialty Types

- Family Medicine MD
- Registered Nurse
- Internal Medicine MD
- Pediatrician MD
- Physician Assistant/Nurse Practitioner
- Psychiatrist
- OB/GYN MD
- Naturopath
- Geriatric
- Registered Nurse - Psychiatric/Mental Health
- Social Worker
- Psychologist
- Counselor
- Counselor - Addiction

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Definition of Primary Care

Examples of universal primary care services:

- Office visits
- Annual wellness exams
- Gynecological exams and breast exams
- FQHC all-inclusive clinic visits
- Administration of vaccines
- Alcohol/smoking/substance abuse screening and counseling
- Psychotherapy
- Visits from a primary care doctor to a nursing facility, assisted living facility, or home visits
- Blueprint payments to medical homes

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Coverage Assumptions: Who is covered?

- All Vermont residents would be covered by universal primary care, except TRICARE due to federal restrictions

- Medicare recipients would have universal primary care as secondary coverage for primary care services

- Legislative changes, a 1332 waiver, and other waiver alignment are required to reduce duplication of primary care coverage for other populations

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Cost Estimates

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How much $ will need to be publicly financed?

	Costs (2017)	UPC with Cost-Sharing	UPC with No Cost-Sharing
A	Medical Claims (netting out Medicaid $)	$113 million	$175 million
B	Administrative Cost Estimate (7%-15%)	$8-$26 million	$12-$35 million
	TOTAL BASE COST (Claims + Admin)	**$121-$139 million**	**$187-$210 million**
C	Provider Reimbursement Increases (modeled 10%-50% increases as possible options)	$25-$135 million additional	
D	Other costs	Identified by AOA and JFO for further study if moving forward	

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How much $ will need to be publicly financed?

- **Decision points:**
  1. Plan design
  2. Plan administration
  3. Finance plan
  4. Provider reimbursement increases

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How much $ will need to be publicly financed?

- **Decision points:**

1. Plan design
2. Plan administration

→ plan design and plan administration decisions will enable a more concrete administrative cost estimate

3. Finance plan
4. Provider reimbursement increases

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Decision Point: Plan Design

- **Cost-sharing or no cost-sharing?**
  - How much?
  - What kind?

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Decision Point: Plan Administration

- **Legal and Waiver Analysis**
  - 1332 waiver and alignment with current waivers
  - ERISA analysis
- **Operational Plan**
  - Transitional and start-up costs
  - Program administration, including coordination of benefits
  - Capitated rate setting and provider payment

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Decision Point: Public Financing

- **Public Financing Plan**
  - Finalize other costs
  - Determine trend
  - Determine taxes and/or fees
- **Economic Analysis of Financing Plan**
  - Micro-simulation and macroeconomic modeling

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Decision Point: Provider reimbursement increases

Provider Reimbursement Increases at 10%, 25%, and 50% above Status Quo

Provider Reimbursement Increases	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
10 % increase	$25,164,000	$24,838,000	$26,941,000
25% increase	$62,709,000	$62,097,000	$67,353,000
50% increase	$125,285,000	$124,193,000	$134,705,000

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Market Impact

- Vet impact of universal primary care on other insurance, benefit plans, and premiums
- Universal primary care will make Vermonters ineligible for HSAs under federal law

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Questions?

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Appendix: Resource Slides

- Act 54 Statutory Definition of Primary Care
- Coverage Assumptions
- 2017 Estimated Total Claim Cost of the Program
- Summary of PMPM Rates
- JFO Independent Review 1/6/16

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Statutory Definition of Primary Care

Act 54, Section 17:

As used in Secs. 16 through 19 of this act, "primary care" means health services provided by health care professionals who are specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and includes pediatrics, internal and family medicine, gynecology, primary mental health services, and other health services commonly provided at federally qualified health centers. Primary care does not include dental services.

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Coverage Assumptions

Coverage Type	Primary Coverage	Secondary Coverage	Considerations
Medicare	Medicare	Universal Primary Care, then Medicare supplemental insurance	Medicare benefits would remain the same. Medicare Supplemental Insurance would remain available.
Military/ TRICARE	Military/ TRICARE	None while on TRICARE	UPC would be available as soon as the individual drops or is no longer eligible for TRICARE coverage. Individuals who are eligible for enhanced benefits from Medicaid would maintain those benefits.
No coverage – uninsured	Universal Primary Care	None	Some uninsured residents may be eligible for Medicaid.
Medicaid/Dr Dynasaur	Universal Primary Care	Medicaid/Dr Dynasaur covers other health services	Alignment with current Medicaid waiver required.
Vermont Health Connect (individuals)	Universal Primary Care	QHP covers other health services	ACA Section 1332 waiver required to carve out and replace primary care services in these plans with UPC.
Employer Sponsored Insurance (ESI, commercial)	Universal Primary Care	ESI plan covers other health services	An ACA Section 1332 waiver is required to replace primary care services in these plans. Large employer coverage through UPC requires a state mandate that these benefits be carved out of plans.
Employer Sponsored Insurance (ESI, self-insured)	Universal Primary Care	ESI plan covers other health services	Employers could choose to carve out primary care from their plans. Members may have duplicative coverage. Requires coordination of benefits with UPC.
Public employees	Universal Primary Care	Public employee plan covers other health services and depends on bargaining agreement	For the purposes of this study we made the assumption to provide primary coverage to all public employees because it was most consistent with the intent of universal coverage.
Retirees	Universal Primary Care (unless on Medicare)	Retiree plan covers other health services	

2017 Estimated Total Claim Cost of the Program

			2017 Estimated Total Claim Cost of Program		
Market	Estimated Members	Universal Primary Care Coverage	Status Quo	Universal Primary Care with Cost Sharing	Universal Primary Care without Cost Sharing
Commercial	296,400	Primary	$103,944,000	$102,464,000	$150,040,000
Military	14,400	Excluded	$0	$0	$0
Federal	14,400	Primary	$4,905,000	$4,905,000	$6,215,000
Medicaid	150,500	Primary	$107,371,000	$107,371,000	$107,371,000
Medicare	140,800	Secondary	$0	$0	$11,382,000
Uninsured	13,100	Primary	$5,527,000	$5,496,000	$6,921,000
Total	**629,600**		**$221,747,000**	**$220,236,000**	**$281,929,000**
Compared to Status Quo				**($1,511,000)**	**$60,182,000**

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Summary of PMPM Rates (claims only) for UPC in 2017, With and Without Cost-Sharing

PMPM	Status Quo	UPC With Cost-Sharing	UPC Without Cost-Sharing
Paid by Plan	$35.14	$34.94	$44.01
Paid by Member	$5.30	$5.24	$0.00
Total Paid PMPM	$40.44	$40.19	$44.01
% Covered by the Payer, on average	87%	87%	100%

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JFO Independent Review 1/6/16

1. The report needs more clarity regarding additional amounts to be publicly financed and potential savings to the private sector.
2. Additional administrative costs would arise from a new system of primary care.
3. As was the case with the State's efforts on single-payer health care and recent experience with Vermont Health Connect, transition costs and issues will be critical.
4. The base case should reflect the updated Medicaid population number.
5. Future health cost trends could mean substantially higher costs in future years.
6. More thought is needed concerning integration with the health care reform initiatives such as the all-payer model.

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VERMONT

Vermont Tobacco Evaluation and Review Board
280 State Drive, Waterbury, VT, 05676
802.398.5373 erin.hurley@vermont.gov
www.humanservices.vermont.gov/tobacco

MEMORANDUM

TO: The Honorable Governor Peter Shumlin
Senate Appropriations Committee
House Appropriations Committee
Joint Fiscal Committee

FROM: Amy Brewer, Chair, Vermont Tobacco Evaluation and Review Board

COPY: Theresa Utton-Jerman, Staff Associate, Joint Fiscal Committee

SUBJECT: Tobacco Prevention, Cessation and Control Program FY 18 budget recommendations from VT Tobacco, Evaluation & Review Board [18 V.S.A. Sec. 9505 (9)] [Agency of Human Services]

DATE: November 30, 2016

(Section 271 of Act 152 (2000), 18 V.S.A. chapter 225, 9505(9))

In 2016, the Vermont Tobacco Evaluation & Review Board reviewed and revised its Tobacco Control State Plan outlining the evidence-based interventions required of the program to succeed in reducing health care costs, of which **$348 million yearly** are related to Vermonter's tobacco use.

Currently:

- 35% of our low income adult residents are smokers;
- 17% of all adults smoke cigarettes, a level that has remained unchanged since 2012;
- **25% of all Vermont High School students** have used some sort of tobacco product (cigarette, smokeless, cigar or electronic or vaping product) in the *past 30 days.* This figure is as high as 33% in some supervisory union regions; and
- High School cigarette use is down significantly to 11%.

Although *smoking* rates are decreased for our youth, The Tobacco Control Program is alarmed that a quarter of students are using *some* type of tobacco product. Furthermore, for the last four years we have made no progress on the 17-18% adult smoking rate, which needs to be significantly lower to adequately protect and support the health of Vermont's citizens and decrease health care costs.

Tobacco control initiatives have a documented **return on investment.** Massachusetts achieved a 2:1 return on investment in three years (reducing health care costs among Medicaid recipients.) California documented a 50:1 return on investment over 10 years (reducing health care costs).

In fact, in Vermont, since 2001, we have realized a 2:1 return on investment. In comparison to the $73 million appropriated to the Tobacco Control Program since 2001, there has been an estimated **$1.43 billion savings** in overall smoking-related healthcare costs between 2001-2014. That figure *includes* $586 million in Medicaid costs. Estimates are that if we reduced adult tobacco use from its current rate of 18% to 12% by 2020, **we would save $229 million between now and 2020**.

Maintaining a holding pattern of level funding year-after-year erodes programs and infrastructure. Additionally, limiting evaluation of the Tobacco Control Program will *not* enable Vermont to achieve its goals. The VT Tobacco Evaluation and Review Board will release its Annual Report this January. In that report you will find details about needed programs and recommended funding levels necessary to maximize Vermont's investments and achieve health care savings and healthier Vermonters. In order to advance the goals, set forth by the Legislature, to reduce tobacco use, reduce health care costs and to improve the health of our residents**, the Tobacco Control Program should be funded at a level high enough to achieve the maximum return on investment possible.** Tobacco Control State Plan: http://humanservices.vermont.gov/boards-committees/tobacco-board/documents-and-resources/vermont-tobacco-control-workplan/view.

SAVE MONEY. SAVE LIVES.

HELP VERMONT QUIT FOR GOOD

$73 million has been appropriated to the Tobacco Control Program since 2001

...

Resulting in an estimated $1.43 billion savings in overall smoking-related healthcare costs (including $586 million in Medicaid costs)

That's a return on investment of **2:1**

Over10 years in California= **50:1**

Over 3 years in Massachusetts= **2:1**

If we reduced adult tobacco use from its current rate of 18% to 12% by 2020...

Vermont would save $229 million dollars!

The toll of annual smoking attributable deaths in Vermont is...

an average of 1,000 per year!

MAKE THE SMART INVESTMENT

In order to advance the goals set forth by the Legislature to:

* reduce tobacco use
* reduce health care costs
* improve the health of our residents...

the Tobacco Control Program must be funded at a level high enough to achieve the maximum return on investment possible.

Maintaining a holding pattern of level funding year after year erodes programs and infrastructure. Additionally, limiting evaluation of the Tobacco Control Program will not enable Vermont to achieve its goals. .

VERMONT

Vermont Tobacco Evaluation and Review Board
280 State Drive, Waterbury, VT, 05676
802.398.5373 erin.hurley@vermont.gov
www.humanservices.vermont.gov/tobacco

MEMORANDUM

TO:	The Honorable Governor Peter Shumlin Senate Appropriations Committee House Appropriations Committee Joint Fiscal Committee
FROM:	Amy Brewer, Chair, Vermont Tobacco Evaluation and Review Board
COPY:	Theresa Utton-Jerman, Staff Associate, Joint Fiscal Committee
SUBJECT:	Sustainability of Tobacco Programs [H.172. Sec. E.300.4]
DATE:	December 7, 2016

Sustaining Funding for Vermont's Comprehensive Tobacco Control Program: An Urgent Need
Per H.172. Sec. E.300.4, the Vermont State Legislature recognized the urgent need to sustain the state's comprehensive tobacco control program in the always-challenging fiscal climate. This urgency is created by the following factors:

- In April 2017, Vermont will receive the last of the ten-year Strategic Contribution Fund payments of approximately $10-12 million annually, reducing the annual Master Settlement Agreement payments from approximately $34 million to $23 million.
- The high rate of smoking among those enrolled in Medicaid accounts for 41% of all smoking-related health care costs in Vermont.[1]
- 29% of Vermonters at or below the federal poverty level are smokers.
- Funding for Vermont's Tobacco Control Program has relied on annual appropriations from the Master Settlement Agreement (MSA). In FY17, this appropriation was approximately 10% of the MSA compared to the nearly 82% directed to Medicaid. In addition, 0% of the annual tobacco product tax revenue (projected to raise $77 million in FY17) is appropriated to the comprehensive tobacco control program.

Sustaining Funding for the Comprehensive Tobacco Control Program: A Return on Investment

- State Tobacco Control Programs have documented **return on investments** (ROI) of between **2:1** (cardiovascular hospital admissions among Medicaid population in Massachusetts over a 3 year period) and **50:1** (health care costs in California over a 10 year period).
- Vermont has appropriated nearly $73 million to the Tobacco Control Program between 2001 & 2014 and there has been an estimated savings of $1.43 billion in overall smoking-related healthcare costs, including $586 million in Medicaid costs. Additional decreases in tobacco use will result in additional health care savings[2].

Historically, the Vermont Tobacco Control Program is receiving its lowest amount of funding since its inception in 2001. Despite youth cigarette use declining to 11%, youth regular tobacco use rates (smoking, smokeless, electronic-cigarettes/vaping devices) is at an alarming 25%. Vermont adult use rates have remained flat in the past 5 years, as program funding declines and effective initiatives, such as continual cessation media campaigns and tobacco price increases through significant tobacco tax increases were not achieved.

Per H.172. Sec. E.300.4, the Vermont Tobacco Evaluation & Review Board (VTERB) met with designees of the Vermont Secretary of the Administration, Vermont Secretary of Human Services and participating stakeholders to begin discussions to develop an action plan for tobacco program funding at a level necessary to maintain the gains made in preventing and reducing tobacco use in Vermont.

Since the published evidence overwhelmingly demonstrates a minimum of a 2:1 return on investment over time in health care costs savings, finding a method to sustain a strong, comprehensive tobacco control program was a priority among the participants. **It was agreed that investment in tobacco control would both save Vermont money and improve the health of Vermonters, especially low income Vermonters.**

Several sustainable funding options were identified which could be used collectively *in addition to* annual Master Settlement Agreement funding allocations to sustain the program. These options included:

1. **Dedicating a percentage of tobacco product excise taxes to the Tobacco Control Program,**
2. **Increasing excise taxes on tobacco products which increases cessation and reduces youth use, and**
3. **Appropriating monies the state receives that were withheld from the tobacco industry.**

The VTERB is committed to working through a process in which we identify expected outcomes that, as a result of sustained funding, will contribute to decreased costs for Vermont and its residents.

Notes:

1. RTI International's "Independent Evaluation of the VT Tobacco Control Program: 2015 Annual Report – a Historical Look at Progress Achieved, Successes, and Lessons Learned and RTI Recommendations for Tobacco Control in Vermont for the Years 2015-2020," pg. 2-5)
2. RTI International's "Independent Evaluation of the VT Tobacco Control Program: 2015 Annual Report – a Historical Look at Progress Achieved, Successes, and Lessons Learned and RTI Recommendations for Tobacco Control in Vermont for the Years 2015-2020," pg. 2-5 & 2-6)

VERMONT

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December 6, 2016

State of Vermont
Legislative Joint Fiscal Committee
One Baldwin Street
Montpelier, VT 05633-5701

To: The Legislative Joint Fiscal Committee

Enclosed is the Annual Report of costs and expenditures for proceedings of the Federal Energy Regulatory Commission [*30 V. S. A. § 20 (b)(9)*] covering the period from July 1, 2016 through September 30, 2016.

Respectfully Submitted,
Vermont Department of Public Service

Christopher Recchia
Commissioner

Enclosure

Public Service Department Expenditures
Related to Proceedings
At the
Federal Energy Regulatory Commission
For the period
July 1, 2016 – June 30, 2017

General Description of Activity

The Department takes action at the Federal Energy Regulatory Committee (FERC) to protect the interest of Vermont ratepayers in many different proceedings. For example, the Department has been active at FERC in ensuring fairness in cost allocations for utility projects and in ensuring Vermont's interests are represented in New England transmission projects. The issues vary from quarter to quarter but it is crucial to Vermont consumers that the Public Service Department intervenes at FERC when necessary to ensure that the costs flowing back to Vermont ratepayers as a result of FERC activity and proceedings are true, accurate, just and reasonable. The Department has contracted Synapse Energy Economics, Inc to monitor FERC activities, and certain in-house expenses are also attributed to FERC activities.

Expenditures

For FERC related activity affecting Vermont[1]		
	Q1 FY2017 $ 9,156.16	
	Q2 FY2017 $	
	Q3 FY2017 $	
	Q4 FY2017 $	
		$9,156.16
Indirect Expenditures[2]		**$0**
Total Expenditures[3] for the Year FY2016		**$9,156.16**

[1] In accordance with Title 30, § 20 (b) (9) the department of public service provides the following quarterly report for expenditures related to FERC proceedings affecting the State and Vermont Utilities for the period July 1, 2015 through June 30, 2016.
[2] Indirect expenditures include telephone, postage and coping expense.
[3] Expenditures include amounts actually paid for the quarter.

Report to
The Vermont Legislature

Substance Abuse Treatment Services
Objectives and Performance Measures Progress:
Second Annual Report

In Accordance with Act 179 (2014) Sec. E.306.2 (a)(2)

Submitted to:	**Joint Fiscal Committee** **House and Senate Committees on Appropriations** **House Committee on Human Services** **Senate Committee on Health and Welfare**
Submitted by:	**Barbara Cimaglio** **Deputy Commissioner**
Prepared by:	**Division of Alcohol and Drug Abuse Programs**
Report date:	**January 15, 2017**

VERMONT
AGENCY OF HUMAN SERVICES
Department of Health

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Substance Abuse Treatment Services Objectives and Performance Measures Progress: Third Annual Report
Due on or Before January 2017

Executive Summary

The initial Substance Abuse Treatment Services Objective and Performance Measures legislative report, required by Act 179 (2014), Sec. E.306.2 (a)(2), was submitted on September 11, 2014 by the Vermont Chief of Healthcare Reform, the Secretary of Human Services, the Commissioner of Health and the Commissioner of Vermont Health Access. The report outlined the program objective (this could also be referred to as a goal or a population outcome) of preventing and eliminating the problems caused by alcohol and drug misuse. In addition, the report outlined five (5) performance measures by which to assess Vermont's progress over time. This year's results of these measures indicate that Vermont is making progress toward its program objective. It is important to note that these performance measures are long-term targets. Once the targets have been achieved and sustained over time, new targets or alternate measures will be considered in order to continuously improve the progress toward meeting the program objective. These five (5) performance measures have also been applied in other areas such as grant performance measures, Vermont Department of Health Performance Dashboard measures, and Programmatic Performance Measure Budgeting for the Agency of Administration.

Performance Measures

1. *Are students who may have a substance abuse problem being referred to community resources?* The percent of students screening positive for possible substance use disorders who are referred for assessment has trended upward over time with the most recent reporting period at the target of 90%.
2. *Are youth and adults who need help starting treatment?* Treatment initiation has been trending upward for three (3) years and there has been an 80% increase in the number of people initiating treatment between 2009 and 2015 due in part to the increased number of individuals diagnosed with a substance use disorder.
3. *Are youth and adults who start treatment sticking with it?* The percent of Medicaid recipients with 2 or more substance abuse services within thirty (30) days of beginning treatment has been trending downward for three (3) years. However, this is due in part to the increased number of people with a substance use diagnoses. There has been a 59% increase in the number of individuals engaged in treatment between 2009 and 2015.

4. *Are youth and adults leaving treatment with more support than when they started?* The number of individuals exiting treatment who have either maintained four or more support services per week or have increased the number of support services between treatment entry and exit has leveled off over the past five (5) quarters after a downward trend between 2011 and 2013.
5. *Are adults seeking help for opioid addiction receiving treatment?* The number of individuals ages 18-64 receiving medication assisted treatment has continued on an upward trend for twelve (12) quarters. This will continue to increase with the addition of the Franklin/Grand Isle hub in early 2017.

The most recent information including a narrative summary identifying the partners involved, strategies used to meet the goals, and an action plan to address the measure is available on the Vermont Department of Health Performance Dashboard:
http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

Legislative Charge:

Act 179 (2014)
Sec. E.306.2(a)(2) SUBSTANCE ABUSE TREATMENT SERVICES
(a) Program Objectives And Performance Measures:

(1) On or before September 15, 2014, the Chief of Health Care Reform, the Secretary of Human Services, and the Commissioners of Health and of Vermont Health Access in consultation with the Chief Performance Officer shall submit to the Joint Fiscal Committee, the House and Senate Committees on Appropriations, the House Committee on Human Services, and to the Senate Committee on Health and Welfare the program objectives for the State's substance abuse treatment services and three performance measures to measure success in reaching those program objectives.

(2) Thereafter, annually, on or before January 15, the Chief, Secretary, and Commissioners shall report to those committees on the service delivery system's success in reaching the program objectives using the performance measure data collected for those services.

Substance Abuse Treatment Services Objectives and Performance Measures Progress: Third Annual Report
Due On or Before January 2017

Introduction:

On September 11, 2014, Vermont's Chief of Healthcare Reform, the Secretary of Human Services, the Commissioner of Health and the Commissioner of the Department of Vermont Health Access submitted a legislative report titled "Substance Abuse Treatment Services Objective and Performance Measures."[1] This report outlined the State's objective[2] in supporting programs to prevent and eliminate problems caused by alcohol and drug misuse. The following five measures were selected to assess consistently how much Vermont is doing, how well Vermont is doing, and whether Vermont is making a difference:

1. Are students who may have a substance abuse problem being **referred** to community resources?
2. Are youth and adults who need help **starting** treatment?
3. Are youth and adults who start treatment **sticking with** it?
4. Are youth and adults leaving treatment with **more support** than when they started?
5. Are adults seeking help for opioid addiction **receiving treatment**?

This is the third annual report of the service delivery system's ability to reach the program objective using the performance measure data. Progress toward the objective and performance measures are reported on the Vermont Department of Health Performance Dashboard.[3] There, progress towards the goals is shown on a continuous basis with many measures updated quarterly. The most recent measures can be reviewed at: http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx.

Progress: Vermont has experienced mixed progress achieving measured targets used to assess success in meeting the objective of preventing and eliminating the problems caused by alcohol and drug misuse. It's important to note that these are long-term targets resulting in the need to track the data over an extended period of time to assess success. Once the targets have been achieved and sustained over time, new targets or alternative measures will be considered in order to continuously improve progress toward meeting the program objective. For example, the target for access to medication assisted treatment was updated in 2015 because the target had been

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[1] http://legislature.vermont.gov/assets/Documents/Reports/302293.PDF

2 The term *objective*, as used in this report and in Act 179, is often referred to as a *goal*. Similarly, in Vermont state government, the term *population outcome* would be used to describe what Act 179 refers to as an *objective*. The term *population outcome* is used as part of Vermont's Results-Based Accountability framework as required by Act 186 of 2014.

[3] http://healthvermont.gov/hv2020/dashboard/alcohol_drug.aspx

achieved. This target is anticipated to change again in 2017 in response to the opening of a new opioid treatment hub in the Franklin/Grand Isle region.

Also, these measures are continuously being refined. For example, the treatment initiation measure was modified in October 2014 to account for Vermont's innovative funding mechanism for hubs, a monthly case rate, which had been excluded in the previous calculation method.

In addition, in 2015 the treatment engagement measure was expanded from a measure specific to the Vermont Department of Health's Division of Alcohol and Drug Abuse Program's Preferred Provider network to a measure that reflects all Vermont Medicaid recipients. This change better reflects statewide service delivery, but will require significant coordinated cross-departmental efforts to reach the goal.

The following presents the Performance Measures, followed by a discussion of each. The report concludes with a discussion of the direction state efforts will take to improve progress toward the achievement of identified targets.

PERFORMANCE MEASURE 1: School Screenings: Are we referring students who may have a substance use problem to community resources?

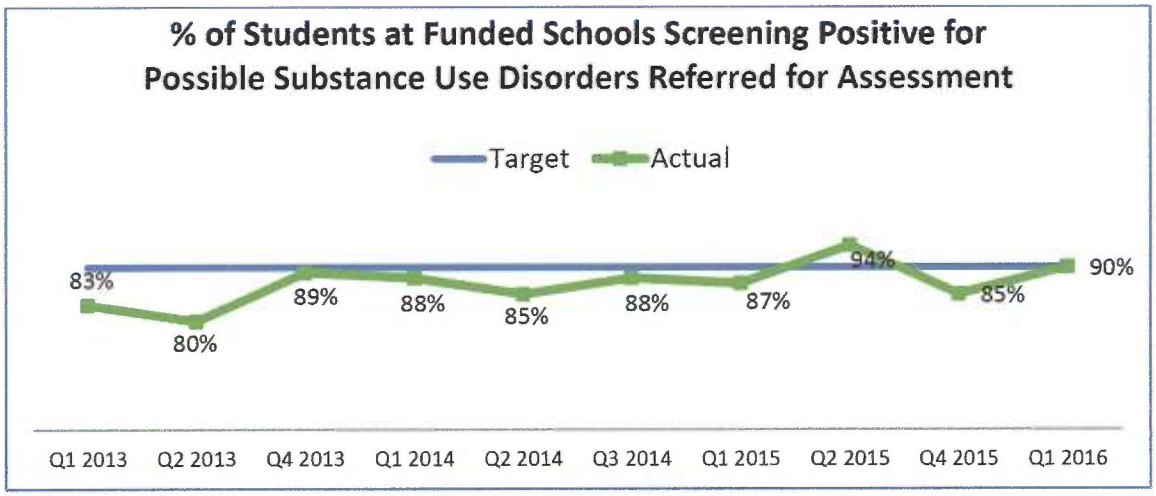
The Centers for Disease Control and Prevention (CDC) has developed an evidence-based model for coordinated school health. Following this model, recipients of state-funded School-Based Substance Abuse Services (SBSAS) grants support a comprehensive substance use prevention effort. Supported activities include:

- Classroom curricula
- Advising and training of youth empowerment groups
- Family outreach and community involvement
- Staff training
- Delivery of educational support groups
- Screening and early identification
- Providing screening and appropriate referral in schools

Early identification of substance use issues has been shown to improve treatment and recovery efficacy and significantly enhance overall health outcomes. Evidence-based screening and referral services for substance use and mental health are essential components of SBSAS. While in most cases referral is appropriate, not everyone who screens positive should be referred for additional services, which is why the target for this performance measure is below 100%.

Percent of supervisory unions with state-funded SBSAS and state funding totals:

Years	Percent of all SUs funded	Total funding amount
2013-2014	35%	$703,237
2014-2015	35%	$947,302
2015-2016	34%	$769,848

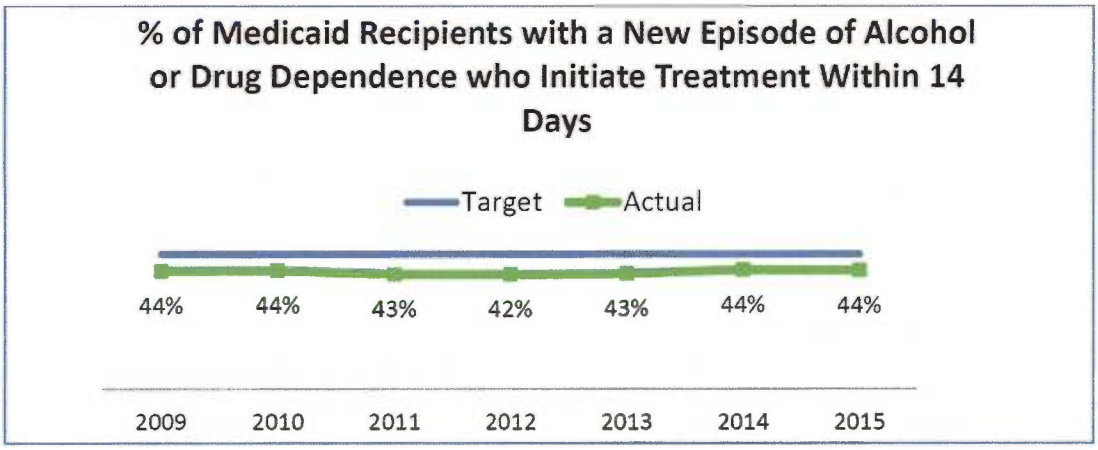


PERFORMANCE MEASURE 2: Treatment Initiation: Are youth and adult Medicaid recipients who need help starting treatment?

When an individual is identified as potentially in need of treatment for a substance use disorder, there are often many perceived or actual barriers to initiating treatment. These barriers may include waiting lists for treatment, lack of transportation, or an inability to find childcare. The most frequently cited reason for not engaging in treatment is the individual's perception that treatment is unnecessary. As with other chronic diseases such as diabetes or heart disease, the sooner an individual seeks treatment, the more likely they are to recover. For successful recovery, individuals with substance use disorders need to know where to get help, and then begin (initiation) and remain in treatment (engagement).

As the numbers in the graph suggest, it is necessary to develop better methods and practices to remove barriers and encourage treatment initiation in a timely manner. One method is for medical professionals to improve screening of patients during office visits. The Agency of Human Services (AHS) has added screening to AHS programs and is currently doing district-level pilot programs to improve coordination between service providers, AHS, and other stakeholders.

The treatment initiation measure is a standardized Healthcare Effectiveness Data and Information Set (HEDIS) Measure used by more than 90% of America's health plans to measure performance. It is defined as, *the percent of adolescent and adult Medicaid recipients with a new episode of alcohol or other drug dependence, as identified by a diagnosis of a substance use disorder, who initiate treatment through an inpatient alcohol or drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization stay within 14 days of the diagnosis.* This standard measure has been modified to compensate for Vermont's monthly case rate funding of opioid treatment hubs and to be more inclusive of residential treatment in the calculations. While the initiation rate has been relatively stable, the number of individuals initiating treatment between 2009 and 2015 has increased 80% in part due to the increased number of individuals diagnosed with a substance use disorder.

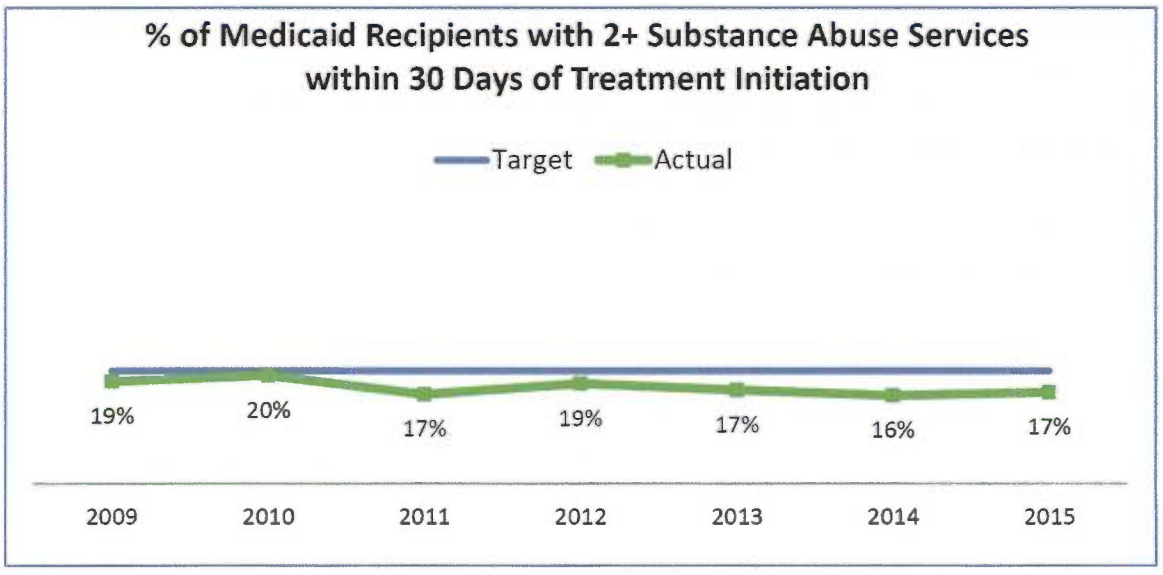


PERFORMANCE MEASURE 3: Treatment Engagement: Are youth and adult Medicaid recipients who start treatment sticking with it?

Behavioral health treatment for substance use is an ongoing process which requires multiple visits in order to modify behavior, build the skills needed to address the contributing factors in addiction, and prevent relapse. In order for substance use treatment to be effective, the individual must attend and stay in treatment. Research indicates that those who are engaged in treatment have better treatment outcomes.[4]

This treatment engagement measure is a standardized Healthcare Effectiveness Data and Information Set (HEDIS) Measure used by more than 90% of America's health plans to measure performance. It is defined as, *the percent of Medicaid recipients age 13 and up who both initiate care, as in Performance Measure 2, and receive two or more additional services with a substance use disorder diagnosis within 30 days of initiation.* This standard measure has been modified to compensate for Vermont's monthly case rate funding of opioid treatment hubs and to be more inclusive of residential treatment in the calculations.

While the engagement rate has been trending slightly lower, the number of Vermont Medicaid recipients engaging in treatment between 2009 and 2015 has increased 59%, likely due to the increased number of individuals diagnosed with a substance use disorder. ADAP is contracting with a quality improvement facilitator to provide assistance to treatment providers in this and other performance measures.



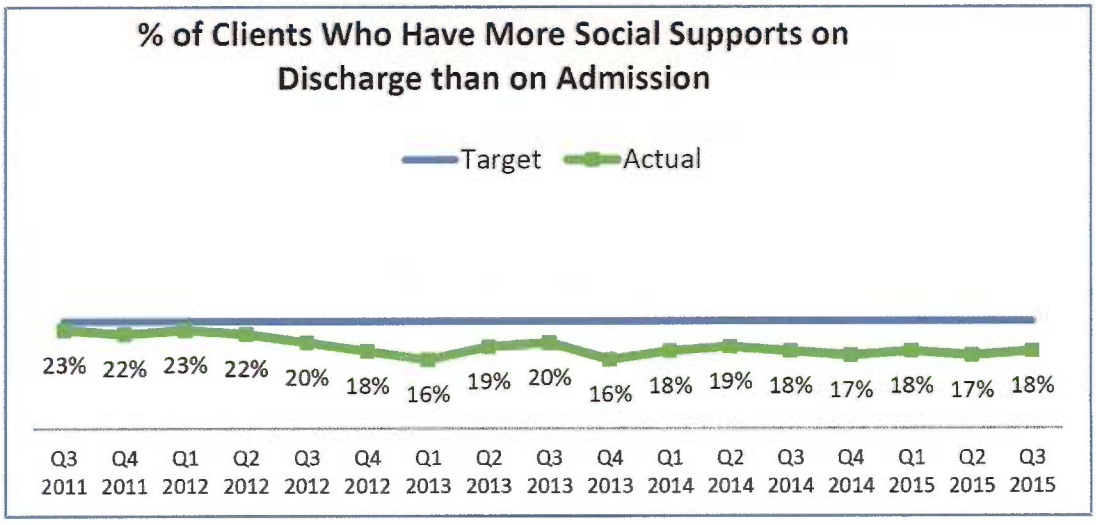
[4] Harris et al, "Does meeting the HEDIS substance abuse treatment engagement criterion predict patient outcomes?", *Journal of Behavioral Health Services and Research* (2010 Jan);37(1):25-39. doi: 10.1007/s11414-008-9142-2. http://www.ncbi.nlm.nih.gov/pubmed/18770044

PERFORMANCE MEASURE 4: Social Supports: Are youth and adults leaving treatment with more support than when they started?

Individuals with addiction often have challenging lives. There is also shame and stigma associated with this disease which can result in isolation for those struggling with addiction. This isolation prevents individuals from accessing positive supports that are needed to assist in recovery from addiction. Socials supports include recovery-oriented self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), supported housing, recovery coaching, faith-based services, as well as substance free gathering places such as the recovery centers. Individuals with positive social networks are more likely to succeed in their recovery.[5]

Social supports is a measure of the portion of individuals exiting treatment in the ADAP-funded Preferred Provider network who have either maintained four or more social support services or have more social supports at discharge than at admission. It is important to note that residential services are excluded from this measure because residential stays are typically 14 days and best practice is for individuals to step down to lower levels of care rather than relying solely on social supports.

ADAP has been working with providers to improve rates of social supports through quality improvement processes and, until the FY16 budget recessions, incentives. There is significant variation in performance between providers and not all providers have participated in quality improvement opportunities. ADAP is leading efforts to strengthen collaboration between Recovery Centers and treatment providers and is beginning to connect clients receiving medication assisted treatment to recovery coaches.

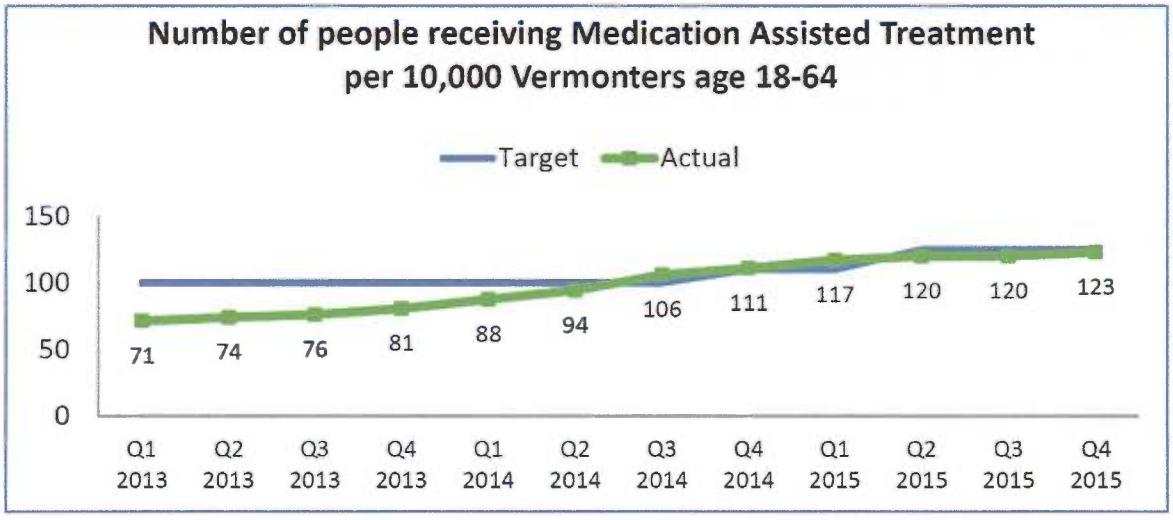


[5] Laudet et al, "The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Ste Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems", *Alcohol Treat Q.* 2006; 24(1-2): 33–73. doi: 10.1300/J020v24n01_04

PERFORMANCE MEASURE 5: Access to Medication-Assisted Therapy (MAT): Are adults seeking help for opioid addiction receiving treatment?

The use of heroin and misuse of other opioids (e.g., prescription narcotics) has been identified as a major public health challenge in Vermont. The potential health, social, and economic consequences of this problem have led to the development of a comprehensive treatment system that is focused on opioid addiction. This system, called the Care Alliance for Opioid Addiction (also called the hub and spoke system), has substantially increased access to care in Vermont. Vermont has a multifaceted approach to addressing opioid addiction that involves multiple community partners. Programs and services include regional prevention efforts, drug take-back programs, intervention services through the monitoring of opioid prescriptions with the Vermont Prescription Monitoring System (VPMS), the Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative, recovery services at eleven Recovery Centers, overdose death prevention through the distribution of Naloxone rescue kits, and a full array of treatment modalities of varying intensities to fit individual needs.

For those with opioid dependence, treatment with methadone or buprenorphine, medications used to reduce cravings for opioids (e.g., heroin or prescription pain relievers), allows individuals the opportunity to lead healthier lives. Medication assisted treatment (MAT) was developed because detoxification followed by abstinence-oriented treatment had been shown to be ineffective and there is clear evidence of effectiveness for MAT using either methadone or buprenorphine.[6] Positive medication assisted treatment outcomes include: abstention from or reduced use of illicit opiates; reduction in non-opioid illicit drug use (e.g., cocaine); decreased criminal behavior; and decreased risk behavior linked to HIV and hepatitis C.



[6] http://healthvermont.gov/adap/treatment/opioids/documents/MAT_Factsheet_Apr2014.pdf

Conclusion:

Performance measures for Vermont substance abuse services show mixed progress toward the long-term program goal of preventing and eliminating the problems caused by alcohol and drug use. These measures offer program funders, planners and administrators consistent feedback about the success of efforts to help youth and adults avoid or recover from alcohol and drug use. State government agencies realize that improvement takes time, requiring ongoing interdepartmental commitment, and a willingness to respond to data. Continued collaboration and attention to metrics of improvement will enable programmatic adjustments in a more timely manner. On the basis of this year's data, the following steps and efforts will be pursued to move Vermont closer to the statewide objective:

- ADAP and DVHA are working on a performance improvement project (PIP) to increase treatment initiation. This group has reviewed data and met with stakeholders including the AHS-wide Substance Abuse Treatment Coordination Initiative (SATC) central and regional groups as well as regional providers such as Central Vermont Medical Center. A PIP is a concentrated effort focused on a particular problem; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.
- ADAP continues to work with treatment providers through regular performance measures meetings. In addition, ADAP has solicited proposals for a quality improvement facilitator to work directly with providers to improve measures. The facilitator will begin in FY2017 and will focus on working with providers to improve treatment engagement and social connectedness.
- Medication assisted treatment capacity is continuing to increase. In the first quarter of 2017, a new hub will open to serve those in Franklin and Grand Isle counties. It is expected that the hub will significantly decrease wait times in the northwest portion of the state and decrease drive times for those individuals receiving services in hubs in the Northeast Kingdom and Burlington. In addition, spoke capacity has been steadily increasing thanks in part to the work of the University of Vermont Medical Center. A new spoke program in Bennington County began in 2015 that serves individuals at high risk of diverting buprenorphine although the program has remained small with approximately 30 patients. ADAP is continuing to link individuals receiving medication assisted treatment to recovery coaches to improve retention in treatment and assist clients in getting the social, physical and cultural resources necessary for successful recovery.
- The school referral measure will continue to be monitored. Vermont will continue to employ the coordinated school health model; provide training on use of evidence-based tools used for screening; monitor referral rates among grantees; and provide training opportunities for best practice. Should the measure continue to exceed the target over time, a new measure with opportunity for improvement will be selected.

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Susanne R. Young, Secretary

MEMORANDUM

TO: Joint Fiscal Committee
FROM: Susanne R. Young
DATE: February 9, 2017
RE: Exempt Positions

I am writing pursuant to Sec. B.1106 of Act 172 (2016) that requires the Secretary of Administration report to the Joint Fiscal Committee in November 2016 to "identify exempt positions within the Executive Branch to be eliminated." It is my understanding the report was deferred to the new administration through a request for an extension.

To date, the following positions have been eliminated with a total General Fund savings of $227,168. We will continue to keep you updated as we take a deliberate and strategic approach to reach this goal and possibly go beyond what is required.

Please do not hesitate to contact me with any questions.

Exempt Positions Eliminated via Act 172

Position Number	Position Title	Department	Annual Cost	General Fund %	Months Unfunded	GF Available
047013	Executive Director	Human Resources	$106,815	0	12	-
074011	Principal Assistant	Human Resources	$106,815	48%	12	$51,090
727018	Special Projects Coordinator	AHS Central Office	$108,671	46%	6	$24,994
737007	Deputy Commissioner	DVHA	$142,436	35%	6	$24,926
737010	Deputy Commissioner	DVHA	$119,847	44%	12	$52,482
027004	Executive Assistant	Finance and Management	$141,704	75%	6	$53,139
727023	Program Director – AHS	AHS Central Office	$135,838	0	5	$0
737011	General Counsel II	VT Health Access	$147,810	1.2% GF 69.79% GC	5	$20,537
087020	General Counsel I	Tax*	$ 96,336	100%	4	$0
Totals			**$1,728,288**			**$227,168**

*This General Counsel I is being eliminated within the Tax Department but the current incumbent has been placed in a previously unbudgeted classified Tax Policy Analyst Position.

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Agency of Administration

TO: **Joint Fiscal Committee**
Government Accountability Committee
House Committee on Government Operations
Senate Committee on Government Operations
FROM: **Michelle Anderson, Interim Commissioner**
DATE: **February 17, 2017**
SUBJECT: **Department of Corrections Position Pilot Request**

In accordance with Act 179, Sec. E.100(d) as amended by 2015 Acts and Resolves No. 4, Sec. 74 and Acts and Resolves No. 172, Sec. E.100.2 in 2016 to include the Department of Corrections (DOC)Correctional Officer I and II's. Secretary of Administration has approved the attached position pilot request from DOC.

The written description required by Act 179, Sec. E.100(d)(4), including the method for evaluating the cost-effectiveness of the positions, as provided by ANR, is attached for your information.

The Department of Human Resources fully supports the request to create 29 positions with the Position Pilot Program. We believe the request is an appropriate use of the Position Pilot. Department of Human Resources has reviewed vacancies, overtime and vacancy turnover at DOC and has determined all vacancies are under active recruitment.

Summary of the Department of Corrections Position Pilot request

The DOC request addresses overtime costs associated with the necessity to fill posts at seven of the 24-hour correctional facilities. As needs arise around (sick, annual, military etc) leave, posts must be filled to adequately staff the facilities. This leads to additional overtime and often burnout of the Correctional Officers. By adding additional staff to cover necessary posts there will be a reduction in overtime cost using this savings to pay for the additional positions. Position request per facility are described in detail in the attached request from DOC along with the cost effectiveness information for the Correctional Officer I positions.

Any questions should be directed to Molly Paulger at 828-3517.

c: Secretary Gobeille
Commissioner Menard
M. Paulger

February 16, 2017

Department of Corrections Position Pilot Request:

In accordance with Act 179, Sec. E.100(d) as amended by 2015 Acts and Resolves No. 4, Sec. 74 and Acts and Resolves No. 172, Sec. E.100.2 in 2016 to include the Department of Corrections (DOC)Correctional Officer I and II's.

The Department of Human Resources fully supports the request to create 29 positions with the Position Pilot Program. We believe the request is an appropriate use of the Position Pilot. Department of Human Resources has reviewed vacancies, overtime and vacancy turnover at DOC and has determined all vacancies are under active recruitment.

Summary of the Department of Corrections Position Pilot request

The DOC request addresses overtime costs associated with the necessity to fill posts at seven of the 24-hour correctional facilities. As needs arise around (sick, annual, military etc) leave, posts must be filled to adequately staff the facilities. This leads to additional overtime and often burnout of the Correctional Officers. By adding additional staff to cover necessary posts there will be a reduction in overtime cost using this savings to pay for the additional positions. Position request per facility are described in detail in the attached request from DOC along with the cost effectiveness information for the Correctional Officer I positions.

Approved: **Date:** 2/16/17

Susanne Young, Secretary of Administration

Request for Hiring Approval

Date: August 18, 2016

Agency/Department/Division/Program	AHS DOC - All in-state facilities			
Requester Name, Phone, email	Michael Touchette, Director of Facility Operations			
Department HR Manager name, email	Roxanne Royce, H.R. Manager roxanne.royce@vermont.gov			
Job Title: Correctional Officer I		Position Number:		
Position type (Permanent, Limited, Exempt): Permanent		Location: Multiple - see below		
Total annual cost for this position including salary and benefits: $72,160. Salary - $49,055, Benefits - $23,104.				
Are these costs fully budgeted? (Yes or No): Yes				
Indicate source of funds:	100 % General	___%Federal	___% Special	___% Other

Justification: Please explain how the position fits into department or agency priorities, how the position is critical to the work of the organization and why the position would likely not be a part of any programmatic or staffing cuts. Attach additional sheets if necessary.

Correctional Officer I's provide supervision 24 hours per day and 365 days a year to inmates who are incarcerated. Correctional Officer I's ensure that inmates are safe, secure and accounted for. These positions are required to provide post coverage in correctional units where inmates reside. These positions are essential to the operations of the Correctional Facilities.

Correctional Officer I positions that are unfilled are covered with the use of overtime; thereby creating more cost than filling the position. Detailed studies have indicated that the more overtime required of these positions, the more sick and other leave time is used, and the rates of fatigue and attrition increase. All of these factors contribute heavily to generating even higher overtime needs and the corresponding costs related to staffing each facility properly.

These 29 positions will be used to backfill vacancy from various types of leave (sick, annual, military, RFD, etc.), thereby reducing facility overtime costs. This has been successfully piloted at the Northeast Correctional Complex and, with the use of 7 Correctional Officers for overtime replacement, a savings was generated in FY16. The Department is confident that these results can be achieved in facilities around the state. There is an analysis attached to this request as well. The Position Pilot sheet has a summary tab, as well as the detail by each facility. The Department projected the total first year salary and estimated benefit costs for a new Correctional Officer I. This was measured against the average cost of overtime at each facility for their respective CO I's as well as the actual overtime costs for the CO I's (initially for FY16, and updated to include the first quarter of FY17). Overall, there is a potential for savings at each location, and this doesn't factor in items such as the Academy and other costs of training new staff, issues related to staff fatigue, attrition, and vacancies, the potential ACA penalties for temps working more than 1,280 hours, or for the statewide percentage of employees with health insurance falling below the acceptable thresholds.

Below are the total Correctional Officer I position requests per facility:

CRCF - 2; MVRCF - 2; NECC - 5; NSCF - 8; NWSCF - 4; SESCF - 2; SSCF - 6 TTL-29

These positions were approved by the Legislature for FY17 and were recommended in a staffing analysis conducted by ASCA in FY15. The report stated that VT DOC needed between 39 and 80 additional positions in order to properly fill all existing posts. There are many benefits from adding these positions, including the reduction of overtime costs, increased safety within facilities, reduced staff fatigue/burnout, reduction of overall temporary employees (helps avoid ACA penalties), staff attrition, and training costs. This request is for less positions than were recommended by ASCA as the minimum number to maintain proper staffing and safety levels.

DHR Recommendation:

Finance & Management:

Department of Corrections													
Overtime Conversion for Position Pilot													
Correctional Officer I													
Dated: September 22, 2016													
Classified Position:													
	A		B	A*B=C	C*7.65%	C*1.1%							
Description:	Hourly Rate		# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total	Net conversion cost	
Total Projected Permanent Full Time Cost CO I	$17.20 / $17.95		2080	$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160		
		heds pay											Curr Vac
1 CRCF 2 Chittenden Regional So BTV		197/166	Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total		
Overtime cost at 2,080 hours (average salary * 1.5)	$ 28.18		2,080	$ 58,614	$ 4,484	$ 10,029		$ 239			$ 73,366	$ (1,206)	
Overtime cost at 2,080 hours (average FY17 CRCF OT cost)	$ 26.85		2,080	$ 55,848	$ 4,272	$ 9,556		$ 227			$ 69,903	$ 2,256	
2 MVRCF 2 Rutland		130/140											
Overtime cost at 2,080 hours (average salary * 1.5)	$ 30.56		2,080	$ 63,565	$ 4,863	$ 10,876		$ 259			$ 79,562	$ (7,403)	
Overtime cost at 2,080 hours (average FY17 MVRCF OT cost)	$ 28.01		2,080	$ 58,261	$ 4,457	$ 9,968		$ 237			$ 72,923	$ (764)	
3 NECC 2 ST J		130/140											
Overtime cost at 2,080 hours (average salary * 1.5)	$ 29.47		2,080	$ 61,298	$ 4,689	$ 10,488		$ 249			$ 76,724	$ (4,565)	
Overtime cost at 2,080 hours (average FY17 NECC OT cost)	$ 28.21		2,080	$ 58,677	$ 4,489	$ 10,040		$ 239			$ 73,444	$ (1,284)	
4 NSCF 2 St. J		414/411											
Overtime cost at 2,080 hours (average salary * 1.5)	$ 28.11		2,080	$ 58,469	$ 4,473	$ 10,004		$ 238			$ 73,184	$ (1,024)	
Overtime cost at 2,080 hours (average FY17 NSCF OT cost)	$ 29.22		2,080	$ 60,778	$ 4,649	$ 10,399		$ 247			$ 76,073	$ (3,914)	
5 NWSCF 4 St Albans		247/222											
Overtime cost at 2,080 hours (average salary * 1.5)	$ 27.42		2,080	$ 57,034	$ 4,363	$ 9,758		$ 232			$ 71,387	$ 772	
Overtime cost at 2,080 hours (average FY17 NWSCF OT cost)	$ 28.32		2,080	$ 58,906	$ 4,506	$ 10,079		$ 240			$ 73,730	$ (1,571)	
6 SESCF 2 Windsor		100/96											
Overtime cost at 2,080 hours (average salary * 1.5)	$ 29.83		2,080	$ 62,046	$ 4,747	$ 10,616		$ 253			$ 77,662	$ (5,502)	
Overtime cost at 2,080 hours (average FY17 SESCF OT cost)	$ 29.31		2,080	$ 60,965	$ 4,664	$ 10,431		$ 248			$ 76,308	$ (4,148)	
7 SSCF 6 So St. Springfield		350/351											
Overtime cost at 2,080 hours (average salary * 1.5)	$ 27.87		2,080	$ 57,970	$ 4,435	$ 9,919		$ 236			$ 72,559	$ (399)	
Overtime cost at 2,080 hours (average FY17 SSCF OT cost)	$ 28.44		2,080	$ 59,155	$ 4,525	$ 10,121		$ 241			$ 74,043	$ (1,883)	
Average salary and average FY17 OT costs are based on FY17 YTD information from payroll and OT reports													

Total FY17 CO I OT - though September 3 (9/15/16 check)					
	Hours	Cost		beds	pop
CRCF	2,541.60	$ 68,230.03	$ 26.85	197	166
MVRCF	1,810.25	$ 50,696.12	$ 28.01	130	140
NECC	3,167.87	$ 89,371.67	$ 28.21	130	140
NSCF	3,751.02	$ 109,600.45	$ 29.22	414	411
NWSCF	5,019.07	$ 142,156.81	$ 28.32	247	222
SESCF	2,697.97	$ 79,069.78	$ 29.31	100	95
SSCF	7,186.00	$ 204,336.77	$ 28.44	350	351
Total	26,173.78	$ 743,461.63	$ 28.40	1,568	1,525
	beds to OT hrs or cost				

Department of Corrections
Overtime Conversion - CRCF
Correctional Officer I
Dated: September 22, 2016

Classified Position:						11328.16	8944.41			
Description:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-In										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-In		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost CO I			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	$ 28.18	2,080	$ 58,614	$ 4,484	$ 10,029		$ 239			$ 73,366
Net Conversation Cost of 1 COI Position			$ (9,559)	$ (731)	$ (1,636)	$ 10,028	$ (39)	$ 701	$ 30	$ (1,206)
Overtime at 2,080 (average FY17 CRCF OT cost)	$ 26.85	2,080	$ 55,848	$ 4,272	$ 9,556		$ 227			$ 69,903

Cost of training new staff
Academy - average of approximately $8,000 per graduate in FY15
this doesn't include travel and meals - these costs are paid by facilities
ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)
OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance

Department of Corrections
Overtime Conversion - MVRCF
Correctional Officer I
Dated: September 22, 2016

Classified Position:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-In										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-In:		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost CO I			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	**$ 30.56**	**2,080**	**$ 63,565**	**$ 4,863**	**$ 10,876**		**$ 259**			**$ 79,562**
Net Conversation Cost of 1 COI Position			$ (14,510)	$ (1,110)	$ (2,483)	$ 10,028	$ (59)	$ 701	$ 30	$ (7,403)
Overtime at 2,080 (average FY17 MVRCF OT cost)	**$ 28.01**	**2,080**	**$ 58,261**	**$ 4,457**	**$ 9,968**		**$ 237**			**$ 72,923**

Cost of training new staff
Academy - average of approximately $8,000 per graduate in FY15
this doesn't include travel and meals - these costs are paid by facilities
ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)
OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance

Department of Corrections
Overtime Conversion - NECC
Correctional Officer I
Dated: September 22, 2016

Classified Position:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-In										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	$ 685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-In		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost CO I			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	$ 28.89	2,080	$ 60,091	$ 4,597	$ 10,282		$ 245			$ 75,214
Net Conversation Cost of 1 COI Position			$ (11,036)	$ (844)	$ (1,888)	$ 10,028	$ (45)	$ 701	$ 30	$ (3,055)
Overtime at 2,080 (average FY17 NECC OT cost)	$ 28.21	2,080	$ 58,677	$ 4,489	$ 10,040		$ 239			$ 73,444

Cost of training new staff
Academy - average of approximately $8,000 per graduate in FY15
this doesn't include travel and meals - these costs are paid by facilities
ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)
OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance

DOC Overtime - NECC Facility and Caledonia Work Camp

Overtime hours worked from June 14, 2015 - June 11, 2016 (includes all check dates from July 9, 2015 through June 23, 2016)

Correctional Officer OT only

Pay Period Start Date	Pay Period End Date	Check Date	Hours	Amount	
6/14/2015	6/27/2015	7/9/2015	1,025.00	$ 29,242.62	
6/28/2015	7/11/2015	7/23/2015	1,015.20	$ 28,816.51	
7/12/2015	7/25/2015	8/6/2015	1,133.25	$ 33,143.86	
7/26/2015	8/8/2015	8/20/2015	1,065.00	$ 31,249.87	
8/9/2015	8/22/2015	9/3/2015	1,120.22	$ 33,158.29	
8/23/2015	9/5/2015	9/17/2015	1,004.75	$ 30,491.26	
9/6/2015	9/19/2015	10/1/2015	985.25	$ 29,440.41	
9/20/2015	10/3/2015	10/15/2015	888.25	$ 26,669.65	
10/4/2015	10/17/2015	10/29/2015	1,330.25	$ 39,702.98	
10/18/2015	10/31/2015	11/12/2015	754.75	$ 22,981.25	South Closed
11/1/2015	11/14/2015	11/26/2015	761.25	$ 22,665.41	South Closed
11/15/2015	11/28/2015	12/10/2015	532.00	$ 15,686.92	South Closed
11/29/2015	12/12/2015	12/24/2015	567.75	$ 16,438.53	South Closed
12/13/2015	12/26/2015	1/7/2016	501.75	$ 15,001.79	South Closed
12/27/2015	1/9/2016	1/21/2016	607.75	$ 18,228.61	South Closed
1/10/2016	1/23/2016	2/4/2016	481.00	$ 14,364.94	South Closed
1/24/2016	2/6/2016	2/18/2016	546.75	$ 15,735.75	South Closed
2/7/2016	2/20/2016	3/3/2016	537.00	$ 15,548.36	South Closed
2/21/2016	3/5/2016	3/17/2016	432.25	$ 12,853.06	South Closed
3/6/2016	3/19/2016	3/31/2016	449.75	$ 13,100.43	South Closed
3/20/2016	4/2/2016	4/14/2016	540.50	$ 15,661.13	South Closed
4/3/2016	4/16/2016	4/28/2016	770.00	$ 22,460.69	South Closed
4/17/2016	4/30/2016	5/12/2016	774.25	$ 22,815.38	South Closed
5/1/2016	5/14/2016	5/26/2016	718.25	$ 21,856.27	South Closed
5/15/2016	5/28/2016	6/9/2016	617.50	$ 18,897.59	South Closed
5/29/2016	6/11/2016	6/23/2016	762.75	$ 19,596.80	South Closed
Overtime Hours FY16			19,922.42	$ 585,808.36	
Averages before South closed			1,063.02	31,323.94	
Averages after South closed			609.13	17,876.05	
Average pay period OT savings			453.89	$ 13,447.89	
Cost of 7 positions			560.00	$ 13,193.60	
Average overall pay period savings				$ 254.29	
Annualized savings				$ 6,611.42	
Savings per new classified position				$ 944.49	
Estimated savings per position at NECC (summary sheet)				$ 1,284.42	

Department of Corrections
Overtime Conversion - NSCF
Correctional Officer I
Dated: September 22, 2016

Classified Position:

Description:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-in										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-in		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost COI			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	$ 28.11	2,080	$ 58,469	$ 4,473	$ 10,004		$ 238			$ 73,184
Net Conversation Cost of 1 COI Position			$ (9,414)	$ (720)	$ (1,611)	$ 10,028	$ (38)	$ 701	$ 30	$ (1,024)
Overtime at 2,080 (average FY17 NSCF OT cost)	$ 29.22	2,080	$ 60,778	$ 4,649	$ 10,399		$ 247			$ 76,073

Cost of training new staff
Academy - average of approximately $8,000 per graduate in FY15
this doesn't include travel and meals - these costs are paid by facilities
ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)
OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance

Department of Corrections

Overtime Conversion - NWSCF

Correctional Officer I

Dated: September 22, 2016

Classified Position:

Description:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-In										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-In		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost COI			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	$ 27.42	2,080	$ 57,034	$ 4,363	$ 9,758		$ 232			$ 71,387
Net Conversation Cost of 1 COI Position			$ (7,978)	$ (610)	$ (1,365)	$ 10,028	$ (32)	$ 701	$ 30	$ 772
Overtime at 2,080 (average FY17 NWSCF OT cost)	$ 28.32	2,080	$ 58,906	$ 4,506	$ 10,079		$ 240			$ 73,730

Cost of training new staff

Academy - average of approximately $8,000 per graduate in FY15

this doesn't include travel and meals - these costs are paid by facilities

ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)

OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance

Department of Corrections

Overtime Conversion - SESCF

Correctional Officer I

Dated: September 22, 2016

Classified Position:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-In										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-in		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost CO I			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	$ 29.83	2,080	$ 62,046	$ 4,747	$ 10,616		$ 253			$ 77,662
Net Conversation Cost of 1 COI Position			$ (12,991)	$ (994)	$ (2,223)	$ 10,028	$ (53)	$ 701	$ 30	$ (5,502)
Overtime at 2,080 (average FY17 SESCF OT cost)	$ 29.31	2,080	$ 60,965	$ 4,664	$ 10,431		$ 248			$ 76,308

Cost of training new staff

Academy - average of approximately $8,000 per graduate in FY15

this doesn't include travel and meals - these costs are paid by facilities

ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)

OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance

Department of Corrections
Overtime Conversion - SSCF
Correctional Officer I
Dated: September 22, 2016

Classified Position:

Description:	Hourly Rate	# Hours	Salary	FICA	Retirement	Health	Life	Dental	EAP	Total
Base Salary:										
Step 1 (PG 18)	$ 17.20	1,040	$ 17,888	$ 1,368	$ 3,061	$ 5,014	$ 73	$ 350	$ 15	$ 27,769
Step 2 (PG 18)	$ 17.95	1,040	$ 18,668	$ 1,428	$ 3,194	$ 5,014	$ 76	$ 350	$ 15	$ 28,746
Sub-Total Salary		2,080	$ 36,556	$ 2,797	$ 6,255	$ 10,028	$ 149	$ 701	$ 30	$ 56,515
Replacement Fill-In										
Sick Leave	$ 26.36	96	$ 2,529	$ 193	$ 433		$ 10			$ 3,166
Annual Leave	$ 17.20	96	$ 1,650	$ 126	$ 282		$ 7			$ 2,065
Pers., Mil., Etc.	$ 17.20	24	$ 413	$ 32	$ 71		$ 2			$ 517
Training	$ 17.20	40	$ 688	$ 53	$ 118		$ 3			$ 861
Comp Time & Floaters	$ 17.20	16	$ 275	$ 21	$ 47		$ 1			$ 344
Roll Call	$ 26.36	26	685	$ 52	$ 117		$ 3			$ 858
Sub-Total Replacement Fill-In		298	$ 6,241	$ 477	$ 1,068		$ 25			$ 7,811
Shift/Weekend Differential										
2nd Shift	0.67	693	$ 465	$ 36	$ 79		$ 2			$ 581
3rd Shift	0.72	693	$ 499	$ 38	$ 85		$ 2			$ 625
Weekend	0.5	832	$ 416	$ 32	$ 71		$ 2			$ 521
Living Unit	0.5	1,387	$ 693	$ 53	$ 119		$ 3			$ 868
Sub-Total Shift/Weekend Differential			$ 2,073	$ 159	$ 355		$ 8			$ 2,595
Holiday Pay										
9 holiday days	$ 26.36	72	$ 1,898	$ 145	$ 325		$ 8			$ 2,376
2 holiday days	$ 17.95	16	$ 287	$ 22	$ 49		$ 1			$ 359
Sub-Total Shift/Weekend Differential			$ 2,185	$ 167	$ 374	$ -	$ 9	$ -	$ -	$ 2,735
Competency Supplement	$ 50.00	40	$ 2,000	$ 153	$ 342		$ 8			$ 2,503
Total Projected Permanent Full Time Cost COI			$ 49,055	$ 3,753	$ 8,393	$ 10,028	$ 200	$ 701	$ 30	$ 72,160
Overtime at 2,080 (average salary * 1.5)	$ 27.87	2,080	$ 57,970	$ 4,435	$ 9,919		$ 236			$ 72,559
Net Conversation Cost of 1 COI Position			$ (8,914)	$ (682)	$ (1,525)	$ 10,028	$ (36)	$ 701	$ 30	$ (399)
Overtime at 2,080 (average FY17 SSCF OT cost)	$ 28.44	2,080	$ 59,155	$ 4,525	$ 10,121		$ 241			$ 74,043
Cost of training new staff										
Academy - average of approximately $8,000 per graduate in FY15										
this doesn't include travel and meals - these costs are paid by facilities										
ACA - penalty of $3,000 per temp over 1,280 hours (CY) / 1,560 hours (12 consecutive months)										
OT reduction would reduce temp usage/need, which would increase statewide percentage of employees with health insurance										

VERMONT

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Office of the Commissioner
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Agency of Administration

TO: **Joint Fiscal Committee**
Government Accountability Committee
House Committee on Government Operations
Senate Committee on Government Operations
FROM: **Beth Fastiggi, Commissioner of Human Resources**
DATE: **April 13, 2017**
SUBJECT: **Agency of Transportation Position Pilot Request**

In accordance with Sec. E.100(d) of Act 179 of 2014, as amended by Sec. 74 of Act 4 of 2015, Secretary of Administration Susanne R. Young has approved the attached position pilot request from the Agency of Transportation (VTrans).

Attached is the required written description as provided by VTrans, including the method for evaluating the cost-effectiveness of the positions.

The Department of Human Resources fully supports this request and we believe the request is an appropriate use of the Position Pilot, and is consistent with the goal of maximizing resources to provide the greatest benefit to Vermont taxpayers.

VTrans is proposing two positions – AOT Stormwater Technician I – to support the new and expanded water quality programs the Agency is facing under the Transportation Separate Storm Sewer System (TS4) Permit and Total Maximum Daily Loads (TMDLs). VTrans does not currently have the resources necessary to comply with the permit programs TS4 and TMDL have set in place for us and would need to utilize consultant services to assist if we cannot bring these two new FTEs into VTrans Maintenance and Operations Bureau's Environmental Program. VTrans will achieve cost savings by avoiding the need for consultants to perform this additional work, and instead hiring additional staff to perform the duties at lower costs. Funding is available for these positions within the proposed FY2018 budget and ongoing.

Please direct any questions to Molly Paulger at 828-3517.

c: Secretary Young
Secretary Flynn
M. Paulger

VERMONT

State of Vermont
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[ttd] 802-253-0191

Agency of Transportation

MEMORANDUM

TO: Susanne R. Young, Secretary of Administration
FROM: Joe Flynn, Secretary of Transportation
DATE: April 3, 2017
SUBJECT: Position Pilot Program – Agency of Transportation

VTrans requests your approval as we are proposing two positions – AOT Stormwater Technician I – to support the new and expanded water quality programs the Agency is facing under the Transportation Separate Storm Sewer System (TS4) Permit and Total Maximum Daily Loads (TMDLs). VTrans does not currently have the resources necessary to comply with the permit programs TS4 and TMDL have set in place for us and would need to utilize consultant services to assist if we cannot bring these two new FTEs into VTrans Maintenance and Operations Bureau's Environmental Program. VTrans will achieve cost savings by avoiding the need for consultants to perform this additional work, and instead hiring additional staff to perform the duties at lower costs (see attached worksheet). Funding is available for these positions within the proposed FY2018 budget and ongoing.

Below are some highlights of the new and expanded duties:

1. Planning, designing, constructing and maintaining at least 54 individual Flow Restoration Stormwater Treatment practices to comply with its regulatory obligations under the Stormwater Impaired TMDLS (mainly in Chittenden County) PLUS another yet undetermined number of phosphorus reduction stormwater treatment practices to comply with the Lake Champlain TMDL. The number of P-reduction practices will be in the high hundreds across the Lake Basin. This will be completed over 20 years, require ongoing field work, inspection, operation & maintenance activities, reporting, asset management and GIS mapping,
2. Develop Stormwater Pollution Prevention Plans (SWPPPs) for all of its District Maintenance Facilities as well as conduct water quality trainings, conduct audits seeking water quality enhancements/remediation, and coordinate inspection, monitoring and reporting at all 67 garages.
3. Participate in ANR Tactical Basin Planning Process and Basin Plan development representing VTrans. There are 15 watersheds across Vermont for which Tactical Basin Plans are developed and VTrans' input into the development of these plans is significant as they are being used to guide TMDL implementation.
4. 94% of the State is or will soon be covered under a TMDL addressing Water Quality Standards. The introduction of the Lake Champlain TMDL alone (not to mention upcoming TMDLs for Lake Memphremagog and Connecticut River/Long Island Sound) is a significant increase over our current water quality obligations in the MS4 where those stormwater impaired stream watersheds make up less than 2% of the state.

Please indicate your approval by signing below.

for Suzanne R. Young, Secretary of Administration — Date 4/6/17

VTrans

Maintenance & Operations Bureau - Technical Services - Environmental Program

Tasks/Activities Required under Current, Expanded or New Regualtory Responsibilities from TS4/TMDL and other Water Quality Regulations	Regulatory Requirment	Annual Hours Needed to Cover Compliance Efforts	Costs	New or Expended Responsibility
Complete SWPPPs for facilities:				
57 garages (assume 60hrs/garage for site visit, SWPPP development and delivery)	MS4/TS4	1220		
Add Green Stormwater Infrastructure (GSI) checklist onto SWPPP site visit & development of document & plan	MS4/TS4	320		New
				New
Annual Inspection, Training, updating SWPPPs, and Reporting:				
57 garages	MS4/TS4	1072		
9 airports	MSGP	144		New and Greatly Expended
3 gravel pits	MSGP	48		Current/Expanded
1 public transit	MSGP	0		Current/Expanded
Updating quarterly monitoring tracking	MSGP	280		Current/Expanded
				Current/Expanded
SW Operational Permit:				
Plan Review of Jurisdictional Projects (assuming 10/year)	VT State SW Operational Permit	80		
Coordinate with PDB & district for review and transfer of constructed project (assuming 10/year)	VT State SW Operational Permit	160		Current/Expanded
Final Inspection and Acceptance	VT State SW Operational Permit	80		Current/Expanded
Annual Inspections	VT State SW Operational Permit	40		Current/Expanded
Coordination of needed maintenance	VT State SW Operational Permit	100		Current/Expanded
Update Operation & Maintenance (O&M) plans	VT State SW Operational Permit	80		Current/Expanded
Create new O&M plans (assume 10 new permit/year)	VT State SW Operational Permit	320		Current/Expanded
Aviation compliance coordination	VT State SW Operational Permit/MSGP/TS4	208		Current/Expanded
				Current/Expanded
General Training and Education	MS4/TS4	168		
				Expanded
Illicit Discharge Detection & Elimination (IDDE):				
Assuming state will need to be complete in 5-year permit cycle				
IDDE - mapping of swales and outfalls	MS4/TS4 MM#3	576		
IDDE - testing	MS4/TS4 MM#3	572		Expanded
IDDE Desktop Mapping Analysis	MS4/TS4 MM#3	70.4		Expanded
		0		Expanded
Vegetation Management Program Assistance - Pesticide Spray Program	6 VSA Chapter 87	248		
				Expanded
Additional Water Quality Assistance:				
Water Quality Remediation Program - poractive approach to coordinate district needs regarding sources of sediment (slope failures, erosion, etc) and supports phosporus reductions under TMDL	MS4/TS4 MM#6 - TMDL development	800		
Assistance of supervision of TMDL required stormwater retrofit projects, phosphorus reduction retrofits and GSI improvements	MS4/TS4 MM#6 - TMDL development	500		Current/Expanded
Working with Partners on water quality improvements (ANR Tactical Basin Planners, NRCS, Agency Ag, UVM extension, other water quality groups (watershed groups, consultants, municipalities, grant applicants))	MS4/TS4 MM#6 - TMDL development	416		New and Greatly Expended
S1111 review	Title 19 S.1111	624		Current/Expanded
Online shared review		200		Current/Expanded
Problem projects (Legacy Projects)	VT State SW Operational Permit	160		Current/Expanded
Meetings and other internal coordination and support under TS4	TS4	400		Current/Expanded
				Current/Expanded
	Total Annual Hours for Compliance Efforts	9286.4		
	Total Annual Hours Covered by Current 2 FTEs (2 x 2080 hours)	4160		
	Remaining Annual Hours Needed to Cover Compliance Efforts	5126.4		
			$ 410,112	Costs to have Consultants cover the remaining 5126.4 hours of work at $80/hour (without NEW FTEs)
				OR
				Costs for 2 NEW FTEs to cover 4160 hours of the additional 5126.4 hours of work load at 2080 hours each/yr. ONE
			$ 200,000	FTE = 2080 hours/yr at +/- $100,000/yr (includes overhead). 2 FTE = 4160 hrs/yr
			$ (210,112)	Cost savings to have 2 new FTEs vs Consultants do the work - reduces consultant work to 966.4 hours/yr
	Remaining annual hours needing consultant assistance after factoring in 4160 hours provied by 2 new FTEs	966.4		
			$ 77,312	Cost for Consultant assistance on remaining 966.4 hours/year at $80/hour
				Savings after factoring in Consultant assistnce on remaining 966.4 hours. This represents total savings after hiring
				2 NEW FTEs to cover 4160 hrs/yr plus consultant costs to cover 966.4 hrs/yr which is beyond average annual hours
			$ (132,800)	for FTEs.

Prepared by VTrans Highway Division, Maintenancae and Operations Bureau Environmental Program 3/21/2017 in support of request for 2 new FTEs starting in SFY18. Contact Craig DiGiammarino, MOB Environmental Program Manager | craig.digiammarino@vermont.gov | 802-922-4681

LEGISLATIVE JOINT FISCAL COMMITTEE AND OFFICE POLICIES

Adopted
JANUARY 2015

[Statutes updated 11-20-2015]

INDEX

JOINT FISCAL COMMITTEE AND OFFICE POLICIES

[January 2015]

Table of Contents

Title 2: Legislature

Chapter 15: Joint Fiscal Committee

§ 501. Creation of committee; purpose

(a) There is created a joint fiscal committee whose membership shall be appointed at the beginning of each biennial session of the general assembly. The committee shall consist of five representatives and five senators as follows:

(1) The chair of the house committee on appropriations;

(2) The chair of the house committee on ways and means;

(3) The chair of the senate committee on appropriations;

(4) The chair of the senate committee on finance;

(5) Two members of the house, one from each major political party, appointed by the speaker of the house;

(6) Two members of the senate, one from each major political party, appointed by the committee on committees; and

(7) One member of the senate to be appointed by the committee on committees and one member of the house to be appointed by the speaker.

(b) The committee shall elect a chair, vice-chair and clerk and shall adopt rules of procedure. The committee may meet at any time at the call of the chair or a majority of the members of the committee. A majority of the membership shall constitute a quorum.

(c) For attendance at a meeting when the general assembly is not in session, members of the joint fiscal committee shall be entitled to the same per diem compensation and reimbursement for actual and necessary expenses as provided members of standing committees under 2 V.S.A. § 406. (Added 1973, No. 128 (Adj. Sess.), § 1, eff. Jan. 24, 1974; amended 1977, No. 247 (Adj. Sess.), § 202; 1983, No. 88, § 12, eff. July 3, 1983; 1997, No. 61, § 273.)

§ 502. Employees; rules; budget

(a) The joint fiscal committee shall meet immediately following the appointment of its membership to organize and conduct its business. The joint fiscal committee shall adopt rules for the operation of its personnel.

(b) The joint fiscal committee shall employ such professional and secretarial staff as are required to carry out its functions and fix their compensation.

(1) Chapter 13 of Title 3 shall not apply to employees of the joint fiscal committee unless this exception is partially or wholly waived by the joint fiscal committee.

(2) All requests for assistance, information, and advice and all information received in connection with fiscal research or related drafting shall be confidential unless the party requesting or giving the information designates in the request that it is not confidential. Documents, transcripts, and minutes of committee meetings, including written testimony submitted to a committee, fiscal notes and summaries which have been released or approved for printing or introduction, and material appearing in the journals or calendars of either house are official documents and shall not be confidential under this subsection.

(c) The joint fiscal committee shall prepare a budget. (Added 1973, No. 128 (Adj. Sess.), § 1, eff. Jan. 24, 1974; amended 2005, No. 215 (Adj. Sess.), § 292.)

§ 503. Functions

(a) The joint fiscal committee shall direct, supervise and coordinate the work of its staff and secretaries.

(b) The joint fiscal committee shall:

(1) Furnish research services and secretarial services of a fiscal nature to the committees on appropriations, the senate committee on finance, the house committee on ways and means, the committees on transportation and the joint fiscal committee;

(2) Carry on a continuing review of the fiscal operations of the state, including but not limited to revenues, budgeting and expenditures;

(3) Accept grants, gifts, loans, or any other thing of value, approved by the governor, under the provisions of 32 V.S.A. § 5, when the general assembly is not in session.

(4) Keep minutes of its meetings and maintain a file thereof. (Added 1973, No. 128 (Adj. Sess.), § 1, eff. Jan. 24, 1974; amended 1977, No. 247 (Adj. Sess.), § 187, eff. April 17, 1978; 1997, No. 144 (Adj. Sess.), § 17.)

§ 504. Intergovernmental cooperation

For the purposes of carrying out its duties, the joint fiscal committee and its staff shall have access to and the right to copy any public record of all executive, administrative and judicial departments of the state, except income and franchise tax returns and other documents classified as confidential by law. (Added 1973, No. 128 (Adj. Sess.), § 1, eff. Jan. 24, 1974.)

505. Basic needs budget and livable wage; report

(a) For the purposes of this section:

(1) "Basic needs" means the essentials needed to run a household, including food, housing, transportation, child care, utilities, health and dental care, taxes, rental and life insurance, personal expenses, and savings.

(2) "Basic needs budget" is the amount of money needed by a Vermont household to maintain a basic standard of living, calculated using current state and federal data sources for the costs of basic needs.

(3) "Livable wage" means the hourly wage required for a full-time worker to pay for one-half of the basic needs budget for a two-person household with no children and employer-assisted health insurance averaged for both urban and rural areas.

(b) On or before January 15 of each new legislative biennium, beginning in 2009, the joint fiscal office shall report the calculated basic needs budgets of various representative household configurations and the calculated livable wage for the previous year. This calculation may serve as an additional indicator of wage and other economic conditions in the state and shall not be considered official state guidance on wages or other forms of compensation.

(c) The methodology for calculating basic needs budgets shall be built on methodology described in the November 9, 1999 livable income study committee report, modified as appropriate by any statutory changes made by the general assembly and subsequent modifications adopted by the joint fiscal committee under subsection (d) of this section.

(d) The joint fiscal committee may adopt modifications to the methodology used to determine the basic needs budget calculations under subsection (c) of this section to account for public policy changes, data availability, or any other factors that have had an impact on any aspects of the methodology. Changes or revisions in methodology adopted by the committee shall be effective no later than November in the year preceding the release of the report. (Added 2005, No. 59, § 1; amended 2007, No. 202 (Adj. Sess.), § 1.)

RULES OF PROCEDURE
COMMITTEE MEETINGS
LEGISLATIVE JOINT FISCAL COMMITTEE
[Revised 3/18/94]

Motions and Voting – Every motion shall be reduced to writing by the mover if the Chair or a member so requests. When a question is pending, no motion may be received except:

To adjourn
To adjourn to a day certain
To take a recess
To lay on the table
To postpone indefinitely
To postpone to a day certain
To amend
To reconsider

which motions shall have precedence in the above order. No motion is in order when the Committee is engaged in voting. All members present, including the Chair, shall vote. Voting shall be by voice or roll call.

Executive Session – The Committee may go into executive session pursuant to the terms, conditions and procedure contained in Section XV of the Permanent Rules of the Vermont Senate.

Reconsideration – Action to reconsider on the same day of original vote shall be by three-quarters vote; at subsequent meeting action shall be by majority vote. A motion to reconsider may be made only by a member who voted on the prevailing side of the question. When the decision of a question has been reconsidered, the matter shall not be reconsidered again. Nor when a motion to reconsider has been rejected may that question be reconsidered, or a like motion be in order again.

Subcommittees – The Committee may authorize the appointment of subcommittees to investigate particular subjects. A member of the Committee shall be chair of each subcommittee and members thereon may include legislators who are not members of the Committee.

Suspension – The Committee's rules may be suspended by three-quarters vote.

Right to Change Rules – The Rules of Procedure of the Joint Fiscal Committee may be changed by a majority of the members present provided that the proposed rule change has been submitted in writing to each member of the Committee no less than fifteen days prior to a meeting of the Committee at which the rule change will be considered.

Procedures Not Covered – In the case of any procedure or business not otherwise addressed by these Rules, the Joint Fiscal Committee shall be guided generally by *Mason's Manual of Legislative Procedure* (latest edition) and specifically by Chapters 54 through 63, inclusive, concerning the conduct of committees.

LEGISLATIVE JOINT FISCAL COMMITTEE
and
JOINT FISCAL OFFICE POLICIES

1. The Joint Fiscal Office is established to provide independent, accurate, analytical, and clerical support for the appropriations and tax writing committees. Its functions and work assignments are subject to approval of the Joint Fiscal Committee and/or the Joint Fiscal Committee chair.

2. It is the intention of the Joint Fiscal Committee that the analyses and work products of the Joint Fiscal Office shall be completed in a factual, reliable, and timely manner to a professional quality standard as required by the Joint Fiscal Committee.

3. Assignments of responsibilities, studies, and work tasks to personnel of the Joint Fiscal Office will be through the Joint Fiscal Committee chair and the Joint Fiscal Officer, except during a session of the General Assembly. During sessions, professional and secretarial personnel will report to the chair of their designated committees for work and scheduling assignments relating to their committee activities. Regularly assigned tasks will continue to be supervised by the Joint Fiscal Officer.

4. The chair of the Joint Fiscal Committee shall assume the responsibility for public information in matters relating to the work of the Joint Fiscal Committee. The individual chairs of the four money committees shall be the principal spokespersons for matters relating to the work and interest of their committees. The Joint Fiscal Officer shall be responsible for information which concerns the operation of the Joint Fiscal Office.

5. Requests for services from legislators other than money committee members will be directed through the Joint Fiscal Committee chair or one of the money committee chairs. Requests for information or facts which do not require research may be addressed to the Joint Fiscal Officer.

6. Detailed analyses or studies which are contrary to established legislative, executive or judicial positions shall be subject to the approval of the Joint Fiscal Committee and/or the chair of the Joint Fiscal Committee.

7. The staff of the Joint Fiscal Office is encouraged to provide analyses and recommendations for improvements and/or alternatives to programs and appropriations for committee consideration.

8. Joint Fiscal Office personnel may serve on study or project task forces other than regular Joint Fiscal Committee work with the approval of the Joint Fiscal Committee or the Joint Fiscal committee chair. Work assignments may also be made as a result of legislation which authorizes or requires Joint Fiscal Office participation in studies and other projects.

9. Joint Fiscal Committee and Joint Fiscal Office records which are covered under the right-to-know statute shall be available to the public at reasonable times and locations upon request to the Joint Fiscal Officer.

10. Records, working papers, studies, and analyses which represent work in process for the Joint Fiscal Committee, the money committees, or individual legislator's services by the Joint Fiscal Office are not public documents and are not available for public inspection through the Joint Fiscal Office.

11. The Joint Fiscal Office shall develop a reasonably representative data base of information related to Joint Fiscal Committee interests and concerns. The information shall be maintained and made available to money committee members.

12. As part of its responsibilities under 2 V.S.A. 502 and 503, the Joint Fiscal Office produces fiscal notes on legislation, issue briefs covering general fiscal issues and a variety of fiscal reports. The Joint Fiscal Committee shall be considered the requesting party for these documents. The Joint Fiscal Committee authorizes the public release of all fiscal notes, issue briefs and fiscal reports produced by the Joint Fiscal Office, once completed and deemed ready for distribution by Joint Fiscal Office staff. [Paragraph 12 added by JFC 11/15/2012]

Title 32: Taxation and Finance

Chapter 1: General Provisions

5. Acceptance of grants

[Voted Revised 2/9/2011]

[Three further addendums from Acts 167, 142, and 179 in 2013]

§ 5. Acceptance of grants

(a) No original of any grant, gift, loan, or any sum of money or thing of value may be accepted by any agency, department, commission, board, or other part of state government except as follows:

(1) All such items must be submitted to the governor who shall send a copy of the approval or rejection to the joint fiscal committee through the joint fiscal office together with the following information with respect to said items:

(A) the source of the grant, gift or loan;

(B) the legal and referenced titles of the grant;

(C) the costs, direct and indirect, for the present and future years related to such a grant;

(D) the department and/or program which will utilize the grant;

(E) a brief statement of purpose;

(F) impact on existing programs if grant is not accepted.

(2) The governor's approval shall be final unless within 30 days of receipt of such information a member of the joint fiscal committee requests such grant be placed on the agenda of the joint fiscal committee, or, when the general assembly is in session, be held for legislative approval. In the event of such request, the grant shall not be accepted until approved by the joint fiscal committee or the legislature. The 30-day period may be reduced where expedited consideration is warranted in accordance with adopted joint fiscal committee policies. During the legislative session the joint fiscal committee shall file a notice with the house and senate clerks for publication in the respective calendars of any grant approval requests that are submitted by the administration.

(3)(A) This section shall not apply to the following items, provided that the acceptance of those items will not incur additional expense to the State or create an ongoing requirement for funds, services, or facilities:

(i) the acceptance of grants, gifts, donations, loans, or other things of value with a value of $5,000.00 or less;

(ii) the acceptance by the Department of Forests, Parks and Recreation of grants, gifts, donations, loans, or other things of value with a value of $15,000.00 or less; or

(iii) the acceptance by the Vermont Veterans' Home of grants, gifts, donations, loans, or other things of value with a value of $10,000.00 or less.

(B) The Secretary of Administration and Joint Fiscal Office shall be promptly notified of the source, value, and purpose of any items received under this subdivision. The Joint Fiscal Office shall report all such items to the Joint Fiscal Committee quarterly. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subdivision.

(4) With respect to acceptance of the original of a federal transportation earmark or of a discretionary federal grant for a transportation project, the provisions of subdivisions (a)(1) and (a)(2) shall apply, except that in addition:

(A) notification of the Governor's approval or rejection shall also be made to the Chairs of the House and Senate Committees on Transportation; and

(B) such grant or earmark shall be placed on the agenda, and shall be subject to the approval, of a committee comprising the Joint Fiscal Committee and the Chairs of the House and Senate Committees on Transportation, if one of the Chairs or a member of the Joint Fiscal Committee so requests.

(b) In accordance with subsection (a) of this section, in conjunction with a grant, a limited service position request for a position explicitly stated for a specific purpose in the grant, may be authorized. The position shall terminate with the expiration of the grant funding unless otherwise funded by an act of the general assembly. Such authorized limited service positions shall not be created until the appointing authority has certified to the joint fiscal committee that there exists equipment and housing for the positions or that funds are available to purchase equipment and housing for the positions. (Added 1971, No. 260 (Adj. Sess.), § 29(a); amended 1977, No. 247 (Adj. Sess.), § 186, eff. April 17, 1978; 1983, No. 253 (Adj. Sess.), § 248; 1995, No. 46, § 52; 1995, No. 63, § 277, eff. May 4, 1995; 1995, No. 178 (Adj. Sess.), § 416, eff. May 22, 1996; 1997, No. 2, § 72, eff. Feb. 12, 1997; 1997, No. 66 (Adj. Sess.), § 60, eff. Feb. 20, 1998; 2007, No. 65, § 394; 2009, No. 146 (Adj. Sess.), § B15; 2009, No. 156 (Adj. Sess.), § E.127.2, eff. June 3, 2010; 2013, No. 142 (Adj. Sess.), § 54; 2013, No. 167 (Adj. Sess.), § 17; 2013, No. 179 (Adj. Sess.), § E.342.7.)

Expedited Grant Review Policy

Under current law, 32 V.S.A. Sec. 5, the Joint Fiscal Committee has 30 days to review any "grant, gift, loan, or any sum of money or thing of value" to the State of Vermont that have been accepted by the Governor. Unless the Committee acts to place an item on its agenda, the grant is considered approved. When a grant is placed on the Joint Fiscal Committee agenda, approval is subject to a vote of the Committee.

Under limited circumstances, it may be necessary for the Joint Fiscal Committee to take action on an item in advance of the expiration of the 30 day review period. The Fiscal Year 2011 Appropriations Act, in Sec. E.127.2, amended current law to explicitly allow the Joint Fiscal Committee to establish a policy for expediting review of these requests. The following policy is set forth to allow the Joint Fiscal Committee to approve acceptance of an item prior to the end of the 30 day review period without necessitating a formal committee meeting.

Pursuant to 32 V.S.A. Sec. 5(a)(2), it is the policy of the Joint Fiscal Committee that the statutory 30 day review period may be waived, and the Governor's approval considered final, if members of the Joint Fiscal Committee agree to waive the balance of the review period.

The process for waiving the balance of the review period is as follows:

1. An agency or department, or a member of the General Assembly, must make a request for expedited consideration of an item to the Chair (or vice-chair) of the Joint Fiscal Committee.
2. The Chair of the Joint Fiscal Committee (or vice-chair) will decide whether or not to grant this request. If the request is granted, staff will be authorized to conduct a canvass of the Committee for the purpose of waiving the balance of the review period.
3. Staff shall canvass members via email, telephone, or mail, and maintain a record of all responses.
4. At least seven (7) affirmative responses to the request to waive the balance of the review period must be received. The review period shall not be waived in the event of an objection by any member of the Joint Fiscal Committee.

5. The Joint Fiscal Office shall notify the requesting agency or department of the result of this action.
6. A memorandum recording the waiving of a review period shall be placed on file at the Joint Fiscal Office.

Statutory Basis:

32 V.S.A. § 5(a)(2). Acceptance of grants

JOINT FISCAL OFFICE AND LEGISLATIVE COUNCIL

GUIDELINES RELATING TO INFORMATION REQUESTS FROM

POLITICAL CANDIDATES

Specifically identified documents, reports, research and bills which previously have been publicly released will be provided on request to political candidates and their staffs. The cost of copying may be charged if copying costs are incurred.

Neither office will undertake to find, identify, research, organize, assemble, or correlate general requests for documents and bills, even if they are publicly available. For example, a request for copies of "all the bills Senator X introduced," or "all the tax bills introduced in the House in 1989," will not be honored.

No new research will be undertaken on request of any candidate or candidate's staff; except that incumbent members who are candidates for reelection will continue to receive the assistance of either office in connection with their ongoing legislative responsibilities or the preparation of bills for introduction in the regular session.

Memoranda, correspondence, and other information materials prepared specifically for individual members will not be provided, even if they have been circulated by the individual member who requested and received them. Candidates making such requests will be referred to those members.

Voting records will not be researched or released, even the vote of a single member on a single bill. Candidates making such requests will be referred to the Journals of the House and Senate.

JOINT FISCAL OFFICE AND THE OFFICE OF LEGISLATIVE COUNCIL

POLICY REGARDING PARTISAN OR POLITICAL REQUESTS FOR ASSISTANCE

The Vermont General Assembly relies upon its professional staff to provide high quality and nonpartisan information and analysis. Legislators need to be confident that the staff person they entrust with their research or drafting request is free from political or partisan bias.

Employees of the Joint Fiscal Office and the Office of Legislative Council shall refrain from participating in any activity that could compromise their ability to do their job in a non-partisan manner. Neither office will undertake research that is for an explicit or direct use in a political campaign. Incumbent members running for office will continue to receive the assistance of both offices in connection with their ongoing legislative responsibilities.

Employees should consult with their supervisor if they believe they are being asked to do work that may violate this policy.

[added: 2014]

JOINT FISCAL COMMITTEE

PERSONNEL POLICIES

It is the policy of the Joint Fiscal Committee that Joint Fiscal Office staff be accorded fringe benefits comparable to those provided to classified employees in the biennial Agreements between the State of Vermont and the Vermont State Employees Association, Inc.

It is the policy of the Joint Fiscal Committee that Joint Fiscal Office staff be accorded annual salary adjustments comparable to that provided to exempt employees of the Executive Branch of Government.
[Provision added by JFC 07/21/94]

Notwithstanding the foregoing, hiring, retention and compensation of the Joint Fiscal Office staff are a function of the Joint Fiscal Committee.

POLICY ON SEXUAL HARASSMENT

The Joint Fiscal Committee endorses, to cover the Joint Fiscal Office staff, the statewide sexual harassment policy applicable to all State of Vermont employees, as set forth in Section 3.1 of the State of Vermont Personnel Policies and Procedures, effective March 1, 1996 and currently applicable (January 2008).