DEPARTMENT OF VERMONT HEALTH ACCESS

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

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MESSAGE FROM THE COMMISSIONER

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

Adoption of Value-Based Payments

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

Management of Information Technology Projects

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

Operational Performance Improvement

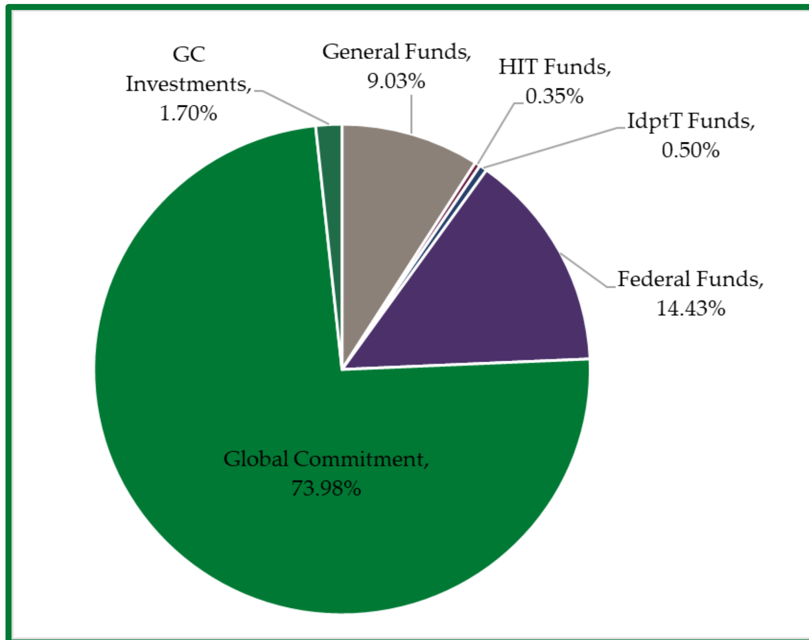
The Department has focused on business efficiencies for improving the way Medicaid members and providers are served and has implemented Scorecards for performance metric tracking as part of its system for strategic management. Each of the Department's units are responsible for assessing performance on identified measures that are aligned with the core responsibilities of enrolling members, paying for care, and promoting health. The performance measures are used to drive decision making and the pursuit of better customer service, a higher quality of care, and operational efficiencies. Targeted performance improvement projects have resulted in numerous operational and financial efficiencies; for example, reduced call center contract costs, improvements in subrecipient grant monitoring, a lean procurement process (Rapid Agile Procurement), improved processes for Early and Periodic Screening, Diagnostic, and Treatment services, Vermont Chronic Care Initiative model evolution, and a reduction in audit findings.

SFY 2021 Governor's Budget Recommendation

Agency of Human Services,
Department of Vermont Health Access

MISSION:

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



SFY 2021 SUMMARY & HIGHLIGHTS

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

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

DVHA BUDGET RECOMMENDATION CHANGES FROM AS PASSED

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

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

Budget Summary Administration

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

Budget Summary Program

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

Budget Summary Total

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

BUDGET CONSIDERATIONS: ADMINISTRATION B.306

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

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

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

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

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

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

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

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

The Department has focused on business efficiencies for improving the way Medicaid members and providers are served and has implemented Scorecards for performance metric tracking as part of its system for strategic management. The Departmental units are responsible for assessing

performance on identified measures that are aligned with the core responsibilities of enrolling members, paying for care, and promoting health. The performance measures are used to drive decision making and the pursuit of better customer service, a higher quality of care, and operational efficiencies. Targeted performance improvement projects have resulted in numerous operational and financial efficiencies and reduced call center contract costs as we improve the call scripting and call escalation process which has led to a gradual, yet sustained, decrease in call times. The anticipated spend for SFY 2020 is approximate $7M as compared to SFY 2017, $9M.

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

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

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

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

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

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

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

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

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

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

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

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

Transfer Management of Funds from AHS
(Agency Net Neutral)

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

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

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

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

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

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

BUDGET CONSIDERATIONS: PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Taking advantage of supplemental drug rebates for HIV- and AIDS-related medications (supplemental drug rebates are not available absent a Preferred Drug List and are thus not currently being collected by the State of Vermont for this therapeutic class of medications).

B. Preferring lower-cost drugs over high cost, non-preferred drugs with equal clinical efficacy, no effect on the frequency of dosing for patients, and minimal impact on "pill burden."

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

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

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

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

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

The federal government allows for states to use Medicaid dollars to "buy-in" to Medicare on behalf of dually eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload and member month costs vary from year to year. This change incorporates a rate increase and trend in member months. DVHA experienced an increase to Buy-In enrollment as a result of progress correcting and updating the eligibility files exchanged between CMS and DVHA.
The Medicare Buy-In Programs help people with low income pay their Medicare premium. There are three distinct Buy-in programs and each has different eligibility requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Budget by Eligibility Group Pullout

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

Budget by Eligibility Group Funding Pullout

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

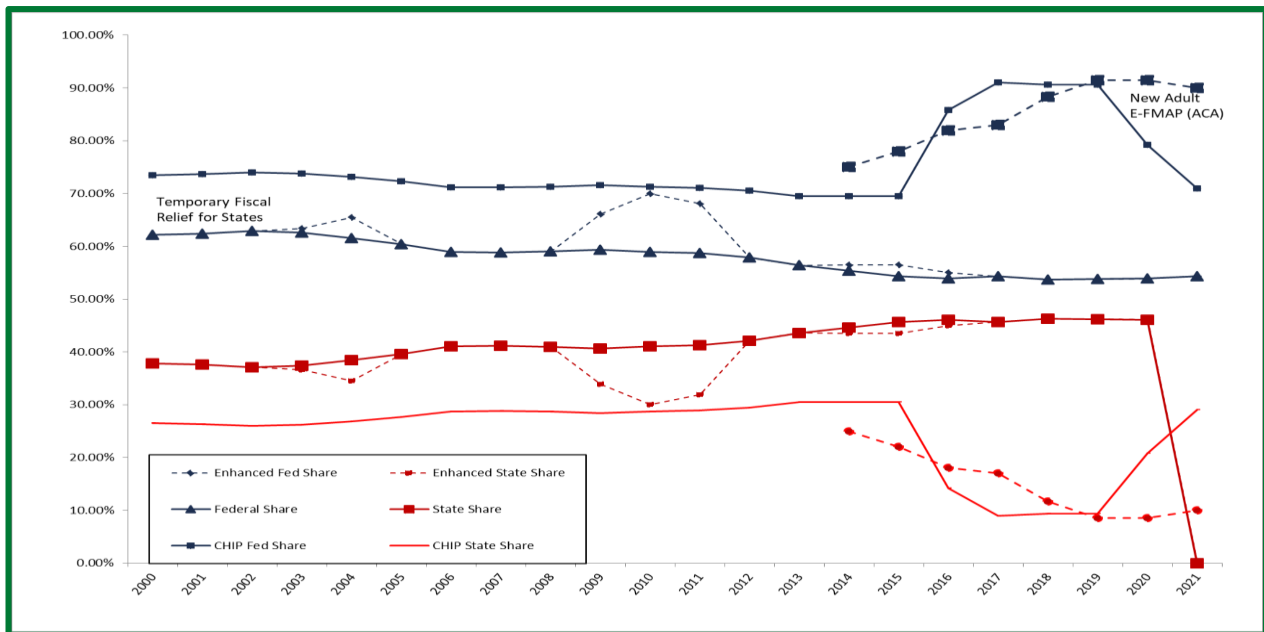
CATEGORIES OF SERVICE

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

Federal Medicaid Assistance Percentage (FMAP)

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

Vermont Medicaid & CHIP, SFY 2000 - 2021



Vermont Medicaid & CHIP Detail, SFY 2019 – 2021

FEDERAL MATCH RATES
Fiscal Years 2019 to 2021

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

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

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

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

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

Program Profile Reporting A1

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

Program Profile Reporting A1 Cont.

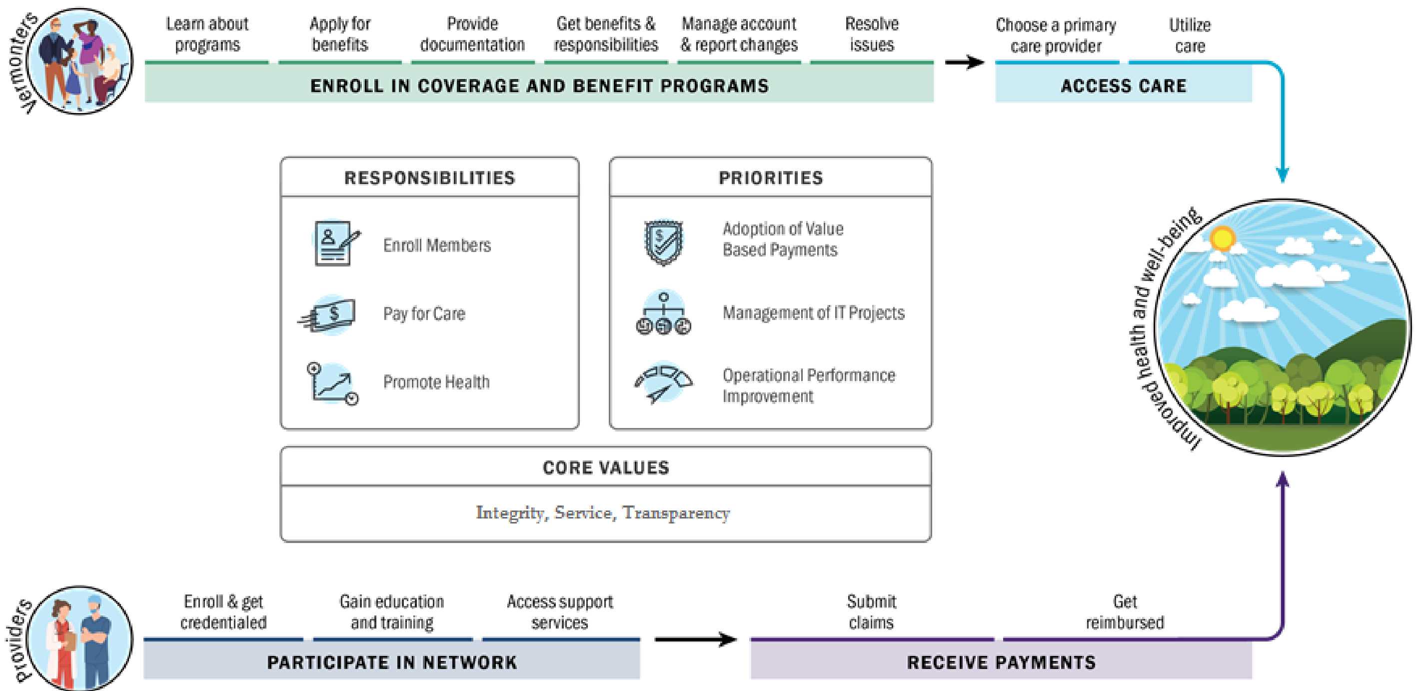
Department of Vermont Health Access		Financial Info					
Programs	**Financial Category**	**GF $$**	**Spec F (incl tobacco) $$**	**Fed F $$**	**All other funds $$**	**Total funds $$**	**Authorized Positions (if available)**
Medicaid Inpatient Psychiatric and Detoxification Utilization							
- Average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

Program Profile Reporting A1 Cont.

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

INTRODUCTION TO DVHA

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



About Us

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

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

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

- **Commercial** health insurance plans are offered by private insurance companies like BlueCross BlueShield of Vermont and MVP® Health Care. Qualified Health Plans offered by BlueCross BlueShield and MVP® in Vermont are certified by the Department of Vermont Health Access. An insurance plan that is certified provides essential health benefits, follows established limits on deductibles, copayments and out-of-pocket maximum amounts, and meets other requirements of the Affordable Care Act.

Our Mission and Responsibilities

When we say our mission is "to improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively," we are really saying that we are striving to do multiple things. First, we are saying what we're trying to do: to improve the health and well-being of Vermonters. Second, we're saying how we're trying to do it: by providing access to quality health care. But that's not all. We're committing to do so cost-effectively. In other words, we are conscious that we are accountable to our members, providers and to taxpayers.

To achieve this mission, our work revolves around three core responsibilities:

1) We engage Vermonters in need to **enroll as members** in appropriate programs. This work is represented by the "Vermonters" path in the diagram above.
2) We **pay for their care**. This work of building, and collaborating with, a robust network of health care providers, pharmacies, and other partners is represented in the "Providers" path above.
3) We recognize that simply signing up thousands of people and paying thousands of invoices will not achieve optimal outcomes at the most efficient cost, so we strategically invest in programs that **promote health**. This work is central to our commitment to quality and improvement.

Our Priorities

Our commitment to continual improvement is not limited to external health outcomes. When we look for opportunities to improve internally – in the way we carry out our responsibilities – three priorities emerge: **adoption of value-based payments, management of information technology projects, and operational performance improvement**. If we successfully execute these priorities, we will be well positioned to deliver on the triple aim of improving patient experience of care, improving population health, and reducing per capita cost growth. Our department is comprised of 20 functional units, every one of which works on one or more of our responsibilities and contributes to one or more of our priorities.

Our Values

Our department commits to executing our responsibilities and priorities while adhering to three core values:

1) **Transparency** – We trust that we will achieve our collective goals most efficiently if we communicate the good, the bad, and the ugly with our partners and stakeholders.
2) **Integrity** – In the words of psychologist Brené Brown, we commit to "choosing courage over comfort … choosing what is right over what is fun, fast, or easy…. choosing to practice [our] values rather than simply professing them."
3) **Service** – Everything we do is funded by taxpayers to serve Vermonters. Therefore, we must ensure that our processes and policies are person-centered. We aim to model, drive, and support the integration of person-centered principles throughout our organizational culture.

These values guide our pursuit of the above responsibilities, priorities, and mission. We are committed to innovation and collaboration. We are not tied to any one way of carrying out our charges. We approach opportunities to manage Medicaid costs differently with an open mind and a commitment to do right by Medicaid members, providers and Vermont taxpayers. We recognize that the success of our initiatives is dependent on strong working relationships with other state agencies, federal and local governments, and community partners.

ACCOMPLISHMENTS

The Department of Vermont Health Access (DVHA) strives to fulfill its responsibilities to members, providers and taxpayers while making progress on its three priorities: adoption of value-based payments, management of information technology projects, and operational performance improvement. This section offers highlights of some of the past year's accomplishments.

ADOPTION OF VALUE-BASED PAYMENTS

DVHA has continued to advance value-based payments through implementing payment reform processes to guide future reforms through the Medicaid Delivery System Reform Work, successfully completing and evaluating the second full year of the Accountable Care Organization (ACO) program and initiating the third year and expanding payment reforms across an array of services.

Implementing Medicaid Delivery System Reform Work

Section 12 of Act 113 of 2016 requires the Secretary of the Agency of Human Services to embark upon a multi-year process of payment and delivery system reform for Medicaid providers aligned with the Vermont All-Payer ACO Model and other existing payment and delivery system reform initiatives. In 2019, DVHA published the Medicaid Delivery System Reform (2018) report to demystify payment and delivery system reform by describing the process and ongoing efforts that occur within AHS and with

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

- Medicaid payments to affected providers;
- changes to reimbursement methodology and the services impacted;
- efforts to integrate affected providers into the All-Payer Model and with other payment and delivery system reform initiatives;
- changes to quality measure collection and identifying alignment efforts and analyses, if any; and
- the interrelationship of results-based accountability initiatives with the quality measures referenced above.

The following payment and delivery system reform initiatives were either completed or in-progress in 2019:

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

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

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

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

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

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

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

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

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

2. **Reduced Provider Administrative Burden**

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

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

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

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

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

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

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

Implementing and Analyzing Applied Behavior Analysis Payment Reform

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

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

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

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

Designing and Developing Developmental Disabilities Services Payment Model Options

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

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

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

MANAGEMENT OF INFORMATION TECHNOLOGY PROJECTS

Effective, secure, and reliable technology is required for the Agency of Human Services (AHS) to administer Vermont's Medicaid program efficiently, with financial integrity, and in compliance with federal and state law. Implementing technology that meets these objectives and does so on time and on budget has been a challenge in Vermont, with the most public example being Vermont Health Connect. DVHA learned difficult lessons from that experience and has worked over the past two years to apply these learnings in a manner that will improve the chances of success on future projects.

DVHA is currently engaged in two large scale IT projects, the Medicaid Management Information System (MMIS) and the Integrated Eligibility & Enrollment (IE&E) program, both of which are designed to replace outdated and poorly performing technology and improve the experience of applicants/enrollees, staff, and providers. DVHA is taking a modular approach to these projects, which means improvements will be delivered incrementally over time. Breaking these projects up into smaller pieces and parts reduces financial risk to the State, allows for the delivery of more frequent business value, and will result in the implementation of a system that is more flexible and able to adapt to regulatory changes, technological innovation, and consumer expectations.

Implementing the Provider Management Module

In order to increase the number of providers participating in the Vermont Medicaid Program and improve the provider experience, the Department needed to develop the capacity to complete the screening and enrollment process within 60 calendar days. Under the Medicaid Management Information System team, the new online Provider Management Module was implemented on May 1st, 2019 on schedule, ahead of the date required by Act 116 of 2018 and continues to demonstrate significant efficiencies for enrolling providers to participate with Vermont Medicaid.[3] The launch of the new online Provider Management Module has significantly reduced the average time to enroll providers. Between May 1st and June 30th, 2019, Vermont Medicaid enrolled 987 providers as compared to the same time frame in 2018 during which 433 providers were enrolled. The average time to enroll a provider in May and June 2019 was 15 days, as compared to 63 days for the same period in 2018. In 2018, there were 9 DXC Enterprise Services (DVHA's fiscal agent) staff and 2 State of Vermont staff completing provider enrollments. For the same time period in 2019, Provider Management Module implementation resulted in an average of 7 DXC staff completing provider enrollments. A survey was conducted in early August 2019 to gauge satisfaction of the provider

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

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

Receiving CMS Certification for the Care Management System

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

Migrating to an Electronic Prior Authorization Process

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

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

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

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

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

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

Implementing an Integrated Health Care Paper Application

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

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

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

Launching the Customer Portal Phase 1 (Document Uploader)

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

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

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

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

Launching an Electronic Payer Initiated Eligibility Matching Process

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

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

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

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

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

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

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

Returning Premium Processing to Insurance Carriers

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

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

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

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

OPERATIONAL PERFORMANCE IMPROVEMENT

The Department of Vermont Health Access is committed to continual improvement. The Department's core values of transparency, integrity, and service call upon all staff to identify opportunities within their sphere of influence to improve the way Medicaid members and Vermont taxpayers are served. In addition to striving for business efficiencies, the Department has implemented results-based accountability (RBA) principles and tools to provide structure to the organization's commitment. Along with other departments in the Agency of Human Services, the Department of Vermont Health Access uses RBA-based strategy management, the Clear Impact Scorecard, and collaboration support software to facilitate project management, data charting and public communication of results.

Identifying Efficiencies in Maximus Contract Management

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

Improving Subrecipient Grant Monitoring

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

Transitioning to a Lean Procurement Process - Rapid Agile Procurement

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

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

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

Evolving the Vermont Chronic Care Initiative Model

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

Data Management & Analysis to Support Advancing Care Coordination

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

Reducing Audit Findings

The Oversight and Monitoring unit within DVHA ensures effectiveness and efficiency of departmental operational processes, reporting, controls, and alignment with applicable laws and regulations. In order to support the strategic direction of the Department, this unit was created to proactively evaluate departmental units for audit readiness and to facilitate and consult on reviews and audits to improve the Department's operational performance and establish professional

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

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

Achieving Compliance with Federal Regulatory Requirements for Vermont's State-Based Health Insurance Exchange

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

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

submissions. A notification of no outstanding action items demonstrates the Department's commitment to compliance with regulatory requirements for operation of Vermont Health Connect. Annually, the Department is required by CMS and CMS' Center for Consumer Information and Insurance Oversight (CCIIO) to provide financial and operational documents via the State-based Marketplace Annual Reporting Tool (SMART). CMS uses the SMART submission, in conjunction with ongoing monitoring activities and readiness reviews, to document the compliance of Vermont's state-based exchange with regulatory requirements and to identify observations and potential action items.

Automatically Renewing Nearly All Qualified Health Plan Members

The first step in the renewal effort involves determining eligibility for the coming year's state and federal subsidies and enrolling members in new comparable versions of their health and/or dental plans. In October 2019, this step was operated with a single, clean, automated run that took care of 99% of eligible cases for the second year in a row, up from 97.8% in 2017 and 91.5% in 2016. The small number of remaining cases were processed by staff the following day. For Vermonters, this means that they are able to log into their online accounts on the very first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they choose to do so.

Supporting the Assister Program to Improve Service Provided to Vermonters

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

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

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

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

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

Effectively Managing the Pharmacy Benefit and Pharmaceutical Spend

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

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

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[11] https://dvha.vermont.gov/global-commitment-to-health/vt-ahs-qe0619-gc-quarterly-report-final-w-attachments.pdf
[12] https://legislature.vermont.gov/assets/Legislative-Reports/2018_Blueprint_for_Health_Annual_Report_final.pdf

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

Strategically Managing Departmental Activities

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

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

APPENDIX A: PERFORMANCE ACCOUNTABILITY SCORECARDS

1. ENROLL MEMBERS

Health Access Eligibility & Enrollment Unit

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

THE TOP PRIORITIES/INITIATIVES FOR HAEEU IN SFY19 WERE:

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

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

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

BUSINESS INSIGHTS FOR SFY19:

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

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

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

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

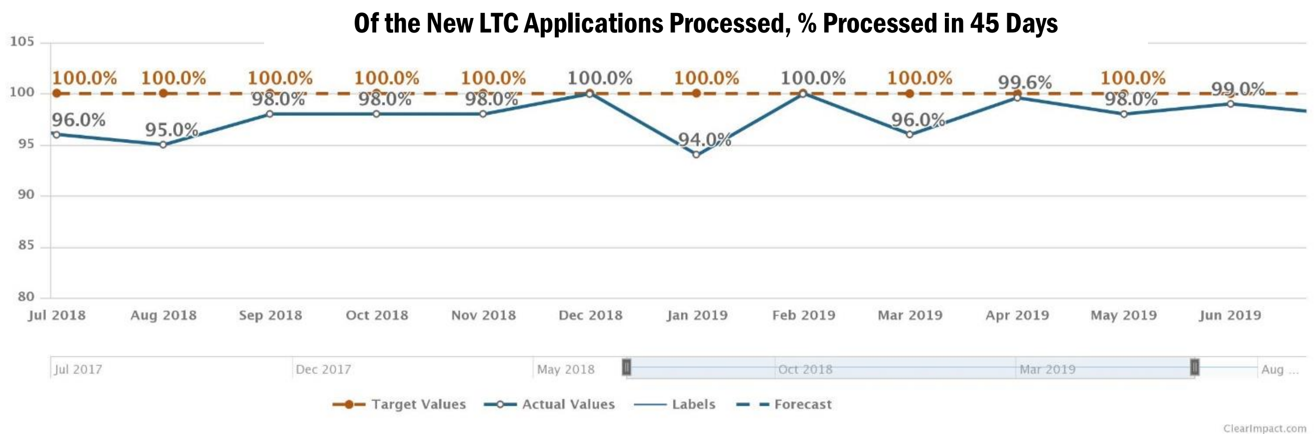
Long-Term Care Unit

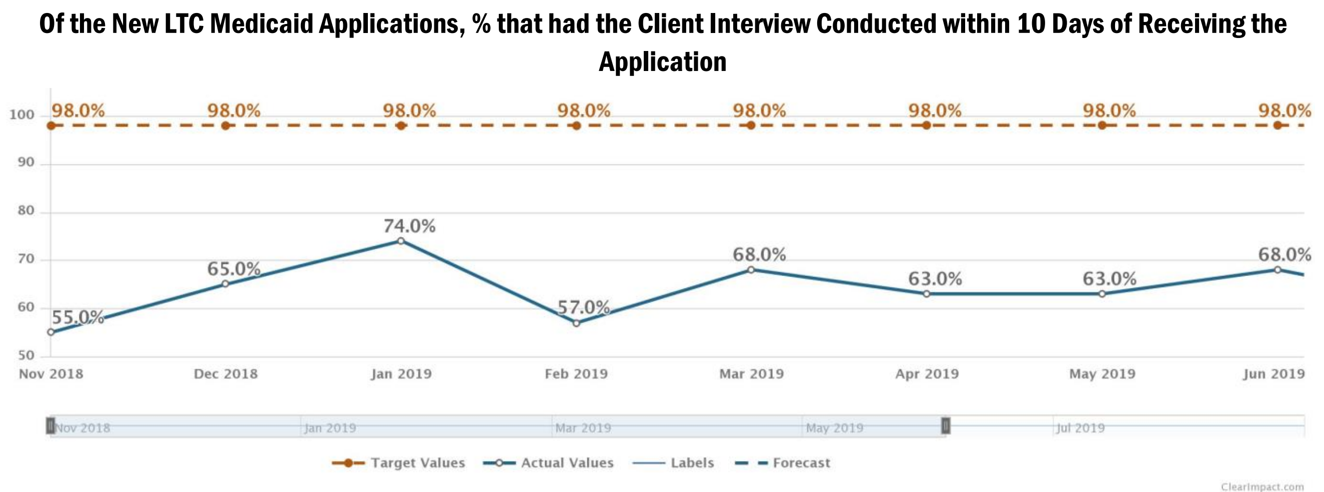
Vermont's Long-Term Care program includes Choices for Care, Developmental Disability Services, Developmental Disability Home- and Community-based Services, Traumatic Brain Injury, and Enhanced Family Treatment. The Long-Term Care unit assists eligible Vermonters with accessing services in their chosen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

THE TOP PRIORITIES/INITIATIVES FOR LTC IN SFY19 WERE:

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

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





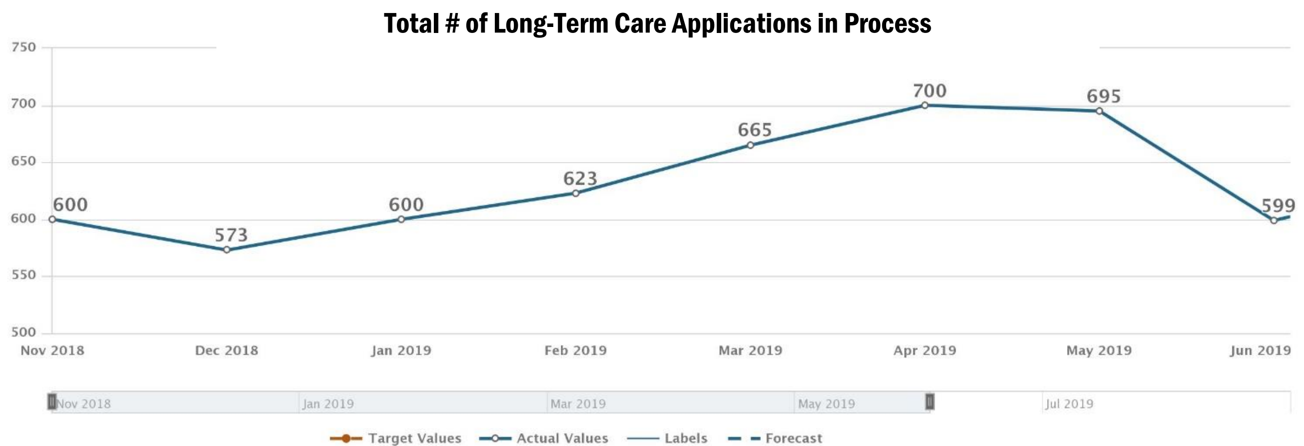
BUSINESS INSIGHTS FOR SFY19:

Accomplishments

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

Challenges

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



Pharmacy Unit

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

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

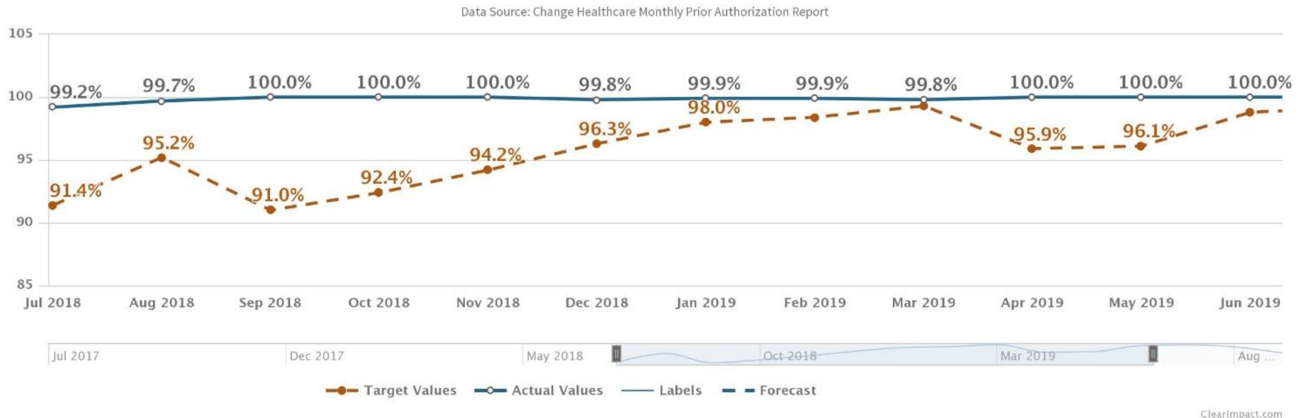
1) Continue to manage high cost medications to encourage use of the most clinically appropriate drugs with the highest value for DVHA in the most efficient manner possible.
2) Promote value-based pharmacy programs such as Vermont pharmacists providing medication management services to DVHA members.
3)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

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

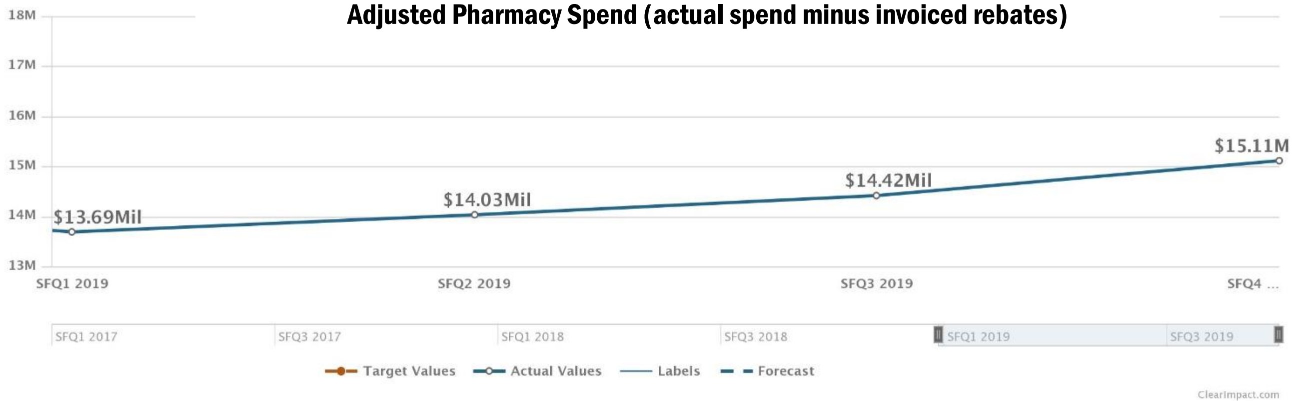
BUSINESS INSIGHTS FOR SFY19:

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

% of Pharmacy Prior Authorizations Processed within 4 and 24 Hours



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



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

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Provider Member Relations

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

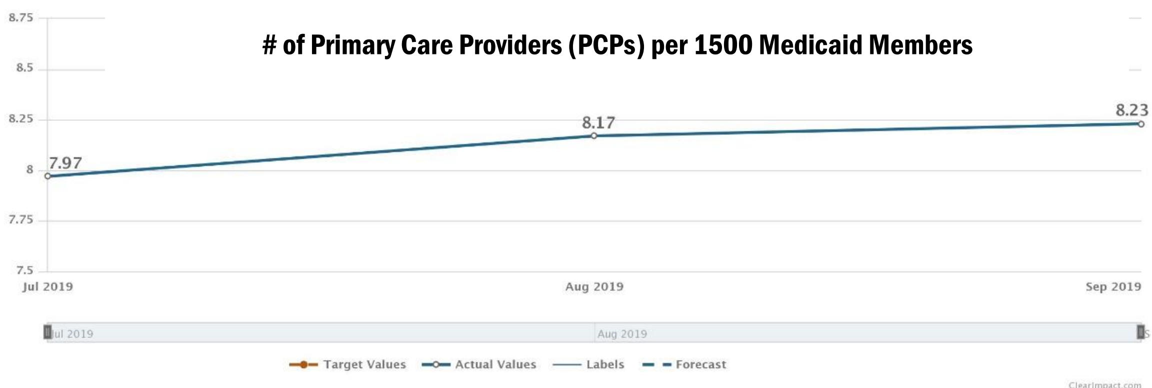
THE TOP PRIORITIES/INITIATIVES FOR THE PMR UNIT IN SFY19 WERE:

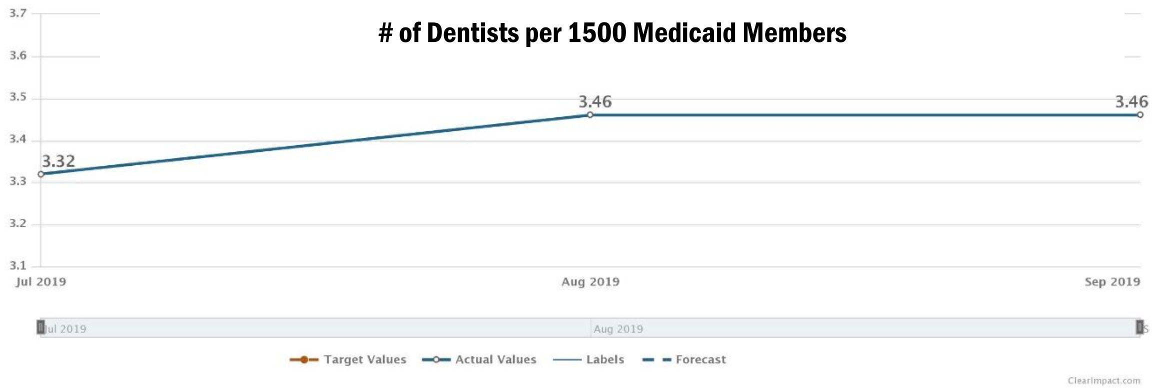
1) PMR is actively working on a Provider Management Module to ensure providers are enrolled or re-validated with Vermont Medicaid within 60 days.
2) PMR is actively working with the NEMT to ensure members are receiving all services afforded to them under the program by performing audits and collaborating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

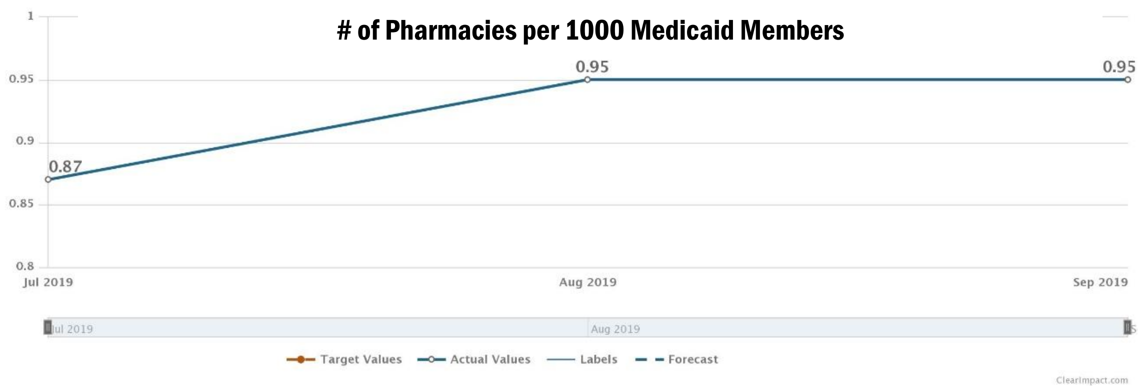
To see what we do, who we serve, how we impact, and our performance measures, see PMR's Section of the DVHA Performance Accountability Scorecard.

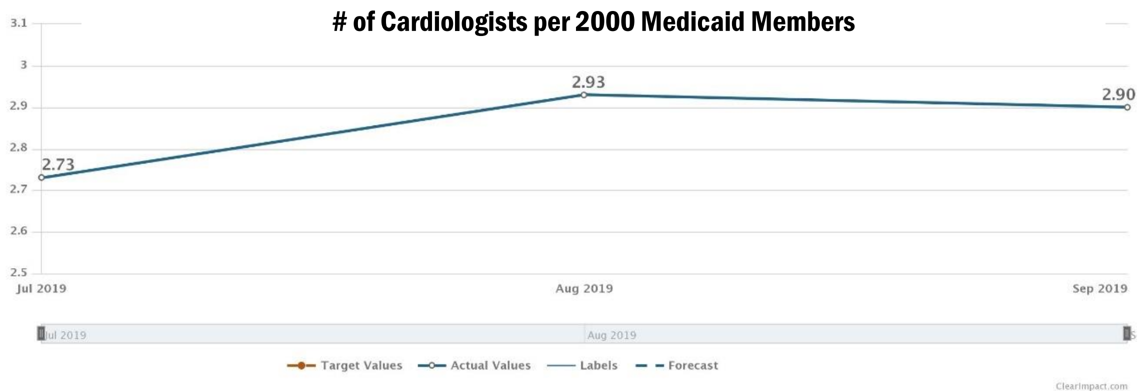
BUSINESS INSIGHTS FOR SFY19:

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




# of Dentists per 1500 Medicaid Members
3.7
3.6
3.5
3.4
3.3
3.2
3.1
3.32
3.46
3.46
Jul 2019
Aug 2019
Sep 2019
Target Values
Actual Values
Labels
Forecast
ClearImpact.com


# of Pharmacies per 1000 Medicaid Members
1
0.95
0.9
0.85
0.8
0.87
0.95
0.95
Jul 2019
Aug 2019
Sep 2019
Target Values
Actual Values
Labels
Forecast
ClearImpact.com


# of Cardiologists per 2000 Medicaid Members
3.1
3
2.9
2.8
2.7
2.6
2.5
2.73
2.93
2.90
Jul 2019
Aug 2019
Sep 2019
Target Values
Actual Values
Labels
Forecast
ClearImpact.com