Governor's Recommended Budget: SFY 2025

Budget Narrative

DVHA's Mission: Improve Vermonters' health and well-being by providing access to high-quality, cost-effective health care.

SFY 2025 Summary: DVHA's state SFY2025 budget request is summarized below. In total for the Department across all funds and all appropriations this results in a total decrease of **-$28,102,727.**

ADMINISTRATION

1. Staffing Budget . . . . . **$3,097,182 GROSS /$1,534,161 GF**

The FY25 staffing budget reflects 378 positions, and six ongoing temporary positions. The figures below reflect all Pay Act and reclass related salary changes; all benefit cost changes including health care and retirement; as well as the new childcare and FMLI assessments. Also reflected is higher recruitment and retention, as our vacancy level is roughly half what was estimated last year. The staffing budget also reflects two net neutral transfers of positions between DVHA and the AHS Central Office. First, the Medicaid Policy Unit is moving to AHS. Second, three Quality positions transferred to DVHA.

Appropriation	GROSS	GF
Salary	1,229,157	845,358
Benefits	906,281	521,599
New Childcare and FMLI	190,022	80,630
Temporary positions	220,000	85,000
Lower vacancy level	1,249,056	252,308
Subtotal Staffing changes	3,794,516	1,784,895
Policy Unit to AHS	-1,030,670	-509,720
Quality Positions from AHS	333,336	166,668
Total Staffing Changes	**3,097,182**	**1,441,843**

2. Operating Expenses and ISFs. . . . . **-$236,694 GROSS /-$79,156 GF**

This reflects the changes in costs we pay to state Internal Service Funds or ISFs. These are charges levied by other departments for shared support services and overhead allocation changes. Also reflected here is the share of operating expenses associated with the Medicaid Policy Unit. Like the staffing cost, these funds are also moving to the AHS Central Office.

Appropriation	GROSS	GF
All Internal Service Funds	-126,269	-24,540
Operating Expenses – Policy Unit move	-110,425	-54,616

Total Change	**-236,694**	**-79,156**

3. **Contracts – Technical Adjustment** . . . . . **-$4,720,746 GROSS / $2,903,711 GF**

DVHA typically has 75 to 90 contract and grant agreements active, we also manage 25 to 40 significant RFP and contract amendment processes annually. This adjustment is the result of review of the budgeted amounts by funding source for DVHA contracts over the past several years as well as the actual total contract expenditure in FY23 by funding source. While the total budgeted amount for contracts has increased, the GF appropriation for contracts remained flat from FY21 through FY24. Actual FY23 GF need was over this level by $2.9m. To close SFY23, funds were transferred to the DVHA administration budget, and some contract payments were pushed into FY24. Examples of specific contracts that have increased significantly in this 3-year period are Archetype (67% small base) Maximus and Change Healthcare Rx (26% mid base) and Gainwell M&O (11% large base). At the same time federal funds have been over appropriated as project timing was not always recalibrated, updated timing is now included for federal funds for pending projects.

4. **Administration Grants – Technical Adjustment** . . . . . **$200,000 GROSS/ $0 GF**

An adjustment to the federal funds spending authority is needed for the portion of the HIE project that is administered as a grant.

PROGRAM

The programmatic changes in DVHA's budget are spread across three different budget lines Global Commitment, State Only, and Medicaid Matched Non-Waiver consistent with specific populations and/or services. The descriptions of these changes are similar across these populations and have been consolidated within this narrative. However, the items are repeated for each population in the Ups/Downs document. DVHA has numerically cross-walked the changes listed below to the Ups/Downs and has included an appropriation-level breakdown table whenever an item is referenced more than once in the Ups/Downs document.

5. **Caseload & Utilization Changes** . . . . . **-$52,493,310 GROSS / -$6,464,536 GF**

Appropriation	GROSS	GF
B.307 Global Commitment	-53,717,150	-7,971,846
B.309 State Only	1,633,538	1,633,538
B.310 Non-Waiver	-409,698	-126,288
Total Changes	**-52,493,310**	**-6,464,536**

The most recent Medicaid Consensus Forecast projects the annualized impact of the unwinding initiative. This is the resumption of annual redeterminations for Medicaid eligibility after the ending of the three-year pandemic suspension of most redeterminations. This covers all the Medicaid Eligibility Groups (MEGs) as well as the SCHIP, VPharm, Vermont Cost Sharing Reduction and Dr. D Expansion populations. Redeterminations began in April 2023. We anticipate the post-pandemic initial redetermination cycle to

complete in the first quarter of FY25 with a normal annual redetermination process in place thereafter.

The Medicaid Consensus Forecast is a collaborative process for estimating caseload and utilization. Annually, DVHA works collaboratively with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services as part of the State's Consensus Revenue Forecasting process to 1) present the steady state caseload and expenditure forecast for adoption by the Emergency Board in January, and 2) assist with the Medicaid Year End Report presented by JFO to Emergency Board in July.

Please note the impact of the redeterminations make the projection of caseloads and PMPM estimates particularly challenging for the current budget cycle. All budget estimates are imperfect, but the margin of error and ensuing budgetary risk is much higher than usual.

6. **Medicare Buy-In and MSP** . . . . . **$6,987,410 GROSS / $2,616,352 GF**

Appropriation	GROSS	GF
B.307 Global Commitment	6,202,028	2,615,395
B.309 State Only	2,268	956
B.310 Non-Waiver	783,114	0
Total Changes	**6,987,410**	**2,616,352**

The federal government allows states to use Medicaid dollars to "buy-in" dually eligible beneficiaries to Medicare and to offer Medicare Savings Programs (MSPs) for income eligible individuals. These are individuals who might otherwise forgo Medicare due to cost. This caseload sees gradual increases consistent with the aging Vermont population. The member month "buy-in" costs are determined at the federal level and tied to annual Medicare financing calculations. This reflects the annualized value of the premium rate changes effective January 2024.

7. **Annual Medicare Part D Clawback**. . . . . **.$3,059,074 GF**

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 and required these people to receive their drug coverage through a Medicare Part D plan. This change reduced state costs. However, the 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. This reflects the fully annualized impact for the most recent federal guidance increasing state Clawback payments to the CMS.

8. **Net Neutral - Family Planning Services**. . . . . **$635,442 GROSS/$0 GF**

Effective on July 1, 2023, DVHA began paying for family planning services via our MMIS system. These services were previously paid for by VDH. This is a net neutral move of funding from VDH to DVHA and this expenditure remains a GC waiver investment. This is the same adjustment reflected in the BAA.

9. **Net Neutral – Safety Net Investments** . . . . . **$240,000 GROSS/$0 GF**

Safety net payments are for services made on behalf of unenrolled, uninsured or underinsured populations and should be under the GC waiver investment provision. This adjustment places these expenditures in the correct State Only budget; they had been incorrectly lodged in the regular Medicaid GC program appropriation. This is the same adjustment reflected in the BAA.

10. **Breast Pump Supplies** . . . . . **$164,000 GROSS/$69,159 GF**

Breast pumps have always been covered but the supplies, primarily storage baggies, have not been covered. Effective January 1, 2024, Vermont has come into alignment with the HRSA recommendations and CMS guidelines in support of nursing mothers. These supplies are now covered. This is the fully annualized cost estimate of this change.

11. **FQHC and RHC 4.6% MEI Adjustment** . . . . . **$2,260,000 GROSS/$953,042 GF**

The funding is to increase the payments to Federally Qualified Health Centers and Rural Health Clinics by the Medicare Economic Index (MEI) which is a measure of practice cost inflation that Vermont applies to the existing FQHC and RHC payments annually. This is the fully annualized cost estimate of this change.

12. **Hospice Rates** . . . . . **$50,000 GROSS/$21,085 GF**

This is the estimated amount to bring Medicaid hospice rates into compliance with CMS minimums for state Medicaid programs to pay for these services. The rate increase was instituted effective January 1, 2024. This is the fully annualized cost estimate of this change.

13. **Brattleboro Retreat - Patient Mix**. . . . . **$0 GROSS/$2,464,683 GF**

The total amount of Retreat funding is not changing, but $4,396,308 is moving from the GC appropriation to the State Only appropriation, however this is not net neutral. Whether the stay of a patient at the Retreat is payable under Medicaid is related to the services and length of stay. Forensic patients, CRT only beneficiaries and patients staying longer than 60-days fall under the IMD restrictions and are not eligible for Medicaid. These patients need to be funded with state General Funds if they do not have other coverage. Substance use disorder and stabilization treatment services provided for stays less than 60 days are

Medicaid eligible. The fiscal impact reflects the federal funds that cannot be drawn due to patient mix. This is the same adjustment reflected in the BAA.

14. **Childcare Payroll Tax – Children's PCS** . . . . . **$15,956 GROSS/ $6,729 GF**

This reflects the impact of the new Childcare Payroll Tax which begins July 1, 2024 on the Children's Personal Care Services program.

15. **Graduate Medical Education (GME)**. . . . . **$7,146,928 GROSS/ $0 GF**

DVHA is seeking Global Commitment spending authority to increase the annual GME amount from $51.2 million to $58.4 million which is the full amount of GME payment potential demonstrated by the approved calculation methodology. This proposed funding mechanism does not require additional General Fund dollars. A more detailed summary of the GME program is provided in the DVHA Budget Book.

16. **Border Hospital Rate Increase** . . . . . **$2,175,000 GROSS/ $917,198 GF**

Intended to ensure that the rate of pay to out of state hospitals ten miles from the border will increase as a percentage of rate paid to in-state hospitals.

17. **Psychiatric Residential Treatment Facility** . . . **$3,557,031 GROSS/ $1,500,000 GF**

AHS issued an RFP for Psychiatric Residential Treatment Facility (PRTF) services in the spring of 2023. A PRTF is a provider of inpatient psychiatric services who has a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21.

DMH and DCF are currently leading the process of contract development with oversight from AHS and technical assistance from DVHA. This should result in instate capacity of 15-16 PRTF beds available to meet the needs of youth in the custody of DMH, DCF and DDAIL that require this level of care and treatment. Specific programmatic questions about this initiative are best directed to the other departments.

DVHA will process the claims for payment once the agreement is executed and the program is in place. This represents an estimate for a partial year of expenditure and may require mid-year adjustment depending on the actual start date and how quickly the program will be able to scale to capacity.

ONE TIME APPROPRIATION

18. **Global Payment Program** . . . . . **$9,279,583 GROSS/ $3,913,200 GF**

The CY 2024 contract with OneCare Vermont allows for the implementation of a new pilot program. Currently, DVHA is able to internally support a very modest pilot program open to

ACO-participating independent primary care practices. This funding would allow up to 5 hospitals to participate in this program in the second half of calendar year 2024. For any entity voluntarily participating in this pilot, one-time resources are needed to cover the cash flow budget impact due to the timing difference of the runout of claims incurred prior to the start of a GPP prospective payment.

Pilot Program: A voluntary payment model to issue separate “global” monthly prospective payments to current hospital and independent primary care participants in the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program who opt into this program. Prospective payments for the GPP will be reconciled to actual fee-for-service (FFS) experience using Medicaid claims data at the end of the performance year. GPP payments would be for Vermont Medicaid members not attributed to the ACO through the VMNG program receiving services comparable to VMNG “Total Cost of Care” services from GPP-participating provider organizations.

- Participation in the GPP would give participants an opportunity to convert a significant portion of their remaining Medicaid FFS revenue into fixed payments in a no-risk model, allowing them to test global budget participation for one payer before it was potentially a requirement for multiple payers.
- A model that reconciles to FFS is not the longer-term model design but would mitigate potential financial exposure for both the state and participating providers at the outset, making this a low-risk steppingstone toward global budgets.
- Implementing the GPP for a small number of “early adopters” will give Vermont early experience as we await additional details about the CMMI AHEAD model, which will help Vermont determine if this is a model for which the state will apply.