VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

GOVERNOR'S BUDGET RECOMMENDATION: SFY 2024 BAA

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

SFY 2024 BAA Summary: DVHA's state SFY2024 budget adjustment request is summarized below. In total for the Department across all funds and all appropriations this results in a total decrease of -$1,683,714.

ADMINISTRATION

1. **Total Staffing Related Budget Changes**

   The SFY24 budget related impacts to staffing for Pay Act, reclassifications, benefits and decreased vacancy are anticipated to be covered by Pay Act allocation if needed, once other available resources are known, and any gap is determined closer to the close of the fiscal year.

2. **Contracts – Technical Adjustment** . . . . . -$4,779,445 GROSS / $2,903,711 STATE 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.

3. **MDWAS neutral transaction with AHS** . . . . . $600,000 STATE GF

   With this application of funds, the current amount budgeted for the Medicaid Data Warehouse and Analytics Solution (MDWAS) project is $48.2 million and the current project timeline for completion is estimated to be June 30, 2027. As with all large, complex technology projects these estimates will be continually updated. This

project is to "construct a centralized data repository, with robust reporting and analysis tools, that contains all Medicaid-related claims and clinical data." This is a crucial step in the strategy to modernize the Medicaid Management Information Systems (MMIS) and meet our Medicaid Enterprise goals for improving the experiences for Members and Providers. CMS recommended focusing on data integration and reporting, prior to procurement of additional MMIS modules. There are two concurrent work streams that make up MDWAS: the Medicaid Data Lake & Analytics Solution (MDLAS) and the Analytics Data Warehouse (ADW).

Status update as of December 2023 for each project:

MDLAS: In July 2023, Vermont contracted with Deloitte to provide the solution and services for MDLAS. The Medicaid Data Lake go-live will roll out in a stages. Two out of the four data sources will go live in May 2024, the third in July 2024, and the fourth in November 2024. Analytics solution efforts are targeted for the 2nd quarter CY 2026. This effort will have a more specific timeline once the current Analytics Data Warehouse (ADW) procurement is complete.

ADW: the Analytics Data Warehouse (ADW) procurement RFP was posted in September 2023 and remains on target for onboarding a vendor by June 2024. The ADW vendor will integrate and work with the MDLAS to meet MDWAS goals.

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.

Caseload & Utilization Changes . . . . . -$5,870,128 GROSS / $4,402,016 STATE GF

Appropriation	GROSS	STATE GF FUNDS
B.307 Global Commitment	($6,275,172)	$3,676,605
B.309 State Only	$865,627	$865,627
B.310 Non-Waiver	($460,633)	($140,216)
Total Changes	($5,870,178)	$4,402,016

Across all funds the appropriation is decreasing, however the GF match need is increasing. This is due to match rate differences for the MEGs that are most impacted.

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.

This covers all the Medicaid Eligibility Groups (MEGs) as well as the SCHIP, VPharm, Vermont Cost Sharing Reduction and Dr. D Expansion populations. The most recent Medicaid Consensus Forecast projects a relatively modest mid-year adjustment for SFY24. Redeterminations began in April 2023 and this estimate reflects the current projections as this continues through the remainder of the fiscal year. The rate of redetermination processing has been influenced by evolving federal requirements and the volume of renewals. 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.

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.

4. **Annual Medicare Buy-In Changes** . . . . . $2,757,119 GROSS / $976,310 STATE GF

Appropriation	GROSS	STATE FUNDS
B.307 Global Commitment	$ 2,244,214	$ 975,784
B.309 State Only	$1,210	$526
B.310 Non-Waiver	$511,695	$0
Total Changes	**$2,757,119**	**$976,310**

The federal government allows states to use Medicaid dollars to "buy-in" dually eligible beneficiaries to Medicare. These are individuals who would otherwise forgo Medicare due to cost and be fully covered by Medicaid programs. 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.

5. **Annual Medicare Part D Clawback**. . . . . .$957,655 STATE 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. The updated SFY24 BAA estimate reflects the most recent federal guidance increasing state Clawback payments to the CMS.

6. **Net Neutral - Family Planning Services**. . . . . .$635,442 GROSS/$0 STATE 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.

7. **Net Neutral – Safety Net Investments** . . . . . $240,000 GROSS/$0 STATE 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.

8. **Net Neutral - Medicaid Rate Alignment**

   DVHA has a goal to be a reliable and predictable payer for Vermont Medicaid-participating providers. Annual rate updates are developed using established rate methodologies (e.g., following Medicare for annual updates to the Resource-Based Relative Value Scale (RBRVS) for physician services, Outpatient Prospective Payment System (OPPS) for hospital outpatient services, among others). Rate changes are part of the State’s annual budget development process and are intended to support and maintain the Medicaid provider network, provide

stabilization to the health care system, and maximize transparency when rate changes are made.

9. **Breast Pump Supplies** . . . . . $82,000 GROSS/$35,654 STATE 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 cost estimate for the remainder of SFY24.

10. **FQHC and RHC 4.6% MEI Adjustment** . . . . . $941,667 GROSS/$408,495 STATE 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 SFY24 funding is in addition to the 10% rate increase the Legislature included in Act 78 of 2023 for SFY24.

11. **Hospice Rates** . . . . . $25,000 GROSS/$10,870 STATE 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. This is the SFY24 amount for the rate increase that was instituted effective January 1, 2024.

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

For FY24, $4,396,308 is moving from the GC appropriation to the State Only appropriation but 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.

13. 2022 ACO Settlement. . . . . $11,887,655 GROSS/ $5,168,752 STATE GF

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) program is a Scale Target ACO Initiative as described in the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services (CMS). This initiative aligns with DVHA's priority to pursue a more integrated and value-based health care system in which providers accept financial risk for the cost and quality of care. DVHA has contracted with OneCare Vermont to participate in the VMNG program since 2017. Each year, DVHA and OneCare agree on cost of care financial targets for attributed Medicaid members up front. In All Payer Model Program Year (PY) 2022, spending for ACO-attributed Medicaid members was less than the target. The contractual risk-sharing arrangement entitles OneCare Vermont to a reconciliation payment of $6.16 million, calculated as a percentage of the difference between the actual payments for services and the target, which OneCare distributes to risk-bearing providers in the ACO network.

In addition to the cost of care reconciliation, a significant true-up for attributed lives is required for CY 2022 of $5.73 million. In CY 2022 an operational change was made to the basis for the per member per month (PMPM) ACO payments, in which the system would use the most current aid category code to automatically determine the amount of the PMPM payment that would be issued to the ACO for each attributed Medicaid member. In prior years, a PMPM amount was manually assigned to each attributed member at the beginning of the performance year and would remain static for all months of payment, regardless of mid-year changes in Medicaid aid categories. The intent of this change was to automate payment determinations and minimize the number of members whose mid-year aid category changes would require manual adjustment in the reconciliation process. However, making this change during the suspension of eligibility redeterminations had a significant unintended consequence that necessitates an adjustment in the CY 2022 reconciliation. This adjustment is for the attributed Medicaid members who were assigned to child aid category codes but actuarially had aged into the adult category since 2020. Suspended redeterminations locked members into child categories who would have normally aged up into adult categories. If the change in basis to the PMPM payments had not been made, this $5.729 million would have been paid out earlier to the ACO in higher 2022 monthly payments. This payment represents the difference between the child and the adult PMPM payment levels for the affected lives. This amount does not represent additional payments for total cost of care savings. It is a technical adjustment for incorrect categorization of attributed lives.

OneCare will distribute these funds to the providers in the ACO network based on their respective contracts. We expect this issue to impact the CY2023 reconciliation as well, but to a much lesser degree, as most age-related aid category code corrections were made early in the redetermination process.

14. 12-month Continuous Enrollment of Children

Effective on January 1, 2024, Section 5112 of the Consolidated Appropriations Act requires all states to implement 12 months of continuous eligibility for children under age 19 in both Medicaid and CHIP. This new requirement will mean that certain children will not lose coverage before their annual renewal period due to most changes in circumstances or due to procedural terminations. Pursuant to federal statute, there are limited circumstances in which continuous eligibility for children in Medicaid may end including:

(1) 12 months from the date a child was determined eligible,
(2) the child is no longer a state resident,
(3) the child turns 19 years old.

DVHA previously projected that this policy would have a fiscal impact due to resulting lack of attrition among Medicaid enrolled children. However, the suspension of redeterminations has resulted in continuous eligibility for all MEGS during the PHE from 2020 through spring 2023. Therefore, the baseline for the DVHA consensus budget process already has the impact of this change embedded. To the extent there is a budget impact, it is reflected in the steady state updated consensus caseload and per member per month estimates. We do believe there is a modest cost to this change in policy that is well below previous estimates, but there is not a current or next fiscal year immediate budget impact due to the starting baseline for child caseloads.

15. Global Payment Program

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. 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.