VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

BUDGET CONSIDERATIONS: FISCAL YEAR 2021 BUDGET ADJUSTMENT

The Department of Vermont Health Access (DVHA) state fiscal year 2021 budget adjustment request includes an increase in Administration of $2,831,095 (gross) and an increase in Program of $2,238,982 (gross) for a total of $5,070,077 (gross) in new appropriations; additional information for explanatory purposes is provided under the Administration and Program sections below.

DVHA is meeting the general fund pressure increases through the continuation of the Federal Medical Assistance Percentage (FMAP) increase of 6.2% that is tied to the federal COVID-19 public health emergency; the FMAP increase of 6.2% is expected to continue through June 2021.[1]

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

ADMINISTRATION — $2,831,095 GROSS / $1,581,095 STATE

1. **ACO DSR (SFY20 carryforward; AHS net-neutral)**. . . . . .$2,500,000 / $1,250,000 state

This request transfers the spending authority from AHS to DVHA for the Accountable Care Organization (ACO) Delivery System Reform investment. As described in the Agency's 2021 Budget Adjustment presentation, this technical adjustment is the fiscal year 2020 carryforward of the approved calendar year 2020 Delivery System Reform investment with OneCare Vermont.[2] The funds were paid to OneCare Vermont in December 2020.

2. **Backfill of unallowable CRF indirects (AHS net-neutral)**. . . . . $331,095 / $331,095 state

This item is the DVHA portion of the fiscal year2020 unallowable Coronavirus Relief Fund (CRF) indirect administrative expenses.[3]

PROGRAM — $2,238,982 GROSS / $52,154 STATE

3. **Caseload & Utilization Changes** . . . . . $8,153,469 / $2,549,639 state

DVHA engaged in an updated Medicaid Consensus Forecast (i.e., a collaborative process for estimating caseload and utilization) with the Joint Fiscal Office, the Department of Finance and Management, and

[1] Continuation of FMAP enhancement through June 2021.
[2] Agency of Human Services, FY2021 Budget Adjustment.
[3] Indirect administrative costs are associated with department-wide or agency-wide costs that benefit all programs and as such, cannot be attributed to directly to any one program.

the Agency of Human Services to be adopted in January by the Emergency Board. Vermont is experiencing growth in Medicaid enrollment because of the pandemic and federal requirements to maintain continuous health care benefits. Most growth has been within income-based eligibility groups.

Vermont is required to maintain continuous health care benefits for Medicaid and CHIP enrollees during the period of the federal COVID-19 public health emergency in order to continue to receive the 6.2% enhancement in Federal Medical Assistance Percentage (FMAP) as authorized in the CARES Act. To ensure continuous health care coverage during the COVID-19 public health emergency, DVHA is facilitating continuous health coverage by:

- Extending Medicaid coverage periods (meaning the Department is not processing the redeterminations that could result in loss of Medicaid) until after the emergency ends.
- Suspending certain termination of health insurance (meaning the Department is generally not ending Medicaid coverage during the Emergency unless the customer requests it).
- Temporarily waiving financial verifications required for those seeking to enroll in health insurance.

Each of these emergency actions contributes to an increased caseload for the Vermont Medicaid program. Due both to the pause in redeterminations and the continuation of the COVID-19 pandemic, utilization trends have been disrupted with most eligibility groups experiencing declines in per member per month costs. The Department's Budget Adjustment request combines the increases due to caseload and reduced utilization per member.

Appropriation	GROSS	STATE FUNDS
Global Commitment	$9,872,602	$4,196,843
State Only	($1,719,133)	($1,647,204)
Non-Waiver	$0	$0

4. **Plan Year 2019 ACO Reconciliation** . . . . . ($6,685,010) / ($2,829,409) state

The Department's participation the All-Payer ACO Model Agreement is through the Vermont Medicaid Next Generation Program. Under the Program, the Department and the Accountable Care Organization (ACO), OneCare Vermont, agree on a set price for Medicaid services for attributed Medicaid members upfront. A portion of that price is paid monthly to the ACO. The remainder is paid using fee-for-service reimbursement. This one-time repayment represents the portion of the set price overpaid in fee-for-service payments for calendar year 2019 so OneCare Vermont repaid nearly $6.7 million dollars to the Department in January 2021.

Appropriation	GROSS	STATE FUNDS
Global Commitment	($6,602,694)	($2,806,805)
State Only	$0	$0
Non-Waiver	($82,316)	($22,604)

5. Medicare Buy-In Price Adjustments . . . . . $770,523 / $331,924 state

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 trends in member months. The Medicare Buy-In programs help people who are income-eligible pay their Medicare premiums. There are three distinct Buy-In programs and each has different eligibility requirements:

- *Qualified Medicare Beneficiary* (QMB): Individuals who are eligible can have Medicaid pay their Medicare Part A and Part B premiums, deductibles, and coinsurance within the prescribed limits.

- *Special Low-Income Medicare Beneficiary* (SLMB): Individuals who are eligible can have Medicaid pay their Medicare Part B premiums.

- *Qualified Individuals* (QI-1): Individuals who are eligible can have Medicaid pay their Medicare Part B premiums.

Appropriation	GROSS	STATE FUNDS
Global Commitment	$772,764	$328,502
State Only	$8,051	$3,422
Non-Waiver	($10,292)	$0

6. SMI & SUD Waivers; moves IMD cost to GC (DVHA net-neutral). . . . . $0 / $0 state

This technical adjustment moves the spending authority for costs for Institutions for Mental Disease (IMD) from Global Commitment Investments within the State-Only Appropriation to Global Commitment Program as a result of the Serious Mental Illness (SMI) and Substance Use Disorder (SUD) Global Commitment 1115 Waiver changes. As Vermont is required to phasedown the Investment authority for IMD services this allows for the continuation of adult inpatient psychiatry services at IMD hospitals.

Appropriation	GROSS	STATE FUNDS
Global Commitment	$11,778,647	$5,007,103
State Only	($11,778,647)	($5,007,103)
Non-Waiver	$0	$0

7. G.F. Savings Carryforward . . . . . $0 / $0 state

The Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act enacted March 27, 2020 allowed for an increase to the Federal Medical Assistance Percentage (FMAP) reimbursement rate applied to Medicare Clawback and CHIP programs. This will result in general fund savings in Non-Waiver and State-Only appropriations; DVHA is required to carryforward these funds into FY2022.

Anticipated Carryforward Medicare Clawback:	$1,418,845 / $1,418,845 state
Anticipated Carryforward CHIP Program:	$0 / $141,114 state