Governor's Recommended Budget Adjustment (BAA): 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 BAA Summary: DVHA's state BAA Request for SFY2025 request is summarized below. The BAA is an increase of $69.7m across all funds. There is also an adjustment to our GPP onetime appropriation included in the BAA.

ADMINISTRATION ($179.0 M)

1. Staffing and Contracts Adjustments — $1,764,412 GROSS /$964,054 GF

The Health Access Eligibility and Enrollment Unit (HAEEU) unit requires temporary positions to support operations related to Medicaid renewals. The "unwinding period" completed in spring of 2024; however, we have a backlog in our Medicaid for the Aged, Blind and Disabled (MABD) caseload that requires more intensive manual work. The Vermont Legal Aid funding was previously carried in our program budget. However, new guidance requires that this expense be moved to our Admin budget. This move is neutral on a gross appropriation basis. Finally, there are several adjustments to DVHA held personal service contracts itemized on our Ups/Downs sheet.

Appropriation	GROSS	GF
HAEEU temps for backlog	$331,758	$165,879
Vermont Legal Aid move from prog.	$547,984	$273,992
DVHA contracts funding adjustments	$884,670	$524,183
Total Staffing & Contract Changes	**$1,764,412**	**$964,054**

2. Operating Expenses — -$4,920,532 GROSS /$1,187,412 GF

The budget adjustment items in our operating are related to projects that are billed through the Agency of Digital Services (ADS). There is a technical timing reduction of -$8.0 million to our federal fund appropriation for ADS held contracts. We are entering a new procurement cycle for our PBM services, this $2 million line item is for project management services through ADS, development of this is anticipated to stretch over several years. The remaining adjustments relate other ADS charges.

PROGRAM ($1.070 Billion)

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.

1. Caseload & Utilization Changes **$83,477,373 GROSS / $35,477,290 GF**

Appropriation	GROSS	GF
B.307 Global Commitment	$78,806,530	$33,232,714
B.309 State Only (IHIP and VPharm)	$1,240,521	$1,240,521
B.310 Non-Waiver (CHIP)	$3,430,322	$1,004,055
Total Changes	**$83,477,373**	**$35,477,290**

The Medicaid Consensus Forecast is a collaborative process for estimating caseload and utilization. Annually, DVHA works with the Joint Fiscal Office, the Department of Finance and Management, and the Agency of Human Services to collective project the caseload by Medicaid Eligibility Group (MEG) and analyze and update the baseline cost per member per month based on the most recent experience of expenditures. This includes adjustments for known baseline changes including rate adjustments enacted by the legislature in the last session.

The initial 'as-passed' budget estimates for SFY25 were made in the Fall of 2023. Enrollment levels were generally consistent with those estimates; however, expenditures for the caseload were higher. To understand the reasons driving the difference between the initial budget and the BAA need, we looked at several areas. Analysis by the DVHA data team does not indicate an increase in claims volume per enrollee using services. The data team also provided preliminary trend analysis of inpatient, outpatient, professional and pharmacy claims over time for beneficiaries who remained enrolled versus beneficiaries who were disenrolled through redetermination during the fiscal year. This analysis shows the remaining enrolled 'stayer' population experienced increases through 2023 for most but not all the adult enrollment groups in several, but not all the service lines analyzed. This trend was not clear in the 2022 and 2023 PMPM analysis we relied upon a year ago but became evident through the close of the fiscal year in June 2024. This analysis indicates these trends leveling in 2024. The forecast for pharmacy rebates has also been reduced as the rebate invoices have declined.

2. Required Rate Changes **$816,667 GROSS/$344,388 GF**

Payments to Federally Qualified Health Centers and Rural Health Clinics are annually adjusted by the Medicare Economic Index (MEI) which is a measure of cost inflation that Vermont applies to the existing FQHC and RHC payments annually. We estimate $791,667 is needed for the 3.5% adjustment over the remainder of SFY25.
State Medicaid Hospice rates must remain at or above the CMS-established floor, we estimate $25,000 is needed for the partial year over the remainder of SFY25. These costs will be fully annualized in our SFY26 budget.

3. One-time offsets for BAA **- $15,333,310 GROSS/ -$6,658,810 GF**

There are two one-time funding offsets applied in the BAA. First is $15 million of Pharmacy Rebates that were pushed into SFY25 as result of the Change Health Care cyber-attack. The second is $333,310 GF onetime carryforward funds available in our State-Only line.

4. ACO Reconciliation **$5,177,695 GROSS/$2,183,434 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) 2023, the result for ACO-attributed Medicaid members was very close to the target Total Cost of Care (TCOC). This portion of the reconciliation is a financial liability of the ACO owed to the state is -$464,758.

Aside from the TCOC reconciliation, a significant true-up for attributed lives is required for CY 2023 of $5,642,454 million. This adjustment is for the attributed Medicaid members who were assigned to the wrong category. Suspended redeterminations locked members into categories who would have shifted to another category (child to adult, general to ABD). This is the adjustment for the differences in PMPM payment levels for the affected lives in CY2023. It is a technical adjustment for incorrect categorization of attributed lives.

5. Neutral Program Adjustments **$0 GROSS**

There are many reviews and audits related to our Medicaid budget, directed internally or by our federal partners. As a result, we often find that program components need to be moved from one part of our budget to another as the nature of programs are clarified and refined. This year it was identified that a portion of the Blueprint Spoke, and Pregnancy Intention programs should be classified as waiver investments. These expenses are moving (in budget parlance getting 're-bucketed') to our State Only line item from which GC investments are made. This is net neutral across all funds.

As noted above, VLA funding is required to be moved from our program budget into our Administration budget, this neutral on a gross basis. These moves will also be reflected in our SFY26 budget. This move is neutral on a gross basis but different FMAPs mean there is a GF impact as a result of this move.

6. Vermont Cost Sharing Reduction **-$750,000 GROSS / -$750,000 GF**

The GMCB made significant changes to the pricing of the silver plans on the exchange for CY 2025, resulting in far less uptake of certain silver plans including those with Vermont Cost Sharing Reductions. This adjustment reflects the lower cost of the VCSR program for the second half SFY25. The amount will be annualized on our SFY26 budget.

ONE TIME APPROPRIATIONS

1. Global Payment Program **$4,020,000 GROSS/ $1,673,124 GF**

This is an adjustment to the onetime funding provided to DVHA in Act 113. Five hospitals opted to participate in the GPP pilot program early in the fiscal year. 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. The adjustment will allow additional hospitals to participate if they so choose, and to true up the actual 'claims tail' for the first five participants.

The GPP issues "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. These are payments 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.