Governor's Recommended Budget: SFY 2026

Budget Narrative

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

SFY 2026 Summary: DVHA's state SFY2026 budget request is summarized below. Our budget in total is $1.26 billion. The increase over FY25 as enacted is $79.4 million across all funds.

ADMINISTRATION (TOTAL $182.3 M)

1. Staffing and Contracts Increase — $8,856,352 GROSS /$3,939.845 GF

DVHA has 372 positions, and several ongoing temporary positions. The figures below reflect all Pay Act and reclassification related salary changes; and all benefit cost changes including health care and retirement. There are 8 new positions requested in the VCCI unit for the Justice Re-Entry initiative.

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
Salary	$2,106,918	$871,565
Benefits	$3,530,841	$1,611,974
Justice Re-entry - 8 New VCCI Positions	$924,532	$462,266
Subtotal Staffing changes	**$6,562,291**	**$2,945,805**
Vermont Legal Aid –gross neutral move	$547,984	$273,992
DVHA Contracts – funding adjustments	$1,746,077	$720,048
Total Staffing and Contract Changes	**$8,856,352**	**$3,939,845**

2. Operating Expenses and ISFs Increases — $7,861,267 GROSS /$470,465 GF

This reflects the annual changes in costs we pay to state Internal Service Funds (ISFs). These are charges levied by other departments for shared support services and overhead allocation charges. There are several large IT contracts that are held by ADS but are funded within DVHA's operating budget. There is a technical timing reduction of -$8.0 million to our federal fund appropriation for an ADS held contract, as well as a neutral adjustment to funding sources related to an Implementation Advance Planning Document (IAPD). Finally, there is funding for the equipment needed to support the new VCCI position above.

Appropriation	GROSS	GF
All Internal Service Funds	$125,733	$16,287
ADS Contracts – technical adjustments	-$8,000,000	$ 447,678
Equipment for 8 new VCCI positions	$13,000	$6,500
Total Change	**-$7,861,267**	**$470,465**

PROGRAM (TOTAL $1.077 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.

3. Caseload & Utilization Changes $51,014,621 GROSS / $21,419,991 GF

Appropriation	GROSS	GF
B.307 Global Commitment	$46,117,063	$18,995,618
B.309 State Only	$1,411,582	$1,411,582
B.310 Non-Waiver	$3,512,976	$1,012,791
Total Changes	**$51,041,621**	**$21,419,991**

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 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 gives us the new baseline position for the program budget.

The primary risks to this baseline forecast are 1) If, how and when changes at the federal level impacting Medicaid rollout. 2) If the underlying trend in claims is higher than the modest increase we have included in this budget. The mix of fee-for-service and prospective payments to our hospital service providers in January 2026 is yet to be fully clarified and may impact this trend. 3) If pharmacy costs rise and rebates shrink at higher rates than anticipated. 4) If caseload ticks up from the current trend.

4. MSP Expansion and Buy-In $10,859,728 GROSS / $1,822,382 GF

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. The federal Buy-In rate increase is within our current buy-In baseline, so no specific adjustment is requested at this time.

The amounts below reflect the net cost of implementing the expansion of our MSP programs on January 1, 2026. Act 113 of 2024 significantly increased eligibility from 100% to 145% FPL for the Qualified Medicare Beneficiaries (QMB) and from 135% to 195% for the Qualified Individual (QI-1) MSP programs. The amounts presented above are the estimated partial year, 5-month MSP expansion costs and corresponding estimated savings to the VPharm program resulting from this eligibility expansion. Please note this expansion will need to be fully annualized in the SFY27 budget.

Appropriation	GROSS	GF
B.307 Global Commitment	$7,114,153	$2,930,320
B.309 State Only	-$1,107,936	-$1,107,936
B.310 Non-Waiver	$4,853,511	$0
Total Changes	**$10,859,728**	**$1,822,384**

5. Required Rate Changes **$2,089,639 GROSS/$860,722 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 $1.9 million is needed for the annualized January 2025 3.5% adjustment in SFY26. State Medicaid Hospice rates must remain at or above the CMS-established floor, we estimate $50,000 is needed for the annualization of the January 2025 increase. The final item included here is the cost to our budget for the collective bargaining agreement for services funded in DVHA provided by direct care workers who are represented by AFSCME.

6. New High-Cost Drugs **$4,500,000 GROSS/$1,853,550 GF**

There are several newly approved high-cost drugs or gene therapies that are anticipated to impact the Medicaid budget. These include treatments for liver disease and hemophilia. In addition, Vermont Medicaid follows the Medicare program which has expanded the application of GLP-1 class drugs for certain cardiac conditions. This amount does **NOT** reflect the cost of GLP-1 class drugs to treat obesity which Vermont Medicaid currently does not cover. This reflects our best fiscal estimate for the FY26 baseline impact. But making this estimate is challenging and an ever-moving target as more drugs and more expanded uses are on the horizon. In the case of new gene therapies for hemophilia, very few Vermont Medicaid beneficiaries are expected to need or qualify for this, but the price tag is expected to range from $2m-$3m per case. The

hope is this will be broadly offset by avoided medical costs and higher quality of life outcomes over the patient's lifetime compared to current treatment.

7. Annualize PRTF Budget **$4,261,269 GROSS/$1,755,217 GF**

A Psychiatric Residential Treatment Facility (PRTF) is a facility that has a provider agreement with a State Medicaid Agency to provide a residential inpatient psychiatric service benefit to Medicaid-eligible individuals under the age of 21. This initiative is led by DMH and DCF for 15 in-state PRTF beds slated to be open in early 2025 at the Brattleboro Retreat. DVHA will process the claims for these services. Last year the DVHA budget received $3.55 million for the FY25 partial year cost of these beds. This amount brings the PRTF total annualized budget amount for SY26 to $7.81 million.

8. Graduate Medical Education (GME) **$7,259,045 GROSS/ $0 GF**

DVHA is seeking Global Commitment spending authority to increase the annual GME amount from $58.4 million to $65.6 million which is the full amount of GME payment demonstrated by the approved calculation methodology. This proposed funding mechanism does not require additional General Fund dollars.

9. 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.

10. Vermont Cost Sharing Reduction **-$1,500,000 GROSS / -$1,500,000 GF**

The GMCB made significant changes to the pricing of the silver plans on the Vermont Health Exchange for CY 2025, resulting in far less uptake of silver plans. The state funded VCSR tied to silver plans therefore has a lower annualized cost.

11. Annual Medicare Part D Clawback **$1,400,000 GROSS / $1,400,000 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 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 CMS.

ONE TIME APPROPRIATION

1. **ACO Transition: SASH and Blueprint $10,800,000 GC/$4,448,520 GF**

   This is to provide one-time bridge funding for the Support and Services at Home (SASH), Primary Care Medical Home (PCMH) and Community Health Team (CHT) services under the Blueprint for Health. Medicare funds to support these programs have flowed through the ACO, and these will not be available in 2026.