July 28, 2022
Emergency Board Meeting
Report on Medicaid for Fiscal Year 2022

32 V.S.A. § 305a(c) requires a year-end report on Medicaid and Medicaid-related expenditures and caseload. Each January, the Emergency Board is required to adopt specific caseload and expenditure estimates for Medicaid and Medicaid-related programs. Action is not required at the July meeting of the Emergency Board unless the Board determines a new forecast is needed in July. The data in this report reflects the most current actual FY22 information to date. The comparison of FY22 actual to budgeted amounts reflects the changes made through the budget adjustment and big bill processes. Though unlikely, there may be adjustments to actual year-end amounts as the close-out for the fiscal year is finalized. If necessary, changes will be included in a subsequent report.

Executive Summary

FY22 marked the third fiscal year contending with impacts from the COVID-19 Public Health Emergency. The bullet points below provide the primary results of FY22 in the Vermont Medicaid, Global Commitment Waiver (GC), Children's Health Insurance Program (CHIP) and related programs. Also included are a few issues to be aware of looking forward. Detailed multiyear charts for overall program expenditures, enrollment and year end positions follow this summary.

- **Expenditures:** Overall FY22 Medicaid and Medicaid-related all funds' expenditures totaled $1.99 billion (see page 6 chart). This is 2% or $40 million below all funds' budgeted amount through budget adjustment, yet still a 10% increase in total spending over FY21. The primary areas of FY22 budgetary underspending include:

    - Choices for Care (CFC) – The CFC GC program expenditures came in below the budgeted level by $7.7 million gross GC funding. Per 33 V.S.A. Chapter 76, this balance must remain in the CFC program and is not available to be used elsewhere. The underspending was entirely due to the Home- and Community-Based Services (HCBS) side of the program at $12.2 million below expectation. This was offset by $4.5 million in higher spending on Nursing Homes. The first $2.3 million of this year-end balance is allocated to meet the 1% reserve requirement. The remainder is slated to provide $4.2 million of emergency fiscal relief to four nursing homes, leaving $1.15 million available for other CFC program reinvestments in FY23.

    - The Clawback line item came in under projection. We believe this is short-term in nature and due to atypical program utilization impacts caused by the pandemic. Clawback is a reimbursement back to the federal government for costs associated with the transfer of prescription drug coverage from state Medicaid programs to Medicare Part D for dually eligible individuals.

    - The waiver investments came in below expectation mostly driven by the phase down and cap on investments for Institutes of Mental Disease (IMD). This means that some funding for the Vermont Psychiatric Care Hospital and the Brattleboro Retreat needed

to be converted from blended Global Commitment Funds to pure General Fund outside of the waiver. This phase down will continue to be a state fiscal pressure in the future, for while it will gradually reduce Medicaid expenditures, it will increase state funding needs outside of the waiver to make up for the loss of federal matching dollars.

  - Program Administration also came in below budget. In FY22, program administration ran just under 7% of total.

- **AHS GC General Fund Position:** The unexpended General Fund in the Agency of Human Services (AHS) Global Commitment line being carried forward into FY23 is $46.3 million. This amount includes the $10 million in contingent one-time year end FY22 funds appropriated in the budget process. This is net of the amount required to remain in the CFC program, and net of the amount required under the ARPA HCBS Plan. Approximately $22m of this balance is generated by the final FY22 quarter 6.2% FMAP enhancement.

  Under the current timing for resumed eligibility redeterminations, it is estimated that $17.4 million of this GF will be needed to fund one-time caseload related expenses in FY23. AHS is developing a plan for the remaining $28.8 million carryforward GF. This is anticipated to include a significant allocation for continued targeted provider stabilization emerging from the COVID-19 pandemic.

- **Caseload:** Vermonters are eligible for coverage for Medicaid programs in a variety of ways subject to income limits. For the vast majority of caseload, these programs provide full or primary health care coverage for beneficiaries. For the remaining caseload, the programs provide supplemental coverage for those whose primary coverage is from another source such as Medicare or commercial plans.

  Most of the FY 22 eligibility groups came very close to the estimates adopted by the Emergency Board in January 2022. There are two areas to note:

  - *Suspended redetermination impacts:* The three non-disabled adult eligibility categories are most impacted by suspension of annual eligibility redeterminations under the federal Public Health Emergency (PHE). For most adults, the top income limit is 138% of the Federal Poverty Level or $18,754/year for an individual. These categories normally experience significant churn off and, on the program, related to employment changes. Under the PHE people can still be enrolled into Medicaid programs but cannot be disenrolled. As such, enrollment numbers have continued to grow. Other eligibility categories are less impacted by PHE suspension because the income limit is higher (household income of up to 317% FPL for children) or tied to a specific disability status so the churn is traditionally much lower.

  - *Vermont Premium Assistance (VPA)*: While it was estimated that the number of people receiving VPA would grow by a modest 5% from FY21 to FY22, the caseload in fact dropped by more than 20% while the caseloads for those with cost-sharing subsidies remained flat (despite an estimated increase of 6%). This represented a

$1.1 million reduction in gross spending. At this time, it is too soon to speculate the cause(s) of this or to what coverage (if any) beneficiaries may have transitioned to.

- **FMAP:** The Federal Medical Assistance Percentage (FMAP) is the federally set rate for each state reflecting the share of costs the federal government will pay for eligible Medicaid expenses. The rate for each state is calculated based on three-year average state per capita income levels in comparison to the overall national level. No state can receive less than 50%. The income data used for this calculation lags the present by several years and is often countercyclical.

  Vermont's base FMAP is currently roughly 56% federal share and 44% state share for program costs. A change of 1% in the base rate can impact the state GF budget by as much as $18 million. There are instances where the FMAP is higher or enhanced due to federal action such as the 90% share for 'Childless New Adults' under the Affordable Care Act (ACA), the Children's Health Insurance Program (CHIP), or state-specific agreements with CMS for certain types of administrative expenditures.

  Under the Families First Coronavirus Response Act passed in March 2020, states received a temporary increase in their FMAP rate of 6.2% for as long as the federal declaration of a public health emergency is in place. Vermont has been drawing this enhanced funding percentage over the state fiscal years as follows:
  - In FY20, two quarters were drawn and saved the General Fund $42 million
  - In FY21, a full year of draw resulted in $84 million in General Fund budget savings
  - In FY22, a full year of draw has resulted in approximately $88 million in General Fund budget savings
  - For FY23, the enhancement will extend at least through the December quarter. This is estimated to result in $45 million in GF savings available for budget adjustment or FY24

- **American Rescue Plan Act (ARPA) Home- and Community-Based Services Initiative:** This funding opportunity provided states with a 10% match enhancement for one year (April 2021 through March 2022) on the broadly defined Home- and Community-Based Services (HCBS)[1]. The savings generated can be matched and expended under a federally approved plan over a multiyear period to strengthen and enhance these services.

  In Vermont a total of $69.3 million of savings was generated by the 10% enhanced match. This match allows for a Vermont ARPA HCBS plan totaling $155 million. AHS conducted a stakeholder process last summer to develop the plan and spending authority related to the plan was authorized in budget Acts 73, 84 and 185 of the 2022 session. Federal approval is pending the revised plan submitted on July 18th. The deadline for expending these funds is March 2025. The money will be used for improving services, promoting a high-performing and stable HCBS workforce, and improving HCBS care through data systems, value-based payment models, and oversight.

[1] The federal definition of HCBS is very broad including much mental health, developmental disabilities and other community based long term care services. (the Vermont budget typically uses HCBS in reference to the CFC program only)

Looking ahead

- **FMAP:** The FFY24 base FMAP has not yet been released by the federal government. JFO and Administration staff will continue to monitor and adjust estimates when the final FMAPs are released in the Fall. The preliminary estimates provided by FFIS are positive for Vermont from an FMAP perspective.

- **Global Commitment Waiver:** In late June, the Scott Administration announced the approval of a new agreement with the Centers for Medicare and Medicaid Services (CMS) to extend the Global Commitment to Health 1115 demonstration project (often referred to as the Global Commitment Waiver). The approval is effective July 1, 2022 through December 31, 2027. Some initial highlights of the agreement include:
  - Providing flexibility to adjust provider payment rates without negatively impacting the waiver's spending cap
  - Including authority to continue to pay for services and fund programs normally outside of Medicaid, known as investments, that improve public health, reduce the rate of uninsured and/or underinsured, increase access to care, and support the health care delivery system
  - Allowing for the use of Medicaid funding to expand access to substance use disorder treatment services
  - Allowing a new pilot program that will help people covered by Medicaid to secure and maintain housing.

- **Health Care Revenues:** FY22 Health Care Revenues came in slightly higher than projected. Most of these revenue line items came in very close to estimates. These taxes are part of the General Fund and included in the General Fund consensus forecast.

  The FY22 employer assessment came in $1.6 million higher than projected. Both Blue Cross Blue Shield of Vermont and MVP Health have submitted requests for double-digit rate increases for their Vermont Health Care Plans. The variables regarding potential premium increases and the evolving workforce environments make the employer assessment complicated to project.

  The hospital provider tax line grew 12% with FY22 final quarter truing up of reported net patient revenue and projected to grow 7% in FY23. Hospital provider taxes are billed annually based on reported net patient revenues. The revenue reported for the year is the billed (accrued) amount not the paid amount. Most hospitals are current with provider tax payments, but two entities continue to lag.

  - Springfield hospital is in arrears by a year, totaling $3.3 million, Under the court decision $6.3 million of previous arrearage was written off and a promissory note is in place to be paid over a period of five years.

  - The Brattleboro Retreat is 20 months in arrears totaling $3.5 million. The State funded beds are built but the Retreat continues to struggle with workforce and capacity issues. It is anticipated that additional support may be needed in budget adjustment to continue to financially stabilize this provider.

Average Medicaid Caseload

(Based on Monthly Enrollment and Staff Group projections)	actual FY19	actual FY20	actual FY21	Est. Ebrd Jan'22 FY22	July 2022 actual FY22	FY23 Bud. Est. Ebrd Jan'22 FY23
Full/Primary Coverage (note1)			*Redeterminations suspended during pandemic emergency........*			
Adult						
Aged, Blind, or Disabled (ABD) Adults	6,485	6,292	6,229	6,227	6,117	6,218
General Adults	10,148	8,366	11,308	14,291	16,712	12,965
New Adult Childless- began 1/1/2014	37,432	35,058	42,064	49,215	47,783	45,289
New Adult w/Kids - began 1/1/2014	19,101	20,196	24,409	26,643	24,645	25,192
Adult subtotal	73,166	69,911	84,010	96,376	95,256	89,664
	-6.4%	-4.4%	20.2%		13.4%	
Children						
Blind or Disabled (BD) Kids	2,093	1,766	1,636	1,553	1,538	1,477
General Kids	58,779	57,772	60,658	61,573	61,866	62,082
CHIP (Uninsured) Kids	4,479	4,549	4,356	4,535	4,712	4,523
Child subtotal	65,351	64,087	66,650	67,661	68,116	68,082
	-2.4%	-1.9%	4.0%		2.2%	
Subtotal -Full/Primary	**138,517**	**133,998**	**150,660**	**164,037**	**163,372**	**157,746**
	-4.6%	-3.3%	12.4%		8.4%	
Partial/Supplemental Coverage						
Choices for Care	4,275	4,387	4,476	4,366	4,472	4,409
ABD Dual Eligibles	17,651	17,546	18,031	18,233	18,342	18,340
Rx -Pharmacy Only Programs	10,382	9,976	9,965	9,853	9,605	9,762
VPA-Vermont Premium Assistance (note2)	17,163	16,237	15,187	15,937	12,470	15,937
CSR-Cost Sharing Reduction (subset of VPA)	*4,919*	*3,518*	*3,044*	*3,236*	*3,040*	*3,236*
Underinsured Kids (ESI upto 312% FPL)	563	568	569	548	618	537
Subtotal -Partial/Supplemental Coverage	**50,034**	**48,713**	**48,227**	**48,937**	**45,508**	**48,985**
	-3.1%	-2.6%	-1.0%		-5.6%	
Total Medicaid Enrollment	**188,551**	**182,711**	**198,887**	**212,974**	**208,880**	**206,731**
	-4.2%	-3.1%	8.9%		5.0%	

Notes: Some Full Coverage enrollees may have other forms of insurance.
VPA-Vermont Premium Assistance counts are subscribers not individuals.

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Summary of Total Expenditures

Medicaid and Medicaid Related	FY18 Actual	FY19 Actual	F20 Actual	F21 Actual	FY22 Bud BAA	FY22 Actual	FY23 Bud. As Passed
Administration (not in Waiver)							
Non Capitated Administration 50/50	80,088,129	72,558,595	76,839,254	70,450,346	73,862,606	69,159,795	73,577,670
Non Capitated Administration 75/25 MMIS M&C	14,272,895	17,333,783	20,103,827	20,862,489	22,752,727	25,587,964	26,575,277
Non Capitated Administration 75/25 SPMP	6,161,582	6,309,453	6,275,782	5,406,553	5,988,094	8,804,095	6,401,509
Sub-total Non Capitated Administration	100,522,606	96,201,831	103,218,863	96,719,388	102,603,427	103,551,853	106,554,456
Non Capitated Administration 75/25 E&E M&O	30,224,766	28,215,235	34,550,270	34,388,430	41,712,396	32,052,293	49,652,632
Total Non Capitated Administration	**130,747,372**	**124,417,065**	**137,769,133**	**131,107,818**	**144,315,823**	**135,604,147**	**156,207,088**
		-4.8%	10.7%	-4.8%		3.4%	15.2%
Global Commitment Waiver							
GC - Program (DVHA, MH, DS etc)	1,176,581,623	1,246,939,045	1,236,841,301	1,268,974,765	1,414,654,127	1,413,780,286	1,456,307,979
GC - VT Premium Assistance	6,332,790	5,941,367	5,864,311	5,689,738	5,615,851	4,524,778	5,615,851
GC - Choices for Care (CY 2015 now in GC)	193,956,348	206,204,809	221,591,137	206,345,993	235,436,956	226,674,507	244,660,753
GC - Investments	139,114,731	135,033,700	124,799,031	98,845,057	123,232,635	108,638,216	114,882,134
GC - Certified (non -cash program & cnom)	27,307,277	26,453,027	23,441,495	18,175,058	25,220,180	21,178,030	25,231,644
GC Waiver total	**1,543,292,769**	**1,620,571,948**	**1,612,537,275**	**1,598,030,610**	**1,804,159,749**	**1,774,795,817**	**1,846,698,361**
		5.0%	-0.5%	-0.9%		11.1%	4.1%
Other Medicaid and Related Programs							
Money Follows the Person (CFC FY08-CY15)	2,607,149	766,828	2,379,542	1,388,847	4,890,379	4,643,428	2,581,912
Cost Sharing Subsidy (State Only)	1,533,802	1,482,370	1,170,612	1,176,262	1,130,724	985,102	1,130,724
Vermont Premium Assistance (State Only)	74,896	-	-	-		-	-
Pharmacy - State Only	1,054,658	4,784,349	4,862,659	4,998,596	1,489,423	2,891,746	1,505,181
DSH	27,448,780	22,704,471	22,704,471	22,704,470	22,704,471	22,704,469	22,704,471
Clawback (state only funded)	33,676,089	34,453,902	35,532,471	30,355,530	36,711,213	33,191,145	40,397,960
SCHIP	11,055,931	12,093,133	13,744,946	14,664,289	13,534,873	14,045,476	13,735,085
Total Other	77,451,305	76,285,053	80,394,701	75,287,995	80,461,082	78,461,367	82,055,332
Total All Expenditures	**1,751,491,446**	**1,821,274,067**	**1,830,701,108**	**1,804,426,423**	**2,028,936,654**	**1,988,861,331**	**2,084,960,781**
	0.1%	4.0%	0.5%	-1.4%		10.2%	4.8%
Blue Cross Blue Shield VT Recon Settlement	4,500,000						
	-						**Doc# 343033**

Choices for Care Year End Summary - SFY22

CFC is managed as one budget, categories are estimated but funding is fluid within them.

DeptID - 3460080000

	SFY22 Budget Plan$s Available (Final Approp)	SFY22 Expend and Obligated	Balance of SFY22 Approp by fund	State Share Amt as of FY22 Year End	State Share converted to GC Available for SFY23 CF/Savings Reinvestment	
H&CB Money Follows the Person General Fund	$ 2,615,046	$ 2,512,850	$ 102,195	$ 102,195	$ -	$102,195.47 GF balance being carried forward to SFY23 - staying as GF for H&CB Money Follows the Person obligations.
H&CB Money Follows the Person Federal Fund	$ 2,275,333	$ 2,130,578	$ 144,755	$ -	$ -	Federal Funds are available to use in SFY23
H&CB Global Commitment Fund	$ 94,118,035	$ 81,876,673	$ 12,241,363	$ 5,386,200	$ 12,241,363	
Nursing Home Global Comittment Fund	$ 140,254,920	$ 144,797,835	$ (4,542,915)	$ (1,998,883)	$ (4,542,915)	
Choices for Care Subtotal all funds	$ 239,263,334	$ 231,317,935	$ 7,945,398	$ 3,489,512	$ 7,698,448	GC Carryforward from SFY21 into SFY22 available before obligations.
					$ -	
NOTES					$ 7,698,448	GC Carryforward to SFY23 (44% GF)
					$ (2,313,179)	1% reserve requirement, calculated by taking 1% of SFY22 expenses not including CRF expenses (if available)
						Less: SFY22 Obligations
					$ (4,231,473)	1) Rate Setting Emergency Fiscal Relief Obligations for 4 Nursing Homes
					$ (1,153,796)	2) Estimated SFY22 Reinvestments that will be SFY23 expenses
					$ (0)	Gross GC amount available for "reinvestment"

Official Forecast Worksheet									
Healthcare Revenues									
(formerly in SHCRF now in GF)					*Jan-22*	**Jul-22**	*Jan-22*	**Jul-22**	**Jul-22**
Fund	SHCRF	GF	GF	GF	*GF*	GF	*GF*		
	FY18	**FY19**	**FY20**	**FY21**	*FY22*	**FY22**	*FY23*	**FY23**	**FY24**
	Actual	**Actual**	**Actual**	**Actual**	*Forecast*	**Actual**	*Forecast*	**Forecast**	**Forecast**
Cigarette and Tobacco taxes	**71.10**	**68.40**	**71.4**	**77.47**	*76.70*	**75.99**	*75.60*	**74.92**	**73.70**
Claims Assessment (GF portion only)	**15.91**	**15.64**	**16.87**	**16.37**	*17.28*	**17.57**	*17.45*	***18.00***	***18.36***
Employer Assessment	**19.84**	**19.75**	**20.23**	**18.36**	*20.30*	**21.89**	*21.50*	***22.98***	***24.71***
Hospital Provider Tax	**143.50**	**146.34**	**150.19**	**143.66**	*153.50*	**161.53**	*155.80*	***173.78***	***182.47***
Nursing Home Tax	**14.85**	**14.80**	**14.71**	**14.56**	*14.66*	**14.66**	*14.66*	***14.66***	***14.66***
Home Health Tax	**4.70**	**4.80**	**5.58**	**5.81**	*5.89*	**5.79**	*6.00*	***5.85***	***6.00***
Ambulance Tax	**0.94**	**0.93**	**1.01**	**0.99**	*0.90*	**0.99**	*0.90*	***0.99***	***1.00***
Pharmacy $0.10/script	**0.81**	**0.77**	**0.80**	**0.81**	*0.80*	**0.86**	*0.80*	***0.80***	***0.80***
ICFMR Tax	**0.07**	**0.09**	**0.08**	**0.03**	*0.00*	**0.00**	*0.00*	***0.00***	***0.00***
Nursing Home Transfer Tax	**0.00**	**0.80**	**0.00**	**0.00**	*0.00*	**0.00**	*0.00*	***0.00***	***0.00***
Total	**271.7**	**272.3**	**280.9**	**278.1**	**290.0**	**299.3**	**292.7**	**312.0**	**321.7**
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