July 31, 2023
Emergency Board Meeting
Report on Medicaid for Fiscal Year 2023

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 FY 23 information to date. The comparison of FY 23 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

The impacts of the COVID-19 Public Health Emergency reverberated through the health care system, the effects of which will be felt for years to come. Some of the effects may be temporary. Others appear to represent a new normal. The impacts of the July 2023 flood could also be a factor in FY 24, although, as of this writing, it is too soon to tell. Legislative and Executive Branch staff have worked closely throughout the year to interpret both short-term and long-term trends on caseloads, expenditures, and revenues.

The bullet points below provide the primary FY 23 results in Vermont's 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 multi-year charts for overall program expenditures, enrollment, and year-end positions follow this summary.

- **Expenditures:** Overall FY 23 Medicaid and Medicaid-related all funds' expenditures totaled $2.17 billion (see Exhibit 1). This is $52 million (2.3%) below all the funds' budgeted amount as passed in budget adjustment, yet still a 9% increase in total spending over FY 22.
    - Global Commitment Program spending came in $57.7 million (4%) below projections. The bulk of the underspend was from Success Beyond Six ($19 million), which draws federal match from a dedicated special fund, and from last-minute drug rebates ($10 million) claimed by the Department of Vermont Health Access (DVHA).
    - Overall program administration ran around 7%, which is consistent with FY 22, yet came in 4% below what was budgeted.
    - State-only pharmacy ran $2.1 million above estimates.
    - Disproportionate Share Hospital (DSH) payments are usually $22.7 million. For FY 23, these payments were increased up to the cap ($46.4 million) using funds earmarked for the Agency of Human Services (AHS) in Act 83 of the 2022 session to address emergency and exigent circumstances following the

COVID-19 pandemic. These funds leveraged additional federal match to help further stabilize hospital providers.

- **AHS GC General Fund Position:** The unexpended General Fund in the Agency of Human Services (AHS) Global Commitment line being carried forward into FY 24 is $12.6 million. Approximately half of this amount will be used towards FY 23 encumbrances, Level 1 cost settlement, private non-medical institutions (PNMI) and Nursing Home Extraordinary Financial Relief (EFR) requests, and Choices for Care carryforward. The remaining carryforward will be used for anticipated BAA Medicaid Consensus and GC-funded caseload and utilization needs, IMD funding pressures, and additional IT project matching funds.

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

  Most of the FY 23 eligibility groups came close to the projections adopted by the Emergency Board in January 2023. There are several areas to note:

  - *Medicaid Continuous enrollment:* Medicaid continuous enrollment (discussed in more depth later in this document) remained in full effect during the first three quarters of FY 23. This ended in April and will take at least a year to "unwind." The non-disabled adult eligibility categories were most impacted by this. Normally, these categories experience significant churn on and off the program due to employment changes. Instead, they have seen significant growth in enrollments over the past three years as result of federal policy. Other eligibility categories were less impacted because the income limits are higher or tied to a specific disability status, so churn is traditionally much lower.

  - *Vermont Premium Assistance (VPA)*: It was anticipated that the number of people receiving VPA would increase from the previous year, as had been the prediction for FY 22. The caseload in fact decreased again by 12% while the caseloads for those with cost-sharing subsidies continued to remain flat. It is speculated that this trend could reverse with the end of Medicaid continuous enrollment.

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

Vermont's base FMAP for SFY 23 was 55.98% federal share and 44.02% 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.

Since March 2020, states have received a temporary 6.2% increase in their FMAP rate as part of the federal government's COVID-19 relief. Under the Consolidated Appropriations Act, 2023, the enhanced FMAP has begun to phase down. On April 1, the enhanced FMAP decreased to 5%. It decreased again to 2.5% on July 1. It will decrease to 1.5% on October 1, and cease altogether at the end of calendar year 2023. Between FY 20 and FY 23, the increased FMAP resulted in over $300 million in General Fund savings for Vermont.

Looking ahead

- **July 2023 Flood:** At the time of the E-board meeting, it will have been three weeks since the historic floods devastated communities around the state. While it is still too soon to fully comprehend the short-term and long-term impacts on Vermonters and their human services needs, the July 2023 Flood could affect caseloads and expenditures for FY 24 and beyond.

- **FMAP:** The FY 24 base FMAP increased in the State's favor by 0.53% (to 56.52% federal share and 43.48% State share). The FY 25 base FMAP has not yet been released by the federal government. JFO and Administration staff will continue to monitor and adjust FY 25 estimates when the final FMAPs are released in the fall. The preliminary estimates provided by *Federal Funds Information for States (FFIS)* continue to be positive for Vermont from a budgetary standpoint, however, experience has shown that preliminary estimates can sometimes differ significantly from the final FMAP determination. Additionally, as mentioned above, the enhanced FMAP that had been available as part of the COVID-19 federal relief will be completely phased out by the end of the second quarter of FY 24.

- **Health Care Revenues:** Health care revenues – which include cigarette and tobacco taxes, the health care claim tax, the employer assessment, and provider taxes – were previously deposited into a special fund. In 2019 these were redirected into the General Fund. As such they are now part of the General Fund forecast.

  Hospital provider taxes projections, which account for the majority of provider taxes, always have some level of volatility. The forecast is based on what hospitals will be billed by AHS, which is based on the Green Mountain Care Board's (GMCB) budgeted estimates. These are later reconciled based on actuals for the first three quarters which may differ significantly from what was budgeted. Additionally, projections do not take into consideration hospitals that are in arrears. At the close of FY 23, four hospitals were in arrears for a total of $9 million.

The home health provider tax, which raised approximately $5.8 million and $6.1 million in FY 22 and FY 23 respectively, sunset at the end of FY 23. There will be no future revenue collection from this source.

The employer assessment came in approximately $950,000 higher than projected. The annual assessment increase is indexed to the rate increase of the second-lowest cost silver plan, whether offered inside or outside the Vermont Health Benefit Exchange. Both Blue Cross Blue Shield of Vermont and MVP Health again submitted rate filing requests to the GMCB for double-digit average annual rate increases across their individual and small group plans. FY 24 employer assessment revenues will depend both on the GMCB's final rate decisions as well as continually evolving workforce environments, for which employers pay based on the number of full-time equivalents (FTEs) they employ who lack health coverage or are covered by Medicaid.

- **Medicaid renewals and redeterminations**: The continuous Medicaid enrollment requirement, initially included in the Families First Coronavirus Response Act passed at the start of the COVID-19 pandemic, ended on March 31, 2023. The process of redetermining eligibility for every Medicaid enrollee began in April and is expected to take 12-14 months. Those who are determined no longer eligible or are unable to complete the renewal process will be disenrolled. This will impact caseload and utilization estimates for both the FY 24 budget adjustment and FY 25 budget. Additionally, while enrollment in the non-disabled adult categories saw increases during this period, the number of people receiving Vermont Premium Assistance (VPA) decreased during this time. Annual redeterminations will resume once the unwinding plan is completed. As redeterminations are once again under way, it's likely that the downward trend in VPA could reverse.

- **Home and Community-Based Services Enhanced Funding**: The American Rescue Plan of 2021 (ARPA) 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). The savings generated can be matched and expended under a federally approved plan over a multi-year period to strengthen and enhance these services.

  In Vermont, a total of $71.8 million of savings was generated by the 10% enhanced match. This allows Vermont to implement an ARPA HCBS plan with activities with matching dollars totaling $161.8 million gross between April 1, 2021 and March 31, 2025. Spending authority for this plan was authorized in Acts 83 and 185 of the 2022 session and Act 78 of the 2023 session. The funds 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.

  The FY 22 budget included a 3% rate increase for HCBS services to mental health, developmental disability, brain injury, Choices for Care, and substance use treatment

preferred providers. This was funded over three years as part of the ARPA HCBS plan. The FY 25 budget will need to include the backfill of these funds to support the rate increase. This is estimated as a $17 million gross cost and reflects a roughly $7 million need for State match.

- **Clawback:** FFIS has projected a 15.9% increase for Vermont beginning in calendar year 2024. Preliminary estimates indicate a General Fund pressure of between $3.5 million and $6.8 million in FY 24, which will become a base pressure in FY 25.

- **IMD Phasedown:** As a condition of the 2022 Global Commitment (GC) Waiver renewal, Vermont must "phase down" its reliance on GC Investment dollars to fund services at the Brattleboro Retreat and the Vermont Psychiatric Care Hospital. This will require a backfill of General Fund dollars. The phasedown is calculated on a calendar year. Preliminary estimates indicate a $2.1 million pressure on the FY 24 budget adjustment and a $6.4 million pressure in FY 25.

- **Continuous Enrollment for Children**: The Consolidated Appropriations Act, 2023 requires all states, as of January 1, 2024, to have 12-month continuous eligibility policies for children covered by Medicaid and the Children's Health Insurance Program (CHIP). Voluntary disenrollment and change of state residency will continue to be reasons for children to come off Vermont Medicaid/CHIP enrollment.

- **High-cost drugs:** DVHA is currently analyzing the potential fiscal impacts of several new high-cost prescription drugs coming down the pipeline. For instance, the FDA recently gave approval for a new drug that slows the rate of cognitive decline and is expected to cost over $25,000 per year.

Exhibit 1

Average Medicaid Caseload

(Based on Monthly Enrollment and Staff Group projections)

	actual FY20	actual FY21	actual FY22	*Ebrd Jan'23* FY23	July 2023 actual FY23	FY 24 Bud. Est. *Ebrd Jan'23* FY24
Full/Primary Coverage (note1)			*Redeterminations suspended during pandemic emergency*			
Adult						
Aged, Blind, or Disabled (ABD) Adults	6,292	6,229	6,108	5,995	6,401	5,884
General Adults	8,366	11,308	16,837	18,804	18,626	17,570
New Adult Childless- began 1/1/2014	35,058	42,064	47,797	50,851	50,596	47,115
New Adult w/Children - began 1/1/2014	20,196	24,409	24,540	24,730	25,925	23,171
Adult subtotal	69,911	84,010	95,282	100,380	101,548	93,740
	-4.4%	20.2%	13.4%			
Children						
Blind or Disabled (BD) Kids	1,766	1,636	1,542	1,447	1,619	1,354
General Kids	57,772	60,658	61,895	61,930	62,070	60,212
CHIP (Uninsured) Kids	4,549	4,356	4,687	4,905	4,635	4,596
Child subtotal	64,087	66,650	68,124	68,282	68,324	66,162
	-1.9%	4.0%	2.2%			
Subtotal -Full/Primary	**133,998**	**150,660**	**163,406**	**168,662**	169,872	**159,902**
	-3.3%	12.4%	8.5%			
Partial/Supplemental Coverage						
Choices for Care	4,387	4,476	4,510	4,492	4,600	4,507
ABD Dual Eligibles	17,546	18,031	18,320	18,350	18,663	18,350
Rx -Pharmacy Only Programs	9,976	9,965	9,586	9,306	9,096	9,033
VPA-Vermont Premium Assistance (note2)	16,237	15,187	12,471	9,722	10,842	9,856
CSR-Cost Sharing Reduction (subset of VPA)	*3,518*	*3,044*	*3,041*	*3,252*	3,106	*3,559*
Underinsured Kids (ESI upto 312% FPL)	568	569	618	640	664	640
Subtotal -Partial/Supplemental Coverage	**48,713**	**48,227**	**45,505**	**42,510**	43,865	**42,386**
	-2.6%	-1.0%	-5.6%			
Total Medicaid Enrollment	**182,711**	**198,887**	**208,911**	**211,172**	**213,737**	**202,288**
	-3.1%	8.9%	5.0%		3.4%	

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

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Exhibit 2

Summary of Total Expenditures

Medicaid and Medicaid Related

	FY20 Actual	FY21 Actual	FY22 Actual	FY23 Budgeted - BAA	FY23 Actual (Estimated as of 7/14/23)	FY24 Budgeted - As Passed
Administration (not in Waiver)						
Non Capitated Administration 50/50	76,839,254	70,450,346	69,159,795	76,717,539	80,648,528	78,089,560
Non Capitated Administration 75/25 MMIS M&O	20,103,827	20,862,489	25,587,964	33,923,783	35,776,207	33,923,782
Non Capitated Administration 75/25 SPMP	6,275,782	5,406,553	8,804,095	9,749,974	8,941,807	9,855,350
Sub-total Non Capitated Administration	103,218,863	96,719,388	103,551,853	120,391,296	125,366,541	121,868,692
Non Capitated Administration 75/25 E&E M&O	34,550,270	34,388,430	32,052,293	42,445,812	31,668,408	53,751,020
Non Capitated Administration total	**137,769,133**	**131,107,818**	**135,604,147**	**162,837,108**	**157,034,949**	**175,619,712**
Global Commitment Waiver						
GC - Program	1,236,841,301	1,268,974,765	1,413,780,286	1,586,374,021	1,528,698,008.06	1,601,426,984
GC - VT Premium Assistance	5,864,311	5,689,738	4,524,778	3,527,563	4,139,283	3,576,184
GC - Choices for Care (CY 2015 now in GC)	221,591,137	206,345,993	226,674,507	266,261,841	257,115,067	265,767,104
GC - Investments	124,799,031	98,845,057	108,638,216	101,744,734	105,146,830	106,311,159
GC - Certified (non -cash program & cnom)	23,441,495	18,175,058	21,178,030	21,962,767	20,590,111	25,050,921
GC Waiver total	**1,612,537,275**	**1,598,030,610**	**1,774,795,817**	**1,979,870,926**	**1,915,689,299**	**2,002,132,352**
Other Medicaid and Related Programs						
~~Choices For Care~~ / Money Follows the Person	2,379,542	1,388,847	4,643,428	2,581,912	2,434,893	2,948,579
Exchange Cost Sharing Subsidy (State Only)	1,170,612	1,176,262	985,102	1,053,656	1,151,486	1,153,124
Pharmacy - State Only	4,862,659	4,998,596	2,891,746	1,432,048	3,538,163	2,678,653
DSH	22,704,471	22,704,470	22,704,469	22,704,471	46,365,645	22,704,471
Clawback (state only funded)	35,532,471	30,355,530	33,191,145	40,397,960	35,919,289	42,762,070
SCHIP	13,744,946	14,664,289	14,045,476	15,204,127	11,729,012	14,294,295
Other Medicaid & Related total	**80,394,701**	**75,287,995**	**78,461,367**	**83,374,174**	**101,138,487**	**86,541,194**
Total All Expenditures	**1,830,701,108**	**1,804,426,423**	**1,988,861,331**	**2,226,082,208**	**2,173,862,735**	**2,264,293,258**

Note: The Budgeted amount for OAPD admin expense reflect the amounts approved by the CMS in submited OAPDs. This does not reflect state appropriated amounts.

OAPD = Operational Advanced Planning Document

Doc #371453

Exhibit 3

Choices for Care Year End Summary - SFY23						
CFC is managed as one budget, categories are estimated but funding is fluid within them.						
DeptID - 3460080000						
	SFY23 Budget Plan$s Available (Final Appropriation)	SFY23 Expend and Obligated	Balance of SFY23 Approp by fund	State Share Amt as of FY23 Year End	State Share converted to Gross GC in SFY24 Available For CF/Savings Reinvestment	
General Fund	$ 3,200,774.47	$ 2,028,666.66	$ 1,172,107.81	$ 1,172,107.81	$ -	
H&CB Money Follows the Person Federal Fund	$ 2,083,333.00	$ 1,826,169.43	$ 257,163.57	$ -	$ -	Federal Funds are available to use in SFY24
H&CB & Nursing Home Global Commitment Fund	$ 257,525,073.00	$257,115,067.31	$ 410,005.69	$ 156,294.17	$ 359,462.21	
Choices for Care Subtotal all funds	$ 262,809,180.47	$260,969,903.40	$ 1,839,277.07	$ 1,328,401.98	$ 359,462.21	GC Carryforward from SFY23 into SFY24 available before obligations.
					$ -	
					$ 359,462.21	GC Carryforward to SFY24 **(43.48% GF)**
					$ (2,609,699.03)	1% reserve calculated by taking 1% of SFY23 expenses
					$ (2,250,236.82)	Total GC available after obligating a 1% reserve, if funds are available, per statute.
					$ -	Funds available for reinvestment (If total GC available after 1% reserve calculation is less than zero, there are no funds for reinvestment purposes)

Exhibit 4

Official Forecast Worksheet
Healthcare Revenues
(formerly in SHCRF now in GF)

	Jan-23	Jul-23	Jul-23	Jul-23	Jul-23			
Fund	GF	GF	GF	GF	GF	GF	GF	GF
	FY20 Actual	FY21 Actual	FY22 Actual	FY23 Forecast	FY23 Actual	FY24 Forecast	FY25 Forecast	FY26 Forecast
Cigarette and Tobacco taxes	71.4	77.47	75.99	73.30	74.85	74.70	73.70	72.70
Claims Assessment (GF portion only)	16.87	16.37	17.57	18.00	18.02	18.93	19.69	20.48
Employer Assessment	20.23	18.36	21.89	23.97	24.93	25.58	26.86	28.20
Hospital Provider Tax	150.19	143.66	161.53	184.18	173.87	186.07	193.48	196.38
Nursing Home Tax	14.71	14.56	14.66	14.66	14.58	14.41	14.41	14.41
Home Health Tax	5.58	5.81	5.79	5.81	6.12	0.00	0.00	0.00
Ambulance Tax	1.01	0.99	0.99	1.10	1.11	1.10	1.10	1.10
Pharmacy $0.10/script	0.80	0.81	0.86	0.80	0.85	0.80	0.80	0.80
ICFMR Tax	0.08	0.03	0.00	0.00	0.00	0.00	0.00	0.00
Nursing Home Transfer Tax	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	**280.9**	**278.1**	**299.3**	**321.8**	**314.3**	**321.6**	**330.0**	**334.1**

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