July 21, 2016
Emergency Board Meeting
Report on Medicaid for Fiscal Year 2016

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 as a result of the year-end report. This report contains the following:

Year End Summaries:

- Summary of Enrollment
  - Status of Redeterminations
  - FY16 monthly enrollment
- Summary of Total Expenditures
- Global Commitment Fund Cash Basis Summary
- State Health Care Resources Fund Detail
- Choice for Care Year End Summary

Key Issues

The data in this report reflects the most current actual FY16 information to date. The comparison for the budgeted amount for FY16 reflects the changes made to the as passed budget by the budget adjustment process. There may be changes as the financial close-out for the fiscal year is completed and finalized. If necessary, changes will be included in a subsequent report.

Context

FY16 is the second full state fiscal year under the federal Affordable Care Act (ACA) and reflects the third open enrollment period in the Vermont Health Connect (VHC) Exchange. The exchange provides the portal for both Qualified Health Plans (QHP) and income eligibility for most Medicaid enrollees.

Expenditures

The close-out experience of FY16 is fully 180 degrees different from the close-out experience of FY15. Medicaid expenditures came in below the budgeted level in both the DVHA State Only[1] and the AHS Global Commitment lines of the budget. Total summary is on Page 11.

- The State Only line ended with $6.4m of GF unspent. Of this amount, $4.87m was reverted in FY16; this allowed the state GF to close the FY16 year in balance despite the GF revenue collections coming in below estimate. The remaining $1.5m is carried forward to FY17 and is available to be reallocated to FY17 needs.

[1]State Only includes programs and payments that are 100% state funded without any federal match; they include the Clawback payment, expanded Pharmacy program, and Cost Sharing assistance.

  - Most of the programs in the State Only line came in slightly below expectation, but the primary reason for the available funds is in the Rx programs, driven by much higher than expected rebates.

- Medicaid Global Commitment (GC) program expenditures came in $28m (gross state and federal dollars) below the level budgeted through the budget adjustment. Within this amount is the Choices for Care (CFC) balance which is statutorily defined as well as the normal year-end identified encumbrances. The total GC expenditures also included the full amount to make the 53rd week of claims payments in FY16.

  - The total amount of unobligated GF in the AHS Global Commitment line is $8.3m (after CFC and encumbrances). This is carried forward to FY17 and is available to be reallocated to FY17 needs.

- The 53rd week of claims payment was budgeted separately across FY16 (in the form of contingent GF) and FY17 (in the form of a one-time appropriation). However, in FY16 the program was able to absorb this cost in the base and still result in the positive fiscal positions described above.

  - The actual 53rd week expense was $15.4m[2] gross with a state match of $7m across all departments with the largest share in DVHA.

  - The current base has absorbed this non-recurring expense. It appears likely that the 53rd week expense can be removed from the base budget without negative program impact.

- Both the GC and State-Only programs were positively impacted by continued higher pharmacy rebate activity. Rebates were estimated to come in at $98.4m or roughly 50% of total Rx spending. Rebates actually came in at $124.6m or roughly 60% of Rx spending. This $26.2m[3] difference is a large part of the reason Medicaid could come in below expectation and absorb the 53rd week in FY16.

  - The state began using a new contractor for the pharmacy rebates part-way through the fiscal year. At the end of the fiscal year, national litigation on rebates with one manufacturer concluded in favor of the states.

  - Further analysis is needed to determine how much of the additional rebates are ongoing and how much were one-time.

- How much of the under-expenditure is due to lower caseload/redeterminations (see discussion below) and how much is due to lower utilization is not yet clear. Analysis will be conducted between October and December for the January 2017 Emergency Board

[2] Based on weekly average.
[3] A portion of this roughly $4m is attributed to the state funded Rx programs; the remainder is in the GC programs. Rebates are netted against Rx cost in both so in GC the rebate reflects the same split as the expenditure.

update. Actual enrollment and spending activity in the first few months of FY17 will help to inform the analysis.

Enrollment

On page 8 is the summary chart of annual enrollment for the past six years. The FY16 actual compared to the estimates adopted are fairly close in most groups with full coverage. The actual enrollment for the partial coverage groups came in a bit below expectation.

However because we are in the midst of eligibility redetermination for the majority of enrollees it is difficult to derive significant meaning from annual average information and how that might inform our next round of estimates.

On page 9 is the actual monthly enrollment for FY16. The second half of the year should increasingly reflect the impact of redeterminations as well as the normal program churn and new enrollments. Retroactive enrollments can also significantly impact the counts for the most recent months.

Status of the Re-Determination Processes

Waiver authority granted by CMS allowed the state to suspend redeterminations in Medicaid. The waiver for the categorically eligible groups[4] expired in February 2016, and the waiver for Modified Adjusted Gross Income (MAGI) eligible groups expires in November 2016.

The CMS approved redetermination process began last fall for categorically eligible enrollees and began in January 2016 for Modified Adjusted Gross Income (MAGI) enrollees. The process will be completed by the end of calendar 2016. This rolling re-determination process was designed so that only low numbers of Medicaid re-enrollees would need to be processed during the commercial plan open enrollment period (Nov-Jan) in this year and in future years.

On page 10 is a summary of the status of the redeterminations through July 11, 2016 for the MAGI enrollees. This summary is a work in progress and will continue to be fleshed out so that final closure/ineligibility determinations can be understood and analyzed for budget impacts and future caseload forecasts including likely reenrollment.

The redeterminations of 10,800 Categorical /ABD households[5] began in November 2015 in groups of 700 to 900 per month. Review dates are based on when enrollees first received coverage and are conducted on an annual basis. Approximately 4,500 households remain to be reviewed from now through October 2016. ABD enrollees typically respond promptly, often after the first notice, which by and large is unlike the MAGI enrollees who tend to wait longer to respond.

Approximately 3,000 closed ABD enrollment cases have been closed, 86% of these cases were because of incorrect coding that placed them in an ABD group erroneously. These roughly 2,600

[4] Categorically eligible enrollees meet a need definition such as aged, blind, disabled or medically needy. The income eligibility for these categories is based on the Protected Income Limit (PIL).

[5] Aged Blind and Disabled (ABD) includes ABD Duals, Adults and Children but SSI recipients are automatically eligible so are not subject to this redetermination process.

incorrectly coded enrollees were eligible under MAGI and have since been enrolled in the proper MAGI group. Work remains to understand the characteristics and expenditure experience of the remaining 400 ABD closed enrollment cases in the context of normal "churn" in the program.

Global Commitment Fund (GCF)

The cash position of the GCF is another area of very good financial news in FY16, see Page 12. At the end of FY14, the cash balance fell from the $86m established level to $29.5m as result of insufficient state funds to fully draw the entire federal match on current eligible expenditures. In other words, there was a state funds induced time lag on our ability to draw matching funds as we paid claims.

In FY15, the balance was able to recover to $47.5m[6] as result of increased funding and the ability to partially catch up on the federal draw timing.

At the close of FY16 the cash balance in the fund has fully recovered to $86.8m. This was possible because:

- Services provided to childless New Adults draw a much higher federal match under the ACA. Within the total utilization of services the percentage actually used by this group was $38.5m higher than initially attributed to this group. Now that these expenditures have been fully attributed, the New Adult match rate results in an $11.3m swing in the share of these expenditures from the state to the federal side.

- The process of truing up the certified matching funds with actual associated expenditures resulted in $4m state funds available[7].

- This $15.3m of freed up state funds was then available as state match. It was used to draw the federal funds for eligible expenditure within FY16 in a timely manner and to increase the cash balance of the GCF back to the pre-FY14 level.

The $86m GCF balance provides the reserve for the "tail" of the GC program. The program is budgeted on a cash basis but there are "incurred but not reported" (IBNR) expenditures at any given time in the program. The intent of the balance is to be used at the end of the waiver demonstration to address this "tail" or IBNR. Once the demonstration ends, the State has two years to process outstanding claims. The current estimate for IBNR claims is $122m on a three month period and $156m across 24 months.

Status of the Global Commitment Waiver Renewal Process

The current Global Commitment Waiver ends on December 31, 2016. Late last fall, the State requested essentially a "no change" five year renewal of the current waiver from the Federal Centers for Medicare & Medicaid Services (CMS). Since that initial request the status of renewal negotiations is:

[6]The FY15 balance provided in this report last year was $37.9m because federal matching funds on some MCO investments were not included at the time of the report. FY15 balance has since been adjusted.
[7] State funds had provided the match prior to this reconciliation.

- Vermont is unique in the depth and scope of its GC waiver and CMS wants to achieve greater standardization in the waiver process, which has been diverse across regions of the country.

- CMS, at Regional and Central Office levels, has been reviewing the MCO Investments in detail as part of the renewal negotiations.

- The 5-year agreement will likely result in the gradual phase out of some of these investments and/or the replacement of some of these investments with other approaches.

- The timing and scope of any fiscal impact to the state is not yet clear as Vermont continues to negotiate a transition plan as part of the renewal process. We expect the waiver will allow Vermont sufficient time to plan and adjust to the full impact of a tightened ability to draw federal match for certain current investments by the end of this final renewal period.

- Vermont will need to plan for the post GC replacement waiver earlier than in the past renewal time frames and will likely need to initiate this process sooner with CMS as well.

Choices for Care (CFC)

Sec. E.308 of the budget specifies uses of unobligated funds in the Choices for Care program. The FY16 year ended with $714k available for program reinvestment as summarized below:

Choices for Care FY16 Close Out		
	FY16	
GCF available funds	$185,216,109	adjusted for actual 53rd week
GCF expenditures	$182,434,143	includes 53rd week payment
Total unspent	$2,781,966	'savings'
CFC GCF 'Savings' Uses		
1% program reserve	$1,856,979	held for moderate needs
Base budget included	$445,000	amount anticipated in FY17 budget
Total	$2,301,979	required uses
Reinvestment Available		
Remaining GCF	$479,987	carryforward for reinvestment
Available GF	$234,306	CFC GF carryforward in DDAIL grants
Total	$714,293	available for reinvest H&C rebalance

State Health Care Resources Fund (SHCRF)

The FY16 balance in the fund closed with $4.7m on the bottom line. This was primarily due to:

- $2.3m of one-time recoveries revenue, including the settlement from Wyeth

- $2m higher hospital provider tax revenue

- The remainder is from modest overages in cigarette and tobacco products taxes as well as the claims and employer assessments.

The FY17 updated funds revenue estimate is $289.3m which is $3.4m higher than the level counted on when the budget was passed in May. This includes the newly adopted ambulance provider tax. With the $4.7m from FY16 brought forward, the result is a current projected fund balance of $8.0m at the beginning of FY17.

This fund does not have a reserve requirement like the other major state funds, so the utilization of this fund balance should include consideration of the current GCF balance in the context of known or likely outstanding liabilities.

Update on Other Medicaid Fiscal Issues

Federal Medical Assistance Percentage (FMAP)
We will receive final notification from FFIS on the FY18 FMAP in September. The preliminary figures provided indicate a potential modest improvement in the base state share from 45.68% in FY17 to 45.61% in FY18 which would have a beneficial GF impact of $1.1m.

Clawback
We have not received state specific Clawback estimates for FY17, but the April and May FFIS briefs and State Policy reports indicate that FFIS projects significant increases in Medicare Clawback in 2017 in the 10% to 12% range.

Medicare Part B Premiums for Dual Eligible Enrollees
Under the intermediate assumptions of the 2016 Annual Report of the Board of Trustees for the Social Security Trust Funds, the cost-of-living-adjustment on Social Security checks is expected to be 0.2 percent. High cost and low cost assumptions suggest increases of 0.0 percent and 0.7 percent, respectively. If the increase in Social Security checks turns out to be 0.2 percent, the increased amount paid by about 70 percent of Social Security beneficiaries for Medicare Part B premiums is limited to 0.2 percent. For dual beneficiaries who receive both Medicare and Medicaid, Medicaid payments by the State of Vermont would have to pick up the increased Medicare Part B premiums.

Following a bipartisan deal on the federal budget late in 2015, the Part B premium in 2016 was $121.80 per month for new beneficiaries, higher-income recipients, and Medicare recipients who do not collect a Social Security check. Nationwide, those groups make up about 14 percent of Social Security beneficiaries. About 16 percent are low-income people whose premiums are paid by their states, also set at $121.80 per month in 2016. Where the 2017 premiums end up for the state covered group may result in a substantial impact to the program, preliminary estimate is $4.7m.

Current ACO Contract FY17 payment
The second annual payment under the current ACO contract will be due in FY17 if warranted. This payment is based on half the demonstrated savings (in the form of avoided costs) as specified by the baseline and performance provisions established in the contract. In FY16 this was calculated at $13m of which $6m was state funds. The FY17 calculation is not yet known, but no funds were budgeted so to the extent a payment is owed, this will need to be included as a budget adjustment item if other fiscal offsets are not identified.

2015 Reconciliation of VHC/QHP
Once the reconciliation is finalized a 100% state funded payment could be necessary.

FY17 Practice Changes
There were several changes in the budget that could result in fiscal impacts.
The budget included a $2m savings estimate associated with clinical reviews for psychotherapy visits after a certain number of visits. The practical outcome, based revisited data and assumptions indicate this may not be achieved.
On July 1, 2016, the provider based billing was ended. While the intention was to remain budget neutral with the offsetting increase in rates, actual services and billing may not result in a net neutral impact.

Status of State All Payer Model and Medicaid ACO Full Risk Contract
The State (the Administration and the Green Mountain Care Board) have been negotiating with the CMS for an agreement that would include Medicare in a statewide All Payer Model based on the CMS Next Generation ACO program. DVHA issued an RFP for a full risk ACO contract that would enable Medicaid to participate in the all payer model. DVHA is in negotiation with the winning bidder. The full risk ACO contract anticipates a prospective, capitated payment arrangement for a specific number of Medicaid attributed lives. Some portion of the payment will be contingent on the ACO achieving quality goals. Contract negotiations have begun. DVHA anticipates reaching a contract in the early Fall, conducting a readiness review in November, and having the contract begin January 1, 2017.

Medicaid Caseload - FY12-FY16 Average (Based on Monthly Enrollment)

			actual	actual	actual	actual	actual	E-BRD Jan-16	actual[2]	E-BRD Jan-16
	AVERAGE ANNUAL CASELOAD		FY11	FY12	FY13	FY14	FY15	FY16	FY16	FY17
		Full Coverage/Primary[1]								
1	Categorical	Aged, Blind, or Disabled (ABD)/Medically Needy	13,786	13,977	14,309	14,852	15,956	16,508	15,757	17,229
2	MAGI/VHC	General Adults	10,896	11,235	11,387	13,115	17,381	20,228	20,315	22,041
3	n/a	VHAP Adults - ended in 2014	36,706	36,991	37,475	36,637	n/a	n/a	n/a	n/a
4	MAGI/VHC	New Adult all - began 1/1/2014	n/a	n/a	n/a	47,315	53,153	58,292	61,292	59,021
5	Categorical	Blind or Disabled (BD)/Medically Needy Kids	3,696	3,712	3,701	3,639	3,603	3,503	3,242	3,417
6	MAGI/VHC	General Kids	55,053	55,274	55,394	56,431	60,863	62,462	60,006	64,846
7	MAGI/VHC	SCHIP (Uninsured) Kids	3,686	3,909	3,986	4,105	4,466	4,649	4,567	4,874
8		**Subtotal -Full/Primary**	123,823	125,098	126,251	139,457	155,422	165,641	165,179	171,428
9										
10		**Partial Coverage/Supplemental**								
11	Categorical	Choices for Care (incl moderates)	3,889	3,891	3,911	4,147	4,342	4,516	4,218	4,623
12	Categorical	ABD Dual Eligibles	16,014	16,634	17,155	17,384	18,244	18,772	18,612	19,153
13	Categorical	Rx -Pharmacy Only Programs	12,751	12,655	12,535	12,653	11,978	11,761	11,612	11,026
14	n/a	Catamount - ended in 2014	9,921	10,713	11,484	13,329	n/a	n/a	n/a	n/a
15	n/a	ESI progs (VHAP&Catamount) - ended in 2014	1,650	1,551	1,535	1,409	n/a	n/a	n/a	n/a
16	QHP/MAGI	VPA-Vermont Premium Assistance[3]	n/a	n/a	n/a	14,013	16,906	17,244	14,893	17,588
17	*subset*	CSR-Cost Sharing Reduction - subset of VPA	n/a	n/a	n/a	*4,452*	*5,322*	*5,481*	*4,976*	*5,646*
18	MAGI/VHC	Underinsured Kids (ESI)	1,131	1,068	978	949	916	865	819	820
		Subtotal -Partial/Supplemental	47,006	48,062	49,133	50,555	52,386	53,158	50,153	53,211
	Total All		170,829	173,160	175,383	190,012	207,808	218,799	215,332	224,640

NOTES	
1	Some Full Coverage enrollees may have other forms of insurance.
2	Redetermination process began in Fall 2015 at 1,000 households/mo for most Categorical groups, and January 2016 at 9,000 households/mo for MAGI/VHC groups
	This process is currently ongoing and will be completed at the end of 2016. It is expected that this will impact the actual enrollment for most groups some significantly
3	VPA-Vermont Premium Assistance counts are subsribers not individuals

Medicaid Enrollment for FY16 By Month

Full Coverage/Primary1	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
ABD Adult	16,299	16,391	16,515	16,595	16,633	16,538	16,180	15,915	15,589	15,149	13,940	13,340
General Adult	19,276	19,647	19,918	20,127	20,339	20,572	20,726	20,848	20,721	20,822	20,798	19,990
New Adult - childless	47,363	47,871	48,251	48,701	49,231	49,897	51,048	51,367	51,460	51,767	50,220	46,464
New Adult	11,060	11,001	11,024	11,110	11,172	11,375	11,751	12,229	12,567	13,064	12,889	12,624
BD Child	3,424	3,410	3,362	3,349	3,321	3,271	3,231	3,218	3,219	3,187	3,006	2,903
General Child	62,755	63,007	63,362	63,554	63,693	63,920	63,444	63,679	63,677	63,767	62,254	60,006
SCHIP (Uninsured) Kids	4,433	4,414	4,433	4,453	4,470	4,502	4,427	4,460	4,505	4,539	4,583	4,567
Subtotal	164,610	165,741	166,865	167,889	168,859	170,075	170,807	171,716	171,738	172,295	167,690	159,894
Partial Coverage/Supplemental												
Choices for Care	3,977	4,002	3,996	4,008	4,016	4,013	4,015	3,999	3,964	3,942	3,887	3,845
WM	240	231	231	228	234	245	252	251	257	254	257	266
ABD Dual	19,008	19,064	19,099	19,120	19,069	18,907	18,594	18,539	18,316	18,116	17,894	17,621
Global Dual Rx	11,574	11,562	11,521	11,488	11,486	11,482	11,567	11,766	11,675	11,703	11,743	11,771
VPA-Vermont Premium Assistance2	15,627	15,640	15,671	14,818	14,535	14,138	12,891	13,242	13,915	15,752	15,960	16,523
Cost Sharing Reduction (CSR) subset	*5,106*	*5,119*	*5,127*	*4,882*	*4,810*	*4,697*	*4,451*	*4,538*	*4,722*	5,349	5,379	5,529
Underinsured Kids (ESI)	809	820	832	825	825	845	831	855	826	810	787	765
Subtotal	51,235	51,319	51,350	50,487	50,165	49,630	48,150	48,652	48,953	50,577	50,528	50,791
Total	215,845	217,060	218,215	218,376	219,024	219,705	218,957	220,368	220,691	222,872	218,218	210,685

NOTES

1 Some Full Coverage enrollees may have other forms of insurance.

2 VPA-Vermont Premium Assistance counts are subsribers not individuals

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work in progress

Redetermination status as of Week of July 11 2016

----------DVHA HH Pie Chart Data----------

MAGI eligibility in VHC		Starting universe of		Status				Determination		Finding		Status of
Waiver expires in Nov.2016		Households=	89,140	Of Initital Outreach				Of Responding		Of Completed		Ineligibles
		To Be Contacted & Just Sent	Initial Outreach	Un-Reachable Closed	No Response Closure Notice	No Response w/in Time Window	Responded	Pending	Complete	Eligible	Ineligible	For QHP VPA/CSR
	Households Ct	*36,000*	*53,140*	5,707	15,642		31,791	8,584	23,207	20,190	3,017	2,353
	%	40%	60%	11%	29%		60%	27%	73%	87%	13%	78%
					No Response Total							
Coverage Type	Individuals			Unreachable & Closure Notice								
Full	General Adults		8,319	1,604		602	6,113				952	n/a
Full	New Adults -all		30,034	9,124		3,179	17,731				1,622	n/a
Full	General Kids		49,103	10,168		5,435	33,500				872	n/a
Full	SCHIP (Uninsured) Kids		564	31		9	524				14	n/a
Partial	Underinsured Kids (ESI)		195	17		5	173				8	n/a
	Total		88,215	20,944		9,230	58,041	17,394	40,647	37,179	3,468	n/a
				24%		10%	66%	30%	70%	91%	9%	
										% of 88k tot	4%	
QHP COVERED- Redetermination is in open enrollment period or reported thru change of circumstance												*potential*
$Assist	VPA-VT Premium Assist	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a	?
$Assist	*CSR-Cost Sharing Reduc.*	n/a	n/a			n/a	n/a	n/a	n/a	n/a	n/a	?

DVHA data - required from various systems

JFO calculated from data provided

Summary of Total Expenditures							
Medicaid and Medicaid Related							
							As Passed
	FY12 Actual	FY13 Actual	FY14 Actual	FY15 Actual	FY16 Budgeted	FY16 Final Est.	FY17 Budgeted
Non Capitated Administration	5,700,438	6,098,492	5,202,413	2,468,599	-	-	
Global Commitment Waiver							
GC - Administration	74,150,382	83,170,036	73,458,966	89,009,358	114,309,219	111,948,848	102,984,542
GC - Program (incl CFC Jan 2015)	913,875,330	1,025,039,146	1,062,318,540	1,218,350,870	1,396,657,204	1,370,505,530	1,416,720,598
GC - VT Premium Assistance			1,961,455	5,471,173	7,841,105	5,256,145	5,964,932
GC - Investments (CNOM)	83,277,460	93,407,332	119,370,840	121,609,350	117,035,005	115,971,292	126,543,340
GC - Certified (non -cash program & cnom)	26,938,357	26,914,096	27,799,832	29,279,458	28,798,499	33,022,148	29,633,327
	1,098,241,529	1,228,530,610	1,284,909,634	1,463,720,209	1,664,641,032	1,636,703,963	1,681,846,739
~~Choices For Care~~ / Money Follows the Person	196,477,952	199,033,009	205,224,249	108,013,364	1,650,000	3,263,786	1,650,000
Exchange Cost Sharing Subsidy (State Only)			332,623	1,138,775	1,196,397	1,186,720	1,232,289
Exchange Vermont Premium Assistance (State Only)			610,022	140,293	700,000	10,097	
Pharmacy - State Only	(4,082,889)	(1,518,496)	1,004,506	1,256,966	1,572,590	(2,604,716)	2,959,869
DSH	37,448,782	37,448,781	37,448,781	37,448,781	37,448,781	37,448,781	37,448,781
Clawback (state only funded)	23,784,030	25,971,679	25,833,314	25,888,658	29,404,521	29,011,845	33,750,064
SCHIP	8,598,982	8,997,996	9,584,604	8,503,097	10,451,404	9,934,555	11,285,329
Total	1,366,168,824	1,504,562,071	1,570,150,146	1,648,578,742	1,747,064,725	1,714,955,030	1,770,173,071
	4.3%	10.1%	4.4%	5.0%	6.2%	4.0%	1.3%
							3.2%
Notes							
FY15 Choice For Care included in GC - Jan 1. 2015							
FY15 (6mos) and FY16 previously Non-capitated Administration is now part of GC - Administration. Therefore, there is a variance between SFY15 budgeted and SFY15 estimated actual for Non-capitated Administration and GC Administration.							
FY13 GC Program includes $60m for GME representing both the FY12 and FY13 years							

Global Commitment - Cash Balance Sheet - FY12 to FY16 (Actuals)							
(these are gross combined federal and state funds)							
	FY12 Actual	FY13 Actual	FY14 Actual [5]	FY15 Actuals[5]	FY16 Budgeted	FY16 Actual	FY17 Budgeted
Revenues - Cash Capitated Payments [4]	**1,061,421,619**	**1,192,428,821**	**1,190,118,931**	**1,442,945,241**	**1,627,989,674**	**1,633,975,029**	**1,644,461,871**
Expenses - Cash Capitated							
Administration	74,150,382	83,170,036	73,458,966	89,009,358	114,309,219	111,948,848	102,984,542
Program	913,875,108	1,025,039,145	1,064,279,995	1,223,822,043	1,404,498,309	1,375,761,675	1,422,685,530
Investment	73,406,946	84,339,985	109,465,255	112,000,874	109,182,146	107,005,238	118,791,799
Total Cash Expenses	**1,061,432,436**	**1,192,549,166**	**1,247,204,216**	**1,424,832,275**	**1,627,989,674**	**1,594,715,762**	**1,644,461,871**
Change in Fund Balance	**(10,817)**	**(120,345)**	**(57,085,285)**	**18,112,966**	**0**	**39,259,267**	**0**
Less encumbrances						(7,117,155)	
						32,142,111	
Prior Year Fund Balance	**86,673,268**	**86,662,450**	**86,542,106**	**29,456,821**	**47,569,787**	**47,569,787**	**86,829,054**
Total Fund Balance	**86,662,450**	**86,542,106**	**29,456,821**	**47,569,787**	**47,569,787**	**86,829,054**	**86,829,054**
Non-capitated administrative expenses [1]	5,700,438	6,098,492	6,291,473	2,468,599	-	-	
Non-cash expenses [2]	26,938,357	26,914,096	27,799,832	29,311,669	28,798,499	33,022,148	29,633,327
Non-cash revenues [3]	26,938,357	26,914,096	27,799,832	29,311,669	28,798,499	33,022,148	29,633,327

Notes:

(1) Non-capitated expenses are cash expenses but are paid outside of capitation pmt and do not affect fund balance. Effective 1/1/15,with consolidation of CFC into GC these expenses are now part of the GC Admin.

(2) Non-cash expenses include 5 certified programs in which non-federal expenses are not State cash expenses.

(3) Non-cash revenues include 5 certified programs in which non-federal revenues are not State cash revenues.

(4) FY10 cash capitated payments reflect the full current-year per-member per-month payment obligation. As a result, the FY11 capitation payments do not assume any payments for prior years other than technical adjustments associated with retroactive enrollment. FY09 and FY10 capitation payments included payments for prior-year shortfalls of $21,379,986 and $25,972,014.

(5) In building the SFY14 budget, matching funds for the GC appropriation were under appropriated relative to budgeted gross expenditures. Therefore, in lieu of claiming all the federal funds for budgeted gross expenditures due to a shortage in State matching funds, the GC Fund balance was used to cover the remaining actual gross costs. Accordingly, the June SFY14 capitation payment to DVHA was less than actual expenditures due to the shortage in matching funds. In July of SFY15, at which time matching funds would become available with the SFY15 appropriations, AHS CO made a reconciling capitation payment to DVHA for the balance due from June of SFY14, replenishing the GC fund balance. This then left appropriated matching funds underfunded for SFY15, and a reconciling capitation payment to DVHA will be made in July of SFY16 for SFY15, as a result. This cycle of reconciling capitation payments will continue each fiscal year. The ongoing GC fund balance will be used to address the "tail," which are incurred but not reported claims to be paid at the end of the GC demonstration.

State Health Care Resources Fund

		adj Cash/Accr'l mix FY13 Actuals	FY14 Actuals	FY15 Actuals	Jan-16 FY16 BAA	Jul-16 FY16 Actual	May-16 FY17 As Passed	Jul-16 FY17	Jan-16 FY18	Jul-16 FY18
State Health Care Resources Fund										
1	Beg. Balance	142,300	5,401,893	(748)	7,337,508	7,337,508	-	4,729,431	-	-
2	Catamount Fd Balance (incorp FY13)	4,757,170	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3	Total Beginning balance	4,899,470	5,401,893	(748)	7,337,508	7,337,508	-	4,729,431	-	-
4										
5	**Revenue**									
6	Cigarette Tax Revenue	67,338,387	64,727,447	68,302,786	69,800,000	70,007,845	67,530,000	68,530,000	65,340,000	66,300,000
7	Tobacco Products Tax - 100%	6,931,690	7,125,892	8,104,758	8,700,000	9,012,347	8,750,000	9,100,000	8,800,000	9,300,000
8	Cigarette Floor Stock Tax	-	88	347,610	900,000	897,670	-	-	-	-
9	Claims Assessment	11,470,283	13,073,292	13,978,648	13,616,505	13,767,674	13,752,670	13,905,351	13,890,197	14,044,404
10	Employer Assessment	11,886,600	12,995,400	15,879,665	17,601,287	17,896,335	19,094,995	19,094,995	19,381,420	20,156,583
11	Catamount 11% Adj - >300%	1,855,062	1,467,338	n/a	n/a	n/a	n/a	n/a	n/a	n/a
12	Graduate Med Education	25,756,529	13,228,943	13,054,500	13,491,000	13,491,750	13,704,000	13,704,000	13,704,000	13,704,000
13	Nursing Home Sale Assessment	320,000	746,400	-	596,000	593,400	3,472,000	3,472,000	-	-
14	Prov Tax - ~~Dr&Den~~ Ambulance						1,200,000	1,200,000	n/a	1,200,000
15	Prov Tax - Hospital	115,505,466	120,087,900	125,293,302	129,647,755	131,712,103	133,570,285	135,992,746	136,909,542	137,911,319
16	Prov Tax - Nursing Home	16,268,103	15,998,993	15,595,924	15,644,925	15,681,383	15,245,623	15,245,623	15,245,623	15,245,623
17	Prov Tax - Home Health	4,529,917	4,097,040	4,373,603	4,487,950	4,488,435	4,521,602	4,521,602	4,521,602	4,521,602
18	Prov Tax - ICF-MR	69,695	71,629	73,759	73,308	73,308	73,708	73,708	73,708	73,708
19	Pharmacy $0.10/script	795,192	780,174	775,297	780,000	783,689	780,000	780,000	780,000	780,000
20	Premiums - Catamount	4,984,683	3,164,335	n/a	n/a	(38)	n/a	n/a	n/a	n/a
21	Premiums - VHAP (mgd care)	2,951,004	1,634,739	(260)	n/a	-	n/a	n/a	n/a	n/a
22	Premiums - Dr. D (medicaid)	183,944	88,237	192,949	50,000	130,524	50,000	135,000	50,000	135,000
23	Premiums - SCHIP	536,649	359,025	928,108	600,000	163,865	600,000	160,000	600,000	160,000
24	Premiums - Rx programs	3,180,120	3,163,777	3,112,356	3,045,450	2,918,910	3,045,450	2,900,000	3,045,450	2,900,000
25	Recoveries	5,049,628	1,279,529	435,377	500,000	2,831,833	500,000	500,000	500,000	500,000
27	Other *(Misc, Interest)*	(721,899)	(166,395)	(39,319)	(965,720)	(962,512)	-			
28	Total Fund Revenue	278,891,053	263,923,782	270,409,063	278,568,460	283,488,521	285,890,333	289,315,025	282,841,542	286,932,240
29										
30	Total Available	283,790,524	269,325,675	270,408,315	285,905,967	290,826,029	285,890,333	294,044,456	282,841,542	286,932,240
31										
32	**Expenditures**									
36	Total GC Expend	278,388,631	269,326,423	263,070,807	284,196,184	286,096,598	286,005,627	286,005,627		
37										
38	**End. Balance**	**5,401,893**	**(748)**	**7,337,508**	**1,709,783**	**4,729,431**	**(115,294)**	**8,038,829**		
39										
40	*Exchange Operations - Allocation*			*1,244,668*	*7,884,268*	*3,448,899*	*5,529,495*	*5,529,495*		

Exchange Operations reflect the operations cost of the Qualified Health Plan (QHP) portion of the exchange,
Medicaid eligibility and exchange operations costs are included in the Global Commitment expenditure