July 27, 2015
Emergency Board Meeting
Report on Medicaid for Fiscal Year 2015

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
- Summary of Total Expenditures
- Global Commitment Fund Cash Basis Summary
- State Health Care Resources Fund Detail
- Choices for Care Year-End Summary

Key Issues
The data in this report reflect the most current actual FY15 information to date. The comparison for the budgeted amount for FY15 reflects the changes made to the as passed budget by the rescission in August 2014 and 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 revised report.

Context
FY15 is the first full State fiscal year under the federal Affordable Care Act and reflects the second 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 programs.

The operation of the VHC Exchange continues to challenge Vermonters, administrators, policy makers, and QHP providers. Progress in improving VHC operations is the subject of separate reporting, but the workgroup consisting of staff from Finance and Management, the Agency of Human Services, the Department of Vermont Health Access, and the Joint Fiscal Office charged with analyzing Medicaid enrollment and cost trends recognize these challenges likely have direct impacts on the data presented in this report which can be noted but not specifically quantified at this time.

Expenditures
The main take-away for the FY15 close out in Medicaid is that Global Commitment (GC) program expenditures came in over $30 million (gross State and federal dollars) above the level

budgeted. A significant cost overage was anticipated based on the weekly expense tracking known as 'The 52 Points" and for which Act 58 (the FY16 Budget Bill) allocated up to $13 million of FY15 surplus General Fund (GF). The availability of the surplus funds could not be determined until all the GF components were finalized in July. In order to allow the Medicaid provider payments to go out in the final week of June, funds particularly in Medicaid administration were unencumbered and these funds were then used in combination with funds transferred from other Medicaid program areas (Premium and Cost subsidy programs, State Only Rx, SCHIP) as a temporary fiscal measure both to pay providers and stay within the appropriated limit. Now that it is clear that the full $13m GF will be available, these administration expenses will be reencumbered and expended in FY16 which will move FY16 expenditures above the amount as passed in Act 58.

Right now, how much of the cost overrun is due to caseload (see discussion below) and how much is due to utilization is not determined. Analysis will be conducted in the fall for the January 2016 Emergency Board update, and should help to make that more clear. At this early stage, it is known that outpatient services were significantly higher than expected but whether this is solely due to a utilization change in this area or if there are offsetting reductions in other service categories will not be known until the caseload impacts can be decoupled.

The rollout fiscal impact on both FY16 and FY17 is likely to be significant as the FY16 budget was developed without the $30 million included in the spending trend. In addition to the trend implications, there are several areas that may also see utilization at a higher level than was assumed and budgeted for in FY16. These include Applied Behavior Analysis (ABA, i.e., Autism) services and Licensed Alcohol and Drug Counselor (LADC) services.

Finally, the first shared savings payment under the ACO contract will be made in FY16 and the funding for this payment will be a budget adjustment item. The payment calculation is specified by the terms of the contract, and it should be a reflection that expenditures in CY2014, in the absence of the ACO contract, would have been at least twice as high as the payment amount. An additional onetime fiscal pressure is a 53rd week of vendor payments. This will have an estimated FY16 budget adjustment or FY17 budget impact of $25 million total of which $11 million will be in state GF.

Enrollment

The main take-away on enrollment for FY15 is that caseload came in significantly higher than the level anticipated in January. The adult Medicaid Eligibility Groups (MEGs) in total came in almost 7.7% above expectation with the largest variance in General Adults by 12.3% and New Adults by 9.5%. The enrollment for children in the aggregate also came in 3.5% higher than expected.

The Vermont Premium Assistant (VPA) program and its subset of Cost Sharing Assistance enrollees is the population that came in significantly under expectation by -28% and -43% respectively.

The changes in income eligibility[1] under the ACA are part of the current income eligibility process for Medicaid enrollment through the VHC Exchange. It is unclear how much of this higher-than-expected level in caseload is a function of:

1. Estimation error, particularly regarding the base assumptions for the uninsured population at various income levels as well as the coverage uptake rate for the uninsured at the eligible income levels;

2. Change in employer coverage patterns, for example, have employers for individuals who fall in these income ranges opted to drop insurance coverage; or

3. Current Medicaid eligibility processes which have relied on the following:

   - Self-attested income. From Oct. 2013 through April 2015, Medicaid enrollees through the exchange relied on self-attested income without an automated process for income verification. Beginning in May 2015, self-attested income now has an electronic post enrollment verification process. A manual monthly check against Vermont Dept. Of Labor (VDOL) is conducted for Medicaid enrollees in the ACCESS system. Information on the error rate of self-attested income after verification is pending. Further enhancements to the income verification process are included in future system planning and updates.

   - Automatic Renewal for Medicaid under a waiver from CMS.

Status of Reenrollment and Eligibility Determination Processes

The Medicaid program is experiencing higher than normal retention for people who have not yet been transitioned off the legacy system – the majority of whom have not gone through another eligibility determination. The auto-renewal is likely capturing people who may no longer be income eligible for programs. It is hard to know what this over-capture rate is. These factors reduce normal "churn" patterns which in turn increase enrollment rates above what they would have been with a normal reenrollment eligibility determination process.

In early March, Vermont Health Connect began to implement its plan to transition approximately 30,885 Medicaid for Children and Adults (MCA) households which reflect 59,157 enrollees from the State's legacy ACCESS system to Vermont Health Connect to receive their MCA eligibility determination. The plan began with a pilot of the 3,000 highest income households.

As of mid-July 2015, two out of five (which is 39% or 1,175 households, 2,199 enrollees) in the pilot had filled out an application for coverage. Of those who applied, nearly one in five (19% of the this 39%, or 222 households, 434 enrollees) no longer had a member who qualified for Medicaid, while four out of five had at least one household member qualify for Medicaid.

Staff is communicating with the Center for Medicare and Medicaid Services (CMS) for approval of a plan and schedule to close pilot customers who have not responded to outreach attempts.

[1] The income eligibility calculations were changed under the Affordable Care Act (ACA). A Federal Poverty Level of 133% in the new Modified Adjusted Gross Income (MAGI) is equivalent to 138% under the pre ACA method.

This is approximately 1,800 households/3,200 enrollees of the 3,000 households/5,466 enrollees in the pilot.

State staff have been closing customer cases when customers have asked for Medicaid to be closed and when customers' outreach letters have been returned with no forwarding address.

The planning and timing of the transition of the remaining 27,000 MCA households from the ACCESS system to VHC reenrollment and eligibility determination process is still under discussion with CMS. An analysis of recent claims specifically related to the cases slated for closure for nonresponse to outreach and well as the 19% (434 enrollees) found income ineligible would provide a foundation for understanding the fiscal implications of the over-capture.

Global Commitment Fund (GCF)
The cash position of the GCF grew through FY11 to a level of $86.5m, and held steady in FY12 and FY13 but declined in FY14 to $29.5 million due to a lack of adequate State funds to fully draw federal match within FY14 for FY14 expenditures. FY14 expenditures were covered by drawing down the fund balance and then immediately using part of the next year (i.e., FY15) State appropriation to draw the federal match owed on FY14 expenditures.

The actual FY15 spending level meant these funds were needed to cover current year instead of replenishing the GCF balance as hoped. Year-end FY15 year transfer actions included some pure GF which did allow for a modest increase in the cash balance of the fund up to $37.9 million.

But again this July, the first use of FY16 State funds will be to draw federal match that could not be drawn in FY15. It is unlikely this will be able to bring the cash balance of the fund back up on anything more than a temporary basis, given the overall spending trend in the program. Without a change in the State funding level it is more likely FY16 will see continued decline in the GCF balance. Program expenditures at the close of FY16 will need to come below the funded level for the fund balance to rise, which is highly unlikely.

The 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. As of last quarter, the estimate for those claims was $100,912,678.

State Health Care Resources Fund (SHCRF)
The FY15 balance in the fund closed $6m ahead of expectation. This was due to tobacco taxes coming in $2.9 million higher than expected and hospital provider taxes receipts $2.2 million over expectation. The other fund revenue lines when combined net $900,000 over target.

The updated revenue estimate for FY16 reflects cigarette/tobacco tax estimates including the rate increase passed in Act 57 of 2015, as well as an updated hospital provider tax estimate which is tied to the Green Mountain Care Board growth target. These result in a projected balance of $10.3 million for FY16.

This fund does not have a reserve requirement as does the GF, EF, or TF, so it will need to be determined if any current balance is directed toward establishing a fund reserve or used to address FY16 budget adjustment and/or FY17 budget pressures. This decision should be made in conjunction with the projected GC fund balance.

Choices for Care (CFC)
Beginning January 1, 2015, the Choices for Care waiver has been consolidated into the Global Commitment Waiver. However a small amount of GF will continue to be appropriated outside the GC for Home and Community Services that are funded through the Money Follows the Person (MFP) grant.

Sec. E.308 of Act 58 of 2015 outlined the methodology for calculating "savings" in the Choices for Care Program. The year-end summary sheet shows actual CFC expenditures in FY15 (including reinvestment expenses) compared to available resources (including reinvestment funding) were pretty much spot on in total.

After accounting for the required 1% program reserve, the amount of unobligated CFC program funding available for reinvestment in the budget adjustment is just under $100,000. This is much lower than in previous years. This means that the program expenditure level is essentially at equilibrium for FY15 which may portend that program increases particularly for the Moderate Needs services may not be able to be funded from Nursing Home and Home and Community Based service savings in the future.

Federal Medical Assistance Percentage (FMAP)
Base FMAP remains an area of pressure for FY17 though at a much lower level than in previous years. In the underlying base FMAP rate, i.e., the State share is going up by 0.25%. On a Medicaid base of $1.7 billion, this change translates into roughly $4 million of addition State funds pressure as we begin to build the FY17 budget.

Clawback
FFIS has provided a preliminary calculation for the next Federal Fiscal 2016 payment levels. This indicates an FY16 budget adjustment impact of $1.3m to $2.4 million and full annualized FY17 impact of $4 million. The Clawback is 100% GF payment states make back to the federal government to reflect state savings associated with the Medicare Part D Rx program. It is tied to federally determined pharmacy inflationary factors and state FMAP level.

All Payer Model
The administration is currently in discussions with CMS exploring the possibility of an All-Payer Model which would include a Medicare Waiver. In order for an all-payer model to go into effect for CY2017, the State and CMS would need an agreement in place by the beginning of CY2016. At this time, it is unknown if the state and CMS will come to an agreement, what the terms and conditions would entail, and if there will be a state budget impact particularly to Medicaid. A white paper is available on the JFO website.

Medicaid and Medicaid Related Enrollment

PROGRAM ENROLLMENT							
Adults	FY 11 Actual	FY 12 Actual	FY13 Actual	FY14 Actual* ACA Beg. Jan 1, 2014	FY15 BAA	FY15 Actual	FY16 As Passed
Aged, Blind, or Disabled (ABD)/Medically Needy	13,786	13,977	14,304	14,852	15,378	15,808	15,680
Dual Eligibles	16,014	16,634	17,118	17,384	17,682	18,163	17,978
General	10,896	11,235	11,375	13,115	15,504	17,412	15,966
VHAP (see note for FY14)	36,706	36,991	37,486	36,637	n/a	n/a	n/a
VHAP ESI (see note for FY14)	904	825	791	720	n/a	n/a	n/a
Catamount (see note for FY14)	9,921	10,713	11,486	13,329	n/a	n/a	n/a
ESIA (see note for FY14)	747	726	746	689	n/a	n/a	n/a
New Adult	n/a	n/a	n/a	47,315	48,500	53,124	48,985
QHP Exhange <300% FPL - Premium Subsidy				14,013	18,007	12,870	18,368
QHP <300% FPL- Silver Plan Cost Share Subsidy subset	*n/a*	*n/a*	*n/a*	*4,452*	*5,859*	*3,307*	*6,034*
Subtotal Adults	88,974	91,101	93,306	VHAP/Cat 96,726	115,071	117,376	116,977
				New Adult/ QHP 106,679			
Children							
Blind or Disabled (BD)/Medically Needy	3,696	3,712	3,695	3,639	3,713	3,579	3,727
General	55,053	55,274	55,361	56,431	58,301	60,756	57,594
Underinsured	1,131	1,068	977	949	1,082	927	981
SCHIP (Uninsured)	3,686	3,909	3,977	4,105	4,273	4,496	4,417
Subtotal Children	63,566	63,963	64,010	65,124	67,369	69,757	66,719
Pharmacy Only Programs	12,751	12,655	12,546	12,653	12,684	12,005	12,709
Choices for Care							
Nursing Home, Home & Community Based, ERC	3,889	3,891	3,886	4,147	4,177	4,280	4,222
Total	**169,180**	**171,610**	**173,748**	VHAP/Cat **178,650**	**199,301**	**203,419**	**200,627**
				New Adult/ QHP **188,603**			

*** FY14 Enrollment Notes**

ACA Began Jan 1, 2014 (mid way thru FY14). VHAP and Catamount are duplicative with many New Adults and Premium Assistance enrollees within FY14

VHAP and Catamount programs phased out Jan-Mar 2014

New Adult Medicaid eligibility group established, many VHAP and some Catamount enrollees transitioned to this group, as well as other newly enrolled

Premium and Costs Sharing programs established, former Catamount enrollees now w/a QHP likely eligible for these programs

Global Commitment - Cash Balance Sheet - FY09 to FY15 (Actuals)

(these are gross combined federal and state funds)

	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual (5)	FY15 Resc. & BAA & Waiver consolidation	Prior to application of FY15 $13m GF surplus funds: FY15 Actuals est. (5)	FY16 Budget
Revenues - Cash Capitated Payments (4)	**1,047,364,322**	**1,061,421,619**	**1,192,428,821**	**1,190,118,931**	**1,397,059,641**	**1,433,336,765**	**1,563,696,326**
Expenses - Cash Capitated							
Administration	72,314,139	74,150,382	83,170,036	73,458,966	105,558,490	82,193,455	125,388,789
Program	900,949,532	913,875,108	1,025,039,145	1,064,279,995	1,202,500,495	1,234,001,800	1,329,028,216
Investment	49,287,654	73,406,946	84,339,985	109,465,255	110,026,347	108,637,020	109,279,321
Total Cash Expenses	**1,022,551,325**	**1,061,432,436**	**1,192,549,166**	**1,247,204,216**	**1,418,085,332**	**1,424,832,274**	**1,563,696,326**
Change in Fund Balance	**24,812,997**	**(10,817)**	**(120,345)**	**(57,085,285)**	**(21,025,691)**	**8,504,491**	**0**
Less encumbrances				(8,797,926)		(762,214)	
				(65,883,211)		**7,742,277**	
Prior Year Fund Balance	**61,860,271**	**86,673,268**	**86,662,450**	**86,542,106**	**29,456,821**	**29,456,821**	**37,961,312**
Total Fund Balance	**86,673,268**	**86,662,450**	**86,542,106**	**29,456,821**	**8,431,130**	**37,961,312**	**37,961,312**
Non-capitated administrative expenses (1)	6,516,131	5,700,438	6,098,492	6,291,473	2,468,599	2,468,599	-
Non-cash expenses (2)	24,782,283	26,938,357	26,914,096	27,799,832	28,393,646	29,311,669	28,995,358
Non-cash revenues (3)	24,782,283	26,938,357	26,914,096	27,799,832	28,393,646	29,311,669	28,995,358

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

(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.

Summary of Total Expenditures

Medicaid and Medicaid Related

	FY11 Actual	FY12 Actual	FY13 Actual	FY14 Actual	FY15 Resc. & BAA & Waiver consolidation	FY15 Final Est.	FY16 As Passed
						Prior to application of FY15 $13m GF surplus funds	
Non Capitated Administration	6,516,131	5,700,438	6,098,492	5,202,413	2,468,599	2,468,599	-
Global Commitment Waiver							
GC - Administration	72,314,139	74,150,382	83,170,036	73,458,966	105,558,490	82,193,455	125,388,789
GC - Program (CFC incl. Jan.1 2015)	900,949,532	913,875,330	1,025,039,146	1,062,318,540	1,194,775,605	1,228,530,627	1,321,187,111
GC - VT Premium Assistance				1,961,455	7,724,888	5,471,173	7,841,105
GC - Investments (CNOM)	49,287,654	83,277,460	93,407,332	119,370,840	117,938,361	118,245,496	116,986,841
GC - Certified (non -cash program & cnom)	24,578,280	26,938,357	26,914,096	27,799,832	28,393,646	29,311,669	28,995,358
	1,047,129,605	1,098,241,529	1,228,530,610	1,284,909,634	1,454,390,990	1,463,752,419	1,600,399,204
Exchange Cost Sharing Subsidy (State Only)				332,623	1,689,945	1,138,775	3,522,615
Exchange Vermont Premium Assistance (State Only)				610,022	250,000.0	140,293.0	700,000
Choices For Care Waiver	191,968,805	196,477,952	199,033,009	205,224,249	108,316,625	108,013,364	1,650,000
Pharmacy - State Only	1,812,342	(4,082,889)	(1,518,496)	1,004,506	3,170,931	1,256,976	2,984,607
DSH	37,448,782	37,448,782	37,448,781	37,448,781	37,448,781	37,448,781	37,448,781
Clawback (state only funded)	17,684,471	23,784,030	25,971,679	25,833,314	26,618,207	25,888,658	26,979,242
SCHIP	7,642,495	8,598,982	8,997,996	9,584,604	10,072,000	8,280,573	10,451,404
Total	1,310,202,631	1,366,168,824	1,504,562,071	1,570,150,146	1,644,426,078	1,648,388,438	1,684,135,853
	3.1%	4.3%	10.1%	4.4%	4.7%	5.0%	2.4%

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

State Health Care Resources Fund

FY16 cigarette tax risk is higher due to timing concerns on revenue reporting

	FY11 Actuals	FY12 Actuals	Cash/Accrual mix FY13 Actuals	FY14 Actuals	Jan. 2015 FY15 BAA	FY15 Actuals	Jan. 2015 + session chg FY16 As Passed	July 2015 FY16 Update	July 2015 FY17
State Health Care Resources Fund									
Beg. Balance	3,904,454	5,093,196	142,300	5,401,893	(748)	(748)	1,313,815	7,337,508	
Catamount Fd Balance (incorp FY13)	793,641	2,212,330	4,757,170		-				-
	4,698,095	7,305,526	4,899,470	5,401,893	(748)	(748)	1,313,815	7,337,508	-
Revenue									
Cigarette Tax Revenue	66,448,755	72,811,427	67,338,387	64,727,447	65,380,000	68,302,786	66,040,000	68,610,000	66,470,000
Tobacco Products Tax - 100%	6,511,841	6,868,340	6,931,690	7,125,892	8,090,000	8,104,758	8,100,000	8,150,000	8,200,000
Cigarette Floor Stock Tax	-	550,272	-	88	350,000	347,610	-	750,000	-
Claims Assessment	-	12,603,108	11,470,283	13,073,292	14,000,000	13,978,648	14,280,000	14,280,000	14,565,600
Employer Assessment	9,316,000	11,168,000	11,886,600	12,995,400	15,640,000	15,879,665	17,549,266	17,549,266	17,549,266
Catamount 11% Adj - >300%	-	1,442,038	1,855,062	1,467,338	-		-		
Graduate Med Education	-	-	25,756,529	13,228,943	13,054,500	13,054,500	13,491,000	13,491,000	13,491,000
Nursing Home Sale Assessment	-	-	320,000	746,400	-		-		
Prov Tax - Hospital	94,739,392	110,642,636	115,505,466	120,087,900	123,132,709	125,293,302	128,166,206	129,052,101	132,011,192
Prov Tax - Nursing Home	12,842,419	15,749,272	16,268,103	15,998,993	15,700,680	15,595,924	15,599,829	15,599,829	15,599,829
Prov Tax - Home Health	3,957,011	4,548,206	4,529,917	4,097,040	4,547,271	4,373,603	4,327,271	4,327,271	4,273,180
Prov Tax - ICF-MR	70,236	82,098	69,695	71,629	73,759	73,759	73,759	73,759	73,759
Pharmacy $0.10/script	790,315	789,877	795,192	780,174	780,000	775,297	780,000	780,000	780,000
Premiums - Catamount	3,912,593	4,597,688	4,984,683	3,164,335	-	-	-		-
Premiums - VHAP (mgd care)	2,205,367	2,858,383	2,951,004	1,634,739	-	(260)	-		-
Premiums - Dr. D (medicaid)	155,259	180,401	183,944	88,237	50,607	192,949	50,000	50,000	50,000
Premiums - SCHIP	478,300	507,101	536,649	359,025	623,382	928,108	600,000	600,000	600,000
Premiums - Rx programs	3,292,209	3,160,264	3,180,120	3,163,777	3,045,450	3,112,356	3,045,450	3,045,450	3,045,450
Recoveries	771,362	625,996	5,049,628	1,279,529	500,000	435,377	500,000	500,000	500,000
Other *(Misc, Interest)*	(339,836)	(32,672)	194,977	(166,395)	-	(39,319)	-	-	
Total Fund Revenue	205,151,223	249,152,435	279,807,929	263,923,782	264,968,358	270,409,063	272,602,781	276,858,676	277,209,276
Total Available	209,849,318	256,457,961	284,707,399	269,325,675	264,967,610	270,408,315	273,916,596	284,196,184	277,209,276
Expenditures									
Global Commitment	202,543,792	251,558,494	278,388,631	268,303,555	259,471,390	261,826,139	272,871,045	272,871,045	272,871,045
Exchange Operations					4,182,405	1,244,668	1,041,736	1,041,736	1,041,736
GC - Excess receipt				1,022,868	-	-	-	-	-
Total GC Expend	202,543,792	251,558,494	278,388,631	269,326,423	263,653,795	263,070,807	273,912,781	273,912,781	273,912,781
End. Balance	**7,305,526**	**4,899,467**	**6,318,768**	**(748)**	**1,313,815**	**7,337,508**	**3,815**	**10,283,403**	**3,296,495**

Catamount Fund into SHCRF in FY13
FY11 & FY12 adjusted for comparison

Note: During SFY14, AHS learned that certain categories of revenue were stated on an accrual basis in previous fiscal years . In order to reflect the cash-basis balance of the SHCRF, the AHS began tracking revenue on a cash basis during SFY14.

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

Choices For Care Year End Summary

CFC is managed as one budget, estimates are made by category but funding is fluid across categories

	FY15 Plan$s Available (thru Resc & BAA)	FY15 Expend and Obligated	Difference	
LTC				
Moderate Needs Group	$6,946,589	$5,567,848	$1,378,741	
H&CB (CFC & MFP combined)	$58,850,870	$57,961,542	$889,328	*GF/Gross mix*
adj for MFP GF only			($310,917)	
Nursing Home	$118,538,079	$119,082,420	($544,341)	
LTC Subtotal	$184,335,538	$182,611,810	$1,412,811	
* Gross up of MFP GF			$691,387	*$310,917/.4497*
			$2,104,198	
Obligations & Requirements				
1% reserve requirement	*incl. in H&CB*	1,826,118	($1,826,118)	
AAA MNG FY16 continuation		179,000	($179,000)	
	$184,335,538	$184,616,928	$99,080	
Acute	$27,278,016	$28,176,557	($898,541)	*Covered w/in GC*
CFC Plan Total	$211,613,554	$212,793,485	*excl.1% reserve*	

* MFP - Money Follows the Person match will remain GF - all other CFC funds are now within the Global Commitment Waiver and will be reflected the GCF fund approrpriations