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May 21, 2015 Joint Committee on Finance Paper #345

MA Cost-to-Continue
(Health Services -- Medical Assistance -- General)

[LFB 2015-17 Budget Summary: Page 201, #1]

CURRENT LAW

The medical assistance (MA) program, also broadly known as "Medicaid," provides health care coverage to adults and children in families with household income below certain levels, and to elderly, blind or disabled individuals who have limited resources. Certified healthcare providers provide a wide range of services to program recipients. The Department of Health Services (DHS) administers the program under a framework of state and federal law through a plan approved by the federal Centers for Medicare and Medicaid Services (CMS).

The program has two primary components -- elderly, blind and disabled (EBD) Medicaid and BadgerCare Plus. EBD Medicaid provides coverage to individuals who are elderly, blind, or disabled who meet the program's income and asset standards. Individuals may receive services provided under the state's long-term care waiver programs, such as Family Care and IRIS (Include, Respect, I Self-Direct), as well as acute care services, including physician services, prescription drugs, and inpatient and outpatient hospital services. Many individuals enrolled in EBD Medicaid also qualify for Medicare benefits. For these "dual eligible" individuals, the state's MA program pays for services not otherwise covered under Medicare, as well as Medicare's cost-sharing requirements.

BadgerCare Plus provides coverage to individuals and families that meet the program's income standards. In general, children and pregnant women in households with income up to 300% of the federal poverty level (FPL), and non-pregnant, non-disabled adults in households with income up to 100% of the FPL, qualify for Badger Care Plus. Enrollees primarily receive acute care services, such as hospital and physician services, prescription drugs, and maternity and prenatal care coverage.

In April, 2015, approximately 1,117,200 individuals participated in MA or MA-related

programs (excluding SeniorCare). Of that total, approximately 818,200 were enrolled in BadgerCare Plus and 215,400 were enrolled in EBD Medicaid. The 83,600 remaining enrollees participated in other MA-supported programs, including limited benefit programs such as the state's family planning only services program and Medicare cost-sharing assistance to individuals who do not qualify for full MA coverage.

MA benefits are funded from the following sources: (a) state general purpose revenue (GPR); (b) federal matching funds (FED); (c) program revenues (PR), primarily rebate revenue provided by drug manufacturers; and (d) segregated revenues (SEG), primarily from the MA trust fund.

GOVERNOR

MA Benefits. Provide $649,722,500 ($262,524,000 GPR, $356,232,900 FED, $85,233,100 PR and -$54,267,500 SEG) in 2015-16 and $1,026,642,500 ($384,026,300 GPR, $557,116,200 FED, $143,065,100 PR, and -$57,565,100 SEG) in 2016-17 to fund the projected costs of MA benefits under the state's MA program during the 2015-17 biennium. These funding changes reflect the administration's estimates of the "cost-to-continue" for the program, reflecting current enrollment and cost trends. Table 1 shows these estimates, by fund source.

TABLE 1

Total Cost-to-Continue MA Benefits Funding
Governor's Recommendations

	2014-15 Base	2015-16	2016-17
GPR	$2,517,510,500	$2,780,034,500	$2,901,536,800
FED	4,652,604,700	5,008,837,600	5,209,720,900
PR	580,166,900	665,400,000	723,232,000
SEG	672,979,200	618,711,700	615,414,100
Total	$8,423,261,300	$9,072,983,800	$9,449,903,800

Adult Protective Services. Provide $518,700 GPR in 2015-16 and $532,300 GPR in 2016-17 to fund adult protective services in seven northeastern counties where the Family Care benefit will first become available in the 2015-17 biennium. This item is not normally categorized as an MA benefit cost.

DISCUSSION POINTS

1. This paper provides a reestimate of the amount of funding needed to support MA benefits costs in the 2015-17 biennium if the Legislature does not make any changes to the program. It reflects updated information on program enrollment and costs trends, federal matching funds, and minor corrections to the administration's estimate of future program costs. The Governor's recommendations for programmatic changes -- such as the extension of disproportionate share

hospital payments and changes to reimbursement for federally qualified health centers -- are discussed in other papers.

2. Additional information about the MA program has become available since the administration developed its budget projections. This information includes several months of additional enrollment and expenditure data, as well as updated projections regarding payments made to or received from the federal government. Based on this information and additional review and analysis by this office and DHS, a number of adjustments should be made to the funding amounts in the bill.

3. The total effect of these adjustments is an increase in MA benefits funding of $138,787,800 ($10,632,800 GPR, $94,953,900 FED, $14,846,200 PR, and $18,354,900 SEG) in 2015-16, and $14,651,500 ($13,211,400 GPR, -$65,102,400 FED, $43,357,700 PR, and $23,184,800 SEG) in 2016-17.

4. This net GPR increase is composed of multiple changes that, considered individually, either increase or decrease program costs, compared to the amounts in the bill. Table 2 shows the biennial GPR effect of these components, which are discussed in more detail below.

TABLE 2

Adjustments to Medicaid GPR Cost-to-Continue
($ in Millions)

Increase Fee-for-Service Expenditures	$69.4
Increase BadgerCare Plus Costs	51.7
Decrease SEG Revenues for HealthCheck-Eligible Services	13.9
Increase "Clawback" Payments	9.6
Decrease FMAP in 2016-17	1.3
Increase Nursing Home/ICF-ID Bed Assessment Revenues	0.5
Decrease Medicare Premium Expenditures	-1.8
Decrease Nursing Home Expenditures	-3.9
Decrease Federally Qualified Health Center (FQHC) Expenditures	-6.8
Decrease Family Care, IRIS, and PACE/Partnership Costs	-23.1
Increase Drug Rebate Revenues	-30.2
Apply CHIP Matching Rate to Portion of Hospital Access Payments	-57.6
Total GPR Change from Listed Factors	$23.0
Other Factors	0.8
Total GPR Change to Bill	$23.8

5. *Fee-for-Service Expenditures (Biennial GPR effect of $69.4 million).* Costs for health care services provided on a fee-for-service basis represent the largest factor of the increase. Although most MA recipients are enrolled in health maintenance organizations or other managed care organizations, Medicaid pays fees directly to health care providers for services provided to individuals who are not enrolled in managed care. In addition, all MA enrollees receive prescription drugs on a fee-for-service basis. The reestimate reflects updated cost data on fee-for-service expenditure categories, such as inpatient and outpatient hospital, physician and clinics, and personal

care.

6. Prescriptions drug costs have grown rapidly, and are the main factor of increases in fee-for-service costs in both the Governor's recommendations and these updated projections. This cost growth reflects recent national drug cost trends, due in part to increased spending on specialty drugs. The reestimate assumes that drug cost "intensity" (or the extent to which enrollees use more or less services, or a different mix of services) will increase by 11.3% in 2015-16 and 10.0% in 2016-17. Total projected drug expenditures (all funds) equal $1.07 billion in 2015-16, and $1.18 billion in 2016-17.

7. Although drug costs are projected to be greater than estimated under the Governor's budget, this increase will generate additional drug rebate revenue. Under federal law, a drug manufacturer must have a national rebate agreement with the Secretary of the Department of Health and Human Services for drugs covered by state Medicaid programs. Those rebates proportionately offset GPR and FED needed to fund MA benefits. The reestimate includes an increase in drug rebate revenues of $30.2 million over the biennium to reflect increased drug expenditures, and a modification to the methodology used to estimate rebates to more accurately reflect the portion subject to the federal matching rate for the Children's Health Insurance Program (CHIP).

8. *BadgerCare Plus Costs ($51.7 million).* Recent caseload trends suggest that enrollment projections for the 2015-17 biennium should be increased from the levels projected in the bill. Table 3 provides the enrollment assumptions in the reestimate, by major MA eligibility group. In total, current projected BadgerCare Plus enrollment exceeds the estimates included in the bill by 20,000 individuals in 2015-16, and 24,000 individuals in 2016-17.

TABLE 3

Average Monthly Enrollment, by Major MA Eligibility Group

	Actual	Projected		
	2013-14	2014-15	2015-16	2016-17
BadgerCare Plus				
Children	478,747	469,852	471,207	475,941
Parents and Caretakers	229,212	178,875	177,780	177,730
Childless Adults	39,046	146,764	159,819	162,104
Pregnant Women	21,160	20,922	20,796	21,005
Total -- BadgerCare Plus	768,164	816,413	829,602	836,780
% Change		*6.3%*	*1.6%*	*0.9%*
EBD Medicaid				
Elderly	34,985	33,886	31,981	30,879
Disabled				
MA/Medicare Dual Eligibles	93,415	96,681	99,172	102,188
MA Only	93,951	93,292	94,164	95,110
Subtotal, Disabled	187,365	189,973	193,336	197,298
Total -- EBD Medicaid	222,351	223,858	225,317	228,177
% Change		*0.7%*	*0.7%*	*1.3%*
Other Groups				
Family Planning Only Services	69,929	45,317	38,934	39,326
Medicare Beneficiaries	21,472	21,985	22,488	23,267
Foster Children	16,747	17,690	18,038	18,220
Well Women	948	806	778	786
Basic Plan	818	0	0	0
Total -- Other Groups	**109,914**	**85,798**	**80,239**	**81,599**
% Change		*-21.9%*	*-6.5%*	*1.7%*
Total	**1,100,429**	**1,126,070**	**1,135,158**	**1,146,556**
% Change		*2.3%*	*0.8%*	*1.0%*

9. As part of several changes to BadgerCare Plus program eligibility enacted as part of the 2013-15 budget act and subsequent legislation, adults without dependent children ("childless adults") with household income up to 100% of the federal poverty level became eligible for coverage under BadgerCare Plus in April, 2014. Since that time, program enrollment for this group has exceeded budget estimates. Large increases in enrollment in January, February, and March of 2015 may have been due to the end of the most recent open enrollment period in the federal health insurance Marketplace established by the federal Patient Protection and Affordable Care Act (ACA). If an individual eligible for Medicaid applies for coverage through the Marketplace, he or she is redirected to the Medicaid program, rather than to subsidized private insurance plans available in the Marketplace. Publicity and outreach efforts surrounding the end of the most recent

open enrollment period may have also contributed to increases in Medicaid enrollment.

10. Enrollment by childless adults decreased in April, 2015, for the first time since the changes enacted under Act 20 went into effect, due to the timing of the re-enrollment of the approximately 83,000 childless adults who entered the program April, 2014. DHS conducts eligibility reviews after an individual has been in the program for 12 months. Childless adult enrollment would be expected to see larger than average decreases in enrollment at the time of this 12-month eligibility review, with some of this group eventually re-enrolling in the program. This has been borne out in the enrollment data for April. The first week of April saw a much larger than average childless adult disenrollment (compared to first week of prior months) when the program processed the April re-enrollment determinations. This was followed by higher than average enrollment in subsequent weeks, as newly unenrolled and new enrollees either regained coverage or accessed coverage for the first time.

11. DHS spread the 12-month eligibility reviews for this group of childless adults over three months to help protect county income maintenance consortia and the Milwaukee Enrollment Services Center from large increases in workload associated with the large group that gained eligibility in April, 2014. This may lead to enrollment decreases in May and June that are similar to that seen in April. After including an adjustment to account for lagging re-enrollment, the updated estimate assumes an April enrollment decrease of 2,700 adults without dependent children, and that enrollment by this group a will decrease by 1,000 in April and May before growing at a rate that more closely matches longer-term enrollment trends for MA-eligible parents.

12. *Clawback Payments ($9.6 million).* Prior to the introduction of Medicare Part D in 2006, state MA programs provided prescription drug coverage for individuals who were fully eligible for MA and Medicare. Medicare Part D now provides that coverage, and federal law requires states to make monthly payments to CMS to help support Medicare Part D. The amounts of these "clawback" payments are adjusted annually, based on per capita drug cost growth and changes in a state's FMAP. In April, 2015, Federal Fiscal Information for States (FFIS) revised its estimates of states' clawback payments for calendar year 2016, which would result in a projected increase in clawback payments of $9.6 million GPR.

13. *Federal Matching Funds ($1.3 million).* Federal funds support most of the Medicaid budget, and are provided based on a matching rate set by a formula in federal statute. The federal medical assistance percentage (FMAP) is based on a state's per capita personal income. FFIS updated its projected FMAP for federal fiscal year (FFY) 2016-17. After this update, the projected FMAP is 58.24% for state fiscal year 2015-16 and 58.15% for 2016-17. This is slightly lower than the bill's estimate of 58.17% in fiscal year 2016-17.

14. Unlike funding for traditional Medicaid benefits, funding for CHIP is subject to ongoing reauthorization by Congress. The bill assumed that enhanced matching rates would apply under that program of 93.76% in FFY 2015-16 and 93.69% in FFY 2016-17, as specified in the ACA. In April, 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act, which reauthorized CHIP funding at the ACA-enhanced matching rates through September 30, 2017. This period includes the entire 2015-17 biennium, though the amount of available federal CHIP funding in the 2017-19 biennium will depend on future action by Congress to reauthorize the program's

funding.

15. *SEG Revenues to Offset GPR (-$43.2 million).* The MA trust fund receives revenue from several sources, including revenue from several provider assessments and certain federal funds allocated to the fund. These segregated revenues offset the amount of GPR otherwise needed to support MA benefits costs. The reestimate includes two modifications to the amount of available SEG revenues in the 2015-17 biennium: (a) increased SEG from the hospital assessment due to the application of the CHIP matching rate to a portion of hospital access payments (-$57.6 million); and (b) elimination of SEG revenues for received for HealthCheck-eligible services provided by residential care centers ($13.9 million). In addition, the amount projected to be generated by the nursing home/ICF-ID bed assessment would offset an additional $0.5 million GPR.

16. Revenue from the hospital assessment totals $414.5 million annually, and supports the non-federal portion of approximately $672.0 million in "access payments" made to hospitals. Critical access hospitals (CAHs) are subject to a separate assessment (in 2013-14, the CAH assessment generated $8.8 million, and the state paid $14.2 in access payments). Any SEG amount not used for the non-federal share of the access payments is credited to the MA trust fund. Applying the higher CHIP matching rate to the appropriate portion of the access payments reduces the amount of SEG needed to support those payments, and increases revenue to the MA trust fund. This has no effect on the total amount of assessments collected from hospitals, or the total amount of access payments made to hospitals.

17. The state currently claims federal MA matching funds for services provided to children in residential care centers under the state's early and periodic screening, diagnosis, and treatment services (EPSDT) benefit, also called "HealthCheck." The non-federal share of these costs is not paid by the state, but rather by counties through a combination of community aids, youth aids, and local tax revenues. The federal government has indicated that the state may not continue to claim those federal revenues, and the reestimate removes that revenue stream from the MA trust fund.

18. Another component of SEG funding available to offset GPR in the program is the nursing home certified public expenditure (CPE) program, under which the state receives federal MA matching funds based on unreimbursed costs that county nursing home facilities incur. All federal revenue the state collects under this nursing home CPE program is deposited to the MA trust fund. DHS must distribute any funds in excess of the amount estimated as part of the biennial budget, when available, as additional supplemental payments to nursing homes. DHS is in the process of updating its projections of nursing home CPE revenues, based on cost reports from calendar year 2013, but has not yet finalized that projection.

19. Table 4 shows updated projected MA trust fund revenues.

TABLE 4

Actual and Projected MA Trust Fund Balances
Fiscal Years 2013-14 through 2016-17

	Actual	Projected		
	2013-14	2014-15	2015-16	2016-17
Provider Assessments				
Hospital Assessment	$151,180,300	$145,219,800	$158,277,800	$162,600,500
Nursing Home/ICF-ID Assessment	76,512,500	74,109,500	71,551,400	69,465,600
Ambulatory Surgery Center Assessment	16,616,600	16,600,000	16,600,000	16,600,000
Critical Access Hospital Assessment	2,548,200	1,859,300	1,893,100	1,751,700
Subtotal	$246,857,600	$237,788,600	$248,322,300	$250,417,800
Federal Funds Deposited in the MA Trust Fund				
Nursing Home Certified Public Expenditure	$24,705,600	$32,131,500	$35,134,200	$35,134,200
Intergovernmental Transfer from UW System	15,955,100	14,419,200	12,685,300	12,685,300
Hospital Certified Public Expenditure	5,178,000	5,400,000	5,400,000	5,400,000
HealthCheck-Eligible Services Provided by Residential Care Centers	8,000,000	7,800,000	0	0
Subtotal	$53,838,700	$59,750,700	$53,219,500	$53,219,500
Transfer from Permanent Endowment Fund	$50,000,000	$50,000,000	$50,000,000	$50,000,000
Interest	-32,300	-100,000	-100,000	-100,000
Total Available	$350,663,904	$347,439,314	$351,441,923	$353,537,352

20. *Family Care and IRIS (-$23.1 million).* The reestimate includes updated enrollment and cost information on the Family Care and IRIS programs which provide community-based long-term care services to MA recipients who are elderly, blind and disabled. Projected program costs have decreased since the introduction of the Governor's budget. The change shown here is not associated with provisions in the Governor's budget relating to changes to the long-term care delivery system, but rather reflect changes in actual and projected program costs under current law.

21. *Other Expenditure Changes (-$12.5 million).* Several specific expenditure categories are projected to be lower than the levels assumed in the Governor's budget, based on updated enrollment and cost data: (a) expenditures for services provided at federally qualified health centers (FQHCs) (-$6.8 million), a decrease not associated with the change to FQHC reimbursement methodology proposed under other provisions of the bill; (b) nursing home expenditures (-$3.9 million); and (c) Medicare Part B premiums paid on behalf of individuals who are dually-eligible for MA and Medicare (-$1.8 million).

Discussion of Alternatives

22. Alternative 1 would make adjustments to MA benefits funding to reflect the current estimates discussed in this paper.

23. Through April, 2015, DHS has received $73.4 million in payments by drug manufacturers to the state to settle lawsuits that alleged improper charges for Medicaid prescription drugs. The Department currently projects that it will need to spend approximately $51.9 million of those funds to enable the Medicaid GPR budget to end the current biennium in balance. Consequently, under current projections, approximately $21.5 million in unexpended drug settlement funding would remain at the end of the 2013-15 biennium.

24. The administration did not account for available drug settlement funding in its Medicaid cost-to-continue estimate. The Committee could reduce the amount of GPR budgeted for the program by $21.5 million in 2015-16, and increase PR expenditure authority by a corresponding amount as the means of reducing the GPR funding that is estimated to be needed in the 2015-17 biennium. (Alternative 2). However, the availability of these funds will depend on actual MA benefits spending through the end of the current biennium.

25. Alternatively, the Committee could adopt the MA benefits funding changes shown in Alternative 1, and require DHS to lapse to the general fund any unexpended drug settlement revenues that remain at the end of 2014-15 (Alternative 3). This would have the same general fund effect as Alternative 3, but would allow for more flexibility if the total amount of drug settlement funding used in the current biennium differs from current projections, as it would not reduce the additional GPR provided for MA benefits under this item by a fixed amount.

ALTERNATIVES

1. Increase funding in the bill by $138,787,800 ($10,632,800 GPR, $94,953,900 FED, $14,846,200 PR, and $18,354,900 SEG) in 2015-16, and $14,651,500 ($13,211,400 GPR, -$65,102,400 FED, $43,357,700 PR, and $23,184,800 SEG) in 2016-17 to reflect current estimates of MA benefits costs in the 2015-17 biennium.

ALT 1	Change to Bill
GPR	$23,844,200
FED	29,851,500
PR	58,203,900
SEG	41,539,700
Total	$153,439,300

2. Increase funding in the bill by $138,787,800 (-$10,867,200 GPR, $94,953,900 FED, $36,346,200 PR, and $18,354,900 SEG) in 2015-16, and $14,651,500 ($13,211,400 GPR, -$65,102,400 FED, $43,357,700 PR, and $23,184,800 SEG) in 2016-17 to reflect current estimates of MA benefits costs in the 2015-17 biennium, and the budgeting of drug settlement funds ($21,500,000 PR) in the Medicaid program in 2015-16 to supplant GPR funding.

ALT 2	Change to Bill
GPR	$2,344,200
FED	29,851,500
PR	79,703,900
SEG	41,539,700
Total	$153,439,300

3. Increase funding in the bill by $138,787,800 ($10,632,800 GPR, $94,953,900 FED, $14,846,200 PR, and $18,354,900 SEG) in 2015-16, and $14,651,500 ($13,211,400 GPR, -$65,102,400 FED, $43,357,700 PR, and $23,184,800 SEG) in 2016-17 to reflect current estimates of MA benefits costs in the 2015-17 biennium. In addition, require DHS to lapse any unexpended drug settlement revenues that remain at the end of fiscal year 2014-15 to the general fund in 2015-16 (an estimated $21.5 million).

ALT 3	Change to Bill
GPR	$23,844,200
FED	29,851,521
PR	58,203,900
SEG	41,539,700
Total	$153,439,300
GPR-Lapse	$21,500,000

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