

MEDICAID EXPENDITURE GROWTH & IMPLICATIONS FOR EXPANSION

House Appropriations Committee

November 16, 2016

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Medicaid Expenditure Growth

- Medicaid Forecast
- Recap of 2015 Forecast and Expenditure Drivers
- November 2016 Forecast of Medicaid Expenditure Growth
- Forecast Adjustments by Major Category
- Factors Affecting Medicaid Spending Growth
- Recent Efforts to Control Medicaid Growth

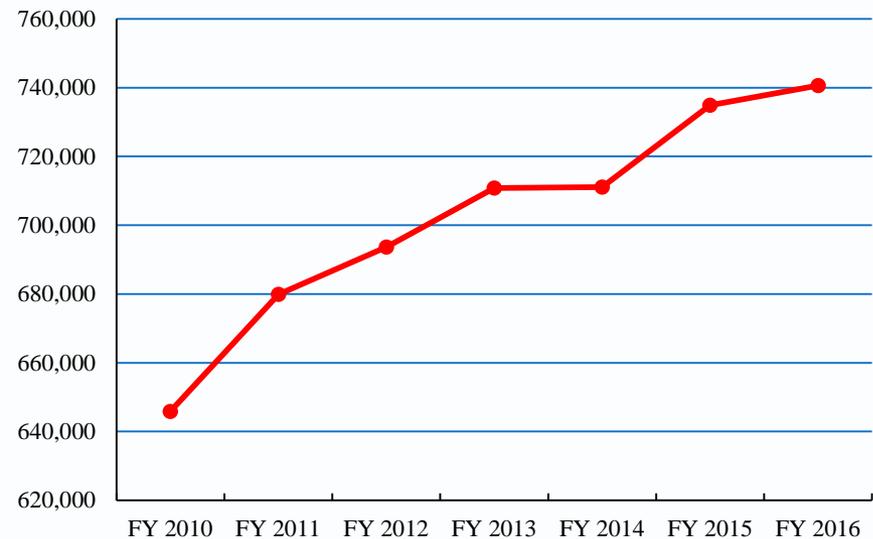
Medicaid Forecast

- Official Medicaid forecast updated every November
- 2016 Official Medicaid forecast updates projected spending for FY 2017 and FY 2018
 - Consensus forecast developed by the Department of Medical Assistance Services and the Department of Planning and Budget
- In addition, Virginia Health Care Fund revenues will influence how much general fund revenue is required to meet the forecast costs of the Medicaid program
 - Revenues in the Fund are used as a portion of the state's match for the Medicaid program
 - Comprised of tobacco taxes, Medicaid recoveries and a portion of the Master Tobacco Settlement Agreement (41.5%)
 - Revenue changes in the Virginia Health Care Fund are not included in Official Medicaid forecast
 - The Fund ended FY 2016 with an additional cash balance of \$26.8 million, which will be carried forward into FY 2017 (Ch. 780 assumed a balance of 17.4 million would be available in the Fund)

Recap of 2015 Forecast and Expenditure Drivers

- Last year's forecast projected a funding need of \$166.6 million GF in FY 2016 and \$789.1 million GF over the 2016-18 biennium
 - \$732.3 million GF was funded over the 2016-18 biennium, adjusted for policy actions adopted by the General Assembly
- Enrollment growth was a major cost factor in late FY 2015 & FY 2016
 - “Woodwork” effect when individuals previously eligible for Medicaid but unenrolled enter program
 - Many referred from the federally facilitated marketplace
 - Began to show up on Medicaid rolls in the last 5 months of FY 2015
- Enrollment growth projected at 5% in FY 2016 and FY 2017, dropping to 2.4% in FY 2018

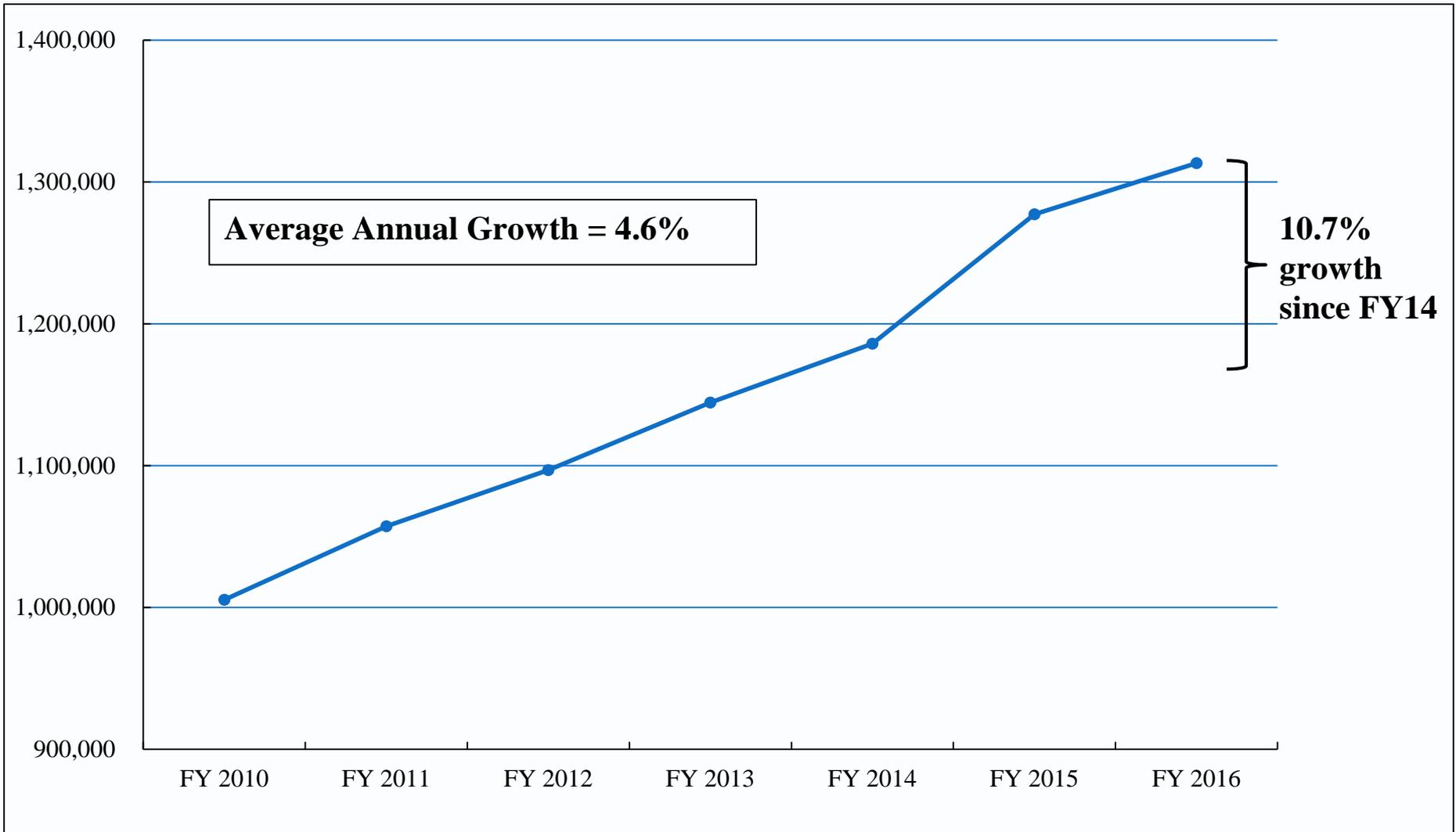
Low-Income Children Annual Enrollment



Low Income Adults Annual Enrollment



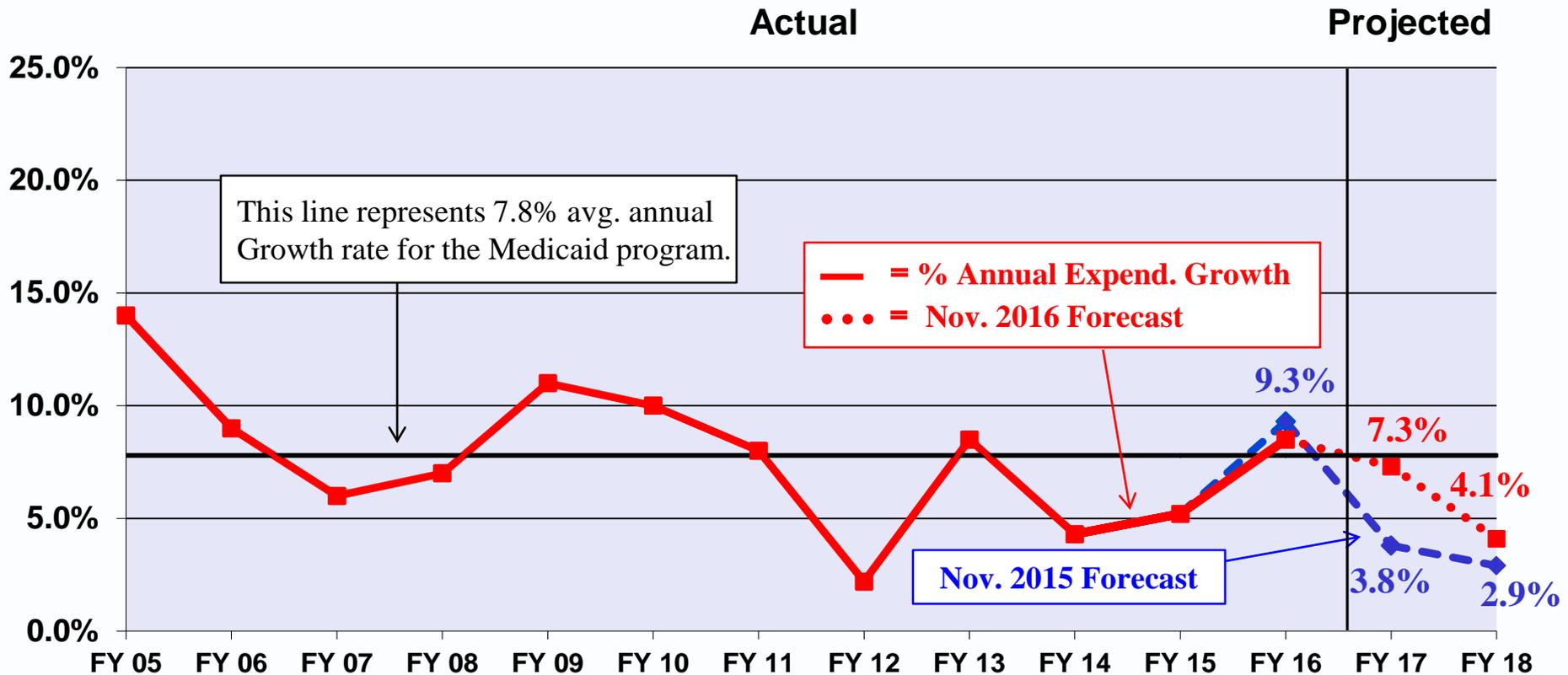
Total Annual Unduplicated Medicaid Enrollment



Recap of 2015 Forecast and Expenditure Drivers

- FY 2016 expenditures were artificially higher because two large payments were moved from FY 2015, due to the impact of fourth quarter enrollment growth on FY 2015 expenditures
 - Fourth quarter indigent care payments to teaching hospitals
 - June Medicare Part D payment
- Forecast included rate increases
 - Managed care organization (MCO) capitation rates
 - 2.8% in FY 2017 and 3.3% in FY 2018 for low-income children and adults
 - 3.5% each year of the biennium for aged, blind and disabled individuals
 - Hospital and nursing home inflationary adjustments
 - 2.6% in FY 2017 and 2.7% in FY 2018 for hospital inpatient expenditures
 - 0.9% in FY 2017 and 2.9% in FY 2018 for nursing facility services
- Included consumer-directed attendant overtime payments in FY 2016 and 2016-18 biennium due to federal ruling

November 2016 Medicaid Forecast: Annual % Change

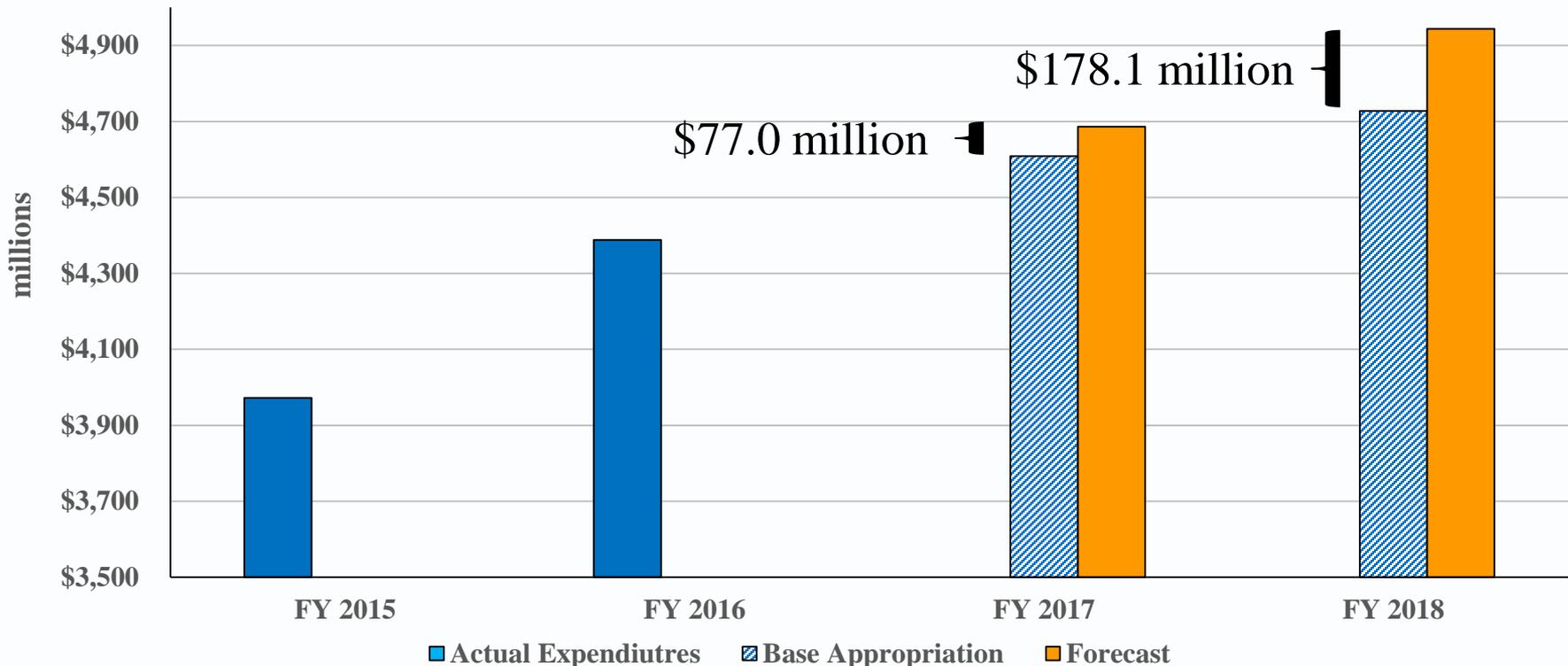


Note: Represents percentage change in all funds, state and federal, adjusted for payment timing changes, cash management, FMAP maximization.
 Source: 2015 and 2016 DPB and DMAS consensus forecast reports, adjusted for Medicare premium rate changes as of November 15, 2016.

Medicaid Forecast: FY 2017 and FY 2018

(GF \$ in millions)

- Projected funding need of \$77.0 million GF in FY 2017 and \$178.1 million GF in FY 2018, totaling \$255.1 million GF over biennium



Nov. 2016 Forecast Adjustments by Major Category

(GF \$ in millions)

Major Forecast Adjustments	FY 2017	FY 2018
Behavioral Health: adult rehabilitation services and intensive in-home services for children	\$31.5	\$54.6
Medicaid fee-for-service expenditures	\$38.8	\$38.3
Medicare Part A, B and Part D premium increases	\$16.9	\$46.8
Managed Care rate changes	(\$15.0)	\$12.0
Total Major Forecast Adjustments	\$72.2	\$151.7
<p>Note: Additional forecast adjustments result in increases and decreases in Medicaid projected expenditures that are incorporated in the final expenditures forecast.</p>		

Factors Affecting Medicaid Spending Growth in 2016-18 Biennium

- Behavioral health services
 - Expenditures for adult mental health skill building services are growing faster than originally projected last year
 - 2015 forecast projected growth of 5.5% and 0.5% in FY 2017 and FY 2018, respectively
 - Now growth projected at 13.5% in FY 2017 and 10.2% in FY 2018
 - Intensive in-home services for children expected to grow at 8.7% in FY 2017 and 3.2% in FY 2018
- Medicaid fee-for-service expenditures
 - Growth primarily in FY 2017 as more individuals are moved to managed care in FY 2018
 - Covers most new Medicaid enrollees until MCO is assigned, GAP population, and dually eligible for Medicare and Medicaid not in the Commonwealth Coordinated Care program
 - Pharmacy services and Clinic services the fastest growing items (not including Medicare Part A, B and D premiums)
 - Pharmacy growing at 16.7% in FY 2017 and 7.4% in FY 2018
 - Clinic services growing at 15.1% in FY 2017 with no growth in FY 2018
- Home and community-based waiver services
 - Last year's Medicaid forecast reflected in Chapter 780 projected growth of 6.6% and 2.2% respectively over the biennium
 - November 2016 forecast projects growth of 8.9% and 4.3% respectively over the biennium

Factors Affecting Medicaid Spending Growth in 2016-18 Biennium

- Federally driven changes
 - 10.0% increase in Medicare Part B premiums
 - 11.9% increase in Medicare Part D premiums
 - “Deemed newborns” must be automatically re-enrolled in Medicaid program at age one
 - Infants born to pregnant women who were receiving Medicaid on the date of delivery are eligible for Medicaid eligibility until the child’s first birthday - “deemed newborns”
 - In past, these children were disenrolled from Medicaid at age one unless parent or guardian re-enrolled them
 - DMAS data indicate that these children were disenrolled for 4 months on average after age one, before being re-enrolled in Medicaid
 - Adds \$9.9 million GF over biennium to Medicaid costs
- Durable medical equipment authorization requirements for physicians to document face-to-face encounters with Medicaid recipients within specified timeframe
 - Added cost of \$3.3 million GF over the biennium for additional physician encounters

Recent Medicaid Reform Efforts

- Commonwealth Coordinated Care (CCC)
 - A multi-year Medicare and Medicaid enrollee (dual eligible) financial alignment demonstration program set to end on December 31, 2017
 - Provides integrated health care services for 31,000 Medicare and Medicaid enrollees who have some of the most complex health care needs of current recipients
- Managed Long Term Services and Supports (MLTSS)
 - Beginning July 1, 2017, the Commonwealth Coordinated Care Plus program will serve three groups of individuals (roughly 212,000 individuals) with complex care needs receiving either:
 - Medicare and full Medicaid (dual eligible) benefits
 - Medicaid long-term services and supports in a facility
 - Home and community based waiver services (excluding Alzheimer's Assisted Living and I/DD waivers)
 - Individuals age 65 and older, blind, or disabled who currently receive full Medicaid benefits
 - Goal is to better manage care, reduce expenditures and provide for budget predictability (full-risk, capitated model)
- Other Managed Care Expansions
 - Transitioned more than 13,000 children in Virginia's foster care and adoption assistance programs into managed care to ensure timely access to behavioral health and medical services
 - December 2014, DMAS launched the a program to manage acute medical services for selected EDCD waiver recipients
 - July 2016 transitioned remaining individuals in the EDCD, Tech, and Alzheimer's Home and Community Based Waivers into managed care

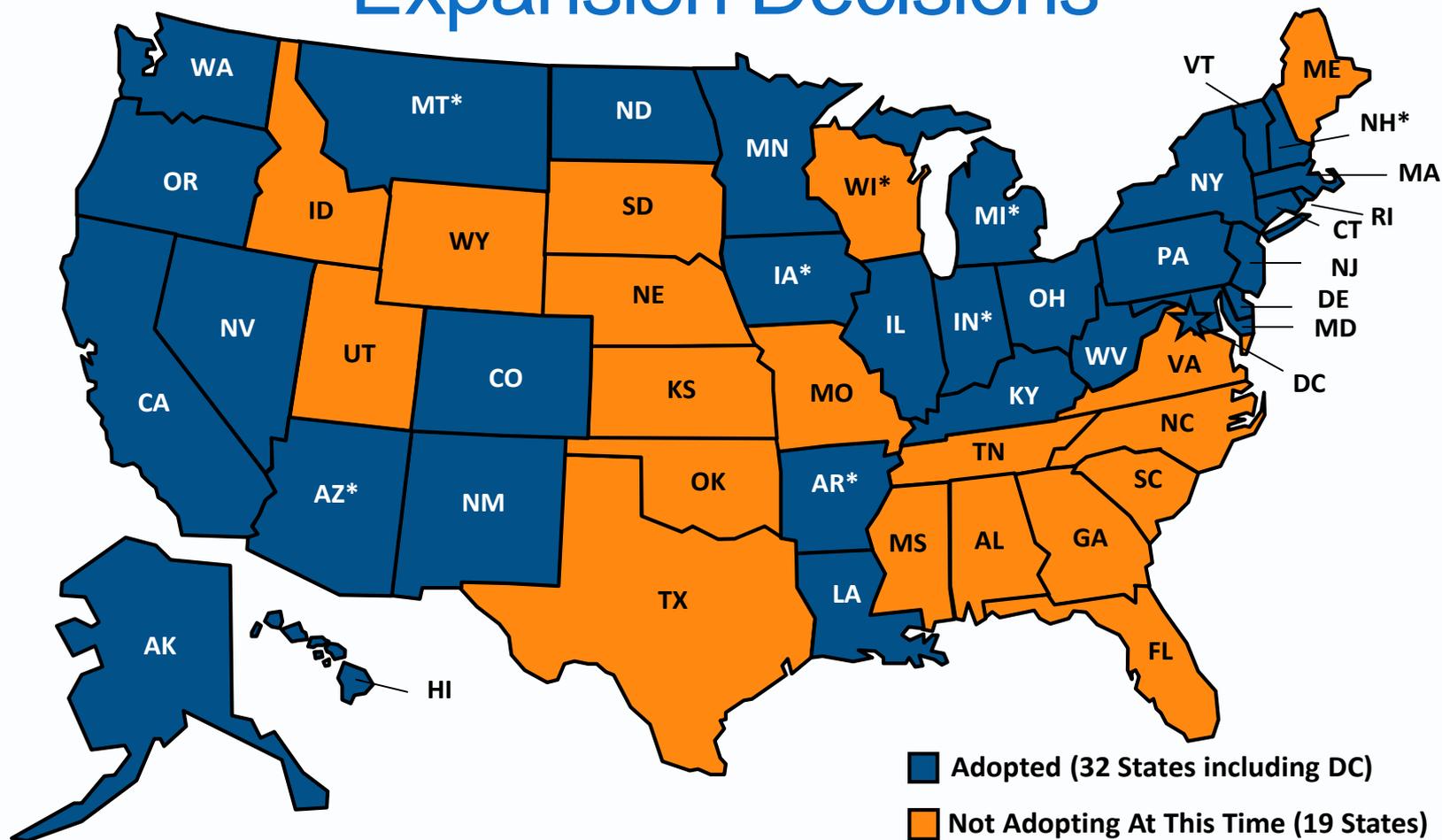
Recent Medicaid Reform Efforts

- **Managed Care Improvements**
 - Revised contracts with managed care organizations to place greater emphasis on chronic care management, including assessments, wellness programs, maternity program improvements, and electronic reporting
 - Implemented a process for withholding of a portion of managed care organization's capitation payments and linking payments to quality metrics and operational performance
- **Behavioral Health Services**
 - Contracted with a Behavioral Health Services Administrator (BHSA) to improve oversight of services and ensure better coordination with primary and acute care services
 - Beginning December 1, 2016, expanding use of BHSA to better manage and oversee Medicaid funded residential treatment for youth with behavioral health needs
 - Emphasizing timely access to care; high intensity, shorter duration services to improve outcomes; and care coordination to ensure successful return to home and community settings
 - BHSA will be single point of entry to services
- **JLARC Final Report in December**
 - Managing costs in Virginia's Medicaid program

Implications for Medicaid Expansion

- National Picture: Medicaid Expenditure and Enrollment Growth
- The Medicaid Experience in Recent Expansion States
- Updated Estimates for Virginia Medicaid Expansion
- Implications for Virginia

Current Status of State Medicaid Expansion Decisions

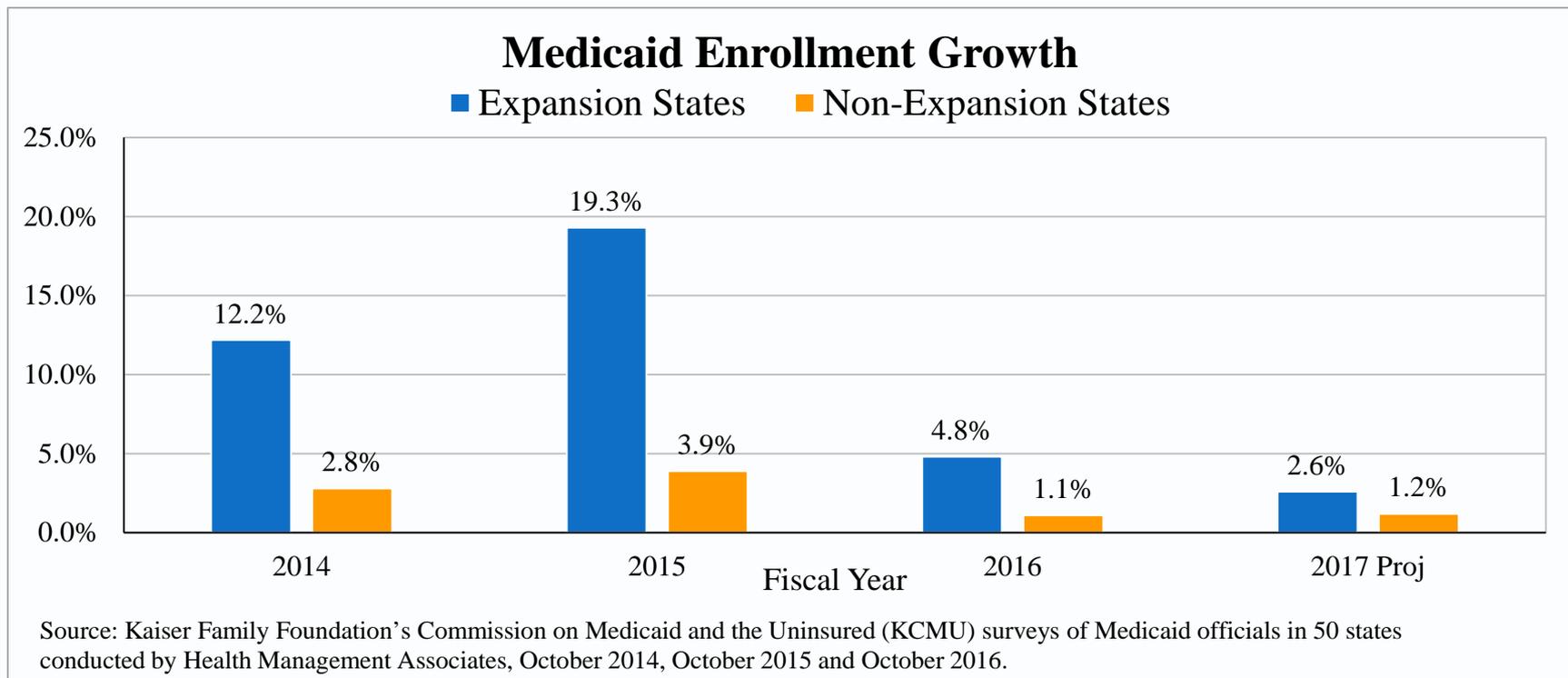


NOTES: Current status for each state is based on Kaiser Family Foundation's Commission on Medicaid and the Uninsured (KCMU) tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated October 14, 2016.

National Picture: Medicaid Enrollment Growth

- Average monthly Medicaid and child health insurance enrollment has increased by almost 28% from the time period prior to the implementation of the Affordable Care Act (ACA) to August 2016.
- Projected enrollment in 17 of the 25 states that implemented expansion on January 1, 2014 exceeded their projected first year enrollment by 91%
- Recent trends are indicating slower growth, but growth is now off a much larger base



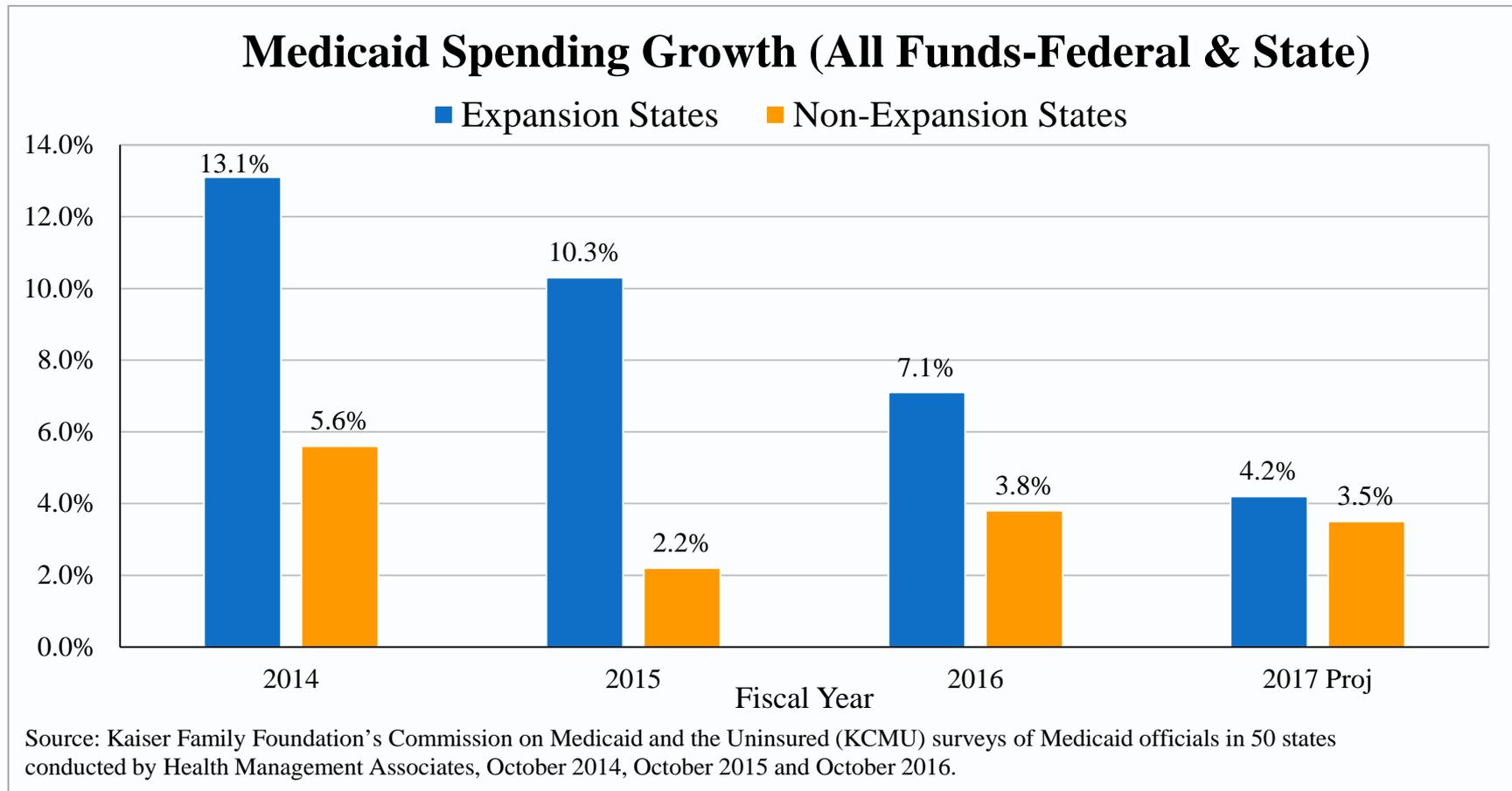
National Picture: Medicaid Expenditure Growth

Findings of the Federal Medicaid Actuary

- Total Medicaid spending increased by 8.4% in FFY 2014 and 12.1% in FFY 2015
 - Medicaid expenditures are projected to grow at an annual rate of 6.4% from 2015 to 2024
- The FFY 2015 estimate of the per enrollee cost for newly eligible adults (expansion population) was on average \$6,366 per person per year
 - 49% higher than the previous year's estimate of \$4,281
- The per enrollee cost for newly eligible Medicaid enrollees was also higher than other Medicaid adults enrollees
 - \$6,366 compared to \$5,159, a 23% difference
- Benefit costs of the newly eligible adult enrollees grew by 16% in same period compared to 5.0% for other Medicaid adult enrollees

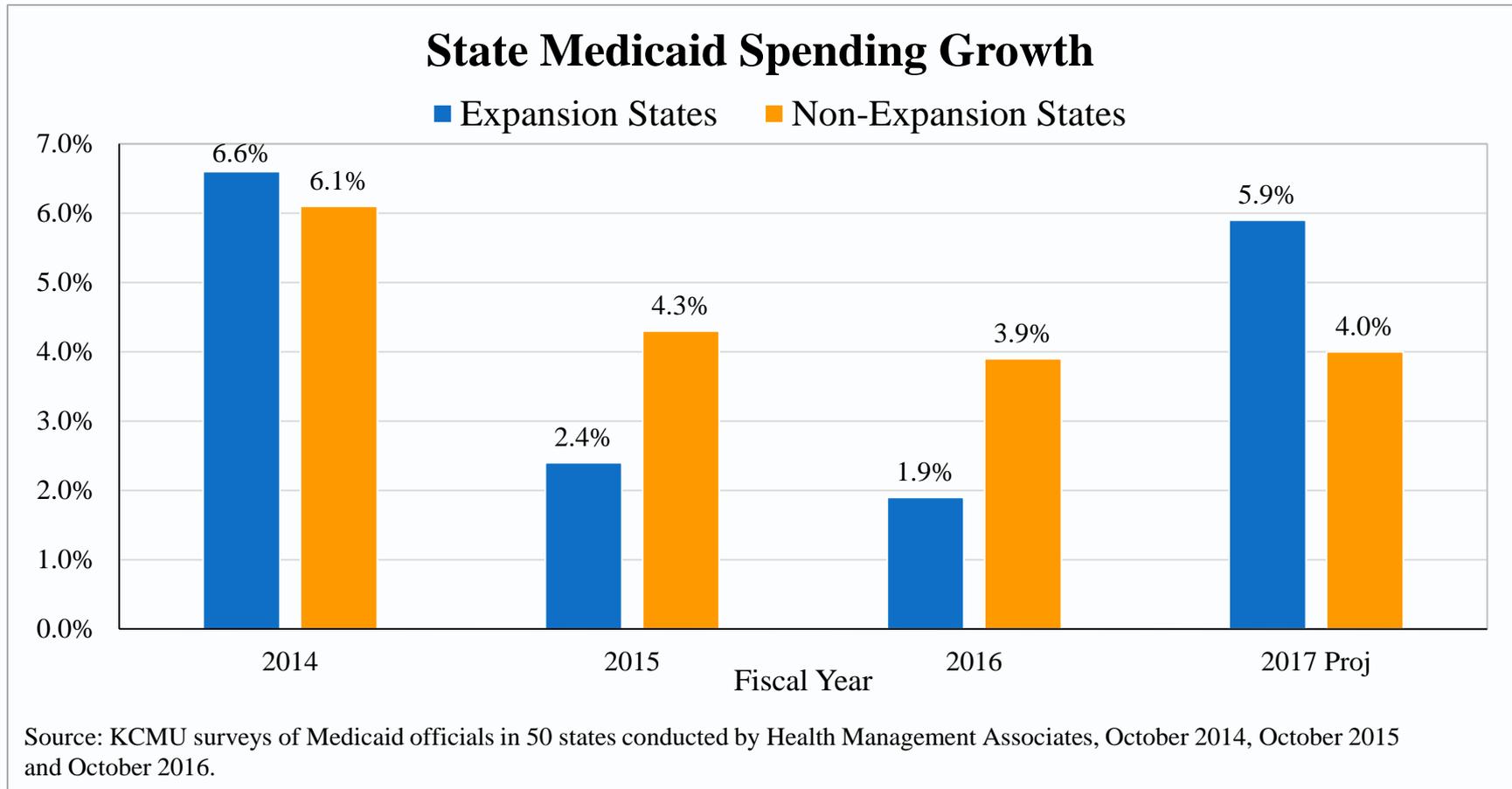
National Picture: Medicaid Expenditure Growth

- A recent 50-state survey for the Kaiser Family Foundation indicated significant Medicaid spending growth in expansion states in the first two years of implementation, with growth rates continuing to remain above non-expansion states in FY 2016 and FY 2017



National Picture: Medicaid Expenditure Growth

- The Kaiser Family Foundation survey also indicated that expansion states will experience higher state spending growth in Medicaid than non-expansion states in FY 2017 as the ACA requirement for cost sharing is implemented
- The state share of expansion costs will be 5% beginning January 1, 2017



Experiences of Expansion States

- Estimating Medicaid enrollment under expansion becomes particularly important as states begin to pay for a 5% share of the costs beginning January 1, 2017
 - Higher than expected enrollment growth will now drive state costs higher
 - According to the Kaiser Family Foundation survey of states, at least 8 expansion states reported plans to use provider taxes to finance the state share of Medicaid expansion costs
- Maryland
 - Enrollment of newly eligible individuals exceeded original projections by almost 34% from 164,724 to 220,442 individuals
 - FY 2017 original estimate of state cost was \$31 million, now estimated at \$51.9 million, a 67% increase
 - Employed use of provider taxes to offset state costs for expansion
- Kentucky's initial enrollment of almost 311,000 individuals was more than double its original projections
 - FY 2017 projected enrollment is 428,947 individuals
 - FY 2017 projected state cost for Medicaid expansion is estimated at \$74 million

Experiences of Expansion States

- Michigan
 - Enrollment of newly eligible exceeded original estimates by about 20% and estimated costs increased 50% due to enrollment growth
 - FY 2017 projected state cost for Medicaid expansion is estimated at \$137 million (3/4 of the fiscal year which runs from Oct. 1 - Sept. 30)
 - Provider assessments and special financing contributions will be used to support certain Medicaid reimbursements for the expansion program, Healthy Michigan
- Ohio
 - In the first 18 months of expansion, enrollment increased by more than 50%
 - Costs exceeded the initial projection of \$2.56 billion growing to nearly \$4.0 billion
 - FY 2017 estimated state costs for Medicaid expansion were about \$130.0 million
- California
 - California originally estimated enrollment growth of 1.4 million newly eligible individuals at a cost of \$390 million (total funds 100% federal match) for the first year of expansion
 - Actual experience was growth of 3.7 million enrollees at a cost of more than \$1.0 billion (100% federal match), not including “woodwork” enrollees
 - FY 2017 projected state cost of Medicaid expansion is estimated at \$385 million

DMAS 2016 Updated Estimates of Virginia Medicaid Expansion

- The Department of Medical Assistance Services (DMAS) updated the estimated cost of Medicaid expansion in August 2016, reflecting an expansion start date of July 1, 2017
- In light of current Medicaid growth projections, questions remain on costs of expansion
 - How accurate are recent cost estimates and enrollment projections?
 - What can we learn from other states experiences?
 - Can future savings be budgeted to offset projected costs?

Components of DMAS Estimated Costs

Estimated Costs of a July 1, 2017 Expansion (\$ in millions)

Costs	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
State GF	\$2.5	\$138.3	\$207.1	\$273.9	\$331.0	\$343.0
Federal	\$9.9	\$2,114.5	\$2,739.7	\$2,788.2	\$2,841.3	\$2,943.6
Total	\$12.4	\$2,252.8	\$2,946.8	\$3,062.1	\$3,172.3	\$3,286.6

Source: DMAS Estimates of ACA Medicaid Expansion, August 2016 Update.

- Assumes coverage of almost 353,000 individuals with incomes up to 138% of the federal poverty level (FPL)
 - Current Medicaid services, including behavioral health services and new substance use disorder treatment services
- Assumes an additional 1,000 eligible but unenrolled individuals (“woodwork effect”)
- Assumes an average per person annual cost of approximately \$6,232 for benefits
 - Reflects a higher per person cost for the low-income adult population than contained in earlier estimates
- Includes administrative costs associated with additional enrollment
- Managed Care Organization (MCO) insurance tax
 - 1.9% applied to MCO capitation payments in the current Medicaid program
- Incorporates declining federal match rate from 95% in CY 2017 to 90% in CY 2020

Cost Estimate Concerns

- Per enrollee cost may be understated
 - Federal Actuary found the average per person costs for the expansion population in FFY 2015 was 23% higher than other Medicaid adult enrollees
 - The estimated annual average per person cost for the expansion population in Virginia is about \$6,232 beginning in FY 2018
 - In contrast, the FY 2016 low-income adult Medicaid enrollee annual average per person cost is \$7,327
 - If you apply federal actuary findings, the average annual per person cost could be closer to \$9,012
 - Would result in total expansion costs of \$3.2 billion
 - State share for FY 2018 costs could be in the range of \$175.0 to \$178.0 million GF, almost \$40 million GF more than the current estimate
- Costs assume an initial enrollment “take up” rate of 75% for those currently uninsured and only 15% for those currently insured (not through the federally facilitated marketplace)

Cost Estimate Concerns

- Enrollment projections may be understated
 - Projections are dated
 - 2015 Current Population Survey data which updated 2012 data
 - 2013 Analysis of American Community Survey (2013) and 2008 Survey of Income and Program Participation is dated
 - Experience of other expansion states indicated projections significantly underestimated enrollment
 - Latest monthly enrollment numbers for caretaker adults indicates growth in FY 2017
 - 3.9% growth in average monthly enrollment since July 1
 - Growth is prior to the current ACA enrollment period
- “Woodwork” effect may be underestimated
 - Current estimates reflect significant reduction from prior estimates
 - Assumes woodwork effect related to the federal facilitated marketplace has been picked up in Medicaid trend data
 - 2016 Medicaid forecast was significantly impacted by the addition of about 50,000 additional adults and children

Components of DMAS Estimated Savings

Estimated Savings of a July 1, 2017 Expansion (\$ in millions)

Savings	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
State GF	--	(\$211.4)	(\$265.1)	(\$278.6)	(\$289.7)	(\$299.7)
Federal	--	(\$135.7)	(\$183.8)	(\$196.7)	(\$206.6)	(\$214.3)
Total	--	(\$347.1)	(\$448.9)	(\$475.3)	(\$496.3)	(\$514.0)

- Eliminates limited benefit programs currently funded by Medicaid or the FAMIS program for certain populations
- Eliminates GF amounts for services to individuals served by programs administered by other state agencies or teaching hospitals
 - Community Services Board programs
 - Department of Corrections inmate inpatient hospital services
 - Indigent care provided by state teaching hospitals

Components of Cost Savings Projections

(GF \$ in millions)

Supplant GF for Public Programs	FY 2017	FY 2018
DMAS Programs:		
Plan First (Family Planning Waiver)	-	(\$0.8)
Breast and cervical cancer program	-	(\$3.8)
FAMIS MOMS (Pregnant Women)	-	(\$31.4)
Medically Needy Diverted from Current Medicaid Pop.	-	(\$4.9)
State funded treatment for Temporary Detention Orders	-	(\$1.2)
GAP for SMI individuals with incomes up to 80% FPL	-	(\$28.5)
Other Programs:		
Dept. of Corrections - inmate inpatient hospital services	-	(\$20.8)
DBHDS Community Services Boards - Assumes 25% of current GF spending is for potential newly eligible persons	-	(\$26.7)
Indigent Care Reductions	-	(\$93.3)
Total	-	(\$211.4)

Note: FY 2018 numbers represent annualized savings to Chapter 780, 2016-18 biennial budget.

Cost Savings Concerns

- Cost savings beyond the current biennium represent “future costs avoided” and aren’t typically budgeted
 - Medicaid forecast going forward would reflect expenditure trends
 - Savings in specific programs becomes a future cost “avoided” but aren’t budgeted, unless amounts are appropriated and reserved each biennium
 - While some states may have considered this approach, none of the expansion states adopted it
- Projections include savings from elimination of public coverage programs for individuals between 138-200% FPL
 - FAMIS MOMS coverage was restored by 2014 General Assembly due to concerns about ability to afford marketplace insurance premiums and deductibles
 - Assumes Family Planning waiver for individuals between 138-200% FPL will be eliminated
- Federal rule changes regarding coverage for inmate hospital care may reduce assumed savings
 - States cannot receive Medicaid reimbursement for inmate hospital inpatient services if the inmate is assigned to a hospital unit based on his security status rather than his medical need
 - May impact Virginia’s ability to obtain federal reimbursement at VCU’s secure hospital unit which serves the majority of DOC inmates needing inpatient care

DMAS Estimate of Medicaid Expansion

August 2016 Update

Estimated Costs/Savings/Net Effect of a July 1, 2017 Expansion (\$ in millions)

Costs	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
State GF	\$2.5	\$138.3	\$207.1	\$273.9	\$331.0	\$343.0
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Total	\$12.4	\$2,252.8	\$2,946.8	\$3,062.1	\$3,172.3	\$3,286.6
Estimated Savings						
State GF	--	(\$211.4)	(\$265.1)	(\$278.6)	(\$289.7)	(\$299.7)
Federal	--	(\$135.7)	(\$183.8)	(\$196.7)	(\$206.6)	(\$214.3)
Total	--	(\$347.1)	(\$448.9)	(\$475.3)	(\$496.3)	(\$514.0)
Estimated Net Effect						
State GF	\$2.5	(\$73.1)	(\$58.0)	(\$4.7)	\$41.3	\$43.2
Federal	\$9.9	\$1,978.7	\$2,555.8	\$2,591.5	\$2,634.7	\$2,729.3
Total	\$12.4	\$1,905.6	\$2,497.8	\$2,586.8	\$2,676.0	\$2,772.5

Source: DMAS Estimates of ACA Medicaid Expansion, August 2016 Update.

Implications for Virginia

- Trajectory of growth in Virginia Medicaid expenditures suggests Virginia's growth rates will be higher than the projected national spending
- Virginia's historical annual rate of expenditure growth is 7.8%
 - Projections for the current biennium have been increased over last year
 - FY 2018 could potential grow by a rate closer to the historical annual average rate
- Provider payment pressures and access to care will not be solved through expansion
 - Pressure will likely increase if enrollment increases by one-third or more of current size
 - While indigent care may decrease at hospitals, low or inadequate Medicaid payments will become a central issue
 - Adequate payment for and access to community providers will also be an issue
- Expansion population will have access to all current Medicaid services including behavioral health and substance abuse services
 - Behavioral health one of the fastest growing line items in the current forecast
- If per person costs are underestimated by 23%, state expenditure projections could increase by about \$40 million GF in FY 2018 from current estimates, lowering the projected net savings
 - Assumes DMAS enrollment projections are accurate