Overview of the Medicaid Expenditure Forecast

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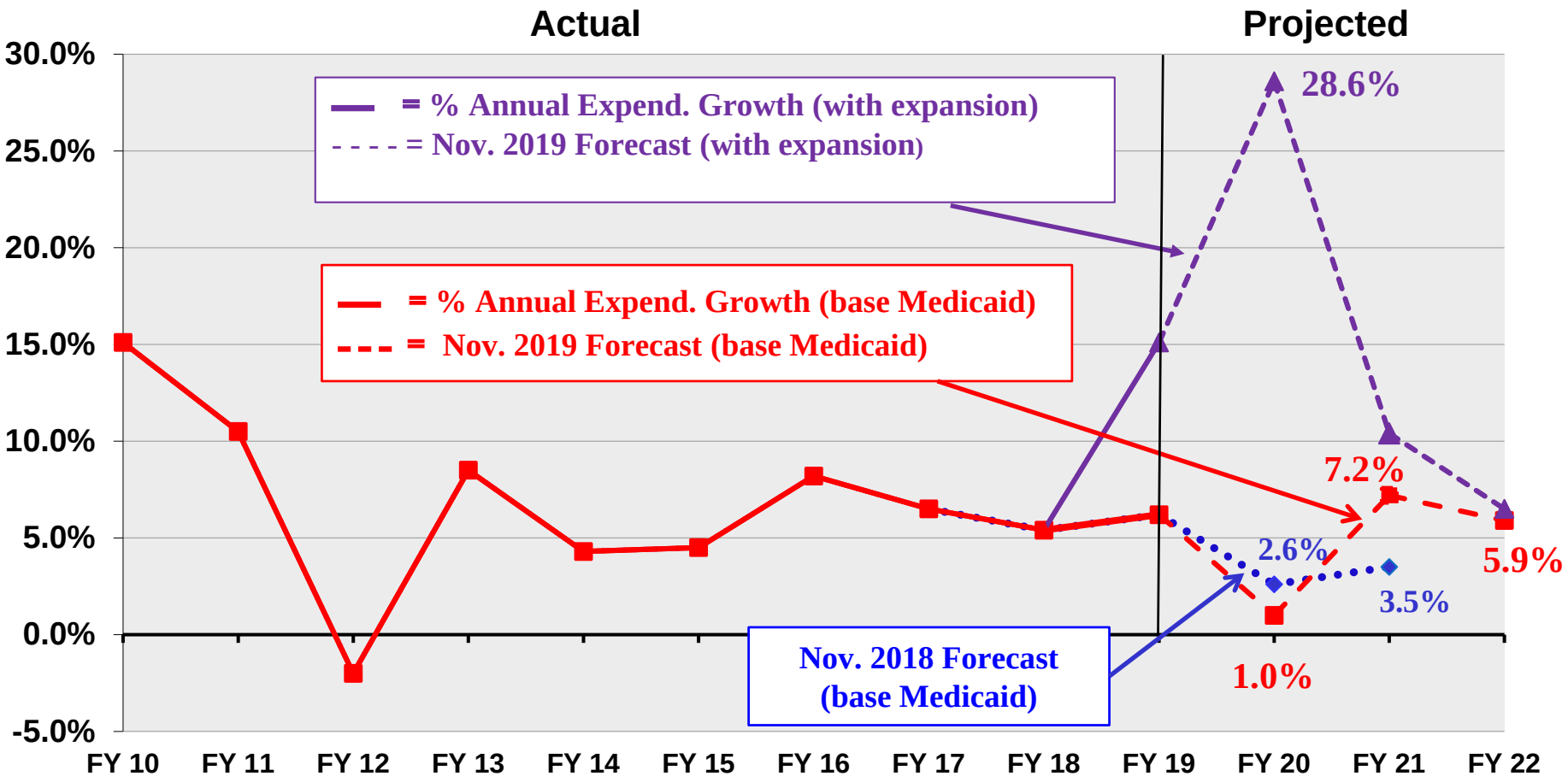
Medicaid Forecast

- Official Medicaid forecast updated every November
- 2019 Official Medicaid forecast updates projected spending for FY 2020 and the 2020-22 biennium for the current Medicaid program
- Virginia Health Care Fund (VHCF) revenues will influence how much general fund dollars are 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 (including drug rebates) and a portion of the Master Tobacco Settlement Agreement (41.5%)
  - Revenue changes in the VHCF are not included in Official Medicaid forecast
  - The VHCF ended FY 2019 with a $53.1 million balance which will be used to offset GF costs in the Medicaid program in FY 2020

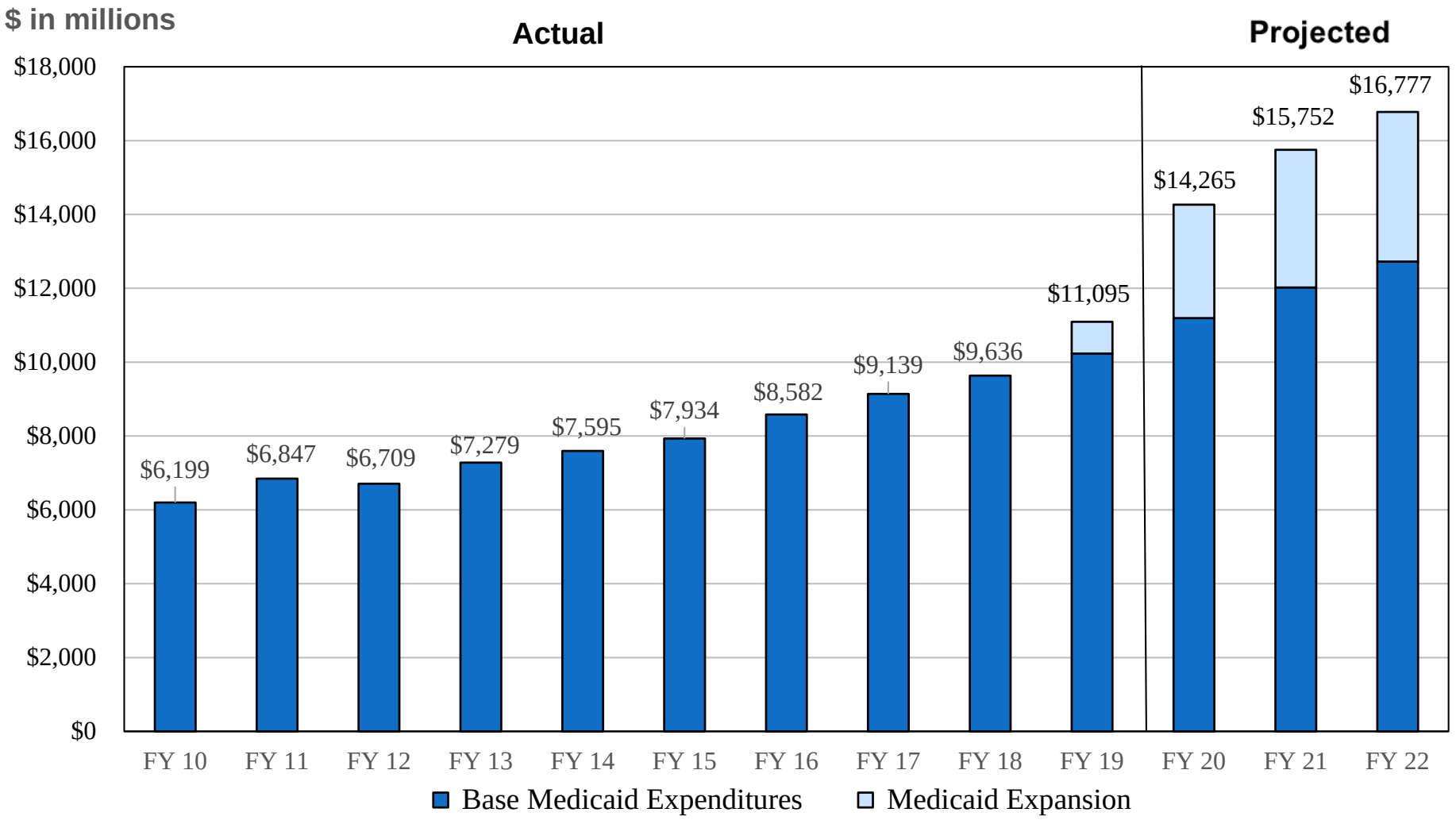
November 2019 Medicaid Forecast: Annual % Change

- 10-year average annual growth rate = 6.7%



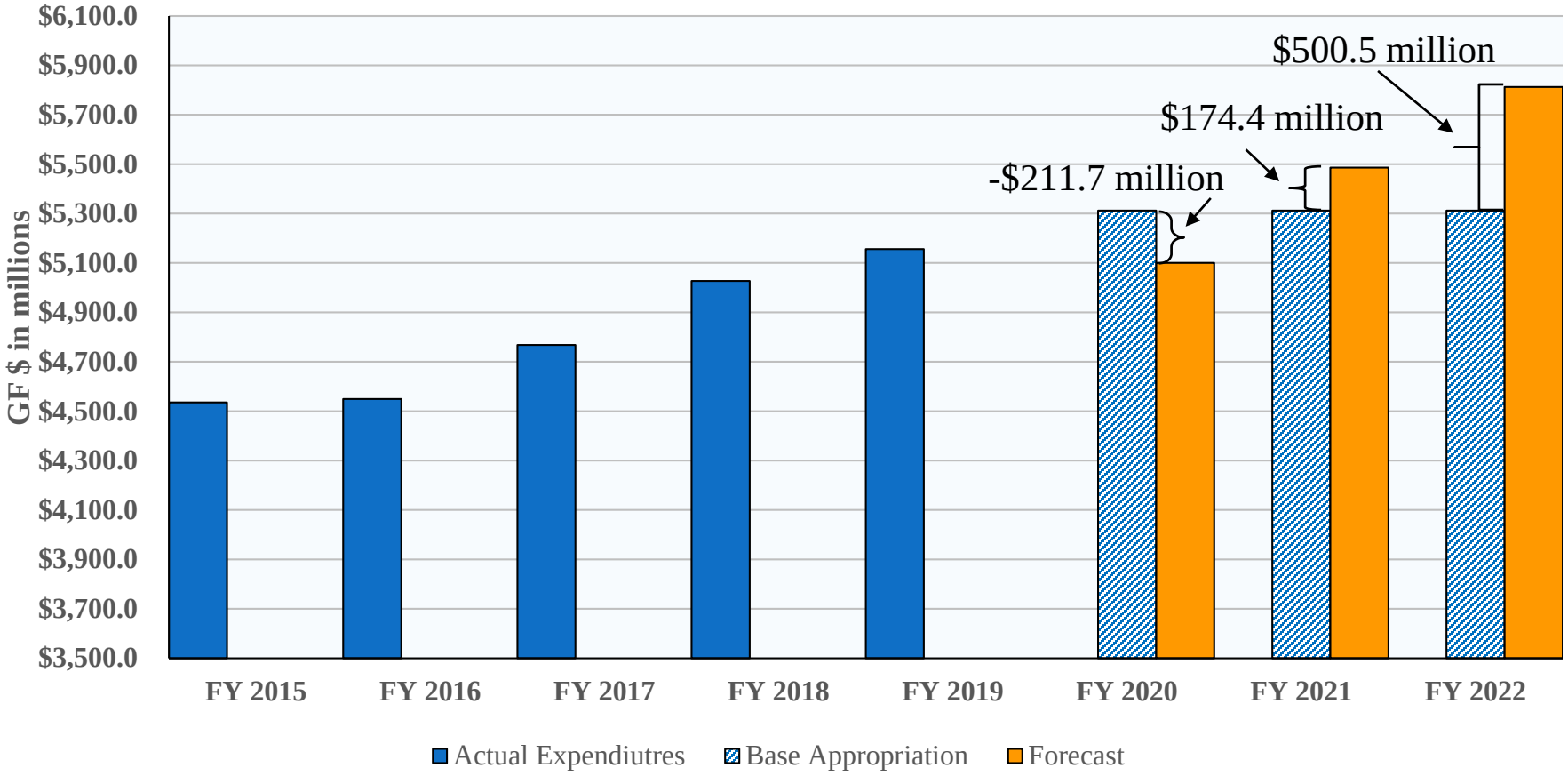
Note: Represents percentage change in all funds, state and federal, adjusted for payment timing changes, cash management, FMAP maximization, excluding payments to DBHDS, administrative expenditures and Medicaid expansion.
Source: 2018 and 2019 DPB and DMAS consensus forecast reports.

Total Medicaid Expenditure Growth
All Funds (includes expansion)



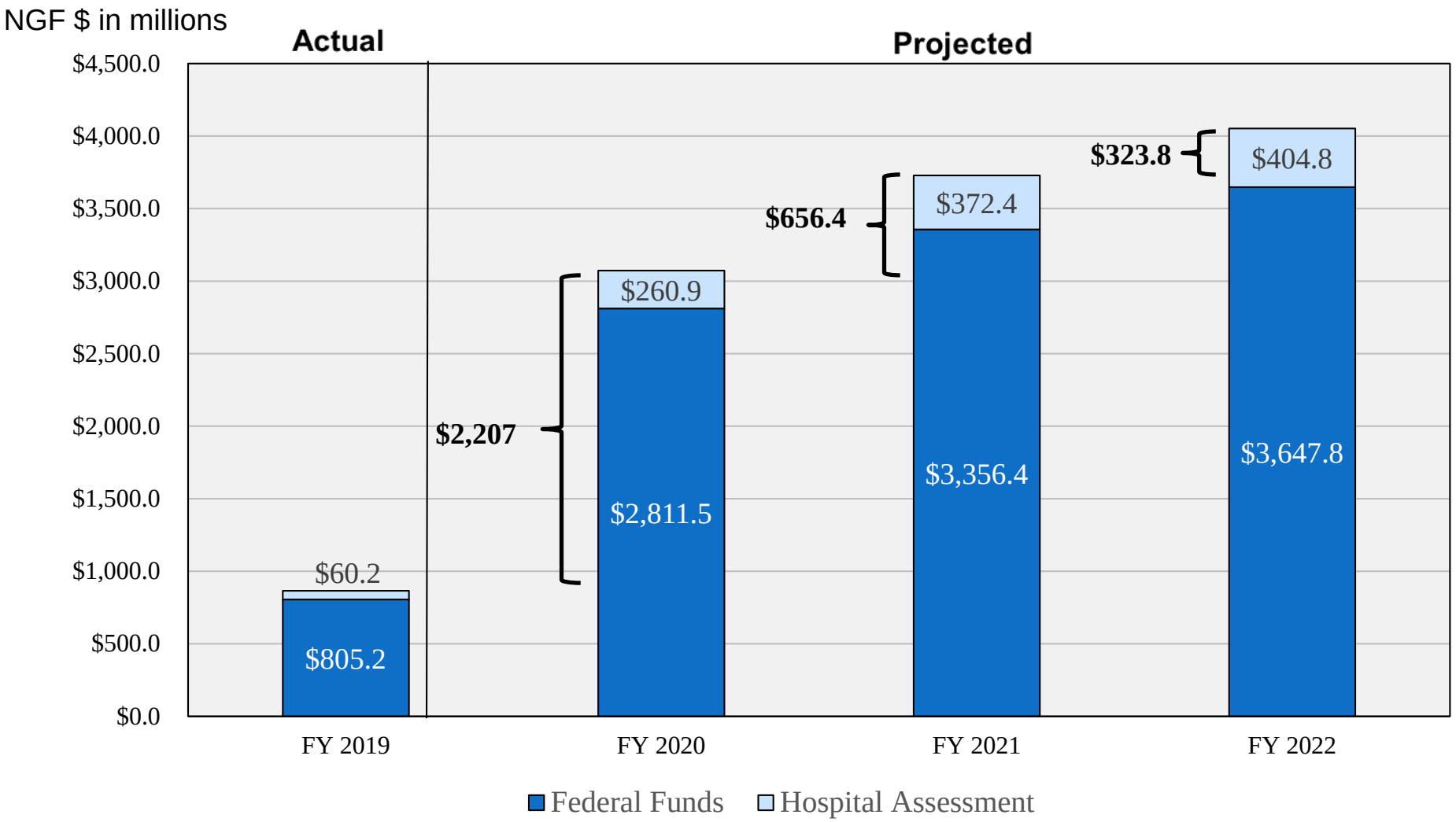
GF Medicaid Forecast: FY 2020, FY 2021 & FY 2022

- Projected GF funding is almost $675.0 million GF over the 2020-22 biennium
  - FY 2020 base Medicaid program will require $211.7 GF million less than the amount contained in Chapter 854 (2019 Appropriation Act)
  - Does not include expansion costs which are funded through a hospital assessment and federal funds



Source: November 1, 2019 DPB and DMAS Consensus Forecast Report, and FY 2015 through FY 2019 DMAS Summary Reports on Medicaid and CHIP Expenditures.

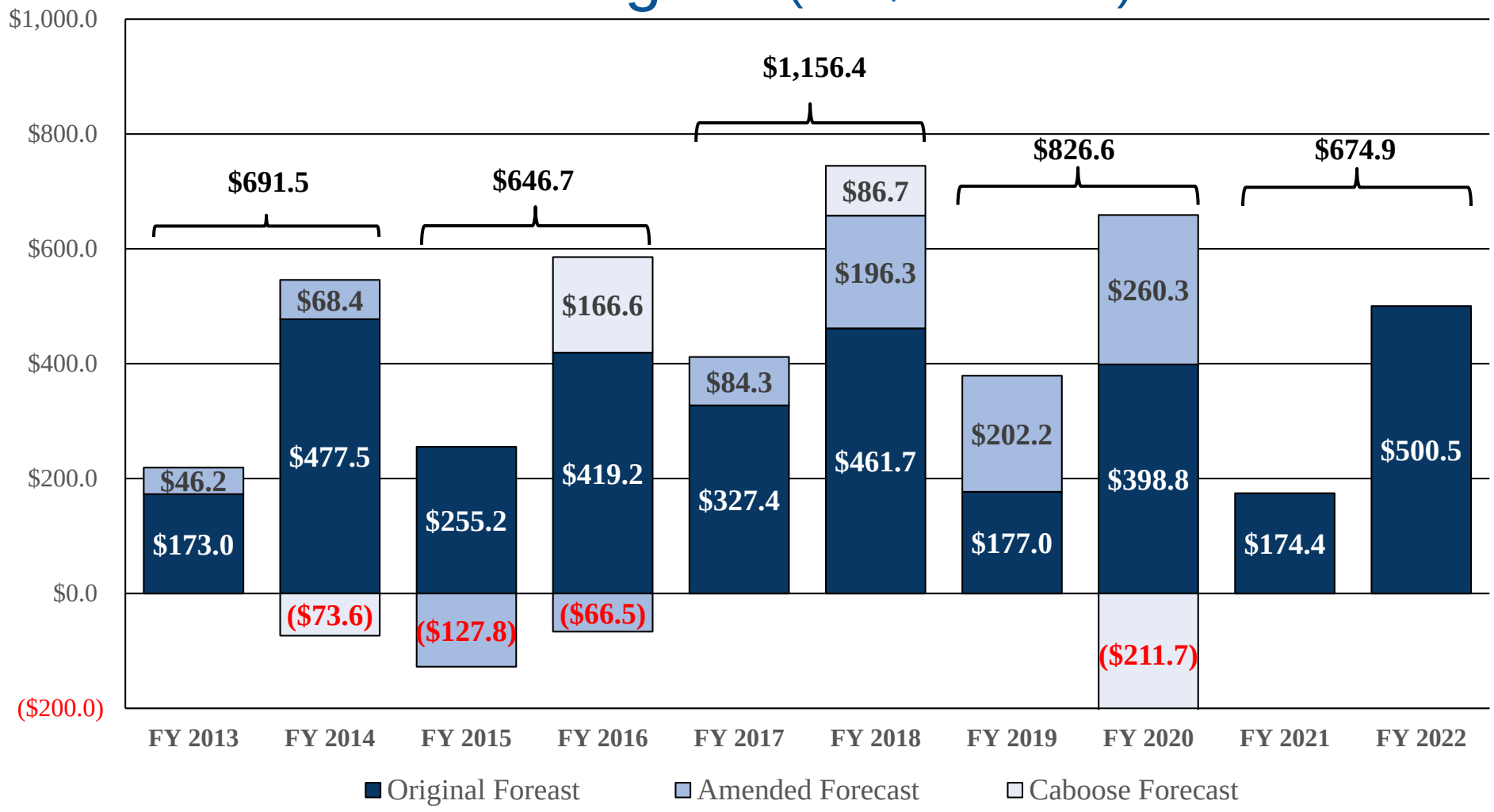
Medicaid Expansion Forecast (NGF)
FY 2020, FY 2021 & FY 2022



Preliminary Medicaid Forecast ($ in millions)

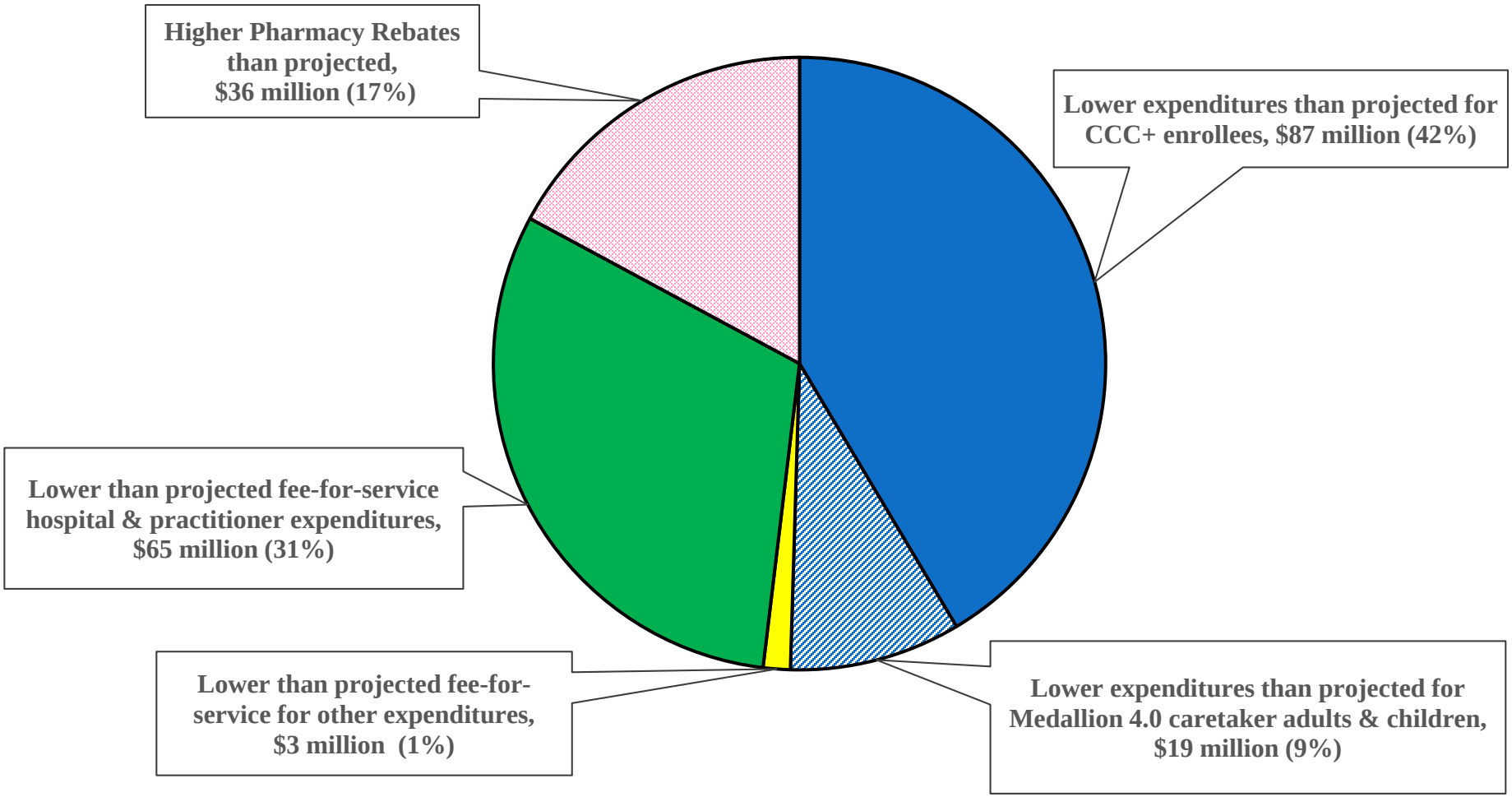
FY 2020	Forecast	Appropriation	Difference
Total Funds	**$14,265.3**	**$14,833.4**	**($568.0)**
General Fund	**$5,100.2**	**$5,311.9**	**($211.7)**
Federal Funds	$8,459.5	$8,823.5	($363.9)
Hospital Assessment for Expansion	260.9	$277.7	($16.8)
Hospital Assessment for Rate Increase	$444.7	$420.3	$24.4
FY 2021	**Forecast**	**Appropriation**	**Difference**
Total Funds	**$14,265.3**	**$14,833.4**	**$568.0**
General Fund	**$5,486.3**	**$5,311.9**	**$174.4**
Federal Funds	$9,416.3	$8,823.5	$592.8
Hospital Assessment for Expansion	$372.4	$277.7	$94.7
Rate Assessment	$477.1	$420.3	$56.8
Total Funds	$15,752.1	$14,833.4	$918.7
FY 2022	**Forecast**	**Appropriation**	**Difference**
Total Funds	**$16,776.9**	**$14,833.4**	**$1,943.5**
General Fund	**$5,812.4**	**$5,311.9**	**$500.5**
Federal Funds	$10,058.7	$8,823.5	$1,235.2
Hospital Assessment for Expansion	$404.8	$277.7	$127.1
Hospital Assessment for Rate Increase	$501.0	$420.3	$80.7

Historical Medicaid Annual Forecast Changes Base Program (GF $ in millions)



Note: Nov. 2017 forecast for the 2018-20 biennium was adjusted downwards to account for an adjustment for CSA transfers and Congressional action to suspend the ACA insurance tax for one additional year.

Factors Influencing FY 2020 Forecast Reduction of $211.7 million GF



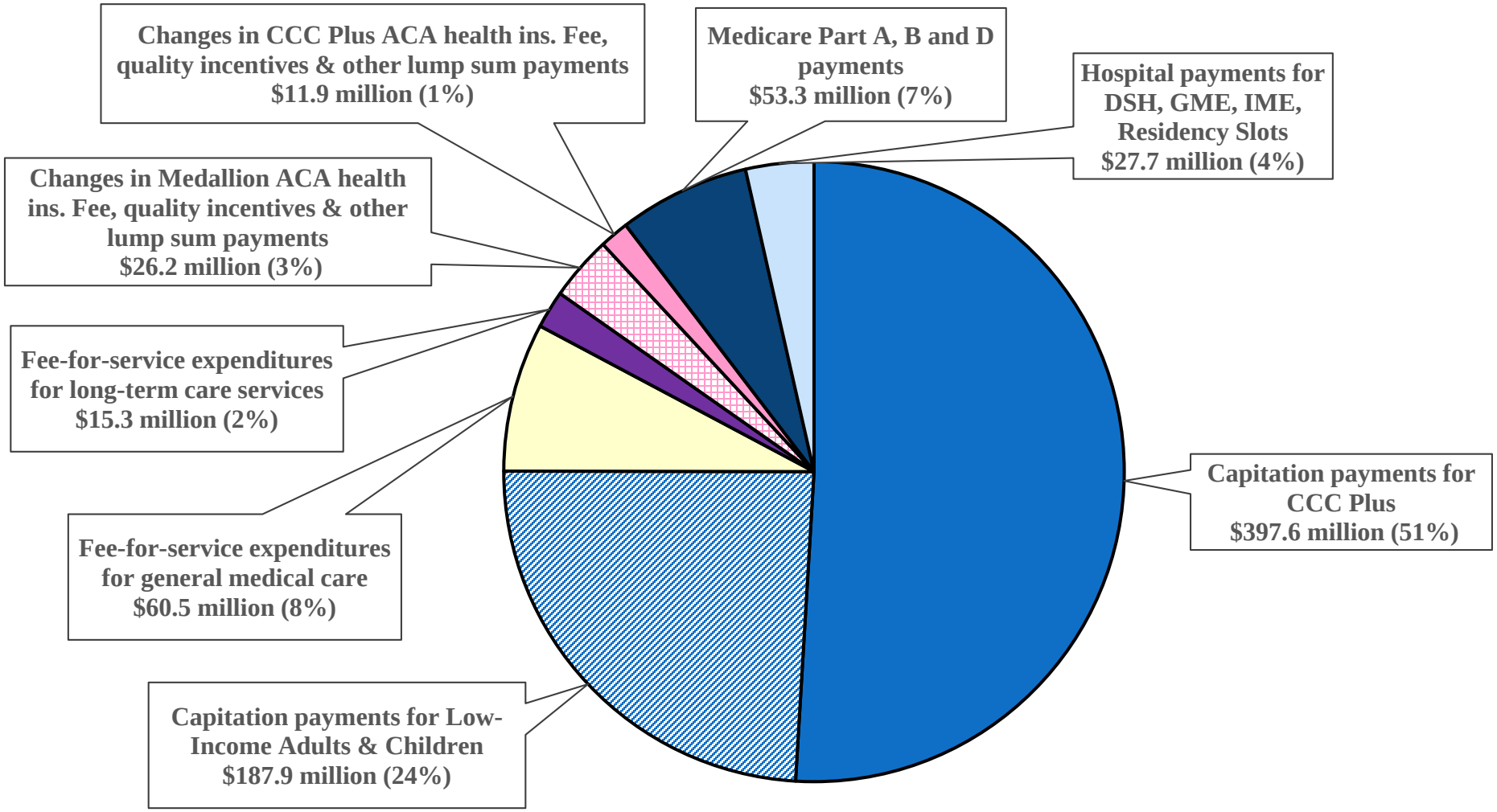
Managed Care Expenditures Lower than Projected

- Coordinated Care Plus (CCC Plus) program fully operational since Jan. 2018
  - 243,395 aged, blind and disabled enrollees, many with complex care needs requiring long-term care, including 26,672 Medicaid expansion members
- CCC Plus program expenditures were less than expected
  - Changes in expenditures due to blending of rates for institutional and community care were not as high as expected
  - Service utilization by aged, blind and disabled individuals who do not receive long-term care services has been less than expected
- Medallion 4.0 program (revised last year, full implementation on Dec. 2018)
  - 974,484 caretaker adults, pregnant women and children, including 283,291 Medicaid expansion adults ages 19-64
  - Added behavioral health, residential psychiatric and early intervention services to traditional medical services
- Lower expenditures in Medallion managed care program for caretaker adults and children
  - Unexpected decline due to some shifting of individuals into Medicaid expansion eligibility category
    - Individuals who receive transitional Medicaid benefits
    - Individuals who are determined to be Medically Needy because their medical expenses exceed their income and assets

Factors Affecting Medicaid Spending Growth in FY 2020

- Declines in fee-for-service (FFS) expenditures greater than anticipated
  - Implemented changes to enroll eligible individuals into managed care more quickly
  - Lower expenditures due to the shifting of individuals for whom third parties have a legal obligation to pay all or part of the expenditures for Medicaid services into managed care (third party liability)
  - Increase in the time lag of hospital remittances, which ultimately pushes some expected hospital expenditures into the next fiscal year
  - Expedited enrollment of some Medicaid recipients receiving limited Medicaid benefits into Medicaid Expansion eligibility category (e.g., GAP recipients receiving behavioral health benefits, recipients of family planning services only)
- Savings from Pharmacy rebates higher than anticipated
  - Rebates have been historically difficult to predict
  - Agency is working with contractor to improve predictability
  - Effect of implementing a different methodology for reimbursing for maternity related services

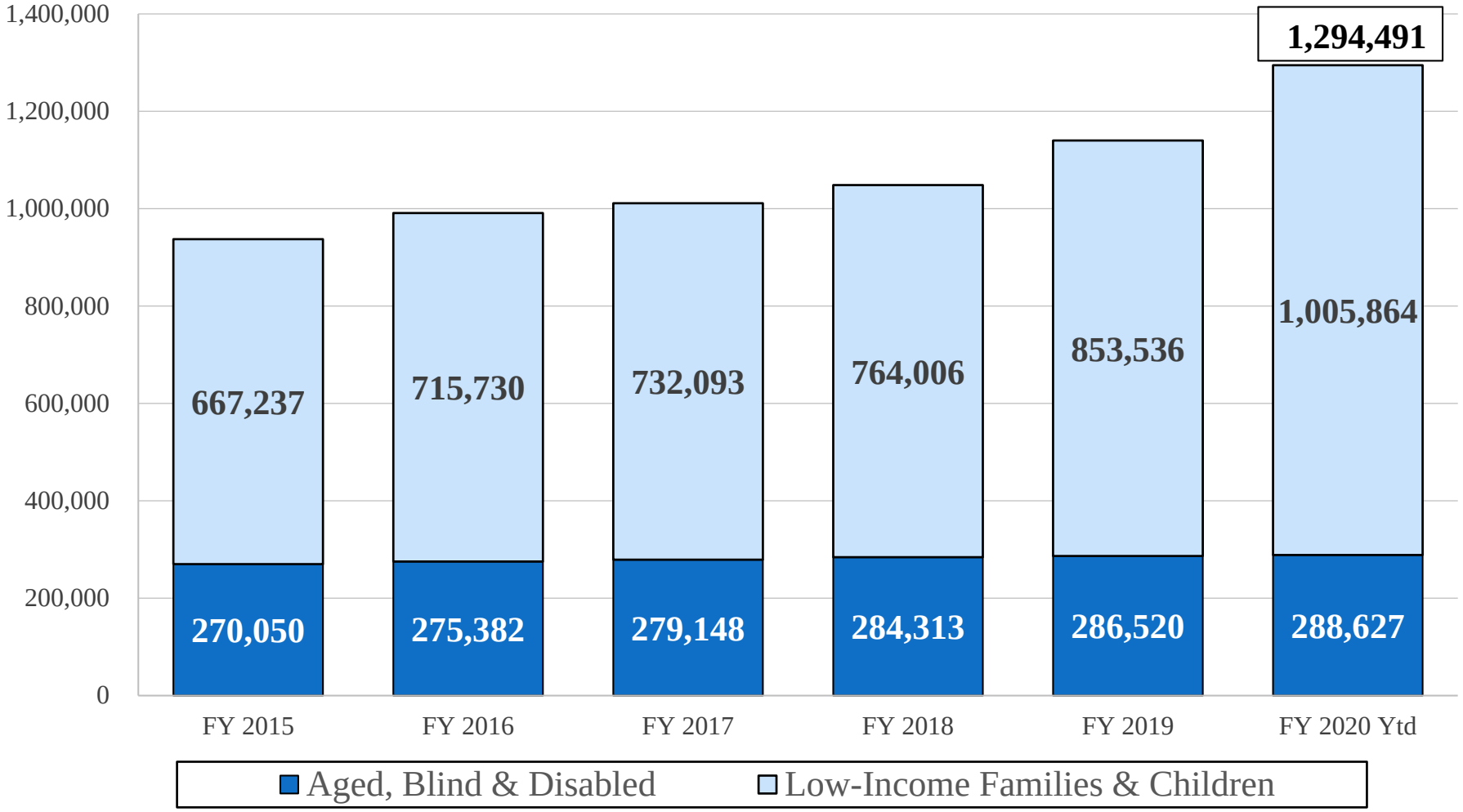
Factors Influencing 2020-22 GF Forecast



Factors Affecting Medicaid Spending Growth in 2020-22

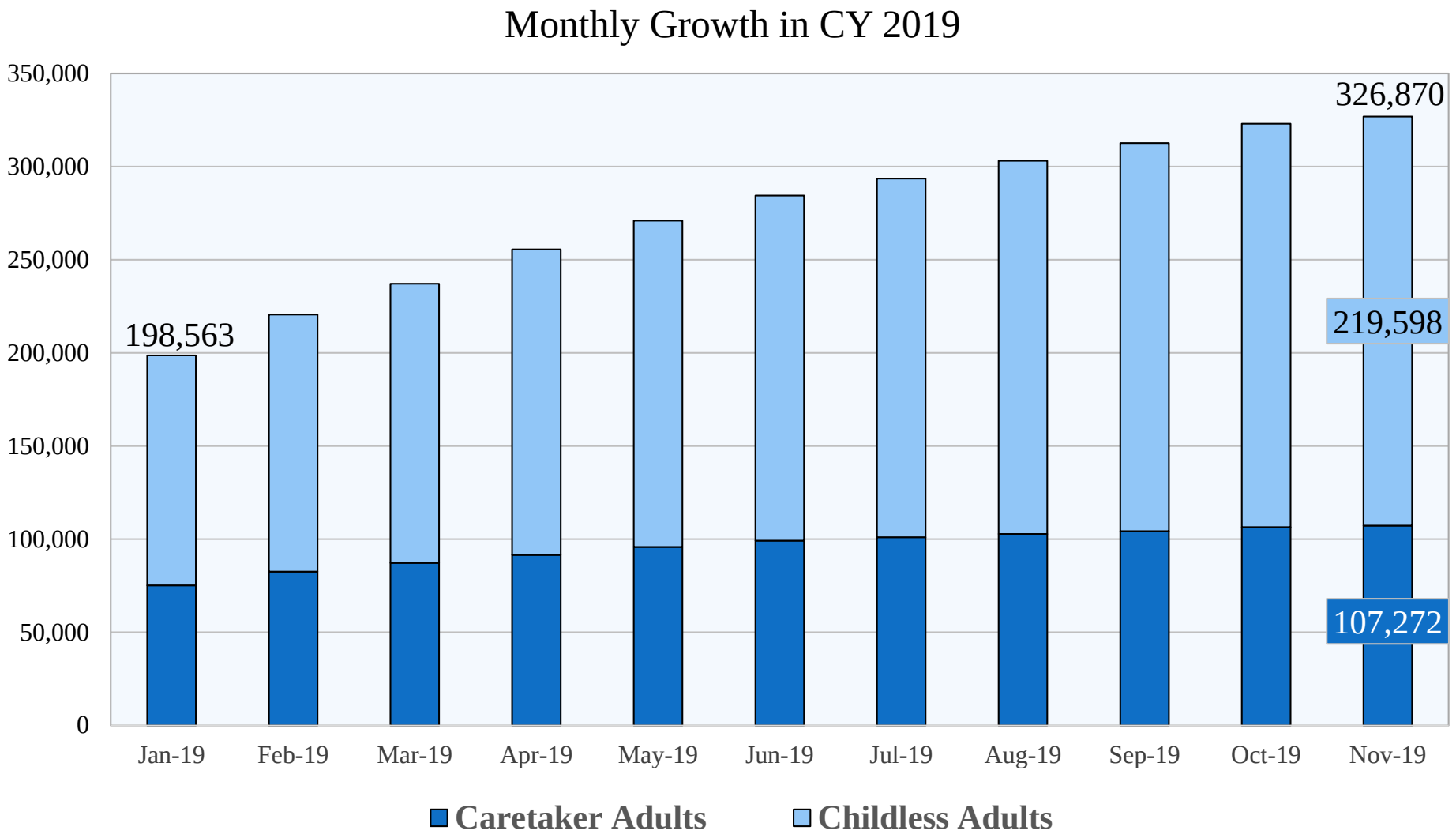
- Medicaid managed care expenditures/rates are the major drivers of Medicaid growth in the 2020-22 biennium
  - Medicaid makes capitation payments for medical, long-term care and behavioral health services to managed care organizations on behalf of 94% of all Medicaid enrollees
  - Consequently, changes in the capitation rates significantly affect Medicaid spending
- Expenditures are largely driven by enrollment and utilization of services
  - Enrollment has averaged about 4.2% growth annually prior to Medicaid expansion
  - Top cost drivers in terms of service utilization
    - Hospital inpatient and outpatient services
    - Nursing home services
    - Personal care services
    - Pharmacy and prescription drugs
    - Community behavioral health services

Average Monthly Enrollment in Medicaid



- Average monthly enrollment has grown about 15% since FY 2015 in the base Medicaid program

Medicaid Expansion Enrollment Growth



- 73% of Medicaid expansion enrollees have incomes below 100% FPL

Managed Care Rate Increases

- Rates required to be actuarially sound by federal government
- Agency hired Mercer as actuary for setting rates beginning January 2019
- CCC Plus Program
  - Beginning July 2020, rates will be set on a fiscal year basis to align with Medallion 4.0 program (rates currently set on a calendar year basis)
  - Rates projected to increase by 4.2% in FY 2021 and 4.5% in FY 2022, compared to a rate of 5.2% from January to June FY 2020
- Medallion 4.0 Program
  - Rates are set on a fiscal year basis
  - Rates to increase by 5.4% in FY 2021 and 5.4% in FY 2022, higher than the 4.1% growth expected in to occur in FY 2020

Impact of MCO Rate Changes in Base Medicaid Program	FY 2021		FY 2022	
	GF	NGF	GF	NGF
CCC Plus	$225.2	$225.2	$351.2	$351.2
Medallion 4.0	$60.3	$60.3	$130.7	$130.7
Total	$285.5	$285.5	$481.9	$481.9

Hospital & Nursing Home Inflation/Rebasing Adjustments

- Hospital and nursing home inflationary adjustments (required by regulations)
  - 3.2% in FY 2021 and 3.1% in FY 2022 for hospital inpatient expenditures
  - 2.8% in FY 2021 and 2.8% in FY 2022 for nursing facility services
  - Impacts managed care and fee-for-service expenditures

Medicaid Inflation Adjustments included in Forecast ($ in millions)	FY 2021		FY 2022	
	GF	NGF	GF	NGF
Hospitals	$16.4	$38.1	$35.6	$82.9
Nursing Homes	$15.4	$15.3	$34.1	$34.1
Total Medicaid Inflation Adj.	$31.8	$53.4	$69.7	$117.0

- Rebasing of nursing home costs occurs every three years and is projected to result in an expenditure reduction in the Medicaid forecast of $14.8 million GF and $14.8 million NGF in FY 2021
- Hospital rebasing for FY 2020 captured in Medicaid spending in Chapter 854, next rebasing would be in FY 2023

Other Factors Affecting Medicaid Spending Growth 2020-22 biennium

- Increase in fee-for-service payments for general medical services and long-term care services
  - Largely driven by growth in enrollment and utilization of services
  - Includes payments on behalf of individuals receiving long-term care services in the DD waiver programs
  - Estimated at $35.9 million GF in FY 2021 and $39.9 million in FY 2022
- Increase in Medicare Part A, Part B and Part D payments on behalf on individuals dually enrolled in Medicare and Medicaid
  - Part A (hospital services) premium increase of 4.8% in CY 2020
  - Part B (medical services) premium increase of 6.7% in CY 2020
  - Part D (prescription drugs) premium increase of 4.8% in CY 2020
  - Impact of $19.3 million GF in FY 2021 and $33.9 million GF in FY 2022

Other Factors Affecting Medicaid Spending Growth 2020-22 biennium

- Health insurance fee on managed care contracts required by the federal Patient Protection and Affordable Care Act (ACA)
  - Congress suspended the fee for CY 2019, however there has been no action to do in future years
  - Impacts 2020-22 Medicaid expenditures
  - Estimated at $30 million GF each year
- Managed care financial incentives to improve performance (often referred to as quality withhold payments)
  - Used to incentivize quality, efficiencies and cost effective delivery of services
  - Funding withheld in prior year and MCOs earn back the amounts withheld
  - Estimated at $14.5 million GF in FY 2021 and $30.9 million GF in FY 2022
- Hospital payments for disproportionate share hospitals (DSH), indirect medical expenditures (IME), graduate medical education (GME), and residency slots, physician supplemental payments & settlements
  - Estimated at $8.5 million GF in FY 2021 and $19.1 million GF in FY 2022

Factors Affecting Spending Growth Outside of the Medicaid Forecast

- DOJ Settlement Agreement (Aug. 2012) requires the addition of 435 new waiver slots over biennium (360 ID waivers and 75 DD waivers) which are not included in Medicaid forecast
  - $18.3 million GF in FY 2021 and $29.1 million GF in FY 2022 (plus like amount of federal matching funds)
  - Funding will support:
    - 860 slots to address the community waiting list allocated between the Community Living, Family and Individual Support and Building Independence waivers that replaced the old ID/DD waivers
    - 150 slots to address facility transitions from intermediate care facilities for the intellectually disabled (ICF-IDs) and nursing homes to the community
- DMAS/DBHDS also identified need for an additional 70 emergency slots
  - $1.1 million GF in FY 2021 and $2.3 million GF in FY 2022 (plus like amount of federal matching funds)
- Hospital services for individuals subject to temporary detention orders
  - DMAS pays the Medicaid rate for these services
  - $2.5 million GF in FY 2021 and $2.6 million GF in FY 2022

Managed Care Benefits & Risks to Medicaid Forecast

- Expected Benefits
  - Improve quality of care and health outcomes
  - Bend the cost curve of Medicaid expenditure growth
  - Provide better budget predictability
  - Stronger MCO contracts and DMAS contract management, including
    - Profits caps
    - Adjustment of rates to ensure they do not cover excessively high spending, account for savings from required initiatives and account for negative historical trends in medical spending to be included in setting rates
    - Provision of additional MCO financial and utilization data and to better monitor spending and service utilization trends
    - Incentives for MCOs to improve performance
- Risks
  - Near term changes in the Medicaid management information system continue disrupt the collection and analysis of critical data to analyze MCO financial and utilization data and set rates
  - Impact of future MCO rate increases due to population growth and utilization of high cost services

Benefits of Managed Care Not Fully Realized

- Expected benefits of managed care changes are in early stages
  - CCC Plus program is 22 months into the full implementation with new populations and services
  - Care management of new services such as behavioral health services continues to be challenging
  - Payment issues and service denials continue to affect some providers
  - IT systems issues continue to affect MCOs and providers
- Replacement of Medicaid Management Information System is not fully complete, but should enhance analytic capability as components are completed
  - New managed care encounter data system has recently been implemented to improve rate setting and oversight
- Managed care programs are beginning to achieve some goals although measurement is hampered by IT systems completion
  - Goal: Improve quality of care and health outcomes
    - Redesigning behavioral health services to bolster outpatient and community-based services to lessen the need for intensive treatment services
  - Goal: Bend the cost curve of Medicaid expenditure growth
    - Implementing consultant recommended improvements to the rate setting and forecasting processes
    - Implementing value based purchasing to promote quality and efficiency, such as implementing incentives for MCOs to transition members from facility-based services back into their communities where possible
  - Goal: Provide better budget predictability
    - Beginning use of encounter data to assist in MCO rate setting and budget predictability
  - Goal: Employ stronger MCO contracts and DMAS contract management
    - Implemented profits caps
    - Implemented rate adjustments to ensure they do not cover excessively high spending, account for savings from required initiatives and account for negative historical trends in medical spending to be included in setting rates
    - Required the provision of additional MCO financial and utilization data and to better monitor spending and service utilization trends
    - Implemented incentives for MCOs to improve performance
    - Working with actuary to begin clinical efficiency analyses to target medically unnecessary or potentially preventable use of high cost, high acuity settings such (e.g., Emergency Room usage, hospital admissions and readmissions)

Stronger Program Oversight

- 2018 General Assembly created the Jt. Subcommittee for Health and Human Resources (HHR) Oversight which has included Medicaid issues at most meetings held in 2018 and 2019
- 2019 General Assembly adopted language to strengthen Medicaid oversight
  - DMAS to convene quarterly meetings to explain material differences in expenditures compared to the official Medicaid forecast
    - Includes Secretaries of Finance and Health and Human Resources, staff from the money committees, JLARC and the Department of Planning and Budget
    - Two meetings have taken place in CY 2019, with three more scheduled for FY 2020
  - Fiscal review of any Medicaid program changes that may result in a general fund impact, including changes to Medicaid managed care capitation rates resulting from contract changes
  - Regular reporting of eligibility renewal data to Medicaid managed care organizations to reduce the number of enrollees who experience coverage lapse due to disenrollment that occurs as part of the annual edibility renewal process
  - Annual reporting on pharmacy claims by managed care organizations
- New JLARC unit on oversight of Health and Human Resources (HHR) agencies has completed a 2019 report on Medicaid expansion related to eligibility accuracy and access to services, and will complete two more reports in December related to enrollment and spending and COMPASS (Medicaid waiver program) readiness