**Legislative Fiscal Bureau**
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

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# Medical Assistance Cost-to-Continue Reestimate (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 250, #2]

## CURRENT LAW

The medical assistance (MA) program, also 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 state plan approved by the federal Centers for Medicare and Medicaid Services (CMS), and several federal waiver agreements.

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.

MA also provides full benefit coverage to other individuals based on categorical status, rather than level of income or assets, or disability status. The largest group of individuals who are categorically eligible for Medicaid include individuals who qualify for benefits under the federal supplemental security income (SSI) program. Other categorically eligible groups include foster children and children for whom subsidized adoption assistance agreements are in effect. Under the well woman program, MA provides full coverage to woman who have been diagnosed with breast or cervical cancer and do not have other insurance.

Finally, MA has subcomponents that provide partial benefits, including Medicare cost sharing assistance (for individuals with limited assets and income who are Medicare eligible but do not meet the income and asset criteria for full MA benefits), family planning only services, emergency services only, and tuberculosis coverage.

As of April of 2021, approximately 1.33 million individuals were enrolled in full benefit or partial benefit MA programs. Of that total, approximately 1.0 million were enrolled in BadgerCare Plus and 260,000 were enrolled in EBD Medicaid. The 80,000 remaining enrollees participated in other MA-supported programs, including limited benefit programs.

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.

**DISCUSSION POINTS**

1. The MA "cost-to-continue" estimate establishes the program's budget for the upcoming biennium under a scenario in which no changes are made to program benefits, eligibility, or provider reimbursement rates. The estimate is based on assumptions for dozens of parameters, but these assumptions generally fall into a few key categories: (a) average monthly enrollment for each of the MA eligibility groups; (b) utilization and cost of services provided on a fee-for-service basis; (c) managed care capitation rates; and (d) federal policy and formula changes, including changes to the federal matching percentage and Medicare premiums for dually-eligible MA members.

2. Table 1 shows the funding change to the appropriation base, by fund source, under the cost-to-continue estimate included in AB 68/SB 111.

**TABLE 1**

**Medical Assistance Cost-to-Continue Change to Base, AB 68/SB 111**

| Fund | 2021-22 | 2022-23 | Biennium |
|---|---|---|---|
| GPR | $163,182,700 | $483,193,800 | $646,376,500 |
| FED | 1,062,244,500 | 702,068,300 | 1,764,312,800 |
| PR | 203,977,500 | 242,751,700 | 446,729,200 |
| SEG | 58,166,600 | -5,073,300 | 53,093,300 |
| Total | $1,487,571,300 | $1,422,940,500 | $2,910,511,800 |

3. This paper presents a cost-to-continue reestimate for the 2021-23 biennium. This estimate is generally based on updated data and projections from the Department of Health Services, but makes certain modifications to the Department's assumptions. Table 2 shows the funding adjustments made under the current cost-to-continue reestimate, expressed both as a change to the appropriation base and a change to the administration's original estimate.

**TABLE 2**

**MA Cost-to-Continue Reestimate, By Fund Source**

| | Change to Base | | | Change to Bill | | |
|---|---|---|---|---|---|---|
| | 2021-22 | 2022-23 | Biennium | 2021-22 | 2022-23 | Biennium |
| GPR | $120,307,000 | $397,244,700 | $517,551,700 | -$42,875,700 | -$85,949,100 | -$128,824,800 |
| FED | 987,447,400 | 652,366,400 | 1,639,813,800 | -74,797,100 | -49,701,900 | -124,499,000 |
| PR | 192,843,400 | 214,277,400 | 407,120,700 | -11,134,100 | -28,474,300 | -39,608,500 |
| SEG | 61,393,500 | -5,314,600 | 56,078,900 | 3,226,900 | -241,300 | 2,985,600 |
| Total | $1,361,991,300 | $1,258,573,900 | $2,620,565,100 | -$125,580,000 | -$164,366,600 | -$289,946,700 |

4. The following sections of this paper provide a discussion of the significant assumptions underlying the cost-to-continue estimate.

**Federal Matching Rate**

5. The federal medical assistance percentage (FMAP) determines the respective share of Medicaid program costs that will be covered with federal and state funds. The FMAP is determined under a formula based on the state's per capita personal income over the previous three years in relation to the nationwide per capita income. Over the past several years, the FMAP has generally been between 58% and 60%, meaning that the state's share of costs has been between 42% and 40%. However, a provision of the federal Families First Coronavirus Response Act (FFCRA), which was passed in March of 2020, provides a temporary 6.2 percentage point increase to the state's FMAP,

applicable for any quarter that the federal public health emergency associated with the COVID-19 pandemic is in effect. Thus, in federal fiscal year 2020-21, while the standard FMAP would have been 59.4%, the enhanced FMAP under FFCRA is 65.6%, reducing the state's share from 40.6% to 34.4%. This increase also affects the applicable matching percentage for the Children's Health Insurance Program (CHIP), since the Medicaid FMAP is the basis for the CHIP formula. In federal fiscal year 2020-21, the enhanced CHIP FMAP is 75.9%, up 4.3 percentage points from the standard CHIP FMAP of 71.6%.

6. A key assumption for the cost-to-continue estimate, as it relates to the state's FMAP, is the duration of the federal public health emergency, since this will determine how many additional quarters the FFCRA enhanced FMAP will be in effect. CMS has told states to expect the public health emergency will remain until at least the rest of calendar year 2021. Based on this notice, the administration's cost-to-continue estimate assumed that the enhanced FMAP will expire at the end of calendar year 2021, meaning that the standard FMAP would be applicable in the final six months of state fiscal year 2021-22 and all of 2022-23. While it is possible that the public health emergency will be extended further, there would be considerable risk in making this assumption for the purposes of establishing the GPR budget for MA. Thus, the estimate presented in this paper adopts the same assumption as the administration's estimate for the expiration of the enhanced FMAP.

7. Table 3 shows the FMAP projections, along with the corresponding state share percentage, used for the cost-to-continue estimate. For the purposes of this table, both the Medicaid and CHIP rates are shown on a state fiscal year basis, which are blended rates for the corresponding federal fiscal years. For both 2020-21 and 2021-22, these rates reflected the effect of enhanced FMAP provided under the FFCRA.

**TABLE 3**

**Federal Medical Assistance Percentage (FMAP) Rates**
**By State Fiscal Year**

| State Fiscal Year | Title 19 (Most MA Services) | Title 21 (Children's Health Insurance Plan) |
|---|---|---|
| 2020-21 | | |
| State | 34.44% | 21.23% |
| Federal | 65.56 | 78.77 |
| 2021-22 | | |
| State | 37.15% | 26.00% |
| Federal | 62.85 | 74.00 |
| 2022-23 | | |
| State | 39.68% | 27.77% |
| Federal | 60.32 | 72.23 |

8. For the purposes of the reestimate presented in this paper, the federal share percentage for 2022-23 has been increased by 0.38 percentage points, relative to the administration's budget

assumption. This increase to the FMAP is based on the most recent estimates developed by the Federal Funds Information for States (FFIS), using new population data from the 2020 U.S. Census and personal income data from the Bureau of Economic Analysis (BEA). FFIS notes that the 2022-23 FMAP is subject to revision, as the impacts of COVID-19 relief legislation on state personal income are not fully incorporated into BEA's figures. The final FMAP for that year will be released in the fall.

**MA Program Enrollment**

9. The total funding increases under this cost-to-continue estimate, $1,362.0 million in 2021-22 and $1,258.6 million in 2022-23 (all funds basis), are significantly higher than in recent biennia. By comparison, the cost-to-continue increase for the 2021-23 budget was $208.2 million in 2019-20 and $633.9 million in 2020-21. The primary reason for the larger adjustment is higher program enrollment due to the effects of the COVID -19 pandemic. Enrollment in full benefit MA eligibility categories is now expected to be approximately 25% higher at the end of the 2019-21 biennium than the projections used to set the Act 9 appropriations. Thus, a significant portion of the 2021-23 cost-to-continue estimate are adjustments to the appropriation base to reflect a higher enrollment baseline.

10. While program enrollment has perhaps the greatest impact on the cost-to-continue estimate, it is also the component subject to the greatest uncertainty. Since some of the conditions currently affecting the program are unique, past enrollment patterns may not be a reliable guide for projecting future enrollment.

11. Enrollment in MA, and in particular BadgerCare Plus, typically increases in response to the job and income losses caused by economic recession, and the contraction caused by the COVID-19 pandemic was particularly rapid. Nationally, the inflation adjusted GDP declined year-over-year by 9.0% in the second quarter of 2020, the largest recorded decrease in at least 70 years. There was a net loss of 18.2 million jobs in the first few months of pandemic, representing over 15% of pre-pandemic employment. These job losses resulted in loss of household income and employ-sponsored health care coverage, leading many to enroll in medical assistance coverage.

12. In addition to the direct impact of job losses on MA enrollment, the program has also been affected by enrollment and eligibility provisions of federal COVID-19 legislation. As a condition of receiving the enhanced FMAP during the COVID-19 public health emergency, states are generally not permitted to disenroll any person who was enrolled at the time of the passage of the Act or who subsequently enrolls in the program. Similar with the enhanced FMAP, this so called "continuous enrollment" requirement lasts for the duration of the public health emergency, in this case until the end of the month that the federal declaration expires.

13. One feature of the enrollment patterns in MA during normal periods is the regular movement on and off of the program, as some individuals lose eligibility and others are newly enrolled. This enrollment "churn" occurs in part because MA eligibility is based on monthly income, rather than annual income levels, so individuals whose income varies throughout the year may move above and below the eligibility threshold. This churning pattern has changed with the continuous enrollment provision since individual who may become eligible during a period of low income will

not be disenrolled if they begin to earn more. The continuous enrollment provision, which was intended to provide a stable source of coverage for low income individuals during the pandemic, means that enrollment can only grow over time, even as the economy improves.

14. To illustrate the enrollment patterns for different eligibility groups during the 2019-21 biennium, Table 4 compares monthly enrollment for major eligibility categories in July of 2019 with enrollment in April of 2020, along with the percentage change.

**TABLE 4**

**MA Enrollment Comparison by Major Eligibility Category**

| Category | July, 2019 | April, 2021* | Pct. Change |
|---|---|---|---|
| EBD | 239,852 | 260,829 | 8.7% |
| BC+ Children | 453,449 | 529,484 | 16.8 |
| Parents | 160,163 | 209,626 | 30.9 |
| Childless Adults | 149,587 | 235,699 | 57.6 |
| Pregnant Women | 19,931 | 28,268 | 41.8 |
| Foster Children | 20,890 | 24,063 | 15.2 |

* Due to the potential for retroactive adjustments, the enrollment figures for April, 2021 are subject to change slightly.

15. Although enrollment can only grow while the continuous enrollment period is in effect, the rate of growth has slowed over time. This suggests that there are fewer individuals among those not already enrolled who are experiencing circumstances that lead to new enrollment, including job or income losses, or health issues that lead them to seek coverage (for those who were already eligible but not enrolled). To illustrate with an example, childless adult enrollment grew by an average of 9,800 per month during the final quarter of 2019-20 (April to June of 2020), but has grown by an average of about 3,500 per month recently.

16. Because the regular process of eligibility redetermination has been suspended since March of 2020, the Department is not able to determine the precise share of those currently enrolled that would not meet eligibility requirements if not for the continuous enrollment provision. Upon completion of the continuous enrollment period, Wisconsin income maintenance agencies will begin the process of redetermining eligibility of all individuals currently enrolled. While CMS has provided some guidance for states, it is generally expected that these procedures will be changed or further refined as the end of the public health emergency draws to a close. One of the key issues to be determined is the length of time states will have to complete the eligibility review for all individuals enrolled. Based on current guidance, this period is expected to last at least six months, but could be extended to one year for the purpose of balancing the renewal caseload going forward.

17. Going forward into the 2021-23 biennium, the key factors that will determine the caseload can be summarized as follows: (a) the rate that enrollment continues to grow during the remainder of the continuous enrollment period; (b) the share of those enrolled upon the termination

of the continuous enrollment period who are determined to be no longer eligible; (c) the length of time needed to complete redetermination; and (d) the underlying trends and balance between individuals who become eligible and individuals who lose eligibility.

18. Regarding disenrollment, the administration's estimate assumes that the share of the caseload that will lose eligibility will vary, depending upon the characteristics of the group. For instance, for childless adults, which is the category that has seen the most growth and is typically subject to a high degree of enrollment churn, it is assumed that one-quarter of the caseload at the conclusion of the public health emergency will eventually be disenrolled. Parents and children are subject to less churn, and so the percentage of the caseload subject to disenrollment is assumed to be lower, at about 19% and 12%, respectively. Because the EBD Medicaid eligibility groups have relatively little churn and so have not been as affected by the continuous enrollment provision, the administration assumes that only about 5% will be subject to disenrollment.

19. The administration assumes that the eligibility redetermination process will occur over a 12-month period, spanning calendar year 2022. However, the rate of disenrollment is expected to be higher in the first few months after the conclusion of the public health emergency, reflecting an assumption that the redetermination process will prioritize individuals who are most likely to be found ineligible for continued coverage.

20. Along with this disenrollment, the administration's estimate makes assumptions regarding the normal process of enrollment and disenrollment for individuals who become newly eligible and those, due to a change in income or other circumstance, are no longer eligible. The administration's caseload estimate makes different assumptions about the net effect of these underlying trends depending on the eligibility group and timing. During the first six months of the biennium, the continuous enrollment provisions will remain in effect, and so the caseload growth is generally expected to be similar to recent growth rates. Beginning in calendar year 2022, the underlying caseload trends will differ by broad program category. For elderly, blind, and disabled groups, the growth rates are assumed to be 2.5% annually for elderly enrollees, 1.5% annually for disabled adults, and 1.0% for disabled children. These rates were generally based on prior trends, although are slightly higher than the growth rates that prevailed in the years prior to the pandemic. For BadgerCare Plus groups, the administration assumed that the underlying growth rates would match the patterns seen in the years following the Great Recession. While that recession had the greatest impact on employment and earnings in 2008 and 2009, the Department notes that the caseload continued to grow throughout 2010 and into the first months of 2011. Thus, the underlying growth rate is estimated at 5.7% in 2021-22, matching the calendar year 2010 growth rate, and 2.0% in 2022-23, matching the growth rate in 2011.

21. The effect of the disenrollment process that will occur upon the expiration of the public health emergency is expected to outweigh the underlying caseload growth rate. Thus, the total caseload is projected to decline throughout 2022, before growing again, at a slower rate, in the final six months of the biennium (the first six months of 2023).

22. The estimate presented in this paper generally accepts the administration's updated projections and assumptions, but with two modifications that have the effect of slightly lowering caseload estimates. First, the growth rates used for BadgerCare Plus groups for the remainder of the

continuous enrollment period are reduced slightly, to more closely match the lower rate of growth seen in recent months for those categories. Second, instead of assuming that the underlying growth rate for BadgerCare categories will be the same as caseload growth seen 2010 and 2011, the reestimate assumes a slightly slower underlying grow rate. This revision is warranted primarily because the current economic forecasts project a more rapid recovery than was the case following the 2009 recession. The major relevant indicators, such as unemployment rate and employment-to-population ratio are already closer to pre-pandemic levels than was the case in 2010 and 2011, following the 2009 recession.

23. The attachment to this paper shows the average monthly caseload estimates used for the cost-to-continue reestimate, for the major eligibility groups. To illustrate how enrollment changes over time, these averages are shown for each calendar quarter, beginning in the first quarter of 2021 and continuing through the second quarter of 2023 (the end of the 2021-23 biennium). The annualized rate of change is also shown for each quarter.

**Enrollment and Utilization Projections for Long Term Care Programs and Services**

24. In addition to overall caseload projections, the cost-to-continue estimate takes into consideration enrollment in MA's long term care programs, such as Family Care and IRIS, as well as nursing home utilization by individuals not enrolled in Family Care. Collectively, these programs typically account for around 40% of MA costs, and so trends in these program can have a significant bearing on the cost-to-continue budget.

25. DHS estimates that average monthly enrollment in Family Care will be approximately 51,100 in 2020-21 (a 0.5% increase from 2019-20 enrollment), and increase to approximately 52,400 in 2021-22 and 53,700 in 2022-23 (increases of 2.7% and 2.5% over the prior year, respectively). For IRIS, the Department estimates that average monthly enrollment will be approximately 22,000 in 2020-21 (a 10.1% increase from 2019-20 enrollment), and increase to approximately 23,900 in 2021-22 and 25,800 in 2022-23 (increases of 8.5% and 7.9% over the prior year, respectively). The percentage increases anticipated for both Family Care and IRIS are lower than actual increases in previous years potentially due to the gradual elimination of the waiting list for elderly, blind, and disabled adults to receive long-term care services. The waiting list, as it pertains to adults seeking home and community based long-term care services, was eliminated in the spring of 2021. The re-estimate as described in this paper adopts the Department's assumptions regarding enrollment in both Family Care and IRIS.

26. The Department indicates the Medicaid program has experienced a long-term trend of declining nursing home utilization, driven by two underlying factors: (1) a reduction in the total number of individuals using nursing home services over time and (2) a decrease in the average length of a nursing home stay. Specifically, DHS projects that the monthly average census of Medicaid fee-for-service nursing home residents will decline from around 8,400 in 2020-21 to 7,800 by 2021-22 and 7,100 by 2022-23. As such, total fee-for-service patient bed days are anticipated to decline by 8.2% in 2020-21, 8.1% in 2021-22, and 8.2% in 2022-23.

27. While DHS has historically estimated that 17% of nursing home patient days are attributable to managed care that trend has been updated, based on the decrease in fee-for-service

patient days and the increase in long-term managed care enrollment, resulting in an associated increase in nursing home services utilization under managed care. DHS indicates that in 2019-20, it is estimated that 38% of nursing home patient days were attributable to managed care. This percentage is expected to increase to approximately 43% in 2020-21, 49% in 2021-22, and 55% in 2022-23. The reestimate as described in this paper adopts the Department's assumptions regarding nursing home utilization in the 2021-23 biennium.

28. As of May, 2021, there are 12,928 children enrolled in the children's long term support (CLTS) waiver program. The administration's cost-to-continue estimate assumes that enrollment in the program will increase to 13,822 by June, 2022, and 14,542 by June, 2023. Both the 2017-19 and 2019-21 budgets included funding to eliminate waiting lists for the program. However, since funding for the program has continued to be budgeted as a sum certain allocation within the larger MA budget, and the number of children eligible to receive CLTS services has continued to grow, there are still children on the waiting list for CLTS services. The Department's cost-to-continue estimate provides sufficient funding to eliminate the waiting list for CLTS services as it exists in May, 2021. However, as with previous budgets, if the number of children applying, and found eligible, for CLTS services continues to increase, there could still be children on the waiting list at the end of the 2021-23 biennium. In order to eliminate this possibility the Governor's recommendation included a statutory provision to require DHS to ensure that any child who is eligible, and applies, for the CLTS waiver program receives services under the CLTS waiver program. [This statutory change is discussed in a separate budget paper].

**Fee-for-Service Utilization and Managed Care Capitation Rates**

29. Typically the cost-to-continue estimate relies on recent trends in claims data by service category and eligibility group to estimate service utilization for the upcoming biennium. However, the Department believes that recent claims data are not a reliable basis for making estimates for the 2021-23 biennium. The COVID-19 pandemic likely affected the use of many medical services during the past year in various ways, meaning that these data are unlikely to be representative of utilization moving forward. Moreover, the composition of the caseload in recent months likely differs from the expected future caseload in ways that affect the average type and quantity of services used. For this reason, the administration has relied on utilization data from 2019, prior to the disruptions resulting from COVID-19 pandemic, as the basis for utilization estimates. Given the lack of more recent reliable data, this approach likely represents the best approximation of future utilization and the estimate presented in this paper uses the same average cost data as the Department's updated estimate.

30. The administration's cost-to-continue estimate assumed 2.0% annual increases to capitation rates for BadgerCare Plus and SSI HMOs, as well as Family Care managed care organizations (MCO). This reestimate retains those assumptions as a reasonable approximation of HMO and MCO costs. Actual capitation rates are established each year based on service utilization data submitted by HMOs and MCOs.

31. Normally, MCO monthly capitation rates are based, in large part, on service utilization data from prior years. However, the projections for MA HMO capitation rates for the next few years, particularly for acute care services, will be subject to the same uncertainties as fee-for-service utilization projections, due to the COVID-19-related disruptions occurring during the past year.

Likewise, the average medical need of the expanded caseload in 2020 and 2021 may differ from what the needs the caseload in a typical year. To account for uncertainties, the Department established a risk corridor provision in the 2021 HMO contract. Under this provision, the state will pay a portion of an HMO's costs that exceed the expected costs by at least 2.0% and HMOs will pay back a portion of their gains if costs are below expectations by at least 2.0%.

**Federal Medicare Premiums and Part D Clawback**

32. MA pays the Medicare Part A and Part B premiums and, in some cases, deductibles and coinsurance for enrollees who are dually-eligible for Medicaid and Medicare. The administration's cost-to-continue estimate is based on projections for these premiums included in the most recent report of the Medicare Trustee. Growth in the number of dually eligible assumes growth in these costs based on recent trends. Since no more recent projections are available, the reestimate presented in this paper does not change the administration's estimates.

33. Since 2006, state Medicaid programs have been required to make a payment each year to fund a portion of the costs of the federal Medicare Part D program, in recognition that Part D results in state Medicaid program savings on drugs for dually-eligible enrollees. The amount of this "clawback" payment is based on a formula that is intended to equal 75% of each state's estimated savings. Year-to-year payments change based on the number of dually-eligible MA beneficiaries, the change in per capita drug spending under Part D, and the state's FMAP. The reestimate is based on the most recent projections of clawback formula adjustments from FFIS, as well as estimates of changes to per capita drug costs included in the Medicare Trustee's report.

**Summary**

34. With limited exceptions, the medical assistance program is required by state and federal law to pay for the cost of all medically necessary services for program enrollees. If the amount of funding provided in the biennial budget is insufficient to fund these costs, the Department's options to administratively reduce costs are somewhat limited. In the event of a budget shortfall in MA, the Committee or the full Legislature may be required to act, either by increasing the MA appropriations or making statutory program changes to reduce costs. For this reason, there are risks associated with underestimating the MA budget.

35. While there is typically some degree of uncertainty in MA budget estimates, the 2021-23 budget period presents particular challenges because the factors that drive program enrollment and health care utilization are difficult to predict in the wake of the COVID-19 pandemic. The estimate presented here largely rests on the assumption that economic conditions will improve as the country emerges from the economic recession caused by COVID-19, although with some lingering effects on low income and medically needy households.

## CONCLUSION

The following table presents the funding changes to the 2020-21 appropriations under the cost-to-continue estimate.

## MA Costs-to-Continue Reestimate

| | Change to Base | | |
|---|---|---|---|
| | 2021-22 | 2022-23 | Biennium |
| GPR | $120,307,000 | $397,244,700 | $517,551,700 |
| FED | 987,447,400 | 652,366,400 | 1,639,813,800 |
| PR | 192,843,400 | 214,277,400 | 407,120,700 |
| SEG | 61,393,500 | -5,314,600 | 56,078,900 |
| Total | $1,361,991,300 | $1,258,573,900 | $2,620,565,100 |

Prepared by: Jon Dyck
Attachment

## ATTACHMENT

### Actual and Projected Monthly Average Enrollment by Calendar Quarter for Major Full Benefit MA Groups

| | 2020 Q1 | 2020 Q2 | 2020 Q3 | 2020 Q4 | 2201 Q1 | 2021 Q2 | 2021 Q3 | 2021 Q4 | 2022 Q1 | 2022 Q2 | 2022 Q3 | 2022 Q4 | 2023 Q1 | 2023 Q2 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EBD Medicaid | 248,094 | 249,948 | 254,359 | 257,992 | 260,964 | *264,576* | *267,557* | *270,310* | *267,619* | *264,881* | *262,767* | *262,102* | *262,866* | *264,215* |
| Children | 452,791 | 473,757 | 493,723 | 509,986 | 522,881 | *532,180* | *540,081* | *547,323* | *533,099* | *520,297* | *507,451* | *499,702* | *498,442* | *499,887* |
| Parents | 160,018 | 174,803 | 187,258 | 197,164 | 205,337 | *211,640* | *216,757* | *221,289* | *211,585* | *202,339* | *193,592* | *188,296* | *187,058* | *187,519* |
| Childless Adult | 154,174 | 176,998 | 196,640 | 214,615 | 229,220 | *238,583* | *246,262* | *253,144* | *238,020* | *223,236* | *209,672* | *201,524* | *199,465* | *199,957* |
| Pregnant Women | 19,169 | 20,844 | 23,581 | 25,491 | 27,152 | *28,579* | *29,701* | *30,718* | *27,918* | *25,096* | *22,687* | *21,288* | *20,905* | *20,949* |
| Foster Children | 20,763 | 21,161 | 22,038 | 22,873 | 23,518 | *24,287* | *24,886* | *25,416* | *25,258* | *25,000* | *24,769* | *24,656* | *24,675* | *24,748* |

### Annualized Percentage Change by Calendar Quarter, Actual and Projected

| | 2020 Q1 | 2020 Q2 | 2020 Q3 | 2020 Q4 | 2201 Q1 | 2021 Q2 | 2021 Q3 | 2021 Q4 | 2022 Q1 | 2022 Q2 | 2022 Q3 | 2022 Q4 | 2023 Q1 | 2023 Q2 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EBD Medicaid | 2.6% | 3.0% | 7.2% | 5.8% | 4.7% | *5.7%* | *4.6%* | *4.2%* | *-3.9%* | *-4.0%* | *-3.2%* | *-1.0%* | *1.2%* | *2.1%* |
| Children | 0.3% | 19.8% | 18.0% | 13.8% | 10.5% | *7.3%* | *6.1%* | *5.5%* | *-10.0%* | *-9.3%* | *-9.5%* | *-6.0%* | *-1.0%* | *1.2%* |
| Parents | -0.2% | 42.4% | 31.7% | 22.9% | 17.6% | *12.9%* | *10.0%* | *8.6%* | *-16.4%* | *-16.4%* | *-16.2%* | *-10.5%* | *-2.6%* | *1.0%* |
| Childless Adults | 8.8% | 73.7% | 52.3% | 41.9% | 30.1% | *17.4%* | *13.5%* | *11.7%* | *-21.8%* | *-22.6%* | *-22.2%* | *-14.7%* | *-4.0%* | *1.0%* |
| Pregnant Women | -4.2% | 39.8% | 63.8% | 36.5% | 28.7% | *22.7%* | *16.6%* | *14.4%* | *-31.8%* | *-34.7%* | *-33.2%* | *-22.5%* | *-7.0%* | *0.8%* |
| Foster Children | -0.1% | 7.9% | 17.6% | 16.0% | 11.8% | *13.7%* | *10.2%* | *8.8%* | *-2.5%* | *-4.0%* | *-3.6%* | *-1.8%* | *0.3%* | *1.2%* |

*Note: Beginning in the second quarter of 2021, the enrollment figures and annualized percentage changes reflect the projections used for the cost-to-continue estimate. These figures are italicized.*