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

[LFB 2019-21 Budget Summary: Page 163, #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, 2019, approximately 1.1 million individuals were enrolled in full benefit or partial benefit MA programs. Of that total, approximately 780,000 were enrolled in BadgerCare Plus and 240,000 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.

GOVERNOR

Provide $192,551,700 ($89,305,200 GPR, $112,358,400 FED, -$13,905,700 PR, and $4,793,800 SEG) in 2019-20 and $584,990,700 ($264,657,600 GPR, $249,975,200 FED, $68,345,200 PR, and $2,012,700 SEG) in 2020-21 to fund projected MA benefits under a cost-to-continue scenario.

DISCUSSION POINTS

1. The bill includes funding to reflect the administration's estimate of the cost of providing MA benefits during the 2019-21 biennium under a scenario in which no changes are made to program benefits, eligibility, or provider reimbursement rates (other than annual adjustments under payment methodologies for hospitals and nursing homes, and amounts set aside to fund future increases in capitation payments to managed care organizations to comply with federal requirements that states establish actuarially sound capitation rates). This "cost-to-continue" 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. Although MA benefits are funded with four funding sources (GPR, FED, PR, and SEG), and all four are adjusted as a result of the cost-to-continue estimate, the primary focus of this paper is the estimated change to GPR-funded costs. Under the administration's cost-to-continue estimate, GPR funding would increase above the 2018-19 appropriation base by $89.3 million in 2019-20 and $264.7 million in 2020-21 for a total of $354.0 million over the biennium. This estimate if $140.7 million less than the amount included in the Department's budget request, submitted in September, 2018.

3. This paper provides a reestimate of the MA cost-to-continue budget, relying on more recent caseload and expenditure trends and current information for federal formula factors. Although some changes to the budget assumptions are warranted, the net change to the administration's estimate is relatively small. Compared to the bill, the reestimate increases total GPR funding by $2.1 million over the biennium, the net effect of a decrease of $6.6 million in 2019-20 and an increase of $8.7 million in 2020-21. The following points provide a description of the principal changes, as well as summary information on the resulting estimate. The final section of this paper provides a discussion of the primary risks inherent in MA budget estimates, and alternatives for the Committee's consideration for mitigating those risks.

Caseload Estimates

4. The administration's program enrollment estimates are generally based on trends over the past one to three years. For eligibility groups enrolled in elderly, blind, and disabled Medicaid (EBD), this generally means increases of between 1.% to 1.5% for nonelderly disabled enrollees, and approximately 2.5% for elderly enrollees. For BadgerCare Plus enrollment, the administration assumed that enrollment by parents and children would continue to decrease, in line with recent trends. Enrollment is assumed to decrease by 2% to 3% annually for parents, 1.0% to 1.5% annually for children, and 1.0% to 2.0% for pregnant women. Childless adult enrollment, in contrast, was projected to increase by 0.8% annually.

5. The reestimate makes several adjustments to caseload estimates, based on updated data on actual enrollment, and also adopting a somewhat more conservative approach to recent enrollment trends. With respect to enrollment in the EBD eligibility groups, the reestimate uses slightly slower growth assumptions for nonelderly adults and children, based largely on more recent information. For BadgerCare Plus, particularly the parent and children, the reestimate assumes that enrollment will remain relatively constant, rather than continue to decrease. Although enrollment in these categories has decreased over the 2017-19 biennium, and this could continue, there is a risk in budgeting based on an assumption that these trends will continue. For childless adults, the rate of growth is projected to be somewhat lower than the administration's estimates, at approximately 0.3% per year.

6. The attachment to this paper shows the caseload assumptions for both the administration's cost-to-continue budget and the updated estimate.

7. The reestimate incorporates updated enrollment information for the children's long-term support (CLTS) waiver services. The Governor's budget bill estimated CLTS enrollment to be 9,910 by June 30, 2021. However, as of April 30, 2019, 9,255 children were enrolled in CLTS, with an additional 963 children on the waiting list. Based on these more recent enrollment and waiting list numbers, the MA cost-to-continue reestimates projected CLTS enrollment to be 10,637 by June 30,

2021. DHS hypothesizes that the publicity surrounding the additional funding provided in the 2017-19 biennium to reduce the waiting list for CLTS services has resulted in more families applying for services, thus increasing the number of eligible children above initial projections.

Fee for Service Utilization and Managed Care Capitation Rates

8. The cost-to-continue estimate generally relies on recent trends in per person costs by eligibility and service category to estimate future fee for service utilization. The Department has now updated the per person costs with the more recent data, which are incorporated into the estimate. In general this update does not substantially change the service category spending estimates, independent from the caseload adjustments discussed above.

9. Along with the updates to service utilization, the Department recommends increasing estimates of manufacturer drug rebates to reflect current rebate trends. Although total gross drug expenditures would increase by $62.0 million over the biennium, relative to the bill estimate (due primarily to higher enrollment), drug rebates would also increase, by a total of $64.1 million. Consequently, net drug spending would decrease by $2.1 million under the reestimate, relative to the bill.

10. The administration's 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.

Federal Formula Factors

11. In addition to caseload and intensity, MA benefit costs are affected by factors related to federal formulas. These include the federal medical assistance percentage (FMAP), the state's "clawback" payment, made by states to the federal government to partially fund Medicare Part D prescription drug benefits, and Medicare premiums and cost sharing assistance for dually-eligible MA beneficiaries.

Federal Matching Percentage

12. The federal medical assistance matching percentage is based on the relationship between the state's per capita income and the national average per capita income. Under the formula, a state with a per capita income equal to the national average has an FMAP of 55%, while states with a per capita income lower or higher than the average will have an FMAP that is higher or lower than 55%, respectively.

13. The administration's MA cost-to-continue estimates were based on projections of the state's FMAP for the 2019-21 biennium available at the time of the introduction of the bill. The estimate assumed an FMAP of 59.36% for both federal fiscal years (FFY) 2019-20 and 2020-21. Since the time of these estimates, the federal Bureau of Economic Analysis has published data on state and national 2018 per capita income. Incorporating this data into the FMAP calculation results

in a slight increase to the FFY 2020-21 FMAP, from 59.36% to 59.61%. Consequently, the state fiscal year 2020-21 FMAP rate is reestimated to be 59.55%, rather than 59.36%, as assumed in the bill. This change has the effect of reducing the GPR costs of MA program benefits by approximately $19.5 million over the biennium and increasing FED costs by a corresponding amount.

14. The increased FMAP for FFY 2020-21 also has the effect of increasing the federal matching rate for services provided to children who are eligible for coverage under the children's health insurance program (CHIP). Federal law provides an enhanced FMAP for CHIP services. The enhanced CHIP FMAP is currently also subject to a temporary increase. The ongoing enhancement has the effect of reducing the state's share by 30%, relative to the standard FMAP. The temporary adjustment increased the CHIP FMAP by an additional 23 percentage points from FFY 2015-16 through FFY 2018-19, decreasing to an 11.5 percentage point increase in FFY 2019-20. No additional increase to the CHIP FMAP is provided in FFY 2020-21 and beyond.

15. The scheduled phase-down of the CHIP FMAP has the effect of increasing GPR costs, since the reduction in federal funds must be replaced with state funds. Over the biennium, the cost-to-continue estimate includes approximately $91 million due to the phase-out of the temporary CHIP FMAP increase. However, the CHIP FMAP increase did produce significant state savings while it was in effect, and the additional costs in this biennium relative to the baseline, can be viewed as the result of the expiration of a provision that was, from the beginning, known to be temporary.

16. The following table shows both the standard and CHIP FMAPs, as well as the corresponding state share, on a state fiscal year basis. Since the state fiscal year does not completely overlap with the federal fiscal year, the FMAPs shown in the table differs slightly from the corresponding federal fiscal year FMAPs.

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)
2018-19		
State	40.78%	5.55%
Federal	59.22	94.45
2019-20		
State	40.64%	14.07%
Federal	59.36	85.93
2020-21		
State	40.45%	25.44%
Federal	59.55	74.56

Clawback Payments and Medicare Premiums

17. 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.

18. 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 assumes growth in these costs based on recent trends and the information available at the time for premium levels.

19. The reestimate updates clawback payments using updated projections for the clawback payment formula factors and for the Medicare premiums. In total, these updates resulted in a slight reduction in the clawback payment estimate, but a slight increase in the Medicare premium payment estimate, such that the net effect is minimal.

Summary and Discussion of the Revised Cost-To-Continue Estimate

20. The revisions to the cost-to-continue estimate assumptions discussed in this paper, result in, relative to the bill, an increase of $2.1 million to the GPR funding for MA benefits over the biennium, a total increase of $75.0 million in combined GPR and FED funding, and an increase of $139.8 million from all fund all sources. Relative to the MA base, GPR funding for MA would increase by $356.1 million GPR over the biennium and by $926.3 million from all fund sources. The following table shows the total funding by year and fund source under the reestimate, along with the corresponding change to the bill cost-to-continue estimate. (Note that this is not the total MA program funding for under the bill, since it excludes the fiscal effect of other items in the bill.)

Reestimated MA Cost-to-Continue Funding

	Reestimate Funding		Change to Bill		
	2019-20	2020-21	2019-20	2020-21	Biennium
GPR	$3,187,475,100	$3,378,168,400	-$6,613,900	$8,727,000	$2,113,100
FED	5,678,446,900	5,856,654,000	16,147,900	56,738,200	72,886,100
PR	1,046,149,300	1,113,547,800	41,369,500	26,517,100	67,886,600
SEG	586,740,900	576,283,900	2,316,200	-5,359,700	-3,043,500
Total	$10,498,812,200	$10,924,654,100	$53,219,700	$86,622,600	$139,842,300

21. The following table shows the change to the appropriation base under the cost-to-continue reestimate. Over the biennium, MA funding would increase by $356.1 million GPR and $917.4 million from all fund sources.

Cost-To-Continue Reestimate Change to Base

	2019-20	2020-21	Biennium
GPR	$82,691,300	$273,384,600	$356,075,900
FED	128,506,300	306,713,400	435,219,700
PR	27,463,800	94,862,300	122,326,100
SEG	7,110,000	-3,347,000	3,763,000
Total	$245,771,400	$671,613,300	$917,384,700

22. 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. In order to provide some context for understanding these risks, the following points discuss some of the uncertainties involved in developing the budget estimates.

23. Chief among the risks to the MA budget estimate is the potential that a change to the state or national economy would result in job losses and a reduction in household income. Depending upon the timing of an economic downturn, the resulting increase in MA enrollment could cause benefit expenditures to exceed the reestimated budget.

24. While conditions may change in ways that increase MA costs above budget estimates, changing conditions can also lower costs below those estimates, as illustrated by the 2017-19 biennium MA budget. According to the Department's most recent estimates, GPR costs for MA benefits during the 2017-19 biennium will be lower than the amount budgeted by over $213 million. There are multiple factors behind this reduction, which amounts to 3.4% of the biennial GPR budget for the program. For instance, the combination of below-expected gross drug spending and above-expected drug manufacturer rebates resulted in GPR savings of approximately $160 million relative to budget estimates.

25. The budget for certain components of the MA program are particularly difficult to predict with confidence. In particular, drug manufacturer rebate payments vary widely from month to month. To illustrate, during the first 10 months of 2018-19, monthly rebate revenue has been more than $150 million three times, but less than $25 million four times. Likewise, it is not uncommon for payments to some providers to be made on an irregular schedule, resulting in large swings in expenditures from month to month. How these expenditure and revenue swings fall within a particular fiscal year can have a large bearing on whether the program ends in a budget surplus or deficit.

26. As with the 2017-19 MA budget estimates, the estimate presented in this paper (Alternative 1) adopts an overall cautious approach that allows for the possibility that MA costs will increase above recent trends, and to account for some level of unpredictability in expenditures or rebate revenues. However, the estimate does not account for the possibility of a significant recession,

which could result in budget deficit, depending upon the severity and timing.

27. The Committee could decide to mitigate the risks associated with an economic recession or other factors that increase GPR-funded MA costs by transferring an amount from the general fund to the medical assistance trust fund (MATF), to create a reserve. The MATF is a segregated fund used to finance a portion of the cost of MA benefits, which has the effect of offsetting GPR costs. The MATF collects revenues from a variety of sources, primarily provider assessments. Normally, the GPR budget is premised on the assumption that all available MATF revenues will be spent for benefits. Providing a transfer from the general fund to the MATF would establish a reserve that would remain unspent unless there is a GPR budget shortfall in the program. In that event, the Department could submit a request under s. 13.10 of the statutes to increase the MATF SEG appropriation, allowing the Department to spend the reserve for MA benefit costs. Any amounts of this reserve not used in the 2019-21 biennium would remain in the MATF and be available for future MA costs. Although the Committee could provide any amount for this purpose, one option would be to transfer $50,000,000, which is equal to approximately 0.75% of the total GPR cost-to-continue budget for the biennium. (Alternative 2). Alternatively, the Committee could transfer one-half of this amount ($25,000,000), to provide a smaller contingency reserve under the assumption that the underlying estimate provides a sufficient margin to allow the MA benefits budget to absorb some of the additional GPR cost associated with an economic recession (Alternative 3).

28. The Committee could determine that providing a reserve in the MA trust fund is unnecessary if the estimated 2019-21 biennium-ending balance in the general fund is deemed sufficient to account for budget contingencies in MA and any other GPR-funded programs.

ALTERNATIVES

1. Increase funding for MA benefits by $53,219,700 (-$6,613,900 GPR, $16,147,900 FED, $41,369,500 PR, and $2,316,200 SEG) in 2019-20 and by $86,622,600 ($8,727,000 GPR, $56,738,200 FED, $26,517,100 PR, and -$5,359,700 SEG) in 2020-21 to reflect a reestimate of MA benefits costs under a cost-to-continue scenario.

ALT 1	Change to Base	Change to Bill
GPR	$356,075,900	$2,113,100
FED	435,219,700	72,886,100
PR	122,326,100	67,886,600
SEG	3,763,000	- 3,043,500
Total	$917,384,700	$139,842,300

2. Adopt the appropriation changes in Alternative 1. In addition, transfer $50,000,000 from the general fund to the medical assistance trust fund to provide a reserve for addressing any potential shortfalls in GPR funding for MA benefits.

ALT 2	Change to Base	Change to Bill
GPR	$356,075,900	$2,113,100
FED	435,219,700	72,886,100
PR	122,326,100	67,886,600
SEG	3,763,000	- 3,043,500
Total	$917,384,700	$139,842,300
GPR-Transfer	$50,000,000	$50,000,000
SEG-Revenue	$50,000,000	$50,000,000

3. Adopt the appropriation changes in Alternative 1. In addition, transfer $25,000,000 from the general fund to the medical assistance trust fund to provide a reserve for addressing any potential shortfalls in GPR funding for MA benefits.

ALT 3	Change to Base	Change to Bill
GPR	$356,075,900	$2,113,100
FED	435,219,700	72,886,100
PR	122,326,100	67,886,600
SEG	3,763,000	- 3,043,500
Total	$917,384,700	$139,842,300
GPR-Transfer	$25,000,000	$25,000,000
SEG-Revenue	$25,000,000	$25,000,000

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Attachment

ATTACHMENT

Projected Enrollment by Category for Cost-To-Continue Estimate Under the Bill and Under the Reestimate

	Bill Estimates		Reestimate	
	2019-20	2020-21	2019-20	2020-21
Elderly, Blind, Disabled MA				
Elderly	69,400	71,100	69,500	71,100
Percent Change	*2.5%*	*2.4%*	*2.5%*	*2.3%*
Disabled, Non-Elderly Adults	140,500	141,900	139,600	140,500
Percent Change	*1.1%*	*1.0%*	*0.6%*	*0.6%*
Disabled Children	33,500	33,600	32,600	32,600
Percent Change	*1.8%*	*0.3%*	*0.9%*	*0.0%*
EBD Total	243,400	246,600	241,700	244,200
Percent Change	*1.6%*	*1.3%*	*1.2%*	*1.0%*
BadgerCare Plus				
Children	447,800	443,400	454,700	454,700
Percent Change	*-1.3%*	*-1.0%*	*-0.2%*	*0.0%*
Parents	149,700	146,800	159,800	159,800
Percent Change	*-3.0%*	*-1.9%*	*1.3%*	*0.0%*
Childless Adults	150,900	152,100	150,700	151,000
Percent Change	*0.7%*	*0.8%*	*0.5%*	*0.2%*
Pregnant Women	19,500	19,300	19,600	19,600
Percent Change	*-2.0%*	*-1.0%*	*-2.0%*	*0.0%*
BadgerCare Plus Total	767,900	761,600	784,800	785,100
Percent Change	*-1.3%*	*-0.8%*	*0.2%*	*0.0%*
Other Full Benefit Groups				
Foster Children	21,300	21,900	21,000	21,400
Percent Change	*2.4%*	*2.8%*	*1.4%*	*1.9%*
Well Woman	500	500	500	500
Percent Change	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Total Full Benefit MA	1,033,100	1,030,600	1,048,000	1,051,200
Percent Change	*-0.5%*	*-0.2%*	*0.5%*	*0.3%*
Partial Benefit Groups				
Family Planning Only	41,200	41,700	39,800	40,200
Percent Change	*1.2%*	*1.2%*	*-0.5%*	*1.0%*
Medicare Cost Sharing	24,900	25,700	23,900	24,100
Percent Change	*2.9%*	*3.2%*	*0.0%*	*0.8%*
Total MA Enrollment	1,099,200	1,098,000	1,111,700	1,115,500
Percent Change	*-0.4%*	*-0.1%*	*0.4%*	*0.3%*