Department of Planning and Budget
2018 Fiscal Impact Statement

1. **Bill Number:** SB 915

House of Origin	☒	Introduced	☐	Substitute	☐ Engrossed
Second House	☐	In Committee	☐	Substitute	☐ Enrolled

2. **Patron:** Dunnavant

3. **Committee:** Education and Health

4. **Title:** Priority Needs Access Program; created, report

5. **Summary:** The proposed legislation directs the Department of Medical Assistance Services (DMAS) to amend the Medicaid demonstration project (Project Number 11-W-00297/3) to create the Priority Needs Access Program (PNAP) to (i) increase the income eligibility for adults with serious mental illness from 100 to 138 percent of the federal poverty level; (ii) include in the benefit package inpatient hospital and emergency room services; (iii) expand program eligibility to individuals with a diagnosis of mental illness, substance use disorder, or a life-threatening or complex chronic medical condition; (iv) and include the entire population of the demonstration project in the Commonwealth Coordinated Care Plus managed care program. The bill also creates an annual hospital assessment for private acute care hospitals.

6. **Budget Amendment Necessary**: Yes. See Item 8.

7. **Fiscal Impact Estimates:** Preliminary. See Item 8.

8. **Fiscal Implications:** The proposed legislation expands the GAP program and imposes a provider assessment that could have significant fiscal implications on the Commonwealth with regard to revenues and expenditures. The specific requirements and associated impacts of this bill will have to be reconciled through budget amendments with the introduced budget's provisions related to Medicaid expansion. This bill does not appear to conflict with the provisions of the introduced budget; therefore, it is not clear if its intent is to replace or co-exist with the provisions of the introduced budget. It is possible that DMAS may be able to be implement both in tandem should SB 915 and the introduced budget be enacted in their current forms. As a result, the following provides the fiscal impact (expenditures and revenue) of the bill, if implemented in a vacuum, without considering the provisions in the introduced budget. In addition, a section discussing the interaction between this bill and the introduced budget is also included.

   Note: All fiscal impact estimates described below assume that the expansion in SB 915 would become effective on October 1, 2018. This effective date was assumed to maintain consistency in comparing it to the Medicaid expansion proposal contained in the introduced budget that also contains an October 1, 2018, effective date. Further, since this proposal will

require extensive negotiations with the Federal Government to gain waiver approval, an October 1, 2018, effective date is more likely.

Expenditures

The proposal would expand the GAP program in three distinct ways. First, the bill would expand the GAP income criteria for adults with serious mental illness from 100 percent of the federal poverty level (FPL) to 138 percent FPL. Second, the bill would include in the benefit package inpatient hospital and emergency room services. Third the bill would expand the diagnoses that qualify individuals for the GAP program to include substance use disorder (SUD) and mental illness (the GAP program already includes coverage for serious mental illness, or SMI) and anyone in that income bracket with a "life-threatening or complex chronic medical condition." The fiscal implications in this statement reflect an assumption that the newly eligible population would only be covered up to 100 percent FPL. This is because the bill's language specifies that the increase from 100 percent to 138 percent is for adults with serious mental illness. The new populations are included through an expansion of the existing program and no increase in income eligibility is specified.

DMAS used data on the number of low-income adults already enrolled in the Medicaid program who also have a diagnosis of mental illness (MI) or substance use disorder (SUD) to extrapolate the number of individuals who would enroll in the program under the provisions of SB 915. Using this data, as well as a ramp up factor, DMAS estimates that 3,830 individuals in FY 2019 and 7,505 individuals in FY 2020 would enroll because of a SMI, MI, or SUD diagnosis. The bill does not define what would constitute a "life-threatening or complex chronic medical condition." To estimate the number of individuals that might qualify for the program based on this definition, DMAS assumed that any individual with three or more chronic medical conditions would qualify. Based on data from the U.S. Agency for Healthcare Research and Quality (AHRQ), 20.7 percent of Americans have three or more chronic conditions[1]. Using this statistic and a ramp-up factor, DMAS estimated that 16,805 individuals in FY2019 and 43,672 individuals in FY2020 would enroll in the program because of a life-threatening or complex chronic medical condition.

The table below summarizes how enrollment is estimated to grow as a result of SB 915.

	Estimated Average Monthly Membership FY 2019	Estimated Average Monthly Membership FY 2020
Existing GAP Program (SMI, FPL at or under 100%)	17,074	17,867
Serious Mental Illness (SMI), 100-138% FPL	1,770	3,652
Substance Use Disorder, 0-100% FPL	1,242	2,323
Mental Illness, 0 – 100% FPL	818	1,530
Life-threatening or Complex Chronic Condition, 0 – 100% FPL	16,805	43,672
Estimated Monthly Average Membership	37,708	69,044

[1] Agency for Healthcare Research and Quality, "Multiple Chronic Conditions Chartbook," p. 4 https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

This legislation would provide the current GAP benefits plus inpatient hospital and emergency room services to its enrollees. The benefits that would not be included, or that would be limited, under this package are: medical equipment and supplies, community-based behavioral health services, and transportation services. To estimate the per person spending, DMAS started with comparable rates paid (Medallion 4.0) for a full benefit adult, then applied a 10 percentage point discount factor to the estimated full benefit cost per person to account for limited benefits. Furthermore, in order to account for the fact that individuals with SMI and SUD may have higher cost than an average low-income adult, a 10 percent factor was added to their per person per month rate. Then, to account for the fact that individuals with a life-threatening or chronic condition may have higher spending, a 20 percent factor was added to the per person per month rate for that group.

DMAS estimates that the total funds cost of providing the coverage described in SB 915 would be $144.7 million in FY 2019 and $491.4 million in FY 2020. In addition to the above medical costs, DMAS has identified administrative costs associated with providing call center and enrollment broker services to the population. DMAS estimates that the total cost of these enrollment activities would be $0.8 million in FY 2019 and $0.8 million in FY 2020. These costs (medical and administrative) would be covered at a 50 percent federal matching rate.

Revenue

The bill requires that every private acute care hospital in the Commonwealth, with a number of exclusions, be subject to an annual assessment representing 0.83 percent of net patient revenue beginning on July 1, 2018, and 1.61 percent of net patient revenue beginning July 1, 2019. DMAS reports that this assessment would generate approximately $144.4 million in FY 2019 and $280 million in FY 2020. These preliminary estimates used the Virginia Health Information's (VHI) 2016 version of the "Hospital Detail Report" (the most recent version of the report) to determine statewide net patient revenue and net patient revenue for each hospital. Public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long-stay hospitals, long-term acute care hospitals, and critical access hospitals were excluded. The total net patient revenue for all included hospitals was multiplied by the specified percentages in SB 915 to arrive at the estimated assessment revenue. The bill requires the revenue generated by this assessment to be deposited into the Virginia Health Care Fund (VHCF). Language in the Appropriation Act requires that any revenue in the VHCF be used as state match for Medicaid costs.

Based on these estimates, it is assumed that the bill's provider assessment would cover the full cost of the new PNAP program in both years, leaving a revenue balance of $71.6 million in FY 2019 and an additional $33.9 million in FY 2020. The following table illustrates this stand-alone impact without regard to the introduced budget or any of its provisions.

SB 915 Stand-Alone Impact		
	FY 2019	FY 2020
Medical Costs	$ 72,358,954	$ 245,724,778
Administrative Costs	$ 413,219	$ 386,926
Provider Assessment Revenue	$ (144,372,402)	$ (280,047,671)
State Costs/(Savings)	**$ (71,600,229)**	**$ (33,935,967)**

Interaction with the Introduced Bill

As stated above, the fiscal implications of SB 915 are highly dependent upon the assumptions included in the introduced budget. The introduced budget includes a provision to expand Medicaid pursuant to 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) and cover the entire cost of coverage with a provider assessment on hospitals. Furthermore, the cost of coverage for the newly eligible population is entirely covered by a provider assessment. As such, the introduced budget counts on additional revenue, $80.8 million in FY 2019 and $226.1 million in FY 2020, to support the cost of Medicaid expansion. This additional revenue allows the Commonwealth to book all Medicaid expansion savings (associated with receiving enhanced federal match for services currently provided) to the general fund ($152.0 million in FY 2019 and $269.7 million in FY 2020).

Again, while the assessment implemented in SB 915 may be intended as an alternative to that which is included in the Appropriation Act, there does not seem to be a conflict between them. Based on the conversations with DMAS and the nature of each assessment, it appears as though each assessment could be implemented concurrently, as long as the overall percentage assessed does not exceed the federally mandated cap on collections, which is six percent of net patient revenue. Under such a scenario, Medicaid would be expanded and paid for with a provider assessment per provisions in the introduced budget. The additional costs identified in SB 915 would not occur, as every individual included in the PNAP program would gain coverage through expansion. However, the provider assessment included in this bill could be implemented thereby generating additional revenue for the VHCF.

Implemention Alongside Expansion (Per Introduced Budget)		
	FY 2019	FY 2020
Expansion Cost (Introduced Budget)	$ 80,823,953	$ 226,123,826
Provider Assessment Revenue (Introduced Budget)	$ (80,823,953)	$ (226,123,826)
Expansion Savings (Introduced Budget)	n/a	n/a
Medical Costs (SB 915)	$ -	$ -
Administrative Costs (SB 915)	$ -	$ -
Provider Assessment Revenue (SB 915)	$ (144,372,402)	$ (280,047,671)
State Costs/(Savings)	**$ (144,372,402)**	**$ (280,047,671)**

In the event that SB 915 is intended as a replacement to the Medicaid expansion, all associated provisions in the introduced budget must be removed. In addition, to the stand-alone fiscal implications of this bill, the budget must be amended to remove funding for the cost of expansion and the associated provider assessment revenue. In addition, the general fund savings generated by expansion and included in the budget would also need to be

replaced to avoid creating a shortfall. The following table provides a summary of these fiscal implications on state funding:

Implementation as an Alternative to Expansion (per Introduced Budget)		
	FY 2019	**FY 2020**
Expansion Cost (Introduced Budget)	$ 80,823,953	$ 226,123,826
Provider Assessment Revenue (Introduced Budget)	$ (80,823,953)	$ (226,123,826)
Expansion Savings (Introduced Budget)	$ 151,993,191	$ 269,691,544
Medical Costs (SB 915)	$ 72,358,954	$ 245,724,778
Administrative Costs (SB 915)	$ 413,219	$ 386,926
Provider Assessment Revenue (SB 915)	$ (144,372,402)	$ (280,047,671)
State Costs/(Savings)	**$ 80,392,962**	**$ 235,755,577**

9. Specific Agency or Political Subdivisions Affected:
Department of Medical Assistance Services
Community Service Boards
Department of Corrections
Department of Social Services

10. Technical Amendment Necessary: No

11. Other Comments: None