



MEDICAID FORCED PROVIDER INFLATION

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANSEN

ISSUE BRIEF

SUMMARY

The Department is requesting \$5,923,600 General Fund (\$15,441,000 Total Funds) for automatic increases in the costs in eight areas of Medicaid. Six of the eight areas increase because of federal requirements while the other two areas increase because of State decisions/market factors outside of the State’s control. Much of the estimated increased costs will take place with or without an approved increase because of federal or State requirements for increases to Medicare programs, rural health clinics, federally qualified health centers, and hospice care. The Analyst recommends funding \$2,647,200 General Fund and \$13,400 General Fund Restricted for the \$5,923,600 agency request.

DISCUSSION AND ANALYSIS

What is Medicaid?

Medicaid is the nation’s public health insurance program for low-income people. It was initially created to provide medical assistance to individuals and families receiving cash welfare. Over the years, Congress has incrementally expanded the scope of the program. Today, Medicaid is no longer a welfare program; rather, it is a health and long-term program for a broader population of low-income individuals.

Forced Provider Inflation in Medicaid

The Department is requesting \$5,923,600 General Fund (\$15,441,000 Total Funds) for automatic increases in the costs in eight areas of Medicaid. Six of the eight areas increase because of federal requirements while the other two areas increase because of State decisions/market factors outside of the State’s control. Of this request the following increases are estimated to take place with or without approval:

1. **Pharmacy** – the State reimburses pharmacy based on the lowest of four price calculations. Two of the four State-selected options for drug reimbursement are based upon prices reported by the pharmaceutical industry. The agency estimates a 6% increase in costs for FY 2012 based on historical pharmacy cost increases. This increased General Fund cost is estimated by the Analyst at \$3,252,400 for FY 2012. While the prices of drugs have been going up, the average cost per drug purchased by Medicaid has been going down. The annual report from the Department of Health’s Drug Utilization Review Board reported that average price per prescription decreased 0.4% and 4.3% in FY 2010 and FY 2009 respectively. The Analyst disagrees with the agency estimate of a 6% increase in pharmacy costs and recommends not funding \$3,252,400 General Fund for these costs. This recommendation is based on reductions in the FY 2012 base of 2.4% from increased Preferred Drug List savings for already approved drugs and a 4.1% reduction passed by this committee to more aggressively update the State’s maximum allowable reimbursement. The agency indicates that it feels it is unrealistic to expect the current trend of decreasing cost per drugs to continue because historically there have been double digit increases. The agency indicates that costs have been decreasing in the last two years to lower reimbursement due to budget reductions and savings from the Preferred Drug List. The table to the right shows the average annual change in Medicaid pharmacy costs for the past 5 years.
2. **Clawback Payments** – the Department estimates a cost of \$1,731,600 General Fund from a 6% increase in Clawback payments to the federal government based on a federal inflationary index. Clawback

Pharmacy Annual Increases	
FY 2006	2.7%
FY 2007	3.0%
FY 2008	5.5%
FY 2009	-4.3%
FY 2010	-0.4%

payments began in 2006 when the federal government took responsibility for the pharmacy costs of clients that are dually eligible for Medicaid and Medicare. The cost per dual eligible has increased an average of 4.3% for the past two years and the caseload for this population is estimated to increase 3.2% for FY 2012.

3. **Medicare Buy-in** - the Analyst estimates a General Fund cost of \$672,200 from a 3.2% increase in Medicare premiums based on FY 2011 rate increases. The federal government requires the State to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the Federal Poverty Level. Additionally, the State has opted to pay for Medicare premiums for qualifying individuals with incomes up to 135 percent of the Federal Poverty Level, which is reimbursed with 100% federal funds. The Department estimates that this optional coverage group saves the State money. For more information on what Medicare covers and costs in 2011 please visit <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>.
4. **Medicare Crossovers** - the Analyst estimates a General Fund cost of \$153,900 from a 3.2% increase in Medicare crossovers based on Medicare rate changes. Medicare crossovers pay up to Medicaid rates for services not covered or not fully reimbursed by Medicare for Medicaid clients who also qualify for Medicare.
5. **Federally Qualified Health Centers** – the Analyst estimates a General Fund cost of \$50,000 from a 3.2% increase in Federally Qualified Health Centers costs based on the Medical Consumer Price Index. Federal law mandates that Medicaid pay Federally Qualified Health Centers their full cost of serving Medicaid clients, rather than just the normal fee-for-service reimbursement schedule. In Utah seven of the Federally Qualified Health Centers receive a prospective payment which in FY 2011 is 124% higher than normal Medicaid reimbursement. The other three Federally Qualified Health Centers after the year end have a cost settlement. FY 2007 was the last year this took place and the centers owed the State 8% of their reimbursement.
6. **Hospice** - the Analyst estimates a General Fund cost of \$43,800 from a 1% increase in hospice costs based on matching Medicare rate changes. Item 7 in the Committee Proposal to Eliminate Deficit passed by this committee on Monday, January 31 reduces total spending on hospice services by 24%. This reduces the State match need down to \$33,200. The Analyst recommends funding 40.5% or \$13,400 of the increase from an increase in the General Fund Restricted – Nursing Care Facilities Account to be consistent with changes enacted from HB 397 “Medicaid Program Amendments” from the 2010 General Session.
7. **Rural Health** - the Analyst estimates a General Fund cost of \$14,300 from a 3.2% increase in rural health based on the Medical Consumer Price Index. Rural health increases automatically because reimbursement is based on actual cost.
8. **Insurance Buy-out** - the Analyst estimates a General Fund cost of \$5,400 from a 3.2% increase for insurance buy-out costs based on the Medical Consumer Price Index. If Utah Medicaid determines it will be less expensive to pay for an individual’s private insurance premiums, then to serve them in Medicaid, Medicaid pays for those premiums.

The table below shows each of the items of the discussed above and the amount of the building block request that they represent. The 3.2% growth factor used for five items totaling \$676,100 General Fund is based on the Medical Consumer Price Index.

FY 2012 Inflation	Growth	General Fund	Total Funds	Agree/Disagree
Pharmacy	6.0%	\$3,252,400	\$11,224,900	Disagree
Clawback Payments	6.0%	\$1,731,600	\$1,731,600	Agree
Medicare Buy-in	3.2%	\$672,200	\$1,561,700	Agree
Medicare Crossovers	3.2%	\$153,900	\$531,100	Agree
Federally Qualified Health Centers	3.2%	\$50,000	\$172,500	Agree
Hospice	1.0%	\$43,800	\$151,200	Disagree
Rural Health	3.2%	\$14,300	\$49,300	Agree
Insurance Buy-out	3.2%	\$5,400	\$18,700	Agree
Total Requested		\$5,923,600	\$15,441,000	

LEGISLATIVE ACTION

The Analyst recommends funding \$2,647,200 General Fund and \$13,400 General Fund Restricted – Nursing Care Facilities Account of the \$5,923,600 General Fund agency request for FY 2012 Medicaid inflation. This recommendation excludes the requested inflationary increase for pharmacy and funds a proportional amount of the hospice increases with General Fund Restricted – Nursing Care Facilities Account.