MEDICAID CONSENSUS FORECASTING

LFA LEGISLATIVE FISCAL ANALYST
EXECUTIVE APPROPRIATIONS COMMITTEE
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ISSUE BRIEF

SUMMARY

The Medicaid consensus forecast team estimates savings to the General Fund in FY 2017 of $8.3 million one-time and an ongoing cost of $10.8 million in FY 2018. The consensus teams recommends a buffer of $9 million from the Medicaid Restricted Account that can be used anywhere in Medicaid or the Children's Health Insurance Program (CHIP) in FY 2017 and in CHIP for FY 2018. These estimates do not include any funding for state administration or any optional provider inflation.

RECOMMENDATIONS

1. By statute, the Legislature must include in the base budget $4.0 million for FY 2017 and $10.5 million for FY 2018 from the General Fund for mandatory program changes and accountable care organization costs. These increases are included in the overall estimate above.
2. In some years the Legislature has opted to address all Medicaid costs in the base budget. For this year, there would be less money appropriated in the base budget if the Legislature funded the entire estimate of $8.3 million reduction in FY 2017 and $10.8 million in FY 2018.

DISCUSSION AND ANALYSIS

Below is a summary of the consensus General Fund mandatory cost estimates for FY 2017 and FY 2018. All numbers for FY 2017 are as compared to the February 2016 estimate for FY 2017.

Medicaid Consensus General Fund Cost Estimates	FY 2017	FY 2018
Caseload	$ (20.0)	$ (15.5)
Inflationary Changes	$ 7.6	$ 19.2
Program Changes	$ 4.1	$ 7.1
Total in Millions	**$ (8.3)**	**$ 10.8**

Medicaid – What is Included in Consensus for Mandatory Costs?

The Medicaid consensus forecast team (Legislative Fiscal Analyst, Governor's Office of Management and Budget, and the Department of Health) estimates reductions to the General Fund in FY 2017 of $8.3 million one-time and an ongoing cost of $10.8 million in FY 2018. The forecast accounts for legislative appropriations changes in FY 2017 and FY 2018. Additionally, the consensus estimates recommend a $9.0 one-time million buffer from the Medicaid Restricted Account, which can be used in any of Medicaid's or CHIP's (Children's Health Insurance Program) line items in FY 2017 and in CHIP for FY 2018. The Medicaid Restricted Account ended FY 2016 with a $17.4 million fund balance. Each of the items in the forecast has a more detailed discussion below. All numbers for FY 2017 and FY 2018 are as compared to the base funding already provided for FY 2017. The estimates for FY 2018 are all ongoing changes.

Caseload - $15.5 Million Reduction in FY 2018

1. **Change in caseloads** – estimated increase over FY 2016 of 3,500 or 1.0% clients in FY 2017 and 4,200 or 1.3% in FY 2018. The current caseload forecast is 1.4% lower for FY 2017 compared to the February 2016 forecast, which results in lower baseline costs of $2.5 million for FY 2017 when

using FY 2016 per member per month costs. The FY 2018 enrollment estimate is 400 clients or 0.1% lower than the February 2016 forecast for FY 2017. Because there are increases in more expensive client groups and decreases in less expensive groups, the changes overall add $4.8 million in costs for FY 2018. The three groups with highest number increase in FY 2017 are: (1) qualified Medicare beneficiary (dual eligible for Medicaid and Medicare), (2) children, and (3) blind/disabled. These changes are shown in the table below.

Eligibility Category	FY 2017 (Feb. 2016)	FY 2017 (Nov. 2016)	FY 2018 (Nov. 2016)	FY 2016 PMPM	Original FY 2017	New FY 2017	FY 2018
Adult	35,962	35,470	35,314	$100.08	$ 43,186,900	$ 42,596,100	$ 42,408,300
Aged	15,660	15,822	16,168	$365.34	$ 68,654,600	$ 69,363,300	$ 70,881,700
Blind/Disabled	40,637	40,572	41,502	$276.50	$ 134,830,600	$ 134,614,900	$ 137,702,800
Child	199,492	195,917	197,938	$ 38.14	$ 91,313,400	$ 89,677,100	$ 90,602,200
Primary Care Network	17,388	16,367	16,556	$ 36.12	$ 7,537,600	$ 7,094,800	$ 7,176,900
Pregnant	6,063	5,772	5,873	$395.94	$ 28,805,700	$ 27,423,100	$ 27,903,000
Qualified Medicare Beneficiary	28,842	29,464	30,275	$142.16	$ 49,200,300	$ 50,262,000	$ 51,644,400
Total	344,043	339,383	343,626		$ 423,529,100	$ 421,031,300	$ 428,319,300
Difference		(4,660)	(418)			$ (2,497,800)	$ 4,790,200

Eligibility Category	FY 2015 PMPM	FY 2016 PMPM	% Change	2016 Actuals	FY 2015 PMPM	FY 2016 PMPM
Adult	$ 90.25	$100.08	11%	35,442	$ 38,383,700	$ 42,562,400
Aged	$368.30	$365.34	-1%	15,303	$ 67,633,100	$ 67,089,500
Blind/Disabled	$257.51	$276.50	7%	39,836	$ 123,098,000	$ 132,174,000
Child	$ 47.00	$ 38.14	-19%	195,117	$ 110,046,900	$ 89,310,900
Primary Care Network	$ 33.07	$ 36.12	9%	15,738	$ 6,245,100	$ 6,822,100
Pregnant	$313.89	$395.94	26%	5,940	$ 22,374,100	$ 28,222,900
Qualified Medicare Beneficiary	$132.36	$142.16	7%	28,512	$ 45,286,200	$ 48,637,500
		Average	6%	335,900	$ 413,067,100	$ 414,819,300
		High	26%		Increased Cost	$ 1,800,000
		Low	-19%		Projected Increased Cost	$ 17,176,600
					Difference	$ (15,376,600)

2. **Change in per member per month cost** – in the February 2016 consensus the forecast team estimated that per member per month costs in FY 2016 would be $17.2 million General Fund higher than in FY 2015. The actual increase was $1.8 million General Fund. The Department of Health believes this is due to a one-time reconciling draw from the federal government to close out prior years grant awards, changes in the case mix, and reduced utilization for fee-for-service clients in FY 2016. These changes are shown in the table on the bottom of page two.
3. **Federal medical assistance percentage** – unfavorable change of 0.34% in FY 2017 with an updated cost estimate $0.2 million lower and a favorable change of 0.19% in FY 2018 for a savings of $2.8 million.
4. **Collections by the Office of the Inspector General, Medicaid Fraud Control Unit, and Office of Recovery Services** – the updated estimates assume that collections from these three entities will be higher (offsetting other costs) by $0.6 million in FY 2017 and $2.3 million in FY 2018. The estimates for FY 2017 and FY 2018 come from each collection agency with one exception. For FY 2018 the Medicaid Fraud Control Unit did not provide a FY 2018 estimate of collections and the consensus team estimated that its collections would be $2.0 million higher in FY 2018.
5. **Medicaid tobacco shortfall** – there will be less money from the Tobacco Settlement Restricted Account appropriations to Medicaid by $0.9 million in FY 2017 and $1.5 million in FY 2018. For more information about this shortfall, please see the brief entitled "Tobacco Settlement Funds" available at http://le.utah.gov/interim/2016/pdf/00002655.pdf.
6. **Other unknown impacts** - the changes above and below account for all but a $2.2 million reduction in costs in FY 2017 and a reduction of $1.3 million in FY 2018. These amounts represent 0.5% and 0.3% respectively of appropriated General Fund for Medicaid services.

Inflationary Changes - $19.2 Million in FY 2018

1. **Accountable care organization contracts** – $2.4 million in FY 2017 to account for a 2% increase in January 2017 and an additional $7.2 million in FY 2018 for 2% increases starting in January 2017 and 2018. Medicaid contracts with four accountable care organizations utilize about 48% of General Fund appropriated to Medicaid to perform services statewide. These organizations serve about 88% of clients. These contracts traditionally have annual increases.
2. **Medicare buy-in** – The federal government requires the State to pay Medicare premiums and coinsurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the Federal Poverty Level. Medicare cost sharing increases are projected to cost the State an additional $3.3 million in FY 2017 and $5.8 million in FY 2018. The State now knows the projected increase beginning January 2017 monthly Medicare Part B premiums will increase 22% from $121.80 to $149.00. The change in premiums for 2018 currently is unknown and no change for 2018 is included in the current forecast.
3. **Clawback** – payments began in 2006 when the federal government took responsibility for the pharmacy costs of clients that are dually eligible for Medicaid and Medicare. State payments are projected to increase costs by an additional $2.4 million in FY 2017 and $4.7 million in FY 2018.
4. **Forced provider inflation** – this primarily includes cost increases to the State's fee-for-service program. The updated forecast for FY 2017 includes a $0.4 million reduction in costs, primarily due to lower than expected inflationary increase in pharmacy drug costs and $1.5 million in FY 2018 over which the state has no control due to federal regulation or has opted not to exercise more state control over cost increases. About 86% of the increases in FY 2018 come from the following two areas: pharmacy drugs and outpatient hospital. The increase keeps the state's outpatient hospital reimbursement rates at 100% of Medicare rates. The federal government has announced plans to increase its Medicare outpatient hospital reimbursement rates 1.6% in 2017.

Program Changes - $7.1 Million in FY 2018

1. **Accountable care organizations' administration rate change –** the federal government ruled that Healthy U, one of Medicaid's contracted accountable care organizations, can no longer seed its money to help pay for its administrative rate. In order to pay Healthy U the same rate as the other three contracted accountable care organizations without seed money, the projected cost is $1.6 million for FY 2017 and $3.2 million in FY 2018.
2. **Autism increased federal requirements** – $0.6 million in FY 2017 and $1.4 million in FY 2018 for a new federal regulation to provide autism spectrum disorder-related services when medically necessary for any Medicaid clients up to age 21 with autism spectrum disorder beginning July 1, 2015. Previously only clients qualifying as disabled or those served by the Utah pilot program for those ages 2 through 6 qualified for these services.
3. **H.B. 437 adjustment** – The original H.B. 437, *Health Care Revisions*, fiscal note from the 2016 General Session had lower General Fund costs due to double counting of reductions of $2.1 million in FY 2017 and $2.5 million in FY 2021. This translates to $2.1 million increased costs in FY 2017 and $2.5 million increase in FY 2018.
4. **Orkambi** – New prescription drug with an annual cost of $257,400 total fund ($76,400 General Fund) indicated for clients 6 years or older with cystic fibrosis who have two copies of the F508del mutation in their genes. Updated forecasted costs for the fee-for-service client population include a reduction in costs $0.2 million in FY 2017 due to lower than anticipated utilization.

Why Did FY 2016 Have $17.4 Million in Unspent General Fund for Medicaid Services?

Medicaid services ended FY 2016 with $17.4 million in unspent General Fund (and General Fund restricted account funds used as General Fund). The consensus estimates for FY 2016 included a buffer of $4.6 million. The unexpected unspent balance was $12.8 million or 2.9%. There was $0.9 million due to higher collections primarily from the Office of Recovery Services. When you factor this out of the error rate for forecasting, there is a $11.9 million underestimate of costs which is a 2.7% error rate. Prior year error rates for FY 2015 through FY 2012 have been 0.4%, 0.3%, 2.6%, and 5%. The Department of Health believes the surplus for FY 2016 was primarily due to a one-time reconciling draw from CMS to close out prior years grant awards, changes in the ACO case mix, and reduced fee-for-service utilization in FY 2016.

Children's Health Insurance Program (CHIP) – Why $11.0 Million Ongoing Cost Estimate?

Why is the ongoing General Fund cost for CHIP increasing $11.0 million? From October 2015 through September 2019, the federal government will pay 100% of the costs for CHIP program services. All ongoing General Fund appropriations can be backed out one-time through September 2019. The ongoing General Fund costs for CHIP have not been adjusted since FY 2016. From FY 2016 through FY 2018 the following changes are forecasted to increase General Fund costs:

1. **Caseload** – 12.1% growth
2. **Per member per month costs** – 7.8% growth
3. **Many CHIP clients now on Medicaid** – effective January 1, 2014, many former CHIP clients are now served by Medicaid. This primarily happened because Medicaid's asset test for children was removed. The federal government will still pay the higher CHIP match rate, but the benefits package for Medicaid costs more than CHIP's benefits package.

There is enough money in CHIP to cover the state's share of costs from July through September of 2015 for FY 2017 and FY 2018. Federal health care reform included a maintenance of effort requirement for states not to change children eligibility levels through September 2019. This cost estimate is not included as part of the official consensus recommendation but it is shared as an information item.

Why Consensus Forecasting for Medicaid?

When arriving at final point estimates for tax revenue projections, economists from the Legislative Fiscal Analyst Office, the Governor's Office of Management and Budget, and the State Tax Commission compare numbers and attempt to reach a consensus. The details of each projection are examined and critiqued against the other offices' numbers. By comparing competing forecasts, all involved parties attempt to flush out any errors or left out factors. These same reasons apply to Medicaid. From June 2000 to June 2012, Utah Medicaid grew from 121,300 clients to 252,600 clients, an increase of 108%. Over the same period, the percentage of the State's population on Medicaid grew from 5.4% to 8.8%.

Officially, Medicaid is an "optional" program, one that a state can elect to offer. However, if a state offers the program, it must abide by strict federal regulations. As Utah has, to this point, chose to offer Medicaid, it has established an entitlement program for qualified individuals. That is, anyone who meets specific eligibility criteria is "entitled" to Medicaid services. An accurate forecast is essential to adequately funding that entitlement.

What Must Be Included in the Base Budget?

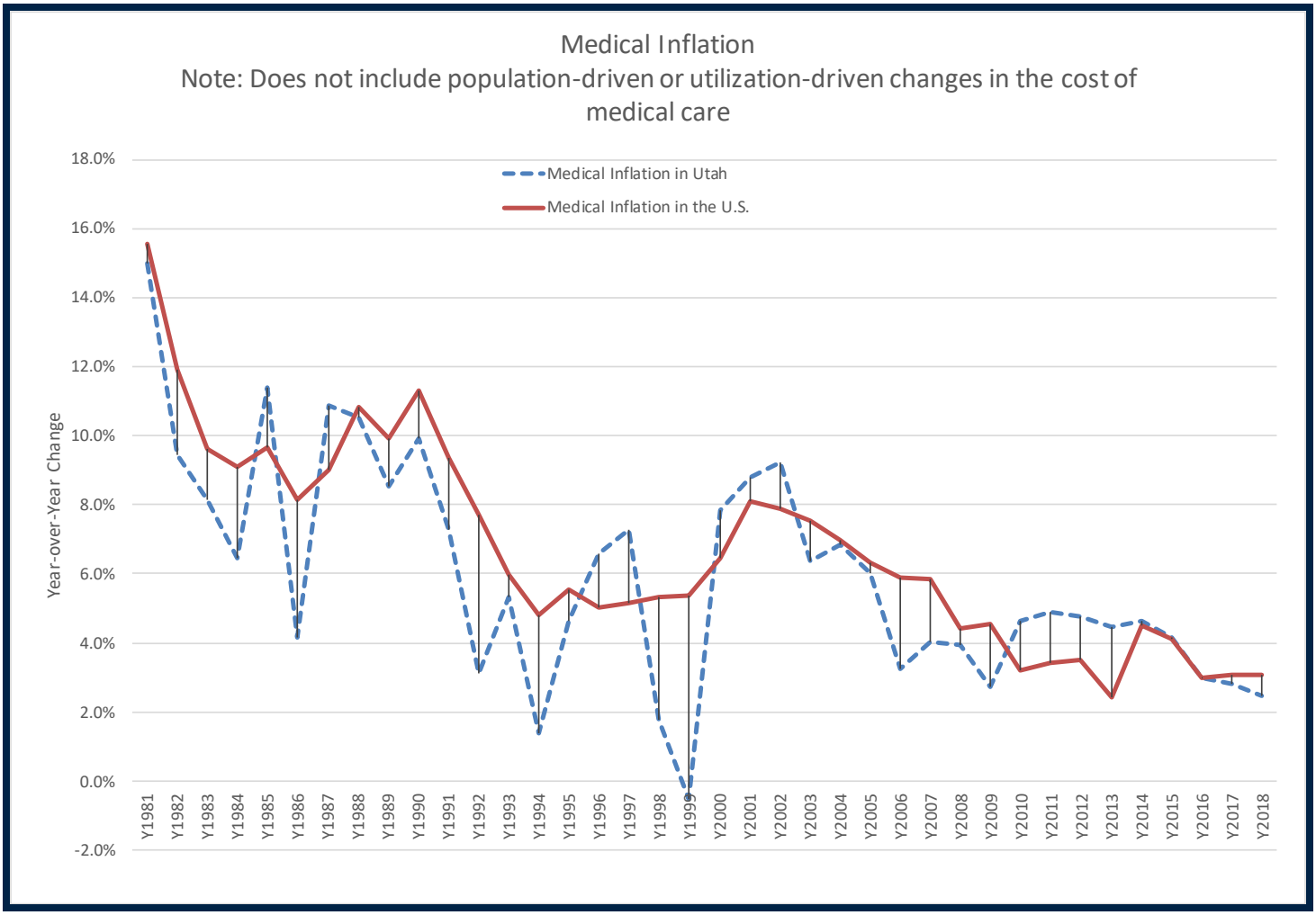
There is $4.0 million in FY 2017 and $10.5 million in FY 2018 General Fund from two items that must be included as per statute in the base budget:

1) **UCA 26-18-405** directs that mandated program changes determined by the Department of Health must be included in the base budget. The Department of Health determined that "Accountable care organizations' administration rate change," which is described under program changes number one on page four. The base budget should receive additional General Fund of $1.6 million for FY 2017 and $3.2 million in FY 2018.

2) **UCA 26-18-405.5** directs that rates paid to accountable care organizations increase at least up to 2% to match the General Fund growth factor. The General Fund growth factor for FY 2018 is not known currently. FY 2017 General Fund growth estimate is 3.5% as per the revenue estimates adopted at the May Executive Appropriations Committee. FY 2018's growth factor may or may not be similar to FY 2017. The growth factor will be announced as part of the December 2016 Executive Appropriations Committee meeting. The costs are described under "Accountable care organization contracts," which is number one under the "inflationary changes" section on page three. As per statute, the base budget should receive additional General Fund of $2.4 million for FY 2017 and $7.2 million in FY 2018.

What is Projected Medical Inflation for Utah?

The fiscal analyst projects medical inflation for Utah at 2.9% in FY 2017 and 2.6% in FY 2018. Medical inflation is defined as the change in the price per unit. The Centers for Disease Control provided medical expenditures by state from 1980 through 2009. By combining that information with National Health Expenditure Data from the Centers for Medicare and Medicaid Services for the remaining years the fiscal analyst has a forecast of medical inflation in Utah. The graph on page six shows both Utah and national medical inflation trends. A figure reporting total medical expenditures would be higher because that would include both population and utilization increases.



The two preceding subsections are the report required by **IR3-2-402(2)(a)(iv)**.

Additional Resources

- *Medicaid Consensus Forecasting* Issue Brief from the 2015 Interim
  http://le.utah.gov/interim/2015/pdf/00005354.pdf
- Kaiser Summary of Federal Health Care Reform
  http://le.utah.gov/interim/2012/pdf/00002141.pdf