



MEDICAID CONSENSUS FORECASTING

EXECUTIVE APPROPRIATIONS COMMITTEE
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ISSUE BRIEF

SUMMARY

The Medicaid consensus forecast team estimates surplus General Fund in FY 2015 of \$12.9 million one-time and an ongoing cost of \$3.4 million in FY 2016. For the Children’s Health Insurance Program, consensus forecast estimates General Fund surplus in FY 2015 of \$2.5 million and \$0.7 million in FY 2016. Both of these estimates are point estimates of costs and include no cushion (no extra money) for potential errors. The Legislature may want to include these estimates in the base budgets for FY 2015 and FY 2016. These estimates do not include any funding for state administration or any optional provider inflation. The 2011-2012 consensus process helped save the State from appropriating an additional General Fund of \$13 million for FY 2012 during the 2012 General Session for medical services in Medicaid.

RECOMMENDATIONS

In some years the Legislature has opted to address Medicaid costs in the base budget. The Legislature may want to consider this option with the estimates contained in this brief. If so there is an estimated General Fund surplus in Medicaid of \$12.9 million in FY 2015 and a cost of \$3.4 million in FY 2016. These estimates do not include any funding for state administration or any optional provider inflation.

DISCUSSION AND ANALYSIS

Below is a summary of the consensus General Fund mandatory cost estimates for FY 2015 and FY 2016:

Consensus General Fund Estimates (Surplus)/Cost	FY 2015	FY 2016
Medicaid	\$ (12.9)	\$ 3.4
CHIP	\$ (2.5)	\$ (0.7)
Total in Millions	\$ (15.4)	\$ 2.7

Medicaid – What is Included in Consensus for Mandatory Costs?

The Medicaid forecast team (Legislative Fiscal Analyst, Governor’s Office of Management and Budget, and the Department of Health) forecast a reduction in mandatory costs of \$12.9 million in FY 2015 and an increase in costs of \$3.4 million in FY 2016. The forecast accounts for legislative appropriations changes in FY 2015 and FY 2016. Additionally, this is the first year where the consensus estimates do not include a cushion (extra money) for potential errors in estimates. Last year’s forecast consensus estimates for the supplemental year included a buffer of \$10.7 million or 3.3%. Each of the items in the forecast has a more detailed discussion below (all items are for FY 2016 unless specifically noted otherwise):

- Change in caseloads and cost per member per month** – estimated increase of 14,400 or 5% clients in FY 2015 and 1,900 or 1% in FY 2016. The majority of the increase in FY 2015 is from children previously eligible for CHIP going to the Medicaid program because the Affordable Care Act required certain expansions to Medicaid eligibility for children.
- Collections by the Office of the Inspector General, Medicaid Fraud Control Unit, and Office of Recovery Services** – the estimates assume that collections from these three entities will be lower by \$13.8 million in FY 2015 and \$14.5 million in FY 2016 as compared to FY 2014 collection of \$33.8 million. These estimates represent each of these three agency’s estimates of collections.
- Medicaid to CHIP adjustment** – transfer of \$8.5 million in FY 2015 and \$8.6 million in FY 2016 about 13,300 children on Medicaid whose services are paid at the higher CHIP match rate. The full

amount of the transfer is much higher, but only the increase over FY 2014 is included in the forecast since the cost per client in FY 2014 includes a partial year of transfers and serve as the basis for forecasting FY 2015 and FY 2016 costs. The Affordable Care Act increased Medicaid's income eligibility levels for children and removed an asset test. As a result of these changes, many CHIP children became eligible for Medicaid.

4. **Accountable care organization contracts** – \$3.9 million for a 2% projected increase starting in January 2016. Medicaid contracts with four accountable care organizations to provide about 50% of all services statewide. These organizations serve about 70% of clients. These contracts traditionally have annual increases.
5. **Autism increased federal requirements** - \$1.0 million in FY 2015 and \$3.0 million in FY 2016 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. Previously only clients qualifying as disabled qualified for these services or those served by the Utah pilot program for those ages 2 through 6. The funding includes 7.5% for administration for utilization control (75%) and program administration (25%) of \$127,200 General Fund (\$254,300 total funds) in FY 2015 and \$354,000 General Fund (\$708,500 total funds) in FY 2016. This administrative structure is the same one used for the Medicaid autism pilot in FY 2014 and FY 2013.
6. **Forced provider inflation** – this includes cost increases of \$3.1 million over which the state has no control due to federal regulation or has opted not to exercise more state control over cost increases. About 93% of the increases come from the following two areas: outpatient hospital (\$1.7 million) and pharmacy drug reimbursement (\$1.2 million). This is the first year for outpatient hospital increases in Medicaid consensus. The \$1.7 million 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 reimbursement rates 2.1% in 2015. The majority of the increase in pharmacy comes from a new drug Sovaldi for treating hepatitis C which can cost up to \$160,000 for a treatment.
 - a. Other increases over \$0.1 million include the following:
 - i. 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.
 - ii. 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.
 - iii. Crossovers – 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.
 - b. The consensus cost estimate is \$0.2 million less General Fund than the agency's request for FY 2016 due to the lowering of an estimated inflation rate for Medicare Buy-in. Additionally, the FY 2015 forced provider inflation estimate was reduced by \$0.5 million.
7. **Rural Utilization Increase** - \$0.9 million increases in FY 2015 and FY 2016 for increased pharmacy claims in the fee-for-service population (clients who live outside of the Wasatch Front counties – Utah, Salt Lake, Davis, Weber) for the new drug Sovaldi.
8. **Federal medical assistance percentage** - unfavorable change of 0.2% for a cost of \$2.4 million.
9. **Preferred Drug List** - additional projected savings of \$0.1 million.

Why Did FY 2014 Have \$20.8 Million in Unspent General Fund in Medicaid?

Medicaid ended FY 2014 with \$20.8 million in unspent General Fund. The consensus estimates for FY 2014 included a buffer of \$10.7 million. There was also a \$0.2 million one-time surplus in Medicaid administration. The unexpected unspent balance was \$9.9 million or 2.8%. There was \$11.0 million due to higher collections than last year for the Medicaid Fraud Control Unit and Office of the Inspector General.

When you factor this out of the error rate for forecasting, there is a \$1.1 million underestimate of costs which is a 0.3% error rate. This is better than the 2.6% or 5% error rate for FY 2013 and FY 2012 respectively.

The 2012 General Session was the first year for consensus forecasting for Medicaid and Children’s Health Insurance Program and saved the State \$13 million General Fund in FY 2012 when compared to the original building block request for Medicaid.

Medicaid Caseload Cost Estimate (General Fund)	FY 2012	Higher/(Lower) Than Building Block
Building Block from Health	\$ 48	\$ -
October 2011 Consensus	\$ 44	\$ (4)
February 2012 Consensus	\$ 35	\$ (13)

Children’s Health Insurance Program (CHIP) – What is Included in Consensus?

The consensus team estimates a General Fund surplus of \$2.5 million in FY 2015 and \$0.7 million in FY 2016. This is the first year where the consensus estimates do not include a cushion for potential errors in estimates. Last year’s forecast consensus estimates for the supplemental year included a buffer of \$0.5 million or 4.3%. The consensus for CHIP includes the following components (all items are for FY 2016 unless specifically noted otherwise):

1. **Caseload changes** –The consensus team estimates an average monthly enrollment of 15,700 for FY 2015. For FY 2016 the forecast projects enrollment growth of 1.4% or 200
2. **Inflation increases** – the Department contracts with two managed care organizations to provide all CHIP medical services. These contracts traditionally have annual increases. For FY 2014 these increases were 0% for one contractor and 9.1% for another contractor. The increase was primarily due to unusually high inpatient mental health expenditures. The forecast has increases in per member per month costs of 1.5% for FY 2015 and 3.0% for FY 2016.
3. **CHIP to Medicaid adjustment** - \$9.3 million in FY 2015 and \$9.4 million in FY 2016 to pay the CHIP match rate for costs of the 13,300 on Medicaid who previously qualified for CHIP. This allows the State to pay the 21% CHIP match rate rather than the 30% Medicaid match rate for these costs.
4. **Nonlapsing balance** – CHIP starts FY 2015 with a \$1.4 million in nonlapsing balances which reduces the need for General Fund. The money comes from unspent funds in FY 2014.

Why Consensus Forecasting for Medicaid?

When arriving at final point estimates for tax revenue projections, economists from the Legislative Fiscal Analysts 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.

Additional Resources

- *Medicaid Consensus Forecasting* Issue Brief from the 2013 Interim
<http://le.utah.gov/interim/2013/pdf/00004144.pdf>
- Kaiser Summary of Federal Health Care Reform
<http://le.utah.gov/interim/2012/pdf/00002141.pdf>