



MEDICAID CONSENSUS FORECASTING

EXECUTIVE APPROPRIATIONS COMMITTEE
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ISSUE BRIEF

SUMMARY

The Medicaid consensus forecast team estimates costs to the General Fund in FY 2018 of \$10.2 million one-time and an ongoing cost of \$29.8 million with one-time offset of (\$4.2) million in FY 2019. The consensus teams recommends a buffer of \$9.4 million that can be used anywhere in Medicaid or the Children’s Health Insurance Program (CHIP) in FY 2018 and in CHIP for FY 2019. These estimates do not include any funding for state administration or any optional provider inflation.

RECOMMENDATIONS

By statute, the Legislature must include in the base budget \$9.1 million for FY 2019 from the General Fund for accountable care organization costs. These increases are included in the overall estimate above. There is disagreement between the Department of Health and the fiscal analyst if \$0.4 million in FY 2018 and \$1.0 million in FY 2019 for blockbuster drugs qualify as a mandated program change as defined in statute and would therefore be included in the base budget.

DISCUSSION AND ANALYSIS

Below is a summary of the consensus General Fund mandatory cost estimates for FY 2018 and FY 2019. All numbers for FY 2018 are as compared to the amounts expended in FY 2017 plus 2017 General Session appropriations for FY 2018 and ongoing appropriations for FY 2019.

Medicaid Consensus General Fund Cost Estimates (\$ in Millions)	FY 2018	FY 2019	One- time Offsets
Caseload	\$465.2	\$474.7	\$0.0
Inflationary Changes	\$4.3	\$17.0	(\$2.5)
Program Changes	\$5.2	\$3.6	\$2.9
Less Base Funding	(\$461.7)	(\$466.8)	\$0.0
Subtotal	\$12.9	\$28.5	\$0.4
Human Services - FMAP	\$0.0	\$1.2	\$0.0
Medicaid Expansion Fund	(\$2.7)	\$0.0	(\$4.6)
Grand Total	\$10.2	\$29.8	(\$4.2)

What is Included in Consensus for the First Time This Year?

- 1. Full ongoing costs of increases that start mid-year** - regardless of when ongoing increases happen, the full ongoing costs is now included in the forecasted cost with one-time offsets to match the cost for the year of implementation. For FY 2019 this makes the ongoing costs \$2.5 million higher than they would have been under the previous methodology. Additionally, there is a \$2.5 million one-time offset to reflect the lower costs in the first year, FY 2019.
- 2. Department of Human Services federal medical assistance percentage** – the federal medical assistance percentage has been included annually for the Department of Health. The same changes that affect Health also affect the Department of Human Services. This adds \$1.2 million to the forecasted costs compared to the previous methodology for FY 2019.

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 increases to the General Fund in FY 2018 of \$10.2 million one-time and an ongoing cost of \$29.8 million in FY 2019. The forecast accounts for legislative appropriations changes in FY 2018 and FY 2019. Additionally, the consensus estimates recommend a \$9.4 one-time million or 2% buffer, which can be used in any of Medicaid’s or CHIP’s (Children’s Health Insurance Program) line items. Each of the items in the forecast has a more detailed discussion below. All numbers for FY 2018 are as compared to the expenditures incurred in FY 2017. The cost increases mentioned for FY 2018 carry forward into FY 2019 unless specifically noted. The FY 2019 numbers are as compared to the updated FY 2018 estimates. The estimates for FY 2019 are all ongoing changes unless specifically noted. All changes in item names in *italics* have not been previously addressed by the Legislature.

Caseload Changes - \$7.9 Million Increase in FY 2019

1. **Change in caseloads** – estimated decrease over FY 2017 of (2,500) or (0.8%) clients in FY 2018 and an increase of 800 or 0.3% in FY 2019 compared to the updated FY 2018 forecast. The current caseload forecast is (7,000) clients or (2.1%) lower for FY 2018 compared to the February 2017 forecast, which results in lower baseline costs of (\$8.1) million for FY 2018 when using FY 2017 per member per month costs. The FY 2019 enrollment estimate is (6,100) clients or (1.8%) lower than the February 2017 forecast for FY 2018. Because there are increases in more expensive client groups and decreases in less expensive groups, the changes overall only reduce costs in FY 2019 by (\$1.4) million. The baseline caseload costs are \$453.1 million in FY 2018 with an additional \$6.7 million in FY 2019. The three traditional groups with highest number increase in FY 2019 are: (1) qualified Medicare beneficiary (dual eligible for Medicaid and Medicare), (2) blind/disabled, and (3) aged. These changes are shown in the table below.

Eligibility Category	FY 2018 (Feb. 2017)	FY 2018 (Oct. 2017)	FY 2019 (Oct. 2017)	FY 2017 PMPM	Original FY 2017	New FY 2017	FY 2018
Adult	34,341	31,272	30,720	\$109.31	\$ 45,046,400	\$ 41,020,500	\$ 40,297,000
Aged	16,210	16,365	16,753	\$413.35	\$ 80,402,900	\$ 81,174,400	\$ 83,099,900
Blind/Disabled	41,352	40,968	41,942	\$310.14	\$ 153,899,800	\$ 152,471,200	\$ 156,094,500
Child	192,690	188,478	187,459	\$ 40.41	\$ 93,446,600	\$ 91,403,700	\$ 90,909,500
Primary Care Network	16,556	17,610	17,610	\$ 36.14	\$ 7,180,200	\$ 7,637,200	\$ 7,637,200
Pregnant	5,718	5,297	5,467	\$341.39	\$ 23,425,400	\$ 21,699,900	\$ 22,394,300
Qualified Medicare Beneficiary	30,539	30,454	31,343	\$157.78	\$ 57,821,500	\$ 57,661,100	\$ 59,343,400
Total	337,400	330,400	331,300		\$ 461,200,000	\$ 453,100,000	\$ 459,800,000
Difference		(7,000)	(6,100)			\$ (8,100,000)	\$ (1,400,000)

Eligibility Category	FY 2016 PMPM	FY 2017 PMPM	% Change	FY 2017 Actuals	FY 2016 PMPM	FY 2017 PMPM
Adult	\$100.08	\$109.31	9%	34,384	\$ 41,291,900	\$ 45,103,200
Aged	\$365.34	\$413.35	13%	15,843	\$ 69,456,500	\$ 78,584,200
Blind/Disabled	\$276.50	\$310.14	12%	40,331	\$ 133,817,800	\$ 150,101,200
Child	\$ 38.14	\$ 40.41	6%	192,429	\$ 88,080,700	\$ 93,320,100
Primary Care Network	\$ 36.12	\$ 36.14	0%	14,772	\$ 6,403,300	\$ 6,406,300
Pregnant	\$395.94	\$341.39	-14%	5,637	\$ 26,782,800	\$ 23,092,500
Qualified Medicare Beneficiary	\$142.16	\$157.78	11%	29,568	\$ 50,438,500	\$ 55,982,700
		Average	5%	333,000	\$ 416,271,500	\$ 452,590,200
		High	13%		Increased Cost	\$ 36,300,000
		Low	-14%		Projected Increased Cost	\$ 30,500,000
					Difference	\$ 5,800,000

- a. **Change in per member per month cost** – in the February 2017 consensus the forecast team estimated that per member per month costs in FY 2017 would be \$30.5 million General Fund higher than in FY 2016. The actual increase was \$36.3 million General Fund, which represents an increase in cost of \$5.8 million. This \$5.8 million increase is already included in the caseload increase described in number one. The Department of Health believes this is due primarily to lower pharmacy rebate collections, lower collections from the Medicaid Fraud Control Unit (MFCU), and lower collections from the Office of Inspector General (OIG). Although there were increased collections from the Office of Recovery Services (ORS), the amount of increase was not significant enough to offset the reductions in the other two areas. These changes are shown in the table above.
2. **2017 General Session appropriations** – The Legislature provided \$8.2 million for FY 2018. The items over \$0.1 million include:
 - a. \$6.5 million for inflationary increase for Medicaid’s accountable care organizations
 - b. \$1.4 million for Medicaid dental coverage for adults with disabilities
 - c. \$0.6 million for direct staff salary increases in intermediate care facilities
 - d. (\$0.3) million transfer to Human Services for disability services portability

For more information please visit <https://le.utah.gov/interim/2017/pdf/00002431.pdf>. These items cost \$0.1 million more in FY 2019 due to the change in the federal medical assistance percentage described in number three below.
3. **Federal medical assistance percentage** – a favorable one-time change of 0.19% in FY 2018 with an updated cost estimate (\$2.9) million lower and unfavorable change of 0.32% in FY 2019 for a cost of \$2.0 million ongoing.
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 lower (costing Medicaid more) by \$0.4 million in FY 2018 and \$0.6 million in FY 2019 primarily due to projected decreases in collections by the Office of Recovery Services of (16%) in FY 2018 and another reduction of (16%) in FY 2019. For the Medicaid Fraud Control Unit collections reported

through mid-October have FY 2018 actuals at \$500,000 General Fund, which is \$0.4 million higher than FY 2017 actuals. The current assumptions assume no more collections for FY 2018 and General Fund collections of \$500,000 in FY 2019. The estimates for FY 2018 and FY 2019 match FY 2017 actual collections for the Office of the Inspector General. For information on the current and historical levels of Medicaid collections, please visit the “Medicaid Collections” measure at <https://le.utah.gov/lfa/fiscalhealth/#revenuesTab>.

5. **Extra pay period** – Every six years the calendar has an extra pay period (53 rather than 52). As fee-for-service claims come in regularly, this results in increased costs only in FY 2018 of \$4.3 million based on the median experience of 48 pay periods for Medicaid in FY 2017. The Department of Health explains why it excluded 4 pay periods data with: “The reason that the average was taken over 48 pay periods was due to the fact that the remaining pay periods were split between old year and new year. This extra week would belong entirely to old year.”
6. **Delay of Medicaid provider taxes** - Medicaid's four accountable care organizations as well as managed care organizations for dental services and the Children's Health Insurance Program will not have to pay all the provider tax in FY 2018 due to the Consolidated Appropriations Act of 2016. Originally, the Department of Health believed that the full tax reduction would happen in FY 2018, but instead ½ took place in FY 2017. This results in higher than expected costs of \$1.6 million in FY 2019 when the full tax must be paid.
7. **Other budget adjustments** – The following items for FY 2018 are not driven by caseload, are paid separately from caseload, and do not represent cost increases:
 - a. Graduate Medical Education - \$1.8 million
 - b. Disproportionate Share Hospital - \$1.1 million
 - c. Medically Complex Children's Waiver – (\$1.0) million reduction because in FY 2017 \$1.0 million General Fund was used whereas in future years nonlapsing balances will be used. General Fund is tracked via the consensus process but not nonlapsing balances, which the Department of Health must track.

Inflationary Changes - \$17.0 Million Increase in FY 2019

1. **Accountable care organization contracts** – A \$4.2 million increase to account for a full year in FY 2019 of the 3.5% increase starting January 2018. A \$4.9 million increase in FY 2019 with a (\$2.5) million one-time back out for a 2% increase starting in January 2019. Beginning this year, the full cost of these increases are included with the original request, which is why there is a one-time back out for FY 2019 to account for the January 2019 start date. Medicaid contracts with four accountable care organizations who utilize about 38% of the General Fund appropriated to Medicaid to perform services statewide. These organizations serve about 84% of clients. These contracts traditionally have annual increases.
2. **Forced provider inflation** – this primarily includes cost increases to the State’s fee-for-service program. The updated forecast includes increases of \$2.4 million for FY 2018 and \$2.5 million for FY 2019, primarily due to a 5.3% projected inflationary increase in pharmacy drug costs. The increases are areas over which the state has no control due to federal regulation or has opted not to exercise more state control over cost increases. About 89% of the increases in FY 2019 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 consensus team is estimating 1.75% annual increases in Medicare outpatient hospital reimbursement rates beginning in 2018 and another increase in 2019.
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 \$0.7 million in FY 2018 and \$1.2 million in FY 2019 based on a 3.1% increase in payments due.

4. **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 Part B premiums rose from \$121.80 to \$134.00 for calendar year 2017. There are no projected increases for 2018 and 2019. Medicare cost sharing increases are projected to cost the State an additional \$1.1 million in FY 2018.

Program Changes - \$3.6 Million Increase in FY 2019

1. **H.B. 437 adjustment** – [H.B. 437, Health Care Revisions](#), from the 2016 General Session requires a shift of \$2.7 million from the Medicaid Expansion Fund to Medicaid services in FY 2018 only. This adjustment helps to properly locate savings and expenses from the delayed start of the program. As part of a Medicaid systemwide reduction of (\$1.7) million one-time in FY 2019 there is a \$2.8 million one-time increase to Medicaid services to adjust appropriations provided for FY 2021 projected expenditures to FY 2019 appropriations.
2. **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 increase is \$1.6 million for FY 2018.
3. **Autism increased federal requirements** – increase of \$0.5 million in FY 2018 and increase of \$0.4 million in FY 2019 for the 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.
 - a. This autism requirement replaced a state pilot program providing autism services which saves the State (\$0.1) million in FY 2018.
4. **Blockbuster drugs** – the Department of Health will be paying for new costly drugs statewide via the fee-for-service system rather than forecasting utilization and costs for inclusion into capitated rates paid to accountable care organizations. There are projected costs of \$0.4 million in FY 2018 and \$0.6 million in FY 2019 for the following five new drugs:
 - a. Pembrolizumab – used to treat certain kinds of cancer.
 - b. Uptravi - used to treat pulmonary arterial hypertension.
 - c. Ilaris – used to treat active Systemic Juvenile Idiopathic Arthritis in children ages 2 and older.
 - d. Bexarotene – used to treat cutaneous T-cell lymphoma.
 - e. Olaratumab – used to treat soft tissue sarcoma cancer.
5. **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 an increase in costs of \$0.1 million in FY 2018 and an increase of \$0.1 million in FY 2019.

Human Services and Juvenile Justice Services-\$1.2 Million Increase in FY 2019

Federal medical assistance percentage – an unfavorable change of 0.32% in FY 2019 for a cost of \$1.2 million, \$1,220,500 for the part of the Department of Human Services overseen by the Social Services Appropriation Submission and \$24,500 for the Juvenile Justice Services portion of Human Services overseen by the Executive Offices and Criminal Justice Appropriations Subcommittee.

Medicaid Expansion Fund - (\$4.6) Million One-time Decrease in FY 2019

The Medicaid Expansion Fund may be used to pay the costs to the state of serving those newly eligible due to [H.B. 437, Health Care Revisions](#), from the 2016 General Session.

- **H.B. 437 adjustment** – a shift of \$2.7 million out of the Medicaid Expansion Fund to Medicaid services in FY 2018 only. This adjustment helps to properly locate savings and expenses from the delayed start of the program. As part of a Medicaid systemwide reduction of (\$1.7) million one-time

in FY 2019 there is a (\$4.6) million one-time decrease in the Medicaid Expansion Fund to adjust appropriations provided for FY 2021 projected expenditures to FY 2019 appropriations.

Why Did FY 2017 Medicaid Actuals Use \$6.2 of the \$9.0 Million Buffer?

Medicaid services ended FY 2017 over budget by \$6.2 million General Fund (and General Fund restricted account funds used as General Fund) but within the \$9.0 million buffer funding provided. The unexpected unspent balance was \$6.2 million or 1.4%. There was \$0.4 million due to lower-than-projected collections. When you factor this out of the error rate for forecasting, there is a \$5.8 million underestimate of costs which is a 1.3% error rate. Prior year error rates for FY 2016 through FY 2012 have been 2.7%, 0.4%, 0.3%, 2.6%, and 5%.

The Department of Health explains the \$5.8 million overage for FY 2017 with: “The New Choices Waiver saw sharp increases in utilization. The New Choices Waiver alone had an increase of \$1.2 million. Given that this program takes people out of nursing homes and places them in community-based services, the increase would have been experienced in nursing homes and would have been much more pronounced had this program not existed. The remaining \$3.1 million is made up of utilization increases. The cost per claim in the fee-for-service program increased by 3.2% and the number of fee-for-service claims increased 2.2%. Both of these percentages illustrate higher utilization in FY 2017 given that overall caseload declined. Additionally, pharmacy rebates were lower than the previous year by \$0.7 million.”

What Optional Medicaid Services Had Cost Increases in Medicaid?

The Department of Health reports the following increases in contractual costs for optional Medicaid services:

- **Non-emergency Medical Transportation** – non-emergency medical transportation is an optional service for Traditional Medicaid clients who do not have transportation to receive medical care. The Department of Health received a request for proposal to increase costs by \$0.6 million General Fund and \$1.5 federal funds on an annual basis beginning April 1, 2017 to replace the current contractor who opted to end its contract.
 - If the Legislature voted to end this optional service, the State would spend \$1.6 million less General Fund and \$3.9 million less federal funds based on the projected FY 2018 spending period.

Children’s Health Insurance Program (CHIP) – Why \$13.2 Million Ongoing Cost Estimate?

Why is the ongoing General Fund cost for CHIP increasing \$13.2 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 2019 the following changes are forecasted to increase General Fund costs:

1. **Caseload** – 23.1% growth
2. **Per member per month costs** – 16.9% 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 through FY 2018 and FY 2019 assuming that the federal government continues to fund CHIP at 100%. 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.

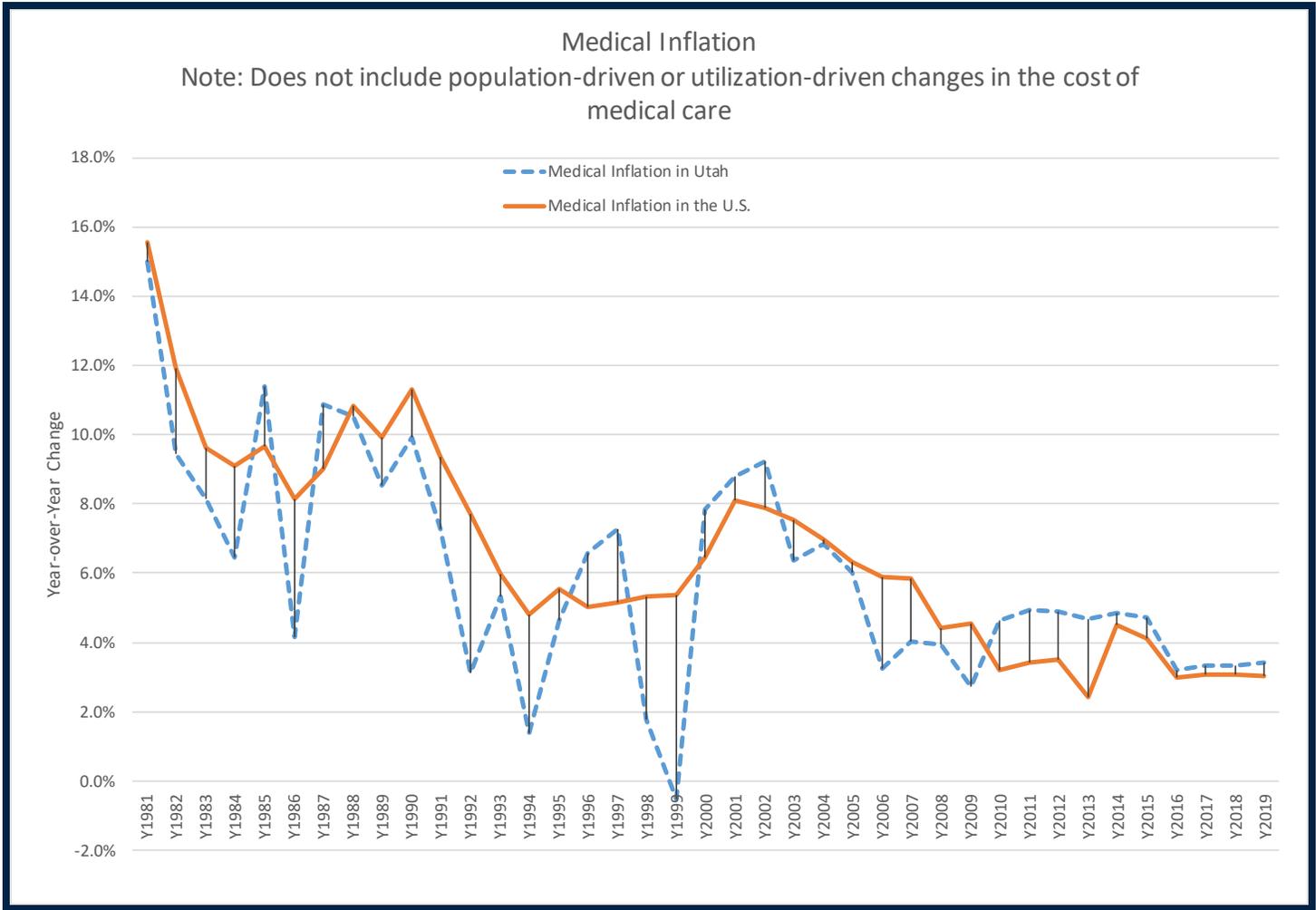
What Must Be Included in the Base Budget?

There is up to \$0.4 million in FY 2018 and \$10.1 million in FY 2019 General Fund from two items that might need to 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 "Blockbuster Drugs," which is described under program changes number four on page five is a mandated program change. The fiscal analyst believes mandated program changes can only be part of accountable care organization contracts and disagrees with the mandatory program change designation by the Department of Health. The amount for possible inclusion in the base budget is \$0.4 million in FY 2018 and \$1.0 million in FY 2019.
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 2019 is not known currently. FY 2018 General Fund growth estimate is 5.0% as per the revenue estimates adopted at the May Executive Appropriations Committee. FY 2019's growth factor may or may not be similar to FY 2018. The growth factor will be announced as part of the December 2017 Executive Appropriations Committee meeting. The Governor's Office of Management and Budget and the Office of the Legislative Fiscal Analyst estimated 3.5% for FY 2019 General Fund revenue growth. The costs are described under "Accountable care organization contracts," which is number one under the "inflationary changes" section on page four. As per statute, the base budget should receive additional General Fund of \$9.1 million in FY 2019 with a one-time offset of (\$2.5) million.

What is Projected Medical Inflation for Utah?

The fiscal analyst projects medical inflation for Utah at 3.3% in FY 2018 and 3.4% in FY 2019. 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 [JR3-2-402\(2\)\(a\)\(iv\)](#).

Additional Resources

- *Medicaid Consensus Forecasting* Issue Brief from the 2016 Interim <https://le.utah.gov/interim/2016/pdf/00004868.pdf>
- *Federal Medical Assistance Percentage or FMAP - Human Services* Issue Brief from the 2017 General Session <https://le.utah.gov/interim/2017/pdf/00000178.pdf>
- For more information on Utah’s Medicaid enhancement, please visit <http://health.utah.gov/MedicaidExpansion/index.html>