Medicaid Consensus Forecasting

Executive Appropriations Committee December 9, 2024

Summary

The Medicaid consensus forecast team estimates changes from traditional Medicaid and Children's Health Insurance Program (CHIP) to the General Fund in FY 2025 of ($83.6) million reduction one-time and changes of $53.4 million ongoing and ($30.6) million one-time in FY 2026. Medicaid ACA Fund ongoing revenues may exceed ongoing expenses by $50 million in FY 2025 and $80 million in FY 2026. The consensus team recommends a 5.0% buffer of $31.2 million from existing funds in the Medicaid Budget Stabilization Account for FY 2025. These estimates do not include any new funding for state administration or any optional provider inflation.

Recommendations

By statute, the Legislature must include in the base budget $8.2 million ongoing General Fund in FY 2026 for accountable care organization costs, increases to funding for mental health, and mandated program changes. These increases are included in the overall estimate above.

Medicaid Consensus General Fund Cost/(Savings) Estimates, $ in Millions	FY 2025	FY 2026	One-time Offsets
Caseload	$533.6	$581.7	($15.0)
Inflationary Changes	($10.1)	$17.0	($5.0)
Program Changes	$62.1	$36.6	($8.2)
Human Services - FMAP (Federal Medical Assistance Percentage)	$0.0	$13.9	$0.0
Children's Health Insurance Program	$2.7	$5.3	($0.3)
Less Base Medicaid Funding	($671.8)	($601.1)	($2.2)
Total - Medicaid & CHIP	**($83.6)**	**$53.4**	**($30.6)**
Medicaid ACA Fund Balance Closing Year Fund Balance (Negative Number = Funds Available)	($380)	($460)	
Medicaid ACA Fund Ongoing Expense vs Revenue - Above/(Below)	($50)	($80)	

Discussion and Analysis

The table above has a summary of the consensus General Fund mandatory cost estimates for FY 2025 and FY 2026. All numbers for FY 2025 are as compared to the amounts expended in FY 2024 plus 2024 General Session appropriations for FY 2025 and ongoing appropriations for FY 2026.

Medicaid – What is Included in Consensus for Mandatory Costs?

The Medicaid consensus forecast team (Legislative Fiscal Analyst, Governor's Office of Planning and Budget, and the Department of Health and Human Services) estimates changes from

traditional Medicaid and Children's Health Insurance Program (CHIP) to the General Fund in FY 2025 of ($83.6) million reduction one-time and changes of $53.4 million ongoing and ($30.6) million one-time in FY 2026. Medicaid ACA Fund ongoing revenues may exceed ongoing expenses by $50 million in FY 2025 and $80 million in FY 2026. The consensus team recommends a 5.0% buffer of $31.2 million from existing funds in the Medicaid Budget Stabilization Account for FY 2025. All numbers for FY 2025 are as compared to the expenditures incurred in FY 2024. The cost increases mentioned for FY 2025 carry forward into FY 2026 unless specifically noted. The FY 2026 numbers are as compared to the updated FY 2025 estimates. The estimates are all ongoing changes unless specifically noted. Further, some inflationary changes take place mid-FY 2026, so the full ongoing cost has been projected with a one-time back out to account for the later start date of the changes.

Eligibility Category	GF PMPM	FY 2025 Est. Enrollment	FY 2025 Costs	FY 2026 Est. Enrollment	FY 2026 Costs
Adult	$ 172.73	23,431	$ 48,600,000	23,561	$ 48,800,000
Breast Cervical Cancer	$ 616.42	47	$ 300,000	45	$ 300,000
Aged	$ 2,698.63	1,865	$ 60,400,000	1,873	$ 60,700,000
Qualified Medicare Beneficiary (QMB)	$ 129.65	11,041	$ 17,200,000	10,978	$ 17,100,000
Blind/Disabled	$ 298.38	41,954	$ 150,200,000	42,316	$ 151,500,000
Tech Dependent	$ 3,460.41	140	$ 5,800,000	140	$ 5,800,000
Child	$ 49.08	134,680	$ 79,300,000	137,856	$ 81,200,000
Medically Needy Child (Spenddown)	$ 87.05	27	$ 30,000	25	$ 30,000
Newborns	$ 321.97	13,920	$ 53,800,000	13,858	$ 53,500,000
Pregnant	$ 137.21	13,264	$ 21,800,000	13,323	$ 21,900,000
Nursing Home	$ 1,452.75	3,590	$ 62,600,000	3,529	$ 61,500,000
Foster Care and Subsidized Adoption	$ 66.91	8,435	$ 6,800,000	8,428	$ 6,800,000
Grand Total		**252,400**	**$ 506,800,000**	**255,900**	**$ 509,100,000**

Caseload Changes – $33.1 Million Combined Ongoing and One-time Increases in FY 2026

1. ***Change in caseloads*** – estimated decrease over FY 2024 of (29,500) or (10.5%) clients in FY 2025 and a decrease of (26,000) or (9.2%) in FY 2026 compared to the FY 2024 actuals. The baseline caseload costs are $506.8 million in FY 2025 and $509.1 million in FY 2026. The three traditional groups with highest number increase in clients in FY 2024 are: (1) child, (2) blind/disabled, and (3) adult. These changes are shown in the table above.
2. ***Federal medical assistance percentage*** – unfavorable ongoing changes of 1.2% in FY 2025 at a cost of $17.7 million ongoing and 1.8% and an additional cost in FY 2026 of $40.3 million with a one-time offset of ($12.8) million. The one-time offset is to help capture the ongoing costs of the higher percentage change for the first three months of FY 2026 since the federal fiscal year runs from October 1 through September 30.

Unfavorable match rate changes of 1.2% and 3.0% in FY 2025 and FY 2026 respectively as compared to FY 2024.

3. ***Qualified Medicare Beneficiary Case mix*** - Billings from the federal government's Centers for Medicare and Medicaid Services based on the case mix of Qualified Medicare Beneficiaries may change which would result in savings of ($4.4) million in FY 2025 and an additional increase of $2.1 million ongoing in FY 2026, which represents a forecasted savings of ($2.3 million in FY 2026).
4. ***Recent General Session ongoing appropriations*** – Reduces ($5.3) million ongoing in FY 2025. The items over $0.1 million include:
    a. ($5.6) million for Expanded Medicaid Coverage for Inmates (H.B. 501)
    b. ($3.7) million for Clients Transitioning Into Home & Community Based Settings
    c. ($1.6) million for FTE Transfer from Medicaid Services to Administration
    d. $1.5 million for S.B. 133, Postpartum Medicaid Coverage Amendments
    e. $1.0 million for Nursing Home Medicaid Rate Increase
    f. $0.7 million for Six Month Delay for Extended Postpartum Medicaid Benefit
    g. $0.5 million for H.B. 290, Medicaid Waiver for Medically Complex Children
    h. $0.5 million Medicaid Pharmacy Dispensing Fee
    i. $0.4 million for Medically Complex Children's Waiver
    j. $0.2 million for Delay for Equal Medicaid Reimbursement Rate for Autism
    k. $0.2 million for Delay for New Choices Waiver Rate Increase
    l. ($0.2) million for Emergency-Only Medicaid Program Savings
    m. $0.2 million for Fertility Treatment Amendments Implementation Delays
    n. $0.1 million for Costs Vs Estimates for Dental Hygienist Amendments (S.B. 103 2021 G.S.)
    o. $0.1 million for Delay for Increase Intermediate Care Facility Medicaid Payment Rates
    p. For all the items above there is an additional collective unfavorable match rate and ramp up cost of $1.5 million in FY 2026.

    For more information on the appropriations listed above, please visit https://cobi.utah.gov/2024/3593/issues.

5. ***Transfer of Preferred Drug List Savings*** – As per UCA 26B-1-315(2)(f), Preferred Drug List savings from psychotropic drugs are to be transferred into the Medicaid ACA Fund. Since FY 2024 saw $2.1 million General Fund less in savings than in FY 2023, ($2.1) million one-time in FY 2025 million and ($2.2) one-time in FY 2026 will be transferred from the Medicaid ACA Fund into traditional Medicaid to reflect the decrease in savings, which will offset other costs.
6. ***Caseload and Match Rate Changes in Behavioral Health*** – This provides funding for caseload and federal medical assistance percentage changes for the behavioral health costs in Medicaid beginning in FY 2026 at a cost of $1.5 million ongoing.

7. ***Collections by the Office of the Inspector General, Medicaid Fraud Control Unit, Department of Health and Human Services, and Department of Workforce Services*** – the updated estimates assume that collections from these five entities will be lower (costing Medicaid more) by $1.7 million in FY 2025 and in FY 2026 an additional savings of ($0.3) million primarily due to a projected decrease in collections from Medicaid Assistance Only Spenddown and the Office of the Inspector General Recoveries. Both of these collection categories had higher than normal collections in FY 2024. The forecast assumes these two collection categories will return to FY 2023 levels. The additional savings in FY 2026 is from a forecasted increase in collections by the Office of Recovery Services.
8. ***Transfer of Collections to Expansion*** – ($0.5) million in FY 2025 and an additional $0.3 million in FY 2026 to transfer these to the Medicaid ACA Fund. These collections are more appropriately reflected in the Medicaid ACA Fund since that is where they took place.
9. ***Federally Qualified Health Center's Scope of Service Changes*** - $0.5 million increase to comply with federal requirements to update payment rates for Federally Qualified Health Centers to reflect changes in services provided.
10. ***COVID Vaccine Normal Match Rate Coverage Required*** - increase of $14,000 in FY 2025 and an additional $6,000 in FY 2026 because the 100% federal match rate for COVID vaccines ends in September 2024 requiring state funds at the normal match rate to reimburse this service beginning in October 2024.
11. ***Other budget adjustments*** – The following item beginning in FY 2025 is not driven by caseload, is paid separately from caseload, and does not represent cost increases:
    a. Nursing and Intermediate Care Facilities Quality Incentive Payments - $2.3 million in FY 2025 and an additional $0.1 million in FY 2026

Inflationary Changes - $22.1 Million Combined Ongoing and One-time Increases in FY 2026

1. ***Accountable care organization contracts*** – $5.4 million in FY 2025 and an additional $6.1 million in FY 2026 to account for 2.0% increase that started in July of 2024 and a rate increase of 2.0% starting July 2025. Medicaid contracts with four accountable care organizations who utilize about 50% of the General Fund appropriated to Medicaid to perform services statewide. These organizations serve about 76% of all clients. These contracts traditionally have annual increases.

2. ***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 decrease ($12.5) million in FY 2025 and an additional cost of $13.4 million in FY 2026 with a ($4.1) million one-time back out based on an estimated 8.3% annual increase starting in January 2026.

3. ***Mental Health Funding Increases*** – H.B. 236, Behavioral Health Amendments, from the 2022 General Session required mental health funding rate be increased up to 2% based on

General Fund growth factor adjusted for county contribution. Increases are for mental health plans primarily run by the counties. This is a $1.1 million increase in FY 2025 and an additional $1.3 million cost in FY 2026. This also requires more ongoing statewide match from the counties of $0.2 million in FY 2025 and an additional $0.3 million in FY 2026.

4. ***Forced provider inflation*** – This primarily includes cost changes to the State's fee-for-service program. The updated forecast includes an increase of $1.2 million for FY 2025 with an additional increase of $1.5 million for FY 2026, primarily due to inflationary increases in pharmacy. The changes are areas over which the state has no control due to federal regulation or has opted not to exercise more state control over cost changes.

5. ***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. The estimates include a projected 2.7% annual increase in Medicare Part B premiums from $174.70 in 2024, $179.42 in 2025, and $184.26 in 2026. Medicare cost sharing increases are projected to save the State ($5.3) million in FY 2025 and an additional $3.3 million ongoing with a ($0.9) million one-time offset in FY 2026.

Program Changes – ($33.6) Million Combined Ongoing and One-time Decreases in FY 2026

1. ***PRISM Delayed Payments*** – Most delayed payment/overpayments have been accounted for via year end accounting accruals and therefore are included in our per member per month forecasts. There are additional categories of delayed payments that were not accrued for in our FINET accruals. This may cost the State $65.2 million in FY 2025 and a reduction of ($30.9) million in FY 2026.

2. ***Preferred Drug List*** – FY 2024 had lower than normal rebates because Change Healthcare system which administered Medicaid's pharmacy benefit was down for part of the year and unable to process rebates. This may save the State ($7.8) million one-time in FY 2025 and ($8.2) million one-time in FY 2026.

3. ***Blockbuster drugs*** – The Department of Health and Human Services will be paying for new costly drugs statewide via a high-risk pool for accountable care organizations and fee-for-service. There are projected costs of $0.8 million in FY 2025 and an additional $0.1 million in FY 2026 for new and emerging drugs where the annual cost per member-drug combination exceeds $240,000.

4. ***CHIPicaid Adjustment*** – $3.3 million in FY 2025 and a change of ($2.5) million in FY 2026 to account for the consensus member growth among children enrolled in Medicaid. This is a transfer of Medicaid child costs, calculated based on a historical percentage and current caseload, to CHIP to receive higher, enhanced federal reimbursement to offset the

effects of the Affordable Care Act that raised income requirements for Medicaid and moved a portion of the CHIP population to Medicaid.

5. ***Twelve Month Continuous Eligibility for Children*** – The federal government requires all States to provide twelve months of continuous eligibility for children beginning in January 2024. This may cost the State $0.5 million in FY 2025 and an additional $0.1 million in FY 2026.

6. ***Sunsetting the Disparity of Benefits in the Adult Expansion Population (Medicaid Reform 1115 Demonstration)*** – increase of $0.1 million for a federal requirement to provide the same non-emergency transportation services to traditional and non-traditional clients beginning in 2025.

Nonlapsing Balance Available

Because Medicaid had nonlapsing authority for FY 2024 appropriations and Medicaid did not spend $78.1 million, there is $78.1 million included in consensus to offset FY 2025 costs.

Human Services, Juvenile Justice Services, and Correctional Health Services – $13.9 Million Increase in FY 2026

Federal medical assistance percentage

FY 2026 – an unfavorable change of 1.8% for a cost of $13.9 million for the Medicaid parts previously in the Department of Human Services, but now in the Department of Health and Human Services.

Why Did FY 2024 Underspend by $78.1 Million for Medicaid Services?

Medicaid services ended FY 2024 $78.1 million General Fund under budget and did not use the $77.5 million buffer provided. The unexpected surplus was $78.1 million or 12.0%. There would have been $79.5 million not spent were it not for $1.4 million lower than expected collections. When you factor this out of the error rate for forecasting, there was a $79.5 million overestimate of costs which is a 12.2% error rate. The Department of Health and Human Services believes there was a surplus in FY 2024 due to: (1) overpayments of capitations that the agency was not aware of in FY 2023 which overstated the per member per month costs used in the prior consensus, (2) Clawback costs came in $17 million lower than anticipated, and (3) additional federal draws being made in FY 2024 due to under-draws in FY 2023.

Children's Health Insurance Program (CHIP) – $2.7 Million One-time Increase in FY 2025 and $5.0 Million Combined Ongoing and One-time Increase in FY 2026

The consensus team estimates General Fund reductions of $2.7 million one-time in FY 2025 and $5.3 million ongoing with ($0.3) million one-time in FY 2026. The consensus estimate for CHIP includes the following components:

1. ***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.
2. ***Caseload*** – caseload increases of 2,300 or 22.7% clients in FY 2025 and (600) or (4.9%) client decrease in FY 2026 vs FY 2025 projected enrollment.
3. ***Per-member-per-month costs*** – 5% inflationary growth in managed care contracts forecasted for both FY 2025 and FY 2026.
4. ***Federal medical assistance percentage*** – Unfavorable ongoing changes of 0.8% in FY 2025 at a cost of $0.4 million and 1.3% in FY 2026 at an additional cost of $0.9 million.
5. ***Loss of premiums, increase in cost sharing*** – beginning July 2024 Utah will no longer charge premiums to members. The federal government recently ruled that States cannot disenroll members for non-payment of premiums. Additionally, the program will increase cost sharing requirements on medical services. This shifts $0.2 million ongoing beginning in FY 2025 from premium revenues to increased cost sharing.

Why Did FY 2024 Overspend by $1.3 Million for CHIP?

CHIP spending exceeded the FY 2024 forecast by $1.3 million, which represents a 4.1% error rate. One of the reasons for spending exceeding the forecast is that the February 2024 consensus projected 9,500 clients for FY 2024, but 10,000 enrolled.

Medicaid ACA Fund – Ongoing Revenue to Exceed Ongoing Expenses by $80 million in FY 2026

The Medicaid ACA Fund may be used to pay the costs to the state of serving those newly eligible for Medicaid as of April 2019. The ongoing revenues may exceed ongoing expenses in the Medicaid ACA Fund by $50 million in FY 2025 and $80 million in FY 2026. The Medicaid ACA Fund might end FY 2025 with $380 million and $460 million in FY 2026. Below are the explanations behind the cost forecasts:

1. ***General Fund Appropriation*** – FY 2026 has appropriations from the General Fund of $29.9 million while FY 2025 has $0.
2. ***Caseload*** - FY 2025 enrollment vs FY 2024 actuals decreasing (19,900) or (20%). FY 2026 vs FY 2025 projected enrollment increasing 1,600 or 1%.
3. ***Change in per-member-per-month costs*** – All PMPMs increased from the prior year and on average increased 68%.
4. ***Sales 0.15% Tax Revenue Forecast*** - $4.6 million forecasted increase compared to FY 2024 actuals.

5. ***Interest Income*** - $1.6 million increase in FY 2025 and another $2.9 million increase in FY 2026 forecast for interest income earned compared to FY 2024 actuals of $16.4 million.

6. ***PRISM Delayed Payments*** – Most delayed payment/overpayments have been accounted for via year end accounting accruals and therefore are included in our per member per month forecasts. There are additional categories of delayed payments that were not accrued for in FINET accruals. This may cost the State $3.8 million.

7. ***Transfer of Preferred Drug List Savings*** – As per UCA 26B-1-315(2)(f), Preferred Drug List savings from psychotropic drugs are to be transferred into the Medicaid ACA Fund. Since FY 2024 saw $2.1 million General Fund less in savings than in FY 2023, $2.1 million one-time in FY 2025 million and $2.2 one-time in FY 2026 will be transferred from the Medicaid ACA Fund into traditional Medicaid to reflect the decrease in savings.

8. ***Accountable care organization contracts*** – $1.0 million in FY 2025 and an additional $1.1 million in FY 2026 due to projected increases in rates paid to accountable care organizations of 2.0% in FY 2025 and 2.0% in FY 2026.

9. ***Transfer of Collections to Expansion*** – $0.9 million less transferred into the Medicaid ACA Fund from traditional Medicaid services compared to FY 2024. These collections are more appropriately reflected in the Medicaid ACA Fund since that is where they took place.

10. ***Federal medical assistance percentage*** – Unfavorable ongoing changes of 1.2% in FY 2025 at a cost of $0.2 million ongoing and 1.8% and an additional cost of $0.4 million with a one-time offset of ($0.2) million in FY 2026 for certain services (i.e. – 12-month continuous eligibility for higher income clients) and clients (i.e. – clients with disabilities but disabled per State rules) who do not qualify for the expansion federal match rate of 90%.

11. ***2024 General Session ongoing appropriations*** – Reduces ($0.3) million ongoing in FY 2025 with an additional cost of $0.4 million in FY 2026. The items over $0.1 million include:

    a. ($0.4) million in FY 2025 an additional cost of $0.4 million in FY 2026 for Expanded Medicaid Coverage for Inmates (H.B. 501)

    b. $0.1 million for Medicaid Pharmacy Dispensing Fee

12. ***Risk Corridor Reconciliation*** - $0.1 million cost because FY 2025 and FY 2026 are not projected to have a year-end take back from the accountable care organizations like what happened in FY 2024 as part of the ongoing two-way risk corridor contracts.

13. ***Mental Health Funding Increases*** – H.B. 236, Behavioral Health Amendments, from the 2022 General Session required mental health funding rate be increased up to 2% based on General Fund growth factor. Increases are for mental health plans primarily run by the counties. This is a $20,000 increase in FY 2025 and an additional increase of $30,000 in FY 2026.

Why Did the FY 2024 Medicaid ACA Fund Balance Come in $30 Million Lower Than Forecasted?

The Medicaid ACA Fund ended FY 2024 $90 million lower than forecasted ($330 vs $420 million); however the Legislature removed $59.4 million in General Fund deposits after consensus, which would make the difference only $30 million or a 8% error rate. February 2024 consensus projected 100,900 clients for FY 2024 vs 98,500 that enrolled, which is 2,400 less than estimated. Interest income came in $9.8 million higher than forecasted. The Department of Health and Human Services believes costs came in higher than forecasted due to the correction of PRISM claims processing issues that caused the higher Medicaid ACA Fund balance in prior year.

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 Planning 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, then it must abide by strict federal regulations. As Utah has, to this point, chosen 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.

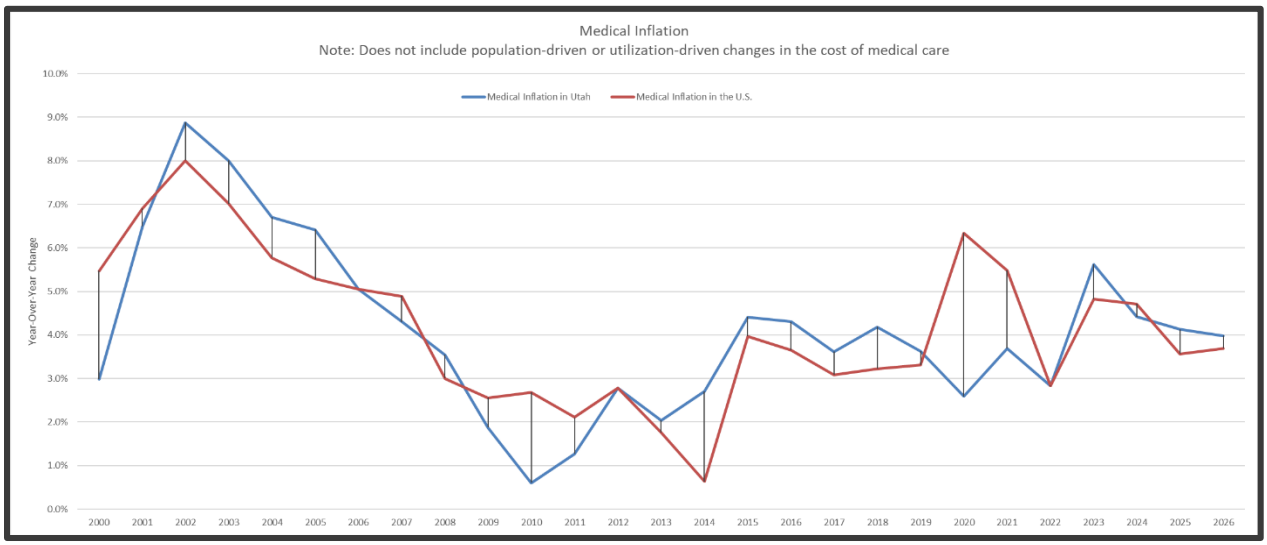
What Must Be Included in the Base Budget?

There is $8.2 million ongoing General Fund in FY 2026 that should be included as per statute in the base budget.

1. UCA 26B-3-203 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 2026 is not known currently. The growth factor used was 3.6%. New growth rates for FY 2025 and FY 2026 will be announced as part of the December 2024 Executive Appropriations Committee meeting. The costs are included 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 $5.8 million in FY 2026.
2. *H.B. 236, Behavioral Health Amendments*, from the 2022 General Session required total mental health funding to be increased up to 2% based on General Fund growth factor

adjusted for county contribution. Increases are for mental health plans primarily run by the counties. Mental Health Funding Increases The costs are included under "Mental Health Funding Increases", which is number three on page four. As per statute, the base budget should receive additional General Fund of $1.2 million in FY 2026.

3. UCA 26B-3-202 directs that mandated program changes determined by the Department of Health and Human Services must be included in the base budget. The Department of Health and Human Services determined that Federally Qualified Health Center's Scope of Service Changes for $0.5 million on page four, COVID Vaccine Normal Match Rate Coverage Required for $20,000 on page four, Twelve Month Continuous Eligibility for Children for $0.6 million on page five, and Sunsetting the Disparity of Benefits in the Adult Expansion Population (Medicaid Reform 1115 Demonstration) for $0.1 million on page six are mandated program changes.



What is Projected Medical Inflation for Utah?

The fiscal analyst projects medical inflation for Utah at 4.1% in FY 2025 and 4.0% in FY 2026. Medical inflation is defined as the change in the price per unit. The Centers for Medicare and Medicaid Services provide medical expenditures by state and the Bureau of Labor Statistics provides medical care inflation data for the Mountain region. 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 above 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(1)(a)(iv).

What is the Ending Balance for the Medicaid Reserve Account?

The Medicaid Reduction and Budget Stabilization Restricted Account is used as a reserve account for Medicaid. Below is a description and the uncommitted ending balance as of FY 2024:

1. Medicaid Reduction and Budget Stabilization Restricted Account with $219.8 million – The account receives a portion of General Fund revenue surplus if Medicaid expenditure growth is less than 8% and any unspent Medicaid funds at year end. As per UCA 63J-1-315(8) the only approved uses for the fund are:
   (a) for the Medicaid program; and
   (b) (i) if Medicaid program expenditures for the fiscal year for which the appropriation is made are estimated to be 108% or more of Medicaid program expenditures for the previous year; or
   (ii) if the amount of the appropriation is equal to or less than the balance in the Medicaid Growth Reduction and Budget Stabilization Account that comprises deposits described in Subsections (3)(a)(ii) through (v) and appropriations described in Subsection (3)(b).
   a. Based on the current consensus forecast, this fund could not be used in FY 2025 nor FY 2026 under the scenario described in subsection (b)(i) above.

What Assumptions Changed From the Prior Consensus?

1. Delivery cost adjustment – this year the cost of deliveries was removed from the per member per month calculation to account for the ten additional months of post-partum coverage beginning January 2024. The estimate includes a forecast of delivery costs that matches FY 2024 with only adjustment for federal medical assistance percentage rate changes included in the totals for "Federal medical assistance percentage" on page two.

2. Caseload and Match Rate Changes in Behavioral Health on page three as a funding item has been added for the first time this year. In prior years only costs associated with medical expenses were included.

3. As per https://le.utah.gov/~2024/bills/static/HB0051.html, the Medicaid Expansion Fund is now the Medicaid ACA Fund.

4. Federal medical assistance percentage capturing full cost of change – for the first time this year, CHIP and Medicaid Expansion consensus includes the three months of the change in the federal match rate for the three months after the two forecasted fiscal years. This is consistent with how other mid-year changes are accounted for in consensus where a full ongoing fiscal year cost is estimated paired with a one-time offset to account for starting dates after the beginning of the fiscal year. Last year the team added this to traditional Medicaid costs.