Governor's Office of Planning and Budget
Office of the Legislative Fiscal Analyst

Medicaid Consensus Evaluation

A Report for the Department of Health and Human Services

November 2025

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EXECUTIVE SUMMARY

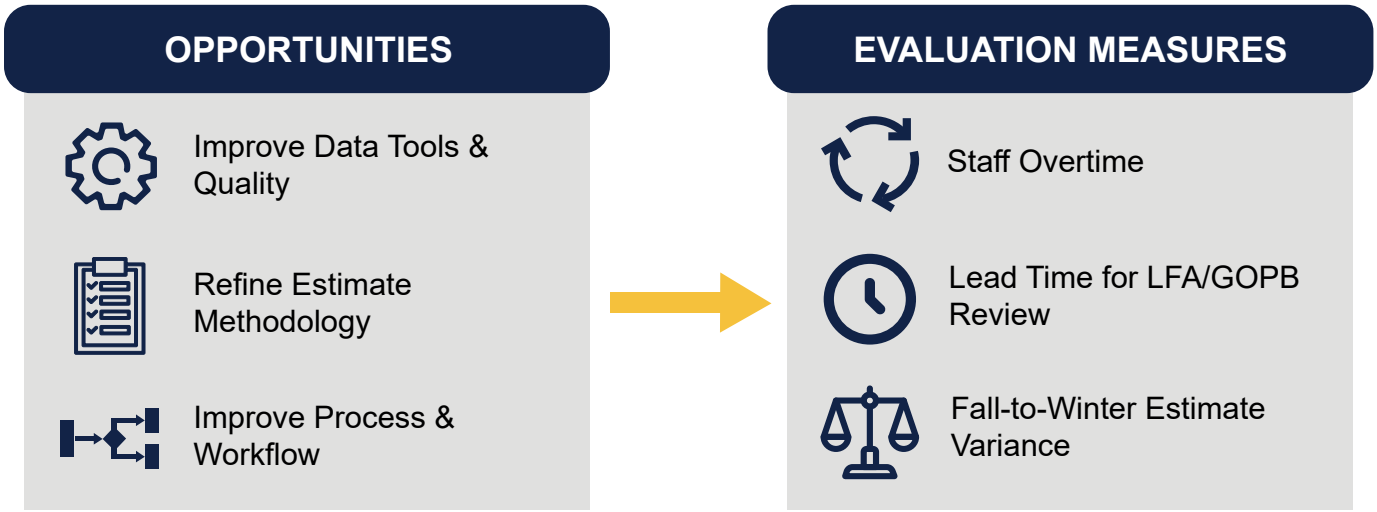
The Governor's Office of Planning & Budget (GOPB), the Office of the Legislative Fiscal Analyst (LFA), and the Department of Health and Human Services (DHHS) meet twice a year to estimate annual state fund expenditures for Medicaid. These estimates inform both the Governor's budget recommendations and final appropriations bills passed by the Legislature each year. The state spends a large portion of its general fund budget on Medicaid costs. Because of this the evaluation team conducted an efficiency evaluation to ensure the consensus process is as reliable and robust as possible in order to optimize the use of state funds.

Through joint analysis, GOPB, DHHS, and LFA identified specific inefficiencies that may limit policymakers' capacity to allocate and utilize state resources efficiently. The inefficiencies identified include a lack of independent accuracy checks, imbalanced use of time for data analysis, insufficient visibility into data inputs, and insufficient documentation of complex processes. This evaluation identifies opportunities to help DHHS, GOPB, and LFA create a reliable, robust, and transparent enrollment forecasting process to more effectively and efficiently forecast cost estimates. Key opportunities to implement include improving data tools and quality, refining estimate methodology, and improving process and workflow.

Finally, this report establishes a set of measures to track resulting improvements in process efficiency and output. The evaluation team supports the three offices' progress toward those improvements through implementation of the opportunities described in this report or through other methods the offices may identify.

This efficiency evaluation will be conducted in three phases:

- *Phase I:* Report on initial findings and make initial improvements for FY27 Cycle (July 2025 - February 2026).
- *Phase II:* Implementation of further improvements for FY28 Cycle (March 2026 - February 2027).
- *Phase III:* Long-term process and data improvement initiatives (March 2027 - September 2027).



INTRODUCTION

PURPOSE & SCOPE

PURPOSE
The purpose of this evaluation is to identify opportunities for improvement within Medicaid consensus to improve process efficiency and to make forecasts of annual state Medicaid spending more robust and reliable.

SCOPE
The evaluation team reviewed the Medicaid consensus process by:

- Conducting a risk assessment
- Analyzing historical data sets
- Conducting interviews with key administrators and staff members
- Reviewing current processes, policies, and procedures
- Researching Medicaid budgeting processes and best practices from other states

What is Medicaid Consensus?

Medicaid consensus is a joint forecasting process between the Department of Health and Human Services (DHHS), the Governor's Office of Planning & Budget (GOPB), and the Office of the Legislative Fiscal Analyst (LFA) that estimates annual state fund expenditures for Medicaid. These estimates inform both the Governor's budget recommendations and appropriation bills passed by the Legislature each year.

State Medicaid costs make up a significant portion of annual expenditures from the General Fund. In FY24, over 15% of General Fund and Income Tax Fund appropriations were related to Medicaid (roughly $892M in FY24).[1] Additionally, the share of Medicaid costs has shifted away from the federal government and toward the state in recent years, as the Federal Medical Assistance Percentage (FMAP) for Utah has steadily decreased (from ~70% covered by the federal government in FY16 to ~62% in FY26).[2,3]

Since the Medicaid consensus process was first implemented in 2013, the accuracy rate of estimates compared to actual expenditures stayed between -1.3% and +2.7% from 2013-2021, with a tendency toward overestimation of costs and corresponding increased appropriations (*see Figure 1 on next page*). From a statewide budgeting perspective, accuracy is key and has been an ongoing concern. While underestimation may require the state to draw on reserves or buffer accounts to fund Medicaid, overestimations lead to the opportunity cost of not funding other key budget priorities. Costs that exceeded appropriations (FY17 and FY25) occurred in only

[1] https://le.utah.gov/interim/2025/pdf/00000585.pdf
[2] https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier
[3] https://www.congress.gov/crs-product/R43847

two years. The overestimations for FY22 and FY24 actuals were relatively high (4.7% and 12.2%). This was partly attributable to external economic and policy changes, as well as methodological and data quality concerns likely stemming from a data system transition. If allocating more state funds than needed to Medicaid becomes a trend, the state could miss out on opportunities to fund other budget priorities.

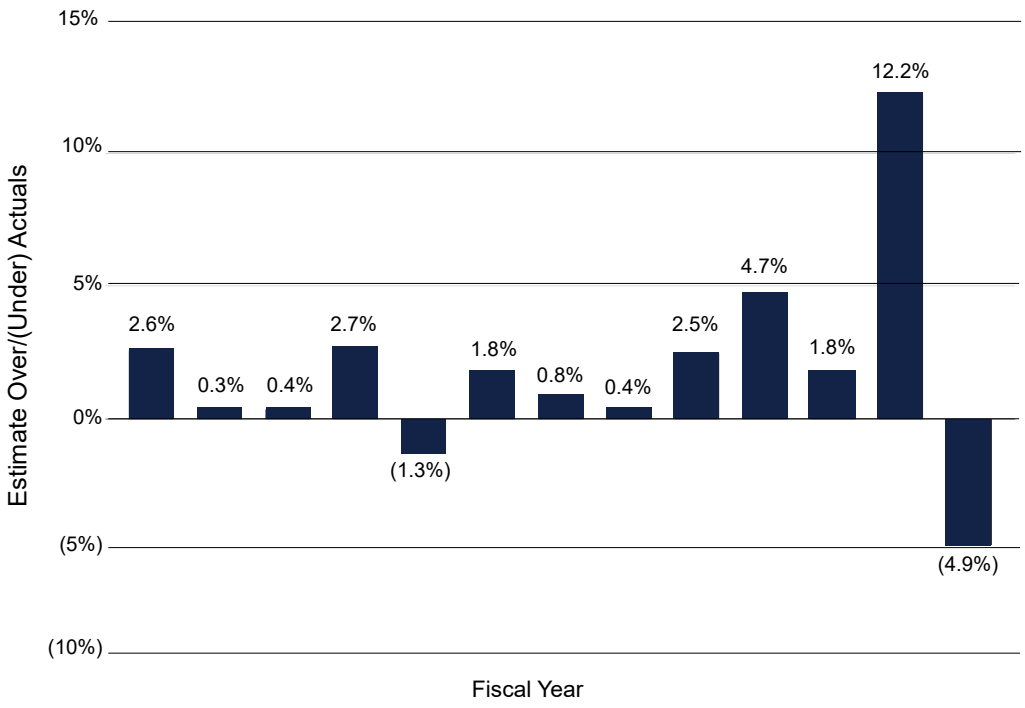
While forecasting Medicaid expenditures is a complex task and accuracy can be impacted by factors outside of forecasters' ability to predict, the state aims to make this estimate as accurate as possible by continuously improving process and methodology.[4]

GOPB, LFA, and DHHS are collaborating on this joint efficiency evaluation to ensure that the process continues to be reliable, robust, and transparent. Opportunities for improvement include improving data tools, workflows, methodology, and documentation so policymakers can optimize the use of state resources.

Summary of Evaluation Measures and Opportunities for Improvement

To ensure that this evaluation and subsequent actions are focused on measurable improvements to operations and outcomes, the evaluation team developed a set of measures for tracking and reporting (*See Table 1*). Progress on each of these measures will be reported by the participating offices. Reporting on each of these measures will begin with the current Medicaid consensus cycle that will produce estimates for FY2027.

Figure 1. Medicaid Consensus vs. Yearly Actuals: 2013-2024.[5,6]



[4] *Medicaid is considered a countercyclical program, meaning that enrollment and costs increase during economic downturns. Cost estimates may be inaccurate if an unexpected economic downturn or upswing occurs between the date of the final estimate and the end of the fiscal year (such as the downturn between FY20 and FY21 due to COVID-19). See https://www.macpac.gov/publication/a-countercyclical-medicaid-financing-adjustment-moving-towards-recommendations/*

[5] *The FY24 estimate was higher than previous years due to known data issues with PRISM implementation and unwinding continuous enrollment from the public health emergency (PHE), which wrapped up in spring 2024. DHHS has reported that the PRISM issues have been largely resolved and data quality is being monitored to ensure that similar impacts on consensus estimates are avoided.*

[6] *The error rate calculations come from the Office of the Legislative Fiscal Analyst Briefs https://le.utah.gov/lfa/publications.html?. The FY2025 number is preliminary and will be reported in an issue brief later in 2025.*

Table 1. Summary of Evaluation Measures

See Appendix for detailed descriptions, baseline value, and target value information

Icon	Title & Description	Baseline	Desired Target Direction	Reporting Timeline
	Process Measures			
	**1. Staff Overtime** Number of overtime hours worked by staff assigned to consensus.	Not currently tracked		• Twice a year • Two weeks before consensus
	**2. Lead Time for LFA/GOPB Review** Time in business days between when LFA/GOPB staff gain access to consensus estimate data, and the date of consensus meeting.	Not currently tracked		• Twice a year • Fall and Winter consensus
	**3. Fall-to-Winter Estimate Variance** Variance between initial and final consensus estimates, (excluding variance due to external economic or policy changes).	Not currently tracked		• Once a year • Winter consensus
	System & Context Measures			
	**4. Percent Error Rate for Overall Budget** Percent difference between final February estimate of Medicaid costs from state funds and budget year actuals (over/ under).	1.85% (including FY 2024) 0.98% (excluding FY2024)	 *Followed by steady state within tolerated range centered around 0% average error rate.	• Once a year • Following closeout
	**5. PRISM Data Quality** Share of cost estimate changes attributable to PRISM data quality.	Not currently tracked		• Data collection twice a year • Measured once a year • Winter Consensus
	**6. DHHS Closeout Time** # of business days between the end of the state fiscal year and DHHS closeout.	Not currently tracked	 *Followed by steady state within tolerated range.	• Once a year in September

Note: All measures will be time-limited based on implementation and outcomes.
Note - Measure 4: A target of an average estimate error rate of 0% could be paired with a statistical methodology for determining a sufficient buffer fund amount, such as basing the recommended amount on the confidence interval of the final estimate (see Section 2.1). Additionally, the buffer account structures and conditions for use by the agency could be updated as needed to ensure that reserve funds are quickly available in the event of underestimation. By doing so, the tendency toward overestimation could be removed from future estimate methodologies, both reducing opportunity costs for statewide budget priorities and maintaining a contingency plan for covering occasional shortfalls.

Additionally, the team identified three broad opportunities for the agencies involved to take action to improve the process (*see Table 2*).

Implementing these opportunities should enable quicker and better-informed decisions regarding cost estimates for Medicaid.

Table 2. Summary of Process Improvement Opportunities			
Opportunity 1: Improve Data Tools & Quality	**Project Phase**	**Responsible Parties**	**Pg. #**
1.1. Improve Payment Data Quality Checks.	II	All	9
1.2. Improve Consensus Spreadsheet.	I, II	LFA, GOPB	9
1.3. Develop Specialized Consensus Data Tool or Platform.	III	All	9
1.4. Establish Procedures for Communicating Methodological and Context Changes.	II	All	9
Relevant Evaluation Measures - 2,3,4,5			
Opportunity 2: Refine Estimate Methodology	**Project Phase**	**Responsible Parties**	**Pg. #**
2.1. Base Final Estimates on a True Consensus Process.	II	All	10
2.2. Include Current Year Utilization Data.	II	All	11
2.3. Prioritize Discussion Items by Impact in Consensus Meetings.	II	All	11
Relevant Evaluation Measures - 3,4			
Opportunity 3: Improve Process & Workflow	**Project Phase**	**Responsible Parties**	**Pg. #**
3.1. Streamline Bottom-Up Cost Analysis.	II	All	13
3.2. Batch Spreadsheet Data for Review.	I, II	All	13
3.3. Develop Resources for Staff Training and Process Continuity.	I, II, II	All	13
Relevant Evaluation Measures - 1,2			

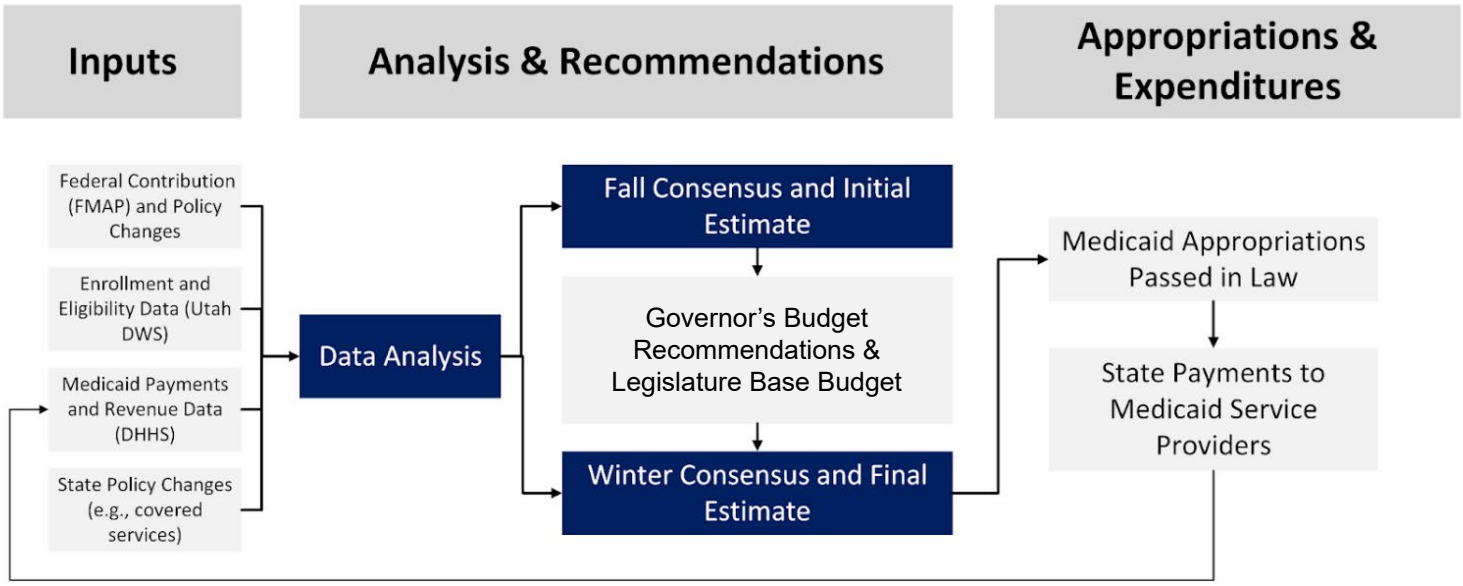
Note: Table 4 on page 15 outlines expected deliverables for each phase.

ANALYSIS OF CURRENT PROCESS

The three agencies involved in Medicaid consensus meet twice a year (typically in October and February) to estimate state Medicaid spending based on changes, such as forecasted enrollment, the FMAP, Per-Member-Per-Month costs (PMPMs), state and federal policy changes, and other factors. *Figure 2* shows a high-level summary of the inputs that factor into the calculation for Medicaid costs and the overall budgeting process.

The data analysis portion of this process is both the most crucial for accuracy and most labor-intensive part of the consensus process for DHHS, GOPB, and LFA staff. The current process involves DHHS employees obtaining, cleaning, and analyzing data based on the most recent year's actual Medicaid payments and enrollment. LFA, GOPB, and DHHS also calculate their own independent projections for the coming year's enrollments, which are presented on and reconciled in the consensus meeting. This information, along with the FMAP, Per-Member-Per-Month costs (PMPMs), state and federal policy changes, and other factors, is used to create an estimate of changes to total Medicaid expenditures for the current and upcoming fiscal years. These estimates are submitted to leadership from all three offices, who convene to determine the final projected adjustments to Medicaid funding for the current and upcoming years, including the appropriate reserve amount to safeguard against potential expenditure underestimations in the consensus forecast expenditure. These estimates inform base budget bills and the Governor's budget recommendations. Each February, the estimate is also updated prior to the end of the Legislative general session.

Figure 2. Medicaid Budgeting & Forecasting Process.



Note: The items in dark blue are the process elements being evaluated in this report.

After conducting a risk assessment, interviewing key stakeholders from all three offices, and analyzing historical data on past years' estimates, the evaluation team identified the four following inefficiencies in the Medicaid consensus process.

1. **Lack of Independent Accuracy Checks:** Currently, the estimate methodology is based on a single forecast model that is not paired with comprehensive, independent checks on the reasonableness of the estimate, increasing the risk that underlying errors go unnoticed.
2. **Imbalanced Use of Time for Data Analysis:** The consensus workflow can get slowed down by spending analysis time on items with smaller cost impacts, preventing the offices from focusing sufficient resources on analyzing higher-cost items.
3. **Insufficient Visibility into Data Inputs:** Budget staff at LFA and GOPB sometimes lack visibility into the complex payment data inputs used to develop cost estimates, reducing their ability to review data, methodology, and assumptions.
4. **Insufficient Documentation of Complex Processes:** The current process lacks sufficient documentation and training materials, potentially causing loss of institutional knowledge and process inefficiencies for staff.

Roadmap for Process Improvement Opportunities

The team identified three broad opportunities for the agencies involved to improve the Medicaid consensus process and reduce inefficiencies (*see Table 2*). Implementing these opportunities by taking the next steps outlined under each opportunity should enable the Medicaid consensus process to run smoothly and reliably, increasing accuracy, data transparency, and workflow efficiency.

Process improvements will be conducted in three phases, as follows. Phase I improvements are already completed or in progress as of the writing of this report:

- *Phase I:* Report on initial findings and make initial improvements for FY27 Cycle (July 2025 - February 2026).
- *Phase II:* Implementation of further improvements for FY28 Cycle (March 2026 - February 2027).
- *Phase III:* Long-term process and data improvement initiatives (March 2027 - September 2027).

OPPORTUNITIES

Opportunity 1: Improve Data & Quality

Discussion & Objectives

High-quality data inputs are the foundation of a successful Medicaid consensus estimate, as is the ability to effectively analyze and interpret that data. Making updates to data-related tools and processes to ensure accuracy of data inputs, increase transparency and coordination, and improve the usability of data tools can improve accuracy and efficiency.

Ensure Accuracy of Data Inputs
Up to this point, the final Medicaid consensus estimate has been produced using a shared spreadsheet tool that requires extensive manual input and complex formula calculations. This increases the risk of human error and makes it difficult to document when, why, or by whom major changes are made to estimate calculations or why large variations are occurring in calculations. Additionally, in past years as Medicaid payment data was being transitioned to a new platform, some concerns arose regarding the accuracy of the data being used for estimates. While these concerns have been largely resolved, it may still be valuable to perform some up-front data quality checks each year to ensure accuracy.

Increase Transparency & Coordination
Currently, PMPM rates are calculated separately and only final rate estimates are included in the shared spreadsheet tool. The whole consensus team could benefit from having access to more underlying data and methodology used by DHHS for calculating PMPMs. Improving visibility into PMPM estimates could greatly increase confidence in numbers as they are a primary driver of Medicaid costs.

Additionally, changes in policy or methodology that could impact the cost estimate are documented inconsistently, making it possible for these changes to go unnoticed by those involved with consensus. A consistent tracking system would ensure that all offices are aware of and able to account for impacts from state legislation, federal policy, and updates to internal methodologies.

Improve Usability of Data Tools
Key stakeholders reported that the shared spreadsheet tool referred to in joint consensus meetings and used to calculate the final estimate was in need of organizational and visual updates to improve usability and readability.

Successful Implementation of Opportunity Should Improve:


Lead Time for LFA/GOPB Review.


Fall-to-Winter Estimate Variance.


Percent Error Rate.


PRISM Data Quality.

Suggested Next Steps

1. 1. **Implement Payment Data Quality Checks (Phase I, II).** Any model used to forecast Medicaid costs must rely on accurate data on actual state Medicaid expenditures, which is now stored in a system known as the Provider Reimbursement Information System for Medicaid (PRISM). While initially reported data quality issues associated with transitioning payment data to PRISM have been addressed, the evaluation team still advises that the consensus team run standard data quality checks on payments data prior to conducting analysis. These checks could be accomplished in multiple ways, such as comparing independent checks on PRISM data to expenditures data stored in the state data warehouse, creating independent checker tools to identify common data errors, or other methods identified to ensure a foundation of high quality, reliable data.

1. 2. **Improve Consensus Spreadsheet (Phase I, II).** The shared spreadsheet tool that is currently used to produce the final Medicaid consensus estimate has been in use for several years and is in need of updates to improve readability, organization, and data entry controls. Many of the needed updates for readability and organization were made in advance of this year's fall consensus meeting. These changes concentrated on increasing the usability of the summary tab which details changes in total estimated costs. Additional updates still need to be made to reduce the number of hard-coded or copied values by using linked cells or formulas so that analysts can more easily trace the source of any given value and identify errors.

1. 3. **Develop Specialized Consensus Data Tool/Platform (Phase III).** While updates to the shared spreadsheet tool can improve the process in the short term, the evaluation team proposes that the state explore more robust technology solutions that could centralize and simplify analysis for Medicaid consensus forecasts in the future. A new platform could centralize analysis, improve visibility into underlying calculations, reduce the need for manual entry and analysis, and perform automated data quality checks. However, this is a long-term initiative that would require discussions with the state's Division of Technology Services about whether current systems could be adapted to fill this need or whether additional time and funding would be needed to develop a new tool. As such, the evaluation team recommends that while discussions and planning for such a tool should be initiated, GOPB, LFA, and DHHS should first focus on refining the consensus methodologies and process flows so that any future systems built are created around an already-efficient process.

1. 4. **Establish Procedures for Communicating Methodological and Context Changes (Phase I, II).** Procedures should be established to ensure that all three offices (DHHS, LFA, and GOPB) are operating upon shared assumptions as they create independent forecasts. For instance, if upcoming federal policy changes, legal actions, or other external circumstances are likely to impact Medicaid estimates, those items should be clearly communicated between all three offices in advance of any analysis. Additionally, any methodological changes to how shared data sources are cleaned, analyzed, or interpreted should also be coordinated up front. This coordination could take the form of a small group that meets prior to the consensus meetings to identify and discuss any such changes.

Opportunity 2: Refine Estimate Methodology

Discussion & Objectives

The three offices can implement several updates to increase methodological rigor and make estimates responsive to the state's most recent data. Given the large share of state funds dedicated to Medicaid, making continuous improvements to the estimate methodology is important for reducing risk and ensuring that the Legislature's appropriations decisions are informed by the best information available.

Increase Methodological Rigor
The current methodology for producing estimates is based on "bottom-up" calculations of each state Medicaid expense type, which are then summed into a final estimate of cost changes. This complexity and reliance on a single model introduces risks to the estimate's overall accuracy if there are errors in formulas or values, which can be difficult to detect and trace. Without an independent or external check to confirm that this detailed estimate falls within an expected range based on past spending and current economic trends, errors that lead to significant variations in the estimate may go unnoticed until relatively late in the consensus process.

Successful Implementation of Opportunity Should Improve:

Fall-to-Winter Estimate Variance.

Percent Error Rate.

Make Estimates Responsive to Most Recent Data
Medicaid is a countercyclical program, meaning enrollment typically increases in an economic downturn. Creating a system built to take into account the most recent data (such as utilization data) and related economic indicators, including data from the current year, can help more accurately forecast cost changes.

Suggested Next Steps

2. 1. **Base Final Estimates on a True Consensus Process (Phase II).** We suggest that in future cycles, that Medicaid estimates be produced using a process in which GOPB and LFA also prepare their own forecasts and then all three offices reconcile their forecasts to produce a final estimate (*see Figure 3*). Initial development of these independent forecasting models is already underway at LFA and GOPB. A true Medicaid consensus model would be similar to the state's annual revenue forecasting process, in which independent forecasts are developed by GOPB, LFA, and the State Tax Commission, then reconciled to a single estimate that is presented to the Legislature.

Introduce Multiple Independent Forecast Models
Incorporating additional independent models that reference macroeconomic trends that are correlated with Medicaid expenditures can serve as a key check of the accuracy of the detailed estimate developed by DHHS. While the DHHS estimate has been a good foundation for estimates, events such as data quality issues, the introduction of new data systems, or other human error can always pose a risk to accuracy.

Provide Estimate Confidence Interval
The consensus group should also provide a confidence interval for the final estimate

that can be used as a logical starting point for calculating the size of "buffer" or reserve funds set aside for cost coverages. While the conditions in which those reserves are used are a policy and budgeting question that must be addressed by decision makers in the legislative and executive branches, introducing a more systematic method for determining the size of those reserves may be a useful improvement and may help free up additional state funds if the state can be confident that Medicaid expenditures are statistically unlikely to exceed a certain threshold in a given year.

Allocate Time for Separate Forecasting Reconciliation Meeting

We suggest that this methodological change be paired with the addition of a standalone meeting in the consensus schedule, in which analysts from all three offices can compare and reconcile their independent enrollment and PMPM forecasts.

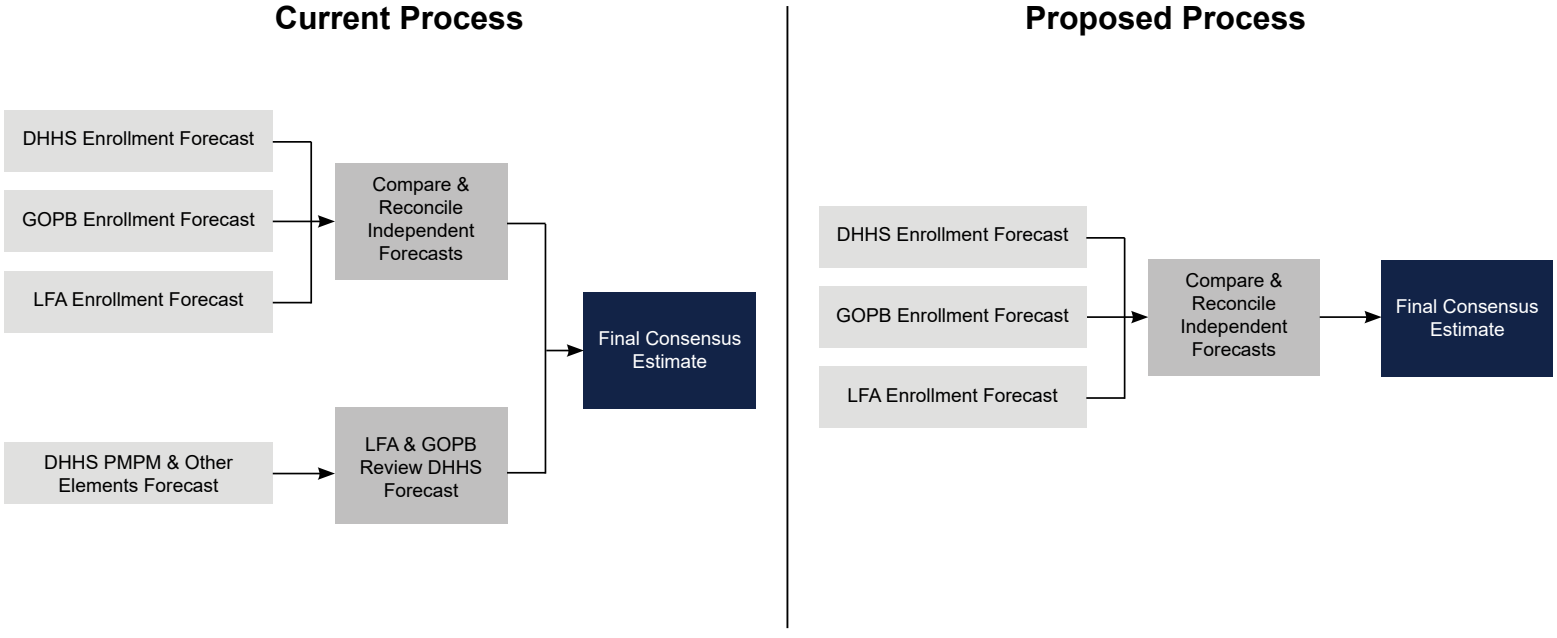
2.2. Include Current Year Utilization Data (Phase I, II).

In past cycles, the consensus estimate has relied upon the prior year's data to predict trends in enrollment, utilization, and payments. In future cycles, the estimate methodology should be updated to consider data from the current fiscal year to more accurately capture any changes in these trends (e.g., the February update to the consensus estimate could include data from the first half of the fiscal year in July-December).

2.3. Prioritize Discussion Items by Impact in Consensus Meetings (Phase I, II).

To most effectively use time during the joint consensus meetings, all three offices should prioritize discussions around items that have the largest cost impacts or the greatest variability from year to year.

Figure 3. Current and Proposed Process for Estimate Forecasting.



Note: The current process includes an opportunity for all three offices to produce independent forecasts for enrollment counts, but not for per-member-per-month (PMPM) estimates.

Opportunity 3: Improve Process & Workflow

Discussion & Objectives

In addition to methodological changes, the process is also in need of some updates to make Medicaid consensus workflows more efficient, and to preserve process continuity and institutional knowledge for future cycles. As several of these next steps are specific to the work currently done at DHHS, Office of Innovation, we suggest that DHHS draw upon their expertise for support in making process and documentation updates.

Make Analysis Workflows More Efficient

The evaluation team found that the time spent calculating the cost for certain elements included in the final consensus estimate does not always correspond with the relative magnitude of those elements' impact on the total estimate amount. For example, DHHS reported to our team that two to three days are typically spent on calculating PMPM rates, one of the largest contributing factors to annual changes in Medicaid costs.[6] In contrast, up to two to three weeks are spent on data analysis for many other elements that result in much smaller net impacts on estimated costs.[7] If this analysis work can be streamlined, all three offices will have more time to review data, check for errors, and gain confidence in estimates leading up to the final consensus meeting.[8]

Our analysis found that of the unique elements included in the total Medicaid cost estimate between 2023-2025, about 29 elements per year were less than $100,000 in value, for net impacts ranging between -$187,791 and $718,290 (*see Table 3*). Given that total state appropriations for Medicaid are hundreds of millions of dollars each year, the time taken to calculate these numbers may be used better for more in-depth analysis of larger true cost change drivers of Medicaid costs. The consensus teams from the three offices should continue discussions about a materiality threshold to ensure that it contemplates the financial and nonfinancial context for each item.

Preserve Process Continuity and Institutional Knowledge

Much of the institutional knowledge around Medicaid consensus processes and methodologies

Table 3. Medicaid Consensus Elements by Amount Threshold and Net Impact, 2023-2025.[9]

	Count of Unique Elements			Net Impact		
Threshold (Less than or Equal To)	2023	2024	2025	2023	2024	2025
$0 - $100K*	32	32	27	$ (187,791)	$ (75,750)	$718,290
$100K - $500K*	15	18	18	$ 2,017,350	$ 270,900	$ 2,086,546
$500K - $1M*	11	10	12	$7,032,700	$ 2,743,000	$ 10,148,107

*Note: *Absolute value–items include both increases and decreases within these ranges. The $100K-$500K and $500K-$1M ranges include values that are greater than $100K and greater than $500K, respectively. Values are the sum of all funding categories for a given item, including ongoing, one-time, and supplemental funding.*

[6] *Evaluation team interview with DHHS staff in June of 2025.*
[7] *Evaluation team's analysis of historical Medicaid consensus data.*
[8] *Risk assessment responses from LFA and GOPB.*
[9] *Analysis of historic Medicaid consensus summary data, FY2023-FY2025 consensus cycles.*

is held by a small group of experienced employees. This lack of documentation can reduce efficiency when training employees who are assisting with Medicaid consensus for the first time and also poses a risk to process integrity if key information is lost with employee or assignment turnover.

Each office has started documenting the consensus process through desk aids (DHHS), dashboards (GOPB), and training documents (LFA). While these are great starts, more can be done to align documentation across the three offices and to ensure that the process is clear and understandable to any employee who joins the consensus team.

Successful Implementation of Opportunity Should Improve:

Staff Overtime.

Fall-to-Winter Estimate Variance.

Suggested Next Steps

3. 1. Streamline Bottom-Up Cost Analysis (Phase I, II). As discussed above, our team identified that many of the cost change items included in past years' consensus estimates are less than +/- $100,000. Taken together, these items often result in net impacts to the final estimate of less than $1M, which represents less than 1% of the total annual appropriations. To reduce this burden of analysis that does not result in significant gains in accuracy, some of these small-value items could be excluded from the detailed bottom-up estimate. Time-intensive analysis should be focused on improving accuracy for the primary cost change drivers, such as PMPM values, or other items with high expenditures or high variability.

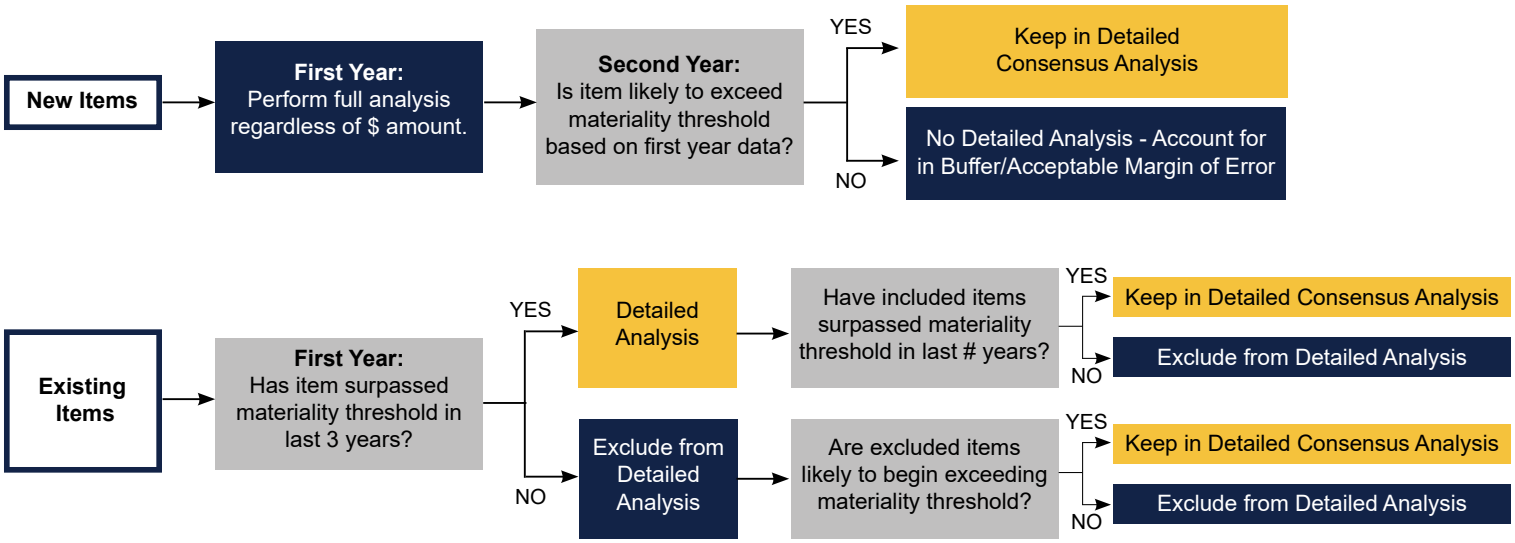
The offices could establish a materiality threshold to guide the consensus team on when to remove or include certain items from detailed analysis (*see Figure 4 for an example process*). This streamlining would not only reduce the burden on DHHS employees, but would also simplify the amount of data that GOPB and LFA analysts need to examine and interpret leading up to the joint consensus meeting each fall. A list of the smaller items that fall below the materiality threshold should still be maintained for continuity.

3. 2. Batch Spreadsheet Data for Review (Phase I, II). In past years, DHHS has finalized its analysis in the shared consensus spreadsheet tool (including supporting calculations on a large number of "backup tabs") and then notified GOPB and LFA when all of the analysis is completed. To help spread out the workload for GOPB and LFA analysts to review this data ahead of the consensus meeting, DHHS could notify GOPB and LFA as smaller "batches" of data are completed, when possible. (Note that as the broader forecasting process moves toward a true consensus process in which offices develop independent forecasts, GOPB and LFA analysts may have less need to conduct in-depth review of these detailed analyses from DHHS and this process change may become less relevant).

3. 3. Develop Resources for Staff Training and Process Continuity (Phase I, II, III). To address the documentation challenges discussed in the findings section above and to preserve institutional knowledge for this key budget forecasting process, GOPB, LFA, and DHHS should collaborate to create a shared Medicaid consensus

process continuity plan. This plan could include documentation such as process maps, standard operating practices (SOPs) for analysis tasks, a glossary, FAQs, etc. Additionally, each office on an individual basis should make its own arrangements to train additional staff to be involved in Medicaid consensus and to delegate tasks away from senior staff where possible. By increasing the pool of individuals who are familiar with the process in each office, they can reduce the risk of losing institutional knowledge and operational efficiencies over time due to limited capacity or employee turnover.

Figure 4. Potential Decision Chart for Including or Excluding Cost Items in Consensus Estimate.



CONCLUSION & NEXT STEPS

DHHS, GOPB, and LFA have already begun their efforts to improve the Medicaid consensus process within their offices to create a clearer, more reliable workflow and cost estimate for the state budget. The three offices should continue working together towards the opportunities provided in this report while reporting on metrics for the evaluation.

Enhancing the consensus workflow and outcomes is the primary objective for this efficiency evaluation. If the offices identify different approaches to improving these target outcomes and the evaluation metrics set in this report, they have the autonomy to pursue alternative solutions. As Phases II and III of this initiative begin and more detailed products and process improvements are developed, this Phase I report will be followed by additional updates as necessary.

Deliverables Expected

Table 4 outlines expected deliverables for all phases of the initiative to enhance the Medicaid consensus cycle.

Table 4. Deliverables Expected.

Phase	Fiscal Year/Cycle	Deliverables Expected
Phase I, II	FY2027-FY2028 Consensus Cycle	• Updated consensus spreadsheet tool • Efficiency evaluation report (this document) • Medicaid Consensus Manual for all three offices containing continuity plans, training plans, standard operating procedures, process maps, glossary, FAQ's, etc. • Description of procedure for coordinating methodological and context changes • Independent forecasting models developed by both LFA and GOPB • Description of method for calculating estimate confidence interval • Updated consensus meeting schedule • Description of methodological changes to include current year utilization data • Decision tree or other description of process to streamline small-item cost analysis • Description of methods proposed to conduct regular PRISM data quality checks
Phase III	FY2029 and Subsequent Consensus Cycles	• Specialized consensus data and analysis platform (additional discussions to come)

APPENDIX

Overview of Efficiency Evaluation Process and Mandate

The Governor's Office of Planning and Budget (GOPB) and the Office of the Legislative Fiscal Analyst (LFA) are directed in UCA 63J-1-904 to "jointly operate a process to identify and prioritize government processes to target for efficiency improvements." To fulfill this directive, GOPB and LFA operate a joint evaluation team to select government processes and conduct reviews. Following the joint team's report and time for the responsible agency to implement process improvements, progress is independently reviewed and verified by the Office of the Legislative Auditor General (OLAG).

In the 2025 General Session, H.B. 317 Executive Agency Innovation Incentives updated the statutory requirements in 63J-1-904 to specify that each efficiency improvement process should address "metrics demonstrating success, including: (i) service delivery savings; (ii) cost-savings; or (iii) time-savings" and "rewards, recognitions, or incentives" for agencies implementing efficiency improvements. Reviewed agencies are also allowed to request that cost-savings resulting from efficiency improvements be retained as non-lapsing funds and be used for employee retention or employee performance incentives.

Methodology

Risk Assessment

The evaluation team conducted three separate interviews with DHHS, GOPB, and LFA discussing roles, potential risks, and confidences in the Medicaid consensus process. After each office completed the risk assessment interview the evaluation team compiled themes from the discussions and sent out a survey to each office to rate the severity of risk and provide an explanation. Those responses were gathered and compiled into one document showing the high risk factors of each theme of risk. The team then used the survey responses to guide development of the opportunities and next steps identified in this report.

Historical Data Review

Data from the past three years' Medicaid consensus estimates (FY2023-FY2025), as found on the shared Medicaid-CHIP consensus spreadsheet summary section, was compiled and analyzed to identify trends in the type, amount, and variability of unique elements considered in the final consensus estimate.

Interviews

The evaluation team conducted interviews with DHHS, GOPB, and LFA staff as needed to gather information on the purpose, history, and evolution of the current Medicaid consensus process.

AUTHORS

This report was written as part of a joint collaboration between the Utah Governor's Office of Planning and Budget and the Office of the Legislative Fiscal Analyst.

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