Ohio Senate
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Committees:
Joint Medicaid Oversight Committee, *Chair*
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Finance
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Dave Burke
State Senator
26th District

November 20, 2014

Dear Colleagues:

In accordance with Section 103.414 of the Revised Code, I respectfully submit this report from the Joint Medicaid Oversight Committee on the projected medical inflation rate for the Medicaid program for the upcoming biennium.

Because of the entitlement nature of the program, Ohio has limited ability to impact the number of people enrolled in the program. But through JMOC, we are increasing the focus on per capita spending to better understand where program dollars are being spent and what health outcomes are being achieved. It is our goal to use this information to both increase the value of the state's investment in its largest program and to lower the growth in program costs to a sustainable level.

The submission of this report marks the committee's first official step towards the development of better tools and information to increase legislative engagement in Medicaid policy. This is an open hand from the legislature to the administration to start working together on Medicaid policies that improve health outcomes and care for the Medicaid population, while bending the cost curve.

Sincerely,

Senator Dave Burke
Chair, Joint Medicaid Oversight Committee

JMOC Report on Projected Medical Inflation for Medicaid Program

The Joint Medicaid Oversight Committee (JMOC) has reviewed and accepted the preliminary recommended ranges for the medical inflation rate for the FY 2016-2017 biennium from its contracted actuary.

Under its statutory requirements, JMOC worked with Optumas, an outside actuarial firm, to develop a projected medical inflation rate for the Medicaid program for the upcoming biennium. The actuary rate includes the cost, on a per capita or per member per month (PMPM) basis, of continuing current Medicaid policy into the next biennium. As part of their analysis, the actuary assessed the impact of trend factors on utilization and unit cost. The preliminary estimates from Optumas are included in the table below.

Preliminary Estimates: Estimated Growth in Aggregate Medicaid PMPM Costs (October 2014)

State Fiscal Year	Lower Bound PMPM	Upper Bound PMPM	Lower Bound Growth Rate	Upper Bound Growth Rate
2014 Actual	$609	$609		
2015 Estimate	$628	$628	3.1%	3.1%
2016 Projection	$638	$647	1.6%	2.9%
2017 Projection	$652	$675	2.2%	4.5%

JMOC uses the three-year average CPI rate for medical services for the Midwest region as a benchmark for growth in the Medicaid program. The most recent three-year average CPI rate is 3.3 percent.

Under Section 5162.70, the Medicaid director must limit growth in the Medicaid program for the upcoming biennium across all Medicaid recipients on a monthly per capita basis (commonly referred to as PMPM) to the lower of the JMOC rate or the three-year average Consumer Price Index (CPI) for medical services. Given these parameters, the Medicaid director must limit growth in monthly member costs, *across the entire program*, to 2.9 percent in FY 2016 and 3.3 percent in FY 2017.

Background

The Office of Health Transformation has restructured Medicaid spending across all agencies to develop a Medicaid budget that can be tracked over time. To provide greater insight into cost drivers for legislators, this report goes a step further and calculates monthly per capita costs across the entire Medicaid program. Per capita spending, or the amount spent per Medicaid enrollee, adjusts for the fact

that increased Medicaid spending is due to the fact that more people are enrolled. Both measures are important and provide additional context about Medicaid spending over time.

Traditionally, Medicaid spending has been segregated by managing agency (Departments of Medicaid, Aging, Developmental Disabilities, Mental Health and Addiction Services, Health, and Education). Every two years, the administration and the Legislative Service Commission prepare forecasts of spending under current policy for the portion of the Medicaid program under the direct management of the Department of Medicaid as part of the development of the state's biennial budget. These forecasts estimate spending on a budgetary basis and include estimates of caseload as well as cost trends. Forecasts are prepared for the introduction of the budget and for conference committee deliberations. The addition of the JMOC rate does not duplicate or replace these forecasts.

The goal of the JMOC rate is to provide a growth target for the administration's Medicaid budget. There are numerous policies that can be implemented to change this trend. It is through the JMOC process that the General Assembly will gain additional insight into underlying program cost drivers to help craft the policies that are necessary to improve health outcomes and to bend the cost curve.

Next Steps

JMOC's actuary, Optumas, will be using more up-to-date and detailed claims-level data to develop more refined per capita costs by population and service.

The longer term goal at JMOC is to be able to assess per capita spending by population, rather than by service; assess quality and health outcomes against benchmarks; and make comparisons over time and against other states to assess performance.

November 14, 2014

Ms. Susan Ackerman
Executive Director
Joint Medicaid Oversight Committee
77 S. High Street, Concourse Level
Columbus, OH 43215
(614) 644-2016

Subject: **Ohio JMOC SFY 2016-2017 Medicaid Budget Projections – Iteration 1**

Dear Susan:

Thank you for the opportunity to assist the Joint Medicaid Oversight Committee with the development of the first iteration of preliminary Medicaid budget projections for the SFY 2016-2017 biennium. It was a pleasure to work with your team throughout this project. The following report summarizes the methodology for the development of the SFY 2016-2017 biennial projections. Please call myself at (480) 588-2499 x105 or Zach at (480) 588-2495 if you have any questions.

Sincerely,

Barry Jordan
Actuarial Consultant

Zachary Aters, ASA, MAAA
Senior Actuary

CC: Steve Schramm, **Optumas**
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Ohio Joint Medicaid Oversight Committee

State Fiscal Years 2016-2017 Biennial Projections – Iteration 1 Report

State of Ohio

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1. Executive Summary

Per ORC Section 103.414, the Ohio Joint Medicaid Oversight Committee (JMOC) must contract with an actuary to determine the projected medical inflation rate for the Ohio Medicaid program for the State Fiscal Year (SFY) 2016-2017 Biennium. Through a competitive procurement process, JMOC contracted with **Optumas** as its consulting actuary for this analysis. The estimated SFY 2016-2017 inflation rate has been developed as a range of projected rates of growth, calculated on a per-member per-month (PMPM) basis, for the entire Medicaid program. Due to the amount of change in the Ohio Medicaid program over the last twelve months, JMOC and **Optumas** agreed that it would be most helpful to JMOC to provide two iterations of the projected growth rate ranges, with each iteration becoming more refined as the level of detail of each data source becomes greater and more robust between now and the end of 2014. As a result, the second, more detailed iteration is anticipated to be available in February 2015.

The PMPM projections are based on summarized data sources acquired from the Ohio Department of Medicaid (ODM), and are projected at various levels of detail; the level of detail in the **Optumas** projection categories are intended to mirror the current projection categories that are developed by ODM. By combining the various projections using a constant population mix from SFY 2015, **Optumas** was able to calculate a program-wide PMPM on a standardized basis to project the rate of increase of the Medicaid program over time.

During the first iteration, **Optumas** developed a range of projected PMPM growth, which is summarized in Figure 1, below.

Figure 1. Projected Rates of Growth

SFY	Lower Bound	Upper Bound	2012-2014 Average Midwest Medical CPI
2016	1.6%	2.9%	3.3%
2017	2.2%	4.5%	3.3%

The projected growth from **Optumas'** SFY 2015 projected midpoint to SFY 2016 is estimated to be between 1.6% and 2.9%. The projected rate of growth from SFY 2016 to SFY 2017 is projected to be between 2.2% and 4.5%. Per the statute, JMOC has the option to select a growth rate that falls within its actuary's projection, or develop its own medical inflation rate with JMOC's selected growth rate benchmarked against the three year average Medical CPI. The three year average Medical CPI for the Midwest is 3.3%, based on the Bureau of Labor Statistics' published Medical CPI from 2012-2014.

Please note that, as part of our peer review process, it was found that **Optumas'** preliminary SFY 2015 estimates were slightly over-stated. As a result, the numbers shown in Figure 1 above will vary slightly from the preliminary figures presented on October 16th, 2014.

This report presents, in five sections, the process used to develop the first iteration of projections for the SFY 2016-2017 biennium. The five sections are described in Figure 2, below.

Figure 2. Report Structure

Section	Contents
Background	Provides a description of **Optumas'** role in developing PMPM projections for the SFY 2016-2017 Ohio biennium.
Data	An overview of the data used when developing the projections, including data sources, limitations, and adjustments.
Trend	Provides a description of trend and the process used to develop trend for the SFY 2016-2017 biennium.
Projection Summary	Provides summarized results of the first iteration of SFY 2016-2017 projected PMPM growth.
Appendices	Detailed tables showing results of data summaries, analyses, and assumptions used in the projection summary methodology.

2. Background

Per ORC Section 103.414, JMOC must contract with an actuary to determine the projected inflation rate for the Ohio Medicaid program for the SFY 2016-2017 Biennium. As JMOC's contracted consulting actuary, **Optumas** has developed the SFY 2016-2017 estimated inflation rate as a range of projected rates of growth on a per-member per-month (PMPM) basis for the entire Ohio Medicaid program.

The Ohio Medicaid PMPM in its most simplified form is calculated as total dollar expenditures divided by total eligible member months. This puts costs on a standardized, or normalized, basis and is a way to measure costs relative to each member rather than on a total expenditure basis. Growth in total expenditures can be influenced purely by an increase in membership, even with all else being equal and costs per person remaining constant. Since enrollment growth is an external factor that Medicaid has very limited control over, **Optumas** has worked with JMOC to focus on projecting a rate of growth specific to a rate of change on a per member basis; in other words, a rate of change in PMPM expenditures over time. The PMPM growth rate developed by **Optumas** will be benchmarked against the three year weighted average of the Midwest Medical CPI, and will be utilized as a comparison to the projected rate of growth in ODM's upcoming biennial budget for certain key portions of Ohio's Medicaid program.

To ensure a comprehensive review of the various factors that contribute to spend within a Medicaid program, **Optumas** has identified the following four key cost drivers, or determinants of risk:

- Program Design – How the program is operationalized
- Population – Who receives the services
- Benefits – What services are offered through the program
- Network – What services are provided in the service delivery network

Each of these determinants of risk can significantly impact both the total dollar and the PMPM spend of the Ohio Medicaid program. The following describes some of the ways that these changes could materialize:

- **Program Design –**
  Changes in program design can impact spend for all populations, or for a specific population(s). A program-wide shift could mean a change in how all populations' eligibility is determined, which could impact total costs. A change for a particular population's eligibility process could exclude one sub-population, resulting in a material change to the entire population's risk profile.
- **Population –**
  Changes in the populations that actually are enrolled in Medicaid managed care programs can impact the program-wide spend. To the extent that a new population enroll and, in general, this population is healthier and cheaper than the average member of the current program, this would drive the overall PMPM cost of the program down. Additionally, this could have the opposite effect if the new population is much more expensive than the previously enrolled population.
- **Benefits –**
  Changes in benefits offered through the program can have an impact to the total PMPM of the program. If a new service is introduced into the Medicaid program, this could increase the overall spend of the program since additional costs would be incurred. However, if these new

services are intended to be preventive in nature, over time this could materialize in overall savings to the program.

- **Network –**
  Changes in the service delivery network can impact the overall spend in various ways. One way this could materialize is through improved networks that include better provider coordination. To the extent that a provider network is able to work together to provide services to enrollees, this could improve the overall care of Medicaid enrollees and in turn, result in reduced costs to the program.

We consider each of these risk determinants to evaluate the source data provided by ODM and make adjustments to data as necessary to ensure it can be used to develop accurate projections of cost on a PMPM basis. The PMPM projections are based on summarized data sources acquired from ODM, projected at various levels of detail that are intended to mirror the current projection categories that are developed by the Ohio Department of Medicaid. Once each projection category has been developed, they are used to calculate a program-wide PMPM projection. Please see Appendix I.A. for a list of projection categories included in this analysis.

As part of the biennial projection, **Optumas** developed a base data set from the historical expenditure data and projected that base data using trends specifically developed for each projection category. For this initial iteration, the underlying detailed claims data for Ohio's Medicaid managed care populations was not available. As a result, projections for the managed care populations were developed based on capitation rates and trend developed by ODM's actuary. While **Optumas** did develop trend for the FFS expenditures, please note that the FFS expenditures available for the first iteration are very high-level and provided on a monthly basis, by projection category. For additional detail on data sources used in the first iteration of projections, please see section 3.01 of this report.

Projected PMPMs include total Medicaid spend, with expenses not tied directly to a member being excluded. The excluded expenses are:

- All-Agency State Administration,
- Hospital Care Assurance Program (HCAP),
- Hospital Upper Payment Limit (UPL), and
- Managed Care Pay for Performance.

In addition, to ensure the projected rates of growth are comparable over time, one-time spending has been removed from projections, which for this iteration are the ACA Enhanced Provider Payments and the Health Insurance Provider Fee.

The projected PMPMs and rate of growth will be developed in two iterations. The projections completed in October 2014 are the first of the two iterations. **Optumas** is working with JMOC and ODM to obtain detailed claims-level data, which will be used to refine the second iteration of this process. The second iteration of biennial projections will focus on developing PMPM estimates that are more detailed and population-specific. Based on the current timeline, these more detailed estimates which make up the second iteration are set to be developed and presented by February 2015.

3. Data

3.01 Sources

Optumas utilized multiple data sources to develop a comprehensive base data set as the starting point to project each service category. The available data sources each had limitations which impacted the level of detail of the biennial projections for the first iteration. Member-level and category of aid-level information was not available for this analysis, which resulted in projections that are a mix of both category of service and population-specific numbers. This limits **Optumas'** ability to project how the mix of membership impacts the program-wide PMPM expenditures. In order to refine this process, **Optumas** is working with JMOC and ODM to receive detailed claims and encounter data, so that the next iteration of the SFY 2016-2017 projections will include PMPM projections specific to population groups.

The following data sources were used to compile the base data for the SFY 2016-2017 biennial projections:

Ohio Projected Medicaid Expenditures SFY 2013-2015 –
The 'Ohio Projected Medicaid Expenditures SFY 2013-2015' (commonly referred to throughout Ohio government as the 'Fatbook') contains summarized historical and projected expenditure experience for SFY2012 and was used to create the SFY 2012 base for expenditures delivered through the fee-for-service (FFS) delivery system. To streamline the development of the base data set, **Optumas** received the Excel-based summarized database that feeds into the Fatbook. This database contains summarized expenditure and membership volume for all Medicaid populations; expenditures for the time period during, or prior to, November 2012 are based on actual incurred expenditures, while expenditures after November 2012 are based on ODM's projections.

Monthly Medicaid Variance Reports –
The monthly Medicaid Variance Reports were used to create the SFY 2013 – SFY 2014 base for FFS expenditures. These reports capture monthly expenditures at the aggregate category of service level, reported on a month of payment basis. For example, all costs associated with FFS Inpatient Hospital claims are reported as one number each month. As these expenditures are done on a paid basis, a lag adjustment has been applied to these expenditures to convert them to an incurred basis. These estimated incurred expenditures were used to project costs across all non-managed care populations.

Ohio Department of Medicaid Caseload Reports –
The Ohio Department of Medicaid Caseload Reports, reported with enrollment through August 2014, were used as the denominator to calculate the PMPM for the base data. Additionally, ODM provided revised SFY 2015 membership projections, which were used to blend the PMPM projections for each category into a program-wide PMPM projection.

Managed Care Certification Letters –
Calendar Year (CY) 2014 and draft 2015 managed care certification letters, their corresponding capitation rates, and SFY 2015 membership projections were used to develop the SFY 2015

PMPM projection. Summarized data included in the draft CY 2015 managed care certification letters and the subsequent rates were used as the base to project forward to the SFY 2016-2017 biennium, which included PMPM costs summarized by rating cohort, region, and category of service summarized on an annual basis.

3.02 Base Data Adjustments

Population Adjustments

In order to project base data into a future time period, historical data needs to be adjusted to reflect any policy and program changes that have occurred between the base data period and the projection period. In the instance that program changes impact certain populations after the base data has been incurred (e.g. populations changing from a FFS delivery system to a managed care delivery system), adjustments to the base data would be required. Additionally, in the case of certain populations only receiving a limited benefit package, membership for these members should not be considered when calculating a PMPM for a service that is excluded from their benefit package. For example, if a population does not receive Inpatient Hospital services through Medicaid, the inclusion of this population's membership when developing an Inpatient Hospital PMPM would skew the true PMPM cost for this service.

The projections for the SFY 2016-2017 biennium are intended to reflect current policy within the Medicaid program. The base data includes expenditures for services incurred dating back to July 1, 2011; since several populations have transitioned into different medical delivery systems since the beginning of the base data, adjustments have been made to reflect these changes. The following adjustments have been made to reflect population changes:

ABD Kids Transition –
Prior to July 1, 2013, all members within the ABD Kids eligibility group received services through the FFS delivery system. Beginning July 1, 2013, the ABD Kids eligibility group began receiving care under ODM's managed care program. Since the base data used for the SFY2016-2017 biennium projections includes data prior to July 1, 2013, FFS expenditures prior to this date include costs for ABD Kids. As the majority of these costs will now be incurred through the managed care program, an adjustment has been made to both the costs and membership volume associated with the FFS categories of service prior to July 1, 2013 to remove costs associated with the ABD Kids population that transitioned to managed care. Included in the managed care certification letters is ABD Kids base data, summarized at a category of aid and category of service level. To estimate the costs associated with the ABD Kids for each category of service, **Optumas** utilized the data for the ABD Kids included within the certification letter. Behavioral health services for this population remain outside of the managed care program, therefore no adjustment is necessary to the behavioral health category of service.

ABD Adults Adjustment –
ABD Adults have been enrolled in managed care throughout the duration of the base data used in the projection period (July 1, 2011 and forward). However, beginning in September 2013, a

greater proportion of the ABD Adult population began enrolling into managed care, compared to FFS. As a result, an adjustment has been made to both the costs and underlying membership of the FFS categories of service, to reflect that a portion of these costs will be experienced in the managed care program moving forward. Included in the managed care certification letters is ABD Adult base data, summarized at a category of aid and category of service level. To estimate the costs associated with the ABD Adults for each category of service, **Optumas** utilized the data for the ABD Adults included within the certification letter. Since behavioral health services for this population remain outside of the managed care program, no adjustment is necessary to the behavioral health category of service.

MyCare Implementation –
Beginning in May 2014, certain members that are dually-eligible for both Medicaid and Medicare (Duals) began enrollment into Ohio's MyCare managed care program. Since Duals that enroll into the MyCare program will receive their services through managed care moving forward, an adjustment has been made to reflect the costs and membership leaving the FFS environment and entering managed care. Included in the managed care certification letters is the Dual population's base data, summarized at a category of aid and category of service level. To estimate the costs associated with the Duals transitioning into MyCare for each category of service, **Optumas** utilized the data for the MyCare managed care program included within the certification letter.

Family Planning Services Program –
To develop a projected PMPM cost for each projection category, both relevant costs and enrollment volume of the population eligible for these services is necessary. To the extent that populations do not incur costs within certain service categories due to ineligibility for a specific FFS category of service, the enrollment volume for that population would need to be removed in order to appropriately calculate a PMPM. Since members in the Family Planning Services program are eligible for limited benefits, enrollment volume for these members has been excluded from the PMPM calculation for the following services: Inpatient Hospital, Outpatient Hospital, and Behavioral Health/Health Homes SPMI.

Policy Change Adjustments

In addition to adjustments utilized to reflect changes in population over time, changes in policy that impact specific services require additional adjustments to the base data. For example, if a one-time 5% increase to Inpatient Hospital reimbursement occurs during the base data period, all data prior to this increase needs to be adjusted by 5% to reflect the fact that going forward, this 5% increase would be inherent in all Inpatient Hospital costs; this brings all base data expenditures up to the most current reimbursement level and avoids projecting base data that does not reflect current policy. Many policy changes have occurred since the beginning of the base data period, starting July 1, 2011. The following section includes policy changes that have been considered in the SFY 2016-2017 biennial projections. In addition to the items noted below, additional reimbursement changes have been captured as part of the trend development, which is described in Section 4.

Health Homes SPMI Benefit –
Beginning October 2012, Ohio implemented Health Homes for members with severe and persistent mental illness (SPMI). As a result of this added benefit, members who receive

services at one of these Health Homes are expected to incur greater behavioral health expenses due to increased access to care, as well as increased care management. However, it is anticipated that the additional behavioral health care that these members receive will act as a preventive measure to avoid more costly inpatient and emergency room visits that may have otherwise occurred if these members were not receiving the level of behavioral health care that they need. Consequently, a downward adjustment has been assumed for the Inpatient Hospital and Outpatient Hospital categories of service projected into the SFY 2016-2017 biennium. Additionally, as more members are anticipated to become eligible over the next few years, an additional increase in behavioral health costs, and subsequent decrease in Inpatient Hospital and Outpatient Hospital costs, has been applied.

Hospital Rate Reduction –
Effective January 1, 2014, an across-the-board rate decrease of 5% has been implemented for Inpatient hospitals; this decrease does not apply to Children's hospitals. Since detailed base data was not available for the first iteration of biennial projections, **Optumas** was unable to identify which costs were incurred at Children's hospitals; as a result, an estimate of historical Inpatient Hospital expenditures incurred by children populations was used to adjust the overall impact of the rate decrease. This resulted in a net downward adjustment of 3%. All FFS Inpatient Hospital expenditures prior to January 1, 2014 have been adjusted downward to reflect this policy change.

APR-DRG Migration –
Effective July 1, 2013, Ohio Medicaid transitioned its Inpatient Hospital reimbursement structure to reimburse on an APR-DRG basis. Since detailed Inpatient Hospital data was not available for the first iteration of projections, **Optumas** used the estimated impact of the APR-DRG transition built into the managed care capitation rates by the State's actuaries. All Inpatient Hospital base data expenditures prior to July 1, 2013 have been adjusted to reflect this change in policy.

Capital Cost Reduction –
Effective January 1, 2014, a reduction to Inpatient capital costs was made. Reimbursement of 100% of capital costs has been reduced to 85% of capital costs. Detailed data was not available to isolate the capital cost component of Inpatient Hospital expenditures; to develop an estimated impact for the capital cost reduction, **Optumas** used the impact estimated by the State's actuaries for this reduction as described in the managed care capitation rate certification letters. All Inpatient Hospital expenditures prior to January 1, 2014 have been adjusted to reflect this policy change.

Outpatient Reimbursement Decrease –
Effective January 1, 2014, a reduction for reimbursement of certain outpatient services was put into place. Detailed data was not available to isolate the specific services impacted by this reimbursement change; **Optumas** used the impact estimated by the State's actuaries for this reimbursement change as described in the managed care capitation rate certification letters. All Outpatient Hospital expenditures prior to January 1, 2014 have been adjusted to reflect this policy change.

ACA PCP Enhanced Payment Removal –
Section 1202 of the ACA states that certain evaluation and management (E & M) services and immunization administration services provided by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine will be paid at a rate no less than 100 percent of the Medicare rate beginning in January 2013. Ohio separately itemizes the amounts paid out as enhanced payment to each provider; since the State has not taken action to continue to reimburse providers at the higher payment rate after December 2014, these additional costs have been excluded from the biennial projections.

One goal of the enhanced payment is increased access to care, which typically leads to a higher rate of utilization. While the costs for the difference between Medicare and Medicaid fees have already been removed from projections, an adjustment to the base data to reflect the change in utilization rate was necessary. This adjustment was applied as follows:

1. Increase base data prior to January 2013 – As a result of higher provider reimbursement rates beginning January 2013, an increase in utilization typically ensues. While detailed base data was not available to review the induced utilization experienced due to the ACA PCP enhanced payment, experience for Medicaid programs in several other states was reviewed to develop a reasonable estimate of this impact. The assumed utilization impact due to the ACA PCP enhanced payment is a 4.5% increase. However, since the enhanced payment will cease to exist after December 2014, it is anticipated that a portion of the induced utilization will go away beginning in 2015. It is estimated that half of the induced utilization will no longer exist, which then results in a 2.25% decrease.
2. Decrease base data beginning January 2013 – As noted above, it is anticipated that a portion of the induced utilization that occurred as a result of the ACA PCP enhanced payment. Since the base data as of January 2013 is reflective of the base period which includes the higher provider reimbursement, the elimination of the enhanced payment is expected to result in a decrease in utilization. A decrease of 2.25%, as described in #1 above, has been applied to the base data for services incurred January 2013 and later.

The impact of each adjustment above can be found in Appendices I.B and I.C.:

Appendix I.B shows the impact that each adjustment has on the overall PMPM of each category by each year of base data. As this will reflect both enrollment and expenditure adjustments, an overall decrease in expenditures for a given adjustment may result in an increase in PMPM, to the extent that a particular population being removed has a lower PMPM than the average. The impact specific to expenditures can be found in Appendix I.C.

Hepatitis C Drugs and Other Biologicals –
In addition to the changes noted above, there are various emerging Hepatitis C treatments, as well as other emerging biologicals that are anticipated to result in significant additional costs for Medicaid. As experience for these biologicals is still emerging, a placeholder to reflect the additional costs of these benefits has been included as part of the FFS pharmacy spend. The placeholder amounts reflected in the biennial projections are $22.5 million, $50 million, and $60 million, for SFY 2015, SFY 2016, and SFY 2017 respectively.

4. Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the SFY 2016-2017 biennial projection period.

Since only total expenditures were available for the FFS projection categories, trend was developed on a PMPM basis. FFS trends were developed through utilization of 3, 6, and 12 month moving averages over the course of the base data period. In addition to reviewing trend inherent in the summarized base data, trend that was developed by ODM's actuary for the managed care capitation rate setting was also reviewed for the same categories of service.

For the first iteration of SFY 2016-2017 biennial projections, the underlying detailed data for Ohio's Medicaid managed care population was not available. As a result, **Optumas** used trends that were developed by ODM's actuary for the draft CY 2015 managed care capitation rates. These trends were displayed at a category of aid and category of service level, and were included in the draft CY 2015 certification letters. **Optumas** used these trend estimates to project the draft CY 2015 capitation rates into the SFY 2016-2017 biennial projection period.

Once trend has been developed, it is varied as part of the development of the projection range. The annualized upper and lower bound trend is then used to project each category from the base into SFY 2016 and SFY 2017. The base used to project each category is SFY 2014, with the following exceptions:

1. Managed Care – All managed care populations, including Group VIII, have been projected based on draft CY 2015 capitation rates.
2. DDD Services – DDD expenditures after November 2012 were only available at a monthly summarized level. Additionally, this category is one in which ODM's projections have historically come very close to its actuals (SFY 2014 actuals were within 1.6% of projections). As a result, **Optumas** and JMOC chose to utilize ODM's projected SFY 2015 DDD Services expenditures. This amount has been projected forward into the SFY 2016-2017 biennium.

The annualized trend used to project each category into the lower bound and upper bound of SFY 2016 and SFY 2017 are shown below:

Projection Category	SFY 2016		SFY 2017	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound
Nursing Facility	0.1%	0.9%	0.1%	0.9%
Dept. of Aging Waivers	0.5%	1.5%	0.5%	1.5%
Home Care Waiver (MCD)	0.5%	1.5%	0.5%	1.5%
Inpatient Hospital	2.5%	5.0%	2.5%	5.0%
Outpatient Hospital	3.5%	6.0%	3.5%	6.0%
Physician	1.6%	4.1%	1.6%	4.1%
Prescribed Drugs	3.9%	5.9%	3.9%	5.9%
Managed Care – ABD	2.6%	5.1%	2.6%	5.1%

Projection Category	SFY 2016		SFY 2017	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound
Managed Care – ABD Kids	2.2%	4.7%	2.2%	4.7%
Managed Care – MyCare	0.8%	3.3%	0.8%	3.3%
Managed Care – CFC	2.9%	5.5%	2.8%	5.3%
Behavioral Health/Health Homes SPMI	2.5%	5.0%	2.5%	5.0%
All Other	1.6%	4.1%	1.6%	4.1%
Medicare Buy In (includes QI)	3.0%	5.0%	3.0%	5.0%
Medicare Part D	2.0%	4.0%	2.0%	4.0%
Group VIII	2.9%	5.4%	2.9%	5.4%
DDD Services	2.0%	4.0%	2.0%	4.0%
Program Wide[1]	**1.6%**	**2.9%**	**2.2%**	**4.5%**

[1]The upper and lower bound trend % is calculated based on the SFY15 projected midpoint to the SFY16 and SFY17 upper and lower bounds.

The aggregate 'Program Wide' trend shown in the table above reflects the following:

- SFY 2016 – This reflects the projected rate of growth from the SFY 2015 projected midpoint to the SFY 2016 projected lower and upper bounds.
- SFY 2017 – This reflects the projected rate of growth from the projected SFY 2016 lower bound to the SFY 2017 lower bound, and the SFY 2016 upper bound to the SFY 2017 upper bound.

As exhibited in the table above, the projected growth rate assuming current policy is:

- Between 1.6% and 2.9% from the projected midpoint of SFY 2015 to SFY 2016
- Between 2.2% and 4.5% from SFY 2016 to SFY 2017

Since the benchmark being utilized by JMOC is the three year average of the Midwestern Medical CPI, **Optumas** suggests that the annual biennial trend also be considered on a multi-year basis. By reviewing the projected annual rate of growth from the projected SFY 2015 midpoint to the SFY 2016-2017 biennial period, we arrive at a projected annualized growth rate of approximately 1.9% to 3.7%. In comparison, the three year average of the Midwest CPI is approximately 3.3%, slightly below the projected rate of growth for the upper bound of the SFY 2016-2017 projections.

The trend figures developed for the first iteration of biennial projections are preliminary results based on limited data sources. While **Optumas** believes these trend figures to be reasonable estimates of what may occur during the biennial projection period, these estimates will be refined in the second iteration. As **Optumas** receives additional data with claims-level detail, trend will be reviewed at various levels, including:

1. Population
2. Category of Service
3. Utilization per 1,000
4. Unit Cost

As a result of a more detailed trend development process to be used in the second iteration, the trend figures shown in this report are subject to change when **Optumas** produces its follow-up report in February of 2015.

5. Projection Summary

To develop a range of expected growth for Ohio's Medicaid program, **Optumas** has developed projections on a PMPM basis for each of the projection categories noted in the preceding sections of this report. Since Medicaid is limited in the amount of control it has over the change in enrollment over time, a growth target based on PMPM expenditures provides a means of limiting the impact of population growth on meeting this target.

As part of **Optumas'** projection development, JMOC provided total expenditure projections developed by ODM for SFY 2015. **Optumas** used these as a benchmark to its SFY 2015 projected midpoint. While variation exists between projection categories, **Optumas'** SFY 2015 midpoint projection is very similar to ODM's projection in aggregate. **Optumas** is projecting SFY 2015 expenditures to be 2.1% lower than the aggregate projections developed by ODM; this is based on PMPMs developed by **Optumas** and SFY 2015 membership projected by ODM. The table below includes a comparison of ODM's projected SFY 2015 PMPM with **Optumas'** projected SFY 2015 midpoint PMPM. Please note that, as part of our peer review process, it was found that **Optumas'** preliminary SFY 2015 estimates were slightly over-stated. As a result, the numbers shown in the two tables below will vary slightly from the preliminary figures presented on October 16th, 2014. For a comparison of SFY 2015 expenditures by projection category, please see Appendix I.D.

SFY 2015 Comparison			
SFY	Optumas Projection	Medicaid Projection	Percent Difference
2015	$628	$642	-2.1%

Once **Optumas** benchmarked the SFY 2015 projections to ODM's projection, the next step was to compare its projected SFY 2015 midpoint to its projected SFY 2016-2017 lower and upper bound PMPMs. Lower bound and upper bound PMPMs were developed for each projection category for SFY 2016 and 2017, and then blended into a program-wide PMPM using the mix of membership inherent in ODM's SFY 2015 membership projections. The table below includes a summary of the projected SFY 2016 and 2017 PMPMs and trends on a program-wide basis. For a detailed list of PMPMs by projection category and SFY, see Appendix I.E.

Overall Projection				
	PMPM		Trend	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2016	$638	$647	1.6%	2.9%
2017	$652	$675	2.2%	4.5%

Please note that the figures included above, and in Appendix I.E should be viewed as estimates of aggregate spend across each projection category. These estimates are only intended to reflect Medicaid's share of spend for each service, and do not include member or recipient liability. For example, the Nursing Facility PMPM reflects Medicaid's share of the cost for members who reside in a Nursing Facility, but would not reflect additional service costs for which a recipient is liable to pay.

Additionally, these projection categories are a mix of both service and population-specific projections. For example, the 'Managed Care – ABD' projections should be viewed as an estimate of the managed care portion of Medicaid's spend on managed care-enrolled ABD Adults. This is inclusive of all managed care services and non-medical load included in the ABD Adult managed care capitation rates. However, the 'Inpatient Hospital' projections represent the average service cost that Medicaid pays for Inpatient Hospital services across all FFS populations eligible for this benefit. This should be viewed as an estimate of projected service costs across all FFS populations based on the SFY 2015 mix of membership. Costs for a particular service can vary greatly across different populations; these should not be used as an estimate for one particular population.

The projections noted above are indicative of target PMPM expenditures based on current policy and population mix. While the PMPM projection provides a method of normalizing for population growth over time, the change in both mix of membership and services delivered within each category above could have a significant impact on the overall program-wide PMPM.

For example, if new populations that cost less than the program average are enrolled into Medicaid, the overall spend of the program would increase. However, since the average cost of these members would be less than the current average, this would drive down the overall PMPM of the program, resulting in a lower aggregate PMPM.

As part of the process used to refine the biennial SFY 2016-2017 projections for the second iteration of our PMPM estimate for Ohio Medicaid expenditures, **Optumas** is working with JMOC and ODM to receive detailed claims-level data. This will allow for more detailed analyses of each projection category, including refinement of each of the adjustments described in the prior sections of this report. Additionally, projections will be targeted towards a more population-specific PMPM total, in order to further mitigate the impact of population mix within each projection category. Once each population-specific PMPM projection has been developed, these will again be aggregated into a program-wide PMPM estimate. These refined PMPM and trend projections can then be benchmarked to the three year average Midwestern Medical CPI of 3.3%.

6. Appendices

Appendix I.A – Projection Categories

Projection Categories	
Nursing Facility	Managed Care - MyCare
Dept. of Aging Waivers	Managed Care - CFC
Home Care Waiver (MCD)	Behavioral Health/Health Homes SPMI
Inpatient Hospital	All Other
Outpatient Hospital	Medicare Buy In (includes QI)
Physician	Medicare Part D
Prescribed Drugs	Group VIII
Managed Care - ABD	DDD Services
Managed Care - ABD Kids	

Appendix I.B – PMPM Adjustment Impacts

Inpatient Hospital - PMPM Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	0.0%	-4.3%
Family Planning	3.4%	23.1%	24.1%
ABD Kids	-1.3%	-1.7%	0.0%
ABD Adults	-3.4%	-3.7%	-2.0%
Duals	20.6%	19.4%	17.2%
Health Homes	-0.4%	-0.4%	-0.4%
Hospital Rate Reduction	-3.0%	-3.0%	-1.6%
APR-DRG Grouper	5.7%	5.7%	0.0%
Capital Cost Reduction	-1.2%	-1.2%	-0.6%

Outpatient Hospital - PMPM Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	0.1%	-3.8%
Family Planning	3.5%	23.1%	24.1%
ABD Kids	-1.4%	-2.2%	0.0%
ABD Adults	-4.5%	-5.4%	-3.2%
Duals	9.6%	6.5%	2.1%
Health Homes	-0.5%	-0.5%	-0.6%
Reimbursement Decrease	-7.2%	-7.2%	-3.9%

Physician - PMPM Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	0.2%	-2.4%
ABD Kids	0.0%	-0.8%	0.0%
ABD Adults	-3.9%	-4.1%	-2.1%
Duals	-8.7%	-12.6%	-13.9%
ACA PCP Utilization Decrease	2.3%	-0.1%	-2.3%

Prescribed Drugs - PMPM Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	-0.8%	0.5%
ABD Kids	-10.3%	-11.2%	0.0%
ABD Adults	-12.0%	-13.1%	-6.8%
Duals	23.6%	17.6%	16.5%

Behavioral Health/Health Homes SPMI - PMPM Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	6.8%	-0.7%
Family Planning	0.9%	5.6%	5.5%
Duals	-2.8%	-3.2%	-1.7%
Health Homes	12.4%	12.7%	10.3%

All Other - PMPM Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	0.5%	-1.5%
ABD Kids	1.6%	1.3%	0.0%
ABD Adults	1.2%	1.0%	0.4%
Duals	-35.4%	-24.7%	-26.5%

Appendix I.C – Total Dollar Adjustment Impacts

Inpatient Hospital - Total Dollar Impact			
Adjustment	**SFY12**	**SFY13**	**SFY14**
Lag Adjustment	0.0%	0.0%	-4.3%
Family Planning	-0.2%	-0.1%	0.0%
ABD Kids	-7.4%	-7.1%	0.0%
ABD Adults	-6.0%	-6.2%	-3.2%
Duals	-5.7%	-6.1%	-6.5%
Health Homes	-0.4%	-0.4%	-0.4%
Hospital Rate Reduction	-3.0%	-3.0%	-1.6%
APR-DRG Grouper	5.7%	5.7%	0.0%
Capital Cost Reduction	-1.2%	-1.2%	-0.6%

Outpatient Hospital - Total Dollar Impact			
Adjustment	**SFY12**	**SFY13**	**SFY14**
Lag Adjustment	0.0%	0.1%	-3.8%
Family Planning	-0.1%	-0.1%	0.0%
ABD Kids	-7.5%	-7.6%	0.0%
ABD Adults	-7.1%	-7.9%	-4.4%
Duals	-14.3%	-16.3%	-18.5%
Health Homes	-0.5%	-0.5%	-0.6%
Reimbursement Decrease	-7.2%	-7.2%	-3.9%

Physician - Total Dollar Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	0.2%	-2.4%
ABD Kids	-6.0%	-5.2%	0.0%
ABD Adults	-6.5%	-6.1%	-3.1%
Duals	-27.9%	-27.5%	-27.8%
ACA PCP Utilization Decrease	2.3%	-0.1%	-2.3%

Prescribed Drugs - Total Dollar Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	-0.8%	0.5%
ABD Kids	-15.6%	-15.2%	0.0%
ABD Adults	-14.3%	-15.0%	-7.7%
Duals	-2.3%	-2.5%	-2.4%

Behavioral Health/Health Homes SPMI - Total Dollar Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	6.8%	-0.7%
Family Planning	0.0%	0.0%	0.0%
Duals	-7.4%	-7.8%	-6.2%
Health Homes	12.4%	12.7%	10.3%

All Other - Total Dollar Impact			
Adjustment	SFY12	SFY13	SFY14
Lag Adjustment	0.0%	0.5%	-1.5%
ABD Kids	-4.4%	-3.2%	0.0%
ABD Adults	-1.5%	-1.1%	-0.6%
Duals	-49.0%	-37.5%	-38.4%

Appendix I.D – SFY 2015 Optumas and ODM Comparison

Projection Category	Optumas Projection	Medicaid Projection	Variance
Nursing Facility	$1,142,900,000	$1,123,300,000	1.7%
Dept. of Aging Waivers	$277,100,000	$254,200,000	9.0%
Home Care Waiver (MCD)	$154,700,000	$137,400,000	12.6%
Inpatient Hospital	$848,800,000	$865,900,000	-2.0%
Outpatient Hospital	$249,400,000	$304,700,000	-18.1%
Physician	$240,700,000	$291,700,000	-17.5%
Prescribed Drugs	$465,600,000	$466,900,000	-0.3%
Managed Care - ABD	$2,141,600,000	$2,298,200,000	-6.8%
Managed Care - ABD Kids	$353,200,000	$372,400,000	-5.2%
Managed Care - MyCare	$3,054,500,000	$3,122,900,000	-2.2%
Managed Care - CFC	$5,062,100,000	$4,997,600,000	1.3%
Behavioral Health/Health Homes SPMI	$752,400,000	$942,600,000	-20.2%
All Other	$885,100,000	$1,265,200,000	-30.0%
Medicare Buy In (includes QI)	$462,100,000	$485,400,000	-4.8%
Medicare Part D	$302,400,000	$301,000,000	0.5%
Group VIII	$2,457,100,000	$2,077,800,000	18.3%
DDD Services	$2,323,500,000	$2,323,500,000	0.0%
Program Wide	**$21,173,100,000**	**$21,630,900,000**	**-2.1%**

Appendix I.E – Program Wide PMPM Projections SFY 2016 – SFY2017

Projection Category	SFY 2016		SFY 2017	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound
Nursing Facility	$3,978	$4,037	$3,982	$4,072
Dept. of Aging Waivers	$1,131	$1,154	$1,137	$1,171
Home Care Waiver (MCD)	$1,853	$1,890	$1,863	$1,919
Inpatient Hospital	$161	$169	$165	$178
Outpatient Hospital	$48	$50	$50	$53
Physician	$33	$35	$34	$36
Prescribed Drugs	$63	$65	$65	$69
Managed Care - ABD	$1,376	$1,378	$1,412	$1,449
Managed Care - ABD Kids	$745	$746	$761	$781
Managed Care - MyCare	$2,193	$2,194	$2,211	$2,266
Managed Care - CFC	$281	$281	$289	$296
Behavioral Health/Health Homes SPMI	$29	$31	$30	$32
All Other	$30	$32	$31	$33
Medicare Buy In (includes QI)	$321	$334	$331	$350
Medicare Part D	$121	$126	$123	$131
Group VIII	$557	$558	$573	$588
DDD Services	$5,968	$6,085	$6,088	$6,329
Program Wide[1]	**$638**	**$647**	**$652**	**$675**

[1]*Please see Section 5 of this report for additional background behind what the figures above represent.*