March 16, 2015

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 2**

Dear Susan:

Thank you for the opportunity to assist the Joint Medicaid Oversight Committee with the development of the second iteration of the 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,

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Actuarial Consultant

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# Ohio Joint Medicaid Oversight Committee

# State Fiscal Years 2016-2017 Biennial Projections – Iteration 2 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 to eighteen 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. The first of these iterations was completed in October 2014. **Optumas** received additional detailed data in November 2014, which was used as the basis for this report, the second, more detailed iteration of the biennial projections.

The PMPM projections for the second iteration are based on a combination of data sources, including detailed claims-level Fee-for-Service (FFS) data acquired from the Ohio Department of Medicaid (ODM), as well as summarized base data and projected capitation rates provided in the managed care certification letters, and are projected at the category of aid and category of service level. 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 this second iteration, **Optumas** developed a range of projected PMPM growth, which is summarized in Figure 1, below. Please note that, as a result of the more refined projection process for the second iteration, the projected growth rates in the second iteration differ from the first iteration. The rate of growth set by JMOC in October 2014 falls within the growth range developed for iteration 2.

**Figure 1. Projected Rates of Growth**

| | Iteration 1 | | Iteration 2 | | | |
|---|---|---|---|---|---|---|
| SFY | Lower Bound | Upper Bound | Lower Bound | Upper Bound | JMOC Selected Rate | 2012-2014 Average Midwest Medical CPI |
| 2016 | 1.6% | 2.9% | 2.1% | 3.0% | 2.9% | 3.3% |
| 2017 | 2.2% | 4.5% | 2.4% | 3.6% | 3.3% | 3.3% |

Projected growth in the second iteration from **Optumas'** SFY 2015 projected midpoint to SFY 2016 is estimated to be between 2.1% and 3.0%. The projected rate of growth from SFY 2016 to SFY 2017 is projected to be between 2.4% and 3.6%. Based on the projections developed in the first iteration, JMOC selected a growth rate of 2.9% in SFY 2016 and 3.3% in SFY 2017, which fell within the developed range of projected growth for both the first and second iterations. JMOC's selected growth rate for each year was based on the lower of the three year average Medical CPI for the Midwest and the upper bound projected in iteration 1.

As shown above, the three year average change in the Medical Care CPI for the Midwest is 3.3%, based on bls.gov published Medical CPI from 2012-2014[1,2,3].

This report presents, in five sections, the process used to develop the second 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 projected PMPM growth developed for the second iteration of the SFY 2016-2017 biennial projections. |
| **Appendices** | Detailed tables showing results of data summaries, analyses, and assumptions used in the projection summary methodology. |

[1]Bureau of Labor Statistics, "Midwest Region Consumer Price Index – August 2012", (14 September, 2012), http://cityofmhk.com/Archive/ViewFile/Item/3230.
[2]Bureau of Labor Statistics, "Consumer Price Index, August 2013, Midwest CPI Summary", (17 September, 2013), http://www.bls.gov/regions/midwest/cpi-summary/2013/consumerpriceindex_summary_midwest_201308.pdf.
[3]Bureau of Labor Statistics, "Consumer Price Index, August 2014, Midwest CPI Summary", (17 September, 2014), http://www.bls.gov/regions/midwest/cpi-summary/2014/consumerpriceindex_summary_midwest_201408.pdf.

## 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 Ohio Medicaid program. Due to the amount of change in the Ohio Medicaid program over the last twelve to eighteen 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. The first of these iterations was completed in October 2014. The remainder of this report focuses on the projections developed for the second iteration.

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 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** in the first iteration was benchmarked against the three year weighted average of the Midwest Medical CPI, and the two figures were used in conjunction to select JMOC's target growth rate for the biennium; JMOC's selected growth rate for each year was based on the lower of the three year average Medical CPI for the Midwest and the upper bound projected in iteration 1. The projected growth rate developed in iteration 2 has again been benchmarked to the Midwest Medical CPI, as well as JMOC's selected rate.

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 for projecting future healthcare expenditures:

- 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 are actually enrolled in Medicaid managed care programs can impact the program-wide spend. To the extent that a new population enrolls and, in general, if 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 the addition of this new service 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 a combination of data sources, including detailed claims-level FFS data acquired from ODM, as well as summarized base data and projected capitation rates provided in the managed care certification letters, and are projected at the category of aid and category of service levels, and aggregated into a category of aid level projection. Once each category of aid projection has been developed, they are used to calculate a program-wide PMPM projection. Please see Appendix I.A. for a list of categories of aid included in this analysis.

As part of the biennial projection, **Optumas** developed a base data set from historical expenditure data, and projected that base data using trends specifically developed for each category of aid and category of service. For the second iteration, the projections for the managed care populations were developed based on capitation rates and trend figures developed by ODM's actuary.

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),
- Managed Care Pay for Performance, and
- Other settlements and rebates paid outside of the claims system and outside of the managed care capitation rates.

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.

# 3. Data

## 3.01 Sources

**Optumas** utilized detailed claims-level cost and utilization fee-for-service (FFS) data in conjunction with member-level eligibility information to develop a comprehensive base data set that includes both category of aid (COA) and category of service (COS) level of detail. This data reflects the historic SFY 2013-2014 FFS cost of the Ohio Medicaid program for all eligible members. This cost and utilization information was used to develop PMPMs for each COS within each COA, allowing for a much finer level of detail in the second iteration of the SFY2016 – SFY2017 biennial projection. In addition to the FFS data, **Optumas** also received detailed claim-level cost and utilization encounter data as well as cost report information from the Managed Care Organizations (MCOs) operating under the Ohio Managed Care Program (MCP). This information was used to validate and inform the projection of the MCP costs based on the capitation rates developed by Mercer on a PMPM basis.

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

**Ohio SFY 2013-2014 FFS Claims Data –**
The Ohio SFY 2013-2014 FFS claims data was provided by Ohio's data vendor HP, and is a comprehensive claims-level data set comprised of all claims incurred and reported through the FFS delivery system. This level of detailed data allowed **Optumas** to quantify various aspects of the Ohio Medicaid program, including average utilization per 1,000 members (util/1,000), unit cost, and per-member-per-month (PMPM) costs for all categories of aid and categories of service. The result of having these metrics available at this level of detail is a much more robust projection of the utilization and cost components of the SFY 2016-2017 biennial budget projection. After a review of both years of base data, as well as policy and program changes that were implemented during this time period, **Optumas** determined that SFY 2014 would serve as the base data for the SFY 2016-2017 biennial projection. This was due ultimately to the major policy changes that took place just prior to or during the SFY 2014 time period that would be captured with the use of this year as the base data. SFY 2013-2014 was utilized for developing the projected trend.

**Ohio CY 2013 and CY 2014Q3 Medicaid Cost Reports –**
The Ohio Medicaid Costs Reports are filled out on a quarterly and annual basis by the MCOs and are a detailed report of their total expenditures and revenue for each period. **Optumas** was provided the Calendar Year (CY) 2013 annual cost reports as well as the cost reports for January 2014 – September 2014 (CY 2014Q3). These reports were used in conjunction with the encounter data to validate the certification letters, both mentioned below.

**Ohio CY 2013 Encounter Data –**
The Ohio CY 2013 encounter data for the MCP was provided by Mercer, the actuarial firm who developed the CY 2014 and CY 2015 Ohio managed care capitation rates referenced in this report. As Mercer notes in their actuarial certification letters, this encounter data is underreported – there are a significant portion of claims that have been incurred by providers

but never reported – and so at face value, the encounter data does not represent a completely accurate picture of the cost and utilization metrics related to the managed care populations. This data can be used, however, to validate portions of the Medicaid Cost Reports that are filled out by the MCOs. Thus this encounter data was used in conjunction with Medicaid Cost Reports to validate the capitation rates that were used as the base data for the MCP portion of the SFY 2016-2017 biennial budget projection.

**Ohio CY 2012 FFS Claims Data (ABD < 21 only) –**
The Ohio CY 2012 FFS claims data for the ABD < 21 population, which is the underlying data used to develop the CY 2014 and CY 2015 managed care capitation rates for the ABD <21 population, was also provided by Mercer. These claims were used by **Optumas** to validate the base data used by Mercer in their capitation rate development.

**Ohio Projected Medicaid Expenditures SFY 2013-2015 –**
The 'Ohio Projected Medicaid Expenditures SFY 2013-2015' (commonly referred to throughout the Ohio state government as the 'Fatbook') contains summarized historical expenditure experience for July 2007 – October 2012 and projected expenditure experience for November 2012 – June 2015. **Optumas** received the Excel-based summarized database that feeds into the Fatbook and used the SFY 2012 historic FFS expenditure experience as part of the base data for the first iteration. With the change to using more detailed claims-level data, the Fatbook is now used to compare the SFY 2013-2014 projected costs to actual costs for this same time period and to analyze the accuracy of the Ohio Department of Medicaid's (ODM's) projections.

**Monthly Medicaid Variance Reports** –
The monthly Medicaid Variance Reports were used to validate the SFY 2013-2014 base 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, and these reports serve as a high-level benchmark to ensure the SFY 2013-2014 base data has been categorized appropriately.

**Ohio Department of Medicaid Caseload Reports** –
The Ohio Department of Medicaid Caseload Reports, reported with enrollment through November 2014, were used as a benchmark for the membership calculated from the member-level eligibility file. 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** –
CY 2014 and CY 2015 managed care certification letters provided by Mercer to ODM as part of the Mercer actuarial contract with ODM, their corresponding capitation rates, and SFY 2015 membership projections were used to develop the SFY 2015 PMPM projection. Summarized data included in the final 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. **Optumas** also relied on their internal clinician with 35+ years of experience to validate the

reasonableness of the managed care savings assumptions and efficiency adjustments used in the capitation rate development for the ABD and CFC populations.

## 3.02 Base Data Adjustments

### *Population Adjustments*

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.

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 for the SFY 2014 time period at both the population and service level, which is an update from the first iteration which included base data that dated back to July 2011 and summarized at the service level only. The use of more recent base data, as well as the ability to separately categorize expenditures by population, allows for costs to be isolated in the base data which captures the majority of the population adjustments that were made in the first iteration. The following section outlines the changes made for the first iteration and notes whether each is still impactful, and also notes additional changes that have taken place.

**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. The base data used for the SFY2016-2017 biennium projections (SFY 2014) for the ABD Kids enrolled in FFS reflects experience for the ABD Kids who remained in FFS after July 1, 2013, so no additional adjustment to the base data has been made.

**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, 2012 and forward). However, beginning in September 2013, a larger proportion of the ABD Adult population began enrolling into managed care. The base data used for the SFY2016-2017 biennium projections (SFY 2014) for the ABD Adults enrolled in FFS only reflects experience for the ABD Adults who were enrolled in FFS during the SFY 2014 base period, so no additional adjustment to the base data has been made.

**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 the base data has now been categorized at the population level, this policy change will be captured through a shifting of membership from FFS to managed care for these members rather than requiring any shifting of costs on a PMPM basis. The average PMPM for the FFS population is based on the SFY 2014 base data in conjunction with the projected membership that will remain

in FFS, while the managed care PMPM is based on the capitation rates included in the managed care certification letters along with the estimated membership that will enroll in managed care.

**Medicaid Other (RoMPIR/Presumptive/Alien) –**
Starting in April 2014, both membership and utilization per 1,000 for the RoMPIR/Presumptive/Alien category of aid increased significantly through the end of the SFY 2014 base period. To ensure that the projected PMPM for this population captured this increase in utilization, **Optumas** brought the SFY 2014 utilization per 1,000 for this population up to the average utilization seen in the last three months of the base period for each category of service. This resulted in a net upward impact to the overall PMPM for this population of 17.8% for the SFY 2014 base period.

### *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%; the adjustment reflects 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, 2013. 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). With the use of SFY 2014 as the base data, no adjustment was necessary as it had been for the first iteration. The experience for this program, as well as any impact the implementation of Health Homes had on the utilization of other services for members with SPMI, will now be captured in the base data experience. Additionally, the first iteration included an adjustment for additional members utilizing the program. This adjustment is no longer being applied as more recent utilization experience indicates that the level of utilization for the Health Homes program remains consistent with the levels seen in the SFY 2014 base data.

**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 or DRG-exempt hospitals. With the use of detailed data for the second iteration, **Optumas** was able to identify which costs were incurred at Children's hospitals and DRG-exempt hospitals in the FFS data; as a result, the 5% reduction was only applied to the portion of total Inpatient Hospital expenditures associated with the hospitals impacted by this reimbursement change prior to the reduction taking place. This resulted in a net downward adjustment of 1.7% for all FFS Inpatient Hospital expenditures for the SFY 2014 base period.

**APR-DRG Migration –**
Effective July 1, 2013, Ohio Medicaid transitioned its Inpatient Hospital reimbursement structure to reimburse on an APR-DRG basis. With the use of SFY 2014 as the base data, no adjustment was necessary to the FFS data, as it had been for the first iteration. The impact of this program change will now be inherent in the base data experience.

**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. To develop an estimated impact for the capital cost reduction, **Optumas** remained consistent with the methodology used in the first iteration by using the impact estimated in the managed care capitation rates for this reduction as described in the managed care capitation rate certification letters. This policy change was estimated to decrease costs for DRG based hospitals by approximately 1.0%, with the exclusion of Children's hospitals, prior to the effective date. This resulted in a net downward adjustment of 0.4% for all FFS Inpatient Hospital expenditures for the SFY 2014 base period.

**Outpatient Reimbursement Decrease –**
Effective January 1, 2014, a reduction for reimbursement of certain outpatient services was put into place. The impact of this program change was estimated by calculating the percentage change in the average unit cost for Outpatient ER and Outpatient Non-ER services before and after this change occurred during the base data time period. This resulted in a net downward adjustment of 3.4% for all FFS Outpatient (ER and Non-ER) Hospital expenditures for the SFY 2014 base period.

**ODADAS/MARP Additional Services–**
The procedure code J8499, which is related to opioid addiction treatment with Buprenorphine, began to be utilized beginning in March 2014 per a detailed analysis of the FFS data. The SFY 2014 base data prior to this time period was adjusted to reflect the average unit cost and utilization of this procedure code after it began to be utilized. This is to ensure that the data is appropriately adjusted for any significant one-time changes. This resulted in a net upward adjustment of 0.4% for all FFS ODADAS/MARP expenditures for the SFY 2014 base period.

**Personal Needs Allowance Increase–**
Effective January 1, 2014, the personal needs allowance for members with patient liability responsibilities increased from $40 per month to $45 per month. The impact of this change was estimated by shifting $5 per month from the member's patient liability amount to the Medicaid reimbursement amount used as the base. This was only done for members who had a patient liability amount greater than $5.

Effective January 1, 2015, the personal needs allowance for members with patient liability responsibilities increased from $45 per month to $50 per month. The impact of this change was estimated by shifting an additional $5 per month from the member's patient liability amount to the Medicaid reimbursement amount used as the base. This was only done for members who had a patient liability amount greater than $5 after the prior adjustment effective January 1, 2014 was made. This change was applied as an adjustment to the SFY 2014 base data to adjust costs to reflect the latest reimbursement levels, and mainly impacted the Skilled Nursing Facility

COS. The combined impact of these two changes to the personal needs allowance resulted in a net upward adjustment of 0.1% for Skilled Nursing Facility expenditures for the SFY 2014 base period in total.

**Clinics Reimbursement Change –**
Effective January 1, 2014, the CPT codes 99201-99205 and 99211-99215 were replaced by HCPCS code G0463 for clinic visits per CMS regulations. The impact of this program change was estimated by bringing the average unit cost and utilization prior to this change to the average unit cost and average utilization after this change for Non-FQHC/RHC Clinic (excluding Clinic-Mental Health) services. This resulted in a net upward adjustment of 4.7% for all FFS Non-FQHC/RHC Clinic (excluding Clinic-Mental Health) expenditures for the SFY 2014 base period.

**Transportation –**
There was a step-wise change in the unit cost and utilization patterns for the FFS Transportation COS that took place January 2014, with the dual populations being impacted the most. The impact of this program change was estimated by bringing the average unit cost and utilization prior to this change to the average unit cost and average utilization after this change for Transportation services. This is to ensure that the data is appropriately adjusted for any significant one-time changes, and resulted in a net downward adjustment of 0.2% for all FFS Transportation expenditures for the SFY 2014 base period.

**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; however, as providers are reimbursed at the higher Medicare rate they resubmit their claims to reflect the updated reimbursement amounts. As such, these costs were inherent in the SFY 2014 base data. Since the State of Ohio discontinued the higher reimbursement for these providers effective January 1, 2015, these additional costs have been excluded from the biennial projections. The impact of this program change was estimated by calculating the percentage change in the average unit cost for PCP services before and after this change occurred during the base data time period. This resulted in a net downward adjustment of 15% for all FFS PCP expenditures for the SFY 2014 base period.

One goal of the enhanced payment is increased access to care, which typically leads to a higher rate of utilization. Upon further analysis of the SFY 2013-2014 data provided, **Optumas** determined that, while induced utilization did appear to be present for these services beginning January 1, 2013, the induced levels did not appear to be at a high enough level to support a downward adjustment due to the enhanced reimbursement being discontinued. As a result, no utilization adjustment has been made to the base data due to the ACA 1202 enhanced payment.

**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. **Optumas** received several months of emerging data for the new Hepatitis C drugs, and estimated an additional $21.0 million for these drugs for the SFY 2015 time period. This is

similar to the $22.5 million place holder that was used for the first iteration. As a result of only having a few months of emerging data, the same placeholder used in the first iteration has been used for the outer years of biennial projection to reflect the additional costs of these benefits to FFS pharmacy spend. The placeholder amounts reflected in the biennial projections are $50 million and $60 million for SFY 2016 and SFY 2017, respectively.

**Extension Adjustment (Pent-Up Demand & Managed Care Removal) –**
The Extension population, also referred to as Group VIII, began enrolling into the Ohio Medicaid managed care program in January 2014. As noted in the CY 2014 and CY 2015 managed care certification letters, the experience for this population was projected to be comparable to a mix between the healthy adult CFC and disabled adult ABD populations. Per the certification letters surrounding the development of the capitation rates for this population, the Extension population was developed using the managed care experience for these populations. Since this is a new population that has previously received little to no health insurance, the second year of experience (CY 2015) was projected to require upward adjustments to the inherent CFC and ABD managed care experience to reflect pent-up demand that had not been fully resolved in the first year. Additionally, the certification letter describes managed care adjustments to reflect the potential differences in utilization (higher Inpatient and outpatient services, and lower dental, pharmacy, and physician-related services) for the newly managed Extension population, as compared to populations who have been managed under a mature managed care environment. The magnitude of these adjustments for the CY 2015 capitation rates have been reduced from the CY 2014 adjustments reported in the certification letters. Moving forward into the SFY 2016-2017 biennium (beginning with the CY 2016 time period) **Optumas** projects that these adjustments will no longer be necessary for this population. As a result, **Optumas** has removed the impact of these adjustments when projecting these costs into the biennial projection period.

**Managed Care Sales & Use Tax –**
As part of the Governor's budget initiative, an increase of 0.5% to the Sales and Use Tax has been planned moving into the biennium. Since the Sales and Use Tax is incorporated into the managed care capitation rates, **Optumas** has adjusted the managed care capitation projections to reflect the upward impact due to the increased tax.

The impact of the adjustments to the FFS and managed care base data expenditures listed above can be found in Appendix I.B by both category of aid and category of service. The overall impact to the FFS expenditures was -0.2% for the FFS population and 0.1% for the managed care population. The overall impact to the managed care capitated expenditures was only slightly negative and is shown as 0.0% overall.

# 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.

The trend figures developed for the first iteration of the biennial projection were preliminary results based on limited data sources. While **Optumas** believed these trend figures to be reasonable estimates of what may occur during the biennial projection period, these estimates were refined for the second iteration. As **Optumas** received additional data with claims-level detail, trend was 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 used in this second iteration, the overall trend estimates differ from those developed in the first iteration, but still remain consistent with, and comparable to, the program-wide trends developed in the first iteration.

Since detailed claims were available for the FFS projection categories, FFS trend was developed at both the unit cost and utilization per 1,000 levels for each category of service within each category of aid. FFS trends were developed through utilization of 3, 6, and 12 month moving averages over the course of the base data period. Known policy and program changes were taken into account as well as any outlier costs so that the projected trends were not influenced by one time spending changes. These one-time changes due to program and policy changes are captured separately as noted above in section 3.02. The unit cost and utilization trends are used to project these components into the SFY 2016-2017 biennial period, and are then used to calculate the implied PMPM growth rate that will be used as a part of the JMOC benchmark.

The biennial projections have been completed assuming current policy will continue. This includes the methodology used for developing the future capitation rates for the managed care program. As a result, **Optumas** used trends that were developed by ODM's actuary for the CY 2015 managed care capitation rates, assuming that both a similar methodology and similar trend projections would be used for future capitation rate contract periods. The trends developed for the CY 2015 capitation rates were displayed at a category of aid and category of service level, and were included in the CY 2015 certification letters. **Optumas** used these trend estimates to project the 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 lower and upper bound trend is then used to project each category from the base to 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 (EXPN), have been projected based on CY 2015 capitation rates

The annualized trend used to project each category into the lower bound and upper bound of SFY 2016 and SFY 2017 are shown below. Each projection category reflects the growth rate across all services incurred by that category. For example, the CFC ADULT category in the managed care section reflects the projected growth rate across both their capitated expenses and FFS expenses. Although the growth rates for the FFS program is generally lower than the managed care program, the significantly larger PMPM for FFS (see Appendix I.C) means that small changes in the FFS growth rate can result in large changes to the overall cost of the Medicaid program.

| | SFY 2016 | | SFY 2017 | |
|---|---|---|---|---|
| FFS Populations | Lower Bound | Upper Bound | Lower Bound | Upper Bound |
| CHIP | 2.1% | 4.1% | 2.6% | 3.6% |
| ADFC | 2.8% | 4.8% | 3.3% | 4.3% |
| HFAM | 2.7% | 4.7% | 3.1% | 4.1% |
| EXPN | 1.9% | 2.5% | 2.6% | 4.0% |
| MYCARE | 0.8% | 2.8% | 1.3% | 2.3% |
| BCCP | 3.5% | 5.6% | 4.0% | 5.0% |
| FAM PLAN | 3.2% | 5.3% | 3.8% | 4.8% |
| PREM ASST | 1.0% | 3.0% | 1.5% | 2.5% |
| OTHER | 3.4% | 5.4% | 3.8% | 4.9% |
| ABD KIDS | 3.5% | 5.6% | 4.0% | 5.0% |
| ABD ADULT | 6.3% | 8.3% | 4.3% | 5.2% |
| DUAL | 2.1% | 4.0% | 2.0% | 2.9% |
| ICF | 0.4% | 2.0% | 0.7% | 1.5% |
| SNF | 0.4% | 2.4% | 0.8% | 1.8% |
| AGING WAIVER | 2.3% | 4.3% | 2.0% | 3.0% |
| DD WAIVER | 2.0% | 4.0% | 2.5% | 3.5% |
| MCD WAIVER | 1.4% | 3.4% | 1.4% | 2.4% |
| **FFS Total[1]** | **1.6%** | **3.5%** | **2.0%** | **3.0%** |

| | SFY 2016 | | SFY 2017 | |
|---|---|---|---|---|
| Managed Care Populations | Lower Bound | Upper Bound | Lower Bound | Upper Bound |
| CFC KIDS | 1.9% | 2.5% | 2.9% | 4.3% |
| CFC ADULT | 5.4% | 5.9% | 3.5% | 4.9% |
| EXPN | 1.9% | 2.5% | 2.6% | 4.0% |
| ABD KIDS | 0.1% | 0.8% | 2.5% | 3.9% |
| ABD ADULT | 1.5% | 2.0% | 2.9% | 4.3% |
| MYCARE | 1.6% | 2.0% | 1.2% | 2.6% |
| **Managed Care Total[1]** | **2.5%** | **3.0%** | **2.6%** | **4.1%** |

| All Populations | SFY 2016 Lower Bound | SFY 2016 Upper Bound | SFY 2017 Lower Bound | SFY 2017 Upper Bound |
|---|---|---|---|---|
| FFS - FFS Costs | 1.6% | 3.5% | 2.0% | 3.0% |
| MC - FFS Costs | 4.4% | 6.4% | 5.1% | 6.1% |
| MC - MC Costs | 2.3% | 2.8% | 2.5% | 3.9% |
| Additional Payments | -1.8% | -1.8% | 1.0% | 1.0% |
| **Program Wide[1]** | **2.1%** | **3.0%** | **2.4%** | **3.6%** |

*[1]The upper and lower bound trend % is calculated based on the SFY15 projected midpoint to the SFY16 and SFY17 upper and lower bounds. All growth rates are based on SFY 2015 membership mix.*

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 2.1% and 3.0% from the projected midpoint of SFY 2015 to SFY 2016
- Between 2.4% and 3.6% 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 2.2% to 3.3%. In comparison, the three year average of the Midwest CPI is approximately 3.3%, which is right at the projected rate of growth for the upper bound of the SFY 2016-2017 projections.

## 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 effect of population growth on 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 1.2% higher 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. For a comparison of SFY 2015 expenditures by projection category, please see Appendix I.G.

| SFY 2015 Comparison | | | |
|---|---|---|---|
| SFY | Optumas Projection | Medicaid Projection | Percent Difference |
| 2015 | $635 | $628 | 1.2% |

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 build-up of the projected PMPMs by category of aid see Appendix I.C. Please also see Appendices I.D-I.E for a categorization of the highest to lowest cost category of aid on a PMPM basis and on a total dollar basis, respectively. Also included is the distribution of costs by category of aid across the entire program in Appendix I.F.

| Overall Projection | | | | |
|---|---|---|---|---|
| | PMPM | | Trend | |
| SFY | Lower Bound | Upper Bound | Lower Bound | Upper Bound |
| 2016 | $648 | $654 | 2.1% | 3.0% |
| 2017 | $664 | $678 | 2.4% | 3.6% |

Please note that the figures noted above, and in Appendices I.C-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 service portion of the SNF (Non-MyCare) PMPM reflects an estimate of 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 population-specific projections for all services utilized by that population. For example, the 'ABD 21+' projections should be viewed as an estimate of the managed care portion of Medicaid's spend on managed care-enrolled ABD Adults, inclusive of all managed care services and non-medical load included in the ABD Adult managed care capitation rates, as well as any of their FFS expenditures for services not covered through the managed care program.

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 moving forward.

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.

## 6. Appendices

## Appendix I.A – Projection Categories

| Categories of Aid | |
|---|---|
| SNF (Non-MyCare) | ABD Children |
| ICF & MR Private | CFC |
| ICF & MR Public | Extension (EXPN) |
| Aging Waivers | MyCare |
| DD Waivers | ADFC |
| Medicaid Waivers | Breast & Cervical Cancer(BCCP) |
| Community Well - Dual | Family Planning |
| Medicare Premium Assistance | RoMPIR/Presumptive/Alien |
| ABD Adults | Refugee/Not Assigned |

| Categories of Service | |
|---|---|
| SNF | Clinics |
| ICF & MR Private | Clinics - Mental Health |
| ICF & MR Public | FQHC/RHC |
| Aging Waivers | Health Homes |
| DD Waivers | Laboratory/Radiology |
| Medicaid Waivers | ODADAS/MARP |
| Home Health/PDN | DME/Supplies |
| Hospice Services | EPSDT |
| Inpatient Hospital | Family Planning |
| Outpatient Hospital | Medicaid Schools Program |
| Prescribed Drugs | Mental Inpatient Hospital |
| PCP | Mental Retardation |
| Specialist | Transportation |
| Dental Services | Vision |

## Appendix I.B – PMPM Adjustment Impacts – FFS Expenditures

### FFS Populations – FFS Expenditures

| COS | SFY 2014 Program Change Impact |
|---|---|
| Clinics - Mental Health | 0.2% |
| Dental Services | 8.7% |
| DME/Supplies | 0.1% |
| EPSDT | 1.8% |
| Family Planning | 7.8% |
| FQHC/RHC | 2.2% |
| HCBS Waiver | 0.0% |
| Health Homes | 0.1% |
| Home Health/PDN | 0.0% |
| ICF & MR Private | 0.1% |
| ICF & MR Public | 0.0% |
| Inpatient Hospital | 1.5% |
| Laboratory/Radiology | 1.3% |
| Medicaid Schools Program | 0.3% |
| Mental Inpatient Hospital | 0.7% |
| Non-FQHC/RHC Clinic | 4.6% |
| ODADAS/MARP | 1.5% |
| Other Services | 0.1% |
| Outpatient Hospital | -1.9% |
| PCP | -14.1% |
| Prescribed Drugs | 0.3% |
| SNF | 0.1% |
| Specialist | 1.2% |
| **Total (SFY 2015 Mix)** | **-0.2%** |

### Managed Care Populations - FFS Expenditures

| COS | SFY 2014 Program Change Impact |
|---|---|
| Clinics - Mental Health | 0.0% |
| FQHC/RHC | 0.0% |
| Health Homes | 0.0% |
| Medicaid Schools Program | 0.0% |
| Mental Inpatient Hospital | 0.0% |
| Mental Retardation | 0.0% |
| ODADAS/MARP | 0.4% |
| Other Services | 0.0% |
| **Total (SFY 2015 Mix)** | **0.1%** |

### Managed Care Populations - Capitated Expenditures

| COA | FY 2014 Program Change Impact |
|---|---|
| CFC KIDS | 0.5% |
| CFC ADULT | 0.5% |
| EXPN | -1.9% |
| ABD KIDS | 0.5% |
| ABD ADULT | 0.5% |
| MYCARE | 0.5% |
| **Total (SFY 2015 Mix)** | **0.0%** |

## Appendix I.C – SFY 2016-2017 Biennium Projection Build-Up

### FFS Populations – FFS Expenditures

| | SFY 2015 | SFY 2014 | SFY 2014 | | SFY 2014 | |
|---|---|---|---|---|---|---|
| COA | MMs | Base PMPM | IBNR | Completed PMPM | Program Change Impact | Final Adjusted Base |
| CHIP | 129,396 | $376 | 96.1% | $392 | -3.6% | $377 |
| ADFC | 342,766 | $441 | 96.7% | $456 | -1.6% | $449 |
| HFAM | 1,157,663 | $317 | 93.1% | $341 | -4.2% | $326 |
| EXPN | 768,495 | $349 | 86.9% | $401 | -1.4% | $396 |
| MYCARE | 201,187 | $1,550 | 98.5% | $1,574 | 0.1% | $1,575 |
| BCCP | 9,132 | $1,843 | 93.3% | $1,975 | -2.7% | $1,921 |
| FAM PLAN | 695,133 | $3 | 95.7% | $3 | -1.9% | $3 |
| PREM ASST | 1,487,297 | $57 | 94.6% | $60 | -1.7% | $59 |
| OTHER | 375,077 | $539 | 83.8% | $643 | 17.1% | $754 |
| ABD KIDS | 87,282 | $1,751 | 95.2% | $1,839 | -3.4% | $1,777 |
| ABD ADULT | 48,399 | $1,867 | 94.8% | $1,969 | -2.8% | $1,915 |
| DUAL | 527,085 | $361 | 96.1% | $376 | -0.7% | $373 |
| ICF | 80,451 | $9,505 | 98.5% | $9,653 | -0.1% | $9,644 |
| SNF | 286,552 | $4,602 | 97.8% | $4,705 | -0.2% | $4,698 |
| AGING WAIVER | 212,165 | $1,885 | 97.7% | $1,930 | -1.1% | $1,909 |
| DD WAIVER | 403,650 | $4,278 | 95.8% | $4,466 | -0.2% | $4,457 |
| MCD WAIVER | 79,982 | $5,047 | 96.9% | $5,208 | -1.2% | $5,146 |
| **Total (SFY 2015 Mix)** | **6,891,712** | **$944** | **95.9%** | **$984** | **-0.2%** | **$983** |

## Appendix I.C – SFY 2016-2017 Biennium Projection Build-Up

### FFS Populations – FFS Expenditures

| | SFY 2015 | SFY 2014 | SFY 2015 | | SFY 2016 | | | |
|---|---|---|---|---|---|---|---|---|
| COA | MMs | PMPM | Projected Growth | PMPM | Projected Growth | Lower Bound | Projected Growth | Upper Bound |
| CHIP | 129,396 | $377 | 3.1% | $389 | 2.1% | $397 | 4.1% | $405 |
| ADFC | 342,766 | $449 | 3.7% | $466 | 2.8% | $478 | 4.8% | $488 |
| HFAM | 1,157,663 | $326 | 3.6% | $338 | 2.7% | $347 | 4.7% | $354 |
| EXPN | 768,495 | $396 | 58.4% | $627 | 1.9% | $639 | 2.5% | $642 |
| MYCARE | 201,187 | $1,575 | 1.8% | $1,603 | 0.8% | $1,616 | 2.8% | $1,648 |
| BCCP | 9,132 | $1,921 | 4.3% | $2,004 | 3.5% | $2,075 | 5.6% | $2,115 |
| FAM PLAN | 695,133 | $3 | 4.1% | $3 | 3.2% | $4 | 5.3% | $4 |
| PREM ASST | 1,487,297 | $59 | 2.0% | $60 | 1.0% | $60 | 3.0% | $62 |
| OTHER | 375,077 | $754 | 4.4% | $787 | 3.4% | $813 | 5.4% | $829 |
| ABD KIDS | 87,282 | $1,777 | 4.5% | $1,858 | 3.5% | $1,923 | 5.6% | $1,961 |
| ABD ADULT | 48,399 | $1,915 | 6.6% | $2,041 | 6.3% | $2,171 | 8.3% | $2,211 |
| DUAL | 527,085 | $373 | 2.8% | $384 | 2.1% | $392 | 4.0% | $399 |
| ICF | 80,451 | $9,644 | 1.0% | $9,741 | 0.4% | $9,777 | 2.0% | $9,939 |
| SNF | 286,552 | $4,698 | 1.3% | $4,761 | 0.4% | $4,778 | 2.4% | $4,874 |
| AGING WAIVER | 212,165 | $1,909 | 3.0% | $1,967 | 2.3% | $2,013 | 4.3% | $2,051 |
| DD WAIVER | 403,650 | $4,457 | 3.0% | $4,591 | 2.0% | $4,684 | 4.0% | $4,777 |
| MCD WAIVER | 79,982 | $5,146 | 2.2% | $5,261 | 1.4% | $5,335 | 3.4% | $5,440 |
| **Total (SFY 2015 Mix)** | **6,891,712** | **$983** | **5.0%** | **$1,032** | **1.6%** | **$1,049** | **3.5%** | **$1,068** |

*Note:*
*The SFY 2014 costs for the Expansion (Group VIII) population represent the first six months of emerging experience for members that did not enroll into managed care. It is projected that by SFY 2015 the FFS costs for this portion of the population will increase to a level similar to the cost seen for the portion of the population that did enroll into managed care. This is the cause of the large increase in the projected growth rate between SFY 2014 and SFY 2015 for this population.*

## Appendix I.C – SFY 2016-2017 Biennium Projection Build-Up

### FFS Populations – FFS Expenditures

| | SFY 2015 | SFY 2016 | | SFY 2017 | | | |
|---|---|---|---|---|---|---|---|
| COA | MMs | Lower Bound | Upper Bound | Projected Growth | Lower Bound | Projected Growth | Upper Bound |
| CHIP | 129,396 | $397 | $405 | 2.6% | $407 | 3.6% | $420 |
| ADFC | 342,766 | $478 | $488 | 3.3% | $494 | 4.3% | $509 |
| HFAM | 1,157,663 | $347 | $354 | 3.1% | $358 | 4.1% | $369 |
| EXPN | 768,495 | $639 | $642 | 2.6% | $655 | 4.0% | $668 |
| MYCARE | 201,187 | $1,616 | $1,648 | 1.3% | $1,636 | 2.3% | $1,686 |
| BCCP | 9,132 | $2,075 | $2,115 | 4.0% | $2,157 | 5.0% | $2,221 |
| FAM PLAN | 695,133 | $4 | $4 | 3.8% | $4 | 4.8% | $4 |
| PREM ASST | 1,487,297 | $60 | $62 | 1.5% | $61 | 2.5% | $63 |
| OTHER | 375,077 | $813 | $829 | 3.8% | $845 | 4.9% | $870 |
| ABD KIDS | 87,282 | $1,923 | $1,961 | 4.0% | $2,000 | 5.0% | $2,059 |
| ABD ADULT | 48,399 | $2,171 | $2,211 | 4.3% | $2,264 | 5.2% | $2,326 |
| DUAL | 527,085 | $392 | $399 | 2.0% | $400 | 2.9% | $411 |
| ICF | 80,451 | $9,777 | $9,939 | 0.7% | $9,847 | 1.5% | $10,092 |
| SNF | 286,552 | $4,778 | $4,874 | 0.8% | $4,817 | 1.8% | $4,962 |
| AGING WAIVER | 212,165 | $2,013 | $2,051 | 2.0% | $2,053 | 3.0% | $2,112 |
| DD WAIVER | 403,650 | $4,684 | $4,777 | 2.5% | $4,801 | 3.5% | $4,944 |
| MCD WAIVER | 79,982 | $5,335 | $5,440 | 1.4% | $5,410 | 2.4% | $5,571 |
| **Total (SFY 2015 Mix)** | **6,891,712** | **$1,049** | **$1,068** | **2.0%** | **$1,070** | **3.0%** | **$1,100** |

## Appendix I.C – SFY 2016-2017 Biennium Projection Build-Up

### Managed Care Populations – FFS Expenditures

| | SFY 2015 | SFY 2014 | SFY 2014 | | SFY 2014 | |
|---|---|---|---|---|---|---|
| COA | MMs | Base PMPM | IBNR | Completed PMPM | Program Change Impact | Final Adjusted Base |
| CFC KIDS | 13,564,414 | $23 | 97.3% | $23 | 0.0% | $23 |
| CFC ADULT | 6,577,693 | $25 | 97.9% | $26 | 0.5% | $26 |
| EXPN | 5,351,741 | $51 | 95.0% | $54 | 0.0% | $54 |
| ABD KIDS | 424,901 | $135 | 97.0% | $140 | 0.0% | $140 |
| ABD ADULT | 1,688,245 | $80 | 98.0% | $82 | 0.2% | $82 |
| MYCARE | 1,210,281 | $0 | 100.0% | $0 | 0.0% | $0 |
| **Total (SFY 2015 Mix)** | **28,817,275** | **$33** | **96.8%** | **$34** | **0.1%** | **$34** |

| | SFY 2015 | SFY 2014 | SFY 2015 | | SFY 2016 | | | |
|---|---|---|---|---|---|---|---|---|
| COA | MMs | PMPM | Projected Growth | PMPM | Projected Growth | Lower Bound | Projected Growth | Upper Bound |
| CFC KIDS | 13,564,414 | $23 | 3.1% | $24 | 2.2% | $25 | 2.0% | $25 |
| CFC ADULT | 6,577,693 | $26 | 7.5% | $28 | 6.6% | $30 | 1.9% | $30 |
| EXPN | 5,351,741 | $54 | 7.8% | $58 | 6.9% | $62 | 1.9% | $63 |
| ABD KIDS | 424,901 | $140 | 3.0% | $144 | 2.1% | $147 | 2.0% | $150 |
| ABD ADULT | 1,688,245 | $82 | 3.2% | $85 | 2.4% | $87 | 1.9% | $89 |
| MYCARE | 1,210,281 | $- | 0.0% | $- | 0.0% | $- | 0.0% | $- |
| **Total (SFY 2015 Mix)** | **28,817,275** | **$34** | **5.3%** | **$35** | **4.4%** | **$37** | **1.9%** | **$38** |

## Appendix I.C – SFY 2016-2017 Biennium Projection Build-Up

### Managed Care Populations – FFS Expenditures

| | SFY 2015 | SFY 2016 | | SFY 2017 | | | |
|---|---|---|---|---|---|---|---|
| COA | MMs | Lower Bound | Upper Bound | Projected Growth | Lower Bound | Projected Growth | Upper Bound |
| CFC KIDS | 13,564,414 | $25 | $25 | 2.7% | $25 | 3.7% | $26 |
| CFC ADULT | 6,577,693 | $30 | $30 | 7.3% | $32 | 8.3% | $33 |
| EXPN | 5,351,741 | $62 | $63 | 7.6% | $66 | 8.6% | $68 |
| ABD KIDS | 424,901 | $147 | $150 | 2.5% | $151 | 3.6% | $155 |
| ABD ADULT | 1,688,245 | $87 | $89 | 3.0% | $89 | 4.0% | $92 |
| MYCARE | 1,210,281 | $0 | $0 | 0.0% | $0 | 0.0% | $0 |
| **Total (SFY 2015 Mix)** | **28,817,275** | **$37** | **$38** | **5.1%** | **$39** | **6.1%** | **$40** |

## Appendix I.C – SFY 2016-2017 Biennium Projection Build-Up

### Managed Care Populations – Capitated Expenditures

| COA | SFY 2015 MMs | PMPM FY2015 | SFY 2016 Projected Growth | SFY 2016 Lower Bound | SFY 2016 Projected Growth | SFY 2016 Upper Bound | SFY 2017 Projected Growth | SFY 2017 Lower Bound | SFY 2017 Projected Growth | SFY 2017 Upper Bound |
|---|---|---|---|---|---|---|---|---|---|---|
| CFC KIDS | 13,564,414 | $196 | 1.9% | $199 | 2.3% | $200 | 2.9% | $205 | 4.4% | $209 |
| CFC ADULT | 6,577,693 | $437 | 5.3% | $461 | 5.7% | $463 | 3.3% | $476 | 4.7% | $484 |
| EXPN | 5,351,741 | $569 | 1.4% | $577 | 1.9% | $579 | 2.0% | $589 | 3.5% | $599 |
| ABD KIDS | 424,901 | $756 | -0.2% | $754 | 0.2% | $757 | 2.5% | $773 | 3.9% | $787 |
| ABD ADULT | 1,688,245 | $1,367 | 1.4% | $1,387 | 1.9% | $1,393 | 2.9% | $1,427 | 4.4% | $1,454 |
| MYCARE | 1,210,281 | $2,155 | 1.6% | $2,190 | 2.0% | $2,199 | 1.2% | $2,216 | 2.6% | $2,256 |
| **Total (SFY 2015 Mix)** | **28,817,275** | **$479** | **2.3%** | **$490** | **2.8%** | **$493** | **2.5%** | **$503** | **3.9%** | **$512** |

### Managed Care Populations – Combined Expenditures

| COA | SFY 2015 MMs | PMPM FY2015 | SFY 2016 Projected Growth | SFY 2016 Lower Bound | SFY 2016 Projected Growth | SFY 2016 Upper Bound | SFY 2017 Projected Growth | SFY 2017 Lower Bound | SFY 2017 Projected Growth | SFY 2017 Upper Bound |
|---|---|---|---|---|---|---|---|---|---|---|
| CFC KIDS | 13,564,414 | $220 | 1.9% | $224 | 2.5% | $225 | 2.9% | $230 | 4.3% | $235 |
| CFC ADULT | 6,577,693 | $465 | 5.4% | $490 | 5.9% | $493 | 3.5% | $507 | 4.9% | $517 |
| EXPN | 5,351,741 | $627 | 1.9% | $639 | 2.5% | $642 | 2.6% | $655 | 4.0% | $668 |
| ABD KIDS | 424,901 | $900 | 0.1% | $901 | 0.8% | $907 | 2.5% | $923 | 3.9% | $942 |
| ABD ADULT | 1,688,245 | $1,452 | 1.5% | $1,474 | 2.0% | $1,482 | 2.9% | $1,516 | 4.3% | $1,546 |
| MYCARE | 1,210,281 | $2,155 | 1.6% | $2,190 | 2.0% | $2,199 | 1.2% | $2,216 | 2.6% | $2,256 |
| **Total (SFY 2015 Mix)** | **28,817,275** | **$515** | **2.5%** | **$527** | **3.0%** | **$530** | **2.6%** | **$541** | **4.1%** | **$552** |

## Appendix I.D – Highest to Lowest Cost per Member – SFY 2015

### FFS Populations – FFS Expenditures

| COA | SFY15 MMs | SFY 2015 PMPM |
|---|---|---|
| ICF | 80,451 | $9,741 |
| MCD WAIVER | 79,982 | $5,261 |
| SNF | 286,552 | $4,761 |
| DD WAIVER | 403,650 | $4,591 |
| ABD ADULT | 48,399 | $2,041 |
| BCCP | 9,132 | $2,004 |
| AGING WAIVER | 212,165 | $1,967 |
| ABD KIDS | 87,282 | $1,858 |
| MYCARE | 201,187 | $1,603 |
| OTHER | 375,077 | $787 |
| EXPN | 768,495 | $627 |
| ADFC | 342,766 | $466 |
| CHIP | 129,396 | $389 |
| DUAL | 527,085 | $384 |
| HFAM | 1,157,663 | $338 |
| PREM ASST | 1,487,297 | $60 |
| FAM PLAN | 695,133 | $3 |
| **Total (SFY 2015 Mix)** | **6,891,712** | **$1,032** |

## Appendix I.D – Highest to Lowest Cost per Member – SFY 2015

### Managed Care Populations – FFS Expenditures

| COA | SFY15 MMs | SFY 2015 PMPM |
|---|---|---|
| ABD KIDS | 424,901 | $144 |
| ABD ADULT | 1,688,245 | $85 |
| EXPN | 5,351,741 | $58 |
| CFC ADULT | 6,577,693 | $28 |
| CFC KIDS | 13,564,414 | $24 |
| MYCARE | 1,210,281 | $0 |
| **Total (SFY 2015 Mix)** | **28,817,275** | **$35** |

### Managed Care Populations – Capitated Expenditures

| COA | SFY15 MMs | SFY 2015 PMPM |
|---|---|---|
| MYCARE | 1,210,281 | $2,155 |
| ABDADULT | 1,688,245 | $1,367 |
| ABDKIDS | 424,901 | $756 |
| EXPN | 5,351,741 | $569 |
| CFCADULT | 6,577,693 | $437 |
| CFCKIDS | 13,564,414 | $196 |
| **Total(SFY2015Mix)** | **28,817,275** | **$479** |

### Managed Care Populations – Combined Expenditures

| COA | SFY15 MMs | SFY 2015 PMPM |
|---|---|---|
| MYCARE | 1,210,281 | $2,155 |
| ABDADULT | 1,688,245 | $1,452 |
| ABDKIDS | 424,901 | $900 |
| EXPN | 5,351,741 | $627 |
| CFCADULT | 6,577,693 | $465 |
| CFCKIDS | 13,564,414 | $220 |
| **Total(SFY2015Mix)** | **28,817,275** | **$515** |

## Appendix I.E – Highest to Lowest Total Cost – SFY 2015

### FFS Populations – FFS Expenditures

| COA | SFY 2015 |
|---|---|
| DD WAIVER | $1,853,100,000 |
| SNF | $1,364,100,000 |
| ICF | $783,600,000 |
| EXPN | $481,500,000 |
| MCD WAIVER | $420,700,000 |
| AGING WAIVER | $417,200,000 |
| HFAM | $391,600,000 |
| MYCARE | $322,500,000 |
| OTHER | $295,000,000 |
| DUAL | $202,200,000 |
| ABD KIDS | $162,100,000 |
| ADFC | $159,500,000 |
| ABD ADULT | $98,700,000 |
| PREM ASST | $89,000,000 |
| CHIP | $50,300,000 |
| BCCP | $18,200,000 |
| FAM PLAN | $2,400,000 |
| **Total (SFY 2015 Mix)** | **$7,111,700,000** |

## Appendix I.E – Highest to Lowest Total Cost – SFY 2015

### Managed Care Populations – FFS Expenditures

| COA | SFY 2015 |
|---|---|
| CFC KIDS | $326,200,000 |
| EXPN | $308,900,000 |
| CFC ADULT | $182,000,000 |
| ABD ADULT | $143,200,000 |
| ABD KIDS | $61,100,000 |
| MYCARE | $- |
| **Total (SFY 2015 Mix)** | **$1,021,400,000** |

### Managed Care Populations – Capitated Expenditures

| COA | SFY 2015 |
|---|---|
| EXPN | $3,044,100,000 |
| CFC ADULT | $2,877,400,000 |
| CFC KIDS | $2,653,700,000 |
| MYCARE | $2,608,600,000 |
| ABD ADULT | $2,308,400,000 |
| ABD KIDS | $321,100,000 |
| **Total (SFY 2015 Mix)** | **$13,813,300,000** |

### Managed Care Populations – Combined Expenditures

| COA | SFY 2015 |
|---|---|
| EXPN | $3,370,300,000 |
| CFC ADULT | $3,186,300,000 |
| CFC KIDS | $2,835,700,000 |
| MYCARE | $2,751,800,000 |
| ABD ADULT | $2,369,500,000 |
| ABD KIDS | $321,100,000 |
| **Total (SFY 2015 Mix)** | **$14,834,700,000** |

### All Populations – All Expenditures

| COA | SFY 2015 |
|---|---|
| FFS | $7,111,700,000 |
| MC - FFS | $1,021,400,000 |
| MC - MC | $13,813,300,000 |
| **Total (SFY 2015 Mix)** | **$21,946,400,000** |
| Additional Payments | $729,400,000 |
| **Total (SFY 2015 Mix)** | **$22,675,800,000** |

## Appendix I.F – Distribution of Cost – SFY 2015

### FFS Populations – FFS Expenditures

| COA | SFY 2015 |
| --- | --- |
| DD WAIVER | 8.4% |
| SNF | 6.2% |
| ICF | 3.6% |
| EXPN | 2.2% |
| MCD WAIVER | 1.9% |
| AGING WAIVER | 1.9% |
| HFAM | 1.8% |
| MYCARE | 1.5% |
| OTHER | 1.3% |
| DUAL | 0.9% |
| ABD KIDS | 0.7% |
| ADFC | 0.7% |
| ABD ADULT | 0.4% |
| PREM ASST | 0.4% |
| CHIP | 0.2% |
| BCCP | 0.1% |
| FAM PLAN | 0.0% |
| **Total (SFY 2015 Mix)** | **32.4%** |

*Note: Percentages are calculated relative to the total projected medical cost of the program, excluding additional payments such as Medicare Part D Clawback or Medicare Buy-in.*

## Appendix I.F – Distribution of Cost – SFY 2015

### Managed Care Populations – FFS Expenditures

| COA | SFY 2015 |
|---|---|
| CFC KIDS | 1.5% |
| EXPN | 1.4% |
| CFC ADULT | 0.8% |
| ABD ADULT | 0.7% |
| ABD KIDS | 0.3% |
| MYCARE | 0.0% |
| **Total (SFY 2015 Mix)** | **4.7%** |

### Managed Care Populations – Capitated Expenditures

| COA | SFY 2015 |
|---|---|
| EXPN | 13.9% |
| CFC ADULT | 13.1% |
| CFC KIDS | 12.1% |
| MYCARE | 11.9% |
| ABD ADULT | 10.5% |
| ABD KIDS | 1.5% |
| **Total (SFY 2015 Mix)** | **62.9%** |

*Note: Percentages are calculated relative to the total projected medical cost of the program, excluding additional payments such as Medicare Part D Clawback or Medicare Buy-in.*

### Managed Care Populations – Combined Expenditures

| COA | SFY 2015 |
|---|---|
| EXPN | 15.4% |
| CFC ADULT | 14.5% |
| CFC KIDS | 12.9% |
| MYCARE | 12.5% |
| ABD ADULT | 10.8% |
| ABD KIDS | 1.5% |
| **Total (SFY 2015 Mix)** | **67.6%** |

### All Populations – Combined Expenditures

| COA | SFY 2015 |
|---|---|
| FFS | 32.4% |
| MC - FFS | 4.7% |
| MC - MC | 62.9% |
| **Total (SFY 2015 Mix)** | **100.0%** |

## Appendix I.G – SFY 2015 Optumas and ODM Comparison

### Optumas PMPMs

| Population | SFY 2015 MMs | SFY 2015 Midpoint PMPM | SFY 2016 Midpoint PMPM | SFY 2017 Midpoint PMPM |
|---|---|---|---|---|
| FFS Populations | 6,891,712 | $1,105 | $1,130 | $1,157 |
| MC Populations | 28,817,275 | $523 | $537 | $554 |
| **Total (SFY 2015 Mix)** | **35,708,987** | **$635** | **$651** | **$671** |

### ODM PMPMs

| Population | SFY 2015 MMs | SFY 2015 Midpoint PMPM | SFY 2016 Midpoint PMPM | SFY 2017 Midpoint PMPM |
|---|---|---|---|---|
| FFS Populations | 6,891,712 | $1,105 | $1,100 | $1,122 |
| MC Populations | 28,817,275 | $514 | $526 | $556 |
| **Total (SFY 2015 Mix)** | **35,708,987** | **$628** | **$636** | **$665** |

### Optumas to ODM Comparison

| Population | SFY 2015 MMs | SFY 2015 Midpoint PMPM | SFY 2016 Midpoint PMPM | SFY 2017 Midpoint PMPM |
|---|---|---|---|---|
| FFS Populations | 6,891,712 | 0.0% | 2.8% | 3.2% |
| MC Populations | 28,817,275 | 1.8% | 2.1% | -0.2% |
| **Total (SFY 2015 Mix)** | **35,708,987** | **1.2%** | **2.3%** | **0.9%** |

*Note: Additional payments associated with Medicare Part D Clawback and Medicare Buy In are included in ODM's figures above. To ensure an accurate comparison is made, these payments have been allocated to the FFS and MC populations in* ***Optumas****' PMPM figures above.*