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September 12, 2024

Ms. Jada Brady
Executive Director
Joint Medicaid Oversight Committee
Vern Riffe Center
77 S. High Street, 19th Floor
Columbus, OH 43215

**Subject: DRAFT Ohio JMOC SFY 2026-2027 Biennium Medicaid Growth Rate Projections**

Dear Ms. Brady:

Thank you for the opportunity to assist the Joint Medicaid Oversight Committee with the development of the JMOC Medicaid growth rate projections for the SFY 2026-2027 biennium. It was a pleasure to work with you and your team throughout this project. The following DRAFT report summarizes the methodology for the development of the SFY 2026-2027 biennial growth rate projections.

We look forward to discussing our findings and methodology with the JMOC team. New to this biennium, the passage of Amended Substitute House Bill 33, Ohio's Operating Budget for SFY 2024-2025, requires the Ohio Department of Medicaid (ODM) to submit its Historical and Projected Expenditures and Utilization Trend Report to JMOC on October 1, 2024, per Ohio Revised Code (ORC) 5162.70, Reforms to Medicaid program. Upon ODM's submission, Optumas and JMOC will review the information and update this preliminary Medicaid growth rate report as necessary. The final report will be delivered to you on Friday, October 4, 2024.

Sincerely,

Dan Skinner, FSA, CERA, MAAA

CC: Barry Jordan, FSA, MAAA, CBIZ Optumas
Lea Petit, CBIZ Optumas
Marshall Dupree, CBIZ Optumas
Scott Campbell, CBIZ Optumas

**CBIZ Optumas, LLC**
**7400 East McDonald Dr., Suite 101**
**Scottsdale, AZ 85250**
**480-588-2499**

# Ohio Joint Medicaid Oversight Committee

# Draft State Fiscal Years 2026-2027 Biennium Growth Rate Projections

State of Ohio

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# 1. Executive Summary

Per Ohio Revised Code (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) 2026-2027 Biennium (July 1, 2025 – June 30, 2027). Through a competitive procurement process, JMOC originally contracted with CBIZ Optumas (Optumas) in 2014 as its consulting actuary for this analysis for the SFY 2016-2017 Biennium. The estimated SFY 2026-2027 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 Ohio Medicaid program. To ensure that the projections are independent of proposed policy changes that have yet to be implemented, these projections are developed with the assumption that current policy continues into the biennial period. This approach is consistent with the approach used to develop the SFY 2016-2017, SFY 2018-2019, SFY 2020-2021, SFY 2022-2023, and SFY 2024-2025 biennial projections.

The PMPM projections are based on a combination of data sources, including detailed claims-level Fee-for-Service (FFS) data and Managed Care encounter data, cost reports acquired from the Ohio Department of Medicaid (ODM), as well as summarized base data and projected capitation rates provided in ODM's Managed Care certification letters. The projections have been developed as a range of PMPM growth, developed at the category of aid (Medicaid eligibility category) and category of service (Medicaid covered services) summarized level. By combining the various projections using a constant category of aid mix, Optumas calculated a program-wide PMPM on a standardized basis to project the rate of increase of the Medicaid program over the biennium.

The federal Department of Health and Human Services declared a public health emergency (PHE) in March 2020. One effect was to freeze all Medicaid disenrollment nationwide, with a few narrow exceptions. This had a significant impact on the Medicaid population mix of every state as the balance shifted toward healthier working adults who had experienced economic disruption. While aggregate Medicaid spending increased with the enrollment, per capita costs were reduced. Medicaid eligibility redeterminations and disenrollment (sometimes called "unwinding") commenced in May 2023 and planned for completion in April 2024, though many states have seen their unwinding process continue for a few more months beyond their target date. In Ohio, the ODM-published caseload reports have shown a continued decline in enrollment from May 2023 through June 2024, based on caseload reports published through July 2024; July 2024 enrollment shows a much smaller decline overall, and a slight increase in managed care enrollment. This observation indicates that the unwinding process is nearly, if not fully, complete. While the pandemic permanently altered aspects of the health care sector and the economy in general, in some ways the unwinding process reversed some of the pandemic-era changes to Medicaid. We will discuss some of these lingering effects and their impact on future projections throughout this report. While the SFY 2024-2025 biennium report required multiple scenarios to explore potential outcomes, this report returns to past form with only one projection.

Optumas developed a range of projected PMPM growth:

***Figure 1. Projected DRAFT Rates of Growth***

| | Annualized Growth | |
|---|---|---|
| **SFY** | **Lower Bound** | **Upper Bound** |
| 2026 | 3.8% | 4.7% |
| 2027 | 3.7% | 4.6% |
| **Avg. Annual** | **3.7%** | **4.7%** |

Projected annualized growth from Optumas' CY 2024 (January 1, 2024 – December 31, 2024) projection to SFY 2026 (July 1, 2025 – June 30, 2026) is estimated to be between 3.8% and 4.7% and the rate of growth from SFY 2026 to SFY 2027 is projected to be between 3.7% and 4.6%. Weighted together equally, the projected growth is projected to be between 3.7% and 4.7% annually, over the course of the biennium[1]. For additional context, CMS released its National Health Expenditure (NHE) projections in June 2024. The average annual growth for Medicaid and CHIP inherent in these projections for the SFY 2025 to SFY 2027 period is 5.4%, which is higher than the upper bound of this biennium projection. This could be caused by a different mix of members and services in the underlying data, as well as differences in methodology.

Per ORC Section 103.414, as the consulting actuary for this analysis, Optumas has developed the range of projected rates of growth; however, JMOC has the choice of selecting a rate within the range presented in Figure 1 or selecting an independent growth rate.

ORC Section 5162.70 requires that, once the JMOC rate is selected, Medicaid must limit the aggregate PMPM growth over the SFY 2026-2027 biennium to be the lower of (1) JMOC's final selected growth rate or (2) the three-year average Medical CPI for the Midwest. Figure 2 below shows the Midwest and US Medical CPI for the past three years.

***Figure 2. Midwest and US Medical CPI***

| Time Period | Midwest CPI | US CPI |
|---|---|---|
| 8/2021 - 7/2022 | 4.1% | 4.8% |
| 8/2022 - 7/2023 | -1.0% | -1.0% |
| 8/2023 - 7/2024 | 1.4% | 3.1% |
| **3 Year Avg. (Unweighted)** | **1.5%** | **2.3%** |

***Negative inflation in the second comparison year is an artifact of the CPI's market basket which includes the cost of commercial health insurance; this does not directly correlate to a decline in Medicaid-related growth.***

A three-year unweighted average has been used by JMOC in the past, however this was in the environment where medical CPI was reasonably stable. In this case negative inflation in the second year is an artifact of the CPI's market basket which includes the cost of commercial health insurance (the coverage most people obtain through their employment). The cost of health insurance fell in this period largely due to lingering effects from the pandemic and does not represent a long-term adjustment we expect to see carried into the future.

[1] Please note that rate increases to nursing facility and waiver services rates were effective July 1, 2024 and were not included in this analysis as the actuarial certification letter was not available at the time of this report.

Medical CPI is a valuable benchmark and an important guardrail around medical spending; however, we believe that in this case a metric that includes negative inflation would be an inappropriate choice for the growth rate this cycle. The cost of commercial health insurance does not directly impact Medicaid growth and therefore Optumas suggests looking to other metrics. As one alternative, we have re-weighted the components of the market basket according to the distribution of dollars in the Ohio Medicaid program while removing commercial insurance. In this case, the weighted CPI is **3.2**%, which is below the lower bound of the projected biennial growth rate. Reasons for this can include that CPI, a backwards-looking measure, does not take into account several important drivers of the SFY 2026-2027 biennium growth rate: higher utilization of certain services, availability of new expensive drugs, and the high rate of wage growth among lower wage healthcare workers that staff nursing facilities and perform waiver services.

The remainder of this report presents the process used to develop the projections for the SFY 2026-2027 biennium. Each of the report sections are described in Figure 3 below.

***Figure 3. Report Structure***

| Section | Contents |
|---|---|
| **Background** | Provides a description of Optumas' role in developing PMPM projections for the SFY 2026-2027 Ohio biennium. |
| **Data** | Provides an overview of the data used when developing the projections, including data sources, limitations, and adjustments. |
| **Trend** | Provides a description of the process used to develop trend and the final trend estimates for the SFY 2026-2027 biennium. |
| **Projection Summary** | Provides summarized results of the projected PMPM growth developed for the SFY 2026-2027 biennial projections. |
| **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 2026-2027 Biennium. As JMOC's contracted consulting actuary, Optumas has developed the SFY 2026-2027 estimated inflation rate as a range of projected rates of growth on a PMPM basis for the 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 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 the Medicaid program has limited control over, Optumas has worked with JMOC to focus on projecting a rate of growth on a per-member basis; in other words, a rate of change in PMPM expenditures over time.

JMOC has the choice to either select a rate of growth within the range developed by Optumas**,** or to select an independent rate. Per ORC Section 5162.70, once the JMOC rate is selected, ODM must limit the aggregate PMPM growth over the SFY 2026-2027 biennium to be below the lower of (1) JMOC's final selected growth rate or (2) the three-year weighted average Medical CPI for the Midwest. Upon Optumas' review, we have concerns that the recent medical CPI does not accurately reflect growing costs in a rapidly changing medical landscape. Of particular note, the market basket used to calculate the medical CPI includes the cost of health insurance, which fell due to pandemic after-effects, and moreover does not directly impact the Medicaid growth rate. For these reasons, Optumas believes it would be an inappropriate choice for the prospective growth rate. Optumas recommends re-weighting the market basket to remove the cost of health insurance, as well as referencing another benchmark produced by the federal government, such as the National Health Expenditure tables.

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 – Where services are provided in the service delivery network

Each of these determinants of risk can significantly impact both the total dollar and PMPM spend of the Ohio Medicaid program. The following describes some of the ways in which 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 enrolled in Medicaid Managed Care programs can impact the program-wide spend. To the extent that a new population enrolls that is healthier and utilizes less services than the average member of the current program, the overall PMPM cost of the program would be driven down. Conversely, if the new population utilizes more services than the previously enrolled populations, the overall PMPM would increase. The distribution of members who are adults versus children is an example of how the population mix can influence the aggregate PMPM. Children often cost between 40-60% of adults (when comparing similar eligibility categories, e.g., CFC children and adults), so if more children enroll, then it would tend to drive the aggregate PMPM down.

**Benefits –**
Changes in benefits offered through the program can have an impact on 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 a new service is 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.

Optumas considers each of these determinants when evaluating the source data provided by ODM and adjusts the 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 and program-wide member-level eligibility acquired from Ohio's data vendor, EDW; summarized base data and projected capitation rates provided in the Managed Care certification letters; actual and projected Medicare Buy-In/Medicare Premiums, and actual and projected Medicare Part D claw-back amounts. The data sources are projected at the detailed category of aid and category of service levels before aggregating into a category of aid level projection. Once each category of aid projection has been developed, the projected PMPMs for each category of aid are weighted together based on the number of member months in each category to calculate a program-wide PMPM projection. Please see Appendix I.A. for a list of categories of aid (COA) and categories of service (COS) included in this analysis.

As part of the biennial projection, Optumas developed a base data set from historical FFS expenditure data and projected that base data using trends specifically developed for each category of aid and category of service. The projections for services delivered via Managed Care were developed based on capitation rates and trend factors developed by ODM's actuary, with some modifications to reflect the growth rate covering periods beyond the particular year for which the capitation rates were developed.

Projected PMPMs include total Medicaid spending, excluding any one-time expenses and expenses not tied directly to a member. Consistent with the SFY 2024-2025 analysis, the following expenses are excluded from the JMOC rate:

- All-Agency State Administration,
- Hospital Care Assurance Program (HCAP),
- Hospital Upper Payment Limit (UPL),
- State Directed Payments,
- Health Insuring Corporation (HIC) Franchise and Premium Tax,
- Care Innovation and Community Improvement Program (CICIP),
- MCP/Hospital Incentive,
- Other settlements, quality incentives, and rebates paid outside of the claims system and outside of the Managed Care capitation rates.

**One exclusion of particular note is the American Rescue Plan Act (ARPA) related one-time provider relief payments, which were made outside of the claims adjudication system.**

The next section of this report outlines the process and steps taken to develop a base data set from which to develop the projections for the SFY 2026-2027 biennium.

# 3. Data

## *3.01 Sources*

Optumas utilized detailed claims-level FFS cost and utilization data in conjunction with member-level eligibility information to develop a comprehensive base data set that includes both COA and COS level of detail. This data reflects FFS services incurred from January 2023 through March 2024 for all Ohio Medicaid eligible members, including pharmacy claims covered under the Single Pharmacy Benefit Manager (SPBM). This cost and utilization information was used to develop PMPMs for the COS within each COA, allowing detailed analysis of Medicaid spend for the SFY 2026-2027 biennial projection. In addition to the FFS data, Optumas also received detailed claims-level cost and utilization encounter data reflective of experience for the Managed Care Plans (MCPs) 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 Milliman, the actuarial firm who contracted with ODM to develop the Calendar Year (CY) 2024 Ohio Managed Care capitation rates, on a PMPM basis.

The following data sources were used to compile the base data for the SFY 2026-2027 biennial projections:

**Ohio January 2023-April 2024 FFS Claims and Managed Care Encounter Data –**

The Ohio FFS claims and Managed Care encounter data was provided by Ohio's data vendor, EDW, and is a comprehensive claims-level data set comprised of all claims incurred and reported through the Ohio Medicaid delivery system. This level of detailed data allowed Optumas to quantify key actuarial metrics for the Ohio Medicaid program, including average annual utilization per 1,000 members (Util/1,000), unit cost (UC), and per-member-per-month (PMPM) costs for all categories of aid and categories of service. Having this level of claims detail and metrics available allows for a robust projection of the utilization and cost components of the SFY 2026-2027 biennial growth rate. After a review of each year of base data, as well as policy and program changes that were implemented during this time period, Optumas determined that calendar year (CY) 2023 would serve as the base data for the FFS component of the SFY 2026-2027 biennial projection. Nevertheless, historic data prior to CY 2023 and the emerging CY 2024 data was utilized when developing the projected trend factors and for benchmarking purposes, after adjusting the data for applicable policy changes to allow for consistent trend review.

**Ohio January 2023-March 2024 Eligibility Data –**

The Ohio eligibility data was provided by Ohio's data vendor EDW and is a comprehensive list of member-level eligibility for all Medicaid enrollees. This includes demographic information, as well as indicators for population types that help identify each member's category of aid. The monthly eligibility data is used to calculate COA-specific and program-wide member months and to link eligible members to the claims incurred for each month to ensure that costs are directly associated with an eligible Medicaid recipient.

**Monthly Medicaid Variance Reports** –

The monthly Medicaid Variance Reports were used to validate the CY 2023 base FFS expenditures. These reports capture monthly expenditures at the aggregate COS 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. These reports serve as a high-level benchmark to ensure the CY 2023 base data has been categorized appropriately.

**Ohio Department of Medicaid Caseload Reports** –

The Ohio Department of Medicaid Caseload Reports, reported with enrollment through March 2024, were used as a benchmark for the membership calculated from the member-level eligibility file. These reports help Optumas ensure that members within the monthly eligibility data have been attributed to the appropriate COA for projection purposes.

**Managed Care Certification Letters and Capitation Rates** –

Optumas received the following Managed Care certification letters provided by Milliman to ODM as part of the Milliman actuarial contract with ODM: Medicaid Managed Care (MMC) CY 2024, MyCare Opt-In and Opt-Out CY 2024, and OhioRISE CY 2024. The corresponding capitation rates and summarized base data and trend projections (by COA, COS, and region) included within these certification letters were used as the basis for projecting the growth rate for Managed Care expenditures. The certification letters described in this section represent changes to the managed care plan contracts for new capitation payments and are the primary contractual change relevant to cost growth projection. Other contract and rate amendments may occur during the course of CY 2024, but the most recent certification letters provide a reasonable basis for reviewing the managed care cost growth. Optumas relied on the CY 2024 MMC certification letter, the CY 2024 MyCare Opt-In certification letter, the CY 2024 MyCare Opt-Out certification letter, and the CY 2024 OhioRISE certification letter as the basis of the Managed Care portion of the biennium projections.

**Actual and Projected Medicare Premium Assistance/Part D Claw-Back Payment –**
As part of the projection process, Optumas received the latest CY 2023-2024 Part D claw-back amounts for dual eligible Medicaid and Medicare members. Additionally, Optumas reviewed projected Medicare Part A and B premiums through CY 2024 as part of the Buy-In population projections. These additional Medicare costs are paid outside of the Medicaid claims delivery system but are tied to a Medicaid recipient. These costs contribute approximately 5% to the overall Ohio Medicaid program spending that is covered by the growth rate analysis. These costs were projected forward into the SFY 2026-2027 biennial period on a PMPM basis and are added to the final PMPMs developed from the FFS data and Managed Care projected rates.

The Ohio Medicaid FFS data allows Optumas to analyze member-specific costs at a very detailed level. Optumas performs the following data validation analyses prior to developing projections to ensure that the base data used for projections is appropriate and complete:

**Referential Integrity Checks –**
This ensures that all claims included in the base data were incurred by a member with a valid eligibility determination at the time of the incurred date associated with the specific claim.

**Volume Checks –**
Optumas checked both volume of claims and total expenditures by category of service by looking at totals longitudinally over time. This ensured that potential gaps or spikes in the data were identified and addressed before creating the base data.

**Benchmark Comparison –**
Optumas compared summarized costs and enrollment data, derived from the detailed data to several sources, including monthly variance reports and caseload reports provided by ODM as described above.

These analyses enabled Optumas to identify and address any significant data limitations associated with the January 2023-April 2024 FFS data prior to developing the rate of growth projections. One issue of particular importance was the non-payment of claims. This issue potentially impacted all FFS data in the base period because the total cost of the Medicaid program could be under-stated. In late 2023 and early 2024 large retroactive adjustments amounting to hundreds of millions of dollars were paid to settle aged claims. After several rounds of discussions with ODM on this topic, ODM stated that it did not expect any further large retroactive adjustments to claim payments in this period. As such, the base data was considered complete and no explicit adjustment for unpaid claims was made.

***One issue of particular importance was the non-payment of claims. As described on this page, an adjustment was deemed unnecessary based on the information provided by ODM. To the extent this issue continues to be present in CY 2024 or if additional settlements are needed for CY 2023, JMOC should stay informed of the issue and the growth rate may need to be amended in such a case.***

As mentioned earlier in this report, Optumas utilized CY 2024 MMC, CY 2024 MyCare Opt-In, CY 2024 MyCare Opt-Out, and CY 2024 OhioRISE capitation rates along with supporting data as the baseline for projecting Managed Care costs into the biennium period[2]. The base data referenced in the certification letters is benchmarked to the encounter data provided by ODM prior to Optumas completing its projections. In addition, the various adjustment and projection factors used by Milliman are reviewed for reasonableness. Ultimately, Optumas relied upon the adjustment and projection factors developed by Milliman for the various managed care programs noted above, within the development of the Managed Care portion of the projection as a basis. Note that in some circumstances, specific adjustments were

[2] An amendment of the CY 2024 managed care rates, effective 7/1/24, was not available at the time of this report and therefore was not included in the analysis.

made to these trends to reflect dynamics expected to impact future periods, further discussed in Section 4 below.

Consistent with the "current policy" approach to the projections, programmatic changes occurring within the biennium and other significant changes in the rate setting process outside the scope of this report are not considered in the biennial projections.

The following section describes the base data adjustments Optumas made to the FFS claims base data to ensure that all data is on the same "current policy" basis before projecting into the biennium.

### *3.02 Base Data Adjustments*

In addition to adjustments used 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%. 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 FFS base data period, starting January 1, 2023. The following section discusses major policy changes that have been considered in the development of the base data used in the SFY 2026-2027 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.

**Next Generation of Managed Care –**
In February 2023, a significant number of non-dual FFS members were shifted to managed care as part of the Next Generation of Managed Care go-live.

**Single PBM –**
In 2019, the Ohio Legislature directed ODM to select and contract with a single PBM (SPBM) for most Medicaid pharmacy services. This project was completed in late 2022 and is fully reflected in the CY 2023 data used in this analysis.

As the managed care plans are no longer responsible for pharmacy costs for their members, this risk was removed from the CY 2024 managed care capitation rates that are set by ODM's actuary. Accordingly, Optumas developed pharmacy trend rates based on Ohio's Medicaid FFS pharmacy data, various industry reports and benchmarks as well as perspective gained as actuary of record for several states within the country.

Effective September 1, 2023, ODM implemented a 5.7% increase to pharmacy dispensing fees for Managed Care prescriptions. Additionally, effective January 1, 2024, ODM implemented a 5.7% increase to pharmacy dispensing fees for FFS prescriptions. The CY 2023 Managed Care and FFS base data was adjusted to reflect the increase in dispensing fees.

**OhioRISE –**
OhioRISE aims to shift the system of care and keep more kids and families together by creating new access to in-home and community-based services for children with the most complex

behavioral health challenges. The OhioRISE program's child and family-centric delivery system recognizes the need to specialize services and support for this unique group of children and families.

For the CY 2024 rating period, ODM's actuary has projected the population and per capita costs for this program, and these costs are fully integrated in the managed care portion of this projection.

**SNF, ICF, and Waiver Services –**
Significant investments in Nursing Facilities and Skilled Nursing Facilities, Intensive Care Facilities, and waiver services effective January 1, 2024 were authorized in various legislative bills:

- Minimum wages for workers performing waiver services overseen by the Department of Developmental Disabilities were increased by about 30%
- Other waiver services, primarily serving the MyCare population and the FFS population enrolled in the Assisted Living, Ohio Home Care, and PASSPORT programs were increased by amounts around 45% to 55%
- Nursing Facility per diems increased approximately 18%
- Minimum wages for ICF workers were increased about 14%

While we do not expect this same rate of growth to extend further into the future, it is expected that a diminished rate of growth of these costs will continue into the biennium through SFY2026-2027. Therefore, we have built in an additional unit cost trend of 3.25-3.75%, with a midpoint estimate of 3.5% to reflect this expectation. This is based on national trend information, including CMS' Medicare NF unit cost trends, and consideration for recent national wage growth.

The aggregate PMPM impact of the adjustments to the FFS and Managed Care populations base data and FFS expenditures listed above can be found in Appendix I.B by major category of aid.

# 4. Trend

Trend factors are 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 are used to project the PMPM costs from the base period to the SFY 2026-2027 biennial projection period.

The trend figures developed for the biennial projection based on claims-level detail were reviewed at various levels, including:

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

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. Known policy and program changes were considered, as well as any outlier costs, so that the projected trends were not influenced by one-time reimbursement 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 2026-2027 biennial period and are 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 Milliman, ODM's actuary, for CY 2024 Managed Care capitation rates as a basis. Using these trends assumes that a similar methodology and similar trend projections would be used for future capitation rate contract periods. The trends developed for the CY 2024 capitation rates were displayed at a category of aid and category of service level and were included in the CY 2024 certification letters. Optumas used these trend estimates, along with a range of variation (assuming that trends for some categories may be higher or lower) to project the CY 2024 capitation rates into the SFY 2026-2027 biennial projection period. A similar process was followed for the CY 2024 MyCare Opt-In and MyCare Opt-Out capitation rates, as well as CY 2024 OhioRISE capitation rates.

An exception to the trend approach noted above pertains to the Nursing Facility (NF) and HCBS Waiver (waiver) services within the MyCare portion of the growth rate development. As is common practice, the periodic changes in NF per diems and waiver service rates are accounted for within the capitation rates as program changes rather than trend by ODM's actuary. Because of this, the developed trend for these services is generally low, as our understanding is that it is not intended to capture reimbursement changes. However, recent policy in Ohio has included regular updates to the Nursing Facility per diems and to waiver service reimbursement. Upon reviewing the changes to these services in recent years, the changes have been significantly higher than normal; for example, the NF per diems increased by nearly 20% from SFY23 to SFY24, and the estimated impact of reimbursement increases across all waiver-related services included within MyCare was approximately 50% effective January 2024. While we do not expect this level of increase to continue (outside of large legislative outlays), we believe that it is reasonable to expect future increases to these services through the biennium as we interpret that current policy has

included increases to these services . Therefore, we have built in an additional unit cost trend of 3.25-3.75%, with a midpoint estimate of 3.5% to reflect this dynamic. This is based on national trend information, including CMS' Medicare NF unit cost trends, and consideration for recent national wage growth.

The above approach has been taken within the MyCare portion of the projection; however, this has also been accounted for within the FFS portion of the projection for NF, ICF/ID, and all waivers (ODM, Aging, and DODD). While the magnitude varies, the same dynamics of large recent rate changes for ICF/ID and DODD waivers were observed and therefore we believe a similar prospective expectation of future rate changes is appropriate.

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 COA and COS from the CY 2023 FFS base (first trended to CY 2024) and the CY 2024 Managed Care base, and CY 2024 MyCare and OhioRISE bases into the SFY 2026-2027 biennium.

The annualized trends used to project each category of aid into the lower bound and upper bound of SFY 2026 and SFY 2027 are shown below in Figures 4 through 6. Each projection category reflects the growth rate across all services incurred by that population category. For example, the Adults category in the Managed Care section reflects the projected growth rate across both their capitated expenses and FFS expenses

***Figure 4: Annualized FFS Trend Projections – FFS Populations:***

| | SFY 2026 | | SFY 2027 | | Average Annual | |
|---|---|---|---|---|---|---|
| **FFS Populations** | **Lower Bound** | **Upper Bound** | **Lower Bound** | **Upper Bound** | **Lower Bound** | **Upper Bound** |
| Adults | 1.9% | 2.9% | 2.0% | 3.0% | 1.9% | 2.9% |
| Children | 1.9% | 2.9% | 1.9% | 2.9% | 1.9% | 2.9% |
| Disabled | 3.5% | 4.4% | 3.5% | 4.5% | 3.5% | 4.5% |
| Dual | 3.4% | 4.4% | 3.4% | 4.4% | 3.4% | 4.4% |
| Other | 1.8% | 2.8% | 1.8% | 2.8% | 1.8% | 2.8% |
| **Total** | **3.4%** | **4.4%** | **3.4%** | **4.4%** | **3.4%** | **4.4%** |

***Figure 5: Annualized Total Spend Trend Projections – MC Populations:***

| | SFY 2026 | | SFY 2027 | | Average Annual | |
|---|---|---|---|---|---|---|
| **Managed Care Populations** | **Lower Bound** | **Upper Bound** | **Lower Bound** | **Upper Bound** | **Lower Bound** | **Upper Bound** |
| Adults | 4.0% | 5.1% | 3.6% | 4.6% | 3.8% | 4.9% |
| Children | 3.7% | 4.7% | 3.6% | 4.6% | 3.7% | 4.7% |
| Disabled | 3.9% | 4.9% | 3.9% | 5.0% | 3.9% | 4.9% |
| Dual | 3.5% | 4.0% | 3.5% | 4.0% | 3.5% | 4.0% |
| Other | n/a | n/a | n/a | n/a | n/a | n/a |
| **Total** | **3.9%** | **4.8%** | **3.6%** | **4.6%** | **3.8%** | **4.7%** |

***Figure 6: Annualized Statewide Trend Projections – All Populations and Services:***

| | SFY 2026 | | SFY 2027 | | Average Annual | |
|---|---|---|---|---|---|---|
| **All Populations** | **Lower Bound** | **Upper Bound** | **Lower Bound** | **Upper Bound** | **Lower Bound** | **Upper Bound** |
| FFS - FFS Costs | 3.4% | 4.4% | 3.4% | 4.4% | 3.4% | 4.4% |
| MC - FFS Costs | 6.1% | 7.2% | 5.8% | 6.9% | 6.0% | 7.0% |
| MC - MC Costs | 3.1% | 4.0% | 2.9% | 3.8% | 3.0% | 3.9% |
| Additional Payments[1] | 4.6% | 5.3% | 5.6% | 6.4% | 5.0% | 5.7% |
| **Program Wide** | **3.8%** | **4.7%** | **3.7%** | **4.6%** | **3.7%** | **4.7%** |

[1] *Includes Buy-In/Part D Clawback*

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

- SFY 2026 – This reflects the projected rate of growth from the CY 2024 projected lower and upper bounds to the SFY 2026 projected lower and upper bounds.
- SFY 2027 – This reflects the projected rate of growth from the SFY 2026 projected lower and upper bounds to the SFY 2027 projected lower and upper bounds.

As exhibited in the table above, the projected growth rate, assuming current policy and constant post-unwinding population mix, is:

- Between 3.8% and 4.7% (annualized) from CY 2024 to SFY 2026
- Between 3.7% and 4.6% from SFY 2026 to SFY 2027

As noted in the Executive Summary, CMS released its National Health Expenditure (NHE) projections in June 2024[3].The average annual growth for Medicaid and CHIP inherent in these projections is 5.4% from 2025-2027, which is higher than the upper bound range in this biennial growth report.

The following section summarizes the overall projection results from the combination of each step of the biennial projection process previously described.

[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469

# 5. Projection Summary

To develop a range of projected 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 ODM is limited in the amount of control it has over the change in enrollment over time, a growth target based on PMPM expenditures, rather than total program dollars, provides a means of reducing the effect of population growth on this target. In addition to developing projections on a PMPM basis, the aggregate PMPM (across all populations) is calculated by weighting the individual COA projections based on a constant post-unwinding enrollment mix. While previous growth rate reports utilized a constant historical population mix, in this case it was appropriate to model the expected "stable" population after that substantially reflected the post-unwinding population. Furthermore, as outlined within Section 3.02 of this report, these projections assume that current policy continues.

Optumas began with the base data time period of CY 2023 for FFS expenditures, CY 2024 Managed Care capitation rates, CY 2024 MyCare Opt-Out and MyCare Opt-Out capitation rates, and CY 2024 OhioRISE capitation rates for Managed Care expenditures. The FFS base period was then adjusted for program changes, based on the current policy within the Medicaid program discussed in Section 3.02. To bring the time periods onto the same relative basis as the biennium, the base periods were trended forwarded to CY 2024 before trending into each year of the biennium using the lower and upper bound trend estimates. These trended values are shown in Appendix I.B. The summary in Figure 7 below shows the blended CY 2024 aggregate PMPM estimates for the base year of the biennium; the CY 2024 PMPM estimates include adjustments for known material program changes effective through 1/1/24. Note that this is an estimate based on a fixed caseload mix (mix of populations) and therefore if the actual enrollment or other programmatic changes occur within CY 2024 the actual CY 2024 experience may fall outside of the range provided below.

***Figure 7: CY 2024 PMPM Estimates:***

| Rating Period | Lower Bound Estimate | Upper Bound Estimate |
|---|---|---|
| CY24 | $909 | $914 |

Using the CY 2024 base described above, Optumas applied the trend factors described within Section 4 of this report to project both the lower bound and upper bound to each fiscal year in the biennium. For each year of the biennium the lower bound trend is applied to the lower bound estimate from CY 2024 to SFY 2026, and a similar approach is applied for the upper bound estimates. Figure 8 below shows the final SFY 2026 and SFY 2027 aggregate PMPM projections and corresponding trends.

***Figure 8: SFY 2026-2027 Projections:***

| Overall Projection | | | | |
|---|---|---|---|---|
| | PMPM | | Annualized Trend | |
| SFY | Lower Bound | Upper Bound | Lower Bound | Upper Bound |
| 2026 | $961 | $979 | 3.8% | 4.7% |
| 2027 | $996 | $1025 | 3.7% | 4.6% |
| **2026 – 2027** | | | **3.7%** | **4.7%** |

The figures above exclude all cost categories as described in Section 2.

The projections shown in Figure 8 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, costs for Nursing Facility services are included within the projections; these expenditures reflect an estimate of Medicaid's share of the cost for members who reside in a Nursing Facility. However, this does not reflect additional service costs for which a recipient is liable to pay (patient share of cost).

The projections noted above are indicative of estimated PMPM expenditures based on current policy and a constant population mix developed from the post-unwind population observed in May-June 2024. The PMPM projection provides a method of normalizing for population growth over time, however the change in both mix of membership and services delivered within each category above, particularly as it pertains to changes that could occur when the PHE ends, could have a significant impact on the overall program-wide PMPM as we move forward into the biennium. For example, if new populations that cost less than the program average begin to enroll 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; at the same time the total aggregate dollars would have increased.

As described in the executive summary, Optumas developed projected growth rates reflective of current policy, for the SFY 2026-2027 biennium per ORC Section 103.414. Upon review of this report and the associated projected growth rates, JMOC is tasked with selecting an overall growth rate within the projected range or selecting an independent growth rate for each year of the SFY 2026-2027 biennium.

## Appendices

Please see the accompanying file titled "OH JMOC - SFY26 - SFY27 Biennial Projection – Appendices_DRAFT.pdf" for the appendices described within this report.