October 1, 2024

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P. Scott Lipps, Representative
Cecil Thomas, Representative
Jada Brady, Joint Medicaid Oversight Committee Executive Director

Re: Reforms to Medicaid program report

Dear Sirs and Madams:

Please find attached the annual report as required by Section 5162.70 of the Ohio Revised Code. This report details reforms implemented by the Medicaid program that address the health objectives outlined in statute while containing program costs. Also attached is the Medicaid Program Expenditure and Utilization Trend Rates as required in even numbered years. This attachment details the Department's historical and projected Medicaid program expenditures and utilization trend rates by Medicaid program and service category.

As outlined in the September 19th, 2024, Joint Medicaid Oversight Committee (JMOC) meeting and the *DRAFT Ohio JMOC SFY 2026-2027 Biennium Medicaid Growth Rate Projections* cover letter, the attached report will be reviewed by CBIZ Optumas before they finalize their Medicaid growth rate report. In response to their draft report and verbal testimony during the September 19th, 2024, JMOC meeting, ODM would like to provide comments.

First, as outlined in the CBIZ Optumas draft report, "the average annual growth for Medicaid and CHIP…for the SFY2025 to SFY 2027 period is 5.4%".[1,2] This is significantly

[1] CBIZ Optumas Draft State Fiscal Years 2026-2027 Biennium Growth Rate Projections report, page 3
[2] While we were not able to identify the 5.4% increase indicated in the Health Affairs article as cited, CMS identifies the National Health Expenditures (NHE) by payer as follows "Medicaid expenditures are projected to rebound to 5.7 percent in 2025-2026, as other personal care spending accelerates due to states' continued

higher than the range of proposed growth in the report. Current per member growth estimates are 5.3% in SFY26 and 5.0% in SFY27.[3] This per member growth rate is not a direct comparison to the JMOC growth rate as, among other things, it is not case mix adjusted. This estimate is close to the high end of the range projected by CBIZ Optumas and better aligned with the national benchmark. The CBIZ Optumas analysis concludes that the CPI Medical Inflation rate is "an inappropriate choice for the growth rate this cycle"[4] . The JMOC actuary also notes that using a rate close to 3.2% excludes important growth drivers like "higher utilization of certain services, availability of new expensive drugs, and the high rate of wage growth among lower wage healthcare workers."

Second, in response to a question regarding the impact of a 1% reduction in growth, it was noted that this reduction would amount to a cut of roughly $330 million. This would result in a $330 million cut in SFY26 and $660 million in SFY27 due to compounding. We suggest that CBIZ Optumas list specific measures that would need to be taken by the executive branch and the General Assembly during the budget process to implement a growth rate below the actual case mix adjusted trend in the upcoming biennium. The rate of growth can only be controlled through material cuts to service access to members or by material cuts to provider rates. For example, a 1% cut in the growth rate would equal a 2.5% across-the-board rate cut on July 1, 2026, impacting nursing facilities, physicians, hospitals and home care providers (and impacting DODD, Aging, and other Medicaid waivers).[5]

Finally, testimony stated "large retroactive payments totaling nearly $1 billion were made at the end of 2023 and beginning of 2024 to settle aged claims incurred in 2023". It appears that the **reprocessing** of claims is being confused with **retroactive/delayed payment of claims**. This amount was not shared with ODM prior to testimony and is factually incorrect.

As indicated in a June 8th, 2024 memo to JMOC, reprocessing can change the paid date on claims without necessarily changing the paid amount. During CY23, $1.18 billion of claims was reprocessed, resulting in a net change of $186 million (2.5% of CY23 fee-for-service paid claims).

The difference between total claims for services provided and total paid claims was only $31 million or 0.14%[6], indicating that payment issues were resolved to the point that there

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expansions and use of home and community-based services." https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

[3] Medicaid Program Expenditure Trend and Utilization Rates, Table III, Forecast by Per Member Per Month by SFY

[4] CBIZ Optumas Draft State Fiscal Years 2026-2027 Biennium Growth Rate Projections report, page 4

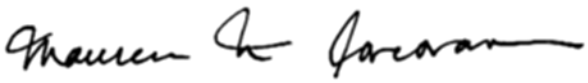
[5] Implementation of rate cuts is subject to the effective date of the budget bill, the rules process, and system changes. To achieve a 1% growth rate cut, the result is an across-the-board rate cut of at least 2.5% on July 1, 2026. To achieve the necessary spending reduction within the biennium, depending on the implementation date of rate cuts, the actual percent cut may be greater than 2.5%.

[6] There were significant delays in processing claims in the first three months of CY23. By the end of 2023 there was essentially no differences ($31m or 0.14%) in total paid claims versus to the total for services

is no material impact to the JMOC growth rate. We ask CBIZ Optumas to correct the legislative record.

Please contact the Ohio Department of Medicaid through our legislative office with any questions or concerns regarding the information in the attached report.

Sincerely,



Maureen M. Corcoran, Director

Attachments:

Medicaid Program Expenditure and Utilization Trend Rates, October 2024

5162.70 Cost Containment Reforms

provided. Consistent with the commonly understood idea of claims run out, in a normal year roughly $400m would be attributable to normal delays in provider submission and processing of claims. ODM has publicly acknowledged our ongoing work to improve and streamline the OMES system.

5162.70 Cost Containment Reforms

In 2014, The Ohio General Assembly enacted ORC Section 5162.70 which required ODM to limit the per-person growth of the Medicaid program by enacting reforms that accomplish various goals identified in the statute. The Ohio Department of Medicaid (ODM) has compiled a list of such reforms and cross-referenced them with which legislative requirement from 5162.70 the reform satisfies.

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
Comprehensive Primary Care for Kids (CPC for Kids) In 2020, ODM implemented a pediatric-focused primary care medical home model to enhance prevention efforts, pediatric-focused activities, and outcomes for kids with Ohio Medicaid.	Research demonstrates investments in childhood primary care result in fewer costly hospitalizations through immunization, screening, and prevention efforts. After launching the program in this biennium, ODM's CPC for Kids program: • Served nearly 1,000,000 kids in 2023 in 300 enrolled primary care practices • Paid more than $9.5 million in monthly payments to participating providers • Provided technical support to pediatric providers to improve practice efficiency and adapt best practices to improve pediatric health outcomes such as lead screening • Awarded $2 million to pediatric practices best able to connect children to care through school-based health, foster care transitions, and other opportunities to engage children and families in receiving supports	• Improve the physical and mental health of medicaid recipients (B)(2)(a) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (C) • Implement evidence-based strategies that include measurable goals (D)
Comprehensive Maternal Care (CMC) In 2023, ODM implemented a maternal-focused obstetric care medical home model to enhance pre-natal care and improve outcomes for infants and mothers with Ohio Medicaid.	Research demonstrates access to high-quality, comprehensive maternal health services, including access to behavioral health services, can improve health outcomes for mothers and their infants. The CMC program uses a framework for providers and community partners to work together to develop person-centered, customized interventions to support women and families who have historically lacked access to high-quality care before and after pregnancy. The CMC program creates financial opportunities for maternal care providers to address patient and family needs across the entire pregnancy and postpartum journey. In the CMC program's first year: • Served nearly 36,000 women in 77 enrolled obstetrical practices	• Improve the physical and mental health of medicaid recipients (B)(2)(a) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (C)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
	• Paid more than $4.2 million in monthly payments to participating providers	
Infant Mortality Grants As discussed at length in Ohio's Infant Mortality Report, African American infants in Ohio are almost three times as likely to die before their first birthday than white babies. In response to this challenge, Ohio Medicaid and the managed care plans have granted funding to target improving Black infant outcomes in communities with the highest racial disparities in infant deaths. This funding has been available since 2018.	ODM's infant mortality grants to Ohio Equity Institute Counties aim to reduce the racial disparity in infant outcomes using community-led, person-centered, evidence-based practices including group pregnancy counseling, home visiting, Centering Pregnancy, community health workers, doula services, lactation support, group support, parenting assistance, care connections to community resources, and fatherhood initiatives. Since 2018, the grants have: • Served 73,949 women • Leveraged 110 unique community-based organizations • Provided more than $78 million dollars in funding	• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Reduce infant mortality rates among medicaid recipients (B)(4) • Implement policies with evidence-based strategies that include measurable goals (C) • Improve the physical and mental health of medicaid recipients (B)(2)(a)
Multi-System Youth Custody Relinquishment Program With leadership from the Governor's Office of Children's Initiatives and the Family and Children First Cabinet Council, ODM administers a state-level program to provide financial and technical support to youth and families with complex needs who may be at risk of custody relinquishment or have already relinquished to the foster care system solely for treatment purposes.	As of June 2024, the program had: • Provided funding to 1,653 youth across all 88 counties. Since 2019 when the fund was created, a total of $93.1 million has been provided to families to preserve custody and obtain access to behavioral health treatment services that are not covered by other funding sources to keep families together and to avoid excessive stays in emergency and inpatient settings • Prevented custody relinquishment in more than 98% of funded cases at the time of writing • Provided technical assistance to an additional 157 children and families (funding not requested)	• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Improve the physical and mental health of medicaid recipients (B)(2)(a) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (D)
Lead Poisoning Prevention and Hazard Control Childhood lead poisoning affects thousands of Ohio children each year. In 2019, Ohio Medicaid received federal approval to conduct a	Research on childhood lead poisoning estimates that each dollar invested in lead paint hazard control results in a return of $17–$221, or a net savings of $181-269 billion in health care, social, and behavioral costs. The ODM/ODH program is available in every Ohio county.	• Improve the physical and mental health of medicaid recipients (B)(2)(a) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)

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Children's Health Insurance Program (CHIP) Health Services Initiative (HSI) to prevent lead poisoning among children with Medicaid. The CHIP program is implemented through the Ohio Department of Health (ODH).	As of SFY 2023-24: • 700 applications for lead hazard control were received. • $10 million in funding was allocated to the program for the biennium. • As of June, 2024, 510 properties have been made lead safe, serving 1,427 children and 25 pregnant women	• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (C)
Electronic Pregnancy Risk Assessment Form (PRAF) and Other Infant Mortality Initiatives The electronic PRAF 2.0 was developed to standardize pregnancy notification and decrease the risk of preterm birth by facilitating the provision of progesterone. Submission of an electronic PRAF automatically notifies county Job and Family Services agencies to maintain Medicaid coverage, the Ohio Department of Health's (DOH) WIC and Department of Children and Youth's (DCY) home visiting central intake program, and managed care providers to address identified needs.	Linking to home visiting intake and maintaining Medicaid coverage can improve pregnancy and infant outcomes. For example, research shows uninsured newborns are more likely to have adverse outcomes, including low birth weight and death, than are insured newborns, and uninsured women are more likely to have poorer outcomes during pregnancy and delivery than women with insurance. In calendar year 2023: • 38,072 electronic PRAF forms were submitted • 401 providers used electronic PRAFs • As of July 2024, the number of PRAFs submitted has reached 30,282 In July of 2024, the PRAF was updated to allow for collection of behavioral health and health related social need screening data, facilitating managed care intervention where needed.	• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Reduce infant mortality rates among medicaid recipients (B)(4) • Implement policies with evidence-based strategies that include measurable goals (C) • Improve the physical and mental health of medicaid recipients (B)(2)(a)
Telehealth Flexibilities On March 9, 2020, ODM adopted emergency telehealth rules to preserve access to vital healthcare services during the temporary delay of elective procedures. Many of these changes were made permanent in November 2020 including: • Relaxed patient and provider site restrictions • Increased provider types utilizing telehealth	Expansion of telehealth began in 2019 but increased during the pandemic to prevent interruption of access to preventive and behavioral healthcare. Providers and individuals in the program report the expansions were helpful in preventing provider closures and maintaining access to crucial services during the pandemic. Pregnancy education and diabetes management services were added as telehealth eligible services in 2022. Pharmacists were added as eligible telehealth providers in 2022 as well. Most of the changes have been made permanent and will continue to benefit the individuals we serve after the public health emergency has concluded. ODM is currently exploring ways to	• Improve the physical and mental health of medicaid recipients (B)(2)(a) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Reduce infant mortality rates among medicaid recipients (B)(4)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
• Reimbursement for telephone and secure portal communications	further improve telehealth provisions since the pandemic has ended.	
Substance Use Disorder (SUD) 1115 Demonstration Waiver Ohio's current SUD 1115 Waiver was approved on October 1, 2019, and is effective through September 30, 2024. The Waiver provides the state with authority to cover high-quality, clinically appropriate treatment to individuals with a SUD across the continuum – including services in the community and residential treatment settings. ODM submitted an application to extend the SUD 1115 Demonstration Waiver for an additional five years on April 1, 2024.	Preliminary findings from the interim waiver evaluation report include a decrease over the measurement period in the rate of overdose deaths, emergency department (ED) and inpatient hospital utilization rates for SUD, and 30-day ED readmission rates for SUD; and an increase over the measurement period in the medications for opioid use disorder (MOUD) provider availability ratio, the proportion of members with OUD receiving MOUD, the proportion of residential treatment stays with MOUD, and the proportion of residential treatment stays with timely follow-up.	• Improve the physical and mental health of medicaid recipients (B)(2)(a) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)
Mental Health Peer Support Effective September 1, 2024, ODM expanded coverage of behavioral health peer support services to include peer support for individuals with mental health conditions. Ohio offers three types of peer supporter certifications: Adult, Family, and Youth/Young Adult. Prior to September 1, 2024, these services were available only for individuals with substance use disorder (SUD) and as a part of several evidenced-based practices	Certified peer supporters use their lived experience to help others impacted by mental illness or substance use disorders. The service has been shown to: • Increase a member's sense of control and ability to bring about positive changes. • Increase engagement in self-care and wellness. • Decrease hospitalizations, inpatient days, and cost of care. • Decrease psychotic symptoms, substance use, and depression. • Strengthen a member's whole health, including the ability to manage chronic conditions like diabetes. Certification attained through the Ohio Department of Mental Health and Addiction Services (OhioMHAS) is required to become a mental health peer support specialist.	• Improve the physical and mental health of medicaid recipients (B)(2)(a) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)
Mobile Response and Stabilization Services (MRSS) MRSS was built on the values of serving children and young adults	MRSS is instrumental in: • Averting unnecessary emergency department (ED) visits, inpatient admissions, out-of-home placements, placement disruptions, and juvenile justice involvement.	• Improve the physical and mental health of medicaid recipients (B)(2)(a)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
with behavioral health crisis needs; maintaining children in their homes and communities; leveraging resources across systems to be more effective in meeting youth and families' needs; and institutionalizing shared governance. ODM implemented MRSS as a Medicaid-covered service in July 2022. ODM has since been working with (OhioMHAS) and DCY on efforts to expand provider capacity to make MRSS available to all youth in Ohio. In August 2024, OhioMHAS issued a request for proposals (RFP) for Regional MRSS Providers (RMPs).	• Reducing system costs. • Keeping a child, youth, or young adult safe at home, in the community, and in school whenever possible. To align with national best practices a "firehouse" model funding approach is being developed within each region. The objective of a "firehouse" model is to: • Create a more predictable funding stream that supports efficiency, availability and access to services. • Allow MRSS services to be staffed during identified times, including periods of low and/or no utilization. The expansion of MRSS services through a regional approach advances the state's goals to expand the crisis services continuum and supports the state's System of Care efforts. When fully in effect, this model will improve the broader behavioral health system to better support youth, families, and caregivers in their homes and communities.	• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)
Unified Preferred Drug List (UPDL) On January 1, 2020, ODM implemented a unified preferred drug list to replace the process of having each managed care plan adopt a different preferred drug list.	Implementing the UPDL has: • Eased administrative burden for prescribers by decreasing unnecessary prior authorization requirements and requiring all MCPs to use one consistent set of requirements. • Maximized the collection of federal and supplemental rebates, ensuring that all supplemental rebates are sent directly to ODM and are not retained by the medicaid MCPs or their PBM. This resulted in an ongoing net savings to the state of $61 million.	• Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e) • Implement policies with evidence-based strategies that include measurable goals (C) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)
Helping Ohioans Move Expanding HOMEChoice Ohio's HOME Choice program transitions eligible Ohioans from institutional settings to home and community-based settings, where they receive services and supports at	Transitioning people who need long-term services and supports (LTSS) out of institutions and back into the community saves taxpayer dollars and improves the quality of life of those we serve. Since the start of the HOME Choice program in 2008, the program has transitioned more than 17,000 individuals to community settings.	• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Improve the physical and mental health of medicaid recipients (B)(2)(a)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
to help them stay in their communities.		• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (C)
Next Generation of Medicaid Managed Care Administrative Savings Creates administrative efficiencies through Single Pharmacy Benefit Manager, Fiscal Intermediary, and Centralized Credentialing while increasing transparency and oversight of Medicaid program.	• Eliminates certain duplicative administrative functions performed by each plan. • Eliminates potential conflicts of interest in the pharmacy program • Increases data integrity and oversight while reducing provider administrative burdens •	• Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)
Eligibility Electronic Database Interfaces ODM currently operates a sophisticated system of electronic interfaces to ensure applicants of Medicaid meet the eligibility qualifications prior to enrolling.	Among these interfaces are: • Quarterly wage reports from the State Wage Information Collection Agency (SWICA) • Social Security Administration (SSA) • Unemployment compensation • Public Assistance Reporting Information System (PARIS) • Bureau of Vital Statistics The interfaces assist with identifying individuals ineligible for program services: • 6,874 individuals were transferred to the Marketplace in August 2024 alone.	• Reduce enrollment without making eligibility requirements more restrictive (D) • Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)
OhioRISE OhioRISE aims to shift the system of care and keep more youth and families together by creating new access to in-home and community-	• Implements "Joint Legislative Committee on Multi-System Youth (MSY) Recommendations" report recommendations to ensure MSY safety-net funding, access to peer support services, Medicaid-reimbursable	• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Improve the physical and mental health of medicaid recipients (B)(2)(a)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
based services for children with the most complex behavioral health challenges.	high-fidelity wraparound services, and facilitation of data collection as shown in OhioRISE White Paper • Targets the most vulnerable families and children to prevent custody relinquishment and reduce Ohio's reliance on costly out-of-state residential treatment • Brings Ohio into compliance with federally enacted Families First Prevention Services Act (FFPSA) • Establishes and increases access to home and community-based services, like Intensive Home-Based Therapy	• Allows Medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (C)
Diabetes Quality Initiative ODM has incorporated key diabetes quality metrics in the managed care quality withhold program to drive better outcomes.	• With the high costs associated with preventable hospitalizations, ODM has increased its focus of controlling blood sugar and other diabetes-related metrics in its managed care quality withhold program • ODM added coverage of the National Diabetes Prevention Program (NDPP) for individuals diagnosed with pre-diabetes and diabetes self-management education (DSME) for individuals living with diabetes and removed prior authorization for continuous glucose monitors in the pharmacy and durable medical equipment (DME) benefit. • By emphasizing this in our population health strategy and allowing access to continuous glucose monitors (CGMs) through the pharmacy (as well as the medical) benefit, ODM is hoping to decrease preventable diabetes-related hospitalizations and complications, bending the cost curve down, and improving patient outcomes.	• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c) • Improve the physical and mental health of medicaid recipients (B)(2)(a) • Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Implement policies with evidence-based strategies that include measurable goals (C)
12-Month Continuous Postpartum Eligibility ODM has implemented the HB 110 requirement to allow continuous postpartum eligibility for one year after giving birth	• The CARES Act permitted states to allow continuous postpartum eligibility with a SPA, rather than a demonstration waiver. • Ohio submitted a SPA to CMS, and it was approved with an effective date of April 1, 2022. • ODM implemented this change in our eligibility system and added it to our suite of infant mortality initiatives. • Continuous postpartum eligibility provides access to healthcare services and helps reduce the prevalence of	• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3) • Reduce infant mortality rates among medicaid recipients (B)(4) • Implement policies with evidence-based strategies that include measurable goals (C) • Improve the physical and mental health of medicaid recipients (B)(2)(a)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
	comorbid health conditions and mortality rates and reduce infant mortality rates	
Ohio Benefits System Updates Beginning early in this administration, ODM worked collaboratively with the Ohio Department of Job and Family Services (ODJFS), the Department of Administrative Services (DAS), and Accenture to identify and categorize 1,500 system defects with Ohio's eligibility and enrollment system. Among these updates were enhancements to reform the number of alerts that are sent to counties prompting them to revisit an enrolled individual's Medicaid eligibility.	• ODM prioritized the most serious defects that can result in an incorrect eligibility determination and fixed nearly 1,000 of them over the course of 9 releases between August 2019 and December 2020. • ODM also, together with ODJFS, continues to streamline these system alerts • Total volume has been nearly cut in half, reducing administrative burdens.	• Reduce enrollment without making eligibility requirements more restrictive (D) • Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)
Enhanced County Engagement and Training As part of our PERM Corrective Action Plan, ODM created a county engagement team split into five regions with a county engagement manager in each region. We engage in quarterly calls with each region to discuss application timeliness, schedule weekly timeliness calls with select counties, and identify and share best practices.	• ODM provided training updates on over 40 topics in CY 2023. • County Engagement meets with all counties in their region quarterly to discuss case processing trends, alert completion, provide hyper care post training and to discuss current hot topics. • ODM and JFS have partnered to create a new worker training curriculum which is hosted at least 3 times a year and covers TANF, SNAP, Medicaid, Child Care and Case Maintenance (all program) policy and system training • ODM hosts monthly webinars with all 88 counties. covering policy updates, training material, and general guidance or instruction on recent changes and issues. • ODM and JFS host quarterly webinars to discuss training topics affecting multiple programs. • For each major system release or system enhancement that impacts the end user, updated training materials are produced and disseminated. County partners provide regular feedback to ODM on Ohio Benefits which assists ODM in identifying system issues and providing prompt workarounds or fixes. . l	• Reduce enrollment without making eligibility requirements more restrictive (D) • Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
Securing Third-Party Vendor for Unwinding from PHE The COVID-19 public health emergency granted states additional Medicaid funding but required that individuals not be disenrolled except in limited circumstances. HB 110 required ODM to procure a vendor to identify those likely ineligible in our program once the public health emergency is declared over to reduce caseload post-pandemic as quickly as possible.	• ODM procured Public Consulting Group (PCG) within the required timeline to identify those likely ineligible and connect to the statutorily required databases. • ODM provided county caseworkers lists of those likely ineligible by PCG to work through the unwinding All cases were processed in accordance with federal and state requirements. Results were audited and found to be highly accurate and efficient. • Caseload was reduced by approximately 500,000 members.	• Reduce enrollment without making eligibility requirements more restrictive (D) • Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)
Risk Corridor A **Medicaid Managed Care Risk Corridor** is a financial mechanism used to limit the financial risk for managed care organizations (MCOs). The risk corridor helps balance the financial outcomes between the MCOs and the state government, sharing the risk of unexpected high or low healthcare costs. The following tools constitute the corridor: 1. **Risk Sharing Tiers Upper Corridor (Profit Limit)** 2. **Lower Corridor (Loss Limit)** 3.	• The risk corridor ensures recovery for the state to limit exposure to dramatic reductions in service utilization. • This risk corridor ended in July 2022 for Medicaid managed care and December 2022 for MyCare. • In April of 2022, ODM recovered $569 million from the rates issued in CY2020 • As of March 2023, an additional estimated $36 million from CY2021 rates will be repaid in CY2024. • In fall 2024, an estimated $151 million from CY2022 rates will be repaid.	• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d) • Implement policies with evidence-based strategies that include measurable goals (C)

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
Medical Loss Ratio As part of the actuarial rate setting process, a specified medical loss ratio (MLR) is included in the managed care capitation rates. Annually the MLR is reported by the managed care plans, reviewed, and submitted to CMS.	• In the event that a MLR is significantly lower than the MLR included in the rates, ODM may recoup dollars from the managed care plans. • Annually, before the next calendar rating period, MLRs are assessed and reported. The next MLR for CY2022 and CY2023 will occur in fall 2024.	• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b) • Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)

Medicaid Program Expenditure and Utilization Trend Rates

October 2024

Ohio Revised Code (ORC) Section 5162.70 (E) states, "In even-numbered years, the report shall include the department's historical and projected medicaid program expenditure and utilization trend rates by medicaid program and service category for each year of the upcoming fiscal biennium and an explanation of how the trend rates were calculated."

The Ohio Department of Medicaid (ODM) budget forecast is intended to provide an accurate estimate of spending on Medicaid services. The forecast is split into different pieces: caseload, managed care capitation, fee-for-service per member per month PMPM, and the pharmacy benefit (SPBM). The general approach is to break enrollment and services into several categories, thereby creating hundreds of individual forecasts, and rolling these together to create a total forecast. This approach takes into account that there may be deviations in individual forecasts, but the assumption is that many of the deviations are not correlated and will cancel each other out (i.e., PMPM for one forecast may be slightly high while another PMPM may be slightly low). Assumptions and groupings are made with the goal of achieving the best overall forecast. ODM uses base SAS and SAS Forecast Studio to develop budget forecasts.

The caseload forecast is the most important piece of the forecast. ODM subdivides caseload into groups by age, eligibility categories (e.g., ABD, Expansion), institutional/waiver status, and rate cell. Using time series forecasting techniques, historical data, and macroeconomic data and projections from S&P (formerly IHS Markit), models are developed to project caseload. Managed care penetration rate forecasts are also developed. If prospective policy or other changes are known (e.g., a conversion of a population from fee-for-service to managed care) adjustments are made to the models. Thus, individual caseload forecasts are made at fairly detailed levels, such as “Medicare dually eligible, non-institutional individuals between the ages of 19 and 64,” and then penetration rates are used to divide the groups into fee-for-service and managed care.

Managed care capitation forecasts are done at the statewide level. Historical data series are used to calculate statewide composite rates for each rate cell, and trend information from ODM’s contracted actuary is then applied to the composite rates. As with the caseload forecast, if prospective policy or other changes are known, adjustments are made to the models.

Fee-for-service (FFS) per member per month (PMPM) forecasts are generated using time series forecasting methods that take into account previous policy changes and other significant events. The fee-for-service PMPM forecasts are subdivided at the same level of detail as the caseload forecast. ODM used to perform more granular fee-for-service forecasts, but as the majority of expenditures have shifted to managed care organizations, rolling up fee-for-service categories is expected to yield a more accurate overall forecast.

The SPBM forecast is similar to the FFS forecast. Time series forecasting methods that take into account previous policy changes and other significant events are utilized.

The individual caseload forecasts are multiplied by the individual per member per month managed care and fee-for-service expenditure forecasts to create a total Medicaid forecast.

ODM does not produce forecasts at the individual provider type or claim type level for payments to providers. Historic trends at the provider type and other levels are considered when forecasts are developed.

This report includes a series of tables reflecting the ODM budget forecast and Medicaid utilization and expenditures.[1] These tables include:

I. **Forecast by Medicaid Program -** shows historic and projected expenditures and caseload by categories shown on the Budget Variance Report by state fiscal year (claims and capitation payment only; excludes DODD). The trend rates were calculated as the year-over-year change.

II. **Forecast by Eligibility Group** - shows historic and projected expenditures and caseload by major eligibility categories by state fiscal year. The trend rates were calculated as the year-over-year change.

III. **Forecast by Per Member Per Month** – shows historic and projected per member per month expenditures by major eligibility groups by state fiscal year (claims and capitation payment only; excludes DODD). The trend rates were calculated as the year-over-year change.

IV. **Medicaid Utilization and Expenditures** - shows historic expenditures and utilization rates by service categories (grouped by pay-to-provider based on claims and encounters) by calendar year view.

[1] For full detail on program and policy changes, please see "Notable Medicaid Policy Changes, SFY22 through SFY25", sent to JMOC in June 2024. Several notable policy changes reflected in tables in this report include:

- Eligibility
  - Federally required continuous coverage requirement ended March 31st, 2023
- Next Generation
  - OhioRISE began enrollment and providing services on July 1st, 2022
  - SPBM began on October 1st, 2022
  - Next Generation Managed Care began on February 1st, 2023
- Rate Increases
  - Dispensing fee increase (managed care September 1st, 2023; FFS January 1st, 2024)
  - Behavioral health provider rate increases on January 1st, 2024
  - Non-institutional provider rate increases on January 1st, 2024
  - Hospital rate increase on January 1st, 2024
  - HCBS provider rate increases on January 1st, 2024
  - NF private room increases begin December 18th, 2024

I. Forecast by Medicaid Program by SFY

Estimated Incurred Cost by SFY - Excludes DODD (Claims Plus Capitation Payments Before Withhold)

	2022	2023	2024	2025	2026	2027
Fee For Service (No DODD)	$4,082,167,037	$4,727,660,855	$5,014,144,825	$5,493,809,284	$5,764,646,427	$5,965,370,696
Managed Care - ADFC	$302,555,694	$199,110,057	$195,909,217	$211,041,512	$231,639,270	$252,220,578
Managed Care - CFC	$7,648,965,081	$6,728,559,898	$6,241,365,948	$6,254,476,659	$6,718,324,802	$7,149,748,629
Managed Care - Delivery	$285,091,520	$299,678,051	$313,809,605	$319,818,478	$333,514,933	$345,545,910
Managed Care - MyCare	$2,886,937,035	$2,982,920,102	$3,326,463,667	$3,624,356,689	$3,768,265,457	$3,923,687,091
Managed Care -ABD Adult	$3,029,585,959	$2,366,467,240	$2,098,913,738	$2,163,717,420	$2,290,379,712	$2,415,634,515
Managed Care -ABD Kids	$715,525,738	$546,015,078	$523,366,362	$560,147,287	$610,826,270	$657,126,682
Managed Care Group VIII	$7,180,444,618	$6,573,751,846	$5,834,985,048	$5,616,450,213	$5,916,785,855	$6,241,252,335
Managed Care -OhioRISE		$259,440,275	$477,301,835	$648,422,531	$712,143,959	$778,565,362
SPBM		$3,902,070,754	$5,463,387,549	$5,624,732,770	$5,960,785,843	$6,339,710,285
Total	**$26,131,272,684**	**$28,585,674,157**	**$29,489,647,795**	**$30,516,972,843**	**$32,307,312,529**	**$34,068,862,084**

Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
Fee For Service (No DODD)	15.8%	6.1%	9.6%	4.9%	3.5%
Managed Care - ADFC	-34.2%	-1.6%	7.7%	9.8%	8.9%
Managed Care - CFC	-12.0%	-7.2%	0.2%	7.4%	6.4%
Managed Care - Delivery	5.1%	4.7%	1.9%	4.3%	3.6%
Managed Care - MyCare	3.3%	11.5%	9.0%	4.0%	4.1%
Managed Care -ABD Adult	-21.9%	-11.3%	3.1%	5.9%	5.5%
Managed Care -ABD Kids	-23.7%	-4.1%	7.0%	9.0%	7.6%
Managed Care Group VIII	-8.4%	-11.2%	-3.7%	5.3%	5.5%
Managed Care -OhioRISE		84.0%	35.9%	9.8%	9.3%
SPBM		40.0%	3.0%	6.0%	6.4%
	9.4%	**3.2%**	**3.5%**	**5.9%**	**5.5%**

II. Forecast by Eligibility Group by SFY

Estimated Incurred Cost by SFY - Excludes DODD (Claims Plus Capitation Payments Before Withhold)

	2022	2023	2024	2025	2026	2027
ABD ADULT	$4,575,196,570	$4,879,799,278	$5,208,729,684	$5,601,563,094	$5,951,961,697	$6,316,306,498
ABD KIDS	$791,328,925	$811,367,556	$878,733,482	$980,435,761	$1,061,880,951	$1,143,176,676
CFC ADULT	$3,888,593,308	$4,308,850,846	$4,191,667,868	$4,138,393,010	$4,385,796,463	$4,608,517,045
CFC KIDS	$4,727,985,060	$4,848,765,133	$5,066,708,678	$5,402,686,792	$5,852,247,209	$6,266,256,862
DUAL	$4,472,759,740	$4,699,477,028	$5,487,385,105	$5,905,191,352	$6,098,701,302	$6,291,379,164
GROUP VIII	$7,584,902,007	$8,950,182,432	$8,546,632,964	$8,357,506,507	$8,814,804,855	$9,290,386,434
OTHERS	$90,507,073	$87,231,886	$109,790,014	$131,196,326	$141,920,051	$152,839,405
Total	**$26,131,272,684**	**$28,585,674,157**	**$29,489,647,795**	**$30,516,972,843**	**$32,307,312,529**	**$34,068,862,084**

Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
ABD ADULT	6.7%	6.7%	7.5%	6.3%	6.1%
ABD KIDS	2.5%	8.3%	11.6%	8.3%	7.7%
CFC ADULT	10.8%	-2.7%	-1.3%	6.0%	5.1%
CFC KIDS	2.6%	4.5%	6.6%	8.3%	7.1%
DUAL	5.1%	16.8%	7.6%	3.3%	3.2%
GROUP VIII	18.0%	-4.5%	-2.2%	5.5%	5.4%
OTHERS	-3.6%	25.9%	19.5%	8.2%	7.7%
	9.4%	**3.2%**	**3.5%**	**5.9%**	**5.5%**

Estimated Enrollment by SFY (Member Months)

	2022	2023	2024	2025	2026	2027
ABD ADULT	2,329,411	2,353,698	2,312,337	2,300,212	2,328,201	2,356,251
ABD KIDS	617,020	623,493	620,229	621,142	624,444	627,741
CFC ADULT	6,833,241	7,207,741	6,265,175	5,554,149	5,585,771	5,585,827
CFC KIDS	15,107,732	15,597,096	14,619,143	14,087,731	14,103,343	14,105,208
DUAL	3,040,559	3,160,304	3,113,641	3,086,890	3,124,555	3,160,592
GROUP VIII	10,270,602	11,494,550	10,318,215	9,366,729	9,353,636	9,355,456
OTHERS	1,685,549	1,679,011	1,637,096	1,722,806	1,808,775	1,894,754
Total	**39,884,114**	**42,115,893**	**38,885,836**	**36,739,659**	**36,928,725**	**37,085,829**

Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
ABD ADULT	1.0%	-1.8%	-0.5%	1.2%	1.2%
ABD KIDS	1.0%	-0.5%	0.1%	0.5%	0.5%
CFC ADULT	5.5%	-13.1%	-11.3%	0.6%	0.0%
CFC KIDS	3.2%	-6.3%	-3.6%	0.1%	0.0%
DUAL	3.9%	-1.5%	-0.9%	1.2%	1.2%
GROUP VIII	11.9%	-10.2%	-9.2%	-0.1%	0.0%
OTHERS	-0.4%	-2.5%	5.2%	5.0%	4.8%
	5.6%	**-7.7%**	**-5.5%**	**0.5%**	**0.4%**

Estimated Enrollment by SFY (Average Monthly Enrollment)

	2022	2023	2024	2025	2026	2027
ABD ADULT	194,118	196,142	192,695	191,684	194,017	196,354
ABD KIDS	51,418	51,958	51,686	51,762	52,037	52,312
CFC ADULT	569,437	600,645	522,098	462,846	465,481	465,486
CFC KIDS	1,258,978	1,299,758	1,218,262	1,173,978	1,175,279	1,175,434
DUAL	253,380	263,359	259,470	257,241	260,380	263,383
GROUP VIII	855,884	957,879	859,851	780,561	779,470	779,621
OTHERS	140,462	139,918	136,425	143,567	150,731	157,896
Total	**3,323,676**	**3,509,658**	**3,240,486**	**3,061,638**	**3,077,394**	**3,090,486**

Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
ABD ADULT	1.0%	-1.8%	-0.5%	1.2%	1.2%
ABD KIDS	1.0%	-0.5%	0.1%	0.5%	0.5%
CFC ADULT	5.5%	-13.1%	-11.3%	0.6%	0.0%
CFC KIDS	3.2%	-6.3%	-3.6%	0.1%	0.0%
DUAL	3.9%	-1.5%	-0.9%	1.2%	1.2%
GROUP VIII	11.9%	-10.2%	-9.2%	-0.1%	0.0%
OTHERS	-0.4%	-2.5%	5.2%	5.0%	4.8%
	5.6%	**-7.7%**	**-5.5%**	**0.5%**	**0.4%**

III. Forecast by Per Member Per Month by SFY

Estimated Incurred PMPM by SFY - Excludes DODD (Claims Plus Capitation Payments Before Withhold)

	2022	2023	2024	2025	2026	2027
ABD ADULT	$1,964.10	$2,073.25	$2,252.58	$2,435.24	$2,556.46	$2,680.66
ABD KIDS	$1,282.50	$1,301.33	$1,416.79	$1,578.44	$1,700.52	$1,821.10
CFC ADULT	$569.07	$597.81	$669.04	$745.10	$785.17	$825.04
CFC KIDS	$312.95	$310.88	$346.58	$383.50	$414.95	$444.25
DUAL	$1,471.03	$1,487.03	$1,762.37	$1,912.99	$1,951.86	$1,990.57
GROUP VIII	$738.51	$778.65	$828.31	$892.25	$942.39	$993.04
OTHERS	$53.70	$51.95	$67.06	$76.15	$78.46	$80.66
Total	**$655.18**	**$678.74**	**$758.36**	**$830.63**	**$874.86**	**$918.65**

Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
ABD ADULT	5.6%	8.6%	8.1%	5.0%	4.9%
ABD KIDS	1.5%	8.9%	11.4%	7.7%	7.1%
CFC ADULT	5.1%	11.9%	11.4%	5.4%	5.1%
CFC KIDS	-0.7%	11.5%	10.7%	8.2%	7.1%
DUAL	1.1%	18.5%	8.5%	2.0%	2.0%
GROUP VIII	5.4%	6.4%	7.7%	5.6%	5.4%
OTHERS	-3.2%	29.1%	13.6%	3.0%	2.8%
	3.6%	**11.7%**	**9.5%**	**5.3%**	**5.0%**

IV. Medicaid Utilization and Expenditures

Provider Type Group[1]	CY 2022 Paid Amount	CY 2022 Unique Patient Count	CY 2022 Claim Count	CY 2023 Paid Amount	CY 2023 Unique Patient Count	CY 2023 Claim Count	CY 2024 TD[2] Paid Amount	CY 2024 TD[2] Unique Patient Count	CY 2024 TD[2] Claim Count
ASC	$42,177,097	50,399	77,423	$42,041,669	47,974	70,720	$21,760,411	23,639	32,337
Ambulance	$106,298,674	283,000	768,233	$102,176,687	260,736	636,067	$59,725,434	115,234	243,546
Behavioral Health	$1,950,331,707	523,439	17,868,304	$2,101,491,403	541,654	18,426,842	$1,221,612,453	411,957	9,324,115
DME / Lab	$518,008,673	962,635	4,728,963	$531,919,856	969,072	4,781,663	$246,403,351	606,378	2,264,759
Dental	$230,568,920	757,122	1,556,261	$199,994,418	685,145	1,299,898	$211,873,930	445,177	726,492
Hospice	$287,181,604	18,306	78,705	$326,707,451	18,079	80,354	$149,613,720	10,285	35,076
Hospital	$7,455,673,158	2,268,650	14,306,466	$7,281,450,279	2,279,897	13,921,439	$3,564,568,863	1,574,142	6,580,918
ICF	$759,502,898	5,361	83,883	$833,100,973	5,331	61,321	$450,570,574	5,054	30,805
Medicaid Schools Prg	$50,300,489	91,456	1,784,196	$48,927,788	88,981	1,778,880	$20,041,952	61,963	794,235
NF	$3,028,929,055	79,148	744,851	$3,085,526,362	78,019	623,315	$1,888,573,549	59,395	351,918
Other	$399,001,252	909,606	4,207,460	$390,445,950	623,924	3,168,722	$217,394,846	451,611	1,919,759
Physician, etc	$2,033,879,653	2,679,119	31,193,586	$2,119,291,283	2,748,909	30,508,145	$1,065,761,173	2,074,349	14,197,998
Renal	$206,952,316	11,406	239,825	$149,840,005	10,622	169,015	$73,653,845	8,303	57,892
Rx	$6,142,330,924	2,308,831	53,551,853	$6,295,048,444	2,387,034	50,605,231	$3,644,489,564	1,911,986	28,292,454
Vision	$36,702,278	412,991	624,067	$20,571,822	281,058	395,889	$6,732,232	105,155	129,508
Waiver HH/PDN	$3,879,825,505	168,639	28,034,741	$4,136,359,157	179,831	29,725,234	$2,806,387,170	153,063	15,098,512
Wheelchair Van	$6,151,933	6,013	69,557	$6,365,099	6,752	68,984	$4,168,772	3,943	34,874
All Medicaid	**$27,133,816,143**	**3,111,496**	**159,918,374**	**$27,671,258,652**	**3,173,443**	**156,321,719**	**$15,653,331,838**	**2,586,145**	**80,115,198**

[1]Abbreviations: Ambulatory Surgery Center (ASC); Durable Medical Equipment (DME); Medicaid Schools Program (Medicaid Schools Prg); Nursing Facility (NF), Pharmacy (Rx), Home Health/Private Duty Nursing (HH/PDN)

[2]Data received and loaded in ODM EDW through 8/26/2024. To date, CY 2024 is consistent with previous year trends given claim submission patterns and decreasing caseload.

Provider Type Group[1]	CY 2022 Expenditures/ Patient	CY 2022 Expenditures/ Claim	CY 2023 Expenditures/ Patient	CY 2023 Expenditures/ Claim	CY 2024 TD[2] Expenditures/ Patient	CY 2024 TD[2] Expenditures/ Claim
ASC	$836.86	$544.76	$876.34	$594.48	$920.53	$672.93
Ambulance	$375.61	$138.37	$391.88	$160.64	$518.30	$245.23
Behavioral Health	$3,726.00	$109.15	$3,879.77	$114.05	$2,965.39	$131.02
DME / Lab	$538.12	$109.54	$548.90	$111.24	$406.35	$108.80
Dental	$304.53	$148.16	$291.90	$153.85	$475.93	$291.64
Hospice	$15,687.84	$3,648.84	$18,071.10	$4,065.85	$14,546.79	$4,265.42
Hospital	$3,286.39	$521.14	$3,193.76	$523.04	$2,264.45	$541.65
ICF	$141,671.87	$9,054.31	$156,274.80	$13,585.90	$89,151.28	$14,626.54
Medicaid Schools Prg	$550.00	$28.19	$549.87	$27.50	$323.45	$25.23
NF	$38,269.18	$4,066.49	$39,548.40	$4,950.19	$31,796.84	$5,366.52
Other	$438.65	$94.83	$625.79	$123.22	$481.38	$113.24
Physician, etc	$759.16	$65.20	$770.96	$69.47	$513.78	$75.06
Renal	$18,144.16	$862.93	$14,106.57	$886.55	$8,870.75	$1,272.26
Rx	$2,660.36	$114.70	$2,637.18	$124.40	$1,906.13	$128.81
Vision	$88.87	$58.81	$73.19	$51.96	$64.02	$51.98
Waiver HH/PDN	$23,006.69	$138.39	$23,001.37	$139.15	$18,334.85	$185.87
Wheelchair Van	$1,023.11	$88.44	$942.70	$92.27	$1,057.26	$119.54
All Medicaid	**$8,720.50**	**$169.67**	**$8,719.63**	**$177.01**	**$6,052.77**	**$195.39**

[1]Abbreviations: Ambulatory Surgery Center (ASC); Durable Medical Equipment (DME); Medicaid Schools Program (Medicaid Schools Prg); Nursing Facility (NF), Pharmacy (Rx), Home Health/Private Duty Nursing (HH/PDN)

[2]Data received and loaded in ODM EDW through 8/26/2024. To date, CY 2024 is consistent with previous year trends given claim submission patterns and decreasing caseload.