JMOC Limit on Growth in Medicaid Per Capita Expenses

February 2015

JMOC is charged with working with an outside actuarial firm to calculate the projected rate of growth for the Medicaid program on a per capita or per member per month (PMPM) basis for the upcoming biennium. The actuary's report projects the cost of continuing current Medicaid policy into the next biennium, which includes the impact of trend factors on utilization and unit cost. JMOC uses the actuary's report to establish the JMOC rate, which becomes the limit for the Executive Budget. Under Section 103.414, the committee must set the JMOC rate at least 90 days before the Governor is required to submit his budget.

The JMOC Rate for FY 2016 and FY 2017

In October, Optumas, JMOC's contracted actuary, provided the committee with a growth range for the upcoming biennium. Without changes to current policy, Optumas estimated that PMPM costs would increase by 1.6% to 2.9% in FY 2016 and by 2.2% to 4.5% in FY 2017.

Due to the compressed time from the organization of JMOC to the due date of the report, the actuary had to rely on summary level data to complete their initial analysis. Because of the data limitations, the JMOC Committee opted to set the JMOC rate at the actuary's upper bound growth rate. In the second year of the biennium, the upper bound rate exceed the three-year average Consumer Price Index (CPI) rate for medical services, so the JMOC limit in FY 2017 was set at the CPI rate, which was 3.3%.

Note that JMOC uses the three-year average CPI rate for medical services for the Midwest region as a benchmark for growth in the Medicaid program. Under Section 5162.70, the Medicaid director must limit growth in the Medicaid program for the upcoming biennium across all Medicaid recipients on a PMPM basis to the lower of the JMOC rate or the three-year average (CPI) for medical services.

The chart below shows the PMPM ranges forecasted by JMOC's actuary, the JMOC limit for the Executive Budget, and the PMPM growth in the Executive Budget.

	JMOC October Actuary Report		October JMOC Rate	Executive Budget Normalized Rate	
	PMPM Range	Growth Range		PMPM	Growth Rate
SFY 15	$628			$628	
SFY 16	$638 -$647	1.6% - 2.9%	2.90%	$636	1.40%
SFY 17	$652 - $675	2.2% - 4.5%	3.30%	$665	4.50%
Biennial Average		**1.9% -3.7%**	**3.10%**		**2.94%**

For the FY 2016-FY 2017 biennium, the Medicaid director was required to limit growth in monthly member costs, to 2.9% in FY 2016 and 3.3% in FY 2017, or a biennial average of 3.1%. The actual growth rate, after policy changes, in the Executive Budget is 2.94% over the biennium.

Why were there two JMOC forecasts of the FY 2016-2017 Budget? Because of the data limitations due to timing in the actuary's October report, the committee asked Optumas to prepare a second iteration using the more up-to-date and detailed claims-level data to develop more refined PMPM rates by population as well as category of service. In future biennia there will only be one analysis using the more detailed data.

Another goal of JMOC is to have better information by population category to enable comparisons over time, between populations, and with other states. Optumas was able to develop per capita costs by population as part of the second iteration. This data provides greater insight into service utilization patterns for these populations. The PMPM calculations are available in the Optumas presentation to JMOC on February 26 and will be included in their final report. Both will be available on the JMOC website.

The chart below shows the overall results of the actuary's October report compared to the February report.

	JMOC October Actuary Report		JMOC February Actuary Report	
	PMPM Range	Growth Rate	PMPM Range	Growth Rate
SFY 15	$628		$635	
SFY 16	$638 -$647	1.6% - 2.9%	$648 - $654	2.1% - 3.0%
SFY 17	$652 - $675	2.2% - 4.5%	$664 - $678	2.4% - 3.6%
Biennial Average		**1.9% -3.7%**		**2.25% -3.3%**

While the growth trend is very similar, the base PMPM rate for FY 2015 increases by $7 from October to February and is above ODM's estimate as well. Optumas notes that the increase is driven by a change in base data – moving from a summarized dataset to a detailed claim-level dataset. In addition to the more refined base data, a change in projected membership mix has been made between the first and second iteration to reflect the most recent FY 2015 projection included in the ODM Forecast Book. The combination of these two changes results in a program-wide membership mix more heavily weighted towards higher cost populations, which drives up the aggregate PMPM. This difference in membership mix is most impactful to the managed care population, where the projections included in ODM's Forecast Book used by Optumas lacked information at the age band and regional detail level. Premiums vary based on a recipient's program, age, gender, and geographic region. In future iterations, Optumas will be better positioned to assess the growth and population mix in this area.

What is per capita or per member per month (PMPM) growth? Historically when we have looked at Medicaid spending, we have focused on total spending or state share GRF spending, and these are important measures, but through JMOC, we're also adding another measure, per capita costs, or PMPM costs. The per capita measure factors out population growth as a factor for growth in spending. The per capita measure, particularly as it is disaggregated by population category and category of service, provides greater insight into underlying cost drivers including utilization and unit cost.

What is the CPI? The Consumer Price Index (CPI), calculated by the US Bureau of Labor Statistics, is a measure of the average change in prices of goods and services purchased by households over time. Data is released monthly and is calculated on a regional and national level. Medical care is one component of the CPI. The medical care market basket includes medical care services (i.e. professional and hospital services and health insurance) and medical care commodities (i.e. drugs and medical equipment). JMOC uses the three-year average CPI rate for medical services for the Midwest region as a benchmark for growth in the Medicaid program.

How does the JMOC forecast differ from the OBM & LSC forecasts? Like the OBM and LSC forecasts, the JMOC forecast is a baseline forecast, which assesses the impact of continuing current policy. The JMOC forecast is required to be prepared first, 90 days prior to the submission of the Executive Budget, and limits the allowable per capita growth in the Medicaid budget submitted by the Executive. Unlike the OBM and LSC forecasts, the JMOC forecast looks only at per capita cost growth and does not calculate caseload growth. The JMOC forecast is based on total spending and does not include an analysis of spending by fund source.

What Medicaid expenses are not included in JMOC rate? One time spending and non-claim expenses (i.e. expenses not directly tied to a recipient) are excluded from the JMOC analysis. Excluded items include state administration, hospital UPL and HCAP payments, managed care pay for performance, federal health insurance fee, and settlements and rebates. Spending on the temporary ACA physician rate increase that expired on December 31, 2014 has also been removed.