JMOC Report on Projected Medical Inflation for Medicaid Program

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

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

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

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

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

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

Background

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

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

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

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

Next Steps

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

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