Report on JMOC Limit for Medicaid Program for FY 2018-2019 Budget

October 2016

The Joint Medicaid Oversight Committee (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 purpose of this report is to notify the Administration of the JMOC rate for the FY 2018-2019 budget.

Under Section 5162.70 of the Revised Code, the Medicaid director must limit PMPM growth in the Medicaid program across all Medicaid recipients to the lower of the JMOC rate or the three-year average Consumer Price Index (CPI) for medical services. *The Joint Medicaid Oversight Committee has selected 3.3% as the JMOC rate for the FY 2018-2019 budget.*

Optumas Estimate for FY 2018-2019

Through a competitive procurement process, JMOC contracted with Optumas as its consulting actuary for this analysis. The estimated FY 2018-2019 medical inflation rate has been developed as a range of projected rates of growth, calculated on a per member per month (PMPM) basis, for the entire Medicaid program. To ensure that the projections are independent of proposed policy changes, they are developed with the assumption that current policy continues into the biennial period. This approach is consistent with the approach used to develop the FY 2016-2017 biennial projections.

Optumas developed a growth range with PMPM costs rising by an average of 2.6% per year at the lower bound of the estimate and by 3.9% per year at the upper bound. The projections and growth rates are summarized in the table that follows.

Optumas Estimate for FY 2017-2019

	2017 Estimate	2018 Projection	Growth Rate	2019 Projection	Growth Rate	Biennial Average
Lower Bound PMPM	\$620	\$638	2.8%	\$653	2.4%	2.6%
Upper Bound PMPM	\$629	\$653	3.8%	\$679	4.0%	3.9%

The full report from Optumas is attached and includes additional information on the estimate as well as trend assumptions.

Consumer Price Index for Medical Services

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 chart below shows the CPI rates for the past three years as well as the unweighted average, which is 3.3%. Note that the CPI grew more quickly between August 2015 and August 2016. Because of this, the committee also considered, but ultimately rejected, using a weighted three-year average CPI of 3.7% that more heavily favored the most recent year.

CPI Rates for Medical Services: Midwest

	Midwest CPI	Weights
August 2014	2.65%	25%
August 2015	2.12%	25%
August 2016	5.01%	50%
	Unweighted	Weighted
3 Year Average	**3.26%**	**3.70%**

Committee Activities and Rationale for Estimate

JMOC heard the actuary's report at its September 22nd hearing and voted to set the projected medical inflation rate at 3.3% at its October 20th hearing. While the committee expressed concerns about certain trends going forward – particularly the upward trend in pharmaceutical prices and the uncertainty regarding the future economic and job growth – the committee ultimately selected the midpoint of the Optumas projection, or an average growth rate of 3.3%.

Ohio Joint Medicaid Oversight Committee

State Fiscal Years 2018-2019 Biennium Growth Rate Projections

State of Ohio

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1. Executive Summary

Per ORC Section 103.414, the Ohio Joint Medicaid Oversight Committee (JMOC) must contract with an actuary to determine the projected medical inflation rate for the Ohio Medicaid program for the State Fiscal Year (SFY) 2018-2019 Biennium. Through a competitive procurement process, JMOC contracted with **Optumas** as its consulting actuary for this analysis. The estimated SFY 2018-2019 inflation rate has been developed as a range of projected rates of growth, calculated on a per-member per-month (PMPM) basis, for the entire Medicaid program. To ensure that the projections are independent of proposed policy changes, 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 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 and 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 time.

Optumas developed a range of projected PMPM growth, which is summarized in Figure 1, below.

Figure 1. Projected Rates of Growth

	Annualized Trend	
SFY	Lower Bound	Upper Bound
2018	2.8%	3.8%
2019	2.4%	4.0%
2018 - 2019	2.6%	3.9%

Projected growth from **Optumas'** SFY 2017 projection to SFY 2018 is estimated to be between 2.8% and 3.8% and the rate of growth from SFY 2018 to SFY 2019 is projected to be between 2.4% and 4.0%. Weighted together equally, the projected growth is projected to be between 2.6% and 3.9% annually, over the course of the biennium. Per ORC Section 103.414, as the consulting actuary for this analysis, **Optumas** has developed the range of projected rates of growth; 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 2018-2019 biennium to be the lower of 1) JMOC's final selected growth rate or 2) the three-year average Medical CPI for the Midwest.

The remainder of this report presents the process used to develop the projections for the SFY 2018-2019 biennium. Each of the report sections are described in Figure 2, below.

Figure 2. Report Structure

Section	Contents
Background	Provides a description of **Optumas'** role in developing PMPM projections for the SFY 2018-2019 Ohio biennium.
Data	An overview of the data used when developing the projections, including data sources, limitations, and adjustments.
Trend	Provides a description of trend and the process used to develop trend for the SFY 2018-2019 biennium.
Projection Summary	Provides summarized results of the projected PMPM growth developed for the SFY 2018-2019 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 2018-2019 Biennium. As JMOC's contracted consulting actuary, **Optumas** has developed the SFY 2018-2019 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 standardized, or normalized basis and is a way to measure costs relative to each member rather than on a total expenditure basis. Growth in total expenditures can be influenced purely by an increase in membership, even with all else being equal and costs per person remaining constant. Since enrollment growth is an external factor that the Medicaid program has limited control over, **Optumas** has worked with JMOC to focus on projecting a rate of growth specific to a rate of change on a per-member basis; in other words, a rate of change in PMPM expenditures over time.

JMOC has the choice to select a rate within the range developed by **Optumas**, or to select an independent rate. Per ORC Section 5162.70, once the JMOC rate is selected, Medicaid must limit the aggregate PMPM growth over the SFY 2018-2019 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.

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 the PMPM spend of the Ohio Medicaid program. The following describes some of the ways that these changes could materialize:

- **Program Design –**
  Changes in program design can impact spend for all populations, or for a specific population(s). A program-wide shift could mean a change in how all populations' eligibility is determined, which could impact total costs. A change for a particular population's eligibility process could exclude one sub-population, resulting in a material change to the entire population's risk profile.
- **Population –**
  Changes in the populations that are enrolled in Medicaid managed care programs can impact the program-wide spend. To the extent that a new population enrolls that is healthier and cheaper than the average member of the current program, the overall PMPM cost of the program would be driven down. Conversely, if the new population is much more expensive 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 (i.e., CFC children and adults).

- **Benefits –**
  Changes in benefits offered through the program can have an impact to the total PMPM of the program. If a new service is introduced into the Medicaid program, this could increase the overall spend of the program since additional costs would be incurred. However, if these new services are intended to be preventive in nature, over time the addition of this new service could materialize in overall savings to the program.
- **Network –**
  Changes in the service delivery network can impact the overall spend in various ways. One way this could materialize is through improved networks that include better provider coordination. To the extent that a provider network is able to work together to provide services to enrollees, this could improve the overall care of Medicaid enrollees and in turn, result in reduced costs to the program.

We consider each of these determinants when evaluating the source data provided by ODM and make adjustments to 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 acquired from ODM, summarized base data and projected capitation rates provided in the managed care certification letters, both 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 the managed care populations (excluding FFS-delivered services) were developed based on capitation rates and trend factors developed by ODM's actuary.

Projected PMPMs include total Medicaid spending, excluding any one time expenses and expenses not tied directly to a member. Consistent with the FY 2016-2017 analysis, the expenses excluded from the JMOC rate are:

- All-Agency State Administration,
- Hospital Care Assurance Program (HCAP),
- Hospital Upper Payment Limit (UPL),
- Federal Health Insurance Providers Fee.
- Managed Care Pay for Performance (P4P), and
- Other settlements and rebates paid outside of the claims system and outside of the managed care capitation rates.

3. Data

3.01 Sources

Optumas utilized detailed claims-level cost and utilization FFS 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 the historic calendar year (CY) 2014-2015 FFS cost of the Ohio Medicaid program for all eligible members. 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 2018-2019 biennial projection. In addition to the FFS data, **Optumas** also received detailed claim-level cost and utilization encounter data and cost report information from the Managed Care Organizations (MCOs) operating under the Ohio Managed Care Program (MCP). This information was used to validate and inform the projection of the MCP costs based on the capitation rates developed by Milliman, the actuarial firm contracted with ODM who developed the CY 2016 Ohio managed care capitation rates, on a PMPM basis.

The following data sources were used to compile the base data for the SFY 2018-2019 biennial projections:

Ohio SFY 2014-2016 FFS Claims and Managed Care Encounter Data –
The Ohio FFS claims and Managed Care encounter data was provided by Ohio's data vendor HP, and is a comprehensive claims-level data set comprised of all claims incurred and reported through the 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 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 2018-2019 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 CY 2014 and CY 2015 would serve as the base data for the SFY 2018-2019 biennial projection. This was due ultimately to major policy changes that took place just prior to or during CY 2014 that would be captured within the base data by using CY 2014 and CY 2015 as the starting point for projections. Nevertheless, historic data prior to CY 2014 and the emerging CY 2016 data was utilized when developing the projected trend factors and for benchmarking purposes, after adjusting the data to allow for consistent trend review.

Ohio SFY 2014-2016 Eligibility Data –
The Ohio eligibility data was provided by Ohio's data vendor HP, 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 helps identify each member's category of aid. The monthly eligibility data is used to calculate COA-specific and program-wide member months, as well as to link eligible members to the claims incurred for each month, to ensure that costs are directly associated with an eligible Medicaid recipient.

Ohio CY 2015-2016 Q1 Medicaid Cost Reports –
The Ohio Medicaid Costs Reports are filled out on a quarterly and annual basis by the MCOs and provide a detailed report of their total revenue and expenditures for each period. **Optumas** was provided the CY 2015 annual cost reports as well as the January 2016 – March 2016 (CY 2016 Q1) quarterly report. These reports were used in conjunction with the encounter data to review the certification letters and corresponding capitation rates (noted below) for reasonableness.

Monthly Medicaid Variance Reports –
The monthly Medicaid Variance Reports were used to validate the CY 2014-2015 base FFS expenditures. These reports capture monthly expenditures at the aggregate category of service level, reported on a month of payment basis. For example, all costs associated with FFS Inpatient Hospital claims are reported as one number each month, and these reports serve as a high-level benchmark to ensure the CY 2014-2015 base data has been categorized appropriately.

Ohio Department of Medicaid Caseload Reports –
The Ohio Department of Medicaid Caseload Reports, reported with enrollment through June 2016, 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 category of aid for projection purposes.

Managed Care Certification Letters and Capitation Rates –
CY 2016 managed care certification letters provided by Milliman to ODM as part of the Milliman actuarial contract with ODM, their corresponding capitation rates, and summarized base data (by COA, COS, and regional) included therein, were used as the basis for projecting the growth rate for managed care expenditures.

Actual and Projected Medicare Premium Assistance/Part D Claw-Back Payment
As part of the projection process, **Optumas** received actual SFY 2015-2016 and SFY 2017 projected values of the Medicare Premiums and Part D claw-back amounts for dual eligible Medicaid and Medicare members. Additionally, **Optumas** reviewed projected Medicare Part A and B premiums through CY 2019 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, so, while fairly small, they are a contributor to the overall Ohio Medicaid program spending. These costs were projected forward into the SFY 2018-2019 contract 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 complete:

1. Referential Integrity Checks – ensures that all claims included in the base data were incurred by a member with a valid eligibility determination that coincided with the incurred date associated with the specific claim.

2. Volume Checks – **Optumas** checked both volume of claims and total expenditures by category of service by looking at totals longitudinally. This ensured that gaps or spikes in the data were identified and addressed before creating the base data.
3. Benchmark Comparison – **Optumas** compared summarized costs and enrollment data, derived from the detailed data, to several sources, including monthly variance reports, cost reports, and caseload reports provided by ODM.

These analyses and benchmark comparisons enable **Optumas** to identify and address any significant data limitations associated with the CY 2014 and CY 2015 FFS data prior to developing the rate of growth projections.

As mentioned earlier in this report, **Optumas** utilized the July 2016 Managed Care capitation rates, along with supporting data, as the baseline for projecting Managed Care costs into the biennium period. The base data referenced in the certification letters is benchmarked to the cost reports and 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 Milliman adjustment and projection factors developed by Milliman for the Ohio Medicaid managed care program for our managed care projection purposes. To the extent that programmatic changes within the managed care environment occur, or significant changes in the rate setting process occur, these are not considered in the biennial projections, consistent with the "current policy" approach to the projections.

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

3.02 Base Data Adjustments

Population Adjustments

To project base data into a future time period, historical data needs to be adjusted to reflect any policy and program changes that have occurred between the base data period and the projection period. For example, if program changes impact certain populations after the base data has been incurred (e.g. populations changing from a FFS delivery system to a managed care delivery system), adjustments to the base data would be required.

The projections for the SFY 2018-2019 biennium are intended to reflect current policy within the Medicaid program. The base data includes expenditures for services incurred during CY 2014 and CY 2015 at both the population and service level. The use of more recent base data, as well as the ability to separately categorize expenditures by population, allows for costs to be isolated in the base data for specific Medicaid populations. **Optumas'** projected growth rate ranges are based on current Medicaid policy and the projections assume that current policies will continue into the future. As such, the following population adjustments have been considered as part of the biennial projections:

MyCare Implementation –
Beginning in May 2014, certain members that are dually-eligible for both Medicaid and Medicare (Duals) began enrollment into Ohio's MyCare managed care program. The historical

base data includes the time period in which this transition occurred; as a result, those members who fit the criteria for MyCare enrollment have been separately identified in the detailed FFS data within CY 2014, and the corresponding costs and enrollment have been removed from the base PMPM calculations. Since these members now receive their full Medicaid benefit package through managed care, the managed care PMPM is based on the July 2016 capitation rates included in the managed care certification letters.

Family Planning Transition Out –
Given the removal of the Family Planning only eligibility group, many members that had received only Family Planning services in the base data (CY 2014-2015) have transitioned to full Medicaid eligibility. While historical PMPM costs exist in the FFS data for this population under their previously limited benefit package, since this population no longer exists effective in CY 2016, the corresponding enrollment for this population has been removed from the calculation of the program-wide PMPM rate of growth. To the extent that these members had already transitioned into a full Medicaid beneficiary prior to the end of CY 2015, their corresponding costs and enrollment in their new COA is already reflected in the base data used to develop the biennial projections.

Elimination of Spenddown –
Beginning in August 2016, spenddown members began to transition within the Medicaid program. The enrollment shifts from these members is still unknown, as some may be transitioned into different rating cohorts, while some members may leave the program entirely. As of August 1, 2016 spenddown members are now enrolled as ABD members receiving full benefits. However, upon redetermination January 1, 2017, many of these members are expected to shift elsewhere or be removed from the program entirely. While it is known that the spenddown program is no longer in place, it is unknown where these enrollees will end up and how many will remain in the program. This level of uncertainty surrounding these members and their associated costs upon transition to their new benefit category, **Optumas** has removed both historical costs and eligibility for these members from the base data used to develop the projections, to avoid this transition from potentially skewing the growth rate projections. While the historical experience for spenddown members has been removed from the base data, it should be noted that no adjustment has been made at this time to re-categorize these members into non-Spenddown enrollment categories. This re-categorization that is anticipated to occur starting January 2017 could materially impact the overall growth rate within the program, depending on the number of enrollees that ultimately remain in the program as full or limited Medicaid beneficiaries.

In addition to the population changes noted above, it is important to recognize that additional policy changes, some more material than others, may occur within the biennium that have not been adjusted for, consistent with the "current policy" approach. One example is the **Behavioral Health Integration** (BHI) into managed care. Since **Optumas** has developed the projections based on current policy, the integration of Behavioral Health into managed care has not been incorporated in the projections. Behavioral Health Integration in the Ohio Medicaid program is expected to occur during the SFY 2018-2019 biennium. Since BHI is not yet considered a current policy at this time, **Optumas** has not made any specific adjustment to the projection to account for the BHI that is anticipated to take place during the projection period. Consistent with the remainder of the projections, this approach assumes that current

policies in effect will continue into the future, rather than adjusting for future policies that are expected to take effect during the biennium.

Policy Change 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%; the adjustment reflects the fact that going forward, this 5% increase would be inherent in all Inpatient Hospital costs. This brings all base data expenditures up to the most current reimbursement level and avoids projecting base data that does not reflect current policy. Many policy changes have occurred since the beginning of the base data period, starting January 1, 2014. The following section discusses policy changes that have been considered in the development of the base data used in the SFY 2018-2019 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.

Increase Homemaker/Personal Care Rates –
Effective January 1, 2016, Ohio increased Homemaker and Personal Care rates in DD waivers by 6%. **Optumas** identified Homemaker and Personal Care services in the FFS data by the following procedure codes:

- MR108-MR109
- MR816-MR819
- MR832-MR834
- MR940, and
- MR951

The expenditures within the CY 2014 and CY 2015 base data associated with homemaker and personal care service procedure codes were increased by 6%. This resulted in a net upward adjustment of 4.3% in CY 2014 and 4.4% in CY 2015 to the Individual Options (IO) Waiver category of service PMPM across all FFS populations.

Increase Medicaid Rate for Home Health Aide Services –
Effective January 1, 2016, Ohio increased rates for Home Health Aides by 5%. **Optumas** identified Home Health Aide services in the FFS data by procedure code G0156. The expenditures within the CY 2014 and CY 2015 base data associated with Home Health Aide services were increased by 5% to adjust for this program change. This resulted in a net upward adjustment of 1.4% in CY 2014 and 1.5% in CY 2015 to the Home Health/Private Duty Nursing (PDN) category of service PMPM.

Increase Intermediate Care Facilities (ICF) Rates –
Effective July 1, 2016 a 2% rate increase was implemented for ICF services. **Optumas** identified the services provided in an ICF within the FFS data and applied a 2% PMPM increase to all services received in an ICF.

Expand Medicaid in Schools Program (MSP) –
Effective July 1, 2015 Ohio expanded the suite of services available within schools. The improvements in the MSP program include incorporating nursing services in school versus the use of state plan private duty nursing, updating claiming codes, billing for assessments and evaluations among other MSP program enhancements. To account for this program change, **Optumas** reviewed the MSP category of service longitudinally over time. The second half of the CY 2015 data includes the expanded services, which appear as an increase in MSP service utilization rather than a unit cost increase. **Optumas** adjusted the service utilization for CY 2014 and the first half of CY 2015 to reflect the increased levels found after the MSP benefit expansion took effect. The final impact to the CY 2014 and CY 2015 base data units for the MSP category of service resulted in an upward adjustment of 43.0% and 19.2%, respectively to the MSP PMPM.

Rebase Nursing Facility (NF) Rates –
Nursing Facility per diem rates were rebased effective July 1, 2016. Using the Nursing Facility per diem fee schedule available on ODM's website, **Optumas** repriced the Nursing Facility services within the FFS data based on the number of service days and the updated per diem rate for each provider within the fee schedule. This repricing analysis places all CY 2014 and CY 2015 Nursing Facility costs on the reimbursement levels that will be in effect through SFY 2017. The Nursing Facility rebasing resulted in a significant upward adjustment to the SNF category of service, namely a 13.8% and 14.6% increase in CY 2014 and CY 2015, respectively to the SNF PMPM.

Eliminate 5% Rate Add-on for Outpatient Services –
Effective January 1, 2016, an across-the-board rate decrease of 5% for Outpatient services has been implemented; this decrease does not apply to Children's hospitals. With the use of detailed data, **Optumas** was able to identify which claims were incurred at Children's hospitals in the FFS data; as a result, the 5% reduction was only applied to the portion of total Outpatient Hospital expenditures associated with non-Children's hospitals. This resulted in a net downward adjustment of 3.9% and 4.0% for all FFS Outpatient Hospital expenditures for the CY 2014 and CY 2015 base periods.

ACA PCP Enhanced Payment Removal & Increase Primary Care Rates –
Section 1202 of the ACA states that certain evaluation and management (E & M) services and immunization administration services provided by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine will be paid at a rate no less than 100 percent of the Medicare rate beginning in January 2013. Ohio separately itemizes the amounts paid out as enhanced payment to each provider; however, as providers are reimbursed at the higher Medicare rate they resubmit their claims to reflect the updated reimbursement amounts. As such, these costs were inherent in the CY 2014 base data. Since the State of Ohio discontinued the higher reimbursement for these providers effective January 1, 2015, these additional costs have been excluded from the biennial projections. The impact of this program change was estimated by calculating the percentage change in the average unit cost for PCP services moving from CY 2014 to January 1, 2015; this results in a decrease to the physician-related unit cost in the CY 2014 base data. This resulted in a net downward adjustment of 14.7% for all FFS PCP expenditures for the CY 2014 base period.

One goal of the enhanced payment is increased access to care, which typically leads to a higher rate of utilization. Upon further analysis of the CY 2014-2015 data, **Optumas** determined that, while induced utilization did appear to be present for these services beginning January 1, 2013, the induced levels did not appear to be at a high enough level to support a downward adjustment due to the discontinuation of the Primary Care Rate Increase. As a result, no utilization adjustment has been made to the base data due to the removal of the ACA 1202 enhanced payment.

Effective January 1, 2016 Ohio increased Medicaid primary care rates. Unlike the temporary Primary Care Rate Increase, the initiative is not limited to particular PCP specialties or physicians. **Optumas** estimated the impact of this rate increase by analyzing the emerging CY 2016 data and adjusting the CY 2014 data (adjusted for the removal of the ACA enhanced reimbursement) and CY 2015 FFS data to reflect the increased unit cost within the emerging CY 2016 data where the primary care rates are at the higher reimbursement levels. The increase to non-dual Professional services is 0.2% in CY 2014 and 0.1% in CY 2015.

Apply Medicaid Maximum Payment to Medicare Crossover Claims –
Effective January 1, 2016 Ohio changed the method of reimbursement for Dual Eligible recipients such that Medicaid will not pay more than the Medicaid FFS rate for dual eligible claims from physicians rather than reimbursing physicians at Medicare cost sharing. **Optumas** estimated the impact of this program change by analyzing the Dual cohorts' Professional services longitudinally over time. The emerging CY 2016 data shows a significant decrease in both the unit cost and utilization of Professional services among the Dual cohorts. The impact of this program change was estimated by calculating the percentage change in the average unit cost and utilization for Professional services before and January 1, 2016 and applying that percent decrease to the CY 2014 and CY 2015 base data. The total adjustment to the Dual PCP service results in a 64.5% decrease to the base data for CY 2014 and 63.2% in CY 2015, and a decrease of the Laboratory and Radiology of 19.6% and 15.9% in CY 2014 and CY 2015 respectively.

Detail-Coded Drugs –
Effective January 1, 2016 Ohio began reimbursing detail-coded drugs administered in an Outpatient setting according to the physician fee schedule rather than at 60% of hospital-specific costs. **Optumas** identified drugs received in the Outpatient setting by claims billed with a procedure codes beginning in J or claims with a revenue code of 0250-0259 and 0631-0637. **Optumas** received ODM's savings estimates for this program change and used this information, along with review of actual emerging cost changes after January 1, 2016 within the data, to adjust the historical FFS data for this program change. The resulting impact was a downward adjustment to the CY 2014 and CY 2015 Outpatient services base data of 2.4% and 3.7%, respectively.

Reduce Rates for Low Acuity NF Residents –
Effective July 1, 2016 rates paid for low acuity individuals in a Nursing Facility were reduced from $130 per diem to $115 per diem. **Optumas** identified the Nursing Facility claims within the data that had a unit cost of $130 per diem and repriced these claims at the updated $115 per

diem rate that will be in effect in SFY 2017. The resulting impact was a downward adjustment to the CY 2014 and CY 2015 SNF base data of 0.21% for each year.

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 service. The overall impact to the FFS expenditures was an increase of 2.7% and 4.0% for CY 2014 and CY 2015 base years in the FFS population and an increase of 1.9% in CY 2014 and 1.0% in CY 2015 for the managed care population.

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 costs from the base period to the SFY 2018-2019 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. FFS trends were developed through utilization of 3, 6, and 12 month moving averages over the course of the base data period. Known policy and program changes were taken into account as well as any outlier costs so that the projected trends were not influenced by one-time spending changes. These one-time changes due to program and policy changes are captured separately as noted above in Section 3.02. The unit cost and utilization trends are used to project these components into the SFY 2018-2019 biennial period, and are then used to calculate the implied PMPM growth rate that will be used as a part of the JMOC benchmark.

The biennial projections have been completed assuming current policy will continue. This includes the methodology used for developing the future capitation rates for the managed care program. As a result, **Optumas** used trends that were developed by Milliman, ODM's actuary, for the CY 2016 (July 2016) managed care capitation rates, assuming that both a similar methodology and similar trend projections would be used for future capitation rate contract periods. The trends developed for the CY 2016 capitation rates were displayed at a category of aid and category of service level, and were included in the CY 2016 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 2016 capitation rates into the SFY 2018-2019 biennial projection period.

Once trend has been developed, it is varied as part of the development of the projection range. The annualized lower and upper bound trend is then used to project each category from the base to SFY 2018 and SFY 2019. The base used to project each category is a blend of CY 2014 and CY 2015 FFS base data. The Managed Care populations and costs are based on the July 2016 capitation rates, which were then projected into the biennium.

The annualized trend used to project each category into the lower bound and upper bound of SFY 2018 and SFY 2019 are shown below in Figures 3 through 5. Each projection category reflects the growth rate across all services incurred by that category. For example, the CFC ADULT category in the managed care section reflects the projected growth rate across both their capitated expenses and FFS expenses. Although the growth rates for the FFS program is generally lower than the managed care program, the

significantly larger PMPM for FFS (see Appendix I.C) means that small changes in the FFS growth rate can result in large changes to the overall cost of the Medicaid program.

Figure 3: Annualized FFS Trend Projections – FFS Populations

FFS Populations	SFY 2018		SFY 2019	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound
CHIP	3.6%	4.8%	3.7%	4.9%
ADFC	3.3%	4.5%	3.4%	4.6%
HFAM	2.7%	3.7%	2.7%	3.8%
EXPN	2.9%	3.9%	2.9%	4.0%
BCCP	1.6%	2.5%	1.6%	2.5%
FAM PLAN	0.0%	0.0%	0.0%	0.0%
PREM ASST	1.3%	2.3%	1.3%	2.3%
OTHER	1.2%	3.3%	1.2%	3.3%
ABD KIDS	3.0%	4.2%	3.1%	4.2%
ABD ADULT	1.1%	2.2%	1.2%	2.2%
DUAL	1.2%	2.2%	1.2%	2.3%
ICF	0.3%	1.0%	0.3%	1.0%
SNF	0.8%	2.0%	0.8%	2.0%
AGING WAIVER	1.5%	2.6%	1.5%	2.6%
DD WAIVER	2.0%	3.1%	2.1%	3.1%
MCD WAIVER	2.0%	3.1%	2.0%	3.1%
FFS Total[1]	**1.6%**	**2.7%**	**1.6%**	**2.7%**

Figure 4: Annualized Total Spend Trend Projections – MC Populations

Managed Care Populations	SFY 2018		SFY 2019	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound
CFC KIDS	3.6%	4.5%	3.3%	5.2%
CFC ADULT	3.3%	4.1%	3.0%	4.9%
EXPN	3.8%	4.8%	3.4%	5.4%
ABD KIDS	5.1%	6.0%	4.9%	6.7%
ABD ADULT	3.8%	4.6%	3.4%	5.2%
MyCare	2.1%	3.1%	1.6%	3.6%
Delivery	0.0%	1.2%	0.0%	1.2%
Managed Care Total	**3.4%**	**4.3%**	**3.0%**	**4.9%**

Figure 5: Annualized Statewide Trend Projections – All Populations and Services

All Populations	SFY 2018		SFY 2019	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound
FFS - FFS Costs	1.6%	2.7%	1.6%	2.7%
MC - FFS Costs	4.4%	5.7%	4.5%	5.8%
MC - MC Costs	3.3%	4.1%	2.9%	4.8%
Additional Payments	4.1%	4.5%	-0.9%	0.0%
Program Wide	**2.8%**	**3.8%**	**2.4%**	**4.0%**

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

- SFY 2018 – This reflects the projected rate of growth from the SFY 2017 projected lower and upper bounds to the SFY 2018 projected lower and upper bounds.
- SFY 2019 – This reflects the projected rate of growth from the SFY 2018 projected lower and upper bounds to the SFY 2019 projected lower and upper bounds.

As exhibited in the table above, the projected growth rate assuming current policy is:

- Between 2.8% and 3.8% from SFY 2017 to SFY 2018
- Between 2.4% and 4.0% from SFY 2018 to SFY 2019

One of the key drivers in trend is the increase in trend for pharmaceutical costs. While pharmacy trend varies by population, in aggregate **Optumas** observed pharmacy trends in Ohio that are commensurate with national trend benchmarks. The Express Scripts 2015 Drug Trend Report, which considers trend at a national level, shows estimated overall Medicaid Pharmacy trends to be between 8-10% annually through 2018. It should be noted that high pharmacy trend impacts the overall spend for populations at different levels. For example, for the populations that enroll in FFS in Ohio, pharmacy accounts for approximately 5-7% of overall PMPM in aggregate, while pharmacy accounts for over 25% of the medical costs underlying the managed care spend. This difference is primarily driven by a different mix of populations enrolled in FFS vs. managed care.

Figure 6 on the page below, shows an example of the impact that high pharmacy has on the overall PMPM for a population with a small overall portion of costs attributed to pharmacy (ICF FFS enrollees) vs. a population with a larger overall portion of spend attributed to pharmacy (CHIP FFS enrollees). As observed below, assuming the same 8-10% (which does not reflect actual projected trends for each COA, but is provided as a consistent example for illustrative purposes) annual pharmacy growth has differing overall impacts to the PMPM for each of these populations.

Figure 6: Pharmacy Trend Impact Illustration

COA:	ICF - FFS	
	SFY 2017 Projected	
	Lower Bound PMPM	Upper Bound PMPM
Rx PMPM	$ 253.13	$ 260.42
Total PMPM	$ 9,843.12	$ 9,987.04
National Rx Trend Benchmark [1]	*8%*	*10%*
Increase due to Rx	$ 20.25	$ 26.04
Resulting Rx PMPM	$ 273.38	$ 286.46
Impact to PMPM due to Rx	**0.21%**	**0.26%**

COA:	CHIP - FFS	
	SFY 2017 Projected	
	Lower Bound PMPM	Upper Bound PMPM
Rx PMPM	$ 73.44	$ 75.99
Total PMPM	$ 274.02	$ 281.35
National Rx Trend Benchmark [1]	*8%*	*10%*
Increase due to Rx	$ 5.88	$ 7.60
Resulting Rx PMPM	$ 79.32	$ 83.59
Impact to PMPM due to Rx	**2.14%**	**2.70%**

[1] *This trend is used for display purposes; this reflects the national benchmark trend noted above.*

This does not reflect actual trend projected for these populations, but is intended to highlight the impact to the overall population PMPM driven by Pharmacy trend

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 Medicaid is limited in the amount of control it has over the change in enrollment over time, a growth target based on PMPM expenditures provides a means of limiting the effect of population growth on this target. In addition to developing projections on a PMPM basis, the aggregate PMPMs (across all populations) is calculated by weighting the individual COA projections based on a point-in-time enrollment snapshot, which is the last quarter of the base data used, CY 2015 Q4. Furthermore, as discussed earlier in this report, these projections are based on the assumption that current policy continues, as outlined in Section 3.02.

Optumas began with the two base data time periods of CY 2014 and CY 2015. These two base periods were then adjusted for program changes, based on the current policy within the Medicaid program discussed previously in Section 3.02. To bring each time period onto the same relative basis, CY 2014 was trended forwarded one year to be on the same basis as CY 2015. Then both of the base data periods are trended to SFY 2017 before trending into the biennium using the lower and upper bound trend estimates. These trended values are shown in Appendix I.C. The two base years are then blended, with equal weights, to ensure credibility. The summary in Figure 7 below shows the blended SFY 2017 estimates for the base year of the biennium.

Figure 7: SFY 2017 PMPM Estimates

SFY 2017 Projection Estimates		
SFY	Lower Bound Estimate	Upper Bound Estimate
2017	$620	$629

Using the blended base described above, **Optumas** used the trend factors from 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 SFY 2017 to SFY 2019, and a similar approach is applied for the upper bound estimates. Figure 8 below shows the final SFY 2018 and SFY 2019 PMPM projections and corresponding trends.

Figure 8: SFY 2018-2019 Projections

Overall Projection				
	PMPM		Trend	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2018	$638	$653	2.8%	3.8%
2019	$653	$679	2.4%	4.0%

Please note that the projections shown above, and in Appendices I.C-I.E, should be viewed as estimates of aggregate spend across each projection category. These estimates are only intended to reflect Medicaid's share of spend for each service, and do not include member or recipient liability. For example, the Nursing Facility service portion of the SNF (Non-MyCare) PMPM reflects an estimate of

Medicaid's share of the cost for members who reside in a Nursing Facility, but would not reflect additional service costs for which a recipient is liable to pay.

The projections noted above are indicative of target PMPM expenditures based on current policy and a constant population mix from CY 2015 Q4. While the PMPM projection provides a method of normalizing for population growth over time, the change in both mix of membership and services delivered within each category above could have a significant impact on the overall program-wide PMPM 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 2018-2019 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 2018-2019 biennium.

6. Appendices

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Appendix I.A – Projection Categories

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

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

Appendix I.B – PMPM Adjustment Impacts – FFS Expenditures

FFS Populations – FFS Expenditures

	Program Change Impact	
COS	CY 2014	CY 2015
Clinics - Mental Health	0.0%	0.0%
Dental Services	0.0%	0.0%
DME/Supplies	0.0%	0.0%
EPSDT	0.0%	0.0%
Family Planning	0.0%	0.0%
FQHC/RHC	0.0%	0.0%
HCBS Waiver	2.8%	2.8%
Health Homes	0.0%	0.0%
Home Health/PDN	1.4%	1.5%
ICF & MR Private	2.0%	7.6%
ICF & MR Public	1.9%	6.7%
Inpatient Hospital	0.0%	0.0%
Laboratory/Radiology	-1.7%	-1.8%
Medicaid Schools Program	43.0%	19.2%
Mental Inpatient Hospital	0.0%	0.0%
Non-FQHC/RHC Clinic	0.0%	0.0%
ODADAS/MARP	0.0%	0.0%
Other Services	-5.0%	-4.6%
Outpatient Hospital	-6.4%	-7.7%
PCP	-26.7%	-14.2%
Prescribed Drugs	0.0%	0.0%
SNF	14.3%	14.4%
Specialist	-27.8%	-14.3%
Total (4Q 2015 Mix)	**2.7%**	**4.0%**

Managed Care Populations - FFS Expenditures

	Program Change Impact	
COS	CY 2014	CY 2015
Clinics - Mental Health	0.0%	0.0%
FQHC/RHC	0.0%	0.0%
Health Homes	0.0%	0.0%
Medicaid Schools Program	41.7%	19.2%
Mental Inpatient Hospital	0.0%	0.0%
ODADAS/MARP	0.0%	0.0%
Other Services	0.0%	0.0%
Total (4Q 2015 Mix)	**1.9%**	**1.0%**

Appendix I.C – SFY 2018-2019 Biennium Projection Build-Up

FFS Populations – CY 2014 FFS Expenditures Buildup

	4Q 2015	CY 2014	CY 2014		CY 2014		CY 2014		CY 2014		CY 2014	
COA	MMs	Base PMPM	IBNR	Completed PMPM	Cost Share Reduction	Adjusted PMPM	Program Change Impact	Adjusted PMPM	Projected Growth to CY 2015	Adjusted PMPM	Remove Spenddown Costs	Final Adjusted PMPM
CHIP	227,832	$283	99.9%	$284	0.0%	$284	-1.6%	$279	4.0%	$290	0.0%	$290
ADFC	333,860	$450	100.0%	$450	0.0%	$450	-1.1%	$445	3.8%	$462	0.0%	$462
HFAM	1,601,832	$261	99.9%	$262	0.0%	$262	-3.2%	$253	3.1%	$261	-0.1%	$261
EXPN	1,116,412	$370	99.9%	$370	0.0%	$370	-2.5%	$361	3.2%	$372	-0.2%	$371
BCCP	8,208	$1,681	99.9%	$1,683	0.0%	$1,683	-5.3%	$1,594	1.7%	$1,622	-0.2%	$1,618
PREM ASST	1,456,432	$52	99.9%	$52	0.0%	$52	-7.8%	$48	1.7%	$49	-28.2%	$35
OTHER	412,464	$416	99.8%	$417	0.0%	$417	-1.8%	$410	2.0%	$418	0.0%	$418
ABD KIDS	17,044	$2,144	99.9%	$2,145	0.0%	$2,145	-1.2%	$2,119	3.5%	$2,193	-0.1%	$2,192
ABD ADULT	61,784	$1,656	99.9%	$1,658	-0.1%	$1,657	-3.8%	$1,594	1.6%	$1,619	-23.3%	$1,241
DUAL	397,744	$399	99.9%	$399	-0.7%	$396	-7.4%	$367	1.7%	$373	-9.1%	$339
ICF	76,228	$10,128	99.8%	$10,147	-5.4%	$9,604	1.7%	$9,762	0.5%	$9,811	0.0%	$9,813
SNF	364,908	$5,134	99.9%	$5,137	-15.0%	$4,365	11.0%	$4,845	1.3%	$4,907	0.0%	$4,906
AGING WAIVER	271,104	$1,874	100.0%	$1,875	-0.1%	$1,872	-1.2%	$1,850	1.9%	$1,885	0.2%	$1,889
DD WAIVER	426,176	$4,364	99.9%	$4,367	0.0%	$4,365	2.7%	$4,483	2.4%	$4,592	0.0%	$4,594
MCD WAIVER	66,724	$5,236	100.0%	$5,238	0.0%	$5,236	-0.9%	$5,190	2.4%	$5,316	0.3%	$5,330
Total (4Q 2015 Mix)	**6,838,752**	**$1,019**	**99.9%**	**$1,020**	**-4.7%**	**$972**	**2.7%**	**$998**	**2.0%**	**$1,017**	**-0.8%**	**$1,009**

FFS Populations – CY 2015 FFS Expenditures Buildup

	4Q 2015	CY 2015	CY 2015		CY 2015		CY 2015		CY 2015	
COA	MMs	Base PMPM	IBNR	Completed PMPM	Cost Share Reduction	Adjusted PMPM	Program Change Impact	Adjusted PMPM	Projected Growth to CY 2015	Adjusted PMPM
CHIP	227,832	$143	98.3%	$146	0.0%	$146	0.1%	$146	0.0%	$146
ADFC	333,860	$458	99.1%	$463	0.0%	$463	0.0%	$463	0.0%	$463
HFAM	1,601,832	$225	97.9%	$230	0.0%	$230	-0.4%	$229	0.0%	$229
EXPN	1,116,412	$340	97.8%	$348	0.0%	$348	-0.5%	$346	0.0%	$346
BCCP	8,208	$1,378	98.4%	$1,401	0.0%	$1,401	-6.5%	$1,311	0.0%	$1,311
PREM ASST	1,456,432	$49	98.5%	$50	0.0%	$50	-8.0%	$46	-27.3%	$33
OTHER	412,464	$234	97.7%	$239	0.0%	$239	-0.9%	$237	0.0%	$237
ABD KIDS	17,044	$2,520	98.7%	$2,554	0.0%	$2,554	0.3%	$2,562	0.9%	$2,584
ABD ADULT	61,784	$1,293	98.1%	$1,318	-0.2%	$1,316	-1.1%	$1,301	-23.0%	$1,002
DUAL	397,744	$379	98.8%	$384	-1.3%	$379	-6.4%	$354	-8.1%	$326
ICF	76,228	$9,613	98.9%	$9,720	-5.4%	$9,199	6.7%	$9,818	0.1%	$9,823
SNF	364,908	$5,058	99.1%	$5,102	-15.2%	$4,324	11.4%	$4,817	0.1%	$4,822
AGING WAIVER	271,104	$1,920	99.3%	$1,934	-0.2%	$1,931	-0.6%	$1,919	0.1%	$1,921
DD WAIVER	426,176	$4,418	98.5%	$4,486	0.0%	$4,485	2.8%	$4,610	0.0%	$4,613
MCD WAIVER	66,724	$5,183	99.0%	$5,235	0.0%	$5,233	-0.3%	$5,219	0.2%	$5,229
Total (4Q 2015 Mix)	**6,838,752**	**$981**	**98.7%**	**$993**	**-4.8%**	**$945**	**4.0%**	**$983**	**-0.7%**	**$976**

FFS Populations – Projected SFY 2017 FFS Expenditures

COA	4Q 2015 MMs	CY 2014 Final Adjusted PMPM	CY 2014 Annual Projected Growth to SFY 2017[1]	CY 2014 PMPM	CY 2015 Final Adjusted PMPM	CY 2015 Annual Projected Growth to SFY 2017[1]	CY 2015 PMPM	Blended LB SFY 2017 PMPM	Blended Midpoint SFY 2017 PMPM	Blended UB SFY 2017 PMPM
CHIP	227,832	$290	4.1%	$308	$146	4.0%	$154	$274	$277	$281
ADFC	333,860	$462	3.8%	$489	$463	3.8%	$489	$484	$489	$495
HFAM	1,601,832	$261	3.1%	$273	$229	3.2%	$240	$263	$267	$270
EXPN	1,116,412	$371	3.2%	$390	$346	3.4%	$364	$366	$369	$372
BCCP	8,208	$1,618	1.8%	$1,662	$1,311	1.9%	$1,349	$1,497	$1,505	$1,523
PREM ASST	1,456,432	$35	4.8%	$37	$33	4.5%	$36	$35	$35	$35
OTHER	412,464	$418	2.0%	$430	$237	2.2%	$245	$241	$245	$249
ABD KIDS	17,044	$2,192	4.5%	$2,342	$2,584	5.0%	$2,782	$2,699	$2,718	$2,744
ABD ADULT	61,784	$1,241	21.5%	$1,663	$1,002	17.8%	$1,282	$1,020	$1,027	$1,036
DUAL	397,744	$339	18.9%	$440	$326	17.1%	$413	$337	$341	$344
ICF	76,228	$9,813	0.9%	$9,951	$9,823	1.0%	$9,971	$9,843	$9,895	$9,987
SNF	364,908	$4,906	3.3%	$5,151	$4,822	2.9%	$5,035	$4,909	$4,958	$5,030
AGING WAIVER	271,104	$1,889	4.5%	$2,017	$1,921	3.9%	$2,034	$1,955	$1,972	$1,990
DD WAIVER	426,176	$4,594	3.4%	$4,829	$4,613	3.4%	$4,847	$4,729	$4,776	$4,825
MCD WAIVER	66,724	$5,330	3.5%	$5,609	$5,229	3.3%	$5,488	$5,424	$5,477	$5,540
Total (4Q 2015 Mix)	**6,838,752**	**$1,009**	**3.7%**	**$1,065**	**$976**	**3.4%**	**$1,027**	**$1,010**	**$1,020**	**$1,032**

[1] Projected Growth at Midpoint

FFS Populations – Projected SFY 2018 – SFY 2019 FFS Expenditures

	4Q 2015	SFY 2017		SFY 2018				SFY 2019			
		Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	MMs	Blended PMPM	Blended PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
CHIP	227,832	$274	$281	3.6%	$284	4.8%	$295	3.7%	$294	4.9%	$309
ADFC	333,860	$484	$495	3.3%	$500	4.5%	$518	3.4%	$517	4.6%	$541
HFAM	1,601,832	$263	$270	2.7%	$271	3.7%	$280	2.7%	$278	3.8%	$291
EXPN	1,116,412	$366	$372	2.9%	$376	3.9%	$387	2.9%	$387	4.0%	$402
BCCP	8,208	$1,497	$1,523	1.6%	$1,521	2.5%	$1,560	1.6%	$1,545	2.5%	$1,599
PREM ASST	1,456,432	$35	$35	1.3%	$35	2.3%	$36	1.3%	$36	2.3%	$37
OTHER	412,464	$241	$249	1.2%	$244	3.3%	$257	1.2%	$247	3.3%	$265
ABD KIDS	17,044	$2,699	$2,744	3.0%	$2,781	4.2%	$2,858	3.1%	$2,866	4.2%	$2,979
ABD ADULT	61,784	$1,020	$1,036	1.1%	$1,031	2.2%	$1,059	1.2%	$1,043	2.2%	$1,083
DUAL	397,744	$337	$344	1.2%	$341	2.2%	$352	1.2%	$345	2.3%	$360
ICF	76,228	$9,843	$9,987	0.3%	$9,870	1.0%	$10,088	0.3%	$9,899	1.0%	$10,192
SNF	364,908	$4,909	$5,030	0.8%	$4,948	2.0%	$5,133	0.8%	$4,988	2.0%	$5,237
AGING WAIVER	271,104	$1,955	$1,990	1.5%	$1,985	2.6%	$2,041	1.5%	$2,015	2.6%	$2,094
DD WAIVER	426,176	$4,729	$4,825	2.0%	$4,824	3.1%	$4,973	2.1%	$4,923	3.1%	$5,127
MCD WAIVER	66,724	$5,424	$5,540	2.0%	$5,532	3.1%	$5,711	2.0%	$5,645	3.1%	$5,890
Total (4Q 2015 Mix)	**6,838,752**	**$1,010**	**$1,032**	**1.6%**	**$1,026**	**2.7%**	**$1,059**	**1.6%**	**$1,043**	**2.7%**	**$1,087**

Managed Care Populations – CY 2014 FFS Expenditures Buildup

	4Q 2015	CY 2014	CY 2014		CY 2014		CY 2014		CY 2014	
COA	MMs	Base PMPM	IBNR	Completed PMPM	Cost Share Reduction	Adjusted PMPM	Program Change Impact	Adjusted PMPM	Projected Growth to CY 2015	Final Adjusted PMPM
ABD ADULT	1,317,524	$81	100.0%	$81	0.0%	$81	0.0%	$81	2.1%	$83
ABD KIDS	320,056	$140	100.0%	$140	0.0%	$140	6.7%	$150	2.6%	$154
CFC ADULT	5,992,560	$25	100.0%	$25	0.0%	$25	0.0%	$25	5.8%	$26
CFC KIDS	13,187,500	$24	100.0%	$24	0.0%	$24	4.5%	$25	4.8%	$26
EXPN	7,032,600	$42	100.0%	$42	0.0%	$42	0.0%	$42	4.8%	$44
MyCare	1,124,424	$-	0.0%	$-	0.0%	$-	0.0%	$-	0.0%	$-
Total (4Q 2015 Mix)	**28,974,664**	**$31**	**100.0%**	**$31**	**0.0%**	**$31**	**1.9%**	**$32**	**4.5%**	**$33**

Managed Care Populations – CY 2015 FFS Expenditures Buildup

	4Q 2015	CY 2015	CY 2015		CY 2015		CY 2015		CY 2015	
COA	MMs	Base PMPM	IBNR	Completed PMPM	Cost Share Reduction	Adjusted PMPM	Program Change Impact	Final Adjusted Base	Remove Spenddown Costs	Final Adjusted PMPM
ABD ADULT	1,317,524	$79	99.4%	$80	0.0%	$80	0.0%	$80	0.0%	$80
ABD KIDS	320,056	$141	99.1%	$142	0.0%	$142	3.1%	$146	0.0%	$146
CFC ADULT	5,992,560	$26	99.3%	$26	0.0%	$26	0.0%	$26	0.0%	$26
CFC KIDS	13,187,500	$26	98.9%	$26	0.0%	$26	2.2%	$26	0.0%	$26
EXPN	7,032,600	$39	99.3%	$39	0.0%	$39	0.0%	$39	0.0%	$39
MyCare	1,124,424	$-	0.0%	$-	0.0%	$-	0.0%	$-	0.0%	$-
Total (4Q 2015 Mix)	**28,974,664**	**$32**	**99.1%**	**$32**	**0.0%**	**$32**	**1.0%**	**$32**	**0.0%**	**$32**

MC Populations – Projected SFY 2017 FFS Expenditures

	4Q 2015	CY 2014	CY 2014		CY 2015	CY 2015				
COA	MMs	Final Adjusted PMPM	Annual Projected Growth to SFY 2017[1]	PMPM	Final Adjusted PMPM	Annual Projected Growth to SFY 2017[1]	PMPM	Blended LB FY 2017 PMPM	Blended Midpoint FY 2017 PMPM	Blended UB FY 2017 PMPM
ABD ADULT	1,317,524	$83	2.1%	$85	$80	2.1%	$83	$83	$84	$85
ABD KIDS	320,056	$154	2.6%	$160	$146	2.6%	$152	$154	$156	$157
CFC ADULT	5,992,560	$26	5.8%	$29	$26	5.8%	$28	$28	$28	$29
CFC KIDS	13,187,500	$26	4.9%	$28	$26	4.9%	$28	$28	$28	$29
EXPN	7,032,600	$44	4.9%	$47	$39	5.1%	$42	$42	$42	$44
MyCare	1,124,424	$-	0.0%	$-	$-	0.0%	$-	$-	$-	$-
Total (4Q 2015 Mix)	**28,974,664**	**$33**	**4.6%**	**$36**	**$32**	**4.7%**	**$34**	**$34**	**$35**	**$35**

[1] Projected Growth at Midpoint

MC Populations – Projected SFY 2018 – SFY 2019 FFS Expenditures

		SFY 2017		SFY 2018				SFY 2019			
	4Q 2015	Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	MMs	Blended PMPM	Blended PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
ABD ADULT	1,317,524	$83	$85	1.6%	$84	2.6%	$87	1.6%	$86	2.6%	$89
ABD KIDS	320,056	$154	$157	2.1%	$158	3.1%	$162	2.1%	$161	3.1%	$167
CFC ADULT	5,992,560	$28	$29	5.5%	$30	6.4%	$30	5.5%	$31	6.5%	$32
CFC KIDS	13,187,500	$28	$29	4.4%	$29	5.5%	$30	4.5%	$30	5.5%	$32
EXPN	7,032,600	$42	$44	5.2%	$44	7.3%	$47	5.3%	$47	7.3%	$50
MyCare	1,124,424	$-	$-	0.0%	$-	0.0%	$-	0.0%	$-	0.0%	$-
Total (4Q 2015 Mix)	**28,974,664**	**$34**	**$35**	**4.4%**	**$36**	**5.7%**	**$37**	**4.5%**	**$37**	**5.8%**	**$39**

Appendix I.C – SFY 2018-2019 Biennium Projection Build-Up

Managed Care Populations – Capitated Expenditures

		SFY 2017		SFY 2018				SFY 2019			
	4Q 2015	Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	MMs	Blended PMPM	Blended PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
ABD ADULT	1,317,524	$1,474	$1,487	3.9%	$1,531	4.7%	$1,556	3.5%	$1,584	5.4%	$1,639
ABD KIDS	320,056	$812	$819	5.7%	$858	6.5%	$873	5.4%	$905	7.4%	$937
CFC ADULT	5,992,560	$380	$384	3.2%	$392	4.0%	$399	2.8%	$403	4.7%	$418
CFC KIDS	13,187,500	$197	$199	3.5%	$204	4.4%	$207	3.1%	$210	5.1%	$218
EXPN	7,032,600	$531	$536	3.7%	$551	4.6%	$560	3.2%	$568	5.2%	$590
MyCare	1,124,424	$2,101	$2,122	2.1%	$2,145	3.1%	$2,187	1.6%	$2,179	3.6%	$2,266
Delivery	52,654	$5,669	$5,702	0.0%	$5,669	1.2%	$5,770	0.0%	$5,669	1.2%	$5,838
Total (4Q 2015 Mix)	**28,974,664**	**$465**	**$469**	**3.3%**	**$480**	**4.1%**	**$489**	**2.9%**	**$494**	**4.8%**	**$512**

Managed Care Populations – Combined Expenditures

		SFY 2017		SFY 2018				SFY 2019			
	4Q 2015	Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	MMs	Blended PMPM	Blended PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
ABD ADULT	1,317,524	$1,557	$1,572	3.8%	$1,615	4.6%	$1,643	3.4%	$1,670	5.2%	$1,729
ABD KIDS	320,056	$966	$977	5.1%	$1,015	6.0%	$1,035	4.9%	$1,065	6.7%	$1,104
CFC ADULT	5,992,560	$408	$412	3.3%	$422	4.1%	$429	3.0%	$435	4.9%	$450
CFC KIDS	13,187,500	$225	$227	3.6%	$233	4.5%	$237	3.3%	$241	5.2%	$250
EXPN	7,032,600	$573	$579	3.8%	$595	4.8%	$607	3.4%	$615	5.4%	$640
MyCare	1,124,424	$2,101	$2,122	2.1%	$2,145	3.1%	$2,187	1.6%	$2,179	3.6%	$2,266
Delivery	52,654	$5,669	$5,702	0.0%	$5,669	1.2%	$5,770	0.0%	$5,669	1.2%	$5,838
Total (4Q 2015 Mix)	**28,974,664**	**$499**	**$504**	**3.4%**	**$516**	**4.3%**	**$526**	**3.0%**	**$531**	**4.9%**	**$551**

Appendix I.D – Highest to Lowest Cost PMPM – SFY 2017

FFS Populations – FFS Expenditures

COA	MMs[1]	SFY 2017 LB	SFY 2017 UB
ICF	76,228	$9,843	$9,987
MCD WAIVER	66,724	$5,424	$5,540
SNF	364,908	$4,909	$5,030
DD WAIVER	426,176	$4,729	$4,825
ABD KIDS	17,044	$2,699	$2,744
AGING WAIVER	271,104	$1,955	$1,990
BCCP	8,208	$1,497	$1,523
ABD ADULT	61,784	$1,020	$1,036
ADFC	333,860	$484	$495
EXPN	1,116,412	$366	$372
DUAL	397,744	$337	$344
CHIP	227,832	$274	$281
HFAM	1,601,832	$263	$270
OTHER	412,464	$241	$249
PREMASST	1,456,432	$35	$35
Total (4Q 2015 Mix)	**6,838,752**	**$1,010**	**$1,032**

[1] *Annualized membership of 4Q 2015*

Appendix I.D – Highest to Lowest Cost PMPM – SFY 2017

Managed Care Populations – FFS Expenditures

COA	MMs[1]	SFY 2017 Lower Bound	SFY 2017 Upper Bound
ABD KIDS	320,056	$154	$157
ABD ADULT	1,317,524	$83	$85
EXPN	7,032,600	$42	$44
CFC ADULT	5,992,560	$28	$29
CFC KIDS	13,187,500	$28	$29
MyCare	1,124,424	$-	$-
Delivery	52,654	$-	$-
Total (4Q 2015 Mix)	**28,974,664**	**$34**	**$35**

[1] *Annualized membership of 4Q 2015*

Managed Care Populations – Capitated Expenditures

COA	MMs[1]	SFY 2017 Lower Bound	SFY 2017 Upper Bound
Delivery	52,654	$5,669	$5,702
MyCare	1,124,424	$2,101	$2,122
ABD ADULT	1,317,524	$1,474	$1,487
ABD KIDS	320,056	$812	$819
EXPN	7,032,600	$531	$536
CFC ADULT	5,992,560	$380	$384
CFC KIDS	13,187,500	$197	$199
Total (4Q 2015 Mix)	**28,974,664**	**$465**	**$469**

[1] *Annualized membership of 4Q 2015*

Managed Care Populations – Combined Expenditures

COA	MMs[1]	SFY 2017 Lower Bound	SFY 2017 Upper Bound
Delivery	52,654	$5,669	$5,702
MyCare	1,124,424	$2,101	$2,122
ABD ADULT	1,317,524	$1,557	$1,572
ABD KIDS	320,056	$966	$977
EXPN	7,032,600	$573	$579
CFC ADULT	5,992,560	$408	$412
CFC KIDS	13,187,500	$225	$227
Total (4Q 2015 Mix)	**28,974,664**	**$499**	**$504**

[1] *Annualized membership of 4Q 2015*

Appendix I.E – Highest to Lowest Total Cost – SFY 2017

FFS Populations – FFS Expenditures

COA	SFY 2017 Lower Bound	SFY 2017 Upper Bound
DD WAIVER	$2,015,300,000	$2,056,400,000
SNF	$1,791,300,000	$1,835,700,000
ICF	$750,300,000	$761,300,000
AGING WAIVER	$530,100,000	$539,500,000
HFAM	$422,100,000	$432,400,000
EXPN	$408,200,000	$415,500,000
MCD WAIVER	$361,900,000	$369,600,000
ADFC	$161,600,000	$165,300,000
DUAL	$134,200,000	$137,000,000
OTHER	$99,600,000	$102,600,000
ABD ADULT	$63,000,000	$64,000,000
CHIP	$62,400,000	$64,100,000
PREM ASST	$50,600,000	$51,600,000
ABD KIDS	$46,000,000	$46,800,000
BCCP	$12,300,000	$12,500,000
Total (4Q 2015 Mix)	**$6,908,800,000**	**$7,054,300,000**

*Note: Total dollars above are **NOT** intended to reflect estimated expenditures in SFY 2017, but are intended to provide a view of the magnitude of total spend by each population, relative to each-other using a constant membership mix. These dollars are calculated by multiplying projected PMPM by the annualized 2015 Q4 MMs used to develop the aggregate PMPM. Total estimated expenditures will vary depending on the number of member months experienced in SFY 2017, as well as to the extent that additional programmatic changes outside of current policy go into effect through the duration of SFY 2017.*

Appendix I.E – Highest to Lowest Total Cost – SFY 2017

Managed Care Populations – FFS Expenditures

COA	SFY 2017 Lower Bound	SFY 2017 Upper Bound
CFC KIDS	$368,700,000	$375,900,000
EXPN	$297,300,000	$306,100,000
CFC ADULT	$168,500,000	$171,500,000
ABD ADULT	$109,500,000	$111,700,000
ABD KIDS	$49,400,000	$50,400,000
MyCare	$-	$-
Delivery	$-	$-
Total (4Q 2015 Mix)	**$993,300,000**	**$1,015,600,000**

Managed Care Populations – Capitated Expenditures

COA	SFY 2017 Lower Bound	SFY 2017 Upper Bound
EXPN	$3,732,100,000	$3,768,000,000
CFC KIDS	$2,594,400,000	$2,619,100,000
MyCare	$2,362,700,000	$2,386,300,000
CFC ADULT	$2,278,300,000	$2,299,200,000
ABD ADULT	$1,941,500,000	$1,958,900,000
Delivery	$298,500,000	$300,200,000
ABD KIDS	$259,800,000	$262,200,000
Total (4Q 2015 Mix)	**$13,467,200,000**	**$13,593,900,000**

Note: The sum of each category may not equal the totals above, as dollars have been rounded to the nearest $100,000.

Managed Care Populations – Combined Expenditures

COA	SFY 2017 Lower Bound	SFY 2017 Upper Bound
EXPN	$4,029,500,000	$4,074,100,000
CFC KIDS	$2,963,100,000	$2,995,100,000
CFC ADULT	$2,446,800,000	$2,470,700,000
MyCare	$2,362,700,000	$2,386,300,000
ABD ADULT	$2,050,900,000	$2,070,500,000
ABD KIDS	$309,200,000	$312,500,000
Delivery	$298,500,000	$300,200,000
Total (4Q 2015 Mix)	**$14,460,600,000**	**$14,609,400,000**

All Populations – All Expenditures

COA	SFY 2017 Lower Bound	SFY 2017 Upper Bound
FFS	$6,908,800,000	$7,054,300,000
MC - FFS	$993,300,000	$1,015,600,000
MC - MC	$13,467,200,000	$13,593,900,000
Total (Q4 2015 Mix)	$21,369,300,000	$21,663,800,000
Additional Payments	$849,300,000	$863,700,000
Total (Q4 2015 Mix)	**$22,218,600,000**	**$22,527,500,000**

*Note: Total dollars shown on this page are **NOT** intended to reflect estimated total dollar expenditures in SFY 2017, but are intended to provide the magnitude of total spend by each population, relative to each-other using a constant membership mix. These dollars are calculated by multiplying projected PMPM by the annualized Q4 2015 MMs used to weight the program-wide PMPM. Total estimated expenditures will vary depending on the number of member months actually experienced in SFY 2017, as well as to the extent that additional programmatic changes outside of current policy go into effect throughout SFY 2017.*

Appendix I.F – Distribution of Cost – SFY 2017

FFS Populations – FFS Expenditures

COA	SFY 2017[1]
DD WAIVER	9.5%
SNF	8.4%
ICF	3.5%
AGING WAIVER	2.5%
HFAM	2.0%
EXPN	1.9%
MCD WAIVER	1.7%
ADFC	0.8%
DUAL	0.6%
OTHER	0.5%
ABD ADULT	0.3%
CHIP	0.3%
PREM ASST	0.2%
ABD KIDS	0.2%
BCCP	0.1%
Total (4Q 2015 Mix)	**32.5%**

[1] *Estimated SFY 2017 Midpoint*

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

Appendix I.F – Distribution of Cost – SFY 2017

Managed Care Populations – FFS Expenditures

COA	SFY 2017[1]
CFC KIDS	1.7%
EXPN	1.4%
CFC ADULT	0.8%
ABD ADULT	0.5%
ABD KIDS	0.2%
MyCare	0.0%
Delivery	0.0%
Total (4Q 2015 Mix)	**4.7%**

[1] *Estimated SFY 2017 Midpoint*

Managed Care Populations – Combined Expenditures

COA	SFY 2017[1]
EXPN	18.8%
CFC KIDS	13.9%
CFC ADULT	11.4%
MyCare	11.1%
ABD ADULT	9.6%
ABD KIDS	1.4%
Delivery	1.4%
Total (4Q 2015 Mix)	**67.5%**

[1] *Estimated SFY 2017 Midpoint*

Managed Care Populations – Capitated Expenditures

COA	SFY 2017[1]
EXPN	17.4%
CFC KIDS	12.1%
MyCare	11.1%
CFC ADULT	10.7%
ABD ADULT	9.1%
Delivery	1.4%
ABD KIDS	1.2%
Total (4Q 2015 Mix)	**62.9%**

[1] *Estimated SFY 2017 Midpoint*

All Populations – Combined Expenditures

COA	SFY 2017[1]
FFS	32.4%
MC - FFS	4.7%
MC - MC	62.9%
Total (SFY 2015 Mix)	**100.0%**

[1] *Estimated SFY 2017 Midpoint*

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