Report from the JMOC Actuary

Presented to the JMOC Committee

May 18, 2023

Setting a Growth Target for Medicaid: JMOC Responsibilities

Under ORC Section 103.414, JMOC must

- Contract with actuary to determine the projected medical inflation rate for the upcoming biennium
- Determine if it agrees with the actuary's findings
  - If not, JMOC must develop its own projected medical inflation rate
- Complete a report and submit to Governor and General Assembly

Setting a Growth Target for Medicaid: Medicaid Responsibilities

Under ORC Section 5162.70, the Medicaid Director must

- Limit growth at an aggregate PMPM level across the entire program to the JMOC rate or 3 year average CPI, whichever is lower; **and**
- Improve the health of Medicaid recipients
- Reduce the prevalence of comorbid conditions and mortality rates of Medicaid recipients
- Reduce infant mortality rates among Medicaid recipients
- Help individuals who have the greatest potential to obtain income move to private health coverage

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Ohio SFY24/SFY25 Biennial

Rate of Growth Projections

Recap and 2023 update

MAY 18, 2023

Agenda

- Recap SFY24-25 Biennium report
  - Purpose
  - Methodology
  - Data
  - Results
  - Committee Vote
- 2023 Updates
  - Buy-In/Clawback costs
  - PHE Unwinding
- Big Picture Thinking
  - Policies to advance Medicaid health and financial outcomes

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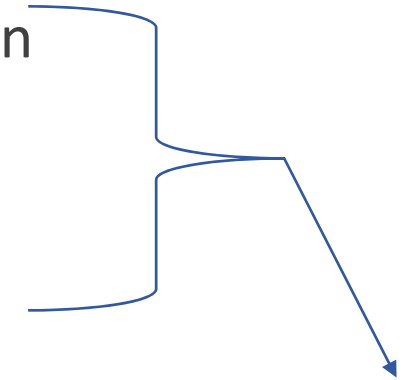
Objective

- Project Ohio's Medicaid medical inflation rate for the upcoming biennium

4 Determinants of Risk:

- Program Design
- Population
- Benefits
- Network



$$\text{PMPM} = \frac{\text{Total cost in dollars}}{\text{Total member months}}$$

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Objective

- PMPM (Per Member Per Month) Projections
  - Develop category of aid level PMPM projections
    - PMPM – Projected costs are normalized at an average per-member per-month level
      - Measure is not influenced by changes in enrollment volume
      - Accounts for total expenditures and total enrollment
    - Comprised of two components:
      - Unit Cost – Average cost per service/visit
      - Utilization – Average rate of service utilization across all eligible members

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Data

- Data Sources:
  - January 2019-April 2022 detailed FFS and Encounter claims-level data
  - January 2019-April 2022 member-level eligibility data by month
  - Monthly Medicaid Variance Reports and MCP Cost Reports for benchmarking
  - Ohio Department of Medicaid Caseload Reports for benchmarking
  - Managed Care Certification Letters
    - July 2022-December 2023 Capitation Rates
    - Calendar Year 2022 MyCare Capitation Rates
  - Actual and Projected Medicare Premiums/Part D claw-back Amounts

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Process

- PMPM Projections
  - CY2021 used as base data to begin projection
    - Consistent CY2021 Membership throughout Biennium used for Scenario A
    - Modeled Public Health Emergency unwinding used for Scenario B
  - Developed at a category of aid (COA) and category of service (COS) level
  - COA and COS PMPMs are projected into the biennium period
  - **Excludes** spending not tied to a recipient[1]

[1] *Detailed exclusions in Appendix*

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Adjustments

- Reflect Current Policy – Adjustments to historical expenditure data to reflect current policy
  - Projections assume current policy continues
- Population/Membership – Adjust CY2021 base year to reflect recent population mix
  - Change in populations covered in Managed Care vs. FFS
- Policy Changes – Adjusts for policies that have potential to impact the risk of the program
  - Reimbursement rate changes
  - Implementation of new programs

Trend

- Adjust Time Period – Trend factors project cost from the base period to future time periods
- Multiple Components
  - Levels of Trend – Trend factors are estimated by major categories of service and categories of aid
  - Secular Trend – Components include:
    - Utilization – Change in frequency of services over time
    - Unit cost – Change in service reimbursement over time, as well as change in mix of services over time
- Other Considerations
  - Public Health Emergency (PHE)
    - Underutilization of services
    - Disenrollment pause

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Inflation ⊆ Trend

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The Two Stories of the SFY24-25 Biennium Report

- Public Health Emergency
- Inflation

Growth Rate Projection

Figure 1. Projected Rates of Growth, Scenario A – Constant CY 2021 popu

SFY	Lower Bound	Upper Bound
2024	2.8%	3.9%
2025	2.6%	3.6%
Avg. Annual	**2.7%**	**3.7%**

Figure 2. Projected Rates of Growth, Scenario B – Modeled PHE unwoun

SFY	Lower Bound	Upper Bound
2024	3.7%	4.8%
2025	3.1%	4.1%
Avg. Annual	**3.4%**	**4.4%**

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CPI

Time Period	Midwest CPI	US CPI
9/2019 - 8/2020	4.3%	4.6%
9/2020 - 8/2021	2.1%	1.7%
9/2021 - 8/2022	2.1%	2.9%
3 Year Avg. (Unweighted)	2.8%	3.1%

This chart represents the average of the last 36 data points of monthly inflation as calculated by BLS. This agrees with the past methodology used in JMOC reports. There is a concern that in an environment of 8.2% (general) inflation (September 2022), 2.8% may understate the medical inflation in the SFY 2024-2025 biennium study period.

CPI – alternative option

Time Period	Modeled medical CPI
SFY 2024	4.3%
SFY 2025	3.3%
2 Year Avg. (Unweighted)	3.8%

We have modeled one potential outcome as an alternative based on three assumptions:

1. Medical inflation lags general inflation
2. We do not expect the current inflationary environment to continue indefinitely
3. In the long run, fiscal and monetary policy will be used to return inflation to historical levels

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JMOC Rate

Voted upon October 20, 2022:

Figure 3. JMOC Rate

SFY	Rate
2024	3.3%
2025	3.4%
Avg. Annual	**3.35%**

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JMOC Rate comparison

Comparator	JMOC Rate	Midpoint Scenario A	CPI - classic	Midpoint Scenario B	CPI - modeled
Avg. Annual	3.35%	3.2%	2.8%	3.9%	3.8%

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Q&A: Round 1

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Buy-In and Clawback – 2023 Update

Buy-in/Clawback total cost projection at midpoint

SFY	Oct 2022 projection	May 2023 projection	Difference
2024	$ 1,373,069,359	$ 1,343,983,547	$ (29,085,812)
2025	$ 1,450,406,365	$ 1,449,543,440	$ (862,925)
Total	$ 2,823,475,725	$ 2,793,526,988	$ (29,948,737)

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Unwinding the effects of the Public Health Emergency

- Ohio was scheduled to begin disenrollments in May 2023
- This is on par with the Midwest and the nation as a whole
- ODM has developed a detailed roadmap described in the document “Unwinding from the Public Health Emergency Whitepaper”
- JMOC should receive regular progress updates from ODM on this process

Q&A: Round 2

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Big Picture Thinking –
3 Policies to Better Ohio's Medicaid Program

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- ODM, like all state Medicaid agencies, regularly monitors:
  - Progress and feedback from new programs and initiatives
  - Emerging trends and "hot spots"
  - Cost and quality outcomes of MCOs, hospitals, and providers
  - Detection of fraud, waste, and abuse

- JMOC and ODM should collaborate and develop a pipeline where reports, monitoring, and data are regularly shared to build JMOC's oversight capabilities.
- This process should evolve as goals are met and new priorities and needs arise

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Big Picture Thinking –
3 Policies to Better Ohio's Medicaid Program

Hospital monitoring

- Identify if hospitals aren't meeting targets:
  - Outliers in cost
    - In aggregate or for certain classes of service
  - Outliers in utilization
    - Common examples are surgeries and advanced imagining
  - Outliers in adverse events
    - Readmissions
    - Hospital acquired infections
    - Falls and errors

- Optumas is contracted to build a demonstration dashboard for JMOC

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Big Picture Thinking –
3 Policies to Better Ohio's Medicaid Program

Value Based Purchasing

- This is main idea of healthcare reform in the last 10 years
- Many different formulations exist:
  - Move from paying for quantity of services (fee-for-service) to paying for outcomes
  - Pay for performance
  - Holding providers accountable for cost and quality
    - Shared risk or shared savings

- Examples:
  - Ohio — 3% withhold – 2 measures
  - Kansas — 3% withhold – 16 measures
  - Colorado — APM – alternative payment model
  - New Mexico — VBP as % of capitation
  - North Dakota — Hospital shared risk
  - California — Risk adjustment bonus or penalty

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Kansas withhold

- 3% of the capitation rate is withheld from the health plans
- It can be earned back, in part or in whole, by achieving quality metrics

Comprehensive Diabetes Care (CDC): CDC - HbA1c Control (< 8.0%)
Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)
Childhood Immunization Status (CIS) - Combination 10
Immunizations for Adolescents (IMA) - Combination 2
Chlamydia Screening in Women (CHL)
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
Prenatal and Postpartum Care (PPC): Postpartum Care
Cervical Cancer Screening (CCS)
Annual Dental Visit
Lead Screening in Children (LSC)
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days
Use of Multiple Concurrent Antipsychotics in children and Adolescents (APC)
Peer Support services utilization for Behavioral Health services
Residents of a NF or NFMH discharged to a community setting

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North Dakota – shared risk

- Hospital systems have 4% at risk using the following quality metrics

Quality Measure
Well-Child Visits First 30 Months of Life (W30-CH)
Child & Adolescent Well-Care Visit (WCV-CH)
Breast Cancer Screening (BCS-AD)
PCP Visit Percentage
Postpartum Care: Prenatal and Postpartum Care (PPC-AD)
Screening for Depression and Documented Follow-up Plan (CDF-AD; CDF-CH)
ED Utilization per 1000
Topical Fluoride for Children (TFL-CH)
Colorectal Cancer Screen (COL-AD)
Controlling High Blood Pressure
Plan All-Cause Readmission (PCR-AD)
Prenatal Care: Prenatal and Postpartum Care (PPC-AD)
Contraceptive Care-Postpartum Women (CCP-AD)
Structural Measure: Perinatal Collaborative Participation
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs

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Q&A: Round 3

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Appendices

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Expenditure Exclusions

- Excludes one-time funds and spending that is not tied to a recipient
  - All-Agency State Administration,
  - Hospital Care Assurance Program (HCAP),
  - Hospital Upper Payment Limit (UPL),
  - Hospital Pass Through Payments,
  - Health Insuring Corporation (HIC) Franchise and Premium Tax,
  - Care Innovation and Community Improvement Program (CICIP),
  - MCP/Hospital Incentive,
  - Other settlements and rebates paid outside of the claims system and outside of the Managed Care capitation rate,
  - Medicaid recipient share of cost (SOC),

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