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September 26, 2022
Ms. Jada Brady
Executive Director
Joint Medicaid Oversight Committee
Vern Riffe Center
77 S. High Street, 19th Floor
Columbus, OH 43215

Subject: **FINAL Ohio JMOC SFY 2024-2025 Biennium Medicaid Growth Rate Projections**

Dear Ms. Brady:

Thank you for the opportunity to assist the Joint Medicaid Oversight Committee with the development of the JMOC Medicaid growth rate projections for the SFY 2024-2025 biennium. It was a pleasure to work with you and your team throughout this project. The following final report summarizes the methodology for the development of the SFY 2024-2025 biennial growth rate projections.

We look forward to discussing our findings and methodology with the JMOC team.

Sincerely,

Dan Skinner, FSA, CERA, MAAA

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Ohio Joint Medicaid Oversight Committee

State Fiscal Years 2024-2025 Biennium Growth Rate Projections

State of Ohio

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1. Executive Summary

Per Ohio Revised Code (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) 2024-2025 Biennium (July 2023 – June 2025). Through a competitive procurement process, JMOC originally contracted with **Optumas** in 2014 as its consulting actuary for this analysis for the SFY 2016-2017 Biennium. The estimated SFY 2024-2025 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 Ohio Medicaid program. To ensure that the projections are independent of proposed policy changes that have yet to be implemented, 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, SFY 2018-2019, SFY 2020-2021 and SFY 2022-2023 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, 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 the biennium.

Optumas developed a range of projected PMPM growth under two separate scenarios. As background, the federal Department Health and Human Services declared a public health emergency (PHE) in March 2020. One effect was to freeze all Medicaid disenrollment nationwide, with a few narrow exceptions. This had a significant impact on the Medicaid population mix of every state as the balance shifted toward healthier working adults who had experienced economic disruption. While aggregate Medicaid spending increased with the enrollment, per capita costs were reduced.

As of September 2022, the PHE and subsequent freeze on disenrollment is still in effect. It will end at some point in the future and standard disenrollment processes will resume. When it does, most disenrollment will be among healthier working adults. This will decrease aggregate Medicaid spending but likely increase per capita costs as these generally lower cost individuals disenroll. No one knows the actual future date this will occur or how long disenrollment will take, but we have a modeled such a scenario for illustrative purposes only and to provide a sense of how the expiration of the PHE could impact the growth rate projections.

The two modeling scenarios are:

Scenario A: The population mix is held constant from CY 2021. This comports with the methodology used in previous reports. But it may not accurately reflect conditions in SFY2024-2025 if disenrollment resumed.

Scenario B: The population mix is modeled such that the PHE was ended and disenrollment resumed. For a detailed explanation of the background and construction of this scenario, please see Section 6: Scenario B Projection.

The growth rates under both scenarios are as follows:

Figure 1. Projected Rates of Growth, Scenario A – Constant CY 2021 population mix:

	Annualized Growth	
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 unwound population mix:

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

Projected annualized growth from **Optumas'** Scenario A Rating Period 2023 (July 1, 2022 – December 31, 2023) projection to SFY 2024 (July 1, 2023 – June 30, 2024) is estimated to be between 2.8% and 3.9% and the rate of growth from SFY 2024 to SFY 2025 is projected to be between 2.6% and 3.6%. Weighted together equally, the projected growth is projected to be between 2.7% and 3.7% annually, over the course of the biennium.

Projected growth from **Optumas'** Scenario B Rating Period 2022-2023 projection to SFY 2024 is estimated to be between 3.7% and 4.8% and the rate of growth from SFY 2024 to SFY 2025 is projected to be between 3.1% and 4.1%. Weighted together equally, the projected growth is projected to be between 3.4% and 4.4% annually, over the course of the biennium.

For additional context, CMS released its National Health Expenditure (NHE) projections in March 2022[1]. The average annual growth for Medicaid and CHIP inherent in these projections is 3.9% from 2023 – 2025, which is higher than Scenario A – CY 2021 population mix, but within the range of Scenario B, Modeled PHE unwound population mix.

Per ORC Section 103.414, as the consulting actuary for this analysis, **Optumas** has developed the range of projected rates of growth; however, JMOC has the choice of selecting a rate within the range presented in Figure 1 or selecting an independent growth rate.

[1] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00113?journalCode=hlthaff

ORC Section 5162.70 requires that, once the JMOC rate is selected, Medicaid must limit the aggregate PMPM growth over the SFY 2024-2025 biennium to be the lower of (1) JMOC's final selected growth rate or (2) the three-year average Medical CPI for the Midwest. Figure 2 below, shows the Midwest and US Medical CPI for the past three years.

Figure 3. Midwest and US Medical 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%**

A three-year unweighted average was an appropriate methodology in the past because medical CPI was reasonably stable. However, the above 2020-2022 data were influenced by severe economic volatility from by the COVID-19 pandemic, the ensuing market crash and wave of unemployment, and the subsequent environment (as of September 2022) of robust jobs recovery and historically high inflation. This has given rise to two major concerns with the CPI calculation:

1. The recent volatility has made the year-over-year calculation highly sensitive to the time frame chosen. For example, August 2022 over August 2021 growth was 4.66%, but February 2022 over February 2021 growth was 1.01%. To smooth the volatility and outliers in the data, we have taken averages of the rolling year data. Each figure above is the average of the twelve monthly year-over-year data points.

2. A 2.8% inflation rate could understate the medical CPI in the projection period. For illustration purposes, we have developed an economic model that projects Midwest medical CPI of 4.3% from SFY23 to SFY24 and 3.3% from SFY24 to SFY25, which averages to **3.8%** in the biennium period.

The remainder of this report presents the process used to develop the projections for the SFY 2024-2025 biennium. Each of the report sections are described in Figure 3, below.

Figure 4. Report Structure

Section	Contents
Background	Provides a description of **Optumas'** role in developing PMPM projections for the SFY 2024-2025 Ohio biennium.
Data	An overview of the data used when developing the projections, including data sources, limitations, and adjustments.
Trend	Provides a description of the process used to develop trend and the final trend estimates for the SFY 2024-2025 biennium.
Projection Summary	Provides summarized results of the projected PMPM growth developed for the SFY 2024-2025 biennial projections.
Scenario B Projection	Provides a description of selected cost drivers influencing the projected PMPM growth for the SFY 2024-2025 biennial projections. Describes the assumptions and methodology behind Scenario A and Scenario B.

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 2024-2025 Biennium. As JMOC's contracted consulting actuary, **Optumas** has developed the SFY 2024-2025 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 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 on a per-member basis; in other words, a rate of change in PMPM expenditures over time. Consider this simplified example, where both Adults and Children are each assumed to have a fixed cost. There are initially 1,000 adults and 1,000 children, then 500 children join the population:

COA	PMPM	Population 1	Population 2
Adults	$400	1,000	1,000
Children	$200	1,000	1,500
Total Dollars		$600,000	$700,000
Total PMPM		$300	$280

The total dollars spent increased while the per capita cost decreased, despite each individual staying at the same cost level in their cohort.

JMOC has the choice to either select a rate of growth 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 2024-2025 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. We have concerns that the rote formula calculating the straight average of the past 3 years' data will understate the Medical CPI in the projection period and suggest that a different weighting be used that favors a higher rate.

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 in which 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 utilizes less services than the average member of the current program, the overall PMPM cost of the program would be driven down. Conversely, if the new population utilizes more services 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 e.g., CFC children and adults), so if more children enroll, then it would tend to drive the aggregate PMPM down.

Benefits –
Changes in benefits offered through the program can have an impact on 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 a new service is 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.

Optumas considers each of these determinants when evaluating the source data provided by ODM and adjusts 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 services delivered via Managed Care 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 SFY 2022-2023 analysis, the following expenses are excluded from the JMOC rate:

- 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 rates.

The next section of this report outlines the process and steps taken to develop a base data set from which to develop the projections for the SFY 2024-2025 biennium.

3. Data

3.01 Sources

Optumas utilized detailed claims-level FFS cost and utilization 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 FFS services incurred from January 2019 through April 2022 for all Ohio Medicaid 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 2024-2025 biennial projection. In addition to the FFS data, **Optumas** also received detailed claims-level cost and utilization encounter data and cost report information from the Managed Care Plans (MCPs) 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 Rating Period 2022-2023 Ohio Managed Care capitation rates, on a PMPM basis.

The following data sources were used to compile the base data for the SFY 2024-2025 biennial projections:

Ohio January 2019-April 2022 FFS Claims and Managed Care Encounter Data –

The Ohio FFS claims and Managed Care encounter data was provided by Ohio's data vendor, Gainwell, 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 (PMPM) 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 2024-2025 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 calendar year (CY) 2021 would serve as the base data for the FFS component of the SFY 2024-2025 biennial projection. Nevertheless, historic data prior to CY 2021 and the emerging CY 2022 data was utilized when developing the projected trend factors and for benchmarking purposes, after adjusting the data for applicable policy changes to allow for consistent trend review.

Ohio January 2019-April 2022 Eligibility Data –

The Ohio eligibility data was provided by Ohio's data vendor Gainwell 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 help identify each member's category of aid. The monthly eligibility data is used to calculate COA-specific and program-wide member months and to link eligible members to the claims incurred for each month to ensure that costs are directly associated with an eligible Medicaid recipient.

NAIC/HMA MLR Reports –

Optumas accessed historical Medical Loss Ratio (MLR) information aggregated and reported by the National Association of Insurance Commissioners (NAIC) and Health Management Associates (HMA). This data contained MLR experience dating from CY 2019 through CY 2021. This information was used to review how expenditures and revenues have changed over time for each MCP and the overall MMC Program. This information was used for benchmarking purposes in-lieu of Medicaid Cost Reports by MCP. While reviewing these figures **Optumas** took care to ensure the figures were used appropriately given the limitations in place. Namely, the MLRs reviewed may not reflect all contractually allowable adjustments necessary to determine whether the MLR meets the minimum target. These adjustments include the omission of fees from the revenue, care management costs, omission of taxes Ohio imposes on Medicaid plans, or rate adjustments such as any recoupments implemented in 2021 and 2022 to account for utilization changes.

Monthly Medicaid Variance Reports –

The monthly Medicaid Variance Reports were used to validate the CY 2021 base FFS expenditures. These reports capture monthly expenditures at the aggregate COS 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. These reports serve as a high-level benchmark to ensure the CY 2021 base data has been categorized appropriately.

Ohio Department of Medicaid Caseload Reports –

The Ohio Department of Medicaid Caseload Reports, reported with enrollment through June 2022, 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 COA for projection purposes.

Managed Care Certification Letters and Capitation Rates –

Optumas received the following Managed Care certification letters provided by Milliman to ODM as part of the Milliman actuarial contract with ODM: MMC CY 2021, MMC Rating Period July 2022-December 2023 (Rating Period 2022-2023); MyCare Opt-In and Opt-Out CY 2021; MyCare Opt-In and Opt-Out July 2021 rate update MyCare Opt-In and Opt-Out CY 2022. The corresponding capitation rates and summarized base data and trend projections (by COA, COS, and regional) included within these certification letters were used as the basis for projecting the growth rate for Managed Care expenditures. The certification letters described in this section represent changes to the managed care plan contracts for new capitation payments and are the primary contractual change relevant to cost growth projection. Other contract amendments may occur, but the certification letters provide the best basis for reviewing the managed care cost growth. **Optumas** relied on the Rating Period 2022-2023 MMC certification letter, the CY 2022 MyCare Opt-In certification letter, and the CY 2022 MyCare Opt-Out certification letter as the basis of the Managed Care biennium projection.

Actual and Projected Medicare Premium Assistance/Part D Claw-Back Payment –
As part of the projection process, **Optumas** received the latest CY 2021-2022 Part D claw-back amounts for dual eligible Medicaid and Medicare members. Additionally, **Optumas** reviewed projected Medicare Part A and B premiums through CY 2022 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 2024-2025 biennial 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 appropriate and complete:

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

Volume Checks –
Optumas checked both volume of claims and total expenditures by category of service by looking at totals longitudinally over time. This ensured that potential gaps or spikes in the data were identified and addressed before creating the base data.

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 as described above.

These analyses enabled **Optumas** to identify and address any significant data limitations associated with the January 2019-April 2022 FFS data prior to developing the rate of growth projections.

As mentioned earlier in this report, **Optumas** utilized the Rating Period 2022-2023 Managed Care, CY 2022 MyCare Opt-In, and CY 2022 MyCare Opt-Out 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 the Managed Care portion of the projection. To the extent that programmatic changes within the Managed Care environment occur within the biennium, 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. One key exception here is that the PHE and disenrollment freeze is the current policy,

but it probably will look much different by the projection period. We have provided, for illustrative purposes, one potential outcome of the PHE ending and disenrollment resuming in Scenario B.

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

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%. 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 FFS base data period, starting January 1, 2021. The following section discusses major policy changes that have been considered in the development of the base data used in the SFY 2024-2025 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.

Rebase Inpatient APR DRG Base Rates and Outlier Update –
Since January 1, 2018 ODM has rebased Inpatient Hospital services under the All Patients Refined Diagnosis Related Groups (APR DRG). This reimbursement rebasing includes changes to APR DRG relative weights and base rates by hospitals delivering the service. **Optumas** did not have the contractual ability to run the APR DRG grouper, so instead compared the published provider base rates of January 1, 2022 to the published base rates for January 1, 2021 for each Inpatient claim and used the difference to develop the impact of this program change. The rate change between the two time periods was applied to the FFS data, resulting in an increase of the Inpatient category of service of 1.1% for the FFS enrolled population and 0.4% for the Managed Care enrolled population. These increases had an overall PMPM increase of 0.1% to the aggregate base data for the FFS enrolled population and an immaterial increase to the aggregate FFS expenditure base data for the Managed Care enrolled population.

Outpatient EAPG Reimbursement –
Since January 1, 2018 ODM has rebased Outpatient services reimbursement with Enhanced Ambulatory Patient Grouping System (EAPG). This reimbursement rebasing includes changes to EAPG relative weights and base rates by the hospitals delivering the service. **Optumas** did not have the contractual ability to run the EAPG grouping software, so instead compared the published provider base rates of January 1, 2022 to the published base rates for January 1, 2021 for each Outpatient claim and used the difference to develop the impact of this program change. This resulted in an increase of the Outpatient category of service of 0.4% for the FFS enrolled population and an immaterial increase for the Managed Care enrolled population. These increases had an immaterial overall PMPM increase to the aggregate base data for the FFS enrolled population and FFS expenditure base data for the Managed Care enrolled population.

Chiropractic Benefit –
The H.B. 136 bill requires the ODM to cover evaluation and management services provided by an Ohio licensed chiropractor. ODM estimates this will cost $16.5M per year. This amount was allocated between the Managed Care and FFS populations. Most of the benefit was inherent in the Rating Period 2022-2023 Managed Care rates, so a small portion was allocated to the FFS population.

Main Operating Biennial Budget Bill –
H.B. 110, the Main Operating Biennial Budget Bill, appropriated significant sums of money for the Medicaid program, summarized in the table below:

	Millions of $	
Program Change	**FY2022**	**FY2023**
Nursing Facility Quality Incentives and Rate Increases	$ 195	$ 295
Nursing Facility Rebasing	$ 125	$ 125
Adult Day Care	$ 5	$ 5
Home and Community Based Services	$ 14.8	$ 42.7
Total	$ 340	$ 468

These amounts were allocated between the Managed Care and FFS populations.

The nursing facility quality incentives and rate increases, together with the nursing facility rebasing adjustments, result in an increase of the Nursing Facility category of service of 8.7% for the FFS enrolled population. These increases had an overall increase of 1.9% to the aggregate base data for the FFS enrolled population.

The adult day care funding results in small increases to the Waiver Services category of service and aggregate base data for the FFS enrolled population. The Home and Community Based Services (HCBS) results in an increase of 0.7% to the Waiver Services category of service and a 0.2% increase to the aggregate base data for the FFS enrolled population.

The Main Operating Biennial Budget Bill also provided for expansion of Medicaid coverage for pregnant women to include the maximum period permitted under federal law, instead of for 60 days after giving birth. This extension was approved and went into effect as of April 1, 2022. It extends coverage to 12 months for Medicaid-eligible new moms for a five-year period, through April 2027. While not directly providing a new medical benefit, this policy results in a small change to the final population mix by extending coverage for the post-partum population. Please note that essentially *all* disenrollment is currently suspended by the PHE, so this policy will effectively activate if and when regular disenrollment resumes.

Single PBM –
In 2019, the Ohio Legislature directed ODM to make a shift in the program and select and contract with a single PBM (SPBM). ODM's goals for SPBM are to improve management and administration of pharmacy benefits for managed care recipients. Through SPBM, ODM will gain increased financial accountability and ensure alignment with our clinical and policy goals, while

also improving transparency. Scheduled on October 1, 2022, the SPBM will begin providing pharmacy services across all managed care plans and members.

In its letter to the JMOC Director dated August 19, 2022 ODM estimates the program will save $128M in SFY 2022 and $184.4M in SFY23. Accordingly, we have removed about $4.49B of drug costs and associated administrative costs from the managed care financial responsibility and added $4.36B to FFS expenditure for the Managed Care enrolled population.

OhioRISE –
OhioRISE aims to shift the system of care and keep more kids and families together by creating new access to in-home and community-based services for children with the most complex behavioral health challenges. The OhioRISE program's child and family-centric delivery system recognizes the need to specialize services and support for this unique group of children and families.

ODM's actuary has projected the population and per capita costs for this program. As the risk for this population remains in managed care, there was little aggregate impact.

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 aid.

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 PMPM costs from the base period to the SFY 2024-2025 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 considered as well as any outlier costs so that the projected trends were not influenced by one-time reimbursement 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 2024-2025 biennial period and are 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 Rating Period 2022-2023 Managed Care capitation rates. Using these trends assumes that a similar methodology and similar trend projections would be used for future capitation rate contract periods. The trends developed for the Rating Period 2022-2023 capitation rates were displayed at a category of aid and category of service level and were included in the Rating Period 2022-2023 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 Rating Period 2022-2023 capitation rates into the SFY 2024-2025 biennial projection period. A similar process was followed for the CY 2022 MyCare Opt-in and MyCare Opt-Out capitation rates

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 COA and COS from the FFS CY 2021 base, Rating Period 2022-2023 Managed Care base, and CY 2022 MyCare bases into the SFY 2024-2025 biennium.

The annualized trends used to project each category of aid into the lower bound and upper bound of SFY 2024 and SFY 2025 are shown below in Figures 4 through 6. Each projection category reflects the growth rate across all services incurred by that population category. For example, the Adults category in

the Managed Care section reflects the projected growth rate across both their capitated expenses and FFS expenses

Figure 5: Annualized FFS Trend Projections – FFS Populations, Scenario A – Constant CY 2021 population mix:

	SFY 2024		SFY 2025		Average Annual	
FFS Populations	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**
Adults	5.0%	6.4%	3.7%	4.8%	4.3%	5.5%
Children	2.6%	4.0%	2.0%	3.0%	2.2%	3.4%
Disabled	3.7%	5.0%	2.8%	3.8%	3.1%	4.3%
Dual	3.9%	5.3%	2.9%	4.0%	3.3%	4.5%
Other	5.3%	6.6%	3.9%	5.0%	4.5%	5.7%
Total	**3.8%**	**5.2%**	**2.9%**	**3.9%**	**3.3%**	**4.5%**

Figure 6: Annualized Total Spend Trend Projections – MC Populations, Scenario A – Constant CY 2021 population mix:

	SFY 2024		SFY 2025		Average Annual	
Managed Care Populations	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**
Adults	2.3%	3.4%	2.5%	3.5%	2.4%	3.5%
Children	3.0%	4.1%	3.0%	4.0%	3.0%	4.1%
Disabled	2.1%	3.3%	2.3%	3.3%	2.2%	3.3%
Dual	0.5%	1.2%	0.4%	0.9%	0.5%	1.0%
Other	N/A	N/A	N/A	N/A	N/A	N/A
Total	**2.2%**	**3.3%**	**2.4%**	**3.3%**	**2.3%**	**3.3%**

Figure 7: Annualized Statewide Trend Projections – All Populations and Services, Scenario A – Constant CY 2021 population mix:

	SFY 2024		SFY 2025		Average Annual	
All Populations	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**
FFS - FFS Costs	3.8%	5.2%	2.9%	3.9%	3.3%	4.5%
MC - FFS Costs	1.8%	3.2%	2.5%	3.6%	2.2%	3.4%
MC - MC Costs	2.3%	3.3%	2.3%	3.2%	2.3%	3.3%
Additional Payments[1]	5.9%	6.5%	5.2%	6.0%	5.5%	6.2%
Program Wide	**2.8%**	**3.9%**	**2.6%**	**3.6%**	**2.7%**	**3.7%**

[1] *Includes Buy-In/Part D Clawback*

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

- SFY 2024 – This reflects the projected rate of growth from the Rating Period 2022-2023 projected lower and upper bounds to the SFY 2024 projected lower and upper bounds.
- SFY 2025 – This reflects the projected rate of growth from the SFY 2024 projected lower and upper bounds to the SFY 2025 projected lower and upper bounds.

As exhibited in the table above, the projected growth rate assuming current policy is, and assuming constant CY 2021 population mix (Scenario A):

- Between 2.8% and 3.9% (annualized) from Rating Period 2022-2023 to SFY 2024
- Between 2.6% and 3.6% from SFY 2024 to SFY 2025

The projected growth rate assuming currently policy, and assuming the population mix is set to reflect the scenario that the PHE unwinds and disenrollment resumed (Scenario B):

- Between 3.7% and 4.8% (annualized) from Rating Period 2022-2023 to SFY 2024
- Between 3.1% and 4.1% from SFY 2024 to SFY 2025

As noted in the Executive Summary, CMS released its National Health Expenditure (NHE) projections in March 2022[2]. The average annual growth for Medicaid and CHIP inherent in these projections is 3.9% from 2023-2025, which is higher than Scenario A but within the range of Scenario B.

The following section summarizes the overall projection results from the combination of each step of the biennial projection process previously described.

[2] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00113?journalCode=hlthaff

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, rather than total program dollars, provides a means of reducing the effect of population growth on this target. In addition to developing projections on a PMPM basis, the aggregate PMPM (across all populations) is calculated by weighting the individual COA projections based on the CY 2021 point-in-time enrollment snapshot. Furthermore, as outlined within Section 3.02 of this report, these projections assume that current policy continues.

Optumas began with the base data time period of CY 2021 for FFS expenditures, Rating Period 2022-2023 Managed Care capitation rates, and CY 2022 MyCare Opt-Out and MyCare Opt-Out capitation rates for Managed Care expenditures. The FFS base period was then adjusted for program changes, based on the current policy within the Medicaid program discussed in Section 3.02. The Managed Care capitation rates were adjusted for the Single PBM program change, and several changes were affected to generate the Scenario B projection [Please see Section 6 for details]. To bring the time periods onto the same relative basis as the biennium, the base periods were trended forwarded to Rating Period 2022-2023 before trending into each year of the biennium using the lower and upper bound trend estimates. These trended values are shown in Appendix I.B. The summary in Figure 7 below shows the blended Rating Period 2022-2023 aggregate PMPM estimates for the base year of the biennium.

Figure 8A: Rating Period 2022-2023 PMPM Estimates, Scenario A – Constant CY 2021 population mix:

Rating Period	Lower Bound Estimate	Upper Bound Estimate
RP 2022-2023	$727	$731

Figure 8B: Rating Period 2022-2023 PMPM Estimates, Scenario B – Modeled PHE unwound population mix:

Rating Period	Lower Bound Estimate	Upper Bound Estimate
RP 2022-2023	$737	$741

Using the Rating Period 2022-2023 base described above, **Optumas** applied the trend factors described within 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 Rating Period 2022-2023 to SFY 2024, and a similar approach is applied for the upper bound estimates. Figure 9 below shows the final SFY 2024 and SFY 2025 aggregate PMPM projections and corresponding trends.

Figure 9A: SFY 2024-2025 Projections, Scenario A – Constant CY 2021 population mix:

Overall Projection				
	PMPM		Annualized Trend[1]	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2024	$743	$752	2.8%	3.9%
2025	$762	$779	2.6%	3.6%
2023 – 2025			**2.7%**	**3.7%**

Figure 9B: SFY 2024-2025 Projections, Scenario B – Modeled PHE unwound population mix:

Overall Projection				
	PMPM		Annualized Trend[1]	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2024	$758	$768	3.7%	4.8%
2025	$781	$799	3.1%	4.1%
2023 – 2025			**3.4%**	**4.4%**

[1]The midpoint of Rating Period 2022-2023 is 9 months before the midpoint of SFY 2024. Therefore the annualized trend is greater than the percentage difference between these two periods' PMPMs.

The figures above exclude all cost categories as described in Section 2. It should be noted that comparing prior JMOC biennium rate of growth PMPM projections will require great care due to numerous experiential and policy differences driven by COVID-19, population mix changes, the disenrollment freeze, and the Single PBM policy.

The projections shown in Figure 8 and in Appendices I.E - I.G, 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, costs for Nursing Facility services are included within the projections; these expenditures reflect an estimate of Medicaid's share of the cost for members who reside in a Nursing Facility. However, this does not reflect additional service costs for which a recipient is liable to pay (patient share of cost).

The projections noted above are indicative of estimated PMPM expenditures based on current policy and a constant population mix from CY 2021. The PMPM projection provides a method of normalizing for population growth over time, however the change in both mix of membership and services delivered within each category above, particularly as it pertains to changes that could occur when the PHE ends, 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 2024-2025 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 2024-2025 biennium.

The following section describes the assumptions and methodology underpinning the Scenario B methodology created for this report.

6. Scenario B Projection

Population Adjustments

In response to the COVID-19 pandemic, ODM (along with all other state and territory Medicaid agencies) implemented a disenrollment freeze for all OH Medicaid populations, with few narrow exceptions in line with federal guidance, effective March 1, 2020 through the duration of the Public Health Emergency (PHE) proclamation. The freeze on disenrollment results in members who would normally lose eligibility now remaining enrolled throughout the COVID-19 PHE declaration. As of August 2022, there is no announcement about the timing for the end of the PHE declaration.

The Health and Human Services department will end the PHE and disenrollment will resume at some date in the future. This date is unknown. The pace and length of the disenrollment period is also unknown – local Medicaid agencies will have to hire case managers, locate members and communicate eligibility changes to them, and process appeals from members who chose to file one. We have modeled one potential outcome of this process, for illustrative purposes only, called Scenario B in this document. The higher trends in Scenario B are due to "addition by subtraction" – healthier members will be disenrolled, leaving higher acuity (more costly) members remaining.

There are two key assumptions underpinning Scenario B: enrollment and acuity.

Enrollment

We leveraged CMS' National Health Expenditure March 2022 projections for national Medicaid enrollment that projects 24.5% of the COVID-driven enrollment gains between 2019 and 2021 will be disenrolled by 2024, and that Medicaid enrollment will then hold fairly steady into 2025. This is predicated on many unknown future economic, epidemiological and political events and, of course, engenders a great deal of uncertainty. The unemployment rate, COVID-19 severity and case count, and actions of political appointees at federal and state health agencies will all have an impact on Medicaid eligibility and enrollment in the future.

Acuity

In developing the CY 2021 Managed Care rates, ODM's actuary applied a negative acuity adjustment to the population. This accounted for the generally healthier people with lower medical costs that joined the Medicaid rolls after experiencing economic disruption. Before COVID-19, they would generally be disenrolled after regaining employment. Disenrollment has been frozen since March 2020 and the balance of covered lives has shifted toward this lower acuity population.

This adjustment mostly affected adult TANF and Expansion populations, whose Medicaid eligibility is weighted toward their income. Medicaid enrollment for children, the elderly, and disabled people are less sensitive to economic disruption and unemployment.

In the Scenario B projection, we partially reversed this adjustment for the Adult population to reflect the assumption that a portion of the Medicaid population has been disenrolled.

The downward acuity adjustment was developed by ODM's actuary in the early stages of the pandemic for the CY 2021 managed care rates. We have leveraged this adjustment, reversed to be an upward acuity adjustment, for the purpose of consistency. It also has a consistent magnitude to the adjustments in other states that were developed by other actuaries for the same purpose.

No actual disenrollment has taken place anywhere yet, so there is no real world comparison available. There are many unknowns: which members will be disenrolled first, how many members will file appeals, how fast disenrollment will be processed and even whether state agencies will have the staffing capacity.

A Note on Nursing Facilities

Throughout the COVID-19 pandemic, **Optumas** has observed a nationwide trend away from nursing facility utilization. This is likely driven by people choosing different settings to live as nursing facilities were extremely vulnerable to outbreaks. It is unknown when or if nursing home utilization will return to pre-pandemic levels. As nursing home costs constitute a very large portion of Medicaid spending, small changes in this rate of utilization can have significant impacts on total costs. In pre-COVID actuarial calculations, the volatility of this statistic was less of a concern.

Both Scenario A and Scenario B include an assumption for positive trend in nursing facility utilization. However, there could be any number of unanticipated changes in circumstance that could drive higher or lower growth in either scenario.