Contact Information
77 S. High St., 11th Fl.
Columbus, OH 43215
(614) 466-4895
Rep07@ohiohouse.gov

Committees
Chair: Finance Subcommittee
on Transportation
Chair: Joint Medicaid Oversight
Finance
Insurance
Public Utilities

THOMAS F. PATTON

7TH HOUSE DISTRICT

May 25, 2021

Dear Colleagues,

In accordance with Section 103.414 of the Ohio Revised Code, I respectfully submit the Joint Medicaid Oversight Committee's Report on the Projected 3.3% Medical Inflation Rate for Fiscal Years 2022 and 2023 for Ohio's Medicaid Program as part of the Main Operating Budget.

The goal of the Joint Medicaid Oversight Committee's (JMOC) rate process is to moderate the growth of Medicaid, which is Ohio's largest program, to a sustainable level of per capita spending while maintaining long-term support of successful policies. For this purpose, JMOC and Optumas, JMOC's actuary, developed and use a per member per month (PMPM) cost formula to better measure the program's trend factors of utilization and unit cost across all of Medicaid's population groups and services. This includes trends across both Fee-for-Service and the Managed Care delivery system. The formula affords greater transparency as to where dollars are being spent, legislative effects, and health outcomes.

The JMOC Growth Rate has now been part of Ohio's Biennium Budget process for the past three (3) operating budgets. It remains an open hand from the legislature to the administration to work together on Medicaid policies that improve health outcomes and care for Ohio's Medicaid population, while bending the cost curve.

Sincerely,

Representative Thomas F. Patton
Chair, Joint Medicaid Oversight Committee

Report on JMOC Limit for the Medicaid Program for the FY 2022-2023 Budget

May 2021

The Joint Medicaid Oversight Committee (JMOC) is charged with working with an outside actuarial firm to calculate the projected rate of growth for Ohio's 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 of the Revised Code, the committee must set the JMOC rate. The purpose of this report is to notify the Governor, the General Assembly, and the Director of Medicaid that the Joint Medicaid Oversight Committee has selected **3.3%** as the JMOC Rate for the FY2022-2023 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 care for the Midwest region.

History of the JMOC Rate

Historically, the review of Medicaid spending has focused on spending at the line item level. While this is an important measure, a review of per capita (or PMPM) costs, which factor out population growth in spending, provides additional insight for state policymakers. The per capita measure, particularly as it is disaggregated by population category and category of service, provides greater insight into underlying cost drivers including utilization and unit cost. While caseload growth is largely driven by external factors such as demographics and the economy, state policymakers have some ability to control growth in per capita costs through the policies that they set for reimbursement, benefit design, and system management.

Like the Medicaid budget forecasts prepared by the Executive and the Legislative Service Commission (LSC), the JMOC rate process assesses the impact of continuing current policy. Unlike the Executive and LSC forecasts, the JMOC rate process does not include an estimate caseload growth. Instead, the actuary assumes a constant population based on the most recent data. The JMOC process is not meant to supplant the forecast process but to provide an additional guardrail to help state policymakers maintain focus on the shared goal of slowing the rate of fiscal growth in the Medicaid program to a sustainable level.

Optumas Estimate for FY 2022-2023

Optumas currently serves as JMOC's consulting actuary and has completed the analysis to support development of the JMOC rate for the past three (3) budgets. Optumas has produced the growth rate range for the upcoming budget cycle that is shown in the table below.

	FY 2021 Estimate	FY 2022 Projection	Growth Rate	FY 2023 Projection	Growth Rate	Biennial Average
Lower Bound PMPM	$761	$785	3.1%	$809	3.1%	3.1%
Upper Bound PMPM	$765	$796	4.0%	$828	4.1%	4.1%

In last month's meeting, Optumas advised the JMOC committee that PMPM growth in the next biennium is driven upwards due to changes to Medicaid's population and policy. Such as the effects of the COVID-19 pandemic and the maintenance of eligibility requirements (MOE) disenrollment freeze creating material changes of the population, which impacts both the number of those covered and utilization. In addition, the COVID-19 pandemic displaces people from employment and decreases utilization by the enactment of stay at home orders. Policy driven increases include All Patient Refined Diagnosis Related Groups and Enhanced Ambulatory Patient Group System fee changes and the effects of the nursing facility market basket adjustment.

Changes in the JMOC Rate for FY 2022-2023

To avoid short term distortions in the JMOC rate and to provide an apples-to-apples comparison over time, JMOC has historically excluded one-time expenses as well as expenses that are not tied to a Medicaid enrollee. Those expenses include:

- State administration;
- HCAP – Hospital Care Assurance Program;
- Hospital UPL (Upper Payment Limit);
- P4P – Managed Care Pay for Performance;
- HIF – Health Insurer Fee;
- Settlements and Rebates handled outside of the claims system and paid outside of managed care capitation rates;
- Physician UPL/CICIP;
- Hospital Pass Through Payments; and
- HIC Franchise & Premium taxes

Note that the JMOC limit pertains to uses of funds, not fund sources.

Review of Consumer Price Index for Medical Care

JMOC uses the three-year average Consumer Price Index (CPI) rate for medical care for the Midwest region as a benchmark for growth in the Medicaid program. The CPI is a measure of the average change in prices of goods and services purchased by households over time. Medical care is a component of the CPI and includes consumer spending on medical services such as health insurance premiums and out-of-pocket

spending including copayments for services like doctor visits, prescription drugs, and other health care services.

The chart below shows the CPI rates for the past three years. While the CPI provides an important benchmark for state policymakers, it does not reflect all of the dynamics that affect state Medicaid spending.

CPI Rates for Medical Care: Midwest

	Midwest CPI
September 2018	1.5%
September 2019	3.0%
September 2020	4.4%
3 Year Average	**3.0%**

Source: Bureau of Labor Statistics

Committee Activities and Rationale for FY 2020-2021 JMOC Rate

The JMOC committee heard the actuary's report at its April 29th hearing and voted unanimously to set the JMOC rate at 3.3% growth for both FY 2022 and FY 2023 at its May 20thhearing.

April 22, 2021

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

Subject: Ohio JMOC SFY 2022-2023 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 2022-2023 biennium. It was a pleasure to work with you and your team throughout this project. The following report summarizes the methodology for the development of the SFY 2022-2023 biennial growth rate projections. Please contact me if you have any questions at chris.dickerson@Optumas.com or 480.588.2496.

Sincerely,

Chis Dickerson, ASA, MAAA
Consulting Actuary

CC: Steve Schramm, **Optumas**
Barry Jordan, **Optumas**
Scott Campbell, **Optumas**
Michael Schmidt, **Optumas**

Schramm Health Partners, LLC
7400 East McDonald Dr, Suite 101
Scottsdale AZ 85250
480.588.2499 main
480.315.1795 fax

Ohio Joint Medicaid Oversight Committee

State Fiscal Years 2022-2023 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) 2022-2023 Biennium. 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 2022-2023 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, and SFY 2020-2021 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, which is summarized in Figure 1, below.

Figure 1. Projected Rates of Growth

	Annualized Growth	
SFY	Lower Bound	Upper Bound
2022	3.1%	4.0%
2023	3.1%	4.1%
Avg. Annual	**3.1%**	**4.1%**

Projected growth from **Optumas'** SFY 2021 projection to SFY 2022 is estimated to be between 3.1% and 4.0% and the rate of growth from SFY 2022 to SFY 2023 is projected to be between 3.1% and 4.1%. Weighted together equally, the projected growth is projected to be between 3.1% and 4.1% annually, over the course of the biennium. For additional context, CMS released its National Health Expenditure (NHE) projections in February 2018[1]. The average annual growth for Medicaid and CHIP inherent in these projections is slightly below 4.2% from 2018 – 2021, which is higher than the projected SFY 2022-2023 growth rate for Ohio Medicaid.

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.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

ORC Section 5162.70 requires that, once the JMOC rate is selected, Medicaid must limit the aggregate PMPM growth over the SFY 2022-2023 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 2. Midwest and US Medical CPI

Time Period	Midwest CPI	US CPI
9/1/2018	1.5%	1.7%
9/1/2019	3.0%	3.5%
9/1/2020	4.4%	4.2%
3 Year Avg. (Unweighted)	**3.0%**	**3.1%**

The remainder of this report presents the process used to develop the projections for the SFY 2022-2023 biennium. Each of the report sections are described in Figure 3, below.

Figure 3. Report Structure

Section	Contents
Background	Provides a description of **Optumas'** role in developing PMPM projections for the SFY 2022-2023 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 2022-2023 biennium.
Projection Summary	Provides summarized results of the projected PMPM growth developed for the SFY 2022-2023 biennial projections.
Key Findings	Provides a description of selected cost drivers influencing the projected PMPM growth for the SFY 2022-2023 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 2022-2023 Biennium. As JMOC's contracted consulting actuary, **Optumas** has developed the SFY 2022-2023 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.

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 2022-2023 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 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 i.e., 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 2020-2021 analysis, the following expenses are excluded from the JMOC rate:

- All-Agency State Administration,
- Hospital Care Assurance Program (HCAP),
- Hospital Upper Payment Limit (UPL),
- Federal Health Insurance Providers Fee (HIPF),
- 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.

In addition to the exclusions noted above, additional cost categories were excluded from the SFY 2022-2023 biennium that were either previously included, or in the case of the Care Innovation and Community Improvement Program (CICIP), did not exist in previous JMOC rate projections. The purpose of excluding these additional costs is that they reflect expenditures outside of the direct control of ODM. These additional cost category exclusions are as follows:

- Hospital Pass Through Payments,
- Health Insuring Corporation (HIC) Franchise and Premium Tax, and
- Care Innovation and Community Improvement Program (CICIP)

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 2022-2023 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 July 2017 through December 2020 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 2022-2023 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 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 CY 2021 Ohio Managed Care capitation rates, on a PMPM basis.

The following data sources were used to compile the base data for the SFY 2022-2023 biennial projections:

Ohio July 2017-December 2020 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 claim-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 2022-2023 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) 2019 would serve as the base data for the FFS component of the SFY 2022-2023 biennial projection. Nevertheless, historic data prior to CY 2019 and the emerging CY 2020 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 July 2017-December 2020 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 2014 through CY 2019. 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 the significant recoupment implemented in 2019 and 2020 to account for utilization changes.

Monthly Medicaid Variance Reports –

The monthly Medicaid Variance Reports were used to validate the CY 2019 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 2019 base data has been categorized appropriately.

Ohio Department of Medicaid Caseload Reports –

The Ohio Department of Medicaid Caseload Reports, reported with enrollment through February 2021, 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 2020, MMC July 2020 rate update; MMC CY 2021; MyCare Opt-In and Opt-Out CY 2020; MyCare Opt-In and Opt-Out July 2020 rate update; and MyCare Opt-In and Opt-Out CY 2021. 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 July 2020 rate update and CY 2021 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 2020-2021 Part D claw-back amounts for dual eligible Medicaid and Medicare members. Additionally, **Optumas** reviewed projected Medicare Part A and B premiums through CY 2021 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 2022-2023 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 July 2017-December 2020 FFS data prior to developing the rate of growth projections.

As mentioned earlier in this report, **Optumas** utilized the CY 2020 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 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.

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 certain populations change from a FFS delivery system to a Managed Care delivery system after the base data period, adjustments to the base data would be required.

The projections for the SFY 2022-2023 biennium are intended to reflect current policy within the Medicaid program. The base data includes expenditures for services incurred during CY 2019 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:

Buy-in Shift to Managed Care
Beginning July 1, 2018, the non-Dual and non-Developmentally Disabled (DD) Medicaid Buy-In for Workers with Disabilities (MBIWD) population was mandatorily enrolled into Managed Care under the ABD cohorts. MBIWD members that were included in the DD waiver population are eligible for voluntary enrollment into Managed Care. For this prospective adjustment, **Optumas** relied on an indicator provided in the eligibility file received from Gainwell. While it was anticipated members would no longer be enrolled in FFS, there were members with a buy-in indicator that were enrolled in FFS during the baseline time period. The membership and costs were removed from the CY 2019 FFS baseline, reflecting that these members will be enrolled in managed care by the project period. The enrollment was then shifted into the Managed Care base, depending on age, to the ABD 21+ or ABD <21 cohorts. In the case of certain services that are still covered under FFS for Managed Care enrolled members, the total amount of FFS expenditures for the Managed Care enrolled members would increase as a result of the shift of members from FFS to Managed Care.

The aggregate population impact of the adjustments to the FFS and Managed Care populations base data listed above can be found in Appendix I.B by major category of aid.

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 need to be adjusted for, consistent with the "current policy" approach taken to develop the biennial rate of growth projections as they now reflect current policy. Consistent with the remainder of the projection process and historical JMOC projections developed by **Optumas**, 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%. 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, 2019. The following section discusses major policy changes that have been considered in the development of the base data used in the SFY 2022-2023 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 reviewed the emerging provider base rates relative to the January 1, 2021 published base rates for the incurral period of 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 12.4% for the FFS enrolled population and 11.2% for the Managed Care enrolled population. These increases had an overall PMPM increase of 0.9% to the aggregate base data for the FFS enrolled population and less than 0.3% 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. Since the emerging costs were not available for review and **Optumas** did not have the contractual ability to run the EAPG grouping software, so instead reviewed the emerging provider base rates relative to the January 1, 2021 published base rates for the incurral period of 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 36.2% for the FFS enrolled population and 35.6% for the Managed Care enrolled population. These increases had an overall PMPM increase of 0.8% to the aggregate base data for the FFS enrolled population and less than 0.2% increase to the aggregate FFS expenditure base data for the Managed Care enrolled population.

Nursing Facility Semi-Annual Reimbursement Updates –

ODM has historically updated nursing facility reimbursement on a semi-annual basis. To approximate the latest reimbursement **Optumas** reviewed the unit cost rate for nursing facilities over time. **Optumas** used the average unit cost emerging from the second half of CY 2020 (July 2020 – December 2020) data to reflect most recent Nursing Facility per diems. Each of the six-month time periods within CY 2019 was then adjusted on a unit cost basis to the emerging 2020 reimbursement levels. This resulted in an overall PMPM increase of 2.6% to aggregate base data for the FFS enrolled population and less than 0.1% to the aggregate FFS expenditure base data for the Managed Care enrolled population.

Behavioral Health Fee Schedule Changes –

Beginning August 1, 2019, ODM implemented a policy and payment rate changes for the following behavioral health (BH) services, reflected in Ohio Administrative Code (OAC) rule 5160-27-03, which resulted in an increase to projected provider reimbursement:

- Crisis Services: Crisis services for both Mental Health (MH) and Substance Use Disorder (SUD) treatment received a 30% increase for certain impacted billing codes.
- Group Therapy: Group Psychotherapy, MH Therapeutic Behavioral Services (TBS), and SUD Counseling services received a 30% fee increase for certain impacted billing codes.
- Evaluation and Management (E&M) Services: E&M services and diagnostic psychiatric evaluations provided by Certified Nursing Practitioners, Clinical Nursing Specialists, and Physician Assistants at BH providers are subject to reimbursement at 100% of the Medicaid maximum rate, which is an increase from the previous policy of 85%.

- Individual TBS: Licensed clinicians employed by BH agencies are allowed to render TBS in an individual setting. We anticipate providers who were previously rendering Community Psychiatric Supportive Treatment (CPST) will not provide TBS at a higher reimbursement rate.

To estimate the impact of this adjustment, **Optumas** repriced the impacted January 2019-July 2019 behavioral health procedure codes to the latest fee schedule. This resulted in an increase of .1% to aggregate base data for the FFS enrolled population and less than 0.1% to the aggregate FFS expenditure base data for the Managed Care enrolled.

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 2022-2023 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 2022-2023 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 CY 2021 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 CY 2021 capitation rates were displayed at a category of aid and category of service level and were included in the CY 2021 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 2021 capitation rates into the SFY 2022-2023 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 COA and COS from the FFS CY 2019 and CY 2021 Managed Care base into the SFY 2022 and SFY 2023 biennium.

The annualized trends used to project each category of aid into the lower bound and upper bound of SFY 2022 and SFY 2023 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. 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.B) means that small changes in the FFS growth rate can result in large changes to the overall cost of the Medicaid program.

Figure 4: Annualized FFS Trend Projections – FFS Populations

	SFY 2022		SFY 2023		Average Annual	
FFS Populations	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
Adults	2.6%	3.6%	2.6%	3.6%	2.6%	3.6%
Children	2.4%	3.4%	2.4%	3.4%	2.4%	3.4%
Disabled	2.6%	3.6%	2.7%	3.6%	2.6%	3.6%
Dual	2.3%	3.3%	2.3%	3.4%	2.3%	3.4%
Other	2.4%	3.4%	2.4%	3.4%	2.4%	3.4%
Total	**2.4%**	**3.4%**	**2.5%**	**3.5%**	**2.5%**	**3.5%**

Figure 5: Annualized Total Spend Trend Projections – MC Populations

	SFY 2022		SFY 2023		Average Annual	
Managed Care Populations	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
Adults	3.4%	4.4%	3.5%	4.5%	3.4%	4.5%
Children	3.2%	4.2%	3.2%	4.2%	3.2%	4.2%
Disabled	3.0%	4.0%	3.0%	4.0%	3.0%	4.0%
Dual	3.7%	4.4%	3.7%	4.4%	3.7%	4.4%
Other	N/A	N/A	N/A	N/A	N/A	N/A
Total	**3.3%**	**4.3%**	**3.4%**	**4.3%**	**3.3%**	**4.3%**

Figure 6: Annualized Statewide Trend Projections – All Populations and Services

	SFY 2022		SFY 2023		Average Annual	
All Populations	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
FFS - FFS Costs	2.4%	3.4%	2.5%	3.5%	2.5%	3.5%
MC - FFS Costs	1.3%	2.3%	1.3%	2.3%	1.3%	2.3%
MC - MC Costs	3.3%	4.3%	3.4%	4.4%	3.4%	4.3%
Additional Payments[1]	3.5%	3.9%	3.8%	4.5%	3.7%	4.2%
Program Wide	**3.1%**	**4.0%**	**3.1%**	**4.1%**	**3.1%**	**4.1%**

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

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

- SFY 2022 – This reflects the projected rate of growth from the SFY 2021 projected lower and upper bounds to the SFY 2022 projected lower and upper bounds.
- SFY 2023 – This reflects the projected rate of growth from the SFY 2022 projected lower and upper bounds to the SFY 2023 projected lower and upper bounds.

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

- Between 3.1% and 4.0% from SFY 2021 to SFY 2022
- Between 3.1% and 4.1% from SFY 2022 to SFY 2023

As noted in the Executive Summary, CMS released its National Health Expenditure (NHE) projections in February 2018[2]. The average annual growth for Medicaid and CHIP inherent in these projections is slightly below 4.2% from 2018 – 2021, which is in the top 25th percentile of the projected SFY 2022-2023 growth rate range for Ohio Medicaid.

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

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

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 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 2019 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 2019 for FFS expenditures, and the CY 2021 Managed Care 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 already reflect current policy, so no program change adjustments were conducted outside of the rates already developed. To bring the time periods onto the same relative basis as the biennium, the base periods were trended forwarded to SFY 2021 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 SFY 2021 aggregate PMPM estimates for the base year of the biennium.

Figure 7: SFY 2021 PMPM Estimates

SFY 2021 Aggregate PMPM Projection Estimates		
SFY	Lower Bound Estimate	Upper Bound Estimate
2021	$761	$765

Using the SFY 2021 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 SFY 2021 to SFY 2022, and a similar approach is applied for the upper bound estimates. Figure 8 below shows the final SFY 2022 and SFY 2023 aggregate PMPM projections and corresponding trends.

Figure 8: SFY 2022-2023 Projections

Overall Projection				
	PMPM		Trend	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2022	$785	$796	3.1%	4.0%
2023	$809	$828	3.1%	4.1%
2021 - 2023			**3.1%**	**4.1%**

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 to these figures would not be an even comparison because of changes in this year's methodology for exclusions. As such, Appendix I.C includes a comparable PMPM development, with the Hospital Pass Through Payments and HIC Franchise and Premium tax that

were removed during the SFY 2022-2023 biennium projection but reflected within the SFY 2018-2019 biennium projections.

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 2019. 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 2022-2023 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 2022-2023 biennium.

The following section describes key findings observed within the development of the projected rate of growth for the Ohio Medicaid Program in the SFY2022-2023 biennium.

6. Key Findings

Membership Increases Due To COVID-19

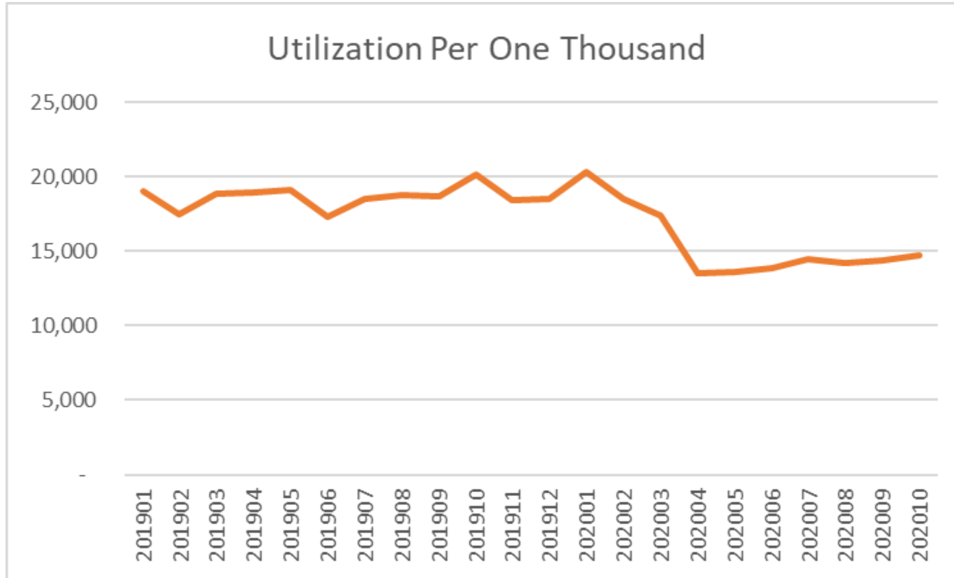
In response to the COVID-19 pandemic, ODM implemented a disenrollment freeze for all OH Medicaid populations, with few exceptions in line with federal guidance, effective March 1, 2020 through the duration of the Public Health Emergency (PHE) proclamation. The freeze on disenrollment results in members who would normally lose eligibility would now remain enrolled throughout the COVID-19 PHE declaration. At this time, the PHE declaration is scheduled to run through the end of CY 2021.

When reviewing the emerging eligibility experience longitudinally over time, **Optumas** observed the overall eligibility enrollment increased by approximately 1% each month since March 2020. This steady increase in enrollment is a direct result of the freeze in disenrollment due to the COVID-19 pandemic. Although enrollment has been growing steadily since the PHE declaration, it is expected that the members who remain in Ohio's Medicaid programs who would have otherwise been disenrolled, have lower acuity (lower PMPM costs) than members who would have remained eligible for the Medicaid program absent the disenrollment freeze. This differential has been observed through nationwide Medicaid redetermination efforts over the past few years and likely results in downward pressure on the average PMPM of the OH Medicaid programs. It is important to note that although the acuity of the Medicaid program is lowering due to the disenrollment freeze, the population of the program is increasing which results in great potential for increases in Medicaid total expenditures in upcoming years. The impact of the disenrollment freeze is a per-person cost decrease but a total cost increase due to the larger number of members served.

Service Utilization Decreases Due To COVID-19

As a result of the COVID-19 pandemic, **Optumas** evaluated the emerging CY 2020 data and observed a large decrease in service utilization beginning in March 2020. Specifically, from February 2020 to March 2020, **Optumas** observed a decrease in service utilization of 6% across the entire Ohio Medicaid program. From March 2020 to April 2020, the aggregate service utilization dropped an additional 22%. These large decreases in utilization are primarily due to stay-at-home orders being enacted coupled with elective surgeries/professional visits being postponed. Figure 9 below shows service utilization per one thousand longitudinally and illustrates the drop in utilization due to the COVID-19 pandemic.

Figure 9: Ohio service utilization per one thousand (graph represents all services combined)



When evaluating the CY 2020 utilization information, it is important to note the decrease in service utilization is a direct result of the COVID-19 pandemic and that the CY 2020 data may be unusable when developing future biennium projections. **Optumas** expects the service utilization to return to pre-pandemic levels as more individuals gain access to the COVID-19 vaccine but has not analyzed when this may occur.

Nursing Facility Reimbursement Updates and Market Basket Expiration

As noted in section 3.02, ODM updates nursing facility reimbursement on a semi-annual basis. To approximate the latest Nursing Facility reimbursement, **Optumas** repriced the impacted CY 2019 Nursing Facility base data to the second half of CY 2020 (July 2020 – December 2020) per diems to approximate the per diems that would be paid during the contract period. Embedded in this policy adjustment is also the impact of the market basket reimbursement increase. Beginning in SFY 2020, ODM implemented the nursing facility market basket adjustment which increased the nursing facility per diems by an additional 2.8% per fiscal year. Although the market basket policy was terminated in January 2021, the effect of the original SFY 2020 adjustment and subsequent cost increases are embedded in all nursing facility per diems after SFY2020. This policy change is projected to impact the Dual cohorts the greatest, since this is where most of the nursing facility costs are incurred.

Impact of Fee Changes

State fee schedule changes implemented by legislation can have a substantial impact on the cost of Medicaid services. Examples of these type of fee changes are the APR DRG and EAPG changes discussed in section 3.02 of this report. The APR DRG change drove an approximately 0.9% aggregate change and the EAPG changes was worth approximately 0.8%. Together, these fee schedule changes were worth nearly a 2% increase in Medicaid expenditures. Any new fee schedule changes that are implemented for future contract periods should be considered in addition to the growth rates projected in this report. When viewed in the context of the projected biennium growth rate of 3.1% to 4.1%, a future fee schedule

change of similar impact would use approximately half of the upper bound growth rate if it was not considered in addition to the growth rates projected in this report.

7. Appendices

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Appendix I.A – Projection Categories

Categories of Aid	Rollup - Categories of Aid
CFC Adults	Adults
Extension	Adults
AFK	Children
CFC Children	Children
CHIP	Children
ABD <21	Disabled
ABD 21+	Disabled
Breast & Cervical Cancer (BCCP)	Disabled
LTSS Institutional Non-Dual Populations[1]	Disabled
LTSS Waiver Non-Dual Populations[2]	Disabled
Community Dual <65 (Non-MC)	Dual
Community Dual 65+ (Non-MC)	Dual
LTSS Institutional Dual Populations[1]	Dual
LTSS Waiver Dual Populations[2]	Dual
MyCare	Dual
Medicare Premium Assistance	Other
Refugee/Not Assigned	Other
RoMPIR/Presumptive/Alien	Other

[1] *DD: ICF*
Non-DD: SNF

[2] *DD: Individual Options, Level One, SELF*
Non-DD: Assisted Living, PASSPORT, OH Home Care, PACE

Categories of Service	
Clinics	Medicaid Schools Program
Clinics - Mental Health	Mental Health and Addiction Services
Dental Services	Other
DME	Other Professional
EPSDT	Outpatient ER
Family Planning	Outpatient Non-ER
FQHC/RHC	PCP
Home Health/PDN	Prescribed Drugs
Hospice Services	Psychology Services
ICF & ID Public	SNF
ICF & ID Private	Specialty
ID Services	Transportation
Inpatient Hospital	Vision
Inpatient Hospital - BH	Waiver Services
Laboratory/Radiology	

Appendix I.B – SFY 2022-2023 Biennium Projection Build-Up

FFS Populations – CY 2019 FFS Data Buildup Eligibility Adjustments

COA	Raw CY 2019 MMs	Raw CY 2019 PMPM	MMs Adj. Percent Impact	PMPM Adj. Percent	Adj. CY 2019 MMs	Adj. PMPM	IBNR Factor	Completed Adj. CY 2019 PMPM	Patient Share of Cost Removal % (Non-LTC)	Adj. CY 2019 PMPM
Adults	731,300	$370	0.0%	0.0%	731,059	$370	1.00	$371	-0.2%	$370
Children	452,056	$266	0.0%	0.0%	452,056	$266	1.00	$267	0.0%	$267
Disabled	531,509	$4,405	-1.8%	-0.5%	521,695	$4,384	1.00	$4,387	0.0%	$4,386
Dual	1,434,912	$2,690	0.0%	0.0%	1,434,912	$2,690	1.00	$2,691	-0.1%	$2,690
Other	1,595,520	$55	-0.2%	0.1%	1,591,830	$55	1.00	$56	-1.0%	$55
Total	**4,745,297**	**$1,408**	**-0.3%**	**-0.5%**	**4,731,552**	**$1,400**	**1.00**	**$1,401**	**-0.1%**	**$1,400**

FFS Populations – CY 2019 FFS Data Buildup Eligibility Adjustments

					SFY 2021							
					Lower Bound				Upper Bound			
COA	Adj. CY 2019 MMs	Adj. CY 2019 PMPM	Retro Program Changes	PC Adj. CY 2019 PMPM	Projected Growth	PMPM	LTC Patient Share of Cost Removal %	PMPM	Projected Growth	PMPM	LTC Patient Share of Cost Removal %	PMPM
Adults	731,059	$370	13.2%	$419	0.0%	$435	0.0%	$435	0.0%	$442	0.0%	$442
Children	452,056	$267	9.6%	$292	0.0%	$303	0.0%	$303	0.0%	$307	0.0%	$307
Disabled	521,695	$4,386	4.4%	$4,579	0.0%	$4,760	-0.5%	$4,734	0.0%	$4,825	-0.5%	$4,799
Dual	1,434,912	$2,690	3.8%	$2,791	0.0%	$2,895	-8.9%	$2,637	0.0%	$2,934	-8.8%	$2,677
Other	1,591,830	$55	12.1%	$62	0.0%	$64	0.0%	$64	0.0%	$65	0.0%	$65
Total	**4,731,552**	**$1,400**	**4.6%**	**$1,465**	**0.0%**	**$1,520**	**-5.3%**	**$1,439**	**0.0%**	**$1,541**	**-5.2%**	**$1,460**

FFS Populations – Projected SFY 2022 – SFY 2023 FFS Expenditures

		SFY 2021		SFY 2022				SFY 2023			
		Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	Adj. CY 2019 MMs	PMPM	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
Adults	731,059	$435	$442	2.6%	$446	3.6%	$457	2.6%	$458	3.6%	$474
Children	452,056	$303	$307	2.4%	$310	3.4%	$318	2.4%	$318	3.4%	$329
Disabled	521,695	$4,734	$4,799	2.6%	$4,859	3.6%	$4,970	2.7%	$4,988	3.6%	$5,149
Dual	1,434,912	$2,637	$2,677	2.3%	$2,698	3.3%	$2,767	2.3%	$2,760	3.4%	$2,860
Other	1,591,830	$64	$65	2.4%	$65	3.4%	$67	2.4%	$67	3.4%	$69
Total	**4,731,552**	**$1,439**	**$1,460**	**2.4%**	**$1,474**	**3.4%**	**$1,511**	**2.5%**	**$1,511**	**3.5%**	**$1,563**

Appendix I.B – SFY 2022-2023 Biennium Projection Build-Up

Managed Care Populations – CY 2019 FFS Data Buildup Eligibility Adjustments

COA	Raw CY 2019 MMs	Raw CY 2019 PMPM	MMs Adj. Percent Impact	PMPM Adj. Percent	Adj. CY 2019 MMs	Adj. PMPM	IBNR Factor	Completed Adj. CY 2019 PMPM	Patient Share of Cost Removal % (Non-LTC)	Adj. CY 2019 PMPM
Adults	11,959,619	$8	0.0%	0.0%	11,959,619	$8	1.00	$8	0.0%	$8
Children	13,264,946	$7	0.0%	0.0%	13,264,946	$7	1.00	$7	0.0%	$7
Disabled	2,428,768	$43	0.6%	-0.1%	2,442,513	$43	1.00	$43	0.0%	$43
Dual	1,488,169	$0	N/A	N/A	1,488,169	$0	N/A	$0	N/A	$0
Other										
Total	**29,141,502**	**$10**	**0.0%**	**0.1%**	**29,155,247**	**$10**	**1.00**	**$10**	**0.0%**	**$10**

Managed Care Populations – CY 2019 – SFY 2021 FFS Expenditures Lower Bound Buildup

					SFY 2021							
					Lower Bound				Upper Bound			
COA	Adj. CY 2019 MMs	Adj. CY 2019 PMPM	Retro Program Changes	PC Adj. CY 2019 PMPM	Projected Growth	PMPM	LTC Patient Share of Cost Removal %	PMPM	Projected Growth	PMPM	LTC Patient Share of Cost Removal %	PMPM
Adults	11,959,619	$8	1.0%	$8	0.0%	$8	0.0%	$8	0.0%	$8	0.0%	$8
Children	13,264,946	$7	0.7%	$7	0.0%	$7	0.0%	$7	0.0%	$7	0.0%	$7
Disabled	2,442,513	$43	7.1%	$46	0.0%	$47	0.0%	$47	0.0%	$48	0.0%	$48
Dual	1,488,169	$0	N/A	$0	N/A	$0	N/A	$0	N/A	$0	N/A	$0
Other												
Total	**29,155,247**	**$10**	**3.2%**	**$10**	**0.0%**	**$10**	**0.0%**	**$10**	**0.0%**	**$10**	**0.0%**	**$10**

Managed Care Populations – Projected SFY 2021 – SFY 2023 FFS Expenditures

		SFY 2021		SFY 2022				SFY 2023			
		Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	Adj. CY 2019 MMs	PMPM	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
Adults	11,959,619	$8	$8	1.2%	$8	2.2%	$8	1.2%	$8	2.2%	$8
Children	13,264,946	$7	$7	0.9%	$7	1.9%	$7	0.9%	$7	1.9%	$7
Disabled	2,442,513	$47	$48	1.7%	$48	2.7%	$49	1.8%	$49	2.8%	$51
Dual	1,488,169	$0	$0	N/A	$0	N/A	$0	N/A	$0	N/A	$0
Other											
Total	**29,155,247**	**$10**	**$10**	**1.3%**	**$10**	**2.3%**	**$11**	**1.3%**	**$10**	**2.3%**	**$11**

Appendix I.B – SFY 2022-2023 Biennium Projection Build-Up

Managed Care Populations – Capitated Expenditures

		SFY 2021		SFY 2022				SFY 2023			
		Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	Adj. CY 2019 MMs	PMPM	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
Adults	11,959,619	$658	$658	3.4%	$681	4.4%	$688	3.5%	$705	4.5%	$719
Children	13,264,946	$290	$290	3.2%	$299	4.2%	$302	3.3%	$309	4.3%	$315
Disabled	2,442,513	$1,506	$1,506	3.0%	$1,551	4.0%	$1,566	3.0%	$1,598	4.1%	$1,630
Dual	1,488,169	$1,504	$1,504	3.7%	$1,560	4.4%	$1,570	3.7%	$1,618	4.4%	$1,640
Other											
Total	**29,155,247**	**$605**	**$605**	**3.3%**	**$625**	**4.3%**	**$631**	**3.4%**	**$646**	**4.4%**	**$659**

Managed Care Populations – Combined Expenditures

		SFY 2021		SFY 2022				SFY 2023			
		Lower Bound	Upper Bound	Lower Bound		Upper Bound		Lower Bound		Upper Bound	
COA	Adj. CY 2019 MMs	Blended PMPM	Blended PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM	Projected Growth	PMPM
Adults	11,959,619	$666	$666	3.4%	$689	4.4%	$696	3.5%	$713	4.5%	$727
Children	13,264,946	$297	$297	3.2%	$306	4.2%	$309	3.2%	$316	4.2%	$322
Disabled	2,442,513	$1,553	$1,553	3.0%	$1,599	4.0%	$1,616	3.0%	$1,647	4.0%	$1,680
Dual	1,488,169	$1,504	$1,504	3.7%	$1,560	4.4%	$1,570	3.7%	$1,618	4.4%	$1,640
Other											
Total	**29,155,247**	**$615**	**$615**	**3.3%**	**$635**	**4.3%**	**$642**	**3.4%**	**$657**	**4.3%**	**$669**

Appendix I.C – Biennium Projection with Historical Inclusions

SFY 2021 Projection PMPM		
SFY	**Lower Bound**	**Upper Bound**
2021	$761	$765

	PMPM		Trend	
SFY	**Lower Bound**	**Upper Bound**	**Lower Bound**	**Upper Bound**
2022	$785	$796	3.1%	4.0%
2023	$809	$828	3.1%	4.1%
2021 - 2023			**3.1%**	**4.1%**

PMPMs are reflective of including Hospital Pass Through Payments and HIC Franchise and Premium Tax expenditures

Appendix I.D – PMPM– SFY 2021

FFS Populations – FFS Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 PMPM	Upper Bound SFY 2021 PMPM
Adults	731,059	$435	$442
Children	452,056	$303	$307
Disabled	521,695	$4,734	$4,799
Dual	1,434,912	$2,637	$2,677
Other	1,591,830	$64	$65
Total	**4,731,552**	**$1,439**	**$1,460**

Appendix I.D – PMPM – SFY 2021

Managed Care Populations – FFS Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 PMPM	Upper Bound SFY 2021 PMPM
Adults	11,959,619	$8	$8
Children	13,264,946	$7	$7
Disabled	2,442,513	$47	$48
Dual	1,488,169	$0	$0
Other	0	$0	$0
Total	**29,155,247**	**$10**	**$10**

Managed Care Populations – Capitated Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 PMPM	Upper Bound SFY 2021 PMPM
Adults	11,959,619	$658	$658
Children	13,264,946	$290	$290
Disabled	2,442,513	$1,506	$1,506
Dual	1,488,169	$1,504	$1,504
Other	0	$0	$0
Total	**29,155,247**	**$605**	**$605**

Managed Care Populations – Combined Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 PMPM	Upper Bound SFY 2021 PMPM
Adults	11,959,619	$666	$666
Children	13,264,946	$297	$297
Disabled	2,442,513	$1,553	$1,554
Dual	1,488,169	$1,504	$1,504
Other	0	$0	$0
Total	**29,155,247**	**$615**	**$615**

Appendix I.E – Total Cost Estimates – SFY 2021

FFS Populations – FFS Estimates

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	731,059	$318,100,000	$322,800,000
Children	452,056	$136,900,000	$139,000,000
Disabled	521,695	$2,469,600,000	$2,503,600,000
Dual	1,434,912	$3,783,700,000	$3,841,300,000
Other	1,591,830	$101,600,000	$103,100,000

*Note: Total dollars above are **NOT** intended to reflect estimated expenditures in SFY 2021 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 adjusted CY 2019 MMs used to develop the aggregate PMPM. Total estimated expenditures will vary depending on the number of member months experienced in SFY 2021, as well as to the extent that additional programmatic changes outside of current policy go into effect through the duration of SFY 2021.*

FFS Populations – FFS Expenditures Annualized 4Q 2020 MMs

COA	Annualized 4Q 2020 Caseload Report MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	660,708	$287,400,000	$291,700,000
Children	285,192	$86,400,000	$87,700,000
Disabled	489,600	$2,317,700,000	$2,349,600,000
Dual	1,388,280	$3,660,700,000	$3,716,500,000
Other	1,646,780	$105,100,000	$106,700,000

*Note: Total dollars above are **NOT** intended to reflect estimated expenditures in SFY 2021 but are intended to provide a view of the magnitude of total spend by each population using the latest 4QCY 2020 annualized membership mix from the Ohio Caseload Reports. These dollars are calculated by multiplying projected PMPM by the annualized MMs used to develop the aggregate PMPM. Total estimated expenditures will vary depending on the number of member months experienced in SFY 2021, as well as to the extent that additional programmatic changes outside of current policy go into effect through the duration of SFY 2021.*

Appendix I.E – Total Cost Estimates – SFY 2021

Managed Care Populations – FFS Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	11,959,619	$93,800,000	$95,200,000
Children	13,264,946	$88,400,000	$89,700,000
Disabled	2,442,513	$115,900,000	$117,600,000
Dual	1,488,169	$0	$0
Other	0	$0	$0

Managed Care Populations – Combined Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	11,959,619	$7,966,600,000	$7,968,100,000
Children	13,264,946	$3,935,700,000	$3,937,100,000
Disabled	2,442,513	$3,793,700,000	$3,795,400,000
Dual	1,488,169	$2,238,000,000	$2,238,000,000
Other	0	$0	$0

Managed Care Populations – Capitated Expenditures

COA	Adj. CY 2019 MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	11,959,619	$7,872,800,000	$7,872,800,000
Children	13,264,946	$3,847,400,000	$3,847,400,000
Disabled	2,442,513	$3,677,800,000	$3,677,800,000
Dual	1,488,169	$2,238,000,000	$2,238,000,000
Other	0	$0	$0

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

All Populations – All Expenditures

COA	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
FFS	$6,809,900,000	$6,909,800,000
MC Enrollment – FFS Spend	$298,100,000	$302,500,000
MC Enrollment – MC Spend	$17,636,000,000	$17,636,000,000
Additional Payments[1]	$1,049,800,000	$1,067,800,000

[1] Includes Buy-in and Part D Clawback

*Note: Total dollars shown on this page are **NOT** intended to reflect estimated total dollar expenditures in SFY 2021 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 adjusted CY 2019 MMs used to weight the program-wide PMPM. Total estimated expenditures will vary depending on the number of member months actually experienced in SFY 2021, as well as to the extent that additional programmatic changes outside of current policy go into effect throughout SFY 2021.*

Appendix I.F – Total Cost – SFY 2021 Annualized 4Q 2020 MMs

Managed Care Populations – FFS Expenditures

COA	Annualized 4Q 2020 Caseload Report MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	14,371,553	$112,800,000	$114,500,000
Children	14,108,031	$94,000,000	$95,400,000
Disabled	2,432,232	$115,400,000	$117,100,000
Dual	1,623,748	$0	$0
Other	0	$0	$0

Managed Care Populations – Capitated Expenditures

COA	Annualized 4Q 2020 Caseload Report MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	14,371,553	$9,460,500,000	$9,460,500,000
Children	14,108,031	$4,091,900,000	$4,091,900,000
Disabled	2,432,232	$3,662,300,000	$3,662,300,000
Dual	1,623,748	$2,441,900,000	$2,441,900,000
Other	0	$0	$0

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	Annualized 4Q 2020 Caseload Report MMs	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
Adults	14,371,553	$9,573,300,000	$9,575,000,000
Children	14,108,031	$4,185,900,000	$4,187,300,000
Disabled	2,432,232	$3,777,700,000	$3,779,400,000
Dual	1,623,748	$2,441,900,000	$2,441,900,000
Other	0	$0	$0

All Populations – All Expenditures

COA	Lower Bound SFY 2021 Expenditures	Upper Bound SFY 2021 Expenditures
FFS	$6,457,300,000	$6,552,200,000
MC Enrollment – FFS Spend	$322,200,000	$327,000,000
MC Enrollment – MC Spend	$19,656,600,000	$19,656,600,000
Additional Payments[1]	$1,049,800,000	$1,067,800,000

[1] Includes Buy-in and Part D Clawback

*Note: Total dollars above are **NOT** intended to reflect estimated expenditures in SFY 2021 but are intended to provide a view of the magnitude of total spend by each population using the latest 4QCY 2020 annualized membership mix from the Ohio Caseload Reports. These dollars are calculated by multiplying projected PMPM by the annualized MMs used to develop the aggregate PMPM. Total estimated expenditures will vary depending on the number of member months experienced in SFY 2021, as well as to the extent that additional programmatic changes outside of current policy go into effect through the duration of SFY 2021.*

Appendix I.G – Distribution of Cost – SFY 2021

FFS Populations – FFS Expenditure Distribution

COA	Lower Bound SFY 2021 Expenditures
Adults	1.3%
Children	0.6%
Disabled	10.0%
Dual	15.3%
Other	0.4%
Total	**27.5%**

Managed Care Populations – Capitated Expenditure Distribution

COA	Lower Bound SFY 2021 Expenditures
Adults	31.8%
Children	14.9%
Disabled	15.5%
Dual	9.0%
Other	0.0%
Total	**71.3%**

Managed Care Populations – FFS Expenditure Distribution

COA	Lower Bound SFY 2021 Expenditures
Adults	0.4%
Children	0.5%
Disabled	0.4%
Dual	0.0%
Other	0.0%
Total	**1.2%**

Managed Care Populations – Combined Expenditure Distribution

COA	Lower Bound SFY 2021 Expenditures
Adults	32.2%
Children	15.3%
Disabled	15.9%
Dual	9.0%
Other	0.0%
Total	**72.5%**

All Populations – Combined Expenditure Distribution

COA	Lower Bound SFY 2021 Expenditures
FFS	27.5%
MC - FFS	1.2%
MC - MC	71.3%
Total - Medical Expenditures	**100.0%**