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Testimony
House Finance Subcommittee on Health and Human Services

March 7, 2017

Chairman Romanchuk, Ranking Member Sykes, and members of the House Finance Subcommittee on Health and Human Services, thank you for the opportunity to provide testimony on the work of the Joint Medicaid Oversight Committee and our budget for fiscal years 2018 and 2019.

I am Susan Ackerman, Executive Director of the Joint Medicaid Oversight Committee (JMOC). JMOC was created by legislation enacted in 2014 to increase the legislature's role in setting direction and policy for and increasing oversight of the state's largest program.

Ten legislators, including five from the House and five from the Senate, form the JMOC Committee with Representative Huffman serving as current chair. Issues under the purview of JMOC include the following:

- Oversight of current and future policy, as it relates to long term cost trend and financial sustainability of the Medicaid program;
- Policies that impact Medicaid population health, including health equity;
- Policies that impact access and quality of care for Medicaid recipients; and
- Changes to the Medicaid service package.

The JMOC office serves as a resource to the General Assembly to help members better understand existing policy and how policy changes can affect the program. JMOC has a specific role with regard to the state budget that I will discuss in greater detail before describing the agency budget request.

Limiting Per Member Per Month Growth

JMOC is charged with working with an outside actuary to determine the projected medical inflation rate for the Medicaid Program for the upcoming biennium. To complete this task, our actuary projects the cost of continuing current Medicaid policy into the next biennium given outside trend factors on utilization and unit cost. The estimate is completed using a case-mixed methodology, meaning per member per month (PMPM) costs are calculated by population group and aggregated using the same member mix across the biennium.

Our actuary, Optumas, developed a projected growth range for the upcoming biennium. They estimated that PMPM costs would grow by an average of 2.6% per year at the lower bound of the range and by 3.9% at the upper bound. In their report to the committee in September, Optumas noted

that increasing prices for prescription drugs was the most significant factor affecting PMPM cost growth.

Under Section 103.414 of the Revised Code, the JMOC committee has the choice of selecting a rate within the actuary's range or selecting an independent growth rate as the JMOC rate for the upcoming biennium. While the JMOC committee expressed concerns about certain trends going forward – particularly the upward trend in pharmaceutical prices and uncertainty regarding the future economic and job growth – the committee ultimately selected the midpoint of the Optumas projection or an average growth rate of 3.3% for the JMOC rate for the FY 2018-2019 biennium.

The table below shows the PMPM ranges forecasted by our actuary and the JMOC rate for the Executive Budget selected by the JMOC Committee in October 2016.

Per Member Per Month (PMPM) Cost Growth: Optumas Estimate/JMOC Rate

	FY 2017 Estimate	FY 2018 Projection		FY 2019 Projection		
	PMPM	PMPM	Growth Rate	PMPM	Growth Rate	Biennial Average
Optumas Lower Bound	$ 620	$ 638	2.8%	$ 653	2.4%	2.6%
Optumas Lower Bound	$ 629	$ 653	3.8%	$ 679	4.0%	3.9%
JMOC Rate			**3.3%**		**3.3%**	**3.3%**

Under Section 5162.70, the Medicaid Director is required to limit growth in the Medicaid program for the upcoming biennium across all Medicaid recipients on a PMPM basis to the lower of the JMOC rate or the three-year average CPI for medical services. JMOC uses the three-year average Consumer Price Index (CPI) rate for medical services for the Midwest region as a benchmark for growth in the Medicaid program. This rate is updated monthly, and the most recent average is 3.3%.

There are a couple of different ways to look at Medicaid costs at the per capita level. The JMOC growth rate is calculated using a case-mix methodology, meaning that per member per month costs are calculated separately by population and aggregated using the same member mix across the biennium. Case-mixing is a well-established approach to standardize measurement over time and across different populations. Without a case-mix approach, changes in enrollment can mask other cost drivers in PMPM growth.

JMOC focuses on PMPM costs – costs driven by benefits, price, and utilization – which can be managed by state policy makers using levers such as delivery system and payment reform. Caseload is largely outside the control of the state – driven mainly by eligibility policy set at the federal level and by larger economic changes.

The Administration has presented three scenarios for PMPM cost growth for the Executive Budget that I will describe.

- **Scenario A:** In this scenario, PMPM is derived by dividing total costs by major population group and delivery system[1] by expected caseload for each fiscal year.
- **Scenario B:** In this case-mixed scenario, PMPM is derived by dividing total costs by major population groups and delivery system by the base year caseload (FY 2017 in this analysis) for each population group in each delivery system. Scenario B uses the same methodology that was used in the last budget.
- **Scenario C:** To better explain some of the underlying policy changes that affect case mix, this scenario further disaggregates the ABD and Dual population groups. This scenario separates the ABD and Dual population groups into a sub-category for individuals who receive long term care services through the Department of Developmental Disabilities (DODD) and for individuals who do not.[2] Like Scenario B, Scenario C is case mixed.

The table below shows the PMPM values and growth rates for the Executive Budget for the three scenarios described.

PMPM Costs in Executive Budget

Scenario	FY 2017 Estimate	FY 2018 Projection		FY 2019 Projection		Biennial Average
	PMPM	PMPM	Growth Rate	PMPM	Growth Rate	
A) Non-Case Mixed	$ 637	$ 676	6.07%	$ 693	2.49%	4.26%
B) Case Mixed	$ 637	$ 651	2.24%	$ 693	6.38%	4.29%
C) Disaggregated/Case Mixed	$ 637	$ 649	1.90%	$ 659	1.54%	1.72%

There is a policy change that is proposed in the Executive Budget that is skewing the growth rate in the ABD Adult population category in Scenario B. The Executive Budget proposes moving all remaining populations into managed care with the exception of individuals receiving long term care services through DODD. With this change, the population mix in the fee for service system will change dramatically. The non-DODD claims that will continue to be paid by the fee for service system will only include retroactive and first month claims for newly enrolled individuals until they enroll in managed care.

Because of this planned move in FY 2019, the use of the FY 2017 case mix (without separately considering the DODD population) is causing a double digit increase in the fee for service ABD adult and Dual categories. Disaggregating the DODD population from the ABD and Dual categories addresses the skew in the data and provides greater detail on population groups in the budget.

What is driving PMPM growth in the upcoming budget?

These three scenarios really help to identify the underlying dynamics that are driving PMPM growth. Change in case mix is driving much of the PMPM growth in this budget – largely caused by moving most of the remaining Fee for Service (FFS) populations to managed care. Additionally, the disability

[1] Major population groups in Scenarios A and B include ABD Adult, ABD Child, CFC Adult, CFC Child, Dual Eligible, Group VIII, and Other. Delivery system includes fee for service and managed care.

[2] Major population groups in Scenario C include ABD Adult/DODD, ABD Adult/Non DODD, ABD Child/DODD, ABD Child/Non-DODD, CFC Adult, CFC Child, Dual Eligible/DODD, Dual Eligible/Non-DODD, Group VIII, and Other. Delivery system includes fee for service and managed care.

simplification process (1634 Transition) is also having a significant impact on the ABD population group as a whole as individuals move from the CFC and Group VIII categories to ABD.

Overall, Medicaid caseloads are expected to rise by about 1% over the biennium, but in this budget caseloads are increasing faster in the more expensive ABD categories (30% increase in ABD Adult and 83% increase in ABD Child). With the expansion of Medicaid, the state saw a number of ABD members shift to Group VIII in fiscal years 2015 and 2016. With the implementation of the 1634 transition, these enrollees are now shifting back to ABD. It is interesting to note the impact that case mix changes have on per capita costs. This provides some foreshadowing of the types of fiscal challenges that Ohio could face under a federal plan for capped payments or a Medicaid block grant.

Other factors affecting PMPM growth in this biennium include pharmacy costs, Medicare premiums, as well as new policy changes outlined in the Administration's budget. The Administration is also proposing changes that will help slow the rate of growth such as the increased use of managed care and payment reforms.

JMOC Operating Budget

We have requested a continuation budget of $351,355 in FY 2018 and $518,538 in FY 2019. At this funding level, we will be able to continue to support a staff of two full time employees as well as continue to contract with Optumas, JMOC's actuary. Because of our role in setting the JMOC rate for the upcoming biennium; our actuarial expenses are higher in second year of the biennium. We have budgeted $80,000 in FY 2018 and $250,000 for FY 2019 for actuarial services to continue this work. The chart below shows our budget request by category of expenditure.

JMOC Budget Request

	FY 2018	FY 2019
Personal Services	$ 254,355	$ 261,538
Purchased Personal Services	$ 80,000	$ 250,000
Maintenance	$ 17,000	$ 7,000
Total	**$ 351,355**	**$ 518,538**

Budget Language

HB 49 contains language that requires JMOC to review certain Department of Health treatment programs. This project was completed in FY 2016, and the language should be deleted. OBM said that that this was overlooked in the bill drafting process.

Thank you Chairman Romanchuk and members of the committee, and I'd be happy to answer any questions.