



**HOUSE FINANCE COMMITTEE TESTIMONY  
Governor Mike DeWine’s Executive Budget Proposal, SFY26–27  
Maureen M. Corcoran, Director, Ohio Department of Medicaid  
Wednesday, February 5, 2025**

Chair Stewart, Vice Chair Dovilla, Ranking Member Sweeney, and members of the House Finance Committee, thank you for the opportunity to be here today. I am Maureen Corcoran, Director of the Ohio Department of Medicaid, and I am pleased to present the Medicaid portion of Governor DeWine’s executive budget proposal for state fiscal years (SFY) 2026–2027.

The Ohio Department of Medicaid (ODM) is the designated single state agency responsible for the administration of Ohio’s Medicaid program. Consistent with Governor Mike DeWine’s vision, Ohio Medicaid helps to give more than 3 million adults, children, pregnant women, seniors, and individuals with disabilities the opportunity to live up to their God-given potential. With an emphasis on improving access to services, innovative treatment for mental and behavioral health issues, and providing the best care to people of all ages, ODM helps set Ohioans up for success. ODM delivers healthcare access and related community support services through a network of more than 200,000 active providers to Medicaid members and our eight managed care organization partners.

The following statistics highlight the important role ODM occupies in serving Ohioans:

- More than half of Ohio’s births are covered by Medicaid.
- More than 1.3 million children (ages 0-21) in our state are served by Medicaid.
- More than 40,000 children with complex behavioral health needs and receiving specialized services through OhioRISE.
- As of December 2024, there were approximately 2.7 million individuals enrolled in the seven Managed Care Program under the Next Generation of Managed Care.

The Ohio Department of Medicaid is engaged in significant healthcare delivery system and payment reform, referred to as the “Next Generation of Managed Care”, implemented in February 2023. Our budget proposal for SFY26–27 is about solidifying the progress made through the previous budgets enacted over the course of the DeWine Administration with the tools for even greater improvements for the health, wellness of Ohioans in the years to come.

## Governor DeWine’s Priorities

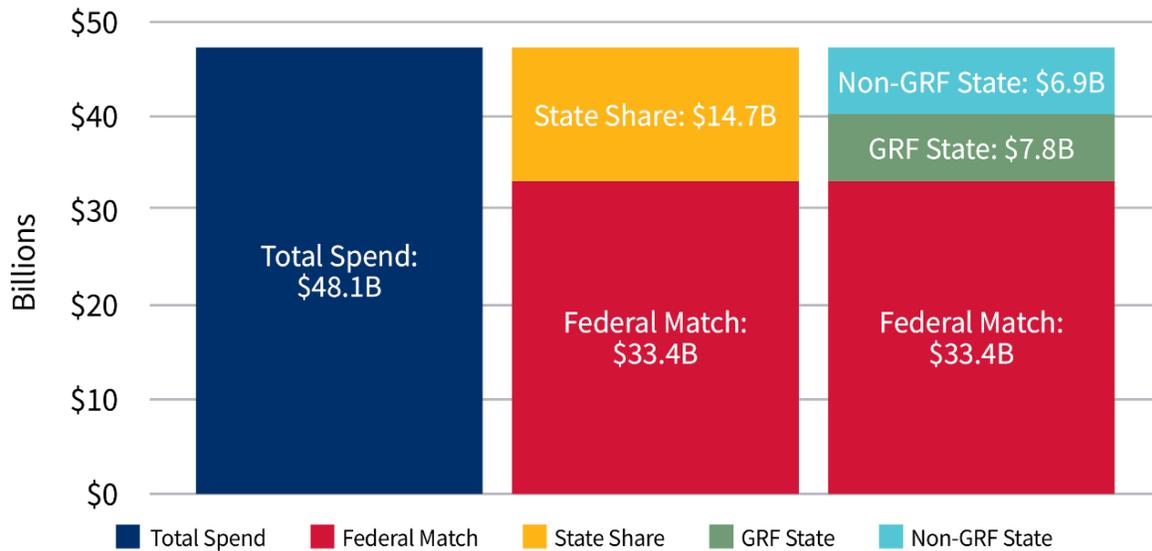
Supporting Healthy Kids	Expanding Access to Behavioral Health Services	Improving Access to Healthcare	Bettering Quality of Care	Advancing Fiscal Responsibility
<p><i>“The single most important thing we can do for Ohio’s future is to ensure that all Ohio children -- no matter where they live, no matter who their parents are -- have the opportunity to live up to their full God-given potential and that they have the chance to pursue their dreams and their passions in life.”</i> 2024 State of the State</p>	<p><i>“We must face the fact that no Ohioan will ever fully live up to their potential or be able to lead purposeful and meaningful lives if their mental illness remains in the shadows and untreated.”</i> 2023 State of the State</p>	<p><i>“And now -- every day in Ohio, we have families in crisis. They need immediate help. And too often, they have nowhere to turn, no idea where to go, so their loved ones suffer – and sometimes, these individuals -- our friends, our family members -- die needlessly.”</i> 2022 State of the State</p>	<p><i>“Our vision for Ohio’s future is one where all Ohioans, no matter where they are from, have the opportunity to live up to their full potential.”</i> 3/22/24</p>	<p><i>“In early 2019, Ohio Governor Mike DeWine called on ODM to ensure Ohioans get the best value in quality care. In response, we developed a bold, new vision for Ohio’s Medicaid program – one that focuses on the individual and not just the business of managed care.”</i> Next Gen Procurement</p>

## BUDGET OVERVIEW

### MEDICAID: A SHARED STATE/FEDERAL HEALTHCARE PROGRAM

Medicaid is a joint federal-state program financed through a matching funds payment arrangement called the Federal Medical Assistance Percentage (FMAP). This means that the federal government will match state spending on healthcare at a certain percentage. In Ohio, that FMAP rate is approximately 65%, meaning for every dollar we spend on a service, 65 cents comes from the federal government and 35 cents is the required state match. I’d like to walk you through Figure 1. The ultimate result is that \$1 of state share spending is expected to purchase \$6.17 worth of services for Ohioans in SFY 2026.

## Medicaid Funding 2026



\*Figure 1

### OVERVIEW OF FUNDING

The Department of Medicaid’s budget (*ODM components only*)

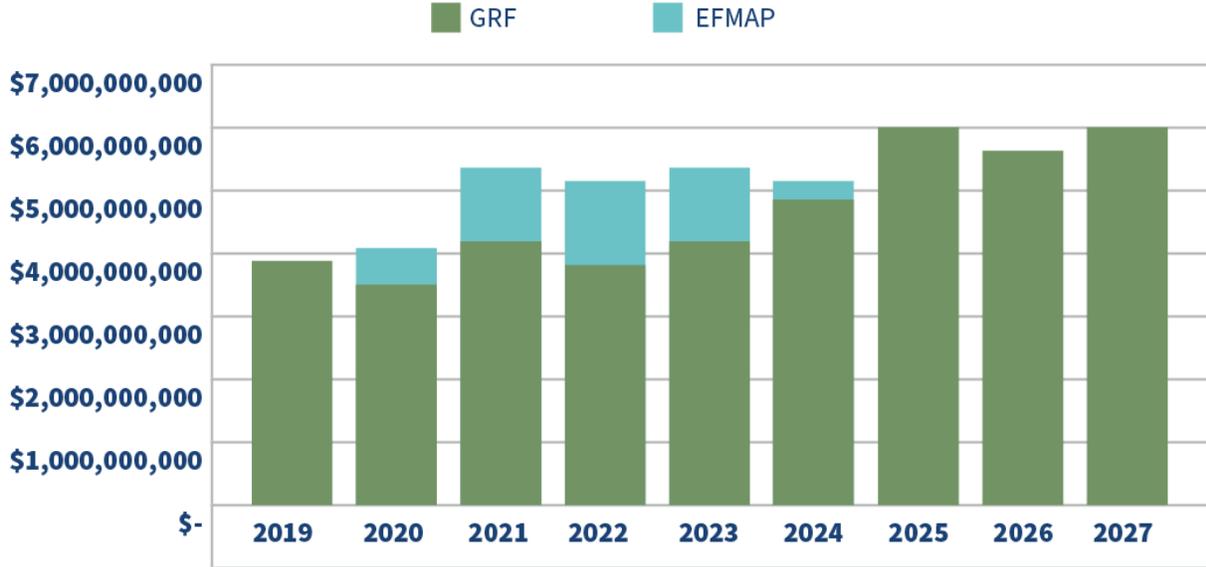
Biennium	Total All Funds	State Share GRF
SFY 2026	\$42.3B	\$6.5B Decrease of 2.8% over FY25
SFY 2027	\$45.0B	\$7.1B Increase of 7.1% from FY26

\*Table 1

While ODM accounts for most of the overall Medicaid program, Medicaid spending also supports services by eight other state agencies: Developmental Disabilities, Job and Family Services, Mental Health and Addiction Services, Health, Aging, Education and Workforce, Children and Youth, and the Pharmacy Board. All departments combined, the Medicaid program’s budget totals \$48.1B in fiscal year 2026 and \$51.1B in fiscal year 2027.

Ohio received enhanced federal funding (eFMAP) in fiscal years 2020 through 2024 of \$5.1B that reduced the amount of state GRF needed to fund the program and support other essential state services. As you can see from the figure below, fiscal years 2026 and 2027 reflect a return to normal funding, without the enhanced federal funds.

## Medicaid Services GRF and EFMAP



\*Figure 2

	SFY24 (Actuals)	SFY25 (Appropriation)	SFY26	SFY27
<b>Total ODM Medicaid Budget</b>	\$34,388,527,590	\$39,740,266,735	\$42,266,105,940	\$44,999,154,905
<b>Total Services</b>	\$33,562,580,490	\$38,715,433,887	\$41,223,763,909	\$43,951,923,676
<b>Total Admin</b>	\$671,947,044	\$766,683,848	\$777,339,031	\$782,228,229
<b>Total Transfer</b>	\$154,000,056	\$258,149,000	\$265,003,000	\$265,003,000
<b>Total GRF (State)</b>	\$5,755,955,473	\$6,902,518,137	\$6,539,259,605	\$7,004,611,436
<b>Total Federal</b>	\$24,136,881,072	\$27,698,807,118	\$29,638,334,089	\$31,694,752,355
<b>Total All Agency</b>	<b>\$39,032,392,149</b>	<b>\$45,242,294,943</b>	<b>\$48,087,668,829</b>	<b>\$51,066,027,439</b>
<b>Total ODM Medicaid Budget</b>	\$34,388,527,590	\$39,740,266,735	\$42,266,105,940	\$44,999,154,905
<b>Total State Agencies</b>	<b>\$4,643,864,559</b>	<b>\$5,502,028,208</b>	<b>\$5,821,562,889</b>	<b>\$6,066,872,534</b>

\*Table 2

The ODM biennial budget totals include:

- Total services budget of \$85.2B, e.g., 97.6% of total spending

- Administrative budget of \$1.6B, e.g., 1.8% of total spending
- Transfer of federal dollars to partner agencies 0.6%

The Department’s administrative budget has increased slightly through implementing the Next Generation of Managed Care program, however, a significant portion of this increase has been offset by reductions in the managed care rates, as some administrative responsibilities have shifted from the managed care plans to the Department. The state share GRF component of ODM’s administration budget, ALI 651425, decreases 4% from SFY25 to SFY26 and is lower than the actuals in SFY24. Just to provide one example, our pharmacy program had three pharmacists prior to implementing the single pharmacy benefit manager. Now we have eight pharmacists that oversee the pharmacy benefit, which is more than \$6B.

The Department’s total administrative spending is historically 1.7% - 2.0% of total spending. Total administrative spending, including partner agencies is historically around 3–3.5% of total service spending, which is below the national average of 4.4% as publicly reported by the Centers for Medicare and Medicaid Services (CMS) and significantly lower than private health insurance administration of 10-11%.

As noted, spending on healthcare services to individuals makes up 97.6% of the Department’s budget. This service spending is driven by **1) rate increases adopted in H.B.33 2) caseload and 3) eligibility**. Different Medicaid eligibility categories have different service costs, with Aged, Blind, and Disabled adults being the most expensive full benefit average per-member-per-month (PMPM) and Covered Families and Children kids being the least expensive full benefit group.

	Aged, Blind, & Disabled - ABD Adults	Aged, Blind, & Disabled - ABD Kids	Covered Families & Children -CFC Adults	Covered Families & Children - CFC Kids	Dual - M'are M'aid	Expansi on Group VIII	Other s
<b>SFY25Avg. PMPM</b>	\$2,466	\$1,669	\$722	\$380	\$1,965	\$902	\$77
<b>FMAP – Federal Share</b>	64.5%	64.5%	64.5%	64.8%*	64.5%	90%	64.5%

*\*Includes CHIP, which is 75.17% FMAP but only ~2.5% of caseload*

*\*Table 3*

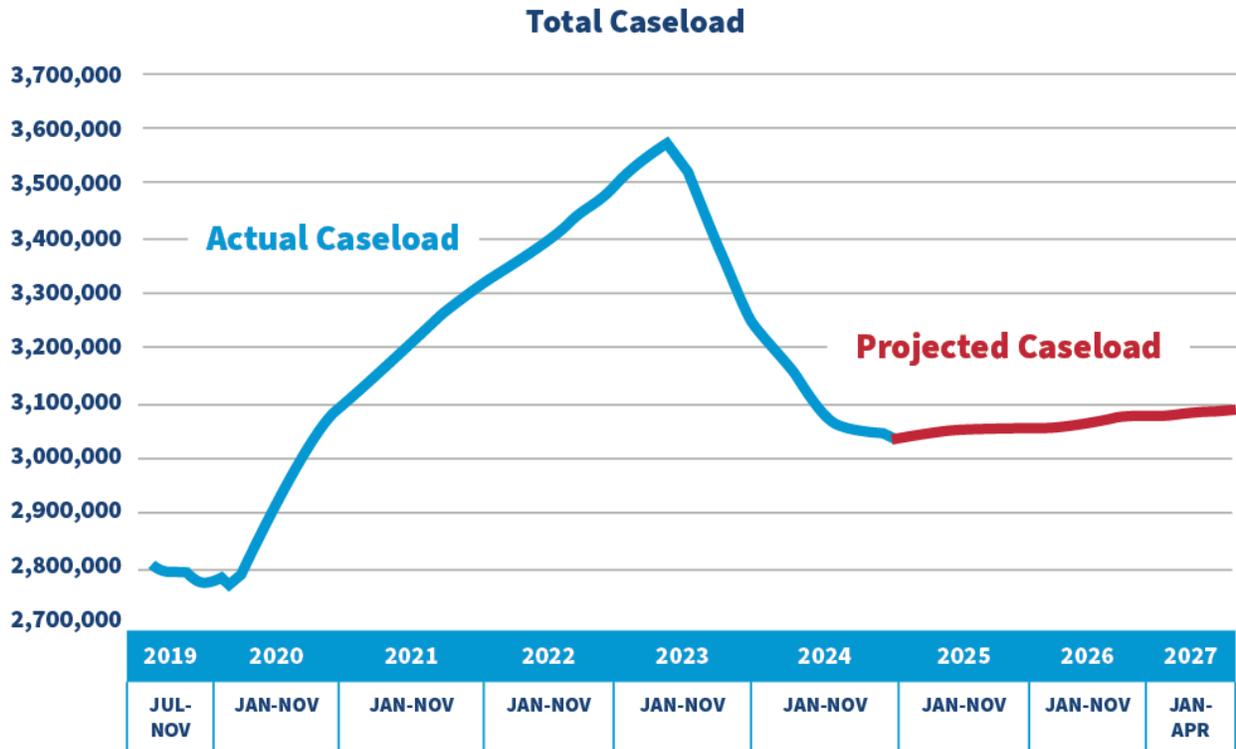
**ELIGIBILITY AND CASELOAD**

Think of eligibility as categories of individuals who can be covered. Medicaid eligibility is dependent on several factors established by federal law including income, disability status, age, and pregnancy status. In recent years Ohio has expanded eligibility with the twelve-month post-partum coverage option, and in HB33 adding continuous eligibility for children zero to three years old.

The caseload, the number of individuals enrolled, is the single largest driver of healthcare service spending.

The aftereffects of the PHE on the caseload are the most important driving factor in our projections. Medicaid completed the post-COVID return to routine eligibility operations (referred to frequently as “Unwinding”) and full eligibility redetermination process in March 2024, through excellent cooperation and performance from Ohio’s County Departments of Job and Family Services and significant improvements in eligibility processing. The entire process was achieved within the federally required timeframes and requirements, while receiving no federal compliance actions or penalties.

The caseload is projected to increase slightly over the biennium, driven largely by projected increases in the number of children and the projected increases in the number of Aged, Blind, and Disabled Ohioans served by the program. In total, the Medicaid caseload is expected to increase from an average monthly total of approximately 3.05 million Ohioans, up to 3.07 million and 3.09 million in fiscal years 2026 and 2027, respectively.



*\*Figure 3*

### Why aren't we down to the same number of people on the program as we had at the start of the PHE?

This is a common question that we get. While eligibility groups that are heavily impacted by the economy **are** expected to decline in fiscal years 2026 and 2027, it's worth reiterating what we stressed during the previous budget deliberations of H.B.33--Ohio's Medicaid caseload will not return to 2020 levels in the foreseeable future, for several reasons:

**The Economy** – Prior to the pandemic, the nation's economy had experienced an unprecedented period of economic growth, and Medicaid caseloads had been in decline month over month for 35 consecutive months.

- While statewide unemployment totals have recovered, employment totals in some lower education groups still lag 2018–2019 levels.

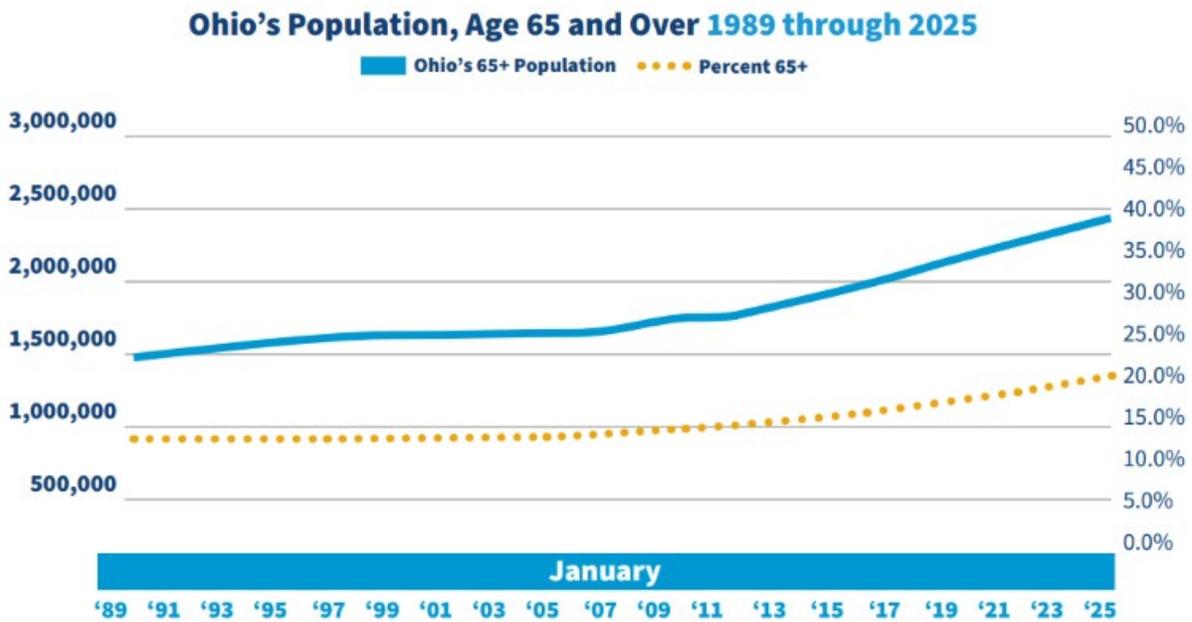
**ABD Individuals on Medicaid**

277,208 individuals  
8% of enrollment  
and  
22% of service expenditures

- Ohio’s labor force participation rate is currently about 1% lower than 2014–2019 norms.

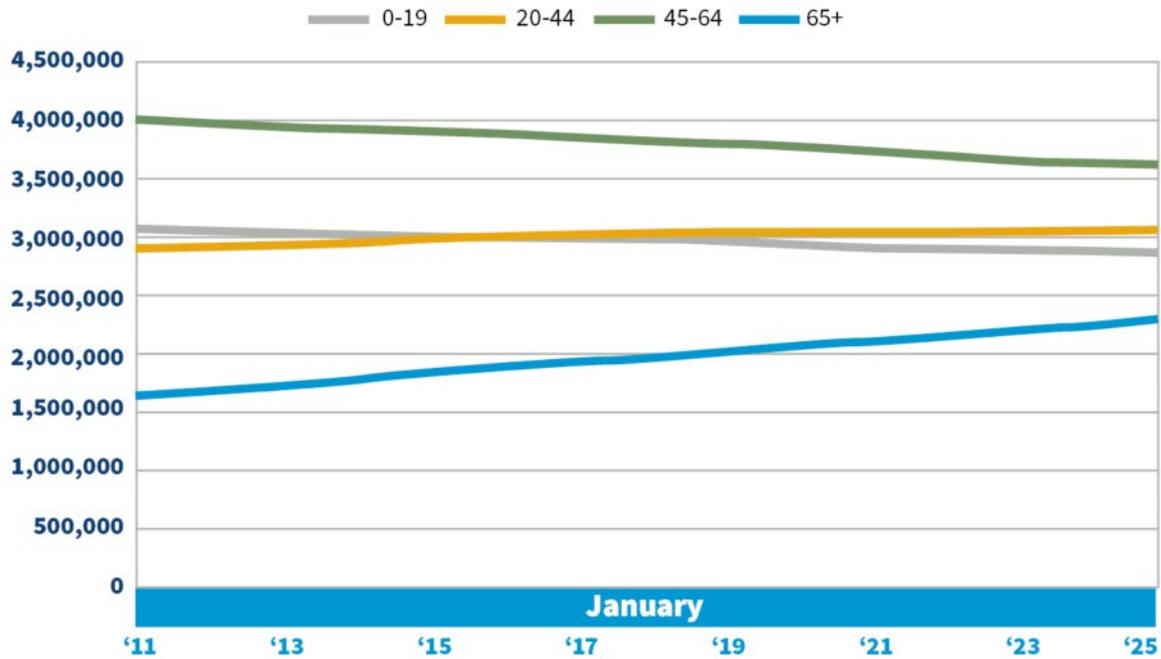
**An Aging Population** – Ohio has added more than 500,000 seniors in the last 10 years

- Ohio’s total over-65 population has been growing quickly, from 1.81 million in January 2015 to an estimated 2.31 million in January 2025.
- Ohioans over the age of 65 made up 19% of the population in 2024—an increase from 17% in 2019.
- **Improved Eligibility Determinations** – a more automated eligibility redetermination process has led to less reliance on manual paperwork, less administrative burden on counties and households, and higher renewal rates.



\*Figure 4

### Ohio's Population by Age Bands (2011-2025)



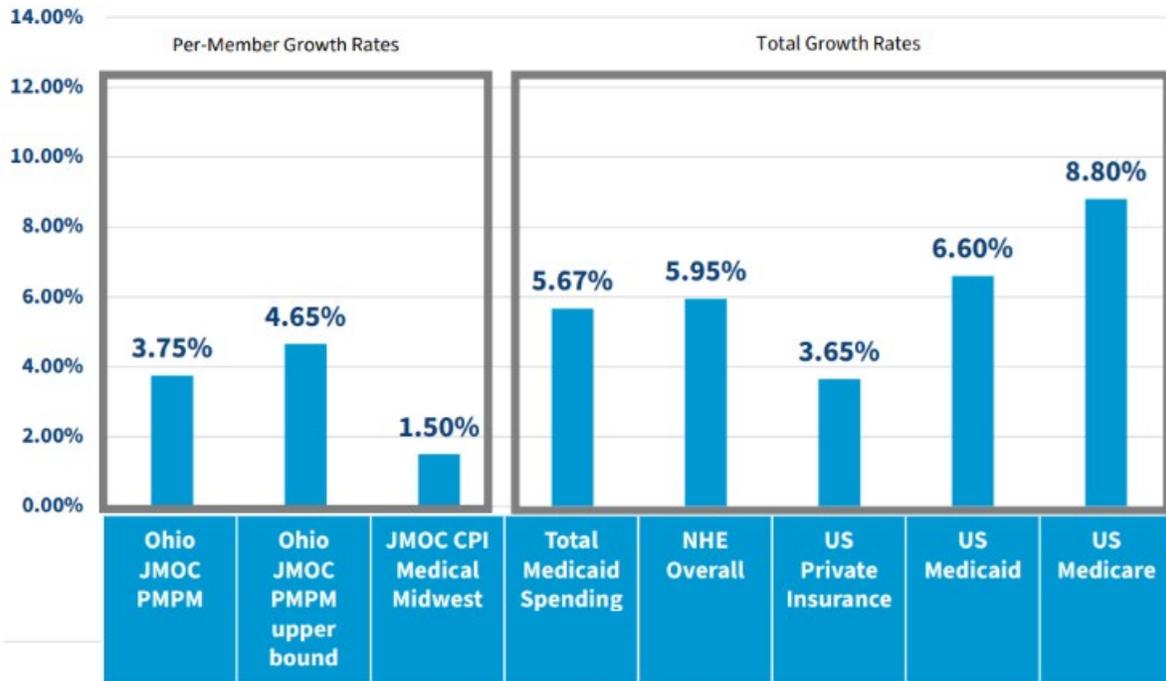
\*Figure 5

### COST DRIVERS IN THE MEDICAID PROGRAM

#### **NATIONAL MEDICAID TRENDS**

Nationally the cost of healthcare is increasing even while Medicaid caseloads are normalizing across the country. The National Health Expenditures (NHE) data, as forecasted by the Centers for Medicare and Medicaid Services (CMS), projects a 6.0% increase in total national health expenditures and an increase of 6.6% in Medicaid expenditures over the period covering the SFY26-27 biennium. While spending is expected to increase overall, there are specific areas of notable growth within the Ohio Medicaid budget attributable to both national trends and Ohio specific policies.

### FY26-27 Average Growth Rate



\*Figure 6

*Note: The above Total Ohio Medicaid Spending growth rate excludes the proposed increase in the hospital franchise fee. Fiscal year growth rates for ODM, calendar year growth rates for NHE.*

Please note that the measures on the right side of the figure above are simple percentage rates of growth for total spending. Measures on the left side are per person growth rates related to JMOc calculations. The JMOc PMPM growth rate is a case mix adjusted, “per member, per month” measure. CPI medical reflects price, but not utilization of services. As introduced, the Medicaid budget has a JMOc growth rate of 3.42% over the biennium, within the limits established by the committee.

### PRESCRIPTION DRUG COSTS

Prescription drug costs are expected to increase by an average of 8.7% annually over the period covering the biennium. ODM expended approximately \$6.2 billion in pharmacy related costs during calendar year 2024. The JMOc’s growth rate report also identified drug spending as one of the largest drivers of cost growth.

Not all portions of the pharmacy spend are equal, however. Notably, there are series of very high cost, specialty drugs that are impacting year-over-year spending (e.g., gene and cell therapies, including treatments for sickle cell disease, hemophilia, and Duchenne Muscular

Dystrophy). There are also high utilization drugs that drive spending, most notably the GLP-1 class of drugs used for diabetes (and more recently, weight loss). Spending on GLP-1 drugs specifically is expected to increase 549% over the biennium even with the Department’s limited coverage of these drugs.<sup>1</sup> If coverage for this class of medications is expanded to include weight loss, it is possible that costs associated with this class of drugs alone could reach \$500 million, which is nearly 10% of the total drug spend in the program.

### LONG TERM SERVICES AND SUPPORTS (LTSS)

Long Term Services and Support costs, both those attributable to services delivered in facilities or institutions like nursing facilities, as well as those delivered through various waivers in a home and community-based setting, are also a contributor to increased costs in the Medicaid program. Similar to the national trend, “rebalancing of care” from institutions to the community has occurred over the last 15 years, but both facility and community services remain critical components to the long-term care strategy and require continued and balanced support.

### Home and Community Based Services Who Medicaid Serves Today

	Individuals Who are Intellectually and Developmentally Disabled (DODD Waivers)			Individuals Who are Elderly, Physically & Developmentally Disabled (ODM & ODA waivers)			
Names of the Waivers	Individual Options	Level One	Self	MyCare	Ohio Home Care	Passport	Assisted Living
Capacity # People	283,000	19,766	3,600	38,262	10,212	37,863	5,583
Total 141,586	<b>Total 51,666</b>			<b>Total 89,920</b>			
Ave. Cost of Waiver	\$65,810	\$11,400	\$14,780	Managed Care	\$17,220	\$10,700	\$11,587

\*Table 4

### RETAINING HB 33 RATE INCREASES

Given the numbers I’ve just shared with you, you can see why community services, waivers, home health care, and especially direct care and community nursing are so important to more than 140,000 Ohioans. In the last budget, the General Assembly passed historic rate increases for providers across the Medicaid program translating into an approximate \$5.2

<sup>1</sup> Coverage exists for diabetes, overweight/obese members with established cardiovascular disease, medically necessary weight loss for pediatric patients. ODM expressly excludes drug coverage for the purpose of weight loss.

billion investment into our healthcare providers including approximately \$2.3 billion in additional annual funding for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), and across ODM, DODD, and ODA waiver systems. This additional funding was critical in stabilizing and enhancing the workforce during and after the pandemic.

To increase transparency and track the impact of the historic increases, ODM, ODA, and DODD submitted the “Direct Service Provider Wage Surveys” report to the General Assembly on December 20, 2024, which included baseline wage data for direct service providers collected from more than 1,800 providers. The calendar year 2024 survey will be completed this spring.

### **COST CONTAINMENT SFY 2026-2027**

As the cost of healthcare continues to grow across the country, finding efficiencies becomes more critical. Capturing savings often requires significant programmatic changes (e.g., restricting eligibility or eliminating covered services) which must be completed within federal rules and regulations. I look forward to discussing these with you.

I’d like to address a variety of our department’s cost containment priorities and mechanisms. ORC 5162.70 (B)(2)(a-g) requires the department to submit an annual cost containment report to JMO. A copy of the most recent report is attached at the end of my testimony.

This budget contains cost containment initiatives totaling more than (\$3.6 B) in state GRF reductions, including revenue offsets. I’ll review them with you now.

### **NEXT GENERATION MANAGED CARE: DELIVERY SYSTEM & PAYMENT REFORMS**

Within days of taking office, Governor DeWine gave us the charge to transform Ohio’s Medicaid program. This significant healthcare delivery system and payment reform, referred to as the “Next Generation of Managed Care” was implemented in February 2023. The Next Gen program re-envisioned and redesigned Ohio’s Medicaid healthcare system into one that focuses on the individual rather than the business of managed care. By focusing on healthy communities, families, and individuals, the Next Generation of care works collaboratively and collectively to improve care quality and reverse healthcare disparities for all Ohioans. While this new program is focused on better health outcomes, population health and working with communities to get at the underlying social drivers that influence poor health, it also includes additional operational efficiencies through administrative consolidation, innovative care delivery systems, and payment reforms.

As part of our Next Generation of Managed Care overhaul and as mandated in the Governor’s first biennial budget, Ohio’s Single Pharmacy Benefit Manager (SPBM) has brought dramatic changes, with significant positive impacts for consumers and for pharmacies. Today, more

than 99% of all the pharmacies in the state are Medicaid providers, the largest network of pharmacies in the program's history. Not only is it providing unprecedented levels of insight into what was previously a black box of costs, but it is saving millions in administrative costs. Further, the SPBM provides an enhanced ability to track prescription drug utilization and costs. In conjunction with our work eliminating administrative burden through a Unified Preferred Drug List (UPDL), Ohio is leading the way on transparency among programs with pharmacy benefits.

The SPBM operates within the broader Medicaid information technology system, Ohio Medicaid Enterprise System (OMES), which is the new technological 'skeleton' of the Medicaid system. As the "single front door" to enter the Medicaid claims system, all claims, regardless of payer, are submitted through OMES, and we can identify potential payment issues faster among all payers helping us react faster to provider concerns and potential system issues saving time and money. One component known as the Fiscal Intermediary (FI) can efficiently handle the health care claims of hundreds of thousands of providers across systems. Another component, the Provider Network Module (PNM) and Centralized Credentialing eliminates administrative work and duplicate work that would otherwise have to be completed by individual providers seven or eight times, with each separate MCO. Moreover, MCOs are all conforming to our single EDI claims payment system standard, meaning providers now have a single rule set to follow across all system payers similarly reducing administrative overhead. Over 98% of claims are successfully being accepted into the system, with only 0.5% of claims failing to correctly adjudicate.

The new managed care program includes delivery system and payment reform, to focus on the best care and preventing some of the costliest care, such as NICU stays, emergency room use, behavioral health services, preventing custody relinquishment and more. This, combined with advanced IT infrastructure gives administrative efficiency, unparalleled transparency and tools for accountability. Both are fundamental to addressing healthcare costs.

#### **PAYMENT REFORM EXAMPLES AND STATEWIDE EXPANSION OF MYCARE**

Programmatically, ODM is actively working to bring the Next Generation MyCare Program statewide as mandated in HB 33. This This program will serve Ohioans eligible for both Medicaid and Medicare by creating a more personalized and coordinated care experience while improving care and reducing costs. Data gathered over the past ten years illustrates the cost savings associated with care coordination for Ohio's dually eligible population while increasing member satisfaction with their care and benefits. Beginning in January 2026, selected managed care plans will cover the full Medicare and Medicaid benefit for those who qualify in the current 29 demonstration counties. Statewide expansion will follow as quickly as possible.

Value-based purchasing (VBP) is both a cost containment and an outcomes improvement strategy. Next Gen requires MCOs to shift **from** today's fee-for-service payment arrangements with providers which incentivizes greater utilization to maximize provider

revenue to value-based arrangements with incentives for cost and quality improvements. MCOs have five years to modify their contracts with providers to reach the goal to pay 50% of their payments to providers through value-based arrangements.

One example of value-based arrangements is a partnership between the Children's Hospitals and all the MCOs. This innovative arrangement is building a collective approach to quality improvement and alignment with Governor DeWine's priorities for improving care. As announced during Governor DeWine's 2024 State of the State address, the Outcomes Acceleration for Kids (OAK) learning collaborative is a first-of-its-kind partnership targeting four health domains: well-child care, Asthma, behavioral health, and Sickle Cell Disease. The infrastructure for the OAK learning network was completed in 2024 by establishing six regional teams for each domain (24 teams total) focused on transforming care delivery in partner practices and organizations to improve child health across Ohio in the coming years.

Likewise, the Comprehensive Primary Care for Kids (CPC) and Comprehensive Maternal Care (CMC) programs are two examples of programmatic quality improvement and cost containment measures through care arrangements: both of which work to reduce the prevalence of co-existing health conditions and mortality rates through evidence-based and measurable goals while encouraging value over volume.

#### **COMMUNITY ENGAGEMENT AND WORK REQUIREMENT**

As required by HB 33, the Department is preparing and will submit a work requirements waiver for the Group VIII expansion population by the end of this month. It is expected that this waiver will reduce overall enrollment in the expansion eligibility group over the course of the biennium. The department and MCOs have been developing programs to work with local jobs agencies and others, under guidance of legislation included in HB33. Cost savings attributed directly to the State are somewhat limited as this program receives 90% federal funding. I look forward to discussing this further with you.

#### **REBALANCING OHIO'S HOSPITAL SUPPORT PORTFOLIO**

Hospitals occupy a unique and vital position within Ohio's healthcare system. They anchor emergency care in our communities while advancing innovation at a global level; they care for individuals from cradle to grave, from our cities through our rural and Appalachian communities, without regard for socioeconomic status. In addition to providing healthcare services, hospitals are part of the safety net in our communities—reflecting the value Ohioans place on healthcare and the health and safety of our citizens. In many ways, the investments Ohio has made in and with our hospitals are like an investment portfolio requiring the same level of care and attention to ensure its future viability.

#### **REBALANCING AND REDISTRIBUTING**

As with any investment, thoughtful rebalancing is an important step to ensure the protection and stability of value for the present and future. It is well understood that the Medicaid reimbursement for direct services is not intended to "keep up" with commercial insurance

rates, nor with Medicare. Because of this, there are federal mechanisms that enable us to draw down additional federal funds without using state GRF. This measure comes in response to growing financial pressure on the hospitals (rural hospital concerns, OB units closing, significant pressure from behavioral health crisis care and more).

We are proposing to increase the Hospital Franchise fee. This increase will draw down more federal dollars that will further support hospitals and other priorities within the healthcare system. These additional dollars will assist in augmenting the Governor's healthcare priorities and contribute to an efficient Medicaid program. Second, we are proposing a realignment of the growing group of intergovernmental transfer/ State Directed Payments (SDPs). When leveraged, these tools provide a valuable avenue to accelerate change and facilitate better health outcomes by tying payments to specific health quality metrics.

Third, we are cutting costs in other areas to support the broader Medicaid program. The Medicaid program is currently losing drug rebates as a result of earlier legislative changes associated with the 340B program. Eligibility for the 340B program is being revised to contain costs by aligning our requirements with our longstanding fee-for-service policy, also the original intent. Those to whom the program was originally aimed—referred to as “Grantees” will retain the ability to access the program through their in-house pharmacies. ODM will utilize a FFS-like reimbursement methodologies for 340B hospitals, and contract pharmacies will be excluded.

One final cost containment item involves our managed care payments. The Department has elected to utilize the actuary's lower bound estimates to project our managed care program spending. As healthcare spending increases, the Department and its partners will continue to seek additional efficiencies and drive down per member per month costs.

These cost containment initiatives totaling more than (\$3.6 B) in GRF reductions and revenue offsets over the SFY26-27 biennium have a material effect on the Medicaid budget. ODM had to transition into the SFY26-27 biennium without enhanced FMAP, is maintaining historic rate increases funded with one-time funding, and is facing continuing inflation pressures on the healthcare environment, and still significant concerns about workforce; against the backdrop of an aging Ohio. ODM's approach excludes any major adverse impacts on providers, makes the program more efficient, and is implementing a work program to improve the capabilities of individuals and assist them with finding employment.

### **CONTINUING GOVERNOR DEWINE'S HEALTHCARE PRIORITIES**

Since the beginning of his first term, Governor DeWine has prioritized strategic investments in Ohio's healthcare continuum, and the General Assembly has answered in kind. In previous budgets there have been investments in behavioral healthcare, in moms and babies, and in home and community-based services, and this budget continues that work toward making sure every Ohioans has a chance to live up to their full potential. Work continues the following key priorities:

**Continuous Eligibility Ages 0–3** – Seeking federal approval for continuous coverage for kids aged 0–3 as required in HB 33. The Department is preparing the state plan amendment to cover these individuals. The budget also continues the array of mom and baby initiatives developed over the last few years, referred to as our maternal and infant support program.

**OhioRISE** – This innovative program represents a significant step forward in achieving the governor’s vision of ensuring every child has the opportunity to reach their full potential.

- The program serves more than 42,000 young people and emphasizes prevention, early intervention, and evidence-based practices for children and families.
- OhioRISE plays a critical and growing role in addressing the needs of youth who could be better served in their homes rather than in out-of-home care (e.g., a foster home or residential care facility).

**Crisis Care Supports** – Crisis care support includes several cross-agency collaboratives and initiatives

between MHAS and ODM. Funding mobile crisis services for youth and funding the service cost from HB 45 capital awards to deliver more behavioral health services to individuals that need care.

- Implementing a regional funding model for mobile response stabilization services (MRSS) to help expand emergency mental health support services statewide.

**Continuation of HCBS rate increases** and implementation of self-direction and associated waiver alignment efforts. Ongoing funding for PACE is also included.

### **Program Enhancements**

This budget includes a few additional program enhancements.

- The personal needs allowance (PNA) is being increased from \$50 to \$100 for qualifying individuals, served under the Department of Aging, Department of Developmental Disabilities and the Department of Medicaid’s programs.
- Dental and Vision CHIP Health Savings Initiatives in partnership with ODH to deliver these services to kids in communities without current access.
- We are continuing updates to the Medicaid School Program to deliver more services to more kids in school through the existing program, without additional state GRF funding required.
- Per federal requirements, we are covering certain services for eligible juveniles in a post-adjudication status as required by the Consolidated Appropriations Act of 2023.
- Expanding mobile crisis services to cover adults in conjunction with MHAS.

## **SECURING OUR PROGRESS FOR OUR FUTURE**

Medicaid plays a unique and necessary role for our state. We have the opportunity to positively change the trajectory of many young Ohioans’ lives. We also have opportunities

to lower barriers to employment for working age adults, and to ensure the full range of home and community-based options for Ohioans who are elderly or have a disability and wish to remain at home.

As Medicaid Director, I take very seriously the responsibility that the Governor and you have given me; for more than three million Ohioan's healthcare, and the financial stewardship of this large program. The achievements of the last few years could not have been accomplished without the partnership with the General Assembly, the Governor's leadership, the trust of families and consumers across Ohio, and amazing hard work and innovation of providers, MCOs and lots of other stakeholders and partners.

We are asking for your support to help solidify these reforms so that the Governor's vision, and the goals of the General Assembly, articulated over these past six years can be secured. Chair Stewart, Vice Chair Dovilla, Ranking Member Sweeney, and members of the House Finance Committee, thank you for your consideration of the ODM SFY26-27 budget, and I would be happy to take any questions.

October 1, 2024

Mark Romanchuk, Joint Medicaid Oversight Committee Chair  
Adam Holmes, Vice-Chair  
Beth Liston, Ranking Minority Member  
Stephen A. Huffman, Senator  
Catherine D. Ingram, Senator  
Michele Reynolds, Senator  
Kent Smith, Senator  
Jennifer Gross, Representative  
P. Scott Lipps, Representative  
Cecil Thomas, Representative  
Jada Brady, Joint Medicaid Oversight Committee Executive Director

Re: Reforms to Medicaid program report

Dear Sirs and Madams:

Please find attached the annual report as required by Section 5162.70 of the Ohio Revised Code. This report details reforms implemented by the Medicaid program that address the health objectives outlined in statute while containing program costs. Also attached is the Medicaid Program Expenditure and Utilization Trend Rates as required in even numbered years. This attachment details the Department's historical and projected Medicaid program expenditures and utilization trend rates by Medicaid program and service category.

As outlined in the September 19<sup>th</sup>, 2024, Joint Medicaid Oversight Committee (JMOC) meeting and the *DRAFT Ohio JMOC SFY 2026-2027 Biennium Medicaid Growth Rate Projections* cover letter, the attached report will be reviewed by CBIZ Optumas before they finalize their Medicaid growth rate report. In response to their draft report and verbal testimony during the September 19<sup>th</sup>, 2024, JMOC meeting, ODM would like to provide comments.

First, as outlined in the CBIZ Optumas draft report, "the average annual growth for Medicaid and CHIP...for the SFY2025 to SFY 2027 period is 5.4%".<sup>1,2</sup> This is significantly

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<sup>1</sup> CBIZ Optumas Draft State Fiscal Years 2026-2027 Biennium Growth Rate Projections report, page 3

<sup>2</sup> While we were not able to identify the 5.4% increase indicated in the Health Affairs article as cited, CMS identifies the National Health Expenditures (NHE) by payer as follows "Medicaid expenditures are projected to rebound to 5.7 percent in 2025-2026, as other personal care spending accelerates due to states' continued

higher than the range of proposed growth in the report. Current per member growth estimates are 5.3% in SFY26 and 5.0% in SFY27.<sup>3</sup> This per member growth rate is not a direct comparison to the JMOC growth rate as, among other things, it is not case mix adjusted. This estimate is close to the high end of the range projected by CBIZ Optumas and better aligned with the national benchmark. The CBIZ Optumas analysis concludes that the CPI Medical Inflation rate is “an inappropriate choice for the growth rate this cycle”<sup>4</sup>. The JMOC actuary also notes that using a rate close to 3.2% excludes important growth drivers like “higher utilization of certain services, availability of new expensive drugs, and the high rate of wage growth among lower wage healthcare workers.”

Second, in response to a question regarding the impact of a 1% reduction in growth, it was noted that this reduction would amount to a cut of roughly \$330 million. This would result in a \$330 million cut in SFY26 and \$660 million in SFY27 due to compounding. We suggest that CBIZ Optumas list specific measures that would need to be taken by the executive branch and the General Assembly during the budget process to implement a growth rate below the actual case mix adjusted trend in the upcoming biennium. The rate of growth can only be controlled through material cuts to service access to members or by material cuts to provider rates. For example, a 1% cut in the growth rate would equal a 2.5% across-the-board rate cut on July 1, 2026, impacting nursing facilities, physicians, hospitals and home care providers (and impacting DODD, Aging, and other Medicaid waivers).<sup>5</sup>

Finally, testimony stated “large retroactive payments totaling nearly \$1 billion were made at the end of 2023 and beginning of 2024 to settle aged claims incurred in 2023”. It appears that the **reprocessing** of claims is being confused with **retroactive/delayed payment of claims**. This amount was not shared with ODM prior to testimony and is factually incorrect.

As indicated in a June 8<sup>th</sup>, 2024 memo to JMOC, reprocessing can change the paid date on claims without necessarily changing the paid amount. During CY23, \$1.18 billion of claims was reprocessed, resulting in a net change of \$186 million (2.5% of CY23 fee-for-service paid claims).

The difference between total claims for services provided and total paid claims was only \$31 million or 0.14%<sup>6</sup>, indicating that payment issues were resolved to the point that there

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expansions and use of home and community-based services.” <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>

<sup>3</sup> Medicaid Program Expenditure Trend and Utilization Rates, Table III, Forecast by Per Member Per Month by SFY

<sup>4</sup> CBIZ Optumas Draft State Fiscal Years 2026-2027 Biennium Growth Rate Projections report, page 4

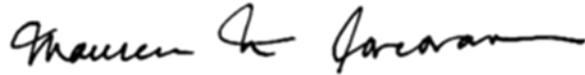
<sup>5</sup> Implementation of rate cuts is subject to the effective date of the budget bill, the rules process, and system changes. To achieve a 1% growth rate cut, the result is an across-the-board rate cut of at least 2.5% on July 1, 2026. To achieve the necessary spending reduction within the biennium, depending on the implementation date of rate cuts, the actual percent cut may be greater than 2.5%.

<sup>6</sup> There were significant delays in processing claims in the first three months of CY23. By the end of 2023 there was essentially no differences (\$31m or 0.14%) in total paid claims versus to the total for services

is no material impact to the JMOC growth rate. We ask CBIZ Optumas to correct the legislative record.

Please contact the Ohio Department of Medicaid through our legislative office with any questions or concerns regarding the information in the attached report.

Sincerely,

A handwritten signature in black ink, appearing to read "Maureen M. Corcoran". The signature is fluid and cursive, with a long horizontal stroke at the end.

Maureen M. Corcoran, Director

Attachments:

Medicaid Program Expenditure and Utilization Trend Rates, October 2024

5162.70 Cost Containment Reforms

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provided. Consistent with the commonly understood idea of claims run out, in a normal year roughly \$400m would be attributable to normal delays in provider submission and processing of claims. ODM has publicly acknowledged our ongoing work to improve and streamline the OMES system.

## 5162.70 Cost Containment Reforms

In 2014, The Ohio General Assembly enacted ORC Section 5162.70 which required ODM to limit the per-person growth of the Medicaid program by enacting reforms that accomplish various goals identified in the statute. The Ohio Department of Medicaid (ODM) has compiled a list of such reforms and cross-referenced them with which legislative requirement from 5162.70 the reform satisfies.

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
<p><b>Comprehensive Primary Care for Kids (CPC for Kids)</b>            In 2020, ODM implemented a pediatric-focused primary care medical home model to enhance prevention efforts, pediatric-focused activities, and outcomes for kids with Ohio Medicaid.</p>	<p><a href="#">Research demonstrates</a> investments in childhood primary care result in fewer costly hospitalizations through immunization, screening, and prevention efforts. After launching the program in this biennium, ODM’s CPC for Kids program:</p> <ul style="list-style-type: none"> <li>• Served nearly 1,000,000 kids in 2023 in 300 enrolled primary care practices</li> <li>• Paid more than \$9.5 million in monthly payments to participating providers</li> <li>• Provided technical support to pediatric providers to improve practice efficiency and adapt best practices to improve pediatric health outcomes such as lead screening</li> <li>• Awarded \$2 million to pediatric practices best able to connect children to care through school-based health, foster care transitions, and other opportunities to engage children and families in receiving supports</li> </ul>	<ul style="list-style-type: none"> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> <li>• Implement evidence-based strategies that include measurable goals (D)</li> </ul>
<p><b>Comprehensive Maternal Care (CMC)</b>            In 2023, ODM implemented a maternal-focused obstetric care medical home model to enhance pre-natal care and improve outcomes for infants and mothers with Ohio Medicaid.</p>	<p><a href="#">Research demonstrates</a> access to high-quality, comprehensive maternal health services, including access to behavioral health services, can improve health outcomes for mothers and their infants. The CMC program uses a framework for providers and community partners to work together to develop person-centered, customized interventions to support women and families who have historically lacked access to high-quality care before and after pregnancy. The CMC program creates financial opportunities for maternal care providers to address patient and family needs across the entire pregnancy and postpartum journey.</p> <p>In the CMC program’s first year:</p> <ul style="list-style-type: none"> <li>• Served nearly 36,000 women in 77 enrolled obstetrical practices</li> </ul>	<ul style="list-style-type: none"> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> </ul>

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
	<ul style="list-style-type: none"> <li>• Paid more than \$4.2 million in monthly payments to participating providers</li> </ul>	
<p><b>Infant Mortality Grants</b> As discussed at length in <a href="#">Ohio's Infant Mortality Report</a>, African American infants in Ohio are almost three times as likely to die before their first birthday than white babies. In response to this challenge, Ohio Medicaid and the managed care plans have granted funding to target improving Black infant outcomes in communities with the highest racial disparities in infant deaths. This funding has been available since 2018.</p>	<p>ODM's infant mortality grants to Ohio Equity Institute Counties aim to reduce the racial disparity in infant outcomes using community-led, person-centered, evidence-based practices including group pregnancy counseling, home visiting, Centering Pregnancy, community health workers, doula services, lactation support, group support, parenting assistance, care connections to community resources, and fatherhood initiatives.</p> <p>Since 2018, the grants have:</p> <ul style="list-style-type: none"> <li>• Served 73,949 women</li> <li>• Leveraged 110 unique community-based organizations</li> <li>• Provided more than \$78 million dollars in funding</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Reduce infant mortality rates among medicaid recipients (B)(4)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> </ul>
<p><b>Multi-System Youth Custody Relinquishment Program</b> With leadership from the Governor's Office of Children's Initiatives and the Family and Children First Cabinet Council, ODM administers a state-level program to provide financial and technical support to youth and families with complex needs who may be at risk of custody relinquishment or have already relinquished to the foster care system solely for treatment purposes.</p>	<p>As of June 2024, the program had:</p> <ul style="list-style-type: none"> <li>• Provided funding to 1,653 youth across all 88 counties. Since 2019 when the fund was created, a total of \$93.1 million has been provided to families to preserve custody and obtain access to behavioral health treatment services that are not covered by other funding sources to keep families together and to avoid excessive stays in emergency and inpatient settings</li> <li>• Prevented custody relinquishment in more than 98% of funded cases at the time of writing</li> <li>• Provided technical assistance to an additional 157 children and families (funding not requested)</li> </ul>	<ul style="list-style-type: none"> <li>• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (D)</li> </ul>
<p><b>Lead Poisoning Prevention and Hazard Control</b> Childhood lead poisoning affects thousands of Ohio children each year. In 2019, Ohio Medicaid received federal approval to conduct a</p>	<p><a href="#">Research on childhood lead poisoning</a> estimates that each dollar invested in lead paint hazard control results in a return of \$17–\$221, or a net savings of \$181-269 billion in health care, social, and behavioral costs. The ODM/ODH program is available in every Ohio county.</p>	<ul style="list-style-type: none"> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>• Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> </ul>

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
<p>Children's Health Insurance Program (CHIP) Health Services Initiative (HSI) to prevent lead poisoning among children with Medicaid. The CHIP program is implemented through the Ohio Department of Health (ODH).</p>	<p>As of SFY 2023-24:</p> <ul style="list-style-type: none"> <li>• 700 applications for lead hazard control were received.</li> <li>• \$10 million in funding was allocated to the program for the biennium.</li> <li>• As of June, 2024, 510 properties have been made lead safe, serving 1,427 children and 25 pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> </ul>
<p><b>Electronic Pregnancy Risk Assessment Form (PRAF) and Other Infant Mortality Initiatives</b> The electronic <a href="#">PRAF 2.0</a> was developed to standardize pregnancy notification and decrease the risk of preterm birth by facilitating the provision of progesterone. Submission of an electronic PRAF automatically notifies county Job and Family Services agencies to maintain Medicaid coverage, the Ohio Department of Health's (DOH) WIC and Department of Children and Youth's (DCY) home visiting central intake program, and managed care providers to address identified needs.</p>	<p>Linking to home visiting intake and maintaining Medicaid coverage can improve pregnancy and infant outcomes. For example, <a href="#">research shows</a> uninsured newborns are more likely to have adverse outcomes, including low birth weight and death, than are insured newborns, and uninsured women are more likely to have poorer outcomes during pregnancy and delivery than women with insurance.</p> <p>In calendar year 2023:</p> <ul style="list-style-type: none"> <li>• 38,072 electronic PRAF forms were submitted</li> <li>• 401 providers used electronic PRAFs</li> <li>• As of July 2024, the number of PRAFs submitted has reached 30,282</li> </ul> <p>In July of 2024, the PRAF was updated to allow for collection of behavioral health and health related social need screening data, facilitating managed care intervention where needed.</p>	<ul style="list-style-type: none"> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Reduce infant mortality rates among medicaid recipients (B)(4)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> </ul>
<p><b>Telehealth Flexibilities</b> On March 9, 2020, ODM adopted emergency telehealth rules to preserve access to vital healthcare services during the temporary delay of elective procedures. Many of these changes were made permanent in November 2020 including:</p> <ul style="list-style-type: none"> <li>• Relaxed patient and provider site restrictions</li> <li>• Increased provider types utilizing telehealth</li> </ul>	<p>Expansion of telehealth began in 2019 but increased during the pandemic to prevent interruption of access to preventive and behavioral healthcare. Providers and individuals in the program report the expansions were helpful in preventing provider closures and maintaining access to crucial services during the pandemic.</p> <p>Pregnancy education and diabetes management services were added as telehealth eligible services in 2022. Pharmacists were added as eligible telehealth providers in 2022 as well.</p> <p>Most of the changes have been made permanent and will continue to benefit the individuals we serve after the public health emergency has concluded. ODM is currently exploring ways to</p>	<ul style="list-style-type: none"> <li>• Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Reduce infant mortality rates among medicaid recipients (B)(4)</li> </ul>

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<ul style="list-style-type: none"> <li>Reimbursement for telephone and secure portal communications</li> </ul>	<p>further improve telehealth provisions since the pandemic has ended.</p>	
<p><b>Substance Use Disorder (SUD) 1115 Demonstration Waiver</b> Ohio’s current SUD 1115 Waiver was approved on October 1, 2019, and is effective through September 30, 2024. The Waiver provides the state with authority to cover high-quality, clinically appropriate treatment to individuals with a SUD across the continuum – including services in the community and residential treatment settings. ODM submitted an application to extend the SUD 1115 Demonstration Waiver for an additional five years on April 1, 2024.</p>	<p>Preliminary findings from the interim waiver evaluation report include a decrease over the measurement period in the rate of overdose deaths, emergency department (ED) and inpatient hospital utilization rates for SUD, and 30-day ED readmission rates for SUD; and an increase over the measurement period in the medications for opioid use disorder (MOUD) provider availability ratio, the proportion of members with OUD receiving MOUD, the proportion of residential treatment stays with MOUD, and the proportion of residential treatment stays with timely follow-up.</p>	<ul style="list-style-type: none"> <li>Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> </ul>
<p><b>Mental Health Peer Support</b> Effective September 1, 2024, ODM expanded coverage of behavioral health peer support services to include peer support for individuals with mental health conditions.</p> <p>Ohio offers three types of peer supporter certifications: Adult, Family, and Youth/Young Adult. Prior to September 1, 2024, these services were available only for individuals with substance use disorder (SUD) and as a part of several evidenced-based practices</p>	<p>Certified peer supporters use their lived experience to help others impacted by mental illness or substance use disorders. The service has been shown to:</p> <ul style="list-style-type: none"> <li>Increase a member’s sense of control and ability to bring about positive changes.</li> <li>Increase engagement in self-care and wellness.</li> <li>Decrease hospitalizations, inpatient days, and cost of care.</li> <li>Decrease psychotic symptoms, substance use, and depression.</li> <li>Strengthen a member’s whole health, including the ability to manage chronic conditions like diabetes.</li> </ul> <p>Certification attained through the Ohio Department of Mental Health and Addiction Services (OhioMHAS) is required to become a mental health peer support specialist.</p>	<ul style="list-style-type: none"> <li>Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> </ul>
<p><b>Mobile Response and Stabilization Services (MRSS)</b> MRSS was built on the values of serving children and young adults</p>	<p>MRSS is instrumental in:</p> <ul style="list-style-type: none"> <li>Averting unnecessary emergency department (ED) visits, inpatient admissions, out-of-home placements, placement disruptions, and juvenile justice involvement.</li> </ul>	<ul style="list-style-type: none"> <li>Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> </ul>

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<p>with behavioral health crisis needs; maintaining children in their homes and communities; leveraging resources across systems to be more effective in meeting youth and families’ needs; and institutionalizing shared governance.</p> <p>ODM implemented MRSS as a Medicaid-covered service in July 2022. ODM has since been working with (OhioMHAS) and DCY on efforts to expand provider capacity to make MRSS available to all youth in Ohio. In August 2024, OhioMHAS issued a request for proposals (RFP) for Regional MRSS Providers (RMPs).</p>	<ul style="list-style-type: none"> <li>Reducing system costs.</li> <li>Keeping a child, youth, or young adult safe at home, in the community, and in school whenever possible.</li> </ul> <p>To align with national best practices a “firehouse” model funding approach is being developed within each region. The objective of a “firehouse” model is to:</p> <ul style="list-style-type: none"> <li>Create a more predictable funding stream that supports efficiency, availability and access to services.</li> <li>Allow MRSS services to be staffed during identified times, including periods of low and/or no utilization.</li> </ul> <p>The expansion of MRSS services through a regional approach advances the state’s goals to expand the crisis services continuum and supports the state’s System of Care efforts. When fully in effect, this model will improve the broader behavioral health system to better support youth, families, and caregivers in their homes and communities.</p>	<ul style="list-style-type: none"> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> </ul>
<p><b>Unified Preferred Drug List (UPDL)</b> On January 1, 2020, ODM implemented a unified preferred drug list to replace the process of having each managed care plan adopt a different preferred drug list.</p>	<p>Implementing the UPDL has:</p> <ul style="list-style-type: none"> <li>Eased administrative burden for prescribers by decreasing unnecessary prior authorization requirements and requiring all MCPs to use one consistent set of requirements.</li> <li>Maximized the collection of federal and supplemental rebates, ensuring that all supplemental rebates are sent directly to ODM and are not retained by the medicaid MCPs or their PBM. This resulted in an ongoing net savings to the state of \$61 million.</li> </ul>	<ul style="list-style-type: none"> <li>Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)</li> <li>Implement policies with evidence-based strategies that include measurable goals (C)</li> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> </ul>
<p><b>Helping Ohioans Move Expanding HOMEChoice</b> Ohio’s HOME Choice program transitions eligible Ohioans from institutional settings to home and community-based settings, where they receive services and supports at</p>	<p>Transitioning people who need long-term services and supports (LTSS) out of institutions and back into the community saves taxpayer dollars and improves the quality of life of those we serve.</p> <p>Since the start of the HOME Choice program in 2008, the program has transitioned more than 17,000 individuals to community settings.</p>	<ul style="list-style-type: none"> <li>Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> </ul>

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
to help them stay in their communities.		<ul style="list-style-type: none"> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> <li>Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>Implement policies with evidence-based strategies that include measurable goals (C)</li> </ul>
<p><b>Next Generation of Medicaid Managed Care Administrative Savings</b> Creates administrative efficiencies through Single Pharmacy Benefit Manager, Fiscal Intermediary, and Centralized Credentialing while increasing transparency and oversight of Medicaid program.</p>	<ul style="list-style-type: none"> <li>Eliminates certain duplicative administrative functions performed by each plan.</li> <li>Eliminates potential conflicts of interest in the pharmacy program</li> <li>Increases data integrity and oversight while reducing provider administrative burdens</li> <li></li> </ul>	<ul style="list-style-type: none"> <li>Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)</li> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> </ul>
<p><b>Eligibility Electronic Database Interfaces</b> ODM currently operates a sophisticated system of electronic interfaces to ensure applicants of Medicaid meet the eligibility qualifications prior to enrolling.</p>	<p>Among these interfaces are:</p> <ul style="list-style-type: none"> <li>Quarterly wage reports from the State Wage Information Collection Agency (SWICA)</li> <li>Social Security Administration (SSA)</li> <li>Unemployment compensation</li> <li>Public Assistance Reporting Information System (PARIS)</li> <li>Bureau of Vital Statistics</li> </ul> <p>The interfaces assist with identifying individuals ineligible for program services:</p> <ul style="list-style-type: none"> <li>6,874 individuals were transferred to the Marketplace in August 2024 alone.</li> </ul>	<ul style="list-style-type: none"> <li>Reduce enrollment without making eligibility requirements more restrictive (D)</li> <li>Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)</li> <li>Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> </ul>
<p><b>OhioRISE</b> OhioRISE aims to shift the system of care and keep more youth and families together by creating new access to in-home and community-</p>	<ul style="list-style-type: none"> <li>Implements “Joint Legislative Committee on Multi-System Youth (MSY) Recommendations” report recommendations to ensure MSY safety-net funding, access to peer support services, Medicaid-reimbursable</li> </ul>	<ul style="list-style-type: none"> <li>Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>Improve the physical and mental health of medicaid recipients (B)(2)(a)</li> </ul>

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<p>based services for children with the most complex behavioral health challenges.</p>	<p>high-fidelity wraparound services, and facilitation of data collection as shown in <a href="#">OhioRISE White Paper</a></p> <ul style="list-style-type: none"> <li>• Targets the most vulnerable families and children to prevent custody relinquishment and reduce Ohio’s reliance on costly out-of-state residential treatment</li> <li>• Brings Ohio into compliance with federally enacted Families First Prevention Services Act (FFPSA)</li> <li>• Establishes and increases access to home and community-based services, like Intensive Home-Based Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Allows Medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> </ul>
<p><b>Diabetes Quality Initiative</b> ODM has incorporated key diabetes quality metrics in the managed care quality withhold program to drive better outcomes.</p>	<ul style="list-style-type: none"> <li>• With the high costs associated with preventable hospitalizations, ODM has increased its focus of controlling blood sugar and other diabetes-related metrics in its managed care quality withhold program</li> <li>• ODM added coverage of the National Diabetes Prevention Program (NDPP) for individuals diagnosed with pre-diabetes and diabetes self-management education (DSME) for individuals living with diabetes and removed prior authorization for continuous glucose monitors in the pharmacy and durable medical equipment (DME) benefit.</li> <li>• By emphasizing this in our population health strategy and allowing access to continuous glucose monitors (CGMs) through the pharmacy (as well as the medical) benefit, ODM is hoping to decrease preventable diabetes-related hospitalizations and complications, bending the cost curve down, and improving patient outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>• Removes barriers to transferring to lower cost, more appropriate services, including HCBS (B)(2)(c)</li> <li>• Improve the physical and mental health of Medicaid recipients (B)(2)(a)</li> <li>• Allows Medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> </ul>
<p><b>12-Month Continuous Postpartum Eligibility</b> ODM has implemented the HB 110 requirement to allow continuous postpartum eligibility for one year after giving birth</p>	<ul style="list-style-type: none"> <li>• The CARES Act permitted states to allow continuous postpartum eligibility with a SPA, rather than a demonstration waiver.</li> <li>• Ohio submitted a SPA to CMS, and it was approved with an effective date of April 1, 2022.</li> <li>• ODM implemented this change in our eligibility system and added it to our suite of infant mortality initiatives.</li> <li>• Continuous postpartum eligibility provides access to healthcare services and helps reduce the prevalence of</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the prevalence of comorbid health conditions and mortality rates (B)(3)</li> <li>• Reduce infant mortality rates among Medicaid recipients (B)(4)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> <li>• Improve the physical and mental health of Medicaid recipients (B)(2)(a)</li> </ul>

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
	comorbid health conditions and mortality rates and reduce infant mortality rates	
<p><b>Ohio Benefits System Updates</b> Beginning early in this administration, ODM worked collaboratively with the Ohio Department of Job and Family Services (ODJFS), the Department of Administrative Services (DAS), and Accenture to identify and categorize 1,500 system defects with Ohio’s eligibility and enrollment system. Among these updates were enhancements to reform the number of alerts that are sent to counties prompting them to revisit an enrolled individual’s Medicaid eligibility.</p>	<ul style="list-style-type: none"> <li>• ODM prioritized the most serious defects that can result in an incorrect eligibility determination and fixed nearly 1,000 of them over the course of 9 releases between August 2019 and December 2020.</li> <li>• ODM also, together with ODJFS, continues to streamline these system alerts</li> <li>• Total volume has been nearly cut in half, reducing administrative burdens.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce enrollment without making eligibility requirements more restrictive (D)</li> <li>• Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)</li> </ul>
<p><b>Enhanced County Engagement and Training</b> As part of our PERM Corrective Action Plan, ODM created a county engagement team split into five regions with a county engagement manager in each region. We engage in quarterly calls with each region to discuss application timeliness, schedule weekly timeliness calls with select counties, and identify and share best practices.</p>	<ul style="list-style-type: none"> <li>• ODM provided training updates on over 40 topics in CY 2023.</li> <li>• County Engagement meets with all counties in their region quarterly to discuss case processing trends, alert completion, provide hyper care post training and to discuss current hot topics.</li> <li>• ODM and JFS have partnered to create a new worker training curriculum which is hosted at least 3 times a year and covers TANF, SNAP, Medicaid, Child Care and Case Maintenance (all program) policy and system training</li> <li>• ODM hosts monthly webinars with all 88 counties. covering policy updates, training material, and general guidance or instruction on recent changes and issues.</li> <li>• ODM and JFS host quarterly webinars to discuss training topics affecting multiple programs.</li> <li>• For each major system release or system enhancement that impacts the end user, updated training materials are produced and disseminated. County partners provide regular feedback to ODM on Ohio Benefits which assists ODM in identifying system issues and providing prompt workarounds or fixes. . I</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce enrollment without making eligibility requirements more restrictive (D)</li> <li>• Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)</li> </ul>

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
<p><b>Securing Third-Party Vendor for Unwinding from PHE</b>  The COVID-19 public health emergency granted states additional Medicaid funding but required that individuals not be disenrolled except in limited circumstances. HB 110 required ODM to procure a vendor to identify those likely ineligible in our program once the public health emergency is declared over to reduce caseload post-pandemic as quickly as possible.</p>	<ul style="list-style-type: none"> <li>• ODM procured Public Consulting Group (PCG) within the required timeline to identify those likely ineligible and connect to the statutorily required databases.</li> <li>• ODM provided county caseworkers lists of those likely ineligible by PCG to work through the unwinding All cases were processed in accordance with federal and state requirements. Results were audited and found to be highly accurate and efficient.</li> <li>• Caseload was reduced by approximately 500,000 members.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce enrollment without making eligibility requirements more restrictive (D)</li> <li>• Implements fraud and abuse prevention and cost avoidance mechanisms (B)(2)(e)</li> </ul>
<p><b><u>Risk Corridor</u></b>  A <b>Medicaid Managed Care Risk Corridor</b> is a financial mechanism used to limit the financial risk for managed care organizations (MCOs). The risk corridor helps balance the financial outcomes between the MCOs and the state government, sharing the risk of unexpected high or low healthcare costs. The following tools constitute the corridor:</p> <ol style="list-style-type: none"> <li>1. <b>Risk Sharing Tiers Upper Corridor (Profit Limit)</b></li> <li>2. <b>Lower Corridor (Loss Limit)</b></li> <li>3.</li> </ol>	<ul style="list-style-type: none"> <li>• The risk corridor ensures recovery for the state to limit exposure to dramatic reductions in service utilization.</li> <li>• This risk corridor ended in July 2022 for Medicaid managed care and December 2022 for MyCare.</li> <li>• In April of 2022, ODM recovered \$569 million from the rates issued in CY2020</li> <li>• As of March 2023, an additional estimated \$36 million from CY2021 rates will be repaid in CY2024.</li> <li>• In fall 2024, an estimated \$151 million from CY2022 rates will be repaid.</li> </ul>	<ul style="list-style-type: none"> <li>• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> <li>• Implement policies with evidence-based strategies that include measurable goals (C)</li> </ul>

Initiative	Initiative Overview	ORC 5162.70 Cost Containment Legislative Requirements Fulfilled
<p><b>Medical Loss Ratio</b> As part of the actuarial rate setting process, a specified medical loss ratio (MLR) is included in the managed care capitation rates. Annually the MLR is reported by the managed care plans, reviewed, and submitted to CMS.</p>	<ul style="list-style-type: none"> <li>• In the event that a MLR is significantly lower than the MLR included in the rates, ODM may recoup dollars from the managed care plans.</li> <li>• Annually, before the next calendar rating period, MLRs are assessed and reported. The next MLR for CY2022 and CY2023 will occur in fall 2024.</li> </ul>	<ul style="list-style-type: none"> <li>• Allows medicaid recipients to receive services in the most cost-effective and sustainable manner (B)(2)(b)</li> <li>• Encourages value over volume and increasing efficiency and effectiveness (B)(2)(d)</li> </ul>



## **Medicaid Program Expenditure and Utilization Trend Rates**

**October 2024**

Ohio Revised Code (ORC) Section 5162.70 (E) states, "In even-numbered years, the report shall include the department's historical and projected medicaid program expenditure and utilization trend rates by medicaid program and service category for each year of the upcoming fiscal biennium and an explanation of how the trend rates were calculated."

The Ohio Department of Medicaid (ODM) budget forecast is intended to provide an accurate estimate of spending on Medicaid services. The forecast is split into different pieces: caseload, managed care capitation, fee-for-service per member per month PMPM, and the pharmacy benefit (SPBM). The general approach is to break enrollment and services into several categories, thereby creating hundreds of individual forecasts, and rolling these together to create a total forecast. This approach takes into account that there may be deviations in individual forecasts, but the assumption is that many of the deviations are not correlated and will cancel each other out (i.e., PMPM for one forecast may be slightly high while another PMPM may be slightly low). Assumptions and groupings are made with the goal of achieving the best overall forecast. ODM uses base SAS and SAS Forecast Studio to develop budget forecasts.

The caseload forecast is the most important piece of the forecast. ODM subdivides caseload into groups by age, eligibility categories (e.g., ABD, Expansion), institutional/waiver status, and rate cell. Using time series forecasting techniques, historical data, and macroeconomic data and projections from S&P (formerly IHS Markit), models are developed to project caseload. Managed care penetration rate forecasts are also developed. If prospective policy or other changes are known (e.g., a conversion of a population from fee-for-service to managed care) adjustments are made to the models. Thus, individual caseload forecasts are made at fairly detailed levels, such as "Medicare dually eligible, non-institutional individuals between the ages of 19 and 64," and then penetration rates are used to divide the groups into fee-for-service and managed care.

Managed care capitation forecasts are done at the statewide level. Historical data series are used to calculate statewide composite rates for each rate cell, and trend information from ODM's contracted actuary is then applied to the composite rates. As with the caseload forecast, if prospective policy or other changes are known, adjustments are made to the models.

Fee-for-service (FFS) per member per month (PMPM) forecasts are generated using time series forecasting methods that take into account previous policy changes and other significant events. The fee-for-service PMPM forecasts are subdivided at the same level of detail as the caseload forecast. ODM used to perform more granular fee-for-service forecasts, but as the majority of expenditures have shifted to managed care organizations, rolling up fee-for-service categories is expected to yield a more accurate overall forecast.

The SPBM forecast is similar to the FFS forecast. Time series forecasting methods that take into account previous policy changes and other significant events are utilized.

The individual caseload forecasts are multiplied by the individual per member per month managed care and fee-for-service expenditure forecasts to create a total Medicaid forecast.

ODM does not produce forecasts at the individual provider type or claim type level for payments to providers. Historic trends at the provider type and other levels are considered when forecasts are developed.

This report includes a series of tables reflecting the ODM budget forecast and Medicaid utilization and expenditures.<sup>1</sup> These tables include:

- I. **Forecast by Medicaid Program** - shows historic and projected expenditures and caseload by categories shown on the Budget Variance Report by state fiscal year (claims and capitation payment only; excludes DODD). The trend rates were calculated as the year-over-year change.
- II. **Forecast by Eligibility Group** - shows historic and projected expenditures and caseload by major eligibility categories by state fiscal year. The trend rates were calculated as the year-over-year change.
- III. **Forecast by Per Member Per Month** – shows historic and projected per member per month expenditures by major eligibility groups by state fiscal year (claims and capitation payment only; excludes DODD). The trend rates were calculated as the year-over-year change.
- IV. **Medicaid Utilization and Expenditures** - shows historic expenditures and utilization rates by service categories (grouped by pay-to-provider based on claims and encounters) by calendar year view.

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<sup>1</sup> For full detail on program and policy changes, please see “Notable Medicaid Policy Changes, SFY22 through SFY25”, sent to JMOC in June 2024. Several notable policy changes reflected in tables in this report include:

- Eligibility
  - Federally required continuous coverage requirement ended March 31<sup>st</sup>, 2023
- Next Generation
  - OhioRISE began enrollment and providing services on July 1<sup>st</sup>, 2022
  - SPBM began on October 1<sup>st</sup>, 2022
  - Next Generation Managed Care began on February 1<sup>st</sup>, 2023
- Rate Increases
  - Dispensing fee increase (managed care September 1<sup>st</sup>, 2023; FFS January 1<sup>st</sup>, 2024)
  - Behavioral health provider rate increases on January 1<sup>st</sup>, 2024
  - Non-institutional provider rate increases on January 1<sup>st</sup>, 2024
  - Hospital rate increase on January 1<sup>st</sup>, 2024
  - HCBS provider rate increases on January 1<sup>st</sup>, 2024
  - NF private room increases begin December 18<sup>th</sup>, 2024

## I. Forecast by Medicaid Program by SFY

### Estimated Incurred Cost by SFY - Excludes DODD (Claims Plus Capitation Payments Before Withhold)

	2022	2023	2024	2025	2026	2027
Fee For Service (No DODD)	\$4,082,167,037	\$4,727,660,855	\$5,014,144,825	\$5,493,809,284	\$5,764,646,427	\$5,965,370,696
Managed Care - ADFC	\$302,555,694	\$199,110,057	\$195,909,217	\$211,041,512	\$231,639,270	\$252,220,578
Managed Care - CFC	\$7,648,965,081	\$6,728,559,898	\$6,241,365,948	\$6,254,476,659	\$6,718,324,802	\$7,149,748,629
Managed Care - Delivery	\$285,091,520	\$299,678,051	\$313,809,605	\$319,818,478	\$333,514,933	\$345,545,910
Managed Care - MyCare	\$2,886,937,035	\$2,982,920,102	\$3,326,463,667	\$3,624,356,689	\$3,768,265,457	\$3,923,687,091
Managed Care -ABD Adult	\$3,029,585,959	\$2,366,467,240	\$2,098,913,738	\$2,163,717,420	\$2,290,379,712	\$2,415,634,515
Managed Care -ABD Kids	\$715,525,738	\$546,015,078	\$523,366,362	\$560,147,287	\$610,826,270	\$657,126,682
Managed Care Group VIII	\$7,180,444,618	\$6,573,751,846	\$5,834,985,048	\$5,616,450,213	\$5,916,785,855	\$6,241,252,335
Managed Care -OhioRISE		\$259,440,275	\$477,301,835	\$648,422,531	\$712,143,959	\$778,565,362
SPBM		\$3,902,070,754	\$5,463,387,549	\$5,624,732,770	\$5,960,785,843	\$6,339,710,285
<b>Total</b>	<b>\$26,131,272,684</b>	<b>\$28,585,674,157</b>	<b>\$29,489,647,795</b>	<b>\$30,516,972,843</b>	<b>\$32,307,312,529</b>	<b>\$34,068,862,084</b>

### Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
Fee For Service (No DODD)	15.8%	6.1%	9.6%	4.9%	3.5%
Managed Care - ADFC	-34.2%	-1.6%	7.7%	9.8%	8.9%
Managed Care - CFC	-12.0%	-7.2%	0.2%	7.4%	6.4%
Managed Care - Delivery	5.1%	4.7%	1.9%	4.3%	3.6%
Managed Care - MyCare	3.3%	11.5%	9.0%	4.0%	4.1%
Managed Care -ABD Adult	-21.9%	-11.3%	3.1%	5.9%	5.5%
Managed Care -ABD Kids	-23.7%	-4.1%	7.0%	9.0%	7.6%
Managed Care Group VIII	-8.4%	-11.2%	-3.7%	5.3%	5.5%
Managed Care -OhioRISE		84.0%	35.9%	9.8%	9.3%
SPBM		40.0%	3.0%	6.0%	6.4%
	<b>9.4%</b>	<b>3.2%</b>	<b>3.5%</b>	<b>5.9%</b>	<b>5.5%</b>

## II. Forecast by Eligibility Group by SFY

### Estimated Incurred Cost by SFY - Excludes DODD (Claims Plus Capitation Payments Before Withhold)

	2022	2023	2024	2025	2026	2027
ABD ADULT	\$4,575,196,570	\$4,879,799,278	\$5,208,729,684	\$5,601,563,094	\$5,951,961,697	\$6,316,306,498
ABD KIDS	\$791,328,925	\$811,367,556	\$878,733,482	\$980,435,761	\$1,061,880,951	\$1,143,176,676
CFC ADULT	\$3,888,593,308	\$4,308,850,846	\$4,191,667,868	\$4,138,393,010	\$4,385,796,463	\$4,608,517,045
CFC KIDS	\$4,727,985,060	\$4,848,765,133	\$5,066,708,678	\$5,402,686,792	\$5,852,247,209	\$6,266,256,862
DUAL	\$4,472,759,740	\$4,699,477,028	\$5,487,385,105	\$5,905,191,352	\$6,098,701,302	\$6,291,379,164
GROUP VIII	\$7,584,902,007	\$8,950,182,432	\$8,546,632,964	\$8,357,506,507	\$8,814,804,855	\$9,290,386,434
OTHERS	\$90,507,073	\$87,231,886	\$109,790,014	\$131,196,326	\$141,920,051	\$152,839,405
<b>Total</b>	<b>\$26,131,272,684</b>	<b>\$28,585,674,157</b>	<b>\$29,489,647,795</b>	<b>\$30,516,972,843</b>	<b>\$32,307,312,529</b>	<b>\$34,068,862,084</b>

### Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
ABD ADULT	6.7%	6.7%	7.5%	6.3%	6.1%
ABD KIDS	2.5%	8.3%	11.6%	8.3%	7.7%
CFC ADULT	10.8%	-2.7%	-1.3%	6.0%	5.1%
CFC KIDS	2.6%	4.5%	6.6%	8.3%	7.1%
DUAL	5.1%	16.8%	7.6%	3.3%	3.2%
GROUP VIII	18.0%	-4.5%	-2.2%	5.5%	5.4%
OTHERS	-3.6%	25.9%	19.5%	8.2%	7.7%
	<b>9.4%</b>	<b>3.2%</b>	<b>3.5%</b>	<b>5.9%</b>	<b>5.5%</b>

**Estimated Enrollment by SFY (Member Months)**

	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>	<b>2027</b>
ABD ADULT	2,329,411	2,353,698	2,312,337	2,300,212	2,328,201	2,356,251
ABD KIDS	617,020	623,493	620,229	621,142	624,444	627,741
CFC ADULT	6,833,241	7,207,741	6,265,175	5,554,149	5,585,771	5,585,827
CFC KIDS	15,107,732	15,597,096	14,619,143	14,087,731	14,103,343	14,105,208
DUAL	3,040,559	3,160,304	3,113,641	3,086,890	3,124,555	3,160,592
GROUP VIII	10,270,602	11,494,550	10,318,215	9,366,729	9,353,636	9,355,456
OTHERS	1,685,549	1,679,011	1,637,096	1,722,806	1,808,775	1,894,754
<b>Total</b>	<b>39,884,114</b>	<b>42,115,893</b>	<b>38,885,836</b>	<b>36,739,659</b>	<b>36,928,725</b>	<b>37,085,829</b>

**Year Over Year Percent Change (SFY)**

	<b>2023 / 2022</b>	<b>2024 / 2023</b>	<b>2025 / 2024</b>	<b>2026 / 2025</b>	<b>2027 / 2026</b>
ABD ADULT	1.0%	-1.8%	-0.5%	1.2%	1.2%
ABD KIDS	1.0%	-0.5%	0.1%	0.5%	0.5%
CFC ADULT	5.5%	-13.1%	-11.3%	0.6%	0.0%
CFC KIDS	3.2%	-6.3%	-3.6%	0.1%	0.0%
DUAL	3.9%	-1.5%	-0.9%	1.2%	1.2%
GROUP VIII	11.9%	-10.2%	-9.2%	-0.1%	0.0%
OTHERS	-0.4%	-2.5%	5.2%	5.0%	4.8%
	<b>5.6%</b>	<b>-7.7%</b>	<b>-5.5%</b>	<b>0.5%</b>	<b>0.4%</b>

**Estimated Enrollment by SFY (Average Monthly Enrollment)**

	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>	<b>2026</b>	<b>2027</b>
ABD ADULT	194,118	196,142	192,695	191,684	194,017	196,354
ABD KIDS	51,418	51,958	51,686	51,762	52,037	52,312
CFC ADULT	569,437	600,645	522,098	462,846	465,481	465,486
CFC KIDS	1,258,978	1,299,758	1,218,262	1,173,978	1,175,279	1,175,434
DUAL	253,380	263,359	259,470	257,241	260,380	263,383
GROUP VIII	855,884	957,879	859,851	780,561	779,470	779,621
OTHERS	140,462	139,918	136,425	143,567	150,731	157,896
<b>Total</b>	<b>3,323,676</b>	<b>3,509,658</b>	<b>3,240,486</b>	<b>3,061,638</b>	<b>3,077,394</b>	<b>3,090,486</b>

**Year Over Year Percent Change (SFY)**

	<b>2023 / 2022</b>	<b>2024 / 2023</b>	<b>2025 / 2024</b>	<b>2026 / 2025</b>	<b>2027 / 2026</b>
ABD ADULT	1.0%	-1.8%	-0.5%	1.2%	1.2%
ABD KIDS	1.0%	-0.5%	0.1%	0.5%	0.5%
CFC ADULT	5.5%	-13.1%	-11.3%	0.6%	0.0%
CFC KIDS	3.2%	-6.3%	-3.6%	0.1%	0.0%
DUAL	3.9%	-1.5%	-0.9%	1.2%	1.2%
GROUP VIII	11.9%	-10.2%	-9.2%	-0.1%	0.0%
OTHERS	-0.4%	-2.5%	5.2%	5.0%	4.8%
	<b>5.6%</b>	<b>-7.7%</b>	<b>-5.5%</b>	<b>0.5%</b>	<b>0.4%</b>

### III. Forecast by Per Member Per Month by SFY

#### Estimated Incurred PMPM by SFY - Excludes DODD (Claims Plus Capitation Payments Before Withhold)

	2022	2023	2024	2025	2026	2027
ABD ADULT	\$1,964.10	\$2,073.25	\$2,252.58	\$2,435.24	\$2,556.46	\$2,680.66
ABD KIDS	\$1,282.50	\$1,301.33	\$1,416.79	\$1,578.44	\$1,700.52	\$1,821.10
CFC ADULT	\$569.07	\$597.81	\$669.04	\$745.10	\$785.17	\$825.04
CFC KIDS	\$312.95	\$310.88	\$346.58	\$383.50	\$414.95	\$444.25
DUAL	\$1,471.03	\$1,487.03	\$1,762.37	\$1,912.99	\$1,951.86	\$1,990.57
GROUP VIII	\$738.51	\$778.65	\$828.31	\$892.25	\$942.39	\$993.04
OTHERS	\$53.70	\$51.95	\$67.06	\$76.15	\$78.46	\$80.66
<b>Total</b>	<b>\$655.18</b>	<b>\$678.74</b>	<b>\$758.36</b>	<b>\$830.63</b>	<b>\$874.86</b>	<b>\$918.65</b>

#### Year Over Year Percent Change (SFY)

	2023 / 2022	2024 / 2023	2025 / 2024	2026 / 2025	2027 / 2026
ABD ADULT	5.6%	8.6%	8.1%	5.0%	4.9%
ABD KIDS	1.5%	8.9%	11.4%	7.7%	7.1%
CFC ADULT	5.1%	11.9%	11.4%	5.4%	5.1%
CFC KIDS	-0.7%	11.5%	10.7%	8.2%	7.1%
DUAL	1.1%	18.5%	8.5%	2.0%	2.0%
GROUP VIII	5.4%	6.4%	7.7%	5.6%	5.4%
OTHERS	-3.2%	29.1%	13.6%	3.0%	2.8%
	<b>3.6%</b>	<b>11.7%</b>	<b>9.5%</b>	<b>5.3%</b>	<b>5.0%</b>

#### IV. Medicaid Utilization and Expenditures

Provider Type Group <sup>1</sup>	CY 2022			CY 2023			CY 2024 TD <sup>2</sup>		
	Paid Amount	Unique Patient Count	Claim Count	Paid Amount	Unique Patient Count	Claim Count	Paid Amount	Unique Patient Count	Claim Count
ASC	\$42,177,097	50,399	77,423	\$42,041,669	47,974	70,720	\$21,760,411	23,639	32,337
Ambulance	\$106,298,674	283,000	768,233	\$102,176,687	260,736	636,067	\$59,725,434	115,234	243,546
Behavioral Health	\$1,950,331,707	523,439	17,868,304	\$2,101,491,403	541,654	18,426,842	\$1,221,612,453	411,957	9,324,115
DME / Lab	\$518,008,673	962,635	4,728,963	\$531,919,856	969,072	4,781,663	\$246,403,351	606,378	2,264,759
Dental	\$230,568,920	757,122	1,556,261	\$199,994,418	685,145	1,299,898	\$211,873,930	445,177	726,492
Hospice	\$287,181,604	18,306	78,705	\$326,707,451	18,079	80,354	\$149,613,720	10,285	35,076
Hospital	\$7,455,673,158	2,268,650	14,306,466	\$7,281,450,279	2,279,897	13,921,439	\$3,564,568,863	1,574,142	6,580,918
ICF	\$759,502,898	5,361	83,883	\$833,100,973	5,331	61,321	\$450,570,574	5,054	30,805
Medicaid Schools Prg	\$50,300,489	91,456	1,784,196	\$48,927,788	88,981	1,778,880	\$20,041,952	61,963	794,235
NF	\$3,028,929,055	79,148	744,851	\$3,085,526,362	78,019	623,315	\$1,888,573,549	59,395	351,918
Other	\$399,001,252	909,606	4,207,460	\$390,445,950	623,924	3,168,722	\$217,394,846	451,611	1,919,759
Physician, etc	\$2,033,879,653	2,679,119	31,193,586	\$2,119,291,283	2,748,909	30,508,145	\$1,065,761,173	2,074,349	14,197,998
Renal	\$206,952,316	11,406	239,825	\$149,840,005	10,622	169,015	\$73,653,845	8,303	57,892
Rx	\$6,142,330,924	2,308,831	53,551,853	\$6,295,048,444	2,387,034	50,605,231	\$3,644,489,564	1,911,986	28,292,454
Vision	\$36,702,278	412,991	624,067	\$20,571,822	281,058	395,889	\$6,732,232	105,155	129,508
Waiver HH/PDN	\$3,879,825,505	168,639	28,034,741	\$4,136,359,157	179,831	29,725,234	\$2,806,387,170	153,063	15,098,512
Wheelchair Van	\$6,151,933	6,013	69,557	\$6,365,099	6,752	68,984	\$4,168,772	3,943	34,874
<b>All Medicaid</b>	<b>\$27,133,816,143</b>	<b>3,111,496</b>	<b>159,918,374</b>	<b>\$27,671,258,652</b>	<b>3,173,443</b>	<b>156,321,719</b>	<b>\$15,653,331,838</b>	<b>2,586,145</b>	<b>80,115,198</b>

<sup>1</sup>Abbreviations: Ambulatory Surgery Center (ASC); Durable Medical Equipment (DME); Medicaid Schools Program (Medicaid Schools Prg); Nursing Facility (NF), Pharmacy (Rx), Home Health/Private Duty Nursing (HH/PDN)

<sup>2</sup>Data received and loaded in ODM EDW through 8/26/2024. To date, CY 2024 is consistent with previous year trends given claim submission patterns and decreasing caseload.

Provider Type Group <sup>1</sup>	CY 2022		CY 2023		CY 2024 TD <sup>2</sup>	
	Expenditures/ Patient	Expenditures/ Claim	Expenditures/ Patient	Expenditures/ Claim	Expenditures/ Patient	Expenditures/ Claim
ASC	\$836.86	\$544.76	\$876.34	\$594.48	\$920.53	\$672.93
Ambulance	\$375.61	\$138.37	\$391.88	\$160.64	\$518.30	\$245.23
Behavioral Health	\$3,726.00	\$109.15	\$3,879.77	\$114.05	\$2,965.39	\$131.02
DME / Lab	\$538.12	\$109.54	\$548.90	\$111.24	\$406.35	\$108.80
Dental	\$304.53	\$148.16	\$291.90	\$153.85	\$475.93	\$291.64
Hospice	\$15,687.84	\$3,648.84	\$18,071.10	\$4,065.85	\$14,546.79	\$4,265.42
Hospital	\$3,286.39	\$521.14	\$3,193.76	\$523.04	\$2,264.45	\$541.65
ICF	\$141,671.87	\$9,054.31	\$156,274.80	\$13,585.90	\$89,151.28	\$14,626.54
Medicaid Schools Prg	\$550.00	\$28.19	\$549.87	\$27.50	\$323.45	\$25.23
NF	\$38,269.18	\$4,066.49	\$39,548.40	\$4,950.19	\$31,796.84	\$5,366.52
Other	\$438.65	\$94.83	\$625.79	\$123.22	\$481.38	\$113.24
Physician, etc	\$759.16	\$65.20	\$770.96	\$69.47	\$513.78	\$75.06
Renal	\$18,144.16	\$862.93	\$14,106.57	\$886.55	\$8,870.75	\$1,272.26
Rx	\$2,660.36	\$114.70	\$2,637.18	\$124.40	\$1,906.13	\$128.81
Vision	\$88.87	\$58.81	\$73.19	\$51.96	\$64.02	\$51.98
Waiver HH/PDN	\$23,006.69	\$138.39	\$23,001.37	\$139.15	\$18,334.85	\$185.87
Wheelchair Van	\$1,023.11	\$88.44	\$942.70	\$92.27	\$1,057.26	\$119.54
<b>All Medicaid</b>	<b>\$8,720.50</b>	<b>\$169.67</b>	<b>\$8,719.63</b>	<b>\$177.01</b>	<b>\$6,052.77</b>	<b>\$195.39</b>

<sup>1</sup>Abbreviations: Ambulatory Surgery Center (ASC); Durable Medical Equipment (DME); Medicaid Schools Program (Medicaid Schools Prg); Nursing Facility (NF), Pharmacy (Rx), Home Health/Private Duty Nursing (HH/PDN)

<sup>2</sup>Data received and loaded in ODM EDW through 8/26/2024. To date, CY 2024 is consistent with previous year trends given claim submission patterns and decreasing caseload.