Joint Medicaid Oversight Committee: Medicaid Budget Update

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On March 24th, the Joint Medicaid Oversight Committee (JMOC) received a Medicaid budget **update** from JMOC's Executive Director Susan Ackerman and Policy Aide Gregory Craig. The update included a review of trends in enrollment and spending as well as a review of major policy initiatives in Ohio and across the nation. In part, this update sought to lay the groundwork for future Medicaid policy discussions in the next biennial budget. The major takeaway from the meeting was that Medicaid spending came in at $1.1 billion under initial budget estimates. The spending reduction was driven by a few key factors including structural aspects of how Medicaid dollars are spent, changes in caseloads, and reductions in Managed Care rates.

The most notable structural influence came from delayed payment in the Hospital Care Assurance Program (HCAP), Ohio's Disproportionate Share Hospital (DSH) payment program. For background, **HCAP** provides regularly scheduled payments to hospitals that serve a large number of Medicaid and uninsured individuals. If this payment was made on time, Medicaid underspending would have been $816 million. Underspending also took place in administration through a delay in payment for **Ohio's Integrated Eligibility System** vendor and a delay in **Health Information Technology incentive payments**. Mr. Craig underscored these points to highlight the importance of looking at monthly expenditures in the context of a given fiscal year.

In addition to these structural issues, the influence of caseload shift, especially the shift resulting from Medicaid expansion, drove underspending. The presentation demonstrated that fee-for-service payments to hospitals, and Managed Care payments for the adults and children in the Aged, Blind and Disabled (ABD) populations, are under budget because more individuals are now eligible through the Medicaid expansion. This shift includes other categorical groups, such as the **Family Planning** group, which saw a reduction of 120,000 individuals. Interestingly, while

caseload estimates for the expansion population have outpaced estimates since inception, enrollment has leveled off and, as of January, spending is below estimates for the first time since Ohio expanded Medicaid. Director Ackerman later explained how Ohio's experience is consistent with actuarial information from the Center for Medicare and Medicaid Services (CMS) which shows how per capita spending for expansion populations levels-off over time.

Another underspending trend came from a reduction in the rates for Managed Care. This part of the presentation was the subject of a number of questions from the JMOC Committee members, particularly in regards to the following slide:

MCP Rates: Decline in Most Categories

Traditional	CY 2015	CY 2016	Change
CFC	$257	$253	-1.6%
ABD <21	$740	$739	-0.2%
ABD >21	$1,359	$1,448	6.6%
Expansion	$553	$529	-4.4%
Delivery	$6,354	$5,669	-10.8%
Average	**$402**	**$395**	**-1.6%**
My Care			
Opt In	$1,897	$1,662	-12.4%
Opt Out	$2,620	$2,704	3.2%

Table shows composite rates based on statewide averages

While the reduction in rates represents a change in $334 million all funds to Managed Care, Senator Burke, Chair of the Senate Medicaid Committee, was surprised that the underspending for Managed Care was not as large a number as he would've expected. Director Ackerman explained that the new rates for 2016 had not yet started and would need more time to realize savings. She also highlighted that the expansion population rates now reflect a population with a higher mix of healthier, lower acuity patients as opposed to what had been previously projected when expansion began. As such, any savings would likely only take place after additional experience.

The Director then fielded questions about the trends in the MyCare Ohio program and prescription drug costs. In regards to MyCare, she explained that many individuals with chronic health problems, mostly those living in nursing facilities, have opted out of Medicare Managed Care, explaining the higher number in the "opt out" category.

Conversely, the significant drop in "opt in" rates reflects the recent budget policy establishing the maximum amount of reimbursement at Medicaid rates, which are historically much lower than Medicare rates. Additionally, prescription drug costs have increased across the board, **reflecting a national trend**. Generally speaking, higher pharmacy prices drove the increases in rates for the nearly 108,000 people in the ABD adult population, who tend to have greater pharmacy needs.

Director Ackerman rounded out the presentation with an overview of cost containment efforts by Ohio and across the nation. This included a review of Ohio's work in the State Innovation Model (SIM), the behavioral health redesign, and other key initiatives of the Office of Health Transformation (OHT) and Ohio Department of Medicaid (ODM). Finally, the Director highlighted key dates for the Committee's work, including the required establishment of the JMOC per member per month limit (PMPM) through an actuarial report (due September 25th) and a final JMOC report (due October 25th). As opposed to the last biennial report, which had two iterations based on data constraints, there will only be one report for the upcoming budget. Importantly, this report will exclude certain one-time spending items (e.g. HCAP) and administrative expenses. Senator Burke stated that the next few meetings were critical to the work of JMOC as they try to develop budget policy given the handful of meetings before the reports will be complete.

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