

Public Assistance Expenditures

Health Care/Medicaid

Overview

The Office of Ohio Health Plans in the Ohio Department of Job and Family Services (ODJFS) operates several state and federally funded programs providing health care coverage to certain low-income and medically vulnerable people of all ages: Medicaid, the State Children's Health Insurance Program (SCHIP, created by the Social Security Act as Title XXI), the Hospital Care Assurance Program (HCAP, also created by the Social Security Act as Title XXI), and the state Disability Medical Assistance (DMA) program.

Medicaid, the largest health program in Ohio, was created by the Social Security Act as Title XIX, and became law in 1965. Medicaid is an entitlement program and is a state-federal partnership, which jointly funds the provision of adequate medical care to eligible needy persons. In this partnership, the federal government establishes broad national guidelines, and each state determines its own eligibility requirements and scope of services, sets payment rates for services, and administers its program.

SCHIP allows Ohio to provide health care coverage to uninsured children whose family income is below 200% of the federal poverty guideline (FPG). Through HCAP, hospitals are reimbursed for some of their costs of providing medical care to persons below 100% of the FPG. The DMA program is state funded and provides limited medical coverage to persons who are not eligible for a federally funded program.

In Ohio, Medicaid and SCHIP provided health care coverage to slightly over 1.7 million Ohioans every month in fiscal year (FY) 2006. These programs apply to people in the following four distinct insurance markets: children in families with incomes at or below 200% of the FPG; pregnant women with incomes at or below 150% of the FPG; parents at or below 90% of the FPG; and low-income elderly and persons with disabilities of all ages, commonly referred to as Aged, Blind, and Disabled (ABD). Many consumers with disabilities have medical needs so extensive that commercial plans would deem them "uninsurable."

Even though Medicare provides coverage for most of Ohio's elderly population, many of these individuals are "dually eligible," and Medicaid supplements their Medicare benefits by providing Medicaid coverage for services such as prescription medications and long-term care. Medicaid also provides assistance with Medicare premiums, copayments, and deductibles to certain low-income seniors.

Although other state agencies provide Medicaid services, the majority of Medicaid spending occurs within the budget of ODJFS. Recognized by the federal government as Ohio's single Medicaid agency, ODJFS provides long-term care and basic medical services with state and federal moneys through GRF line item 600-525, Health Care/Medicaid. In addition to the funding from the GRF, several provider tax programs and other special revenues are used to pay for Medicaid services.⁶

The federal financial share of Ohio's Medicaid program changes every federal fiscal year. In accordance with federal law, the federal government shares in the states' cost of Medicaid at a matching rate known as the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated for each state based upon the state's per capita income in recent years relative to the entire nation. The general description of how this cost-sharing mechanism works has traditionally been as follows: for every one dollar Ohio spends on Medicaid, the federal government gives Ohio 59 cents. However, while the majority of the spending in line item 600-525, Health Care/Medicaid, is reimbursed at the FMAP, a few items, primarily contracts, are reimbursed at 50%, and all family planning services are reimbursed at 90%. In addition, the State Children's Health Insurance Program is reimbursed at an enhanced FMAP of about 71%.

Forecast Summary

The total number of persons eligible for Medicaid grew by 2.5% from 1,686,670 in FY 2005 to 1,729,103 in FY 2006. The total number of eligibles is estimated to reach 1,741,065 in FY 2007, a 0.7% increase over FY 2006. LSC forecasts that the number of persons eligible for Medicaid will decline to 1,724,593 in FY 2008, a 0.9% decrease, before falling to 1,684,897 in FY 2009, a 2.3% decrease.

Spending within the 525 line item can generally be placed into one of the following major categories: long-term care (nursing facilities, or NFs, and Intermediate Care Facilities for the Mentally Retarded, or ICFs/MR), hospitals (inpatient and outpatient), physician services, prescription drugs, managed care plans (MCP), Medicare buy-in, waiver, and all other care.

LSC projects an increase in health care expenditures in FY 2008 of 3.1%, or \$326 million, in combined state and federal dollars, with a state share increase of \$130 million. For FY 2009, LSC projects total health care expenditures will go up by

⁶ Provider tax programs refer to assessments on hospitals and managed care providers, as well as bed taxes on nursing facilities and intermediate care facilities for the mentally retarded. The programs serve as a mechanism by which to draw additional federal reimbursement. Other special revenues include funds for the Disproportionate Share Hospital (DSH) offset and drug rebates.

another 4.5%, or \$495 million, in combined state and federal dollars, with a state share increase of \$197 million.

Eligibility

While individuals can become eligible for Medicaid programs that are funded out of the 525 line item by meeting any one of many sets of eligibility criteria, all of these various eligibility groups can be categorized into seven major types: (1) Aged, Blind, and Disabled (ABD), (2) Qualified Medicare Beneficiaries (QMBs), (3) Specified Low-Income Medicare Beneficiaries (SLMBs), (4) Healthy Families (HF), (5) Healthy Start (HS), (6) uninsured children in families with incomes at or below 150% of the FPG known as CHIP-I, and (7) uninsured children in families with incomes between 150% and 200% of the FPG known as CHIP-II. Generally, Healthy Families, Healthy Start, CHIP-I, and CHIP-II are grouped as Covered Families and Children (CFC). Each of these groups will be discussed briefly in turn.

ABD. The ABD eligibility group is loosely based on the Supplemental Security Income (SSI) program. Although SSI eligibility generally leads to Medicaid eligibility in most states, Ohio and 11 other states exercise what is known as the "spend-down" option. In other words, Ohio has opted to use a more restrictive income test than that incorporated in the eligibility guidelines of the SSI program (100% of the FPG); however, once individuals who do not meet the initial ABD income test spend an amount on medical care such that their income after medical expenses is at or below the more restrictive ABD income level of about 63% of the FPG, they "spend-down" to Medicaid eligibility for the month. This allows individuals who have expensive medical needs, but who may have incomes over the SSI level, to receive Medicaid coverage for the remainder of the month.

The ABD eligibility group is the most costly of the seven groups. Not only do ABD eligibles generate more costly acute care services than the other groups, almost all of the Medicaid long-term care recipients come from the ABD eligibility group.

QMBs and SLMBs. The following two eligibility groups, Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs), are created by a federal mandate that states' Medicaid programs must "buy-in" to Medicare coverage for certain individuals. QMBs have incomes below 100% of the FPG, and Medicaid must pay for their Medicare premiums, copayments, and deductibles.⁷ For SLMBs, Medicaid covers the Medicare Part B premiums only for those with incomes

⁷ The QMB grouping in the eligibility table refers only to those QMB individuals who do not "spend-down" to ABD eligibility. Because many individuals who are initially eligible for Medicaid through the QMB program spend-down to ABD eligibility during the month, the reported QMB population is understated.

between 100% and 120% of the FPG. Premiums for both of these eligibility groups (and for Medicare-eligible ABD eligibles for whom the state chooses to buy-in to Medicare)⁸ are reflected in the Medicare buy-in service category. The copayments and deductibles of QMBs are reflected in the appropriate service categories, which Medicare covers.

Healthy Start. Children up to age 19 and pregnant women, whose families' incomes are below 150% of the FPG, are Medicaid eligible through the Healthy Start program.

Healthy Families. Apart from Healthy Start eligibles, Medicaid provides health care to other families and children. Prior to the enactment of the federal Personal Responsibility and Work Opportunity Act of 1996, which created the TANF program (implemented in Ohio as Ohio Works First) to provide income maintenance services to low-income families, recipients of Aid to Dependent Children (ADC) were automatically eligible for Medicaid. Although TANF severs the link between cash assistance and Medicaid eligibility, a provision of the federal law requires states to provide Medicaid coverage to families who meet guidelines for ADC eligibility as they were on July 16, 1996. In fact, federal law mandates that eligibility for a state's Medicaid program cannot be more restrictive than the ADC guidelines that existed in each state on July 16, 1996. "Ohio has designed OWF and made the allowable modifications to the July 1996 ADC plan in order to meet Ohio's goal that all OWF cash assistance recipients also automatically receive Medicaid. In addition, in some instances where OWF is more restrictive than the July 1996 ADC rules, individuals who will not be eligible to receive cash will be eligible for Medicaid under the Low-Income Families group which uses the July 1996 ADC policy."⁹ These Low-Income Families, who would have previously received cash assistance, continue to grow as a subset of an eligibility group referred to as Healthy Families.

In addition to individuals who meet eligibility guidelines for 1996 ADC cash assistance, Medicaid eligibility is given to individuals who no longer meet ADC eligibility guidelines due to increased income, but previously received OWF cash assistance. Transitional Medicaid eligibles receive an additional six months of health care coverage that can be extended for an additional six months if monthly income is less than or equal to 185% of the FPG. Families whose incomes exceed ADC guidelines due to the collection, or increased collection, of child or spousal support payments receive

⁸ Under Medicare, eligibility is not limited to age alone. Eligibility is also based on work history (individual's payroll deductions while they were working, similar to Social Security qualifications). Ohio's Medicaid program allows a buy-in into Medicare for Medicaid eligibles who do not have the necessary work history, for example, to qualify for Medicare and purchases Medicare hospital coverage.

⁹ Source: *Ohio Medicaid Report*, December 1998, Ohio Department of Human Services.

Medicaid coverage for four months and are referred to as Extended Medicaid. As a subset of Extended Medicaid, coverage is provided to individuals eligible for Title IV-E foster care and other miscellaneous groups.

CHIP-I. The Balanced Budget Act of 1997 added a sixth eligibility group to the Medicaid population that Ohio funds out of the 525 line item. The Act created the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act, giving states another option to initiate or expand health care to uninsured low-income children. The program affords states increased flexibility in designing and implementing SCHIP programs and provides states a higher federal reimbursement rate than under the regular Medicaid program. Prior to the passage of the Federal Balanced Budget Act of 1997, which included SCHIP, Ohio included in its biennial budget a children's health insurance expansion for children up to the age of 19 in families at or below 150% of the FPG. Combining the state's initiative with the federal SCHIP opportunity, Ohio submitted an SCHIP State Plan to the Center for Medicare and Medicaid Services (CMS) to implement a Medicaid expansion under SCHIP. CMS approved Ohio's SCHIP State Plan on March 23, 1998—making Ohio the fifth state approved to draw down SCHIP funding. Ohio implemented its Children's Health Insurance Plan (CHIP-I) by expanding Healthy Start, to include Medicaid coverage for low-income children up to age 19 in families at or below 150% of the FPG.

CHIP-II. Am. Sub. H.B. 283 of the 123rd General Assembly, the main appropriations act, appropriated funds for the Children's Health Insurance Plan II (CHIP-II) under Title XXI, for uninsured children under age 19 in families with incomes between 150% and 200% of the FPG. CHIP-II commenced on July 1, 2000.

Caseload Forecast

Total Caseload. The total number of persons eligible for Medicaid grew by 2.5% from 1,686,670 in FY 2005 to 1,729,103 in FY 2006. The total number of eligibles is estimated to reach 1,741,065 in FY 2007, a 0.7% increase over FY 2006. LSC forecasts that the number of persons eligible for Medicaid will decline to 1,724,593 in FY 2008, a 0.9% decrease, before falling to 1,684,897 in FY 2009, a 2.3% decrease.

The last time the Medicaid program had major expansions was in July 2000. At that time, ODJFS implemented two expansions. First, coverage was extended to parents with enrolled children for families with incomes at or below 100% of the FPG under the Healthy Families program. Second, ODJFS rolled out CHIP-II, expanding eligibility to uninsured children from families with incomes between 150% and 200% of the FPG. However, the expansion to parents with enrolled children for families with incomes at or below 100% of the FPG was rolled back to 90% on January 2006. No other program reductions or expansions were implemented during the FY 2006-2007 biennium or the preceding biennium. The forecast assumes that no program reductions or expansions will be implemented during the coming biennium.

Two factors have been primarily responsible for changes in the rate of growth of the Medicaid caseload during FYs 2006 and 2007: overall labor market conditions and the roll back of eligibility for parents mentioned above. Labor market conditions in Ohio have remained weak since the recent recession (which officially ended for the nation as a whole in late 2001), but Ohio employment began to increase again, although not steadily, in late 2003 according to seasonally adjusted data from the U.S. Bureau of Labor Statistics. The combination of improving labor market conditions and the eligibility restriction for parents reduced rates of growth of the Medicaid caseload. Growth in overall caseload, both CFC and ABD, fell from 6.0% in FY 2004¹⁰ to 4.2% in FY 2005 and, 2.5% in FY 2006. LSC expects the overall caseload to grow even more slowly, by 0.7% in FY 2007, before declining in FYs 2008 and 2009.

One additional factor has been affecting caseload since September 2006. Starting that month, the federal government imposed a policy requiring individuals applying (or reapplying) for Medicaid to prove their citizenship. Officials at ODJFS and at OBM indicate that this is the primary reason for the decline in caseload seen since September 2006. Due to this policy change, LSC staff have reduced the forecast caseload growth for the remainder of FY 2007 and increased the forecast caseload growth for the four quarters beginning the second quarter of FY 2008. The latter adjustment is to capture individuals who should be eligible but are having trouble documenting their citizenship; however, these individuals will eventually provide documentation and gain (or regain) eligibility.

Covered Families and Children. LSC forecasts that recent declines in the overall CFC caseload will continue through the biennium. The rate of decline is forecast to decelerate slightly during the first two quarters of FY 2008, then to accelerate again. The rate of decline is predicted to remain below 1% per quarter until the second quarter of FY 2009, at which time the decline is projected to accelerate to over 1% per quarter. This forecast is based on a statistical model of the relationship between the Healthy Families caseload and the unemployment rate. Forecasts of future unemployment rates used for the caseload projections are taken from the winter 2007 economic forecast for Ohio by Global Insight.

Aged, Blind, and Disabled. Growth in the ABD caseload decelerated in FY 2006, but LSC staff believe that the rate of growth will be more stable for the coming biennium. Those eligible due to disability are the largest single subcategory within the ABD category of eligibility. The Social Security Administration forecast acceleration in the number of blind or disabled recipients of federally administered SSI benefits in CY 2006 and again in CY 2007 in its *2006 Annual Report of the Supplemental Security Income Program*. While this forecast is for a national figure, statistical analysis conducted by

¹⁰ That is, the average monthly caseload in FY 2004 was 6.0% higher than the average monthly caseload in FY 2003.

LSC staff indicates that growth in Ohio's blind and disabled caseload is highly correlated with this national data historically. LSC forecasts the number of ABD eligibles to grow by 2.5% from FY 2006 to FY 2007, with growth remaining stable at 2.5% in FY 2008, and then decelerating to 2.3% in FY 2009. The Aged subcategory is projected to increase at average historical rates.

Managed Care. Primary care services include prescription drugs, inpatient hospital services, outpatient hospital services, and physician services. Generally speaking, managed care has been shown to achieve an initial spending reduction of 3% to 5% compared to the traditional fee-for-service model of health care delivery.

Ohio Medicaid has incorporated the use of managed care since 1978. Although Ohio has contracted with managed care plans since the late 1970s to provide care for certain Medicaid eligibles, the use of capitated rates was not given major emphasis in Ohio's program until the state received an 1115 demonstration waiver in January 1995. As one initiative of the federally approved OhioCare proposal, the state was given the freedom to require mandatory managed care enrollment by CFC Medicaid eligibles.

In FY 2004, Medicaid provided health care coverage to approximately 500,000 Ohioans per month through managed care. The Department of Job and Family Services contracted with 6 MCPs that served 15 Ohio counties. MCP membership was mandatory for the CFC population in 4 counties (Cuyahoga, Stark, Lucas, and Summit) and optional in the other 11 (Butler, Clark, Franklin, Greene, Hamilton, Lorain, Montgomery, Pickaway, Warren, and Wood).

H.B. 66 of the 126th General Assembly, the FY 2006-2007 biennial budget act, required the MCP to be implemented in all counties and required ODJFS to designate the CFC population for participation. The bill also required that ODJFS designate the participants not later than January 1, 2006. Not later than December 31, 2006, all designated participants were required to enroll in Medicaid MCPs.

The FY 2006-2007 biennial budget act also required ODJFS to implement the MCPs for certain aged, blind, and disabled Medicaid recipients in all counties. The requirement did not apply to: (1) persons under age 21, (2) institutionalized persons, (3) persons eligible for Medicaid by spend-down, (4) dual eligibles, and (5) Medicaid waiver recipients. Not later than December 31, 2006, all designated participants were required to enroll in Medicaid MCPs.

Prior to the mandated expansions in H.B. 66, Ohio Medicaid MCPs were limited to large metro areas and exclusively focused on the CFC population. The statewide expansion includes rural areas such as Appalachia where access to health care is more difficult. And for the first time, the elderly population is included in managed care. As of February 1, 2007, 1.1 million CFC and 23,662 ABD Medicaid recipients are receiving their health care via participating MCPs. According to ODJFS's February 2007 issue of

the "Medicaid Managed Care Weekly," Ohio's Medicaid managed care expansion is almost complete for the CFC population and is well underway for the ABD population. All participating Medicaid recipients will be enrolled in managed care arrangements by June 2007.

LSC's baseline forecast uses the penetration rates anticipated by ODJFS. Penetration rate is the percentage of managed care recipients of the total population. There are two definitions of "penetration rate." One is the number of managed care recipients divided by total Medicaid recipients. The other is the number of managed care recipients divided by the number of eligibles for managed care. According to both state and federal regulations, managed care enrollment is optional for children receiving adoption assistance under the Federal Title IV-E program, foster care assistance, or out of home placement. In addition, as mentioned above, the managed care expansion only applies to certain aged, blind, and disabled Medicaid recipients. Table 3 shows the penetration rates using the first definition. If ODJFS is to accomplish its plan according to its schedule, the penetration rates will reach about 28% for ABD and almost 90% for CFC in FY 2008. In other words, about 28% of all ABD recipients and almost 90% of all CFC recipients are expected to enroll in a Medicaid MCP during the next biennium. Table 4 shows the penetration rates using the second definition. If ODJFS is to accomplish its plan according to its schedule, the penetration rates will reach 95% for both ABD and CFC in FY 2008. In other words, about 95% of ABD recipients who are eligible for ABD MCPs and 90% of CFC recipients who are eligible for CFC MCPs are expected to enroll in a Medicaid MCP during the next biennium.

Cost Forecast for the Medicaid Program

A key distinction made in forecasting Medicaid expenditures is between "fee-for-service" and "managed care." Medicaid does not directly provide medical services to eligible individuals enrolled in the program. It provides financial reimbursement to health care professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. Traditionally, Medicaid has paid most service providers a set fee for the specific type of service rendered to Medicaid enrollees (termed "fee-for-service" reimbursement). Payments are based on the lowest of the State's fee schedule, the actual charge, or federal Medicare allowances.

An alternative to traditional fee-for-service reimbursement is managed care. A typical managed care plan, called capitated at-risk plans, is one in which the beneficiary receives all care through a single point of entry, and the plan is paid a fixed monthly premium per beneficiary for any health care included in the benefit package, regardless of the amount of services actually used. The beneficiary is responsible for, at most, modest copayments for services; the provider is at risk for the remaining cost of care. A capitated plan can be a network of physicians and clinics, all of whom participate in the plan and also participate in other plans or fee-for-service systems, or it can be one which hires all the physicians who provide all the care required.

In forecasting Medicaid expenditures, the costs of recipients enrolled in managed care plans are generally treated separately from the fee-for-service categories. This practice means that services provided to managed care enrollees are not to be included when forecasting the large fee-for-service categories such as Inpatient Hospital Services and Physician Services. Although the expenditures for managed care were not highest in FY 2006, managed care becomes the biggest factor in forecasting Medicaid expenditures in the upcoming biennium due to the managed care expansions for both the CFC and ABD populations.

LSC staff generates baseline forecasts for major expenditure categories described in the "*Forecast Summary*" section using the "classic expenditure model" suggested by the U.S. Department of Health and Human Services. This classic expenditure model can be characterized as:

$$\text{Expenditures} = \text{Caseload} \times \text{Average Utilization} \times \text{Price}.$$

Consequently, for the typical expenditure category, LSC staff generates a separate forecast for the average number of claims per recipient (corresponding to average utilization) and another separate forecast for average cost per claim submitted (corresponding to price). LSC staff employs two approaches in its forecasts of the average number of claims per recipient and average cost per claim submitted for each expenditure category and its subcategories. The principal method is time series regression models. The other approach utilizes time series forecasting techniques such as simple moving averages and exponential smoothing.

Moving averages predict the next value in a time series based on the average of some finite number of previous observations. Moving averages that count recent values more are weighted moving averages.

Exponential smoothing is a form of a weighted moving average applied to time series data. An exponential smoothing model is a special case of a weighted moving average: the weight for the most recent observation in the time series is the largest, and the other weights decline in size as other observations become more distant in time (declining at a rate resembling an exponential function). In addition, exponential smoothing models can be adjusted to take trends and seasonal effects in the time series data into account. Exponential smoothing forecasts can be very sensitive to the choice of model parameters. Further, the values of these parameters that maximize the fit of the model to the actual data may change over time. Thus, if a statistically significant change in the time series trend is found, then LSC staff would use a regression model that uses time as an independent variable and that explicitly allows for changes in trend. If a statistically significant change in the time series trend is not found, then the moving average approach would be used.

Due to the delayed submissions of claims by providers and delays in processing payments, claims are not always paid in the same month in which services are given to Medicaid eligibles. In fact, it is generally the case that providers are not completely reimbursed for all of the services they give to Medicaid eligibles until well over a year following the date of service. Thus, it is necessary to make the distinction between the date of service and the date of payment.

Because disbursements from the 525 line item reflect the payment of claims and not the provision of services, it is necessary to incorporate the appropriate payment lags when estimating spending from the 525 line item.

In short, forecasting Medicaid spending involves the estimation of the number of Medicaid eligibles in each month. Then it is necessary to estimate the demand each eligibility group will have for each category of service. The next step is to estimate the relevant cost per claim. Taken together, these estimates can be used to predict the cost of services in a given period (in this case, monthly). However, disbursement estimates reflect the payment of claims—so it is necessary to apply the appropriate payment lags before the estimates are complete.

The forecasts for several of the service categories are summarized in the following sections.

Nursing Facilities. Expenditures for the Nursing Facilities category were \$2.65 billion and represented approximately 28.6% of the total Medicaid expenditures from line item 600-525, Health Care/Medicaid, in FY 2006.

The formula for determining per diem reimbursements to nursing facilities was changed by Am. Sub. H.B. 66, so there is insufficient history with which to conduct an econometric analysis of historical rates. Based on the observed per diem rate during the first two quarters of FY 2007, LSC staff projects an average per diem rate statewide for FY 2007 of \$161.84. The FY 2007 rate is based on the new formula, subject to a provision that no facility's reimbursement rate will be increased or decreased by more than 2% from its June 30, 2006, level as a result of implementing the new formula. ODJFS officials report that the removal of this stop loss/stop gain provision for FY 2008 will have no effect on the statewide average per diem rate for FYs 2008 and 2009. Accordingly, average FY 2008 and FY 2009 per diem rates were increased from the FY 2007 average using the inflation adjustment factors for the direct care cost center and the ancillary and support cost center contained in the new formula. The per diem rates assumed for FY 2008 average \$164.64 and for FY 2009 they average \$167.29. Estimated expenditures for Nursing Facilities are \$2.67 billion in FY 2008 and \$2.68 billion in FY 2009.

Managed Care. The statewide expansion of Medicaid managed care began in July 2005 with the enactment of H.B. 66. Within a period of 18 months, Ohio Medicaid

is required to transfer an additional 800,000 Medicaid recipients from fee-for-service to managed care. This expansion dramatically shifts expenditures from the fee-for-service categories to the Managed Care categories.

In addition to the increase in the managed care population, MCP capitation rates are also rising. Ohio Medicaid chose Mercer as its state contracted actuarial firm. The actuaries perform analyses of historic Medicaid spending and consumer utilization patterns for Ohio's Medicaid populations. Separate analyses have to be done for the CFC and ABD populations because of the differences in their health care needs, utilization patterns, and overall Medicaid costs. After this rate-setting process is completed per-member monthly payment rates are ready to be measured against the required federal standard of "actuarial soundness" and released to the MCPs. Historically, MCP capitation rates have been annually adjusted at the beginning of each calendar year. The capitation rates for the CFC population on average increased 4.9% in FY 2005, 9.5% in FY 2006, and 11.4% in FY 2007. For CFC, the average capitation rate paid was \$162.75 in FY 2004, \$170.77 in FY 2005, and \$187.03 in FY 2006. For CY 2007, ODJFS assumed the CFC capitation rate would be \$208.30, and the ABD capitation rate would be \$1,054 per member per month.

LSC's forecast includes growth rates of 8.5% for ABD, and 6.8% for CFC for CYs 2008 and 2009. These growth rates are provided by ODJFS, and were calculated by Mercer. Estimated expenditures for ABD Managed Care are \$1.6 billion in FY 2008 and \$1.8 billion in FY 2009. Estimated expenditures for CFC Managed Care are \$3.1 billion in FY 2008 and \$3.2 billion in FY 2009. The total Managed Care expenditure represents approximately 43.4% of total Medicaid expenditures from the 525 line item in FY 2008 and approximately 43.7% in FY 2009.

Inpatient and Outpatient Hospital Services. Expenditures for Inpatient and Outpatient Hospital Services categories were \$2.2 billion and represented approximately 20.66% of total Medicaid expenditures from the 525 line item in FY 2006. The mandated managed care expansions are projected to reduce expenditures in the Inpatient and Outpatient Hospital Services categories substantially. Estimated expenditures for Inpatient and Outpatient Hospital Services are \$933 million in FY 2008 and \$960 million in FY 2009, and represent approximately 8.5% of total Medicaid expenditures from the 525 line item in FY 2008 and approximately 8.3% in FY 2009.

The Ohio Administrative Code requires an annual inflationary update to inpatient rates; however, outpatient rates are based on a fee schedule that is not automatically inflated. Health economists are predicting increased health care inflation in the coming years. In addition, demand for more and expanded health care services continues to push up the costs. Thus, LSC's projection is that after a sharp drop in expenditures in the Inpatient and Outpatient Hospital Services categories in FY 2008 due to the managed care expansions, expenditures in both categories is anticipated to grow in FY 2009.

Physician Services. The cost estimates for the Physician Services category reflect the historical costs of providing medical care. Estimated expenditures for the Physician Services category are \$290.0 million in FY 2008 and \$302.0 million in FY 2009.

The utilization in the Physician Services category declined significantly in response to the managed care expansions. Absent managed care expansions increasing utilization started to cause an increase in expenditures starting in FY 2009. The FY 2008 expenditures in this category are projected to decrease primarily because of the managed care expansions. After FY 2008, increasing utilization and the expenditures for physician services are expected to continue.

Prescription Drugs. Expenditures for the Prescription Drug Services category were \$1.7 billion and represented approximately 15.70% of total Medicaid expenditures from the 525 line item in FY 2006. Medicare Part D is having a substantial effect on Prescription Drug Services category expenditures in the 525 line item in FY 2007. Estimated expenditures for the Prescription Drug Services category are \$938 million in FY 2007, and represent approximately 8.76% of total Medicaid expenditures from the 525 line item.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)* establishes "Part D" in Medicare that gives people access to a private Medicare prescription drug plan. The MMA requires state Medicaid programs to determine eligibility for new groups of low-income Medicare beneficiaries, and to contribute to the cost of federal prescription drug coverage for dual eligibles.

The mechanism through which the states will help finance the new Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down State contribution"). In brief, the clawback is a monthly payment made by each state to the federal Medicare program beginning in January 2006. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles.

Prior to the implementation of Medicare Part D, outpatient prescription drug coverage was provided to dual eligibles through Medicaid; in Ohio, the federal government pays its financial share of about 59% (the FMAP), and the state pays the remaining 41% of the cost of this coverage. Approximately 175,000 monthly low-income Medicare beneficiaries were enrolled in Medicaid in 2006 in Ohio for full coverage, including nursing home care and outpatient prescription drugs. Beginning January 2006, line item 600-526, Medicare Part D, is used to make the clawback payment to the federal government.

The mandated managed care expansions will result in a sharp reduction the Prescription Drug Services category expenditures. Estimated expenditures for

Prescription Drug Services are \$464 million in FY 2008 and \$509 million in FY 2009, and represent approximately 4.2% of total Medicaid expenditures from the 525 line item in FY 2008 and approximately 4.4% in FY 2009. Higher prescription drugs utilization and the introduction of new expensive drugs into the market have and will continue to contribute to expenditure growth in FY 2009.

Medicare Buy-In. Medicaid covers the monthly Medicare premiums for the Medicare/Medicaid dual eligible population. The number of individuals for whom premiums are paid has increased steadily in recent years. The cost of the premiums is adjusted each January when the federal government revises the Medicare rates. The rate increase for Part B premiums in recent years has been significantly higher than past history. The Part B premiums increased 13.5% in January 2004, 17.4% in January of 2005, and 13.2% in January 2006. On September 12, 2006, the U.S. Department of Health and Human Services announced another increase of 5.6% in Medicare Part B monthly premiums. The projections for FY 2008 and forward is higher due to continued increases in Part B premiums and recent outreach efforts to ensure that all dual eligible recipients are enrolled in Medicare. The managed care expansion does not impact the expenditure for Medicare Buy-In Services category since dual eligibles are exempted from the mandated expansion population.

The cost estimates for Medicare Buy-In Services reflect the historical trend and the above policy changes. The growth rate in spending is projected to be 15.14% from FY 2007 to FY 2008, and 13.23% from FY 2008 to FY 2009. Estimated expenditures for Medicare Buy-In Services are \$316 million in FY 2008 and \$358 million in FY 2009.

**Medicaid Table 1
Health Care Spending (ALI 600-525 Only)**

	FY 2007			FY 2008			FY 2009		
	LSC Estimated	JFS Estimated	LSC minus JFS	LSC Estimated	JFS Estimated	LSC minus JFS	LSC Estimated	JFS Estimated	LSC minus JFS
Nursing Facilities	\$2,622,413,608	\$2,619,417,333	\$2,996,275	\$2,671,949,151	\$2,668,329,500	\$3,619,651	\$2,678,961,432	\$2,656,034,976	\$22,926,456
ICFs/MR	\$516,007,293	\$518,757,863	(\$2,750,570)	\$563,272,349	\$574,855,755	(\$11,583,405)	\$581,813,889	\$597,632,092	(\$15,818,203)
Inpatient	\$1,234,317,995	\$1,200,046,215	\$34,271,779	\$644,971,790	\$673,186,466	(\$28,214,676)	\$661,992,271	\$662,991,794	(\$999,523)
Outpatient	\$553,156,910	\$531,499,481	\$21,657,429	\$288,148,257	\$251,380,147	\$36,768,110	\$298,618,636	\$248,909,871	\$49,708,765
Physicians	\$510,119,679	\$523,593,685	(\$13,474,006)	\$289,684,785	\$265,367,260	\$24,317,526	\$301,993,322	\$264,861,805	\$37,131,517
Prescription Drugs	\$937,732,792	\$913,613,370	\$24,119,422	\$463,573,338	\$425,831,835	\$37,741,503	\$509,369,039	\$472,605,448	\$36,763,591
Waiver	\$297,923,682	\$331,226,316	(\$33,302,634)	\$281,772,051	\$326,994,607	(\$45,222,556)	\$302,334,923	\$332,486,253	(\$30,151,330)
Managed Care - ABD	\$401,045,081	\$463,064,564	(\$62,019,483)	\$1,637,918,545	\$1,628,815,967	\$9,102,578	\$1,815,046,190	\$1,780,838,279	\$34,207,912
Managed Care - CFC	\$2,416,612,584	\$2,473,454,618	(\$56,842,034)	\$3,136,295,669	\$3,049,185,076	\$87,110,593	\$3,212,325,506	\$3,262,410,224	(\$50,084,718)
All Other Care	\$922,092,445	\$903,883,991	\$18,208,454	\$718,519,897	\$837,257,541	(\$118,737,644)	\$786,784,838	\$906,738,308	(\$119,953,470)
Medicare Buy-In	\$274,846,860	\$278,409,748	(\$3,562,888)	\$316,455,520	\$323,124,474	(\$6,668,954)	\$358,328,655	\$368,657,089	(\$10,328,434)
Total	\$10,686,268,929	\$10,756,967,184	(\$70,698,255)	\$11,012,561,353	\$11,024,328,627	(\$11,767,274)	\$11,507,568,701	\$11,554,166,138	(\$46,597,436)
State share	\$4,257,409,541	\$4,285,575,726	(\$28,166,185)	\$4,374,189,369	\$4,378,863,331	(\$4,673,961)	\$4,422,358,652	\$4,440,266,047	(\$17,907,395)
Federal share	\$6,428,859,388	\$6,471,391,458	(\$42,532,070)	\$6,638,371,983	\$6,645,465,296	(\$7,093,313)	\$7,085,210,049	\$7,113,900,091	(\$28,690,041)

1. This table only includes health care spending through the Department of Job and Family Services' 600-525 line item. It includes spending for Medicaid, CHIP-I, and CHIP-II.
2. The forecasts are baseline, which assume no change in the state health care policies and program for the upcoming biennium.
3. "All Other Care" includes services such as dental care, home health care, and other practitioners, and includes various contracts.
4. The FMAP rate used here is a blended FMAP.

Medicaid Table 2
Medicaid Caseload by Eligibility Group

SFY	Healthy Families		Healthy Families Expansion		Healthy Start Pregnant Women		Healthy Start		CHIP-I		CHIP-II		Adopted Children & Foster Care Children		Dual CFC		Total CFC	
	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates	Monthly Average	Growth Rates
2002	721,962		989		21,835		131,429		70,073		38,494		26,977		360		1,012,119	
2003	701,976	-2.8%	127,157	12758.2%	21,512	-1.5%	143,294	9.0%	76,914	9.8%	44,933	16.7%	28,309	4.9%	1,915	432.2%	1,146,011	13.2%
2004	709,136	1.0%	182,475	43.5%	21,805	1.4%	147,364	2.8%	82,866	7.7%	48,856	8.7%	29,211	3.2%	3,230	68.6%	1,224,942	6.9%
2005	739,070	4.2%	206,081	12.9%	22,025	1.0%	141,983	-3.7%	85,508	3.2%	50,754	3.9%	29,886	2.3%	4,075	26.2%	1,279,382	4.4%
2006	784,889	6.2%	185,558	-10.0%	22,892	3.9%	144,451	1.7%	87,714	2.6%	52,071	2.6%	30,054	0.6%	4,098	0.6%	1,311,728	2.5%
2007*	803,884	2.4%	144,662	-22.0%	24,409	6.6%	158,529	9.7%	93,372	6.5%	54,069	3.8%	30,230	0.6%	3,988	-2.7%	1,313,142	0.1%
2008*	775,411	-3.5%	138,935	-4.0%	24,754	1.4%	160,990	1.6%	95,935	2.7%	54,599	1.0%	31,337	3.7%	3,980	-0.2%	1,285,942	-2.1%
2009*	736,158	-5.1%	131,902	-5.1%	24,502	-1.0%	159,019	-1.2%	94,832	-1.1%	53,407	-2.2%	32,349	3.2%	3,970	-0.2%	1,236,139	-3.9%

SFY	ABD		Dual ABD		QMBO		SLMB		Total ABD	
	Monthly Average	Growth Rates								
2002	170,215		158,291		21,576		18,019		368,101	
2003	176,562	3.7%	164,418	3.9%	22,280	3.3%	17,784	-1.3%	381,044	3.5%
2004	183,987	4.2%	171,909	4.6%	22,505	1.0%	15,528	-12.7%	393,928	3.4%
2005	187,988	2.2%	179,217	4.3%	24,079	7.0%	16,004	3.1%	407,288	3.4%
2006	191,408	1.8%	175,433	-2.1%	32,076	33.2%	18,458	15.3%	417,375	2.5%
2007*	195,984	2.4%	166,085	-5.3%	42,430	32.3%	23,424	26.9%	427,922	2.5%
2008*	199,797	1.9%	167,799	1.0%	44,614	5.1%	26,442	12.9%	438,652	2.5%
2009*	204,263	2.2%	170,119	1.4%	45,644	2.3%	28,733	8.7%	448,758	2.3%

Total ABD & CFC		
SFY	Monthly Average	Growth Rates
2002	1,380,220	
2003	1,527,055	10.6%
2004	1,618,870	6.0%
2005	1,686,670	4.2%
2006	1,729,103	2.5%
2007*	1,741,065	0.7%
2008*	1,724,593	-0.9%
2009*	1,684,897	-2.3%

MCP				
SFY	CFC		ABD	
	Monthly Average	Growth Rates	Monthly Average	Growth Rates
2002	334,043		10	
2003	403,717	20.9%	13	30.0%
2004	483,346	19.7%	18	38.5%
2005	521,929	8.0%	773	4194.4%
2006	621,096	19.0%	952	23.2%
2007*	958,261	54.3%	26,687	2703.0%
2008*	1,150,577	20.1%	123,165	361.5%
2009*	1,103,806	-4.1%	126,461	2.7%

FFS				
SFY	CFC		ABD	
	Monthly Average	Growth Rates	Monthly Average	Growth Rates
2002	678,076		368,091	
2003	742,294	9.5%	381,031	3.5%
2004	741,596	-0.1%	393,910	3.4%
2005	757,453	2.1%	406,515	3.2%
2006	690,632	-8.8%	416,423	2.4%
2007*	354,882	-48.6%	401,236	-3.6%
2008*	135,365	-61.9%	315,486	-21.4%
2009*	132,333	-2.2%	322,297	2.2%

*LSC baseline estimates

Medicaid Table 3

Percentage of Total Caseload		
Date	Penetration Rate	
	ABD	CFC
Jul-04	0.0%	40.7%
Aug-04	0.0%	40.6%
Sep-04	0.0%	40.5%
Oct-04	0.0%	40.7%
Nov-04	0.1%	40.7%
Dec-04	0.1%	40.8%
Jan-05	0.1%	40.8%
Feb-05	0.2%	41.1%
Mar-05	0.4%	40.9%
Apr-05	0.5%	41.0%
May-05	0.7%	41.0%
Jun-05	0.9%	41.1%
Jul-05	1.2%	41.3%
Aug-05	1.2%	41.3%
Sep-05	0.9%	41.0%
Oct-05	0.1%	42.5%
Nov-05	0.0%	46.8%
Dec-05	0.0%	47.3%
Jan-06	0.0%	48.7%
Feb-06	0.0%	49.3%
Mar-06	0.0%	52.1%
Apr-06	0.0%	52.5%
May-06	0.0%	52.5%
Jun-06	0.0%	52.9%
Jul-06	0.0%	52.9%
Aug-06	0.0%	53.2%
Sep-06	0.0%	57.0%
Oct-06	0.0%	62.1%
Nov-06	0.0%	68.9%
Dec-06	0.0%	73.3%
Jan-07	0.4%	78.5%
Feb-07	3.9%	84.2%
Mar-07	8.1%	85.2%
Apr-07	13.2%	86.8%
May-07	21.9%	87.6%
Jun-07	26.8%	88.4%
Jul-07	27.9%	89.7%
Aug-07	28.4%	89.7%
Sep-07	28.2%	89.7%
Oct-07	28.2%	89.7%
Nov-07	28.1%	89.7%
Dec-07	28.1%	89.7%
Jan-08	28.1%	89.7%
Feb-08	28.1%	89.7%
Mar-08	28.2%	89.7%
Apr-08	28.1%	89.7%
May-08	28.1%	89.7%
Jun-08	28.1%	89.7%
Jul-08	28.0%	89.7%
Aug-08	28.0%	89.7%
Sep-08	27.9%	89.7%
Oct-08	27.9%	89.7%
Nov-08	27.8%	89.7%
Dec-08	27.8%	89.7%
Jan-09	27.8%	89.7%
Feb-09	27.8%	89.7%
Mar-09	27.8%	89.7%
Apr-09	27.8%	89.7%
May-09	27.8%	89.7%
Jun-09	27.8%	89.7%

Medicaid Table 4

Percentage of Those Eligible for Managed Care		
Date	Penetration Rate	
	ABD	CFC
Jul-04	0.0%	43.1%
Aug-04	0.0%	43.2%
Sep-04	0.0%	43.0%
Oct-04	0.0%	43.1%
Nov-04	0.1%	43.1%
Dec-04	0.2%	43.1%
Jan-05	0.3%	43.3%
Feb-05	0.5%	43.4%
Mar-05	0.9%	43.2%
Apr-05	1.4%	43.3%
May-05	1.7%	43.3%
Jun-05	2.3%	43.4%
Jul-05	3.2%	43.7%
Aug-05	3.1%	43.8%
Sep-05	2.5%	43.5%
Oct-05	0.1%	45.0%
Nov-05	0.0%	49.4%
Dec-05	0.0%	49.9%
Jan-06	0.0%	51.6%
Feb-06	0.0%	51.9%
Mar-06	0.0%	55.1%
Apr-06	0.0%	55.4%
May-06	0.0%	55.3%
Jun-06	0.0%	55.9%
Jul-06	0.0%	55.9%
Aug-06	0.0%	56.1%
Sep-06	0.0%	60.1%
Oct-06	0.0%	65.5%
Nov-06	0.0%	72.6%
Dec-06	0.0%	77.3%
Jan-07	1.1%	82.9%
Feb-07	13.1%	88.9%
Mar-07	27.0%	89.9%
Apr-07	44.2%	91.7%
May-07	73.1%	92.5%
Jun-07	89.6%	93.3%
Jul-07	93.3%	94.7%
Aug-07	95.0%	94.7%
Sep-07	95.0%	94.7%
Oct-07	95.0%	94.7%
Nov-07	95.0%	94.7%
Dec-07	95.0%	94.7%
Jan-08	95.0%	94.7%
Feb-08	95.0%	94.7%
Mar-08	95.0%	94.7%
Apr-08	95.0%	94.7%
May-08	95.0%	94.7%
Jun-08	95.0%	94.7%
Jul-08	95.0%	94.7%
Aug-08	95.0%	94.7%
Sep-08	95.0%	94.7%
Oct-08	95.0%	94.7%
Nov-08	95.0%	94.7%
Dec-08	95.0%	94.7%
Jan-09	95.0%	94.7%
Feb-09	95.0%	94.7%
Mar-09	95.0%	94.7%
Apr-09	95.0%	94.7%
May-09	95.0%	94.7%
Jun-09	95.0%	94.7%

Note: Tables 3 & 4 - March 2007 to June 2009 provided by ODJFS and based on ODJFS's roll-out plans for the statewide expansions.