PUBLIC ASSISTANCE EXPENDITURE FORECASTS

Health Care/Medicaid

Overview

Established in 1965, Medicaid is a joint state-federal program that provides health care coverage to the poor. The federal government establishes broad national guidelines for the program, while states determine their own eligibility requirements and scope of services, set provider payment rates, and administer their own programs. The Medicaid Program in Ohio provides health care coverage to children up to age 19 whose families' incomes are below 150% of the federal poverty guideline (FPG), pregnant women with incomes up to 200% of the FPG, parents with incomes up to 90% of the FPG, and the elderly and persons with disabilities of all ages with incomes up to 64% of the FPG.

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 long-term care. Medicaid also provides assistance with Medicare premiums, copayments, and deductibles to certain low-income seniors.

Medicaid services are an entitlement for those who meet eligibility requirements. Entitlement means that if an individual is eligible for the program then they are guaranteed the benefits. The state is obligated to pay for these benefits. It is for this reason that LSC staff forecast Medicaid expenditures.

The State Children's Health Insurance Program (SCHIP) currently provides health care coverage under Medicaid to *uninsured* children whose family income is below 200% of the FPG and who otherwise do not qualify for Medicaid. SCHIP is expected to expand starting July 1, 2009 to include uninsured children whose family income is up to 300% of the FPG.

Forecast Summary

In FY 2008, Medicaid provided health care coverage to over 1.76 million Ohioans. In FY 2009, Medicaid is expected to cover 1.86 million Ohioans. LSC forecasts that the total number of persons eligible for Medicaid will increase by 5.6%, or 104,999 persons, in FY 2010, and by 3.1%, or 61,764 persons, in FY 2011.

Medicaid expenditures, in combined state and federal dollars, totaled $10.75 billion in FY 2008. Estimated FY 2009 combined state and federal Medicaid expenditures are $12.38 billion. LSC forecasts that Medicaid expenditures, in combined state and federal dollars, will increase by 3.4%, or $417.9 million, in FY 2010, and by 6.1%, or $780.3 million, in FY 2011.

Caseload Forecast

Total Caseload

As can be seen in Table 1 below, the total number of persons eligible for Medicaid grew by 1.4% from 1.74 million in FY 2007 to 1.76 million in FY 2008. The total number of persons eligible is estimated to reach 1.86 million in FY 2009, a 5.9% increase over FY 2008. LSC forecasts that the number of persons eligible for Medicaid will increase to 1.97 million in FY 2010, a 5.6% increase, before increasing to 2.03 million in FY 2011, a 3.1% increase.

Table 1: Total Medicaid Caseloads

Fiscal Year	Monthly Average	Growth Rate
2002	1,380,235	--
2003	1,527,076	10.64%
2004	1,618,900	6.01%
2005	1,687,462	4.24%
2006	1,730,075	2.53%
2007	1,736,143	0.35%
2008	1,759,873	1.37%
2009	**1,863,917**	**5.91%**
2010	**1,968,916**	**5.63%**
2011	**2,030,680**	**3.14%**

H.B. 119 of the 127th General Assembly, the FY 2008-FY 2009 biennial budget act, required the Ohio Department of Job and Family Services (ODJFS) to do all of the following:

1. Implement, beginning January 1, 2008, a federal option under which an individual under age 21 qualifies for Medicaid if the individual (a) was in foster care under the responsibility of the state on the individual's 18th birthday, (b) received Title IV-E foster care maintenance payments or independent living services before turning age 18, and (c) meets all other applicable eligibility requirements.
2. Raise the income eligibility limit for pregnant women to family income of 200% (from 150%) of the FPG.
3. Establish a new component of the Medicaid Program to be known as the Medicaid Buy-In for Workers with Disabilities Program.
4. Expand SCHIP to include persons under age 19 with family incomes up to 300% of the FPG starting not earlier than January 1, 2008.
5. Establish the Children's Buy-In Program for individuals under age 19 who have countable income exceeding 300% of the FPG, have not had creditable health insurance for at least six months, and meet other eligibility requirements.

The expansions for young adult foster children and pregnant women went into effect January 1, 2008. Starting April 2008, the Children's Buy-In Program became available for individuals under age 19 at 300% FPG, and the Medicaid Buy-In Program for Workers with Disabilities became available to individuals with incomes up to 250% of the FPG. The forecast assumes that SCHIP expansion will be implemented during the upcoming biennium.

Medicaid caseload is driven by a number of factors. These include changes in state eligibility standards, health care costs, employer offers of health insurance coverage, and changes in income. The business cycle is also an important determinant particularly for nondisabled adults and children. As unemployment increases, workers and their dependants may lose access to employer coverage. This can happen because of unemployment, reduced employer contributions to health insurance, reduced eligibility for employer sponsored insurance, and movement from full-time to part-time work. Individuals then either become eligible and enroll in public coverage, purchase nongroup coverage, or become uninsured.

The U.S. economy continues to decline. The Ohio unemployment data released on January 29, 2009 by the Bureau of Labor Statistics shows that the December 2008 unemployment rate had increased to 7.8% and that 464,800 people had either become unemployed or left the labor force. Global Insight January 2009 baseline forecast projected that the Ohio unemployment rate will continue to increase to 10.44% in the first quarter of calendar year (CY) 2010 and decline to 9.54% by the second quarter of CY 2011.

Individuals eligible for Medicaid are grouped into two major categories. Generally, children up to age 19 whose families' incomes are below 200% of the FPG, pregnant women with incomes up to 200% of the FPG, and parents with incomes up to 90% of the FPG are grouped as Covered Families and Children (CFC). The aged, blind, and disabled (ABD) category includes the low-income elderly who are age 65 or older and individuals with disabilities. The forecasted caseload for each of these two categories is discussed below.

Covered Families and Children

LSC forecasts that the recent increase in the overall CFC caseload will continue through the biennium (see Table 2 below). The rate of increase is projected to decelerate in FY 2011. This forecast is based on a statistical estimation of the relationship between the Healthy Families (families with incomes up to 90% of the FPG, which include a child up to age 19) caseload and the unemployment rate. Forecasts of future unemployment rates used for the caseload projections are taken from the winter 2008 economic forecast for Ohio by Global Insight.

Table 2: Medicaid Caseloads – Covered Families and Children (CFC)

Fiscal Year	Healthy Families		Healthy Start		SCHIP		Total CFC	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	750,288	--	153,264	--	108,567	--	1,012,119	--
2003	859,358	14.54%	164,806	7.53%	121,847	12.23%	1,146,011	13.23%
2004	924,052	7.53%	169,169	2.65%	131,722	8.10%	1,224,942	6.89%
2005	979,112	5.96%	164,008	-3.05%	136,262	3.45%	1,279,382	4.44%
2006	1,004,599	2.60%	167,343	2.03%	139,785	2.59%	1,311,728	2.53%
2007	982,058	-2.24%	182,566	9.10%	144,227	3.18%	1,308,851	-0.22%
2008	995,854	1.40%	179,770	-1.53%	144,460	0.16%	1,320,084	0.86%
2009	**1,078,693**	**8.32%**	**176,744**	**-1.68%**	**148,268**	**2.64%**	**1,403,705**	**6.33%**
2010	**1,160,781**	**7.61%**	**183,600**	**3.88%**	**149,848**	**1.07%**	**1,494,229**	**6.45%**
2011	**1,205,872**	**3.88%**	**185,959**	**1.29%**	**150,920**	**0.72%**	**1,542,751**	**3.25%**

Aged, Blind, and Disabled

Growth in the ABD caseload accelerated in the first quarter of FY 2009. LSC forecasts that the total ABD caseload will increase by 4.6% in FY 2009, 3.2% in FY 2010, and 2.8% in FY 2011. Individuals who become eligible for Medicaid due to disability are the largest single subcategory within the ABD Only eligibility category. The Social Security Administration forecasted acceleration in the number of blind or disabled recipients of federally administered supplemental security income (SSI) benefits in CY 2008 and again in CY 2009 in its 2008 Annual Report of the Supplemental Security Income Program. While this forecast is for a national figure, statistical analysis conducted by LSC staff indicates that historically, growth in Ohio's blind and disabled caseload is highly correlated with this national trend.

Table 3: Medicaid Caseloads – Aged, Blind and Disabled

Fiscal Year	ABD Only		Dual ABD		QMB		SLMB		Total ABD	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	170,230	--	158,291	--	21,576	--	18,019	--	368,116	--
2003	176,584	3.73%	164,418	3.87%	22,279	3.26%	17,784	-1.30%	381,065	3.52%
2004	184,016	4.21%	171,909	4.56%	22,505	1.01%	15,528	-12.69%	393,958	3.38%
2005	188,780	2.59%	179,217	4.25%	24,079	6.99%	16,004	3.07%	408,079	3.58%
2006	192,380	1.91%	175,433	-2.11%	32,076	33.21%	18,458	15.34%	418,347	2.52%
2007	196,247	2.01%	165,752	-5.52%	42,157	31.43%	23,136	25.34%	427,292	2.14%
2008	197,168	0.47%	170,438	2.83%	45,931	8.95%	26,253	13.47%	439,790	2.92%
2009	**201,848**	**2.37%**	**175,682**	**3.08%**	**47,380**	**3.15%**	**35,302**	**34.47%**	**460,212**	**4.64%**
2010	**207,220**	**2.66%**	**181,744**	**3.45%**	**49,130**	**3.69%**	**36,592**	**3.65%**	**474,687**	**3.15%**
2011	**211,910**	**2.26%**	**186,860**	**2.81%**	**51,397**	**4.61%**	**37,763**	**3.20%**	**487,929**	**2.79%**

QMB – Qualified Medicare Beneficiaries
SLMB – Specified Low-income Medicare Beneficiaries

Managed Care

H.B. 66 of the 126th General Assembly, the FY 2006-FY 2007 biennial budget act, required managed care to be implemented in all counties. Prior to this, Medicaid services were largely provided under a fee-for-service system. H.B. 66 required ODJFS to designate the CFC population for participation. All designated CFC participants were required to enroll in Medicaid MCPs by December 31, 2006. It also required ODJFS to implement managed care 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) individuals eligible for both Medicaid and Medicare, and (5) Medicaid waiver recipients. All designated ABD participants were also required to enroll in Medicaid MCPs by December 31, 2006.

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 included rural areas such as Appalachia where access to health care is more difficult. And for the first time, the elderly population was included in managed care.

In FY 2008, Medicaid provided health care coverage to approximately 1.1 million CFC and 336,000 ABD per month through managed care. According to ODJFS, Ohio's Medicaid managed care expansion is complete for the CFC population.

LSC's baseline forecast uses the penetration rates anticipated by ODJFS. Penetration rate is the percentage of managed care recipients of the total population. LSC's baseline forecast uses penetration rates of about 19% for ABD and 86% for CFC throughout the upcoming biennium.

Tables 4 and 5 below summarize Medicaid caseloads under managed care plans and under the fee-for-service system.

Table 4: Medicaid Caseloads – Fee-For-Services (FFS) vs. Managed Care Plans (MCP)

Fiscal Year	CFC-FFS		CFC-MCP		ABD-FFS		ABD-MCP	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	677,824	--	334,295	--	368,116	--	0	--
2003	742,041	9.47%	403,970	20.84%	381,065	3.52%	0	--
2004	741,352	-0.09%	483,590	19.71%	393,958	3.38%	0	--
2005	757,197	2.14%	522,185	7.98%	408,079	3.58%	0	--
2006	690,363	-8.83%	621,364	18.99%	418,347	2.52%	0	--
2007	364,846	-47.15%	944,005	51.92%	401,735	-3.97%	25,556	--
2008	196,253	-46.21%	1,123,830	19.05%	335,552	-16.47%	104,237	307.88%
2009	**193,079**	**-1.62%**	**1,210,625**	**7.72%**	**370,755**	**10.49%**	**89,457**	**-14.18%**
2010	**205,495**	**6.43%**	**1,288,735**	**6.45%**	**386,382**	**4.21%**	**88,304**	**-1.29%**
2011	**212,068**	**3.20%**	**1,330,683**	**3.26%**	**397,626**	**2.91%**	**90,303**	**2.26%**

Table 5: Total Medicaid Caseloads – FFS vs. MCP

Fiscal Year	Total FFS		Total MCP	
	Monthly Average	Growth Rate	Monthly Average	Growth Rate
2002	1,045,940	--	334,295	--
2003	1,123,107	7.38%	403,970	20.84%
2004	1,135,310	1.09%	483,590	19.71%
2005	1,165,277	2.64%	522,185	7.98%
2006	1,108,710	-4.85%	621,364	18.99%
2007	766,582	-30.86%	969,561	56.04%
2008	531,806	-30.63%	1,228,068	26.66%
2009	**563,835**	**6.02%**	**1,300,082**	**5.86%**
2010	**591,877**	**4.97%**	**1,377,039**	**5.92%**
2011	**609,694**	**3.01%**	**1,420,986**	**3.19%**

Expenditure Forecast

Summary

Medicaid expenditures in ODJFS 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 forecasts expenditures for each of these categories. Table 6 below summarizes Medicaid expenditures by service category.

Table 6: Projected Medicaid Expenditures for FY 2010 and FY 2011

(Baseline Assumptions, Combined State and Federal Dollars)

Category	FY 2009	FY 2010			FY 2011		
	Estimate	Forecast	Dollar Increase	% Increase	Forecast	Dollar Increase	% Increase
Nursing Facilities	$2,570,831,252	**$2,567,679,030**	($3,152,222)	-0.12%	**$2,562,521,616**	($5,157,414)	-0.20%
ICFs/MR	$544,720,182	**$544,035,450**	($684,732)	-0.13%	**$542,839,162**	($1,196,287)	-0.22%
Inpatient	$1,062,428,250	**$1,148,249,508**	$85,821,258	8.08%	**$1,237,363,734**	$89,114,225	7.76%
Outpatient	$398,525,770	**$429,354,053**	$30,828,284	7.74%	**$460,215,030**	$30,860,977	7.19%
Physicians	$344,733,742	**$363,469,270**	$18,735,528	5.43%	**$381,089,030**	$17,619,760	4.85%
Prescription Drugs	$593,100,010	**$654,796,839**	$61,696,829	10.40%	**$703,992,442**	$49,195,603	7.51%
Home Care Waiver	$339,243,620	**$375,595,832**	$36,352,212	10.72%	**$419,401,400**	$43,805,568	11.66%
Managed Care - ABD	$1,371,952,129	**$1,274,800,440**	($97,151,690)	-7.08%	**$1,378,249,059**	$103,448,619	8.11%
Managed Care - CFC	$3,369,959,067	**$3,517,004,347**	$147,045,281	4.36%	**$3,853,271,674**	$336,267,327	9.56%
All Other	$1,201,020,572	**$1,306,011,657**	$104,991,085	8.74%	**$1,381,753,237**	$75,741,579	5.80%
Medicare Buy-In	$317,388,167	**$336,775,321**	$19,387,154	6.11%	**$368,174,995**	$31,399,674	9.32%
Disability Medical	$10,994,732	**$8,470,724**	($2,524,008)	-22.96%	**$2,231,691**	($6,239,033)	-73.65%
Medicare Part D	$255,205,839	**$271,746,617**	$16,540,778	6.48%	**$287,194,790**	$15,448,173	5.68%
Total Expenditures	$12,380,103,332	**$12,797,989,090**	$417,885,758	3.38%	**$13,578,297,860**	$780,308,770	6.10%

Methodology

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. Until recent years, 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 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 that 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. Due to the managed care expansions for both the CFC and ABD populations, managed care has become the biggest factor in forecasting Medicaid expenditures in the upcoming biennium.

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:

Expenditures = Caseload x Average Utilization x Price

For each typical expenditure category and subcategory, separate forecasts are done for the average number of claims per recipient (corresponding to average utilization) and for the average cost per claim submitted (corresponding to price). Time series regression models are used in these forecasts.

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 for Medicaid reflect

the payment of claims and not the provision of services, it is necessary to incorporate the appropriate payment lags when estimating Medicaid spending.

In short, forecasting Medicaid spending involves two steps. The first step is to estimate the number of Medicaid eligibles in each month. In this step 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 also necessary to apply the appropriate payment lags before the forecasts are complete.

Medicaid Expenditures for Selected Service Categories

Managed Care. The statewide expansion of Medicaid managed care that began in July 2005 has dramatically shifted expenditures from the fee-for-service categories to the managed care categories. 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. In FY 2008, expenditures for the managed care categories were $3.9 billion and represented approximately 37.3% of the total Medicaid expenditures in ODJFS.

In addition to the increase in the managed care population, MCP capitation rates are also rising. Ohio Medicaid chose Milliman as its state contracted actuarial firm. The actuary performs 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 managed care companies. Historically, MCP capitation rates have been adjusted at the beginning of each calendar year. The capitation rates on average increased 4.2% for CFC and 6.2% for ABD, from 2008 to 2009. In 2009, the average capitation rate is $225.7 for CFC and $1,211 for ABD.

LSC's forecast includes annual growth rates of 7.2% for ABD, and 5.2% for CFC for 2010 and 2011. These growth rates were calculated by Milliman. In addition, LSC's baseline forecast includes a 5.5% rate reduction effective October 1, 2009 due to the termination of the managed care assessment. Forecasted expenditures for ABD managed care are $1.3 billion in FY 2010 and $1.4 billion in FY 2011. Forecasted expenditures for CFC managed care are $3.5 billion in FY 2010 and $3.9 billion in FY 2011.

Nursing Facilities. In FY 2008, expenditures for the Nursing Facilities category were $2.5 billion and represented approximately 24.2% of the total Medicaid expenditures in ODJFS.

The formula for determining per diem reimbursements to nursing facilities was changed by H.B. 66. There is insufficient history with which to conduct an econometric analysis of historical rates. The average per diem for FY 2007 was $162.50 and was based on the new formula, subject to a provision that no facility's reimbursement was increased or decreased by more than 2% from its June 30, 2006 level as a result of implementing the new formula. The average per diem for FY 2008 was $164.60 and was based on the new formula, subject to a provision that no facility's reimbursement was increased by more than 2.75% or no facility's reimbursement was decreased from its June 30, 2007 level. LSC projects the average per diem for FY 2009 to be $166.60. The per diem increase from FY 2008 to FY 2009 is due to the capital compensation that Am. Sub. H.B. 562 of the 127th General Assembly provided for qualifying nursing facilities to receive additional quarterly payments for its capital compensation. As assumed in the Governor's proposed budget, LSC's baseline forecast assumes no rate increase in the per diem for the upcoming biennium.

Inpatient and Outpatient Hospital Services. In FY 2008, expenditures for Inpatient and Outpatient Hospital Services categories were $1.3 billion and represented approximately 12.2% of total Medicaid expenditures in ODJFS. Forecasted expenditures for Inpatient and Outpatient Hospital Services are $1.6 billion in FY 2010 and $1.7 billion in FY 2011.

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. As assumed in the Governor's proposed budget, LSC's baseline forecast assumes no inflation adjustment for the upcoming biennium. However, the demand for more and expanded health care services continues to push up the costs. Thus, LSC anticipates expenditures in both categories to grow in FY 2010 and FY 2011.

Ohio Home Care Waiver. Forecasted expenditures for the Ohio Home Care Waiver are $375.6 million in FY 2010 and $419.4 million in FY 2011.

Ohio Home Care is Medicaid's integrated program of home care services, consisting of three benefit packages: Core, Ohio Home Care Waiver, and Transitions Waiver. All three packages include "core" services of nursing, daily living, and skilled therapies. As assumed in the Governor's proposed budget, LSC's baseline forecast assumes 600 new waiver slots each year for the upcoming biennium.