

# Assessment of the Milliman Report on Medicaid Managed Care Expansion in Ohio



April 2005



## EXECUTIVE SUMMARY

The House passed version of the budget added a provision to require moving a selected group of the non-Dual Adult Disabled Medicaid population into full risk managed care plans as quickly as possible.

The Health Policy Institute of Ohio (HPIO) received requests of assistance from several staff members of the Ohio General Assembly regarding this proposal, especially regarding the projected estimated savings. To provide assistance, HPIO reviewed a report submitted to the Ohio Commission to Reform Medicaid entitled “Implementation Plan for Medicaid Managed Care Expansion in Ohio.” This report provided the initial framework for the proposal now in front of the legislature. HPIO further reviewed a letter from Mercer which evaluated the Milliman Report and a follow up Milliman document that gave additional details on its managed care budget savings estimation methodology.

Our assessment of the Implementation Plan for Medicaid Managed Care Expansion in Ohio includes the following:

- Mercer’s analysis agrees with use of a 7.6% managed care savings discount from fee-for-service expenditures for the non-Dual Adult Disabled Medicaid population.
- Any assessment of savings must consider how the new federal actuarial soundness test for managed care rates—which does not let states set managed rates as a specific discount off of fee-for-service expenditures—will affect future savings.
- Given the timeline assumptions in the report, this expansion could not begin enrollment until January 2007. Moreover, these timeline assumptions may be overambitious. As the Mercer analysis notes they are “overly aggressive.”
- Accepting all of the report’s assumptions, the incurred savings from expanding managed care to the non-Dual Disabled population will be no more than \$24.5 million (state General Revenue Fund money, which excludes the federal Medicaid match) in SFY 07, with no savings in SFY 06. Because this effort will not be at full enrollment beginning January 2007, the incurred savings will likely be appreciably less than \$24.5 million (state GRF money, excluding the federal match).
- The report notes that ODJFS faces a need for a 13% increase in spending during the first fiscal year of full implementation to cover implementation costs.

executive summary continued on page 2

## Executive Summary (continued from page 1)

- If this spending increase requires state GRF dollars, these start up costs will be greater than the first year savings, requiring additional dollars in SFY 2006/07.
- The report also overstates total savings from this expansion because it does not subtract the savings that the ECM projected is already expected to generate and it does not deal with the fact that some of ABD dollars go to hospitals as payment for Graduate Medical Education, a payment they will still expect to receive.
- The move to full risk managed care could threaten the viability of financing mechanisms to aid hospitals that serve a large portion of low income consumers, such as the upper payment limit for public hospitals and HCAP.
- The report's timeline is ambitious. It is likely to take longer to implement this program than the report suggests for several reasons including: federal resistance to the proposed managed care assessment to pay for implementation costs; the time it takes for new managed care plans to become operational; and time required to deal with potential consumer or provider resistance before CMS will approve the required waiver and/or JCARR will pass the rules needed for the expansion.
- This expansion proposal does not alleviate future annual budgetary pressures. The report's own numbers assumes that the annual increase in managed care expenditures would be 8.7% per year. The second Milliman report states that Milliman assumes that trend for managed care spending will grow at .5% less than the trend for the fee-for-service system.

HPIO agrees that Ohio Medicaid needs to increase its use of care management tools, especially for the ABD population (even if it requires an upfront investment of money). Without investing in care management, Ohio Medicaid will not be able to effectively improve health outcomes while also saving money. A key question for the Ohio General Assembly is whether to go with the full risk managed care option or the enhanced care management proposal of the Administration.

For more specific information, please refer to HPIO's complete assessment, which begins on the next page.

For more information on the different issues that arise in attempting to reform Ohio's Medicaid program, please refer to the Health Policy Institute of Ohio's publication *Ohio Medicaid Reform: Key Issues to Consider*. For more general information about Ohio's Medicaid program, including federal eligibility requirements, benefits, financing, and administration, please refer to the Institute's publication *Ohio Medicaid Basics*. Both publications are available by calling the Health Policy Institute of Ohio at 614.224.4950 or by visiting the Institute's website at [www.healthpolicyohio.org](http://www.healthpolicyohio.org).

If you have any questions about any part of this assessment, or about other issues related to Medicaid, please feel free to contact the Institute.

# ASSESSMENT OF THE MILLIMAN REPORT ON MEDICAID MANAGED CARE EXPANSION IN OHIO

by William D. Hayes, Ph.D., President  
Health Policy Institute of Ohio

Robert M. Damler, FSA, MAAA, principal and consulting actuary for Milliman, Inc., developed a report which created an implementation plan for Medicaid managed care expansion to all of the Covered Families and Children (CFC) population not currently enrolled in managed care and to all of the non-dual Disabled population, except children, people being served on waivers, and people residing in nursing homes or ICF-MR facilities. Mr. Damler submitted this report for consideration by the Ohio Commission to Reform Medicaid.

The Ohio Association of Health Plans contracted with Mr. Damler to produce this report. This report likely served as the basis for the proposal to expand Medicaid full risk managed care to the adult, non-Dual Disabled Medicaid population adopted in the House passed version of the budget. The CFC expansion mentioned in the report was already included in the Governor's budget proposal.

This analysis provides an assessment of this report to evaluate its assumptions, implementation requirement points, and projected savings. It also incorporates information from a Mercer analysis of this same report and a follow up document from Milliman that gives additional information on its methods used in this report. This analysis primarily focuses on the non-dual Disabled population since the Governor's budget already included the expansion of managed care to all of the CFC population.

While this analysis focuses directly on the report submitted to the Ohio Commission to Reform Medicaid, policy makers and other assessing any other estimate of savings from moving to full risk managed care should consider the issues and concerns raised above. Some of these issues and concerns would also relate to savings estimates for other care management proposals.

## Opening Comments

Before beginning this analysis I need to make a couple of opening remarks. First, I believe that Medicaid must figure out how to best employ care management tools with its ABD populations for it to become an effective value purchaser. This group accounts for almost two-thirds of total Medicaid service expenditures. ODJFS and other analyses suggest that effective care management could improve health outcomes and quality of care for these populations and produce appreciable reductions in expenditures.

Second, a critical question facing policymakers and ODJFS is what method of care management is best to use to maximize savings and improve quality and health outcomes. Two competing models are the full-risk model recommended in Mr. Damler's report and the enhanced care management model that ODJFS recommended.

Third, I bring over 13 years of experience working with Medicaid and managed care either during my time at the Ohio Department of Health or my four year period as Assistant Deputy Director for the Office of Ohio Health Plans. During this four year period the Bureau of Managed Care reported to me. In this capacity I fought to help get that Bureau the tools and policy changes

needed to allow for expansion of full risk managed care in the CFC population. I also convened a workgroup to identify how Ohio could most effectively bring care management tools to the ABD population. That process led to the creation of the Enhanced Care Management Model.

## What the Report States

To effectively assess this report it is important to be clear on its assumptions and findings. This section uses the wording of the report itself, except for comments in italics. These comments are my responses or reaction to certain statements in the report.

According to the report, the expansion of the managed care program will bring increased quality of care and consumer satisfaction to the remaining CFC population and non-Dual Disabled population while providing a savings opportunity to the State of Ohio. (p. 11)

Development of the incurred savings estimates includes the following factors and methods:

- It assumes full implementation of mandatory managed care (p.11)
- It was developed with traditional actuarial and budget forecasting methods and follow generally accepted standards and practices prescribed by the Actuarial Standards Board of the American Academy of Actuaries. (p. 11)
- It reports the savings on an incurred basis, having not adjusted the savings estimates to reflect a cash budget (p.11)
- It bases its estimates on data from ODJFS, OAHP, and other public resources. If this data and information are not complete or are inaccurate, the estimates may need to be modified (p. 13)
- The savings shown reflect a single point in time estimate. It would be expected that the actual values in future periods may vary from the illustrated projections. Actual results will be dependent upon future population growth, medical inflation, and contracted capitation rates. (p. 13) *(Given the goal of the Ohio Commission to Reform Medicaid to hold the rate of Medicaid spending growth to no more than the average rate of growth in state expenditures, which they noted has been 4.5% a year, it would be helpful to identify what Mr. Damler expects the rate of annual spending growth for managed care expenditures would be under this proposal)*

Successful realization of these savings requires effective implementation of the proposed managed care expansion. According to the report this effective implementation must deal with the following issues:

- The State of Ohio would need to file an amendment and receive federal approval to the current 1915(b) waiver in order to expand coverage to the non-dual disabled population. The waiver amendment process requires a 90-day approval period from CMS. (p. 5) *(Note that this 90-day approval period can last longer than 90 days as CMS has the ability to stop the 90 day clock anytime that it asks the State for more information or to respond to specific questions. Ohio, and other states, have often experienced it taking longer than 90 days to get final CMS approval for a state plan amendment.)*
- The savings estimate is based on an implementation timeline that begins on October 1, 2004 and contains 8 steps.
- Based on these steps, the report predicts that mandatory enrollment in urban counties could begin by October 1, 2005 for the CFC population *(one year after the beginning of the*

*implementation process*) and by January 1, 2006 for the disabled population (*15 months after the beginning of the implementation process*). The initial enrollment would occur in the urban regions and non-waiver rural counties. Final enrollment for the waiver counties begins in April 2006 (*18 months after the beginning of the implementation process*). (p.6)

- Without the support and partnership with hospitals around the State, the successful implementation of mandatory risk-based managed care would encounter many difficulties. (p. 8)
- Unless the State of Ohio requires the providers to accept Medicaid payments or implement other incentives, the State of Ohio will not be able to meet the rapid implementation time periods or realize the savings that have been projected. (p. 8) (*The report gave no estimate for any costs associated with providing these other incentives*)
- In order to successfully accomplish this expansion, there must be enough health plans operating in the State with access to provider services and administrative resources to handle increased enrollment. (p. 8)
- With the introduction of new managed care plans, along with the existing plans, the system would have capacity to accept the new enrollee population.
- Since the State of Ohio operates on a cash basis, the implementation of a mandatory risk-based managed care program, in which the State pays a capitated dollar amount each month, will temporarily increase the cash-flow during a portion of a single fiscal year (page 9). This increase would require an estimated 13% increase in claims payments during the first fiscal year of implementation.
- Offsetting the fiscal impact with the savings associated with mandatory risk-based managed care program, the fiscal impact would be reduced to approximately 4% increase in expenditures in the initial fiscal year. The increase in cash expenditure would be limited to the first fiscal year of implementation. (p. 9)
- The fiscal impact to any individual state fiscal year could be further reduced by implementing mandatory enrollment on a phased-in approach over a six to twelve month period (p.9) (*Any phase-in approach would also phase-in the savings*)
- Other states have considered delaying capitation payments by one month or maintaining a withhold amount from the capitation payment. However, with the requirement for actuarially sound capitation rates under federal regulation 42 CFR 438.6 (c), each of these approaches would need to be discussed with CMS and may not be viable options. (p.10) (*Actuarial soundness is a new CMS requirement. It is important to know if the savings estimates drawn from other state experiences reflect experience under rates set with the actuarial soundness test and to find out how Mr. Damler has taken this new test into consideration in his future budget projections and savings estimates*)
- Based on experiences in other states that operate a more robust Medicaid managed care program with fewer full time employees dedicated to the program, it is realistic to assume that there is administrative capacity at ODJFS. (p. 10)
- Successful expansion of the Medicaid managed care program will require a commitment by State leadership in pushing to make needed changes in policies, procedures, reviews, and approvals necessary to get contracts signed with managed care plans and begin enrollment of beneficiaries in plans of their choice. The implementation period set out in this document is based on experiences in other states and is a realistic plan. (p. 10) (*The report does not specify what these changes would need to be. It would be good to understand what these changes entail to determine if State leadership would want to push for them*)

Based on these assumptions and methods caveats, Mr. Damler estimates the following savings to result from moving to full-risk managed care. For SFY 2006, he calculates an incurred all funds (state and federal) savings of \$215.1 million and state share savings of \$86.7 million or 7.6% of anticipated fee for service expenditures. The savings associated with the expansion to full risk managed care for the non-Dual Disabled only would be \$121.9 million (all funds) and \$49.2 million (state share).

This estimate, however, does not include the first year costs associated with moving from the existing cash basis. As Mr. Damler noted, in the first fiscal year of implementation this proposal would require the State to budget an additional 4% increase in spending to cover the costs of the transition to managed care capitation payments. This 4% estimate consists of a 13% expenditure increase minus a 9% savings from moving to managed care.

For the five year period of SFY 2006 to SFY 2010, Mr. Damler estimates the following incurred total savings (not counting the first fiscal year implementation costs of moving from the cash basis) of \$1453.9 (all funds) and \$586.2 million (state share).

## Assessment of the Report

Mr. Damler's report appears to be well reasoned and developed. However, this report did not give a specific five year savings estimate for the CFC and the non-Dual Disabled population. However, using the same percentage that Mr. Damler used for expenditures for the CFC and the non-dual Disabled in SFY 2006 I was able to provide an estimate for savings associated with both population groups. For the CFC population, the five year incurred savings estimate is \$630 million (all funds) or \$254 million (state share). The non-Dual Disabled population savings estimate is \$823.9 million (all funds) or \$332.2 million (state share). For my calculations, see Appendix A.

The SFY 2006/07 incurred savings estimate would be:

- Total savings of \$463.5 million (all funds) or \$186.9 million (state share)
- CFC population-related savings of \$200.8 million (all funds) or \$81 million (state share)
- Non-Dual Disabled population-related savings of \$262.7 million (all funds) or \$105.9 million (state share)
- These savings estimates for SFY 2006/2007 do not include first fiscal year increase in costs associated with the cash basis issue. As mentioned before, since the State of Ohio operates on a cash basis, the implementation of a mandatory risk-based managed care program, in which the State pays a capitated dollar amount each month, will temporarily increase the cash-flow during a portion of a single fiscal year (page 9). This increase would require an estimated 13% increase in claims payments during the first fiscal year of implementation. These costs must be subtracted from the total incurred savings calculation to obtain the total overall GRF savings (unless Ohio finds an alternate source of funds to cover this implementation cost).
- The Governor's budget proposed a 4.5% assessment on the total book of business for all Medicaid serving managed care plans to cover these costs for expanding to the CFC population. Creating this assessment requires another CMS approval process, which is not included in the report's timetable. Moreover, the Bush administration Medicaid budget reform proposals would limit the total provider assessment rate to 4%. It also wants to change how that rate would apply to managed care plans, a change which could undermine its acceptance to Ohio's managed care plan community.
- It is not certain that the proposed assessment is sufficient to cover the implementation

costs of expanding full risk managed care to the non-Dual disabled population. If not, either the assessment must be increased (6% is the current federal maximum assessment rate) or some other source of funds needs to be tapped to cover these costs.

This report did not calculate the total net GRF savings from the move to managed care. I attempt to make that estimate by using Mr. Damler's 13% cost increase estimate for the effect of dealing with the cash basis situation. This 13% increase on the total fee-for-service expenditures for SFY 2006 would equal \$366.1 million (all funds) or \$147.6 million (state share). If this increase should be based on total managed care expenditures in SFY 2006 (the report was not clear on this point), the increase would equal \$338.1 million (all funds) or \$136.3 million state share. Based on this calculation the total net savings should be \$97.4 million (all funds) or \$39.3 million (state share) using the FFS expenditure calculation, or \$125.4 million (all funds) or \$50.1 million (state share).

If CMS approved a managed care assessment fee sufficient to cover these first year fiscal costs, the total net savings would equal Mr. Damler total incurred savings estimate.

### ***Mercer's assessment on cost savings estimate***

Though the Mercer report concurred with Milliman's managed care savings estimate for the non-Dual Disabled population, it finds a lower, though real, total savings from moving to managed care. According to Mercer, "the expected total State savings for CY 2006 is \$74.4 million (state share for both CFC and Blind and Disabled) and the savings from CY 2006 to CY 2010 is \$531.1 million (state share for both CFC and Blind and Disabled). These projections are approximately 14% and 9% less than the numbers in the Implementation Plan Report, respectively." Mercer's first year savings estimate for the disabled population is \$84 million (all funds) compared to \$121.9 million (all funds) in the Milliman report.

### ***Does the new actuarial soundness test affect savings estimates?***

The report indicates that managed care will generate a savings discount from fee-for-service of 8% for both the CFC and non-Dual Disabled population groups. Based on the experience in other states, Mercer concurs with the non-Dual savings estimate, but believes that the CFC rate should be reduced to 6%. Past savings estimate have come from the ability of the state to negotiate a capitation rate that would provide a discount off of the existing fee-for-service system. (keep rest of the sentences in this paragraph.) However, the new actuarial soundness rate setting method no longer allows state to set rates pegged to the fee-for-service system. Therefore, it would be vital to confirm if these savings would stand up under the new actuarial soundness test for setting managed care rates. The State of Michigan in its last two budgets has had to find over \$100 million in state funds to bring its managed care rates into compliance with the federal actuarial soundness test requirements for setting capitation payment rates.

### ***Need to recalculate SFY 06 savings because of a different implementation timeline***

Mr. Damler bases his savings calculation on certain assumptions. One of these assumptions is that a full risk mandatory managed care program is operating for both the CFC and the non-Dual Disabled population. The report also notes that it takes implementation time before managed care enrollment (and therefore savings) can begin.

Accepting the assumptions outlined in Mr. Damler's report, but modifying them to reflect an implementation timeline that would not begin until July 1, 2005 at the earliest (the beginning date of authorization to move forward on this expansion proposal), the earliest date that the CFC population could

move into full risk managed care would be July 1, 2006 (or SFY 07, the second year of the biennial budget period). The move of the non-Dual Disabled population into full risk managed care would not begin until October 1, 2006 and the inclusion of the entire non-Dual population would not begin until January 1, 2007.

Since the Governor's budget already includes expanding to the CFC population, the pertinent issue is the savings associated with the non-Dual Disabled population. This timeline means that Ohio will be operating, at best, for only six months under the full risk mandatory managed care program assumption for the non-dual Disabled population. Therefore, the cost savings that this expansion would generate should be no more than half of his incurred savings estimate for SFY 2007, which would be \$61.5 million (all funds) or \$24.6 million (state share), assuming that Ohio covered the first fiscal year implementation costs from non-GRF revenues. If Ohio had to use GRF revenues to cover these costs, the expansion would produce no savings in the SFY 2006/07 budget period and require an infusion of additional funds to cover these implementation costs.

Moreover, the actual SFY 2007 savings would be appreciably less than \$24.6 million because enrollment will not be at the complete level assumed in the report for several months.

### ***Reasons why the savings estimate is likely overstated***

Mr. Damler's cost savings estimate is likely overstated for two reasons. First, this estimate does not take into consideration any savings from the Enhanced Care Management (ECM) initiative (which the state estimates to be four percent). Since the Administration's proposal already assumes certain savings for SFY 07 from the ECM Initiative, an accurate estimate of total savings would need to subtract those savings from the projected savings from full risk managed care. The estimates for the other years within the five year savings projection would also need to subtract the anticipated savings from the ECM initiative.

Second, the fee-for-service expenditures for the ABD population include money for graduate medical education (GME) payments to hospitals. This GME payment is added on to the reimbursement for each hospital service. If the capitation payment to managed care plans does not either include a requirement that the plans pass on this GME payment to hospitals or excludes an amount equal to the GME payment from the capitation rate, hospitals will lose money and managed care plans will be paid too much.

Mr. Damler's savings estimate did not account for this GME policy issue. As a result, he overstated the amount of expenditures that would go to managed care plans and thus overstated the total amount of incurred savings.

### ***Full risk managed care for all populations could undermine existing policies that seek to provide extra financial assistance to hospitals***

In addition to the hospital payment issue related to GME, hospitals face two other potential negative financial consequences from this type of proposal. First, the payment formula under the hospital care assurance program includes payments associated with Medicaid losses. CMS has not supported creating an HCAP funding formula that includes a factor for Medicaid losses from managed care payments. The more money that comes to hospitals through managed care plans, the less money they can recoup through the Medicaid loss element of the HCAP formula.

Second, Ohio has created an upper payment agreement with CMS for Ohio's public hospitals, such as Metro Health. The methodology for this agreement relies on using fee-for-service expenditures to calculate the upper payment amount due to a given public hospital. My understanding is that CMS was unwilling to allow Ohio to include HMO expenditures when calculating the upper payment amount.

### ***Challenges that could slow the implementation timeline***

The projected savings may take longer to achieve because Mr. Damler's timeline assumptions are very aggressive. Mercer's analysis refers to Milliman's timeline as "very aggressive." This timeline assumes that Ohio will have sufficient managed care plan capacity at the moment that enrollment could begin. He notes that Ohio may need additional plans to enter this market and that there are plans with such interest. However, his list of tasks does not include the time it would take new plans to Ohio to get a license from the Ohio Department of Insurance.

To avoid problems that occurred in the 1990s ramp up of managed care, Ohio needs to ensure that it signs contracts with only solvent, well managed companies. It also must make sure that the speed of implementation does not overwhelm the capacities of even these well managed plans. Experience shows that it can take some time for plans to effectively absorb the addition of a large number of new enrollees. Going too fast could stretch the capacity of some plans and threaten the effectiveness of the effort.

Other challenges that could slow the implementation timeline include:

- CMS-generated delays to the waiver approval process
- CMS opposition or prolonged review and concern with the provider assessment proposal. Without this assessment ODJFS will not have sufficient funds to cover the necessary first fiscal year implementation costs
- The length of time it takes to reach an agreement with hospitals over issues related to GME payments, upper limit payments, and HCAP payments
- The length of time it takes to reach agreement with managed care plans on the capitation payment rate and any shared savings incentives between the State and the plans
- State administrative rule process requirements, which could be dragged out if there is appreciable opposition from providers and/or consumers, especially those with disabilities. *Opposition from consumers could be especially strong if people with disabilities do not believe that ODJFS has put in sufficient quality and monitoring protections. Opposition from providers could be strong if they doubt that the state has established sufficient protections from plan insolvencies or there has not been an acceptable resolution of the GME payment issue.*
- Any need to rebid, or at least amend, the enrollment services broker contract with the expansion of managed care to the non-Dual ABD group
- CMS opposition or prolonged concerns to any proposal to delay capitated payments to managed care plans, even if for just one month
- Complications that arise between managed care plans and Ohio's locally funded behavioral health systems over the financing and delivery of behavioral health services

### ***Likelihood that the move to managed care will not stave off future budget increase pressures***

Finally, the move to full risk managed care may not relieve the Administration and Ohio General Assembly of future budget increase pressures. My analysis of Mr. Damler's future spending projections suggests that he is assuming an 8.7% increase in total managed care expenditures per year (see Appendix B). That rate of increase is almost two times the suggested maximum expenditure growth target from the Ohio Commission to Reform Medicaid.

The follow up Milliman document states that the report assumes that the composite annual trend rate (per member per month costs, caseload effect excluded) would be 0.5% less than for the fee-for-service system. Therefore, this trend would be 3.5% for CFC (versus 4.0% for fee-for-service) and 5.3% for the Blind and Disabled Population (versus 5.8% for fee-for-service).

This annual rate of expenditure growth suggests the need to ask the managed care industry a couple of questions:

- What would it take for them to hold the increase in Medicaid managed care expenditures to no more than 4.5% per year, including increases associated with caseload growth?
- Would the Medicaid managed care industry accept a deal that holds the rate of managed care expenditures increase at only 4.5% per year, including caseload? This rate of increase would mean that the capitation rates would have to increase at less than 4.5% per year.
- Would this type of capitation rate setting, that held the maximum capitation rates could increase to 4.5% a year, meet the federal actuarial soundness test?

## Conclusion

It is imperative that Ohio Medicaid bring more care management tools into serving its ABD population. This effort, however, will require new initial expenditures to cover various implementation costs. That these expenditures are needed should not hold the Administration and Ohio General Assembly back from making this investment. Without making this investment in this budget, the costs will only be postponed and the savings from care management will be pushed out even farther.

One budget challenge is that these savings will not be very significant during the SFY 06/07 biennial budget period. Enrollment of the non-Dual Disabled population will not be able to begin before January 2007. The savings over a five year period would be much greater, assuming that the expectation that capitation payments which meet the actuarial soundness test created the amount of expenditure savings that Mr. Damler predicts. The other budget challenge is that this proposal does not assure that ODJFS can keep payment increases to managed care plans at or below 4.5% a year, the budget target cap recommended by the Ohio Commission to Reform Medicaid.

Importantly, this assessment of Mr. Damler's report does not deal with the question of whether a full risk or ECM type model would work better in Ohio and produce more savings. Without a doubt the full risk model provides more predictability in spending and a greater certainty regarding the amount of savings (if any) based on the negotiated capitation rate. The ECM model could well generate as much or even greater savings than the full risk model, if the assumptions underlying that approach are met.

In addition, any move to care management must manage the tension between needing to get the effort up and running with due speed and needing to make sure that the implementation occurs smoothly and does not create unplanned burdens on either the plans or providers.

Finally, this current budget proposal could fall apart, even for the CFC population, if the Bush Administration follows through with its proposals to reduce the allowable provider assessment rate and/or alters the rules for establishing such assessment for managed care plans.

The Milliman Report on Medicaid Managed Care Expansion in Ohio is available on the Ohio Commission to Reform Medicaid's website at <http://www.ohiomedicaidreform.com/pdf/OAHPCommissionReport4.pdf>. The report was originally presented to the Sub-Committee on Eligibility and Covered Families and Children of the Ohio Commission to Reform Medicaid on August 24, 2004.

## Appendix A Calculation of Savings

<i>Savings Projection (millions of dollars)</i>	Total savings	CFC total	CFC state	ABD total	ABD state
<i>columnar calculation basis</i>	<b>A (=B+D)</b>	<b>B (0.4332 x A)</b>	<b>C (B x 0.4032)</b>	<b>D (0.5667 x A)</b>	<b>E (D x 0.4032)</b>
2006	\$215.1	\$93.2	\$37.6	\$121.9	\$49.2
2007	\$248.4	\$107.6	\$43.4	\$140.8	\$56.8
2008	\$286.0	\$123.9	\$50.0	\$162.1	\$65.4
2009	\$328.4	\$142.3	\$57.4	\$186.1	\$75.0
2010	\$376.0	\$162.9	\$65.7	\$213.1	\$85.9
Total expenditures all	\$1,453.9	\$630.0	\$254.0	\$823.9	\$332.2
State Share	<b>X 0.4032</b>	<b>X 0.4032</b>	<b>X 0.4032</b>	<b>X 0.4032</b>	<b>X 0.4032</b>
Total expenditures state share	\$586.2	\$254.0	\$102.4	\$332.2	\$133.9
Total expenditures SFY 06/07	\$463.5	\$200.8	\$81.0	\$262.7	\$105.9
State Share	<b>X 0.4032</b>	<b>X 0.4032</b>	<b>X 0.4032</b>	<b>X 0.4032</b>	<b>X 0.4032</b>
Total state share 06/07 expenditures	\$186.9	\$81.0	\$32.6	\$105.9	\$42.7

  

<i>Estimate of first year fiscal cash basis costs &amp; net Medicaid savings</i>				
	13% all funds cost	Total All Funds 06/07 savings	13% state cost	Total state net 06/07 savings
<b>Total</b>	\$463.5	\$186.9	\$186.9	\$39.3
Option 1	\$366.1	\$97.4	\$147.6	\$50.6
Option 2	\$338.1	\$125.4	\$136.3	\$27.8
<b>ABD</b>	\$262.7	\$105.9	\$105.9	\$27.8
Option 1	\$209.6	\$53.1	\$84.5	\$21.4
Option 2	\$193.7	\$68.9	\$78.1	\$21.4

  

	Total Spending	Savings
<b>Projected Expenditures</b>		
Fee For Service	\$2,815.9	
Managed Care	\$2,600.8	
Fee For Service - Non-Dual	\$1,612.1	
Managed Care - Non-Dual	\$1,490.2	

Note: The red and black lines above show the calculation paths.

## Appendix B Projection of Expenditures

<i>(millions)</i>							
Expenditures Projected	Total Spending	% growth all	CFC total	% growth CFC	ABD total	% growth ABD	
2006	\$2,600.8		\$1,110.6		\$1,490.2		
2007	\$2,827.4	8.7%	\$1,225.1	10.3%	\$1,602.3	7.5%	
2008	\$3,073.3	8.7%	\$1,331.6	8.7%	\$1,741.7	8.7%	
2009	\$3,341.4	8.7%	\$1,447.8	8.7%	\$1,893.6	8.7%	
2010	\$3,632.6	8.7%	\$1,574.0	8.7%	\$2,058.6	8.7%	
Total expenditures all funds	\$15,475.5		\$6,689.0		\$8,786.5		
State Share	<b>X 0.4032</b>		<b>X 0.4032</b>		<b>X 0.4032</b>		
Total state share expenditures	\$6,239.7		\$2,697.0		\$3,542.7		
Total all funds 06/07 expenditures	\$5,428.2		\$2,352.0		\$3,076.2		
Total state share 06/07 expenditures	\$2,188.7		\$948.3		\$1,240.3		

## **For More Information About Medicaid, Reforming Ohio's Medicaid Program, and the Health Policy Institute of Ohio**

For more information on the different issues that arise in attempting to reform Ohio's Medicaid program, please refer to the Health Policy Institute of Ohio's publication *Ohio Medicaid Reform: Key Issues to Consider*.

For more general information about Ohio's Medicaid program, including federal eligibility requirements, benefits, financing, and administration, please refer to the Institute's publication *Ohio Medicaid Basics*. Both publications are available by calling the Health Policy Institute of Ohio at 614.224.4950 or by visiting the Institute's website at [www.healthpolicyohio.org](http://www.healthpolicyohio.org).

The Health Policy Institute of Ohio is an independent, nonpartisan organization that forecasts health trends, analyzes key health issues, and communicates current research to Ohio policymakers, legislators, and other decision makers.



37 West Broad Street, Suite 350  
Columbus, OH 43215-4198  
Phone: 614.224.4950; Fax: 614.224.2205  
[www.healthpolicyohio.org](http://www.healthpolicyohio.org)