Joint Medicaid Oversight Committee
Minutes
March 20, 2025
136th General Assembly

The Joint Medicaid Oversight Committee was called to order pursuant to the meeting notice at approximately 9:00 a.m. in the Senate Finance Hearing Room.

The clerk called the roll, and a quorum was present. The minutes of the February 27, 2025, meeting was approved without objection.

The Chair opened with an overview of the day's agenda; first, the Ohio Department of Medicaid presenting their 1115 Demonstration Waiver Application for Ohio's Group VIII Work Requirement and Community Engagement, which was submitted to U.S. Department of Health & Human Services on February 28, 2025. To be followed by Greg Moody, former Executive Director of the Ohio Governor's Office of Health Transformation, on Ohio's Medicaid Expansion History and Impact.

Maureen Corcoran, Director of the Ohio Department of Medicaid, was called forth and reviewed their Medicaid Work and Community Engagement Requirements slide packet. Director Corcoran did not provide written testimony.

Questions were asked

Vice Chair Romanchuk asked if the previous allocation of monies to design, develop and implement a new IT system for the last waiver is being used to launch this new initiative. The funding was approved, but never took place because of the COVID Pandemic. Director Corcoran explained that the details in which the program will be designed is subject to Centers for Medicare and Medicaid Services (CMS) guidance and requirements. Also, that the planning for the IT design is underway and that much of that can be built upon, but cannot be completed until their agency receives final approval from CMS.

Patrick Beatty, Deputy Director of Policy for the Ohio Department of Medicaid, provided an explanation to Representative Gross, on the details of self-attestation. Self-attestation is accepted for many different factors including residency, age, and things that are not generally subject to questioning. Proof of pregnancy is not required unless there's reason

to doubt or if the anticipated due date has passed. Mr. Beatty further explained the variety of checks from multiple data sources available to verify a person's address, citizenship, employment status et cetera. The agency receives regular file downloads that generate alerts to county case workers that require follow-up action to confirm an individual's, income, address or third-party insurance.

Senator Liston brought up concerns of uncompensated care for our safety net hospitals and those that would bare the brunt of the cost. Director Corcoran recommended a through research into the program and although she does not have an estimated cost of what the hospitals and other entities will likely absorb to treat uninsured individuals, there will be a cost.

Additional questions were asked.

Chair Holmes reiterated the intent of this initiative is to have people obtain medical coverage through other means, ideally, their employer, not to have them uninsured.

Chair Holmes then introduced Greg Moody. Greg Moody is the former Director of former Governor John Kasich's Office of Health Transformation. It was through Greg Moody's work along with Governor Kasich and Ohio's 130th General Assembly, that the Ohio Department of Medicaid was created as a stand- alone agency with the goal to make the program fiscally sustainable and improve health outcomes. The Office of Health Transformation shepherd through Ohio's Group VIII Medicaid Expansion in 2014.

Mr. Moody gave testimony on the history and impact of Ohio's Medicaid Expansion. He explained how Expansion has a small impact on the state share of the budget but brings in billions of federal dollars. Last year, Ohio spent $838 million to draw $7.5 billion in federal funds, totaling $8.4 billion. The money goes directly to health care providers across the state, boosting Ohio's economy. The Expansion saves at least $68 million by converting state-funded programs to ninety percent (90%) federal funds, for example hospital stays for prisoners and hospital upper payment limit programs. The state also would lose at least $72 million in drug rebates and $415 million in managed care taxes. In addition, he shared two concerns in House Bill 96, Governor DeWine's kill switch on mental health and addiction services, and runaway spending that jeopardizes the expansion and coverage for everyone on Medicaid. Mr. Moody provided both written testimony as well as charts illustrating his testimony.

Questions were asked.

Representative Gross asked for Mr. Moody to expand on the history of the Single Pharmacy Benefit Manager (SPBM) and how the state could possibly decrease cost after getting used to spending in the space.

Mr. Moody responded by providing the details of how the SPMB came to be and different components of the program that should be reviewed for cost savings. In 2017 pharma funded a national campaign to under mind PMB in State Medicaid Programs. They worked with independent pharmacies, to point out as the middleman in the drug equation, PBM's, were pocketing large sums of money. The Office of Health Transformation conducted a report and found that the PBM's were keeping a margin of 8.8% vs. 20% as the pharmacy's had claimed. However, 8.8 percent was still high and by the end of the Kasich administration, the state required full transparency of PBM pricing. This let the program decide what a reasonable rate of return should be. This model was set and place and adopted by many other states as best practice.

There are several things within the SPBM that drive cost:

1. Fees the PBM's pay to Pharmacies. This is important for independent pharmacies. The fees were less than one dollar and increased to more than ten dollars. This rate increase was given to both the independent pharmacy and the retail-chain pharmacy. It is unclear why the fee increase was given to the retail chain, as they don't need the dispensing fees based on their volume.
2. There are specific areas within the SPBM where there are possible savings. Another being, giving plans the right to contract with the retail chains. They would be able to negotiate a dispensing fee.
3. Another component of the PBM is the preferred drug list. The idea behind the list is there are similar drugs that do the same thing. You negotiate a rebate for one of the drugs. The rebated drug gets put on the list and the other does not.
   The way to save the most money is to allow each health plan to have its own preferred drug list. This forces competition among the manufactures to get on the list. The downfall is the providers will have to work off several different drug list.

Ranking Member Liston wants to know what information can be separated out to determine areas of savings related to policy changes vs. increased cost in specialty drugs.

Mr. Moody shared that JMOC would want to look further into the monthly variance reports posted on the ODM website and look at the PBM spending by month. Determine what was the spending: Net of rebates and dispensing fees. Obtain an account of component cost presently and what it was prior to the SPBM implementation. The data involved would take the involvement of JMOC's actuary to complete a report finding.

Additional questions asked.

Based upon Senator Manchester's question, Mr. Moody recommended the Committee ask questions of local Family and Children First providers along with local Behavioral Health providers to get a better understanding of how the care coordination for OhioRISE is operating and if there are areas for improvement.

Senator Huffman noted the Medicaid's growth rate increase for this budget and where that money will come from in the future, but the need for the last budget's provider rate increases especially for home healthcare and mental health and to ensure providers accept Medicaid. He asked how you stop that growth rate going forward and yet have enough providers and networks who want to accept Medicaid. Mr. Moody stated he was absolutely right, that groups such as direct care provider had not seen an increase in a decade or more and we were losing them to other industries. As a result, the workforce diminished and in turn patient care was affected. However, to be mindful of provider rate increases across the board. Such increases cause one group to get too much of an increase and the other group to not receive enough. An example is one urban hospital not needing a rate increase as much as a rural critical health access hospital that might.

Former Director Moody answered Senator Ingram's inquiry about the recent National Public Radio story concerning from Ohio's Medicaid providers not receiving payments and this issue, which was created by ODM's new Fiscal Intermediary as part of its Next Generation. Moody explained prior to 2022 and ODM's Next Generation initiative, Ohio was known for having a fast turnaround time for Medicaid payments to its providers. The providers would submit a payment to Ohio's Medicaid managed Care Plans (MCPs) who would in turn pay the claim. That information was then shared with ODM who would verify, reconcile and review for policy reasons. Currently, the providers submit their claims to ODM through the new Fiscal Intermediary which then processes the claim and sends it to the MCPs to pay. Mr. Moody once again encourages JMOC to request data on the length of time it takes the fiscal intermediary to process a claim.

Several members asked varying questions regarding Group VIII, the trigger language and its budget impact on the state. In summation, Former Director Moody recommends keeping the Expansion group if possible. To do so, he recommends that the legislature change the language in Section 126.70 of the proposed budget bill from "shall" to "may" allowing the state to weigh its options if federal funding changes. Or be sure to adopt Section 126.10 that says state may reduce, discontinue, pause or suspend" any program if federal funding for that program is cut. By adopting and or changing the language as introduced, Ohio's General Assembly will have flexibility to determine at what point does it no longer make financial sense to keep the program.

Ranking member Liston's final question asked about history and any other helpful insight Mr. Moody may have of Nursing Facility rates. Mr. Moody shared there were rate increases for nursing facilities written into statue ensuring an annual rate increase would occur. There are no provisions tying the rate increase into the number of patients being served. Therefore, even if the bed occupancy were low, the state payment obligation continues to increase. This is another opportunity to review for potential cost savings in the budget.

Without further business, Chairman Holmes adjourned the Committee at approximately 10:58 a.m.

Adam Holmes, Chair

Beth Liston, Secretary