THE BUCKEYE INSTITUTE

History and Suggested Ohio Medicaid Reforms

Interested Party Testimony
Ohio House Medicaid Committee

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As Prepared for Delivery

Chair Gross, Vice Chair Barhorst, Ranking Member Banker, and members of the Committee, thank you for the opportunity to testify regarding Medicaid and suggest options for reform.

My name is Rea S. Hederman, Jr. I am the vice president of policy at **The Buckeye Institute**, an independent research and educational institution—a think tank—whose mission is to advance free-market public policy in the states.

As the Committee knows, Medicaid is a voluntary joint program administered by states under rules and oversight from Washington, with the federal government covering most of the program's costs. Medicaid is an entitlement program, which means that an eligible participant has rights to access program services. And it is means-tested, which means that a recipient benefits when their earnings surpass the income eligibility limit.

Program eligibility depends on various factors, including age, income, and wellness. The primary Medicaid eligibility categories include: children and parents; adults 19-64 with income below 138 percent of the federal poverty level (Group VIII); and those considered aged, blind, or disabled (ABD). Although originally designed to help provide medical care for low-income households, eligibility expanded significantly under the Affordable Care Act and Ohio's Group VIII rolls have climbed to nearly **800,000 participants** since 2012, instead of a mere 15,000 participants that it would have added without the expansion. Roughly 90 percent of Ohio's three million Medicaid enrollees are in managed care, which means that Ohio Medicaid pays a per-member-per-month (PMPM) fee to insurers for Medicaid services. The remaining enrollees are in fee-for-service (FFS) Medicaid or a limited coverage plan. In considering Medicaid reforms and improvements, it is important to remember that because the program includes varied segments of the population, policy reforms that affect one Medicaid enrollment pool may not affect the others.

Funding Facts

Medicaid is the largest part of the Ohio all funds budget and the second largest line item of the general operating budget due to federal contributions. Governor DeWine's proposed FY 2026 budget calls for $48 billion in all funds and $22.4 billion in all general revenue funds.

States pay for Medicaid services and Washington reimburses them for some of the costs. The federal government reimburses all states 90 percent for all care provided to low-income, Group VIII enrollees, but it otherwise reimburses states according to the federal matching assistance percentage (FMAP), which varies by state per capita income, with wealthier states receiving less assistance than poorer states (the actual funding formula is 100%-((State per Capita Income)^2/(US Per Capita Income)^2 *.45). Ohio's FMAP is 65 percent for traditional Medicaid services, which means that the federal government reimburses the state that percentage for traditional Medicaid spending. Congress can adjust the FMAP and the federal rules governing Medicaid, as it did during the COVID pandemic, for example, when it increased the FMAP but also made it nearly impossible for states to disenroll anyone from Medicaid for several years.

ABD is Medicaid's most expensive category, with enrollees dually eligible for both Medicaid and Medicare making up almost half of all Medicaid expenditures despite comprising less than one-

fifth of Medicaid enrollees. This is not surprising since unhealthy individuals account for most health care spending. Group VIII enrollees account for about a quarter of enrollees and a quarter of expenditures. And eligible families and children account for over half of enrollees and under a quarter of expenditures because children are cheaper to cover than adults. Medicaid managed care companies receive premium payments based on these cost differences.

Program Integrity

Maintaining Medicaid's integrity is a difficult task, and the program routinely makes improper payments to ineligible participants. Because Ohio administrates Medicaid, enforcing program integrity and policing proper payments falls to state rather than federal agencies. Some improprieties are deliberate while others are merely mistakes, exacerbated by the fact that many Medicaid enrollees are transient and difficult to find. The Ohio auditor, for example, recently attempted to verify Ohio residency for managed care enrollees and **found** that he was "unable to confirm Ohio residency for 40 percent of the tested capitation payments. The reviewed data indicated residency in another state for 26 percent of the payments and, for 14 percent of the payments, the documentation was inconclusive as to the residency of the individual. Using these results, we estimate that the potential impact for Ohio due to concurrent enrollment of individuals in these top 11 states to be $209 million." The auditor observed that allowing the self-attestation of an address increases Ohio's risks of improper payment and enrollment. Similarly, a **previous auditor report** found that Ohio was making improper or duplicate payments for tens of thousands of individuals due to faulty record keeping.

Recent national estimates of **almost $100 billion in improper Medicaid payments** likely represent a best-case scenario, and an inaccurate one at that, given that rule changes during the COVID pandemic dramatically restricted state Medicaid audits and barred them from removing ineligible enrollees. Even now, federal rules allow states only one annual review of an enrollee's eligibility. It is therefore imperative that Ohio ensure that review is accurate and uses integrated data that can track enrollees' residence and employment history. As part of its integrity enforcement protocols, Ohio should ensure that managed care plans know where their enrollees reside if they are being paid to take care of them.

Changes in Washington

Medicaid reform is often touted by Republicans and Democrats in Washington as a means to save money and reduce the national debt. President Obama once proposed a blended Medicaid match rate that would have lowered the Group VIII 90 percent match rate and saved billions of dollars. Republicans have also advocated reducing the Group VIII match rate and the Trump administration's new leadership has expressed interest in revising Medicaid to curb federal spending. Adjusting the 90 percent match rate presents an attractive approach because it would not only save the federal government money, but it would encourage states to tighten program oversight. With states only paying ten percent of Group VIII expenses, they lack adequate incentive to enforce Group VIII integrity.

Federal officials may also soon take a harder look at how states tax health care providers. States may use taxes on health care providers to pay for Medicaid if the taxes satisfy federal criteria. Washington is wary of such taxes because increasing Medicaid services uses more federal tax dollars and benefits the state. Not surprisingly, as Medicaid costs rise and states use taxes on health care providers more aggressively, there are more federal Medicaid audits and talk of making the federal criteria more difficult to satisfy. Governor DeWine's proposed budget includes a **provider tax increase** that raises 53 percent more in revenue in the hospital franchise fee that pays for Medicaid services. Reformers in Washington dislike this kind of tax because it allows states to pass the bill to the federal government instead of running a more efficient program. Ohio has been cited for improper Medicaid service provider taxes before, and the federal government may further restrict such taxes, removing them as a Medicaid revenue source for the state.

Suggested Reforms

Ohio can make several Medicaid reforms to enhance program integrity and safeguard it against potential rule changes in Washington.

First, Ohio should require address verification for Medicaid payments and not rely on error-prone enrollee self-attestation. Disallowing ineligible recipients to enroll is more effective than trying to purge ineligible enrollees later. Accordingly, the state should improve and integrate its data systems by connecting various agencies and data sources to provide a unified framework that will reduce redundancy and minimize errors. Real-time data sharing among integrated data systems will improve payment accuracy and monitoring, ensure that resources are allocated appropriately, and help administrators detect fraud and abuse.

Second, Ohio should continue working on its **proposed 1115 work and community engagement waiver** "(i) to promote economic stability and financial independence, and (ii) to improve health outcomes by encouraging individuals to be engaged with their health and healthcare." Ohio's proposed waiver will require Group VIII recipients to meet one of the following criteria: be employed; be at least 55 years old; attend school or an employment training program; suffer mental health issues or intense physical needs; be a drug or alcohol addict. The Ohio Department of Medicaid estimates that less than 10 percent (under 62,000) of current Group VIII enrollment will lose coverage. Work requirements offer substantial benefits to Medicaid enrollees. Unfortunately, as the Congressional Budget Office estimated, many Americans reduce their work effort to lower their income so that they qualify for Medicaid. Reducing work effort or dropping out of the labor force altogether reduces an individual's immediate wages and their lifetime earning potential. The Buckeye Institute's research shows that Medicaid work requirement waivers can increase lifetime earnings by hundreds of thousands of dollars for enrollees.

Finally, Ohio can protect itself against changes to the FMAP rate by adopting a trigger that would freeze Group VIII enrollment if the FMAP rate declines. If the Group VIII FMAP was reduced from 90 percent to the traditional FMAP rate, for example, the Ohio Medicaid budget would need to increase by $1.5 billion annually to maintain existing coverage. Such an increase would put severe pressure on Ohio taxpayers and other state programs. Barring new Group VIII participants

would not affect current enrollees, but it would eventually reduce Group VIII enrollment as current enrollees leave the program. Governor Kasich line-item vetoed such a freeze in 2017, but several states have successfully used enrollment freezes to relieve fiscal pressure on the program and state budgets.

Thank you for your time and attention. I would be happy to answer any questions that the Committee might have.

About The Buckeye Institute

Founded in 1989, The Buckeye Institute is an independent research and educational institution – a think tank – whose mission is to advance free-market public policy in the states.

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