OHIO MEDICAID SINGLE PHARMACY BENEFIT MANAGER (SPBM): PROGRAM UPDATE AND FISCAL IMPACT

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Chairman Holmes, Vice Chair Romanchuk, Ranking Member Liston, and members of the Joint Medicaid Oversight Committee, thank you for the opportunity to discuss the Ohio Medicaid Single Pharmacy Benefit Manager (SPBM) program. My name is Sean Eckard, and I serve as Pharmacy Director for the Ohio Department of Medicaid. The SPBM program has garnered much attention - both within Ohio and nationally - and as such, I'm excited to discuss the operational history of the program as well as its fiscal performance to date. Ohio has been recognized as a national leader in Pharmacy Benefit Manager (PBM) reform, and the Ohio Department of Medicaid is focused on ensuring all Ohioans served by Medicaid have ready access to clinically appropriate pharmaceutical care. Additionally, it is our goal to provide a best-in-class pharmacy program for all beneficiaries, pharmacy providers, and medical professionals that interact with the single PBM.

Operational History of the SPBM Program

The Single Pharmacy Benefit Manager program was conceived in 2019 when the Ohio General Assembly passed House Bill 166, which directed ODM to procure a single PBM that would provide pharmacy benefits for all Medicaid beneficiaries in the care management system. After passage of the bill, ODM immediately began the work of procuring a qualified pharmacy benefit manager. Through a very competitive procurement, Gainwell Technologies, formerly DXC, was selected as the SPBM vendor. Once the contract was awarded, the design, development, and implementation phase (DDI phase) was immediately undertaken, culminating in the full implementation (go-live) of the program on October 1, 2022. Gainwell is responsible for most aspects of pharmacy benefit management, including the following:

1. Operating a call center to answer inquiries from beneficiaries, pharmacies, prescribers, and managed care plans;
2. Maintaining an adequate, qualified network of pharmacies;
3. Managing utilization of pharmaceutical products through prior authorization;
4. Processing/Adjudicating all pharmacy claims;
5. Providing timely payments to pharmacy providers;
6. Maintaining adequate and secure systems, and;
7. Storing pharmacy program data and providing analytics and reporting on pharmacy trends.

Gainwell is not responsible for developing reimbursement amounts or payment rates for pharmacy services, developing the Unified Preferred Drug List, processing drug rebates, or managing clinical pharmacy programs. These functions are administered by other vendors or by the Department of Medicaid directly.

Concurrently with the SPBM implementation, Ohio Medicaid worked to implement another innovative prong of the Next Generation Pharmacy Program: the **Pharmacy Pricing and Audit Consultant, or PPAC**. The PPAC vendor, currently Myers and Stauffer, works in coordination with ODM and Gainwell to improve transparency, accountability, and efficiency within ODM's pharmacy benefits program. The Ohio Medicaid PPAC assists and supports ODM in the performance of two critical pharmacy services functions: first, **pharmacy reimbursement and benefit design**; and second**, pharmacy program oversight and auditing**. The PPAC is central to achieving transparency through its work in determining reimbursement methodology, conducting Cost of Dispensing (COD) and Actual Acquisition Cost (AAC) surveys, maintaining accurate and up to date AAC rates, and conducting oversight of the SPBM. The success of this pharmacy benefit administration model, and the PPAC specifically, is demonstrated by fair, accurate, and value-based reimbursement to pharmacies; additional oversight ensuring the SPBM complies with ODM's expectations; improved provider and member satisfaction; and continuous quality improvement within the pharmacy program.

Moving back to the SPBM program, full implementation or 'go-live' occurred at midnight on October 1, 2022. During the initial go-live period, two significant complications arose. First, call center volumes were extremely elevated, driven primarily by the need for pharmacies to obtain beneficiary member identification numbers. While ODM and managed care plans issued new identification cards to all members prior to October 1, a significant portion of members did not present their physical card at the pharmacy. This resulted in the pharmacies relying on external systems, such as SureScripts, to validate patient enrollment information. The second complication was concerning prior authorizations. While ODM, Gainwell, and the managed care plans worked to coordinate the transfer of prior authorization data before go-live, we observed a significant number of prescription rejections over the first weekend for 'PA Required'. This was concerning as many of these rejections were for non-first fills; this indicated that the member should have already had a prior authorization on file or that the prior PBM had issued an automatic PA that allowed prior claims to process. Due to differences in how PBM systems process claims, the scope of the issue varied by managed care plan and PBM. To mitigate this, ODM and Gainwell implemented a transitional pharmacy benefit on October 3, 2022, that allowed members to continue to receive medications that they had previously received. Additionally, we directed Gainwell to pause all new prior authorizations, to allow those staff to address the high volume of calls during the first three months of the program.

In January 2023, Gainwell began re-implementing prior authorizations in a phased approach, with prior authorizations being fully re-implemented in May 2023. Since this time, Gainwell has performed well in decisioning **more than 99 percent of prior authorizations** within the statutorily required 24-hour timeframe, which is among the most stringent in the industry.

Despite the initial implementation challenges, Ohio Medicaid and Gainwell received numerous compliments from stakeholders regarding the immediate go-live period. One national chain leader even indicated that ODM should provide consultation to other states that are implementing a single PBM, owing to our availability and willingness to quickly collaborate to resolve issues. During this time, we routinely communicated with stakeholders (including the Ohio Pharmacists Association, National Association of Chain Drug Stores, Ohio Retail Merchants, and various large chain, small chain, and independent pharmacy leaders); during these communication sessions, we shared updates bidirectionally, solicited feedback from providers, worked to troubleshoot various technical issues, and collaborated to resolve macro- and micro-level pharmacy access issues. This level of cooperation with pharmacy stakeholders allowed us to quickly identify problems, develop solutions, and implement them to reduce patient and provider impact and best serve our 3 million beneficiaries.

Since the initial go-live, ODM and Gainwell have reached several other important milestones. I'd like to take a few moments to discuss those before moving on to highlighting program results.

On July 1, 2023, Gainwell assumed responsibility for pharmacy benefits in the fee-for-service pharmacy program, which is approximately ten percent of the total Medicaid population, or approximately 300,000 beneficiaries. While the population is significantly smaller than the managed care population, **this group represents some of the most vulnerable beneficiaries in the program**. As part of this milestone, Gainwell and ODM participated in a significant number of design sessions, as the fee-for-service program is a separate and distinct program, with its own set of claims adjudication rules, reimbursement policies, and federal requirements. Each of these required a full design session, testing, and post-implementation validation activities to ensure the FFS system accurately adjudicated and paid claims.

In 2024, Gainwell implemented electronic prior authorization, also known as "ePA", through two national vendors, SureScripts and CoverMyMeds. Electronic prior authorization replaces the traditional process of submitting a prior authorization, which is typically done via FAX or through a secure website. ePA can be submitted directly through the electronic medical record system at the point of care, dramatically reducing the time required to request a prior authorization and reducing administrative burden for prescribers and their staff. **As part of this initiative, the SPBM also implemented Automatic Decisioning, which in many cases allows for an immediate decision when certain criteria are met.** This is a substantial improvement and allows for beneficiaries to begin treatment immediately when medically necessary, rather than waiting 24 hours for standard Medicaid decisioning timeframes or up to 10 days for commercial payers. The process also reduces provider frustration with the prior authorization process, as denial reasons are communicated clearly and immediately so that an alternative treatment plan can be developed, such as in instances where a preferred drug must be tried first. The ePA initiative was a significant effort spanning over one year and involving extensive commitment from both technical and clinical staff to implement. ODM and Gainwell look forward to increasing availability of Automatic Decisioning, where clinically appropriate, to ensure the best possible experience for all utilizers of the pharmacy program while controlling costs associated with manual decisioning of prior authorizations.

Also in 2024, ODM successfully renewed the SPBM 1915(b) waiver through CMS, which must be completed every two years to continue to operate the program. SPBM requires this waiver to mandatorily enroll all beneficiaries into the SPBM. In renewing the waiver, **CMS determined, based upon evidence submitted, that the SPBM program was consistent with the purposes of the Medicaid program, will meet all statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to the Ohio Medicaid population.** The renewal process required an Independent Assessment to be conducted – which was completed by ODM's External Quality Review Organization and the Ohio Colleges of Medicine Government Resource Center, which supported CMS' findings regarding quality of services and cost effectiveness.

Provider Satisfaction with the SPBM Program

Next, I'd like to share results from a separate independent evaluation of the SPBM program, again conducted by the Ohio Colleges of Medicine Government Resource Center. This evaluation consisted of repeated surveys of pharmacy managers and clinical providers (prescribers) participating in the Medicaid program, beginning in Spring of 2022 and repeated annually thereafter. The major aims of this study were to determine improvement (or deterioration) over time of the SPBM program's performance and to compare perceptions of the SPBM program versus other health plans, such as commercial payers. Among pharmacy managers, the survey found the following:

1. A **large increase in satisfaction with the overall level of administrative burden from the SPBM program**, rising from 7.5% satisfaction in 2022 under the traditional MCO model to 40.8% in 2024. SPBM also outperformed commercial insurance on this metric in 2024, as only 18.3% of pharmacy managers were satisfied with commercial payers.
2. **More efficient prior authorization**, with more than half (54.7%) of pharmacy managers reporting that the PA process was more efficient with the SPBM versus other PBMs.
3. **Increased pricing transparency.** There was a large increase in the percentage of pharmacy managers who reported satisfaction with the level of pricing transparency since implementation of the SPBM (16.5% satisfaction in 2022 versus 40.9% in 2024). SPBM also outperformed commercial insurance on this metric (only 19.8% satisfaction with commercial payers).
4. A **high level of satisfaction with the Unified Preferred Drug List (UPDL)**, with more than half (56.6%) of pharmacy managers reporting satisfaction.
5. **Reduced delays in patients' prescription access due to prior authorizations.** There was a large decline in the percentage of pharmacy managers who reported that the PA process often or always resulted in delays in patient access to medications, from 77.5% in 2022 under the traditional MCO model to 49.8% in 2024 under SPBM.

We believe the survey is well summarized in the words of one pharmacy manager, who stated:

> "I am very happy with the improvement in the Medicaid system since the SPBM implementation. The process is now streamlined and more predictable. We are also not losing money on every prescription we fill for Medicaid patients…we were considering dropping Medicaid insurance or closing our pharmacy if there wasn't a change. This change has given our pharmacy the chance to continue to serve our community."

Among clinical providers (prescribers), the survey found minimal changes in satisfaction with the prior authorization process under SPBM, with about one-quarter of respondents (24.0%) reporting that the PA process had become more efficient since SPBM implementation. Of note, the latest survey was conducted before significant prescriber-facing improvements were implemented, and we anticipate that satisfaction rates will increase with these changes.

While several other states have implemented single PBMs within their Medicaid programs, **Ohio's SPBM model was highlighted in a recent letter from the American Pharmacists Association to President Trump.** As APhA notes[1], "this model delivers transparency and stability while achieving cost savings, making it a clear candidate for national consideration [for PBM reform]". We believe this acknowledgement is a testament to the effectiveness of the SPBM program as a truly innovative model in pharmacy.

Effectiveness of the Unified Preferred Drug List (UPDL)

In January 2020, ODM implemented the Unified Preferred Drug List (UPDL) that consolidated six preferred drug lists into one. This initiative **reduced the administrative burden** for providers by streamlining the prior authorization process, **facilitated greater coordination of care** across all three million covered lives, **reduced member movement** between Ohio's managed care plans, and assisted pharmacies in **streamlining drug inventories**, since only one set of preferred drugs was needed. An additional benefit of the preferred drug list is **optimization of Medicaid drug rebates**, specifically supplemental rebates. The Preferred Drug List is administered jointly by ODM and the Pharmacy and Therapeutics Committee, which is an independent expert panel of physicians, advanced practice nurses, and pharmacists. In creating the UPDL, drug efficacy, safety, and cost-effectiveness are considered.

Within the Medicaid program, there are two main types of rebates, termed 'statutory' and 'supplemental'. Statutory rebates are rebates owed to ODM as a result of the Medicaid Drug Rebate Program, which is a program administered by the federal government and is a prerequisite for Medicaid coverage of most drugs. Drug manufacturers voluntarily enter into the National Drug Rebate Agreement and agree to pay a rebate of between 13% of the Average Manufacturer Price for generic drugs up to 23.1% for brand name or 'innovator' drugs. In addition to this base rate, a manufacturer may need to pay an additional rebate based upon their drug product's rate of price increases compared to the Consumer Price Index for all urban consumers (CPI-U). If a manufacturer increases their product's price

[1] American Pharmacists Association. APhA PBM Reform Recommendations to the President. April 2025. Available at: https://www.pharmacist.com/Advocacy/Issues. Accessed 23 June 2025.

by more than the CPI-U, they must pay the difference in the form of an increased rebate; this is termed the "inflation penalty". Manufacturers must also generally offer the best price to Medicaid and there is an additional check to ensure that the statutory rebate reduces Medicaid's net price down to this figure. Statutory rebates are generally paid on all claims for which Medicaid is a payer – except when a provider elects to use a 340B drug; in this case, the statutory rebate is not payable to Medicaid since the provider would have received a near-equivalent 340B discount for the drug.

While statutory rebates are administered by the federal government, supplemental rebate programs are administered by the states and represent an additional revenue source for the Medicaid program. Ohio currently participates in a multi-state drug purchasing pool called the Sovereign States Drug Consortium (SSDC), which negotiates supplemental rebates with all willing manufacturers. The SSDC is comprised of 15 state Medicaid programs amounting to over 14 million covered lives**; Ohio's participation with this purchasing pool allows for negotiation of more favorable supplemental rebates than could otherwise be secured by an individual state or health plan.** Supplemental rebates are paid for all drugs which are covered under a Supplemental Rebate Agreement, except when a 340B drug is used. In this instance, ODM is not permitted to claim a rebate since the provider already received a 340B discount.

Under the SPBM program, **adherence to the UPDL is at the highest rate since UPDL implementation**, with approximately 94 percent of all claims being for preferred drugs (which constitutes 79.6% of total drug spend). This high rate of compliance is due in large part to collaboration between ODM and Gainwell to effectively drive utilization to preferred products, maximizing use of the safest, most efficacious, and most cost-effective products within a drug class. **Supplemental rebate amounts have also shown an impressive increase**, from approximately $246 million in 2022 under the traditional MCO model to $424 million in the most recent four quarters. Even after adjusting for drug price inflation, total pharmacy program spend, and the negative impact of the 340B program on drug rebates, growth in supplemental rebate revenues is significantly above pre-SPBM levels.

Fiscal Performance of the SPBM Program

Next, I'd like to address the fiscal performance of the SPBM program to date. Due to the complexity of the analysis, ODM's contracted actuary, Milliman, performed a cost-effectiveness analysis of the SPBM program, covering the first two years of operation. I've attached this analysis to my testimony as a supplement.

Before discussing the Milliman analysis, I'd like to note that this analysis only examined managed care experience. As I discussed previously, Medicaid FFS beneficiaries were brought under the SPBM program beginning in July 2023, although FFS continues to be a separate and distinct program. In prior testimony to this committee, there was a mention of an $84 million monthly increase in budget projections for the SPBM program. This increase, which occurred in July 2023, was related to the implementation of the FFS pharmacy benefit, as both programs were combined on the same budget line. It did not represent a true $84 million increase in budgeted pharmacy expenditures. Additionally, this line item on the budget variance report in 2024 included an additional scope of claims, namely professional claims billed by

pharmacies. These drugs were previously billed through the medical benefit but due to a policy change were required to be billed through pharmacy. This shift was accounted for in managed care capitation rates and it does not represent a true increase in spend for the Medicaid program.

Moving back to the Milliman analysis, at a high level, Milliman examined how expenditures changed from the pre-SPBM period to the two years post-SPBM implementation and attributed those changes to specific drivers of spend. They then worked to make a determination as to whether those drivers *would have occurred* under the traditional MCO model. In other words – **Milliman was seeking to determine what the expenditures would have been under the traditional, capitated MCO model compared to the actual experience in the first two years of SPBM.**

As an example, effects from the Public Health Emergency unwinding were assumed to be the same between the SPBM and MCO models, since the changes would have occurred regardless of SPBM status; in other words, SPBM did not drive these changes.

In the converse, changes in drug utilization patterns could have materially varied between the SPBM and MCO models due to differences in how the respective PBMs would have managed utilization – and as such, modeling was performed to identify the respective impact of the SPBM. To attribute an impact to the SPBM, Milliman utilized national datasets, such as the National Healthcare Expenditure (NHE) data, as well as other state Medicaid program data (including projections and actual experience from those states).

Milliman also noted several qualitative impacts of the SPBM program that occur outside of the direct fiscal impacts, such as:

1. A shifting of ODM expenditures from MCO administrative overhead directly to pharmacy providers, in the form of increased dispensing fees
2. **Uniform and transparent reimbursement** for pharmacy providers, with no clawbacks, effective rate contracting, or post-payment reconciliation/true-ups
3. A **streamlined and uniform pharmacy benefit**, from multiple MCOs/PBMs to a single point of contact
4. A **comprehensive, robust pharmacy network**, made up of greater than 99% of Ohio pharmacies, which represents the largest network of pharmacy providers ever for managed care beneficiaries
5. The nature of drug utilization changes which implies **greater access to pharmaceutical care**

In calculating the fiscal impact analysis, Milliman compared the actual SPBM expenditures and invoiced rebates to the “alternative estimate”, or MCO model.

As depicted in Figure 2 of the Milliman report, for the two-year SPBM period, total expenditures net of rebates were $5.260 billion. This includes $55 million in non-benefit (administrative) expenses, which are SPBM contract expenses, PPAC contract expenses, rebate vendor expenses, and additional ODM staffing needed to support the SPBM program.

In estimating the pharmacy benefit expense that *would have occurred* had the benefit remained in the traditional MCO-based capitated arrangement, Milliman started with expenditures that occurred during the one-year period immediately preceding the SPBM (October 1, 2021 – September 30, 2022). Next, they adjusted this experience to account for the cost drivers that were expected to occur over the following two years. These cost drivers included the following:

1. Differences in enrollment mix among populations
2. Changes in population acuity due to the PHE and subsequent unwinding
3. COVID-19 vaccine and administration costs
4. Continuous glucose monitor utilization
5. Ingredient cost and dispensing fees paid to pharmacies
6. Utilization trends, including changes in brand/generic utilization

Milliman modeled rebate collections equal to 55% in year one and 45% in year two, to align with observed experience within the pharmacy program. Historically, this number remained relatively constant – that is, until recently. Due to uncontrolled and exponential growth in the federal 340B program, rebate collections as a percentage of total spend have declined significantly during the SPBM period. This decrease in rebate collections is in no way related to the SPBM program; rather, it is due in large part to the passage of SB 263 (133rd General Assembly) that removed Ohio Medicaid's ability to control utilization of 340B drugs for Medicaid beneficiaries.

Milliman's analysis culminated in three scenarios for estimating benefit expense that would have occurred under the MCO-based model: *Baseline*, *Higher Managed Care*, and *Lower Managed Care*. The *Baseline* scenario was based upon a review of trends in other state managed care programs over the same time period. The *Higher* and *Lower Managed Care* scenarios include sensitivity tested assumptions that resulted in higher and lower managed care expenses, respectively.

Milliman also estimated the total non-benefit (administrative) expenses that would have otherwise occurred under the MCO-based model. These estimates were based upon historical and reasonable capitation rate development assumptions in the managed care program. PBM administrative fees incurred by MCOs were assumed to be $3 per script, and MCO capitation rate risk margin was assumed to be equal to 1.5%. Additionally, Milliman added ODM administrative expenditures for our PDL and drug rebate vendor.

The results of each scenario are summarized in Figure 4 of the report. The Baseline scenario indicates that the implementation of the SPBM program produced net savings to ODM of $19 million over the first two years of the program. This result is consistent with Milliman's conclusion that, "pharmacy expenditures under the SPBM were not materially different than what may have been incurred under the [MCO-based] program".

In reviewing the Milliman analysis, **ODM projects that the SPBM program has saved approximately $140 million over the first two years.** While this projection draws from the *Higher Managed Care* scenario, Milliman notes that this scenario is, **"well within observed MCO trend rates in other state Medicaid programs"**. Additionally, a recent study by KFF[2] examining trends in state Medicaid pharmacy spend found that net spending (spending after rebates) on Medicaid prescription drugs increased by 72%, from $30 billion in FFY 2017 to $51 billion in FFY 2023, despite only small increases in the number of prescriptions dispensed per year. Most notably, **gross Medicaid pharmacy expenditures increased by approximately 14% from 2022 to 2023, while net increases were even higher at approximately 18%.** These national trends aligned closely with Ohio's experience under SPBM and further support the use of the *Higher Managed Care* scenario from the Milliman report.

Lastly, and very importantly, Milliman notes an observation of lower pharmacy claims trend for SPBM members from year one of the program to year two. Furthermore, emerging experience through December 2024 suggests that year-over-year trends are emerging lower than earlier experience in SPBM. **This suggests that utilization management efforts are working to control utilization as the program matures**.

Conclusion

In conclusion, I'd like to thank the committee for the opportunity to provide operational and fiscal updates on the SPBM program. Over the past nearly three years, ODM, Gainwell, and our other pharmacy partners have worked tirelessly to optimize the agility, efficiency, and cost-effectiveness of the SPBM program. While we believe significant progress has been made, there is still much work to be done. As the pharmacy landscape evolves, we stand ready to recognize and adapt to new challenges, doing so in a clinically sound and cost-effective manner.

Thank you again for your time, and I will be happy to answer any questions you may have.

[2] KFF. Recent Trends in Medicaid Outpatient Prescription Drugs and Spending. Available at: https://www.kff.org/medicaid/issue-brief/recent-trends-in-medicaid-outpatient-prescription-drugs-and-spending/. Accessed 30 March 2025.