

Office of Health Transformation **Reform Hospital Payments**

Background:

Ohio Medicaid currently uses prospective payment methods developed in the late 1980s to pay for inpatient and outpatient hospital services provided to Medicaid consumers. Prospective payment methods were designed to contain costs, permit providers to operate in a less regulated environment, and allow sharing of savings for those providers who identify ways to provide quality services more efficiently and economically. However, these types of payment methodologies are volume-based and do not have the ability to reward providers for improved outcomes. For these reasons, both inpatient and outpatient hospital reimbursement methodologies need to be revised to support provider reimbursement reforms as a component of Medicaid modernization and movement towards improved outcomes.

Governor Kasich's first budget directed Ohio Medicaid to update its hospital diagnosis-related group (DRG) reimbursement system. Currently, Ohio is using DRG version 15, even though Medicare is on version 30, and more modern versions can assign up to two and a half times as many DRGs as Ohio's system, which allows for more accurate and efficient reimbursement. For example, the current outdated version 15 limited Ohio Medicaid's ability to enforce non-payment for "never events" (e.g., hospital acquired infections) because the system is not granular enough to detect when those events occur. The updated DRG system, which goes into effect in April 2013, is budget neutral statewide, but individual hospitals may gain or lose revenue as a result of the new system. Ohio Medicaid will implement a stop-loss policy to ensure no individual hospital is reduced more than five percent under the new system.

Executive Budget Proposal and Impact:

The Executive Budget includes several provisions that impact hospitals. It reauthorizes temporary assessment programs and supplemental payment programs that would otherwise expire, makes several significant changes in hospital payment policy, and expands Medicaid eligibility to adults with income below 138 percent of the federal poverty level, many of whom might otherwise be a source of uncompensated care for hospitals.

ASSESSMENT PROGRAMS

- ***Hospital franchise permit fee program.*** The Executive budget reauthorizes the hospital franchise permit fee program, which otherwise would sunset June 30, 2013. The budget incorporates the franchise fee allocation methodology developed by the Ohio Hospital Association, which collects \$524 million in annual fees that are used to draw federal funds and make payments back to hospitals totaling \$840 million (Figure 1).

- **Hospital care assurance program.** The Ohio Hospital Care Assurance Program (HCAP) is Ohio's primary means of implementing the federal disproportionate share hospital (DSH) payment program, which provides additional payments to hospitals that provide care to a disproportionate share of indigent patients. Ohio hospitals fund the state share of this program through a provider assessment. Ohio's program sunsets every two years and must be reauthorized. The Executive Budget reauthorizes HCAP until October 2015, which will result in hospitals receiving approximately (depending on federal allotments) \$1.1 billion in DSH payments over the biennium, \$726 million net of HCAP assessments.¹

PAYMENT CHANGES

The Executive Budget makes several Medicaid hospital payment changes that reduce overall hospital spending 3.8 percent in FY 2014 and 7.4 percent in FY 2015 (Figure 1). Over the biennium, the following payment changes save \$500 million (\$185 million state share):

- **Create a children's' hospital quality improvement program.** The Executive Budget redirects the temporary special children's hospital funding that was authorized in the last budget (line item 600-537) to financially support delivery system changes that improve outcomes for children enrolled in Medicaid. Examples include reducing nonemergency use of the emergency room and reducing admissions to neonatal intensive care units. As a result, \$33 million (\$12 million state share) over the biennium will be redirected (the provision is budget neutral) to support payments to children's hospitals for developing programs that achieve specific performance outcomes.
- **Reduce hospital readmissions.** The Executive Budget will limit Medicaid payments to hospitals for readmissions within 30 days by establishing percentage-based benchmarks for readmission reductions. These readmission reductions will be 25 percent of total readmissions based on stays for all non-psychiatric hospitals per fiscal year. Hospitals will be provided with a report that tracks their readmission rates over a seven-year period and will have the responsibility to implement hospital-developed approaches to reducing their readmission rates by 25 percent. Failure to achieve this will result in the state recovering 25 percent of the value of Medicaid payments to the hospital for readmissions from the base year. The base year will be the prior year's readmissions and payments for readmissions. If hospitals meet the benchmark each year, readmissions will be reduced by 44 percent in total and result in substantially fewer program payments for readmissions. This provision is expected to save \$103 million (\$38 million state share) over the biennium. Over the long term, Ohio Medicaid will incorporate "potentially preventable readmissions" and "potentially preventable complications" into the DRG system. These groupers use clinical information from historical claims to determine the appropriateness of paying a current claim if it is related to a readmission.

¹ HCAP payments are projected to be \$577 million in FY 2014 and \$570 million in FY 2015, and assessments are projected to be \$210 million in FY 2014 and \$211 million in FY 2015.

- **Improve direct medical education.** The Executive Budget does not change the current level of Medicaid direct graduate medical education funding – about \$200 million over the biennium – but it does propose to target those funds to support health sector workforce priorities related to primary care and recruiting minorities into health professions. (See also “Coordinate workforce and training programs.”) Today, Medicaid direct medical education payments are made as an add-on to inpatient hospital claims. Beginning July 1, 2014, Medicaid direct medical education payments will be allocated based on rules that will be developed to support: a workforce trained in comprehensive primary care with a commitment to serve all Ohioans; dollars following residents into community practices; primary care placements in recognized patient-centered medical homes; a residency mix that recognizes and supports the needs of Ohio; and strategies that mitigate underserved areas in Ohio. While budget neutral, the opportunity to focus \$200 million over the biennium to positively improve workforce priorities is significant.
- **Eliminate the five-percent rate add-on for inpatient and outpatient services.** The Executive Budget will allow the temporary five percent rate increase for hospitals authorized in the last budget to expire on December 31, 2013. Ohio currently uses franchise fee proceeds to fund the rate add-on. Eliminating the add-on will save \$260 million (\$96 million state share) over the biennium.
- **Reduce the rate taxpayers pay for hospital capital projects.** The budget will reduce inpatient capital rates from 100 percent of cost to 85 percent of cost for both fee-for-service and Medicaid managed care plans. Historically, Medicaid health plans have reimbursed hospitals using the same capital rate as calculated for fee-for-service inpatient capital costs. Beginning January 1, 2012, Ohio Medicaid set specific Medicaid managed care capital rates for hospitals and, as a result of that process, determined that further adjustment to the capital rates is needed to reduce the extent to which Ohio taxpayers subsidize hospital building campaigns through Medicaid. The budget also eliminates fee-for-service capital cost settlement. This provision will save \$58 million (\$21 million state share) over the biennium.
- **Adjust DRG-exempt hospital rates.** Ohio Medicaid currently reimburses hospital services provided by DRG-exempt hospitals at 100 percent of cost, which is higher than what Medicaid pays for other inpatient hospital services through the DRG system. The Executive Budget will adjust reimbursement for DRG-exempt hospitals to pay 90 percent of cost. The budget also eliminates fee-for-service cost settlement. This provision will align reimbursement for DRG-exempt hospitals with Ohio Medicaid’s strategic pricing goals and save \$12 million (\$5 million state share) over the biennium.
- **Control the cost of outpatient services.** The Executive Budget will set fixed prices for all outpatient services currently reimbursed at cost. Ohio Medicaid reimburses most hospitals for outpatient services based on predetermined fee schedules. Although the majority of services have a set reimbursement rate, there are a few services, such as unlisted surgeries, drugs administered with IV therapy, and independently billed drugs

and medical supplies that are reimbursed at cost. This results in large variations in payment for these services. Reimbursement for independently billed drugs and medical supplies will be set at 60 percent of costs, and the hospital laboratory fee schedule will be recalibrated to align payment rates to prescribed Medicare ceilings. These changes will save \$67 million (\$25 million state share) over the biennium.

FEDERAL LAW CHANGES

- ***Extend Medicaid coverage to more low-income Ohioans.*** Extending Medicaid coverage to more adults will convert some otherwise uncompensated care into Medicaid payments. Ohio Medicaid estimates that, as a result of increased enrollment from more currently eligible individuals coming onto the program (woodwork) and Ohio's decision to extend Medicaid coverage to adults with income below 138 percent of poverty, hospitals will receive an additional \$1.6 billion in Medicaid payments over the biennium. Taking into account the net impact of the franchise fee, payment reforms, and new revenue from woodwork and Medicaid expansion populations, overall Medicaid hospital spending increases 15 percent in FY 2014 and 28 percent in FY 2015 (Figure 1).

Figure 1. Executive Budget Medicaid Impact on Hospitals

All funds in millions	SFY 2014	SFY 2015	SFY 2014-2015
Hospital Baseline (FFS + MCO)	\$ 3,999	\$ 4,235	\$ 8,235
- Total Hospital Franchise Fee	\$ (524)	\$ (524)	\$ (1,048)
Hospital Baseline (FFS + MCO) minus Franchise Fee	\$ 3,476	\$ 3,711	\$ 7,187
Supplemental Payments Supported by the Franchise Fee			
- Upper Payment Limit Program	\$ 502	\$ 502	\$ 1,003
- Managed Care Incentive	\$ 162	\$ 162	\$ 324
- Support of 5% Rate Increase	\$ 177	\$ 177	\$ 353
Subtotal	\$ 840	\$ 840	\$ 1,681
Baseline Plus Supplemental Payments Supported by Franchise Fee	\$ 4,316	\$ 4,552	\$ 8,868
Hospital SFY 14/15 Budget Initiatives (All Funds)			
- Eliminate hospital 5% inpatient and outpatient rate update	\$ (83)	\$ (177)	\$ (260)
- Reduce readmissions by 25%	\$ (34)	\$ (69)	\$ (103)
- Cap Capital to 85% of Cost with No FFS Settlement	\$ (19)	\$ (38)	\$ (58)
- Pay DRG exempt hospitals at 90% of cost with no FFS settlement	\$ (4)	\$ (8)	\$ (12)
- Modify outpatient fee schedule	\$ (22)	\$ (44)	\$ (67)
Subtotal	\$ (163)	\$ (337)	\$ (500)
Estimated Reimbursement	\$ 4,153	\$ 4,215	\$ 8,368
<i>Percent Change</i>	-3.8%	-7.4%	-5.6%
ACA Mandates			
- Woodwork (all) now enrolled	\$ 218	\$ 408	\$ 627
- Expansion (all) now enrolled	\$ 211	\$ 788	\$ 999
Subtotal	\$ 430	\$ 1,196	\$ 1,626
Net Change between ACA Mandates and Budget Initiatives	\$ 266	\$ 859	\$ 1,126
Total Executive Budget for Hospitals	\$ 4,582	\$ 5,411	\$ 9,993
<i>Dollar Change from Baseline</i>	\$ 583	\$ 1,176	\$ 1,759
<i>Percent Change</i>	14.6%	27.8%	21.4%

Updated January 31, 2013