

Office of Health Transformation **Reform Hospital Payments**

Governor Kasich's Budget:

- *Reduces payments for preventable hospital readmissions.*
- *Converts medical education subsidies into a primary care rate increase.*
- *Increases the hospital franchise fee from 2.75 percent to 3.0 percent.*
- *Saves \$233 million (\$336 million state share) over two years.*

Background:

When Governor Kasich took office, Ohio was using prospective payment methods developed in the late 1980s to pay for inpatient and outpatient hospital services provided to Medicaid consumers. Prospective payment methods are 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 payments are volume-based and do not have the ability to reward providers for improved outcomes. For these reasons, the Kasich Administration made it a priority to revise both outpatient and inpatient hospital reimbursement methodologies as a component of Medicaid modernization and movement toward improved outcomes.

First Four Years:

Governor Kasich's first budget (enacted in 2011) directed Ohio Medicaid to update its hospital diagnosis-related group (DRG) reimbursement system. At the time, Ohio was using DRG version 15, even though Medicare was 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. The updated DRG system was implemented in July 2013 with a three-year stop-loss transition policy to ensure no individual hospital is reduced more than three, five and eight percent in each subsequent year under the new system.

Governor Kasich's Jobs Budget 2.0 (enacted in 2013) reauthorized temporary assessment programs and supplemental payment programs that would otherwise have expired, reduced the rate taxpayers pay for hospital capital projects, made several significant changes in hospital payment policy, and proposed expanding Medicaid 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. Extending Medicaid coverage, which took effect in January 2014, resulted in Ohio's hospitals receiving a 27 percent increase in Medicaid payments in 2015 (Table 1).

Executive Budget Proposal and Impact:

The Executive Budget reduces Medicaid hospital spending \$97 million in 2016 and \$229 million in 2017 (Table 1). However, because additional Ohioans are now covered by Medicaid instead of entering the hospital uninsured, total Medicaid spending on hospital services increases 2.0 percent in 2015 and 4.3 percent in 2017.

- **Reform payment methodology for detail-coded drugs.** Most Medicaid outpatient services are reimbursed using Ohio’s prospective payment system, but in some cases hospitals are reimbursed 60 percent of their hospital-specific costs for administering drugs in an outpatient setting or when a hospital chooses to independently bill for an expensive drug. The Executive Budget will require Medicaid to pay for these drugs based on the Medicaid physician fee schedule instead of hospital costs. This change will result in greater payment consistency across provider types for essentially the same product. Any pharmaceutical(s) not currently on the Medicaid physician fee schedule will continue to be reimbursed at 60 percent of cost. This provision will save \$66.5 million (\$25 million state share) over the biennium.
- **Consolidate outpatient charges occurring within 72 hours of an inpatient stay.** Hospitals are currently permitted to submit outpatient claims for charges related to an outpatient visit the day before or after an inpatient stay to the same facility. The Executive Budget requires hospitals to include any outpatient charges that occur 72 hours before or after an inpatient stay to be included on the inpatient claim. This change will result in a more detailed claim of all the services provided related to the treatment, and not just the visit or stay. It will also make paying for episodes of care, through programs like the State Innovation Model (SIM), more efficient with all services included on one claim. This provision will save \$16.7 million (\$6.3 million state share) over the biennium.
- **Eliminate the five-percent rate add-on for outpatient services.** The Executive Budget will allow the temporary five percent rate increase for outpatient hospital services that was authorized in the last budget expire for all but children’s hospitals in December 2015. During the debate on Medicaid expansion, Ohio Medicaid argued that because hospitals benefit from converting previously uncompensated costs into Medicaid payments, the five percent increase was unnecessary. Now with Medicaid expansion in place, the Administration again recommends allowing the temporary rate increase to expire. This provision saves \$157 million (\$59 million state share) over the biennium.
- **Reduce potentially preventable hospital readmissions.** Across Ohio, the statewide average for inpatient hospital potentially preventable readmission (PPR) is 9.2 percent. While Ohio Medicaid currently targets claims related to readmissions at the same hospital within 30 days, the state’s utilization review process and policies do not focus on readmissions that occur *among* hospitals. The Executive Budget will require the

implementation of PPR software that analyzes clinically-related readmissions across hospital providers. By incorporating this critical tool, the statewide average PPR rate is expected to decrease by 1 percent annually and save \$42.4 million (\$15.9 million state share) over the biennium. The State will also implement a one-percent penalty on hospitals whose PPR rate exceeds an acceptable benchmark, saving an additional \$3.2 million (\$1.2 million state share) over the biennium.

- **Converts subsidies for medical education into a primary care rate increase.** Ohio Medicaid spends approximately \$100 million annually to subsidize physician training through direct graduate medical education (GME) payments to teaching hospitals. The current formula has not been updated since 1982 and currently results in different hospitals being paid from \$4,000 to \$64,000 to train a medical resident. The variation is an unintended consequence of the outdated formula. The Executive Budget requires Ohio Medicaid to update the GME formula in a way that is budget neutral, and also diverts a portion of Medicaid GME to offset the cost of a primary care physician rate increase (described under *Reform Physician Payments*). This provision will save \$25 million (\$9.4 million state share) in hospital GME payments in 2017 and apply the full amount to increase primary care physician rates \$25 million in 2017.
- **Implement correct coding standards to hospital claims processing.** The National Correct Coding Initiative (NCCI) was introduced to promote national correct coding methodologies that reduce instances of improper coding which may potentially result in inappropriate payments of Medicaid claims. Ohio Medicaid has aligned necessary edits within the Medicaid Information Technology System (MITS) to properly process outpatient Medicaid claims in accordance with federal regulations. The department will activate the NCCI edits in MITS not later than January 1, 2016. This will save approximately \$15 million (\$5.6 million state share) over the biennium.
- **Streamline administration of the hospital franchise fee program and increase the rate.** The assessment rate for Ohio's Hospital Franchise Fee Program must be established for each program year by amending the Ohio Administrative Code. This causes delays in Ohio Medicaid's ability to assess and collect fees in a timely manner and forces hospitals to make substantial payments to the state in a very short period of time. The Executive Budget streamlines this process by establishing a fixed assessment rate of 3.0 percent to be adopted in the Ohio Administrative Code (slightly above the current 2.7 percent fee). Ohio Medicaid will also work with the hospital industry to create a collection schedule that takes into account the cash flow needs of hospitals. This provision will save \$568.9 million (\$213.7 million state share) over two years, a portion of which (\$92.8 million in federal-only funds) will flow back to hospitals through the upper payment limit program.

Table 1. Executive Budget Medicaid Impact on Hospitals				
All funds in millions	SFY 2014 actual	SFY 2015 estimated	SFY 2016 proposed	SFY 2017 proposed
Hospital Baseline (FFS + MCO)	\$ 4,302	\$ 5,434	\$ 5,722	\$ 6,105
- Total Hospital Franchise Fee ¹	\$ 514	\$ 554	\$ 661	\$ 695
Hospital Baseline (FFS + MCO) minus Franchise Fee	\$ 3,788	\$ 4,880	\$ 5,061	\$ 5,410
Supplemental Payments Supported by the Franchise Fee	\$ -	\$ -		
- Upper Payment Limit Program ²	\$ 492	\$ 582	\$ 612	\$ 644
- Managed Care Incentive	\$ 162	\$ 162	\$ 162	\$ 162
Subtotal	\$ 654	\$ 744	\$ 774	\$ 806
Baseline Plus Supplemental Payments	\$ 4,442	\$ 5,624	\$ 5,835	\$ 6,216
Hospital Payment Reforms (All Funds)				
- Reform payment method for detail-coded drugs			\$ 22	\$ 44
- Consolidate outpatient charges			\$ 6	\$ 11
- Eliminate the five percent rate add-on for outpatient services			\$ 50	\$ 107
- Reduce potentially preventable hospital readmissions			\$ 14	\$ 32
- Implement correct coding standards			\$ 5	\$ 10
- Convert medical education subsidies into a primary care rate increase ³			\$ -	\$ 25
Subtotal			\$ 97	\$ 229
Ohio Medicaid Hospital Spending	\$ 4,442	\$ 5,624	\$ 5,738	\$ 5,987
<i>Percent Change</i>		26.6%	2.0%	4.3%
1. Includes the Executive Budget proposal to increase the fee from 2.75 to 3 percent (\$107 million in 2016, \$142 in 2017).				
2. Includes funds that result from increasing the franchise fee (\$30 million in 2016, \$62 million in 2017).				
3. A portion of this amount will flow back to hospital based physicians via a rate increase.				

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