HEALTH ECONOMICS & POLICY UPDATE
OHA ANNUAL MEETING 2025

OHA HEP Team

May 19, 2025

SPEAKERS

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Disclaimer: We have no real or perceived conflicts of interest that relate to this presentation.

OHIO HOSPITAL ASSOCIATION

AGENDA

HEALTH ECONOMICS AND POLICY UPDATE

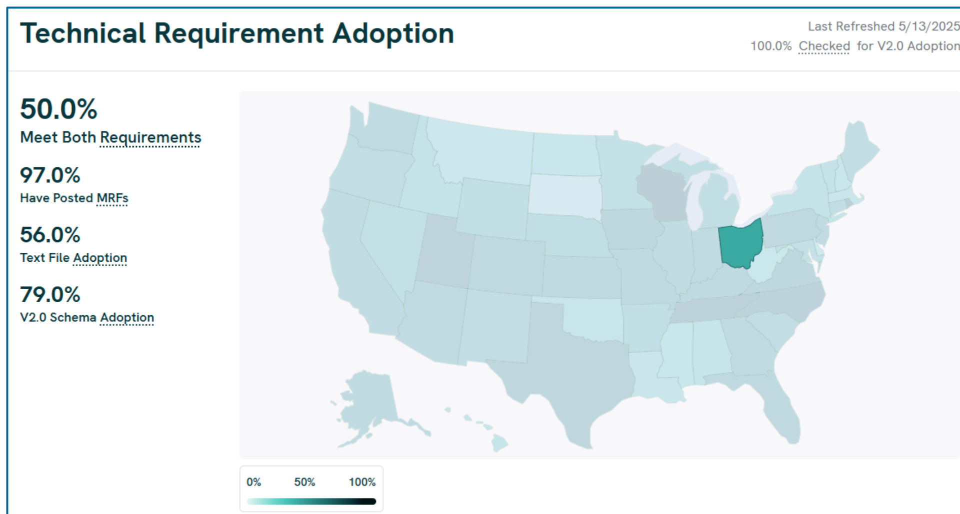
I. Federal & State Hospital Price Transparency
II. Ohio Medicaid Updates
III. Payer Relations
IV. HCAP
V. Franchise Fee
VI. Behavioral Health
VII. Q&A

I. FEDERAL & STATE HOSPITAL PRICE TRANSPARENCY

HOSPITAL PRICE TRANSPARENCY

Federal

- Ensure compliance with price transparency file format and version requirements
  - Standardized Machine-Readable File with specific naming convention
  - Easily accessible on website with .txt file in Root Folder



Source: *https://turquoise.health/mrf_tracker*

- Health care price transparency Executive Order issued Feb. 25 directs agencies to issue guidance or proposed rules to:
  - Require hospitals and insurers to disclose actual prices, not estimates, including for prescription drugs
  - Standardize pricing information to enable comparisons across hospitals and health plans
  - Strengthen enforcement to ensure accurate, complete, and transparent pricing data

HOSPITAL PRICE TRANSPARENCY

State

- Effective April 3, 2025, ORC 3727.32 requires hospitals to publish:
  - Machine-Readable File of standard charges for all hospital items/services
  - Consumer-friendly list of standard charges for shoppable services or use an internet-based price estimator tool
- Ohio Department of Health granted regulatory and enforcement authority over hospitals' compliance
  - Federal MRF template and CMS-approved estimator tools meet Ohio's requirements
  - ODH to publish list of noncompliant hospitals 90 days after law's effective date
- Updates to price lists or tools must be submitted to ODH via Hospital Price Transparency Reporting form
  - Annual updates are required and shall be submitted between Sept. 1 - Oct. 31 each year, though list changes may be submitted at any time
- See ODH's Hospital Price Transparency webpage for more info

II. OHIO MEDICAID UPDATES

MEDICAID WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

ODM seeking CMS approval to impose new eligibility criteria for Group VIII enrollees under Section 1115 Demonstration waiver, effective Jan. 1, 2026 through Dec. 31, 2030

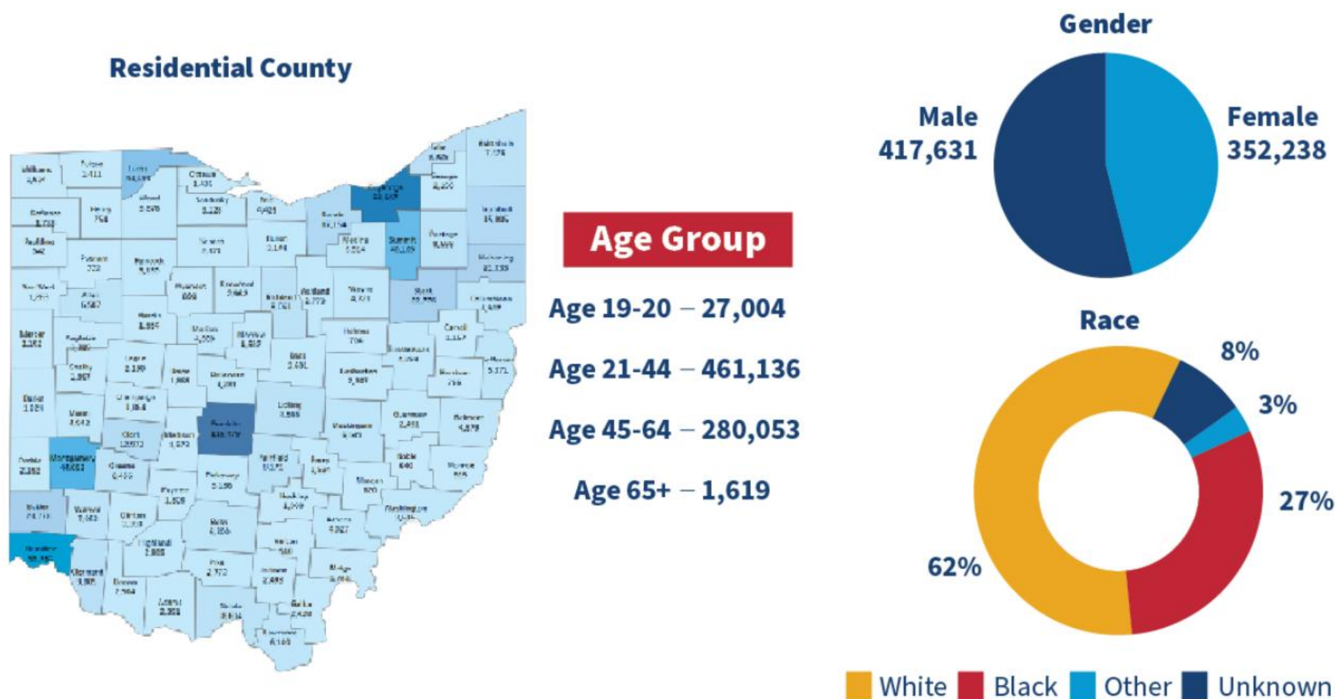
Total Public Comments Received		
654		
Opposed	**Neutral**	**Supportive**
589 (90%)	21 (3%)	44 (7%)

- One of the following criteria must be met to be eligible for Group VIII Medicaid benefits:
  - Be at least 55 years of age; or
  - Be employed; or
  - Be enrolled in school or an occupational training program; or
  - Be participating in an alcohol and drug addiction treatment program; or
  - Have intensive physical health care needs or serious mental illness.
- See here for more information on ODM's Group VIII Demonstration

MEDICAID WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

General view of the individuals in that group

Most are male, residing in major metropolitan areas and most are between the ages of 21 and 44



Source: https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Home/1115_Work_Requirements_JMOC_2025.pdf

MEDICAID WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

- Eligibility reviews will be conducted in accordance with the standard eligibility renewal dates
  - Will evaluate work requirements
- No reporting requirements by enrollees

Group VIII Composition (Dec. 2024 eligibility)

Category	All counties	% total
Individuals meeting eligibility requirement	**584,569**	**73.0%**
Individuals currently working (>20 hrs or 10-20 hrs)	325,905	40.7%
Age	75,208	9.4%
SUD Inpatient & Residential Treatment*	19,017	2.4%
Severe Chronic Condition*	63,364	7.9%
Other Medicaid Eligibility	101,075	12.6%
Require assessment	**215,008**	**27.0%**
Total population	**799,577**	

~62,000 Group VIII enrollees estimated to lose Medicaid benefits in SFY 26-27 biennium

Source: https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Home/1115_Work_Requirements_JMOC_2025.pdf

MEDICAID WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

SFY 26-27 State Budget Implications

- Executive budget requires immediate termination of expansion eligibility group if FMAP falls below 90%
- Am. Sub H.B. 96 establishes Group VIII transition plan
  - ODM redirect impacted individuals to private insurance subsidies or charity care programs that provide medical assistance
  - ODM Director may implement a temporary hospital assessment to cover uncompensated care costs for former Group VIII members

Ohio Medicaid Matters Coalition

- Comprised of over 35 orgs, including OHA
- Urges Ohio General Assembly & DeWine administration to “maintain flexibility and authority” as feds consider significant Medicaid funding cuts

NEXT GENERATION MYCARE PROGRAM

- Ohio Medicaid MyCare transitioning from demonstration to Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) model, effective Jan. 1, 2026
  - Aligning with Next Generation Medicaid program goals (e.g., focus on the individual, personalized care experience, increase program transparency and accountability)
- Eligibility criteria change from current age 18 and older to age 21 and older
- Selected Next Gen MyCare plans
  - Anthem Blue Cross and Blue Shield (new)
  - Buckeye Health Plan
  - CareSource
  - Molina HealthCare of Ohio
- MyCare Ohio members enrolled in Aetna or UHC will need to select a Next Gen MyCare plan for Jan. 1, 2026 coverage
- See here for more information on ODM's Group VIII Demonstration

NEXT GENERATION MYCARE PROGRAM

Phased implementation starting Jan. 1, 2026 in current 29 MyCare counties then expansion to remaining counties throughout the year

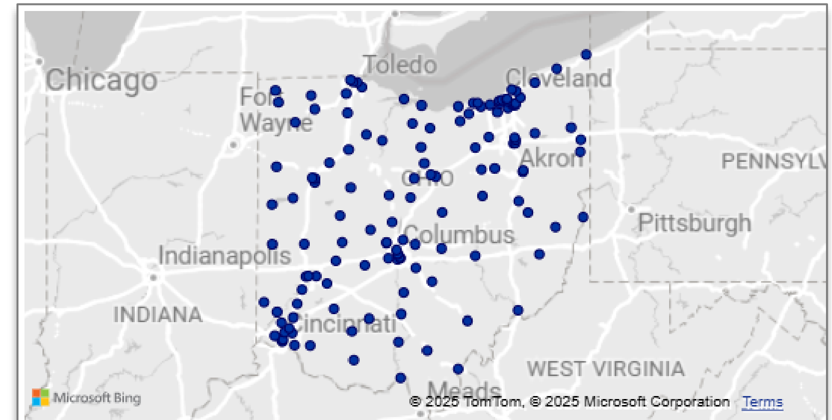
Phase 1: Current MyCare Counties On January 1, 2026, ODM will roll out the Next Generation MyCare program in the 29 counties where MyCare is currently available today.	
January 1, 2026	AAA1: Butler, Warren, Clinton, Hamilton, Clermont AAA2: Montgomery, Clark, Greene AAA6: Franklin, Delaware, Union, Madison, Pickaway AAA4: Lucas, Fulton, Ottawa, Wood AAA10a: Lorain, Cuyahoga, Medina, Lake, Geauga AAA10b: Summit, Portage, Stark, Wayne AAA11: Columbiana, Mahoning, Trumbull
Phase 2: Remaining Counties Starting on April 1, 2026, and continuing through the year, ODM will roll out the Next Generation MyCare program in the remaining counties.	
April 1, 2026	AAA4: Sandusky, Erie, Henry, Williams, Defiance, Paulding AAA6: Fayette, Fairfield, Licking AAA11: Ashtabula
May 1, 2026	AAA2: Preble, Darke, Miami, Shelby, Champaign, Logan AAA3: Van Wert, Putnam, Hancock, Allen, Mercer, Auglaize, Hardin AAA5: Seneca, Huron, Wyandot, Crawford, Richland, Ashland, Marion, Morrow, Knox
June 1, 2026	AAA7: Ross, Vinton, Highland, Pike, Jackson, Gallia, Brown, Adams, Scioto, Lawrence
July 1, 2026	AAA9: Holmes, Tuscarawas, Carroll, Jefferson, Coshocton, Harrison, Belmont, Guernsey, Muskingum
August 1, 2026	AAA8: Hocking, Perry, Morgan, Noble, Monroe, Washington, Athens, Meigs

Source: https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/mycareohio/mycare-ohio

III. PAYER RELATIONS

OHA PAYER SCORECARD

- **Round 13 complete**
  - Thank you to everyone who participated!
  - Data covers accounts from CY 2024
- **Continued strong response rate from OHA membership**
  - Thirteen rounds covering seven years of data (2018-2024)
  - Respondents represent approximately 80% of statewide facility costs



Survey Round Response Rate

Round Number	Submission Period	Survey Respondents	Hospitals Represented	% of Statewide Facility Costs
Round 13	1/1/2024 - 12/31/2024	41	116	79.2%
Round 12	7/1/2023 - 6/30/2024	43	118	79.4%
Round 11	1/1/2023 - 12/31/2023	44	119	79.5%
Round 10	7/1/2022 - 6/30/2023	45	119	80.2%
Round 9	1/1/2022 - 12/31/2022	49	122	80.7%
Round 8	7/1/2021 - 6/30/2022	52	127	81.4%
Round 7	1/1/2021 - 12/31/2021	48	122	79.3%
Round 6	7/1/2020 - 6/30/2020	46	121	81.9%
Round 5	1/1/2020 - 12/31/2020	47	120	78.2%
Round 4	7/1/2019 - 6/30/2019	43	119	80.7%
Round 3	1/1/2019 - 12/31/2019	42	116	76.8%
Round 2	7/1/2018 - 6/30/2019	41	115	80.0%
Round 1	1/1/2018 - 12/31/2018	34	105	77.1%

SUMMARY OF ROUND 13

- **All Payer denials remain consistent from prior rounds**
  - Initial denials at 14% ($23.4B) of total charges
  - Over 80% ($19.0B) of initial denials continue to be administrative denials
  - Finals denials consistent at <1% ($1.2B) of total charges

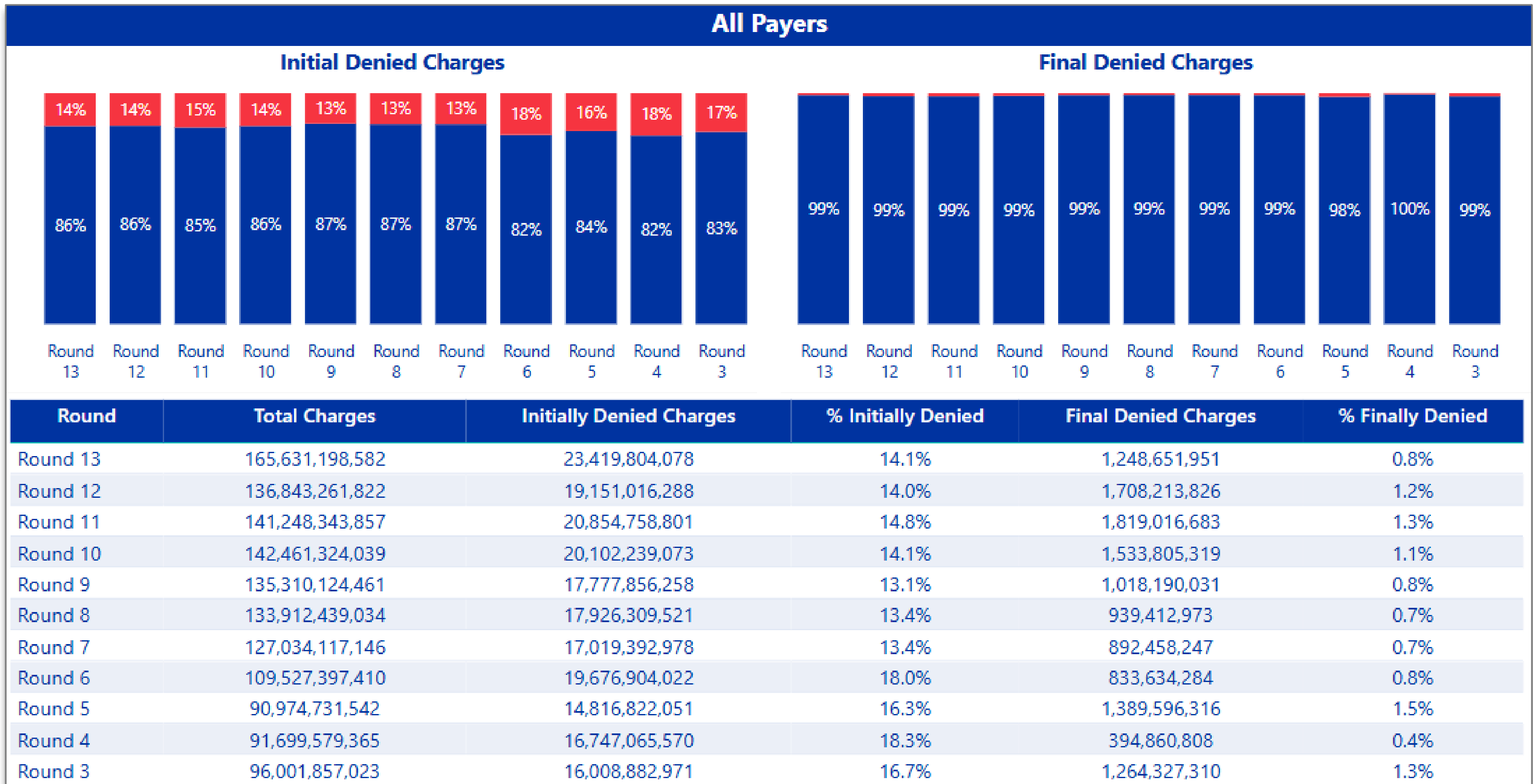
- **Medicare FFS remains the consistent favorite**
  - 6.4% ($2.5B) initially denied, 0.3% ($122M) finally denied, the lowest of any large payer
  - Highest qualitative score across all like payers at 4.0

- **Medicaid Plans continue to struggle**
  - Initial denials increased to 19.0% ($6.1B), back to pre-COVID levels
  - Final denials decreased to 0.8% ($248M) between last two rounds
  - Aging AR >30 Days almost doubled from 36% ($860M) in CY22 to 62% ($2.3B) in CY24

- **Commercial Plans show little improvement**
  - Initial denials remain at 17% ($8.2B), no change vs. last round
  - Leading commercial insurers for initial denials were Anthem ($4.0B, 18%), Medical Mutual ($1.4B, 22%), and UnitedHealthcare ($1.4B, 15%)

INITIAL & FINAL DENIED CHARGES

Final Round 13 Trend – All Payers



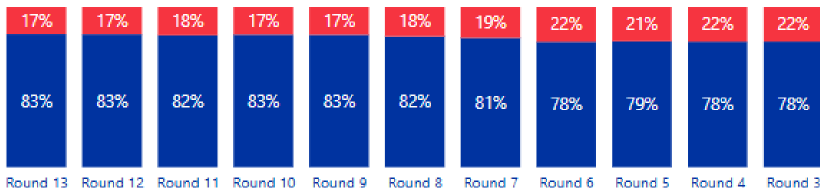
Round	Total Charges	Initially Denied Charges	% Initially Denied	Final Denied Charges	% Finally Denied
Round 13	165,631,198,582	23,419,804,078	14.1%	1,248,651,951	0.8%
Round 12	136,843,261,822	19,151,016,288	14.0%	1,708,213,826	1.2%
Round 11	141,248,343,857	20,854,758,801	14.8%	1,819,016,683	1.3%
Round 10	142,461,324,039	20,102,239,073	14.1%	1,533,805,319	1.1%
Round 9	135,310,124,461	17,777,856,258	13.1%	1,018,190,031	0.8%
Round 8	133,912,439,034	17,926,309,521	13.4%	939,412,973	0.7%
Round 7	127,034,117,146	17,019,392,978	13.4%	892,458,247	0.7%
Round 6	109,527,397,410	19,676,904,022	18.0%	833,634,284	0.8%
Round 5	90,974,731,542	14,816,822,051	16.3%	1,389,596,316	1.5%
Round 4	91,699,579,365	16,747,065,570	18.3%	394,860,808	0.4%
Round 3	96,001,857,023	16,008,882,971	16.7%	1,264,327,310	1.3%

INITIAL & FINAL DENIED CHARGES

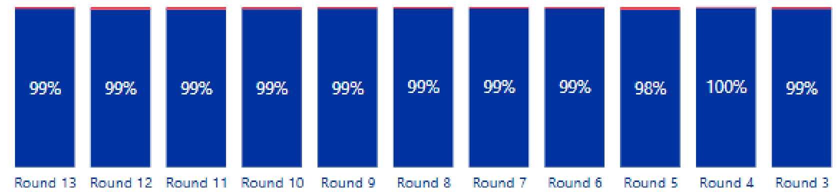
Final Round 13 Trend – Payer Category

All Commercial Plans

Initial Denied Charges

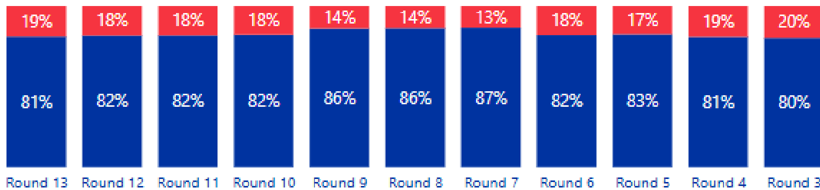


Final Denied Charges



All Medicaid Plans

Initial Denied Charges



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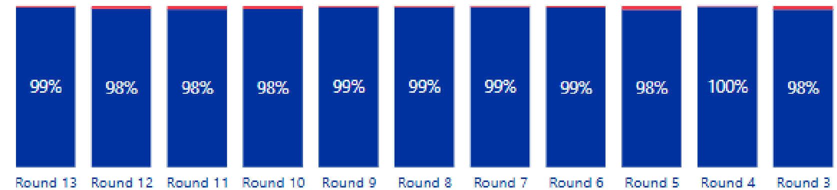
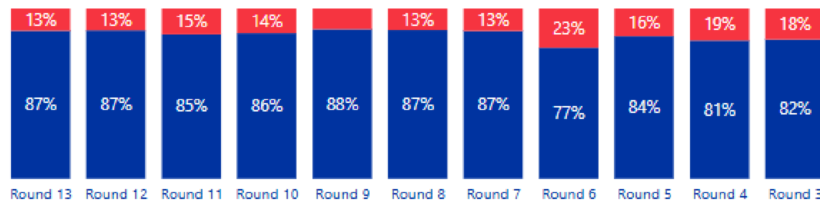


All Medicare Plans

Initial Denied Charges



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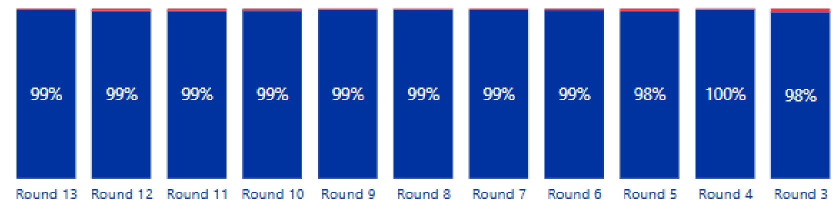
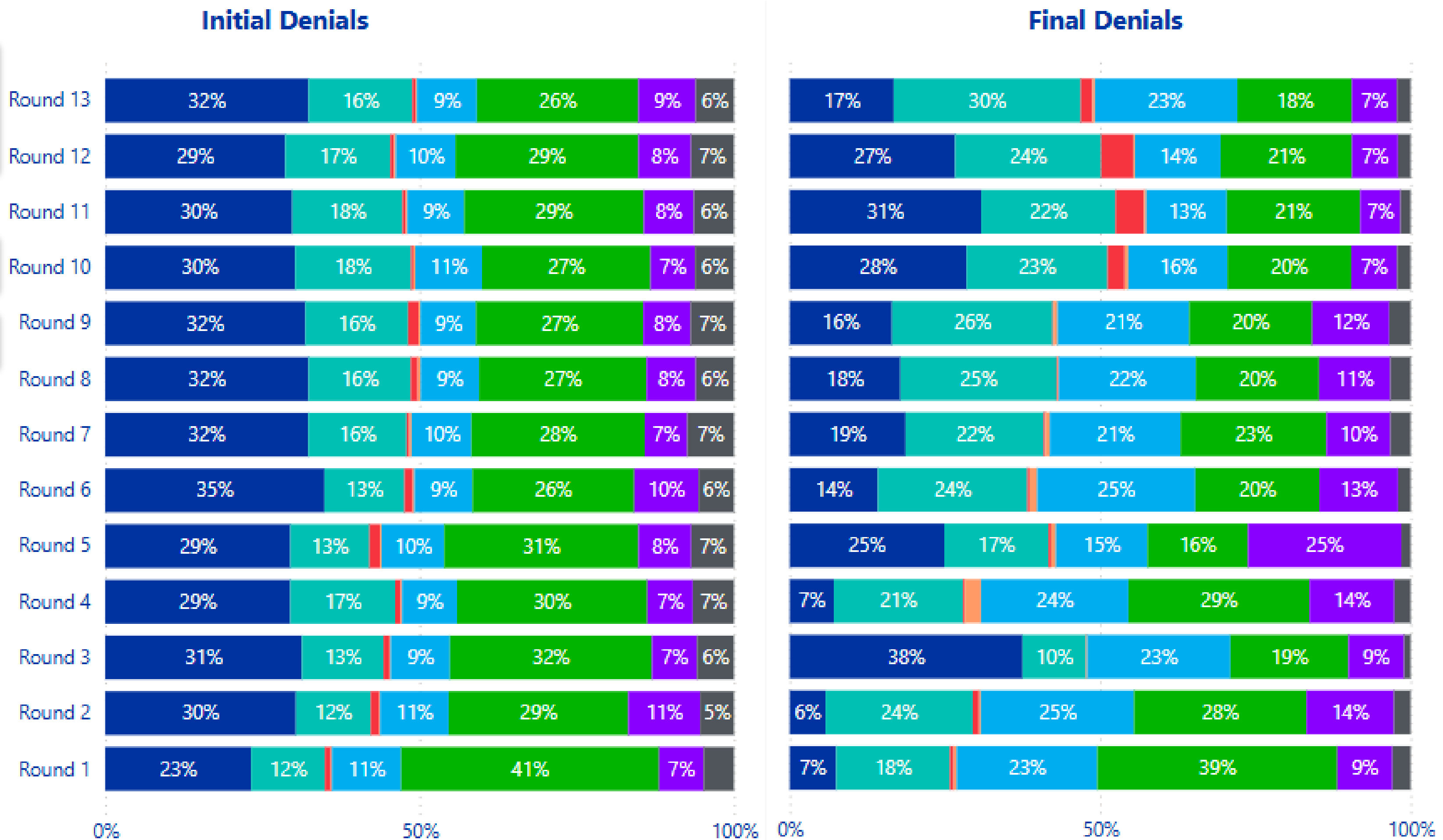


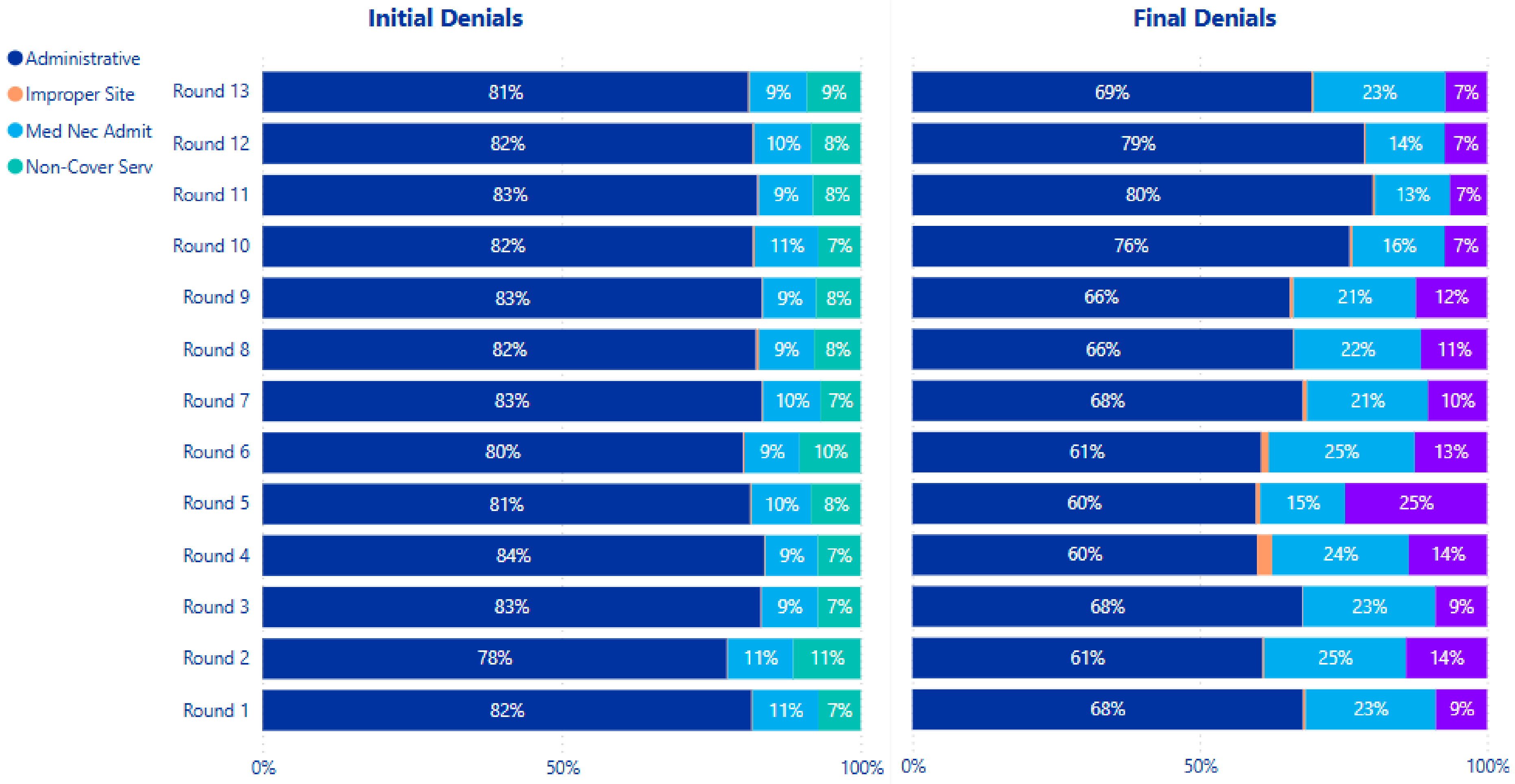
DENIAL RATIONALES

Isolating administrative denials…



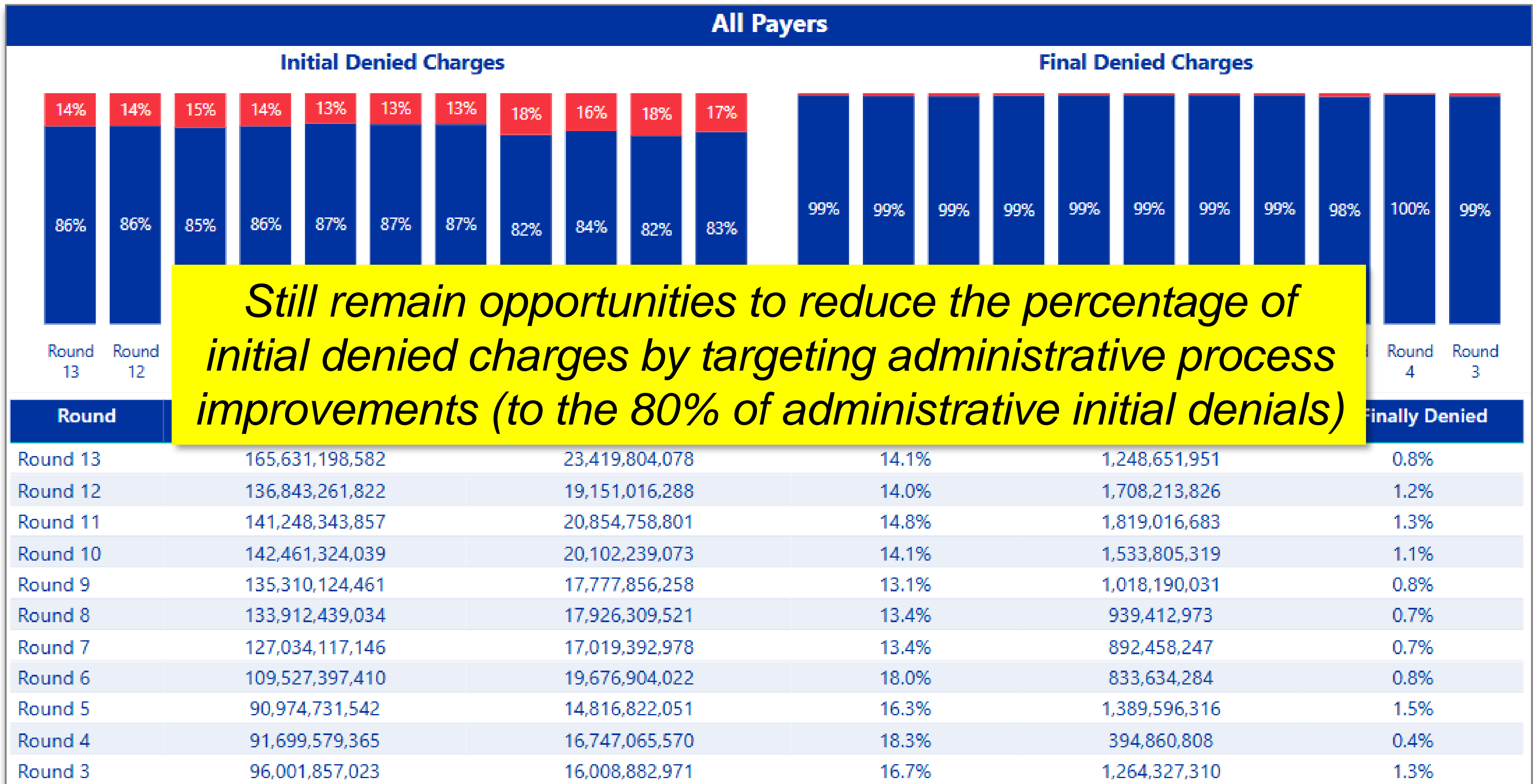
DENIAL RATIONALES

>80% of initial denials are administrative



ADVOCACY FOCUS

Critical Measure: Initial and Final Denied Charges



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OHA PAYER RESOURCES

Available at www.ohiohospitals.org

- Member Scorecard Business Toolkit
  - Focused on helping members engage insurance brokers, local employers and the broader business community
  - Includes PowerPoint, talking points, template letter, and other supporting info

- Payer-Related Resources and Webinars
  - Nine-part payer relations and contracting webinar series
  - Ohio Department of Insurance webinar
  - Guidance to submit provider complaints to ODI, CMS and ODM

OHIO HOSPITAL ASSOCIATION | OHA exists to collaborate with member hospitals and health systems to ensure a healthy Ohio.

Talking Points

LEVERAGE OHA PAYER SCORECARD DATA WITH YOUR COMMUNITY LEADERS AND EMPLOYERS

TACTIC 1: CONTRAST HOSPITAL ECONOMIC CHALLENGES WITH MASSIVE WINDFALL OF PAYERS AND RISING COST OF EMPLOYER PREMIUMS

Substitute your hospital's figures for Ohio or national figures where you like.

Employer health care premiums continue to escalate at the same time the oligopoly of major payers is reporting record profits and huge cash reserves.

- Employers in the U.S. saw an average 9% increase in health insurance costs per employee in 2024.[i] Your increase may have been even higher. These premium increases are occurring despite reductions in health care consumption, and despite massive profit margins enjoyed by the payers.

- UHC has roughly 20% of Ohio's commercial market; Anthem has nearly 50% market share in Ohio. This tremendous market share provides the payers with significant leverage over providers, including hospitals.

Health Insurer	2024	2023	2022	2021	2020
UnitedHealth Group (national)	$14.4 billion	$22.4 billion	$20.1 billion	$17.3 billion	$15.4 billion
Aetna (CVS Health, national)	$4.6 billion	$8.3 billion	$4.3 billion	$8.0 billion	$7.2 billion
Elevance (Anthem, national)	$6.0 billion	$6.0 billion	$8.5 billion	$7.5 billion	$6.4 billion
Cigna Healthcare (national)	$3.4 billion	$5.2 billion	$6.7 billion	$5.4 billion	$8.5 billion
Centene (national)	$3.3 billion	$2.7 billion	$1.2 billion	$1.4 billion	$1.8 billion
Humana (national)	$1.2 billion	$2.5 billion	$2.8 billion	$2.9 billion	$3.4 billion
CareSource (Ohio)	$107 million through Q3	$540 million	$647 million	$43 million	$167 million
Anthem (primarily Ohio)	$473 million through Q3	$517 million	$271 million	$320 million	$175 million

- These massive profits resulted in large part because during the pandemic many health care services were shut down for extended periods of time, and even when they restarted, patients were slow to return to receiving services. However, the insurance companies continued to collect the full amount of their premiums without having to pay claims because of the reduction in health care consumption.

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HEALTH CARE CLAIMS

Possible delays in care, sometimes beyond 10 days, although OH law requires decision within 10 days

Coding and charge entry of services rendered for claim

Claim paid

Claim partially or fully denied

Hospital corrects and resubmits claim

Claim denied again

Hospital wins appeal and claim is paid OR corrected and resubmitted claim is paid (hospital may decide to accept full or partial payment, as applicable)

PAYERS ULTIMATELY PAY MORE THAN 99% OF CLAIMS, BUT NOT BEFORE DENYING MORE THAN 14% OF TOTAL CHARGES INITIALLY ($19 B IN SFY 2024)

Commercial insurers, Medicaid and Medicare payers implement complex and burdensome policies that create unnecessary waste and cost in the health care system

- 82% of these initial denials are administrative in nature
  - Additional documentation and non-clinical issues alone make up almost 60% of initially denied charges; just 9% of initial denials are due to medical necessity reasons
- Ohio's hospitals and health systems spend more than $350 million/year just appealing initial denials

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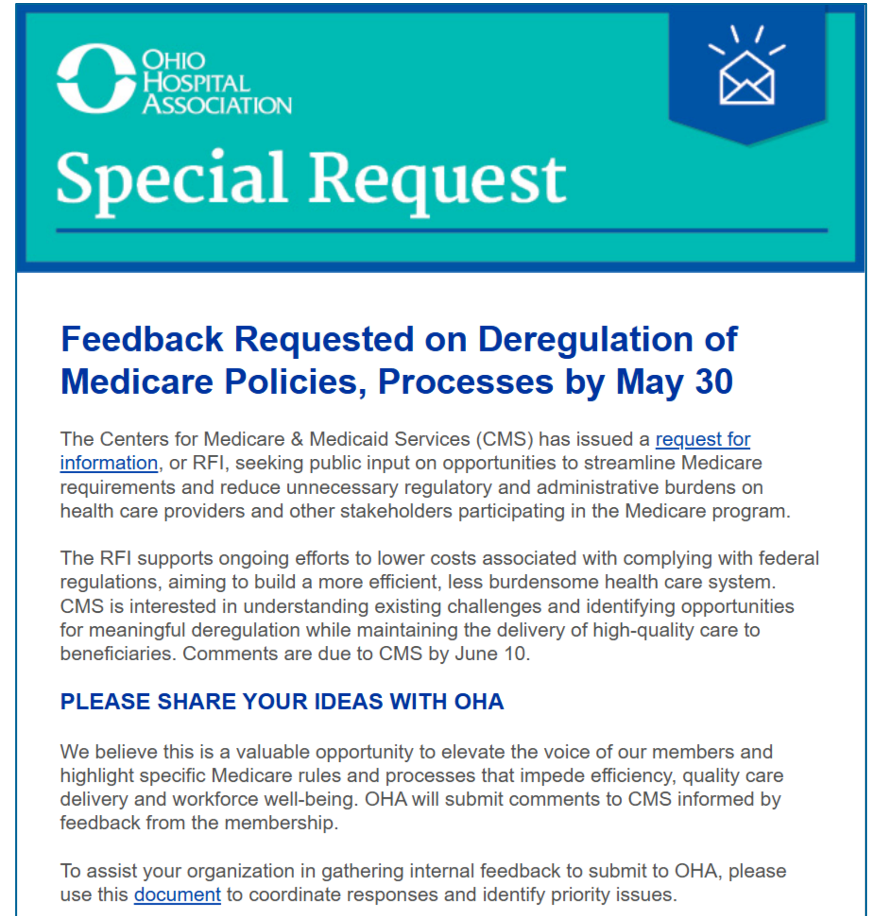
OHIO INSURANCE REFORM BILLS

- **Led by Ohio State Medical Association**
- **OHA Payer Task Force analyzing these bills further**

Bill #	Title	Description
HB 214	PA Gold Carding	Require insurers to waive prior authorization for 12 months for providers that have a 90% approval rate over 12-month period
SB 160	Non-Medical Switching	Prohibit mid-year drug formulary changes
SB 165	Automatic Down-coding	Prohibit down-coding, strengthen prudent layperson standard
HB 219	Network Adequacy	Establish network adequacy and maintenance standards
SB 162	Takebacks & Claw-backs	Reduce current 24-month takeback timeframe to same time given to a provider to submit a claim
SB 166	No Fees for EFTs	Prohibit fees for EFTs
HB 220	PA, Retro Denials, P2P, & Appeals	Limit retroactive denial to non-covered benefits or lack of coverage; require identification of clinical peer; prohibit charges for appealing claims; account for dosage adjustments post-PA approval for chronic conditions
SB 164	Transparency in AI	Require insurer transparency around AI

RFI: DEREGULATION OF THE MEDICARE PROGRAM

- Seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries and other interested parties participating in the Medicare program
- **Submit feedback to OHA by May 30th here**
- OHA submitting comments, members encouraged to submit feedback as well
- Comments due June 10



Ohio Hospital Association

Special Request

Feedback Requested on Deregulation of Medicare Policies, Processes by May 30

The Centers for Medicare & Medicaid Services (CMS) has issued a request for information, or RFI, seeking public input on opportunities to streamline Medicare requirements and reduce unnecessary regulatory and administrative burdens on health care providers and other stakeholders participating in the Medicare program.

The RFI supports ongoing efforts to lower costs associated with complying with federal regulations, aiming to build a more efficient, less burdensome health care system. CMS is interested in understanding existing challenges and identifying opportunities for meaningful deregulation while maintaining the delivery of high-quality care to beneficiaries. Comments are due to CMS by June 10.

PLEASE SHARE YOUR IDEAS WITH OHA

We believe this is a valuable opportunity to elevate the voice of our members and highlight specific Medicare rules and processes that impede efficiency, quality care delivery and workforce well-being. OHA will submit comments to CMS informed by feedback from the membership.

To assist your organization in gathering internal feedback to submit to OHA, please use this document to coordinate responses and identify priority issues.

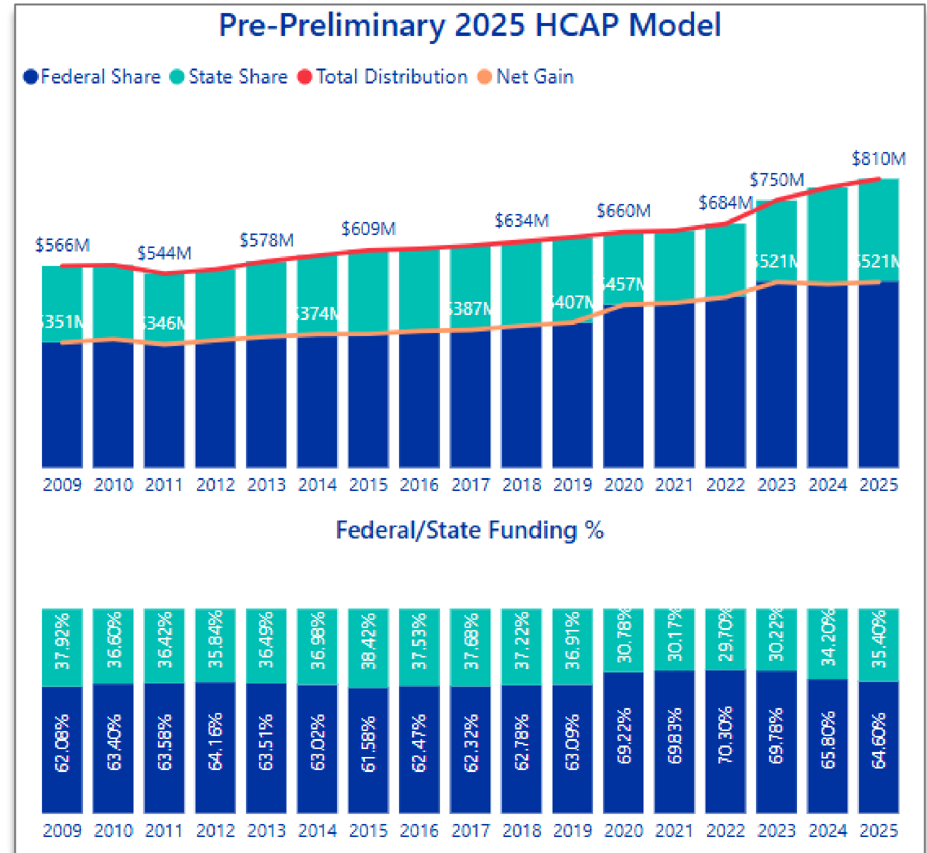
IV. HCAP

PRE-PRELIMINARY 2025 HCAP

Congressional Action

- **Congress has delayed the previously-scheduled DSH cuts through the entirety of FFY 2025**
  - Cuts now scheduled for FFY 2026-2028 at $8B each year
  - Not delaying would have been a 64% cut to both the Total Payment and Net Gain

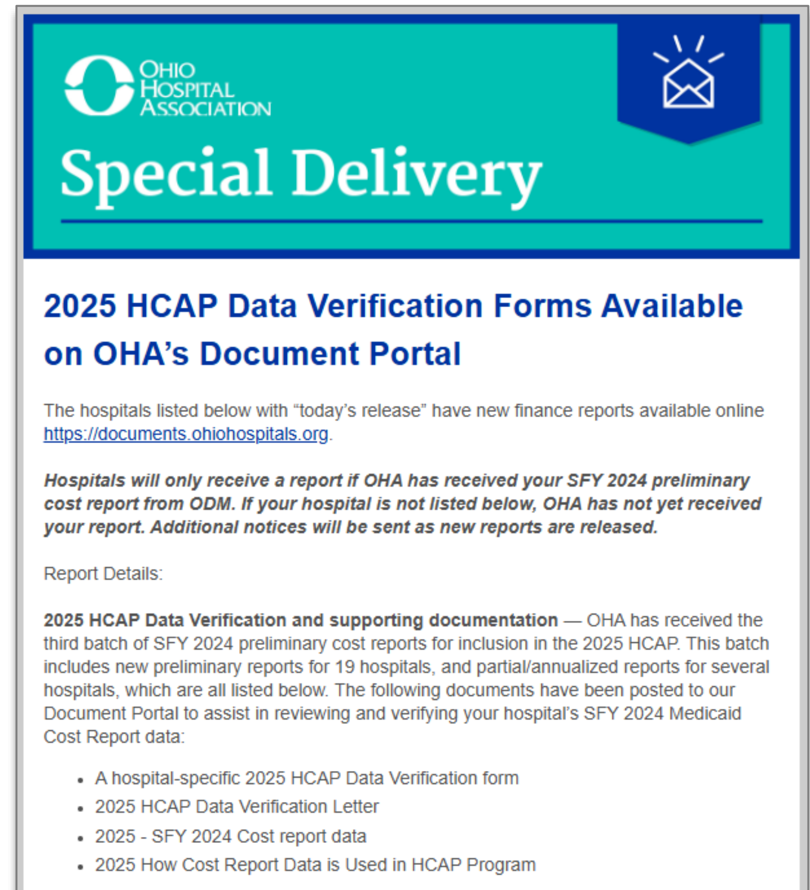
	No Cut	Cut	Impact
Total Payment	$809M	$292M	($518M)
Federal Allocation	$523M	$189M	($335M)
State Assessment	$287M	$103M	($183M)
Net Gain	$521M	$186M	($334M)



PRE-PRELIMINARY 2025 HCAP

Model Development Process

1. ODM releases **preliminary cost reports** in batches, beginning 30-day clock to revise data
2. OHA creates and releases an **HCAP Data Verification Sheet**
3. OHA begins **Pre-Preliminary Model**
4. **Final Preliminary Model** after data is finalized
   - Final revisions to SFY24 data due June 2, 2025



2025 HCAP Data Verification Forms Available on OHA's Document Portal

The hospitals listed below with "today's release" have new finance reports available online https://documents.ohiohospitals.org.

Hospitals will only receive a report if OHA has received your SFY 2024 preliminary cost report from ODM. If your hospital is not listed below, OHA has not yet received your report. Additional notices will be sent as new reports are released.

Report Details:

2025 HCAP Data Verification and supporting documentation — OHA has received the third batch of SFY 2024 preliminary cost reports for inclusion in the 2025 HCAP. This batch includes new preliminary reports for 19 hospitals, and partial/annualized reports for several hospitals, which are all listed below. The following documents have been posted to our Document Portal to assist in reviewing and verifying your hospital's SFY 2024 Medicaid Cost Report data:

- A hospital-specific 2025 HCAP Data Verification form
- 2025 HCAP Data Verification Letter
- 2025 - SFY 2024 Cost report data
- 2025 How Cost Report Data is Used in HCAP Program

PRE-PRELIMINARY 2025 HCAP

2025 PRE-PRELIMINARY MODEL

Details the pre-preliminary modeling for the 2025 HCAP, subject to change prior to finalization.

Provider Name

All

Choose an item:

Model Progress

Data Trends

Hospital-Specific

Model Progress:

Hospitals file their preliminary cost reports with the Ohio Department of Medicaid for use in the upcoming HCAP. These preliminary cost reports are sent to OHA to assist hospitals in reviewing and finalizing their cost reports.

To create the 2025 Pre-Preliminary Model, preliminary SFY 2024 cost reports are blended with finalized SFY 2023 cost reports as used in the 2024 HCAP.

The charts to the right detail the progress in receiving preliminary cost reports for use in the 2025 HCAP.

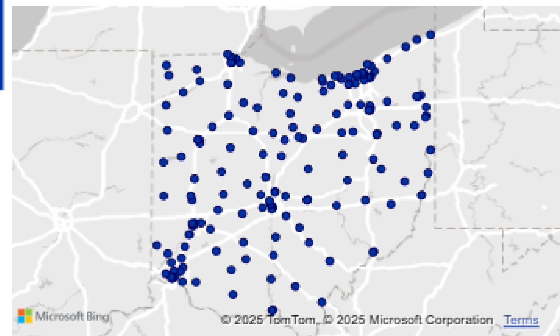
If your hospital is in the "Current Year" list on the right, visit OHA's Document Portal to review your 2025 HCAP Data Verification Sheet.

Last update:
5/5/2025 @ 10:45 AM

2025 HCAP Year Cost Reports

100%
% of ATFC

189
Number of Providers



HCAP Year ● 2025

2024 HCAP Year Cost Reports

(Blank)
% of ATFC

(Blank)
Number of Providers

Current Year (2025 HCAP) Cost Report
Provider Name
Acute Care Specialty Hospital @ Aultman
Adams County Hospital
Adena Regional Medical Center
Advanced Specialty Hospital of Toledo
Akron General Medical Center
Allen Medical Center
Alliance Community Hospital
Arthur G. James Cancer Hospital
Ashtabula County Medical Center
Atrium Medical Center
Aultman Hosp Orville

Prior Year (2024 HCAP) Cost Report
Provider Name

PRE-PRELIMINARY 2025 HCAP

2025 PRE-PRELIMINARY MODEL

Details the pre-preliminary modeling for the 2025 HCAP, subject to change prior to finalization.

Provider Name

All

Choose an item:

Model Progress

Data Trends

Hospital-Specific

Data Trends:

The charts to the right detail the data trends of the blended cost report for the 2025 Pre-Preliminary HCAP compared to the 2024 HCAP.

Note: *This data includes all hospitals in the HCAP, not just those hospitals with a positive OBRA Cap.*

This pre-preliminary model will change as additional hospitals file their preliminary cost reports and details are finalized for the 2025 HCAP.

Last update:
5/5/2025 @ 10:45 AM

2025 Pre-Preliminary vs. 2024 HCAP

OBRA Cap	Total Medicaid Shortfall	Uncompensated W/O Ins.
$1,784,463,035	$1,134,342,972	$488,472,193
-0.7%	-8.0%	18.2%

Measure	2025	2024	Change	
Adjusted Total Facility Cost	$47,608,529,417	$45,441,900,076	4.8%	
FFS Costs	$1,094,812,589	$1,380,504,447	-20.7%	
FFS Payments	$785,257,709	$974,921,892	-19.5%	
FFS Shortfall	$309,554,880	$405,582,555	-23.7%	
MCP Costs	$8,299,100,953	$8,625,967,220	-3.8%	
MCP Payments	$7,565,402,864	$7,897,206,802	-4.2%	
MCP Shortfall	$733,698,089	$728,760,417	0.7%	
Total Medicaid Shortfall	$1,043,252,969	$1,134,342,972	-8.0%	↓ $91M
UC <100% Without	$83,228,768	$68,813,456	20.9%	
UC >100% Without	$494,128,243	$419,658,737	17.7%	
Total Uncompensated Without Insurance	$577,357,011	$488,472,193	18.2%	↑ $89M
Section 1011	$144,782	$566,998	-74.5%	
OBRA Cap	$1,772,143,641	$1,784,463,035	-0.7%	↓ $12M

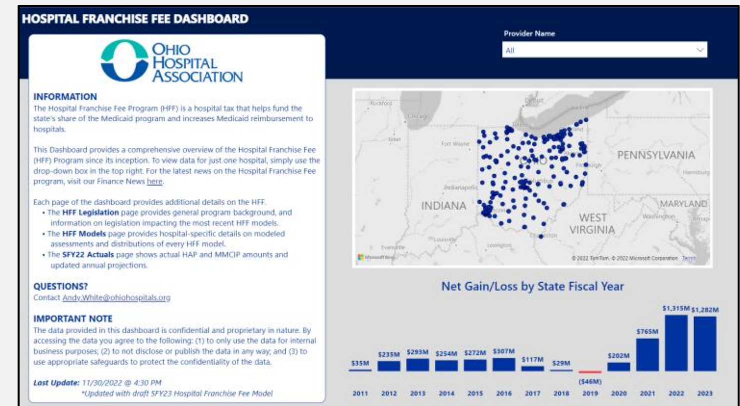
V. HOSPITAL FRANCHISE FEE

2025 HOSPITAL FRANCHISE FEE

- **CMS clears ODM to process SFY25 Q3-Q4 HAP payments**
- **Q3-Q4 HAP amounts released**
  - $881M, 100% of total $1.762B
  - Amounts adjusted to account for AmeriHealth MCIP overpayment from Jan. 2024
- **Q3-Q4 incremental assessment payments were due May 12**
- **Hospitals should receive lump sum HAP payment before June 30th**
  1. ODM pays the MCOs
  2. MCOs transfer to OHA
  3. OHA transfers to individual hospitals as lump sum

Hospital Franchise Fee Dashboard

https://InsightAnalytics.OhioHospitals.org



The Hospital Franchise Fee Dashboard provides a comprehensive overview of the HFF Program since its beginning in SFY 2011 and walks through all components of the assessments and distributions.

HAP CALCULATION

- **Calculation driven by YTD Total Payments over the pre-print period**
  - Each quarter additional utilization data is added to the model, and;
  - A new **YTD Total** is calculated for each hospital
    - Proportional allocation of **YTD IP Funding** and **YTD OP Funding** based on each hospital's **% of Total Utilization**
    - This methodology sets an equal *Per IP Discharge* and *OP % Increase* for each hospital

HAP & MMCIP ACTUALS

Updates projections and tracks actual quarterly payments

SFY: 2025 | Provider Name: All

Choose an item: MMCIP | Directed Payments

Directed Payments/Hospital Additional Payments:

Since the Directed Payments/Hospital Additional Payments are distributed to hospitals by OHA via quarterly lump sum payments, OHA is able to track these distributions as they are released.

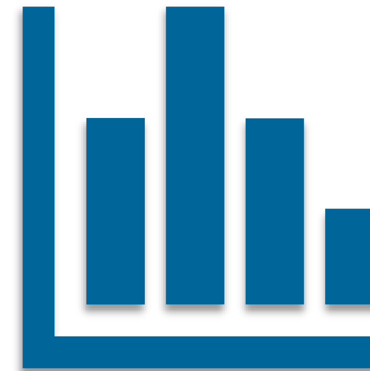
In addition, OHA is able to project the total annual distribution based on each hospital's percentage of total distributions made so far in the state fiscal year.

Projections are annualized amounts of each hospital's percent of total HAP funding distributed so far. These amounts will be updated as HAP amounts are released.

For the latest spreadsheet of HAP payments, visit our Finance News here.

Provider Name	Directed Payment/ HAP Projection	Q1 HAP Actual	Q2 HAP Actual	Q3 HAP Actual	Q4 HAP Actual
Access Hospital Dayton	$869,767	$156,882	$278,002	$0	$0
Adams County Regional Medical Center	$1,387,910	$355,282	$338,673	$0	$0
Adena Regional Medical Center	$18,335,395	$4,446,382	$4,721,316	$0	$0
Advanced Specialty Hospital of Toledo	$170,408	$29,524	$55,680	$0	$0
Akron General Medical Center	$23,754,625	$6,012,598	$5,864,715	$0	$0
Allen Medical Center	$894,094	$211,525	$235,522	$0	$0
Alliance Community Hospital	$3,119,556	$765,496	$794,283	$0	$0
Appalachian Behavioral Healthcare	$980,151	$336,096	$153,980	$0	$0
Arrowhead Behavioral Health	$2,408,865	$649,650	$554,783	$0	$0
Arthur G. James Cancer Hospital	$31,426,697	$7,830,423	$7,882,926	$0	$0
Ashtabula County Medical Center	$6,081,312	$1,516,092	$1,524,564	$0	$0
Atrium Medical Center	$9,532,585	$2,254,877	$2,511,415	$0	$0
Aultman Hosp Orville	$1,684,379	$412,688	$429,502	$0	$0
Aultman Hospital	$19,881,261	$4,877,178	$5,063,453	$0	$0
Avita Ontario Hospital	$3,321,327	$784,983	$875,680	$0	$0
Barnesville Hospital Association	$360,169	$77,891	$102,193	$0	$0
Bay Park Community Hospital	$4,410,246	$1,176,393	$1,028,730	$0	$0
Beckett Springs	$1,594,788	$419,133	$378,260	$0	$0
Bellevue Hospital	$1,838,563	$466,298	$452,984	$0	$0
Belmont Pines Hospital	$1,779,200	$415,025	$474,575	$0	$0
Berger Hospital	$4,012,761	$1,005,574	$1,000,807	$0	$0
Bethesda Hospital	$19,134,637	$4,996,947	$4,570,371	$0	$0
Blanchard Valley Reg. Hlth - Bluffton	$300,257	$74,371	$75,758	$0	$0
Total	**$1,762,000,000**	**$440,500,000**	**$440,500,000**	**$0**	**$0**

- **Quarterly HAP amounts are the difference between your YTD Total and prior quarterly payments made during the pre-print period**
  - While your quarterly HAP payments may not be equal to each, your *Per IP Discharge* and *OP % Increase* are equal to everyone else



- **Prior year reconciliation built into the amounts**
  - Full amount is typically spread evenly across the pre-print period

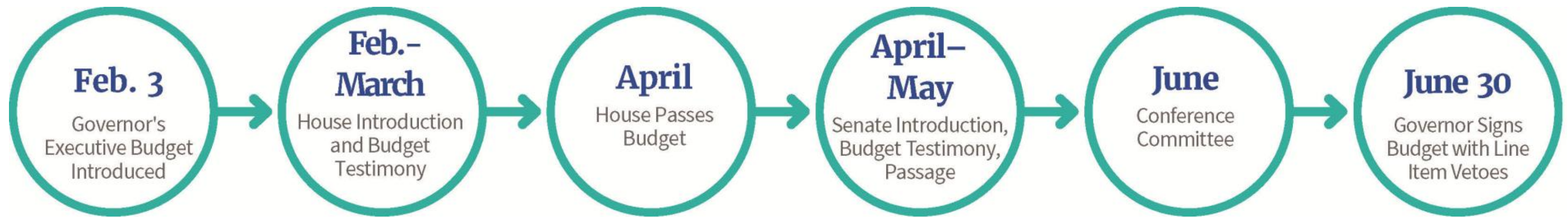
SFY 2026-27 STATE BUDGET

OHA Advocacy Priorities

- ❑ **Protect Medicaid expansion**
  - *Political climate continues to grow more unpredictable*
- ❑ **Protect Medicaid provider rates**
  - *State tax revenue underperformance threatens ability to fund Medicaid without cuts*
- ❑ **Preserve and fully fund HCAP**
  - *Federal DSH cuts slated for FFY 2025*
- ❑ **Enhance the franchise fee**
  - *Leverage new federal flexibilities to increase the fee and provide all OHA member hospitals more resources to tackle the workforce crisis and endure unprecedented inflation in labor, drugs, and supplies.*
- ❑ **Defeat bad ideas**

SFY 2026-27 STATE BUDGET

Timeline & Process



April 9th	Ohio House of Representatives passed their version of the State Operating Budget 60-39
April 10th-25th	Legislative spring break
May 13th	Senate Medicaid committee public testimony
Early June	Senate unveils their budget proposal
June 12th	Senate votes on state operating budget

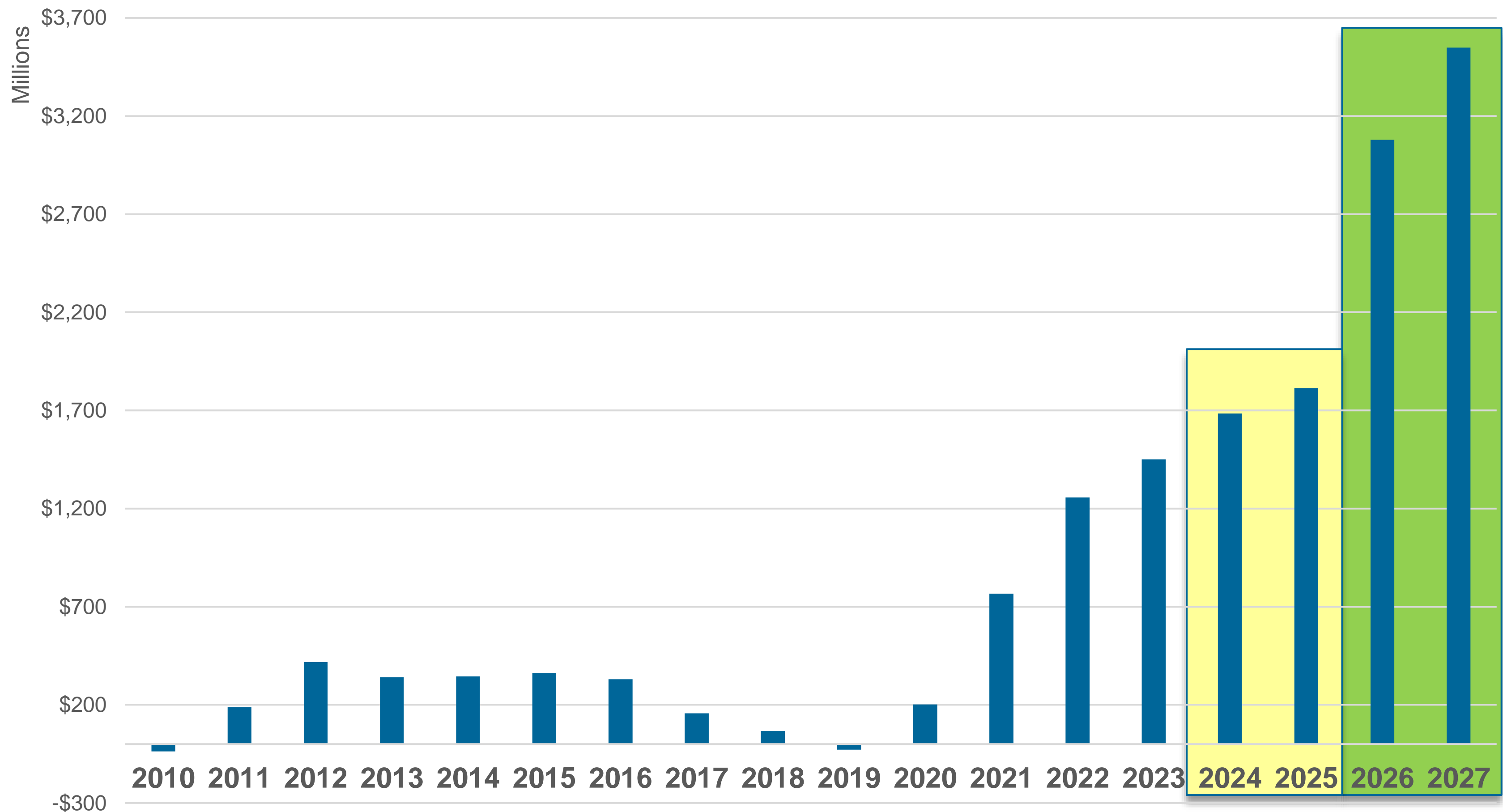
2026-27 STATE BUDGET

Executive Budget Proposal – Hospital Provision Summary

	SFY 2025	SFY 2026	SFY 2027
Hospital Additional Payments (SDP)	$1,762,000,000	$3,600,000,000	$3,900,000,000
Governor's Hospital Initiatives	-	$179,602,000	$359,203,000
Other SDPs (Hospital & Physician)	~$500,000,000	$697,000,000	$833,700,000
1% HFF to ODM	-	($368,000,000)	($368,000,000)
340b Impact	-	($158,244,000)	($317,916,000)

OHIO HOSPITAL FRANCHISE FEE

Hospital Net Gains 2010 – 2027 proj.



VI. BEHAVIORAL HEALTH

WORK PLAN

New Tools

Created and deployed in 2024

- ✓ Local Outreach Toolkit
- ✓ Behavioral Health Data Summary
- ✓ OHA Behavioral Health Website
- ✓ OHA Well-Being Report

Policy Opportunities

Analyze & explore in 2024-2025

- ✓ ED Psychiatric Services
  - ODM allows for professional billing on Psychiatrists in ED setting
- ✓ IP Telepsychiatry
  - OMHAS allows for telepsychiatry on IP psychiatric units, *with caveats*
- ⚠ Care Coordination and Transitions
  - RecoveryOhio Care Portal—*on-going*
  - HAP Quality Collaborative—*begun 5/6/25*
- ⚠ Collaborative & Integrated Care Models
  - Annual Mental Health Visit
- Psychiatric ICU Models
- Alternative Payment Models
- Licensing Board Barriers

HAP QUALITY COLLABORATIVE

1st Tuesday of the month, 10-11am

- **HAP program tied to advancing NCQA Measure 0576**
  - 7- and 30-Day Follow-Up After Hospitalization for Mental Illness
  - Ohio Medicaid MCOs, including OhioRISE
  - Aged 6 years and older
  - Hospitalized for treatment of selected mental illness or intentional self-harm diagnoses
  - Measured at statewide level based on claims
- **Evaluated annually by CMS (IPRO)**
  - Quality improvement process/tools
- **OHA has convened a Collaborative**
  - Interested? Contact Andy

	Measure 0576: Follow-Up After Hospitalization for Mental Illness (National Committee for Quality Assurance)
Description	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.
Numerator	30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. 7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge.
Numerator Details	For both indicators, any of the following meet criteria for a follow-up visit. •An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider. •An outpatient visit (BH Outpatient Value Set) with a mental health provider. •An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set). •An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). •A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set). •Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set). •A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider. •An observation visit (Observation Value Set) with a mental health provider. •Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider. •A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set). •A telephone visit (Telephone Visits Value Set) with a mental health provider. (See corresponding Excel document for the value sets referenced above). Mental Health Provider Definition: A provider who delivers mental health services and meets any of the following criteria: •An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. •An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.

ANNUAL MENTAL HEALTH VISIT

OHA Recommendation

Ensuring Ohioans' Access to High-Quality Hospital Care in Their Communities

1) Requiring all individual and group health insurers to cover one annual mental health wellness examination, which may be integrated with an existing annual physical.
2) Allowing the visit to be provided by a primary care provider or a licensed mental health professional.
3) Prohibiting cost-sharing, prior authorization requirements, and the exclusion of behavioral health or physical health services on the basis they were provided on the same day or at the same facility.
4) Requiring all insurers, including Medicaid, to reimburse for an existing set of Current Procedural Terminology (CPT) codes, which better connect patients to timely and appropriate behavioral health treatment:
   a. Collaborative Care Model—99484, 99492-99494
   b. SBIRT (Screening, Brief Intervention, and Referral to Treatment)—99408-99409
   c. Health Behavior Assessment and Intervention—96156-96171
   d. Consultation—99446-99451

d. Consultation—99446-99451

The data around unmet behavioral health needs indicates the potential value of an Annual Mental Health Visit. More than 1 in 5 U.S. adults currently live with a mental illness, but only half receive treatment.[1] Several factors contribute to these poor outcomes, including limited behavioral health workforce capacity, limited access to timely treatment, and inconsistent insurance coverage.

Meeting patients where they are would help address these issues. According to a 2024 Gallup survey, 7 in 10 U.S. adults say they would prefer their healthcare provider ask about both their physical and mental health

[1] National Institute of Mental Health (NIMH). "Mental Illness," https://www.nimh.nih.gov/health/statistics/mental-illness.

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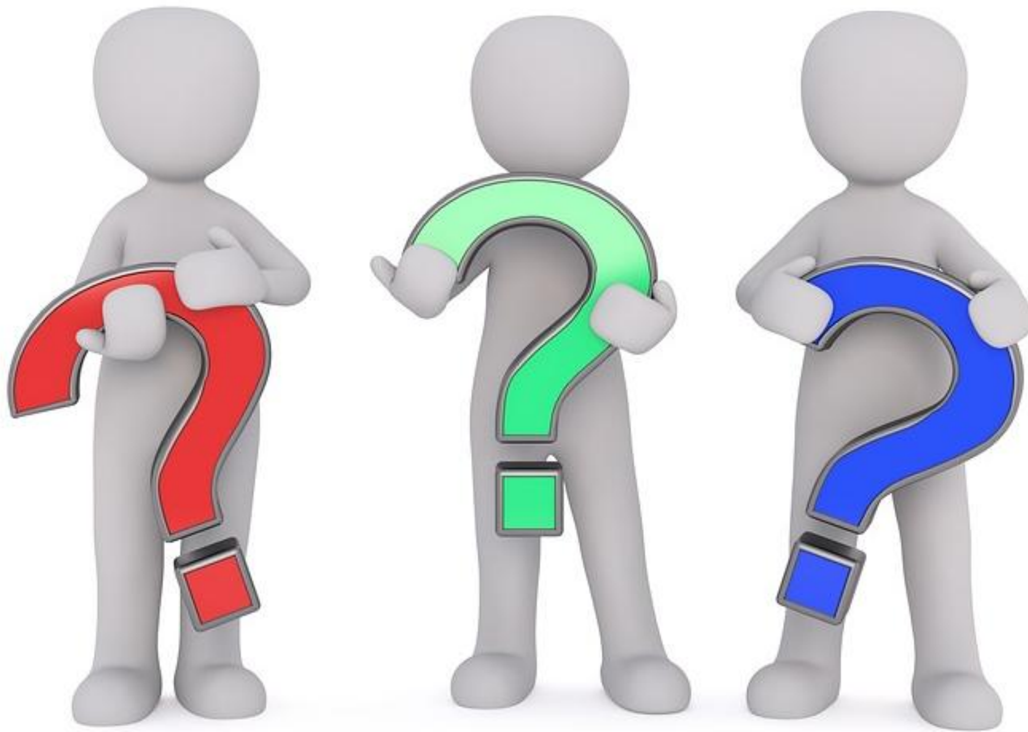
- Draft legislation being refined by ODI
- Governor's Office indicates language would also apply to Medicaid program
- Next steps TBA

VII. Q&A

QUESTIONS?



Ohio | Department of Medicaid

Hospital Policy

OHA collaborates with member hospitals and health systems to ensure a healthy Ohio

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