



HEALTH ECONOMICS & POLICY UPDATE OHA ANNUAL MEETING 2026

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SPEAKERS



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

HEALTH ECONOMICS AND POLICY UPDATE

- I. CMS Proposed & Final Rules**
- II. WISeR Model**
- III. Group VIII Work & Community Engagement Requirements**
- IV. Payer Scorecard**
- V. HCAP**
- VI. Hospital Franchise Fee**
- VII. Rural Health Transformation Program**
- VIII. Behavioral Health**
- IX. Q&A**

CMS PROPOSED & FINAL RULES

FFY 2027 IPPS PROPOSED RULE

Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

Key Proposal Highlights

- Mandatory participation for most acute care hospitals
- Begins Oct. 1, 2027
- Hospitals accountable for total Medicare spending during certain lower extremity joint replacement episodes
 - Includes Medicare Part A and B spending, episode begins with IP admission or OP procedure
 - Extends through 90 days post-discharge, includes post-acute care, readmissions, and related services
- CMS to conduct annual retrospective reconciliation beginning Spring 2029
 - Actual episode spending later compared against CMS-established benchmark
 - Quality outcomes influence reconciliation payments and shared savings opportunities

CMS
CENTERS FOR MEDICARE & MEDICAID INQUIRY
PRACTICE TRANSFORMATION GUIDE

Comprehensive Care for Joint Replacement (CJR) Model

Lessons Learned from the First 5 Years

MODEL OVERVIEW	PARTICIPANTS	
The CJR model is a mandatory model that launched on April 1, 2016 to test whether an episode-based payment approach for lower extremity joint replacements (LEJR) can lower payments while maintaining or improving quality.	733 Hospitals	67 Metropolitan Statistical Areas
Mandatory participation was scaled back to 34 MSAs in year 3		

PRIMARY DATA COLLECTION ACTIVITIES

Over the first 5 years of the CJR model, data were collected to assess care transformation strategies implemented by participant hospitals.

313 Phone Interviews	40 Case Studies	3 Provider Surveys
Provide insight into specific topics of interest, including care coordination efforts, relationships with surgeons and post-acute care providers (PAC), and hospital internal cost-savings.	250 interviews completed with 700+ hospital staff and PACs.	644+ providers responded, including hospital administrators, orthopedic surgeons, and care coordinators.

FINDINGS

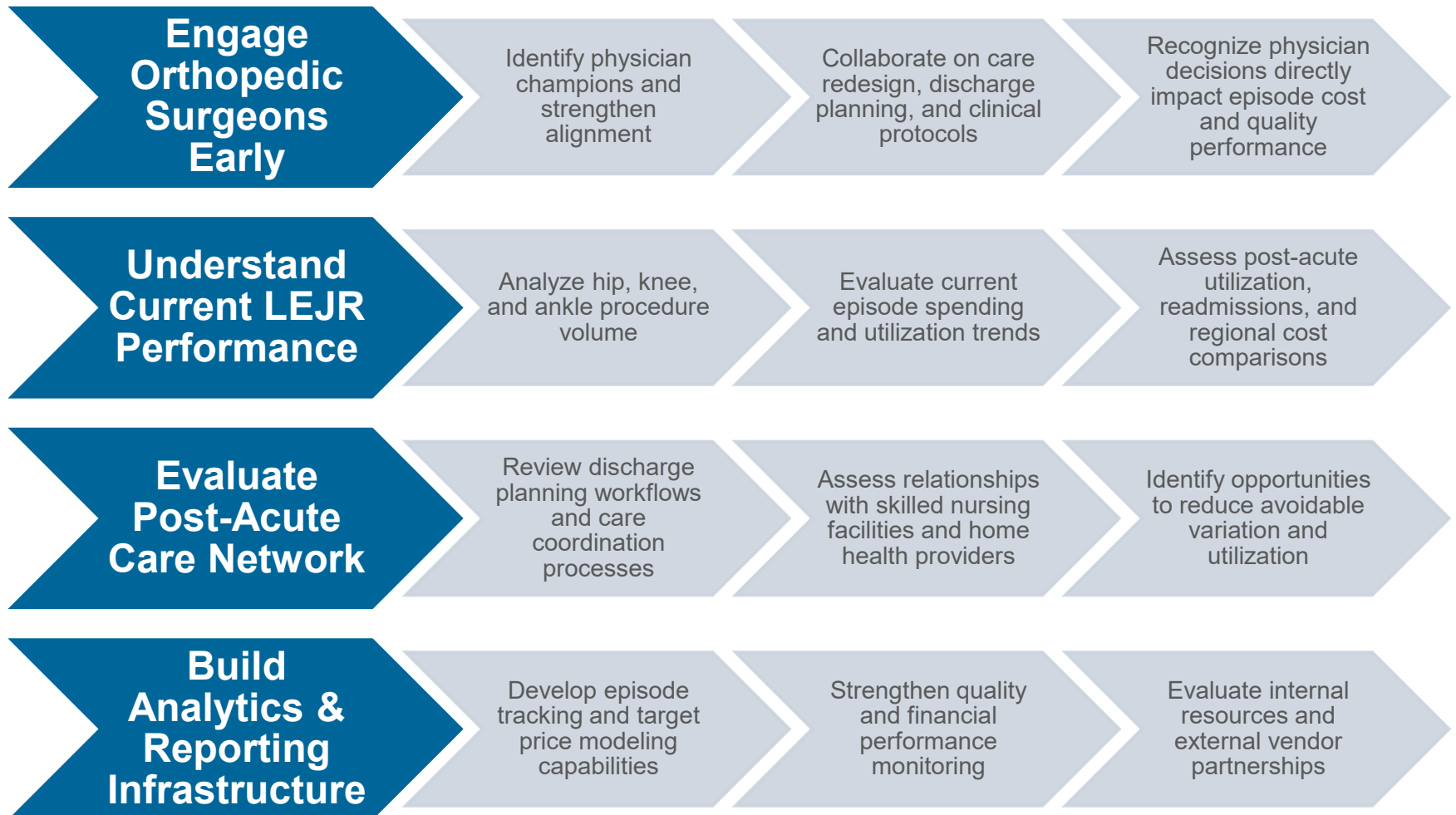
Hospitals were driven to respond to the CJR model due to market and payment pressure and the opportunity to prepare for future bundled payment models.

The opportunity to prepare for future bundled payment models was a key driver in hospitals' decisions to respond to the CJR model. Interviewees at one hospital noted that "the future looked like bundles were going to be rolling out all over the place" and the CJR model was the "training wheels" to prepare for other models.	The alignment of the financial incentives with other market pressures influenced hospitals' choice of action in responding to the CJR model. Hospitals were able to react quickly to the CJR model by leveraging established partnerships and standardized care protocols. Hospitals refined their strategies based on Medicare and clinical data.
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This document summarizes the evaluation reports prepared by an independent contractor. To learn more information about the CJR model and to download the evaluation reports and case studies, visit <https://innovation.cms.gov/innovation-models/cjr>

FFY 2027 IPPS PR - COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL EXPANSION

Prepare Now



INTEROPERABILITY & ADMINISTRATIVE SIMPLIFICATION

2026 CMS Interoperability Standards & PA for Drugs Proposed Rule – Comments due June 15

- Requires impacted payers (Medicare Advantage, Medicaid, CHIP, QHPs) to support electronic prior auth requests for drugs
- Real-time electronic PA status tracking: Submission, pending, approval, denial updates
- Compliance date: Oct. 1, 2027 for most requirements

CMS Administrative Simplification Final Rule – Claims Attachments & Electronic Signatures

- Establishes national HIPAA standards for electronic health care claims attachments
- Requires standardized use of electronic signatures for claims-related documentation
- Compliance date: May 26, 2028

WISER MODEL

Wasteful and Inappropriate Service Reduction Model

Voluntary Model: 2026 - 2031

The Wasteful and Inappropriate Service Reduction Model (WISeR) will harness enhanced technologies like Artificial Intelligence (AI) and Machine Learning (ML) to streamline the review process for certain services that are vulnerable to fraud, waste and abuse, helping people with Medicare receive safe and appropriate care and protecting federal taxpayers.



Model Goals

- Focus health care spending on services that will improve patient well-being
- Apply commercial payer processes that may be faster, easier, and more accurate
- Increase transparency of existing Medicare coverage policy
- De-incentivize and reduce use of medically unnecessary care

Performance Measures

Model participants will be assessed on performance across quality measures such as:



Volume of prior authorization requests processed



Timeliness of response



Clarity of explanation of request determination

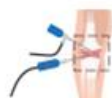
Examples of Included Services



Skin and tissue substitutes



Electrical nerve stimulators



Knee arthroscopy for knee osteoarthritis

WISER MODEL

- OHA continues ongoing engagement with CMS CMMI and Innovaccer, Ohio's WISeR model participant
- Compared to other participating states, Ohio's implementation has progressed relatively smoothly despite some operational challenges
 - System enhancements are forthcoming to help improve the ADR process and provider experience
 - WISeR gold carding program anticipated to launch this summer
- Members are encouraged to continue sharing implementation concerns, operational challenges, and examples of system issues with OHA

GROUP VIII WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

OHIO'S HISTORY WITH GROUP VIII WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

FY 2018–2019 State Budget

Required ODM to seek demonstration waiver to implement work & community engagement requirements

- Waiver approved in 2019
- Jan. 2021 implementation date delayed due to COVID-19 pandemic
- Aug. 2021 waiver approval rescinded

July 4, 2025 – H.R. 1 Enacted

H.R. 1 (One Big Beautiful Bill Act) requires all expansion states to implement work and community engagement requirements no later than Dec. 31, 2026

- States may request extension until Jan. 2029, subject to CMS approval

State budget required ODM to submit a new demonstration waiver request

- Waiver submitted Feb. 2025, anticipated implementation date Jan. 1, 2026

FY 2024–2025 State Budget

Ohio implementing requirements as a condition of Medicaid eligibility

Jan. 1, 2027

GROUP VIII WORK & COMMUNITY ENGAGEMENT REQUIREMENTS

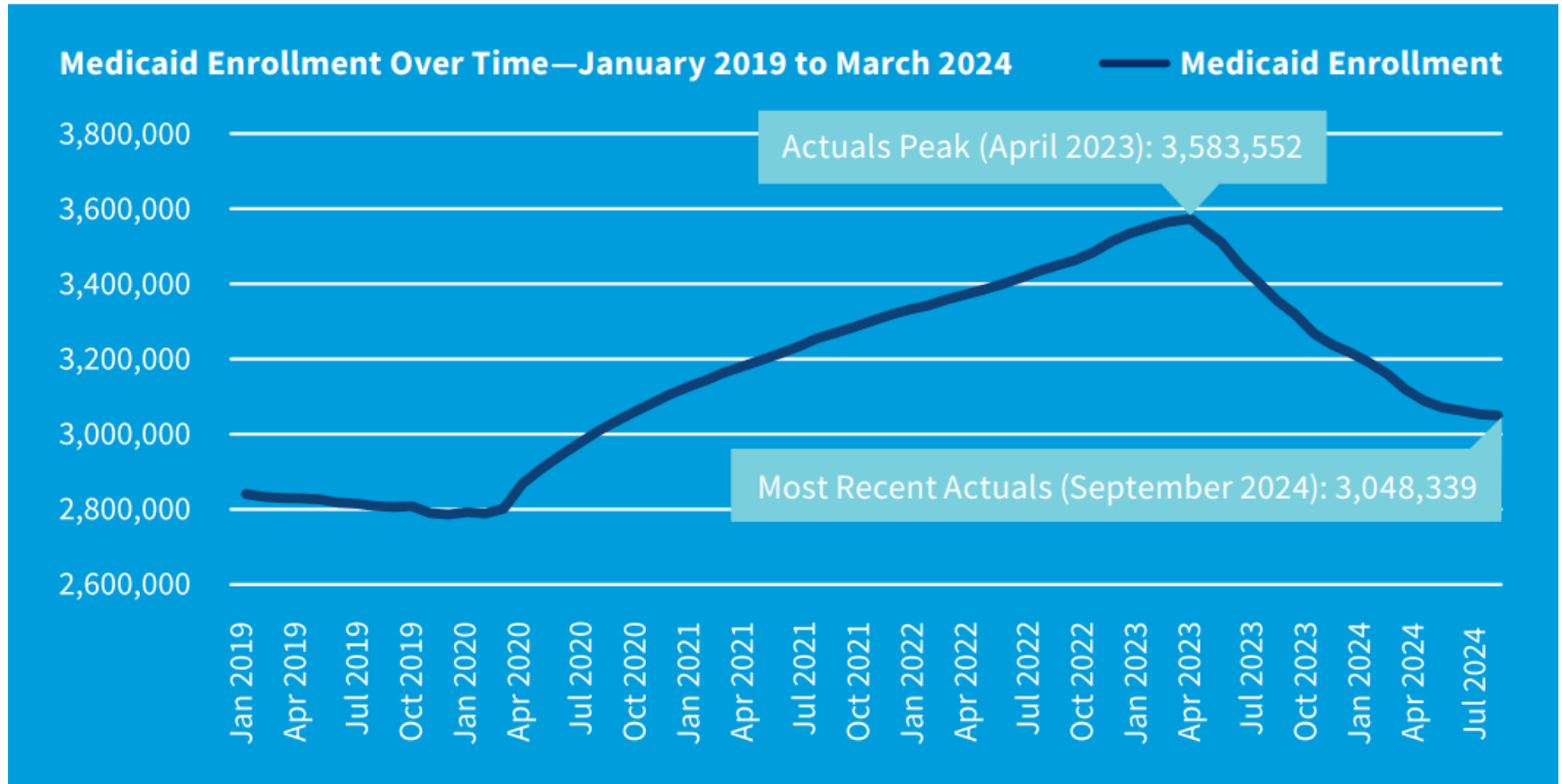
Comparison of Waiver and H.R. 1 Program Components

	H.R.1	ODM 1115 Waiver
Start Date	<ul style="list-style-type: none"> No later than December 31, 2026, with possibility of an extension until January 2029 	<ul style="list-style-type: none"> June 2026
Verification of eligibility or exemption	<ul style="list-style-type: none"> Verification of the status of qualifying activities or exemptions with existing data sources is required. Members will have to submit verification where data isn't available 	<ul style="list-style-type: none"> Same process
Qualifying Activities		
Hours of work, community service, work program, educational program, or a combination	<ul style="list-style-type: none"> 80 hours per month 	<ul style="list-style-type: none"> 20 hours per week <ul style="list-style-type: none"> Note: Unpaid family caregiver[s] for disabled family member are recognized as working
Exemptions		
Age	<ul style="list-style-type: none"> Under the age 19 or over age 64 	<ul style="list-style-type: none"> Over age 55
Dependents	<ul style="list-style-type: none"> Caregivers to children 13 or under, or disabled dependents 	<ul style="list-style-type: none"> [See note above]
Pregnancy	<ul style="list-style-type: none"> Pregnant or postpartum individuals 	<ul style="list-style-type: none"> None
Other Exemptions	<ul style="list-style-type: none"> Medically frail (full list included in the Appendix) Veteran with a disability rated as total Participate in a drug or alcohol treatment and rehabilitation program Incarcerated or recently released from incarceration 	<ul style="list-style-type: none"> Same process
Optional Short-Term Hardships	<ol style="list-style-type: none"> Short term hospital or institutional stay; Living in a county with a federal declared emergency; Living in a county with an unemployment rate above 8% or 1.5 X the national unemployment rate 	<ul style="list-style-type: none"> None

Note: The content presented here is subject to change prior to program implementation based on future CMS guidance

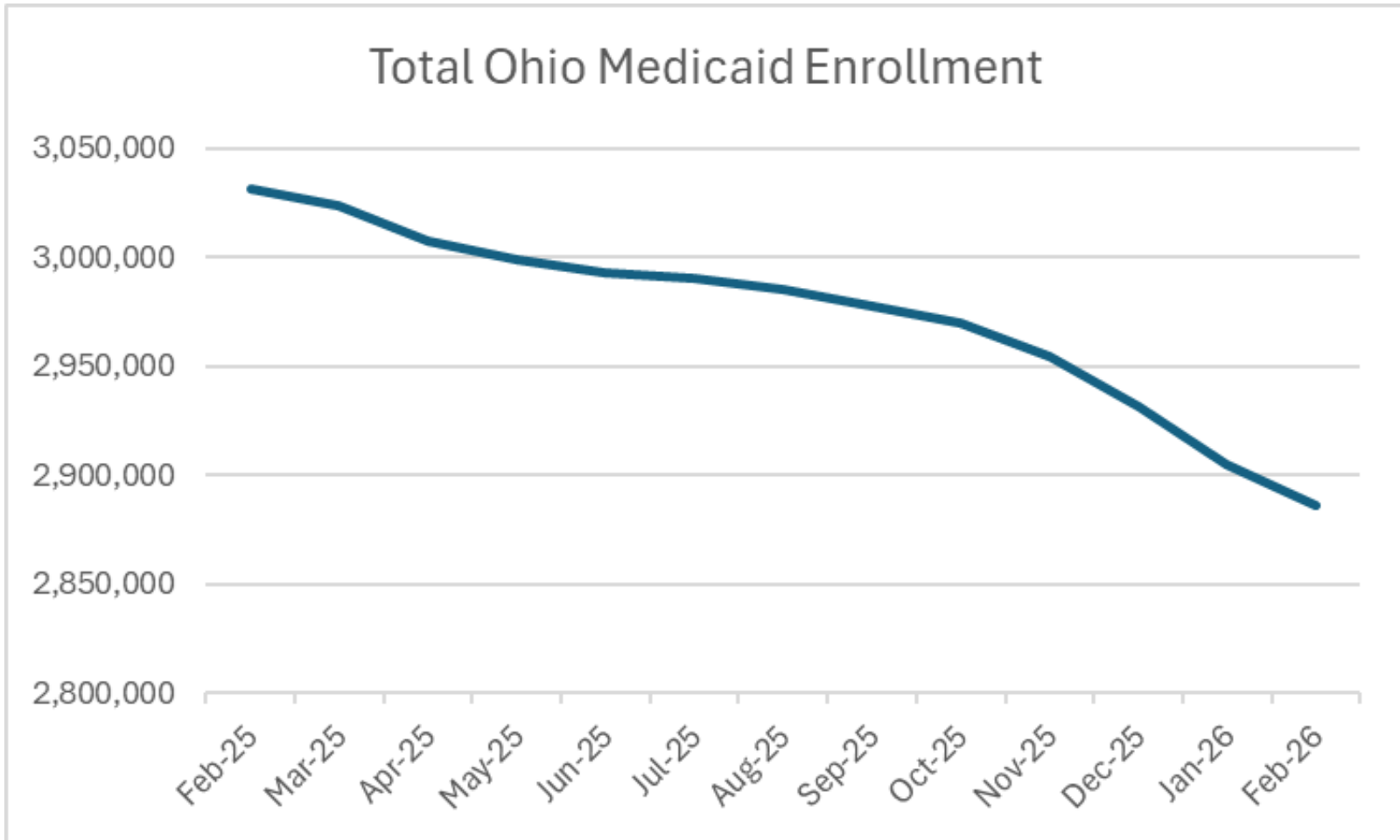
Source: [ODM Nov. 7, 2025 Stakeholder Webinar](#)

OHIO MEDICAID ENROLLMENT TRENDS



Source: [ODM Unwinding Report \(June 2024\)](#)

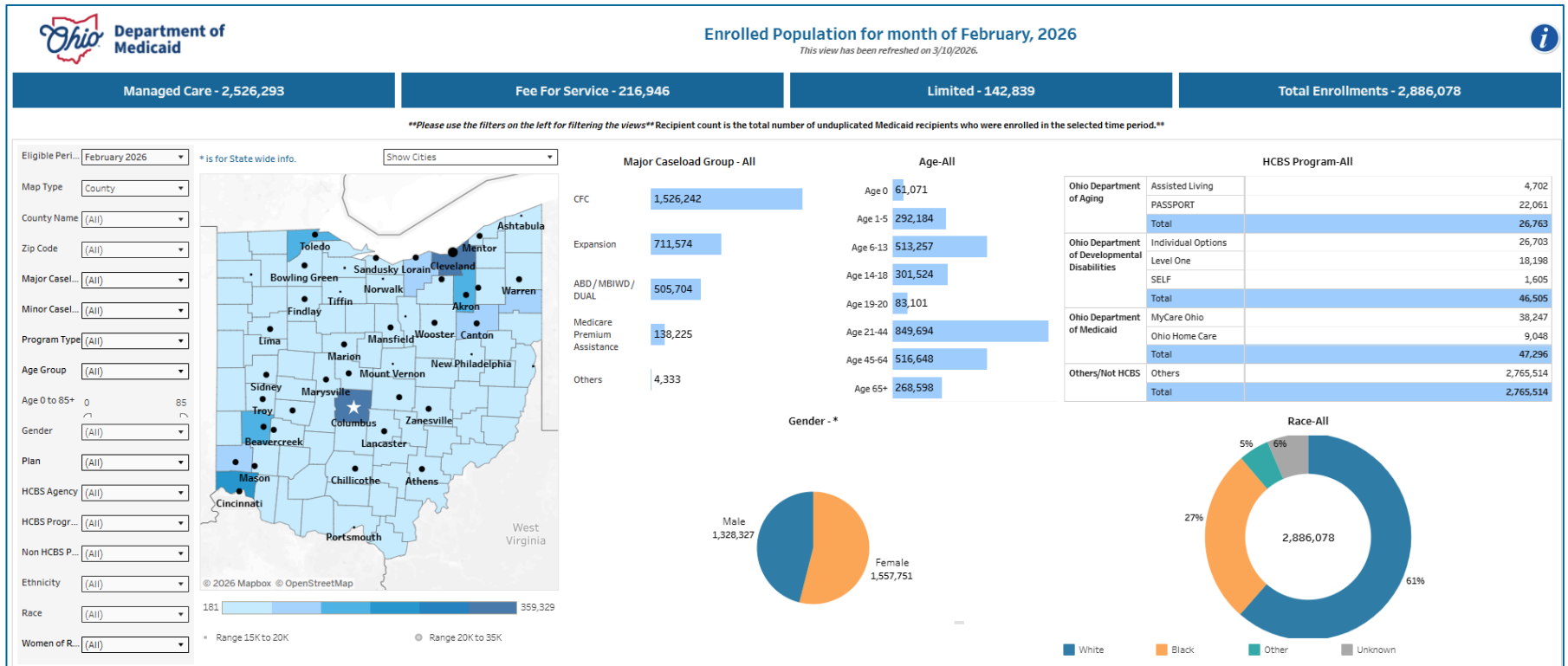
OHIO MEDICAID ENROLLMENT TRENDS



Source: [ODM Dashboard: Who We Serve – Timeline](#)

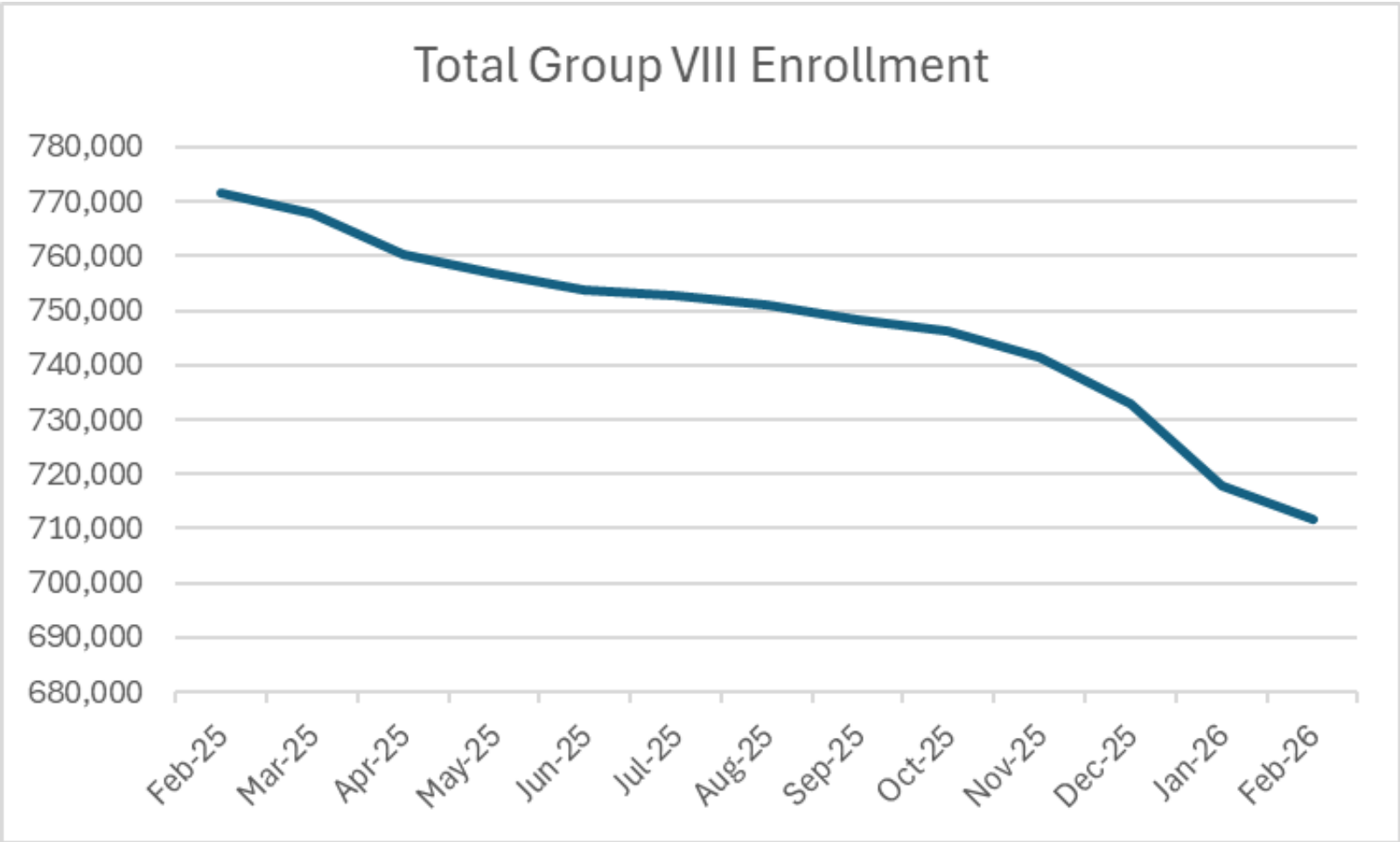
OHIO MEDICAID ENROLLMENT SNAPSHOT

Almost 2.9 million Ohioans receive Medicaid coverage (24% of Ohio's total population)



Source: [ODM Dashboard: Who We Serve](#) (Feb. 2026)

OHIO MEDICAID GROUP VIII ENROLLMENT TRENDS



Source: [ODM Dashboard: Who We Serve – Timeline](#)

OHIO'S GROUP VIII POPULATION

General View of the Individuals in Group VIII as of July 2025 Eligibility

Group VIII Breakdown

Total Group VIII population

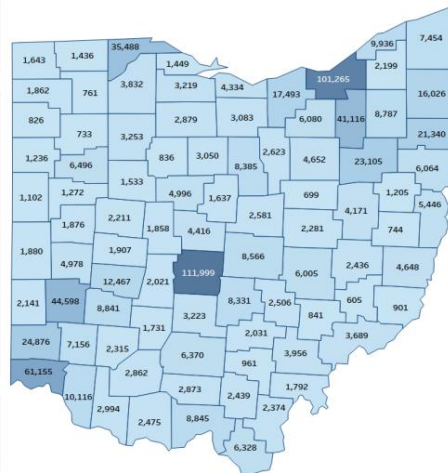
774,342

Group VIII Population by Age

Group	#	%
Age 19-20	62,384	8.2%
Age 21-44	435,547	56.9%
Age 45-64	266,546	34.8%
Age 65+	553	0.1%

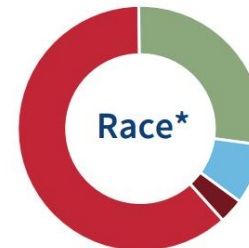
Total Group VIII population

- 57% are between the ages of 21 and 44
- 35% live in our three major counties
- 61% are white
- 54% are male
- 94% are in Managed Care



County of Residence
(Enrolled Group VIII Population)

Group VIII Race & Gender



- White: 61% (470,011)
- Black: 27% (209,375)

*Due to rounding, percentages do not add up to 100%



- Male: 54% (412,560)
- Female: 46% (352,484)

** ~9.3k Group VIII recipients were omitted from the view due to missing demographic information

Note: The content presented here is subject to change prior to program implementation based on future CMS guidance

Source: [ODM Nov. 7, 2025 Stakeholder Webinar](#)

OHIO'S PROJECTED IMPACT

H.R. 1 Sec. 71119

Sec. 71119 Work and Community Engagement Requirements

- Requires states to establish work and community engagement requirements for expansion adults

Section Number	Key Effective Date	Policy Impact	Fiscal Impact Costs (Savings)		
			SFY26	SFY27	Long-term Impact*
71119	12/31/2026, as Ohio will not pursue an extension request.	<ul style="list-style-type: none"> Law will now require all states to ensure Group VIII population is engaged in work requirement activities to maintain coverage Approximately ~70,000 people could be impacted Potential impact to administrative cost for counties to handle additional eligibility assessments. 	\$0	~(\$4M)	~(\$40M) per SFY

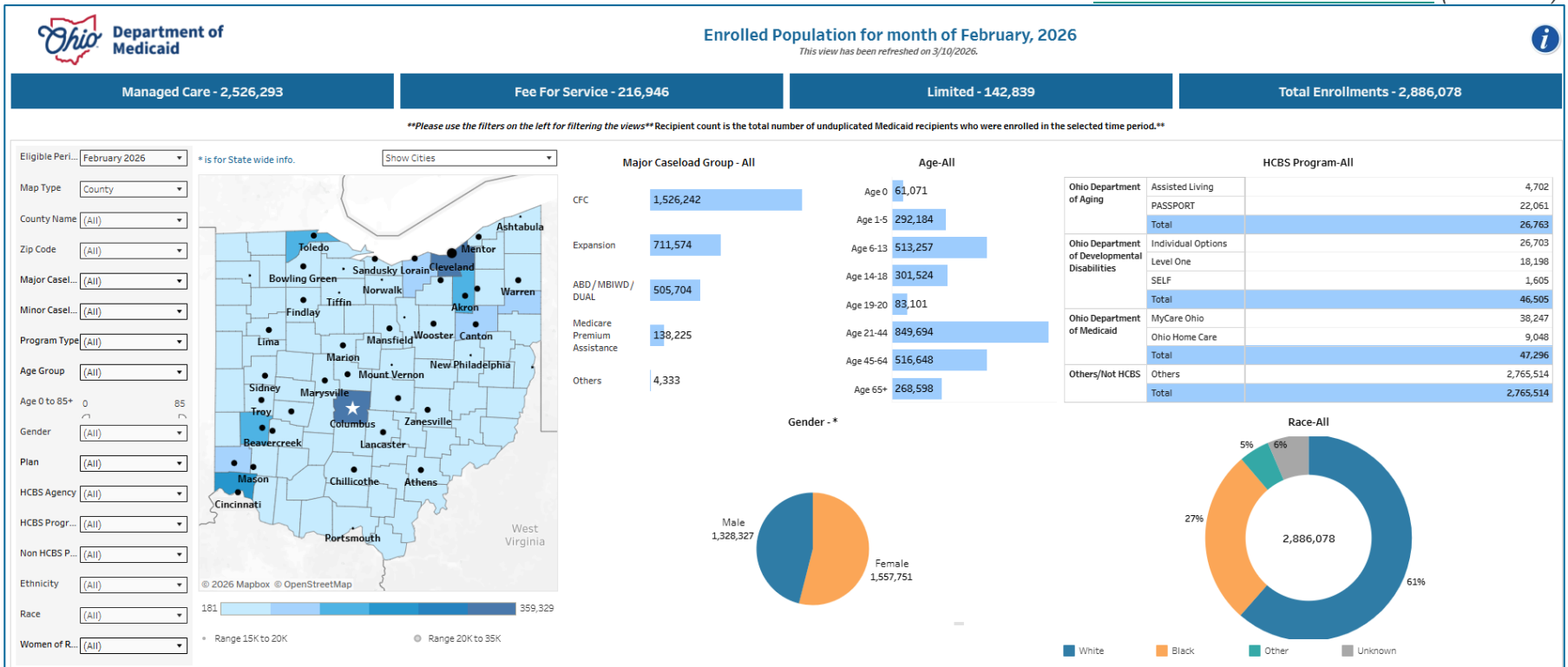
*Long-term fiscal impacts are current projections based on present law, rule, policy, fiscal, and federal regulatory realities and may be subject to change. All amounts are state share of GRF.



Source: [Joint Meeting of the House and Senate Medicaid Committees – February 19, 2026](#)

OHIO'S PROJECTED IMPACT

Source: [ODM Dashboard: Who We Serve](#) (Feb. 2026)

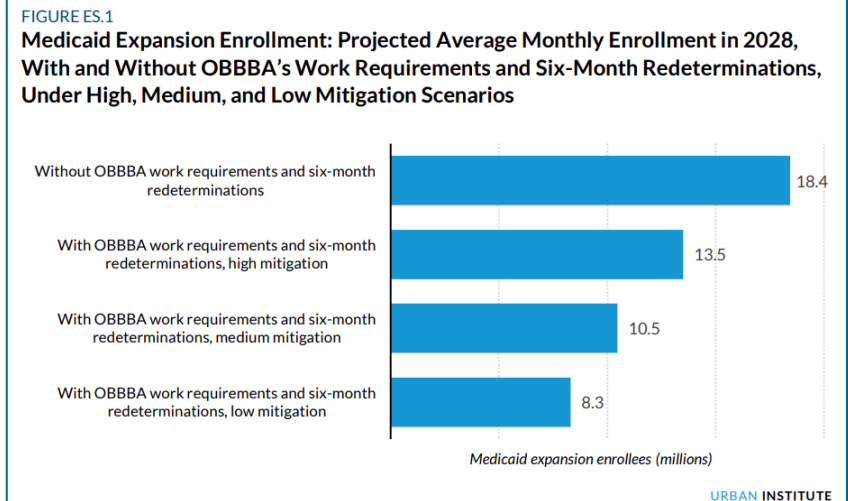


Per ODM, approximately 70,000 Group VIII members could lose Medicaid coverage due to non-compliance with work and community engagement requirements

- Represents 9.8% of Group VIII enrollment
- Represents 2.4% of total Medicaid enrollment

NEW REPORT PROJECTS IMPACT OF WORK REQUIREMENTS & 6-MONTH ELIGIBILITY CHECKS

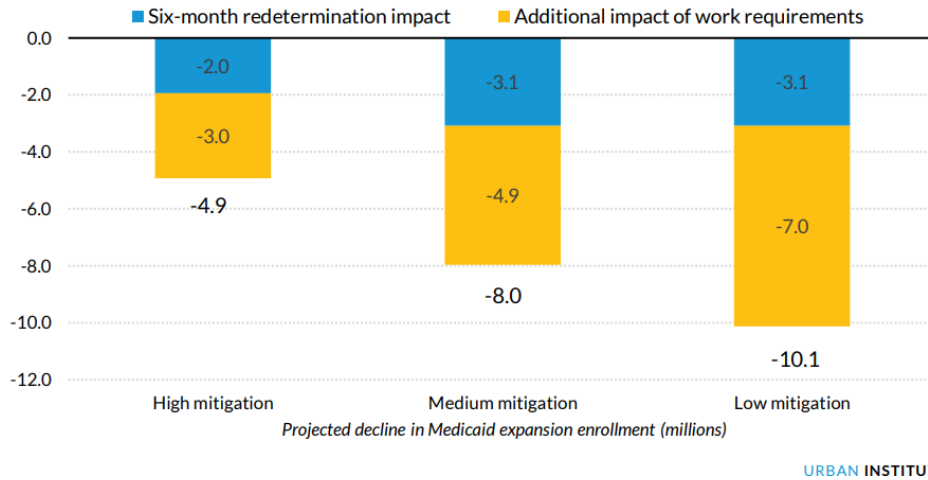
- New report projects more disruptive impact and loss
 - Includes impact of 6-month eligibility checks (only Group VIII)
- Report modeled three scenarios to estimate coverage impacts among Medicaid expansion enrollees, based on how aggressively states mitigate coverage loss through implementation choices
 - High mitigation: States maximize use of automated data matching for eligibility and work requirement compliance, apply minimum work thresholds, and adopt broader exemption criteria
 - Medium mitigation: States take a balanced approach, with moderate use of automation and standard exemption policies
 - Low mitigation: States rely less on automation, require more manual reporting from enrollees, impose higher work thresholds, and apply narrower exemptions



Source: [Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and More Frequent Eligibility Checks](#)

NEW REPORT PROJECTS IMPACT OF WORK REQUIREMENTS & 6-MONTH ELIGIBILITY CHECKS

FIGURE ES.2
Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA's Work Requirements and Six-Month Redeterminations, By Mitigation Scenario



Projected National Impact

4.9 – 10.1 million individuals could lose Medicaid coverage in 2028 due to work requirements and more frequent eligibility checks

Projected Ohio Impact

176 – 356 thousand Ohioans could lose Medicaid coverage by 2028, after accounting for frequent eligibility checks

TABLE 3

Projected Decline in Average Monthly Medicaid Expansion Enrollment in 2028 Under OBBBA Work Requirements and Six-Month Redeterminations, Number and Percent, by State and Mitigation Scenario

	High Mitigation Scenario		Medium Mitigation Scenario		Low Mitigation Scenario	
	Number (thousands)	Percent	Number (thousands)	Percent	Number (thousands)	Percent
Ohio	-176	-25%	-285	-40%	-356	-50%

Source: [Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and More Frequent Eligibility Checks](#)

OHIO'S POLICY DECISIONS

Table 1

Ohio Verification Plans and Adoption of Short-Term Hardship Exceptions, March 2026

Planned Implementation Date	01/01/2027
Compliance Check Frequency	Every six months at renewal
Application Look-Back Period	1 month
Renewal Look-Back Period	1 month
Short-Term Hardship Exceptions State Plans to Adopt:	
Receiving Care in Hospital/Nursing Facility	Yes
Travel for Medical Treatment	Yes
Lives in an Emergency/Disaster County	Yes
Lives in a High Unemployment County	Yes

Note: TBD (to be determined) means the state had not made a decision at the time the survey was fielded.

Source: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2026



Table 2

Ohio Plans for Accessing New Data Sources and Medical Frailty Verification, March 2026

Plans to Access New Data Sources to Verify Work/Exemption Status	Yes
New Data Sources State Plans to Access:	National Student Clearinghouse, VA Benefit Summary Letter, State-specific Program Enrollment Data, Corrections Agency Data
State Currently Has a Medically Frail Definition	Yes
Medically Frail Definition State Plans to Use	TBD
Verification Sources for Medically Frail Exemption	
Claims Data	Yes
Managed Care Utilization or Claims Data	Yes
Managed Care Case Management Data	No
Data Match with Other Programs	Yes
Confirmation from Treating Provider	Yes
Self-Attestation (If Allowed)	Yes
Health Assessment Screener	No

Note: TBD (to be determined) means the state had not made a decision at the time the survey was fielded.

Source: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2026



Source: [KFF 2026 Medicaid Eligibility, Enrollment, and Renewal Policies Annual Survey \(Jan. – March 2026\)](#)

CALL TO ACTION

- Assess operational and financial impacts such as eligibility, charity care, and cash flow
- Expand financial counseling capacity and staff training
- Engage community partners and use hospital communication channels to promote coverage continuity
 - Utilize [ODM's Partner Packet](#) as a resource to inform Medicaid patients of upcoming changes

Draft Communications

Full-page Flyer

Rack Card

Attention Medicaid Individuals!

Did you know?
Medicaid eligibility will be changing for certain individuals in Group VIII
Due to new federal laws, Medicaid individuals eligible for and enrolled in Group VIII coverage (also known as MAGI Adult or Ribicoff coverage), are subject to a Work and Community Engagement Requirement (42 U.S.C.1396a(xx)).

How do I know if this applies to me?
The requirement only applies to Medicaid individuals who are covered in Group VIII (also known as MAGI Adult or Ribicoff coverage) – generally, adults ages 19–64 who have Medicaid because their income is at or below 138% of the Federal Poverty Level.
If you are in Group VIII but have certain health conditions or meet other exemptions, you may not need to participate in activities to keep your Medicaid.
Please refer to your most recent Notice of Action (NOA) or the Ohio Medicaid Self-Service Portal (SSP) to find out your current category of eligibility.

To learn more about how these changes could apply to you, please contact the Ohio Medicaid Consumer Hotline at (800) 324-8680, or visit us online at:

ODM Webpage [\[Link\]](#) ODM Self Service Portal [\[https://benefits.ohio.gov\]](https://benefits.ohio.gov)

Attention Medicaid Individuals!

Medicaid eligibility requirements will be changing for some Medicaid Individuals.

To learn more about how these changes could apply to you, please visit us online at ODM Webpage [\[Link\]](#)

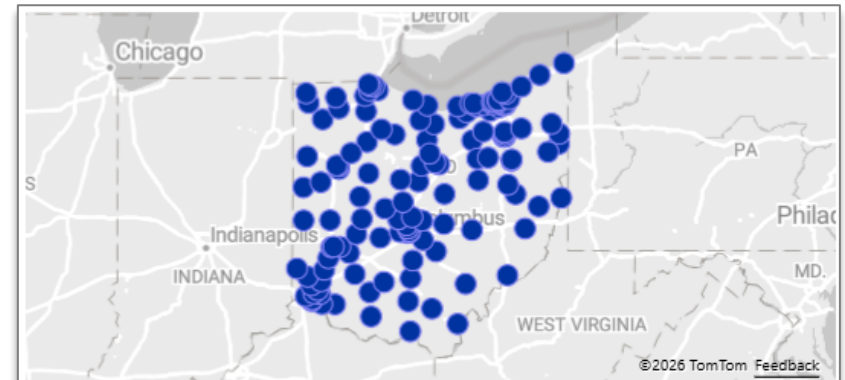
Don't miss important updates about your Medicaid Eligibility & Coverage, visit our website today.

Flyer (see the full-page flyer on the following page) **Rack Card** (see the full-size Rack Card on the follow

PAYER RELATIONS

SURVEY RESPONDENTS

- **Round 15 is now complete**
 - Thank you to everyone who participated!
 - Data covers accounts from CY25
- **Continued strong response rate from OHA membership**
 - Fifteen rounds covering 8 years of account data (CY18-CY25)
 - Respondents represent ~80% of statewide costs
 - Indication of the continued value that this data provides



Survey Round Response Rate

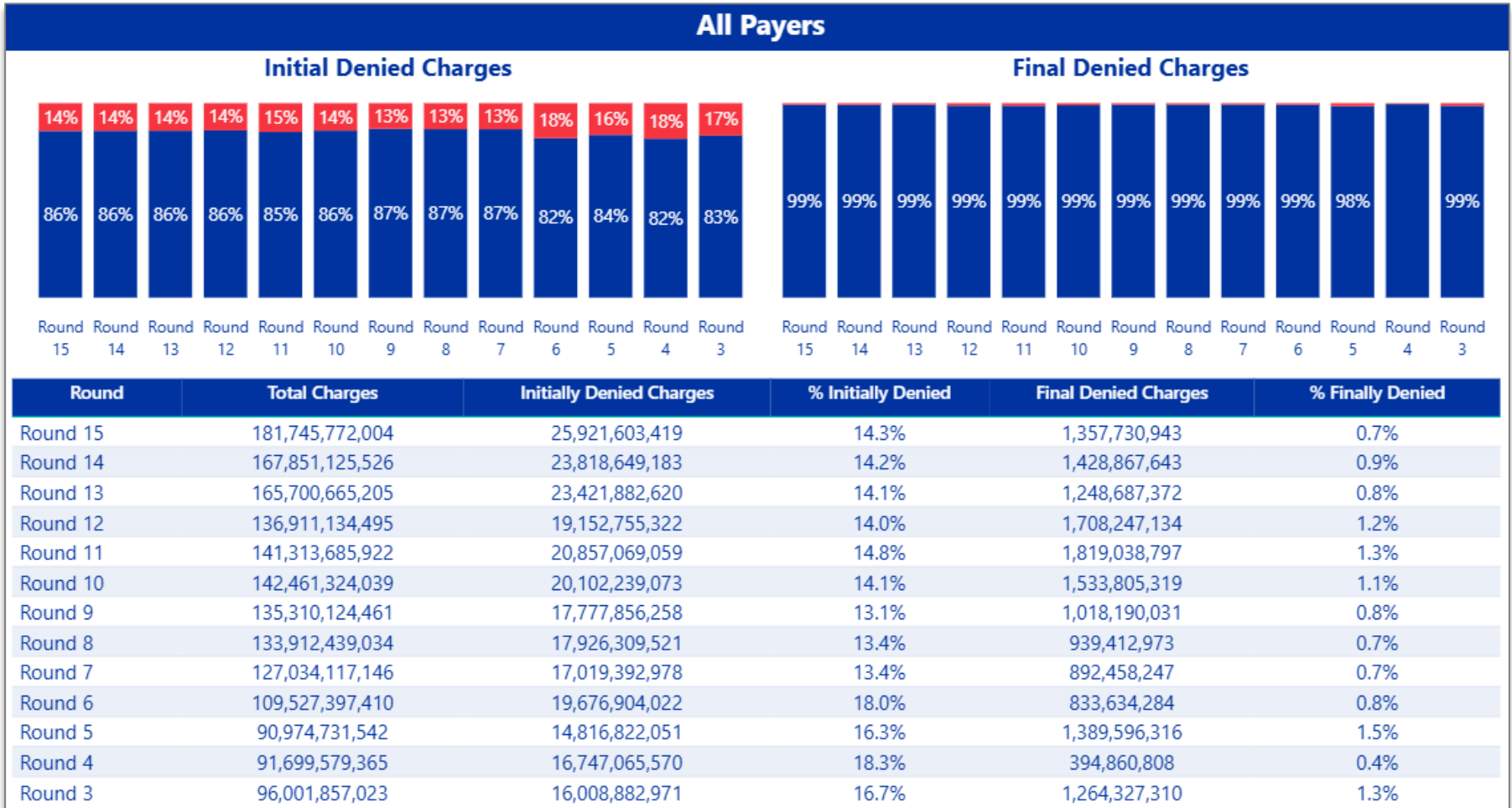
Round Number	Submission Period	Survey Respondents	Hospitals Represented	% of Statewide Facility Costs
Round 15	1/1/2025 - 12/31/2025	43	118	80.2%
Round 14	7/1/2024 - 6/30/2025	42	117	79.5%
Round 13	1/1/2024 - 12/31/2024	42	117	79.3%
Round 12	7/1/2023 - 6/30/2024	44	119	79.5%
Round 11	1/1/2023 - 12/31/2023	45	120	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 FINAL ROUND 15

- **Initial and final denial figures remain consistent from last 4 years**
 - All payers initially deny 14% (\$25.9B) of total charges, finally denied <1% (\$1.4B)
 - Approximately 80% (\$20.3B) of initially denial charges continue to be administrative denials
- **Medicare FFS remains the consistent favorite**
 - FFS—Initially denies 7.4% (\$3.1B), finally denies 0.4% (\$175M), lowest of large payers
 - Advantage—Initially denies 12.6% (\$6.3B), finally denies 0.7% (\$322M)
- **Medicaid Plans continue to struggle 3-years post-Next Gen**
 - Initial denials flat-lined at 18.0% (\$6.2B), final denials at 0.9% (\$312M)
 - Aging AR has improved slightly post-Next Gen, but 53% still >30 Days
- **Commercial Plans got worse**
 - Initial denials increased to 19% (\$9.4B), highest denial rate in last 4 years
 - Leading commercial insurers for initial denials were Anthem (\$4.6B, 19%), UnitedHealthcare (\$1.8B, 18%), and Medical Mutual (\$1.7B, 22%)

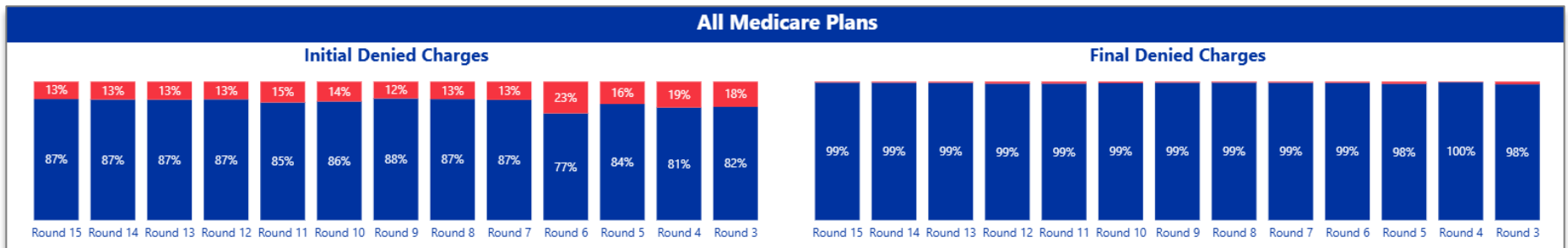
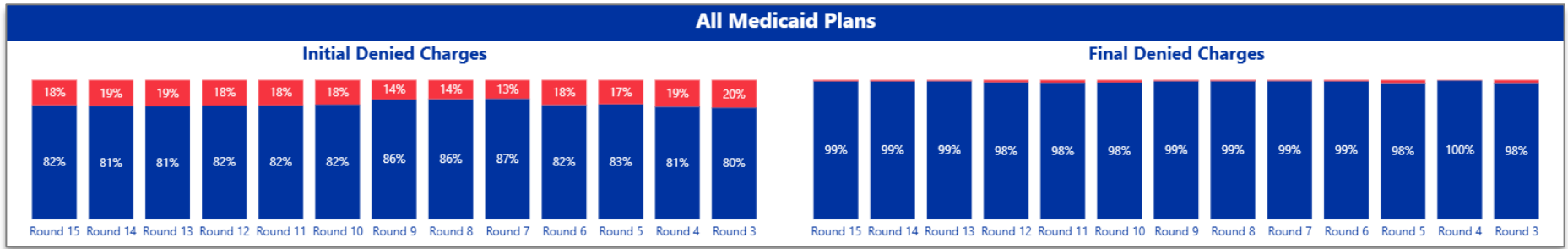
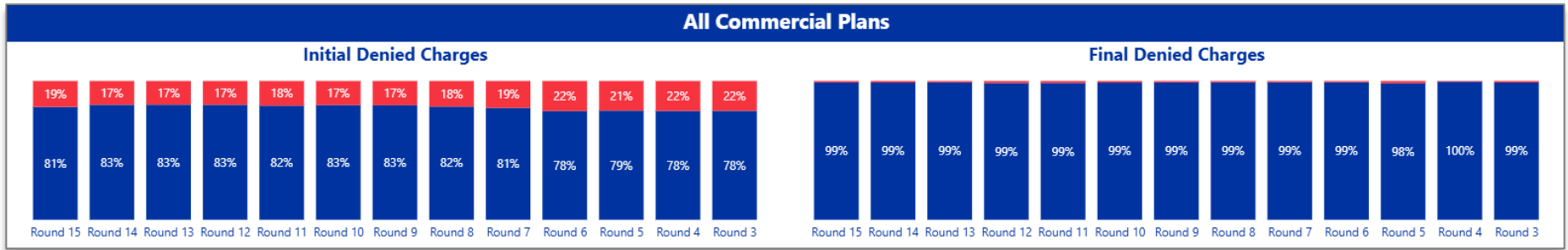
INITIAL & FINAL DENIED CHARGES

Final Round 15 Trend – All Payers



INITIAL & FINAL DENIED CHARGES

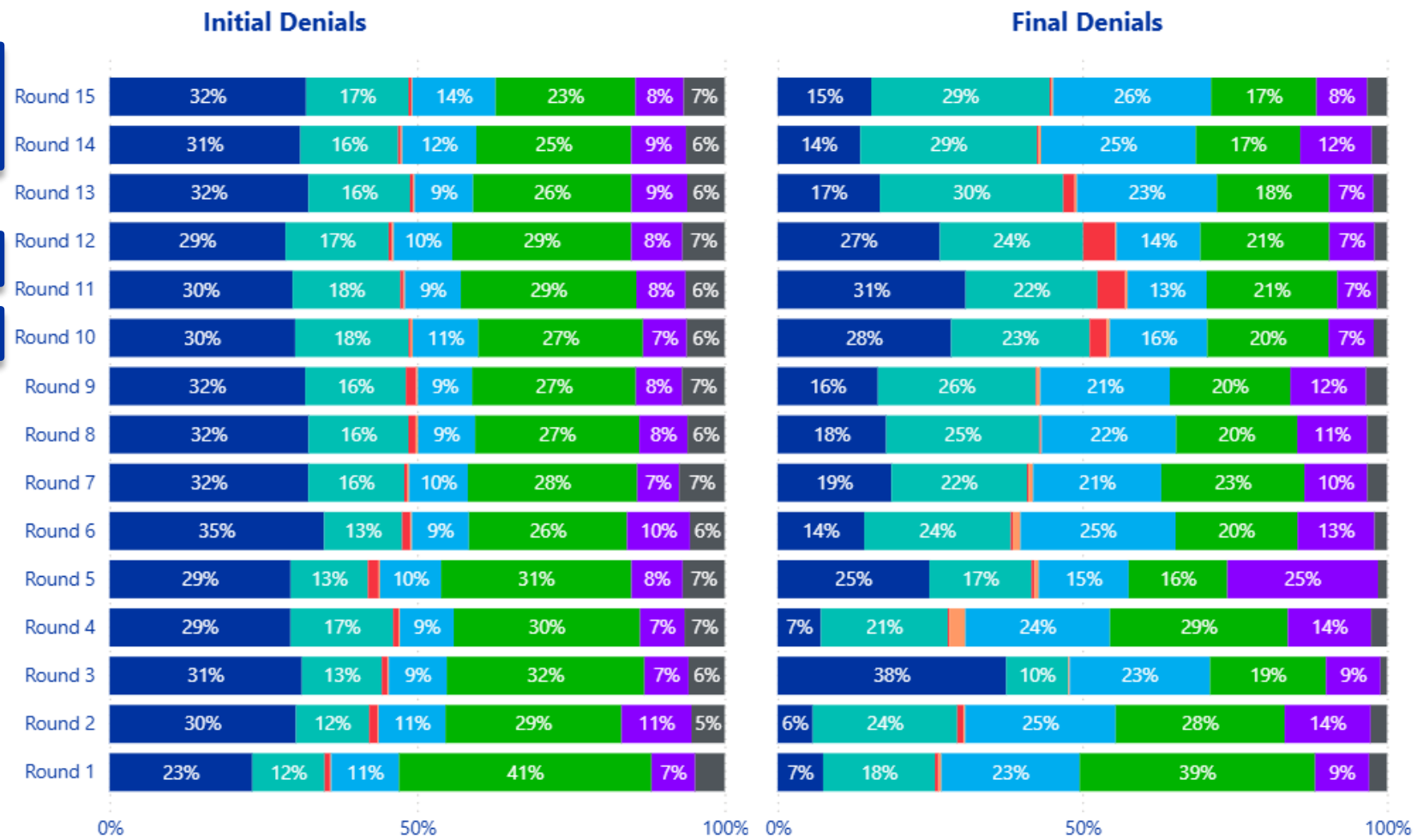
Final Round 15 Trend – Payer Category



DENIAL RATIONALES

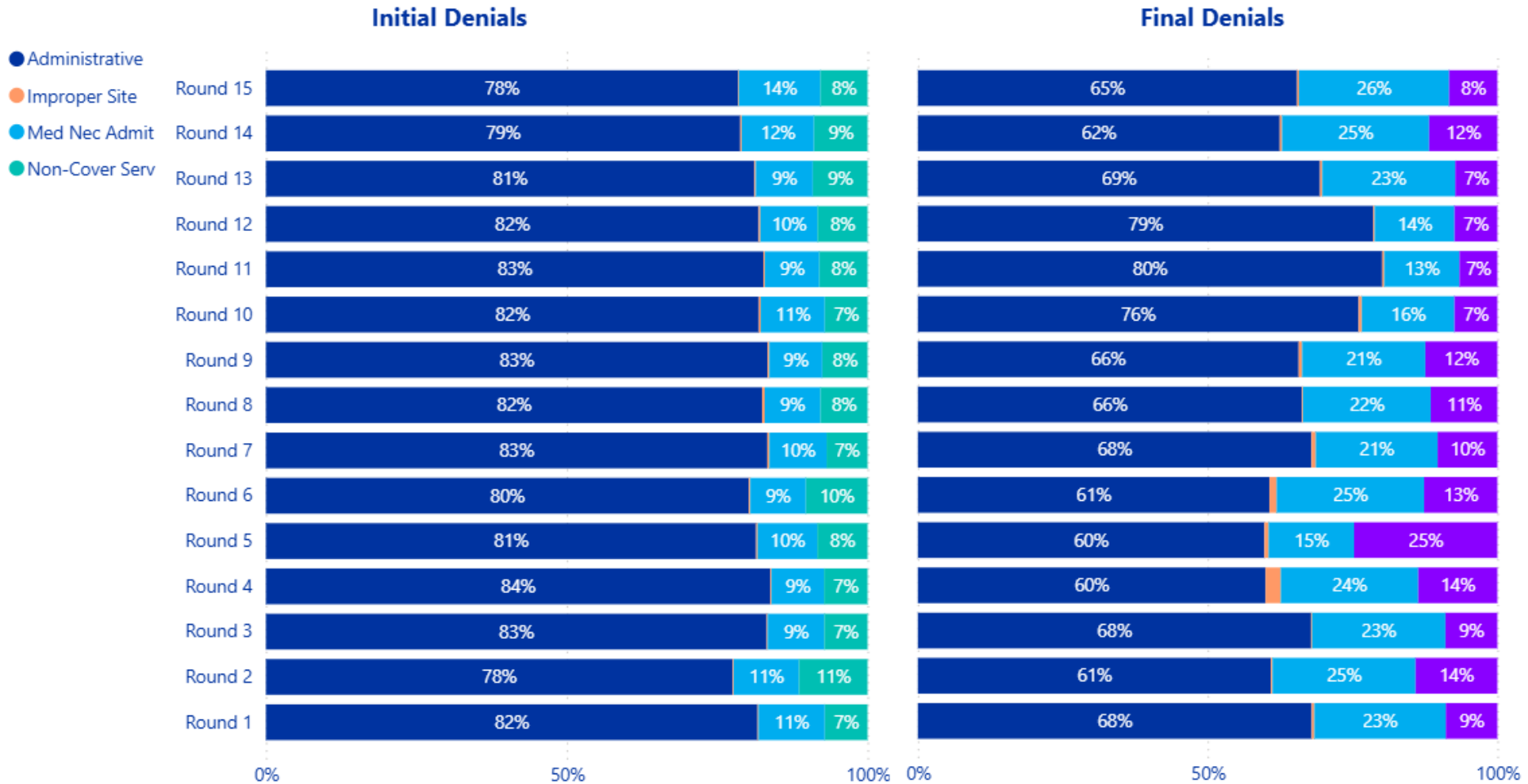
Isolating administrative denials...

- Addl Document
- Authorization
- Eligibility
- Improper Site
- Med Nec Admit
- Non-Clinical Issue
- Non-Cover Serv
- Registration



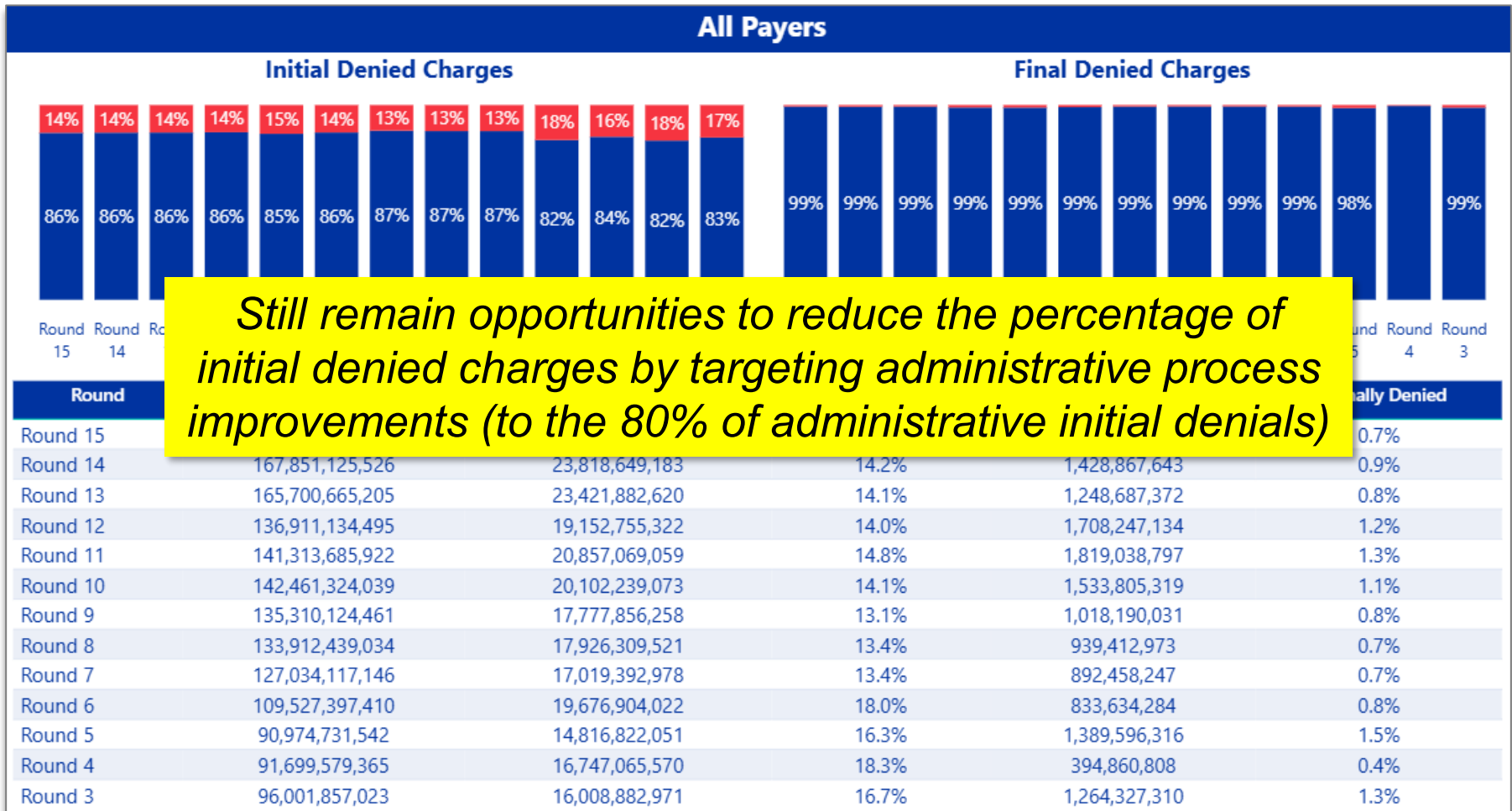
DENIAL RATIONALES

~80% of initial denials are administrative



ADVOCACY FOCUS

Critical Measure: Initial and Final Denied Charges

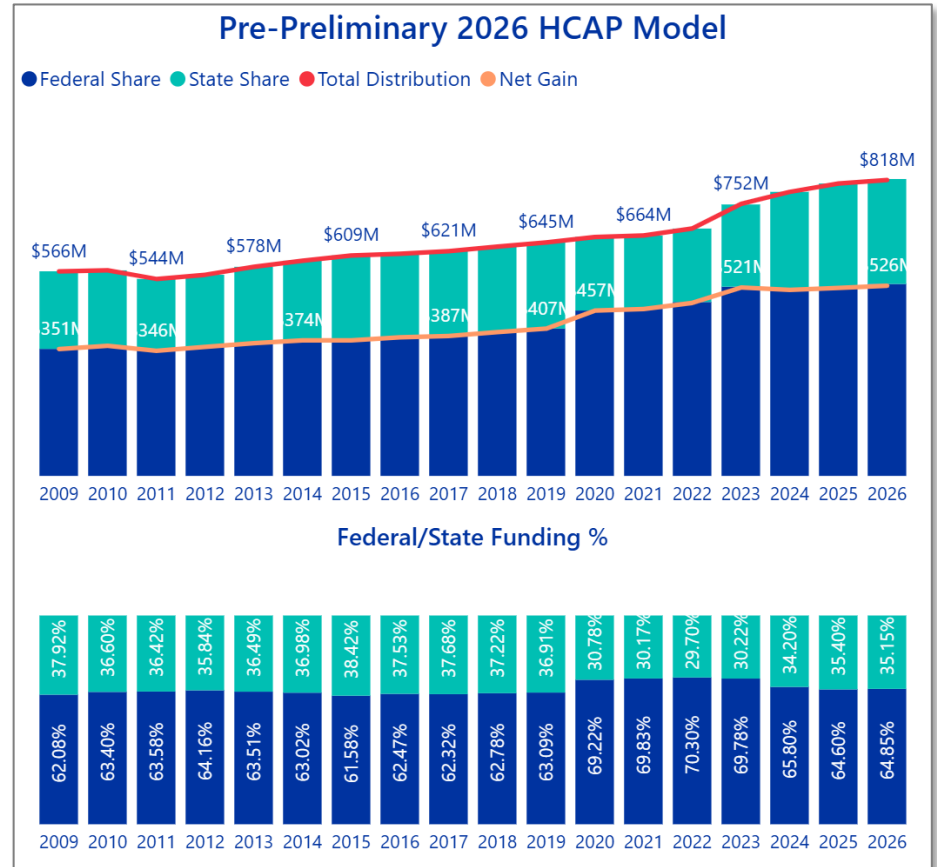


HOSPITAL CARE ASSURANCE PROGRAM (HCAP)

CONGRESSIONAL ACTION

DSH Cuts Delayed

- Congress delayed the DSH cuts through both FFY26 and FFY27
 - Cuts now scheduled to begin in FFY 2028 (2028 HCAP) at \$8B total
 - Not delaying would have been a 64% cut to both the Total Payment and Net Gain in the 2026 HCAP
- Gives OHA high-level numbers to develop a Pre-Preliminary Model



	No Cut	Cut	Impact
Total Payment	\$818M	\$327M	(\$491M)
Federal Allocation	\$531M	\$214M	(\$317M)
State Assessment	\$290M	\$118M	(\$172M)
Net Gain	\$528M	\$211M	(\$317M)

PRE-PRELIMINARY 2026 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** that is continuously updated in the HCAP Dashboard
4. **Final Preliminary Model** after data is finalized

2026 PRE-PRELIMINARY MODEL
Details the pre-preliminary modeling for the 2026 HCAP, subject to change prior to finalization.

Provider Name
All

Choose an item:

Model Progress

Data Trends

Hospital-Specific

Hospital-Specific:

This pre-preliminary HCAP model will change and is not to be used for budgeting purposes. Please have your team verify the OBRA Cap number for your hospital(s).

The model will be refreshed as additional preliminary cost reports are released, data is revised, and funding pool and other details are finalized.

Congress has delayed the scheduled DSH cuts through the entirety of FFY 2026 (2026 HCAP) and FFY 2027 (2027 HCAP), and reduced the nationwide cuts from \$24B over 3 years to \$5B in FFY 2028 (2028 HCAP).

Assumptions in the pre-preliminary model:

- 1.5% increase in the federal allocation
- Traditional FMAP rate of 64.85%
- Same assumptions from the 2025 HCAP (ATFC threshold of \$216.4M, upper rate of 0.460150%, same pot distribution percentages and eligibility criteria)
- The modeling has not been updated to reflect all Pot 5 closed hospital distributions.

Last update: 4/1/2026 @ 9:00 AM

Again, this model will change and is not to be used for budgeting purposes.

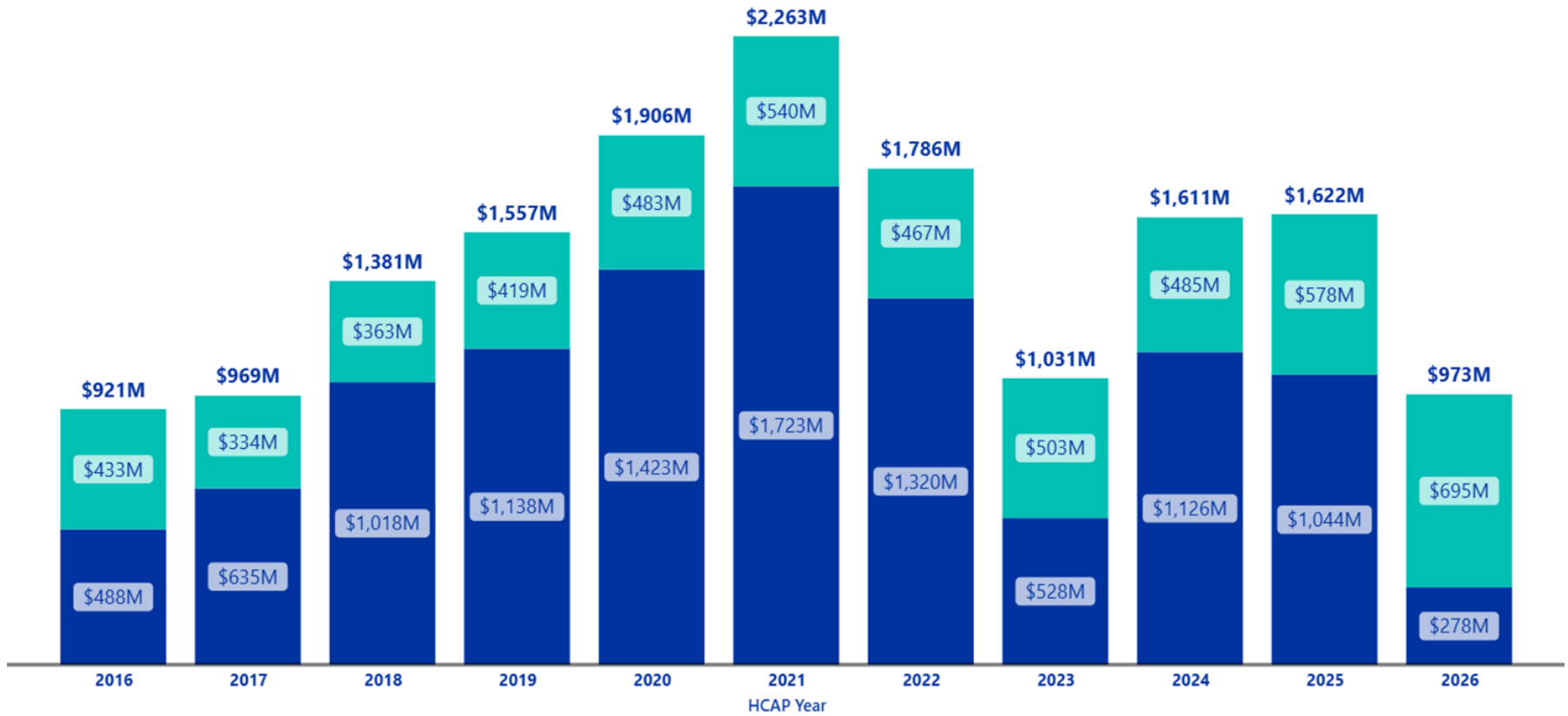
2026 Pre-Preliminary HCAP *Preliminary subject to change, not to be used for budgetary purposes.*

Provider Name	HCAP Year	OBRA Cap	Total Assessment	Pot 1 Qualify*	Total Distribution	Net Gain/Loss
Adams County Hospital	2026	\$0	\$285,894	NO	\$0	(\$285,894)
Adena Regional Medical Center	2026	\$6,025,041	\$2,419,617	NO	\$6,025,041	\$3,605,424
Advanced Specialty Hospital of Toledo	2026	\$0	\$105,577	NO	\$0	(\$105,577)
Akron General Medical Center	2026	\$13,424,482	\$3,759,441	NO	\$6,765,519	\$3,006,078
Allen Medical Center	2026	\$0	\$195,864	NO	\$0	(\$195,864)
Alliance Community Hospital	2026	\$3,897,352	\$658,190	NO	\$1,964,144	\$1,305,954
Arthur G. James Cancer Hospital	2026	\$0	\$8,652,378	NO	\$0	(\$8,652,378)
Ashtabula County Medical Center	2026	\$12,814,414	\$991,710	NO	\$12,814,414	\$11,822,704
Atrium Medical Center	2026	\$6,505,741	\$1,686,654	NO	\$3,278,690	\$1,592,036
Aultman Hosp Orville	2026	\$0	\$488,919	NO	\$0	(\$488,919)
Aultman Hospital	2026	\$8,028,151	\$3,236,790	NO	\$4,045,937	\$809,147
Avita Ontario Hospital	2026	\$4,577,726	\$750,019	NO	\$2,307,031	\$1,557,012
Barnesville Hospital Association	2026	\$1,875,752	\$176,484	NO	\$1,875,752	\$1,699,268
Bay Park Community Hospital	2026	\$0	\$612,248	NO	\$0	(\$612,248)
Bellevue Hospital	2026	\$1,478,171	\$357,651	NO	\$1,478,171	\$1,120,520
Berger Hospital	2026	\$2,068,823	\$731,355	NO	\$1,042,622	\$311,267
Bethesda Hospital	2026	\$47,974,125	\$4,684,490	NO	\$24,177,460	\$19,492,971
Blanchard Valley Reg. Hlth - Bluffton	2026	\$661,708	\$153,772	NO	\$661,708	\$507,937
Blanchard Valley Regional Hlth Ctr	2026	\$3,464,493	\$1,777,788	NO	\$3,464,493	\$1,686,705
Bucyrus Community Hospital	2026	\$1,484,714	\$408,302	NO	\$1,484,714	\$1,076,411
Children's Hospital Med Ctr Akron	2026	\$45,898,146	\$4,710,263	YES	\$31,861,817	\$27,151,554
Children's Hospital Med Ctr Cincinnati	2026	\$116,295,015	\$8,407,837	YES	\$11,009,805	\$63,301,968
Total		\$1,388,688,779	\$291,562,855		\$818,075,929	\$526,513,078

COST REPORT TRENDS

MCD Shortfall + UCC W/O Insurance

● Total MCD Shortfall ● Total UCC W/O

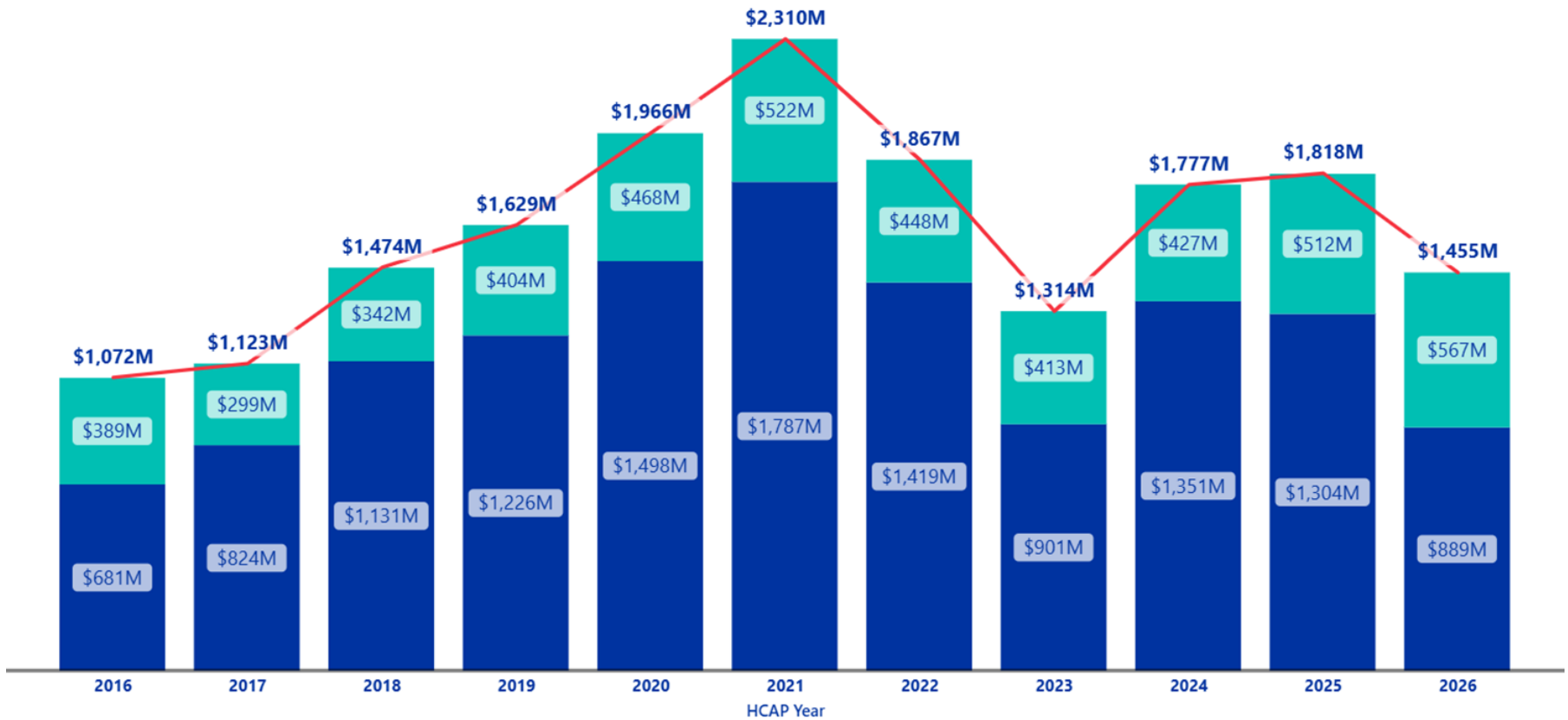


* Preliminary SFY25 cost report data, subject to change, includes only hospitals in the HCAP (i.e. no psychiatric hospitals)

COST REPORT TRENDS

OBRA Cap

● Total MCD Shortfall ● Total UCC W/O ● OBRA Cap



* Preliminary SFY25 cost report data, subject to change

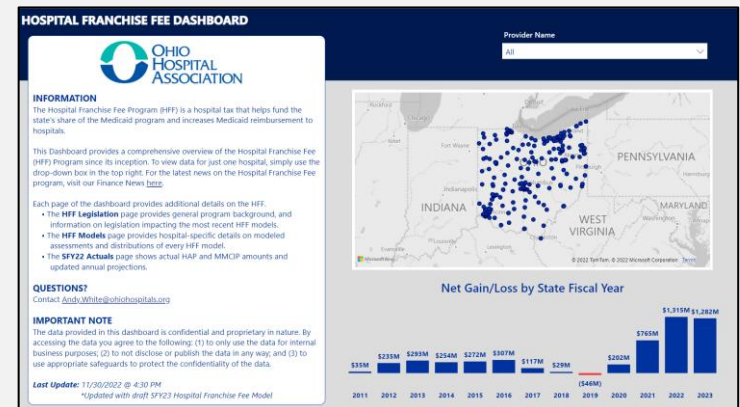
HOSPITAL FRANCHISE FEE

2026 HOSPITAL FRANCHISE FEE

- ODM awaiting CMS approval of CY26 HAP preprint request
- 3rd round of CMS questions, technical in nature related to incremental tax
- **SFY26 HAPs = \$4.969B**
 - \$3.019B, 61% of total
 - \$1.95B, 39% of total
- Once CMS approves, hospitals will be emailed an updated assessment letter for the combined SFY26 Q3+Q4 incremental assessment

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.

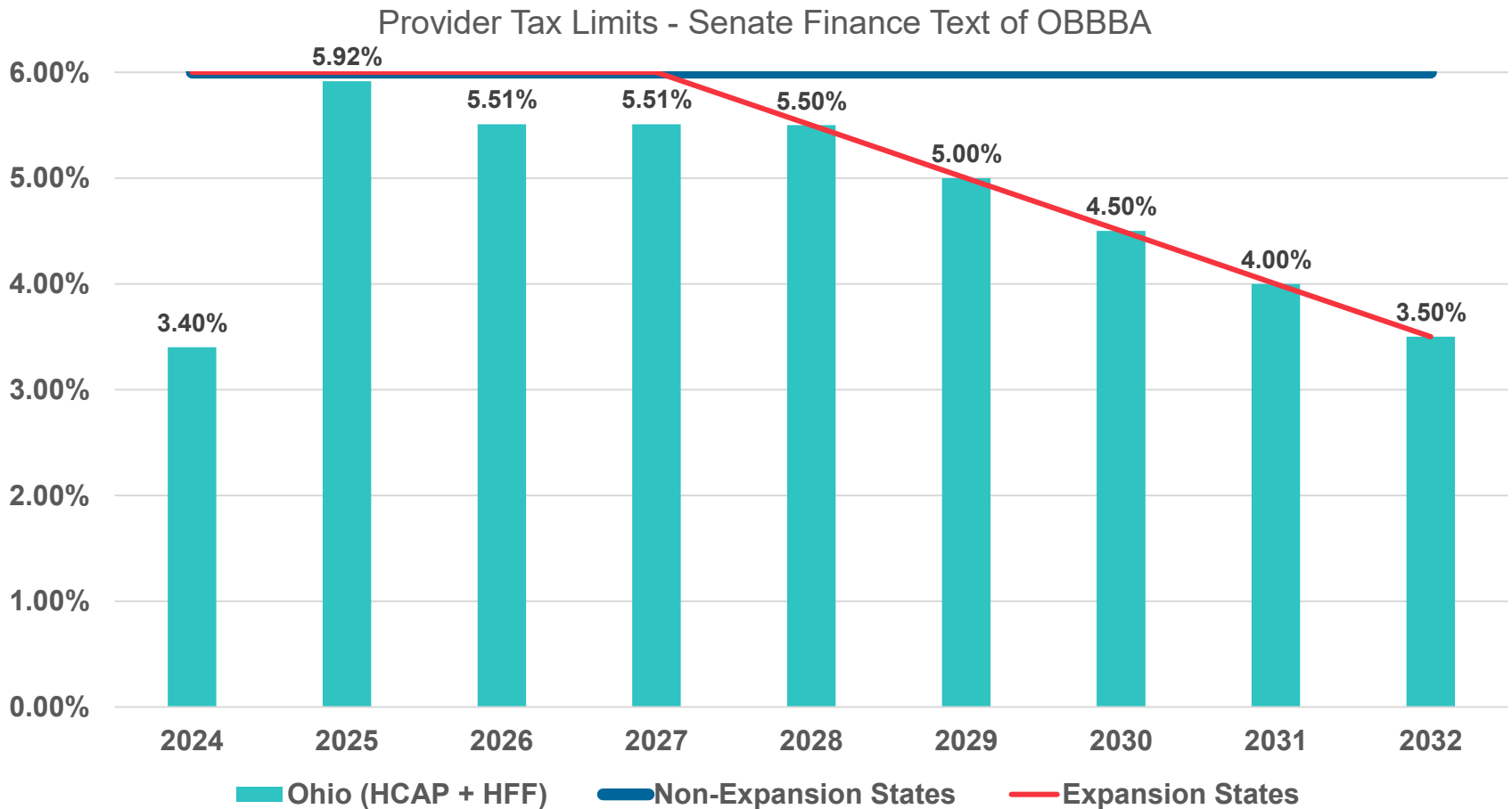
NEW CONGRESSIONAL LIMITS

One Big Beautiful Bill Act Changes

- **Provider Taxes:**
 - **All States**—froze provider tax rates on date of the OBBBA's enactment (7/4/25)
 - **Medicaid Expansion States**—phases down cap from 6% NPR to 3.5% NPR by increments of 0.5% per year beginning in FFY 2028
 - **Non-Expansion states**—froze rates at current levels and prohibited increased/new rates
- **State Directed Payments (SDPs)**
 - **Medicaid Expansion States**—reduces upper cap from Average Commercial Rate to 100% of Medicare levels
 - **Non-Expansion States**—reduces upper cap from Average Commercial Rate to 110% of Medicare levels
 - **All States**
 - Grandfathers existing and submitted SDPs on date of OBBBA's enactment
 - Phases down SDPs by 10% per year starting 1/1/2028, until State reaches new cap

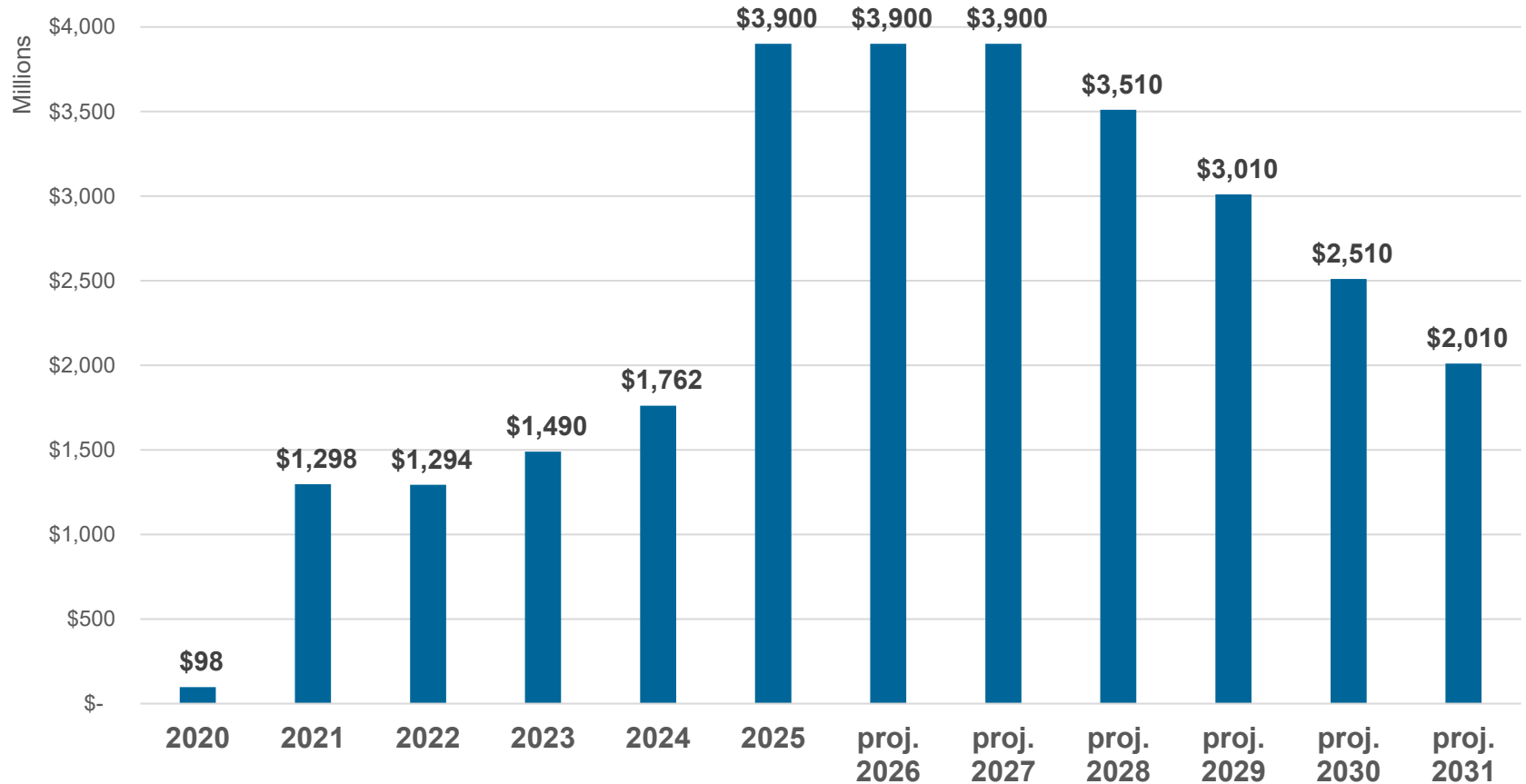
PROVIDER TAXES

Ohio Impact of Reduction from 6% to 3.5% NPR



STATE DIRECTED PAYMENTS

Ohio Impact to HAPs



RURAL HEALTH TRANSFORMATION PROGRAM

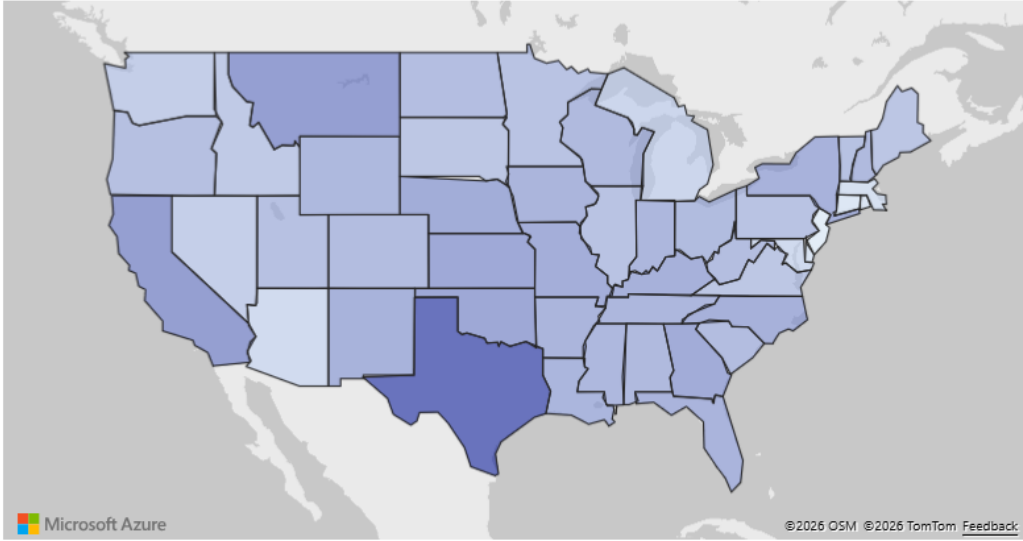
RURAL HEALTH TRANSFORMATION

Program Overview

- Part of federal One Big Beautiful Bill Legislation (H.R. 1)
- Strategic Goals
 - Make Rural American Health Again
 - Sustainable Access
 - Workforce Development
 - Innovative Care
 - Tech Innovation
- Nationwide—\$50B (*minus \$5B for admin*) over 5 years
- Ohio—Awarded \$202M annually
- Lead agency—Ohio Dept. of Health



FFY 2026 RHT AWARDS



Nationwide

\$200M
Average

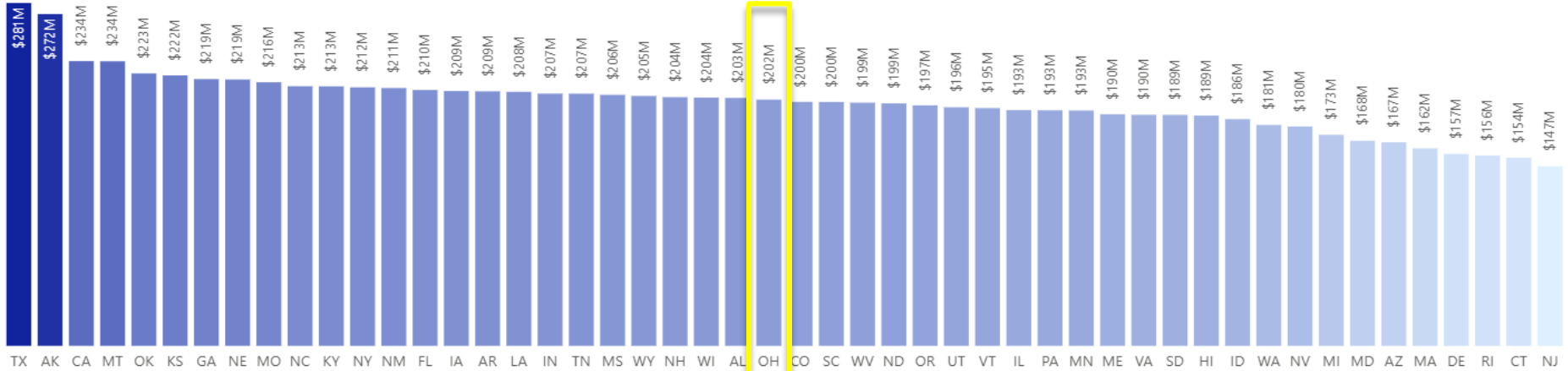
\$201M
Median

\$25M
Standard Deviation

Ohio

\$202M
Award Amount

25
Rank of 50



73 COUNTIES OF FOCUS

Ohio Rural Health Transformation Counties of Focus



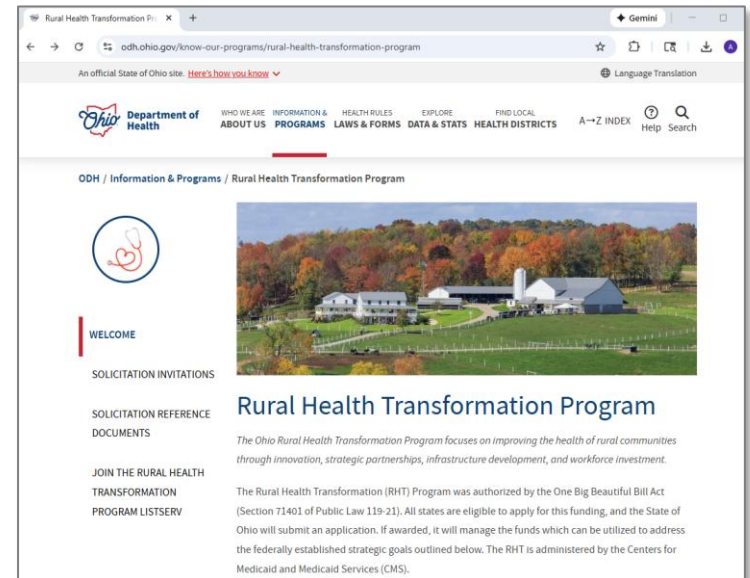
Counties of focus for the Rural Health Transformation Program

STATE PLAN & RFPS

Initiative	FFY 26	RFP Award	RFP Purpose	RFP Due
Innovation Hubs	\$92.0M		Innovative and transformational work within hospitals	
OH SEE Expansion	\$25.0M		Mobile vision services	
School-Based Health Centers	\$21.2M		Health clinics in school settings	
Healthier Ohio Initiatives	\$16.7M	Up to 73 @ \$14.6M	Chronic disease treatment and prevention	6/16/2026
EMS Transformation	\$12.0M		Improved access, support workforce	
Workforce Development	\$13.5M	1 @ \$10M	Pipelines, recruit & retain, upskilling, etc.	3/10/2026
		1@ \$750K	CHWs	6/15/2026
Maternal/Infant Health	\$7.0M		Focus on health behaviors, prenatal care, breastfeeding, etc.	
Pharmacy	\$3.5M	1 @ \$2M	Interoperability & training	3/11/2026
Equipment & Supplies	\$9.0M	ODH \$9.0M	Centralized purchasing to support local projects (mobile units, monitoring devices)	
ODH Admin	\$2.1M	ODH \$2.1M	1.1% of total award	
Grand Total	\$202.0M	\$38.5M		

NEXT STEPS

- **Monitor ODH's RHT website for latest RFPs**
- **Monitor OHA's communications for any additional information and any sub-award RFPs**



BEHAVIORAL HEALTH

ANNUAL BH WELL CHECK

Ohio H.B. 724

- Drafted by ODI Behavioral Health Working Group, co-sponsored by two Republicans in Ohio House
- Includes all the following:
 - Requires health plans to cover an annual “Behavioral Health Well Check” for both children and adults
 - Performed by licensed BH professional (includes PCPs and Psychiatric NPs)
 - Provided in a BH or primary care setting
 - Reimbursed within any type of integrated care model
 - Prohibits cost-sharing, PA requirements, and exclusion of coverage for same day/same facility services
 - Reimbursement details under ODI rule-making
- Advances Collaborative and Integrated Care

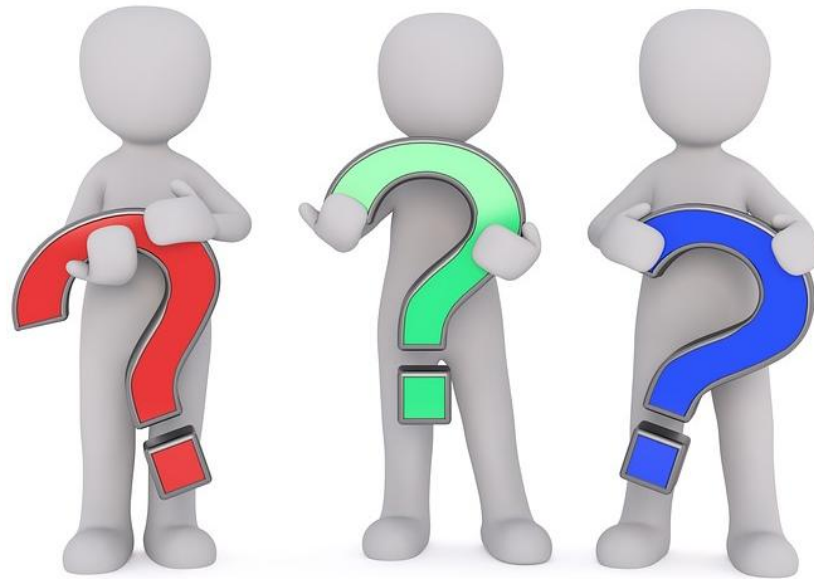


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Q&A

WHAT QUESTIONS DO YOU HAVE?



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

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