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John E. Callender  
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155 E. Broad St., 15<sup>th</sup> Floor  
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Subject: Response to Comments on OAC Rule 5101:3-2-07.4

Dear Mr. Callender:

Thank you for your testimony during the public hearing for OAC rule 5101:3-2-07.4 *Basic methodology for determining prospective payment rates* held on October 26, 2005. As I understand your comments, OHA believes that Medicaid funding should keep pace with health care inflation. In addition, your testimony cites concerns about the effect of this rate freeze in addition to the limited federal allotment of funding available to compensate hospitals for charity care and to the state's shift to managed care. Lastly, OHA feels that without an economic impact analysis of this provision on the Ohio hospitals that serve a disproportionate share of low-income patients, this rule would violate 42 U.S.C. 1396a(a)(13)(A)(iv).

Federal law, 42 U.S.C. 1396a(a)(30)(A), requires a state plan for medical assistance to provide payments for hospital care that are consistent with efficiency, economy, and quality of care and that are sufficient to provide access to services similar to the access available to the general population in the geographic area. As mentioned in the public notice of the hearing, Ohio hospitals have reported increases in their costs that exceed various indices measuring reasonable cost growth. For many hospitals, reported costs are growing at rates that exceed twice the published inflation factors for hospital services. The Department has provided annual inflationary updates for inpatient services in almost all the years since the DRG payment system has been in place. This non-provision of an inflationary adjustment for inpatient hospital base rates and education allowances is intended to help balance state resources among competing demands by constraining the rate of growth of inpatient hospital expenditures while maintaining a rate that is consistent with the level of payment required by federal law.

In regard to the testimony about the effect of this rate freeze in combination with the limited availability of federal dollars for uncompensated care programs, the Department understands that a charitable mission is a component of the justification for not-for-profit hospitals' tax-

exempt status. In addition, the Department has questions about hospitals' reported costs as other analysis has shown them to be in excess of established Ohio-specific hospital cost indices. However, the Department will continue to distribute the maximum dollars available federally for disproportionate share programs, and to focus those dollars towards the cost of services provided to those in greatest financial need.

The testimony also raised the issue that managed care plans will assume "this rate cut" in contract negotiations with the hospitals. This provision will not reduce the rates hospitals are currently receiving—it is not a cut—rather it holds the base rate and the education allowance constant at the calendar year (CY) 2005 levels for the CY 2006 and CY 2007 rate years. Hospitals will receive the base rate and the education allowance they received for inpatient services as of December 31, 2005. In any case, managed care contractual arrangements occur between hospitals and the managed care plan. While Medicaid rates may be a basis for the plans reimbursement, the very nature of a contractual agreement allows hospitals to negotiate alternative payments.

In regard to the last concern listed, that without an economic impact analysis for hospitals which serve a disproportionate share of low-income patients this rule would violate statute 42 U.S.C. §1396a(a)(13)(A)(iv), that statute stipulates such consideration of disproportionate share hospitals be consistent with 42 U.S.C. §1396r-4. 42 U.S.C. §1396r-4 describes the basis for states to make disproportionate share payments. Ohio does take into account the situation of hospitals which serve a disproportionate share of low-income patients with special needs as it fully complies with federal law and it distributes the maximum dollars available federally under its disproportionate share programs, primarily the Hospital Care Assurance Program (HCAP). The Department works and will continue to work closely with OHA in developing HCAP policy. In addition, as with past HCAP policy, OHA has stated its support for HCAP 2005.

Again, thank you for sharing your comments. It is the Department's intention to proceed with the implementation of the proposed change which holds the base rate and educational allowance constant at the CY 2005 levels for the CY 2006 and CY 2007 rate years.

Sincerely,



Robyn B. Colby

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