



**Presentation to the House Appropriations
Subcommittee on Article II:
Overview of Texas Medicaid Hospital Finance and
the Section 1115 Demonstration Waiver**

Health and Human Services Commission

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Overview of Hospital Finance

Texas Medicaid Hospital Payment Overview

- Historically hospital payments have been made using four mechanisms:
 - Inpatient payments
 - Outpatient payments
 - Disproportionate Share Hospital (DSH) payments
 - Upper Payment Limit (UPL) payments
 - UPL payments transitioned to Medicaid 1115 Transformation Waiver Uncompensated Care (UC) Pool payments in FFY 2012.
- A fifth mechanism, Delivery System Reform Incentive Payments (DSRIP) under the waiver, began in early FFY 2013.
- An additional mechanism, the Network Adequacy Improvement Program (NAIP), began in March 2015.

- Inpatient Methodology

- Standard Dollar Amounts (SDAs):

- Represent a percentage of the average cost of an inpatient admission
- General; Children's; Rural (facility-specific)
- SDAs only change through Legislative action

- All Patient Refined Diagnosis-Related Group (APR – DRGs) weights

- Outlier Payments for cost and length of stay outliers (children only)

- Add-ons: geographic wage; teaching; safety net, trauma (not available for Children's since all Children's are trauma-certified and trauma costs are included in base). No add-ons for Rural since they are paid using facility-specific SDAs.



- State-owned hospitals reimbursed through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (cost-based)

- **Methodology: Outpatient**

- **Percent of cost; percentage depends on whether a hospital is a high volume provider (received at least \$200,000 in 2004). Currently, 54% of Medicaid hospitals are high volume providers.**
- **Imaging and clinical lab fee schedules (typically a percentage of Medicare; limited to 125% of Acute Care Medicaid fee for same procedure). Additional add-ons for imaging for rural hospitals.**
- **Special provisions for non-emergent emergency room visits (65% of emergent fee for rural hospitals; 125% of Medicaid fee for office visit for all other hospitals)**

Table 1. Outpatient Medicaid Reimbursements as a Percentage of Cost

| Hospital Type | High Volume Provider Reimbursement | Non-high Volume Provider Reimbursement |
|-------------------------------|---|---|
| Children's State-owned | 76.03% of cost | 72.70% of cost |
| Rural | 100% of cost | 100% of cost |
| All Other Providers | 72% of cost | 68.44% of cost |

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Inpatient Funding Increases from 84th Session

- **Safety Net Add-on for Children's and Urban Hospitals**
 - Special Provision 59; FY 2016 = \$135,340,736 AF; FY 2017 = \$133,777,545 AF.
 - Must have qualified for DSH in most recently completed DSH program year.
 - Rates determined by allocating appropriated funds by the number of Medicaid days for each qualified hospital. The allocated amount was then divided by the hospital's total relative weights, which yields the add-on amount.
 - Funds started flowing for services provided on or after September 1, 2015.

- **Increased Trauma Add-on**
 - Special Provision 32; FY 2016 = \$178,780,092 AF; FY 2017 = \$176,715,177 AF.
 - Funds started flowing for services provided on or after September 1, 2015.

- **Quality Add-on for Safety Net Hospitals**
 - Special Provision 59; FY 2016 = \$15,037,860 AF; FY 2017 = \$14,864,172 AF.
 - Must be a Safety Net Hospital.
 - Based on performance on PPRs and PPCs.
 - Goals is to pay FY 2016 funds in lump sums to qualifying hospitals prior to end of FY 2016.

Overview of Hospital Finance

Outpatient Funding Increases from 84th Session

- Special Provision 58 directed HHSC to expend certain funds to provide increases in, or add-ons to, Medicaid outpatient provider rates for rural hospitals to ensure access to critical services.
 - FY 2016 = \$28,043,936 AF; FY 2017 = \$30,030,030 AF
 - Increased general outpatient reimbursement such that final payments do not exceed 100% of cost.
 - Increased reimbursement for outpatient emergency department services that do not qualify as emergency visits such that final payments do not exceed 65% of cost.
 - Created rural hospital add-ons to the outpatient hospital imaging services fee schedule.

- Legislative appropriations from the state's trauma fund (GR dedicated Designated Trauma Facility and Emergency Medical Services account 5111) support Medicaid trauma related payments to 290 hospitals.
 - \$150 million annually matched with \$192 million in federal funds totals \$343 million in higher hospital payments which reduce the size of the Medicaid shortfall.
 - An additional \$24 million is appropriated for other purposes.
 - This appropriation level includes prior year fund balances as well as current biennium revenues.
 - Certification Revenue Estimate includes \$117,959,000 annual revenue for account 5111.
 - Use of fund balance achieves two goals:
 - Use of dedicated account for statutorily authorized purposes.
 - Wind down reliance on GR-D funds for GR certification purposes.
 - As a result, the annual appropriation level is not sustainable beyond this biennium (subject to Revenue Estimate).
 - Further revenue may be affected by legislative action as the Driver Responsibility Program and other revenue sources for account 5111 are reviewed.

Overview of Hospital Finance Children's and Rural Hospitals

- Prior to September 1, 2013, children's and rural hospitals' inpatient costs were reimbursed using a cost-based methodology that followed principles laid out in the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).
- The 2014-2015 General Appropriations Act, Article II, Rider 38 directed HHSC to rebase rural hospital rates by implementing a facility-specific prospective full cost standard dollar amount (SDA) based on historical costs, trended forward for inflation and limited by a floor and a ceiling.
- Rider 51.b.(17) and (19) directed HHSC to pay more appropriate outlier payments and to adjust inpatient hospital reimbursement for labor and delivery services provided to adults at a children's hospital.
- Rider 71 directed HHSC to implement an All Patient Refined Diagnostic Related Group (APR-DRG) prospective payment system for inpatient services provided by a children's hospital, trended forward for inflation.

Overview of Hospital Finance Children's and Rural Hospitals (cont.)

- **Currently, Children's Hospitals:**

- Are reimbursed for inpatient services using a single, children's statewide base SDA with add-ons for geographic wage differences and for teaching medical education.
- The children's hospital single base SDA is currently \$9,506 (by way of comparison, the urban base SDA is \$2,994)
- The average children's hospital inpatient SDA with add-ons is \$12,040.
- Average adult delivery rate in a children's hospital is \$3,305.
- Outpatient reimbursement as percentage of cost is approximately 4 percent greater than for urban hospitals.

- **Currently, Rural Hospitals:**

- Are reimbursed for inpatient services using facility-specific SDA's with a floor of \$4,533 and a ceiling of \$12,968.
- Because SDAs are facility-specific based on each hospitals' costs, there are no add-ons.
- General outpatient services are reimbursed at 100% of cost.
- Non-emergent, emergency room services are reimbursed at 65% of cost.
- Imaging and clinical laboratory services are reimbursed via a fee schedule with special rural hospital add-ons for imaging.

Overview of Hospital Finance

“Medicaid Shortfall” and Hospital-specific Limit

- “Medicaid Shortfall”
 - Definition: Medicaid costs not covered by Medicaid rates result in the Medicaid shortfall.
 - Inpatient: In 2014, Medicaid rates covered approximately 57% of Medicaid costs, on average, for general Medicaid hospitals (excluding children’s, rural and state-owned) and 67% of Medicaid costs, on average, for all Medicaid hospitals.
 - Outpatient rules for general hospitals limit payments to 72% of cost for high volume providers and 68.44% of cost for all other hospitals. For children’s and state-owned hospitals, outpatient rules limit payments to 76.03% for high volume providers and 72.70% for all others. Rural hospitals are reimbursed 100% of cost for general outpatient services.
- For each hospital, a hospital-specific limit (HSL) is calculated as the sum of:
 - The hospital’s Medicaid shortfall (difference between hospital costs for Medicaid patients and Medicaid claims payments); and
 - The hospital’s unreimbursed costs of caring for low-income uninsured individuals.
- Each hospital that is eligible may receive combined DSH and UC payments up to its HSL, if there are sufficient non-federal funds to support these payments. Under the Transformation Waiver, hospitals may also receive payments for uncompensated physician, clinic and pharmacy costs.

Overview of Hospital Finance Supplemental Payments

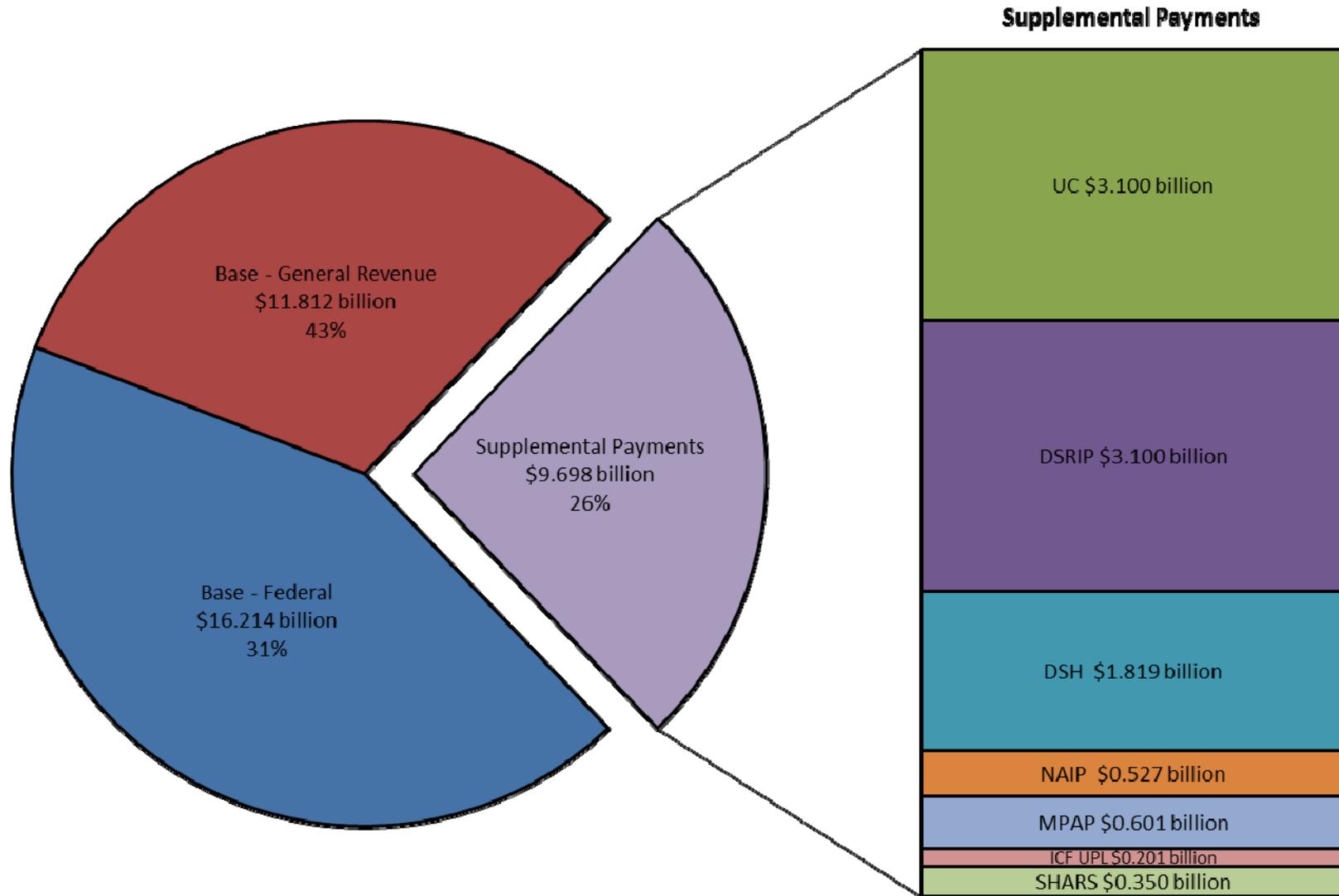
| Program | Supplemental Payment? | Provider Beneficiaries | State (billions) | IGT ¹ (billions) | Federal (billions) | Total (billions) | Payment Basis |
|---------------------------------------|-----------------------|---|------------------|-----------------------------|--------------------|------------------|--|
| Medicaid Client Services ² | No | All Medicaid Providers | \$11.812 | \$0.000 | \$16.214 | \$28.026 | Provision of services (claims, monthly capitation, etc.) |
| UC | Yes | Hospitals, certain physician group practices, public ambulance and dental | \$0.000 | \$1.329 | \$1.771 | \$3.100 | Uncompensated care: Medicaid shortfall + uninsured cost (not charges) |
| DSRIP | Yes | Hospitals, Local Mental Health Authorities, other | \$0.000 | \$1.329 | \$1.771 | \$3.100 | Achievement of metrics |
| DSH | Yes | Hospitals | \$0.000 | \$0.780 | \$1.039 | \$1.819 | Uncompensated care: Medicaid shortfall + uninsured costs (not charges) |
| NAIP | Yes | Public Hospitals | \$0.000 | \$0.226 | \$0.301 | \$0.527 | Achievement of metrics |
| MPAP | Yes | Public Nursing Facilities | \$0.000 | \$0.257 | \$0.344 | \$0.601 | Difference between Medicare and Medicaid rates |
| ICF UPL | Yes | Public ICF/IIDs | \$0.000 | \$0.084 | \$0.117 | \$0.201 | Difference between estimate of Medicare and Medicaid rates |
| SHARS | Yes | Public Schools | \$0.000 | \$0.146 | \$0.204 | \$0.350 | Medicaid allowable cost |
| Supplemental Payment Sub-Total | | | \$0.000 | \$4.150 | \$5.547 | \$9.698 | Supplemental payments equal 25.7% of Total Medicaid provider payments. |
| Grand Total | | | \$11.812 | \$4.150 | \$21.761 | \$37.724 | |

¹ CPEs for UC public ambulance and SHARS public schools

² Does not include \$1.633 billion all funds for Administration and Survey and Certification

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FY 2016 Estimated Texas Medicaid Client Services and Supplemental Payments; \$37.724 Billion (All Funds)

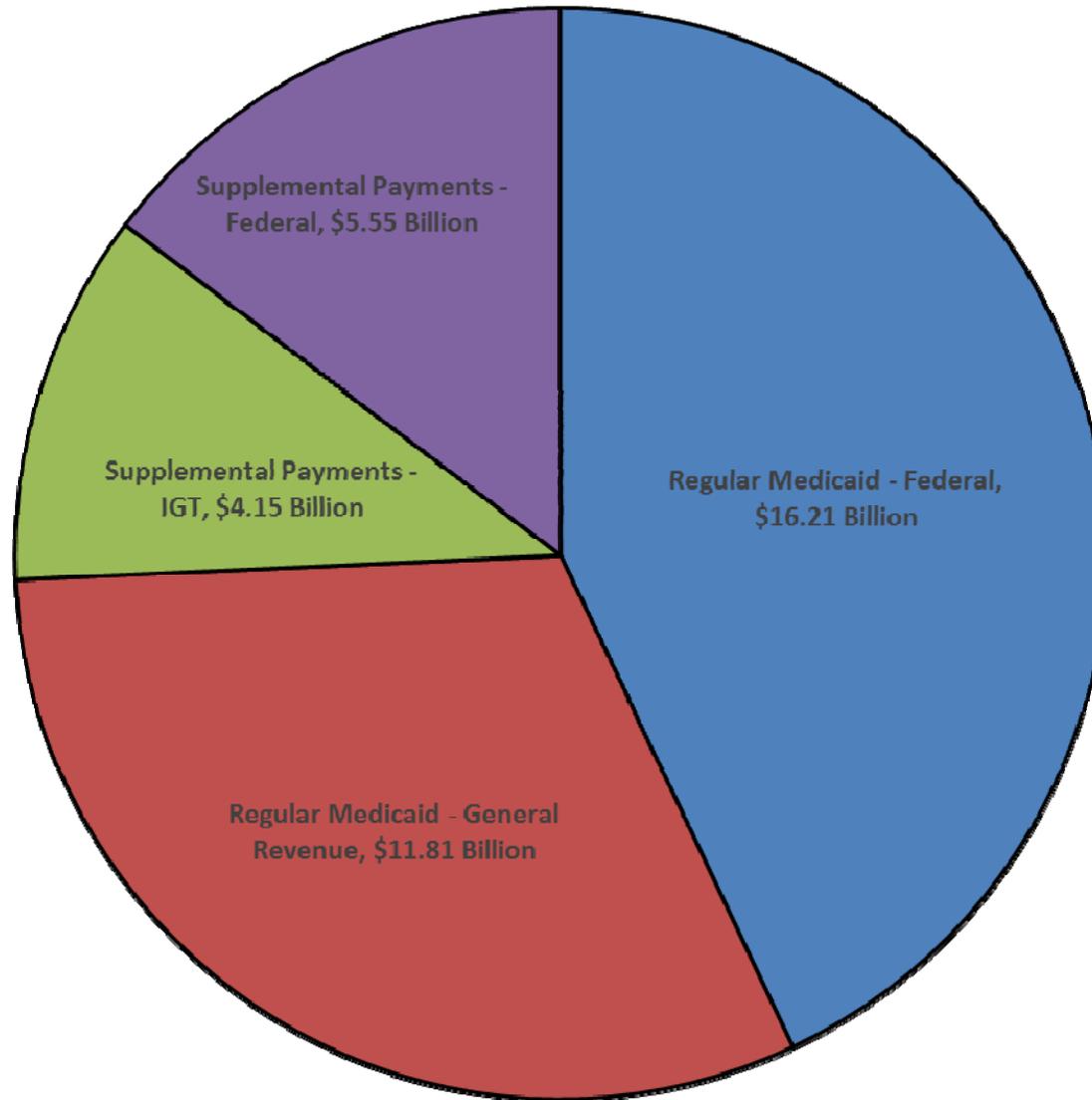


Note: Does not include \$1.633 billion All Funds for Administration and Survey and Certification

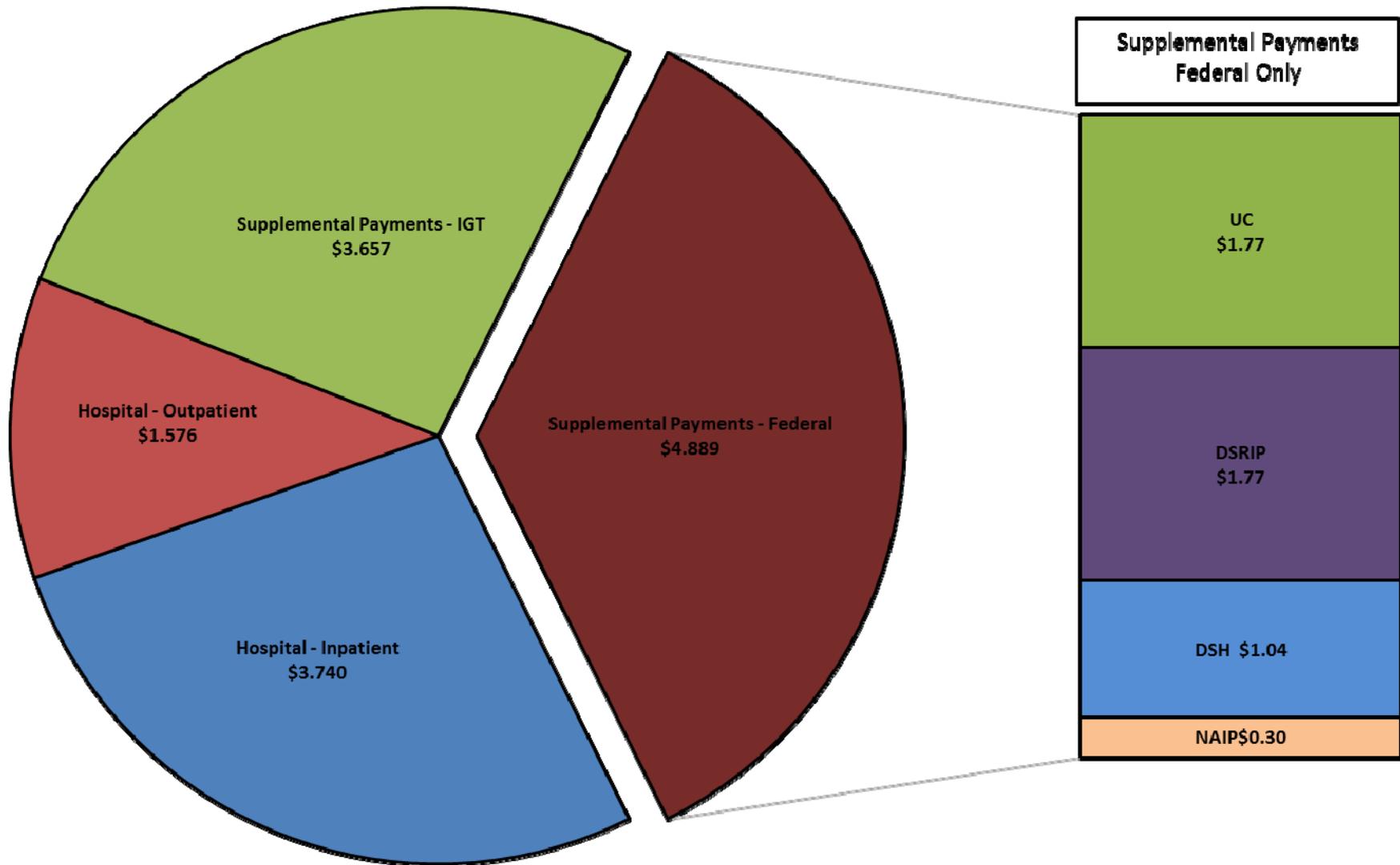
Source: HHSC Rate Analysis; 2/16 Submission CMS-37

Overview of Hospital Finance

FY 2016 Estimated Texas Medicaid Client Services and Supplemental Payments for Health Services Expenditures by Method of Finance; \$37.724 Billion (All Funds)



Source: HHSC Rate Analysis; 2/16 Submission CMS-37



NOTE: Outpatient figures exclude Federally Qualified Health Center, Rural Health Center and Renal Dialysis Clinic expenditures that may have been included in previous presentations of hospital outpatient expenditures.

Source: HHSC Rate Analysis

Overview of Hospital Finance Risks to Supplemental Payment Programs

- While HHSC has administered various supplemental payment programs for at least a decade, these programs exist in a perpetually changing regulatory environment which exposes them to risks that do not apply to base Medicaid payments.
- Risks are predominantly due to the funding of the non-federal share of these programs through intergovernmental transfers (IGT) rather than state general revenue.
- Risks include:
 - CMS interpretations of federal regulations pertaining to the use of certain types of public-private arrangements such as Low-Income and Needy Care Collaboration Agreements, Collaborative Endeavor Agreements and Public-Private Partnerships.
 - New federal managed care regulations limiting the use of IGT Responsibility Agreements.
 - Statutory reductions in future DSH allocations under the Affordable Care Act (to be discussed in detail below)
 - CMS UC pool principles (to be discussed in detail below).
 - CMS' position regarding “pay-to-play” arrangements (to be discussed in detail below).

Overview of Hospital Finance

Disproportionate Share Hospital (DSH) Basics

- Participation in the DSH program is limited to hospitals that bear a disproportionate share of the state's Medicaid and low-income uninsured care burden.
- DSH funds are distributed to qualifying hospitals based on each hospital's sum of Medicaid and low-income uninsured days as a percentage of all qualifying hospitals' sum of Medicaid and low-income uninsured days.
- Each hospital's DSH payment is limited to its HSL.
- HHSC is required by the Social Security Act to annually complete an independent certified audit of each DSH hospital. Starting with the 2011 audit, HHSC has been recouping overpayments of DSH funds and redistributing the recouped funds to DSH providers that are eligible for additional payments.
- The nonfederal share of DSH payments to public hospitals is funded through IGTs from each public hospital. The nonfederal share of DSH payments for private hospitals is funded through IGTs from six large public hospital districts.

Overview of Hospital Finance

ACA DSH allocation reductions

- The ACA reduced the aggregate DSH allotment for all states.
 - Future DSH allotments will be linked to the number of uninsured and how states target their funds.
 - Specific DSH reductions for Texas Medicaid are unknown at this time.

Table 4: National ACA DSH Reductions and Amendments

| FFY | Original ACA Reductions (\$ millions) | Revised per Medicare Access and CHIP Reauthorization Act of 2015 (\$ millions) |
|------|--|--|
| 2014 | \$500 | \$0 |
| 2015 | \$600 | \$0 |
| 2016 | \$600 | \$0 |
| 2017 | \$1,800 | \$0 |
| 2018 | \$5,000 | \$2,000 |
| 2019 | \$5,600 | \$3,000 |
| 2020 | \$4,000 | \$4,000 |
| 2021 | Each state's 2021 allotment is equal to its 2020 allotment increased by % change in CPI for FFY 2020 | \$5,000 |
| 2022 | Each state's 2022 allotment is equal to its 2021 allotment increased by % change in CPI for FFY 2021 | \$6,000 |
| 2023 | Revert to methodology in place prior to reductions | \$7,000 |
| 2024 | See 2023 | \$8,000 |
| 2025 | | \$8,000 |
| 2026 | | Revert to methodology in place prior to reductions |

- Managed care expansion
 - Allows statewide Medicaid managed care services (STAR, STAR+PLUS, and Children's Medicaid Dental Services) while preserving historical UPL funding.
- Hospital financing component
 - Uncompensated Care (UC) Pool:
 - Replaces UPL
 - Covers Medicaid shortfall and costs of care provided to individuals who have no third part insurance coverage.
 - Creates 20 Regional Healthcare Partnerships (RHPs)
 - Delivery system Reform Incentive Payment (DSRIP) Pool
 - New incentive program to support coordinated care and quality improvements through the RHPs.
 - Goals: transform delivery systems to improve care for individuals (including access, quality and health outcomes), improve health for the population and lower costs through efficiencies and improvements.
 - Targets Medicaid recipients and low income uninsured individuals
- Five year waiver FFY 2011-2016 (15 month extension to December 31, 2017, awarded by CMS April 2016)

UC & DSRIP Pool Funding Distribution (All Funds)

| Type of Pool | DY1 FFY 2012 | DY2 FFY 2013 | DY3 FFY 2014 | DY4 FFY 2015 | DY5 FFY 2016 | Extension DY6 FFY 2017 | Extension Partial DY7 Oct - Dec 2017 |
|--------------|-----------------|-----------------|-----------------|-----------------|-----------------|------------------------------|--|
| UC | \$3,700,000,000 | \$3,900,000,000 | \$3,534,000,000 | \$3,348,000,000 | \$3,100,000,000 | \$3,100,000,000 | \$775,000,000 |
| DSRIP | \$500,000,000 | \$2,300,000,000 | \$2,666,000,000 | \$2,852,000,000 | \$3,100,000,000 | \$3,100,000,000 | \$775,000,000 |
| Total | \$4,200,000,000 | \$6,200,000,000 | \$6,200,000,000 | \$6,200,000,000 | \$6,200,000,000 | \$6,200,000,000 | \$1,550,000,000 |
| % UC | 88% | 63% | 57% | 54% | 50% | 50% | 50% |
| % DSRIP | 12% | 37% | 43% | 46% | 50% | 50% | 50% |

- UC Allocation Methodology:
 - Establish distinct UC pools for different types of providers (including large public, small public, and private hospitals). If UC costs in a pool exceed the funds allocated to that pool, reduce payments to providers in the pool so that total payments from the pool do not exceed funds allocated to the pool.
 - Pool sizes based on the ratio of each pool’s “UC need” to the total of all pools’ “UC need”. “UC need” was defined as follows:
 - Large public hospitals: sum of HSLs less payments made under DSH plus an amount equal to the IGTs they transferred to support DSH payments to private hospitals and their own hospitals.
 - Small public hospitals: sum of HSLs less payments made under DSH plus an amount equal to the IGTs they transferred to support DSH payments to their own hospitals.
 - Private hospitals: sum of HSLs less payments made under DSH
 - Special protections for Rider 38 rural hospitals.
- Any unused pool funds used to offset \$466 million “UPL debt” to CMS.

- 1,451 active DSRIP projects
- 298 providers – hospitals (public and private), physician groups, community mental health centers and local health departments
- Major project focuses:
 - Over 25% - behavioral healthcare
 - 20% - access to primary care
 - 18% - chronic care management and helping patients with complex needs navigate the healthcare system
 - 9% - access to specialty care
 - 8% - health promotion and disease prevention.
- Over \$7.1 billion earned through January 2016

- HHSC was required to submit to the federal Centers for Medicare and Medicaid Services (CMS) a request to extend the waiver by September 30, 2015.
- In September, HHSC requested to continue all three components of the waiver (statewide managed care, UC pool and DSRIP pool) for another five years
 - Continue DY5 funding level for DSRIP (\$3.1 billion annually)
 - Increase UC pool to equal the unmet need in Texas adjusted to remain within budget neutrality each year (ranging from \$5.8 billion to \$7.4 billion per demonstration year)
- Texas has made progress related to all five waiver goals, and has proposed program improvements to make further progress toward those goals to support and strengthen the healthcare delivery system for low-income Texans

- CMS is requiring Texas to submit an Evaluation of Uncompensated Care Costs for the Uninsured report by August 31, 2016,
 - Report must be completed by an independent entity (HHSC is using Health Management Associates and Deloitte Consulting)
 - Should review the role of UC and DSRIP payments in the overall Medicaid system for paying hospitals.
 - Consider adequacy of base Medicaid payment levels and their relation to Medicaid shortfalls and indicate degree to which UC pool and DSRIP payments compensate for insufficient base payment levels.
 - Identify percentage of UC pool payments not specifically related to Medicaid shortfalls.
 - Define UC costs as those associated with charity care as defined by the principles of the Healthcare Financial Management Association and not include bad debt or Medicaid shortfall.
 - Estimate what Texas' UC burden would be in FFY 2017 if Texas Medicaid rates fully funded the Medicaid shortfall and if Texas opted to expand Medicaid as allowed under the ACA.

- As part of the 15 month extension, CMS required Texas to agree that:
 - CMS and Texas will work over the next 15 months on an agreement to reform the state's UC pool and DSRIP.
 - If, at the end of calendar year (CY) 2017, CMS and the state have not come to an agreement that is consistent with CMS' UC pool principles and a DSRIP that supports Texas' commitment to managed care:
 - DSRIP will not be renewed except as a phasedown starting at the end of CY 2017. The phase down would begin at 25 percent in 2018, and phase down by an additional 25 percentage points each year afterwards.
 - UC will not be renewed except at a reduced level consistent with CMS' principles for uncompensated care.
 - CMS' UC pool principles are that:
 - Coverage is the best way to assure beneficiary access to healthcare for low income individuals and UC pool funding should not pay for costs that would otherwise be covered in a Medicaid expansion;
 - Medicaid should support the provision of services to Medicaid and low income uninsured individuals; and
 - Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care (e.g., UC should not cover costs associated with Medicaid shortfall).

- Florida has a Low Income Pool (LIP) that serves a similar purpose to Texas' UC pool.
- CMS granted Florida a one year extension of its pool when it initially expired but required Florida to commission a UC study similar to the study now required of Texas and indicated that it would apply the same principles to Florida's UC pool renewal as detailed on the previous slide.
- In June 2015, CMS and Florida agreed to extend the LIP for two years with pool size limited to projected costs of care for those uninsured individuals who would not be eligible for Medicaid coverage if Florida had expanded Medicaid, whether or not Florida actual expands Medicaid.
- Final LIP pool size is \$1 billion for July 2015 – June 2016 and \$608 million for July 2016 – June 2017.

Overview of Hospital Finance

1115 Waiver – Differences between Florida and Texas

- While there are similarities between Texas’ UC pool and Florida’s LIP pool waivers, there are also key differences:

| Florida LIP Pool | Texas UC Pool |
|---|--|
| CMS concern: lack of transparency | Transparent, cost-based methodology developed with CMS |
| CMS concern: funds distributed based on access to local funds rather than services to Medicaid patients | While contingent on IGT, funds are distributed based on auditable UC costs for Medicaid patients and the uninsured |
| <p>\$2.2 billion in FY15:</p> <ul style="list-style-type: none"> \$1 billion for supplemental payments – primarily to hospitals, but also some for FQHCs and community health depts. Distribution each year is determined by the FL Legislature based on recommendations from the LIP Council \$963 million for self-funded hospital IGT rate enhancements \$204 million for teaching physician supplemental payment program | <p>\$3.3 billion in FY15:</p> <ul style="list-style-type: none"> Cost-based methodology to offset uncompensated care costs for hospitals (public and private) and public physician groups, dental groups, and ambulance providers |

- While not specifically a hospital program, public hospital districts and authorities that own nursing facilities (NFs) benefit from MPAP.
 - MPAP has existed since NFs were carved in to managed care on March 1, 2015.
 - 279 publically owned NFs will receive \$601 million in MPAP for FY 2016
 - Since the implementation of the precursor program NF UPL in October, 2013, the number of publically owned NFs has grown from about 20 to 279.
 - Most MPAP NFs are owned by small public hospital districts but Dallas County Hospital District and Bexar County Hospital District also participate.
 - In an April 2016, letter to HHSC, CMS indicated that it would not approve the continuation of the MPAP beyond August 31, 2016 because:
 - HHSC requires MPAP NFs to enter into an agreement to provide an IGT to fund the non-federal share of the MPAP.
 - MPAP payments are only made to NFs that have entered into such an agreement, making the funding contingent upon the IGTs.
 - This funding arrangement represents a stipulation on provider payments which violates section 1902(a)(2) of the Social Security Act and 42 Code of Regulations 433.53(c)(2).
 - HHSC requested an extension of MPAP through August 2017 (at which time HHSC expects to implement a compliant replacement program), CMS denied this request.