HHSC: Hospital Payment Advisory Committee, February 6, 2020

The Hospital Payment Advisory Committee, a subcommittee of the Medical Care Advisory Committee (MCAC), advises MCAC and HHS about hospital reimbursement methodologies for inpatient hospital prospective payment and on adjustments for disproportionate share hospitals. **Members are listed below.**

Diana J. Strupp, HPAC Chair Tenet Health Systems Dallas	**Michael L. Nunez** University Medical Center of El Paso El Paso
Steven Hand, HPAC Vice Chair Memorial Hermann Health System Houston	**Daniel "Dan" Olvera** Covenant Health System Lubbock
Rebecca McCain, MHA Electra Hospital District Electra	**Sharon Clark** Tarrant Country Hospital District (JPS) Fort Worth
William R. Bedwell University Health System San Antonio	**Natalie Erchinger** Baylor Scott & White Health Temple
Stephen W. Kimmel Cook Children's Healthcare System Fort Worth	**Julie Holly** Seton Healthcare Austin

1. Welcome, introductions, and opening remarks. The meeting was convened by the Chair, Diana Strupp, on February 6, 2020. A quorum was present.

2. Approval of October 31, 2019, minutes. The minutes were approved as written.

INFORMATIONAL ITEMS

3. Uncompensated Care (UC) Secondary Reconciliation (PDF) - Charles Greenberg, Director, HHSC Hospital Finance and Waiver Programs

Proposal. The Health and Human Services Commission (HHSC) proposes to eliminate the requirement that a secondary reconciliation be performed for a hospital that submitted a request for an adjustment to cost and payment data for their UC application in demonstration year 2.

Background. The Health and Human Services Commission received federal approval to create the Uncompensated Care (UC) pool via a waiver from section 1115 of the Social Security Act. The UC pool's role in Medicaid financing, as described in this section, is to provide supplemental payments to hospitals for the cost of uncompensated care resulting from the Medicaid shortfall and providing care to persons without insurance. As part of the UC

application process, historic utilization and cost data are used to estimate the amount of the UC funds for which a hospital may be eligible. A reconciliation of actual utilization and cost data with the estimated data occurs two years after receipt of a UC payment. This process ensures a hospital did not receive more funding than allowed per its hospital specific limit.

The UC application process allowed hospitals the option to request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs resulting from changes in operation or circumstances. If a hospital requested an adjustment, it would be subject to a secondary reconciliation process.

The purpose of the proposal is to eliminate the requirement that a secondary reconciliation be performed for a hospital that submitted a request for an adjustment to cost and payment data for their UC application for demonstration year (DY) 2 (October 1, 2012, to September 30, 2013). The UC applicants did not have the benefit of fully knowing the consequences of requesting an adjustment before they submitted their UC applications. The adjustments were requested prior to the effective date of the rule amendment that required a secondary reconciliation process to occur if cost and payment data adjustments were requested.

Fiscal Impact. HHSC does not have sufficient data to determine how specific hospitals would be impacted by this rule amendment. However, hospitals that requested adjustments to cost and payment data for DY 2 of the UC program would be exempt from a secondary reconciliation process and not be subject to any potential recoupments that could have occurred if the exemption was not in place.

Rule Development Schedule.
January 3, 2020 - Publish proposed rules in Texas Register
February 6, 2020 - Present to the Hospital Payment Advisory Committee
February 13, 2020 - Present to the Medical Care Advisory Committee
February 20, 2020 - Present to HHSC Executive Council
April 2020 - Publish adopted rules in Texas Register
May 2020 - Effective date

Mr. Greenberg stated that this rule has to be closed quickly because it must be adopted before this section of the rule can be reopened to address other issues.

The Chair expressed her appreciation to HHSC for their work on this since Summer of 2017.

Mr. Bedwell asked if other years are also being reviewed? Mr. Greenberg stated they have received comments along those lines and changes to other years are possible.

Public Comment on this issue:

Monica Leo, Texas Children's Hospital stated that they support the rule change related to year two. They are concerned because the proposed amendments don't address the change to the final HSL that is being considered. If that happens because the interim HSLs were used, there is a possibility that final HSLs will be less than the interim HSLs. HHSC should address this before adoption of the final rule, thus protecting hospitals against a penalty. They believe they have a way to do this: at the time the final reconciliation is done for that demonstration year, to calculate of proxy HSL, solely for the secondary reconciliation that would use the same methodology at the time that the interim HSL was calculated. That way, you will be comparing apples to apples. This was submitted in their written comments.

Q: When that's done, could there be a minimum established? Ms. Leo stated that that would have to be a policy decision for HHSC.

4. Payment Caps in Disproportionate Share Hospital Programs - Charles Greenberg, Director, HHSC Hospital Finance and Waiver Programs

The rule has been published as adopted.

Proposal. This proposed rule describes new payment caps for the Disproportionate Share Hospital (DSH) and UC Medicaid supplemental payment programs to reimburse hospitals providing services to predominantly Medicaid and low-income patients. HHSC proposes to implement a full offset methodology for the Texas payment cap, meaning any payment for services provided to a Medicaid client will be included as an offset to all appropriate Medicaid costs.

Background. The rule amendments describe new payment caps for the Disproportionate Share Hospital (DSH) and Uncompensated Care (UC) Medicaid supplemental payment programs. When combined, DSH and UC represent almost $5.5 billion in Medicaid payments for Texas hospitals. The programs are meant to reimburse hospitals that provide services to predominantly Medicaid and low-income patients. So, the allocation methodology among such providers should account for the relative amounts of Medicaid and low-income patients served, as well as the overall payments hospitals receive for those patients.

In Texas, two payment caps exist for hospitals that participate in DSH and UC. There is a federal payment cap, known as the final hospital-specific limit (final HSL), that is described in federal law. There is also a state payment cap, known as the interim hospital-specific limit (interim HSL), that HHSC may define. The state payment cap is calculated in the payment year for DSH and UC, but the federal payment cap is calculated two years after the payment year using updated data. HHSC linked the interim HSL to the final HSL so that there would be a limited chance that a recoupment would occur after the final HSL was calculated.

The federal payment cap has been the subject of ongoing federal litigation for several years. That litigation relates to the inclusion of payments from other insurance payors and Medicare when a Medicaid client also has other insurance or Medicare. HHSC will continue to monitor this litigation and examine if the Texas payment cap should change in response to the outcome of the federal litigation. However, HHSC is implementing a full offset methodology for the state payment cap. That means any payment for services provided to a Medicaid client from any source will be included as an offset to all appropriate Medicaid costs.

HHSC seriously considered two other options for the state payment cap before proposing this amendment. HHSC considered the approach recommended by the Medicaid and CHIP Payment and Access Commission (MACPAC), where the Texas payment caps would not contain either the costs or payments for a Medicaid client who also has other insurance or Medicare. HHSC also considered capping, in the aggregate, other insurance and Medicare payments at the Medicaid allowable cost. However, HHSC determined that including all Medicaid costs and all third-party payments provides a more appropriate measure of financial need given the purpose of the payment programs at issue.

HHSC met with and received feedback from stakeholders prior to publication of the proposal. After publication, HHSC evaluated both written comments and oral testimony that was received during a public hearing.

The rule will be in effect for the February payment.

Q: When you say, "all payment," do you mean all payments paid into the file regardless of source? Mr. Greenberg concurred.

The Chair stated that the rule was adopted on January 24th, and the comments pertained to issues outside the scope of the proposed rule. Is there consideration to reopen the rule to address such comments? Mr. Greenberg stated these comments will be on their radar, but he cannot guarantee any action on them.

Q: Does this take us back to what the rule was before the CHAT issue? Mr. Greenberg stated that it matches the federal hospital-specific limit.

Mr. Bedwell asked if they did a hospital by hospital impact analysis. Mr. Greenberg stated that they looked at the data at the class level.

Public Comment on the Item.

Maureen Milligan, Teaching Hospitals of Texas, spoke in support of the rule. The rule considers all the payments that are made and keeps the idea that Medicaid is the payer of

last resort. They recently looked at fee-for-service data. It is important to look at the payments hospitals receive relative to their costs.

UPDATE ITEMS REQUESTED BY CHAIR

5. Medicaid Fiscal Accountability Regulation (MFAR) - Charles Greenberg, Director, HHSC Hospital Finance and Waiver Programs

On November 12, 2019, Today, the Centers for Medicare & Medicaid Services (CMS) has issued the proposed Medicaid Fiscal Accountability Rule (CMS-2393-P) to strengthen the fiscal integrity of the Medicaid program and help ensure that state supplemental payments and financing arrangements are transparent and value-driven. The last several years have seen a rapid increase in Medicaid spending from $456 billion in 2013 to an estimated $576 billion in 2016. Much of this growth came from the federal share that grew from $263 billion to an estimated $363 billion during the same period. Supplemental payments, or additional payments to providers beyond the base Medicaid payment for particular services, have steadily increased from 9.4 percent of all other payments in FY 2010 to 17.5 percent in FY 2017. Independent analysis by oversight agencies including the Government Accountability Office (GAO), the Office of Inspector General (OIG) and the Medicaid and CHIP Payment and Access Commission (MACPAC), has resulted in the observation that expenditures for hospital Upper Payment Limit (the maximum payment a state Medicaid program may pay a certain provider type in the aggregate) supplemental payments increased for Medicaid benefits between 2001 and 2016, resulting in a total of $16.4 billion in supplemental payments for 2016. With this significant growth comes an urgent responsibility to ensure sound stewardship and oversight of the Medicaid program.

CMS currently lacks available timely and adequate State Medicaid payment and financing data to enable the most effective oversight of the Medicaid program. While CMS does not believe that all states necessarily are participating in Medicaid financing schemes or making inappropriate payments, CMS has determined that the agency does not always have adequate information to always properly determine when a state is financing its state share of Medicaid expenditures from impermissible sources or otherwise making inappropriate payments. The lack of data on state supplemental payment programs makes our oversight of such payment programs and any underlying, associated financing of those payments, vulnerable to speculation. Additionally, oversight agencies, including OIG and GAO, have made recommendations to CMS to better oversee and understand Medicaid supplemental payments, disproportionate share hospital payments and the associated non-federal share. CMS used these recommendations from these entities to inform the proposed policies and procedures included in the NPRM.

Through this proposed rule, CMS continues its commitment to strengthening the oversight and fiscal integrity of the Medicaid program. This rule proposes to establish regulations to:

1. **Improve Reporting on Supplemental Payments**
    - Currently, states report aggregate payment detail for base and supplemental payments. Under this proposed rule, states would be required to furnish provider-level payment detail to support the aggregate level information received through UPL demonstrations. The reporting of provider-level data will aid with transparency within the Medicaid program as well as support both states and CMS in better oversight of the program.
    - States would also be required to report provider-specific payment information on payments received for state plan services and through demonstration programs, as well as identify the specific authority for these payments (i.e. state plan amendment (SPA) or demonstration), and the source of the non-federal share for these payments. This would ensure better consistency of reporting from states and will help CMS to better track payments and analyze payment detail– ensuring accurate and timely payments, and that issues can be identified and addressed more quickly.
    - The proposed rule would allow CMS and states to evaluate the effects of supplemental payments by sun-setting existing and new supplemental payment methodologies after no more than 3 years and requiring states to request a new CMS approval to continue a supplemental payment beyond the maximum 3 year approved period. This would ensure that both the state and CMS have opportunities to ensure that supplemental payment methodologies continue to comport with all applicable legal requirements and align with current programmatic goals.
    - Lastly, this proposed rule would mandate the use of OMB-approved templates and CMS guidelines on acceptable UPL calculations. This would ensure standardization of data applicable to UPL demonstrations, allowing the state and CMS to better ensure compliance with applicable payment limits and measure the effect of payments on advancing Medicaid program goals.
2. **Clarify Medicaid Financing Definitions**
    - The proposed rule would establish new regulatory definitions for Medicaid "base" and "supplemental" payments, which are not currently defined.
    - It would also clarify the definitions and processes associated with non-federal share financing arrangements and the upper payment limit ownership categories to close potential loopholes and be more consistent with the statute.
3. **Reduce Questionable Financing Mechanisms**

State Reliance on Providers to Fund the Non-federal Share

- The proposed rule re-affirms the statutory requirement that intergovernmental transfers (IGTs) must be derived from state or local tax revenues and would clarify the current regulations that describe "public funds" As qualifying for use as non-federal share. This would align the regulatory text with the statutory language.

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- It would also clarify that providers must receive and retain 100 percent of the payment, helping preventing states and units of government from reusing Medicaid payments as the source of state financing for additional payments. This means that 100 percent of the state's claim of expenditure must be paid to and retained by the Medicaid provider.
- Lastly, CMS proposes to clarify that facilities that enter into certain questionable transactions to change ownership on paper, but remain substantially unchanged in their operations and in most respects, cannot qualify for additional Medicaid payments on the basis of the purported ownership transfer. This would help to ensure that supplemental payments are distributed to providers in a manner that comports with applicable requirements and aligns with Medicaid program goals.

Health Care-Related Taxes and Donations

- The proposed rule clarifies the prohibition on financial arrangements designed to mask impermissible donations. Currently, some states, localities, and private health care providers continue to design various complex financing structures to mask impermissible provider-related donations, which are used to fund the state share of Medicaid expenditures. This would help CMS' ongoing efforts to ensure that the state share of Medicaid expenditures is funded in accordance with the law.
- It also proposes to prohibit states from structuring health care-related taxes that unduly burden the Medicaid program (e.g., higher tax rates on Medicaid services than non-Medicaid services). This change would close an existing inadvertent regulatory loophole.
- The proposed rule would clarify the statutory prohibition on states circumventing health care–related tax requirements by masking health care-related taxes in a tax program that also taxes non-health care items and services, codifying existing policy.
- CMS proposes to allow health insurers to be considered a permissible tax class. This would help modernize the regulatory list of permissible classes.
- It seeks to strengthen oversight and monitoring of approved tax waivers. This would help ensure that states' health care related taxes are transparent and continue to meet federal requirements over time.

Medicaid Disproportionate Share Hospital (DSH) Payments

- The statute allows states to make DSH payments to qualifying hospitals to take into account the circumstances of hospitals that serve a disproportionate share of low-income patients with special needs, such as increased costs associated with uncompensated care provided to low-income patients, including Medicaid-eligible and uninsured individuals. Payments made under the DSH statutory authority are not considered part of the base rate payments or supplemental payments, as they are made under distinct statutory authority.
- Currently, states must submit an independent audit report for each plan rate year. The reports are due approximately three years after the completion of the rate year and are published after CMS reviews the data for completeness.

- This proposed rule would strengthen transparency and oversight of this annual process by requiring a quantification of individual audit findings by hospital and clarifying reporting requirements.
- It would also clarify the overpayment discovery and redistribution procedures associated with DSH payments to ensure timely and proper DSH claims and to ensure that any DSH overpayments are redistributed to other hospitals or returned to the federal government, as appropriate, under the approved state plan.
- Additionally, CMS proposes to modernize the DSH allotment publication process by making allotment information available to states and the public through Medicaid's website, which would be timelier than the current Federal Register process.

How did findings from Oversight Agencies (GAO and OIG) impact the proposals included in this proposed rule?
Oversight agencies have recommended changes to better oversee and understand Medicaid supplemental payments, disproportionate share hospital payments and the associated non-federal share. In 2015, the GAO issued a report entitled, "Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy," that stated, "[w]ithout good data on payments to individual providers, a policy and criteria for assessing whether the payments are economical and efficient, and a process for reviewing such payments, the federal government could be paying states hundreds of millions, or billions, more than what is appropriate." In 2006, the OIG published a report entitled, "Audit of Selected States' Medicaid Disproportionate Share Hospital Programs," in which the OIG recommended that CMS establish regulations requiring states to: 1) implement procedures to ensure that future DSH payments were adjusted to actual incurred costs; 2) incorporate these adjustment procedures into their approved state plans; and 3) include only allowable costs as uncompensated care costs in their DSH calculations. Lastly, in 2012, the GAO published the report, "Medicaid: More Transparency of and Accountability for Supplemental Payments are Needed," in which examined how information on DSH audits facilitates the agency's overall oversight of DSH payments. These recommendations were all used to inform the proposed policies and procedures included in the NPRM.

The NPRM will was published in the Federal Register for public review and comment for a period of 60 days, with a 15-day extension.

Mr. Greenberg stated that MFAR was proposed in the middle of November and is a very impactful set of policies. HHSC issues:

- There is a large expansion of reporting and transparency.
- Nonfederal share of payments, governments can use other public revenues including tax revenue. CMS is removing the definition of public funds and using more limited language taken from the statute. This would limit it to taxed revenue and eliminate the nontax revenue.

- The Hold Harmless test will be changed to include a subtest (net effects test) and that language can be used to look behind tax structures. This can impact Texas significantly.
- HHSC has submitted their comments, which included their belief that the proposal was very subjective and can vary from one regional office to another.
- HHSC has stated that CMS does not have the authority to make the net effects test and that they are overreading their statute.
- There is uncertainty in the proposed tests and the new requirements are not certain with three-year renewal periods.
- The Tax waiver issue does not impact Texas except in one Graduate Medical Education Program.
- HHSC knows the programs impacted but the dollar amount is impossible to determine due to ambiguity in the rule.

Questions:

What are the next steps for CMS? Mr. Greenberg stated that the comment period closed, and they will have to look into the 4,000 comments they received and address them.

Clarification of the nonpublic funds issue. Mr. Greenberg stated that there had been a bucket of public funds based on commercial payments and taxing authority, but now the proposal would eliminate the commercial payments.

Would LPPFs be considered state and local taxes? Mr. Greenberg stated that these are not a problem from the tax perspective. They must guard against the pooling of funds from taxpayers.

Medicaid supplement programs impact. Mr. Greenberg stated that it could impact uncompensated Care, DSRIP, DSH, the Network Access Improvement Program and several other supplemental programs.

6. Private hospital Graduate Medical Education program - Victoria Grady, Director, HHSC Rate Analysis

Ms. Grady stated that a state plan amendment (SPA) was submitted to create a private medical education program. Mr. Greenberg stated that CMS gave HHSC the opportunity to withdraw the answers they provided to Formal Request for Additional Information (RAI) or CMS would disapprove the GME SPA because HHSC had not answered the questions adequately (local participation funds). HHSC is taking this into consideration. By withdrawing the responses, the original start date of April 1, 2019 can be maintained retroactively.

7. Affordable Care Act Disproportionate Share Hospitals cuts - Charles Greenberg, Director, HHSC Hospital Finance and Waiver Programs

The cuts have been delayed to May of 2020, and there have been no updates on a further delay. HHSC stated they are trying to figure out if there will be proration. The process will begin in Texas in May, and it is believed that the impact will be significant, but there is not an exact figure. There is concern about the downstream effects on providers and the issues related to UC. The federal funds team is monitoring this. There is a possibility the DSH payment in July will be delayed so adjustments can be made.

The Chair stated that the final DSH payment is made in June. Staff stated that depending on the timing, there would be a delay to ensure HHSC does not pay more than their allotment.

For the interim payments, they are going out to providers at the reduced rate so there will not be an overpayment. Staff state that when interim payments are made, they are made as a percentage of the total potential pool and they could be done based on the assumed reduced amount. HHSC stated they will have to check with the federal funds team.

Is this a uniform cut across all providers (state and nonstate)? If the reductions take effect, those public policy decisions would still have to be made. The current rule allows a percentage of payments made to state-run hospitals.

Dollar impact of the DSH cuts? Staff stated it would be significant, but they have not made an estimate. It could be greater than $250 million, but under $450 million.

Are there written comments about the defense of Texas on this issue. Staff stated that the state did make comment to CMS, but the rule was adopted without change.

This is part of the Affordable Care Act, so the cuts are there, but what we have been doing is seeking a delay or reprieve. Staff stated that the reductions are statutorily directed, but there are rules as to how the reductions would be made. That rule is now final.

Would the implementation require a change in state DSH recommendations? Staff stated that they do not believe so. DSH is in the state plan, but the MFAR and renewal of programs requirement could impact the future DSH programs.

8. Local Provider Participation Fund Reporting - Charles Greenberg, Director, HHSC Hospital Finance and Waiver Programs

This went into effect last quarter, and there is a reporting portal that was reviewed by stakeholders. There is a technical guide and webinar available. The portal closes 10 days after the end of the federal fiscal quarter. There are 28 LPPFs and 26 of them are in actual

operation. Reports were received from 27 LPPFs. Every operational LPPF (requiring payments form private hospitals) must report, and all 26 did. If reports are not submitted on time, then the private funding will not be allowed by HHSC. This was not a problem this quarter. There were 27 reporting because one non-operating LPPF still had some funds in their account, and so complied with the reporting requirement.

HHSC is going through the data as it was received. These payments have to be broad-based, uniform, and there cannot be a Hold Harmless. HHSC will be focusing on the source of the net patient revenue.

There is a very wide range of rates reported (0.12% to 6.0%). Sometimes a rate changes within a fiscal year, and that was not anticipated. There are four entities that have reported at 6%. That six percent is the maximum amount they are allowed to take in. The average rate was about 2.5%.

Rider 26 requires reporting. HHSC is tracking administrative expenses. $220,000 was spent on contracts for the administration of LPPFs; $10,000 on the collection of assessment function of LPPFs; just under $400,000 was spent on noncontract administration. How that gets applied varies from one LPPF to another. By state law, there is a cap on administration of LPPFs to $150,000. They will be going back to several units of government for clarification.

Questions/Comments:

The quarter by quarter basis is working well for the LPPFs and the changes that are needed are appreciated.

9. Public comment.

Stacy Wilson, CHAT, stated that Children's Hospitals are heavily dependent on Medicaid. The new full offset methodology will result in four hospitals not being able to participate in DSH and there will be an impact to UC. That leaves only Uniform Hospital Rate Increase Program (UHRIP) as an alternative funding mechanism. There is uncertainty with UHRIP and the impact of the full offset allocation methodology on children's hospitals. There could be a loss of $34 million, and $24 million of that is coming from one hospital. They are asking for relief from these losses.

Mr. Greenberg stated that Ms. Wilson was correct. HHSC sent out two notices this week regarding the UHRIP program, tying directly into the issues that children's hospitals are facing as a result of the changing way that the state payment cap is calculated. The first notice dealt with changes to UHRIP for the second half of FY20. We had anticipated adding ~ $170-$200 million to the overall amounts available in UHRIP and adding a new class of hospital to receive funds. That would be freestanding psych hospitals, and only for the under 21 population.

Ultimately, CMS was not able to give us an indication of approval or disapproval by last Friday. HHSC had to exclude the changes from the managed care contracts, as it would have created huge issues to include the changes and then receive a disapproval notice from CMS. About $30 million will be added to UC, and will not be flowing through UHRIP due to the reconciliation process.

10. Proposed next meeting: May 7, 2020, at 1:30 p.m. at Brown Heatly.

11. Adjourn. The being no further business, the meeting was adjourned.

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