HHSC: Hospital Payment Advisory Committee, August 6th, 2020

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

Welcome, introductions, and opening remarks. The meeting was convened by Diana Strupp, HPAC Chair. A quorum was established.

Approval of February 6, 2020 minutes. The minutes were approved as written.

Behavioral Health Hospitals update. Victoria Grady made the presentation. She stated they are going to be reaching out to mental health hospitals for behavioral health data to implement a UPL demonstration. The analysis has to be conducted for potential rate increases. They will be looking at the rate calculations and methodology as well.

Medicaid Fiscal Accountability Regulation. The Chair stated that CMS published this in November of 2019. Trey Wood made the presentation. MFAR was released and comments were to be received in January 2020. The comment period was extended to February 2020. The goal is to promote transparency for payment to providers for different Medicaid programs. The proposed rules can impact state budgets. Many states do not know how CMS will apply the regulations, which have raised concerns. HHSC commented on the rules and cited ambiguity as an issue. Texas has worked with CMS in the past and informed them that this could cause service issues. A new piece of legislation was introduced by Eddie Bernice Johnson to delay MFAR. A provision was added into the HEROES Act that would not allow MFAR's implementation until after the COVID-19 crisis has ended.

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Q: Assuming the MFAR rues will be implemented, when will the rule be put into place? HHSC stated they do not know the effective date, but it depends on the impact of the proposed rule. There can be different effective dates for different provisions.

Uncompensated Care (UC)/Disproportionate Share Hospital Redistribution. The Medicaid DSH final payment was a concern. Megan Wolfe and Victoria Grady made the presentation. The final payment should be paid out by December 30th. The updated calendar shows the payments and they start and are completed for Demonstration Year 3 in September; October for Demonstration Year 4; and May for Demonstration Year 5 and 6. Follow this link for the DSH Payment Schedule.

Uniform Hospital Rate Increase Program.
The new UHRIP was approved and will start September 1, 2020. This will allocate $2.67 billion, which is an increase from last year. The rates are targeted to be at least the same as for 2020, or an increase.

The Chair stated that she would like to understand the quality strategy for 2020. HHSC stated that the quality strategy is required under federal regulation. They are interested in the state having a final version of the strategy where payment programs have to be linked to the quality strategy. The HPAC will be consulted for this effort and strategy development. A more rigorous quality strategy will be required for UHRIP.

A question was asked about the allocation strategy since it is uneven across the state. HHSC is aware that there were differences among hospitals. An analysis had to be conducted on the reasonableness of the rates paid by provider class on a service delivery area basis. They looked at average commercial reimbursement, but because of the proprietary nature of the information and timing of the request, comparisons were only able to be made using Medicare.

The Chair asked, regarding methodologies, do we have examples of what CMS would approve/is looking for? HHSC stated that CMS approved rate increases that exceed Medicare in certain directed payment programs in other states, but those states provided an average commercial reimbursement demonstration on a provider-specific and procedure code detailed level. CMS indicated that they have never approved a rate increase that exceeds the average commercial reimbursement, but that Medicare is generally seen as an appropriate barometer.

Steve Hand stated that HHSC should look at what is out there in the Medicare world (PPR, PPC, PPD) where TMHP is making adjustments already.

The Chair asked if HHSC would consider an industry workgroup. HHSC stated they were trying to figure out how to pull together a technical workgroup, given the COVID-19 restrictions. The workgroup will be brought together in early September.

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Q: Are there models out there that will tell hospitals what they will receive in 2021 and compare to 2020? HHSC stated that they can do that showing percentage change from 2020. UHRIP is performance-based, and so that would be a caveat that should be considered. Follow this link for more detailed UHRIP information.

Delivery System Reform Incentive Program (DSRIP). HHSC provided an update on the achievement levels during the April 2020 reporting period. DSRIP-participating providers reported on Performance Year 2 of their Category C outcome measures, which accounts for 75-85% of the total valuation per provider. They reported for 92% of their pay-for-performance measures. Of those measures that reported second-year performance data, 77% of those measures were reported 100% achievement for the second-year goal. This level is higher than what was reported in the same time-period for the first DSRIP demonstration (68%/100%). For April 2020 reporting, providers achieved DY7-9 DSRIP total of $2.41 billion, and were paid based on the available IGT and an enhanced COVID-19 FMAP rate of 67.09, a total of $2.37 billion. Of the total payments earned in April 2020, $18.2 million was for provisional approvals, which we negotiated with CMS as a flexibility for provider reporting during this period. Very few providers ultimately used this allowance. To-date, providers have received $18.9 billion in DSRIP payments for Demonstration Years 1-9. Aside from the provisional approvals, we have requested additional flexibility from CMS regarding measurement during Calendar Year (CY) 2020. For Category B (patient population by provider), HHSC requested authority to amend the allowable variation, which is a percent range of 1-5 that a provider is allowed to be **under 100% goal** and **still earn 100% payment**. The pending request would allow HHSC to determine, based on the impact and duration of the pandemic, a higher percentage allowable variation. The potential range, based on the ongoing pandemic and what providers have reported to us, is 30-50 percent. For Category C (outcome measures), based on a proposal offered by CMS to all DSRIP states, HHSC proposed that providers earn payment on CY 2020 outcome measures based on

- the higher of their CY 2019 achievement value for the measure,
- the average CY 2019 achievement for the measure class, or
- the actual CY 2020 performance on the measure.

This proposal was shared with stakeholders for public comment. We anticipate a final decision from CMS in the next week or two.

The Chair inquired about the average as an alternative for CY 2020 Category C— is that average based on a statewide average, or is it an RHP average? If COVID-19 continues into DY10, will any of these flexibilities extend that long? There's no carry-forward period for DY10. HHSC stated the average is a statewide average. DY10 is split. What we have drafted in the proposed changes to the program funding and mechanics protocol is that changes to Category B (allowable variation) would apply to DYs nine and 10. For Category C, the proposal was specific to CY 2020 data/measurement reporting. At the time of our initial communication with CMS about their proposal, they were not interested in changing/lowering goals or

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specifications, but realized that things are in flux. Follow this link for Hospital involvement in DSRIP.

Medicaid Disproportionate Share Hospital Program. Rene Cantu made the presentation. DSH 2020 payments were completed early to support providers during the COVID-19 crisis. We intend to send out our request link at the end of this month and we will be on the same schedule we've had in the past for completing the DSH application. There will be a regular payment schedule for the 2021 DSH program of three advance DSH payments— each 18% and occurring in October, November, and February. The final payment occurs in June and will be 46% of the DSH allotment. Follow this link for DSH 2020 payments.

Regarding the reduction, as we work through making the advance payment, we would assume a reduction in the DSH allotment and make our 18% calculation off of the reduced amount. Currently, we believe the reduction would be ~ $400 million; for 2021 we have a DSH allotment of $1.864 million. Therefore, ~ $1.499 billion would be the reduced amount if the reduction occurs. The reduction was supposed to occur in 2014 and 2020 and did not; we're making the assumption that it could occur in 2021 and that the reduced allotment would make it $1.449 billion (speaker did not clarify whether $1.499 or $1.449 was the correct amount).

Q: As we move forward to the next Fiscal Year, can the March interim payment be moved up to take advantage of the enhanced FMAP before December 31st? HHSC stated that at this time, HHSC has not announced a different payment schedule. We are reviewing stakeholder requests related to expedited or combined payments, but one of the things we're looking at is variation in what providers received in advance payments, because we want to ensure that no providers are pushed into overpayment status. Some COVID-19 relief bills include percentage increases to the DSH 2020 and 2021 allotments. It's unclear if those measures will pass, and if they do, how to reconcile a percentage increase to the allotment combined with the potential reductions. We anticipate making Fall payments assuming a reduced allotment until or unless there is an additional congressional action to defer the reductions.

Q: How is HHSC modeling the UHRIP increases? HHSC stated that they make UHRIP adjustments to the base or historical cost data; in addition, there are applications to project any anticipated hospital-specific limit. That adjustment would take into consideration the higher reimbursement rates folks are anticipated to receive through UHRIP.

Public Health Emergency (PHE)/Enhanced Federal Medical Assistance Percentage (eFMAP) extension and Expedited Demonstration Year 10 Uncompensated Care payment

At the time of the agenda the PHE had not been extended, but it is now extended and the enhanced FMAP will be extended through Calendar Year 2020. Stakeholders have requested moving the enhanced payment back into the fall to take advantage of the enhanced FMAP, but HHSC has to look at cash flow and IGT availability. IGT payments get challenging at the

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end of the Fiscal Year. Providers could have obligations for DSH that preclude this from happening. We want to see an expedited payment without putting providers into a challenging situation.

Medicaid Supplemental Payment Issues. Victoria Grady and Gary Young made the presentation. HHSC stated that a biennial fee review process is already in place to review all rates. This would not include, however, appropriation-limited rates. The goal is to reduce the number of hearings from four, to two per year. The time saved will address rate reviews that were not included in the regular review process. HHSC is undertaking a review of the utilization assumptions for the request in November and making decisions based on the IGT collected under an assumption that the enhanced FMAP.

The Chair inquired about the IGTs for UHRIP and whether they would be included in the reconciliation. HHSC stated that for Fiscal Year 20, there will be a refund to providers. The November IGT for FY21 will be reduced, but there will be no refund.

Medicaid Funding Issues Related to Texas Hospitals. Gary Young made the presentation. The issues have all been covered in the previous topics discussed.

Rural Hospital Advisory Committee update. Victoria Grady and Ms. McCain provided the update. This is part of the development of the rural hospital strategic plan. Under the plan, HHSC developed three strategies with three goals each:

- Increase inpatient rates for hospitals (completed)
- Realigning rural hospital rates (September 1, 2021)
- Implement a minimum fee schedule for MCOs that will be implemented in 2020.

There is an education training program being developed to implement March of 2021. The Rural Hospital Advisory Committee was part of this strategic planning process. HHSC will provide an update to the strategic plan by November 1 of every even-numbered year. The committee will work across agencies to create a sustainable reimbursement model. The subcommittee will begin work very soon.

The minimum fee schedule is required by federal rule. MCOs must pay rural hospitals at the same rate that commercial insurance would have paid. The UHRIP increases are applied on top of the contracted rate.

Upcoming Member Appointments. Applications have been reviewed for the Rural Hospital Advisory Committee. COVID-19 is impacting the appointment process.

The Chair stated that at the end of 2020, several HPAC members' tenures will expire. HHSC stated that at the end of the first term, members can reapply through the application process like the general public.

Public comment. No public comment was offered.

Proposed next meeting. November 5, 2020, at 1:30 p.m.

Adjourn. There being no further business, the meeting was adjourned.

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