HHSC: Hospital Payment Advisory Committee August 5, 2021

Hospital Payment Advisory Committee, 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.

Diana J. Strupp, HPAC Chair Tenet Health Systems Dallas	**Julie Holly** Seton Healthcare Austin
Steven Hand, HPAC Vice Chair Memorial Hermann Health System Houston	**Stephen W. Kimmel** Cook Children's Healthcare System Fort Worth
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Sharon Clark Tarrant Country Hospital District (JPS) Fort Worth	**Daniel Olvera** Covenant Health System Lubbock
Natalie Erchinger Baylor Scott & White Health Temple	**Jerry Pickett (RHAC member)** Bosque County District Hospital Clifton
Nathan Flood (RHAC member) Castro County Hospital District Dimmitt	**Todd Scroggins (RHAC member)** Wise Health Systems Decatur
John Henderson (RHAC member) Texas Organization of Rural and Community Hospitals (TORCH) Round Rock	

Welcome, introductions, and opening remarks. The meeting was convened by Diana Strupp, Chair.

Consideration of June 3, 2021, minutes for approval. The minutes were approved with a minor correction.

Informational Item

Hospital Augmented Reimbursement Program (HARP)

- Rene Cantu, Director of Hospital Finance, HHSC Provider Finance Department

The Texas Health and Human Services Commission (HHSC) has proposed a new rule which describes a new program to preserve financial resources many Texas hospitals depend on to provide access and quality care to Medicaid clients and the uninsured. Subject to approval by the Centers for Medicare and Medicaid Services (CMS), HARP would be created through the Medicaid state plan. State plan programs and services do not impact 1115 waiver budget neutrality. HHSC intends to submit state plan amendments to CMS requesting authorization to make payments as described under new the new rule at Title 1, Texas Administrative Code, §355.8070 to non-state government owned and operated hospitals and to private hospitals.

Fiscal Impact. None reported

Rule Development Schedule.

July 2021	Publish proposed rules in Texas Register
August 5, 2021	Present to the Hospital Payment Advisory Committee
August 12, 2021	Present to the Medical Care Advisory Committee
August 19, 2021	Present to HHSC Executive Council
September 2021	Publish adopted rules in Texas Register September 2021 Effective date

Question/Answers/Comments

Private hospitals will be limited to a single IGT source. What is the reasoning behind that? HHSC stated they would get back to the committee.

It shouldn't be limited to one source

Have you been working with TMHP and are they ready to implement the program? HHSC could not answer.

What is the lag time for the gap? The lag time is two years.

Is this new HARP funding limited to only hospitals who only participated in DSRIP. HHSC stated the main purpose is to mitigate the loss from DSRIP withdrawal.

Is the program traditional Medicaid? It is for fee for service only

When will the enrollment process begin? HHSC did not have an answer

Update Items Requested by The Chair

87th Legislative Session update. Laura Skaggs made the presentation.

Rider 8 item F appropriated additional 60 million for rural hospitals. Changes to rules are being made. Cost to charge reimbursement is being addressed (about 16 percent). Changes should be effective on November 1st. Other changes are effective on September 1.

SB1136 seeks to preserve and build upon the successes of the DSRIP program and enhance the efforts by HHSC to reduce hospital emergency room visits and increase access to primary care providers. It amends current law relating to implementation of certain health care provider initiatives and measures designed to reduce costs and improve recipient health outcomes under Medicaid.

SB809 requires health care institutions who have received federal funding during the coronavirus disease public health emergency, including under the federal Coronavirus Aid, Relief, and Economic Security Act and the federal American Rescue Plan Act of 2021, to provide a monthly report of the funding received to the Health and Human Services Commission (HHSC). HHSC would be required to compile the information received from health care institutions and submit a quarterly written report to the Governor, Lieutenant Governor, Speaker of the House of Representatives, the Legislative Budget Board, and the standing committees of the Legislature with primary jurisdiction over state finance and public health. Additionally, the bill would allow the appropriate licensing agency of a health care institution to take disciplinary action against a health care institution that violates reporting requirements as if the health care institution violated an applicable licensing law.

Questions/Answers/Comments

On the $30 million will HHSC provide what the RCCs will be? Will be clinical lab fee schedules be provided. HHSC stated that they will be sending out letters to hospitals and a rate hearing has been held on the rates.

1115 waiver update. On July 14th the 1115 extension application was submitted. January 28th CMS sent back a completeness letter. There were over 1,000 public comments received. There were numerous comments on budget neutrality. Where we have statutory authority HHSC is proceeding. There is a quarterly monitoring report that will address a number of the issues of concern to this

group. They are working to address communications. STCs from January are still operational presently. The extension application requests approval by September 30th.

Briefing on Comprehensive Hospital Increase Reimbursement Program (CHIRP), Texas Incentives for Physician and Professional Services (TIPPS) Program, and Rural Access to Primary and Preventive Services (RAPPS) Program. Victoria Grady and Gary Young made the presentation. CMS has not approved any Directed Payment programs for 2022 but HHSC is working on flexibilities to ensure the programs are ready when approved.

Questions/Answers/Comments

What happens on September first? Directed payment programs are approved on a year-by-year basis. As such URHIP will cease to exist as of September 1, without federal approval. Other programs face a similar fate.

Directed Payment Programs:

Uniform Hospital Rate Increase Program is a statewide program that provides for increased Medicaid payment for inpatient and outpatient services. Texas Medicaid managed care organizations (MCOs) receive additional funding through their monthly capitation rate from HHSC and are directed to increase payment rates for certain hospitals.

- UHRIP program operational information

The Comprehensive Hospital Increase Reimbursement Program replaces UHRIP beginning September 1, 2021. HHSC and stakeholders wanted to reform certain aspects of UHRIP, such as improving its tie to the state's Medicaid quality strategy and incorporate the efforts to further healthcare transformation and quality improvement in the Medicaid program. CHIRP continues to be a statewide program that provides for increased Medicaid payments for inpatient and outpatient services to participating Texas hospitals. Texas Medicaid managed care organizations receive additional funding through their monthly capitation rate from HHSC and are directed to increase payment rates for enrolled hospitals. CHIRP is comprised of two payment components:

- The Uniform Hospital Rate Increase Payment
- The Average Commercial Incentive Award

The UHRIP component provides hospitals an increased payment that is based on a percentage of the Medicare gap, which is the difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services. The ACIA component is an optional component and hospitals can choose to participate. It provides hospitals a payment based on a percentage of the average commercial reimbursement gap difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid

for the same services, less payments received under the UHRIP component. Enrollment for CHIRP begins March 15, 2021.

- CHIRP Program operational information

Quality Incentive Payment Program is a statewide program that provides for incentive payments to qualifying nursing facilities. STAR+PLUS MCOs are directed to make payments to qualifying nursing facilities once the facilities demonstrate meeting the required goals.

- QIPP operational information
- QIPP scorecards and payment information
- QIPP frequently asked questions
- QIPP resources

Network Access Improvement Program is a pass-through payment program designed to further the state's goal of increasing the availability and effectiveness of primary care for persons with Medicaid. NAIP accomplishes this by incentivizing health-related institutions and public hospitals to provide quality, well-coordinated, and continuous care in exchange for additional funding.

- NAIP Reports

HHSC created the **Texas Incentives for Physicians and Professional Services program** to replace Delivery System Reform Incentive Payment program and the Network Access Improvement Program that are ending in state fiscal years 2022 and 2023, respectively. TIPPS is a value-based directed payment program for certain physician groups providing health care services to persons enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. Eligible physician groups include health-related institution physician groups, physician groups affiliated with hospitals that receive indirect medical education funding and other physician groups. These classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. TIPPS payments are paid to MCOs through three components in their capitation rates and distributed to eligible physician groups based on each physician group meeting performance requirements. Component 1 is a monthly performance incentive payment based upon the implementation of quality improvement activities. Component 2 is a semi-annual performance incentive payment based on the achievement of quality metrics focused on primary care and chronic care. Health-related institutions and indirect medical education physician groups are the only classes eligible for Components 1 and 2. Component 3 is a uniform rate increase on paid claims for certain outpatient services based on the achievement of quality metrics that measure aspects of maternal health, chronic care, behavioral health and social determinants of health. All participating physician groups are eligible for Component 3. Enrollment for TIPPS begins March 15, 2021.

- TIPPS Operational Information

The Rural Access to Primary and Preventive Services is a directed payment program that incentivizes primary and preventive services for persons in rural areas of the state enrolled in the

STAR, STAR+PLUS and STAR Kids Medicaid programs. RAPPS focuses on the management of chronic conditions. Two classes of Rural Health Clinics are eligible to participate:

- Hospital-based RHCs, which include non-state government-owned and private RHCs
- Free-standing RHCs

Eligible RHCs must serve an annual minimum volume of 30 Medicaid managed care encounters. RAPPS is comprised of two payment components: Component 1 is a monthly prospective uniform dollar increase paid to all participating RHCs to promote improvement activities with a focus on improving access to primary and preventive care services. Providers report semi-annually on certain structure measures that include electronic health record use, telemedicine/telehealth capabilities, and care coordination. Component 2 is a uniform percent rate increase for certain services. Providers will report their progress on process measures for preventive care and screening and management of chronic conditions.

- RAPPS Operational Information

HHSC created the **Directed Payment Program for Behavioral Health** to incentivize the Certified Community Behavioral Health Clinic model of care for persons enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. Eligible providers include Community Mental Health Centers. The Certified Community Behavioral Health Clinic model provides a comprehensive range of evidence-based mental health and substance use disorder services with an emphasis on offering 24-hour crisis care, care coordination with local primary care and hospital providers and integration with physical health care. The DPP BH is comprised of two payment components. Component 1 provides a monthly uniform dollar increase paid to all participating community mental health center providers in the program. Providers must report their progress towards gaining or maintaining certification for the Certified Community Behavioral Health Clinic model and other activities foundational to quality improvement, such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange. Component 2 is a uniform percent increase applied to certain Certified Community Behavioral Health Clinic services based on achieving quality metrics that align with its measures and goals.

- DPP BH Operational Information

What other programs are in this limbo? QIPP is in limbo, Behavioral health is in limbo and RAPPS are in limbo also. CMS has the discretion to grant approval retroactively.

There is no plan B correct? HHSC stated that there are no other options.

What is the fastest we have been able to implement after approval. HHSC stated that they are able to change and load rates once a month. The minute approval is received, HHSCV will load the rates into the system or will do it manually. CMS knows there are tight timeframes the state is operating under.

Private Hospital graduate medical education (GME) program update. There was a call last week with CMS and they reviewed the formal and informal responses. CMS still has questions and concerns about the source of the nonfederal share.

Medicaid Disproportionate Share Hospitals (DSH) workgroup briefing. Rene Cantu made the presentation. The objective of the workgroup was to engage stakeholders in the issues around DSHS and address changes.

Disproportionate Share Hospital payments are authorized by federal law to provide hospitals that serve a large share of Medicaid and low-income patients with additional funding. DSH payments are supplemental payments to help cover more of the cost of care for Medicaid and low-income patients. These payments cannot exceed a hospital's uncompensated costs for both Medicaid-enrolled and uninsured patients.

Who participates? Hospitals that provide care to a high percentage of Medicaid and/or indigent patients.

Source of funding: Local government funds and federal funds
Relationship to other supplemental payments – DSH payments are the only Medicaid payment in federal law that is explicitly for paying the unpaid costs of care for uninsured patients. It can be used by states to offset or make up for low Medicaid base payments. However, it is affected by Medicaid base payments and other supplemental funding. For example, an increase to a hospital's base Medicaid payment and to its other non-DSH supplemental funding may decrease a hospital's Medicaid shortfall and result in a reduction in its uncompensated care costs for which DSH pays.

- DSH audit and payment information
- DSH/UC applications

The group looked at the low-income utilization rate. This was found to not match the federal LAUR. They set a goal of having the state match the federal LAUR. The allocation of funds among classes of hospitals was also explored. They explored the state cap implementation and are there incentives for long term financing. Disqualification was explored and the issues that would disqualify a provider. The then looked at modeling of different payment options. The looked at data and standardization of the data. Tax revenue was evaluated.

There were nine modeling options developed and evaluated. The information is being used to work on the DSH rule.

Questions/Answers/Comments

The group was hesitant to make any recommendations for change until other CMS decisions were made. Is HHSC going to make changes to the DSHS program? HHSC stated that they are working on that and changes are under discussion. They want to see what the other hospital programs are going to do before recommending change. They are looking at specific places in the rule for updating. A new model may have to be advanced to fit in with the timing for the next payment year.

What will be the hierarchy (priority) of payments. HHSC stated that all payments made under the state plan are factored into the state payment cap before any DSH or UC payments are made.

Rural Hospital Advisory Committee update. The committee met today, and they heard about the realignment rates for rural hospitals were reviewed in addition to other updates that this committee heard this afternoon. Deliverables to CMS were discussed. The CHART program was presented and awards will be made September 10th.

Medicaid funding issues related to Texas hospitals. There were no additional updates discussed.

Public comment. No public comments were offered.

Proposed next meeting: November 4, 2021, at 1:30 p.m.

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

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