Texas Hospital Association

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Emailed to Monica.Leo@hhsc.state.tx.us

Monica Leo
Staff Counsel
Texas Health and Human Services Commission
Brown Heatly Building, MC: 1100
4900 North Lamar Blvd
Austin, TX 78714-9030

Re: Uniform Hospital Rate Increase Program

Dear Ms. Leo:

On behalf of its more than 450 member hospitals, the Texas Hospital Association appreciates the opportunity to comment on the proposed Texas Health and Human Services Commission regulations to implement the Uniform Hospital Rate Increase Program. If approved, the program would reduce, but not eliminate, hospitals' Medicaid shortfall in the managed care service delivery areas in which the program is implemented. Reducing the Medicaid shortfall would alleviate some of the pressure on the already-oversubscribed uncompensated care pool payments available through the Medicaid 1115 waiver.

We support this proposal as it increases Medicaid reimbursement rates so that they more closely approximate the actual costs of delivering care. Because it relies solely on local governmental funds provided by hospitals, the UHRIP program uses no state general revenue and will not impact the state's budget cap.

PROPOSED RULE §353.1301 General Provisions

- As proposed, if CMS determines that an arrangement associated with the funding of payments under this subchapter constitutes an impermissible provider donation, resulting in a disallowance of federal matching funds, the governmental entities responsible for the non-federal share of such payments must transfer funds to THHSC in the amount of the disallowed federal funds.

  We understand the potential for the disallowance of funds is a concern, but we disagree with the proposal to always hold the IGT entity responsible. We recommend the language regarding impermissible provider donations be similar to and consistent with that proposed for other CMS disallowances. As revised, the language would now read "……to the extent allowed by federal and state law and contract, HHSC may recoup the amount of the disallowance from MCOs, providers, or governmental entities that participated in the program associated with the disallowance."

PROPOSED RULE §353.1305 Regional Uniform Rate Increases for Hospital Services

We offer the following comments concerning Texas hospitals' reliance on Medicaid, the implementation timeline, the timeliness of the intergovernmental transfer, and the payment reconciliation process.

Hospitals' Reliance on Medicaid

- In 2015, Medicaid accounted for more than 19 percent of Texas hospital discharges and 14 percent of hospital payments (includes supplemental payments);
- Medicaid base rates are low (approximately 60 percent of cost, on average, for general acute care hospitals). Any additional funds received under the UHRIP program will help to bring reimbursement closer to the actual costs of care. The rate increase is not a windfall to hospitals. Rather, in the absence of state general revenue, it is a mechanism to fill some of the gap between what hospitals are paid and the costs incurred to serve the Medicaid population;
- Because of the Medicaid shortfall, hospitals have to rely on supplemental payments primarily funded by hospital districts and other governmental agencies. Local taxes (IGTs) constitute almost as much of hospital payments as inpatient reimbursement. For FY 2016, the IGT portion for Texas Medicaid supplemental payments was $3.6B. For the same period, inpatient hospital payments funded by state general revenue and federal matching funds were $3.7B; and
- Rate enhancements provide needed financial stability, which is particularly critical given the uncertainty around the future of Medicaid and the 1115 waiver.

Implementation Timeline

- We recommend the expeditious implementation of this rule. **THHSC should allow the service delivery areas that are ready to move forward with the program to begin this year**.

Timeliness of IGT

- As proposed, the hospitals that are required to make an IGT will have to do so by May. They are then eligible to receive higher MCO payments beginning Sept. 1 Asking public hospitals to wait 16 months to recoup their payments is challenging in this current fiscal climate;
- Sponsoring governmental entities are required to make at least two transfer of funds with the first IGT completed by May 1. Although we understand the need to solidify the IGT amounts in advance to establish the PMPM rates, an alternative is to secure **some type of commitment from the transferring entity with no immediate transfer of money (e.g. establishment of a dedicated account or a line of credit).** This would allow the IGT funds to be transferred closer to the Sept. 1 start date;
- The transfer amounts must cover the projected costs of the program plus 10 percent. Rather than requiring one large IGT transfer to cover six months of the program, we propose instead allowing **IGT entities to make more frequent transfers of smaller amounts.** This would help hospitals by minimizing the amount of funds tied up for long periods of time; and
- Given the short timeframe for participation, many service delivery areas that might be interested will be unable to initially participate. We propose that SDAs be allowed to participate as soon as possible, pending CMS approval. At a minimum, SDAs should be allowed to enter the program mid-year, especially during the first year of the program.

Payment Reconciliation Process

- Under the current MPAP program, there are concerns about the accuracy of the encounter data submitted by the MCOs. As the proposed provider payments also will go through the MCOs, THHSC should establish a process that will ensure the **underlying encounter data are correct and that the payment reconciliations are done expeditiously.**

Other Comments

- There appears to be an overlap of classes especially concerning rural hospitals. Although the "Rider 38" language is appropriate to determine who constitutes rural providers, there should be a distinction between public and private providers. In addition, publicly financed rural providers, who are rural under the proposed rule, should be able to self-determine their class;
- Although seven classes are initially identified, we ask that THHSC be open to additional classes in the future. This will provide much needed flexibility to the program;
- Based on the distribution of hospitals within a service delivery area, it is possible that a class of hospital may contain only one hospital. We assume this would be an allowable class for payment distribution;
- THHSC will direct the MCOs to increase payments based on the service(s) that will best advance the goals and objectives of THHSC's quality strategy. It is unclear what quality metrics will be utilized. We ask that THHSC ensure that hospitals are included in the development of these quality metrics from the beginning; and
- A contract "term sheet" was recently released. Does THHSC plan on reviewing the various MCO/hospital contracts?

We appreciate the opportunity to provide these comments. If you have any questions, please feel free to contact me at 512/465-1505 or jhawkins@tha.org.

Sincerely,

John Hawkins
Senior Vice President
Advocacy & Public Policy
Texas Hospital Association