Texas Association
of Voluntary
Hospitals

2 July 2018

On behalf of the Texas hospital industry, we greatly appreciate your ongoing support of Texas hospitals and advocacy on behalf of continuing the state's 1115 Medicaid Transformation Waiver. As you know, the state and federal governments successfully negotiated a new five-year Waiver for Texas that continues vital hospital supplemental payments through 2022.

However, because the Waiver's Special Terms and Conditions make significant changes to both the uncompensated care and delivery system reform incentive payment program components of the Waiver, certain challenges have arisen in its implementation.

For this reason, we respectfully ask for your assistance to ensure that available uncompensated care funding *is commensurate with Texas hospitals' documented uncompensated care need*s and that CMS not proceed with its flawed methodology that will penalize Texas with reduced uncompensated care funding for all eligible Texas hospitals.

We ask each member of the Texas Congressional delegation to contact the CMS Office of Legislative Affairs:

1. To ask that **CMS drop its proposed flawed methodology for determining the size of the uncompensated care payment pool.**
    - CMS proposes to reduce total available uncompensated care funding by a share of payments Texas hospitals earn under the Medicaid Disproportionate Share Hospital Payment Program. CMS is eliminating a share of funding for uninsured services, that although not eligible for uninsured Charity Care pool payments, are eligible DSH payments to Texas.

    - The impact of CMS' proposal is a reduction in total available uncompensated care funding of an estimated $600 million each year. As a result, *Texas hospitals' unfunded uninsured care costs (after supplemental payments) would increase from an estimated $780 million to an estimated $1.374 billion. Unfunded costs will increase annually thereafter.*

2. To ask that the uncompensated care pool size methodology ensure fair access to uncompensated care funding consistent with the negotiated Waiver Standard Terms and Conditions and commensurate with Texas' hospitals documented uncompensated care needs.

Background:

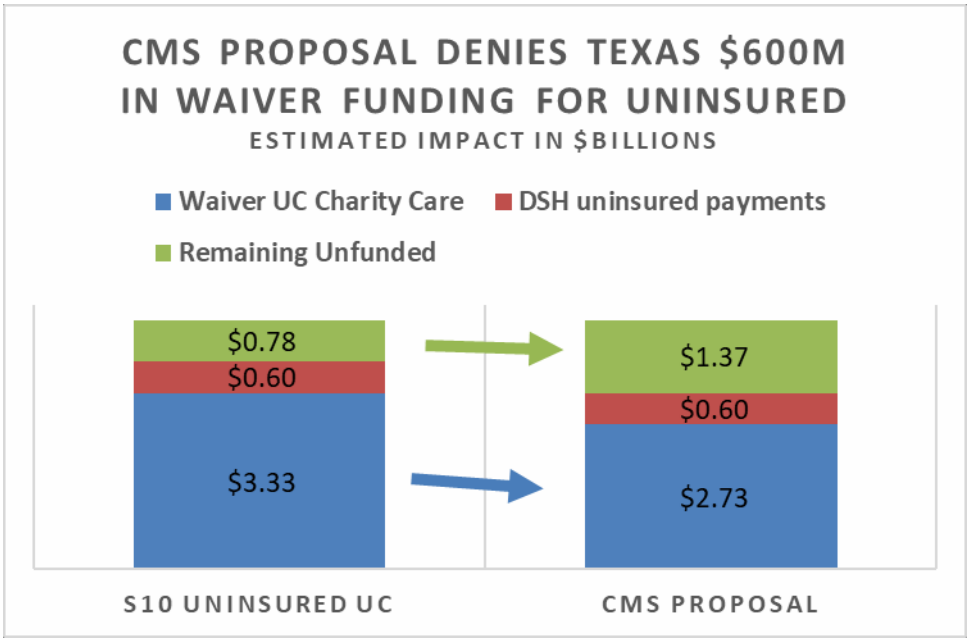
Beginning in 2020, the uncompensated care payment pool available through the Medicaid 1115 Transformation Waiver will be resized based on a new methodology. According to the Waiver Standard Terms and Conditions approved in December 2017, total uncompensated care funding will be based on uninsured charity care costs reported on schedule S-10 of 2017 Medicare cost reports (or a proxy for hospitals that do not use the S-10).

CMS recently shared its proposed methodology for uncompensated care pool resizing with the Texas Health and Human Services Commission. That methodology will further reduce the agreed-upon S-10 reported uncompensated care costs. **Based on this proposal, available uncompensated care pool funding could be reduced by an estimated $600 million per year.** As a result, Texas hospitals' unfunded uninsured care costs (after supplemental payments) would increase from an estimated $780 million to an estimated $1.37 billion based on recent data. Unfunded uninsured costs would be even larger in 2020 when the change would be in effect and increase annually thereafter.

CMS' methodology reduces a hospital's total charity care costs by the charity care component of Medicaid DSH payments (what CMS calls "overpayments".[i]) For example, a hospital with Medicaid DSH payments that exceed its Medicaid payment shortfall by $1 million will have its reported charity care costs reduced by $1 million. Approximately 100 Texas hospitals will be deemed to have "overpayments" in Medicaid, 20 of which account for 80 percent of the "overpayments." This includes four state hospitals.

The result of CMS' methodology is that the total UC funding pool will be reduced.

According to CMS, this reduction for "overpayments" is a standard policy applied to four other states that have UC or low-income payment pools through an 1115 Waiver (California, Florida, Massachusetts and Tennessee).



CMS proposes to reduce Texas' UC waiver pool by an estimated $600M, increasing Texas' estimated unfunded uninsured UC costs. Sources: Texas 2017 UC reports indicate $4.7 billion in unfunded uninsured UC costs. HHSC initial models show $3.3 billion of that in S10 uninsured charity care costs and $597 or nearly $600 million in "overpayments" that CMS would reduce from Texas' UC pool, leaving Texas with an estimated 1.37 billion in unfunded costs.

CMS' proposed methodology and rationale are flawed for several reasons:

1. The Waiver STCs and state-proposed UC payment methodologies already prohibit "overpayments". Hospitals that participate in both Medicaid DSH and UC already cannot be paid more than their total eligible costs. CMS' proposed methodology double counts DSH payments, to the detriment of all hospitals that participate in the UC pool.

2. Deeming a hospital to have "overpayments" in Medicaid and reducing its eligible charity care costs by using a share of Medicaid DSH payment ignores the fact that Medicaid DSH payments are intended to compensate for more than UC pool-qualifying uninsured care costs. Medicaid DSH payments, in part, compensate for Medicaid shortfall costs and other uninsured costs that do not qualify under the new UC pool definition but are bona fide DSH eligible costs.

3. CMS' methodology only counts data from hospitals where there is an excess payment that will reduce the UC pool. It does not count data from hospitals that still would have unfunded costs. Instead of cutting the UC pool by the Texas total non-shortfall share DSH payments, CMS only includes data from those hospitals that will reduce the UC pool. In effect, rather than averaging, CMS is selecting only a subgroup of hospital data to reduce the pool size.

4. Applying a blanket policy across all states with UC or low-income pools through an 1115 Waiver ignores the intent and purpose of 1115 Waivers, which are intended to be reflective of an individual state's characteristics and needs and support state-specific solutions. Texas is unique in its size, geography, demographics, economy and has relied on its Medicaid 1115 Waiver to support hospitals in providing care to the uninsured and low-income populations, both of which are growing as the state's population grows.

5. CMS has not demonstrated that the funding policy actually has been applied to other states. According to the Texas Health and Human Services Commission, three of the states cited by CMS are unaware of the details of how CMS calculated and sized their UC/low-income pools, and CMS has yet to provide these other states' calculations to the agency. Further, all other states include DSH in their Waivers.[ii] Texas is unique as its 1115 Waiver always has excluded DSH.

6. CMS' methodology also reduces the UC pool size based on Graduate Medical Education payments, even though the UC pool, by CMS' requirement, excludes those same GME costs.

Again, we very much appreciate your longstanding support of the 1115 Medicaid Transformation Waiver as it is fundamental to our ability to provide the best care to all Texans. We recognize the complexities of the issues under discussion and encourage you to contact any of us for more information. As always, we are ready to assist in any way needed.

Sincerely,

John Henderson
President
Texas Organization of Rural and Community Hospitals

Maureen Milligan, Ph.D.
President/CEO
Teaching Hospitals of Texas

Ted Shaw
President/CEO
Texas Hospital Association

Larry Tonn
Texas Association of Voluntary Hospitals

Stacy Wilson, J.D.
President
Children's Hospital Association of Texas

---

[i] CMS defines this as the Medicaid DSH payments that exceed the Medicaid payment shortfall; but only for hospitals with DSH UC payments exceeding their shortfalls.

[ii] While Tennessee officially has no DSH program the waiver STCs do include shadow DSH payments reflecting the value of historical DSH funding