TEXAS SUPPLEMENTAL PAYMENTS: HOW DID WE GET HERE? WHERE ARE WE GOING? HOW IS MY COUNTY IMPACTED?

AHCV

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TEXAS SUPPLEMENTAL PAYMENTS: HOW DID WE GET HERE?

I. History: How Indigent Care Departments Transformed the Texas Healthcare Safety-Net System.

History: How County Indigent Care Departments Transformed The Texas Healthcare Safety-Net

- Counties and their indigent care departments strengthened their local safety-net systems by helping to fund supplemental payment programs for their local providers.
  - The Medicaid Upper Payment Limit Program (UPL)
  - The Texas 1115 Waiver
- Counties created innovative funding mechanisms to help access the federal funds that were available to local providers
  - The Past (2006)- “charity care expansion”, “expense alleviation”
  - The Future (2013)- The Local Provider Participation Fund (LPPF).

ELEMENTS OF THE WAIVER

- End of UPL (Public, Private, Rural) Payments and Supplemental Physician Payments
- Creation of New Payment Pools to Allow Continued Payments in Managed Care Context - $29 Billion
  - Uncompensated Care (UC) Pool - $17.6 Billion
  - Delivery System Reform Incentive Payment (DSRIP) Pool - $11.4 Billion
- Non-Federal Share Funded by Local Governmental Entities Not the State
- Created Regional Healthcare Partnerships (RHPs)

TEXAS SUPPLEMENTAL PAYMENTS: WHERE ARE WE?

II. Current issues involving the availability of supplemental payments to your local safety-net hospitals

WHAT IS THE STATUS OF THE WAIVER?

- Formally submitted July 15, 2011
- Proposed effective date September 1, 2011
- HHSC and CMS agreement in principle September 14, 2011
  - Permission for Texas to move forward with managed care expansion under existing Section 1115 waiver authority
- Final approval received December 12, 2011
- Extended through December 2017
- HHSC expecting a five year extension.

WHAT IS THE DALLAS DISALLOWANCE, AND HOW DOES IT IMPACT MY COUNTY?

- **What is the Dallas Disallowance:**
  - CMS disallowed $27 Million of federal funding that was paid to providers in Dallas County. Disallowance at DAB.
  - CMS alleges that the private hospitals in Dallas were funded by impermissible provider donations.
  - CMS refused to reconsider the disallowance even though there is documentation explicitly saying that the transaction is permissible. CMS and Texas agreed to 45 day stay.
- **How does this impact my county?**
  - Jurisdictions with should review their structure to see if they are impacted. LPPF counties are not at risk.
  - Are my county's ad valorem property taxes at risk if we are using the county's traditional budget for IGTs?

TEXAS SUPPLEMENTAL PAYMENTS: WHERE ARE WE GOING?

III. The Future: Where is Texas headed, and how can counties prepare for the new world of Texas healthcare funding?

THE LOCAL PROVIDER PARTICIPATION FUND ("LPPF")

- **Assessing the availability of supplemental payments for local safety-net providers.**
  - Counties with hospital districts were able to claim 100% of the funding available to their providers. Counties without hospital districts were only able to access between 12%-15% of the available funding. Today, hospital districts are abandoning the old model and replacing it with the LPPF.
  - Safety-net providers accessed 100% of available funds without raising taxes, without touching $1 of ad valorem property tax revenue, and without asking the State for $1 of their money.
- **What is the LPPF?**
  - The LPPF is a county administered fund that is utilized to help local safety-net providers access supplemental payments.
  - The only organizations that can pay into the fund are the hospitals in your counties. Individual taxpayers do not pay $1.
  - LPPF must comply with federal healthcare and tax regulations.
- **What jurisdictions have LPPFs?**
  - Counties: Hidalgo, Cameron, Webb, Bell, Gregg, Brazos, McLennan, Bowie, Hays, Cherokee, Smith, Angelina, Williamson, Tom Green, Grayson and Potter
  - City: Beaumont
  - Hospital Districts: Dallas County Hospital District (Parkland), Tarrant County Hospital District (JPS), and Amarillo Hospital District
- **Who can legally pursue LPPFs?**
  - Counties with more than one hospital
  - Cities with more than one hospital (county and city may not both have LPPFs)
  - Hospital districts

Uniform Rate Improvement Program (UHRIP)Final Rule

- UHRIP Final Rule (published March 31, 2017) provides:
  - when HHSC will direct an MCO to provide a uniform percentage rate increase to hospitals in the MCO's network in a designated service delivery area ("SDA"); and
  - how HHSC will calculate and administer such a rate increase.
- HHSC may direct the MCOs to increase rates for all or a subset of inpatient services, all or a subset of outpatient services, or all or a subset of both, based on the service or services that will best advance the goals and objectives of HHSC's quality strategy.

UHRIP Authorized Class of Providers

- HHSC may direct MCOs in a SDA to provide a uniform percentage rate increase to one or more of the following classes of hospitals:
  - children's hospitals;
  - non-urban public hospitals;
  - rural hospitals;
  - state-owned hospitals;
  - urban public hospitals;
  - institutions for mental diseases; and
  - all other hospitals.
- If HHSC directs rate increases to more than one class within the SDA, the percentage rate increases may vary between classes of hospital.

UHRIP Application

- On February 1, 2017, HHSC released the UHRIP Application.
  - Sponsoring governmental entities submitted applications on March 1, 2017.
  - All SDAs except for the Travis submitted applications
- Originally, applications submitted by March 1 were intended to apply to SDAs that were prepared to start September 1.
  - HHSC informed industry representatives on April 28 that UHRIP would not be operationalized on September 1. HHSC delayed the start date to March 1, 2018.
- SDAs received significant haircuts due to the small size of the Pool.
- HHSC released new UHRIP applications October 16, 2017. Applications were due October 23, 2017.
- HHSC will release final UHRIP IGT number on October 30, 2017. IGTs are due November 3, 2017.

Issue 1- Budget Neutrality

- Challenge: HHSC limited the size of the pool from $800 million to $600 million.
  - In order to comply with waiver budget neutrality, the pool was limited
- Solution: Identify and communicate the correct budget neutrality numbers.
  - Last summer, the AHCV team estimated that Texas had $2.4 Billion under the budget neutrality cap.
  - How can the industry get HHSC to acknowledge the difference between their estimates and what we believe is correct?
  - The industry needs support from key state leaders
  - At the very least, the delay should not result in a diminishment of HHSC's commitment to UHRIP

Issue 2- Data Challenges & Cash Flow

- Challenge: Receiving accurate data to establish rates and arrange IGTs.
  - Estimating the percentage increase is difficult because HHSC is relying on historical data.
  - In some areas, we were unable to set mandatory payment rates because we did not want to overshoot the need and cause potential cash flow problems for providers.
  - IGTS are due 72 hours after the numbers are released.
- Solution: Delay LPPF Mandatory Payment rate setting until data are final.
  - Counties should be cautious in setting the rate to quickly.
  - Setting mandatory payment rates before data is final can create significant challenges.

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Issue 3- Coordinating IGTs When Multiple Counties Are Funding UHRIP For The SDA

- Challenge: Counties that typically do not collaborate are required to work together to coordinate UHRIP funding.
  - Each SDA elected a UHRIP liaison. The liaison is required to communicate with all hospitals and counties involved in the SDA.
  - Coordination of the SDA requires significant work.
- Solution: Work with your local providers to gather all necessary data and rely on their relationships with sister facilities.
  - Most SDAs include large geographic areas. Very few SDAs find it easy to find all necessary contacts.

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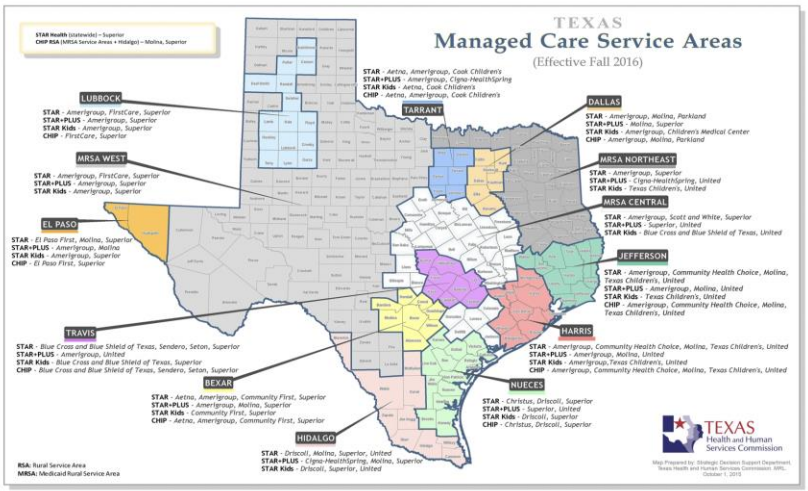
Map of All Texas Medicaid Managed Care Service Delivery Areas (SDAs)



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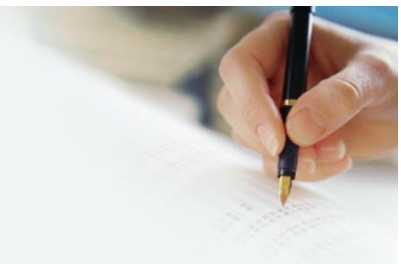

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