TEACHING HOSPITALS of TEXAS

THOT Members

AUSTIN
Central Health
Seton Healthcare Family

CORPUS CHRISTI
CHRISTUS Spohn Health System
Nueces County Hospital District

DALLAS
Children's Medical Center
Parkland Health & Hospital System
The University of Texas Southwestern Medical Center

EL PASO
University Medical Center of El Paso

FORT WORTH
JPS Health Network

GALVESTON
The University of Texas Medical Branch

HOUSTON
Harris Health System
The University of Texas MD Anderson Cancer Center

LUBBOCK
UMC Health System of Lubbock

MIDLAND
Midland Memorial Hospital

ODESSA
Medical Center Health System

SAN ANTONIO
University Health System

TYLER
UT Health Northeast

July 29, 2016

TO: HMA

FROM: Teaching Hospitals of Texas

RE: Comments on 7.26.16 UC study discussion

Thank you for the opportunity to participate in a discussion of the Texas UC study and to provide comments. Regarding whether payments in DSH and UC for projected amounts and for current payments should reflect the IGT provided by IGTing entities, we believe that the IGT should be identified. Both DSH and UC payments should be included to show both gross and net payments. Net would be defined as the total payments less IGT contributions. Without identifying the IGT contributions, conclusions about the funds received will be skewed to the detriment both of IGTing entities, all hospitals and the state in work with CMS.

In its 2016 report to Congress, MACPAC identifies the issue of not identifying gross vs. net payments: "Additionally, neither the Medicare cost report nor the Medicaid DSH audit fully account for the non-federal share of Medicaid payments that is contributed by hospitals themselves, resulting in a potential overstatement of the net amount of Medicaid payments that hospitals receive. Although hospital provider taxes are included in calculations of Medicaid costs, intergovernmental transfers (IGTs) and certified public expenditures (CPEs) are not. **The amount of money represented by this absence is significant:** in 2012 about two-thirds of DSH payments were financed by non-state sources of funding and eight states used non-state funds to finance more than 90 percent of their DSH payments (GAO 2014)."[1] IGT in Texas is also significant. In Texas, when DSRIP payments are included, IGTs account for more than half of the state match used to fund **all Medicaid hospital payments**.

The California UC study performed by Navigant also references this issue noting that "for services where the non-Federal portion of funding is satisfied through CPEs and IGTs, **the DPH hospitals do not receive the full economic benefit of amounts claimed** by DHCS through the claim (base) payments, DSH and SNCP and UCP for purposes of claiming FMAP. In other words, since the non-Federal portion of these services are

[1] MACPAC Report to Congress on Disproportionate Share Hospital Payments, February, 2016; pp.43-43.

satisfied by the hospital or other related local funding sources, the net economic benefit for a substantial proportion of Medicaid and uninsured services provided by these hospitals equates to only half of the amounts claimed by DHCS."[2]

Not including the value of IGT in the report would both fail to capture the true financial impacts of UC, but could raise questions regarding why IGT is not included as it was in the Navigant report and as highlighted by MACPAC.

It's our understanding that HMA plans to provide information to CMS regarding the validity of the different data sources (DSHS annual survey, S10, and the HHSC DSH/UC data). Your inclusion of the pros/cons of the different data sets for accurately and validly measuring UC is very important both for documentation to CMS and for subsequent discussions should CMS choose to use a data set that has less validity than other available data sets.

Finally, it is important to note the impact of the loss of funding to essential hospitals. Essential hospitals provide a significant amount of care to Medicaid and uninsured individuals, and are also significant providers of other community, state and national health resources such as: graduate medical education, trauma and disaster planning, response, and management; care coordination and public health engagement and investment. While all hospitals that receive UC will be affected by a reduction in UC, the impact will be most severe for those hospitals and health systems that individually provide a disproportionate amount of care to Medicaid and uninsured individuals.

For individual hospitals with Medicaid and uninsured representing, for example 40 – 80 percent of the patient days, the impact of reduced UC will be more significant than for those individual hospitals with much smaller percentages of Medicaid and uninsured. Beyond the impact to these individual essential hospitals, the loss of UC also will affect community, state and national health resources now provided by essential hospitals: trauma care and disaster planning, response and management; graduate medical education, care coordination and outpatient care, and public health investment. Navigant's report highlights this phenomenon in California on page 28. The same phenomenon exists in Texas.

Thank you for the excellent work you are doing in Texas and for the opportunity to provide input. Please let me know if you have any questions or need information that might be helpful.

Sincerely,

Maureen Milligan
President/CEO
Teaching Hospitals of Texas.

cc: Pam McDonald; Ardas Khalsa

[2] Navigant: Evaluation of Uncompensated Care Financing for California Designated Public Hospitals. May 15, 2016, p. 27.