In current modeling, there are a number of assumptions made that collectively reflect public safety net hospitals in ways that are probably not accurate and could skew decision making without context –

1) IGT and LPPF:
2) Inclusion of NAIP and DSRIP – costs that are not captured in the cost reports; and aren't included in hospital cost reports – so you are offsetting unrelated

NAIP – payments should be excluded from HHSC's payment to cost analysis.

Rationale: NAIP payments, even when made to hospitals, are for Part B physician services and not for hospital services. These costs are excluded from cost reporting; therefor payments should also be excluded to avoid skewing payment/cost analysis.

DSRIP – payments should be excluded from HHSC's payment to cost analysis.

Rational: DSRIP includes funding for costs also excluded from hospital cost reports including:

- Professional services e.g., physician costs, e.g., when providers seek to improve access to primary and particularly specialty providers and fund physician payments. These costs are not reflected in hospital cost reporting.
- Community based costs, e.g., paramedic costs for services to reduce unnecessary ED costs, community based organization services, e.g., homeless shelter improvements and programs; mobile dental clinics; community based care managementMilligan2, etc. and other costs for services representing an expansion of services never performed in a hospital and not reported but which support innovation and access to needed care including factors affecting social determinants of care.

Issues with HHSC's Calculation of Cost-to-Revenue Percentages

HHSC has created a file that compares hospital costs and payments over time for various classes of hospitals. The information presented in this file is misleading and disadvantages public hospitals due to the two factors described below.

1) Per 1 TAC 355.8065(h)(2)(C) Pool Three: DSH payments to Urban public hospitals – Class one and Class two and non-urban public hospitals include repayment of the IGTs for DSH payments received by HHSC from these hospitals that support DSH payments to <u>all</u> hospitals. These payments are in addition to the payments of the federal matching funds associated with the IGTs which are available to all hospital classes. Per HHSC, the revenues accruing from the repayment of IGTs are included in payments used in their calculations of percentage of costs covered over time.[1] This inclusion overstates the revenues of IGT entities used in HHSC's calculations by approximately $173 million. There is no similar impact for private hospitals contributing to LPPFs because LPPF funds are statutorily prohibited from supporting the DSH program.

[1] See "Hospital Costs and Payments Over Time (Including DSRIP)", HHSC Provider Finance Department, September 16, 2020

2) Per the combined DSH/UC Application (TxHUC), hospitals are to report their payments to their local provider participation funds (LPPF) allocated to Medicaid and uninsured care as DSH and UC eligible costs (UC eligible costs are limited to those associated with charity care)[2]. These LPPF costs are included in HHSC's calculations of percentage of costs covered over time further skewing comparisons of cost coverage across various classes of hospitals.

As a result of these two issues, e.g., IGT entities having their repayment of IGTs, which pull down federal funds for both public and private hospitals, included in their revenues and private hospitals having their Medicaid/UI LPPF payments included in their costs, the results presented in HHSC's "Hospital Costs and Payments Over Time (Including DSRIP)" are misleading. While it might be difficult for HHSC to remove LPPF its analyses, removal of IGT repayments is fairly straightforward since they are recorded as separate payments under the DSH methodology.

[2] Hospital Data" tab of the TxHUC, Section 6.7: "For hospitals who pay a local provider participation cost in their counties, this cost must be isolated to the portion of the LPPF that is paid for Medicaid/uninsured care. Providers may use a ratio of Medicaid/uninsured to total charges, payments, or days to calculate the portion of the LPPF tax that can be claimed."