TEACHING HOSPITALS of TEXAS

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RIO GRANDE VALLEY - EDINBURG
Doctors Hospital at Renaissance

September 30, 2020

House Committee on Appropriations, Article II Subcommittee
Texas Capitol – E1.032
Austin, TX 78701

RE: Interim Charge 3 – Review the ability of hospital finance methods, including trauma funding, graduate medical education payments, and supplemental payment programs, to support all hospitals in Texas (including rural and children's hospitals), and the potential impact from state and federal budgetary changes.

Chair Davis and Members of the Committee,

Thank you for the opportunity to provide information relating to Interim Charge 3. The Teaching Hospitals of Texas members include large public urban teaching hospitals and several affiliated non-profit health systems sharing three core commitments. They provide quality care to all, in particular vulnerable Texans; prepare for and provide trauma and disaster services and care; and support Texas' health care workforce and graduate medical education (GME) as well as clinical and delivery system research and transformation.

As you know, hospital financing in Texas is a web of funding streams interwoven to provide stability and help maintain access for Medicaid clients and others to hospital care in Texas. Hospital financing is made up of Medicaid base rates funded by general revenue and federal matching funds, Medicaid add-on payments for trauma, safety-net, and rural hospitals funded by dedicated general revenue and federal matching funds, and supplemental payments funded by local intergovernmental transfers (IGTs) and federal matching funds. Still, after receiving these various Medicaid payments, hospitals continue to have Medicaid allowable costs that are unfunded.

The most straightforward way to assess the ability of Medicaid payments to support hospitals is to follow the Centers for Medicare and Medicaid Services' (CMS) approach. CMS compares Medicaid base and supplemental payments to Medicaid allowable costs. That basic approach is used by CMS, HHSC, and auditors reviewing Medicaid payments and costs. These are also core reporting elements in hospitals' reports to HHSC used for Disproportionate Care Hospital (DSH) and Uncompensated Care (UC) payment allocations. Using this standardized and auditable approach to assessing the ability of Medicaid payments to support hospitals provides a standardized benchmark and basis for comparing sufficiency of Medicaid payments for the industry as a whole and for particular hospital groups such as private, public, children's, and rural hospitals.

A complexity in performing these analyses is the fact that a significant portion of Texas' Medicaid hospital payments are self-funded by the hospital industry, either through local provider participation funds (LFFPs) or hospital district intergovernmental transfers (IGTs). Public IGTs are unique because the IGTs (which were used to draw down federal matching funds for these public hospitals and, in the DSH program, for private hospitals as well) are required to be reported as a payment while the costs of IGTs are not considered. Simply put, calculation of payment-to-cost ratios for hospitals controlled by hospital districts is distorted because it includes payment of IGTs without including associated costs. By way of comparison, LPPF costs and payments are both captured at an aggregate level in Medicaid reported data which avoids the types of distortions described above for public hospitals.[1]

Using data provided by HHSC, we compared Medicaid base and supplemental payments to allowable Medicaid costs and uninsured costs for Medicaid-allowable services[2]. We also reduced payments by IGT contributions, since not excluding those payments skews the actual net payments (and pay ratios) that IGT contributors receive. (Including IGT as a payment inflates the payment-to-cost ratio since IGT payments are included in the calculation but IGT costs are not.)

Based on that analysis, in 2020, no hospital group received Medicaid payments that covered their Medicaid allowable costs. The historical data shows movement by hospital groups that reflect federal Medicaid and state financial policy changes over time. (For example, in 2018 and 2019, HHSC decided that in its calculations of DSH and UC funding, it would ignore commercial and Medicare payments made for Medicaid patients. The data show hospitals with fewer commercially covered Medicaid patients, like public hospitals, having a significant reduction in payments-to-costs ratios, while hospitals that have a higher share of Medicaid patients who also have commercial and Medicare insurance (like Children's hospitals) having a decreased payment-to-cost ratio in those years. Similarly in 2020, when the CMS directed that waiver UC funding only be used as a source of funding for charity care patients (and HHSC followed suit), hospital groups with more charity care saw an increase in their pay/cost ratios while those with fewer charity care (like Children's hospitals) saw a reduction in pay/cost ratios.)

Any assessment of state hospital financing's ability to support all hospitals in Texas must have a comparator: an objective standard to assess and answer that question. We believe that using CMS' approach and adjusting it for IGTs (which otherwise show up as payments, but not as costs), is the best approach. THOT therefore recommends that an assessment of the degree to which hospital finance methods support hospitals start with a reliable industry benchmark; i.e., the percentage of Medicaid payments to Medicaid allowable costs. As noted above, our assessment shows that no Texas hospital group is supported above its Medicaid allowable costs. This means that comparing Medicaid costs to payments for hospitals shows payments insufficient to support Medicaid costs. As a policy, to be sustainable, hospitals should receive Medicaid payments that, at a minimum, cover their Medicaid costs.

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[1] Hospitals providing LPPFs to support Medicaid do include the costs of those LPPFs in their reporting, and the payments related to LPPF financing in Medicaid are also included. Since within an SDA, the costs of these LPPFs and the payments including LPPFs are both captured, a payment/cost calculation should accurately reflect payments and costs at an aggregate level for hospitals providing LPPFs.

[2] Both payments and costs related to DSRIP are excluded from this analysis. CMS excludes DSRIP payments from its calculations because DSRIP is not a cost-based program. In addition, the costs of DSRIP programs are not reported to HHSC and are not accounted for in HHSC's data. In Texas' 2016 UC Report to CMS, provided to CMS as a waiver requirement, DSRIP payments were not included in an analysis of Medicaid allowable payments to Medicaid allowable costs. https://www.healthmanagement.com/knowledge-share/briefs-reports/report-evaluates-uncompensated-care-medicaid-payments-texas-hospitals/

Using this equitable approach to determine the ability of Medicaid payments to support Medicaid costs, urban public hospitals are shown to be among the lowest pay/cost hospital classes. Federal policy targets public safety net hospitals for higher payments, e.g., in the DSH program and legislative history, because public hospitals have more uninsured non-paying patients, often have unfunded GME teaching missions, and have other "public good" costs that are typically not adequately supported. (For example disaster, trauma, and public health planning and response.) Yet in Texas, public hospitals have lower Medicaid pay/cost ratios.

THOT also recommends that any variance by hospital group in the pay/cost ratio should be based on an explicit policy basis. For example, maintaining continued rural access to critical care could be the state's rationale for a higher pay/cost ratio for rural hospitals.

Thank you for your consideration of these comments. Please let me know if you have any questions or if we can be of assistance to the Committee.

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Appendix:

Medicaid Base Payments

In Texas, Medicaid base payments funded by general revenue to hospitals cover on average only 69 percent of hospital costs, according to the most recently published state public data. Some hospital types receive less than the average, for example large urban public hospitals received just over 50 percent of their Medicaid costs.

During the last legislative session, children's hospitals and rural hospitals received additional funding to increase their base payments. Children's hospitals through the supplemental appropriations bill received an additional $50 million in general revenue for a rate increase in Medicaid. Legislation also directed HHSC to evaluate rural hospital rates and develop a plan to ensure citizens in rural areas of the state have access to hospital services. HHSC has developed a minimum fee schedule to require Managed Care Organizations to pay at least this rate to rural hospitals.

Add on Payments

In addition to base rates, add on payments play a critical role in maintaining the hospital safety net. The Legislature created a dedicated revenue stream for trauma funding and has also directed that some of this funding be used for a safety-net and a rural hospital add on.

Trauma systems are ready 24/7 for our first responders and for all Texans. Today, more than 280 designated trauma facilities statewide provide care related to more than 120,000 trauma incidents each year.[3] These include motor vehicle crashes, assaults, falls and any kind of traumatic injury requiring immediate medical attention.

A coordinated system of care is necessary to make sure that patients can be transported, received and cared for at the appropriate level of care within 60 minutes, also known as the golden hour, for medical intervention to be most effective in saving lives and saving function.[4]

The Texas trauma system has been highly effective at saving lives. The state's trauma case fatality rates and overall mortality rates are lower than the national average. These life-saving successes would not be possible without a strong statewide trauma system and dedicated trauma care funding. Even with the trauma funding about $100 million in uncompensated trauma care remains annually.

The safety net add on is directed to hospitals serving a large number of Medicaid clients, including many children's hospitals.

Supplemental Payments

Since Medicaid base payments only cover on average 69 percent of costs, the hospital safety net is very dependent on intergovernmental transfer funded supplemental payments.

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[3] Texas Department of State Health Services. "*Texas Trauma System: Presentation to the House Appropriations Committee Article II;" DSHS.* July 13, 2016. https://www.dshs.texas.gov/emstraumasystems/etrauma.shtm

[4] American College of Surgeons: https://www.facs.org/quality%20programs/trauma

Supplemental payments include uncompensated care (UC), the uniform hospital rate enhancement program (UHRIP), and graduate medical education (GME). The state also has supplemental payment programs to increase access to primary care and for quality improvements in nursing facilities.

Recently the UC pool, which previously covered Medicaid shortfall and uncompensated care, methodology was changed to comply with federal requirements from the Center for Medicaid and Medicare Services (CMS). The pool now only funds uncompensated charity care, and as a result funding distribution has shifted from historic allocations to those hospitals providing charity care.

In order to help fill some of the Medicaid costs no longer covered in uncompensated care pool, HHSC negotiated with CMS to increase the uniform rate increase program from $1.6 billion to $2.67 billion. This increase will help hospitals with large Medicaid losses (Medicaid shortfall) cover these costs.

The graduate medical education (GME) supplemental payment program allows teaching hospitals to access federal funding to help cover their losses associated with direct costs of running graduate medical education programs. Prior to this program, GME was underfunded in the state as Medicare was the primary payor for these programs. $400M was the estimated annual GME losses per year to Texas teaching hospitals. These payments help cover a portion of these losses. While the program is currently limited to state and public teaching hospitals, HHSC has submitted a state plan amendment to CMS for the addition of private teaching hospitals but the method of finance appears to be an issue that is stalling this program from moving forward.