Hospital Uncompensated Care Report

As Required by
2020-2021 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 4)

Health and Human Services Commission

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Executive Summary

Uncompensated care (UC) costs and reimbursements can have a major impact on the hospitals that are serving indigent persons and Medicaid recipients as well as the multiple levels of government that reimburse facilities for these costs. UC costs continue to increase, and funding is inadequate to attenuate the deficits hospitals face.

The 2020-2021 General Appropriations Act, House Bill (H.B.) 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 4) stipulates that:

> *No funds appropriated above for medical assistance payments may be paid to a hospital if the Health and Human Services Commission (HHSC) determines that the hospital has not complied with the commission's reporting requirements. HHSC shall ensure that the reporting of uncompensated care by Texas hospitals is consistent for all hospitals and subjected to a standard set of adjustments that account for payments to hospitals that are intended to reimburse uncompensated care. These adjustments are to be made in such a way that a reliable determination of the actual cost of uncompensated care in Texas is produced.*
>
> *The Commission shall conduct an appropriate number of audits to assure the accurate reporting of uncompensated hospital care costs.*
>
> *HHSC shall submit a biennial report on uncompensated care costs to the Governor and Legislative Budget Board no later than December 1, 2020, which details the impact of healthcare reform efforts on the funding streams that reimburse uncompensated care and assess the need for those funding streams in future biennia. HHSC may report by hospital type. Although HHSC must report on all Texas hospitals, HHSC may use the most accurate data available for each hospital.*

1. Introduction

Each year, Texas hospitals provide services to Medicaid and indigent persons, resulting in approximately $21.4 billion in cost-of-care. HHSC administers various programs that hospitals utilize to reimburse these costs. These reimbursement streams include both patient-specific and lump-sum supplemental payment programs. Using federal fiscal year (FFY) 2018 Managed Care Organization (MCO) payments to approximate 2020 payment amounts, hospitals are estimated to receive:

1. Patient-Specific Payments:
   a. Medicaid fee-for-service (FFS) base payments – $1.16 billion in 2018
   b. MCO payments – $5.1 billion in 2018
   c. Uniform Hospital Rate Increase Program (UHRIP) – $1.6 billion in 2020[1]

2. Supplemental Payments:
   a. Disproportionate Share Hospital (DSH) – $1.8 billion in 2020[2]
   b. UC – $3.9 billion[3] in 2020
   c. Graduate Medical Education (GME) – $118.9 million in 2020

This report details the impact of these payments by the following hospital types: state-owned, public, private, rural, and children's hospitals. Medicaid claims payment databases and historical audits performed by independent auditors for HHSC produced most of the underlying data used in this report. Uncompensated cost continues to grow, and these funding streams remain a necessity.

[1] In state fiscal year (SFY) 2021, payments are estimated to increase to $2.67 billion
[2] In SFY 2021, payments may be reduced due to required federal reductions to the federal funding allotments, as required by the Affordable Care Act.
[3] The UC program also makes payments to non-hospital providers (public emergency medical services, certain physician practice groups, and public dental practices) and this amount represents the total available pool for all provider types.

2. Background

2.1 Current System for Uncompensated Care

UC is an overall measure of hospital care provided for which no payment was received from the patient or insurer. These payment shortages fall into two different categories: charity care and bad debt. Charity care is unreimbursed costs to hospitals for services provided to low income for free or at reduced prices; hospitals assume minimal payment on behalf of the patient. Bad debt refers to uncollectible inpatient and outpatient charges that result from the extension of credit to the patient after the facility expected payment for the care. There is no absolute standard for what constitutes bad debt and charity charges because each hospital has its own methods and standards to categorize whether or not a patient is medically or financially indigent. Charity care costs at one facility may be bad debt at another, depending on the hospital's charity care policy and program.

HHSC sets base reimbursement rates for the Medicaid FFS programs. Reimbursements for inpatient services use a prospective payment methodology based on diagnosis-related groups (DRGs). Outpatient services are reimbursed on a reasonable cost basis using a percentage of the hospital's most recent interim Medicaid cost report settlement. When a Medicaid FFS patient receives a service, the provider bills Texas Medicaid Healthcare Partnership (TMHP) and receives a payment that corresponds with the fee schedule associated with this service. The payments offset a portion of the cost and the remainder is then added to the providers' UC cost. Overall, in 2018, hospitals received roughly $1.16 billion in Medicaid FFS payments.

UC Payments intend to help offset the costs of UC provided by hospitals or other providers to Medicaid clients or individuals who have no sources of third party coverage. Every private hospital that participates in the supplemental payment programs under the 1115 waiver must execute an affiliation agreement with the governmental entity that provides the Intergovernmental Transfer (IGT) for any type of payment (transition, UC, or Delivery System Reform Incentive Payment [DSRIP]).

These UC costs and reimbursements can account for billions of dollars. The possible fiscal impact on hospitals that serve indigent persons and the entities who reimburse the facilities can be significant. An ongoing concern to all major participants is that UC costs continue to increase, while the funding needed to mitigate the losses does not cover the full costs of services for the hospitals.

2.2 Current System for Audits of Uncompensated Hospital Care Cost

On December 19, 2008, the Centers for Medicare and Medicaid Services (CMS) published the Federal DSH Final Rule (*Federal Register, Vol. 73, No. 245)*, effective January 19, 2009. This rule requires states to perform an independent audit of their DSH programs that includes verification of methodologies used to calculate DSH payments. CMS allowed a grace period until 2011 for states to implement the collection payment recoupments. Since the rule's effective date, HHSC has complied with the audit requirement and has made recoupments as required.

DSH funds are different from most other Medicaid payments because they are not tied to specific services for Medicaid-eligible patients. Currently, DSH accounts for $1.8 billion annually in supplemental funding for eligible hospitals. DSH is entirely funded by local governments, unlike the base rates and capitation rates for the Medicaid FFS and MCO programs (discussed in Section 3).

DSH reimburses hospitals based on their hospital-specific limit (HSL), which is their cost of providing care to Medicaid and uninsured patients, minus all payments received for these patients. Of the roughly 600 hospitals in Texas, about 360 apply for DSH funding each year. Only about half (180) qualify to receive payments. DSH is currently funded entirely by local governments that provide the approximate 40 percent non-federal share of the payment. The federal government provides an approximate 60 percent match. Currently, there is no state General Revenue appropriated for any supplemental and directed payment programs, and the state funds base rate FFS and MCO payments through legislative appropriations. As a result, local governments must provide the non-federal share to fund the payments.

Table 1. Medicaid DSH Payment by Class, 2019-2020

Hospital Class	2019 (DY 8)	2020 (DY 9)
Large Public Hospitals	$730,105,411	$622,895,708
Private Rural Hospitals	$29,581,462	$22,999,034
Private Non-Rural Hospitals	$457,344,269	$512,422,707
Children's Hospitals	$97,371,880	$29,599,382
Public Rural Hospitals	$59,899,274	$42,398,162
Public Non-Rural Hospitals	$108,285,550	$115,189,230
State Chest Hospital	$ -	$ -
State Teaching Hospitals	$134,728,479	$88,005,305
State/IMD Hospitals	$272,155,353	$241,666,593
Total	**$1,889,471,679**	**$1,675,176,122**[4]

The UC program uses a similar process for the UC Final Reconciliation as established in Attachment H of the 1115 Healthcare Transformation Waiver (the Waiver). Interim UC payments made to hospitals and physician groups in each demonstration year (DY) are calculated using two-year-old historical data. For each provider, the sum of all payments for patient care services provided to Medicaid recipients and uninsured persons must not exceed the cost of those services. The waiver requires HHSC to perform a reconciliation of interim payments against final eligible payments using actual program year data. Any identified overpayments in the reconciliations must be recouped from providers. The federal portion of the recoupments is returned to CMS, and the state share is returned to the IGT entities (i.e., local governments).

In both the UC and DSH programs, HHSC has a one-year time frame to recoup the overpayments and redistribute them to eligible hospitals. The DSH one-year time frame begins on December 31 with the annual submission of the audit report to CMS. The UC time frame begins with HHSC's acceptance of the reconciliation report, currently recognized as the date of discovery of the overpayment. Failure to meet this redistribution requirement within the required time frame would result in an adjustment to the federal Medicaid payment to the state.

[4] The all funds payments for DSH 2020 (DY 9) were lower because the non-federal share needed to draw the federal funds was reduced due to COVID-19.

3. Hospital Uncompensated Care

3.1 Uncompensated Care Charges and Estimated Costs

3.1.1 Medicaid Cost

Providers may annually apply for the DSH program and UC funding through a joint application that calculates the cost of services through center-specific cost-to-charge ratios (CCRs). Claims data derived from the Healthcare Cost Report Information System (HCRIS) and TMHP ensure the DSH/UC application is capturing appropriate information and that claims adjudication dates fall within the covered FFY for DSH and UC payments.

The application calculates costs through CCRs when providers complete the application with charges that the Medicare Cost Report and TMHP data are unable to determine. To more accurately calculate costs and ensure they fall within acceptable ranges, the application requires charges to be entered per cost center or department; CCRs vary per cost center. Once HHSC staff reviews supporting documentation for self-reported amounts, state payment caps are determined, a payment calculation is performed, and hospitals receive a final payment.

3.1.2 Traditional Uninsured Cost

Traditional uninsured costs refer to those associated with providing inpatient and outpatient hospital services to uninsured persons, or individuals who do not have a third-party payer source. Providers must include these charges in their DSH/UC. It is important to note that there is a clear distinction between uninsured persons and persons who are both uninsured and also qualify for the hospital's charity care policy. Further, providers may only include charges discharged during that particular data year. The DSH/UC application applies CCRs to convert uninsured charges to cost, applies all payments received from or on behalf of the persons, and calculates the remaining uninsured shortfall.

Providers may include the following allowable costs for uninsured persons:

- Discounts for uninsured persons
- Services provided to undocumented residents
- Outpatient pharmacy drugs
- Services provided in an outpatient clinic

Institutions of Mental Disease (IMDs) should report charges for covered Medicaid services provided to Medicaid-eligible persons between the ages of 21 and 65

during the data year. They cannot be reimbursed for care to persons in this age range in the Medicaid shortfall calculation. Institutions should also report facility fees associated with sub-providers providing services to uninsured persons (e.g., rehabilitation services).

Uninsured charges that are not allowed include:

- Services for inmates or other incarcerated individuals
- Outpatient retail pharmacy services
- Physician and professional services not billed under the hospital's Texas Provider Identifier (TPI)
- Services paid for with public employees' worker's compensation programs
- Services that are not medically necessary
- Services paid in total or in part by a third-party payer
- Medicaid or CHIP-eligible individuals
- Services that would not be covered under Medicaid had the patient been Medicaid eligible

3.1.3 Uninsured Charity Care Cost

CMS recently changed the methodology for UC-qualifying persons to require providers to self-report uninsured charity care charges. This change requires persons to qualify for this classification under the hospital's charity care policy, which can be based on criteria including federal poverty guidelines. The application requires providers to distinguish between uninsured charity or non-covered services (i.e., non-covered services for persons with a form of insurance), inpatient charges, and outpatient charges. Providers must also indicate the total inpatient days associated with inpatient services for charity care charges. Providers must only report accounts written off during the data year the application covers.

When considering accounts that fall under both DSH and UC qualifying criteria, providers will inevitably find duplicates, or UC charges that also qualify under DSH criteria. It is imperative to differentiate between these two payment types and avoid including the same persons in both programs. Differentiation avoids both the duplication of DSH and UC payments for the same cost, as well as potential overpayment during the performance of DSH audits and UC reconciliations.

3.2 Impact of Patient-Specific Uncompensated Care Cost Offset Funding

3.2.1 Base Rates

Inpatient services are reimbursed using a prospective payment methodology based on DRGs, while outpatient services are reimbursed on a reasonable cost basis; a

percentage of the hospital's most recent, tentative Medicaid cost report settlement. When a service is provided for a Medicaid FFS patient, the provider bills TMHP and receives a payment that corresponds with the fee schedule associated with this service. The payments are used to offset a portion of the cost, while the remainder is added to the provider's UC cost. Overall, in 2018, hospitals received roughly $1.16 billion in Medicaid FFS payments.

HHSC sets general acute care hospital reimbursement rates for FFS Medicaid clients using a prospective payment system (PPS) based on All Patient Refined Diagnosis Related Groups (APR-DRG) patient classification system. PPS classifies each patient into a DRG based on clinical information. Hospitals are paid a pre-determined rate for each DRG stay, regardless of the actual services provided. The rate calculation uses a formula-based standardized average cost of treating a Medicaid inpatient admission (the Standard Dollar Amount or SDA) and a relative weight for each DRG. "Outlier" payments are made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay. Currently, Medicaid hospital PPS rates are determined for three hospital categories: Urban, Rural, and Children's Hospitals. HHSC reimburses freestanding psychiatric hospitals on a per diem basis.

Urban hospitals are defined as hospitals enrolled as Medicaid providers that are located in a metropolitan statistical area (MSA) and do not meet the criteria of a rural, children's, or freestanding psychiatric hospital. HHSC sets urban hospital base rates by determining a statewide base SDA for all urban hospitals. These hospitals are eligible for an increase to their statewide base SDA through add-ons (SDA add-ons). Currently, urban hospitals may qualify for add-ons related to their geographical wage index, indirect medical education status, trauma designation, and safety-net designation. Current urban hospital rates are based on fiscal year (FY) 2010 Medicaid inpatient claims data inflated to 2013. The rates set (also known as "rebasing") for FY 2013 were established under budget neutrality, with no additional funding. The rates were set to reimburse providers at approximately 55 percent of total cost. SDA add-on information for the urban hospital rates is validated annually for any changes in trauma designation, safety-net status, or teaching status.

According to the Texas Administrative Code (TAC) §355.8052 related to Inpatient Hospital Reimbursement, hospitals may receive an annual SDA adjustment based upon their physical location, trauma designation, and qualification as a safety-net hospital. Further, if qualified, hospitals may also receive a medical education add-on at the beginning of the state fiscal year (SFY). To comply with the rule, HHSC requires verification of the facility-specific information related to these SDA add-ons.

Trauma funds are used for hospital inpatient reimbursement for two separate SDA add-ons. The trauma add-on is for hospitals designated as Trauma level I-IV. The add-ons are incremental depending on the acuity of the trauma level with "IV" being the lowest add-on and "I" being the most acute. The add-on is determined as a percentage of the base SDA. Trauma funds also subsidize the safety-net add-on. It is an SDA add-on for hospitals that meet the definition of a safety-net hospital in the hospital reimbursement TAC. The add-on is determined using an allocation of the funds that are dependent on the number of Medicaid hospital days. These add-ons are to the hospital SDA and are included in each qualifying hospital's inpatient claim reimbursement.

Before September 1, 2013, rural hospitals were cost reimbursed. Starting on that date, rural hospitals began receiving APR-DRG reimbursement pursuant to Texas statute. The rural hospital SDAs are based on their individual hospital cost. The current rural hospital rates were calculated using FY 2010 Medicaid claims data and implemented September 1, 2013 on a budget neutral basis. The rates were inflated to 2014 and have not been updated since that time.

HHSC analysis of rural hospital reimbursement indicates rural hospitals are not being reimbursed all their Medicaid cost. HHSC estimates an increase of approximately $24 million GR for the biennium would be required to bring rural hospital inpatient reimbursement up to cost.

Children's hospitals are Medicaid enrolled hospitals that are designated by Medicare as a children's hospital. On September 1, 2013, children's hospitals transitioned from cost-based reimbursement to APR-DRGs. Children's hospital payments are based on the standardized average cost of treating a Medicaid inpatient admission in a children's hospital. Base rates for children's hospitals are set by determining a statewide base rate for all children's hospitals. The children's hospitals are eligible for an increase to their statewide base SDA through add-ons. Currently children's hospitals may qualify for add-ons related to their geographical wage index, indirect medical education status, and safety-net designation. The current children's hospital SDA rates are based on FY 2011 Medicaid claims data.

3.2.2 Capitated Rates

Medicaid beneficiaries can also receive services through MCOs. Texas utilizes actuarially sound methodologies to develop a per member per month rate, or capitation rate, for each risk group within each of the state's service delivery areas. These capitation rates differ across risk groups and service delivery areas but are the same for each MCO within a service delivery area. Each year, HHSC sets these rates using base year experience data that is adjusted for cost, inflation, and utilization trends. Since most Medicaid clients are enrolled in managed care, MCO

capitation rates are the primary way the state pays for services. As with FFS, providers bill MCOs and receive payments that correspond with their respective contracted rates. MCOs pay providers to administer services to their members and negotiate rates for those services. In 2020, hospitals will receive roughly $5.1 billion total in Medicaid MCO payments.

3.2.3 Uniform Hospital Rate Increase Program (UHRIP)

In FFY 2018, HHSC anticipated the change in UC and enacted UHRIP in conjunction with CMS. Initially, only STAR and STAR+PLUS Medicaid Managed Care Programs participate in UHRIP. UHRIP is a provider payment initiative program through Medicaid MCOs under which a service delivery area may apply to receive an increase in hospital rates for inpatient and outpatient services for all hospitals in a particular class, such as urban public hospitals, children's hospitals, or rural private hospitals. HHSC rolled out a pilot UHRIP program on December 1, 2017, in the El Paso and Bexar managed care service delivery areas. A rollout of UHRIP across the remaining service delivery areas was implemented with effective date from March 1st, 2018.

After demonstrating success in these regions, the pilot program funding grew from $100 million and two service delivery areas to $2.67 billion and all 13 service delivery areas for SFY 2021. UHRIP payments to hospitals are allocated based on a class' collective Medicaid shortfall, in addition to accounting for rate increases requested by providers. Each year during the application process, hospitals can opt in to the program. The hospitals are separated into eight classes across 13 service delivery areas and apply for a collectively increased rate. The uniform rate increase is calculated based on actuarially trended data, and the collective requests of the service delivery area and hospitals in each class. These rate increases are conducted as a percent increase for the rate the MCO pays each hospital per claim. HHSC is currently working with providers to reform UHRIP to ensure that the program addresses the needs of the provider community and by proxy, the clients that HHSC serves.

3.3 Impact of Lump-Sum Supplemental Payments Offset Funding

3.3.1 Medicaid, Traditional Uninsured, and Uninsured Charity Shortfalls

The impact of patient-specific and lump-sum supplemental payment funding has significantly offset the costs hospital providers would otherwise incur by serving Medicaid recipients and uninsured persons. Despite these payments, hospitals continue to incur an estimated $4.5 billion in Medicaid and uninsured shortfall

annually (calculated based on Medicaid Shortfall by (Class + Traditional Uninsured – Uninsured Charity). The tables below represent the estimated cost shortfalls each hospital class is experiencing in FY 2020.

Table 2. Medicaid Shortfall by Class, 2020

Hospital Class	2020 Medicaid Shortfall[5]
Large Public Hospitals	$415,112,961
Private Rural Hospitals	$70,053,404
Private Non-Rural Hospitals	$1,884,031,835
Children's Hospitals	$(16,292,414)
Public Rural Hospitals	$57,519,696
Public Non-Rural Hospitals	$126,429,940
State Chest Hospital	$513,911
State Teaching Hospitals	$97,985,938
State/IMD Hospitals	$72,055,285
Total	**$2,707,410,556**

Table 3. Traditional Uninsured Shortfall by Class, 2020

Hospital Class	2020 Traditional Uninsured Shortfall
Large Public Hospitals	$1,583,082,119
Private Rural Hospitals	$193,852,095
Private Non-Rural Hospitals	$2,527,415,754
Children's Hospitals	$83,756,603
Public Rural Hospitals	$102,722,770
Public Non-Rural Hospitals	$240,215,697
State Chest Hospital	$13,968,715
State Teaching Hospitals	$71,650,044
State/IMD Hospitals	$392,912,718
Total	**$5,209,576,515**

[5] The Medicaid shortfall is calculated as Medicaid FFS and MCO cost less other insurance payments, Medicare payments, and Medicaid FFS/MCO payments including/after UHRIP.

Table 4 - Uninsured Charity Shortfall by Class, 2020

Hospital Class	2020 Uninsured Charity Shortfall[6]
Large Public Hospitals	$1,213,336,126
Private Rural Hospitals	$114,776,318
Private Non-Rural Hospitals	$1,722,956,937
Children's Hospitals	$96,299,863
Public Rural Hospitals	$86,823,095
Public Non-Rural Hospitals	$156,335,723
State Chest Hospital	$511,944
State Teaching Hospitals	$51,145,738
State/IMD Hospitals	$21,811,991
Total	**$3,463,997,735**

3.3.2 Disproportionate Share Hospital (DSH) Program

Federal law requires Medicaid programs to make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. These hospitals are called DSH and receive DSH funding. DSH funds are different from most other Medicaid payments because they are not tied to specific services for Medicaid-eligible patients.

Currently, DSH accounts for $1.8 billion annually in supplemental funding for eligible hospitals. DSH is entirely funded by local governments, unlike the base rates and capitation rates for the Medicaid FFS and MCO programs.

DSH reimburses hospitals based on their HSL, which is their cost of providing care to Medicaid and uninsured patients, minus all payments received for these patients. Of the roughly 600 hospitals in Texas, about 360 apply for DSH funding each year. Only about half (180) qualify to receive payments. DSH is currently funded entirely by local governments that provide the roughly 40 percent non-federal share of the payment. The federal government provides an approximate 60 percent match. Currently, no state General Revenue is appropriated for any supplemental and directed payment programs, and the base rate FFS and MCO payments are funded

[6] The uninsured charity shortfall is the total physician, pharmacy, and uninsured charity cost that are in uncompensated care only and does not include the portion of uninsured that is in both DSH and UC. Therefore Table 3 and Table 4 can be combined to get the total uninsured shortfall for DSH plus UC.

by the state through legislative appropriations. As a result, local governments must provide the non-federal share to fund the payments.

3.3.3 Waiver Payments to Hospitals for Uncompensated Charity Care

Adopted and implemented in 2012, the 1115 Healthcare Transformation Waiver granted Texas the ability to further fund UC costs through the UC program. This program was initially intended to fund UC using the same patient combination that DSH funded, Medicaid recipients, and uninsured persons. DSH has strict eligibility requirements that restrict several hospitals despite their significant Medicaid and uninsured shortfalls. UC was intended to address this issue by allowing hospitals that could not qualify for DSH the opportunity for supplemental reimbursement of their Medicaid and uninsured shortfall. The UC program also provided the opportunity for hospitals to claim costs for directed patient care provided by physicians and mid-level professionals, in addition to costs incurred by hospitals participating in the Texas Vendor Drug program, costs otherwise excluded in DSH.

While hospitals were previously able to report charges and costs for both uninsured and qualifying Medicaid recipients, CMS is implementing a change beginning with the FFY 2020 payments that will only allow hospitals to report costs for uncompensated charity care they have provided. To ensure uniformity, HHSC requires uninsured charity costs meet the charity care guidelines set by the Healthcare Financial Management Association (HFMA).

3.3.4 Graduate Medical Education (GME) Payments

Currently, HHSC administers Medicaid GME supplemental payments to four state owned teaching hospitals: University of Texas (UT) Medical Branch at Galveston, UT Health Science Center at Tyler, UT MD Anderson, and UT Southwestern - Clements. The non-federal share of these GME payments comes from appropriations or patient revenues belonging to the state-owned teaching hospitals that are transferred to HHSC. HHSC draws down the federal match and makes quarterly interim Medicaid GME payments directly to the hospitals based on resident full-time equivalents (FTEs) and inpatient days reported by the hospital. The interim payments are reconciled and cost settled based on audited final cost report data. GME supplemental funding is based on real time data. These programs pay based on two-year-old historical data and are not subject to federal audits or reconciliations. Medicaid GME supplemental payment amounts are calculated annually for each eligible hospital using data from the hospital's most recently submitted cost report. These amounts are divided into two payments per year.

The GME TAC rule was most recently amended in October of 2018 to allow non-state government owned and operated teaching hospitals to receive GME Medicaid supplemental payments, provided that the non-federal share is provided by the governmental entity that owns and operates the hospital. The payment will be based on the number of FTE medical residents, Medicare per resident amount (PRA) reported on CMS Form 2552-10, and the Medicaid inpatient utilization percentage.

HHSC and CMS are currently working on a GME program for private hospitals. The state GME program is successfully promoting growth and reducing the cost burden for teaching hospitals. Therefore, HHSC is looking to expand that benefit to positively impact private Texas teaching hospitals as well.

Table 5 - GME Payment by Class, 2019-2020

Hospital Class	2019 (DY 8)	2020 (DY 9)
Large Public Hospitals	$84,359,191	$81,591,255
Private Rural Hospitals	$ -	$ -
Private Non-Rural Hospitals	$ -	$ -
Children's Hospitals	$ -	$ -
Public Rural Hospitals	$ -	$ -
Public Non-Rural Hospitals	$5,066,941	$5,935,828
State Chest Hospital	$ -	$ -
State Teaching Hospitals	$31,477,991	$31,400,498
State/IMD Hospitals	$ -	$ -
Total	**$120,904,123**	**$118,927,581**

3.4 Healthcare Reform and Future Funding Streams

3.4.1 Medicaid Fiscal Accountability Regulation

On November 18, 2019, CMS proposed the Medicaid Fiscal Accountability Regulation (MFAR), CMS-2393-Pin, an effort to increase transparency, accountability, and oversight of Medicaid dollars. However, on September 14, 2020, CMS withdrew the proposal from the unified agenda due to multiple states' concerns, including Texas, over the rule's unintended consequences. The State of Texas believes that the use and derivation of Medicaid funds should be transparent so that taxpayers and Medicaid clients are able to examine how Medicaid funds are spent. However, the proposed changes to the Medicaid program, including Medicaid

supplemental payments, could have serious consequences to the continued operation of vital healthcare safety nets in Texas due to the vague nature of the proposed changes. The regulation as proposed could negatively impact hospitals, nursing facilities, community mental health centers, schools, and physicians. MFAR could also threaten up to 30 percent of Texas' annual Medicaid spending, including approximately $750 million for rural hospitals.

HHSC believes that portions of the proposed rules may both introduce unnecessary uncertainty and exceed CMS's statutory authority. HHSC does support efforts to have information regarding supplemental payments made widely available. HHSC hopes that CMS will continue to work with stakeholders to find optimal ways to implement greater accountability in these vital programs prior to re-introducing MFAR or a similar regulation for adoption.

Texas HHSC has recently introduced a Local Funds Monitoring Plan, which is our Texas-solution to ensuring transparency and accountability over the use of local funds while also protecting the right for local control to develop locally-driven financial solutions.

3.4.2 DSH Reductions

The Affordable Care Act (ACA) reduced DSH allotments based on the assumption that the expansion of healthcare coverage would reduce the number of uninsured people and result in lower UC costs . The reductions were initially scheduled to begin FFY 2014 but have been delayed repeatedly. On September 23, 2019, CMS released a final rule which reduces DSH allotments from FFY 2020 to 2025, but in November 2019, Congress temporarily delayed the reductions again. According to the final rule, the FFY 2020 reduction to Federal Financial Participation would have been $4 billion, with the subsequent reductions set at $8 billion a year. In the $2 trillion COVID-19 relief plan passed by the Senate in March 2020, the FFY 2020 reductions were eliminated, and the FFY 2021 reductions were reduced to $4 billion.

The national Medicaid and CHIP Payment and Access Commission (MACPAC) recommended that Congress revise the reductions for a gradual implementation, apply reductions to those states that do not spend their entire allotment, and distribute reductions that consider allotment size and the non-elderly low-income population in the state.

The ACA specified that the reductions be implemented to accomplish the following objectives:

- Smaller percentage reductions for low DSH-utilization states
- Larger percentage reductions for states that:
  - Have a low percentage of uninsured individuals

    - Do not target DSH payments to hospitals with high Medicaid in-persons
    - Do not target DSH payments to hospitals with high levels of uncompensated care
- No reduction greater than 90 percent of any state's unreduced DSH allotment

CMS has not yet released estimates on the state-specific effects of a FFY 2021 implementation. However, in March 2019, MACPAC estimated that a $4 billion reduction in total DSH allotment would result in a $440 million reduction (approximately 22.7 percent) for Texas. Reductions in other states range from a 3.8 percent in South Dakota to 46.6 percent in Rhode Island. The federal share of Texas' payment reduction was estimated at $256 million by MACPAC. Using the federal share, Texas approximates the total DSH reduction at $414 million in 2021 and $833 million per year from 2022 to 2025.

3.4.3 Expiring 1115 Transformation Waiver

The enactment of the ACA also provided Texas with the 1115 Transformation Waiver, the vehicle that provides the federal match for UC funding. HHSC has released the final revised Texas UC payment protocol that was submitted to and approved by CMS on July 26, 2018. Many stakeholders provided valuable feedback to HHSC on the preliminary on the preliminary working draft of the protocol that was released on February 23, 2018.

Texas is required by CMS to submit a revised protocol under Special Terms and Conditions (STC) for the Section 1115 Demonstration Waiver renewal. The STCs require a UC protocol that only allows for charity costs allowed under a provider's charity policy (that adhere to the charity care principles of the HFMA - Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers) and also based on Medicare cost principles. The revised protocol was due to CMS no later than March 30, 2018. CMS had 90 calendar days to provide feedback to Texas, and subsequent changes were made based on that feedback. Failure to meet the March 30, 2018, deadline would have resulted in a 20% reduction in expenditure authority in the UC program. HHSC successfully met all required deadlines, preserving 100% of the negotiated funding pool.

There have been extensions to the waiver, but the current extension expires in DY 11, or FFY 2022. HHSC is in the process of submitting a fast-track application for an extension of the 1115 Waiver through FFY 2027, which would sustain the existing UC pool.

4. Conclusion

The impact of patient-specific and lump-sum supplemental payment funding has significantly offset the costs hospital providers would otherwise incur by serving Medicaid and uninsured persons. However, hospitals continue to incur about $4.6 billion in Medicaid and uninsured shortfalls despite these payments. The table below represent the reaming shortfalls each hospital class is experiencing in 2020.

Table 6. Remaining Uncompensated Care Shortfall less all payments by Class, 2020

Hospital Class	2020 (DY 9) Medicaid and Uninsured Cost Less Other Insurance, Medicare, Medicaid FFS/MCO, DSH, UC, and UHRIP Payments (Remaining Uncompensated Cost)
Large Public Hospitals	$1,043,324,786
Private Rural Hospitals	$54,195,935
Private Non-Rural Hospitals	$3,100,375,508
Children's Hospitals	$(128,894,735)
Public Rural Hospitals	$47,297,528
Public Non-Rural Hospitals	$185,863,046
State Chest Hospital	$14,533,820
State Teaching Hospitals	$71,355,442
State/IMD Hospitals	$224,832,203
Total	**$4,612,883,531**

Providers incur this shortfall each year, and it continues to grow each year. The impact of future healthcare reform, like the ACA DSH program allotment reductions, will significantly increase the shortfall each year the allotment lessens.

Future healthcare reform, will significantly increase the shortfall each year if the allotment is decreased. Additionally, reforms like the MFAR could significantly shift the landscape of how local governments fund many of Texas' supplemental payment programs. Due to the growing uncompensated costs incurred by providers and methodology changes regarding program funding, the burden for compensating these costs could shift from local governments to the State. Alternatively, these costs could continue to be uncompensated altogether.

HHSC increased the SFY 2021 UHRIP compared to the SFY 2020 program to the greater of either maintaining the SFY 2020 reimbursement rates for most classes or increasing reimbursement rates to the equivalent of 100% of Medicare for classes that remained below Medicare reimbursement levels. Reimbursement rates without UHRIP only cover part of the cost of caring for Medicaid beneficiaries, and UHRIP will direct reimbursement increases to increase access to high quality care. The resulting pool size related to the method described above for SFY 2021 is $2,690,912,082. Increasing reimbursement rates through this uniform rate increase should support hospitals that are financially stressed in normal times but now require additional and substantial resources to address COVID-19.

Inpatient hospital stays except in state-owned teaching hospitals are reimbursed according to a prospective payment methodology based on DRGs. The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to Texas Medicaid's Utilization Review requirements.

According to TAC §355.8052 related to Inpatient Hospital Reimbursement, hospitals may receive an annual SDA adjustment based upon their physical location, trauma designation, qualification as a safety-net hospital, and if qualified, hospitals may also receive a medical education add-on at the beginning of the SFY. To comply with the rule, HHSC requires verification of the facility-specific information related to these SDA add-ons.

To comply with the 2020-21 General Appropriations Act H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Riders 11 and 28) relating to rural hospital reimbursement, HHSC will implement the following:

- Rider 11 subsection (d) directs HHSC to provide increases to inpatient SDAs for rural hospitals by trending forward to 2020 using an inflationary factor. Rural rates effective September 1, 2019 will include a 17.68% increase in the SDA for each hospital. Additionally, subsection (e) of the same rider directs HHSC to provide increases to inpatient SDA rates in addition to those identified in subsection (d), using a specific amount of appropriated funding. This additional funding will increase rural rates by another 6.25%. The combination of these two increases will result in new Final SDAs for rural hospitals. The new Final SDAs will apply to all rural hospital inpatient services.
- Rider 28 directs HHSC to provide an additional add-on payment for labor and delivery services provided by rural hospitals. This change will be implemented by using an alternate SDA for inpatient stays related to labor and delivery in rural hospitals. The alternate SDA will be equal to the new Final SDA plus an SDA add-on sufficient to increase the actual payment for

each claim by no less than $500. Only payments for APR-DRGs that involve an actual delivery will be increased by using the alternate SDA.

In addition, Senate Bill 500 appropriated $50 million in general revenue funds for increased Medicaid reimbursement to children's hospitals. HHSC implemented a new SDA add-on, called the Children's Hospital Supplemental Add-on, for children's hospitals for inpatient hospital discharges occurring after August 31, 2019 and before September 1, 2020. The add-on amount is $1128.18.

HHSC complies with all federally and state-required audit reports and submits these reports annually. HHSC will continue to work with stakeholders to understand the best methods to reduce these types of shortfalls.

Appendix A. List of Acronyms

Acronym	Full Name
ACA	Affordable Care Act
APR	All Patient Refined
CCR	Cost-to-Charge Ratio
CHIP	Children's Health Insurance Plan
CMS	Centers for Medicare and Medicaid Services
DRGs	Diagnosis-Related Groups
DSH	Disproportionate Share Hospital
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FTE	Full-Time Equivalent
FY	Fiscal Year
GME	Graduate Medical Education
HCRIS	Healthcare Cost Report Information System
HHSC	Health and Human Services Commission
HFMA	Healthcare Financial Management Association
HSL	Hospital Specific Limit
IGT	Intergovernmental Transfer
IMD	Institutions of Mental Disease
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
MFAR	Medicaid Fiscal Accountability Regulation
MSA	Metropolitan Statistical Area
NAIP	Network Access Improvement Program
PPS	Prospective Payment System
PRA	Per Resident Amount
SDA	Standard Dollar Amount
SFY	State Fiscal Year

STC	Standard Terms and Conditions
TAC	Texas Administrative Code
TMHP	Texas Medicaid Healthcare Partnership
TPI	Texas Provider Identifier
UC	Uncompensated Care
UT	University of Texas
UHRIP	Uniform Hospital Rate Increase Program

Appendix B. Charity Care Guidelines

Healthcare Financial Management Association (HFMA)

Eligibility Criteria for Charity Care

- Individual or family income, which may take into account family size, geographic area, and other pertinent factors. Individual or family income generally is not the exclusive criterion for determining the appropriate amount of charity care.
- Individual or family net worth, which considers liquid and non-liquid assets owned, minus liabilities and claims against assets. It should be noted that when this information comes from the patient, it is useful to clarify whether it will be used solely to determine eligibility or whether the assets would be considered as a possible source of payment.
- Employment status criteria should consider the likelihood of future earnings sufficient to meet the healthcare-related obligation within a reasonable period of time.
- Other financial obligations such as living expenses and other items of a reasonable and necessary nature.
- Amount and frequency of healthcare bills, or the potential for medical indigence (sometimes referred to as medical hardship), must be considered in relation to all of the other factors outlined above. The history of service and the need for future service by the institution or other providers may be considered. In these cases, a separate determination of the amount of charity care for which a patient is eligible is made on each occasion of service, or regular confirmation of eligibility is made during extended programs of service.

Other financial resources available to the patient, such as Medicaid and other public assistance programs, will affect the determination of the appropriate amount of charity care.