Advanced Level – Hospital Financial Affairs

Presenter

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Today's Goals

- History and Update on 1115 Waiver Programs
- Major Healthcare Hot Topics
  - Healthcare Trends
  - Medicare Advantage Plans
  - Pricing Transparency

Original Healthcare Transformation Waiver

- The Center for Medicare & Medicaid Services (CMS) allows for exceptions to the state plan based on a waiver process.
- Waivers are subject to CMS approval.
- The waiver includes plans for:
  - Statewide expansion of Medicaid managed care, while protecting federal supplemental hospital payment funds.
  - Creation of Regional Healthcare Partnerships (RHPs).
- Under the waiver, HHSC will allocate waiver savings payments to two sub-pools:
- Uncompensated Care Pool (UCC) will defray the costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers.
- Delivery System Reform Incentive Payments (DSRIP) will support coordinated care and quality improvements and incentive payments to transform hospital care delivery systems.

Original Healthcare Transformation Waiver

- Uncompensated care amounts will be based on:
  - Uncompensated care payments limited to actual costs
  - Shortfalls not paid by disproportionate share hospitals (DSH).
  - Uncompensated care costs and uninsured patients costs not covered by DSH.
  - Medicaid non-hospital uncompensated care costs (such as physician, clinic and pharmacy settings).
- Delivery System Reform Incentive Payment amounts will be based on:
  - Creating project area standardization and allowing flexibility in achieving goals
  - Setting achievable standards that enable system transformation
  - Ensuring selected projects are reasonable and measure intended innovative program changes
  - Consider data availability and existing systems

Section 1115(a) Waiver

Pool	DY1 (2011 – 2012)	DY2 (2012 – 2013)	DY3 (2013 – 2014)	DY4 (2014 – 2015)	DY5 (2015 – 2016)	DY6 (2016 – 2017)
UC	$3,700,000,000	$3,900,000,000	$3,534,000,000	$3,348,000,000	$3,100,000,000	$3,100,000,000
DSRIP	$500,000,000	$2,300,000,000	$2,666,000,000	$2,852,000,000	$3,100,000,000	$3,100,000,000
Total	$4,200,000	$6,200,000,000	$6,200,000,000	$6,200,000,000	$6,200,000,000	$6,200,000,000
UC %	88%	63%	57%	54%	50%	50%
DSRIP %	12%	37%	43%	46%	50%	50%

First Waiver Renewal –DSRIP and Uncompensated Care Pool & Payments

CMS approved four additional years for the Texas DSRIP program.

- Two years of level funding, followed by two years of funding that will decrease each year.
- The fifth year of the waiver extension does not include any funding for DSRIP.

UC- Allowable costs and payments (S-10)

- **Beginning in DY 9,** UC pool payments will be based on charity costs incurred by qualifying providers and must exclude amounts for Medicaid shortfall as CMS prefers that reimbursement rates be adequate to cover Medicaid costs. Providers receiving both DSH and UC payments cannot be paid more than total eligible uncompensated costs.
- The UC payment protocol must include precise definitions of eligible uncompensated provider charity care costs for each qualifying provider type.

Section 1115(a) Waiver

Pool	DY1 (2011 – 2012)	DY2 (2012 – 2013)	DY3 (2013 – 2014)	DY4 (2014 – 2015)	DY5 (2015 – 2016)	DY6 (2016 – 2017)	DY7 (2017 – 2018)	DY8 (2018 – 2019)	DY9 (2019 – 2020)	DY10 (2020 – 2021)	DY11 (2021 – 2022)
UC	$3.7B	$3.9B	$3.534B	$3.348B	$3.1B	$3.1B	$3.1B	$3.1B	$3.8B	$3.8B	$3.8B
DSRIP	$500M	$2.3B	$2.666B	$2.852B	$3.1B	$3.1B	$3.1B	$3.1B	$2.91B	$2.49B	$0
Total	$4.2B	$6.2B	$6.2B	$6.2B	$6.2B	$6.2B	$6.2B	$6.2B	$6.7B	$6.3B	
UC %	88%	63%	57%	54%	50%	50%	50%	50%	57%	60%	
DSRIP %	12%	37%	43%	46%	50%	50%	50%	50%	43%	40%	

Another Waiver Renewal –Uncompensated Care & Direct Payment Programs

- **Supplemental payment programs** - A long journey… for another renewal
  - January 2021 – Waiver programs approved for 10 years
  - April 2021 – HHS notified Texas that approval was denied stating error in public notice exemption
  - September 2021 – HHS approves temporary continuation of UC and QIPP
  - March 2022 – HHS approved some new programs included in initial applications
  - April 2022 – HHS notified Texas that they are withdrawing their April 2021 notice

New Direct Payment Programs replaced the DSRIP Funding

- CHIRP- Comprehensive Hospital Increase Reimbursement Program – Hospital Only
- RAPPS- Rural Access to Primary & Prevention Services- RHC's Only
- TIPPS- Texas Incentives for Physicians and Professional Services- Doctors Only
- DPPBH- Directed Payment Program Behavioral Health Services- Behavioral Health Only

CHIRP- Comprehensive Hospital Increase Reimbursement Program – (Hospital Only)

- A statewide program that provides for increased Medicaid payments to hospitals for IP and OP services provided to persons with Medicaid.
- Texas Medicaid managed care organizations (MCOs) receive additional funding through their monthly capitation rate from HHSC and are directed to increase payment rates for participating hospitals.
- Hospitals receive a percent increase paid on claims submitted to a Medicaid MCO

CHIRP- Comprehensive Hospital Increase Reimbursement Program – (Hospital Only)

- SFY22- (9-1-21 to 8-31-22) Year 1- Total Funds $4.7B
  - MCO retains $275M
  - $4.4B goes to Hospitals
- SFY23- (9-1-22 to 8-31-23) Year 2- Total Funds $5.2B
  - MCO retains $305M
  - $4.9B goes to Hospitals
- SFY24- (9-1-23 to 8-31-24) Year 3- Total Funds $6.5B
  - MCO retains $378M
  - $6.1B goes to Hospitals

RAPPS- Rural Access to Primary & Prevention Services- (RHC's Only)

- Incentivizes primary and preventive services for persons with Medicaid in rural areas of the state enrolled in STAR, STAR+PLUS and STAR kids.
- The program focuses on the management of chronic conditions
- 2 types of rural health clinics are eligible to participate:
  - (1) Hospital based RHC's
  - (2) Freestanding RHC's
- Eligible RHC's must provide at least 30 Medicaid managed care encounters per year

RAPPS- Rural Access to Primary & Prevention Services- (RHC's Only)

- SFY22- (9-1-21 to 8-31-22) Year 1- Total Funds $11M
  - MCO retains $650K
  - $10.6M goes to RHCs
- SFY23- (9-1-22 to 8-31-23) Year 2- Total Funds $31.2M
  - MCO retains $1.8M
  - $29.4M goes to RHCs
- SFY24- (9-1-23 to 8-31-24) Year 3- Total Funds $25M
  - MCO retains $1.5M
  - $23.5M goes to RHCs

TIPPS- Texas Incentives for Physicians and Professional Services- (Doctors Only)

- A physician-directed payment program for certain physician groups to help cover the cost of health care services provided to persons with Medicaid in STAR, STAR+PLUS and STAR kids.
- Also serves as a transition from the Network Access Improvement Program (NAIP) and Delivery System Reform Incentive Payment (DSRIP) program for specific physician groups.
- Promotes optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities and healthcare systems to address the root of the causes of poor health.

TIPPS- Texas Incentives for Physicians and Professional Services- (Doctors Only)

- SFY22- (9-1-21 to 8-31-22) Year 1- Total Funds $600M
- SFY23- (9-1-22 to 8-31-23) Year 2- Total Funds $738M
- SFY24- (9-1-23 to 8-31-24) Year 3- Total Funds $756M

DPPBH- Directed Payment Program Behavioral Health Services- (Behavioral Health Only)

- A new value-based payment program for CMHCs to incentivize them to continue providing services to Medicaid-enrolled individuals that are aligned with the Certified Community Behavioral Health Clinic model of care.
- Payments will be included in the MCO capitation rates and distributed to enrolled CMHCs who meet program requirements.

DPPBH- Directed Payment Program Behavioral Health Services- (Behavioral Health Only)

- SFY22- (9-1-21 to 8-31-22) Year 1- Total Funds $194M
- SFY23- (9-1-22 to 8-31-23) Year 2- Total Funds $252M
- SFY24- (9-1-23 to 8-31-24) Year 3- Total Funds $164M

Non-Federal Share Funding for Certain Medicaid Payments

- Medicaid is a program jointly funded by federal and state governments
- The federal government provides funds to states for a specific percentage of Medicaid expenditures
- To receive the federal funding, states must use public funds generated at either the state or local government level as the non-federal share of the Medicaid expenditure
- In Texas, locally derived funds are used to finance a vast majority of the non-federal share of Medicaid supplemental and directed payments
- All states must provide the non-federal share to receive federal matching funds

Intergovernmental Transfers- IGTs

- IGTs are transfers of public funds from a governmental entity to the state.
- The state receives the federal matching funds for IGTs used as the non-federal share
- The transfer must occur before a Medicaid payment is made
- HHSC – the State Medicaid Agency- is responsible for ensuring all funds received from governmental entities are permissible sources of non-federal share

Types of Local Funding Used in Texas

Local governmental entities can use:

- State-appropriated funding or funds received through the implementation of an ad-valorem tax
- Patient revenues (excluding federal payor program funds)
- Implementation of a health-care related tax

In Texas, some jurisdictions have chosen to implement a Local Provider Participation Fund (LPPF)- which is a health-care related tax that is implemented on a local level, administered by an existing unit of local government and that is designed specifically to meet the federal requirements associated with eligible local funds

Local Provider Participation Funds- LPPFs

- Beginning in 2013, local governments received approval from the Texas Legislature to operate LPPFs as an optional method of finance for local governments to generate and collect local funding for Texas Medicaid supplemental programs
- They are accounts that local units of government deposit *mandatory payments* from hospitals to use as an IGT to HHSC
- Hospitals that are not operated by a unit of government and provide IP services in each local jurisdiction pay into the fund and use this money as the non-federal portion of the Medicaid match

Local Provider Participation Funds- LPPFs

- Financial assessments nonpublic hospitals pay based on their annual net revenue. Most units of government operating a LPPF determine the assessment rate annually. However, the rate cannot exceed 6% of total net patient revenue from all paying hospitals.
- The type of hospital that makes the mandatory payments is a nonpublic hospital that provides IP services

Financial Impact after Covid

Specific Healthcare Challenges before, during and after COVID

What has kept your hospital afloat for many years?

- ✓ Good to Moderate volume in both inpatient and outpatient services
- ✓ Good Offering of Patient Services
- ✓ Good Collection Efforts to provide for cash flow
- ✓ Good Revenue Cycle Management
- ✓ Good Cost Controls

Healthcare Trends in 2023

- High Cost of Care- More than 45% of American Adults say its difficult to afford health care
- Labor Shortages
- Endemic COVID-19

Future Healthcare Trends

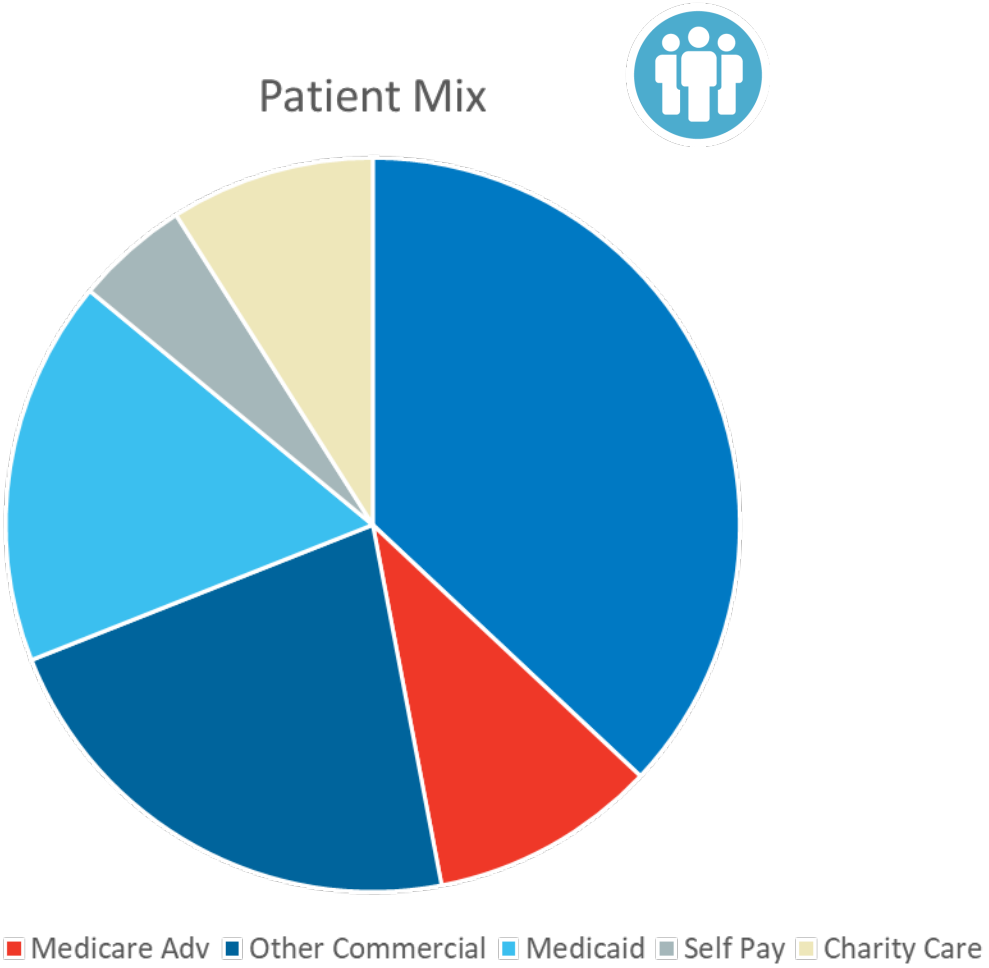
- More patients
- More Technology
- Increasing numbers of Uninsured
- Less Pay to Providers
- Continued need for a new healthcare system

What is the future plan for keeping your hospital afloat going forward?

- Market Studies for Increased Volume
- Operational Assessments
- Managing Cost or Cost Cutting
- Physician Assessments and Physician Management
- Increased Revenue Cycle Management
- Increased Collection Efforts for Cash Flow
- Mergers, Acquisitions or Affiliations

Medicare Advantage Plans

Payer Mix/Insurance Market



Urban County Texas
Medicare Advantage Plans -2023

	Medicare Part C Enrollees	Part C Penetration %
Dec 2009	99,940	27.33%
Dec 2015	192,926	40.33%
Mar 2023	359,067	59.75%

Urban County Texas
Medicare Advantage Plans -2023

KS Plan Administrators	9%
Amerigroup Insurance	9%
Sierra Health and Life Insurance Company	9%
United HealthCare	9%
HealthSpring Life & Health Insurance	8%
WellCare of Texas	7%
Devoted Health Plan of Texas	6%
CHA HMO	6%
Over 40 other Plans listed with less than 6% of total enrollees	

Rural County Texas
Medicare Advantage Plans -2023

	Medicare Part C Enrollees	Part C Penetration %
Dec 2009	117	7.20%
Dec 2015	349	20.52%
Mar 2023	868	49.45%

Rural County Texas
Medicare Advantage Plans -2023

Care Improvement Plus	23%
Superior HealthPlan	18%
Physicians HealthChoice of Texas	15%
Sierra Health and Life Insurance	15%
Humana	12%
Over 5 other Plans listed with less than 12% of total enrollees	

Pricing Transparency

CMS Price Transparency Final Rule

Effective January 1, 2021 - Two primary requirements to publicize standard charges

1 COMPREHENSIVE MACHINE-READABLE FILE

A comprehensive single machine-readable file that makes public all standard charge information for all items & services provided by the hospital

Five Standard Charges

1. Gross charges
2. Payor-specific negotiated charges
3. Discounted cash prices
4. De-identified minimum negotiated charge
5. De-identified maximum negotiated charge

2 CONSUMER-FRIENDLY SHOPPABLE SERVICES

A consumer-friendly list of 'standard charges' for 300 (70 CMS-specified + 230 hospital-selected) "shoppable" services provided by the hospital

Additional Considerations

- Hospitals must group primary shoppable service with ancillary services, *e.g.*, laboratory, radiology, drugs, room & board charges, employed professional charges, etc., customarily provided by hospital
- Hospitals can meet shoppable services requirement by offering an **internet-based price estimator** if the tool meets specific requirements

CY 2022 OPPS Final Rule Update

In the CY 2022 OPPS Final Rule, CMS finalized several hospital price transparency policies to further encourage compliance.

The most notable change to the price transparency requirement is an increase to the amount of the monetary penalty for noncompliance using a scaling factor based on hospital bed count. While the previous civil monetary penalty for noncompliance did not exceed $300 per day for any hospital, the updated penalty, effective January 1, 2022, is $10 per day per hospital bed for hospitals with more than 30 beds, which would increase penalties up to $5,500 per day for a hospital with more than 550 beds.

Number of Beds	Penalty Applied per Day	Total Full-Year Penalty
30 or fewer	$300 per hospital	$109,500 per hospital
31 up to 550	$310–$5,500 per hospital (number of beds * $10)	$113,150–$2,007,500 per hospital
More than 550	$5,500 per hospital	$2,007,500 per hospital

Source: CMS CY 2022 OPPS Final Rule

Summary

- Updates on Medicaid 1115 Waiver Programs
- Trends in Healthcare
- Medicare Advantage Plans
- Pricing Transparency

Questions and Answers

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