Texas Hospital Association

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Victoria Grady
Director of Provider Finance
Texas Health and Human Services Commission
Mail Code H400
P.O. Box 13247
Austin, Texas 78711-3247

RE: Comments on Proposed Rule 21R027.

Submitted via email to RAD_1115_Waiver_Finance@hhsc.state.tx.us

Dear Ms. Grady:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide comments on the proposed rule on the Comprehensive Hospital Increase Reimbursement Program.

The COVID-19 pandemic has had an unprecedented and alarming impact on our healthcare system, including our hospitals. The continuation of the UHRIP program, without any major structural changes that significantly impact hospital payments, offers hospitals stability to continue providing care for Texas patients as the COVID-19 pandemic continues.

UHRIP has been a successful method to increase hospital payments without the use of any general revenue funds. It has helped to expand Medicaid managed care in Texas, coordinate care, and ensure Medicaid and uninsured patients have access to hospital and community care.

We appreciate the significant staff resources devoted by HHSC to both the payment and quality workgroups. These two workgroups met on numerous occasions in an effort to obtain hospital input. Several of the workgroup recommendations were included in the proposed UHRIP amendment.

Although we are supportive of HHSC's proposed CHIRP program, we have several questions/comments on the following issues:

- Opt-in Procedure
- Class Designation Correction
- Budget Neutrality Capacity

- IMD Class Inclusion
- Intergovernmental Transfers
- Medicaid DSH Exemption

Background

The Uniform Hospital Rate Increase Program was initially implemented on December 1, 2017. UHRIP is a statewide program that provides increased Medicaid payments to hospitals for inpatient and outpatient services provided to persons with Medicaid. The program aims to reduce the Medicaid shortfall for hospitals that serve people who receive Medicaid.

Consistent with CMS' requirements, all hospitals within each class received a uniform rate increase percentage within a participating service delivery area (Attachment A). Each class may have a different rate increase percentage, but the percentage may not vary within a class.

Beginning September 1, 2021, the Comprehensive Hospital Increase Reimbursement Program will be comprised of the Uniform Hospital Rate Increase Payment and the Average Commercial Incentive Award. CHIRP funds will be paid through two components of the managed care per member per month capitation rates. Each component's value will be determined as a percentage of the amount of funding available for the CHIRP program.

The UHRIP Component will be equal to a percentage of the estimated difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services (Medicare gap) on a per class basis. UHRIP payments will be paid as a uniform rate increase per class and will be distributed based upon actual paid claims.

The ACIA Component will be equal to a percentage of the difference between what an average commercial payer is estimated to pay for the services and what Medicaid actually paid for the same services (ACR gap) less payments received under UHRIP. ACIA payments will be paid as a uniform rate increase per class and will be distributed based upon actual paid claims.

For each program, HHSC will specify the performance requirements that will be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the managed care quality strategy.

Issue # 1 -Opt-In Procedure

We appreciate the proposed rule including an "opt-in" procedure in which the hospital must select whether it will participate in the optional program components. Many hospitals are unsure of the potential impact as the quality metrics have not been finalized. In addition, there are several unknowns concerning the impact of the CHIRP payments on the other Medicaid supplemental payment systems.

Issue # 2 – Class Designation Correction

We appreciate HHSC proactively identifying a mistake in the proposed rule concerning the class designations. The proposed "urban public hospital" category should actually be "urban hospitals" and should include both private and public hospitals. HHSC staff have already taken steps to include the correction in the final rule.

Issue # 3 – Budget Neutrality Capacity

The CHIRP dollars and other programs under the waiver will be limited by the 1115 waiver budget-neutrality capacity and the amount of IGT funds available for the program. We strongly support carrying forward the maximum amount of budget neutrality dollars in the waiver. This will allow Texas to move toward a system that reflects the actual cost of care and continues funding uncompensated care costs.

Issue # 4 – IMD Class Inclusion

We appreciate HHSC including the IMD hospitals as a separate class. As you know, behavioral health hospitals are a critical element of the health care safety net. However, due to the IMD exclusion, behavioral health hospitals are unable to receive Medicaid funds for eligible adults, except through a fifteen-day exemption. The exclusion makes CHIRP funds for this adult population unavailable to behavioral health hospitals, leaving this class at a disadvantage. THA encourages the agency to continue to explore avenues for behavioral health hospitals to maximize their CHIRP dollars, including working toward allowing CHIRP funds for the IMD excluded population.

Issue # 5- Intergovernmental Transfers

We are concerned that it is the state's intention to source and credit the nonfederal share of the program at a statewide level, instead of on an SDA basis as is done with the current UHRIP program.

We recommend that the rate increases and the non-federal share of the program should continue to be determined and administered on an SDA by SDA basis. Allocating funds on a statewide basis by hospital class type, combined with their Medicare gap, should not affect funding the non-federal share on an SDA by SDA basis. The addition of a Medicare gap on a statewide basis for the UHRIP component is likely to lead to rates that are very similar throughout the state.

In the current version of UHRIP, hospital classes are established on a statewide basis, but hospital eligibility for rate increases is determined by the service delivery area and class of hospital. The language in the current UHRIP program acknowledges that HHSC will set rates for each class based on a number of factors including "the amount of IGT the sponsoring governmental entities proposed to transfer to HHSC to support the non-federal share of the increased rates" and "the hospital market dynamics within the SDA". Rates in the current UHRIP program are reasonable because they are set with reference not

only to the external benchmark applicable to the class, but also with an eye to the unique geographic, demographics, and other factors that affect participating hospitals in each SDA.

Texas' supplemental payment programs (UC and UHRIP) have historically been fully IGT-funded because pooling IGTs by SDA ensures that local government funds will only be used for the benefit of providers who support safety net services in their respective communities. This change would strain the concept of the State's Local Provider Participation Funds, which operate on a local basis to support the funding of hospitals in their region. Any perceived issue of "free riders" may be exacerbated by the implementation of a statewide IGT methodology.

The consolidation of local government funds into a statewide pool would reduce the incentive for regional coordination to support the program. Local government authorities may find that despite their commitment of the full share of the funding needed for their local hospitals, their local dollars have been used to support a shortfall in a distant area of the State, resulting in a reduction in local hospital payments. Without regional coordination, the State would struggle to gather the local funding support necessary to fully fund the program.

We are concerned that if the IGTs are sourced and credited on a statewide basis, we will encounter the same problems as Florida experienced. While the available annual Florida LIP pool is $1.5 billion, the state has only used $757 million, $858 million, and $954 million in state fiscal years 2018, 2019 and 2020 when actual UC costs fully supported the use of the $1.5 billion. Local IGTs were held back based on their fiduciary mandates, local governmental entities' uncertainties and concerns with how local funds would benefit their respective communities. This resulted in a significant amount of available federal matching funds being left untapped and a reduction in reimbursements.

Issue # 6 – Medicaid DSH Exemption

HHSC has acknowledged that the increase in CHIRP funding will cause some hospitals to lose their entitlement to Medicaid DSH and UC funding. The proposed transformation of UHRIP into CHIRP is tied to the ongoing efforts to transition from DSRIP. We recognize the importance of continuing the quality improvements and initiatives that DSRIP facilitated and understand why HHSC plans to utilize UHRIP/CHIRP to transition DSRIP. **But DSRIP was fiscally feasible largely because DSRIP payments did not offset Medicaid DSH entitlement and did not reduce the payment room under Medicaid managed care actuarial soundness limits.** HHSC and CMS recognized that the incentives for hospitals to invest in DSRIP activities would be severely hampered if DSRIP payments reduced Medicaid DSH entitlement.

Now that the ACIA component of CHIRP—for which quality reporting is a condition of participation—could comprise approximately 60% of the total $5 billion of CHIRP funding, **HHSC should work with CMS to ensure that a DSRIP-like exemption is afforded to the ACIA portion of CHIRP. HHSC should seek to gain approval of a provision in the Section 438.6(c) preprint that exempts all or a reasonable portion**

of the ACIA component payments (such as an amount up to a hospital's most recent year of DSRIP payment entitlement) from the Medicaid DSH hospital specific limit calculations in recognition of CHIRP's role in the DSRIP transition and quality reporting requirements.

Failure to secure such an exemption could severely limit participation in the Medicaid DSH, Uncompensated Care, and CHIRP programs such that hospitals are worse off under the reformed UHRIP/CHIRP program. This risk is heightened by the fact that the UC program pool under the recent Waiver is required to be rebased at two separate intervals. The use of global Medicaid DSH and CHIRP participation assumptions could lead to a reduction in the UC pool in the resizing.

In addition, it is unclear whether the state-owned hospitals—a major DSRIP beneficiary—would be eligible to receive any benefit from the CHIRP program because any CHIRP payments a state hospital receives would result in a dollar-for-dollar reduction to their Medicaid DSH payment caps.

We urge the commission to complete modeling to evaluate the impact of the increase in CHIRP funding on the state's other supplemental payment programs. Preliminary evaluation of the CHIRP data suggests significant payment swings between key safety net components.

Thank you for your consideration of these comments. We look forward to working with you on these issues. Should you have any questions, please do not hesitate to contact me at rschirmer@tha.org or 512/465-1056.

Respectfully submitted,

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Texas Hospital Association