RECENT DEVELOPMENTS IN TEXAS MEDICAID

UHRIP, LPPF AND THE 1115 WAIVER

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HFMA DISCUSSION
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I. Funding the Texas Healthcare Safety-Net System.

II. Current issues involving the availability of supplemental payments to your local safety-net hospitals

III. The Future: Where is Texas headed, and how can counties prepare for the new world of Texas healthcare funding?

IV. National Medicaid Issues - Proposed Reforms and Next Steps
Funding the Texas Healthcare Safety-Net

• Depending on the jurisdiction, counties, hospital districts, cities (and other governmental entities) are collaborating with local safety-net hospitals systems by helping to fund supplemental payment programs for their local providers.
  - The Medicaid Upper Payment Limit Program (UPL)
  - The Texas 1115 Waiver

• Local governmental entities identified funding mechanisms to help access the federal funds that are available to local providers.
  - The Past (2006)- “charity care expansion”, “expense alleviation”
  - The Future (2013)- The Local Provider Participation Fund (LPPF).
WHAT IS THE STATUS OF THE WAIVER?

• Five year extension approved December 21, 2017 (DYs 7-11)
  - DSRIP: **Four** years of funding, with two years of level funding, followed by two years of funding which will decrease each year.
  - UC Pool: **Five** years of funding. Approximately $3.1 billion allocated for first two years; for subsequent years, amount will be determined pursuant to revised STCs.

• Notable UC Pool changes:
  - Eliminate any Relationship Between UC Pool Payments and the Source of the Non-Federal Share
  - Payments Limited to Services Provided to the Uninsured as Charity Care (excludes Medicaid losses)
  - Transition Distribution Methodology Towards Charity Care (with onerous timeline and penalties)
  - Size of the UC Pool Based on Charity Care (transition to S-10)
CMS disallowed $27 Million of federal funding that was paid to providers in Dallas County.
- CMS alleges that the private hospitals in Dallas were funded by impermissible provider donations.

CMS refused to reconsider the disallowance even though there is documentation explicitly saying that the transaction is permissible.

Currently before the DAB. HHSC filed a Reply to CMS's Brief in Support of Disallowance with the DAB the week of January 1.
THE LOCAL PROVIDER PARTICIPATION FUND (“LPPF”)

- **What is the LPPF?**
  - The LPPF is a county administered fund that is utilized to help local safety-net providers access supplemental payments.
  - The only organizations that can pay into the fund are the hospitals in your counties. Individual taxpayers do not pay $1.
  - LPPF must comply with federal healthcare and tax regulations.

- **What jurisdictions have LPPFs?**
  - Counties: Hidalgo, Cameron, Webb, Bell, Gregg, Brazos, McLennan, Bowie, Hays, Cherokee, Smith, Angelina, Williamson, Tom Green, Grayson and Potter
  - City: Beaumont
  - Hospital Districts: Dallas County Hospital District (Parkland), Tarrant County Hospital District (JPS), and Amarillo Hospital District

- **Who can legally pursue LPPFs?**
  - Counties with more than one hospital
  - Cities with more than one hospital (county and city may not both have LPPFs)
  - Hospital districts
## 2017 LPPF Legislative Successes

<table>
<thead>
<tr>
<th>County</th>
<th>Bill Number</th>
<th>LPPF SFY18 Projected Gross Revenue (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelina County</td>
<td>HB 2995</td>
<td>$14.93</td>
</tr>
<tr>
<td>Amarillo Hospital District</td>
<td>SB 2117</td>
<td>$36.13</td>
</tr>
<tr>
<td>Dallas County Hospital District</td>
<td>HB 4300</td>
<td>$322.20</td>
</tr>
<tr>
<td>Grayson County</td>
<td>HB 2062</td>
<td>$15.00</td>
</tr>
<tr>
<td>Smith County</td>
<td>HB 2995</td>
<td>$30.07</td>
</tr>
<tr>
<td>Tarrant County Hospital District (incorporated into clean up legislation)</td>
<td>SB 1462</td>
<td>$174.06</td>
</tr>
<tr>
<td>Tom Green County</td>
<td>HB 3398</td>
<td>$18.29</td>
</tr>
<tr>
<td>Williamson County</td>
<td>HB 3954</td>
<td>$58.77</td>
</tr>
<tr>
<td>Clean up legislation</td>
<td>SB 1462</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Other LPPF Opportunities?

- Florida
- Virginia
- New Jersey
- Kansas
- New Mexico
In May 2016, CMS published the Medicaid Managed Care Final Rule (the "Final Rule"). 81 Fed. Reg. 27498 (May 6, 2016).

Retained preexisting prohibition on states directing payments to providers, but finalized several exceptions to allow states to direct MCOs to make payments to certain providers:
- Value-Based Purchasing
- Delivery System Reform
- Minimum or Maximum Fee Schedules and Rate Enhancements

CMS also included a limited transition period for existing pass through payments.
Uniform Rate Improvement Program (UHRIP)

- Pursuant to new regulatory requirements, HHSC proposed Regional Uniform Rate Increases for Hospital Services (1 Tex. Admin. Code § 353.1305)
- UHRIP Final Rule (published March 31, 2017) provides:
  - when HHSC will direct an MCO to provide a uniform percentage rate increase to hospitals in the MCO’s network in a designated service delivery area ("SDA"); and
  - how HHSC will calculate and administer such a rate increase.
- HHSC may direct the MCOs to increase rates for all or a subset of inpatient services, all or a subset of outpatient services, or all or a subset of both, based on the service or services that will best advance the goals and objectives of HHSC's quality strategy.
Federal regulations require that contracts arrangements that direct the MCO expenditures must have written approval from CMS prior to implementation.

- The CMS "preprint" implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any arrangements.

HHSC appears to have submitted a preprint and received approval of UHRIP for STAR and STAR+PLUS in all 13 managed care SDAs.

- 12 of the 13 SDAs are included in the first UHRIP program period (including 2 pilot regions).
Map of All Texas Medicaid Managed Care Service Delivery Areas (SDAs)
• HHSC may direct MCOs in a SDA to provide a uniform percentage rate increase to one or more of the following classes of hospitals:
  - children's hospitals;
  - non-urban public hospitals;
  - rural hospitals;
  - state-owned hospitals;
  - urban public hospitals;
  - institutions for mental diseases; and
  - all other hospitals.

• If HHSC directs rate increases to more than one class within the SDA, the percentage rate increases may vary between classes of hospital.
UHRIP Implementation Timing

• On February 1, 2017, HHSC released the UHRIP Application. Sponsoring governmental entities submitted applications on March 1, 2017.
• HHSC informed industry representatives on April 28 that UHRIP would not be operationalized on September 1. HHSC delayed the start date to March 1, 2018.
• HHSC released new UHRIP applications October 9, 2017. Following multiple requests for additional information and revisions, applications were due October 23, 2017.
• HHSC published UHRIP IGT call on November 6, 2017. IGTs were due November 10, 2017.
• Two pilot regions implemented December 1, 2017 (Bexar and El Paso)
• March 1, 2018 statewide implementation.
Amendment to MCO network provider agreements implementing uniform rate increase.
- LOA between the MCOs and each of the MCO's network hospitals in the MCO's designated service delivery areas.

Two primary purposes:
- First, (1) ensure that the MCO implements the defined percentage rate increase for the hospital's class in the SDA and (2) avoid the need for a separate contractual amendment to the managed care contract between the MCO and the hospital. In effect, the LOA is that amendment.
- Second, creates a Quality Incentive Fund ("QIF"),(1) to ensure that MCOs actually pay out the money received from HHSC to make rate increases to hospitals and (2) to ensure that MCOs do not have excessive losses because they paid out more they received from HHSC to make rate increases to hospitals.
UHRIP Challenge: 
Budget Neutrality

• To comply with budget neutrality, HHSC limited the size of the pool from $800 million to $600 million.
• SDAs received significant haircuts due to the small size of the Pool.
  - Despite concerns over budget neutrality room, the AHCV team estimated that Texas had $2.4 billion under the budget neutrality cap.
• IGTs were due November 10, 2017.
• Challenge: Counties that typically do not collaborate are required to work together to coordinate UHRIP funding.
  - Each SDA elected a UHRIP liaison. The liaison is required to communicate with all hospitals and counties involved in the SDA.
  - Coordination of the SDA requires significant work.
• Solution: Work with your local providers to gather all necessary data and rely on their relationships with sister facilities.
  - Most SDAs include large geographic areas. Very few SDAs find it easy to find all necessary contacts.