Top Issues Affecting Texas Hospitals

Lone Star Winter Conference
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Agenda

- Update from the 86th Texas Legislature
  - Legislation and Rulemaking
- Texas Medicaid and Supplemental Payment Update
- Other Operational Issues
- Federal Update
  - Legislation and Rulemaking
- Judicial Activity
- Looking Ahead
86th Texas Legislature
In the 2019 session lasting 140 days:

- 7,851 bills filed
  - 1,506 passed
  - 58 vetoed
- THA tracked 1,538
  - Impacted (or amended to impact) hospitals’
    - Budget
    - Operation
    - Policy
  - 276 passed
2020-2021 State Budget

- H.B. 1 – “must pass” bill

- 86th Legislature had ~ $10 billion (16%) more to spend than past biennium
  - Thanks to revised and raised oil and gas revenue, positive economic forecast and a more favorable match rate for Medicaid (feds will pay higher percentage).

- HB 1 is a $250.7 billion all funds two-year budget
  - Spends $84.4 billion in all funds on health and human services (1% increase).

- Increases to public schools ($6.5B) and funds to buy down property taxes ($5.1B).

- $6.1 Billion used from Rainy Day Fund
  - For Hurricane Harvey relief, leftover Medicaid expenses, future disaster preparedness, state hospital construction, school district safety upgrades.
Hospital Funding in State Budget

- No Provider Rate Cuts
- Maintained funding for Medicaid rate enhancements:
  - $360 million all funds for trauma hospitals.
  - $300 million all funds for safety net hospitals.
  - $60 million all funds for rural hospitals.

- New state funding for rate enhancements for:
  - $35 million for rural hospitals’ inpatient services.*
  - $6.2 million for rural hospitals' labor and delivery services.*
  - $50 million for children's hospitals.*

- $15 million in new grant funding to support infrastructure improvements at trauma hospitals.*

*Denotes state general revenue.
Hospital Funding in State Budget

- Inpatient and outpatient behavioral health care:
  - $445.4 million for phase II of the state psychiatric hospital redesign planning and construction (Rusk, Austin and San Antonio state hospitals).
  - $26 million for 50 new inpatient beds at non-state psychiatric hospitals.*
  - $5 million for substance use disorder treatment.*

- $7 million for statewide maternal safety initiatives, which includes $3 million for TexasAIM to reduce preventable maternal mortality and morbidity.*

- $19.9 million to help reduce the nursing workforce shortage.*

- $60 million expansion of graduate medical education for physician training.*

*Denotes state general revenue.
New Source of Trauma Funding

- HB 2048 repeals Driver Responsibility Program.
- Replaces the source of revenue for state’s trauma fund (Account 5111), which provides:
  - $176.4 million all funds to offset trauma hospitals’ $320 million in unreimbursed trauma care costs.
  - $150.8 million all funds for safety net hospitals Medicaid payment.
- Revenue comes from:
  - increasing the existing state traffic fine from current $30 to $50.
  - increasing the administrative fee on issuers of motor vehicle insurance from the current $2 to $4.
  - increasing fines on individuals convicted of driving while intoxicated; fines would range from $3,000 to $6,000, depending on the circumstances.
Caps on Property Tax Revenue

- Limiting local governments’ ability to raise property tax rates was a priority for Gov. Greg Abbott and state leadership.
- Proposed legislation sought to reduce the amount by which local governments, including hospital districts, could increase property taxes from 8 to 2.5 percent.
- Caps threatened hospitals’ ability to generate revenue to provide the state share of hospitals’ supplemental payments and support indigent health care programs.
- THA successfully worked to exempt hospital districts and county hospitals from SB 2, the property tax reform legislation that passed in May.
Local Provider Participation Funds

- 28 cities and counties now have legislative authority to create local provider participation funds to generate a source of the non-federal share of supplemental Medicaid payments.

- The 86th Legislature approved LPPFs for Bexar, Ellis, El Paso, Harris, Lubbock, Nueces, Taylor, Travis and Wichita counties and renewed LPPFs for Dallas and Tarrant counties.

- A new state law from the 2019 session now allows certain local government entities to temporarily establish an LPPF without waiting until 2021 for legislative approval. Authority to administer the LPPF lasts only until Sept. 1 following the second anniversary of its authorization, and maintaining the LPPF requires specific legislative authority the following session.
Bipartisan and bicameral attention on eliminating surprise medical billing.

THA supported and helped pass SB 1264 to eliminate surprise bills for emergency or unplanned out-of-network health care services, while maintaining mediation for hospitals and health plans to negotiate a fair payment amount, free from government-set rate parameters.

As the U.S. Congress works on a legislative solution, Texas’ new surprise billing law can serve as a model for the nation.
Surprise Billing (cont.)

- Prohibits out-of-network balance bills
  - Hospitals may not balance bill for out-of-network emergency care
  - Facility-based providers may not balance bill for services provided at an in-network facility
  - Diagnostic imaging and lab may not balance bill for services performed in connection with health care occurring in a network facility
- Creates a mandatory dispute resolution process for:
  - out of network emergency care (facility’s bill or provider’s bill);
  - care provided at an in-network facility by an out-of-network provider (the provider’s bill)
  - diagnostic imaging or laboratory services provided in connection with an in-network physician or provider.
- Gives regulatory agencies the authority to enforce violations through disciplinary action or AG referral
- Mediation process applicable to disputes between payers and facilities (no government set payment parameters other than usual and customary rate)
- Arbitration process applicable to disputes between payers and providers who are not facilities
Rulemaking

- Many laws are fully self-implementing, others require rules to be issued by various regulatory agencies, e.g.:
  - Texas Health and Human Services Commission
  - Texas Department of State Health Services
  - Texas Medical Board
  - Texas Board of Nursing
  - Texas State Board of Pharmacy
  - Texas Department of Insurance
  - Texas Attorney General

- TDI Surprise Billing Rules
- TMB Surprise Billing Rules
- Nursing and Medical Board Rules
  - Continuing Education Requirements for Opioid Prescribing
  - Physician Delegation
- Texas HHSC Recodification of Mental Health Rules
Other Operational Issues
Operational Issues

- End-of-Life and Challenge to the Texas Advance Directives Act
- Implementation of Legislative Changes
  - Maternal and Neonatal Designation (SB 749)
  - Infection Reporting (SB 384)
  - Sexual Assault Forensic Exams (HB 8, HB 616, HB 531, HB 4531)
  - Physician Anti-Retaliation (HB 1532)
- Opioids and Controlled Substances
  - New CE requirements (HB 3285, HB 2454)
  - Limits on prescriptions for acute pain (HB 2174)
- Inpatient Psychiatric Pre-Admission Exam (SB 1238)
Operational Issues

- Behavioral Health
  - Challenges in the emergency department
  - SB 359 Veto (2015) and SB 362 Rulemaking
  - Licensing agency scrutiny and rulemaking
1115 Waiver and Supplemental Payment Update
Texas Medicaid

- Medicaid covers 3.8 million Texans
  - 13% of Texans
  - 53% of Texas births
  - 40% of Texas children
  - 62% of nursing home residents
  - 95% enrollees receive Medicaid through managed care organizations

- Texas hospitals reported nearly $7 billion in uncompensated care (bad debt and charity) in 2017.

- Base Medicaid rates (without supplemental payments) cover on average 67% of hospitals’ costs.
Texas Medicaid

- Enrollment and Spending
Texas Medicaid 1115 Waiver

Texas’ five-year Medicaid 1115 Waiver implemented two major changes:

1) Transitioning from use of the current “uncompensated care tool” to a modified S-10 Worksheet to calculate and distribute UC payments based on hospital charity care costs. Medicaid shortfall and bad debt costs no longer are allowed.

2) Wind down of DSRIP funding.
UC Pool Resizing

• The new methodology to calculate UC payment is based on hospital-reported charity care costs and cannot include the Medicaid shortfall or bad debt. This new methodology took effect Oct. 1, 2019.

• The waiver’s terms also require the UC pool to be resized for fiscal years 2020-2022 (demonstration years 9-11) based on 2017 S-10 charity care costs.

• In late September 2019, THHSC announced CMS’ approval of a $3.9 billion UC pool size.
DSRIP Wind Down

- DSRIP funding ends September 2021.

- THHSC’s DSRIP transition plan outlining how health care delivery system reforms can continue without DSRIP funding was submitted to CMS on Oct. 1, 2019

- THA is participating in THHSC’s DSRIP stakeholder meetings and provided feedback on the transition plan based on discussions with THA members.
DSRIP Transition Plan

- Opportunities THHSC is considering to build DSRIP reforms into the Medicaid program while leveraging existing waiver financing structures include:
  - Directed payments in managed care (including UHRIP and QIPP).
  - Targeted enhancements of benefits.
  - Implementing quality initiatives that align with the transition plan’s identified focus areas.

- Some of the key focus areas to direct all post-DSRIP initiatives include behavioral health, primary care, chronic care management, and patient navigation/care coordination for high utilizers.

- THHSC’s ability to build on DSRIP successes likely will be limited by CMS’ new methodology to calculate budget neutrality for Waiver programs.
Changes for Medicaid Supplemental Payment Programs

THHSC announced it will:

1. Modify the methodology used to calculate Medicaid Disproportionate Share Hospital payments for fiscal year 2020.
2. Disburse the uncompensated care payments that were withheld during FYs 2014-2017 and pay the upper payment limit obligation to CMS related to the transition to the Medicaid 1115 Waiver in 2011.
3. Potentially increase the Uniform Hospital Rate Increase Program for FYs 2020 and 2021.
4. Reform UHRIP starting in FY 2021.
DSH Cuts

- All states’ federal Medicaid Disproportionate Share Hospital allotments were scheduled to be reduced by $4 billion beginning Oct. 1, 2019. Cuts would then increase to $8 billion a year in fiscal years 2021 to 2025.

- In late September, the U.S. Congress passed a short-term budget that delays Medicaid DSH payments cuts from Oct. 1 to Nov. 21

- November 19, Congress delayed cuts until December 20

- December 19, Congress passed funding bill delaying cuts to May 20, 2020

- The Medicaid and CHIP Payment Access Commission estimates the reduction will be $450 million, or 22.8 percent of DSH payments, in 2020.
Medicaid Fiscal Accountability Rule

• Published in the November 18, 2019 Federal Register
• Potentially limits states’ ability to draw down federal Medicaid payments
• For Texas hospitals, could jeopardize >$10 billion in supplemental Medicaid payments in federal fiscal year 2020
• Among other things, the Rule would:
  • Tighten the definition of public providers and the parameters under which they own and operate other providers
  • Broaden CMS authority to deny certain methods states can use to finance the non-federal share of Medicaid payments
  • Restrict the sources of IGT to state or local tax revenue only
  • Require detailed provider-level and aggregate reporting of supplemental payment programs and sources of the non-federal share.
• Deadline to comment is February 1, 2020 (extended from 1/15/2020)
Federal Update
Surprise Billing

- “Congress likely to punt on drug prices, surprise billing as year-end deadline nears” – FierceHealthcare, December 13, 2019
- “Congress will try to score drug pricing, surprise billing wins in 2020” – Modern Healthcare, January 4, 2020
- Several different approaches being considered
  - Murray-Alexander bill: requires providers to accept the median in-network rate if out-of-network
- Bipartisan support for relief from surprise medical bills
Stark and Antikickback Rules

- Represents an attempt to modernize Stark and Antikickback statutes and provide flexibility with respect to care coordination and value-based arrangements
- Comments were due on December 31, 2019
- Both proposed rules contain new exceptions/safe harbors for risk-based value-based arrangements
- Significant shortcomings in the rules that need to be addressed in the final rules
  - Risk thresholds are too high
  - Non-risk based exceptions are too narrow
Pricing Transparency

- Finalized and published in the November 27 *Federal Register*; effective 1/21/2021

- Hospitals must:
  - Make public all standard charges for all items and services in a machine readable form, including a description of each item and service (including packages) and any code used for accounting or billing
  - Standard charges includes:
    - Gross Charge: The charge for an item or service that is reflected on a hospital’s chargemaster, absent any discounts.
    - Payer-Specific Negotiated Charge: The charge the hospital has negotiated with a third-party payer for an item or service.
    - Discounted Cash Price: The charge that applies to an individual who pays cash for a hospital item or service.
    - De-Identified Minimum Negotiated Charge: The lowest charge that a hospital has negotiated with all third-party payers for an item or service.
    - De-Identified Maximum Negotiated Charge: The highest charge that a hospital has negotiated with all third-party payers for an item or service.
Pricing Transparency

- Hospitals must also:
  - Display at least 300 “shoppable services” in a consumer-friendly manner
    - “Shoppable Service” means a service that can be scheduled by a patient in advance
    - 70 CMS-specified and 230 hospital-selected
    - Must display payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least such 300 “shoppable services.”
  - Information must be displayed prominently and be easily accessible without barriers, free of charge, without password protection, and digitally searchable.
  - Information must be updated at least annually and indicate when last updated.
  - CMS has the authority to monitor hospital compliance
    - warning notice, and may request corrective action plan
    - If a hospital fails to respond to the request for a corrective action plan or comply with the requirements of the corrective action plan, $300 per day civil monetary penalty and publicize the penalty on a CMS website
Site-Neutral Payment Rules and Litigation

- In 2018 CMS attempted to phase in a reduction in payments to grandfathered provider-based outpatient hospital departments to match the payment to other clinical sites
- The reduction was to be phased in over two years
- AHA sued CMS over the rule
- In September 2019, the court agreed with AHA
- CMS said it would restore the payments from 2019, but intended to fully implement the reductions in 2020 under the original 2-year plan
- AHA filed suit in December to stop the reductions in 2020
Recent Court Decisions
Texas vs. U.S.A.

- Challenge to the constitutionality of the Affordable Care Act
- U.S. District Court (Northern District) ruled that the individual mandate was unconstitutional when the Shared Responsibility Payment was reduced to $0 in the Tax Cuts and Jobs Act (2017)
- Also ruled that the individual mandate was inseparable from the remainder of the ACA, thereby invalidating the entire Act
- Appealed to the 5th U.S. Circuit Court of Appeals
Texas vs. U.S.A. (cont.)

- 5th Circuit decision issued 12/18/2019
- Agreed with the lower court
  - Prior decision of the U.S. Supreme Court upheld the individual mandate as a proper exercise of Congress’ taxing power
  - When the shared responsibility payment was eliminated by the TCJA, it could no longer be considered a tax
  - The individual mandate is essentially a mandate by Congress to engage in commerce which is not a proper exercise of Congress’ authority to regulate commerce
  - Therefore the individual mandate is unconstitutional
- Did not agree with the lower court on severability and remanded
  - Lower court’s analysis on severability was too superficial
  - Lower court must “employ a finer-toothed comb” to determine what provisions of the ACA can be severed from the individual mandate
Children’s Hospital Association of Texas vs. Azar

- CHAT challenged the validity of a 2017 CMS rule related to how Medicaid disproportionate share payments are calculated.
- The issue was the hospital specific limit and whether Medicare and other insurance payments received by hospitals could be subtracted from the HSL as provided for in the rule.
- CHAT contended that the 2017 rule was contrary to the federal Medicaid Act and was arbitrary and capricious.
- The district court agreed with CHAT.
- On August 13, 2019, the D.C. Circuit Court of Appeals reversed the lower court and upheld the rule; rehearing petition overruled 11/8/2019.
- CHAT has 90 days to seek appeal to U.S. Supreme Court.
Looking Ahead
2020 Elections are here!

• March 3 Primary/November 3 General Election
  • Early Voting Starts February 18.

• U.S. Congress
  • 6 Texas GOP not returning (Olson, Conaway, Hurd, Marchant, Thornberry, Flores).

• Texas House
  • 83 - 67 GOP majority (9 seats to move majority).
  • 10 GOP House seats in districts that went Beto.

• Rep. Zerwas retiring

• Speaker Bonnen not running for re-election
Interim Charges

• House
  • Appropriations -
    • Monitor fulfillment of requirements in Health and Human Services Commission (HHSC) Rider 114, including HHSC Office of Inspector General alignment of oversight of managed care organizations
    • Monitor progress on construction of state hospitals and the capacity of the state hospital system to provide mental health support in all regions across Texas
    • Review how Texas is preparing for state and federal budgetary changes that impact the state’s health programs, including: the Family First Prevention Services Act; the next phase of the 1115 Healthcare Transformation and Quality Improvement Program Waiver; Texas’ Targeted Opioid Response Grant; the Centers for Medicare and Medicaid Services proposed Medicaid Fiscal Accountability rule, and the Healthy Texas Women Section 1115 Demonstration Waiver
    • 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.

• Business and Industry
  • Monitor implementation of HB 1941, which makes certain freestanding emergency room pricing practices a deceptive trade practice and authorizes the Attorney General's consumer protection division to bring an action to enforce the law. Work with the Office of the Attorney General to review complaints related to freestanding emergency room pricing, enforcement actions, and additional steps to be taken to address these issues
Interim Charges

- House
  - Insurance
    - Monitor implementation of SB 1264, which prohibits balance billing (surprise billing) and creates an arbitration system to settle balance bills; review the TDI’s rules implementing the legislation’s exception for non-emergency “elective” services to determine whether the rules limit the exception to out-of-network services that a patient has actively elected after receiving a complete written disclosure; monitor or follow up on TDI’s process for selecting the benchmarking database and determine whether the database chosen provides the most accurate available data and its sources are transparent
  - Judiciary and Civil Jurisprudence
    - Monitor implementation of HB 4531, which authorizes adults under guardianship to consent to forensic medical examination protocols, and monitor the impact of the legislation on the prevention, investigation, and prosecution of sexual assault, and study the impact on other related offenses and the treatment and services provided to victims of those offenses
  - Public Health
    - Monitor implementation of SB 749, related to maternal and neonatal facility designations
    - Monitor implementation of HB 2174, related to limits for opioid prescriptions for treatment of acute pain
  - State Affairs
    - Study how governmental entities use public funds for political lobbying purposes, examine what types of governmental entities use public funds for lobbying purposes, make recommendations to protect taxpayers from paying for lobbyists who may not represent the taxpayers’ interests
Interim Charges

- Senate
  - Business and Commerce
    - Health Care Costs
      - Study the cost of health care in Texas
      - Make recommendations to increase access to affordable quality health care
      - Explore potential opportunities and recommend best practices to continue to curb rising health care costs
      - Study and report on ways to increase consumer health care options, provide flexibility in the market, and decrease the uninsured rate in Texas, including 1115 and 1332 waivers
  - Health and Human Services
    - Health Care Costs
      - Examine the state health and human services finance system including, but not limited to, the following programs and methods of finance: Local Provider Participation Funds, the Delivery System Reform Incentive Payment Program, Medicaid 1115 waivers and Section 1332 State Innovation waivers, Pay for Quality programs, the Quality Incentive Payment Program, and other state and local funding used to finance health care systems in Texas.
      - Identify ways to streamline functions and reduce unnecessarily burdensome and costly requirements in the Texas Medicaid program. Provide recommendations to ensure the sustainability of the state's health and human services system and judicious use of taxpayer dollars.
Thank you!

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