Hospital Financing
RHP-9 Learning Collaborative
August 17, 2017

Richard Schirmer, FACHE, FHFMA
Vice President, Health Care Policy Analysis
Texas Hospital Association

New Health Care Laws In Texas? Ask Banda After Lunch!

Hospital Financing

Look Familiar?

A Little Help With The Abbreviations Used

- APG-Ambulatory Payment Group
- CAH-Critical Access Hospital
- CMS-Centers for Medicare & Medicaid Services
- DRG-Diagnosis Related Group
- DSH-Disproportionate Share Hospital
- DSRIP-Delivery System Reform Incentive Payment Program
- EMTALA-Emergency Medical Treatment And Labor Act
- EPM-Episode Payment Model
- FFS-Fee For Service
- FPL-Federal Poverty Level

HHSC-Health and Human Services Commission

HMO-Health Maintenance Org.

IGT-Intergovernmental Transfer

IO-Investor Owned

LOS-Length Of Stay

MCO-Managed Care Organization

MOON-Medicare Outpatient Observation Notice

NFP-Not For Profit

Per Diem-Fixed Payment Per Day

PPS-Prospective Payment System

Setting The Stage

Hospital Financing

August 17, 2017

Texas Hospitals - 2015

	Govt	NFP	IO	Total
Number Hospitals	116	166	337	619
	18.7%	26.8%	54.4%	100.0%
Licensed Beds	13,320	34,729	38,639	86,688
	15.4%	40.1%	44.6%	100.0%
Admits	384,802	1,240,005	1,171,790	2,796,597
	13.8%	44.3%	41.9%	100.0%
Inpatient Days	2,886,865	6,328,454	7,018,465	16,233,784
	17.8%	39.0%	43.2%	100.0%
LOS	7.5	5.1	6.0	5.8
Beds/Hospital	115	209	115	140

Texas Hospitals - 2015

Charges-Inpatient	$	151,388,527,078		56%
Charges-Outpatient	$	118,713,593,932		44%
Charges-Total	$	270,102,121,010		100%
Net Patient Revenue	$	65,982,475,120		91%
Tax Appropriations	$	2,980,587,080		
Other Operating Rev	$	2,730,903,132		
Non-Operating Rev	$	763,978,202		
Total Revenue	$	72,457,943,534		

Hospital District Tax Revenue – 2015

Hospital District (X147)	MARKET VALUE	TAXABLE VALUE	TOTAL RATE	Total LEVY
Chillicothe Hospital District	143,363,110	73,571,670	0.761	559,918
Schleicher County Hospital District	961,640,423	362,161,976	0.680	2,462,701
South Limestone Hospital District	1,800,850,971	1,731,499,645	0.292	5,055,979
Dallas County Hospital District	224,007,655,110	189,691,067,219	0.286	542,516,452
Culberson County Hospital District	1,047,250,770	846,222,290	0.283	2,394,005
Palo Pinto Hospital District	4,503,516,110	2,931,988,100	0.280	8,209,567
Gonzales County Hospital District	5,541,569,140	265,040,630	0.280	742,114
Reagan County Hospital District	2,915,171,390	2,575,292,136	0.278	7,159,879
University Health System	147,362,492,994	133,933,125,748	0.276	369,970,170
Stratford Hospital District	450,759,700	447,584,790	0.275	1,230,858
Stephens County Hospital District	1,694,775,131	633,466,819	0.240	1,519,560
Ballinger Memorial Hospital District	709,560,590	331,173,301	0.230	762,056
Crane County Hospital District	1,583,610,050	1,534,310,170	0.230	3,528,913
Terry County Memorial Hospital District	1,209,737,530	971,259,069	0.230	2,233,896
Haskell Hospital District	751,304,735	400,893,468	0.229	917,244
Tarrant County Hospital District	156,045,413,013	143,003,104,600	0.228	325,899,785
Dawson County Hospital District	1,130,942,110	1,127,408,170	0.228	2,567,999
R. E. Thomason General Hospital District	42,822,840,120	40,186,525,580	0.221	88,684,428
Reeves County Hospital District	3,484,683,130	2,956,974,850	0.214	6,338,364
Grapeland Hospital District	522,575,430	288,701,100	0.010	28,581
Higgins/Lipscomb Hospital District	488,573,340	434,167,682	0.009	38,641
Texhoma Hospital District	119,630,840	118,710,820	0.008	10,012

Texas Hospitals - 2015

Payer	Charges	Payments	Payor % Charges	Payor % Payments	Payments % Of Charges
Medicare-FFS	77,517,232,385	14,034,907,483	28.7%	21.3%	18.1%
Medicare-Mged	29,456,859,209	4,537,081,453	10.9%	6.9%	15.4%
Medicare-Total	106,974,091,594	18,571,988,936	39.6%	28.2%	17.4%
Medicaid-FFS	12,607,782,527	1,717,087,517	4.7%	2.6%	13.6%
Medicaid-Mged	26,056,844,727	4,074,478,271	9.6%	6.2%	15.6%
Medicaid-Base Pymt	38,664,627,254	5,791,565,788	14.3%	8.8%	15.0%
Medicaid DSH		1,268,896,527	0.0%	1.9%	3.3%
Supp. Pyments		2,470,258,573	0.0%	3.8%	6.4%
Medicaid-Total		9,530,720,888	0.0%	14.5%	24.6%
Other Govt	8,521,044,816	2,746,941,691	3.2%	4.2%	32.2%
Non-Govt-Self Pay	27,402,036,822	1,290,195,119	10.1%	2.0%	4.7%
Non-Govt-Mged Care	73,302,325,472	27,694,576,757	27.1%	42.1%	37.8%
Non-Govt-Other 3rd	14,636,189,635	5,862,457,715	5.4%	8.9%	40.1%
Non-Govt-Other	629,043,632	126,195,666	0.2%	0.2%	20.1%
Total	270,129,359,225	65,823,076,772	100.0%	100.0%	24.4%

Uncompensated Care

- Uncompensated care: Care for which no payment is expected or no charge is made. It is the sum of bad debt and charity care absorbed by a hospital or other health care organization in providing medical care for patients who are uninsured or are unable to pay.
- Bad debt: The provision for actual or expected uncollectibles resulting from the extension of credit. Report as a deduction from revenue.
- Financial Assistance (Includes Charity care). Financial assistance and charity care refer to health services provided free of charge or at reduced rates to individuals who meet certain financial criteria. For purposes of this survey, charity care is measured on the basis of revenue forgone, at full- established rates.

Texas Hospitals - 2015

Bad Debt (Charges)	8,442,286,212
Charity (Charges)	13,495,689,034
Total Uncomp Care (Charges)	21,937,975,246
Overall RCC	23.5%
Bad Debt (Cost)	2,095,884,466
Charity (Cost)	4,044,976,344
Total Uncomp Care (Cost)	6,140,860,809

Federal Poverty Guidelines - 2017

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,180 for each additional person.	
1	$12,060
2	$16,240
3	$20,420
4	**$24,600**
5	$28,780
6	$32,960
7	$37,140
8	$41,320

Charity Care Policy – Financially Indigent (% FPL)

Hospital A (NFP)

- 1. 100%
- 2. <133%
- 3. <150%
- 4. <200%
- 5. Other, specify 175% or less

Hospital B (NFP)

- 1. 100%
- 2. <133%
- 3. <150%
- 4. <200%
- 5. Other, specify 400%

Charity Care Policy - Medically Indigent

Hospital A (NFP)

Does your hospital have a charity care policy for the Medically Indigent?

IF yes, provide the definition of the term Medically Indigent.

- Medically Indigent patients are applicants for charity status whose income exceeds 175% of the federal poverty guidelines will be considered for charity care on a case by case review based on a percentage of their income.

Hospital B (NFP)

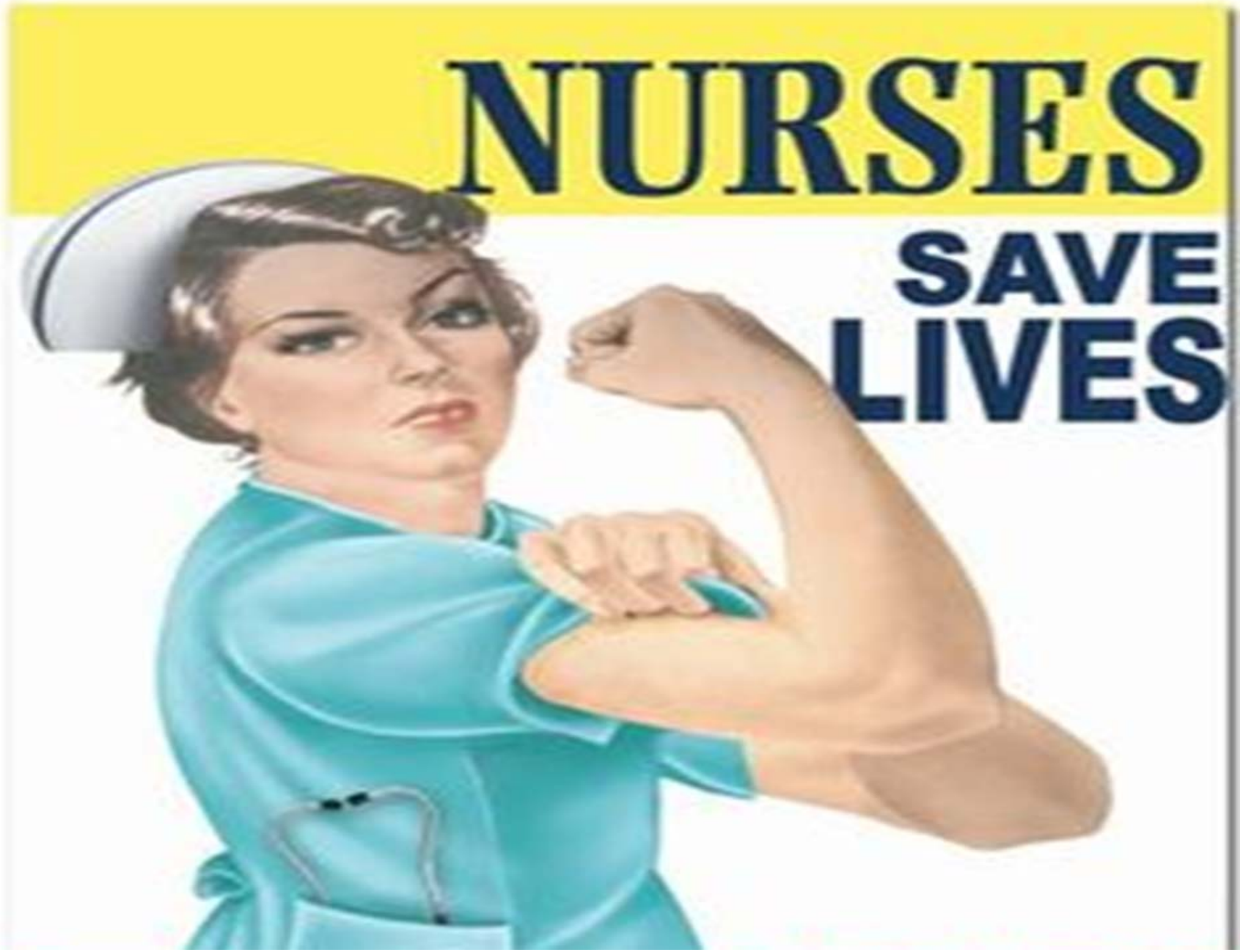
Does your hospital have a charity care policy for the Medically Indigent?

IF yes, provide the definition of the term Medically Indigent.

- Refers to individuals who this Hospital determines are unable to pay all or a portion of their remaining bill balance after payment, if any, by third party payors; or have outstanding account balances of at least $5,000 owed on their Hospital bills, after crediting all health insurance payments, if any, and such account balance exceeds twenty percent (20%) of the person's annual gross family income

Salaries & Benefits Are A Major Expense Item

Salaries	**$ 23,364,750,879**
Benefits	**$ 5,469,052,875**
Total Payroll	**$ 28,833,803,754**
Total Expenses	**$ 64,103,641,089**
Payroll As % Of	
Total Expenses	**45.0%**


NURSES
SAVE
LIVES

A Significant Number Of A Hospital's FTEs Are Nursing-Related

RN-Full Time	100,792	
RN-Part Time	24,656	
RN-Total	125,448	
RN-FTE	107,701	30.4%
LVN-Full Time	8,101	
LVN-Part Time	1,761	
LVN-Total	9,862	
LVN-FTE	8,697	2.5%
Total Nursing-Full Time	108,893	
Total Nursing-Part Time	26,417	
Total Nursing-Total	135,310	
Total Nursing-FTE	116,398	32.9%
All Staff-Full Time	331,858	
All Staff-Part Time	71,560	
All Staff-Total	403,418	
All Staff-FTE	353,698	

Job # : 1420 **Job Title:** **Registered Nurse (RN) I**

Job Description: Provides nursing care to a group of patients for a designated time frame. Routinely leads team of care providers. May assume charge responsibility for unit when assigned. Experience is 0-2 years.

Education: Registered Nurse License

			Hourly Base Wage						Hourly Total Cash Compensation						Pay Range		Hourly Shift Differential		
	No. of Orgs	No. of Empl	Avg	10th %tile	25th %tile	Med	75th %tile	90th %tile	Avg	10th %tile	25th %tile	Med	75th %tile	90th %tile	Avg Min	Avg Max	Evening	Night	Weekend
All Firms	70	23364	30.79	23.77	25.64	29.84	35.10	38.96	30.81	23.77	25.65	29.87	35.11	38.97	25.23	37.78	2.90	3.72	4.44
THA DISTRICT																			
District 1																			
District 2	6	255	27.75	22.56	23.30	25.48	31.56	36.35	27.75	22.56	23.30	25.48	31.56	36.35	23.27	36.17			
District 3	11	2930	29.75	23.98	25.11	28.79	34.00	36.12	29.75	23.98	25.11	28.79	34.00	36.12	23.80	35.96	2.68	4.22	4.69
District 4 - Houston	5	1662	38.19	29.76	32.76	38.33	43.07	47.92	38.19	29.76	32.76	38.33	43.07	47.92	30.12	46.43	3.36		
District 5 - Dallas	7	2267	33.41	26.01	27.99	33.48	38.32	40.89	33.41	26.01	27.99	33.48	38.32	40.89	26.38	41.19	3.71		5.51
District - East Texas	11	1422	26.93	21.85	23.43	25.44	30.43	34.65	26.93	21.85	23.43	25.44	30.43	34.65	23.19	36.64	2.71	3.83	1.77
District 6																			
District 7	5	2531	30.84	25.45	26.04	28.87	35.61	39.18	30.84	25.45	26.04	28.87	35.61	39.18					
District 8	12	2598	31.20	23.47	25.19	30.18	35.86	41.08	31.20	23.47	25.19	30.18	35.86	41.08	25.48	38.13	3.27	4.44	6.41
GROSS REVENUE																			
<25 Million	7	153	30.11	22.28	26.08	29.36	32.98	38.35	30.11	22.28	26.08	29.36	32.98	38.35	23.73	41.34	3.19		4.08
25-150 Million	9	313	28.94	22.95	25.03	28.64	32.50	34.07	29.58	22.95	25.53	29.70	32.50	35.07	23.04	34.35		3.78	2.69
150 Million or more	30	14920	29.15	23.43	25.27	28.00	33.12	36.00	29.15	23.43	25.27	28.00	33.12	36.00	24.00	35.92	2.63	3.63	3.26
LICENSED BED SIZE																			
Critical Access																			
Less than 75 Beds	8	135	29.00	24.50	26.00	28.64	31.56	33.90	30.98	25.52	27.95	29.98	32.96	37.30	23.81	37.22		3.23	3.67
76-250 Beds	15	2564	31.20	23.00	25.80	30.67	36.66	40.00	31.20	23.00	25.80	30.67	36.66	40.00	24.32	40.19	2.99	4.08	3.99
251 or more Beds	22	13147	29.17	23.50	25.45	28.11	33.09	35.88	29.17	23.50	25.45	28.11	33.09	35.88	24.13	35.78	2.75	3.63	3.18
COMMUNITY POPULATION																			
50,000 or less	16	732	27.63	22.00	23.95	27.30	31.34	33.02	27.91	22.00	23.95	27.87	31.54	33.51	21.88	36.13	2.96	4.05	2.70
50,001 to 100,000	6	1129	30.34	22.16	24.93	28.16	35.92	41.42	30.34	22.16	24.93	28.16	35.92	41.42	24.80	41.55	2.35	3.75	2.60
100,001 to 200,000	8	1707	27.63	22.50	23.52	26.46	30.67	34.64	27.67	22.50	23.52	26.51	30.73	34.66	23.53	36.93		2.86	4.32
200,001 or more	26	11243	31.40	24.00	25.86	30.75	35.26	40.93	31.40	24.00	25.86	30.75	35.26	40.93	25.68	37.94	2.91	3.92	5.01
OWNERSHIP																			
Government	12	2433	37.73	28.63	32.28	37.95	42.51	46.84	37.73	28.63	32.28	37.95	42.51	46.84	30.99	44.72	3.80	3.87	9.19
Investor Owned	25	10716	30.63	23.42	25.76	30.07	35.00	38.18	30.63	23.42	25.79	30.07	35.00	38.18	25.13	36.89	2.74	3.41	3.51
Not-for-Profit	33	10215	29.32	23.76	25.45	27.98	33.57	36.35	29.34	23.76	25.45	28.00	33.62	36.35	23.94	37.05	2.67	3.88	3.13

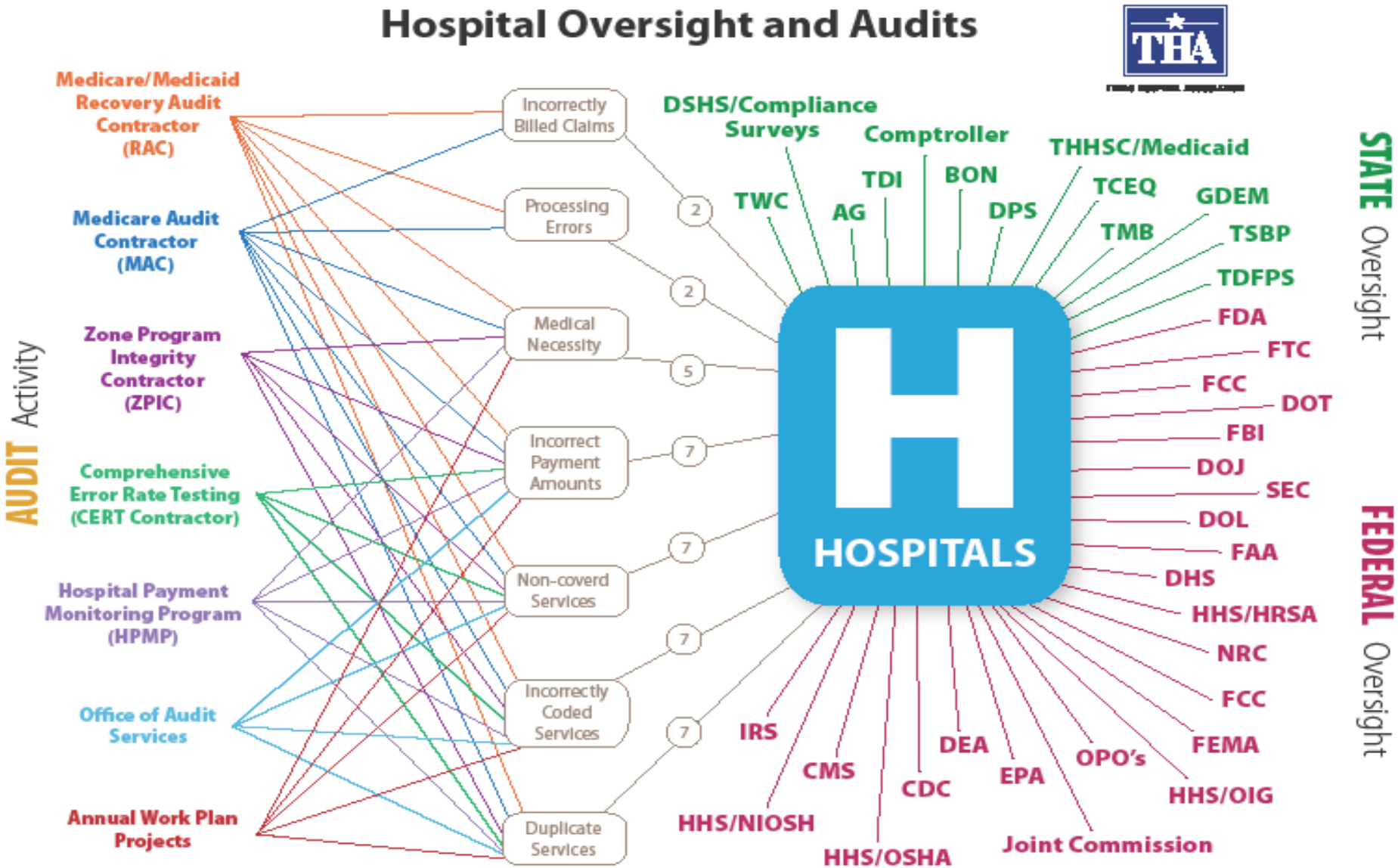
Other Significant Cost Drivers

- Inpatient Drug Spending
- Medical Devices
- Electronic Health Records
- Regulatory Requirements

Other Issues Impacting Hospitals

Hospital Financing

August 17, 2017


Hospital Oversight and Audits
THA
AUDIT Activity
Medicare/Medicaid Recovery Audit Contractor (RAC)
Medicare Audit Contractor (MAC)
Zone Program Integrity Contractor (ZPIC)
Comprehensive Error Rate Testing (CERT Contractor)
Hospital Payment Monitoring Program (HPMP)
Office of Audit Services
Annual Work Plan Projects
Incorrectly Billed Claims
Processing Errors
Medical Necessity
Incorrect Payment Amounts
Non-coverd Services
Incorrectly Coded Services
Duplicate Services
2
2
5
7
7
7
7
HOSPITALS
STATE Oversight
DSHS/Compliance Surveys
Comptroller
THHSC/Medicaid
TWC
AG
TDI
BON
DPS
TCEQ
TMB
GDEM
TSBP
TDFPS
FEDERAL Oversight
FDA
FTC
FCC
DOT
FBI
DOJ
SEC
DOL
FAA
DHS
HHS/HRSA
NRC
FCC
FEMA
HHS/OIG
IRS
CMS
CDC
DEA
EPA
OPO's
HHS/NIOSH
HHS/OSHA
Joint Commission

Unfunded Mandate – Emergency Medical Treatment & Labor Act

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Hospitals Are Economic Engines

The health care sector has traditionally been an economic mainstay, providing stability and job growth in communities. Health care added more than 35,000 jobs per month in 2016.1 Hospital care is an important component of the health care sector. Hospitals:

- Employ more than 5.7 million people.
- Are one of the top sources of private-sector jobs.
- Purchase nearly $852 billion in goods and services from other businesses.

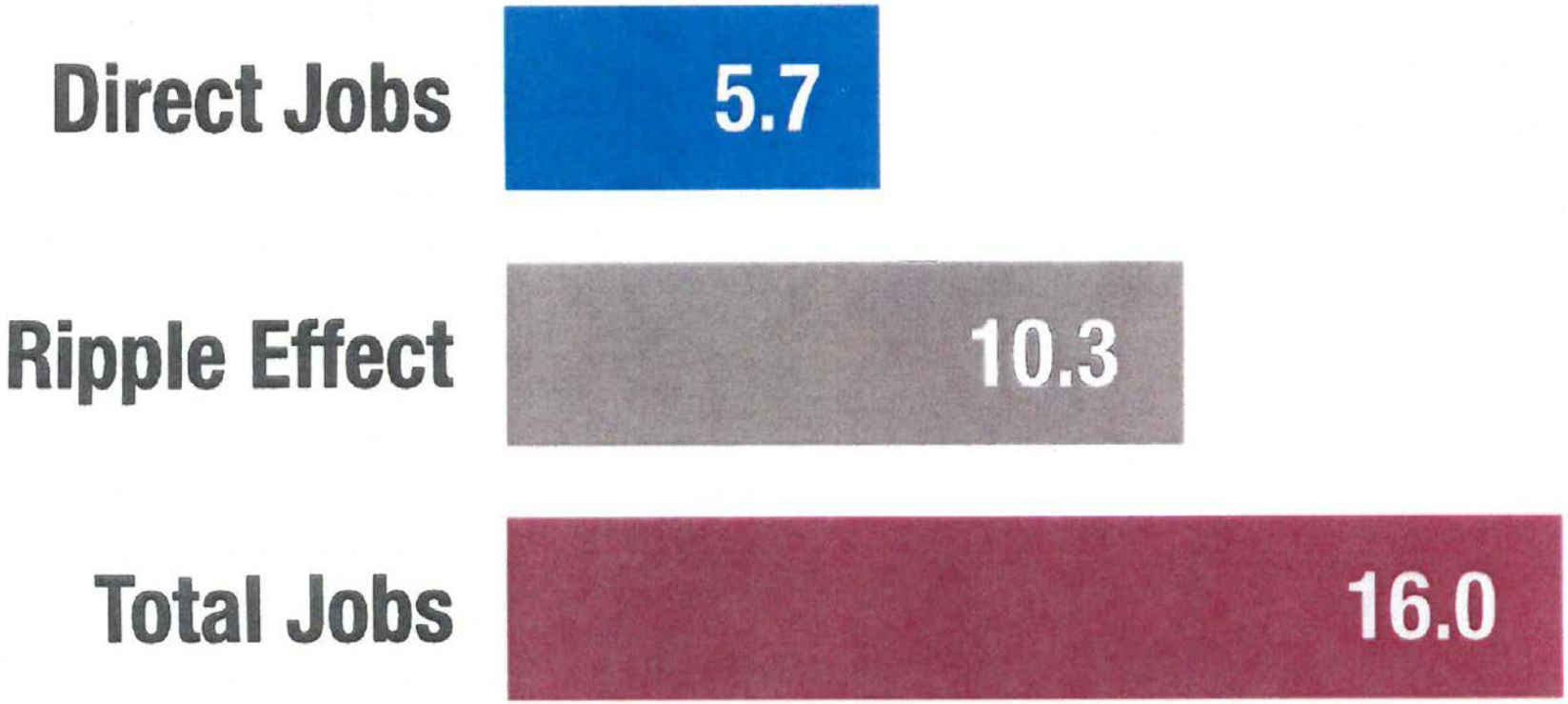
Ripple Effect of Hospitals on Their Community

The goods and services hospitals purchase from other businesses create additional economic value for the community. With these "ripple effects" included, each hospital job supports about two additional jobs, and every dollar spent by a hospital supports roughly $2.30 of additional business activity. Overall, hospitals:

- Support 16 million total jobs, or one of 9 jobs, in the U.S.
- Support more than $2.8 trillion in economic activity.
- Texas Multipliers for jobs (2.4134), wages (1.9941) and expenditures (2.3918)

...but with "ripple effects" included, support 16 million total jobs.

Impact of Community Hospitals on U.S. Jobs (in millions), 2015

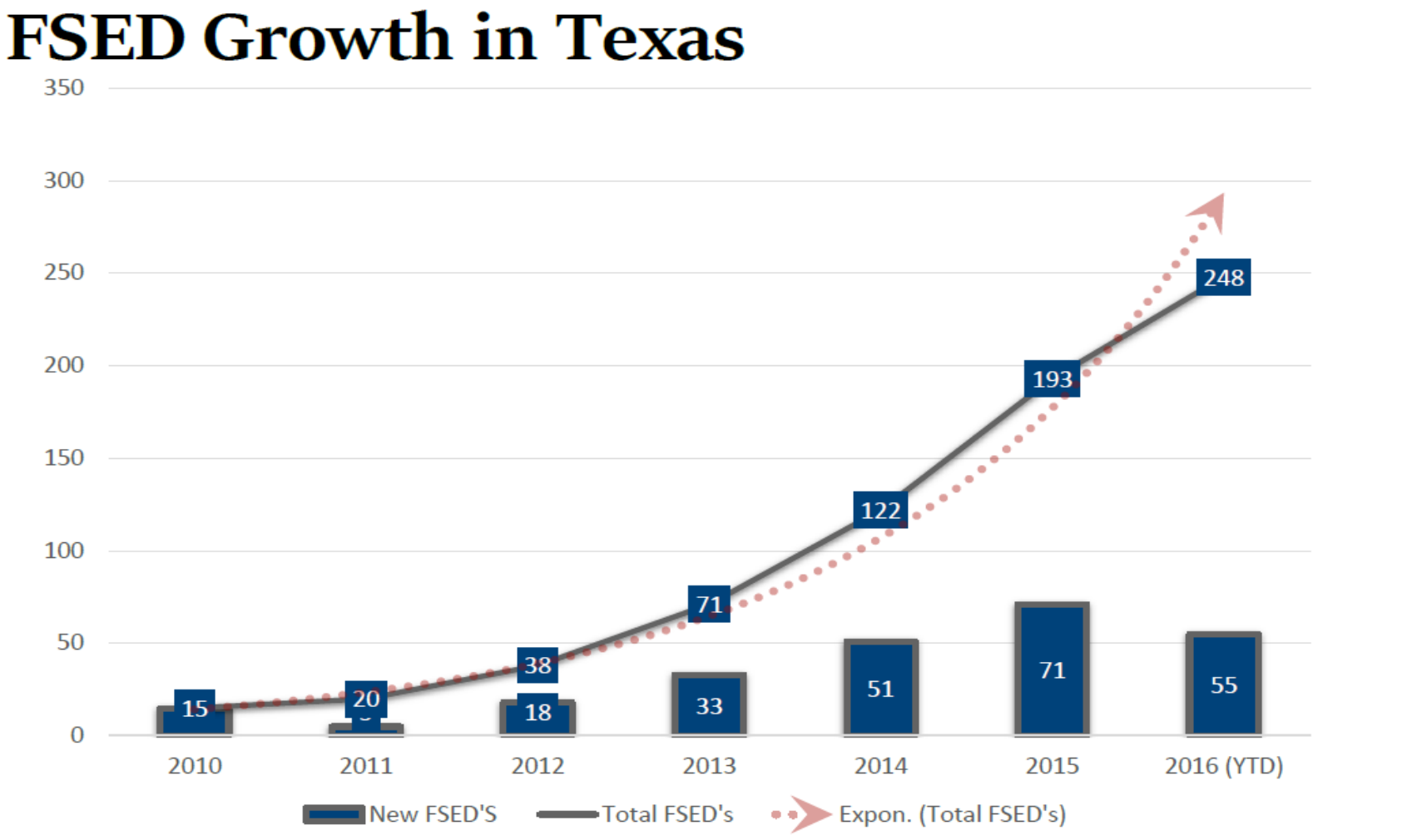


Source: Analysis, using BEA RIMS-II (1997/2006) multipliers, released in 2008, applied to 2015 American Hospital Association Annual Survey data. Note: Multipliers released in 2010 and subsequent years no longer include the national level multipliers needed for this chart. The sum of the direct and ripple effect may be less than or greater than the total contribution due to rounding.

Note: Data updated annually.

Transition To A Free Standing Emergency Room

Free Standing EDs – 351 (217 Plus Exempt)



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Setting the Record Straight on Freestanding Emergency Centers in Texas

Texas Hospital Association

QUICK FACTS
ON FREESTANDING EMERGENCY CENTERS

Freestanding emergency centers provide health care services for patients who may be experiencing emergent conditions; FECs often are not owned or operated by hospitals.

More than 60 percent of freestanding emergency centers in Texas are not owned and operated by a hospital.

Independent FECs are not required to comply with federal laws and regulations governing emergency care.

Hospital-owned FECs are subject to more state regulations and requirements because they are licensed as part of a hospital than independent FECs.

Only hospital-owned FECs can bill for care provided to patients covered through Medicare and Medicaid.

Hospital-owned FECs are fully clinically integrated with the parent hospital. Independent FECs are required only to have transfer agreements with an area hospital.

Freestanding emergency centers are not hospitals, and they are not urgent care centers. Rather, they are entities that are structurally separate from a hospital but are capable of delivering at least some level of emergency health care services 24-hours a day, seven days a week.

Texas has more FECs than any other state – 345. More than 60 percent of these FECs are not owned by or affiliated with a Texas hospital. The majority of FECs are owned and operated by for-profit, non-hospital entities. Independent FECs are subject to less stringent state and federal laws, regulations and licensing standards than hospital-owned FECs.

	Independent EMERGENCY CENTER	Hospital EMERGENCY CENTER
Part of Health Care Safety Net	✗	✓
Must Comply with Federal EMTALA Law	✗	✓
Participate in Medicare/Medicaid/TRICARE/	✗	✓
Subject to State Reporting Requirements for Hospitals	✗	✓

HELPING TEXAS PATIENTS

As the number of independent FECs grows exponentially in Texas, concerns are mounting about:

- consumer confusion;
- differences in regulation and licensing;
- insurance network participation; and
- the potential that independent FECs exacerbate existing physician, nurse and allied health professional shortages, particularly in already underserved rural areas.

Health Care Reform – Current Status?

- Three big issues
  - Eliminate pre-existing conditions/community ratings? Community rating requires health insurance providers to offer health insurance policies within a given territory at the same price to all persons without medical underwriting, regardless of their health status.
  - Tax credits-Impacts the poorer/sicker patients. Is $70B enough to deal with premiums increasing from $2K to $13K for an individual?
  - Medicaid and taxes. Will they have enough dollars to deal with non-expansion states? Will they scale back the tax cuts? May move forward with House proposal and make a few tweaks around the edges
  - It's all about MEDICAID!!!!!!!!

Our Issue With Health Care Reform

- Texas chose the fiscally conservative option not to expand Medicaid. We should not be penalized for this choice
- The average Medicaid reimbursement for inpatient care is just 58 percent of costs
- Well over 90 percent of Medicaid beneficiaries are enrolled in managed care
- AHCA will disadvantage states like Texas that chose not to expand and already operate efficient programs through managed care
- Although AHCA establishes a $10B safety-net fund for non-expansion states, Texas sustains the third largest federal funding impact of all non-expansion states-$56.4 billion (2014-2025)
- Actual per capita Medicaid spending was $753 for non-expansion states versus $1,578 for expansion states

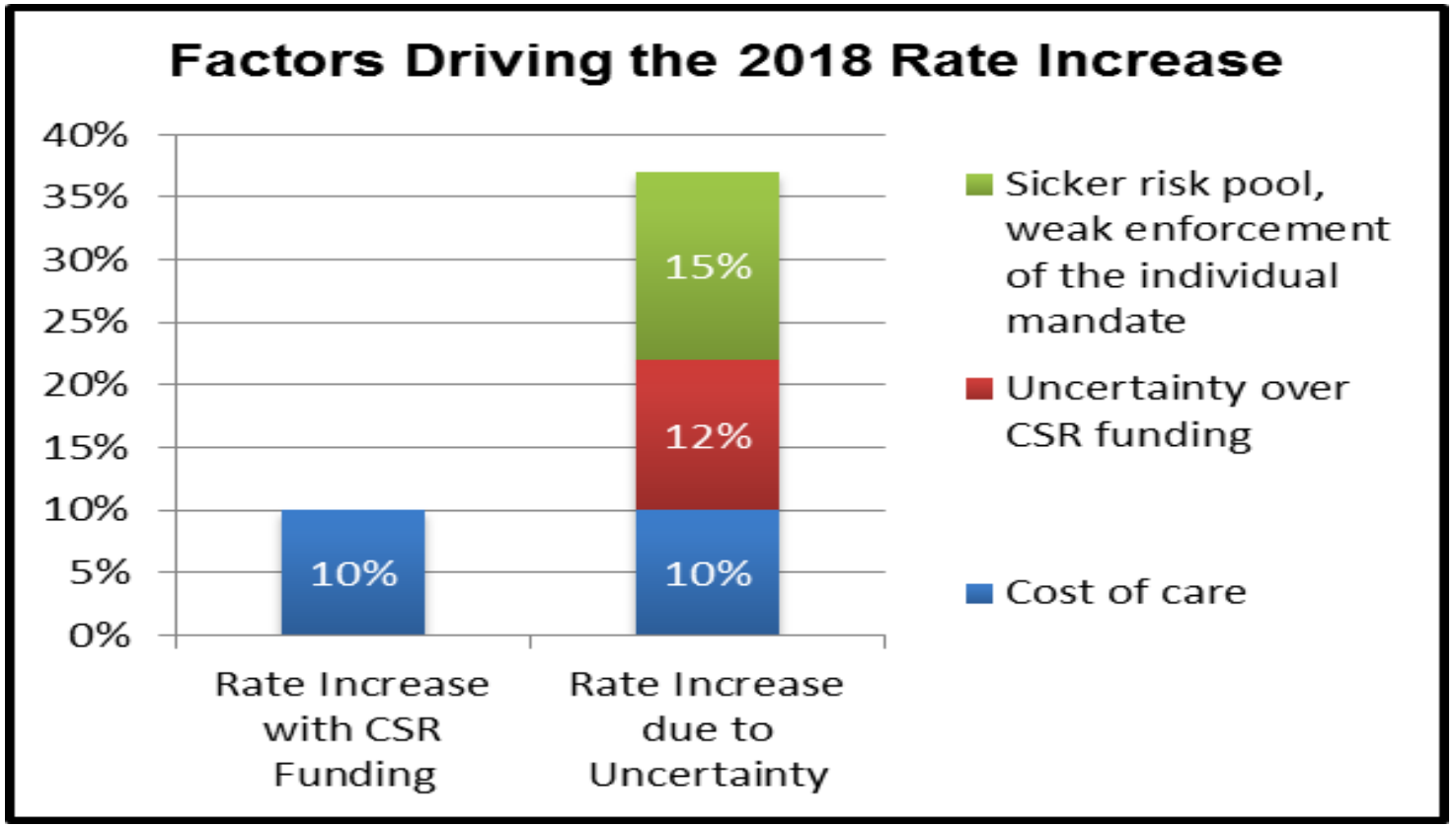
Health Care Reform - Recommendations

- For non-expansion states, eliminating the federal funding cuts to Medicaid and Medicare that are part of the ACA and were predicated on expanded health care coverage. ACA reduces funding to Texas hospitals by more than $17 billion (2017-2026).
- Increasing funding to the federal safety net pool for non-expansion states and provide mechanism to direct funding to providers that disproportionately serve low-income and uninsured populations. Regulatory relief will be needed.
- Supporting safety net hospitals by ensuring adequate base funding or supplemental payments that acknowledge projected increases in the number of uninsured and, as a result, hospitals' uncompensated costs.

Better Care Reconciliation Act

1. It will increase the number of uninsured Texans and hospitals' uncompensated care costs. According to the nonpartisan Congressional Budget Office, more than 3.3 million Texans will become uninsured under the BCRA by 2026. This represents more than 15 percent of the total in the U.S.
2. It will limit federal Medicaid funding through the use of per capita caps and limit growth in the per capita cap to an inadequate inflator (medical consumer price index). Texas will lose more than $60 billion over 10 years.
3. It will negatively incentivize the state to cut hospital payments, reduce Medicaid benefits and restrict eligibility and enrollment.
4. It eliminates provisions intended to make enrollment of eligible-but-uninsured patients easier, such as retroactive Medicaid eligibility. Eliminating these provisions will further increase hospitals' uncompensated care costs.
5. The provisions dealing with Medicaid disproportionate share hospital payments are insufficient to give Texas the Medicaid funds it needs to achieve parity with states that did expand their Medicaid programs.

Cost Drivers-ACA Rate Increases-Community Health Choice (Houston)



Cost Sharing Reductions are a strict pass-through for costs such as co-pays to physicians; insurers are not allowed to keep unused CSR funds.

Medicare Payments

Hospital Funding

August 17, 2017

What Happened To The Good ‘Ole Days?

Medicare FFS Market Share – Patient Origin

Provider Number	Zip Code	Total Days	Total Charges	Total Cases	Percent Of Total Cases
450565	76067	2,373	13,811,529	511	68.7%
450565	76068	165	936,740	35	4.7%
450565	76449	127	759,596	29	3.9%
450565	76486	64	392,347	19	2.6%
450565	76484	53	366,779	15	2.0%
450565	76066	57	283,294	12	1.6%
450565	76453	53	367,722	12	1.6%
450565	76475	39	272,055	12	1.6%
450565	76087	45	304,478	9	1.2%
450565	76088	43	344,156	9	1.2%
Other		358	2,066,944	81	10.9%
		3,377	19,905,640	744	100.0%

Medicare FFS Market Share – Patient Destination

Provider Number	Zip Code	Total Days	Total Charges	Total Cases	Percent of Total Cases	
450565	76067	2,373	13,811,529	511	35.8%	Palo Pinto
450672	76067	1,507	30,170,691	236	16.5%	Plaza Medical-Ft Worth
450203	76067	823	8,966,426	183	12.8%	Weatherford
450135	76067	942	10,681,264	150	10.5%	Harris Methodist-Ft Worth
450137	76067	307	2,851,407	50	3.5%	Baylor All Saints-Ft Worth
673062	76067	417	862,307	34	2.4%	
450779	76067	124	2,125,819	26	1.8%	Harris Methodist SW-Ft Worth
452044	76067	727	6,356,990	26	1.8%	Lifecare Plano
Other		2,327	15,683,879	211		
		9,547	91,510,312	1,427	100.0%	

A Bilingual Moment

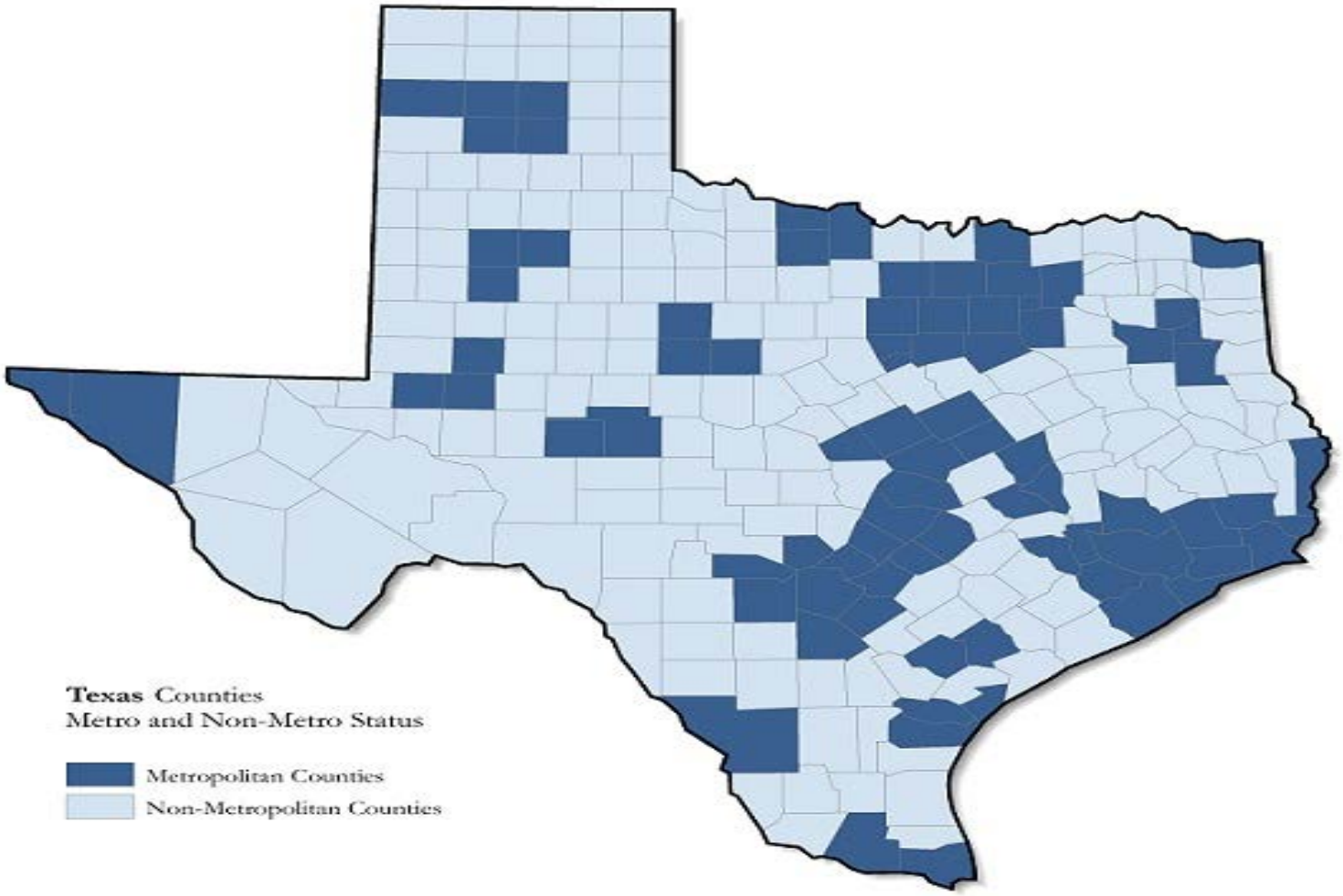
Hospitals Paid Under Medicare's Prospective Payment System

- Methodist Dallas
- Baylor Medical Center
- Texas Health Harris Methodist Ft Worth
- HCA Medical City Dallas
- Parkland
- JPS

Critical Access Hospitals (CAH)

- Big Bend Regional
- McCamey County Hospital District
- Winkler County Memorial
- Ward Memorial Monahan
- Presbyterian Commerce

Texas Metropolitan Statistical Areas (MSA)



Counties In Dallas & Fort-Worth MSAs/CBSAs

	County	CBSA NAME
1	COLLIN	Dallas-Plano-Irving, TX
2	DALLAS	Dallas-Plano-Irving, TX
3	DENTON	Dallas-Plano-Irving, TX
4	ELLIS	Dallas-Plano-Irving, TX
5	HUNT	Dallas-Plano-Irving, TX
6	KAUFMAN	Dallas-Plano-Irving, TX
7	ROCKWALL	Dallas-Plano-Irving, TX
1	HOOD	Fort Worth-Arlington, TX
2	JOHNSON	Fort Worth-Arlington, TX
3	PARKER	Fort Worth-Arlington, TX
4	SOMERVELL	Fort Worth-Arlington, TX
5	TARRANT	Fort Worth-Arlington, TX
6	WISE	Fort Worth-Arlington, TX

There Are Several Types of Rural Hospitals In Texas

There are 254 counties in Texas. Hospitals located in one of 26 Core Based Statistical Areas (82 counties) in Texas are classified by Medicare as “urban”. Hospitals located outside the CBSA, in one of the remaining 172 counties, are considered “rural”. There are approximately 155 Rural Hospitals located in Texas. Medicare has several different “rural” designations:

- 82 Critical Access Hospitals
- 80 Low-Volume Hospitals
- 15 Medicare Dependent Hospitals
- 45 Sole Community Hospitals
- 6 Rural Referral Centers

So What Is A Critical Access Hospital?

- Located in a rural area;
- Maintain no more than 25 inpatient beds that may also be used for swing bed services. May also operate a distinct part rehabilitation and/or psychiatric unit with no more than 10 beds;
- Have an annual length-of-stay of 96 hours or less (exc. swing beds);
- Be located more than 35 mile drive from any hospital or other CAH. Mileage requirement may be less if designated by state as a necessary provider prior to January 2006;
- Inpatient and outpatient services are paid at 101 percent of cost (less 2 percent sequestration reduction);
- Have their own Medicare Conditions of Participation as well as a separate payment method (Paid on a per diem basis); and
- Physicians who furnish care in a CAH located within a Health Professional Shortage Area are eligible for a 10 percent HPSA bonus payment for outpatient services

What Is A Swing Bed?

- A swing bed is a bed that can be used for either acute care or care that is equivalent to Skilled Nursing Facility (SNF) care. The Centers for Medicare and Medicaid Services approves CAHs, and other hospitals, to furnish swing beds, which gives the facility flexibility to meet unpredictable demands for acute care and SNF care.
- Swing beds offer an alternative to a long-term care facility. This option is particularly useful in rural areas, which are less likely to have a stand-alone long-term care facility. In addition, the population in rural areas are older, and swing beds are very useful in treating health problems typically seen in aging patients. The most commonly reported need was for aging patients who need rehabilitation following their hospital stay, Furthermore, swing beds help stabilize healthcare facilities census and provide financial benefits due to their cost-based reimbursement.

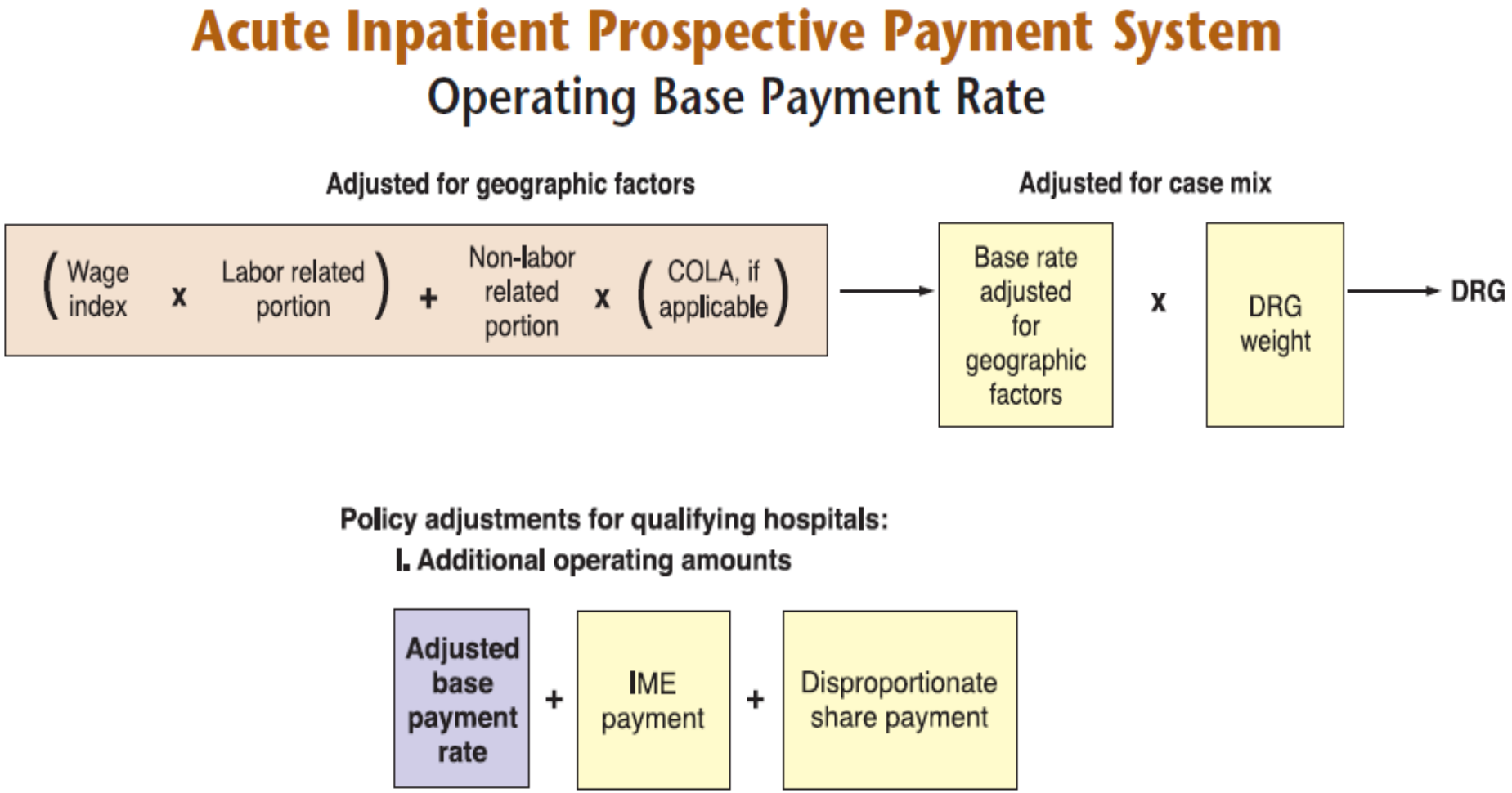
Outpatient Services Provided In A CAH

CAH services are subject to Medicare Part A and Part B deductible and coinsurance amounts. The copayment amount for most outpatient CAH services is 20 percent of applicable Part B charges and is not limited by the Part A inpatient deductible amount.

The Centers for Medicare & Medicaid Services (CMS) encourages CAHs to engage in consumer-friendly communication with patients about their charges to help patients understand their potential financial liability for services they may obtain at the CAH.

Let’s Talk About “Relatives”

Computing A DRG Payment



Medicare Base Payment Rates Vary

FY 2018 NPRM Tables 1A-1E

TABLE 1A. PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (68.3 PERCENT LABOR SHARE/31.7 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.75 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.425 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.025 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.15 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,822.07	$1,773.93	$3,740.37	$1,736.01	$3,794.84	$1,761.29	$3,713.14	$1,723.37

TABLE 1B. PROPOSED NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.75 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.425 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.025 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.15 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,469.52	$2,126.48	$3,395.36	$2,081.02	$3,444.80	$2,111.33	$3,370.64	$2,065.87

CBSA	Area Name	Wage Index
42100	Santa Cruz-Watsonville, CA	1.7971
42034	San Rafael, CA	1.7657
41884	San Francisco-Redwood City-South San Francisco, CA	1.7359
41940	San Jose-Sunnyvale-Santa Clara, CA	1.7349
41500	Salinas, CA	1.6937
12420	Austin-Round Rock, TX	0.9786
19124	Dallas-Plano-Irving, TX	0.9776
26420	Houston-The Woodlands-Sugar Land, TX	0.9733
23104	Fort Worth-Arlington, TX	0.9456
28660	Killeen-Temple, TX	0.9298
36220	Odessa, TX	0.9078
48660	Wichita Falls, TX	0.9062
18580	Corpus Christi, TX	0.9057
33260	Midland, TX	0.8934
43300	Sherman-Denison, TX	0.8888
17780	College Station-Bryan, TX	0.8815
15180	Brownsville-Harlingen, TX	0.8762
31180	Lubbock, TX	0.8694
41700	San Antonio-New Braunfels, TX	0.8586
47380	Waco, TX	0.8550
10180	Abilene, TX	0.8545
32580	McAllen-Edinburg-Mission, TX	0.8306
13140	Beaumont-Port Arthur, TX	0.8267
45500	Texarkana, TX-AR	0.8199
47020	Victoria, TX	0.8194
11100	Amarillo, TX	0.8158
41660	San Angelo, TX	0.8100
30980	Longview, TX	0.7906
29700	Laredo, TX	0.7894
21340	El Paso, TX	0.7877
46340	Tyler, TX	0.7846
45	TEXAS-Rural	0.7826

18 DRGs Account For 34 Percent Of Cases

	Table 7B - Medicare Prospective Payment System Selected Percentile Lengths of Stay; FY 2015 MedPAR Update - March 2016 Grouper V34 MS-DRGs			
	MS_DRG	Number of Discharges	Percent of Total	Cumulative Percent of Total
1	871	521,572	5.4%	5.4%
2	470	454,024	4.7%	10.1%
3	291	223,907	2.3%	12.4%
4	292	194,548	2.0%	14.4%
5	392	184,873	1.9%	16.3%
6	690	152,638	1.6%	17.8%
7	872	152,038	1.6%	19.4%
8	683	150,347	1.5%	21.0%
9	194	149,756	1.5%	22.5%
10	193	147,281	1.5%	24.0%
11	190	144,309	1.5%	25.5%
12	378	141,011	1.5%	27.0%
13	189	134,528	1.4%	28.3%
14	603	122,984	1.3%	29.6%
15	682	120,341	1.2%	30.9%
16	191	114,750	1.2%	32.0%
17	641	106,133	1.1%	33.1%
18	065	104,594	1.1%	34.2%

Can You Name The High Volume DRGs?

	TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2017			
	MS-DRG	TYPE	MS-DRG Title	Weights
1	871	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.7660
2	470	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0671
3	291	MED	HEART FAILURE & SHOCK W MCC	1.4796
4	292	MED	HEART FAILURE & SHOCK W CC	0.9574
5	392	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7402
6	690	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7777
7	872	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0283
8	683	MED	RENAL FAILURE W CC	0.9191
9	194	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9469
10	193	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3860
11	190	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1481
12	378	MED	G.I. HEMORRHAGE W CC	0.9860
13	189	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2135
14	603	MED	CELLULITIS W/O MCC	0.8445
15	682	MED	RENAL FAILURE W MCC	1.4989
16	191	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9184
17	641	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7181
18	065	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0431

Complications And Comorbidities?

MS-DRG	MDC	TYPE	MS-DRG Title	Weights
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3860
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9469
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7028
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6748
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9968
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7463
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.6925
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7544
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5190
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.8646
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.6875
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.2105
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2214
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.3505
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0198

Does Coding Make A Difference?

MS-DRG	MS-DRG Title	Weights	Base Payment Rate	DRG Payment
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3860	$4,752.45	$6,586.90
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9469	$4,752.45	$4,500.09
195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.7028	$4,752.45	$3,340.02

TABLE 2- PROPOSED CASE MIX INDEX AND WAGE INDEX TABLE BY CCN - FY 2018 (CONTAINS THE FOLLOWING PROPOSED DATA: AVERAGE HOURLY WAGE, WAGE INDEXES, GEOGRAPHIC AND RECLASSIFICATION/REDESIGNATION CBSA,			
[1]CCN	[2]Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2015		County Name
670058	0.7477	Emerus Hospital	FORT BEND
670097	0.7585	Baylor Emergency	ROCKWALL
670107	0.7745	Baylor Emergency	JOHNSON
450370	1.2371	Columbus Community	COLORADO
450597	1.2486	Cuero Community	DE WITT
450403	1.5394	HCA Medical Center McKinney	COLLIN
450678	1.5557	Doctors White Rock Lake	DALLAS
450002	1.5597	Providence	EL PASO
450563	1.5668	Baylor Scott & White Grapevine	TARRANT
450064	1.5912	Tx Health Arlington Memorial	TARRANT
450101	1.6873	Hillcrest	MC LENNAN
450137	1.7177	Baylor All Saints	TARRANT
450024	1.7339	University	EL PASO
450651	1.7726	HCA Medical Center Plano	COLLIN
450135	1.7734	Tx Health Harris Methodist	TARRANT
450015	1.7848	Parkland	DALLAS
450723	1.8265	Methodist Charlton Medical	DALLAS
450054	1.8596	Scott & White	BELL
450102	1.8961	Christus Mother Frances	SMITH
450056	1.9407	Seton Medical	TRAVIS
450039	1.9724	John Peter Smith	TARRANT
450853	2.1532	Baylor Medical Frisco	COLLIN
450051	2.1939	Methodist Dallas	DALLAS
450021	2.2051	Baylor University Medical	DALLAS
450856	2.8352	South Texas Spine	BEXAR
450851	2.8807	Baylor Heart & Vascular	DALLAS
450877	3.1670	Foundation Surgical	EL PASO
450808	3.1916	NW Hills Surgical	TRAVIS
670025	3.5455	Heart Hospital	COLLIN

Present On Admission

Since 2008, Medicare no longer pays hospitals for additional costs associated with select conditions that are considered by the Centers for Medicare & Medicaid Services (CMS) to be preventable medical errors or hospital-acquired conditions (HACs).

Hospitals are required to submit present-on-admission (POA) indicators with each claim. If a Medicare claim includes a selected HAC that wasn't identified on the POA indicator, the hospital won't receive the higher resulting diagnosis-related group (DRG) payment. In other words, if the condition is POA, then payment will be approved for a certain diagnosis. If not, then the payment is withheld. The idea is that this will incentivize hospitals to improve the quality of care and patient outcomes. It also means that hospitals have much at stake in terms of reimbursement when it comes to POA documentation.

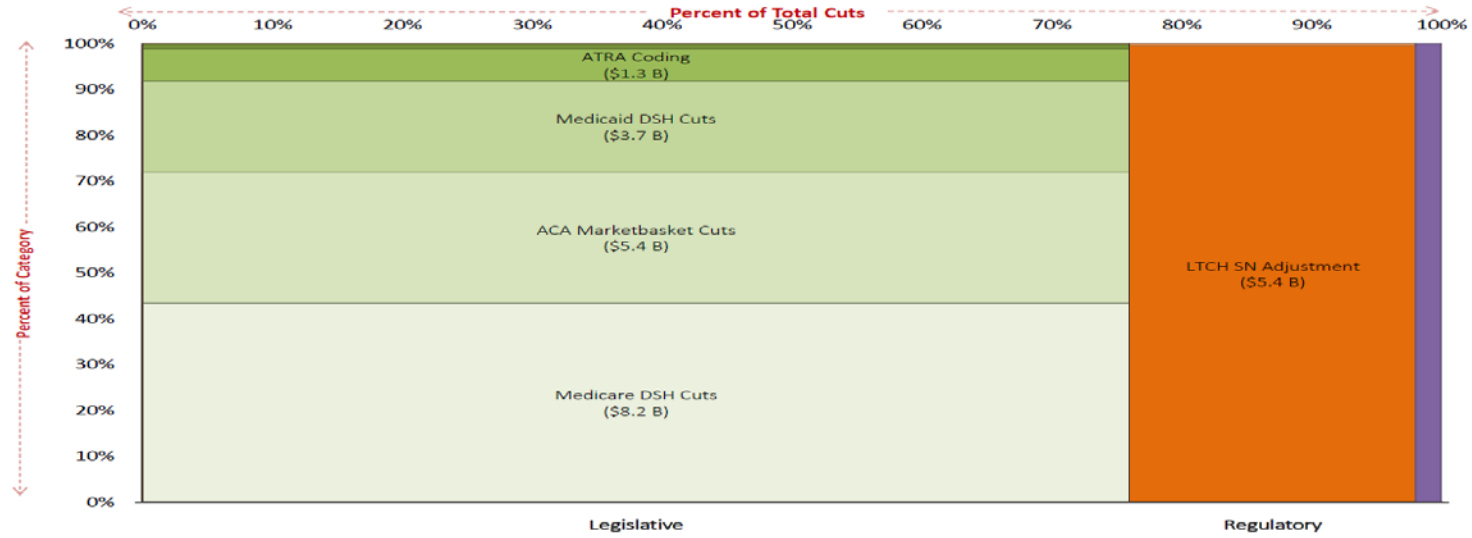
Enacted Medicare Cuts (Texas)

Enacted Medicare Cuts Analysis

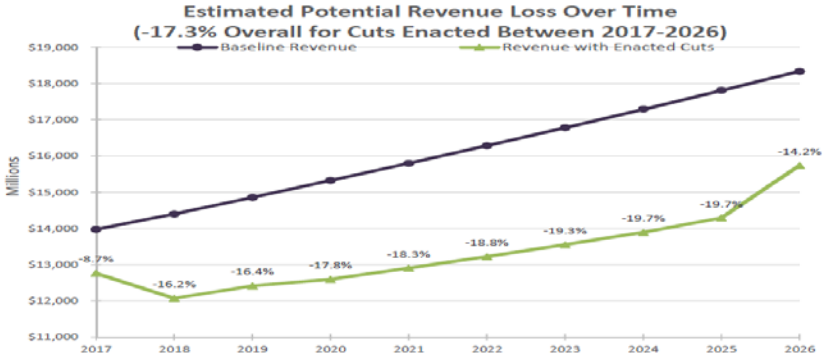
Relative Magnitude of Enacted Medicare Cuts

Texas

The graph below reflects the relative magnitude of each cut included in this analysis. Cuts are grouped together by category - with additional details in subsequent reports. The horizontal axis indicates the relative size of each category as a percent of the whole; the vertical axis indicates each individual cut's share of its category.



Cuts Enacted (2017-2026): Legislative	
Medicare DSH Cuts	($8,155,376,100)
ACA Marketbasket Cuts	($5,374,596,200)
Medicaid DSH Cuts	($3,746,639,000)
ATRA Coding	($1,330,260,500)
MACRA Post Acute MB Cut	($211,477,100)
Sequestration	$8,714,100
Total Legislative Cuts	**($18,809,634,800)**
Cuts Enacted (2017-2026): Regulatory	
LTCH SN Adjustment	($5,364,248,000)
Coding Cuts	($30,635,300)
Total Regulatory Cuts	**($5,394,883,300)**
Quality Based Payment Reform (2017-2026)	
Quality	($490,843,100)
Total Cuts Enacted	**($24,695,361,200)**



Medicare Inpatient Payments – FFY 2017

Inpatient Prospective Payment System (IPPS) Federal Fiscal Year (FFY) 2017 Final Rule Analysis

Estimated Change in Medicare Payments

FFY 2016 Final Rule Compared to FFY 2017 Final Rule

Texas

	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2016 IPPS Payments	**$6,746,926,300**		**$500,753,400**		**$7,247,679,600**	
(1) Marketbasket Update (Includes Budget Neutrality)	$165,950,000	2.5%	$6,639,900	1.3%	$172,591,400	2.4%
(1) ACA-Mandated Marketbasket Reductions	($65,241,000)	-1.0%	*Not Applicable*		($65,241,000)	-0.9%
(1) Forecast Error Adjustment	*Not Applicable*		($1,501,700)	-0.3%	($1,501,700)	0.0%
(1) ATRA-Mandated Coding Adjustment	($91,694,000)	-1.4%	*Not Applicable*		($91,694,000)	-1.3%
(1) 2-Midnight Rule Adjustment	$49,868,200	0.7%	$4,047,500	0.8%	$53,916,700	0.7%
Wage Index/GAF	$20,048,400	0.3%	$1,919,800	0.4%	$21,967,700	0.3%
(1) DSH: Traditional DSH Payment Changes	($3,400)	0.0%	$0	0.0%	($3,400)	0.0%
(1) DSH: UCC Payment Changes	($37,988,300)	-0.6%	*Not Applicable*		($37,988,300)	-0.5%
(1) Change in Hospital Specific Rate	$0	0.0%			$0	0.0%
(1) MS-DRG Updates	$5,223,000	0.1%	$453,300	0.1%	$5,675,700	0.1%
(2) Quality Based Payment Adjustments	($6,507,300)	-0.1%	($158,400)	0.0%	($6,665,800)	-0.1%
Net Change due to Low Volume Adjustment	($220,700)	0.0%	$1,500	0.0%	($219,400)	0.0%
Estimated FFY 2017 IPPS Payments	**$6,786,364,000**		**$512,153,900**		**$7,298,517,200**	
Total Estimated Change FFY 2016 to FFY 2017¥	***$39,437,700***	***0.6%*** ▲	***$11,400,500***	***2.3%*** ▲	***$50,837,800***	***0.7%*** ▲

¥ The bottom line impacts shown in the table above do not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2025. It is estimated that the impact of sequestration on FFY 2017 IPPS-specific payments would be: -$145,970,400.

Medicare Inpatient Payments – Part 2

[1] Detail on DSH UCC Payment Changes

The table to the right provides detail on DSH payment changes specific to the UCC component of the DSH program. National DSH program information is from the FFY 2016 IPPS final rule and FFY 2017 IPPS final rule. Hospital-specific UCC payment factors are from the FFY 2016 and FFY 2017 DSH Supplemental files published with those same rules.

	FFY 2016	FFY 2017	Change
Total Funding for UCC Payments	$10.058 Billion	$10.797 Billion	+$0.739 Billion
ACA-Mandated Reduction	-36.31%	-44.64%	-8.33%
Redistribution Pool	**$6.406 Billion**	**$5.977 Billion**	**-$0.429 Billion**
Hospital Specific Payment Factor	Hospital-Specific		
Hospital UCC Payment Amount	**$542,340,700**	**$504,312,200**	**($37,988,300)**

[2] Detail on Quality-Based Payment Adjustments

The table to the right provides impact estimates for performance under the VBP, Readmissions Reduction, and HAC Reduction Programs from FFY 2016 to FFY 2017. The FFY 2017 Readmissions adjustment factors are from IPPS final rule Table 15, and were calculated by applying the FFY 2017 excess readmission ratios to claims data for the period July 1, 2012 to June 30, 2015. The list of hospitals that could potentially be subject to the FFY 2017 HAC Reduction Program penalty is derived from hospital quality data available with the June 2016 update of Hospital Compare (CMS did not provide this list with the final rule). Although CMS has stated that no more than 25% of hospitals will be penalized under the HAC program, this analysis assumes that all hospitals at or over the 75th percentile breakpoint will receive a penalty. As a result, HAC penalties may be overstated. The FFY 2017 VBP adjustment factor is estimated based on hospital quality data available with the June 2016 update of Hospital Compare (CMS' FFY 2017 VBP proxy adjustment factors from final rule Table 16A are based on a prior program year). The FFY 2016 VBP and Readmissions adjustment factors, as well as HAC flags, are from the FFY 2016 IPPS final rule.

	FFY 2016	FFY 2017
Base Operating Dollars Subject to Quality Programs	$5,782,786,800	$5,858,746,500
Value Based Purchasing Program Impact	($2,946,100)	($3,305,300)
Readmissions Reduction Program Impact	($19,728,400)	($23,962,900)
HAC Reduction Program Impact	($18,269,200)	($20,340,900)
Net Impact of Quality Programs	($40,943,700)	($47,609,100)

Detail on Value of Small Hospital Programs

The table to the right displays the isolated value of the Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH) programs for FFYs 2016 and 2017; excluding adjustments due to the quality adjustment programs, **and each other**. Because of this, these numbers will not tie to the values listed above.
Per the Medicare and CHIP Reauthorization Act of 2015 (MACRA), these two programs are set to expire at the end of FFY 2017.

	FFY 2016	FFY 2017
Medicare Dependent Hospital Program	$5,911,000	$5,745,100
Low Volume Hospital Adjustment	$31,206,800	$30,913,500
Combined Value of Both Programs	**$37,386,500**	**$36,944,500**

Notes:

Medicare Margins – PPS Hospitals (Texas)

FFY	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Medicare Discharges										
Total	820,727	795,790	769,215	764,636	755,581	746,929	719,939	688,685	686,589	588,515
Hospital	784,956	763,816	738,784	732,491	724,831	715,984	690,351	657,946	655,654	563,225
Sub I	26,179	22,975	21,229	22,714	17,969	14,545	13,755	13,617	13,567	10,519
Sub II	9,592	8,999	9,202	9,431	12,781	16,400	15,833	17,122	17,368	14,771
Sub Other	0	0	0	0	0	0	0	0	0	0
Total										
Revenue	$9,617,294,518	$9,650,047,310	$9,896,740,741	$10,505,805,085	$10,750,508,399	$10,772,993,047	$10,759,290,265	$10,638,622,311	$10,910,703,943	$9,415,064,079
Cost	$9,915,569,627	$10,192,708,187	$10,591,833,019	$10,986,746,981	$11,225,053,761	$11,291,070,543	$11,316,639,860	$11,358,432,280	$11,832,867,970	$10,462,014,049
Gains/(Losses)	($298,275,110)	($542,660,878)	($695,092,278)	($480,941,896)	($474,545,362)	($518,077,496)	($557,349,594)	($719,809,969)	($922,164,027)	($1,046,949,970)
Margin	-3.10%	-5.62%	-7.02%	-4.58%	-4.41%	-4.81%	-5.18%	-6.77%	-8.45%	-11.12%
Inpatient										
Revenue	$7,311,504,188	$7,329,662,345	$7,429,399,503	$7,737,649,631	$7,840,683,627	$7,763,550,817	$7,659,524,951	$7,525,946,142	$7,550,503,963	$6,526,001,556
Cost	$7,316,402,400	$7,540,503,751	$7,769,879,551	$7,900,587,993	$8,044,501,886	$8,034,198,170	$7,965,315,908	$7,914,611,836	$8,060,727,523	$7,187,812,958
Gains/(Losses)	($4,898,212)	($210,841,406)	($340,480,048)	($162,938,362)	($203,818,259)	($270,647,353)	($305,790,957)	($388,665,694)	($510,223,560)	($661,811,402)
Margin	-0.07%	-2.88%	-4.58%	-2.11%	-2.60%	-3.49%	-3.99%	-5.16%	-6.76%	-10.14%
Outpatient										
Revenue	$1,668,507,515	$1,729,451,538	$1,945,515,646	$2,194,427,419	$2,363,389,639	$2,491,724,072	$2,544,172,049	$2,601,367,594	$2,867,351,010	$2,425,366,745
Cost	$1,859,840,860	$1,935,896,320	$2,170,259,554	$2,368,662,569	$2,510,124,906	$2,636,125,081	$2,702,692,433	$2,871,200,439	$3,250,737,569	$2,754,134,186
Gains/(Losses)	($191,333,345)	($206,444,782)	($224,743,908)	($174,235,150)	($146,735,267)	($144,401,009)	($158,520,384)	($269,832,845)	($383,386,559)	($328,767,441)
Margin	-11.47%	-11.94%	-11.55%	-7.94%	-6.21%	-5.80%	-6.23%	-10.37%	-13.37%	-13.56%

Medicare Margins – CAH (Texas)

FFY	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Medicare Discharges										
Total	20,210	19,995	19,631	18,284	18,782	18,217	16,619	15,386	13,748	12,095
Hospital	20,210	19,995	19,631	18,284	18,625	18,128	16,619	15,386	13,748	12,095
Sub I	0	0	0	0	157	89	0	0	0	0
Sub II	0	0	0	0	0	0	0	0	0	0
Sub Other	0	0	0	0	0	0	0	0	0	0
Total										
Revenue	$245,108,660	$267,088,294	$285,920,370	$299,263,202	$321,608,589	$342,976,640	$361,577,487	$368,670,375	$366,021,578	$365,107,848
Cost	$243,044,581	$264,113,093	$283,278,321	$296,316,706	$319,220,210	$342,655,838	$361,356,621	$372,309,515	$370,672,312	$369,013,306
Gains/(Losses)	$2,064,079	$2,975,201	$2,642,049	$2,946,496	$2,388,379	$320,802	$220,866	($3,639,140)	($4,650,734)	($3,905,458)
Margin	0.84%	1.11%	0.92%	0.99%	0.74%	0.09%	0.06%	-0.99%	-1.27%	-1.07%
Inpatient										
Revenue	$104,868,988	$108,295,015	$114,094,272	$115,079,149	$125,285,047	$128,539,628	$124,239,171	$117,629,980	$111,899,668	$102,983,072
Cost	$103,831,593	$107,223,890	$112,965,915	$113,941,095	$124,045,667	$127,266,959	$123,009,078	$118,312,021	$113,374,299	$104,537,628
Gains/(Losses)	$1,037,395	$1,071,125	$1,128,357	$1,138,054	$1,239,380	$1,272,669	$1,230,093	($682,041)	($1,474,631)	($1,554,556)
Margin	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	-0.58%	-1.32%	-1.51%
Outpatient										
Revenue	$92,799,604	$98,839,554	$108,652,149	$114,864,207	$130,101,580	$139,567,426	$148,023,028	$157,738,897	$156,513,836	$162,057,689
Cost	$91,880,796	$97,860,945	$107,576,385	$113,726,938	$128,813,446	$138,185,570	$146,642,957	$157,426,570	$156,860,859	$162,380,057
Gains/(Losses)	$918,808	$978,609	$1,075,764	$1,137,269	$1,288,134	$1,381,856	$1,380,071	$312,327	($347,023)	($322,368)
Margin	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.93%	0.20%	-0.22%	-0.20%

Medicare's Two Day Stay Policy

- Under the two-midnight rule, CMS generally presumes that hospital stays crossing two midnights are properly billed as inpatient, while shorter stays are probably not, with a few exceptions, unless patients are admitted for inpatient-only procedures *(RMC 5/5/14, p. 1)*. Before patients are discharged, physicians must sign certifications that include authentication of the admission order, the physician's expectation that the patient will stay two midnights, the reason for the inpatient services and plans for post-hospital care. Medicare will pay for Part A stays even when patients are discharged early if physicians document the unforeseen circumstances (e.g., they recovered faster than expected, were transferred, died or left against medical advice).
- MACs are now auditing inpatient claims under the CMS probe-and-educate program, and are starting to hold one-on-one meetings with hospitals to elaborate on Medicare expectations for compliance with the two-midnight rule and discuss the claim denials. Hospitals also seize the chance to rebut some of the denials and perhaps avoid formal appeals, and to have their concerns about the two-midnight rule addressed.

Medicare Outpatient Observation Notice

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Medicare Outpatient Observation Notice

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

Medicare Disproportionate Share Payments

The Medicare DSH adjustment provision under section 1886(d) (5) (F) of the Act was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986. According to section 1886(d) (5) (F) of the Act, there are two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method is for a hospital to qualify based on a statutory formula that results in the DSH patient percentage. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. The DSH patient percentage is defined as:

DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)

Medicare Advantage (HMO) Is Growing (July 2017)

County Name	Medicare Eligibles	HMO Enrolled	HMO Penetration
El Paso	121,714	68,280	56.10%
Nueces	56,888	28,801	50.63%
San Patricio	12,641	6,346	50.20%
Johnson	28,130	12,627	44.89%
Bexar	276,921	122,860	44.37%
Harris	509,961	222,522	43.64%
Tarrant	253,688	107,459	42.36%
Dallas	308,403	108,066	35.04%
Brooks	1,604	557	34.73%
Lubbock	43,556	15,025	34.50%
Denton	85,864	25,705	29.94%
Henderson	20,052	6,000	29.92%
Kaufman	18,693	5,493	29.39%
Ellis	25,475	7,451	29.25%
Travis	126,329	36,668	29.03%
Wise	10,885	3,037	27.90%
Collin	105,334	29,136	27.66%
Hood	15,230	4,147	27.23%
Rockwall	13,231	3,513	26.55%
Smith	42,676	11,306	26.49%
Tyler	4,874	1,197	24.56%
Grayson	26,687	6,195	23.21%
Tom Green	20,766	4,811	23.17%
Cooke	7,828	1,805	23.06%
Ector	18,821	4,297	22.83%
Erath	6,291	1,419	22.56%
Navarro	9,909	2,201	22.21%
Fannin	7,450	1,489	19.99%
Hunt	17,216	3,156	18.33%
Palo Pinto	5,976	1,012	16.93%
Ochiltree	1,260	134	10.63%
Young	4,235	404	9.54%
Parmer	1,420	116	8.17%
Sutton	725	51	7.03%
Texas-Statewide	3,901,484	1,358,891	34.80%

Medicare Quality

Hospital Financing

August 17, 2017

CMS' Vision

HHS also set a goal of tying **85 percent** of all traditional Medicare payments to quality or value by **2016** and **90 percent by 2018** through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

Quality Based Payment Reforms

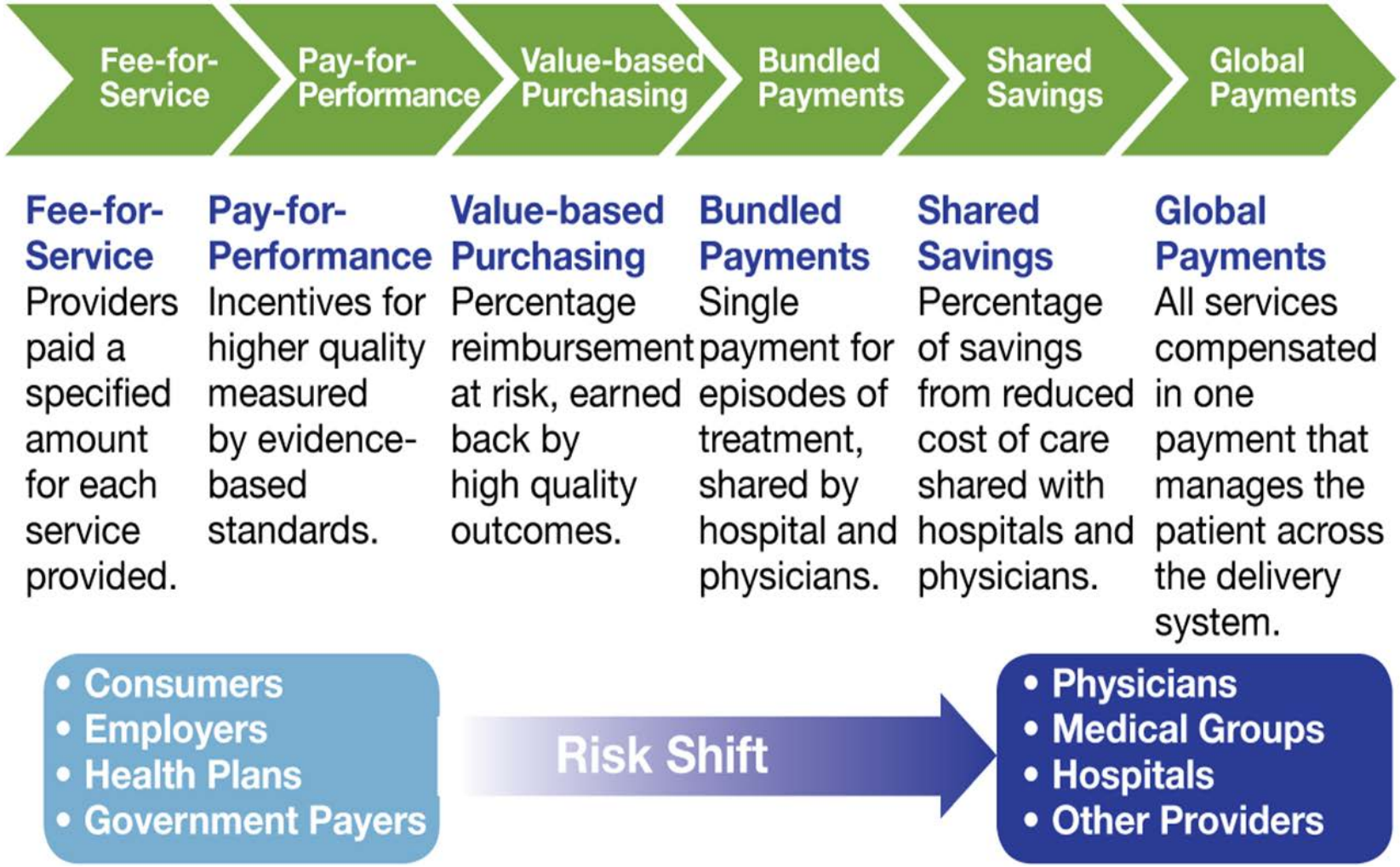
Inpatient Prospective Payment System (IPPS) Policy	Fiscal Year									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Market Basket (MB) Cuts for Productivity Adjustment (P)[1] and Medicare Savings	MB – 0.25	MB – 0.25	MB – (P + 0.1)	MB – (P + 0.1)	MB – (P + 0.3)	MB – (P + 0.2)	MB – (P + 0.2)	MB – (P + 0.75)	MB – (P + 0.75)	MB – (P + 0.75)
Reporting Hospital Quality Data for the Annual Payment Update[2] (Pay for reporting)	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – 2.0 If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report	MB – ¼ of MB If Failure to Report
Hospital Value-Based Purchasing[3]				MB – 1.0 Potential for Earn Back	MB – 1.25 Potential for Earn Back	MB – 1.5 Potential for Earn Back	MB – 1.75 Potential for Earn Back	MB – 2.0 Potential for Earn Back	MB – 2.0 Potential for Earn Back	MB – 2.0 Potential for Earn Back
Readmissions[4]				MB – Hosp-specific amount capped at 1.0	MB – Hosp-specific amount capped at 2.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0	MB – Hosp-specific amount capped at 3.0
Hospital Acquired Conditions						MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals	MB – 1.0 For Bottom Quartile Hospitals
Health Information Technology Meaningful Use[5] (MU)						MB – ¼ of MB If Failure to Meet MU	MB – ½ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU	MB – ¾ of MB If Failure to Meet MU

Note: all numeric reductions represent a percentage point reduction from the market basket rate. For example if the market basket is projected to be 3% and the reduction is 2 percentage points, then the remaining amount for the update is 1%.

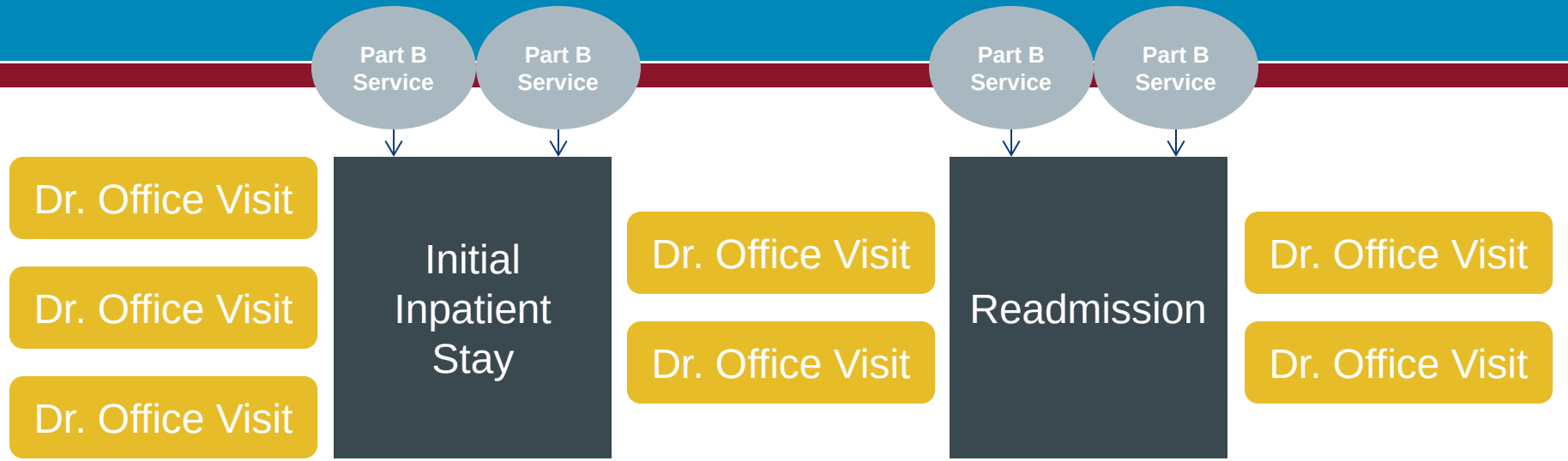
Impact of Medicare's Quality Payment Programs – FFY 2017 (Texas)

- No Penalties – 84 hospitals
- One Penalty – 142 hospitals
- Two Penalties – 95 hospitals
- Three Penalties – 22 hospitals

A Transition Of Payment Models



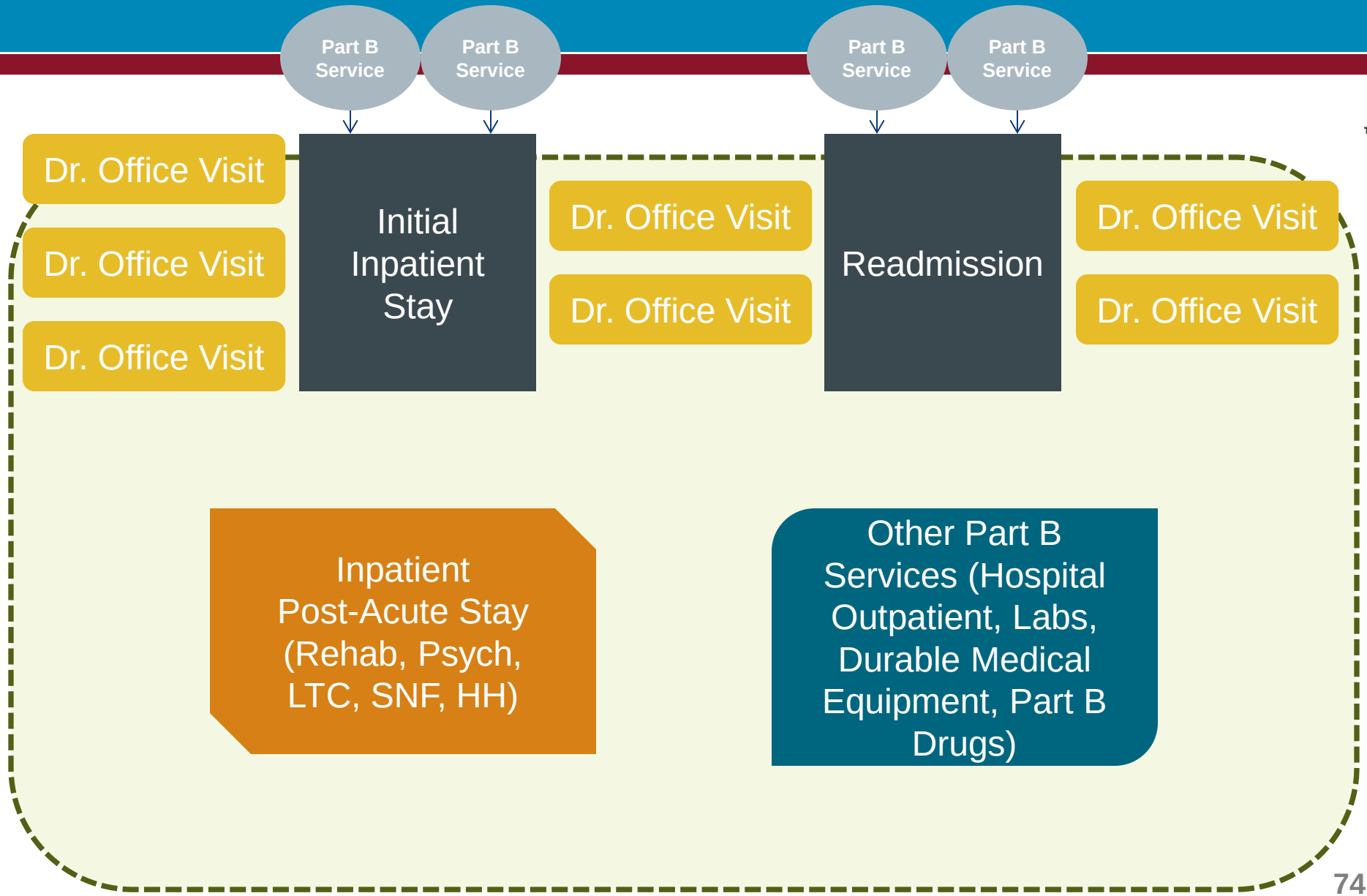
Provider Services - Today



Inpatient Post-Acute Stay (Rehab, Psych, LTC, SNF, HH)

Other Part B Services (Hospital Outpatient, Labs, Durable Medical Equipment, Part B Drugs)

Bundled Services



Medicare Payments For Episodes Are Expanding

	TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2017			
	MS-DRG	CASES	MS-DRG Title	Weights
CABG	231	1,100	CORONARY BYPASS W PTCA W MCC	8.0662
CABG	232	886	CORONARY BYPASS W PTCA W/O MCC	5.8874
CABG	233	12,751	CORONARY BYPASS W CARDIAC CATH W MCC	7.4876
CABG	234	17,711	CORONARY BYPASS W CARDIAC CATH W/O MCC	4.9523
CABG	235	9,544	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.7644
CABG	236	20,019	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.8520
		62,011		
cardiac	246	35,524	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W MCC OR 4+ VESSELS/STENTS	3.2525
cardiac	247	85,090	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.1226
cardiac	248	8,616	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W MCC OR 4+ VES/STENTS	3.0445
cardiac	249	13,879	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9358
cardiac	250	4,027	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.6299
cardiac	251	6,781	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6868
cardiac	280	68,360	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6748
cardiac	281	44,256	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9968
cardiac	282	24,052	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7463
		290,585		
CJR	469	27,619	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC	3.2906
CJR	470	454,024	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2.0671
		481,643		
SHFFT	480	28,147	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0014
SHFFT	481	81,299	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0036
SHFFT	482	25,322	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6344
		134,768		
		969,007	Total- Four Bundles	

Episode Payment Models Plus One

Acute Myocardial Infarction (AMI) - Abilene, Austin, Dallas-Fort Worth, Sherman-Denison

Coronary Artery Bypass Graft (CABG) - Abilene, Austin, Dallas-Fort Worth, Sherman-Denison

Comprehensive Joint Replacement (CJR) - Austin, Beaumont, Corpus Christi, Killeen-Temple, Lubbock, Tyler

Surgical Hip/Femur Fracture Treatment (SHFFT) - Austin, Beaumont, Corpus Christi, Killeen-Temple, Lubbock, Tyler

Cardiac Rehabilitation – Abilene, Corpus Christi, Dallas-Fort Worth, Waco

Times Are Changing

In a press release today (Sept. 15), CMS announced a proposed rule to change the CJR model and cancel the mandatory EPM and CR Incentive payment model.

This proposed rule proposes to cancel the Episode Payment Models (EPMs) and Cardiac Rehabilitation (CR) incentive payment model and to rescind the regulations governing these models. It also proposes to revise certain aspects of the Comprehensive Care for Joint Replacement (CJR) model, including: giving certain hospitals selected for participation in the CJR model a one-time option to choose whether to continue their participation in the model; technical refinements and clarifications for certain payment, reconciliation and quality provisions; and a change to increase the pool of eligible clinicians that qualify as affiliated practitioners under the Advanced Alternative Payment Model (APM) track

Episode Payment Models - Highlights

- EPM episodes end 90 days after initial inpatient discharge
- Includes inpatient stay and all related care (Parts A & B) during 90 days
- Unrelated readmissions and care are removed
- Episode target includes West South Central Census region (Tx, Ok, Ark, La)
- CMS is limiting how much HOSPITALS can gain (5 %) or lose (20%)
- CMS has established limitations on losses and gain
- Quality metrics will affect reconciliation payments
- First performance period for 3 new EPMs is July 2017-December 2017.

EPM Limitations On Losses / Gains

Year	Risk Level	Target Price (hospital-specific /regional split)	Discount Range for Calculating Reconciliation	Discount Range for Calculating Repayment	Stop-Gain/ Stop-Loss
PY 1	Upside Only	2/3 hospital 1/3 regional	1.5% - 3.0% *	N/A *	Stop-gain: 5%
PY 2	Voluntary Two-Sided	2/3 hospital 1/3 regional	1.5% - 3.0% *	0.5% - 2.0% *	Stop-gain: 5% Stop-loss (voluntary): 5%
PY 3	Two-Sided	1/3 hospital 2/3 regional	1.5% - 3.0% *	0.5% - 2.0% *	5% for both
PY 4	Two-Sided	100% regional	1.5% - 3.0% *	0.5% - 2.0% *	10% for both
PY 5	Two-Sided	100% regional	1.5% - 3.0% *	1.5% - 3.0% *	20% for both

EPM Quality Impacts Hospital Payments

Quality Category	AMI Composite Quality Score	CABG Composite Quality Score	SHFFT Composite Quality Score	Eligible for *Reconciliation* Payments	Eligible for *Quality Incentive Payment* *	Discount for Calculating *Reconciliation* (All Program Years)	Discount for Calculating *Repayment* (Years 2(DR)** 3 and 4)	Discount for Calculating *Repayment* (Year 5)
Below Acceptable	< 3.6	< 2.8	< 5.0	No	No	3.0%	2.0%	3.0%
Acceptable	≥ 3.6 and < 6.9	≥ 2.8 and < 4.8	≥ 5.0 and < 6.9	Yes	No	3.0%	2.0%	3.0%
Good	≥ 6.9 and ≤ 14.8	≥ 4.8 and ≤ 17.5	≥ 6.9 and ≤ 15.0	Yes	Yes	2.0%	1.0%	2.0%
Excellent	> 14.8	> 17.5	> 15.0	Yes	Yes	1.5%	0.5%	1.5%

DataGen Comparative Report

Model		Sample Hospital				Middle Atlantic			
	# of CY 2015 Episodes *	230				20,691			
	Average CY 2015 Total Payment	$20,877				$25,122			
	Episode Component/Service Type	Average Number of Units per Episode	Average Payment Per Units	Average Payment per Episode	% of Average Episode Payment	Average Number of Units per Episode	Average Payment Per Unit	Average Payment per Episode	% of Average Episode Payment
Acute Myocardial Infarction (AMI)/Percutaneous Coronary Intervention (PCI)	Anchor Admission	1.0	$12,461	$12,461	60%	1.0	$12,774	$12,774	51%
	Acute Transfer	0.0	$0	$0	0%	0.0	$0	$0	0%
	Readmission	0.3	$10,846	$3,642	17%	0.4	$9,752	$3,866	15%
	Inpatient Rehabilitation (IRF)	0.0	$11,867	$89	0%	0.0	$17,315	$520	2%
	Home Health (HH)	6.3	$144	$906	4%	6.0	$153	$921	4%
	Skilled Nursing Facility (SNF)	2.6	$460	$1,187	6%	7.6	$492	$3,729	15%
	Long-Term Care Hospital (LTCH)	0.0	$0	$0	0%	0.0	$43,578	$167	1%
	Inpatient Psychiatric (IPF)	0.0	$0	$0	0%	0.0	$10,194	$62	0%
	Hospice	0.0	$0	$0	0%	0.1	$3,181	$220	1%
	Physician Office	2.1	$560	$1,150	6%	2.0	$613	$1,246	5%
	Durable Medical Equipment	1.0	$1	$0	0%	1.0	$5	$5	0%
	Outpatient	2.7	$526	$1,441	7%	2.5	$637	$1,611	6%

CMS Inpatient Payment Rule-FY 2018

- Report Quality Data & Meaningful Users – 1.2 percent rate increase
- Disproportionate Share Payments-CMS will use S-10 data-big change
- HCAHPS (Patient Satisfaction Survey)-Replace HCAHPS question on paint management with communication about pain management
- Readmissions Program-Implement socioeconomic adjustment in FY 2019
- EHR Reporting-Meaningful use period changed from full year to 90 day
- VBP Program-Remove PSI-90 measure in FY 2019

Medicaid Payments

Hospital Financing

August 17, 2017

Texas Health and Human Services Commission

Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas' Uncompensated Care Pool

As prepared by
Health Management Associates

August 26, 2016

With correction, reissued on

September 13, 2016

HMA
HEALTH MANAGEMENT ASSOCIATES

1115 Waiver

Hospital financing component

- Uncompensated Care (UC) Pool:
  - Replaces UPL
  - Covers Medicaid shortfall and costs of care provided to individuals who have no third part insurance coverage.
- Creates 20 Regional Healthcare Partnerships (RHPs)
- Delivery system Reform Incentive Payment (DSRIP) Pool
  - New incentive program to support coordinated care and quality improvements through the RHPs.
  - Goals: transform delivery systems to improve care for individuals (including access, quality and health outcomes), improve health for the population and lower costs through efficiencies and improvements.
  - Targets Medicaid recipients and low income uninsured individuals

1115 Waiver – HHSC Position

Negotiations are ongoing with CMS

- HHSC submitted a renewal request on September 29, 2015.
- CMS granted a 15 month extension on May 2, 2016. The extension goes through December 2017.
- HHSC requested an extension of the waiver beyond 2017 to Sept. 30, 2019.
- HHSC is continuing ongoing renewal negotiations.
- HHSC will discuss opportunities for a new global Medicaid waiver.
- Flexibility in the use of intergovernmental transfers

CMS Disallowance Of Provider Donations

I. Background

On September 1, 2016, CMS sent notice to HHSC of Disallowance Number TX/2016/001/MAP (the disallowance).[1] The amount of the disallowance is $26,844,551 in federal financial participation as reported on the CMS-64 quarter ending December 31, 2015. CMS believes that arrangements between the hospital districts that provide the non-federal share of uncompensated care (UC) waiver payments and the private hospitals that receive those payments constitute non-bona fide provider donations under federal law and under guidance issued by CMS in May 2014 in the form of a state Medicaid director letter (SMDL #14-004).

CMS Disallowance – HHSC Response

- HHSC is appealing CMS's December denial of their request for reconsideration.
- HHSC will also ask the new administration to reconsider the denial.
- HHSC feels the denial reneged on previous agreements, erred in calculating the amount of the disallowance and was contrary to federal regulations.
- HHSC states they have had great support from the Texas congressional delegation
- HHSC is also working to get CMS to reverse its disallowance of payments to Metroplex hospitals, on what we feel are, at best, technical grounds.

CMS Disallowance – Hospital Response

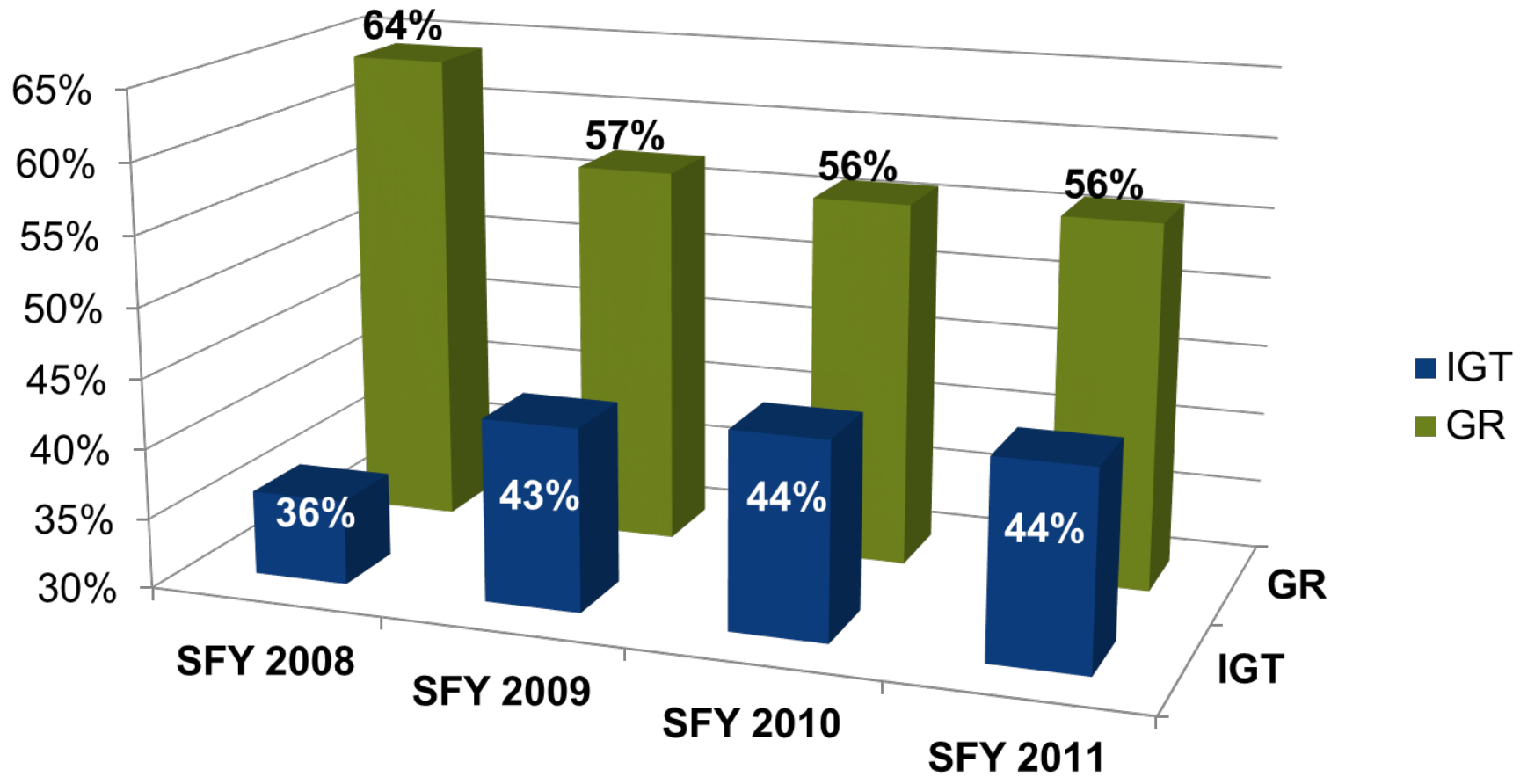
As you are aware, CMS issued a disallowance letter on September 1, 2016, contesting the long-standing method of finance for supplemental payments to private hospitals in Dallas and Tarrant counties. Upholding the disallowance in these counties jeopardizes the financing mechanism utilized to fund Medicaid supplemental payments across the state. We appreciate your support in urging that this disallowance be rescinded and want to provide you with an update.

Impermissible Provider Donations-Times Are Changing

Regarding the change for recoupment in the case of a disallowance for impermissible provider-related donations, it appears that HHSC is going to address the constitutional issue that was raised by hospitals.

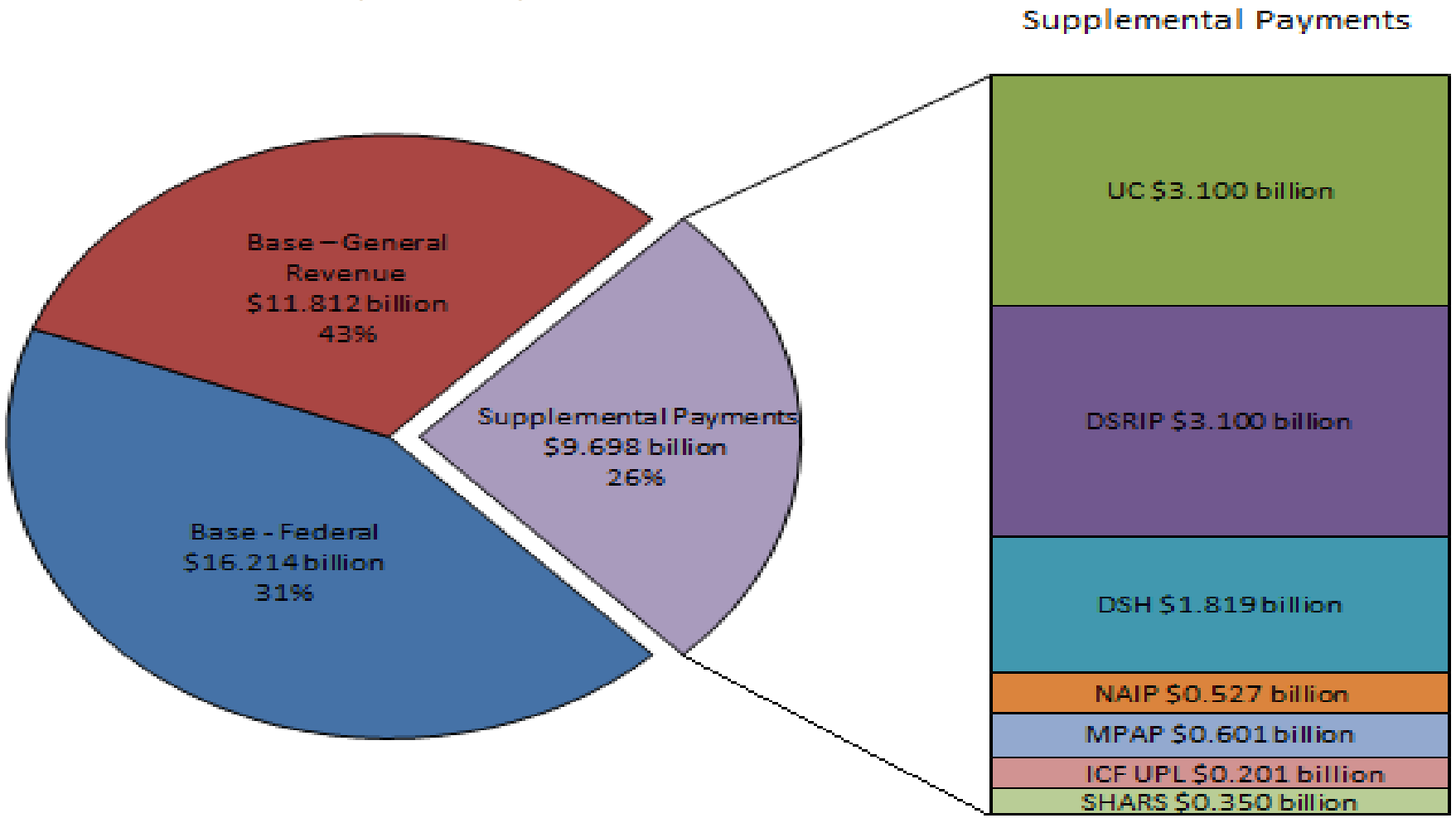
Increasing Reliance on Intergovernmental Transfers (IGT)

Intergovernmental Transfers Have Increased Over Time



Medicaid Payments – FY 2016

$37.724 Billion (All Funds)



Supplemental Payment Programs

Program	Supplemental Payment?	Provider Beneficiaries	State (billions)	IGT[1] (billions)	Federal (billions)	Total (billions)	Payment Basis
Medicaid Client Services[2]	No	All Medicaid Providers	$11.812	$0.000	$16.214	$28.026	Provision of services (claims, monthly capitation, etc.)
UC	Yes	Hospitals, certain physician group practices, public ambulance and dental	$0.000	$1.329	$1.771	$3.100	Uncompensated care: Medicaid shortfall + uninsured cost (not charges)
DSRIP	Yes	Hospitals, Local Mental Health Authorities, other	$0.000	$1.329	$1.771	$3.100	Achievement of metrics
DSH	Yes	Hospitals	$0.000	$0.780	$1.039	$1.819	Uncompensated care: Medicaid shortfall + uninsured costs (not charges)
NAIP	Yes	Public Hospitals	$0.000	$0.226	$0.301	$0.527	Achievement of metrics
MPAP	Yes	Public Nursing Facilities	$0.000	$0.257	$0.344	$0.601	Difference between Medicare and Medicaid rates
ICF UPL	Yes	Public ICF/IIDs	$0.000	$0.084	$0.117	$0.201	Difference between estimate of Medicare and Medicaid rates
SHARS	Yes	Public Schools	$0.000	$0.146	$0.204	$0.350	Medicaid allowable cost
Supplemental Payment Sub-Total			$0.000	$4.150	$5.547	$9.698	Supplemental payments equal 25.7% of Total Medicaid provider payments
Grand Total			$11.812	$4.150	$21.761	$37.724	

Regional Uniform Hospital Rate Increase Proposal (UHRIP)

Regional Uniform Hospital Rate Increase Proposal

- The Texas Health and Human Services Commission (HHSC) is currently seeking approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Uniform Hospital Rate Increase Program (UHRIP) for hospital services beginning September 1, 2017. If approved, the rate increases would reduce hospitals' Medicaid shortfall in the managed care service delivery areas in which the program is implemented.
- Uses intergovernmental transfers (IGT) from non-state governmental entities to support capitation payment increases for one or more service delivery area.
- MCOs are required to increase hospital rates by a uniform dollar or percentage increase for all of its public and private contracted hospitals.

Regional Uniform Hospital Rate Increase Proposal

- We support the proposal put forth by the Health and Human Services Commission to facilitate uniform rate increases in Medicaid Managed Care. The draft rules authorize a much-needed mechanism to fortify the delivery of care to the state's vulnerable populations. As you know, private hospitals provide almost 80% of the care in Medicaid and provide more than half of all uncompensated care in Texas.
- The uniform rate increases in Medicaid are badly needed – hospitals are paid less than 60% of cost for inpatient and outpatient care, combined, in the Medicaid program. These rate increases could help stabilize the state as we enter a period of transformation yet again.

Regional Uniform Hospital Rate Increase Proposal

- Eligibility. HHSC determines eligibility for rate increases by service delivery area and class of hospital.
- (1)Service delivery area. Only hospitals in a service delivery area that includes at least one sponsoring governmental entity are eligible for a rate increase.
- (2)Class of hospital. HHSC will identify the class or classes of hospital within each service delivery area described in paragraph (1) of this subsection to be eligible for a rate increase. HHSC will consider the following factors when identifying the class or classes of hospital eligible for a rate increase and the percent increase applicable to each class:
- (A)whether a class of hospital contributes more or less significantly to the goals and objectives in HHSC's quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;
- (B)which class or classes of hospital the sponsoring governmental entity wishes to support through intergovernmental transfers (IGTs) of public funds; and
- (C)the percentage of Medicaid costs incurred by the class of hospital in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any uniform rate increase administered under this section.

Regional Uniform Hospital Rate Increase Proposal

- HHSC may direct the MCOs in a service delivery area to provide a uniform percentage rate increase to all hospitals within one or more of the following classes of hospital with which the MCO contracts for inpatient or outpatient services

- (A) children's hospitals;
- (B) non-urban public hospitals;
- (C) rural hospitals;
- (D) state-owned hospitals;
- (E) urban public hospitals;
- (F) institutions for mental diseases; and
- (G) all other hospitals.

Texas UHRIP Programs

The Texas Health and Human Services Commission (HHSC) has received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Uniform Hospital Rate Increase Program (UHRIP) for hospital services beginning **March 1, 2018**, in the El Paso and Bexar managed care service deliver areas (SDA) and is currently seeking approval for additional SDAs. If approved, the rate increases would reduce hospitals' Medicaid shortfall in the SDAs in which the program is implemented.

Texas UHRIP Programs -Times Are Changing

HHSC proposes to add §353.1305(k), which allows for a limited Dec. 1, 2017, entry into UHRIP for a subset of Service Delivery Areas.

Specifically, if HHSC received an approval from CMS for any particular SDA by July 1, 2017, that SDA would be able to participate in UHRIP for dates of service beginning Dec. 1, 2017.

Approved UHRIP Programs (X 12)

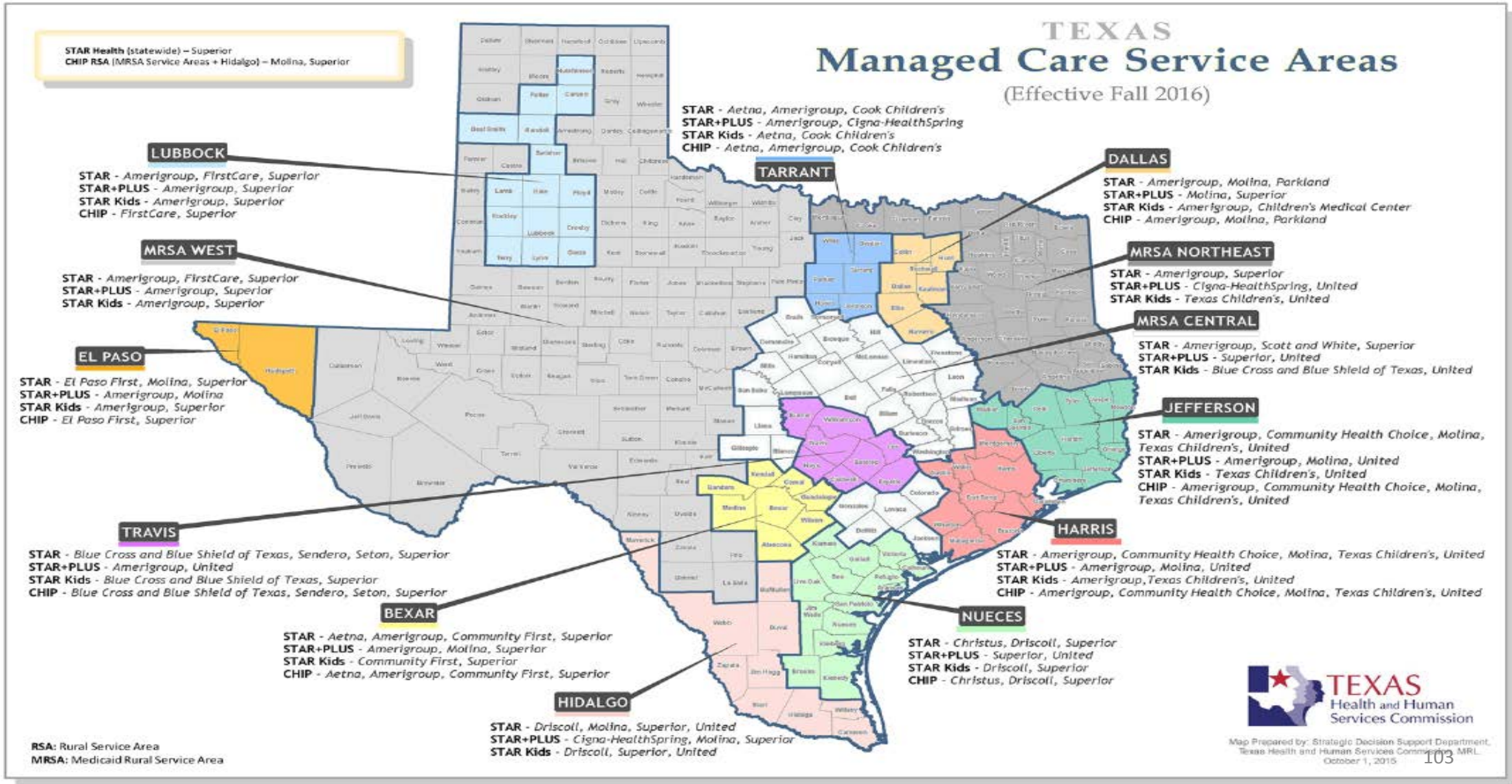
Round 1-

1. Bexar
2. El Paso

Round 2- (approved July 2017)

1. Dallas
2. Harris
3. Hidalgo
4. Jefferson
5. Lubbock
6. MRSA Central
7. MRSA NE
8. MRSA West
9. Nueces
10. Tarrant

Managed Care Service Areas



Local Provider Participation Funds (LPPF)

Local Provider Participation Funds (LPPF)

In 2011, Texas pursued a Health Care Transformation and Quality Improvement Program Medicaid Section 1115 Waiver (Waiver) at the direction of the Texas Legislature. The Waiver empowers local communities to transform the delivery of health care by establishing local projects tailored to meet communities' unique health care needs. However, the Waiver requires local government funds to support Waiver payments. As such, communities without hospital districts are disadvantaged because they lack a mechanism to generate funds for Intergovernmental Transfers (IGT) to draw down federal dollars.

The Local Provider Participation Fund will provide the opportunity to solve local problems a local solution, without burdening local tax payers or requiring state general revenue.

Local Provider Participation Funds (LPPF)

- Texas Health and Safety Code § 296.103. Local Provider Participation Fund; Authorized Uses of Money

- (c) Money deposited to the local provider participation fund may be used only to:
- (1) fund intergovernmental transfers from the county to the state to provide the nonfederal share of a Medicaid supplemental payment program authorized under the state Medicaid plan, the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), or a successor waiver program authorizing similar Medicaid supplemental payment programs;
- (2) subsidize indigent programs;
- (3) pay the administrative expenses of the county solely for activities under this chapter;
- (4) refund a portion of a mandatory payment collected in error from a paying hospital; and
- (5) refund to paying hospitals the proportionate share of money received by the county from the Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments.
- (d) Money in the local provider participation fund may not be commingled with other county funds.
- (e) An intergovernmental transfer of funds described by Subsection (c)(1) and any funds received by the county as a result of an intergovernmental transfer described by that subsection may not be used by the county or any other entity to expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152)

Local Provider Participation Funds (# 20)

- Beaumont
- Bowie
- McLennan
- Bell
- Beaumont
- Gregg
- Hays
- Rusk
- Brazos
- Hidalgo/Cameron/Webb
- Tarrant
- Grayson
- Tom Green
- Williamson
- Angelina
- Smith
- Amarillo
- Dallas

LPPFs Are Quite Specific (McLennan)

C.S.H.B. 2913 amends the Health and Safety Code to set out provisions relating to county health care provider participation programs applicable to a county that is not served by a hospital district or a public hospital, in which a military base with more than 30,000 military personnel is partially located, and that has a population of more than 300,000. The bill establishes that such a program authorizes a county to collect a mandatory payment from each institutional health care provider located in the county to be deposited in a local provider participation fund established by the county and authorizes money in the fund to be used by the county to fund certain intergovernmental transfers and indigent care programs. The bill authorizes a county commissioners court to adopt an order authorizing a county to participate in the program, subject to certain limitations. The bill defines an "institutional health care provider" as a licensed nonpublic hospital.

LPPF – City Of Beaumont

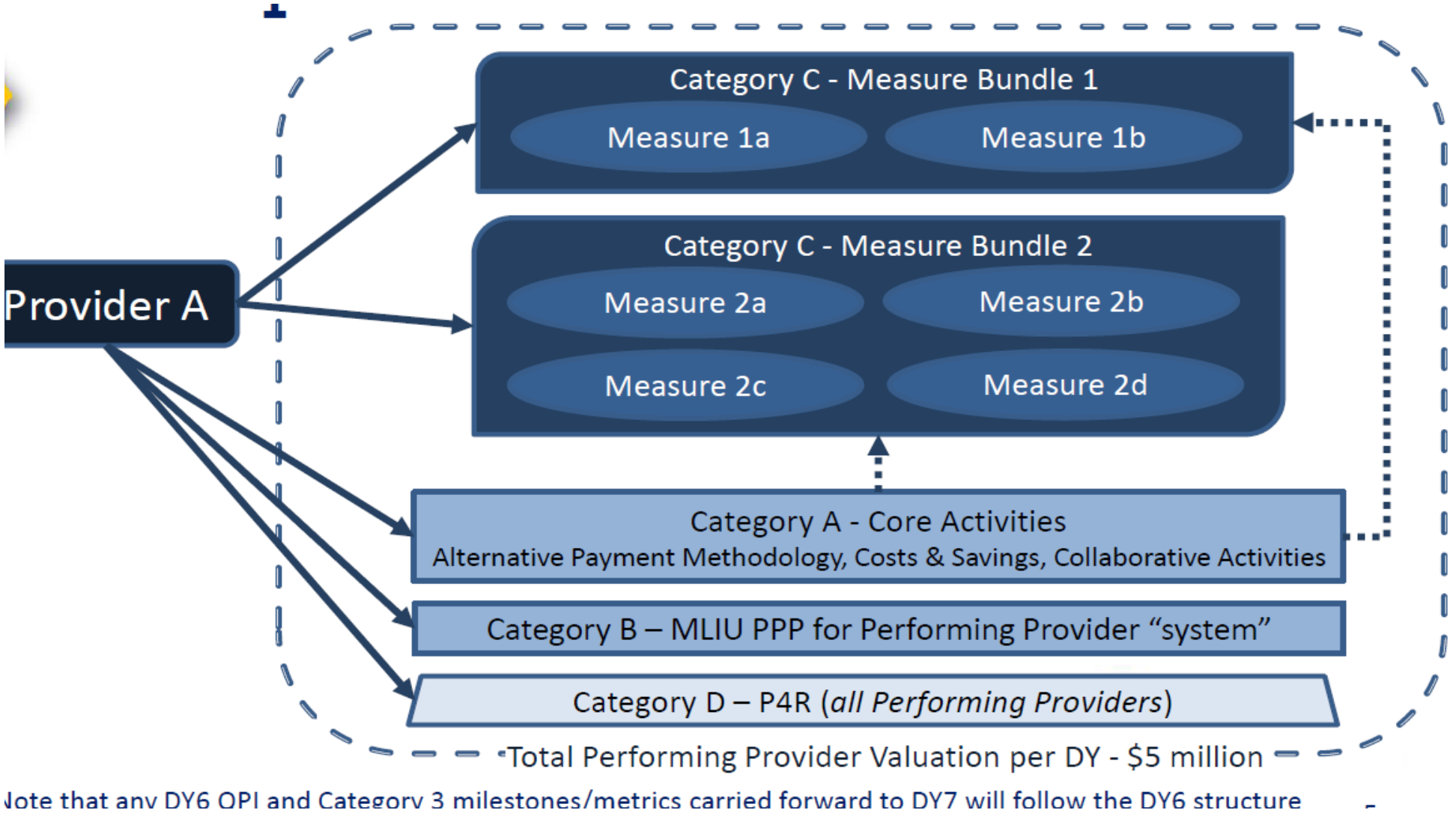
- Sec. 295.151. MANDATORY PAYMENTS BASED ON PAYING HOSPITAL NET PATIENT REVENUE. (a) Authorizes the governing body of a municipality that collects a mandatory payment authorized under this chapter, except as provided by Subsection (e), to require an annual mandatory payment to be assessed on the net patient revenue of each institutional health care provider located in the municipality. Authorizes the governing body to provide for the mandatory payment to be assessed quarterly. Provides that, in the first year in which the mandatory payment is required, the mandatory payment is assessed on the net patient revenue of an institutional health care provider as determined by the data reported to DSHS under Sections 311.032 and 311.033 in the fiscal year ending in 2013 or, if the institutional health care provider did not report any data under those sections in that fiscal year, as determined by the institutional health care provider's Medicare cost report submitted for the 2013 fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report. Requires the municipality to update the amount of the mandatory payment on an annual basis.
- (b) Requires that the amount of a mandatory payment authorized under this chapter be uniformly proportionate with the amount of net patient revenue generated by each paying hospital in the municipality. Prohibits a mandatory payment authorized under this chapter from holding harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).
- (c) Requires the governing body of a municipality that collects a mandatory payment authorized under this chapter to set the amount of the mandatory payment. Prohibits the amount of the mandatory payment required of each paying hospital from exceeding an amount that, when added to the amount of the mandatory payments required from all other paying hospitals in the municipality, equals an amount of revenue that exceeds six percent of the aggregate net patient revenue of all paying hospitals in the municipality.
- (d) Requires the governing body of a municipality that collects a mandatory payment authorized under this chapter, subject to the maximum amount prescribed by Subsection (c), to set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the municipality for activities under this chapter, to fund the nonfederal share of a Medicaid supplemental payment program, and to pay for indigent programs, except that the amount of revenue from mandatory payments used for administrative expenses of the municipality for activities under this chapter in a year is prohibited from exceeding the lesser of four percent of the total revenue generated from the mandatory payment or $20,000.
- (e) Prohibits a paying hospital from adding a mandatory payment required under this section as a surcharge to a patient.

DSRIP DY 7-8 Proposal

DSRIP DY 7-8 Proposal

- The implementation of the DSRIP structure is dependent on CMS approval of the additional 21 months and DSRIP protocols.
- The DY7-8 draft program structure evolves from project-level reporting to targeted Measure Bundles that are reported by DSRIP Performing Providers as a provider system.
- DY7-8 serves as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of alternative payment models to continue services for Medicaid and low-income or uninsured individuals after the waiver ends

Proposed DY 7-8 DSRIP Structure



Note that any DY6 QPI and Category 3 milestones/metrics carried forward to DY7 will follow the DY6 structure

DSRIP Category Funding Distribution

	DY 7	DY 8
Category A - required reporting	0%	0%
Category B - MLIU PPP	10%	10%
Category C- Measure Bundles	80 or 85%	80 or 85%
Category D - Statewide Reporting Measure Bundle	5 or 10%	5 or 10%

*If private hospital participation minimums in the region are met, then Performing Providers may increase the Statewide Reporting Measure Bundle funding distribution to 10%.

DSRIP Category C – Measure Bundles

Measure Bundles would consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities.

Bundling measures:

- Allows for ease in measure selection and approval.
- Increases standardization of measures across the state for providers with similar activities.
- Facilitates the use of regional networks to identify best practices and share innovative ideas.
- Continues to build on the foundation set in the initial waiver period while providing additional opportunities for transforming the healthcare system and bending the cost curve.

TEXAS Health and Human Services

DSRIP Measure Bundles

HHSC will work with stakeholders to finalize a menu of Measure Bundles.

The final menu may include measures taken from common existing Category 3 outcome measures, new or updated measures from authoritative sources, and innovative measures developed for DSRIP by participating entities to fill gaps in current standardized measures.

Innovative measures may be developed--pending interest--by a Texas entity functioning as a measure steward.

Bundles would include a mix of related process measures (currently designated as non-standalone [NSA]) and patient clinical outcomes (currently designated as standalone [SA]).

DSRIP Measure Bundles Point Value

Each Measure Bundle would be assigned a point value based on one or more of the following factors:

- The number of measures in the bundle and the difficulty of the measures in the bundle. (Ex: Current Category 3 stand-alone [SA] measures are worth 3 points, and current Category 3 non stand-alone [NSA] measures are worth 1 point).
- Whether the measure is pay-for-performance (P4P) or pay-for-reporting (P4R).
- Whether the bundle is considered a state priority. (Ex: If the bundle is considered a state priority, one point could be added to its value).

DSRIP Measure Bundle Selection Criteria

Each Performing Provider would be assigned a minimum point threshold for Measure Bundle selection based on DY7 valuation and its size and role in serving the Medicaid and uninsured population.

- HHSC is considering using factors such as Medicaid and uninsured costs and inpatient days as reported in the Uncompensated Care (UC) Tool, UC payments, and Disproportionate Share Hospital (DSH) payments.
- There will be a cap on the minimum point threshold for providers with very high valuations.

Performing Providers would select one or more bundles to meet or exceed their minimum point threshold.

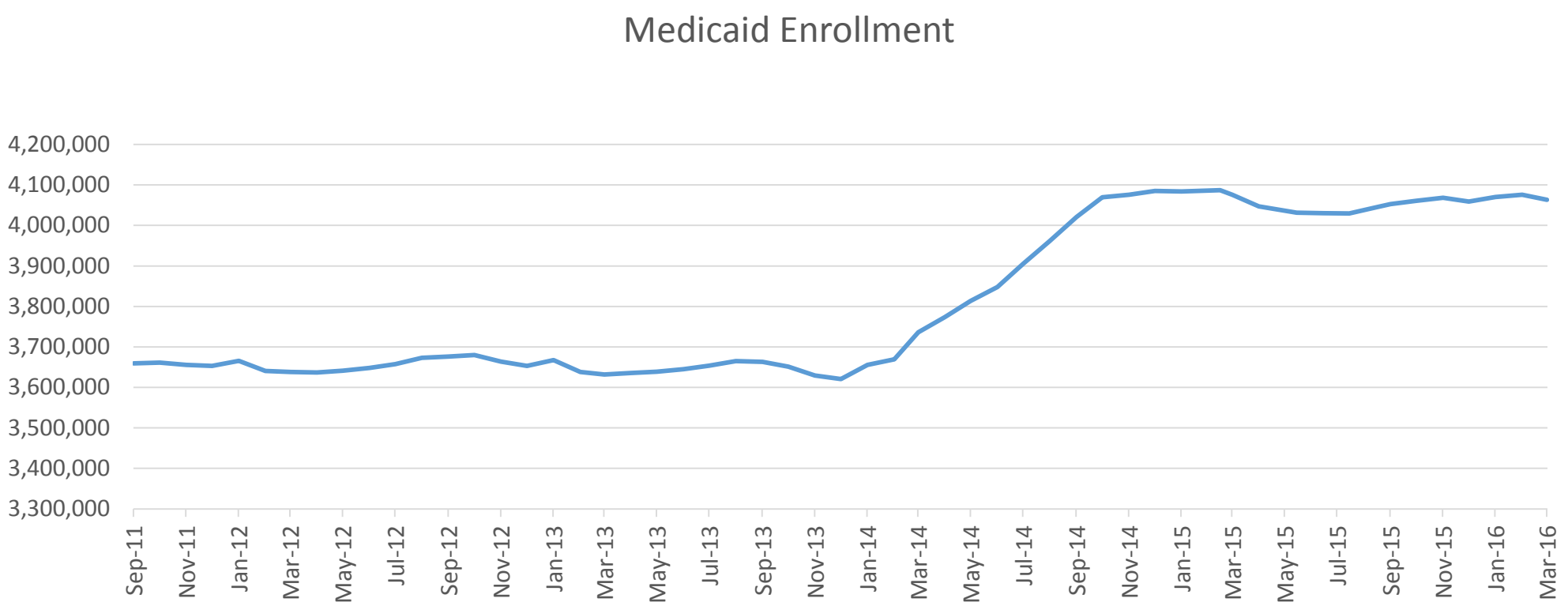
Minimum Point Threshold - Example

- Standard point valuation: $200,000
- Minimum point value cap: 100
- Minimum points increased for providers with a statewide ratio greater than 2

	Hospital A	Hospital B	Hospital C	Hospital D
DY7 Valuation	$2,000,000	$2,000,000	$2,000,000	$100,000,000
% of Statewide DY6 valuation	.05%	.05%	.05%	4.5%
% of Medicaid/UC Factors	.04%	0.02%	.01%	4.2%
Statewide Ratio	1.25	2.5	5	1.07
Minimum Points	10	13	25	100 (not 268)

Future Medicaid Funding Options

Medicaid Enrollment In Texas



Block Grant Option

Block grants would end the current federal matching rate approach to Medicaid funding and instead would give states an annual fixed budget within which they must manage their programs. This annual federal allotment likely would be based on some measure of current or historical Medicaid expenditures. Growth in the federal allotment would be tied to a predictable amount, such as general inflation or the consumer price index. However, there is the risk that the block grant amount will not increase annually if Congress does not appropriate funding increases as has been the case for the TANF block grants.

Speaker of the House Paul Ryan has offered his plan for Medicaid overhaul in a document titled "A Better Way." In that blueprint, he advocates for a block grant approach to Medicaid funding but provides no formula for how Medicaid block grants would be calculated or trended forward, or what growth factors would be considered.

Block grants also most likely would end the federal mandate for states to cover particular populations and benefits. For example, under current law, states must cover children ages 1 to 6 with family incomes under 133 percent of the federal poverty level and must cover hospital and physician services. Under a block grant, states could instead structure Medicaid on their own terms, determining eligibility and benefits themselves and requiring enrollees to pay more towards the cost of health care services than currently is allowed. The flexibility is critical because under a fixed budget, any Medicaid-related costs that exceed the budget cap are entirely the state's responsibility.

Per Capita Spending Cap Option

Per Capita Spending Caps

Another option being considered to limit federal spending on Medicaid and give states more flexibility to manage their programs is to impose a spending limit on each enrollee. Unlike block grants that would determine a state's federal Medicaid allotment based on aggregate spending, per capita spending caps would allocate funds based on current or historical spending per enrollee. These caps could apply to all Medicaid enrollees or could differentiate among different categories, such as children, the elderly or persons with disabilities. The caps also could be structured to carve out certain covered services, such as prescription drugs. As with the block grant approach, how much the caps are allowed to increase over time is a critical element.

Under Speaker Ryan's proposal, per capita spending caps would be based on Medicaid enrollment and costs in 2016. Each state would have four separate caps – for children, adults, the elderly and people with disabilities. Caps would increase over time, but the only detail provided is that the growth rate must be below that allowed in "current law."

As with a block grant, per capita caps likely would come with significant flexibility for states to determine coverage, benefits and other program elements.

Industry Principles

Texas hospitals advocate for the following parameters for fixed federal funding to ensure that coverage, access and reimbursement are not adversely affected:

- A funding baseline that is related to the need for services and ensures adequate reimbursement for hospitals and other health care providers.
- Protections for states like Texas that have large and growing low-income populations.
- Financial protections for states in the event of an economic downturn or recession.
- Funding allocation that accounts for supplemental payments and their associated method of finance.

Medicaid Payments

Medicaid Payment Structure

Standard Dollar Amounts (SDAs):

- Represent a percentage of the average cost of an inpatient admission
- General; Children's; Rural (facility-specific)
- SDAs only change through Legislative action

Add-ons: geographic wage; teaching; safety net, trauma (not available for Children's since all Children's are trauma-certified and trauma costs are included in base). No add-ons for Rural since they are paid using facility-specific SDAs.

Medicaid Payment Add-On For Trauma Hospitals

- (B) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:
- (i) by 28.3 percent for hospitals with Level 1 trauma designation;
- (ii) by 18.1 percent for hospitals with Level 2 trauma designation;
- (iii) by 3.1 percent for hospitals with Level 3 trauma designation; or
- (iv) by 2.0 percent for hospitals with Level 4 trauma designation

Medicaid Payments – Children's Hospitals

Currently, Children's Hospitals:

- Are reimbursed for inpatient services using a single, children's statewide base SDA with add-ons for geographic wage differences and for teaching medical education.
- The children's hospital single base SDA is currently $9,506 (by way of comparison, the urban base SDA is $2,994)
- The average children's hospital inpatient SDA with add-ons is $12,040.
- Average adult delivery rate in a children's hospital is $3,305.
- Outpatient reimbursement as percentage of cost is approximately 4 percent greater than for urban hospitals.

Medicaid Payments – Rural Hospitals

Currently, Rural Hospitals:

- Are reimbursed for inpatient services using facility-specific SDA's with a floor of $4,533 and a ceiling of $12,968.
- Because SDAs are facility-specific based on each hospitals' costs, there are no add-ons.
- General outpatient services are reimbursed at 100% of cost.
- Non-emergent, emergency room services are reimbursed at 65% of cost.
- Imaging and clinical laboratory services are reimbursed via a fee schedule with special rural hospital add-ons for imaging.