Members Present:
William Galinsky, Chair  
Dan Olvera  
Steven Hand  
Rebecca McCain  
Diana Strupp  
Michael Nunez  
Bill Bedwell  
Stephen Kimmel  
Eric Hamon

Members Absent:
Timothy McVey, Vice Chair  
Phillip Caron  
Sharon Clark

1. Opening comments: William Galinsky, Hospital Payment Advisory Committee Chair

   Bill Galinsky called the meeting to order at 1:33 pm and based upon the members in attendance, a quorum was present.

2. Approval of February 9, 2017, meeting minutes.

   Steve Hand motioned for approval  
   Diana Strupp seconded the motion  
   The motion to approve the minutes passed unanimously

HHSC Staff Updates:

Status of the Disallowance in Dallas and Tarrant counties.

Monica Leo, Staff Attorney, Office of the Chief Counsel, provided an update on the status of a CMS disallowance issued last September 1, 2016. Ms. Leo stated the Centers for Medicare & Medicaid Services (CMS) asserts some arrangements between private hospitals in the Dallas and Tarrant County areas and the Dallas County Hospital District Parkland and Tarrant County Hospital District constitute impermissible provider donations; HHSC disagrees. HHSC requested reconsideration of the disallowance directly to CMS; CMS denied the request and upheld the disallowance. HHSC filed an appeal with the departmental appeals board and filed a brief on June 2, 2017. CMS has 30 days to file their brief in response. Some of the private hospital systems affiliated with the hospital districts in Dallas and Tarrant County filed a motion with the departmental appeals board to intervene in the proceedings; CMS has been given until December 16, 2017. The board also asked CMS whether they plan to request an extension of their time to file their brief. There may or may not be a hearing.
Bill Galinsky asked what the other statewide ramifications are and what are the next steps? Ms. Leo replied, the disallowance is for one quarter for uncompensated care (UC) payments. CMS has conveyed they see this as a test case for arrangements which are similar to the ones in Dallas and Tarrant County. HHSC should not face any retroactive disallowances but will have to act quickly and will need to work closely with stakeholders to help make the transition. Mr. Galinsky asked for clarification of CMS being given until December 16, 2017 to decide whether they have an issue with the interveners. Ms. Leo clarified CMS has been given until June 16, 2017.

Bill Bedwell asked for clarification of an intervenor. Ms. Leo stated an intervenor is typically a party in a lawsuit, usually not one of the original parties but because they have a substantial interest in the outcome of the case and then the court is very interested in hearing their position on the issues especially when their perspective or their positions or the impact to them may differ from those of the actual original parties to the case. They would be able to separately brief and possibly separately argue.

**Healthcare Transformation for the 1115 Waiver**

Ardas Khalsa, Deputy Director, Medicaid and CHIP Services, stated the initial waiver ended September 30, 2016 and HHSC is currently in a 15 month extension, granted by CMS, until December 31, 2017. HHSC submitted a request to CMS for an additional 21 months. Commissioner Smith travelled to Washington DC to meet with the new CMS administrator to discuss the importance of the waiver, budget neutrality and compensated care pool and the delivery system reform incentive payment pool; there is no decision yet. Programmatically HHSC has until September 30, 2017. The protocols need to have approval from CMS. HHSC released a draft program in mechanics protocol in January 2017. HHSC is staying on track with the timelines and is keeping CMS posted operationally of when protocol approval will be needed. HHSC has rules to be released in August 2017 to be in place for the December decisions programs will have to make.

Michael Nunez: Are the demonstration year 6 payments still scheduled for January reporting? Ms. Khalsa replied yes, final results will be released and then HHSC will be making payments in July for the first reporting period. Payments for the second reporting are set for January. Diana Strupp asked if CMS has been given a timeline. Ardas replied there have not been any definitive timelines set.

Bill Galinsky commented the lead time going into December makes a huge difference. Ardas responded HHSC has a webinar scheduled. CMS is expecting to see next steps and further transformative efforts. HHSC has already made some adjustments and has to have 20% of the demonstration year (DY) 7 payments to providers on an approved plan to help with cash flow. HHSC is definitely paying attention to the challenges of the timeline.

Bill Galinsky asked if for planning purposes HHSC considers the DY6 time segment to really be part of DY7. Ardas responded yes. HHSC anticipates, once staff level discussions with CMS have been held, special terms and conditions will be adjusted. Michael Nunez expressed appreciation for sensitivity to the schedule as some hospitals are already in the budget process.
Legislation and Appropriations

Pam McDonald, Director of Rate Analysis, provided an update on legislative activities. HHSC is still working on pulling together everything that came out of the session. Ms. McDonald stated HHSC does have certainty there are no across the board reductions for hospitals and funding was found to fill any gaps caused by shortfalls in the trauma fund. The Governor has not acted on the Senate Bill 1 yet. All of the Local Provider Participation Fees (LPPFs) added language to their statute to have the ability to fund payments through managed care organizations for programs. The Appropriations Bill also included the usual reporting rider. There are a number of riders which require HHSC to report on a number of items relating to hospitals, none of those changed in any significant way. Pam noted another rider which contains the funding to preserve the trauma fund increases and also contains a revised definition of what a rural hospital is. The nursing facility reinvestment allowance bill did not pass in the Senate.

UHRIP

Gary Young, Director, Medicaid and CHIP Services, stated the UHRIP program was approved in April, 2017 for the Bayer and El Paso Service delivery areas. HHSC subsequently submitted a revised concept paper to CMS for 12 additional service delivery areas. CMS only asked one question about the resubmission. In the run-up to the planned September 2017 implementation, a number of operational issues were identified by the managed care organizations (MCOs) and some of the hospitals. HHSC is working through those issues and looking for an implementation in March, 2018. Pam McDonald noted HHSC came really close on a September 1, 2017 roll out but there are issues. For the March 2018 implementation, HHSC will use lessons learned from the initial attempted roll out to have a smoother roll out. HHSC will ask each service delivery area to name a contact who is either with the hospital or with an MCO or someone who is actually involved in the program. Pam McDonald stated HHSC is going to give more detail and instructions on how to complete the application and will be asking for the application or an attachment to the application to include information likely from hospital’s S-10s for hospitals who are neither in DSH or UC to determine hospital specific limits - one of the factors which goes into determining the UHRIP increases and the capitation rates. HHSC is anticipating a smoother enrollment process.

Diana Strupp asked if the program were to be rolled out March 1, 2018, would there still be the requirement of the intergovernmental transfers (IGT) to 4 months ahead of time putting it at November 1, 2017. Pam McDonald replied, yes, that is the rule for all of these types of programs. It is the rule for the quality incentive payment program, and the reboot of the minimum payment amounts. It has to do with CMS regulations which prohibit IGT responsibility agreements which was the vehicle HHSC was using to ensure General Revenue was not at risk in any of these programs. HHSC needs to protect general revenues by having the IGT on hand before the capitation rates are sent to CMS, which is why the money needs to be submitted earlier than under other programs. Steven Kimmel noted there was some discussion under the budget around the dollars available for UHRIP nursing. Mr. Kimmel asked if there been any further work to determine what is available for all the UHRIP programs under budget neutrality.

Pam stated, at this point HHSC is still working under budget neutrality under the current waiver and believe we had somewhere between 1.3 or 1.2 billion dollars of room. HHSC had a number of
competing programs, one of which was UHRIP, one of which was Qualified Incentive Payment Program (QIPP), and at the time the Commissioner was determining what budget neutrality room would be allocated to what programs, he had determined $800 million for UHRIP. With the delay until March, 2018, it will be $400 million. HHSC is working with CMS, negotiating budget neutrality for a waiver renewal; budget neutrality is almost as important as pool size because of opportunities to do programs like UHRIP and QIPP. The size of all those programs is limited by budget neutrality; HHSC is working with CMS to see what kind of room and flexibility exists to ensure necessary payments exist to support the safety net.

Dan Olvera noted in the last biennium there was funding for the safety net add on to the scattered dollar amounts and asked were funds appropriated for the next biennium and is the dollar amount appropriated more or less than previously appropriated? Pam McDonald replied, money was appropriated to maintain.

NOTICE OF INFORMATIONAL ITEMS:

3. Inpatient Direct Graduate Medical Education Reimbursement -- withdrawn

The Texas Health and Human Services Commission (HHSC) proposes amendments to Texas Administrative Code (TAC) Title 1, Part 15, Chapter 355, Subchapter J, Division 4, §355.8058, relating to Inpatient Direct Graduate Medical Education (GME) Reimbursement. The proposed amendments are necessary to comply with the 2018-2019 General Appropriations Act (Article II, Health and Human Services Commission, Senate Bill 1, 85th Legislature), which directs HHSC to allow public hospitals not owned by the State and private hospitals to receive GME supplemental payments, provided the non-federal share is provided. Currently, only state-owned hospitals are eligible to receive GME supplemental payments. The Act allows public hospitals not owned by the State to use intergovernmental transfers (IGT) to provide the non-federal share for Medicaid GME payments to public hospitals. The Act also allows private hospitals with access to allowable matching funds (e.g., local provider fees or other arrangements) to receive Medicaid GME payments.

- Kevin Niemeyer, HHSC Rate Analysis for Hospitals

4. Inpatient Hospital Reimbursement - Selvadas Govind:

HHSC proposes an amendment to TAC Title 1, Part 15, Chapter 355, Subchapter J, Division 4, §355.8052, relating to Inpatient Hospital Reimbursement, to modify the definition of a rural hospital. The proposed amendment is necessary to comply with the 2018-2019 General Appropriations Act (Article II, Health and Human Services Commission, Senate Bill 1, 85th Legislature, Rider 37). Rider 37 directs HHSC to define a rural hospital as (1) a hospital located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a Critical Access Hospital (CAH), Sole Community Hospital (SCH), or a Rural Referral Center (RRC) not located in a Metropolitan Statistical Area (MSA); or (3) a hospital which (a) has 100 or fewer beds, (b) is designated by Medicare as a CAH, an SCH, or an RRC, and (c) is located in an MSA. Current rule language defines a rural hospital as a hospital in a county with 60,000 or fewer persons based on the 2010 Decennial census, a hospital designated by Medicare as a CAH, an SCH, or an RRC.
There are two proposed rules, both of which are driven by a legislatively-directed change in the definition of rural hospitals. The first one relates to inpatient hospital reimbursement. HHSC is an amendment to 355.8052, Inpatient Rural Hospital Reimbursement. The amendment to the rule is proposed to comply with the 2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 180) which allocates funds to HHSC to provide for increased reimbursement to rural hospitals. For purposes of the allocation, the rider defines rural hospitals as:

1. A hospital located in a county with 60,000 or fewer persons according to the 2010 census.
2. A hospital designated by Medicare as a critical access hospital, a sole community hospital or a rural referral center not located in the metropolitan statistical area.
3. A hospital with 100 or fewer beds designated by Medicare as a critical access hospitals or community hospital or a rural referral center and is located in the metropolitan statistical area.

The amendment is required because the rule currently defines rural hospitals as hospitals in counties with 60,000 of fewer persons according to the 2010 census, a hospital designated by Medicare as critical access or a sole community access center or a rural referral center. In order to have the rule implemented by September 1, 2017, the proposed rule will have to be submitted to the Texas Register on June 12, 2017.

Bill Bedwell noted the fiscal note is a lot of money, with no money on the next item and asked what is the logic behind it? Selvadas Govind responded, HHSC anticipated the nine hospitals to be excluded from the new rural hospital definition and the fiscal impact; the avoidance in state funds was based on the estimated payments to these nine hospitals. Rebecca McCain asked how many of the nine hospitals are sole community hospitals and how many are rural referral centers? Selvadas Govind responded, one is a community hospital and the rest are rural referral centers.

Dianna Strupp asked, of the nine hospitals, have all of them been rural referral centers or sole community hospitals for a number of years or is this fiscal impact something new which would happen if this rule were put into place? Selvadas Govind replied, most of the nine have been treated as rural hospitals only for a number of months. Of the rural referral centers, the earliest was July 1, 2016. The sole community hospital has been designated to be reimbursed using a rural SDA and has been in effect from January 5, 2017. Ms. Strupp asked, is it correct the fiscal impact here is a prospective fiscal impact and was in the 2006 or 2017 expenditures? Selvadas Govind replied, that is correct. Bill Bedwell asked when the rule will be implemented. Selvadas Govind replied the implementation is September 1, 2017.

Dan Olvera stated, heretofore there's never been mention of the hundred bed criterion, how did the 100 bed criterion get implemented into the definition of a rural hospital? Pam McDonald responded, HHSC cannot answer the question because HHSC did not draft the rider.

Daniel Olvera voiced concern certain small hospitals are going to be located in urban areas and are still going to be able to enjoy the benefit of rural designation. Mr. Olvera questioned the fairness of the designation. Bill Bedwell asked if analysis had been performed and questioned if there are
currently any hospitals which meet the requirement of being under 100 beds. Selvadas Govind asked, are you looking for hospitals which would qualify under the new criteria but had not qualified in the past? Bedwell: Yes, which continue to qualify. Selvadas Govind replied, all of the existing hospitals qualify except for these nine. Bedwell: Are some of the existing hospitals in Metropolitan Statistical Area (MSAs)? Selvadas Govind: Yes.

5. Waiver Payments to Hospitals for Uncompensated Care

HHSC proposes amendments to TAC Title 1, Part 15, Chapter 355, Subchapter J, Division 11, §355.8201, relating to Waiver Payments to Hospitals for Uncompensated Care. The proposed rule amendments are necessary to comply with the 2018-2019 General Appropriations Act (Article II, Health and Human Services Commission, Senate Bill 1, 85th Legislature, Regular Session, 2017, Rider 37) which revises the definition of a rural hospital as: (1) a hospital located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a CAH, an SCH, or an RRC not located in a MSA; or (3) a hospital which (a) has 100 or fewer beds, (b) is designated by Medicare as a CAH, an SCH or an RRC, and (c) is located in an MSA. The current rural hospital definition is a hospital located in a county with 60,000 or fewer persons according to the most recent United States Census, a Medicare-designated RRC, an SCH, or an CAH.

- Selvadas Govind, HHSC Director of Rate Analysis for Hospitals

This rule is related to rule 355.8201 on waiver payments to hospitals for the UC program. In this rule we have a definition of a Rider 38 hospital and the definition was meant to conform with the definition of a rural hospital in 2014-15 General Appropriations Act. S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 38). Since the recently-concluded session redefined what a rural hospital is, HHSC needed to update the rule to reflect the change. What HHSC has done in this rule is removed reference to rural hospitals because rural numbers changed from biennium to biennium. For definition of a rural hospital we have referred back to the inpatient hospital rule previously discussed. There is no fiscal impact because the UC program is funded by the IGTs so there is no impact to the state revenues or expenditures. The effective date is September 1, 2017 and is driven by the state fiscal year.

Bill Galinsky responded; it is confusing since it is a UC rule and UC is on a Federal fiscal basis instead of a state fiscal basis. Does this mean hospitals changing status as a result of the change in the rule definition would be impacted for one month or is it just the qualification date and the qualification applies to the whole period? Selvadas replied, HHSC understands there is some confusion and inconsistency between the UC program and the definition of the rules and HHSC is drafting communication to stakeholders defining what the one month discrepancy would mean for UC waiver payments. Diana Strupp; you indicated there is a forthcoming communication to stakeholders to further explain how this will affect the DY6 UC allocation? Selvadas Govind replied, part is driven by the fact that many of these were not paid as rural hospitals in HHSC’s data year 2015; as a result it would have a higher hospital specific limit. If they are being treated as rural hospitals for this program year, they will have certain protections which rural hospitals have under the UC rule which could mean a possibility of an overpayment situation and reconciliation if done in three years time. HHSC will be communicating in the next week or two.
Bill Bedwell asked if a rural hospital has less taken away for outpatient reimbursement. Selvadas Govind agreed outpatient payments would be affected. If a hospital is a rural hospital it is treated as a rural hospital for both inpatient and outpatient purposes.

Bill Galinsky questioned the use of the terms MSA and CBSA being used interchangeably. Selvadas Govind responded the MSA designation still exists and is driven by the Office of Management and Budget (OMB); HHSC uses their designations. Bill Galinsky recommended clarification of the terms moving forward and verification the terms are interchangeable.

Steven Kimmel questioned as hospitals fall out of rural status are there financial implications for them individually? How does it impact individual facilities which are either complying with the rule definition or not? Selvadas Govind responded HHSC has not completed the calculations for the payments for UC program 2017. With UC payments there is a two-year data lag and also some other factors which could affect what the reimbursement would be. UC programs do not allow for adjustments or for hospitals requests for adjustments of cost, something HHSC needs to be looking at before calculations for UC payments are completed.

Dan Olvera shared his findings on the critical access hospitals located in MSAs in Texas. There are approximately 12 hospitals located in MSAs, all of these critical access hospitals have 25 beds or less. The new definition will allow these hospitals to continue to enjoy rural status. Mr. Olvera wanted to make the comment so HHSC would be cognizant of the inequity.

Testimony:

Phyllis Cowling, CEO, United Regional, Wichita Falls Texas, spoke in opposition of Agenda Item 5

Ms. Cowling stated United Regional Community Hospital is a sole community hospital (SCH) designated by CMS in October 2012 as a rural hospital. Ms. Cowling provided data to show there is no comparable hospital available within their geographic region, a predominantly rural area of the state. It is their understanding United Regional is the only SCH in the state which will be negatively affected by the revised definition of rural hospital. United Regional requested it be held harmless in these proposed rule changes.

Richard Schirmer, Texas Hospital Association, spoke in opposition of Agenda Item 4 & 5

Mr. Schirmer stated Texas Hospital Association (THA) felt the need to comment even though the items are informational. He gave the following THA recommendations:

- HHSC pay hospitals which have already been approved as a rural hospital using the current rule payment methodology.
- HHSC should provide a transition period if it moves forward.
- Medicare designation should be paid according to the current Medicaid payment methodology.
- HHSC should allow transition periods when complex changes are made, as hospitals set their budget 6 to 9 months in advance.
• Rider 180 does not address inpatient services or uncompensated care and THA is asking for a review of this.
• THA is seeking clarification of legislative intent for sole community hospitals.

6. Public comment.

Maureen Milligan, President of the Teaching Hospitals of Texas.

Regarding the graduate medical education (GME) issue, Teaching Hospitals of Texas (THOT) wished to highlight some of the opportunities additional funding for GME brings to Texas. Medicaid does not pay for direct GME cost in Texas with the exception of state-owned teaching hospitals. THOT has analysis which shows in the neighborhood of about $400 million in GME unfunded cost; a hundred twenty-five million of this amount is related to Medicaid unfunded GME direct costs. What this means is if Medicaid were to pay direct GME costs as it did prior to 2003, this would be the amount of funding which is now not funded, that would go to teaching hospitals. Analysis has shown teaching hospitals lose on average around $70,000 to $80,000 per resident per year. There is a grant program which has about $52 million but these are only for new residency positions. An individual already doing teaching hospital work is not eligible for these grants. A new rider provides match for grants for GME.

Bill Bedwell questioned why the GME agenda item was removed? Pam McDonald responded the rules being presented today are all on a super expedited timeline because they’re the result of legislative action and need to be in place by September 1, 2017. The deadlines for drafting rules for the super expedited process came before the final appropriations bill was voted out of the legislature. The final bill did not include the rider and so HHSC pulled the rule.

Diana Strupp and Bill Galinsky suggested a work group within HPAC, at HHSC’s discretion, regarding TAC rule §355.8201, relating to Waiver Payments to Hospitals for Uncompensated Care to discuss issues related to the rural hospital definition. Gary Young responded the suggestion of a workgroup will be taken to leadership for their preference.

7. Proposed next meeting: August 17, 2017, at 1:30 p.m.

8. Meeting adjourned.

Contact: Questions regarding agenda items, content, or meeting arrangements should be directed to Suzanna Carter, Committee Coordinator, Medicaid and CHIP Services Department, 512-730-7423, suzanna.carter@HHSC.state.tx.us.

This meeting is open to the public. No reservations are required, and there is no cost to attend this meeting.

People with disabilities who wish to attend the meeting and require auxiliary aids or services should contact Carter at 512-730-7423 at least 72 hours before the meeting so appropriate arrangements can be made.