Evaluation of Rural Hospital Funding Initiatives

As Required by

2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017

(Article II, HHSC, Rider 52)

Health and Human Services

Commission

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Executive Summary

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission (HHSC), Rider 52), Evaluation of Rural Hospital Funding Initiatives, requires HHSC to provide a progress report on its evaluation of Medicaid funding initiatives for rural inpatient and outpatient hospital services, including determining the percentage of estimated allowable hospital cost reimbursed by payments for services provided to managed care clients; the percentage of wrongful denials; the average wait time for final payment; and any remedies taken to improve compliance of vendors.

HHSC has undertaken three different approaches to collect and evaluate the elements of payments to rural hospitals addressed in Rider 52. This status update provides the overview of those approaches and the current status of findings.

1. Introduction

Rider 52 requires HHSC to submit a progress report on the evaluation of Medicaid funding initiatives for rural inpatient and outpatient hospital services to the Legislative Budget Board (LBB) and the Office of the Governor (OOG) by August 1, 2018 and submit a report on the evaluation findings to the LBB and the OOG by August 1, 2019. For purposes of the above evaluations, and as defined by Rider 46, rural hospitals are defined as (1) hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; (2) a hospital designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA); or (3) a hospital that has 100 or fewer beds, is designated by Medicare as a CAH, a SCH, or a RRC, and is located in an MSA.

HHSC is pursuing three different strategies to collect data and address the requested rider deliverables as discussed in this report.

2. Progress Report

HHSC has engaged in numerous activities to comply with Rider 52, starting with changes to the state's claims administrator's data systems to better be able to evaluate Medicaid managed care payments to rural hospitals. This system change is necessary because rate analysis has traditionally been based on fee-for-service (FFS) claims, but the majority of Medicaid services are paid through the managed care model which captures encounter data. As indicated in the LBB staff report titled "Use Improved Data to Evaluate Rural Hospital Medicaid Funding," HHSC initiated a change order request (COR 16-025) with the Texas Medicaid and Healthcare Partnership (TMHP), the state's claims administrator, in 2016 to facilitate utilization of encounter data for rate analysis. The goal of the system change is to be able to calculate a FFS equivalent price from managed care encounter data and to identify allowable Medicaid charges. The change order also requested to modify cost settlement templates to include managed care encounter data. The system updates were completed in May 2018.

However, TMHP and HHSC staff have identified a number of provider-related issues that preclude the successful collection and integration of encounter data. Until these issues are corrected, HHSC does not have sufficient data to estimate the percentage of estimated allowable rural hospital costs reimbursed by payments for services provided to managed care clients. In the absence of this corrected data, HHSC can only use the billed charges as an estimate of hospital costs, but they are not an accurate demonstration of allowable charges. Comparisons of Medicaid payments to estimates based on billed charges understates the percentage of costs that are being covered because billed charges are typically higher than allowable costs.

In April 2018, HHSC met with the managed care organizations (MCOs) to discuss the provider-related issues identified during this project, as well as next steps. In an effort to improve rural inpatient hospital data and all other data, HHSC began enhancing provider-related inputs to TMHP's system to strengthen the validation and validity of encounter data. These technology changes are scheduled for implementation September 1, 2018. HHSC is currently working with MCOs to correct and resubmit encounter data for fiscal year 2016 and fiscal year 2017 by October 31, 2018.

In addition to the system changes at TMHP, HHSC is obtaining data from MCOs that is necessary for the evaluation. HHSC has created a reporting template to collect the necessary data, including:

- total costs reimbursed for all hospital claims;
- total costs reimbursed for rural inpatient services;
- percentage of allowable costs reimbursed for rural outpatient hospital services;
- total number of rural inpatient hospital claims that were reprocessed due to MCO errors;
- average wait time for final payment; and,
- remedies assessed or corrective action taken for non-compliance of subcontractors.

HHSC collected data in the MCO templates for fiscal year 2016 and fiscal year 2017 and will request fiscal year 2018 data in January 2019. HHSC continuously engaged with MCOs to ensure the accuracy of the data collected to date and will utilize the data to evaluate the required elements of the rider. Once all data are collected, HHSC will analyze the data and determine if trends exist across MCOs and the programs that they administer, and, if possible, draw conclusions about the data.

Finally, HHSC initiated an internal audit as part of its annual audit plan related to the timeliness of payments by MCOs to rural hospitals. Six MCOs were selected for the audit based on a risk assessment of the number of rural hospital that processed claims during the first quarter in fiscal year 2018 and the number of rural hospitals in each of their provider networks. The claims and number of rural hospitals are being reviewed as part of their procedures.

HHSC internal audit has completed their field work and analysis for the audit of the six MCOs, and is currently drafting their report. The report is expected to be released in early fall and may inform the final evaluation required by Rider 52.

3. Conclusion

HHSC has identified barriers to collect data required by Rider 52 and has been actively working with partners to address these challenges and complete a meaningful evaluation of rural hospital funding initiatives. HHSC will submit a report on the evaluation findings to the LBB and the OOG by August 1, 2019.

List of Acronyms

Include a list of all acronyms that appear in the report. Add each new entry in its own row of this table.

Acronym	Full Name
CAH	Critical Access Hospital
HHSC	Health and Human Services Commission
LBB	Legislative Budget Board
OOG	Office of the Governor
CAH	Critical Access Hospital
SCH	Sole Community Hospital
RRC	Rural Referral Center
MSA	Metropolitan Statistical Area
MCO	Managed Care Organization
TMHP	Texas Medicaid Healthcare Partnership