REVISED CONCEPT PAPER

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REGIONAL UNIFORM HOSPITAL RATE INCREASES UNDER TEXAS MEDICAID MANAGED CARE

Introduction

This concept paper describes a proposal for regional uniform hospital rate increases under Texas Medicaid Managed Care. Currently, 88 percent of Texas Medicaid recipients receive their Medicaid services through managed care; effective November 1, 2016, with the roll-out of StarKids, that percentage will increase to 92 percent. Texas' Medicaid managed care capitation premiums do not allow for payments that cover 100 percent of hospital Medicaid allowable inpatient and outpatient costs resulting in a Medicaid shortfall. Regional uniform hospital rate increases under managed care would significantly reduce the size of Texas' Medicaid shortfall.

Background

Currently, Texas' Medicaid payments, made through either the fee-for-service (FFS) or managed care models, do not cover costs. On the outpatient side, FFS and managed care payments cover between 68.44 percent and 72.00 percent of Medicaid allowable costs for urban hospitals, between 72.27 percent and 76.03 percent for children's hospitals, and 100 percent for rural hospitals. A portion of the Medicaid shortfall is reimbursed through supplemental payment programs such as the disproportionate share hospital (DSH) program and the uncompensated care (UC) pool under the 1115 waiver known as the Texas Healthcare Transformation and Quality Improvement Program. These supplemental payments are paid outside of the managed care capitation apparatus.

Healthcare policy experts posit that reimbursing provider costs more fully through managed care payments would enhance care coordination. Flowing additional funds for hospital services prospectively through managed care entities, rather than retrospectively reimbursing hospitals for services provided but not fully reimbursed through Medicaid, would increase the ability of the state and its managed care contractors to pursue approaches to provider reimbursement that prioritize achieving health outcomes versus the delivery of services.

Concept

Texas proposes to use intergovernmental transfers (IGT) from non-state governmental entities to support capitation payment increases for one or more service delivery areas (SDAs), which may vary based on the circumstances of each SDA. Each managed care organization (MCO) within the SDA would then be contractually required by the state to increase hospital payment rates by a uniform dollar or percentage increase for all of its public and private contracted hospitals.

Example - El Paso SDA

The El Paso County Hospital District d/b/a University Medical Center of El Paso (UMC El Paso) agrees to fund the non-federal share of an increase in capitation rates paid to all MCOs (El Paso First, Molina, Amerigroup, and Superior) in the El Paso SDA (inclusive of El Paso and Hudspeth counties) to support managed care rate increases for all hospitals in the El Paso SDA.

HHSC will require all El Paso SDA MCOs to adopt a uniform percent rate increase for one or more classes of network providers. HHSC's actuaries will calculate per member per month (PMPM) capitation rates for the El Paso SDA with and without the uniform percent rate increase. HHSC will communicate the required non-federal share to support the cost of the uniform percent rate increase, including associated premium taxes, risk margin and administration fee to UMC El Paso and UMC El Paso will transfer to HHSC the amount required to support the uniform percent rate increase for a six month time period. The required non-federal share will be based on the difference between the two PMPMs (e.g., the PMPM without the uniform percent increase requirement and the PMPM with the requirement) and projected member months for the rate period.[1]

El Paso SDA MCOs will modify their contracts with El Paso hospitals to incorporate the specified uniform percent rate increase. HHSC will modify its contracts with all Medicaid MCOs in the El Paso SDA to base payments for hospital inpatient and outpatient services for their contracted hospitals in the El Paso SDA on the specified uniform percent rate increase. and include contract language requiring the MCOs to agree to their understanding that the federal funding for the rate increase may be reduced or eliminated in future years.

Intergovernmental Transfers

Funds to support the non-federal share of the first six months of an annual PMPM increase would be transferred to HHSC no later than four months prior to the effective date of the increased PMPM. Following the first six-month transfer, HHSC will then request smaller transfers on a monthly basis to ensure HHSC receives funding for the second six months of the PMPM increase at least four months in advance.[2] Alternatively, PMPMs could be set for a six month period with changes from one period to the next dependent, among other factors, upon any changes in MCO contracts with hospitals in the specified SDA to increase or decrease MCO payments to their contracted hospitals. All Medicaid hospitals contracted with an MCO in the impacted SDA would receive the managed care rate increase(s) regardless of whether the hospital transfers funds to HHSC.

Implementation and operation of this program will be subject to the availability of IGT and federal funds. No General Revenue will be used in the event that IGT is not made available, or if federal funding decreases or is eliminated.

[1] Initial IGT requirements will include a mark-up to cover possible differences between actual member months and projected member months. As well, IGT reconciliations may performed at any time during the rate period if actual member months vary significantly from projected member months.

[2] HHSC is also willing to explore CMS' request to analyze the possibility of drafting contracts with its MCOs such that the PMPM can float along with available IGT so that if there is an IGT shortfall, new contracts between HHSC and its MCOs are not required.

Compliance with Approval Criteria

Utilization and Delivery of Services
The increased payments from MCOs to hospitals for inpatient and outpatient services will be based on the utilization and delivery of those services by the hospitals to a MCO's Medicaid managed care members. Payments will be made according to the regular MCO claims payment processes and deadlines.

Expenditures and Classes
The required uniform percent rate increase will not vary within each class of hospitals (e.g., state-owned, non-state government-owned, private, children's, and rural); the percent rate increase may vary between classes.

Link to Goals and Objectives of State Quality Strategy
Among the specific goals of the State Quality Strategy are to "improve access by expanding the provider network and enhancing the timeliness of care." HHSC believes the uniform hospital rate increases resulting from implementation of this initiative will have the effect of increasing hospital participation in Managed Care Organizations' networks, including the participation of affiliated physicians and physician group practices. This impact may vary by service area.

Evaluation Plan
HHSC will evaluate the impact of this initiative through a combination of on-going performance assessment activities which are already part of HHSC's managed care operations monitoring. These include encounter data analysis, provider network adequacy analysis and reporting, External Quality Review Organization ad hoc studies, Medicaid managed care member complaints, and MCO-reported financial and program reports. The purpose will be to ensure that the initiative is advancing the goal of improving access to hospital services and specialty care, including specialty physician services, and that the timeliness of care is improved.

With respect to network expansion, HHSC will track and report on the status of new hospital contracts by MCO and of those facilities affiliated physician groups by specialty. The results may be included as part of the quarterly network access report HHSC submits to CMS pursuant to the Section 1115 Demonstration Waiver.

Regarding timeliness of care, HHSC may adapt one or more measures from the CMS Medicare Hospital Care Timely and Effective Care measures set for purposes of this evaluation. For example, two measures in particular are most relevant to our Medicaid managed care members: (1) Children's Asthma Care (the percentage of children and caretakers who receive a home management plan of care); and (2) Pregnancy and Delivery Care (percent of mothers whose

deliveries were scheduled too early). Both of these measures address issues which are of importance to Texas Medicaid. The program has a large percentage of children with asthma and encouraging home management of the condition improves health and avoids costs. Texas has also identified an issue with respect to pre-term deliveries. Leveraging the hospital rate increase program to encourage vaginal deliveries is in keeping with HHSC's other initiatives to improve birth outcomes.

Both the network expansion and the timely and effective care measures can be evaluated using existing data sources.

IGT and Provider Participation

As noted above, each network provider hospital in the SDA will be permitted to participate. No network provider hospital's participation will be conditioned on the provision of an IGT, nor on their entering into or adhering to an IGT agreement.

No Automatic Renewal

HHSC understands that the initiative is not eligible for automatic renewal and will seek approval from CMS for any extension of the program beyond the initial approval period.

Conclusion

The State believes this proposal is compliant with all federal regulations and statutes. The increases in care coordination and access to care could have an important impact on Medicaid recipients, and would enhance the role of Texas' Medicaid MCOs in achieving delivery system and payment reforms. The proposed methodology would increase the likelihood of the state and its MCOs pursuing approaches to provider reimbursement that prioritize achieving health outcomes versus the delivery of services. Perhaps most importantly, the proposal would reduce the size of the Medicaid shortfall and lessen hospitals' reliance on supplemental funding sources such as DSH and UC.