NAVIGATING CHANGE:
TEXAS MEDICAID IN FOCUS

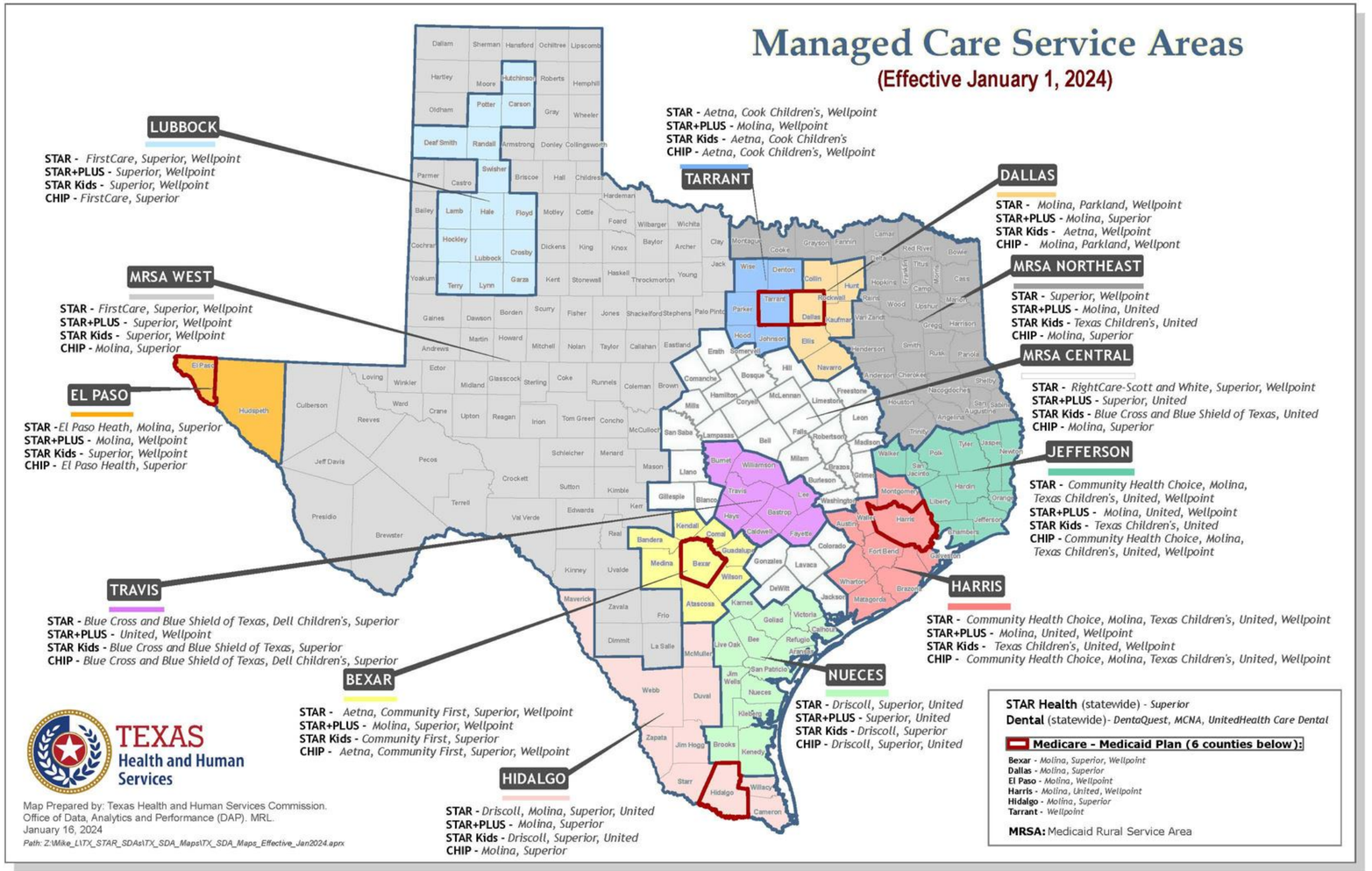
August 2024

AHCV
Adelanto HealthCare Ventures L.L.C.

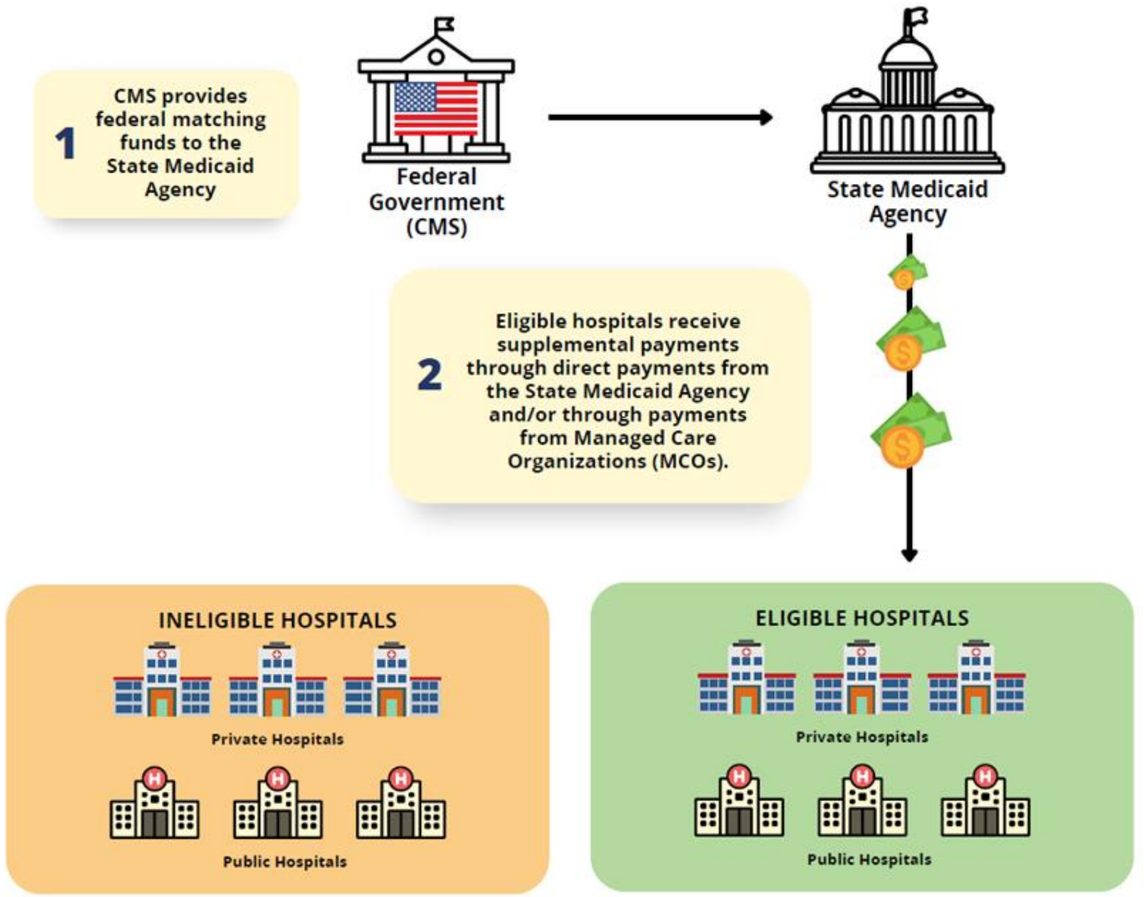
Objectives

- Program Mechanics & Background
- Financing Directed Payment Programs
- Texas Supplemental Payment Programs
- Future of Texas Programs
- Medicaid Managed Care Final Rule
- Q&A

Program Mechanics & Background

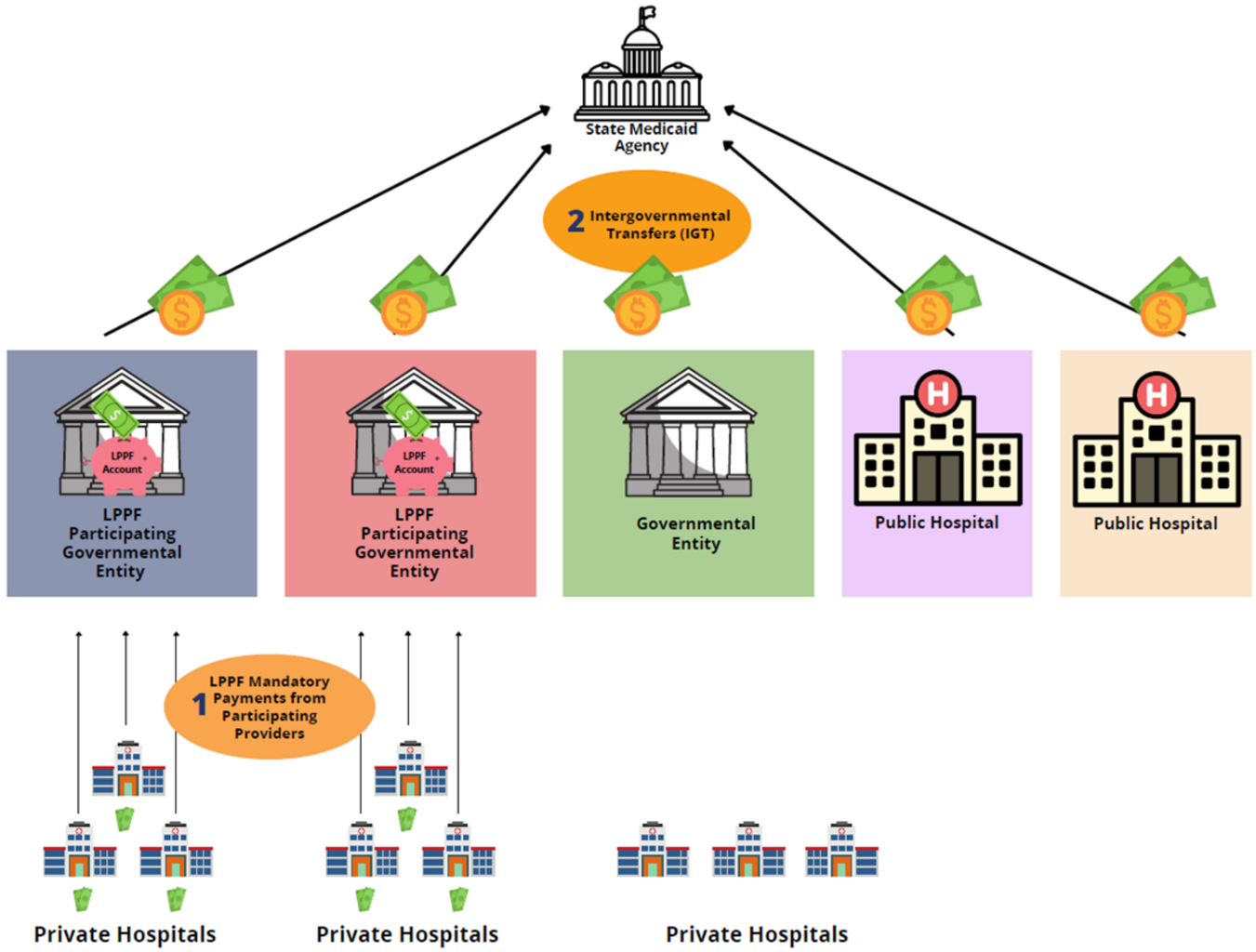


Program Mechanics & Background



*Not all hospitals that make IGTs or mandatory payments are eligible to receive supplemental payments. Hospitals must meet supplemental payment program criteria to be eligible for payments.

Program Mechanics & Background



Program Mechanics & Background

Who can fund an IGT?

What is an LPPF?

Who can participate?

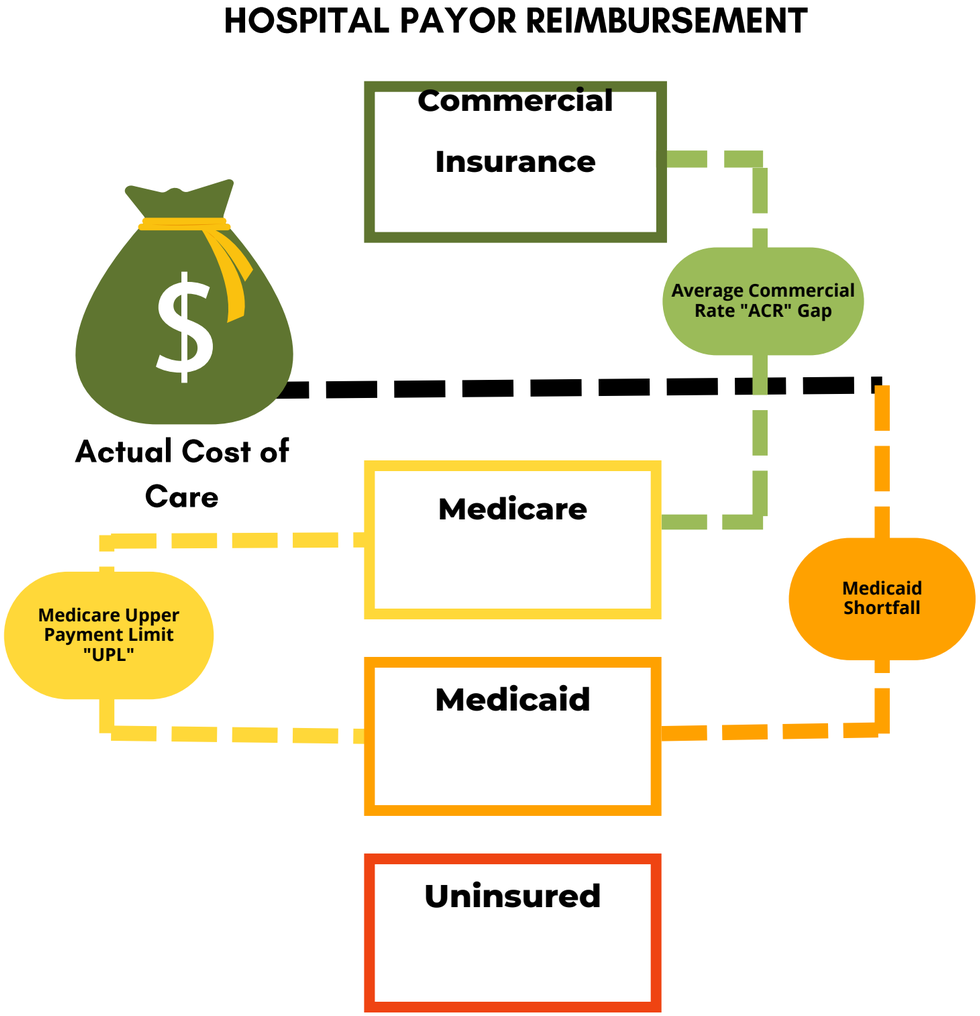
Who authorizes?

Local Provider Participation Fund Enabling Legislation and Statutory Authority

Service Delivery Area	Jurisdiction	Enacted Bill	Session	Year Enacted	Texas Health and Safety Code
Hidalgo	Cameron County	SB 1623	83R	2013	Chapter 288
Hidalgo	Hidalgo County	SB 1623	83R	2013	Chapter 288
Hidalgo	Webb County	SB 1623	83R	2013	Chapter 288
MRSA Central	Bell County	HB 2913	84R	2015	Chapter 297
MRSA Northeast	Bowie County	SB 1587	84R	2015	Chapter 292
MRSA Central	Brazos County	HB 3185	84R	2015	Chapter 296
MRSA Northeast	Cherokee County	SB 1587	84R	2015	Chapter 292
MRSA Northeast	Gregg County	SB 1587	84R	2015	Chapter 292
Travis	Hays County	HB 3175	84R	2015	Chapter 293
MRSA Central	McLennan County	HB 2809	84R	2015	Chapter 294
Lubbock	City of Amarillo Hospital District	SB 2117	85R	2017	Chapter 295A
MRSA Northeast	Angelina County	HB 2995	85R	2017	Chapter 291A
Dallas	Dallas County Hospital District	HB 4300	85R	2017	Chapter 298A
MRSA Northeast	Grayson County	HB 2062	85R	2017	Chapter 292A
MRSA Northeast	Smith County	HB 2995	85R	2017	Chapter 291A
Tarrant	Tarrant County Hospital District	SB 1462	85R	2017	Chapter 298B
MRSA West	Tom Green County	HB 3398	85R	2017	Chapter 293A
Travis	Williamson County	HB 3954	85R	2017	Chapter 292B
Lubbock	Lubbock County Hospital District	SB 2448	86R	2019	Chapter 298D
Dallas	Ellis County	HB 4548	86R	2019	Chapter 296A
Bexar	Bexar County Hospital District	SB 1545	86R	2019	Chapter 298F
Harris	Harris County Hospital District	HB 3459	86R	2019	Chapter 299
MRSA West	Wichita County	SB 2286	86R	2019	Chapter 292C
Travis	Travis County Hospital District	SB 1350	86R	2019	Chapter 298E
MRSA West	Taylor County	HB 1142	86R	2019	Chapter 293C
Nueces	Nueces County Hospital District	SB 2315	86R	2019	Chapter 298C
El Paso	El Paso County Hospital District	SB 1751	86R	2019	Chapter 298G
MRSA Northeast	Nacogdoches County Hospital District	HB 4700	88R	2023	Chapter 298H
Jefferson	Jefferson County*	HB 4835	88R	2023	Chapter 292D *(Effective 9/1/2025)*
Dallas	Collin County	HB 4289	86R	2019	Chapter 300
	Not Specific – Single Jurisdiction	HB 4289	86R	2019	Chapter 300
	Not Specific – Multi-Jurisdictional	HB 4289	86R	2019	Chapter 300A

Program Mechanics & Background

- Relevant Information of Calculations:
  - Medicaid actuarial data
  - Medicare actuarial data
  - Hospital provided data
  - Payments and IGT's calculated
  - What is an IGT?



Texas Supplemental Payment Programs

	CHIRP	TIPPS	RAPPS
Pool Size	$6.5 Billion	$714 Million	$23.5 Million
Hospital Classes	Children's, Rural, State-owned Non-IMD, Urban, Non-state-owned IMD, and State-owned IMD	IME, HRI and other Physician Groups	Hospital-based RHCs (Non-state government owned and Private) and Freestanding RHCs
Quality	Yes - Reporting Requirements	Yes - Reporting Requirements	Yes - Reporting Requirements
Type of Payment	Claim by Claim	C1: Monthly C2: Semi-Annually C3: Claim by Claim	C1: Semi-Annually C2: Claim by Claim

Texas Supplemental Payment Programs

CHIRP SUMMARY	HHSC PROJECTION BASE DATA IN MAY 2023
CHIRP (after fees)	$6,126,476,732
UHRIP	$4,090,314,156
ACIA	$2,036,162,576

Future of Texas Programs

- ATLIS
- CHIRP
- UC
- DSH
- TIPPS
- Other Supplemental Programs

Future of Texas Programs

Aligning Technology by Linking Interoperable Systems (ATLIS)

ATLIS is a brand new program that is unlike any other program that has ever existed in Texas.

- This program is NOT a hospital program, rather it's an MCO-incentive payment program.
- HHSC is NOT required to mandate MCO's to pass any payments to hospitals.
- Incentives associated with ATLIS payments are tied to hospital HIE connectivity.
- Pool size is capped at 5% of an MCO's STAR, STAR Kids, and STAR Plus total capitation.
- Estimated full pool size at $1.8 billion – first year pilot program at $700 million.
- FY25 – starts 9/1/2024 with two semiannual payments.
- Currently ATLIS allocations are based on projected CHIRP losses.
- This program is expected to be funded via IGT dollars like other programs.
- Unified Network Initiatives of Texas (UNIT), special purpose network

Future of Texas Programs

Aligning Technology by Linking Interoperable Systems (ATLIS)

A Limited Scale ATLIS will be launched for FY 2025.

- HHSC has worked to develop the ATLIS program in an effort to introduce a new, innovative solution to support managed care organizations in improving the receipt of electronic data submissions from hospitals in their networks.
- The program serves a multitude of purposes, including and especially enabling forward momentum on various quality goals and the development of alternative payment models. The program will be focused for FY 2025 on implementing HIE solutions in STAR Kids between MCOs and Children's Hospitals, in STAR Plus between Rural and Urban hospitals, and in STAR in select service delivery areas (Bexar, Dallas, Jefferson, Nueces, and Tarrant).
- The MCOs will be eligible to earn percentages varying from 0.05% of their capitation to 5.00% of their capitation, depending on their achievement related to milestones related to certain provider classes within their networks. The total program value will be restricted to ensure that the first and second years of the program are operationally manageable.

Future of Texas Programs

Aligning Technology by Linking Interoperable Systems (ATLIS)

Current Structure - PGY3 CHIRP (9/1/23-8/31/24) $6,126,476,732	
UHRIP	**ACIA**
$4,090,314,156	$2,036,162,576
438.6(c)	438.6(c)
Hospital SDP	Hospital SDP

HHSC Proposed Structure - CHIRP Replacement $6,931,155,001			
UHRIP	**ACIA**	**APHRIQA**	**ATLIS**
$4,408,179,450	$385,154,515	$1,409,279,670	$728,541,366
438.6(c)	438.6(c)	438.6(c)	438.6(b)(2)
CHIRP	CHIRP	New CHIRP	MCO Incentive Payment Program
Hospital SDP	Hospital SDP	Hospital SDP	MCO Payment, no state direction
Preprint	Preprint	Preprint	State Contract
Utilization	Utilization with reporting	Utilization with P4P	Capped at 5% of capitation rate

Future of Texas Programs

Comprehensive Hospital Increased Reimbursement Program (CHIRP)

CHIRP will be restricted to approximately $6.2 billion in hospital payments.

- In evaluating the Medicare upper payment limit (UPL), average commercial reimbursement (ACR), and provider cost data, in combination with the forecasted changes in Medicaid managed care caseload, HHSC is observing the potential for significant changes in the potential CHIRP size. If left unrestricted, CHIRP is modeled that it could increase to as much as $7.2 billion in hospital payments – an increase of $1.1 billion from the estimated value of CHIRP for SFY 2024.
- HHSC is still waiting for CMS to determine the available budget neutrality room under the Texas 1115 Waiver. In the absence of that information, it is prudent that the state limit managed care expenditures until the budget neutrality room is established and HHSC can ensure with confidence that all Medicaid managed care expenditures will be eligible for federal financial participation (FFP).

Future of Texas Programs

Comprehensive Hospital Increased Reimbursement Program (CHIRP)

CHIRP will introduce the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) at $1.4 billion.

- 42 CFR 438.6(c) requires that directed-payment programs, including CHIRP, advance a quality goal or strategy. UHRIP, CHIRP's predecessor, existed solely as a uniform rate increase from December 1, 2017 through August 31, 2021; CHIRP has been in place since September 1, 2021 to now.
- While CMS has approved CHIRP (or UHRIP) to exist as a uniform rate increase only for more than 6.5 years, CMS has signaled strongly to Texas (and other states) that year-over-year improvement is necessary for annual reapproval of the program. Based upon the regulatory requirements, and the tenure and size of CHIRP, HHSC believes it is necessary and prudent to introduce a pay-for-performance component to CHIRP.
- HHSC has been discussing the design of APHRIQA with CMS since January 2024 and CMS has responded extremely favorably to the concept. CMS recently reviewed a draft pre-print that includes APHRIQA as a component of CHIRP and has not provided any feedback that indicates that they believe APHRIQA conflicts with the existing or new regulations. To ensure a timely approval of CHIRP, HHSC will pursue approval of CHIRP with this component incorporated.

Future of Texas Programs

Comprehensive Hospital Increased Reimbursement Program (CHIRP)

Starting in state fiscal year 2026, HHSC will modify CHIRP to allocate ACIA on a per-class per-SDA basis, rather than by hospital

- Currently, ACIA payments in CHIRP are restricted to a uniform percentage of each individual hospital's ACR "room." As permitted by federal regulation, HHSC will transition ACIA to allow all hospitals within a class within a service delivery area to share the ACR room generated by their class in their SDA.
- This calculation will function substantially similarly to the current allocation of the UHRIP component of CHIRP and will enable hospitals that have fewer or less advantageous commercial payments to benefit from amount generated by other hospitals that have higher or more advantageous commercial payments.

CHIRP may be authorized to increase to use the full Medicare UPL and full ACR UPL in the future

- HHSC will seek to increase the UHRIP component of CHIRP back to 100% of Medicare UPL and 90% of ACR for FY 2026. HHSC will then seek to increase to 95% of ACR in FY2027 to 100% of ACR in FY2028.

Future of Texas Programs

Comprehensive Hospital Increased Reimbursement Program (CHIRP)

CHIRP SUMMARY	HHSC PROJECTION BASE DATA IN APRIL 2024
CHIRP (before fees)	$6,202,613,635
UHRIP	$4,408,179,450
APHRIQA	$1,409,279,670
ACIA	$385,154,515

Future of Texas Programs

Uncompensated Care Program (UC)

UC is projected to decrease for the final 3 years of the 1115 Waiver

- HHSC's current models indicate that the UC pool will be reduced to approximately $3.1 billion annually
- The UC pool is required to be resized for demonstration year (DY) 17 through 19 of the 1115 Waiver. In accordance with the methodology agreed to between CMS and HHSC in 2016 (during the first waiver renewal), the UC pool size will be based exclusively on uncompensated charity care costs, and will be reduced by any perceived Medicaid "overpayments".
- Medicaid "overpayments" are any hospital payments received that exceed the costs of delivering care to Medicaid fee-for-service or managed care beneficiaries. Medicaid uncompensated costs and uninsured non-charity care costs are not allowed to be included in the total UC resizing. While Medicaid costs and UC costs continue to grow, the introduction of new supplemental payments or directed-payments has outpaced the cost growth, resulting in an overall projected reduction in UC that will be allowed in the future.

Future of Texas Programs

Uncompensated Care Program (UC)

Starting in DY 17, HHSC will reallocate the UC pool to prioritize $1 billion in UC to hospitals eligible for the High Impecunious Charge Hospital (HICH) pool

- The HICH pool was introduced as a mechanism to prioritize new UC pool room to certain hospitals that had high levels of uninsured charges, rural hospitals, and state-owned hospitals. The sub-pool was capped at the difference between the amount of the UC program beginning in DY 12 and the amount of the UC program in DY 11 (approximately $600 million).
- When considering the prospect that the UC pool could decrease to levels at or below the levels seen in DY 6 or earlier, it is prudent to reconsider the way the HICH sub-pool is sized and where in the payment methodology it is issued.
- HICH will in the future move to become the first payment allocation made in UC, and will enable any HICH hospital to receive payments before any non-HICH hospital. The total HICH allocation will be set at a level that does not exceed $1billion in total. HICH hospitals will continue to be eligible for non-HICH UC funding that remains after payment of HICH, subject to each hospital's state payment cap.

Future of Texas Programs

Disproportionate Share Hospital (DSH)

Starting in federal fiscal year 2025, HHSC will deem all rural hospitals eligible for the Disproportionate Share Hospital (DSH) program and will change the calculation of the low-income utilization ratio, as suggested by the Texas Organization of Rural and Community Hospitals.

- Rural hospitals are critical to Texans in rural communities receiving health care, including emergency hospital services.
- While tradition methods of determining what hospitals qualify as a "DSH" hospital do include many rural hospitals, not all rural hospitals are currently eligible for DSH.
- Enabling all rural hospitals to participate in DSH provides increase protection for rural hospitals by enabling them access to the last possible source of payment for any uncompensated Medicaid costs or for costs associated with uninsured non-charity care patients.

Future of Texas Programs

Texas Incentives for Physicians and Professional Services (TIPPS)

- There are three categories of providers who are eligible to participate in TIPPS:
  - Health Related Institutions ("HRI")
  - Indirect Medical Education ("IME")
  - Other Physician Groups
- HRI and IME providers suggested to IGT for the other physician groups (Class 3).
- Funding determinations are made by SDA.
- Managed Care Programs include STAR, STAR Plus, and STAR Kids.
- There are a minimum of 250 Medicaid managed care members serviced.
- The TIPPS program is optional.
- TIPPS has historically been paid in monthly, semi-annually and as rate add-ons, beginning on 9/1 TIPPS will be paid as 100% rate add-ons.

Future of Texas Programs

Other Supplemental Payment Programs

DSH: Disproportionate Share Hospitals

UC: Uncompensated Care Program

GME: Medicaid Graduate Medical Education

HARP: Hospital Augmented Reimbursement Program

QIPP: Quality Incentive Payment Program

NAIP: Network Access Improvement Program

PHP-CCP: Public Health Provider – Charity Care Pool

Medicaid Managed Care Final Rule

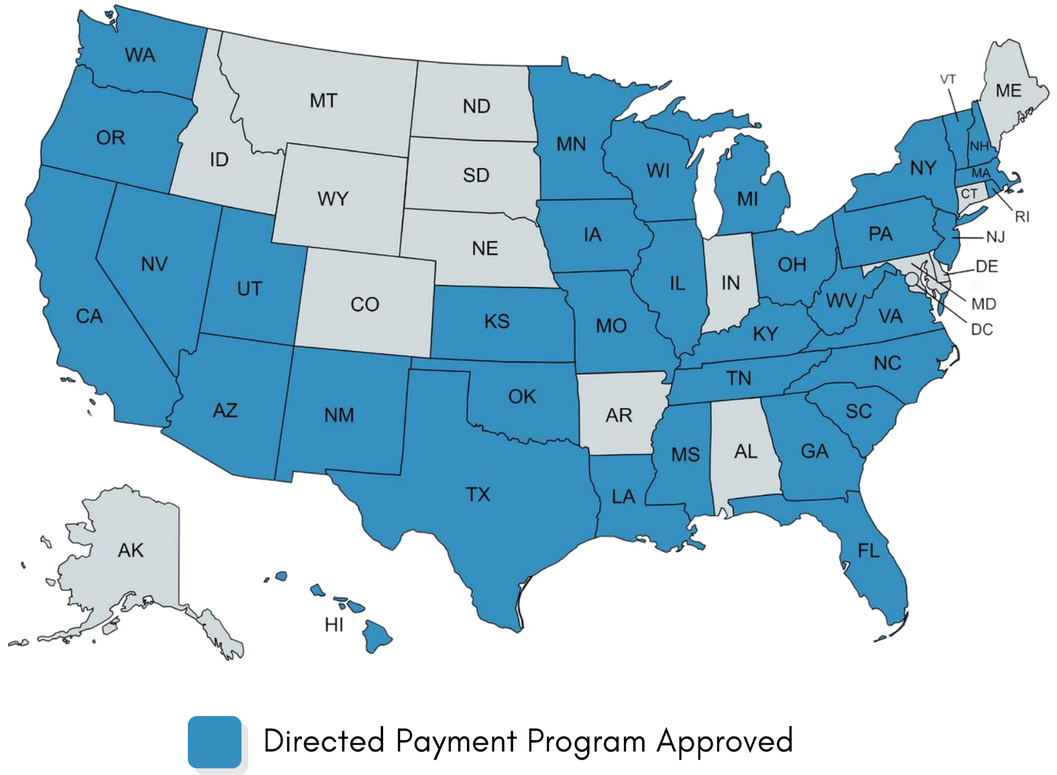
Final Rule titled Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

- An unpublished version of the rule was released on April 22, 2024
- The official version of the rule was published to the Federal Register on May 10, 2024
- On April 22, 2024, CMS issued an Informational Bulletin related to health care-related tax programs with hold harmless arrangements involving the redistribution of Medicaid payments

Medicaid Managed Care Final Rule

- Per federal regulations, state Medicaid agencies can require Managed Care Organizations (MCOs) to make specific payments to eligible providers (Directed Payments):
  - Value-Based Purchasing Models
  - Delivery System Reform/ Performance Improvement Initiatives
  - Uniform Rate Increases/Minimum or Maximum Fee Schedules
- Not all hospitals that make IGTs or mandatory payments can receive supplemental payments.
- Hospitals must meet supplemental payment program criteria to be eligible for payments.

As of 2024, 35 states have received CMS approval for a DPP that benefits hospitals, compared to 29 in 2019.



Medicaid Managed Care Final Rule

STATE	DIRECTED PAYMENT PROGRAM SIZE (FY24)	%OF ACR [4,2]	BASIS FOR POOL SIZE
California [1]	7,190,000,000	-	Medicare Equivalent
Texas	6,500,000,000	90%	Average Commercial Rate
Michigan	4,780,000,000	76%	Average Commercial Rate
Illinois [2]	4,670,000,000	75%	Average Commercial Rate
Virginia [3]	2,330,000,000	72%	Medicare Equivalent
Florida [4]	3,400,000,000	41%	Medicaid Cost
North Carolina [5]	2,890,000,000	88%	Medicare Equivalent
Louisiana [6]	2,740,000,000	88%	Average Commercial Rate
Kentucky [7]	2,430,000,000	96%	Average Commercial Rate
Arizona	2,259,000,000	64%	Average Commercial Rate

Footnotes:
1 - The overall Payment Level calculation was omitted from the preprint. Total Payment Level, in terms of Medicare Equivalent, is currently undetermined.
2- In Illinois, there are sixteen different hospital pools. The 75% of ACR above represents the average of the eight largest pools (96.9% of total payments).
3 - In Virginia, IP and OP Hospital Services are paid at 123% of Medicare equivalent. This results in IP and OP payments at 80% and 64% of ACR, respectively, or an average of 72%.
4 - 41% of ACR in Florida is an aggregate. Private hospitals are estimated to receive 50% of ACR. The Florida DPP has been approved only through 2023.
5 - The North Carolina ACR percentage was obtained from a financing model from the state. The North Carolina DPP has been approved only through 2023.
6 - Tier 1 hospitals are paid at 68.8% of ACR; Tiers 2 through 5 are paid at 95% of ACR. The 88% of ACR shown above is a weighted average rate based on pool sizes per hospital tier.
7 - Inpatient and Outpatient Hospital Services are paid at 95% and 97% of ACR, respectively, with the 96% above representing the average.

Medicaid Managed Care Final Rule

AS OF THE JULY 9, 2024 EFFECTIVE DATE:

- In an effort to close the "grey area payment" loophole, reiterates the prohibition on any unauthorized State direction of a managed care plan's payments to providers, regardless of specificity or even if tied specifically to utilization and delivery of services.
- Allows appeals of denied SDP preprints to be heard by the U.S. Department of Health and Human Services Departmental Appeals Board.
- Allows SDPs to apply to non-network providers.

Medicaid Managed Care Final Rule

EFFECTIVE NO LATER THAN THE FIRST RATING PERIOD AFTER JULY 9, 2024:

- Requires reporting and documentation related to the total payment rate.
- Codifies the average commercial rate ("ACR") as a total payment rate ceiling that applies to inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers (the "Four Services"), unless a state uses a minimum fee schedule based on State plan or Medicare rates. States will be required to provide two new pieces of documentation: (1) an ACR demonstration (to be submitted with any preprint submission); and (2) a total payment rate comparison to the ACR. CMS is not requiring States to use specific data sources for the ACR demonstration.

Medicaid Managed Care Final Rule

EFFECTIVE NO LATER THAN THE FIRST RATING PERIOD AFTER JULY 9, 2026:

- Requires States to submit preprints (and all other required documentation, such as an ACR demonstration) requiring written approval before the specified start date of the payment arrangement. Required documentation for a complete SDP submission includes at least the completed preprint, the total payment rate analysis and the ACR demonstration, and the evaluation plan as applicable.

Medicaid Managed Care Final Rule

EFFECTIVE NO LATER THAN THE FIRST RATING PERIOD AFTER JULY 9, 2027:

- Generally prohibits any payments for provider payment initiatives that are not tied to actual utilization and not made during the rating period (e.g., no estimated payments based on prior year activity), with exceptions for administrative reconciliation processes associated with runout adjudication and appeal
- Specifically prohibits interim payments.
- Specifically prohibits separate payment terms (where states do not incorporate SDPs into capitation rates)
- Requires States to annually report, no later than one year after each rating period, to CMS's Transformed Medicaid Statistical Information System specifying the total dollars expended by each MCO for SDPs that were in effect for the rating period, including amounts paid to individual providers.

EFFECTIVE NO LATER THAN THE RATING PERIOD AFTER JANUARY 1, 2028:

- Requires providers receiving a SDPs attest to compliance with hold harmless provisions in Medicaid provider tax regulations.
- In a separate new Informational Bulletin, announced enforcement discretion regarding provider tax hold harmless arrangements involving private redistribution arrangements.

Questions?

- Ryan Hales – Chief Financial Officer / Chief Operating Officer
- Colt Sullivan – VP of Finance – Texas Division
- Justin Flores – Finance Director – Texas Division