Funding Impacts of the Delivery System Reform Incentive Payment Program Transition

As Required by
2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 15(j))

Health and Human Services Commission

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Executive Summary

The Texas Health and Human Services Commission (HHSC) has operated portions of the Medicaid program under the authority of an 1115 Healthcare Transformation and Quality Improvement Demonstration Waiver (1115 Waiver) since 2011. When the 1115 Waiver began, Texas received authority for Medicaid-managed care for several populations of existing Medicaid beneficiaries as well as expenditure authority for two supplemental funding pools – the Delivery System Reform Incentive Payment (DSRIP) Program and the Uncompensated Care (UC) Program. Four provider types received payments through DSRIP – hospitals, physicians, community mental health centers (CMHCs), and local health departments (LHDs). The non-federal share of the payments was funded using primarily local funds matched with federal Medicaid funds. Payments were valued based on allocations that were made early in the waiver development process and were based upon projects, and then achievement, not the utilization of services. When the waiver was renewed in 2017, the Special Terms and Conditions of the 1115 Waiver required Texas to reduce expenditures through DSRIP before ultimately ending the DSRIP program on September 30, 2021.

The 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 15(j)), requires HHSC to evaluate the funding impact, by class and provider type, of the financial transition from DSRIP to successor programs. The full text of the rider can be found in Appendix A.

Through the successor financial programs, HHSC was able to fully replace (and exceed) the total Medicaid expenditures that would have been lost due to the end of DSRIP. This overall maintenance of funding in the health care system is important because the overall economic stability of Texas is not projected to be negatively impacted by the DSRIP Transition. However, complicating the DSRIP Transition, the COVID-19 global pandemic overlapped with the time frame and caused provider market instability and fundamental shifts in historically stable utilization.

As a result of various limitations on expenditures and reimbursements contained within various federal statutes and regulations, HHSC was unable to replace expenditures on a per-provider or even a per-class basis, and the regional impact of the transition has resulted in disparate impacts in rural and urban markets. Additionally, it is unknown at this time whether the DSRIP funding will be replaced

for all provider types, even if the expenditure authority is available under the 1115 Waiver; some payments will not be calculated and made until after the publication of this report. In other cases, such as rural hospitals and large urban public hospitals, their current payment projections for fiscal year 2022 and after are not equivalent to their payment levels under DSRIP. This difference is largely a result of all successor programs being based in some manner on Medicaid beneficiary utilization, rather than an allocation basis.

Lastly, due to the impact of a significant delay by the Centers for Medicare and Medicaid Services (CMS) in approval of the directed-payment programs (DPPs) that were intended to constitute a major aspect of the financial transition from DSRIP, HHSC was unable to evaluate and implement potential solutions in the Disproportionate Share Hospital (DSH) and the UC programs. The delay in CMS' approval created uncertainty in the payment levels for a long period. Understanding that financial stability is essential for the continued delivery of services, this report includes five recommendations to continue to stabilize the financial impact of the DSRIP Transition and includes information about the statutory or resource needs for implementation of some of the recommendations.

Introduction and Background

CMS initially approved the 1115 Waiver in December 2011. A key component of the Waiver was DSRIP, which authorized incentive payments for four provider types: hospitals, physician groups, CMHCs, and LHDs.

Texas received CMS approval for a five-year 1115 Waiver renewal on December 21, 2017. Under the renewal, the DSRIP pool was $3.1 billion each year in federal fiscal years 2018 and 2019, $2.91 billion in 2020, $2.49 billion in 2021, and $0 in 2022. DSRIP's endurance as a payment mechanism in the health care system in Texas for 10 years resulted in a reliance on those funds for many participating providers to not just incentivize performance, but to finance their underlying infrastructure and cover costs. For hospitals, DSRIP was one of several funding streams that providers relied on, and the transition from DSRIP to successor programs resulted in significant shifts among providers. For the other three provider types that participated in DSRIP, additional or alternate funding streams in Medicaid were much more limited. For example, certain physician groups were participants in the Network Access Improvement Project (NAIP) or UC, but CMHCs and LHDs did not have any additional supplemental or directed payments.

When the 1115 Waiver terms were negotiated in 2017, a global pandemic was not forecasted to overlap with the conclusion of DSRIP. As early as March 2020, HHSC began hearing concerns from providers and stakeholders regarding COVID-19 and the forthcoming expiration of DSRIP. As a result of those communications, HHSC recognized signs of a developing market contraction across Texas. HHSC determined that due to the terms of the 1115 Waiver negotiated in 2017, combined with policies related to the budget neutrality calculation for the 1115 Waiver, there would be no ability to sustain replacement funding for the DSRIP Transition if Texas renewed the 1115 Waiver at the end of September 2022 (the original end date). This reduction in health care funding would be extremely detrimental to the Medicaid provider networks and harmful to the overall economy in Texas.

The DSRIP Transition is broader than a shift from a pool-based payment structure to other financial mechanisms. However, the replacement of equivalent funds being paid through DSRIP was a significant component of the efforts undertaken by HHSC. For purposes of this report, the references to the DSRIP Transition focus exclusively on the implementation or expansion of DPPs and supplemental payment programs.

To create financial programs that could be utilized, HHSC focused primarily on DPPs, which are authorized pursuant to 42 Code of Federal Regulations 438.6(c). DPPs are so named because it is a specific circumstance in which HHSC can direct payments by Medicaid managed care organizations (MCOs) to specific providers. Generally, HHSC is not able to direct MCOs regarding how they may pay providers as HHSC is not a party to the agreements between MCOs and the providers in their networks. However, federal regulations permit HHSC to direct payments when the program or direction meets the following criteria:

- Is based on the utilization and delivery of services;
- Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;
- Expects to advance at least one of the goals and objectives in the quality strategy in Section 438.340;
- Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in Section 438.340;
- Does not condition provider participation in contract arrangements under paragraphs (c)(1)(i) through (iii) of this section on the provider entering into or adhering to intergovernmental transfer (IGT) agreements; and
- Is not renewed automatically.

To receive federal authority to implement a DPP, a state must request and receive written approval from CMS before implementation. To receive such authorization, the state must demonstrate, among other things, that the payments received by the provider are appropriate and attainable for the services being delivered. Or, in other words, the state must demonstrate that the payments are reasonable as compared to an external benchmark such as cost, Medicare, or commercial payors for the same services.

It is important to identify that the limitations on the payments for these reasons and the allocation of the payments for utilization are fundamentally different than what was possible under DSRIP. DSRIP payments were incentive payments for performance and not payment for services for only Medicaid clients.

Texas realized in October 2020 that the 1115 Waiver terms that were agreed to in 2017 were likely to result in an inability to sustain the DSRIP Transition programs that were planned due to limitations on budget neutrality and policy changes that

were made by CMS in 2018. Upon this realization, and with an understanding of the unforeseen destabilizing impact of COVID-19 on the health care system, Texas submitted an urgent application in November 2020 to renew the 1115 Waiver. The new terms of this renewal would allow for the restoration of stability and sustainability of the DSRIP Transition.

Texas received a renewal of the 1115 Waiver for a 10-year period on January 15, 2021. As a result of the renewal, Texas was able to maintain, implement, or expand five DPPs: the Comprehensive Hospital Increased Reimbursement Program (CHIRP), the Quality Incentive Payment Program (QIPP), the Texas Incentives for Physicians and Professional Services (TIPPS), the Directed Payment Program for Behavioral Health Services (DPP BHS), and the Rural Access for Primary and Preventive Services (RAPPS). In addition, Texas negotiated for the creation of the Public Health Provider – Charity Care Program (PHP-CCP) to authorize uncompensated care payments for CMHCs and LHDs, as well as the continuation of the UC program. HHSC intended to examine and implement modifications to DSH and UC for the new programs. However, efforts to examine and make modifications were paused due to HHSC's inability to determine the stability of the financial systems because CMS notified HHSC in April 2021 that they were rescinding the approval of the 1115 Waiver from January 2021.

Texas sued for restoration of the 1115 Waiver and spent nearly a year negotiating for approval of the proposed DSRIP successor programs from March 2021 through March 2022. In November 2021, December 2021, and March 2022, CMS issued approval retroactively for CHIRP, QIPP, TIPPS, DPP BHS, and RAPPS to an effective date of September 1, 2021. Additionally, CMS notified Texas that they were rescinding their prior rescission letter, and the 1115 Waiver as approved in January 2021 was reinstated.

From September 1, 2021 through May 2022, provider payments from DPPs were halted, and the instability in the health care industry was severe and compounded by the instability created by COVID-19. Following the reinstatement of the 1115 Waiver and the approval of the various programs, HHSC has moved to resume the exploration and implementation of other modifications and new programs necessary to complete the DSRIP Transition and mitigate some of the funding shifts on the provider level.

Financial and Economic Impacts of DSRIP Transition

DSRIP Financial Transition Programs

During demonstration year 10, DSRIP had an authorized expenditure amount of $2.49 billion for all provider types. HHSC designed or modified four DPPs and one new supplemental payment program to replace the DSRIP funding. In addition, HHSC negotiated to resize UC to reflect more current charity care costs but was able to get CMS to agree to use different data years that would allow HHSC to avoid any impact of COVID-19 on the data used for the effort. Detailed descriptions of the DPPs and supplemental payment program are contained in the following sections of this report.

Table 1. Estimated Financial Support for Providers.

	DY 10 (FFY 2021)	DY11 (FFY 2022)	DY12+ (FFY 2023+)***
UC POOL Payments	$ 3,873,206,193	$ 3,873,206,193	$ 4,512,075,400
DSRIP Payments	$ 2,490,000,000		
PHP CCP Payments		$ 500,000,000	$ 500,000,000
NAIP*	$ 537,693,283	$ 491,375,364	$ 250,000,000
QIPP	$ 971,897,174	$ 997,322,319	$ 1,100,000,000
DSRIP Transition Programs			
UHRIP & CHIRP**	$ 3,178,431,342	$ 5,956,281,077	$ 5,200,000,000
TIPPS		$ 670,123,256	$ 696,000,000
RAPPS		$ 12,583,984	$ 33,000,000
DPP BHS		$ 188,443,115	$ 238,000,000
Totals	$ 11,051,227,992	$ 12,689,335,309	$ 12,529,075,400

*Both NAIP and UHRIP are larger than initially projected for fiscal year (FY) 2021 as a result of an increased caseload associated with the Public Health Emergency enhanced federal medical assistance percentage (FMAP).

**UHRIP reflects 11 months of costs for federal fiscal year (FFY) 2021. FFY 2022 DPP figures are estimated based on state fiscal year (SFY) 2022 premiums since rates are developed on an SFY basis.

***DPP sizes for Demonstration Year (DY) 12 are baseline estimates and will vary depending on caseload growth.

Comprehensive Hospital Increase Reimbursement Program

CHIRP replaced the Uniform Hospital Rate Increase Program (UHRIP) beginning September 1, 2021. CHIRP provides increased Medicaid payments to hospitals for inpatient and outpatient services provided to persons enrolled in STAR and STAR+PLUS. Six classes of providers are eligible to participate: (1) children's hospitals, (2) rural hospitals, (3) state-owned hospitals that are not institutions for mental diseases (IMDs), (4) urban hospitals, (5) non-state-owned IMDs, and (6) state-owned IMDs.

CHIRP funds are paid through two components of the managed care capitation rates:

- The UHRIP component provides a uniform rate increase payment based on a percentage of the Medicare gap (the difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services).
- The Average Commercial Incentive Award (ACIA) component is an optional component. It provides a uniform rate increase payment based on a percentage of the average commercial reimbursement (ACR) gap (the difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services), less payments received under the UHRIP component. ACIA payments are capped at 90 percent of the total estimated ACR for the hospital class.

As a condition of participation in CHIRP, all participating hospitals are required to report on all program measures in the components for which they are eligible. On March 25, 2022, CMS approved CHIRP for the program period covering September 1, 2021 to August 31, 2022, which is the fifth year of the program.

Texas Incentives for Physicians and Professional Services

The TIPPS program provides increased Medicaid payments to certain physician groups providing health care services to persons enrolled in STAR, STAR+PLUS, and STAR Kids. Three classes of providers are eligible to participate: (1) health-related institution (HRI) physician groups, (2) physician groups affiliated with hospitals that receive indirect medical education (IME) funding, and (3) other physician groups.

TIPPS funds are paid through three components of the managed care capitation rates:

- Component 1 is equal to 65 percent of the total program value and provides a uniform dollar increase paid monthly. Only HRIs and IME physician groups are eligible for Component 1.
- Component 2 is equal to 25 percent of the total program value and provides a uniform rate increase paid semi-annually. Only HRIs and IME physician groups are eligible for Component 2.
- Component 3 is equal to 10 percent of the total program value and provides a uniform rate increase for applicable outpatient services and is paid at the time of claim adjudication. All participating physician groups are eligible for Component 3.

As a condition of participation in TIPPS, all participating physician practice groups are required to report on all measures in the components for which they are eligible. On March 25, 2022, CMS approved TIPPS for the program period covering September 1, 2021 to August 31, 2022, which is the first year of the program.

Rural Access to Primary and Preventive Services

The RAPPS program provides increased Medicaid payments to rural health clinics (RHCs) that provide primary care and long-term care services to persons in rural areas of the state enrolled in STAR, STAR+PLUS, and STAR Kids. Two classes of providers are eligible to participate: (1) hospital-based RHCs, which include non-state government-owned and private RHCs, and (2) free-standing RHCs.

RAPPS funds are paid through two components of the managed care capitation rate:

- Component 1 is equal to 75 percent of the total program value and provides a uniform dollar increase paid monthly that is based on RHC class.
- Component 2 is equal to 25 percent of the total program value and provides a uniform rate increase on applicable services.

As a condition of participation in RAPPS, all participating RHCs are required to report on all measures. On March 25, 2022, CMS approved RAPPS for the program period covering September 1, 2021 to August 31, 2022, which is the first year of the program.

Directed Payment Program for Behavioral Health Services

DPP BHS provides increased Medicaid payments to CMHCs that serve persons enrolled in STAR, STAR+PLUS, and STAR Kids. Two classes of providers are eligible to participate: (1) CMHCs with the Certified Community Behavioral Health Center (CCBHC) certification, and (2) CMHCs without CCBHC certification.

DPP BHS funds are paid through two components of the managed care capitation rates:

- Component 1 is equal to 65 percent of the total program value and provides a uniform dollar increase paid monthly.
- Component 2 is equal to 35 percent of the total program value and provides a uniform rate increase applied to certain CCBHC services and is paid at the time of claim adjudication.

As a condition of participation in DPP BHS, all participating CMHCs are required to report on all measures in all components. On November 15, 2021, CMS approved DPP BHS for the program period covering September 1, 2021 to August 31, 2022, which is the first year of the program.

Public Health Provider – Charity Care Program

HHSC developed the PHP-CCP Program which is designed to allow qualified providers to receive reimbursement for the cost of delivering health care services, including behavioral health services, immunizations, and other preventative

services, when those costs are not reimbursed by another source. The program is authorized under the 1115 Waiver. Year 1 of the program will consist of uncompensated care and Medicaid shortfall. In year 2, the program will transfer to charity care only.

To participate in the program, providers must be funded by a unit of government able to certify public expenditures in accordance with the Special Terms and Conditions of the 1115 Waiver. Publicly-owned and operated providers eligible to participate include those established under the Texas Health and Safety Code Chapters 533 and 534 that provide primarily behavioral health services:

- CMHCs
- Community Centers
- Local Behavioral Health Authorities
- LMHAs
- LHDs and Public Health Districts established under the Texas Health and Safety Code Chapter 121

Beginning October 1, 2021, the PHP-CCP was operational and allowed certain providers to receive a supplemental payment for certain medical services. Payments from the pool are to defray the uncompensated costs of providing medical services to Medicaid-eligible or uninsured individuals. Total funding will not exceed $500 million (total computable) in each of the first two years of the program. In future years, this pool is subject to resizing based on actual charity care costs incurred by eligible providers.

Market Stability and Economic Impact of DSRIP Transition

As noted earlier in this report, COVID-19 had an unanticipated and destabilizing impact on the entire health care system overlying the same timeframe as the planned DSRIP Transition. HHSC recognized the instability experienced that compounded providers' uncertainty about what was going to replace DSRIP. However, due to budget neutrality limitations resulting from CMS policies announced in 2018, HHSC anticipated that there would not be a pathway to sustain DSRIP funding beginning in demonstration year 12 without a new 1115 Waiver.

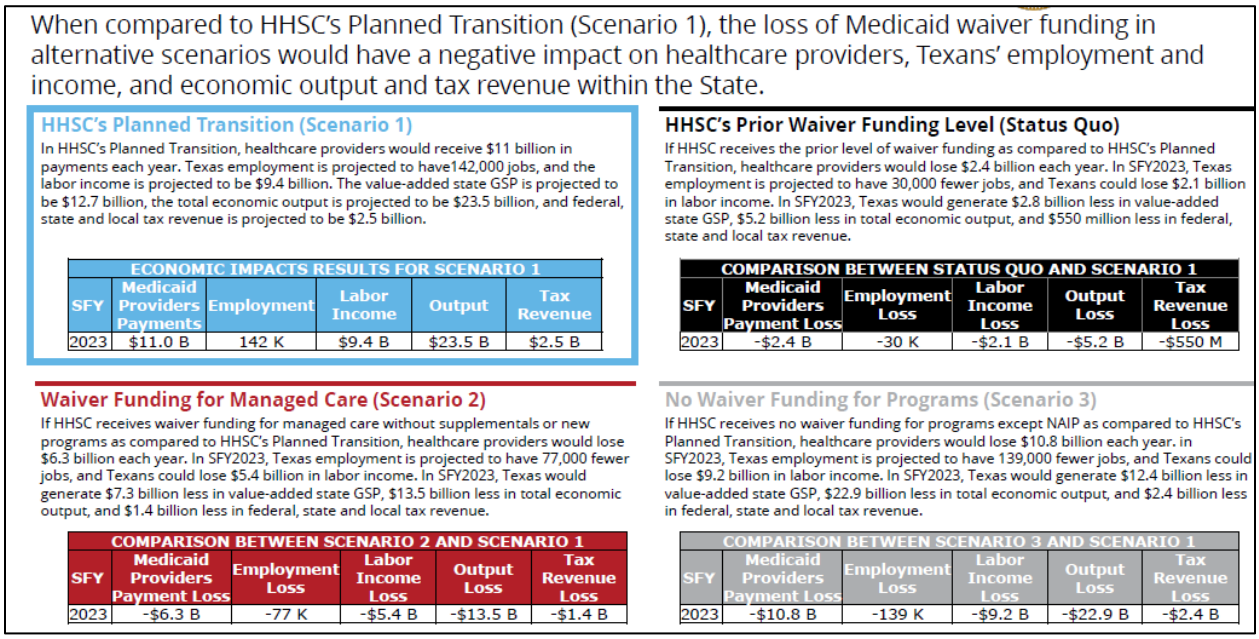
HHSC worked with a contractor to model the economic impact of various scenarios and examine the impact on the providers as well as on the overall economy. In these scenarios, HHSC used a comparison of the planned transition as compared to the prior 1115 Waiver funding (status quo). The status quo represents what would have occurred had HHSC simply maintained the extant programs and allowed for the loss of DSRIP funding. A list of each program that was considered can be found in the following table.

Figure 1. A list of each program that was considered in comparing the planned transition to the prior 1115 Waiver funding (status quo).

HHSC's Planned Transition Requested	HHSC's Prior Waiver Funding
Texas's Medicaid waiver contemplates funding for the following Programs and/or Supplemental Payment Pools:	Previously, Texas receives Medicaid waiver funding for the following Programs and/or Supplemental Payment Pools:
• Uncompensated Care Pool (UC)	• Delivery System Reform Incentive Program (DSRIP) ending on September 30, 2021
• Quality Incentive Payment Program (QIPP)	• Uncompensated Care Pool (UC)
• Network Access Improvement Program (NAIP)	• Uniform Hospital Rate Increase Program (UHRIP)
• Comprehensive Hospital Increased Reimbursement Program (CHIRP)	• Quality Incentive Payment Program (QIPP)
• Texas Incentives for Physicians and Professional Services (TIPPS)	• Network Access Improvement Program (NAIP)
• Rural Access Primary and Preventive Services (RAPPS)	
• Directed Payment Program for Behavioral Health Services (DPP BHS)	

The additional scenarios represent what would occur if there was a continuation of Medicaid-managed care, but no supplemental payment programs (a possibility if HHSC had pursued maintaining Medicaid-managed care through a federal authority other than the 1115 Waiver). The last scenario is compared against a loss of all 1115 Waiver funding. A summary of the scenarios' findings is copied below. This summery illustrates that the results of the planned DSRIP Transition that was supported by the renewed 1115 Waiver resulted in a positive impact of value-added gross state product (GSP) of $12.7 billion, $11 billion in Medicaid payments, 142,000 jobs, and economic outputs of $23.5 billion in state fiscal year 2023. Comparatively, the loss of economic output in the other scenarios ranges from $5.2 billion to $22.9 billion.

Figure 2. The financial impact of the Status Quo as compared to Scenarios 1 to 3.



When compared to HHSC's Planned Transition (Scenario 1), the loss of Medicaid waiver funding in alternative scenarios would have a negative impact on healthcare providers, Texans' employment and income, and economic output and tax revenue within the State.

HHSC's Planned Transition (Scenario 1)

In HHSC's Planned Transition, healthcare providers would receive $11 billion in payments each year. Texas employment is projected to have142,000 jobs, and the labor income is projected to be $9.4 billion. The value-added state GSP is projected to be $12.7 billion, the total economic output is projected to be $23.5 billion, and federal, state and local tax revenue is projected to be $2.5 billion.

ECONOMIC IMPACTS RESULTS FOR SCENARIO 1					
SFY	Medicaid Providers Payments	Employment	Labor Income	Output	Tax Revenue
2023	$11.0 B	142 K	$9.4 B	$23.5 B	$2.5 B

HHSC's Prior Waiver Funding Level (Status Quo)

If HHSC receives the prior level of waiver funding as compared to HHSC's Planned Transition, healthcare providers would lose $2.4 billion each year. In SFY2023, Texas employment is projected to have 30,000 fewer jobs, and Texans could lose $2.1 billion in labor income. In SFY2023, Texas would generate $2.8 billion less in value-added state GSP, $5.2 billion less in total economic output, and $550 million less in federal, state and local tax revenue.

COMPARISON BETWEEN STATUS QUO AND SCENARIO 1					
SFY	Medicaid Providers Payment Loss	Employment Loss	Labor Income Loss	Output Loss	Tax Revenue Loss
2023	-$2.4 B	-30 K	-$2.1 B	-$5.2 B	-$550 M

Waiver Funding for Managed Care (Scenario 2)

If HHSC receives waiver funding for managed care without supplementals or new programs as compared to HHSC's Planned Transition, healthcare providers would lose $6.3 billion each year. In SFY2023, Texas employment is projected to have 77,000 fewer jobs, and Texans could lose $5.4 billion in labor income. In SFY2023, Texas would generate $7.3 billion less in value-added state GSP, $13.5 billion less in total economic output, and $1.4 billion less in federal, state and local tax revenue.

COMPARISON BETWEEN SCENARIO 2 AND SCENARIO 1					
SFY	Medicaid Providers Payment Loss	Employment Loss	Labor Income Loss	Output Loss	Tax Revenue Loss
2023	-$6.3 B	-77 K	-$5.4 B	-$13.5 B	-$1.4 B

No Waiver Funding for Programs (Scenario 3)

If HHSC receives no waiver funding for programs except NAIP as compared to HHSC's Planned Transition, healthcare providers would lose $10.8 billion each year. in SFY2023, Texas employment is projected to have 139,000 fewer jobs, and Texans could lose $9.2 billion in labor income. In SFY2023, Texas would generate $12.4 billion less in value-added state GSP, $22.9 billion less in total economic output, and $2.4 billion less in federal, state and local tax revenue.

COMPARISON BETWEEN SCENARIO 3 AND SCENARIO 1					
SFY	Medicaid Providers Payment Loss	Employment Loss	Labor Income Loss	Output Loss	Tax Revenue Loss
2023	-$10.8 B	-139 K	-$9.2 B	-$22.9 B	-$2.4 B

A complete copy of the economic models and impact analysis can be found in Appendix B.

Understanding the economic impact of the DSRIP Transition and the significance of the 1115 Waiver for all Texans, HHSC prioritized ensuring that equivalent or additional funding was available for the state. This macro-approach to the DSRIP Transition considered at a high-level the various DSRIP provider types that had been participating, but meant that program designs were not concentrated on ensuring funding was replaced on a class or per-provider level.

Definitions of Cost and Payment Equity Considerations

As the DSRIP Transition successor programming became known, some provider classes became interested in how shifts among provider types or classes were compensating providers equitably. To analyze equity first requires defining the parameters through which payments will be compared to costs and understanding the historical changes in the definition used to calculate costs for hospitals.

From 1993 to 2012, Section 1923 (g)(1)(A) of the Social Security Act (SSA) limits a hospital's payments to no more than

> "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under [the Medicaid Act], other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year."

This definition describes the federal Hospital Specific Limit (HSL), the maximum amount a hospital can be reimbursed for the cost of services provided to Medicaid and uninsured patients. It is the sum of the Medicaid shortfall and the hospital's unreimbursed costs of services to the uninsured. The HSL limits payments to hospitals in DSH and UC. A higher HSL means a higher potential payment from one or both of those programs. Both programs have a set amount of funds that may be distributed in a program year. Consequently, a hospital's DSH and UC payment is also dependent (to a certain extent) on the size of its HSL relative to the HSLs of other hospitals in those programs.

Section 1923(g) of the SSA has limited DSH payments to the HSL since 1993. The uninsured component of the calculation has not changed. Until 2010, HHSC calculated the Medicaid shortfall component using Medicaid claim and payment data submitted to Texas Medicaid and Healthcare Partnership (TMHP). Only costs associated with submitted claims were included; only Medicaid payments offset those costs. However, CMS issued guidance in the form of answers to Frequently Asked Questions (FAQs) in January 2010 that interpreted Section 1923(g) to require that private insurance payments and Medicare payments offset costs in the HSL calculation. CMS' response to FAQ 33 instructed that all costs and payments associated with Medicaid-eligible patients, who were also covered by private insurance, must be included in the HSL calculation.

This guidance primarily impacts children's hospitals because they serve many children who are presumptively eligible for Medicaid based on low birth weight or catastrophic illnesses, without regard to family income or insurance coverage. As a result, many low-weight babies and children with disabilities may have family coverage even if they are also eligible for Medicaid. If the insurer pays for care at rates higher than the reported Medicaid cost, the insurance payment then acts to offset the uninsured or Medicaid shortfall costs of other patients.

FAQ 34 instructed that costs and payments for patients dually eligible for Medicare and Medicaid must be included. This guidance primarily impacts hospitals with high Medicare populations – i.e., those that serve a lot of dual-eligible patients.

In response to CMS' guidance, HHSC revised the data it collected from hospitals to calculate the HSL for interim payments and the DSH audit. Starting in 2011, HHSC reduced hospitals' costs for the DSH program by their total private insurance and Medicare payment amounts, thus lowering their DSH or UC payments. This method of calculating costs is frequently referred to as a "full-offset" methodology.

In December 2014, Texas Children's Hospital (TCH) filed suit against CMS in federal district court in the District of Columbia (D.C.) challenging FAQ 33. TCH successfully obtained a temporary injunction. CMS was enjoined from enforcing, applying, or implementing FAQ 33 and from taking any action to recoup federal DSH funds based on a state's noncompliance with the policy. The definition at issue was one in which costs for Medicaid-secondary clients would be included, but any payments from third-party payors would not. This method is frequently referred to as a "no-offset" methodology.

In August 2016, CMS proposed a rule requiring that Medicare and other third-party insurance payments be considered when determining costs for calculating the HSL for DSH program payments. The rule codified CMS' interpretation of Section 1923(g) as articulated in FAQs 33 and 34 and CMS' arguments in various courts.

The rule became final effective June 2, 2017. In addition to the TCH lawsuit, numerous lawsuits were filed in federal district courts challenging FAQs 33 and 34 and CMS' final rule. Courts issued preliminary injunctions against CMS in some cases and permanent injunctions when the cases have been decided on the merits.

On February 21, 2018, Doctors Hospital of Renaissance filed suit against CMS in the United States District Court for D.C. challenging FAQ 34 and the final rule. In May 2017, The Children's Hospital Association of Texas (CHAT) and four free-standing children's hospitals located in Minnesota, Virginia, and Washington filed suit in the United States District Court for D.C. alleging that CMS' final rule is contrary to the Medicaid Act. On March 2, 2018, the court ruled in favor of the plaintiffs and vacated the rule. On March 6, 2018, the court issued its memorandum opinion explaining the decision. The court determined that Section 1923(g), on its face, does not authorize including Medicare payments and private payments in the DSH-limit calculation. The court vacated the rule and applied the decision to CMS nationwide; not just to plaintiffs.

On November 4, 2019, the 8th Circuit Court of Appeals ruled in favor of CMS and its final rule implementing FAQs 33 and 34. The decision was consistent with the August 2019 holding by the D.C. Circuit Court of Appeals that ruled against CHAT.

On December 27, 2020, the Consolidated Appropriations Act for 2021 was signed into law. Included within the legislation was a federal statutory change to remove the cost and payments of individuals with Medicare or third-party coverage from the definition and calculation of the HSL. This definition is commonly referred to as the "MACPAC" definition.

However, in Texas, two payment caps exist for hospitals that participate in DSH and UC. The HSL and the state payment cap (SPC), previously known as the interim HSL, that HHSC may define. The SPC is calculated in the payment year for DSH and UC but the federal payment cap is calculated two years after the payment year using updated data. HHSC had previously linked the interim HSL to the final HSL so there would be a limited chance that recoupment would occur after the final HSL was calculated.

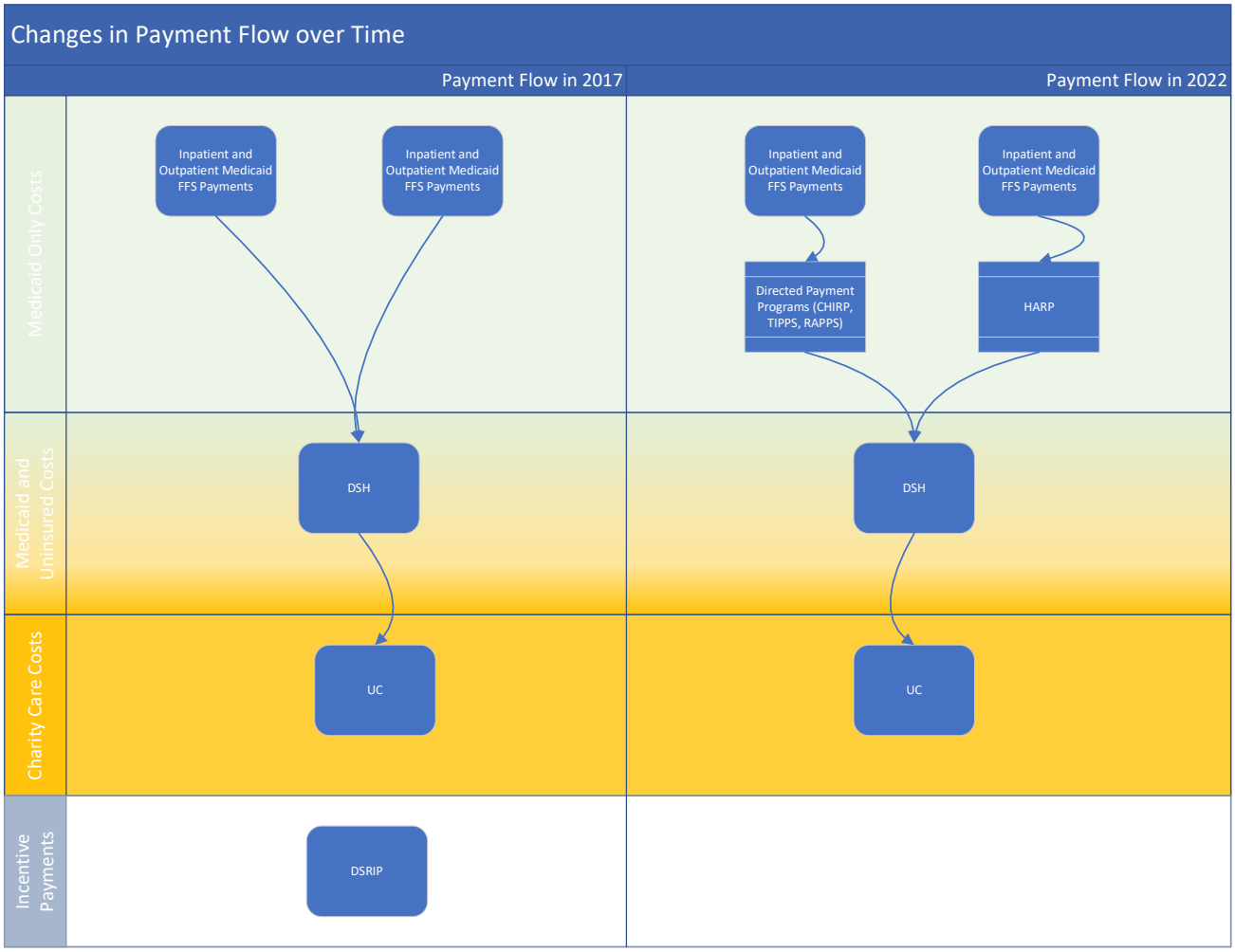
Due to the ongoing changes to the HSL, HHSC implemented an SPC that is wholly defined by the state and utilizes the full-offset methodology. HHSC reviewed multiple options for the Texas payment cap and also seriously considered two other options. HHSC considered an approach where the Texas payment caps do not contain either the costs or payments for Medicaid clients that also have either other insurance or Medicare. HHSC also considered capping, in the aggregate, other insurance and Medicare payments at the Medicaid allowable cost. However, HHSC determined that including all Medicaid costs and all third-party payments provides a more appropriate measure of financial need given the purpose of the payment programs at issue. Understanding that different methods of calculating costs may be supported by various reasoning, HHSC has analyzed the impact of the DSRIP Transition using each of the three definitions described above for the purposes of this report.

Step-by-Step Continued Transition

Medicaid payment programs are made in succession with payments and costs being calculated at each respective stage. Programs (including base payments for inpatient and outpatient services) for Medicaid beneficiaries are the first payments made and first costs considered. Supplemental payments, like the Hospital Augmented Reimbursement Program (HARP), and directed-payment programs, are included in this stage. Next, DSH allows for the reimbursement of uncompensated

costs associated with Medicaid clients as well as costs for the uninsured, after offsetting payments made in Medicaid for services. Finally, UC incorporates both payments made in base Medicaid and DSH. UC is restricted to reimbursing for charity care only (at the exclusion of Medicaid shortfall and uninsured non-charity care). Incentive payments, like DSRIP, are wholly outside of the cost calculations as it relates to payment program methodologies and cost limits at the state and federal levels. A figure illustrating this flow is depicted in Figure 3.

Figure 3. Changes in payment flow over time, comparing 2017 to 2022.



Understanding that programs are interlinked, HHSC's approach to the DSRIP Transition was to create programs that were related to the delivery of Medicaid services. Given that Medicaid managed care is the Medicaid model through which the majority of services are delivered, HHSC focused efforts on the modification or creation of DPPs that would enable HHSC to increase payments to providers up to the ACR.

HHSC intended to move successively through each program in the payment flow to determine whether modifications or the creation of new programs were appropriate to support the DSRIP Transition. However, due to significant delays in the approval of the DPPs planned for the DSRIP Transition, these efforts were largely paused until a time when HHSC would have more certainty about the landscape of approved payments.

Following the approval of CHIRP, TIPPS, and RAPPS in March 2022, HHSC began focusing efforts quickly on getting the programs implemented and reinvigorating efforts to examine the other programs.

HHSC pursued a Medicaid state plan amendment (SPA) to create a new fee-for-service (FFS) program to act as a mechanism to increase reimbursements for public and private providers. CMS approved the SPA for public hospitals on August 31, 2022. The SPA for private hospitals remains pending.

Hospital Augmented Reimbursement Program

The Hospital Augmented Reimbursement Program (HARP) is a statewide supplemental program providing Medicaid payments to hospitals for inpatient and outpatient services that serve Texas Medicaid FFS patients. The program serves as a financial transition for providers historically participating in DSRIP. HARP will provide additional funding to hospitals to assist in offsetting the cost hospitals incur while providing Medicaid services. Subject to CMS approval, eligible participants in federal fiscal year 2022 include non-state government-owned and operated hospitals and private hospitals. The public HARP SPA was approved for non-state government-owned and operated hospitals on August 31, 2022.

Disproportionate Share Hospital

DSH payments are authorized by federal law to provide hospitals that serve a large share of Medicaid and low-income patients with additional funding. DSH payments are supplemental payments to help cover more of the cost of care for Medicaid and low-income patients. These payments cannot exceed a hospital's uncompensated costs for both Medicaid-enrolled and uninsured patients.

DSH payments are the only Medicaid payment in federal law that is explicitly for paying the unpaid costs of care for uninsured patients. It can be used by states to offset or make up for low Medicaid base payments. However, it is affected by Medicaid base payments and other supplemental funding. For example, an increase to a hospital's base Medicaid payment and its other non-DSH supplemental funding

may decrease a hospital's Medicaid shortfall, resulting in a reduction in its uncompensated care costs for which DSH pays.

Uncompensated Care

UC payments to hospitals are authorized under Section 1115 demonstrations. UC payments originated as a way for Texas to continue to expand managed care in Medicaid programs and continue making supplemental payments to hospitals. States negotiate the parameters of their UC pools with CMS. Texas UC payments may be used to reduce the actual uncompensated cost of medical services provided to uninsured individuals who meet a provider's charity care policy. The medical services must meet the definition of "medical assistance" as defined in federal law.

Funding Impact Analysis for Hospitals

Estimated Medicaid Program Payments

From fiscal year 2020 to 2022, estimated hospital Medicaid supplemental and directed payments to DSH and UC hospitals have increased from approximately $9 billion to $11 billion. Hospitals receive DSH, UC, DSRIP, Graduate Medical Education (GME), NAIP, RAPPS, TIPPS, CHIRP, UHRIP, and HARP payments. CHIRP, TIPPS, and RAPPS are new DPPs that were created in state fiscal year 2022 to help with the DSRIP Transition. TIPPS payments are to physician groups, but a portion of payments included in this analysis was for physicians associated with a hospital that receives the IME inpatient rate add-on. RAPPS payments included are payments for hospital-based RHCs. HHSC has also implemented the new HARP program for publicly-owned and operated hospitals in fiscal year 2022 as another program related to the DSRIP Transition. Payments included in the analysis correspond to the applicable program year, except for UHRIP or CHIRP payments, which are estimated based on the federal fiscal year instead of the state fiscal year.

Table 2. Estimated Program Payments from 2020 to 2022.

Program	2020	2021	2022
DSH	$ 1,874,951,884	$ 1,834,423,887	$ 1,985,225,144
UC	$ 3,608,875,177	$ 3,740,328,945	$ 3,680,595,924
GME	$ 118,022,801	$ 118,665,632	$ 127,479,309
DSRIP	$ 1,870,719,369	$ 1,556,346,179	$ 0
NAIP	$ 274,211,254	$ 344,993,488	$ 310,347,761
UHRIP or CHIRP (for FFY)	$ 1,327,274,662	$ 2,541,487,992	$ 4,467,117,590
HARP	$ 0	$ 0	$ 712,105,821
RAPPS	$ 0	$ 0	$ 9,327,535
TIPPS	$ 0	$ 0	$ 52,182,831
Total	$ 9,074,055,146	$ 10,136,246,124	$ 11,344,381,915

The payments included in Table 2 are estimates, based on the most recently available year-to-date payments. An additional $99 million in DSRIP funds will be paid in January 2023, which is not included in the data above.

Percent of Costs Covered

Hospital costs are compared to hospital payments by class to derive a percent of costs covered. Hospitals are divided into the following classes: children's, large public, non-rural private, non-rural public, private IMD, rural private, rural public, state non-IMD, and state IMD. The rural definition is based on the UC definition, and the definitions of public and private are based on the DSH program. Costs and payments included in the analysis are based on the hybrid DSH/UC applications submitted for UC demonstration years 9 through 11 and federal fiscal years 2020 to 2022. Estimated program payments for all of the Medicaid programs listed in the previous section are included in payments. The median percentage of costs covered is used to avoid outliers skewing the data.

Federal HSL Percent of Costs Covered

Federal HSL costs include Medicaid-only, uninsured, and UC-only costs. Federal HSL payments include Medicaid payments, cost report settlements, uninsured payments, and all program payments listed in the previous section.

Below are some key takeaways from the data presented below in Table 3:

- Children's hospitals, private IMDs, and state non-IMDs have their costs fully covered by Medicaid payments in 2022, based on the median percent of costs covered.
- The median percent of costs covered for all public hospitals has dropped from 2020 to 2022. The percent of costs covered for large public hospitals decreased by 12 percent, non-rural public hospitals decreased by 23 percent, and rural public hospitals decreased by 21 percent.
- The median percent of costs covered for rural private hospitals has decreased by 10 percent from 2020 to 2022.
- The median percent of costs covered for non-rural private hospitals increased by 10 percent from 2020 to 2022.
- The median percent of costs covered for state IMDs has increased by 23 percent since 2020.

Table 3. Median Federal HSL Percent of Costs Covered, 2020 to 2022.

Class	2020	2021	2022	Change from 2020 to 2022
Children's	99%	103%	106%	7%
Large Public	100%	102%	87%	-12%
Non-Rural Private	60%	76%	71%	10%
Non-Rural Public	101%	92%	77%	-23%
Private IMD	76%	90%	102%	26%
Rural Private	97%	105%	87%	-10%
Rural Public	110%	113%	89%	-21%
State Non-IMD	123%	117%	108%	-15%
State/IMD	66%	92%	89%	23%

Full-Offset Percent of Costs Covered

Full-Offset costs include Medicaid-only, Medicare crossover, other insurance, uninsured, and UC-only costs. Payments include Medicaid payments, Medicaid secondary payments, Medicare payments, other insurance payments, cost report settlements, uninsured payments, and all program payments listed in the previous section.

Below are some key takeaways from Table 4 below:

- Children’s hospitals, private IMDs, and state non-IMDs have their costs fully covered by Medicaid payments in 2022, based on the median percent of cost covered.
- The median percent of costs covered for all public hospitals has dropped from 2020 to 2022. The percent of costs covered for large public hospitals decreased by 9 percent, non-rural public hospitals decreased by 16 percent, and rural public hospitals decreased by 18 percent.
- The median percent of costs covered for rural private hospitals has decreased by 7 percent from 2020 to 2022.
- The median percent of costs covered for non-rural private hospitals increased by 10 percent from 2020 to 2022.

- The median percent of costs covered for state IMDs has increased by 35 percent since 2020.

Table 4. Median Full-Offset Percent of Costs Covered, 2020 to 2022.

Class	2020	2021	2022	Change from 2020 to 2022
Children's	103%	105%	110%	7%
Large Public	99%	101%	90%	-9%
Non-Rural Private	65%	78%	75%	10%
Non-Rural Public	96%	92%	79%	-16%
Private IMD	79%	96%	107%	28%
Rural Private	92%	98%	85%	-7%
Rural Public	102%	102%	84%	-18%
State Non-IMD	119%	109%	102%	-17%
State/IMD	52%	89%	87%	35%

No Offset Percent of Costs Covered

No Offset costs include Medicaid-only, Medicare crossover, other insurance, uninsured, and UC-only costs. Payments include Medicaid payments, Medicaid secondary payments, cost report settlements, uninsured payments, and all program payments listed in the previous section.

Below are some key takeaways from Table 5 (below):

- Children’s hospitals, private IMDs, and state non-IMDs have the highest amount of their costs covered, around 90 percent.
- The median percent of costs covered for all public hospitals has dropped from 2020 to 2022. The percent of costs covered for large public hospitals decreased by 8 percent, non-rural public hospitals decreased by 14 percent, and rural public hospitals decreased by 14 percent.
- The median percent of costs covered for rural private hospitals has decreased by only 2 percent since 2020.
- The median percent of costs covered for non-rural private hospitals increased by 11 percent from 2020 to 2022.

- The median percent of costs covered for state IMDs has increased by 34 percent since 2020.

Table 5. Median No Offset Percent of Costs Covered, 2020 to 2022.

Class	2020	2021	2022	Change from 2020 to 2022
Children's	94%	92%	98%	4%
Large Public	92%	94%	84%	-8%
Non-Rural Private	48%	58%	59%	11%
Non-Rural Public	79%	77%	65%	-14%
Private IMD	73%	83%	97%	25%
Rural Private	72%	77%	71%	-2%
Rural Public	82%	86%	68%	-14%
State Non-IMD	100%	99%	90%	-10%
State/IMD	51%	88%	85%	34%

Utilization by Hospital Class

Medicaid charges, DSH uninsured charges, uninsured charity charges, duplicate charges, and total allowable hospital revenue fields from the DSH/UC applications were used to approximate Medicaid, uninsured, and charity utilization by class. The UC-only uninsured charges were calculated based on the difference between the UC charity charges and duplicated charity charges. If the difference was negative, the value was set at zero to avoid negative charity charges in the analysis.

Large public hospitals have the largest percentage of Medicaid, uninsured, and charity utilization compared to all other classes. Their utilization for 2022 was 66 percent. The next highest provider class was state IMDs at 58 percent, followed by children’s hospitals at 57 percent. Children’s hospitals’ Medicaid, uninsured, and charity utilization are primarily Medicaid. The large public and state IMD classes are primarily made up of uninsured utilization.

Table 6. Average Medicaid, DSH Uninsured, and UC Uninsured Charity Utilization.

Class	2020	2021	2022
Children's	54%	54%	57%
Large Public	66%	69%	66%
Non-Rural Private	28%	25%	25%
Non-Rural Public	26%	28%	30%
Private IMD	32%	38%	32%
Rural Private	30%	28%	29%
Rural Public	28%	27%	28%
State Non-IMD	32%	27%	25%
State/IMD	54%	57%	58%

An additional analysis was performed to check for a correlation between utilization and the percent of costs covered. No significant consistent correlation was found.

Large Public Hospital DSH IGT

Large public hospitals transfer IGTs for private hospitals in DSH to fund the non-federal share of their DSH payments. The list of large public hospitals transferring IGT has diminished over the years, increasing the burden on hospitals that remain large and public. As of 2021 only five hospital districts transfer IGT for private hospitals in DSH: Bexar County Hospital District, Dallas County Hospital District, El Paso County Hospital District, Harris County Hospital District, and Tarrant County Hospital District. Approximately half of the total DSH IGT transferred by large public entities is IGT for private hospitals, as shown in Table 7 below.

Table 7. DSH IGT for the Five Large Public Hospitals.

IGT	2020	2021	2022
IGT for Self	$ 225,610,779	$ 201,424,116	$ 217,012,542
IGT for Privates	$ 213,051,490	$ 204,346,514	$ 218,167,104
Total DSH IGT	**$ 438,662,269**	**$ 405,770,630**	**$ 435,179,646**

Local Provider Participation Funds

Beginning in 2013, local governments received approval from the Texas Legislature to operate Local Provider Participation Funds (LPPFs). LPPFs are accounts into which local units of government deposit mandatory payments from hospitals as an IGT to HHSC. Hospitals that are not operated by a unit of government and provide inpatient services in each local jurisdiction pay into the fund, so the local jurisdiction can use this money as the non-federal portion of the Medicaid match. To date, multiple LPPFs are in operation across the state. Currently, LPPFs provide funding for several supplemental and directed payment programs, like UC supplemental payments and CHIRP.

Below is a table of estimated LPPF funds. They are grouped based on when the expenditure occurred, not by program year.

Table 8. Local Provider Participation Funds, 2017-2022.

Year	Amount
2017	$ 34,822,267
2018	$ 322,808,406
2019	$ 508,355,788
2020	$ 1,781,135,806
2021	$ 1,842,940,912
2022	$ 2,917,982,498

Recommendations

Recommendation 1: Evaluate the SPC Definition for DSH and UC

At the request of many external stakeholders, HHSC plans to examine the definition of the SPC to determine whether modifications are appropriate. The current definition uses a full-offset approach where all costs for Medicaid beneficiaries (including those for whom Medicaid is a secondary payor) are included, as well as all payments. Since the federal HSL definition now uses a different calculation than the SPC, some providers, especially rural hospitals, have had some supplemental payments recouped from DSH and UC during the audit and reconciliation process.

HHSC recommends that consideration be given to a new definition with the dual goal of limiting interim payments to an amount that is not anticipated to result in recoupment at the time of audit and reconciliation, as well as limiting interim payments to hospitals that do not have demonstrated payments that could already be used to offset unreimbursed costs. Changes to the definition of the SPC would require changes to the Texas Administrative Code. HHSC estimates that the work to evaluate different definitions and to conduct rulemaking could be absorbed with existing resources.

Recommendation 2: Evaluate and Modify the DSH Allocation Methodology

Rather than continuing to use the SPC as the primary mechanism for allocating DSH funding, HHSC recommends that consideration be given to a new allocation methodology that considers the percent of total Medicaid and uncompensated costs reimbursed to date. DSH is the only Medicaid reimbursement option that remains to reimburse for any uncompensated Medicaid costs or non-charity uncompensated care. As such, providers who have high levels of non-Medicaid utilization, which is common among rural and large public providers, may benefit from a method that considers the unique opportunity for reimbursement available under DSH. Additionally, a reimbursement methodology that considers the proportion of total costs covered could help providers achieve more similar percentages of total costs reimbursed.

Changes to the allocation methodology would require changes to the Texas Administrative Code as well as the formation of new calculation tools. HHSC estimates that the work to evaluate different methodologies and to conduct rulemaking could be absorbed with existing resources.

Recommendation 3: Prioritize New, Additional UC Funding by Ownership Type and Class

Under the terms of the January 15, 2021 1115 Waiver, HHSC negotiated for the continuation and resizing of the UC pool. The results of the first pool resizing is an increase in the pool by approximately $600 million annually, for a total of $4.5 billion for demonstration years 12 through 16. This expenditure authority may be utilized only for providers that are authorized to participate in UC who demonstrate charity care expenses.

HHSC recommends that the new, additional UC funding be considered for a different allocation methodology than the previously extant $3.9 billion. Recognizing that there are hospital classes and some state-owned providers (like HRIs) that have not reached an equivalent estimated payment level as what they were receiving under DSRIP, HHSC recommends reviewing the allocation methodology to determine whether funding should be prioritized for the historical DSRIP participants. Changes to the allocation methodology would require changes to the Texas Administrative Code as well as the formation of new calculation tools. HHSC estimates that the work to evaluate different methodologies and to conduct rulemaking could be absorbed with existing resources supported by funds received under the authority of Section 531.021135, Texas Government Code.

Recommendation 4: Utilize Any General Revenue Appropriations for Rural Hospitals Efficiently

Senate Bill 8, 87th Legislature, 3rd Called Session, 2021, appropriated funds to HHSC for grants to support Texas health care providers affected by the COVID-19 pandemic. During fiscal years 2022 and 2023, the $75 million for rural hospitals were distributed in two tiers: $38 million ($250,000 per rural hospital) via direct awards and $37 million distributed via a competitive award process, or Request for Applications. The grant funding distributed to the rural hospitals undoubtedly served as a stabilizer during the transition from DSRIP, particularly when the

implementation of the DPPs, CHIRP and RAPPS, was delayed. However, the grant-making process was time and resource intensive, which delayed the distribution of funds for longer than was anticipated.

If there are future general revenue funds appropriated to support rural hospitals beyond the funds necessary to support the inpatient and outpatient reimbursement rates for Medicaid services, HHSC recommends consideration be given to mechanisms that would utilize the funds as efficiently as possible. Some potential options for utilizing appropriations, if any are available in the future, would be the potential to utilize the funds as the non-federal share for certain programs currently supported by local funds, requiring less administrative burden on HHSC and providers. Alternately, an open enrollment procurement could also be utilized as this option would be significantly less resource intensive for HHSC and could help expedite the issuance of funds to providers, though it would still require providers to apply and enter into contracts. It is unknown at this time whether any future additional appropriations similar to those made under Senate Bill 8 would be available so there are not any HHSC estimates regarding the required resources to implement this recommendation.

Recommendation 5: Evaluate Options to Administer Payment Programs with Increased Efficiency

The administration of DPPs is more complex than supplemental payment programs for both HHSC and participating providers. Medicaid MCOs have been required to make systems changes to ensure their claiming systems can implement rate increases, but information on the Explanation of Payment does not typically reflect for providers the portion of the payments attributable to the DPP and which are related to base payments. Therefore, all participating providers, MCOs, and HHSC have had to manage substantial complexity when trying to reconcile payments, oversee the program, and utilize underlying claim and encounter data for various analyses.

HHSC recommends that evaluations be conducted to identify potential administrative efficiencies that can be implemented to either simplify program structures or make tracking funds paid on encounters more easily identifiable. Some of these solutions may have technology costs associated with them but have not been estimated at this time.

Conclusion

Due to CMS' significant delay in approval of the DPPs intended to constitute a major aspect of the financial transition from DSRIP, HHSC was unable to evaluate and implement potential solutions in DSH and UC because of uncertainty in the payment levels during the extended delay. Understanding that financial stability is essential for the continued delivery of services, HHSC plans to evaluate potential modifications to payment programs as identified in the recommendations to continue stabilizing the financial impact of the DSRIP Transition. HHSC has prioritized the overall economic stability of Texas but continues to monitor the impact to individual provider types or classes.

List of Acronyms

Acronym	Full Name
ACIA	Average Commercial Incentive Award
ACR	Average commercial reimbursement
CCBHC	Certified Community Behavioral Health Center
CHAT	Children's Hospital Association of Texas
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
D.C.	District of Columbia
DPP	Directed Payment Program
DPP BHS	Directed Payment Program for Behavioral Health Services
DSH	Disproportionate Share Hospital
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
FAQ	Frequently Asked Question
FFS	Fee-for-service
FFY	Federal Fiscal Year
FY	Fiscal Year
GME	Graduate Medical Education
HARP	Hospital Augmented Reimbursement Program
HHSC	Texas Health and Human Services Commission
HRI	Health Related Institution
HSL	Hospital Specific Limit
IGT	Intergovernmental transfer
IMD	Institutions for Mental Diseases
IME	Indirect Medical Education

Acronym	Full Name
LHD	Local Health Departments
LMHA	Local Mental Health Authorities
LPPF	Local Provider Participation Fund
MACPAC	The removal of cost and payments of individuals with Medicare or third-party coverage from the definition and calculation of the HSL.
MCO	Managed Care Organization
NAIP	Network Access Improvement Project
PHP-CCP	Public Health Provider – Charity Care Program
QIPP	Quality Incentive Payment Program
RAPPS	Rural Access for Primary and Preventive Services
RHC	Rural Health Clinic
SFY	State Fiscal Year
SPA	State Plan Amendment
SPC	State Payment Cap
SSA	Social Security Act
STAR	State Medicaid Managed Care
STAR+PLUS	Texas Medicaid Managed Care program for people who have disabilities or are age 65 or older
TCH	Texas Children's Hospital
TIPPS	Texas Incentives for Physicians and Professional Services
TMHP	Texas Medicaid and Healthcare Partnership
UC	Uncompensated Care
UHRIP	Uniform Hospital Rate Increase Program

Appendix A. Rider 15(j) Text

HHSC shall evaluate the funding impact, by provider type and class, of the discontinuation of the DSRIP program and implementation of successor programs on public and rural hospitals. HHSC shall report on the evaluation and findings and recommendations to the Governor, the Legislative Budget Board, the Lieutenant Governor, and the Speaker of the House of Representatives by October 1, 2022.

Appendix B. Healthcare Market Final Report

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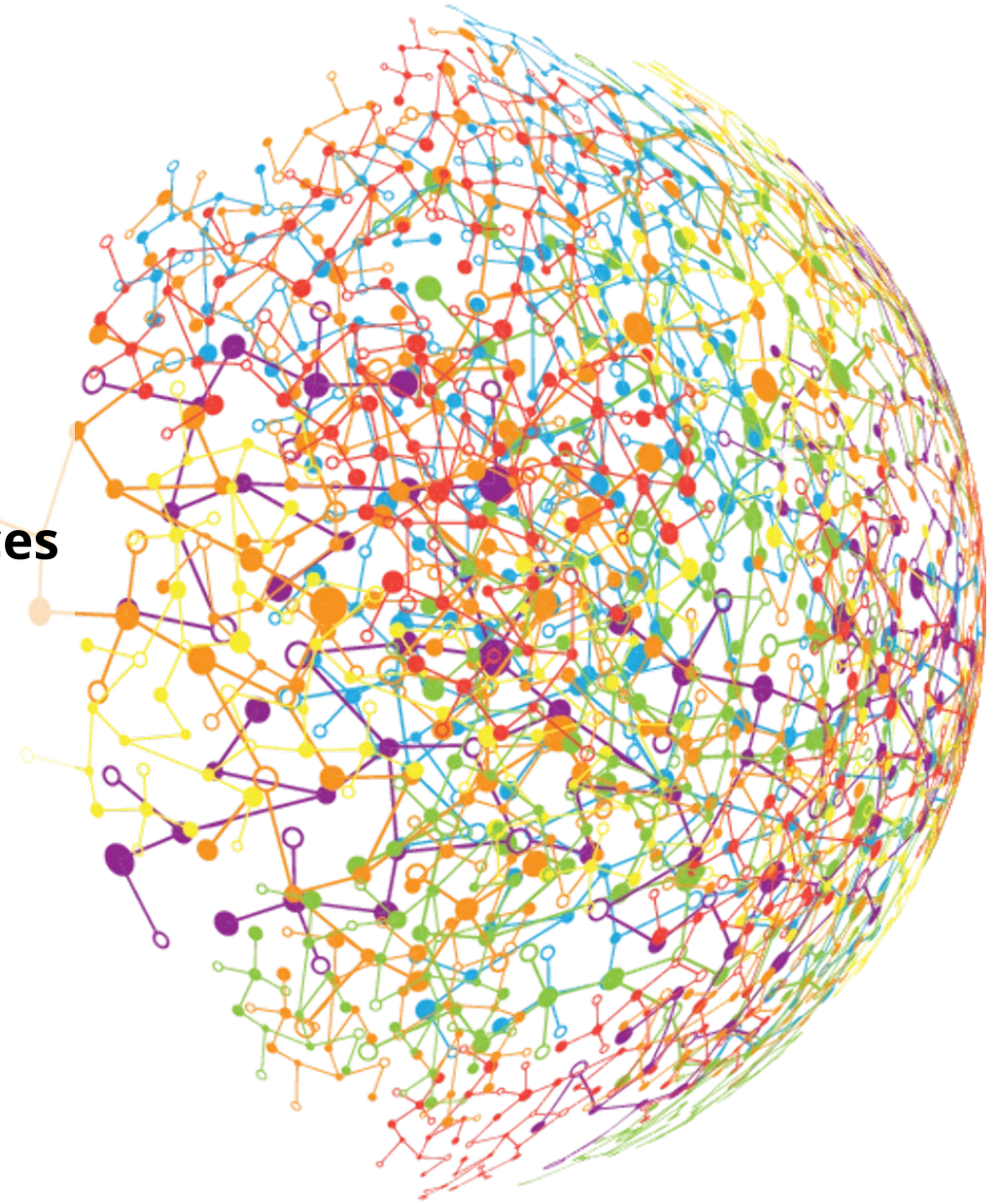
TEXAS
Health and Human Services



2021 Hospital Financial Services

Deliverable 3

Healthcare Market Final Report

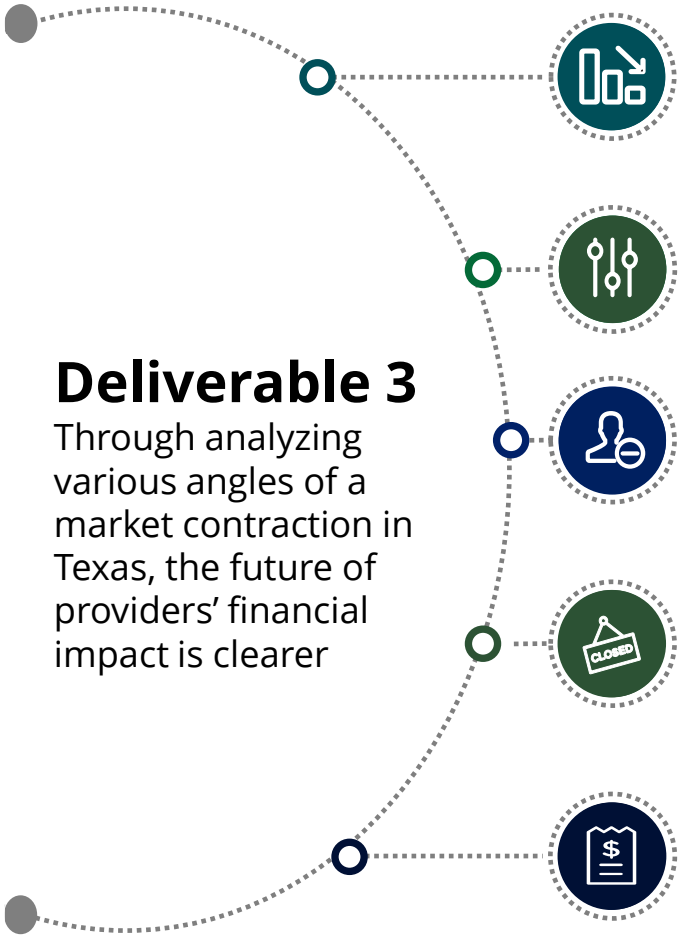
HHSC Contract No. HHS000446600001
Project Quote 0008
November 11, 2021

Executive Summary

This report evaluates recovery from a potential market contraction if Medicaid funding is uncertain and/or not sustained.

Deliverable 3

Through analyzing various angles of a market contraction in Texas, the future of providers' financial impact is clearer



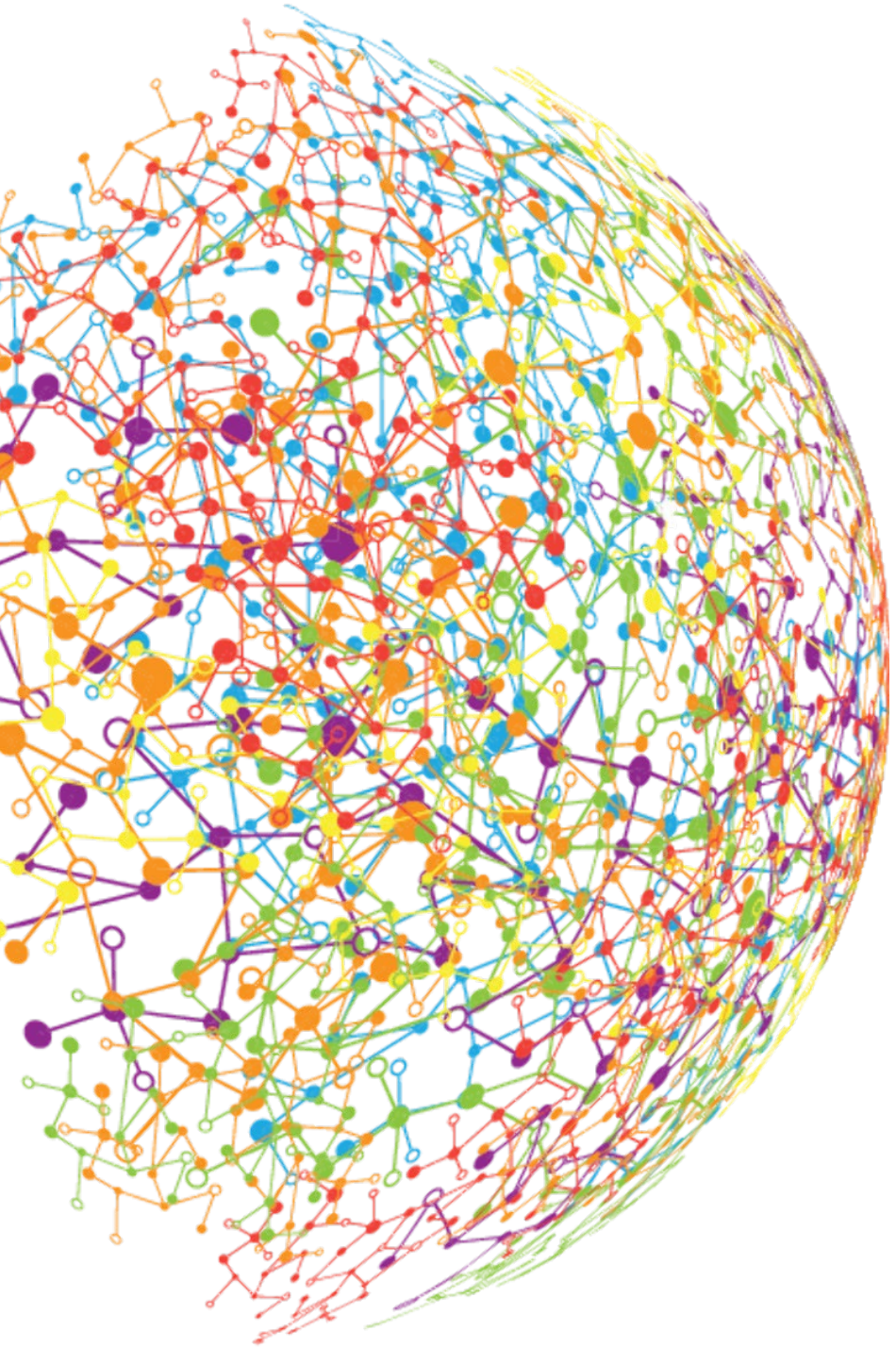
The loss of Section 1115 Medicaid waiver demonstration funding is expected to have a negative impact on Texans' healthcare providers, employment and income, economic output, and tax revenue when compared to HHSC's Planned Transition. The severity of the impact on the Texas economy will correlate to the loss of Medicaid waiver funding.

Without Section 1115 Medicaid waiver funding, the physician shortage in Texas is likely to become worse in coming years and could lead to unmet demand of up to 14% by 2030.

If the State of Texas and providers lose Section 1115 Medicaid waiver funding, providers may exit the market. Recruiting providers and establishing or re-establishing practices in rural Texas will take significant time, energy and resources – at least 2-3 times longer than in urban areas – and may not be successful.

Many Texas providers, concerned about the financial impacts from COVID-19, took cost-cutting measures such as reducing their capacity, reducing services, closing facilities/locations, and/or furloughing staff; all of which had an impact on rural Texas.

If the COVID-19 pandemic had not happened, Texas Medicaid expenditures likely would have continued to increase while Medicaid enrollment remained relatively constant. Given the effects of the COVID-19 pandemic on projected enrollment and per member per month (PMPM) expenditures, total Medicaid expenditures are projected to increase in 2021 and beyond.



TEXAS Health and Human Services

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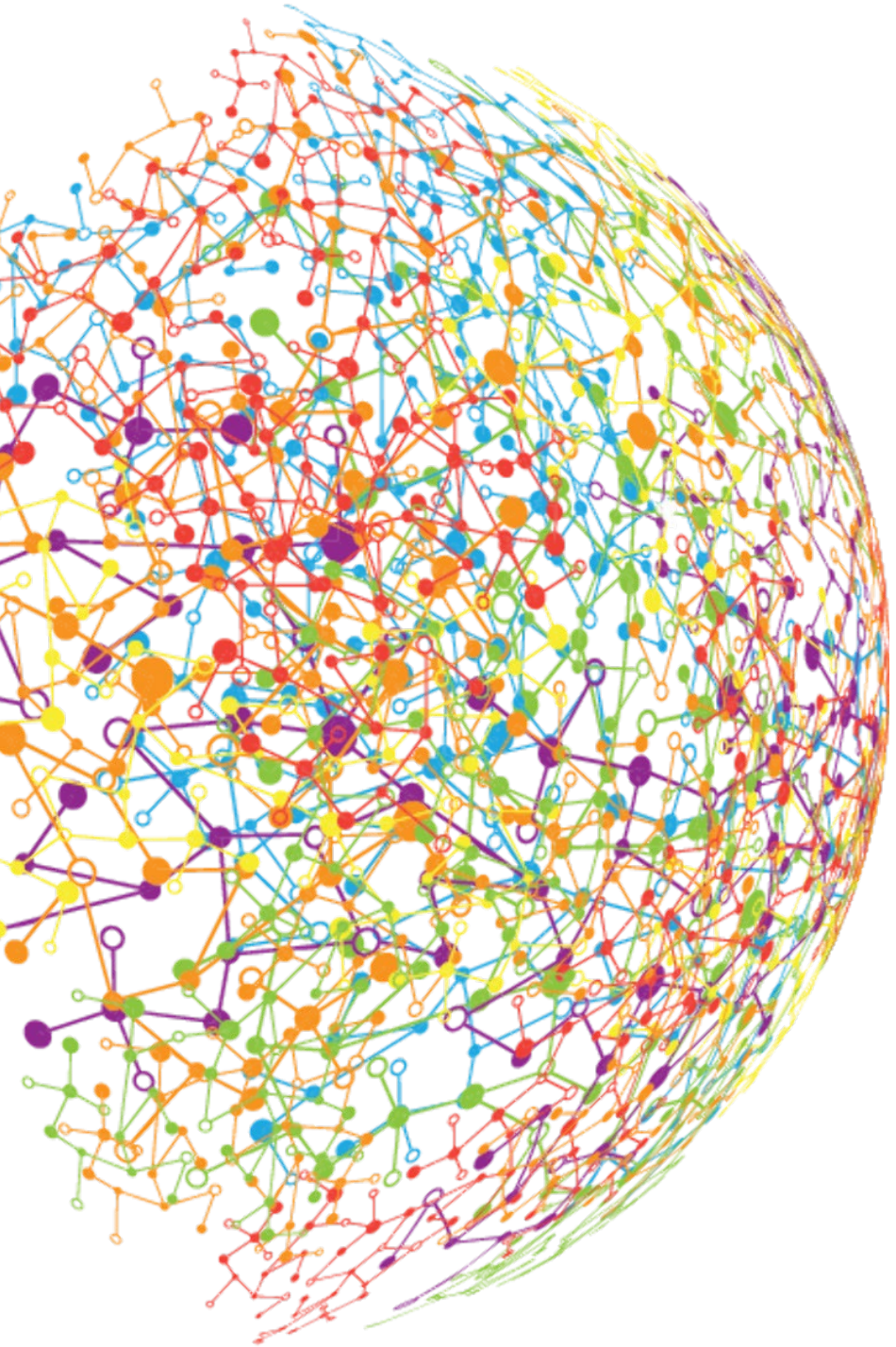
Deliverable 3: Enhance Financial Model(s) [from Deliverable 2], and Create Documentation and Report



TEXAS
Health and Human Services

Section 1

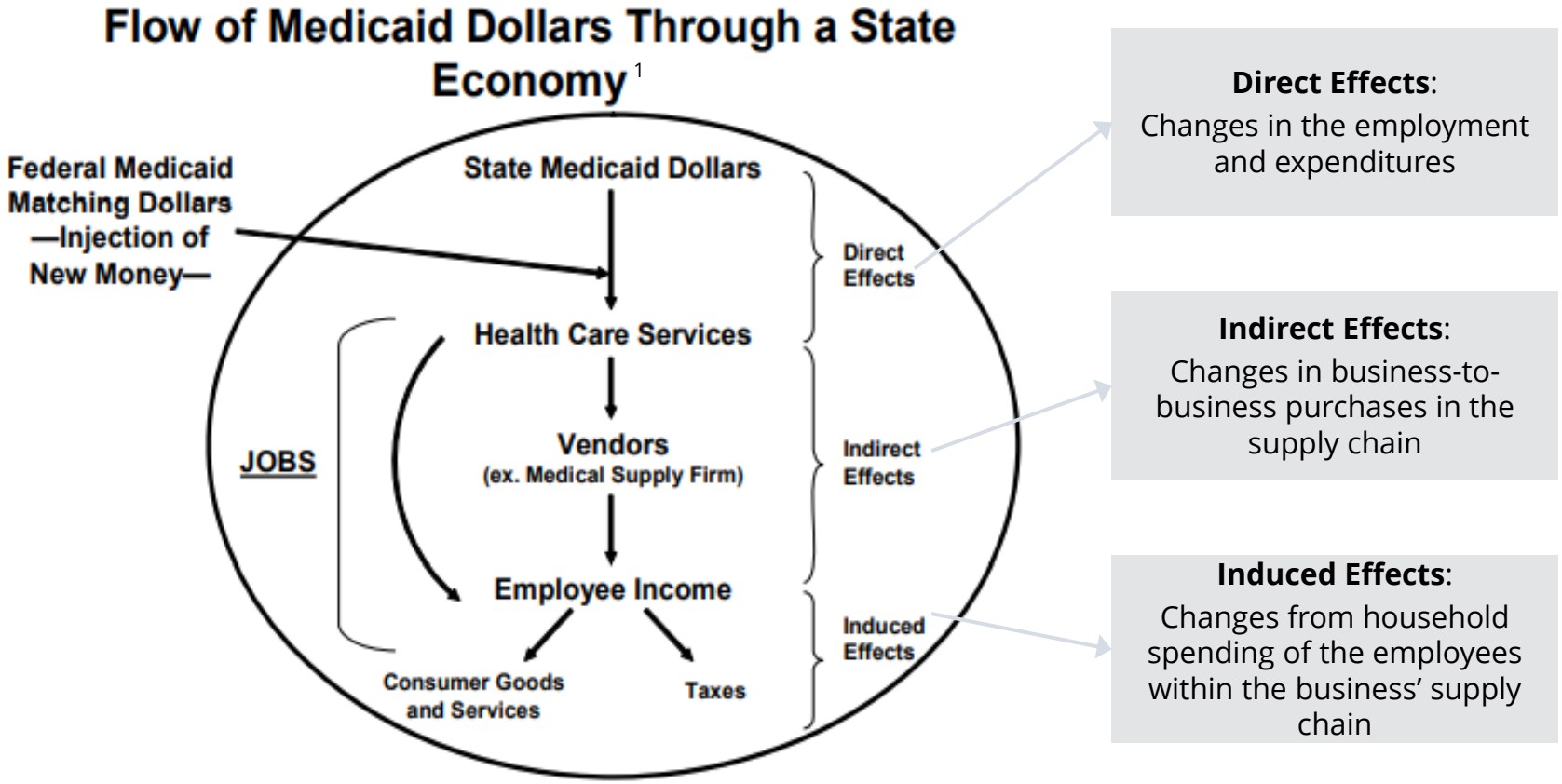
Create economic modeling of the effects of Medicaid waiver funding using IMPLAN

IMPLAN Models Economic Impacts

TEXAS Health and Human Services

The Section 1115 Medicaid waiver demonstration would infuse direct health care spending into the State of Texas from SFY 2022 to SFY 2030. This infusion would flow through Texas's overall economy, creating jobs, providing tax revenue, and adding economic value to the State. The loss of the Medicaid waiver funding could have the opposite effect on the Texas economy.

- The software uses an input-output methodology that is commonly used for modeling economic impacts. This approach has been a staple by States to quantify the economic impact of Medicaid on state economies[1], as it quantifies the impact of cash flows in one sector on other sectors in the economy.
- In the public sector, IMPLAN has generally been used to inform policy makers on the overall impact of program decisions. Within Texas, its modeling capabilities have been used on a number of occasions, including the recent Texas Water Development Board's 2021 Regional Water Plans.[2]



Sources:
1. Kaiser Family Foundation. The Role of Medicaid in State Economies: A Look at the Research. December 2008. Retrieved from: The Role of Medicaid in State Economies: A Look at the Research | KFF
2. Texas Water Development Board. 2021 Regional Water Plans. Socioeconomic Impact Analysis Methodology. March 2020. Retrieved from: Socioeconomic Impact Analysis Methodology (texas.gov).

Section 1115 Waiver Funding At Stake

TEXAS Health and Human Services

Texas received an extension of the Section 1115 Medicaid waiver demonstration known as the 'Texas Healthcare Transformation and Quality Improvement Program' in January 2021, which contemplates an estimated $11 billion per year in supplemental and directed payment programs.

- HHSC would continue to advance the goals of the waiver under this extension and align new programs with overall Medicaid.

HHSC's Planned Transition Requested

Texas's Medicaid waiver contemplates funding for the following Programs and/or Supplemental Payment Pools:

- Uncompensated Care Pool (UC)
- Quality Incentive Payment Program (QIPP)
- Network Access Improvement Program (NAIP)
- Comprehensive Hospital Increased Reimbursement Program (CHIRP)
- Texas Incentives for Physicians and Professional Services (TIPPS)
- Rural Access Primary and Preventive Services (RAPPS)
- Directed Payment Program for Behavioral Health Services (DPP BHS)

HHSC's Prior Waiver Funding

Previously, Texas receives Medicaid waiver funding for the following Programs and/or Supplemental Payment Pools:

- Delivery System Reform Incentive Program (DSRIP) ending on September 30, 2021
- Uncompensated Care Pool (UC)
- Uniform Hospital Rate Increase Program (UHRIP)
- Quality Incentive Payment Program (QIPP)
- Network Access Improvement Program (NAIP)

- If the waiver is not sustained by the CMS, the potential loss of waiver funding "is likely to lead to a severe market contraction amongst healthcare providers - a contraction from which the market will not recover for, at a minimum, years." [1]

Source:
1. The State of Texas; Texas Health and Human Services Commission v. Chiquita Brooks-Lasure, Case No. 6:21-cv-00191, Motion for Preliminary Injunction filed on 7/16/2021. Retrieved from: texasattorneygeneral.gov

Comparing Impacts to HHSC's Planned Transition

TEXAS Health and Human Services

This report used the IMPLAN economic modeling software to estimate the economic impacts of Medicaid waiver funding in different potential scenarios. The projected health care spending is based on Medicaid waiver funding amounts projected by the State of Texas from SFY 2023 to SFY 2030, and are inputs into IMPLAN.* Compared the economic impacts projected for HHSC's Planned Transition against the economic impacts projected for the status quo prior waiver levels, Scenario 2, and Scenario 3.

Texas Receives Funding As Planned	*Texas Receives Funding at Prior Waiver Levels*		*Texas Receives Some Funding for Managed Care*		*Texas Does Not Receive Any Funding*	
Scenario 1 - Planned Transition	**Status Quo at Prior Waiver Levels**	**Comparative Loss/Gain from Planned Transition to Prior Waiver**	**Scenario 2 - Managed Care, No Supplementals, and No New Programs**	**Comparative Loss from Planned Transition to Scenario 2**	**Scenario 3 - No Programs at all**	**Comparative Loss from Planned Transition to Scenario 3**
	✓ DSRIP - ends on September 30, 2021	Loss of DSRIP		No Change to DSRIP		No Change to DSRIP
✓ UC	✓ UC	No Change to UC		Loss of UC		Loss of UC
	✓ UHRIP	Gain of UHRIP	✓ UHRIP	Gain of UHRIP		No Change to UHRIP
✓ QIPP	✓ QIPP	No Change to QIPP	✓ QIPP	No Change to QIPP		Loss of QIPP
✓ NAIP for Physicians - ends on Aug 2022	✓ NAIP for Physicians - ends on Aug 2022	No Change to NAIP	✓ NAIP for Physicians - ends on Aug 2022	No Change to NAIP	✓ NAIP for Physicians - ends on Aug 2022	No Change to NAIP
✓ NAIP for Hospitals - ends on Aug 2027	✓ NAIP for Hospitals - ends on Aug 2027	No Change to NAIP	✓ NAIP for Hospitals - ends on Aug 2027	No Change to NAIP	✓ NAIP for Hospitals - ends on Aug 2027	No Change to NAIP
✓ CHIRP		Loss of CHIRP		Loss of CHIRP		Loss of CHIRP
✓ TIPPS		Loss of TIPPS		Loss of TIPPS		Loss of TIPPS
✓ RAPPS		Loss of RAPPS		Loss of RAPPS		Loss of RAPPS
✓ DPP for BHS		Loss of DPP for BHS		Loss of DPP for BHS		Loss of DPP for DHS
$11,026,796,936 in SFY2023	**$8,582,583,536 in SFY2023**	**-$2,444,213,401**	**$4,700,504,991 in SFY2023**	**-$6,326,291,945**	**$272,807,891 in SFY2023**	**-$10,753,989,045**

* Texas HHSC provided input data containing Medicaid waiver funding amounts, by program and by provider type, for the purpose of IMPLAN modeling. The same funding amounts to provider types are assumed year-over-year for CHIRP, RAPPS, TIPSS, DPP BHS and UC. Medicaid claims payments and MCO premiums and payments are excluded from the IMPLAN model.

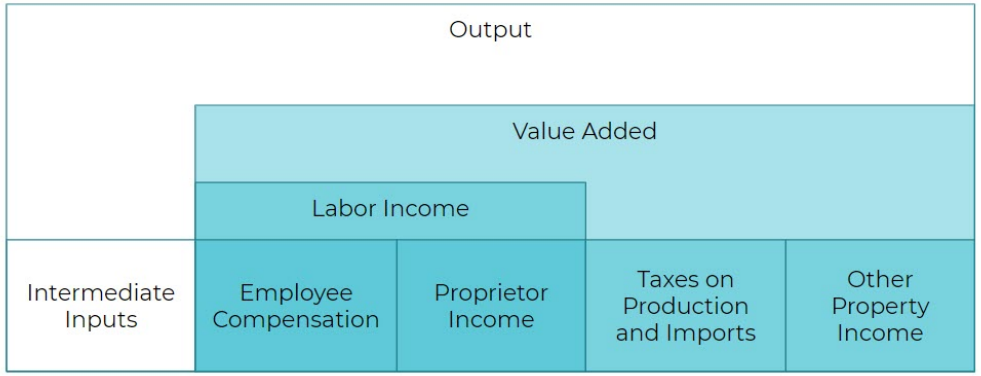
Economic Impact Projections from IMPLAN (1/2)

TEXAS Health and Human Services

For this review of the impact of Medicaid waiver funding on the State of Texas from SFY 2023 to SFY 2030, the IMPLAN tool modeled the total economic effect on a variety of indicators, such as output, value added, employment counts, and tax revenue.*

- **Medicaid Provider Payments:**
  - The payments to Medicaid providers funded by the Medicaid waiver would be a direct impact to healthcare providers. These amounts serve as the input into IMPLAN and are the basis for the remaining economic impact projections.
- **Employment:**
  - Many Texans' jobs are also at stake should the Section 1115 waiver not be re-approved and/or rescinded. Employment impact is the number of jobs created or lost in Texas's regional economy due to economic activity. Removing potential funding that could be input into the economy will result in the loss of potential direct jobs, indirect jobs, and induced jobs being created. Employment data in IMPLAN follows the same definition as Bureau of Economic Analysis Regional Economic Accounts (BEA REA) and Bureau of Labor Statistics Census of Employment and Wages (BLS CEW) data, which is full-time equivalent (FTE) employment counts.
- **Labor Income:**
  - Labor Income represents the total value of all forms of employment income paid throughout a defined economy during a specified period. It reflects the combined cost of total payroll paid to employees (e.g., wages and salaries, benefits, payroll taxes). Direct labor income is the wages paid to workers in industry sectors directly impacted by the funding. Indirect labor income is wages paid to employees in the supply chain. Induced labor income is paid to employees in the local economy supported by the economic activity.
- **Value Added:**
  - The loss to "Value Added" is equivalent to the impacted industry's contribution to Texas's Gross State Product. Value Added is a large portion of Output, as it encompasses Labor Income (LI), Other Property Income (OPI), and Taxes on Production and Imports (TOPI). Output is the sum of Value Added and Intermediate Expenditures to suppliers.
- **Output:**
  - Output is the total annual production value the funding would lead to in Texas. The loss to labor income, taxes paid, all profits, and any expenditures to suppliers is the loss of Output. When the funding leads to labor income expenses, that leads to Output spillover in the other categories listed, leading to a higher Output value.

*IMPLAN models economic outcomes given purchasing and transaction data. In no way are these results actual or definite.



Sources: IMPLAN. (2021). Understanding Value Added (VA). and Understanding Output.

Economic Impact Projections from IMPLAN (2/2)

TEXAS Health and Human Services

Impact projections for each scenarios are based on analysis using IMPLAN economic modeling software.

- **Tax revenue (federal, state and local):**
  - The waiver funding would impact tax revenue. Provider payments funded by the Medicaid waiver supports jobs in the healthcare industry and at healthcare suppliers, and the income that these workers spend locally supports jobs in a variety of industries. The Texans who hold these healthcare, restaurant, and other jobs pay federal and state income and sales taxes. The spending also increases the state's corporate profit tax revenues, along with some other smaller taxes and fees. IMPLAN projects the impacts to different types of tax revenue:
    - **Federal Government Tax Revenue**: Federal tax revenue is a combination of taxes for employee compensation, production and imports, households, and enterprises (corporations). Federal taxes encompass employee compensation taxes such as proprietor income taxes and income tax, motor vehicle license tax, natural resource/severance tax, property tax, sales tax, social insurance tax, and taxes on corporate profits.
    - **State Tax Revenue**: The IMPLAN model includes the following types of state taxes: income tax, motor vehicle license tax, natural resource/severance tax, property tax, sales tax, and social insurance tax. This state tax represents a broader set of taxes than those recorded within indirect business taxes; however, indirect business taxes include both a state and local component, whereas the former does not, and only includes state tax.
    - **Local Tax Revenue**: Local tax revenue is a combination of taxes assessed by counties, general sub-counties, and special districts.

Assumptions and Limitations

TEXAS Health and Human Services

The analysis using IMPLAN economic modeling software is based on the following assumptions.

- Conducted an economic impact analysis on HHSC's proposed Medicaid waiver expenditures between the years 2022-2030. The target geography is the state of Texas.
- Texas HHSC provided input data containing Medicaid waiver funding amounts, by program and by provider type, for the purpose of IMPLAN modeling. Although the data was checked for reasonableness compared to publicly reported figures and consistency between related figures (e.g., waiver application and public presentations), the data was not independently audited or verified the information provided. This is not providing an opinion on the information provided, nor or supporting the use of data in this report for legal, regulatory or tax purposes. Differences between amounts used in this report and other regulatory and financial filings/records may be due to differences in the purpose and classification of the information.
  - The same funding amounts to provider types are assumed year-over-year for CHIRP, RAPPS, TIPSS and DPP BHS and UC. Medicaid claims payments and MCO premiums and payments are excluded from the IMPLAN model
- The analysis is based upon economic contribution estimation techniques (“multipliers”) for the calendar years 2022 to 2030, provided through the IMPLAN software. These multipliers are based on industry, sector and national or statewide averages and create an estimate of the indirect and induced effects.
  - Waiver funding amounts by State Fiscal Year were the inputs into IMPLAN. The difference between State Fiscal Year and Calendar Year is assumed to be minimal on the resulting projections.
  - IMPLAN models investment or influx into an economy. For the loss of investment or funds injected into the economy modeled in Scenario 3, it is assumed the multipliers still stand and the projections measured the potential loss of impacts.
- IMPLAN models economic outcomes given purchasing and transaction data. In no way are these results actual or definite. This analysis uses IMPLAN projections from 2019, reflecting the pre-pandemic economy. The economic impacts could vary from these estimates somewhat depending on the extent to which the economy recovers by 2022 and consumption and employment patterns return to pre-pandemic patterns.
- Leakage of Economic Inputs implicitly assume that new hires living outside the target area (i.e., State of Texas) spend none of their disposable income within the target area. The underlying logic is that out-of-area employees would take their compensation back to their respective living areas and spend the majority of it there. Thus, a higher level of leakage reduces inputs by a factor of the leakage percentage and lowers outputs. Leakage assumptions attempt to control for outputs that would not be realized by the target geography (i.e., State of Texas).
- Labor Income in IMPLAN reports the value of wages, bonuses, and employee benefits supported by the waiver funding. Payroll tax impacts are separately reported under Employee Compensation, decomposed by federal and state taxes. Labor income consists of two components: Employee Compensation and Proprietor Income. Since proprietor income was not specified by HHSC, it is assumed this value to be $0, such that direct labor income impacts match the direct payroll inputs.
- This analysis does not include other potential effects on the economy that are more difficult to predict and model. These include the effects in the Medicare or individual insurance market, consumer health spending and financial security, nor potential effects of a Medicaid Fee-For-Service service delivery model compared to a Medicaid managed care system delivery model.
- Additionally, it is outside of the scope of this report to model how Texans’ healthcare utilization patterns would change with the loss of the waiver funding to healthcare providers.

Summary of the Three Scenarios

TEXAS Health and Human Services

When compared to HHSC's Planned Transition (Scenario 1), the loss of Medicaid waiver funding in alternative scenarios would have a negative impact on healthcare providers, Texans' employment and income, and economic output and tax revenue within the State.

HHSC's Planned Transition (Scenario 1)

In HHSC's Planned Transition, healthcare providers would receive $11 billion in payments each year. Texas employment is projected to have142,000 jobs, and the labor income is projected to be $9.4 billion. The value-added state GSP is projected to be $12.7 billion, the total economic output is projected to be $23.5 billion, and federal, state and local tax revenue is projected to be $2.5 billion.

ECONOMIC IMPACTS RESULTS FOR SCENARIO 1					
SFY	Medicaid Providers Payments	Employment	Labor Income	Output	Tax Revenue
2023	$11.0 B	142 K	$9.4 B	$23.5 B	$2.5 B

HHSC's Prior Waiver Funding Level (Status Quo)

If HHSC receives the prior level of waiver funding as compared to HHSC's Planned Transition, healthcare providers would lose $2.4 billion each year. In SFY2023, Texas employment is projected to have 30,000 fewer jobs, and Texans could lose $2.1 billion in labor income. In SFY2023, Texas would generate $2.8 billion less in value-added state GSP, $5.2 billion less in total economic output, and $550 million less in federal, state and local tax revenue.

COMPARISON BETWEEN STATUS QUO AND SCENARIO 1					
SFY	Medicaid Providers Payment Loss	Employment Loss	Labor Income Loss	Output Loss	Tax Revenue Loss
2023	-$2.4 B	-30 K	-$2.1 B	-$5.2 B	-$550 M

Waiver Funding for Managed Care (Scenario 2)

If HHSC receives waiver funding for managed care without supplementals or new programs as compared to HHSC's Planned Transition, healthcare providers would lose $6.3 billion each year. In SFY2023, Texas employment is projected to have 77,000 fewer jobs, and Texans could lose $5.4 billion in labor income. In SFY2023, Texas would generate $7.3 billion less in value-added state GSP, $13.5 billion less in total economic output, and $1.4 billion less in federal, state and local tax revenue.

COMPARISON BETWEEN SCENARIO 2 AND SCENARIO 1					
SFY	Medicaid Providers Payment Loss	Employment Loss	Labor Income Loss	Output Loss	Tax Revenue Loss
2023	-$6.3 B	-77 K	-$5.4 B	-$13.5 B	-$1.4 B

No Waiver Funding for Programs (Scenario 3)

If HHSC receives no waiver funding for programs except NAIP as compared to HHSC's Planned Transition, healthcare providers would lose $10.8 billion each year. in SFY2023, Texas employment is projected to have 139,000 fewer jobs, and Texans could lose $9.2 billion in labor income. In SFY2023, Texas would generate $12.4 billion less in value-added state GSP, $22.9 billion less in total economic output, and $2.4 billion less in federal, state and local tax revenue.

COMPARISON BETWEEN SCENARIO 3 AND SCENARIO 1					
SFY	Medicaid Providers Payment Loss	Employment Loss	Labor Income Loss	Output Loss	Tax Revenue Loss
2023	-$10.8 B	-139 K	-$9.2 B	-$22.9 B	-$2.4 B

HHSC's Planned Transition (Scenario 1)

- Economic Impact Summary
- Waiver Funding by Program
- Impact on Medicaid Providers
- Impact on Employment
- Impact on Compensation
- Impact on Output
- Impact on Tax Revenue
- Impact on Employment Loss for Top Five Sectors
- Impact on Output for Top Five Sectors

***Texas Receives Funding As Planned in* Scenario 1 - Planned Transition**
✓ UC
✓ QIPP
✓ NAIP for Physicians - ends on Aug 2022
✓ NAIP for Hospitals - ends on Aug 2027
✓ CHIRP
✓ TIPPS
✓ RAPPS
✓ DPP for BHS
$11,026,796,936 in SFY2023

Scenario 1: Economic Impact Summary

TEXAS Health and Human Services

In Scenario 1, Healthcare providers would receive payments from the Uncompensated Care Pool (UC), Quality Incentive Payment Program (QIPP), Network Access Improvement Program (NAIP), Comprehensive Hospital Increased Reimbursement Program (CHIRP), Texas Incentives for Physicians and Professional Services (TIPPS), Rural Access Primary and Preventive Services (RAPPS), and Directed Payment Program for Behavioral Health Services (DPP BHS), which would be about $11 billion to providers each year between 2023 and 2030, or $87.4 billion in total.

Between 2023 and 2030, Texas employment is projected to have one million FTE jobs, and the labor income is projected to be $71.8 billion. The value-added state GSP is projected to be $96.9 billion, the total economic output is projected to be $178.9 billion, and federal, state and local tax revenue is projected to be $18.8 billion.

IMPLAN projections suggest the Hospital sector and the Nursing & Community Care Facilities sector would be the most impacted sectors in terms of employment and economic output.

ECONOMIC IMPACT SUMMARY FROM HHSC's PLANNED TRANSITION						
Year	**Total Medicaid Providers Payments**	**Total Employment FTE Count**	**Total Labor Income**	**Total Value-Added**	**Total Output**	**Total Tax Revenue**
2023	$11,026,796,936	141,957	$9,422,770,460	$12,707,979,644	$23,464,584,296	$2,471,372,595
2024	$11,026,796,936	140,323	$9,316,418,209	$12,564,920,216	$23,200,802,422	$2,443,501,692
2025	$11,026,796,936	138,707	$9,211,301,397	$12,423,516,195	$22,940,066,227	$2,415,954,044
2026	$11,026,796,936	137,112	$9,107,405,086	$12,283,747,674	$22,682,339,208	$2,388,725,754
2027	$11,026,796,936	135,535	$9,004,714,525	$12,145,594,998	$22,427,585,318	$2,361,812,973
2028	$10,753,989,045	130,870	$8,683,879,998	$11,711,494,079	$21,624,131,860	$2,277,626,219
2029	$10,753,989,045	129,436	$8,589,662,237	$11,584,523,869	$21,389,782,887	$2,252,915,428
2030	$10,753,989,045	128,018	$8,496,470,475	$11,458,935,146	$21,157,982,649	$2,228,473,720
Total	**$87,395,951,819**	**1,081,958**	**$71,832,622,386**	**$96,880,711,821**	**$178,887,274,867**	**$18,840,382,424**

Scenario 1: Waiver Funding by Program

TEXAS Health and Human Services

The table shows the payment amounts by program, by year to Medicaid providers by IMPLAN sector, as a result of receiving funding requested in HHSC's Planned Transition. These payments to providers would be about $11 billion each year between 2023 and 2030.

Prog.	IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030
UC		**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**
	Hospitals	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942
	Offices of Physicians	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717
	Residential … mental health … facilities	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148
	Offices of dentists	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165
	Other ambulatory health care services	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572
QIPP		**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**
	Nursing and community care facilities	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000
NAIP for Physicians and Hospitals		**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$0**	**$0**	**$0**
	Hospitals	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$0	$0	$0
CHIRP		**$5,020,198,353**	**$5,020,198,353**	**$5,020,198,353**	**$5,020,198,353**	**$5,020,198,353**	**$5,020,198,353**	**$5,020,198,353**	**$5,020,198,353**
	Hospitals	$4,995,979,558	$4,995,979,558	$4,995,979,558	$4,995,979,558	$4,995,979,558	$4,995,979,558	$4,995,979,558	$4,995,979,558
	Residential … mental health … facilities	$24,218,795	$24,218,795	$24,218,795	$24,218,795	$24,218,795	$24,218,795	$24,218,795	$24,218,795
TIPPS		**$564,000,000**	**$564,000,000**	**$564,000,000**	**$564,000,000**	**$564,000,000**	**$564,000,000**	**$564,000,000**	**$564,000,000**
	Hospitals	$531,841,442	$531,841,442	$531,841,442	$531,841,442	$531,841,442	$531,841,442	$531,841,442	$531,841,442
	Offices of Physicians	$32,158,558	$32,158,558	$32,158,558	$32,158,558	$32,158,558	$32,158,558	$32,158,558	$32,158,558
RAPPS		**$11,262,525**	**$11,262,525**	**$11,262,525**	**$11,262,525**	**$11,262,525**	**$11,262,525**	**$11,262,525**	**$11,262,525**
	Hospitals	$9,916,929	$9,916,929	$9,916,929	$9,916,929	$9,916,929	$9,916,929	$9,916,929	$9,916,929
	Outpatient care centers	$1,345,596	$1,345,596	$1,345,596	$1,345,596	$1,345,596	$1,345,596	$1,345,596	$1,345,596
DPS BHS		**$176,449,623**	**$176,449,623**	**$176,449,623**	**$176,449,623**	**$176,449,623**	**$176,449,623**	**$176,449,623**	**$176,449,623**
	Outpatient care centers	$176,449,623	$176,449,623	$176,449,623	$176,449,623	$176,449,623	$176,449,623	$176,449,623	$176,449,623
Total Medicaid Providers Payments in Scenario 1		**$11,026,796,936**	**$11,026,796,936**	**$11,026,796,936**	**$11,026,796,936**	**$11,026,796,936**	**$10,753,989,045**	**$10,753,989,045**	**$10,753,989,045**

'Residential …mental health … facilities' refers to the IMPLAN sector for residential mental retardation, mental health, substance abuse and other facilities.

Scenario 1: Impact on Medicaid Providers

The funding requested as part of HHSC's Planned Transition represent about 87.4 billion in total payments to Medicaid providers between 2023 and 2030. From which, nearly $9 out of every $10 in Medicaid waiver funding would be for hospitals. Nursing and community care facilities represents 10 percent of Medicaid waiver funding requested in HHSC's Planned Transition. Those two healthcare sectors combined are the majority (96%) of the Medicaid waiver funding requested in HHSC's Planned Transition.

The table shows the payments to Medicaid providers by sector, as a result of receiving funding requested in HHSC's Planned Transition.

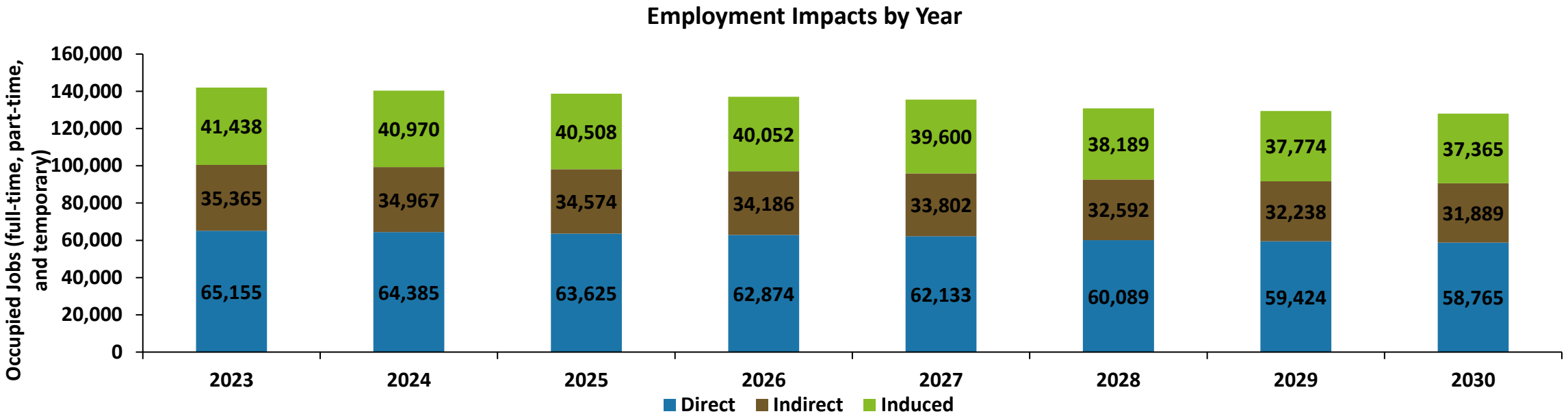
WAIVER FUNDING BY IMPLAN SECTOR FOR HHSC'S PLANNED TRANSITION								
IMPLAN Sector	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
Offices of Physicians	$108,733,275	$108,733,275	$108,733,275	$108,733,275	$108,733,275	$108,733,275	$108,733,275	$108,733,275
Offices of dentists	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165
Outpatient care centers	$177,795,219	$177,795,219	$177,795,219	$177,795,219	$177,795,219	$177,795,219	$177,795,219	$177,795,219
Other ambulatory health care services	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572
Residential mental retardation, mental health, substance abuse and other facilities	$41,509,944	$41,509,944	$41,509,944	$41,509,944	$41,509,944	$41,509,944	$41,509,944	$41,509,944
Hospitals	$9,513,594,763	$9,513,594,763	$9,513,594,763	$9,513,594,763	$9,513,594,763	$9,240,786,872	$9,240,786,872	$9,240,786,872
Nursing and community care facilities	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000
Total Payments in Scenario 1	**$11,026,796,936**	**$11,026,796,936**	**$11,026,796,936**	**$11,026,796,936**	**$11,026,796,936**	**$10,753,989,045**	**$10,753,989,045**	**$10,753,989,045**

These amounts were inputted into IMPLAN to determine the economic impacts from the waiver funding received for HHSC's Planned Transition.

Scenario 1: Impact on Employment

The funding received in HHSC's Planned Transition would result in increased employment, which IMPLAN projections measures in 'job years'. Approximately 135,000 jobs (full-time, part-time, and temporary) on average are projected each year as a result of receiving funding requested in HHSC's Planned Transition. That would be a total of one million FTE jobs between 2023 and 2030.

"Direct" jobs would average 62,000 each year. "Indirect" jobs from suppliers of healthcare would average 34,000 each year. Workers spending more would result in "induced" jobs, which is projected to be an average of 39,000 jobs each year.

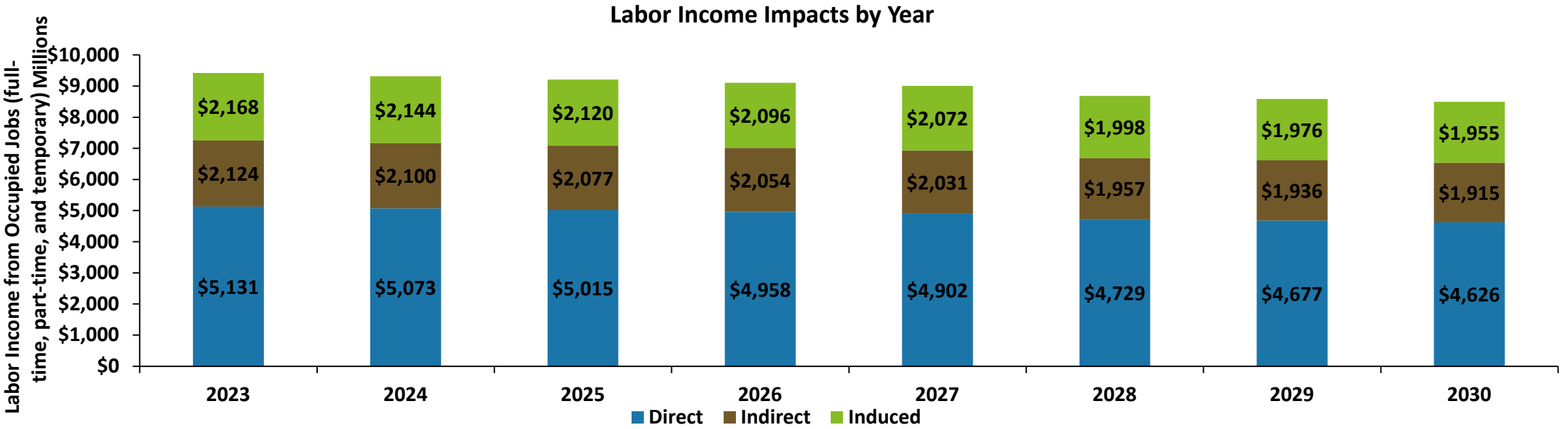


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5 year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs.

Scenario 1: Impact on Compensation

Using the employment modeling across multiple sectors, IMPLAN also extrapolates labor income paid to the workforce.* The modeling suggests that as a result of receiving funding requested in HHSC's Planned Transition, total labor income between 2023 to 2030 is projected to be $71.8 billion, which is an average of $9.0 billion income each year.

"Direct" labor income would average $4.9 billion each year. "Indirect" labor income from suppliers of healthcare would average $2.0 billion each year. Workers spending more would result in "induced" labor income that is projected to be an average of $2.1 billion each year.

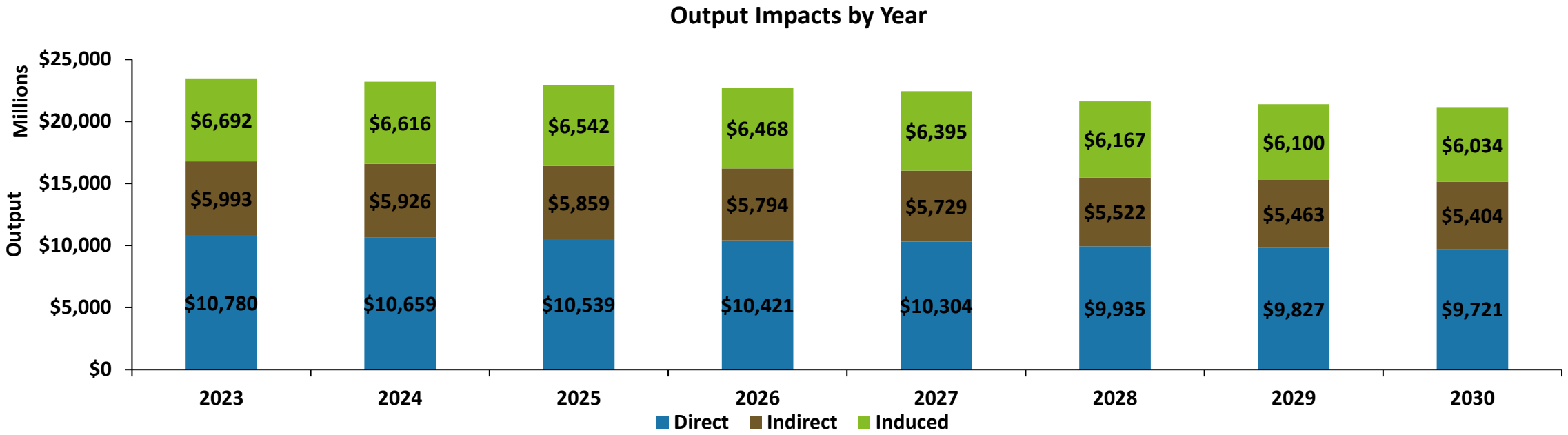


* Labor Income is the sum of employee compensation (wages and benefits) and proprietor income. Employee Compensation, is the total payroll cost of wage and salary employees to the employer. This includes wages and salaries, all benefits (e.g., health, retirement) and payroll taxes (both sides of social security, unemployment insurance taxes, etc.). It is also referred to as fully-loaded payroll. Proprietor Income consists of payments received by self-employed individuals and unincorporated business owners.

Scenario 1: Impact on Output

Output, which refers to the value of intermediate and final goods produced in a time period, is one metric the IMPLAN model produces to size and gauge economic impact. This approach to modeling economic impact estimates a total $178.9 billion output along Texas's supply chain across all sectors between 2023 and 2030.

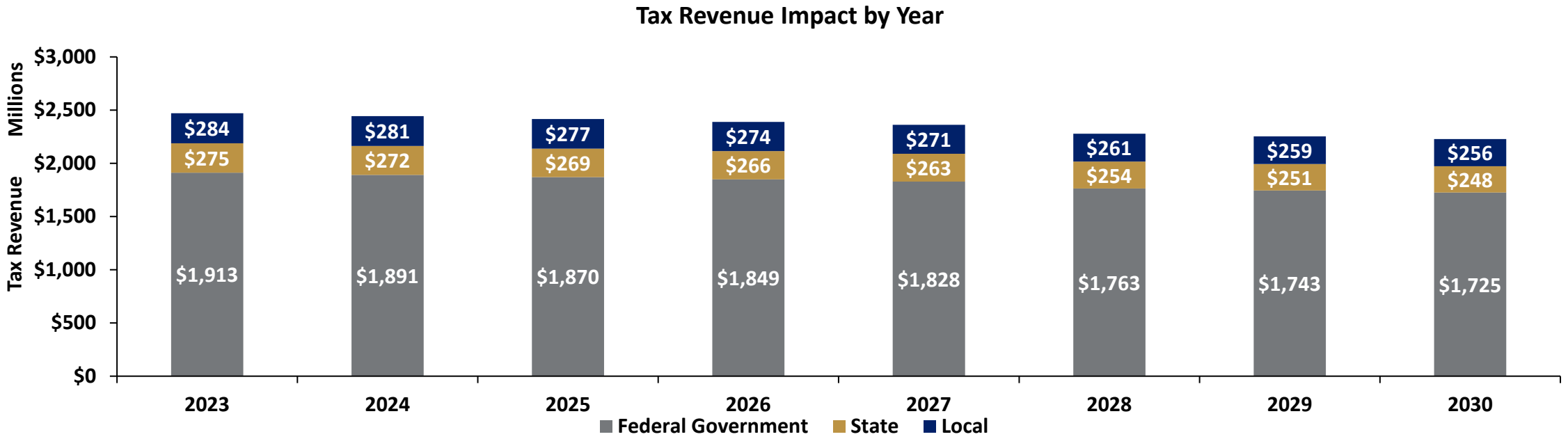
The table summarizes the output projected from receiving funding for HHSC's Planned Transition between 2023 and 2030. This includes the direct output from the healthcare industry sectors, the indirect output from suppliers, and the induced effect of increased spending by affected workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the State's economy.



Scenario 1: Impact on Tax Revenue

A total $18.8 billion in federal, state and local tax revenue is projected between 2023 and 2030 from the economic activity related to Medicaid waiver funding requested in HHSC's Planned Transition. Medicaid waiver funding supports jobs in the healthcare industry and at healthcare suppliers, and the income that these workers spend locally supports jobs in a variety of industries. The Texans who hold these healthcare, restaurant, and other jobs pay federal and state income and sales taxes. The spending also increases the state's corporate profit tax revenues, along with some other smaller taxes and fees. The received funding could spur these types of tax revenues.

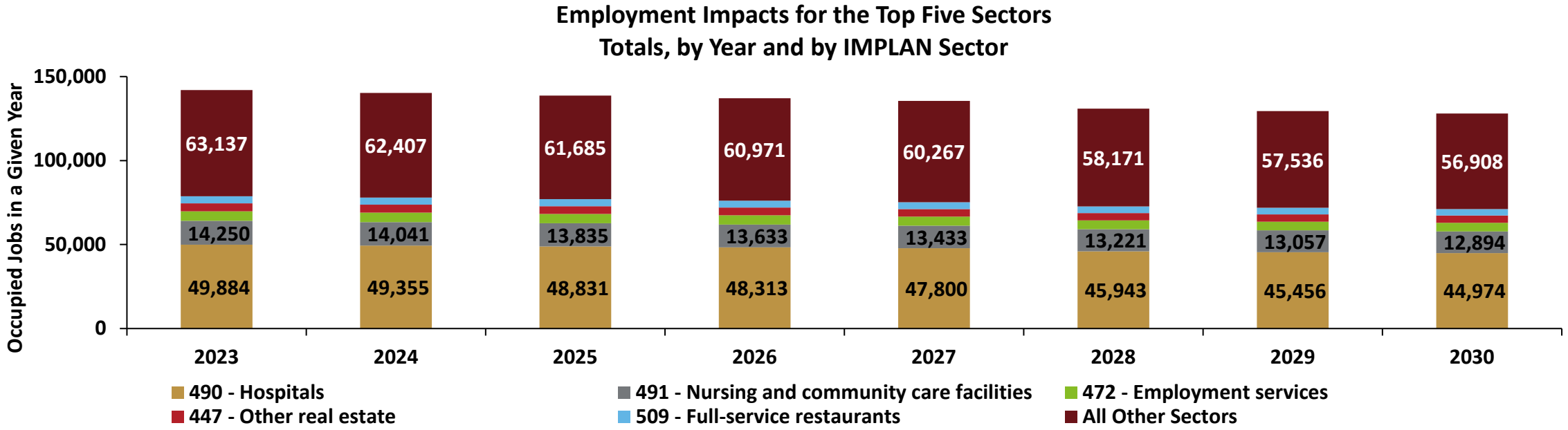
The table breaks down projected tax revenue by year.



* Federal tax revenue is a combination of taxes for employee compensation, production and imports, households, and enterprises (corporations). Local tax revenue is a combination of taxes assessed by counties, general sub-counties, and special districts.

Scenario 1: Impact on Employment by Sector

The table shows a breakdown of the top five sectors impacted by the funding requested in HHSC's Planned Transition in terms of projected employment, measured in 'job years'. Of the jobs created across all sectors between 2023 and 2030, these five sectors combined account for 56% of the total one million jobs created. All other sectors represent the remaining 44%.

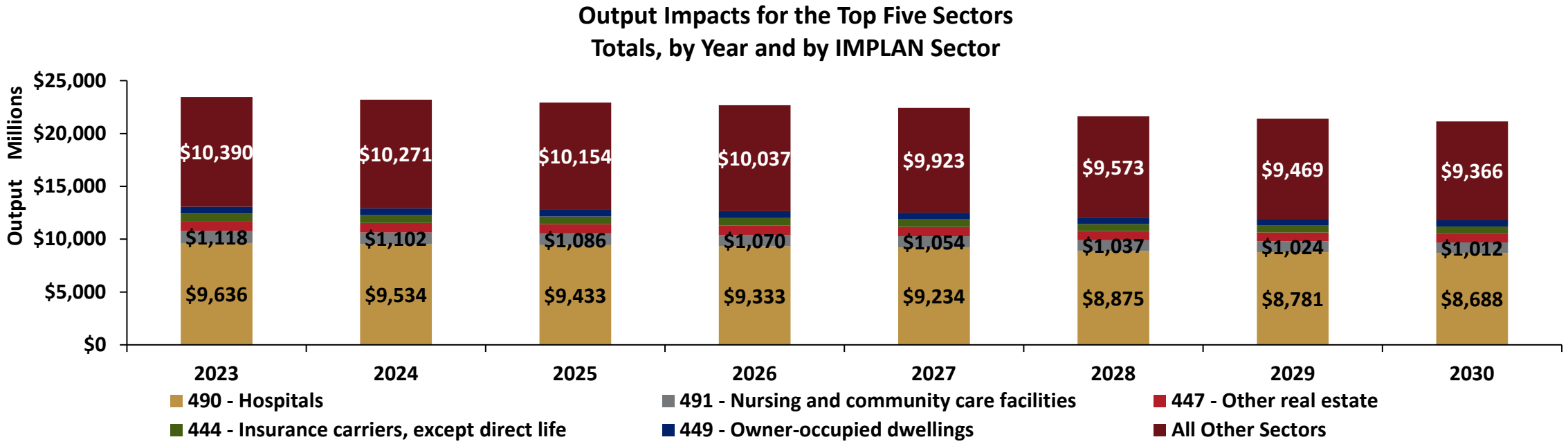


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5 year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs.

Scenario 1: Impact on Output by Sector

The table summarizes the total output* projected in the top five industry sectors. These five sectors represent 56% of the total projected $178.9 billion output between 2023 and 2030. All other sectors represent the remaining 44% of economic output generated.

IMPLAN projections suggest 41% of the total output would be in the Hospital sector, with $73.5 billion in output between 2023 and 2030. The Nursing and Community Care Facilities sector would experience the second largest impact, with $8.5 billion in output between 2023 and 2030. The output for the other top three industry sectors is projected to be $17.7 billion between 2023 and 2030.



* Total Output is the sum of three different types of impacts: direct effects, indirect effects, and induced effects. This includes the direct effect on the healthcare industry sectors, the indirect effect on suppliers, and the induced effect of reduced spending by affected healthcare workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the state's economy.

HHSC's Prior Waiver Funding Level (Status Quo Scenario)

- Economic Impact Summary
- Funding under the Prior Waiver
- Comparative Impact on Medicaid Providers
- Comparative Impact on Employment
- Comparative Impact on Compensation
- Comparative Impact on Output
- Comparative Impact on Tax Revenue
- Comparative Employment for Top Five Sectors
- Comparative Output for Top Five Sectors

Texas Receives Funding at Prior Waiver Levels	
Status Quo at Prior Waiver Levels	**Comparative Loss/Gain from Planned Transition to Prior Waiver**
✓ DSRIP - ends on September 30, 2021	Loss of DSRIP
✓ UC	No Change to UC
✓ UHRIP	Gain of UHRIP
✓ QIPP	No Change to QIPP
✓ NAIP for Physicians - ends on Aug 2022	No Change to NAIP
✓ NAIP for Hospitals - ends on Aug 2027	No Change to NAIP
	Loss of CHIRP
	Loss of TIPPS
	Loss of RAPPS
	Loss of DPP for BHS
$8,582,583,536 in SFY2023	**-$2,444,213,401**

Status Quo: Economic Impact Summary

If HHSC receives their prior level of waiver funding as compared to HHSC's Planned Transition (Scenario 1), healthcare providers would lose payments from DSRIP and Directed Payment Programs (specifically with CHIRP, TIPPS, RAPPS, and DPP for BHS), yet they would receive payments from UHRIP, UC, QIPP and NAIP. These payments to providers would be about $8.5 billion each year between 2023 and 2030. Compared to HHSC's Planned Transition (Scenario 1), these payments would be $2.4 billion less than Scenario 1 each year between 2023 and 2030 to providers, or $19.6 billion less than Scenario 1 in total.

Between 2023 and 2030, Texas employment is projected to have 230,000 fewer jobs, and Texans are projected to lose $16.2 billion in labor income. Texas would generate $21.8 billion less in value-added state GSP, $40.1 billion less in total economic output, and $4.2 billion less in federal, state and local tax revenue.

The Hospital sector would be the most impacted sector in terms of losses to employment and economic output.

ECONOMIC IMPACT COMPARISON SUMMARY (EMPLOYMENT, LABOR INCOME, VALUE ADDED, AND OUTPUT) BETWEEN PRIOR WAIVER FUNDING (STATUS QUO) AND HHSC's PLANNED TRANSITION (SCENARIO 1)						
Year	**Total Medicaid Providers Payment Loss**	**Total Employment FTE Count Loss**	**Total Labor Income Loss**	**Total Value-Added Loss**	**Total Output Loss**	**Total Tax Revenue Loss**
2023	-$2,444,213,401	-29,960	-$2,110,904,324	-$2,830,370,591	-$5,215,330,506	-$550,349,611
2024	-$2,444,213,401	-29,619	-$2,086,933,810	-$2,798,469,492	-$5,156,718,327	-$544,126,681
2025	-$2,444,213,401	-29,281	-$2,063,248,605	-$2,766,943,755	-$5,098,792,711	-$537,977,338
2026	-$2,444,213,401	-28,948	-$2,039,845,075	-$2,735,788,675	-$5,041,545,104	-$531,900,652
2027	-$2,444,213,401	-28,619	-$2,016,719,636	-$2,704,999,610	-$4,984,967,069	-$525,895,708
2028	-$2,444,213,401	-28,293	-$1,993,868,755	-$2,674,571,981	-$4,929,050,282	-$519,961,601
2029	-$2,444,213,401	-27,989	-$1,972,431,045	-$2,645,863,614	-$4,876,177,916	-$514,376,452
2030	-$2,444,213,401	-27,688	-$1,951,224,393	-$2,617,464,075	-$4,823,873,891	-$451,189,230
Total	**-$19,553,707,207**	**-230,397**	**-$16,235,175,641**	**-$21,774,471,793**	**-$40,126,455,804**	**-$4,175,777,275**

Status Quo: Funding under the Prior Waiver

TEXAS Health and Human Services

With the prior level of waiver funding, the table shows the payments by program, by year to Medicaid providers by IMPLAN sector. These payments to providers would be about $8.5 billion each year between 2023 and 2030.

Prog.	IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030
DSRIP		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	State Govt, Hospitals and Health Services	$0	$0	$0	$0	$0	$0	$0	$0
	Hospitals	$0	$0	$0	$0	$0	$0	$0	$0
	Offices of Physicians	$0	$0	$0	$0	$0	$0	$0	$0
	Outpatient care centers	$0	$0	$0	$0	$0	$0	$0	$0
UC		**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**	**$3,882,078,544**
	Hospitals	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942	$3,703,048,942
	Offices of Physicians	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717	$76,574,717
	Residential … mental health … facilities	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148	$17,291,148
	Offices of dentists	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165	$395,165
	Other ambulatory health care services	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572	$84,768,572
UHRIP		**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**
	Hospitals	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756
	Residential …mental health … facilities	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345
QIPP		**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**
	Nursing and community care facilities	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000
NAIP for Physicians and Hospitals		**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$0**	**$0**	**$0**
	Hospitals	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$0	$0	$0
Total Medicaid Providers Payments at Prior Waiver Level		**$8,582,583,536**	**$8,582,583,536**	**$8,582,583,536**	**$8,582,583,536**	**$8,582,583,536**	**$8,309,775,645**	**$8,309,775,645**	**$8,309,775,645**

These amounts were inputted into IMPLAN to determine the economic impacts from the prior level of waiver funding, then the economic impacts were compared to those from HHSC's Planned Transition described in Scenario 1.

Status Quo: Impact on Medicaid Providers

TEXAS Health and Human Services

The loss of DSRIP and Directed Payment Programs while funding UHRIP, UC, QIPP and NAIP represents about $19.6 billion in total payment loss to Medicaid providers between 2023 and 2030. Most of the funding loss would be to hospitals, $17.9 billion or 92%. The remaining funding loss would be for providers in other IMPLAN sectors such as Residential Mental Health Facilities, Physicians Offices, and Outpatient Care Centers.

The table shows the payment loss to Medicaid providers by IMPLAN sector due to the waiver funding difference between prior waiver level and HHSC's Planned Transition (Scenario 1).

WAIVER FUNDING LOSS BY IMPLAN SECTOR
WITHOUT DSRIP OR DIRECTED PAYMENT PROGRAMS and WITH UHRIP

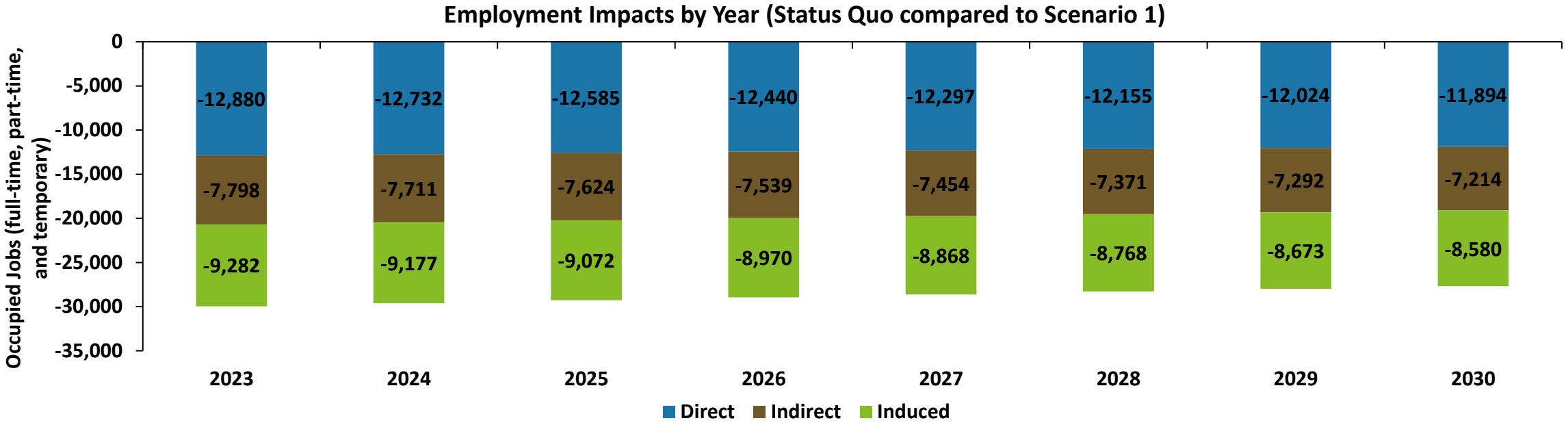
IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030	Grand Total
Hospitals	-$2,238,937,173	-$2,238,937,173	-$2,238,937,173	-$2,238,937,173	-$2,238,937,173	-$2,238,937,173	-$2,238,937,173	-$2,238,937,173	**-$17,911,497,384**
Residential …mental health … facilities	+$4,677,549	+$4,677,549	+$4,677,549	+$4,677,549	+$4,677,549	+$4,677,549	+$4,677,549	+$4,677,549	**+$37,420,394**
Offices of Physicians	-$32,158,558	-$32,158,558	-$32,158,558	-$32,158,558	-$32,158,558	-$32,158,558	-$32,158,558	-$32,158,558	**-$257,268,465**
Outpatient care centers	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	**-$1,422,361,752**
Total	**-$2,444,213,401**	**-$2,444,213,401**	**-$2,444,213,401**	**-$2,444,213,401**	**-$2,444,213,401**	**-$2,444,213,401**	**-$2,444,213,401**	**-$2,444,213,401**	**-$19,553,707,207**

'Residential …mental health … facilities' refers to the IMPLAN sector for residential mental retardation, mental health, substance abuse and other facilities.

Status Quo: Impact on Employment

The waiver funding difference between prior waiver level and HHSC's Planned Transition (Scenario 1) would result in the loss of employment, which IMPLAN projections measures in 'job years'. As a result of receiving the prior level of waiver funding, approximately 106,000 jobs (full-time, part-time, and temporary) on average would be generated each year, which is approximately 29,000 fewer jobs than in HHSC's Planned Transition (Scenario 1). That would be a total of 230,000 fewer FTE jobs between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

"Direct" job losses would occur in the healthcare sectors directly impacted by the difference of waiver funding and would average 12,000 fewer direct jobs each year than HHSC's Planned Transition (Scenario 1). Jobs would also be lost in other industries. Suppliers of the healthcare industry, such as food service, janitorial, and accounting firms, would experience decreased demand, leading to "indirect" job loss averaging 8,000 fewer jobs each year. The employment loss also includes those lost due to the "induced effect" of workers spending less at restaurants, retail stores, and other local businesses and would average 9,000 fewer jobs each year between 2023 and 2030.

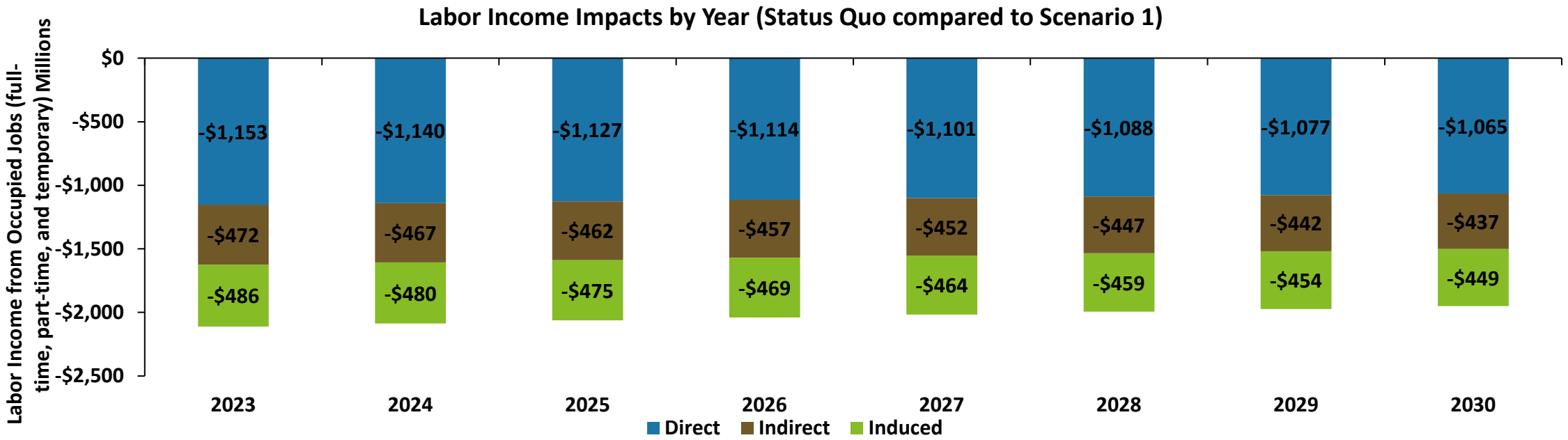


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5-year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs.

Status Quo: Impact on Compensation

Using the employment modeling across multiple sectors, IMPLAN also extrapolates labor income paid to the workforce.* The modeling suggests that with the prior level of waiver funding, Texans would earn an average of $6.9 billion income each year, which is $2 billion less each year than in HHSC's Planned Transition (Scenario 1). That would be a total of $16.2 billion less in labor income between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

"Direct" labor income loss would average $1.1 billion less each year than HHSC's Planned Transition (Scenario 1). "Indirect" labor income from suppliers of healthcare would lose an average $454 million each year. Workers spending less would result in "induced" labor income loss that is projected to be an average of $467 million less each year.

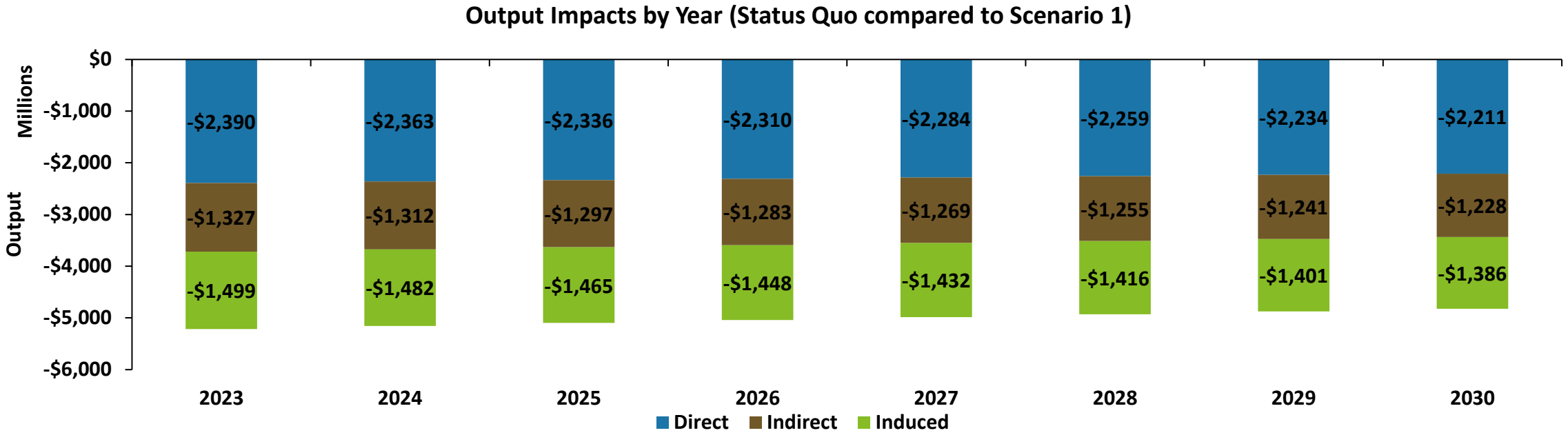


* Labor Income is the sum of employee compensation (wages and benefits) and proprietor income. Employee Compensation, is the total payroll cost of wage and salary employees to the employer. This includes wages and salaries, all benefits (e.g., health, retirement) and payroll taxes (both sides of social security, unemployment insurance taxes, etc.). It is also referred to as fully-loaded payroll. Proprietor Income consists of payments received by self-employed individuals and unincorporated business owners.

Status Quo: Impact on Output

Output, which refers to the value of intermediate and final goods produced in a time period, is one metric the IMPLAN model produces to size and gauge economic impact. This approach to modeling economic impact estimates that the prior waiver funding level could lead to an economic output of $17.3 billion each year, which is $5.0 billion less than in HHSC's Planned Transition (Scenario 1). That would be a total loss of $40.1 billion output along Texas's supply chain across all sectors between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

The table summarizes the output loss between 2023 and 2030 due to the waiver funding difference between the prior waiver and HHSC's Planned Transition (Scenario 1). This includes the losses in direct output from the healthcare industry sectors, the indirect output from on suppliers, and the induced effect of reduced spending by affected workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the State's economy.

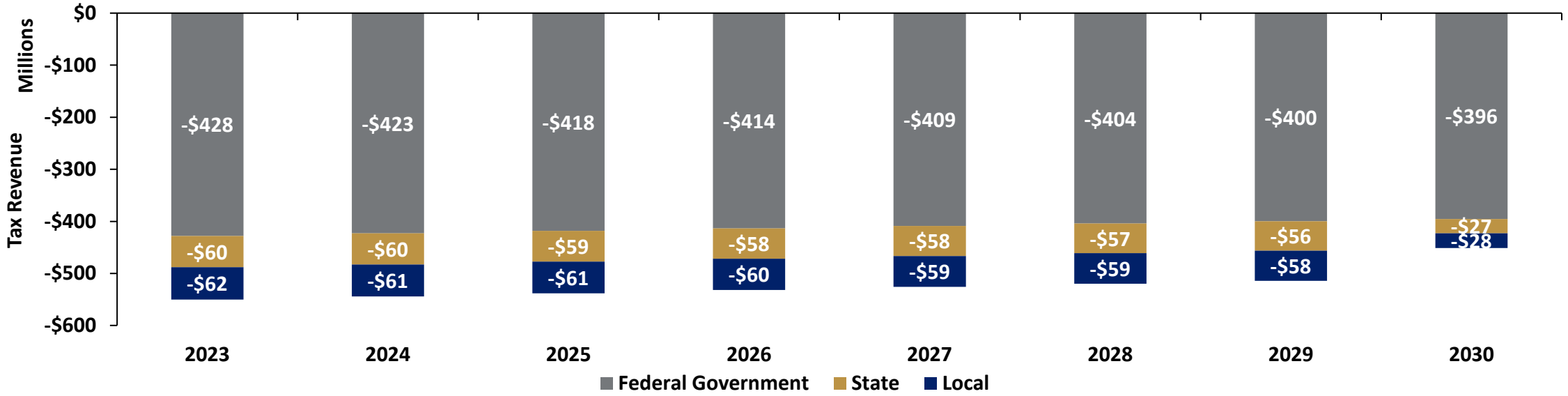


Status Quo: Impact on Tax Revenue

Economic activity related to prior waiver level could generate $14.7 billion in federal, state and local tax revenue between 2023 and 2030, which is $4.2 billion less than HHSC's Planned Transition (Scenario 1). Medicaid waiver funding supports jobs in the healthcare industry and at healthcare suppliers, and the income that these workers spend locally supports jobs in a variety of industries. The Texans who hold these healthcare, restaurant, and other jobs pay federal and state income and sales taxes. The spending also increases the state's corporate profit tax revenues, along with some other smaller taxes and fees. If HHSC receives the prior waiver level of funding as compared to HHSC's Planned Transition (Scenario 1), the loss of waiver funding would spur a loss of these types of tax revenues.

The table breaks down by year, the projected tax revenue loss due to the waiver funding difference between the prior waiver and HHSC's Planned Transition (Scenario 1).

Tax Revenue Impact by Year (Status Quo compared to Scenario 1)



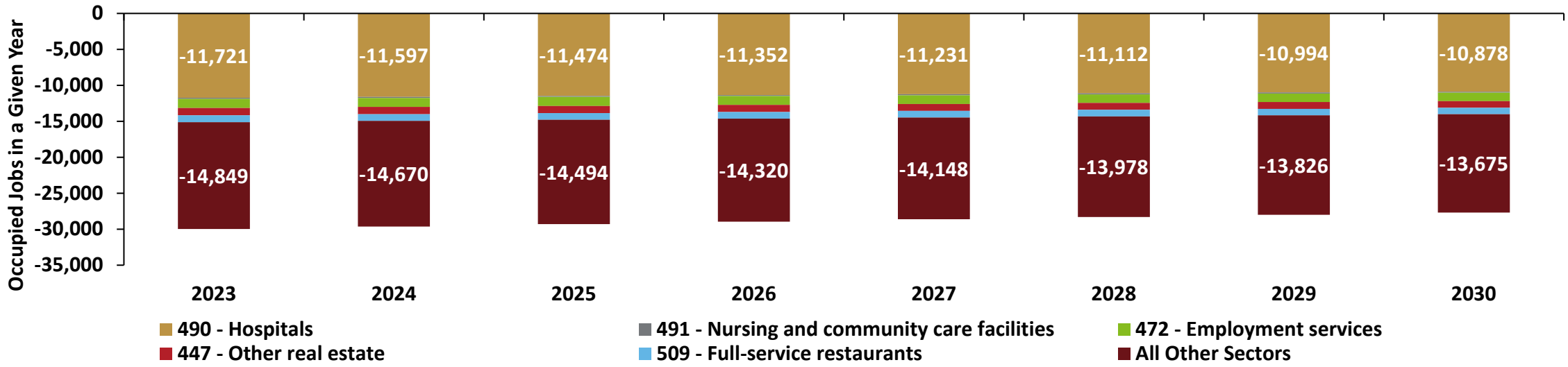
* Federal tax revenue is a combination of taxes for employee compensation, production and imports, households, and enterprises (corporations). Local tax revenue is a combination of taxes assessed by counties, general sub-counties, and special districts.

Status Quo: Employment Loss by Sector

The table shows a breakdown of the top five sectors impacted in terms of projected loss of employment measured in 'job years' due to the waiver funding difference between the prior waiver and HHSC's Planned Transition (Scenario 1). Of the total of 230,000 fewer FTE jobs across all sectors between 2023 and 2030, these five sectors combined account for 116,000 of those lost FTE jobs, or 51%.

Comparing the employment impact from the prior waiver funding to HHSC's Planned Transition (Scenario 1), IMPLAN projections suggest the Hospital sector would lose 90,000 total FTE jobs between 2023 and 2030, which is an average 11,000 FTE jobs each year. In 2019, the Hospital sector employed approximately 334,000 total FTE jobs, so the average annual loss of 11,000 FTE jobs represents about a 3.4% loss to the Hospital sector's employment. The other top four industry sectors impacted would lose about 3,000 FTE jobs each year between 2023 and 2030.

Comparison between Status Quo and Scenario 1 of Employment Impacts for the Top Five Sectors
Totals, by Year and by IMPLAN Sector

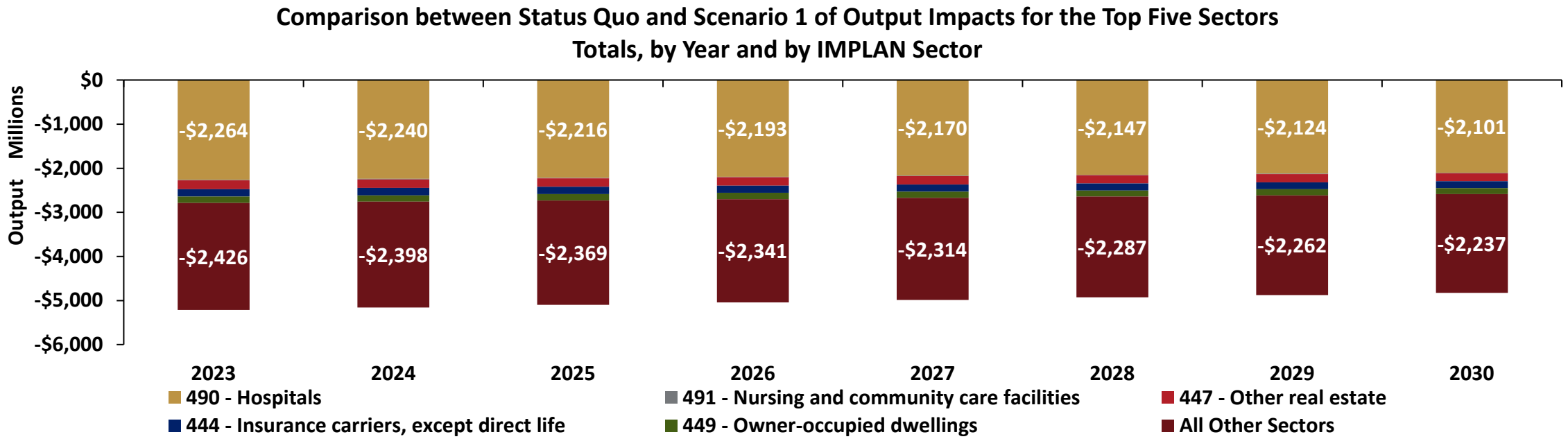


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5 year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs. For comparison purposes, the top five sectors impacted are from HHSC's Planned Transition in Scenario 1.

Status Quo: Output Loss by Sector

The table summarizes the total output* loss in the top five sectors impacted from 2023 to 2030 due to the waiver funding difference between the prior waiver level and HHSC's Planned Transition (Scenario 1). Of the total $40.1 billion output loss across all sectors between 2023 and 2030, these five sectors combined account for $21.5 billion of the lost output, or 54%.

Comparing the output impact from the prior waiver funding to HHSC's Planned Transition (Scenario 1), IMPLAN projections suggest 43% of the total output loss would be in the Hospital sector, losing $17.5 billion in total output between 2023 and 2030, or an average loss of $2.2 billion each year. The other top four industry sectors impacted would represent about 10% of the output loss, or roughly $4.0 billion in total output loss between 2023 and 2030.



* Total Output is the sum of three different types of impacts: direct effects, indirect effects, and induced effects. This includes the direct effect on the healthcare industry sectors, the indirect effect on suppliers, and the induced effect of reduced spending by affected healthcare workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the state's economy. For comparison purposes, the top five sectors impacted are from HHSC's Planned Transition in Scenario 1.

Waiver Funding for Managed Care (Scenario 2)

- Economic Impact Summary
- Managed Care Funded by the Waiver without Supplementals or New Programs
- Comparative Impact on Medicaid Providers
- Comparative Impact on Employment
- Comparative Impact on Compensation
- Comparative Impact on Output
- Comparative Impact on Tax Revenue
- Comparative Employment for Top Five Sectors
- Comparative Output for Top Five Sectors

Texas Receives Some Funding for Managed Care	
Scenario 2 - Managed Care, No Supplementals, and No New Programs	**Comparative Loss from Planned Transition to Scenario 2**
	No Change to DSRIP
	Loss of UC
✓ UHRIP	Gain of UHRIP
✓ QIPP	No Change to QIPP
✓ NAIP for Physicians - ends on Aug 2022	No Change to NAIP
✓ NAIP for Hospitals - ends on Aug 2027	No Change to NAIP
	Loss of CHIRP
	Loss of TIPPS
	Loss of RAPPS
	Loss of DPP for BHS
$4,700,504,991 in SFY2023	**-$6,326,291,945**

Scenario 2: Economic Impact Summary

If HHSC received Medicaid waiver funding for managed care without supplementals or new programs in Scenario 2, healthcare providers would lose payments from UC and Directed Payment Programs (specifically with CHIRP, RAPPS, TIPPS, and DPP for BHS), and there would still be no DSRIP. Providers would receive payments from UHRIP, QIPP and NAIP. These payments to providers would be about $4.6 billion each year between 2023 and 2030. Compared to HHSC's Planned Transition (Scenario 1), these payments would be $6.3 billion less than Scenario 1 each year between 2023 and 2030 to providers, or $50.6 billion less than Scenario 1 in total.

Between 2023 and 2030, Texas employment is projected to have 592,000 fewer jobs than HHSC's Planned Transition (Scenario 1), and Texans are projected to lose $41.7 billion in labor income. Texas would generate $56.2 billion less in value-added state GSP, $103.7 billion less in total economic output, and $10.9 billion less in federal, state and local tax revenue.

The Hospital sector would be the most impacted sector in terms of losses to employment and economic output.

ECONOMIC IMPACT COMPARISON SUMMARY (EMPLOYMENT, LABOR INCOME, VALUE ADDED, AND OUTPUT) BETWEEN SCENARIO 2 AND HHSC's PLANNED TRANSITION (SCENARIO 1)						
Year	**Total Medicaid Providers Payment Loss**	**Total Employment FTE Count Loss**	**Total Labor Income Loss**	**Total Value-Added Loss**	**Total Output Loss**	**Total Tax Revenue Loss**
2023	-$6,326,291,945	-76,942	-$5,419,870,484	-$7,306,562,626	-$13,471,249,641	-$1,416,701,649
2024	-$6,326,291,945	-76,089	-$5,360,021,249	-$7,226,161,192	-$13,323,326,862	-$1,401,095,102
2025	-$6,326,291,945	-75,246	-$5,300,854,072	-$7,146,670,784	-$13,177,074,246	-$1,385,665,706
2026	-$6,326,291,945	-74,413	-$5,242,360,775	-$7,068,080,574	-$13,032,472,055	-$1,370,411,349
2027	-$6,326,291,945	-73,589	-$5,184,533,287	-$6,990,379,874	-$12,889,500,802	-$1,355,329,948
2028	-$6,326,291,945	-72,774	-$5,127,363,642	-$6,913,558,132	-$12,748,141,245	-$1,340,419,446
2029	-$6,326,291,945	-71,996	-$5,072,566,844	-$6,839,730,173	-$12,612,075,305	-$1,326,101,808
2030	-$6,326,291,945	-71,402	-$5,026,335,158	-$6,777,002,168	-$12,495,189,206	-$1,313,984,115
Total	**-$50,610,335,560**	**-592,450**	**-$41,733,905,510**	**-$56,268,145,522**	**-$103,749,029,360**	**-$10,909,709,123**

Scenario 2: Managed Care Funded by the Waiver, without Supplementals or New Programs

TEXAS Health and Human Services

If the Medicaid waiver funded managed care without supplementals or new programs in Scenario 2, the table shows the payments for by program, by year to Medicaid providers by IMPLAN sector. These payments to providers would be about $4.6 billion each year between 2023 and 2030.

Prog.	IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030
UHRIP		**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**	**$3,327,697,101**
	Hospitals	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756	$3,298,800,756
	Residential mental retardation, mental health, substance abuse and other facilities	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345	$28,896,345
QIPP		**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**	**$1,100,000,000**
	Nursing and community care facilities	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000	$1,100,000,000
NAIP for Physicians and Hospitals		**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$0**	**$0**	**$0**
	Hospitals	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$0	$0	$0
Total Medicaid Providers Payments in Scenario 2		**$4,700,504,991**	**$4,700,504,991**	**$4,700,504,991**	**$4,700,504,991**	**$4,700,504,991**	**$4,427,697,100**	**$4,427,697,100**	**$4,427,697,100**

These amounts were inputted into IMPLAN to determine the economic impacts from Scenario 2, then the economic impacts were compared to those from HHSC's Planned Transition described in Scenario 1.

Scenario 2: Impact on Medicaid Providers

TEXAS Health and Human Services

The loss of waiver funding in Scenario 2 represents about $50.6 billion in total payment loss to Medicaid providers between 2023 and 2030 when compared to HHSC's Planned Transition (Scenario 1). Most of the funding loss would be to hospitals, $47.5 billion or 94%. The remaining funding loss would be for providers in other IMPLAN sectors such as Residential Mental Health Facilities, Physicians Offices, Dentists Offices, Outpatient Care Centers, and Other Ambulatory Health Care.

The table shows the payment loss to Medicaid providers by IMPLAN sector due to the waiver funding difference between Scenario 2 and HHSC's Planned Transition (Scenario 1).

WAIVER FUNDING LOSS BY IMPLAN SECTOR BETWEEN SCENARIO 2 AND HHSC's PLANNED TRANSITION (SCENARIO 1)

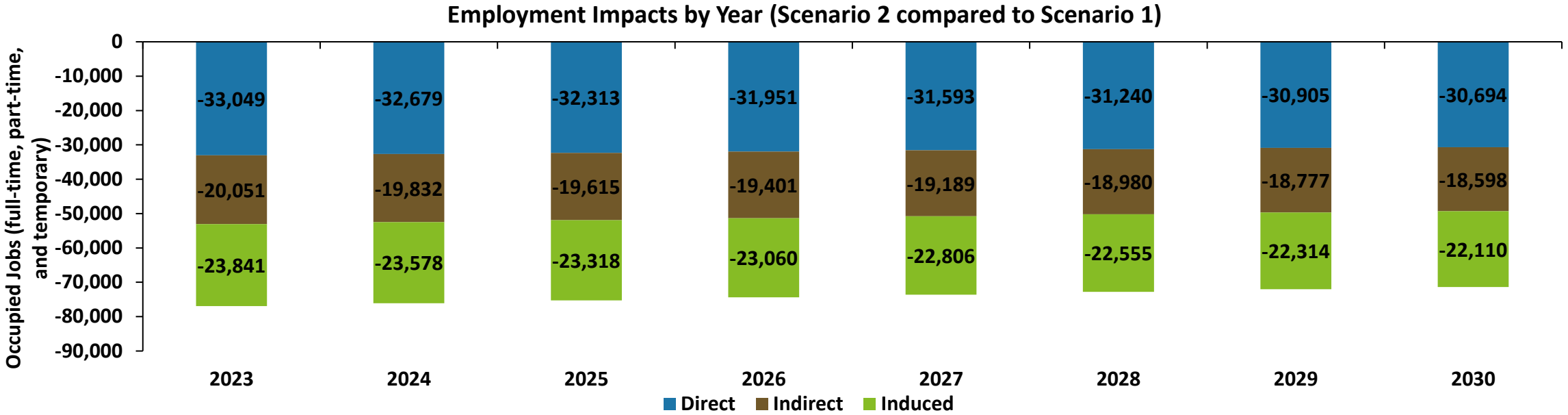
IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030	Grand Total
Hospitals	-$5,941,986,115	-$5,941,986,115	-$5,941,986,115	-$5,941,986,115	-$5,941,986,115	-$5,941,986,115	-$5,941,986,115	-$5,941,986,115	**-$47,535,888,922**
Residential …mental health … facilities	-$12,613,599	-$12,613,599	-$12,613,599	-$12,613,599	-$12,613,599	-$12,613,599	-$12,613,599	-$12,613,599	**-$100,908,792**
Offices of Physicians	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	**-$869,866,198**
Offices of dentists	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	**-$3,161,320**
Outpatient care centers	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	**-$1,422,361,752**
Other ambulatory health care services	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	**-$678,148,576**
Total	**-$6,326,291,945**	**-$6,326,291,945**	**-$6,326,291,945**	**-$6,326,291,945**	**-$6,326,291,945**	**-$6,326,291,945**	**-$6,326,291,945**	**-$6,326,291,945**	**-$50,610,335,560**

'Residential …mental health … facilities' refers to the IMPLAN sector for residential mental retardation, mental health, substance abuse and other facilities.

Scenario 2: Impact on Employment

The waiver funding difference between Scenario 2 and HHSC's Planned Transition (Scenario 1) would result in the loss of employment, which IMPLAN projections measures in 'job years'. As a result of receiving funding for managed care without supplementals or new programs in Scenario 2, approximately 62,000 jobs (full-time, part-time, and temporary) on average would be generated each year, which is approximately 74,000 fewer jobs than in HHSC's Planned Transition (Scenario 1). That would be a total of 592,000 fewer FTE jobs between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

"Direct" job losses would occur in the healthcare sectors directly impacted by the loss of waiver funding and would average 32,000 fewer direct jobs each year than HHSC's Planned Transition (Scenario 1). Jobs would also be lost in other industries. Suppliers of the healthcare industry, such as food service, janitorial, and accounting firms, would experience decreased demand, leading to "indirect" job loss averaging 19,000 fewer jobs each year. The employment loss also includes those lost due to the "induced effect" of workers spending less at restaurants, retail stores, and other local businesses and would average 23,000 fewer jobs each year between 2023 and 2030.

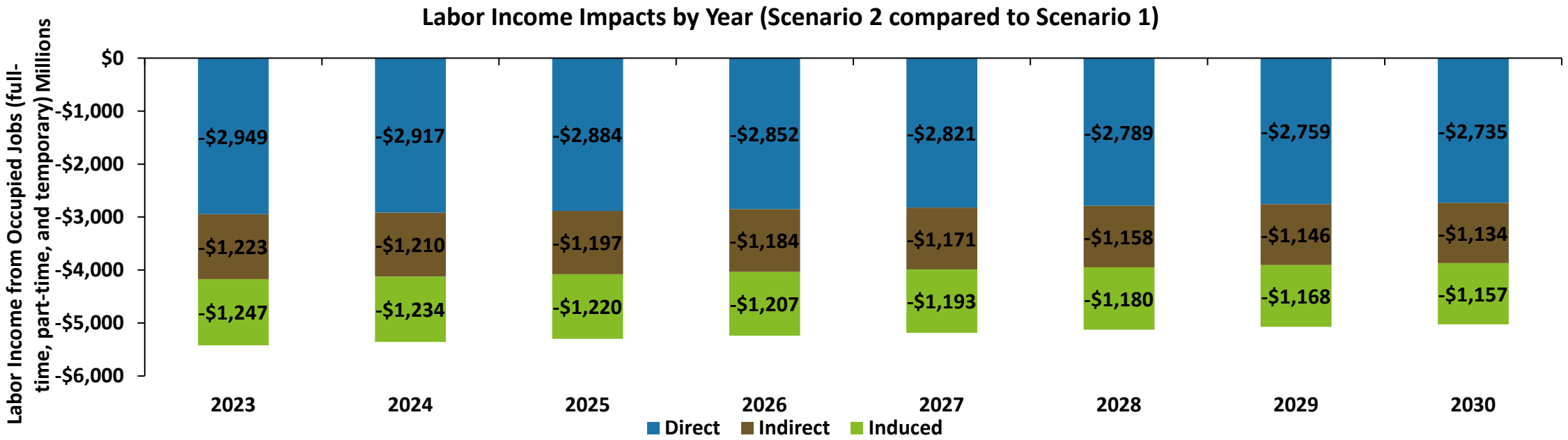


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5 year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs.

Scenario 2: Impact on Compensation

Using the employment modeling across multiple sectors, IMPLAN also extrapolates labor income paid to the workforce.* The modeling suggests that funding managed care without supplementals or new programs in Scenario 2, Texans would earn an average of $3.8 billion income each year, which is $5.2 billion less each year than in HHSC's Planned Transition (Scenario 1). That would be a total of $41.7 billion less in labor income between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

"Direct" labor income loss would average $2.8 billion less each year than HHSC's Planned Transition (Scenario 1). "Indirect" labor income from suppliers of healthcare would lose an average $1.2 billion each year. Workers spending less would result in "induced" labor income loss that is projected to be an average of $1.2 billion less each year.



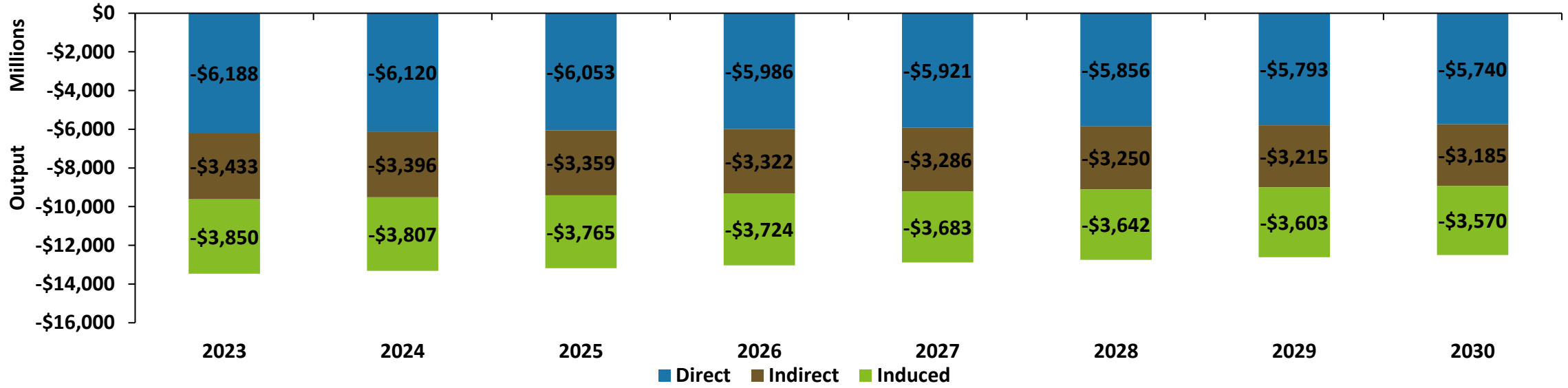
* Labor Income is the sum of employee compensation (wages and benefits) and proprietor income. Employee Compensation, is the total payroll cost of wage and salary employees to the employer. This includes wages and salaries, all benefits (e.g., health, retirement) and payroll taxes (both sides of social security, unemployment insurance taxes, etc.). It is also referred to as fully-loaded payroll. Proprietor Income consists of payments received by self-employed individuals and unincorporated business owners.

Scenario 2: Impact on Output

Output, which refers to the value of intermediate and final goods produced in a time period, is one metric the IMPLAN model produces to size and gauge economic impact. This approach to modeling economic impact estimates that funding managed care without supplementals or new programs in Scenario 2 could lead to an economic output of $9.4 billion each year, which is $13.0 billion less than in HHSC's Planned Transition (Scenario 1). That would be a total loss of $103.7 billion output along Texas's supply chain across all sectors between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

The table summarizes the output loss between 2023 and 2030 due to the waiver funding difference between Scenario 2 and HHSC's Planned Transition (Scenario 1). This includes the losses in direct output from the healthcare industry sectors, the indirect output from on suppliers, and the induced effect of reduced spending by affected workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the State's economy.

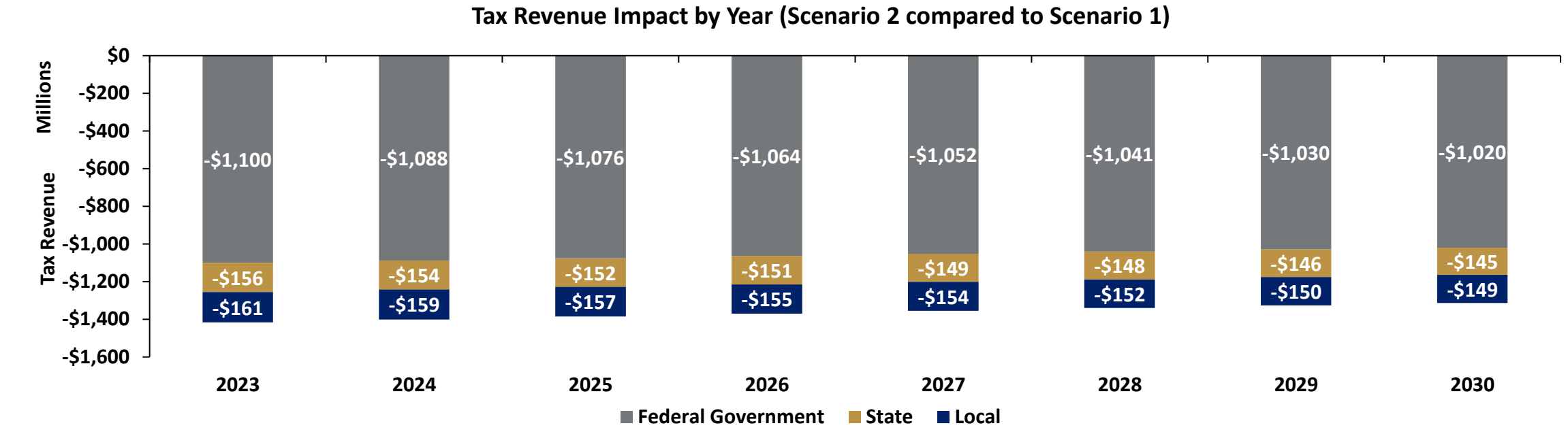
Output Impacts by Year (Scenario 2 compared to Scenario 1)



Scenario 2: Impact on Tax Revenue

Economic activity related to receiving funding for managed care without supplementals or new programs (Scenario 2) could generate $7.9 billion in federal, state and local tax revenue between 2023 and 2030, which is $10.9 billion less than HHSC's Planned Transition (Scenario 1). Medicaid waiver funding supports jobs in the healthcare industry and at healthcare suppliers, and the income that these workers spend locally supports jobs in a variety of industries. The Texans who hold these healthcare, restaurant, and other jobs pay federal and state income and sales taxes. The spending also increases the state's corporate profit tax revenues, along with some other smaller taxes and fees. If HHSC receives funding for managed care without supplementals or new programs (Scenario 2) as compared to HHSC's Planned Transition (Scenario 1), the loss of waiver funding would spur a loss of these types of tax revenues.

The table breaks down by year, the projected tax revenue loss due to the waiver funding difference between Scenario 2 and HHSC's Planned Transition (Scenario 1).

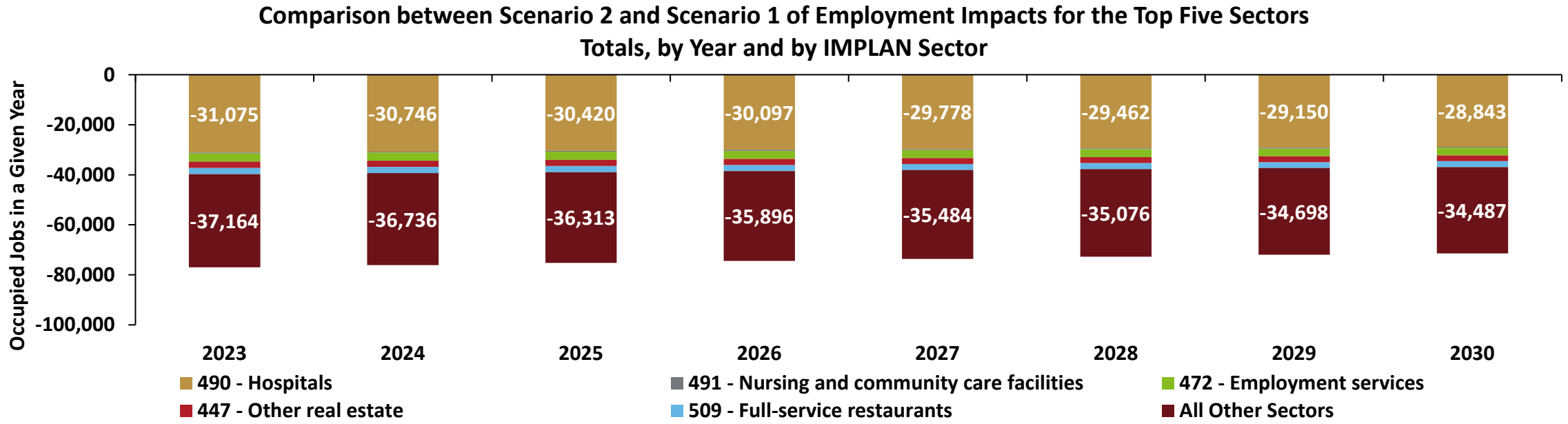


* Federal tax revenue is a combination of taxes for employee compensation, production and imports, households, and enterprises (corporations). Local tax revenue is a combination of taxes assessed by counties, general sub-counties, and special districts.

Scenario 2: Employment Loss by Sector

The table shows a breakdown of the top five sectors impacted in terms of projected loss of employment measured in 'job years' due to the waiver funding difference between Scenario 2 and HHSC's Planned Transition (Scenario 1). Of the total of 592,000 fewer FTE jobs across all sectors between 2023 and 2030, these five sectors combined account for 307,000 of those lost FTE jobs, or 52%.

Comparing the employment impact from Scenario 2 to HHSC's Planned Transition (Scenario 1), IMPLAN projections suggest the Hospital sector would lose 240,000 total FTE jobs between 2023 and 2030, which is an average 30,000 FTE jobs each year. In 2019, the Hospital sector employed approximately 334,000 total FTE jobs, so the average annual loss of 30,000 FTE jobs represents about a 9% loss to the Hospital sector's employment. The other top four industry sectors impacted would lose about 8,000 FTE jobs each year between 2023 and 2030.



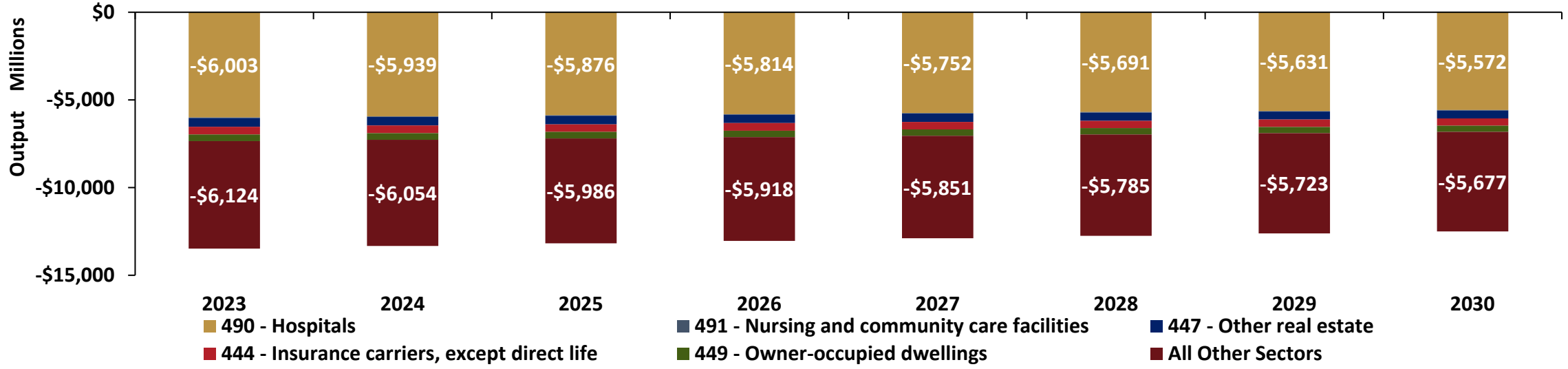
* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5 year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs. For comparison purposes, the top five sectors impacted are from HHSC's Planned Transition in Scenario 1.

Scenario 2: Impact on Output by Sector

The table summarizes the total output* loss in the top five sectors impacted from 2023 to 2030 due to the waiver funding difference between Scenario 2 and HHSC's Planned Transition (Scenario 1). Of the total $103.7 billion output loss across all sectors between 2023 and 2030, these five sectors combined account for $56.6 billion of the lost output, or 55%.

Comparing the output impact from Scenario 2 to HHSC's Planned Transition (Scenario 1), IMPLAN projections suggest 45% of the total output loss would be in the Hospital sector, losing $46.3 billion in total output between 2023 and 2030, or an average annual loss of $5.8 billion each year. The other top four industry sectors impacted would represent about 10% of the output loss, or roughly $10.4 billion in total output loss between 2023 and 2030.

Comparison between Scenario 2 and Scenario 1 of Output Impacts for the Top Five Sectors
Totals, by Year and by IMPLAN Sector



* Total Output is the sum of three different types of impacts: direct effects, indirect effects, and induced effects. This includes the direct effect on the healthcare industry sectors, the indirect effect on suppliers, and the induced effect of reduced spending by affected healthcare workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the state's economy. For comparison purposes, the top five sectors impacted are from HHSC's Planned Transition in Scenario 1.

No Waiver Funding for Programs (Scenario 3)

- Economic Impact Summary
- Funding under Scenario 3
- Comparative Impact on Medicaid Providers
- Comparative Impact on Employment
- Comparative Impact on Compensation
- Comparative Impact on Output
- Comparative Impact on Tax Revenue
- Comparative Employment for Top Five Sectors
- Comparative Output for Top Five Sectors

Texas Does Not Receive Any Funding	
Scenario 3 - No Programs at all	**Comparative Loss from Planned Transition to Scenario 3**
	No Change to DSRIP
	Loss of UC
	No Change to UHRIP
	Loss of QIPP
✓ NAIP for Physicians - ends on Aug 2022	No Change to NAIP
✓ NAIP for Hospitals - ends on Aug 2027	No Change to NAIP
	Loss of CHIRP
	Loss of TIPPS
	Loss of RAPPS
	Loss of DPP for DHS
$272,807,891 in SFY2023	**-$10,753,989,045**

Scenario 3: Economic Impact Summary

If HHSC receives no waiver funding for programs, healthcare providers would lose payments from UC, QIPP, and Directed Payment Programs (specifically with CHIRP, TIPPS, RAPPS, and DPP for BHS), and there would still be no DSRIP or UHRIP. Providers would receive payments from NAIP. These payments to providers would be $273 million each year between 2023 and 2027, then $0 between 2028 and 2030. Compared to HHSC's Planned Transition (Scenario 1), these payments would be about $10.8 billion less than Scenario 1 each year between 2023 and 2030 to providers, or $86 billion less than Scenario 1 in total.

Between 2023 and 2030, Texas employment is projected to have one million fewer jobs than HHSC's Planned Transition (Scenario 1), and Texans are projected to lose $70.7 billion in labor income. Texas would generate $95.3 billion less in value-added state GSP, $176.0 billion less in total economic output, and $18.5 billion less in federal, state and local tax revenue.

The Hospital sector would be the most impacted sector in terms of losses to employment and economic output.

ECONOMIC IMPACT COMPARISON SUMMARY (EMPLOYMENT, LABOR INCOME, VALUE ADDED, AND OUTPUT) BETWEEN SCENARIO 3 AND HHSC's PLANNED TRANSITION (SCENARIO 1)						
Year	**Total Medicaid Providers Payment Loss**	**Total Employment FTE Count Loss**	**Total Labor Income Loss**	**Total Value-Added Loss**	**Total Output Loss**	**Total Tax Revenue Loss**
2023	-$10,753,989,045	-138,681	-$9,191,443,669	-$12,394,167,407	-$22,882,787,730	-$2,410,638,552
2024	-$10,753,989,045	-137,081	-$9,087,541,080	-$12,254,431,130	-$22,625,166,859	-$2,383,410,799
2025	-$10,753,989,045	-135,500	-$8,984,847,990	-$12,116,315,069	-$22,370,526,425	-$2,356,499,491
2026	-$10,753,989,045	-133,938	-$8,883,349,733	-$11,979,799,690	-$22,118,830,614	-$2,329,900,802
2027	-$10,753,989,045	-132,395	-$8,783,031,833	-$11,844,865,707	-$21,870,044,064	-$2,303,610,954
2028	-$10,753,989,045	-130,870	-$8,683,879,998	-$11,711,494,079	-$21,624,131,860	-$2,277,626,219
2029	-$10,753,989,045	-129,436	-$8,589,662,237	-$11,584,523,869	-$21,389,782,887	-$2,221,207,013
2030	-$10,753,989,045	-128,018	-$8,496,470,475	-$11,458,935,146	-$21,157,982,649	-$2,197,174,298
Total	**-$86,031,912,364**	**-1,065,919**	**-$70,700,227,013**	**-$95,344,532,097**	**-$176,039,253,089**	**-$18,480,068,127**

Scenario 3: No Programs Funded by the Waiver

If no programs are funded by the waiver except for NAIP, the table shows the payments for the NAIP program, by year to Medicaid providers by IMPLAN sector. These payments to providers would be $273 million each year between 2023 and 2027, then $0 between 2028 and 2030.

Prog.	IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030
NAIP for Physicians and Hospitals		**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$0**	**$0**	**$0**
	Hospitals	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$272,807,891	$0	$0	$0
Total Medicaid Providers Payments in Scenario 3		**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$272,807,891**	**$0**	**$0**	**$0**

These amounts were inputted into IMPLAN to determine the economic impacts from Scenario 3, then the economic impacts were compared to those from HHSC's Planned Transition described in Scenario 1.

Scenario 3: Impact on Medicaid Providers

TEXAS Health and Human Services

The loss of waiver funding in Scenario 3 represents about $10.8 billion in total payment loss to Medicaid providers between 2023 and 2030 when compared to HHSC's Planned Transition (Scenario 1). Most of the funding loss would be to hospitals, $73.9 billion or 86%. The remaining funding loss would be for providers in other IMPLAN sectors such as Residential Mental Health Facilities, Physicians Offices, Dentist Offices, Outpatient Care Centers, Other Ambulatory Health Care, and Nursing and Community Care Facilities.

The table shows the payment loss to Medicaid providers by IMPLAN sector due to the waiver funding difference between Scenario 3 and HHSC's Planned Transition (Scenario 1).

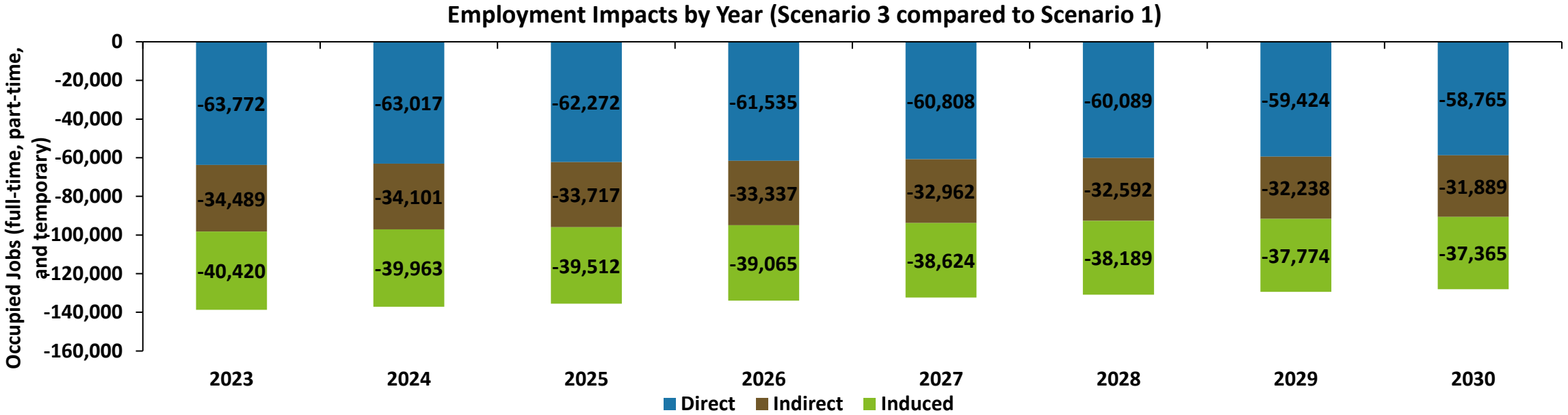
WAIVER FUNDING LOSS BY IMPLAN SECTOR BETWEEN SCENARIO 3 AND HHSC's PLANNED TRANSITION (SCENARIO 1)

IMPLAN Sector	2023	2024	2025	2026	2027	2028	2029	2030	Grand Total
Hospitals	-$9,240,786,872	-$9,240,786,872	-$9,240,786,872	-$9,240,786,872	-$9,240,786,872	-$9,240,786,872	-$9,240,786,872	-$9,240,786,872	**-$73,926,294,972**
Residential …mental health … facilities	-$41,509,944	-$41,509,944	-$41,509,944	-$41,509,944	-$41,509,944	-$41,509,944	-$41,509,944	-$41,509,944	**-$332,079,549**
Offices of Physicians	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	-$108,733,275	**-$869,866,198**
Offices of dentists	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	-$395,165	**-$3,161,320**
Outpatient care centers	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	-$177,795,219	**-$1,422,361,752**
Other ambulatory health care services	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	-$84,768,572	**-$678,148,576**
Nursing and community care facilities	-$1,100,000,000	-$1,100,000,000	-$1,100,000,000	-$1,100,000,000	-$1,100,000,000	-$1,100,000,000	-$1,100,000,000	-$1,100,000,000	**-$8,799,999,997**
Total	**-$10,753,989,045**	**-$10,753,989,045**	**-$10,753,989,045**	**-$10,753,989,045**	**-$10,753,989,045**	**-$10,753,989,045**	**-$10,753,989,045**	**-$10,753,989,045**	**-$86,031,912,364**

Scenario 3: Impact on Employment

The waiver funding difference between Scenario 3 and HHSC's Planned Transition (Scenario 1) would result in the loss of employment, which IMPLAN projections measures in 'job years'. As a result of receiving no program funding in the waiver except for NAIP, approximately 2,000 jobs (full-time, part-time, and temporary) on average would be generated each year, which is approximately 133,000 fewer jobs than in HHSC's Planned Transition (Scenario 1). That would be a total of one million fewer FTE jobs between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

"Direct" job losses would occur in the healthcare sectors directly impacted by the loss of waiver funding and would average 61,000 fewer direct jobs each year than HHSC's Planned Transition (Scenario 1). Jobs would also be lost in other industries. Suppliers of the healthcare industry, such as food service, janitorial, and accounting firms, would experience decreased demand, leading to "indirect" job loss averaging 33,000 fewer jobs each year. The employment loss also includes those lost due to the "induced effect" of workers spending less at restaurants, retail stores, and other local businesses and would average 39,000 fewer jobs each year between 2023 and 2030.

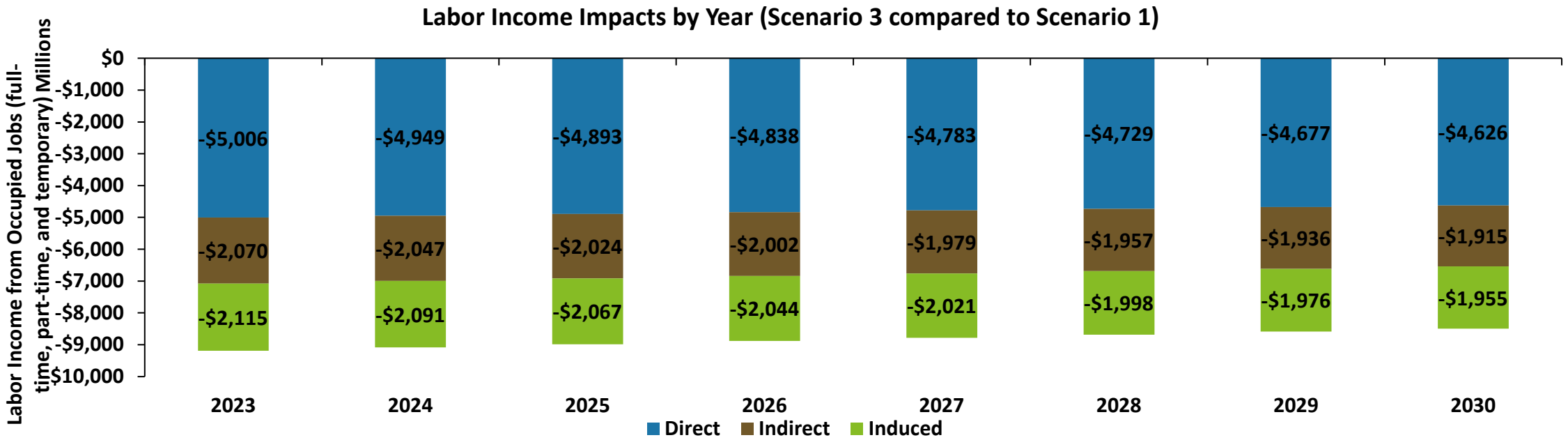


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5-year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs.

Scenario 3: Impact on Compensation

Using the employment modeling across multiple sectors, IMPLAN also extrapolates labor income paid to the workforce.* The modeling suggests that receiving no program funding in the waiver except for NAIP, Texans would earn an average of $141 million income each year, which is $8.8 billion less each year than in HHSC's Planned Transition (Scenario 1). That would be a total of $70.7 billion less in labor income between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

"Direct" labor income loss would average $4.8 billion less each year than HHSC's Planned Transition (Scenario 1). "Indirect" labor income from suppliers of healthcare would lose an average $2.0 billion each year. Workers spending less would result in "induced" labor income loss that is projected to be an average of $2.0 billion less each year.

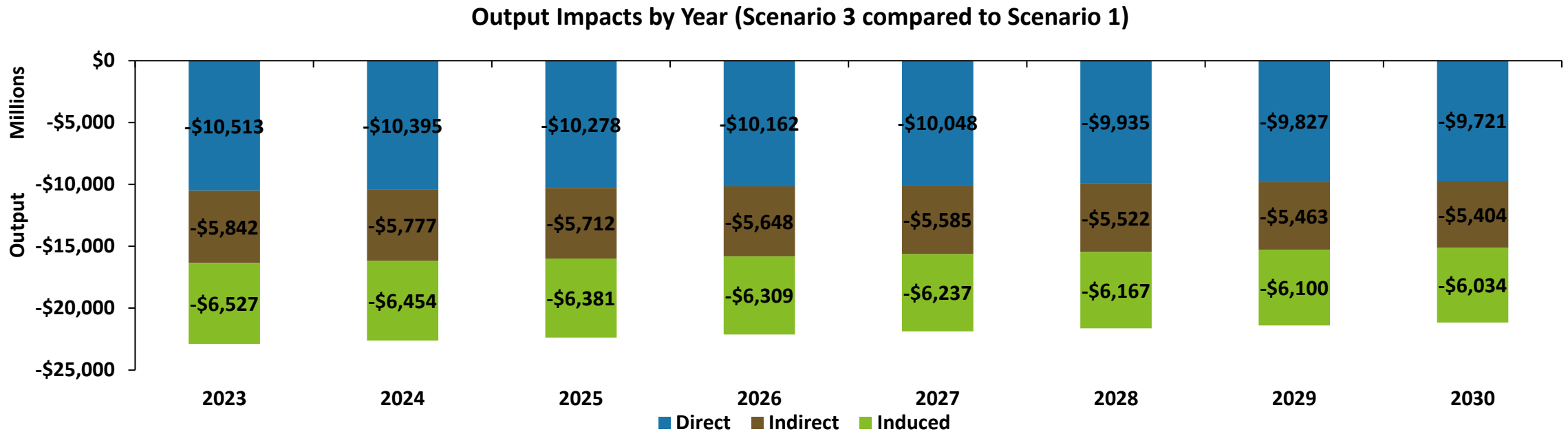


* Labor Income is the sum of employee compensation (wages and benefits) and proprietor income. Employee Compensation, is the total payroll cost of wage and salary employees to the employer. This includes wages and salaries, all benefits (e.g., health, retirement) and payroll taxes (both sides of social security, unemployment insurance taxes, etc.). It is also referred to as fully-loaded payroll. Proprietor Income consists of payments received by self-employed individuals and unincorporated business owners.

Scenario 3: Impact on Output

Output, which refers to the value of intermediate and final goods produced in a time period, is one metric the IMPLAN model produces to size and gauge economic impact. This approach to modeling economic impact estimates that receiving no program funding in the waiver except for NAIP could lead to an economic output of $356 million each year, which is $22.0 billion less than in HHSC's Planned Transition (Scenario 1). That would be a total loss of $176.0 billion output along Texas's supply chain across all sectors between 2023 and 2030 than HHSC's Planned Transition (Scenario 1).

The table summarizes the output loss between 2023 and 2030 due to the waiver funding difference between Scenario 3 and HHSC's Planned Transition (Scenario 1). This includes the losses in direct output from the healthcare industry sectors, the indirect output from on suppliers, and the induced effect of reduced spending by affected workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the State's economy.

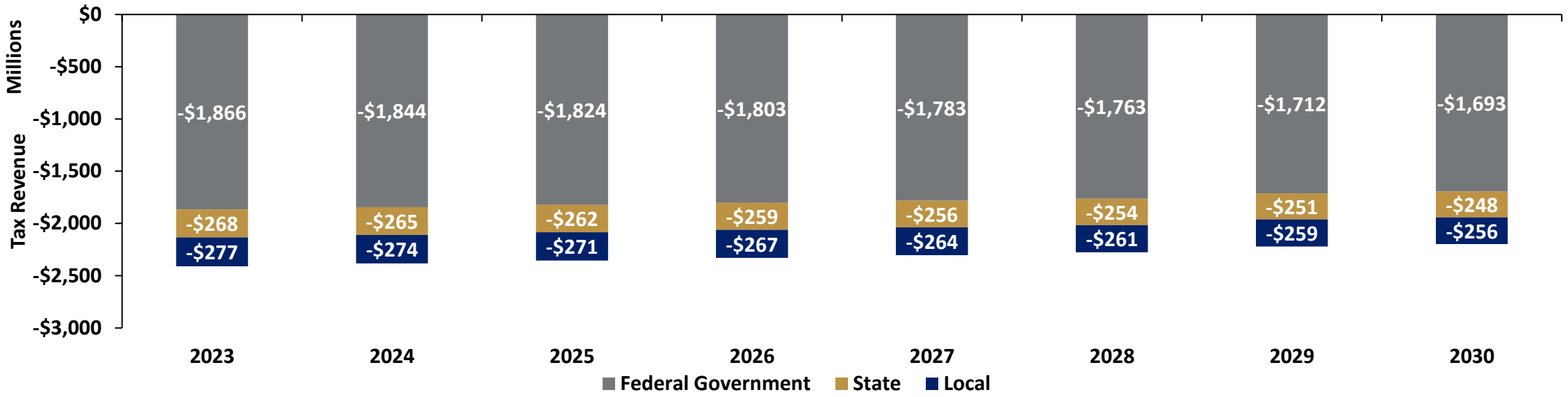


Scenario 3: Impact on Tax Revenue

Economic activity related to receiving no program funding in the waiver except for NAIP (Scenario 3) could generate $360 million in federal, state and local tax revenue between 2023 and 2030, which is $18.5 billion less than HHSC's Planned Transition (Scenario 1). Medicaid waiver funding supports jobs in the healthcare industry and at healthcare suppliers, and the income that these workers spend locally supports jobs in a variety of industries. The Texans who hold these healthcare, restaurant, and other jobs pay federal and state income and sales taxes. The spending also increases the state's corporate profit tax revenues, along with some other smaller taxes and fees. If HHSC receives no program funding in the waiver except for NAIP (Scenario 3) as compared to HHSC's Planned Transition (Scenario 1), the loss of waiver funding would spur a loss of these types of tax revenues.

The table breaks down by year, the projected tax revenue loss due to the waiver funding difference between Scenario 3 and HHSC's Planned Transition (Scenario 1).

Tax Revenue Impact by Year (Scenario 3 compared to Scenario 1)



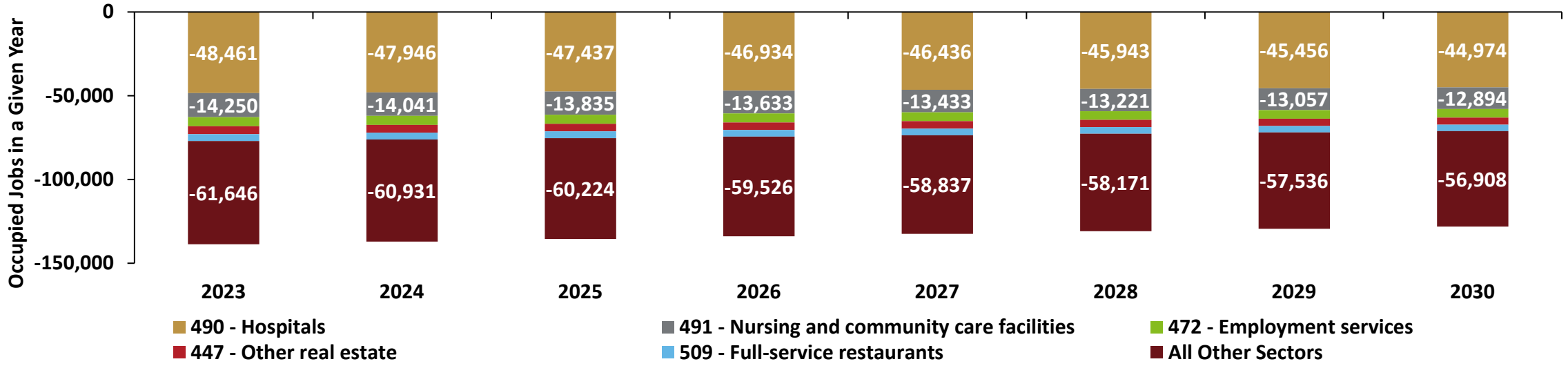
* Federal tax revenue is a combination of taxes for employee compensation, production and imports, households, and enterprises (corporations). Local tax revenue is a combination of taxes assessed by counties, general sub-counties, and special districts.

Scenario 3: Employment Loss by Sector

The table shows a breakdown of the top five sectors impacted in terms of projected loss of employment measured in 'job years' due to the waiver funding difference between Scenario 3 and HHSC's Planned Transition (Scenario 1). Of the total of one million fewer FTE jobs across all sectors between 2023 and 2030, these five sectors combined account for 592,000 of those lost FTE jobs, or 56%.

Comparing the employment impact from Scenario 3 to HHSC's Planned Transition (Scenario 1), IMPLAN projections suggest the Hospital sector would lose 374,000 total FTE jobs between 2023 and 2030, which is an average 47,000 FTE jobs each year. In 2019, the Hospital sector employed approximately 334,000 total FTE jobs, so the average annual loss of 47,000 FTE jobs represents about a 14% loss to the Hospital sector's employment. The Nursing and Community Care Facilities sector would lose 108,000 FTE jobs between 2023 and 2030, or an average 14,000 FTE jobs each year. In 2019, the Nursing Facilities sector employed approximately 163,000 total FTE jobs, so the average annual loss of 14,000 FTE jobs represents about an 8% loss to the Nursing Facilities sector's employment. The other top three industry sectors impacted would lose about 14,000 FTE jobs each year between 2023 and 2030.

Comparison between Scenario 3 and Scenario 1 of Employment Impacts for the Top Five Sectors Totals, by Year and by IMPLAN Sector

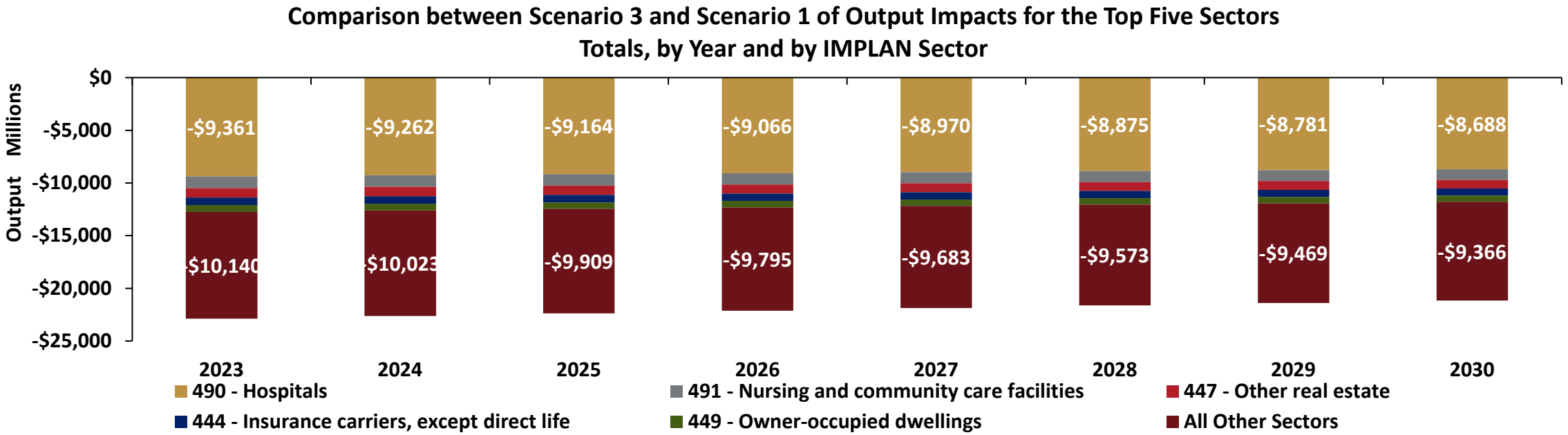


* Employment impacts in IMPLAN are reported in 'job years'; the number of positions that are filled over a given year, as a result of the project. For example, a construction worker on a 5 year contract would count as 5 job years. IMPLAN reports both full-time and part-time jobs. For comparison purposes, the top five sectors impacted are from HHSC's Planned Transition in Scenario 1.

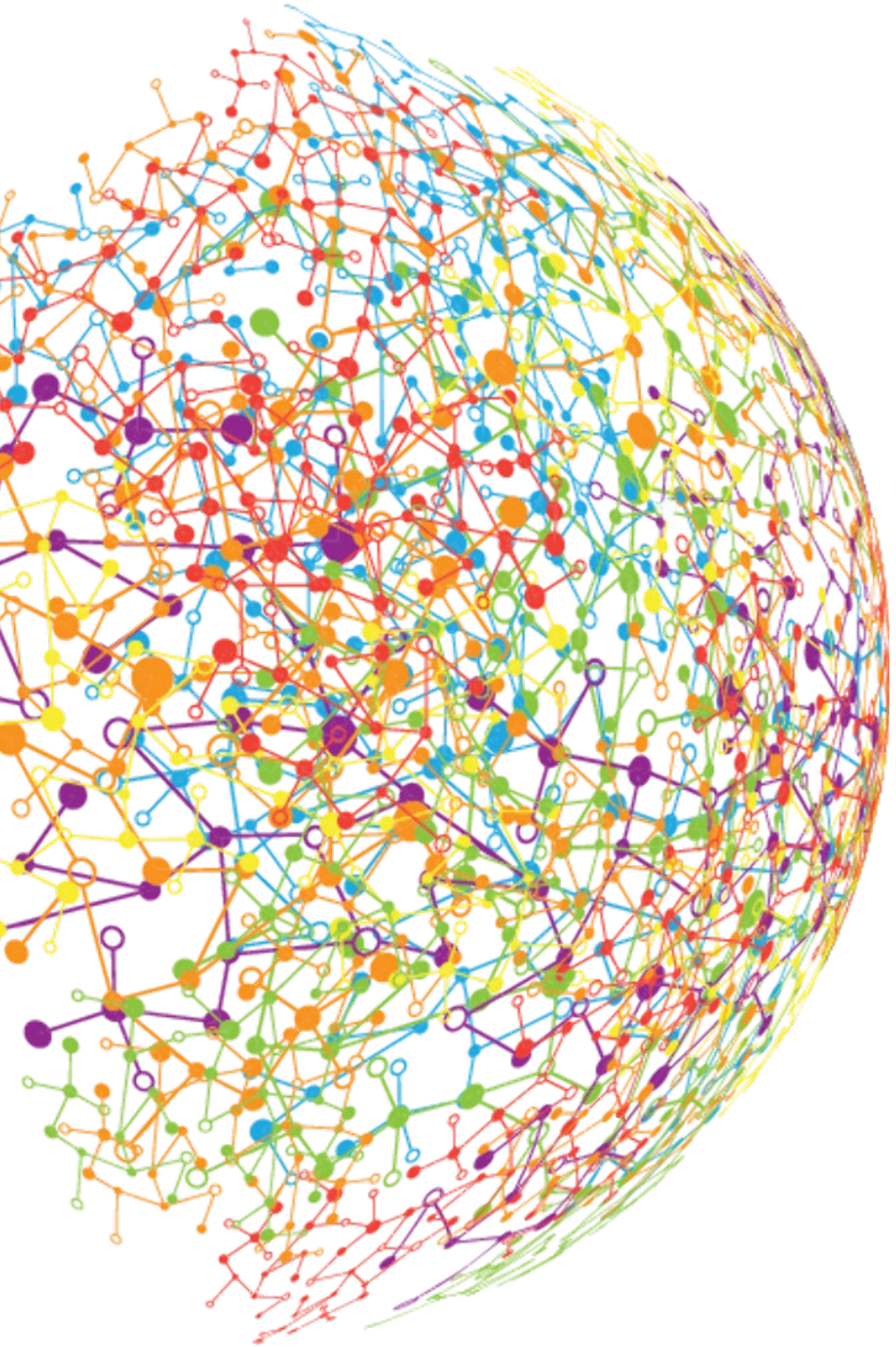
Scenario 3: Output Loss by Sector

The table summarizes the total output* loss in the top five sectors impacted from 2023 to 2030 due to the waiver funding difference between Scenario 3 and HHSC's Planned Transition (Scenario 1). Of the total $176 billion output loss across all sectors between 2023 and 2030, these five sectors combined account for $98 billion of the lost output, or 56%.

Comparing the output impact from Scenario 3 to HHSC's Planned Transition (Scenario 1), IMPLAN projections suggest 41% of the total output loss would be in the Hospital sector, losing $72.2 billion in total output between 2023 and 2030, or an average annual loss of $9 billion each year. The other top four industry sectors impacted would represent about 15% of the output loss, or roughly $25.9 billion in total output loss between 2023 and 2030.



* Total Output is the sum of three different types of impacts: direct effects, indirect effects, and induced effects. This includes the direct effect on the healthcare industry sectors, the indirect effect on suppliers, and the induced effect of reduced spending by affected healthcare workers in their communities. This estimate also reflects multiple rounds of effects as the dollars circulate through the state's economy. For comparison purposes, the top five sectors impacted are from HHSC's Planned Transition in Scenario 1.



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Health and Human Services

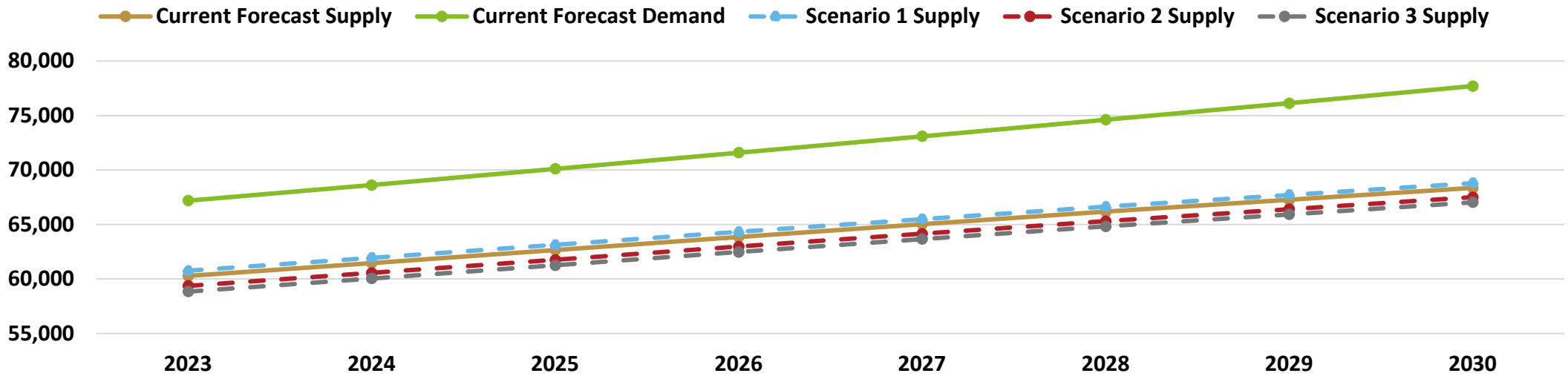
Section 2

Forecast provider shortages as result of Medicaid waiver funding loss

Physician Shortage Forecast (1/2)

Based on the scenarios' projections, the physician shortage in Texas is likely to become worse in coming years and could lead to unmet demand of up to 14% by 2030.

Physician Employment Impact of The Three Scenarios In Comparison to Texas's Physician Supply and Demand Projections



Percent of Demand Unmet by Scenario, By Year

	2023	2024	2025	2026	2027	2028	2029	2030
Current Forecast / Status Quo	10.3%	10.4%	10.6%	10.8%	11.0%	11.3%	11.6%	12.0%
1	9.6%	9.7%	10.0%	10.1%	10.4%	10.7%	11.1%	11.4%
2	11.6%	11.7%	11.9%	12.0%	12.2%	12.5%	12.8%	13.1%
3	12.4%	12.5%	12.6%	12.7%	12.9%	13.1%	13.4%	13.7%

Sources:
1. Texas's Physician Supply and Demand Projections, Texas Health Data - Workforce Supply & Demand Projections (Health Professions Resource Center and Texas Center for Nursing Workforce Studies at the Texas Department of State Health Services).
2. Using IMPLAN, economic impact projections of employment within the Physicians' Offices sector were conducted for different waiver funding scenarios (see Section 1 of this report).

Physician Shortage Forecast (2/2)

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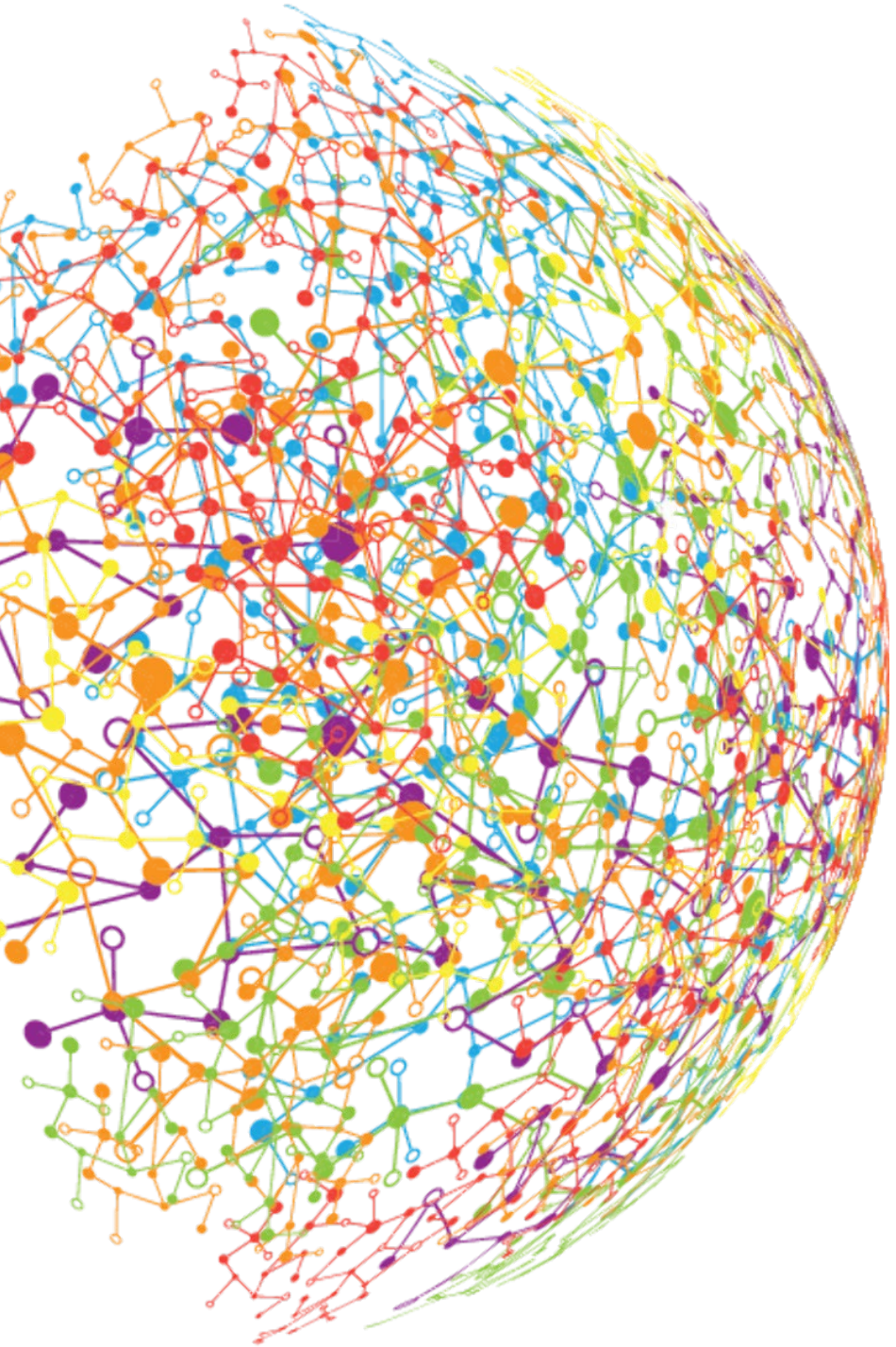
The employment losses for Physicians Offices, as projected by IMPLAN, could impact the supply of Physicians (all specialties) across Texas.

		2023	2024	2025	2026	2027	2028	2029	2030
Current DSHS Forecast (includes Prior Waiver Funding)	Current DSHS Forecast Supply	60,275	61,466	62,658	63,862	65,031	66,180	67,266	68,362
	Physician FTEs attributed from Status Quo Funding in Prior Waiver	1,464	1,448	1,432	1,416	1,400	1,354	1,340	1,325
	Current DSHS Forecast Demand	67,190	68,618	70,113	71,595	73,096	74,623	76,140	77,703
	% Met Demand	**89.7%**	**89.6%**	**89.4%**	**89.2%**	**89.0%**	**88.7%**	**88.3%**	**88.0%**
Scenario 1	Physician FTEs from Scenario 1	1,948	1,926	1,905	1,883	1,863	1,812	1,792	1,773
	Net New Physician FTEs (= Physician FTEs from Scenario 1 Compared to Physician FTEs attributed from Status Quo Funding in Prior Waiver)	+484	+478	+473	+467	+463	+458	+452	+448
	Scenario 1 Supply (= Current Supply + Net New Physician FTEs)	60,759	61,944	63,131	64,329	65,494	66,638	67,718	68,810
	Current DSHS Forecast Demand	67,190	68,618	70,113	71,595	73,096	74,623	76,140	77,703
	% Met Demand	**90.4%**	**90.3%**	**90.0%**	**89.9%**	**89.6%**	**89.3%**	**88.9%**	**88.6%**
Scenario 2	Physician FTEs from Scenario 2	557	540	534	528	522	486	480	474
	Net New Physician FTEs (= Physician FTEs from Scenario 2 Compared to Physician FTEs attributed from Status Quo Funding in Prior Waiver)	-907	-908	-898	-888	-878	-868	-860	-851
	Scenario 2 Supply (= Current Supply + Net New Physician FTEs)	59,368	60,558	61,760	62,974	64,153	65,312	66,406	67,511
	Current DSHS Forecast Demand	67,190	68,618	70,113	71,595	73,096	74,623	76,140	77,703
	% Met Demand	**88.4%**	**88.3%**	**88.1%**	**88.0%**	**87.8%**	**87.5%**	**87.2%**	**86.9%**
Scenario 3	Physician FTEs from Scenario 3	32	31	31	31	30	0	0	0
	Net New Physician FTEs (= Physician FTEs from Scenario 3 Compared to Physician FTEs attributed from Status Quo Funding in Prior Waiver)	-1,432	-1,417	-1,401	-1,385	-1,370	-1,354	-1,340	-1,325
	Scenario 3 Supply (= Current Supply + Net New Physician FTEs)	58,843	60,049	61,257	62,477	63,661	64,826	65,926	67,037
	Current DSHS Forecast Demand	67,190	68,618	70,113	71,595	73,096	74,623	76,140	77,703
	% Met Demand	**87.6%**	**87.5%**	**87.4%**	**87.3%**	**87.1%**	**86.9%**	**86.6%**	**86.3%**

Sources:
1. Texas's Physician Supply and Demand Projections, Texas Health Data - Workforce Supply & Demand Projections (Health Professions Resource Center and Texas Center for Nursing Workforce Studies at the Texas Department of State Health Services).
2. Using IMPLAN, economic impact projections of employment within the Physicians' Offices sector were conducted for different waiver funding scenarios (see Section 1 of this report).



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Section 3

Share timelines of attracting new providers and standing up new practices

Re-Building Provider Capacity in Texas

TEXAS Health and Human Services

If the State of Texas and providers lose Section 1115 Medicaid waiver funding, providers may exit the market, which can take significant time, energy and resources to rebuild in the future

PROCESS OF ESTABLISHING NEW PROVIDER PRACTICES[1]

HIGH-LEVEL PHASE	DURATION
Build/Acquire Facilities With permitting and regulatory hurdles, **creating a healthcare a facility takes substantial time/money**. If using an existing brick and mortar facility, the investment would be smaller but can still take several months to obtain a lease and certifications/licensures/accreditation and develop a working healthcare facility.	6-12 months
Recruit Physicians Following a market contraction**, recruiting skilled physicians and specialists is more difficult** as they are not likely to join an organization unless they have a brand worth joining and a place where they believe their practice can become successful – this is exasperated by the existing shortage in specialty care.	6-12 months
Establish Practice and Physicians Depending on the region of Texas and current population, growing patient volume to **reach median levels of productivity takes significant time**. This is dependent upon location, service area, demand, and other factors that could either shorten or lengthen the projected duration.	18-24 months

If Texas loses provider capacity due to the loss of the waiver, it could take **upwards of 2.5 - 4 years to rebuild capacity** to pre-exit levels – in addition to ample investment and resources.

[1]Based on client experience and industry experience from subject matter experts

Re-Building Provider Capacity in Texas

TEXAS Health and Human Services

Additional considerations in re-building provider capacity may accelerate or decelerate the timeline established on the prior slide

ROADBLOCKS

Regulations on Transparency Pricing[1]

- Hospitals and health systems are expected to face more competition, simplify pricing strategies, and offer patients accurate estimates assist consumers in making health care decisions

Smaller Talent Pool

- Providers and hospitals are concerned about the future of the health care workforce as the recruitment pool for nurses and other health care workers has continued to shrink
- Even if Texas can temporarily close facilities while waiting for potential funding, the closure could result in human capital being permanently lost as talent scatters to new professions or localities

Safety

- Hospitals reported that vaccination efforts were positive steps toward pandemic recovery, but they are still challenged with access to vaccinations for rural, senior, and low-income populations, as well as personal hesitation

ACCELERATORS

Existing Facilities

- Being able to develop a healthcare facility in an existing facility shortens ramp-up time by about a year by almost eliminating the first step in rebuilding capacity (see previous slide)

Virtual Health

- The future of healthcare delivery will likely necessitate a more permanent expansion in telehealth, remote care, and outpatient delivery which will shorten the duration necessary to “build facilities”

“Right-sizing“ Health Care Facilities

- The delivery system is changing to deliver non-acute care in lower-cost outpatient settings that better match the scope and acuity of patients’ needs and are conveniently located and accessible to patients (e.g., ASCs)

[1] Example regulations on Transparency Pricing include the Hospital Price Transparency Rule effective in January 2021, Transparency in Coverage Rule effective in January 2022, No Surprises Act effective in January 2022, and Medicare OPPS and ASC 2020 Final Rule

Re-Building Provider Capacity: Rural vs. Urban

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Recruiting providers and establishing or re-establishing practices in rural Texas will take significant time, energy and resources – at least 2-3 times longer than in urban areas – and may not be successful[1]

CONSIDERATIONS FOR RURAL PROVIDERS

Even Smaller Talent Pool

Due to the lower reimbursement rates and difference in lifestyle, it is more difficult to recruit new physicians to live and work in rural areas with significant Medicaid populations. This may not be as successful once providers exit the market

Riskiness of Reopening Practice

Many providers in rural areas have their own practice and if these close due to loss of funding, it is a difficult, risky road back to rebuild their practice mid- to late in their career

Social Determinants of Health (SDoH)

The Medicaid population oftentimes has SDoH, care management needs, and complex and chronic conditions that all require a certain set of skills to be held by physicians, specialists and providers

Virtual Health and Infrastructure are Key

In order to mitigate many of these considerations, telehealth/telemedicine and a supportive healthcare system are critical in ensuring providers from around the state (or even broader) can provide care to the rural Medicaid population – this is heavily reliant on establishing technology infrastructure with ease of access to these populations

[1]Based on client experience and industry experience from subject matter experts

Re-Building Provider Capacity: Rural vs. Urban

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Not only are certain provider types harder to recruit in rural areas, but they are also even more important for the typical rural Medicaid population that is battling complex chronic conditions[1]

EFFORT OF RECRUITING PROVIDER IN RURAL AREAS

More Difficult in Rural Areas ← → **More Doable in Rural Areas**

Behavioral Health

- More difficult to recruit psychiatrists and the like to rural areas
- Unable to recruit even alternatives to physicians – such as APNs
- Virtual Health is proven to be a helpful vehicle for behavioral health services

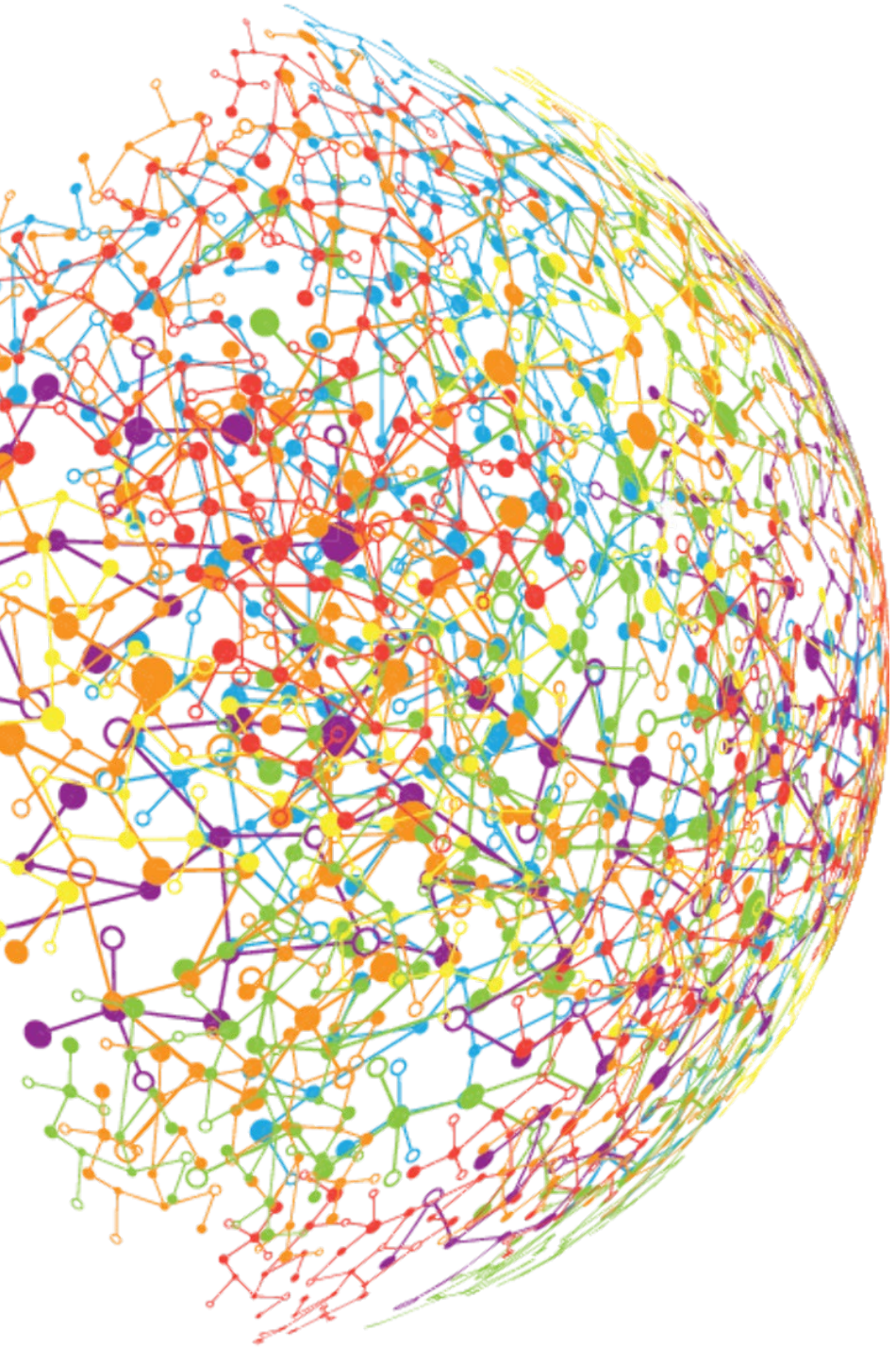
Endocrinologists, Cardiologists

- Important to have for the Medicaid population as Diabetes and Heart Disease is common
- Specialty providers are unlikely to establish themselves in an area with fewer potential people to serve
- Virtual health can help if telemedicine legislation is in favor of these outpatient services being covered

Primary Care

- They have an advantage of being able to apply for federally designated status to get a better rate for Medicare and Medicaid patients (e.g., Health Professional Shortage Area, Medically Underserved Area, Rural)
- Easier to recruit PCPs if there is an affiliated critical access hospital within 30 minutes

[1]Based on client experience and industry experience from subject matter experts



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Section 4

Analyze the market contraction and recovery, using the 2020 and 2021 COVID-19 provider surveys and research

Medicaid Enrollment Trends

DRAFT

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There are three different projection sources to consider when trending enrollment forward

Status Quo:

Modeling TX Medicaid Enrollment as if COVID-19 did not happen

- **2018-2019:** Actual Texas Medicaid enrollment trend
- **2020-2025:** 7-year average of 2013-2019 Texas Medicaid enrollment trend

Texas Waiver:

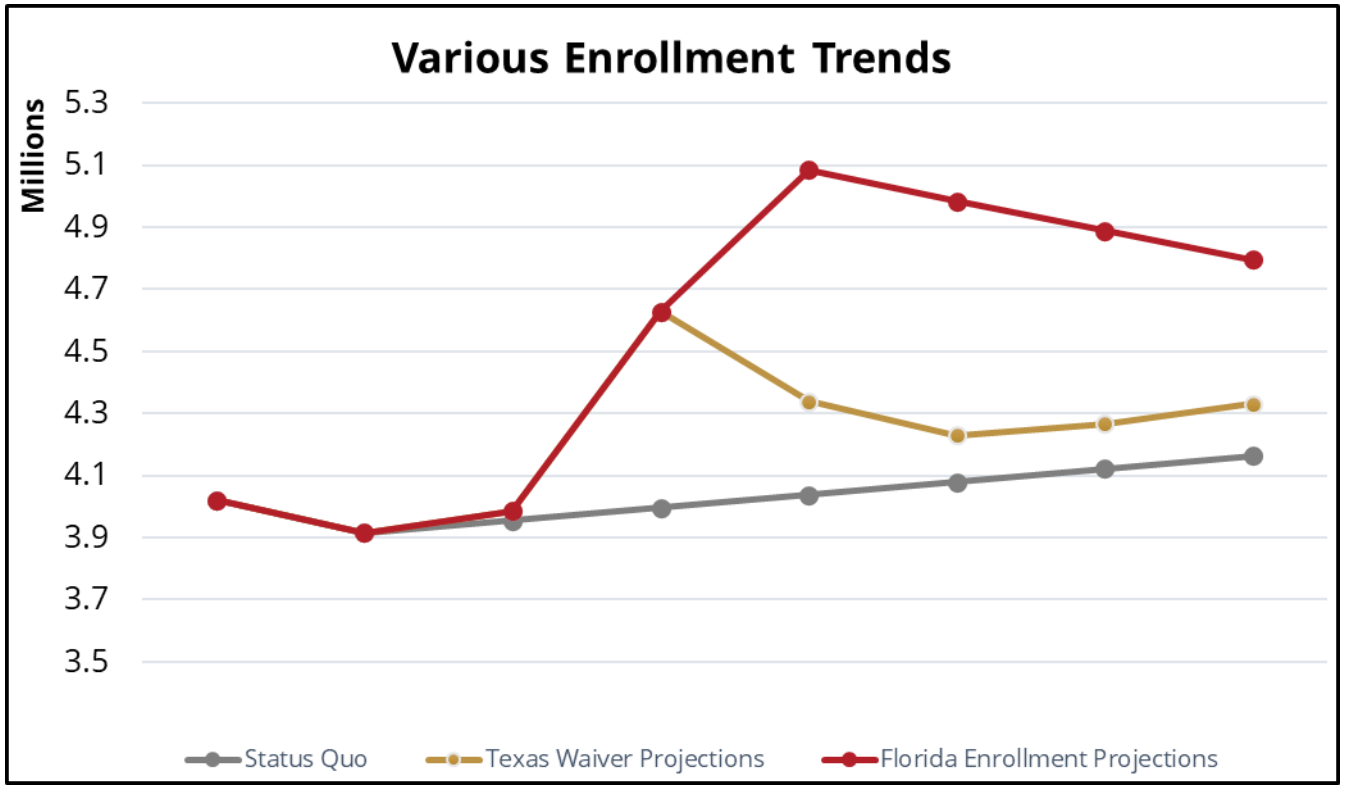
Modeling TX Medicaid Enrollment to historical trends in the TX Waiver application

- **2018-2021:** Actual Texas Medicaid enrollment trend **note that 2021 enrollment is only complete through June 2021 and may change*
- **2022-2025:** Trends documented in TX 1115 Waiver application

Florida Projections:

Modeling TX Medicaid Enrollment using Florida's recently updated Medicaid caseload trends post-COVID-19

- **2018-2021:** Actual Texas Medicaid enrollment trend **same caveat as above*
- **2022:** FL's expected rate adjusted **TX 2021 experience is ~40% lower than FL's 2021 projected trend, so FL's 2022 projected trend was adjusted to be 40% lower*
- **2023-2025:** Florida's expected enrollment trends[1]



	2018	2019	2020	2021	2022	2023	2024	2025
Status Quo	-1.1%	-2.7%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
TX Waiver	-1.1%	-2.7%	1.9%	16.1%	-6.2%	-2.5%	0.9%	1.5%
FL Project.	-1.1%	-2.7%	1.9%	16.1%	9.9%	-2.0%	-1.9%	-1.9%

Source: 1. FL Medicaid Caseload Summary July 2021. Social Services Estimating Conference Medicaid Caseload and Expenditures (state.fl.us). Note: Florida's total population is projected to grow, and the projected Medicaid per Capita is approximately 21-22% for FY2021 and future years. As a result of the caseload increases that have already materialized in FY2021, as well as the uncertainty arising from the future course of the current COVID-19 Public Health Emergency, Florida revised their projected Medicaid caseload for FY2021 and future years.

Medicaid PMPM Trends

DRAFT

There are also three different projection sources to consider when trending Texas PMPM forward

Status Quo:

Modeling TX Medicaid PMPM as if COVID-19 did not happen – does not include the Directed Payment Programs (DPPs)

- **2018-2019:** Actual Texas Medicaid PMPM
- **2020-2025:** 4-year average of 2016-2019 Texas Medicaid PMPM trend

Texas Waiver:

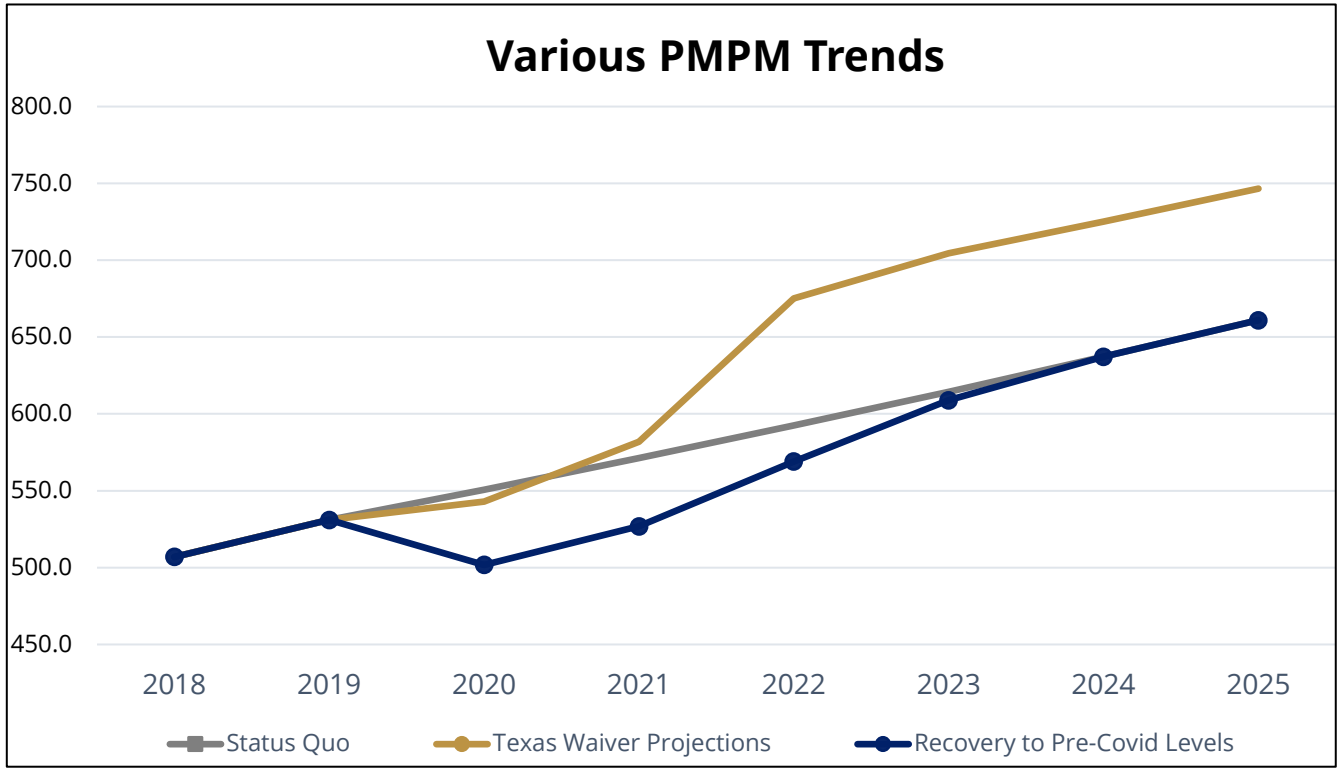
Modeling TX Medicaid PMPM according to historical trends in the TX Waiver application – does include DPPs

- **2018-2020:** Actual Texas Medicaid PMPM
- **2021-2025:** Trends documented in TX 1115 Waiver application

Economic Recovery:

Modeling TX Medicaid PMPM projection assumptions post-COVID-19 using actual Medicaid expenditures – not capitation rates

- **2018-2019:** Actual Texas Medicaid PMPM trend
- **2020:** Assumption of decreased Medicaid expenditures due to COVID-19 halting electives and preventive care
- **2021-2024:** Economic recovery increases PMPM eventually back to pre-COVID rates
- **2025:** Assumed back to status quo



	2018	2019	2020	2021	2022	2023	2024	2025
Status Quo	2.0%	4.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
TX Waiver	2.0%	4.7%	2.3%	7.2%	16.0%	4.4%	2.9%	3.0%
Recovery	2.0%	4.7%	-5.5%	5.0%	8.0%	7.0%	4.6%	3.7%

Status Quo

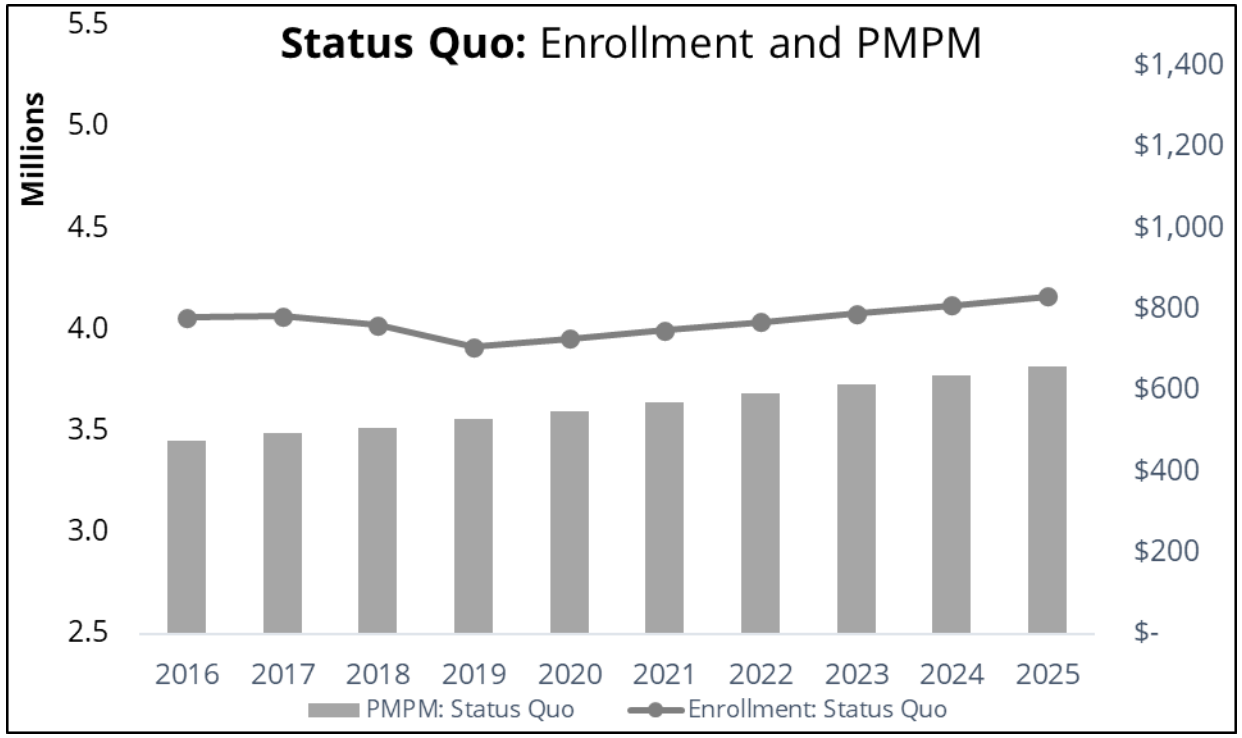
Texas Medicaid Enrollment and PMPM costs were historically modeled and projected forward at historical growth rates to allow for a comparison to various potential scenarios

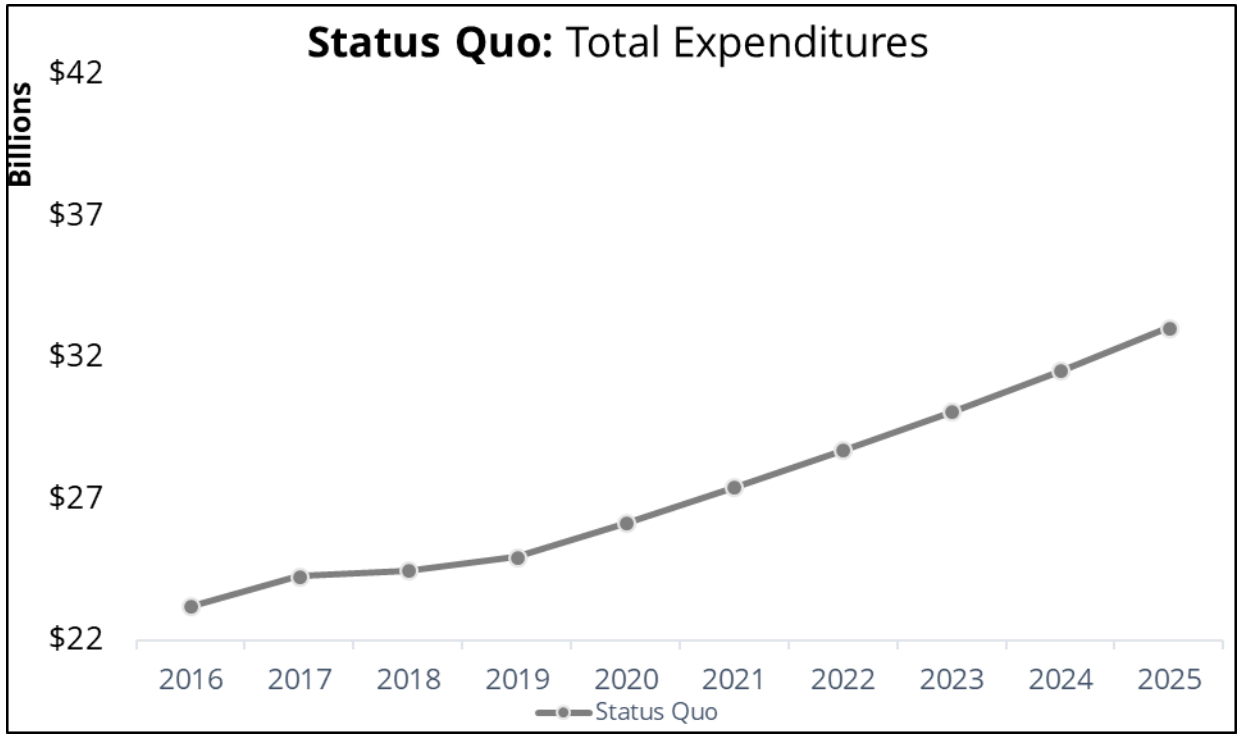
Considerations:

- If the COVID-19 pandemic had not happened, the Status Quo is most likely that Texas Medicaid PMPM's would have continued to increase at the historical rate and enrollment would have remained relatively constant

Status Quo Assumptions:

- Assumes 2019 PMPM continues to grow at Texas historical 4-year average from 2016-2019 (approximately 3.7%)
- Assumes 2019 Texas Medicaid enrollment continues to grow at historical growth rate (approximately 1%)





Scenario A: Texas Waiver Projections

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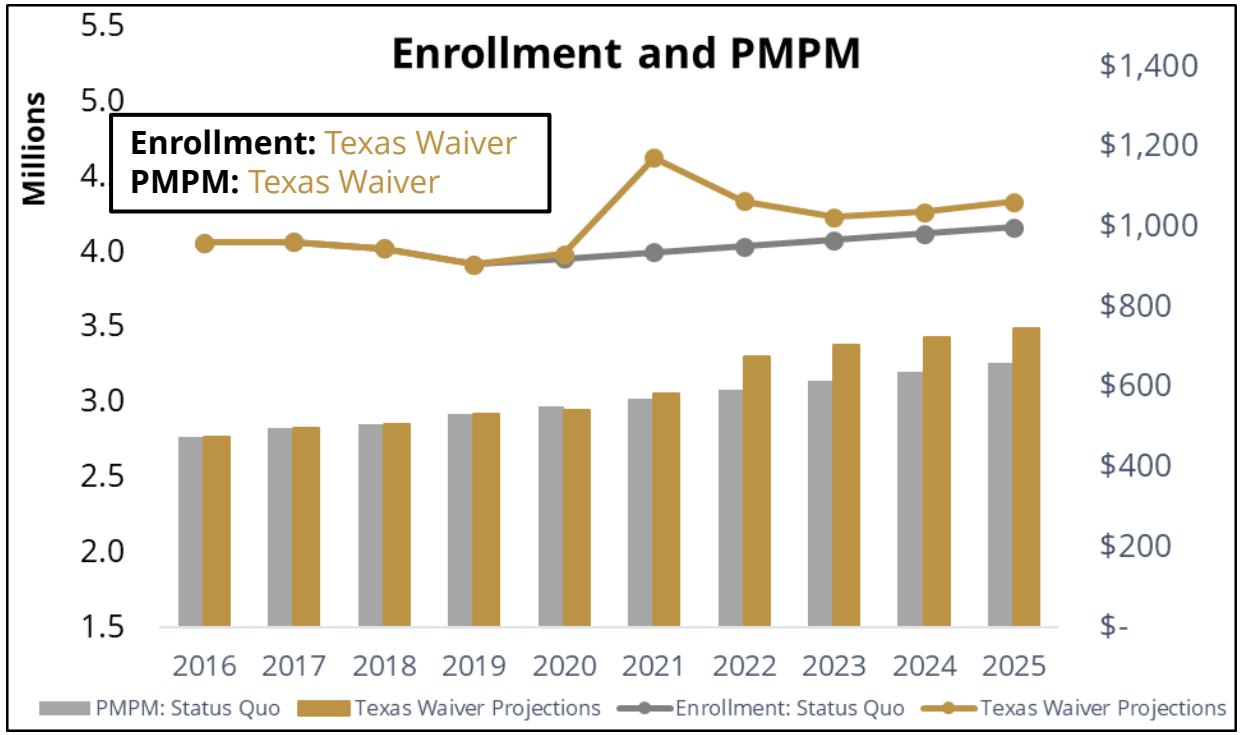
This scenario models both the PMPM and enrollment projections forecasted in the Texas 1115 Waiver Application

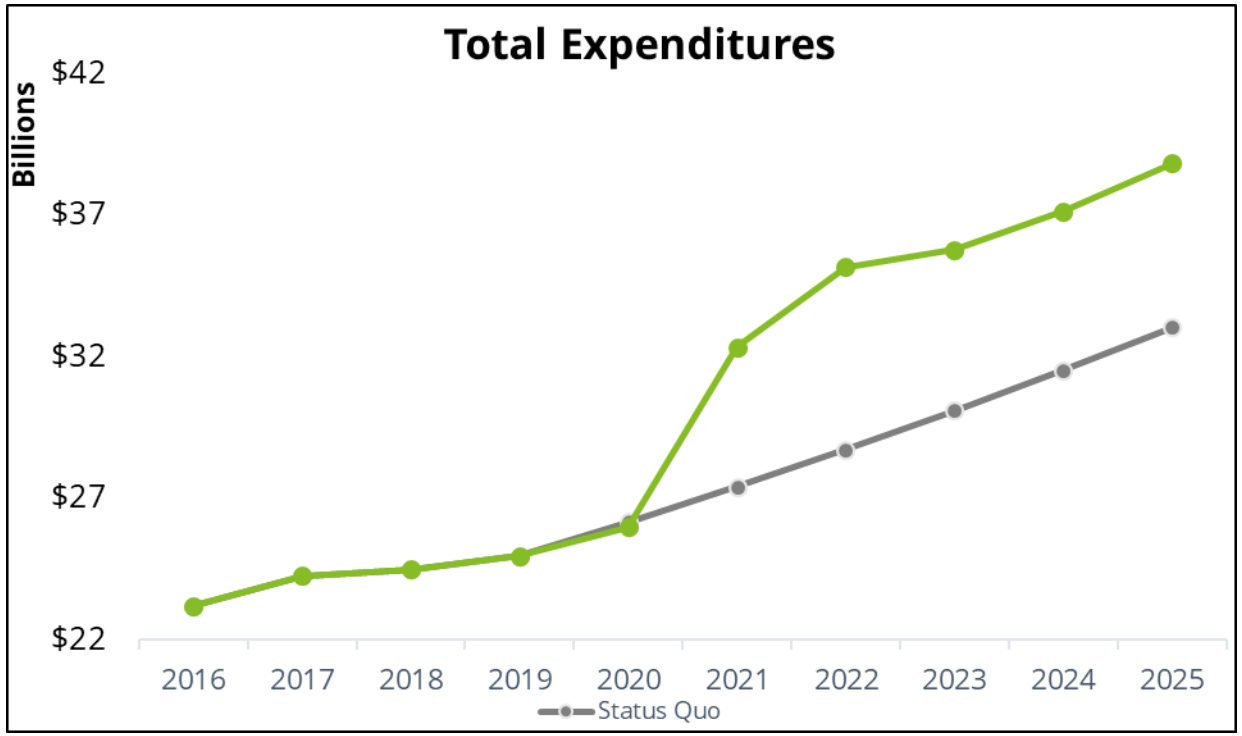
Considerations:

- Using the Texas enrollment and PMPM projections included in the 1115 Waiver application, total expenditures are projected to increase significantly in 2021 and remain well-above status quo from then on

Scenario A Assumptions:

- The estimated count of 2021 Texas Medicaid recipients experienced a 16.1% growth from 2020 before slowly decreasing back to near-status quo
- PMPM growth is expected to be 7.2% higher in 2021, followed by 16% in 2022





Scenario B: Texas Waiver and Econ Recovery

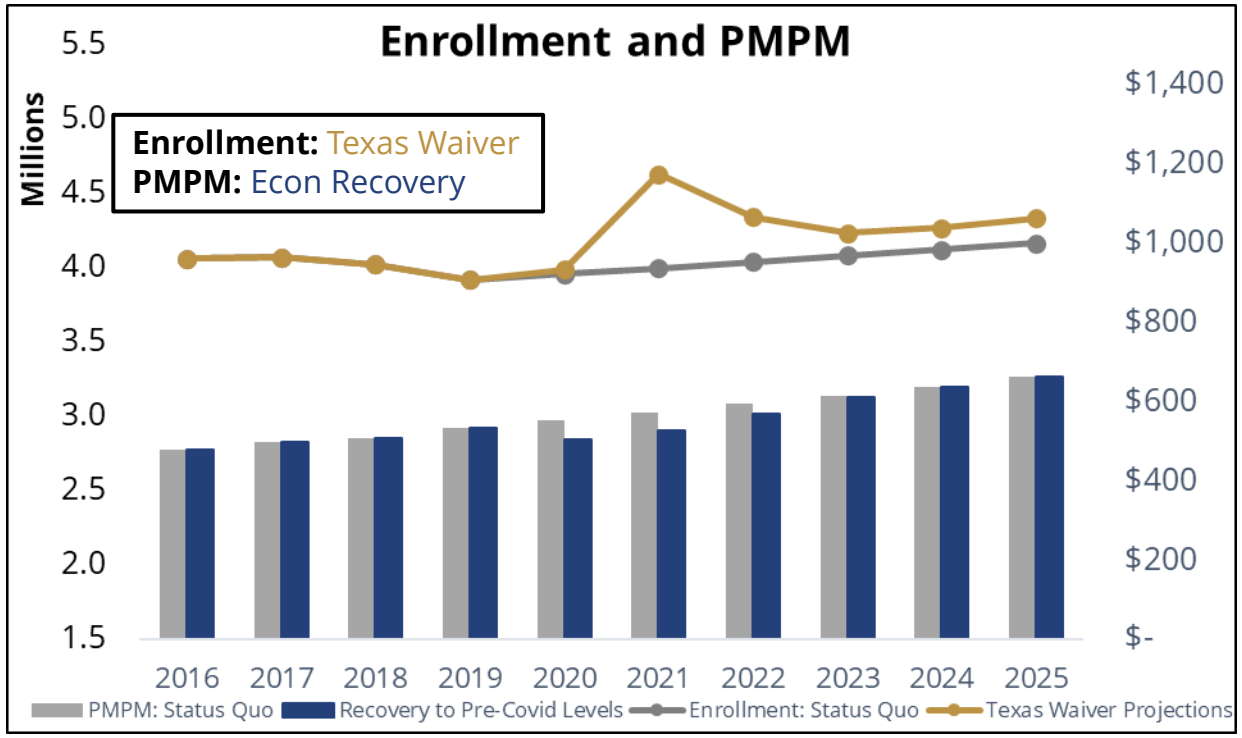
This scenario models enrollment projections from the Texas Waiver and economic recovery PMPM projections

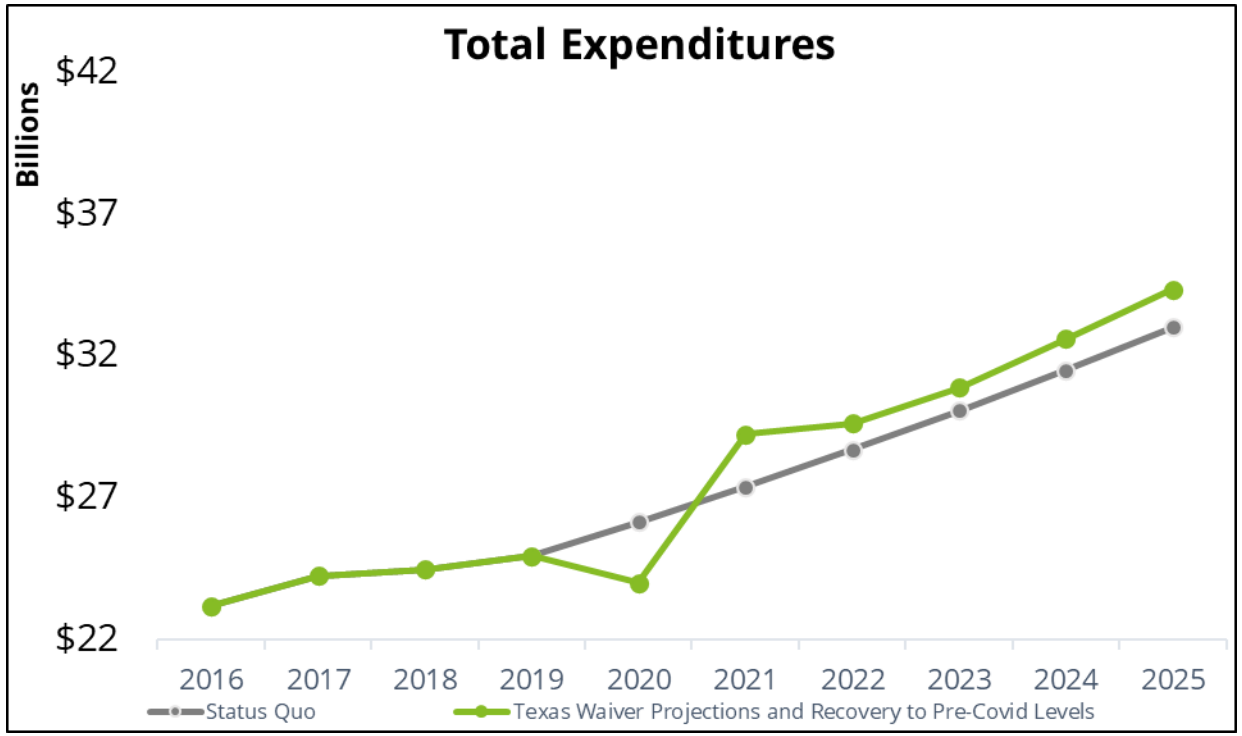
Considerations:

- Using Texas's enrollment projections, combined with the economic recovery PMPM scenario, the actual Medicaid expenditures dip in 2020, rise in 2021 due to the increase in enrollment, and then revert back to near-status quo in 2022 and beyond

Scenario B Assumptions:

- The estimated count of 2021 Texas Medicaid recipients experienced a 16.1% growth from 2020 before slowly decreasing back to status quo
- Healthcare PMPM is estimated to shrink in 2020 followed by a steady increase back to status quo by 2024





Scenario C: Florida Enrollment and Econ Recovery

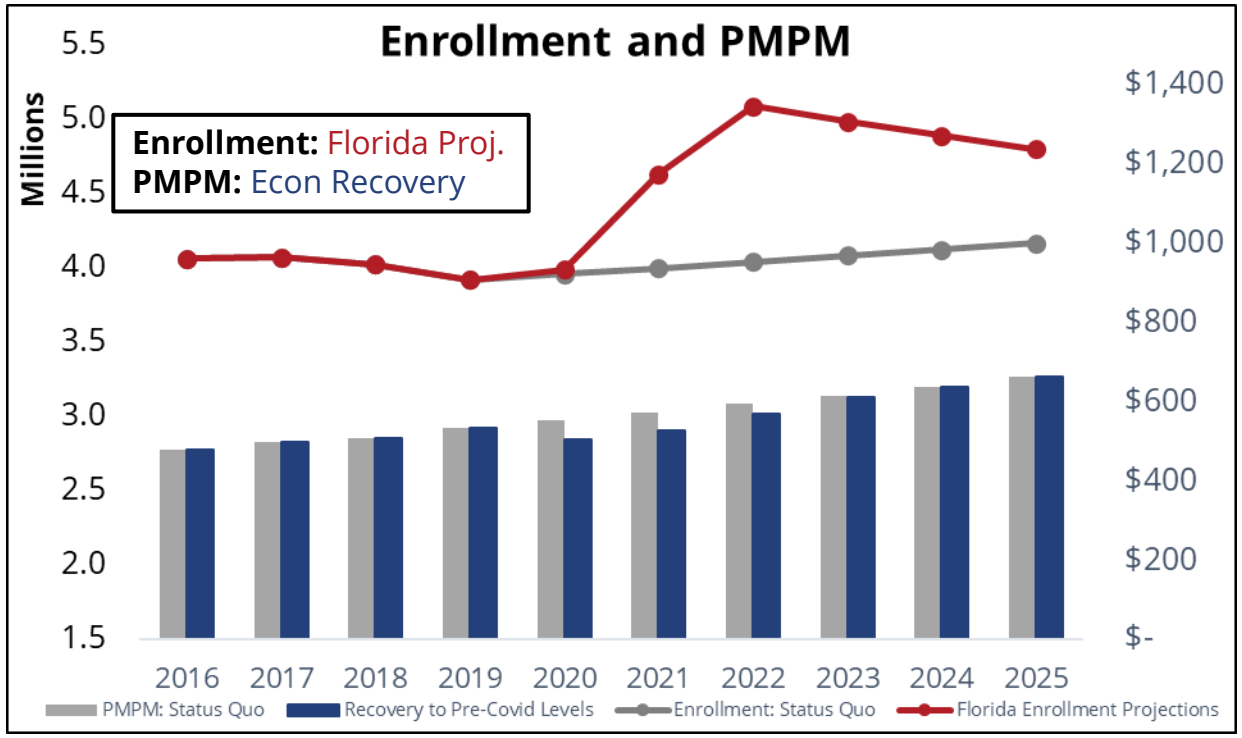
This scenario models enrollment projections based on Florida's estimates and PMPM projections forecasted off economic predictions

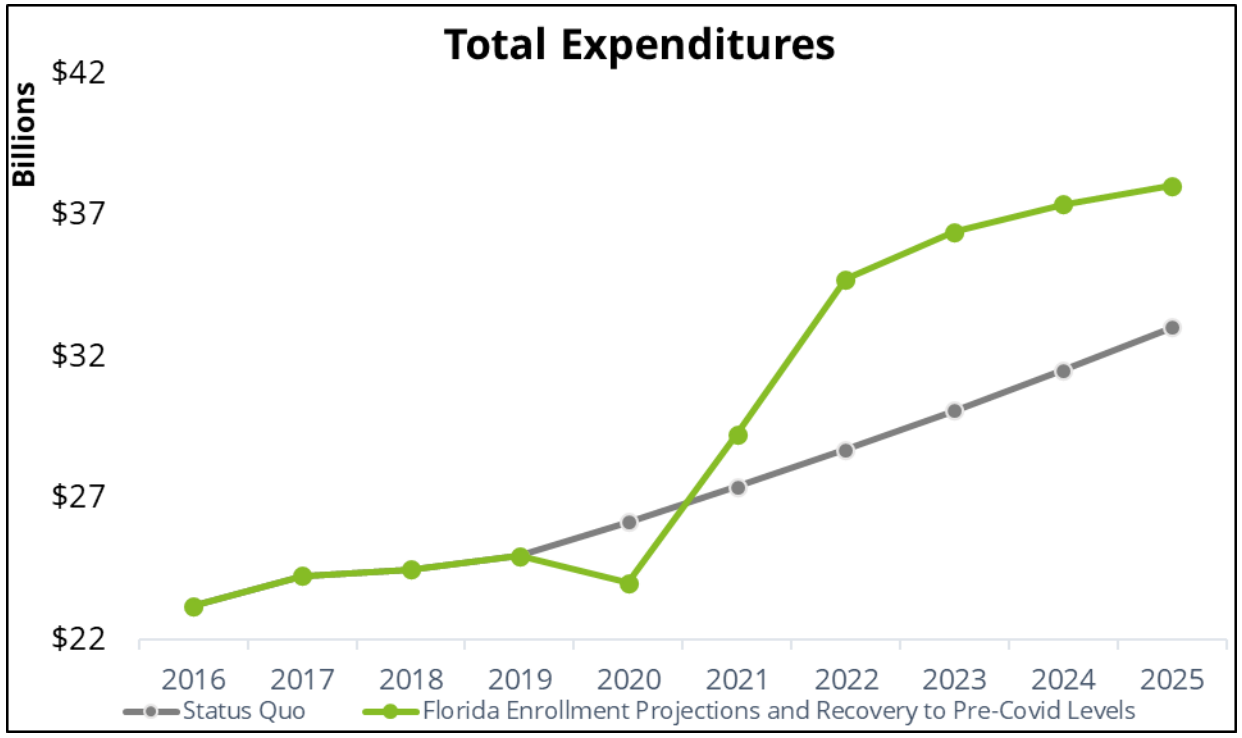
Considerations:

- US Health plan executives interviewed by HRI agreed that healthcare spending in 2022 would return to pre-pandemic baselines with some adjustments to account for the pandemic's persistent effects [1]

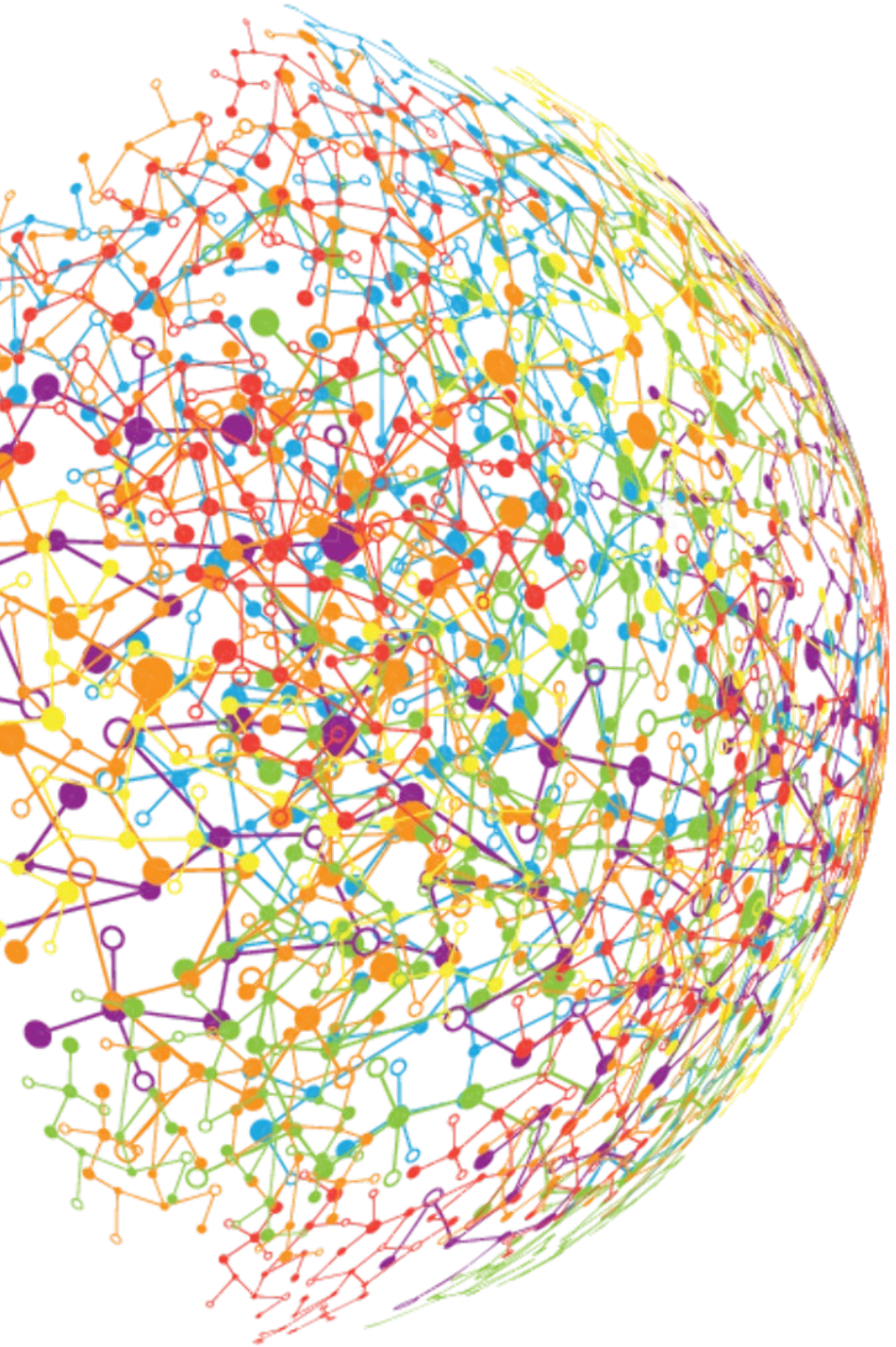
Scenario C Assumptions:

- The count of 2021 Texas Medicaid recipients is estimated to increase 16% in 2021, 10% in 2022, before slowly tapering off
- Healthcare PMPM is estimated to shrink in 2020 followed by a steady increase back to status quo by 2024





Source:
1. Medical cost trend: Behind the numbers 2022.



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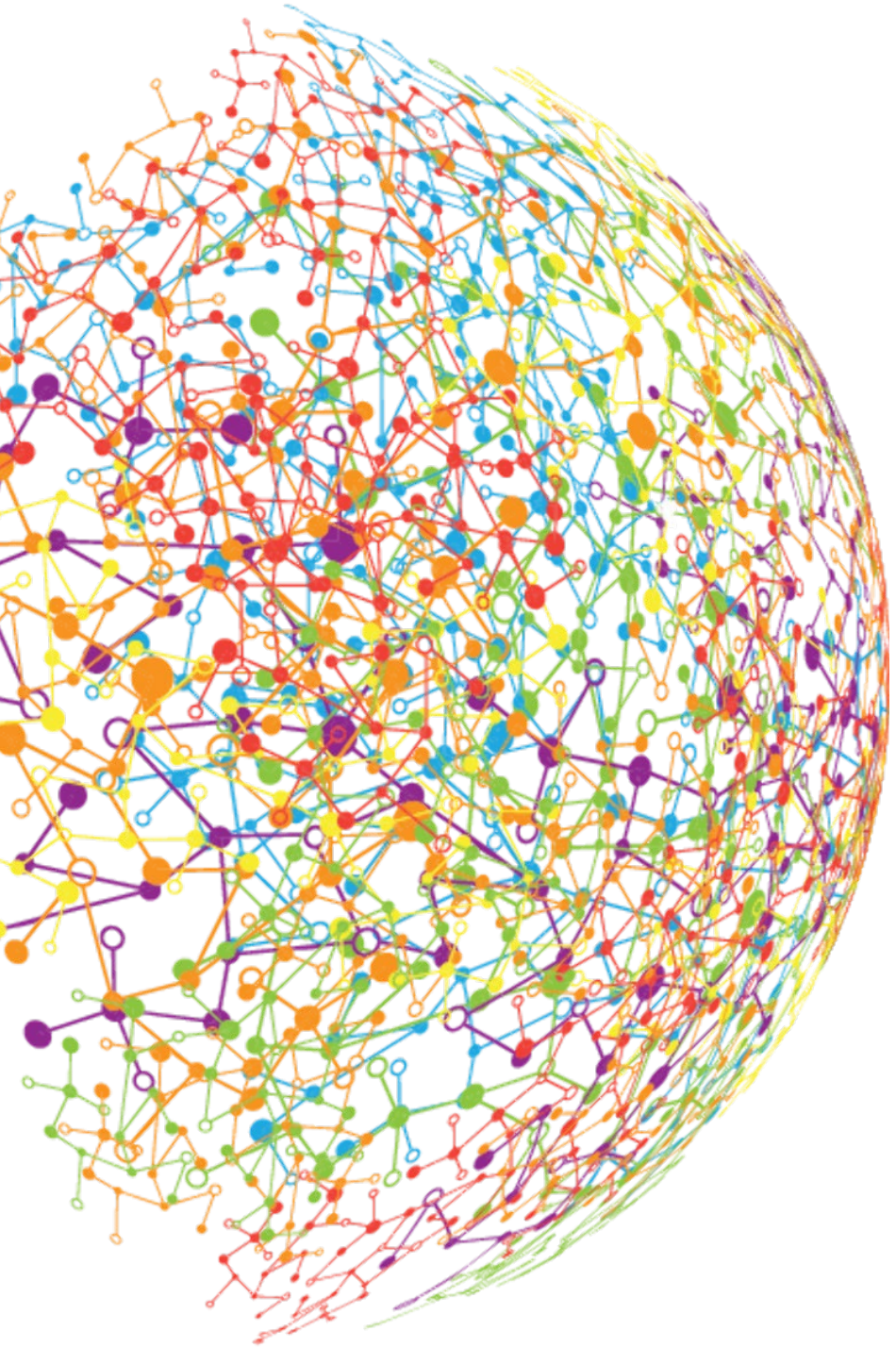
Appendices



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Appendix A

Details on the economic modeling using IMPLAN
(*Section 1*)

Industry-Standard Tool for Economic Modeling

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IMPLAN, an industry-standard model, is an economic impact analysis software that allows for the exploration of economic changes in a given region.

A Brief History

In the 1970's, the U.S. government recognized the need for a more sophisticated system for transforming national economic data into actionable assets for local economies. In 1976, the National Forest Management Act required the United States Forest Service (USFS) to develop a 5-year management plan that explored alternative land management strategies and potential resource outputs while also exploring the socioeconomic effects on local communities. In cooperation with the Federal Emergency Management Agency (FEMA), two linear models were produced: FORPLAN and IMPLAN. FORPLAN (Forest Planning) focused on land management strategies while IMPLAN (Impact Analysis For Planning) produced the economic effects of these strategies on local communities. Since 1978, the USFS has been modeling economic impacts using IMPLAN.[1]

In 1985, the University of Minnesota took over the responsibility of developing IMPLAN data sets. As demand grew for economic modeling grew across sectors, IMPLAN (then Minnesota IMPLAN Group (MIG, Inc.)) was established as an independent corporation purposed to develop and sell the IMPLAN database and software.[1]

What is IMPLAN?

IMPLAN utilizes a methodology called input-output analysis to evaluate the potential economic impact on a proposed region. Input-output analysis is a tool that explores the relationships within an economy between businesses and between businesses and consumers.[2]

What Does IMPLAN Measure? [2]

Direct Effects

Refers to the changes in the employment and expenditures.

Indirect Effects

Refers to the changes in inter-industry purchases as they respond to demands of directly affected industries. Indirect impacts include business-to-busines purchases arising from local spending for goods and services.

Induced Effects

Refers the effects on all local industries caused by the expenditures of household income generated by the direct and indirect effects.

Sources:
1. IMPLAN (2019). *Where it All Started.*
2. IMPLAN (2018). *What is IMPLAN?*

Application of IMPLAN's Economic Modeling

IMPLAN has been used by a myriad of industries to quantify the economic impacts of their organization and to uncover the impact of a policy changes. Included below are four diverse applications of the tool.

PROJECT	State of Louisiana Conservation	Mayo Clinic Hospital Expansion	Texas Regional Water Plan	Habitat For Humanity Housing	State Economies Medicaid
AMBITION	To Understand the Economic Impacts of Severe Storms.	To Understand the Economic Output Produced from their Hospitals in Arizona, Florida, and Minnesota.	To Quantify the Socioeconomic Impacts of Areas Experiencing Physical Shortages of Water Due to the Recurrence of Drought.	To Create Fiduciary Evidence That Illustrates Why Habitat For Humanity in Greenville, South Carolina Needed to be Exempt From Sales Tax.	This Case Brief Identified 15 States That Used IMPLAN to Quantify the Economic Impact of Medicaid on State Economies during the Great Recession.
RESULTS	Up to $7.4 Billion Costs to Commercial, Residential, and Network Infrastructure.	Across the 3 States, the Mayo Clinic had a $12.7 Billion Economic Impact.	Results Included that the Mining Industry lost $1.6 Million Across Two Counties in Texas.	The Results Concluded That For Every House Built, $658,640 Was Added to the Local Economy.	Sample Results Included: The State of Oklahoma's FY2006 Medicaid expenditures of $1.16 Billion resulted in 99K jobs and $315 million in tax revenue.

IMPLAN Industry Sectors

TEXAS Health and Human Services

IMPLAN is organized by 546 Industry Sector codes that is based largely on the US Bureau of Economic Analysis (BEA) and crosswalks to the North American Industry Classification System (NAICS). The following IMPLAN Sector codes are healthcare related.

IMPLAN Code	Description of Health Care related IMPLAN Codes
50	Construction of new health care structures
60	Maintenance and repair construction of nonresidential structures
171	Medicinal and botanical manufacturing
172	Pharmaceutical preparation manufacturing
173	In-vitro diagnostic substance manufacturing
174	Biological product (except diagnostic) manufacturing
311	Electromedical and electrotherapeutic apparatus manufacturing
376	Surgical and medical instrument manufacturing
377	Surgical appliance and supplies manufacturing
378	Dental equipment and supplies manufacturing
379	Ophthalmic goods manufacturing
380	Dental laboratories
444	Insurance carriers, except direct life
481	Junior colleges, colleges, universities, and professional schools
483	Offices of physicians

IMPLAN Code	Description of Health Care related IMPLAN Codes
484	Offices of dentists
485	Offices of other health practitioners
486	Outpatient care centers
487	Medical and diagnostic laboratories
488	Home health care services
490	Hospitals
491	Nursing and community care facilities
492	Residential mental retardation, mental health, substance abuse and other facilities
493	Individual and family services
494	Child day care services
495	Community food, housing, and other relief services, including rehabilitation services
540*	Employment and payroll of state govt, hospitals and health services
543*	Employment and payroll of state govt, hospitals and health services

*Government Healthcare related IMPLAN Codes

Provider Types Map to IMPLAN Sectors (1/2)

TEXAS Health and Human Services

HHSC's assisted with aligning the waiver's funding amounts by program / provider type to the IMPLAN Sector codes used by IMPLAN (that crosswalk to NAICS).

IMPLAN Sector Description	Medicaid Provider Type	Participates in which waiver funded program
Offices of Physicians	Class 3	TIPPS
	Physician Groups	DSRIP and UC
Outpatient care centers	CCBHC (Certified, Pending Certification, or No Certification)	DPS BHS
	Community Mental Health Centers	DSRIP
	Freestanding Rural Health Clinics	RAPPS
Nursing and community care facilities	NSGO	QIPP
	Privately Owned	QIPP
Residential mental retardation, mental health, substance abuse and other facilities	IMD	UHRIP
	Non-State-Owned IMD	CHIRP
	Private Non-Rural IMD Hospitals	UC
	Private Rural IMD Hospitals	UC
	State IMD Hospitals	UC
	State-Owned IMD	CHIRP
Employment and payroll of state govt, hospitals and health services *	Local Health Departments	DSRIP
Offices of dentists	Dental	UC
Other ambulatory health care services	Ambulance	UC

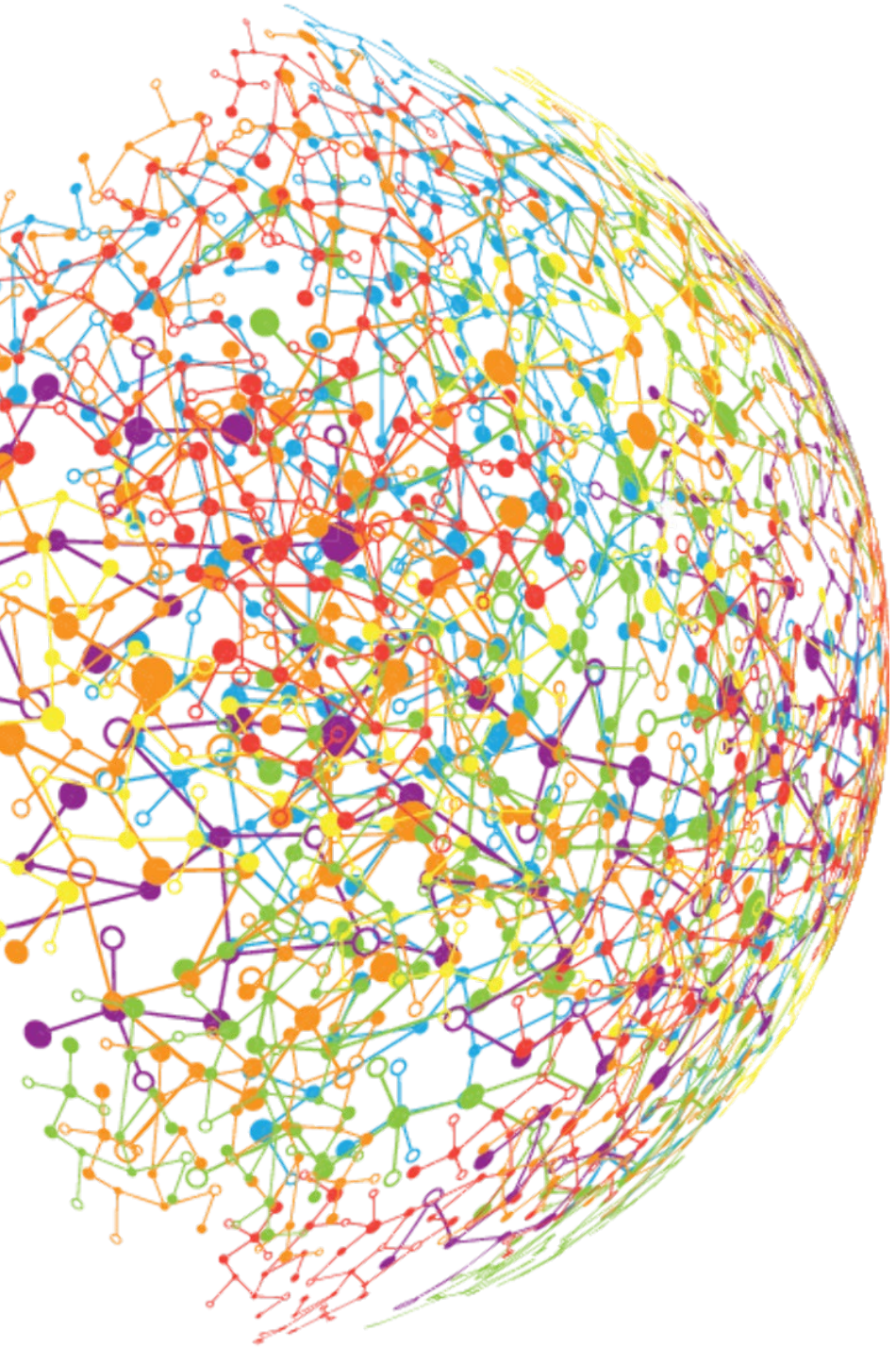
*Government Healthcare related IMPLAN Codes

Provider Types Map to IMPLAN Sectors (2/2)

HHSC's assisted aligning the waiver's funding amounts by program / provider type to the IMPLAN Sector codes used by IMPLAN (that crosswalk to NAICS).

IMPLAN Sector Description	Medicaid Provider Type	Participates in which waiver funded program
Hospitals	Children's Hospital	CHIRP, DSRIP, and UHRIP
	Childress County Hospital District	NAIP
	Harris Health System	NAIP
	Hospital-based Rural Health Clinics	RAPPS
	HRI	TIPPS
	IME	TIPPS
	Large Public Hospitals	UC
	Lubbock County Hospital District dba University Medical Center	NAIP
	Midland Memorial Hospital	NAIP
	Non-Urban Public Hospitals	UHRIP
	Nueces County Hospital District	NAIP
	Other Hospitals	UHRIP
	Palo Pinto General Hospital	NAIP
	Parkland Health & Hospital System	NAIP
	Private Non-Rural Non-IMD Hospitals	UC

IMPLAN Sector Description	Medicaid Provider Type	Participates in which waiver funded program
Hospitals	Rural Hospitals	DSRIP and CHIRP
	Rural Private Hospitals	UHRIP and UC
	Rural Public Hospitals	UHRIP
	Small Public Non-Rural Hospitals	UC
	Small Public Rural Hospitals	UC
	State Non-IMD Hospitals	UC
	State-Owned Hospitals	UHRIP
	State-Owned Non-IMD	CHIRP
	Texas A&M Health Science Center	NAIP
	Texas Tech University Health Sciences Center	NAIP
	Texas Tech University Health Sciences Center at El Paso	NAIP
	University Health System	NAIP
	University Medical Center of El Paso	NAIP
	Urban Hospitals	DSRIP and CHIRP
	Urban Public Hospitals	UHRIP
	UT Physicians	NAIP
	UT Southwestern Accountable Care Network	NAIP



TEXAS
Health and Human Services

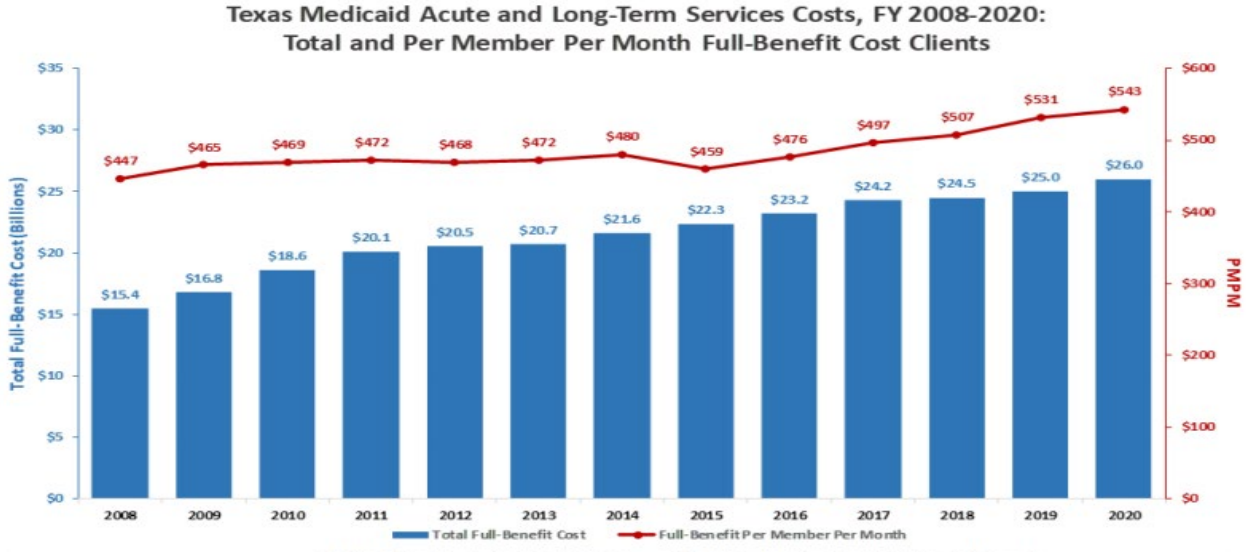
Appendix B

Conduct research to inform the market contraction and recovery analysis (*Section 4*)

Status Quo Data to Analyze and Model

To estimate the COVID-19 related market contraction and recovery, the projected aggregate expenditures based on publicly available HHSC data, survey findings, and external research on trends

Aggregate Medicaid Expenditures and Enrollment are sourced from the public presentation[1] to the Texas House Appropriations Committee on February 23, 2021.



Medicaid Caseload - Recipient Months and Per Member Per Month Costs with Trends

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
RMs	2,878,126	3,005,620	3,298,099	3,543,057	3,655,930	3,658,629	3,746,124	4,056,702	4,060,564	4,067,380	4,021,686	3,915,011	3,988,580
RM Trend		*4%*	*10%*	*7%*	*3%*	*0%*	*2%*	*8%*	*0%*	*0%*	*-1%*	*-3%*	*2%*
PMPM	$447	$465	$469	$472	$468	$472	$480	$459	$476	$497	$507	$531	$543
PMPM Trend		*4%*	*1%*	*1%*	*-1%*	*1%*	*2%*	*-4%*	*4%*	*4%*	*2%*	*5%*	*2%*

Notes: FY20 is not yet final. Excludes Supplemental & Directed Payment Programs, Medicare premiums, and agency admin. Source: PPS, CMS-37 Historical (FFY). HHSC Forecasting, November 2020.

ADDITIONAL SOURCES INFORMED TREND FORECASTS

- 2020 COVID-19 Provider Survey results
- 2021 COVID-19 Provider Survey results
- Published literature on recovery shapes/patterns and healthcare sector recovery [2]
- Published literature on employment recovery after recessions [3] and Texas-specific employment [4]
- Economic analysis and forecast from the Texas Comptroller of Public Accounts [5]

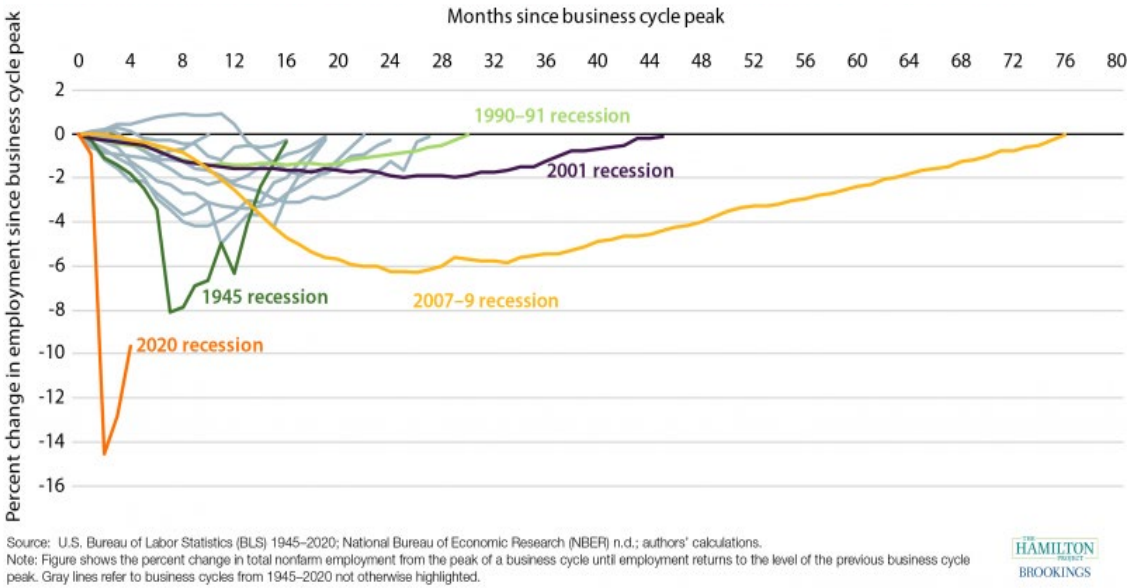
Sources:

1. Presentation to the Texas House Appropriations Committee on February 23, 2021, from Cecile Young, Executive Commissioner and Michael Ghasemi, Director of Forecasting
2. Examples include Swartz, P., Reeves Martin, Carlsson-Szlezak, P. (2020). What Coronavirus Could Mean for the Global Economy. *Harvard Business Review*. and HealthCare Drive (2020). Most of the healthcare industry in V-Shaped recovery from COVID-19, S&P says. *HealthcareDive*.
3. Examples include Rhyan, C., Turner, A., & Miller, G. (2020). Tracking the U.S. Health Sector: The Impact of the COVID-19 Pandemic. *Business Economics, 55*(4), 267–278. and Edelberg, W. and Shambaugh, J. (2020) How the Pandemic Is Changing the Economy. *The Hamilton Project*.
4. Bureau of Labor Statistics; Texas Workforce Commission; Federal Reserve Bank of Dallas. (June 2021). Texas Employment by Industry.
5. Texas Comptroller of Public Accounts. (January 2021) Fiscal Notes: Weathering the Pandemic: Texas Industries and COVID-19 and (August 2021) Summer 2021 Economic Forecast.

Trends in Employment After Recessions

The United States will face challenges for years resulting from this shock. Research shows that deep and protracted recessions can have long-lasting negative effects as some individuals leave the labor force, some firms fail, and some firms forgo making investments

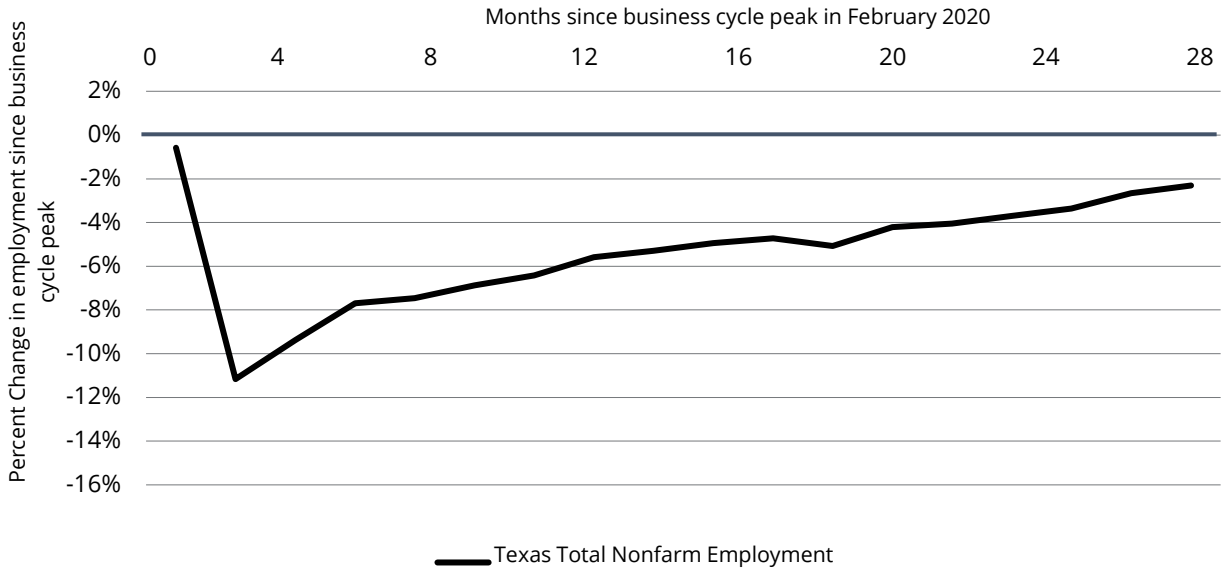
Percent Change in Employment Relative to Business Cycle Peak By Business Cycle, 1945 – 2020



Source: U.S. Bureau of Labor Statistics (BLS) 1945–2020; National Bureau of Economic Research (NBER) n.d.; authors' calculations.
Note: Figure shows the percent change in total nonfarm employment from the peak of a business cycle until employment returns to the level of the previous business cycle peak. Gray lines refer to business cycles from 1945–2020 not otherwise highlighted.

Source: Percent Change in Employment Relative to Business Cycle Peak by Business Cycle, 1945-2020. Edelberg, W. and Shambaugh, J. (2020) How the Pandemic Is Changing the Economy. *The Hamilton Project*.

Percent Change in Texas Nonfarm Payroll Employment Relative to Business Cycle Peak in Feb 2020

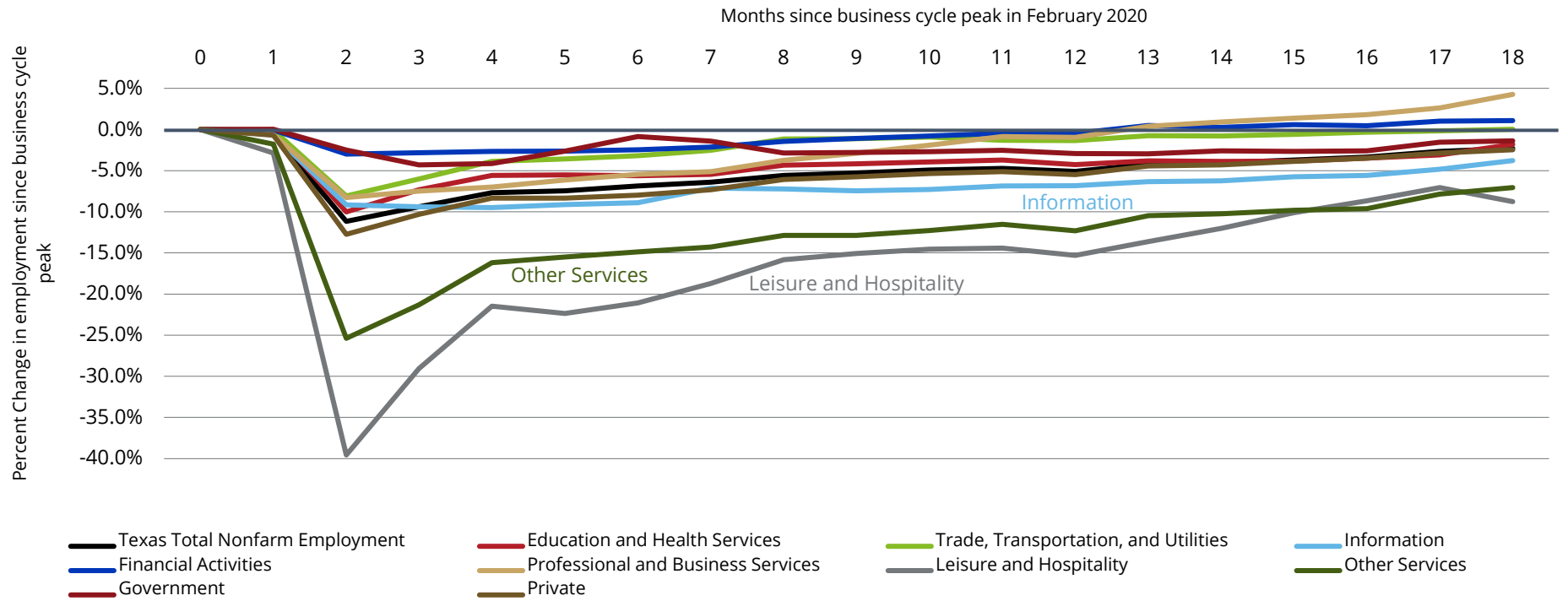


Source: Bureau of Labor Statistics; Texas Workforce Commission; Federal Reserve Bank of Dallas. (August 2021). Texas Employment by Industry. with a linear trendline projecting 10 months forward. The calculated trendline equation is y = 0.0029x - 0.0804
Note: Early benchmarked through fourth quarter 2020 and two-step seasonally adjusted.

Texas Employment After COVID-19 Recession

Employment across major industries in Texas is recovering at different rates after the recession in February 2020.

Percent Change in Texas Payroll Employment in Major Industries Providing Services Relative to Business Cycle Peak in Feb 2020



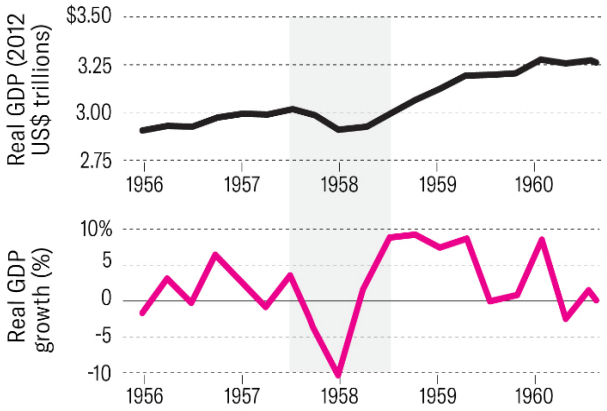
Source: Bureau of Labor Statistics; Texas Workforce Commission; Federal Reserve Bank of Dallas. (August 2021). Texas Employment by Industry.
Note: Early benchmarked through fourth quarter 2020 and two-step seasonally adjusted. The Other Services industry includes Repair and Maintenance; Personal and Laundry Services; and Religious, Grantmaking, Civic and Professional Organizations.

Past Epidemics Had V-shaped Economic Recoveries

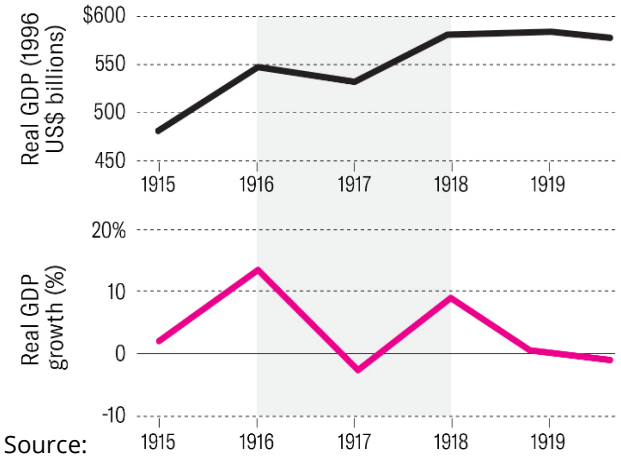
TEXAS Health and Human Services

According to the Harvard Business Review, prior epidemics were all V-shaped – meaning a sharp decline in GDP was followed by a relatively sharp increase in GDP shortly after

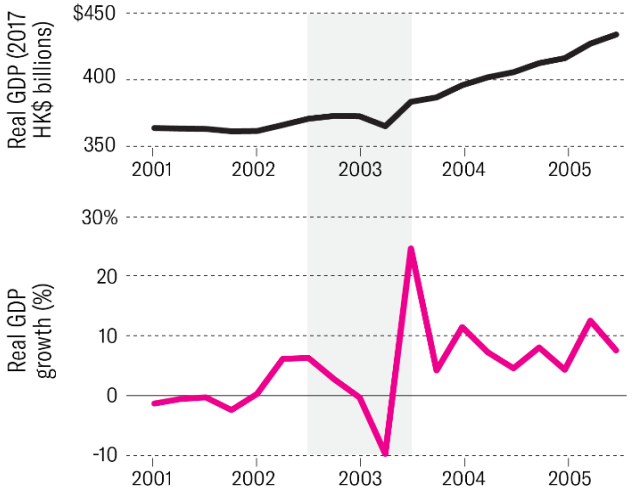
1958 H2N2 ("Asian") flu – *116,000 U.S. deaths*



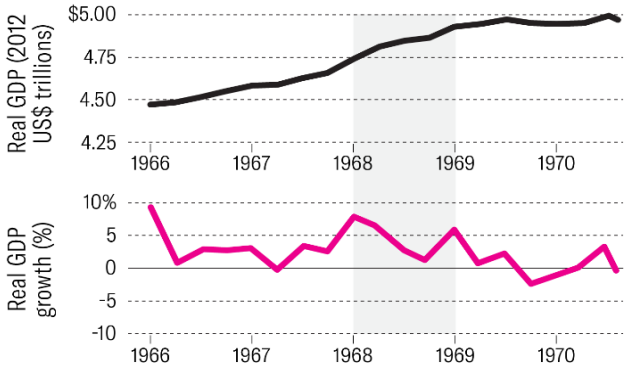
1918 Spanish flu – *675,000 U.S. deaths*



2002 SARS – *286 global deaths*

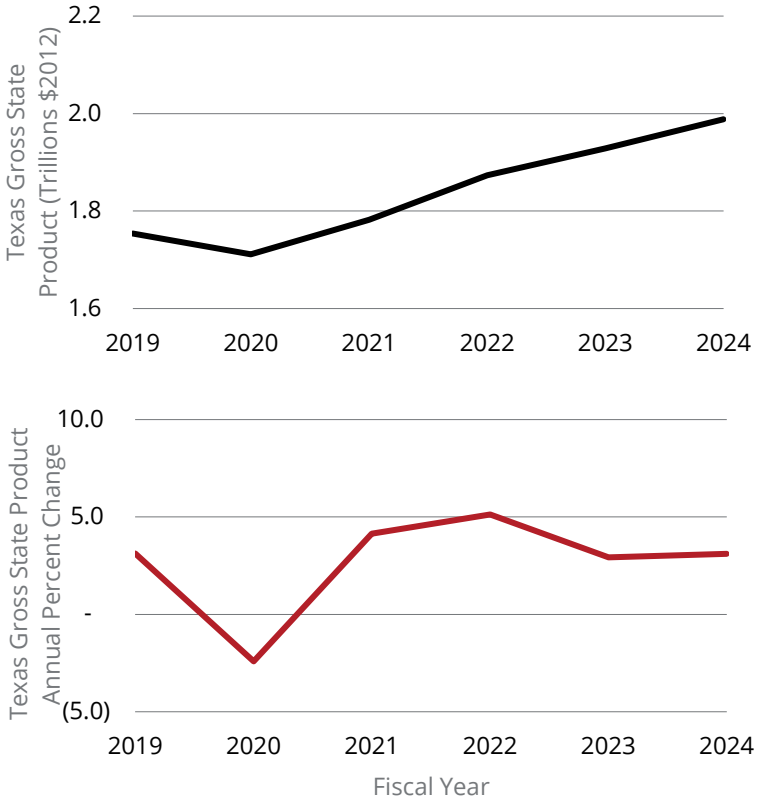


1968 H3N2 ("Hong Kong") flu – *100,000 U.S. deaths*



Source:
Philipp Carlsson-Szlezak, Martin Reeves, and Paul Swartz. Harvard Business Review. March 2020. Retrieved from: What Coronavirus Could Mean for the Global Economy (hbr.org)

COVID-19 Pandemic – *63,976 Texas deaths (as of Sept 30, 2021)*



Sources:
IHS Markit, Glenn Hegar, Texas Comptroller. Retrieved from Spring 2021 Economic Forecast (texas.gov)
Texas Department of Health State Services. DSHS COVID-19 Dashboard. Retrieved from https://dshs.texas.gov/coronavirus/AdditionalData.aspx

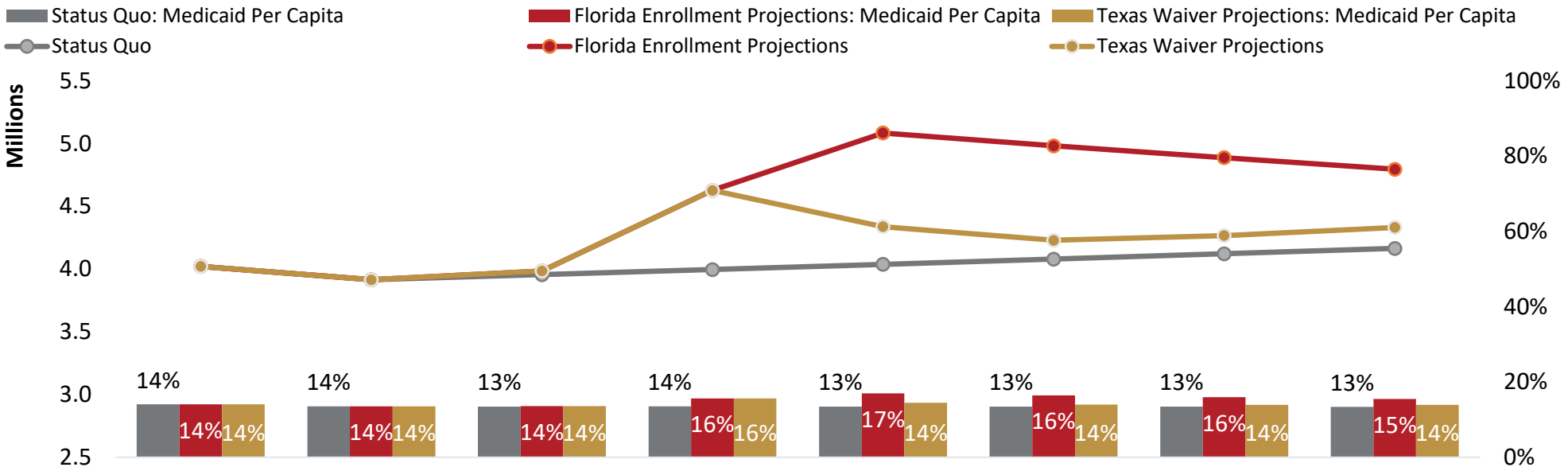
Medicaid Caseload with Texas Population Growth

TEXAS Health and Human Services

DRAFT

Around 14% of the Texas resident population is served by Texas Medicaid. As the resident population is projected to grow, Medicaid could serve 13-17% per capita in the three enrollment scenarios.

Enrollment Trends In Comparison to Comptroller's Resident Population Projections



	2018	2019	2020	2021	2022	2023	2024	2025
Resident Population	28.6M	28.9M	29.3M	29.6M	29.9M	30.3M	30.6M	31.0M
Population Growth	+1.2%	+1.3%	+1.3%	+1.0%	+1.1%	+1.2%	+1.2%	+1.2%
Status Quo	-0.3%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TX Waiver	-0.3%	-0.5%	+0.1%	+2.0%	-1.1%	-0.5%	0.0%	0.0%
FL Project.	-0.3%	-0.5%	+0.1%	+2.0%	+1.4%	-0.5%	-0.5%	-0.5%

Medicaid per Capita Year Over Year Change

Source:
Texas Resident Population: IHS Markit, Glenn Hegar, Texas Comptroller. Retrieved from Summer 2021 Economic Forecast (texas.gov)

Florida as a Comparable State

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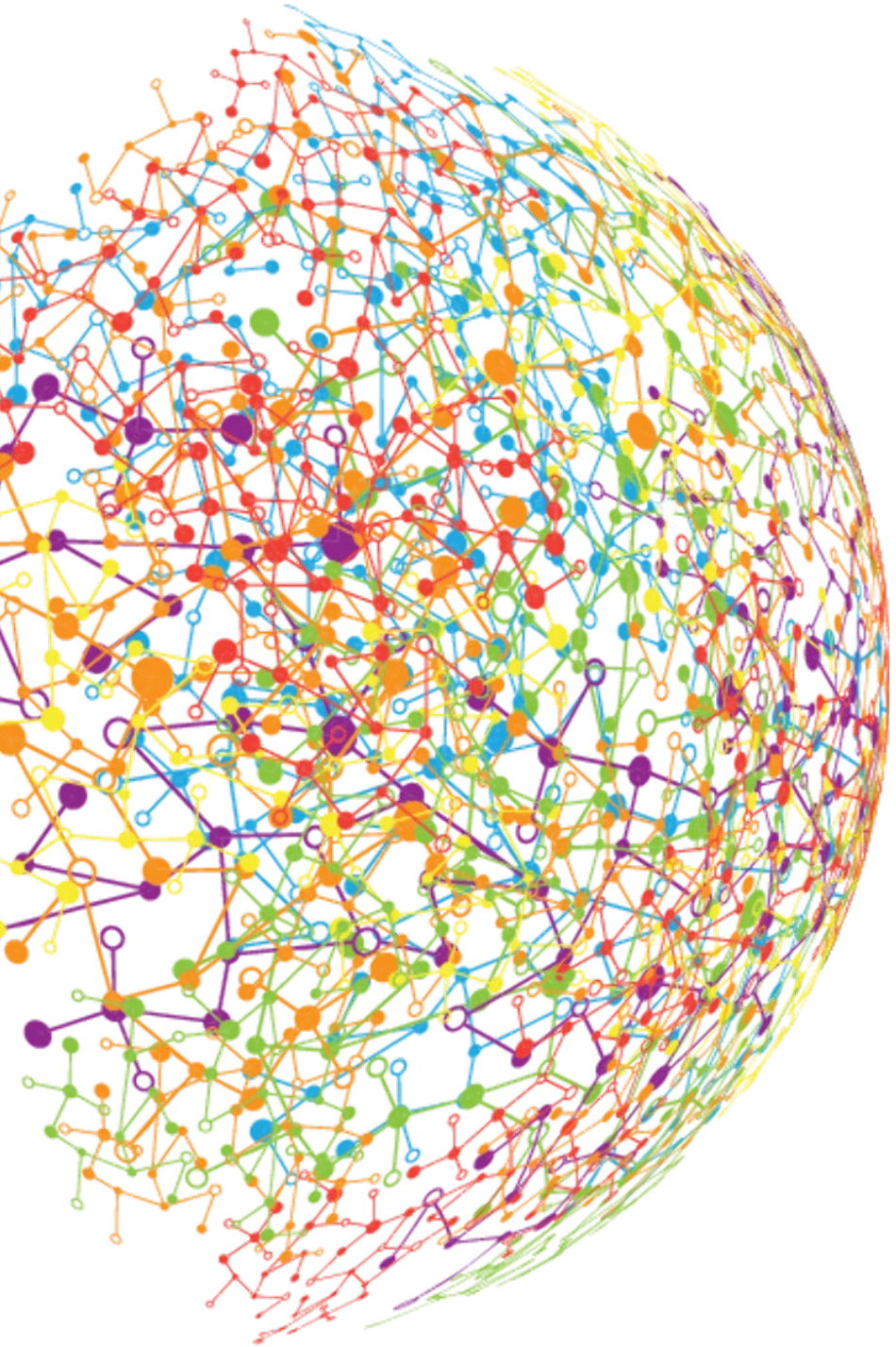
Due to various statistics surrounding Texas's and Florida's Medicaid and the populations in general, Florida is a reasonable comparison state to Texas

	% of State Enrolled in Medicaid/ CHIP, 2019 [1]	March 2021 Medicaid/ CHIP Enrollment [2]	% of Medicaid Population in MCOs, 2019 [3]	2018 # of MCOs (For acute care services) [4]	2019 Medicaid Services Expend-itures [5]	Medicaid Expansion	Annual GDP, 2020 [6]	GDP per Capita, 2020 [6]	Unemploy-ment Rate, July 2021 [6]	Population [6]
Texas	16%	~4.9M	94%	17	$37.6M	Not Adopted	$1,759B	$60,689	6.2%	28,995,881
Florida	17%	~4.2M	90%	15	$22.8M	Not Adopted	$1,096B	$51,024	5.1%	21,477,737

Sources in order of the columns:

1. Health Insurance Coverage of the Total Population
2. Total Monthly Medicaid/CHIP Enrollment and Pre-ACA Enrollment
3. Share of Medicaid Population Covered Under Different Delivery Systems
4. Total Medicaid MCOs
5. Annual Medicaid & CHIP Expenditures
6. U.S. States comparison: Texas vs Florida Unemployment Rate 2021



TEXAS
Health and Human Services

Appendix C

Analyze 2020 and 2021 Impact of COVID-19 on Providers Survey and Report of Findings, to inform the market contraction and recovery analysis (*Section 4*)

Texas Provider Experience in 2020

TEXAS Health and Human Services

In 2020, providers were feeling financial pressure from COVID-19, resulting in them requesting more support from HHSC and seeing a need to increase telemedicine as a way of affordably meeting patients where they are

FINANCIAL PRESSURE

76%

of respondents are extremely or very concerned about the financial impact of COVID-19

RISE OF TELEHEALTH

71%

of respondents who practice telemedicine have purchased additional equipment to shift services to telemedicine

ADDITIONAL FUNDING

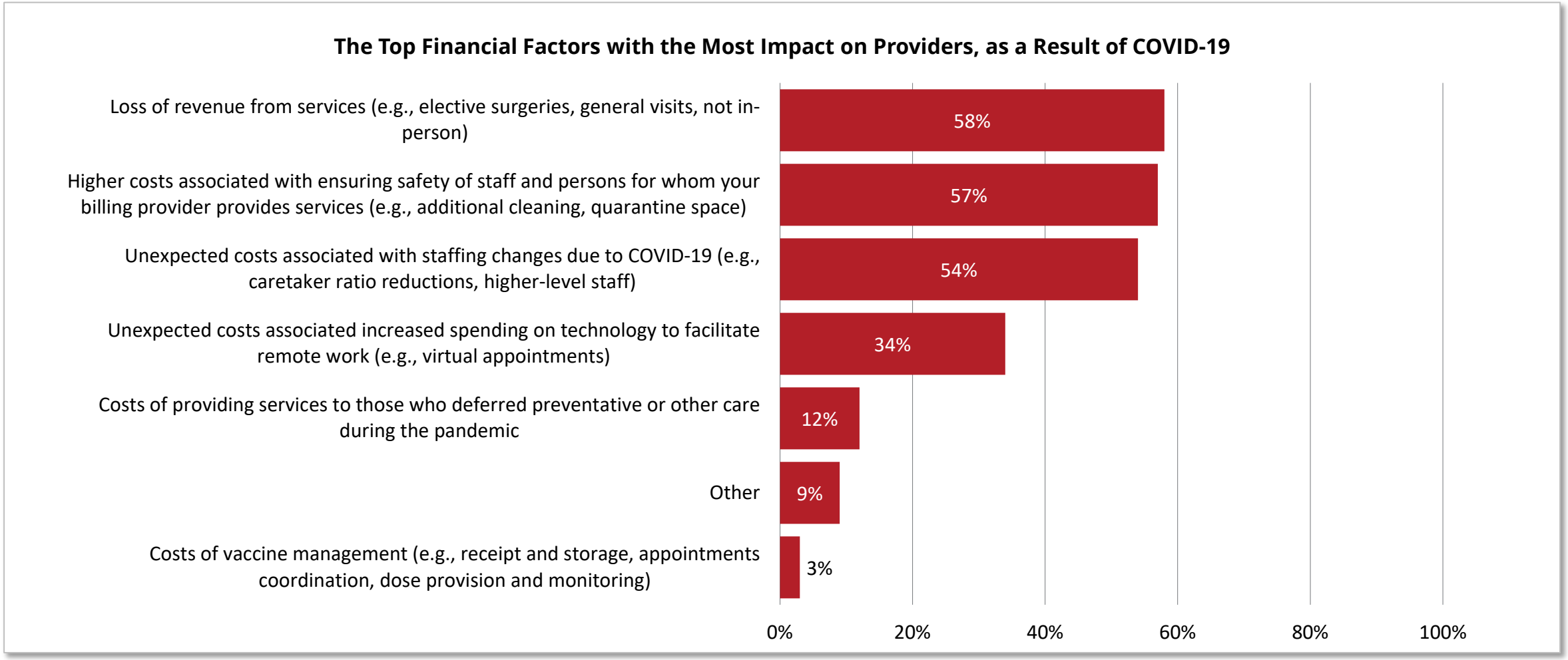
57%

of respondents indicted desire for additional funding from HHSC

The results of the Texas 2020 Provider survey made it evident that COVID-19 placed significant pressure on providers that will likely extend past the pandemic

Financial Pressure from COVID-19 in 2021

In 2021, 69% of provider respondents are extremely or very concerned about the financial impacts from COVID-19

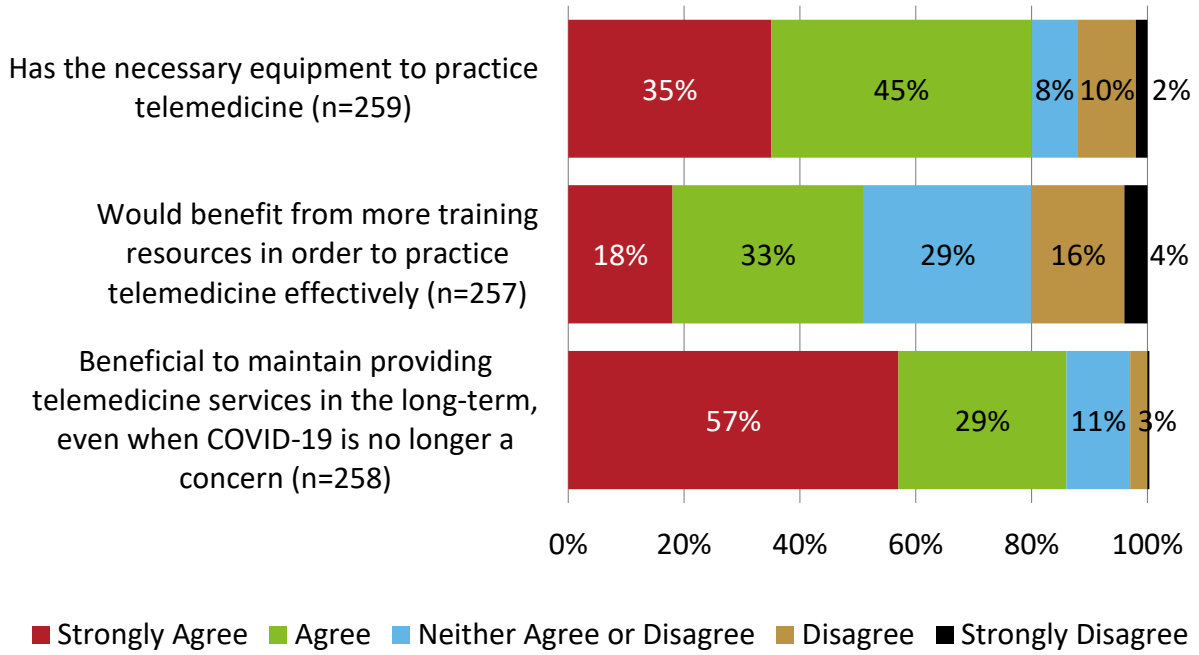


Respondents selected up to three financial factors that have had the most substantial impact on their billing provider as a result of COVID-19

Texas Providers Offer Virtual Health

Providers invested in providing virtual health services and would like to maintain virtual health services in the long-term, as indicated by the 2021 Texas provider survey

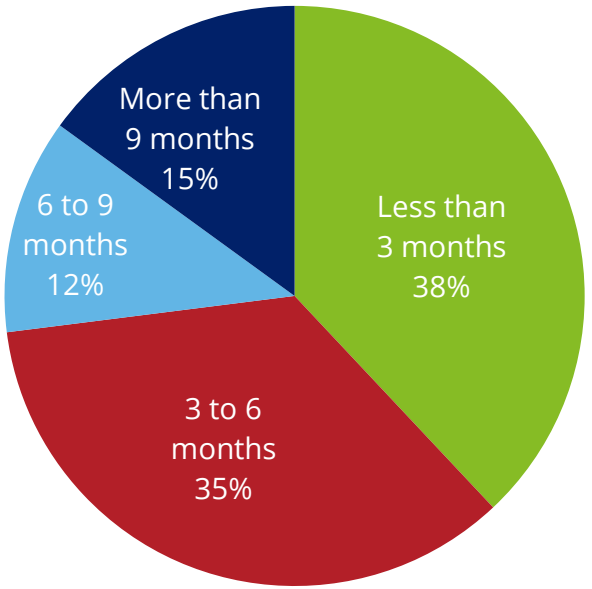
53% of provider respondents indicated they practice telemedicine



49% of provider respondents overall indicated they will offer new or additional telemedicine services in the future

Texas providers are continuing to invest in virtual health capabilities, as indicated by 62% of rural providers anticipating new or additional telemedicine services in the future.

Most providers (88 of 120 provider respondents) anticipate it will take **less than 6 months** to stand up new or additional telemedicine services.



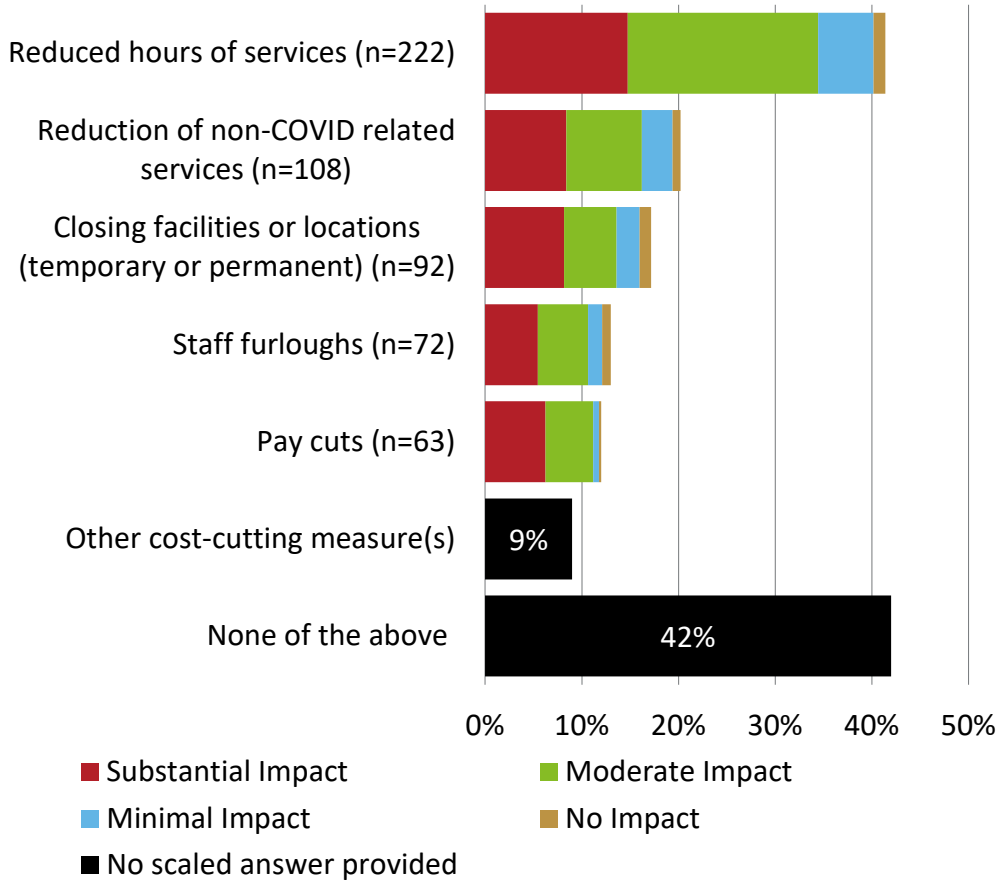
Texas providers are continuing to invest in virtual health capabilities, as evident by 62% of rural providers indicating they will offer new or additional telemedicine service in the future

Texas Providers Took Cost-Cutting Measures

TEXAS Health and Human Services

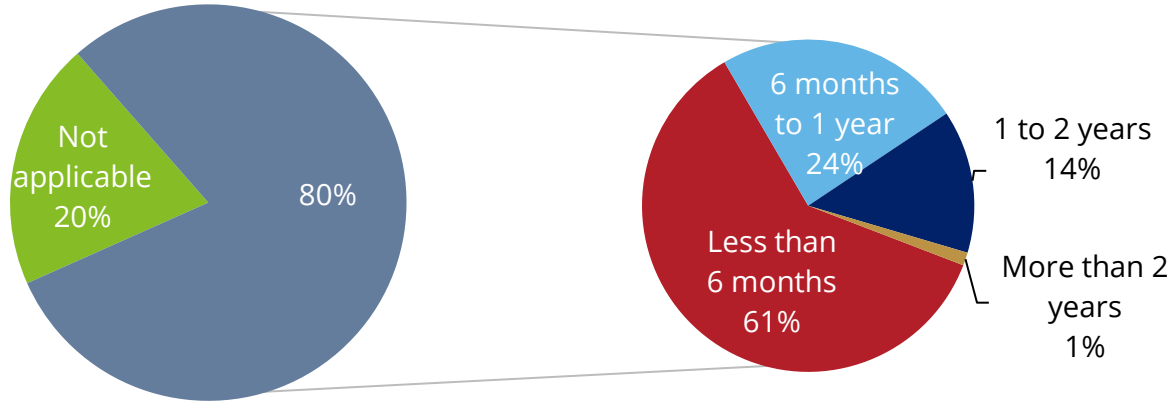
As a result of COVID-19, many Texas providers took cost-cutting measures and reduced their capacity by reducing services, closing facilities/locations, and/or furloughing staff

Of the 557 provider respondents, 58% took one or more cost-cutting measures

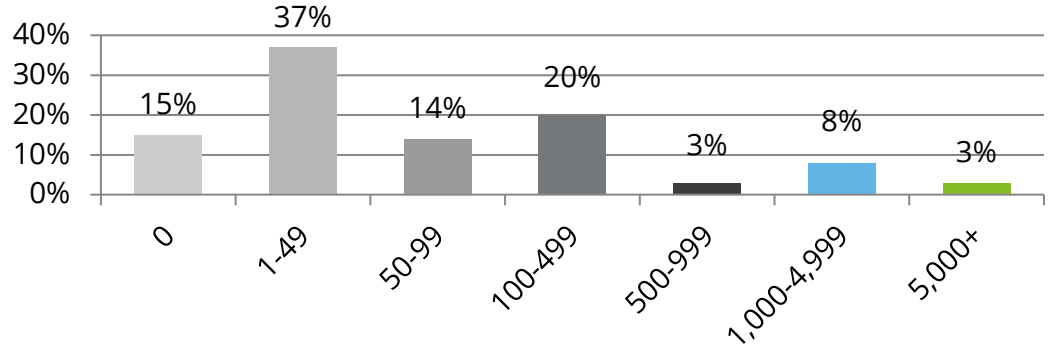


92 Provider respondents indicated they closed facilities or locations between September 2020 and May 2021 (temporary or permanent) as a cost-cutting measure

80% of billing providers closed their facility or location(s) after experiencing increased costs and/or decreased revenues for a certain period of time.



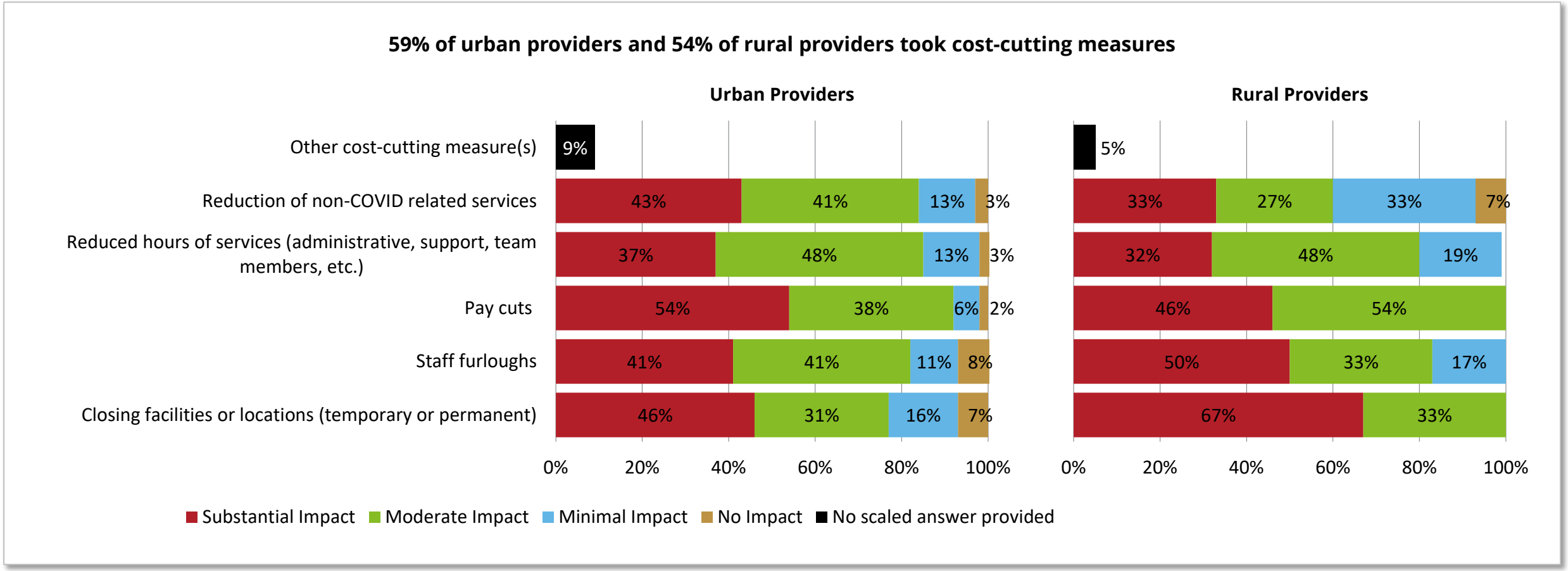
85% of closed provider location(s) served Medicaid recipients in the year before closing.



Urban and Rural Providers Impacted by Cost-Cutting Measures

TEXAS Health and Human Services

Rural and urban providers were impacted to varying degrees, as a result of taking cost-cutting measures due to COVID-19.



All Rural provider respondents were impacted substantially or moderately by closing facilities or locations and taking pay cuts

Appendix C. Financial Impact of DSRIP Transition

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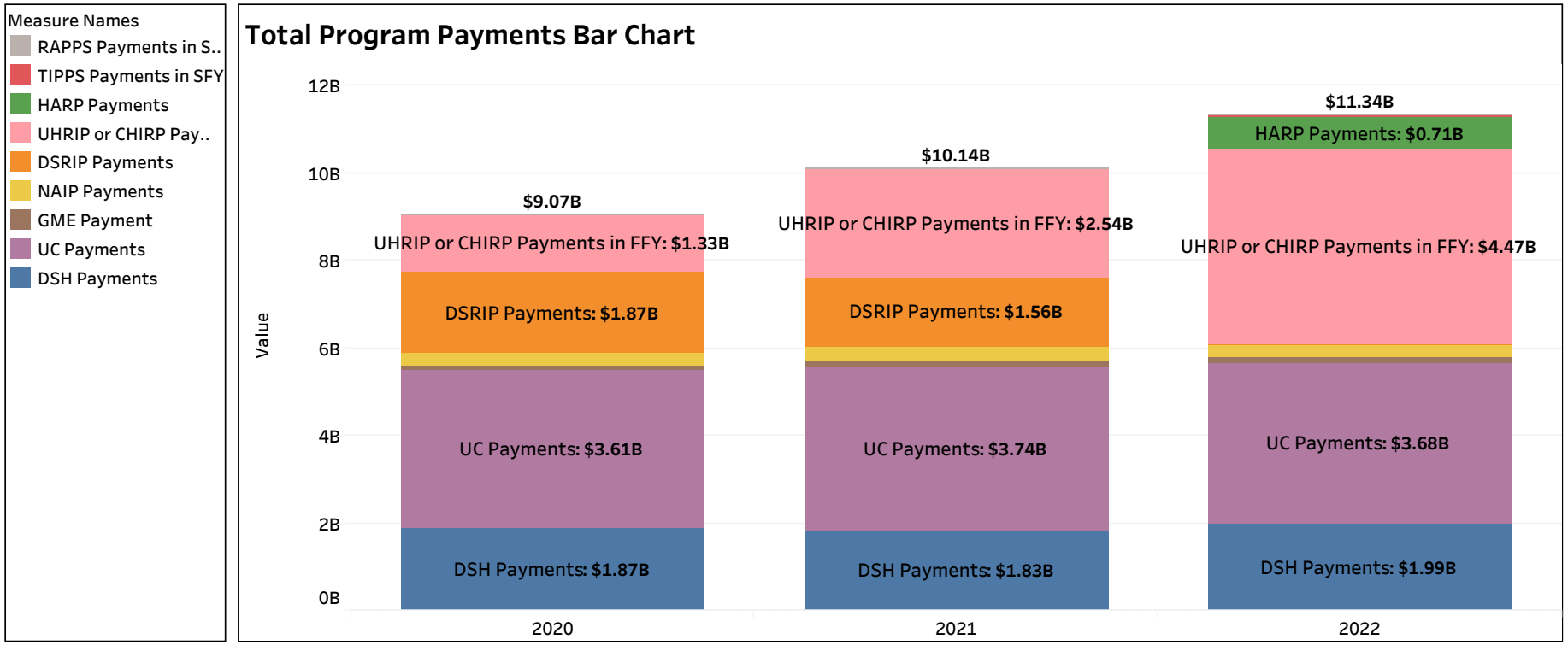
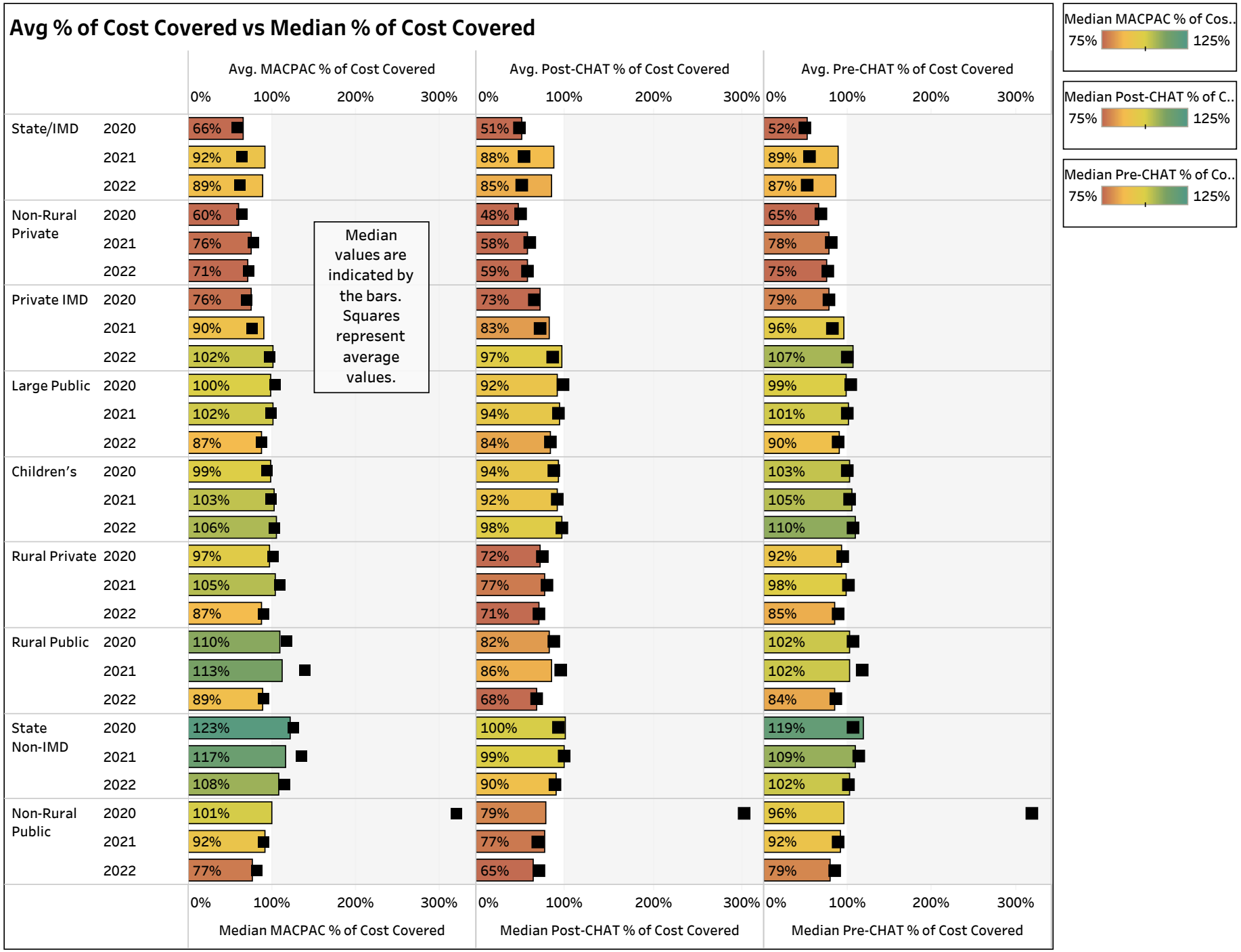


Total Program Payments Table

	2020	2021	2022
RAPPS Payments in SFY	$0	$0	$9,327,535
TIPPS Payments in SFY	$0	$0	$52,182,831
HARP Payments	$0	$0	$712,105,821
UHRIP or CHIRP Payments in FFY	$1,327,274,662	$2,541,487,992	$4,467,117,590
DSRIP Payments	$1,870,719,369	$1,556,346,179	$0
NAIP Payments	$274,211,254	$344,993,488	$310,347,761
GME Payment	$118,022,801	$118,665,632	$127,479,309
UC Payments	$3,608,875,177	$3,740,328,945	$3,680,595,924
DSH Payments	$1,874,951,884	$1,834,423,887	$1,985,225,144
Total Program Payments	$9,074,055,146	$10,136,246,124	$11,344,381,915

Assumptions:
-Unless otherwise noted, all payments are year to date payments as of September 9, 2022 and are grouped by program year.
-Estimated UHRIP and CHIRP payments are displayed based on the federal fiscal year rather than state fiscal year.
-Estimated RAPPS payments are for rural health clinics. The estimated payments included are to a hospital-based rural health clinic associated with the hospital. The program operates on the state fiscal year, so the payments included are for the state fiscal year.
-Estimated TIPPS payments are for physicians. The estimated payments listed are to an indirect medical education physician group associated with the hospital.
-An additional $99 million will be paid in DY10 DSRIP in January 2023. This amount has not been included in the 2021 payments.
-2022 state hospital GME payments are a combination of year to date payments and estimated quarter 4 payments, and are subject to change.
-NAIP payments for 2021 will not be finalized until July 2023 payments are made, and payments for 2022 will not be finalized until July 2024 payments are made. ..


Avg % of Cost Covered vs Median % of Cost Covered
Avg. MACPAC % of Cost Covered
Avg. Post-CHAT % of Cost Covered
Avg. Pre-CHAT % of Cost Covered
0%
100%
200%
300%
State/IMD
Non-Rural Private
Private IMD
Large Public
Children's
Rural Private
Rural Public
State Non-IMD
Non-Rural Public
2020
2021
2022
66%
92%
89%
51%
88%
85%
52%
89%
87%
60%
76%
71%
48%
58%
59%
65%
78%
75%
76%
90%
102%
73%
83%
97%
79%
96%
107%
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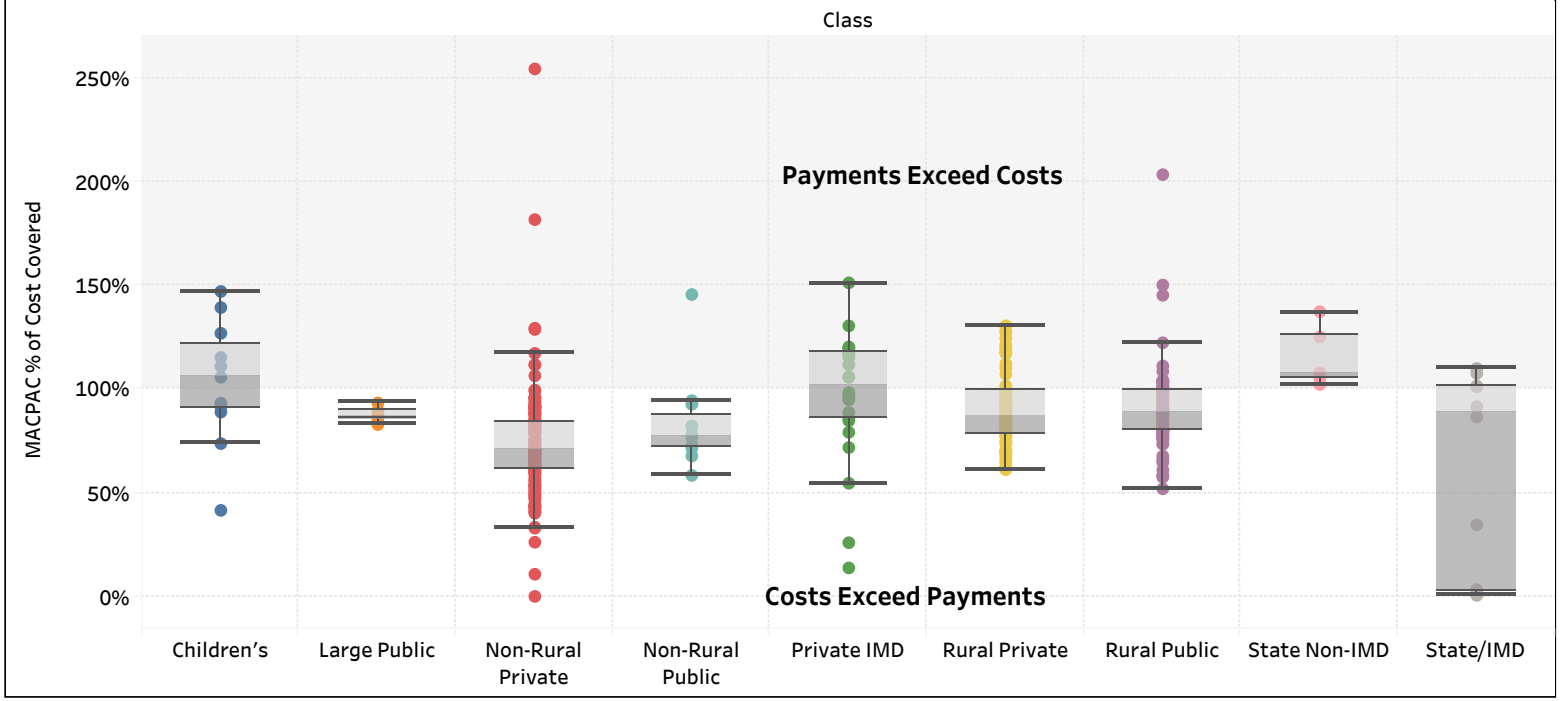
82%
86%
68%
102%
102%
84%
123%
117%
108%
100%
99%
90%
119%
109%
102%
101%
92%
77%
79%
77%
65%
96%
92%
79%
Median values are indicated by the bars. Squares represent average values.
Median MACPAC % of Cos..
75%
125%
Median Post-CHAT % of C..
75%
125%
Median Pre-CHAT % of Co..
75%
125%
Median MACPAC % of Cost Covered
Median Post-CHAT % of Cost Covered
Median Pre-CHAT % of Cost Covered

Data was only included for Ascension Seton in 2020 because in 2021 and 2022 they changed to a private hospital for purposes of DSH.

MACPAC 2022 % of Cost Covered



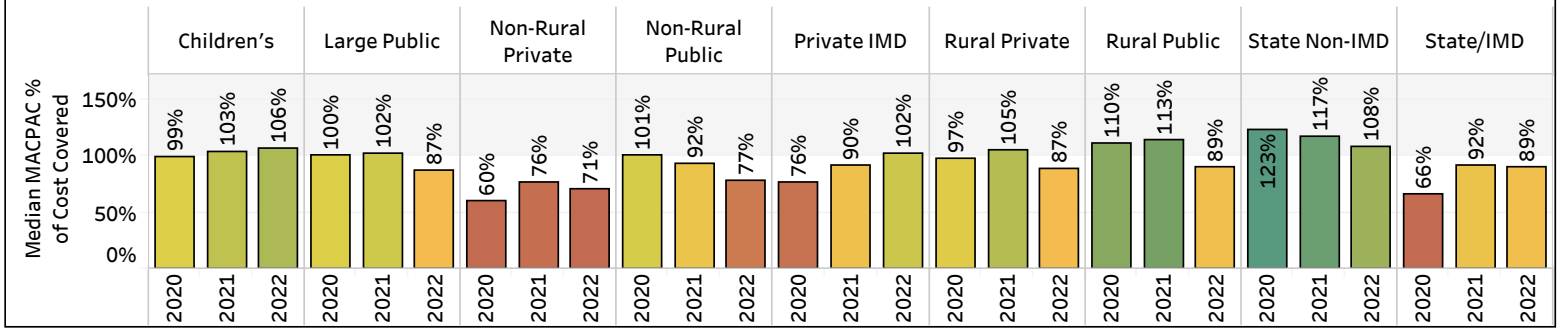
Class
- Children's
- Large Public
- Non-Rural Private
- Non-Rural Public
- Private IMD
- Rural Private
- Rural Public
- State Non-IMD
- State/IMD

Median MACPAC % of Cos..
75% 125%

Difference in Median MA..
-23% 26%

Notes:
MACPAC Costs include Medicaid-Only Cost, Uninsured Cost, and UC only cost. MACPAC Payments include Medicaid Payments, Cost Report Settlements, Uninsured Payments, UHRIP or CHIRP Payments in the federal fiscal year, GME payments, DSH payments, UC payments, DSRIP payments, NAIP payments, RAPPS Payments, and TIPPS Payments.

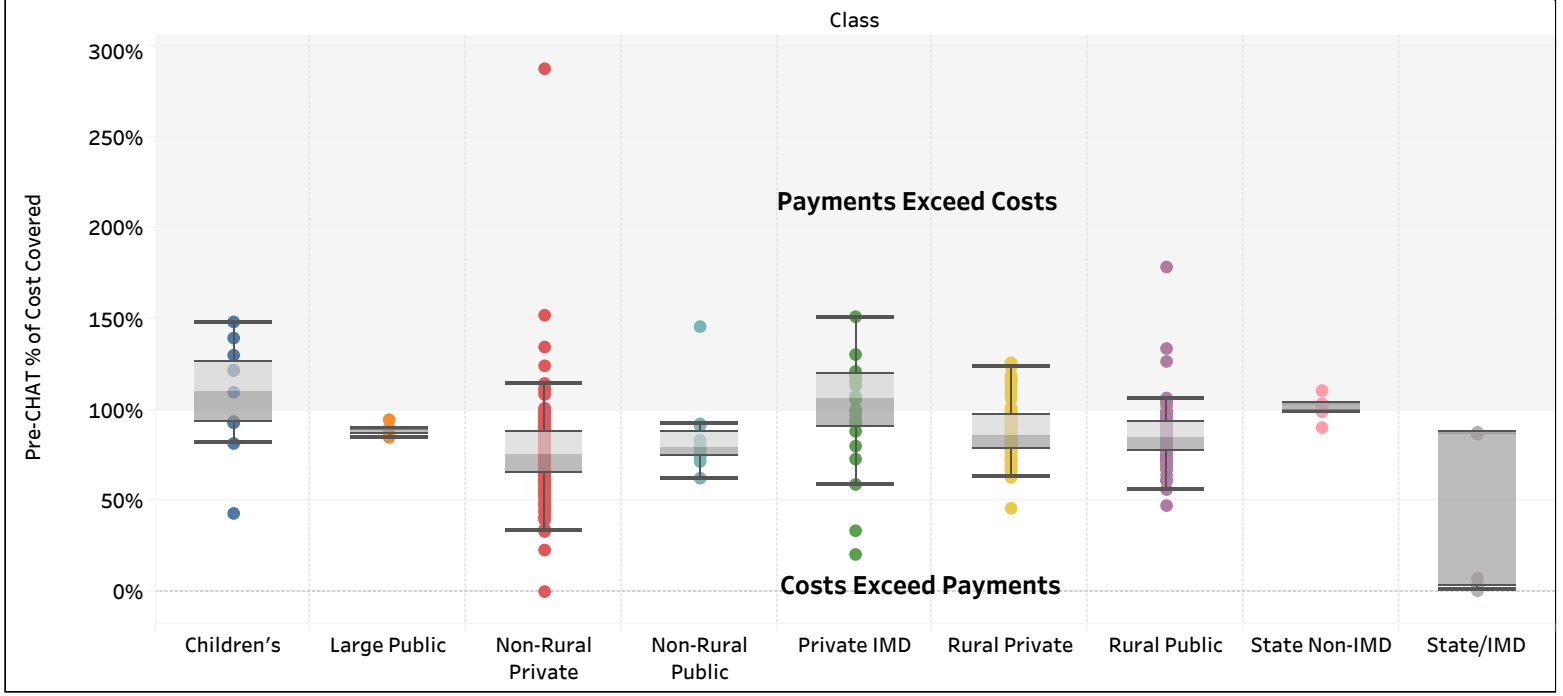
Median MACPAC % of Cost Covered



MACPAC Cumulative Difference in % of Cost Covered

	Children's	Large Public	Non-Rural Private	Non-Rural Public	Private IMD	Rural Private	Rural Public	State Non-IMD	State/IMD
2021	5%	2%	15%	-9%	15%	7%	3%	-6%	25%
2022	7%	-12%	10%	-23%	26%	-10%	-21%	-15%	23%

Pre-CHAT 2022 % of Cost Covered



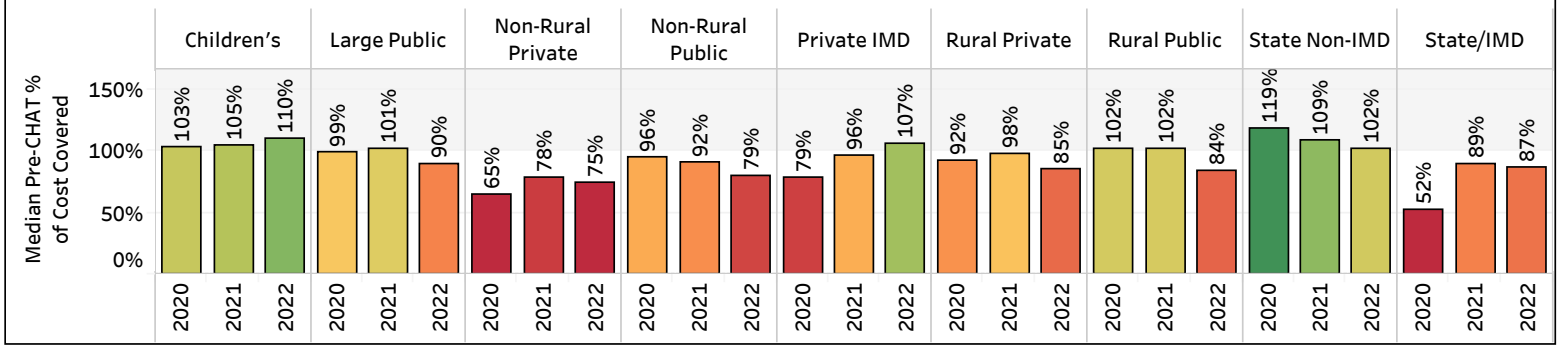
Class
- Children's
- Large Public
- Non-Rural Private
- Non-Rural Public
- Private IMD
- Rural Private
- Rural Public
- State Non-IMD
- State/IMD

Median Pre-CHAT % of Co..
75% 125%

Difference in Median Pre-..
-18% 37%

Notes:
Pre-CHAT Costs include Medicaid-Only Cost, Medicare Crossover Cost, Other Insurance Cost, Uninsured Cost, and UC only cost. Payments include Medicaid Payments, Medicaid Secondary Payments, Medicare Payments, Other Insurance Payments, Cost Report Settlements, Uninsured Payments, UHRIP or CHIRP Payments in the federal fiscal year, GME payments, DSH payments, UC payments, DSRIP payments, NAIP payments, RAPPS Payments, and TIPPS Payments.

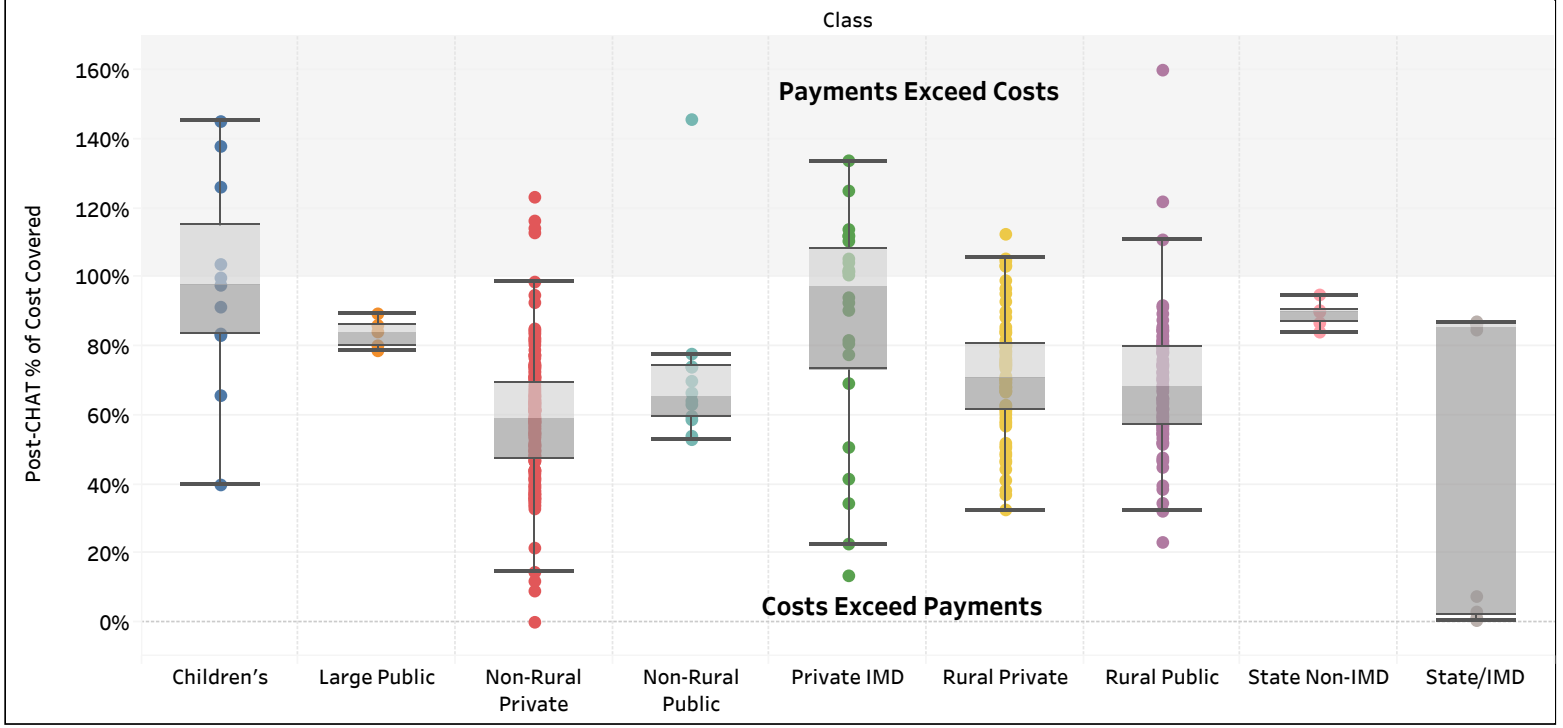
Median Pre-CHAT % of Cost Covered



Pre-CHAT Cumulative Difference in % of Cost Covered

	Children's	Large Public	Non-Rural Private	Non-Rural Public	Private IMD	Rural Private	Rural Public	State Non-IMD	State/IMD
2021	2%	2%	13%	-4%	18%	6%	0%	-10%	37%
2022	7%	-9%	10%	-16%	28%	-7%	-18%	-17%	35%

Post-CHAT 2022 % of Cost Covered



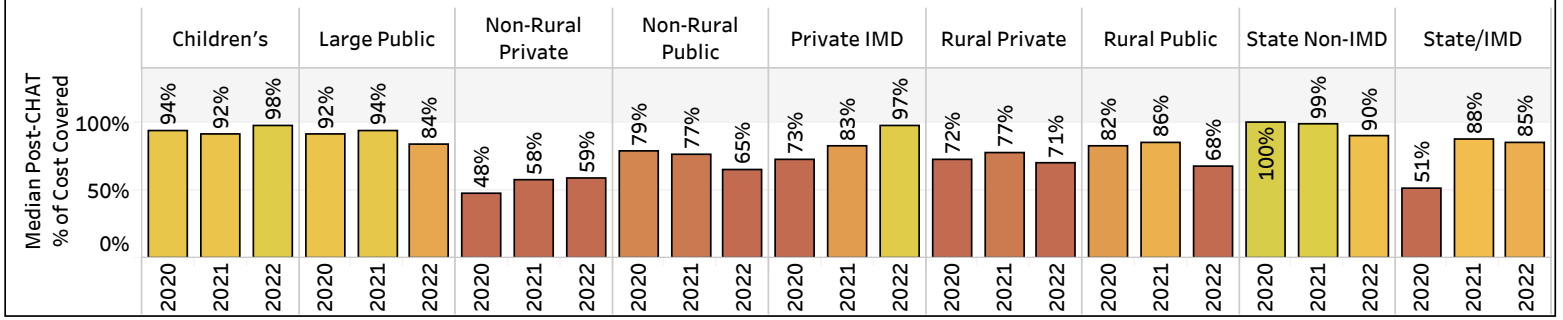
Class
- Children's
- Large Public
- Non-Rural Private
- Non-Rural Public
- Private IMD
- Rural Private
- Rural Public
- State Non-IMD
- State/IMD

Median Post-CHAT % of C..
75% 125%

Difference in Median Pos..
-14% 36%

Notes:
Post-CHAT Costs include Medicaid-Only Cost, Medicare Crossover Cost, Other Insurance Cost, Uninsured Cost, and UC only cost. Payments include Medicaid Payments, Medicaid Secondary Payments, Cost Report Settlements, Uninsured Payments, UHRIP or CHIRP Payments in the federal fiscal year, GME payments, DSH payments, UC payments, DSRIP payments, NAIP payments, RAPPS Payments, and TIPPS Payments.

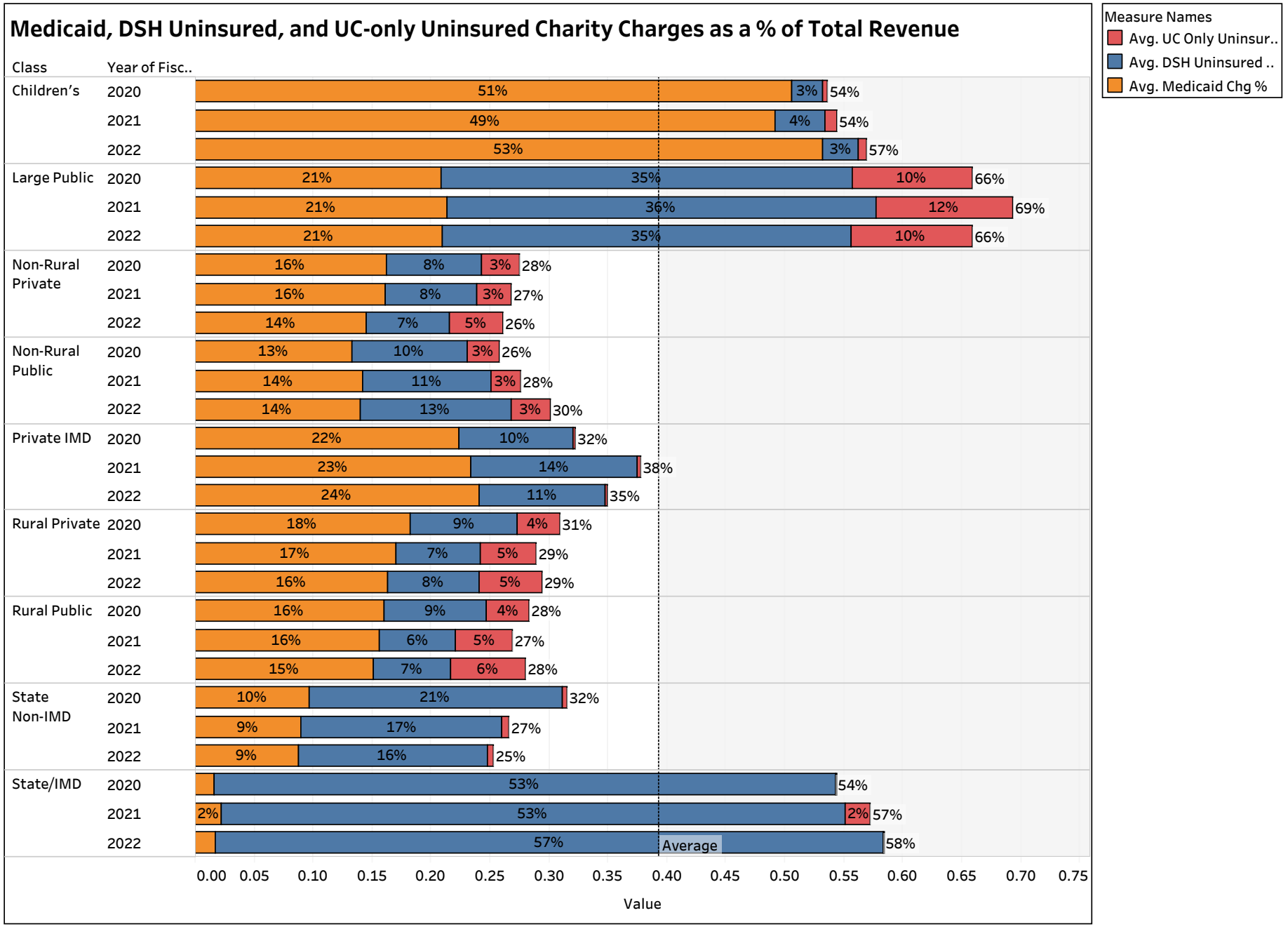
Median Post-CHAT % of Cost Covered



Post-CHAT Cumulative Difference in % of Cost Covered

	Children's	Large Public	Non-Rural Private	Non-Rural Public	Private IMD	Rural Private	Rural Public	State Non-IMD	State/IMD
2021	-2%	2%	10%	-2%	10%	5%	3%	-1%	36%
2022	4%	-8%	11%	-14%	25%	-2%	-14%	-10%	34%

Medicaid, DSH Uninsured, and UC-only Uninsured Charity Charges as a % of Total Revenue



This data is based on information reported in the DSH/UC applications. The UC-only uninsured charges are based on the difference between the UC charity charges and duplicated charity charges. If the difference was negative, the value was set at zero so there would not be negative charity charges.