Evaluation of Rural Hospital Funding Initiatives

As Required by

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

(Article II, HHSC, Rider 52)

Health and Human Services

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Executive Summary

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

Based on analysis using State Fiscal Year 2017 data, rural hospitals were paid approximately 83 percent of cost for inpatient services and 53 percent for general outpatient services. The 86th Legislature appropriated additional funds for the next biennium that are anticipated to increase inpatient reimbursement to approximately 95 percent of cost.

HHSC has undertaken a number of steps to improve the process for evaluating timeliness of payments to rural hospitals. HHSC is launching a new project in response to this rider and internal audit findings to calculate timeliness of payments to rural hospitals and identify improvements in encounter data. HHSC will implement contractual remedies as necessary based on the findings of the project. HHSC continues to implement systematic changes to validate the accuracy of submitted encounter and claims data.

1. Introduction and Background

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

Rider 52 was adopted in the 85th legislative session in response to concerns that rural hospitals were not being paid sufficiently and a number of them were closing their doors. Historically rural hospital reimbursement has been modified to try to meet the needs of these hospitals that are critical to maintain accessible healthcare in the rural areas of Texas. Table 1 outlines the historical methodologies used for the rural facilities.

Table 1. Historical Rural Hospital Reimbursement Methodology

Hospital Description	Service Begin Date	Service End Date	Inpatient Reimburse-ment Method	Inpatient Cost Settlement [1] (FFS Only)	General Outpatient Reimburse-ment Method	Outpatient Cost Settlement (FFS Only)
100 Beds or Fewer	9/1/1989	8/31/2005	DRG	Yes	Cost	Yes
Rural Hospitals[2]	9/1/2005	8/31/2007	DRG	Yes	Cost	Yes
Rural Hospitals[3]	9/1/2007	8/31/2011	DRG	Yes	Cost	Yes
Rural Hospitals[2]	9/1/2011	8/31/2013	TEFRA (Cost)[4]	Yes	Cost	Yes
Rural Hospitals[5]	9/1/2013	8/31/2017	APR DRG[6]	No	Cost	Recoup Only

[1] Cost Settlement – The process of calculating each hospital's cost or providing Texas Medicaid services from the CMS 2552 cost report. Costs are compared to interim payments and a settlement is completed between HHSC and the provider to reimburse the provider at their allowable cost in the Fee for Service Program. No cost settlement is performed in Managed Care.

[2] Hospitals located in a rural area with fewer than 101 beds or more than 100 beds and not located in a Metropolitan Statistical Area (MSA) and designated as either Rural Referral Center or Sole Community Hospital.

[3] Hospitals located in a county with 50,000 or fewer in population or hospitals not located in a Metropolitan MSA and designated as either Rural Referral Center or Sole Community Hospital. All Critical Access Hospitals regardless of location.

[4] TEFRA - Cost reimbursement as defined by Tax Equity and Fiscal Responsibility Act.

[5] Hospitals located in a county with 60,000 or fewer in population according to the 2010 U.S. Census or hospitals designated as either Rural Referral Center, Sole Community Hospital or Critical Access Hospital.

[6] APR DRG – All Patient Refined Diagnosis Related Group – Method of payment that reimburses claims based on the diagnosis and other factors of the client's condition.

Hospital Description	Service Begin Date	Service End Date	Inpatient Reimburse-ment Method	Inpatient Cost Settlement [1] (FFS Only)	General Outpatient Reimburse-ment Method	Outpatient Cost Settlement (FFS Only)
Rural Hospitals[7]	9/1/2017	8/31/2019	APR DRG	No	Cost	Recoup Only
Rural Hospitals[4]	9/1/2017	8/31/2019	APR DRG	No	Cost	Recoup Only
Rural Hospitals[4] [8]	9/1/2019	Current	APR DRG	No	Cost	Recoup Only

Reimbursement rates prior to September 1, 2019, were developed using state fiscal year 2010 inpatient admissions with inflation to 2014. At that time, the rates were based on 100 percent of cost (TAC §355.8052); however, the rates were not adjusted subsequently and no longer cover 100 percent of cost.

[7] Hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or a hospital designated by Medicare as a CAH, a SCH, or a Rural Referral Center (RRC) that is not located in an MSA; or a hospital that has 100 or fewer beds, is designated by Medicare as a CAH, a SCH, or an RRC, and is located in an MSA.

[8] Appropriations from 86th Session include Inflationary Standard Dollar Amount (SDA) Increase, SDA Percentage Increase and SDA add-on for Labor and Delivery services

2. Evaluation

Rural Hospital Reimbursement

If the legislature had not appropriated additional funds for rate increases, based on projections created from state fiscal year 2017 data, rural hospitals would be paid about 83 percent of cost for inpatient services and 53 percent for general outpatient services in fiscal year 2020. Please see Table 2 and Table 3. Actual percentages are likely higher since the percentages cited in this report are based on available managed care data that include billed charges. Charges are used to determine cost; billed charges are higher than allowable charges, and services may be included in the data that are not payable Medicaid services.

Percentages of Estimated 2020 Payments to Estimated 2020 Costs[9]

Table 2. Estimated Rural Hospital Outpatient Medicaid Cost, Payments, and Percentage Covered[10]

	Cost	Payments	Percentage of Cost
FFS (Fee-for-Service) Cost	$20,559,248	$20,673,669	101%
MCO (Managed Care) Cost	$156,977,637	$74,081,280	47%
Total	$177,536,885	$94,754,949	53%

[9] Estimates based on SFY 2016 claim and encounter data Inflated to 2020.

[10] General Outpatient excludes Imaging, Clinical Laboratory and Hospital Ambulatory Service Centers paid on a fee schedule.

Table 3. Estimated Rural Hospital Inpatient Medicaid Cost, Payments, and Percentage Covered[11]

	Cost	Payments	Percentage of Cost
FFS (Fee-for-Service) Payment	$44,543,880	$39,335,363	88%
MCO (Managed Care) Payment	$175,326,477	$142,358,191	81%
Total	$219,870,357	$181,693,554	83%

The 2020-2021 General Appropriations Act, House Bill 1, 86th Regular Session (Article II, HHSC Rider 11, Hospital Payments), appropriated $11,484,360 in General Revenue Funds and $17,715,640 in Federal Funds in fiscal year 2020 and $12,773,550 in General Revenue Funds and $20,726,450 in Federal Funds in fiscal year 2021 to increase inpatient rates for rural hospitals in the coming biennium to trend forward rates from FY 2014 levels with an inflation adjustment. Section (e) of the same rider increased appropriations for inpatient rates specifically for rural hospitals by an additional $5,371,045 in General Revenue Funds and $8,285,311 in Federal Funds in fiscal year 2020 and $5,371,045 in General Revenue Funds and $8,715,095 in Federal Funds in fiscal year 2021.

In addition, the 2020-2021 General Appropriations Act, House Bill 1, 86th Regular Session (Article II, HHSC Rider 28, Rural Labor and Delivery Medicaid Add-on Payment) appropriated $3,146,400 in General Revenue and $4,853,600 in Federal Funds in fiscal year 2020 and $3,050,400 in General Revenue and $4,949,600 in Federal Funds in fiscal year 2021 for HHSC to provide a $500 Medicaid add-on payment for labor and delivery services provided by rural hospitals.

Total additional appropriations are $50.8 million in All Funds for the biennium. HHSC estimates that the additional funding from these riders will increase rural hospital reimbursement for inpatient services to 95 percent of cost. The increased rates will be effective September 1, 2019.

[11] Inpatient estimate does not include the additional funding from the 86th Legislature.

Senate Bill 170, 86th Legislature, Regular Session, 2019, requires HHSC to develop a minimum fee schedule, or other directed payment program, by September 1, 2020 for the MCOs to follow to maximize the funds available to the rural hospitals. HHSC will also be creating a strategic plan required by the legislature that will make recommendations for reimbursement methodologies for these critical facilities.

General outpatient services are currently reimbursed by a percentage of cost; however, in state fiscal year 2014, reimbursement for outpatient services were capped at the rate in effect on September 1, 2013. The cap eliminated any increases in reimbursement for these services regardless of cost. The cap will not allow for an outpatient rate, based on cost, to increase but will allow for decreases if the providers' cost to charge ratio decreases because of cost report settlement. The cost report settlement may result in a recoupment; however, if the provider is reimbursed less than cost, no additional funds are paid to the provider (TAC §355.8061).

HHSC has also taken administrative actions to help maintain reimbursements at rural hospitals. Effective February 1, 2018 imaging services provided by rural hospitals were reimbursed a percentage of the CMS fee for hospital imaging. The percentage is subject to change depending on fluctuations in the Medicare fee schedule. Due to reductions to the Medicare fee schedule, effective July 1, 2019, clinical lab services at rural hospitals will be based upon a revised methodology by using 96 percent of the Medicare fee for rural hospitals. This increased percentage will help maintain reimbursement rates that are currently paid, but which will be a higher percentage of the Medicare fee schedule than are currently paid.

Wrongful Denials, Average Wait Times, and Vendor Compliance

Current managed care contracts do not provide a specific definition of wrongful denials. However, MCOs are required to track and report timely provider payments and denials. Claims can be denied for a number of reasons, including, but not limited to: incorrect billing codes, invalid Medicaid ID number, billing for non-covered service, or incorrect National Provider Identification (NPI) or Texas Provider Identification (TPI). Consistent payment denials can lead to provider abrasion and a decrease in the MCO's provider network. HHSC works with providers who submit complaints and provides ongoing education to providers and MCOs to ensure both understand the claims submission processes and contractual requirements.

In early fiscal year 2019, HHSC internal audit released its findings on timeliness of managed care payments to rural hospitals. The findings indicated that based on data provided by MCOs, five out of the six tested MCOs were timely in their payments to rural hospital providers. The one MCO that was not found to be timely "paid a total of 11,044 claims to identified rural hospitals of which 1,222 (11.1 percent) were not paid timely."[12]

The audit also made recommendations to implement a process to ensure timeliness of payments to rural hospitals. While all providers are required by the HHSC Uniform managed Care Contract (UMCC) to pay or reject clean claims within 30-days, encounter data did not contain elements necessary to identify rural hospitals.

HHSC has begun a project that will calculate timeliness payment specifically for rural hospitals, which will implement by September 1, 2019. In this project HHSC will identify the data fields used to calculate timeliness payments, define what HHSC considers paid, and create an additional section on the Encounter Monthly Status Report demonstrating compliance. Based on the results of this project, HHSC will track timely claims payments to rural hospitals and determine if additional contract requirements or remedies are needed based on non-compliance. HHSC also implemented changes to the posted rate reports to identify rural hospitals consistently for the MCOs. The reports are updated monthly and are posted on the rate analysis web site.

[12] Audit of Managed Care Payments to Rural Hospitals, November 9, 2018, Project Number 18-01-019

3. Conclusion

HHSC continues to make progress to address concerns regarding payments to rural hospital providers. Appropriations from the 86th Legislature, will provide rural hospitals with increases in inpatient reimbursements beginning September 1, 2019. HHSC continues to monitor and make improvements to encounter data collections for the purposes of identifying rural hospitals and monitoring timelines of payments. The Rate Analysis Division at HHSC will produce a plan on Medicaid reimbursements for rural hospitals that is due in January 2020. HHSC will continue to strive to ensure the best practices for payments to our Medicaid providers.

List of Acronyms

Acronym	Full Name
CAH	Critical Access Hospital
FFS	Fee for Service
HHSC	The Health and Human Services Commission
LBB	Legislative Budget Board
MCO	Managed Care Organization
MSA	Metropolitan Statistical Area
NPI	National Provider Identification
OOG	Office of the Governor
RRC	Rural Referral Center
SCH	Sole Community Hospital
TPI	Texas Provider Identification
UMCC	Uniform Managed Care Contract