Evaluation of Children's Hospital Reimbursement

As Required by

2020-21 General Appropriations

Act, House Bill 1, 86th Legislature,

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Health and Human Services

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Executive Summary

The 2020-21 General Appropriations Act, House Bill (H.B.) 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 36), requires the Texas Health and Human Services Commission (HHSC) to evaluate Medicaid and Children's Health Insurance Program (CHIP) reimbursement methodologies for free-standing, non-profit children's hospitals.

Based on an analysis using state and federal fiscal year data from 2017-2019, children's hospitals were paid via their base reimbursement approximately 80 percent of cost for Medicaid direct services. When considering supplemental Medicaid payments, including Delivery System Reform Incentive Payment Program (DSRIP) reimbursements, children's hospitals received payment for approximately 97 percent of cost for Medicaid services.

HHSC surveyed children's hospitals as part of the evaluation of the reimbursement. The survey responses provide insight to some of the challenges that children's hospitals experience. In addition, HHSC conducted a forum in collaboration with the Children's Hospital Association of Texas (CHAT) for individual children's hospital representatives to have an opportunity to provide additional feedback from the survey. This report includes a summary of the survey results.

1. Introduction

The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 36), requires HHSC to evaluate Medicaid and CHIP reimbursement methodologies for free-standing, non-profit children's hospitals. HHSC submits this report with evaluation findings to the Legislative Budget Board (LBB) and the Office of the Governor (OOG) in response to the rider. The report examines Texas Medicaid program payments and utilization affecting children's hospitals for state fiscal years 2017, 2018, and 2019.

Texas Medicaid defines a children's hospital as a Medicaid hospital designated by Medicare as a children's hospital and exempt from the Medicare Prospective Payment System (PPS) by the Centers for Medicare and Medicaid Services (CMS). (1 Texas Administrative Code §355.8052.) A certified children's hospital is a free-standing or hospital-within-hospital that predominantly treats individuals age 20 and younger. (42 CFR § 495.302.)

Children's hospitals encounter unique hurdles compared to other hospitals because providing hospital-level care to children, including those children with medically complex conditions, creates challenges that are not experienced when treating an adult population. HHSC assessed Medicaid and CHIP reimbursement methodologies for adequacy, consistency, and predictability by examining year-to-year payment and cost trends.

The majority of Medicaid and CHIP beneficiaries (eighty-two percent) are children, and thirty-seven percent of those children receive treatment in a children's hospital. Consequently, children's hospitals depend heavily on Medicaid/CHIP, as 50 percent to 80 percent of their inpatient days are reimbursed by Medicaid.

Several reimbursement changes have impacted children's hospitals during the past decade. Major impacts to Medicaid and CHIP hospital reimbursements include moving from cost-based reimbursement to a prospective payment system for inpatient claims. Texas Medicaid currently reimburses using the All Patient Refined Diagnosis Related Groups (APR-DRG), which applies a weight to a standard dollar amount (SDA), to determine a payment for an entire hospital visit based upon the diagnosis of the patient receiving services.

Additional impacts to reimbursement include reduction of outpatient reimbursement and implementation of federal and state decisions related to supplemental reimbursement for these hospitals, causing some fluctuation in payments. To ensure that these critical hospitals remain available to all children, especially those

with medically complex conditions, the hospitals need adequate, predictable, and consistent Medicaid and CHIP reimbursement.

HHSC gathered information for the report from children's hospitals and their representatives. They provided valuable information regarding reimbursement methodologies used by other state programs and coordinated with the children's hospitals in Texas to gather survey data requested by HHSC.

2. Children's Hospital Reimbursement

2.1 Medicaid Reimbursement

Inpatient general acute care hospital reimbursement rates for Fee for Service (FFS) clients are based on the Prospective Payment System (PPS) methodology using the APR-DRG patient classification system. Reimbursement rates for managed care are set through actuarially sound methodologies. Texas develops a per member per month (PMPM) rate, or capitation rate, for each risk group within each of the state's service delivery areas. These capitation rates differ across risk groups and service delivery areas but are the same for all Managed Care Organizations (MCOs) in a single service delivery area. The MCO negotiates a contracted rate with each of their member providers. The negotiated MCO rate can fall above or below the established FFS rate. MCOs may pay the providers using any established reimbursement method and are not required to use the APR-DRG methodology.

2.1.1 Inpatient

Previously, Texas Medicaid children's hospitals were reimbursed for inpatient services according to the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. TEFRA is a reimbursement principle based on the hospital's reasonable costs. The method of reimbursement used the cost to charge ratio from the hospital's most recent tentative cost report settlement. Over- or under-payments were settled based on annual cost report audits, thus reimbursing the provider at 100 percent of its Medicaid allowable cost.

In accordance with legislative direction, the inpatient reimbursement methodology for children's hospitals transitioned on September 1, 2013, from the TEFRA methodology to APR-DRG. When the hospitals transitioned to APR-DRG, the cost settlement for inpatient services ended. However, rate setting and supplemental payment determinations still use cost reports.

APR-DRGs are an expansion of the basic DRGs to be more representative of non-Medicare patients and to incorporate severity of illness subclasses. The APR-DRG system classifies each patient into a diagnosis-related group (DRG) based on clinical information. Hospitals are paid a pre-determined amount for each specific DRG admission. Payments are calculated using a provider-specific Standard Dollar Amount (SDA) multiplied by the DRG specific relative weight. When treatments are exceptionally costly, or the stay is longer than the maximum expected for the DRG, an outlier payment is made for treatment of clients aged 20 and younger.

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 59) created an appropriation for a safety-net add-on to the SDA. The add-on was created for urban and children's hospitals that are considered "Safety-Net" hospitals. The add-on was implemented at the beginning of state fiscal year 2016.

2.1.2 Outpatient

Outpatient reimbursements for children's hospitals were historically based on 100 percent of allowable outpatient costs. Rates were established using the hospital's most recent tentative cost report settlement. The outpatient reimbursement methodology follows 1 Texas Administrative Code (TAC) §355.8061.

Children's hospital outpatient reimbursement gradually decreased over an 18-year period. The current rate of reimbursement is 76.03 percent of allowable costs for high-volume providers and 72.27 percent of allowable costs for non-high-volume providers. Additionally, effective September 1, 2013, outpatient cost settlements resulting in a payment were discontinued. Also, all cost-to-charge ratios used for the payment of outpatient claims were capped at the rate in effect on August 31, 2013.

Effective from September 1, 2011, to August 31, 2013, the legislature reduced rates for outpatient emergency department (ED) services that did not qualify as emergent to 60 percent of the estimated cost for a visit. Rates for non-emergent ED services were reduced to 125 percent of the Medicaid physician office visit fee effective September 1, 2014. The current fee is $51.36 per non-emergent emergency room visit.

Prior to state fiscal year 2016, outpatient diagnostic imaging services, provided by the hospital, were reimbursed using a percentage of the Medicare fee schedule. HHSC modified the reimbursement for imaging services to pay 125 percent of the Medicaid acute care fee beginning in state fiscal year 2016.

2.1.3 Current Medicaid Reimbursement

HHSC has modified reimbursement methods as required by federal and state requirements. Table 1 outlines reimbursement changes currently impacting children's hospitals from 2017-2019.

Table 1. Current Reimbursement Methods

Reimbursement Program Changes	Effective Date	Summary of Change	Reference
Conversion of Payment Methodology	9/1/2013	Inpatient reimbursement converted from TEFRA to APR-DRG.	Section 1.12(a), S.B. 7, 82nd Legislature, First Called Session, 2011
Outpatient Reimbursement Rates Capped	9/1/2013	Outpatient Ratio of Cost to Charges is capped at the rate in effect 8/31/2013. Cost settlement no longer payable on outpatient services.	1 TAC §355.8061
Safety-Net Add On	9/1/2015	Standard Dollar Amount increased by Safety-Net Add-On for hospitals meeting the definition.	2016-2017 General Appropriations Act H.B. 1, 84th Legislature, Regular Session (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 59)
Uncompensated Care transition	10/01/2019	Federal direction required the Uncompensated Care program be based on charity care and uninsured clients only.	1 TAC §355.8212
Supplemental Add-on to Standard Dollar Amount	09/01/2019 (ended on 08/31/2020)	Children's hospitals were granted a one-time appropriation	S.B. 500, 86th Legislature, Regular Session, 2019

2.1.4 Supplemental Payments

Supplemental payments are Medicaid payments to healthcare providers that are separate from and in addition to base payments. Supplemental payments may be linked to providers achieving certain goals or to support healthcare providers that see significant number of Medicaid or uninsured patients. HHSC administers various programs that hospitals utilize to compensate for financial losses incurred when providing care to Medicaid and uninsured patients.

Disproportionate Share Hospital

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. Disproportionate share hospitals are defined in Section 1886(d)(1)(B) of the Social Security Act. DSH payments are supplemental payments to help cover 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 reimburses hospitals based on their hospital state payment cap (SPC), previously referred to as the hospital specific limit (HSL), which is their cost of providing care to Medicaid and uninsured patients, minus all payments received for these patients. As of federal fiscal year 2020, the DSH program accounts for $1.8 billion annually in supplemental funding for eligible hospitals. Of the roughly 600 hospitals in Texas, about 360 apply for DSH funding each year. Only about half (180) qualify to receive payments based on their Medicaid and low-income utilization rates. Texas deems children's hospitals as qualified for DSH, regardless of their utilization, because they typically have the highest Medicaid utilization rates. In federal fiscal year 2017, 10 of the 13 children's hospitals that applied qualified for DSH and received roughly $64 million in payments.

In federal fiscal years 2018 and 2019, children's hospitals saw a significant increase in their DSH payments because of a change in the calculation of the HSL.[1] Consistent with the district court's decision in *Children's Hospital Association of Texas v. Azar*, 300 F.Supp.3d 190 (D.D.C. 2018), the revised calculation did not include Medicare and third-party payments. The district court's order vacated CMS's final 2017 rule that defined uncompensated costs as the remaining costs after all payments, including third party and Medicare payments, for Medicaid individuals were considered. However, on August 13, 2019, the United States Court of Appeals for the D.C. Circuit reversed the district court's decision, reinstating CMS's 2017

[1] In federal fiscal year 2018 and 2019, 12 of the 13 children's hospitals that applied to DSH received approximately $97 million each year.

rule.[2] Therefore, in federal fiscal year 2020, 9 of the 13 children's hospitals that applied to DSH received roughly $32 million in payments, about one third of the payments in federal fiscal years 2018 and 2019.

DSH is currently funded entirely by local governments that provide the approximately 40 percent non-federal share of the payment for all private hospitals, including children's hospitals, while the federal government provides an approximate 60 percent match. Currently, no state general revenue is appropriated for any supplemental or directed payment programs, and the base rate, FFS and MCO, payments are funded by the state through legislative appropriations.

Uncompensated Care

In 2011, the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver was adopted and implemented. The waiver authorized Texas's Uncompensated Care (UC) program. Uncompensated Care payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers.

Though previously defined as unreimbursed costs for Medicaid and the cost of uninsured patients incurred by hospitals, uncompensated care costs are currently defined as unreimbursed charity care costs. These costs are reported on the UC application submitted to HHSC. Until federal fiscal year 2020, UC reimbursed hospitals for their unfunded HSL after accounting for DSH payments received. HHSC adjusted the HSL for hospitals eligible for both DSH and UC to account for their DSH payment, and only the remaining HSL was eligible for UC reimbursement. Further, effective in federal fiscal year 2020, providers are no longer reimbursed for Medicaid and low-income patients through the UC program. The modified program reimburses providers for the care of uninsured charity patients.

In addition to the changes in methodology, CMS resized the Demonstration Year (DY) 8 UC funding pool from $3.1 billion to $3.8 billion in DY 9. CMS resized the pool based on the uncompensated hospital uninsured charity costs reported in worksheet S-10 of the Medicare cost report for all hospital providers. Children's hospitals received a significant increase in UC payments in federal fiscal years 2018 ($127 million) and 2019 ($168 million) compared to what they were paid in federal fiscal year 2017 ($73 million). However, because of the previously mentioned CMS regulation that impacted the HSL calculation, children's hospitals were able to maintain only their pre-2018 UC payment amounts in federal fiscal year 2020. Children's hospitals received roughly $70 million, even after the change in methodology, to reimburse the costs of uninsured charity care only.

[2] *Children's Hospital Assoication of Texas v. Azar*, 933 F.3d 764 (D.C. Cir. 2019).

Uniform Hospital Rate Increase Program (UHRIP)

In federal fiscal year 2018, HHSC anticipated the change in UC and enacted the Uniform Hospital Rate Increase Program (UHRIP) in conjunction with CMS. UHRIP is a directed payment program for hospitals that is paid through MCOs. The payments for this program are based on the non-federal share that local governments choose to fund, uniform rate increases requested by providers, and final approval and administration of the rate increases by HHSC. Hospital providers are paid based on their service delivery area (SDA) and class category (public, state, children's, rural, private, etc.). For the first three years of the program (state fiscal years 2018-2020), UHRIP payments to hospitals were limited to 95 percent of each class's collective Medicaid shortfall, because the program was still limited to hospitals' uncompensated cost of care. In just three years, the UHRIP program increased from $600 million to $1.6 billion and now has a pool of $2.67 billion for year four (state fiscal year 2021). Children's hospitals have seen a significant increase in UHRIP payments. Children's hospitals received $8 million in UHRIP payments for state fiscal year 2018, $18 million in UHRIP payments for state fiscal year 2019, and $193 million in UHRIP payments for state fiscal year 2020. They are expected to receive $215.5 million in UHRIP payments for state fiscal year 2021. HHSC is currently working with stakeholders to reform the UHRIP program in state fiscal year 2022.

Delivery System Reform Incentive Payment (DSRIP)

The Delivery System Reform Incentive Payment (DSRIP) program is part of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. The program is designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers, and local health departments for investments in delivery system reforms that increase access to healthcare, improve the quality of care, and enhance the health of patients and families they serve. Children's hospitals received $139 million in federal fiscal year 2017, $154 million in federal fiscal year 2018, $116 million in federal fiscal year 2019, and $122 million in federal fiscal year 2020. The payments in each federal fiscal year reflect payments in multiple DSRIP demonstration years.

The waiver's special terms and conditions require HHSC to develop a DSRIP transition plan to describe how the state will further develop its delivery system reform efforts when DSRIP funding is no longer available. Program parameters for DSRIP are outlined in two protocols. The transition plan was approved by CMS on September 2, 2020. The DSRIP Transition Plan is available publicly on the 1115 Waiver website.

2.1.5 Payment Information

Table 2. Medicaid Payments to Children's Hospitals

Year	Direct	Supplemental*	DSRIP	TOTAL
2017	$1,622,209,736	$137,079,925	$138,966,931	$1,898,256,592
2018	$1,746,258,795	$233,310,358	$154,426,189	$2,133,995,342
2019	$1,786,192,899	$283,195,135	$116,336,576	$2,185,724,610
2020	$2,144,264,603	$294,819,807	$122,126,014	$2,561,210,424

*Supplemental payments include DSH, UC and UHRIP.

Table 3. Medicaid Costs Incurred by Children's Hospitals

Year Category	Year	Costs
Historical	2017	$2,017,762,791
Historical	2018	$2,083,356,571
Historical	2019	$2,295,698,325
Historical	2020	$2,559,493,295
Projected*	2021	$2,636,278,094
Projected*	2022	$2,715,366,437

*Projections based on 2020 CMS Market Basket Inflation Factor

Table 4. Payments to Childrens' Hospitals by Year and by Fiscal Program

Year	DSH	UC	UHRIP	DSRIP	TOTAL
2017	$63,731,846	$73,348,078	-	$138,966,931	$276,046,855
2018	$97,403,965	$127,434,662	$8,471,731	$154,426,189	$387,736,547
2019	$97,371,880	$168,270,945	$17,552,310	$116,336,576	$399,531,711
2020	$31,760,403	$70,251,035	$192,808,370	$122,126,014	$416,945,822
TOTAL	$290,268,095	$439,304,720	$218,832,410	$531,855,710	$1,480,260,935

Table 5. Historical Medicaid Volumes of Patients Served by Childrens' Hospitals

Year	Medicaid Days	Total Days	Staffed Beds	Medicaid Days per Staffed Bed	Medicaid Days to Total Days
2017	286,643	593,491	2,524	113.57	48.30%
2018	284,993	611,689	2,591	109.99	46.59%
2019	363,721	639,521	2,673	136.07	56.87%

Table 6. Projected* Medicaid Volumes of Patients Served

Year	Medicaid Days	Total Days	Staffed Beds	Medicaid Days per Staffed Bed	Medicaid Days to Total Days
2020	370,427	651,312	2,673	138.58	56.87%
2021	408,906	718,969	2,673	152.98	56.87%
2022	388,690	683,423	2,673	145.41	56.87%

*Based on Medicaid Acute Care Cost Trend (Managed Care + Fee for Service) provided by HHSC Forecasting Department, September 2020 - All Children (NB + Children 1-21)

2.1.6 How Children's Hospitals are Reimbursed by Other States' Medicaid Programs

The chart below is a comparison between like states identified by children's hospital representatives with similar size, number of free-standing children's hospitals, and similar demographics. The data used was from Kaiser Health News October 2019.

Table 7. State Comparison

State	Number of Children's Hospitals	State Population	Medicaid and CHIP Population	Ratio of Medicaid Children	Total Medicaid Spending
Texas	14*	27.6 Million	17%	2 In 5	$38.2 Billion
Ohio	7	11.3 Million	21%	3 In 8	$21.9 Billion^
Florida	15	20.5 Million	19%	3 In 7	$23 Billion
California	13	38.7 Million	26%	3 In 7	$83.9 Billion^

*Enrolled in Texas Medicaid as a children's hospital.
^Expanded Medicaid programs with the Affordable Care Act.

The Children's Hospital Association of Texas (CHAT) shared information with HHSC regarding children's hospitals in other states. CHAT received responses from three states (Ohio, California, and Florida) regarding their reimbursement to free-standing children's hospitals.

After research and conversations with these states and their children's hospitals, CHAT informed HHSC there are different needs that each state addresses in different ways. States have flexibility in addressing the unique needs of children's hospitals because these hospitals have higher acuity patients and are more dependent on Medicaid as a payor. A summary of the information provided to HHSC is included below.

Table 8. Summary of Differences Among Selected States' Children's Hospitals Reimbursement

	IP Reimbursement Methodology	Inpatient Add-Ons or Adjusters	Supplemental Payments	Outpatient Reimbursement
Texas	**All Patient Refined Diagnosis Related Grouping–Specific Children's Hospitals Methodology**	• Medical Education Add-On • Safety-Net Add-On • Enhanced Outliers	• Disproportionate Share - Separate Hospital Class • Uncompensated Care - Separate Hospital Class • Uniform Hospital Rate Increase Program - Separate Class	• General Outpatient Ratio of Cost to Charges • Fee Schedule for Imaging and Clinical Lab
Ohio	**All Patient Refined Diagnosis Related Grouping–Specific Children's Hospitals Methodology**	• Capital Allowance • Medical Education Allowance • Transplant Allowance • Hospital Cost Coverage Add-on • Enhanced Outliers	• Supplemental Per Diem Payment for Children's Hospitals • Disproportionate Share - Separate Hospital Pool - Lump Sum	• Enhanced Ambulatory Patient Grouping

	IP Reimbursement Methodology	Inpatient Add-Ons or Adjusters	Supplemental Payments	Outpatient Reimbursement
Florida	**All Patient Refined Diagnosis Related Grouping**	• Age Adjuster - for less than 21 years old • Pediatric Adjuster -Age Policy Adjusters based on the level of severity of the DRG (Only Wolfson Hospital) • Outliers - Enhanced for SOI 3 or 4 for Pediatric, Transplant Pediatric, or Neonate • Enhanced Trauma Add-On for Children's	• Low Income Pool - Returns 100% of Children's Hospital Charity Care Costs • Graduate Medical Education • Disproportionate Share - Separate Methodology for Children's Hospitals	• Enhanced Ambulatory Patient Grouping (EAPG)
California	**All Patient Refined Diagnosis Related Grouping**	• Age Adjuster - for less than 21 years old in the miscellaneous or respiratory pediatric care categories. • Obstetrics Adjuster – SOI 4 in the miscellaneous or respiratory pediatric, or neonate care category. • NICU Surgery Adjuster - designated NICU facilities and surgery sites for neonate DRGs	• Supplemental reimbursement children's hospitals based % of funding received – • Children's hospitals must either provide emergency services or qualify as a Disproportionate Share Hospital • Supplemental reimbursement for qualified private hospitals (including children's hospitals) based % of funding received	• Outpatient Fee Schedule (General Outpatient Rate and Conversion Factor for Children’s)

2.2 Children's Health Insurance Program Reimbursement

Children's Health Insurance Program (CHIP) is a healthcare program for children in low-income families. CHIP health benefits are delivered solely through managed care models and reimbursed through a MCO. The HHSC Managed Care and Actuarial Analysis Unit uses actuarial models to derive MCO-capitated premium rates. This derivation is done primarily based upon health plan financial experience.

Table 9. Historical CHIP Enrollment Information

Year	Children's Hospital Utilization	All Hospital Utilization	Percent of patients served by Children's Hospital
2017	59,043	105,806	55.80%
2018	57,701	165,212	34.93%

Table 10. Projected CHIP Enrollment Information*

Year	Children's Hospital Utilization	All Hospital Utilization	Percent of patients served by Children's Hospital
2020	60,144	166,431	36.14%
2021	66,391	183,719	36.14%
2022	63,109	174,636	36.14%

*Based on Medicaid Acute Care Cost Trend (Managed Care + Fee for Service) provided by HHSC Forecasting Department, September 2020 - All Children (NB + Children 1-21

Table 11. Historical CHIP MCO Payments

Year	Direct Children's Hospital Payments	Direct All Hospital Payments
2017	$133,188,519	$205,222,581
2018	$126,272,748	$198,172,356
2019	$133,833,342	$204,774,065

Table 12. Projected CHIP MCO Payments*

Year	Direct Children's Hospital Payments	Direct All Hospital Payments
2020	$137,848,342	$210,917,287
2021	$141,983,793	$217,244,806
2022	$146,243,306	$223,762,150

*Projections based on 2020 CMS Market Basket Inflation Factor

2.3 Survey Results

HHSC surveyed children's hospitals to collect information regarding reimbursements. The survey responses provide insights into the impact of current reimbursement rates from the hospitals' perspective. The survey results fall into two main categories:

1. Direct financial impact of reimbursement rates and communication
2. Access to information

2.3.1 Survey Metrics

Chart 1. Payor Adequacy

Do reimbursements for claims from the following payors typically meet the total cost to deliver required services?

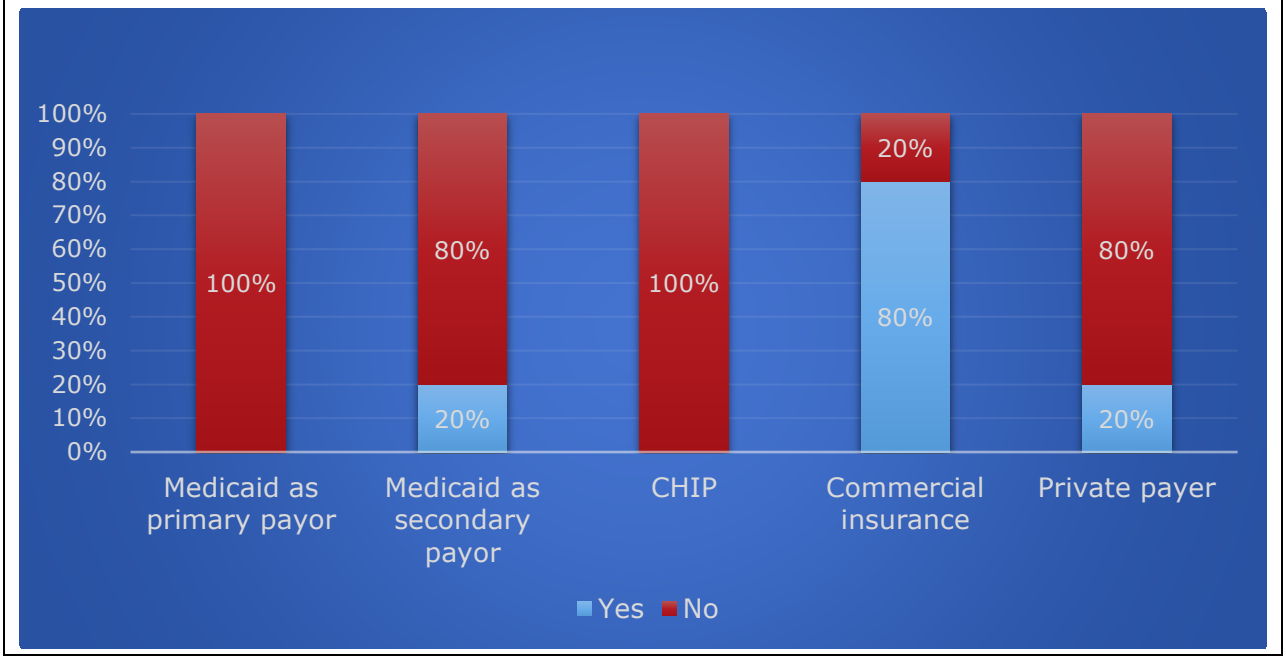


Chart 2. Payment Timeframe

What is the typical timeframe (in days) for your facility to receive reimbursement when a clean claim (requiring no edits or updates) is submitted?

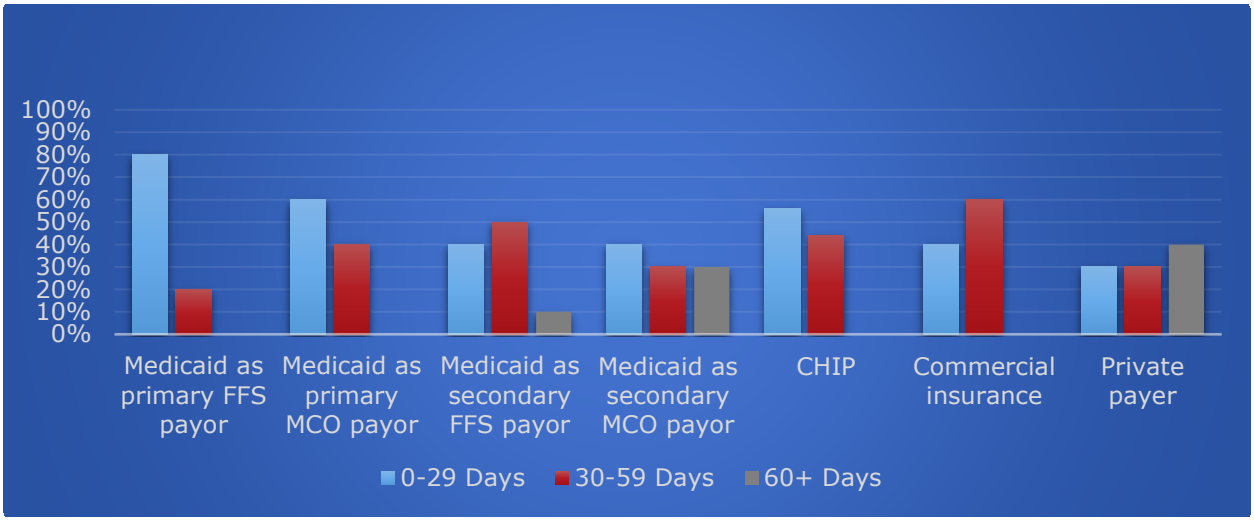


Chart 3. Staffing

Do current reimbursements influence staffing decisions, particularly when deciding whether to hire full-time staff or contractors?

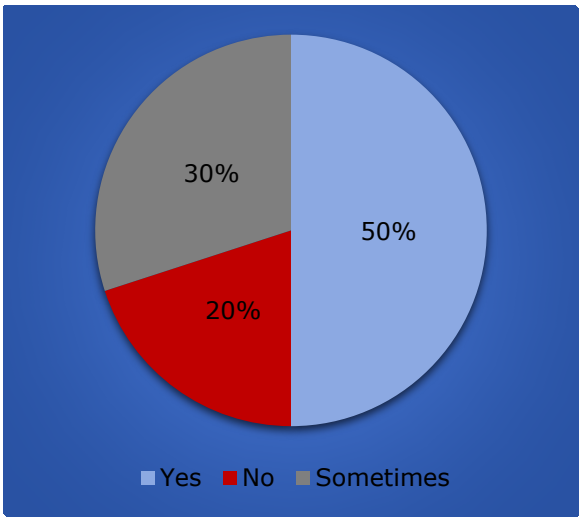


Chart 4. Equipment

Do current reimbursements influence equipment purchasing decisions, particularly when deciding whether to buy or lease equipment?

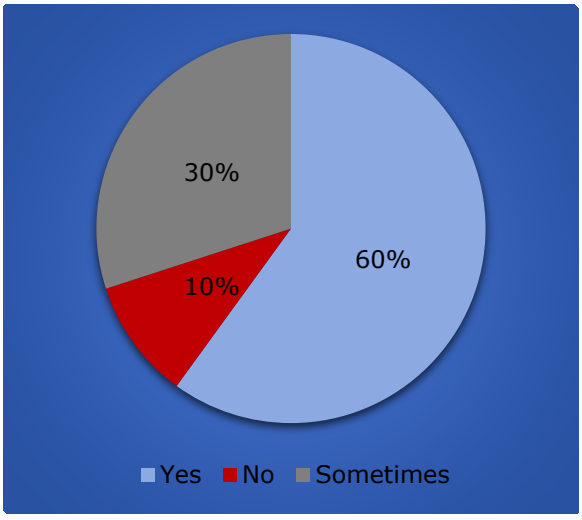
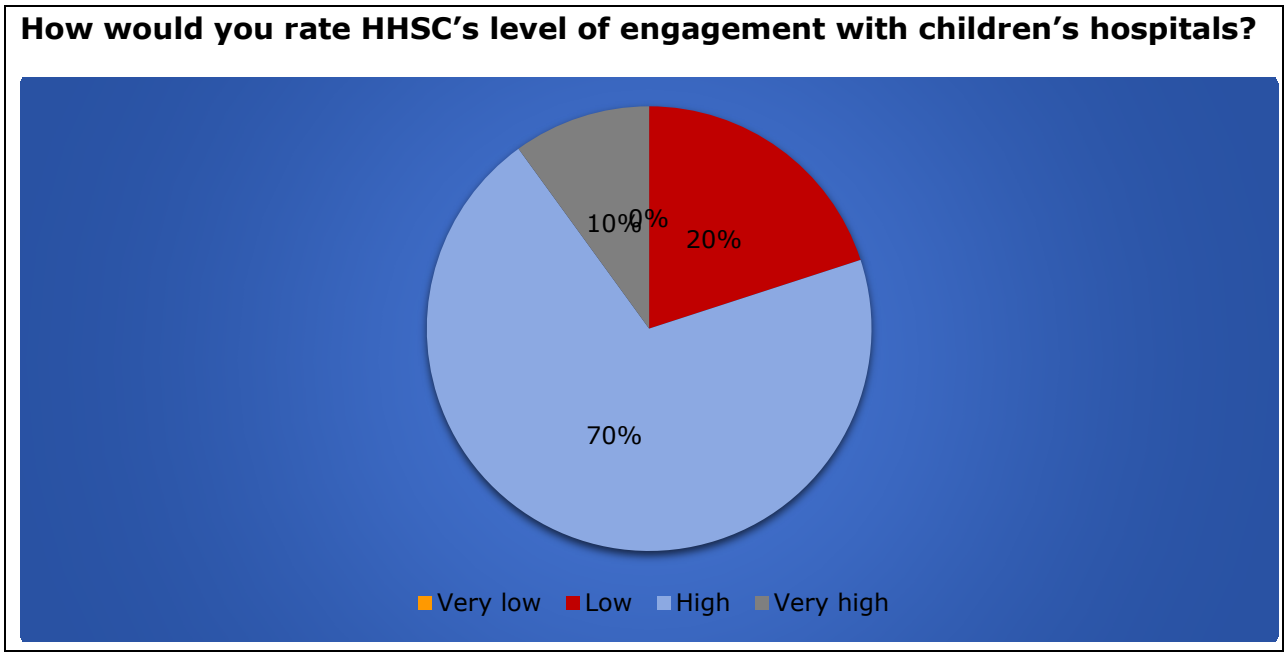


Chart 5. Level of Engagement



2.3.2 Survey Comments

The survey requested commentary on some of the questions. The comments are summarized below. The summary is not a comprehensive list of all responses. It highlights the most notable and consistent points submitted by the hospitals in relation to Medicaid reimbursement. The survey's overall comments indicate that Medicaid and CHIP reimbursements do not cover these hospitals' rising costs.

When asked about the greatest challenges that children's hospitals face, respondents indicated that fixed or declining Medicaid reimbursement rates are a major challenge as costs to serve Medicaid patients continue to increase faster than reimbursements. Respondents also indicated concerns about declining opportunities for reimbursement through Disproportionate Share and Uncompensated Care programs. The providers indicated that Medicaid rates do not cover the cost of care. Several comments specify that 50 percent or more of their patients are Medicaid clients, and children's healthcare costs are generally higher than adult care costs. The widening gap between cost of care for these children and reimbursement makes it hard for the hospitals to expand services, continue the full array of current services, and find sources to cover those costs.

The survey inquired whether reimbursement from several different payor types meet hospitals' total cost to deliver required services. The consensus was that Medicaid, Medicare, and Children's Health Insurance Program do not meet those needs. Commercial Insurance comes closest to covering the costs, but not always.

Comments related to this question indicated that Medicaid reimbursements are lower than the cost of providing the services. The hospitals indicated that no reimbursement is available for extensive support programs such as Child Life and Schooling. Comments also stated that outpatient reimbursement has not increased in many years and continues to decline. Multiple hospitals reported losses more than $100 million per year on Medicaid services. Providers also commented on physician subsidies. Due to unreimbursed physician costs, the hospitals find it essential to subsidize physician payments to retain their services. Specialized equipment and supplies required for small children also represent an extensive cost incurred by children's hospitals. Several comments indicated concerns about supplemental Medicaid payments moving away from children's hospitals, which will lower overall reimbursement. Certain DSH policies do not allow for program year adjustments.

Hospitals also commented on the current payment methodology for children's hospitals. Prior to September 1, 2013, Texas Medicaid reimbursed children's hospitals for inpatient services using a cost-based methodology. That methodology changed when the legislature directed HHSC to implement a prospective payment system for children's hospitals. In response, HHSC established a single, statewide base Standard Dollar Amount (SDA) with add-ons available to individual children's hospitals based on high-cost services such as medical education and geographic wage differences. Children's hospitals commended HHSC's efforts in establishing a separate SDA in recognition of their differences from adult hospitals in payor mix and the higher costs associated with a pediatric population in the survey. As is true for any reimbursement rate based on averages, low-cost providers benefit, and high-cost providers are brought down. The statewide SDA and add-on amounts have not been rebased since 2013 and are not adjusted annually to account for inflation. Additionally, hospitals with costs not addressed by the add-ons, and hospitals with rapidly growing costs, are disadvantaged by the statewide approach since they are limited to the same base rate as hospitals that do not provide such an extensive array of services. Hospitals also expressed concerns about reimbursement using Grouper version 37 which is used in the calculation of APR-DRG payments.

3. Conclusion

The report analyzes both interim and supplemental payments for children's hospitals within Texas. A survey of the hospitals was performed by HHSC to get an understanding of their concerns with Medicaid and CHIP reimbursement. Staff worked with the children's hospitals and their representatives to gather and summarize information related to other state programs. HHSC reviewed payments made by the Medicaid and CHIP programs for coverage of cost between supplemental payments and interim claim payments.

Results indicate several reimbursement changes impact children's hospitals. The transition from TEFRA to APR-DRG eliminated reimbursement at the cost of Medicaid services in these hospitals. Under TEFRA, rate adjustments occurred annually based on the provider's annual cost report submissions. Since the implementation of the APR-DRG methodology, rates have remained primarily unchanged. Medicaid appropriations have not allowed for increases for inpatient claim payment rates since 2016 when the legislature appropriated the Safety-Net add-on. HHSC is currently reviewing Grouper 37 concerns indicated by the children's hospitals to determine improvements.

HHSC implemented UC and DSRIP while continuing the DSH program. The payments from these programs to the children's hospitals will steadily decline due to federal and state-directed changes. The decline of payments through these programs will potentially decrease the overall 97 percent coverage of costs. UHRIP, implemented to reduce the gap created by changes in other programs, has significantly improved reimbursement. HHSC is collaborating, through the UHRIP Reform Workgroup, with hospital representatives to modify the UHRIP program for state fiscal year 2022. The goal is to create a program beneficial to all Texas Medicaid hospitals.

Reimbursement for all providers is an ongoing challenge in Medicaid and CHIP. HHSC recognizes children's hospitals' concerns and continues to collaborate with providers and their associations to identify creative solutions.

List of Acronyms

Acronym	Full Name
APR-DRG	All Patient Refined Diagnosis Related Groups
CHAT	Children's Hospital Association of Texas
CHIP	Children's Health Insurance Program
CMS	Center for Medicare and Medicaid Services
DSH	Disproportionate Share Hospitals
DSRIP	Delivery System Reform Incentive Payment Program
DY	Demonstration Year
ED	Emergency Department
FFS	Fee for Service
HHSC	Health and Human Services Commission
HSL	Hospital Specific Limit
LBB	Legislative Budget Board
MCO	Managed Care Organization
PMPM	Per Member Per Month
PPS	Prospective Payment System
SDA	Standard Dollar Amount
SPC	State Payment Cap
TAC	Texas Administrative Code
TEFRA	Tax Equality and Fiscal Responsibility Act
UC	Uncompensated Care
UHRIP	Uniform Hospital Rate Increase Program