TEXAS CONCEPT PAPER:
SOUTH TEXAS MCO PASS-THROUGH PAYMENT PILOT
MAY 13, 2016

INTRODUCTION

This concept paper describes the South Texas MCO Pass-Through Payment Pilot ("Pilot") proposed by the Texas Health and Human Services Commission ("HHSC"). This Pilot is designed to use the authority for MCO pass-through payments clarified in the May 6, 2016, Final Medicaid managed care rule (the "Final Rule") to address significant cash shortfalls being experienced by certain Medicaid-dependent South Texas hospitals in Cameron, Hidalgo, Maverick, Starr and Webb Counties. It is expected that these payments will transition over time to other provider payment initiatives contained in the Final Rule.

BACKGROUND

The Final Rule provided substantial clarity in a new 42 CFR § 438.6(d) regarding the permissibility of MCO pass-through payments to hospitals, physicians and nursing facilities as an exception to the general prohibition against states directing MCOs to make certainpayments. The Centers for Medicare & Medicaid Services ("CMS") acknowledges in the Rule that MCO "pass-through payments have served as a critical source of support for safety net providers who provide care to Medicaid beneficiaries." 81 Fed. Reg. 27498, 27589 (May 6, 2016).

South Texas is home to a substantial portion of Texas Medicaid beneficiaries. The five counties included in the Pilot in 2013 contained 12.14 percent of all Texas Medicaid beneficiaries,[1] despite constituting only 6.14 percent of the Texas population.[2] The hospitals in South Texas have been hard hit by reductions in the size of the Section 1115 Waiver uncompensated care ("UC") pool and by the "haircuts" necessary from the continued substantial demands on the UC pool.

HHSC recognizes that the Final Rule phases out the ability of states to make MCO pass-through payments over ten years, beginning July 1, 2017. HHSC anticipates that the Pilot payments will transition to another permissible category of payment under the Final Rule that will continue to allow critical support to the South Texas hospitals.

HHSC also recognizes that the Final Rule provides a statewide limit on the amount of MCO pass-through payments a state can make to hospitals. This limit is calculated as a percentage of a "base amount" as defined in 42 C.F.R § 438.6(d)(3). HHSC believes that the Pilot payments are significantly under this limit.

HHSC also recognizes that the payments to the MCOs, including the Pilot payments, must be actuarially sound. HHSC will provide appropriate actuarial documentation

[1] See http://www.hhsc.state.tx.us/research/MedicaidEnrollment/ME/201310.html.
[2] See https://www.tsl.texas.gov/ref/abouttx/popcnty2010-11.html

in connection with the Pilot payments, consistent with requirements in the regulations and accompanying rate development guide, to CMS as soon as it is available.

OBJECTIVES

By creating Pilot payments consistent with the Final Rule, Texas hopes to achieve the following objectives:

- Guarantee access to vital medical servies for Medicaid beneficiaries in a regiona that does not have a single major public hospital. Supporting the South Texas safety-net hospitals will mitigate trauma to beneficiaries who would otherwise be forced to travel significant distances at greater costs to the Medicaid program.
- Ensure Texas meets its requirements under federal law on beneficiary access to medically necessary services.
- Support Texas' efforts to meet market rates for provider services while ensuring actuarially sound rates for MCOs.
- Promote economic stability for local economies.
- Better align the coordination of care between MCOs and safety-net hospitals for a population that is over 90% Hispanic.
- Ensure accountability for scarce taxpayer dollars.
- Ensure access to medically necessary services for low-income non-Medicaid populations.

These objectives will assist the state and local communities in meeting their goals related to economic prosperity and improve the health of their citizens. Without timely access to medically necessary care at the local level, overall Medicaid spending will ultimately increase faster than current trends. To be independent and fully engaged in employment, individuals and families need access to medically necessary care. Healthy people in turn contribute to economic growth in their communities, and by extension, in the state.

METHODOLOGY

As discussed above, HHSC will adopt managed care pass-through payments for hospitals in Cameron, Hidalgo, Maverick, Starr and Webb Counties (the “Counties”). Hereinafter, we refer to this class of providers as the “Eligible Hospitals.” To implement pass-through payments, HHSC will increase the capitated rates under its contracts with MCOs that operate in the Counties, and the MCOs will in turn pass the enhanced capitation amounts through to the Eligible Hospitals. The non-federal share of the pass-through payments will be financed through intergovernmental transfers (“IGTs”) from the Counties.

Additional detail regarding the steps required to implement pass-through payments is below.

MCO Rate Enhancement

- A projected pass-through payment amount will be calculated for each Eligible Hospital providing services under the contract (the "Target Pass-Through Amount"). This amount will be equal to the difference between the hospital's UC limit calculated pursuant to the Special Terms and Conditions of the 1115 waiver, and all Medicaid payments otherwise projected to be made to the hospital for the contract year, including fee-for-service and managed care claims payments, disproportionate share hospital payments, and UC pool payments under the waiver (but exclusive of any delivery system reform incentive payments).
- The sum of all Eligible Hospitals' Target Pass-Through Amounts will be the Total Target Pass-Through Amount.
- HHSC will ensure that the Total Target Pass-Through Amount, when combined with any other managed care pass-through payments projected for hospitals for the contract year, is less than or equal to the relevant percentage of the Base Amount specified pursuant to 42 C.F.R. § 438.6(d)(3). If total statewide pass-through payments would exceed that amount, HHSC will reduce all pass-through payments on a pro rata basis to remain within the limit. In such circumstance, the Total Target Pass-Through Amount will reflect such pro rata reductions.
- The actuaries will determine a Pass-Through per member per month ("PMPM") amount for each MCO in the Hidalgo Service Area according to relative utilization of hospital services, such that payment of each MCO's PMPM amount for the full contract year would be projected to ensure full payment across all MCOs of the Total Target Pass-Through Amount.
- HHSC and its actuaries will submit documentation regarding pass-through payments to CMS, as required by 42 C.F.R. § 438.6(d)(4) and CMS' Medicaid Managed Care Rate Development Guide.

Contract Amendments

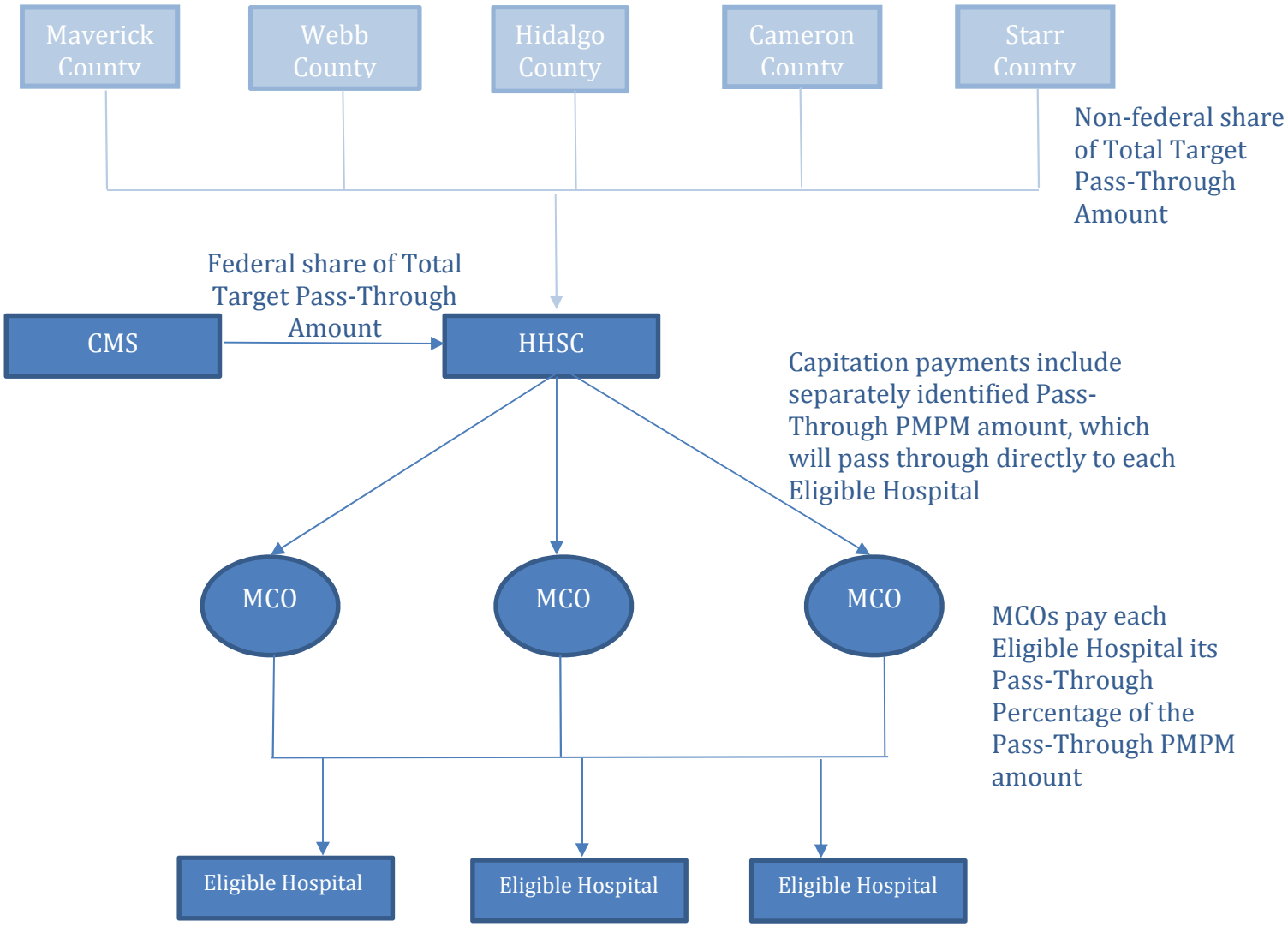
- HHSC will determine each Eligible Hospital's pro-rata share of the Total Target Pass-Through Amount by dividing each Eligible Hospital's Target Pass-Through Amount by the Total Target Pass-Through Amount (the Eligible Hospital's "Pass-Through Percentage").
- HHSC will include in its contracts with MCOs a requirement that on a monthly basis the MCOs pay each Eligible Hospital its Pass-Through Percentage of the total monthly Pass-Through PMPM amount to the MCO (see funds flow below). Sample contract language is attached as Attachment A.
- CMS will need to approve the MCO contract amendments.

Funds Flow

- On a monthly basis, the MCOs will, as contractually required, pay each Eligible Hospital its Pass-Through Percentage of the total monthly Pass-Through PMPM amount to the MCO.

- On a semi-annual basis, HHSC will invoice the Counties for their portion of the IGTs necessary to fund the projected next six months of the non-federal share of pass-through payments and reconcile based on prior period actual non-federal share need.
- On a monthly basis, HHSC will report to each MCO and Eligible Hospital the total amounts paid in pass-through payments to each MCO so that pass-through payments operate transparently to all parties and so that all parties can be held accountable.

The funds flow is represented graphically below.



CONCLUSION

The Texas HHSC believes that the Pilot payments are an important tool, authorized by the recent Final Rule, that will help Texas address needs of Medicaid dependent South Texas safety net hospitals. It is expected that these payments will transition over time to other provider payment initiatives contained in the Final Rule.

Attachment A
Sample Contract Language

Section 10.20 Pass-through Payments for Hidalgo Managed Care Service Area

(a) The capitation rates include funding to cover the cost of pass-through payments for hospitals in Hidalgo Managed Care Service Area.
(b) HHSC will provide a list of eligible providers to the MCO, which will specify each eligible provider's percentage share of aggregate pass through payments.
(c) If the MCO does not otherwise have a contract with an eligible provider, it will enter into a limited contract for the purpose of paying the provider its share of pass-through payments.
(d) On a monthly basis, HHSC will notify the MCO of the total dollar amount of capitation payments paid to the MCO for pass-through payments.
(e) On a monthly basis, the MCO will pay each eligible provider their percentage share of the total pass-through payment capitation amount.
(f) The MCO will report to HHSC its expenditure of pass-through capitation amounts in a format specified by HHSC.
(g) The MCO is prohibited from using any capitation amounts paid for pass through payments for any purpose other than paying eligible providers pursuant to this section.