Semi-Virtual

Torch Conference 2021

Brandon Durbin
brandon@dhcg.com
469-361-0120

Back in 2011

DSRIP

4CC

Then in 2013

DSRIP

4CC

MPAP /
QIPP

TIPPS

2021

CHIRP

UHRIP

ACIA / ACR

PPP

CARE$

RAPPS

QIPP

TNIP

What is all of this?

- Shifting from waiver program payments – UC / DSRIP
- Directed Program Payments – DPP through the managed care companies – Similar to a Waiver program
- DPP's should technically be easier than the UC/DSRIP programs
  - HHSC control vs MCO/Provider Control
  - CMS intentionally limits state control
  - HHSC does not like lack of transparency into the underlying arrangements

DSRIP / UCC Termination

- UCC became UC and UHRIP
  - UCC was based on the DSH limits, called HSL
    - Self Pay
    - Medicaid shortfall
  - UC is only charity component – CMS dictated
  - UHRIP is the Medicaid Shortfall – Industry Created
- DSRIP terminating has required programs to capture the budget neutrality
  - ACIA – when combined with UHRIP they call it CHIRP
  - RAPPS is for RHC's
  - TIPPS is for hospital physician's
  - TNIP is a new one – Industry Developed

If they would just pay us the cost…

- We are way past cost with these new programs
  - UHRIP is cost or rather Medicare cost payment method
    - Supposed to be based on CAH and SCH rates for rural hospitals
  - ACIA is based on market payments
- DSRIP was not cost based, it was like a grant
  - DSRIP had a minimum to each rural hospital
  - The cost of the program was also part of your cost report
  - The loss of DSRIP is the single largest part of the CHIRP loss for rural providers

Apply

Commit

IGT

	Comprehensive Hospital Increase Reimbursement Program (CHIRP)	Texas Incentives for Physician and Professional Services (TIPPS)	Quality Incentive Payment Program (QIPP)	Rural Access to Primary and Preventive Services (RAPPS)	Directed Payment Program for Behavioral Health Services (DPP BHS)
March 2021					
Enrollment period opens; Providers submit applications to HHSC	March 15			March 24	
April 2021					
Enrollment period ends; Last day to submit application	April 5		April 15	April 13	
HHSC communicates suggested IGT responsibilities and estimated revenues	April 20	April 21	April 27	April 25	
Declaration of intent due to HHSC with IGT commitment	April 30				
May 2021					
Declaration of intent due to HHSC with IGT commitments		May 01	May 12	May 05	
HHSC issues IGT notification for first half of IGT due	May 11	May 12		May 14	
IGT Due; Last day to enter funds in TexNet	May 28				
June 2021					
IGT Due; Last day to enter funds in TexNet		June 01	June 02	June 03	
IGT settlement for first half of IGT	June 01	June 02	June 03	June 04	
September 2021					
State fiscal year 2022 program begins	September 01				

Comprehensive Hospital Increase Reimbursement Program (CHIRP)

- Application is due April 5th and is for hospitals only.
- Comprised of two components:
  - UHRIP -
    - ✓ SDA Region calculation - AVERAGE
    - ✓ Offsets for NAIP
  - Average Commercial Incentive Award (ACIA). Average Commercial Rate (ACR)
    - ✓ Not average - Specific
- Open to six classes of hospitals: children's, rural, state-owned that are not IMDs, urban, non-state owned IMDs, and state owned IMDs.
- IGT is accumulated and based on each SDA

CHIRP Modeling

CHIRP Rural Impact

	CURRENT PROGRAM PAYMENT AMOUNTS			*NEXT YEAR 2021-2022 PROGRAM PAYMENT AMOUNTS*			
	DSRIP DY10	Current Year UHRIP	Total UHRIP & DSRIP Payment	UHRIP Payment	ACIA Payment	Total CHIRP Payment	Gain (Loss)
Grand Total	**147,458,186**	**119,824,313**	**267,282,499**	**42,556,885**	**74,128,421**	**116,685,306**	**(150,597,192.91)**

	UHRIP Rate %	ACIA Rate Average %
Bexar	36%	18%
Dallas	50%	127%
Harris	33%	0%
Hidalgo	0%	30%
Jefferson	10%	17%
Lubbock	81%	21%
MRSA Central	13%	16%
MRSA Northeast	15%	19%
MRSA West	15%	8%
Nueces	21%	80%
Tarrant	14%	154%
Travis	23%	19%
	20%	16%

Uniform Rates

- This is not uniform. The rates vary *considerably*.
- Public vs Private rural impact:
  - It is combined to eliminate a pay to play issue
  - Public loss - $117M
  - Private loss - $34M

What is ACR

- The general rule has always been that the Upper Payment Limit was the equivalent to Medicare.
- Physician UPL programs wanted something more reasonable and in an MCO environment made the case that the commercial rate should replace Medicare as the upper limit.
- It is a theoretical state wide limit.
- They could have paid rural more.
  - They can also use 150% of Medicare as a default ACR
- Both were pushed to HHSC, both rejected

Quality Metrics for the CHIRP ACIA Rural Hospital Component

- Comprised of two components:
  1. Tobacco Use: Screening & Cessation Intervention
     - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months **AND** who received tobacco cessation intervention if identified as a tobacco user.
  2. Influenza Immunization
     - Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization **OR** who reported previous receipt of an influenza immunization.
- Reporting periods for both:
  - October 2021 – measurement period of 1/1/21 to 6/30/21 – LIVE!!!
  - April 2022 – measurement period of 1/1/21 to 12/31/21 – LIVE!!!
- Payer types: Medicaid, uninsured, and other
- Must have at least one encounter for each component during the measurement period

CHIRP Public Model

- The public providers also get a CHIRP program for Fee For Service
- This means for the TMHP paid claims
- Regular CHIRP is the MCO Program and Public & Private
- Does *not* include dual eligible Medicare / Medicaid.
- Urban public are made whole by this program that pays $737M
- Rural received only $27M
- ACR Data is again the problem – Please file by April 5th
- Lobby State for 150% Medicare as a default ACR

CHIRP- Public Modeling

FFS & MCO CHIRP Combined			
Option 1 Payment (Medicare UPL)	Option 2 Payment (ACR Gap)	Option 3 Payment (Max of Medicare UPL and ACR Gap)	CHIRP Combined Rural Impact
2,892,284	25,223,205	27,011,665	($123,585,528)

Rural Access to Primary and Preventive Services (RAPPS)

- For RHC's – hospital-based or free standing
- Application is due April 13th
- Each SDA with at least one sponsoring governmental entity for the IGT
- Minimum volume of 30 Medicaid MCO unique encounters in the prior fiscal year
- Payment methodology:
  - Component 1 - Uniform dollar – 75 % of total program value. Performance based
  - Component 2 - Percent rate increase for certain services. Providers must report quality metrics – 25% of total program value.

RAPPS Metrics

- Component 1 –
  - Reporting on electronic health record (E.H.R) use
  - Telemedicine/telehealth capabilities
  - Care coordination
- Component 2 –
  - Providers must report quality metrics
  - Have not released codes
- Not very well defined, especially for the pay IGT and chase methodology.

RAPPS Modeling

Rural Access to Primary and Preventive Services

Modeling for Illustrative Purposes Only

	Freestanding	Hospital-based
Per Unit Increase for Component 1	*$18.36*	*$27.55*
Uniform Rate Increase on Eligible Codes for Component 2	*6%*	*6%*

	Component 1	**Component 2**	**Total DPP**
Grand Total	**$ 14,000,631**	**$ 4,666,877**	**$ 18,667,508**
Percent of Total Program Value	*75%*	*25%*	*100%*

Model based on SFY 2019 managed care claims adjusted for assumed caseload growth

Comparison point is RHC Medicare cost-reports

Texas Incentives for Physician and Professional Services (TIPPS)

- Application is due April 5th and is filed by hospital Physician NPI
  - Not for RHCs– RHCs are eligible for RAPPS
    - Physician can bill non-RHC services in a group and potentially qualify for TIPPS
- Have not released the NPI data or the source
- Open to physician groups defined as
  - HRI – Medical Schools
  - IME – Teaching Interns & Residents
    - HRI & IME Physician practice groups must have a minimum volume of 30 Medicaid patients
  - Other - Must serve 250 Medicaid managed care clients
    - No list of who qualifies
    - The IGT is an issue
    - Who is the IGT source? By group in the SDA or SDA

Texas Incentives for Physician and Professional Services (TIPPS)

- There are three components to the program:
    1. Paid as a per-member-per month payment – *HRIs and IMEs only are eligible*
    2. Serves as a performance incentive payment - *HRIs and IMEs only are eligible*
    3. Serves as a rate enhancement for certain outpatient services – ***all*** physician practice groups are eligible
- HRI & IME – report 50% of the quality metrics in CY 2021 for components 2 and/or 3 to be eligible to participate.
- This is tilted to favor State institutions and Urban groups
- The other group only covers group practices,
    - Single and multi specialty
    - Make sure and revalidate your groups. Must use the group Taxonomy codes

Class	HRI/ IME/ Other Physician Expenditures	Total ACR Pool	ACR UPL	Room Percentage	Final UPL	Component Total Room	TIPPS Payment
Component 1							
HRI	$184,294,964.32	$ 651,997,798	$558,054,060.50	85.59%	$482,735,511.15	$313,778,082.25	$313,778,082.25
IME Add-on	$54,750,276.47	$ 651,997,798	$93,943,737.16	14.41%	$81,264,488.85	$52,821,917.75	$52,821,917.75
Component 2							
HRI	$184,294,964.32	$ 651,997,798	$558,054,060.50	85.59%	$482,735,511.15	$120,683,877.79	$120,683,877.79
IME Add-on	$54,750,276.47	$ 651,997,798	$93,943,737.16	14.41%	$81,264,488.85	$20,316,122.21	$20,316,122.21
Component 3							
HRI	$184,294,964.32	$ 651,997,798	$558,054,060.50	85.59%	$482,735,511.15	$48,273,551.11	$3,530,831.96
IME Add-on	$54,750,276.47	$ 651,997,798	$93,943,737.16	14.41%	$81,264,488.85	$8,126,448.89	$202,996.26
Other physicians	$458,798,709.63						$52,666,171.78
Total HRI	$184,294,964.32				$482,735,511.15	$482,735,511.15	$437,992,791.99
Total IME Add-on	$54,750,276.47				$81,264,488.85	$81,264,488.85	$73,341,036.23
Total Other Physicians	$458,798,709.63				$0.00	$0.00	$52,666,171.78
Grand Total	**$697,843,950.42**				**$564,000,000.00**	**$564,000,000.00**	**$564,000,000.00**

TIPPS Modeling

SDA	Procedure Count	NPI's Billed Count	Units of Service	Total Paid	Total Supplemental Payment
Bexar	220,686	980	884,387	42,541,351	5,229,597
Dallas	331,727	977	1,239,098	51,648,902	6,349,185
El Paso	107,414	354	435,112	18,525,039	2,277,278
Harris	660,552	1,249	2,564,576	126,278,380	15,523,367
Hidalgo	358,857	1,047	2,142,366	77,586,786	9,537,723
Jefferson	72,436	772	303,744	13,249,588	1,628,768
Lubbock	63,397	489	244,502	10,018,538	1,231,576
MRSA Central	94,405	1,054	356,615	13,549,495	1,665,636
MRSA NE	127,229	998	464,639	18,666,383	2,294,653
MRSA West	104,551	1,085	394,348	16,122,455	1,981,929
Nueces	83,228	749	363,054	11,206,094	1,377,562
Statewide	36,119	1,406	167,910	7,641,273	939,340
Tarrant	228,785	794	841,805	34,691,020	4,264,558
Travis	106,303	802	369,165	17,073,404	2,098,829
Grand Total	2,595,689	12,756	10,771,321	$ 458,798,708	$ 56,400,000

Quality Metrics for TIPPS

- Payment comprised of one component for rurals' with the following measures:
  1. Food Insecurity Screening
  2. Maternity Care: Post-Partum Follow-Up & Care Coordination
  3. Behavioral Health Risk Assessment for Pregnant Women
  4. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
  5. Depression Response at Twelve Months
  6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Reporting Periods:
  - Quarter 1 (September- November 2021)
    - Report data based on January to June 2021 – LIVE!!
  - Quarter 3 (March- May 2022)
    - Report data based on January to December 2021 – LIVE!!
- Payer types: Medicaid, Uninsured, and Other
- At least 30 Medicaid patients in at least 50% of the quality metrics in 2021 to participate
  - After this, all measures must be reported for a provider to be eligible (Pay for performance in later years)

Texas Network Incentive Program (TNIP)

- TNIP is a managed care quality incentive arrangement that will reward Medicaid MCOs and providers that achieve performance milestones and improve enrollee health outcomes.
- Federal law explicitly authorizes HHSC to make additional payments to Medicaid MCOs for quality incentive arrangements totaling up to 5% above actuarially sound capitation payments attributable to covered enrollees or services.
- Statewide capitation payments in Texas currently total $23.5 billion.
- With all the new programs this will be closer to $30B

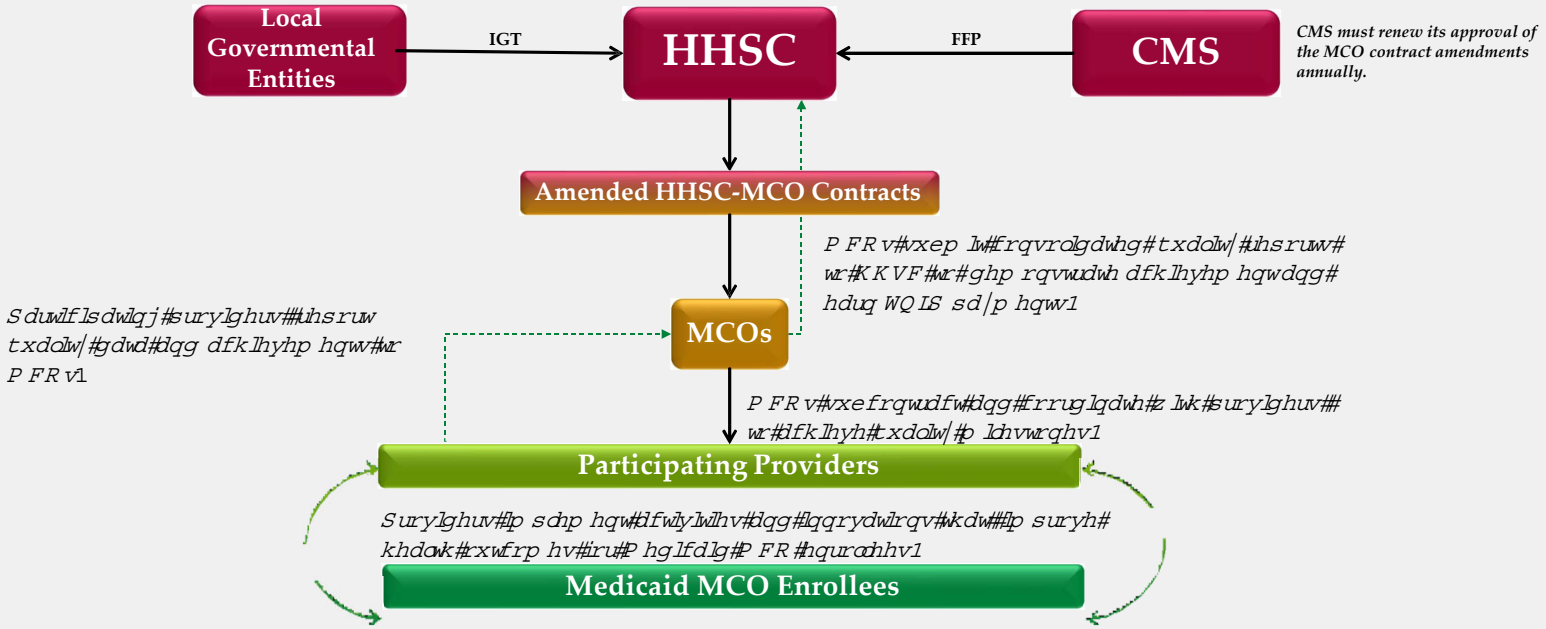
TNIP

- This is proposed and has been developed by Gjerset & Lorenz / Don Gilbert, and others.
- This was discussed and presented in the workgroups
- HHSC dismissed this alternative
- The commissioner is now considering this program

TNIP

- About a $1.2 to $1.5B program
- Could have a rural carve out similar to DSRIP
- This program is based on meeting performance of the group, so it would be all hospitals in a SDA.
- Need SDA based organizing entities
  - Like super RHP's / Co-op / Etc.
  - Urbans are organized
- Funds do not count as HSL for DSH or other purposes.

TNIP: INCENTIVE PAYMENT MECHANICS



TNIP: OPPORTUNITY BY SERVICE DELIVERY AREA

Service Delivery Area	Estimated Annual TNIP Opportunity
Bexar	$110 - $135 million
Dallas	$155 - $195 million
El Paso	$40 - $50 million
Harris	$260 - $330 million
Hidalgo	$150 - $185 million
Jefferson	$35 - $45 million
Lubbock	$30 - $35 million
MRSA Central	$60 - $75 million
MRSA Northeast	$80 - $100 million
MRSA West	$70 - $90 million
Nueces	$45 - $55 million
Tarrant	$100 - $125 million
Travis	$65 - $80 million
Statewide Total	**$1.2 - $1.5 billion**

Uncompensated Care

- Granted a ten-year extension to September 30, 2030
  - CMS is ***not*** making substantive changes to the methodology of the current UC Pool through this demonstration renewal
- Resizing the existing UC pool in 2022
  - Used for years 2022-2026
  - The rebase in 2022, **will use hospital fiscal year 2019 data**
    - This represents the best way to avoid capturing data impacted by COVID-19 expenditures or changes in utilization.
  - Resize again in 2027, using the most recent complete cost reports from eligible hospital providers (hospital fiscal year 2025 data).
- Charity audits will occur.

RHC Modernization Act

- The RHC Cap will be raised to $100 on April 1, 2021 and then the cap will gradually rise each year to $190 in 2028.
  - January – March 31, 2021 = $87.52
  - $13 increase each year beginning in 2022
- ***All newly established RHCs will be subject to this cap*** meaning no new RHC (even those purchased or established by hospitals with less than 50 beds) could receive uncapped cost-based reimbursement
- Uncapped RHCs in existence will be grandfathered with their current All-Inclusive Rate (AIR) and would still see year-over-year increases but will be restricted to their current AIR *plus* an adjustment for MEI (Medicare Economic Index).
- RHCs can now bill for hospital attending physician services
  - TIPPS Conflict

Update to the RHC Modernization Act.

Medicare Sequester Bill *with* RHC Grandfathering Fix Passes House

The House bill contains several technical corrections to recently passed legislation including a provision addressing our grandfathering issue from Section 130 of the Consolidated Appropriations Act of 2021.

Specifically, the bill contains a technical correction that would:

1. Fix the effective date for the RHC payment modernization changes passed last December from December 31, 2019, to December 31, 2020. This means that all new small (less than 50 beds) hospital-based RHCs that were certified in 2020 will have their upper payment limit based on either: their 2020 RHC payment rate (plus MEI adjustments); or the new "main" upper payment limit, whichever is higher.
2. Extend the grandfathering provision to small hospital-based RHCs that had filed an application to enroll in the Medicare program as an RHC prior to December 31, 2020.
3. Sets the upper limit for small hospital-based RHCs that do not have 2020 reimbursement rates at their 2021 rate plus annual MEI adjustments for 2022 and beyond.

RHC Fix

- Senate passed a version too
- The RHC provisions are identical to what the House passed last week. This fix **allows for qualified provider-based RHCs established before December 31, 2020, and those RHCs which submitted an 855A application before December 31, 2020, to be eligible for the grandfathered-in rates.**

- There was a push to have Senate include additional language that would have also allowed RHCs that had entered a construction contract or agreement by December 31, 2020, to also be eligible for the grandfathered-in rates. Unfortunately, this text was not included in the final package.

- Link to H.R 1868 – 117th Congress https://www.congress.gov/bill/117th-congress/house-bill/1868

And…

- The House is working in the districts and will convene April 13th.
- CMS is urged to not process any payments for dates of Service after 3/31/2021 in order to let Congress correct the Sequestration.


SPRING
BREAK
FOXADHD.COM

2021 IPPS Final Rule
Medicare Bad Debt Revisions

- CR periods beginning on or after 10/1/20 will be impacted
- Timely Billing:
  - Provider must issue the bill "on or before 120 days after the latter of"
    - The date of the final Medicare RA
    - The date of the remit from the secondary payer, if any
    - The date of the notification that the secondary payer does not cover the service(s)
- Reasonable Collection effort defined
  - Emails, phone calls, and text messages are valid mechanisms for billing
- CMS 120-day Rule:
  - Write-off must occur at least 120 days after 1st bill date
  - 120-day clock ***resets*** upon receipt of ***any*** partial payment
  - If using a collection agency, there must be 120-days between 1st bill & date returned

PRF Reporting Requirements

- We are continuing to monitor the Provider Relief Funds (PRF) guidance and routinely check for updates.
  - Latest guidance released as of January 15th
  - More is in the works….
- Two-Step Process:
    - Step 1: Calculate Healthcare Related Expenses Attributable to Coronavirus
      - Unreimbursed Expenses Incurred to Prevent, Prepare for, and/or Respond to Coronavirus
    - Step 2: Remaining PRF funds are Applied to Patient Care Lost Revenues
      - The Difference between 2019 and 2020 actual patient care revenue received
      - Revised rules for the Consolidated Appropriations Act (CAA) have not been written

Possible new rules

- The CAA went back to define lost revenue as of the June 2020 method, which included budget revenue.
- *Pg 1843 - Provided further, That, for any reimbursement from the Provider Relief Fund to an eligible healthcare provider for health care related expenses or lost revenues that are attributable to coronavirus (including reimbursements made before the date of the enactment of this Act), such provider may calculate such lost revenues using the Frequently Asked Questions guidance released by the Department of Health and Human Services in June 2020, including the difference between such provider's budgeted and actual revenue budget if such budget had been established and approved prior to March 27, 2020:*
- Rural GME – Will there be a Medicaid IME track?
  - TIPPS Component 2

PRF Allowable Expenses

- Two Categories:
  - Administrative & General Expenses Attributable to Coronavirus
    - Mortgage/Rent
    - Insurance: All insurance premiums paid
    - Personnel: Workforce-related expenses paid to Prevent, Prepare for, and/or Respond to Coronavirus
    - Fringe Benefits
    - Utilities/Operations
    - Other A&G Expenses: Costs not captured above that are generally considered part of overhead structure
  - Healthcare Related Expenses Attributable to Coronavirus
    - Supplies: PPE, hand sanitizer, etc.
    - Equipment: Ventilators, HVAC systems, etc.
    - Information Technology
    - Facilities: Facility modifications

Allowable Expense Calculation Example

Administrative & General:	
Mortgage/Rent	$ 120,000
Insurance	100,000
Personnel	14,000,000
Fringe Benefits	900,000
Utilities/Operations	200,000
Other G&A	2,000,000
Actual Healthcare Related Expenses:	
Equipment	1,000,000
Total Expenses Attributable to Coronavirus	$18,320,000
Less: Reimbursement from Other Sources	
PPP Loan	($3,000,000)
CARES Act Testing	(100,000)
Local, State & Other Assistance	(50,000)
Cash Receipts from Patients	(10,000,000)
Total Unreimbursed Healthcare Expenses	$5,170,000

Allowable Expense Calculation Example (Cont'd)

Total PRF Funds Received		$6,000,000
Total Unreimbursed Healthcare Expenses		(5,170,000)
PRF Funds Remaining (Apply to Lost Revenue)		830,000
Lost Revenue (2019 – 2020):		
Cash Received from Patients	1/1/2019 – 6/30/2019	$10,000,000
Cash Received from Patients	1/1/2020 – 6/30/2020	9,000,000
Lost Revenue		$1,000,000
Total PRF Funds Expended in FY 2020:		
Total Unreimbursed Healthcare Expenses		$5,170,000
Lost Revenue		830,000
Total PRF Funds Expended in FY 2020		$6,000,000

PPP Updates

- Deadline for PPP Draw 1 and Draw 2 forgiveness applications extended to May 31st.
- Expenses paid with a PPP loan are deductible and forgiveness of the PPP loan is not taxable.
- PPP borrowers can also use the Employee Retention Credit as long as the same wages are not used for both.

Other Things to Know

- Price Transparency
  - Big providers blocked searches
  - Must have your machine-readable and human-readable (searchable) posted on your website as of January 1st, 2021
    - If you need help with this, please let us know. Avoid the $300 per day non-compliance hit.
- Employee Retention Credit
  - IRS guidance does not include the 2021 changes, which is what applies to most of the rural hospitals.
- Disaster declaration in Texas
  - Extended filing due date to June 15, 2021
- E-File of Cost Reports
  - Available to all providers registered in the IDM system of the CMS portal