

TORCH Conference Spring 2022

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



Topics

- **Updates and Current Events**

- Directed Payment Programs and Medicaid Financing
- RHC Modernization
- PRF
- DSH/UC
- Pricing Transparency

- **Preparing for the Future**

- Community Engagement
- Under Arrangements
- Medicare Advantage
- Observations of Trends



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Directed Payment Programs (DPP)

- District Court ordered CMS to issue a final approval or denial decision on the SFY2022 DPP programs by March 25, 2022.
- On March 25, 2022, CMS approved CHIRP, RAPPS, and TIPPS for 2022
 - QIPP was already approved for SFY 2022 on November 15, 2021
- HHSC and CMS have not agreed to an acceptable method of funding
 - Per CMS, all LPPFs will be subject to OIG Audits
- 2023 (Year 2) CHIRP applications were due on March 22nd to HHSC
 - Private Hospital are required to pay a \$8,500 application fee. Those fees were due on April 15th
- IGT for CHIRP / RAPPS / TIPPS-DPP is due by May 6th
- CMS has not approved the various DPP for 2023



Trial Status

- Trial is set for September 2022 on the 10 year extension.
- Primary issue is the revocation of the Trump Administration waiver extension by the Biden Administration
 - The injunction hearing had to prove that Texas would probably prevail, and the judge agreed.
 - If Texas prevails, the 10 year extension of the waiver would stand.
 - CMS will likely still be difficult to deal with on year by year approvals.
- In the March ruling, the judge also hinted that he would agree that the LPPF private payments are permissible, but that such issue was not plead by Texas
 - Did offer that he would rule if Texas amended his petition.



Directed Payment Programs

- **CHIRP (Comprehensive Hospital Increased Reimbursement Program)**
 - Replaces UHRIP program as of Sept 1, 2021 – **Now retro to this date**
 - Continues to provide a uniform rate enhancement similar to UHRIP
 - Uses average commercial incentive award payments to allow providers to earn higher reimbursement rates
 - Hospitals providing healthcare services to adults and children enrolled in STAR and Star + Plus. Eligible hospitals include children's, rural, mental health, state owned and urban
 - All participating hospitals are required to report on all program measures in the components for which they are eligible
- **QIPP (Quality Improvement Payment Program)**
 - Incentive payment program for Texas nursing facilities for residents enrolled in STAR + PLUS
 - Providers earn payments for meeting participation and performance requirements
 - Non-state government owned facilities are eligible
- Source & More Info: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/medicaid-supplemental-payment-directed-payment-programs/directed-payment-programs> -



Directed Payment Programs

- **RAPPS (Rural Access to Primary and Preventive Services Program)**

- Directed payments program for rural health clinics that provide primary care and long-term care services to STAR, STAR +PLUS and STAR Kids members
- Focus on management of chronic conditions
- 2 types of RHC's Eligible:
 - Hospital-Based (including non-state gov't owned & private RHCs)
 - Free-Standing
- 2 payment components:
 1. Monthly prospective uniform dollar increase
 2. Uniform % increase for certain services

- **TIPPS (Texas Incentives for Physicians and Professional Services)**

- Value-based directed program for certain physician groups providing health care services to children and adults enrolled in STAR, STAR + PLUS and STAR Kids Medicaid programs.
- Eligible groups include health related institutions, IME physician groups affiliated with hospitals and other physician groups
- 3 payment components:
 1. Monthly performance incentive pmt
 2. Semi-annual performance incentive pmt
 3. Uniform rate increase on paid claims for certain services based on metrics achieved

- Source & More Info: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/medicaid-supplemental-payment-directed-payment-programs/directed-payment-programs> -



ALL DPP's

- HHSC is going to cram through these programs as fast as possible
- Accelerating IGT payments
 - Various payment dates. We will send emails of deadlines to all on our list
 - The dates change very often
 - Cash flow concerns, especially for QIPP providers, may be critical
- The rules, processes, and payments will also be changing very quickly
- Data on the HHSC web site is not always up to date. It is changing too quickly.



Comprehensive Hospital Increase Reimbursement Program (CHIRP)

- Payments are to be made shortly (no promise of a date) for a retro on the first 6 months.
- Quality Measure Reporting for CHIRP Year 1 is due between April 29 to May 26th
 - HHSC is hosting a webinar on April 26th
- 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



Quality Metrics for the CHIRP ACIA Rural Hospital Component

- For rural, this is 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
 - April 2022 – measurement period of 1/1/21 to 12/31/21
- Payer types: Medicaid, uninsured, and other
- Must have at least one encounter for each component during the measurement period



Rural Access to Primary and Preventive Services (RAPPS)

- For RHC's – hospital-based or free standing
- Application was due April 13th
- Quality Measure Reporting for RAPPS year 1 is due by May 26th
 - HHSC is hosting a webinar on April 26th
- 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



Texas Incentives for Physician and Professional Services (TIPPS)

- Application was 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
 - This is primarily an URBAN and State & Large system program



DSRIP DY11 Schedule

April Reporting

- April 30, 2022 - Deadline for reporting to HHSC
- May 18, 2022 - HHSC will post estimated IGT for providers
- June 1, 2022 - IGT change forms due to HHSC
- June 15, 2022 - HHSC to send out IGT notifications
- July 6, 2022 - IGT settlement date
- July 29, 2022 - Payment to all providers



Medicaid Financing

- CMS is trying to limit these programs by attacking the source of the State match
- MFAR was the proposed rule, that was withdrawn
 - CMS is still trying to implement through approval process many of the MFAR principles. CMS admitted in the previous hearing.
- Community benefit programs – These were eliminated with the DAB trial. Still in District court December 2022
- LPPF's – The local agreements between private hospitals are being attacked.
- Loans – If loans for IGT are made, then the source of repayment is an issue. If this is from program funds, this is an issue. This is recycling of federal funds.



Loans

- Very complicated issues
 - Is an MCO dollar still a Federal dollar?
 - Can State dollars be reused?
 - How long does it take for a dollar to lose this identity?
 - Permanent?
- Real issue – CMS wants “real” public funds - tax dollars



RHC Modernization Act

RHC Certified *after* 12/31/2020?

→ Cap of \$113 per visit in 2022
(increasing by \$13/ year through
2028)

RHC Certified *before* 12/31/2020?

→ Cap of your 2020 per visit rate
plus an adjustment for MEI
(Medicare Economic Index) each
year OR your actual cost per visit
for the year (*whichever is lower*)



New Rules regarding Telemedicine visits in the RHC (during health emergency)

- Telemedicine is NOT an RHC encounter and should NOT be included in the visits on the cost report
- Payment for telemedicine visits are approx. \$92.03/ visit
 - *Will increase each year with inflation*



PRF Phase 4 Payments

- 92% of all applications have now been processed as of April 13th
 - The remaining 8% will be processed before June of 2022
 - You have until June of 2023 to spend these funds



PRF Phase 4 Payments (to date)

Funding Distribution	Number of Providers	Payment Total
Batch 1 - December 2021	68,954	\$8,703,783,581
Batch 2 - January 2022	7,658	\$2,028,577,215
Batch 3 - February 2022	4,171	\$560,111,674
Batch 4 - March 2022	3,651	\$413,776,448
Batch 5 - April 2022	3,680	\$1,754,244,019



PRF Important Dates

	Payment Received Period (Payments Exceeding \$10,000 in Aggregate Received)	Period of Availability	Reporting Time Period
Period 1 ✓	From April 10, 2020 to June 30, 2020	January 1, 2020 to June 30, 2021	July 1, 2021 to September 30, 2021*
Period 2 ✓	From July 1, 2020 to December 31, 2020	January 1, 2020 to December 31, 2021	January 1, 2022 to March 31, 2022
Period 3	From January 1, 2021 to June 30, 2021	January 1, 2020 to June 30, 2022	July 1, 2022 to September 30, 2022
Period 4	From July 1, 2021 to December 31, 2021	January 1, 2020 to December 31, 2022	January 1, 2023 to March 31, 2023
Period 5	From January 1, 2022 to June 30, 2022	January 1, 2020 to June 30, 2023	July 1, 2023 to September 30, 2023

*Grace period ended on November 30, 2021.



Missed Period 1 and Period 2 Reporting?

Make a request with HRSA before April 22nd at:

<https://www.hrsa.gov/provider-relief/reporting-auditing>



PRF Uses Strategy

- One and Done – Using funds for current operations
- Lasting Future Benefits – Investing funds for longer term benefits. (Just like DSRIP)
 - Recruiting & Retaining Personnel
 - Facility Improvements
 - Allied Health & Nursing School
 - Community Outreach / Education – Strengthen market presence
 - Develop New Service Lines
 - Under Arrangement
 - Technology
 - EHR upgrades
 - Community Engagement
- Regardless of strategy, who have to report and justify the funds



HRSA Programs Cancelled

- HRSA Uninsured Claims Reimbursement for Testing, Treatment, and Vaccine Administration ended March 22nd
- HRSA Coverage Assistance Fund ended April 5th

Important to write these off to charity where qualified and claim under UC



Current Developments Update

DSH/UC

2018/2019 DSH audits completed: many hospitals are in recoup status due to change in CHAT rule

DY 8 UC reconciliations are in process and due May 6th, but expect CHAT rule audit exposure on these

2022 DSH/UC Applications were filed in early December 2021

2022 and probable 2023 recoupments for UC CHAT impact may be as much as \$200,000-\$800,000 per facility



2018/2019 DSH Audits & CHAT

$$(Medicaid Shortfall + Uninsured Shortfall) \times DSH \text{ inflator} = HSL$$

Example: \$1,000 in Costs, \$300 Medicaid pmts, \$200 Medicare pmts, \$100 Other Ins pmts

CHAT rule during DSH/UC App timeframe:
EXCLUDED Medicare and Other Insurance pmts

Medicaid + Medicare + Other Costs	\$1,000
↓	↓
-Medicaid pmts	(\$300)
↓	↓
- Medicare pmts	0
↓	↓
- Other ins pmts	0
↓	↓
= Medicaid Shortfall	\$700

CHAT rule during DSH Audit timeframe: INCLUDED
Medicare and Other Insurance payments

Medicaid + Medicare + Other Costs	\$1,000
↓	↓
-Medicaid pmts	(\$300)
↓	↓
- Medicare pmts	(\$200)
↓	↓
- Other ins pmts	(\$100)
↓	↓
= Medicaid Shortfall	\$400



Ways to improve DSH/UC:

DSH

- Preservation of Trauma Designation
- Maintenance of 2 physician rule

UC

- Charity claims must be written off in FY to claim
- Is your charity policy written to maximize this program? Do you have the actual data?
- Time Studies by physicians are crucial for Sch 1

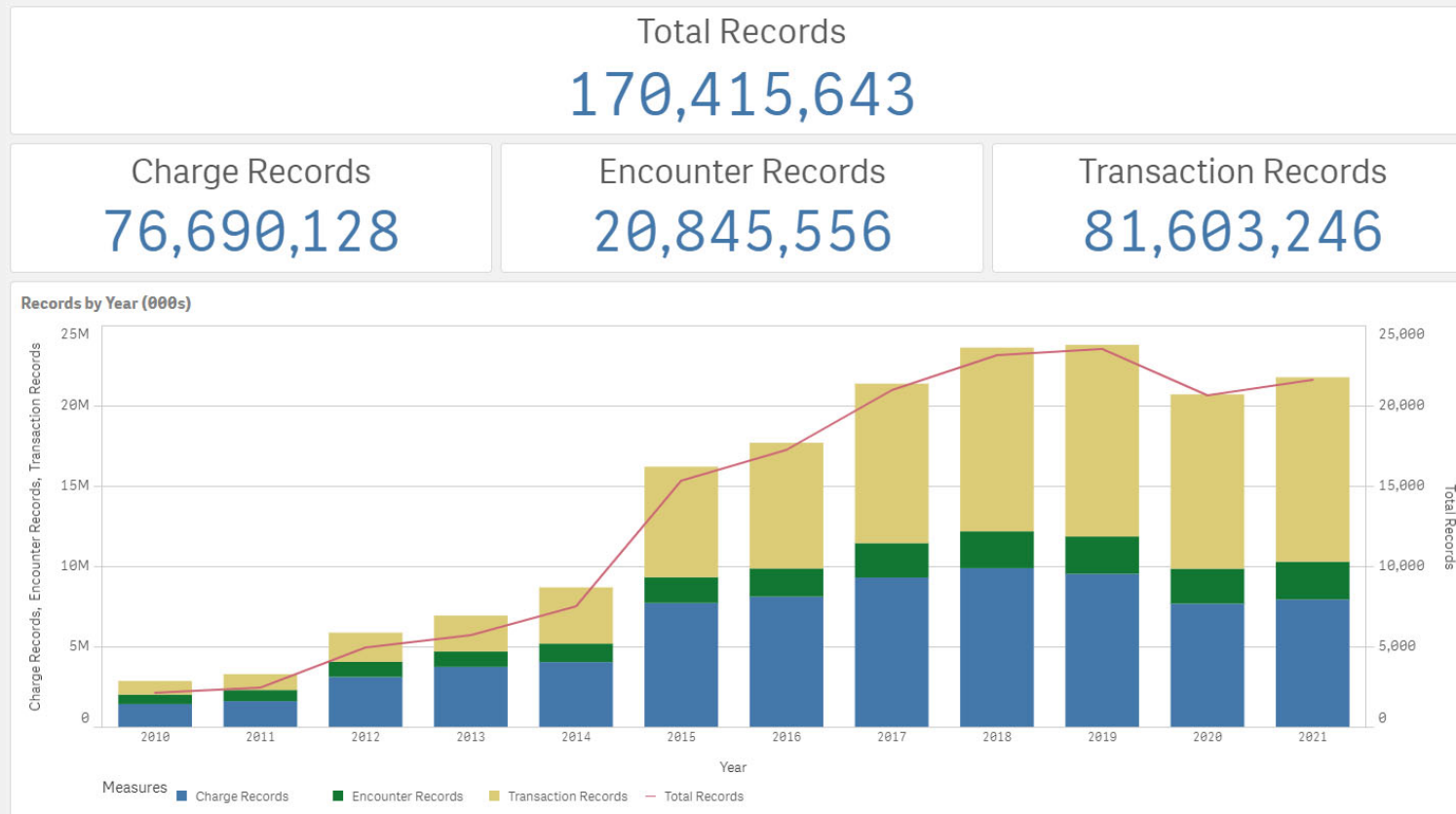
DATA

- The key to all of these programs is DATA
- We have developed a software application to overcome EHR system inadequacies
- **EHR system conversions can be catastrophic**



Data

(The Lifblood of Your Business)



Advantages of Data Warehouse

- Allows us to have more timely reporting and results
- Allows for data to be used in multiple ways
 - Price Transparency
 - DSH / UC / CHIRP
 - Charity and other cost report modeling
 - New State rules – Whatever they come up with next
 - Impact of possible rule changes
 - Community Engagement
 - Managed Care
- HIPAA compliant, redundancy and secure – Much better than email and other methods.
- Not shared or otherwise used.



Price Transparency

Where are we now?

- Many are not compliant - Do your due diligence and verify that you are
 - CMS has proposed an increase in penalty of up to \$2 Million a year.
 - Basic requirements are posted on CMS website:
 - Machine-Readable File
 - Shoppable File
- Published Data/Machine readable files are being consumed
 - Beware of chargemaster reviews that don't consider the implications to your Medicare reimbursement!



Examples of Non-Compliance

- Pricing Estimators do not constitute as a machine-readable file
- Historic data is not compliant- *based on claim data*
- All contracted payors must be listed
- Incomplete excel files could be problematic
- Most do not include EMPLOYED physician's & mid-level's charges



Pricing Transparency

(Data (or lack of) becomes fodder for Activism)

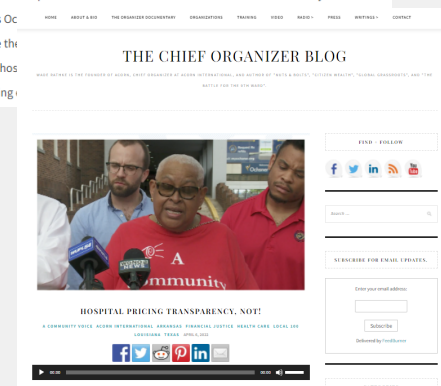
Campaigns



<https://twitter.com/EvanMcMullin>

Community Organizers

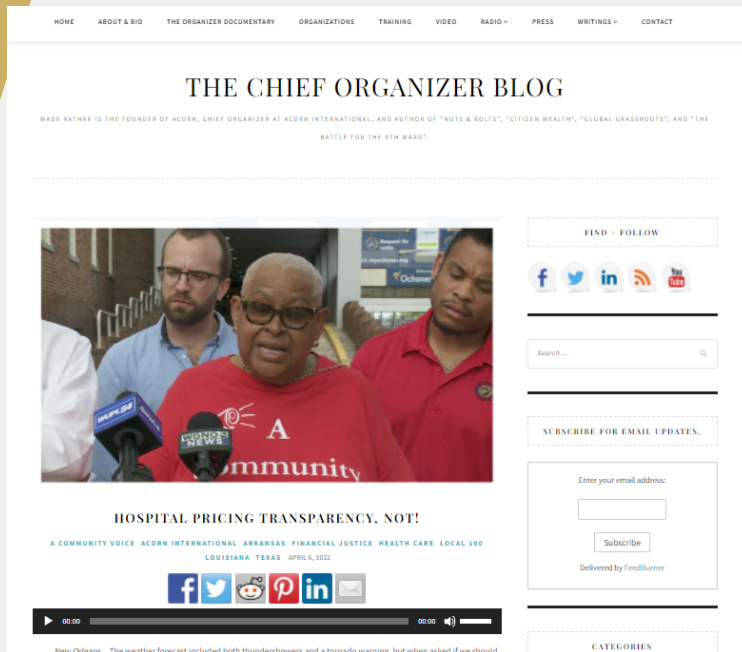
We didn't have the resources to look at all the hospitals in the country, so we focused on the more than 600 hospitals in the Arkansas-Louisiana-Texas industry that aligned with many of our offices and the union's membership and jurisdiction. Our report found that the effort had failed miserably. In each state more than half of the hospitals continue to be scofflaws and haven't even posted yet. We've filed more than 100 complaints on non-filers with CMS. Others tried to block easy access or steer people into their proprietary "price tool", as Oc procedures to get a snapshot of the problem, like the from hospital to hospital, but also in some cases hos coding system and insurance chargemaster, sowing,



<https://chieforganizer.org/2022/04/06/hospital-pricing-transparency-not/>



Pricing Transparency (Texas is being Examined)



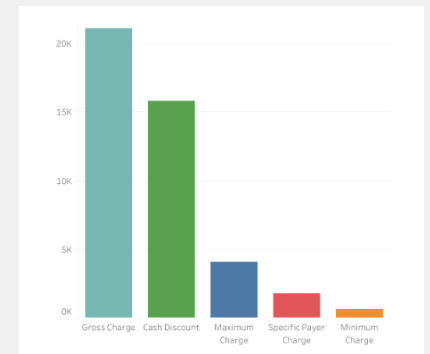
We found that price comparison tools were only truly accessible at 33% of Arkansas hospitals, 42% of Louisiana's, and 30% of Texas's. Of that minority whose tools were accessible, unfortunately, the estimates were often useless.

Chambers Memorial Hospital MasterPriceIndex .XLS

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	A	B	C	D
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56	230068	CLOSED TREATMENT RADIAL FX WITH MANIP	EA	1059.0325
57	230070	FRACTURE TR THUMB FING	EA	436.7419
58	230071	INJECT TENDON LIGAMENT	EA	429.1663
59	230072	VAGINAL DELIVERY ONLY	EA	2303.603
60	230073	VAGINAL DELIVERY ONLY	EA	1735.6042
61	230074	OPEN TREATMENT PHALANX FALX	EA	2915.8035



• ACORN stands ready to help researchers and patients in these three states get better understandings of the costs of care.

References: <https://chieforganizer.org/2022/04/06/hospital-pricing-transparency-not/> AND <https://acorninternational.org/index.php/hospital-price-transparency-arkansas-louisiana-texas/>



Pricing Transparency (Texas is being Examined)

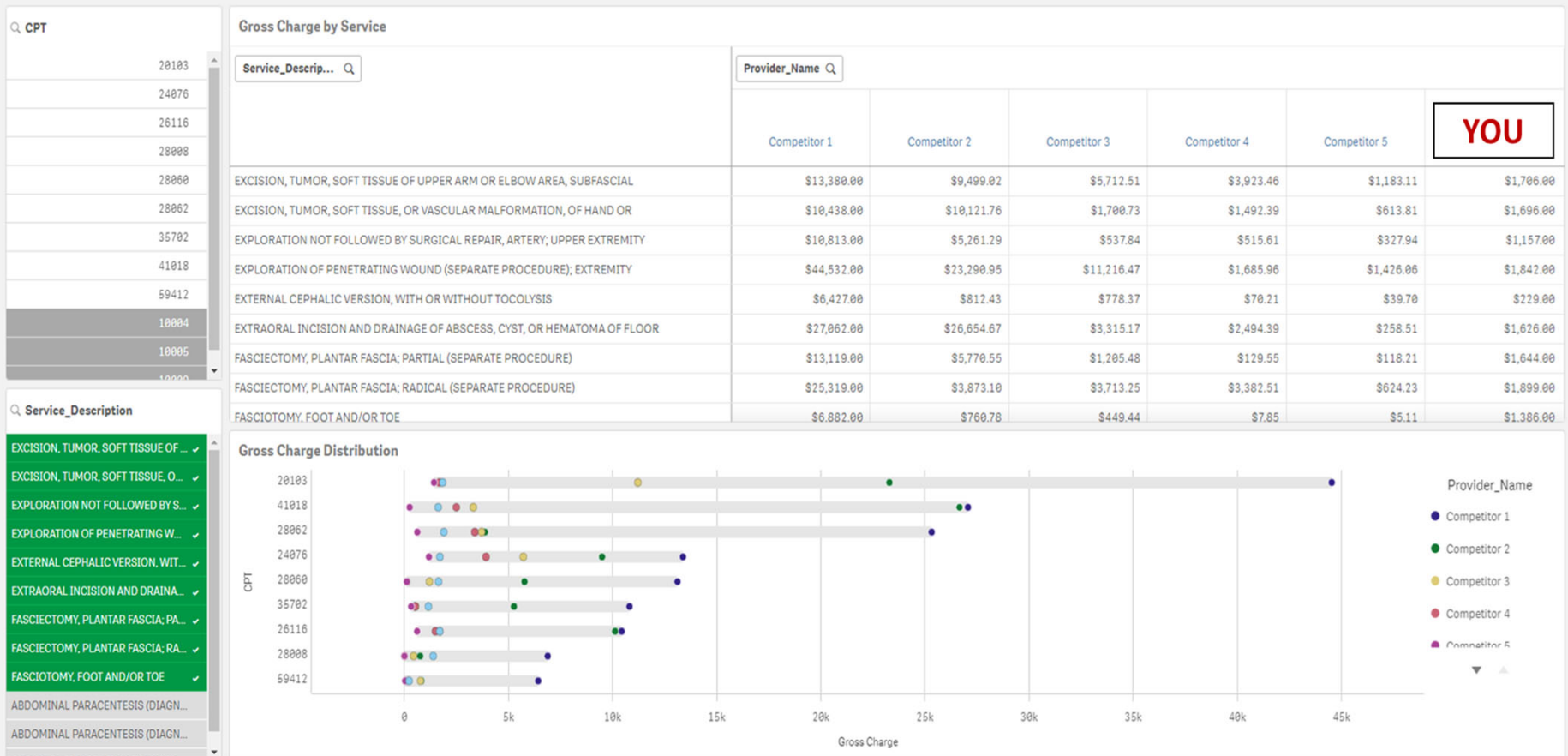


References: <https://acorninternational.org/index.php/hospital-price-transparency-arkansas-louisiana-texas/>



From Burden to Benefit (Pricing Transparency benefits?)

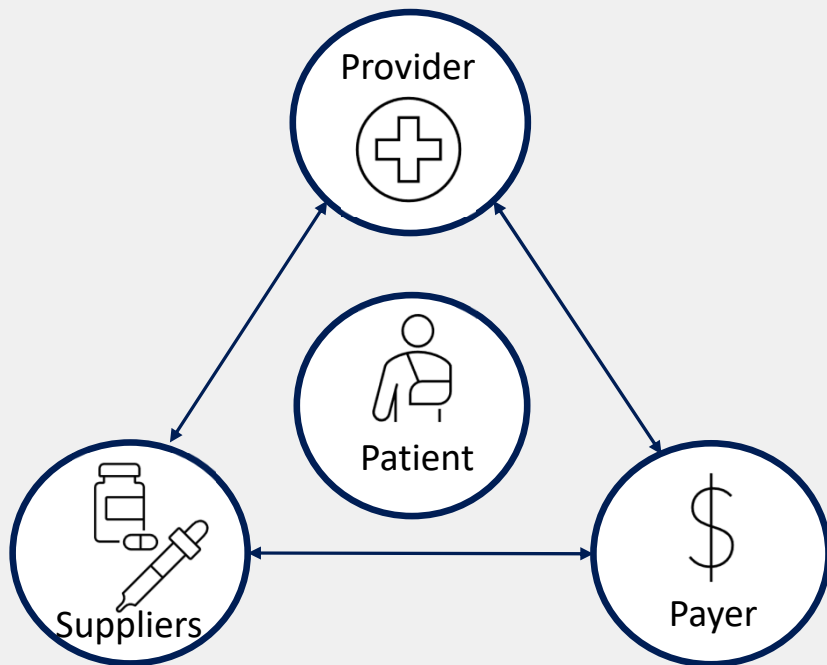
Competitive Pricing Analysis



Changing Role of the “Patient”

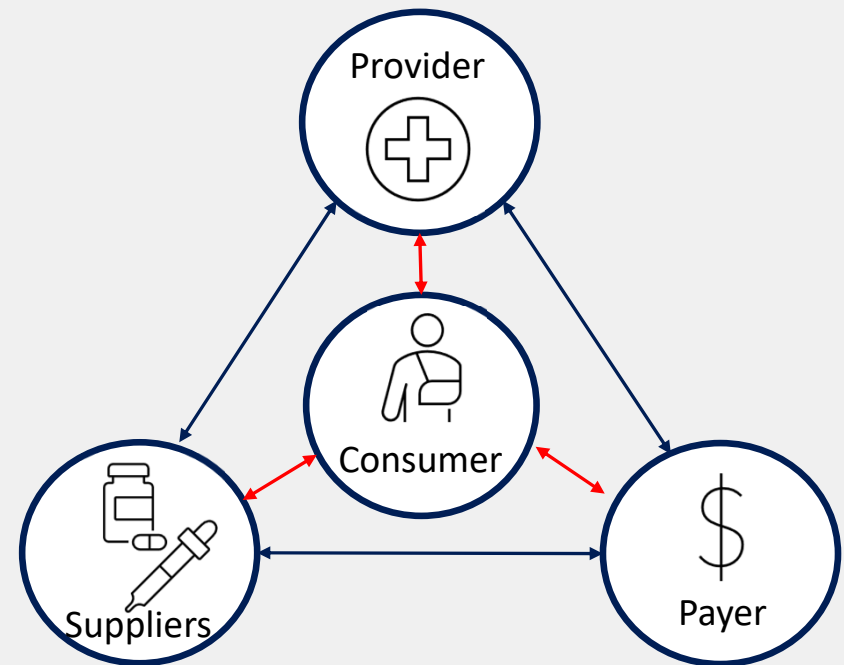
Historical Healthcare

(Links between stakeholders often bypassed the patient)

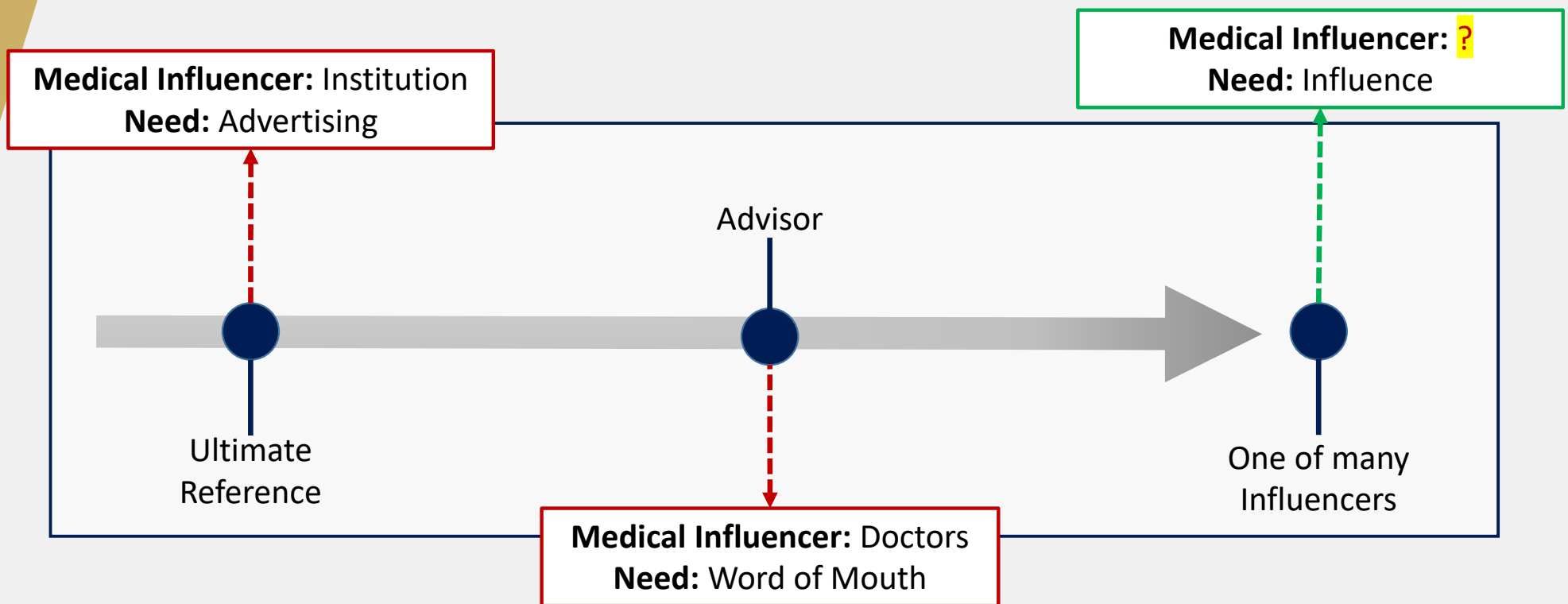


Future Healthcare

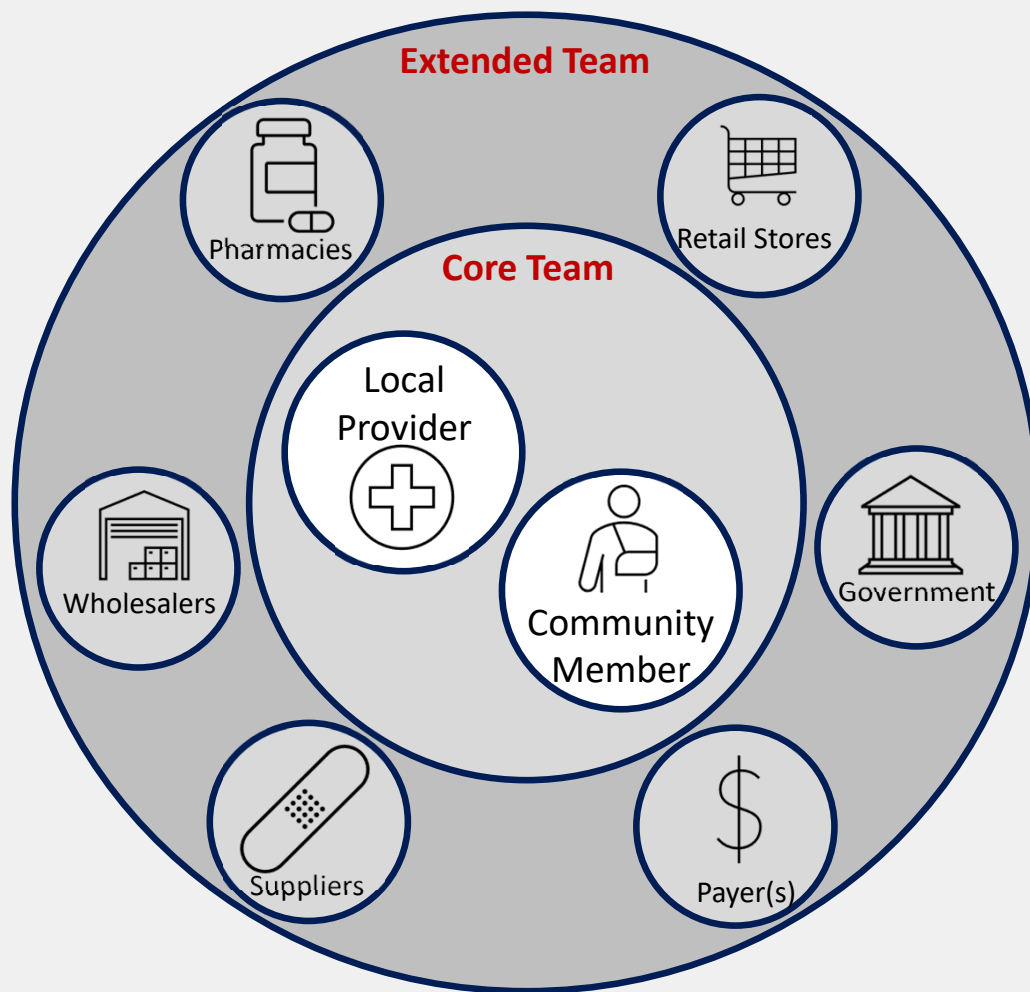
(“Patients” have a consumer mindset and direct connection to stakeholders)



Provider's Role has Changed



Re-Establishing the Core Team

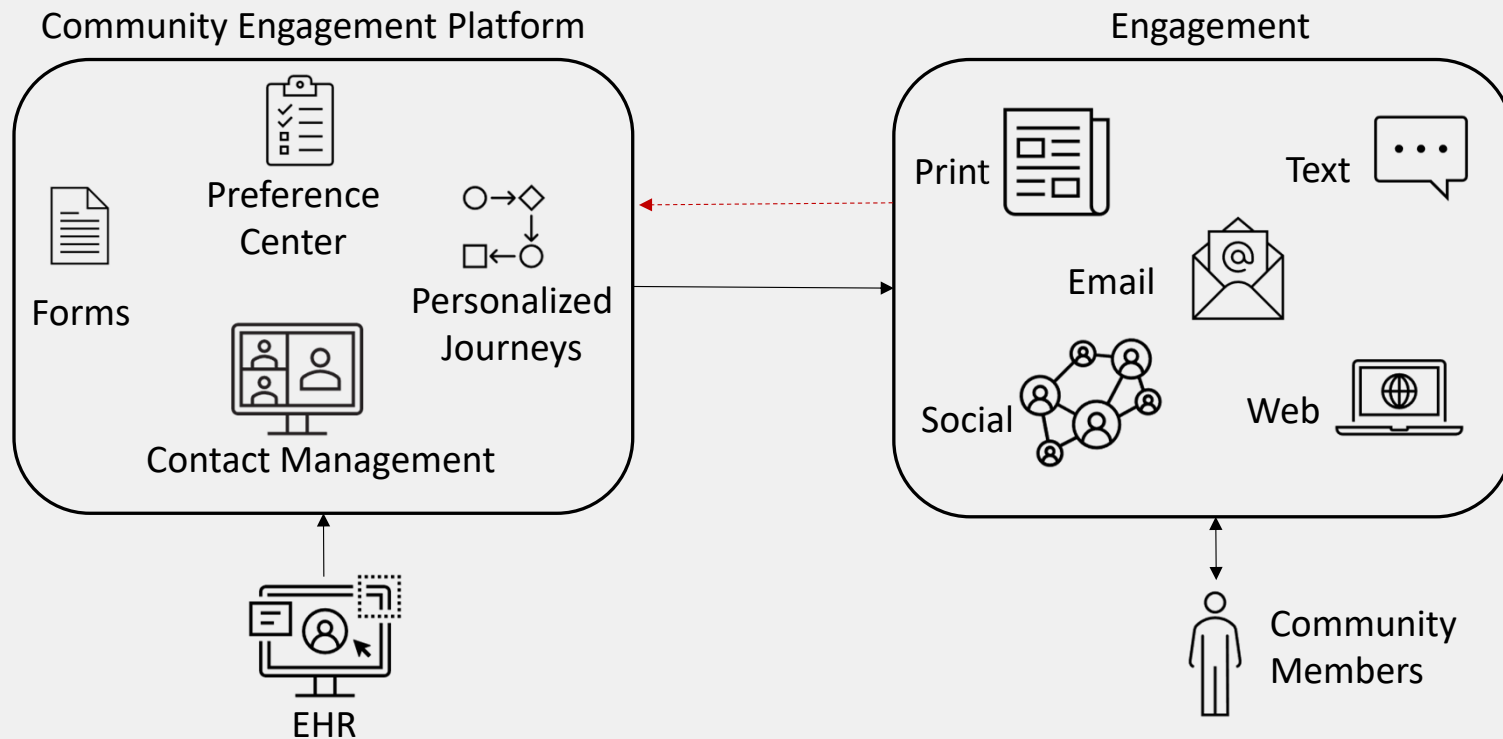


Observations:

- The forces influencing healthcare decisions HAVE totally changed
- People still need trustworthy, knowledgeable, medical professionals to make good healthcare choices
- Nobody is more knowledgeable about your community member's needs than YOU
- We need to re-establish the local, trusted, knowledgeable, medical professionals as THE healthcare **Core Team**
- It will require deeper Engagement with Community Members than the Extended healthcare team

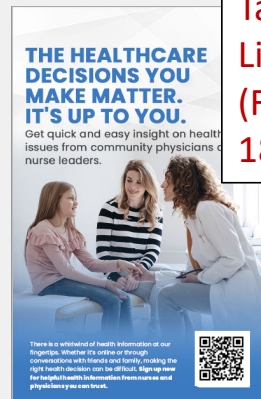


Community Engagement Capabilities



Targeted Actionable Content

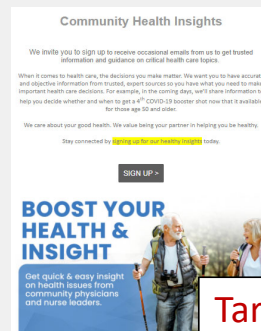
Print
Digital Signs
Articles



Target ->
Likely Moms
(Female age
18 -45)



Email
Social Posts
Web
Text



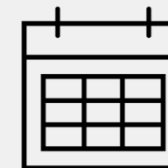
Target ->
(Age > 50)

A form titled "Your Logo" and "Healthy Community Newsletter Signup". It includes fields for "First Name", "Last Name", and "Email Address", followed by a "Submit" button.

Form Fill

A form titled "Create Your Account". It includes a series of yes/no questions about marital status, children, exercise, and device usage. Below the questions are radio buttons for "Interests" (Reading, Swimming, Weights, Yoga). At the bottom, there are fields for "Market ID" and "Address 2" with dropdown menus for "San Francisco", "CA", and "94105".

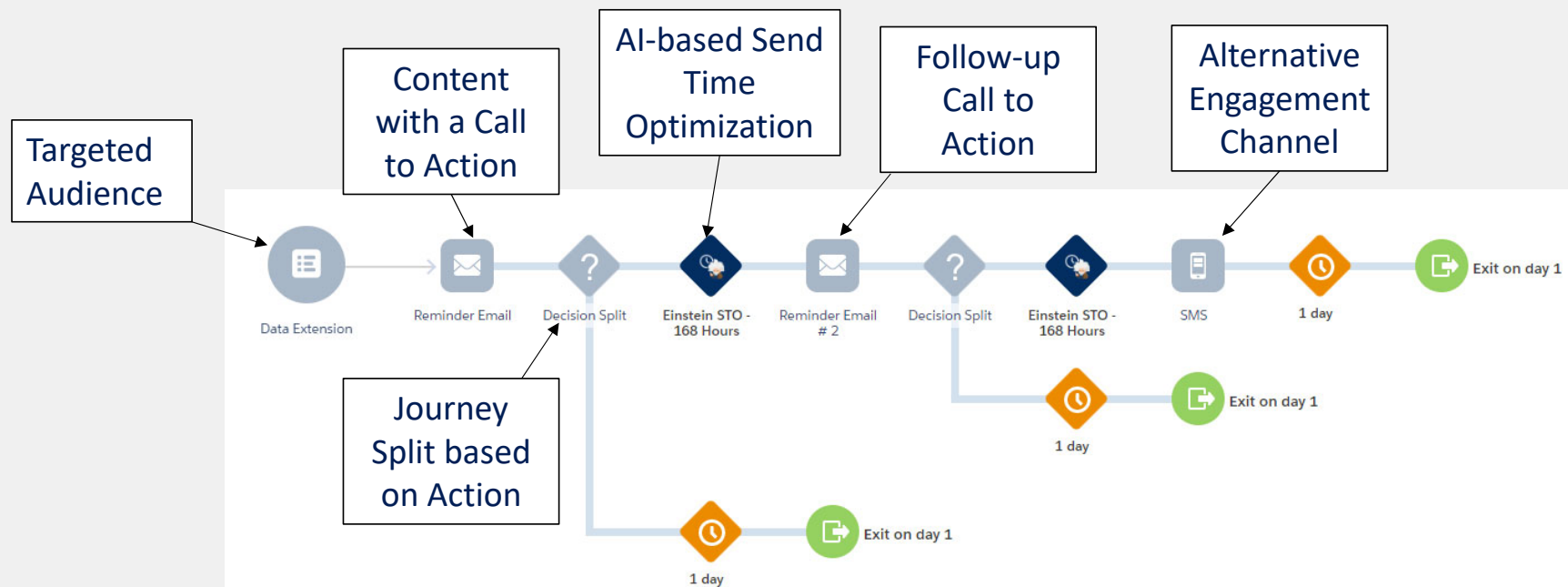
Assessment



Appointment
Request



Personalized Journeys



Objectives

- Community perception
 - Larger health systems have apps built into their EMR or already fully integrated
 - Epic – MyChart is the largest
 - Constant Contact – Common simple solution
 - Goal - to present a technical platform to enhance credibility
- Utilize better technology
 - Email & even social programs are falling out of favor
 - The phone is the connection of choice for most American
 - Constant contact is one way communication
 - Goal – to have two-way automated communication
 - Provide an economical and efficient marketing platform
 - Ultimate Goal – Own your market!



Opportunities are Endless

New
Staff/Services

Follow-up
Appointments

Under utilized
Services

Preventative
Care

Building your
Foundation

Personalized
Diagnosis
Education



Summary on Community Engagement

- Increased engagement = Improved Healthcare
- Better integration/data = Smarter Journeys and Improved Engagement
- Partnerships will be critical



Physician / Hospital Arrangements

- Primary care physicians have moved to an employment model
- Specialist are still more of private practice model
 - All physicians are looking for opportunities for ancillary income
 - More Phys Ancillary income = less hospital revenue
- Options
 - In urban areas JV's are no longer permitted
 - Momentum to restoring the physician ownership
 - CMS lifted the cap on expansion of physician owned hospitals
 - Rural options are still available
 - Regular JV's
 - Under Arrangement



Under Arrangements – What is it?

- Hospital can joint venture with physicians (third-party entity) to provide services to hospital patients.
- Help in recruitment/retention of physicians.
 - Especially Specialist
- Has been done in other states.
 - Imaging Center
 - Cancer Center
- Currently working on a surgical center in Texas. Set to start 5/1/2022.

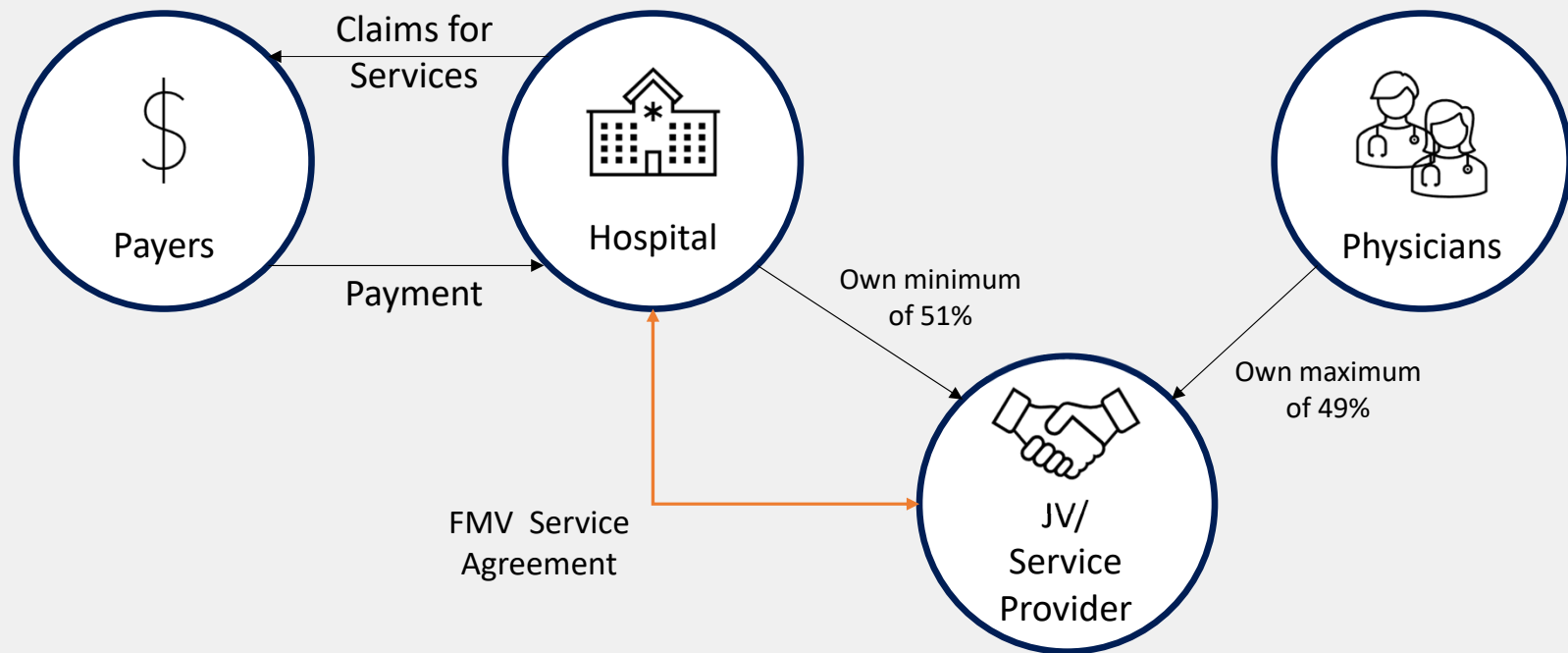


Entity that Would Provide the “Under Arrangements” Services

1. LLC that could be jointly owned by a Hospital and Physicians (51%/49%).
2. Physicians’ Interests must be at Fair Market Value.
3. Physicians would need to be actively involved with LLC and management.



Under Arrangements with a Joint Ventured Services Provider



Possibilities

- ❖ Surgery
- ❖ Imaging
- ❖ Physical Therapy
- ❖ Radiology
- ❖ Infusion Therapy
- ❖ Cancer programs (Medical and Radiation)



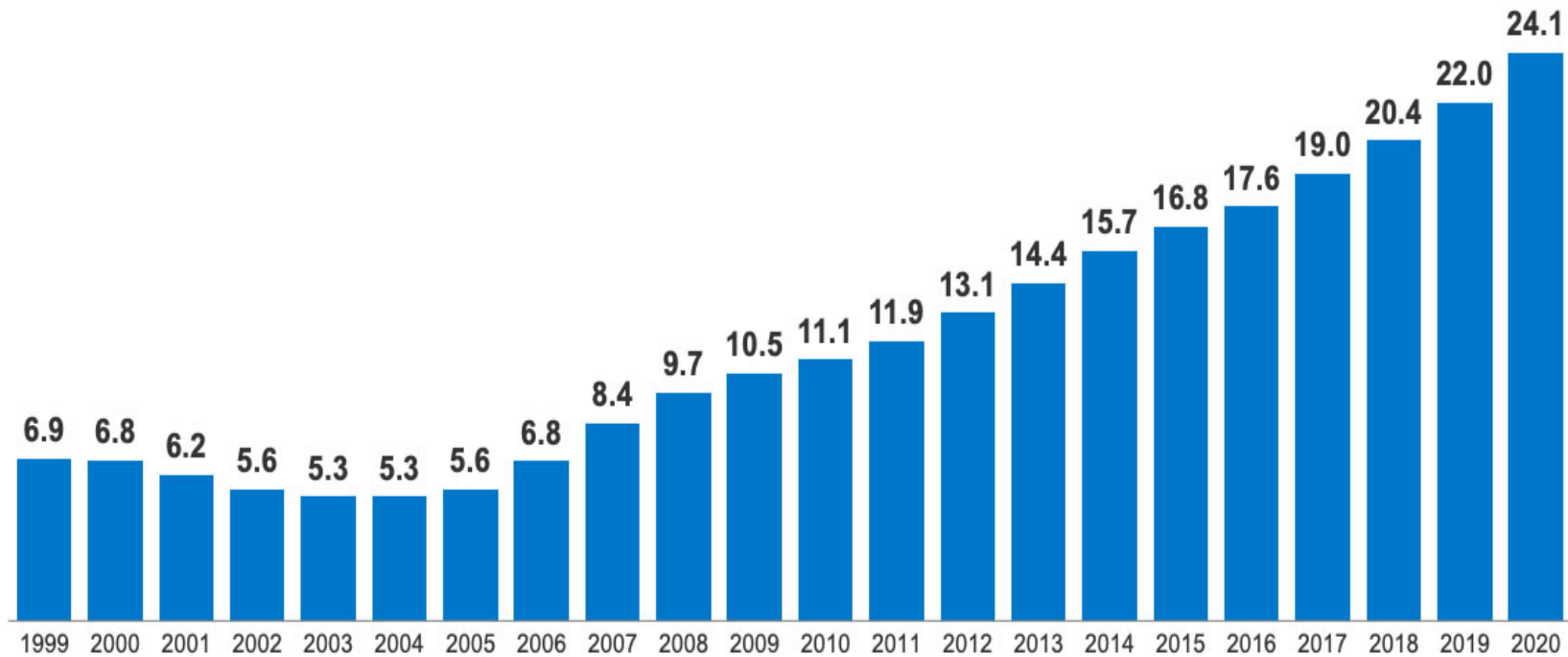
Guardrails

- MUST BE IN A RURAL AREA (NON-METROPOLITAN) PER THE OMB.
- HOSPITAL EXERCISES PROFESSIONAL RESPONSIBILITY OVER ARRANGED SERVICES.
 - Accept patient for treatment in accordance with admission policies
 - Maintain complete and timely clinical record on patient
 - Maintain liaison with attending physician regarding patient's progress
 - Hospital's utilization review and quality assurance programs apply to the service



Considerations of Medicare Advantage Growth

Total Medicare Advantage Enrollment, 1999-2020
(in millions)



Trends in Rural Healthcare Transition to Managed Care

- Continued transition in payments to managed care
 - Medicaid has already transitioned – mostly
 - Growing trend of Medicare patients are transitioning to Advantage Plans (MA)
 - Consistency in payment / aggregate reimbursement



Trends in Rural Healthcare Transition to Managed Care

- Current Transitional trends – Texas
 - Medicaid MCO accounts for 95% of the aggregate claims volume
 - Medicare enrollment in Texas is approximately 36% of the Medicare population
 - Medicare Advantage enrollment has doubled in the past decade and increased, on average, 8-10% per year
 - CBO projects Medicare Advantage to at 50% or greater of the aggregate Medicare population by 2029.



Trends in Rural Healthcare Transition to Managed Care

- **Medicare Advantage continues to grow**
 - (39% of Medicare population in TX)
- Topics of Consideration with Medicare Advantage Plans
 - Contract language
 - Using CAH / SCH Reimbursement
 - Periodic Internal Claims Review –
 - Do you have the data?



Considerations of Medicare Advantage Growth

- Lack of peripheral or non-claim payments (i.e. bad debt, charity)
- Contract often has “Lesser of Medicare or Charge” based wording or limitations on charge adjustments.
 - This can create line item anomalies, where the provider always gets shorted
- No settlement on Under / Over payment
- Standard review of claims for medical review
- Peer to Peer review of claims is not generally successful



Future of Healthcare

- Patient Demographics
- Medicare Beneficiaries
 - Expectation - 54M to 80M by 2030
 - Baby Boomer growth. (birth mid 1946 - late 1964)
 - Age Gap - Rapid Growth in Longevity of Life (est. 85 years old - 2030)
- Characteristics of Culture
 - Fewer smokers than previous generations of Medicare patients
 - Higher rates of Obesity and Diabetes
 - Higher rates of certain other chronic conditions - (i.e. Kidney disease)
 - Higher Prescription drug needs / availability



Future of Healthcare

- Patient Treatment - Continued Transition from IP to OP
- Technology is playing more roles, and care management.
- Physician / Hospitalist Practice
- Electronic Health Records (Patient Record-keeping Systems)
 - Integration capabilities
- Payor Systems Internal Evaluations (increased Internal Medical Review)
- Community and Patient Involvement - Better Consumers



Questions?



Dallas


Phone

 972-312-9102

Fax

 469-277-2797

Location

 101 W Renner, Suite 475, Richardson, TX 75082

Lubbock


Phone

 806-791-1591

Fax

 806-791-3974

Location

 1500 Broadway, Suite 1000 Lubbock, TX 79401

Waco

Phone

 254-757-2448

Fax

 254-255-4474

Location

 400 Austin, Suite 1001, Waco, TX 76701

