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Texas Health and Human Services Commission
Cecile Erwin Young, Executive Commissioner
P.O. Box 13247
Austin, TX 78711-3247

Via electronic submission to
CFOStakeholderFeedback@hhs.texas.gov

Texas Hospital Association Recommendations for Texas HHSC Legislative Appropriations Request, 2026-2027

Dear Commissioner Young:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching, specialty hospitals and private psychiatric facilities, the Texas Hospital Association is pleased to submit these comments on the Texas Health and Human Services Commission's (HHSC) forthcoming legislative appropriations request for the 89th Legislature.

We respectfully ask HHSC to consider the following items in its budget request:

1. Fully fund Medicaid inpatient hospital rates and standard dollar amount add-on payments commensurate with current costs
2. Fully fund improvements to HHSC's eligibility system and workforce
3. Fully fund HHSC's better birth outcomes strategies, including the full array of Medicaid and women's health programs
4. Increase reimbursement for inpatient behavioral health hospital care
5. Maintain dedicated funding for the state's trauma hospital network
6. Increase oversight and transparency of Medicaid managed care organizations (MCOs)

Fully fund Medicaid inpatient hospital rates and add-on payments commensurate with current costs

Trauma, Safety-net and Rural Add-on Payments

The 88th Texas Legislature appropriated $404.9 million in state revenues for the 2024-2025 biennium to fund enhanced Medicaid standard dollar amount add-on payments to trauma, safety-net and rural hospitals. These included an additional $36 million annually in general revenue (GR) over the prior fiscal biennium to fund cost-based reimbursement for rural hospitals' payment rates. The 88th Texas Legislature also tripled the Medicaid rural labor and delivery add on payment from $500 to $1,500 per delivery, at a total cost of $47 million. Labor and delivery services are costly to provide in rural areas and can be vulnerable to reductions when financially distressed rural hospitals make operational changes necessary to keep their doors open.

We encourage HHSC to request funding to maintain all current standard dollar amount add-on payments and rural labor and delivery add-on payments, and include the $1,500 per delivery add-on amount in the base budget for the next biennium. These funding enhancements will financially sustain the hospitals that continue to provide this care, and the enhanced labor and delivery add-on payment will reinforce access to maternal health care in rural areas.

Inpatient Rate Rebasing

Beginning in early 2024, HHSC will perform an inpatient Medicaid rate rebasing for rural, urban and children's hospitals. Implementation is planned for Sept. 1, 2026. An inpatient rate rebasing recalculates all standard dollar amounts, add-ons, diagnosis-related group relative weights, mean length of stay and day outlier thresholds to align to costs in a selected base year. This long-overdue exercise has not occurred in Texas since FY 2013.[1]

Failing to adjust Medicaid base rates for inflation and cost growth in the last ten years has meant that even "fully funded" Medicaid rates are increasingly distant from hospitals' costs of care. Today, Texas Medicaid base rates only reimburse hospitals 72% of inpatient costs on average.[2] Texas has applied piecemeal rate increases to preserve access in distressed markets and services, such as rural health and maternal care, but has not addressed generally flagging reimbursements that underpin the entire safety net. Hospitals' reliance on self-financed supplemental payments has also increased. From 2013 to 2023, the share of total Medicaid payments in Texas made through supplemental programs has grown from 13% to 31%.[3] Furthermore, Texas uses its Medicaid 1115 waiver to partially offset over $7 billion in uninsured charity care costs incurred by hospitals each year from delivering care to 5 million uninsured Texans.[4] In short, safety net hospitals must depend on a patchwork of targeted and temporary rate increases, add-on payments, and supplemental payments to compensate for underfunded base rates and a heavy uninsured burden.

Reliance on supplemental payments leaves Texas with less control over its safety net and carries significant administrative complexity. The Medicaid 1115 waiver and directed payment programs are subject to periodic federal government reapproval. Since 2020, HHSC has endured repeated challenges, protracted negotiations, and multiple rounds of litigation with the federal government to preserve the 1115 waiver, Delivery System Reform Incentive Payment (DSRIP) successor programs and their underlying method of finance. The Centers for Medicare & Medicaid Services (CMS) has made multiple attempts to increase regulatory authority over non-GR-funded supplemental payments and has proposed spending and finance limits that could keep the state from continuing to operate its current programs. HHSC has also incurred millions of dollars in administrative and legal costs related to the 1115 waiver and directed payments that it has charged hospitals additional fees to cover.[5] THA unequivocally supports HHSC's comprehensive legal and policy defense of its programs. However, the financial stakes of such challenges in the future could be lowered if Medicaid base rates were updated to reflect current costs and funded with state GR.

We are pleased HHSC recognizes the threat that stagnant base rates present to the safety net and will be taking action to rebase most hospitals. THA urges HHSC to request full funding in its 2026-2027 base budget for rural, urban and children's Medicaid inpatient hospital base rates aligned to costs in the most recent available

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[1] Texas Health and Human Services Commission. (January 2023). 2024-2025 PFD Hospitals Rate Table.
[2] Texas Health and Human Services Commission. (January 2023). 2024-2025 PFD Hospitals Rate Table.
[3] Texas Health and Human Services Commission. CMS-37 Medicaid History Reports.
[4] Texas Health and Human Services Commission. (June 2023). DY 12 Uncompensated Care Pool Final Rule Modeling.
[5] Texas Health and Human Services Commission. (November 2022). Annual Revenue and Expenditure Report.

data year at the time of FY 2025 rebasing. We note that a budget-neutral inpatient rebasing could lead to harm for certain hospitals in Medicaid. Our support is specifically for a funding request that seeks the full amount necessary to fund rates rebased to current costs. THA looks forward to strongly supporting the commission's full funding request.

Furthermore, we hope HHSC will agree that rate adjustments should occur on a defined, more frequent cadence. We encourage HHSC to recommend that the 89th Texas Legislature follow the lead of other state legislatures and install a standardized annual or biennial Medicaid inflation adjustment that tracks with commonly accepted inflators, such as those used in the Medicare inpatient prospective payment system (IPPS). This would ensure Medicaid payment rates track more closely with costs and reduces gaps in access that can be caused by interruptions in non-GR-financed payments.

Fully fund improvements to the HHSC eligibility system and workforce

Over the past year, HHSC has taken on the unprecedented Medicaid continuous eligibility unwinding project. We appreciate the diligent effort and collaboration the agency has invested to date. Close communication with stakeholders and advocates helped to inform Texans of the changes. However, as with any large project, the Medicaid unwinding implementation shed light on areas for improvement within the system. The state's eligibility workforce and information technology systems were stretched to the brink, making it even more difficult to address unanticipated issues timely.

Texas has disenrolled 1,250,063 people as of October 2023,[6] about 500,000 more than were projected to be disenrolled by this time.[7] Most lost coverage due to procedural denials, meaning recipients were not able to submit all necessary information for a renewal. Given that the legislature only partially funded HHSC's initial eligibility system and workforce funding request to support Medicaid unwinding, we urge the agency to assess remaining needs, and factor those activities and costs into their appropriation request. This is an opportunity to act on lessons learned and remove unintended barriers by investing in Texas 2-1-1 call centers, modernizing the YourTexasBenefits website and app, and the eligibility workforce.

Fully fund HHSC's better birth outcomes strategies, including the full array of Medicaid and women's health programs

In its last published report, the Texas Maternal Mortality and Morbidity Review Committee (MMMRC) repeated its number one recommendation: "Increase access to comprehensive health services during pregnancy, the year after pregnancy, and throughout the preconception and interpregnancy periods."[8] House Bill 12 passed in the 88th Legislature extending Medicaid coverage to 12 months postpartum. HB 12 is a major step in fulfilling the recommendations of the MMMRC and improving health outcomes for women across the state. We look forward to full implementation in early 2024.

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[6] Texas Health and Human Services Commission. (October 2023). End of Continuous Medicaid Coverage Dashboard.
[7] HMA. (November 2023). Unwinding Medicaid Data: A Real-Time 50-State Assessment as Redeterminations Approach the Midpoint.
[8] Texas Department of State Health Services. (2022). Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022.

Coverage is the first step in making the necessary postpartum health services accessible and affordable. Next, HHSC should request funds to fully implement and maximize the policy, such as outreach to pregnant Medicaid participants, monitoring utilization to ensure services are accessible, and incentivizing managed care plans that coordinate care for pregnant women on Medicaid. HHSC should also request funds for patient advocates to navigate women through postpartum services. Furthermore, we encourage HHSC to request funding sufficient to maintain the 6% Medicaid rate increases for birth and women's health related surgeries introduced in the 2023-2024 budget. These rate increases will ensure reproductive health care delivered in hospitals remains accessible to Medicaid enrollees, including amniocentesis, cerclage and hysterectomies.

The 88th Legislature also substantially increased funding for HHSC's women's health programs, consistent with MMMRC recommendations. Access to preventive and preconception care – including health screenings and contraception – means healthy, planned pregnancies and early detection of cancers and other treatable conditions. While the women's health programs do not provide comprehensive care like Medicaid, they form a safety net that many Texas women rely on during preconception and interpregnancy periods. Providing women access to preventive care prior to pregnancy promotes better birth outcomes for mothers and babies. THA urges HHSC to request funding in its base budget request at the new funding levels to support the increased caseload due to the state's growing population, as well as enrollees losing coverage during the Medicaid unwinding.

Increase reimbursement for inpatient behavioral health hospital care

Pursue an IMD Exclusion Waiver

Today, patients otherwise eligible for Medicaid coverage are prohibited from receiving Medicaid benefits in freestanding psychiatric hospitals beyond 15 days. This creates a gap in the continuum of care. Patients in acute psychiatric distress may present to hospital emergency departments, and without an available transition to the inpatient psychiatric setting, preventable emergency department boarding can result. The exclusion also obstructs mental health parity and discourages investment in community mental health hospitals. Securing an IMD exclusion waiver could boost rates for psychiatric hospitals by closing the Medicaid gap, encourage investment in the community, save the state boarding costs and, most importantly, lead to better outcomes for patients. THA encourages HHSC to request any appropriation necessary to fund the IMD exclusion waiver.

Implement Behavioral Health Hospital Rate Increases

The need for behavioral health inpatient services continues to rise across the state, even as society returns to a new normal from the COVID-19 pandemic. Even before the pandemic, inpatient psychiatric beds were hard to come by and that has only been exacerbated in the past few years. Despite the increase in demand for these services, reimbursement rates for behavioral health providers in the Medicaid program have not increased since 2008. These low rates blunt psychiatric hospitals' ability to expand capacity, hire necessary staff and meet the demand for services for both adults and children.

Additionally, while THA applauds the funding dedicated to purchased psychiatric beds in the 2024-2025 General Appropriations Act, there is no consistency guaranteed in the rate hospitals will receive when they contract with local mental health authorities (LMHAs) to make those beds available. Historically, the rates provided do not cover the actual cost of the bed and services, meaning hospitals operate at a loss, which can be destabilizing and impact an entity's ability to serve its community.

As described in 1 TAC §355.8060, HHSC reimburses freestanding psychiatric facilities for inpatient care using a different methodology than for children's, urban and rural hospitals. The latter are scheduled to be rebased in FY 2025. To ensure behavioral health hospitals are not left behind after other hospitals are rebased, boosting behavioral health inpatient rates will take on added urgency. To bolster access to much-needed inpatient behavioral health services, THA urges HHSC to (1) re-examine Medicaid rates for behavioral health services; (2) update those rates to better reflect the cost of delivering services; and (3) ensure funding for purchased psychiatric beds reflects both an increase in the number of beds and a rate commensurate with the cost of providing those beds.

Maintain dedicated funding for the state's trauma hospital network

A robust and effective trauma care system ensures Texans receive the appropriate level of care in emergencies. Hospitals' capacity to manage stroke, cardiac arrest, maternal and perinatal care is layered on top of the state's trauma system. Uncompensated trauma care payments are vital for Texas hospitals, as they are used to help offset a portion of the cost of providing unreimbursed trauma care to Medicaid and other low-income patients ordinarily written off as bad debt or charitable care. Uncompensated care trauma payments are funded out of GR and GR-dedicated appropriations from the state's designated trauma and EMS accounts. Because of the payment sequence prescribed in rule, shortfalls in these accounts necessarily reduce uncompensated trauma care payments to Level 3 and Level 4 trauma facilities first. Level 3 and Level 4 facilities comprise most of the rural trauma system.

Texas must ensure dedicated funding for the state's trauma network keeps pace with utilization. During the interim, HHSC is charged with issuing a report on uncompensated trauma care. If the report identifies any threats to maintaining current funding levels supported by designated trauma funding accounts, or an increased volume of uncompensated care, THA recommends HHSC request increased appropriations or recommend modifications to its underlying financing to preserve a consistent and sustainable source of funds for the state's trauma program.

Increase oversight and transparency of Medicaid MCOs

Reduce overuse and misuse of utilization management practices
Today, 97% of Texas' Medicaid beneficiaries are enrolled in managed care.[9] Ensuring Medicaid managed care enrollees have the same access to medically necessary care as commercially insured patients is a key administrative responsibility of HHSC. A recent audit by the federal Health and Human Services Office of Inspector General (OIG) finds that in some cases, Medicaid beneficiaries are prevented from accessing covered services because of MCO misuse and overuse of utilization management practices, including prior authorization denials.[10]

In the seven Texas Medicaid MCOs sampled, OIG found high variance in prior authorization denial rates, including one plan that denied prior authorization requests at a rate nearly three times the national average

[9] Texas HHSC. (2022). Texas Medicaid and CHIP Reference Guide, 14th ed.
[10] U.S. Health and Human Services Office of Inspector General. (July 2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

(Table 1). OIG also noted Texas does not offer external medical reviews as an option for enrollees when MCOs uphold a prior authorization denial at the first level of appeal.

Table 1: Prior Authorization Request Denial Rates, Select Texas Medicaid MCOs, 2019

MCO	Enrollment	Denial Rate
Molina Healthcare of Texas, Inc.	178,509	34.2%
Amerigroup Texas, Inc.	593,798	17.0%
Amerigroup Insurance Co.	150,159	14.6%
Superior Health Plan	838,407	13.0%
NATIONAL AVERAGE		*12.5%*
United Healthcare Community Plan of TX	296,898	10.9%
Aetna Better Health of Texas	75,617	10.0%
Aetna Parkland Community Health Plan, Inc.	154,219	6.4%

Source: U.S. Health and Human Services Office of Inspector General. (July 2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

THA urges HHSC to request any resources needed to enhance state oversight of Medicaid MCOs as recommended in the OIG audit, including (1) enhancing reviews of prior authorization denial rates; (2) delivering technical assistance or corrective action to plans when warranted; and (3) establishing a process for external medical reviews.

HHSC should also use its oversight of Medicaid MCOs to improve transparency, speed and clarity of Medicaid prior authorizations to adhere to new expectations communicated by CMS. In December 2022, CMS proposed a rule (CMS-0057-P) that, if finalized, would require Medicaid managed care plans to publicly report the percentage of standard prior authorization requests that were approved, denied, or approved after appeal. HHSC would be required to report related metrics to CMS annually. The rule proposes additional requirements for managed care plans to electronically automate certain elements of the prior authorization request process, adhere to new minimum response times for prior authorization requests and provide a specific reason for all denied requests.

THA strongly supported CMS's proposals in public comment, and they reflect goals the Texas Medicaid program should pursue. HHSC should seek funding from the legislature for administrative support necessary to deliver new or enhanced technical assistance and oversight of MCOs' prior authorization practices that are likely to become required.

Transparency of payments in supplemental payment programs

Texas hospitals have repeatedly advocated for – and both CMS and HHSC have acknowledged – the need for improved transparency of dollars flowing through MCOs to providers in directed payments. We believe HHSC, the legislature, providers and the public have an interest in understanding what portion of directed payment funding is reaching providers as payments for care, and what portion is retained by the MCO.

There is often an assumption that the entire dollar value of a directed payment program reaches providers (less the taxes and fees MCOs withhold). Texas hospitals know and have experienced firsthand that in a utilization-dependent risk-based arrangement, that does not always occur. Capitation is paid to the MCO based on caseload but only reaches the provider if enrollees use care. The overall stability of the safety net can suffer

for this reason during periods of aberrant caseloads and utilization, such as recently occurred in the public health emergency when caseloads soared, but utilization did not.

Currently Texas makes no information available on the amount of directed payment funds that MCOs pay providers because the necessary reporting does not exist. MCOs do not separate out the base payments from directed payments on Financial Statistical Reports they submit to the state. This makes it difficult for the state to know what portion of aggregate program funds are spent on patient care.

In the case of directed payment programs operating under the authority of 42 CFR §438.6(c), HHSC can direct an MCO when, why and how much to pay a Medicaid provider. In the case of a 42 CFR §438.6(b) quality incentive program, which HHSC plans to establish for FY 2025, HHSC pays an MCO based on achieving quality metrics, and any payments distributed to providers participating in that arrangement occur on a negotiated basis. Going forward, transparency on aggregate or class-specific amounts paid from MCOs to providers should be an expectation in both program types, regardless of whether HHSC directs the payment. Aggregate or class-level reporting would not require HHSC to seek information on private contracts between individual providers and MCOs.

THA recommends HHSC amend current Rider 15: Supplemental Payment Programs Reporting to include requirements for HHSC to publish periodic expenditure reporting by MCOs on supplemental provider payments. Any additional reporting that cannot be accomplished with existing resources should be funded from legislative appropriations and not from additional fees on hospitals.

THA thoroughly appreciates HHSC's effective stewardship of the Medicaid program and other dollars. We look forward to working with HHSC to ensure the agency's funding needs are addressed during the legislative session and that the state's obligation to sustain essential health services to Medicaid clients is fully met. Please contact astelter@tha.org with any questions.

Respectfully submitted,

/s/

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