Future of the Uncompensated Care program (UC) and Stability in Medicaid Payments for Hospitals

The Health and Human Services Commission (HHSC) has been working since September 2022 to evaluate the future of the Medicaid hospital financing system in a post-public health emergency environment. With the combination of new Medicaid fee-for-service and managed care rules, the unwinding of the Medicaid caseload coverage from the PHE, and the interplay of new supplemental payment programs (e.g. the private graduate medical education (GME) and Hospital Augmented Reimbursement program (HARP)), hospital financing in Medicaid and for the uninsured has been challenging to forecast. With the support of hospitals and their representatives, Medicaid managed care organizations and their representatives, industry subject matter experts, and the staff at the Centers for Medicare and Medicaid Services (CMS), HHSC has come to final decisions about strategies to ensure stability in the event that the UC pool is reduced in the future.

UC is projected to decrease for the final 3 years of the 1115 Waiver

HHSC's current models indicate that the UC pool will be reduced to approximately $3.1 billion annually

The UC pool is required to be resized for demonstration year (DY) 17 through 19 of the 1115 Waiver. In accordance with the methodology agreed to between CMS and HHSC in 2016 (during the first waiver renewal), the UC pool size will be based exclusively on uncompensated charity care costs, and will be reduced by any perceived Medicaid "overpayments". Medicaid "overpayments" are any hospital payments received that exceed the costs of delivering care to Medicaid fee-for-service or managed care beneficiaries. Medicaid uncompensated costs and uninsured non-charity care costs are not allowed to be included in the total UC resizing. While Medicaid costs and UC costs continue to grow, the introduction of

new supplemental payments or directed-payments has outpaced the cost growth, resulting in an overall projected reduction in UC that will be allowed in the future.

Starting in state fiscal year 2026, HHSC will modify CHIRP to allocate ACIA on a per-class per-SDA basis, rather than by hospital

Currently, ACIA payments in CHIRP are restricted to a uniform percentage of each individual hospital's ACR "room." As permitted by federal regulation, HHSC will transition ACIA to allow all hospitals within a class within a service delivery area to share the ACR room generated by their class in their SDA. This calculation will function substantially similarly to the current allocation of the UHRIP component of CHIRP and will enable hospitals that have fewer or less advantageous commercial payments to benefit from amount generated by other hospitals that have higher or more advantageous commercial payments.

Starting in federal fiscal year 2025, HHSC will deem all rural hospitals eligible for the Disproportionate Share Hospital (DSH) program and will change the calculation of the low-income utilization ratio, as suggested by the Texas Organization of Rural and Community Hospitals.

Rural hospitals are critical to Texans in rural communities receiving health care, including emergency hospital services. While tradition methods of determining what hospitals qualify as a "DSH" hospital do include many rural hospitals, not all rural hospitals are currently eligible for DSH. Enabling all rural hospitals to participate in DSH provides increase protection for rural hospitals by enabling them access to the last possible source of payment for any uncompensated Medicaid costs or for costs associated with uninsured non-charity care patients.

Starting in DY 17, HHSC will reallocate the UC pool to prioritize $1 billion in UC to hospitals eligible for the High Impecunious Charge Hospital (HICH) pool

The HICH pool was introduced as a mechanism to prioritize new UC pool room to certain hospitals that had high levels of uninsured charges, rural hospitals, and state-owned hospitals. The sub-pool was capped at the difference between the amount of the UC program beginning in DY 12 and the amount of the UC program in DY 11 (approximately $600 million). When considering the prospect that the UC pool could decrease to levels at or below the levels seen in DY 6 or earlier, it is prudent to reconsider the way the HICH sub-pool is sized and where in the payment methodology it is issued. HICH will in the future move to become the first payment

allocation made in UC, and will enable any HICH hospital to receive payments before any non-HICH hospital. The total HICH allocation will be set at a level that does not exceed $1billion in total. HICH hospitals will continue to be eligible for non-HICH UC funding that remains after payment of HICH, subject to each hospital's state payment cap.

HHSC will continue to evaluate innovative payment solutions

CHIRP may be authorized to increase to use the full Medicare UPL and full ACR UPL in the future

HHSC will seek to increase the UHRIP component of CHIRP back to 100% of Medicare UPL and 90% of ACR for FY 2026. HHSC will then seek to increase to 95% of ACR in FY2027 to 100% of ACR in FY2028.

HARP public may be authorized to increase to use the full FFS UPL in the future

HARP Public will be increased to use 100% of the available fee-for-service UPL room in FY 2026.

HHSC will continue to evaluate, within the limitations of federal regulations, options for new and innovative programs to support state policy and quality goals