



Presentation to the House Appropriations Committee: Overview of Texas Medicaid Hospital Finance

Health and Human Services Commission

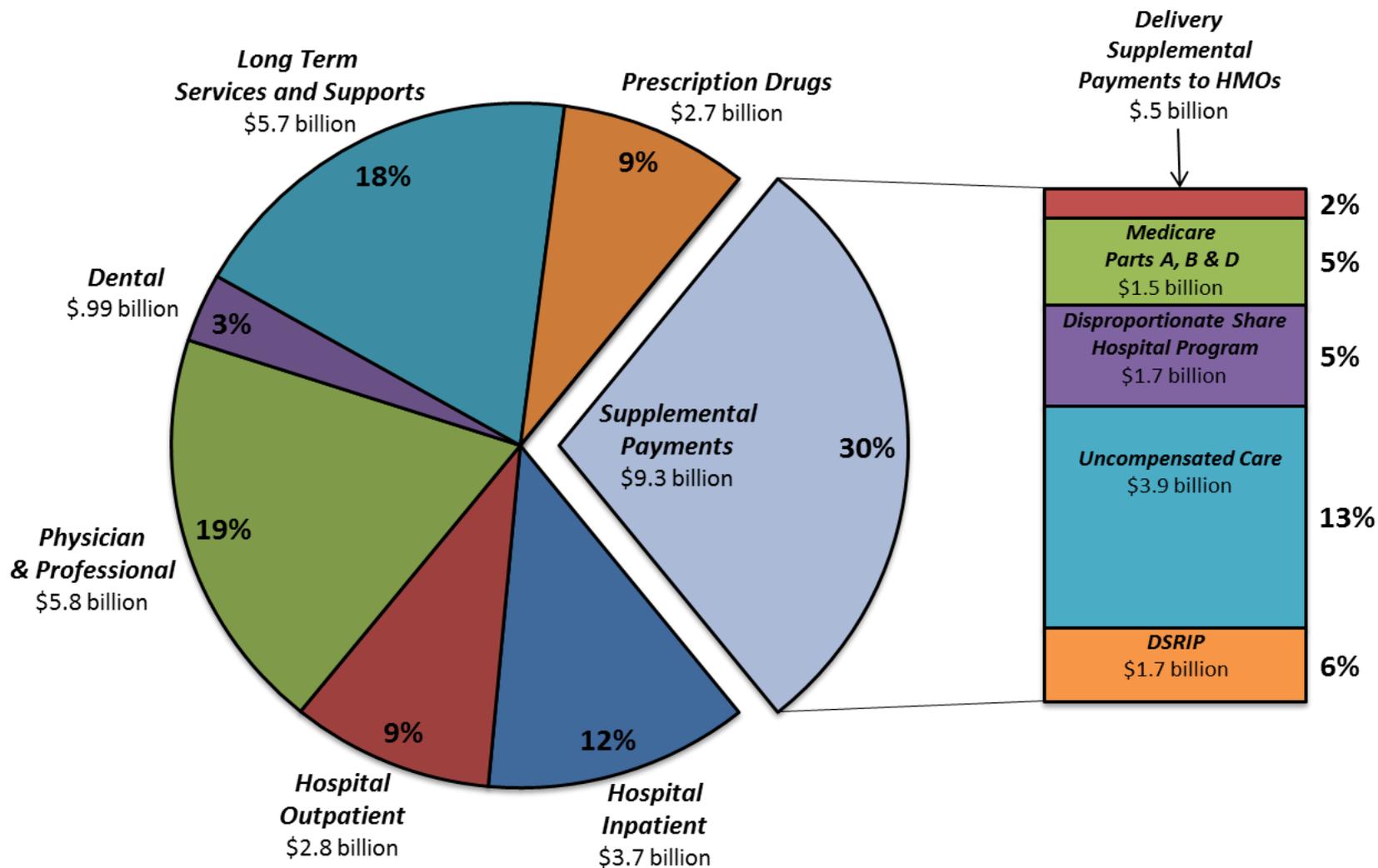
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Overview of Hospital Finance

FY 2013 Texas Medicaid Expenditures by Service Type

Total = \$31 Billion All Funds



- Historically hospital payments have been made using four mechanisms:
 - Inpatient payments
 - Outpatient payments
 - Disproportionate Share Hospital (DSH) payments
 - Upper Payment Limit (UPL) payments
 - UPL payments transitioned to Medicaid 1115 Transformation Waiver Uncompensated Care (UC) Pool payments in FFY 2012.
- A fifth mechanism, Delivery System Reform Incentive Payments (DSRIP) under the waiver, began in early FFY 2013.

- Inpatient Methodology

- Standard Dollar Amounts (SDAs):

- Represent a percentage of the average cost of an inpatient admission
- General; Children's; Rural (facility-specific)
- SDAs only change through Legislative budget action

- All Patient Refined Diagnosis-Related Group (APR – DRGs) weights

- Outlier Payments for cost and length of stay outliers (children only)

- Add-ons: geographic wage; teaching; trauma (trauma not available for Children's since all Children's are trauma-certified and trauma costs are included in base SDA, no add-ons for Rural since they are paid using facility-specific SDAs)



- State-owned hospitals reimbursed through TEFRA (cost-based)

- Methodology: Outpatient

- Percent of cost; percentage depends on whether a hospital is a high volume provider (received at least \$200,000 in 2004). Currently, 54% of Medicaid hospitals are high volume providers. Rates frozen pending implementation of enhanced ambulatory payment groups (EAPG) methodology.
- Imaging and clinical lab fee schedules (typically a percentage of Medicare; limited to 125% of Acute Care Medicaid fee for same procedure)
- Special provisions for non-emergent emergency room visits (60% of emergent fee for rural hospitals; 125% of Acute Care Medicaid fee for office visit for all other hospitals)

Table 1. Outpatient Medicaid Reimbursements as a Percentage of Cost

Hospital Type	High Volume Provider Reimbursement	Non-high Volume Provider Reimbursement
Children's State-owned Rural	76.03% of cost	72.70% of cost
All Other Providers	72% of cost	68.44% of cost

Overview of Hospital Finance

“Medicaid Shortfall” and Hospital-specific Limit

- “Medicaid Shortfall”
 - Inpatient: Medicaid rates cover approximately 58% of Medicaid costs, on average, for general Medicaid hospitals (excluding children’s, rural and state-owned) and 66.80% of Medicaid costs, on average, for all Medicaid hospitals.
 - Outpatient rules for general hospitals limit payments to 72% of cost for high volume providers and 68.44% of cost for all other hospitals. For children’s, rural and state-owned hospitals, outpatient rules limit payments to 76.03% for high volume providers and 72.70% for all others.
 - Medicaid costs not covered by Medicaid rates constitute the Medicaid shortfall.
- For each hospital, a hospital-specific limit (HSL) is calculated as the sum of:
 - The hospital’s Medicaid shortfall (difference between hospital costs for Medicaid patients and Medicaid claims payments); and
 - The hospital’s unreimbursed costs of caring for low-income uninsured individuals.
- Each hospital that is eligible may receive combined DSH and UC payments up to its HSL, if there are sufficient non-federal funds to support these payments. Under the Transformation Waiver, hospitals may also receive payments for uncompensated physician, clinic and pharmacy costs.

Overview of Hospital Finance

Make-up of Texas' Hospital Safety Net

- Texas' healthcare safety net requires the participation of both public and private hospitals.
 - Among all DSH hospitals, private hospitals provide a majority of Medicaid inpatient days (74.4%) and low-income uninsured inpatient days (50.6%).

Table 2. Public v. Private Medicaid and Low-income Uninsured Burdens, FFY 2013 DSH*

Hospital Ownership Type	Number of DSH Hospitals	Medicaid Days	Low Income Days	HSL
State	12	117,214	834,730	\$248,656,904
Public	61	505,255	864,462	\$1,967,497,527
Private	107	1,808,271	1,737,600	\$2,519,168,857
Total	180	2,430,740	3,436,792	\$4,735,323,288
Percent State	6.7%	4.8%	24.3%	5.3%
Percent Public	33.9%	20.8%	25.2%	41.5%
Percent Private	59.4%	74.4%	50.6%	53.2%

* FFY 2013 DSH based on FFY 2011 data.

Overview of Hospital Finance Supplemental Payment Funding Pools

Table 3. Supplemental Funds Available during the Waiver Period

Type of Pool	DY1 FFY 2012	DY2 FFY 2013	DY3 FFY 2014	DY4 FFY 2015	DY5 FFY 2016	Total
	(in billions)					
DSH	\$1.682	\$1.694	\$1.738	\$1.782	\$1.828*	\$8.724
UC	\$3.700	\$3.900	\$3.534	\$3.348	\$3.100	\$17.582
DSRIP	\$0.500	\$2.300	\$2.666	\$2.852	\$3.100	\$11.418
Total	\$5.882	\$7.894	\$7.938	\$7.982	\$8.028	\$37.724
DSH - Non federal	\$0.703	\$0.690	\$0.718	\$0.748	\$0.784*	\$3.642
UC - Non federal	\$1.546	\$1.587	\$1.460	\$1.404	\$1.329	\$7.326
DSRIP - Non federal	\$0.209	\$0.936	\$1.101	\$1.196	\$1.329	\$4.771
Total - Non federal	\$2.458	\$3.213	\$3.279	\$3.348	\$3.442	\$15.739

* = Estimated.

- Notes:
1. Payments do not have to be processed in the year for which they are allocated.
 2. The DSH Program is not part of the Section 1115 waiver.

- Participation in the DSH program is limited to hospitals that bear a disproportionate share of the state's Medicaid and low-income uninsured care burden.
- DSH funds are distributed to qualifying hospitals based on each hospital's sum of Medicaid and low-income uninsured days as a percentage of all qualifying hospitals' sum of Medicaid and low-income uninsured days.
- Each hospital's DSH payment is limited to its HSL.
- HHSC is required by the Social Security Act to annually complete an independent certified audit of each DSH hospital. Starting with the 2011 audit, HHSC will recoup any overpayment of DSH funds and redistribute the recouped funds to DSH providers that are eligible for additional payments.
- The nonfederal share of DSH payments to public hospitals is primarily funded through intergovernmental transfers (IGTs) from each public hospital. The nonfederal share of DSH payments for private hospitals is primarily funded through IGTs from six large public hospital districts.
- However, general revenue funding supplemented IGTs in FFY 2013 (\$137M); FFY 2014 (\$160M); and FFY 2015 (\$140M).

Overview of Hospital Finance ACA DSH allocation reductions

- The ACA reduced the aggregate DSH allotment for all states.
 - Future DSH allotments will be linked to the number of uninsured and how states target their funds.
 - Specific DSH reductions for Texas Medicaid are unknown at this time.

Table 4: National ACA DSH Reductions and Amendments

FFY	Original ACA Reductions (\$ millions)	Revised per Medicare Access and CHIP Reauthorization Act of 2015 (\$ millions)
2014	\$500	\$0
2015	\$600	\$0
2016	\$600	\$0
2017	\$1,800	\$0
2018	\$5,000	\$2,000
2019	\$5,600	\$3,000
2020	\$4,000	\$4,000
2021	Each state's 2021 allotment is equal to its 2020 allotment increased by % change in CPI for FFY 2020	\$5,000
2022	Each state's 2022 allotment is equal to its 2021 allotment increased by % change in CPI for FFY 2021	\$6,000
2023	Revert to methodology in place prior to reductions	\$7,000
2024	See 2023	\$8,000
2025		\$8,000
2026		Revert to methodology in place prior to reductions

- UC Allocation Methodology:
 - Establish distinct UC pools for different types of providers (including large public, small public, and private hospitals). If UC costs in a pool exceed the funds allocated to that pool, reduce payments to providers in the pool so that total payments from the pool do not exceed funds allocated to the pool.
 - Pool sizes based on the ratio of each pool's "UC need" to the total of all pools' "UC need". "UC need" was defined as follows:
 - Large public hospitals: sum of HSLs less payments made under DSH plus an amount equal to the IGTs they transferred to support DSH payments to private hospitals and their own hospitals.
 - Small public hospitals: sum of HSLs less payments made under DSH plus an amount equal to the IGTs they transferred to support DSH payments to their own hospitals.
 - Private hospitals: sum of HSLs less payments made under DSH
 - Special protections for Rider 38 rural hospitals.
- Any unused pool funds used to offset \$466 million "UPL debt" to CMS.

Overview of Hospital Finance

Who Benefits from Supplemental Payments?

Table 5: Distribution of Medical Payments by Hospital Ownership Type
All Funds, Federal Fiscal Year 2013

Hospital Type	Number of Hospitals	Medicaid Payments	DSH Payments	Number of Receiving DSH Payments	UC Payments	Number of Receiving UC Payments*	Total
State Owned	15	\$226,373,605	\$390,823,470	12	\$130,144,627	23	\$747,341,702
Public	108	\$762,640,025	\$687,527,711	61	\$1,448,489,790	106	\$2,898,657,525
Private Not for Profit	150	\$2,662,461,622	\$344,629,078	63	\$1,389,197,207	116	\$4,396,287,907
Private for Profit	268	\$1,419,189,852	\$269,876,673	44	\$861,977,640	89	\$2,551,044,165
Total	541	\$5,070,665,103	\$1,692,856,932	180	\$3,829,809,264	334	\$10,593,331,299

*State Owned UC participants included Physicians Groups classified as State Owned receiving UC payments.

NOTE: DSH and UC payments to public and state-owned hospitals are not net of repayment of IGTs and payments to private hospitals are not net of the cost of to these hospitals of community benefit activities.