



Presentation to the
House Appropriations Subcommittee on
Article II:
Disproportionate Share Hospital Program

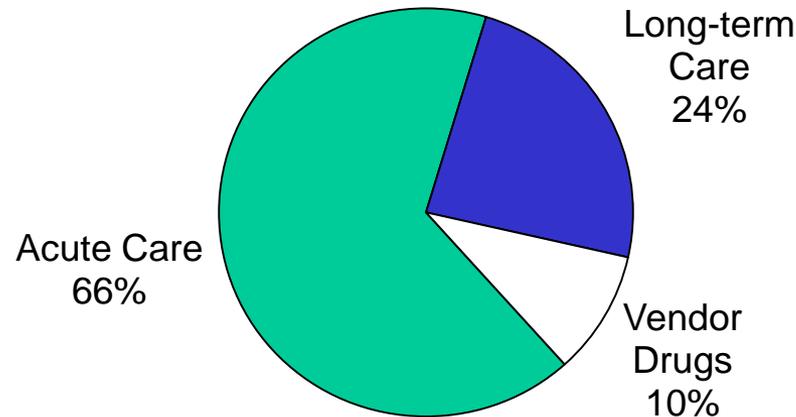
Thomas Suehs
Executive Commissioner

July 12, 2012

Hospital Funding Overview

- Total federal and state expenditures for Texas Medicaid in FY 2011 were approximately \$28.0 billion All Funds. Acute care services represented about 66% of these expenditures (about \$17.6 billion All Funds).

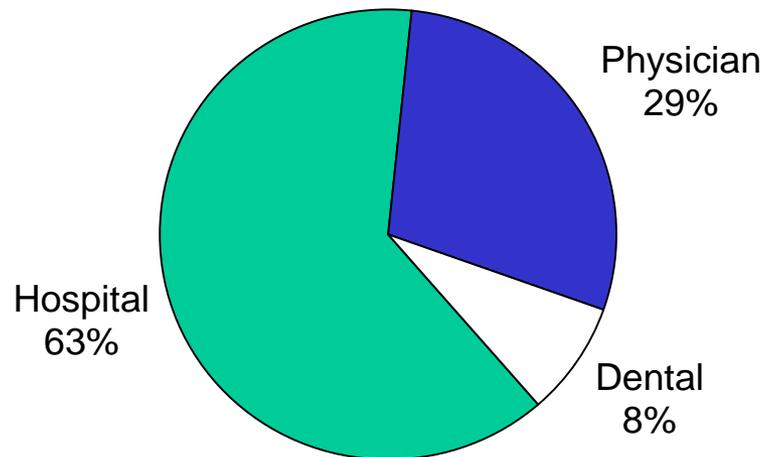
Medicaid Expenditures, FY 2011
Total = \$28.0 billion All Funds



Hospital Funding Overview

- Hospital payments represented approximately 63% of Medicaid expenditures for acute care services in FY 2011 (about \$11.1 billion of \$17.6 billion All Funds).

Medicaid Acute Care Expenditures, FY 2011
Total = \$17.6 billion All Funds



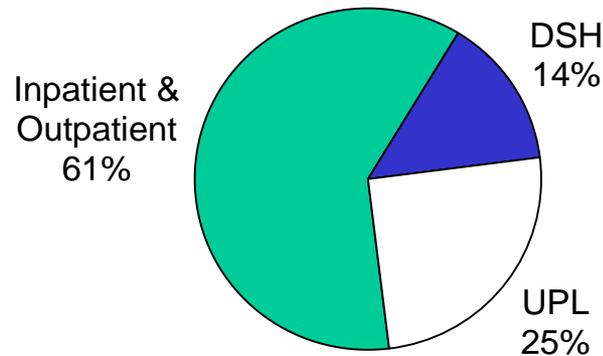
Medicaid Hospital Funding Overview

- Historically, hospital payments have been made using four mechanisms:
 - Inpatient payments
 - Outpatient payments
 - Disproportionate Share Hospital (DSH) payments
 - Upper Payment Limit (UPL) programs
 - UPL payments transition to Medicaid 1115 Transformation Waiver Uncompensated Care (UC) Pool payments in FY 2012.
 - Delivery System Reform Incentive Payment (DSRIP) Pool payments under the waiver begin in late FY 2012 / early FY 2013.

Medicaid Hospital Funding Overview

- DSH and UPL represented approximately 39% of total payments to hospitals in FY 2011 (about \$4.4 billion of \$11.1 billion All Funds).

Medicaid Hospital Expenditures, FY 2011
Total = \$11.1 billion All Funds



General Revenue - Inpatient & Outpatient:	\$1.6 billion
Delivery Supplemental Payments:	\$329.7 million
General Revenue - Delivery Supplemental Payments:	\$107.8 million
Intergovernmental Transfers for DSH:	\$488.2 million
Intergovernmental Transfers for UPL:	\$940.7 million

History/Background of DSH

- The Omnibus Budget Reconciliation Act (OBRA) of 1981 authorized the federal government to allocate additional funds to states for the purpose of making supplemental Medicaid payments to hospitals that “serve a disproportionate number of low-income patients with special needs.”
 - The federal government establishes each state’s allotment of DSH funds each year based, in part, on changes in the consumer price index for urban consumers.
- Texas established its DSH program in 1986.
 - The DSH program has been funded since its inception with local funds transferred by as many as 11 hospital districts.

History/Background of DSH

- DSH payments are calculated for each hospital based on a combination of criteria, including:
 - the number of days a hospital provided services to low income patients and Medicaid recipients,
 - hospital payment data, and
 - the difference between the cost of caring for Medicaid patients and the amount Medicaid paid for such care.
- Each hospital that is eligible may receive DSH payments up to a ceiling calculated for each hospital (the hospital-specific limit) if there are sufficient local funds transferred to support these payments.

Medicaid Hospitals by Ownership/Classification FY 2010 Funding (State & Federal)

Hospital Type	# of Hospitals	Medicaid Payments**	DSH Payments	# Hospitals Receiving DSH Pmts *	UPL Payments	# Hospitals Receiving UPL Pmts *	Total	% of Total Payments
State Owned	14	\$228,634,904	\$253,396,668	12	\$80,481,274	4	\$562,512,846	6.8%
Public	107	\$552,832,730	\$437,718,012	46	\$640,103,642	76	\$1,630,654,384	19.6%
Private Not for Profit	164	\$1,821,642,609	\$732,000,290	58	\$1,049,222,332	77	\$3,602,865,232	43.3%
Private for Profit	296	\$1,453,156,680	\$257,561,023	54	\$804,833,856	91	\$2,515,551,559	30.3%
Total	581	\$4,056,266,923	\$1,680,675,993	170	\$2,574,641,104	248	\$8,311,584,020	100.0%

* Use of IGT

** Includes Inpatient and Outpatient hospital related services

** outpatient services (ASC, home health, DME, FQHCs, RHCs, etc.) not related to hospitals, are excluded from the totals above.

Need for DSH Reform

- The DSH program in Texas no longer serves the intended goals of the program.
 - While DSH was intended to provide support for the disproportionate costs of care to providers of significant low-income care, DSH in Texas has become a Medicaid rate subsidy program.
 - Under the current formula, payments are made based upon a hospital's Medicaid days and low-income days. These days are weighted equally, though Medicaid care is reimbursed, albeit at an inadequate level, while uninsured care is not.
 - Texas has significantly expanded managed care, and managed care organizations negotiate rates with providers.
 - Uninsured care is much more concentrated among a smaller number of hospitals.
 - The Affordable Care Act changes the amount of DSH funds and how they would be allocated beginning in FY 2014.

Need for DSH Reform

- Over the last decade, there has been a significant shift in the percentage of DSH dollars away from the transferring hospitals that have high uninsured costs. At the same time, the transferring hospitals must transfer more and more dollars to support the program.
 - The proportion of the federal matching funds generated by the transferring hospitals' IGTs that are returned to them through DSH payments has declined from about 50% in FFY 1996 to about 14% in FFY 2012.
- Every dollar transferred is a dollar of cost to a transferring hospital.
 - For UPL, (or UC Pool payments under the Medicaid 1115 Transformation Waiver), public hospitals received about 60 cents for each dollar of cost in FY 2011, after taking into account the IGT.
 - For DSH, public hospitals received about 24 cents for each dollar of cost in FY 2011 because of the significant IGTs required to fund other DSH hospitals.
- This results in just a handful of counties funding the state system for uninsured care, primarily from local property taxes.

DSH Reform Proposal

- On February 21, 2012, the Texas Coalition of Transferring Hospitals submitted to HHSC a petition to change the DSH funding methodology. HHSC published the proposal for public review and comment.
- Following the comment period, the following agreements were reached for FFY 2012:
 - The transferring hospitals will increase their amount of IGTs from the “limited amount” of \$425 million (the amount offered in the proposal) to \$502 million. The FY 2011 amount of IGT was \$488 million.
 - There will be established, pre-determined funding pools for:
 - Public urban (transferring) hospitals – \$613 million
 - Private urban hospitals - \$417 million
 - Rural hospitals - \$71.5 million
 - Children’s hospitals - \$100 million

DSH Reform Goals

- Beginning in the 4th quarter of FFY 2012, shift DSH funding to pools.
- Create incentives to maximize the funding of the Medicaid 1115 Transformation Waiver.
- Consider identifying a broad-based funding source for DSH. This would eliminate the IGT on transferring hospitals, and make the program sustainable in the long term.
- For FFY 2012, modify the formula to reallocate DSH dollars in a manner consistent with the goals above and taking into account historical allocations of funds.

DSH Reform Goals

- HHSC proposes the following initial allocation of Regional Health Plan's (RHP's) annual DSRIP funds:
 - Hospitals are allocated 75% of the RHP's annual DSRIP funds. Of this amount, each hospital shall be assigned a potential DSRIP allocation based on a provider's size and role in serving Medicaid patients.
 - RHPs shall have minimum representation of non-profit and private hospitals in the DSRIP plans. Minimum representation will be defined as an RHP Plan that reflects at least a certain percent of the assigned DSRIP annual amount allocated to non-profit and private hospitals (percent still to be determined).
 - Local Mental Health Authorities are allocated 10% of the RHP's annual DSRIP funds.
 - Physician Practices associated with an Academic Health Science Center are allocated 10% of the RHP's annual DSRIP funds.
 - Local Health Districts are allocated 5% of the RHP's annual DSRIP funds.

DSH Reform 2013 and Beyond

- There is no agreement on how DSH will be funded for FFY 2013 and beyond, but the transferring hospitals have set out the following principles:
 - Continue the established, pre-determined funding pools for public urban (transferring) hospitals, private urban hospitals, rural hospitals, and children's hospitals. The total amount in each pool will equal the FFY 2012 amount adjusted for any change in the federal DSH allocation.
 - Transferring hospitals will not be responsible for making IGTs to fund DSH payments to urban private hospitals or rural hospitals. Funding of DSH payments to children's hospitals was not addressed.
 - Rural public hospitals will become responsible for making IGTs beginning in FFY 2013 to the degree they have allowable sources of public funds available.
- The Legislature will ultimately need to make the final determination of how DSH will be funded in FFY 2013 and beyond.

DSH Reform 2013 and Beyond

- Next Steps
 - HHSC will work with the hospitals to reach a compromise on DSH funding for FFY 2013 and develop funding options for the Texas Legislature to consider for FFY 2014 and beyond.

Appendix A

Relevant Terms and Definitions

Relevant Hospital Reimbursement Terms

- **Cost Based** – Reimbursement to hospitals based on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rules which reimburses hospitals for their allowable costs. This is to be distinguished from DRG-based reimbursement, whose rates are prospectively determined.
- **Disproportionate Share Hospital Reimbursement (DSH)** – Federal law requires Medicaid make payments to hospitals serving a disproportionately large number of Medicaid and low-income patients. Federal funding to Texas is capped. Texas uses IGTs to fund the state match.
- **Upper Payment Limit (UPL)** – Financing mechanism used by Texas to provide supplemental payments to hospitals. The basis for this funding is the difference between what Medicare and Medicaid pays for essentially the same patient. The formula results in increased payments because Medicare's aggregate payments are higher than Medicaid's. Texas uses IGTs to fund the state match. To be replaced by Transformation Waiver Replacing the UPL will be replaced by the two Transformation Waiver funding pools, one based on costs and the other based on performance outcomes.
- **Graduate Medical Education (GME)** – Medicaid provides payments to hospitals to support its share of direct costs related to medical training programs and to support higher patient care costs associated with the training of residents.

Relevant Hospital Reimbursement Terms

- **Intergovernmental Transfers (IGTs)** – Methodology employed by Texas to obtain state match for Federal funding and does not require General Revenue. IGT has limitations in that only public funds can be used (only transfers between governmental entities), the result is a limitation in the available non-General Revenue funding to match Federal funds and potential Federal revenue is lost.
- **Diagnosis Related Group (DRG)** – A method for grouping hospital patients using diagnoses.
- **Case Mix Index (CMI)** – A numerical description used to identify the complexity of a hospital's patient case load throughout the year.
- **Standard Dollar Amount (SDA)** – The value that determines the individual hospital's Medicaid reimbursement payment. Each hospital has its own SDA which results from dividing its average cost per admission by its CMI. This calculation essentially "standardizes" the standard dollar amount.
- **Ratio of Costs to Charges (RCC)** – Providers claims for reimbursement are stated in terms of charges. Medicaid, which pays "allowable costs" converts charges to costs for the hospital. The RCC is the basis for making this conversion. The RCC is derived from an analysis of the providers Medicare cost report. The analysis determines allowable costs and then creates the RCC by dividing costs by charges.

Relevant Hospital Reimbursement Terms

- **Transformation Waiver** - The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the Transformation Waiver, is a five-year demonstration waiver that allows the State to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as UPL payments. UPL payments were supplemental payments making up the difference between what Medicaid pays for a service and what Medicare would pay for the same service. The Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds through a program and process that is transparent and accountable for public funds. Replacing the UPL payment methodology are two funding pools, one based on costs (Uncompensated Care Pool) and the other based on performance outcomes (Delivery System Reform Incentive Payment [DSRIP] Pool).
- **Trauma Funding** – Hospital designated as trauma facilities can receive payments from the Trauma Facility and Emergency Medical Services account established for the purpose of reimbursing hospitals for unreimbursed trauma care.

Relevant Hospital Reimbursement Terms

- **Uncompensated Care** – Identifies the costs for a hospital resulting from the provision of treatment to patients who are unable to reimburse the hospital for their care. Formally defined as the sum of a hospital's bad debt expense and its charity care.
- **Rebasing** – Updating to a more recent year the data used to calculate the hospitals' SDA payment. The effect of rebasing is to capture changes in cost that impact the amount of Medicaid allowable reimbursement paid to a hospital.
- **Medicaid Hospital Shortfall** – Hospital costs for providing treatment to Medicaid patients which are allowable under Medicaid rules but are not reimbursed because the DRG-based payment does not fully reimburse the full amount of these costs. Shortfall costs that originate in the SDA reimbursement system are passed to the DSH system where they are reimbursed.