



# **House Border & Intergovernmental Affairs**

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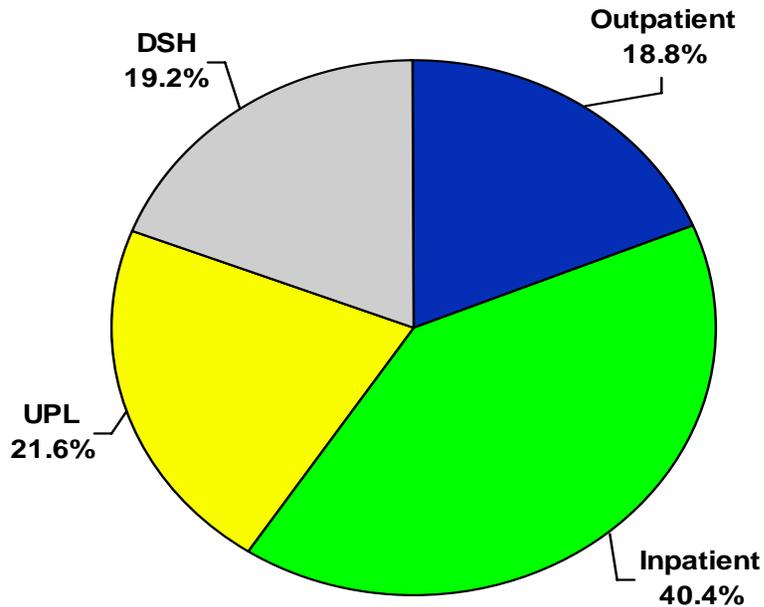
**August 27, 2010**

- SB 1, Article II, HHSC Rider 68 (81<sup>st</sup> Regular Session, 2009) directed the Health and Human Services Commission (HHSC) to proportionately rebase inpatient Medicaid acute care hospital reimbursement rates.
- Rider 68 noted that the current reimbursement formula was calculated using cost data that was outdated and was established under a methodology that does not adequately reflect changes in federal and state laws, regulations, allowable costs, and current economic factors.
- The rider specified that:
  - HHSC was to update the standard dollar amounts (SDAs) and diagnosis related group (DRG) factors with more recent cost data and proportionately adjust the SDAs; and
  - Any changes could not result in higher expenditures for the state.

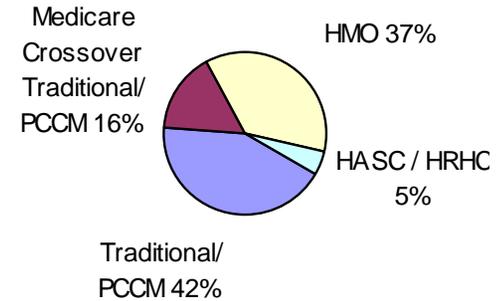
- Rebasing of hospital rates has not occurred since 2002. In lieu of rate increases, several new Upper Payment Limit (UPL) programs have been implemented since 2004
  - o The amount of UPL payments made to acute care hospitals for Medicaid services has increased from \$682 million in FY 2004 to an estimated \$2.2 billion in FY 2009 or an increase of 69% over a four year period
  - o The total number of hospitals who receive UPL payments has risen from 11 in FY 2004 to 264 in FY 2009
- In addition, HHSC pays approximately \$1.5 billion per year in Disproportionate Share Hospital (DSH) payments to an average of 180 hospitals to help offset the costs of providing services to uninsured and Medicaid patients

# Hospital Funding – FY 2008

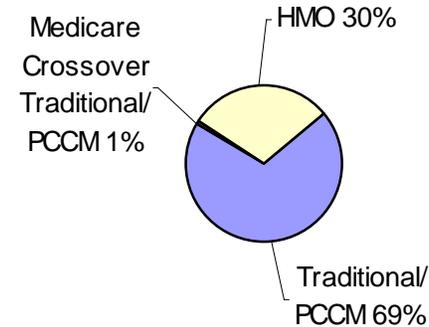
## Hospital Funding



## Outpatient Funding



## Inpatient Funding



<u>Hospital Financing</u>	<u>Total Payments (millions)</u>	<u>State Match (millions)</u>	<u>Match Type</u>
Inpatient	\$3,087.0	\$1,216.8	GR
Outpatient	\$1,425.3	\$561.8	GR
UPL (non-appropriated funding)	\$1,659.3	\$12.5 / \$641.6	GR / IGT
DSH (non-appropriated funding)	\$1,464.8	\$179.0 / \$398.5	GR / IGT
Total*	\$7,636.4	\$1,970.1 / \$1,040.1	GR / IGT

\* Approximately \$300 million outpatient services (home health, DME, FQHCs, RHCs, etc.) not related to hospitals, are excluded from the totals above.

- Because rebasing of inpatient hospital rates has not occurred since FY 2002 (based on FY 2000 cost data), wide variations have developed in the amount of costs covered in the reimbursement system.
- Rebasing is the first step in a multiple step process to shift hospitals to a performance based system and is intended to achieve payment equity among hospitals by recalculating Medicaid inpatient hospital reimbursement rates so that hospitals are reimbursed proportionately to their estimated costs.
  - Historical patient claims and cost data are used to determine the actual cost incurred for each hospital providing Medicaid services.
  - Rebased rates should proportionately reflect a hospital's current cost and case mix (patient complexities), as well as changes in costs for services that have occurred since fiscal year 2002 such as new procedures and advances in medical technology.

# Rebasing Impact to Hospitals

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## Factors resulting in fiscal impacts to hospitals:

- No-cost provision of Rider 68
- The proportional rebasing of individual hospitals SDAs increasing and decreasing;
- Some high volume relative weights decreasing after recalculating the DRG, based on current costs;
- The gap between the current rates and a hospital's actual costs as the result of no increases in rates for the previous eight years in addition to rate reductions in FYs 2004 and 2005;
- Because rates have been unchanged since 2002 some hospitals have been receiving a new hospital SDA rate that was based on the universal mean rate and not on their own cost experience.

- The proportional rebasing of individual hospitals standard dollar amounts (SDAs) has resulted in some hospitals whose SDA will decrease and some hospitals whose SDA will increase, thus having different positive and negative fiscal impacts.
- HHSC received feedback from hospitals that were concerned about the substantial financial impact to their hospital as well as other hospitals in their geographic region.
- To help mitigate the impact on negatively impacted hospitals and achieve the no-cost provision in Rider 68, transitional rebasing rates will be implemented. Under the transitional rebasing methodology:
  - A hospital's individual loss will be limited to no more than ten percent.
  - A hospital's individual gain will be limited to no more than 38 percent.

# Rebasing Timeline

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- August 2009 to May 2010 - Meetings were held between HHSC and hospital representatives.
- May 2010 - Notification letters were sent to each hospital informing them of their newly calculated standard dollar amount (SDA) (prior to adjustments to remain within available funds).
- June 2010 to July 2010 - Proposed rule was presented in public meetings to the Hospital Payment Advisory Committee and the Medical Care Advisory Committee.
- August 18, 2010 - A public rate hearing was held on the one percent rate reduction and the no-cost rebasing rates.
- September 1, 2010 – August 31, 2010 rates will remain in effect less the one percent rate reduction.
- September to October 2010- Updated transitional rebasing rules will be promulgated.
- November 1, 2010- Transitional rebasing rates become effective.