



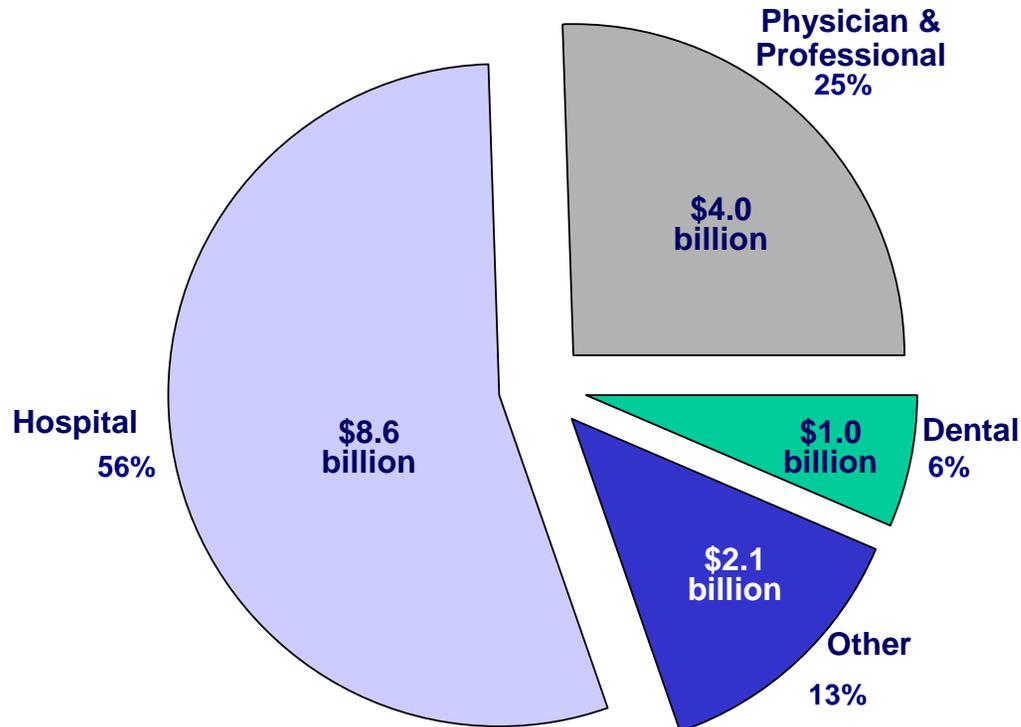
Presentation to the House Committee
on County Affairs:
Upper Payment Limit (UPL) &
Disproportionate Share Hospital (DSH) Programs

Thomas M. Suehs, Executive Commissioner

March 8, 2011

Acute Care Spending – FY 2009

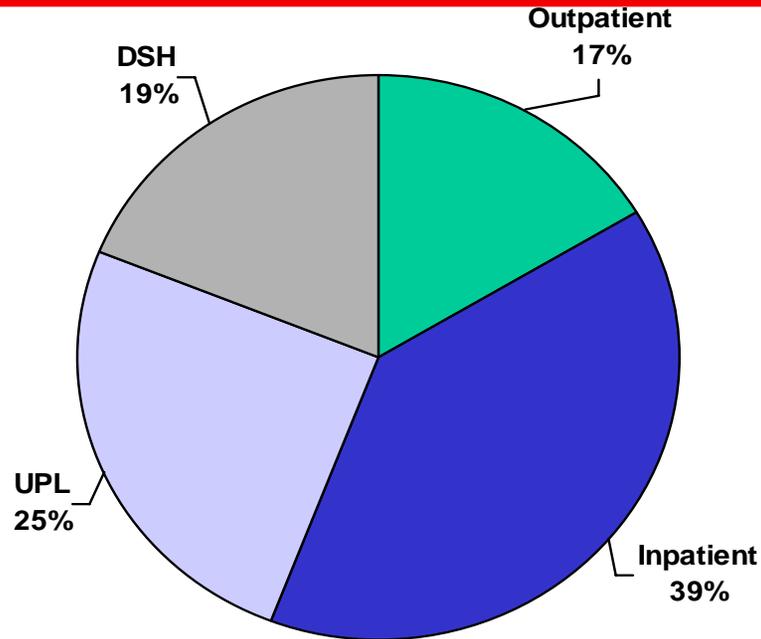
Total Acute Care Spending with HMO Payments to Providers – \$15.7 billion



Notes:

- Acute Care spending includes all Fee-for-Service, PCCM claims and payments to providers by HMOs.
- Hospital total includes Disproportionate Share and Upper Payment Limit payments.
- Other costs include Medicare Part A and Part B premium payments, Medicare Part D give-back payments, and payments to HMOs not captured in service encounter data that reflects delivery supplemental payments, administrative and unreported service costs.
- Due to the rounding component, totals and percentages may not total exactly.

Hospital Financing – FY 2009



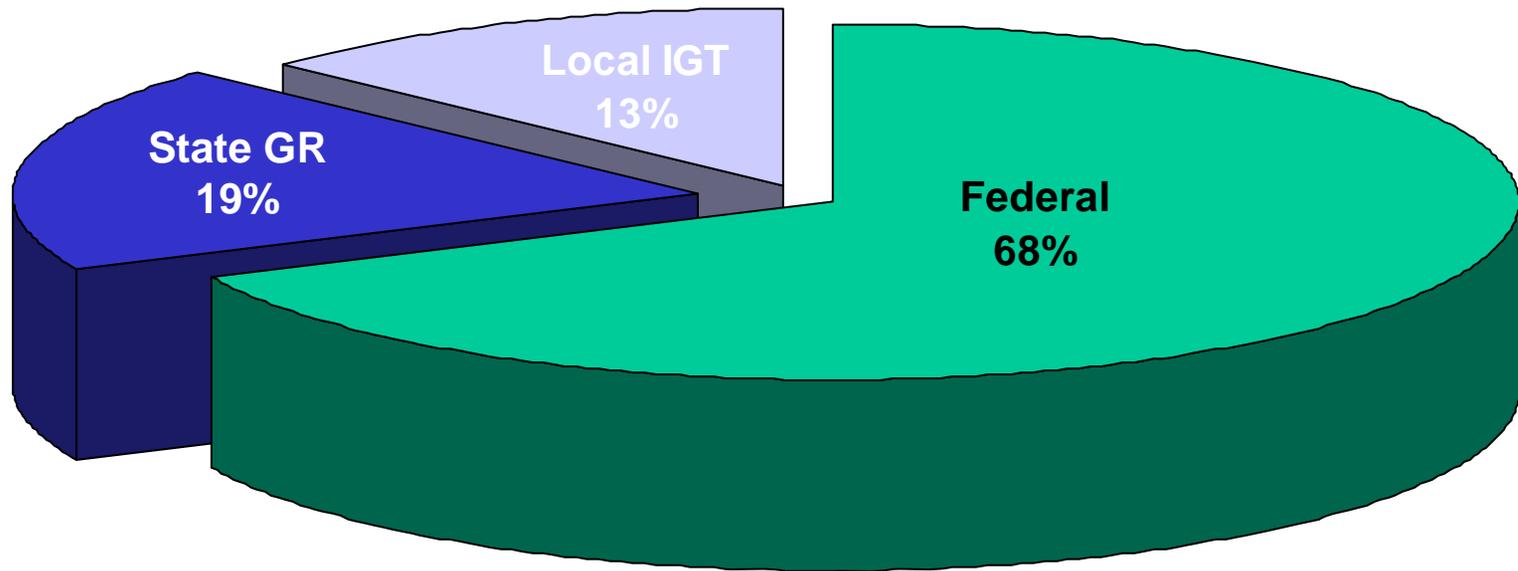
<u>Hospital Financing</u>	<u>Total Payments (billions)</u>	<u>State Match (billions)</u>	<u>Match Type</u>
Inpatient	\$3.4	\$1.1	GR
Outpatient	\$1.4	\$.4	GR
UPL (non-appropriated funding)	\$2.2	\$.01 / \$.6	GR / IGT
<u>DSH (non-appropriated funding)</u>	<u>\$1.6</u>	<u>\$.1 / \$.5</u>	<u>GR / IGT</u>
Total	\$8.6	\$1.7 / \$1.1	GR / IGT

Notes: Of the total state match required for FY 2009 hospital payments, 40% is provided through inter-governmental transfers.

Numbers may not add due to rounding.

Hospital Funding by Source of Funds

FY 2009



Hospital Upper Payment Limit (UPL)

- The UPL program provides supplemental payments to hospitals to make up for the lower reimbursement rates paid by Medicaid for inpatient services.
- UPL payments represent the difference between Medicaid reimbursement rates and the lesser of what Medicare would reasonably pay or the hospital's charges.
- Inter-governmental transfers from state-owned or local governmental entities finance the state share of UPL payments.
- There are federal restrictions on making UPL payments for managed care claims.

Upper Payment Limit (UPL)

- Federal Medicaid rules impose limits on Medicaid payments to hospitals. These rules provide the basis for making UPL payments to hospitals.
- Limit by hospital class: Medicaid payments made to all hospitals within a class may not exceed a reasonable estimate of what Medicare would pay.
- Hospital classes:
 - State-owned
 - Non-state publicly owned
 - All other hospitals
- Hospital-specific limit: Medicaid payments may not exceed a hospital's aggregate charges to the general public.

Upper Payment Limit (UPL)

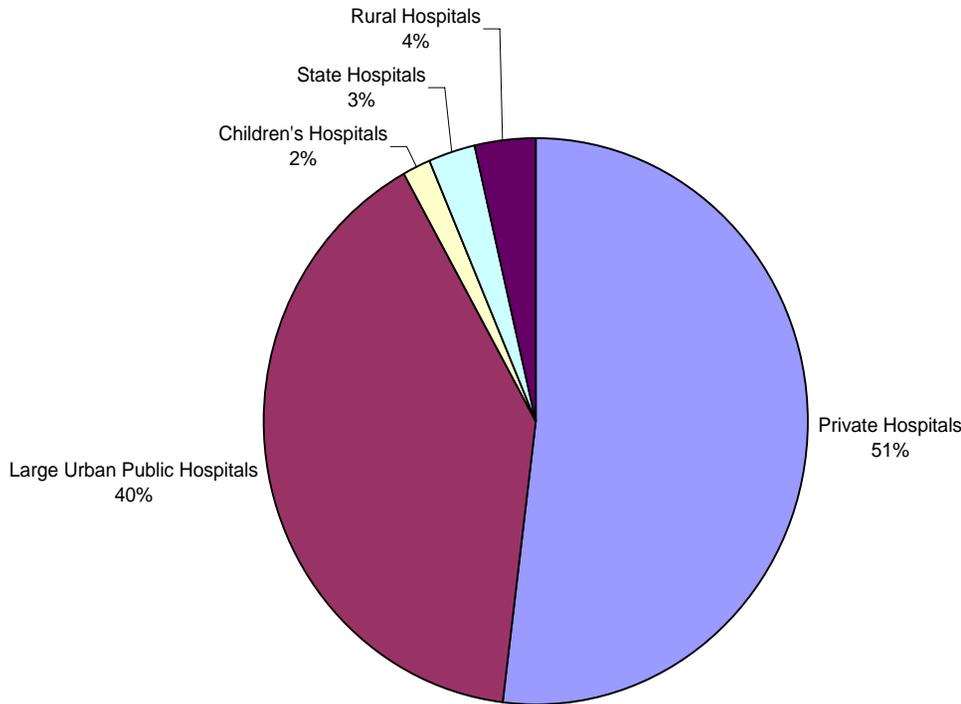
Texas Upper Payment Limit (UPL) Programs	
Hospital UPL Programs	Effective Dates
Large Public Hospitals	Jul 2001
Rural Hospitals	Jan 2002
State-Owned Hospitals	Dec 2003
Private Hospitals	Jun 2005 & Nov 2005*
Children's Hospitals	Apr 2006
Physician UPL Programs	Effective Dates
State-Owned Hospital Physicians	May 2004
Tarrant County Hospital District Physicians	Nov 2004

* The UPL program for private hospitals required two state plan amendments with different effective dates.

Note: There are two pending Medicaid state plan amendments to add Texas A&M Health Science Center and Scott and White Memorial Hospital to the Physician UPL Program.

Upper Payment Limit (UPL)

Hospital Funding Categories



**Total FY 2009 UPL
Payments -\$2,177,567,579**

Total FY 2009 UPL Payments by Type of Hospital		
Type of Hospital	Number of Hospitals	Payments (in millions)
Private	112	\$ 1,133.1
Large Urban	11	\$ 866.6
Rural	85	\$ 77.3
State-owned	4	\$ 60.2
Children's	7	\$ 40.4
Total	219	\$ 2,177.6

Disproportionate Share Hospital (DSH) Payments

- Federal law requires Medicaid programs to make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients.
- These hospitals are called disproportionate share hospitals (DSH) and receive DSH funding.
- DSH funds are different from most other Medicaid payments because they are not tied to specific services for Medicaid-eligible patients.
 - Hospitals may use DSH payments to cover the cost of uncompensated care for indigent or low-income patients.
 - DSH payments help hospitals:
 - Expand health care services to the uninsured
 - Defray the costs of treating indigent patients
 - Recruit physicians and other health care professionals

Disproportionate Share Hospital (DSH) Payments

- DSH payments are funded using the same Medicaid matching rate as for medical services.
- Large public hospitals provide the inter-governmental transfers (IGT) that provide the state matching dollars to fund the DSH program.
- The state match for the state hospitals that participate in the DSH program is funded with state appropriations to state-owned hospitals (teaching, psychiatric, and chest).
- Managed care claims are included in the calculation of DSH payments.

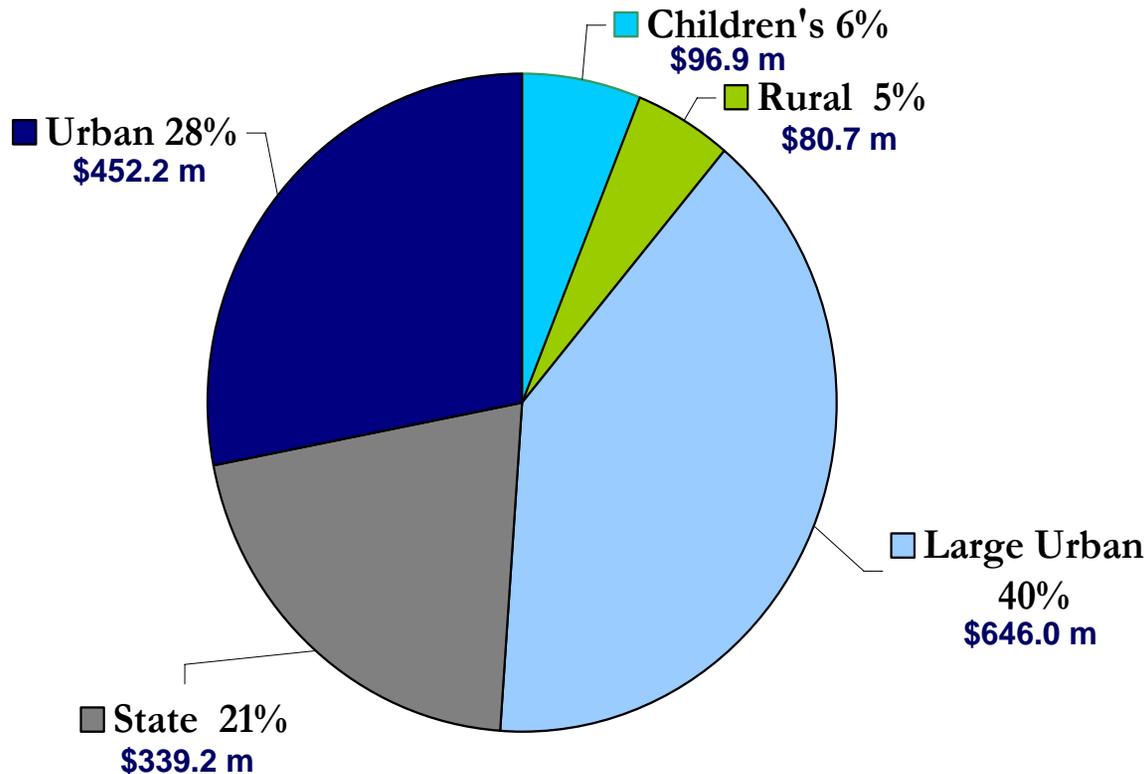
Disproportionate Share Hospital (DSH) Payments

- Texas began making DSH payments to providers in 1987.
- In 2009, 182 Texas hospitals qualified to receive DSH payments:
 - 85 were public
 - 57 were private non-profit
 - 40 were private for-profit
- Of the total DSH providers:
 - 101 were located in urban areas
 - 8 were large urban public facilities
 - 8 were children's hospitals
 - 81 were located in rural areas

Disproportionate Share Hospital (DSH) Payments

Hospital Category Funding

Total FY 2009 DSH Payment: \$1,615,026,519



UPL and DSH Payments and IGTs

Hospital UPL Program	FFY 2010 UPL Payments	FFY 2010 IGTs
Large Urban Hospitals	958,948,345	282,329,306
Rural Hospitals	110,890,515	32,420,225
State Hospitals	124,307,590	<i>36,236,698</i>
Private Hospitals	1,387,183,980	403,115,664
Children's Hospitals	43,014,453	<i>12,500,000</i>
	<u>2,624,344,883</u>	<u>766,601,893</u>

DSH Program	FFY 2010 DSH Payments
DSH Payments	1,682,184,767
IGT's (State Hospitals)	<i>131,747,544</i>
IGT's (Public Hospitals)	562,490,109
Federal Share (State Hospitals)	187,485,662
Federal Share (Public Hospitals)	800,461,452
	<u>1,682,184,767</u>

Amounts in italics are IGT's from State entities that are funded with general revenue. All other IGT's are funded by local government entities.

Additional Information

Hospital Financing Terms

- **Cost Based** - Reimbursement to hospitals based on the Tax Equity and Fiscal Responsibility Act of 1985 (TEFRA) rules which reimburse hospitals for their allowable costs. This is to be distinguished from DRG-based reimbursement, whose rates are prospectively determined.
- **Diagnosis Related Group (DRG)** – A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. This system of classification is used in the calculation of acute care hospital reimbursement.
- **Inter-Governmental Transfers (IGT)** – Methodology employed by Texas to obtain state match for federal funding and does not require state general revenue. An IGT can only be provided by a governmental entity and must be considered to be public funds.
- **Disproportionate Share Hospital (DSH)** – Federal law requires Medicaid to make additional reimbursement to hospitals that serve a disproportionate share of Medicaid and low income patients. Federal funding to Texas is capped at an annual amount. Texas uses IGT's to fund the state match for non-state hospitals.
- **Standard Dollar Amount (SDA)** – Is the hospital payment rate paid to a DRG prospectively reimbursed hospital based on the hospital's standardized average cost of treating a Medicaid inpatient admission.
- **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 for UPL payments.
- **Primary Care Case Management (PCCM)** – A non-capitated model, where each PCCM participant has a primary care physician (PCP). PCPs receive fee-for-service reimbursement and a monthly case management fee and the PCPs and hospitals contract directly with the state.
- **Health Maintenance Organizations (HMO)** – An organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost and administrative costs.