Presentation to the
Senate Finance Committee

Uncompensated Care
and
Medicaid Hospital Reimbursement

(Senate Bill 1, Article II, HHSC Riders 60 and 61)

October 10, 2006

Objectives for Presentation

A. Understand uncompensated care costs as reported by Texas hospitals (HHSC Rider 61).

B. Understand the current methodology for reimbursing hospitals (HHSC Rider 60).

C. Enhance the state's ability to be a prudent purchaser of Medicaid healthcare by determining the amount of hospital cost that should be reimbursed by Medicaid. (HHSC Rider 60).

D. Identify preliminary issues associated with the reform of the current Medicaid reimbursement system (HHSC Rider 60).

Understanding Uncompensated Care

Senate Bill 1, 79th Legislature, Article II, HHSC

Rider 61. Study Regarding Uncompensated Care.

The Health and Human Services Commission shall conduct a study of the components and assumptions used to calculate Texas hospitals' uncompensated care amounts. The Commission shall provide a report to the 80th Legislature with recommendations for standardizing hospitals' uncompensated care amounts.

Presentation Objective for Rider 61

A. *To understand uncompensated care costs as reported by Texas hospitals:*

- Uncompensated care in Texas is a central component of a larger public policy debate regarding:
  - Medicaid eligibility
  - Charity care
  - The uninsured
  - Medicaid reform
  - Local tax decisions

- Uncompensated care is reported in charges and without standardized rules for adjusting these charges to costs with respect to non-patient-specific revenue.
  - There is a need to adjust reported charges to identify the actual amount of uncompensated care costs.

Presentation Objective for Rider 61, *continued*

- The amount of uncompensated care affects hospital rates in Texas and can impact private insurance premiums.
- Uncompensated care is a factor in the Medicaid reimbursement system.
- Uncompensated care is a component in the Disproportionate Share Hospital Reimbursement (DSH) formula, and the level of DSH funding will impact the availability of Upper Payment Limit (UPL).
- Uncompensated care impacts a hospital's not-for-profit tax status and ultimately the trade-off between tax revenue forgone by the state and the value of charity care provided.
- Uncompensated care impacts local charity care and the level of tax to support charity care.

Uncompensated Care in Texas: The Annual Hospital Survey

- All Texas hospitals must submit annually to the Texas Department of State Health Services (DSHS) the Cooperative Annual Survey.
  - Survey represents the state's "only comprehensive source of information on issues such as uncompensated care…" [(1)]
  - According to this survey, Texas hospitals in 2003 reported $7.6 billion in uncompensated care charges and in 2004 this amount increased to an estimated $9.2 billion or by 21 percent.
  - Local tax revenues for public hospital services increased in 2004 above the 2003 level by an estimated 12 percent.
  - DSH and UPL payments made in 2004 increased by 29 percent over 2003 levels.

Issues in Reporting:

How Much Uncompensated Care Is There In Texas?

- Five different reports are completed by the hospitals with no official relationship structure among them.
  - Cooperative Annual Survey
  - Medicare Cost Report
  - Annual Statement of Community Benefits
  - DSH Conditions of Participation
  - IRS Form 990 – Return of Organization Exempt From Income Tax
- Reporting issues highlight:
  - Inconsistencies in terminology across reports
  - Reports that have different functions but use common terms with possible inconsistent interpretations
  - Conflicting calculated results possible under current, uncoordinated sets of rules and terminology
  - Little consistency in use of ratio of cost to charges (RCC) across different reporting mechanisms

Methodology for Evaluating Consistency in Reporting of Uncompensated Care

- Interviews with finance, accounting and operations personnel of Texas hospitals
- Interviews with representatives of the Attorney General's Office
- Reviews and analysis of relevant data from the Centers for Medicare Medicaid Services, American Hospital Association, and Texas Hospital Association financial statements and other regulatory filings of public hospitals
- Reviews and analysis of the following reports/documents:
  - Cooperative Annual Hospital Survey
  - DSH Survey for Low-Income Utilization
  - Community Benefits Survey
  - Medicare Cost Report
  - Tax Documents

Interpreting Reported Uncompensated Care

- Uncompensated care is self-reported by hospitals on the Annual Cooperative Survey at $9.2 billion in hospital charges.
- By adjusting billed charges to allowable costs and accounting for other offsetting payments, HHSC estimates the cost of uncompensated care to be between $443 million and $2.3 billion.
- As revealed in the table on page 11, this estimate is contingent on the ratio of costs to charges (RCC) used to convert charges to costs as well as the adjustments made to costs.
- A number of assumptions must be made to arrive at an understanding of how uncompensated care is defined, calculated and eventually reported.
- These assumptions include how public funding for uncompensated care is reflected in the different reports and across the individual hospitals.
- The need for these assumptions is evidence of the need for standardizing the reporting of uncompensated care.

Recommendations: How Do We Appropriately Define Uncompensated Care?

Define uncompensated care in all reports to mean the sum of bad debt and charity care after being reduced to cost, and after all patient-specific and non-patient specific funding have been accounted for and applied. This leads to a standardized calculation:

1	Aggregate charges: bad debt and charity care (with transparent definition of both components)
2	Adjustment from charges to cost by uniform Ratio of Costs to Charges (RCC) (selected and uniformly applied after comments considered from relevant stakeholders)
3	Subtraction of patient-specific payments received for otherwise uncompensated care
4	Subtraction of federal DSH and UPL payments
5	Subtraction of other payments received for otherwise uncompensated care
=	ESTIMATE OF UNCOMPENSATED CARE COST

Estimating the Costs of Uncompensated Care in 2004: An Example

Item	HHSC Interpretation Scenario Using	Alternative Scenario Using
	Medicaid RCC	Medicare RCC
2004 Bad Debt and Charity Care Charges [1]	$9,200,000,000	$9,200,000,000
Adjustment from Charges to Costs (via RCC) [2]	x 34%	x 54%
2004 Bad Debt and Charity Care at Estimated Cost	$3,128,000,000	$5,152,000,000
Less Federal Portion of DSH [3]	(345,000,000)	(345,000,000)
Less Federal Portion of UPL [4]	(458,000,000)	(458,000,000)
Less Charitable Contributions Received [5]	(82,000,000)	(82,000,000)
Less Tax Revenue [6]	(1,800,000,000)	(1,800,000,000)
Estimate of Aggregate Uncompensated Care [7]	**$443,000,000**	**$2,283,000,000**

Other Revenue Not Included In Estimated Aggregate Due to Uncertainty: Local Government Funding - $688,000,000 Tobacco Settlement Funding - $28,500,000	**$716,500,000**	**$716,500,000**

Reference Appendix B for explanatory footnotes.

Costs of Uncompensated Care: Basic Conclusions

- The cost of uncompensated care is not $9.2 billion.
- Level of local tax revenue is increasing for uncompensated care.
- Accurate reporting of uncompensated care will require moving to standardized reports based on costs rather than charges.
- Estimating uncompensated care based on costs provides a more accurate and realistic view of the magnitude and presents better opportunities for the state to develop policies and strategies to use available resources more effectively to improve access to healthcare for low-income Texans.

Uncompensated Care Recommendations

- HHSC recommends legislative action to enact the following recommendations:
  - Develop a more standard and comprehensive center for data reporting and analysis.
  - Improve tracking of charges, costs and adjustments associated with under-insured and uninsured patients.
  - Develop and apply a standard set of adjustments that account for all non-patient specific funding streams and that offset hospitals' initially reported uncompensated care charges and can reliably estimate the amount of uncompensated care cost experienced by hospitals.
  - Implement one uniform ratio of costs to charges (RCC) that must be used for all reporting purposes.
  - Standardize definitions and adjustments used to determine uncompensated care costs incurred by hospitals.

Uncompensated Care Recommendations, *continued*

- Coordinate the reporting structure across reports that are used to assess uncompensated care, e.g., charity care, low-income utilization, and bad debt, for Texas hospitals.

- Ensure that the requirements and methodology for completing the Statement of Community Benefits are appropriate to its function of evaluating a hospital's community benefits performance as a basis for retaining its tax exempt status, that the actual performance of a hospital is meaningful with respect to the value of its community benefits, and that this performance, as indicated by the Statement, is auditable.

- Identify the population for targeting state funding for uncompensated care.

Understanding the Current Hospital Reimbursement Methodologies

Senate Bill 1, 79th Legislature, Article II, HHSC

Rider 60. Medicaid Provider Reimbursement.

…the Health and Human Services Commission shall convene a workgroup to assist the Executive Commissioner in studying and making recommendations for changes in the hospital (both inpatient and outpatient services) reimbursement rate methodology. These recommendations shall include cost inflators, rebasing of the rates, and other alternatives, such as waivers that would combine Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Upper Payment Limit (UPL) funds. Alternatives could be considered in determining hospital rates that would reward efficient providers, critical care providers, rural hospitals and special children hospitals, as well as incentives for hospitals to serve Medicaid clients and control medical costs. …

Presentation Objective for Rider 60

B. To understand the current methodology for reimbursing hospitals:

- Hospital expenditures represent over 62 percent of the Medicaid acute care expenditures.
- Approximately 42 percent of current level of state funding for hospital providers is through intergovernmental transfers (IGTs).
- The adequacy of Medicaid rates impacts the amount of DSH that can be spent on uncompensated care.
- The amount of DSH funding spent on uncompensated care impacts local taxing districts.
- Inadequate Medicaid rates result in Hospital Medicaid Reimbursement Shortfall.

Presentation Objective for Rider 60, *continued*

- The Medicaid Hospital Shortfall costs are reimbursed through Medicaid's DSH program. DSH is intended to reimburse hospitals for the provision of uncompensated care. Thus, low hospital payment rates limit a hospital's ability to cover the cost of care to the uninsured.

- The cost of uncompensated care is passed to the local community through local taxes or private citizens through increased premiums.

- The multiple funding streams of Medicaid hospital reimbursement are intertwined with uncompensated care, community tax burden, insurance premiums, and the number of uninsured in Texas.

- Hospital supplemental payment methodologies, e.g., DSH and UPL, encourage hospital use by the uninsured.

Presentation Objective for Rider 60, *continued*

C. To enhance the state's ability to be a prudent purchaser of Medicaid healthcare by determining the amount of hospital cost that should be reimbursed by Medicaid:

- Currently, hospital payments are directly linked to the mix of patients treated by each individual hospital and expenditure decisions made by each individual hospital (Standard Dollar Amount or SDA).
- Consequently, there is considerable variation in SDA costs across hospitals.
- This variation is not adequately explained by the different types of services provided or local market factors. However, there is a general perception that there is some "value-added" effect from the variation.

Presentation Objective for Rider 60, *continued*

- There is no objective standard or measure by which to determine whether expenditures are reasonable and necessary. Rather, reimbursement for Medicaid services is driven by the individual hospital's decisions regarding expenditures and accounting.
- Medicaid reimbursement should be informed by objective measures that demonstrate that expenditures are reasonable and necessary.

An Example of Variation Across Hospitals for "Same" DRG-Reimbursable Patients in 2004

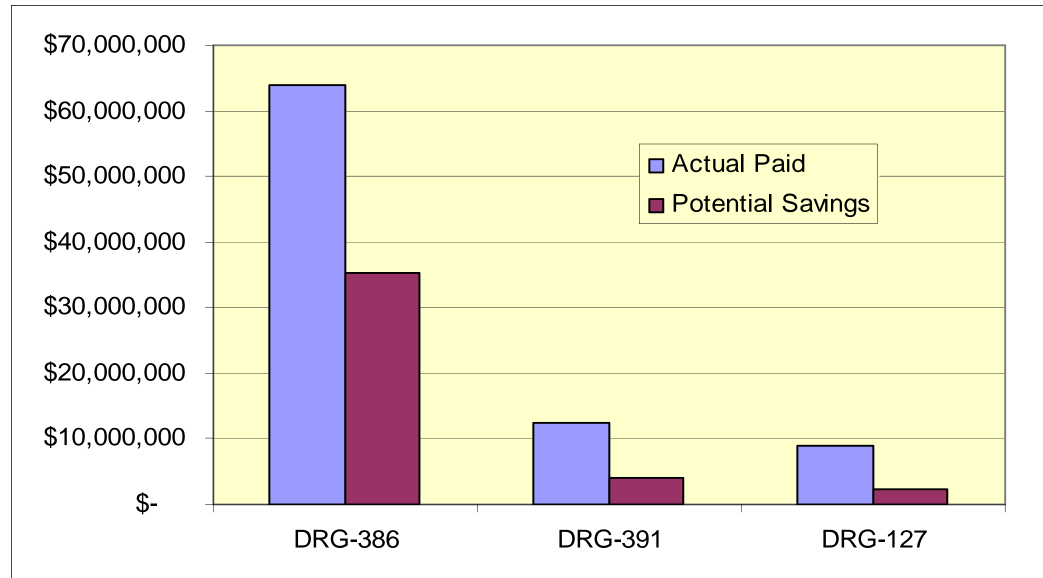
Hospital	Neonatal Respiratory Distress DRG-386		Normal Delivery DRG-391		Heart Failure & Shock DRG-127	
	Total Paid Amount	Paid Per Day Billed	Total Paid Amount	Paid Per Day Billed	Total Paid Amount	Paid Per Day Billed
BAYLOR UNIVERSITY MEDICAL CENTER	$72,659	$1,239	$568	$304	$7,344	$1,487
ST PAUL HOSPITAL	$91,452	$2,218	$571	$240	$7,260	$1,242
PARKLAND MEMORIAL HOSPITAL	$62,414	$1,476	$401	$187	$5,065	$1,192
HARRIS HOSPITAL-FT WORTH	$58,501	$1,307	$449	$219	$5,936	$900
JOHN PETER SMITH	$72,085	$1,996	$452	$286	$5,892	$992
MEMORIAL HERMANN HEALTHCARE	$54,477	$1,260	$452	$249	$5,884	$1,167
HARRIS COUNTY HOSPITAL DISTRICT	$76,204	$1,645	$472	$232	$6,037	$818
HERMANN HOSPITAL	$75,044	$1,217	$620	$314	$7,950	$1,704

Range							
	Low	$30,702	$998	$306	$154	$4,315	$582
	High	$91,452	$1,811	$997	$441	$8,335	$1,704

An Illustration of Potential Savings for Selected DRGs When Eliminating the Variation in DRG-Rates

All Hospitals in Dallas, Tarrant, and Harris Counties

Total Medicaid reimbursement for the selected DRGs vs. potential savings if all cases within a DRG were reimbursed on lowest hospital DRG rate paid to a hospital within the area

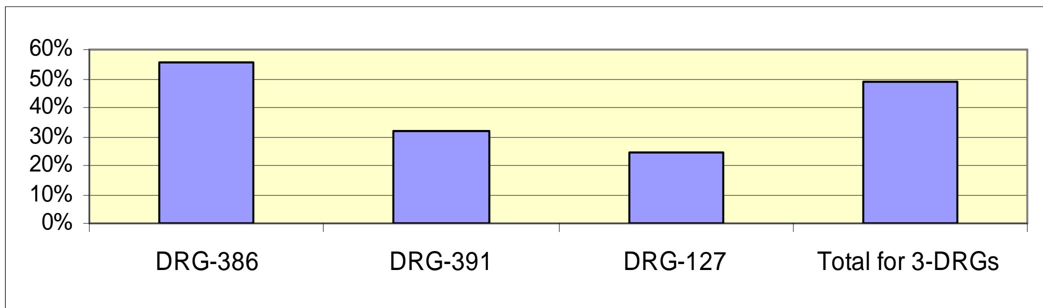


DRG-386 Neonatal Respiratory Distress

DRG-391 Normal Delivery

DRG-127 Heart Failure & Shock

Percent of potential savings by DRG



Hospital Funding

In responding to the role hospitals will play in Texas' future healthcare system, we must understand the options for reimbursement.

- Hospital expenditures were approximately 62 percent of acute care Medicaid costs in 2005.
  - This is a conservative estimate since a considerable amount of the other 38 percent is for professional services delivered in hospital inpatient and outpatient settings.
- Approximately $2.5 billion of 2005 Medicaid hospital funding is through DSH and UPL supplemental payments, which are not subject to the direct legislative appropriations process.
  - The burden of much of the state match is on local communities through the IGT mechanism.
  - The local funding burden is augmented by local communities indigent care funding through such funding streams as tax revenues, e.g., hospital districts; and County Indigent Care Program, e.g., for counties without public hospitals.

A New Structure for Hospital Reimbursement

- A major purpose for transforming the hospital reimbursement methodology is to enhance Medicaid's ability to be a prudent purchaser of healthcare. Should Medicaid continue to reimburse at different rates for the "same" DRG-based treatment or should HHSC seek the best value? Is the amount of variation that exists across hospitals value-added, and should it be Medicaid reimbursed?
  - There is variation across hospitals in what Medicaid pays for the "same" DRG.
  - The industry is concerned about how the considerable variation across virtually all hospitals will be addressed as we attempt to determine value-added variation.

- A strategy for enhancing HHSC's ability to be a prudent purchaser of Medicaid services is to develop a structure that guides the reform of the hospital rates.
  1) Reform Hospital Reimbursement
     - Market area hospital rates
     - Cap the reimbursement of administration and capital costs
  2) Rebase Hospital Rates
  3) Raise Hospital Rates
     - Goal is to increase rates to remove the hospital inpatient portion of the Medicaid Shortfall

(1) Reform Hospital Reimbursement: Market Area Hospital Standard Dollar Amount

- Establish an objective benchmark that limits payments to hospital expenditures that are determined to be reasonable and necessary, and reduce the variation in what Medicaid pays for the "same" diagnosis.
- A potential benchmark is to define a market area where labor costs and other relevant factors are similar for all hospitals in that area.
- A variety of geographical divisions or market areas already exist.
  - HHS regions (11)
  - Texas trauma regions (21)
  - Service delivery areas (8)
  - Economic regions (13) (used by Comptroller's Office)
  - Standard Metropolitan Statistical Areas (SMSA) (25)

(1) Reform Hospital Reimbursement: Cap Administration and Capital Costs, *continued*

- Currently, the SDA payment to a hospital includes all the allowable costs associated with providing Medicaid treatment.
  - These costs include (a) direct patient treatment, (b) administrative, and (c) capital construction.
- Instead of including all costs in the calculation of the SDA, it is worth consideration to construct the SDA on the basis of direct care costs only.
  - Remove both administrative and capital costs from the initial SDA calculation then "add-back" these costs at a predetermined capped level.
- Reforming the SDA rate in terms of market area and separating the administrative and capital costs provides leadership with opportunities to manage hospital costs in ways currently not available.
  - A transition period will be needed to move to a more standard reimbursement methodology. Transition to this new methodology would be phased-in over a specified time period.

(2) Rebase Hospital Rates

- Most hospitals are paid on the basis of a prospectively based reimbursement methodology, known as Diagnostic Related Groups (DRG).
- The base rate for each hospital is determined, in part, by that hospital's costs (and in part, the costs of all other hospitals), which when standardized, is referred to as the Standard Dollar Amount (SDA).
- Each hospital's SDA (which is unique to a hospital) is multiplied by the value of a DRG (its "relative weight," which characterizes the intensity of the patient's treatment). The result is the hospital's payment for that patient's episode of treatment.
- Currently, the SDA methodology uses hospital claim data that is six years old. When Medicaid pays a hospital's claim for payment, that reimbursement under-pays the hospital with respect to its allowable costs. The amount of this underpayment for each Medicaid patient, for each hospital for the year, is the basis of the Medicaid Hospital Shortfall.

(2) Rebase Hospital Rates, *continued*

- The existence of the Medicaid Hospital Shortfall is important because:
  - Its presence means that DSH payments to hospitals go first to make up the Shortfall, and in doing so, reduces funds available to the hospital to pay for uncompensated care costs.
  - The state match for DSH comes from a small number of local communities through the IGT mechanism. Thus, the presence of a Medicaid Shortfall represents the shifting of costs from the State (because the SDA payment does not cover the full amount of allowable costs) to local communities.
- Rebasing updates the claims experience of hospitals to a year closer to the year in which Medicaid SDA reimbursement is made.
- The impact of rebasing is to substantially reduce the inpatient portion of the Medicaid Hospital Shortfall. In doing so, a greater amount of DSH funds are available to reimburse for the costs associated with the treatment of the uninsured.

(3) Raise Hospital Rates

- Raising rates will increase market area SDAs and would occur after rebasing. The combined results (rebasing and raising rates) will eliminate the inpatient portion of the hospital Medicaid Shortfall.
- Reducing the inpatient-related Medicaid Shortfall is significant from several perspectives, including:
  - ➢ Shortfall will be significantly reduced, enabling DSH funds to have a substantially greater impact on the expense of uncompensated care.
  - ➢ More of the DSH funding is available to offset uncompensated care and the local community benefits by:
    - less pressure on its tax base, and
    - potential for reduced insurance premiums.
      - Not only might premiums go down for Texans already insured, but the potential for lower premiums may motivate an increase in the purchase of insurance by currently uninsured Texans.
  - ➢ A substantial reduction in the inpatient-related Medicaid Shortfall helps create alternatives with respect to any future Medicaid reform.

Reform Scenarios

- For discussion purposes, the slides on the following pages present two exploratory scenarios which apply the 3-tiered reform structure.
  - *Scenario A* - models the impact of calculating an average SDA for all hospitals within the same market area and then rebasing and raising the Medicaid rates to eliminate the inpatient portion of the Medicaid Hospital Shortfall.
  - *Scenario B* - models the impact of capping the SDA for a hospital at the lower of its current SDA or at the 80th percentile SDA for the market area.

Scenario A: Market Area Average SDA

Model Structure
Market area average for direct costs
Market area average for administration costs
Market area average of capital costs
Raise based on individual hospital basis

Estimated Impact on FFS Hospitals	Structural Component	%	Total Annual Dollars
	Rebase Payment Change	18.4%	$267,861,000
	Reform: Direct Costs	0.0%	$0
	Reform: Administration Costs	0.0%	$0
	Reform: Capital Costs	0.0%	$0
	Raise Rates (SDA)	14.7%	$214,275,000
	Total Payment Change		
	All Funds	33.1%	$482,136,000
	Federal Funds		$289,281,000
	State Funds		$192,854,000

Estimated Impact on STAR Program		
	All Funds	$141,500,000
	Federal Funds	$84,900,000
	State Funds	$56,600,000

Estimated Total Impact of Model		
	All Funds	$623,636,000
	Federal Funds	$374,181,000
	State Funds	$249,455,000

Scenario B: SDA Capped at 80th Percentile

Model Structure
Direct care costs capped at current or 80th percentile of market area if greater
Administration costs capped at 80th percentile of market area
Capital cost paid at 9% of direct costs
Raise based on individual hospital basis

Estimated Impact on FFS Hospitals	Structural Component	%	Total Annual Dollars
	Rebase Payment Change	18.4%	$267,861,000
	Reform: Direct Costs	(2.8%)	($40,526,000)
	Reform: Administration Costs	(1.2%)	($17,320,000)
	Reform: Capital Costs	0.4%	$6,269,000
	Raise Rates (SDA)	14.7%	$214,275,000
	Total Payment Change		
	All Funds	29.5%	$430,559,000
	Federal Funds		$258,335,400
	State Funds		$172,223,600

Estimated Impact on STAR Program		
	All Funds	$114,200,000
	Federal Funds	$68,500,000
	State Funds	$45,700,000

Estimated Total Impact of Model		
	All Funds	$544,759,000
	Federal Funds	$326,835,400
	State Funds	$217,923,600

Presentation Objective for Rider 60

D. *To identify preliminary issues associated with the reform of the current Medicaid reimbursement system:*

- In preliminary meetings with the hospital industry, several issues regarding Rider 60 were identified that may need to be addressed as reform progresses, including:
  - ➢ Current system reflects individual hospital costs
  - ➢ Variation is due to many factors, including types of services provided among hospitals
  - ➢ Capital cost limits will penalize hospitals building new facilities and acquiring new equipment
  - ➢ Supports increased funding for rebasing cost or raising the SDA
  - ➢ Supports mechanisms that maximizes federal funds.
- The timing of any changes regarding reimbursement reform must be in sync with other Medicaid reform, including DSH and UPL.

Presentation Recap

- Standardize the reporting of uncompensated care to determine the actual cost of uncompensated care in Texas.
- Enhance HHSC's ability to be a prudent purchaser of healthcare services.
- Optimize federal funding through a more transparent, planned, and systematic approach to the allocation of available funding for Medicaid healthcare.

Potential Waiver Considerations

Potential Waiver Considerations

- Reduce the hospital Medicaid shortfall and combine DSH funds with UPL funds into a low-income pool (LIP) to be used to fund uncompensated care in a systematic way that focuses on a market area network of healthcare providers rather than, almost exclusively, on hospital reimbursement for such care.

- Stabilize UPL funding to remove potential CMS “threat” of reducing or eliminating this funding source, e.g., CMS’ effort to reimburse Medicaid cost only.

- Incorporate both DSH and UPL funding streams into the legislative appropriations process, consider the role of certified public expenditures (CPE) as basis for obtaining federal match for currently unmatched healthcare provided by public hospitals to the non-Medicaid medically indigent Texan.

- Employ changes in the current funding methodologies, (e.g., SDA-rebase to reduce the Medicaid shortfall, consolidate DSH/UPL and incorporate into LIP to fund market area provider networks) to reduce costs of uninsured care in Texas by increasing the number of Texans with insurance or who participate in Bexar county-type CareLink coverage programs.

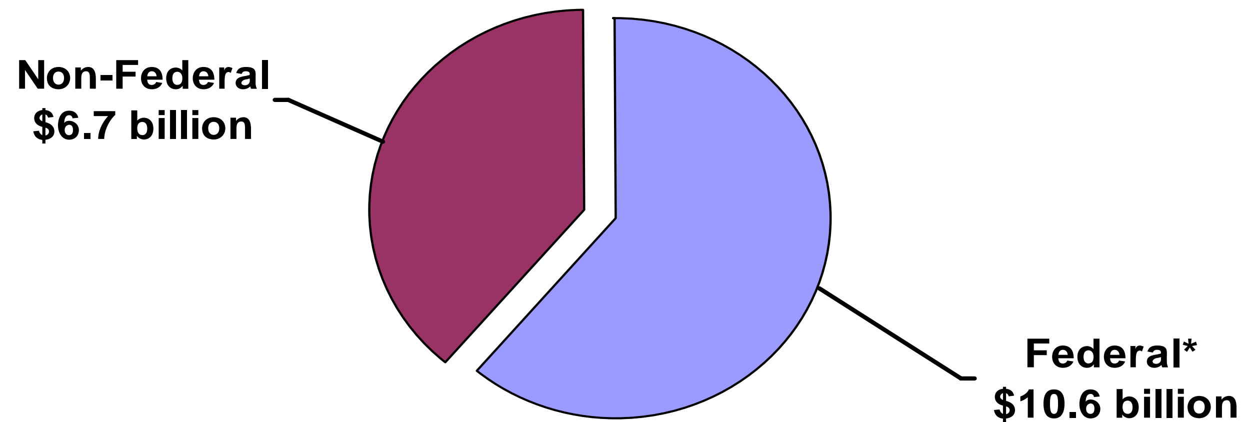
Background Information

TEXAS
Health and Human
Services Commission

Hospital Funding Provisions – 79th Legislature

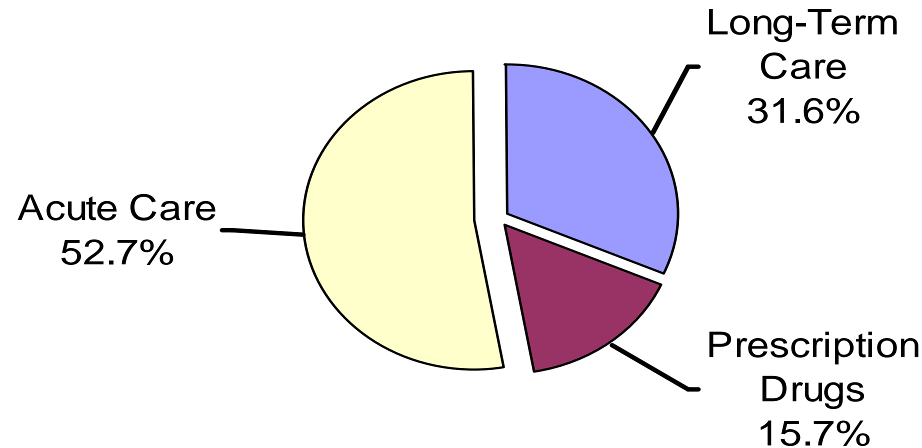
- Allow expansion of the use of intergovernmental transfers (IGTs) to fund Graduate Medical Education (S.B. 1188, Sec. 2(c) (3)) and Adult Medically Needy. (S.B. 1, Article II, HHSC Rider 74)
- Discontinue the General Revenue funded non-public urban UPL
- Continue IGT payments to preserve Medicaid rates. (S.B. 1)
- Expand managed care while preserving local funded UPL for aged/blind/disabled Medicaid populations. (S.B. 1, Article II, Special Provisions, Sec. 49)
- Establish a General Revenue funded Children's Hospital UPL. (S.B. 1, Article II, Special Provisions, Sec. 73)
- Expand UPL through a regional concept using IGTs and local dedicated taxes (H.B. 2463)
- HHSC to study the hospital reimbursement system and make recommendations to the 80th Legislature that address maximizing federal funds, allow legislative policy flexibility, and integrate and define uncompensated care. A report must be submitted by October 1, 2006. (S.B. 1, Article II, HHSC, Riders 60 and 61)
- DSHS to conduct a study regarding the impact of niche hospitals on financial viability of other general hospitals located in the State (S.B. 872)

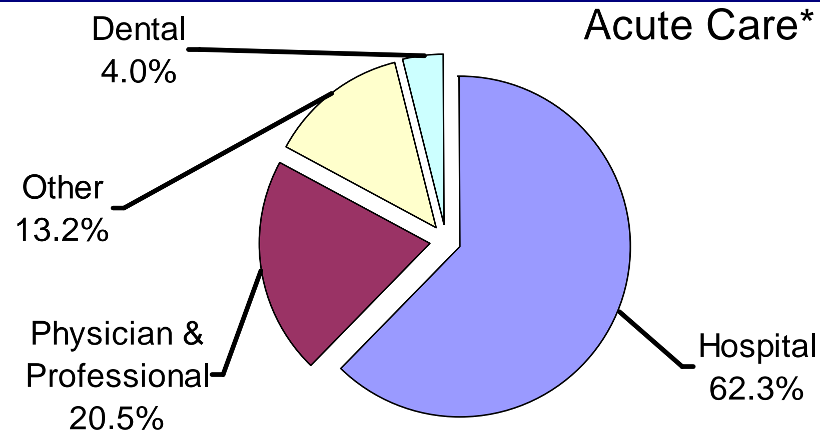
FY 2005 Medicaid Expenditures in the State Budget



*Excludes UPL and DSH payments to the hospitals totaling $903 million and $1,487 million, respectively.

Texas Medicaid Spending by Major Function, FY 2005





*Includes UPL and DSH payments to the hospitals totaling $903 million and $1,487 million, respectively.

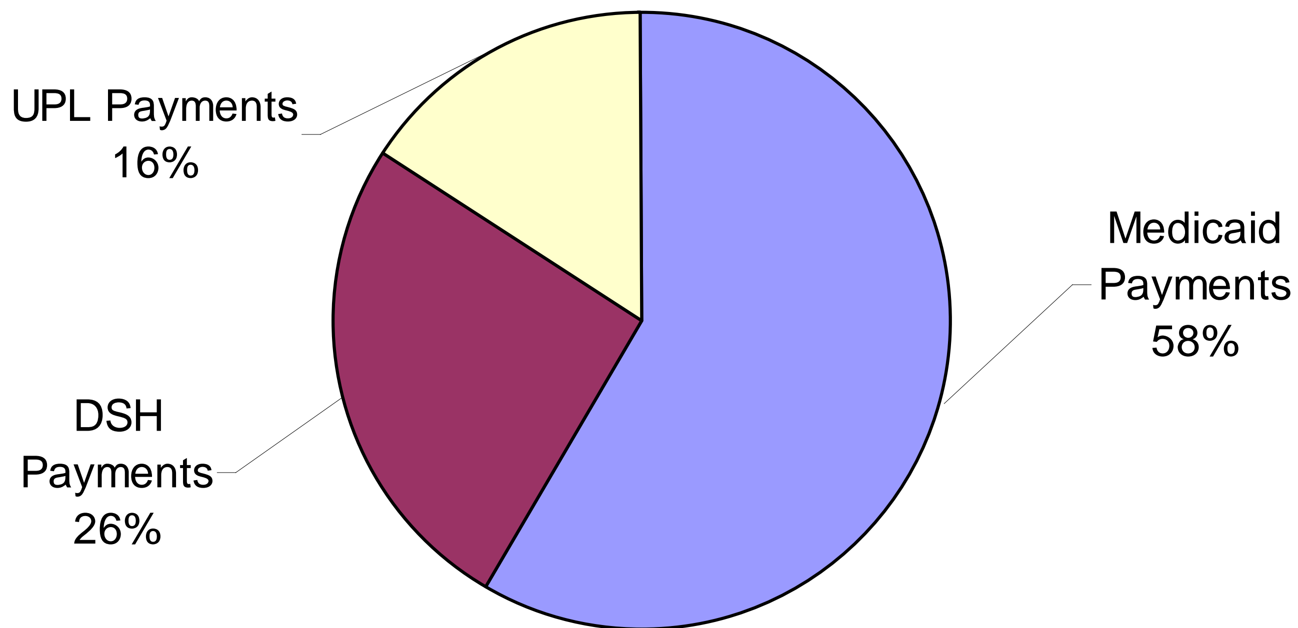
Medicaid Hospitals by Ownership/Classification FY2005 Funding (State & Federal)

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	$165,675,634	$600,990,747	14	$65,264,559	4	$831,930,940	14.5%
Public	129	$701,829,752	$565,049,110	90	$764,277,099	41	$2,031,155,961	35.3%
Private Not for Profit	135	$1,577,600,087	$208,694,696	49	$49,488,019	47	$1,835,782,802	31.9%
Private for Profit	128	$914,805,235	$112,313,036	27	$24,442,578	23	$1,051,560,849	18.3%
Total	406	$3,359,910,708	$1,487,047,589	180	$903,472,255	115	$5,750,430,552	100.0%
State Share		$1,316,413,015	$582,625,245*		$353,980,430*		$2,253,018,690	

*Use of IGT

**Inpatient and Outpatient

Medicaid Hospitals
FY 2005 Funding



General Revenue - Medicaid Payments: $1,316.4 million
Intergovernmental Transfers - DSH: $582.6 million
Intergovernmental Transfers - UPL: $354.0 million

Medicaid Program Structures Affecting Hospital Reimbursement

Medicaid Program	Impact on Hospital Reimbursement
Traditional Fee-For-Service (FFS)	▪ Children's hospitals reimbursed at 100 percent of allowable Medicaid cost (these hospitals are not SDA reimbursed) ▪ Hospitals with 100 beds or less are reimbursed at the greater of 100 percent of allowable Medicaid cost or SDA based reimbursement. ▪Acute care hospitals reimbursed on a SDA basis.
Primary Care Case Management (PCCM) Managed Care (STAR Program)	▪ Texas Medicaid & Healthcare Partnership (TMHP) negotiates discounted rates for hospital services for all hospitals participating in PCCM provider networks (thus, reimbursement is based on negotiation).
HMO Plan Capitated Managed Care (STAR Program)	▪ HMO plans negotiate discounted rates for hospital services for all hospitals participating in HMO provider network (thus, reimbursement is based on negotiation).

Active Upper Payment Limit (UPL) Programs in Texas

- **Large Urban Public Hospitals**
  - Supplemental payments are made for inpatient and outpatient hospital services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, Potter, and Randall counties. This UPL program makes supplemental payments to 11 of the largest public hospitals in Texas. This UPL program became **effective on July 6, 2001**.
  - SFY 2006 $659,398,464 All Funds; $399,991,108 Federal Funds
  - SFY 2007 $659,398,464 All Funds; $400,782,387 Federal Funds

- **State-Owned Hospital UPL**
  - Supplemental payments are made for inpatient hospital services provided by state government-owned or operated hospitals. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas. This UPL program became **effective on December 13, 2003**.
  - SFY 2006 $65,200,000 All Funds; $39,200,000 Federal Funds
  - SFY 2007 $65,200,000 All Funds; $39,200,000 Federal Funds

Active Upper Payment Limit (UPL) Programs in Texas, *continued*

- **Rural Hospital UPL**
  - Supplemental payments are made for inpatient hospital services provided by approximately 118 rural hospitals that are either publicly owned or affiliated with a local governmental entity. For purposes of this program, "rural hospital" means a hospital affiliated with a city, county, hospital authority, or hospital district located in a county of less than 100,000 population based on the most recent federal decennial census. This UPL program became **effective on January 1, 2002**.
  - SFY 2006 $75,090,336 All Funds; $45,549,798 Federal Funds
  - SFY 2007 $75,090,336 All Funds; $45,639,906 Federal Funds

- **Urban Non-Public Hospitals (High-Volume Payments to Private Hospitals)**
  - High-volume payments not exceeding $26,400,000 would be allocated in proportion to uncompensated care loss for eligible hospitals participating in the current year DSH program. Eligible hospitals are defined as non-state owned or operated, non-public, hospitals located in urban counties. This became **effective on September 1, 2005.** The state share for this UPL program would come from General Revenue instead of IGT's. However, this program was not funded by the Legislature for the 2006-07 biennium. Funds have been requested for the 2008-09 biennium.
  - SFY 2006 $0 All Funds; $0 Federal Funds
  - SFY 2007 $0 All Funds; $0 Federal Funds

Active Upper Payment Limit (UPL) Programs in Texas, *continued*

- **Regional UPL for Private Hospitals (NEW)**
  - UPL program that was created as a result of the recently approved SPA TX-05-001. It is the private hospital UPL for just Bexar, Montgomery, Webb, Hidalgo, Potter, Maverick, Travis, Randall, and Midland counties. This SPA became effective retroactive to **June 10, 2005**.
  - SFY 2006 $251,691,309 All Funds; $152,783,497 Federal Funds
  - SFY 2007 $200,353,741 All Funds; $121,534,580 Federal Funds

- **Statewide UPL for Private Hospitals (SPA TX-05-011) (NEW)**
  - This would create a statewide UPL program for privately owned hospitals with an indigent care affiliation agreement with a hospital district or other local governmental entity. This SPA became effective retroactive to **November 12, 2005**.
  - SFY 2006 $292,825,602 All Funds; $177,628,010 Federal Funds
  - SFY 2007 $369,831,643 All Funds; $224,339,875 Federal Funds

UPL-Related State Plan Amendments Currently Pending with CMS

- **State Hospital Physician UPL (SPA TX-04-010)**
  - Creates a physician UPL for practitioners employed by state academic health systems, specifically hospitals that are part of the systems of the University of Texas, Texas Tech University, and the University of North Texas. This SPA has an **effective date of May 11, 2004**.
  - SFY 2007 $382,063,712 All Funds; $231,923,879 Federal Funds
  - SFY 2008 $111,878,908 All Funds; $68,000,000 Federal Funds

- **Tarrant County Physician UPL (SPA TX-04-029)**
  - Creates a physician UPL for practitioners employed by Tarrant County. This SPA has an **effective date of November 26, 2004**.
  - SFY 2007 $11,074,243 All Funds; $6,668,909 Federal Funds
  - SFY 2008 $6,040,496 All Funds; $3,665,977 Federal Funds

- **Children's Hospital UPL (SPA TX-06-021)**
  - Results in UPL payments to certain in-state children's hospitals for the 2006-07 biennium. State share for this UPL program is GR. The legislature would have to extend these appropriations for this to continue next biennium. This SPA is set to have an **effective date of April 1, 2006**.
  - SFY 2007 $63,742,988 All Funds; $38,742,988 Federal Funds

Totals shown for FY 2007 includes retroactive amounts.

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.
- **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.
- **Inter-Governmental 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.

Relevant Hospital Reimbursement Terms

- **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 diving costs by charges.
- **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.
- **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.

Relevant Hospital Reimbursement Terms

- **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.

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- **Primary Care Case Management (PCCM)** – Medicaid recipients assigned to primary care provider who manages services and controls costs by authorizing services.
- **Health Maintenance Organization (HMO)** – Delivers and manages services under a capitation arrangement that is embedded in a risk-based contract. There are strong incentives to control costs.

Appendix B

Explanatory Footnotes

Explanatory Footnotes

The Explanatory Footnotes below relate to the table on page 11.

1. The 2004 Annual Hospital Survey reports uncompensated care as the sum of bad debt ($4.4 billion) and charity care ($4.8 billion) in charges.
2. The 34 percent is calculated based on the Texas Provider Identifiers (TPIs) included in Deloitte Consulting’s 2006 SDA recalculation analysis, based on 2004 data. The national, weighted-average Medicare RCC estimate is calculated using the same method as the Medicaid RCC, but using Medicare costs.
3. The net federal share of the non-Medicaid-shortfall DSH payments to Texas hospitals in 2004 was $345 million.
4. HHSC reports the 2004 net federal share of UPL was $458 million.

Explanatory Footnotes

5. Annual Survey, Item J1d, reports 2004 charitable donations total as $82.0 million.
6. The 2004 reported tax revenues were $1.8 billion.
7. In the 2004 Annual Survey approximately $688 million in local payments were made to hospitals for "…services that were provided under the County Indigent Health Care Program or were the responsibility of any city or county governmental program…." It was not possible to know if these funds as reported by the hospitals had already been accounted for in reducing the amount of uncompensated care or not. This is another example of the difficulty in knowing how much uncompensated care there is in Texas.
8. The 2004 distribution of Tobacco Settlement funding is reported as $28.5 million. Reported by DSHS at http://www.dshs.state.tx.us/tobaccosettlement/pay2004.shtm.