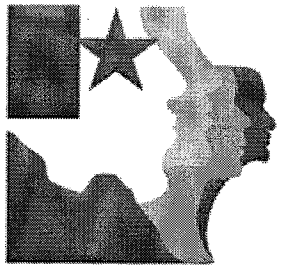

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Presentation to the Senate Finance Subcommittee on Medicaid: Hospitals

Thomas M. Suehs, Executive Commissioner

February 21, 2011

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Hospital Financing

- Introduction
  - Cost Reduction Proposals
  - Acute Care Spending
  - Hospital Financing
- Hospital Payments
  - Inpatient Hospital Reimbursement
  - Outpatient Hospital Reimbursement
  - Managed Care Rates
  - Upper Payment Limit (UPL) Payments
  - Disproportionate Share Hospital (DSH) Payments
- Additional Information

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Summary for Medicaid Hospital Cost Reduction Proposals (in millions)

	Medicaid Cost Reduction Proposals for Hospital Services	Total GR	Total All Funds
1	Payment Reform	$ 8.9	$ 20.8
2	Neonatal Intensive Care Unit Management and Maternity Care Services	$ 13.7	$ 32.5
3	Hospital Reimbursement in Managed Care	$ 35.0	$ 83.2
4	Outpatient Fee Schedule	$ 11.9	$ 28.0
5	Medical Imaging Fees	$ 16.7	$ 39.6
6	Reimburse Flate Fee of $25 for Non-Emergent Visits	$ 34.1	$ 81.0
7	Reduce Payment by 40% for ED Non-Emergent Services	$ 16.8	$ 40.0
8	Apply Utilization Limits to Non-Emergent Use of the Emergency Room (ER)		
9	Limit Reimbursement for Visits to the ER to a 24-hour Period	$ 0.0	$ 0.0
10	Elective Inductions/C-Sections	$ 1.7	$ 4.0

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Summary for Medicaid Cost Reduction Proposals (in millions)

	Medicaid Cost Reduction Proposal for Hospital Services	Total GR	Total All Funds
11	Reduce Payments to Institutions for Mental Diseases (IMD) for Patients Receiving Medicare Part D Drugs	$ 0.0	$ 0.0
12	Reduce Hospital Rates for Medical Devices and Supplies Purchased through Group Purchasing Organizations	$ 0.0	$ 0.0
13	Implement an Average Statewide Standard Dollar Amount (SDA)	$30.9	$74.3
14	Amend Statutory Language that Currently Limits the Standard Dollar Amount (SDA) to the $1,600 minimum	$1,175.2	$ 2,793.1
15	1% Change on NICU Utilization	$ 3.1	$ 7.4
16	1% Change on C-Section Rates	$ 1.4	$ 3.4
17	Allow Trauma and Tobacco Funds to Draw Medicaid Match	$ 0.0	$ 155.2
18	Implement Rate Reductions for Tax-exempt Hospitals		

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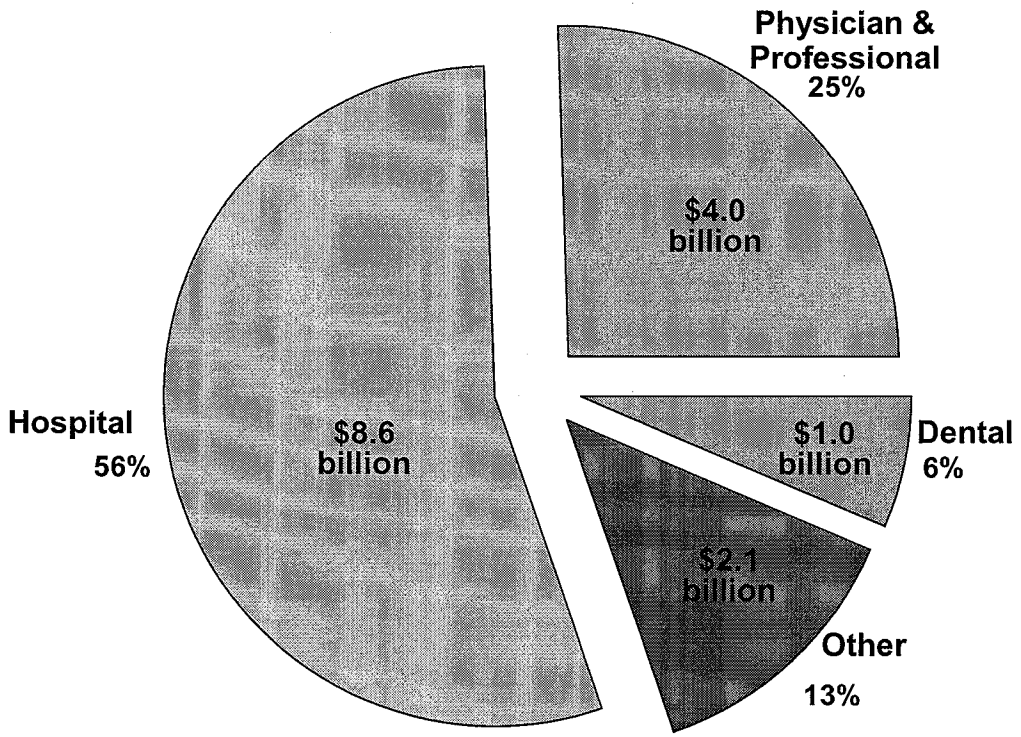
Acute Care Spending – FY 2009

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.

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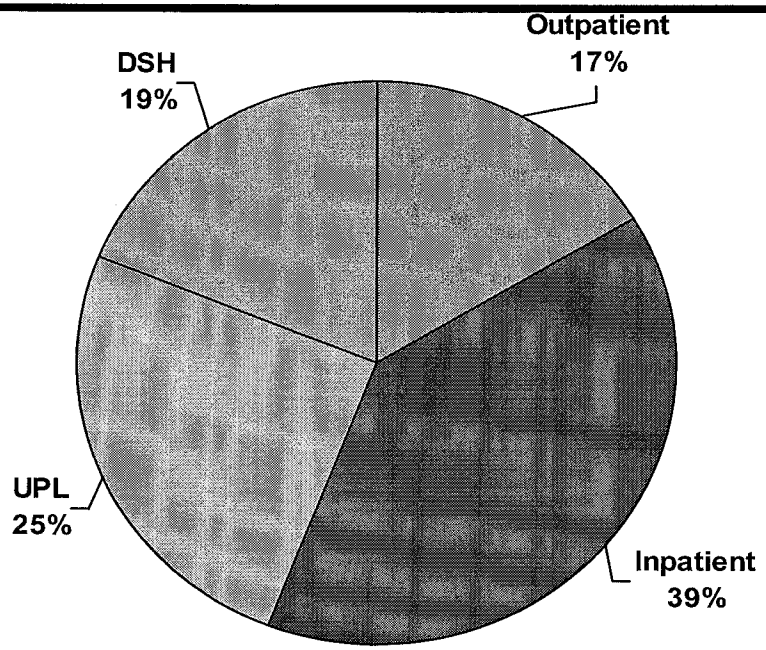
Hospital Financing – FY 2009



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

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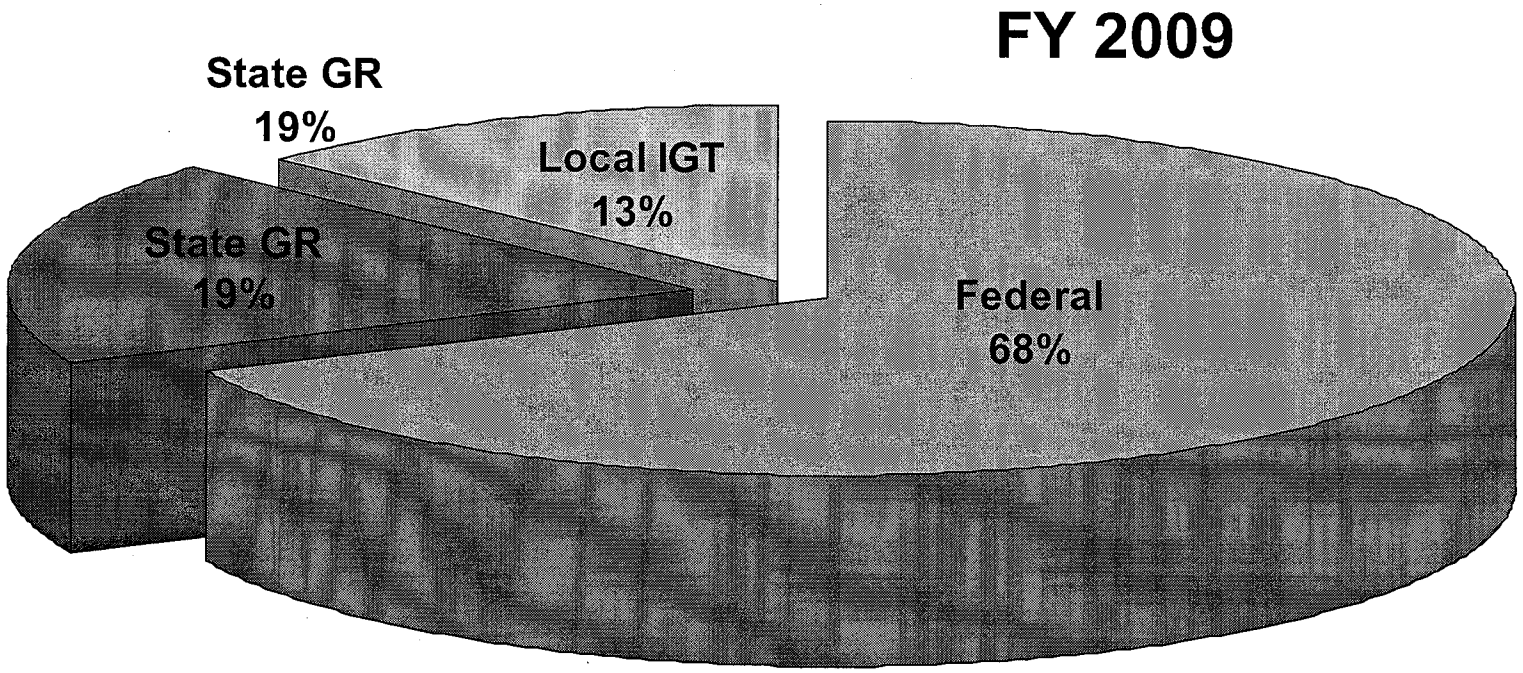
Hospital Funding by Source of Funds



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Inpatient Hospital – FFS and PCCM

- General Acute Care Hospitals
- Texas Medicaid uses a reimbursement methodology for general acute care hospitals that is based on the Medicare reimbursement methodology.
- Texas Medicaid pays each general acute care hospital a different amount for inpatient services based on the:
  - Hospital's costs to provide services
  - Clients served (case mix) at the hospital
- For PCCM, HHSC negotiates a discount on the FFS reimbursement rates.
- For STAR+PLUS, inpatient hospital services are carved out of the HMO capitation payments and reimbursed based on the FFS rates.

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Inpatient Hospital – FFS and PCCM

- Texas Medicaid uses the following formula to determine reimbursement for
- an inpatient hospital admission:

Standard Dollar Amount X Diagnosis Related Group Relative Weight

- Standard Dollar Amount (SDA)
- The SDA is an estimate of the average cost for an inpatient stay at a specific hospital.
- The SDA is different for each hospital, because the cost for each hospital to provide inpatient services and the severity of patients served at each hospital is different.

- Diagnosis-Related Group (DRG)
- DRGs are used to classify similar patients into groups based on diagnosis and other clinical information. For example: Heart failure = DRG 293; Renal failure = DRG 682.
- HHSC gives each DRG a relative weight. For example, the DRG relative weight for renal failure (2.00) is two times the DRG relative weight for heart failure (1.00), because the average cost is twice as much.
- The DRG relative weight is the same for all hospitals.

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

Hospital		Neonatal Respiratory Distress DRG-790		Normal Delivery DRG-795		Heart Failure DRG-293	
		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	$2,218	$997	$441	$8,335	$1,704

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Inpatient Hospital – FFS and PCCM

- The Texas Medicaid program reimburses other hospitals differently than general acute care hospitals.
- Children's and state-owned teaching hospitals receive cost-based reimbursement.
  - Based on reasonable cost of providing care to Medicaid clients using the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) cost principles.
- Rural hospitals in counties with less than 50,000 are reimbursed the greater of DRG-based reimbursement or cost-based reimbursement (TEFRA).
- Freestanding psychiatric hospitals are reimbursed a per diem.
  - Based on federal per diem with facility specific adjustments for wages, rural location, and length of stay.

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Outpatient Hospital – FFS and PCCM

- Outpatient hospital services are reimbursed using a different methodology than inpatient services.
- The Texas Medicaid program reimburses outpatient hospital services at reasonable cost.
- Reasonable cost is:
  - 84.48 percent of allowed costs for high-volume providers
    - High volume provider: a provider that Medicaid paid at least $200,000 for outpatient services during calendar year 2004
  - 80.3 percent of allowed costs for other providers

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Managed Care

- Unlike FFS, Medicaid managed care organizations (MCOs) negotiate the reimbursement rates for inpatient and outpatient services with hospitals.
- Inpatient Hospital Reimbursement
  - Often set at a percentage, which could be higher or lower, than the Medicaid FFS rates
  - Some MCOs use per diems, based on DRGs
  - Non-contracted hospitals are reimbursed:
    - 95 percent of the FFS rate if in the MCO's service area
    - 100 percent of the FFS rate if out of the MCO's service area
- Outpatient Hospital Reimbursement
  - Negotiated with contracted hospitals
  - Non-contracted hospitals use the above inpatient rules

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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.

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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.

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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.

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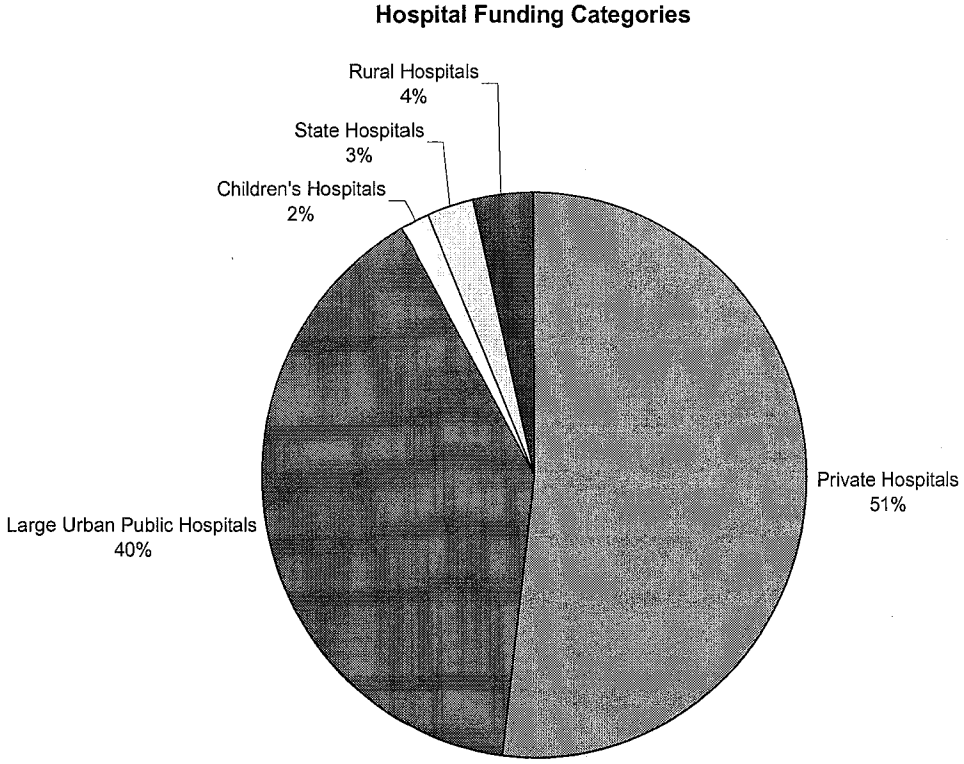
Upper Payment Limit (UPL)



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**

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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

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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.

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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

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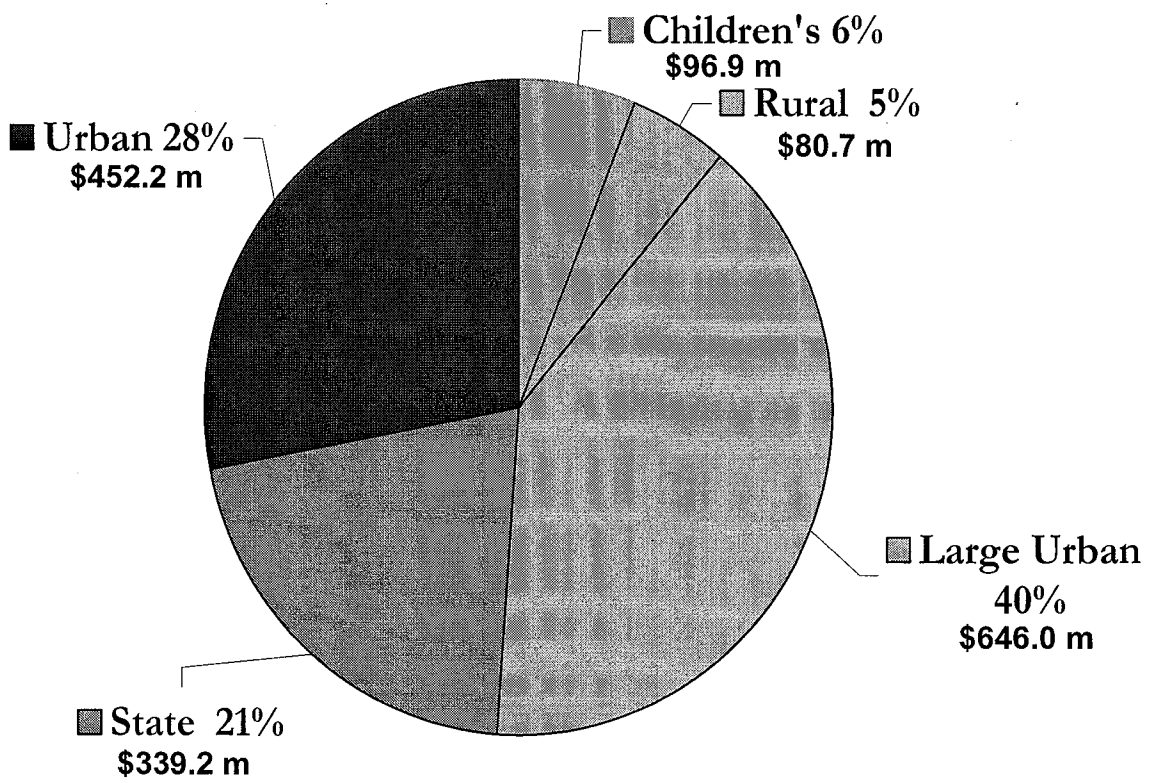
Disproportionate Share Hospital (DSH) Payments

Hospital Category Funding

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



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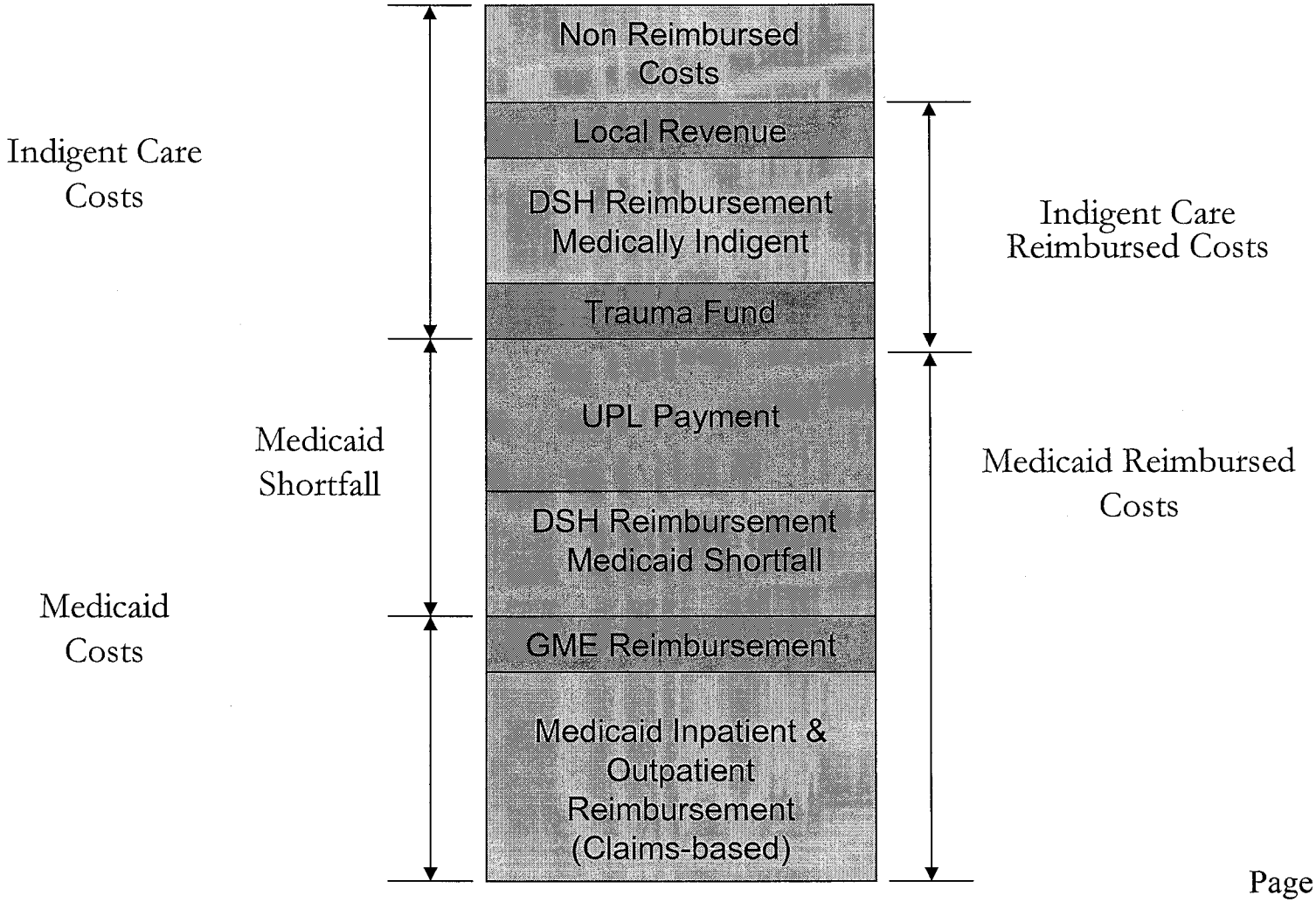
Overview of the Dynamic Interdependence of a Hospital's Medicaid & Medically Indigent Cost Reimbursement



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Additional Information

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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.