

Chapter 8: Medicaid

Spending From All Angles

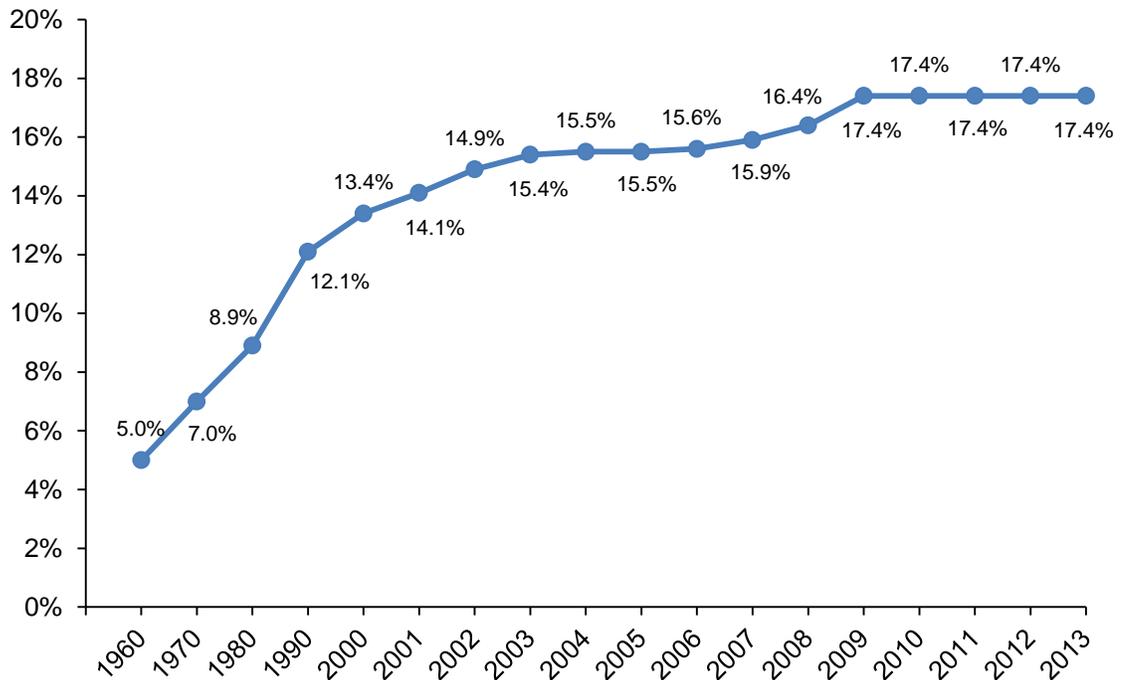
Medicaid is one of the largest programs in the Texas budget. Where does that money come from? Where does it go? How fast is the program growing?

Health Care Spending in the United States

Health care spending in the United States rose from \$724 billion in 1990 to \$2.79 trillion in 2012, an increase of 285 percent.¹ Over the same period, the economy grew by 172 percent. The faster growth of health spending relative to the growth of the economy is the reason that **Figure 8.1** shows a sustained long-term trend of health care spending representing a growing share of Gross Domestic Product (GDP). This increasing share of health care spending out of all spending can be attributed to a variety of factors. One of the most important of these factors is the increasing cost of care. As newer, more expensive treatments are developed and used, costs rise.ⁱ Another important factor is the aging of the population. As people age, as a group they tend to spend more on health care. Because the average age of the country's population is increasing, total demand for health care is rising as a consequence.

ⁱ Increasing the expenditure by itself does not necessarily guarantee increased quality of care or additional services.

Figure 8.1 Health Care Spending as a Percentage of GDP



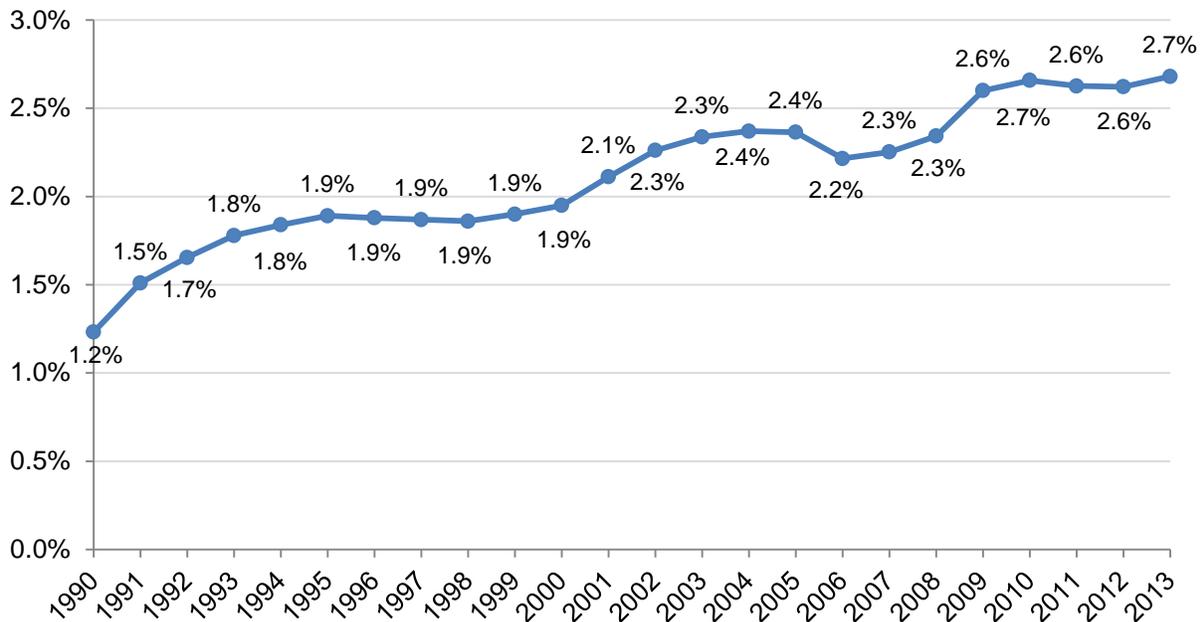
Source: Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures; Aggregate, Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2013 (December 2014). <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Medicaid Spending as a Percentage of the GDP

Just as total health expenditures have been rising, Medicaid expenditures have also been rising. See **Figure 8.2**. Total Medicaid expenditures rose from \$73.7 billion in 1990 to \$449.4 billion in 2013, an increase of 510 percent. The increase in Medicaid expenditures was generated partly by the same factors that affected the increase in medical expenditures for the general population and partly by factors unique to Medicaid. The increases in expenditures for the general population were mainly generated by more expensive care and an older population. The costs for Medicaid are affected up by these causes, but have also been pushed up by increases in the Medicaid caseload and the fact that Medicaid serves a specially selected demographic group. Over the period 1990 to 2013, the Medicaid caseload grew from 22.8 million

individuals to 59.3 million individuals, an increase of 160 percent. The demographic selection of the Medicaid population occurs because eligibility to enter the Medicaid population is governed by laws designed to provide medical help to the needy. Because the needy on Medicaid tend to have many more, and more serious, untreated medical conditions per enrollee than the population as a whole has per capita, this demographic factor induces additional costs for serving the Medicaid population.

Figure 8.2: Medicaid Spending as a Percentage of the GDP



Source: Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2013."

The Bottom Line

Since its inception in 1967, the Texas Medicaid program has grown from serving fewer than one million Texans to serving almost four million Texans. Combined federal and state Medicaid spending has increased from under \$200 million per year to over \$25.6 billion per year in federal fiscal year (FFY) 2013. This amount excludes disproportionate share hospital (DSH), uncompensated care, and DSRIP funds. When these funds are included, combined federal and state spending on Texas Medicaid in FFY 2013 was \$33 billion. Health care services accounted for \$24.2 billion, and administration of the program accounted for \$1.4 billion, or 4.5 percent of total costs. DSH, uncompensated care, and DSRIP reimbursements added another \$7.5 billion to program costs.

Administrative Costs

Medicaid administrative costs accounted for \$1.4 billion in FFY 2013, comprising 4.5 percent of the total Medicaid budget.

Historical Medicaid Spending

Table 8.1: Percent of Medicaid Expenditures in Texas State Budget

Year	Medicaid Budget, All Funds**	Total State Budget, All Funds***	Annual Percentage
2000	\$10,000	\$49,453	20.22%
2001	\$10,952	\$52,440	20.88%
2002	\$12,678	\$56,621	22.39%
2003	\$14,593	\$59,058	24.71%
2004	\$14,585	\$61,507	23.71%
2005	\$15,561	\$65,204	23.87%
2006	\$16,534	\$69,961	23.63%
2007	\$17,275	\$75,099	23.00%
2008	\$19,053	\$82,150	23.19%
2009	\$20,798	\$89,981	23.11%
2010	\$22,821	\$92,056	24.79%
2011	\$24,816	\$95,461	26.00%
2012	\$25,438	\$92,914	27.38%
2013	\$25,614	\$97,840	26.18%

* Dollars in millions

** Excludes Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), Uncompensated Care (UC) and DSRIP funds

*** Medicaid is FFY, State Budget reflects the state fiscal year, beginning one month prior (September)

Sources: Texas Medicaid History Report, August 2014, and Fiscal Size-Up(s).

Trends in Texas Medicaid Caseloads and Costs

Budget and Caseload Growth

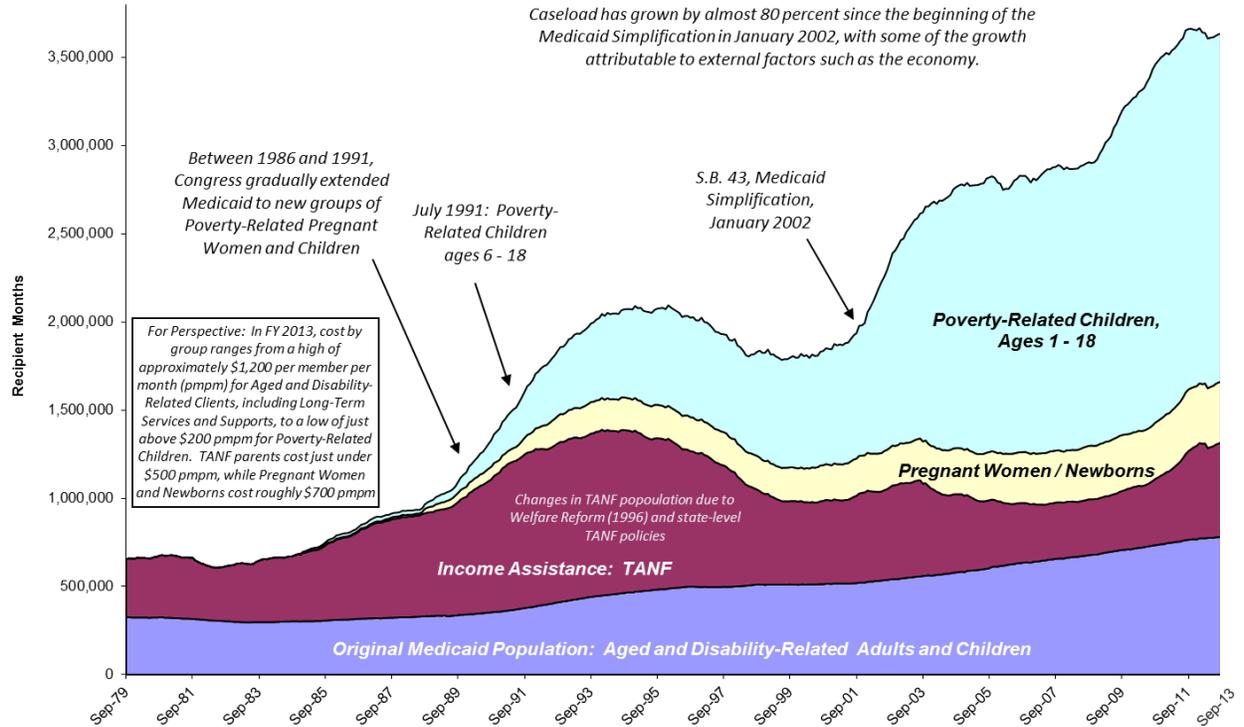
The rapid acceleration of Texas Medicaid spending from the late 1980s to the early 1990s was primarily due to increasing caseloads and costs. Escalating DSH payments and medical inflation contributed to the increase in overall costs of the Medicaid program. At the same time, program changes contributed to the increase in the number of Medicaid beneficiaries, thereby increasing caseload.

In the 1990s, Texas sought to include existing state-funded programs in the Medicaid program so that they could be eligible to receive federal matching dollars. These factors combined to increase the Texas Medicaid budget five-fold from 1987 to 2001.

In 1988, Congress dramatically expanded Medicaid eligibility standards to include groups of people with incomes higher than the Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance for Needy Families or TANF) cap. Other federal expansions and the economic recession in the early 1990s resulted in more increases in the number of children and pregnant women who became eligible for Medicaid. Beginning in the mid-1990s, welfare reform began to impact not only the size of the Medicaid caseload as TANF clients declined, but the composition of the caseload. While caseloads declined overall in the late 1990s, the numbers of clients over the age of 65 or who have a disability, as well as pregnant women and newborns, continued to increase and comprise a larger proportion of caseload. These high-cost clients offset any cost savings that could have resulted from caseload declines.

Texas' implementation of continuous eligibility for children as well as simplifying the eligibility process resulted in even more caseload increases after 2000. Again, however, the caseload for TANF-related Medicaid recipients began to decline further after September 2003 when the Full Family Sanctions policy was implemented. This policy requires TANF clients to sign a "Personal Responsibility Agreement" (PRA) whereby the family must comply with work and other requirements, such as child/medical support assignment, immunizations, school attendance, Texas Health Steps, parenting skills, and cooperation with drug and alcohol requirements. If clients fail to comply with the PRA, the family loses cash assistance. The adult family member, with the exception of pregnant women, loses Medicaid coverage for non-compliance with work requirements or medical support requirements. **Figure 8.3** shows the Texas Medicaid caseload growth rates from September 1979 to August 2013.

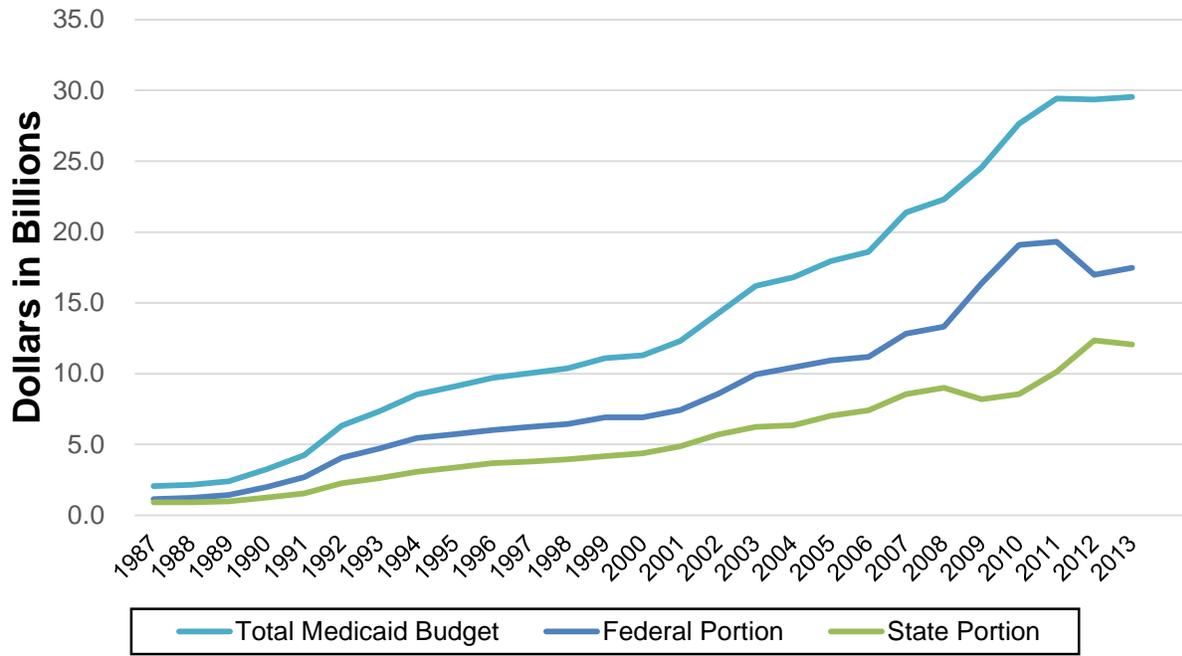
**Figure 8.3: Medicaid Caseload by Group
September 1979–August 2013**



Source: HHSC, Financial Services, HHS System Forecasting.

Changing Trends

Figure 8.4: Texas Medicaid Annual Budget Growth Rates

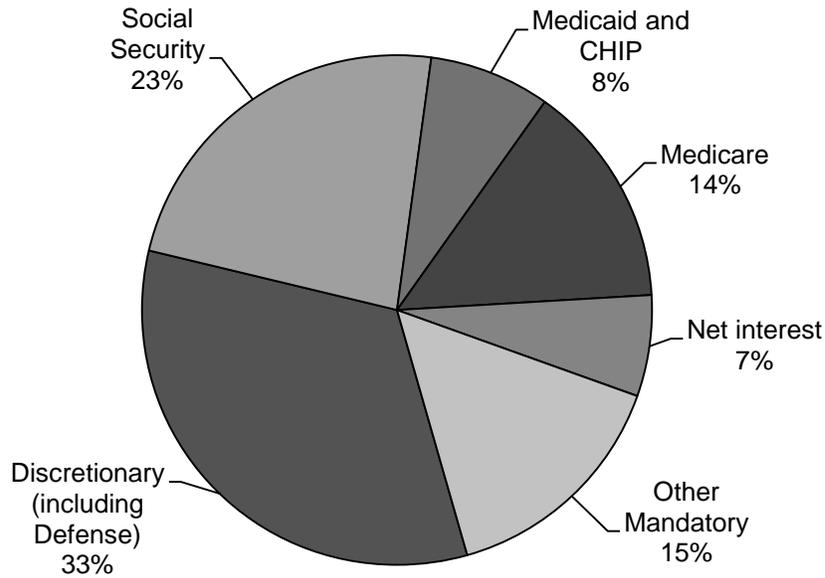


Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid and the Federal Budget

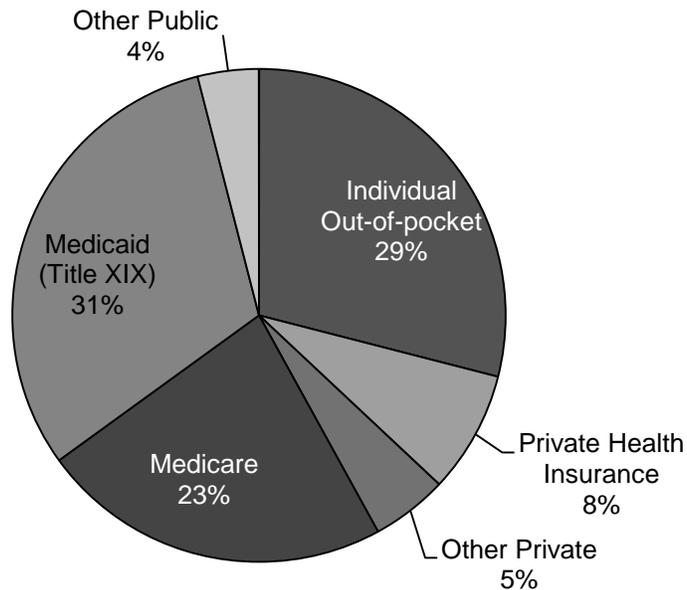
Medicaid and the Children’s Health Insurance Program (CHIP) account for eight percent of the federal budget in FFY 2015. **Figure 8.5** illustrates federal government spending by type of expenditure for FFY 2015.

Figure 8.5: Federal Budget Expenditures FFY 2015



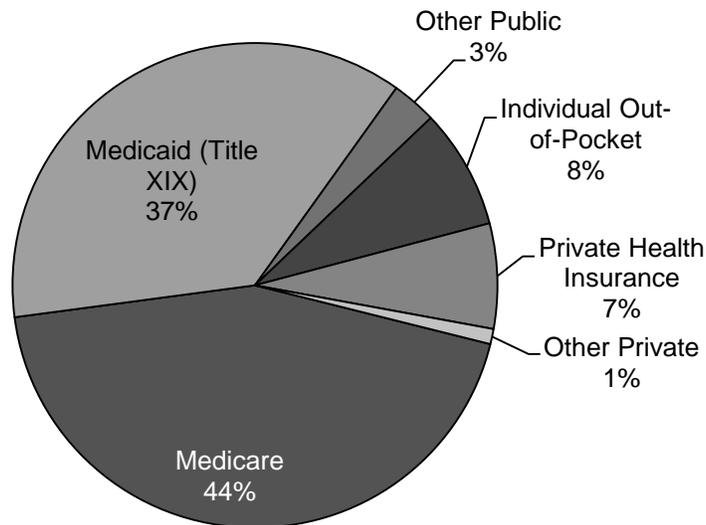
Source: Budget of the United States Government FY 2015. Table S-5. Proposed Budget by Category. Page 170. <http://www.gpo.gov/fdsys/pkg/BUDGET-2015-BUD/pdf/BUDGET-2015-BUD-28.pdf>

Figure 8.6: National Nursing Facility Payor Sources for Calendar Year 2012



Source: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Figure 8.7: National Home Health Payor Sources for Calendar Year 2012



Source: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Federal Funding

Federal funds are a critical component of health care financing for the state of Texas. For the 2014-15 biennial appropriations, federal funds account for \$42.4 billion (about 57 percent) of the total biennial budget of \$73.9 billion for health and human services. Medicaid represents 76 percent of this amount, with \$33.4 billion in federal funds and \$56.2 billion in all funds.

The amount of federal Medicaid funds Texas receives is based primarily on the federal medical assistance percentage (FMAP) or Medicaid matching rate. Derived from each state's average per capita income, the Centers for Medicare & Medicaid Services (CMS) updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. For FFY 2015, the Medicaid FMAP is 58.1 percent.

Building a Medicaid Budget

Staffs of the Medicaid operating departments develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations requests. This

process requires projections of the number of people eligible for and applying for the program, estimations of cost trends, analyses of any new federal mandates affecting eligibility or services and/or changes in program policy, and outreach efforts.

As evident from **Table 8.2**, a significant amount of time elapses between the development of the initial agency budget request and the time an appropriations bill takes effect. Medicaid enrollment trends and other factors that drive budget projections can change significantly before the budgeted period ends. Caseload or cost changes can cause considerable differences between appropriated budgets and actual expenditures.

Table 8.2: Medicaid Timeframes in the 2016-2017 Budget Process

August 2014	Agencies submit Legislative Appropriations Requests (LARs) for SFYs 2016 and 2017 (September 2014 - August 2017). Most recent program data available is through April 2014.
January 2015	Legislature convenes.
April 2015	Legislature works on appropriations bills; last chance to provide up-to-date Medicaid projections for bill. Most recent program data available is through March 2015.
May 2015	Legislature finishes appropriations for SFYs 2016-2017.
September 2015	SFY 2016 begins.
August 2017	2016-2017 biennium ends.

Note: At the beginning of the 2016-2017 biennium in September 2015, the Medicaid data used for projections is five months old. By the end of the biennium in August 2017, the data is 29 months old. If Medicaid budget projections were too low, this could result in a budget shortfall. If projections were too high, it could result in an unexpected surplus.

Deferrals and Disallowances

CMS can impose deferrals and disallowances on a state's Medicaid program based on its determination that the state acted outside of CMS regulations or the state's Medicaid state plan. Deferrals and disallowances impact the availability of federal financial participation (FFP) for the program.

CMS can impose deferrals or disallowances following a federal audit or a change to the Medicaid state plan, the state's contract with CMS. A deferral or disallowance may be imposed for the federal fiscal quarter(s) for which CMS asserts the state is out of compliance with CMS regulations or its Medicaid state plan, and in the case of a disallowance, may retroactively encompass several years of claims.

Deferrals: CMS can reduce current Medicaid federal funding when it determines that a state may be out of compliance with federal regulations or its Medicaid state plan. CMS withholds funds until it determines the state has come into compliance or until the state provides additional information to support the validity of the claim.

Disallowance: CMS can also recoup federal funds when it alleges a claim is not allowable, but states have the option to appeal the CMS determination. The state can request reconsideration by submitting a request to the chair of HHS' Departmental Appeals Board within 30 days after receipt of the disallowance letter and include a statement of the amount in dispute and a brief statement of why the disallowance is incorrect. CMS then has 30 days to provide a written response to the state's argument. Within 15 days of receiving CMS' response, the state may submit a short rebuttal to CMS' argument. The Departmental Appeals Board can make a ruling based on the written statements provided by both parties or can hold a hearing to discuss the matter prior to making a ruling.

Total Spending by Type of Eligibility

Texas Medicaid spending patterns are not uniform across all eligibility groups. The risk group made up of people who are age 65 and older and disability-related is the smallest portion of Medicaid clients, yet it accounts for the majority of expenditures. (See Chapter 1, **Figure 1.1**, Texas Medicaid Beneficiaries and Expenditures, SFY 2013.)

Table 8.3 and **Table 8.4** show SFY 2013 average monthly cost per eligibility category and expenditures.

Table 8.3: Average Monthly Cost per Eligibility Category SFY 2013

The average monthly cost per full-benefit recipient in SFY 2013 was \$534 per client per month. These costs are for all services (acute and long-term) for clients considered "full-benefit" Medicaid, excluding Medicare premiums paid by Medicaid. Average monthly client costs look very different when examined by category:

Full-Benefit Clients:

- Children (not including disability-related children): \$240 per client per month.
- People age 65 and over and/or disability-related: \$1,470 per client per month.
- Pregnant Women: \$720 per client per month
- Adult Parents: \$455 per client per month

Source: HHSC, Financial Services, HHS System Forecasting

Costs for non-full benefit clients are not included in the cost per client per month by group, nor are costs for Medicare premiums for full-benefit clients. Costs for non-full clients not included are, but include costs for Medicare Part A&B premiums for partial duals, Emergency Medicaid Services for Non-Citizens costs, and Women's Health Waiver costs. Cost per client per month are lower when all services and clients are

included, as many of the partial benefit clients have, by definition, expenses only for very specific, often lower cost, services, such as Medicare partial premiums or women's health services.

**Table 8.4: Texas Medicaid Clients and Expenditures
SFY 2013**

- Children are the least expensive population that Medicaid covers. While 67 percent of Texas Medicaid clients were Non-Disability-Related Children, they accounted for only 31 percent of expenditures.
- The Aged (65+) and Disability-Related account for a large portion of Texas Medicaid spending. Only 26 percent of Texas Medicaid clients were Aged or Disability-Related, but they accounted for 60 percent of program spending.
- Non-Disability-Related Adults are relatively inexpensive to insure. Parents and Pregnant Women accounted for 9 percent of the population and 9 percent of expenditures.

Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid Rates

The following sections discuss the different methodologies used to calculate the rates of reimbursement for some types of providers.

Fee-for-Service Rates

The Texas Health and Human Services Commission (HHSC) is responsible for establishing Medicaid fee-for-service (FFS) reimbursement methodologies by rule and/or approval by CMS. HHSC consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are also subject to a public hearing and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process.

Physicians and Other Practitioners

Medicaid rates for FFS services delivered by physicians and other practitioners (which include payments for laboratory services, including x-ray services, radiation therapy services, physical and occupational therapists' services, physician services [including anesthesia and physician-administered drugs], podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services, and certified nurse midwife services) are calculated in accordance with Title 1 of the Texas

Administrative Code (TAC), §355.8085. Rates are uniform statewide and are either resource-based fees (RBFs) or access-based fees (ABFs).

RBFs are based on the actual resources required by an economically efficient provider to deliver a service and are calculated by multiplying the relative value units (RVUs) for a service times a conversion factor. Total RVUs are assigned to each service, covering the three components of the cost to deliver the service. The three components are intended to reflect the work, overhead, and professional liability expense for a service. The Medicaid RBFs were first established in 1992 and used the RVUs specified in the Medicare Physician Fee Schedule at the time in concert with Texas Medicaid conversion factors. As new services are added, the Medicaid RVUs for new services are based on the Medicare RVUs in effect at the time. Base units, which serve a similar function as RVUs, are used for anesthesia services.

ABFs are developed to account for deficiencies in RBF methodology related to adequacy of access to health care services for Medicaid clients and are based on historical charges, the current Medicare fee for a service, review of Medicaid fees paid by other states, survey of providers' costs to deliver a service, and/or Medicaid fees for similar services.

Nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, anesthesiology assistants, and physician assistants are reimbursed for covered professional services at 92 percent of the physician rate for the same professional service. Licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, and licensed psychological associates are reimbursed for covered professional services at 70 percent of the rate paid to psychiatrists and psychologists for the same professional service. Physicians are reimbursed for assistant surgery services at 16 percent of the amount paid to the primary surgeon.

Physician-Administered Drugs/Biologicals

Effective October 1, 2006, Medicaid rates for physician-administered drugs/biologicals are determined under 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their billed charges and the Medicaid fee established by HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug or biological.

Prescription Drug Reimbursement

Reimbursement for MCO pharmacy prescription claims is determined by contract terms between the health plan and the pharmacy provider and is independent of FFS reimbursement rates.

Reimbursement for FFS pharmacy prescription claims includes two components: an amount for the ingredient cost of the drug product and a professional dispensing fee. HHSC will implement new FFS ingredient cost and dispensing fee methodology in SFY 2015.

Ingredient cost reimbursement:

- Pharmacies' Estimated Acquisition Costs (EAC) are determined by the Medicaid Vendor Drug Program (VDP) using actual manufacturer reported prices as well as national pricing data services. The EAC is based on the pharmacy's reported source of purchase. This source of purchase could be through a wholesale company, directly from the drug manufacturer, or through a central purchasing entity such as a warehouse.
- Ingredient cost is the product of the EAC times the quantity dispensed.
- Ingredient cost represents over 90 percent of total reimbursement for VDP claims.

Dispensing fee reimbursement:

- Dispensing fees are based on an average pharmacy's cost to dispense a prescription, including costs for staff and overhead. The dispensing fee consists of two separate components, a fixed component and a variable component. Effective September 2011, the fixed component is \$6.50 per prescription and the variable component is 1.96 percent of the ingredient cost plus the fixed component.
- Pharmacies that provide no-charge delivery services to Medicaid clients may be eligible for a delivery incentive, currently \$0.15 per prescription.

All reimbursement amounts determined by the above methodology are reduced to a pharmacy's reported Usual and Customary (U&C) or Gross Amount Due (GAD) price if either of those reported prices are less than the total reimbursement determined by adding the ingredient cost and the professional dispensing fee.

Hospitals

Historically, Texas' hospital funding methodologies included inpatient and outpatient hospital reimbursements, UPL funding, graduate medical education (GME) funding, and DSH funding. Not every hospital was eligible for all of these different funding sources.

Only hospitals that met certain eligibility criteria could receive UPL, GME, and DSH funds. The UPL program no longer exists in Texas with the approval of the 1115 Transformation Waiver described in Chapter 4. The waiver provides two new sources of funds for hospitals (and certain other providers); the Uncompensated Care pool and the Delivery System Reform Incentive Payment pool.

Inpatient Hospital Reimbursement Rates

General acute care hospital reimbursement rates for FFS Medicaid clients are set using a prospective payment system (PPS) based on the All Patient Refined Diagnosis Related Groups (APR-DRG) patient classification system. Under PPS, each patient is classified into a diagnosis related group (DRG) on the basis of clinical information and then hospitals are paid a pre-determined rate for each DRG (admission), regardless of the actual services provided. The rate is calculated using a formula-based standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG. "Outlier" payments are made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay. Effective September 1, 2013, children's and rural hospitals were transitioned from cost-based reimbursement to APR-DRGs. Children's hospital payments are based on the standardized average cost of treating a Medicaid inpatient admission in a children's hospital. Rural hospital payments are based on each rural hospital's facility-specific cost of treating a Medicaid inpatient admission.

Rates paid to freestanding psychiatric hospitals and state-owned or operated teaching hospitals are set using a different methodology. Freestanding psychiatric hospitals are reimbursed a PPS per diem based on the federal base per diem with facility specific adjustments for wages, rural location, and length of stay. State-owned or operated teaching hospitals are reimbursed for their reasonable cost of providing care to Medicaid clients using the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) cost principles.

Outpatient Hospital Reimbursement Rates

Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital's reasonable cost. For children's, state-owned, and rural hospitals, reimbursement for outpatient hospital services for high-volume providers is 76.03 percent of the hospital's allowable cost and reimbursement for all other high-volume providers is 72 percent of the hospital's allowable cost. With regard to outpatient services, a high-volume provider is defined as one that was paid at least \$200,000 for FFS and Primary Care Case Management (PCCM) Medicaid services during calendar year 2004. For non-high-volume children's, state-owned, and rural hospitals,

reimbursement for outpatient hospital services is 72.27 percent of the hospital's allowable cost and reimbursement for all other non-high-volume providers is 68.44 percent of the hospital's allowable cost. Outpatient rates were frozen effective September 1, 2013, in preparation for a transition to an Enhanced Ambulatory Payment Groups (EAPG) reimbursement methodology.

Uncompensated Care Waiver Payments

In 2011, CMS approved the Texas Healthcare Transformation and Quality Improvement Program Section 1115(a) Medicaid demonstration waiver. Section 1115 of the Social Security Act authorizes CMS to waive compliance by a state of specific provisions of its state plan if, in the judgment of CMS, the state's proposal promotes the objectives of the Medicaid statute.

Under the waiver, federal matching funds for traditional supplemental payments (UPL) under the Texas Medicaid state plan are no longer available. (The Disproportionate Share Hospital (DSH) program is not considered by CMS to be a supplemental payment program subject to this limitation, so DSH remains outside the waiver.)

The funding of the Section 1115 waiver for supplemental payment is for two statewide pools worth \$29 billion (all funds) over five years, with \$17.6 billion allocated for uncompensated care and \$11.4 billion allocated for Delivery System Reform Incentive Payments (DSRIP). The purpose of the uncompensated care (UC) pool, which replaced the former UPL programs under a new methodology, is to reimburse providers for uncompensated care costs. The purpose of the DSRIP pool is to encourage hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. (See Chapter 4, Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, Delivery System Reform Incentive Payment Pool.)

**Table 8.5: Historical Upper Payment Limit (UPL) and Uncompensated Care Waiver Spending
FFYs 2002-2013**

Year	Upper Payment Limit
FFY 2002	\$ 168,056,432
FFY 2003	\$ 289,181,118
FFY 2004	\$ 775,847,457
FFY 2005	\$ 897,899,580
FFY 2006	\$ 526,735,788
FFY 2007	\$1,734,191,128
FFY 2008	\$1,693,792,595
FFY 2009	\$2,219,683,156
FFY 2010	\$2,693,221,610
FFY 2011	\$2,789,436,532
FFY 2012*	\$ 2,482,701,375

Uncompensated Care Waiver Program Payouts

Year	Upper Payment Limit
FFY 2012	\$ 1,152,697,475
FFY 2013	\$3,845,408,143

Source: HHSC, Financial Services. Includes Physician UPL.

*FFY 2012 UPL payments to some hospitals were made under a transition arrangement where UC funds were used to make payments under the UPL program that was being phased out.

Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals without training programs. The Medicaid share of these additional costs is covered by GME payments to teaching hospitals. GME payments cover the costs of residents' and teaching physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs.

The 2014-15 GAA (Article II, HHSC, Rider 40, S.B. 1, 83rd Legislature, Regular Session, 2013), authorizes HHSC to spend Appropriated Receipts–Match for Medicaid for GME

payments to teaching hospitals. The payments are contingent upon receipt of intergovernmental transfers of funds from public teaching hospitals for the non-federal share of Medicaid GME payments. The Legislature directed HHSC to use only intergovernmental transfers of funds (Appropriated Receipts-Match for Medicaid) for the non-federal share of Medicaid GME payments for the 2014-15 biennium.

Disproportionate Share Hospital Funding

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such hospitals are called disproportionate share hospitals and receive disproportionate share funding under the program commonly known as “DSH.” DSH funds differ from all other Medicaid payments in that they are not tied to specific services for Medicaid-eligible patients. Hospitals may use DSH payments to cover the uncompensated costs of care for indigent or low-income patients, including Medicaid patients. DSH payments have been an important source of revenue by helping hospitals expand health-care services to the uninsured, defray the cost of treating indigent patients, and recruit physicians and other health-care professionals to treat patients.

Who Gets DSH?

In FFY 2013, 180 Texas hospitals qualified to receive DSH payments: 61 were non-state public, 107 were private and 12 were state hospitals. Of the 180 DSH hospitals, 102 were located in urban areas and 78 were located in rural or equivalent areas. Of the urban hospitals, eight were large urban public facilities and nine were children’s hospitals. Three University of Texas teaching hospitals and all children’s hospitals in Texas are deemed DSH hospitals provided they meet federal and state qualification criteria. All other hospitals must qualify for DSH funds by meeting one of the following three criteria: (1) a disproportionate total number of inpatient days are attributed to Medicaid patients; (2) a disproportionate percentage of all inpatient days are attributed to Medicaid patients; or (3) a disproportionate percentage of all inpatient days are attributed to low-income patients.

How DSH Is Funded

As in other “matching” Medicaid programs, the federal government and the state each pay a share of total DSH program costs. Payments are funded using the same matching rate as medical services (59.30 percent federal funds and 40.70 percent state funds for Texas in FFY 2013). The state share of DSH is funded through a combination of state general revenue-dedicated, intergovernmental transfers from public hospitals and state-appropriated funds from state-owned hospitals (teaching, psychiatric, and chest). In FFY 2013, the DSH allocation for Texas totaled \$1.694 billion in federal and state funds.

How DSH Can Be Spent

There are no federal or state restrictions on how DSH hospitals can use their funds. Hospitals have used DSH funds to:

- Defray the cost of treating indigent patients;
- Recruit physicians and other healthcare professionals to treat patients;
- Obtain replacement or additional equipment/technology to treat patients; and
- Renovate existing structures or build new ones.

DSH reimbursement allows hospitals to make the human and capital investments necessary to continue and improve patient care.

Federal Legislation Affecting DSH

Nationally, between 1989 and 1992, federal funding for DSH significantly increased from \$400 million to \$10.1 billion. By 1992, DSH funds accounted for 15 percent of all federal Medicaid spending. Starting in 1991, various pieces of federal legislation were passed, limiting or capping DSH funding increases. Furthermore, as a discrete component of Medicaid funds nationally, the DSH program has on occasion been targeted as a possible source of budget savings.

In 1991, federal law capped the size of Texas' DSH program at \$1.513 billion. In 1993, a federal budget act established hospital caps on the amount of DSH funds an individual hospital could receive. The act also mandated that at least one percent of total patient-days in DSH hospitals must be from Medicaid patients. These changes reduced DSH payments to state-owned hospitals from approximately \$729 million in SFY 1995 to about \$427 million in SFY 2008. Total Texas DSH funds were constant, however, and the additional residual funds went to non-state local hospitals.

The 1997 federal Balanced Budget Act (BBA) had two significant impacts on the Texas DSH program. First, it set specific annual limits on total federal contributions to the Texas DSH program. Those limits, since increased by the Benefits Improvement and Protection Act (BIPA) of 2000 and the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, have resulted in annual fluctuations in providers' DSH funding.

The second impact of the BBA was to limit DSH payments to Institutions for Mental Disease (IMD) to a fixed percentage of total annual DSH funds. This provision has caused IMD payments to vary each year.

The Patient Protection and Affordable Care Act (PPACA) decreases the size of the federal DSH allocations in anticipation of the reduction in the size of the uninsured

population. The statute requires annual aggregate reductions in federal DSH funding from FFY 2014 through FFY 2020. To implement these annual reductions, the statute requires the Secretary of Health and Human Services to develop a methodology to allocate the reductions that must take into account five factors: impose a smaller percentage reduction on low DSH states; impose larger percentage reductions on states that have the lowest percentages of uninsured individuals; impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients or with high levels of uncompensated care, and the methodology must take into account whether the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under Section 1115 as of July 31, 2009.

The Pathway for SGR Reform Act of 2013 delayed the annual aggregate reductions in federal DSH funding from FFY 2014 to FFY 2016. The Act also increased the overall level of reductions and extended the timeframe for the cuts through FFY 2023.

Table 8.6 shows Texas DSH funding for 2002-2014.

Table 8.6: Texas DSH Federal Fund Trends

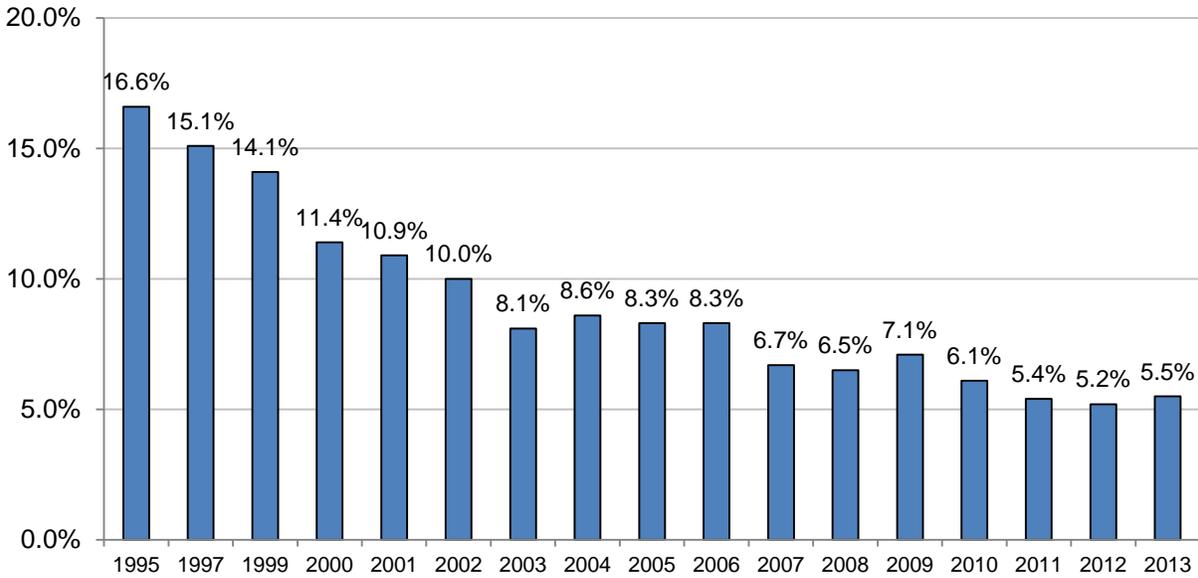
Year	Federal Funds
2002	\$856 million
2003	\$776 million
2004	\$901 million
2005	\$901 million
2006	\$901 million
2007	\$901 million
2008	\$901 million
2009	\$964 million*
2010	\$988 million**
2011	\$964 million
2012	\$981million
2013	\$1 billion
2014	\$1.019 billion

* Includes \$23.5 million in ARRA federal stimulus funds.

**Includes \$47.6 million in ARRA federal stimulus funds.

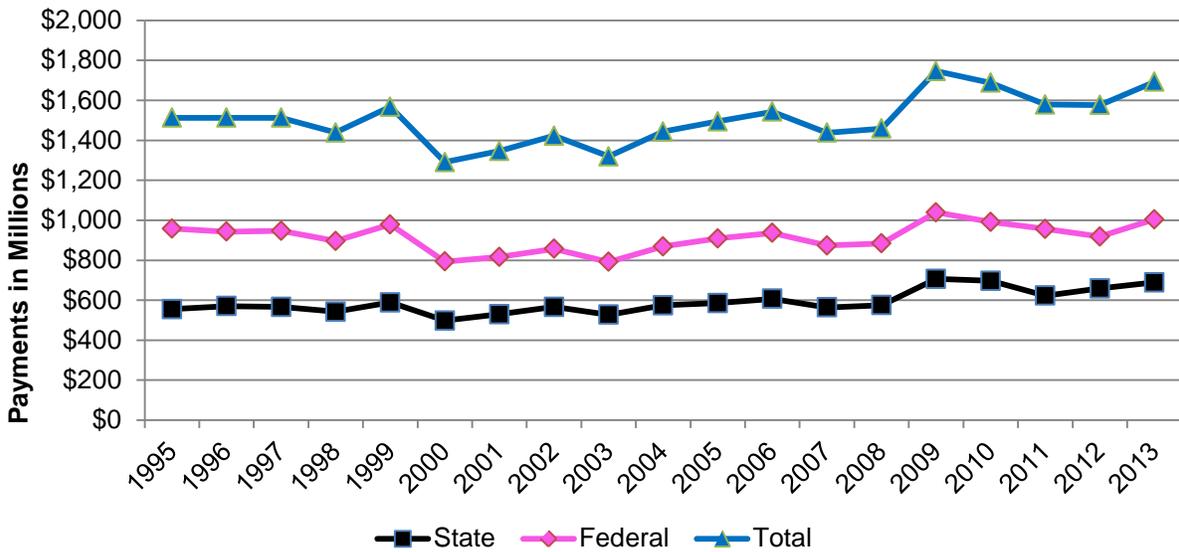
Source: BBA 1997, BIPA 2000, the Medicare Prescription Drug Improvement and Modernization Act of 2003, Federal Register, July 26, 2013 (Vol. 78 No. 144), pp. 45217, Federal Register, February 28, 2014 (Vol. 79 No. 40), pp. 11436, [Federal Register, February 28, 2014 \(Vol. 79 No. 40\), pp. 11436.](#)

Figure 8.8: Disproportionate Share Hospital Funds as a Percentage of the Total Medicaid Budget FFYs 1995-2013



Source: HHSC, Financial Services, Texas Medicaid History Report, February 18, 2014.

Figure 8.9: Payments for Disproportionate Share Hospital Program FFYs 1995-2013



Source: HHSC, Financial Services, Texas Medicaid History Report, February 18, 2014

Managed Care Organizations

Premium rates for the Medicaid managed care organizations (MCOs) are determined through actuarially sound methodologies. These rates determine the state's capitation payments to MCOs for contractually required services. Further detail on Medicaid managed care programs is provided in Chapter 7, Medicaid Managed Care.

STAR

The managed care rating process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. STAR MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims cost through the addition of a risk margin.

Another adjustment made is the removal of newborn delivery expenses from the total cost rate, resulting in an "adjusted premium rate" for each service area. A separate lump sum payment, called the "Delivery Supplemental Payment," is computed for each service area for expenses related to each newborn delivery.

The resulting underlying base rates vary by service area and risk group but are the same for each MCO in a service area. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. The final capitated premiums that are paid to the MCOs are based on this acuity risk-adjusted premium for each combination of service area and risk group. In addition to the final capitated premium rates, MCOs also receive the Delivery Supplemental Payment for each newborn.

Pharmacy costs associated with all STAR clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR rates above.

STAR+PLUS

The STAR+PLUS program rates are calculated in a similar manner as the STAR program, except that STAR+PLUS MCOs do not receive a Delivery Supplemental Payment for newborn deliveries.

Pharmacy costs associated with all STAR+PLUS clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR+PLUS rates above.

Medicaid Dental

The Medicaid Dental program became a managed care program March 1, 2012. Medicaid dental rates are based on claims experience for the covered population in the base period. The base cost is totaled and trended forward to the time period for which the rates apply. A reasonable provision for administrative expenses, taxes, and risk margin is added to the claims component in order to project the total cost for the rating period. These projected total costs are then converted to a set of statewide rates that vary by age group.

NorthSTAR

Capitation rates for the NorthSTAR Behavioral Health Organization (BHO) are derived primarily from BHO historical encounter experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for BHO expenses such as projected increases in Medicaid enrollment and utilization, changes in plan benefits, administrative expenses, and other miscellaneous costs. In addition to these costs, the NorthSTAR BHO rates include amounts for fixed contract fees and various other adjustments. Lastly, a provision is made for the possible fluctuation in claims by the addition of a risk margin. The NorthSTAR BHO is reimbursed using premium rates which vary by risk group.

STAR Health

The capitation rate for the STAR Health program is derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. Adjustments are applied for MCO expenditures, which include reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims by the addition of a risk margin. The rate also includes a special allowance for the additional administrative services in the program, including the Health Passport. The Health Passport is a web-based electronic medical record that is intended to improve quality of care. A single MCO provides services under the STAR Health program. The MCO is reimbursed using a single premium rate which does not vary by age, gender or area.

Pharmacy costs associated with all STAR Health clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR Health rates above.

Nursing Facilities

Nursing facilities are reimbursed for services provided to Medicaid residents through daily payment rates that are uniform statewide by level of service (i.e., case-mix class). Enhanced rates are available for enhanced staffing. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific staffing and/or spending requirements.

Rates are based on costs submitted annually by providers on facility cost reports. Costs are categorized into five rate components: (1) direct care staff; (2) other resident care; (3) dietary; (4) general and administrative; and (5) a fixed capital asset use fee. Each rate component is calculated separately based on HHSC formulas and may vary according to the characteristics of residents. The total rate for each level of service is calculated by adding together the appropriate rate components.ⁱⁱ

Nursing Facility cost reports are subjected to either a desk review or on-site audit to determine that reported costs are allowable. Nursing facility rates are recalculated once every two years coincident with the legislative biennium.

MCOs are required to reimburse nursing facilities providing services to their members, at minimum, the same daily payment rate, including any enhancements, as would've been paid under FFS.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions

ICF/IID are reimbursed for services delivered to Medicaid residents through daily payment rates that are prospective and uniform statewide by facility size and level of need. The total daily payment rate may be retroactively adjusted if a provider fails to meet specific direct care spending requirements.

In 1997, initial model-based rates were determined using a representative sample of provider information (cost, financial, statistical, and operational) collected during site

ⁱⁱ H.B. 154, 77th Texas Legislature, Regular Session, 2001, requires HHSC to ensure that only those facilities that purchase liability insurance acceptable to HHSC receive credit for that cost. Therefore, liability insurance costs are excluded from the rate calculation and facilities that verify liability insurance coverage acceptable to HHSC receive additional funds in the form of a liability insurance add-on.

visits performed by an independent consultant. Currently, the modeled rates are updated, when funds are available, using the service providers' most recent audited cost reports. Enhanced rates are available for enhanced attendant compensation. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific attendant compensation spending requirements.

Facility cost reports are subjected to either a desk review or on-site audit to determine that reported costs are allowable. ICF/IID rates are recalculated once every two years coincident with the legislative biennium.

Endnotes

¹ The material in this section and the next, is drawn entirely from: Centers for Medicare and Medicaid Services, Historical National Health Expenditure Data (December 2014), “Table 1: National Health Expenditures” found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>