Texas Hospital Uncompensated Care Report

As Required by

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Executive Summary

Uncompensated care (UC) costs and reimbursements run into the billions of dollars. This can have a major impact on the hospitals that are serving indigent patients and the multiple levels of government that reimburse facilities for these costs. Uncompensated care costs continue to increase and funding is inadequate to attenuate the deficits hospitals face.

This report on Texas Hospital Uncompensated Care Costs focused on the years 2013 to 2016, coinciding with the change in repayments in the 1115 Waiver from Upper Payment Limit to Uncompensated Care payments. This report examined hospitals by three different categories: Non-government, not-for-profit (NFP); government, nonfederal (public); and investor-owned, for-profit.

Key findings of this report are:

- With the exception of a single year decrease in 2015, estimated uncompensated care costs have climbed since 2013 both nationally and in Texas. In 2016 the uncompensated care cost was estimated to be more than $6.8 billon.
- Patient-specific funding to offset the cost was $300 million, while lump sum funding was $4.4 billion in 2016.
- The estimated Medicaid shortfall was $3.5 billion in 2016, up from $2.9 billion in 2013. UC and DSH payments, which partially cover the shortfall, also increased to $4.3 billion from $2.9 billion over that same time period.
- Eighty six percent of the combined Medicaid shortfall and uncompensated care was covered with various forms of payments.
- By hospital type, public hospitals have the highest burden of uncompensated costs. However, after taking into account all payments, not-for-profit hospitals have the lowest amount of uncompensated care covered.

1. Introduction

Uncompensated care is defined as the unreimbursed costs associated with services provided by hospitals to the financially or medically indigent. The estimated amount of UC in the United States (US) has increased over time, and Texas mirrors this national trend. Reimbursement systems exist to moderate the economic impact for the facilities. Various forms of patient-specific dollars (monies that can be tied to an individual client) and lump sum revenues (where matching dollars to an individual is not possible) are available for offsets. Additionally, it is imperative to include the Medicaid shortfall (the differences between the Medicaid costs and payments) into the financial analysis. Two important federal programs that help subsidize the losses due to Medicaid and uninsured clients are 1) a DSH allotment for facilities that serve a disparate amount of Medicaid clients and 2) Uncompensated Care payments.

In order to ascertain the expenditures and the reimbursements, the Texas Annual Hospital Survey (AHS) from The Texas Department of State Health Services' (DSHS) Hospital Survey Unit was utilized. All licensed hospitals are required to respond to the self-reported survey. The survey reports UC in the form of charges, which are then converted into estimated costs. Therefore, although several internal validity checks are used, the numbers cited in this report may differ from other Texas UC sources.

2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 10) stipulates:

No funds appropriated under this Article for medical assistance payments may be paid to a hospital if the Health and Human Services Commission (HHSC) determines that the hospital has not complied with the commission's reporting requirements. HHSC shall ensure that the reporting of uncompensated care (defined to include bad debt, charity care and unreimbursed care) by Texas hospitals is consistent for all hospitals and subjected to a standard set of adjustments that account for payments to hospitals that are intended to reimburse uncompensated care. These adjustments are to be made in such a way that a reliable determination of the actual cost of uncompensated care in Texas is produced. The commission shall conduct an appropriate number of audits to assure the accurate reporting of uncompensated hospital care costs.

HHSC shall submit a biennial report on uncompensated care costs to the Governor and Legislative Budget Board no later than December 1, 2018, which details the impact of patient-specific and lump sum funding as offsets to uncompensated costs, impact of health care reform efforts on the funding streams that reimburse uncompensated care, and assess the need for those funding streams in future biennia. HHSC may report by hospital type.

2. Background

2.1 Current System for Uncompensated Care

Of Texas's 4.5 million uninsured, representing 16.6 percent of the state's population,[1] nearly 60 percent have an income below 200 percent of the Federal Poverty Level, the upper threshold for most assistance programs. Those who are uninsured are inclined to put off routine medical care and tend to seek assistance in emergency rooms and hospitals, which are typically the most expensive locations for care. In addition to the uninsured, the underinsured (those having inadequate coverage) may not seek medical treatment until they are in a hospital setting and then have issues paying their entire medical bills.

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. These payment shortages fall into two different categories. Charity care is unreimbursed costs to hospitals for services provided to low income patients for free or at reduced prices; hospitals assume minimal payment on behalf of the patient. Bad debt is defined as uncollectible inpatient and outpatient charges that result from the extension of credit to the patient after the facility expected payment for the care. There is no absolute standard for what bad debt and charity charges are because each hospital has their own methods and standards to categorize whether or not a patient is medically or financially indigent. Thus, what is charity at one facility may be bad debt at another.

These UC costs and reimbursements can account for billions of dollars. The possible fiscal impact on hospitals who serve indigent individuals and the entities who reimburse the facilities can be significant. An ongoing concern to all major participants is that UC costs continue to increase, while the funding needed to mitigate the losses is not sufficient to cover the full costs of services for the hospitals.

The Texas Constitution states that care for the uninsured is a local government responsibility. The Texas Department of State Health Services oversees this law in the form of The County Indigent Health Care Program. Counties must provide select medical care to all of their residents who are at or below 21 percent of the Federal Poverty Level, have an income that is less than $2,533 for a single-person household in 2017, who do not qualify for other government health care programs,

and have resources that total less than $2,000. Benefits for these individual include primary, preventative, and some specialty services such as vaccinations, medical screenings, annual physical examinations, inpatient and outpatient hospital visits, laboratory and radiology tests, and skilled nursing facility services. Similarly, public hospitals and hospital districts are compelled to aid the aforementioned population. Both counties and hospitals are allowed to offer assistance above the constitutionally stated minimum.

Furthermore, the Texas Health and Safety Code Chapter 311, for health facilities, lays out rules and regulations for community benefits and charity care, stipulating the requirements that NFP hospitals must meet in order to maintain their non-profit status in Texas. The justification is that the tax benefits 'pay' for the charity care. Hospitals have the latitude to set the income level thresholds to operationalize charity care, but again, must be at least 21 percent of the Federal Poverty Level.

2.2 Current System for Repayments

Three main types of payments are analyzed in this report: patient-specific, lump sum, and Medicaid payments.

Patient-Specific Funding

Patient-specific funding includes payments that are received on behalf of certain patients. There are several sources for these payments including: local governments, workers' compensation, auto insurance, third party health insurance, the State of Texas in the form of Crime Victims Compensation, Kidney Health, burn victims, and others. These revenue streams are designed to help offset the costs to charity care.

Lump Sum Funding

Lump sum funds are paid to facilities, but are not affiliated with any particular patient. Lump sum payments include, but are not limited to: trauma care, the master settlement agreement with tobacco companies,[i] federal funding (e.g. immigrants, prisoners, Ryan White,[ii] etc.), collections previously reported as uncompensated, and tax revenue (tax revenues or collections, less any intergovernmental transfers (IGTs) in support of Medicaid payments reported by public hospitals).

[i] Specific details about this settlement can be found at the Texas DSHS website: https://www.dshs.texas.gov/tobaccosettlement/faq.shtm

[ii] Largest federally funded program in the United States for people living with HIV/AIDS.

Medicaid and Other Federal Payments

There is often a difference between the amount facilities are reimbursed for Medicaid services and the actual costs of the services. Medicaid shortfalls occur when the costs of services are in excess of Medicaid disbursements.

The Texas Medicaid 1115 Waiver specifically lays out two different vehicles to relieve some of the financial burden in treating those individuals who are on Medicaid or are uninsured.

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.

The other main source of Medicaid offset is from the UC pool. Currently these payments are used to pay for the Medicaid shortfall and uninsured costs. Starting in federal fiscal year 2020 (October 1, 2019) it will partially cover the charity care that facilities provide to the uninsured population, but will not include bad debt or Medicaid payment shortfalls. Before UC funds are disbursed to a hospital, the DSH payments to the facility are taken into account by HHSC.

2.3 Annual Hospital Survey

The AHS is a mandatory assessment that is distributed by DSHS and is sponsored by the American Hospital Association (AHA). State law[2] requires DSHS to collect aggregate financial, utilization, and other data from all licensed hospitals. As Rider 10 requires HHSC to report topics associated with these data, HHSC has historically used the data collected by DSHS. The AHS is self-reported and does not necessarily involve audited financial documents. DSHS sends out the survey[iii] in March of each year and inquires about the most recent fiscal year for hospitals; so each hospital may be reporting about slightly different time periods because they each have their own fiscal year. This can be problematic as the hospital fiscal years are not uniform. For example, if a health phenomenon takes place (e.g. an outbreak, large natural disaster, etc.) it may not be captured equally across the hospitals.

[iii] Current and past surveys can be found at the DSHS website: https://www.dshs.texas.gov/chs/hosp/hosp2.aspx

It is important to note, there are a number of data sources and methods that may be used to determine UC costs and payments. No analysis is more correct than another, when sources and methods are taken into account. In the DSH and UC programs operated by HHSC, providers submit applications that include data supported by cost reports and accounting systems that inform the actual payments to hospitals. Given the difference in data sources, there is a difference between what this report states and what HHSC presents in other settings. HHSC will endeavor to harmonize this report to figures and reports in other settings in the future.

2.4 Healthcare Reform Impact and Funding Streams

Since the last Hospital UC Rider report was released in December of 2016, there have been pertinent changes in health care policies and laws about how UC will be funded at the federal, state, public, and private level. Recent laws and policy changes have been enacted that will affect the insured rate of Texans, including a removal of the health insurance mandate for all US citizens, the expansion of short-term health insurance, limited coverage of certain emergency room visit, and the reduction of DSH allotments in federal fiscal year 2020. At the State level, HHSC is working with managed care organizations to increase hospital payments.

3. Hospital Uncompensated Care

3.1 Uncompensated Care Charges and Estimated Costs

Finding: Uncompensated care charges and estimated costs have continued to climb since 2013. The most recent estimate puts UC costs at $6.8 billion in 2016 for which public hospitals bear the biggest economic burden.

The AHA works in collaboration with each state to produce and distribute the AHA's Annual Survey of Hospitals. Each year, the AHA amalgamates each state's survey and produces a hospital UC cost fact sheet[3]. Since the survey requests charges, and not the actual cost of treatment, it is necessary to convert these charges into estimated costs. The three step conversion process for each hospital is as follows:

1. Uncompensated Care Charges=Bad Debt Charges + Charity Care
2. Cost-to-Charge Ratio=Total Expenses Exclusive of Bad Debt / (Gross Patient Revenue + Other Operating Revenue)
3. Estimated Uncompensated Care Costs=Uncompensated Care Charges X Cost-to-Charge Ratio

Since the methods of calculating bad debt versus charity differ between facilities, this process standardizes UC costs across hospitals.

Despite UC charges sharply increasing in Texas each year (Table 1), the estimated UC costs have a less dramatic growth (Table 2).

Table 1. Texas[a] Charity Care, Bad Debt and Total Uncompensated Care Charges by Survey Year (in Millions)

Year	Charity Care Charges	Bad Debt Charges	Total Uncompensated Care Charges[b]
2013	$12,597	$8,805	$21,402
2014	$13,842	$9,634	$23,476
2015	$13,742	$10,712	$24,454
2016	$15,401	$11,178	$26,579

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

[a] Federal hospitals are not reported in the Annual Hospital Survey.

[b] Uncompensated charges only include charity care and bad debt, not Medicaid shortfall.

Table 2. Texas Charity Care, Bad Debt and Total Uncompensated Care Estimated Costs[a] by Survey Year (in Millions)

Year	Charity Care Costs	Bad Debt Costs	Total Uncompensated Care Costs
2013	$4,328	$2,177	$6,505
2014	$4,366	$2,300	$6,667
2015	$4,106	$2,430	$6,535
2016	$4,291	$2,559	$6,850

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

[a] Costs are estimated per hospital based on the uncompensated care cost and then aggregated.

Financial policies and responsibilities are influenced by the hospital's organizational structure and control, causing UC to vary among hospitals. The majority of hospitals, including for-profit ones, have at least some UC costs since all Medicare-

participating facilities are obligated by federal law[iv] to provide medical screening and treatment for emergency conditions regardless of the patients' ability to pay. This report focuses on non-federal government (public), non-government NFP, and investor-owned, for-profit hospitals.[v]

Public hospitals have the highest total and average UC costs since they treat all individuals regardless of ability to pay. NFP hospitals have the second highest total and mean UC costs due to laws regarding providing charity care to preserve their non-profit status. Private hospitals have the lowest UC costs and average costs among the three hospital categories (Table 3).

[iv] The Emergency Medical Treatment & Labor Act (EMTALA) was enacted in 1986 which assured access to emergency treatment, regardless of the individuals' ability to pay.
[v] Public hospitals include nonfederal government facilities (State, County, City, City-County, and Hospital district or authority). Non-government, not-for-profit hospitals include church-operated and other NFPs. Investor-owned, for-profit hospitals are controlled by an individual, partnership or corporation.

Table 3. Estimated Uncompensated Care Costs by Hospital Type (in Millions)

Year	Hospital Type	Charity Care Cost	Bad Debt Cost	Total UC Cost	Average UC Cost per Hospital[a]
2013	**Public**	$2,484	$698	$3,182	$27
	NFP	$1,596	$786	$2,382	$14
	Private	$249	$693	$941	$3
	Total	**$4,328**	**$2,177**	**$6,505**	**$11**
2014	**Public**	$2,437	$785	$3,222	$28
	NFP	$1,680	$742	$2,422	$14
	Private	$249	$774	$1,023	$3
	Total	**$4,366**	**$2,300**	**$6,667**	**$11**
2015	**Public**	$2,139	$800	$2,939	$25
	NFP	$1,716	$830	$2,546	$16
	Private	$250	$800	$1,050	$3
	Total	**$4,106**	**$2,430**	**$6,535**	**$11**
2016	**Public**	$2,124	$865	$2,989	$26
	NFP	$1,849	$848	$2,696	$17
	Private	$318	$846	$1,164	$3
	Total	**$4,291**	**$2,559**	**$6,850**	**$11**

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

[a] Hospitals whose entire responses on the AHS were submitted with 'Not Available' were removed from the analysis.

3.2 Lump Sum and Patient-Specific Uncompensated Care Cost Offset Funding

Findings: Multiple streams of patient-specific and lump sum funds are available to compensate hospitals for charity care and bad debt. Although UC costs continue to increase, the facility reimbursements are also rising, peaking at $4.8 billion.

Despite the fact that UC costs are on the rise for hospitals, the available payments have been moving in tandem. These funds come from a wide array of sources

including local, state, and federal governments, third party insurers, the patients themselves, and charity donations.

Patient-Specific Offsets

Patient-specific funding are revenues paid to the hospital from third parties on behalf of a specific patient. The five main classifications of patient-specific funds are local payments, state payments, private insurance payments, patient payments, and other payments. Local payments include payments received from local governments for specific patients, but exclude payments for public sector employees' care. State payments include funds received from the State of Texas associated with particular individuals. Private insurance payments include payments received from third party health insurance for charity care. Patient payments are those received by either the patient or their family. Other payments include payments received on behalf of patients such as worker's compensation and auto insurance. Since these reimbursements are patient-specific, they vary widely from year to year (Table 4).

Table 4. Patient-Specific Offsets for Uncompensated Care in Texas Hospitals, 2013 - 2016 (in Millions)

Patient-Specific Fund	2013	2014	2015	2016
Local Payments	$11	$60	$8	$8
State Payments	$29	$22	$21	$36
Private Insurance Payments for Charity Care	$88	$119	$177	$188
Patient Payments	$39	$65	$44	$71
Other Payments	$24	$21	$17	$56
Total Payments	**$191**	**$287**	**$266**	**$359**

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

Lump Sum Offsets

In addition to the patient-specific offsets, lump sum funding is available to defray some of the UC costs. Lump sum reimbursements account for a substantially larger portion of the offsets than that of patient-specific ones (Table 5). Lump sum payments include the tobacco settlement, trauma related care, local government, federal government, other government payments, tax revenue, and collections from patients previously reported as uncompensated.

The tobacco settlement is Texas's master settlement with the tobacco companies which provides money for units of local government to be compensated for their health care expenditures. The court settlement specified that hospital districts and public hospitals be awarded a pro rata distribution of funds based on their unreimbursed health care expenditures.

Trauma related care includes funds provided by the DSHS, from the Trauma Facility and Emergency Medical Services account, and collections from trauma patients previously reported as uncompensated.

Local government includes payments from other city or county programs for uninsured residents. Federal government includes federal funds received directly, such as funding for immigrants or prisoners, Ryan White, etc., but exclude Medicare funding. Other government payments are from other sources of net patient revenue. Tax revenue is from public hospital collections, less any intergovernmental transfers in support of Medicaid payments.

Collections received from patients whose care was previously reported as uncompensated (charity, self-pay/uninsured, or partially insured) after reporting information to the state, regardless of the year of service, are not used to recalculate prior year(s) residual UC but are considered available revenue to offset the cost of care provided to other patients in the current reporting period.

Table 5. Lump Sum Funding Offsets for Uncompensated Care in Texas Hospitals, 2013 - 2016 (in Millions)

Fund	2013	2014	2015	2016
Tobacco	$40	$39	$42	$40
Trauma	$30	$38	$107	$41
Local Government	$118	$173	$104	$90
Federal Government	$1,261	$1,354	$1,681	$1,548
Other Government	$472	$411	$494	$454
Tax Revenue	$1,068	$1,482	$2,025	$2,165
Previous Patient Collections	$203	$24	$49	$57
Charitable Contributions	$361	$288	$295	$380
Total Payments	**$3,554**	**$3,809**	**$4,797**	**$4,774**

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

3.3 Medicaid Shortfall and Payments

Findings: Medicaid shortfall has increased from $2.9 billion in 2013 to $3.5 billion in 2016. Supplemental DSH and UC payments have also increased over the time period from $2.9 billion to $4.3 billion, helping offset some of the shortfall.

The difference between Medicaid costs and payments is known as Medicaid shortfall, which is absorbed by the hospital providing the services. The DSH and UC programs exist to bolster the regular Medicaid payments that hospitals receive. It is imperative to note that DSH and UC payments pay for both Medicaid and uninsured costs so the 'Medicaid residual' amount is overinflated. Since the AHS does not differentiate whether the DSH and UC payments covered Medicaid or uninsured costs, they are combined together. The Medicaid net revenue increased from $5.6 billion in 2013 to $6.3 billion in 2016. The estimated Medicaid costs also increased from $8.5 billion to $9.8 billion, leading to an increase in the Medicaid shortfall from $2.9 billion to $3.5 billion (Table 6). The Medicaid shortfall is not evenly distributed among hospitals as more than 50 percent of the total shortfall is faced by the NFP facilities. Public hospitals have the lowest rate of reimbursement as nearly 50 percent of the estimated Medicaid costs are not covered by the Medicaid payments.

Table 6. Medicaid Shortfall by Hospital Type (in Millions)

Year	Hospital Type	Medicaid Charges	Medicaid Costs	Medicaid Net Revenue	Medicaid Shortfall
2013	**Public**	$4,570	$1,800	$963	$(837)
	NFP	$14,957	$4,519	$2,867	$(1,652)
	Private	$13,295	$2,161	$1,783	$(378)
	Total	**$32,822**	**$8,480**	**$5,612**	**$(2,867)**
2014	**Public**	$4,863	$1,828	$921	$(907)
	NFP	$15,564	$4,609	$2,967	$(1,643)
	Private	$14,595	$2,269	$1,686	$(583)
	Total	**$35,021**	**$8,706**	**$5,574**	**$(3,133)**
2015	**Public**	$5,172	$1,936	$910	$(1,026)
	NFP	$17,167	$4,966	$3,016	$(1,950)
	Private	$16,330	$2,410	$1,866	$(544)
	Total	**$38,669**	**$9,312**	**$5,792**	**$(3,520)**
2016	**Public**	$5,692	$2,057	$1,018	$(1,039)
	NFP	$18,472	$5,253	$3,471	$(1,782)
	Private	$17,953	$2,535	$1,822	$(714)
	Total	**$42,117**	**$9,846**	**$6,311**	**$(3,535)**

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

Despite these large initial shortfalls, the supplemental payments have also risen, which helps reduce losses, although public and NFP facilities still face a loss during some years (Table 7).

Table 7. Medicaid Payments by Hospital Type

Year	Hospital Type	Shortfall	DSH Payment[a]	UC Payment	Medicaid Residual[b]
2013	Public	$(837)	$443	$671	$276
	NFP	$(1,652)	$266	$934	$(452)
	Private	$(378)	$212	$325	$159
	Total	**$(2,867)**	**$920**	**$1,930**	**$(17)**
2014	Public	$(907)	$276	$608	$(22)
	NFP	$(1,643)	$269	$1,289	$(85)
	Private	$(583)	$221	$511	$149
	Total	**$(3,133)**	**$766**	**$2,408**	**$42**
2015	Public	$(1,026)	$571	$563	$108
	NFP	$(1,950)	$357	$1,243	$(351)
	Private	$(544)	$344	$441	$241
	Total	**$(3,520)**	**$1,273**	**$2,247**	**$(1)**
2016	Public	$(1,039)	$767	$521	$249
	NFP	$(1,782)	$424	$1,585	$227
	Private	$(714)	$334	$653	$273
	Total	**$(3,535)**	**$1,525**	**$2,759**	**$749**

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016.

[a] Two variables exist on the AHS for DSH payment. If one response was not available or $0 then the other one was used.

[b] DSH and UC payments are for both Medicaid shortfall and uninsured UC costs so the amount of Medicaid residual is exaggerated because not all funds are used to reimburse the Medicaid shortfall.

3.4 Combined Medicaid Residual, UC Costs, and Other Payments

Findings: Amalgamating the Medicaid residual, estimated UC costs and the patient specific and lump sum payments leads to 86 percent of the UC covered in 2016.

The percent of UC reimbursed differs depending on the hospital type and the year (Table 8). Overall, hospitals have seen their estimated UC coverage improve from 57 percent in 2013 to 86 percent in 2016. Public hospitals are the major drivers on the rise in the percentage of UC reimbursed as these facilities are responsible for the majority of payments and UC costs. Their percentage of UC covered rose from 66 percent in 2013 to over 100 percent in 2016. However, the table below includes the non-federal share payment that was provided by the public hospitals through the ad valorem taxes and thus overstates the percentage of UC covered. Private for profit hospitals have actually seen their coverage slightly drop from 48 percent to 46 percent over that same time period.

Table 8. Percent of UC Costs Covered by Payments by Hospital Type

Year	Hospital Type	Payments[a]	Total UC Costs	% of UC Covered
2013	**Public**	$2,089	$(3,182)	66%[b]
	NFP	$1,149	$(2,382)	48%
	Private	$490	$(941)	52%
	Total	**$3,728**	**$(6,505)**	**57%**
2014	**Public**	$2,285	$(3,222)	71% [b]
	NFP	$1,335	$(2,422)	55%
	Private	$518	$(1,023)	51%
	Total	**$4,138**	**$(6,666.9)**	**62%**
2015	**Public**	$2,934	$(2,939)	100% [b]
	NFP	$1,539	$(2,546)	60%
	Private	$589	$(1,050)	56%
	Total	**$5,062**	**$(6,535)**	**77%**
2016	**Public**	$3,287	$(2,989)	110% [b]
	NFP	$2,060	$(2,696)	76%
	Private	$536	$(1,164)	46%
	Total	**$5,883**	**$(6,850)**	**86%**

Source: Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services Annual Hospital Survey 2013-2016

[a] The payments column consists of patient specific payments, lump sum payments and Medicaid residual, noted in tables 4, 5, and 7. Since uncompensated care is defined as bad debt and charity care, the Medicaid residual amount is added to the total payments field.

[b] Inludes the non-federal share payment that was provided by the public hospitals through the ad valorem taxes and thus overstates the percentage of UC covered.

The NFP organizations may also have additional offsets in the form of tax exemptions, which could increase their percentage of UC reimbursed. However, this information is not readily available from the AHS.

3.5 Healthcare Reform and Future Funding Streams

Findings: There have been several health care policy and law changes that might curtail the positive trend in the percent of UC reimbursed Texas is increasing its hospital payments which can offset some of these issues.

Federal Changes

Higher insured rates are correlated with lower UC costs.[4] Thus any rules, regulations, or laws that discourage comprehensive insurance coverage will likely lead to increased UC costs. The Tax Cut and Jobs Act of 2017 repeals the individual mandate created by the Patient Protection and Affordable Care Act (PPACA) by removing the insurance penalty for not carrying health insurance, starting in 2019.[5] Although the exact results of this change are unknown, initial estimates by the US Congressional Budget Office state that four million less people will be insured in the US by 2019, rising to 13 million in 2027.[6] Since Texas is the second most populous state in the US, it is likely to be disproportionately affected by the expanding uninsured population.

The AHA recently raised additional concerns regarding potential for higher UC costs in the future.[7] Since, PPACA also sets limits for temporary insurance plans known *as short-term health-insurance plans*, allowing enrollment for only three months and creating an inability to be renewed. A new rule allows enrollment for up to 12 months and may be renewed for up to 36 months.[8] Although these insurance policies are relatively cheap and help fill gaps in coverage, they do not have to meet the requirements of the PPACA. These less regulated plans often have higher deductibles, coinsurance, and out of pocket maximums while providing less coverage. With consumers absorbing a larger portion of their medical bills, the likelihood of delinquent payments increases which leads to lower partially insured payments and thus higher UC costs.

Private Insurance Changes

Blue Cross Blue Shield of Texas, under the Health Care Service Corporation, is one of the largest providers of health insurance in Texas. As of August 2018, they no longer cover emergency room visits for select non-emergent conditions when the provider is out-of-network. Instead of Blue Cross Blue Shield of Texas paying for

these services, the patient is responsible for up to the entire billed amount.[9]This shift in payment responsibility is likely to increase the amount of UC.

DSH and DSRIP Payment Reductions

DSH and the Delivery System Reform Incentive Payment (DSRIP) Program, the latter which disburses money to hospitals to help them enhance access to care, the quality of care, and the general health of their patients, are two significant sources of funds for hospitals. With the passage of the PPACA, it was assumed that the increase in insured individuals would decrease the need for the DSH allotments and the pool of funds would be curtailed. However, Congress has delayed this reduction several times; most recently with the passage of the Bi-Partisan Budget Act of 2018,[10] which pushes back the cuts until federal fiscal year 2020. As of September 2018, the country-wide cuts of $4 billion in federal fiscal year 2020 and $8 billion in federal fiscal year 2021-2025 are still planned to take place, which represents a substantial portion of the current $12 billion disbursed.[11]

Although DSRIP is not designed to reimburse for UC, it is responsible for billions of dollars in funds to hospitals, among other providers. With the renewal of the 1115 Waiver, the DSRIP pool will be $3.1 billion in Demonstration Year (DY) 7-8 (October 1, 2017 to September 30, 2019), and then decrease in DY9 and DY10 until it is $0 in DY11.[12]With this significant loss in funds, hospitals may have to cut the amount of services or UC that they can offer or will have to make up these lost funds in another way that could be detrimental to their stakeholders or patients.

Uniform Hospital Rate Increase Program

The Uniform Hospital Rate Increase Program (UHRIP) is a new Centers for Medicare & Medicaid Services approved payment initiative that was rolled out as a pilot for the El Paso and Bexar service delivery areas on December 1, 2017, and then expanded statewide, with the exception of Travis service delivery area, on March 1, 2018.[13] HHSC is directing Medicaid managed care organizations to provide a uniform rate increase to the hospitals in their network. The goal of this program is to reduce the Medicaid shortfall and to provide facilities with a continuous revenue source rather than paying the hospitals lump sums retroactively. The rate increases vary depending on the hospital class; ranging from 0-3 percent for children's hospitals to 22-81 percent for other types of hospital (see Appendix B for hospital classes and rate increase ranges). Although the actual allotments to the providers are still unknown, the pool of funds available is over $1.25 billion in program year 2019.

4. Conclusion

This report uses DSHS's and AHA's AHS to estimate the UC costs for hospitals and the payments received to offset these costs. In addition, some policy changes by federal, state, and private establishments that can affect the future funding steams are examined. The AHS represents estimates of UC costs and payments, using bad debt, charity care, and Medicaid shortfall. It may not be directly comparable to other reports of UC.

The results of the survey suggest that:

- A positive trend of UC reimbursement exists as 86 percent of UC costs are reimbursed in 2016 compared to only 57 percent in 2013 (Table 8).
- Uncompensated charges have increased from $21.4 billion in 2013 to $26.6 billion in 2016 (Table 1). These charges can be converted to estimated costs using the AHA's cost-to-charge ratio, leading to as estimated UC cost of $6.8 billion in 2016 (Table 2).
- Although these UC costs are increasing over time, the payments that exist to partially offset these costs are also increasing. These offsets include $359 million in patient-specific funds (Table 4), $4.8 billion in lump sum funds (Table 5), and $4.3 billion in DSH and UC payments (Table 7).
- Public and NFP facilities experience the greatest share of the UC costs, but they also receive the greatest proportion of UC payments (Table 8).
- UC reimbursements remain a dynamic process as modifications are made, or delayed, by the federal or state government and by health insurers themselves.

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List of Acronyms

Acronym	Full Name
AHA	American Hospital Association
AHS	Annual Hospital Survey
DSH	Disproportionate Share Hospital
DSHS	Texas Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
HHSC	Texas Health and Human Services Commission
NFP	Not-for-Profit Hospital
PPACA	Patient Protection and Affordable Care Act
UC	Uncompensated Care
UHRIP	Uniform Hospital Rate Increase Program
US	United States

Appendix A. Definitions

Bad Debt—Inpatient or outpatient charges which are not paid in full by a patient or insurer after the facility expected payment for the care.

Charity Care—Unreimbursed costs to hospitals for services provided to low income patients for free or at reduced prices; there is no expectation of payment on behalf of the patient.

Cost-To-Charge Ratio—The ratio is used to convert hospital charges to estimated costs on a facility by facility basis.

$$CCR = \frac{\text{Total expenses exclusive of bad debt}}{\text{(Gross patient revenue + other operating revenue)}}$$

Delivery System Reform Incentive Payment—Disbursement of money to hospitals to help them enhance access to care, the quality of care, and the general health of their patients. Terms and Conditions are spelled out in the Medicaid 1115 Waiver and funds are scheduled to end on September 30, 2022.

Disproportionate Share Hospital Payment—Funds for facilities that serve a disparate amount of Medicaid clients. Qualifications are spelled out in the Medicaid 1115 Waiver. Cuts in this fund are scheduled to start in October 1, 2019.

Lump Sum Funding—Uncompensated care offsets in which it is not possible to match the dollars to a particular clients.

Medicaid Shortfall—the difference in the cost of medical services and the actual Medicaid reimbursements. If reimbursements are higher than the costs, this creates a Medicaid surplus.

Patient-Specific Funding—Uncompensated care offsets in which the dollars paid can be tied to specific individuals.

Uncompensated Care—The unreimbursed costs associated with services provided by hospitals to the financially or medically indigent. The summation of bad debt and charity care charges.

Uncompensated Care Payment—Supplemental payment from the Medicaid 1115 waiver to subsidize the costs incurred by hospitals for patient care services provided to Medicaid and Uninsured patients that are not reimbursed through the claims adjudication process or by other supplemental payments.

Uniform Hospital Rate Increase Program—A new program to provide hospitals with a continuous revenue source rather than paying the facilities lump sums retroactively. Medicaid managed care organizations, directed by HHSC, are to provide a uniform rate increase to the hospitals in their network.

Appendix B. UHRIP Rate Increases

The UHRIP rate increase range depends on several factors, including the hospital class. All managed care organizations will be required to pay the same rates to all contracted hospitals within their service delivery area. However, it is up to the Texas Health and Human Services Commission on whether the rate increases are for all services at the inpatient and/or outpatient level or just certain subcategories. Below are the potential rate increase percentages.

UHRIP Rate Increase Range by Hospital Class for 9/1/2018-8/31/2019 Period	
Hospital Class	**Rate Increase Range**
Children's Hospital	0%-3%
Non-Urban Public Hospital	0%-74%
Rural Hospital	
Rural Private	0%-25%
Rural Public	10%-30%
Urban Public Hospital	0%-81%
State Hospitals	Not participating in current period
All Other Hospitals[a]	22%-81%

Source: Texas Health and Human Services Commission, Rate Analysis

[a] Institutions for Mental Diseases are excludes