Texas Health and Human Services Commission

Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas' Uncompensated Care Pool

As prepared by
Health Management Associates

August 26, 2016

HMA
HEALTH MANAGEMENT ASSOCIATES

Contents

Executive Summary **1**

Section I – Purpose of Report **14**

Background 14

Waiver Renewal 17

Requirements – Special Terms and Conditions 17

Other Analysis Requested by HHSC 18

Definitions 18

Section II – Medicaid Reimbursement for Hospitals **19**

Overall Structure and Financing 19

Base Payments 19

Fee for Service Inpatient and Outpatient 19

Managed Care 21

Base Payment Summary 23

Supplemental Payments 23

Graduate Medical Education 23

Disproportionate Share Hospital Payments 24

UC Pool Payments 27

Delivery System Reform Incentive Payments 29

Reporting Waiver Payments to CMS 32

Trends in Hospital Utilization and Reimbursement 33

Financing the Non-Federal Match 34

Section III – Measuring Uncompensated Care **37**

HHSC Approach 37

UC Protocol 37

Components - Payments and Cost 38

Non-hospital Participants 40

Review of TXHUC Tool 41

Defining and Estimating Uncompensated Care 42

Section IV – Adequacy of Medicaid Reimbursement and Access for Low Income Populations 49
Trending to FY 2015 49
Payment to Cost Percentage 50
Using Base Payments Only 50
Base Payments and Supplemental Payments 51
All Payments Net of IGTs 53
Payment to Cost, by Type of Hospital 54
Payment to Cost based on Prevalence of Low-Income Patients 55
Financial Impact of the UC Pool 57
Adequacy, Equity, Accountability and Sustainability 58
Access and Network Adequacy 59
A Spotlight on Harris Health System 60
Access and Adequacy Statewide 61
Summary Observations 63
Section V – Comparison to Other States 64
Section VI – Projections and Additional Considerations 65
Environmental Trends and Factors 65
Trending from FY 2015 to FY 2017 72
Pro Forma Impact of a Medicaid Expansion 72
Changes in Coverage 73
Financial Impact of Coverage Changes 75
Impact of DSH Reductions on Texas Hospitals 76
What if Texas Reestablished UPL Payments? 79
Impact of the State Fully-Funding Hospital Medicaid Costs 79
Section VII – Conclusions 82
Appendices 87
Appendix I – Excerpt from Special Terms and Conditions – New Reporting Requirement .. 87
Appendix II – Instructions in TXHUC Tool for Reporting Uninsured Charges 90
Appendix III – Assessment of State of Texas Medicaid Hospital Payments and Distribution of Services 92

Appendix IV – Revenue and Cost Estimates, FY 2015 114
Appendix V – Supplemental Pools (FY 2015) and DSRIP Payments (FY 2013) 122
Appendix VI – Unreimbursed Medicaid and Uninsured Costs, FY 2015 130
Appendix VII - Hospital Characteristics and Tiers 138

Executive Summary

Background and Purpose of Study

In December 2011, the Texas Health and Human Services Commission (HHSC) received federal approval of the Texas Healthcare Transformation and Quality Improvement Program Waiver. The plan extended managed care, addressed concerns related to preservation of Texas' hospital safety net, and facilitated a critical transformation of the health care safety net from one driven by volume to one driven by value. A focal point within the waiver was funding for both a Delivery System Reform Incentive Payment (DSRIP) program and an Uncompensated Care program (UC Pool). Five-year funding authorized for the two statewide pools includes $17.6 billion allocated for the UC Pool and $11.4 billion for DSRIP.

Based on information published by the state, many key objectives of the demonstration waiver have been achieved. Medicaid managed care is now in place in all 254 Texas counties and many services previously carved out of managed care are now included. The DSRIP program has helped move the focus of health care to improved access, quality and outcomes. Over 1,450 DSRIP projects are operating and over $7 billion in incentive payments have been earned by providers through April 2016. The UC Pool has provided critical funding to hospitals with the largest low-income patient populations, helping to preserve the financial viability of the state's safety net providers.

In September 2015, HHSC submitted a request for a five-year extension of the Section 1115 waiver. After several months of discussion, CMS and HHSC agreed that additional time was required to negotiate a long-term renewal. Subsequently, CMS approved a 15-month waiver extension at the same funding level as demonstration year 5 of the current waiver.

As part of the extension, CMS modified the Special Terms and Conditions (STCs) to include a new reporting section. Under this section HHSC was required to engage an independent entity to evaluate the role of Texas' UC Pool and DSRIP program in the overall Medicaid system for paying hospitals. It is anticipated that information from this report will inform sizing the UC pool beyond 2017. HHSC engaged Deloitte Consulting to perform a review of one of the reporting requirements (see 6. below) and engaged Health Management Associates to address the remainder of the requirements. A summary of the objectives and reporting requirements follows:

1. Prepare a detailed description of the composition of current Medicaid hospital payments.
2. Provide an analysis of Medicaid financing and how the non-federal match is funded.
3. Estimate the cost incurred by hospitals to provide services to Medicaid beneficiaries and compare the cost to the corresponding payments received.
4. Estimate the cost of uncompensated care provided by hospitals and the portion of uncompensated care attributed to charity care.
5. Analyze the adequacy of Medicaid payments in relation to cost incurred by hospitals.

   a. Ascertain the degree to which supplemental pool payments and DSRIP payments compensate for base payment shortfalls, and the degree to which UC Pool and other safety net funding helps defray uncompensated care.
   b. The review should also address whether beneficiary access to care is dependent on Medicaid safety net funding.
6. Analyze how Texas Medicaid compares to other states in terms of payment adequacy.
7. Assess recent economic and environmental trends within Texas that may impact future reimbursement levels and the cost of caring for low-income populations.
8. Estimate the financial effects of four scenarios:
   a. The impact on hospitals if the state opted to expand Medicaid to low-income adults as allowed under the Affordable Care Act.
   b. The impact of reductions in Medicaid Disproportionate Share Hospital payments required by the Affordable Care Act.
   c. The effect on hospitals if Texas reestablished UPL payments.
   d. The uncompensated care burden if the state fully funds Medicaid hospital costs.

Definitions

Throughout this report, except as otherwise noted, the term "uncompensated care" refers to the sum of:

1. Unreimbursed costs (the excess of costs over payments) from patient care services provided to Medicaid enrollees, often referred to as Medicaid shortfall, and
2. Unreimbursed costs from patient care services provided to uninsured persons.

Most of the annual information in this report covers the federal fiscal year (FY) and the 1115 waiver demonstration year (DY), both of which end on September 30. In some instances, the period referenced is the state fiscal year (SFY), which ends on August 31.

Data Sources

The majority of information used in this report was derived from an HHSC data resource that was developed pursuant to the current 1115 Waiver STCs. Attachment H to the STCs entitled "UC Claiming Protocol and Application" establishes the process for obtaining information from hospitals and calculating unreimbursed costs for Medicaid and uninsured patients. Under the UC Protocol each hospital is required to certify the accuracy of the information and HHSC undertakes extensive verification and review procedures.

At the conclusion of the UC Protocol process, HHSC has data and supporting calculations of Medicaid cost and payments, uninsured cost, and payments received by hospitals from non-state sources to offset uninsured cost. The process relies on two-year lagged information (e.g., FY 2013 data is used for FY 2015 program purposes). In addition to documenting and calculating the unreimbursed costs used in the UC Pool distribution, the same data is used to calculate

estimated hospital-specific limits used for Medicaid Disproportionate Share Hospital (DSH) purposes.

There are over 600 hospitals licensed in Texas, of which 356 participated in the Texas Medicaid DSH/UC Pool program in FY 2015 (participating hospitals). The majority of information in this report is from or related to these 356 participating hospitals, as HHSC has the necessary information for these hospitals only. The participating hospitals account for more than 98 percent of Medicaid payments and therefore the exclusion of a large number of hospitals has a relatively small effect on the analysis herein.

For purposes of defining uncompensated care, a possible alternative source of data is Worksheet S-10 of the CMS 2552-10 report (Medicare cost report). The S-10 includes Medicaid, charity care and bad debt charges reported by the hospital and a calculation of Medicaid, charity and bad debt cost. In states that do not have statutory or regulatory reporting requirements, the S-10 may be the best source of information about hospital charity care and bad debts but that is not the case in Texas. After careful review and comparison of the S-10 data to the HHSC data, it was decided not to use the S-10 for several reasons:

- First, hospitals have strong incentives to report all care to uninsured patients to HHSC, because the data submitted to HHSC has a direct bearing on the amount of DSH and UC Pool payments that hospitals receive. In contrast, the S-10 has heretofore not been used directly or indirectly in any Medicare or Medicaid reimbursement calculations.
- Second, the HHSC data is carefully reviewed by the Department and is subject to an intensive audit as required under Medicaid DSH regulations. In contrast, the S-10 has typically received little to no attention in the Medicare cost report audits.
- Third, the S-10 data is more prone to inconsistent and inaccurate reporting because of misunderstandings. In fact, CMS' own analysis recently led to the conclusion that the S-10 form is not reliable for reimbursement policy, noting that additional quality control and data improvement measures are needed before the S-10 can be used.

In addition to the payment and cost information supplied by HHSC for the hospitals participating in the DSH/UC process, several external data sources were utilized for this report including files assembled by CMS from hospitals' Medicare cost reports, Texas Administrative Code, as well as various publications and research papers relevant to the topics covered in this study.

Uncompensated Care in Texas Hospitals

Using the FY 2013 data for participating hospitals and applying assumptions about changes since FY 2013, the total Medicaid shortfall in FY 2015 is estimated to be $3.5 billion and the total unreimbursed costs associated with treating uninsured persons is estimated to be $5.2 billion – a total of $8.7 billion in uncompensated care. Supplemental payments (mainly DSH and UC Pool payments) reduce this figure from $8.7 billion to $4.0 billion. This remainder represents a significant amount of unreimbursed cost associated with caring for low-income persons.

The following summarizes the findings and conclusions for the objectives and reporting requirements described above.

Description and the composition of current Medicaid hospital payments

The Texas Medicaid program utilizes a variety of methods to reimburse hospitals for care provided to enrollees including:

1. Inpatient and outpatient claim-based payments for fee-for-service recipients. For inpatient care, each inpatient discharge is reimbursed a unique amount based on the patient's condition, certain characteristics of the patient stay, and a hospital-specific rate. Texas Medicaid employs several policy adjustments that consider differences in the type of hospital, the location of the hospital, whether the hospital hosts graduate medical education programs, and whether the hospital qualifies for a safety net or trauma facility adjustment. Outpatient services are reimbursed using a combination of methods that vary with the type of service including percentage of cost and HHSC-established fee schedules.
2. Capitation payments to Medicaid Managed Care Organizations (MCOs), which in turn pay hospitals for services to managed care recipients, often pursuant to contracts between the MCOs and providers. HHSC does not require plans to utilize specific payment methodologies for hospitals, nor does it establish payment floors or other payment guidelines. MCOs may utilize the fee-for-service reimbursement structure for the majority of hospital payments.
3. Supplemental payments, including DSH and UC, whereby fixed pools are determined and disbursed annually to eligible providers in accordance with pre-established formulae. DSH and UC Pool payments are both intended to offset a portion of eligible hospitals' Medicaid shortfall and the unreimbursed costs associated with treating uninsured persons. The methods for allocating these pools to hospitals are very complex, and there are statutory limits on the amount of DSH and UC payments an individual hospital may receive. Texas Medicaid also has a Graduate Medical Education (GME) pool that distributes a specified amount of funds to state-owned teaching hospitals.

Hospitals are also eligible to participate in DSRIP and earn additional revenue if the specific metrics of the DSRIP program are met. Texas' DSRIP program operates under a Regional Healthcare Partnership (RHP) structure that requires providers to participate in regional coalitions within specific geographic areas. Each of the 20 separate RHPs developed a DSRIP implementation plan to address the specific needs of the region. DSRIP payments to providers are generally based on achieving pre-approved metrics and milestones.

Following is a summary of base and pool payments from the most recent year for each type of payment[1].

Medicaid Base Payments and Pool Payments

in millions	Inpatient	Outpatient	Total
Fee for service payments	$1,431	$311	$1,742
Managed Care encounter payments	$1,998	$1,143	$3,141
Adjustments and settlements			$365
Total base payments -participating hospitals			***$5,248***
GME pool			$31
DSH pool			$1,722
UC Pool – hospital only			$2,947
DSRIP payments –hospitals only			$1,276
Total all payments – participating hospitals			***$11,224***

Analysis of Medicaid financing and how the non-federal match is funded

Texas Medicaid receives federal matching funds based on the Federal Medical Assistance Percentage (FMAP), which was 58.05 percent in FY 2015. The remaining 41.95 percent is the responsibility of the state. States are permitted to obtain funds from local units of government, or from providers that are owned or operated by local governments, via transfers to the state—that can be used to finance the nonfederal share of Medicaid payments. These transfers are known as intergovernmental transfers (IGTs).Nearly all states utilize health care providers and/or local governments to finance a portion of the non-federal share of Medicaid.

Texas uses state general revenue to finance the non-federal share of all base payments to hospitals and managed care premiums paid to MCOs. Texas uses IGTs from hospital districts, counties and certain state-owned entities to fund the state match on all GME, DSH, UC and DSRIP payments except for a portion of DSH that is financed with general funds. Overall, approximately 50 percent of the non-federal match associated with hospital payments is financed from state general revenue and the remaining 50 percent from IGTs.

The state requires each private hospital participating in an IGT-financed payment pool to have an affiliation agreement with a governmental entity making the IGTs. In addition, each hospital and each governmental entity must certify to HHSC that no supplemental payments or other funds in consideration of supplemental payments will be returned or reimbursed to the governmental entity; and that the amount of IGT or the amount of supplemental payments to the hospital is conditioned on the amount of indigent care provided by the hospital.

Although there is no direct relationship between supplemental payments and the IGTs made to finance the non-federal match and the IGTs cannot and should not be associated with individual

[1] Includes hospitals participating in the DSH and UC program in FY 2015, and represents FY 2013 for base payments and DSRIP payments, because of the two-year lag in available data, and FY 2015 for supplemental payments.

hospitals, it may be appropriate to consider the IGTs in evaluating the financial impact of the UC and DSRIP programs on hospitals in the aggregate.

Cost and payment - services to Medicaid beneficiaries

As described above, HHSC undertakes an extensive analysis and review of hospital-specific information for purposes of deriving payments and costs associated with Medicaid and care to the uninsured. The HHSC processes and calculations appear to be very effective and for purposes of this report the data provided by HHSC for participating hospitals was used without exception.

Generally, the payments and costs used in the HHSC analyses are consistent with amounts required to be included in the hospital-specific DSH limit under federal guidelines, and the costs are consistent with Medicare hospital policy. There are three exceptions. Under the UC Protocol, hospitals may include (1) certain unreimbursed costs of provider-based physicians and mid-level providers, (2) pharmacy costs related to the Texas Vendor Drug program, which provides prescription drug support for low-income individuals, and (3) unusual cost or revenue changes that occur in a year subsequent to the base year. Each of these adjustments appears to be reasonable and appropriate.

Cost of uncompensated care and the portion attributed to charity care

Under the UC Protocol, uncompensated care is based on the cost of all services to Medicaid and uninsured patients less payments received. This is a reasonable definition of uncompensated care and is consistent with federal Medicaid policy.

The STCs call for an alternative calculation of uncompensated care, defining uncompensated care costs "as those associated with charity care as defined by the principles of the Healthcare Financial Management Association, and not including bad debt or Medicaid shortfall".

The Healthcare Financial Management Association (HFMA) principles cited in the STCs refer to a document published in December 2012 by the Principles and Practice Board of HFMA entitled "Statement 15, Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers" (referred to as "P&P Statement 15" hereinafter). P&P Statement 15 is intended to provide guidance to hospitals and other healthcare facilities to identify and distinguish between charity care and bad debt.

Under P&P Statement 15,charity care should be recorded when a hospital determines a patient is unable to pay for services Bad debts result when a patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim.

An initial estimate of charity care was made for purposes of this report using charity care data reported by hospitals to the Texas Department of State Health Services (DSHS) pursuant to state statute that requires most hospitals to report charity care data annually.

However, there is one major concern with using externally reported charity care amounts: charity care is typically recorded when a strict set of conditions are met, and bad debt is used as the default for other unreimbursed patient charges. In fact, a large component of bad debt may meet the requirements for charity care in substance. There are many reasons why a patient account may be classified as bad debt, even if the patient had no ability to pay, including:

- Frequently the hospital is unable to determine ability to pay.
- A patient may not meet the income or assets tests to qualify for charity care at time of service, but subsequent changes in the patient's financial condition may occur including medical hardship resulting from the cost of hospital services.
- Lack of cooperation or compliance by the patient is common. If the patient does not follow through with the policy requirements of a hospital, the policy may not allow the hospital to record the account as charity care.

The HFMA principles recognize these challenges and contemplate this broader set of circumstances where charity care may be applicable. However, as a practical matter, there are many situations when requirements under the hospital's charity care policy are not met and the hospital is not permitted to assume charity care would have been appropriate.

In a recently issued study on uncompensated care for the California Medicaid[2] program the problem with differentiating between charity care and bad debt was addressed. In this study, 21 public hospitals were surveyed and asked to provide a breakdown of their uninsured costs between charity care and bad debt, using an expanded definition of charity care that was intended to reflect the principles articulated by HFMA. In the California study, the survey concluded that 49.7 percent of bad debt charges should be reclassified to charity care. This same percentage is used in this report.

Following is an estimated allocation of FY 2013 uninsured cost between charity and bad debt.

Allocation of Uninsured Cost to Charity Care and Bad Debt

Dollars in Millions	Charity Care	Bad Debt	Total
Total uninsured charges allocated based on DSHS reporting	$13,429	$8,623	$22,051
Reallocated 49.7% of bad debt to charity (California study)	$4,285	($4,285)	
Total uninsured charges, after reallocation	$17,714	$4,338	$22,051
Average cost to charge ratio (from UC Protocol data)	0.2205	0.2205	
Estimated charity care and bad debt cost before adjustments	***$3,906***	***$956***	***$4,862***
Adjustments to cost pursuant to the UC Protocol, UC portion	$310	$76	$386
Estimated charity care and bad debt cost	***$4,216***	***$1,032***	***$5,248***

[2] Evaluation of Uncompensated Care Financing for California Designated Public Hospitals, dated May 15, 2016, California Department of Health Care Services on behalf of Blue Shield of California Foundation

Adequacy of Medicaid payments in relation to cost incurred by hospitals

For purposes of this report and as is common practice in the industry, payment adequacy is measured by comparing payments to cost. A payment to cost percentage of less than 100 percent indicates that payments are not sufficient to cover the cost of care. In Texas, as is the case in most states, the majority of hospitals receive Medicaid base payments that are well below cost. Supplemental payments help to close the gap but usually do not eliminate the Medicaid shortfall, and safety net funds help mitigate but typically do not offset the uncompensated care burden.

To improve the relevance of the payment to cost percentages, the FY 2013 base payments and costs were trended forward to FY 2015 to account for changes in cost, price and utilization. To ascertain the degree to which Medicaid supplemental payments compensate for base payment shortfalls and mitigate uncompensated care, the DSH and UC Pools were first allocated between Medicaid and uninsured cost, using unreimbursed cost as the basis for allocation.

The following table shows the results of these analyses.

Payment to Cost Summary, FY 2015

In Millions	Medicaid	Uninsured	Total
Total Cost (1)	$11,287	$5,563	$16,850
Base Payments (1)	$7,767	$389	$8,156
Payment to cost percentage before pool payments	***68.8%***	***7.0%***	***48.4%***
Unreimbursed cost before pool payments	***($3,520)***	***($5,174)***	***($8,694)***
Medicaid GME Payments	$31	$0	$31
DSH Payments	$560	$1,162	$1,722
UC Pool payments	$1,107	$1,840	$2,947
Payments including supplemental pools	$9,465	$3,391	$12,856
Payment to cost percentage after pool payments	***83.9%***	***61.0%***	***76.3%***
Remaining Unreimbursed Cost	***($1,822)***	***($2,172)***	***($3,994)***

(1) FY 2013 data trended to FY 2015

The Medicaid and uninsured payment to cost percentages are 68.8 percent and 7.0 percent, respectively, and 48.4 percent combined. The total unreimbursed cost before considering supplemental pools is $8.7 billion. After applying the supplemental pool payments, the payment to cost percentages increase significantly to 83.9 percent for Medicaid, 61.0 percent for the uninsured, and 76.3 percent combined. However, a $4.0 billion unreimbursed cost burden remains.

As required under the STCs, an additional calculation looks at the impact of offsetting DSRIP payments against Medicaid shortfall. DSRIP payments are intended as incentive payments for delivery system transformation and performance, rather than reimbursement for expenditures or payment for services, and are typically not accounted for in payment-to-cost analyses. However,

if DSRIP payments to hospitals from FY 2013 (the latest year that is relatively complete) are added to supplemental payments, the Medicaid payment to cost percentage increases to 95.2 percent and the Medicaid shortfall is reduced to $0.5 billion.

Finally, the analysis includes an additional calculation to consider the effect of IGTs made by or on behalf of public hospitals. From an accounting standpoint, IGTs are not an expense and cannot be included in Medicaid or uninsured cost. However, when IGTs are made by public hospitals or a governmental entity that owns a public hospital, the resources of such organizations are considered by CMS to be a portion of their reimbursement. In substance an IGT made by or on behalf of a public hospital is an expenditure that reduces the amount of Medicaid revenue available to run its operations and serve its patient population. Accordingly, IGTs made by or on behalf of public hospitals may be considered an offset against payments in the assessment of Medicaid payment adequacy.

After offsetting public hospital IGTs against the related supplemental payments, the overall payment to cost percentage decreases from 76.3 percent to 70.1 percent and the remaining amount of unreimbursed cost increases from $4.0 billion to $5.0 billion.

Beneficiary access to care and dependence on Medicaid safety net funding

While it is difficult to predict the specific impact on access to care, the data point toward the possibility of access problems in some communities in the absence of supplemental safety net funding. Analysis of uninsured data as well as proxy data for access indicates that communities with the highest level of need and access issues receive the greatest amount of uncompensated care funding.

As a financial measure of dependence, UC Pool payments were compared to total revenue and net income for all hospitals where such data is available. In FY 2015, UC Pool payments accounted for 4.6 percent of all revenue for Texas hospitals and 54.9 percent of aggregate net income. Among the hospitals with the highest concentrations of Medicaid patients, UC Payments represent 8.1 percent of total revenue and 187 percent of net income, indicating that – at least in some cases – these hospitals would face losses without UC Pool funding.

Comparison of Texas Medicaid to other states in terms of payment adequacy

HHCS engaged Deloitte Consulting to perform a comparison of Texas Medicaid to a sample of other states and the report in included as Appendix III.

Recent economic and environmental trends within Texas that may impact future reimbursement levels and the cost of caring for low-income populations

Because UC Pool payments are a critical funding mechanism for providing health services to Texas' low income population, it is important to consider population trends and economic and environmental factors that impact access to care and variations in the health care delivery system across the state.

One of the key factors relative to expected costs for uncompensated care is the number and percent of individuals without health insurance. Texas currently has the highest rate of uninsured residents at 19.1 percent, compared to a national average of 11.1 percent, driven both by the state's decision not to expand Medicaid and one of the nation's largest concentrations of unauthorized immigrants, who are not eligible for Medicaid or Exchange coverage. Nationally, unauthorized immigrants accounted for 3.5 percent of the total U.S. population in 2012 but represented 6.3 percent of the Texas population, nearly twice the national average.

At the same time, Texas is experiencing significant population growth relative to other states, a fact that is likely to contribute to an increasing number of uninsured individuals and put additional pressure on the current health care infrastructure. Texas' annual population growth rate is more than twice the national rate at 1.71 percent in 2013 and 1.77 percent in 2014. Relative to other states, Texas is experiencing lower levels of participation in Exchange coverage, lower insurance offer rates among small employers, and higher employee cost of coverage.

These factors, combined, point to increasing numbers of uninsured Texans in the coming years.

Impact on hospitals if the state opted to expand Medicaid to low-income adults as allowed under the Affordable Care Act

As of July 2016, Texas is one of 19 states opting not to expand its Medicaid program to low-income adults as provided for under the Affordable Care Act (ACA). A Medicaid expansion would likely result in:

1. A shift from uninsured to Medicaid, which would increase hospital revenue and decrease uninsured costs.
2. A shift from individual and group insurance coverage to Medicaid, which in most cases would decrease hospital revenue.
3. An increase in overall hospital care as a result of improved access, which would increase hospital's operating costs.
4. Potentially more provider financing of the state share of Medicaid cost.

Two primary sources were relied upon to derive assumptions and make estimates for each of these factors. First, HHSC periodically makes forecasts of the effects of a possible Medicaid expansion and recently updated its assumptions for purposes of this report. Second, the Robert Wood Johnson Foundation and Urban Institute (RWJF/UI) recently published an analysis of the potential impact of Medicaid expansion on the number of Medicaid enrollees and uninsured residents in each of the 19 states that have not expanded.

Based on an understanding of the Texas environment and extensive review of the scenarios depicted in the aforementioned analyses, a set of assumptions was selected for enrollment and cost and the corresponding impact on services to the uninsured, resulting in the following estimates:

Pro Forma Impact of a Medicaid Expansion

Additional Medicaid Enrollment	
Currently uninsured	668,000
Currently insured, marketplace exchange and private	440,000
Total Medicaid Enrollment	***1,108,000***
Annual Changes in Revenue, Expense (000s)	
Increase in Medicaid payments	$2,235,000
Decrease in uninsured payments	($167,000)
Decrease in insurance payments	($1,108,000)
Increase in operating costs	($602,000)
Net Financial Effect on Hospitals	***$358,000***
Change in Uninsured Cost (000s)	
Decrease in uninsured cost	$1,782,000
Decrease in uninsured payments	($167,000)
Net Decrease in Uninsured Cost	***$1,615,000***

The costs of Medicaid expansion are being financed 100 percent with federal funds through 2016. In 2017, states will be required to fund 5 percent of the costs and the state share increases over the next three years to 10 percent in 2020. Many states have responded to this budget challenge by raising provider taxes or other sources of provider financing. Because Texas is currently not contemplating expansion, it is not known how this state would respond.

The combined effect of the projected increase in Medicaid shortfall and net decrease in uninsured cost is a $358 million financial gain to Texas hospitals, before any offset for provider financing of the state match.

Reductions in Medicaid DSH payments required by the Affordable Care Act

Pursuant to the Affordable Care Act, DSH allotments are scheduled to undergo significant reductions based on the rationale that increased rates of coverage through Medicaid expansion and subsidized private insurance should significantly reduce the uncompensated care burden on providers. The DSH allotment reductions were originally scheduled to begin in FY 2014 but have been delayed several times and are now scheduled to being in FY 2018 and extend through FY 2025.

Because CMS has not yet updated the DSH methodology for FY 2018 and beyond, and the inputs to the methodology are highly variable, it is difficult to predict the impact of DSH cuts on Texas hospitals. Under the most favorable assumptions, the reductions for Texas Medicaid will range from $134 million in FY 2018 to $537 million in FY 2025. Under the most unfavorable assumptions the cuts will range from $386 million in FY 2018 to $1,543 million in FY 2025. Despite high levels of uncertainty on the amount of the reductions, the overall impact of the DSH reductions, once implemented, will be a significant increase in unreimbursed Medicaid and uninsured costs.

Effect on hospitals if Texas reestablished UPL payments

Prior to the implementation of the 1115 waiver, Texas had a significant upper payment limit (UPL) gap – the difference between what it could pay for hospital services and what was being paid. In SFY 2011, the hospital upper payment limit program reimbursed hospitals $2.5 billion in supplemental payments that were essential for assuring access to care.

As part of the waiver, UPL spending was incorporated into the UC Pool. The waiver along with the UC Pool allowed HHSC to make a major shift from fee-for-service to managed care. The critical need and role of supplemental payments previously led the state to exclude hospital services from managed care in order to utilize the UPL framework. Without an adequate UC Pool under waiver, it is conceivable that the state could carve hospital services out of managed care and revert back to a UPL-like program in order to preserve access to care.

It is estimated that by removing hospital services from managed care, HHSC could create a hospital UPL program of approximately $3 billion in SFY 2017. Furthermore, if the state both excluded hospital services from managed care and expanded Medicaid, the hospital UPL program capacity would increase by an additional $1.3 billion to a create a total hospital UPL gap of $4.3 billion.

Uncompensated care burden if the state fully funds Medicaid hospital costs

The FY 2017 Medicaid cost in excess of base payments is projected to be approximately $3.1 billion (excluding approximately $0.7 billion associated with dual eligible and out of state cost and payments). Adding $3.1 billion to base rates would require a rate increase of approximately 36 percent and $1.3 billion in non-federal match. However, there are three important concerns with this scenario.

First, the majority of Texas Medicaid beneficiaries are in managed care. Federal regulations prohibit state direction of managed care premiums to providers and, accordingly, there is no assurance that if managed care premiums were increased by an amount sufficient to fund the managed care portion of a provider rate increase, the funds would actually be paid to hospitals.

Second, the state may not be able to generate the non-federal match associated with the rate increase. The state has four constitutional limits on spending and an increase in Medicaid spending to the degree contemplated in this section could cause one or more limits to be exceeded. If the rate increase was coupled with a reduction in DSH and/or UC funds, local units of government would be relieved of much of their responsibility for financing the state share of DSH and UC payments and may redirect their IGTs to finance a rate increase. However, there is no assurance that local units of government would participate to the same degree if safety net funding was replaced with base rate increases.

Third and most importantly, the scenario would result in a significant redistribution of revenue among hospitals. Many hospitals that are currently dependent on DSH/UC payments would experience decreases that could jeopardize their ability to serve their communities. In fact,

because DSH/UC payments are targeted to the hospitals with the highest Medicaid and uninsured costs, the redistribution could be very detrimental to the state's health care safety net.

Conclusions

Under the current funding and reimbursement structure, Texas hospitals incur significant amounts of unreimbursed costs serving Medicaid and uninsured patients. Texas's uncompensated care burden is almost certain to grow, based on demographics, underlying market factors, and projected DSH cuts. While the implementation of a Medicaid expansion would blunt the impact to a certain degree, it would not come close to eliminating the uncompensated care burden in the state and it is unlikely to be implemented in the near future.

Summary of Hospital Unreimbursed Costs FY 2017 Pro Forma

In Millions	Medicaid	Uninsured	Total
Unreimbursed cost, participating hospitals (1)	($3,804)	($5,517)	($9,321)
Non-participating hospitals (1)	($50)	($207)	($258)
Unreimbursed cost, before supplemental payments	***($3,854)***	***($5,724)***	***($9,579)***
GME pool (2)	$31	$0	$31
DSH pool (2)	$560	$1,162	$1,722
Unreimbursed cost, after supplemental payments	***($3,264)***	***($4,562)***	***($7,825)***
Pro forma effect, Medicaid expansion	($1,257)	$1,615	$358
Pro forma effect, DSH reductions (3)	$0	($749)	($749)
Unreimbursed cost, after pro forma adjustments (4)	***($4,521)***	***($3,696)***	***($8,216)***

(1) FY 2013 base payments and costs trended to FY 2017
(2) FY 2015 amounts, not expected to be materially different in FY 2017
(3) Represents FY 2021 estimate, assuming Texas' share of the ACA DSH reduction is the same as its current share of the federal DSH allotment
(4) Hospitals only

This pro forma analysis estimates that without payments from the 1115 waiver Texas hospitals could incur $8.2 billion in uncompensated care even after a Medicaid expansion. Including unreimbursed costs from the physician groups, ambulance providers and dental providers that currently receive a portion of the UC Pool payments adds $420 million to this amount, yielding a combined total in excess of $8.6 billion.

In the current environment, reimbursement from the 1115 waiver program helps ensure that adequate resources are available to millions of low-income Texas residents and the UC Pool provides an equitable, accountable and sustainable funding mechanism to help ensure access to care for the state's most vulnerable residents.

Section I – Purpose of Report

Background

In 2011, the Texas Legislature instructed the Texas Health and Human Services Commission (HHSC) to extend Medicaid managed care statewide in order to address rising health care costs and improve health care delivery and quality of care for Medicaid enrollees. At the time, the state faced an unprecedented budget deficit and Medicaid expenses accounted for 26 percent of the annual budget. Based on the State's previous success with Medicaid managed care, extension statewide was identified as an effective strategy for managing growing costs while improving service delivery for Medicaid recipients.

However, with managed care extension statewide and the significant reduction in Medicaid fee-for-service enrollment, the State faced the loss of an estimated $2.8 billion per annum in "upper payment limit" (UPL) funds due to federal rules that only allow UPL funding for services provided through a Medicaid fee-for-service program. To address concerns related to maintaining access to care and preservation of Texas' hospital safety net, the Legislature instructed HHSC to seek approval from the Centers for Medicare and Medicaid Services (CMS) to preserve UPL program supplemental payments that would be lost in the transition from fee-for-service to managed care. At the same time, the State also recognized the need for funding to support the critical transformation of the health care safety net from one driven by volume to one driven by value.

Pursuant to this directive, in September 2011, HHSC submitted a proposal to CMS for a five year Section 1115 demonstration waiver with three major components:

1. Extend the managed care delivery system
2. Create and fund the Delivery System Reform Incentive Payment (DSRIP) program, and
3. Establish funding for Uncompensated Care costs (UC Pool).

Goals of the demonstration proposal included:

- Extend risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the health care infrastructure to serve a newly insured population; and
- Transition to quality-based payment systems across managed care and hospitals.[3]

In December 2011, Texas received federal approval of the Texas Healthcare Transformation and Quality Improvement Program Waiver authorizing managed care extension statewide and

[3] Texas Health and Human Services Commission, "*Texas Healthcare Transformation and Quality Improvement Program Section 1115 Demonstration Waiver Extension Application*," September 30, 2015.

funding for both the UC and DSRIP programs. Five-year funding authorized for the two statewide pools includes $17.6 billion allocated for uncompensated care and $11.4 billion for DSRIP.

Health and Human Services is the second largest budget item of the Texas state government, driven primarily by Medicaid services. In the state fiscal year (SFY) 2016- SFY 2017 biennium, Medicaid appropriations totaled $25.1 billion in General Revenue; with federal funds, the program costs are estimated at $61.2 billion over the two-year period.[4] Appropriations for the biennium included an increase of $573.3 million for additional Medicaid payments to trauma hospitals, safety net hospitals, and rural hospitals.

The biennium budget also assumed $869.6 million in savings from Medicaid cost containment initiatives, including managed care extension. Since the authorization of the 1115 waiver, Texas has successfully extended full risk, capitated managed care to cover all 254 Texas counties. With extensions under STAR and STAR+PLUS, and implementation of a new managed care Children's Medicaid Dental Services program, more than 3.3 million Medicaid enrollees are now covered under managed care programs. Roughly 12 percent of Medicaid enrollees remain in Fee-For Service in SFY 2016.

Beginning in November 2016, Texas will launch the new STAR Kids managed care program for children and youth age 20 and younger with disabilities, who receive Medicaid benefits through SSI or 1915(c) programs. While some of this population voluntarily participates in managed care, STAR Kids will move all eligible children and youth into this program that is specifically designed for this high-need group, with a focus on care coordination.

Under the waiver, the State also carved several benefits into managed care from fee-for-service, including pharmacy services for all programs, inpatient hospital services and nursing facility services for STAR+PLUS, and mental health rehabilitation and targeted case management services for members with chronic mental illness.

While the State has not published an estimate of cost savings attributed to managed care implementation, a recent study by the Milliman actuarial firm estimates that savings from Medicaid managed care for SFY 2010 – SFY 2015[5] totaled nearly $3.8 billion or 7.9 percent over the six year time period.[6] To leverage the success of the managed care program and DSRIP, under the waiver extension HHSC will continue to strengthen collaborations between Medicaid managed care organizations and DSRIP providers to expand successful DSRIP initiatives and enhance long term sustainability and financial support for DSRIP for Medicaid beneficiaries.

The State also made significant progress in implementation of the DSRIP program, the second major component of the approved waiver. Under the Texas DSRIP program, hospitals and other

[4] Legislative Budget Board, Summary of Fiscal Size-Up 2016-17 Biennium, May 2016.
[5] Texas' fiscal year runs from September 1st through August 31st.
[6] Milliman, "*Texas Medicaid Managed Care Cost Impact Study*," February 2015.

providers are encouraged to develop and implement programs, strategies, and investments to enhance access, quality, cost-effectiveness, and health of the patients and families served.

As the largest DSRIP program in the country, Texas currently has over 1,450 DSRIP projects which are operated by nearly 300 provider organizations across all 254 counties of the state. As of April 2016, DSRIP providers have earned approximately $7.1 billion (all fund sources) for achievement of over 12,000 project-specific milestones across four separate DSRIP categories including Infrastructure Development, Program Innovation and Redesign, Quality Improvements, and Population Focused Improvements. Projects were selected by providers based on regional community needs assessments and collaborations, and are locally designed to address specific needs and gaps in services.

The program's target populations are Medicaid and low income uninsured. More than 25 percent of projects focus on improving access to behavioral health care services; 20 percent are designed to improve access to primary care; 18 percent address chronic care management and helping patients with complex needs navigate the health care system. Others projects are working on initiatives to improve access to specialty care, promote healthy lifestyles and improve disease prevention, increase healthcare workforce training, and expand reporting and Health Information Technology systems and capabilities.

As mentioned above, the waiver renewal includes plans to increase alignment of the DSRIP and Medicaid managed care programs in several ways, including through coordination of quality strategies and value based payment efforts. DSRIP projects are being reviewed to identify initiatives that may be promising for value-based reimbursement arrangements between managed care organizations (MCOs) and participating DSRIP providers in the MCO networks. HHSC plans to develop concrete steps for establishing value based purchasing arrangements between MCOs and their network DSRIP providers.

The Transformation Waiver also enabled the State to ensure low-income Texans continued to receive vital health care services through establishment of the UC Pool, which is a critical financial component of the healthcare safety net in Texas. Approved UC Pool funds authorized in the waiver provide financing for more than 300 hospitals, public physician groups, dental providers, and ambulance providers who serve Medicaid enrollees and uninsured low-income Texans throughout the state. UC Pool funds "may be used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types, as agreed upon by CMS and the state."[7]

The UC Pool fund amounts were negotiated at a time when states thought Medicaid expansion would be required by the Affordable Care Act and fewer Texans would remain uninsured in the

[7] Centers for Medicare and Medicaid Services, "*Special Terms and Conditions- Texas Healthcare Transformation and Quality Improvement Program*," Document Number 11-W-00278/6.

later years of the waiver. As a result, UC Pool funds over the five-year waiver period decreased gradually from a total of $3.7 billion in year one to $3.1 billion in year five.[8] The decline is consistent with the expectation that uncompensated care costs incurred by hospitals and other providers would decrease over time with the implementation of Medicaid expansion. However, as noted in the waiver renewal application and discussed later in this report, Texas' high rate of population growth and continued demand for healthcare services by uninsured individuals as reported by hospitals indicates UC Pool funding continues to be of vital importance to hospitals and the healthcare economy.

Waiver Renewal

In September 2015, HHSC submitted a request for a five-year extension of the 1115 waiver, including all three components of the initial waiver:

- Continuation of statewide managed care
- Continuation of the DSRIP program, and
- Continuation of the UC Pool.

After several months of discussion, CMS and HHSC agreed that additional time was required to negotiate a long-term renewal. Subsequently, CMS approved a HHSC request for an initial 15-month waiver extension at the same funding level as demonstration year (DY) 5 of the current waiver. The request was approved, with $3.875 billion for both the UC Pool and the DSRIP program over 15 months, for a total of $7.5 billion for the 15-month extension period.

Requirements – Special Terms and Conditions

As part of the extension of the 1115 waiver, CMS modified the Special Terms and Conditions (STCs) to include a new reporting section entitled "Evaluation of Uncompensated Care Costs for the Uninsured".[9] Under this section HHSC is required to engage an independent entity to evaluate the role of Texas' UC Pool and DSRIP program in the overall Medicaid system for paying hospitals. It is anticipated that information from this report will be an input into sizing the UC Pool beyond 2017.

The STCs state that the report is to consider the degree to which base Medicaid payment levels are adequate in relation to the cost of providing services to Medicaid beneficiaries and should indicate the degree to which UC Pool and DSRIP payments compensate for insufficient base payment levels. The report should also identify the percentage of UC Pool payments related to uncompensated care costs. The STCs include several specific requirements including:

- A detailed description of the composition of current Medicaid hospital payments including base and supplemental payments.

[8] "*Health Care Innovation in Texas: Renewing the Medicaid Transformation Waiver*," Texas Hospital Association, 2014-2015.
[9] Centers for Medicare and Medicaid Services Special Terms and Conditions dated April 27, 2016, Section 44.c.

- Information about non-hospital provider participation in the UC Pool.
- Information about Medicaid financing and the way in which the source of the non-federal share of payments interacts with payment distribution.
- Analysis of the adequacy of current Medicaid payment levels to hospitals, relating payments to the cost of care and the impact of Disproportionate Share Hospital (DSH), UC and DSRIP payments on uncompensated care and the Medicaid shortfall.
- Analysis of how Texas Medicaid compares to other states in terms of payment adequacy.
- Analysis of the cost of uncompensated care and the extent to which pool payments have addressed these costs.
- An estimate of Texas hospitals' uncompensated care burden if the state fully funded Medicaid costs and if the state opted to expand Medicaid to low-income adults as allowed under the ACA.
- Information about economic and environmental trends within Texas that may impact future reimbursement levels and the cost of caring for low-income populations.
- Information about total revenue from all-payers, Medicaid patient care revenue and other Medicaid revenue for hospitals, in aggregate and in appendices providing individual hospital details.

Other Analysis Requested by HHSC

In addition to the CMS requirements, HHSC requested that the report be supplemented with other observations and perspectives. The principal addition to the scope is an assessment of the impact of UC payments on access to hospital care. This includes a review of HHSC's assessment of managed care network adequacy, and an analysis of the extent to which UC and DSH payments provide essential financial support to hospitals that provide the majority of care to Medicaid beneficiaries and the low-income uninsured. HHSC also requested a review of the financial impact of replacing UC payments with an Upper Payment Limit program similar to what Texas Medicaid had in place before the 1115 waiver.

Definitions

Throughout this report, except as otherwise noted, the term "uncompensated care" refers to the sum of:

1. Unreimbursed costs (the excess of costs over payments) from patient care services provided to Medicaid enrollees, often referred to as Medicaid shortfall, and
2. Unreimbursed costs from patient care services provided to uninsured persons.

Most of the annual information in this report covers the federal fiscal year (FY) and the 1115 waiver demonstration year (DY), both of which end on September 30. In some instances, the period referenced is the state fiscal year (SFY), which ends on August 31.

Section II – Medicaid Reimbursement for Hospitals

Overall Structure and Financing

The STCs require a detailed description of current Medicaid hospital payments focused on the hospital services supported with UC Pool funds. This section provides an overview of the recent history and current structure of Texas Medicaid hospital payments and financing. The Texas Medicaid program utilizes a variety of methods to reimburse hospitals for care provided to enrollees including:

1. Inpatient and outpatient claim-based payments for fee-for-service recipients;
2. Capitation payments to Medicaid Managed Care Organizations (MCOs), which in turn pay hospitals for services to managed care recipients, often pursuant to contracts between the MCOs and providers;
3. Supplemental payments, including UC and DSH, whereby fixed pools are determined and disbursed annually to eligible providers in accordance with pre-established formulae.

Hospitals are also eligible to participate in DSRIP and earn additional revenue if the specific metrics of the DSRIP program are met.

The payments to hospitals are financed from three sources: 1) Texas state general revenue; 2) Intergovernmental transfers (IGTs) from non-state governmental entities and other state and local governmental agencies; and 3) federal matching funds.

The Medicaid program has presented the State of Texas with budgetary challenges for decades. As in most states, enrollment and cost increases have made Medicaid one of the largest and fastest growing components of the state budget. In order to maintain a balanced budget as required by the state constitution and in response to Medicaid cost pressures, the state has taken a number of actions intended to curtail the rate of growth. Many of these actions fall into three categories – freezing or reducing provider base payment rates and increasing reliance on supplemental pools, shifting the Medicaid population to managed care programs, and increasing reliance on local governmental entities to finance some of the non-federal portion of Medicaid spending.

Base Payments

Fee for Service Inpatient and Outpatient

Inpatient and outpatient payments are made pursuant to the Texas Administrative Code (TAC)[10] as implemented through the Texas Medicaid State Plan. HHSC implements the rate-setting requirements of the Code and monitors reimbursement for all provider types. This section provides an overview of inpatient and outpatient reimbursement models for hospitals.

[10] Texas Administrative Code Sections 355.8052 for inpatient and 355.8061 for outpatient.

Inpatient

The majority of hospitals are reimbursed under a prospective payment system utilizing Diagnosis Related Groups. Exceptions are freestanding psychiatric facilities, which are reimbursed using prospective per diem rates, and state-owned teaching hospitals, which are reimbursed on a cost basis.

Texas Medicaid uses the All Patient Refined Diagnosis Related Group (APR-DRG) structure whereby each hospital discharge is assigned to one of approximately 1,200 APR-DRG classifications based on the principal and secondary diagnoses and procedures entered by the hospital on its billed claims. Each APR-DRG is assigned a relative weight intended to reflect the average cost of discharges assigned to that APR-DRG relative to the average cost of all discharges. The APR-DRG relative weight is multiplied by the sum of the hospital's Standard Dollar Amount (SDA) and its hospital-specific add-ons to derive the base claim payment. SDAs are established separately for urban hospitals, children's hospitals and rural hospitals. Urban and children's hospitals SDAs are uniform by class of hospital while rural hospital SDAs are hospital-specific within a ceiling and floor. Additional payments referred to as outlier payments may be made for children's cases meeting high cost or high length of stay thresholds.

Texas Medicaid rate-setting policy for urban hospitals includes several add-ons intended to recognize the impact that differences in location, patient population and services have on the cost of care. The following add-ons are part of the rate development for urban hospitals:

- Geographic wage add-on, to recognize differences in average wages across each of Texas' urban locations. This add-on ranges from $22 to $531 per discharge in SFY 2016.
- Medical education add-on, to recognize the additional costs associated with hosting graduate medical education programs and the higher average severity of patients typically treated at teaching hospitals. The medical education add-on is as large as $930 per discharge in SFY 2016.
- Trauma add-on, to provide additional payment for hospitals designated by the Texas Department of State Health Services as trauma facilities. This add-on ranges from $59 to $847 per discharge depending on the specific designation of the hospital.
- Safety net add-on, included for hospitals that share a primary burden for operating the Texas hospital safety net, ranging from $197 to $363 per discharge in SFY 2016.

Each urban hospital's rate starts with a state-wide urban SDA totaling $3,133 per discharge in SFY 2016. After incorporating the add-ons for which the hospital is eligible, the final rate may increase significantly.

The SDAs for children's hospitals are established in a similar manner to urban hospitals, except that the SDA is derived from the average cost of children's hospitals and the trauma add-on does not apply since all children's hospitals are trauma designated and the cost of trauma is included in the base SDA. Children's hospital SDAs plus add-ons range from $11,185 to $12,774 per

discharge in SFY 2016. The hospital-specific SDAs for rural hospitals are based on each hospital's own costs, subject to a floor and a ceiling. Rural hospital SDAs range from $4,533 to $12,968 per discharge in SFY 2016 and are not eligible for add-ons.

Outpatient

Most outpatient services are reimbursed a percentage of cost, established by multiplying billed charges by an average cost-to-charge ratio and the applicable percentage of cost. Rural hospitals are reimbursed at 100 percent of cost and urban, children's and state-owned hospitals are reimbursed at rates ranging between 68 percent of cost and 76 percent of cost.

Exceptions to the percentage of cost model: hospital imaging, outpatient surgery and clinical laboratory. These services are reimbursed using HHSC-established fee schedules. There is also a provision to reduce payments for emergency room services that do not meet criteria as emergencies.

Recent Rate History

For the biennial periods SFY 2004-SFY 2005 through SFY 2014-SFY 2015, hospitals did not receive any increases in inpatient or outpatient rates, except for budget neutral adjustments as part of the state's transition from hospital-specific SDAs to statewide SDAs with add-ons, and in a number of years the state budget required permanent or temporary rate decreases. For the SFY 2016-SFY 2017 biennium both inpatient and outpatient rate increases were funded by the state legislature. The following chart summarizes hospital rate changes at a high level from SFY 2004-SFY 2017 for each biennial period:

Table 1: Hospital Rate Changes, SFY 2004 - SFY 2017

State Fiscal Biennium	2004-2005	2006-2007	2008-2009	2010-2011	2012-2013	2014-2015	2016-2017
Inpatient Hospital Rate Changes	7.5% decrease	none	none	2% decrease	8% decrease	none	8.8% increase
Outpatient Hospital Rate Changes	2.5% decrease	none	2.5%[11] increase	2% decrease	8% decrease	4% decrease	1.8% increase

The SFY 2016-SFY 2017 rate adjustments are estimated to generate inpatient and outpatient hospital payment increases of $314 million per year and $28 million per year, respectively.

According to HHSC officials, total Medicaid expenditures for hospitals increased in each of the above biennial periods due to increases in caseload and case mix, even in periods when hospital rates decreased.

Managed Care

As noted above the large majority of Texas Medicaid beneficiaries are in one of several managed care programs. HHSC contracts with managed care organizations (MCOs), who are paid a monthly premium to coordinate and provide all covered medically necessary services to their

[11] Restoration of SFY 2004-SFY 2005 2.5% decrease.

members, as well as mental health targeted case management and mental health rehabilitative services.

MCO Hospital Reimbursement

Pursuant to applicable federal law,[12] the Texas Administrative code,[13] and the Uniform Managed Care Contract for Medicaid and CHIP, [14] MCOs are paid an actuarially sound capitation rate for each enrollee. All MCOs start with the same overall average community rate, with adjustments made to the community rate to reflect each's MCO's acuity level for its panel of members. Rates are established for each managed care program, type of service (acute care, long-term care, and pharmacy), geographical service area, and risk group (e.g., Pregnant Women, TANF adults, Children's age-groups, and Dual Eligible Individuals).

Rates are developed based on historical encounter data and other supplemental data trended forward based on historical claim patterns and known and expected changes in average per member cost. Adjustments are made to rates to reflect changes in policy, changes in Medicaid fee schedule rates, cost containment initiatives and other factors consistent with actuarial standards.

HHSC does not require MCOs to utilize specific payment methodologies for hospitals, nor does it establish payment floors or other payment guidelines. The uniform contract does include a provision requiring MCOs to "develop and submit to HHSC a written plan for expansion of value-based contracting with its physician and non-physician providers that encourages innovation and collaboration, and increases quality and efficiency." MCOs are not required, however, to move a specified amount of payments into value-based methodologies under the contract but are required to demonstrate a "measurable increase in the percent of business (providers, dollars, or other) being incentivized from the previous year." Anecdotal information and discussions with HHSC contract management staff indicates that MCOs by and large utilize the fee-for-service reimbursement structure for the majority of hospital payments.

In FY 2013, participating hospitals received approximately $3.1 billion in Medicaid managed care payments on just under $5.0 billion in Medicaid costs. MCO enrollment has increased since FY 2013 as a result of extending managed care coverage to more areas of the state and more beneficiaries.

Quality-based Incentive Program for Safety-Net Hospitals

Utilizing data from HHSC's existing potentially preventable readmission (PPR) and complications (PPC) programs the state has created a $15 million incentive program to reward safety net hospitals for improvements in care. Whereas the existing PPR and PPC programs penalize hospitals for high rates of PPR and PPC, the new program rewards safety net hospital

[12] 42 CFR 438.6(c).
[13] 1 Tex. Admin. Code §355.8361
[14] Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions, Version 2.17.

performance on either of these metrics that is significantly lower than the statewide average and as long as the hospital had no penalties for either metric relative to the overall group's performance. There is a base payment level as well as a variable component that is scaled based on hospitals' relative performance and volume. This innovative plan just began in SFY 2016 and therefore no payment detail is available yet.

Base Payment Summary

The following chart shows the base payments to all hospitals participating in the Texas Medicaid program for FY 2013, the latest year for which all of the relevant data is available.

Table 2: FY 2013 Base Medicaid FFS and MCO Payments

in 000s	Inpatient	Outpatient	Not Identified	Total
Fee for service payments	$1,430,955	$311,270	$778	$1,743,002
Managed Care encounter payments	$1,997,787	$1,143,194	$2,325	$3,143,306
Combined - base payments from MMIS	***$3,428,742***	***$1,454,464***	***$3,102***	***$4,886,308***
Adjustments reported by hospitals (see table 12)				$405,598
Cost report settlements (see table 12)				($43,752)
Total - hospitals in DSH/UC program[15]				***$5,248,154***
Non-participating hospitals				$140,376
Total base payments - all hospitals				***$5,388,530***

Supplemental Payments

Graduate Medical Education

Graduate Medical Education (GME) payments are permitted but not required under federal Medicaid regulations. GME is one of the few exceptions to the general rule that prohibits states from directly paying providers for managed care services; this exception affords states that have large managed care programs the ability to participate in funding GME.[16]

Texas Medicaid has a relatively modest program for funding GME direct costs; approximately $31 million per year is paid to eligible hospitals, and eligibility is limited to state-owned teaching hospitals. As noted in the fee-for-service reimbursement section above, there is a substantial medical education adjustment included in the inpatient SDA for teaching hospitals. Also, the fact that outpatient reimbursement is partially cost-based results in partial recognition of the higher costs borne by teaching hospitals.

Total direct GME costs for Texas hospitals (as reported in FY 2014-FY 2015 Medicare cost reports) was $680 million and the portion allocable to the Medicaid program is approximately $90 million.

[15] All hospitals that supplied HHSC with data to be used in the DSH and UC Pool programs are referred to as hospitals participating in the UC program or participating hospitals in the table above and elsewhere in this report.
[16] 42 CFR 438.60

Disproportionate Share Hospital Payments

Federal Requirements

Disproportionate Share Hospital (DSH) payments are required under federal Medicaid regulations and must be made to hospitals serving a significant level of Medicaid and uninsured patients. Beginning in FY 1993, legislation was enacted requiring the Secretary of Health and Human Services to publish state DSH allotments limiting the federal match available to each state for each federal fiscal year.[17] These allotments are recalculated annually and published in the *Federal Register*. As a result of this legislation, although DSH payments at the state level must be targeted to hospitals serving a high proportion of the Medicaid and low income population, the relative size of current state allotments can generally be traced back to 1992 DSH spending, rather than the distribution of low income hospital utilization nationwide, giving states that had the highest DSH spending in 1992 the largest allotments today.

Under a provision of the ACA[18], DSH allotments were originally scheduled for reductions starting in FY 2014 in anticipation of declines in uncompensated care due to an increase in the number of individuals covered by insurance and Medicaid; however, through several pieces of legislation, these reductions have been delayed. The most recent legislation, the Medicare Access and CHIP Reauthorization Act of 2015, delays the implementation of the cuts to FY 2018 and extends them to FY 2025.[19]

In addition to aggregate limits on federal funding for DSH payments, the Omnibus Budget Reconciliation Act of 1993[20] added section 1923(g) of the Social Security Act to require that states pay no more in DSH payments than 100 percent of each hospital's indigent care costs, defined as the sum of the cost of inpatient and outpatient hospital care to Medicaid enrollees and to those with no source of third party coverage less the payments made for those services. This limit is referred to in Texas as the "Hospital-Specific Limit" (HSL). States are required to reconcile DSH payments made against each hospital's limit through an annual DSH audit.[21] Beginning with the findings related to state plan rate year 2011, recoupments are required from hospitals found to have been paid in excess of their hospital-specific DSH limit.[22] To the extent authority is granted within the state plan, a state may redistribute recouped funds to other DSH eligible hospitals which received payments below their HSL.

Federal regulations also set forth minimum qualifying criteria that hospitals must meet to receive DSH payments and stipulate that hospitals meeting certain thresholds for the proportion of care provided to Medicaid and low-income patients must be automatically eligible for DSH. Like

[17] P.L. 102-234
[18] P.L. 111-148, as amended
[19] See Section VII for the projected impact of the DSH reductions on Texas hospitals.
[20] P.L. 103-66
[21] P.L. 108-173
[22] 42 CFR 455

GME, DSH payments are also exempt from the general rule prohibiting states from directly paying providers for managed care services.

State Eligibility and Distribution

Beyond the federal criteria, states are given flexibility to define Medicaid DSH eligibility and payment distributions within the Medicaid state plan that uniquely target the safety net providers in their state. The State of Texas has several criteria for establishing DSH eligibility. Generally, hospitals must have or be actively pursuing a trauma facility designation, and meet certain Medicaid and low-income utilization thresholds above the minimum federal requirements. These thresholds result in a DSH program more targeted to hospitals with the highest levels of Medicaid and low income utilization statewide. In FY 2015, 184 hospitals received Texas Medicaid DSH payments, which represent approximately 30 percent of the total hospitals in the state.

Texas expends its full DSH allotment annually with one exception. As a result of litigation surrounding the calculation of the HSLs under the DSH audits[23] and the potential corresponding redistribution ramifications, HHSC instituted an annual 3.5 percent withhold on all DSH payments to be distributed when the outcome of the litigation is known. The following chart shows the full Texas DSH allotments from FY 2012-FY 2015. These totals do not deduct the amounts withheld by HHSC.

Table 3: Recent History of DSH Allotments

in 000s	FY 2012	FY 2013	FY 2014	FY 2015
Federal	$981,193	$1,004,741	$1,019,812	$1,036,129
State	$704,126	$689,595	$717,813	$748,762
Total	***$1,685,319***	***$1,694,336***	***$1,737,625***	***$1,784,891***

Texas Medicaid DSH funds are distributed across eligible and qualifying hospitals based on the following priorities:[24]

1. **State-owned teaching hospitals, state-owned IMDs, and state chest hospitals[25] (state hospitals)**. HHSC may reimburse state-owned teaching hospitals, state-owned IMDs, and state chest hospitals an amount less than or equal to their interim hospital-specific limits, except that aggregate payments to IMDs statewide may not exceed federally mandated DSH reimbursement limits for IMDs. In FY 2015, total DSH payments for these three groups of hospitals were equal to 80 percent of their collective HSLs.
2. **Other hospitals.** HHSC distributes the remaining available DSH funds to other qualifying hospitals.

[23] Texas Children's Hospital v. Burwell, 2014 BL 364694, D.D.C., No. 1:14-cv-2060
[24] 1 Tex. Admin. Code §355.8065(g)
[25] A public health facility operated by the Department of State Health Services designated for the care and treatment of patients with tuberculosis.

In FY 2015, of the total $590 million in non-federal funds necessary to spend the $1.406 billion in remaining DSH payments[26] available for non-state-owned hospitals, $140 million was financed through general revenue funds. Those funds supported a portion of the DSH payments to all of the non-state-owned hospitals participating in the FY 2015 DSH program. The all-funds amount supported by state general revenue comprised Pool One (see discussion below). The non-federal share of the remaining DSH funding was provided by local governmental entities and comprised Pool Three. The federal matching funds associated with the non-federal funds from Pool Three comprised Pool Two. More specifically, the hospital districts in the largest metropolitan areas of the state[27] provided the non-federal share of payments to the large public hospitals in their districts and to the private hospitals throughout the state; smaller governmental entities, including hospital districts, hospital authorities, counties, and cities, provided funding for public hospitals in areas outside of the largest metropolitan areas.

In the state's 2016 budget, no general revenue funds were allocated to the DSH program. Otherwise, the funding sources for the FY 2016 DSH program year were the same as those for FY 2015.

The hospitals eligible for funding from the three pools are described below.[28]

- **Pool One** payments are available to all DSH eligible non-state-owned hospitals.
- **Pool Two** payments are available to all DSH eligible non-state-owned hospitals.
- **Pool Three** payments are available to all DSH eligible non-state-owned public hospitals.

Pools One and Two are distributed based on each hospital's proportion of total DSH days. A hospital's total DSH days are equal to the sum of weighted Medicaid inpatient days[29] and weighted low income days.[30] Pool Three payments are distributed based on the level of IGT contribution made by the governmental entity that owns or is affiliated with each public hospital. Additional adjustments are made to ensure payments to hospitals do not exceed their HSL. Any remaining allotment funds are distributed proportionally to public hospitals located in counties of 500,000 populations or fewer. The following chart shows the distribution of DSH payments by ownership class.

[26] Total includes reduction for 3.5% withhold
[27] This includes Tarrant County Hospital District, Dallas County Hospital District, Harris County Hospital District, Bexar County Hospital District, University Medical Center at Brackenridge, and University Medical Center of El Paso.
[28] 1 Tex. Admin. Code §355.8065(h)
[29] Each non-urban public hospital's weighting factor is equal to 1 + (1 - FMAP in effect for the program year) multiplied by .50 rounded to two decimal places. All other DSH hospitals have a weighting factor of 1.00.
[30] Low income days are equal to a hospital's Low Income Utilization Rate (LIUR) multiplied by the hospital's total inpatient days.

Table 4: Summary of FY 2015 DSH Payments

In 000s	Amounts
Private	$624,455
Small Public	$149,607
Large Public	$632,550
State	$315,529
Total	***$1,722,141***
Approximate Amount Withheld	***$62,471***

UC Pool Payments

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver (1115 Waiver) approved on December 12, 2011, gave the state of Texas authority to create two new funding pools. The first of these is the UC Pool.

UC Pool payments are cost-based and help offset the uncompensated costs of providing care to Medicaid and uninsured patients by hospitals and other providers. Total spending from the UC Pool is limited to annual amounts authorized in the 1115 waiver as shown in the table below.[31]

Table 5: UC Pool Size, Annual Payment Authority under 1115 Waiver

in Billions	DY1 FY 2012	DY2 FY 2013	DY3 FY 2014	DY4 FY 2015	DY5 FY 2016	*Total*
Uncompensated Care Pool	$3.70	$3.90	$3.53	$3.35	$3.10	***$17.58***

To qualify for a UC Pool payment, a provider must submit to HHSC an annual application that collects cost and payment data for services eligible for reimbursement under the pool. Initial UC Pool payments are based on cost and payment data from two years prior to the DY in which payments are made. Subsequently, HHSC collects cost and payment data to reconcile payments made in prior demonstration years to each provider's actual uncompensated costs for that year. No provider is paid in excess of estimated uncompensated care costs as demonstrated on the UC Applications, and all overpayments found at the time of reconciliation are recouped by HHSC with the federal share of the recoupments returned to CMS. Additional detail on the application and claiming protocol is discussed in Section III.

Any provider meeting all required program criteria, including the two provisions listed below, may submit a UC Application to HHSC to be eligible to receive a UC Pool payment.

1. Private providers must have an executed indigent care affiliation agreement on file with HHSC.
2. Providers must participate in a Regional Health Care Partnership under the DSRIP program (see "DSRIP Program Features" below), although exceptions may be granted.

[31] 1 Tex. Admin. Code §355.8201

HSLs under this section include offsets for DSH payments made in the applicable demonstration year. As such, the outcome of the DSH audit litigation will directly impact the distribution of the UC Pool. To mitigate any potential recoupments and redistributions as a result of the final judgment, HHSC withholds 5 percent of the UC Pool funding annually.

From the total annual authorized amount available for the UC Pool, HHSC establishes the following seven pools: a state-owned hospital pool; a large public hospital pool; a small public hospital pool; a private hospital pool; a physician group practice pool; a governmental ambulance provider pool; and a publicly owned dental provider pool. All of these pools are financed through IGTs with the exception of the ambulance provider pool which is financed through certified public expenditures (CPEs).

A set aside amount, effectively an additional pool, is determined for all hospitals meeting the state definition of "Rider 38" hospitals. The following are classified as Rider 38 hospitals under the state definition:

- Hospitals located in a county with 60,000 or fewer persons according to the most recent United States Census
- Medicare-designated Rural Referral Centers
- Sole Community Hospitals
- Critical Access Hospitals.

This set aside amount is equal to the sum of the remaining HSLs for all Rider 38 hospitals (prior to any adjustments to reflect increases or decreases in costs resulting from changes between the data year and the program year) reduced by the percentage decline in the maximum aggregate amount of UC Pool funds approved by CMS from the 2013 demonstration year to the demonstration year in question. Payments from this set aside are allocated proportionately across all Rider 38 hospitals. This set aside was put in place in recognition of the financial vulnerability of these hospitals and the critical role they play in preserving the rural safety net in Texas.

The remaining available UC funds are then distributed across the seven provider pools based on the ratio of each pool's "UC need" to the total of all pools' "UC need". UC need is defined as follows based on the providers eligible under each pool:

- State-owned hospital pool: The sum of HSLs related to physician and/or mid-level professional direct patient care costs and pharmacy costs only.
- Large public hospital pool: The sum of HSLs with an adjustment for the cost related to the IGTs provided to fund DSH payments.
- Small public hospital pool: The sum of HSLs with an adjustment for the cost related to the IGTs provided to fund DSH payments excluding the HSLs for Rider 38 hospitals.
- Private hospital pool: The sum of HSLs excluding the HSLs for Rider 38 hospitals.

- Physician group practice pool: The sum of UC costs as reported on the UC physician application for physicians and mid-level professionals.
- Governmental ambulance pool: The sum of total allowable UC costs.
- Publically-owned dental pool: The sum of total allowable UC costs (based on a cost-to-billed-charges ratio).

Payments are distributed within each pool based on each provider's allowable UC costs as a percentage of all allowable UC costs for providers in the pool. The table below shows the allocation of FY 2015 (DY 4) UC Pool payments by provider class.

Table 6: FY 2015 UC Pool Payment Summary

In 000s	UC Payments
Private Hospitals	$1,857,119
Small Public Hospitals	$189,899
Large Public Hospitals	$864,410
State Hospitals	$35,693
Total - Participating Hospitals	***$2,947,121***
Non-Hospital Providers	***$179,118***
Total All Providers	***$3,126,239***
Approximate Amount Withheld	***$167,400***

Delivery System Reform Incentive Payments

Texas' Delivery System Reform Incentive Payment Program (DSRIP) program is the largest of its kind in the country, with over 1,450 innovation projects and nearly 300 participating providers. Authorized by CMS in December 2011, the program was created to pursue larger health system and Medicaid goals for delivery system reforms that were already underway within the state.

Texas was the second approved DSRIP program following California. While the Texas initiative incorporates many of the same features as California, it clearly took a different approach to several important aspects. Unlike California, the Texas program is not limited to public hospitals but also includes private hospitals, community mental health centers, local health departments, physician practice plans affiliated with an academic health science center, and other providers specifically approved by the state and CMS. The inclusion of more provider types required a significant investment in program design and implementation, but was strongly encouraged by health care providers and stakeholders. The initiative is widely viewed as a very successful strategy for supporting healthcare transformation and innovation and received overwhelming support during public meetings held as part of the waiver extension application. As described in the waiver renewal public hearings and letters of support, benefits of the program include:

- Tangible improvements in access to both primary care and specialty care services
- Increased patient responsibility and understanding of the health care system

- Reductions in health care costs
- Reductions in avoidable ER utilization
- Earlier diagnosis and better management of chronic disease
- Increased focus on local health care challenges and cooperation among providers across all spectrums of care
- Improved social supports that contribute to better outcomes, particularly for individuals in mental health crisis.

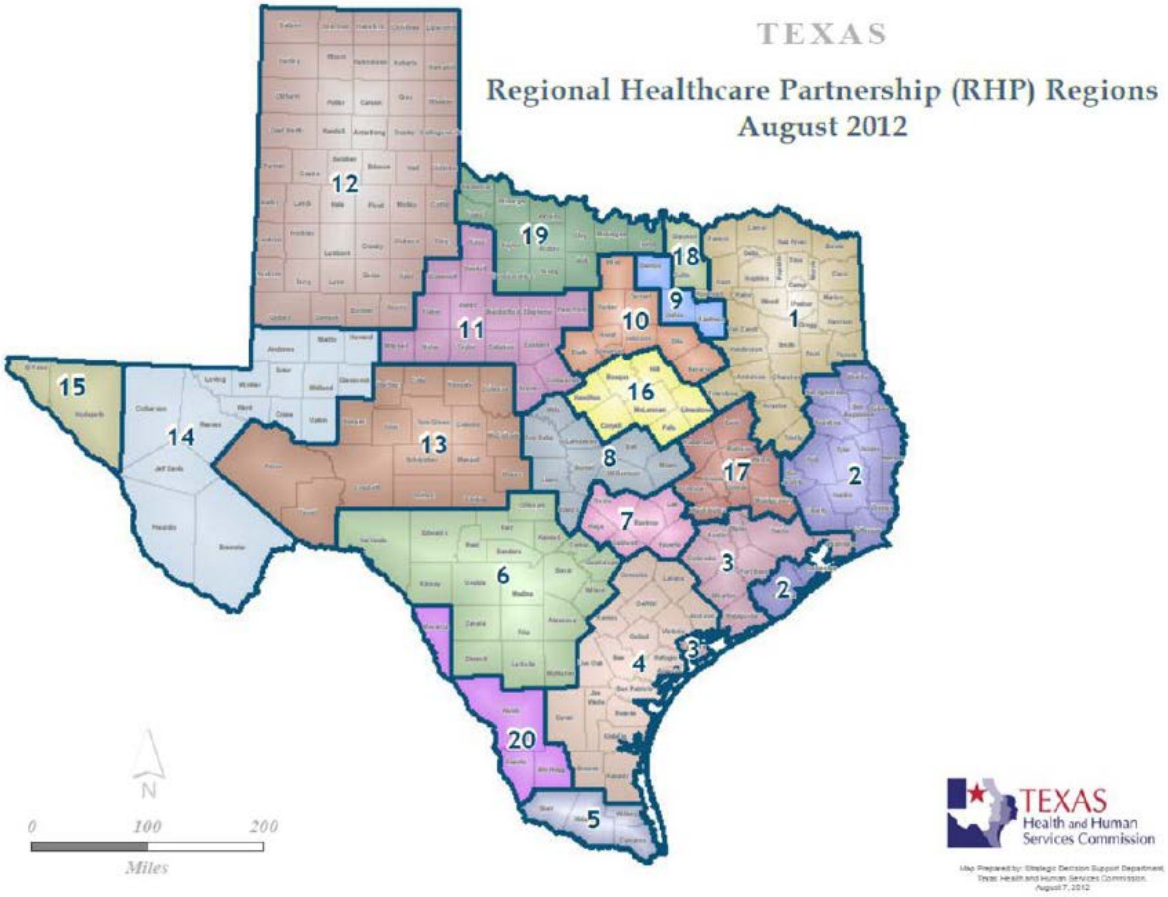
Though not without some implementation challenges, participating providers appreciate the DSRIP program for the opportunities it provides to improve health care delivery at the local level rather than a "one size fits all" statewide approach. Stakeholders repeatedly noted in their testimony and letters of support the importance of specific DSRIP projects within individual communities and the improvements in collaboration among providers the program has facilitated. Commenters almost unanimously voiced their support for continuation of the program and the healthcare improvements it has fostered.[32]

DSRIP Program Features

Texas' DSRIP program operates under a Regional Healthcare Partnership (RHP) structure that requires providers to participate in regional coalitions within specific geographic areas. The program has 20 separate RHPs (encompassing all 254 counties) which include a combination of rural and urban communities within each region and a broad mix of providers. Each RHP includes an anchoring entity that is the lead health-care provider or local governmental entity that serves as the primary liaison between the RHP and HHSC, and coordinates planning, activities, and reporting among all RHP participants. Organizations that can serve as the Anchor include public hospitals, hospital districts, a hospital authority, a county, or a State university with a health science center or medical school.

[32] Texas Health and Human Services Commission, *Texas HHSC 1115 Transformation Waiver Renewal Extension Application – Public Stakeholder Meeting Summary of Comments*, July 7-24, 2015

Figure 1: Texas Regional Healthcare Partnership Regions



In the first year of the DSRIP program, participants within each RHP worked with providers and other stakeholders to develop a regional DSRIP implementation plan that was submitted to HHSC for review and approval. The plan required each region to complete a community needs assessment (CNA) and engage stakeholders in the selection of specific projects.

Participating providers within each RHP were required to select projects from the RHP Planning Protocol, which was approved by CMS on September 26, 2012. The RHP Planning Protocol includes a menu of project areas across four related categories:

- Category 1: Infrastructure Development – Lays the foundation for the delivery system through investments in people, places, processes and technology. *Payment Basis: Pay for Performance*
- Category 2: Program Innovation and Redesign – Pilots, tests and replicates innovative care models. *Payment Basis: Pay for Performance*
- Category 3: Quality Improvements – Healthcare delivery outcomes improvement targets tied to Category 1 and 2 projects. *Payment Basis: Pay for Outcomes*
- Category 4: Population Focused Improvements – Requires all participating hospital providers to report on the same standard measures. *Payment Basis: Pay for Reporting*

Projects are targeted to include both Medicaid enrollees and low-income uninsured individuals. Providers are required to select a combination of Category 1 and 2 projects and related outcome/improvement measures and metrics included under Category 3.

DSRIP Payments to Providers

As part of the project design and RHP plan submission process, providers included a proposed total project value and scheduled performance payments across each year of the project. Once approved by HHSC and CMS, payments to providers are based on meeting the pre-selected, approved performance metrics and milestones included in the provider's project submission. In the first year of the waiver (DY1), all participating providers that submitted approved projects as part of the RHP plan were eligible for DSRIP funding.[33]

In demonstration years 2-5, providers must submit to HHSC semi-annual progress reports in a prescribed format for review, approval and payment. Payments are made based on achievement of project-specific milestones and available IGT funding. If providers do not fully achieve a milestone, they can carry forward the available funding for that specific milestone for up to one additional DY.

Category 4 payments are available to hospitals who meet reporting requirements related to the five required domains or an optional sixth domain. Payment is based solely on the reporting of required measures; hospitals are not required to achieve improvement in Category 4 to receive payment. Payment for reporting can be no more than 5 percent of the hospital's total DSRIP allocation amount in DY 2, and no more than 10 percent of their total allocation in DY 3-DY 5 at the time of RHP plan submission unless they also report on the optional Domain 6, which allows them to receive up to 15 percent of their total allocation.

Table 7: DSRIP Pool Size, Annual Payment Authority under 1115 Waiver

Annual Payment Authority in Billions	DY 1 FY 2012	DY 2 FY 2013	DY 3 FY 2014	DY 4 FY 2015	DY 5 FY 2016	*Total*
DSRIP	$0.50	$2.30	$2.67	$2.85	$3.10	***$11.42***

Special Terms and Conditions (STC) 45(e)[34] states explicitly that "DSRIP payments are not direct reimbursement for expenditures or payments for services", and as such, do not count against a hospital's HSL for DSH or UC Pool purposes.

Reporting Waiver Payments to CMS

Section 43(b) of the 2011 STCs requires Texas to inform CMS of the funding of all payments from the pools to hospitals or other providers and the funding source associated with each type of payment through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter. Section 44(c) of the modified STCs requires that the UC study address how the

[33] All 20 RHPs submitted their complete plans to HHSC by the December 31, 2012 due date.
[34] Centers for Medicare and Medicaid Services, "*Special Terms and Conditions- Texas Healthcare Transformation and Quality Improvement Program*," Document Number 11-W-00278/6. Approved October 24, 2014.

waiver payments and funding sources correspond to the CMS-64, a quarterly expenditure report that all states are required to provide to CMS under federal administrative policy.

To satisfy this requirement, HHSC prepared documents summarizing the key procedures that are followed from the receipt of IGTs prior to making payments to completion of the quarterly report on waiver payments and financing sources. HHSC's procedures also include steps to reconcile payments to the CMS-64 before it is provided to CMS. These procedures ensure that provider payments and financing sources correspond to the amounts entered into the CMS-64 submission. Based on review of the documentation provided, it appears that the procedures and quality controls are adequate to assure that reporting sources accurately reflect waiver payments and financing activity to providers.

Trends in Hospital Utilization and Reimbursement

Just fewer than 4.1 million individuals are currently enrolled in Medicaid in Texas, an increase of 14.8 percent from the pre-waiver period (SFY 2011) to the present, or approximately 2.8 percent annually. Enrollment increases were driven by enrollment growth among school-aged children and TANF adults (see Table 8 below).

Table 8: Texas Medicaid Caseloads, SFY 2011-SFY 2016

Enrollment in 000s	% of 2016 Enrollment	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2016/ SFY 2011	Ave. Annual Growth
Children 6 - 14	34%	1,046	1,095	1,108	1,171	1,360	1,372	31%	5.6%
Children 15 - 18	10%	289	303	303	324	395	405	40%	6.9%
TANF Adults	3%	79	116	122	129	147	141	79%	12.4%
All Other	53%	2,129	2,142	2,126	2,122	2,154	2,141	1%	0.1%
Total	***100%***	***3,543***	***3,656***	***3,659***	***3,746***	***4,057***	***4,059***	***15%***	***2.8%***

Source: HHSC Medicaid Caseload File (Managed Care and Fee-for-Service Average Monthly Recipient Months)

On an annualized basis, total Medicaid inpatient days declined by 0.7 percent annually between the pre-waiver period (FY 2011) and FY 2014, the most recent full year for which complete data are available, from 3,028,185 days in FY 2011 to 2,967,816 days in FY 2014. At the same time, Medicaid enrollment grew by 5.7 percent, from 3.5 million to 3.7 million, such that, on a per capita basis, inpatient utilization declined from 0.85 days/enrollee to 0.79 between FY 2011 and FY 2014. Data is not case mix adjusted and, therefore, caution should be used in drawing conclusions. However, the ratio of children to total hasn't changed materially between FY 2011 and FY 2016, indicating that changes in payment and utilization are not primarily driven by changes in caseload composition.

Between FY 2011 and FY 2014, total Medicaid base payments to hospitals, which include both payments made directly by the state under the fee-for-service program and payments made by MCOs increased by 1.2 percent, or 0.4 percent annually. Inpatient payments increased by 4.0 percent, or 1.3 percent annually, while outpatient payments decreased by 5.1 percent, or 1.7

percent annually. When payments are adjusted for overall caseload growth, however, Medicaid base payments per enrollee declined by 4.3 percent between FY 2011 and FY 2014, from $1,433 to $1,371 driven by a combination of utilization changes (see above) and changes in payment rates (see the "Base Payments" section above for additional detail on trends in Medicaid payment rates).

During the FY 2011 to FY 2015 time period, supplemental payments (including GME, UPL payments, UC payments, and DSH, and excluding DSRIP) increased by 5.7 percent, or 1.4 percent annually. DSRIP payments are not included in this comparison as they are not a supplemental payment designed to address targeted cost shortfalls. Rather, DSRIP is an incentive-based transformation program, designed to encourage providers to invest in organizational transformation efforts that will have a long-term positive impact to the health care system, but may have a short-term negative impact on the provider.

Table 9: Texas Medicaid Payments to Hospitals, FY 2011-FY 2015

in 000s	FY 2011	FY 2013	FY 2015	Percent Change FY 2011-FY 2015
Base Payments	**$5,298,290**	**$5,388,530**	**$5,227,164**	**1.5%**
UPL Payments	$3,003,320	$ -	$ -	
GME Payments	$32,789	$30,943	$30,777	
DSH Payments	$1,579,008	$1,694,904	$1,722,141	
UC Payments (1)	$ -	$3,739,696	$3,126,239	
Total Supplemental	***$ 4,615,116***	***$5,465,543***	***$4,879,157***	***5.7%***
Total Payments	***$9,913,407***	***$10,854,073***	***$10,106,320***	***1.9%***

(1) UC Payments include payments to non-hospital providers

Financing the Non-Federal Match

Texas Medicaid receives federal matching funds based on the Federal Medical Assistance Percentage (FMAP), which was 58.05 percent in FY 2015. The remaining 41.95 percent is the responsibility of the state.

Federal Medicaid permits states to obtain funds from local governments (e.g., hospital districts, counties, and cities), or from hospitals or other providers that are owned or operated by local governments, via fund transfers to the state—known as intergovernmental transfers (IGTs) that can be used to finance the nonfederal share of Medicaid payments.

Nearly all states utilize health care providers and/or local governments to finance a portion of the non-federal share of Medicaid. A General Accounting Office (GAO) study[35] found that in 2012, states financed 26 percent of the non-federal share of Medicaid expenditures with provider and local government funds. In the GAO report, Texas' use of provider and local government

[35] General Accounting Office report GAO-14-627, "States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection", dated July 2014 and reissued March 2015.

funding as a percentage of non-federal share was estimated to be well below the national average.

Prior to the 1115 waiver, Texas used IGTs to fund the non-federal share of UPL and GME payments and most of the Medicaid DSH payments. No provider or local government funding sources were used to finance the non-federal portion of base payments to hospitals. This general approach to financing the non-federal share of hospital payments has remained consistent over the last five years, whereby all base payments are financed by state general revenue and all supplemental payments except for a relatively small portion of DSH are financed by IGTs.

The following table summarizes the current source of funding for hospital payments:

Table 10: Summary of Financing Source by Payment Type

In 000s	State General Revenue	Inter-governmental transfers	Federal Matching Funds	Total Medicaid Payments (1)	IGT % of state share	IGT % of total
Base Payments (1)	$2,260,488	$0	$3,128,042	$5,388,530	0%	0%
DSH	$135,100	$587,338	$999,703	$1,722,141	81%	34%
UC (2)	$0	$1,236,317	$1,710,804	$2,947,121	100%	42%
DSRIP (3)	$0	$535,535	$741,068	$1,276,603	100%	42%
GME	$0	$12,622	$18,321	$30,943	100%	41%
Total	***$2,395,588***	***$2,371,813***	***$6,597,937***	***$11,365,338***	***50%***	***21%***

(1) Base payments include participating and non-participating hospitals from FY 2013. Supplemental payments with the exception of DSRIP are from the FY 2015 program year and reflect payments made to date.

(1) Excludes payments to non-hospital providers.

(2) DSRIP payments reflect DY 2 – FY 2013, the most complete year paid to date. Non-federal funding for DSRIP payments is matched based on the period paid, not the allocation period, and as such, payments from the DY 2 allocation reflect a composite of payments matched using FMAPs ranging from 58% to 59%. For purposes of this table, IGTs were estimated using a 58.05 percent FMAP.

The state's payment distribution policy interacts directly with the source of non-federal funding for two of the supplemental pools, DSH and GME. Under the DSH distribution policy, one of the DSH pools is equal to the sum of the IGTs made for DSH payments and is paid to hospitals that are operated by or leased by the governmental entities making the IGTs. Under the GME policy, payments are limited to state-owned teaching hospitals and inter-agency transfers are made by the agencies operating the hospitals to fund the non-federal share.

In the case of UC and DSRIP, there is no direct relationship between pool payments and the source of non-federal share. In order to participate in the supplemental payment pools hospitals are required to enter into affiliation agreements with a governmental entity responsible for making UC and DSRIP-related IGTs. The state does not prescribe the nature or terms of the affiliation agreements but does require each private hospital to submit an annual certification with the state. The certification stipulates among other things that:

- The hospital has an indigent care affiliation agreement with the governmental entity to collaborate on the funding for and provision of health care to indigent individuals in a community or region of Texas;
- No supplemental payments or other funds in consideration of supplemental payments will be returned or reimbursed to the governmental entity;
- The agreement does not condition the amount of IGT or the amount of supplemental payments to the hospital on the amount of indigent care provided by the hospital.

The STCs require that the report indicate the percentage of Medicaid payments that hospitals receive and retain. Under Texas Medicaid policy, all of the gross computable amounts (federal and non-federal shares) for all types of payment, base and supplemental, are paid to hospitals. HHSC officials represented that providers receive and retain 100 percent of the UC and DSRIP payments made under the waiver. HHSC is not aware of any agreements or arrangements under which providers return or redirect any portion of a Medicaid payment.

Although there is no direct relationship between certain supplemental payments and the IGTs made to finance the non-federal match and the IGTs cannot and should not be associated with individual hospitals, it may be appropriate to consider the IGTs in evaluating the financial impact of the UC and DSRIP programs on hospitals in the aggregate.

Section III – Measuring Uncompensated Care

In total, the cost of care to Medicaid beneficiaries typically exceeds the payments received by providers and the difference is referred to as the Medicaid Shortfall. Individual hospitals may receive payments in excess of cost; however, across all hospitals in a given state the Medicaid Shortfall is often substantial.

Uncompensated care also includes the cost of services to uninsured individuals less payments received. Because most uninsured individuals are low-income and many are living in poverty, the ability of the uninsured to pay for their care is often minimal, especially in comparison to the cost of hospital services.

The modified STCs reference Uncompensated Care as the costs associated with charity care as defined by the principles of the Healthcare Financial Management Association. As explained further below, hospitals do not report an amount that conforms to this definition. The amounts used in this report are derived from participating hospital reports and HHSC calculations. Differences between the two definitions can be explained but not readily quantified.

This section describes the components and calculations of Uncompensated Care, data sources, and methods, and summarizes the results.

HHSC Approach

UC Protocol

The majority of information used in this report was derived from an HHSC data resource that was developed pursuant to the current 1115 Waiver STCs. Attachment H to the STCs entitled "UC Claiming Protocol and Application" establishes the process for obtaining information from hospitals and calculating unreimbursed costs for Medicaid and uninsured patients. Under the UC Protocol:

- A document referred to as the Texas Hospital Uncompensated Care Tool (TXHUC) is used to capture the necessary information for each program year. HHSC annually prepares the TXHUC for each participating hospital, prepopulating the TXHUC with payment information extracted from MMIS and cost report information extracted from CMS' Hospital Cost Report Information System (HCRIS).
- The TXHUC is validated and completed by hospital participants. Hospitals provide information about uninsured charges and payments, information about certain allowable non-hospital costs, adjustments as needed to the MMIS and cost report data supplied by HHSC, and an officer certification.
- HHSC reviews the submitted TXHUC forms, performs the calculations of unreimbursed costs, and provides the results to hospitals for their review.

The process relies on two-year lagged information (e.g., FY 2013 data is used for FY 2015 program purposes). In addition to documenting and calculating the unreimbursed costs used in

the UC Pool distribution, the same tool is used to calculate estimated hospital-specific limits used for DSH purposes. The definitions of Medicaid and Uninsured unreimbursed costs are generally the same under the UC protocol and the CMS policy for Medicaid DSH.

Components - Payments and Cost

There are over 600 hospitals licensed in Texas, of which 356 participated in the Texas Medicaid DSH/UC Pool program in FY 2015 (participating hospitals). The majority of information in this report is from or related to these 356 participating hospitals, as HHSC has the TXHUC information for these hospitals only.

Of the remaining hospitals, there are 163 hospitals that had FY 2013 charges and payments recorded in MMIS. These hospitals do not participate in the DSH/UC Pool program. HHSC does not collect information from non-participating hospitals to ascertain why they elected not to participate. However, possible reasons for non-participation include the following: (1) Eligibility – there may be hospitals that do not meet the conditions for participation as summarized in Section II of this report. (2) Small amounts of uncompensated care – 60 of the non-participating hospitals have less than $100,000 of estimated uncompensated care cost and would not qualify for a significant UC payment. (3) Awareness – although all hospitals participating in Medicaid receive communications about the annual application process, it is possible that some are not aware of their potential eligibility for UC payment.

Although the 163 non-participating hospitals represent a large percentage of Texas hospitals by number, the participating hospitals account for more than 98 percent of Medicaid payments and over 97 percent of Medicaid and uninsured cost.

The FY 2013 cost reports were obtained for the 163 non-participating hospitals to derive overall ratios of cost to charges, which were utilized to estimate Medicaid cost, and the hospital's form S-10 was used where applicable to estimate uninsured cost. The resulting information was incorporated into the aggregate calculation of uncompensated care, in order to provide a more complete picture for Texas hospitals.

The TXHUC database was used by HHSC officials to determine the FY 2013 (base period) payments and cost for each component of Medicaid and Uninsured activity for participating hospitals. A summary of information and a brief description of each component follow:

Table 11: Summary of FY 2013 Base Payments and Costs

In 000s	Payments	Cost	Difference
Medicaid FFS	$1,857,195	$2,792,366	($935,172)
Medicaid MCO	$3,390,959	$4,958,271	($1,567,312)
Total, Medicaid Primary	***$5,248,154***	***$7,750,637***	***($2,502,483)***
All Medicaid Dual-Eligible	$2,361,850	$2,561,204	($199,354)
Out of State Medicaid	$158,212	$335,264	($177,053)
Total Medicaid and Medicaid-related	***$7,768,216***	***$10,647,105***	***($2,878,889)***
Uninsured	$385,907	$5,247,934	($4,862,028)
Total, participating hospitals	***$8,154,122***	***$15,895,040***	***($7,740,917)***
Non-participating hospitals, Medicaid	$140,376	$189,582	($49,206)
Non-participating hospitals, Uninsured	$0	$195,131	($195,131)
Grand Total (excluding supplemental pool payments)	***$8,294,498***	***$16,279,753***	***($7,985,254)***

Table 12: Uncompensated Care Component Descriptions

Component	Description
Medicaid FFS	Activity for Medicaid beneficiaries not enrolled in managed care. Payments are made by the state; costs are estimated using the TXHUC methodology described below.
Medicaid MCO	Activity for Medicaid beneficiaries enrolled in managed care. Payments are made by the MCOs and reported to the state as encounter data; costs are estimated using the TXHUC methodology described below.
Medicaid-related Payment Adjustments	Hospitals are provided an opportunity to review the data extracted from MMIS and submit proposed corrections which are then reviewed by HHSC staff for validity. The total validated FY 2013 amount for this category was a $406 million net increase in payments and is allocated to FFS and MCO payments in the table above.
Cost Report Settlement Adjustment	Certain components of Texas Medicaid reimbursement are subject to retrospective settlement. HHSC includes the settlements as a separate component of FFS payment, which in the aggregate was a $43 million payment reduction for FY 2013.
Adjustments to cost after the base year	From time to time hospitals experience unusual cost changes that were not incurred in the base year. Texas policy, STC 44 and the UC protocol allow hospitals to request additions to total cost for such circumstances. Each request must be adequately documented and is subject to HHSC review and approval. The total FY 2013 cost increase for this category was $250 million and is allocated to FFS, MCO and uninsured costs in the table above.
Unreimbursed physician and pharmacy costs	Texas policy, STC 44 and the UC protocol allow hospitals to request additions to total cost for certain items excluded from reimbursable cost in the Medicare cost report: (1) the direct patient care component of physician and mid-level provider compensation (less revenue collected for their services), and (2) pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program. The total FY 2013 cost increase for this category was $616 million and is allocated to FFS, MCO and uninsured costs in the table above.
Medicare/Medicaid Dual-Eligible	Many low-income seniors are dually-eligible for Medicare and Medicaid. In most cases, Medicare is the primary payer for hospital services and the majority of payment is from Medicare. Cost and revenue from dual-eligible beneficiaries is included in the state's UC calculations, consistent with CMS policy for Medicaid DSH; however, the requirement to include Medicare revenue in the calculation of the HSL is currently under litigation and if successful, the exclusion of the revenue would lead to higher UC costs moving forward.

Component	Description
Out of State Medicaid	When hospitals provide services to Medicaid-covered residents from other states, the hospital bills and collects from the other state's Medicaid program. Cost and revenue from non-Texas Medicaid beneficiaries is included in the state's UC calculations, consistent with CMS policy for Medicaid DSH.
Other Dual Eligible	Medicaid enrollees may have other insurance coverage (such as auto insurance medical coverage). Costs not billed for Medicaid eligible beneficiaries where Medicaid is the secondary payer are included. Payment from other insurance is included in the state's UC calculations, consistent with CMS policy for Medicaid DSH; however, this requirement is also under litigation and if successful, the exclusion of the revenue would lead to higher UC costs moving forward.
Uninsured	Hospitals report uninsured charges and payments in the TXHUC tool following definitions of uninsured services that are consistent with CMS policy for Medicaid DSH. Uninsured charges are converted to estimated cost using the TXHUC methodology.

Each of the components was evaluated and each is reasonable and appropriate to include in the calculation of uncompensated care. Each component is consistent with analogous calculations under Medicaid DSH policy and has been approved by CMS via its approval of the UC Protocol.

Non-hospital Participants

While the vast majority of payments under the UC Pool are for participating hospitals, approximately 6 percent of payments go to qualifying non-hospital participants, which include public dental, physician group and ambulance providers.

Table 13: FY 2015 UC Pool, Non-Hospital Providers

In 000s	Number of Participants	Uncompensated Care	UC Pool Payment Amount
Ambulance	46	$266,106	$69,623
Dental	1	$28	$28
Physician Group Practice	15	$153,784	$109,467
Non-Hospital Providers	***62***	***$419,918***	***$179,118***
Hospitals	356	$7,985,254	$2,947,121
Total All Providers	***418***	***$8,405,172***	***$3,126,239***

Prior to late 2011, Texas had several UPL programs authorized under its Medicaid state plan, including public and private hospitals, public physician groups, and public dental groups. When CMS approved the state's five year 1115 demonstration waiver, these historic UPL programs were combined with managed care savings to create two funding pools – a UC Pool and a DSRIP pool. Any public physician group, dental or ambulance provider can participate in the UC Pool program as long as they meet eligibility requirements below and file the required cost report and additional documentation with the state.

- **Physician Group Practices** -Participation in the UC Pool is limited to physician group practices that are enrolled in Texas Medicaid, have a source of IGT funds, and have submitted a complete UC application. In addition, the physician group must have either

participated in the former physician UPL program or be a successor in a contract to a physician group that participated in the former physician UPL program.[36]

- **Governmental ambulance providers** – Providers are eligible to participate if their allowable costs exceed the fee-for-service, managed care and uninsured payments received during the same period. Eligible providers may receive UC payments up to reconciled costs with the submission of an annual cost report.[37]
- **Governmental dental providers** – Providers are eligible to participate if their allowable costs exceed the fee-for-service, managed care and uninsured payments received during the same period. Eligible providers may receive UC payments up to reconciled costs with the submission of an annual cost report.[38]

Review of TXHUC Tool

Although the scope of this study does not include verification of data or other audit procedures, limited review procedures and validation work were performed in order to gain an adequate understanding of the calculations underlying HHSC processes and results.

As part of the review, the cost calculations were evaluated for reasonableness. HHSC generally follows Medicare cost reimbursement principles and processes. Costs are accumulated by cost center and divided by patient days (routine centers) or total charges (ancillary and other cost centers) to derive per diem costs and cost to charge ratios. HHSC does not allocate program patient days and ancillary/other charges by cost center using revenue code mapping, as is required in the Medicare cost report. Instead, program patient days are allocated by cost center using the same ratio of cost center to total patient days. Inpatient ancillary and outpatient program charges are allocated by cost center using the same spread as total inpatient ancillary and outpatient charges. The HHSC costing model has more specificity than models that estimate costs using an aggregate cost to charge ratio (e.g., the costing approach utilized on Worksheet S-10 of the Medicare cost report) and, therefore, should be more precise than such models. Although the HHSC costing model does not use revenue code mapping, such mapping is utilized in the DSH audit process.

A sample of ten hospitals was selected for a more detailed review of the TXHUC hospital submission and HHSC detailed calculations. Information from the HHSC payment and cost summaries was compared to the TXHUC files and Medicaid charges were compared to a report from MMIS. The compilation of each component of unreimbursed Medicaid and uninsured cost was tested for this sample of ten hospitals as well. Based on these limited procedures, no errors or exceptions were noted.

Based on the limited review and validation procedures performed, the cost and payment data provided by HHSC was deemed reliable for purposes of the study.

[36] 1 TAC §355.8202(c)
[37] 1 TAC §355.8081 and 1 TAC §355.8600
[38] 1 TAC §355.8085 and 1 TAC §355.8441

Defining and Estimating Uncompensated Care

Uncompensated care is based on the cost of all services to Medicaid and uninsured patients, and in some instances patients with insurance who for various reasons are not covered for medically necessary services, less payments received from uninsured patients and from state and federal indigent care grants. The unreimbursed cost of Medicaid and uninsured patients is a reasonable and appropriate basis for determining uncompensated care, and Texas' policy is consistent with the Medicaid DSH program.

The modified STCs call for an alternative calculation of uncompensated care, defining uncompensated care costs "as those associated with charity care as defined by the principles of the Healthcare Financial Management Association, and not including bad debt or Medicaid shortfall".

The following pages provide an analysis of care to the uninsured, in total along with an estimate of the charity care portion of uninsured care.

Sources of Uncompensated Care Data

Three sources of hospital uninsured data were identified.

First, the TXHUC tool described above captures charges for services to uninsured patients consistent with the UC protocol, an estimate of the cost of these services, and payments from the uninsured and from state and federal indigent care grants.

A second possible source of information about uninsured care is Worksheet S-10 of the CMS 2552-10 (Medicare cost report). The S-10 includes charity care and bad debt charges reported by the hospital and a calculation of charity and bad debt cost. The S-10 worksheet is not required for children's hospitals and certain specialty providers. In FY 2013, 318 of the 356 hospitals participating in Texas' UC program completed the S-10 worksheet.

Third, most Texas hospitals are required under state statute[39] to report financial and utilization data annually, including charity care and bad debt charges. Section 311.031 of the code includes a definition of charity care:

> "Charity care" means the unreimbursed cost to a hospital of:
> a) providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as "financially indigent" or "medically indigent"; and/or
> b) providing, funding, or otherwise financially supporting health care services provided to financially indigent persons through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

[39] Texas Health and Safety Code, Chapter 311, Subchapter C. "Hospitals Data Reporting and Collection System"

The Texas Department of State Health Services (DSHS) publishes an annual report on hospital charity care and other data, although the last report that includes charity care and bad debt charges was published in December 2013 and includes 2012 data.[40]

A comparison of charity care and bad debt charges and cost (where applicable) follows:

Table 14: Charity Care and Bad Debt Information from Different Sources

in 000s	TXHUC Tool (2013)	S-10 Data (2013)	DSHS Report (2012)
Number of hospitals	356	318	536
Charity care charges	$10,147,820	$10,596,581	$13,545,357
Bad debt charges (1)	$11,903,639	$5,957,170	$8,697,790
Total uninsured charges	***$22,051,458***	***$16,553,751***	***$22,243,147***
Charity to uninsured percentage	***46%***	***64%***	***61%***
Average cost to charge ratio	0.2205	0.2311	n/a
Estimated cost of uninsured care	$4,861,318	$3,825,572	
Unreimbursed physician and pharmacy cost	$291,247	n/a	
Adjustments to cost	$95,369	n/a	
Total Uninsured Cost	***$5,247,934***	***$3,825,572***	

(1) Bad debt charges in the TXHUC tool and the DSHS Report are derived from uninsured services only; the S-10 does not separate uninsured from insured bad debts and the amount in this table includes both.

The TXHUC data is more reliable and accurate than the S-10 data for several reasons.

First, hospitals have strong incentives to report all care to uninsured patients in the TXHUC tool, because the data collected in the tool has a direct bearing on the amount of DSH and UC Pool payments that hospitals receive. In contrast, the S-10 has heretofore not been used directly or indirectly in any Medicare or Medicaid reimbursement calculations.

Second, the TXHUC data is carefully reviewed by HHSC and is subject to an intensive audit as required under Medicaid DSH regulations. In contrast, the S-10 has typically received little to no attention in the Medicare cost report audits.

Third, the S-10 data is more prone to inaccurate reporting because of misunderstandings about the instructions.[41] For example, many hospitals offer significant discounts to patients under their financial assistance policies. Although discounts given may be included for patients meeting the hospital's charity care policy, the worksheet S-10 instructions include the following statement: "*Uncompensated care does not include courtesy allowances or discounts given to patients."* This sentence has been construed by many hospitals to prohibit inclusion of all discounts to uninsured

[40] Report titled "Charity Care Charges and Selected Financial Data for Texas Acute Care Hospitals by County, 2012" from the Texas Department of State Health Services
[41] Provider Reimbursement Manual, Part 2, Provider Cost Reporting Forms and Instructions, Section 4012

patients. In addition, the definitions do not provide for circumstances where the provider is unable to make a determination of ability to pay and hospitals may exclude unreimbursed accounts from patients where no determination of ability to pay is made.

The S-10 is intended to capture charity care and bad debt information for both insured and uninsured patient populations while the TXHUC tool captures uninsured amounts only. Therefore, the S-10 total should be larger than the TXHUC total. However, after removing the 38 hospitals from the TXHUC data that did not complete the S-10 in FY 2013, the S-10 total charges are $3.9 billion less than the TXHUC total.

A small sample of hospitals with large differences was selected, and these hospitals were asked to explain the differences between their S-10 charity and bad debt charges and their TXHUC uninsured charges. Each of the responses noted an underreporting of charges in the S-10. For several of the hospitals, most of the difference is attributed to patient discounts. Under these hospitals' financial assistance policies, the prevalent method of financial assistance is to provide large discounts rather than 100% free care. The instructions to the Form S-10 state that discounts should not be included in charity care. As such, despite giving patient discounts as a form of financial assistance, these hospitals did not include their charity care discounts in the S-10 because of their interpretation of the instructions. In other instances, the hospitals incorrectly reported charity cost on the S-10 instead of charges.

The findings from this sample of discrepancies underscore the concerns about misunderstanding the instructions and underreporting uncompensated care in the S-10 form.

Finally, CMS' own analysis recently led to the conclusion that the S-10 form is not reliable for reimbursement policy. In connection with its annual rulemaking for Medicare inpatient hospital payments,[42] CMS proposed using data in the S-10 in the allocation of Medicare uncompensated care funds. The large majority of public comments on this proposal expressed concerns about the accuracy and consistency of the data reported in the S-10. In the final rule, CMS acknowledged the overwhelming number of concerns about S-10 reliability and accuracy, concluding that additional quality control and data improvement measures are needed.

Once the uninsured charges have been determined, the next step is to estimate the cost. The TXHUC tool includes a calculation of uninsured cost, using Medicare cost report principles as discussed above. The TXHUC tool also incorporates the unreimbursed cost of hospital-based physicians and mid-level providers, participation in the Texas Vendor Drug program, and applicable adjustments to hospital expenses since the base year.

There is also a cost to charge ratio in the S-10 form that is used to convert charity care and bad debt charges to cost. However, the S-10 cost to charge ratio is less appropriate because it

[42] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Notice of Proposed Rulemaking dated April 27, 2016 and Final Rule dated August 2, 2016

excludes GME costs and the S-10 utilizes an all-payer cost to charge ratio whereas the TXHUC ratio is specifically developed for Medicaid and uninsured charges. Accordingly, the cost to charge ratio in the TXHUC tool is the best option for estimating uninsured cost.

Estimating the Charity Care Component of Uncompensated Care

The Healthcare Financial Management Association (HFMA) principles cited in the STCs refer to a document published in December 2012 by the Principles and Practice Board of HFMA entitled "Statement 15, Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers" (referred to as "P&P Statement 15" hereinafter). P&P Statement 15 is intended to provide guidance to hospitals and other healthcare facilities to identify and distinguish between charity care and bad debt, and to provide practical implementation guidance on recordkeeping, accounting valuation, and financial reporting and disclosure requirements for each.

P&P Statement 15 does not offer concise definitions of charity care. Instead, the Statement offers a set of considerations and examples for identifying charity care. A summary of the document's key points is as follows:

- Charity care is defined by each organization's financial assistance policy. Except in states that have established uniform criteria and mandatory reporting, each organization must establish its own policy. There is no general rule of thumb for defining charity care – each organization should tailor its policy to meet its own circumstances. There are several factors that may influence an organization's policy such as access to philanthropic or local tax revenues, whether a provider is located in a wealthy or low-income area, and specialized services offered.
- Charity care is based on a determination that a patient does not have the ability to pay. Patient or household income is a commonly used factor in determining ability to pay, but other factors may be applicable such as assets available to the patient or employment status. Also, some organizations have different criteria depending on the size of the bill.
- For a service to be considered charity care, the provider should make no further attempt to collect from the patient once the charity care determination is made. Ideally, determinations are made at the time of service although often this is not possible. Under P&P Statement 15, a charity care determination can be made any time during the revenue cycle. For example, an account may be referred to a collection agency when information about the patient's ability to pay first comes to light.

P&P Statement 15 provides minimal information about recognizing bad debt, but there is a concise and seemingly straightforward definition: bad debts result when a patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim.

As discussed above, three possible sources of uninsured charges were identified and each source includes a breakdown of charity care and bad debt charges. The TXHUC tool seems to be an excellent source for the total uninsured charges, as there is very strong incentive under the DSH and UC Pool programs to report the total accurately as payments are driven by this reporting and all reporting is audited and reconciled by HHSC. However, there is no requirement to consistently break out the charity care component of uninsured charges in the TXHUC tool as this subcomponent is not separately used in either the DSH or UC Pool calculations. The S-10 data, as noted above, is prone to misinterpretation and underreporting and is not used by all hospitals. The data in the DSHS report appears to be the most appropriate of the three sources for segregating charity care from bad debt charges because accurate reporting of charity care is required by statute and it has the highest participation rate.

However, there is one major concern: Charity care is typically recorded when a strict set of conditions are met, and bad debt is used as the default for other unreimbursed patient charges. In fact, a large component of bad debt may meet the requirements for charity care in substance. There are many reasons why a patient account may be classified as bad debt, even if the patient had no ability to pay, which may be generalized as follows:

- Frequently the hospital is unable to determine ability to pay. Many services to the uninsured are performed on an emergency basis and there is not an opportunity for in-depth financial counseling work. Follow-up efforts with the patient after discharge may not be sufficient to collect the information required for the hospital's ability-to-pay assessment.
- A patient may not meet the income or assets tests to qualify for charity care at time of service, but subsequent changes in the patient's financial condition may occur including medical hardship resulting from the cost of hospital services.
- Lack of cooperation or compliance by the patient is common. Often hospital financial assistance policies require the patient to supply verifications for income or assets claimed on the charity care application. Another common provision is that patients potentially eligible for Medicaid or other third party coverage must apply for such coverage before being granted charity care. If the patient does not follow through with the hospital requirements, the policy may not allow the hospital to record the account as charity care.

The HFMA principles recognize these challenges and contemplate this broader set of circumstances where charity care may be applicable. However, as a practical matter, there are many situations when requirements under the hospital's charity care policy are not met and the hospital is not permitted to assume charity care would have been appropriate.

In a recently issued study on uncompensated care for the California Medicaid program[43] the problem with differentiating between charity care and bad debt was addressed. In this study, 21 designated public hospitals were surveyed and asked to provide a breakdown of their uninsured costs between charity care and bad debt, using an expanded definition of charity care that was intended to reflect the principles articulated by HFMA. This concept was referred to as "imputed charity" care and is defined below:

> **Self-pay (imputed charity)** includes individuals who either (i) were not originally classified as charity or low-income because they never completed a charity assessment but were means-tested at a different service date or (ii) are likely to be low-income based on information from other data sources such as income analysis by zip code or demographic, other available county data, etc. This methodology is consistent with how non-profit hospitals report bad debt in Schedule H of IRS Form 990, which allows hospitals to estimate and provide reasonable methodologies for the amount of bad debt attributable to low-income populations though sampling or some other means.

Using this survey, the California study concluded that 49.7 percent of reported bad debt expense met this more expansive definition of charity care. It would not be practical to conduct a similar survey for all hospitals in Texas, but the California result may be relevant.

Cost of Charity Care and Bad Debt

Taking into account the considerations noted above, an estimate of charity care and bad debt cost follows:

Table 15: Estimated Charity Care and Bad Debt Cost

Dollars in 000s	Charity Care	Bad Debt	Total
Total uninsured charges from TXHUC reports, allocated based on DSHS charity and bad debt charges	$13,428,625	$8,622,833	$22,051,458
Reallocated 49.7% of bad debt to charity (imputed charity care)	$4,285,548	($4,285,548)	
Total uninsured charges, after reallocation	$17,714,173	$4,337,285	$22,051,458
Cost to charge ratio from TXHUC data	0.2205	0.2205	
Estimated charity care and bad debt cost before adjustments	***$3,905,975***	***$956,371***	***$4,861,318***
Adjustments to cost from TXHUC data	$310,639	$75,978	$386,617
Estimated charity care and bad debt cost	***$4,216,614***	***$1,032,349***	***$5,247,935***

Reasonable Definition of Uncompensated Care

Regardless of the method used to estimate the charity care component of uninsured cost, it would not be reasonable or appropriate to exclude bad debt. Whether it represents bad debt in the narrow sense (an unwillingness of a patient to pay his or her bills) or in a broader sense (the

[43] Evaluation of Uncompensated Care Financing for California Designated Public Hospitals, dated May 15, 2016, California Department of Health Care Services on behalf of Blue Shield of California Foundation

default category when charity care guidelines are not met), federal and state policies have consistently used all unreimbursed uninsured cost in calculations of uncompensated care. Most of the uninsured persons in Texas are low-income. Given that hospitals collected less than 2 percent of uninsured charges in FY 2013 ($385 million in payments compared to $20 billion in charges), it can be reasonably assumed that a very large percentage of unreimbursed care to the uninsured is for persons with limited or no ability to pay. Accordingly, the entire estimate of uninsured cost less payments should be utilized for the purpose of determining uncompensated care.

Section IV – Adequacy of Medicaid Reimbursement and Access for Low Income Populations

As over half of US hospital care is provided to individuals covered by Medicare and Medicaid, federal and state governments have an enormously important responsibility to ensure that provider payments are adequate. Unlike most other industries where the supplier has an opportunity to accept, reject or negotiate a price offer from the purchaser, in the case of Medicare and Medicaid the price is largely dictated by the government. Reimbursement from all sources must cover the operating costs of efficiently-run providers in order to ensure high-quality care and sufficient access to services.

This section examines the adequacy of Texas Medicaid payments to hospitals. The primary measure of payment adequacy used in this report is a comparison of payment to cost. The percentage of payment to cost is calculated under various views:

- Using Medicaid base payments only.
- Including Medicaid supplemental payments (GME, DSH, UC and DSRIP).
- Offsetting IGT costs applicable to public hospitals.

These percentages are first presented in the aggregate for all hospitals participating in the state's UC Pool program, followed by a series of analyses that divide hospitals into peer groups based on selected hospital characteristics. Ownership status, type of hospital, setting, and teaching status are the groupings selected. Finally, the hospitals are disaggregated into tiers based on differences in the amount of Medicaid and uninsured patient care.

For additional information on the relative importance of UC Pool funding, payments from the UC Pool are compared to hospitals' total revenue and net income.

Trending to FY 2015

The latest available data for base payments and costs is from FY 2013, while supplemental payment information is available for FY 2015 as discussed in Section II. The first step in the analysis is to trend the FY 2013 data forward to FY 2015, using estimates of the rate of payment and cost increase.

Costs are inflated using the CMS Hospital Market Basket, an index developed by CMS to be used in payment model updates and cost limit calculations.[44] The market basket index is a measure of changes in the cost of goods and services purchased by a hospital.

Payment Rates are adjusted by the Texas legislature as part of the state's annual budget.

[44] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

Utilization represents an estimate of the change in hospital Medicaid patient activity, a combination of changes in Medicaid enrollment, hospital admission and outpatient use rates, and changes in the mix of services.

Table 16: Selected Trend Factors

	FY 2013-FY 2014	FY 2014-FY 2015	Compounded FY 2013 to FY 2015
Annual Change in Costs	2.6%	2.5%	5.2%
Annual Change in Payment Rates	-1.2%	0.0%	-1.2%
Annual Change in Utilization	0.4%	0.4%	0.8%

Payment to Cost Percentage

Using Base Payments Only

Using the above trend factors, FY 2013 base payments and costs are trended forward to FY 2015 with the following results:

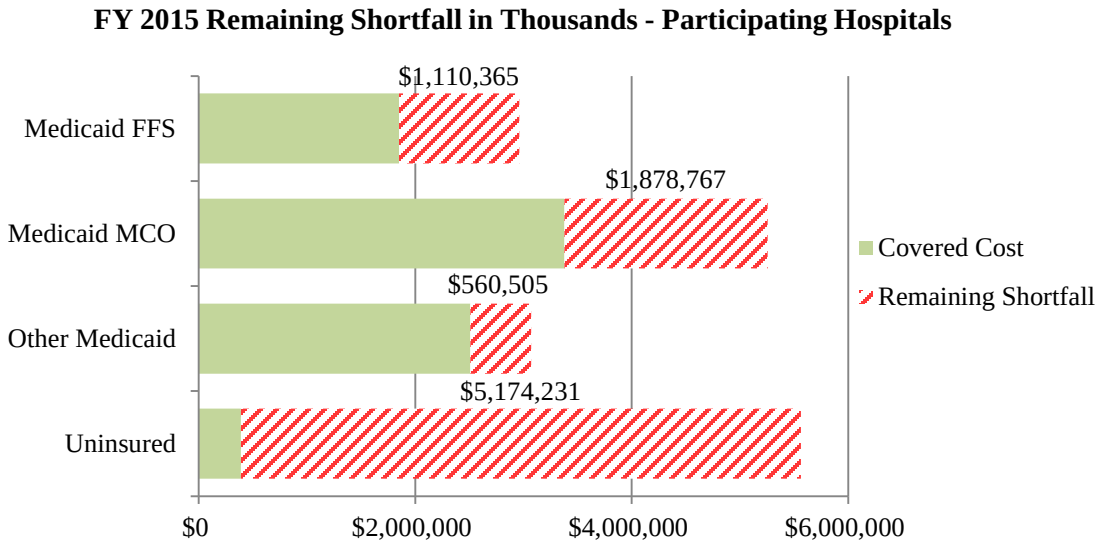
Table 17: Base Payment and Costs, FY 2015 Estimates

In 000s	Payments (1)	Cost	Difference	Payment to Cost Percent
Medicaid FFS	$1,849,767	$2,960,132	($1,110,365)	62.5%
Medicaid MCO	$3,377,397	$5,256,164	($1,878,767)	64.3%
Total, Medicaid Primary	***$5,227,164***	***$8,216,296***	***($2,989,132)***	***63.6%***
All Medicaid Dual-Eligible	$2,380,783	$2,715,081	($334,298)	87.7%
Out of State Medicaid	$159,480	$355,407	($195,927)	44.9%
Total Medicaid and Medicaid-related	***$7,767,426***	***$11,286,784***	***($3,519,357)***	***68.8%***
Uninsured	$389,000	$5,563,231	($5,174,231)	7.0%
Total, participating hospitals	***$8,156,426***	***$16,850,014***	***($8,693,588)***	***48.4%***
Non-participating hospitals, Medicaid	$139,815	$200,973	($61,158)	
Non-participating hospitals, Uninsured	$0	$206,854	($206,854)	
Grand Total (excluding supplemental pool payments)	***$8,296,241***	***$17,257,841***	***($8,961,600)***	

(1) Figures above have been trended to reflect FY 2015 and therefore do not account for the rate increases effective 9/1/2015

Before considering supplemental payments, the payment to cost percentage across all hospitals participating in the UC Pool program is 68.8 percent for Medicaid and 7.0 percent for uninsured. The remaining Medicaid and uninsured shortfalls total $3.5 billion and $5.2 billion, respectively.

Figure 2: Remaining Cost Shortfall, FY 2015



Base Payments and Supplemental Payments

GME and DSH payments are supplemental payments paid directly to hospitals to cover the costs of serving Medicaid and in the case of DSH, also the uninsured. These payments are made under state plan authority and do not require the 1115 waiver. In the tables below, the payments related to GME and DSH are included as offsets to cost.

GME is allocated 100% to Medicaid. DSH payments are allocated between Medicaid and uninsured based on the proportion of Medicaid shortfall and uninsured net cost to the sum of Medicaid shortfall and uninsured net cost. The allocation of DSH payments between Medicaid and uninsured was computed at the hospital specific level. In aggregate, DSH is allocated 33 percent to Medicaid and 67 percent to uninsured.

Table 18: Payment to Cost after Including GME and DSH, FY 2015

In 000s	Medicaid	Uninsured	Total
Base Payments	$7,767,426	$389,000	$8,156,426
Medicaid GME Payments	$30,943	$0	$30,943
DSH Payments	$559,796	$1,162,345	$1,722,141
Payments with GME and DSH	$8,358,166	$1,551,345	$9,909,511
Total Cost	$11,286,784	$5,563,231	$16,850,014
Percentage of Cost Paid	***74.1%***	***27.9%***	***58.8%***
Remaining Unreimbursed Cost	***($2,928,618)***	***($4,011,886)***	***($6,940,503)***

As shown above, by including GME and DSH as offsets to cost, the payment to cost percentage across all hospitals participating in the UC Pool program increases from 48.4 percent to 58.8

percent. The remaining Medicaid and uninsured shortfalls total $2.9 billion and $4.0 billion, respectively.

The tables and charts above have shown payment to cost absent any payments authorized under the 1115 waiver. In the table below, UC Pool payments are added as an additional offset to costs.

UC Pool payments are allocated between Medicaid and uninsured based on the proportion of Medicaid shortfall and uninsured net cost to the sum of Medicaid shortfall and uninsured net cost. The allocation of UC Pool payments between Medicaid and uninsured was computed at the hospital specific level. In aggregate, the UC Pool is allocated 38 percent to Medicaid and 62 percent to uninsured.

Table 19: Payment to Cost after Including GME, DSH and UC Pool, FY 2015

In 000s	Medicaid	Uninsured	Total
Payments with GME and DSH	$8,358,166	$1,551,345	$9,909,511
UC Pool Payments	$1,107,539	$1,839,582	$2,947,121
Payments with GME, DSH and UC	$9,465,705	$3,390,927	$12,856,632
Total Cost	$11,286,784	$5,563,231	$16,850,014
Percentage of Cost Paid	***83.9%***	***61.0%***	***76.3%***
Remaining Unreimbursed Cost	***($1,821,079)***	***($2,172,304)***	***($3,993,382)***

As shown above, by including UC pool payments as offsets to cost, the payment to cost percentage across all hospitals participating in the UC Pool program increases from 58.8 percent to 76.3 percent. The remaining Medicaid and uninsured shortfalls total $1.8 billion and $2.2 billion, respectively.

As noted above in Section II, STC 45(e) states explicitly that "DSRIP payments are not direct reimbursement for expenditures or payments for services," and as an incentive program, payments are not applicable to a hospital's HSL for DSH or UC Pool purposes. Further, the investments and operating costs associated with implementing and maintaining DSRIP initiatives are not reported to the state and some expenditure may not be eligible to be claimed for Medicaid. The state's costing model allocates hospital costs, including applicable DSRIP-related Medicaid expenditures, to Medicaid using Medicaid's share of charges and patient days. Consequently, the Medicaid and uninsured share of costs used in this report are understated with respect to DSRIP because they include only a portion of DSRIP-related expenditures. Although including DSRIP payments in this analysis distorts the resulting Medicaid shortfall based on the issues raised above, the inclusion of DSRIP is required by the STCs.

Table 20: Medicaid Shortfall after Including GME, DSH, UC, and DSRIP FY 2015

In 000s	Amounts
Medicaid Payments with GME, DSH, UC	$9,465,705
DSRIP DY 2 payments through June 2016 (1)	$1,276,603
Medicaid Payments with GME, DSH, UC and DSRIP	$10,742,308
Total Medicaid Cost	$11,286,784
Percentage of Cost Paid	***95.2%***
Remaining Medicaid Shortfall	***($544,476)***

(1) An additional $16.4 million in DY 2 DSRIP payments was allocated to hospitals based on project valuation but remain unearned to date.

All Payments Net of IGTs

Each of the foregoing calculations of Medicaid shortfall and payment to cost percentages use gross computable payments (both the federal and non-federal share).

As noted in Section II, IGTs play a significant role in financing the non-federal share of Medicaid. In FY 2015, IGTs associated with hospital payments totaled nearly $2.4 billion of the supplemental pool payments. From an accounting standpoint, IGTs are not an expense and cannot be included in uncompensated care cost. However, when IGTs are made by public hospitals or a governmental entity that owns a public hospital, the resources of such organizations are considered by CMS to be a portion of their reimbursement. In substance an IGT made by or on behalf of a public hospital is an expenditure that reduces the amount of Medicaid revenue available to run its operations and serve its patient population. Accordingly, IGTs made by or on behalf of public hospitals may be considered an offset against payments in the assessment of Medicaid payment adequacy.

IGTs also finance the same portion of supplemental payments made to private hospitals. However, federal and state regulations prohibit private hospitals from reimbursing governmental units for IGTs made on their behalf. Accordingly, IGTs are not a factor in assessing Medicaid payment adequacy for private hospitals.

The following table shows the Medicaid shortfall before and after supplemental payments, net of IGTs from or on behalf of public hospitals.

Table 21: Payment to Cost Considering Offset of Public Hospital IGTs, FY 2015

In 000s	Medicaid	Uninsured	Total
Payments with GME, DSH and UC	$9,465,705	$3,390,927	$12,856,632
Less IGTs from or on behalf of public hospitals	($373,184)	($665,444)	($1,038,628)
Payments net of public hospital IGT	$9,092,521	$2,725,483	$11,818,004
Total Cost	$11,286,784	$5,563,231	$16,850,014
Percentage of Cost Paid	***80.6%***	***49.0%***	***70.1%***
Remaining Unreimbursed Cost	***($2,194,262)***	***($2,837,748)***	***($5,032,010)***

Payment to Cost, by Type of Hospital

Supplemental payments, including GME, DSH, and UC pool payments, have varying impacts on payment to cost ratios across different types of hospitals. The tables below highlight several of these variations. In all of the tables, three comparisons are made: (1) Medicaid base payments only, whereby Medicaid base includes Medicaid FFS, Medicaid managed care, out-of-state Medicaid, and Medicaid dual eligible patients; (2) Medicaid with supplemental payments including GME and the Medicaid portions of DSH and UC Pools; (3) Uncompensated Care, which includes all base and supplemental payments except DSRIP, and combined Medicaid and uninsured cost. All tables exclude any offset for IGT financing.

Ownership Type The table below shows payment to cost percentages by ownership type. Public hospitals frequently have higher costs than private hospitals, and consequently do not fare as well under reimbursement systems that use statewide averages for rate-setting purposes.

Table 22: Payment to Cost Percentage by Ownership Type, FY 2015

	Number of Hospitals	Medicaid Base Payments only	Medicaid with Supplemental Pools	Uncompensated Care with Supplemental Pools
Private	230	71.7%	83.9%	77.2%
Large Public	6	51.2%	79.4%	69.8%
Small Public	102	63.6%	86.8%	82.7%
State	18	66.5%	91.4%	80.2%
Total	***356***	***68.8%***	***83.9%***	***76.3%***

Hospital Type Children's hospitals receive base reimbursement at significantly higher rates than all other Medicaid providers. Although there are only 10 children's hospitals statewide, their Medicaid volumes are large enough to substantially influence the statewide totals. It is also worth noting that outside of children's hospitals, critical access hospitals receive the highest payment to cost ratios after supplemental payments, at least 3.0 percent higher than all other types of hospitals.

Table 23: Payment to Cost Percentage by Hospital Type, FY 2015

	Number of Hospitals	Medicaid Base Payments only	Medicaid with Supplemental Pools	Uncompensated Care with Supplemental Pools
General Acute	246	65.0%	81.9%	74.0%
Critical Access	78	63.9%	87.3%	82.3%
Specialty	3	67.1%	79.4%	75.6%
IMD	19	45.0%	84.3%	74.5%
Children's	10	87.5%	92.3%	91.5%
Total	***356***	***68.8%***	***83.9%***	***76.3%***

County Size For purposes of this analysis, counties with a population of 137,000 residents or greater are classified as "Metro" counties. The table below shows payment to cost ratios for

hospitals within Metro counties compared to those outside of Metro counties. While non-Metro county hospitals receive a lower base reimbursement rate, their benefit from supplemental payments exceeds those of Metro counties, bringing their payment to cost ratios to 1.0 percent above the average statewide.

This targeted benefit to rural areas is even more pronounced when comparing counties with less than 10,000 residents to all others. Including GME, DSH, and UC Pool payments, hospitals in these rural counties receive Medicaid payments at a ratio of 89.7 percent to cost, 5.8 percent higher than the statewide average.

Table 24: Payment to Cost Percentage by County size, FY 2015

	Number of Hospitals	Medicaid Base Payments only	Medicaid with Supplemental Pools	Uncompensated Care with Supplemental Pools
Metro	165	69.3%	83.7%	75.9%
Non-Metro	191	65.5%	84.9%	78.9%
Total	***356***	***68.8%***	***83.9%***	***76.3%***
Counties < 10,000	44	64.1%	89.7%	86.1%
All Others	312	68.8%	83.8%	76.2%
Total	***356***	***68.8%***	***83.9%***	***76.3%***

Teaching Status Teaching hospitals frequently have higher than average costs associated with their academic mission and often treat a more complex and costlier patient population. Texas has a modest direct GME supplemental payment but significant medical education adjustments may be included in the inpatient rate. As a result, teaching and non-teaching hospitals have similar results relative to their costs.

Table 25: Payment to Cost Percentage by Teaching Status, FY 2015

	Number of Hospitals	Medicaid Base Payments only	Medicaid with Supplemental Pools	Uncompensated Care with Supplemental Pools
Teaching	64	68.1%	83.7%	76.3%
Non-Teaching	292	70.1%	84.1%	76.2%
Total	***356***	***68.8%***	***83.9%***	***76.3%***

Payment to Cost based on Prevalence of Low-Income Patients

Hospitals with greater prevalence of Medicaid and uninsured patients are clearly important to the state's goal of ensuring sufficient access to care; hospitals with greater prevalence of low-income patients may be facing greater financial pressures than the average hospital. In the following analysis hospitals are divided into five tiers, based on ranking all hospitals under two different definitions of "prevalence of low-income patients": 1) a measure of dependence on low-income patients, using Medicaid and uninsured charges as a percentage of a hospital's total charges, and

2) a measure of volume of low-income patients, using a hospital's Medicaid and uninsured costs as a percentage of total Medicaid and uninsured costs across all hospitals. For each of these two measures the same five tiers are used:

Tier 1: the top 5 percent of hospitals
Tier 2: the next 5 percent of hospitals
Tier 3: the next 15 percent of hospitals
Tier 4: the next 25 percent of hospitals
Tier 5: the remaining 50 percent of hospitals

Table 26: Payment to Cost Percentage, Stratified by Low-income Prevalence, FY 2015

	Number of Hospitals	Medicaid Base Payments only	Medicaid with Supplemental Pools	Uncompensated Care with Supplemental Pools
Tiers based on Medicaid/Uninsured charges to total charges				
Tier 1	17	69.4%	85.5%	76.1%
Tier 2	18	77.4%	88.8%	81.9%
Tier 3	53	74.7%	88.3%	82.4%
Tier 4	89	68.9%	84.4%	77.3%
Tier 5	179	62.8%	78.8%	71.2%
All hospitals	***356***	***68.8%***	***83.9%***	***76.3%***
Tiers based on Medicaid/Uninsured volume				
Tier 1	17	68.4%	83.8%	76.2%
Tier 2	18	77.0%	87.9%	80.8%
Tier 3	53	67.3%	83.5%	76.5%
Tier 4	89	63.9%	79.9%	71.7%
Tier 5	179	67.9%	84.9%	77.6%
All hospitals	***356***	***68.8%***	***83.9%***	***76.3%***

Hospitals classified into the top tiers based on Medicaid and uninsured dependence are those with a high Medicaid plus uninsured payer mix. Tier 1 under the dependence ranking includes a broad array of hospitals of all ownership types (state, large public, small public, and private) and service types (general acute, children's, critical access, IMD, and specialty). Hospitals in this tier receive the greatest increase to Medicaid payments as a percentage of costs through the supplemental pools (16.2 percent). The 50 percent of hospitals falling into the Tier 5 under this approach represent the hospitals with the smallest Medicaid and uninsured payer mix. Although these hospitals also receive a significant increase to Medicaid payments as a percentage of costs through the supplemental pools (16.0 percent), hospitals in Tier 5, representing those least dependent on Medicaid and uninsured populations, receive the lowest payments as a percentage of costs under all three measures.

Hospitals falling into the top tiers based on Medicaid and uninsured volume are hospitals accruing the highest absolute Medicaid and uninsured costs across the state. Tier 1 under the

volume approach comprises large metro hospitals providing significant levels of Medicaid and uninsured care regardless of the size of their commercial business. Due to their overall size, all critical access hospitals and the vast majority of small public hospitals, both critical access and general acute, fall into Tier 5 and hospitals in this tier receive the greatest increase to Medicaid payments as a percentage of costs through the supplemental pools (17.0 percent).

A listing of hospitals in each tier is included in Appendix VII.

Financial Impact of the UC Pool

As one of the objectives of this study is to inform the decision about the size of the UC Pool in the future, it is important to understand the financial impact of the UC Pool for hospitals that receive UC Pool funding. For this purpose, comparisons of UC Pool payments to total revenue and net income[45] were made. These comparisons provide useful information about the extent to which Texas hospitals rely on UC Pool payments. The following table summarizes the comparisons, in total and for the high-Medicaid and uninsured volume tiers described above.

Table 27: UC Pool payments to Total Revenue and Net Income (1)

	Total Revenue (000s)	UC Pool to Total Revenue	UC Pool to Net Income
All hospitals	***$63,491,205***	***4.6%***	***54.0%***
Tiers based on Medicaid/Uninsured charges to total charges (dependence)			
Tier 1	$6,684,287	10.9%	236.6%
Tier 2	$5,818,144	5.0%	120.9%
Tier 3	$5,262,606	5.5%	98.1%
Tier 4	$14,916,247	4.8%	52.4%
Tier 5	$30,809,922	2.9%	28.2%
Tiers based on Medicaid/Uninsured volume			
Tier 1	$22,079,936	5.6%	65.9%
Tier 2	$9,001,600	3.7%	26.7%
Tier 3	$15,890,376	4.2%	56.1%
Tier 4	$11,475,484	3.9%	60.0%
Tier 5	$5,043,809	4.3%	69.5%

(1) Total Revenue is derived from the latest version of CMS' Hospital Cost Report Information System (HCRIS), Worksheet G-3 net patient revenue and other revenue. The information in this table includes 341 of the 356 participating hospitals, for whom the latest HCRIS files include total revenue information.

In FY 2015 the UC Pool accounted for 4.6 percent of all revenue for Texas hospitals and 54.0 percent of aggregate net income. These percentages indicate that many hospitals have come to rely heavily on this revenue source to funds their operations. The table further demonstrates that for the 25 percent of hospitals with the highest dependence on Medicaid (tiers 1-3), reliance on

[45] Total revenue is from Worksheet G-3, lines 3 and 25 of the Medicare cost report. Net income is from Worksheet G-3, line 29 of the Medicare cost report.

UC Pool payments is much greater: on a combined basis, UC Pool payments represent 8.1 percent of total revenue, and 187 percent of net income, indicating that these Medicaid-dependent hospitals would have had losses in the aggregate without the UC Pool.

Adequacy, Equity, Accountability and Sustainability

The STCs require an assessment of the adequacy, equity, accountability and sustainability of the state's funding mechanisms for making payments to hospitals.

Adequacy: Under federal statute, payment adequacy is evaluated in the context of whether provider payments are "…sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[46] Texas Medicaid does not fully fund the cost of services, as is the case in the majority of states, but payment adequacy requires only that the shortfall not be so large that it results in insufficient beneficiary access to care. Consistent with the requirements under a recent Medicaid final rule, "Methods for Assuring Access to Covered Medicaid Services,"[47] HHSC is in the process of reviewing network adequacy. At this time, minimum standards for access to hospital services have been met with a few exceptions (see Access and Network Adequacy section below), inferring that current hospital reimbursement levels including all supplemental payments meet the minimum threshold for adequacy.

Equity: Using Medicaid payment to cost as a measure of equity, the peer group analysis included above shows reasonable consistency in Medicaid reimbursement across hospital types and geographies, with high Medicaid volume hospitals, such as children's hospitals, and hospitals serving rural regions reimbursed at slightly higher rates.

Additionally, equity is enhanced through the distribution of the supplemental pools. Because both DSH and UC Pool payments are driven by the cost of providing care to the low income populations, the range of Medicaid payment to cost ratios by peer group including supplemental payments is generally narrower than the range by peer group including base payments only.

Accountability: In the aggregate, excluding supplemental payments, Texas hospitals are reimbursed for providing Medicaid services well below cost at a rate of 68.8 percent. The vast majority of the supplemental payments made in addition to base payments for Medicaid services are distributed based on, and limited to, cost. Therefore, under current reimbursement policy, there is little risk that hospitals will be paid in excess of the cost of providing care to the Medicaid population. Additionally, of the 356 hospitals which completed the DSH/UC application for FY 2015 and account for 98 percent of total Medicaid hospital revenue, only 21 hospitals did not receive a DSH or UC Pool payment. As such, 94 percent of the 356 hospitals (335 hospitals) are subject to audit under the federally mandated DSH audits and/or the UC Pool

[46] Section 6402(a), Pub. L. 101-239 (1989)
[47] 80 FR 67575 published Monday, November 02, 2015.

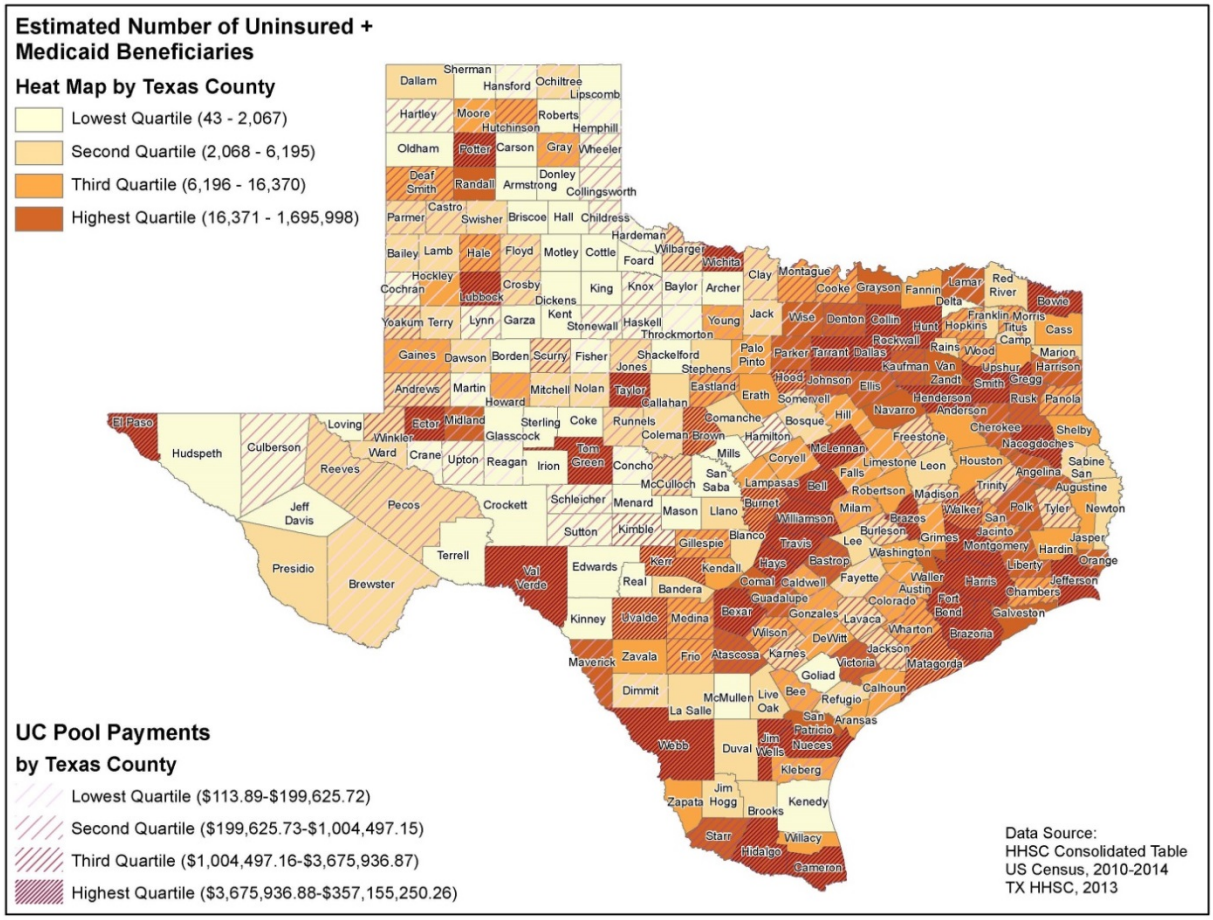
audit under the STCs. These audits measure actual costs from the payment period against revenue received and require return of any payments received in excess of costs.

Sustainability: In FY 2015, state general funds comprised 57 percent of the non-federal share of Medicaid payments to hospitals including supplemental payments. The remaining was financed through IGTs. Hospitals and the communities they serve depend on these IGT-funded payments to sustain care to low income populations, and their public partners have historically assisted Texas in fully funding the DSH and UC Pool payments to the maximum amounts allotted. Discussions with HHSC and hospital stakeholders indicate these public funders continue to prioritize care to the underserved and are committed to sustaining these funds into the future. In fact, public funders IGT capacity annually exceeds the amount necessary to fully fund the supplemental pools.

Access and Network Adequacy

One of the main reasons for uncompensated care funding is to help ensure safety net providers have the resources needed, which in turn helps ensure sufficient access to care for Medicaid beneficiaries and the uninsured. As shown in Figure 3, a strong correlation exists between the number of Medicaid beneficiaries and uninsured individuals residing in each Texas county and the level of UC Pool funding received by hospitals located in those counties. This suggests UC Pool payments currently target counties of highest need, supporting the goal of improving access to care.

Figure 3: Texas Uninsured and Medicaid Beneficiaries and UC Pool Funding by County, FY 2015



The remainder of this section discusses a number of the issues and concerns around access to care by low-income individuals, starting with a focus on one large urban safety net provider.

A Spotlight on Harris Health System

Harris Health System (HHS) is the largest recipient of UC Pool funds in Texas and provided more than $626 million in charity care in FY 2015. As an urban safety-net health system in the largest county in Texas (with more than 4.5 million residents), HHS includes three hospitals, 23 community centers, five school based health clinics, a dialysis center, dental center, mobile health units, a rehabilitation and specialty hospital, and two full service hospitals. The patients they serve are overwhelmingly minority, including 59.6 percent Hispanic, 24.9 percent African American, and 8.3 percent Caucasian. In FY 2015, they provided nearly two million outpatient clinic visits and more than 182,000 emergency visits. In FY 2015, their reported payer mix was 63.6 percent self-pay, 20.7 percent Medicaid and CHIP, 9.5 percent Medicare, and 6.2 percent commercial and other funding.[48] Because they provide such a significant volume of uncompensated care, they rely heavily on the UC Pool to serve the low income population.

[48] Harris Health System at https://www.harrishealth.org/en/about-us/who-we-are/pages/financials.aspx

In a May 2015 interview, Harris Health's CEO George Masi reported that UC Pool funding represented 21 percent of the hospital system's patient revenue in 2013.[49] Masi noted that UC Pool funds are "absolutely critical" to their ability to provide services to low income members of the community, and without current levels of UC Pool funding, services provided to both uninsured and Medicaid patients through the community health clinics would likely be cut in order to maintain more critical hospital and emergency services.

While urban hospitals like Harris Health serve the highest volumes of uninsured patients and have the highest uncompensated care costs, rural hospitals are also vulnerable to significant changes in payment levels. The state's current 171 rural hospitals cover 85 percent of the state's geography and often treat high percentages of uninsured individuals. Of the 20 counties with the highest uninsured rates, 17 are located in rural areas.[50] Uninsured rates in these counties range from 34 percent to 41 percent. Since 2013, 13 Texas rural hospitals have closed, forcing many uninsured – and insured – individuals to travel longer distances to receive services, including emergency care, or go without care. In August, 2015, the Texas Organization of Rural and Community Hospitals (TORCH) reported cuts in Medicare and Medicaid payments over the previous four years resulted in revenue loss totaling almost $100 million a year for Texas' 171 rural hospitals.[51]

Access and Adequacy Statewide

Analysis by iVantage Health Analytics evaluated rural hospitals using 71 performance indicators across nine pillars of performance to determine which hospitals are most vulnerable or at risk for closure.[52] The study identified 673 hospitals that overall face significant challenges. Texas is the state with highest number of vulnerable hospitals, with 75 rural hospitals (50 percent) identified at risk of closure. These hospitals were found to treat a disproportionate number of the especially sick, expensive, and physically challenged population. These hospitals are also under significant financial stress due in part to reimbursement cuts due to sequestration, charity care reimbursement cuts, DSH payment cuts, and continued high uninsured rates. Based on these factors and other measures, across the nine pillars of the Hospital Strength Index, the median vulnerable hospital earns an overall score of 16.22 out of a possible 100.

The study also found that more than half of the hospitals vulnerable to closure were located in communities with the highest health disparities based on twelve baseline health measures, including such factors as adult obesity rate, child poverty rate, lack of insurance, cost of care, and access to primary care, mental health, and dental care. The report notes that if these vulnerable

[49] Becca Aaronson and Edgar Watters, *With Hospital Funds in Question, Who's at Risk?* Texas Tribune, May 20, 2015.
[50] County Health Rankings and Roadmaps, Robert Wood Johnson Foundation, 2015
[51] Enrique Rangel, *Leaders say federal health needed as some Texas rural hospitals remain on brink of closure,"* Lubbock Avalanche Journal, August 8, 2015.
[52] Rural Relevance – Vulnerability to Value. 2016 iVantage Health Analytics.

populations lose access to critical acute care and outpatient services, the loss would be catastrophic for some communities where hospitals are the primary source of health care.

UC payments may also have direct implications for Medicaid managed care organizations (MCOs) and their ability to meet state and federal network adequacy requirements. With the implementation of the STAR Kids managed care program in 2016, more than 90 percent of Texas Medicaid clients will be enrolled in Medicaid managed care. Updates to Medicaid managed care network adequacy requirements were finalized in April 2016 and include new time and distance standards and other access requirements that MCOs must meet.

To ensure compliance, HHSC monitors member and provider complaints and tracks total network participation, geo-mapping results, and out-of-network utilization. For hospital and physician services, MCOs provide self-reported geo mapping data by MCO and Service Delivery Area (SDA) for several provider types by program and population. The State also has begun conducting "secret shopper" calls to samples of PCPs in MCOs in each SDA to determine if waiting times for appointments exceed the 14 day requirement for routine primary care. Results of this study are currently being compiled.

The Health and Human Services Commission reports that based on geo-mapping results, all plans met the majority of access standards for both children and adult services, with a few exceptions. For hospital services, one of the two STAR+PLUS plans serving the Medicaid Rural Service Area (MRSA) in West Texas failed to meet the requirements.

However, despite the fact that the majority of MCOs meet the minimum access standards, HHSC reports a number of MCOs failed to meet the Out-Of-Network (OON) threshold requirements in various SDAs in the fourth quarter of SFY 2015.

Failure to meet the OON limitations suggests that, despite reporting an adequate network, MCOs are in some cases unable to meet members' needs within the existing network. One issue that has been raised at various Medicaid stakeholder meetings is concern that MCO networks may meet minimum standards but in reality many providers either are not accepting new patients or are so overbooked that enrollees cannot get an appointment within a reasonable time frame. While HHSC has increased monitoring and has implemented new oversight functions such as conducting Secret Shopper calls, enrollees continue to report at least anecdotal concerns with accessing services, including both primary and specialty care.

Access to care issues for both Medicaid patients and the uninsured are identified in more detail in a report summarizing the results of a survey of low income individuals.[53] The 2013 Kaiser Survey of Low Income Americans provides several key findings related to access to care for both uninsured individuals and Medicaid enrollees in Texas:

[53] Katherine Young and Rachel Garfield, *The Uninsured Population in Texas: Understanding Coverage Needs and the Potential Impact of the Affordable Care Act*, Kaiser Family Foundation, July 11, 2014.

- Only 48 percent of uninsured adults report they have a usual source of care or a place to go when they are sick;
- Only 28 percent of uninsured adults have a regular doctor as a usual source of care
- 56 percent of uninsured adults reported at least one health care visit in the past year, compared to 89 percent of Medicaid beneficiaries and 85 percent of adults with employer coverage;
- 47 percent of the uninsured and 50 percent of Medicaid beneficiaries report needing but postponing care, compared to 31 percent of adults with employer coverage. Appointment availability was reported as a significant reason for postponing care; and
- 17 percent of uninsured adults reported the emergency room as their usual source of care.

The report concludes by noting the importance of the continuing role of safety net providers in Texas, acknowledging that the low income uninsured relied on FQHCs and public hospitals for much of their care. The authors also note future cuts in DSH funding, and suggest close monitoring of the safety net to see if it is able to meet the continued and growing demand for services.

Summary Observations

Even though Texas hospitals provide an estimated $5.5 billion in care for the uninsured annually, there are significant access challenges for the uninsured population. Although minimum adequacy standards appear to be met in the majority of managed care networks, there are also many concerns about the ability of the provider community to meet the access needs of the Medicaid population. With increased population growth and growing numbers of uninsured expected in the coming years as discussed in Section VI, these challenges will increase as well. Safety net providers are highly dependent on safety net funding support, in particular the Medicaid DSH and UC payments. As the DSH payments are going to be sharply reduced beginning in FY 2018, maintaining an adequate level of Medicaid revenues including UC payments will likely be a key factor in the viability of many safety net providers.

Section V – Comparison to Other States

In response to one of the requirements of the modified STCs, HHSC engaged Deloitte Consulting to perform two analyses:

1. Medicaid Reimbursement Assessment: Compare the percent of hospitals' Medicaid costs that other states pay through their Medicaid inpatient and outpatient hospital provider rates to the Texas reimbursement percentages;
2. Distribution of Medicaid Services by Hospital Type Assessment: Assess the Medicaid dependencies (i.e. usage) of public versus private hospital providers in Texas compared to other comparative states.

For the first analysis Texas' FY 2013 payment to cost percentage (using base payments only, excluding supplemental payments) was compared to the payment to cost percentage supplied by three other states, Oklahoma (SFY 2013), Florida (SFY 2013) and New York (SFY 2012). The data for Texas yielded a 69.6 percent payment to cost percentage; Oklahoma, Florida and New York reported 43.9 percent, 78.7 percent, and 79.4 percent, respectively.

For the second analysis, the distribution of inpatient days and outpatient visits between private and public hospitals in Texas was compared to the distribution in Oklahoma, Louisiana and Florida. Using FY 2013 data, Texas had 80.5 percent of inpatient days and 75.4 percent of outpatient visits provided by private hospitals. Oklahoma reported that 90.9 percent of inpatient days were from private hospitals in SFY 2013. Louisiana reported that that 70.1 percent of inpatient days and 62.8 percent of outpatient visits were from private hospitals in SFY 2013. Florida reported that 79.1 percent of inpatient days and 81.9 percent of outpatient visits were from private hospitals in FY 2015.

Requests for detailed data are outstanding from one additional state (California).

The entire report from Deloitte Consulting is included as Appendix III.

Section VI – Projections and Additional Considerations

In the previous three sections, the current situation was analyzed from several perspectives – How large is the Medicaid shortfall, before and after supplemental payments? How much uncompensated care is provided by Texas hospitals and to what degree do supplemental payments offset the uncompensated care burden? What is the relative financial importance of the UC Pool?

In this section the focus is on possible and probable future events, and the extent to which the financial fortunes of Texas hospitals would change if they occur. The following questions are addressed in this section:

- What is the likely effect on Medicaid shortfall and uncompensated care of recent and near-term future changes in the Texas environment?
- What would be the effect on hospitals' Medicaid shortfall and uncompensated care losses if Texas opted to expand Medicaid as allowed under the Affordable Care Act?
- What is the estimated impact of Medicaid DSH reductions, as called for in federal law?
- What would happen to hospital funding levels if the UC Pool was replaced by UPL payments or an analogous approach to funding the UPL gap?
- What would be the impact of the state fully-funding hospital Medicaid costs?

While the foregoing sections are based on actual historical data and a limited number of estimates, the projections in this section are, by definition, all predictions and conjecture. In some cases, the possible answers to these questions may be stated in estimated dollars while in others a directional assessment is all that is practical.

Environmental Trends and Factors

Because UC Pool funds are a critical funding mechanism for providing health services to Texas' low income and uninsured population, it is important to consider population trends and economic and environmental factors that impact access to care and variations in the health care delivery system across the state. This section does not attempt to address all of the factors that impact utilization of services but instead focuses on some of the key data and indicators that impact the size of the safety net population and the availability of services for this population.

Uninsured Rates

One of the most important factors relative to expected costs for uncompensated care is the number and percent of individuals without health insurance. Texas experienced a significant reduction in the number of uninsured individuals from 2013 to 2014 following implementation of the ACA. However, the state still continues to have the highest rate of uninsured citizens at 19.1 percent, compared to a national average of 11.1 percent.[54] In 2014, the U.S. Census Bureau

[54] Smith, Jessica C. and Carla Medalia, U.S. Census Bureau, *Current Population Reports, P60-253, Health Insurance Coverage in the United States: 2014*, U.S. Government Printing Office, Washington, DC, 2015.

reported that 5,047,000 Texans were without health insurance, down from 5,748,000 in 2013 (22.1 percent of the population). By comparison, in 2014 California and New York (which have both implemented a Medicaid expansion) had 4,767,000 uninsured residents (12.4 percent) and 1,697,000 uninsured (8.7 percent), respectively. Florida, which, like Texas, has not implemented a Medicaid expansion, had 3,245,000 (16.6 percent) uninsured residents.

Primary sources of coverage for Texans included employer sponsored coverage at 47 percent (compared to a national average of 49.9 percent) and Medicaid coverage for 18 percent of the population (19 percent nationally). While the Texas rate of employer sponsored coverage is not significantly lower than the national average, the number of employers offering insurance in Texas is only 44.7 percent compared to a national average of 49.9 percent, another troubling trend that could indicate lower rates of coverage in the future.[55]

While lack of insurance does not necessarily mean individuals lack access to care, numerous studies have found individuals without insurance fare poorly in the health system and often suffer from lack of care, or care that comes too late. For example:

- Uninsured women with breast cancer have a 30 to 50 percent higher risk of dying than those with health insurance, and uninsured individuals with colorectal cancer are 50 percent more likely to die than individuals with coverage.[56]
- The uninsured report higher rates of postponing care and are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[57]
- The uninsured receive less preventive care and recommended screenings. In 2014, only 27 percent of uninsured adults reported a preventive visit compared to 65 percent of adults who had coverage since before 2014.[58]
- The uninsured often have difficulty finding a primary care doctor who will accept them. More than 41 percent of uninsured adults reported they were turned away from a doctor or clinic from which they sought primary care services.[59]

For many Texans who do not have insurance, cost is cited as the primary reason. A 2015 survey of uninsured Texans found that the overwhelming reason cited for remaining uninsured was the cost of insurance.[60] A total of 69.1 percent of survey respondents reported the primary reason for remaining uninsured was the high cost of coverage, followed by 19.3 percent who did not want coverage, and 6.3 percent who did not know how to find information on available options.

---

[55] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. *2013 Medical Expenditure Panel Survey Insurance Component*, 2013.
[56] Code Red, *The Critical Condition of Health in Texas*, Task Force on Access to Health Care in Texas.
[57] Institute of Medicine, *Health Insurance is a Family Matter*, 2002.
[58] R. Garfield and K. Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults*, Kaiser Family Foundation, 2015.
[59] Sara. R. Collins, Ruth Robertson, Tracy Garber, and Michelle M. Doty, *The income Divide in Health Care: How the Affordable Care Act Will Restore Fairness to the U.S. Health System*, The Commonwealth Fund, February 2012.
[60] Rice University's Baker Institute, Health Reform Monitoring Survey – Texas, *Issue Brief 18: Why were 20% of Adult Texans Uninsured in 2015?* January 2016

Population Trends

A review of recent population data indicates that Texas is experiencing significant population growth relative to other states, a fact that is likely to contribute to increasing uninsured and put additional pressure on the current health care infrastructure. According to a May news release by the U.S. Census Bureau, Texas is home to five of the 15 fastest growing cities in the country.

As illustrated in Table 28 below, Texas' annual population growth rate is more than twice the national rate at 1.71 percent in 2013 and 1.77 percent in 2014. Additional analysis conducted by the State Demographer provides future projections indicating the state will continue to grow significantly over the next four years. Between 2000 and 2010, the state added an additional 4.3 million individuals. By 2020, the state's population is projected to increase by an additional 3.6 million people for a total of nearly 29 million.[61] Much of the expected growth is projected to come from the large urban counties of Harris, Dallas, Tarrant, Bexar and Travis, but significant growth is also expected in suburban counties surrounding the five largest urban counties. In addition, Hidalgo County in South Texas along the Texas/Mexico border is also identified as one of the top 10 fastest growing counties.

In addition to population growth trends, economic factors including household income and poverty status can have a significant impact on utilization of health care services and uncompensated care. In all three years included in Table 28, Texas' median household income has lagged slightly behind the national average, but the gap decreased from 2.8 percent in 2012 to 1.7 percent in 2014.

Poverty level data for 2012 and 2014 reveals a wider gap between state and national averages. For all three years, the percentage of individuals below 100 percent of the Federal Poverty Level (FPL) and between 100 and 199 percent FPL were at least two full percentage points higher for Texas than the national average. Conversely, the percentage of individuals at or above 200 percent FPL was at least 4 full percentage points lower than the national average. Between 2012 and 2014, the percentage of Texans at or above 200 percent FPL actually decreased slightly from 61.5 percent to 61.3 percent. These data suggest that although median incomes have increased slightly in Texas over the three year period, financial status has not significantly changed for many Texans.

Enrollment for Food Stamp/SNAP benefits is another indicator of financial status. Consistent with income and poverty rates, the percentage of enrollees in SNAP exceeded the national average in all three years and increased from 12.3 percent in 2012 to 13.5 percent in 2014, nearly a 10 percent increase.

[61] Lloyd B. Potter, *Texas Population Projections 2010 to 2050*, Office of the State Demographer, November 2014.

Table 28: Texas and National Population Characteristics 2012-2014

Characteristic	2012		2013		2014	
	Texas	US	Texas	US	Texas	US
Population	25,208,897	309,138,711	25,639,373	311,536,594	26,092,033	314,107,084
% change			1.71%	0.78%	1.77%	0.83%
Median Household Income	$51,563	$53,046	$51,900	$53,046	$52,576	$53,482
With Food Stamp, SNAP benefit	12.3%	11.4%	13.2%	12.4%	13.5%	13.0%
Poverty Status in the Past 12 months						
Population for whom poverty status is known	24,607,114	301,333,410	25,032,531	303,692,076	25,478,976	306,226,394
Below 100 % FPL	17.4%	14.9%	17.6%	15.4%	17.7%	15.6%
100 to 199 % FPL	21.1%	18.7%	21.2%	18.9%	21.1%	18.9%
At/above 200 % FPL	61.5%	66.4%	61.2%	65.8%	61.3%	65.5%

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5 Year Estimates

Unauthorized Immigrants in Texas

Second only to California, the state of Texas has the highest number of unauthorized immigrants in the nation. As of 2012, a total of 1.65 million unauthorized immigrants lived in Texas, up from 1.5 million in 2005 and 1.2 million in 2009.[62] Nationally, unauthorized immigrants accounted for 3.5 percent of the total U.S. population in 2012 but represent 6.3 percent of the Texas population, nearly twice the national average. Only Nevada has a higher percentage (7.6 percent, for a total of 210,000). California's immigrant population is also estimated at 6.3 percent, with a total of 2.45 million.

With the exception of emergency medical care, unauthorized immigrants are not eligible for federally funded programs including Medicaid, CHIP or Medicare and are unlikely to purchase commercial insurance. Unauthorized immigrants are also ineligible for federal subsidies to purchase coverage via ACA health Marketplaces. Due in part to a lack of coverage, many unauthorized immigrants have unmet health needs. Despite common misconceptions about high health care costs at taxpayers' expense, studies have repeatedly shown that spending on health care for immigrants is lower compared to U.S. citizens.[63]

For those who do access services, many unauthorized immigrants rely on safety-net providers, including public and not-for-profit hospitals, federally qualified community health centers (FQHCs), and migrant health centers.[64] While the ACA included some additional funding for FQHCs, it also called for reductions in DSH payments based on the assumption that hospitals will need to provide less charity care. While this may be true in states that experienced

[62]Passel, Jeffrey S. and D'Vera Cohn, *Unauthorized Immigrant Totals Rise in 7 States, Fall in 14: Decline in Those From Mexico Fuels Most State Decreases*. Washington D. C. Pew Research Center's Hispanic Trends Project, November 2014.
[63]Michael E. Gusmano, *Undocumented Immigrants in the United States: Use of Care*, The Hastings Center, March 27, 2012.
[64] Ibid.

significant declines in the uninsured or have seen drops in unauthorized immigrants, Texas continues to experience very high uninsured rates, continued growth of unauthorized immigrants, and significant population increases that outpace most other states.

Health Insurance Trends

Insurer participation or lack thereof, is also an important indicator of the challenges individuals may face in obtaining affordable insurance, even with significant tax credits available through Marketplace plans. An analysis by Kaiser Family Foundation in March 2016 found insurer participation varied significantly by state.[65] The report noted that in 2015, an average of 6.1 insurer groups offered Marketplace coverage in each state, up from 5.0 in 2014. Since then, however, numerous insurers have either withdrawn from the Marketplace or have announced plans to withdraw in the coming year.

Texas is one of the identified states where consumers are faced with decreasing options for coverage. Although the Texas Marketplace includes 16 carriers that have filed rates for 2017, many of those carriers offer coverage in a very limited geographic area, often within a single urban community. In Texas, the average number of participating insurers per county was 2.7 in 2015, dropping to 2.0 in 2016. Individuals residing in 62 percent of Texas counties had only one or two insurer choices in 2015, increasing to enrollees in 78 percent of counties in 2016. Nationally, the average number of participating insurers per county was 3.4 in 2015, decreasing slightly to 3.1 in 2016. In 2015, 35 percent of all counties had only one or two insurers, increasing to 40 percent in 2016. The study also noted that while the number of participating insurers is generally higher in urban counties, the Marketplace has seen a continued decline in insurers participating in urban counties.

Marketplace premium cost trends were examined to identify the potential impact on access to affordable coverage for uninsured Texans. Declines in uninsured rates in recent years are largely attributed to a combination of reduced premium costs due to rate reforms and tax credits that reduced the costs of coverage for many Marketplace enrollees. To stabilize the market and ensure premiums remained affordable during the initial years as insurers began pricing policies in an unpredictable environment, the ACA also provided risk adjustment provisions and a temporary reinsurance program that protected insurers that enrolled a disproportionate share of high cost enrollees. However, despite these protections, many insurers have experienced significant losses from health plans sold on the Marketplace and have responded with large premium increases, or have withdrawn from the Marketplace as described above.

Blue Cross and Blue Shield of Texas (BCBST) is currently the only insurer offering individual plans through the Marketplace in all 254 counties. After losses of $400 million in 2014 and $321 million in 2015, BCBST raised premium rates in 2016, discontinued all preferred provider organization (PPO) plans, and now offers only Health Maintenance Organization (HMO) benefit

[65] *Analysis of Insurer Participation in 2016 Marketplaces,* Kaiser Family Foundation, November 3, 2015. Available at http://kff.org/health-reform/issue-brief/analysis-of-insurer-participation-in-2016-marketplaces/

plans, many with restricted "narrow networks" that drastically reduced the number of providers available to the more than 365,000 enrollees affected by the decision.[66] Despite these changes, Blue Cross and Blue Shield continued to experience losses throughout 2016 and recently filed for rate increases of nearly 60 percent for 2017 for its three HMO plans that cover more than 600,000 Texans.[67]

Other Texas plans have described similar experiences. After years of significant losses, United Healthcare is leaving the Marketplace in Texas and in most other states. While United only offers Marketplace plans in 30 of the 254 Texas counties, these are the counties with the most enrollees.[68] United's exit from Texas will result in 7 counties with a total of 26,323 enrollees left with only one health plan (BCBST) from which to choose. Three other counties with 9,780 enrollees will be left with only two available health plans.

Of the remaining carriers, all filed proposed rate increases for 2017 ranging from 7.7 percent to 58.4 percent. Eight plans filed increases above 20 percent, and three proposed rate hikes above 30 percent. Like BCBST, other carriers remaining in the Marketplace have also chosen to reduce the number of plans they offer, with several offering only HMO options. In some parts of the state – including Houston, the largest urban area in the state with more than 6 million people – there are no PPO plans available on the Marketplace.[69]

Cost of coverage appears to have impacted enrollment in the Texas Marketplace. Nationally, 40 percent of potential enrollees were enrolled in 2016 while only 35 percent (1,092,650) of identified eligible Texans (3,084,000) purchased coverage.[70] As noted previously, 69.1 percent of surveyed uninsured Texans reported they are uninsured because the cost was unaffordable.[71] If the cost of coverage continues to increase relative to incomes, many of the individuals who are currently insured will likely drop coverage, contributing to an increase in the number of uninsured.

Increasing costs for employer insurance also contributes to uninsured rates. While most Texans obtain health insurance through an employer-sponsored plan, not all workers qualify for coverage or, if offered, can afford their share of the premiums. Of the uninsured employees who have access to workplace coverage but decline to enroll, the most common reason was that the coverage was unaffordable. Since 2010, the employee's share of premium costs for family

[66] *Blue Cross Blue Shield seeks 60% rate hike in 2017*, The Houston Chronical, June 1, 2016.
[67] Texas Rate Review Submissions posted at Healthcare.gov.
[68] Kaiser Family Foundation, *Analysis of UnitedHealth Group's Premiums and Participation in ACA Marketplaces*, April 18, 2016. Available at http://kff.org/health-reform/issue-brief/analysis-of-unitedhealth-groups-premiums-and-participation-in-aca-marketplaces/
[69] HealthInsurance.org, *United Healthcare existing, but Texas exchange still robust*, July 29, 2016.
[70] Kaiser Family Foundation, *Marketplace Enrollment as a Share of the Potential Marketplace Population*, March 31, 2016. Available at http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/
[71] Rice University's Baker Institute, Health Reform Monitoring Survey – Texas, *Issue Brief 18: Why were 20% of Adult Texans Uninsured in 2015?* January 2016

coverage has increased 27 percent, for an average annual cost of $4,955, far outpacing average wage growth of 10.7 percent over the same period.[72]

The annual 2014 Medical Expenditure Panel Survey (MEPS) reports that while the rate of employer-sponsored insurance availability is not significantly lower in Texas than in other states, employees working for small businesses are "significantly" less likely to have insurance compared to other states.[73] Compared to a national average of 49.8 percent, only 42.3 percent of small businesses offer insurance in Texas. For all Texas workers with employer sponsored coverage, the required annual employee cost for family premiums is "significantly higher" than the national average.

Conclusions Regarding Impact on Uncompensated Care Costs

As discussed above, despite the recent declines in the number of uninsured attributed to the Affordable Care Act, all data indicators point to increasing numbers of uninsured Texans in the coming years:

- Texas' high rate of population growth is expected to result in an increasing number of new residents without health insurance. Assuming the rate of growth in the number of uninsured Texans is consistent with the projected statewide population growth estimates developed by the State Demographer, if all other factors remain equal, the number of uninsured Texans will increase by more than 1.2 million by 2025.
- Increasing premium rates in the individual Marketplace plans available in Texas are expected to result in lower enrollment rates in 2017, and a subsequent increase in the number of uninsured Texans. Though it is impossible to predict the change in enrollment, or the impact of future premium costs beyond 2017, because cost is identified as the primary reason why Texans are likely to be uninsured, extended trends of increasing premium costs will likely have a significant impact.
- Although, overall, Texans have comparable access to employer-sponsored coverage relative to other states, the higher employee contribution costs for family coverage prevents many workers from purchasing family coverage. Because eligibility for Marketplace advanced tax credits are based on affordability of employee-only coverage, many of these family members likely do not qualify for subsidies on the Marketplace. As premium costs continue to increase, it is reasonable to assume that a growing number of employees will continue to be unable to afford family coverage, potentially leaving even more Texans without health insurance.

The cumulative impact of rapid population growth, coupled with increasingly higher premium costs will almost certainly result in increasing numbers of uninsured Texans in the coming years.

[72] Kaiser Family Foundation and Health Research and Educational Trust, *2015 Employer Health Benefits Survey*, 2015.
[73] Medical Expenditure Panel Survey Insurance Component Chartbook 2014. Rockville, MD: Agency for Healthcare Research and Quality; August 2015. AHRQ Publication No. 14(15)-0053-EF.

As more of these individuals seek care at hospitals and other safety net providers, we anticipate that uncompensated care costs will also continue to increase. While the health care cost trends are lower than in the past, even without an increase in the number of uninsured, hospital costs for uncompensated care will increase consistent with the cost trends. Coupled with increasing numbers of uninsured, we expect those costs will grow at an even higher rate, reflective of the state's population growth and affordability challenges that prevent many residents from purchasing coverage.

Trending from FY 2015 to FY 2017

In Section IV, analyses of payment adequacy and the impact of supplemental payments were based on estimated FY 2015 payments and costs. To establish a baseline for pro forma analyses in the next sections of this report, costs and payments are projected forward to FY 2017. To make these projections, costs are inflated using the CMS Hospital Market Basket for FY 2016 and FY 2017, averaging 5.4 percent across the two years. Payment rates are adjusted by the Medicaid hospital price increases enacted by the Texas legislature as part of the SFY 2016-SFY 2017 biennium budget. For utilization, the same percentage change used to trend FY 2013 to FY 2015 is used for FY 2015 to FY 2017.

Based on these assumptions, the Medicaid shortfall for participating hospitals will increase from $3.5 billion in FY 2015 to $3.8 billion in FY 2017, and uninsured costs (net of payments) will increase from $5.2 billion in FY 2015 to $5.5 billion in FY 2017. Including an estimate for non-participating hospitals, the combined Medicaid and uninsured shortfall excluding supplemental payments will increase from $9.0 billion in FY 2015 to $9.6 billion in FY 2017.

Table 29: Base Payment and Costs, FY 2017 Estimates

In 000s	Payments	Cost	Difference
Total Medicaid and Medicaid-related	$8,184,038	$11,988,172	($3,804,134)
Uninsured	$392,118	$5,908,943	($5,516,825)
Total, participating hospitals	***$8,576,156***	***$17,897,115***	***($9,320,959)***
Non-participating hospitals, Medicaid	$151,015	$214,315	($63,300)
Non-participating hospitals, Uninsured	$0	$220,587	($220,587)
Grand Total (excluding supplemental pool payments)	***$8,727,171***	***$18,332,017***	***($9,604,846)***

Pro Forma Impact of a Medicaid Expansion

As of July 2016, Texas is one of 19 states opting not to expand its Medicaid program to low-income adults as provided for under the Affordable Care Act (ACA). Initially, the ACA intended for Medicaid expansion to be a requirement, but a June 2012 U.S. Supreme Court ruling resulted in each state having the option of whether to expand Medicaid. Currently the State of Texas does not cover nonelderly adults under Medicaid except for those receiving disability benefits,

pregnant women and a limited number of adults with children in the Medicaid program. Under a Medicaid expansion, coverage would be available to legal residents of the state between the ages of 19-64 with annual income of 138 percent of the federal poverty level or less.

The STCs require an estimate of the impact on Texas hospitals if the state decided to adopt Medicaid expansion. This analysis does not address the potential impacts of a Medicaid expansion on access to or quality of care, health status of the affected population, or economic impacts on the state. Instead, this analysis is focused solely on the financial impact of a Medicaid expansion on Texas hospitals. Holding all other factors constant, Medicaid expansion would likely result in:

1. A shift from uninsured to Medicaid, which would increase hospital revenue and decrease uninsured costs.
2. A shift from individual and group insurance coverage to Medicaid, which in most cases would decrease hospital revenue.
3. An increase in overall hospital care as a result of improved access, which would increase hospital's operating costs.
4. Potentially more provider financing of the state share of Medicaid cost.

Two primary sources were relied upon to derive assumptions and make estimates for each of these factors. First, HHSC periodically makes forecasts of the effects of a possible Medicaid expansion and recently updated its assumptions for purposes of this report. Second, the Robert Wood Johnson Foundation and Urban Institute (RWJF/UI) recently published an analysis[74] of the potential impact of Medicaid expansion on the number of Medicaid enrollees and uninsured residents in each of the 19 states that have not expanded.

The HHSC forecast is focused on eligible low-income uninsured adults who may opt to enroll in Medicaid, and the cost to the Medicaid program. The RWJF/UI report addresses a number of additional potential coverage changes including persons with subsidized marketplace exchange coverage, persons with individual or employer-sponsored group policies, and children who are currently eligible but not enrolled who may follow their parents into Medicaid. The two sources result in very different estimated impacts, and both are presented below.

Changes in Coverage

HHSC compiled information about the 2014 number of uninsured in Texas and forecasted changes from 2014 to 2017. The following table summarizes the forecast.

[74] "What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured" by Matthew Buettgens and Genevieve M. Kenney, dated July 2016

Table 30: Summary of HHSC 2017 Texas Uninsured Forecast

Uninsured	US Citizens	Non-Citizens	Total
Age 19-64, incomes from 0% to 138% of poverty level	1,112,933	774,334	1,887,267
Age 19-64, other income levels	1,804,160	794,818	2,598,978
Under 19, all	795,323	158,262	953,585
65 and older, all	20,553	48,048	68,601
Total	***3,732,969***	***1,775,462***	***5,508,431***

The HHSC forecast assumes that the non-elderly adult citizens with incomes of 138% of poverty or less will be eligible and that 60 percent of those eligible will elect to enroll in Medicaid. The RWJF/UI report uses a similar number of eligible adults and assumes 70 percent would opt to enroll based on the average experience in states that expanded Medicaid in 2014. Texas has historically had lower participation rates than the national average and accordingly, the 60 percent participation estimate derived by HHSC appears to be more reasonable for a Texas projection. Applying a 60 percent to projected eligible uninsured persons yields an estimated 668,000 enrollment increase.

The RWJF/UI also identifies three other groups that may enroll in Medicaid and estimates the number of enrollees:

- Persons with subsidized marketplace exchange coverage with incomes below 138% of poverty would be required to move into Medicaid if Texas extended Medicaid eligibility to them. The RWJF/UI report estimates that there are 440,000 individuals in this category.
- Persons currently eligible for but not enrolled in Medicaid may opt-in if the state were to expand eligibility. The most common example is children, who may be enrolled if their parents gain eligibility. The RWJF/UI report estimates that there are 220,000 individuals in this category.
- Low-income persons with individual or employer-sponsored coverage, who may qualify for Medicaid based on income level and may opt to move to Medicaid because of lower cost-sharing or better benefits. The RWJF/UI report estimates that there are 368,000 individuals in this category.

A migration of low-income persons with subsidized marketplace exchange coverage to Medicaid is a reasonable expectation, because if Medicaid coverage was available the exchange coverage would no longer be subsidized.

With regard to the other two categories cited above, additional Medicaid enrollment from uninsured persons currently eligible and from those with private insurance are less likely to be significant numbers. Also, these two categories would have offsetting financial impact on hospitals: both categories would generate more Medicaid payment, but the latter would result in a decrease in private insurance reimbursement.

For purposes of the following financial projections, Medicaid enrollment is assumed to increase by 1,108,000 persons comprised of 668,000 currently uninsured and 440,000 currently insured.

Financial Impact of Coverage Changes

To estimate the cost of covering newly-eligible adults, the managed care premium rate for adults participating in the Temporary Assistance for Needy Families (TANF) program (excluding pregnant women) was used, with an adjustment for severity. The TANF-Adult rate represents a reasonable starting point, as it is likely that if Texas decided to expand Medicaid the state would utilize managed care for most coverage. The severity adjustment is intended to address the expectation that the average uninsured adult would require more care than the average insured adult. Also, because of lack of insurance there is likely a pent-up demand for health care – access to diagnostic and treatment services are often less accessible to the uninsured than insured persons. HHSC recommends an adjustment of 25 percent to account for higher costs of uninsured adults gaining Medicaid coverage.

Another factor to account for is emergency services coverage available to non-citizens, whereby Medicaid will cover and reimburse providers for treatment of emergency medical conditions applicable to certain individuals otherwise not eligible for Medicaid. Under the ACA, emergency services coverage is expanded to low-income non-citizen adults in states that elect to expand Medicaid. Given the number of non-citizens in Texas (see Table 30), this is an important consideration. HHSC has derived forecasts of the amount of Medicaid cost associated with expanded emergency services coverage.

Applying the rate and cost assumptions and an estimate of the hospital share of such costs to the aforementioned enrollment projection yields an estimated annual increase in Medicaid payments to hospitals of $2,235 million. As noted above, a portion of the Medicaid increase is the result of providing more services on average than uninsured persons currently receive. Applying average cost ratios to the portion of payment increase associated with increased services yields an estimated annual increase in hospital operating costs of $602 million.

The final set of assumptions needed to estimate the impact of a Medicaid expansion on hospitals is related to the revenue that hospitals currently derive from populations that would be covered by Medicaid. From the uninsured, hospitals currently receive approximately 7 percent reimbursement of their costs. Applying this average to the reduction in uninsured cost associated with the assumed coverage expansion described above yields an estimated $167 million reduction in payments from the uninsured.

For marketplace and privately insured persons, hospitals typically receive more than cost. It is common for hospitals to have payments in excess of cost from non-governmental insurers and payers. The amount of reimbursement in excess of cost would be partially offset by a reduction in hospital bad debt, because private insurance policies often have significant patient pay requirements that lead to uncollectible amounts. Data on current Texas hospital experience is not

publicly available; for purposes of this report it is assumed that marketplace and private insurance reimbursement is equal to cost, a very conservative assumption. Applying this assumption to the cost of persons shifting coverage from marketplace/private insurance to Medicaid yields an estimated $1,107 million decrease in hospital insurance revenue.

Based on the coverage and financial assumptions noted above, estimates of the financial impact of a Medicaid expansion are as follows:

Table 31: Financial Impacts of a Medicaid Expansion

Additional Medicaid Enrollment	
Currently uninsured	668,000
Currently insured, marketplace exchange and private	440,000
Total Medicaid Enrollment	***1,108,000***
Annual Changes in Revenue, Expense (000s)	
Increase in Medicaid payments	$2,235,000
Decrease in uninsured payments	($167,000)
Decrease in insurance payments	($1,108,000)
Increase in operating costs	($602,000)
Net Financial Effect on Hospitals	***$358,000***
Change in Uninsured Cost (000s)	
Decrease in uninsured cost	$1,782,000
Decrease in uninsured payments	($167,000)
Net Decrease in Uninsured Cost	***$1,615,000***

The costs of Medicaid expansion are being financed 100 percent with federal funds through 2016. In 2017, states will be required to fund 5 percent of the costs and the state share increases over the next three years to 10 percent in 2020. Using the cost estimate described above, the state would need to identify $341 million to fund the 5 percent match in 2017 and $682 million to fund the 10 percent requirement in 2020. Many states have responded to this budget challenge by raising provider taxes or other sources of provider financing. Because Texas is currently not contemplating expansion, it is not known how this state would respond.

The combined effect of the projected increase in Medicaid shortfall and decrease in uninsured cost is a $358 million financial gain to Texas hospitals, before any offset for provider financing of the state match.

Impact of DSH Reductions on Texas Hospitals

As described in Section II, Disproportionate Share Hospital (DSH) payments are required under federal Medicaid regulations to be made to hospitals serving a significant level of Medicaid and uninsured patients. In FY 2015, the total computable DSH payment for Texas hospitals was $1.78 billion, which offset an estimated 10 percent of uncompensated care in that year.

As a component of the ACA, DSH allotments (the maximum federal share of Medicaid DSH payments) were targeted for major reductions. The rationale for the reductions – Medicaid and subsidized private insurance were expected to significantly reduce the size of the uninsured population and, accordingly, reduce the uncompensated care burden. The DSH allotment reductions were originally scheduled to begin in FY 2014; however, through several pieces of legislation the effective date has been delayed. The most recent of legislation, the Medicare Access and CHIP Reauthorization Act of 2015, delays the implementation of the cuts to FY 2018 and extends them to FY 2025. The statutory reductions in the federal share of DSH payments for all states under current law are:

- FY 2018 – $2.0 billion
- FY 2019 – $3.0 billion
- FY 2020 – $4.0 billion
- FY 2021 – $5.0 billion
- FY 2022 – $6.0 billion
- FY 2023 – $7.0 billion
- FY 2024 – $8.0 billion
- FY 2025 – $8.0 billion

In preparation for the reductions originally scheduled to begin in FY 2014, CMS issued regulations in 2013 addressing the allocation of the cuts by state and developed a methodology to be used for the first two years. The ACA set forth several criteria that must be used in the allocation of the cuts by state and CMS considered each of these criteria in its methodology, including:

- States with low DSH allotments would receive a smaller proportion of the reduction.
- States that have lower uninsured rates relative to other states would receive a larger reduction.
- The reductions would be smaller for states that target DSH payments to hospitals with high Medicaid volume, and states that target DSH payments to hospitals with high levels of uncompensated care.

Predicting Texas' share of the DSH reductions is complicated by the fact that CMS has yet to update the methodology for FY 2018 and beyond and the inputs to the methodology are volatile. The current state by state uninsured rates differ from what they were in 2013. As noted in Section II, Texas does target DSH payments to hospitals with high Medicaid volumes and those with high levels of uncompensated care; however, Texas will be judged in relation to all other states, some of which may have more aggressive policies in place or even have modified their DSH policies to better target hospitals with high Medicaid volume and uncompensated care in order to enhance their share of future DSH allotments. To estimate the impact of the DSH reductions on Texas, three alternatives were considered.

First, in FY 2016 Texas represents 8.7 percent of the nationwide total DSH allotment. If Texas receives an average DSH reduction, its future allotments would be reduced by 8.7 percent of the nationwide cuts.

Second, in the FY 2014 Proposed Rule that led to the aforementioned regulatory guidance, CMS published a table illustrating the state by state impact of its methodology though noting the limitations of the base data utilized. In this table, Texas' share of the FY 2014 DSH reduction was estimated to be 11.2 percent of the nationwide total.

Third, in March 2016 the Medicaid and CHIP Payment and Access Commission (MACPAC) published the results of its analysis of the DSH reductions.[75] MACPAC utilized the methodology promulgated by CMS in 2013 and applied it to more recent, but still limited data. As a result of its analysis, Texas' allotment would be reduced by 3.9 percent of the nationwide total.

The difference between the CMS estimate in 2013 (11.2 percent) and the MACPAC estimate in 2016 (3.9 percent) underscores the uncertainty in the eventual impact on Texas Medicaid DSH especially given the limited data available to make the necessary relative comparisons. Both approaches used the same methodology, yet one shows an impact on Texas that is 30 percent higher than the national average and the other shows an impact that is less than half of the national average.

The following table shows the effect on Texas Medicaid DSH payments under each of the three alternatives discussed above and assuming no change in the unreduced DSH allotment or FMAP.

Table 32: Future Reductions in Texas Federal DSH Allotment under Various Assumptions

		Decrease in Texas Federal DSH Allotment based on			Decrease in Medicaid DSH Payments based on		
in 000s	**Statutory decrease, all states**	**Current Share (8.7%)**	**CMS model (11.2%)**	**MACPAC model (3.9%)**	**Current Share (8.7%)**	**CMS model (11.2%)**	**MACPAC model (3.9%)**
FY 2018	($2,000,000)	($174,000)	($224,000)	($78,000)	($300,000)	($386,000)	($134,000)
FY 2019	($3,000,000)	($261,000)	($336,000)	($117,000)	($450,000)	($579,000)	($202,000)
FY 2020	($4,000,000)	($348,000)	($448,000)	($156,000)	($599,000)	($772,000)	($269,000)
FY 2021	($5,000,000)	($435,000)	($560,000)	($195,000)	($749,000)	($965,000)	($336,000)
FY 2022	($6,000,000)	($522,000)	($672,000)	($234,000)	($899,000)	($1,158,000)	($403,000)
FY 2023	($7,000,000)	($609,000)	($784,000)	($273,000)	($1,049,000)	($1,351,000)	($470,000)
FY 2024	($8,000,000)	($696,000)	($896,000)	($312,000)	($1,199,000)	($1,543,000)	($537,000)
FY 2025	($8,000,000)	($696,000)	($896,000)	($312,000)	($1,199,000)	($1,543,000)	($537,000)

As shown above, Texas Medicaid DSH reductions under the most favorable assumptions will range from $134 million in FY 2018 to $537 million in FY 2025. Under the most unfavorable assumptions the cuts will range from $386 million in FY 2018 to $1,543 million in FY 2025.

[75] "Report to Congress on Medicaid and CHIP", March 2016, Medicaid and CHIP Payment and Access Commission

What if Texas Reestablished UPL Payments?

Federal regulations prohibit federal financial participation for Medicaid fee-for-service (FFS) payments in excess of an upper payment limit (UPL). This is intended to prevent Medicaid from paying a class of providers more than Medicare would pay for the same services.

Prior to the implementation of the 1115 waiver, Texas had a significant gap between what they could pay for hospital services and what was being paid (UPL gap). In SFY 2011, the hospital upper payment limit program paid hospitals $2.5 billion in supplemental payments that were essential for assuring access to care. In addition, HHSC complemented the hospital supplemental program with targeted physician, dental, and ambulance UPL programs.

As part of the waiver, UPL spending was incorporated into the UC Pool. The waiver along with the UC Pool allowed HHSC to make a dramatic shift from fee-for-service to managed care. Because the UPL is an artifact of the FFS structure, the movement to managed care compromised the ability to maintain the past UPL structure. The most recent calculations of the UPL shared by the state indicate that even with the limited fee-for-service utilization in place today, the state has capacity to create a UPL supplemental program of at least $400 million.

The critical need and role of supplemental payments previously led the state to exclude hospital services from managed care in order to utilize the UPL framework. Without an adequate UC pool under the waiver, it is conceivable that the state could carve hospital services out of managed care and revert back to a UPL-like program in order to preserve access to care.

Utilizing the cost analysis derived in this report, it is estimated that by removing hospital services from managed care, HHSC could create a hospital UPL program of approximately $3 billion in SFY 2017. This estimate was derived by utilizing the estimated shortfall from cost in the base period and adjusting for actual and projected changes in utilization, costs, and payments. Furthermore, if the state both excluded hospital services from managed care and expanded Medicaid, the hospital UPL program capacity would increase by an additional $1.3 billion to create a total hospital UPL gap of $4.3 billion.

Impact of the State Fully-Funding Hospital Medicaid Costs

The STCs require an analysis of a scenario in which the State of Texas increases base payments by an amount sufficient to fully fund the Medicaid shortfall, and the effect that a base payment increase would have on supplemental safety net funding.

The FY 2017 Medicaid cost in excess of base payments is projected to be approximately $3.1 billion (excluding approximately $0.7 billion associated with dual eligible and out of state cost and payments). Adding $3.1 billion to base rates would require a rate increase of approximately 36 percent and $1.3 billion in non-federal match. If Texas were to expand Medicaid coverage, as estimated earlier in this section, the total Medicaid shortfall would increase to $4.3 billion given current reimbursement rates at approximately 64% of cost. This increased shortfall would require

a nominal increase to non-federal funds with the costs related to the expansion population funded at 95 percent for calendar year 2017.

Adding $3.1 billion to base rates (or a larger amount under a Medicaid expansion) could replace a significant amount of supplemental DSH and UC payments. However, there are three important concerns with this scenario.

First, the majority of Texas Medicaid beneficiaries are in managed care. Federal regulations prohibit state direction of managed care premiums to providers and, accordingly, there is no assurance that if managed care premiums were increased by an amount sufficient to fund the managed care portion of a provider rate increase, the funds would actually be paid to hospitals. In fact, a more conservative assumption is only 85 percent of the premium increase would be paid to hospitals because states are required to ensure that at least 85 percent of premiums are used for medical costs.

Second, the state may not be able to generate the non-federal match associated with the rate increase. The state has four constitutional limits on spending: a balanced budget limit, which is commonly referred to as the pay-as-you-go limit; a limit on the rate of growth of appropriations from certain state taxes, commonly referred to as the spending limit; a limit on welfare spending; and a limit on tax-supported debt.

The pay-as-you-go limit and the spending limit both restrict the total amount the Legislature can appropriate, but in different ways. The pay-as-you-go limit prohibits the General Revenue Fund budget from exceeding available revenue. The spending limit prohibits appropriations funded with tax revenues not dedicated by the constitution from growing faster than the state's economy. Since both limits apply, even when available revenue grows, the spending limit may not permit all the affected revenue to be appropriated, moderating potential spikes in spending.

Texas must meet the totality of General Revenue funding needs of the state including Medicaid, and manage within the constraints imposed by the state's constitution. A significant increase in Medicaid funding would not likely be possible without significant cuts elsewhere in the budget.

If the rate increase was coupled with a reduction in DSH and/or UC funds, local units of government would be relieved of much of their responsibility for financing the state share of DSH and UC payments and may redirect their IGTs to finance a rate increase. However, there is no assurance that local units of government would participate to the same degree if safety net funding was replaced with base rate increases.

Third and most importantly, the scenario would result in a significant redistribution of revenue among hospitals. As discussed above and as demonstrated in Appendices III and IV, there is wide variation in the distribution of base payments and DSH/UC payments. Additionally, Texas Medicaid does not establish payment floors or other payment guidelines regarding hospital reimbursement under Medicaid managed care. Many hospitals that are currently dependent on

DSH/UC payments would experience decreases that could jeopardize their ability to serve their communities. In fact, because DSH/UC payments are targeted to the hospitals with the highest Medicaid and uninsured costs, the redistribution could be very detrimental to the state's safety net.

In short, while this scenario may appear to be viable on the surface, replacing safety net funding with higher rates could have negative consequences.

Section VII – Conclusions

Texas hospitals face a large and growing uncompensated care burden. In FY 2015, the net costs of uninsured care for all participating hospitals prior to supplemental pool payments were estimated at $5.2 billion. When Medicaid shortfall is included, unreimbursed costs grow to $8.7 billion in FY 2015. Before supplemental payments are considered, the payment to cost percentage across all hospitals is 48.4 percent (68.8 percent for Medicaid and 7.0 percent for uninsured). After the application of GME and DSH payments as offsets to cost, the payment to cost percentage across the participating hospitals increases to 58.8 percent (74.1 percent for Medicaid and 27.9 percent for uninsured).

Unreimbursed Hospital Costs, FY 2015

Amounts in billions	FY 2015
Total uninsured care	$5.2
Total Medicaid shortfall	$3.5
Total uncompensated care before supplemental payments	$8.7
Percentage of cost paid before supplemental payments	48.4%
GME and DSH payments	$1.8
UC Pool payments	$2.9
Total unreimbursed Medicaid and uninsured after supplemental payments	$4.0
Percentage of cost paid after supplemental payments	76.3%

Applying UC Pool payments as an additional offset to costs increases the payment to cost percentage to 76.3 percent (83.9 percent for Medicaid and 61.0 percent for uninsured). While this represents a significant improvement in the coverage ratio relative to base payments only, it is important to note that even after applying UC Pool payments, Texas hospitals still face approximately $4 billion in remaining unreimbursed cost, including $1.8 billion in Medicaid shortfall and $2.2 billion in net uninsured cost (see Table 19).

The estimates included in this report are the result of rigorous data collection and analysis to arrive at the most accurate and complete accounting of unreimbursed costs based on the data available. Specifically, the estimates were developed utilizing the following methodological parameters. Each of these has important implications for understanding the scale and composition of unreimbursed costs, as well as the implications for any increases or reductions in the size of supplemental payment pools:

Source of data The best source of data for estimating Medicaid and uninsured costs is the Texas Hospital Uncompensated Care (TXHUC) tool, a data collection instrument approved under the "UC Claiming Protocol and Application" in the Waiver STCs. The TXHUC captures charges for services to uninsured patients, an estimate of the costs for these services, and payments for the uninsured from state and federal sources.

The Medicare cost report S-10 worksheet was evaluated for the purpose of determining uninsured cost. Medicare cost report data has been the best publicly available source of hospital

financial information for decades. However, the S-10 worksheet has shortcomings and several significant gaps and variances have been noted as described in detail in this report. Indeed, many of these concerns were echoed in CMS' recent decision to delay the use of the S-10 for Medicare reimbursement policy. While the S-10 may be the best (or only) available source of uncompensated care data in some states, it should not preclude the use of other, more complete and accurate data sources that may exist in other states like Texas.

Defining and estimating uncompensated care Federal and state policies have consistently used all unreimbursed uninsured cost (including both uninsured charity care and uninsured bad debt) for quantifying uncompensated care. Using this definition and the TXHUC cost calculations, there was an estimated $5.2 billion of uninsured cost incurred in FY 2015 by Texas hospitals.

The waiver STCs call for a more limited calculation of uncompensated care, focused on charity care as defined in a Healthcare Financial Management Association (HFMA) publication and one that excludes bad debt. Due to significant variations in how hospitals classify charity care versus bad debt, many hospitals routinely under-report the portion of uninsured care that should be classified as charity care under HFMA principles.

This issue was recognized in a recent study of uncompensated care costs within the California Medicaid program. To address this concern, the study's authors asked participating hospitals to re-calculate their charity care and bad debt using a definition of charity care that reflected the HFMA principles. The study concluded that nearly half (49.7 percent) of reported bad debt expense met the definition of charity care. After applying this "imputed charity care" factor to uninsured bad debt, an estimated $4.2 billion of the $5.2 billion of uninsured cost is attributed to charity care and the remainder is bad debt. Consistent with the principles applied across the Medicare and Medicaid programs, the entire estimate of uninsured cost less payments should be utilized for the purpose of defining uncompensated care.

Treatment of Medicaid shortfall The STCs also specifically exclude all costs related to Medicaid shortfall from the calculation of uncompensated care cost. This provision stands in contrast to the original purpose of the UC Pool, as articulated in the STCs, to "defray the actual uncompensated costs of medical services that meet the definition of "medical assistance" contained in Section 1905(a) of the Act that are provided to Medicaid eligible or uninsured individuals incurred by hospitals, clinics, or by other provider types …"

While the state has recently increased Medicaid rates after several years of stagnation, base rates do not fully cover costs and many hospitals are reliant on supplemental funding, including UC Pool payments, to maintain critical services. Among the hospitals with the highest reliance on Medicaid, UC Pool payments represent such a significant proportion of net income that the elimination of the UC Pool would shift their net income from positive to negative (see Table 27).

Financing Medicaid payments As is the case in many states, Texas finances a large portion of the non-federal share of its Medicaid program through intergovernmental transfers from public

hospitals, governmental entities that own public hospitals, or other units of government. In FY 2015, 40 percent of supplemental pool payments in Texas were financed by IGTs. While IGTs are not considered an expense from an accounting standpoint and cannot be included in uncompensated care cost, the economic reality for hospitals that self-finance a portion of their revenue through IGTs is that they are left with less overall revenue to support operations. Therefore, IGTs may be considered and offset against payments in determining Medicaid payment adequacy and shortfall. When IGTs made directly by public hospitals are treated this way, unreimbursed Medicaid and uninsured cost (FY 2015) grows from $4.0 billion to $5.0 billion (see Table 21).

Medicaid Expansion impact As of July 2016, Texas is one of 19 states that have opted not to expand their Medicaid program to low-income adults, as allowed under the Affordable Care Act. Should the state reverse this decision, it would impact Texas hospitals in several ways:

- Currently uninsured individuals would enroll in Medicaid, increasing hospital revenue. Based on projections described in this report, an estimated 668,000 individuals would be both eligible for and enroll in the new coverage. This would provide an additional $2.2 billion in Medicaid payments for Texas hospitals, while reducing uninsured cost and payments by $1,782 million and $167 million, respectively.
- Individuals currently receiving subsidized coverage through the Marketplace with incomes between 100% FPL and 138% FPL would move to Medicaid coverage. Based on a recently released report from the Robert Wood Johnson Foundation and Urban Institute, an estimated 440,000 individuals would fall into this category. Assuming that marketplace insurance currently reimburses hospitals at cost (a conservative assumption), this change would reduce payments to Texas hospitals by an estimated $1.1 billion.
- Persons currently eligible for, but not enrolled in Medicaid, may enroll under an expansion, a phenomenon commonly known as the "woodwork effect." In addition, low-income individuals with individual or employer-sponsored coverage may drop current coverage in favor of lower-cost Medicaid coverage. These two phenomena would have offsetting financial impacts on hospitals and, based on recent experience in the state of Texas, are likely to have a negligible impact on enrollment. Therefore, they were excluded from the estimates in this report.

The combined impact of the above changes would be an estimated $1.6 billion decrease in net uninsured cost and a $1.2 billion offsetting increase in the Medicaid shortfall. The impact on uncompensated care would be significant, as has been the case in most states that have expanded Medicaid, but as of the writing of this report, Medicaid expansion in Texas does not appear to be likely in the near future.

DSH Reduction impact Disproportionate Share Hospital (DSH) payments are required under federal Medicaid regulations to be made to hospitals serving a significant level of Medicaid and

uninsured patients. In FY 2015, DSH payments to Texas hospitals totaled $1.72 billion, which offset approximately 10 percent of uncompensated care in that year.

Pursuant to the Affordable Care Act, DSH allotments are scheduled to undergo significant reductions based on the rationale that increased rates of coverage through Medicaid expansion and subsidized private insurance should significantly reduce the uncompensated care burden on providers. The DSH allotment reductions were originally scheduled to begin in FY 2014 but have been delayed several times and are now scheduled to being in FY 2018 and extend through FY 2025.

CMS has not yet updated the DSH methodology for FY 2018 and beyond, and the inputs to the methodology are highly variable. Accordingly, it is difficult to predict the impact of DSH cuts on Texas hospitals. Under the most favorable assumptions, the reductions will range from $134 million in FY 2018 to $537 million in FY 2025. Under the most unfavorable assumptions the cuts will range from $386 million in FY 2018 to $1,543 million in FY 2025. Despite high levels of uncertainty on the amount of the reductions, the overall impact of the DSH reductions, once implemented, will be a significant increase in unreimbursed Medicaid and uninsured costs.

Importance of UC Funding As described in detail in this report, Texas's high rate of population growth, coupled with high demand for healthcare services by uninsured individuals, point toward continued increases in uncompensated care.

While it is difficult to predict the specific impact on access to care, aggregate data points toward the possibility of access problems in some communities. Analysis of uninsured data as well as proxy data for access indicates that communities with the highest level of need and access issues receive the greatest amount of uncompensated care funding. In FY 2015, UC Pool payments accounted for 4.6 percent of all revenue for Texas hospitals and 54.9 percent of aggregate net income. Among the hospitals with the highest concentrations of Medicaid patients, UC Payments represent 8.1 percent of total revenue and 187 percent of net income, indicating that in many cases hospitals would face losses without UC Pool funding (see Table 27, Tiers 1 and 2 combined).

It is similarly difficult to predict how the state would respond to a reduction in supplemental payment funding, but one scenario would be the re-establishment of the state's UPL program. Prior to the implementation of the 1115 waiver, the state maintained a $2.5 billion UPL supplemental payment program. Based on estimates developed for this report, Texas could establish a hospital UPL program of approximately $3 billion in FY 2017 if it were to remove hospital services from managed care.

An alternative scenario would be to increase base payments by an amount sufficient to fully fund Medicaid cost. Doing so may reduce the state's reliance on supplemental payments. However, there are major concerns with this scenario. The base payment increase would require an estimated $1.3 billion in non-federal match, an amount not likely to be available given Texas'

constitutional spending limits and other budget challenges. Also, under the managed care structure the full amount of the increase would not be expected to accrue solely to hospitals and there could be a significant amount of redistribution as the state would be precluded from directing payments to compensate providers with high uncompensated care costs. As a result, public hospitals and other units of government that are currently financing the supplemental payment pools through IGTs may elect not to do so, leaving the state without a stable source of non-federal share.

Under the current funding and reimbursement structure, Texas hospitals incur significant amounts of unreimbursed costs serving Medicaid and uninsured patients. Texas's uncompensated care burden is almost certain to grow, based on demographics, underlying market factors, and projected DSH cuts. While the implementation of a Medicaid expansion would blunt the impact to a certain degree, it would not come close to eliminating the uncompensated care burden in the state and it is unlikely to be implemented in the near future.

Summary of Hospital Unreimbursed Costs, FY 2017 Pro Forma

In Millions	Medicaid	Uninsured	Total
Unreimbursed cost, participating hospitals (1)	($3,804)	($5,517)	($9,321)
Non-participating hospitals (1)	($63)	($221)	($284)
Unreimbursed cost, before supplemental payments	***($3,867)***	***($5,737)***	***($9,605)***
GME pool (2)	$31	$0	$31
DSH pool (2)	$560	$1,162	$1,722
Unreimbursed cost, after supplemental payments	***($3,277)***	***($4,575)***	***($7,852)***
Pro forma effect, Medicaid expansion	($1,257)	$1,615	$358
Pro forma effect, DSH reductions (3)	$0	($749)	($749)
Unreimbursed cost, after pro forma adjustments (4)	***($4,534)***	***($3,709)***	***($8,243)***

(1) FY 2013 base payments and costs trended to FY 2017
(2) FY 2015 amounts, not expected to be materially different in FY 2017
(3) Represents FY 2021 estimate, assuming Texas' share of the ACA DSH reduction is the same as its current share of the federal DSH allotment
(4) Hospitals only

This pro forma analysis estimates that without payments from the 1115 waiver Texas hospitals could incur $8.2 billion in unreimbursed Medicaid and uninsured care even after a Medicaid expansion. Including unreimbursed costs from the physician groups, ambulance providers and dental providers that currently receive a portion of the UC Pool payments adds $420 million to this amount, yielding a combined total in excess of $8.6 billion.

In the current environment, reimbursement from the 1115 waiver program helps ensure that adequate resources are available to millions of low-income Texas residents and the UC Pool provides an equitable, accountable and sustainable funding mechanism to help ensure access to care for the state's most vulnerable residents.

Appendices

Appendix I – Excerpt from Special Terms and Conditions – New Reporting Requirement

HHSC and the Centers for Medicare and Medicaid Services (CMS) have agreed to a 15-month extension of the Texas 1115 Waiver. The agreement extends the program through December 2017. The Special Terms and Conditions (STCs), which set forth the federal involvement and state obligations under the Demonstration Waiver, were modified to incorporate a new reporting requirement of the state. This requirement is found at Section 44.c.of the amended STCs and is included below.

c. **Evaluation of Uncompensated Care Costs for the Uninsured.** The following sets forth the requirements for the evaluation of Texas' uncompensated care pool and DSRIP program through an independent report on the use of such pools, and the relationship of such payments to base Medicaid provider payment rates. Texas shall submit the report by the end August of 2016, and it will be used to rebase the size of the Uncompensated Care pool.

i. General Description. The state must commission a report from an independent entity on Medicaid provider payment in the state that reviews the role of uncompensated care and DSRIP payments in the overall Medicaid system for paying hospitals. The report should consider adequacy of base Medicaid payment levels and their relation to Medicaid shortfalls (as reported in provider cost reports), and should indicate the degree to which uncompensated care pool and DSRIP payments compensate for insufficient base payment levels. The report should also identify the percentage of uncompensated care pool payments that are not specifically related to Medicaid shortfalls, and define uncompensated care costs as those associated with charity care as defined by the principles of the Healthcare Financial Management Association, and not include bad debt or Medicaid shortfall.

ii. Funding for Uncompensated Care Pool Evaluation. $500,000 (total computable) will be funded from the Texas demonstration's general administrative budget for commissioning this report, unless the state receives written authorization from CMS to expend a lower amount. The state may use more than $500,000 of its general administrative budget for this report. Expenditures for the creation of the report will be considered Medicaid administrative expenditures and be eligible for FFP at the usual matching rate for administrative expenditures

iii. Specific Evaluation Requirements. The report must meet the following criteria:

A. **Goal of the Report.** The goal is to ensure sustainable, transparent, equitable, appropriate, accountable and actuarially sound Medicaid payment systems and

funding mechanisms for hospital providers that will ensure quality health care services to Texas' Medicaid beneficiaries throughout the state.

B. **Framework of the Report.** The report must include a detailed description and analysis of the current Medicaid provider payment (for all Texas hospitals) and financing system, with a major focus on services currently supported with pool funds. The report must also include information regarding the non-federal share for the various payments and how payments to providers correspond to amounts reported on the CMS- 64. The report must note any shortfall or overages in provider payments across all payment types in the current funding structure.

I. The report should include information on external trends within Texas (e.g. the economy, possible reductions to DSH) that may affect the data being analyzed.
II. The report must include an analysis of non-hospital providers and their participation within the UC Pool.
III. The report must include detailed information on the historical methods of funding hospital payments, the way in which the source of non-federal share interacts with payment distribution methodology, and describe the composition of payments, including base and supplemental payments, and the percentage of payment providers receive and retain.
IV. The report must analyze the adequacy of current payment levels for Medicaid hospital providers, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms for making these payments. The report will include the impact of UC, DSH, and DSRIP funding on uninsured and Medicaid shortfall. The report will primarily focus on the types of providers supported by the pool.
V. The report will include an analysis of how Texas Medicaid compares with other states regarding what portion of Medicaid hospital costs are covered by Medicaid provider payment rates.
VI. The report must include the cost of uncompensated care provided to uninsured individuals by hospitals, and the extent that historical pool payments have addressed these costs.
VII. The report will also estimate what Texas' UC burden would be in FFY 2017 if Texas Medicaid rates fully funded Medicaid shortfall, and if Texas opted to expand Medicaid as allowed under the ACA.
VIII. All data presented in the report must be submitted to CMS in unlocked Excel worksheets to assist in review of the analysis, and the state will provide an appendix with individual hospital details.
IX. The report should provide the following information for the hospital providers covered in the report:

1. Total hospital system revenue from all payors
2. Total Medicaid revenue (including patient care revenue and all other Medicaid revenue such as demonstration revenue and incentive payments)
3. Total Medicaid patient care revenue
4. Total UC and DSRIP pool revenue

iv. Deadlines, Monitoring, and Funding

A. A draft report will be due for CMS preliminary review no later than July 15, 2016
B. The final report will be due no later than August 30, 2016.
C. Monthly monitoring calls with the state will include an update of progress on the report.
D. If the state does not timely submit either stage of the report, including all requested analyses and recommendations, the state's expenditure authority for uncompensated care pools will be reduced by up to $500,000. The state may seek, and CMS may grant, relief from this reduction, if needed.

Appendix II – Instructions in TXHUC Tool for Reporting Uninsured Charges

The following instructions are included on the Hospital Data section of the TXHUC Tool

Section 7: UNINSURED CHARGES & PAYMENTS FOR DATA YEAR 2013 (10-1-2012 THROUGH 9-30-2013)

The following material is meant to help a hospital determine its uninsured charges and payments for the DSH program. This is not an exhaustive list and HHSC recommends hospitals review the final DSH Audit Rule, published December 18, 2008, Federal Register pages 77803 to 77852, which identifies information CMS has adopted as a permissible uninsured claim and payment data. Information on proposed changes in the uninsured definition is included in Section 8, below. HHSC will not consider applications that complete section 8 without completing section 9. Section 9 will be added to the interim payments at HHSC discretion, but only if the final rule is adopted by CMS.

UNINSURED DEFINITION: The uninsured section of the program refers to the charges associated with providing inpatient and outpatient hospital services to uninsured patients minus the payments (revenues) actually received from or made on behalf of the patient. Uninsured patients do not have a third party payer source, where a third party payer refers to creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146 as well as coverage from a legally liable third party payer. Hospitals should make every effort to ensure that a patient does not have a valid form of insurance before including the patient in the uninsured program.

CHARGES: Report inpatient and outpatient hospital charges for services to uninsured patients discharged during the Data year. HHSC will convert uninsured charges to uninsured costs using cost center ratio(s) of cost-to-charges (inpatient and outpatient hospital services). HHSC will reduce uninsured costs by the amount of any payments from or made on behalf of an uninsured patient received by the hospital during the Data year to derive the net uninsured costs. Services provided to the uninsured should be consistent with the definitions of eligible inpatient and outpatient services stated in Texas' Medicaid State Plan.

Hospitals must exclude charges associated with the following:

- Services for inmates or other incarcerated individuals;
- Outpatient retail pharmacy services;
- Physician and professional services not billed under the hospital's TPI;
- Services paid for with public employees worker's compensation programs;
- Duplicated uninsured charges (i.e.; charges that appear in both the Medicaid files and Uninsured files or that appear multiple times in the uninsured files);
- Services that are not medically necessary;
- Services paid in total or in part by a third party payer, including amounts associated with unpaid co-pays, deductibles for individuals with third party coverage, other bad debt or

payer discounts related to services furnished to individuals who have health insurance or other third party payer;

- Any patient who has any third party payer under 45 CFR Parts 144 and 146, no matter how insignificant the payment is;
- Medicaid or CHIP eligible individuals; and
- Services that would not be covered under the Texas Medicaid State Plan had the individual been Medicaid eligible.

Hospitals should include charges associated with the following:

- Provider discounts for uninsured patients (these discounts are not revenues, but are discounted costs);
- Services provided to undocumented residents;
- All other inpatient services provided to uninsured patients;
- All other outpatient services provided to uninsured patients;
- Outpatient pharmacy drugs/services provided in an outpatient clinic and billed under the hospital's TPI;
- IMDs should report charges for services that would be covered by Medicaid that were provided during the data year to Medicaid eligible patients between the ages of 21 and 65; and
- Facility fees associated with subproviders providing services to uninsured patients (e.g.; rehabilitation services)

Appendix III – Assessment of State of Texas Medicaid Hospital Payments and Distribution of Services

In response to one of the requirements of the modified Standard Terms and Conditions (STCs), the State of Texas Health and Human Services Commission ("HHSC") engaged Deloitte Consulting to perform two analyses:

1. *Medicaid Reimbursement Assessment: Compare the percent of hospitals' Medicaid costs that other states pay through their Medicaid inpatient and outpatient hospital provider rates to the Texas reimbursement percentages;*

2. *Distribution of Medicaid Services by Hospital Type Assessment: Assess the Medicaid dependencies (i.e. usage) of public versus private hospital providers in Texas compared to other comparative states.*

The report from Deloitte Consulting dated August 25, 2016 is included on the following pages.

Deloitte Consulting LLP

50 South Sixth Street
Suite 2800
Minneapolis, MN 55402-1538
USA

Tel: 612-397-4000
Fax: 612-397-4450
www.deloitte.com

August 25, 2016

Pam McDonald
Health & Human Services Commission
4900 N Lamar Blvd
Austin, TX 78751

Subject: Assessment of State of Texas Medicaid Hospital Payments and Distribution of Services by Hospital Provider Type

Dear Ms. McDonald:

We appreciate the opportunity to provide actuarial services for the State of Texas Health and Human Services Commission ("HHSC"). This letter summarizes the results of the analyses performed by Deloitte Consulting LLP ("Deloitte Consulting") to research and assess (1) the current national environment for Medicaid reimbursement compared to cost and, (2) the proportion of Medicaid services provided by public and private hospitals. For both analyses, the Texas market was compared to comparative state Medicaid programs.

In this document, we have included detailed information regarding the results, approach, and assumptions of the analyses performed. The remainder of our analysis is organized into the following sections:

I. Executive Summary

II. Background

III. Project Scope and Methodology

IV. Findings

V. Conclusions

VI. Appendices

This analysis has been solely prepared for HHSC. The analysis is intended to supplement a report on uncompensated care in Texas, as requested by the Centers for Medicare and Medicaid Services ("CMS") as part of the State of Texas's 1115 transformation waiver renewal. The information within this document should not be reproduced in any form outside of the intended use without the prior consent of Deloitte Consulting and should not be relied upon by any entity other than HHSC. HHSC may share a copy of this report in its entirety with CMS.

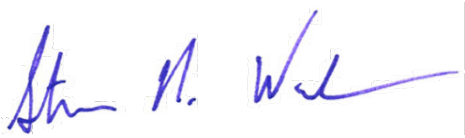
Our analysis is based upon data supplied by the State of Texas, other selected states, and other publicly available information. This information is listed in the body of the documentation. While we have performed general reasonableness checks of the data received for the analysis, we have not tested or audited the accuracy of the data, and we have relied upon the data provided by Texas and the comparative states in performing the financial analysis. If the underlying data or information provided is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Actuarial methods, considerations, and analyses used in the preparation of the attached documentation conform to the appropriate standards of practice as promulgated by the Actuarial Standards Board.

I, Steve Wander, am associated with the firm Deloitte Consulting LLP. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained within this analysis.

If you have any questions, please feel free to contact me by phone (612-397-4312) or by email (swander@deloitte.com).

Sincerely,



Steven N. Wander, FSA, MAAA
Principal
Deloitte Consulting LLP

Deloitte.

Assessment of State of Texas Medicaid Hospital Payments and Distribution of Services

Deloitte Consulting LLP
August 25, 2016

Table of Contents

I. Executive Summary 5

II. Background 8

III. Project Scope and Methodology 9

IV. Findings 11

V. Conclusions 14

Appendix A: Summary of Texas Data 16

Appendix B: Summary of Florida Data 17

Appendix C: Summary of Oklahoma Data 18

Appendix D: Summary of New York Data 19

Appendix E: Summary of Louisiana Data 20

Appendix F: Data Considerations 21

Solely for the information and use of State of Texas Health and Human Services Commission
and not to be relied upon by any other person or entity

I. Executive Summary

Overview

In response to one of the requirements of the modified Standard Terms and Conditions (STCs), the State of Texas Health and Human Services Commission ("HHSC") engaged Deloitte Consulting to perform two analyses:

1. Medicaid Reimbursement Assessment: Compare the percent of hospitals' Medicaid costs that other states pay through their Medicaid inpatient and outpatient hospital provider rates to the Texas reimbursement percentages;

2. Distribution of Medicaid Services by Hospital Type Assessment: Assess the Medicaid dependencies (i.e. usage) of public versus private hospital providers in Texas compared to other comparative states.

These assessments are intended to supplement a report on uncompensated care in Texas, as requested by the Centers for Medicare and Medicaid Services ("CMS") in conjunction to the State of Texas's 1115 transformation waiver renewal. Data was collected from officials from Texas and other state representatives in order to illustrate how reimbursement and the distribution of services by hospital type in Texas compare to other Medicaid programs. A summary of the results can be found below.

To develop this report, data from comparable states was requested and data received to date is included within the report and appendices. To lessen the effort required of states where data was requested, a high level discussion was conducted to indicate what data was needed and preferred level of detail to be summarized, as available. We recognize that the states did not necessarily use a consistent methodology to estimate costs (as noted in Appendix F). In addition, some states are not able to parse out the services that Deloitte has requested to be included or excluded from the analysis. We did not attempt to adjust the results from each state to account for known differences or attempt to quantify the impact of methodology differences. However, we have noted the known differences that we are aware of in the data section of this report. These differences in methodology and data across states should be considered before drawing any conclusions from the analysis.

As of the date of this report, detailed data has been received from Florida, Louisiana, and Oklahoma. Data has been collected for New York for State Fiscal Year ("SFY") 2010 to SFY 2012 which has been included in the findings for comparison. Medicaid distribution and payment data has been received from Louisiana, however, cost data was not available. Detailed SFY 2013 and SFY 2014 data has also been requested from New York and California. We received partial data for New York that was reviewed as able, while data from California has not yet been received at the release of this report. If we receive additional data after the date of this report, adjustments may be needed to the observations and a revised report may need to be issued.

Primary Findings - Summary

For the first analysis (Task 1) Texas' Federal Fiscal Year ("FFY") 2013 payment to cost percentage (using base payments only, excluding supplemental payments) was compared to the SFY2013 payment to cost percentage supplied by three other states, Oklahoma, Florida and New York. The data for Texas yielded a 69.6 percent payment to cost percentage; Oklahoma, Florida, and New York reported 43.9 percent, 78.7 percent and 79.4 percent (SFY2012), respectively.

Solely for the information and use of State of Texas Health and Human Services Commission
and not to be relied upon by any other person or entity

For the second analysis (Task 2), the distribution of inpatient days and outpatient visits between private and public hospitals in Texas was compared to the distribution in Oklahoma, Louisiana, and Florida. Using FFY 2013 data, Texas had 80.5 percent of inpatient days and 75.4 percent of outpatient visits provided by private hospitals. Oklahoma reported that 90.9 percent of inpatient days were from private hospitals in FY 2013. Louisiana reported that that 70.1 percent of inpatient days and 62.8 percent of outpatient visits were from private hospitals in SFY 2013. Florida reported that 79.1 percent of inpatient days and 81.9 percent of outpatient visits were from private hospitals in FY 2015.

Requests for detailed data are outstanding from one additional state (California).

Primary Findings - Details

Task 1 - Assessment of Medicaid Reimbursement

To gain an understanding of how the Medicaid reimbursement as a percentage of cost in Texas compares to other states, we collected Medicaid cost and payment information from Florida, Oklahoma, and New York. A summary of how FFY 2013 Medicaid reimbursement in Texas compares to the range developed from those states is shown in Figure 1.

Figure 1: Summary of Medicaid Reimbursement for Texas and Comparative States

	Total Medicaid Cost [76] (millions)	Total Medicaid Payments[77,78] (millions)	Percentage of Cost Reimbursed
Texas (FFY2013) [79]	$7,357.53	$5,120.49	69.6%
Comparative States[80]			43.9%-79.4%

Medicaid reimbursement as a percentage of cost in Texas falls within the range of Medicaid reimbursement percentages observed in comparable states. The Texas Medicaid reimbursement rates as a percentage of cost (or reimbursement percentages) are closer to the top end of the range for comparable states. In addition, the two previous statements hold true when comparing inpatient only reimbursement percentages in Texas against comparable states. However, the outpatient Medicaid reimbursement as a percentage of cost in Texas are lower than both of the other two states included in the analysis. The inpatient and outpatient data can be reviewed in more detail in Tables A.3, B.3 and C.3 of Appendix A, B, and C respectively.

---

[76] *Medicaid cost does not include dual eligibles, clinics, nursing homes, administrative costs, long-term-care facilities, psychiatric or Medicare crossover claims.*

[77] *Medicaid payments include reimbursement through provider rates only. Supplemental programs such as Disproportionate Share Hospital payments, Uncompensated Care Pool payments, Graduate Medical Education payments, etc. are not included.*

[78] *Medicaid payments do not include dual eligibles, clinics, nursing homes, administrative costs, long-term-care facilities, psychiatric or Medicare crossover claims.*

[79] *Based on claims incurred in FFY 2013*

[80] *Data includes SFY2013 data for Florida and Oklahoma, and SFY2012 data for New York. Cost data for Louisiana was not available*

Figure 2: Summary of Medicaid Reimbursement for Texas and Comparative States for Private Hospitals

	Total Medicaid Cost (millions)	Total Medicaid Payments (millions)	Percentage of Cost Reimbursed
Texas Private Hospitals (FFY2013)	$5,866.17	$4,152.27	70.8%
Comparative States[81]			43.0%-82.6%

Figure 2 above summarizes how FFY2013 Medicaid reimbursement for private hospitals in Texas compares to the range developed from private hospitals of comparable states. The Texas Medicaid reimbursement percentages are closer to the top of the range of percentage of costs reimbursed when compared to other states for services provided in a private hospital setting.

Figure 3 below summarizes how FFY2013 Medicaid reimbursement for public and state-owned hospitals in Texas compares to the range developed from public and state-owned hospitals of comparable states. Medicaid reimbursement in Texas falls within the range of Medicaid reimbursement percentages observed in other states. The Texas Medicaid reimbursement percentages are closer to the lower end of the range when under this review. However, note that the range of observations is extremely wide with Oklahoma at the low end at 51.8%, New York near the average at 71.1%, and Florida at the high end of the range at 99.0%.

Figure 3: Summary of Medicaid Reimbursement for Texas and Comparative States for Public and State-Owned Hospitals

	Total Medicaid Cost (millions)	Total Medicaid Payments (millions)	Percentage of Cost Reimbursed
Texas (FFY2013)	$1,491.36	$968.22	64.9%
Comparative States[82]			51.8%-99.0%

Based on the results above, it appears the Medicaid payment rates in Texas reimburse hospitals at a similar percentage of their costs as seen in other states. This comparison holds true when reviewing results in aggregate across all hospitals and claims types, as well when reviewing the reimbursement breakdown between public and state-owned hospitals, and private hospitals. Note this observation is based on a limited sample set of information available from other states.

Task 2 - Assessment of the Distribution of Medicaid Services by Hospital Type

---

[81] *Data includes SFY2013 data from Florida and Oklahoma and SFY2012 data for New York. Cost data for Louisiana was not available*

[82] *Data includes SFY2013 data from Florida and Oklahoma and SFY2012 data for New York. Cost data for Louisiana was not available*

To gain an understanding of how the distribution of Medicaid services provided by hospital type in Texas compares to other states, we collected Medicaid inpatient days, outpatient visits, and total inpatient and outpatient payments from Oklahoma, Louisiana, and Florida. This assessment compares both the utilization (e.g. inpatient days or outpatient visits) and Medicaid paid amount for Texas to the comparison states. A summary of how the distribution of inpatient days and outpatient visits provided by public and private hospitals in Texas compares to those provided by the other states is summarized in Figure 4 below.

Figure 4: Summary of Medicaid Inpatient Days and Outpatient Visits for Texas and Comparative States

	Percentage of Inpatient Days by Hospital Type			Percentage of Outpatient Visits by Hospital Type		
	Private	Public	State-Owned	Private	Public	State-Owned
Texas (FFY2013)	80.5%	17.0%	2.5%	75.4%	20.7%	3.9%
Comparative States (SFY2013) [83]	70.1% -90.9%	9.1% -29.9%	N/A	62.8%-81.9%	18.1%-37.2%	N/A

As shown in Figure 4 above, the distribution of Medicaid services by hospital type in Texas is similar to the distribution seen in comparative states, including private hospital utilization. When analyzing inpatient utilization, the distribution of inpatient days within private hospitals in Texas falls within the range of utilization seen in other states. For outpatient utilization, private hospital utilization based on outpatient visits is within the range of outpatient utilization seen in other state private hospitals. Note that these results are based on limited information available from other states, however, based on the information provided, it appears that the distribution of Medicaid services by hospital type in Texas does not vary significantly from that of other states.

II. Background

In September 2015, HHSC submitted a request to CMS to continue all three components of the current 1115 waiver (statewide managed care, the Uncompensated Care ("UC") pool program, and the Delivery System Reform Incentive Payment ("DSRIP") pool program) for another five years. In response to this extension request, CMS is requiring Texas to submit a report related to how the two pools in the waiver interact with the Medicaid shortfall, and what uncompensated care would be if Texas opted to expand Medicaid.[84] It will address questions such as how hospitals' uncompensated care costs would be reduced under a Medicaid expansion.[85] HHSC has engaged Health Management Associates to complete the study. HHSC engaged Deloitte Consulting to perform two assessments as a supplement to the study:

Task 1 - Assessment of Medicaid Reimbursement: Assess and compare the percent of hospitals' Medicaid costs that Texas and other states pay through their Medicaid inpatient and outpatient hospital provider rates.

---

[83] *Data included only from Florida, Louisiana, and Oklahoma as of the date of the report*
[84] *http://www.hhsc.state.tx.us/news/presentations/2016/051616-1115-waiver-extention-update.pdf*
[85] *https://www.texastribune.org/2016/05/02/texas-feds-agree-short-term-medicaid-funds-renewal*

The goal of Task 1 is to determine how the level of reimbursement through provider rates in Texas compares to other states. In particular, HHSC is interested in understanding if the percentage of cost reimbursed through provider rates (i.e. fee-for-service or MCO payments) is similar to that of other states.

Task 2 - Assessment of the Distribution of Medicaid Services by Hospital Type: Assess and compare the distribution of public versus private hospital provider services provided in Texas Medicaid to other states, as measured by the percentage of utilization based on inpatient days and outpatient visits. We also compared the distribution of Medicaid payments by state for both inpatient and outpatient provider type (i.e. public versus private).

The goal of Task 2 is to determine how the distribution of inpatient days and outpatient visits provided by public and private hospitals in Texas compares to other states. HHSC is particularly interested in understanding whether private hospitals in Texas provide a higher or lower percentage of services when compared with other states.

III. Project Scope and Methodology

Methodology and Activities

The following summarizes the project steps completed for the Assessment of State of Texas Medicaid Hospital Payments and the Distribution of Services analysis:

Task 1 - Assessment of Medicaid Reimbursement:

1. Collect Medicaid cost and payment information from Texas:

    a. Texas HHSC provided Medicaid inpatient and outpatient cost information by Texas hospital. Cost was calculated by multiplying charges, as seen on hospitals' Program Year 2015 and 2016 Disproportionate Share Hospital ("DSH") Program summary reports, by the Ratio of Cost to Charges ("RCC")[86] from the hospital's cost report. Data was provided for FFY2013 and FFY2014. The Texas data included costs across all hospitals providing Medicaid services whether the member was in the managed care program or fee-for-service. Medicaid cost did not include dual eligibles, clinics, nursing homes, administrative costs, long-term-care facilities, psychiatric or Medicare crossover claims.

    b. Texas HHSC provided Medicaid inpatient and outpatient payment information for Texas. Data was provided for FFY2013 and FFY2014. The data included payments across all hospitals providing Medicaid services whether the member was in the managed care program or fee-for-service. Medicaid payments were not provided for dual eligibles, clinics, nursing homes, administrative costs, LTC facilities, psychiatric or Medicare crossover claims. It should be noted that the State of Texas implemented an increase in their SFY2017 rates, which is not reflected in the historical rates used in this analysis.

2. Collect Medicaid cost and payment information from comparative states:

    a. Comparative States: Deloitte Consulting held meetings and collected detailed Medicaid cost and payment data from Florida, Oklahoma, and Louisiana. These states provided

[86] *The RCCs used for Texas were current as of March 9, 2016.*

incurred data on a state fiscal year basis. Data summaries and data considerations are provided for each comparative state in the Appendix of this document. Cost data from Louisiana was not available. Deloitte Consulting also conducted meetings and requested SFY 2013 and SFY 2014 data from New York and California. We received partial data for New York that was reviewed as able, while data from California has not yet been received at the release of this report.

For more details regarding Medicaid cost and payment data sources for each state as well as data considerations, please refer to Appendices A-F.

3. Analyze and describe the percent of hospitals' Medicaid costs that other states pay through their Medicaid provider rates compared to Texas. The results of this analysis are shared in the Findings section below.

Task 2 - Assessment of the Distribution of Medicaid Services by Hospital Type:

1. Collect Medicaid claims information from Texas and comparative states:

    a. Texas: HHSC provided Medicaid inpatient days and outpatient visits by hospital type and total Medicaid paid amounts by hospital type. Data was provided for FFY2013 and FFY2014, for public, private, and state-owned hospitals. This data did not include utilization for dual eligibles, clinics, nursing homes, administrative costs, LTC facilities, psychiatric or Medicare crossover claims.

    b. Comparative States: Deloitte Consulting held meetings and collected Medicaid inpatient days and outpatient visits and total Medicaid paid amounts by type of hospital from Florida, Louisiana, and Oklahoma. These states provided data on a state fiscal year basis. Data summaries and data considerations are provided for each comparative state in the Appendices of this document.

    For more details regarding Medicaid inpatient days and outpatient claims data sources, please refer to Appendices A-F.

2. Analyze the distribution of Medicaid services by hospital type in Texas Medicaid using comparative state data. The results of this analysis are shared in the Findings section on the following page.

Reliance and Data Considerations

This analysis has been solely prepared for HHSC. The analysis is intended to supplement a report on uncompensated care in Texas, as requested by the Center of Medicare and Medicaid Services ("CMS") as part of the State of Texas's 1115 transformation waiver renewal. The information within this document should not be reproduced in any form outside of the intended use without the prior consent of Deloitte Consulting and should not be relied upon by any entity other than HHSC. HHSC may share a copy of this report in its entirety with CMS.

This analysis was based on information provided by HHSC and similar agencies in other states, including some information collected through interviews with personnel as noted above. Additional information can be found in Appendices A-F for more detail on data limitations for each state. We have performed general

reasonableness checks of the data received for the analysis by comparing the data received from each state to publicly available data sources. We investigated any material differences between data received for the states and the publicly available data sources. Otherwise, we assumed without audit or verification that all data and information provided was done so in good faith and is reliable. If the underlying data or information provided is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

This report focuses on analyzing the reimbursement as a percentage of cost through Medicaid provider rates (i.e. fee-for-service and MCO payments) and the distribution of services provided by public and private hospitals in Medicaid in Texas and other comparative states. No adjustments (trend, completion, etc.) were made to the data (see Appendices A-F for detailed documentation regarding the data used for each state).

Note that the New York data (Appendix D) is provided on a SFY2012 plan year basis and included in our analysis where the information was available. In addition to New York, detailed SFY2013 and SFY2014 data has been requested from California but has not yet been received at the release of this report. If we receive additional data after the date of this report, adjustments may be needed to the observations and a revised report may need to be issued.

IV. Findings

Task 1 - Assessment of Medicaid Reimbursement:

For the purposes of this analysis, the Medicaid reimbursement percentage was defined as the percentage of cost reimbursed through Medicaid payments, exclusive of supplemental payments as noted previously. Medicaid cost and payment data was collected for Texas and several other states for inpatient and outpatient services, and for both fee-for-service claims and managed care claims. Supplemental payments such as DSH payments and Uncompensated Care pool payments were not included in this analysis.

Figure 5: Medicaid Cost and Payment Data for Texas and Comparative States in 2013

	Total Medicaid Cost (millions)	Total Medicaid Payments (millions)	Percentage of Cost Reimbursed
Texas (FFY2013)	$7,357.53	$5,120.49	69.6%
Florida (SFY2013)	$5,770.19	$4,544.00	78.7%
Oklahoma (SFY2013)	$1,966.60	$864.30	43.9%
New York (SFY2012)	$19,449.24	$15,437.55	79.4%

As shown in Figure 5, aggregate Medicaid reimbursement as a percentage of cost in Texas falls within the range of Medicaid reimbursement percentages observed in comparable states. The Texas Medicaid reimbursement rates as a percentage of cost (or reimbursement percentages) are closer to the top end of the range for comparable states. In addition, the two previous statements hold true when comparing inpatient only reimbursement percentages in Texas against comparable states (as shown in more detail in Tables A.1, B.1 and C.1 of Appendix A, B, and C respectively).

Note that the New York data (Appendix D) is provided on a SFY2012 plan year basis and included in our analysis where the information was available. In addition to New York, detailed SFY 2013 and SFY 2014 data has been requested from California but has not yet been received at the release of this report. If we receive additional data after the date of this report, adjustments may be needed to the observations and a revised report may need to be issued.

Figure 6: Medicaid Cost and Payment Data for Texas and Comparative States in 2013 for Private Hospitals

	Total Medicaid Cost (millions)	Total Medicaid Payments (millions)	Percentage of Cost Reimbursed
Texas (FFY2013)	$5,866.17	$4,152.27	70.8%
Florida (SFY013)[87]	N/A	N/A	74.0%
Oklahoma (SFY2013)	$1,760.80	$757.60	43.0%
New York (SFY2012)	$13,976.68	$11,543,91	82.6%

As shown in Figure 6, Medicaid reimbursement in Texas as a percentage of cost for private hospitals is near the top of the range observed across comparable states. Private hospitals, which make up the bulk of the hospitals providing Medicaid services within Texas (greater than 80% of Medicaid payments as shown in table A.5), are reimbursed slightly higher as a percentage of costs as public hospitals. This is contrary to what is seen in both Florida and Oklahoma.

Figure 7: Medicaid Cost and Payment Data for Texas and Comparative States in 2013 for Public and State-Owned Hospitals

	Total Medicaid Cost (millions)	Total Medicaid Payments (millions)	Percentage of Cost Reimbursed
Texas (FFY2013)	$1,491.36	$968.22	64.9%
Florida (SFY2013)[88]	N/A	N/A	99.0%
Oklahoma (SFY2013)	$205.80	$106.70	51.8%
New York (SFY2012)	$5,472.56	$3,893.63	71.1%

[87] *Based figure 18 from the Study of Hospital Funding and Payment Methodologies for Florida Medicaid report by Navigant*

[88] *Based figure 18 from the Study of Hospital Funding and Payment Methodologies for Florida Medicaid report by Navigant*

Figure 7 summarizes how Medicaid reimbursement for public and state-owned hospitals in Texas compares to that of comparative states. Medicaid reimbursement in Texas for public and state-owned hospitals falls within the range of Medicaid reimbursement percentages observed for public and state-owned hospitals in other states.

Based on the results reviewed throughout Task 1 above, it appears the Medicaid payment rates in Texas reimburse hospitals at a similar percentage of their costs as seen in other states. This comparison holds true when reviewing results in aggregate across all hospitals, as well when reviewing the reimbursement breakdown between public and state-owned hospitals, and private hospitals. Note this observation is based on a limited sample set of information available from other states.

Task 2 - Assessment of the Distribution of Medicaid Services by Hospital Type:

For the purposes of this analysis, the proportion of Medicaid services provided by public and private hospitals was measured through inpatient days or outpatient claims provided to Medicaid members as well as the proportion of total Medicaid paid amounts to public and private hospitals for inpatient and outpatient services. Summarized Medicaid claims data was collected for Texas and several other states for inpatient and outpatient services. This allows us to analyze whether the distribution of Medicaid services provided by public and private hospitals in Texas is similar to the distribution in other states.

Figure 8: Medicaid Inpatient Days and Outpatient Visits Data for Texas and Comparative States

	Percentage of Inpatient Days by Hospital Type		Percentage of Outpatient Visits by Hospital Type	
	Private	**Public/State-Owned**	**Private**	**Public/State-Owned**
Texas (FFY2013)	80.5%	19.5%	75.4%	24.6%
Florida (SFY2015)	79.1%	20.9%	81.9%	18.1%
Oklahoma (SFY2013)	90.9%	9.1%	N/A	N/A
Louisiana (SFY2013)	70.1%	29.9%	62.8%	37.2%

As shown in Figure 8, the private hospitals in Texas cover a similar percentage of utilization on both an inpatient and outpatient basis as private hospitals in other states. On an inpatient basis, private hospitals provide services to a percentage of the population in the range of percentages observed in other states. The same is true of outpatient services.

When reviewing utilization across public and state-owned hospitals, based on the data provided it appears inpatient utilization in public and state-owned hospitals in Texas is greater than the utilization seen in Oklahoma, slightly less than utilization in Florida, and much less than Louisiana. On an outpatient basis, utilization in Texas for public and state-owned hospitals is approximately 6.5% greater than the distribution seen in Florida but about 12.6% less than Louisiana (note this breakdown was not available for Oklahoma). Note that the Florida data provided is from SFY2015, vs. SFY2013 information provided for Texas, Louisiana, and Oklahoma. However, we do not anticipate the differences in time periods will have a significant impact on the results shown above.

Figure 9: Medicaid Inpatient and Outpatient Total Paid Amounts for Texas and Comparative States

	Percentage of Inpatient Total Paid Amounts by Hospital Type		Percentage of Outpatient Total Paid Amounts by Hospital Type	
	Private	Public/State-Owned	Private	Public/State-Owned
Texas (FFY2013)	81.1%	18.9%	81.1%	18.9%
Oklahoma (SFY2013)	89.6%	10.4%	81.5%	18.5%
Florida (SFY2015)	77.5%	22.5%	79.6%	20.4%
Louisiana (SFY2013)	73.0%	27.0%	56.5%	43.5%

As shown in Figure 9, the private hospitals in Texas provide similar levels of care to the Texas Medicaid population based on total Medicaid payments as seen in comparable states. Note there is some variability in the results when reviewing across inpatient and outpatient services, but not a material difference (with the exception of Louisiana's outpatient claims distribution). Note that New York is not included in Figure 9 since the claims were not available split by inpatient and outpatient.

Based on currently available data that was reviewed throughout Task 2 above, Texas distribution of hospitals and Medicaid services provided between private and public institutions appear to be in line with the comparative states. This remains consistent when comparing across inpatient and outpatient individually and in aggregate. Note this observation is based on a limited sample set of information available from other states.

V. Conclusions

Based on data currently available from Florida, Louisiana, New York, and Oklahoma, a review of the Texas Medicaid payments as a percentage of cost (or reimbursement percentages) fall within the range of the percentages observed in other states, although that range is fairly wide. We investigated whether this held true when analyzing the data for Private hospitals versus Public hospitals and for inpatients versus outpatient services.

We found that the Texas reimbursement percentages are still within the range of observed rates from other states when looking at the breakdown between public and state-owned hospitals, and private hospitals. Texas reimburses Public and Private hospitals on a fairly consistent basis.

We discovered that the Texas reimbursement percentages are still within the range of observed rates from other states when looking at Inpatient services and outpatient services separately.

When reviewing Medicaid Inpatient Days and Outpatient Visits Data and Medicaid Payments data for Texas and Comparative States, we found that the private hospitals in Texas provide similar levels of care to the overall Texas Medicaid population as seen in comparable states. Note there is some variability in the results when reviewing across inpatient and outpatient services.

As discussed throughout this report, only data from Florida, Oklahoma, and Louisiana with the addition of limited data reviews for data provided by New York were included, where applicable. Even though only a few states for each task were reviewed, it does appear that in general, the results observed in Texas are relatively consistent with what is observed in other states.

In addition to the detailed Florida and Oklahoma data received and reviewed along with higher level data provided by New York and Louisiana, detailed SFY 2013 and SFY 2014 data has been requested from California. We received partial data for New York and Louisiana that was reviewed as able, while data from California has not yet been received at the release of this report. If we receive additional data after the date of this report, adjustments may be needed to the observations and a revised report may need to be issued. If more data becomes available we may update our findings of this report.

Appendix A: Summary of Texas Data

Task 1 - Medicaid Reimbursement Analysis Data

Table A.1: Fee-for-Service Cost and Payment Data (in millions)						
	FFY2013			FFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$2,032.31	$585.42	2,617.73	$2,155.58	$645.58	$2,801.16
Payments (millions)	$1,434.63	$286.40	1,721.03	$1,467.33	$300.01	$1,767.34
Medicaid Reimbursement Percentage	70.6%	48.9%	65.7%	68.1%	46.5%	63.1%

Table A.2: Managed Care Cost and Payment Data (in millions)						
	FFY2013			FFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$2,925.25	$1,814.55	$4,739.80	$3,054.62	$1,827.17	$4,881.79
Payments (millions)	$2,148.20	$1,251.26	$3,399.46	$2,113.74	$1,243.41	$3,357.15
Medicaid Reimbursement Percentage	73.4%	69.0%	71.7%	69.2%	68.1%	68.8%

Table A.3: Total Cost and Payment Data (in millions)						
	FFY2013			FFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$4,957.56	$2,399.97	$7,357.53	$5,210.20	$2,472.75	$7,682.95
Payments (millions)	$3,582.83	$1,537.66	$5,120.49	$3,581.07	$1,543.42	$5,124.49
Medicaid Reimbursement Percentage	72.3%	64.1%	69.6%	68.7%	62.4%	66.7%

Task 2 - Distribution of Medicaid Services by Hospital Type Analysis Data

Table A.4: Medicaid Inpatient Days and Outpatient Claims Count Data								
	FFY2013				FFY2014			
	Inpatient Days		Outpatient Visits		Inpatient Days		Outpatient Visits	
Public/State-owned[89]	546,280	19.5%	1,281,166	24.6%	559,281	19.6%	1,379,759	26.0%
Private	2,249,019	80.5%	3,931,381	75.4%	2,299,168	80.4%	3,929,385	74.0%
Total	2,795,299	100.0%	5,212,547	100.0%	2,858,449	100.0%	5,309,144	100.0%

Table A.5: Medicaid Inpatient and Outpatient Payment Data (in millions)								
	FFY2013				FFY2014			
	Inpatient Medicaid Payments		Outpatient Medicaid Payments		Inpatient Medicaid Payments		Outpatient Medicaid Payments	
Public/State-owned[11]	$678.08	18.9%	$290.13	18.9%	$690.39	19.3%	$302.69	19.6%
Private	$2,904.75	81.1%	$1,247.53	81.1%	$2,890.68	80.7%	$1,240.73	80.4%
Total	$3,582.83	100.0%	$1,537.66	100.0%	$3,581.07	100.0%	$1,543.42	100.00%

Table A.6: Number of Hospitals by Ownership Type				
	FFY2013		FFY2014	
	Number of Hospitals	Percentage of Hospitals	Number of Hospitals	Percentage of Hospitals
Public/State-owned[11]	114	24.2%	116	24.9%
Private	357	75.8%	350	75.1%
Total	471	100.0%	466	100.0%

[89] ***Includes Military Hospitals***

Appendix B: Summary of Florida Data

Task 1 - Medicaid Reimbursement Analysis Data

Table B.1: Fee-for-Service Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$3,384.66	$1,250.29	$4,634.95			
Payments (millions)	$2,738.44	$896.17	$3,634.61			
Medicaid Reimbursement Percentage	80.9%	71.7%	78.4%			

Table B.2: Managed Care Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$614.99	$520.25	$1,135.24			
Payments (millions)	$476.77	$432.62	$909.39			
Medicaid Reimbursement Percentage	77.5%	83.2%	80.1%			

Table B.3: Total Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total[90]	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$3,999.65	$1,770.54	$5,770.19			
Payments (millions)	$3,215.21	$1,328.79	$4,544.00			
Medicaid Reimbursement Percentage	80.4%	75.0%	78.7%			

Task 2 - Distribution of Medicaid Services by Hospital Type Analysis Data

Table B.4: Medicaid Inpatient Days and Outpatient Claims Count Data								
	SFY2015[91]				SFY2014			
	Inpatient Days		Outpatient Visits		Inpatient Days		Outpatient Visits	
Public/State-owned		20.9%		18.1%				
Private		79.1%		81.9%				
Total		100.0%		100.0%				

Table B.5: Medicaid Inpatient and Outpatient Payment Data								
	SFY2013				SFY2014			
	Inpatient Medicaid Payments		Outpatient Medicaid Payments		Inpatient Medicaid Payments		Outpatient Medicaid Payments	
Public/State-owned		22.5%		20.4%				
Private		77.5%		79.6%				
Total		100.0%		100.0%				

Table B.6: Number of Hospitals by Ownership Type				
	SFY2013		SFY2014	
	Number of Hospitals	Percentage of Hospitals	Number of Hospitals	Percentage of Hospitals
Public/State-owned	35	12.2%		
Private	252	78.8%		
Total	287	100.0%		

---

[90] *See page 20 of the Navigant Medicaid Funding and Payment Study (Table 1) https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/LIP/docs/FL_Medicaid_Funding_and_Payment_Study_2015-02-27.pdf*

[91] *SFY15 was only timeframe readily available for this information from Florida and is considered, is comparable to other state data as a distribution of inpatient days and outpatient visits*

Appendix C: Summary of Oklahoma Data

Task 1 - Medicaid Reimbursement Analysis Data

Table C.1: Fee-for-Service Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$1,704.10	$262.50	$1,966.60	$1,772.00	$293.80	$2,065.80
Payments (millions)	$660.20	$204.10	$864.30	$640.10	$220.60	$860.70
Medicaid Reimbursement Percentage	38.7%	77.8%	43.9%	36.1%	75.1%	41.7%

Table C.2: Managed Care Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)						
Payments (millions)						
Medicaid Reimbursement Percentage						

Table C.3: Total Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)	$1,704.10	$262.50	$1,966.60	$1,772.00	$293.80	$2,065.80
Payments (millions)	$660.20	$204.10	$864.30	$640.10	$220.60	$860.70
Medicaid Reimbursement Percentage	38.7%	77.8%	43.9%	36.1%	75.1%	41.7%

Task 2 - Distribution of Medicaid Services by Hospital Type Analysis Data

Table C.4: Medicaid Inpatient Days and Outpatient Claims Count Data								
	SFY2013				SFY2014			
	Inpatient Days		Outpatient Visits		Inpatient Days		Outpatient Visits	
Public/State-owned	64,789	9.1%			68,199	9.1%		
Private	650,596	90.9%			679,616	90.9%		
Total	715,385	100.0%	1,061,047		747,815	100.0%	1,035,198	

Table C.5: Medicaid Inpatient and Outpatient Payment Data (in millions)								
	SFY2013				SFY2014			
	Inpatient Medicaid Payments		Outpatient Medicaid Payments		Inpatient Medicaid Payments		Outpatient Medicaid Payments	
Public/State-owned	$68.90	10.4%	$37.80	18.5%	$64.90	10.1%	$39.40	17.9%
Private	$591.30	89.6%	$166.30	81.5%	$575.20	89.9%	$181.20	82.1%
Total	$660.20	100.0%	$204.10	100.0%	$640.10	100.0%	$220.60	100.0%

Table C.6: Number of Hospitals by Ownership Type				
	SFY2013		SFY2014	
	Number of Hospitals	Percentage of Hospitals	Number of Hospitals	Percentage of Hospitals
Public/State-owned	48	32.2%	46	30.7%
Private	101	67.8%	104	69.3%
Total	149	100.0%	150	100.0%

Appendix D: Summary of New York Data

Task 1 - Medicaid Reimbursement Analysis Data

Table D1: Total Cost and Payment Data (Billions)									
	Total	Public	Private	Total	Public	Private	Total	Public	Private
	2010	2010	2010	2011	2011	2011	2012	2012	2012
Inpatient/Outpatient Medicaid Costs	**$18.89**	$5.38	$13.44	**$19.30**	$5.50	$13.79	**$19.45**	$5.47	$13.98
FFS Payments	**$9.95**	$2.54	$7.42	**$9.74**	$2.46	$7.28	**$9.00**	$2.20	$6.81
MC Payments	**$5.32**	$1.54	$3.78	**$5.66**	$1.51	$4.15	**$6.43**	$1.70	$4.74
Total Payments	**$15.27**	$4.07	$11.19	**$15.40**	$3.97	$11.43	**$15.44**	$3.89	$11.54
Medicaid Reimbursement Percentage	**80.8%**	75.8%	83.3%	**79.8%**	72.2%	82.9%	**79.4%**	71.1%	82.6%

Task 2 - Distribution of Medicaid Services by Hospital Type Analysis Data

Table D.2: Number of Hospitals by Ownership Type						
	SFY2010		SFY2011		SFY2012	
	Number of Hospitals	Percentage of Hospitals	Number of Hospitals	Percentage of Hospitals	Number of Hospitals	Percentage of Hospitals
Public/State-owned	48	23.3%	46	23.2%	46	22.5%
Private	158	76.7%	152	76.8%	158	77.5%
Total	206	100.0%	198	100.0%	204	100.0%

Appendix E: Summary of Louisiana Data

Task 1 - Medicaid Reimbursement Analysis Data

Table E.1: Fee-for-Service Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)						
Payments (millions)	$431.66	$182.15	$613.81	$425.34	$191.20	$616.54
Medicaid Reimbursement Percentage						

Table E.2: Managed Care Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)						
Payments (millions)	$308.93	$187.99	$496.92	$273.83	$185.37	$459.20
Medicaid Reimbursement Percentage						

Table E.3: Total Cost and Payment Data (in millions)						
	SFY2013			SFY2014		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Medicaid Cost (millions)						
Payments (millions)	$740.59	$370.14	$1,110.73	$699.17	$376.57	$1,075.74
Medicaid Reimbursement Percentage						

Task 2 - Distribution of Medicaid Services by Hospital Type Analysis Data

Table E.4: Medicaid Inpatient Days and Outpatient Claims Count Data								
	SFY2013				SFY2014			
	Inpatient Days		Outpatient Visits		Inpatient Days		Outpatient Visits	
Public/State-owned	60,809	29.9%	302,364	37.2%	52,173	26.1%	250,230	32.4%
Private	142,553	70.1%	510,097	62.8%	147,808	73.9%	521,644	67.6%
Total	203,362	100.0%	812,461	100.0%	199,981	100.0%	771,874	100.0%

Table E.5: Medicaid Inpatient and Outpatient Payment Data (in millions)								
	SFY2013				SFY2014			
	Inpatient Medicaid Payments		Outpatient Medicaid Payments		Inpatient Medicaid Payments		Outpatient Medicaid Payments	
Public/State-owned	$199.89	27.0%	$161.09	43.5%	$138.16	19.8%	$133.23	35.4%
Private	$540.66	73.0%	$209.05	56.5%	$561.01	80.2%	$243.34	64.6%
Total	$740.55	100.0%	$370.14	100.0%	$699.17	100.0%	$376.57	100.0%

Table E.6: Number of Hospitals by Ownership Type				
	SFY2013		SFY2014	
	Number of Hospitals	Percentage of Hospitals	Number of Hospitals	Percentage of Hospitals
Public/State-owned	55	30.7%	57	31.8%
Private	124	69.3%	122	68.2%
Total	179	100.0%	179	100.0%

Appendix F: Data Considerations

Texas

Claims are shown on an incurred basis. Claims for dual eligibles, clinics (which are not a department of the hospital), nursing homes, administrative costs, long-term-care facilities, psychiatric facilities and Medicare crossover claims are not included in the analysis. The claims are paid through June 10, 2016.

Florida

As noted during our discussions with Florida, the data provided includes cost for Medicaid services and Medicaid claim payments. Low income pool (LIP) payments are not included. Automatic and self-funded rate enhancements are included within the FFS claim payments.

The 2015 private vs. public hospital distribution data was pulled for the SFY 2014-15 FL Medicaid UPL Analysis spreadsheets supplied by the state. We excluded hospitals with under 200 Medicaid days since total inpatient cost rather than Medicaid inpatient cost for those hospitals and we excluded the out of state hospitals in the data. We also used data from the Navigant Medicaid Funding and Payment Study to supplement data received from the state.

Oklahoma

As indicated in their communications, the data provided by Oklahoma is based on state fiscal year incurred dates from the most recent available Medicare cost report. All data excludes Indian Health Service (“”is") and Tribal Hospitals. State officials indicated that the Inpatient upper payment limits (“UPL”) for most hospitals are not calculated based on costs, which is the reason for the low reimbursement percentages shown in the figures above. The Oklahoma Health Care Authority (“OHCA”) uses a Medicare equivalent Diagnosis-Related Group (“DRG”) method for the inpatient UPL measurement and pays up to the actual gap through its Supplemental Hospital Offset Payment Program. The gap is inflated for the included cost data due to current cost to charge ratio calculation method that is not applicable to most hospitals. Claim count data was not available in the source data used for all other items on the survey, so it was taken from the Management Administration Reporting system which reports based on paid date, but does not breakout by hospital classification.

The Oklahoma data was compared to publically available resources and it was found to be consistent with these sources when including supplemental payments.[92] [93]

New York

To supplement initial high level data summaries provided, New York State was able to provide KPMGs 2010, 2011 and 2012 DSH audit reports. 2013 DSH audits have not yet commenced, so that information was not provided at this time.

Louisiana

Per the documentation Louisiana provided with their data summary submission, they indicated they did not include crossover claims in their data as they are unable to breakdown those claims between inpatient and outpatient as requested. They also noted that managed care did not being until SFY2012 and was phased in.

---

[92] http://www.ardmoreite.com/article/20141028/NEWS/141029740
[93] http://newsok.com/article/3730224

Appendix IV – Revenue and Cost Estimates, FY 2015

This table provides select revenue and cost data for hospitals participating in the UC Pool program in FY 2015. The information in each column follows:

- *Total Revenue – All Payers: Patient and other revenue derived from Worksheet G-3 of the latest Medicare cost report included in CMS' cost report public use files (hospitals with no value in this column did not have total revenue information included in the latest HCRIS file)*
- *Total Medicaid Revenue before Supplemental Payments: FY 2013 Medicaid fee for service and managed care base payments plus dual eligible and out of state Medicaid payments, derived from HHCS' TXHUC tool, trended to FY 2015*
- *Total Medicaid Revenue with Medicaid Share of All Pools: Same as above, plus an allocated Medicaid share of FY 2015 GME, DSH, and UC Pool payments, and FY 2013 DSRIP payments*
- *Total Medicaid Cost: FY 2013 cost of Medicaid and related services, derived from HHCS' TXHUC tool, trended to FY 2015*
- *Total Uninsured Cost: FY 2013 cost of services to uninsured patients, derived from HHCS' TXHUC tool, trended to FY 2015*

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
450002	Tenet Hospitals Limited	$320,015,860	$62,307,711	$80,163,573	$81,395,032	$13,431,897
450005	Baptist Orange Hospital	$12,772,664	$3,566,075	$3,622,214	$6,204,446	$3,420,094
450007	Sid Peterson	$129,573,505	$10,947,789	$15,315,557	$14,199,242	$7,627,204
450010	United Regional Health Care System, Inc.	$311,443,972	$30,502,074	$44,096,309	$49,828,852	$27,916,666
450011	St. Joseph Regional Health Center	$335,430,637	$27,848,480	$36,382,747	$44,630,248	$28,530,356
450015	Dallas County Hospital District	$1,564,923,560	$196,701,979	$458,281,148	$429,422,033	$552,067,055
450018	UT Medical Branch At Galveston	$902,102,802	$139,685,108	$201,310,298	$169,006,152	$47,091,188
450021	Baylor University Medical Center	$1,446,265,978	$81,246,411	$129,074,302	$152,480,703	$69,609,324
450023	Citizens Medical Center County Of Victoria	$146,223,421	$11,197,607	$17,643,465	$18,303,331	$13,098,304
450024	El Paso County Hospital District	$382,754,631	$33,112,831	$92,398,423	$53,366,697	$109,200,173
450028	Valley Baptist Medical Center Of Brownsville	$196,723,706	$43,656,177	$49,783,432	$54,413,077	$14,428,732
450029	Laredo Texas Hospital Co	$309,289,591	$62,319,629	$71,652,047	$76,652,024	$15,747,257
450032	Harrison County Hospital Association	$67,189,338	$12,172,690	$13,439,366	$15,047,816	$5,958,287
450033	Valley Baptist Medical Center	$241,875,495	$61,706,836	$71,932,311	$81,039,589	$22,866,432
450034	Christus Hospital SE Texas St. Elizabeth	$375,680,777	$37,718,285	$51,873,003	$59,594,810	$29,598,313
450035	St. Joseph Medical Center	$291,772,990	$46,699,430	$66,330,975	$70,690,921	$17,567,859
450037	The Good Shepherd Hospital, Inc.	$293,105,246	$45,952,763	$57,379,674	$65,864,676	$28,700,415
450039	Tarrant County Hospital District	$1,081,155,111	$105,868,424	$250,117,404	$206,065,630	$334,029,036
450040	Covenant Health System	$439,278,768	$45,207,531	$69,942,152	$66,935,828	$33,168,853
450042	Providence Health Center	$306,380,399	$25,541,270	$32,729,925	$36,961,320	$24,069,213
450044	UT Southwestern Medical Center St. Paul	$814,092,377	$35,714,865	$55,317,572	$64,668,363	$20,468,973
450046	Christus Spohn Hospital - Corpus Christi	$558,968,877	$79,661,968	$129,877,768	$114,722,468	$80,798,139
450051	Methodist Dallas Medical Center	$418,474,441	$65,492,718	$88,230,693	$97,663,180	$37,823,619
450052	Goodall-Witcher Hospital Authority	$36,688,326	$1,522,614	$2,807,060	$1,788,581	$344,196
450054	Scott And White Memorial Hospital	$1,238,355,018	$101,372,426	$159,985,555	$337,461,597	$59,733,105
450055	Rolling Plains Memorial Hospital	$32,210,709	$4,114,483	$7,269,554	$6,417,504	$2,334,580
450056	Seton Medical Center Austin	$491,352,756	$33,036,526	$38,864,886	$46,825,915	$21,771,618
450058	VHS San Antonio Partners	$1,218,072,044	$157,483,430	$177,247,063	$179,876,353	$66,989,029
450064	Texas Health Arlington Memorial Hospital	$251,388,188	$21,641,670	$27,903,064	$36,385,837	$18,315,540

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
450068	Memorial Hermann Texas Medical Center	$1,431,050,437	$174,320,124	$247,993,688	$282,032,217	$86,488,567
450072	Community Hospital Of Brazosport	$78,803,599	$8,928,350	$11,280,229	$11,729,362	$6,943,708
450073	Scurry County Hospital District	$28,255,523	$2,477,832	$6,319,619	$5,274,332	$2,509,792
450076	UT MD Anderson Cancer Center	$3,356,623,926	$99,270,495	$126,340,661	$118,808,343	$74,655,661
450078	Anson General Hospital	$7,084,512	$844,741	$1,250,240	$1,258,742	$164,255
450079	Baylor Medical Center At Irving	$288,979,055	$17,932,611	$28,353,801	$36,665,667	$23,796,706
450080	Titus County Memorial Hospital	$67,484,008	$11,231,521	$15,732,760	$13,690,189	$4,007,518
450082	Christus Spohn Hospital - Beeville	$32,911,529	$6,841,159	$10,466,963	$8,867,300	$4,382,495
450083	East Texas Medical Center	$394,854,573	$48,414,488	$60,206,074	$63,210,547	$30,496,206
450085	Graham Hospital District	$21,426,149	$2,208,315	$3,308,337	$2,874,400	$1,441,335
450087	Columbia North Hills Hospital	$121,712,848	$8,760,340	$10,704,606	$12,350,084	$14,521,596
450090	Gainesville Hospital District	$37,175,487	$5,058,732	$9,644,885	$8,737,397	$3,421,741
450092	Fort Duncan Medical Center, LP	$74,613,777	$19,950,065	$20,050,547	$21,234,500	$5,324,196
450097	CHCA Bayshore, LP	$286,676,247	$65,409,456	$79,295,056	$79,511,338	$38,535,349
450099	Prime Healthcare Services-Pampa LLC	$33,934,206	$3,735,322	$6,278,034	$5,904,624	$3,633,919
450101	Hillcrest Baptist Medical Center	$257,370,591	$24,401,854	$35,694,753	$39,793,218	$17,607,465
450102	Mother Frances Hospital	$772,888,817	$40,023,856	$67,453,408	$69,930,401	$34,261,261
450104	Guadalupe Valley Hospital	$103,027,694	$10,069,346	$16,238,628	$16,762,890	$8,747,468
450107	El Paso Healthcare System, Ltd.	$463,255,184	$95,306,175	$116,298,962	$108,675,974	$28,049,834
450108	Wilson County Memorial Hospital District	$35,178,144	$2,434,986	$4,517,757	$3,988,626	$2,237,536
450119	McAllen Hospitals LP	$467,154,678	$79,219,560	$93,935,770	$108,662,857	$39,195,001
450124	University Medical Center At Brackenridge	$379,457,820	$49,879,918	$109,799,563	$94,610,065	$95,232,033
450128	Knapp Medical Center	$109,605,172	$37,275,170	$41,552,335	$46,119,854	$12,104,726
450130	Nix Hospital System, LLC	$130,030,653	$21,052,400	$32,742,906	$33,857,800	$2,904,674
450132	Ector County Hospital District	$265,215,894	$30,534,450	$59,380,425	$50,948,645	$26,521,719
450133	Midland Memorial Hospital	$302,106,872	$18,413,345	$39,067,223	$33,402,986	$21,927,957
450135	Texas Health Harris Methodist Fort Worth	$741,482,260	$63,123,538	$85,654,889	$108,963,089	$52,854,484
450137	Baylor All Saints Medical Center	$364,339,134	$32,764,672	$47,878,692	$72,756,656	$15,852,325
450143	Seton Smithville Regional Hospital	$14,718,411	$1,536,302	$2,485,791	$3,548,755	$1,850,900
450144	Andrews County Hospital District	$49,438,038	$2,141,071	$4,057,104	$3,684,277	$2,060,715
450147	Victoria Of Texas	$245,611,065	$20,568,103	$29,841,266	$29,231,444	$8,634,523
450148	TX Health Harris Methodist Hospital Cleburne	$67,923,151	$6,904,986	$7,565,549	$11,504,004	$8,628,537
450152	Metroplex Hospital	$112,389,941	$13,078,579	$17,346,863	$21,215,879	$8,609,435
450154	Val Verde Hospital Corporation	$53,019,630	$13,053,243	$19,266,017	$18,800,285	$7,139,387
450155	Deaf Smith County Hospital District	$27,210,606	$2,345,615	$4,682,586	$3,967,412	$1,609,914
450162	Lubbock Heritage Hospital	$50,955,227	$1,299,004	$2,434,633	$2,303,689	$1,726,194
450163	Christus Spohn Hospital - Kleberg	$39,527,277	$9,028,938	$13,052,802	$12,138,593	$3,857,896
450165	Jourdanton Hospital Corp.	$63,990,439	$5,946,390	$7,709,197	$9,490,769	$4,976,865
450176	Mission Regional Medical Center	$103,750,534	$38,369,636	$44,965,642	$50,806,833	$12,949,178
450177	Uvalde County Hospital Authority	$103,513,340	$9,926,944	$17,967,179	$16,624,887	$6,931,264
450178	Pecos County Memorial Hospital	$29,946,383	$3,630,972	$6,424,164	$4,703,672	$2,656,422
450184	Memorial Hermann Hospital System	$1,312,614,196	$134,093,758	$206,686,588	$232,204,154	$109,262,273
450187	Scott & White Hospital - Brenham	$33,135,533	$3,893,681	$4,377,521	$6,834,410	$3,800,163
450188	East Texas Medical Center Clarksville	$6,196,323	$1,598,110	$1,931,899	$2,929,527	$1,258,818
450192	NCHI Of Hillsboro Inc.	$30,330,638	$4,615,689	$6,380,604	$7,439,601	$2,714,425
450193	St. Lukes Episcopal Hospital	$890,564,218	$39,477,324	$62,083,798	$79,507,163	$25,737,310
450194	East Texas Medical Center Jacksonville	$31,373,009	$7,250,774	$9,791,292	$9,417,488	$2,751,109

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
450196	Essent PRMC LP	$124,565,398	$21,870,259	$22,603,502	$24,586,286	$7,076,057
450200	Wadley Regional Medical Center	$118,345,818	$17,984,756	$22,048,450	$25,973,495	$6,816,725
450203	Weatherford Regional Medical Center	$115,093,217	$7,396,805	$10,119,095	$13,367,623	$8,299,624
450209	Northwest Texas Health System, Inc.	$313,453,780	$47,479,984	$66,506,113	$83,722,291	$46,601,762
450210	East Texas Medical Center Carthage	$20,901,506	$3,177,556	$5,326,519	$5,295,688	$2,696,527
450211	Memorial Medical Center - Lufkin	$126,581,846	$18,795,906	$21,681,697	$23,664,023	$14,319,389
450213	Bexar County Hospital District	$1,243,693,349	$103,834,541	$236,814,642	$180,215,551	$221,275,588
450219	Scott & White Hospital - Llano	$47,795,091	$2,836,400	$3,257,959	$5,446,393	$3,591,673
450221	Moore County Hospital District	$32,918,940	$3,159,409	$4,957,705	$5,072,001	$1,913,038
450222	CHCA Conroe, LP	$225,341,753	$30,811,681	$32,663,284	$35,898,143	$25,827,394
450229	Hendrick Medical Center	$318,072,104	$29,917,244	$50,741,004	$44,472,367	$26,019,973
450231	Baptist St Anthonys Healthcare System	$435,375,719	$21,812,256	$30,466,173	$38,902,055	$22,312,987
450235	Gonzales Healthcare Systems	$46,571,081	$2,371,263	$3,632,357	$3,616,247	$1,557,099
450236	Hopkins County Hospital District	$84,744,275	$9,305,926	$13,992,532	$13,702,870	$4,896,272
450237	Christus Santa Rosa Hospital	$376,285,424	$51,296,458	$69,604,919	$79,871,415	$31,527,850
450241	Jack County Hospital District	$12,027,334	$453,638	$1,765,860	$881,433	$630,731
450243	Hamlin Hospital District	$3,929,136	$327,769	$686,305	$739,816	$204,081
450253	Bellville St Joseph Health Center	$12,756,916	$549,226	$1,099,145	$1,564,930	$1,214,164
450271	Decatur Hospital Authority	$189,914,959	$10,866,788	$22,104,955	$16,826,312	$11,181,776
450272	Central Texas Medical Center	$92,713,000	$9,752,163	$15,715,942	$14,962,553	$9,153,205
450280	Baylor At Garland And McKinney	$193,787,060	$20,548,876	$28,797,151	$33,425,733	$21,435,052
450289	Harris County Hospital District	$1,281,110,989	$152,395,447	$396,898,663	$289,428,687	$596,986,195
450292	Texas Health Presbyterian Hospital Kaufman	$36,450,599	$6,393,662	$7,439,232	$7,430,620	$4,678,334
450293	Frio Hospital Association	$13,276,322	$2,246,945	$3,953,324	$3,655,241	$1,313,264
450299	College Station Medical Center	$144,538,908	$12,200,378	$17,701,258	$21,734,663	$5,159,381
450306	Jones County Regional Healthcare System	$10,391,509	$721,760	$1,878,463	$1,717,209	$1,214,921
450324	UHS Of Texoma	$259,597,579	$21,264,907	$28,009,950	$33,329,317	$10,864,988
450330	Oakbend Medical Center	$115,255,311	$16,237,703	$28,494,225	$27,382,269	$10,766,047
450340	San Angelo Community Medical Center	$135,357,936	$10,529,398	$15,552,284	$20,446,731	$3,957,558
450346	Baptist Hospital Of Southeast TX - Beaumont	$261,829,560	$29,784,855	$40,485,274	$44,739,179	$18,341,535
450347	Huntsville Memorial Hospital	$84,682,695	$4,355,048	$10,369,422	$7,841,823	$7,332,399
450348	Falls Community Hospital And Clinic	$15,368,309	$1,724,813	$2,199,414	$3,057,028	$1,433,010
450351	Texas Health Harris Methodist Stephenville	$46,951,476	$4,877,884	$4,903,841	$6,948,653	$3,766,798
450352	Hunt Memorial Hospital District	$110,543,681	$14,419,675	$24,537,479	$21,848,387	$10,736,068
450358	The Methodist Hospital	$1,526,904,283	$74,567,813	$91,400,757	$103,788,528	$46,389,658
450369	Childress County Hospital District	$29,205,572	$2,029,345	$4,121,785	$3,392,627	$1,014,863
450370	Columbus Community Hospital	$29,237,677	$3,189,447	$3,502,551	$3,632,331	$1,379,318
450372	Baylor Medical Center At Waxahachie	$111,077,150	$4,130,630	$4,130,630	$7,009,331	$7,735,134
450373	East Texas Medical Center Mount Vernon	$6,510,664	$1,013,074	$1,157,208	$1,741,772	$931,161
450388	Methodist Healthcare System Of San Antonio	$1,329,473,667	$191,670,618	$237,436,100	$258,302,369	$86,076,771
450389	East Texas Medical Center Athens	$80,960,727	$11,885,594	$18,272,925	$17,738,754	$9,710,913
450395	Memorial Medical Center Livingston	$42,740,014	$8,414,153	$9,925,115	$11,476,177	$5,221,432
450399	Terry County Memorial Hospital District	$16,242,255	$1,991,904	$3,853,896	$3,289,764	$1,384,739
450403	Columbia Medical Center Of McKinney	$138,530,692	$16,777,825	$19,092,585	$22,458,915	$9,844,874
450411	Eastland Memorial Hospital District	$19,143,208	$1,507,107	$3,019,138	$2,186,791	$1,638,507
450419	Texas Health Harris Methodist Azle	$33,566,085	$3,033,927	$4,117,105	$5,402,170	$5,261,690
450424	Methodist San Jacinto Hospital	$217,990,647	$27,407,240	$36,948,132	$40,072,886	$21,759,540

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
450431	St. Davids Healthcare Partnership	$606,471,522	$62,017,994	$73,439,324	$83,410,900	$24,988,161
450447	Navarro Hospital, LP	$84,570,567	$10,216,222	$11,942,753	$13,301,979	$4,310,029
450451	Somervell County Hospital District	$16,522,827	$1,043,269	$1,840,966	$2,118,929	$1,757,415
450460	Tyler County Hospital	$10,285,780	$1,265,397	$2,043,908	$2,084,416	$1,669,105
450462	Texas Health Presbyterian Hospital Dallas	$622,600,719	$41,430,612	$61,315,473	$70,132,670	$31,006,178
450465	Matagorda County Hospital District	$63,279,816	$8,165,598	$12,254,612	$11,081,150	$5,949,951
450469	Sherman Grayson Hospital LLC	$105,883,226	$11,342,691	$11,342,691	$16,967,009	$9,435,029
450475	East Texas Medical Center Henderson	$31,690,136	$6,128,672	$7,560,587	$7,430,599	$4,264,045
450484	Woodland Heights Medical Center	$121,647,718	$13,324,289	$15,419,757	$16,619,592	$2,503,319
450489	Dawson County Hospital District	$21,531,310	$1,775,112	$4,038,647	$3,520,271	$1,028,639
450497	Bowie Hospital Authority	$16,539,722	$1,641,720	$2,340,286	$2,006,043	$852,847
450498	Stephens Memorial Hospital District		$924,332	$1,678,667	$1,836,559	$1,012,070
450508	Memorial Hospital-Nacogdoches	$83,694,161	$13,420,931	$22,000,847	$19,671,907	$9,721,864
450518	The Medical Center Of Southeast Texas	$172,150,246	$15,961,508	$20,101,246	$23,357,460	$6,658,677
450537	Methodist Richardson Medical Center	$189,526,973	$6,757,826	$10,220,646	$11,484,113	$9,120,226
450539	Methodist Hospital Plainview	$40,266,751	$6,394,938	$7,123,284	$7,566,144	$3,581,586
450558	Abilene Regional Medical Center	$163,550,941	$11,750,977	$16,110,721	$20,094,189	$4,799,593
450563	Baylor Regional Medical Center At Grapevine	$260,230,909	$5,267,256	$6,754,226	$9,498,806	$10,612,374
450565	Palo Pinto County Hospital District	$43,792,832	$5,947,968	$10,698,999	$8,165,499	$2,766,154
450571	Shannon Medical Center	$254,898,864	$24,586,201	$39,465,059	$38,938,442	$19,702,976
450573	Christus Jasper Memorial Hospital	$26,571,775	$7,575,484	$7,737,847	$8,456,917	$2,767,594
450578	Hemphill County Hospital District	$14,978,882	$224,745	$488,507	$560,295	$1,038,505
450580	East Texas Medical Center Crockett	$13,156,602	$3,088,028	$4,117,043	$4,497,142	$1,593,472
450584	Wilbarger County Hospital District	$18,597,838	$1,370,251	$1,798,081	$2,082,881	$1,320,378
450586	Baylor County Hospital District	$13,381,162	$1,175,771	$2,311,736	$1,580,049	$235,142
450587	Brownwood Hospital	$106,616,219	$12,467,419	$14,918,088	$16,299,789	$4,549,022
450591	Angleton Danbury Medical Center	$29,457,191	$3,394,018	$6,792,017	$6,551,619	$522,884
450596	Granbury Hospital Corp	$138,707,295	$6,358,936	$8,067,374	$9,533,477	$4,512,265
450597	Cuero Community Hospital	$33,242,922	$3,690,694	$5,794,488	$6,293,939	$1,695,584
450604	Hill Country Memorial Hospital	$78,607,520	$4,801,298	$6,694,815	$6,457,421	$3,239,752
450610	Memorial Hermann Memorial City	$467,130,015	$23,750,413	$34,283,836	$46,554,797	$27,600,737
450617	Clear Lake Regional Medical Center	$467,492,410	$67,369,701	$71,973,814	$78,555,664	$33,715,910
450620	Dimmit Regional Hospital	$16,355,290	$3,183,439	$5,990,751	$4,397,284	$2,244,915
450634	Columbia Medical Center Of Denton	$160,159,394	$13,239,903	$16,861,997	$19,390,362	$14,121,364
450638	Houston Northwest Operating Co, LLC	$276,852,725	$37,126,686	$47,377,253	$57,273,365	$29,683,054
450639	Texas Health Harris Methodist Hospital HEB	$253,402,016	$13,761,809	$17,446,232	$27,333,969	$24,762,525
450641	Nocona Hospital District	$8,383,952	$526,751	$801,651	$756,733	$464,673
450643	Laredo Regional Medical Center, LP	$135,872,439	$24,065,132	$29,368,590	$33,623,406	$7,344,602
450644	CHCA West Houston Medical Center	$188,539,349	$35,537,104	$42,365,171	$44,623,886	$14,800,769
450647	Columbia Hospital At Medical City Dallas	$731,222,192	$78,969,685	$90,074,766	$90,635,709	$25,771,723
450651	Columbia Medical Center Of Plano	$356,964,196	$24,972,132	$29,054,135	$34,734,919	$24,563,088
450653	Big Spring Hospital Corporation	$61,272,724	$5,734,256	$6,486,314	$7,163,017	$3,529,601
450654	Starr County Memorial Hospital	$35,629,691	$9,153,629	$13,989,551	$13,420,141	$3,408,502
450656	Nacogdoches Medical Center	$69,032,446	$8,826,135	$10,164,019	$11,007,448	$2,607,791
450658	East Texas Medical Center Fairfield	$14,635,801	$1,098,108	$2,069,323	$1,907,026	$1,558,758
450659	TH Healthcare Ltd D/B/A Park Plaza Hospital	$81,474,780	$16,158,506	$20,913,189	$26,644,977	$2,759,917
450661	Odessa Regional Medical Center	$178,677,909	$18,274,806	$36,160,167	$31,988,197	$5,207,670

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
450662	Valley Regional Medical Center	$162,629,582	$49,128,788	$52,571,125	$56,275,562	$13,401,891
450668	Sierra Medical Center	$199,011,944	$22,670,549	$28,508,115	$35,809,721	$5,996,155
450669	Columbia Medical Center Of Lewisville	$122,632,458	$11,993,953	$16,347,720	$19,443,694	$13,128,536
450670	Tomball Regional Medical Center	$174,189,170	$10,379,517	$13,299,354	$16,917,335	$10,147,744
450672	Columbia Plaza Medical Center Of Fort Worth	$192,308,966	$17,840,703	$22,920,136	$25,949,046	$7,587,481
450674	CHCA Womans Hospital Of Texas	$347,696,557	$62,600,265	$62,600,265	$57,793,796	$1,366,244
450675	Columbia Medical Center Of Arlington	$229,505,557	$34,655,008	$44,449,850	$49,284,129	$14,231,376
450677	TX Health Huguley Hospital Fort Worth South	$183,996,652	$18,043,967	$20,671,785	$26,099,198	$14,512,151
450678	Doctors Hospital At White Rock Lake	$101,669,567	$12,738,239	$18,087,221	$22,686,281	$10,356,564
450684	Memorial Hermann Northeast	$213,193,032	$22,220,475	$27,161,345	$33,573,974	$21,647,028
450686	Lubbock County Hospital District	$561,499,974	$77,068,341	$121,408,257	$119,159,207	$56,578,322
450690	UT Health Science Center At Tyler	$183,845,419	$11,651,791	$18,344,112	$20,485,413	$5,525,114
450694	El Campo Memorial Hospital	$16,907,297	$903,490	$1,927,740	$1,895,442	$1,332,603
450697	Southwest General Hospital	$159,268,929	$38,063,753	$44,454,488	$47,988,681	$9,981,144
450698	Lamb County Hospital	$10,841,950	$1,113,564	$2,623,172	$2,447,328	$1,272,802
450702	Longview Medical Center LP	$320,534,389	$12,542,849	$15,572,335	$19,466,612	$6,628,486
450709	Christus Saint John Hospital	$109,628,156	$68,036,065	$68,036,065	$67,019,389	$16,931,017
450711	Rio Grande Regional Hospital	$214,653,141	$68,602,482	$71,846,328	$76,879,868	$19,445,107
450713	St. Davids South Austin Medical Center	$239,279,847	$26,084,656	$28,616,616	$32,753,906	$21,795,645
450716	Cypress Fairbanks Medical Center	$165,846,416	$24,537,797	$30,337,662	$36,510,962	$12,026,179
450718	St. Davids Healthcare Partnership	$155,924,030	$10,781,617	$15,656,360	$15,354,840	$11,589,049
450723	Methodist Charlton Medical Center	$232,467,269	$38,414,812	$47,985,361	$52,858,234	$22,374,025
450730	Baylor Medical Center At Carrollton		$9,213,412	$15,425,870	$22,136,935	$14,160,935
450742	Lake Pointe Operating Company	$149,596,052	$13,551,958	$17,284,559	$18,551,050	$8,064,861
450743	Texas Health Presbyterian Hospital Denton	$179,488,129	$13,645,121	$20,261,798	$26,648,595	$13,302,881
450746	Knox County Hospital District	$8,489,422	$386,639	$862,896	$778,267	$298,329
450747	Palestine Principal Healthcare	$72,229,177	$12,768,697	$13,108,436	$14,440,990	$3,822,034
450749	East Texas Medical Center Trinity	$8,922,392	$1,533,277	$2,682,245	$2,580,872	$1,158,595
450754	Hamilton General Hospital	$25,153,114	$1,606,880	$10,242,973	$2,468,455	$1,921,030
450755	Methodist Hospital Levelland	$20,788,502	$2,658,577	$3,719,327	$3,944,499	$1,391,148
450766	UT Southwestern Medical Center Zale Lipshy	$172,162,304	$5,726,255	$7,965,962	$10,498,360	$8,229,178
450771	Texas Health Presbyterian Hospital Plano	$361,505,546	$12,531,239	$12,644,665	$26,131,649	$18,260,602
450775	Kph-Consolidation, Inc.	$257,674,523	$28,968,693	$32,857,075	$38,588,349	$15,147,377
450779	TX Health Harris Methodist SW Fort Worth	$264,728,568	$12,651,803	$16,770,163	$24,765,731	$10,578,630
450780	Methodist Healthcare System Of San Antonio	$22,880,247	$1,117,647	$1,373,846	$1,699,545	$459,813
450788	Corpus Christi Medical Center	$295,247,028	$40,429,056	$60,275,139	$55,929,549	$15,244,094
450801	Christus St. Michael Health System	$272,803,718	$28,019,384	$40,376,264	$51,260,265	$14,378,023
450803	Doctors Hospital Tidwell	$19,928,088	$13,956,332	$15,776,213	$21,543,827	$2,755,791
450809	St. Davids North Austin Medical Center	$351,164,007	$28,803,483	$31,988,449	$36,977,392	$15,918,502
450820	Methodist Sugar Land Hospital	$332,257,498	$18,990,402	$24,563,035	$31,353,721	$15,807,160
450822	Columbia Medical Center Of Las Colinas Inc.	$82,975,444	$3,680,247	$5,165,391	$6,513,921	$6,943,098
450828	Christus Spohn Hospital - Alice	$46,745,489	$13,727,776	$20,475,297	$19,192,005	$6,504,586
450832	Christus Saint Catherine Hospital	$29,078,086	$7,048,125	$7,048,125	$17,158,425	$5,848,768
450833	PRHC-Ennis, LP-Ennis Regional Medical Center	$23,122,867	$4,772,758	$5,704,346	$7,184,732	$2,777,786
450844	Methodist Willowbrook Hospital	$278,793,536	$21,850,891	$29,739,201	$35,771,347	$17,861,787
450847	Memorial Hermann Katy Hospital	$188,175,119	$11,267,440	$13,607,212	$16,669,736	$10,420,234
450848	Memorial Hermann Sugar Land Hospital	$151,799,958	$18,066,191	$23,222,238	$27,701,716	$6,848,848

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
450851	Baylor Heart & Vascular Center LLP	$152,675,106	$4,696,667	$4,926,954	$5,445,642	$2,994,776
450855	Harlingen Medical Center LP	$115,353,585	$19,651,044	$23,800,435	$27,992,892	$8,483,443
450862	St. Lukes Community Health Services	$189,048,502	$9,515,882	$15,167,645	$17,083,340	$9,124,586
450865	Seton Southwest	$41,783,327	$1,631,099	$2,233,614	$2,951,979	$3,603,316
450867	Seton Northwest	$113,229,263	$6,411,893	$8,124,316	$10,271,429	$9,522,264
450869	Doctors Hospital At Renaissance	$441,134,235	$127,253,192	$156,725,804	$155,403,224	$15,417,113
450884	East Texas Medical Center Gilmer	$3,933,186	$1,754,017	$1,754,017	$2,578,487	$1,650,965
450885	Centennial Medical Center	$95,836,553	$3,155,282	$4,825,789	$6,353,963	$5,447,962
450890	Baylor Regional Medical Center At Plano	$229,705,103	$3,826,601	$3,826,601	$7,985,353	$5,605,907
451300	Parmer County Community Hospital, Inc.	$9,217,079	$339,597	$772,332	$669,994	$939,361
451301	Reagan Hospital District	$11,327,861	$278,786	$588,522	$412,390	$831,316
451303	South Limestone Hospital District	$21,637,688	$1,673,831	$2,690,707	$2,847,332	$2,162,324
451304	Preferred Hospital Leasing Eldorado, Inc.	$4,453,632	$313,109	$507,722	$550,878	$406,880
451305	Burleson St Joseph Health Center	$10,855,153	$1,018,621	$1,308,541	$1,417,820	$1,168,124
451306	Preferred Hospital Leasing Junction, Inc.	$7,947,190	$807,385	$1,594,111	$1,525,368	$1,124,247
451307	Iraan General Hospital	$11,051,484	$135,148	$230,705	$257,296	$212,287
451308	Yoakum County Hospital	$20,527,889	$2,301,246	$3,801,407	$3,297,760	$1,466,912
451309	McCamey County Hospital District	$11,298,493	$287,958	$476,970	$604,245	$641,664
451310	Ballinger Memorial Hospital District	$6,186,456	$386,291	$927,115	$822,872	$864,475
451311	Sweeny Hospital District	$10,994,546	$1,333,940	$2,024,592	$2,235,694	$2,603,847
451312	CAHRMC Dba Rice Medical Center	$11,339,516	$884,326	$5,003,157	$1,194,854	$854,852
451313	Fisher County Hospital District	$8,238,877	$292,279	$912,746	$676,696	$811,561
451314	Winkler County Memorial Hospital	$8,574,208	$513,372	$990,413	$1,017,831	$1,484,111
451315	North Runnels Hospital	$5,177,852	$264,194	$437,572	$444,975	$354,047
451316	Madison St. Joseph Health Center	$11,151,865	$1,398,547	$1,876,157	$2,030,054	$1,307,700
451317	Refugio County Memorial Hospital District	$12,991,963	$1,890,819	$2,692,844	$2,646,205	$971,190
451318	Stonewall Memorial Hospital District	$9,161,617	$436,544	$849,048	$602,187	$455,093
451319	Trinity Mother Frances Jacksonville	$27,425,658	$4,190,803	$5,613,123	$6,912,586	$5,376,735
451320	Chambers County Public Hospital District #1	$20,893,673	$678,752	$797,483	$855,085	$1,360,651
451321	Presbyterian Hospital Of Commerce	$4,327,985	$1,256,360	$1,608,865	$2,078,361	$1,184,879
451322	Grimes St. Joseph Health Center	$12,460,618	$1,578,268	$1,993,754	$2,494,788	$1,842,567
451323	Rollins Brook Community Hospital	$15,773,084	$1,617,516	$1,672,505	$2,260,473	$1,442,047
451324	Sutton County Hospital District	$9,237,892	$483,069	$1,070,428	$847,478	$940,170
451325	Concho County Hospital	$7,455,945	$681,901	$872,187	$690,789	$400,943
451326	Chillicothe Hospital	$2,090,778	$29,014	$56,015	$62,243	$137,632
451328	Winnie Community Hospital LLC	$18,037,921	$735,200	$879,072	$943,074	$628,119
451329	Rankin County Hospital District	$11,119,370	$157,109	$213,633	$232,327	$836,530
451330	Medina County Hospital District	$43,378,455	$1,793,076	$3,645,781	$3,356,777	$3,493,370
451331	Dallam-Hartley Counties Hospital District	$25,690,038	$1,298,483	$2,019,542	$1,652,636	$846,074
451332	Palacios Community Medical Center	$7,534,079	$637,985	$1,034,357	$1,147,256	$733,147
451333	Martin County Hospital District	$21,080,985	$657,453	$1,383,653	$1,512,405	$1,461,596
451334	North Wheeler County Hospital District	$7,667,949	$179,454	$245,177	$263,664	$511,559
451335	Muenster Hospital District	$9,754,375	$272,719	$314,703	$357,910	$401,955
451337	Lockney General Hospital District	$10,482,716	$1,091,539	$1,557,975	$1,641,564	$811,021
451338	Preferred Hospital Leasing Van Horn, Inc.	$6,548,253	$714,146	$879,243	$777,943	$481,815
451339	Throckmorton County Memorial Hospital	$3,675,247	$86,383	$224,127	$176,168	$159,719
451341	Haskell County Hospital District	$8,257,443	$448,772	$967,785	$609,993	$372,054

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
451342	Mitchell County Hospital	$19,780,410	$1,048,704	$1,752,969	$1,451,710	$1,435,915
451343	Electra Hospital District	$28,071,039	$765,251	$9,018,735	$2,329,900	$1,187,427
451344	Hansford County Hospital District	$18,214,889	$398,150	$851,200	$735,507	$780,340
451345	Crosbyton Clinic Hospital	$6,121,573	$652,845	$898,007	$977,123	$377,257
451346	Yoakum Community Hospital	$19,991,768	$2,154,716	$3,114,783	$2,876,448	$1,385,030
451347	Preferred Hospital Leasing Coleman, Inc.	$11,293,477	$1,212,577	$1,854,021	$1,482,472	$975,564
451348	Heart Of Texas Healthcare System	$19,303,353	$1,056,643	$2,823,105	$1,692,744	$1,320,786
451349	Swisher Memorial Healthcare System	$10,653,987	$146,286	$169,535	$193,934	$1,094,494
451350	Castro County Hospital District	$12,040,785	$727,530	$1,062,804	$1,010,562	$662,148
451351	Lynn County Hospital District	$11,607,040	$214,133	$407,941	$408,583	$1,434,921
451352	Hardeman County Memorial Hospital	$9,137,563	$838,944	$1,062,304	$1,134,348	$394,163
451353	Crane County Hospital District	$9,531,419	$535,327	$694,592	$831,842	$176,142
451354	Olney Hamilton Hospital District	$11,798,415	$1,388,560	$2,573,539	$2,345,981	$619,320
451355	Preferred Hospital Leasing, Inc.	$6,402,775	$699,106	$1,018,341	$994,004	$314,571
451356	Memorial Medical Center	$23,844,590	$3,220,406	$5,160,900	$4,460,224	$2,145,638
451357	Rockdale Blackhawk LLC	$54,274,335	$2,600,182	$4,465,753	$3,500,719	$1,323,598
451358	Seminole Hospital District	$41,183,575	$2,864,805	$4,044,489	$4,077,306	$4,228,462
451359	Ochiltree County Hospital District	$18,050,637	$1,153,767	$1,465,536	$1,256,902	$1,096,006
451360	Memorial Medical Center San Augustine	$4,523,567	$928,380	$986,779	$1,293,642	$807,860
451361	Preferred Hospital Leasing Hemphill, Inc.	$9,365,231	$775,212	$2,141,089	$1,296,432	$606,433
451362	Clay County Memorial Hospital	$7,394,732	$341,605	$775,385	$499,192	$391,215
451363	Jackson County Hospital District	$18,256,971	$1,523,638	$2,868,959	$2,576,219	$1,613,888
451364	Karnes County Hospital District	$24,683,756	$1,884,879	$2,415,127	$2,337,607	$1,916,622
451365	Seton Highland Lakes	$61,192,441	$1,751,962	$3,913,397	$2,856,206	$5,129,925
451366	Cochran Memorial Hospital	$5,169,596	$80,415	$241,877	$275,359	$634,714
451367	East Texas Medical Center Pittsburg	$32,997,137	$3,110,552	$6,456,511	$5,745,664	$2,489,958
451369	GPCH Dba Golden Plains Community Hospital	$23,932,589	$2,744,876	$7,844,142	$5,434,672	$3,435,898
451370	Fannin County Hospital Authority	$22,030,794	$1,931,286	$3,783,675	$2,869,072	$1,499,045
451371	Seton Edgar B. Davis	$32,099,783	$2,230,496	$2,452,113	$2,619,554	$3,448,138
451372	Muleshoe Area Medical Center	$2,978,773	$883,326	$1,370,446	$1,316,605	$840,244
451373	Ward Memorial Hospital	$10,088,633	$1,241,508	$1,609,640	$1,896,083	$2,279,096
451374	Scott & White Hospital - Taylor	$9,611,721	$982,672	$982,672	$1,589,063	$2,137,154
451375	Liberty Dayton Regional Medical Center	$9,268,108	$657,316	$2,332,717	$1,374,447	$1,009,174
451376	Lavaca Hospital District	$17,203,898	$1,345,667	$1,663,505	$1,814,737	$1,032,147
451377	Reeves County Hospital District	$27,210,218	$2,839,590	$5,070,418	$4,948,080	$3,284,731
451378	Big Bend Regional Medical Center	$22,672,258	$2,367,100	$3,681,365	$4,158,932	$2,053,288
451379	Coryell County Memorial Hospital	$129,183,214	$790,146	$9,875,410	$1,146,309	$1,840,523
451380	East Texas Medical Center Quitman	$16,354,067	$1,007,027	$2,511,889	$2,150,312	$1,850,202
451381	Trinity Mother Frances Winnsboro	$16,108,545	$2,648,503	$3,610,650	$3,961,321	$2,994,057
451382	Comanche County Medical Center Company		$1,622,170	$2,659,442	$2,415,457	$1,362,927
452017	Baylor Specialty Health Center	$1,439,554	$2,613,837	$2,613,837	$4,182,582	$1,374,215
452033	DSHS TCID	$477,840	$34,338	$4,368,272	$1,245,654	$12,287,985
453300	Cook Childrens Medical Center	$827,535,542	$326,123,058	$341,846,388	$358,793,394	$10,774,114
453301	Driscoll Childrens Hospital	$334,675,196	$125,412,030	$153,038,574	$135,697,245	$4,804,178
453302	Children's Medical Center Of Dallas	$1,167,993,927	$470,810,232	$546,027,623	$550,964,928	$27,781,049
453304	Texas Childrens Hospital	$1,738,007,835	$564,684,088	$594,913,466	$609,181,442	$21,471,340
453306	Methodist Childrens Hospital		$27,141,721	$35,079,493	$38,620,172	$1,272,467

CCN	Hospital Name	Total Revenue - All Payers	Total Medicaid Revenue before Supplemental Payments	Total Medicaid Revenue with Medicaid Share of All Pools	Total Medicaid Cost	Total Uninsured Cost
453308	Baylor Specialty Health Centers		$12,878,095	$14,802,278	$17,723,555	$100,028
453309	Healthbridge Children's Hospital		$8,912,754	$11,053,903	$10,869,243	$0
453310	Dell Children's Medical Center	$553,284,028	$107,06 8,049	$115,240,338	$114,909,755	$5,831,736
453313	El Paso Children's Hospital	$83,398,826	$44,577,893	$54,249,478	$63,199,586	$6,541,628
453315	CHRISTUS Children's Hospital Of San Antonio	$222,282,863	$82,786,414	$110,040,226	$119,390,319	$3,817,147
453323	Clarity Child Guidance Center		$9,828,183	$12,432,088	$12,134,642	$806,899
4533C6	DSHS - Waco Center For Youth		$0	$6,239,395	$7,925,569	$8,675,443
4533D6	West Oaks Hospital		$5,558,213	$4,563,749	$4,912,024	$2,100,580
4533E7	Cypress Creek Hospital		$2,106,541	$2,106,541	$1,880,017	$1,813,756
4533I7	Seton Shoal Creek		$1,586,196	$1,764,955	$2,053,125	$6,455,231
454000	DSHS	$23,961,219	$78,230	$1,493,641	$1,869,314	$22,864,275
454006	DSHS - Terrell	$37,061,349	$1,484,519	$4,902,693	$5,965,277	$29,979,530
454008	DSHS - Vernon	$36,411,299	$1,432,382	$9,766,696	$12,259,099	$36,888,759
454008	DSHS - Wichita Falls	$103,435,562	$4,830,443	$9,450,526	$11,370,705	$33,200,397
454009	DSHS - Rusk	$6,147,135	$83,587	$3,210,525	$4,148,142	$37,289,918
454011	DSHS - San Antonio	$46,355,713	$2,573,318	$10,044,442	$12,417,095	$32,611,259
454014	DSHS - Kerville		$0	$0	$690,813	$21,370,784
454064	River Crest Hospital	$12,532,285	$1,609,384	$1,224,386	$1,324,141	$1,866,192
454076	UTHealth Harris County Psychiatric Center	$50,123,226	$1,322,614	$1,569,274	$1,726,051	$16,090,422
454084	DSHS - Austin	$48,670,087	$1,541,111	$10,653,101	$13,209,749	$30,896,070
454088	DSHS - Rio Grande	$30,237,676	$21,356	$953,399	$1,210,966	$10,213,880
454093	Lubbock Regional Mhmr Center	$4,468,611	$0	$2,065,362	$0	$3,019,278
454100	DSHS - El Paso Psych	$12,243,803	$435,139	$1,914,329	$2,356,524	$11,036,201
454103	Kingwood Pines Hospital	$21,774,636	$6,648,845	$5,463,172	$5,879,615	$1,578,563
454114	HMIH Cedar Crest, LLC	$19,696,165	$3,009,399	$1,927,875	$2,614,035	$921,177
670004	St. Mark's Medical Center	$30,318,944	$3,310,179	$3,475,362	$4,181,893	$1,434,880
670023	Methodist Mansfield Medical Center	$188,791,248	$10,245,355	$12,650,819	$14,546,968	$11,445,242
670025	Texas Heart Hospital Of The Southwest LLP	$256,795,798	$4,577,990	$4,577,990	$7,490,902	$4,372,044
670031	St Lukes Patients Medical Center	$75,787,740	$2,620,168	$3,137,964	$3,811,446	$2,380,088
670034	Scott & White	$276,104,658	$6,448,686	$7,512,171	$13,800,165	$10,301,446
670041	Hospital - Round Rock	$158,080,266	$13,954,933	$18,508,507	$24,043,363	$16,503,490
670043	Seton Medical Center Williamson	$119,860,834	$5,043,634	$6,123,913	$7,900,846	$7,166,813
670047	Cedar Park Health System, LP	$168,310,616	$23,757,978	$32,583,278	$32,618,184	$9,422,226
670053	Sierra Providence East Medical Center	$58,958,838	$5,723,365	$8,610,314	$11,906,128	$6,785,646
670055	St Lukes Sugar Land Hospital	$174,653,279	$6,666,974	$8,286,608	$10,340,278	$8,013,074
670056	Methodist Healthcare Of San Antonio	$138,782,720	$11,719,523	$14,593,483	$18,242,527	$11,805,615
670059	Seton Medical Center Hays	$41,228,241	$477,578	$649,911	$853,012	$431,479
670075	St Lukes Lakeside Hospital	$61,361,258	$4,558,607	$8,131,546	$12,072,433	$6,455,591
670077	St Lukes Hospital At The Vintage	$207,609,265	$8,844,176	$12,643,304	$17,064,861	$12,184,513
670080	Methodist West Houston Hospital	$71,015,631	$6,523,295	$8,747,619	$11,447,160	$10,173,533
670082	Seton Medical Center - Harker Heights	$150,626,414	$4,495,385	$4,495,385	$12,388,037	$8,886,465
670085	Baylor At Garland And McKinney	$86,290,716	$568,468	$793,592	$1,262,679	$4,398,177
670088	TX Health Harris Methodist Hospital Alliance		$25,002	$3,696,352	$9,445,001	$8,840,422
670089	Scott & White Hospital - College Station		$0	$454,113	$931,774	$2,395,264
670090	Nix Community General Hospital, LLC		$2,085	$2,085	$1,281,240	$4,108,518
	Total Participating Hospitals	**$63,491,205,225**	**$7,767,426,386**	**$10,742,307,856**	**$11,286,783,508**	**$5,563,230,520**

Appendix V – Supplemental Pools (FY 2015) and DSRIP Payments (FY 2013)

This table includes hospital supplemental pool (GME, DSH and UC) payments from FY 2015, and DSRIP payments from FY 2013 (the latest year for which payments are reasonably complete).

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
450002	Tenet Hospitals Limited	$0	$9,891,822	$7,361,487	$7,609,831
450005	Baptist Orange Hospital	$0	$0	$130,394	$0
450007	Sid Peterson	$0	$0	$7,544,394	$2,317,200
450010	United Regional Health Care System, Inc.	$0	$5,777,029	$17,628,129	$4,330,768
450011	St. Joseph Regional Health Center	$0	$4,776,876	$17,288,882	$221,130
450015	Dallas County Hospital District	$0	$187,826,006	$267,506,810	$128,207,464
450018	UT Medical Branch At Galveston	$27,355,525	$15,394,680	$0	$29,477,688
450021	Baylor University Medical Center	$0	$14,716,348	$54,550,437	$13,470,141
450023	Citizens Medical Center County Of Victoria	$0	$0	$8,130,256	$3,482,082
450024	El Paso County Hospital District	$0	$41,175,033	$40,987,028	$46,619,824
450028	Valley Baptist Medical Center Of Brownsville	$0	$6,323,408	$9,744,620	$0
450029	Laredo Texas Hospital Co	$0	$8,746,756	$7,480,894	$2,018,622
450032	Harrison County Hospital Association	$0	$1,261,230	$3,207,440	$0
450033	Valley Baptist Medical Center	$0	$7,589,273	$16,566,510	$0
450034	Christus Hospital Se Texas St. Elizabeth	$0	$7,925,510	$19,727,158	$2,819,070
450035	St. Joseph Medical Center	$0	$11,688,607	$12,743,811	$5,900,000
450037	The Good Shepherd Hospital, Inc.	$0	$8,291,739	$19,632,242	$758,751
450039	Tarrant County Hospital District	$0	$100,390,732	$151,569,293	$87,672,807
450040	Covenant Health System	$0	$4,563,265	$22,871,723	$14,310,392
450042	Providence Health Center	$0	$0	$15,942,534	$2,317,273
450044	UT Southwestern Medical Center St. Paul	$1,232,445	$0	$21,615,349	$5,474,147
450046	Christus Spohn Hospital - Corpus Christi	$0	$13,197,763	$45,888,942	$33,322,731
450051	Methodist Dallas Medical Center	$0	$12,268,012	$24,147,714	$6,484,050
450052	Goodall-Witcher Hospital Authority	$0	$0	$171,868	$1,159,667
450054	Scott And White Memorial Hospital	$0	$13,917,114	$58,147,800	$822,232
450055	Rolling Plains Memorial Hospital	$0	$1,684,116	$1,988,505	$1,367,520
450056	Seton Medical Center Austin	$0	$0	$15,654,501	$0
450058	VHS San Antonio Partners	$0	$22,601,874	$25,828,258	$11,372,965
450064	Texas Health Arlington Memorial Hospital	$0	$0	$7,805,871	$2,828,704
450068	Memorial Hermann Texas Medical Center	$0	$27,689,607	$72,801,338	$18,235,084
450072	Community Hospital Of Brazosport	$0	$0	$4,111,222	$1,236,432
450073	Scurry County Hospital District	$0	$2,038,221	$2,452,747	$1,406,543
450076	UT MD Anderson Cancer Center	$1,446,627	$27,936,768	$5,982,175	$14,943,701
450078	Anson General Hospital	$0	$0	$408,615	$116,000
450079	Baylor Medical Center At Irving	$0	$0	$18,597,023	$2,330,960
450080	Titus County Memorial Hospital	$0	$3,387,796	$1,148,832	$2,953,073
450082	Christus Spohn Hospital - Beeville	$0	$788,674	$4,131,068	$2,185,346
450083	East Texas Medical Center	$0	$6,191,176	$15,425,856	$4,860,926
450085	Graham Hospital District	$0	$683,284	$888,013	$625,664
450087	Columbia North Hills Hospital	$0	$0	$8,318,047	$426,655
450090	Gainesville Hospital District	$0	$2,228,204	$2,427,699	$2,203,886
450092	Fort Duncan Medical Center, LP	$0	$2,425,257	$775,357	$0
450097	CHCA Bayshore, LP	$0	$11,466,564	$17,539,992	$7,637,791

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
450099	Prime Healthcare Services-Pampa LLC	$0	$487,601	$4,124,930	$865,876
450101	Hillcrest Baptist Medical Center	$0	$4,831,042	$12,494,825	$3,393,581
450102	Mother Frances Hospital	$0	$6,796,049	$23,899,788	$13,017,570
450104	Guadalupe Valley Hospital	$0	$0	$6,165,038	$3,362,562
450107	El Paso Healthcare System, Ltd.	$0	$12,458,670	$10,053,637	$15,802,783
450108	Wilson County Memorial Hospital District	$0	$1,147,590	$1,687,839	$838,972
450119	McAllen Hospitals LP	$0	$12,670,397	$23,663,736	$0
450124	University Medical Center At Brackenridge	$0	$34,925,232	$49,530,974	$33,845,488
450128	Knapp Medical Center	$0	$5,051,010	$6,322,024	$0
450130	Nix Hospital System, LLC	$0	$0	$6,882,518	$6,018,794
450132	Ector County Hospital District	$0	$19,083,310	$9,659,546	$15,522,004
450133	Midland Memorial Hospital	$0	$13,366,636	$9,310,617	$11,290,910
450135	Texas Health Harris Methodist Fort Worth	$0	$11,903,502	$23,213,998	$6,438,610
450137	Baylor All Saints Medical Center	$0	$7,133,045	$9,028,972	$3,552,121
450143	Seton Smithville Regional Hospital	$0	$0	$1,817,162	$0
450144	Andrews County Hospital District	$0	$1,219,375	$1,154,253	$854,832
450147	Victoria Of Texas	$0	$2,600,517	$6,098,936	$4,945,433
450148	TX Health Harris Methodist Hospital Cleburne	$0	$0	$1,147,558	$272,096
450152	Metroplex Hospital	$0	$2,759,638	$6,483,707	$0
450154	Val Verde Hospital Corporation	$0	$3,614,727	$3,687,911	$3,042,263
450155	Deaf Smith County Hospital District	$0	$1,228,024	$1,237,432	$1,070,873
450162	Lubbock Heritage Hospital	$0	$0	$1,079,561	$675,817
450163	Christus Spohn Hospital - Kleberg	$0	$1,388,783	$4,141,502	$1,684,067
450165	Jourdanton Hospital Corp.	$0	$594,085	$3,668,229	$0
450176	Mission Regional Medical Center	$0	$5,601,876	$8,033,658	$0
450177	Uvalde County Hospital Authority	$0	$4,352,105	$5,923,390	$3,031,402
450178	Pecos County Memorial Hospital	$0	$1,518,194	$1,343,052	$2,034,989
450184	Memorial Hermann Hospital System	$0	$23,018,810	$80,417,672	$22,771,461
450187	Scott & White Hospital - Brenham	$0	$568,950	$0	$245,700
450188	East Texas Medical Center Clarksville	$0	$0	$0	$333,789
450192	NCHI Of Hillsboro Inc.	$0	$467,943	$3,012,291	$0
450193	St. Lukes Episcopal Hospital	$0	$0	$28,397,076	$4,999,178
450194	East Texas Medical Center Jacksonville	$0	$698,531	$2,900,700	$1,106,637
450196	Essent PRMC LP	$0	$2,248,784	$1,602,403	$0
450200	Wadley Regional Medical Center	$0	$2,814,442	$4,976,175	$0
450203	Weatherford Regional Medical Center	$0	$0	$6,560,923	$0
450209	Northwest Texas Health System, Inc.	$0	$12,789,438	$32,296,016	$0
450210	East Texas Medical Center Carthage	$0	$1,427,672	$2,278,467	$415,082
450211	Memorial Medical Center - Lufkin	$0	$2,733,404	$10,800,643	$0
450213	Bexar County Hospital District	$0	$81,630,133	$100,689,177	$88,267,360
450219	Scott & White Hospital - Llano	$0	$500,607	$0	$212,596
450221	Moore County Hospital District	$0	$1,487,948	$1,000,014	$499,234
450222	CHCA Conroe, LP	$0	$0	$13,723,475	$238,250
450229	Hendrick Medical Center	$0	$5,114,342	$15,452,514	$13,582,393
450231	Baptist St Anthonys Healthcare System	$0	$4,089,300	$16,019,636	$0
450235	Gonzales Healthcare Systems	$0	$1,233,349	$974,388	$243,900
450236	Hopkins County Hospital District	$0	$3,927,914	$2,658,582	$1,653,146

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
450237	Christus Santa Rosa Hospital	$0	$0	$27,165,478	$5,686,483
450241	Jack County Hospital District	$0	$325,458	$533,900	$960,158
450243	Hamlin Hospital District	$0	$262,282	$178,886	$50,388
450253	Bellville St. Joseph Health Center	$0	$0	$1,099,626	$0
450271	Decatur Hospital Authority	$0	$0	$13,200,013	$6,854,431
450272	Central Texas Medical Center	$0	$1,810,950	$5,853,444	$3,369,912
450280	Baylor At Garland And McKinney	$0	$0	$14,838,140	$2,868,803
450289	Harris County Hospital District	$0	$186,603,060	$254,127,127	$164,207,871
450292	Texas Health Presbyterian Hospital Kaufman	$0	$0	$2,333,151	$744,945
450293	Frio Hospital Association	$0	$261,101	$1,765,689	$577,453
450299	College Station Medical Center	$0	$2,059,842	$5,221,401	$461,916
450306	Jones County Regional Healthcare System	$0	$0	$979,305	$677,186
450324	UHS Of Texoma	$0	$3,606,675	$0	$4,877,422
450330	Oakbend Medical Center	$0	$4,464,500	$7,150,031	$6,372,965
450340	San Angelo Community Medical Center	$0	$1,227,556	$5,542,139	$0
450346	Baptist Hospital Of Southeast TX - Beaumont	$0	$6,251,375	$12,139,116	$2,819,068
450347	Huntsville Memorial Hospital	$0	$1,288,502	$4,413,730	$4,215,641
450348	Falls Community Hospital And Clinic	$0	$119,232	$868,703	$0
450351	Texas Health Harris Methodist Stephenville	$0	$0	$0	$25,957
450352	Hunt Memorial Hospital District	$0	$8,042,785	$3,929,247	$5,396,971
450358	The Methodist Hospital	$0	$0	$28,733,133	$4,526,438
450369	Childress County Hospital District	$0	$936,514	$921,878	$1,012,599
450370	Columbus Community Hospital	$0	$460,511	$733,701	$92,560
450372	Baylor Medical Center At Waxahachie	$0	$0	$0	$0
450373	East Texas Medical Center Mount Vernon	$0	$0	$0	$144,134
450388	Methodist Healthcare System Of San Antonio	$0	$35,425,573	$49,544,137	$11,372,967
450389	East Texas Medical Center Athens	$0	$1,819,284	$5,994,592	$3,507,176
450395	Memorial Medical Center Livingston	$0	$1,104,457	$3,373,063	$0
450399	Terry County Memorial Hospital District	$0	$1,053,873	$1,169,207	$775,236
450403	Columbia Medical Center Of McKinney	$0	$0	$6,851,030	$0
450411	Eastland Memorial Hospital District	$0	$0	$1,569,645	$1,039,098
450419	Texas Health Harris Methodist Azle	$0	$0	$2,085,936	$445,651
450424	Methodist San Jacinto Hospital	$0	$0	$27,624,820	$0
450431	St Davids Healthcare Partnership	$0	$12,487,366	$14,066,379	$0
450447	Navarro Hospital, L.P.	$0	$1,005,436	$3,503,745	$0
450451	Somervell County Hospital District	$0	$0	$1,528,573	$139,752
450460	Tyler County Hospital	$0	$0	$1,376,582	$337,278
450462	Texas Health Presbyterian Hospital Dallas	$0	$8,085,826	$21,365,934	$5,740,567
450465	Matagorda County Hospital District	$0	$3,923,387	$3,253,568	$1,857,979
450469	Sherman Grayson Hospital LLC	$0	$0	$0	$0
450475	East Texas Medical Center Henderson	$0	$818,497	$2,162,328	$741,210
450484	Woodland Heights Medical Center	$0	$0	$3,766,024	$0
450489	Dawson County Hospital District	$0	$1,075,503	$1,227,430	$756,945
450497	Bowie Hospital Authority	$0	$0	$938,586	$448,480
450498	Stephens Memorial Hospital District	$0	$0	$1,285,160	$140,758
450508	Memorial Hospital-Nacogdoches	$0	$7,094,290	$4,916,481	$4,063,834
450518	The Medical Center Of Southeast Texas	$0	$3,622,292	$4,326,275	$0

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
450537	Methodist Richardson Medical Center	$0	$0	$5,751,073	$1,478,292
450539	Methodist Hospital Plainview	$0	$1,160,349	$2,623,820	$0
450558	Abilene Regional Medical Center	$0	$1,815,058	$4,818,621	$0
450563	Baylor Regional Medical Center At Grapevine	$0	$0	$5,125,255	$0
450565	Palo Pinto County Hospital District	$0	$2,336,067	$1,450,062	$3,073,276
450571	Shannon Medical Center	$0	$3,909,548	$13,541,980	$7,719,388
450573	Christus Jasper Memorial Hospital	$0	$1,069,997	$0	$0
450578	Hemphill County Hospital District	$0	$0	$980,329	$20,688
450580	East Texas Medical Center Crockett	$0	$0	$0	$1,029,015
450584	Wilbarger County Hospital District	$0	$0	$1,216,669	$25,000
450586	Baylor County Hospital District	$0	$249,957	$143,134	$791,444
450587	Brownwood Hospital	$0	$1,549,830	$3,967,481	$0
450591	Angleton Danbury Medical Center	$0	$0	$0	$3,397,999
450596	Granbury Hospital Corp	$0	$0	$4,188,838	$0
450597	Cuero Community Hospital	$0	$2,048,355	$1,204,449	$0
450604	Hill Country Memorial Hospital	$0	$0	$3,416,643	$755,422
450610	Memorial Hermann Memorial City	$0	$0	$21,622,710	$0
450617	Clear Lake Regional Medical Center	$0	$11,532,195	$13,488,591	$0
450620	Dimmit Regional Hospital	$0	$2,040,981	$506,554	$1,908,303
450634	Columbia Medical Center Of Denton	$0	$0	$9,094,970	$962,437
450638	Houston Northwest Operating Co, L.L.C	$0	$6,968,124	$18,365,076	$0
450639	Texas Health Harris Methodist Hospital HEB	$0	$0	$6,643,457	$1,347,485
450641	Nocona Hospital District	$0	$0	$534,634	$104,913
450643	Laredo Regional Medical Center, LP	$0	$4,362,931	$4,749,946	$0
450644	CHCA West Houston Medical Center	$0	$0	$10,078,580	$3,371,740
450647	Columbia Hospital At Medical City Dallas	$0	$11,552,758	$9,247,884	$6,435,921
450651	Columbia Medical Center Of Plano	$0	$0	$15,747,451	$0
450653	Big Spring Hospital Corporation	$0	$627,121	$2,272,099	$0
450654	Starr County Memorial Hospital	$0	$2,638,284	$3,286,727	$1,521,043
450656	Nacogdoches Medical Center	$0	$0	$3,070,975	$0
450658	East Texas Medical Center Fairfield	$0	$0	$1,684,300	$345,710
450659	TH Healthcare Ltd D/B/A Park Plaza Hospital	$0	$0	$5,602,070	$0
450661	Odessa Regional Medical Center	$0	$4,467,432	$6,072,441	$10,000,000
450662	Valley Regional Medical Center	$0	$6,544,135	$6,513,189	$0
450668	Sierra Medical Center	$0	$0	$8,382,418	$0
450669	Columbia Medical Center Of Lewisville	$0	$0	$9,362,092	$1,031,193
450670	Tomball Regional Medical Center	$0	$0	$7,580,303	$0
450672	Columbia Plaza Medical Center Of Fort Worth	$0	$0	$6,943,457	$1,572,270
450674	CHCA Womans Hospital Of Texas	$0	$0	$0	$0
450675	Columbia Medical Center Of Arlington	$0	$7,140,118	$9,224,361	$1,854,466
450677	TX Health Huguley Hospital Fort Worth South	$0	$0	$7,140,939	$297,950
450678	Doctors Hospital At White Rock Lake	$0	$0	$9,154,185	$814,747
450684	Memorial Hermann Northeast	$0	$0	$14,780,611	$0
450686	Lubbock County Hospital District	$0	$35,402,219	$24,072,454	$19,587,584
450690	UT Health Science Center At Tyler	$854,265	$9,508,728	$92,177	$0
450694	El Campo Memorial Hospital	$0	$0	$1,858,312	$211,096
450697	Southwest General Hospital	$0	$6,559,003	$5,154,625	$1,105,121

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
450698	Lamb County Hospital	$0	$926,579	$1,273,047	$383,189
450702	Longview Medical Center LP	$0	$0	$5,681,219	$0
450709	Christus Saint John Hospital	$0	$0	$0	$0
450711	Rio Grande Regional Hospital	$0	$9,884,859	$6,551,863	$0
450713	St. Davids South Austin Medical Center	$0	$0	$12,597,258	$0
450716	Cypress Fairbanks Medical Center	$0	$4,506,726	$7,032,181	$0
450718	St. Davids Healthcare Partnership	$0	$0	$3,391,818	$3,931,204
450723	Methodist Charlton Medical Center	$0	$0	$15,701,883	$3,818,935
450730	Baylor Medical Center At Carrollton	$0	$0	$11,788,306	$536,550
450742	Lake Pointe Operating Company	$0	$2,410,634	$7,474,727	$0
450743	Texas Health Presbyterian Hospital Denton	$0	$0	$11,241,507	$998,646
450746	Knox County Hospital District	$0	$243,519	$252,178	$140,049
450747	Palestine Principal Healthcare	$0	$1,620,626	$0	$0
450749	East Texas Medical Center Trinity	$0	$0	$1,593,696	$388,759
450754	Hamilton General Hospital	$0	$0	$1,515,324	$8,174,822
450755	Methodist Hospital Levelland	$0	$423,683	$1,754,601	$0
450766	UT Southwestern Medical Center Zale Lipshy	$54,588	$0	$5,875,291	$0
450771	Texas Health Presbyterian Hospital Plano	$0	$0	$238,784	$0
450775	Kph-Consolidation, Inc.	$0	$0	$10,941,093	$0
450779	TX Health Harris Methodist SW Fort Worth	$0	$0	$4,371,487	$1,742,674
450780	Methodist Healthcare System Of San Antonio	$0	$0	$413,246	$0
450788	Corpus Christi Medical Center	$0	$8,419,626	$9,446,157	$11,365,813
450801	Christus St. Michael Health System	$0	$5,878,477	$14,210,182	$0
450803	Doctors Hospital Tidwell	$0	$2,503,792	$0	$0
450809	St. Davids North Austin Medical Center	$0	$0	$9,827,929	$0
450820	Methodist Sugar Land Hospital	$0	$0	$12,341,963	$0
450822	Columbia Medical Center Of Las Colinas Inc.	$0	$0	$4,436,843	$192,546
450828	Christus Spohn Hospital - Alice	$0	$1,480,321	$7,766,143	$2,620,202
450832	Christus Saint Catherine Hospital	$0	$0	$0	$0
450833	PRHC-Ennis,LP-Ennis Regional Medical Center	$0	$694,708	$788,286	$242,771
450844	Methodist Willowbrook Hospital	$0	$0	$14,221,131	$1,663,106
450847	Memorial Hermann Katy Hospital	$0	$0	$6,558,607	$0
450848	Memorial Hermann Sugar Land Hospital	$0	$3,098,773	$5,361,552	$0
450851	Baylor Heart & Vascular Center LLP	$0	$0	$1,550,481	$0
450855	Harlingen Medical Center LP	$0	$1,380,996	$7,447,967	$0
450862	St Lukes Community Health Services	$0	$0	$7,453,370	$2,196,708
450865	Seton Southwest	$0	$0	$2,126,856	$0
450867	Seton Northwest	$0	$0	$6,085,279	$0
450869	Doctors Hospital At Renaissance	$0	$19,929,550	$7,808,661	$11,456,155
450884	East Texas Medical Center Gilmer	$0	$0	$0	$0
450885	Centennial Medical Center	$0	$0	$3,847,197	$180,000
450890	Baylor Regional Medical Center At Plano	$0	$0	$0	$0
451300	Parmer County Community Hospital, Inc.	$0	$0	$927,858	$176,618
451301	Reagan Hospital District	$0	$0	$495,591	$210,661
451303	South Limestone Hospital District	$0	$890,726	$1,290,307	$250,335
451304	Preferred Hospital Leasing Eldorado, Inc.	$0	$0	$516,653	$7,457
451305	Burleson St Joseph Health Center	$0	$0	$1,233,292	$0

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
451306	Preferred Hospital Leasing Junction, Inc.	$0	$0	$1,474,860	$210,661
451307	Iraan General Hospital	$0	$0	$267,516	$0
451308	Yoakum County Hospital	$0	$894,418	$1,121,776	$652,924
451309	McCamey County Hospital District	$0	$0	$533,593	$10,000
451310	Ballinger Memorial Hospital District	$0	$0	$719,271	$292,658
451311	Sweeny Hospital District	$0	$0	$2,657,949	$0
451312	CAHRMC Dba Rice Medical Center	$0	$0	$931,126	$3,894,518
451313	Fisher County Hospital District	$0	$284,083	$507,487	$364,737
451314	Winkler County Memorial Hospital	$0	$0	$1,396,733	$97,573
451315	North Runnels Hospital	$0	$0	$160,783	$29,766
451316	Madison St Joseph Health Center	$0	$0	$1,527,870	$0
451317	Refugio County Memorial Hospital District	$0	$364,061	$632,073	$347,141
451318	Stonewall Memorial Hospital District	$0	$0	$326,511	$327,939
451319	Trinity Mother Frances Jacksonville	$0	$347,851	$3,949,008	$0
451320	Chambers County Public Hospital District #1	$0	$299,085	$563,326	$0
451321	Presbyterian Hospital Of Commerce	$0	$0	$899,015	$0
451322	Grimes St Joseph Health Center	$0	$0	$1,311,085	$0
451323	Rollins Brook Community Hospital	$0	$0	$197,790	$0
451324	Sutton County Hospital District	$0	$421,162	$431,685	$337,678
451325	Concho County Hospital	$0	$67,083	$195,601	$210,661
451326	Chillicothe Hospital	$0	$65,574	$69,252	$0
451328	Winnie Community Hospital LLC	$0	$0	$621,512	$0
451329	Rankin County Hospital District	$0	$0	$757,904	$0
451330	Medina County Hospital District	$0	$1,345,109	$1,991,614	$825,628
451331	Dallam-Hartley Counties Hospital District	$0	$380,397	$386,827	$471,833
451332	Palacios Community Medical Center	$0	$0	$971,645	$0
451333	Martin County Hospital District	$0	$0	$1,905,060	$36,320
451334	North Wheeler County Hospital District	$0	$211,302	$263,398	$0
451335	Muenster Hospital District	$0	$0	$234,660	$0
451337	Lockney General Hospital District	$0	$590,800	$568,177	$0
451338	Preferred Hospital Leasing Van Horn, Inc.	$0	$0	$419,891	$143,423
451339	Throckmorton County Memorial Hospital	$0	$0	$197,277	$65,407
451341	Haskell County Hospital District	$0	$0	$395,975	$412,564
451342	Mitchell County Hospital	$0	$0	$1,320,297	$421,322
451343	Electra Hospital District	$0	$0	$1,600,413	$7,343,487
451344	Hansford County Hospital District	$0	$0	$508,683	$266,215
451345	Crosbyton Clinic Hospital	$0	$0	$555,314	$0
451346	Yoakum Community Hospital	$0	$685,504	$973,662	$418,123
451347	Preferred Hospital Leasing Coleman, Inc.	$0	$368,405	$670,748	$461,414
451348	Heart Of Texas Healthcare System	$0	$0	$1,496,786	$1,273,889
451349	Swisher Memorial Healthcare System	$0	$0	$411,007	$0
451350	Castro County Hospital District	$0	$0	$722,733	$132,308
451351	Lynn County Hospital District	$0	$0	$446,968	$48,709
451352	Hardeman County Memorial Hospital	$0	$249,745	$310,078	$0
451353	Crane County Hospital District	$0	$0	$179,258	$0
451354	Olney Hamilton Hospital District	$0	$552,071	$527,578	$527,380
451355	Preferred Hospital Leasing, Inc.	$0	$0	$463,934	$102,905

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
451356	Memorial Medical Center	$0	$1,103,847	$1,109,439	$1,164,542
451357	Rockdale Blackhawk LLC	$0	$0	$827,586	$1,485,000
451358	Seminole Hospital District	$0	$1,508,582	$2,096,112	$400,916
451359	Ochiltree County Hospital District	$0	$714,712	$63,360	$281,604
451360	Memorial Medical Center San Augustine	$0	$0	$205,570	$0
451361	Preferred Hospital Leasing Hemphill, Inc.	$0	$0	$0	$1,365,877
451362	Clay County Memorial Hospital	$0	$0	$434,815	$315,991
451363	Jackson County Hospital District	$0	$581,895	$1,523,885	$500,000
451364	Karnes County Hospital District	$0	$0	$1,862,723	$232,087
451365	Seton Highland Lakes	$0	$0	$4,867,915	$1,292,635
451366	Cochran Memorial Hospital	$0	$0	$631,013	$0
451367	East Texas Medical Center Pittsburg	$0	$0	$3,879,800	$1,240,231
451369	GPCH Dba Golden Plains Community Hospital	$0	$333,542	$3,675,937	$3,330,007
451370	Fannin County Hospital Authority	$0	$0	$1,920,116	$1,144,059
451371	Seton Edgar B Davis	$0	$0	$3,091,612	$0
451372	Muleshoe Area Medical Center	$0	$0	$1,006,385	$161,095
451373	Ward Memorial Hospital	$0	$0	$1,407,507	$0
451374	Scott & White Hospital - Taylor	$0	$0	$0	$0
451375	Liberty Dayton Regional Medical Center	$0	$0	$751,816	$1,365,877
451376	Lavaca Hospital District	$0	$0	$697,321	$85,608
451377	Reeves County Hospital District	$0	$1,335,840	$2,088,345	$884,651
451378	Big Bend Regional Medical Center	$0	$247,229	$2,500,128	$0
451379	Coryell County Memorial Hospital	$0	$0	$1,604,140	$8,826,865
451380	East Texas Medical Center Quitman	$0	$0	$2,177,208	$592,705
451381	Trinity Mother Frances Winnsboro	$0	$0	$3,176,570	$0
451382	Comanche County Medical Center Company	$0	$0	$1,506,560	$453,629
452017	Baylor Specialty Health Center	$0	$0	$0	$0
452033	DSHS TCID	$0	$10,052,643	$0	$3,411,687
453300	Cook Childrens Medical Center	$0	$16,325,022	$1,307,096	$5,951,096
453301	Driscoll Childrens Hospital	$0	$0	$1,150,361	$27,204,136
453302	Children's Medical Center Of Dallas	$0	$22,108,571	$33,656,538	$38,226,390
453304	Texas Childrens Hospital	$0	$0	$14,277,664	$24,987,886
453306	Methodist Childrens Hospital	$0	$3,579,449	$1,950,221	$2,926,060
453308	Baylor Specialty Health Centers	$0	$1,920,828	$0	$0
453309	Healthbridge Children's Hospital	$0	$2,141,149	$0	$0
453310	Dell Children's Medical Center	$0	$5,489,457	$2,371,491	$6,644,359
453313	El Paso Children's Hospital	$0	$5,578,775	$7,300,154	$401,725
453315	CHRISTUS Children's Hospital Of San Antonio	$0	$11,035,691	$12,963,223	$5,686,483
453323	Clarity Child Guidance Center	$0	$2,342,422	$234,990	$829,333
4533C6	DSHS - Waco Center For Youth	$0	$12,848,091	$184,390	$0
4533D6	West Oaks Hospital	$0	$758,502	$0	$0
4533E7	Cypress Creek Hospital	$0	$0	$0	$0
4533I7	Seton Shoal Creek	$0	$2,025,391	$277,011	$0
454000	DSHS	$0	$19,380,084	$87,614	$0
454006	DSHS - Terrell	$0	$26,755,224	$0	$0
454008	DSHS - Vernon	$0	$28,716,804	$380,915	$0
454008	DSHS - Wichita Falls	$0	$36,730,893	$134,089	$0

CCN	Hospital Name	GME	DSH	UC Pool	DSRIP
454009	DSHS - Rusk	$0	$31,726,857	$80,880	$0
454011	DSHS - San Antonio	$0	$32,350,456	$268,549	$0
454014	DSHS - Kerville	$0	$0	$0	$0
454064	River Crest Hospital	$0	$1,294,055	$0	$0
454076	UTHealth Harris County Psychiatric Center	$0	$12,225,067	$477,448	$0
454084	DSHS - Austin	$0	$32,917,605	$460,096	$0
454088	DSHS - Rio Grande	$0	$8,937,058	$5,848	$0
454093	Lubbock Regional Mhmr Center	$0	$0	$0	$2,065,362
454100	DSHS - El Paso Psych	$0	$10,048,190	$47,784	$0
454103	Kingwood Pines Hospital	$0	$121,953	$0	$0
454114	HMIH Cedar Crest LLC	$0	$414,601	$0	$0
670004	St. Mark's Medical Center	$0	$306,019	$148,880	$0
670023	Methodist Mansfield Medical Center	$0	$0	$6,293,431	$738,455
670025	Texas Heart Hospital Of The Southwest LLP	$0	$0	$0	$0
670031	St Lukes Patients Medical Center	$0	$0	$1,506,547	$0
670034	Scott & White	$0	$0	$2,530,170	$0
670041	Hospital - Round Rock	$0	$0	$12,386,856	$0
670043	Seton Medical Center Williamson	$0	$0	$3,664,750	$0
670047	Cedar Park Health System, LP	$0	$3,718,988	$6,081,117	$4,272,529
670053	Sierra Providence East Medical Center	$0	$0	$5,930,296	$0
670055	St. Lukes Sugar Land Hospital	$0	$0	$5,284,505	$0
670056	Methodist Healthcare Of San Antonio	$0	$0	$8,384,682	$0
670059	Seton Medical Center Hays	$0	$0	$293,756	$0
670075	St. Lukes Lakeside Hospital	$0	$0	$6,541,777	$0
670077	St. Lukes Hospital At The Vintage	$0	$0	$9,320,159	$0
670080	Methodist West Houston Hospital	$0	$0	$6,816,319	$0
670082	Seton Medical Center - Harker Heights	$0	$0	$0	$0
670085	Baylor At Garland And McKinney	$0	$0	$1,584,110	$0
670088	TX Health Harris Methodist Hospital Alliance	$0	$0	$6,926,752	$0
670089	Scott & White Hospital - College Station	$0	$0	$1,598,183	$0
670090	Nix Community General Hospital, LLC	$0	$0	$0	$0
	TOTALS	**$30,943,450**	**$1,722,140,773**	**$2,947,121,085**	**$1,276,602,878**

Appendix VI – Unreimbursed Medicaid and Uninsured Costs, FY 2015

The amounts in this table are derived from FY 2013 base payments and costs trended to FY 2015, and FY 2015 GME, DSH and UC Pool payments allocated between Medicaid and Uninsured. Hospitals participating in the UC Pool program in FY 2015 are included. A description of each column follows:

- *Medicaid Shortfall: The difference between base payments for services to Medicaid-eligible beneficiaries plus the Medicaid share of supplemental payments, and estimated Medicaid costs.*
- *Uninsured Payments less Cost: The difference between payments from or on behalf of uninsured patients plus the uninsured share of supplemental payments, and estimated uninsured costs.*
- *Total Unreimbursed Cost: The sum of the first two amounts.*
- *Payment to Cost, Medicaid: Base payments plus the Medicaid share of supplemental payments for services to Medicaid-eligible beneficiaries, divided by estimated Medicaid costs.*
- *Payment to Cost, Total: Medicaid plus uninsured payments including supplemental payments (excluding DSRIP), divided by estimated Medicaid plus uninsured costs.*

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
450002	Tenet Hospitals Limited	($8,841,289)	($3,722,211)	($12,563,500)	89.1%	86.8%
450005	Baptist Orange Hospital	($2,582,232)	($3,146,288)	($5,728,520)	58.4%	40.5%
450007	Sid Peterson	($1,200,885)	($1,567,590)	($2,768,475)	91.5%	87.3%
450010	United Regional Health Care System, Inc.	($10,063,311)	($12,730,356)	($22,793,667)	79.8%	70.7%
450011	St. Joseph Regional Health Center	($8,468,631)	($11,486,237)	($19,954,868)	81.0%	72.7%
450015	Dallas County Hospital District	($99,348,349)	($211,226,077)	($310,574,426)	76.9%	68.4%
450018	UT Medical Branch At Galveston	$2,826,458	($34,963,782)	($32,137,325)	101.7%	85.1%
450021	Baylor University Medical Center	($36,876,542)	($32,770,610)	($69,647,153)	75.8%	68.6%
450023	Citizens Medical Center County Of Victoria	($4,141,948)	($6,195,559)	($10,337,507)	77.4%	67.1%
450024	El Paso County Hospital District	($7,588,098)	($31,167,844)	($38,755,942)	85.8%	76.2%
450028	Valley Baptist Medical Center Of Brownsville	($4,629,644)	($3,516,906)	($8,146,550)	91.5%	88.2%
450029	Laredo Texas Hospital Co	($7,018,598)	($4,379,151)	($11,397,750)	90.8%	87.7%
450032	Harrison County Hospital Association	($1,608,450)	($2,311,774)	($3,920,224)	89.3%	81.3%
450033	Valley Baptist Medical Center	($9,107,279)	($7,617,432)	($16,724,710)	88.8%	83.9%
450034	Christus Hospital Se Texas St. Elizabeth	($10,540,877)	($12,046,187)	($22,587,064)	82.3%	74.7%
450035	St. Joseph Medical Center	($10,259,946)	($5,816,302)	($16,076,248)	85.5%	81.8%
450037	The Good Shepherd Hospital, Inc.	($9,243,753)	($10,621,762)	($19,865,515)	86.0%	79.0%
450039	Tarrant County Hospital District	($43,621,034)	($128,414,245)	($172,035,280)	78.8%	68.1%
450040	Covenant Health System	($11,304,068)	($14,389,152)	($25,693,219)	83.1%	74.3%
450042	Providence Health Center	($6,548,668)	($11,610,757)	($18,159,425)	82.3%	70.2%
450044	UT Southwestern Medical Center St. Paul	($14,824,938)	($9,587,961)	($24,412,899)	77.1%	71.3%
450046	Christus Spohn Hospital - Corpus Christi	($18,167,431)	($34,047,929)	($52,215,360)	84.2%	73.3%
450051	Methodist Dallas Medical Center	($15,916,537)	($15,046,963)	($30,963,500)	83.7%	77.1%
450052	Goodall-Witcher Hospital Authority	($141,188)	($32,741)	($173,928)	92.1%	91.8%
450054	Scott And White Memorial Hospital	($178,298,274)	($42,678,505)	($220,976,778)	47.2%	44.4%
450055	Rolling Plains Memorial Hospital	($515,469)	($295,874)	($811,344)	92.0%	90.7%
450056	Seton Medical Center Austin	($7,961,030)	($10,204,986)	($18,166,015)	83.0%	73.5%
450058	VHS San Antonio Partners	($14,002,256)	($22,228,723)	($36,230,979)	92.2%	85.3%
450064	Texas Health Arlington Memorial Hospital	($11,311,476)	($12,849,041)	($24,160,518)	68.9%	55.8%
450068	Memorial Hermann Texas Medical Center	($52,273,612)	($34,206,214)	($86,479,826)	81.5%	76.5%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
450072	Community Hospital Of Brazosport	($1,685,565)	($3,132,407)	($4,817,972)	85.6%	74.2%
450073	Scurry County Hospital District	($361,256)	($191,589)	($552,845)	93.2%	92.9%
450076	UT MD Anderson Cancer Center	($7,411,383)	($8,175,028)	($15,586,410)	93.8%	91.9%
450078	Anson General Hospital	($124,503)	($32,715)	($157,217)	90.1%	89.0%
450079	Baylor Medical Center At Irving	($10,642,826)	($12,501,764)	($23,144,590)	71.0%	61.7%
450080	Titus County Memorial Hospital	($910,503)	($475,296)	($1,385,799)	93.3%	92.2%
450082	Christus Spohn Hospital - Beeville	($585,684)	($456,814)	($1,042,497)	93.4%	92.1%
450083	East Texas Medical Center	($7,865,400)	($11,163,458)	($19,028,857)	87.6%	79.7%
450085	Graham Hospital District	($191,727)	($145,746)	($337,473)	93.3%	92.2%
450087	Columbia North Hills Hospital	($2,072,133)	($7,020,548)	($9,092,681)	83.2%	66.2%
450090	Gainesville Hospital District	($1,296,398)	($957,649)	($2,254,047)	85.2%	81.5%
450092	Fort Duncan Medical Center, LP	($1,183,953)	($1,085,844)	($2,269,797)	94.4%	91.5%
450097	CHCA Bayshore, LP	($7,854,073)	($14,239,135)	($22,093,208)	90.1%	81.3%
450099	Prime Healthcare Services-Pampa LLC	($492,467)	($483,038)	($975,505)	91.7%	89.8%
450101	Hillcrest Baptist Medical Center	($7,492,046)	($7,242,340)	($14,734,387)	81.2%	74.3%
450102	Mother Frances Hospital	($15,494,563)	($15,024,686)	($30,519,249)	77.8%	70.7%
450104	Guadalupe Valley Hospital	($3,886,824)	($4,026,547)	($7,913,371)	76.8%	69.0%
450107	El Paso Healthcare System, Ltd.	($8,179,795)	($9,095,422)	($17,275,217)	92.5%	87.4%
450108	Wilson County Memorial Hospital District	($309,841)	($240,623)	($550,463)	92.2%	91.2%
450119	McAllen Hospitals LP	($14,727,087)	($15,000,203)	($29,727,290)	86.4%	79.9%
450124	University Medical Center At Brackenridge	($18,655,990)	($34,982,488)	($53,638,478)	80.3%	71.7%
450128	Knapp Medical Center	($4,567,520)	($4,086,356)	($8,653,875)	90.1%	85.1%
450130	Nix Hospital System, LLC	($7,133,687)	($1,289,247)	($8,422,935)	78.9%	77.1%
450132	Ector County Hospital District	($7,090,223)	($6,407,319)	($13,497,542)	86.1%	82.6%
450133	Midland Memorial Hospital	($5,626,673)	($6,587,305)	($12,213,979)	83.2%	77.9%
450135	Texas Health Harris Methodist Fort Worth	($29,746,810)	($30,920,254)	($60,667,065)	72.7%	62.5%
450137	Baylor All Saints Medical Center	($28,430,085)	($10,583,092)	($39,013,178)	60.9%	56.0%
450143	Seton Smithville Regional Hospital	($1,062,964)	($894,644)	($1,957,609)	70.0%	63.7%
450144	Andrews County Hospital District	($482,005)	($447,303)	($929,308)	86.9%	83.8%
450147	Victoria Of Texas	($4,335,611)	($3,245,839)	($7,581,450)	85.2%	80.0%
450148	TX Health Harris Methodist Hospital Cleburne	($4,210,551)	($7,447,484)	($11,658,035)	63.4%	42.1%
450152	Metroplex Hospital	($3,869,016)	($3,605,806)	($7,474,822)	81.8%	74.9%
450154	Val Verde Hospital Corporation	($2,576,531)	($2,403,414)	($4,979,945)	86.3%	80.8%
450155	Deaf Smith County Hospital District	($355,699)	($211,234)	($566,933)	91.0%	89.8%
450162	Lubbock Heritage Hospital	($544,873)	($658,960)	($1,203,832)	76.3%	70.1%
450163	Christus Spohn Hospital – Kleberg	($769,857)	($335,631)	($1,105,489)	93.7%	93.1%
450165	Jourdanton Hospital Corp.	($1,781,573)	($2,052,119)	($3,833,692)	81.2%	73.5%
450176	Mission Regional Medical Center	($5,841,191)	($3,981,872)	($9,823,063)	88.5%	84.6%
450177	Uvalde County Hospital Authority	($1,689,110)	($1,185,510)	($2,874,620)	89.8%	87.8%
450178	Pecos County Memorial Hospital	($314,497)	($288,200)	($602,697)	93.3%	91.8%
450184	Memorial Hermann Hospital System	($48,289,028)	($44,056,532)	($92,345,560)	79.2%	73.0%
450187	Scott & White Hospital – Brenham	($2,702,589)	($3,433,245)	($6,135,834)	60.5%	42.3%
450188	East Texas Medical Center Clarksville	($1,331,417)	($1,172,301)	($2,503,719)	54.6%	40.2%
450192	NCHI Of Hillsboro Inc.	($1,058,998)	($771,903)	($1,830,900)	85.8%	82.0%
450193	St. Lukes Episcopal Hospital	($22,422,543)	($12,485,362)	($34,907,905)	71.8%	66.8%
450194	East Texas Medical Center Jacksonville	($732,833)	($450,432)	($1,183,264)	92.2%	90.3%
450196	Essent PRMC LP	($1,982,783)	($3,256,733)	($5,239,516)	91.9%	83.5%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
450200	Wadley Regional Medical Center	($3,925,044)	($2,720,375)	($6,645,420)	84.9%	79.7%
450203	Weatherford Regional Medical Center	($3,248,528)	($3,996,696)	($7,245,224)	75.7%	66.6%
450209	Northwest Texas Health System, Inc.	($17,216,177)	($19,679,588)	($36,895,766)	79.4%	71.7%
450210	East Texas Medical Center Carthage	($384,251)	($246,854)	($631,105)	92.7%	92.1%
450211	Memorial Medical Center - Lufkin	($1,982,326)	($3,236,337)	($5,218,663)	91.6%	86.3%
450213	Bexar County Hospital District	($31,668,269)	($77,994,150)	($109,662,419)	82.4%	72.7%
450219	Scott & White Hospital - Llano	($2,401,029)	($3,120,989)	($5,522,018)	55.9%	38.9%
450221	Moore County Hospital District	($613,531)	($400,240)	($1,013,770)	87.9%	85.5%
450222	CHCA Conroe, LP	($3,473,109)	($12,502,830)	($15,975,940)	90.3%	74.1%
450229	Hendrick Medical Center	($7,313,756)	($10,402,091)	($17,715,847)	83.6%	74.9%
450231	Baptist St Anthonys Healthcare System	($8,435,882)	($9,559,624)	($17,995,506)	78.3%	70.6%
450235	Gonzales Healthcare Systems	($227,790)	($114,730)	($342,520)	93.7%	93.4%
450236	Hopkins County Hospital District	($1,363,484)	($970,070)	($2,333,554)	90.0%	87.5%
450237	Christus Santa Rosa Hospital	($15,952,979)	($15,001,388)	($30,954,367)	80.0%	72.2%
450241	Jack County Hospital District	($75,731)	($74,045)	($149,776)	91.4%	90.1%
450243	Hamlin Hospital District	($103,898)	($38,742)	($142,641)	86.0%	84.9%
450253	Bellville St. Joseph Health Center	($465,786)	($445,285)	($911,071)	70.2%	67.2%
450271	Decatur Hospital Authority	($1,575,788)	($1,898,172)	($3,473,960)	90.6%	87.6%
450272	Central Texas Medical Center	($2,616,523)	($3,997,386)	($6,613,910)	82.5%	72.6%
450280	Baylor At Garland And McKinney	($7,497,385)	($11,180,862)	($18,678,247)	77.6%	66.0%
450289	Harris County Hospital District	($56,737,896)	($212,704,031)	($269,441,927)	80.4%	69.6%
450292	Texas Health Presbyterian Hospital Kaufman	($736,333)	($2,394,593)	($3,130,926)	90.1%	74.1%
450293	Frio Hospital Association	($279,370)	($132,263)	($411,632)	92.4%	91.7%
450299	College Station Medical Center	($4,495,321)	($1,739,561)	($6,234,882)	79.3%	76.8%
450306	Jones County Regional Healthcare System	($515,931)	($506,964)	($1,022,895)	70.0%	65.1%
450324	UHS Of Texoma	($10,196,789)	($8,418,339)	($18,615,127)	69.4%	57.9%
450330	Oakbend Medical Center	($5,261,008)	($4,222,658)	($9,483,666)	80.8%	75.1%
450340	San Angelo Community Medical Center	($4,894,447)	($1,530,727)	($6,425,174)	76.1%	73.7%
450346	Baptist Hospital Of Southeast TX - Beaumont	($7,072,973)	($7,155,321)	($14,228,294)	84.2%	77.4%
450347	Huntsville Memorial Hospital	($1,688,042)	($3,121,670)	($4,809,712)	78.5%	68.3%
450348	Falls Community Hospital And Clinic	($857,614)	($824,208)	($1,681,822)	71.9%	62.5%
450351	Texas Health Harris Methodist Stephenville	($2,070,768)	($3,375,565)	($5,446,333)	70.2%	49.2%
450352	Hunt Memorial Hospital District	($2,707,879)	($2,887,112)	($5,594,991)	87.6%	82.8%
450358	The Methodist Hospital	($16,914,209)	($17,513,351)	($34,427,561)	83.7%	77.1%
450369	Childress County Hospital District	($283,441)	($122,559)	($406,000)	91.6%	90.8%
450370	Columbus Community Hospital	($222,340)	($175,751)	($398,091)	93.9%	92.1%
450372	Baylor Medical Center At Waxahachie	($2,878,700)	($7,269,144)	($10,147,844)	58.9%	31.2%
450373	East Texas Medical Center Mount Vernon	($728,697)	($798,394)	($1,527,091)	58.2%	42.9%
450388	Methodist Healthcare System Of San Antonio	($32,239,236)	($30,628,939)	($62,868,175)	87.5%	81.7%
450389	East Texas Medical Center Athens	($2,973,005)	($3,945,955)	($6,918,959)	83.2%	74.8%
450395	Memorial Medical Center Livingston	($1,551,062)	($2,055,310)	($3,606,372)	86.5%	78.4%
450399	Terry County Memorial Hospital District	($211,104)	($104,859)	($315,963)	93.6%	93.2%
450403	Columbia Medical Center Of McKinney	($3,366,330)	($4,693,168)	($8,059,497)	85.0%	75.1%
450411	Eastland Memorial Hospital District	($206,751)	($293,217)	($499,968)	90.5%	86.9%
450419	Texas Health Harris Methodist Azle	($1,730,716)	($3,539,713)	($5,270,429)	68.0%	50.6%
450424	Methodist San Jacinto Hospital	($3,124,755)	($2,836,582)	($5,961,336)	92.2%	90.4%
450431	St Davids Healthcare Partnership	($9,971,576)	($8,346,097)	($18,317,672)	88.0%	83.1%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
450447	Navarro Hospital, L.P.	($1,359,226)	($1,248,447)	($2,607,673)	89.8%	85.2%
450451	Somervell County Hospital District	($417,715)	($494,076)	($911,791)	80.3%	76.5%
450460	Tyler County Hospital	($377,786)	($650,988)	($1,028,773)	81.9%	72.6%
450462	Texas Health Presbyterian Hospital Dallas	($14,557,765)	($13,188,545)	($27,746,310)	79.2%	72.6%
450465	Matagorda County Hospital District	($684,516)	($464,845)	($1,149,361)	93.8%	93.3%
450469	Sherman Grayson Hospital LLC	($5,624,319)	($8,930,352)	($14,554,671)	66.9%	44.9%
450475	East Texas Medical Center Henderson	($611,222)	($847,207)	($1,458,429)	91.8%	87.5%
450484	Woodland Heights Medical Center	($1,199,835)	($371,761)	($1,571,596)	92.8%	91.8%
450489	Dawson County Hospital District	($238,569)	($78,232)	($316,801)	93.2%	93.0%
450497	Bowie Hospital Authority	($114,237)	($66,181)	($180,418)	94.3%	93.7%
450498	Stephens Memorial Hospital District	($298,651)	($274,824)	($573,475)	83.7%	79.9%
450508	Memorial Hospital-Nacogdoches	($1,734,893)	($1,600,817)	($3,335,710)	91.2%	88.7%
450518	The Medical Center Of Southeast Texas	($3,256,214)	($2,171,552)	($5,427,766)	86.1%	81.9%
450537	Methodist Richardson Medical Center	($2,741,759)	($4,511,579)	($7,253,339)	76.1%	64.8%
450539	Methodist Hospital Plainview	($442,860)	($268,116)	($710,976)	94.1%	93.6%
450558	Abilene Regional Medical Center	($3,983,468)	($1,758,891)	($5,742,359)	80.2%	76.9%
450563	Baylor Regional Medical Center At Grapevine	($2,744,580)	($6,035,515)	($8,780,094)	71.1%	56.3%
450565	Palo Pinto County Hospital District	($539,776)	($245,585)	($785,361)	93.4%	92.8%
450571	Shannon Medical Center	($7,192,770)	($8,374,292)	($15,567,062)	81.5%	73.5%
450573	Christus Jasper Memorial Hospital	($719,069)	($1,494,481)	($2,213,550)	91.5%	80.3%
450578	Hemphill County Hospital District	($92,476)	($245,882)	($338,358)	83.5%	78.8%
450580	East Texas Medical Center Crockett	($1,409,114)	($1,428,094)	($2,837,208)	68.7%	53.4%
450584	Wilbarger County Hospital District	($309,801)	($469,147)	($778,948)	85.1%	77.1%
450586	Baylor County Hospital District	($59,757)	($8,006)	($67,763)	96.2%	96.3%
450587	Brownwood Hospital	($1,381,701)	($851,449)	($2,233,150)	91.5%	89.3%
450591	Angleton Danbury Medical Center	($3,157,601)	($89,413)	($3,247,014)	51.8%	54.1%
450596	Granbury Hospital Corp	($1,466,103)	($1,592,686)	($3,058,789)	84.6%	78.2%
450597	Cuero Community Hospital	($499,451)	($174,193)	($673,644)	92.1%	91.6%
450604	Hill Country Memorial Hospital	($518,028)	($489,894)	($1,007,921)	92.0%	89.6%
450610	Memorial Hermann Memorial City	($12,270,961)	($11,681,482)	($23,952,444)	73.6%	67.7%
450617	Clear Lake Regional Medical Center	($6,581,850)	($11,442,139)	($18,023,989)	91.6%	83.9%
450620	Dimmit Regional Hospital	($314,837)	($245,724)	($560,561)	92.8%	91.6%
450634	Columbia Medical Center Of Denton	($3,490,802)	($6,662,153)	($10,152,955)	82.0%	69.7%
450638	Houston Northwest Operating Co, L.L.C	($9,896,112)	($11,416,703)	($21,312,816)	82.7%	75.5%
450639	Texas Health Harris Methodist Hospital HEB	($11,235,222)	($19,260,722)	($30,495,944)	58.9%	41.5%
450641	Nocona Hospital District	($59,996)	($68,351)	($128,346)	92.1%	89.5%
450643	Laredo Regional Medical Center, LP	($4,254,816)	($2,128,239)	($6,383,055)	87.3%	84.4%
450644	CHCA West Houston Medical Center	($5,630,456)	($6,855,482)	($12,485,938)	87.4%	79.0%
450647	Columbia Hospital At Medical City Dallas	($6,996,864)	($7,503,845)	($14,500,709)	92.3%	87.5%
450651	Columbia Medical Center Of Plano	($5,680,784)	($12,042,288)	($17,723,072)	83.6%	70.1%
450653	Big Spring Hospital Corporation	($676,702)	($971,005)	($1,647,707)	90.6%	84.6%
450654	Starr County Memorial Hospital	($951,633)	($354,259)	($1,305,892)	92.9%	92.2%
450656	Nacogdoches Medical Center	($843,429)	($447,630)	($1,291,059)	92.3%	90.5%
450658	East Texas Medical Center Fairfield	($183,412)	($217,192)	($400,604)	90.4%	88.4%
450659	TH Healthcare Ltd D/B/A Park Plaza Hospital	($5,731,788)	($905,377)	($6,637,165)	78.5%	77.4%
450661	Odessa Regional Medical Center	($5,828,030)	($1,640,385)	($7,468,415)	81.8%	79.9%
450662	Valley Regional Medical Center	($3,704,437)	($2,504,661)	($6,209,098)	93.4%	91.1%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
450668	Sierra Medical Center	($7,301,606)	($2,655,231)	($9,956,837)	79.6%	76.2%
450669	Columbia Medical Center Of Lewisville	($4,127,167)	($6,246,783)	($10,373,950)	78.8%	68.2%
450670	Tomball Regional Medical Center	($3,617,981)	($4,846,670)	($8,464,652)	78.6%	68.7%
450672	Columbia Plaza Medical Center Of Fort Worth	($4,601,180)	($3,564,896)	($8,166,076)	82.3%	75.7%
450674	CHCA Womans Hospital Of Texas	$4,806,469	($1,028,102)	$3,778,367	108.3%	106.4%
450675	Columbia Medical Center Of Arlington	($6,688,745)	($4,942,065)	($11,630,810)	86.4%	81.7%
450677	TX Health Huguley Hospital Fort Worth South	($5,725,363)	($9,657,445)	($15,382,807)	78.1%	62.1%
450678	Doctors Hospital At White Rock Lake	($5,413,806)	($4,796,832)	($10,210,638)	76.1%	69.1%
450684	Memorial Hermann Northeast	($6,412,629)	($10,213,354)	($16,625,983)	80.9%	69.9%
450686	Lubbock County Hospital District	($17,338,534)	($18,199,640)	($35,538,174)	85.4%	79.8%
450690	UT Health Science Center At Tyler	($2,141,301)	($1,491,244)	($3,632,545)	89.5%	86.0%
450694	El Campo Memorial Hospital	($178,798)	($168,832)	($347,630)	90.6%	89.2%
450697	Southwest General Hospital	($4,639,314)	($2,948,219)	($7,587,532)	90.3%	86.9%
450698	Lamb County Hospital	($207,345)	($137,296)	($344,640)	91.5%	90.7%
450702	Longview Medical Center LP	($3,894,277)	($2,832,674)	($6,726,951)	80.0%	74.2%
450709	Christus Saint John Hospital	$1,016,677	($15,822,837)	($14,806,160)	101.5%	82.4%
450711	Rio Grande Regional Hospital	($5,033,540)	($4,219,994)	($9,253,534)	93.5%	90.4%
450713	St. Davids South Austin Medical Center	($4,137,291)	($10,399,468)	($14,536,759)	87.4%	73.4%
450716	Cypress Fairbanks Medical Center	($6,173,301)	($4,687,368)	($10,860,669)	83.1%	77.6%
450718	St. Davids Healthcare Partnership	($3,629,685)	($7,801,257)	($11,430,942)	76.4%	57.6%
450723	Methodist Charlton Medical Center	($8,691,807)	($11,269,386)	($19,961,194)	83.6%	73.5%
450730	Baylor Medical Center At Carrollton	($7,247,614)	($7,269,668)	($14,517,282)	67.3%	60.0%
450742	Lake Pointe Operating Company	($1,266,490)	($791,672)	($2,058,162)	93.2%	92.3%
450743	Texas Health Presbyterian Hospital Denton	($7,385,442)	($6,634,160)	($14,019,602)	72.3%	64.9%
450746	Knox County Hospital District	($55,420)	($22,143)	($77,563)	92.9%	92.8%
450747	Palestine Principal Healthcare	($1,332,554)	($2,211,206)	($3,543,760)	90.8%	80.6%
450749	East Texas Medical Center Trinity	($287,386)	($223,410)	($510,796)	88.9%	86.3%
450754	Hamilton General Hospital	($400,304)	($719,936)	($1,120,240)	83.8%	74.5%
450755	Methodist Hospital Levelland	($225,172)	($76,854)	($302,027)	94.3%	94.3%
450766	UT Southwestern Medical Center Zale Lipshy	($2,532,398)	($3,870,230)	($6,402,629)	75.9%	65.8%
450771	Texas Health Presbyterian Hospital Plano	($13,486,984)	($14,289,405)	($27,776,389)	48.4%	37.4%
450775	Kph-Consolidation, Inc.	($5,731,274)	($7,285,566)	($13,016,840)	85.1%	75.8%
450779	TX Health Harris Methodist SW Fort Worth	($9,738,241)	($7,590,551)	($17,328,792)	60.7%	51.0%
450780	Methodist Healthcare System Of San Antonio	($325,699)	($167,644)	($493,343)	80.8%	77.2%
450788	Corpus Christi Medical Center	($7,020,223)	($5,155,190)	($12,175,413)	87.4%	82.9%
450801	Christus St. Michael Health System	($10,884,002)	($5,892,318)	($16,776,320)	78.8%	74.4%
450803	Doctors Hospital Tidwell	($5,767,614)	($1,862,775)	($7,630,389)	73.2%	68.6%
450809	St. Davids North Austin Medical Center	($4,988,943)	($6,944,498)	($11,933,442)	86.5%	77.4%
450820	Methodist Sugar Land Hospital	($6,790,686)	($7,056,453)	($13,847,139)	78.3%	70.6%
450822	Columbia Medical Center Of Las Colinas Inc	($1,541,076)	($3,259,555)	($4,800,631)	76.3%	64.3%
450828	Christus Spohn Hospital - Alice	($1,336,910)	($695,096)	($2,032,006)	93.0%	92.1%
450832	Christus Saint Catherine Hospital	($10,110,299)	($5,151,823)	($15,262,122)	41.1%	33.7%
450833	PRHC-Ennis, LP-Ennis Regional Medical Center	($1,723,157)	($1,673,116)	($3,396,273)	76.0%	65.9%
450844	Methodist Willowbrook Hospital	($7,695,252)	($8,291,438)	($15,986,689)	78.5%	70.2%
450847	Memorial Hermann Katy Hospital	($3,062,525)	($4,419,545)	($7,482,070)	81.6%	72.4%
450848	Memorial Hermann Sugar Land Hospital	($4,479,478)	($2,230,841)	($6,710,319)	83.8%	80.6%
450851	Baylor Heart & Vascular Center LLP	($518,687)	($1,561,332)	($2,080,019)	90.5%	75.4%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
450855	Harlingen Medical Center LP	($4,192,457)	($3,489,396)	($7,681,853)	85.0%	78.9%
450862	St Lukes Community Health Services	($4,112,403)	($4,153,474)	($8,265,877)	75.9%	68.5%
450865	Seton Southwest	($718,366)	($1,588,888)	($2,307,254)	75.7%	64.8%
450867	Seton Northwest	($2,147,113)	($4,529,120)	($6,676,234)	79.1%	66.3%
450869	Doctors Hospital At Renaissance	($10,133,575)	($1,705,342)	($11,838,916)	93.5%	93.1%
450884	East Texas Medical Center Gilmer	($824,470)	($1,328,909)	($2,153,378)	68.0%	49.1%
450885	Centennial Medical Center	($1,708,174)	($2,455,560)	($4,163,734)	73.1%	64.7%
450890	Baylor Regional Medical Center At Plano	($4,158,751)	($5,201,861)	($9,360,612)	47.9%	31.1%
451300	Parmer County Community Hospital, Inc.	($74,280)	($149,576)	($223,856)	88.9%	86.1%
451301	Reagan Hospital District	($34,530)	($95,422)	($129,952)	91.6%	89.6%
451303	South Limestone Hospital District	($406,960)	($586,406)	($993,365)	85.7%	80.2%
451304	Preferred Hospital Leasing Eldorado, Inc.	($50,612)	($60,213)	($110,826)	90.8%	88.4%
451305	Burleson St Joseph Health Center	($109,279)	($165,583)	($274,862)	92.3%	89.4%
451306	Preferred Hospital Leasing Junction, Inc.	($141,917)	($155,565)	($297,483)	90.7%	88.8%
451307	Iraan General Hospital	($26,590)	($34,017)	($60,607)	89.7%	87.1%
451308	Yoakum County Hospital	($149,277)	($33,908)	($183,185)	95.5%	96.2%
451309	McCamey County Hospital District	($137,275)	($242,669)	($379,944)	77.3%	69.5%
451310	Ballinger Memorial Hospital District	($188,415)	($320,978)	($509,393)	77.1%	69.8%
451311	Sweeny Hospital District	($211,102)	($392,704)	($603,806)	90.6%	87.5%
451312	CAHRMC Dba Rice Medical Center	($86,215)	($114,878)	($201,093)	92.8%	90.2%
451313	Fisher County Hospital District	($128,687)	($236,896)	($365,584)	81.0%	75.4%
451314	Winkler County Memorial Hospital	($124,991)	($264,874)	($389,865)	87.7%	84.4%
451315	North Runnels Hospital	($37,169)	($19,081)	($56,250)	91.6%	93.0%
451316	Madison St Joseph Health Center	($153,897)	($165,592)	($319,489)	92.4%	90.4%
451317	Refugio County Memorial Hospital District	($300,502)	($245,824)	($546,326)	88.6%	84.9%
451318	Stonewall Memorial Hospital District	($81,078)	($168,561)	($249,639)	86.5%	76.4%
451319	Trinity Mother Frances Jacksonville	($1,299,463)	($2,147,785)	($3,447,248)	81.2%	71.9%
451320	Chambers County Public Hospital District #1	($57,602)	($133,676)	($191,278)	93.3%	91.4%
451321	Presbyterian Hospital Of Commerce	($469,496)	($621,708)	($1,091,205)	77.4%	66.6%
451322	Grimes St Joseph Health Center	($501,034)	($887,119)	($1,388,153)	79.9%	68.0%
451323	Rollins Brook Community Hospital	($587,968)	($1,290,339)	($1,878,307)	74.0%	49.3%
451324	Sutton County Hospital District	($114,729)	($216,291)	($331,020)	86.5%	81.5%
451325	Concho County Hospital	($29,263)	($96,587)	($125,851)	95.8%	88.5%
451326	Chillicothe Hospital	($6,228)	($18,883)	($25,111)	90.0%	87.4%
451328	Winnie Community Hospital LLC	($64,001)	($77,860)	($141,862)	93.2%	91.0%
451329	Rankin County Hospital District	($18,694)	($129,535)	($148,229)	92.0%	86.1%
451330	Medina County Hospital District	($536,624)	($976,932)	($1,513,556)	84.0%	77.9%
451331	Dallam-Hartley Counties Hospital District	($104,926)	($73,357)	($178,283)	93.7%	92.9%
451332	Palacios Community Medical Center	($112,899)	($115,167)	($228,066)	90.2%	87.9%
451333	Martin County Hospital District	($165,073)	($222,781)	($387,853)	89.1%	87.0%
451334	North Wheeler County Hospital District	($18,488)	($56,548)	($75,035)	93.0%	90.3%
451335	Muenster Hospital District	($43,208)	($132,236)	($175,443)	87.9%	76.9%
451337	Lockney General Hospital District	($83,589)	($30,765)	($114,354)	94.9%	95.3%
451338	Preferred Hospital Leasing Van Horn, Inc.	($42,123)	($66,970)	($109,093)	94.6%	91.3%
451339	Throckmorton County Memorial Hospital	($17,448)	($22,760)	($40,208)	90.1%	88.0%
451341	Haskell County Hospital District	($54,771)	($81,493)	($136,265)	91.0%	86.1%
451342	Mitchell County Hospital	($120,063)	($236,923)	($356,986)	91.7%	87.6%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
451343	Electra Hospital District	($654,653)	($465,514)	($1,120,167)	71.9%	68.2%
451344	Hansford County Hospital District	($150,521)	($231,552)	($382,074)	79.5%	74.8%
451345	Crosbyton Clinic Hospital	($79,116)	($55,236)	($134,351)	91.9%	90.1%
451346	Yoakum Community Hospital	($179,787)	($124,533)	($304,321)	93.7%	92.9%
451347	Preferred Hospital Leasing Coleman, Inc.	($89,864)	($101,032)	($190,896)	93.9%	92.2%
451348	Heart Of Texas Healthcare System	($143,528)	($183,486)	($327,014)	91.5%	89.1%
451349	Swisher Memorial Healthcare System	($24,399)	($293,816)	($318,215)	87.4%	75.3%
451350	Castro County Hospital District	($80,066)	($103,568)	($183,635)	92.1%	89.0%
451351	Lynn County Hospital District	($49,351)	($129,175)	($178,526)	87.9%	90.3%
451352	Hardeman County Memorial Hospital	($72,044)	($41,703)	($113,747)	93.6%	92.6%
451353	Crane County Hospital District	($137,250)	($20,634)	($157,884)	83.5%	84.3%
451354	Olney Hamilton Hospital District	($299,822)	($144,200)	($444,022)	87.2%	85.0%
451355	Preferred Hospital Leasing, Inc.	($78,568)	($46,825)	($125,393)	92.1%	90.4%
451356	Memorial Medical Center	($463,866)	($514,047)	($977,913)	89.6%	85.2%
451357	Rockdale Blackhawk LLC	($519,967)	($457,439)	($977,406)	85.1%	79.7%
451358	Seminole Hospital District	($433,734)	($978,554)	($1,412,288)	89.4%	83.0%
451359	Ochiltree County Hospital District	($72,970)	($65,703)	($138,674)	94.2%	94.1%
451360	Memorial Medical Center San Augustine	($306,863)	($640,294)	($947,157)	76.3%	54.9%
451361	Preferred Hospital Leasing Hemphill, Inc.	($521,220)	($606,433)	($1,127,653)	59.8%	40.7%
451362	Clay County Memorial Hospital	($39,797)	($56,215)	($96,013)	92.0%	89.2%
451363	Jackson County Hospital District	($207,259)	($191,758)	($399,018)	92.0%	90.5%
451364	Karnes County Hospital District	($154,566)	($259,123)	($413,689)	93.4%	90.3%
451365	Seton Highland Lakes	($235,445)	($636,441)	($871,886)	91.8%	89.1%
451366	Cochran Memorial Hospital	($33,483)	($87,992)	($121,474)	87.8%	86.7%
451367	East Texas Medical Center Pittsburg	($529,384)	($316,328)	($845,712)	90.8%	89.7%
451369	GPCH Dba Golden Plains Community Hospital	($920,537)	($966,370)	($1,886,907)	83.1%	78.7%
451370	Fannin County Hospital Authority	($229,456)	($212,625)	($442,080)	92.0%	89.9%
451371	Seton Edgar B Davis	($167,441)	($439,065)	($606,506)	93.6%	90.0%
451372	Muleshoe Area Medical Center	($107,254)	($122,977)	($230,230)	91.9%	89.3%
451373	Ward Memorial Hospital	($286,443)	($636,363)	($922,806)	84.9%	77.9%
451374	Scott & White Hospital - Taylor	($606,391)	($1,957,698)	($2,564,089)	61.8%	31.2%
451375	Liberty Dayton Regional Medical Center	($407,606)	($529,579)	($937,185)	70.3%	60.7%
451376	Lavaca Hospital District	($236,841)	($338,996)	($575,836)	86.9%	79.8%
451377	Reeves County Hospital District	($762,313)	($943,068)	($1,705,381)	84.6%	79.3%
451378	Big Bend Regional Medical Center	($477,567)	($379,880)	($857,447)	88.5%	86.2%
451379	Coryell County Memorial Hospital	($97,764)	($279,586)	($377,350)	91.5%	87.4%
451380	East Texas Medical Center Quitman	($231,128)	($259,099)	($490,226)	89.3%	87.7%
451381	Trinity Mother Frances Winnsboro	($350,671)	($477,247)	($827,918)	91.1%	88.1%
451382	Comanche County Medical Center Company	($209,644)	($199,518)	($409,162)	91.3%	89.2%
452017	Baylor Specialty Health Center	($1,568,744)	($1,374,063)	($2,942,808)	62.5%	47.0%
452033	DSHS TCID	($289,070)	($2,859,665)	($3,148,735)	76.8%	76.7%
453300	Cook Childrens Medical Center	($22,898,101)	($2,020,692)	($24,918,793)	93.6%	93.3%
453301	Driscoll Childrens Hospital	($9,862,807)	($3,276,067)	($13,138,874)	92.7%	90.6%
453302	Children's Medical Center Of Dallas	($43,163,695)	($6,836,011)	($49,999,707)	92.2%	91.4%
453304	Texas Childrens Hospital	($39,255,862)	($7,389,986)	($46,645,848)	93.6%	92.6%
453306	Methodist Childrens Hospital	($6,466,739)	($503,110)	($6,969,848)	83.3%	82.5%
453308	Baylor Specialty Health Centers	($2,921,278)	($1,570)	($2,922,848)	83.5%	83.6%

CCN	Hospital Name	Medicaid Shortfall	Uninsured payments less cost	Total Unreimbursed Costs	Payment to Cost: Medicaid	Payment to Cost: Total
453309	Healthbridge Children's Hospital	$184,660	$0	$184,660	101.7%	101.7%
453310	Dell Children's Medical Center	($6,313,775)	$1,377,340	($4,936,435)	94.5%	95.9%
453313	El Paso Children's Hospital	($9,351,833)	($2,565,131)	($11,916,964)	85.2%	82.9%
453315	CHRISTUS Children's Hospital Of San Antonio	($15,036,576)	($1,115,937)	($16,152,514)	87.4%	86.9%
453323	Clarity Child Guidance Center	($531,887)	$40,530	($491,357)	95.6%	96.2%
4533C6	DSHS - Waco Center For Youth	($1,686,173)	($1,838,093)	($3,524,266)	78.7%	78.8%
4533D6	West Oaks Hospital	($348,275)	($27,673)	($375,948)	92.9%	94.6%
4533E7	Cypress Creek Hospital	$226,524	($1,438,868)	($1,212,345)	112.0%	67.2%
4533I7	Seton Shoal Creek	($288,170)	($2,338,375)	($2,626,545)	86.0%	69.1%
454000	DSHS	($375,673)	($4,731,353)	($5,107,026)	79.9%	79.4%
454006	DSHS - Terrell	($1,062,584)	($6,608,738)	($7,671,321)	82.2%	78.7%
454008	DSHS - Vernon	($1,920,179)	($8,536,532)	($10,456,711)	83.1%	76.5%
454008	DSHS - Wichita Falls	($2,492,403)	($8,223,673)	($10,716,076)	79.7%	78.2%
454009	DSHS - Rusk	($937,617)	($8,553,564)	($9,491,181)	77.4%	77.1%
454011	DSHS - San Antonio	($2,372,653)	($7,434,956)	($9,807,610)	80.9%	78.2%
454014	DSHS - Kerville	($690,813)	($21,233,720)	($21,924,533)	0.0%	0.6%
454064	River Crest Hospital	($99,755)	($19,345)	($119,099)	92.5%	96.3%
454076	UTHealth Harris County Psychiatric Center	($156,777)	($3,620,608)	($3,777,384)	90.9%	78.8%
454084	DSHS - Austin	($2,556,648)	($6,553,987)	($9,110,635)	80.6%	79.3%
454088	DSHS - Rio Grande	($257,567)	($2,202,942)	($2,460,509)	78.7%	78.5%
454093	Lubbock Regional Mhmr Center	$0	($3,019,278)	($3,019,278)	0.0%	0.0%
454100	DSHS - El Paso Psych	($442,195)	($2,414,733)	($2,856,928)	81.2%	78.7%
454103	Kingwood Pines Hospital	($416,443)	($21,214)	($437,657)	92.9%	94.1%
454114	HMIH Cedar Crest LLC	($686,161)	$679,808	($6,352)	73.8%	99.8%
670004	St. Mark's Medical Center	($706,531)	($907,523)	($1,614,053)	83.1%	71.3%
670023	Methodist Mansfield Medical Center	($2,634,604)	($5,689,211)	($8,323,815)	81.9%	68.0%
670025	Texas Heart Hospital Of The Southwest LLP	($2,912,911)	($3,048,369)	($5,961,281)	61.1%	49.7%
670031	St Lukes Patients Medical Center	($673,482)	($1,033,083)	($1,706,564)	82.3%	72.4%
670034	Scott & White	($6,287,993)	($8,193,534)	($14,481,527)	54.4%	39.9%
670041	Hospital - Round Rock	($5,534,856)	($8,123,052)	($13,657,908)	77.0%	66.3%
670043	Seton Medical Center Williamson	($1,776,933)	($3,575,669)	($5,352,602)	77.5%	64.5%
670047	Cedar Park Health System, LP	($4,307,436)	($3,388,608)	($7,696,044)	86.8%	81.7%
670053	Sierra Providence East Medical Center	($3,295,814)	($3,152,378)	($6,448,192)	72.3%	65.5%
670055	St. Lukes Sugar Land Hospital	($2,053,670)	($3,797,447)	($5,851,117)	80.1%	68.1%
670056	Methodist Healthcare Of San Antonio	($3,649,044)	($5,708,599)	($9,357,643)	80.0%	68.9%
670059	Seton Medical Center Hays	($203,101)	($133,720)	($336,822)	76.2%	73.8%
670075	St. Lukes Lakeside Hospital	($3,940,887)	($3,070,653)	($7,011,540)	67.4%	62.2%
670077	St. Lukes Hospital At The Vintage	($4,421,557)	($5,714,389)	($10,135,945)	74.1%	65.3%
670080	Methodist West Houston Hospital	($2,699,541)	($4,791,947)	($7,491,488)	76.4%	65.4%
670082	Seton Medical Center - Harker Heights	($7,892,652)	($8,447,785)	($16,340,437)	36.3%	23.2%
670085	Baylor At Garland And Mckinney	($469,088)	($2,647,115)	($3,116,203)	62.8%	45.0%
670088	TX Health Harris Methodist Hospital Alliance	($5,748,649)	($5,119,948)	($10,868,597)	39.1%	40.6%
670089	Scott & White Hospital - College Station	($477,661)	($1,205,745)	($1,683,406)	48.7%	49.4%
670090	Nix Community General Hospital, LLC	($1,279,155)	($4,082,344)	($5,361,499)	0.2%	0.5%
	TOTALS	**($1,821,078,529)**	**($2,172,303,814)**	**($3,993,382,343)**	**83.9%**	**76.3%**

Appendix VII - Hospital Characteristics and Tiers

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
450002	Tenet Hospitals Limited	Private	General Acute	4	3	Metro	Yes
450005	Baptist Orange Hospital	Private	General Acute	2	5	Non-metro	No
450007	Sid Peterson	Private	General Acute	5	4	Non-metro	No
450010	United Regional Health Care System,Inc.	Private	General Acute	4	3	Non-metro	Yes
450011	St. Joseph Regional Health Center	Private	General Acute	4	3	Metro	Yes
450015	Dallas County Hospital District	Large Public	General Acute	1	1	Metro	Yes
450018	UT Medical Branch At Galveston	State	General Acute	5	1	Metro	Yes
450021	Baylor University Medical Center	Private	General Acute	5	1	Metro	Yes
450023	Citizens Medical Center County Of Victoria	Small Public	General Acute	4	4	Non-metro	No
450024	El Paso County Hospital District	Large Public	General Acute	2	2	Metro	Yes
450028	Valley Baptist Medical Center Of Brownsville	Private	General Acute	2	3	Metro	No
450029	Laredo Texas Hosp Co	Private	General Acute	3	3	Metro	No
450032	Harrison County Hospital Association	Private	General Acute	3	4	Non-metro	No
450033	Valley Baptist Medical Center	Private	General Acute	3	3	Metro	Yes
450034	Christus Hospital Se Texas St. Elizabeth	Private	General Acute	4	3	Metro	No
450035	St. Joseph Medical Center	Private	General Acute	3	3	Metro	Yes
450037	The Good Shepherd Hospital, Inc.	Private	General Acute	4	3	Non-metro	Yes
450039	Tarrant County Hospital District	Large Public	General Acute	1	1	Metro	Yes
450040	Covenant Health System	Private	General Acute	5	3	Metro	Yes
450042	Providence Health Center	Private	General Acute	5	3	Metro	Yes
450044	UT Southwestern Medical Center St. Paul	State	General Acute	5	3	Metro	Yes
450046	Christus Spohn Hospital - Corpus Christi	Private	General Acute	3	2	Metro	Yes
450051	Methodist Dallas Medical Center	Private	General Acute	3	2	Metro	Yes
450052	Goodall-Witcher Hospital Authority	Small Public	General Acute	5	5	Non-metro	No
450054	Scott And White Memorial Hospital	Private	General Acute	5	1	Metro	Yes
450055	Rolling Plains Memorial Hospital	Small Public	General Acute	3	5	Non-metro	No
450056	Seton Medical Center Austin	Private	General Acute	5	3	Metro	No
450058	VHS San Antonio Partners	Private	General Acute	4	1	Metro	No
450064	Texas Health Arlington Memorial Hospital	Private	General Acute	4	3	Metro	No
450068	Memorial Hermann Texas Medical Center	Private	General Acute	4	1	Metro	Yes
450072	Community Hospital Of Brazosport	Private	General Acute	5	4	Metro	No
450073	Scurry County Hospital District	Small Public	General Acute	4	5	Non-metro	No
450076	UT MD Anderson Cancer Center	State	General Acute	5	1	Metro	Yes
450078	Anson General Hospital	Small Public	General Acute	5	5	Non-metro	No
450079	Baylor Medical Center At Irving	Private	General Acute	4	3	Metro	No
450080	Titus County Memorial Hospital	Small Public	General Acute	4	4	Non-metro	No
450082	Christus Spohn Hospital - Beeville	Private	General Acute	3	5	Non-metro	No
450083	East Texas Medical Center	Private	General Acute	5	3	Metro	No
450085	Graham Hospital District	Small Public	General Acute	5	5	Non-metro	No
450087	Columbia North Hills Hospital	Private	General Acute	4	4	Metro	No
450090	Gainesville Hospital District	Small Public	General Acute	4	5	Non-metro	No
450092	Fort Duncan Medical Center, LP	Private	General Acute	3	4	Non-metro	No
450097	Chca Bayshore, LP	Private	General Acute	3	2	Metro	No

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
450099	Prime Healthcare Services-Pampa LLC	Private	General Acute	4	5	Non-metro	No
450101	Hillcrest Baptist Medical Center	Private	General Acute	5	3	Metro	Yes
450102	Mother Frances Hospital	Private	General Acute	5	3	Metro	Yes
450104	Guadalpe Valley Hospital	Small Public	General Acute	4	4	Non-metro	No
450107	El Paso Healthcare System, Ltd.	Private	General Acute	4	2	Metro	No
450108	Wilson County Memorial Hospital District	Small Public	General Acute	5	5	Non-metro	No
450119	Mcallen Hospitals LP	Private	General Acute	2	2	Metro	Yes
450124	University Medical Center At Brackenridge	Large Public	General Acute	2	1	Metro	Yes
450128	Knapp Medical Center	Private	General Acute	3	4	Metro	No
450130	Nix Hospital System, LLC	Private	General Acute	5	4	Metro	No
450132	Ector County Hospital District	Small Public	General Acute	4	3	Metro	Yes
450133	Midland Memorial Hospital	Small Public	General Acute	5	3	Non-metro	Yes
450135	Texas Health Harris Methodist Fort Worth	Private	General Acute	5	2	Metro	Yes
450137	Baylor All Saints Medical Center	Private	General Acute	5	3	Metro	No
450143	Seton Smithville Regional Hospital	Private	General Acute	4	5	Non-metro	No
450144	Andrews County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450147	Victoria Of Texas	Private	General Acute	5	4	Non-metro	No
450148	TX Health Harris Methodist Hospital Cleburne	Private	General Acute	4	4	Metro	No
450152	Metroplex Hospital	Private	General Acute	4	4	Metro	No
450154	Val Verde Hospital Corporation	Small Public	General Acute	3	4	Non-metro	No
450155	Deaf Smith County Hospital District	Small Public	General Acute	4	5	Non-metro	No
450162	Lubbock Heritage Hospital	Private	General Acute	5	5	Metro	No
450163	Christus Spohn Hospital - Kleberg	Private	General Acute	3	5	Non-metro	No
450165	Jourdanton Hospital Corp.	Private	General Acute	3	5	Non-metro	No
450176	Mission Regional Medical Center	Private	General Acute	2	3	Metro	No
450177	Uvalde County Hospital Authority	Small Public	General Acute	3	4	Non-metro	No
450178	Pecos County Memorial Hospital	Small Public	General Acute	3	5	Non-metro	No
450184	Memorial Hermann Hospital System	Private	General Acute	4	1	Metro	Yes
450187	Scott & White Hospital - Brenham	Private	General Acute	4	5	Non-metro	No
450188	East Texas Medical Center Clarksville	Private	General Acute	2	5	Non-metro	No
450192	NCHI Of Hillsboro Inc	Private	General Acute	3	5	Non-metro	No
450193	St. Lukes Episcopal Hospital	Private	General Acute	5	3	Metro	Yes
450194	East Texas Medical Center Jacksonville	Private	General Acute	3	5	Non-metro	No
450196	Essent PRMC LP	Private	General Acute	5	4	Non-metro	No
450200	Wadley Regional Medical Center	Private	General Acute	5	4	Non-metro	Yes
450203	Weatherford Regional Medical Center	Private	General Acute	5	4	Non-metro	No
450209	Northwest Texas Health System, Inc	Private	General Acute	2	2	Non-metro	Yes
450210	East Texas Medical Center Carthage	Small Public	General Acute	3	5	Non-metro	No
450211	Memorial Medical Center - Lufkin	Private	General Acute	4	4	Non-metro	No
450213	Bexar County Hospital District	Large Public	General Acute	2	1	Metro	Yes
450219	Scott & White Hospital - Llano	Private	General Acute	5	5	Non-metro	No
450221	Moore County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450222	CHCA Conroe, LP	Private	General Acute	4	3	Metro	Yes
450229	Hendrick Medical Center	Private	General Acute	5	3	Non-metro	No
450231	Baptist St Anthonys Healthcare System	Private	General Acute	5	3	Non-metro	Yes
450235	Gonzales Healthcare Systems	Small Public	General Acute	4	5	Non-metro	No

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
450236	Hopkins County Hospital District	Small Public	General Acute	4	4	Non-metro	No
450237	Christus Santa Rosa Hospital	Private	General Acute	4	2	Metro	Yes
450241	Jack County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450243	Hamlin Hospital District	Small Public	General Acute	5	5	Non-metro	No
450253	Bellville St. Joseph Health Center	Private	General Acute	5	5	Non-metro	No
450271	Decatur Hospital Authority	Small Public	General Acute	5	4	Non-metro	No
450272	Central Texas Medical Center	Private	General Acute	4	4	Metro	No
450280	Baylor At Garland And Mckinney	Private	General Acute	3	4	Metro	Yes
450289	Harris County Hospital District	Large Public	General Acute	1	1	Metro	Yes
450292	Texas Health Presbyterian Hospital Kaufman	Private	General Acute	3	5	Non-metro	No
450293	Frio Hospital Association	Private	General Acute	3	5	Non-metro	No
450299	College Station Medical Center	Private	General Acute	4	4	Metro	Yes
450306	Jones County Regional Healthcare System	Private	General Acute	5	5	Non-metro	No
450324	UHS Of Texoma	Private	General Acute	5	4	Non-metro	No
450330	Oakbend Medical Center	Small Public	General Acute	5	4	Metro	Yes
450340	San Angelo Community Medical Center	Private	General Acute	5	4	Non-metro	No
450346	Baptist Hospital Of Southeast TX - Beaumont	Private	General Acute	5	3	Metro	No
450347	Huntsville Memorial Hospital	Private	General Acute	5	5	Non-metro	No
450348	Falls Community Hospital And Clinic	Private	General Acute	4	5	Non-metro	No
450351	Texas Health Harris Methodist Stephenville	Private	General Acute	5	5	Non-metro	No
450352	Hunt Memorial Hospital District	Small Public	General Acute	4	4	Non-metro	Yes
450358	The Methodist Hospital	Private	General Acute	5	2	Metro	Yes
450369	Childress County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450370	Columbus Community Hospital	Private	General Acute	5	5	Non-metro	No
450372	Baylor Medical Center At Waxahachie	Private	General Acute	5	5	Metro	No
450373	East Texas Medical Center Mount Vernon	Private	General Acute	5	5	Non-metro	No
450388	Methodist Healthcare System Of San Antonio	Private	General Acute	4	1	Metro	Yes
450389	East Texas Medical Center Athens	Private	General Acute	3	4	Non-metro	No
450395	Memorial Medical Center Livingston	Private	General Acute	3	5	Non-metro	No
450399	Terry County Memorial Hospital District	Small Public	General Acute	4	5	Non-metro	No
450403	Columbia Medical Center Of Mckinney	Private	General Acute	5	4	Metro	No
450411	Eastland Memorial Hospital District	Small Public	General Acute	4	5	Non-metro	No
450419	Texas Health Harris Methodist Azle	Private	General Acute	3	5	Metro	No
450424	Methodist San Jacinto Hospital	Private	General Acute	5	3	Non-metro	Yes
450431	St Davids Healthcare Partnership	Private	General Acute	5	2	Metro	No
450447	Navarro Hospital, L.P.	Private	General Acute	4	5	Non-metro	No
450451	Somervell County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450460	Tyler County Hospital	Small Public	General Acute	3	5	Non-metro	No
450462	Texas Health Presbyterian Hospital Dallas	Private	General Acute	5	3	Metro	Yes
450465	Matagorda County Hospital District	Small Public	General Acute	4	5	Non-metro	No
450469	Sherman Grayson Hospital Llc	Private	General Acute	4	4	Non-metro	No
450475	East Texas Medical Center Henderson	Private	General Acute	4	5	Non-metro	No
450484	Woodland Heights Medical Center	Private	General Acute	5	5	Non-metro	No
450489	Dawson County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450497	Bowie Hospital Authority	Small Public	General Acute	5	5	Non-metro	No
450498	Stephens Memorial Hospital District	Small Public	General Acute	5	5	Non-metro	No

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
450508	Memorial Hospital-Nacogdoches	Small Public	General Acute	4	4	Non-metro	No
450518	The Medical Center Of Southeast Texas	Private	General Acute	5	4	Metro	No
450537	Methodist Richardson Medical Center	Private	General Acute	5	4	Metro	No
450539	Methodist Hospital Plainview	Private	General Acute	4	5	Non-metro	No
450558	Abilene Regional Medical Center	Private	General Acute	5	4	Non-metro	No
450563	Baylor Regional Medical Center At Grapevine	Private	General Acute	5	4	Metro	No
450565	Palo Pinto County Hospital District	Small Public	General Acute	4	5	Non-metro	No
450571	Shannon Medical Center	Private	General Acute	5	3	Non-metro	No
450573	Christus Jasper Memorial Hospital	Private	General Acute	3	5	Non-metro	No
450578	Hemphill County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450580	East Texas Medical Center Crockett	Private	General Acute	3	5	Non-metro	No
450584	Wilbarger County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450586	Baylor County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450587	Brownwood Hospital	Private	General Acute	4	4	Non-metro	No
450591	Angleton Danbury Medical Center	Small Public	General Acute	5	5	Metro	No
450596	Granbury Hospital Corp	Private	General Acute	5	5	Non-metro	No
450597	Cuero Community Hospital	Small Public	General Acute	5	5	Non-metro	No
450604	Hill Country Memorial Hospital	Private	General Acute	5	5	Non-metro	No
450610	Memorial Hermann Memorial City	Private	General Acute	5	3	Metro	No
450617	Clear Lake Regional Medical Center	Private	General Acute	5	2	Metro	No
450620	Dimmit Regional Hospital	Small Public	General Acute	3	5	Non-metro	No
450634	Columbia Medical Center Of Denton	Private	General Acute	5	4	Metro	No
450638	Houston Northwest Operating Co, L.L.C	Private	General Acute	4	3	Metro	Yes
450639	Texas Health Harris Methodist Hospital Heb	Private	General Acute	5	3	Metro	No
450641	Nocona Hospital District	Small Public	General Acute	5	5	Non-metro	No
450643	Laredo Regional Medical Center, LP	Private	General Acute	4	4	Metro	No
450644	CHCA West Houston Medical Ctr	Private	General Acute	4	3	Metro	Yes
450647	Columbia Hospital At Medical City Dallas	Private	General Acute	5	2	Metro	Yes
450651	Columbia Medical Center Of Plano	Private	General Acute	5	3	Metro	No
450653	Big Spring Hospital Corporation	Private	General Acute	3	5	Non-metro	No
450654	Starr County Memorial Hospital	Small Public	General Acute	3	5	Non-metro	No
450656	Nacogdoches Medical Center	Private	General Acute	5	5	Non-metro	No
450658	East Texas Medical Center Fairfield	Private	General Acute	4	5	Non-metro	No
450659	TH Healthcare Ltd D/B/A Park Plaza Hospital	Private	General Acute	4	4	Metro	Yes
450661	Odessa Regional Medical Center	Private	General Acute	4	4	Metro	No
450662	Valley Regional Medical Center	Private	General Acute	3	3	Metro	No
450668	Sierra Medical Center	Private	General Acute	5	4	Metro	No
450669	Columbia Medical Center Of Lewisville	Private	General Acute	4	4	Metro	No
450670	Tomball Regional Medical Center	Private	General Acute	5	4	Metro	No
450672	Columbia Plaza Medical Center Of Fort Worth	Private	General Acute	5	4	Metro	Yes
450674	CHCA Womans Hospital Of Texas	Private	General Acute	4	3	Metro	No
450675	Columbia Medical Center Of Arlington	Private	General Acute	4	3	Metro	No
450677	TX Health Huguley Hospital Fort Worth South	Private	General Acute	4	4	Metro	No
450678	Doctors Hospital At White Rock Lake	Private	General Acute	4	4	Metro	No
450684	Memorial Hermann Northeast	Private	General Acute	4	3	Metro	No
450686	Lubbock County Hospital District	Small Public	General Acute	3	1	Metro	Yes

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
450690	UT Health Science Center At Tyler	State	General Acute	5	4	Metro	Yes
450694	El Campo Memorial Hospital	Private	General Acute	5	5	Non-metro	No
450697	Southwest General Hospital	Private	General Acute	2	3	Metro	No
450698	Lamb County Hospital	Small Public	General Acute	4	5	Non-metro	No
450702	Longview Medical Center Lp	Private	General Acute	5	4	Non-metro	No
450709	Christus Saint John Hospital	Private	General Acute	5	2	Metro	No
450711	Rio Grande Regional Hospital	Private	General Acute	3	3	Metro	No
450713	St. Davids South Austin Medical Center	Private	General Acute	4	3	Metro	No
450716	Cypress Fairbanks Medical Center	Private	General Acute	3	3	Metro	No
450718	St. Davids Healthcare Partnership	Private	General Acute	5	4	Metro	No
450723	Methodist Charlton Medical Center	Private	General Acute	4	3	Metro	Yes
450730	Baylor Medical Center At Carrollton	Private	General Acute	4	4	Metro	No
450742	Lake Pointe Operating Company	Private	General Acute	5	4	Non-metro	No
450743	Texas Health Presbyterian Hospital Denton	Private	General Acute	4	4	Metro	No
450746	Knox County Hospital District	Small Public	General Acute	5	5	Non-metro	No
450747	Palestine Principal Healthcare	Private	General Acute	4	5	Non-metro	No
450749	East Texas Medical Center Trinity	Private	General Acute	3	5	Non-metro	No
450754	Hamilton General Hospital	Small Public	General Acute	5	5	Non-metro	No
450755	Methodist Hospital Levelland	Private	General Acute	4	5	Non-metro	No
450766	UT Southwestern Medical Center Zale Lipshy	State	General Acute	5	4	Metro	Yes
450771	Texas Health Presbyterian Hospital Plano	Private	General Acute	5	4	Metro	No
450775	Kph-Consolidation, Inc.	Private	General Acute	5	3	Metro	Yes
450779	TX Health Harris Methodist Sw Fort Worth	Private	General Acute	5	4	Metro	No
450780	Methodist Healthcare System Of San Antonio	Private	General Acute	5	5	Metro	No
450788	Corpus Christi Medical Center	Private	General Acute	5	3	Metro	Yes
450801	Christus St. Michael Health System	Private	General Acute	5	3	Non-metro	Yes
450803	Doctors Hospital Tidwell	Private	General Acute	1	4	Metro	No
450809	St. Davids North Austin Medical Center	Private	General Acute	5	4	Metro	Yes
450820	Methodist Sugar Land Hospital	Private	General Acute	5	4	Metro	No
450822	Columbia Medical Center Of Las Colinas Inc	Private	General Acute	5	5	Metro	No
450828	Christus Spohn Hospital - Alice	Private	General Acute	3	4	Non-metro	No
450832	Christus Saint Catherine Hospital	Private	General Acute	1	4	Metro	No
450833	PRHC-Ennis,LP-Ennis Regional Medical Center	Private	General Acute	3	5	Metro	No
450844	Methodist Willowbrook Hospital	Private	General Acute	5	3	Metro	No
450847	Memorial Hermann Katy Hospital	Private	General Acute	5	4	Metro	No
450848	Memorial Hermann Sugar Land Hospital	Private	General Acute	4	4	Metro	No
450851	Baylor Heart & Vascular Center Llp	Private	General Acute	5	5	Metro	Yes
450855	Harlingen Medical Center Lp	Private	General Acute	4	4	Metro	No
450862	St Lukes Community Health Services	Private	General Acute	5	4	Metro	No
450865	Seton Southwest	Private	General Acute	4	5	Metro	No
450867	Seton Northwest	Private	General Acute	4	4	Metro	No
450869	Doctors Hospital At Renaissance	Private	General Acute	3	2	Metro	No
450884	East Texas Medical Center Gilmer	Private	General Acute	1	5	Non-metro	No
450885	Centennial Medical Center	Private	General Acute	5	5	Metro	No
450890	Baylor Regional Medical Center At Plano	Private	General Acute	5	5	Metro	No
451300	Parmer County Community Hospital, Inc.	Private	Critical Access	5	5	Non-metro	No

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
451301	Reagan Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451303	South Limestone Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451304	Preferred Hospital Leasing Eldorado, Inc.	Small Public	Critical Access	5	5	Non-metro	No
451305	Burlseon St Joseph Health Center	Small Public	Critical Access	4	5	Non-metro	No
451306	Preferred Hospital Leasing Junction, Inc.	Private	Critical Access	3	5	Non-metro	No
451307	Iraan General Hospital	Small Public	Critical Access	5	5	Non-metro	No
451308	Yoakum County Hospital	Small Public	Critical Access	5	5	Non-metro	No
451309	Mccamey County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451310	Ballinger Memorial Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451311	Sweeny Hospital District	Small Public	Critical Access	3	5	Metro	No
451312	CAHRMC Dba Rice Medical Center	Private	Critical Access	5	5	Non-metro	No
451313	Fisher County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451314	Winkler County Memorial Hospital	Small Public	Critical Access	3	5	Non-metro	No
451315	North Runnels Hospital	Small Public	Critical Access	5	5	Non-metro	No
451316	Madison St Joseph Health Center	Private	Critical Access	3	5	Non-metro	No
451317	Refugio County Memorial Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451318	Stonewall Memorial Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451319	Trinity Mother Frances Jacksonville	Private	Critical Access	4	5	Non-metro	No
451320	Chambers County Public Hospital District #1	Small Public	Critical Access	3	5	Non-metro	No
451321	Presbyterian Hospital Of Commerce	Small Public	Critical Access	2	5	Non-metro	No
451322	Grimes St Joseph Health Center	Private	Critical Access	3	5	Non-metro	No
451323	Rollins Brook Community Hospital	Private	Critical Access	5	5	Non-metro	No
451324	Sutton County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451325	Concho County Hospital	Small Public	Critical Access	5	5	Non-metro	No
451326	Chillicothe Hospital	Small Public	Critical Access	5	5	Non-metro	No
451328	Winnie Community Hospital LLC	Private	Critical Access	5	5	Non-metro	No
451329	Rankin County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451330	Medina County Hospital District	Small Public	Critical Access	4	5	Non-metro	No
451331	Dallam-Hartley Counties Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451332	Palacios Community Medical Center	Private	Critical Access	4	5	Non-metro	No
451333	Martin County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451334	North Wheeler County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451335	Muenster Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451337	Lockney General Hospital District	Small Public	Critical Access	4	5	Non-metro	No
451338	Preferred Hospital Leasing Van Horn, Inc.	Private	Critical Access	4	5	Non-metro	No
451339	Throckmorton County Memorial Hospital	Small Public	Critical Access	5	5	Non-metro	No
451341	Haskell County Hosptial District	Small Public	Critical Access	5	5	Non-metro	No
451342	Mitchell County Hospital	Small Public	Critical Access	5	5	Non-metro	No
451343	Electra Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451344	Hansford County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451345	Crosbyton Clinic Hospital	Private	Critical Access	5	5	Non-metro	No
451346	Yoakum Community Hospital	Small Public	Critical Access	5	5	Non-metro	No
451347	Preferred Hospital Leasing Coleman, Inc.	Small Public	Critical Access	4	5	Non-metro	No
451348	Heart Of Texas Healthcare System	Private	Critical Access	5	5	Non-metro	No
451349	Swisher Memorial Healthcare System	Small Public	Critical Access	5	5	Non-metro	No
451350	Castro County Hospital District	Small Public	Critical Access	4	5	Non-metro	No

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
451351	Lynn County Hospital District	Small Public	Critical Access	3	5	Non-metro	No
451352	Hardeman County Memorial Hospital	Small Public	Critical Access	5	5	Non-metro	No
451353	Crane County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451354	Olney Hamilton Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451355	Preferred Hospital Leasing, Inc.	Private	Critical Access	4	5	Non-metro	No
451356	Memorial Medical Center	Small Public	Critical Access	4	5	Non-metro	No
451357	Rockdale Blackhawk LLC	Private	Critical Access	5	5	Non-metro	No
451358	Seminole Hospital District	Small Public	Critical Access	3	5	Non-metro	No
451359	Ochiltree County Hospital District	Small Public	Critical Access	4	5	Non-metro	No
451360	Memorial Medical Center San Augustine	Private	Critical Access	3	5	Non-metro	No
451361	Preferred Hospital Leasing Hemphill, Inc.	Private	Critical Access	5	5	Non-metro	No
451362	Clay County Memorial Hospital	Small Public	Critical Access	5	5	Non-metro	No
451363	Jackson County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451364	Karnes County Hospital District	Small Public	Critical Access	4	5	Non-metro	No
451365	Seton Highland Lakes	Private	Critical Access	4	5	Non-metro	No
451366	Cochran Memorial Hospital	Small Public	Critical Access	4	5	Non-metro	No
451367	East Texas Medical Center Pittsburg	Private	Critical Access	4	5	Non-metro	No
451369	GPCH Dba Golden Plains Community Hospital	Private	Critical Access	3	5	Non-metro	No
451370	Fannin County Hospital Authority	Small Public	Critical Access	4	5	Non-metro	No
451371	Seton Edgar B Davis	Private	Critical Access	3	5	Non-metro	No
451372	Muleshoe Area Medical Center	Small Public	Critical Access	1	5	Non-metro	No
451373	Ward Memorial Hospital	Small Public	Critical Access	3	5	Non-metro	No
451374	Scott & White Hospital - Taylor	Private	Critical Access	5	5	Metro	No
451375	Liberty Dayton Regional Medical Center	Small Public	Critical Access	4	5	Non-metro	No
451376	Lavaca Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451377	Reeves County Hospital District	Small Public	Critical Access	5	5	Non-metro	No
451378	Big Bend Regional Medical Center	Private	Critical Access	4	5	Non-metro	No
451379	Coryell County Memorial Hospital	Small Public	Critical Access	5	5	Non-metro	No
451380	East Texas Medical Center Quitman	Private	Critical Access	5	5	Non-metro	No
451381	Trinity Mother Frances Winnsboro	Private	Critical Access	5	5	Non-metro	No
451382	Comanche County Medical Center Company	Private	Critical Access	5	5	Non-metro	No
452017	Baylor Specialty Health Center	Private	Specialty	5	5	Metro	No
452033	DSHS TCID	State	Specialty	1	4	Metro	No
453300	Cook Childrens Medical Center	Private	Children's	1	1	Metro	Yes
453301	Driscoll Childrens Hospital	Private	Children's	1	2	Metro	Yes
453302	Children's Medical Center Of Dallas	Private	Children's	1	1	Metro	Yes
453304	Texas Childrens Hospital	Private	Children's	2	1	Metro	Yes
453306	Methodist Childrens Hospital	Private	Children's	5	4	Metro	No
453308	Baylor Specialty Health Centers	Private	Specialty	5	4	Metro	No
453309	Healthbridge Children's Hospital	Private	Children's	5	5	Metro	No
453310	Dell Children's Medical Center	Private	Children's	2	2	Metro	Yes
453313	El Paso Children's Hospital	Private	Children's	1	3	Metro	No
453315	CHRISTUS Children's Hospital Of San Antonio	Private	Children's	1	2	Metro	Yes
453323	Clarity Child Guidance Center	Private	IMD	5	4	Metro	No
4533C6	DSHS - Waco Center For Youth	State	Children's	5	4	Metro	No
4533D6	West Oaks Hospital	Private	IMD	5	5	Metro	No

CCN	Hospital Name	Ownership Type	Hospital Type	TIER: Medicaid + Uninsured as % of Hospital Charges	TIER: Medicaid + Uninsured Cost as % of Total Across State	Metro/Non-metro	Teaching
4533E7	Cypress Creek Hospital	Private	IMD	5	5	Metro	No
4533I7	Seton Shoal Creek	Private	IMD	5	5	Metro	No
454000	DSHS	State	IMD	1	4	Non-metro	No
454006	DSHS - Terrell	State	IMD	2	4	Non-metro	No
454008	DSHS Vernon	State	IMD	2	3	Non-metro	No
454008	DSHS - Wichita Falls	State	IMD	4	3	Non-metro	No
454009	DSHS - Rusk	State	IMD	1	3	Non-metro	No
454011	DSHS - San Antonio	State	IMD	2	3	Metro	No
454014	DSHS - Kerville	State	IMD	5	4	Metro	No
454064	River Crest Hospital	Private	IMD	3	5	Non-metro	No
454076	Uthealth Harris County Psychiatric Center	State	IMD	3	4	Metro	Yes
454084	DSHS - Austin	State	IMD	2	3	Metro	No
454088	DSHS - Rio Grande	State	IMD	1	5	Metro	No
454093	Lubbock Regional Mhmr Center	Private	IMD	1	5	Metro	No
454100	DSHS - El Paso Psych	State	IMD	5	4	Metro	No
454103	Kingwood Pines Hospital	Private	IMD	2	5	Metro	No
454114	HMIH Cedar Crest LLC	Private	IMD	3	5	Metro	No
670004	St. Mark's Medical Center	Private	General Acute	5	5	Non-metro	No
670023	Methodist Mansfield Medical Center	Private	General Acute	5	4	Metro	No
670025	Texas Heart Hospital Of The Southwest LLP	Private	General Acute	5	5	Metro	No
670031	St Lukes Patients Medical Center	Private	General Acute	5	5	Metro	No
670034	Scott & White	Private	General Acute	5	4	Metro	No
670041	Hospital - Round Rock	Private	General Acute	4	4	Metro	No
670043	Seton Medical Center Williamson	Private	General Acute	5	4	Metro	No
670047	Cedar Park Health System, LP	Private	General Acute	4	4	Metro	No
670053	Sierra Providence East Medical Center	Private	General Acute	5	4	Metro	No
670055	St. Lukes Sugar Land Hospital	Private	General Acute	5	4	Metro	No
670056	Methodist Healthcare Of San Antonio	Private	General Acute	4	4	Metro	No
670059	Seton Medical Center Hays	Private	General Acute	5	5	Metro	No
670075	St. Lukes Lakeside Hospital	Private	General Acute	5	4	Metro	No
670077	St. Lukes Hospital At The Vintage	Private	General Acute	5	4	Metro	No
670080	Methodist West Houston Hospital	Private	General Acute	5	4	Metro	No
670082	Seton Medical Center - Harker Heights	Private	General Acute	5	4	Metro	No
670085	Baylor At Garland And Mckinney	Private	General Acute	5	5	Metro	No
670088	Tx Health Harris Methodist Hospital Alliance	Private	General Acute	5	4	Metro	No
670089	Scott & White Hospital - College Station	Private	General Acute	5	5	Non-metro	No
670090	Nix Community General Hospital, LLC	Private	General Acute	5	5	Metro	No