



Uncompensated Care in 2010:

A Report on Rider 37 from the 82nd Legislature

December 2012

Executive Summary

This report provides a context for understanding hospitals contributions toward care for the uninsured and the indigent. It provides a framework for considering the interrelations between these programs and the related funding streams. However, it must be recognized at the outset that the primary data source, (i.e., Annual Hospital Survey), used to generate the following analyses of uncompensated care in Texas hospitals was developed with the purpose of reporting uncompensated care as a relatively simple set of hospital charges and as such, has weaknesses in its design and content when used to go beyond charges in an effort to identify, in as clear a way as possible, the related funding streams necessary to arrive at an estimate of unreimbursed uncompensated care cost.

Uncompensated care has typically been reported as the sum of charity care and bad debt charges. A 2008 analysis reported these at \$13.6 billion; in 2010, that amount had grown to \$17.6 billion. Of this total, approximately \$9.7 billion (55 percent) was charity care charges while \$7.9 billion (45 percent) was for bad debt, not a substantial from 2008.

Charges are not the best measure of uncompensated care (UCC) since charges can vary widely between hospitals. Therefore, this analysis converts charges to cost. While there are a variety of methods and data sources for doing so, this report used financial information in the Annual Hospital Survey to calculate a ratio of costs to charges (RCC) for each hospital. These RCCs were then applied to charity and bad debt charges to estimate uncompensated care costs for 2010 at just about \$5.3 billion (\$4.7 billion in 2008). Charity care costs were \$3.2 billion while costs for bad debt totaled \$2.1 billion in 2010.

In an effort to identify revenue streams that offset the reported uncompensated care costs, this report makes an attempt to segregate these streams into patient specific revenue (where the payment can be reasonably tied to an individual patient) and lump sum revenue (where matching funding to an individual patient is not possible). Based on Survey responses, there was about \$270 million in payments associated with charity care patients.

There are also a variety of lump sum revenues that hospitals receive. While lump sum funding is not linked to specific patients, it is a significant funding stream for offsetting costs of uncompensated care. Lump sum revenues include tax revenues, donations and federal grants. In the 2010 Survey, these amounts were reported at \$3.5 billion.

In the analyses that follow, the specific Medicaid lump sum funding streams--Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL)--were associated with government program shortfalls. Hospitals reported funding for these two major revenue streams at approximately \$1 billion for DSH and \$2.7 billion for UPL.

When uncompensated care costs are associated with funding streams for all hospitals participating in the Survey, the total amount of residual uncompensated care cost is estimated at approximately \$1 billion. In 2008, the estimated residual cost was approximately \$3.2 billion.¹

Certain analyses in this report present uncompensated care by three hospital types, for-profit hospitals, nonprofit hospitals and public hospitals. While all hospitals provide significant amounts of charity care, public hospitals provided the most with 15 percent of their charges coming from charity care, and of these, about 62 percent arising from outpatient care and 38 percent from inpatient. Patient populations access care from hospitals differentially. This may have implications for how the rules for accessing funding from the two major Medicaid funding streams, Medicaid DSH and UPL, are developed as the Medicaid 1115 waiver is implemented throughout Texas.

Key Findings

- Nonprofit and public hospitals have the bulk of their uncompensated care in the form of charity care charges, whereas in for-profit hospitals, uncompensated care is concentrated in bad debt. (Table 2)
- Public hospitals have a substantially higher amount of their gross charges related to uncompensated care. (Table 3)
- When the 2010 AHS is compared to a 2008 analysis, outpatient UCC charges (both charity and bad debt) increased by \$2.6 billion, from \$6 billion in 2008 to \$8.6 in 2010. (Table 4)
- There are differences in the source of uncompensated care charges. For-profit hospitals have their largest share of uncompensated care from inpatient bad debt charges, while nonprofit hospitals have their largest share from inpatient charity charges. Public hospitals have their largest share of uncompensated care from outpatient charity charges. (Table 4)
- There is about \$3.5 billion of lump sum revenue available to offset charity and bad debt costs. (Table 9)
- When lump sum revenues are considered as offsets to charity and bad debt costs, as well as government program shortfalls, hospitals have \$1 billion in residual unreimbursed costs. (Table 14)
- The numbers of uninsured are estimated to decrease by 1.7 million with the advent of the individual mandate and premium tax credit subsidies in 2014. However, the impact on Texas hospitals' residual UCC cost is not clear because of the many variables involved, including:
 - The projected reduction in the federal contribution to DSH associated with implementation of the Patient Protection and Affordable Care Act.
 - Texas specific DSH formula issues.
 - The impact of Medicaid 1115 waiver on "replacing" Upper Payment Limit funding to hospitals through the waiver's UC Pool.

¹ A precise understanding of the difference between 2010 and 2008 is not possible for several reasons but part of the difference may lie in the amount of UPL reported in 2010 (\$2.7 billion) as opposed to 2008 (\$1.1 billion). Another aspect of the difference might be assumptions regarding whether DSH funding was reported as part of net patient revenue or separately.

- Community decisions regarding continuation of local tax revenue to offset UCC costs.

Recommendations

- The Annual Hospital Survey (AHS) serves as the basis for calculating UCC costs from hospitals across the state. While the Survey provides a methodology for using financial data to convert self-reported reported charges to cost, it appears to be lacking in structure when it comes to identifying offsetting hospital revenue streams as a basis of calculating residual uncompensated care. To address the validity and reliability of the data, the following recommendations might be considered:
 1. Identify a core set of critical policy questions associated with UCC in Texas.
 2. Formulate a core set of questions that will support policy decisions regarding the impact of UCC on both the state and local governments.
 3. Identify a single, clear source for obtaining this data (e.g., AHS).
 4. Unambiguously identify which questions from this source generate the information required.
 5. Develop a clear set of definitions that are capable of generating valid responses from all participants.
 6. Consider amending the Health and Safety Code, Chapter 311, Powers and Duties of Hospitals, to address financial reporting of UCC unreimbursed costs.
- Develop a vision for addressing UCC in Texas including:
 1. Identifying the role of the different types of hospitals (e.g., for-profit, nonprofit and public) because each appears to have a different role in the provision of UCC.
 2. Identifying the role of the different “lump sum” funding streams including DSH and the Medicaid 1115 waiver’s UC Pool.
 3. Integrating into policy (and rules) the role of the Medicaid waiver’s newly formulated 20 Regional Healthcare Partnerships (RHPS) to fully articulate what their roles are with respect to Medicaid’s “lump sum” funding streams.
 4. Amending the Health and Safety Code, Chapter 61: Indigent Health Care and treatment Act as necessary to consider the impact of the ACA individual mandate and premium tax credits as well as the Medicaid 1115 waiver.

Rider 37 Report on Uncompensated Care Costs

Texas has the highest rate of uninsured in the nation, with 25 percent of the population, or just over 6 million people, without health insurance. About 60 percent of Texas' uninsured adults have incomes below 200 percent of the Federal Poverty Level, an upper boundary for assistance programs.

Today, care for uninsured Texans often takes place in hospitals and emergency rooms – the most expensive points in the health care system. The cost of that care is passed on to local governments and those with private insurance. When businesses drop insurance coverage because of rising costs, this results in more uninsured people seeking healthcare in Texas emergency rooms, or through Medicaid or other public programs)., This can lead to even higher costs for those who can afford health insurance. It has been estimated that approximately \$1,500 is added to the cost of Texas family premiums for costs for the uninsured that have been shifted to commercial payers. Not only is there a general cost shift to insured Texans, but taxpayers also subsidize the health care costs of the uninsured through the various reimbursement programs for uncompensated care in Texas.

Rider 37, General Appropriations Act, 82nd Legislature, directed the Health and Human Services Commission (HHSC) to submit a biennial report on uncompensated care costs, while considering the impact of patient specific and lump sum funding as offsets to uncompensated costs.²

When hospital uncompensated care has been reported in the past, it has been calculated as the sum of bad debt and charity care charges. In its *2008-2010 Residual Uncompensated Care Costs* report HHSC made an initial effort to provide an additional context for understanding uncompensated care by converting charges to cost and then subtracting associated payments. These payments can take the form of patient specific payments or lump sum payments. The intent of the current analysis is to continue this approach and update the impact of UCC in Texas hospitals for 2010.

Uncompensated care (UCC) includes the charges for the uninsured (those with no source of third party insurance) and the underinsured (those with insurance who after contractual adjustments and third party payments have a responsibility to pay for an amount which they do not pay). Uncompensated care also includes the unreimbursed costs from government sponsored health programs. Against these costs, both patient specific funding and lump sum funding will be reported to show amounts available to offset the cost of uncompensated care. The result is residual uncompensated care.

Understanding residual uncompensated care can be an important foundation for consideration of the impact of the 2011 Medicaid 1115 waiver on reimbursements for uncompensated care to the 20 regions newly created under this waiver authority. An initial effort to review the impact of UCC on the waiver regions is contained in Appendix 3.

² House Bill 1, 82nd Legislature, Regular Session, p. II-93.

While care for the uninsured has direct and indirect costs to society, measuring the exact scale is problematic. The general concept of uncompensated care is relatively simple in theory (care that a provider receives no payment for) in practice, there are multiple avenues through which uncompensated care occurs. While the traditional view of uncompensated care is that of the person in a hospital emergency room with no insurance, a more complex picture of uncompensated care has evolved where even patients with insurance can create uncompensated care by being unable to afford to pay their coinsurance and/or deductibles. As more individuals and employers select insurance policies with higher deductibles and more cost sharing by the patient, bad debt resulting from the underinsured or partially insured may continue to grow, yet current reporting mechanisms do little to measure this effect.³

Uncompensated care is most often reported in terms of gross charges, without consideration of offsetting payments received. However, programs exist to reimburse uncompensated care costs. Some programs are targeted to a particular type of care or population group, while others are more encompassing. As these funding streams developed independently of each other, there is little consideration of their interaction and limited understanding of the actual financial impact of uncompensated care on hospitals. To better assess the effectiveness of the various governmental funding streams directed at reducing uncompensated care, they must be considered together.

An aggregate measure of unreimbursed costs after considering all of the funding streams (amounting to billions of dollars) available to offset these costs is necessary for a complete analysis. This measure is referred to in this report as residual uncompensated care. While there may be alternative methods of calculating residual uncompensated care, this report utilizes the methodology outlined in the *2008 – 2009 Report on Residual Uncompensated Care Costs* in developing estimates of residual costs of UCC.

The Current System⁴

To begin to better understand the landscape of uncompensated care reporting, this report will discuss the various programs shaping the current system and key concepts that influence uncompensated care reporting and financing. Understanding these components will provide context for the analysis of residual uncompensated care.

The Texas Constitution delineates care for the uninsured as a local government function. Counties are required to provide certain services to all persons at or below 21 percent of the Federal Poverty Level (FPL).⁵ The required basic health services include primary and preventative services, inpatient and outpatient hospital services, rural health clinics, laboratory

³ Federal health care reform may mitigate this effect through limitations on out-of-pocket expenses for people receiving subsidies to purchase insurance.

⁴ Since this report is based on AHS data reported for 2010, the “current system” is primarily an overview of the programs available at that time. However, references are made to known changes that include the advent of the Medicaid 1115 waiver (December 2011), termination of the historical UPL program (as required by the waiver) and implementation of the Patient Protection and Affordable Care Act (ACA).

⁵ Counties may elect to serve residents at higher than 21 percent FPL. The cost of care for individuals up to 50 percent FPL may be included in the county’s request for state assistance funds.

and X-ray services, family planning services, physician services, prescription drugs, and skilled nursing facility services, regardless of the patient's age.

Counties report these expenditures on a monthly and annual basis to the Department of State Health Services (DSHS). If the cost of services exceeds eight percent of the county's general tax levy, a county is eligible to request state assistance funds. If state appropriations for assistance are not available, the county is not liable for the cost of care that exceeds the eight percent.⁶

Where they exist, public hospitals and hospital districts have the same constitutional obligation to provide care to indigent persons. Using local tax revenues, these hospitals often provide more hospital care to the uninsured than the constitutional minimum requirement.

Various state and federal funding sources are available to offset some of the costs of care for the uninsured, however, providing the care and financing it remains largely a local responsibility.

Community Benefit/Charity Care–Unreimbursed Costs

In addition to the requirements placed on counties and hospital districts, Texas statutes also require nonprofit hospitals to provide charity care to low income Texans. Texas Health and Safety Code Chapter 311, also known as the Charity Care Law, sets out requirements for certain hospitals to maintain their status as nonprofit entities in the state of Texas. This statute requires nonprofit hospitals to establish a charity care policy that provides free or reduced price care to low income persons.⁷ The value of the tax benefits received in a sense "pay for" the charity care provided. By not having to pay taxes, a nonprofit hospital is able to afford to provide more free care than it would as a for-profit hospital.

Each nonprofit hospital has flexibility to set the income level qualifications for the charity care, provided that it covers, at a minimum, persons at less than 21 percent of the Federal Poverty Level (FPL). A hospital may set its charity care policy to cover persons up to 200 percent FPL.⁸ This has resulted in significant differences among hospitals with respect to what is bad debt or charity care. It is conceivable that care for a person at 100 percent FPL could be fully covered by charity care, partially covered on a sliding scale, or not covered as charity, and likely resulting in bad debt.

This implies that any universal definition of uncompensated care that focuses exclusively on charity care will be misleading with respect to the burden of health care costs for the uninsured. To provide meaningful perspective for public policy discussions, the measurement of uncompensated care must not arbitrarily limit the scope of uncompensated care by limiting its definitions.

⁶ The Department of State Health Services distributed approximately \$2.5 million in State Assistance Funds to qualifying counties in fiscal 2010.

⁷ For-profit hospitals are not required to provide charity care. However, those that operate emergency rooms must treat people who have emergency medical conditions, regardless of their ability to pay.

⁸ Reportable charity care may also include care for patients above 200 percent FPL if the patient is determined to be medically indigent by the hospital's eligibility system. Bills remaining after payment by third-party payers exceed a specified percentage of the patient's income and the person is financially unable to pay the remaining bill(s).

Among other requirements for nonprofit hospitals is the filing of the Annual Statement of Community Benefit (ASCB). The ASCB is also required of public hospitals, as well as for-profit hospitals that participate in the Disproportionate Share Hospital program. The ASCB report requires a hospital to demonstrate that they provide community benefits at a level sufficient to meet at least one of several standards:

- “reasonable” as it relates to their community’s needs, resources of the hospital, and tax exempt benefits received;
- 5 percent of net patient revenues, as long as charity care and government sponsored indigent health care equal at least 4 percent of net patient revenues; or
- amounts equal to tax benefits of nonprofit status, excluding federal income tax.

Charity care is free or reduced price care provided to low income persons who qualify based on the hospital’s eligibility standards. Community benefits are other activities undertaken by hospitals that serve a broader population or where the hospital receives payments but does not cover its costs. Community benefits include activities that are not directly related to patient care such as health fairs, immunization programs, and education of medical staff,⁹ as well as operation of subsidized health services (emergency, trauma, neonatal intensive care and community clinics). Hospitals may also count as a community benefit the unreimbursed costs from governmental programs.

These unreimbursed costs of government programs fall into two categories—government-sponsored indigent health care and other government sponsored programs. The first is for costs for providing health services to programs based on financial need. Medicaid is the primary example, but other federal, state and local indigent care programs that are means-tested also fall in this category. Other government sponsored programs are for the costs for providing health care that is not based on need. Medicare is the principal component, but so are CHAMPUS, Tricare and other federal, state or local programs.

In the community benefit reporting mechanism, hospitals are allowed to use an RCC that is calculated from their financial statements. The financial statements must be prepared in accordance with generally accepted accounting principles (GAAP) so this ratio is sometimes referred to as a GAAP RCC. This RCC is higher than those calculated from Medicare/Medicaid cost reports since the financial statements will reflect hospital expenses that are not allowed on the cost reports for governmental health programs.¹⁰

While the ASCB is required of public and for-profit hospitals that participate in DSH, they are not required to complete all of the data elements in the report. This exclusion limits the usefulness of the ASCB data for a comprehensive analysis of uncompensated care. In particular,

⁹ Measurement of community benefits can be difficult, especially when they involve activities where there is no charge for services (such as a health fair) as there is not a readily available financial data element to capture. Likewise, hospitals may face difficulty in estimating the value of their tax exempt status. This can be especially true as it relates to the value of a property tax exemption. The appraised or market value of the hospital’s facilities and land are typically not known.

¹⁰ Some of the items that are not allowed on the Medicare/Medicaid cost reports include some general and administrative costs, physician on-call charges, and portions of depreciation and interest costs.

the information on revenues or value of tax exempt status that helps to offset the costs of uncompensated care is not known.

Annual Hospital Survey–Uncompensated Care

The Annual Hospital Survey (AHS) sponsored by the American Hospital Association (AHA) in conjunction with the Texas Hospital Association and the Department of State Health Services (DSHS) provides one of the most comprehensive measurements of uncompensated care. In that instrument, uncompensated care is defined as the sum of inpatient and outpatient charges for charity care and the inpatient and outpatient charges associated with bad debt. A summary provided each year by DSHS reports these uncompensated amounts in full charges, as is discussed above. This figure has grown from \$6.5 billion in 2002 to just over \$17 billion in 2010. Slightly more than half of this measure of uncompensated care (56 percent) is reported as charity care, that is care for which hospitals expect no reimbursement.

Charges are not the best data point upon which to make comparisons between hospitals.¹¹ When the Department of State Health Services publishes the results of the Survey for the state, it does not use an RCC to convert charges to cost, although other data elements in the Annual Hospital Survey could be used to calculate one.¹² To provide a basis for comparison between hospitals, charges must be converted to costs since charges do not reflect the actual impact on a hospital from providing uncompensated care.

Disproportionate Share Hospital Program–Uninsured Costs and Hospital Specific Limit

One of the most significant sources of funding available to provide payment to hospitals related to uncompensated care is the Disproportionate Share Hospital program (DSH), a component of the Medicaid program. DSH is a capped federal program that provides about \$1.6 billion in funding to approximately 170 hospitals that are more extensively utilized by Medicaid clients and other low income persons. In the DSH program, each hospital's payment is based on a Hospital Specific Limit (HSL) that is the sum of its Medicaid shortfall¹³ and uninsured costs. The DSH program defines uninsured costs as the charges for care for patients with no source of payment for the care they receive. These charges are converted to costs using a methodology that is specific to each cost center on the individual hospital's Medicaid (i.e., Medicare) cost report,¹⁴ and from these costs any payments made by or on behalf of those individuals are subtracted.

¹¹ When AHA prepares an annual assessment of uncompensated care, they convert the charges to costs stating "Uncompensated care data are sometimes expressed in terms of hospital charges, but charge data can be misleading, particularly when comparisons are being made among types of hospitals, or hospitals with very different payer mixes." American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* December, 2010, [http://www.aha.org/aha/content/00-10/10uncompensated care.pdf](http://www.aha.org/aha/content/00-10/10uncompensated%20care.pdf)

¹² The AHA converts charges to cost with a ratio of total expenses (excluding bad debt) over the sum of gross patient revenue and other operating revenue. One difficulty in using this RCC, especially for comparisons of hospitals, is that the AHS data is not always complete for every hospital. To address this issue, statistical methods were used to estimate missing values for hospitals. Those methods are discussed further in the appendix.

¹³ A Medicaid shortfall is the difference between the allowable costs to a hospital for providing services to Medicaid clients and the Medicaid payments received by that hospital.

¹⁴ The "all-payer" RCC used to convert charges to costs is calculated from the hospital's cost report. The Medicaid program has specific rules for determining allowable costs that do not allow hospitals to include all of their operational costs in the reporting and it can be argued that a Medicaid RCC may understate a hospital's costs. The

For the purpose of identifying reimbursable costs, only payments directly tied to the patient are used to offset the reported cost. If the hospital received a local tax appropriation for the general purpose of offsetting the hospital's uncompensated care this payment does not show up in the reporting of DSH. What is considered uninsured costs in the DSH program may not necessarily be unreimbursed costs from a broader policy perspective.

There are at least two major factors that forecast potential changes in DSH in 2010. Neither of these changes was in effect in 2010, the year of this report but being aware of them is important for any understanding of how DSH will fund UCC in the future. The first factor that became operation in 2012 is the federal approval of Texas' Medicaid 1115 waiver.¹⁵ While Appendix 3 discusses the waiver in more detail, for this DSH discussion, its significance lies in how the waiver changed the funding incentives for the large urban public hospitals that have historically been the principle source of the state match for DSH. While the DSH methodology is well beyond the scope of this report, the essential issue is that the waiver creates a Pool for funding uncompensated care incurred by hospitals. The presence of this waiver-created UC Pool provides the large urban public hospitals with an alternative mechanism for receiving Medicaid payments for their UCC. The UC Pool will pay hospitals the lesser of their hospital specific limit (HSL) or the amount in the Pool, just as DSH does. However, the Pool does not require the large urban public hospitals to provide the state match for any hospital other than themselves because under the waiver, they can earn a much higher rate of federal funding through the UC Pool than through DSH. In this way, the Medicaid waiver has substantially changed the rules under which historical Medicaid funding programs have operated.

The potential impact on future DSH is that fewer state matching funds could be provided by the urban hospitals which will limit the amount of DSH payments to hospitals, especially the private hospitals participating in the DSH program.

The second major factor is embedded in the Affordable Care Act of 2010. While not set to take effect until 2014, the Act requires the Secretary of HHS to evaluate the federal allocation of funds to Medicaid DSH program and reduce these allocations according to a methodology that she will develop; however, she must take into consideration the amount of uncompensated care within each state.

Interestingly, there is the possibility of an unintended interaction between these two factors if Texas is unable to draw the full amount of federal DSH available to Texas because of limitations in the state match (Factor 1) and if the Secretary develops a federal funds reduction methodology that assumes, as a baseline, the amount of federal funding to Texas in DSH in FFY 2013 (for example) then the federal reduction under the ACA may be magnified by the inability of Texas to fully fund its DSH program.

all-payer RCC allows a higher percentage of charges to convert to costs than a Medicaid ratio, which is limited to the costs that Medicaid program rules allow.

¹⁵ Although DSH is not included in the Medicaid waiver, there are funding formulas that transcend the waiver requirements and impact DSH.

Trauma–Uncompensated Trauma Care

The Texas Legislature has provided state funding for hospitals to help address the costs of the uncompensated trauma care they provide.¹⁶ Uncompensated trauma care is defined as the sum of the unreimbursed costs of bad debt and charity care provided on an inpatient or emergency room basis. By rule, the reported trauma charges are converted to cost using the all-payer RCC calculated from hospital Medicare/Medicaid cost reports submitted to the state’s Medicaid fiscal intermediary. Information on charges is collected on a separate Survey instrument for the trauma program on a calendar year basis. Charges for trauma patients must exclude any ambulance charges.

While limited to specific diagnosis codes, the charges associated with trauma care are a subset of uncompensated care and could easily be reported in both the DSH program and the trauma program.

Tobacco Settlement–Unreimbursed Health Expenditures

Texas’ master settlement with the tobacco companies provided for units of local government to be compensated for their health care expenditures. The court settlement specified that hospital districts and public hospitals be awarded a pro rata distribution of funds based on their unreimbursed health care expenditures. Rather than have hospitals report those expenditures, the settlement defines unreimbursed costs as the amount of tax revenues collected by hospital districts and public hospitals. Tax collections in effect serve as a proxy for unreimbursed costs.

Since tax revenues serve as the state match for DSH and the Upper Payment Limit supplemental payment programs, as well as being the *de facto* basis for allocating tobacco settlement revenues, essentially the same dollars serve as the basis to draw uncompensated care funding across different programs.

County governments are also eligible for funding from the settlement. However, counties are required to provide a more detailed accounting of the actual expenditures classified as unreimbursed. Reporting requirements related to distribution of funds from the settlement do not involve an RCC.

While this funding stream is based on “unreimbursed health costs,” political subdivisions are not required to use the funds for health related purposes. There is an incentive for counties to use their tobacco settlement proceeds for health care since expenditures that are financed by the tobacco settlement proceeds may be counted as unreimbursed expenditures in the next reporting period.

Upper Payment Limit–Uninsured Costs

While not contributing to the varying array of definitions related to uncompensated care, Medicaid’s Upper Payment Limit (UPL) program provided a major source of uncompensated care reimbursement for participating hospitals. The UPL program makes supplemental payments to offset the difference between what Medicare would pay for services and actual Medicaid payments. However, for hospitals that receive DSH payments the hospital specific limit (HSL) is carried over to UPL. For example, a hospital that had an HSL for Medicaid

¹⁶ Trauma funding is principally from drivers’ license surcharges and from court fines.

shortfall and uninsured costs of \$20 million and received \$15 million in DSH payments could be eligible for \$5 million in UPL payments.

Acting as a cap on UPL payments for hospitals that participate in both the DSH and UPL programs, the HSL indirectly brings uninsured costs into the UPL program and therefore, transforms the UPL program into a major funding stream for the uncompensated care of hospitals.¹⁷

Lump sum payments to hospitals resulting from the UPL supplemental payment program are included in the analysis of UCC that follows even though the 1115 Medicaid waiver approved by CMS in December 2011 effectively terminated this program. Under this waiver, federal funding flowing to Texas through the UPL program was “redirected” into two newly created waiver pools. The rules that governed the allocation of UPL funds no longer exist and are replaced by the rules negotiated with CMS to determine how waiver pool funds are to be distributed to eligible providers. However, since this report uses UCC data from the 2010 Annual Hospital Survey, funding from the now defunct UPL program is included in the analysis. The impact of the waiver is discussed in more detail in Appendix 3.

While the UPL funds were preserved through the creation of the waiver pools, the disappearance of these rules has the potential to create a significant change in how the former UPL funds are allocated to hospitals. As this report is being drafted, there are virtually no rules governing the dispersion of UC Pool funds that can replace those which governed UPL dispersion. The significance of this lies in the potential for a substantial redistribution of federal funding among hospitals that does not match the flow of patients nor the UCC costs that they create.

Timing Issues

Reporting of uncompensated care, regardless of the instrument, presents a series of timing issues. Surveys or reports of uncompensated care, by their nature, deal with a single point in time. The information systems associated with patient care, however, are a series of feedback loops and evolving data.

Patients with a single source of third party payment can be reported on with relative ease. For the uninsured, hospitals face additional steps trying to secure some sort of payment, typically a governmental program. This can be hampered by incomplete or inaccurate information provided by the patient. Frequently, the patient has long since left the hospital’s care when all of the determinations have been made.

Similarly, once the patient’s financial responsibility is known, there is additional time and effort devoted to collections. Some patients arrange payment plans that can extend the time their accounts are kept open.

¹⁷ This gets more complex because there is a substantial subset of hospitals that participated in the UPL program that were “charged capped.” This is a different type of cap from the HSL cap because charged capped hospitals did not participate in the DSH program and therefore, their UPL payment may not reflect any UCC burden.

While imperfect, time boundaries are set to allow for collection of data and subsequent analysis. Some care reported as bad debt or charity care, may eventually be covered to a degree by patient or third party payments.

Data Sources

In adopting the residual uncompensated care methodology, HHSC elected to use the 2010 Annual Hospital Survey as the principal source of data since it has data for all hospitals. It should also be noted that the AHS data is self-reported, meaning hospitals are asked, but not required to use audited financial statements to prepare their responses. Due to timing issues, this is not always possible. For example, the AHS is typically sent to hospitals around March, and hospitals are to report based on their hospital fiscal year that ended in the previous calendar year.

Timing issues can limit the effectiveness of comparisons between hospitals. For example, two hospitals in the same community but different hospital fiscal years would not necessarily have the same number of months of a spike in activity (i.e. flu epidemic or disaster response) in their reported AHS data.

The AHS seems to have been initially developed to look at hospital-based UCC on the basis of charges, presumably since reporting in charges allows timelier data reporting than would be the case if costs were reported. The Survey does provide a methodology for converting reported financial data from charges to costs, as discussed previously. However, the Survey appears to be lacking in structure when it comes to identifying offsetting hospital revenue streams as a basis of calculating residual uncompensated care.

The AHS used in Texas contains multiple sections which ask for the reporting of overlapping financial information that make it difficult to identify the appropriate source of UCC-associated payments or interpret the amount of the payment reported.

For example, Section I of the Survey has questions on UCC charges and payments, while Section J has other revenue question, some apparently overlapping with those of other sections. Finally, Section L asks questions regarding UCC charges and payments. Many of the questions in these four sections appear to be similar or vary only slightly and that variation is so nuanced as to make uncertain whether the question provides the correct data to calculate residual UCC correctly. Furthermore, Section J asks about state and local government revenue while Section I asks about state and local government payments. There are also multiple questions on DSH and UPL funding that appear to confuse the role of local IGTs (either they are included or not in the revenue/payment stream). For example, questions in Section L explicitly exclude IGT but whether or not this is how data is reported is uncertain. The instructions do not uniformly provide a clear set of directions as to how to resolve apparent ambiguities.

A major reason for this ambiguity is that the AHS was not designed to accommodate a calculation of residual UCC and future efforts should be directed to resolve this problem.

Recommendations for Defining a Clean Data Base Include:

1. Identify a core set of critical policy questions associated with UCC in Texas.
2. Formulate a core set of questions that will support policy decisions regarding the impact of UCC on both the state and local governments.

3. Identify a single, clear source for obtaining this data (e.g., AHS)
4. Unambiguously identify which questions from this source generate the information required.
5. Develop a clear set of definitions that are capable of generating valid responses from all Survey participants.
6. Consideration for amending Health and Safety Code Chapter 311.033 to address financial reporting of UCC unreimbursed costs.

Analysis of Charity Care and Bad Debt Charges

As mentioned earlier, uncompensated care has typically referred to the sum of charity care and bad debt charges. While it is not the best measure of the impact on hospitals, it is still useful to analyze the uncompensated care charges more fully before looking at hospitals' costs. Table 1 shows that charity care charges account for just over half of all uncompensated care charges. Inpatient and outpatient charges account for virtually equivalent amounts of UCC.

Table 1: 2010 Description of Uncompensated Care Charges

	Charity Care Charges	Bad Debt Charges	Uncompensated Care Charges
Inpatient	\$5,079,923,082	\$3,600,300,533	\$8,680,223,615
Outpatient	\$4,599,549,739	\$4,031,482,216	\$8,631,031,955
Other*	\$39,882,057	\$220,545,471	\$260,427,528
Total	\$9,719,354,878	\$7,852,328,220	\$17,571,683,098
Percent of UCC	55.3%	44.7%	

*The sum of Inpatient and Outpatient from the Survey does not equal the Total from the Survey. This row represents the difference. Hospitals completed questions on inpatient and outpatient separately, but when added together, they did not equal the total amount that they entered for question that asked for total.

When the totals in Table 1 are compared to the same analysis on 2008 AHS data, the percent of outpatient charity charges increased by approximately 4 percent, from 46 percent of the 2008 total UCC to approximately 50 percent of the 2010 total. When compared to 2008, total charges for both charity and bad debt increased by almost \$4.4 billion, from the 2008 amount of \$13,147,890,975 to \$17.5 billion in 2010.

It is also useful to understand which types of hospitals are providing uncompensated care because the distribution of uncompensated care between charity care and bad debt varies significantly by hospital type, as shown in Table 2. Charity care makes up the majority of public hospitals' uncompensated care, while bad debt is the majority of for profit hospitals' uncompensated care.

Table 2: 2010 Charity Care Charges and Bad Debt Charges by Hospital Type

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Number of Hospitals	312	165	124	601
Charity Care Charges	\$1,350,698,820	\$4,656,595,225	\$3,712,060,833	\$9,719,354,878
% of Charity Care Charges	30%	64%	64%	55%
Bad Debt Charges	\$3,110,291,708	\$2,646,933,151	\$2,095,103,361	\$7,852,328,220
% of Bad Debt Charges	70%	36%	36%	45%
Subtotal	\$4,460,990,528	\$7,303,528,376	\$5,807,164,194	\$17,571,683,098

There can be fluctuations in reported uncompensated care charges from year to year. When Table 2 is compared to 2008 results, the most significant changes occur in for-profit hospital's bad debt, which increased by \$1.2 billion in charges, and for nonprofit hospitals, which saw an increase in their charity care charges by \$1.2 billion. This increase for the nonprofit hospitals brought their percent of charity charges to 64 percent of the total UCC charges, up from 58 percent in 2008.

To provide some additional context to uncompensated care charges, it is useful to compare them to gross charges¹⁸ for all patients. Texas' nonprofit hospitals have the most uncompensated care charges in absolute terms, but Table 3 shows that this might be anticipated given that they have the most gross charges as well. For-profit hospitals have lower amounts of uncompensated care charges, while it appears the indigent care mission of Texas' public hospitals is reflected in the greater percentage of their services devoted to uncompensated care.

Table 3: 2010 Gross Charges by Hospital Type and Relative Charity Care and Bad Debt (includes inpatient and outpatient)

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Gross Charges	\$72,115,033,865	\$80,315,458,463	\$24,469,853,318	\$176,900,345,646
Charity Care Charges as % of Gross Charges	2%	6%	15%	6%
Bad Debt Charges as % of Gross Charges	4%	3%	9%	4%

Analyzing charges by type of service provided (inpatient vs. outpatient) demonstrates some further differences in uncompensated care by hospital type. For-profit hospitals have the largest share of their uncompensated care from bad debt incurred for inpatient services, though outpatient bad debt is not far behind. Nonprofit hospitals have the largest portion of their uncompensated care charges resulting from inpatient charity care. In contrast, outpatient charity care charges are the largest share of public hospitals' uncompensated care.

¹⁸ Gross charges, also referred to as gross patient revenue, are hospitals' full established rates for services rendered to patients.

Table 4 indicates that not only is there a difference between charity care and bad debt by hospital type in general, but also by the services provided (inpatient vs. outpatient). Strategies to reduce uncompensated care that are focused on outpatient alternatives would most likely not only address the substantial outpatient costs seen in Table 4 but would function as buffers to reduce inpatient costs as well. As discussed in Appendix 3, the Medicaid 1115 waiver is intended to fund programs that help transform the regional healthcare system.

Table 4: 2010 Inpatient and Outpatient Uncompensated Care Charges by Hospital Type

	For-Profit Hospitals	% UCC Charges	Nonprofit Hospitals	% UCC Charges	Public Hospitals	% UCC Charges	All Hospitals	% UCC Charges
Inpatient Charity Charges	\$908,226,305	21%	\$2,773,762,287	38%	\$1,397,934,490	25%	\$5,079,923,082	29%
Outpatient Charity Charges	\$403,407,235	9%	\$1,882,832,930	26%	\$2,313,309,574	40%	\$4,599,549,739	27%
Inpatient Bad Debt Charges	\$1,660,329,765	39%	\$1,034,460,661	14%	\$905,510,107	16%	\$3,600,300,533	21%
Outpatient Bad Debt Charges	\$1,326,317,293	31%	\$1,612,472,491	22%	\$1,092,692,432	19%	\$4,031,482,216	23%
Subtotal	\$4,298,280,598	100%	\$7,303,528,369	100%	\$5,709,446,603	100%	\$17,311,255,570	100.0%

Note: These amounts differ slightly from others used elsewhere in this report since a subset of hospitals did not report charity care and bad debt broken out by inpatient and outpatient.

Converting charges to cost

The previous tables added detail to help identify some of the underlying themes in UCC contained in its aggregate reporting. As previously noted, charges are not the best measure of uncompensated care since they can vary widely between hospitals. For the rest of this report, uncompensated care will be discussed in terms of costs, which is based on the conversion of charges to costs through the use of a ratio of costs to charges.

In this analysis, the RCC was calculated from financial information reported in the AHS using the methodology that the American Hospital Association (AHA) uses in its reports. The AHA converts charges to cost with a ratio of total expenses (excluding bad debt) over the sum of gross patient revenue and other operating revenue. Because the AHS data is not complete for every hospital, statistical methods were used to estimate missing values for hospitals.

Table 5 shows estimated charity care and bad debt costs using the RCC computed from financial data in the AHS. The \$17.6 billion reported in charity care and bad debt charges converts to \$5.3 billion in costs.

Table 5: 2010 Estimated Charity Care and Bad Debt Costs by Hospital Type*

	For Profit Hospitals	% of UCC	Nonprofit Hospitals	% of UCC	Public Hospitals	% of UCC	All Hospitals	% of UCC
Charity Costs	\$256,481,823	34.6%	\$1,236,724,760	62.6%	\$1,707,143,715	66.7%	\$3,200,350,299	60.6%
Bad Debt Costs	\$484,790,938	65.4%	\$740,266,858	37.4%	\$852,691,744	33.3%	\$2,077,749,539	39.4%
Subtotal of UCC Costs	\$741,272,761		\$1,976,991,618		\$2,559,835,459		\$5,278,099,838	
Total Expenses, excluding bad debt	\$13,755,708,134		\$23,129,128,257		\$11,427,839,986		\$48,312,676,377	
Subtotal as a percent of Total Expenses, excluding bad debt	5.4%		8.5%		22.4%		10.9%	

*To estimate costs, the RCC formula was applied at the hospital level and then rolled up the costs in the various buckets. It was done this way to make sure the relationship between costs and charges would remain consistent across all the tables, regardless of how the amounts were summarized.

Similar to Table 2, which showed charges by hospital type, Table 5 demonstrates that charity care and bad debt *costs* are not evenly distributed among hospital types. Total expenses (excluding bad debt) also are shown to provide a sense of scale. As evidenced in Table 5, charity care is about two-thirds of public hospitals uncompensated care, while bad debt is the major cost component of for-profit hospital uncompensated care.

Total UCC costs grew between 2008 and 2010 by approximately \$620 million (UCC cost in 2008 was about \$4.6 billion).

Bad Debt from Uninsured and Partially Insured Patients

In the 2008, Annual Hospital Survey questions were added to get more information on the nature of bad debt. Hospital industry representatives had raised a concern that insurance coverage had been giving patients additional financial responsibility through higher deductibles, co-pays and co-insurance. While this might allow Texans to keep their insurance through lower premiums, it is discernible that those insured patients may not be able to afford their share of their hospital bills. The unpaid patient payments likely would be classified by hospitals as bad debt.

The questions that were new to the 2008 AHS asked hospitals to identify bad debt arising from uninsured patients and bad debt from partially insured patients, also sometimes referred to as underinsured. The amounts, as reported on the 2010 Survey, are shown in Table 6.

Table 6: 2010 Bad Debt Costs from Uninsured and Partially Insured

	Bad Debt Costs from the Uninsured	Bad Debt Costs from the Partially Insured	All Bad Debt Costs
Amount	\$1,302,101,696	\$391,769,200	\$2,077,749,539
Percent of Total	62.7%	18.9%	
Number of hospitals reporting*	352	301	566
Hospital response rate	58.6%	50.1%	94.2%

Note: Table does not add across since a subset of hospitals did not supply responses to the Survey questions.

On the 2010 Annual Hospital Survey, bad debt costs were estimated to be approximately \$2.1 billion (up from the 2008 cost of \$1.9 billion). Roughly 50 – 60 percent of respondents provided additional detail on bad debt from the uninsured and the partially insured respectively. The estimated bad debt costs for those that responded totaled \$1.7 billion, or about 82 percent of total bad debt costs of \$2,077,749,539. Bad debt from partially insured patients was \$392 million down from the \$463 million reported on the 2008 AHS (however, only 301 hospitals responded to this question while in 2008 respondents totaled 502). This Survey element can be monitored over time to determine if “bad insurance” is becoming a larger component of uncompensated care. This is an area where the requirements of federal health care reform could have an impact as the requirements for higher medical loss ratios and limitations on out of pocket costs take effect.

Funding Offsets

Having estimated hospitals uncompensated care costs, it is necessary to consider the funding available to hospitals to offset these costs. There are patient-specific funding associated with some charity care and bad debt costs as shown in Table 7. While the amounts are dwarfed by the overall costs of providing the care (less than 10 percent), they should be noted. For example, patients could have third party payments (auto insurance, workers’ compensation) that defray some of the costs of their charity care and still be eligible for charity care according to the hospital’s eligibility system.

Table 7: 2010 Patient Specific Funding for Charity Care Costs by Hospital Type

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Charity care costs	\$256,481,823	\$1,236,724,760	\$1,707,143,714.93	\$3,200,350,299
State government payments	\$3,024,363	\$17,323,220	\$220,158	\$20,567,741
Local government payments	\$9,824,954	\$27,032,849	\$442,570	\$37,300,373
Private insurance payments	\$35,730,810	\$48,527,148	\$4,535,372	\$88,793,330
Patient payments	\$2,061,006	\$21,349,069	\$20,680,345	\$44,090,420
Other third party payments	\$2,636,914	\$70,392,665	\$4,297,261	\$77,326,840
Subtotal of patient funding	\$53,278,047	\$184,624,951	\$30,175,706	\$268,078,704
Charity costs after patient specific funding	\$203,203,776	\$1,052,099,809	\$1,676,968,009	\$2,932,271,595

In the 2008 AHS, the charity costs after patient specific funding were about \$2.5 billion; in 2010, costs increased by almost \$2.9 billion.

There are also a series of lump sum payments that hospitals receive that are not necessarily associated with specific patients. These payments and their sources are shown in Table 8.

Table 8: 2010 Lump sum funding offsets, as reported in AHS

Medicare supplemental payments	\$145,828,526
Medicaid Disproportionate Share Hospital (DSH)	\$1,050,759,144
Medicaid Upper Payment Limit (UPL)	\$2,709,120,627
State trauma	\$77,842,547
Tobacco settlement	\$45,231,234
Federal government	\$1,034,565,689
Other state government funding	\$31,915,366
Charitable contributions	\$253,177,608
Local government funding	\$138,259,422
Tax revenue	\$1,487,168,013
Other government revenue	\$449,332,007
Collections from patients previously reported as uncompensated	\$58,080,678
Subtotal of lump sum funding	\$7,481,280,861

It is likely that some of the lump sum amounts reported in Table 8 were also included in the patient specific payments reported with government programs. In an effort to avoid double counting of revenue, Table 9 represents a modified amount of lump sum payments to minimize duplication. In addition, it was difficult to discern how individual hospitals treated IGT for DSH and UPL on the AHS. The assumptions in this table are that IGT was included for DSH, and not for UPL. Thus, for UPL, an estimate of the IGT amount from the Survey was made and added to the Survey reported amount.

Table 9: 2010 Selected Lump Sum Funding Offsets *

State trauma	\$77,842,547
Other state government funding	\$31,915,366
Tobacco settlement	\$45,231,234
Federal government	\$1,034,565,689
Charitable contributions	\$253,177,608
Tax revenue	\$1,487,168,013
Other IGTs for Medicaid	(\$53,905,080)
Other government revenue	\$449,332,007
Local government funding	\$138,259,422
Collections from patients previously reported as uncompensated	\$58,080,678
Subtotal of lump sum funding	\$3,521,667,484

* UPL and DSH are excluded from Table 9 while in Table 8 because the assumption is that these funding streams are included in the "Medicaid Shortfall" calculation in Table 11.

With these modifications to lump sum revenue reported in Table 9, there appears to be close to \$3.5 billion in non-patient specific revenue available to offset the almost \$5.3 billion costs of uncompensated care summarized in Table 5. This results in unreimbursed charity and bad debt

costs of about \$1.5 billion as shown in Table 10 after consideration of patient specific revenue. After considering the lump sum revenues, nonprofit hospitals have the largest amount of unreimbursed charity and bad debt costs with the public hospitals having the next highest costs. It is noteworthy that of the 601 hospitals reporting on the AHS, 27 percent are nonprofit, 21 percent are public, and 51 percent are for profit hospitals.

Table 10: 2010 UCC Costs After Funding Offsets

	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
UCC Costs	\$741,272,761	\$1,976,991,618	\$2,559,835,459	\$5,278,099,838
Patient Specific Payments	\$53,278,047	\$184,624,951	\$30,175,706	\$268,078,704
Lump Sum Funding	\$475,712,956	\$1,049,858,578	\$1,996,095,950	\$3,521,667,484
Unreimbursed UCC Costs	\$212,281,758	\$742,508,089	\$533,563,803	\$1,488,353,650

Government Program Shortfalls

There are a variety of governmental health programs, most of which are designed to serve people with specific health conditions or of specific income levels. These include Medicaid, Kidney Health Care, and Children with Special Health Care Needs. Sometimes, Medicare, the federal health insurance program for the elderly, also can be considered a source of hospital shortfall funding.

To gain a more comprehensive understanding of the impact of unreimbursed care on hospitals, HHSC considered these shortfalls in its assessment of residual uncompensated care.

Medicaid Shortfall

Hospitals frequently express concern about Medicaid payment rates. The DSH and UPL programs serve to enhance the regular Medicaid payments received.¹⁹ Based on the 2010 AHS, Medicaid costs exceeded Medicaid net patient revenue by \$1.8 billion million, as shown in Table 11. This difference is shown as the “Medicaid Shortfall – Initial”, which means that this “shortfall” was calculated prior to including the Medicaid DSH and UPL funding streams. When these are included, this “initial” shortfall disappears and the Medicaid Shortfall becomes a positive, essentially no shortfall \$1,924,215,887. In the 2008 UCC analysis, the Medicaid Shortfall was \$475 million. However, in this previous calculation it is uncertain as to whether both DSH and UPL were included.

Table 11: Medicaid Shortfall Calculated from 2010 Annual Hospital Survey

Medicaid Charges	\$25,621,857,621
Medicaid Costs, using AHA derived ratio of cost to charges	\$7,143,144,554
Medicaid net patient revenue	\$5,307,480,670
Medicaid Shortfall - Initial	\$1,835,663,884
DSH Payment	\$1,050,759,144

¹⁹ Both DSH and UPL programs will be discussed in Appendix 3 with regard to the impact of the Medicaid 1115 waiver on funding streams. For the purpose of this 2010 report on UCC, both programs were in effect in 2010 and are included into the current UCC analysis.

UPL Payment	\$2,709,120,627
Remaining costs, or shortfall	-\$1,924,215,887

The amounts reported in Table 11 are from the Annual Hospital Survey. They may differ from other amounts reported by HHSC in that they are self-reported data. They also differ from other self-reported amounts for ostensibly the same questions in the current Survey, e.g., (self-reported DSH and UPL in response to questions D6a2c2 vs. J1c, and D6a2d2 vs. J1d). There may also be differences in the reporting periods used (i.e. state fiscal year versus hospital fiscal year).

In addition, hospitals are instructed in the Survey to include DSH and UPL payments, but there is no clear evidence that it is done. It is also unclear whether hospitals that transfer local funds to match federal funds report the full payment, or deduct the local funds.

The inclusion of both DSH and UPL as offsetting revenue for Medicaid has to be considered in the larger context of UCC. DSH, for example, is a Medicaid payment stream that reimburses a hospital for its uncompensated care costs. Medicaid uses a different definition of UCC than the AHS definition, which is the definition employed in this report. DSH uncompensated care includes Medicaid Shortfall and uninsured costs incurred by a hospital. It is anticipated that hospital patients for whom there is no expectation of payment are included in the AHS charity care charges. Uncompensated care costs in DSH are for those individuals without creditable insurance coverage irrespective of FPL. In addition, the Survey includes bad debt in its UCC calculation, while DSH includes the Medicaid shortfall but excludes bad debt. Also, under the charity care law, hospitals are free to identify a Federal Poverty Level (FPL) above the minimally required 21percent to define charity care, thus, bad debt and charity care can differ between hospitals according to their specific charity care policy.

Other Government Program shortfalls

To provide a comprehensive view of the impact of unreimbursed care on hospitals, it is necessary to consider other state programs for the indigent or those with specific health conditions. These programs may include the Tobacco Settlement, Children with Special Health Care Needs, Crime Victims Fund and Kidney Health program. These amounts are reported in Table 12.

Table 12: Other Governmental Program Shortfalls from the 2010 Annual Hospital Survey

	Charges	Estimated Costs	Payments	Remaining Costs, or Shortfall
State Governmental Health Programs	\$1,592,666,707	\$539,967,339	\$154,989,147	\$384,978,192
Local Governmental Health Programs	\$981,465,640	\$227,837,697	\$138,259,422	\$89,578,275
Medicare	\$70,324,928,018	\$17,626,635,991	\$15,843,215,889	\$1,783,420,102

Local Governmental Health Programs include County Indigent Health program and City/County initiatives to fund indigent health care locally.

Medicare is a major source of third party payments for most hospitals. Even so, many hospitals argue that the payments are not sufficient to cover their costs. Covering those remaining costs can also influence how much a hospital can participate in state and local programs, and how much charity care and bad debt hospitals can absorb. In Table 12, an effort was made to estimate the Medicare shortfall. However, a case could also be made that state policy makers should not be responsible for offsetting federal program shortfalls.

Unreimbursed Costs after Patient Specific Payments

Having reviewed the individual programs that comprise uncompensated care, these components can now be viewed together in an effort to generate a broad picture of the impact on hospitals. These costs and payments are summarized in Table 13 for all hospitals.

Table 13: 2010 Uncompensated Care Costs and Government Program Shortfall Costs after Patient Specific Revenue

	Uncompensated Care Costs		Government Program Shortfall Costs			Total
	Charity	Bad Debt	Medicaid	State, local government programs	Medicare	
Charges	\$9,719,354,878	\$7,852,328,220	\$25,621,857,621	\$2,574,132,347	\$70,324,928,018	\$116,092,601,084
Estimated Costs	\$3,200,350,299	\$2,077,749,539	\$7,143,144,554	\$767,805,037	\$17,626,635,991	\$30,815,685,420
Medicaid payments			\$5,307,480,670			\$5,307,480,670
State/local government payments	\$57,868,114			\$293,248,569		\$351,116,683
Medicare					\$15,843,215,889	\$15,843,215,889
Private insurance	\$88,793,330			\$19,390,347	\$496,610,318*	\$604,793,995
Patient payments	\$44,090,420			\$966,139	\$177,824,752	\$222,881,311
Other third party payments	\$77,326,840			\$222,440	\$86,080,428	\$163,629,708
DSH payments			\$1,050,759,144			\$1,050,759,144
UPL payments			\$2,709,120,627			\$2,709,120,627
Subtotal Payments	\$268,078,704	\$0	\$9,067,360,441	\$402,398,385	\$16,603,731,387	\$26,252,998,027
Subtotal of cost after patient specific funding and DSH and UPL	\$2,932,271,595	\$2,077,749,539	-\$1,924,215,887	\$453,977,542	\$1,022,904,604	\$4,562,687,393

Putting It All Together

After converting charity, bad debt and government programs charges to costs and considering all both patient specific and lump sum funding available to hospitals, an estimated \$1 billion in unreimbursed uncompensated costs remain as shown in Table 14.

Table 14: 2010 Estimates of Residual Uncompensated Care Costs

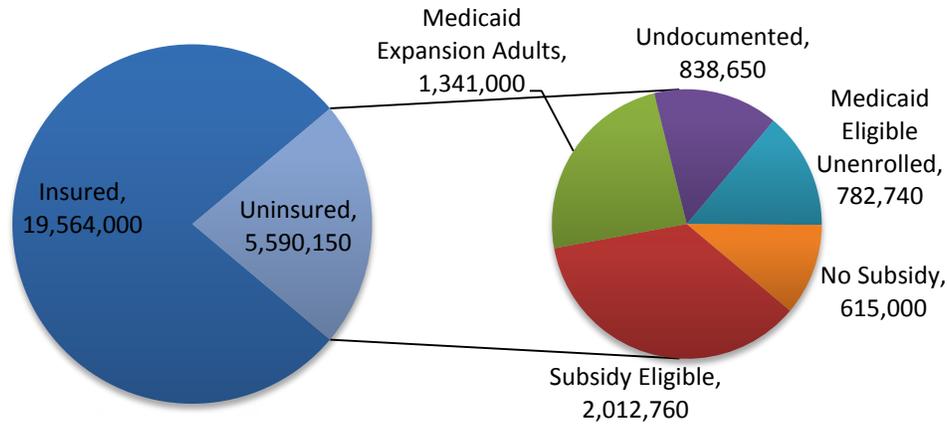
	For Profit Hospitals	Nonprofit Hospitals	Public Hospitals	All Hospitals
Uncompensated Care and Government Program Charges	\$46,876,072,989	\$52,122,467,691	\$17,094,060,404	\$116,092,601,084
Estimated Costs	\$8,896,244,706	\$14,553,759,708	\$7,365,681,005	\$30,815,685,420
Subtotal patient specific funding including DSH/UPL	\$9,652,919,012	\$11,927,367,019	\$4,672,712,164	\$26,252,998,195
Subtotal of costs after patient specific funding	-\$756,674,306	\$2,626,392,689	\$2,692,968,841	\$4,562,687,225
Subtotal Lump Sum Funding	\$475,712,956	\$1,049,858,578	\$1,996,095,950	\$3,521,667,484
Residual unreimbursed uncompensated care costs	-\$1,232,387,262	\$1,576,534,111	\$696,872,891	\$1,041,019,741

Residual unreimbursed uncompensated care costs seem largely concentrated at nonprofit hospitals. As was outlined earlier in the report, this class of hospitals has the largest amount of activity, both in terms of gross charges and total expenses. While it is difficult to estimate, nonprofit hospitals may also have an offset to their costs in the form of exemption from taxes that allows them to absorb more uncompensated and unreimbursed costs. Determining the value of this tax exemption “offset” warrants further consideration.

Patient Protection and Affordable Care Act (aka ACA) Considerations

The ACA, which was signed on March 23, 2010, has over 900 pages of health care requirements, many of which will not be implemented until January 2014. Of particular relevance to this report is the impact of the individual mandate and its associated premium tax credits for individuals with income levels below 400 percent FPL. The chart on the next page shows that in 2010, there were approximately 5.6 million Texans below 65 years of age without insurance. The smaller graph to the right provides a breakdown of the 5.6 million individuals in terms of categories that have relevance for ACA coverage. Since the AHS data is for 2010, this number of uninsured, in conjunction with shortfall costs associated with government programs, created a residual UCC cost of approximately \$1 billion (Table 14).

Current: Insured & Uninsured by ACA Subsidy Type

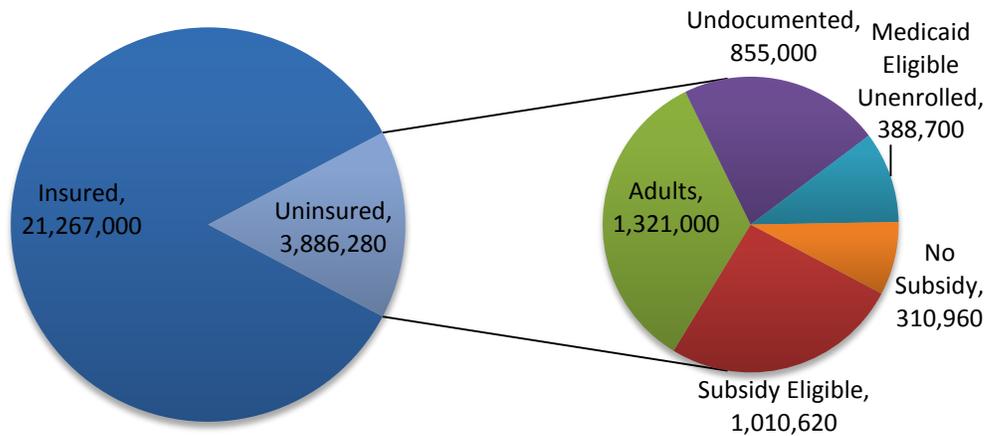


Key for Chart. Medicaid Expansion (adults 138 percent FFPL or below); Medicaid Eligible Unenrolled (children 200 percent FPL or below; TANF adults); Subsidy Eligible [children 201 percent – 400 percent FPL, adults ages 0-64 139 percent – 400 percent FPL includes Lawful Permanent Residents (LPRs)]; No Subsidy (children & adults > 400 percent FPL includes LPRs and adults ages 65+); Undocumented (children & adults).²⁰

The following chart “Under ACA without Medicaid Expansion” estimates the potential impact on the number of uninsured in Texas following the implementation of the individual mandate and associated premium tax credits in 2014.

²⁰ Both charts are from “Presentation to Senate Health & Human Services and Senate State Affairs Committees on the Affordable Care Act, August 1, 2012.

Under ACA Without Medicaid Expansion



In comparing the two charts, the number of uninsured is estimated to fall from 5.6 million to 3.9 million for a 30 percent decrease. The smaller chart to the right shows that the majority of the decrease in uninsured is expected to come from the Subsidy Eligible group. This chart presumes that Texas will not expand Medicaid so the adult uninsured population that would have been Medicaid eligible under the expansion decreases, but only minimally (from 1,341,000 to 1,321,000).

It would be difficult to determine the impact of a decreased number of uninsured on the amount of residual UCC in 2014. It might be hypothesized that residual UCC could go down by 30%, but this would assume that there is a one-to-one reduction in UCC costs associated with the reduction in uninsured. This is unlikely due to the underlying complexity of such costs. Even Texans subsidized by the tax credits retain a responsibility for various copays and deductibles, which vary according to the FPL. For example, the actuarial value of the basic benefit plan under ACA ranges from 94 percent for FPLs between 100 percent and 150 percent to 70 percent for FPLs between 250 percent and 400 percent.

Other variables include whether or not local and state governments continue to provide tax revenue to offset UCC costs when the insurance mandate and premium tax credits are implemented.

There is also the previously discussed ACA impact on DSH federal funding, which is projected to decrease according to a methodology that the Secretary of HHS is to develop. It is possible that this formula might be especially hard on states which have not expanded Medicaid eligibility. Otherwise, it might be construed that the Secretary is supporting such decisions by providing federal DSH payments which essentially subsidize the otherwise Medicaid-eligible uninsured population.

Appendices

Appendix 1 Rider 37

Rider 37. Hospital Uncompensated Care. No funds appropriated under this Article for medical assistance payments may be paid to a hospital if the Health and Human Services Commission determines that the hospital has not complied with the Commission's reporting requirements. The Commission shall ensure that the reporting of uncompensated care (defined to include bad debt, charity care and unreimbursed care) by Texas hospitals is consistent for all hospitals and subjected to a standard set of adjustments that account for payments to hospitals that are intended to reimburse uncompensated care. These adjustments are to be made in such a way that a reliable determination of the actual cost of uncompensated care in Texas is produced. In pursuing this objective, the commission, in coordination with the Attorney General, and with advice from representatives from the hospital industry, will:

- a. review the current instruments for reporting uncompensated care by Texas hospitals to ensure that accounting for uncompensated care as well as its reporting is consistent across hospitals;
- b. coordinate the different instruments for reporting uncompensated care in Texas, e.g., Statement of Community Benefits, Annual Hospital Survey, and DSH Survey, so that there is consistency in reporting among these instruments while maintaining the integrity of each instrument's purpose;
- c. identify the sources of funding to hospitals that are intended to offset uncompensated care;
- d. develop a standard set of adjustments that apply the funding sources to reported uncompensated care in such a manner that a reliable determination of the actual cost to a hospital for uncompensated care can be made; and
- e. identify a standard ratio of cost to charges (RCC) to standardize the conversion of reported charges to costs.

The commission shall conduct an appropriate number of audits to assure the accurate reporting of the cost of uncompensated hospital care.

The commission shall submit a biennial report on uncompensated care costs, which considers the impact of patient specific and lump sum funding as offsets to uncompensated costs, to the Governor and Legislative Budget Board no later than December 1, 2012. The commission may report by hospital type.

The commission shall also review the impact of health care reform efforts on the funding streams that reimburse uncompensated care, assess the need for those funding streams in future biennia, and consider which funds might be redirected to provide direct health coverage.

Appendix 2
Relevant UCC References

Context	Reference	Requirement
Title 4, Subtitle F, Chapter 311, Subchapter B	Charity Care	<ul style="list-style-type: none"> • Unreimbursed cost to a hospital of: <ul style="list-style-type: none"> ○ 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 ○ Providing, funding, or otherwise financially supporting health care services to financially indigent persons through other nonprofit or public outpatient clinics, hospitals, or health care organizations.
	Financially indigent	<ul style="list-style-type: none"> • An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital’s eligibility system.
	Medically indigent	<ul style="list-style-type: none"> • A person who’s medical or hospital bills after payment by 3rd party payors exceed a specified percentage of the patient’s annual gross income, determined in accordance with the hospital’s eligibility system and the person is financially unable to pay the remaining bill.
Subchapter D	Community Benefits	<ul style="list-style-type: none"> • The unreimbursed cost to a hospital of providing charity care, <u>government-sponsored program services</u>, research, and subsidized health services.
Subchapter B	Government-sponsored indigent health care	<ul style="list-style-type: none"> • Unreimbursed cost to a hospital of providing health care services to recipients of Medicaid and other federal, <u>state, or local indigent health care programs</u>, eligibility for which is based on financial need.
	Nonprofit hospital	<ul style="list-style-type: none"> • A hospital that is: <ul style="list-style-type: none"> ○ Eligible for tax-exempt bond financing, or ○ Exempt from state franchise, sales, ad valorem, or other state or local taxes; and ○ Organized as a nonprofit corporation or a charitable trust under the laws of this state or any other state or

Context	Reference	Requirement
	<p>Duty of nonprofit hospitals to provide community benefits</p>	<p>country.</p> <ul style="list-style-type: none"> • Nonprofit hospitals shall provide health care services to the community and shall comply with all federal, state, and local government requirements for tax exemption to maintain such exemption. • These health care services to the community shall include: <ul style="list-style-type: none"> ○ Charity care ○ Government-sponsored indigent health care, and may include ○ Other components of the community benefits
	<p>Nonprofit hospital's compliance with requirements for tax exempt status</p>	<ul style="list-style-type: none"> • Nonprofit hospital or hospital system shall annually satisfy the requirements of this subchapter to provide community benefits which include charity care and government-sponsored indigent health care by complying with one or more of the standards set forth in Subsection (b). • Subsection (b). a nonprofit hospital or hospital system may elect to provide community benefits, which include charity care and government-sponsored indigent health care, according to any of the following standards: <ul style="list-style-type: none"> ○ Charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system; ○ Charity care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's tax-exempt benefits, excluding federal income tax; or ○ Charity care and community benefits are provided in a combined amount equal to at least 5 percent of the

Context	Reference	Requirement
		<p>hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least 4 percent of net patient revenue.</p>
<p>Title 2, Subtitle C, Chapter 61, Subchapter A</p>	<p>General revenue levy</p>	<ul style="list-style-type: none"> • The property taxes imposed by a county that are not dedicated to: <ul style="list-style-type: none"> ○ Construction and maintenance of farm-to-market roads ○ Flood control ○ Further maintenance of public roads, ○ Payment of principal or interest on county debt • Sales and use tax revenue received
<p>Subchapter B</p>	<p>County responsibility for persons not residing in an area served by a public hospital or hospital district</p>	<ul style="list-style-type: none"> • A county shall provide health care assistance as prescribed by this subchapter to each of its eligible county residents.
<p>Subchapter A</p>	<p>General eligibility for county sponsored services (61.006)</p>	<ul style="list-style-type: none"> • The minimum eligibility standards must incorporate a net income eligibility level equal to 21 percent of the federal poverty level • Each person who meets the basic income and resources requirements for Temporary Assistance for needy Families program payments but who is categorically ineligible for TANF will be eligible for assistance under Subchapter B.
	<p>Basic health care services</p>	<ul style="list-style-type: none"> • Services eligible for state payment assistance: <ul style="list-style-type: none"> ○ Primary and preventative services ○ Inpatient and outpatient hospital services ○ Rural health clinics ○ Lab and X-ray services ○ Family planning services ○ Physician services ○ 3 prescription drug per month (not more) ○ Skilled nursing facility services • Other services but may not credit the assistance towards eligibility for state

Context	Reference	Requirement
		assistance except as provided by Section 61.0285
	County responsibility and limitations on liability (Section 61.035)	<ul style="list-style-type: none"> • To the extent prescribed by this chapter, a county is liable for health care services provided under this subchapter by any provider, including a public hospital or hospital district, to an eligible county resident. • A county is not liable for the cost of a health care service provided under Section 61.028 or 61.0285 that is in excess of the payment standards for that service established by DSHS under Section 61.006 (e.g., general eligibility) • Limitation on county liability <ul style="list-style-type: none"> ○ Maximum county liability for each state fiscal year for health care services provided by all assistance providers, including a hospital and skilled nursing facility, to each eligible county resident is: <ul style="list-style-type: none"> • \$30,000 or • payment of 30 days of hospitalization or treatment in skilled nursing facility or both, or \$30,000 whichever occurs first.
	County eligibility for state assistance	<ul style="list-style-type: none"> • To be eligible for state assistance, a county must: <ul style="list-style-type: none"> ○ Spend in a state fiscal year at least 8 percent of its general revenue levy for that year to provide health care services ○ Notify DSHS
State distribution of assistance funds	<ul style="list-style-type: none"> • State funds provided to a county must be equal to at least 90 percent of the actual payment for the health care services for the county's eligible residents during the remainder of the state fiscal year after the 8 percent expenditure level is reached. • If DSHS fails to provide assistance to an eligible county the county is not liable for payments for health care services provided to its eligible county residents after the county reaches the 8 percent expenditure level. 	
Subchapter C	Persons who reside	<ul style="list-style-type: none"> • This subchapter applies to health care

Context	Reference	Requirement
	in an area served by a public hospital or hospital district	services and assistance provided to a person who resides in the service area of a public hospital or hospital district.
	General eligibility for public hospital or hospital district sponsored services (61.006)	<ul style="list-style-type: none"> • The minimum eligibility standards must incorporate a net income eligibility level equal to 21 percent of the federal poverty level • Each person who meets the basic income and resources requirements for Temporary Assistance for needy Families program payments but who is categorically ineligible for TANF will be eligible for assistance under Subchapter B.
	Basic health services provided by a public hospital or hospital district	<ul style="list-style-type: none"> • Essentially the same as those provided by a county.
	Payment for services	<ul style="list-style-type: none"> • To the extent prescribed by this chapter, a public hospital is liable for health care services provided under this subchapter by any provider, including another public hospital to an eligible resident in the hospital's service area.
	Payment rates and limits	<ul style="list-style-type: none"> • The payment rates and limits prescribed by Section 61.035 that relate to county services apply to inpatient and outpatient hospital services a public hospital is required to provide.
Annual Hospital Survey	Uncompensated care definition	<ul style="list-style-type: none"> • Care for which no payment is expected nor charge is made. It is the sum of bad debt and charity care absorbed by a hospital or other health care organization in providing medical care for patients who are uninsured or unable to pay.
	Charity care	<ul style="list-style-type: none"> • Health services that were never expected to result in cash inflows. Charity care results from the provider's policy to provide health care services free of charge to individuals who meet their financial criteria.
	Bad debt	<ul style="list-style-type: none"> • The provision for actual or expected uncollectables resulting from the extension of credit. Because bad debt is reported as expense and not a reduction from revenue, the gross charges that result in bad debt remain in gross revenue.

Appendix 3 Consideration of Medicaid 1115 Waiver's Potential Impact on UCC

The Medicaid 1115 waiver was approved by CMS in December 2011. It had multiple purposes including the preservation of the federal funding stream associated with the Medicaid UPL program. The conversion to a capitated managed care for those areas of the state where hospitals were, prior to the waiver, paid on a Fee-For-Services (FFS) basis, meant that the federal UPL payments to these hospitals would be terminated. The Medicaid 1115 waiver was negotiated to preserve these payments.²¹

Table 1 shows that the two Medicaid funding pools created under the authority of the waiver²² have a total of \$29 billion all funds (both the federal and state). The combined pools not only include the savings projected from five years of statewide capitated managed care implementation but also contain the projected UPL payments over this five-year waiver period. Notice that the UC Pool begins at \$3.7 billion and decreases to \$3.1 billion by DY5 (demonstration year). The DSRIP Pool moves in the opposite direction reflecting the primary concept behind the waiver which is funding the transformation of the Texas healthcare delivery system.

Appendix 3: Table 1 - Pool Allocations According to Demonstration Year

Type of Pool	DY 1 (2011-2012)	DY 2 (2012-2013)	DY 3 (2013-2014)	DY 4 (2014-2015)	DY 5 (2015-2016)	Totals
UC	3,700,000,000	3,900,000,000	3,534,000,000	3,348,000,000	3,100,000,000	\$17,582,000,000
DSRIP	500,000,000	2,300,000,000	2,666,000,000	2,852,000,000	3,100,000,000	\$11,418,000,000
Total/DY	4,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	\$29,000,000,000
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%

A major requirement of the waiver for achieving this transformation is the creation of 20 Regional Healthcare Partnerships (RHPs). An RHP is composed of multiple counties, providers (i.e., Performing Providers in waiver nomenclature), sources of state match, (i.e., IGT-Entities) and an RHP Anchor (typically but not always a public hospital).

The complexity of the methodology for the allocation of DSRIP Pool funds to each of the RHPs and what they must do to develop fundable regional plans is well beyond the scope of this report.²³ The DSRIP allocation methodology is detailed and complex with multiple source

²¹ For detailed description of the Medicaid 1115 waiver see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/TexasHealthcareTransformationandQualityImprovementProgramCurrentApprovals.pdf>

²² The two pools were created, in part, as a replacement for the UPL program which was terminated with the advent of the waiver.

²³ The Program and Funding Mechanics Protocol on the HHSC website provides a complete description. <http://www.hhsc.state.tx.us/1115-docs/TX-DSRIP-Protocol-Approval.pdf>

documents providing the direction and requirements for an approvable plan by CMS. However, when compared to the DSRIP requirements, there are virtually no requirements for how the UC Pool is to be allocated beyond the submission of a hybrid Medicare cost report.

The allocation of DSRIP funding to the 20 regions created throughout Texas under the authority of the Medicaid 1115 waiver necessitated the calculation of the amount of Medicaid acute medical costs incurred in 2011 by each region. For the purposes of this analysis, acute medical care was defined as:

- FFS payments
- Managed care payments
- PCCM payments, and
- Vendor Drug pharmacy payments

The analysis presented in Appendix 3: Table 2 strongly indicates that a disproportionate share of these costs is incurred by private hospitals throughout the state. One reason for this is that there are more private hospitals (defined within the context of the waiver analysis as for-profit and nonprofit hospitals) than public hospitals.

Appendix 3: Table 2 -- 2011 Medicaid Acute Medical Costs by Hospital Type

	Private Hospitals	Public Hospitals	Total
Medicaid Acute Medical Care Cost	\$3,535,816,402	\$978,037,869	\$4,513,854,271
% of Total Cost	78%	22%	

The data in this Table is in contrast to the analysis presented in Table 3 (in the body of this UCC report) which shows that 15 percent of the public hospital’s total charges are for charity care while the for-profit and nonprofit hospitals are 2 percent and 6 percent respectively. When these two tables are compared what emerges is a somewhat more complete picture of what uncompensated care means in Texas. Table 3 shows that care provided to individuals with no insurance coverage is a major component of the cost of public hospitals, while Appendix 3: Table 2 shows that for individuals with Medicaid coverage, this unreimbursed cost (which exists as a shortfall cost, the difference between what Medicaid allows to be paid and what the state of Texas actually does pay) lies in the private sector. That is, Medicaid recipients seek care in private hospitals for whatever reasons. This distinction between the roles of the for-profit, nonprofit hospitals and the public hospitals has significant implications for funding under the waiver’s UC Pool.

As a condition of receiving waiver approval from CMS, HHSC terminated the UPL program. The funding associated with this Medicaid supplemental payment program was “preserved” by the waiver through the development of the waiver’s UC Pool and DSRIP Pool. It may be supposed that the funds from the UC Pool are a “substitute” for the historical UPL funding. However, the waiver does not provide any structure or incentives that would direct UC Pool funding to the private hospital system in support of the Medicaid safety net that they represent. That is, without incentives for doing so, public hospitals do not have to fund private hospitals for UC Pool payments.

Under rules formed prior to the negotiation of the Medicaid waiver, both DSH and the UPL program were major funding sources for hospital care. This resulted from the state’s “shifting” of inpatient costs from the state (and its reliance on General Revenue through the Diagnostic Related Groups program) to the DSH and UPL programs where the primary source of state match was local tax revenue. With the advent of the waiver, the rules for DSH and UPL are somewhat obsolete, or at least, do not perform the previous function of offsetting the reduced Medicaid inpatient payments made through the state’s DRG hospital payment methodology.

Under the waiver, incentives for UC Pool payments favor the public hospitals that have the vast majority of the state match for drawing the federal funds available in the UC Pool. This imbalance, as mentioned in the section “Current System,” page 8, Disproportionate Share Hospital Program—Uninsured Costs and Hospital Specific Limit, also creates the potential for the large urban public hospitals to minimize their funding to the DSH program, resulting in substantially reduced DSH payments to public hospitals.

In essence, the movement to the UC Pool under the authority of the 1115 waiver, creates a completely new set of incentives for where the public hospitals allocate their state match, has the potential to undermine the historical Medicaid patient use of private hospitals.

Another area where the waiver may potentially impact the funding of UCC is identified in Appendix 3-Table 1. Over the five years of the waiver, the funding for UC Pool steadily decreases. This decline is in keeping with the transformational nature of the waiver. That is, DSRIP Pool amounts increase so as to fund the planning and implementation of projects throughout the state that are anticipated to increase the ability of the local provider system to more efficiently provide health care to Texans. The outcome of this effort is expected to be a reduction in the cost of indigent health care.

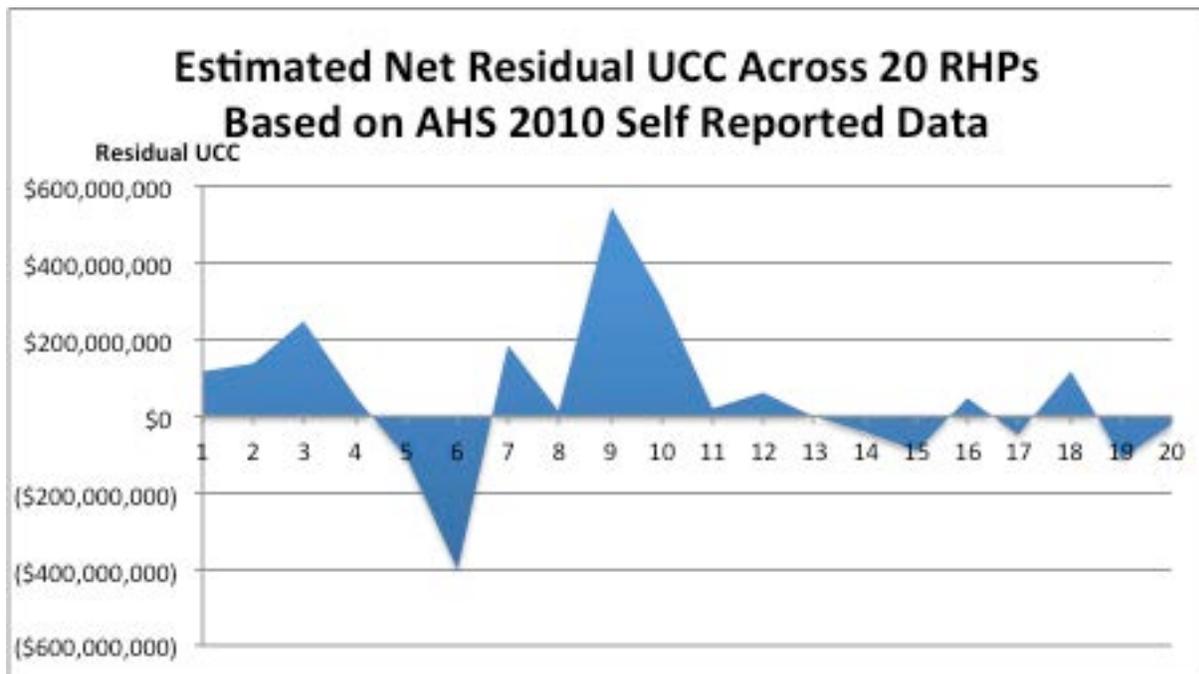
Because waiver pool funding relies on the ability of the state to provide a state match and because the waiver divides the state into 20 RHPs with separate allocations of DSRIP funding, it is not entirely clear that those RHPs with little ability to fund the state match for DSRIP projects will be able to engage in the transformation envisioned by the terms of the negotiated waiver. Thus, there remains the possibility that these historically poorer regions which have substantial amounts of UCC already will see their proportion of the UCC cost increase relative to the rest of the state if they remain unable to provide the state match necessary to fund the DSRIP transformational projects.

The waiver created 20 regions, which did not exist in 2010. The graph below shows the 2010 AHS data for each of the 20 regions. It is important to keep in mind the aforementioned limitations of the AHS with respect to the calculation of residual UCC. With this in mind, one can see substantial variation across the 20 regions with respect to residual UCC. The largest amount of UCC is in region 9 (which is centered in Dallas) while the least amount is found in region 6, centered in Bexar County. It is not clear why the graph has the shape it does. Two possibilities that might be considered are:

1. The number of uninsured in a region (seen in the tables that follow) is not necessarily predictive of the amount of residual UCC (a correlation between number of uninsured and residual UCC = $-.12$, which essentially means there is no correlation). This may be

understood in that the number of uninsured is certainly one source of UCC cost, but it is not the only one. The presence of a Medicaid shortfall is another source that must be considered. The costs of the shortfall are not contained in the number of uninsured, thus, potentially accounting for the small correlation.

2. A second possibility is the impact of funding mechanisms developed for the private UPL program. Without going into detail about these, such mechanisms allow for the movement of UPL funding in regions of the state where other sources of funding to offset the cost of uninsured (and Medicaid shortfall) is not readily available. It is possible that this diverse funding mechanism accounts for some of the negative residual UCC that is found in the right hand tail of the graph. As mentioned previously, the funding mechanisms created under the UPL program are, for the most part, unavailable under the waiver on the scale used in that supplemental payment program. This can have significant implications for how the graph may look in its next iteration. It is hypothesized that without other changes in funding mechanisms, there may be no negative residual UCC in the tail in the next iteration of this graph.



The following tables estimate the amount of residual UCC for each of the 20 regions created by the Medicaid 1115 waiver. Please keep in mind the inherent limitations of the original data source, (i.e., AHS) in reviewing these tables.

RHP:	1	2	3	4	5
Population Under 65	1,041,579	1,185,706	4,467,305	627,234	1,123,461
Percent Uninsured Under 65	26.43%	24.05%	28.53%	24.23%	37.70%
Avg. self pay discharge charges	\$6,780	\$5,814	\$7,355	\$5,119	\$5,621
Avg. self pay discharge cost	\$1,479	\$1,521	\$2,517	\$1,113	\$1,064
Charity + Bad Debt Charges	\$1,267,519,849	\$747,265,005	\$3,555,223,793	\$503,270,745	\$705,084,260
UCC Charges Converted to Cost	\$273,302,330	\$210,955,254	\$1,232,561,355	\$107,793,747	\$143,469,177
Cost as % of Net Pt. Rev.	9.21%	9.98%	9.05%	6.58%	6.91%
UCC Cost per capita	\$262.39	\$177.92	\$275.91	\$171.86	\$127.70
Estimated Total Costs	\$1,802,592,713	\$1,511,701,036	\$7,301,100,456	\$1,038,211,236	\$1,324,134,444
Patient Specific Revenue					
Medicaid payments	\$187,592,274	\$236,676,788	\$1,206,532,881	\$231,904,844	\$296,439,926
State/local government payments	\$15,705,807	\$51,440,284	\$69,351,837	\$4,893,215	\$10,530,032
Medicare	\$1,163,425,100	\$673,503,282	\$3,295,788,068	\$552,517,220	\$812,871,114
Private insurance	\$41,614,241	\$24,551,286	\$151,173,395	\$4,272,003	\$5,233,544
Patient payments	\$16,458,989	\$7,553,597	\$31,155,313	\$2,667,680	\$1,154,761
Other third party payments	\$17,384,678	\$2,755,553	\$42,178,325	\$2,229,648	\$395,476
DSH Payments	\$85,795,020	\$17,940,499	\$146,955,783	\$32,265,632	\$87,483,248
UPL Payments	\$97,283,838	\$90,963,524	\$661,829,160	\$113,574,400	\$54,734,584
Total Patient Specific Revenue	\$1,625,259,947	\$1,105,384,813	\$5,604,964,762	\$944,324,642	\$1,268,842,685
Lump Sum Funding					
Trauma funding	\$2,724,790	\$3,114,749	\$27,717,806	\$870,050	\$2,166,606
Other State Government Funding	\$1,073,668	\$687,242	\$10,675,113	\$1,345,544	\$2,095,080
Tobacco Settlement funding	\$3,008,711	\$319,801	\$22,886,695	\$173,742	\$79,707
Federal Government	\$10,057,391	\$12,462,266	\$552,928,392	\$12,249,646	\$51,979,636
Charitable Contributions	\$3,870,075	\$998,563	\$123,085,787	\$1,056,674	\$60,700,289
Tax Revenue	\$14,657,212	\$220,208,191	\$544,437,875	\$9,565,279	\$3,889,175
Local Government Funding	\$5,761,267	\$33,190,742	\$7,875,614	\$2,503,897	\$6,045,803
Other IGTs for Medicaid	(\$2,949,293)	(\$16,195,597)	\$11,007,912	(\$9)	(\$123,263)
Other Government Revenue	\$17,626,478	\$3,212,680	\$141,607,400	\$5,036,958	\$37,493,922
Collections from patients previously reported as uncompensated	\$4,799,610	\$9,109,705	\$6,485,656	\$11,323,678	\$164,063
Total Lump Sum Funding	\$60,629,909	\$267,108,342	\$1,448,708,250	\$44,125,459	\$164,491,018
Net residual UCC	\$116,702,857	\$139,207,881	\$247,427,444	\$49,761,135	(\$109,199,259)

RHP:	6	7	8	9	10
Population Under 65	2,032,775	1,200,130	762,752	2,842,697	2,172,149
Percent Uninsured Under 65	23.47%	23.13%	20.20%	27.98%	23.85%
Avg. self pay discharge charges	\$5,752	\$8,164	\$5,161	\$5,236	\$6,917
Avg. self pay discharge cost	\$1,912	\$2,106	\$1,420	\$1,563	\$2,178
Charity + Bad Debt Charges	\$1,744,715,984	\$996,174,474	\$445,442,120	\$2,515,020,075	\$1,795,672,435
UCC Charges Converted to Cost	\$480,188,212	\$285,844,316	\$125,569,568	\$874,060,265	\$589,861,816
Cost as % of Net Pt. Rev.	11.26%	10.21%	8.43%	11.00%	11.24%
UCC Cost per capita	\$236.22	\$238.18	\$164.63	\$307.48	\$271.56
Estimated Total Costs	\$2,341,045,944	\$1,404,204,696	\$734,105,245	\$4,494,058,570	\$2,926,457,266
Patient Specific Revenue					
Medicaid payments	\$515,806,732	\$232,733,760	\$94,650,868	\$945,429,449	\$574,044,406
State/local government payments	\$28,201,968	\$34,765,282	\$9,063,931	\$28,940,608	\$11,959,156
Medicare	\$1,413,518,771	\$699,191,115	\$463,320,381	\$1,963,070,724	\$1,379,397,434
Private insurance	\$166,150,121	\$5,578,400	\$17,203,879	\$52,182,344	\$40,599,829
Patient payments	\$5,214,236	\$2,355,057	\$3,790,043	\$17,298,269	\$21,486,989
Other third party payments	\$7,310,078	\$15,363,635	\$1,424,422	\$17,945,849	\$2,077,813
DSH Payments	\$168,005,693	\$57,168,587	\$16,982,695	\$122,274,980	\$48,996,623
UPL Payments	\$270,299,492	\$138,313,135	\$8,025,726	\$510,649,958	\$229,707,978
Total Patient Specific Revenue	\$2,574,507,091	\$1,185,468,971	\$614,461,945	\$3,657,792,181	\$2,308,270,228
Lump Sum Funding					
Trauma funding	\$5,967,579	\$3,602,282	\$1,435,198	\$13,717,603	\$5,028,234
Other State Government Funding	\$1,586,501	\$2,378,523	\$73,764	\$3,853,874	\$3,076,247
Tobacco Settlement funding	\$5,686,928	\$628,181	\$0	\$8,253,892	(\$9)
Federal Government	\$15,258,570	\$5,102,711	\$5,944,197	\$178,366,817	\$596,169
Charitable Contributions	\$3,419,821	\$10,731,403	\$23,746,614	\$12,642,536	\$5,793,261
Tax Revenue	\$153,730,173	(\$54)	(\$9)	\$0	\$281,512,991
Local Government Funding	\$12,200,170	\$3,281,358	\$7,163,312	\$1,992,054	\$3,475,470
Other IGTs for Medicaid	(\$45,398,973)	(\$54)	(\$9)	(\$244,455)	(\$9)
Other Government Revenue	\$15,703,327	\$5,958,013	\$65,410,429	\$71,902,535	\$4,696,726
Collections from patients previously reported as uncompensated	\$26,298	\$795,892	\$1,040,674	\$0	\$950,966
Total Lump Sum Funding	\$168,180,394	\$32,478,255	\$104,814,170	\$290,484,856	\$305,130,046
Net residual UCC	(\$401,641,541)	\$186,257,470	\$14,829,130	\$545,781,533	\$313,056,992

RHP:	11	12	13	14	15
Population Under 65	252,541	747,396	152,711	333,237	706,668
Percent Uninsured Under 65	25.87%	26.07%	26.64%	27.11%	32.85%
Avg. self pay discharge charges	\$4,391	\$4,950	\$3,984	\$4,447	\$9,116
Avg. self pay discharge cost	\$1,290	\$1,567	\$1,272	\$1,686	\$2,291
Charity + Bad Debt Charges	\$149,555,326	\$748,281,424	\$113,308,143	\$247,348,275	\$464,737,284
UCC Charges Converted to Cost	\$43,888,945	\$211,148,486	\$33,063,853	\$117,229,688	\$162,200,692
Cost as % of Net Pt. Rev.	6.46%	9.47%	8.16%	14.51%	11.25%
UCC Cost per capita	\$173.79	\$282.51	\$216.51	\$351.79	\$229.53
Estimated Total Costs	\$396,739,378	\$1,327,909,157	\$222,647,091	\$522,754,479	\$867,153,069
Patient Specific Revenue					
Medicaid payments	\$44,357,181	\$197,745,111	\$21,129,593	\$53,585,035	\$193,260,771
State/local government payments	\$5,033,543	\$7,854,238	\$1,494,324	\$22,247,120	\$19,110,459
Medicare	\$248,677,587	\$729,372,969	\$146,236,233	\$244,036,493	\$457,549,191
Private insurance	\$7,794,381	\$14,873,869	\$290,270	\$202,659	\$991,745
Patient payments	\$2,427,453	\$11,978,591	\$5,275,960	\$328,328	\$4,366,094
Other third party payments	\$16,542	\$32,169,911	\$4,478,265	\$32,134	\$3,785,461
DSH Payments	\$9,908,471	\$46,877,624	\$5,823,322	\$35,660,164	\$47,160,302
UPL Payments	\$30,473,021	\$113,355,938	\$15,932,316	\$122,811,597	\$85,271,237
Total Patient Specific Revenue	\$348,688,179	\$1,154,228,251	\$200,660,283	\$478,903,530	\$811,495,260
Lump Sum Funding					
Trauma funding	\$1,471,340	\$3,100,479	\$506,248	\$1,345,296	\$2,484,956
Other State Government Funding	\$53,938	\$658,258	\$102,418	\$265,138	\$2,380,699
Tobacco Settlement funding	\$370,334	\$1,093,732	\$170,041	\$1,163,128	\$1,127,380
Federal Government	\$208,062	\$27,424,714	\$3,986,689	\$260,836	\$19,965,413
Charitable Contributions	\$1,231,995	\$1,689,251	\$20,509	\$1,075,327	\$3,750
Tax Revenue	\$16,164,149	\$59,044,978	\$13,585,804	\$62,758,182	\$94,650,693
Local Government Funding	\$2,673,201	\$622,944	\$43,724	\$19,149,534	\$13,033,516
Other IGTs for Medicaid	\$0	(\$1,309)	\$0	(\$9)	(\$8)
Other Government Revenue	\$209,564	\$13,025,274	\$765,183	\$96,527	\$6,108,498
Collections from patients previously reported as uncompensated	\$3,694,405	\$5,040,749	\$1,909,310	\$208,882	\$6,076,473
Total Lump Sum Funding	\$26,076,988	\$111,699,070	\$21,089,926	\$86,322,841	\$145,831,370
Net residual UCC	\$21,974,211	\$61,981,836	\$896,882	(\$42,471,892)	(\$90,173,561)

RHP:	16	17	18	19	20	Total
Population Under 65	337,059	716,278	896,489	207,997	292,037	22,098,201
Percent Uninsured Under 65	24.21%	22.75%	18.01%	25.50%	36.21%	26.34%
Avg. self pay discharge charges	\$5,048	\$6,725	\$4,979	\$4,427	\$4,252	\$6,251
Avg. self pay discharge cost	\$1,563	\$1,288	\$1,175	\$1,529	\$699	\$1,811
Charity + Bad Debt Charges	\$207,448,656	\$713,023,829	\$294,688,978	\$198,511,168	\$159,391,275	\$17,571,683,098
UCC Charges Converted to Cost	\$64,007,795	\$135,937,578	\$78,003,748	\$81,878,030	\$27,134,982	\$5,278,099,838
Cost as % of Net Pt. Rev.	10.40%	8.68%	3.72%	13.93%	5.62%	9.58%
UCC Cost per capita	\$189.90	\$189.78	\$87.01	\$393.65	\$92.92	\$238.85
Estimated Total Costs	\$365,317,314	\$799,945,484	\$818,082,512	\$362,202,033	\$255,323,298	\$30,815,685,420
Patient Specific Revenue						
Medicaid payments	\$38,173,408	\$94,078,954	\$55,695,238	\$35,074,711	\$52,568,740	\$5,307,480,670
State/local government payments	\$3,439,295	\$8,764,936	\$2,802,240	\$1,560,680	\$13,957,728	\$351,116,683
Medicare	\$226,126,762	\$507,569,977	\$495,885,343	\$206,038,336	\$165,119,789	\$15,843,215,889
Private insurance	\$2,924,773	\$53,342,522	\$11,785,286	\$2,668,956	\$1,360,492	\$604,793,995
Patient payments	\$4,752,799	\$4,486,090	\$56,314,056	\$23,318,380	\$498,626	\$222,881,311
Other third party payments	\$9,995,558	\$3,834	\$2,340,040	\$215,895	\$1,526,591	\$163,629,708
DSH Payments	\$8,652,076	\$8,572,442	\$3,163,247	\$83,836,656	\$17,236,080	\$1,050,759,144
UPL Payments	\$6,140,182	\$88,002,905	\$39,427,283	\$21,165,482	\$11,158,871	\$2,709,120,627
Total Patient Specific Revenue	\$300,204,853	\$764,821,660	\$667,412,733	\$373,879,096	\$263,426,917	\$26,252,998,027
Lump Sum Funding						
Trauma funding	\$973,863	\$389,436	\$372,811	\$754,639	\$98,582	\$77,842,547
Other State Government Funding	\$211,796	\$959,085	\$130,939	\$114,866	\$192,673	\$31,915,366
Tobacco Settlement funding	\$69,226	\$0	\$0	\$199,745	\$0	\$45,231,234
Federal Government	\$858,674	\$36,147,750	\$12,441,738	\$86,421,655	\$1,904,363	\$1,034,565,689
Charitable Contributions	\$802,510	\$226,213	\$375,331	\$1,531,789	\$175,910	\$253,177,608
Tax Revenue	\$4,827,687	\$208,333	\$0	\$7,927,354	\$0	\$1,487,168,013
Local Government Funding	\$1,926,106	\$7,400,694	\$1,763,852	\$491,430	\$7,664,734	\$138,259,422
Other IGTs for Medicaid	\$0	\$0	\$0	\$0	\$0	(\$53,905,076)
Other Government Revenue	\$3,529,161	\$34,079,035	\$17,121,669	\$91,473	\$5,657,155	\$449,332,007
Collections from patients previously reported as uncompensated	\$2,500,491	\$2,975,212	\$804,823	\$173,791	\$0	\$58,080,678
Total Lump Sum Funding	\$15,699,514	\$82,385,758	\$33,011,163	\$97,706,742	\$15,693,417	\$3,521,667,488
Net residual UCC	\$49,412,947	(\$47,261,934)	\$117,658,616	(\$109,383,805)	(\$23,797,036)	\$1,041,019,905

RHP 1

1. Anderson
2. Bowie
3. Camp
4. Cass
5. Cherokee
6. Delta
7. Fannin
8. Franklin
9. Freestone
10. Gregg
11. Harrison
12. Henderson
13. Hopkins
14. Houston
15. Hunt
16. Lamar
17. Marion
18. Morris
19. Panola
20. Rains
21. Red River
22. Rusk
23. Smith
24. Titus
25. Trinity
26. Upshur
27. Van Zandt
28. Wood

RHP 2

1. Angelina
2. Brazoria
3. Galveston
4. Hardin
5. Jasper
6. Jefferson
7. Liberty
8. Nacogdoches
9. Newton
10. Orange
11. Polk
12. Sabine
13. San Augustine
14. San Jacinto
15. Shelby
16. Tyler

RHP 3

1. Austin
2. Calhoun
3. Chambers
4. Colorado
5. Fort Bend
6. Harris
7. Matagorda
8. Waller
9. Wharton

RHP 4

1. Aransas
2. Bee
3. Brooks
4. DeWitt
5. Duval
6. Goliad
7. Gonzales
8. Jackson
9. Jim Wells
10. Karnes
11. Kenedy
12. Kleberg
13. Lavaca
14. Live Oak
15. Nueces
16. Refugio
17. San Patricio
18. Victoria

RHP 5

1. Cameron
2. Hidalgo
3. Starr
4. Willacy

RHP 6

1. Atascosa
2. Bandera
3. Bexar
4. Comal
5. Dimmit
6. Edwards
7. Frio
8. Gillespie
9. Guadalupe
10. Kendall
11. Kerr

12. Kinney
13. La Salle
14. McMullen
15. Medina
16. Real
17. Uvalde
18. Val Verde
19. Wilson
20. Zavala

RHP 7

1. Bastrop
2. Caldwell
3. Fayette
4. Hays
5. Lee
6. Travis

RHP 8

1. Bell
2. Blanco
3. Burnet
4. Lampasas
5. Llano
6. Milam
7. Mills
8. San Saba
9. Williamson

RHP 9

1. Dallas
2. Denton
3. Kaufman

RHP 10

1. Ellis
2. Erath
3. Hood
4. Johnson
5. Navarro
6. Parker
7. Somervell
8. Tarrant
9. Wise

RHP 11

1. Brown
2. Callahan
3. Comanche
4. Eastland
5. Fisher

6. Haskell
7. Jones
8. Knox
9. Mitchell
10. Nolan
11. Palo Pinto
12. Shackelford
13. Stephens
14. Stonewall
15. Taylor

RHP 12

1. Armstrong
2. Bailey
3. Borden
4. Briscoe
5. Carson
6. Castro
7. Childress
8. Cochran
9. Collingsworth
10. Cottle
11. Crosby
12. Dallam
13. Dawson
14. Deaf Smith
15. Dickens
16. Donley
17. Floyd
18. Gaines
19. Garza
20. Gray
21. Hale

22. Hall
23. Hansford
24. Hartley
25. Hemphill
26. Hockley
27. Hutchinson
28. Kent
29. King
30. Lamb
31. Lipscomb
32. Lubbock
33. Lynn
34. Moore
35. Motley

36. Ochiltree
37. Oldham
38. Parmer
39. Potter
40. Randall
41. Roberts
42. Scurry
43. Sherman
44. Swisher
45. Terry
46. Wheeler
47. Yoakum

RHP 13

1. Coke
2. Coleman
3. Concho
4. Crockett
5. Irion
6. Kimble
7. Mason
8. McCulloch
9. Menard
10. Pecos
11. Reagan
12. Runnels
13. Schleicher
14. Sterling
15. Sutton
16. Terrell
17. Tom Green

RHP 14

1. Andrews
2. Brewster
3. Crane
4. Culberson
5. Ector
6. Glasscock
7. Howard
8. Jeff Davis
9. Loving
10. Martin
11. Midland
12. Presidio
13. Reeves
14. Upton
15. Ward

16. Winkler

RHP 15

1. El Paso
2. Hudspeth

RHP 16

1. Bosque
2. Coryell
3. Falls
4. Hamilton
5. Hill
6. Limestone
7. McLennan

RHP 17

1. Brazos
2. Burleson
3. Grimes
4. Leon
5. Madison
6. Montgomery
7. Robertson
8. Walker
9. Washington

RHP 18

1. Collin
2. Grayson
3. Rockwall

RHP 19

1. Archer
2. Baylor
3. Clay
4. Cooke

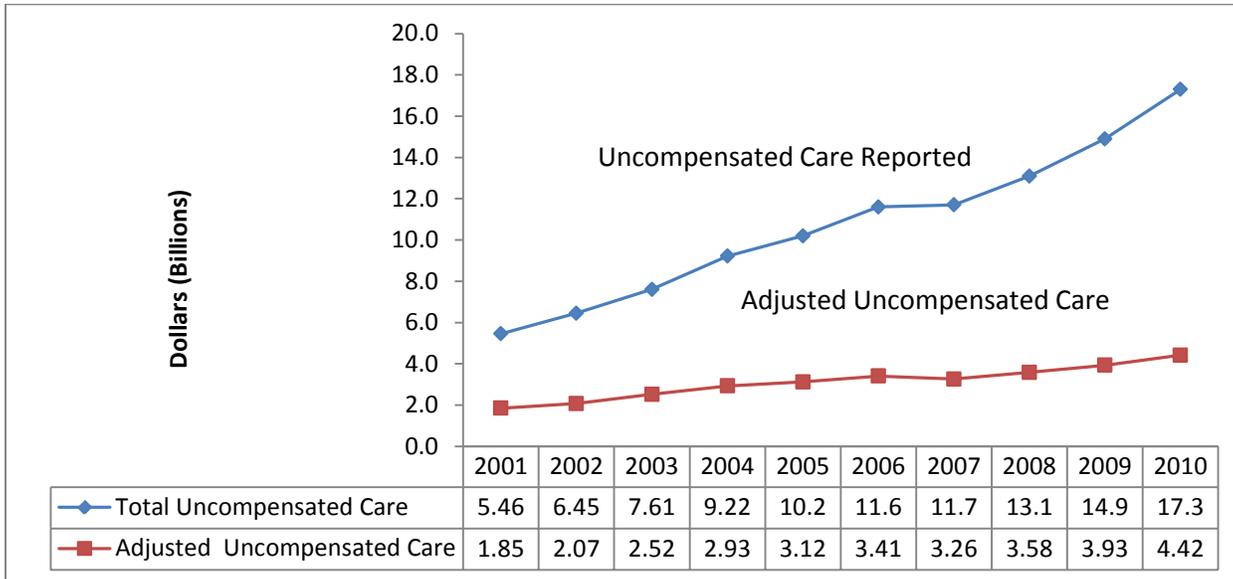
5. Foard
6. Hardeman
7. Jack
8. Montague
9. Throckmorton
10. Wichita
11. Wilbarger
12. Young

RHP 20

1. Jim Hogg
2. Maverick
3. Webb
4. Zapata

Appendix 4

Texas Acute Care Hospitals: Total Uncompensated Care Charges Adjusted for Inflation, 2001-2010



DEFINITIONS:

- **Uncompensated Care:** The services provided for which no payment is received from the patient or from third-party payers. Uncompensated care is the sum of bad debt expense and charity charges. (AHA/DSHS Survey, item I1c + I2c)
- **Bad Debt Charges:** Consist of uncollectible inpatient and outpatient charges that result from the extension of credit. (AHA/DSHS Survey, item I1c)
- **Charity Charges:** The total amount of hospital charges for inpatient and outpatient services attributable to charity care in a cost reporting period. These charges do not include bad debt charges, contractual allowances or discounts (other than for indigent patients not eligible for medical assistance under the approved Medicaid state plan); that is, reductions or discounts in charges given to other third party payers such as, but not limited to, health maintenance organizations, Medicare or Blue Cross.

Source: 2010 DSHS/AHA/THA Cooperative Annual Survey of Hospitals
 Prepared by: Center for Health Statistic-HSU, Texas Department of State Health Services, January 2012