Uncompensated Care in Texas

Moving Toward Uniform, Reliable and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs

Executive Summary

The 80th Legislature created a Hospital Uncompensated Care Work Group in the General Appropriations Bill and in Senate Bill 10 to study and advise the Executive Commissioner of Health and Human Services on standardizing a definition of uncompensated care, coordinating the reporting instruments, and developing a standard set of adjustments to apply funding sources and determine actual cost.

With an estimated 25 percent of the population lacking health insurance, Texas faces a significant challenge of uncompensated care. Hospitals reported $11.6 billion in uncompensated care charges in 2006. There are state and federal programs that provide some reimbursement for portions of that care, but these programs operate virtually independent of each other. Each program has its own version of allowable uncompensated care and as a result uncompensated care in Texas is an uncoordinated patchwork of funding efforts. This patchwork of overlapping reporting and funding mechanisms is a major obstacle to the development of a clear picture of how the system as a whole functions.

In preparing for the initial work group meeting and identifying the parameters for the current reporting requirements, it was determined that a single definition across uncompensated care "payers" would not be feasible. The strategy was to develop a methodology to standardize uncompensated care reporting to account for the various sources of funding and allow for the calculation of unreimbursed uncompensated care costs, or residual uncompensated care.

> For the purposes of calculating residual uncompensated care, uncompensated care 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 they are unable to pay). Uncompensated care also includes the unreimbursed costs from government sponsored health programs. Against these costs, hospitals will report both patient specific funding and lump sum funding available to offset the cost of uncompensated care.

It is believed that this provides the basis for making valid policy with respect to addressing the financing and care of uninsured Texans who create the cost. This strategy led to the development of a reporting methodology for measuring unreimbursed uncompensated care costs.

Development of the reporting methodology for this definition guided the agenda for work group meetings. A subcommittee of Work Group members volunteered to address the detailed reporting of uncompensated care costs. Consideration was given to a proposal to collect claims level data on uncompensated and unreimbursed care. While determined to be feasible, collecting claims level data would require protracted time for development and substantial, costly changes to state and hospital computer systems.

The subcommittee suggested an alternate approach–capturing required data via report(s). Several options were considered for collecting the data necessary to calculate residual uncompensated care. The data from existing surveys is not particularly helpful; not all hospitals complete each of the instruments and the level of detail is not sufficient to calculate residual uncompensated care. It was determined that a new methodology would best measure residual uncompensated care.

In determining what data to report, the work group considered several policy issues. The $11.6 billion of uncompensated care reported in 2006 is the sum of charges for charity care and bad debt. Charity care is free or reduced price care that a hospital provides to low income patients while bad debt can result from insured or uninsured patients. There is variability among hospitals in the income threshold for charity care; what is charity at one hospital could be bad debt at another hospital. As such, uncompensated care reporting must consider both.

Current reporting related to uncompensated care gathers information on charges. Considering hospital uncompensated care in reported charges results in a distorted view of the situation since charges rarely reflect the cost of providing services or the payments received from insurance. Furthermore, charges may vary significantly from one hospital to another for the same services. Instead, charges need to be converted to costs through a ratio of cost to charges (RCC).

There are several ways to calculate an RCC, with variation on the source of the data. Two of the significant reimbursement mechanisms use an RCC that is calculated by state agency staff from cost reports submitted by hospitals. As this RCC is uniformly calculated and is from data that is routinely subject to audit, it is recommended that it be used to convert uncompensated care charges to cost.

While charity care and bad debt are the major components of uncompensated care, hospitals also point to the contributions they make in providing care to patients participating in government sponsored health programs. While these programs do provide payment for care, these payments do not always cover the cost of the care. The “shortfalls” from Medicaid and other governmental programs need to be considered, as they can influence the capacity of hospitals to provide care to the uninsured.

Consideration was also given on how to collect better information on the growing phenomenon of underinsured persons. Those with insurance coverage are moving toward plans with higher cost sharing requirements, in part to keep premium costs lower. However, these ‘underinsured’ or partially insured Texans contribute to hospital bad debt when they are unable to pay their deductibles and/or co-pays. Distinguishing between reported bad debt related to those with some insurance and reported bad debt related to the uninsured provides valuable information for policy consideration.

Having converted charity and bad debt charges to cost and calculating the shortfalls from governmental programs, then the lump sum funding sources that are not specific to individual

patients need to be recognized to measure the residual impact on hospitals of uncompensated care.

The proposed methodology encompasses the variability of the current funding arrangements and begins to provide clarity on the amount of uncompensated care that is unreimbursed after consideration of the variety of funding sources available, or calculation of residual unreimbursed uncompensated care. Determination of residual uncompensated care in a uniform manner that allows for comparisons across hospitals will provide useful data for future policy considerations on this matter.

Summary of Recommendations

Recommendation 1: Because some of the definitions related to uncompensated care are outside the control of Texas policy makers, a single uniform definition is not feasible. Instead, an overarching hierarchical definition should be adopted that accommodates the variability of the varying programs and payer sources.

Recommendation 2: The definition of uncompensated care must include bad debt, in addition to charity care, to recognize the variability allowed under statute and allow for accurate comparisons of the care provided by hospitals.

For the purposes of calculating residual uncompensated care, uncompensated care includes the charges for the uninsured (those with no source of third party insurance) and the underinsured (those with insurance who after third party payments have a responsibility to pay for an amount that they are unable to pay). Uncompensated care will also include unreimbursed costs from government sponsored health programs.

Broadening the classifications for unreimbursed uncompensated care reporting will capture the complete picture of hospitals' efforts while at the same time providing more detailed information to support the development of policy responses.

Recommendation 3: It is recommended that the all-payer ratio used for the DSH and trauma programs be adopted as the basis for uniformly converting charges to costs for the purposes of estimating the cost of unreimbursed uncompensated care. The parameters are known, so the all-payer RCC is uniformly calculated and the data source is routinely subject to audit. This ratio is already used for the DSH and trauma programs so the use of this ratio advances consistency in reported uncompensated care data. It is unlikely that CMS would approve a change to an RCC in the DSH program that would result in higher estimated costs or be more favorable from the hospital perspective.

Recommendation 4: Reporting of uncompensated care must clarify the extent to which charges for the same care may be submitted more than once for reimbursement. Trauma programs reimburse some of the costs that also are reported in the DSH program. Charity care also is reported on multiple instruments. The degree of this overlap should be made clearer.

To avoid duplication in data reporting, consideration should be given to allocating trauma reimbursement funding on a hospital fiscal year basis. To begin this transition, the data elements needed for the pro rata distribution of funds should be collected via the Annual Hospital Survey. While duplicative in the short run, this data collection should provide for a smoother transition from a calendar year basis to a distribution based on hospital fiscal year basis.

While the Tobacco Settlement distribution provides another lump sum funding source for hospital uncompensated care, it is not recommended to change the basis for this distribution. The basis for the distribution is tax revenues collected by hospital districts and public hospitals in a calendar year and as such there is not a need to match to other reported uncompensated care charges.

Recommendation 5: Adopt a new detailed reporting methodology that uses the hierarchical definition of uncompensated care, providing a reliable, valid and auditable measurement of residual uncompensated care. The current categories of charity care and bad debt will be included but the sources of bad debt will be broken out in greater detail, including uninsured and underinsured, to provide policymakers with more detailed information to guide future consideration of responses to uncompensated care. The measurement will also include the unreimbursed costs of participation in government sponsored health care programs, i.e. program shortfalls.

Recommendation 6: The methodology for calculating residual uncompensated care should include both patient-specific payments (regardless of source) as well as revenue from the various sources of uncompensated care funding streams (non-patient specific).

Recommendation 7: To ensure ongoing data validity, hospitals must be provided feedback on their reported data. If payments will be based on the reported data, then some form of audit scrutiny should be supplied.

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Uncompensated Care in Texas:
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Measuring Residual Unreimbursed Uncompensated Care Costs

Texas has the highest rate of uninsured in the nation, with 25 percent of the population, or 5.5 million people, lacking insurance. An estimated 17 percent of the uninsured are not citizens and are therefore ineligible for most forms of assistance. About 1.4 million of the uninsured are children and 3.6 million are adult citizens or legal permanent residents. About 60 percent of Texas' uninsured adults have incomes below 200 percent of the Federal Poverty Level, typically an upper boundary for assistance programs.

Today, care for uninsured Texans too 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 group coverage because of rising costs, this means more uninsured people in our emergency rooms (or on Medicaid or other public programs), which leads to even higher costs for those who can pay. It is estimated that $1,502 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.

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 arises. While the traditional view of uncompensated care is that of the person in a hospital emergency room with no insurance, there has arisen a more complex picture of uncompensated care where even patients with insurance can create uncompensated care by not being able to afford to pay their coinsurance and/or deductibles. As insurance coverage moves more toward higher deductibles and more cost sharing by the patient, this aspect of uncompensated care (underinsured or partially insured) will only grow, yet current reporting mechanisms do little to measure this effect.

In most cases, care for the uninsured is reported as charges. In a few cases, it is reported as actual expenditures. Where care for the uninsured is reported as charges, some programs require a conversion to costs through application of a ratio of cost to charges (RCC). In the same manner as there are multiple definitions related to uncompensated care, there is variability in the RCC used by the payer or funding stream. A ratio that includes more items as allowable costs results in a higher RCC which when applied to charges allows for a greater portion of the charges to be reported as costs resulting in a higher uncompensated care cost. An RCC that excludes particular expenses as costs will be lower, lessening the portion of charges that will be reported, and as such, uncompensated care costs appear lower even though the charges are exactly the same as those converted by a higher RCC.

This variability plays out in the fragmented approach to reimbursing the costs of uncompensated care. Various programs exist to reimburse uncompensated care costs. Some 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 the interaction between them. As a result of this analytical ambiguity, it is currently extremely challenging to understand the real financial burden of uncompensated care on providers, particularly hospitals. Because of this difficulty in measurement, it is also difficult to assess the success of the various governmental funding streams directed at reducing the unreimbursed costs associated with uninsured Texans.

In addition, there is no single place where each of the funding sources for uncompensated care is measured against the cost of that care. In fact, some of the funding streams specifically allow state and local government payments to be excluded from consideration. While this is within the purview of those payers to determine the allocation of their funds, a coherent state level analysis must consider all funding sources to measure the remaining burden of uncompensated care.

What is needed is an understanding of residual uncompensated care, that is, an aggregate measure of unreimbursed costs after considering all of the funding streams (amounting to billions of dollars) available to offset those costs.

As the sources of uncompensated care have grown, so have the payers or funding streams to reimburse these costs. As these sources of reimbursement have arisen in an effort to address the growing burden of uncompensated care, their presence has introduced variation in definitions, rules and requirements for measuring and reimbursing the cost of care.

To provide clarity and achieve an understanding of the true measure of societal burden of care for the uninsured, Senate Bill 10 and Rider 44 for HHSC in the General Appropriations Act (from the 80th Legislature) created an Uncompensated Care Work Group to study uncompensated care reporting issues and advise the Executive Commissioner. The objectives for the group include reviewing the reporting instruments for uncompensated care, coordinating the instruments for consistency, identifying sources of funding to offset uncompensated care, developing a standard set of adjustments for a reliable determination of the actual costs of uncompensated care and identifying a standard ratio of cost to charges. Attachment 1 includes the requirements of SB 10 and Rider 44 related to uncompensated care reporting.

The work begins with identification of the various definitions and measurements related to uncompensated care by the funding sources and programs. Attachment 2 (Summary of reporting instruments) summarizes some of these differences. The table illustrates the difficulty of reconciling the various measurements of uncompensated care related information. The reports are due at various points of the year. Many are based on each hospital's fiscal year, but others have a calendar year or state fiscal year basis. Some are based on hospital charges, while others capture expenditure information. The definitions of key elements, while similar, have nuanced meanings based on the program. Even if the timing of the reports and reporting periods were the same, the varying definitions make it virtually impossible to determine where there is overlap or where the reported amounts could be added together.

The Current System

To begin to better understand the landscape of uncompensated care reporting, this paper will discuss the various programs shaping the current system and key concepts that influence uncompensated care reporting and financing.

County indigent health program–indigent health services
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.[1] The required basic health services include:

- primary and preventative services (such as immunizations, medical screenings and annual physical exams);
- inpatient and outpatient hospital services;
- rural health clinics;
- laboratory and X-ray services;
- family planning services;
- physician services;
- payment for not more than three prescription drugs a month; and
- skilled nursing facility services, regardless of the patient's age.

Counties report 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.

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 care to the uninsured that 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 largely financing it) remains a local responsibility.

Community benefit/charity care–unreimbursed costs
In addition to the requirements placed on counties and hospital districts, Texas statutes also require non-profit hospitals to provide charity care to low income Texans. Texas Health and Safety Code Chapter 311 (sometimes called the Charity Care Law) lays out requirements for certain hospitals to maintain their status as non-profit entities in the state of Texas. This statute requires non-profit hospitals to establish a charity care policy that provides free or reduced price care to low income persons.[2] The value of the tax benefits received in a sense "pay for" the

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[1] 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.
[2] 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.

charity care provided. By not having to pay taxes, a non-profit hospital is able to afford to provide more free care than it would as a for-profit hospital.

Each non-profit 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.[3] This means there is significant differences among hospitals with respect to what is bad debt or charity care. 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.

Among other requirements for non-profit 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
- equal to tax benefits of non-profit 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,[4] 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

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[3] 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 payors exceed a specified percentage of the patient's income and the person is financially unable to pay the remaining bill(s).

[4] 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.

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.[5]

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, 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 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.[6] A summary provided each year by DSHS reports these uncompensated amounts in full charges. This figure has grown from $5.5 billion in 2002 to $11.6 billion in 2006. Slightly more than half of this measure of uncompensated care (55 percent) is reported as charity care, that is care for which hospitals expect no reimbursement.[7]

Charges are not the best data point upon which to make comparisons between hospitals.[8] When Texas publishes the results of the survey for the state, it does not use an RCC to convert charges

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

[6] The survey also collects community benefit information, but these amounts are not included in the reported uncompensated care charges.

[7] In the state specific section of the Annual Hospital Survey, Texas hospitals must also report charity and bad debt charges broken out by inpatient and outpatient charges. While one would expect the sum of inpatient and outpatient charity charges to equal charity charges hospitals reported in the main survey, they do not. In 2006, the sum of charges reported in the state section exceeded the lump sum reported in the main section of the AHS by $516 million. Similarly, the sum of inpatient and outpatient bad debt reported in the Texas section of the survey exceeded the lump sum amount reported in the main survey by another $258 million. As will be discussed later in the paper, these differences are far from uniform, with some regions reporting greater amounts of charity and bad debt charges in the main section of the survey than they do in the Texas section. It is clear that hospitals interpret the definitions and instructions differently.

[8] 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

to cost, although other data elements in the Annual Hospital Survey could be used to calculate one[9]. 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.

As the Medicaid reform effort progresses, the need to compare hospitals may increase and hospitals' funds will become contingent on their strategies to reduce uncompensated care. As such, there needs to be a more appropriate method of comparison.

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 state-federal Medicaid program. DSH is a capped federal program that provides about $1.5 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 shortfall[10] 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 an "all-payer" RCC,[11] and from these costs any payments made by or on behalf of those individuals are subtracted.

One difficulty with CMS' definition is the "payments made by or on behalf of" the patient. For the purpose of identifying reimburseable costs, only payments directly tied to the patient can be 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. This is a telling example of a limitation particular to a funding source/payer that inhibits a thorough understanding of the net impact on hospitals' care for the uninsured.

Trauma–uncompensated trauma care
The Texas Legislature has provided state funding for hospitals that relate to the trauma care they provide.[12] 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 fiscal intermediary. Information on

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mixes." American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* October 2007, http://www.aha.org/aha/content/2007/pdf/07-uncompensated-care.pdf

[9] 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. A difficulty in using this RCC more widely, especially for comparisons of hospitals, is that the AHS data is not always complete for every hospital.

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

[11] 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 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.

[12] Trauma funding is principally from drivers' license surcharges and from court fines.

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. While hospitals have a fiduciary responsibility to seek payment from any and all available sources, the reporting system needs to be improved to highlight where the same care may be reported multiple times and provide a source of verification that the combination of the multiple payment sources does not exceed the total cost of uncompensated care.

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 specifies 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 and they are 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. This raises a similar question to the overlap of charges reported for both DSH and trauma reimbursement, reinforcing the need for the measurement of uncompensated care to assess the impact of using the same reported amounts to seek funding from multiple public 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 provides 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 (discussed above), the hospital specific limit (HSL) is carried over to UPL. For example, a hospital that had an HSL for

Medicaid 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. [13]

Timing issues
Reporting of uncompensated care, regardless of the instrument, presents a series of timing issues which are illustrated in flow charts toward the end of Attachment 3. 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.

While imperfect, time boundaries are set to allow for collection of data. Then the choice is whether to accept the amount of "error" that results, or whether data should be amended/updated, basically in perpetuity.

Analysis of Regional Data

Under the currently fragmented and incomplete reporting of uncompensated care by hospitals in Texas, the only comprehensive reporting is through the Annual Hospital Survey. While there are different reporting mechanisms as discussed above, none are comprehensive with respect to the number of hospitals or the range of data provided. Since the Annual Hospital Survey is the most frequently cited reference for uncompensated care data in Texas, HHSC staff assessed the unreimbursed amount of uncompensated care for 2006 by hospitals using their self-reported data from the survey. This analysis explores the current reporting of uncompensated care data and tests its usefulness for more in depth review of uncompensated care policy.

Since one of the objectives in this analysis was to measure the amount of residual unreimbursed uncompensated care, it was necessary to obtain financial data from several different sources

[13] Currently, close to $3 billion is paid to hospitals each year via the DSH and UPL programs. This makes up just over half of total Medicaid funding provided to hospitals. These programs that were initially intended as supplements and funding enhancements now match traditional payments but little is known about the care provided to justify the payments or the quality of services provided.

because the Annual Hospital Survey is incomplete as a source of data for these revenues. This analysis has two other objectives:

1. To determine the viability of hospital reported data using the structure of the AHS to measure unreimbursed uncompensated care, or what we call residual uncompensated care.
2. To determine if unreimbursed uncompensated care is uniformly distributed throughout the state.

To better address the three objectives, data for 2006 were compiled for several public health regions in the state. This analysis can be found in Attachment 4. The regions selected were Region 1 (Panhandle area including Amarillo and Lubbock), Region 3 (Dallas and Fort Worth area), Region 6 (Houston area) and Region 11 (Corpus Christi, Laredo and Lower Rio Grande Valley). The major source of data was the Annual Hospital Survey. The all-payer RCC (used in the DSH and trauma programs) was applied to the reported charges. Available revenues were taken both from the survey data and from state agency payment information. To eliminate duplication, intergovernmental transfers (IGTs) used to support Medicaid payments were deducted from reported tax appropriations.

As mentioned previously, the AHS contains both national questions and a series of state specific sections. Texas has elected to have a section for Disproportionate Share Hospital program information. This section asks hospitals to report charity care and bad debt, separated into inpatient and outpatient components. Inpatient charity charges have a major role in program qualification and payment allocation for DSH. This Texas section also surveys for governmental payments for inpatient care. As the DSH program rules consider only payments made by or on behalf of uninsured patients, revenue data is not highly useful for a broader understanding of uncompensated care. Many funding streams available to offset the cost of uninsured care are not patient specific payments and typically are not reported with DSH data.

Even so, this regional analysis examined reported uncompensated care (charity and bad debt) in the main portion of the survey and the Texas portion of the survey. Charity care is provided with no expectation of payment while bad debt results when payment is expected but not received. Charity care and bad debt each comprise roughly half of reported uncompensated care. Likewise, inpatient and outpatient care comprise about half of reported charges.[14] The comparisons between regions utilize charge information from the main portion of the AHS, largely because these reported charges are used to create the $11.6 billion figure that is widely cited as the amount of uncompensated care in Texas.

Reported charges were converted to cost using the all payer RCC. This ratio is also used in the DSH and trauma programs. Although it is calculated from the Medicare cost reports, it is not as restrictive or narrow as a Medicare or Medicaid ratio.

Discharge data for inpatient hospital care that is reported to the Department of State Health Services also was considered to provide some information about the number of hospital stays and

[14] Outpatient charges are for patients who are not lodged at the hospital while receiving care.

their average costs.[15] About 86 hospitals are exempt from reporting discharge information so it is not appropriate to compare these charges to the more comprehensive data from the AHS.

The analysis focused on charges associated with the direct provision of care. Hospitals, especially non-profits, will also point to other community benefits that they supply. Except for the unreimbursed costs of the Medicaid program, community benefits data were excluded from this analysis. Due to exemptions from reporting, not all hospitals report community benefits information, which could have skewed the analysis. Furthermore, community benefits that are not related to direct care are difficult to quantify.

The Medicaid shortfall (an allowable community benefit data point) was included in the analysis. DSH payments are one of the major funding sources available to offset costs of care for the uninsured. However, the program also exists to offset a hospital's Medicaid shortfall. To fairly consider the revenue source, all of the costs involved also needed to be included.

The summaries of analysis in Attachment 4 demonstrate that despite significant charges related to charity care and bad debt, it appears that the available funding sources offset the majority of the cost of the care. However, since this analysis is done at a regional level the specific impact on individual hospitals within a region could vary widely. Other interesting points:

- Region 11 has the highest rate of uninsured, but has the lowest uncompensated care cost per capita.
- The two predominantly urban regions (3 and 6) had higher uncompensated care costs as a percent of net patient revenue, but they also have substantially greater amounts of offsetting funding sources.
- Region 6 has the highest average cost per discharge, perhaps reflecting the specialized care available to the hospitals of the Texas Medical Center. Further, the discharge data shows the curious relationship between charges and costs. Region 6 had the second lowest average discharge charges, but the highest average cost.
- The amounts reported as charity and bad debt in the main portion of the Annual Hospital Survey do not match the amounts in the Texas portion of the survey. There is not uniformity in which amounts are higher, appearing to indicate there is ambiguity on the part of the reporting hospitals.
- The amounts reported as DSH receipts in the Annual Hospital Survey do not match the amounts paid by the state. Some of this could result from consideration of different fiscal periods. Nevertheless, it hightlights the difficulties in verifying data.
- The negative tax appropriations figure (after deducting intergovernmental transfers used to support Medicaid payments) indicates either underreporting or misreporting of tax revenue or the possible use of non-tax revenue for IGTs.

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[15] On a quarterly basis, many hospitals submit claims level information to the Texas Health Care Information Collection (THCIC) at the Department of State Health Services. THCIC collects information from hospitals and health maintenance organizations to provide Texans with information to make health care decisions. Data collected on discharges from hospital inpatient stays provides consumers with both cost and quality information on Texas hospitals.

This analysis revealed limitations of using the AHS survey data as currently collected to calculate unreimbursed uncompensated care. While not obvious in the summary region data, at an individual hospital level the revenue data is suspect. Some public hospitals do not report tax appropriations while some non-profit hospitals did. As mentioned above, DSH payments, which are specifically broken out on the survey, did not match the amounts in the state's payment records. Likewise, known state payments from trauma and tobacco settlement did not match reported state revenues. Some hospitals that receive these payments reported little or no state program revenue.

Moreover, the variability between reported charges between the main portion of the survey and the Texas specific questions calls in to doubt the validity of the data. Simply breaking out bad debt and charity data between inpatient and outpatient components should not yield such largely different results. Even assuming a definitional difference, one would assume that the direction of the difference would be the same.[16] Yet two regions (1 and 6) had greater amounts of bad debt in the main portion of the survey. Likewise, two regions (1 and 11) had greater amounts of charity care in the main section of the survey. The fact that it wasn't even the same effect for the same two regions demonstrates a lack of consistent reporting of data.

Even with the breakout between inpatient and outpatient components in the Texas portion of the AHS, there is not much granularity to the data. Bad debt can arise from patients with no insurance, as well as those who are insured but don't pay for the patient's portion of costs. As mentioned in the introduction, the growth in underinsurance is not clearly identifiable in existing reported data.

The AHS also does not collect data on the "shortfalls" that result from some government sponsored health programs. Some hospitals include this information in their ASCB reporting in order to fulfill their required amounts of community benefits to maintain their non-profit status. However, not even all non-profits hospitals report this information, let alone hospitals that do not file the ASCB. For this analysis, Medicaid shortfalls were added from other state data sets.

While analysis of existing survey data yields some insights on the impact of uncompensated care on hospitals, more detailed data is needed that is reliable, transparent and can provide policymakers with information they require to shape policy that effectively addresses uncompensated care.

The New System: Residual Uncompensated Care

The current instruments for reporting uncompensated care and its multiple funding streams do not provide a coherent and meaningful picture of the unreimbursed costs of treating uninsured and underinsured Texans. These different instruments arose independently of each other, with different purposes in mind and different obligations to their respective funding streams. Yet the

[16] The analysis also revealed that there were hospitals that did report the same amount of charity care and bad debt in the main section of the AHS and the state specific section, a further indication of a lack of agreement about the data requested.

variability among the instruments does not end there. These instruments also have different definitions of uncompensated care, different eligibility criteria, etc. The table in Attachment 2 provides an overview of this variation.

Because much of this variation in definitions emanates from the requirements of the payers and is therefore not subject to the control of Texas policy makers (DSH and tobacco settlement in particular), it is not possible to have a single definition of uncompensated care that will fit in all circumstances and across all payers and/or instruments. Instead, a hierarchical structure can be created that measures uncompensated care broadly in a way that can encompass the variability of the individual payers and reflects the relevant funding sources available to offset the cost of the care and thereby develop a valid measurement of residual uncompensated care.

Residual uncompensated care will be a more valid measurement of the hospital's burden of caring for the uninsured than the currently fragmented and overlapping reporting. With this new methodology for considering uncompensated care, policymakers are in a much better position to formulate strategies to address uncompensated care in Texas.

Definition of Uncompensated Care

For the purposes of constructing a hierarchical approach to the measurement and calculation of residual unreimbursed uncompensated care, we define "uncompensated care" as hospital-based inpatient and outpatient charges for individuals with no source of third party coverage for the care they receive or for whom third party payments do not cover the care received and the patient is unable to pay the cost of care. A payer discount or contractual adjustments in reimbursement provided to third parties do not constitute uncompensated care.

To begin to clarify the understanding of uncompensated care, HHSC will focus on hospital-based care. This is in no way intended to minimize the contributions of care funded by local governments or provided at free or reduced rates by other providers.

For the purposes of calculating residual uncompensated care, uncompensated care 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 that they are unable to pay).[17] Uncompensated care will also include unreimbursed costs from government sponsored health programs such as Medicare and Medicaid.

Due to the flexibility allowed in hospital charity care policies, charges for an uninsured person could be considered charity care at one hospital and be classified as bad debt at another hospital. Therefore both elements (charity and bad debt) will be captured in the new reporting methodology. However, bad debt can also result from patients with insurance, but for whom the patient portion of the costs exceed their ability to pay. As employers seek to reduce the cost

[17] As discussed throughout the paper, the various payers have different criteria for what is calculable as uncompensated care for that program. There will be some hospital expenses that will be reportable under the broad definition used for calculating residual uncompensated care that may not be reimbursable under a particular funding stream. For example, bad debt is a component of uncompensated care, but not every payer treats bad debt as fully allowable.

and/or cost increases for providing health insurance, employees/patients are being asked to contribute more to the cost of their care. Similarly, those who buy insurance in the individual market are selecting higher deductible policies to afford premiums. For this reason, the reporting methodology will collect information on underinsured/partially insured.

Unreimbursed costs from government sponsored health programs are another component of uncompensated care.[18] Some of these programs impose limitations on the amount that can be collected from patients and government payments do not always keep pace with health care costs. As supplemental payments like DSH and UPL link the costs for the uninsured and program funding shortfalls, both need to be included in the analysis.

"Residual unreimbursed uncompensated care" is charges for uncompensated care converted to cost with a ratio of cost to charges calculated from the hospital's cost report minus payments received specifically for those patients and minus lump sum funding available to support the cost of that care.

Options considered

Several options were considered as to how to present policymakers with robust and detailed data on uncompensated care costs and to calculate residual uncompensated care. To provide maximum detail of clinical and financial information, options were explored that would build up from claim and charge information from individual patients. More detail on all of the options is available in Attachment 5. Two will also be summarized here.

To complement information available on care provided to Medicaid patients, the first option considered would require hospitals to submit individual claims for uncompensated care to the state's fiscal intermediary (currently Texas Medicaid and Healthcare Partnership (TMHP)). This would provide substantial information on the types of care provided to the uninsured based on the charges and diagnoses submitted. This would allow consideration of targeted solutions to address the most common, or most costly, diagnoses. While submitting the clinical information for the uninsured is fairly straightforward, the financial-related components proved more complex, especially for those with some portion of their care covered by insurance. Financial information is tracked differently across the hospital industry, requiring individualized system enhancements to report the required data elements. The timelines for such changes would likely be lengthy. See Attachment 3 for more details on the feasibility of this option.

The other individual-based reporting option considered was the use of hospital discharge data. As mentioned in the regional analysis section, some hospitals already report clinical information to the Department of State Health Services for inpatient discharges. This data set does not currently include outpatient care thereby excluding a substantial amount of uncompensated care charges and a greater volume of individuals. There are also limitations in the classification of individual patients. One would have to accept "self-pay" as a proxy for uncompensated care to

[18] Except for the Medicaid shortfall, these unreimbursed costs were excluded from the regional analysis discussed earlier. They are currently reported by some hospitals in the Annual Statement of Community Benefits, but the data elements are not required of all hospitals. Medicaid and Medicare are the largest programs; others include CHAMPUS/Tricare, Kidney Health Care, and County Indigent Health Care.

utilize the discharge data set to measure uncompensated care.[19] DSHS's rules and the underlying statute yielded a system that requires a quarterly data collection. Given the time lag in determination of some patients' payment status, the limited period for reporting would present difficulties for meaningful calculation of uncompensated care. Also the discharge data reporting requirement exempts about 86 mostly rural hospitals, about half of which participate in DSH.

Like the submission of claims to the fiscal intermediary, use of the discharge data for measuring uncompensated care would require hospital system changes to report the financial-related data associated with individual uninsured and underinsured patients.

Both of these options would require supplemental reporting of non-patient specific revenue sources to calculate residual uncompensated care.

Recommended approach for measuring and calculating residual uncompensated care

In light of the hurdles for implementing individual claims based reporting of uncompensated care and based on the feedback of the Work Group, it was determined that a more detailed reporting methodology would provide better data in a much more reasonable timeframe and with lower implementation costs for the state and the hospital industry. This reporting methodology would capture more detailed classifications of uncompensated care patients (charity, self pay or uninsured, and partially insured) and payments made specific to their care, as well as capturing lump sum funding sources that offset uncompensated care in general.

The new methodology for calculating residual unreimbursed uncompensated care is laid out in Attachment 6. Many of these data elements are already collected via the Annual Hospital Survey. Attachment 7 contains the questions that will be added to the Annual Survey to allow for further analysis of residual uncompensated care.

Because care provided to the financially or medically indigent (charity care) is an important data element for several of the payment sources for uncompensated care reimbursement, hospitals shall indicate whether the uncompensated care charge is covered by the charity care policy (adopted in compliance with Health and Safety Code Chapter 311). Likewise, the hospital should indicate the portion of patient charges submitted as uncompensated care that were written off as bad debt in a manner that complies with generally accepted accounting principles.

Reflecting the contributions of hospitals in providing care under governmental payment programs, the methodology will calculate shortfalls (or "profits" if they exist) for these programs. The Medicaid shortfall is a major component of the allocations of Disproportionate Share funding so consideration of that funding source must include the shortfall, as well as uninsured costs.

Reported charges for all programs will be converted to cost using the "all-payer" RCC calculated by the Health and Human Services Commission. The RCC is a critical component to an accurate

[19] Previously, there was a data element available to categorize a discharge as charity care. However, this option was not widely used and DSHS combines self-pay with charity and unknown payer categories, reporting them all as self-pay in their data set.

calculation of residual uncompensated care. As such, using the all-payer RCC calculated from the Medicare/Medicaid cost reports will ensure uniformity in its calculation from established data.

Against the costs calculated via the RCC, hospitals shall report any payments made by the patient or payments made by any other party on behalf of the patient.

Hospitals shall also report lump sum payments available to support the care for the uninsured, including but not limited to payments from the:

1. disproportionate share hospital (DSH) program,
2. upper payment limit (UPL) program,
3. state trauma programs,
4. tobacco settlement proceeds,
5. federal grant funding, including payments made for care for undocumented persons (Section 1011),
6. payments or grants from local governments for the care of the indigent,
7. unrestricted donations and donations made to support care for low income persons,
8. publicly supported hospitals shall also report their tax appropriations, less any intergovernmental transfers made in support of the DSH and UPL programs, and
9. other payments or revenue streams that support care for the uninsured.

Also hospitals shall report payments from patients or on behalf of patients for care that was reported as uncompensated in prior reporting periods. These “subsequent recoveries” shall be considered as revenue available to the hospital for uncompensated care in the current reporting period. These amounts may not be substantial for all hospitals. However, collecting this data reflects that residual uncompensated care will be calculated at a point in time even though resolution of a patient account can extend over multiple reporting periods.

Deployment

Many of the data elements necessary for calculation of residual unreimbursed uncompensated care are already collected via the Annual Hospital Survey. Rather than duplicate those efforts, questions will be added to the 2008 survey (completed in 2009) to provide additional useful information for policy consideration.

HHSC recognizes there is a tremendous amount of variability in hospital administrative systems. While we have received useful feedback from the members of the Work Group, there may be additional concerns that have yet to come to light. The most substantial change for many hospitals may be the further delineation of bad debt into the subcategories of bad debt from uninsured and bad debt from underinsured or partially insured. Not every hospital will be able to provide this data immediately, and the data will improve over time. HHSC recognizes that the data may not be perfect, especially initially, but the new methodology will provide policymakers with more useful information and data over the long run.

Deployment should also consider a series of meetings with hospital groups to discuss the system and provide “training.”

The Center for Health Statistics at the Department of State Health Services should provide the technical support for the collection of the data. This group has ongoing data interactions with the hospital industry.

Summary of Recommendations

Recommendation 1: Because some of the definitions related to uncompensated care are outside the control of Texas policy makers, a single uniform definition is not feasible. Instead, an overarching hierarchical definition should be adopted that accommodates the variability of the varying programs and payer sources.

Recommendation 2: The definition of uncompensated care must include bad debt, in addition to charity care, to recognize the variability allowed under statute and allow for accurate comparisons of the care provided by hospitals.

For the purposes of calculating residual uncompensated care, uncompensated care includes the charges for the uninsured (those with no source of third party insurance) and the underinsured (those with insurance who after third party payments have a responsibility to pay for an amount that they are unable to pay). Uncompensated care will also include unreimbursed costs from government sponsored health programs.

Broadening the classifications for unreimbursed uncompensated care reporting will capture the complete picture of hospitals' efforts while at the same time providing more detailed information to support the development of policy responses.

Recommendation 3: It is recommended that the all-payer ratio be adopted as the basis for uniformly converting charges to costs for the purposes of estimating the cost of unreimbursed uncompensated care. The parameters are known, the all-payer RCC is uniformly calculated and the data source is routinely subject to audit. This ratio is already used for the DSH and trauma programs so the use of this ratio advances consistency in reported uncompensated care data. It is unlikely that CMS would approve a change to an RCC in the DSH program that would result in higher estimated costs or be more favorable from the hospital perspective.

Recommendation 4: Reporting of uncompensated care must clarify the extent to which charges for the same care may be submitted more than once for reimbursement. Trauma programs reimburse some of the costs that also are reported in the DSH program. Charity care also is reported on multiple instruments. The degree of this overlap should be made clearer.

To avoid duplication in data reporting, consideration should be given to allocating trauma reimbursement funding on a hospital fiscal year basis. To begin this transition, the data elements needed for the pro rata distribution of funds should be collected via the Annual Hospital Survey. While duplicative in the short run, this data collection should provide for a smoother transition from a calendar year basis to a distribution based on hospital fiscal year basis.

While the Tobacco Settlement distribution provides another lump sum funding source for hospital uncompensated care, it is not recommended to change the basis for this distribution. The basis for the distribution is tax revenues collected by hospital districts and public hospitals in a calendar year and as such there is not a need to match to other reported uncompensated care charges.

Recommendation 5: Adopt a new detailed reporting methodology that uses the hierarchical definition of uncompensated care, providing a reliable, valid and auditable measurement of residual uncompensated care. The current categories of charity care and bad debt will be included but the sources of bad debt will be broken out in greater detail, including uninsured and underinsured, to provide policymakers with more detailed information to guide future consideration of responses to uncompensated care. The measurement will also include the unreimbursed costs of participation in government sponsored health care programs, i.e. program shortfalls.

Recommendation 6: The methodology for calculating residual uncompensated care should include both patient specific payments (regardless of source) as well as revenue from the various sources of uncompensated care funding streams (non-patient specific).

Recommendation 7: To ensure ongoing data validity, hospitals must be provided feedback on their reported data. If payments will be based on the reported data, then some form of audit scrutiny should be supplied.

Attachments:

1. Requirements from SB 10 and HB 1 for uncompensated care reporting
2. Comparison of major uncompensated care reporting instruments
3. Assessment of Claims based uncompensated care reporting via the UB04 and flow charts on determination of uncompensated care
4. Regional data analysis
5. Options for collecting residual uncompensated care data
6. New methodology to calculate residual uncompensated care
7. Additional Questions for the Annual Hospital Survey

<u>Next steps</u>

The more detailed reporting of the components of uncompensated care and all of the patient specific and non-patient specific funding streams for the purpose of calculating residual uncompensated care will provide new clarity to this policy area. With more detailed data on the causes of bad debt (uninsured, underinsured), policy makers will be in a better position to craft responses. It may be that the needs vary in different areas of the state, requiring regional responses.

While not entirely useful for measuring the costs of uncompensated care, the hospital discharge data for "self-pay" patients may provide policy makers with insights on the types of treatments

that are most prevalent. This information too could help shape targeted responses to address uncompensated care.

By measuring residual uncompensated care and taking into account all of the funding sources available to offset the cost of care, policy makers will be provided a clearer picture of the net impact on individual hospitals. From the regional analysis, it appears that the available funding sources to offset the cost of uncompensated care may not be uniformly distributed. This could prompt discussions of alternate allocation mechanisms to match funding to need or could provide insight into where additional targeted funding might be appropriate.

The $11 billion in reported uncompensated care charges reported from the Annual Hospital Survey is a daunting number to consider. When that number is converted to cost and when all available funding sources are considered, the remaining number may prove to be more manageable to assess and address.

Attachment 1
Uncompensated Care Work Group Charges

80th Legislature, Regular Session, 2007
HB 1, Article II, Health and Human Services Commission

Rider 44. 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.

80th Legislature, Regular Session, 2007

SENATE BILL 10 (Excerpt)

Sec. 531.552. WORK GROUP ON UNCOMPENSATED HOSPITAL CARE. (a) In this section, "work group" means the work group on uncompensated hospital care.

(b) The executive commissioner shall establish the work group on uncompensated hospital care to assist the executive commissioner in developing rules required by Section 531.551 by performing the functions described by Subsection (g).

(c) The executive commissioner shall determine the number of members of the work group. The executive commissioner shall ensure that the work group includes representatives from the office of the attorney general and the hospital industry. A member of the work group serves at the will of the executive commissioner.

(d) The executive commissioner shall designate a member of the work group to serve as presiding officer. The members of the work group shall elect any other necessary officers.

(e) The work group shall meet at the call of the executive commissioner.

(f) A member of the work group may not receive compensation for serving on the work group but is entitled to reimbursement for travel expenses incurred by the member while conducting the business of the work group as provided by the General Appropriations Act.

(g) The work group shall study and advise the executive commissioner in:

(1) identifying the number of different reports required to be submitted to the state that address uncompensated hospital care, care for low-income uninsured persons in this state, or both;

(2) standardizing the definitions used to determine uncompensated hospital care for purposes of those reports;

(3) improving the tracking of hospital charges, costs, and adjustments as those charges, costs, and adjustments relate to identifying uncompensated hospital care and maintaining a hospital's tax-exempt status;

(4) developing and applying a standard set of adjustments to a hospital's initial computation of the cost of uncompensated hospital care that account for all funding streams that:

(A) are not patient-specific; and

(B) are used to offset the hospital's initially computed amount of uncompensated care;

(5) developing a standard and comprehensive center for data analysis and reporting with respect to uncompensated hospital care; and

(6) analyzing the effect of the standardization of the definition of uncompensated hospital care and the computation of its cost, as determined in accordance with the rules adopted by the executive commissioner, on the laws of this state, and analyzing potential legislation to incorporate the changes made by the standardization.

(b) The executive commissioner of the Health and Human Services Commission shall:

(1) establish the work group on uncompensated hospital care required by Section 531.552, Government Code, as added by this section, not later than October 1, 2007; and

(2) adopt the rules required by Section 531.551, Government Code, as added by this section, not later than January 1, 2009.

(c) The executive commissioner of the Health and Human Services Commission shall review the methodology used under the Medicaid disproportionate share hospitals supplemental payment program to compute low-income utilization costs to ensure that the Medicaid disproportionate share methodology is consistent with the standardized adjustments to uncompensated care costs described by Subdivision (4), Subsection (g), Section 531.552, Government Code, as added by this section, and adopted by the executive commissioner.

Attachment 2
Summary of Major Reporting Requirements

Item	Annual Survey	Community Benefits	DSH Program	State Trauma	Tobacco Settlement	County Indigent
Key definition(s)	**Uncompensated care:** Care for which no payment is expected or no 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 are unable to pay. **Bad debt expense:** The provision for actual or expected uncollectibles resulting from the extension of credit. Because bad debts are reported as an expense and not a deduction from revenue, the gross charges that result in bad debts will remain in net patient revenue. **Charity care:** Health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria. For purposes of this survey, charity care	**Unreimbursed costs** means the costs a hospital incurs for providing services after subtracting payments received from any source for such services including but not limited to the following: third-party insurance payments; Medicare payments; Medicaid payments; Medicare education reimbursements; state reimbursements for education; payments from drug companies to pursue research; grant funds for research; and disproportionate share payments. **Hospital eligibility system** means the financial criteria and procedure used by a hospital to determine if a patient is eligible for charity care. The system shall include income levels and means testing indexed to the federal poverty guidelines provided, however, that a hospital may not establish an eligibility system which	**Cost of services to uninsured patients.** Inpatient and outpatient charges to patients who have no health insurance or other source of third party payment for services provided during the year, multiplied by the hospital's ratio of costs to charges (inpatient and outpatient), less the amount of payments made by or on behalf of those patients. Uninsured patients are patients who have no health insurance or other source of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment. **Charity charges.** Total amount of hospital charges for inpatient and outpatient services attributed to charity care in a hospital fiscal	**Uncompensated trauma care:** The sum of "bad debt" and "charity care" resulting from trauma care after due diligence to collect. Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (to include but not limited to Medicaid, Medicare, Children's Health Insurance Program (CHIP), Crime Victims Account, etc.) are not uncompensated trauma care. **Bad debt**-- The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person who is financially unable to pay, in whole or in part, for the services rendered and whose account has been classified as bad debt based upon the hospital's bad debt policy. A hospital's bad debt policy should be in accordance with generally accepted	**Unreimbursed health care expenditures:** "those actual expenditures made by a Political Subdivision which are directly attributable to the provision of health care services to the general public, either directly or by contract or agreement with a third party provider, and for which no reimbursement is made by or expected from any third party source or fund. (Lump Sum Trust Account or Permanent Trust Account payments shall not count as reimbursement.)" The term "unreimbursed expenditures" does not include contractual allowances or discounts for health care services required under a third party payor agreement. For Counties, they are defined as "all unreimbursed amounts, including unreimbursed jail health care, expended by such county for health care	**Reimbursable Expenditure:** A health care expenditure that may be applied to state assistance funds eligibility/reimbursement and that is for a service provided to a person who is eligible under a monthly net income standard that is at least 21% of the Federal Poverty Guideline (FPG) or up to 50% of the FPG.

Item	Annual Survey	Community Benefits	DSH Program	State Trauma	Tobacco Settlement	County Indigent
	is measured on the basis of revenue forgone, at full-established rates.	sets the income level eligible for charity care lower than that required by counties under Section 61.023 or higher, in the case of the financially indigent, than 200 percent of the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent pursuant to the hospital's eligibility system after health care services are provided.	year. 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 care maintenance organizations, Medicare or Blue Cross. The amount of total charity charges must be consistent with the amount reported on the Department of State Health Services (DSHS) annual hospital survey.	accounting principles. **Charity care**-- The unreimbursed cost to a hospital of providing health care services on an inpatient or emergency department basis to a person classified by the hospital as "financially indigent" or "medically indigent".	services to the general public during that year, plus 15% of that total." For Hospital Districts, they are defined as "the total amount of taxes collected by the hospital district, together with the unreimbursed amounts expended by a county coterminous with such hospital district for jail health care." For Non-Hospital District public hospitals, they are defined as "the total unreimbursed amount of political subdivision funds paid to such public hospital by any political subdivision during that year."	
Common definitions (essentially)	**Financially indigent**-- 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**-- A person whose medical or hospital bills after payment by third-party payors (to include but not limited to Medicaid, Medicare, CHIP, etc.) 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.				NA	NA
Data Submission	Online	Online	Online (from survey) and hard copy for supplemental information in application	Hard copy	Hard copy or email	Hard copy
Reporting Period	12 month period, preferably last completed hospital fiscal year	12 month period	Hospital fiscal year	Calendar Year	Calendar Year	State Fiscal Year for year end report; monthly data submission

Item	Annual Survey	Community Benefits	DSH Program	State Trauma	Tobacco Settlement	County Indigent
Report Due	April 30	April 30	August 3	January 14	March 31	Monthly with year end report
Reporting Entity	Hospitals	Hospitals	Hospitals	Hospitals	Hospital districts and counties	Counties
Principal Data Element	Uncompensated care (bad debt and charity care charges)	Unreimbursed costs	Hospital specific limit (Medicaid shortfall plus uninsured costs)	Uncompensated trauma (bad debt and charity care charges for select ICD-9s)	Counties report unreimbursed amounts (including jail health care) for services to the general public. Hospital districts report as unreimbursed health care the amount of tax collections.	Health care expenditures for certain covered services to eligible residents.
Ratio of Costs to Charges	Charges only.	Generally Accepted Accounting Procedures (GAAP), based on audited data.	All payor from the Medicaid cost report.	All payor from the Medicaid cost report.	Report expenditures and tax collections.	Expenditures only.
Funding	NA	NA	$1.4 billion All Funds	$31 million in fiscal 2007 to 240 hospitals	$11.9 million in fiscal 2007 to county governments $70.8 million to hospital districts and public hospitals	$2.6 million in fiscal 2007 paid to select counties with expenditures exceeding 8 percent of general tax levy
Issues		Includes community activities that are not acute care			Includes community activities that are not acute care	
Item	**Annual Survey**	**Community Benefits**	**DSH Program**	**State Trauma**	**Tobacco Settlement**	**County Indigent**

Attachment 3

Feasibility of Claims Based Reporting via UB 04 claim form and Flow charts on determination of uncompensated care status

Tracking Texas Hospitals' Uncompensated Care

Introduction

Deloitte Consulting has teamed with the Texas Health and Human Services Commission (the "HHSC") to identify possible means and approaches for tracking Texas hospitals' uncompensated care. HHSC has undertaken this project in response to a recent legislative mandate. Under Senate Bill 10, passed during the Texas Legislature's 2007 Regular Session, the HHSC's Executive Commissioner was directed to establish a hospital Work Group on uncompensated[1] care. This Work Group is required to advise the Commissioner on numerous items related to hospitals' provision of such care.

The Work Group is required to advise the Commissioner regarding terminology, accounting adjustments, and tracking of data items related to uncompensated care. Progress made toward these three goals will be used as the basis for additional efforts to optimize the Medicaid program's financial effectiveness.

Project Approach

This Report summarizes our initial findings, developed in collaboration with HHSC, related to uncompensated care measurement and associated data tracking and storage. Working from the patient care/financial status scenarios developed by HHSC, we isolated a set of data elements that captures and categories the components of uncompensated care. The data elements are set out in detail in Exhibit 1, and the scenarios in Exhibit 2.

We then explored means for accurately gathering these data elements with modifications or enhancements to existing industry claim processes. The required modifications to the customary use of claim form (UB-04) fields are explained in the following report, and they are tied to data elements and patient scenarios in Exhibits 1 and 2. Exhibit 3 shows typical claim flows and Exhibit 4 provides example of the types of information which can be gathered from a well designed data base.

Our procedures, findings, and associated background information are set forth in the following report sections.

1- Terminology clarification and other industry background information

- Current industry understanding of terminology and identification of specific areas of inconsistency
- Identification of sub-categories of charity care and bad debt needed for comprehensive uncompensated care tracking
- Lessons from Massachusetts and New Jersey approaches, including cut-off standards for uncompensated care claim submission

[1] Most broadly, "uncompensated care" may be understood to include under-compensated care.

2- Workflows associated with patient financial status determination, claims processing, and uncompensated care analysis

3- Uncompensated care claim scenarios

- Patient situations generating uncompensated care
- Components of uncompensated care generated in likely claim scenarios
- Balancing the need for sufficient detail with the need for accurate and efficient tracking

4- Tracking system based on UB-04

- Clearly defined, uniform inputs for claim tracking system
- Tying of necessary inputs to current and potential usage of standard claim form fields
- Sequencing and timing of information gathering and reporting

5- Tracking data to allow for the production of meaningful information

- Tracking should be designed with sufficient modularity of data components that artful queries can be later designed to meet as-yet-undefined informational needs
- Division and combination of trackable components in ways that allow for as-yet-undetermined uses for collected data

6- Concluding Remarks

- Undertaking the tracking of data has many challenges which need to be considered before a path is determined

A summary of data items, their current or possible sources, and the issues associated with various approaches to improved tracking are examined below.

Analysis

1- Terminology clarification and other industry background information

Discussion of uncompensated care is aided by a brief explanation of key terms, because the healthcare provider industry inconsistently defines "uncompensated care," "charity care," and "bad debt." The following definitions, if applied consistently within the contemplated uncompensated care measurement efforts, should help provide a foundation for discussion.

Uncompensated Care: For purposes of this analysis, "uncompensated care" is the portion of a patient's care (up to 100% of that care) for which a charge is recorded but for which there is no applicable contractual adjustment required by the payor, and for which no payment is received. Although a charge might bear little relationship to cost in the healthcare setting, greater reporting consistency will likely be achieved by capturing the raw data associated with charges, rather than making an early adjustment to account for the relationship between charges and costs. Legislative policy can ultimately determine the reimbursement implications related to a cost-to-charge ratio adjustment.

Uncompensated care is made up of two components: *charity care* and *bad debt*.

Charity Care: Based on a patient's inability to pay, "charity care" charges are those charges not collected due to a patient's inability to pay. Such care is generally provided (and not billed to patients) pursuant to a hospital's charity care policy. Such policies often provide for a *financial indigence* sliding scale discount tied to the federal poverty line (i.e., a patient may be entitled to a 100% discount if family income is less than 200% of the FPL, 80% discount for someone with income between 200% and 300% of the FPL, etc.). In some instances, a patient's medical bills may qualify him for "*medically indigent*" status. Such status is dependent on facts and circumstances associated with a patient's financial resources in relation specifically to medical bills (particularly catastrophic medical bills).

Bad Debt: Bad debt is the portion of a bill for which the hospital expects payment, based on factors including the patient's ability to pay, but does not receive payment. Several sources describe bad debt as that resulting from "extension of credit,"[2] but it may be more instructive for uncompensated care reporting purposes not to add such a qualifying statement to the definition. That is, appending the terms "extension of credit" to a definition of bad debt may imply that a financial credit process was completed in order to extend financial credit to a patient. Much healthcare is provided with only nominal up-front patient payment, with patient-responsibility balances determined while or after a claim is submitted for insurance payment. Regardless of financial credit process semantics, the simpler definition (payment reasonably expected but not received) is manageable and sufficient for purposes of uncompensated care tracking.

[2] For example, both the Texas Administrative Code (§ 355.8065) and the Medicaid DSH Annual Survey (Section I) both refer to bad debt as that resulting from "the extension of credit."

Industry complexity drives this definitional variation as well as the variety of approaches taken by state legislatures to respond to uncompensated care challenges. New Jersey, North Carolina, and Massachusetts, haveaddressed the issue in ways different from the approaches currently under consideration by Texas.

New Jersey.

Approach: New Jersey has instituted a system of prospective payment for charity care, under which hospitals are paid 10%-98% of the Medicaid rates for charity claims. The percentage payment is based on a distribution formula that takes into account individual hospital need, the fixed amount of statewide funding available for charity care, and the hospital's previous submission of charity care claims. In pricing claims, the Medicaid intermediary applies a cost-to-charge ratio to outpatient claims. Inpatient claim pricing is based on Medicaid DRGs. Payments from primary insurers are deducted from this total to arrive at the charity-care-eligible amount.

Tracking: New Jersey has state-mandated discounting policies that may provide for greater consistency than that in Texas. New Jersey providers do not report bad debt to the State as part of the Charity Care program. Providers also do not distinguish such sub-categories as medical indigence (versus financial indigence). Essentially, financial indigence levels are captured in the sliding scale discount amounts, which are tracked in charity-specific fields of the Form 837, which is submitted electronically to the fiscal intermediary that pays Medicaid claims. These sliding scale discounts are uniform. Patients at or below 200% of FPL are entitled to a 100% write-off. Between 200% and 300%, are sliding scale discounts of 80%, 60%, 40%, and 20%. The applicable percentage is applied to the charity care eligible amount noted above.

Timing: Charity Care claims are allowable in the year written off but date of service must be within 24 months of write-off (change instituted within the last two years). A claims processing schedule is issued annually. Hospitals generally have through the last date in February to submit claims for the previous calendar year. Claims submitted in January and February are assigned to the current or former calendar year based on date of service. Thus, a tight deadline is, in effect, offset by a provider's right to claim the write-off in a subsequent year.

New Jersey program features that promote accuracy and encourage willingness to incur programming costs:

- Charity care reporting on the 837 affects reimbursement
- Periodic audits
- State-mandated (consistent) discounting policies[3]
- Much of the programming required for hospitals to submit Medicaid claims to the fiscal intermediary resulted in system modifications could also be used for Charity Care claims submission

[3] A hospital may have a customized self-pay discount policy, but only discounts within the state parameters will be counted for charity purposes. This issue would seem to be addressed by Texas' determining precise distinctions between financial indigence charity, self-pay discount charity, and bad debt.

North Carolina.

Approach: North Carolina hospitals report their charity care in order to justify certain preferential tax treatment.

Tracking: North Carolina hospitals report their charity care on a Community Benefit Inventory for Social Accountability (CBISA) form through the North Carolina Hospital Association (NCHA) website. Some hospitals accomplish this task by using the UB-04 (837i protocol) to accumulate the data, which is then reported through the NCHA website. Other hospitals accumulate the data through a financial clearance process. This process may involve recording accounts receivable at net realizable value. That is, the total "value" of the charity care would theoretically be captured in the net realizable value figure. However, more specific components' identification would be more challenging.

Massachusetts.

Approach: Massachusetts instituted a universal coverage plan a few years ago. Under the State's full coverage plan, there is recognition that for various reasons, some patients will not enroll in the plans available to them. Thus, a Safety Net program to which claims may be submitted has been incorporated to address the issue. Claims for this program are cross-walked from the UB-04 to the 837I electronic claims submission format.

Timing issues: Charity care claims must be submitted within 90 days of service. This is a very tight deadline, but in theory, everyone in Massachusetts has health insurance, so this program relates only to patients that somehow slip through the cracks.

Like people, information can "slip through the cracks." There are several workflows that occur more-or-less in tandem any time a patient receives hospital care. Each such instance provides an opportunity for uncompensated care.

2- Workflows associated with patient financial status determination, claims processing, and uncompensated care analysis

Exhibit3 depicts the human processes and data flow processes that occur from the time a patient begins the process of receiving hospital care (whether by pre-registering for some hospital service or by appearing at the hospital for care). As shown in the flowcharts in Exhibit 3, the processes involved in turning patient hospital encounters into financial data elements occur along three tracks, with a fourth applicable for uncompensated care measurement and tracking.

- A patient enters the system and receives care;

- The registration process includes, at times, an initial indication of eligibility for charity care and/or likelihood of reduced ability to pay for services;
- Each claim is processed for payment, which includes the movement of data among numerous parties and the analysis of different pieces of that data by different parties for different purposes;
- Payment data may be analyzed for the purpose of gathering uncompensated care information.

Care delivery associated with these process flows may in some instances be fully or partially uncompensated. The process of estimating, measuring, and reporting uncompensated care begins with the patient's hospital entry/intake process (either pre-intake registration for the pre-registered patient, or upon intake itself for the patient that is not pre-registered). The process flows may also be considered in terms of various compensated, uncompensated, and under-compensated care scenarios.

3- Uncompensated care claim scenarios

Patient financial status drives the mix of compensated and uncompensated care (if any) associated with a particular claim. As noted above, Exhibit 1 provides a descriptive list of the uncompensated-care-relevant data elements associated with patient claims that will be relevant for future tracking of bad debt and charity care. Exhibit 2 displays examples of these elements in terms of the charges, adjustments, payments, and write-offs associated with various claim scenarios. Claims scenarios shown in Exhibit 2 are those provided by HHSC. It was determined that those represented the most common situations to produce bad debt and/or charity care.

The data elements noted in Exhibit 1 form the basis of an uncompensated care tracking system's design. The scenarios displayed include varying levels of covered and uncovered charges (for the insured patient), indigence discounts (for the insured and uninsured), and self-pay discounts (for the uninsured). By dividing data into the 13 key elements, both the charity care sub-components and the final bad-debt component of uncompensated care will be captured.

These 13 elements are analyzed below in terms of how they might be tracked in an uncompensated care data system based on the UB-04 in its typical use, as well as in uses possible with different levels of programming and, in some instances, manual data entry.

4- Tracking system based on UB-04; opportunities and challenges noted

As noted, there are 13 data elements preliminarily identified as those that should be captured in an uncompensated care tracking system. Although some of these items are already captured in industry-standard claim submission processes, others require varying degrees of information systems modification and other programming enhancements. Exhibit 1 describes the source of each element and the level of programming potentially required by the hospital to provide the information requested.

Very generally, the claims submission process occurs according to the following steps. The process is represented with additional detail in the flows shown in Exhibit 3.

a. PROVIDER. Sends scrubbed claim on UB-04 using 837i standard to a commercial payor or to a clearinghouse (which forwards claim to payor). Commercial payor determines covered expenses, contractual adjustments, and payment amounts.

b. PRIMARY PAYOR. Sends Explanation of Benefits/Remittance Advice ("EOB" or "RA") to provider, communicating covered and non-covered charges, contractual adjustments, and payment amounts. Information is crosswalked (automated process) from EOB to UB-04 fields. This process may be automated, manual or a combination.

c. PROVIDER. Submits UB-04 to secondary payors.

d. SECONDARY PAYOR. Sends EOB/RA to provider, communicating payment amounts.

e. HOSPITAL ADJUSTMENTS. Sliding scale, other financial indigence, medical indigence, and other adjustments may be applied to the patient's balance before the patient is billed (or in some cases when the patient supplies additional information to the hospital in response to the receipt of a bill).

f. PATIENT. Patient is billed the balance. Patient payments are applied to that balance.

All six steps may be relevant in the insured-patient scenarios. Only steps e. and f. are usually undertaken in the uninsured patient scenario.

There are fields available on the UB-04 to capture these steps and their associated data "events." Capturing this data however does not happen without some level of effort due to the complex interrelationships among systems (within even a single hospital). The following list provides some insight into how to address these challenges at various steps in the process.

Possible Process intervention: Steps e. and f. In the insured and uninsured patient situations, steps e and f provide an opportunity for adding or modifying steps efficiently so that charitable care and bad debt write-offs can be accounted for in a uniform manner, taking the UB-04 and database approach.

Possible Process intervention: Step c-d. Hospitals often have features of their electronic billing software and patient accounting systems customized. There may be unused capacity for such customization that could be tapped for the tracking of uncompensated care. However, UB-04 fields unused for one payor may not be available for all claims from every payor. "Extra" or "new" fields on the UB-04 are not necessarily available.

Possible Process intervention: Step f. UB-04 fields 39-41 essentially provide twelve 2-part fields, each with space for a 2-digit alphanumeric code and space for a dollar amount. The uncompensated care portions requiring the most programming (as noted in Exhibit 1), could feasibly be assigned an alphanumeric financial status tag to indicate, for example, financial indigence, sliding scale discount eligibility (with sub-categories within this group, if desired), medical indigence, etc.

Thus, using the UB-04 may provide an effective, though challenging, basis for capturing uncompensated care data. The financial investment required is difficult to estimate, though it is likely substantial. Other data collection means such as surveys might appear to provide a lower-cost and easier implementation alternative, but there are distinct disadvantages. A hospital survey approach would suffer from significant data integrity issues, as well as possible deficiencies related to consistency in reporting (form and content). Survey results might require extensive re-work in order for CMS to accept such data for UPL, DSH, or other purposes. Further, the retrospective audit work effort and expense would likely outweigh any cost savings achieved up-front.

The UB-04 approach would have greater up-front programming requirements (and cost) which would likely intimidate some providers. Furthermore, terminology inconsistency could generate data integrity issues. However, claim-specific data could be stored, using information either already in the UB or addable to the UB with programming related to unused fields.

5- Tracking data to allow for the production of meaningful information

The data elements captured will only provide meaningful information if they are defined precisely and tracked accurately. Data layout which is considered in the early stages of design, will allow the user to create queries of the data to easily and quickly produce the information desired. A well designed and constructed data base could allow for artful database queries to achieve as-yet-undetermined information needs.

In addition to the data elements discussed above, database queries could be designed for numerous uncompensated care stratification needs, provided there is access to additional standard claim information, such as demographic data (zip codes, etc.), provider information, and similar data elements.

Exhibit 4 includes examples of specific queries that would be supported by data accumulated in the categories laid out in this report.

6- Concluding Remarks

As discussed above, the UB-04 with some modifications and programming could allow the State a mechanism to capture uncompensated care costs.

In our discussions with hospital executives and claims processing professionals, the following suggestions emerged.

1. In order to take advantage of the 837i format, a state would create an additional payor (“Texas Uncompensated Care”) to accept claim images and adjudicate (i.e., to accept the claim and collect the uncompensated care information) that are based on the state’s Medicaid UB-04 (837i) requirements. That is, a new payor image could be adjusted to capture only the data necessary to meet uncompensated care tracking requirements (i.e., omit or not require all of the Medicaid fields).
2. A companion guide could be created to assist hospitals and scrubbing vendors in implementation and further training.
3. Hospitals could “drop claims” for uncompensated care patients, and treat these claims’ patients as having a specific/unique financial class. New payor plan codes might be added to accomplish certain tracking goals.

While not fully explored in this document, numerous challenges have been identified related to the accurate and consistent tracking of uncompensated care which arise from the complexity of systems in place and from the volatile nature of healthcare finance generally. These items should be considered before moving forward with any solution related to tracking costs. Notable issues and challenges include the following:

- Any system would benefit from (and would likely require) robust auditing with enforcement/ corrective action capabilities. Development of auditing standards should occur in tandem with design of tracking program.
- Some hospitals have not yet converted to the UB-04, but instead still use the UB-92. Claim scrubbing vendors convert the UB-92 images into acceptable formats.
- Patient financial status determination is complex; initial consideration of patient eligibility for charity care may occur before or upon his entry into the care delivery system, during the provision of his care, or long after he has received services. Medicaid eligibility is fluid. Financial status is fluid, and supporting documentation is of extremely variable quality, reliability, and completeness.
- Timing issues related to uncompensated care filing should be articulated and resolved. It seems reasonable either to have a fairly “long” deadline, or to allow uncompensated care claims to be submitted for consideration in the fiscal year following the associated date of service (or date of initial billing).

- Numerous patient accounting systems are in use, with complex inter-play among customized and standardized components. Although there are similarities among systems (driven by commonality in goals among purchasers of such systems), there are also many unique characteristics even within the "standard" issue of primary vendors like Siemens, McKesson, Cerner, MediTech, Epic, Eclipsys, *et al*. Claims scrubbing vendor contracts with hospitals may, in some instances, have addressed the addition of new payors. Additional programming charges ($150-$200 per hour) may be incurred in some instances.
    - Even when there are commonalities among hospitals that use the same software, the skill level of the users may vary enormously from hospital to hospital.
    - Hospitals differ on the extent of in-house versus external (or remote, in some instances) data management, even with commonly used systems.
- Similar complexities exist in relation to claims editing software. Vendors include SSI, NDC-Premis, Cirius.
- Identified challenges with terminology precision remain. Training and other guidance must include standardized terminology.
- An early step toward development of a state-wide tracking system requires working closely with a hospital group to refine estimates related to difficulty, cost, and timing of implementation.
    - Workgroup communication would aid in eliminating any needless conformation of data elements to the UB-04. That is, individual hospitals are the best source of information regarding actual add-on capabilities required to track some of the key data elements. Some elements may already be captured by other means.
    - Individual hospitals are the best source of information related to the challenges associated with a UB-04-based system versus an 837i-based system.
- A publicized plan for more robust statewide audits of the many current uncompensated care reporting mechanisms would reduce the viability of the current financial incentive for hospitals to over-report their uncompensated care. Removing this incentive would aid in achieving hospital buy-in to a more comprehensive and organized system for uncompensated care tracking and reporting.

Exhibit 1. Uncompensated Care Data Elements: UB-04 and ANSI X12 837i Data Transmission Protocol.

<table>
<tr><th></th><th>Data Element</th><th>UB-04 Field</th><th>ANSI X12 837i</th><th>Programming Required</th><th>Data Source</th></tr>
<tr><td>I</td><td>Total Gross Patient Charges[4]</td><td>47</td><td>2400|SV203
2300|CL02</td><td rowspan="3">UB-04 Fields, standard usage
(or calculated therefrom)</td><td rowspan="3">UB-04</td></tr>
<tr><td>II</td><td>Covered Patient Charges</td><td>47 less 48</td><td></td></tr>
<tr><td>III</td><td>Non-covered Patient Charges</td><td>48</td><td>2400|SV207</td></tr>
<tr><td>IV</td><td>Insurance Payments</td><td>54 A to C</td><td>2000|SBR01
2320|SBR02 and AMT02
2300|AMT02</td><td rowspan="5">UB-04 Fields, with programming & entry of data from EOBs/Remittance Advices and patient accounting systems</td><td rowspan="5">EOB/Remittance Advice and Patient Accounting System</td></tr>
<tr><td>V</td><td>Payor Contractual Adjustment[5]</td><td>Calculated</td><td></td></tr>
<tr><td>VI</td><td>Patient Balance</td><td>55 A to C</td><td>2300|AMT02
2000B|SBR01
2320|AMT02</td></tr>
<tr><td>VII</td><td>Patient Payments</td><td>55A to C</td><td>2300|AMT02
2000B|SBR01
2320|AMT02</td></tr>
<tr><td>VIII</td><td>Uncompensated Care[6]</td><td>Calculated</td><td></td></tr>
<tr><td>IX</td><td>Sliding Scale Discount (>200 FPL)[7]</td><td>39A to 41D</td><td>2300|HI01|CO22-02
and HI02 through HI12</td><td>UB-04 Fields, with programming & entry of data from several possible sources</td><td>- Registration/patient mgmt system
- Patient accounting system
- Contract management system
- Claims scrubbing system
- Decision support system</td></tr>
</table>

[4] Total Gross Patient Charges: total amount charged for all services, supplies, etc. associated with a patient's hospital care. For the insured patient, total charges will equal the sum of [III] covered (insurance covered) and [II] non-covered (not covered by insurance) components. For the uninsured patients, Total Gross Patient Charges are the starting point for patient responsibility calculations.

[5] Payor contractual adjustments: reductions from charges agreed to between provider and payor. These adjustments are not counted as uncompensated care.

[6] Uncompensated care: balance remaining after insurance adjustments and insurance or patient payments.

[7] Sliding scale discount: hospitals may have discounts that apply proportionally according to a patient's level of financial indigence. These policies are often tied to the federal poverty line (FPL).

Exhibit 1 (continued)

	Data Element	***UB-04 Field***	***ANSI X12 837i***	***Programming Required***	***Data Source***
X	Other Financial Indigence[8]		2300|HI01|CO22-02 and HI02 through HI12		
XI	Medical Indigence[9]		2300|HI01|CO22-02 and HI02 through HI12		
XII	Self-pay Discount for Uninsured[10]				
XIII	Bad-debt Write-off[11]				
	CLAIM NOTE	80	2300|NTE02 2330A|N301 and N401-403 2010BA|N301 and N401-403	Programming required. Used by some vendors, but may not be practical given the complexity of data in the contemplated uncompensated care scenarios.	

[8] "Other Financial Indigence" could capture any financial indigence not included by the sliding scale figure.

[9] Medical indigence discounts or adjustments might apply when medical expenses themselves force a patient into an indigent state.

[10] Hospitals may apply discounts for uninsured patients. Adjustments based on such discounts should be isolated for uncompensated care tracking purposes.

[11] Any unpaid amount not accounted for by indigence or other means-generated situations will be written off as bad debt. Such amounts should be tracked as their own data element.

Exhibit 2. Financial Coverage Scenarios.

		Insured Patient Scenarios[12]							*Uninsured Patient Scenarios*[13]						*UB-04 Field*
		A[14]	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	
I	Total Gross Patient Charges	100	150	150	150	150	150	150	100	100	100	100	100	100	47
II	*Covered Patient Charges*	100	100	100	100	100	100	50							47 less 48
III	*Non-Covered Patient Charges*	-	50	50	50	50	50	100	-	-	-	-	-	-	48
IV	Insurance Payments	(80)	(80)	(80)	(80)	(80)	(80)	(40)	-	-	-	-	-	-	54A to 54C
V	Payor Contractual Adjustment	(10)	(10)	(10)	(10)	(10)	(10)	(5)	-	-	-	-	-	-	Calculated
VI	Initial Patient Balance	10	60	60	60	60	60	105	100	100	100	100	100	100	55 A to 55C
VII	Patient Payments	(10)	(10)	-	-	(20)	(5)	(5)	(20)	(50)	-	(5)	-	-	55A to 55C
VIII	Uncompensated Care[15]	-	50	60	60	40	55	100	80	50	100	95	100	100	Calculated Balance
IX	Sliding Scale Discount (> 200 FPL)	-	-	-	-	(10)	-	-	(50)	(50)	-	-	-		39A to 41D
X	Other Financial Indigence	-	-	-	-	-	(55)	-	-	-	(100)	-	-	-	39A to 41D
XI	Medical Indigence	-	-	(30)	-	-	-	-	-	-	-	(95)	(100)	-	39A to 41D
XII	Self-Pay Discount for Uninsured[16]								(10)					(10)	Manual Entry
	Additional Patient Payments (if any)	-	(10)	(10)	(10)	(10)	-	(10)	(10)	-	-	-	-	(10)	Manual Entry
XIII	Bad Debt Write-Off[17]	-	40	20	50	20	-	90	10	-	-	-	-	80	Calculated Balance

[12] Scenarios A through G represent hypothetical situations involving patients with varying levels of insurance coverage. Line VI indicates the patient responsibility portion of charges after all insurance contractual adjustments, insurance payments, and patient payments have been applied.

[13] Scenarios H through M represent situations involving patients without insurance. The initial patient balance is equal to total gross patient charges.

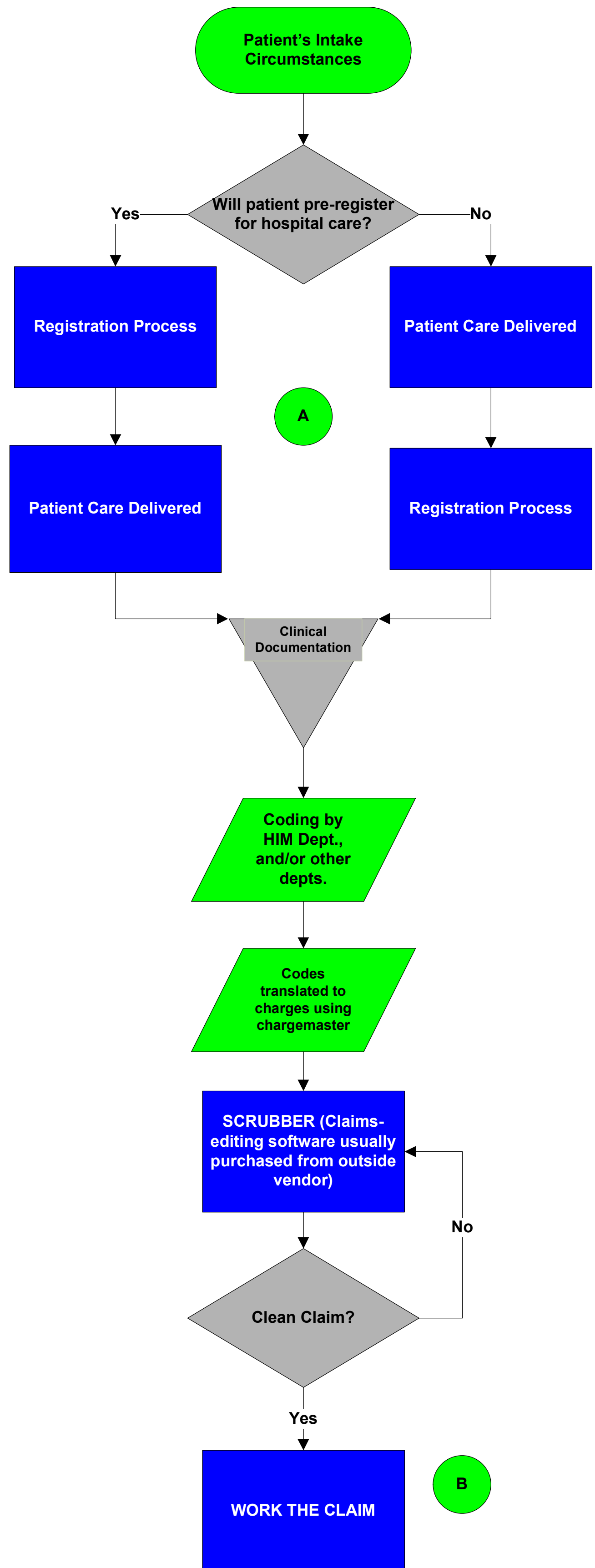
[14] In this scenario, in which insurance payments, insurance adjustments, and patient payments cover the entire balance, there is no uncompensated care.

[15] Uncompensated care (to be broken into its component parts) is the balance remaining after any insurance payments/adjustments and patient payments.

[16] For the patient without insurance, any self-pay discount offered by the hospital should be tracked as its own data element.

[17] Bad debt is the amount the hospital expects to collect but does not (all adjustments, discounts, payments have been applied to charges).

Exhibit 3
Flowchart 1
Patient Intake Through Claim Preparation



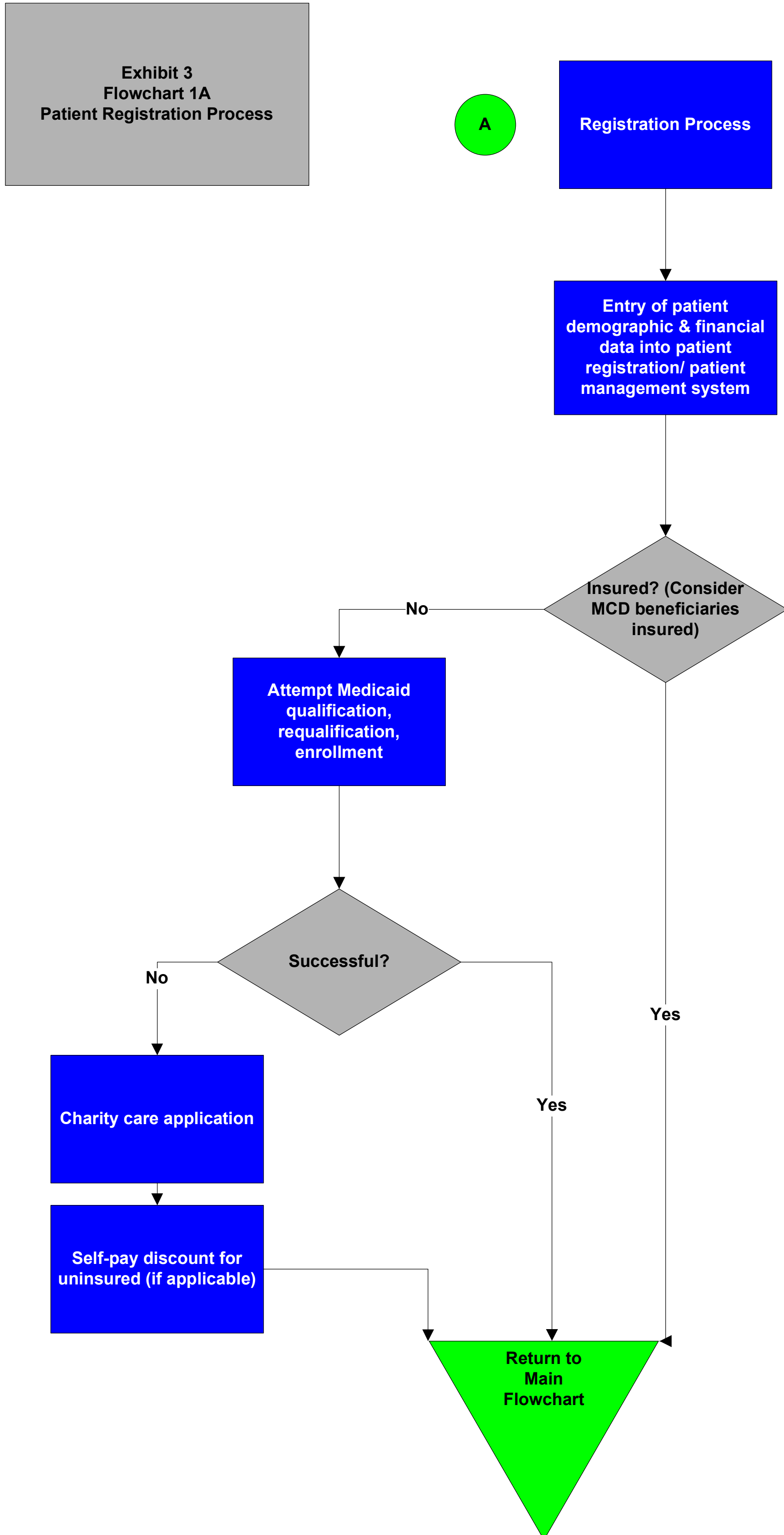


Exhibit 3
Flowchart 1A
Patient Registration Process
A
Registration Process
Entry of patient demographic & financial data into patient registration/ patient management system
Insured? (Consider MCD beneficiaries insured)
No
Attempt Medicaid qualification, requalification, enrollment
Successful?
No
Charity care application
Self-pay discount for uninsured (if applicable)
Yes
Yes
Return to Main Flowchart

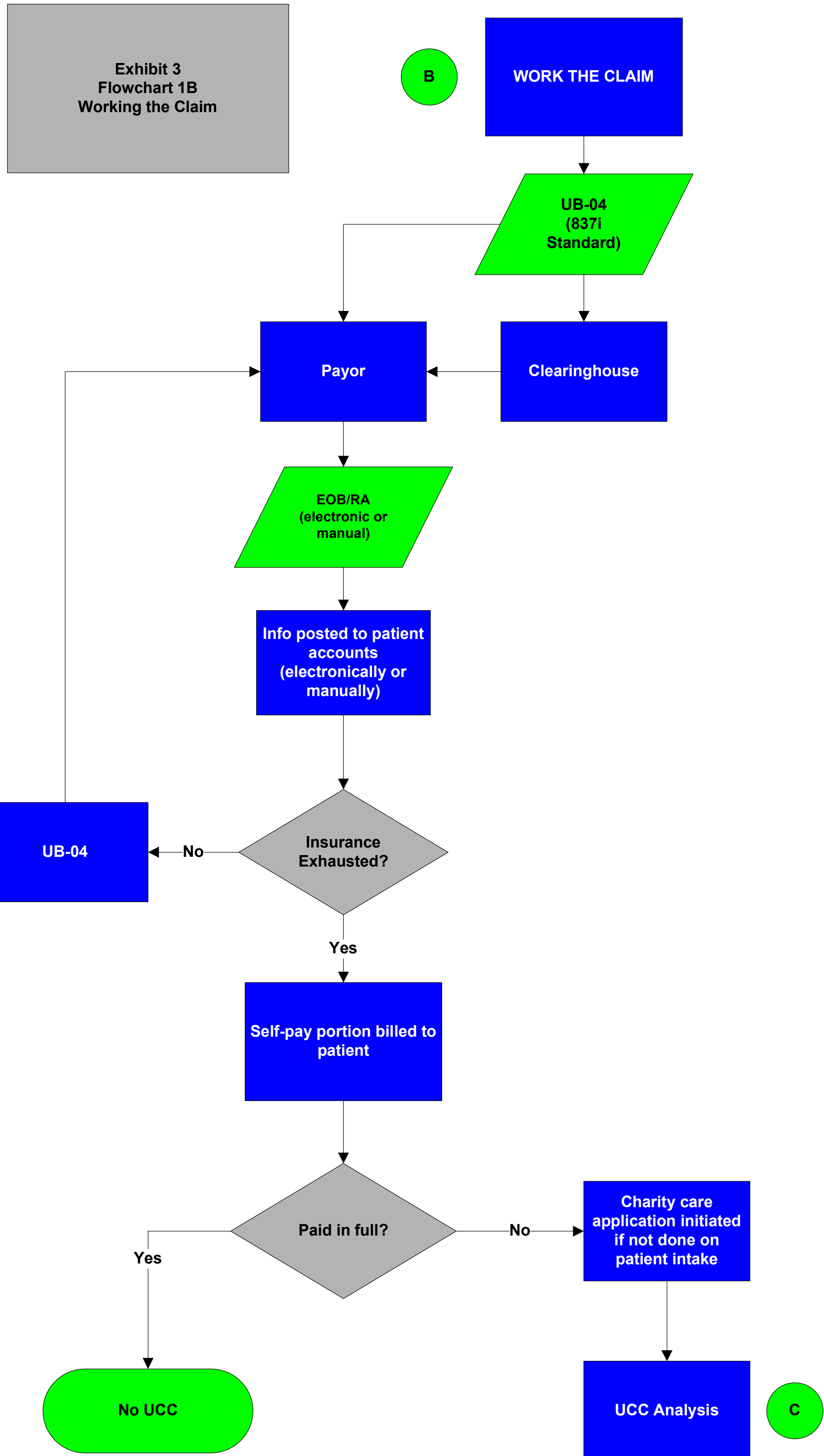
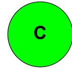


Exhibit 3
Flowchart 1B
Working the Claim
B
WORK THE CLAIM
UB-04
(837i
Standard)
Payor
Clearinghouse
EOB/RA
(electronic or
manual)
Info posted to patient
accounts
(electronically or
manually)
UB-04
No
Insurance
Exhausted?
Yes
Self-pay portion billed to
patient
Paid in full?
Yes
No
Charity care
application initiated
if not done on
patient intake
No UCC
UCC Analysis
C

Exhibit 3
Flowchart 2
Uncompensated Care
Analysis



For Insured Patient:
I. Total gross patient charges [47]
III. Non-covered charges [48]
II. Covered charges [47 less 48]

For Uninsured Patient
I. Total gross patient
charges

Standard UB-04 fields, standard use

Programming and/or manual entry required

I. Total gross patient charges [47]
(IV. Insurance payments [54A to C])
VI. Initial patient balance [55A to C]

From UB-04, with programming and data entry form EOBs/RAs

VI. Initial patient balance [55A to C]
(VII. Patient payments [55A to C])
(V. Payor contractual adjustment [calculated])
VIII. Uncompensated care [calculated]

VIII. Uncompensated care
(IX. 55 discount [39A to 41D])
(X. Other fin – indigence discount [39A to 41D])
XIII. Bad debt

VIII. Uncompensated care
(XI. Medical indigence discount [39A to 41D]
XIII. Bad debt

VIII. Uncompensated care
(XII. Self-pay discount for uninsured [manual entry])
XIII. Bad debt

Is bad debt greater than zero?

Yes → Bad debt write-off

No → All UCC is charity

Exhibit 4. Sample queries supported by data tracked in this manner. List is for illustrative purposes and is not comprehensive.

- Total uncompensated care (charity care and bad debt)
- Total charity care
- Total bad debt, and/or bad debt as percentage of uncompensated care
- Total charity care arising from sliding scale discounts, and/or other financial indigence adjustments, and/or medical indigence adjustments (or any of these items as percentage of uncompensated care, etc.)
- Total bad debt associated with insured patients incurring non-covered charges
- Total bad debt associated with medically indigent (but not financially indigent) patients
- Total self-pay discounts applied for uninsured patients (or self-pay discounts as percentage of uncompensated care)
- Total bad debt associated with patients for whom self-pay discount was given
- Total bad debt associated with patients that made at least a partial payment on the balance due
- Total collections as percentage of total patient charges (this figure could be a proxy for "expected profit," which could be used to work toward a figure to assign as the true "value" of the lost profit associated with uncompensated care; that is, hospital collects 65% of charges when it is "fully compensated"; therefore, it could be argued that the hospital could reasonably expect to collect 65% of its gross charges across the board, and anything that reduces its collections below that 65% is uncompensated care)
- Total charges associated with uncompensated care patients, and payments made by insurers and patients. The charges could be used to estimate cost, and payments from insurers and patients could be netted to arrive at net uncompensated care cost. This net figure could be used (in addition to or instead of) some version of the cost reporting cost-to-charge ratio in order to validate or report the cost of uncompensated care
- Using other standard UB-04 fields, information such as uncompensated care by patient zip code could be identified
- Combining this data with diagnosis data would allow for the tying of any of the elements of uncompensated care (bad debt, self-pay discount, etc.) to certain conditions and/or zip codes, which would allow for more precise identification of the types of conditions within specific patient populations that generate uncompensated care (thereby providing information for the targeting of Medicaid reform or other healthcare finance or delivery reforms)

Attachment 4
Summary of Regional Analysis, 2006 Data

	Region 1 Panhandle	Region 3 Dallas area	Region 6 Houston area	Region 11 Corpus Christi area
Population	795,141	6,168,594	5,418,163	1,943,197
Percent Uninsured	23%	23%	28%	31%
Avg. self pay discharge charges	22,943	18,660	20,931	22,271
Avg. self pay discharge cost	6,560	5,988	7,286	5,398
Charity+Bad Debt Charges	$ 481,995,104	$ 2,236,094,108	$ 2,478,762,969	$ 650,500,200
UCC Charges Converted to Cost	$ 150,128,895	$ 773,760,075	$ 978,232,479	$ 155,723,019
Cost as % of Net Pt. Rev	8.74%	12.05%	11.15%	7.25%
UCC per capita	$ 188.81	$ 125.44	$ 180.55	$ 80.14
UCC + Med. Shortfall	$ 184,887,375	$ 980,739,667	$ 1,182,589,017	$ 223,741,300
Revenue sources to offset UCC costs				
DSH payment	$ 44,967,459	$ 303,306,793	$ 262,934,946	$ 111,986,544
UPL payments	70,359,927	368,451,909	307,176,521	56,886,299
Trauma funding	2,242,905	13,781,856	13,541,041	3,021,729
Tobacco Settlement funding	2,171,357	23,804,673	16,570,299	1,609,909
	$ 119,741,648	$ 709,345,231	$ 600,222,806	$ 173,504,481
Local revenue sources to offset UCC costs				
Tax appropriations (less IGTs)	$ (10,558,694)	$ 299,560,223	$ 479,272,707	$ (13,649,144)
Local government revenue	18,266,658	19,278,650	98,546,768	183,144,624
Charitable contributions	132,824	13,635,433	67,512,609	16,230,121
	$ 7,840,788	$ 332,474,306	$ 645,332,084	$ 185,725,601
Net residual UCC	$ 57,304,939	$ (61,079,869)	$ (62,965,874)	$ (135,488,782)

This analysis should be considered illustrative only, based primarily on data as currently collected from the Annual Hospital Survey. Current data systems are insufficient to calculate a reliable amount of residual unreimbursed uncompensated care. Additional data elements as recommended in this report should provide for more accurate estimates in the future.

Region 1, 2006 Data

Counties: Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, Yoakum

Uninsured	181,525	23%
Population	795,141	
Net patient revenue	$ 1,717,835,756	

	Self pay discharges	Average
Charges	$ 128,687,321	$ 22,943
Cost	36,795,429	6,560
# of discharges	5,609	

	AHA main survey			Texas portion of survey		
	Charity	Bad Debt	Sum	Charity	Bad Debt	Sum
Charges	$ 257,568,291	$ 224,426,813	$ 481,995,104	$ 254,641,878	$ 182,051,033	$ 436,692,911
Cost with All Payer RCC (UCC)	78,489,808	71,639,086	150,128,895	77,549,417	57,268,768	134,818,185
as a percent of net patient revenue			8.74%			7.85%
Uncompensated care per capita			$ 188.81			$ 169.55
Medicaid Shortfall			34,758,480			34,758,480
UCC plus Shortfall			184,887,375			169,576,665
Net residual uncompensated care (UCC - total revenue)			$ 57,304,939			$ 41,994,229

Revenue sources to offset UCC costs		*(AHA survey)*
DSH payment (HHSC)	$ 44,967,459	*$ 39,024,195*
UPL payments	70,359,927	
Trauma funding	2,242,905	
Tobacco Settlement funding	2,171,357	
	$ 119,741,648	

Local sources of revenue	
Charitable contributions	$ 132,824
Tax appropriations (less IGTs)	(10,558,694)
Local government revenue	18,266,658
	$ 7,840,788

This analysis should be considered illustrative only, based primarily on data as currently collected from the Annual Hospital Survey. Current data systems are insufficient to calculate a reliable amount of residual unreimbursed uncompensated care. Additional data elements as recommended in this report should provide for more accurate estimates in the future.

Region 3, 2006 Data

Counties: Collin, Cooke, Dallas, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise

Uninsured	1,424,906	23%
Population	6,168,594	
Net patient revenue	$ 6,422,114,666	

	Self pay discharges	Average
Charges	$ 819,967,724	$ 18,660
Cost	263,129,324	5,988
# of discharges	43,942	

	AHA main survey			Texas portion of survey		
	Charity	Bad Debt	Sum	Charity	Bad Debt	Sum
Charges	$ 1,389,042,898	$ 847,051,210	$ 2,236,094,108	$ 1,413,206,034	$ 948,358,264	$ 2,361,564,298
Cost with All Payer RCC (UCC)	485,113,675	288,646,400	773,760,075	492,529,170	313,001,877	805,531,047
as a percent of net patient revenue			12.05%			12.54%
Uncompensated care per capita			$ 125.44			$ 130.59
Medicaid Shortfall			206,979,592			206,979,592
UCC plus Shortfall			980,739,667			1,012,510,639
Net residual uncompensated care (UCC - total revenue)			$ (61,079,869)			$ (29,308,897)

Revenue sources to offset UCC costs		*(AHA survey)*
DSH payment (HHSC)	$ 303,306,793	*$ 329,129,340*
UPL payments	368,451,909	
Trauma funding	13,781,856	
Tobacco Settlement funding	23,804,673	
	$ 709,345,231	

Local sources of revenue	
Charitable contributions	$ 13,635,433
Tax appropriations (less IGTs)	299,560,223
Local government revenue	19,278,650
	$ 332,474,306

This analysis should be considered illustrative only, based primarily on data as currently collected from the Annual Hospital Survey. Current data systems are insufficient to calculate a reliable amount of residual unreimbursed uncompensated care. Additional data elements as recommended in this report should provide for more accurate estimates in the future.

Region 6, 2006 Data

Counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton

Uninsured	1,493,750	28%
Population	5,418,163	
Net patient revenue	$ 8,776,870,123	

Self pay discharges		Average
Charges	$ 1,282,702,268	$ 20,931
Cost	446,475,756	7,286
# of discharges	61,281	

	AHA main survey			Texas portion of survey		
	Charity	Bad Debt	Sum	Charity	Bad Debt	Sum
Charges	$ 1,515,050,498	$ 963,712,471	$ 2,478,762,969	$ 1,694,223,991	$ 869,246,644	$ 2,563,470,635
Cost with All Payer RCC (UCC)	639,003,542	339,228,937	978,232,479	724,615,927	315,507,599	1,040,123,526
as a percent of net patient revenue			11.15%			11.85%
Uncompensated care per capita			$ 180.55			$ 191.97
Medicaid Shortfall			204,356,538			204,356,538
UCC plus Shortfall			1,182,589,017			1,244,480,065
Net residual uncompensated care (UCC - total revenue)			$ (62,965,874)			$ (1,074,826)

Revenue sources to offset UCC costs		*(AHA survey)*
DSH payment (HHSC)	$ 262,934,946	*$ 221,921,537*
UPL payments	307,176,521	
Trauma funding	13,541,041	
Tobacco Settlement funding	16,570,299	
	$ 600,222,806	

Local sources of revenue	
Charitable contributions	$ 67,512,609
Tax appropriations (less IGTs)	479,272,707
Local government revenue	98,546,768
	$ 645,332,084

This analysis should be considered illustrative only, based primarily on data as currently collected from the Annual Hospital Survey. Current data systems are insufficient to calculate a reliable amount of residual unreimbursed uncompensated care. Additional data elements as recommended in this report should provide for more accurate estimates in the future.

Region 11, 2006 Data

Counties: Aransas,Bee,Brooks,Cameron,Duval,Hidalgo,Jim Hogg,Jim Wells,Kenedy,Kleberg,Live Oak,McMullen,Nueces,Refugio,San Patricio,Starr,Webb,Willacy,Zapata

Uninsured	607,946	31%
Population	1,943,197	
Net patient revenue	$ 2,149,245,737	

Self pay discharges		Average
Charges	$ 266,410,607	$ 22,271
Cost	64,568,461	5,398
# of discharges	11,962	

	AHA main survey			Texas portion of survey		
	Charity	Bad Debt	Sum	Charity	Bad Debt	Sum
Charges	$ 457,552,194	$ 192,948,006	$ 650,500,200	$ 456,266,858	$ 200,852,303	$ 657,119,161
Cost with All Payer RCC (UCC)	104,729,113	50,993,906	155,723,019	104,371,189	51,725,017	156,096,206
as a percent of net patient revenue			7.25%			7.26%
Uncompensated care per capita			$ 80.14			$ 80.33
Medicaid Shortfall			68,018,281			68,018,281
UCC plus Shortfall			223,741,300			224,114,486
Net residual uncompensated care (UCC - total revenue)			$ (135,488,782)			$ (135,115,595)

Revenue sources to offset UCC costs		*(AHA survey)*
DSH payment (HHSC)	$ 111,986,544	*$ 130,378,126*
UPL payments	56,886,299	
Trauma funding	3,021,729	
Tobacco Settlement funding	1,609,909	
	$ 173,504,481	

Local sources of revenue	
Charitable contributions	$ 16,230,121
Tax appropriations (less IGTs)	(13,649,144)
Local government revenue	183,144,624
	$ 185,725,601

This analysis should be considered illustrative only, based primarily on data as currently collected from the Annual Hospital Survey. Current data systems are insufficient to calculate a reliable amount of residual unreimbursed uncompensated care. Additional data elements as recommended in this report should provide for more accurate estimates in the future.

Attachment 5
Options for Reporting Residual Uncompensated Care

With the new hierarchical definition in mind, several options were considered to collect the necessary data to calculate residual uncompensated care. The strengths and weaknesses of the options considered will be discussed below. Criteria considered include the comprehensiveness of the approach (how many hospitals), the cost for the state, the cost for hospitals, timeframes for adoption, ease of compliance and collection of data on the underinsured.

1. Claims based reporting with a fiscal intermediary

Significant consideration was given to collecting the information on a claim by claim basis via a fiscal intermediary for the state. This would allow hospitals to submit information to the state that could be compiled in a database and used to support the allocations of state funding streams. Patient specific funding (applicable insurance payments and patient payments) would be available from the claims data with the charges. A supplemental reporting tool would gather lump sum funding available to offset the cost of care.

This approach would provide the best data regarding uncompensated care as claims can have demographic, clinical and financial information. Attachment 3 reviews the feasibility of such an approach. To support compliance, this approach was envisioned to revolve around electronic submission of claims to a state fiscal intermediary, similar to the Medicaid program.

The benefits of this approach include:

- the capacity to replace other hospital reporting requirements as the database would have a level of detail sufficient to complete other state reporting requirements,
- detailed clinical information to shape targeted programs for the uninsured, such as specific disease management,
- comparison of patient information to databases of coverage, possibly resulting in third party coverage for the care,
- the ability to price uncompensated care with Medicaid-like parameters.

To lessen the reporting burden on hospitals, this option contemplated using standardized claim forms and reporting elements as much as possible.

While considered feasible, there were several drawbacks:

1. The timing issues and multiple feedback loops in patient records would make it difficult for hospitals to determine when to submit the claim. As they would not be directly paid for submitted claims, it is unlikely that hospitals would be willing to submit multiple iterations of uncompensated care claims, reflecting the on-going resolution of the patient file.
2. Despite efforts to design within the parameters of existing claim forms, uncompensated care has data aspects that are not captured on the current forms, thus requiring modifications to hospital systems.
3. There is variability in how hospitals track information internally and with how many systems. Some would lack the capacity to submit information electronically. Others might need to modify as many as three systems to comply.

4. Preliminary discussions with the state's current fiscal intermediary indicated it would require 9 to 12 months from the time a contract amendment is executed to program and operationalize a claims-based uncompensated care system. That means it is unlikely that data would be collected prior to state fiscal year 2010. This also assumes that hospital systems would be updated by that time.

2. Inpatient discharge data reported to the Department of State Health Services.
The Department of State Health Services (DSHS) collects inpatient discharge data from hospitals, regardless of payer. This data is collected for each calendar year quarter. This clinical data could be used to provide information on the types of services provided to uninsured and provide data to support target programs in response.

The category of "self-pay" could be used as a proxy for uninsured/uncompensated care. There is a mechanism for reporting charity charges electronically, but hospitals do not use this option. The hospitals would argue that they do not know a patient's financial status in a timely enough manner to submit uninsured claims within two months after the quarter the services are provided.

Using this approach would preclude measurement of underinsured in calculating residual uncompensated care. Medicaid shortfall, part of uncompensated care for DSH purposes, could continue to be calculated as it is now. Hospitals also would like to include the community benefit provided by participating in government sponsored care (such as Medicare, Tricare, Kidney Health, etc.)

The DSHS discharge data is limited in the financial information that is collected, in part due to statutory restrictions. The authorizing statute for the hospital discharge data prevents disclosure of payment or contractual discount information. Financial information could be reported lump sum fashion on a financial reporting tool/survey, but this would limit the analysis that could be performed on the individual claims. Virtually every payment sources for reimbursing uncompensated care prohibits consideration of payer discounts as uncompensated care. This data element must be measured if underinsured are to be included.

Use of the discharge data would not address outpatient care, as this data is not yet collected. The Annual Hospital Survey might be used in the short term to supply outpatient charges/costs. The current discharge system doesn't seem to have the capacity to receive all of the outpatient claims. Barring changes, DSHS staff expects it will be a multi-year effort.[1]

About half of the 86 hospitals that are exempt from the discharge data reporting requirement are recipients of DSH payments. If claims based reporting is used as the basis of calculation of DSH payments, these hospitals will have to submit discharge data.

Changes to the DSHS system could affect data continuity. The discharge data is made available to the public for sale. Some portion of the interest in purchasing the data is based on the data as

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[1] Outpatient data will be added in modules to the existing discharge data system. DSHS contracts for the data management services will be up for renewal/reissuance in 2011, which may govern how much change to the discharge reporting could be achieved before then due to system limitations.

an on-going source. Funding from the sale of data helps fund the operations and data management.

3. Amend the Annual Hospital Survey.
The Annual Hospital Survey has value in that it gathers data from all hospitals, but it is a protracted process and data typically lags by 1.5 to 2 years. For example, the most recent year available for the analysis in this report is 2006.

The data is also only reported in charges, which is not the best reflection of the actual impact on each hospital. Charges need to be converted to cost and reflect the payment streams available to offset the cost of care. AHA uses financial information from the survey data to calculate an RCC and convert charges to cost in their data summaries.

The regional data analysis performed for this paper demonstrated that there are some data integrity issues related to the survey. Numbers that should match, do not. The fact that there is not a pattern in the mismatch indicates either confusion or the lack of consequences from supplying inaccurate information.

Using this existing reporting mechanism could help with compliance, as hospitals are already "in the habit" of responding to the AHS. However, since the American Hospital Association hosts the online survey, some control over the process is ceded.

4. Require completion of the Annual Statement of Community Benefits by all hospitals.
The ASCB is another measurement of uncompensated care. While the information is still reported in lump sum fashion, it provides greater detail than the AHS. Furthermore, the ASCB reduces charges to costs (using a GAAP based RCC) and requires information on offsetting payments.

Currently, the ASCB is required of all non-profit hospitals and hospitals that receive DSH funding. However, DSH hospitals do not need to submit the same level of data. As such, there would be a learning curve for many hospitals to report via this instrument.

A few aspects of the reporting mechanism would be awkward or inappropriate for for-profit hospitals.

The Annual Statement of Community Benefits has the same lag in the data as the AHS.

5. IRS 990.
The Internal Revenue Service has recently applied additional scrutiny to non-profit entities, including hospitals. To qualify for exemption from federal income tax, non-profit entities must file information on a 990 form. The 990 form has been expanded to capture additional information and a new schedule for hospitals has been developed (but not finally adopted). The new hospital schedule will require reporting of information that substantiates the amount of care provided free (or reduced price) for low income persons.

This approach could streamline reporting requirements for hospitals, but would rely on a reporting mechanism outside of the ability of the state to directly control. Like the ASCB, some of the reporting requirements would not necessarily make sense for for-profit hospitals.

It is likely that the IRS may dedicate some auditing resources to this new form, improving the quality of data supplied (not applicable to for-profits). This could improve the data integrity of this instrument.

Using the IRS 990 hospital form in lieu of the ASCB could provide an opportunity to streamline hospital reporting, as it appears that many of the key elements will match the ASCB. This would likely involve a statutory change, and the Office of Attorney General would have to agree that it meets the requirements for maintaining non-profit status in Texas.

General Comment:

Regardless of the method adopted, additional scrutiny (audits, review, etc.) should be conducted to ensure data accuracy. Without this attention, hospital industry representatives admitted that the value and accuracy of the data will degrade over time. If possible, tying payments to the data submitted by hospitals will ensure that completion of the reporting requirements is given on-going attention by hospitals and by existing audit plans.

Attachment 6
New Methodology to Calculate Residual Uncompensated Care

Worksheet 1
Calculation of Uncompensated Care Costs

		Charity	Bad debt		Governmental Health Programs				Total
			Uninsured, self-pay	Partially insured	Medicaid	State programs	Local programs	Medicare	
		A	B	C	D	E	F	G	H
Inpatient charges	1								0
Inpatient charges (trauma)	1A								
Outpatient charges	2								0
Outpatient charges (trauma)	2A								
Ratio of cost to charges	3								
Cost (row 1 and 2 x RCC)	4	0	0	0	0	0	0	0	0
Patient-specific funding									
State government payments	5								0
Local government payments	6								0
Medicare payments	7								0
Private insurance payments	8								0
Patient payments	9								0
Other third party payments	10								0
Subtotal of patient funding	11	0	0	0		0	0	0	0
Subtotal of cost after patient-specific payments	12	0	0	0	Medicaid shortfall calculated by HHSC	0	0	0	0

Worksheet 1A
Offseting funding and Calculation of Residual Uncompensated Care

			Amount	
Uncompensated Care Costs (After Patient Specific Payments)				H12 from Worksheet 1
Other funding available to support uncompensated care				
Medicare supplemental payments	15			
Medicaid Disproportionate Share Hospital (DSH)	16			
Medicaid Upper Payment Limit (UPL)	17			
State trauma	18			
Tobacco settlement	19			
Federal grants, including Section 1011	20			
Other state government funding	21			
Donations	22			
Local government funding	23			
Tax revenue	24			Equals 24A-(24B+24C+24C)
Initial tax revenue receipts	24A			
Intergovernmental transfers for DSH	24B			
Intergovernmental transfers for UPL	24C			
Other IGTs for Medicaid	24D			
Collections from patients previously reported as uncompensated	25			
Subtotal of other funding	26		0	**Less Total Non-patient-specific Funds**
Residual uncompensated care	27		0	**= Total Residual Uncompensated Care**

Attachment 7
Additional Questions for the Annual Hospital Survey to Assist in the Calculation of Residual Uncompensated Care

Note: Actual formatting of the survey may differ from the pages as presented here. This excerpt contains the sections where the new questions are found. Most of the questions were asked in previous versions of the survey.

I. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM

COMPLETION OF THIS SECTION IS MANDATORY, REGARDLESS OF WHETHER YOUR HOSPITAL EXPECTS TO BE A MEDICAID DSH PROVIDER. ALONG WITH OTHER DATA SOURCES AND OTHER VARIABLES FROM THIS SURVEY, the following data will be used to determine eligibility for the Texas Medicaid DSH Program. Your hospital may not qualify for the Texas Medicaid DSH Program if this section is not completed. PLEASE USE THE DEFINITIONS ON PAGE 27 IN COMPLETING THIS SECTION. THE DEFINITIONS FOR BAD DEBT CHARGES AND CHARITY CHARGES IN ITEMS 1 AND 2 ARE SPECIFIC TO THE DSH PROGRAM AND ARE DIFFERENT FROM THE AHA DEFINITIONS (pages 16 and 18). The complete DSH program rules are found in 1 Texas Administrative Code §355.8065. Please call the Bureau of Reimbursement Analysis and Contract Compliance at (512) 491-1367 or (512) 491-1368 if you have questions about this section or the Medicaid DSH Program.

1. INPATIENT AND OUTPATIENT BAD DEBT CHARGES

a. Inpatient Bad Debt charges .... $ ________

b. Outpatient Bad Debt charges .... $ ________

c. **TOTAL BAD DEBT CHARGES** (please add lines a and b) .... $ ________

d. Bad debt from uninsured patients........ $ ________

(1) Inpatient bad charges from uninsured patients .... $ ________

(a) Inpatient bad debt charges from uninsured patients meeting trauma eligibility........ $ ________

(2) Outpatient bad debt charges from uninsured patients .... $ ________

(1) Outpatient bad debt charges from uninsured patients meeting trauma eligibility........ $ ________

(3) State government payments .... $ ________

(4) Local government payments .... $ ________

(5) Patient payments........ $ ________

(6) Other third party payments........ $ ________

e. Bad debt from partially insured patients .... $ ________

(1) Inpatient bad debt charges from partially insured patients .... $ ________

(a) Inpatient bad debt charges from partially insured patients meeting trauma eligibility .... $ ________

(2) Outpatient charges from partially insured patients........ $ ________

(a) Outpatient bad debt charges from partially insured patients meeting trauma eligibility .... $ ________

(3) Private insurance payments from partially insured patients .... $ ________

(4) Patient payments from partially insured patients .... $ ________

(5) Other third party payments from partially insured patients .... $ ________

2. INPATIENT AND OUTPATIENT CHARITY CHARGES

a. Inpatient Charity charges........ $ ________

(1) Inpatient charity charges meeting trauma eligibility .... $ ________

b. Outpatient Charity charges........ $ ________

(1) Outpatient charity changes meeting trauma eligibility........ $ ________

c. **TOTAL CHARITY CHARGES** (please add lines a and b) .... $ ________

d. State government payments for specific charity patients........ $ ________

e. Local government payments for specific charity patients........ $ ________

f. Private insurance payments for charity patients........ $ ________

g. Patient payments for charity care .... $ ________

h. Other third party payments for charity care patients .... $ ________

i. Federal Poverty Level percentage for eligibility as financially indigent .... % ________

SECTION I
DEFINITIONS APPLICABLE TO SECTION I CONCERNING THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM
Instructions and Definitions

Please use the following definitions in completing Section I:

Charity Care: The unreimbursed cost to a hospital of providing, funding or otherwise financially supporting healthcare services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent or providing, funding or otherwise financially supporting healthcare services provided to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

Bad Debt charges: Uncollectible inpatient and outpatient charges that result from the extension of credit.

Charity charges: 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.

Financially indigent: 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: A person whose medical or hospital bills after payment by third-party payers 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.

Uninsured or self pay: Include charges for those patients who (1) do not qualify for a government program, (2) have no private or third party insurance, (3) do not qualify for free or reduced price care under the hospital's eligibility system developed in compliance with Health and Safety Code Ch. 311, and (4) do not pay the full cost of their care. Exclude inmates or prisoners.

Partially insured: Include cases where there is an unpaid patient balance after insurance at the time of reporting.

Charges for patients meeting trauma eligibility. The portion of hospital-based charges that is eligible for consideration in the state trauma reimbursement program. These charges are for care provided to patients who met the facility's trauma team activation criteria and/or were entered into the facility's Trauma Registry and underwent treatment as specified in the Texas Administrative Code §157.131. These charges should be reported on a hospital fiscal year basis. Reporting is optional for those hospitals that are not eligible for reimbursement in the state trauma program.

State payments: Include payments received from the State of Texas associated with particular individuals. Examples include, but are not limited, to Crime Victims Compensation, Kidney Health, Children with Special Health Care Needs, and burn victims. Lump sum payments that are made for care provided to groups of patients (such as trauma funding) should be reported in the appropriate places in Sections J and L.

Local payments: Includes payments received from local governments for specific patients. Excludes payments for public sector employees' care.

Other third party payments: Includes other third party payments received on behalf of patients. Examples include, but are not limited, to workers' compensation and auto insurance.

Patient payments: Includes payments received from the patient or their family.

Private insurance payments: Includes payments received from third party health insurance.

I.3.a. Local Government Inpatient: Payments received for inpatient hospital services that were provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental program. DO NOT include tax revenue or care which was provided under your facility's charity care policy, e.g., hospital district patients.

I.3.b State Government Inpatient: Payments received for inpatient hospital services which were the responsibility of a unit of state government such as the Children with Special Health Care Needs, and the Kidney Health Program, and state trauma funds, etc.

I.4.a. Newborn Days: Report the number of inpatient days for normal newborn nursery. DO NOT include neonatal intensive or intermediate care inpatient days.

I.4.b. Swing Bed Services: A hospital bed that can be used to provide either acute or long-term care depending on community or patient needs. To be eligible a hospital must have a Medicare provider agreement in place, have fewer than 100 beds, be located in a rural area, do not have a 24 hour nursing service waiver in effect, have not been terminated from the program in the prior two years, and meet various service conditions.

3. PAYMENTS RECEIVED FOR INPATIENT CARE FROM OTHER GOVERNMENTAL SOURCES — **PAYMENTS RECEIVED**
Exclude Medicaid Payments

a. Local Government - Inpatient Care Only (County, City) .... $ ________

b. State Government - Inpatient Care Only (CSHCN, Kidney Health Care, etc.) .... $ ________

4. INPATIENT DAYS — **INPATIENT DAYS**

a. Please report the total number of newborn nursery days .... ________
b. Please report the total number of swing bed inpatient days that the swing beds were used in the provision of swing services........ ________

5. NON-TEXAS RESIDENT MEDICAID ELIGIBLE PATIENTS
Please report the total number of inpatient days attributable to individuals eligible for Medicaid in another state (please exclude Medicaid days reported in D.2.d.1 on page 15)........ ________

J. OTHER FINANCIAL AND UTILIZATION DATA (Please see the definitions on page 26 in completing this section.)

1. FINANCIAL DATA

a. TOTAL GROSS PATIENT SERVICE REVENUE FROM SELECTED GOVERNMENT SOURCES — **GROSS SOURCES OF REVENUE**

(1) Medicaid (including Inpatient and Outpatient)

(a) Non-Managed Care Medicaid .... $ ________

(b) Medicaid Managed Care. .... $ ________
(c) TOTAL MEDICAID (please add lines a through b - Must equal D.6.a.2.c.(1) on page 17)........ $ ________

(2) Other Government Sources of Revenue (including Inpatient and Outpatient)

(a) Local Government (County, City)........ $ ________

(b) State Government (CSHCN, Kidney Health Care, CHIP, etc.)........ $ ________

(c) Other Government (CHAMPUS, etc., please specify: (________) ... $ ________
(d) TOTAL Other Government (please add lines a through c - Must equal D.6.a.3. (1) on page 17)........ $

b. NET PATIENT SERVICE REVENUE FROM SELECTED GOVERNMENT SOURCES — **NET SOURCES OF REVENUE**

(1) Trauma .... $ ________

(2) Tobacco Settlement .... $ ________

(3) Kidney Health. .... $ ________

(4) Children with Special Health Care Needs........ $ ________

(5) Crime Victims .... $ ________

(6) Local Government

(a) County Indigent: .... $ ________

(b) Hospital District: .... $ ________

(c) City/County Government: .... $ ________

(7) Federal government .... $ ________

(8) Other government revenue (please specify: ________)........ $ ________

c. Medicaid Disproportionate Share Hospital Payments (DSH)........ $ ________

d. UPPER PAYNENT LIMIT RECEIPTS .... $ ________

e. TOTAL ASSETS AND LIABILITIES — **ASSETS/ LIABILITIES**

(1) Please report the amount of total hospital assets. .... $ ________

(2) Please report the amount of total hospital liabilities and fund balance .... $ ________

f. CHARITABLE CONTRIBUTIONS — **CHARITABLE CONTRIBUTIONS**
Indicate charitable contributions received by your hospital during this fiscal year (exclude contributions which are restricted to capital expenditure usage)........ $ ________

SECTION J
OTHER FINANCIAL AND UTILIZATION DATA
Instructions and Definitions

Account for all hospital admissions and patient days by the sources indicated. Exclude newborn utilization.

Please use the following definitions in completing Section J:

Local Government: Inpatient and Outpatient hospital services that were provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental program. DO NOT include care which was provided under your facility's charity care policy, e.g., hospital district patients.

State Government: Inpatient and Outpatient patient hospital services which were the responsibility of a unit of state government such as the Children with Special Health Care Needs, and the Kidney Health Program, etc.

Self Pay: Hospital services for patients without any form of health insurance coverage, or hospital services not covered by a given patient's insurance.

Third Party Payor: Hospital services which were the responsibility of Blue Cross/Blue Shield and other commercial and /or private insurers.

Managed Care: Systems that integrate the financing and delivery of healthcare services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to covered individuals, explicit criteria for the selection of participating health-care providers, differential coverage or payments of financial incentives for covered individuals to use providers and procedures associated with the plan and formal programs for quality assurance and utilization review.

Trauma: Funds provided by the Department of State Health Services from the Trauma Facility and Emergency Medical Services account.

Tobacco settlement: Funds provided from the master settlement agreement with tobacco companies for local governments and hospitals.

Kidney Health: Funds provided from the Kidney Health program at the Department of State Health Services.

Children with Special Health Care Needs: Funds provided from the CSHCN program at the Department of State Health Services.

Crime Victims: Include funds provided by the Office of Attorney General from the Crime Victims Compensation Fund for patient care of eligible crime victims.

Hospital district: Funding from the hospital district's tax revenue for the support of the hospital.

Federal government: Funding for care of undocumented persons provide by Section 1011 of the Medicare Modernization Act and other federal funds, excluding research grants, provided directly by the federal government to the hospital Examples include but are not limited to Title V and Ryan White funds. **Exclude Medicare**.

State programs: Programs such as the Children's Health Insurance Program and the Kidney Health Program, where the State of Texas pays for care or provides insurance based on specific medical conditions and/or financial need. This section includes care provided to state inmates or prisoners. **Exclude Medicaid.**

Local Programs: Include County Indigent Health Care that covers all those under 21 percent Federal Poverty Level (FPL) who are not eligible for Medicaid. Also include other programs where a unit of local government pays for the care or provides insurance based on specific medical conditions and/or financial need. **Exclude** public sector employees' care and related payments. This section includes care provided to local inmates or prisoners.

Medicare/CHAMPUS: Include charges for persons enrolled in the federal Medicare program under Title XVIII of the Social Security Act. Enrollees are typically elderly or the disabled. May also include other governmental health programs that do not require meeting indigency or other financial eligibility criteria. **Exclude Medicaid.** Medicare payments should include all patient specific payments for Medicare patients, including interim rates for Medicare Disproportionate Share, Medicare GME and Medicare IME.

L. CHARITY CARE AND COMMUNITY BENEFITS INFORMATION (continued)

(4) *Community health education through informational programs, publications, and outreach activities in response to community needs.*

(a) TOTAL AVAILABLE FUNDS .... $ ______________

(b) LESS TOTAL EXPENSES .... $ ______________

(c) TOTAL NET FUNDS [Item 4d(4)(a) - item 4d(4)(b)] .... $ ______________

(5) *Other educational services that satisfy the definition of "education-related costs"*

(a) TOTAL AVAILABLE FUNDS. .... $ ______________

(b) LESS TOTAL EXPENSES .... $ ______________

(c) TOTAL NET FUNDS [Item 4d(5)(a) - item 4d(5)(b)] .... $ ______________

5. STATE INDIGENT HEALTH PROGRAMS (Optional for hospitals completing worksheet 3 of the Annual Statement of Community Benefits)

a. Inpatient charges for state indigent health programs .... $ ______________

b. Outpatient charges for state indigent health programs .... $ ______________

c. State government payments .... $ ______________

d. Private insurance payments for patients in state indigent health programs .... $ ______________

e. Patient payments from patients in state indigent health programs .... $ ______________

f. Other third party payments for patients in local indigent health programs .... $ ______________

6. LOCAL INDIGENT HEALTH PROGRAMS (Optional for hospitals completing worksheet 3 of the Annual Statement of Community Benefits)

a. Inpatient charges for local indigent health programs .... $ ______________

b. Outpatient charges for local indigent health programs .... $ ______________

c. Local government payments for patients in local indigent health programs .... $ ______________

d. Private insurance payments for patients in local indigent health programs .... $ ______________

e. Patient payments from local indigent health programs $ ______________

f. Other third party payments for patients in local indigent health programs $ ______________

7. MEDICARE/CHAMPUS (Optional for hospitals completing worksheet 4-B of the Annual Statement of Community Benefit)

a. Inpatient charges fro federally supported health programs $ ______________

b. Outpatient charges for federally supported health programs $ ______________

c. Medicare payments, other federal payments $ ______________

d. Private insurance payments patients in federally supported health programs $ ______________

e. Patient payments from patients in federally supported health programs $ ______________

f. Other third party payments for patients in federally supported health programs $ ______________

8. LUMP SUM FUNDING

a. Medicare supplemental payments $ ______________

b. Tax revenue (should equal 1 minus 2 minus 3 minus 4 from below) $ ______________

1. Initial tax revenue receipts $ ______________
2. Intergovernmental transfers for DSH $ ______________
3. Intergovernmental transfers for UPL $ ______________
4. Other IGTs for Medicaid $ ______________

c. Collections from patients previously reported as uncompensated $ ______________

1. Collections from trauma patients previously reported as uncompensated $ ______________

SECTION L CHARITY CARE AND COMMUNITY BENEFITS INFORMATION (Definitions continued)

8a Medicare supplemental payments: Report reconciling or settle-up payments received from the federal government for the Medicare Program received during the reporting period, regardless of the data of service.

8b. Tax revenue: Public hospitals shall report tax revenue or collections, less any intergovernmental transfers (IGTs) in support of Medicaid payments.

8b1 Initial tax revenue: Initial tax revenue assessed and collected by the hospital or appropriated to the hospital.

8b2 Intergovernmental transfers for DSH: Tax revenues used as intergovernmental transfers (IGTs) to the state in support of the Disproportionate Share Hospital (DSH) program in Medicaid, if applicable.

8b3 Intergovernmental transfers for UPL: Tax revenues used as intergovernmental transfers (IGTs) to the state in support of the Upper Payment Limit (UPL) programs, if applicable.

8b4 Other IGTs: Tax revenues used as intergovernmental transfers (IGTs) to the state to be used as match in federal funding programs, excluding DSH and UPL. Report only if applicable.

8c. Collections from patients previously reported as uncompensated: Payments from the patients whose care was reported as uncompensated (charity, self-pay/uninsured, or partially insured) received after reporting information to the state, regardless of the year of service. These amounts will not be used to recalculate prior year(s) residual uncompensated care but are considered available revenue to offset the cost of care provided to other patients in the current reporting period.

8c1 Collections from patients meeting trauma eligibility previously reported as uncompensated: Payments from patients whose care was reported as uncompensated (charity, bad debt, uninsured/self-pay and/or partially insured) and eligible for reimbursement under the state trauma program received after reporting information to the state, regardless of the date of service. These payments are considered available revenue to offset the cost of care provided to trauma patients in the current reporting period.