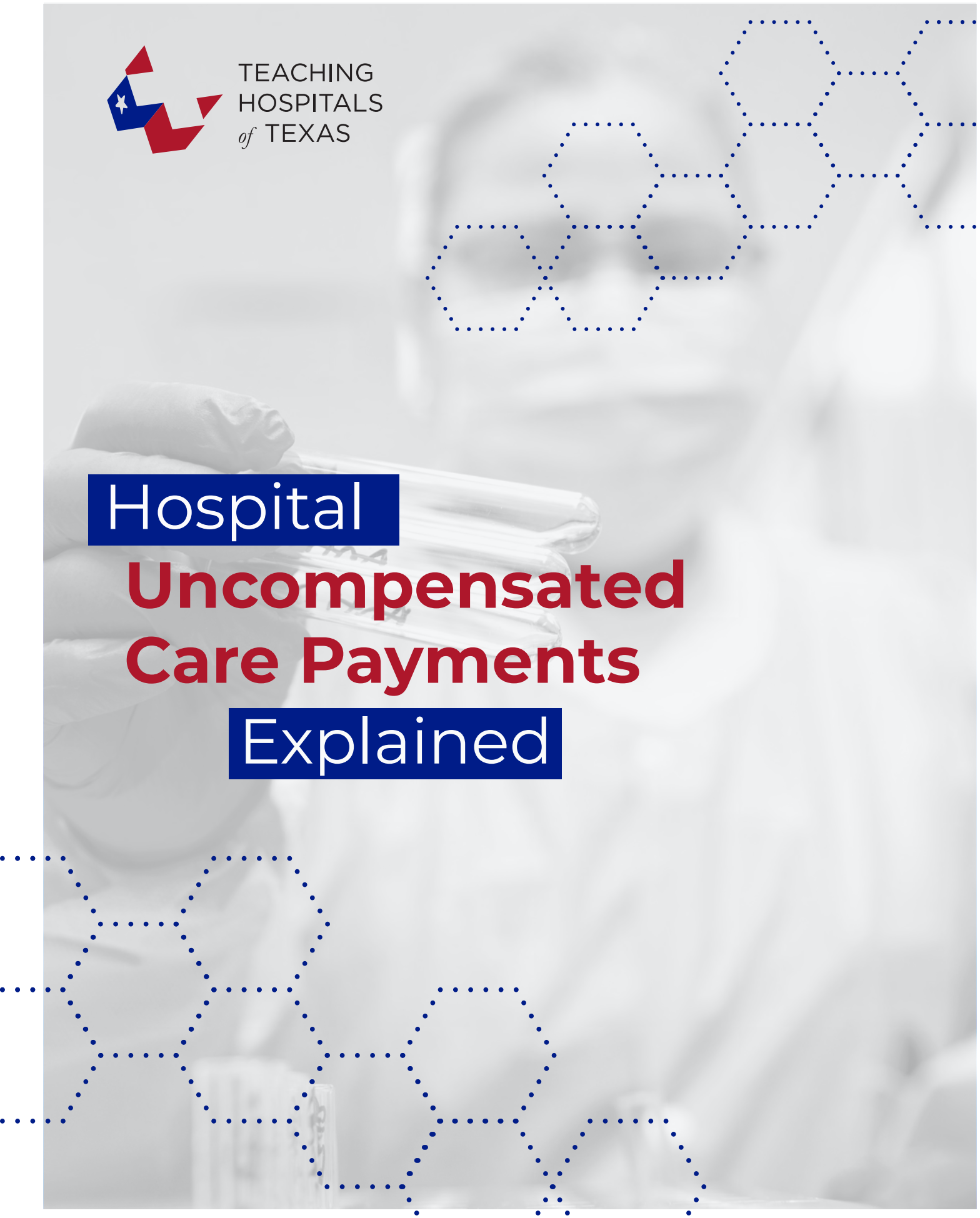
TEACHING HOSPITALS of TEXAS

Hospital Uncompensated Care Payments Explained



Since the 2011 creation of Texas' Medicaid 1115 Waiver, the hospital Uncompensated Care (UC) payment program has made more than $38 billion in payments potentially available to Texas' public and private hospitals to offset some of their unreimbursed charity care costs. Texas hospitals reported $7 billion in unreimbursed charity care costs in 2021 alone. As the number of uninsured Texans remains persistently high – currently 21.4 percent of the population, or 5.2 million – UC payments to offset some of the costs of their care are essential.

Effective October 1, 2019, CMS limited hospitals' eligible UC costs to charity care costs only. As a result, hospitals' Medicaid shortfall and bad debt are no longer eligible costs, and the UC program is now the only supplemental payment program dedicated to offsetting hospitals' costs associated with care for the uninsured.

The future of this vital program, however, is uncertain for two reasons. First, because the Centers for Medicare & Medicaid Services decided in April 2021 to rescind previously granted approval of the 1115 Waiver's continuation, without an extension or waiver approval, the UC program will end September 30, 2022. Second, a provision in the Build Back Better Act being considered by Congress proposes to limit UC pools in states, like Texas, that have not expanded Medicaid as of October 2022.

Eligibility for UC Payments

In federal fiscal year 2021, 368 hospitals (351 non-state owned and 17 state-owned) qualified for UC payments.

To qualify for UC payments, hospitals must be enrolled as a Texas Medicaid provider and submit an uncompensated care application – a form prescribed by the Texas Health and Human Services Commission (THHSC) to identify uncompensated costs for Medicaid-enrolled providers – to THHSC by its established due date.

Definition, Intent, and Statutory Requirements

Texas' Medicaid 1115 Waiver, approved in October 2011, created the hospital UC program. With the waiver's authorization of statewide mandatory managed care enrollment for Medicaid recipients, the UC program replaced the previous hospital fee-for-service Upper Payment Limit program. Under the waiver, hospitals and certain non-hospital providers qualified for UC payments. [1]

Qualifying unreimbursed costs originally included:

- The uncompensated costs of care for Medicaid-eligible patients due to lower-than-cost Medicaid payment rates. The uncompensated costs of care for Medicaid-eligible patients are the difference between the allowable cost ofproviding the service and the Medicaid payment for the service and is known as the Medicaid shortfall. On average, state-funded Medicaid rates cover just two-thirds of the cost of care.
- Bad debt, defined as costs resulting when a patient who has been determined to have the financial capacity to pay for health care services is unwilling to settle the claim.
- The uncompensated costs of care for patients without health insurance.

[1] Qualifying non-hospital providers include: physician practice groups (grandfathered), government ambulance providers, and government dental providers.

[2] i.e., charity care defined as the costs of care for Texans enrolled in a hospital's charity care program.

Funding of the Non-federal Share of UC Payments

As a supplemental payment authorized under the Medicaid program, uncompensated care payments must be funded with both federal and non-federal funds. Federal funds are not available without submission of required non-federal funds. The non-federal share of Texas hospitals' UC payments is provided through intergovernmental transfers (IGT) of funds from public entities, typically taxing hospital districts, and local provider participation funds (LPPF).

In August 2018, the U.S. Department of Health and Human Services' Departmental Appeals Board ruled that a hospital's receipt of UC payments may not be tied to its provision of IGT funds. As a result, there is the risk of "free riders" if one or more IGT entities does not contribute its required non-federal share. To mitigate this risk, IGT requirements for non-state-owned hospitals are divided into sub-pools based on designated Medicaid service delivery area (SDA). If the IGT entities within an SDA do not transfer required funds, UC payments to all hospitals in that SDA are reduced on a pro-rata basis to levels supported by the IGTs. While this approach reduces the risk of "free riders," the risk is not eliminated.

Hospital-Specific Payment Limits

An individual hospital's UC payments are limited to its unreimbursed charity care costs.[3] In addition, UC payments received by a hospital count as Medicaid revenue and, therefore, must be included as offsetting revenue in annual disproportionate share hospital (DSH) audit reports to the state. Hospitals receiving both DSH and UC payments cannot receive total payments (DSH + UC) that exceed their total eligible inpatient and outpatient uncompensated costs.

[3] UC limited to charity care only

[4] Submitted October 2021 by HHSC to CMS.

UC Payment Pool Size

The 1115 Waiver establishes the maximum amount of UC payments, known as the UC pool, for each waiver demonstration year (DY). While Texas health care providers' UC costs consistently exceed the available UC pool size, UC payments for a specific program year may not exceed the UC pool size for that same year. In addition, no matter the pool size, actual payments to providers are contingent on the availability of IGT funds.

DY 1 FFY 2012	DY 2 FFY 2013	DY3 FFY 2014	DY4 FFY 2015	DY 5 – DY 8 FFY 2016-2019	DY 9 – DY 11 FFY 2020-2022[3]	DY 12 – DY 16 FFY 2023-2027
$3.7 billion	$3.9 billion	$3.534 billion	$3.348 billion	$3.1 billion	$3.873 billion	$4.5 billion

*Amount requested by THHSC but not yet approved by CMS.

UC Payment Distribution Methodology

- A hospital's maximum UC payment equals its charity care costs minus the DSH payments it receives to offset charity care costs. The maximum UC payment for each of the five large public hospitals[5] that provide IGT funding for private hospitals' DSH payments is increased by the IGT they contribute to support DSH payments.
- Hospitals eligible for both DSH and UC payments cannot receive total UC and DSH payments that exceed their total eligible uncompensated costs (Medicaid shortfall + bad debt + charity care).
- The UC pool is divided among health care providers: state-owned hospitals, non-state-owned hospitals, physician group practices, governmental ambulance providers, and publicly owned dental providers.
- If the total UC costs from any group of providers exceed that group's pool size, payment amounts for providers in that group are reduced proportionally so payments do not exceed the pool size.
- Within the non-state-owned hospital pool, rural hospitals are guaranteed total UC payments at least equal to their FFY 2020 (DY 9) aggregate payments.

[5] Parkland Health in Dallas, Harris Health in Houston, University Health in San Antonio, UMC El Paso, and John Peter Smith in Fort Worth provide IGT to support private hospital DSH payments.

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