

Improvements to Medicare Disproportionate Share Hospital (DSH) Payments

Final Report

HHSM-500-2011-00014I; Task Order: HHSM-500-TO001

Dobson | DaVanzo

KING
HEALTH
CONSULTING LLC

Improvements to Medicare Disproportionate Share Hospital (DSH) Payments

Final Report

HHSM-500-2011-00014I; Task Order: HHSM-500-TO001

Submitted to:

Centers for Medicare & Medicaid Services (CMS)

Nisha Bhat (COTR)

Submitted by:

Dobson | DaVanzo

Allen Dobson, Ph.D.

Audrey El-Gamil

Matt Shimer, Ph.D.

Anne Pick, M.P.H.

Kevin Reuter

Joan E. DaVanzo, Ph.D., M.S.W.



Lane Koenig, Ph.D.

Sheila Sankaran, M.A.

Thursday, May 09, 2013 — *Final Report*

Table of Contents

Executive Summary.....	ES-1
Introduction	1
Overview of Analytic Approach	7
Literature Review of Uncompensated Care Definitions	9
Introduction	9
Methodology	9
Key Findings from Stakeholder Interviews	17
Criteria for Stakeholder Selection and Interview Protocol Development.....	17
Additional Interviews and Technical Meetings.....	18
Cross-Cutting Themes.....	19
Discussion and Conclusions	26
Analysis of the Uninsured Data Sources	30
Analysis of Data Sources and Uninsured Definitions.....	32
Uninsured Estimates from the Congressional Budget Office	36
Comparison of Survey Estimates	37
Comparison of Selected Survey Design Components.....	41
Analysis of the Uncompensated Care Data Sources.....	46
Common Definitions of Uncompensated Care	46
The Role of Medicaid DSH Definition of Uncompensated Care in Determining Hospital-Specific DSH Limits	47
Methods for Identifying Data Sources.....	49
Analysis of Data Sources and Uncompensated Care Definitions.....	50
Impact Analysis of Worksheet S-10 Data	65
Distributional Analysis of Raw Worksheet S-10 Data	66
Methodology for “Cleaning” Worksheet S-10 Data	67
Analysis of “Cleaned” Worksheet S-10 Data	70
Timing and Feasibility of Implementing Available Data Sources	74
Conclusions and Next Steps.....	75

Appendix A: National Provider Call Presentation	A-1
Appendix B: Uncompensated Care Evidence Table	B-1
Appendix C: Stakeholder Interview Protocol.....	C-1
Appendix D: Summary of Key Survey Characteristics.....	D-1
Appendix E: Calculated Statewide Average RCCs	E-1
Appendix F: Release Calendar of Medicare Cost Report	F-1

Executive Summary

Purpose

The Dobson | DaVanzo Team – Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) and KNG Health Consulting LLC, (KNG Health) – was commissioned to provide technical assistance to the Centers for Medicare & Medicaid Services (CMS) as it implements a revised Medicare Inpatient Prospective Payment System (IPPS) disproportionate share hospital (DSH) payment policy (DSH payments) as called for by Section 3133 of the Affordable Care Act of 2010 (ACA). ACA sets forth a set of requirements intended to reduce overall Medicare DSH payments as the number of uninsured falls under the ACA and to better target the remaining DSH payments to hospitals with higher levels of uncompensated care.

This document presents the Dobson | DaVanzo Team's final report, providing background information on calculating DSH payments under Section 3133, analyses of uninsured and uncompensated care data sources that could be used to determine Medicare DSH payments, and a discussion of timing and feasibility issues to inform CMS' drafting of the Medicare DSH sections of the 2014 IPPS Notice of Proposed Rulemaking (NPRM) and Final Rule. We will continue to provide analytic and technical support as CMS drafts the FY 2014 IPPS NPRM and receives comments in preparation for the Final Rule.

Determining Medicare DSH Payments under ACA

Section 3133 of ACA addresses two long-standing critiques of the current Medicare DSH payment policy: 1) Medicare DSH payments exceed their empirically-justified levels; and 2) Medicare DSH payments are not targeted well to hospitals that treat the uninsured. First, Section 3133 requires that, beginning in FY 2014, CMS reduce Medicare DSH payments made under subsection (d)(5)(F) of the Act to 25 percent of what otherwise would have been paid. This represents the empirically justified DSH payment amount

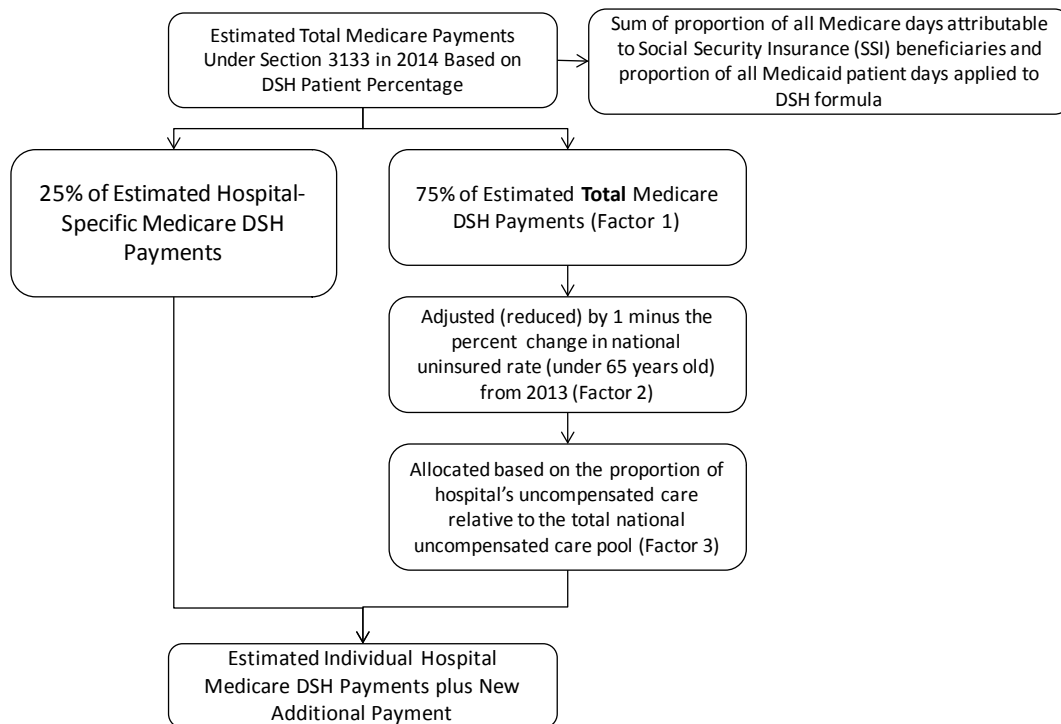
Executive Summary

determined by the Medicare Payment Advisory Commission (MedPAC) in its March 2007 Report to Congress.¹

In addition to reducing Medicare DSH payments as prescribed under 1886(d)(5)(f), the provision requires that CMS provide subsection (d) hospitals an additional payment beginning in FY 2014, which we refer to as “the uncompensated care add-on payment.” This additional payment is linked directly to changes in the national uninsured rate and a hospital’s share of aggregate national uncompensated care costs. Decreases in the uninsured rate would reduce the total amount available for the uncompensated care add-on payment and hospitals with a greater share of the nation’s aggregate uncompensated care costs would receive larger shares of remaining dollars available.

The uncompensated care add-on payment, which determines the new DSH payments for each hospital, is based on the product of three factors, which are presented on the right side of Exhibit ES-1.

Exhibit ES-1: Methodology for Determining Medicare DSH Payments for FY 2014 and Subsequent Years under Section 3133



¹ Medicare Payment Advisory Commission. (2007). Section 2a – inpatient and outpatient hospitals. *Report to the Congress – Medicare Payment Policy*, 72– 79.

Executive Summary

Exhibit Caption: Exhibit ES-1 shows how Medicare DSH payment will be calculated beginning in 2014. First, Medicare DSH payments to a hospital will be estimated using the DSH patient percentage and current formula. The DSH patient percentage is the sum of the proportion of all Medicare days attributable to Social Security Insurance (SSI) beneficiaries and proportion of all Medicaid patient days applied to DSH formula. Beginning in 2014, hospitals will receive 25% of these Medicare DSH Payments. Second, hospitals will receive an additional amount calculated as follows:

- Step 1: Calculate 75% of estimated total Medicare DSH payments, across all hospitals (Factor 1)
- Step 2: Adjust the total DSH payments from step 1 by 1 minus the percent change in national uninsured rate (under 65 years old) from 2013 (Factor 2)
- Step 3: Allocate the adjusted total DSH payments from step 2 to each hospital based on each hospital's uncompensated care costs relative to the total national uncompensated care pool (Factor 3)

The results from Step 3 are added to the 25% of estimated hospital-specific Medicare DSH payments to produce the estimated individual hospital Medicare DSH payment under Section 3133.

Study Methods in Brief

This study consists of three approaches to assess alternative definitions and data sources for measuring uninsured rates and uncompensated care costs:

1. **FOCUSED LITERATURE REVIEW:** to identify definitions of the uninsured and uncompensated care;
2. **STRUCTURED INTERVIEWS:** to seek policy and measurement expertise of stakeholders and survey experts; and
3. **ANALYSIS OF DATA SOURCES AND DEFINITIONS:** to assess strengths and limitations of alternative sources.

The results of these analyses were presented during a National Provider Call. Public comments were reviewed and the Dobson | DaVanzo Team submitted a summary of the comments to CMS to help inform the development of the NPRM. While this report does not explicitly summarize the comments from the National Provider Call, we note findings from the literature and structured interviews that help us interpret comments received during the National Provider Call. Based on the public comments, the Project Team

Executive Summary

conducted impact analyses using the universe of Worksheet S-10s reported within the available FY 2010 and FY 2011 Medicare Cost Reports (MCR) to determine the impact of various definitions of uncompensated care by hospital and hospital type. The results of these analyses are presented in a separate chapter of this report.

Key Findings

The goal of Section 3133 is to reduce the overall amount of Medicare DSH payments, creating a separate additional payment consistent with decreases in the uninsured rate and to target these additional payments to hospitals with a high proportion of uncompensated care. Any modification to the definition of uncompensated care will not increase the aggregate amount of Medicare DSH and additional payments for uncompensated care in the system; rather, it will change the distribution of the available DSH payments. The key driver of aggregate payment reductions is the estimated decrease in the number of uninsured persons, as it reduces the total funds available to hospitals.

Uninsured

- **UNINSURED TIME SERIES DATA ARE NOT COMPLETELY CONSISTENT WITH EACH OTHER:** The five federal surveys examined in this study produce annual national estimates of the uninsured using high-quality sampling and estimation methods. However, each survey has a different focus—some collect labor force and income data, while others collect health data—and, each survey defines “uninsured” differently. Thus, strict comparisons among the surveys are not feasible. In addition, the uninsured data series produced by the surveys differs in magnitude and overall trends. The extent to which measures of change in the uninsured rate will differ between those produced by the Congressional Budget Office (CBO) and those produced through surveys of the uninsured is currently unknown. If the overall trends in the CBO uninsured estimates (which may be used at least until 2017) differ greatly from those found in the survey estimates (which may be used starting in 2018), the decision as to which data source to use starting in 2018 could have a significant impact on the amount of available Medicare DSH funds.

Consistency between Measures of Uninsured and Uncompensated Care Burden

- **EACH OF THE FEDERAL SURVEYS AND CBO USE DIFFERENT DEFINITIONS OF THE UNINSURED:** Some surveys measure whether individuals are uninsured at the time of the survey interview (point-in-time), some measure whether individuals are uninsured for the full year, and some produce multiple measures of the uninsured. A measure that is able to capture the variable nature of health

Executive Summary

insurance coverage would track more closely with uncompensated care costs and thus may be more appropriate for calculating the uncompensated care add-on payment. Point-in-time estimates are more likely to capture uninsured spells and are preferable to estimates based on other definitions. For example, full-year estimates do not capture the movement of individuals in and out of the uninsured pool, and part-year estimates treat those who are uninsured for one month the same as those uninsured for longer periods.

Uncompensated Care

- **AVAILABILITY OF UNCOMPENSATED CARE DATA:** Hospital-level uncompensated care cost data are currently available from Worksheet S-10 for most DSH hospitals for FY 2010 and FY 2011. Worksheet S-10 data are the only primary national data available for individual hospital uncompensated care amounts and thus, and a focus of this report. Other sources of uncompensated care data are either incomplete or not publicly available.
- **STAKEHOLDER CONCERNS REGARDING THE DEFINITION OF UNCOMPENSATED CARE:** We developed a core definition of uncompensated care limited to bad debt and charity care. Findings from stakeholder interviews, however, suggest that **Medicaid and other payer underpayments** could be considered for inclusion in the definition, as these shortfalls represent non-payment for low-income populations. However, there are several compelling reasons against including Medicaid underpayments in the Section 3133 definition of uncompensated care, such as: 1) lack of consistency with the Government Accountability Office (GAO), American Hospital Association (AHA), and MedPAC's advancement of the more narrow definition of uncompensated care;^{2,3,4,5} 2) using Medicare funds to cross-subsidize Medicaid underpayments; 3) reallocating funds toward hospitals with high Medicaid payer mix and low Medicaid payments, and away from hospitals with high uninsured payer mix; 4) lack of transparency in actual Medicaid underpayments net of supplemental funding; and 5) potential reduction in Medicaid shortfall due to proposed expansion of the uncompensated care definition as it relates to the Medicaid DSH hospital-specific limit.

² Walker DM. (2005). Testimony before the Committee on Ways and Means, House of Representatives – nonprofit, for-profit and government hospitals: uncompensated care and other community benefits. Government Accountability Office (GAO), 1.

³ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁴ Hackbarth G. (2009). Medicare Payment Advisory Commission (Letter to M Shortt re: Document identifier CMS-2552-10).

⁵ Atkinson G, Helms WD, Needleman J. (1997). State trends in hospital uncompensated care. *Health Affairs*, 233.

Executive Summary

On the other hand, one reason to include Medicaid shortfalls is that the current Medicare DSH payments are, in part, influenced by Medicaid days. Thus, the use of Medicaid shortfalls in the definition of uncompensated care could reduce the redistributive effects of Section 3133 DSH payments. This would need to be balanced against the legislative intent that Section 3133 DSH payments should be better targeted. CMS will need to decide, from a policy perspective, if a broader definition of uncompensated care is appropriate, and if so, how it should be defined.

Stakeholders also recommended using the **total hospital ratio of cost-to-charges** (RCC) to convert uncompensated care charges into costs. They felt this was more appropriate than using the Medicare-allowable RCC, as the uncompensated care costs are not generally associated with Medicare beneficiaries. Many stakeholders also wanted to include direct graduate medical education (DGME) costs in the RCC to better reflect overall hospital costs.

Impact Analyses of Using Worksheet S-10 Data

The Dobson | DaVanzo Team analyzed the publicly available Worksheet S-10 data for FY 2010 and FY 2011 to estimate the impact of the Section 3133 DSH policy by individual hospital, state, and hospital type if CMS were to use Worksheet S-10 data to determine the uncompensated care add-on payment. The results of this analysis indicated that there are some anomalous hospitals that have reported uncompensated care costs that are significantly skewed relative to other hospitals or to their own reported Medicare DSH payments from 2010. A “double-trim” approach to adjust an extreme RCC corrects for most of the extreme cases and results in a distribution of payments that closely mirrors the concentration of payments to hospitals under the current DSH system in aggregate (although the hospitals that receive the payments differ). However, even with the trimmed data, use of the Worksheet S-10 data could produce disproportionate shares of DSH payments for select states and hospital types under either definition of uncompensated care – bad debt and charity care (Line 30) or bad debt, charity care, and payment shortfalls (Line 31).

Timing and Feasibility of Implementing Available Data Sources in FY 2014

In addition to the qualitative findings on the data sources for uninsured estimates and uncompensated care data, a critical determinant of which data sources would be most appropriate for the development of the FY 2014 IPPS NRPM and Final Rules will be timing. Each data source has its own schedule for data collection, processing, and release. Those sources with longer durations between the data collection phase and the release date

Executive Summary

will be less feasible for the purpose of determining the uncompensated care add-on payment. As CMS determines how to implement the uncompensated care add-on payment starting in FY 2014, these timing issues will need to be considered along with the qualitative aspects of each data source.

Next Steps

Following the completion of the National Provider Call and the synthesis of the public comments, the Project Team provided technical assistance for the development of the 2014 IPPS NPRM and is prepared to provide technical assistance for the development of the Final Rule. In addition to the impact analyses presented in this report, the Dobson | DaVanzo Team worked with CMS to model alternative definitions of uncompensated care using the Worksheet S-10 and to determine the impacts by hospital, state, and hospital type. The Dobson | DaVanzo Team also determined the predicted change in the number of uninsured between 2013 and 2014 using CBO estimates to determine the size of the add-on payment pool in 2014. Upon the release of the 2014 NPRM, we will also assist CMS in responding to public comments.

Introduction

The purpose of this project is to provide technical assistance to the Centers for Medicare & Medicaid Services (CMS) as it implements a revised Medicare Inpatient Prospective Payment System (IPPS) disproportionate share hospital (DSH) payment policy (DSH payments) as called for by Section 3133 of the Affordable Care Act of 2010 (ACA). The ACA sets forth a set of requirements intended to: 1) reduce overall Medicare DSH payments, 2) create funding to be distributed to DSH hospitals as the number of uninsured falls under the ACA, and 3) target this funding to hospitals with higher levels of uncompensated care. These objectives reflect the expectation that provisions in ACA should reduce the need for Medicare DSH payments with the expansion of insurance coverage and commensurate reductions in uncompensated care. Further, empirical findings demonstrate that existing Medicare DSH payments are too large in aggregate, and are not well-targeted at the individual hospital level.

The Dobson | DaVanzo Team – Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) and KNG Health Consulting, LLC (KNG Health) – was awarded a contract under HHSM-500-2011-00014I; task order HHSM-500-TO001 to conduct this study. Dobson | DaVanzo has taken lead responsibility for the uncompensated care analyses and impact analyses, and KNG Health has taken lead responsibility for the uninsured analyses.

This document presents the Dobson | DaVanzo Team's final report to provide background information to assist CMS in drafting the Medicare DSH sections of the FY 2014 IPPS NPRM and will serve as a resource for the Medicare DSH rulemaking process in later years. The document focuses on our assessment of alternative definitions, measures, and data sources for: 1) the rate of uninsured individuals under the age of 65 years, and 2) hospital-specific uncompensated care costs. The validity of our analyses has been informed through feedback from CMS program staff and the CMS Office of the General Counsel, fact-finding interviews with Congressional Budget Office (CBO) and CMS Medicare Cost Report (MCR) experts, and a series of interviews with stakeholders and

survey experts. Being able to identify the strengths and limitations of alternative definitions and data sources will help to inform CMS as it drafts the relevant sections of the FY 2014 IPPS Proposed and Final Rules. The presentation used to guide the National Provider Call is attached to this report for further reference (referred to as Appendix A, but attached separately).

1. Current Medicare DSH Payment Policies

Current Medicare DSH payment policies have long been questioned due to their alleged lack of payment accuracy at the individual hospital level, and more fundamentally, for their lack of an empirical foundation. Past research determined that Medicare costs-per-case are not well related to empirical indicators of the use of inpatient hospital care by the low-income population.⁶ Despite the lack of an explicit empirical foundation, Medicare has made DSH payments to hospitals serving large numbers of low-income patients since 1986 on the policy justification that low-income populations are more costly to treat, therefore hospitals with more low-income patients cost Medicare more per case. Exhibit 1.1 shows Medicare DSH payment rules, all of which are driven by the disproportionate patient percentage (DPP).⁷

Exhibit 1.1: Current DSH Adjustment Formulas for Operating Payments

Hospital qualifies if:	Percentage adjustment Formula	Percentage adjustment Cap
Low-income patient share is 15% to 20.2%	2.5% + 0.65 times portion of share over 15%	None
Low-income patient share is more than 20.2%: Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, and rural referral centers	5.88% + 0.825 times portion of share over 20.2%	None
All others	5.88% + 0.825 times portion of share over 20.2%	12%
Special provision: 30% of net patient revenue (excluding Medicare/ Medicaid) is obtained from state/local government subsidies	35%	None

Source: Medicare Payment Advisory Commission (MedPAC). (2007) Inpatient and Outpatient Hospitals. Report to the Congress – Medicare Payment Policy, p. 72.

The Medicare Payment Advisory Commission (MedPAC) has recently observed that Medicare DSH payments are not well-targeted to an individual hospital's level of

⁶ Unpublished HCFA (now CMS) Office of Research analyses led by Dr. Dobson shortly after the enactment of IPPS in the early 1980's.

⁷ DPP = [Medicare SSI Days/ Total Medicare Days] + [Medicaid, Non Medicare Days/Total Patient Days].

uncompensated care and are too large relative to empirical estimates. MedPAC has found a positive cost relationship between Medicare DSH measures and Medicare cost-per-case only for urban hospitals with 100 beds or more, suggesting a weak relationship between Medicare DSH payment policy and aggregate hospital treatment of low-income populations.⁸ In addition, MedPAC has noted on frequent occasions that hospitals receiving Medicare DSH payments have higher Medicare margins than community hospitals not receiving these payments. These findings may indicate an inefficient use of Medicare Trust Fund expenditures, as many hospitals may be disadvantaged at the expense of hospitals receiving Medicare DSH payments.

2. ACA Section 3133: Medicare DSH Payment Policy Revisions

Section 3133 of the ACA amends the Medicare DSH portion of the Medicare statute at 1886(d)(5)(F). First, Section 3133 requires that, beginning in FY 2014, CMS reduce Medicare DSH payments made under subsection (d)(5)(F) of the Act to 25 percent of what otherwise would have been paid. This represents the empirically justified DSH payment amount determined by MedPAC in its March 2007 Report to Congress.⁹

In addition to reducing Medicare DSH payments as prescribed under 1886(d)(5)(f), the provision requires that CMS provide subsection (d) hospitals¹⁰ an additional payment beginning in FY 2014 which we refer to as “the uncompensated care add-on payment.” Commenters from the National Provider Call have requested CMS to explicitly comment on the question of what hospitals will be eligible for the add-on payment. The uncompensated care add-on payment is based on the product of three factors:

- Factor 1: Seventy-five (75) percent of estimated DSH payments that would otherwise be made under subsection (d)(5)(F) before the reduction of 25 percent.
- Factor 2: One minus the percent change in percent of uninsured individuals who are under the age of 65 between the most recent year for which data are available and 2013.
- Factor 3: A hospital’s uncompensated care relative to the uncompensated care for all subsection (d) hospitals receiving payments under subsection (d)(5)(F).

⁸ Medicare Payment Advisory Commission. (2007). Section 2a – inpatient and outpatient hospitals. *Report to the Congress – Medicare Payment Policy*, 72– 79.

⁹ Medicare Payment Advisory Commission. (2007). Section 2a – inpatient and outpatient hospitals. *Report to the Congress – Medicare Payment Policy*, 72– 79.

¹⁰ “Subsection (d) hospitals” are general, acute care, short-term hospitals in 50 states and DC. These hospitals are defined in Section 1886 of the Social Security Act as which hospitals are excluded rather than included: (a) psychiatric hospitals, (b) rehabilitation hospitals, (c) hospitals with a majority of patients ≤18 years old, (d) hospitals with average patient stays ≥ 25 days, and (e) comprehensive cancer or clinical cancer research centers as recognized by the National Cancer Institute of the National Institutes of Health.

Introduction

According to Section 3133 (2)(B)(i), for FY 2014 through FY 2017, Factor 2 is to be based on the percent of uninsured individuals as calculated by the Secretary based on the most recent estimates available, with the 2013 numbers coming from CBO's March 20, 2010 letter to Representative Nancy Pelosi and estimates for each of the subsequent years until FY 2017 coming from the latest estimates available from CBO in those years. Following the National Provider Call, participants expressed the need for clarity from CMS, through the FY 2014 NPRM process, on the specific CBO sources for the years 2013 and 2014. According to Section 3133 (2)(B)(ii), for FY 2018 and beyond, Factor 2 is to be based on estimates by the Secretary based on data from the U.S. Census Bureau, or other sources the Secretary determines to be appropriate, and certified by the Chief Actuary of CMS.

Exhibit 1.2 illustrates how DSH payments under Section 3133 will be determined, based on the three factors described above.

Exhibit 1.2: Methodology for Determining Medicare DSH Payments for FY 2014 and Subsequent Years under Section 3133

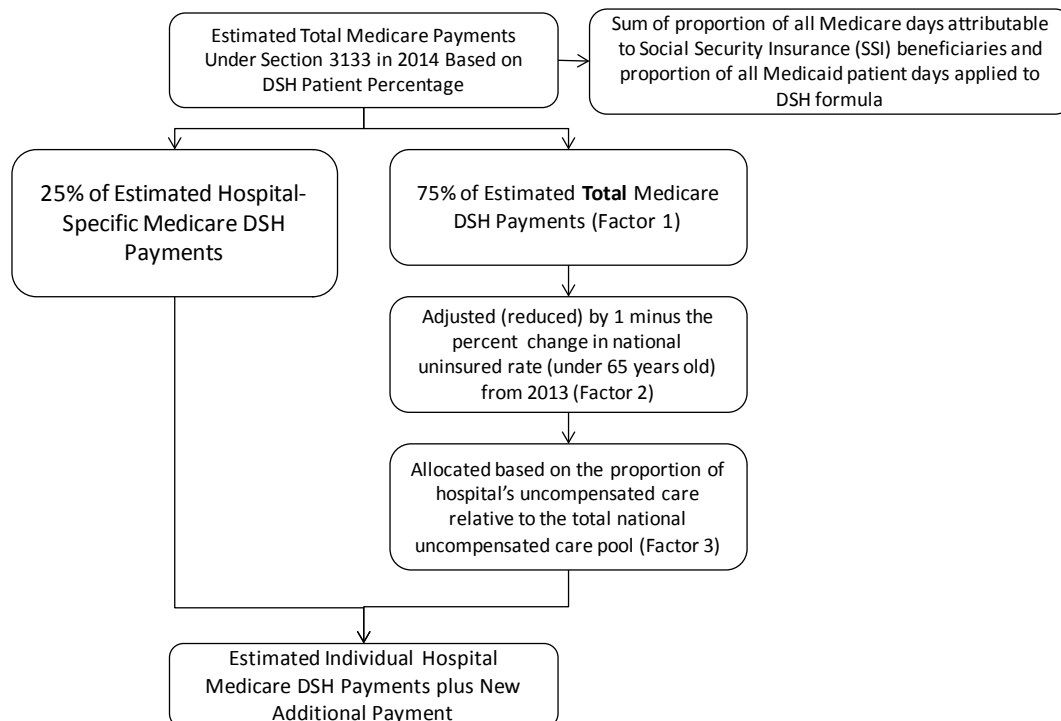


Exhibit Caption: Exhibit ES-1 shows how Medicare DSH payment will be calculated beginning in 2014. First, Medicare DSH payments to a hospital will be estimated using the DSH patient percentage and current formula. The DSH patient percentage is the sum of the proportion of all Medicare days attributable to Social Security Insurance (SSI) beneficiaries and proportion of all

Introduction

Medicaid patient days applied to DSH formula. Beginning in 2014, hospitals will receive 25% of these Medicare DSH Payments. Second, hospitals will receive an additional amount calculated as follows:

- Step 1: Calculate 75% of estimated total Medicare DSH payments, across all hospitals (Factor 1)
- Step 2: Adjust the total DSH payments from step 1 by 1 minus the percent change in national uninsured rate (under 65 years old) from 2013 (Factor 2)
- Step 3: Allocate the adjusted total DSH payments from step 2 to each hospital based on each hospital's uncompensated care costs relative to the total national uncompensated care pool (Factor 3)

The results from Step 3 are added to the 25% of estimated hospital-specific Medicare DSH payments to produce the estimated individual hospital Medicare DSH payment under Section 3133.

The implementation of the uncompensated care add-on payment requires CMS to potentially use data sources that have not been previously used to calculate Medicare DSH payments, in addition to determining which hospitals in the baseline would receive DSH payments under current law in future time periods. Section 3133 gives the Secretary discretion concerning the data sources to calculate the uncompensated care add-on payment. Therefore, CMS and its technical advisors need to investigate the availability of data sources that comply with Section 3133 and go through notice and comment rulemaking to determine how to implement Section 3133 for FY 2014 and beyond.

3. Study Questions

As noted above, the purpose of this study effort is to analyze definitions of the uninsured and hospital-level uncompensated care amounts, and to identify data sources to create measures that conform to those definitions. The study will inform the implementation of Section 3133, specifically Factors 2 and 3.

With respect to Factor 2, the study aims to identify and analyze data sources to measure the rates of the uninsured for individuals under the age of 65, as described in Section 3133(2)(B). The potential transition from CBO to another data source in FY 2018 provides some context for the study questions presented below.

Study questions related to measures of the *uninsured* include:

- How could rates of uninsured be defined?

Introduction

- What are the strengths and limitations of alternative data sources?
- How do the different data sources treat certain populations (i.e. the prison population, population treated by the Indian Health Service, institutionalized populations)?
- How do CBO estimates of the uninsured relate to publicly available measures of the uninsured?
- Should CMS depart from CBO baseline estimates of the uninsured in FY 2018?

With respect to Factor 3, we investigate a variety of definitions of uncompensated care. The goal of this analysis is to determine which data elements should be included in the definition of uncompensated care at the individual hospital level.

Study questions related to measures of *uncompensated care* include:

- What are available data sources to measure uncompensated care for individual subsection (d) hospitals?
- In the absence of a single data source to measure uncompensated care beginning in 2014, what approaches could be established that would bridge across data sources and years?
- What are the advantages and disadvantages of alternative data sources and approaches?

For the first year of the study, the Dobson | DaVanzo Team addressed the study questions described above. In year two of the study, the Dobson | DaVanzo Team has already assisted CMS in preparing for the National Provider Call. The Dobson | DaVanzo Team is currently assisting CMS in rulemaking activities that implement Section 3133, including the development of technical documentation for making policy proposal(s) and providing support in developing responses to public comments received on the policy proposal(s) for FY 2014.

Overview of Analytic Approach

In order to assess alternative definitions and data sources and to develop appropriate measurements of uncompensated care and uninsured rates, the Dobson | DaVanzo Team used the following three approaches:

1. Literature review
2. Structured interviews
3. Analysis of data sources and definitions

The Dobson | DaVanzo Team first conducted a literature review to capture the various methods and measurements of the uninsured and uncompensated care that have been used previously. The literature review was helpful in providing a base understanding of how data have been previously used to create measures of uninsured and uncompensated care, and aided us in clarifying the questions for our interviews. The summary of these literature reviews are included within the respective chapter of this report. The next chapter in this report presents the findings of a more expansive literature review that investigates the current definitions of uncompensated care used by federal and state programs, ratings and research organizations, and provider associations with particular attention to how uncompensated care is calculated and if it duplicates Medicare DSH payments.

The Dobson | DaVanzo Team conducted two series of interviews. The first series of interviews was with CBO analysts and CMS MCR experts to better understand the CBO baseline estimates and the timing and sequencing of MCR flows, respectively. Additional interviews were conducted with experts who are knowledgeable about the sampling and analytic methodology within select surveys that estimate uninsured rates, such as those at the U.S. Census Bureau. These interviews enabled the Dobson | DaVanzo Team to understand the details of the various survey methods for collecting information on an individual's insurance status. Furthermore, the interviews afforded the Team an

Overview of Analytic Approach

understanding of potential future methodological changes in how those data are collected and reported.

The second series of interviews was with industry stakeholders, who were asked about their views on the measures of uninsured and uncompensated care, the legislation regarding the DSH adjustments, and any concerns they had regarding alternative approaches.

With a thorough grasp of the measured components of DSH payments and how various measurement methodologies are affected, we analyzed each data source that can be used to measure the national uninsured rate or provide hospital-level measures of uncompensated care. For each survey or data source, we present the pertinent definition, and the advantages and disadvantages of incorporating the data source into the methodology for calculating the uncompensated care add-on payment.

The results of these approaches were presented during the National Provider Call held on January 8, 2013. The Dobson | DaVanzo Team submitted a summary of the comments to CMS to help inform the development of the NPRM. While this report does not explicitly summarize the comments of the National Provider Call comments, we note findings from the literature and structured interviews that confirm or contradict the comments received during the National Provider Call.

In the following chapter we present our analysis of the literature on current definitions of uncompensated care. Following that discussion, we present the cross-cutting themes from our stakeholder interviews. Our findings from our literature review, our discussions with the CBO and CMS MCR experts, and the federal survey experts are presented in the chapters of the uninsured data sources and the uncompensated care data sources.

Literature Review of Uncompensated Care Definitions

Introduction

CMS is looking to examine the range and variability in uncompensated care definitions as used by various stakeholders prior to determining the definition that will apply to Section 3133 implementation and perhaps be included in the future version of the Worksheet S-10 MCR form and instructions. In order to identify definitions of uncompensated care, the Dobson | DaVanzo Team conducted a focused literature review of the various definitions used by federal programs, states, research and rating organizations, and provider associations. In this section, we outline our methodology for conducting the literature review, and discuss common themes found across sources. Additional information is presented in the introduction of the uncompensated care discussion.

Methodology

Our literature review focused on examining state and federal legislation, in addition to industry reports to capture the various definitions of uncompensated care across stakeholder groups. Through stakeholder interviews, we were able to identify reputable and informative sources of relevant information pertaining to uncompensated care. Additionally, these interviews helped to verify our findings from the literature, and explore additional aspects of our findings. Federal and state program definitions of uncompensated care were identified primarily in legislation, and supplemented by reports summarizing this legislation. All states were examined through our search, although only those with readily available comprehensive definitions of uncompensated care were included in this review. In locating documents, we used search terms such as

Literature Review

“uncompensated care,” “bad debt,” “charity care,” “free care,” and other terms that emerged during our initial literature search such as “unreimbursed care,” “uninsured care,” and “Medicaid 1115 waiver.” In particular, the Health Information Technology for Economic and Clinical Health Act (HITECH) and state Medicaid documents presented various descriptive definitions of uncompensated care. Reports from research and ratings organizations and provider associations (such as the American Hospital Association [AHA]) further augmented our findings on the definitions of uncompensated care.

Findings from our literature review are outlined in the uncompensated care evidence table attached as Appendix B. Findings were organized by the source defining uncompensated care and categorized by federal program, state, research and rating organization, or provider association. State regulations were further divided into Medicaid waiver states and non-Medicaid waiver states. Each source included how the regulation or report defined uncompensated care and what terminology was used in the definition (e.g., charity care, bad debt, etc.), how the definition is used to apportion uncompensated care funds, and the eligible populations and services covered by uncompensated care.

State Medicaid waivers were especially useful in exploring definitions of uncompensated care. Medicaid waiver states are those that have received Medicaid 1115 waivers in order to restructure aspects of their Medicaid program, while also preserving federal funding received by hospitals to offset the costs of uncompensated care. The plans for reforming a state’s Medicaid program often include specific guidelines for reimbursing hospitals for uncompensated care, and therefore frequently include explicit definitions of uncompensated care. In waiver and non-waiver states we also explored state legislature and other reports on state-based uncompensated care to uncover more detailed definitions. Examining the literature as well as gaining a broader industry-level perspective strengthened our current definition of uncompensated care and helped to identify any possible gaps or additions that might be needed to complete our definition.

Key Point: Uncompensated care definitions vary significantly by states, counties, and hospitals in order to accommodate the population served, and the financial “giving ability” of the institution.

Defining Uncompensated Care

In examining the literature, there was variation in how different states, provider organizations, and federal programs defined uncompensated care. A common theme was that most sources included both charity care and bad debt under their definitions of uncompensated care. Charity care was consistently defined as care provided to uninsured individuals that meet certain financial eligibility criteria, for which the hospital does not expect to receive payment. This definition varies somewhat hospital by hospital.

Literature Review

Conversely, bad debt was consistently defined as unreimbursed care for persons for whom the hospital expected, but did not receive payment. Several definitions also included payment shortfalls from government-funded plans, such as Medicaid, or payment shortfalls from third-party payments. These shortfalls are often defined as the loss suffered when reimbursement is less than the cost of care provided.

Key Point: Uncompensated care is typically defined as charity care plus bad debt, but may also include payment shortfalls from government-funded plans, or other third party payers.

Definitions also regularly state that patients must meet several guidelines for their care provision to qualify as charity care. These guidelines usually state that the patient must be uninsured, unqualified for a federal program such as Medicaid, and fall under a certain Federal Poverty Line (FPL) standard (although this varies significantly by state/region/hospital and can range from less than 100 percent to up to 300 percent FPL for partial reimbursement). Some charity care is directed at insured individuals when insurance does not cover all medical care or there are annual or lifetime limits.

Key Point: Uncompensated care services for qualified patients can sometimes be limited. Most notably physician services are excluded from uncompensated care definitions by several federal programs and states.

The services reimbursed through uncompensated care programs often included reimbursement for services covered under state Medicaid programs. However, several definitions excluded physician services and care to illegal immigrants.

Federal Programs

Several federal programs provide definitions of uncompensated care in order to set regulations for uncompensated care reimbursement to hospitals. Medicaid provides an explicit definition of uncompensated care as outlined below:

“The total cost of care for furnishing inpatient and outpatient services to Medicaid eligible individuals and to individuals with no source of third-party coverage for the services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/ enhanced Medicaid payments, and indigent care revenue.”¹¹

While Medicaid includes charity care and shortfalls from Medicaid payments in its definition of uncompensated care for determining hospital-specific Medicaid DSH limits, it does not include bad debt, payer discounts, or nonpayment of co-payments from those

¹¹ 73 FR 77904

Literature Review

with third-party coverage. Medicaid is unusual in comparison to other federal and state programs in that bad debt is excluded in its definition of uncompensated care. Bad debt is defined by Medicaid as a non-payment by those who have third-party coverage. Additionally, Medicaid does not include physician services in its definition of uncompensated care.¹² HITECH and General Accepted Accounting Principles (GAAP), on the other hand, are two sets of directions that include bad debt in their definition of uncompensated care, and do not prohibit physician service costs under definitions of uncompensated care.¹³

State Medicaid Programs

In examining state regulations for definitions of uncompensated care, state Medicaid 1115 waivers were useful in providing definitions. The waivers are used to restructure Medicaid programs to fit the needs of the individual state. Some states have used these waivers to restructure how hospitals are reimbursed for providing uncompensated care. Six states included explicit definitions of uncompensated care for Medicaid waivers: Arizona, California, Florida, Massachusetts, Tennessee, and Texas. Those states that had waivers, but which did not address uncompensated care, were not included in this review. All of the Medicaid waiver states encompassed by our review defined uncompensated care to include both charity care and bad debt, but several did not include shortfalls from government-sponsored health care programs. Specifically, California, and Massachusetts did not include shortfalls from the difference in cost of care and Medicaid or other government program reimbursements.^{14,15} Arizona, Florida, and Tennessee included shortfalls from Medicaid, while Texas included shortfalls from Medicaid as well as from Medicare, CHAMPUS, Tricare, and other federal, state or local programs.^{16,17,18,19}

Legislation from non-Medicaid waiver states was also examined to identify definitions of uncompensated care. Through this search, we found that all states with comprehensive definitions of uncompensated care include charity care and bad debt, with the exception of South Carolina, which does not include bad debt.²⁰ As seen with Medicaid waiver states, some states' legislation included shortfalls from Medicaid payments (Oklahoma,

¹² 73 FR 77904

¹³ Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009), *codified at* 42 U.S.C. §§300jj *et seq.*; §§17901 *et seq.*

¹⁴ Insure the Uninsured Project (ITUP) summary of California's 1115 Medicaid waiver. Accessed online at: http://itup.org/legislation-policy/2012/01/23/summary-of-%c2%a71115-waiver/#_ednref1

¹⁵ Medicaid hospital waivers: comparing California, Florida, and Massachusetts. (2006). California Healthcare Foundation. Issue Brief, pp. 2-13.

¹⁶ Arizona Health Care Cost Containment System Medicaid Section 1115 Waiver Amendment Supporting Uncompensated Care.

¹⁷ California Healthcare Foundation. (2006). Medicaid hospital waivers: comparing California, Florida, and Massachusetts. Issue Brief, pp. 2-13.

¹⁸ Free Care Compendium. Community Catalyst. (2011). http://www.communitycatalyst.org/projects/hap/free_care/

¹⁹ 2008-2009 Report on Residual Uncompensated Care Costs. Texas Health and Human Services Commission.

²⁰ S.C. Code Ann. Regs. 61-15-202(2)(c)(1)(c).

Literature Review

Oregon, and Rhode Island), while others did not (Alabama, Maryland, New York, Pennsylvania, South Carolina, and Wisconsin).²¹

Certain states excluded particular services from reimbursement for uncompensated care. Alabama excludes physician services, home health services, and long-term care services from uncompensated care reimbursement,²² and South Carolina excludes all non-emergency psychiatric inpatient hospital services.²³ A majority of states which provide definitions of uncompensated care include “medically necessary services” under their definitions of uncompensated care, and therefore reimburse uncompensated costs for most services that are covered under state Medicaid programs. Rhode Island legislation defines the services covered as those for conditions that “endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction.”²⁴ Texas, which only allows for reimbursement of three prescription drugs a month,²⁵ and Alabama, which excludes services for the chronically ill,²⁶ also have limitations on services provided under their uncompensated care definitions.

Research and Ratings Organizations

Reports from several research and ratings organizations also contributed to our understanding of the ways uncompensated care has been defined. Consistent with our findings from federal and state programs, Standard & Poor’s (S&P), the Healthcare Financial Management Association (HFMA), and PricewaterhouseCooper’s Health Research Institute (PwC’s HRI) include charity care and bad debt in their definition of uncompensated care, as well as self-pay discounts (shortfalls).^{27,28,29,30} The HFMA also set out standards that charity policies should address including financial eligibility criteria, requirements for verification of eligibility, time frame for eligibility, frequency of evaluation of policies, discounts for low-income, uninsured patients who pay a portion of the bill, and criteria for collection that is assured by GAAP. Additionally, the HFMA

²¹ Free Care Compendium. Community Catalyst. 2011. http://www.communitycatalyst.org/projects/hap/free_care/

²² Ala. Code §§ 22-21-211; 22-21-212; and 22-21-219.

²³ S.C. Code Ann. Regs. 126-530.

²⁴ 14 090 028 R.I. Code R.

²⁵ Tex. Health & Safety Code Ann. §§ 61.028; 61.054; 61.055.

²⁶ Ala. Code §§ 22-21-211; 22-21-212; and 22-21-219.

²⁷ GICS Sub-Industry Summary: Health Care Facilities. (2012) *Standard and Poor’s*. <http://solutions.standardandpoors.com/SP/sectortool/subindustrySummary.do?contentId=WS-coindustry:info&pc=JAN&auth=085150196224055233187040139188220016243096142070&tracking=JAN?pagewanted=all&ticker=WOOF>

²⁸ P&P Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers. (December 2006). *Healthcare Financial Management*.

²⁹ From HFMA stakeholder interview

³⁰ PricewaterhouseCoopers’ Health Research Institute. Acts of charity: charity care strategies for hospitals in a changing landscape. Accessed online at: <http://www.nonprofithealthcare.org/resources/Acts%20of%20Charity.pdf>

Literature Review

stated that there is no single set of charity care policies that is universally applicable and that uncompensated care should be defined at the community and hospital levels.

Through our literature, we found that uncompensated care definitions may vary not only by region and state, but also by individual hospitals based on the organization's mission and financial ability.³¹ This is an important consideration, as several comments received from the National Provider Call requested uniformity in the definition of uncompensated care to ensure the appropriate distribution of Medicare DSH payments across hospitals.

In addition to research and ratings organizations, we also examined several provider organizations that have developed definitions of uncompensated care. AHA included charity care and bad debt, but excluded underpayments from Medicaid, Medicare, and discounts to private payers in its TrendWatch publication,³² whereas the Catholic Hospital Association (CHA), which cites Form 990 regulations, included shortfalls from Medicaid, and other "government means-tested programs," but did not include shortfalls from Medicare or bad debt.^{33,34}

Calculating Uncompensated Care Costs

A number of state and federal programs and organizations provided a method for the calculation of uncompensated care.

Key Point: Uncompensated care is more frequently reported and reimbursed as "costs" rather than "charges," but is sometimes reimbursed based on Medicaid or Medicare payment rates. Ratio of cost-to-charges (RCCs) for hospitals is often used to calculate uncompensated care costs. Some hospitals use the total hospital RCC (which includes expenses related to marketing, entertainment, and bad debt, in addition to those included by the Medicare allowable RCC), while others use the Medicare allowable RCC, and/or Medicare department level allowable RCC (charges x RCC = costs).

Texas was one waiver state to describe in detail how it calculated uncompensated care costs. These costs are calculated by multiplying an individual's uncompensated hospital care charges by the total hospital RCC. These individual costs are then totaled to find the cost of providing uncompensated care.³⁵ Using a similar method, Oklahoma instructs hospitals to calculate uncompensated care by first calculating a total hospital RCC. This

³¹ P&P Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers. *Healthcare Financial Management*. December 2006.

³² American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 2. AHA did, however, call for the inclusion of Medicaid and other payer shortfalls in its public comments to the National Provider Call.

³³ Letter to Ron Schultz. Catholic Health Association of the United States. 12 September 2007. We note that AHA's comments submitted after the National Provider Call supports Medicaid underpayments as a part of the uncompensated care definition.

³⁴ Catholic Health Association. (2008). The IRS Form 990, Schedule H: community benefit and Catholic health care governance leaders. pp.3-15.

³⁵ Texas Administrative Code. Title 34, Part 1, Chapter 3, Subchapter V, Rule §3.587

Literature Review

RCC is then applied to uncompensated care charges to estimate costs of charity care, Medicaid services, legislated care services, and bad debts. These costs are then totaled less payments received for these services to find total uncompensated care costs (Exhibit 3.2).³⁶

Exhibit 3.2 Oklahoma Hospital Association Recommended Calculation of Uncompensated Care³⁷

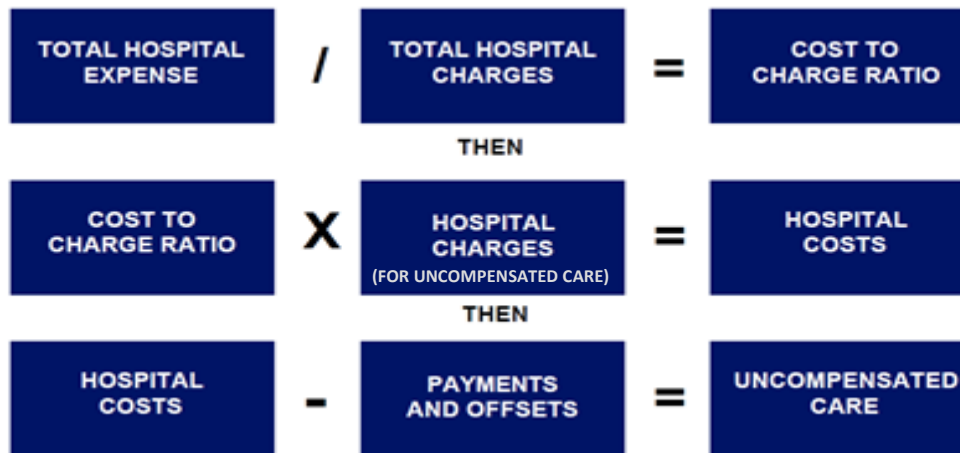


Exhibit Caption: Exhibit 3.2 presents the calculation of uncompensated care recommended by the Oklahoma Hospital Association. First, total hospital expenses are divided by total hospital charges, producing the cost to charge ratio. Then, the cost to charge ratio is multiplied by hospital charges for uncompensated care to produce hospital uncompensated care costs. Hospital uncompensated care costs minus payments and offsets equals uncompensated care cost.

Rhode Island and Pennsylvania used similar methods of applying RCCs to estimate uncompensated care costs,^{38,39} which was also recommended by GAAP and AHA.^{40,41}

³⁶ A Statewide Survey- Uncompensated Care in Oklahoma Hospitals. (2006 April). Center for Health Policy Research. Oklahoma Hospital Association.

http://www.okoha.com/AM/Template.cfm?Section=Uncompensated_Care&Template=/CM/ContentDisplay.cfm&ContentID=3904

³⁷ A Statewide Survey- Uncompensated Care in Oklahoma Hospitals. (2006). Center for Health Policy Research. Oklahoma Hospital Association.

http://www.okoha.com/AM/Template.cfm?Section=Uncompensated_Care&Template=/CM/ContentDisplay.cfm&ContentID=3904

³⁸ 35 Pa. Cons. Stat. § 5701

³⁹ R.I. Gen. Laws § 23-17.14-4(16); 14 090 028 R.I. Code R. § 1.33.

⁴⁰ Measuring Charity Care for Disclosure a consensus of the FASB Emerging Issues Task Force. (2010). Health Care Entities (Topic 954)

Financial Accounting Standards Board of the Financial Accounting Foundation. No. 2010-23.

⁴¹ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 2.

Literature Review

Duplicative Payments

In that the Medicare and Medicaid definitions of uncompensated care could both include charity care and bad debt, as well as Medicaid shortfalls, there is the potential for hospitals to receive duplicative payments based on the amount of uncompensated care they provide. In order to prevent duplicative payments, Medicare could account for Medicaid payments to hospitals to reduce these shortfalls when calculating Medicare DSH payments. There would also be the potential for Medicare funds to cross-subsidize Medicaid programs in this situation as Medicare DSH payments would reduce shortfalls in Medicaid underpayments, leading to substantial cost-shifting across programs. To avoid this, Medicare payments could also be made net of county allowances and other forms of payments that reduce uncompensated care burden. In states such as Texas, where state federal and county programs provide reimbursement for uncompensated care, this would prevent duplicative payments.⁴²

⁴² Uncompensated Care in Texas: Moving Toward Uniform, Reliable, and Transparent Data Measuring Residual Unreimbursed Uncompensated Care Costs. (2009). *Texas Health and Human Services Commission*.

Key Findings from Stakeholder Interviews

An important component of the study was a series of external stakeholder interviews. We used these interviews to better understand respondents' views concerning: 1) the definitions and measures of uninsured and uncompensated care; 2) the legislation regarding the DSH adjustments; and 3) alternative approaches to definitions and measurement approaches and the timing of data availability. In this chapter, we review the methodology for conducting these stakeholder interviews and discuss our cross-cutting themes.

Criteria for Stakeholder Selection and Interview Protocol Development

The focus of our stakeholder selection was hospital associations and other organizations that represent hospitals or constituents who would be affected by the new DSH payment policy. Given the relevance of this policy to their members, these organizations have developed views concerning the possible impact of the reduction in DSH payments and associated distributive impacts, and the implications of a national uninsured estimate. We also sought to identify organizations that have expertise in defining and measuring uncompensated care. Since the interview specifically focused on the appropriateness of a proposed definition of uncompensated care, we aimed to identify representatives within each organization who are familiar with MCRs and their constituents' internal definition of uncompensated care.

It is useful for CMS to be aware of the viewpoints of these groups prior to calibrating the ACA Section 3133 system, as many of them participated in the National Provider Call and submitted public comments to the FY 2014 Proposed and Final Rules.

With the approval of the CMS project team, we conducted stakeholder interviews with representatives from the following organizations:

Key Findings from Stakeholder Interviews

- American Hospital Association (AHA)
- Association of American Medical Colleges (AAMC)
- Catholic Health Association (CHA)
- Federation of American Hospitals
- Healthcare Financial Management Association (HFMA)
- Kaiser Family Foundation
- National Association of Public Hospitals (NAPH)

Representatives of each organization were contacted and provided a written interview protocol, which included the background context of the study, questions related to how to define uncompensated care (based on the “new Worksheet S-10”), and questions about how to measure the change in the uninsured over time. The interview protocol is provided in Appendix C.

The interviews were facilitated by Dobson | DaVanzo and KNG Health. Dobson | DaVanzo facilitated the discussion of the uncompensated care section, while KNG Health facilitated the discussion of the uninsured. Following each interview, we performed a content analysis to identify major themes and to develop our definitions and associated strengths and weaknesses of various alternatives. The findings discussed in this chapter represent the most frequent comments from both the uninsured and uncompensated care sections.

Additional Interviews and Technical Meetings

In addition to the stakeholder interviews, the Dobson | DaVanzo Team conducted interviews with selected survey experts. The goal of these interviews was to understand the target survey’s methodology and sampling frame, as well as to gain a more detailed understanding of how the researchers develop their estimates of the uninsured. We also asked each respondent if there were any potential plans to modify the survey questions or design. These interviews were conducted with the following agencies about their specific surveys:

- Agency for Healthcare Research and Quality (AHRQ) – Medical Expenditure Panel Survey (MEPS)
- Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) – National Health Interview Survey (NHIS)
- U.S. Census Bureau – American Community Survey (ACS), Current Population Survey (CPS), and Survey of Income and Program Participation (SIPP)

Since these interviews were more explanatory in nature, we discuss their results within the discussion of the uninsured data sources.

Key Findings from Stakeholder Interviews

We also held technical advisory meetings with the CBO and CMS MCR experts. The purpose of these meetings was to obtain information to better inform our team about the legislation, and the scope and timing of CBO and MCR information as it relates to the development of the FY 2014 IPPS Proposed and Final Rules.

Cross-Cutting Themes

Uninsured

The stakeholder interview questions related to the uninsured were designed to elicit general feedback on the use of uninsured rates in calculating Medicare DSH payments to subsection (d) hospitals, as well as to elicit specific feedback on survey-based estimates of the uninsured. Stakeholders tended to focus on high-level issues concerning the provisions and intent of Section 3133. While this focus was partially a result of unfamiliarity with the technical aspects of the alternative national surveys of the uninsured, it also reflected stakeholder recognition that defining what it means to be uninsured is critical to determining the success of the policy.

As described earlier, the uncompensated care add-on payment outlined in Section 3133 for FY 2014 and beyond is calculated as a product of three factors:

- Factor 1: 75 percent of estimated DSH payments that would otherwise be made in FY 2014
- Factor 2: One minus the percent change in the percent of uninsured individuals under age 65 between the most recent year for which data are available and 2013
- Factor 3: A hospital's uncompensated care relative to the uncompensated care for all subsection (d) hospitals estimated to receive payments under subsection (d)(5)(F)

The product of Factors 1 and 2 together determine the total national pool of dollars associated with the uncompensated care add-on payment, and Factor 3 determines how those dollars are distributed to each eligible subsection (d) hospital. For Factor 2, as specified in the statute, CMS intends to use uninsured estimates from CBO's March 20, 2010 letter to Representative Nancy Pelosi as the 2013 baseline measure and the latest estimates available from CBO for 2014 to 2017 to estimate changes in the uninsured for DSH payments in FY 2014 through FY 2017. CMS may consider alternate sources of uninsured estimates starting in FY 2018 (with certification from the CMS Office of the Actuary and approval from the Secretary for the Department of Health and Human Services).

Most of our discussions with stakeholders focused on the intent of DSH payments and whether using a national measure of the uninsured in computing DSH payments is

Key Findings from Stakeholder Interviews

aligned with that intent. Introduced in 1986, DSH adjustments were designed to compensate hospitals that treat substantially more low-income patients, who may not be able to fully reimburse those hospitals for the services provided. Stakeholders generally agreed that, while using a measure of the change in the uninsured in computing DSH payments for hospitals may make sense at a conceptual level, the way the measure is designed and used in the computation must reflect the realities that hospitals face in treating low-income patients. A few themes emerged from our discussions with stakeholders.

Uninsured Survey Overarching Themes:

1. Consistency with uncompensated care burden
2. Implications of national estimates for regions
3. Transitioning away from CBO estimates in FY 2018

1. CONSISTENCY WITH UNCOMPENSATED CARE BURDEN

Key Point: Any measure of the uninsured should correlate strongly with the uncompensated care burden.

Some stakeholders noted that uncompensated care is a function of the level of underinsurance and the number of uninsured. Patients may be insured—and counted as such in national statistics—but lack sufficient coverage and thus contribute to the uncompensated care burden incurred by hospitals. In this context, some stakeholders raised concerns regarding the national minimum standard benefit package and potential state variation in benefits offered by insurers. One stakeholder pointed out that a reduction in the number of uninsured may not translate into a corresponding reduction in hospital uncompensated care costs as use of inpatient care by the uninsured can vary over time and across geographic area due to differences in the composition of the uninsured (e.g., an older versus younger uninsured population).

All of our discussions with stakeholders touched on the undercount of Medicaid patients in surveys that measure the uninsured rate. CBO estimates include people who are eligible for Medicaid, even if they are not enrolled.⁴³ Though the national surveys that we examined are designed to include persons who are eligible for Medicaid (through direct questions and/or through post-collection data edits), these surveys generally tend to undercount Medicaid participants.⁴⁴ Additionally, stakeholders raised the issue that hospitals may be treating Medicaid-eligible patients who are not enrolled in Medicaid.

⁴³ Congressional Budget Office . Letter to Representative Nancy Pelosi . March 20, 2010, Table 4.

⁴⁴ See Medicaid Undercount Project, <http://www.census.gov/did/www/snacc/index.html>

Key Findings from Stakeholder Interviews

Some hospitals try to identify Medicaid-eligible patients and enroll them in Medicaid while the patients are being treated, but identifying and enrolling Medicaid-eligible patients is not always feasible (i.e., if patients do not stay long in the hospital or if the hospital does not have adequate staff to enroll patients). Thus, from the hospitals' standpoint, Medicaid-eligible does not equal Medicaid-covered. Stakeholders also questioned whether and how unauthorized immigrants are included in national uninsured statistics, as they are more likely, as a group, to be underinsured or uninsured.

2. IMPLICATIONS OF NATIONAL ESTIMATES

Key Point: Measuring changes in the percent uninsured at a national level does not reflect changes in hospitals' provision of uncompensated care at the local level.

All hospitals incur costs as a result of uncompensated care, but the magnitude of those costs, relative to total expenses, varies widely among hospitals and geographic areas. Factor 3, the uncompensated care ratio, accounts for that variation in terms of how the total pool of dollars is distributed among hospitals. Underlying the comment by stakeholders, however, is a concern that if certain areas (or hospitals) experience a slower reduction in the uninsured than what is observed at the national level, the hospitals in those areas will experience greater reductions in Medicare payments than is warranted. However, hospitals in those areas should have a higher share of uncompensated care than they otherwise would have, and, thus, a larger Factor 3. This would result in higher uncompensated care add-on payments for those hospitals. Some stakeholders suggested that the source of any measure of the uninsured should be the providers themselves. A hospital-specific measure of the uninsured, according to this line of reasoning, would more accurately reflect the volume and characteristics of uninsured patients treated at hospitals. In practice this would be very difficult to accomplish and would likely lead to very different ways of estimating local uninsured levels.

3. TRANSITIONING AWAY FROM CBO ESTIMATES IN FY 2018

Key Point: Transitioning from CBO estimates in FY 2017 to another data source in FY 2018 will likely require smoothing.

While the overall trends and rates of change appear to be directionally similar among the various sources of uninsured rates, the actual percent changes in the uninsured can differ among the sources (as described later in this report). Thus, stakeholders expressed the need to incorporate some sort of smoothing technique starting in FY 2017 to avoid a large change between the CBO-based estimate for FY 2017 and the estimate from some other source in FY 2018. A couple of stakeholders questioned why CMS would need to switch from using CBO estimates in FY 2017 to some other source in FY 2018.

Key Findings from Stakeholder Interviews

In discussing the national measures of the uninsured with stakeholders, we found they exhibited a wide range of familiarity with estimates of uninsured rates, ranging from in-depth knowledge of surveys that measure the uninsured to very little experience with data on the uninsured. As we probed with questions about the recall periods associated with each survey, point-in-time estimates versus full-year estimates, and other dimensions, no one expressed any strong opinions, and no single measure emerged as a preferred measure. One stakeholder who is an intensive user of uninsured survey estimates indicated that her organization's choice of which data series to use is driven by the scope and goals of the analysis they are undertaking. For example, if they are interested in uninsured rates at the state or county level, they might use the Current Population Survey (CPS) or the American Community Survey (ACS) because their large sample sizes yield robust sub-national estimates. But if they are interested in exploring the dynamics of being uninsured, the National Health Interview Survey (NHIS) would be more useful, since respondents are asked to describe their health insurance status over the past 12 months. Finally, if timeliness is a strong factor, then the NHIS would be their first choice.

Uncompensated Care

As a part of the interview protocol that was provided to interviewees in advance of the meeting, we provided a copy of Worksheet S-10 of the MCR, and a proposed definition based on Worksheet S-10 to review. The definition identified to the respondents is below:

$$\begin{aligned} &\text{Cost of charity care (line 23) + Cost of non-Medicare bad debt expense (line 29) =} \\ &\text{Cost of non-Medicare uncompensated care (Line 30)} \end{aligned}$$

Whereas:

- Cost of charity care = Cost of initial obligation of patients approved for charity care (line 21) minus partial payment by patients approved for charity care (line 22)
- Cost of non-Medicare bad debt expense = Cost to charge ratio (line 1) times non-Medicare and non-reimbursable bad debt expense (line 28)

We provided interviewees with a review of the Section 3133 legislative mandates that require that uncompensated care within a hospital be used so that Medicare DSH payments could be “targeted” to hospitals based on their uncompensated care. Second, we noted that the change in the national uninsured rates over the appropriate time frames will determine the size of the total pool of add-on payments.

The interviewees were then asked to give feedback on whether these variables would yield a complete and appropriate measure of uncompensated care. Through a thorough content analysis, we identified three overarching themes to summarize their feedback. We discuss these components, and their possible inclusion in the Medicare DSH uncompensated care formula, below.

Uncompensated Care Survey Overarching Themes:

Key Findings from Stakeholder Interviews

1. Underinsured offsets
2. Medicaid and other payer payment shortfalls
3. Ratio of cost-to-charges (RCC)

Some stakeholders indicated that a broader definition of uncompensated care, which accounts for all care that is unreimbursed, should be used rather than the more narrow definition we provided. The general concern was that any time care is unpaid, that care should be considered to be uncompensated care. We discuss each of the key themes in detail below.

1. UNDERINSURED OFFSETS

Key Point: Hospitals consider all forms of underpayment as sources of uncompensated care. This applies to the underinsured as well as the insured.

There is a definitional issue that centers on whether the goal of Medicare DSH payments is to offset the cost of the uninsured *and* “underinsured,” or solely just the uninsured. Including the unpaid balance of the “underinsured” in the definition of uncompensated care could retarget Section 3133 Medicare DSH payments. The consensus from the stakeholder interviews was that the uncompensated care definition must include charity care and bad debt, but could also factor in lack of payments for the underinsured. (See the Uncompensated Care Data Sources chapter below for a discussion on how Medicaid will handle the issue of services that are not covered by the otherwise insured).

The underinsured are defined in numerous ways. Often, underinsured is used to define patients with non-comprehensive benefits. That is, patients may not have all hospital services covered, or may have inadequate benefit annual and lifetime benefit limits. One form of underinsurance that may be very relevant in 2014 is the identification of “essential health benefits” through the Affordable Care Act. U.S. Department of Health and Human Services (HHS) must define a level of coverage for “essential benefits” that will be included under any small group or individual insurance policy inside or outside a state Exchange. Because essential benefits are meant to be flexibly defined by states, this requirement adds another possible source of variation in the uncompensated care definition. That is, states with limited or inadequate essential benefits are more likely to have uncompensated care for Exchange enrollees. If the Medicare DSH payments are not targeted to capture this population, the hospitals could have significant unmet costs.

Since the essential benefits have not yet been defined, the degree of underinsured patients still remains an open issue. While some of these underinsured patients may be captured under a hospital’s charity care policy, the degree to which charity care policies will be directed at this form of underpayment is not known, nor is the potential for bad debt for these patients.

Key Findings from Stakeholder Interviews

Another category of the underinsured is patients with needs that exceed annual or lifetime benefit limits. Cancer patients, for example, often find themselves under-insured due to the high cost of drugs and the benefit limit ceilings. While, again, some hospitals can provide continued cancer care under their charity care policy, it is a hospital-specific decision, as are bad debt and collection policies.

2. MEDICAID PAYMENT SHORTFALLS

Key Point: Medicaid shortfalls could be included in the definition of uncompensated care since it is unpaid care and is directly linked to the low-income population.

The longstanding Medicaid definition of uncompensated care used to define Medicaid DSH hospital-specific DSH limits⁴⁵ includes Medicaid payment shortfalls. The hospital-specific limitation on Medicaid DSH payments (SSA § 1923(g)(1)) limits Medicaid DSH payments to the uncompensated costs of providing services to Medicaid-eligible individuals, and individuals who “have no health insurance (or other source of third party coverage) for the services furnished during the year.” The difference, if any, between “incurred inpatient hospital and outpatient hospital costs and associated revenues” is considered a hospital’s uncompensated care cost limit, or hospital-specific DSH limit. For purposes of defining uncompensated care costs for the Medicaid hospital-specific DSH limit, CMS believes that uncompensated costs of services to individuals who do not have coverage for those specific services should be considered “costs for which there is no liable third party payer and thus eligible costs for Medicaid DSH payments.” Several stakeholders indicated that, ideally, the definition of uncompensated care should be consistent across Medicare and Medicaid.

The relevance of these definitions to Medicare DSH, however, is not direct. Stakeholders noted that there is an “implicit understanding” that Medicare DSH covers low-income populations. Medicaid, of course, is a health program for the low income. Therefore, capturing Medicaid underpayments in the definition of uncompensated care is further identifying hospitals with a high low-income population. Furthermore, Medicaid is currently included in the eligibility formula for Medicare DSH payments, as defined as the percentage of Medicaid and non-Medicare days of total days added to SSI days as a percentage of Medicare days.

As noted above, some interviewees argued more broadly that all care for which there is no payment is “unpaid care.” In this concept, the source of payer for the portion of payment received is irrelevant, as the remainder is still uncompensated. For instance, use of the “total unreimbursed and uncompensated care cost” line (Line 31) would include

⁴⁵ The calculation of uncompensated care for Medicaid DSH payments include the cost of each service furnished to an individual who had no health insurance or other source of third party coverage for that service. CMS Proposed Rule for FY 2012, 42 CFR Part 447, Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition .

Key Findings from Stakeholder Interviews

total unreimbursed cost for Medicaid, SCHIP, and state and local indigent care programs plus charity care and non-Medicare uncompensated care costs. We note, however, that inclusion of Medicaid shortfalls into the definition of uncompensated care would not increase the amount of Medicare DSH payments, but could very likely change the allocation of DSH payments to individual hospitals. Accordingly, given limited DSH payment resources, some stakeholders feel that it would be best to first “target” Medicare DSH funds to those hospitals with the “greatest need” (i.e., focusing on the charity care and bad debt for the uninsured).

3. RATIO OF COST-TO-CHARGES: MEDICARE VS. HOSPITAL-WIDE

Key point: A hospital’s total ratio of cost-to-charges (RCC) may better account for both Medicare and non-Medicare patient unreimbursed costs than the narrower Medicare CCR.

Some stakeholders noted that the uncompensated care definition should include a change from using the Medicare-allowable RCC⁴⁶ to a total hospital-level RCC when bad debt and charity care charges are stepped down to costs. Currently, a hospital’s bad debt and charity care are captured in the MCR as charges, and converted to costs using the Medicare-allowable RCC. In developing this RCC, unallowable hospital expenses such as marketing and entertainment are excluded. Therefore, the costs of the hospital are underestimated, decreasing the RCC. This underestimates the cost of the uncompensated care the hospital incurs. Stakeholders argue that since the patients represented in the bad debt and charity care are (generally) not Medicare beneficiaries, it is inappropriate to apply a Medicare RCC to the costs of these patients. This argument suggests that it would be more appropriate to apply the total hospital RCC.

Secondary Uncompensated Care Issues to Consider

Other issues of note that were mentioned during the interviews were the possible reporting lag of charity care, and the possible inaccuracy of reporting bad debt prior to the completion of all collection activities. Charity care determinations are not always made at the time of admission. Occasionally, patient’s cost of care is considered charity care several months after the care has been provided. This could potentially result in a misalignment of the fiscal year in which the care was provided, and the fiscal year the charity care is reported. While the charity care will be represented as uncompensated care either way (whether the reporting is timely or not), in extreme cases, this could possibly skew the allocation of Medicare DSH payments from one year to the next.

⁴⁶ Worksheet S-10, Line 1

Key Findings from Stakeholder Interviews

A similar reporting lag can occur with bad debt. Hospitals may record bad debt at different stages of collections. Stakeholders noted that bad debt should be defined as debt for which “collection activities have ceased” to keep the definition consistent with the financial statements. We have heard, however, that some hospitals may report bad debt on the MCR while collection activities are ongoing. For a small number of patients, a collection agency may recover some portion of the payment, or a hospital may collect payments through legal proceedings. To the extent that these payments are not reflected in the “bad debt” variable of the MCR, the bad debt estimates are overstated and may result in overcompensation to the hospital. Lack of clear directions and a common understanding of how to record patient care costs that are involved in collection activities make the new Worksheet S-10 vulnerable to this issue calling for future changes in Worksheet S-10 instructions.

Discussion and Conclusions

Uninsured

When considering how to measure the uninsured for the purpose of calculating the uncompensated care add-on payment, stakeholders viewed the question from a hospital’s perspective: how do the uninsured seek hospital care in a community and how should that be captured in a measure of the uninsured? According to stakeholders, the number of uninsured and their use of inpatient hospital care vary across geographic areas because of differences in economic conditions and the profile of the uninsured across areas. Further, hospitals will experience reductions in uncompensated care costs from lower rates of the uninsured differently. For example, hospitals that currently serve relatively more of the uninsured population will likely continue to do so. From this perspective, stakeholders concluded that the uninsured could be measured at a local level and suggested that the best source of this information could be the hospitals themselves.

While stakeholders raised valid concerns as to how to measure the uninsured, the implications for implementing Section 3133 are less clear. First, measuring changes in the percent uninsured at a state or local level may not be permitted under the law; the third factor in the uncompensated care add-on payment is a hospital-specific measure of uncompensated care relative to the total uncompensated care costs all subsection (d) hospitals receiving a payment under subsection (d)(5)(F). Because each hospital’s uncompensated care is measured relative to a national measure of aggregate uncompensated care, the change in the percent uninsured should be measured at a similar (i.e., national) level. Second, variations in changes in the uninsured and how those changes impact hospital uncompensated care will be reflected, to some extent, in changes in a hospital’s uncompensated care share (the Factor 3 of the uncompensated care add-on payment). For example, one would expect that hospitals in a market area whose uninsured rate remains higher than the national average would incur a larger share of

Key Findings from Stakeholder Interviews

national uncompensated care. As a result, the hospitals in this market should be allocated a larger share of the available funds for the add-on payment (Factor 1 of the uncompensated care add-on payment). In such a situation, how a hospital's Medicare DSH payments would change depends on the size of the change in the uncompensated care share (Factor 3) relative to the change in the uninsured rate (Factor 2).

The discussion above highlights the importance of using a measure of the change in the uninsured that correlates strongly with the level of uncompensated care. Although the level of underinsurance could be expected to contribute to uncompensated care levels, Section 3133 only explicitly mentions measuring changes in the uninsured. In addition, CBO does not incorporate the notion of underinsurance in its projections of the number of uninsured. On the other hand, we hypothesize that measures that include partial-year uninsured individuals may correlate better with uncompensated care levels than those that only count individuals who are uninsured for a full year. In addition, although a measure of the uninsured that incorporates hospital utilization could improve the correlation with uncompensated care levels, the CMS project team determined that it was not practical to pursue it at this time.

Uncompensated Care

Our key informants represented the vast majority of U.S. hospitals in aggregate and by type of hospital. The distinctions within the definition presented by each stakeholder are dependent upon their constituents' set of general reporting guidelines and hospital missions.

While our initial definition of uncompensated care represents a reasonable and conventional starting place, there was consensus that there is significant variability in what constitutes bad debt and charity care across hospitals. Most hospitals have written charity care policies that indicate the types of individuals and services that are eligible for charity care. Generally, charity care is reserved primarily for low-income uninsured or under-insured individuals, for example cancer care patients who exceed their annual benefit maximum or transplant services not covered by insurance.

Most stakeholders indicated that Medicaid payment shortfalls (and the State Children's Health Insurance Program – SCHIP – and other government program shortfalls) should be included in our preliminary definition of uncompensated care, as any payment shortfall represents care that was not compensated for. Given the frequency of this recommendation, we have considered this issue at some length.

Based on our assessment of stakeholder comments, there are two primary reasons to include Medicaid shortfalls in the Section 3133 definition of uncompensated care.

Key Findings from Stakeholder Interviews

1. Medicaid payment shortfalls represent non-covered care; therefore, providers have unmet costs when treating these patients.
2. The overarching goal of Medicare DSH payments is to provide partial relief from charity care that is provided to (primarily) low-income patients. Since Medicaid enrollees are low-income persons, the underpayments associated with their care is a form of charity care.

There are, however, several compelling arguments against including Medicaid underpayment in the Section 3133 definition of uncompensated care, as listed below.

1. Several government agencies and key stakeholders define uncompensated care as bad debt plus charity care, without consideration for Medicaid payment shortfalls.^{47,48,49,50,51} Specifically, MedPAC, GAO, and the AHA in their annual TrendWatch reports exclude Medicaid underpayments. AHA indicates “charity care is care for which hospitals are never expected to be reimbursed” while bad debt reflects patients’ inability or unwillingness to pay their bills. “Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicare and Medicaid.”⁵²
2. The inclusion of Medicaid shortfall as a determinant for Medicare DSH payments would represent a form of cross-subsidization from Medicare to cover Medicaid costs. In the past, CMS and MedPAC have not supported these actions.
3. Non-inclusion of Medicaid shortfalls from the uncompensated care definition allows Medicare payments to better target hospitals with a disproportionate share of uncompensated care for patients with no insurance coverage. That is, under this definition, Medicare DSH payments under Section 3133 would target the limited government resources toward those with the most need. While hospitals may not receive payments to cover 100 percent of the cost to treat Medicaid enrollees, on average, in 2008, Medicaid payments were estimated by AHA to be 88.7 percent of provider costs (including Medicaid DSH payments).⁵³ Typically, charity care recipients are uninsured or have exceeded a catastrophic coverage limit – resulting in no third-party payments to the hospital.

⁴⁷ Walker DM. (2005). Testimony before the Committee on Ways and Means, House of Representatives – nonprofit, for-profit and government hospitals: uncompensated care and other community benefits. Government Accountability Office (GAO), 1.

⁴⁸ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁴⁹ Hackbarth G. (2009). Medicare Payment Advisory Commission (Letter to M Shortt re: Document identifier CMS-2552-10).

⁵⁰ Atkinson G, Helms WD, Needleman J. (1997). State trends in hospital uncompensated care. *Health Affairs*, 233.

⁵¹ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁵² American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁵³ American Hospital Association. (2010). Trendwatch Chartbook 2010: Trends Affecting Hospitals and Health Systems, Chapter 4: Trends in Hospital Financing.

Key Findings from Stakeholder Interviews

4. Medicaid shortfalls captured in the MCRs of state-provided financial statements do not necessarily report the actual underpayment the hospital incurred. Stakeholders indicated that the Medicaid shortfall reported is often misleading. A given hospital may have a variety of sources of funding that are designed to cover Medicaid shortfalls (e.g. inter-governmental transfers - IGT, Medicaid DSH, state and county allowances). The reporting of these funds may or may not be linked or reported in relationship to Medicaid patients in the hospital's accounting system. This is primarily because many sources of funds are for both the uninsured and to cover Medicaid underpayments. It is often difficult to determine the correct allocation. The Dobson | DaVanzo Team has observed this many times in its field observations. Therefore, it is difficult to determine the actual degree to which hospitals' costs are unmet by Medicaid payments and other revenue sources.

While the arguments are compelling on both including and excluding Medicaid shortfalls from the uncompensated care definition, CMS will need to identify the uncompensated care definition that best meets the goals of Medicare DSH from the stakeholder perspective. It is important to note that adding Medicaid shortfalls to the definition of uncompensated care does not increase total Medicare DSH payments, it just retargets them toward hospitals with either a disproportionately high number of Medicaid patients in states with a slight underpayment, or hospitals within a state that have a large Medicaid underpayment.

In the following two chapters, we present our assessment of possible data sources, as well as the advantages and disadvantages of each source as it related to identifying the uninsured and uncompensated care.

Analysis of the Uninsured Data Sources

In this chapter, we describe and analyze the data sources for uninsured estimates that could be used to calculate the uncompensated care add-on payment starting in FY 2018. The federal government produces five national surveys designed to estimate the level, duration, and other characteristics of the uninsured. While it may seem duplicative to fund five surveys yielding the same type of data, a closer look at these national surveys shows that each survey is designed for a different purpose and yields estimates that can be linked to different sets of characteristics, depending on the survey.

Understanding the Data Sources

The data sources we analyzed include:

1. Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC)
2. American Community Survey (ACS)
3. Survey of Income and Program Participation (SIPP)
4. Medical Expenditure Panel Survey (MEPS)
5. National Health Interview Survey (NHIS)

Because these data sources serve critical research and policymaking needs, these surveys and their methodologies for measuring the uninsured have been the topic of numerous studies and reports. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services, for example, produces reports

Uninsured Data Sources

on understanding the estimates of the uninsured.⁵⁴ A 2003 paper by the CBO offers insight into the dynamics of the uninsured by comparing results from three of the surveys.⁵⁵ More recently, the five federal surveys were the main topic of a 2010 workshop, convened by the National Research Council, focused on estimating health insurance coverage for children.⁵⁶

Using these studies as models for our own research, we began our analysis by developing a conceptual definition of the uninsured that mirrors the intent of Section 3133 of the ACA. The goal of drafting this conceptual definition was to establish a basis for comparison as we proceeded through our literature review, our interviews with survey experts, and our research on the government surveys that measure the uninsured rate.

Conceptual definition of uninsured:

Individuals who are under the age of 65 and did not have comprehensive health insurance coverage from private sources (employer-provided or self-purchased) or public sources in a particular year.

While this definition is consistent with the legislative language, it is ambiguous on many levels, such as the length of the uninsured period being measured.

We expected to gain some understanding of other possible definitions of the uninsured and how they differ from our conceptual definition through our literature review, but we found that the discussion in the literature centered on analysis of the surveys that collect data on health insurance, rather than on how uninsured should be defined. To identify relevant articles, we conducted a search of PubMed, where the MeSH term “medically uninsured” was used to narrow down results. Additional search terms such as “insurance” and “partially insured” were individually combined with the MeSH term. Approximately 500 article titles and 100 abstracts were read. An estimated 20 relevant articles were read thoroughly. Additionally, reports by government agencies and non-government entities were identified and reviewed based on web searches using similar terms to those noted above.

Our understanding of the surveys and their methodologies was also greatly enhanced by our interviews with the experts from the federal agencies that produce these surveys. In preparation for each interview, we prepared a summary of key characteristics of the survey to be discussed, including the definition of the uninsured, data availability, reference and recall periods, and the sample size and design (See Appendix D). We started each interview by reviewing the summary to confirm that our understanding of the survey characteristics

⁵⁴Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Understanding Estimates of the Uninsured: Putting the Differences in Context,” *ASPE Issue Brief*, September 2005, <http://aspe.hhs.gov/health/reports/05/uninsured-understanding-ib/index.htm>

⁵⁵ Congressional Budget Office, “How Many People Lack Health Insurance and for How Long?”, May 2003.

⁵⁶ Plewes TJ. (2010). *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. National Research Council.

Uninsured Data Sources

was correct and to seek clarification as needed. We also developed a standard list of questions designed to probe about two particular topics—coverage of Medicaid enrollees and inclusion of unauthorized immigrants—and to solicit information about future plans for the survey. In particular, we were interested in plans to change the methodologies and data series. We have incorporated the feedback from these experts with the discussions of the data sources below. We also interviewed analysts from the CBO about their methodology and have included their feedback below.

Following our discussion of the data sources, we identified several key dimensions of the data sources for evaluation purposes and summarized the strengths and limitations of the data sources.

Analysis of Data Sources and Uninsured Definitions

Of the five surveys described below, three are conducted by the Census Bureau: the Current Population Survey-Annual Social and Economic Supplement (CPS-ASEC), the American Community Survey (ACS), and the Survey of Income and Program Participation (SIPP). The other two surveys are conducted by agencies within the Department of Health and Human Services. The Medical Expenditure Panel Survey (MEPS) is run by the Agency for Healthcare Research and Quality (AHRQ), while the National Health Interview Survey (NHIS) is run by the National Center for Health Statistics, a component of the Centers for Disease Control and Prevention (CDC).

All but one of these surveys define their universe as the civilian non-institutional population residing in the 50 states and the District of Columbia—all civilian residents of the United States, excluding residents of prisons, nursing homes, and other such institutional settings and persons on active duty in the Armed Forces. The ACS uses the civilian non-institutional population but also includes residents of Puerto Rico, residents of institutional group quarters, and active-duty military staff. The other four national surveys do not include households in Puerto Rico in their samples, and the CBO does not include residents of Puerto Rico in its model-based estimation of the uninsured.

We examined the effect of using a data source that excludes Puerto Rico (PR) on changes in the uninsured rate. The effect of excluding PR depends on whether the change in the uninsured in Puerto Rico is comparable to the national change in the uninsured. We estimate a scenario where the rate of change observed in PR is either half as fast or twice as fast as the national rate of change. Our simulated results show that when PR's rate of change in the uninsured is half as fast as the nation's rate of change, the percentage change in the uninsured between 2013 and 2014 is 22.64 percent excluding PR and 22.57 percent including PR. On the other hand, if PR experiences a rate of change in the uninsured that is twice that of the nation, the percentage change in the uninsured between 2013 and 2014 is 22.64 percent excluding PR and 22.79 percent including PR.

Uninsured Data Sources

Similarly, insurance coverage, at a high level, is defined the same way across all surveys. That is, an individual is considered insured if he/she has comprehensive insurance coverage (i.e., insurance that covers most medical expenses, including hospitalizations). Thus, single-service plans (e.g., dental plans) and plans sponsored by the Indian Health Service (IHS) are not counted as insurance coverage. All but one of the surveys uses in-person computer-aided interviews, known as CAPIs, to conduct the survey, which generally allows for more targeted probing to help respondents understand and answer the questions. The ACS, on the other hand, is a paper survey. Household respondents receive it in the mail, complete it without the aid of a data collector, and mail it back to the Census Bureau. Telephone interviews and personal interviews are used for non-response follow-up. Respondents in group quarters sometimes complete their forms themselves or sometimes have their forms completed by a data collector, depending on the size of the facility. Finally, all the surveys perform edits on particular respondents' records, known as post-collection processing, to address possible reporting errors. For example, if a respondent indicated that they had private insurance and provided the name of a plan that is actually a Medicaid plan, that person's record would be edited, after the data collection phase, to correct that reporting error.

1. Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC)

The monthly Current Population Survey is the nation's primary source of labor force, income, and poverty data and has a large enough sample to be able generate national and state estimates. The Annual Social and Economic Supplement (ASEC) survey, fielded from February to April each year, includes a series of health insurance questions and probes that refer to the previous calendar year. If the respondent's answers to the questions about different types of insurance indicate that the respondent had no coverage during the previous calendar year, the survey instrument is designed to then ask a verification question to confirm that the respondent had no coverage. Though the CPS-ASEC provides a consistent time series at a national level from 1987 to 2010, its main limitation is that it potentially overstates the number of uninsured for the entire year. Though respondents are instructed to recall the previous calendar year, which amounts to a recall period of 14-16 months, it is suspected that respondents actually answer the question relative to their current insurance status, i.e., as a point-in-time question.⁵⁷ An expert from the Census Bureau informed us that the CPS will be changing its health insurance questions starting with the 2014 CPS. These changes will result in two specific outcomes that are relevant for our study. First, although the full-year questions will be retained, they will be changed significantly, which will result in a break in the data series that captures full-year insurance status. The break in the published data series will be between 2012 and 2013. Second, a point-in-time question will be added, which, in

⁵⁷ Congressional Budget Office. (2003, May). "How Many People Lack Health Insurance and for How Long?".

Uninsured Data Sources

essence, is the start of a new data series with 2014 as the reference period for the first estimate of the series. The questions will also be refined to better capture Medicaid enrollees, though the current survey instrument includes probes to remind respondents of the specific state Medicaid program names.

2. American Community Survey (ACS)

The ACS is an ongoing nationwide mail survey with a very large sample (nearly 2 million households) that covers every county and census tract. Thus, ACS has the greatest geographic detail of the five surveys reviewed, with the ability to produce a variety of sub-state estimates. Further, the ACS has a high response rate of 98 percent.⁵⁸ The health insurance question was added in 2008 and instructs the respondent to report insurance status for each person by marking “yes” or “no” to 8 different types of insurance coverage. One main limitation of the survey is that, since it is a mail survey, respondents answer the questions without the aid of a knowledgeable interviewer who could define concepts and ask probing questions to elicit correct responses. Also, the health insurance question does not list Medicaid as a separate type of insurance, but, rather, groups it with other forms of government insurance.⁵⁹ Further, the ACS does not mention the name of each state-specific Medicaid program, as doing so in a paper-based survey instrument would be costly. Like the CPS, the ACS health insurance question will be revised, but probably not before 2014.

Additionally, we also learned that the ACS is being considered as the replacement for the CPS in determining Children’s Health Insurance Program (CHIP) allocations for all states. The ACA amends the Social Security Act (SSA) to redefine the previous allocation process. Whereas previously, state allocations were determined by looking at children’s uninsured rate estimates from three-year pooled state estimates from the CPS-ASEC to determine the child component factor, the corrections to SSA now require allocations to be based on a state’s percentage of low-income children without insurance according to “the most timely and accurate published estimates of the Bureau of the Census.”⁶⁰ The 2009 Children’s Health Insurance Program Reauthorization Act (CHIPRA) also calls for an assessment of the effectiveness of the ACS survey in providing timely and accurate children’s coverage estimates on a state level.⁶¹

3. Survey of Income and Program Participation (SIPP)

The SIPP is a longitudinal survey in which the same respondents are interviewed three times a year over the course of three to four years, collecting information on health insurance status, income, labor force activity, and federal program participation. The

⁵⁸ Plewes TJ. (2010). *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. National Research Council. P19.

⁵⁹ Plewes TJ. (2010). *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. National Research Council. P20.

⁶⁰ Plewes TJ. (2010). *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. National Research Council. P10.

⁶¹ Plewes TJ. (2010). *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. National Research Council. P4.

Uninsured Data Sources

sample size ranges from 14,000 to 36,700 interviewed households per panel. As a longitudinal survey, the SIPP data can help analyze the dynamics of health insurance by measuring spells without coverage and providing a variety of estimates, from point-in-time to monthly to annual. The health insurance data can also be linked to other sections of the survey that track utilization of health care services, child well-being, and disability. The SIPP data are not timely; the most recent data available are from 2008. High-level estimates from the SIPP are not published and released on a regular schedule. Users typically access the microdata, which are released on a regular schedule, to prepare their own estimates.

The above discussion highlights a significant drawback for SIPP: timeliness of published estimates. In addition, in 2014, the current SIPP survey instrument will be replaced with the new SIPP-EHC instrument. Respondents will be contacted once a year, rather than every 4 months.

Additionally, as tends to happen with longitudinal studies, SIPP suffers from a significant attrition rate, as participants refuse to continue participating or can no longer be located. By wave ten of the 1996-1999 panel, the attrition rate was 34 percent. Further, if those who drop out differ systematically from those who remain, the SIPP may yield biased estimates despite its recognized accuracy for point-in-time estimates.⁶²

4. Medical Expenditure Panel Survey (MEPS)

MEPS Household Component (MEPS-HC) collects data on medical expenses for both individuals and households several times over the course of two years. MEPS collects detailed data on demographic characteristics, health conditions and status, health services utilization and costs, access to care, satisfaction with care, health insurance coverage, income, and employment. Like the SIPP, MEPS data can be used to examine health insurance dynamics. In addition, MEPS data can be used to analyze the relationship between insurance status and a variety of individual and household characteristics, including use of and expenditures for health insurance.

About 14,000 households and about 35,000 individuals are interviewed each year, and the sample is drawn from a nationally representative subsample of households that participated in the previous year's National Health Interview Survey. Through a series of questions, each respondent's insurance status is determined for each month since the previous interview, which results in a variable recall period of three to six months. From the monthly data collected, three estimates are constructed: uninsured for the first half of the year, uninsured for the entire survey year, and uninsured at any time during the survey year. As of January 2013, the latest estimates available from MEPS were

⁶² Congressional Budget Office. (2003, May). "How Many People Lack Health Insurance and for How Long?". P16.

Uninsured Data Sources

estimates for the first half of 2011 (January-June). Full-year estimates for 2010 were also available.

5. National Health Interview Survey (NHIS)

The main objective of the NHIS, which has been conducted since 1957, is to monitor the health of the United States population through the collection and analysis of data on a broad range of health topics. A major strength of this survey lies in the ability to associate these health characteristics with many demographic and socioeconomic characteristics. Also, because it is a health-focused survey, respondents are asked to recall many details about their health and use of health services, which may help them understand and answer the coverage-related questions correctly. One report from a 2010 workshop on databases for measuring health insurance coverage for children indicates that there is a general consensus that NHIS provides the most valid health insurance coverage estimates.⁶³

The sample for the NHIS is about 35,000 households and 87,500 individuals. NHIS produces three estimates of insurance coverage: uninsured for more than a year (defined as the 12 months preceding the interview), uninsured for at least part of the year (i.e., the 12 months preceding the interview), and uninsured at the time of interview. Estimates for January-June 2012 were released in January 2013.

Uninsured Estimates from the Congressional Budget Office

CBO developed a simulation model to analyze several public policy options involving health insurance coverage. The base case, or current law, estimate of distribution of coverage from 2008 to 2017 was based on the 2002 SIPP and supplemented with the MEPS and data from the National Bureau of Economic Research.

The decision to utilize the SIPP rather than the CPS, which has a larger sample size, was mainly due to the SIPP's longitudinal design, where all participants are asked the same questions over a period of time. This makes the SIPP more useful to model policy proposals that would assert eligibility depending on a person's coverage status during a specific period of time.⁶⁴

To increase accuracy of the model predictions, CBO performs several adjustments for the base case. For example, the sample weights are adjusted to account for expected demographic changes in the U.S. population. The simulation model matches the Census Bureau's projection of the non-institutionalized U.S. populations by adjusting the sample weight of each SIPP observation. The sample weights are also adjusted to match

⁶³ Plewes TJ. (2010). *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary*. National Research Council, Chapter 8.

⁶⁴ Congressional Budget Office. (2007, October). "CBO's Health Insurance Simulation Model: A Technical Description." P 4, accessed February 25, 2013, at: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf>.

Uninsured Data Sources

estimates of the uninsured populations and estimates of the type of coverage held by those who are insured.

Next, CBO also adjusts SIPP data to better estimate the actual number of the uninsured. CBO recognizes that, according to recent research, survey-based estimates of the number of Medicaid enrollees are lower than the number of Medicaid enrollees reflected by administrative data due to participants mistakenly reporting being uninsured or being covered by other type of health insurance. Accordingly, CBO adjusted the number of people covered by Medicaid upward and the number of people reporting no coverage or other types of coverage downward.⁶⁵ In regard to SCHIP, while CBO projects that enrollment will decline with available funding through 2017, the CBO model assumes that SCHIP funding will be provided to maintain current programs.

CBO also adjusts estimates of the uninsured to reflect the effect of growth in average health insurance premiums and projections of private insurance growth rates.

Comparison of Survey Estimates

The analysis presented in this section was completed in 2012 as a preliminary examination of the trends in the survey-based data sources. As 2018 approaches, we would recommend updating this analysis to better ascertain which data sources would be most appropriate for Section 3133 implementation in FY 2018 and beyond.

The categorization of the estimates from the five surveys and CBO provided in the table below illustrates not only the differences in the estimates of the uninsured from the surveys and CBO, but also the differences in the types and numbers of definitions produced by each source. The NHIS definitions, in particular, do not fit within the categories used in the table: their “full-year” estimates are defined as being uninsured for more than a year and their “part-year” estimate is defined as at least part of the year. Similarly, the MEPS definition of “part of the year” is actually a measure of being uninsured throughout the first half of the year. CPS, at this time, produces only a calendar-year estimate, while NHIS and MEPS each produce three types of estimates. ACS, SIPP, NHIS, and CBO all produce point-in-time estimates, but CPS and MEPS do not. Complete SIPP data for 2010 and MEPS final full-year estimates for 2010 were not available at the time this analysis was completed.

⁶⁵ Congressional Budget Office. (2007, October). “CBO’s Health Insurance Simulation Model: A Technical Description.” pp 13-14.

Uninsured Data Sources

Exhibit 4.1: Uninsured Estimates for Individuals under Age 65, 2010

Data Source	Length of Uninsured Period Uninsured for Full Year	Length of Uninsured Period Point-in-Time	Length of Uninsured Period Uninsured for Part of Year
	<i>For calendar-year 2010:</i>		
CPS	<ul style="list-style-type: none"> • 49.1 million persons • 18.4% (calendar year 2010) • 90% CI: +/-0.3% 	<ul style="list-style-type: none"> • Not Produced 	<ul style="list-style-type: none"> • Not Produced
ACS	<ul style="list-style-type: none"> • Not Produced 	<ul style="list-style-type: none"> • 46.8 million persons* • 17.7%* (point-in-time) 	<ul style="list-style-type: none"> • Not Produced
SIPP	<ul style="list-style-type: none"> • Not Available 	<ul style="list-style-type: none"> • March 2010 estimate for persons age 18-64: 22.8%** • SE: 0.5% 	<ul style="list-style-type: none"> • Not Available
MEPS	<ul style="list-style-type: none"> • Not Available 	<ul style="list-style-type: none"> • Not Produced 	<i>For first half of 2010 (January–June):</i> <ul style="list-style-type: none"> • 55.5 million persons • 21.0% for first half of 2010 (SE: 0.53%)
NHIS	<i>For more than a year (12 months prior to interview):</i> <ul style="list-style-type: none"> • 35.4 million persons • 13.3% (SE: 0.24%) 	<ul style="list-style-type: none"> • 48.2 million persons • 18.2% (SE: 0.08%) 	<i>For at least part of the 12 months prior to interview:</i> <ul style="list-style-type: none"> • 59.6 million persons • 22.5% (SE: 0.33%)
CBO	<ul style="list-style-type: none"> • Not Produced 	<ul style="list-style-type: none"> • 19% 	<ul style="list-style-type: none"> • Not Produced

*Dobson | DaVanzo Team's calculations based on published estimates.

**Steinweg, A. (2011). "Deconstruction of the Time Trend in Health Insurance: A look inside the SIPP 2008 health insurance rates." Census Bureau, SEHSD Working Paper Number 2011-6, http://www.census.gov/sipp/workpaper/Deconstruction_of_the_Time_Trend_in_Health_Insurance.doc

The inconsistencies among the definitions used in the different surveys make it difficult to definitively compare estimates among surveys. Thus, in Exhibit 4.2, we isolate the 2010 point-in-time estimates from the two surveys for which they are available and compare them to the CPS full-year estimate and the MEPS half-year estimate. (Because the SIPP estimate for 2010 is derived from a research paper, not an official data release, we did not include it in Exhibit 4.2). The MEPS estimates are less precise than the CPS and NHIS estimates, likely due to the smaller sample used by MEPS.

Uninsured Data Sources

Exhibit 4.2: Comparison of Uninsured Estimates for Point-in-Time and Full-Year Estimates, 2010

Survey	% Uninsured (2010)	Standard Error	Coefficient of Variation
CPS Full-Year Estimates	18.4	0.3	1.6
ACS Point-in-Time Estimates*	17.7	n/a	n/a
MEPS First-Half Year Estimates	21.0	0.5	2.4
NHIS Point-in-Time Estimates	18.2	0.3	1.6

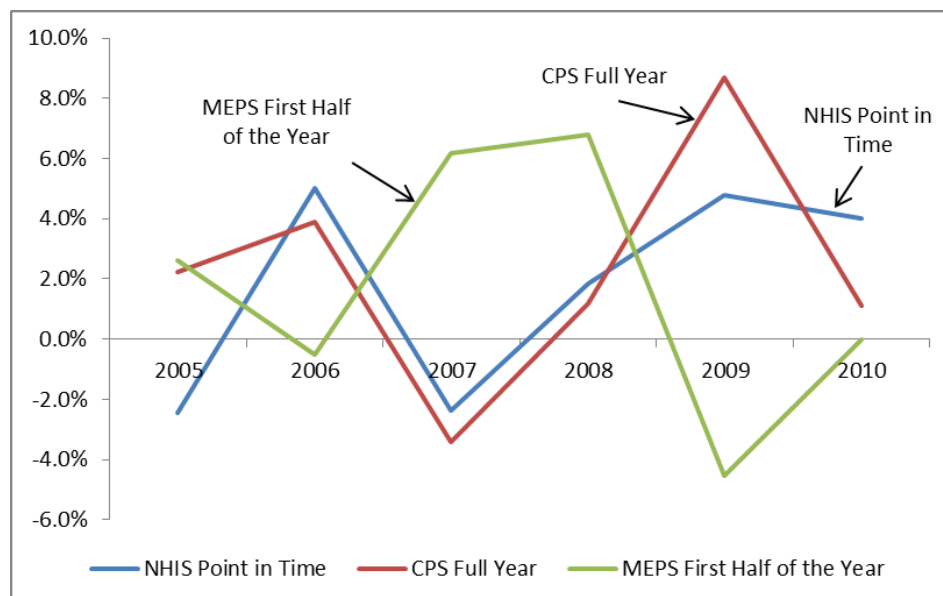
*Dobson | DaVanzo Team's calculations based on published estimates.

For purposes of determining which data series might be most appropriate for the uncompensated care add-on payment, a comparison of the rates of change among the data series is more informative than a cross-section of the uninsured estimates. In Exhibit 4.3, we show the year-to-year percent change in the CPS, NHIS and MEPS series from 2005 to 2010. (The SIPP and the ACS data are excluded due to limited availability for this time period). The CPS and NHIS series exhibit similar trends and rates of change, despite being based on different time periods. This observation is consistent with the view of CPS as a point-in-time estimate.

That said, there does not appear to be complete consistency of survey time series results. This indicates that some judgment will be required to decide which survey's rate of change should drive the Section 3133 DSH payments from FY 2018 onwards. Alternatively, the CBO modeled estimates could continue to be used for Section 3133 implementation, as they reflect a series of adjustments to survey estimates.

Uninsured Data Sources

Exhibit 4.3: Percent Change in Percent Uninsured among Persons under age 65 for Three Surveys, 2005-2010*



*Dobson | DaVanzo Team's calculations based on published estimates available at: http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=1&subcomponent=0, <http://www.cdc.gov/nchs/nhis.htm>, and <http://www.census.gov/hhes/www/hlthins/data/index.html>.

Exhibit Caption: This exhibit shows the year-to-year percent change in the MEPS, CPS, and NHIS data series from 2005 to 2010. (The SIPP and the ACS data are excluded due to limited availability for this time period).

The MEPS series consists of estimates from the first half of each year. Starting in 2005, the MEPS estimates show a percent change of nearly 3 percent, down to just under -1 percent in 2006. The percent changes are higher for the next 2 years: about 6 percent in 2007 and nearly 7 percent in 2008. In 2009, the MEPS showed a decline of over 4 percent, while in 2010, there is no change.

Despite being based on different time periods, the CPS full-year estimates and the NHIS point-in-time estimates exhibit similar trends and rates of change. This observation is consistent with the view of CPS as a point-in-time estimate.

In 2005, the CPS shows a 2-percent increase, followed by an increase in 2006 of nearly 4 percent. The CPS shows a decline of 4 percent in 2007, followed by increases for 3 years: 1 percent in 2008, 8 percent in 2009, and 1 percent in 2010.

Like the CPS, the NHIS showed an increase from 2005 to 2006, from negative 2 percent in 2005 to about 5 percent in 2006. The NHIS then declined in 2007 by about 2 percent. The NHIS then increased for the next 3 years: 2 percent in 2008, 4 percent in 2009, and slightly over 3 percent in 2010.

Uninsured Data Sources

Comparison of Selected Survey Design Components

As we proceeded through the various components of our research (e.g., the surveys, the literature review, and our consultations with stakeholders, survey experts and CBO analysts), we focused on several specific dimensions of these data sources. These dimensions formed the basis for the comparison criteria presented in the next section.

Length of Uninsured Period

Given that health insurance status can be very volatile, estimates of different durations can have very different meanings. It is more likely that someone will be insured for some part of the year as compared with being uninsured at the time of the survey. And the likelihood that someone is uninsured for an entire year is less than the likelihood of being uninsured for any smaller duration. While the NHIS estimates confirm these conceptual notions, the CPS estimates, as compared with the other survey estimates, do not. As mentioned above, many analysts have surmised that CPS respondents are treating the health insurance question as a point-in-time question, and the resulting CPS uninsured rate time series seems to confirm that hypothesis.

The 2003 CBO study compares three measures – the number of people who are continuously uninsured for an entire year, the number who are uninsured at any time during the year, and the number who are uninsured at a point in time – to draw more accurate conclusions concerning the uninsured rate. Analysis of SIPP and MEPS data show that the uninsured population is very fluid, with roughly 63 percent of the people who were uninsured at any time in 1998 losing coverage or gaining coverage at some point during the year. Furthermore, in CBO's 2003 study, estimates of the uninsured at one point in time are similar for NHIS, MEPS and SIPP. These are also similar to CPS estimates of uninsured rates for the entire year.

Recall Periods

The amount of time a respondent has to recall is also a critical difference among the surveys, especially when respondents are being asked to recall their experience with something as variable as health insurance status. Shorter recall periods are recognized as being more useful in accurately estimating relationships between insurance status and economic variables such as eligibility for coverage and their change over time.^{66,67,68,69}

CPS has a recall period of 14 to 16 months, depending on which month the respondent is participating. MEPS, SIPP, and NHIS have shorter recall periods than the CPS. Also,

⁶⁶ CBO. (2003, May). "How Many People Lack Health Insurance and for How Long?"

⁶⁷ Bennefield. (1996). "A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP" (presented at Joint Statistical Meetings, American Statistical Association, Chicago)

⁶⁸ Swartz K. (1986) "Interpreting the Estimates From Four National Surveys of the Number of People Without Health Insurance.", *Journal of Economic and Social Measurement*, vol. 14. Pp 233 - 242

⁶⁹ Thiede K, et al. (Winter 2001/2002). "Uncovering the Missing Medicaid Cases and Assessing their Bias for Estimates of the Uninsured." *Inquiry*, vol. 38 no. 4 pp396-408

Uninsured Data Sources

because they produce different estimates associated with different uninsured durations, these surveys have different recall periods for each type of estimate. In the MEPS, respondents are asked about their insurance status for the previous three to six months through several probes, and their responses are coded on a month-by-month basis. In the SIPP, respondents are asked to recall their insurance over the last four months, since their previous SIPP interview. And in the NHIS, respondents are asked about their insurance status for the previous 12 months through several probes.

The recall period combined with the type of survey—cross-sectional versus longitudinal—can also have implications for the quality of the estimates, as shown by comparing the CPS and the SIPP. While the CPS has a larger sample size, its longer recall period may affect the precision of its estimates. The SIPP, on the other hand, loses sample size over the course of the three- to four-year survey, but studies argue that the monthly information makes the SIPP more accurate than the CPS.⁷⁰

Medicaid Coverage

The subject of how surveys capture Medicaid coverage came up in our consultations with stakeholders and survey experts. An analyst at the Census Bureau confirmed that the “Medicaid undercount” is a shortcoming of all federal surveys and told us that Medicaid enrollees are getting categorized, through their responses, as either uninsured or privately insured. The Census Bureau analyst indicated, however, that the CPS and the SIPP, in particular, fare better than the ACS in capturing Medicaid enrollment because they use the specific names of state Medicaid programs as probes in determining whether a respondent is covered by Medicaid. And, as noted above, all of these surveys will be making improvements to their Medicaid questions in the near future.

A multi-phase research study by the University of Minnesota’s State Health Access Data Assistance Center (SHADAC) and four DHHS agencies (NCHS, ASPE, AHRQ, and CMS) was undertaken to determine the extent to which survey-based estimates of Medicaid enrollment are lower than enrollment numbers reported in state and national administrative data. Studies resulting from this project and other research efforts using different surveys show that discrepancies range from about 10 percent to 38 percent.⁷¹

Unauthorized Immigrants

Our discussions with the survey experts indicated that all surveys use a household address as the basis for being included in the sample and that questions about legal status are not used in the survey instruments. Thus, in theory, unauthorized immigrants are just

⁷⁰ Bhandari, Shailesh. (2004). “People with Health Insurance: A Comparison of Estimates from Two Surveys.” US Census Bureau. June 8.

⁷¹ Lynch V. “Medicaid Enrollment: The Relationships between Survey Design, Enrollee Characteristics, and False-Negative Reporting,” http://www.census.gov/did/www/snacc/docs/Lynch_JSM.pdf

Uninsured Data Sources

as eligible to participate in these surveys as those with legal status, but undercounts of this population are widely suspected.

Timeliness

Different surveys have different lag times between when the data are collected from respondents and when they are released. Some surveys are able to release data in a timelier manner than others for the same time period or reference period. The NHIS is the most timely survey, while the SIPP is the least timely and does not release high-level estimates on a regular schedule. The MEPS releases microdata before the final estimates are complete, enabling users to construct their own uninsured estimates before the published estimates are released. The NHIS, CPS, and ACS release microdata along with the published estimates.

Strengths and Limitations of Data Sources

From a conceptual standpoint, point-in-time estimates are preferable to the other definitions available because they are more likely to be correlated with any measure of uncompensated care. A measure that is correlated with uncompensated care needs to capture the uninsured spells. Full-year estimates do not capture this movement in and out of the uninsured pool. Even partial-year estimates fall short in this respect; as someone who is uninsured for just one month is counted the same way as someone who is uninsured for eleven months.

All the surveys examined in this study are based on high-quality survey and sample designs and generate high-quality estimates, as determined through standard errors. As noted earlier, though all surveys undercount Medicaid enrollment, our discussions with the survey experts indicate that the surveys are designed to probe respondents appropriately to assign Medicaid coverage correctly. Similarly, all the surveys use the civilian non-institutional population as their sample base and do not include any questions about immigration status. In Exhibit 4.4, we have chosen to focus, then, on those attributes that differ among the surveys and that are most relevant for the implementation of Section 3133.

Uninsured Data Sources

Exhibit 4.4: A Comparison of the Strengths and Limitations of Sources for Estimates of the Uninsured

Survey	Source	Strengths	Limitations
CBO March Estimates ⁷²	CBO	<ul style="list-style-type: none"> Availability: CBO will continue to update its estimates of the uninsured in its March analysis of the President's budget Point-in-Time estimates of the uninsured 	<ul style="list-style-type: none"> Based on projections; actual change in uninsured could differ from CBO estimates
CPS	U.S. Census Bureau	<ul style="list-style-type: none"> By 2014, CPS is expected to yield point-in-time and full-year estimates of the uninsured rates Detailed questions about health insurance coverage 	<ul style="list-style-type: none"> CPS currently only reports full-year uninsured estimates; criticism that measure may not reflect full-year estimates. Break in published series for full-year estimates expected between 2012 and 2013. Point-in-time series will start in 2014, precluding comparisons between 2013 and subsequent years.
ACS	U.S. Census Bureau	<ul style="list-style-type: none"> Is being considered for use in developing estimates of uninsured children for the SCHIP Large sample 	<ul style="list-style-type: none"> Expected break in series between 2013 and 2018. Mail-based survey; itemized list for coverage
SIPP	U.S. Census Bureau	<ul style="list-style-type: none"> Supports Point-in-Time estimates of the uninsured, as well as other measures. Basis of CBO estimates of the uninsured 	<ul style="list-style-type: none"> Panel survey - subject to attrition bias Timeliness Break in series expected; exact timing is unknown.
NHIS	NCHS	<ul style="list-style-type: none"> Supports Point-in-Time estimates of the uninsured, as well as other measures Detailed questions about health insurance coverage Health-focused survey Timeliness: Estimates for January-June 2012 were released January 2013 	(None identified)
MEPS	AHRQ	<ul style="list-style-type: none"> Detailed questions about health insurance coverage Health-focused survey 	<ul style="list-style-type: none"> Panel survey - subject to attrition bias Smaller sub-sample of NHIS Timeliness

Feasibility of Implementation

The conceptual and timing issues highlighted in the above discussion will need to be evaluated from the standpoint of feasibility, taking into account the process for developing the FY2014 NRPM and Final Rules. Each data source has its own schedule for data collection, processing, and release. Those with longer lags between the data collection phase and the release date will be less feasible for the purpose of determining the uncompensated care add-on payment. To aid CMS in evaluating these options, we prepared a table documenting the release of estimates for FY 2013 (Exhibit 4.5).

⁷² These estimates are typically released along with CBO's *Budget and Economic Outlook*, which is produced in January each year and updated in August and includes projections of spending and revenues under current law over the next 10 years. CBO also updates its budget projections in March each year in conjunction with its analysis of the President's budgetary proposals. Since 2010, CBO has released uninsured estimates at least once each year, usually coinciding with the March *Budget and Economic Outlook* releases.

Uninsured Data Sources

Exhibit 4.5: Release of Estimates for FY2013

Survey	Sample Period	When Estimate is Available	Type of Estimate
CPS-ASEC*	CY 2013	September 2014	Full-year
ACS	CY 2013	October 2014	Point-in-time
SIPP	Unknown	Unknown	Unknown
MEPS	January-July 2013	May 2014	Part-year
	CY 2013	September 2015	Full-year
NHIS	January-March 2013	September 2013	Point-in-time
	January-June 2013	December 2013	Point-in-time
	January-Sept 2013	March 2014	Point-in-time
CBO**	n/a	Updated every year, usually in March.	Point-in-time

*CPS-ASEC will not have a point-in-time estimate available for 2013.

** These estimates are typically released along with CBO's *Budget and Economic Outlook*, which is produced in January each year and updated in August and includes projections of spending and revenues under current law over the next 10 years. CBO also updates its budget projections in March each year in conjunction with its analysis of the President's budgetary proposals. Since 2010, CBO has released uninsured estimates at least once each year, usually coinciding with the March *Budget and Economic Outlook* releases.

In addition, we have concluded this study with a discussion of timing and feasibility that includes calendars of data collection activities and release dates covering 2012 to 2017 (Exhibit 6.1 to 6.3).

Analysis of the Uncompensated Care Data Sources

In this section, we describe our approach to identifying and analyzing alternative data sources and definitions of uncompensated care. Prior to identifying possible definitions of uncompensated care for the purpose of Section 3133 payments, we first review the definition of uncompensated care generally. We then discuss the relationship of Medicaid DSH to uncompensated care. Finally, we discuss how uncompensated care relates to specific populations, such as the Indian Health Service (IHS) population.

Common Definitions of Uncompensated Care

Uncompensated care – the amount of care written off by hospitals – is defined differently by different provider types, and what the calculated uncompensated care is used for. Uncompensated care often is limited to bad debt and charity care costs.^{73,74,75,76} AHA’s TrendWatch calculates uncompensated care as “bad debt expense and charity care, at cost.”⁷⁷ AHA defines charity care as “care for which hospitals are never expected to be reimbursed” while bad debt reflects patients’ inability or unwillingness to pay their bills.⁷⁸ As calculated in the AHA TrendWatch, uncompensated care excludes other unfunded costs of care, such as underpayment from Medicare and Medicaid. While uncompensated care is often comingled with underpayments by Medicare and Medicaid, these are separate financial measures.⁷⁹ We note, however, that AHA’s comments to the

⁷³ Walker DM. (2005). Testimony before the Committee on Ways and Means, House of Representatives – nonprofit, for-profit and government hospitals: uncompensated care and other community benefits. Government Accountability Office (GAO), 1.

⁷⁴ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁷⁵ Hackbarth G. (2009). Medicare Payment Advisory Commission (Letter to M Shortt re: Document identifier CMS-2552-10).

⁷⁶ Atkinson G, Helms WD, Needleman J. (1997). State trends in hospital uncompensated care. *Health Affairs*, 233.

⁷⁷ American Hospital Association. (2010). Trendwatch Chartbook 2010: Trends Affecting Hospitals and Health Systems, Chapter 4: Trends in Hospital Financing.

⁷⁸ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁷⁹ American Hospital Association. (2010). Underpayment by Medicare and Medicaid fact sheet. 1.

Uncompensated Care Data Sources

National Provider Call requested the inclusion of Medicaid and all other underpayments. As we analyze alternative data sources and definitions of uncompensated care, we explore the implications of adding Medicaid shortfalls to our working definition of uncompensated care.

The Role of Medicaid DSH Definition of Uncompensated Care in Determining Hospital-Specific DSH Limits

Medicaid defines uncompensated care in order to determine the hospital-specific limit for Medicaid DSH payments. Therefore, uncompensated care is used as an upper threshold, and not a driver of how Medicaid DSH payments are allotted to hospitals up to that limit. Medicaid DSH payments to a hospital “cannot exceed the uncompensated costs of furnishing hospital services by the hospital to individuals who are Medicaid-eligible or have no health insurance (or other source of third party coverage) for the services furnished during the year.”⁸⁰ In essence, the hospital-specific Medicaid DSH limit is capped at the Medicaid and uninsured payment shortfall amount. It is relevant to understand the impact of including Medicaid shortfalls in the Medicare definition of uncompensated care for individual hospitals, as these shortfalls may decrease in the future under proposed legislative changes.

Since Medicaid’s definition of uncompensated care is used to determine the maximum amount of Medicaid DSH payments a hospital can receive, there is great specificity in defining uncompensated costs and patients who have no health insurance coverage. In determining hospital-specific DSH limits, uncompensated costs, as of now, can only include inpatient and outpatient hospital services to Medicaid-eligible and uninsured individuals. Inpatient and outpatient hospital services must meet the federal and state definitions of these services and be included in the State plan. Under Medicaid statute, all medically necessary inpatient and outpatient services are eligible to be considered as uncompensated care, but additional services furnished by the hospital that are outside the scope of inpatient and outpatient hospital services (including skilled nursing facilities, for example) are excluded from this amount.⁸¹

Other than pertaining to specific services, uncompensated care costs can only be captured by the hospital for certain populations. Under current Medicaid law, services for patients with “credible coverage” are not to be counted as uncompensated care, even if the service is not covered under the credible coverage. However, according to the proposed rule, which clarified existing policy, CMS proposed to define “uninsured” patients as those with “no health insurance or other source of third party coverage for the services provided.”⁸² Therefore, while a patient may have credible coverage through a third party,

⁸⁰ 77 FR 2500

⁸¹ 77 FR 2500

⁸² 77 FR 2502

Uncompensated Care Data Sources

if the service the patient receives is not a covered service, the patient is deemed “uninsured” for the service and the service costs can be considered as uncompensated costs. For example, if a Medicaid patient is hospitalized, but requires a service excluded from the State plan (e.g., transplant services), under current law, the costs for the excluded service would not be considered uncompensated, as the patient has “credible coverage.” However, under the proposed rule, the patient’s costs would be considered uncompensated costs, as the patient is “uninsured” in respect to the services rendered.⁸³

Medicaid Uncompensated Care and Indian Health Service Care Provision

This above definition of uninsured is particularly pertinent to patients enrolled in IHS. Under current law, patients enrolled in IHS or contract health services (CHS) are deemed to have credible coverage. IHS only covers patient services when they receive services directly from IHS or when the service is approved through CHS. As a result, if a patient receives care from a non-IHS hospital, and does not otherwise have third party coverage (such as a CHS arrangement), the services cannot be counted as uncompensated by the hospital. However, under the proposed rule, CMS revised the definition of uninsured such that costs for IHS patients who receive services from a non-IHS hospital would be considered uncompensated costs as the patient does not have “credible coverage” for the services rendered.⁸⁴ As a result, the hospital-specific limit for Medicaid DSH would be increased by the amount of IHS-related uncompensated care, possibly increasing the amount of Medicaid DSH a hospital could receive to offset the Medicaid and uninsured payment shortfalls.

Role of Bad Debt in Determining Payment Shortfalls within Medicaid DSH

While bad debt is often included in a hospital’s definition of uncompensated care, the role of bad debt as it relates to determining payment shortfalls and the hospital-specific DSH limit is handled differently. As discussed above, bad debt is defined as the cost of care that patients are unable or unwilling to pay.⁸⁵ Under current law (and reiterated in the proposed rule⁸⁶), bad debt, including any unpaid coinsurance and deductibles and payer discounts for patients with third party coverage for a given service, cannot be included as uncompensated care in calculating Medicaid hospital-specific DSH limits.⁸⁷ These cost categories are considered “uncollected revenues” as opposed to “uninsured costs.”⁸⁸ Therefore, bad debt for any patient with third party coverage for a service cannot be considered uncompensated care. This is different, however, from how a hospital may determine bad debt within its internal accounting.

⁸³ 77 FR 2503-2504

⁸⁴ 77 FR 2503

⁸⁵ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁸⁶ 77 FR 2504

⁸⁷ 73 FR 77909

⁸⁸ 77 FR 2504

Uncompensated Care Data Sources

Summary of Definition of Uncompensated Care within Medicaid DSH

In calculating uncompensated care for the purpose of determining Medicaid hospital-specific DSH limits, under current law, uncompensated costs for patients with credible coverage cannot be considered uncompensated care. Uncompensated care costs are restricted to patients with Medicaid or no third party coverage overall (not just for the services rendered). If the proposed rule were to be implemented, uncompensated costs for non-covered services for patients with credible coverage would be considered uncompensated. AHA⁸⁹ and NAPH⁹⁰ have submitted formal comments to CMS supporting the decision to define “uninsured” as service-specific and to therefore include the uncompensated costs for patients with credible coverage, but no service-specific coverage, in the hospital-specific Medicaid DSH limit. However, both organizations stress the importance of CMS expanding the definition of uncompensated costs as it relates to the Medicaid DSH hospital-specific limit to patients who have exceeded or exhausted their benefits, or patients with high-deductible plans or catastrophic coverage until patients reach these limits.

The expanded definition of uncompensated care could directly impact the amount of Medicaid shortfall within a hospital. The expansion of the hospital-specific DSH limit would increase the amount of Medicaid DSH a hospital could receive. This increase could ultimately offset the hospital’s cost for some of these services, reducing the overall Medicaid shortfall.

Methods for Identifying Data Sources

We have identified and analyzed several different data sources to determine the extent to which the definitions of uncompensated care vary and the advantages and disadvantages of using the data source in the uncompensated care add-on formula.

Based on a literature review and key stakeholder interviews, we identified six potential data sources that could provide measures of uncompensated care. For each data source identified, we conducted a focused literature review and an analysis of the component pieces of each data set. We also assess the advantages and disadvantages of relying on this data source for the uncompensated care add-on payment. The advantages and disadvantages were developed based on the feedback from the stakeholder interviews and through our methodical analysis of data components.

The goal of this task is to identify potential data sets that contain the necessary variables that could be used to calculate uncompensated care at a hospital level, which can then be aggregated to the state or national level. It is important to note that the definition of

⁸⁹ Letter to Marilyn Tavenner (February 16, 2012), Re: CMS-2315-P: Medicaid; Disproportionate Share Hospital Payments-Uninsured Definition, (Vol. No. 11) January 18, 2012.

⁹⁰ Letter to Marilyn Tavenner (February 17, 2012), Re: CMS-2315-P: Medicaid; Disproportionate Share Hospital Payments-Uninsured Definition.

Uncompensated Care Data Sources

uncompensated care will only be used to allocate a pool of funds across providers. The size of the pool remains fixed, regardless of the number and amount of cost components included in the uncompensated care formula.

Data sources we analyzed include:

1. AHA Annual Survey estimates of uncompensated care
2. Publicly-available hospital financial data provided by state agencies
3. Medicaid DSH audit data
4. IRS Form 990 for Non-Profit Hospitals
5. Medicare Cost Report CMS-2552-96, Worksheet S-10 (“old” MCR)
6. Medicare Cost Report CMS-2552-10, Worksheet S-10 (“new” MCR)

Following a systematic review of each data source, we summarize our conclusions.

Analysis of Data Sources and Uncompensated Care Definitions

1. AHA Annual Survey Estimates of Uncompensated Care

The AHA Annual Survey of Hospitals is the “nation’s most comprehensive source of hospital financial data”⁹¹ as of 2012. Collected since 1946, the AHA Annual Survey documents hospitals’ services, utilization, personnel and finances. Today, the survey is completed by most hospitals and profiles a universe of more than 6,500 hospitals throughout the country.⁹² The survey data are analyzed and reported in AHA’s TrendWatch.

DEFINITION: AHA ANNUAL SURVEY ESTIMATES OF UNCOMPENSATED CARE

According to the most recent AHA survey instrument, uncompensated care is defined as bad debt expense plus charity care. An excerpt from the instructions and definitions for the uncompensated care variables are below.⁹³

5. 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.

5a. 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 revenue (D3a).

5b. 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

⁹¹ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 1.

⁹² American Hospital Association. Survey History & Methodology. Available at: <http://www.ahadata.com/ahadata/html/historymethodology.html>

⁹³ American Hospital Association. 2009 AHA Annual Survey, Instructions and Definitions for Section D: Total Facility Beds, Utilization, Finances, and Staffing.

Uncompensated Care Data Sources

who meet certain financial criteria. For purposes of this survey, charity care is measured on the basis of revenue forgone, at full-established rates.

At the national level, annual AHA data indicate that uncompensated care costs as a percent of hospital costs ranged from 5.4 percent to 6.2 percent between 1999 and 2009, but centered around 6.0 percent. Charity care accounts for slightly over half of these percentages. These estimates are net of county allowances and other forms of payments covering hospital charity care burden. The offset of charity care expenses by government funding is a definitional issue that focuses on costs for which there are no payments.

ADVANTAGES AND DISADVANTAGES OF USING AHA ANNUAL SURVEY ESTIMATES OF UNCOMPENSATED CARE

Advantages

The AHA Annual Survey is completed by more than 6,500 hospitals each year, with 98 percent of the survey universe represented by AHA registered hospitals. With the assistance of state and local associations, Medicare and Medicaid centers, national organizations, and governmental bodies, the survey is also distributed to non-registered hospitals. It is with the support of the local communities that the survey is able to consistently have high response rates.⁹⁴

The use of a consistent survey instrument over time and the rigorous analysis and data validation steps by AHA ensures stable results that are able to be generalized each year. Responses by hospital type, size and geographic area are aggregated and compared to previous years' data, identifying inconsistencies with historic trends. In the event that questions are not completed in a given survey, the data are imputed based on historical data and current trends within similar hospitals.⁹⁵

Disadvantages

While these data are useful as benchmarks, they are only available at the national level. The instructions of the Annual Survey note that the uncompensated care section "...will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association."⁹⁶ Therefore, while the Dobson | DaVanzo Team has used the national-level data from the AHA to benchmark analyses from other data sources, these data cannot be used to derive hospital-level estimates, as required by Section 3133. The Annual Survey data collection process,

⁹⁴ American Hospital Association. Survey History & Methodology. Available at: <http://www.ahadata.com/ahadata/html/historymethodology.html>

⁹⁵ American Hospital Association. Survey History & Methodology. Available at: <http://www.ahadata.com/ahadata/html/historymethodology.html>

⁹⁶ American Hospital Association. 2009 AHA Annual Survey.

Uncompensated Care Data Sources

however, indicates that uncompensated care data can be consistently collected over a long period of time.

2. Publicly-Available Hospital Financial Data provided by State Associations

The second data source we analyzed is publicly-available hospital financial data provided by state agencies. Several states provide data on varying measures of uncompensated care, including California, Florida, Georgia, Indiana, and Texas.^{97,98} Dobson | DaVanzo and KNG Health recently used data from California, Florida, Indiana, New Jersey, New York, Pennsylvania, Texas, Vermont, and Washington to produce measures of uncompensated care for a study commissioned by The Commonwealth Fund. Dobson | DaVanzo also recently published an uncompensated care analysis in *Health Affairs* using California data.⁹⁹ MedPAC specifically notes how Texas uses a definition of uncompensated care corresponding to the new MCR Worksheet S-10 form.¹⁰⁰

To analyze the feasibility of using state-level hospital data, we requested and analyzed the FY 2009 and FY 2010 state-provided hospital-level financial data for California, Florida, and Texas. These states were chosen based on the availability of data that can be used to calculate uncompensated care costs and the large number of hospitals within each state that can enable additional analyses by hospital type.

DEFINITION: PUBLICLY-AVAILABLE HOSPITAL FINANCIAL DATA

For each state selected, we obtained and loaded the hospital-level data into a standardized database, collecting information on the hospital's characteristics, gross patient revenue, net patient revenue, bad debt, and charity. We reviewed all documentation provided by the state to better understand how variables were defined and collected. In earlier studies, we have also worked with state representatives to better understand their data.¹⁰¹

None of the states we analyzed calculated total uncompensated care, but did separately isolate bad debt from charity care. While there was general consistency on the definition of charity care (charity care minus any partial payments received for these cases, presented as charges), each state calculated bad debt differently. For example, bad debt was either considered an expense (presented as costs), or a deduction from revenue (presented as charges), both of which are acceptable under GAAP. Furthermore, some states allocated bad debt to each payer or as its own payer category. Significant data cleaning was required to develop "standard" measures of bad debt and charity care. States

⁹⁷ Medicare Payment Advisory Commission. (2007). Section 2a – inpatient and outpatient hospitals. *Report to the Congress – Medicare Payment Policy*, 72– 79.

⁹⁸ Walker DM. (2005). "Testimony before the Committee on Ways and Means, House of Representatives – Nonprofit, For-Profit and Government Hospitals: Uncompensated Care and Other Community Benefits" (GAO-05-743T), p. 1.

⁹⁹ Dobson, A, DaVanzo, J.E., El-Gamil, A.M., et al. (2009). How a new 'public plan' could affect hospitals' finances and private insurance premiums. *Health Affairs*, 1013-1024.

¹⁰⁰ Hackbarth G. (2009). Medicare Payment Advisory Commission (Letter to M Shortt re: Document identifier CMS-2552-10).

¹⁰¹ Commonwealth

Uncompensated Care Data Sources

also provided data that could be used to calculate Medicaid shortfalls. We note that Worksheet S-10 converts both charity care and bad debt from charges to costs using the ratio of cost-to-charges.

We present the definition of each applicable variable by state in Exhibit 5.1, below:

Exhibit 5.1: Definition of Uncompensated Care Variables by State

State (Most Recent Data)	Definition of Charity Care	Definition of Bad Debt	Medicare DSH Amounts Reported?	Variables on Medicaid Shortfalls?
California (2010) ¹⁰²	Charges for services rendered to patients who are unable to pay for all or part of the services provided (net of the amount paid by or on behalf of the patient)	The amount of accounts receivable (charges) which are determined to be uncollectible due to the patient's unwillingness to pay	No	Yes
Florida (2010) ¹⁰³	Charges for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts, for care provided to a patient in accordance with their charity care policy ¹⁰⁴	Periodic estimates of the amounts in accounts and notes receivable that are likely to be credit losses. The estimated amount of bad debts may be based on an experience percentage applied to the balance of accounts receivable or charges to patients' accounts during the period, or it may be based on a detailed aging and analysis of patients' accounts	No	Yes
Texas (2010) ¹⁰⁵	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. Reported as full-established rates (charges)	The provision for actual or expected uncollectables resulting from the extension of credit Bad debt can be reported as either as a cost or charge to the hospital, and captured in total expenses or net patient revenue	No	Yes

Exhibit 5.2 compares U.S. and Florida uncompensated care statistics. The Florida data, while at a higher absolute level, appear to track the AHA annual survey estimate data. This comparison highlights the value of using national AHA data as a benchmark for our eventual measures of uncompensated care expenditures.

¹⁰² Office of Statewide Health Planning and Development. Healthcare Information Division - Annual Financial Data. Glossary of 2010 Pivot Profiles. Available at: <http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfiles/default.asp>

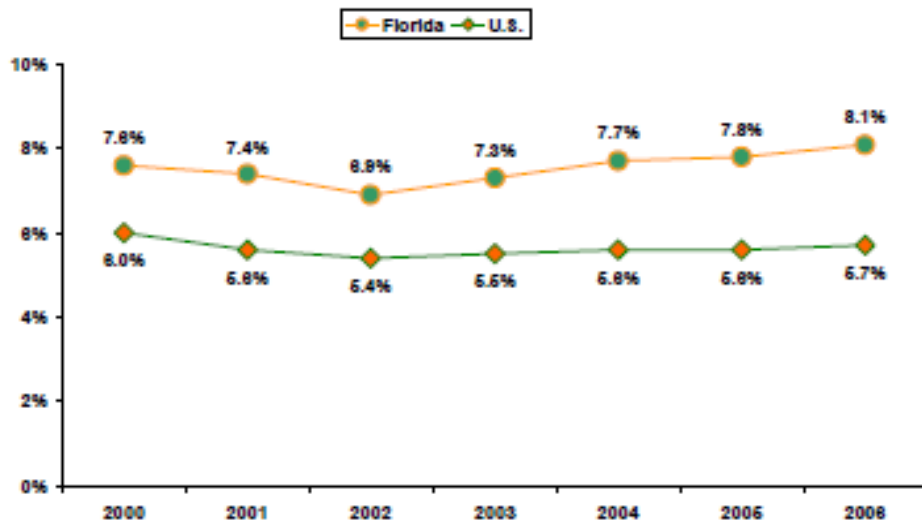
¹⁰³ Florida Agency for Health Care Administration. State Of Florida Hospital Uniform Reporting System Manual: 2010-1, January 2010. Available at: http://ahca.myflorida.com/MCHQ/CON_FA/fa_data/documents/FHURS_MANUAL_Jan-2010.pdf

¹⁰⁴ Charity care is provided for patients "whose family income for the twelve months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four be considered charity."

¹⁰⁵ Texas Department of State Health Department. 2010 Annual Survey of Hospitals. Available at: <http://www.dshs.state.tx.us/chs/hosp/hosp2/>

Uncompensated Care Data Sources

Exhibit 5.2: Percent of Hospital Expenses Going to the Care of the Uninsured



Source: Florida Hospital Administration. Data Brief – uninsured and the impact on Florida’s hospitals: 2000-2006, 6.

Exhibit Caption: Exhibit 5.2 shows the proportion of hospital expenses allocated to for caring for the uninsured in Florida and the U.S. overall from 2000 to 2008. The proportion of hospital expenses for the uninsured in both Florida and the U.S remained relatively stable over this time period. In the U.S., the proportion of hospital expenses for the uninsured ranged from 5.4% in 2002 to 6.0 in 2000. In 2008, approximately 5.7% of hospital expenses are allocated to care for the uninsured. For Florida, the proportion of hospital costs for the uninsured ranges from 6.8% in 2002 to 8.1% in 2008.

To date, we have received limited information on the usability of the state data from the stakeholder interviews. Interviewees did reiterate, however, that the definitions of bad debt and charity care differ significantly across the state datasets as they are created only as a state resource. Furthermore, there is no consistent format, variables, or definitions across the state datasets. Indeed the definition of charity care varies from hospital to hospital within a state depending on the generosity of the hospital’s charity care policy.

Uncompensated Care Data Sources

ADVANTAGES AND DISADVANTAGES OF USING PUBLICLY-AVAILABLE STATE DATA

There are some advantages and disadvantages to using the state-level data

Advantages

Under the Freedom of Information Act (FOIA), most states make their hospital-level financial data publicly available. These data are available for a nominal charge (if any). Additionally, staff are typically available within the state to help address any questions regarding the use of the data.

Disadvantages

Since there is no national effort to collect or report data at the hospital-level within states, not all states collect this information. For the states that do, there is also no mechanism to ensure consistent definitions, database construction, or data validation. Therefore, if these data were to be collected from each state with available information, it would take considerable effort to clean and organize the data into a useable format.

Additionally, state databases generally do not contain all the needed variables to determine the impact of implementing the new uncompensated care add-on payment. The state data only generally provide the bad debt and charity care costs (or payments). To make the data useable for analyses, they need to be linked to other resources, such as the MCR (to determine the amount of Medicare DSH received) and the Hospital Impact Files (to determine hospital characteristics and MCR RCCs to convert uncompensated charges to costs). Therefore, we conclude that the state data could not support the implementation of the Section 3133 Medicare DSH policy.

3. Medicaid DSH Audit Data

For states to receive federal funding in the form of a Federal Medical Assistance Percentage (FMAP) for Medicaid DSH payments, states are required to submit an independent certified audit and an annual report to CMS describing DSH payments made to each DSH hospital.¹⁰⁶ The Medicaid Audit data annual report for each state are made available through CMS. These data, however, only cover hospitals receiving Medicaid DSH in a specific year. For these hospitals, data are reported on Medicaid patient care costs, total Medicaid payments, Medicaid payment shortfalls, cost of care for uninsured patients, total payments for uninsured patients, uncompensated care costs for uninsured patients, and the total uncompensated care cost.

¹⁰⁶ Centers for Medicare and Medicaid Services. Medicaid Disproportionate Share Hospital Payments. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html>.

Uncompensated Care Data Sources

DEFINITION: MEDICAID DSH AUDIT DATA

The Medicaid DSH Audit Data contain several components of uncompensated care for each hospital. Specifically, uninsured and Medicaid uncompensated care costs are identified:

- **Uninsured uncompensated care:** the total uninsured cost net of any federal payments under section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and uninsured revenue.
- **Medicaid uncompensated care:** the total Medicaid payments minus Medicaid costs.
- **Total uncompensated care:** the total of uninsured and Medicaid uncompensated care.

ADVANTAGES AND DISADVANTAGES OF MEDICAID DSH AUDIT DATA

Advantages

The Medicaid DSH Audit data are available on CMS' website in a downloadable format. Each state is contained in a separate file.

Disadvantages

There are four major disadvantages of the Medicaid DSH Audit Data. First, there is a significant time lag in that the most recent audit data available are for FY 2007. Second, only 39 states reported Medicaid audit data in 2005-2007. Third, the data do not contain uncompensated care costs for those hospitals that did not receive Medicaid DSH payments or did not otherwise report. Therefore, hospitals who receive Medicare DSH, but not Medicaid DSH, are not contained in these data. We were not able to immediately determine how many Medicare DSH hospitals are reflected in this database. Lastly, the variables related to uncompensated care do not capture the bad debt of the hospital. This could be a significant omission for some hospitals.

Since only hospitals who report receiving Medicaid DSH are captured in the Audit Data, and uncompensated care data are not available for all states and all hospitals who receive Medicare DSH, we concluded that this file is also not appropriate for the distribution of Medicare DHS payment policies.

4. IRS Form 990, Schedule H

A small number of the participants of our stakeholder interviews referred us to Schedule H of the Form 990, which is completed by not-for-profit hospitals. While we recognized that the form does not apply to all hospitals, we researched the definition of uncompensated care and its advantages and disadvantages.

Uncompensated Care Data Sources

DEFINITION: IRS FORM 990, SCHEDULE H

Schedule H of the Form 990 does not include a field for uncompensated care. Rather, the form asks detailed information about the hospital's cost for providing social services to those patients who received federal assistance and participated in means-tested government programs. Specifically, the form discusses "financial assistance" (also referred to as charity care within the form's instructions" and identifies the number of programs, persons served, and the total community benefit expense (cost) and offsetting revenue. Additionally this form also allows hospitals to identify their Medicaid shortfall and costs for other "means-tested government programs." The form also separately captures the total amount of bad debt.

While the form captures the charity care and bad debt aspects of uncompensated care, the goal of the reporting is to track the hospital's continued responsibility to the community.

ADVANTAGES AND DISADVANTAGES OF MEDICAID DSH AUDIT DATA

Advantages

Since the form is required by the IRS for not-for-profit hospitals and contains detailed instructions, the methods used to complete the worksheet are likely fairly standardized across hospitals. It is also publicly available.

Disadvantages

The main disadvantage to using Schedule H of the Form 990 is that it is only required for not-for-profit hospitals. Therefore, it would only represent a large portion of the nation's hospitals.

5. "Old" Cost Report Form: CMS 2552-96, Worksheet S-10

In 2003, CMS added Worksheet S-10 to the MCR forms so IPPS hospitals could report uncompensated care costs as part of their MCR. In its initial version, this form has not provided accurate data on the levels of uncompensated care. For instance, MedPAC has indicated, that the "current form and instructions have produced unreliable data."¹⁰⁷

¹⁰⁷ American Hospital Association. (2010). Uncompensated hospital care cost fact sheet, 2.

Uncompensated Care Data Sources

DEFINITION: “OLD” MEDICARE COST REPORT FORM

In the “old” MCR, uncompensated care is defined as:

Total State and local indigent care program cost (line 25) + Total SCHIP cost (line 27) +
Total gross Medicaid cost (line 29) = Total uncompensated cost to the hospital (line 32)

Whereas:

- Total State and local indigent care program cost = Total charges for patients covered by State and local indigent care programs (line 23) times Cost to Charge Ratio
- Total SCHIP cost = Total SCHIP charges from your records (line 26) times Cost to Charge Ratio (line 24)
- Total gross Medicaid cost = Total gross Medicaid charges from your records (line 28) times Cost to Charge Ratio (line 24)

According to this definition, total uncompensated care for a hospital not only factors in state and local indigent care for the uninsured, but also includes the cost for SCHIP and Medicaid. Therefore, the formula does not explicitly include bad debt, charity care, or Medicaid shortfalls. However, this formula implies that a portion of Medicaid costs may be uncompensated.

An excerpt of lines from Worksheet S-10 of the CMS-2552-96 is presented below.

- Line 23: Total charges for patients covered by State and local indigent care programs
- Line 24: Cost to Charge Ratio (Wkst C, Part I, column 3 line 103, divided by column 8, line 103)
- Line 25: Total State and local indigent care program cost (line 23 x line 24)
- Line 26: Total SCHIP charges from your records
- Line 27: Total SCHIP cost, (line 24 x line 26)
- Line 28: Total gross Medicaid charges from your records
- Line 29: Total gross Medicaid cost (line 24 x line 28)
- Line 30: Other uncompensated care charges from your records (see instructions)
- Line 31: Uncompensated care cost (line 24 x line 30)
- Line 32: Total uncompensated cost to the hospital (Sum of lines 25, 27, and 29)

Consistent with the sentiments of MedPAC and others we have talked to over the past several years, use of the “old” MCR’s reported uncompensated care provides unreliable results, compared to known national benchmarks. Exhibit 5.3 shows uncompensated care costs taken from the “old” Worksheet S-10 from the inception of reporting period ending 2003 to reporting period ending 2005.¹⁰⁸ The percent of uncompensated care costs as a percentage of total cost ranges from 11.5 to 12.9 percent over the period. These percentages do not match the AHA and Florida reported numbers shown in Exhibit 2 of the state-level analyses presented above.

¹⁰⁸ BNet. (2007). Uncompensated hospital care: a look at the trends, 1-2.

Uncompensated Care Data Sources

Inspection of the “old” Worksheet S-10 and associated instructions indicate why this might be the case. Total uncompensated care for the hospital (line 32) comingles problematic payment concepts with the definition of uncompensated care, violating the AHA, MedPAC, and GAO definition of uncompensated care presented above.

Our analysis of the 2009 MCRs calculated Line 32 as 16.54 percent of total hospital costs, using only hospitals with reported Worksheet S-10 information. We also used Line 31 which is “uncompensated care cost” and obtained 4.44 percent of total hospital costs. Neither estimate is consistent with the six percent expected using AHA annual statistics as benchmarks.

Exhibit 5.3: Uncompensated Care as a Percentage of Total Hospital Cost, Reporting Period Ending 2003-2005

Category	Period Ending 2003	Period Ending 2004	Period Ending 2005	Total
Number of Hospitals (Available MCRs)	2,614	2,687	2,280	7,581
Total Hospital Cost (\$ millions)	\$311,319	\$341,654	\$295,498	\$948,471
Total Cost of Uncompensated Care (\$ millions)	\$40,165	\$39,323	\$34,089	\$113,577
Uncompensated Care as a Percentage of Total Cost	12.9%	11.5%	11.5%	12.0%

Source: CMS-2552-96 data (HCRIS file @ 6/30/2006) for proprietary and voluntary hospitals.

ADVANTAGES AND DISADVANTAGES OF USING “OLD” MEDICARE COST REPORT DATA

Advantages

Use of the current MCRs has some advantages that the other data sources do not possess. Unlike the other data sources, the MCR data are collected by CMS and completion is required by all hospitals. While there are some data lag issues, a completed MCR series for a given year can present a national estimate of uncompensated care costs.

Disadvantages

Current literature would suggest that the data collected for uncompensated care in this version of the MCR are invalid and unreliable. Our assessment of the reported uncompensated care supported that notion, as it did not match known benchmarks.

Additionally, the definition of uncompensated care differs significantly from commonly used definition, in that it factors in aspects of hospital costs that are not included in the other data sources that we reviewed.

Uncompensated Care Data Sources

6. “New” Medicare Cost Report CMS-2552-10, Worksheet S-10

Based on a systematic review of the above data sources, we conclude that the only data source that will provide consistent uncompensated care estimates on a national level and is publicly available is the “new” Worksheet S-10 of the MCR (CMS-2552-10). Effective FY 2010, the new Worksheet S-10 replaced the “old” Worksheet S-10. When assessing the new form, which MedPAC helped develop, MedPAC noted that, “the revised form also allows the separation of uncompensated care into charity care for the uninsured, charity care for the underinsured, and the costs of bad debts. This detailed level of information will be critical for evaluating policies that consider linking Medicare DSH payments to hospitals’ uncompensated care costs, as well as analyses of the distribution of uncompensated care costs among hospitals.”¹⁰⁹

DEFINITION: “NEW” MEDICARE COST REPORT

The new Worksheet S-10 defines the cost of non-Medicare uncompensated care as follows:

$$\text{Cost of charity care (line 23) + Cost of non-Medicare bad debt expense (line 29) =} \\ \text{Cost of non-Medicare uncompensated care (Line 30)}$$

Whereas:

- Cost of charity care = Cost of initial obligation of patients approved for charity care (line 21) minus partial payment by patients approved for charity care (line 22)
- Cost of non-Medicare bad debt expense = Cost to charge ratio (line 1) times non-Medicare and non-reimbursable bad debt expense (line 28)

We also note that uncompensated care, as defined in the new Worksheet S-10 includes the portion of Medicare bad debt (attributed to deductibles and co-payments) that is unreimbursed by Medicare. Select comments from the National Provider Call requested that this component of bad debt be included in the definition of uncompensated care.

The form also yields, however, a calculation for total unreimbursed and uncompensated care costs (Line 31), which includes other unreimbursed costs for Medicaid, SCHIP, and state and local indigent care programs, which are captured in Line 19 of the form. This suggests that the new Worksheet S-10 has the flexibility and all required variables for more expansive definition of uncompensated care.

Worksheet S-10 is included in the accompanying Excel document.

¹⁰⁹ Hackbarth G. (2009). Medicare Payment Advisory Commission (Letter to M Shortt re: Document identifier CMS-2552-10).

Uncompensated Care Data Sources

While the Worksheet S-10 appears to have advantages to determining hospital-specific uncompensated care, there was a large concern that the Worksheet S-10 data would not be available in time for CMS analysis and development of the uncompensated care add-on payment methodology. To better understand the projected timeframe for the Worksheet S-10 data, the Dobson | DaVanzo Team participated in a meeting with CMS MCR experts. Based on their information, we have concluded that data for a large proportion of hospitals based on the new Worksheet S-10 (either FY 2010 or FY 2011) should be available by January or February of 2013. Finally, we anticipate that Worksheet S-10 information from nearly all hospitals should be available by the summer of 2013. This would allow for early modeling of the impact of Section 3133 DSH payments as compared to current law. At this time, the validity and reliability of the Worksheet S-10 data cannot be determined.

Based on this information as to the timing of Worksheet S-10 data availability, this would enable CMS to design its simulation models in preparation for the receipt of completed annual data early in 2013. We have not attempted to crosswalk the “old” Worksheet S-10 to the “new” form, which would be very difficult, if not impossible, due to the changes in the instructions and definitions.

FEEDBACK FROM STAKEHOLDER INTERVIEWS

In this section, we reiterate, at a higher level, the key themes that were identified during our stakeholder interviews. A more detailed discussion was presented above in the “Key Findings from Stakeholder Interviews” chapter.

Generally, all interviewees agreed that bad debt and charity care were appropriate measures of uncompensated care, as they identify the cost of care provided that was not reimbursed. However, several interviewees recommended the inclusion of Medicaid and other shortfalls into the formula, and recommended that the cost-to-charge ratio used to convert charges into hospital costs should reflect total hospital costs, not just Medicare allowable costs, as captured in Line 1 of the Worksheet S-10. We outline their rationale below.

Inclusion of Medicaid Shortfalls in Uncompensated Care

There were several arguments for and against the inclusion of Medicaid shortfalls in the formula for uncompensated care. Proponents of including Medicaid shortfalls in uncompensated care argued that Medicaid payments typically do not cover the cost of treating Medicaid patients. Therefore, the hospital is incurring significant costs that are not reimbursed – therefore, uncompensated. If the goal of DSH is to provide partial relief to hospitals with high uncompensated care costs, the inclusion of payment shortfalls must be included. In the case of Medicaid, which covers low-income individuals, this argument ties back to the notion that DSH payments largely reflect uncompensated care costs for low-income individuals.

Uncompensated Care Data Sources

The interviewees also recognized that while the same argument could be made for including Medicare shortfalls into the formula, it would not be appropriate for Medicare to cover its own shortfalls through the use of Medicare DSH payments.¹¹⁰

Interviewees also provided arguments against including Medicaid shortfalls into the formula of uncompensated care. The argument for excluding Medicaid shortfalls pivots on the goal of proper targeting of DSH funds to providers with the most need in terms of covering the uninsured. The inclusion of the Medicaid shortfalls will not increase the amount of DSH funds to be distributed across providers; thus, the inclusion of Medicaid shortfalls could greatly alter the distribution of DSH funds by provider. That is, providers with a large Medicaid payer-mix in states that underpay Medicaid costs by a wide margin, but a small amount of bad debt and charity care, would be allocated a disproportionately high amount of DSH payments. This would reduce the DSH amount that could be provided to other providers. One interviewee argued that if you only have a fixed amount of DSH payments which cannot cover all of the uncompensated care for all hospitals; it should be targeted to the providers in the most need – those with a disproportionate amount of charity care and bad debt.

Interviewees asserted that the use of Medicaid shortfalls would also redistribute Medicare DSH payments across states to states that pay hospitals less relative to their Medicaid costs. They further asserted that it would also move money to states that participate in the Medicaid expansion under the ACA.

Another argument against the inclusion of Medicaid shortfalls is the lack of transparency of total Medicaid shortfalls. Interviewees mentioned that the Medicaid shortfalls included in the Worksheet S-10 are not necessarily the net amount of shortfalls following state and local indigent care payments. Without knowing how each hospital allocates its state and local appropriations to each payer, the reported Medicaid shortfalls reported in either Line 8 or Line 19 of the MCR could be misleading.

Use of Total Hospital Ratio of Cost-to-Charges (RCC)

The formula for uncompensated care presented in Line 30 of the Worksheet S-10 relies on the Medicare allowable RCC for the hospital. This ratio excludes Medicare unallowable costs, such as marketing and bad debt and direct GME. Several interviewees suggest that the use of this RCC is in error. In order to determine the true cost of uncompensated care, CMS in this view should incorporate the costs associated with Medicare unreimbursable costs, and should use the total hospital RCC, which can be calculated from the MCR. Since the majority of patients reflected in the charity care or bad debt components of uncompensated care are not Medicare beneficiaries, select interviewees indicated that the use of Medicare-allowed RCCs produces an inappropriate measure of “cost.”

¹¹⁰ Medicare does, however, cover a portion of its own bad debt for deductibles and co-payments.

Uncompensated Care Data Sources

ADVANTAGES AND DISADVANTAGES OF USING NEW WORKSHEET S-10

While there are clear differences of opinions in how uncompensated care should be defined within new Worksheet S-10, there is consensus that new Worksheet S-10 should eventually be used as the data source in allocating DSH payments across hospitals. However, as noted above, there are advantages and disadvantages to the use of these data, especially in the near term.

Advantages

Based on our stakeholder interviews and literature review, the Worksheet S-10 is the only database that provides publicly available estimates of uncompensated care at the hospital level on a national scale. Filing of MCRs is required for all hospitals treating Medicare patients; therefore, CMS will have access to estimates of uncompensated care for all hospitals, eventually increasing the precision of the DSH allocation.

Additionally, MCR data are submitted annually, providing relatively timely estimates of how uncompensated care costs change at the provider-level. Lastly, the use of a standardized form allows for uniformity in the definition across hospitals within and across states, in that uncompensated care will include charity care and bad debt, and either include or exclude Medicaid shortfalls. In the event that CMS supports a policy that alters the definition of uncompensated care beyond Line 30 of Worksheet S-10, this worksheet allows for alternate definitions to be used without additional reporting by hospitals.

Disadvantages

There are several limitations to the Worksheet S-10 form that could impact its use. First, stakeholder interviews indicated that while the instructions provided for the new form are vastly improved from the old form, there is still vagueness in how the applicable variables (charity care and bad debt) are calculated and reported by each hospital. For example, should the hospital only report bad debt once collection efforts have stopped, or can bad debt include costs that are actively being collected by collection agencies? Limitations of this type could be mitigated over time as CMS provides further direction and interpretation of how the forms should be completed. Furthermore, the detail required in the form is often different than the way hospitals report and monitor their charity care and bad debt. Therefore, it is hard for some hospitals to estimate some of the variables reported on Worksheet S-10, as they are not regularly reported hospital measures.

Additionally, a current limitation of relying on the Worksheet S-10 is the lack of validation for these measures. Hospitals are currently completing the form for the first time in FY 2011. There is no evidence of the level of accuracy of the data that are being collected at this point. Since several of the stakeholders we interviewed did not have feedback from their constituents on the difficulty of completing the form, we are unable to opine on the validity of the data.

Uncompensated Care Data Sources

Lastly, possibly due to the inconsistent interpretation of directions and lack of data validation, as well as the difference in the current Medicare DSH methodology and Section 3133, use of the Worksheet S-10 data could result in a disproportionate redistribution of Medicare DSH payments to hospitals. As presented in the next chapter, we reviewed the raw S-10 data to determine the extent to which some outlier hospitals reported implausible uncompensated care costs. While some redistributive effects can be mitigated by applying a trimming methodology to better control for data outliers, there will continue to be a redistribution of Medicare DSH payments across hospitals, states, and hospital types by using the S-10 data. The results of our impact analyses by state and hospital type are presented in the next chapter.

Impact Analysis of Worksheet S-10 Data

Using the most recently available MCRs, we conducted an impact analysis to determine the extent to which the Worksheet S-10 data would be appropriate for calculating Factor 3. Based on all completed Worksheet S-10s as of the December 2012 HCRIS update and a list of hospitals expected to receive Medicare DSH payments in 2014 provided by CMS, we examined the distribution of uncompensated care, current DSH payments, and modeled DSH payments based on Worksheet S-10 data under Section 3133. In this chapter we present our analysis of raw Worksheet S-10 data, present a methodology for trimming outliers, and present the resulting impact of using the “cleaned” Worksheet S-10 data to distribute Medicare DSH payments.

Exhibit 6.1 shows the inventory of hospitals with completed Worksheet S-10 data relative to the number of IPPS hospitals. In 2014, there will be approximately 3,435 IPPS hospitals, of which 3,233 hospitals, or 94.1 percent, have a completed Worksheet S-10 for either 2010 or 2011. Of the hospitals that have a completed S-10, about two-thirds are current DSH hospitals (2,248) and one-third are non-DSH hospitals (985). CMS estimates that in 2014, 2,711 hospitals will be DSH-eligible.

Exhibit 6.1: Number of Hospitals with Completed Worksheet S-10s for FY2010 or 2011

Hospital Category	Number of Hospitals	Percent of IPPS Hospitals in FY2014
Estimated IPPS Hospitals in FY2014	3,435	100.0%
IPPS Hospitals in FY2014 with Completed Worksheet S-10	3,233	94.1%
IPPS DSH Hospitals in FY2014 with Completed Worksheet S-10	2,248	65.4%
IPPS Non-DSH Hospitals in FY2014 with Completed Worksheet S-10	985	28.7%
Expected 2014 DSH Hospitals	2,711	78.9%

Source: Dobson | DaVanzo Team analysis of 2010 and 2011 Hospital Cost Reports and 2010 MedPAR.

Impact Analyses of Worksheet S-10 Data

We conducted an analysis of the available Worksheet S-10 data to understand how reported uncompensated care costs vary across hospitals. The goal of this analysis was to understand how the use of Worksheet S-10 data in developing Factor 3 could impact the Medicare DSH payments hospitals could receive, relative to their current Medicare DSH payments. Following our review of the raw data, we propose a trimming algorithm to “clean” the Worksheet S-10 data of outliers and produce the results for two different DSH models for determining Factor 3: 1) Factor 3 calculated using uncompensated care defined as bad debt and charity care (Worksheet S-10 Line 30), and 2) Factor 3 calculated using uncompensated care defined as bad debt, charity care, and payment shortfalls (Worksheet S-10 Line 31).

Distributional Analysis of Raw Worksheet S-10 Data

We analyzed the raw Worksheet S-10 data to better understand the feasibility of using the submitted Worksheet S-10 data to identify hospital’s uncompensated care. In our review, we identified considerable variation in the reporting of uncompensated care costs among the 3,233 hospitals with cost reports for either FY 2010 or 2011. As identified by the public comments received following the National Provider Call, there was concern that the extreme variation in uncompensated care costs (likely due to entry error, accounting errors, or inconsistency in definitions) could lead to disproportionately high Medicare DSH payments for a few hospitals and a shortfall of appropriate payments for remaining hospitals.

Our analysis identified at least two main sources for the variation in reported Worksheet S-10 data:

- **EXTREME RATIO OF COST-TO-CHARGES (RCC):** While most hospitals reported RCCs within a reasonable range, a few hospitals had extreme RCCs, which are used to convert the uncompensated care charges into costs. For example, the maximum RCC reported was 68.3 (i.e., costs are 68.3 times larger than charges), and the 95th percentile of the RCCs was 0.54. Higher RCCs produce higher uncompensated care costs.
- **EXTREME UNCOMPENSATED CARE COSTS:** As discussed in the previous chapter, uncompensated care costs can be calculated by using Line 30 (excluding payment shortfalls) or Line 31 (including payment shortfalls). The uncompensated care cost for each hospital serves as the numerator in their hospital-specific Factor 3, which determines the amount of Medicare DSH payments they receive. The larger the proportion of uncompensated care represented by one hospital, the larger share of total Medicare DSH payments they will receive.

If Worksheet S-10 data were to be used to determine Factor 3, significant data cleaning would be required to remove “outliers.” Based on raw data, a single

Impact Analyses of Worksheet S-10 Data

provider accounted for 9.4 percent of all uncompensated care costs in the country. Public comments following the National Provider Call suggested that this distribution of Medicare DSH payments is implausible. For perspective, this is larger than the cumulative share of the lowest 64 percent of expected DSH hospitals. Furthermore, the top percentile of hospitals accounts for 29.6 percent of total uncompensated care, while the top fifth percentile accounts for 52.7 percent of total uncompensated care. Hospitals with extreme uncompensated care costs also often have extreme RCCs. Therefore, for most hospitals, correcting the RCC would better align the distribution of uncompensated care cost.

Implementation of Section 3133 based on these raw data would produce a significant disproportionate distribution of Medicare DSH payments to select hospitals, at the expense of remaining hospitals.

Methodology for “Cleaning” Worksheet S-10 Data

To improve the appropriateness of using the Worksheet S-10 data, we developed a methodology to clean the data of extreme outliers. Given that the main sources of variation were the RCC and the uncompensated care costs, we developed a “double-trimmed” approach to ensure that the RCC used to convert charges to costs within the Worksheet S-10 were in line with other reported hospitals, ultimately correcting for many of the uncompensated care cost outliers. A step-by-step summary of our methodology is presented below. The calculated statewide RCCs used in our analysis are contained in Appendix E.

Impact Analyses of Worksheet S-10 Data

Exhibit 6.2: Methodology for Double-Trim Cleaning and Determining Factor 3

Step 1: Identify IPPS Hospitals to be included

CMS provided a list of hospitals projected to receive Medicare DSH payments in 2014
Hospitals involved in the Rural Community Demonstration or hospitals that receive hospital-specific payments are considered "Non-DSH" hospitals
Hospitals without a filled Worksheet S-10 for 2010 or 2011 are excluded from analysis

Step 2: Determine State Average RCC Using Worksheet S-10

Any hospital with a reported RCC on the Worksheet S-10 (Line 1) of greater than 5.0 is isolated
The unweighted average RCC is calculated by state for the remaining hospitals using the Worksheet S-10 calculated value

Step 3: Trim RCCs using Statewide Average

Any hospital with a reported RCC greater than 5.0 is assigned the state average RCC
The natural logarithm of the RCC for all hospitals is calculated
The average (geometric mean) and the standard deviation of the log values is calculated
Any hospital with an RCC greater than 3 standard deviations above the geometric mean is assigned the calculated state average RCC

Step 4: Recalculate Uncompensated Care and Unreimbursed Amounts with New RCCs

Total uncompensated care costs (Line 30) and unreimbursed amounts (Line 31) are recalculated for any hospital assigned the statewide average RCC
$$\text{Uncompensated Care (Line 30)} = \text{Line 1} * (\text{Line 20} + \text{Line 28}) - \text{Line 22}$$
$$\text{Uncompensated Care} + \text{Unreimbursed (Line 31)} = \text{Line 1} * (\text{Line 6} + \text{Line 10} + \text{Line 14} + \text{Line 20} + \text{Line 28}) - (\text{Line 2} + \text{Line 5} + \text{Line 9} + \text{Line 13} + \text{Line 22})$$

Step 5: Negative Values

To ensure that no hospital has a negative uncompensated care cost (resulting in negative uncompensated care payments), any negative values for Line 30 or Line 31 are set to zero for purposes of modeling

Step 6: Calculate Factor 3

Factor 3 is calculated as the provider's non-Medicare uncompensated care costs (Line 30) or unreimbursed amounts (Line 31) divided by the sum of the uncompensated care costs across all DSH hospitals

Step 7: Calculate Modeled DSH Percent

$$\text{Model DSH \%} = [25 \% \times \text{Current DSH \%}] + [75 \% \times \text{Factor 2} \times \text{Factor 3}] = 91.6\%$$

Current DSH payments obtained from 2010 MedPAR

IMPACT OF THE DOUBLE-TRIM APPROACH

Only five hospitals were affected by the first trim (i.e., replacing hospital RCCs with the statewide average), while an additional 43 hospitals were affected by assigning the

Impact Analyses of Worksheet S-10 Data

statewide average to hospitals with an RCC greater than three standard deviations from the geometric mean.

Adjusting these 48 hospitals had a large impact on the overall distribution of Medicare DSH payments, as presented in Exhibit 6.3.

Exhibit 6.3: Impact of Double-Trim Approach

Characteristics	Raw Worksheet S-10	Cleaned Worksheet S-10
Maximum RCC Modeled	68.3	1.02
Maximum Uncompensated Care Share	9.4%	2.4%
Proportion of Total Uncompensated Care Represented by Top 1% of Providers (By Uncompensated Care)	29.6%	15.1%
Proportion of Total Uncompensated Care Represented by Top 5% of Providers (By Uncompensated Care)	52.7%	37.6%

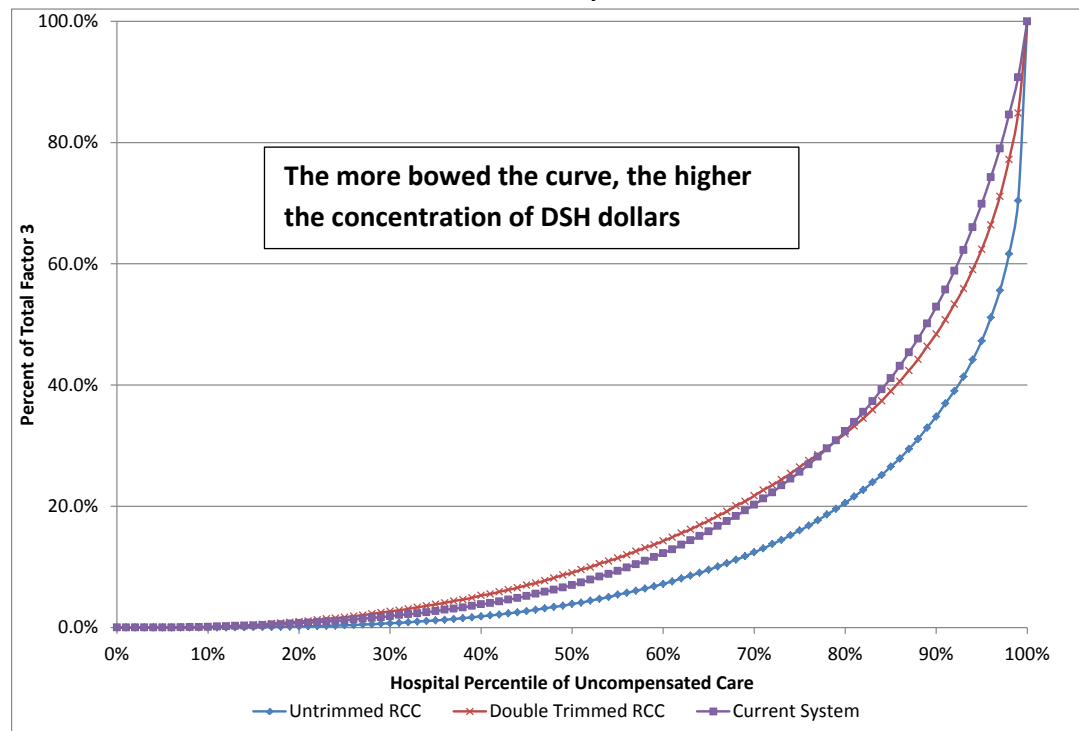
Source: Dobson | DaVanzo Team analysis of 2010 and 2011 Hospital Cost Reports and 2010 MedPAR.

Following the double-trim, the maximum RCC used in calculating DSH payments under Section 3133 is 1.02, compared to 68.3 prior to data cleaning. Furthermore, whereas prior to data cleaning the maximum share of a single hospital was 9.4 percent (larger than the cumulative share of the lowest 64 percent of hospitals), after data cleaning, the largest share is 2.4 percent, equivalent to the cumulative share of the lowest 28 percent of hospitals. After data cleaning, the top percentile and top fifth percentile represent 15.1 percent and 37.6 percent of all uncompensated care costs, respectively. For purpose of comparison, under the current DSH system, no hospital receives more than 0.96 percent of total Medicare DSH payments in 2010.

Both the current DSH system and the trimmed approach result in a more smooth distribution of Medicare DSH payments to hospitals compared to the untrimmed data. Exhibit 6.4 shows the distribution of payments by hospital percentile of uncompensated care costs. That is, prior to trimming, only 35 percent of DSH payments are concentrated within the bottom 90 percentile of hospitals. Therefore, the top 10 percentile of hospitals overall would receive about 65 percent of DSH payments (based only on Factor 3). After the trim, and consistent with the current system, the top 10th percentile of hospitals would receive about 50 percent of DSH payments. (Note that the specific hospitals contained in the top 10th percentile may differ under each model.)

Impact Analyses of Worksheet S-10 Data

Exhibit 6.4: Distribution of Current Medicare DSH Payments and Factor 3 under Various Scenarios



Source: Dobson | DaVanzo Team analysis of 2010 and 2011 Hospital Cost Reports and 2010 MedPAR.

Exhibit Caption: Exhibit 6.4 shows the distribution of Medicare DSH payments under the current system and for both the untrimmed and double-trimmed RCCs by the hospital percentile of uncompensated care. The distribution of payments using the double-trimmed RCC is similar to the current system. The untrimmed RCC model has a higher concentration of DSH payments to hospitals with higher percentiles of uncompensated care.

Analysis of “Cleaned” Worksheet S-10 Data by Hospital Type

Using the cleaned Worksheet S-10 data for all hospitals expected to receive Medicare DSH payments in 2014, we conducted a distributional analysis to determine how Medicare DSH payments would shift across hospital types based on a methodology using Line 30 (bad debt and charity care) and Line 31 (bad debt, charity care, and payment shortfalls).

Exhibit 6.5 summarizes the impact of using both Line 30 and Line 31 to model Medicare DSH payments by hospital type. After factoring in the change in the uninsured, the largest redistribution of Medicare DSH payments is evidenced by hospital ownership type, regardless of whether Line 30 or Line 31 is used to determine Factor 3. Voluntary and proprietary hospitals are expected to receive a significantly lower share of Medicare DSH payments than under the current system. Voluntary hospitals are expected to reduce their share of DSH payments by 12.3 percentage points using Line 30 and 9.4 percentage points

Impact Analyses of Worksheet S-10 Data

using Line 31 relative to current DSH payments. Proprietary hospitals are expected to experience a smaller impact and have their share of Medicare DSH payments reduced by 4.9 percentage points using Line 30 and 4.3 percentage points using Line 31, relative to current DSH payments. Government hospitals are expected to increase their share of DSH payments under both models by 8.8 and 5.4 percentage points, respectively.

Overall, urban hospitals and hospitals with a moderate Medicare utilization percentage (25 to 50 percent) are expected to experience the largest decrease in their share of Medicare DSH payments.

Exhibit 6.5: Impact of Factor 3 Models for Estimated FY 2014 DSH Hospitals by Hospital Type

Hospital Type	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
All Hospitals	2,248	100.00%	-8.40%	-8.40%

Hospital Type by Geographic Location	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
Urban Hospitals	1,758	94.46%	-8.46%	-8.62%
Large Urban Areas	948	60.17%	-4.88%	-5.64%
Other Urban Areas	810	34.29%	-3.58%	-2.98%
Rural Hospitals	488	5.54%	0.06%	0.22%
Unknown	2	0.00%	0.00%	0.00%

Hospital Type by Bed Size (Urban)	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
0 to 99 Beds	290	1.08%	1.10%	1.36%
100 to 249 Beds	785	21.76%	-0.99%	0.02%
250 to 499 Beds	500	37.78%	-3.11%	-3.41%
500 to 749 Beds	129	20.00%	-3.02%	-3.94%
750 or More Beds	54	13.85%	-2.44%	-2.64%

Hospital Type by Bed Size (Rural)	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
0 to 49 Beds	146	0.48%	0.20%	0.25%
50 to 99 Beds	194	1.40%	0.11%	0.21%
100 to 149 Beds	86	1.35%	-0.12%	-0.10%
150 to 199 Beds	36	0.97%	0.25%	0.14%
200 or More Beds	26	1.33%	-0.38%	-0.28%

Impact Analyses of Worksheet S-10 Data

Hospital Type by Urban by Region	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
New England	90	4.13%	-0.43%	0.02%
Middle Atlantic	207	17.92%	-5.17%	-5.66%
South Atlantic	294	17.03%	1.99%	-0.69%
East North Central	283	12.00%	0.59%	1.80%
East South Central	130	5.84%	-1.05%	-1.56%
West North Central	100	4.06%	0.01%	-0.23%
West South Central	228	11.06%	0.23%	-1.18%
Mountain	99	4.09%	0.40%	0.46%
Pacific	292	18.19%	-4.95%	-1.50%
Puerto Rico	35	0.13%	-0.08%	-0.08%

Hospital Type by Rural by Region	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
New England	10	0.15%	0.02%	0.10%
Middle Atlantic	33	0.39%	-0.15%	-0.04%
South Atlantic	109	1.46%	0.46%	0.24%
East North Central	65	0.47%	0.20%	0.40%
East South Central	131	1.82%	-0.51%	-0.46%
West North Central	23	0.21%	0.00%	-0.01%
West South Central	100	0.92%	0.04%	-0.03%
Mountain	11	0.06%	0.03%	0.02%
Pacific	6	0.07%	-0.02%	-0.01%

Hospital Type by Payment Classification	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
Urban Hospitals	1,780	94.25%	-8.18%	-8.32%
Large Urban Areas	961	60.04%	-4.74%	-5.48%
Other Urban Areas	819	34.21%	-3.44%	-2.85%
Rural Hospitals	466	5.75%	-0.22%	-0.08%
Unknown	2	0.00%	0.00%	0.00%

Hospital Type by Teaching Status	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
Nonteaching	1,439	28.97%	-0.86%	0.53%
Fewer than 100 residents	589	34.69%	-6.09%	-5.32%
100 or more residents	218	36.35%	-1.45%	-3.62%
Unknown	2	0.00%	0.00%	0.00%

Impact Analyses of Worksheet S-10 Data

Hospital Type by Type of Ownership	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
Voluntary	1,351	66.65%	-12.31%	-9.43%
Proprietary	482	14.35%	-4.94%	-4.34%
Government	412	19.00%	8.84%	5.36%
Unknown	3	0.00%	0.00%	0.00%

Hospital Type by Medicare Utilization Percent	Number of Estimated 2014 DSH Hospitals	Current DSH %	Percentage Point Impact Uncompensated Care Model DSH	Percentage Point Impact Unreimbursed and Uncompensated Care Model DSH
0-25	272	17.66%	6.51%	4.24%
25-50	1,326	71.42%	-15.10%	-13.07%
50-65	573	10.27%	0.36%	0.44%
Over 65	75	0.65%	-0.16%	-0.01%
Unknown	2	0.00%	0.00%	0.00%

Source: Dobson | DaVanzo Team analysis of 2010 and 2011 Hospital Cost Reports and 2010 MedPAR.

Hospital categories were derived from 2010 Provider of Service file and FY 2013 Final Rule IPPS Impact File.

Uncompensated Care pulled from Worksheet S-10, Line 30.

Unreimbursed and Uncompensated Care pulled from Worksheet S-10, Line 31. RCCs are trimmed by first replacing any RCC that is greater than 5 with the state average RCC (calculated using the Worksheet S-10 for RCCs that are below 5) and then replacing any RCC that is 3 standard deviations above the geometric mean RCC with the state average RCC.

Model DSH distributions calculated by $[0.25 \times \text{Current DSH}] + [\text{Factor 2} \times \text{Factor 3} \times 0.75]$

The hospital-specific impact comparing Factor 3s derived from Line 30 and Line 31 can be found in the attached spreadsheet.

Timing and Feasibility of Implementing Available Data Sources

A critical determinant of which data sources would be most feasible for the development of the FY2014 IPPS Proposed and Final Rules will be timing. Each data source has its own schedule for data collection, processing, and release. Those sources with longer durations between the data collection phase and the release date will be less feasible for the purpose of determining the uncompensated care add-on payment. As CMS determines how to implement the uncompensated care add-on payment starting in FY 2014, these timing issues will need to be considered along with the qualitative aspects of each data source. If, for instance, early reported Worksheet S-10 data may provide unreliable or invalid.

In this section, we introduce three tables that describe the data collection and release dates for the different data sources discussed in this report for 2012 to 2017. The tables are contained in the accompanying Excel document.

In Exhibit 7.1, we present data collection and release dates for the MCR and MedPAR activities from FY 2012 to 2017. The table illustrates the data continuum in the context of the CMS IPPS rulemaking period. This calendar will inform CMS on the timing of data availability for use in their decision making process. (Release dates of data for additional fiscal years are provided in Appendix F).

The next two tables highlight the data collection and release schedules for the uninsured data sources – CPS-ASEC, ACS, MEPS, NHIS, and the CBO. We do not include SIPP in these tables because SIPP estimates are not released on a regular schedule. In Exhibit 7.2, we show the timing of data collection for these sources, and in Exhibit 7.3, we show the timing of the release of estimates from these data sources.

Conclusions and Next Steps

The results of our preliminary analyses of data sources, definition, and potential impact by hospital type are encouraging, in that we feel that CMS will be able to implement Section 3133 Medicare DSH payment policy by FY 2014. There are, however, several challenges that remain that must be addressed prior to developing a final payment methodology.

Through the rule making process, CMS will need to clarify the specific CBO sources of data to be used for 2013 and 2014. CMS will also need to determine when it will need to finalize the regulation on what data to use starting in 2018.

CMS will also need to consider what definition of uncompensated care is the most appropriate in order to reallocate Medicare DSH payments. The core measure of bad debt plus charity care better targets scarce resources to the hospitals with the highest proportion of uninsured patients. The arguments for including Medicaid shortfalls were made by stakeholders and need to be considered from the context of how CMS wants to target the Medicare DSH payments. Commenters from the National Provider Call also requested to ensure that the redistributive effects are muted and that hospitals receive their appropriate share of Medicare DSH payments.

The largest obstacle to implementing Section 3133 will likely be the availability of a national datasets that contains all hospitals uncompensated care costs defined in a uniform manner. The Dobson | DaVanzo Team conducted micro-simulations using the hospital-level Worksheet S-10 data to determine the impact of our alternative definitions of uncompensated care. To the extent that the Worksheet S-10 data are incomplete (not all hospitals have reported) or unreliable (hospitals have reported uncompensated care costs that appear to be anomalies or calculated inconsistently from other hospitals), CMS could consider alternative data sources for implementing Section 3133 by FY 2014. During this “transition” time, CMS could request that hospitals resubmit Worksheet S-10 data using a clarified set of instructions.

Appendices

Appendix A: National Provider Call Presentation	A-1
Appendix B: Uncompensated Care Evidence Table	B-1
Appendix C: Stakeholder Interview Protocol.....	C-1
Appendix D: Summary of Key Survey Characteristics	D-1
Appendix E: Calculated Statewide Average RCCs	E-1
Appendix F: Release Calendar of Medicare Cost Report	F-1

Appendix A: National Provider Call Presentation

PowerPoint Presentation

Improvements to Medicare Disproportionate Share Hospital (DSH) Payments: National Provider Call

January 8, 2013

PRESENTED BY:

Al Dobson, Ph.D., Dobson DaVanzo & Associates, LLC

Lane Koenig, Ph.D., KNG Health Consulting, LLC

PREPARED BY:

Al Dobson, Ph.D., Lane Koenig, Ph.D., Audrey El-Gamil, Anne Pick, M.P.H., Sheila Sankaran, M.A.

Dobson | DaVanzo



Dobson DaVanzo & Associates, LLC Vienna, VA 703.260.1760 www.dobsondavanzo.com

Presentation Overview

- **Goal of National Provider Call**
- **Dobson | DaVanzo Team Scope of Work**
- **Review of Section 3133**
- **Analytic Methods**
- **Uninsured Definitions and Data Sources**
- **Uncompensated Care Definitions and Data Sources**
- **Conclusions**
- **Next Steps**
- **Discussion: Public Comment**

Goal of National Provider Call

- **Solicit public comment to inform the implementation of Section 3133 of the Affordable Care Act (ACA) as it relates to definitions and measures of the uninsured and uncompensated care**
- **The National Provider Call will:**
 - Review Medicare DSH payment requirements under the ACA, which is effective in FY 2014
 - Present findings of our analyses identifying possible data sources and definitions for measuring the change in the uninsured and uncompensated care

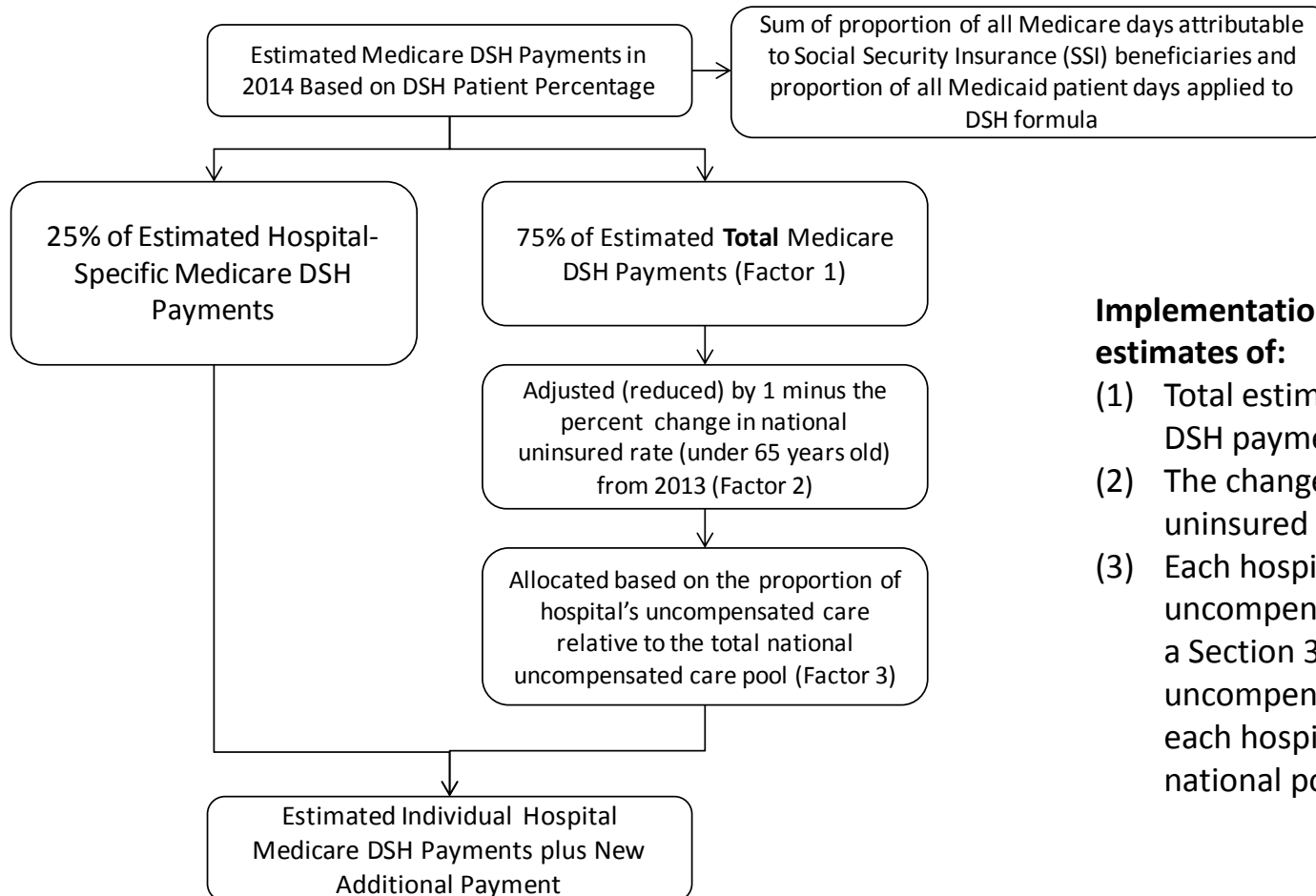
Scope of Work

- **Dobson DaVanzo & Associates, LLC, and its partner, KNG Health Consulting, LLC, have been commissioned to provide CMS with technical assistance as it implements a revised Inpatient Prospective Payment System (IPPS) Medicare DSH payment policy as called for by Section 3133 of the ACA of 2010**
- **The scope of work includes analyses of potential definitions and data sources for measuring the change in the uninsured and levels of uncompensated care**
- **The scope of work does not include interpretation of Section 3133 provisions**

Review of Section 3133

- **Beginning in FY 2014, 25% of estimated Medicare DSH payments will continue to be paid to each hospital**
 - The remaining 75% share of estimated Medicare DSH payments (Factor 1) will be adjusted by two additional factors and distributed as an additional payment
 - Factor 2: Reduce remaining 75% of estimated Medicare DSH payments as a result of the estimated decrease in the uninsured
 - Factor 3: Target remainder of 75% of estimated Medicare DSH payments to individual hospitals based on their proportion of the amount of uncompensated care provided by DSH hospitals

Review of Section 3133 (cont'd)



Implementation requires estimates of:

- (1) Total estimated Medicare DSH payments
- (2) The change in the uninsured rates
- (3) Each hospital's share of uncompensated care using a Section 3133 definition of uncompensated care for each hospital and a national pool

Analytic Methods

1. Focused literature review

- Identified possible definitions of uninsured and uncompensated care and data sources for measuring the uninsured and uncompensated care

2. Structured interviews

- Sought expertise from survey experts for uninsured data sources and other key stakeholders for direction on uncompensated care definitions

3. Analysis of data sources and definitions

- Assessed strengths and limitations of alternative data sources and consistency of possible definitions with existing measures

Uninsured Definitions and Data Sources

Legislative Context for Factor 2

- **FY 2014 – FY 2017: Section 3133 prescribes use of uninsured estimates from Congressional Budget Office (CBO)**
- **FY 2018 onwards: Section 3133 permits use of other sources:**
 - (ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—
 - (I) who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and
 - (II) who are uninsured in the most recent period for which data is available (as so estimated and certified), minus 0.2 percentage points for each of fiscal years 2018 and 2019

Researching Uninsured Data Sources

- **Review National Surveys.** Reviewed design and methodology for 5 surveys used to construct estimates of the uninsured
- **Interviews with Survey Experts and CBO Analyst.** Interviewed senior experts on each of the 5 surveys and CBO analyst to clarify our understanding of their methodologies
- **Comparative Analysis.** Compared data sources along several dimensions; identified strengths and limitations of each

Dimensions for Comparison

- **Conceptual definition and coverage.** How is “uninsured” defined and what population is being measured?
 - Any measure of uninsured should correlate with uncompensated care burden
- **Length of uninsured period.** Is the survey asking respondents about their insured status at the time of the survey or for some time period (partial-year or full-year) before the survey?

Dimensions for Comparison (cont'd)

- **Recall period.** How far back in time does a respondent have to remember in order to answer the survey question correctly?
 - Shorter recall periods are likely to elicit more accurate responses regarding changes in insurance status
- **Timeliness.** What is the time period between the reference period, the time period for which data are being collected, and the release of uninsured estimates?

Dimensions for Comparison (cont'd)

- **Continuity of data series.** Have the survey definitions changed over time or are they expected to change?
 - Implementation of the ACA may result in modifications to surveys to collect additional information or existing information differently
- **Medicaid coverage.** How accurately is the survey capturing those respondents who are covered by Medicaid?
- **Undocumented immigrants.** Does the survey design inhibit participation by undocumented immigrants?

Five National Surveys

Survey	Sponsor	Description
Current Population Survey, Annual Social and Economic Supplement (CPS-ASEC)	U.S. Census Bureau and Bureau of Labor Statistics	<ul style="list-style-type: none">• CPS is a computerized monthly survey—Respondents participate for 4 consecutive months, leave sample for 8 months, return for another 4 months• CPS contains questions on labor force participation and earnings• ASEC data are collected from mid-February to mid-April each year• ASEC contains health insurance coverage questions and other questions related to socioeconomic status and well-being• Sample size: 60,000 households
American Community Survey (ACS)	U.S. Census Bureau	<ul style="list-style-type: none">• Ongoing paper survey—Mailed to respondents, who complete it and return it by mail• Contains questions on economic, social, demographic, and housing characteristics and provides local-level estimates. Health insurance question was added in 2008• Sample size: 2 million households

Five National Surveys (cont'd)

Survey	Sponsor	Description
Survey of Income Program and Participation (SIPP)	U.S. Census Bureau	<ul style="list-style-type: none">• Computerized longitudinal panel survey—Respondents interviewed 3 times/year for 3-4 years• Contains questions on labor force participation, health insurance coverage, and federal program participation• Sample size: Ranges from 14,000 to 36,700 households per panel
Medical Expenditure Panel Survey (MEPS)	Agency for Healthcare Research and Quality	<ul style="list-style-type: none">• Computerized panel survey—Respondents interviewed several times over 2 years• Contains questions on health conditions, health services utilization and costs, labor force participation, health insurance coverage• Sample size: 14,000 households and 35,000 individuals
National Health Interview Survey (NHIS)	National Center for Health Statistics	<ul style="list-style-type: none">• Computerized ongoing survey• Contains questions on health characteristics, health services utilization, and demographic and socioeconomic characteristics• Sample size: 35,000 households and 87,500 individuals

Commonalities Across Surveys

- **Conceptual definition of uninsured**
- **Sampling frame**
- **Data collection method**
- **Medicaid coverage estimation**
- **Undocumented immigrants**

Differences Across Surveys

Survey	Length of Uninsured Period	Recall Period	Timeliness	Continuity
CPS-ASEC	<ul style="list-style-type: none"> Current: Previous calendar year Starting in 2014: <ul style="list-style-type: none"> Point-in-time Previous calendar year 	<ul style="list-style-type: none"> Variable, up to 14-16 months 	<ul style="list-style-type: none"> Estimates released 9 months after reference period 	<ul style="list-style-type: none"> Updated questions on previous-year insurance coverage and new point-in-time question scheduled to be introduced in 2014 Break in full-year data series expected between 2012 and 2013
ACS	<ul style="list-style-type: none"> Point-in-time—At time of survey 	<ul style="list-style-type: none"> Current 	<ul style="list-style-type: none"> Estimates released 10 months after reference period 	<ul style="list-style-type: none"> Health insurance question will be revised Break in series expected sometime after 2013
SIPP	<ul style="list-style-type: none"> Multiple periods can be measured with microdata 	<ul style="list-style-type: none"> Variable, up to 4 months 	<ul style="list-style-type: none"> No regular release schedule 	<ul style="list-style-type: none"> Health insurance questions will be revised Break in series expected sometime after 2014

Differences Across Surveys (cont'd)

Survey	Length of Uninsured Period	Recall Period	Timeliness	Continuity
MEPS	<ul style="list-style-type: none"> • Uninsured for first-half of year • Uninsured for entire year • Uninsured at any time during survey year 	<ul style="list-style-type: none"> • Variable, up to 6 months 	<ul style="list-style-type: none"> • Estimates released 11-20 months after reference period 	<ul style="list-style-type: none"> • No break in series expected
NHIS	<ul style="list-style-type: none"> • Point-in-time—At time of interview • Uninsured at least part of year prior to interview • Uninsured more than 12 months at time of interview 	<ul style="list-style-type: none"> • Variable, up to 12 months 	<ul style="list-style-type: none"> • Estimates released 6 months after reference period 	<ul style="list-style-type: none"> • No break in series expected

Point-in-Time vs. Other Estimates

- **Point-in-time estimates have several advantages over other types of estimates**
 - Full-year and partial-year estimates do not capture movement in and out of the uninsured pool as well as point-in-time estimates
 - Shorter recall period for point-in-time estimates is likely to yield more accurate estimates than estimates based on longer recall periods
 - Point-in-time estimates are more likely to be correlated with any measure of uncompensated care, as compared with full- and partial-year estimates

Assessment of Data Sources

- **Timeliness.** The time between the reference period and the release of estimates
- **Continuity.** Does the data source provide a continuous time series from 2013 onwards?
- **Data Collection.** What topics are covered in the survey (i.e., health topics)? How often are data collected (i.e., once a year or throughout the year)? How are data collected?
- **Accuracy.** What is the sample size? What are the standard errors associated with the survey estimates?

Assessment of Data Sources (cont'd)

Survey/Source	Point-in-Time Estimates?	Timeliness	Continuity	Data Collection	Accuracy
		Time between reference period and release date		Type of data collected and collection timing/mode	
			Continuous from 2013 onwards?		Sample size; standard error (SE)
CPS-ASEC	Yes (2014)	Good	Fair	Good	Excellent
ACS	Yes	Good	Fair	Good	Excellent
SIPP	Yes	Fair	Fair	Good	Good
MEPS	Yes	Good	Excellent	Excellent	Good
NHIS	Yes	Excellent	Excellent	Excellent	Excellent
CBO*	Yes	Not applicable	Excellent	Not applicable	Not applicable

*CBO's estimates and projections are based on a model that uses SIPP microdata

Uncompensated Care Definitions and Data Sources

Identifying Existing Definitions of Uncompensated Care

- **Through a literature review and stakeholder interviews, we found variation in how existing programs and entities define uncompensated care including:**
 - Federal programs (Medicare, Indian Health Service, Health Information Technology for Economic and Clinical Health)
 - States (waiver and non-waiver Medicaid)
 - Ratings and research organizations
 - Provider organizations
- **Across programs and entities, charity care and bad debt were always included in definitions of uncompensated care**
- **Some entities also include payment shortfalls from government-funded plans, or third party payers**

High-Level Summary: Literature Review

Federal Entities	Bad Debt	Charity Care	Includes Governmental Payment Shortfalls	Includes Commercial and/or Discounts
Medicare (Worksheet S-10)	Y	Y	N	N
Health Information Technology for Economic and Clinical Health	Y	Y	N	N
MedPAC	Y	Y	N	N
Medicaid	Bad Debt	Charity Care	Includes Governmental Payment Shortfalls	Includes Commercial and/or Discounts
Arizona (waiver state)	Y	Y	Y	N
Florida (waiver state)	Y	Y	Y	N
Maryland (non-waiver state)	Y	Y	N	N
New York (non-waiver state)	Y	Y	N	N
Ratings Organizations	Bad Debt	Charity Care	Includes Governmental Payment Shortfalls	Includes Commercial and/or Discounts
Standard & Poor	Y	Y	N	Y
Healthcare Financial Management Association	Y	Y	N	N
PricewaterhouseCoopers	Y	Y	N	Y
Provider Organizations	Bad Debt	Charity Care	Includes Governmental Payment Shortfalls	Includes Commercial and/or Discounts
American Hospital Association (Trend Watch)	Y	Y	N	N
Catholic Health Association	Y	Y	Y	N

Cross-Cutting Themes of Existing Uncompensated Care Definitions

- **Uncompensated care is most often defined as charity care plus bad debt but may include governmental and/or commercial payer payment shortfalls**
 - Charity care – care provided to uninsured who meet financial eligibility requirements and for whom the hospital does not expect to receive payment
 - Bad debt – unreimbursed care provided to persons for whom the hospital expected but did not receive payment
 - Payer shortfalls – difference between payments and costs by payer

Cross-Cutting Themes of Existing Uncompensated Care Definitions (cont'd)

- Uncompensated care is reported as costs rather than charges. Cost-to-charge ratios (CCRs) for hospitals are typically often used to calculate uncompensated care costs (charges x CCR = costs)
- Charity patients must meet guidelines to qualify for uncompensated care, such as uninsured, disqualified for a federal program, under a certain Federal Poverty Level (FPL) etc. Each hospital defines its charity care patients and different costs according to these definitions
- Definitions of charity care varied significantly by states, counties, and hospitals in order to accommodate the population served, and the financial mission/“giving ability” of the institution

Data Sources Analyzed to Calculate Uncompensated Care

- Based on findings from our literature review and stakeholder interviews, the most common definition of uncompensated care is:

Bad Debt + Charity Care = Uncompensated Care

- **We examined a variety of data sources to determine how this definition of uncompensated care (and others) could be measured during implementation**
 - AHA Annual Survey/AHA TrendWatch
 - Publicly-available hospital financial data (from state agencies)
 - Medicaid DSH audit data
 - IRS Form 990 (Nonprofit hospitals)
 - “Old” Medicare Cost Report (CMS-2552-96)
 - “New” Medicare Cost Report (CMS-2552-10)
- **We compared data sources across several dimensions and determined strengths and limitations of each data source**

Medicare Cost Report: Worksheet S-10 (CMS-2552-10)

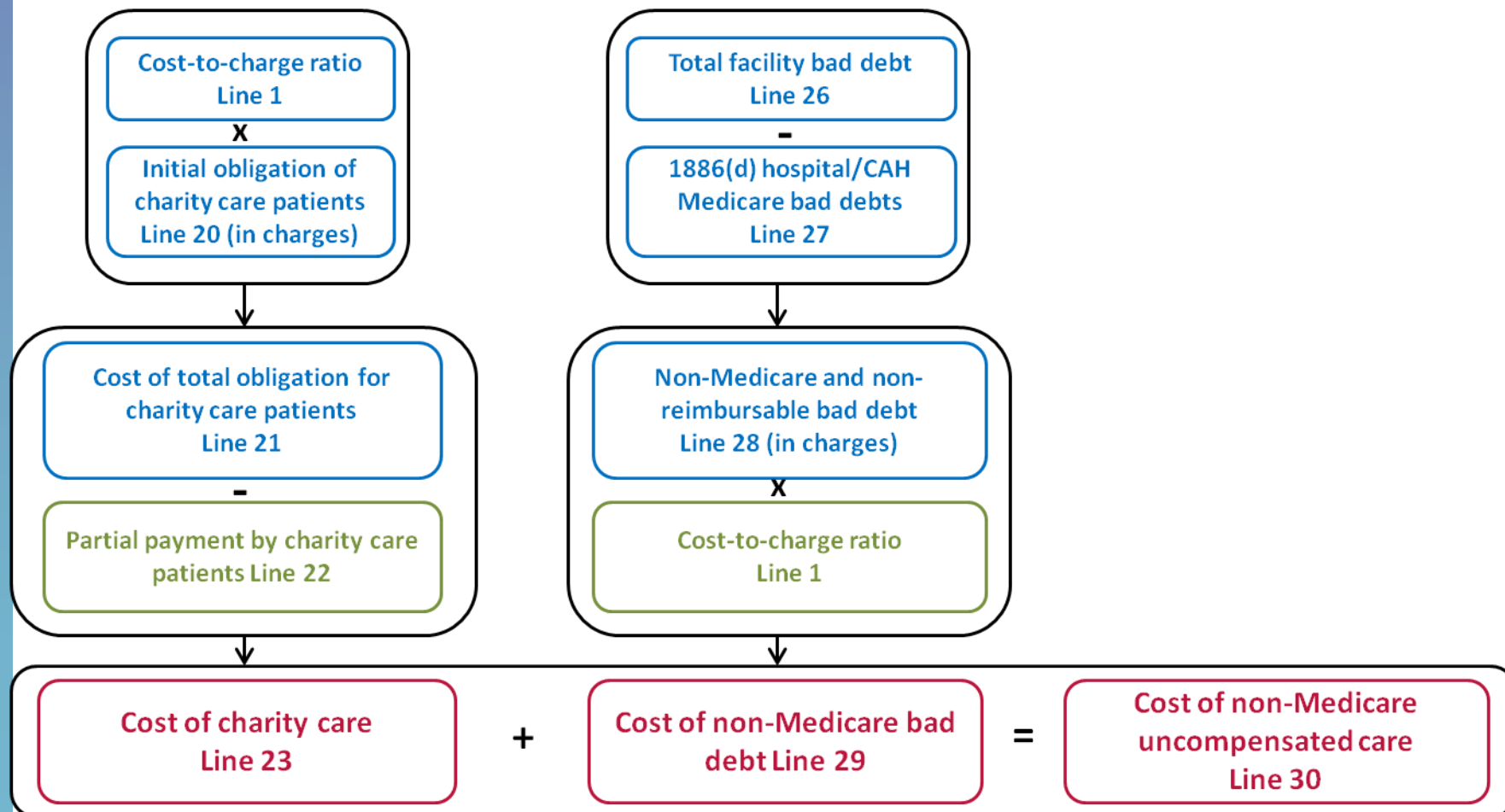
- **S-10 was the only publicly available data source that contains the required variables to capture uncompensated care as described previously**

Cost of charity care (line 23)

+ Cost of non-Medicare bad debt expense (line 29)

Cost of non-Medicare uncompensated care (line 30)

Worksheet S-10: Line Components



Worksheet S-10: Stakeholder Considerations

- **Through our stakeholder interviews, we identified areas for further consideration/clarification:**
 - Inclusion of all uncompensated costs and unreimbursed costs (contained in line 19)
 - Line 19: Total unreimbursed costs for Medicaid, SCHIP and state/local indigent care programs
 - Under this definition, total unreimbursed costs would equal **Line 19 + Line 30 = Line 31**
 - Inclusion of charity care write-offs for services provided outside of the reporting period (due to the difficulty of receiving documentation from patients in a timely manner)
 - Inclusion of GME costs in the calculation of cost-to-charge ratios (CCRs) by using costs from Worksheet B (Column 24, Line 118)
 - Currently Line 1 of S-10 (CCR) does not account for GME
 - Including GME costs on S-10 could more accurately match costs to gross revenues (charges)
 - Would affect cost-to-charge ratio reported in Line 1

Worksheet S-10: Timing of Data Release

- **The new Worksheet S-10 data (CMS-2552-10) will be available in time for CMS to develop its FY 2014 IPPS NPRM**
 - New form CMS-2552-10 is reported in cost reports for hospital fiscal years on or after May 1, 2010
 - Given the lag in cost report submission and approval, S-10 data are available for hospitals approximately 8 months from the end of the hospital Fiscal Year
 - Many hospitals did not report CMS-2552-10 data in hospital FY 2010. More complete data are available in hospital FY 2011. As of November 2012, the uptake of S-10 for FY 2010 was approximately 50% of hospitals, and 75% of hospitals for FY 2011
 - As of 2012 year end, most hospitals will have reported S-10 data to be used in the 2014 IPPS NPRM

Conclusions

- For measurement of the change in the uninsured from FY 2018 onwards (Factor 2), point-in-time estimates of insurance status have several advantages over other estimates
- Other considerations for selecting an uninsured data source are timeliness, continuity, the survey focus, and accuracy
- The common definition of bad debt plus charity care aligns with existing measures and uses of uncompensated care but stakeholder concerns suggest that other types of uncompensated care be considered for inclusion in the Section 3133 definition of uncompensated care

Next Steps

- **No Section 3133 DSH policies will be released by CMS until the FY 2014 NPRM is available**
 - CMS will address data sources, definitions, procedures, and timing in the NPRM

Discussion: Public Comment

- **Public comments**
- **Additionally, stakeholders can submit formal comments on the implementation of Section 3133 by emailing Section3133DSH@cms.hhs.gov, by January 15th**

Appendix B: Uncompensated Care Evidence Table

Uncompensated Care Evidence Tables

Below are summary charts illustrating how uncompensated care is defined by select federal and state programs, ratings organizations, and provider organizations in terms of:

- Terminology used for referring to uncompensated care (UCC);
- Definition of uncompensated care (UCC);
- Reasoning for definition (such as statute or legislation);
- Eligible populations; and
- Services covered.

Appendix B: Uncompensated Care Evidence Table

Federal Programs

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Medicaid ¹	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- The total cost of care for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. Uncompensated care costs do not include bad debt or payer discounts or nonpayment of co-payments and deductibles from those with third-party coverage, including denials due to improper billing.</p> <p>Charity care- Policies for providing free or reduced cost care to those that qualify for a hospital's specific charity care program.</p> <p>Bad debt- non-payment on behalf of an individual who has third party coverage.</p>	Total DSH payments should not exceed the total amount of uncompensated care at the hospital. Obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment cannot be included as uncompensated care for purposes of the hospital-specific DSH limit. Uncompensated care cost limit or hospital specific DSH limit is the difference between incurred inpatient and outpatient hospital costs and associated revenues.	Those receiving reimbursement must be DSH-eligible hospitals	Uncompensated care includes all services normally covered by Medicaid, but does not include physician costs.
Indian Health Services ² (IHS)	Uncompensated Care	Uncompensated care- Not defined by the IHS but CMS has amended its policy on uncompensated care to include unreimbursed costs of IHS patients.	Under the recent Notice of Proposed Rulemaking (NPRM), CMS revised the definition of uninsured such that costs for IHS patients who receive services from a non-IHS hospital, are considered uncompensated costs because the patient does not have "credible coverage."	NA	NA

¹ 73 FR 77904

² 77 FR 2503

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Health Information Technology for Economic and Clinical Health Act ³	Uncompensated Care; Charity Care	<p>Uncompensated care- Includes charity care and bad debt (non-Medicare bad debt and non-reimbursable Medicare bad debt). Excludes courtesy allowances or discounts given to patients.</p> <p>Charity care- Health services for which a hospital demonstrates that the patient is unable to pay.</p>	HITECH Act of 2009: Facilities must follow the Hill-Burton Obligation stating that they must continue to provide a specified level of free care determined by the DHHS annually in the Federal Register in order to receive federal financial assistance.	Facilities should provide free care to those with incomes up to the determined annual income guidelines. Facilities can offer free or reduced-cost services to those up to twice the guideline, and nursing homes can offer free or reduced-cost services homes for up to three times the guideline.	Determined on a facility basis. Services fully covered by third-party insurance or governmental program are not eligible.
Generally Accepted Accounting Principles ^{4,5}	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes charity care and bad debt.</p> <p>Charity care- Includes direct and indirect costs. Contributions to offset or subsidize charity care must be separately disclosed (such as grants restricted for charity care).</p> <p>Bad debt- Although not specifically defined, requires hospitals to report bad debt expense as a deduction from net patient service revenues separately.⁶</p>	Accounting Standard Update (ASU) <i>Measuring Charity Care for Disclosure</i> requires a cost based measurement for charity care starting after December 15, 2010. Calculated by applying a specific hospital cost-to-charge ratio to the charity care gross charges.	Facilities should provide uncompensated care services to patients with a “demonstrated inability to pay.”	NA

³ Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009), *codified at* 42 U.S.C. §§300jj *et seq.*; §§17901 *et seq.*

⁴ Measuring Charity Care for Disclosure a consensus of the FASB Emerging Issues Task Force. Health Care Entities (Topic 954) *Financial Accounting Standards Board of the Financial Accounting Foundation*. No. 2010-23. August 2010

⁵ ASU 2010-23

⁶ ASU 2011-07

Appendix B: Uncompensated Care Evidence Table

Medicaid Waiver States- These states have submitted Medicaid Transformation waivers in order to expand Medicaid managed care in their states, while also preserving federal funding received by hospitals to offset the costs of uncompensated care.

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Arizona ¹	Uncompensated Care	Uncompensated care- Includes costs of services provided to uninsured patients, and unreimbursed costs associated with eligible and enrolled Medicaid members.	Under States Section 1115 Research and Demonstration Waiver, in April 2012, the Arizona Health Care Cost Containment System (AHCCCS) received approval from the AZ Legislature for two new programs: Safety Net Care Pool (SNCP) and Indian Health Services Program . SNCP is open to all AZ hospitals and uses monies from political subdivisions to draw down federal matching dollars.	The AHCCCS includes several programs that are available to low-income, uninsured state residents who are not eligible for Medicare or traditional Medicaid. Uncompensated care funding is directed towards safety-net hospitals that provide the highest percentage of care to low-income uninsured patients, rural or critical access hospitals, and DSH hospitals.	Preventive services and treatment for catastrophic illness or injury. ² Includes inpatient and outpatient hospital care, physician and non-physician services, pharmacy costs, home health services provided by eligible providers, emergency and non-emergency transportation, and non-hospital community clinic costs. Excludes non-emergency medical services and services to non-qualified aliens.

¹ Arizona Health Care Cost Containment System Medicaid Section 1115 Waiver Amendment Supporting Uncompensated Care

² Ariz. Rev. Stat. § 36-774(A).

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
California ³	Uncompensated Care	<p>Uncompensated care- Cost of care provided to individuals with no source of third party coverage for the services they received by hospitals or other providers; based on charity care, plus bad debt, minus any gifts and subsidies for indigent care</p> <p>SNCP (Safety Net Care Pool) payments for uncompensated care can also be used to pay for care to the uninsured in hospital, clinic, or other provider settings that are not otherwise reimbursed by the county Medicaid expansion funds or DSH.</p>	<p>Section 1115 waiver proposal⁴ expands the SNCP to provide additional resources to support safety net hospitals' UCC costs and other critical state programs paid for through SNCP.</p> <p>SNCP provides funds for UCC to individuals with no source of third party coverage for services from hospitals or other providers.</p> <p>Under California's Hospital Fair Pricing Policies law, general acute hospitals must provide free or discounted care to financially qualified patients as a condition of licensure.</p>	<p>SNCP should be billed as a last resort for hospital and outpatient care to indigents with incomes between 133% and 200% of FPL.</p> <p>The Hospital Fair Pricing law sets minimum standards for determining who is eligible for free or discounted care under a hospital's charity care policy. For example, an uninsured patient whose individual/family income is at or below 350 percent of the FPL.</p>	Includes inpatient hospital services and outpatient clinic services provided to uninsured patients, including physician costs. Excludes services to illegal immigrants.

³ Insure the Uninsured Project (ITUP) summary of California's 1115 Medicaid waiver. Accessed online at: http://itup.org/legislation-policy/2012/01/23/summary-of-%c2%a71115-waiver/#_ednref1

⁴ California Bridge to Reform – a section 1115 waiver fact sheet (November 2010). Accessed online at: <http://www.dhcs.ca.gov/Documents/1115%20Waiver%20Fact%20Sheet%2011.2.10.pdf>

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Florida ⁵	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes bad debt and charity care and Medicaid shortfalls. Cost of care provided to those who are uninsured, underinsured, or enrolled in Medicaid is also included in uncompensated care. Funding for care must not be available from any other payor, including federal or state programs, but reimbursement for uncompensated care can include costs for Medicaid services provided that they exceed Medicaid payments.</p> <p>Charity care- Defined by the Florida Agency for Health Care Administration (AHCA) as “the medical care provided by a health care entity to a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources which are required to meet his basic needs for shelter, food, or clothing.”</p> <p>Bad debt- The cost of care provided to a patient (not paid for by the patient) who fails to qualify for charity care. Bad debt does not include “administrative or courtesy discounts, contractual allowances to third-party payors, or failure of the hospital to collect full charges due to partial payment by government programs.”⁶</p>	<p>Florida’s Low-Income Pool (LIP) was established for health care expenditures “incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured.” Funds may be used for “premium payments, payments for provider access systems, and insurance products for such services.” Florida law contains a general requirement that nonprofit hospitals must provide charity care and care to Medicaid patients, but does not set standards for how much charity care a provider must give. AHCA makes quarterly payments of Medicaid DSH funds to hospitals that provide a disproportionate share of Medicaid and charity care.⁷</p>	<p>The Health Care Responsibility for Indigents Act was established to split responsibility for providing indigent care between the state and the county (although it does not mandate hospitals to provide any financial assistance), and to set eligibility criteria that hospitals must follow in order to be eligible for reimbursement. Hospitals may only claim services as charity care for individuals with family incomes up to 150% FPL.</p>	<p>Does not require counties to reimburse an out-of-county hospital for any elective or non-emergency care that their residents could have received at the local county hospital.⁸</p>

⁵ California Healthcare Foundation. (2006). Medicaid hospital waivers: comparing California, Florida, and Massachusetts. Issue Brief, pp. 2-13.

⁶ Fla. Admin. Code r. 59C-1.039.

⁷ 409.911(c) of the Florida Statutes.

⁸ Fla. Stat. § 154.306(2).

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Massachusetts ⁹	Uncompensated Care; Bad Debt	<p>Uncompensated care- Includes Health Safety Net services (free care) to low income patients, medical hardship services (to patients with large medical bills), and bad debt.^{10,11}</p> <p>Bad debt- An account receivable based on services furnished to any patient following reasonable collection efforts, which is regarded as uncollectible, which regulations shall allow third-party payers to negotiate with hospitals to collect the bad debt of its enrollees, is charged as a credit loss, is not the obligation of a government sponsored program, and is not free care.¹²</p>	<p>Unlike California SNCP and Florida LIP, the MA SNCP includes the state's annual DSH allotment. The Health Safety Net Office allocates the shortfall as the calculation of each Hospital's total patient care costs multiplied by the total shortfall amount.¹³</p> <p>The Health Safety Net Office, part of the Division of Health Care Finance & Policy, administers the Health Safety Net Trust Fund and the Essential Community Provider Trust Fund.¹⁴</p>	<p>Under the section 1115 waiver program known as MassHealth, the Health Safety Net Trust Fund was created to replace the Uncompensated Care Pool. The Fund, like the Pool before it, operates as a "payor of last resort" by reimbursing certain providers for medically necessary services rendered to eligible uninsured and underinsured individuals.¹⁵</p>	<p>Medically necessary services provided at Massachusetts hospitals and community health centers that are on the list of MassHealth Standard covered services.¹⁶ MassHealth Standard is comprehensive health insurance, including long-term-care, for low-income children, parents, the elderly, the disabled, and certain other groups. Coverage includes preventive and medical services, prescription drugs, and hospitalization.</p>

⁹ California Healthcare Foundation. (2006). Medicaid hospital waivers: comparing California, Florida, and Massachusetts. Issue Brief, pp. 2-13.

¹⁰ Massachusetts Health Safety Net (Free Care). Massresources.org

¹¹ 114.6 Code Mass Regs. 13.03

¹² Mass. Gen. Laws ch. 118G, § 1.

¹³ 114.6 CMR: Division of health care finance and policy - CMR 14:00 Health safety net payments and funding, p. 6.

¹⁴ Mass. Gen. Laws ch. 118G, § 35(b)

¹⁵ Mass. Gen. Laws ch. 118G, § 39(a); 114.6 Code Mass. Regs. 13.03(1)(b).

¹⁶ 114.06 Code Mass. Regs. 13.03.

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Tennessee	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes charity care, medically indigent care, bad debt, and shortfall in TennCare reimbursement.</p> <p>Charity care- Reductions in charges made by the provider due to the indigence or medical indigence of the patient as determined by the provider.</p> <p>Bad debt- amounts considered to be uncollectible from accounts and notes receivable. Must have been a reasonable attempt to collect debt and still remains unpaid after 120 days following the first bill. Bankrupt accounts should be considered bad debt unless the medical bill caused bankruptcy.¹⁷</p>	The Indigent Health Care Fund reimburses hospitals providing disproportionately high amounts of indigent and uncompensated care and is overseen by the commissioner of Finance and Administration. ¹⁸	Hospitals must have some practice in place to provide uncompensated services to a person that has committed all available, current and expected resources to pay for medical bills. However, uncompensated care reimbursement is not restricted to hospitals that provide free care up to a specific percent of the Federal Poverty guidelines (i.e. 150 % FPL). Funds are provided to hospitals that meet or exceed the state average in terms of uncompensated care and indigent care provided and takes into account amount of government subsidies the hospital receives and other factors related to indigent care. ¹⁹	Includes hospital and some non-hospital services furnished to Medicaid recipients and individuals with no source of third party coverage for which hospitals did not receive full reimbursement. ²⁰

¹⁷ Free Care Compendium. Community Catalyst. 2011. http://www.communitycatalyst.org/projects/hap/free_care/

¹⁸ Tenn. Code Ann. § 68-11-1102(a).

¹⁹ Tenn. Code Ann. § 68-1-109(2)(A)(ii)

²⁰ TennCare II Medicaid Section 1115 Demonstration. Tennessee Department of Finance and Administration. Centers for Medicare & Medicaid Services. No. 11-W-00151/4 Title XIX

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	How the Definition is Used	Eligible Populations	Services Covered
Texas	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes charity care, bad debt, and shortfalls in payment from government-sponsored programs including Medicaid, Medicare, CHAMPUS, Tricare, and other federal, state, or local programs.²¹</p> <p>Charity care- The unreimbursed cost to a hospital of providing, funding, or otherwise supporting health care services to a person classified as “financially indigent,” uncompensated costs not covered by DSH for inpatient and outpatient services with no source of third party coverage, and costs not otherwise covered by DSH for Medicaid shortfalls.²² Uncompensated care costs are calculated using an uncompensated care ratio, which is equal to uncompensated care charges minus partial payments divided by total charges. This is then multiplied by the operating expenses of the hospital to produce the actual cost of uncompensated care.²³</p> <p>Bad debt- The unreimbursed cost of providing health care services for inpatient or emergency care to a person who is financially unable to pay, in whole or in part.</p>	Under the Indigent Care Program , public hospitals and counties are mandated to provide health care assistance to eligible county residents, as payers of last resort. The county is responsible for reimbursing the hospitals uncompensated care costs up to a point that the county has spent 8% of its general revenue levy on health service costs. Once this limit is reached, hospitals are reimbursed for uncompensated care through state funding. Ninety percent of the state funds received by hospitals must go directly to health care services. ²⁴	<p>In order to receive reimbursement, hospitals must provide uncompensated care to patients below 21% of FPL, but hospitals can receive reimbursement for patients up to 200% of FPL.</p> <p>Includes hospitals not eligible for DSH and those that did not receive DSH payments up to the allowable hospital specific limit.²⁵</p>	<p>Public hospitals and counties must provide the following as uncompensated care: primary and preventative services, inpatient and outpatient care, services by rural health clinics, laboratory and x-ray services, family planning, physician services, payment for no more than three prescription drugs a month, and skilled nursing services. The county may also provide additional services.</p> <p>Also includes non-hospital services including physician, other professional, pharmacy, and clinic costs to Medicaid individuals and individuals with no third party coverage.²⁶</p>

²¹ 2008-2009 Report on Residual Uncompensated Care Costs. Texas Health and Human Services Commission

²² Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver

²³ Texas Administrative Code. Title 34, Part 1, Chapter 3, Subchapter V, Rule §3.587

²⁴ Tex. Health & Safety Code Ann. § 61.038.

²⁵ Tex. Health & Safety Code Ann. §§ 61.006; 61.052

²⁶ Tex. Health & Safety Code Ann. §§ 61.028; 61.054; 61.055.

Appendix B: Uncompensated Care Evidence Table

Non-Waiver States

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
Alabama ²⁷	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Sum of net free care (charity care) and emergency bad debt.²⁸</p> <p>Charity care- “Health services for which a provider’s policies determine a patient is unable to pay,” valued at the provider’s charge for services rendered. Providers report charity care based on their individual charge rates.²⁹</p> <p>Bad debt- “Unpaid charges/rates for services rendered from a patient and/or third party payer, for which the provider reasonably expected payment.”³⁰</p>	The Alabama Legislature enacted the Health Care Responsibility Act with the goal of placing ultimate financial responsibility for unreimbursed cost of care to indigents on their counties of residence.	County participation in the Hospital Service Program is voluntary, but counties that choose to participate are eligible for State funding as appropriated annually by the State Board of Health.	Excludes reimbursement for home health services or long-term care for the disabled and chronically ill and for professional medical services (including physician services) received while hospitalized. ³¹

²⁷ Free Care Compendium. Community Catalyst. 2011. http://www.communitycatalyst.org/projects/hap/free_care/

²⁸ 114.6 CMR 11:00 Division of Health Care Finance and Policy Regulations

²⁹ Ala. Code § 410-2-2-.06.

³⁰ Ala. Admin. Code r. § 410-2-2-.06(1)(d).

³¹ Ala. Code §§ 22-21-211; 22-21-212; and 22-21-219.

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
Maryland ^{32,33}	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Care provided for which no compensation is received (includes bad debt and charity care).³⁴</p> <p>Charity care- The difference between the hospital's approved rates and the amount received from such patients.</p> <p>Bad debt services- The Health Services Cost Review Commission (HSCRC) regulates services rendered for which payment is anticipated. Credit is extended to the patient, but payment is not received. Hospitals must have made reasonable collection efforts, and write-offs are limited to the difference between the authorized CHAMPUS payment for ambulatory surgery, plus co-payment and deductible and approved hospital charges. Charges for medically unnecessary hospital services, contractual allowances, administrative discounts to those not meeting charity care guidelines, and charges written off that are not the result of a patient's ability to pay cannot be reported as bad debt.</p>	Uncompensated care (both charity care and bad debt) and graduate medical education are built into rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. The HSCRC sets the rates that hospitals can charge private insurers, HMOs, Medicaid, Medicare, and self-pay patients alike, building in the cost for uncompensated care so that the burden is borne equally. Annually, each hospital receives its own provision for uncompensated care in its rate structure. This provision is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year. While the uncompensated care provisions are not "pass-throughs," they do vary by hospital and generally reflect each facility's bad debt and charity care loads.	The HSCRC requires each hospital to develop a financial assistance policy for providing free and reduced-cost care to all patients whose health care coverage does not pay the full cost of their hospital bill. Each policy must include, at a minimum, free medically necessary care for patients with income below 150% of the FPL, and reduced-cost medically necessary care for low-income patients with family income above 150% of the FPL.	Medically unnecessary hospital services are excluded from bad debt.

³² Free Care Compendium. Community Catalyst. 2011. http://www.communitycatalyst.org/projects/hap/free_care/

³³ Md. Code, Health-Gen. § 19-214.1

³⁴ Md. Code Regs. 10.37.10.01(K).

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
New York ³⁵	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes charity care and losses from bad debts valued at costs for inpatient and ambulatory services, excluding referred ambulatory services. Excludes cost of services offered as an employee benefit or courtesy.</p> <p>Charity care- Reduction in charges made by the provider for services due to the indigence or medical indigence of the patient.</p> <p>Bad debt- The amounts considered uncollectible from accounts and notes receivables which were created or acquired through providing services.</p>	The Indigent Care Pool is overseen by the Commissioner of the Department of Public Health. Pools are financed through an assessment on general hospitals of 5.48% of total reimbursable inpatient costs, excluding Medicare, but including bad debt.	For a hospital to receive uncompensated care distributions it must provide uncompensated care at a proportion at or equal to 0.5% of its costs. It also must give discounts to patients with incomes below 300% FPL. For those at 100% FPL or lower, hospitals can charge only a small amount; 100-250% FPL- sliding fee schedule is used; and 250%-300%- hospitals cannot charge more than what is charged for the highest volume payor, such as a private insurer, Medicare, or Medicaid.	Emergency services and medically necessary services.

³⁵ NY Pub. Health Law § 2807

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
Oklahoma ^{36,37}	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes cost of charity care, shortfall between cost of care and payments received for Medicaid and legislated care services, plus cost of care from bad debts. Total uncompensated cost of care is calculated first by calculating total hospital expenses divided by patient charges reported to CMS (which excludes bad debt expense). This is then used to create a hospital-specific cost-to-charge ratio that is applied to hospital charges to estimate the costs of charity care, Medicaid services, legislated care services, and bad debts. The payments received for these services are then subtracted from calculated cost of care.</p> <p>Charity care- “Care rendered to a patient with no expectation of payment because the patient is unable to pay.”</p> <p>Bad debt- “Care rendered with an expectation of payment but for which no payment was received.”</p>	The Indigent Health Care Act created a state program that reimburses participating hospitals and clinics at rates determined by the Department of Human Services. Funded by the Indigent Health Care Revolving Fund, Oklahoma residents have the option of donating a portion of their refund on state income tax returns towards the Indigent Health Care Revolving Fund.	The Indigent Health Care Act requires hospitals to provide uncompensated care to patients with incomes at or below 100% FPL in order to receive reimbursement. The patients with unpaid costs submitted for reimbursement must also be uninsured, and have made no transfer of property in order to establish eligibility in the past 2 years. Also, patients cannot be eligible for any existing state or federal health care programs.	Medically necessary services.

³⁶ A Statewide Survey- Uncompensated Care in Oklahoma Hospitals. Center for Health Policy Research. Oklahoma Hospital Association. 2006 April. http://www.okoha.com/AM/Template.cfm?Section=Uncompensated_Care&Template=/CM/ContentDisplay.cfm&ContentID=3904

³⁷ Okla. Stat. Ann. 56 § 63

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
Oregon ³⁸	Unreimbursed Care; Charity Care; Bad Debt	<p>Unreimbursed care- The sum of the provision for bad debts plus charity care services, Medicare deductions, Medicaid deductions, and contractual deductions.</p> <p>Charity care- The uncollectible value, at the hospital's full established rates, of providing services to those who cannot afford to pay and which a hospital expects no payment.</p> <p>Bad debt- The cost of care provided to patients, who have been determined to be able to pay but have not done so. Also includes unpaid deductibles and coinsurance for insured patients.³⁹</p>	Establishes unreimbursed care definitions for the purpose of meeting hospital financial reporting requirements.	Oregon law does not establish eligibility standards.	NA
Pennsylvania ⁴⁰	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- The cost of care provided to those financially unable or unwilling to pay for services. Determined by the Health Care Cost Containment Council utilizing reported data. The cost-to-charge ratio used to calculate costs should include charity care expense and bad debt expense.</p> <p>Charity care- Cost of care for which hospital ordinarily charges a fee but is provided free or reduced to patients who cannot afford to pay and are ineligible for public programs.</p> <p>Bad debt- Cost of care for which a hospital expects from the patient or third-party payer but determines to be uncollectible.</p>	The Department of Public Welfare administers the Uncompensated Care Program using funding from the Tobacco Settlement Act to reimburse hospitals for uncompensated care provided. Hospitals are reimbursed based on an uncompensated care score. The score is based on: eligibility for other public or private coverage; income eligibility threshold; employment status and earning capacity; other sources of funds available to the hospital such as endowments or donations specified for charity care.	Hospitals must accept all individuals regardless of ability to pay. They must seek collections of a claim, attempt to obtain health coverage for patients, ensure that an emergency admission is not delayed or denied, post availability of free services, and provide date of service to the Health Care Cost Containment Council.	NA

³⁸ Or. Admin. R. 409-015-0005(3).

³⁹ Uncompensated Hospital Care in Oregon 1995 to 2005. Office for Oregon Health Policy and Research. August 2006.

⁴⁰ 35 Pa. Cons. Stat. § 5701

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
Rhode Island	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- includes free care, which the hospital provides at no cost to the patient, bad debt which the hospital bills for but does not collect, and Medicaid shortfalls.</p> <p>Charity care- services provided to those that are uninsured, underinsured, or otherwise ineligible at the time of the service, cost adjusted using the total hospital cost-to-charge ratio in the hospital's Medicare Cost Reports.</p> <p>Bad debt- uncollectable billed services, cost adjusted using cost-to-charge ratio from Medicare cost report.⁴¹</p>	The Department of Health oversees licensure of health care facilities and has the authority to establish rules regarding the mandatory provision of charity care as a provision of licensure. ⁴² The Director of the Department of Health conducts a yearly review of each hospital's adherence to charity and uncompensated care policies. ⁴³	Must provide full charity care for patients up to 200% FPL with no insurance, or discounted care to those between 200 and 300% FPL. ⁴⁴	All inpatient and outpatient medical services which are essential and routinely billed by the hospital, and regularly reimbursed by Medicaid. "Essential" is defined as hospital services provided for conditions that "endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction." There also must be no more conservative or substantially less costly alternative treatment. ⁴⁵

⁴¹ R.I. Gen. Laws § 23-17.14-4(16); 14 090 028 R.I. Code R. § 1.33.

⁴² R.I. Gen. Laws §§ 23-17-36 23-17-43

⁴³ 14 090 028 R.I. Code R. § 11.1

⁴⁴ 14 090 028 R.I. Code R. § 11.3(f)

⁴⁵ 14 090 028 R.I. Code R.

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
South Carolina	Indigent Care	Indigent care - does not include bad debt, contractual adjustments, or care which is reimbursed by a governmental program (Medicare, Medicaid, county indigent program), church, or philanthropic organization. ⁴⁶	The Medically Indigent Assistance Program is overseen by the Department of Health and Human Services Finance Commission to pay for inpatient hospital services for patients in need. ⁴⁷	Must provide full sponsorship to those with a gross family income less than 100% FPL and partial sponsorship to those with a gross family income than 200% FPL. ⁴⁸	Same services as covered by the state Medicaid program and only psychiatric inpatient hospital services if these are a result of an emergency admission. ⁴⁹
Wisconsin ⁵⁰	Uncompensated Care; Charity Care; Bad Debt	Uncompensated health care - Includes both charity care plus bad debt. Charity care - Health care a hospital provides to a patient who is not qualified for a public program and is determined by the hospital to be unable to pay all or a portion of the hospital's normally billed charges. Bad debt - Claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible.	The Department of Health and Family Services oversees hospital reporting of uncompensated health care services and dissemination of key information to the public. ⁵¹	Each hospital must submit an annual report to the Department of Health and Family services stating the definitions used; procedures used to determine whether a patient is able to pay for care; and the amount of outstanding state loans the hospital has. Hospitals must also submit fiscal surveys stating the uncompensated care charges accrued, breaking down charity care and bad debt expenses and the number of patients they expect to provide uncompensated care to for the next two years.	Does not include contractual adjustments, professional courtesies, employee or prisoner discounts, or care to patients for which grants or public programs pay for any portion of the care.

⁴⁶ S.C. Code Ann. Regs. 61-15-202(2)(c)(1)(c).

⁴⁷ S.C. Code Ann. § 44-7-140.

⁴⁸ Charity Care- In Some States. *Commission on the Public's Health System*. <http://www.cphynyc.org>

⁴⁹ S.C. Code Ann. Regs. 126-530.

⁵⁰ Wis. Admin. Code [HFS] §120

⁵¹ See Wis. Stat. §§ 153.05; 153.20; 153.21

Appendix B: Uncompensated Care Evidence Table

Research and Ratings

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
Standard & Poor's ⁵² (S&P)	Uncompensated Care	Uncompensated care - Sum of bad debt, charity care, and self-pay discounts. S&P notes that uncompensated care is at historically high levels.	NA	NA	NA
Healthcare Financial Management Association ⁵³ (HFMA)	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care⁵⁴ – bad debt plus charity care; should be defined by the community due to factors such as differing poverty levels. HFMA advises hospitals to perform a community health needs assessment to form the community benefit and assess the financial health of a hospital (e.g. amount of endowment funds) to determine the hospital's "giving" ability.</p> <p>Charity care- Provided to a patient with demonstrated inability to pay.</p> <p>Bad debt- Occurs when patient who has been determined to have the financial capacity to pay for healthcare services is unwilling to settle the claim.</p>	No single set of charity care policies is universally applicable. Each institutional provider of healthcare services must establish its own policies consistent with the organization's mission and financial ability, as well as with state laws.	<p>In addition to financial eligibility criteria (i.e. FPL), charity care policies should also address:</p> <ul style="list-style-type: none"> • Eligibility determinations when insufficient patient information, and ability to pay cannot be determined • Degree of verification necessary for eligibility determinations • Any modification of determination • Time frame for charity care eligibility • Frequency of evaluation of charity care allowance adequacy • Discounts for low-income, uninsured patients who have ability to pay portion of bill • Criteria for a collection to be soundly assured under GAAP 	NA

⁵² GICS Sub-Industry Summary: Health Care Facilities. *Standard and Poor's*. 30 July 2012. <http://solutions.standardandpoors.com/SP/sectortool/subIndustrySummary.do?contentId=WS-coindustry:info&pc=JAN&auth=085150196224055233187040139188220016243096142070&tracking=JAN?pagewanted=all&ticker=WOOF>

⁵³ P&P Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers. *Healthcare Financial Management*. December 2006.

⁵⁴ From HFMA stakeholder interview

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definition of Uncompensated Care	Statute/ Legislation	Eligible Populations	Services Covered
PricewaterhouseCoopers' Health Research Institute (PwC's HRI) ⁵⁵	Uncompensated Care; Charity Care; Bad Debt Expense	<p>Uncompensated care- the amount of healthcare services provided to patients who are either unable or unwilling to pay. Includes charity care, discounts, and bad debt.</p> <p>Charity care- Healthcare services that never were 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.</p> <p>Bad debt expense- The current period charge for actual or expected doubtful accounts resulting from the extension of credit.</p>	NA	NA	NA

⁵⁵ PricewaterhouseCoopers' Health Research Institute. Acts of charity: charity care strategies for hospitals in a changing landscape. Accessed online at: <http://www.nonprofithealthcare.org/resources/Acts%20of%20Charity.pdf>

Appendix B: Uncompensated Care Evidence Table

Provider Organizations

Stakeholders	Terminology	Definitions of Uncompensated Care	Reasoning for Definition	Eligible Populations	Services Covered
American Hospital Association ¹⁷²	Uncompensated Care; Charity Care; Bad Debt	<p>Uncompensated care- Includes charity care and bad debt. Hospital care provided for which no payment was received from the patient or insurer. Excludes any voluntary or involuntary discounts or "reductions in revenue," such as underpayment from Medicaid and Medicare or discounts to private payers.</p> <p>Charity care- Care for which hospitals never expected to be reimbursed. Care for which patients are unwilling or unable to pay.</p> <p>Bad debt- Services for which hospitals anticipate but do not receive payment.</p>	Uncompensated care is expressed in terms of costs and calculated by combining bad debt and charity care charges. A total hospital-specific cost-to-charge ratio is applied to the uncompensated care charges to calculate uncompensated care costs.	NA	NA

¹⁷² American Hospital Association. (2010).Uncompensated hospital care cost fact sheet, 2.

Appendix B: Uncompensated Care Evidence Table

Stakeholders	Terminology	Definitions of Uncompensated Care	Reasoning for Definition	Eligible Populations	Services Covered
Catholic Health Association ^{173 174}	Community Benefit	Hospitals reporting on Form 990, Schedule H report Charity Care as one category of community benefit. The form also includes unreimbursed Medicaid and other government means-tested programs, community health improvement services, community benefit operations, etc. Community benefits do not include community building activities, Medicare shortfalls and bad debt. The IRS used CHA's framework for defining and reporting community benefit in the development of the Form 990, Schedule H.	In the 1980s, the CHA Board of Trustees reaffirmed that community benefit was integral to the mission of Catholic health care. It directed a study of ministry community benefit practices leading to the development of the Social Accountability Budget, recently updated with the publication <i>A Guide for Planning and Reporting Community Benefit</i> . In 2005, CHA committed to reporting community benefits using standard definitions and accounting principles.	NA	NA
Form 990	Financial Assistance; Charity Care	Form 990 uses the term "financial assistance" (also referred to as charity care) and identifies the number of programs, persons served, and the total community benefit expense (cost) and offsetting revenue. Additionally this form also allows hospitals to identify their Medicaid shortfall and costs for other "means-tested government programs." The form also separately captures the total amount of bad debt.	Schedule H of the Form 990 does not include a field for uncompensated care. Rather, the form asks detailed information about the hospital's cost for providing social services to those patients who received federal assistance and participated in means-tested government programs. Form 990 is only completed for non-profit hospitals.	NA	NA

¹⁷³ Letter to Ron Schultz. Catholic Health Association of the United States. 12 September 2007.

¹⁷⁴ Catholic Health Association. (2008). The IRS Form 990, Schedule H: community benefit and Catholic health care governance leaders. pp.3-15.

Appendix C: Stakeholder Interview Protocol

Context

Dobson DaVanzo & Associates, LLC, and its partner, KNG Health Consulting, LLC, has been commissioned to assist the Centers for Medicare & Medicaid Services (CMS) with implementing a revised IPPS Medicare disproportionate share hospital (DSH) payment policy as called for by Section 3133 of the Affordable Care Act of 2010 (ACA). ACA sets forth a set of requirements intended to reduce overall Medicare DSH payments and to better target the remaining DSH payments. These objectives reflect the fact that provisions in ACA should reduce the need for DSH payments with the expansion of insurance coverage and commensurate reductions in uncompensated care amounts.

In addition to reducing the Medicare DSH payment as prescribed under 1886(d)(5)(f), the provision requires that CMS provide subsection (d) hospitals an additional add-on payment beginning in FY 2014 (referred to as “the uncompensated care add-on payment”) up to FY 2017. In FY 2014, the uninsured rate to be used in the uncompensated care add-on payment calculation will be reduced by 0.1 percentage point. In FY2015 through FY2017, that reduction will be 0.2 percentage points. The uncompensated care add-on payment is based on the product of three factors:

- Factor 1: Seventy-five (75) percent of DSH payments that would otherwise be made under subsection (d)(5)(F) before the reduction of 25 percent.
- Factor 2: One minus the percent change in percent of uninsured individuals who are under the age of 65 between the most recent year for which data are available and 2013.
- Factor 3: A hospital’s uncompensated care costs relative to the uncompensated care costs for all subsection (d) hospitals.

As one part of our analysis, we are conducting a series of external stakeholder interviews to better understand viewpoints on 1) the measures of uninsured and uncompensated care, 2) the legislation regarding the DSH adjustments, and 3) thoughts regarding alternative approaches.

Appendix C: Stakeholder Interview Protocol

Questions Related to Uncompensated Care

Worksheet S-10 of the Medicare Cost Report (CMS-2552-10) contains variables that could be used in determining the proportion of uncompensated care in each hospital. (Worksheet S-10 is included on page 4 of this document). We are investigating the extent to which these variables could yield an appropriate measure of uncompensated care. According to Worksheet S-10 of the Medicare Cost Report, the definition of non-Medicare uncompensated care is as follows:

$$\begin{aligned} &\text{Cost of charity care (line 23) + Cost of non-Medicare bad debt expense (line 29)} \\ &= \text{Cost of non-Medicare uncompensated care (Line 30)} \end{aligned}$$

Whereas:

- Cost of charity care = Cost of initial obligation of patients approved for charity care (line 21)¹⁷⁵ minus partial payment by patients approved for charity care (line 22)
 - Cost of non-Medicare bad debt expense = Cost to charge ratio (line 1) times non-Medicare and non-reimbursable bad debt expense (line 28)¹⁷⁶
1. Is the definition for uncompensated care consistent with your organization's definition? If not, how do the definitions differ?
 2. Do you have any concerns on using this definition to appropriately measure the level of uncompensated care for your hospital constituents?
 3. Are there any variations to this definition that you would recommend using in identifying the level of uncompensated care?
 4. Are there any other datasets you are aware of that could be used to calculate hospital specific uncompensated care?
 5. Have your constituents expressed any difficulty completing the S-10?

¹⁷⁵ Line 21 includes cost to charge ration times total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility

¹⁷⁶ Line 28 includes total bad debt expense for the entire hospital complex minus Medicare bad debts for the entire hospital complex.

Appendix C: Stakeholder Interview Protocol

Questions Related to the Uninsured

Given that uninsured rates will be used in calculating uncompensated care add-on payments starting in FY2014, as described above, we would like to discuss your thoughts on measuring uninsured rates.

1. What are your concerns regarding the inclusion of uninsured rates in calculating the uncompensated care add-on payments?
 - a. Beginning in 2017, the ACA calls for the use of the most recent publicly available data on the uninsured. It is likely that these data will cover a period 1 to 2 years earlier than the year in which the uncompensated add-on payments are to be made. How concerned are you regarding the timeliness of available data?
 - b. Do you have any other concerns?
2. Are you familiar with any of the different estimates of the uninsured rate that are produced through different government surveys? If so, can we discuss some aspects of those surveys and the estimates that result from them?

For the purposes of these consultations, the following definitions of survey design terms will apply:

- Recall period: The time lag between the date of data collection from the respondent and the reference period.
- Reference period: The timeframe for which survey respondents are asked to report on their insurance status.
- Release date: The date on which the final estimates are published.
- Uninsured: An individual is considered uninsured if he/she does not have any insurance coverage—private or public—for the time period referenced in the survey.

Because government surveys are designed differently, there are always trade-offs in using one survey's estimates over another's. For example, one survey may calculate the uninsured rate more appropriately but have a long recall period (and a larger standard error), while another may have a shorter recall period but a questionable calculation for the uninsured rate. Taking into account those types of differences, we have a few questions:

- a. Which (if any) surveys have you used to estimate the uninsured rate and why?
- b. What components used in calculating uninsured rates or survey design elements used to measure the uninsured do you consider most sensitive and why?
- c. Which survey instrument or methodology do you consider most appropriate for the calculation of the uncompensated care add-on payments and why?

Appendix D: Summary of Key Survey Characteristics

Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC)

Category	Description
Uninsured definition	No health insurance coverage for the entire reference period, which is a calendar year.
Years available	1987-2010
Most recent data available	2010 estimates <ul style="list-style-type: none"> • 2010: 18.4% for people under age 65 • 90% CI: +/-0.3%
Data collection period	February - April each year
Data collection method	Household computer-aided personal interview (CAPI)
Geographical coverage	Nation, states.
Universe	Civilian non-institutional population of the United States.
Respondent	One person responding on behalf of household
Sample/panel design	<ul style="list-style-type: none"> • 2002: Sample expansion to improve state estimates of children's health insurance coverage. • Sample is supplemented with an additional 4,500 Hispanic households. • Sample is located in 792 sample areas comprising 2,007 counties and cities in every state and DC.
Sample size	57,000 households, which included 112,000 persons aged 15 or older and 31,000 children age 0-14.
Reference and recall periods	<ul style="list-style-type: none"> • Reference period: Any coverage during the last calendar year. Survey is fielded in March, 2-3 months after calendar year. • Recall period is 14-16 months.
Insurance coverage options	Private Coverage: Employer/Union, direct purchase Public Coverage: Medicare, Medicaid, other state programs, military-related (including TRICARE and VA)

Appendix D: Summary of Key Survey Characteristics

American Community Survey (ACS)

Category	Description
Uninsured definition	No health insurance coverage at the time of completing the form.
Years available	2008-2010
Most recent data available	2010 estimates <ul style="list-style-type: none"> • 2010: 17.7% for people under age 65 (as calculated by authors) • 2010: 15.5% for total population • Margin of error: +/- 0.1%
Data collection period	Continuous
Data collection method	Mail-out, telephone non-response follow-up, and personal visit non-response follow-up
Geographical coverage	<ul style="list-style-type: none"> • 1-year-period estimates for areas with population 65,000 or more • 3-year-period estimates for areas with populations of 20,000 or more (health insurance coverage estimates available in 2011) • 5-year-period estimates for all statistical, legal and administrative entities (health insurance coverage estimates available in 2013)
Universe	Civilian non-institutional population of the United States, plus residents of Puerto Rico, Group Quarters residents, and active-duty military staff.
Respondent	One person answering on behalf of household
Sample/panel design	Covers every state, county, and census tract.
Sample size	Nearly 2 million addresses annually
Reference and recall periods	<ul style="list-style-type: none"> • Reference period: Coverage at the point in time of the interview. • Recall period: Current
Insurance coverage options	Private Coverage: Employer/Union-based, direct purchase, TRICARE and other military health care Public Coverage: Medicare, Means-tested public coverage (e.g., Medicaid), VA Health Care

Appendix D: Summary of Key Survey Characteristics

Survey of Income and Program Participation (SIPP)

Category	Description
Uninsured definition	No health insurance for each of the last four months (since last interview).
Years available	1984-2008
Most recent data available	2008 microdata available
Data collection period	Continuous
Data collection method	Household computer-aided personal interview (CAPI) and telephone
Geographical coverage	National and regional estimates.
Universe	Civilian non-institutional population of the United States.
Respondent	Anyone 15 years or older responds for themselves (if feasible). For others, proxy respondent within household is used.
Sample/panel design	Each panel participates for 2.5 to 4 years.
Sample size	Ranging from approximately 14,000 to 36,700 interviewed households per panel (each panel spans a period of 2.5 years to 4 years)
Reference and recall periods	<ul style="list-style-type: none">Reference period: Monthly coverage for each of the 4 months prior to the interview.Recall period: 4 months
Insurance coverage options	Private Coverage: Employer/Union, direct purchase, military related (including TRICARE and VA) Public Coverage: Medicare, Medicaid, other state programs

Appendix D: Summary of Key Survey Characteristics

Medical Expenditure Panel Survey (MEPS)

Category	Description
Uninsured definition	<p>Three definitions are constructed from monthly data: Interviews are conducted five times over a 2.5 year period (approximately) covering the 2-year reference period. Health insurance status is obtained; from this, month by month health insurance variables are constructed.</p> <ul style="list-style-type: none"> • Uninsured for the first half of the year. • Uninsured for the entire survey year. • Uninsured at any time during the survey year.
Years available	1996-2010 (2009 for full year data, 2010 first half of year)
Most recent data available	<ul style="list-style-type: none"> • 2010 point-in-time public use file: 21.0% for first half of 2010 (Standard error: 0.53). for population less than age 65 • From round 3 panel 14 and round 1 panel 15.
Data collection period	2.5 years, with 5 rounds of interviews during that time. (reference period 2 years)
Data collection method	In person computer-aided personal interview (CAPI)
Geographical coverage	National
Universe	Civilian non-institutional population of the United States.
Respondent	One person responding on behalf of household
Sample/panel design	<ul style="list-style-type: none"> • Overlapping panel design with 5 rounds of interviews over 2.5 years (reference period 2 years) • New panel starts each calendar year. • Sample drawn from previous year's NHIS sample.
Sample size	Each year, as a rule, number of families is about 14,000 and number of individuals is about 35,000.
Reference and recall periods	<ul style="list-style-type: none"> • Reference period: Two years. Health insurance status is determined for each month during that time using the questionnaire. Then, different estimates (described above) are constructed. • Recall period: Variable. On average, 3 to 6 months depending on when interviews scheduled, month by month variables constructed.
Insurance coverage options	<ul style="list-style-type: none"> • Insured: People were classified as insured if they were covered by Medicare, TRICARE (Armed-Forces-related coverage), Medicaid, other public hospital/physician programs, or private hospital/physician insurance (including Medigap coverage). • Uninsured: Individuals covered only by non-comprehensive State specific programs (e.g., Maryland Kidney Disease Program) or private single-service plans (e.g., coverage for dental or vision care only, coverage for accidents or specific diseases) were not considered insured.

Appendix D: Summary of Key Survey Characteristics

National Health Interview Survey (NHIS)

Category	Description
Uninsured definition	<p>Three definitions:</p> <ul style="list-style-type: none"> Uninsured at time of interview Uninsured for at least part of the year (i.e., 12 months) prior to the interview (which also includes persons uninsured for more than a year) Uninsured for more than a year (i.e., 12 months) at time of the interview
Years available	1997-2011 (2011: January-June)
Most recent data available	<p>January-June 2011: For people under age 65</p> <ul style="list-style-type: none"> Uninsured at time of interview: 17.4% (SE: 0.38%) Uninsured for at least part of past year: 22.3% (SE: 0.42%) Uninsured for more than a year: 12.7% (SE: 0.33%) <p>2010: For people under age 65</p> <ul style="list-style-type: none"> Uninsured at time of interview: 18.2% (SE: 0.08%) Uninsured for at least part of past year: 22.5% (SE: 0.33%) Uninsured for more than a year: 13.3% (SE: 0.24%)
Data collection period	<ul style="list-style-type: none"> Continuous throughout each year.
Data collection method	Household computer-aided personal interview (CAPI)
Geographical coverage	National and some states.
Universe	Civilian non-institutional population of the United States.
Respondents	<ul style="list-style-type: none"> For Family Core Questionnaire, a single respondent answers survey. A Sample Adult chosen to respond to the Sample Adult Core Questionnaire. Adults aged 65+ who are black, Hispanic, or Asian have an increased chance of being selected as the Sample Adult. A Sample Child is chosen to respond to the Sample Child Core Questionnaire.
Sample/panel design	<ul style="list-style-type: none"> Current sampling design was implemented in 2006. Each year's sample is divided into 4 representative panels, which are fielded one per each quarter of the year. Sample is drawn from each state and DC. Some minority populations are oversampled: Blacks, Hispanics, and Asians.
Sample size	<ul style="list-style-type: none"> 35,000 households covering 87,500 persons (completed interviews) In 2011, a sample expansion was implemented, bringing total sample to over 100,000. More sample expansion planned for 2012.
Reference and recall periods	<ul style="list-style-type: none"> Reference periods: At time of interview, one year prior to interview. Recall period: Variable; up to 12 months.
Insurance coverage options	<ul style="list-style-type: none"> Insured: People were classified as insured if they were covered by Medicare, TRICARE, Medicaid, other public hospital/physician programs, or private hospital/physician insurance (including Medigap coverage). Uninsured: Individuals covered only by non-comprehensive State specific programs (e.g., Maryland Kidney Disease Program) or private single-service plans (e.g., coverage for dental or vision care only, coverage for accidents or specific diseases).

Appendix E: Calculated Statewide Average RCC

Calculated State Average Ratio of Cost to Charges (RCC)

State	State Average RCC
Alabama	0.2996
Alaska	0.5642
Arizona	0.2423
Arkansas	0.2892
California	0.2336
Colorado	0.3250
Connecticut	0.4182
Delaware	0.3776
District of Columbia	0.3091
Florida	0.2125
Georgia	0.3074
Hawaii	0.3804
Idaho	0.3913
Illinois	0.3038
Indiana	0.3150
Iowa	0.3609
Kansas	0.3896
Kentucky	0.2965
Louisiana	0.3353
Maine	0.4530
Massachusetts	0.4106
Michigan	0.3707
Minnesota	0.4089
Mississippi	0.3369
Missouri	0.3297
Montana	0.4570
Nebraska	0.3547
Nevada	0.2400
New Hampshire	0.3587
New Jersey	0.1845
New Mexico	0.3445
New York	0.4291
North Carolina	0.3129
North Dakota	0.3952
Ohio	0.3217
Oklahoma	0.3202

Appendix E: Calculated Statewide Average RCC

State	State Average RCC
Oregon	0.4082
Pennsylvania	0.2819
Puerto Rico	0.6281
Rhode Island	0.3584
South Carolina	0.2743
South Dakota	0.3408
Tennessee	0.2589
Texas	0.2950
Utah	0.4064
Vermont	0.4882
Virginia	0.3348
Washington	0.3314
West Virginia	0.3782
Wisconsin	0.3686
Wyoming	0.4173

Source: Dobson | DaVanzo Team analysis of 2010 and 2011 Hospital Cost Reports.

Appendix F: Release Calendar Medicare Cost Report

See Accompanying Excel Document