



June 2016

HOSPITAL UNCOMPENSATED CARE

Federal Action Needed to Better Align Payments with Costs

GAO Highlights

Highlights of [GAO-16-568](#), a report to congressional requesters

Why GAO Did This Study

Hospitals have historically incurred billions of dollars in costs for services provided to uninsured and other low-income individuals. The Patient Protection and Affordable Care Act (PPACA) offered ways for states to increase insurance levels including by expanding their Medicaid programs. In anticipation of the expected decline in the uninsured and uncompensated hospital costs, PPACA also reduced federal support for hospitals serving a disproportionate share of low-income and uninsured individuals and redirected some support to Medicare UC payments for hospital uncompensated care costs.

GAO was asked to examine federal support for hospital uncompensated care. GAO examined (1) the key sources and amounts of federal support for hospital uncompensated care costs; (2) the basis for determining hospital uncompensated care payments made under Medicaid and Medicare; and (3) the extent to which Medicare UC payments align with hospital uncompensated care costs. GAO analyzed federal payment data for fiscal years 2013 and 2014, the most recent available, reviewed relevant laws and regulations, and interviewed CMS officials.

What GAO Recommends

GAO recommends that CMS take two actions: (1) improve alignment of Medicare UC payments with hospital uncompensated care costs; and (2) account for Medicaid payments made when making Medicare UC payments to individual hospitals. In commenting on a draft of this report, HHS concurred with both recommendations.

View [GAO-16-568](#). For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

June 2016

HOSPITAL UNCOMPENSATED CARE

Federal Action Needed to Better Align Payments with Costs

What GAO Found

Key sources of federal support for hospitals incurring costs for services provided to uninsured and other low-income individuals (uncompensated care costs) include multiple types of Medicaid and Medicare payments totaling about \$50 billion annually. GAO's analysis shows that through Medicaid, a joint federal-state program for low-income individuals, states made three types of payments that helped offset uncompensated care in fiscal years 2013 and 2014 totaling over \$35 billion annually. Medicare, a federal program for aged and certain disabled individuals, made two types of payments in 2013 and three in 2014—including a new type called Medicare Uncompensated Care (UC) payments—totaling over \$14 billion annually. Federal tax law also provides tax benefits—estimated by researchers to be billions of dollars annually—to tax-exempt nonprofit hospitals that incur uncompensated care costs.

The basis for determining these different types of Medicaid and Medicare payments varies somewhat by type of payment. As shown in the table, however, the payment types are based on similar factors—generally hospitals' costs or workloads related to providing services to Medicaid, uninsured, or low-income Medicare patients, or some combination of these.

Key types of payments that help offset hospital uncompensated care costs	Description of the basis for determining payments in the payment formula ^a
Medicaid disproportionate share hospital	Services provided to Medicaid and uninsured patients ^a
Medicaid upper payment limit	Services provided to Medicaid patients ^a
Medicaid demonstration uncompensated care	Services provided to Medicaid and uninsured patients ^a
Medicare disproportionate share hospital	Number of days Medicaid and low-income Medicare patients were in the hospital
Medicare uncompensated care	Number of days Medicaid and low-income Medicare patients were in the hospital

Source: GAO analysis of Medicaid and Medicare payments. | GAO-16-568

^aFor Medicaid, states determine and make payments subject to federal payment limits. GAO examined the basis for Medicaid payments by examining federal payment limits, not state payments.

Medicare's UC payments are not well aligned with hospital uncompensated care costs for two reasons. First, payments are largely based on hospitals' Medicaid workload rather than actual hospital uncompensated care costs. Centers for Medicare & Medicaid Services (CMS) officials acknowledge this could result in payments not aligned with uncompensated costs, particularly in states that have expanded Medicaid resulting in fewer uninsured individuals and lower uncompensated costs. In an April 2016 proposed rule, the agency announced that it is considering using hospitals' actual uncompensated care costs as the basis for making Medicare UC payments. Second, CMS does not account for hospitals' Medicaid payments that offset uncompensated care costs when making Medicare UC payments, even though the bulk of Medicare's payments—about 85 percent or \$7.7 billion in 2014—were made on the basis of hospitals' Medicaid workloads, for which hospitals may have also received Medicaid payments. CMS officials said that the Medicaid and Medicare programs are operated separately. Medicare UC payments that are not aligned with uncompensated care costs or adjusted to reflect Medicaid payments undermine CMS's efforts to efficiently pay for health care services.

Contents

Letter		1
	Background	6
	Multiple Sources of Federal Support for Hospital Uncompensated Care Totaled Nearly \$50 Billion Annually in 2013 and 2014	8
	Medicaid and Medicare Payments That Help Offset Hospital Uncompensated Care Costs Are Generally Based on Similar Factors	16
	Medicare UC Payments Are Not Well Aligned with Hospitals' Uncompensated Care Costs	20
	Conclusions	24
	Recommendations for Executive Action	26
	Agency Comments and Our Evaluation	26
Appendix I	Comments from the Department of Health and Human Services	28
Appendix II	GAO Contact and Staff Acknowledgments	31
Related GAO Products		32
Figure		
	Figure 1: Medicare Payments That Help Offset Hospital Uncompensated Care by Type, 2013 and 2014	14

Abbreviations

ASPE	Assistant Secretary of Planning and Evaluation
CMS	Centers for Medicare & Medicaid Services
DSH	Disproportionate Share Hospital
JCT	Joint Committee on Taxation
MedPAC	Medicare Payment Advisory Commission
PPACA	Patient Protection and Affordable Care Act
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
UC	Uncompensated Care
UPL	Upper Payment Limit

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



June 30, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Hospitals historically have incurred billions of dollars in costs for services they provided to uninsured and low-income patients for which they are not fully compensated. These costs are referred to as uncompensated care costs, and longstanding, federally supported programs provide funds to help offset these uncompensated costs. These programs include Medicaid, the joint federal-state partnership health coverage program for low-income and medically needy individuals, and Medicare, the federal health coverage program for the elderly and certain disabled individuals. At the federal level, the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS), oversees state Medicaid programs and administers the Medicare program. For Medicaid, CMS provides guidance to states on federal requirements for Medicaid hospital uncompensated care payments and oversees compliance with these requirements. States are responsible for day to day administration of the program, including determining payment amounts to individual hospitals consistent with any applicable federal limits. For Medicare, CMS administers Medicare payment policies, including making Medicare payments to hospitals for uncompensated care.

Legislative changes made under the Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010, have implications for the amount of uncompensated care hospitals provide, as well as for the amount and allocation of federal support for hospital uncompensated care

costs.¹ Under PPACA, states have the option to expand their Medicaid programs to cover nearly all adults with incomes at or below 133 percent of the federal poverty level.² PPACA also required the establishment of health insurance exchanges by January 1, 2014—marketplaces offering private health insurance coverage—and provided for federal subsidies to qualified individuals and families who purchase health insurance through the exchanges. As a result of these changes, the number of people with health insurance has increased. For example, the Congressional Budget Office and the Joint Committee on Taxation (JCT) have estimated that the number of uninsured individuals would decline by 12 million in 2014.³ Given that increases in the number of people with health insurance could significantly lower the amount of uncompensated care hospitals provide, PPACA also made changes intended to more closely align certain Medicare and Medicaid funds with hospital uncompensated care costs. For example, PPACA redirected some existing Medicare funds paid to hospitals serving a disproportionate share of the nation’s low-income individuals in order to establish a Medicare Uncompensated Care (UC) payment specifically to offset hospitals’ uncompensated care costs, including the cost of treating uninsured patients. Researchers have noted that the reduction in the number of uninsured individuals varies by state; for example, states expanding Medicaid to cover the newly eligible adults have had greater reductions in the number of uninsured individuals than others.⁴

¹Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (HCERA). In this report, references to PPACA include any amendments made by HCERA.

²PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the FPL. States were eligible for increased federal matching funds available for enrollees covered under the expansion beginning in January 2014.

³The Congressional Budget Office and JCT estimate of the decrease in the number of uninsured individuals is based on comparing estimates of the number of uninsured individuals in 2014 absent PPACA with estimates of uninsured individuals in 2014 with PPACA enacted. See Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014* (Washington, D.C.: 2014).

⁴See Office of the Assistant Secretary of Planning and Evaluation, *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014* (Washington, D.C.: Sept. 24, 2014.); and Robert Wood Johnson Foundation, State Health Reform Assistance Network, *The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States*, (Princeton, N.J.: June 2015).

In light of the multiple changes that have affected, and will continue to affect, the amount and costs of hospital uncompensated care and the financial support hospitals receive from federal programs, you asked us to examine the various federal efforts to help hospitals with uncompensated care costs and the basis for determining federal payment amounts for hospital uncompensated care costs. This report examines

- (1) the key sources and amounts of federal support for hospitals' uncompensated costs of care in 2013 and 2014;
- (2) the basis for determining hospital uncompensated care payments made under Medicaid and Medicare; and
- (3) the extent to which Medicare UC payments align with hospital uncompensated care costs.

To examine the key sources and aggregate amounts of federal government support for hospital uncompensated care, we gathered data on reported aggregate payment amounts for hospital uncompensated care for each type of payment available under the Medicaid and Medicare programs in fiscal years 2013 and 2014—the most recent available.⁵ We also obtained information on the value of tax-exemptions for nonprofit hospitals available in 2006 under federal tax laws. For Medicaid payments, we analyzed data from the quarterly Medicaid Expenditure Reports—referred to as the CMS-64—that states use to report Medicaid expenditures to CMS for the purpose of receiving federal matching funds. For Medicare payments, we obtained reported data on projected spending in fiscal years 2013 and 2014 from CMS.⁶ We also reviewed available information from the Internal Revenue Service (IRS) on tax exemptions provided to nonprofit hospitals, including relevant laws and

⁵We did not include Medicaid or Medicare supplemental payments made by managed care plans that may offset hospital uncompensated care costs.

⁶See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>. The aggregate payments reported by CMS are projected based on data in the most recent Hospital and Hospital Health Care Complex Cost Report (Hospital Cost Report) that all Medicare-certified hospitals are required to submit to CMS on an annual basis. The reports provide information on hospitals' charges, costs, and utilization for all payers. The reports are audited before they are finally settled. CMS officials stated that this is a process that can take between 3 to 4 years. They also said that actual settled payment amounts for 2013 and 2014 will therefore not be available on the CMS website until 2017 at the earliest.

IRS regulations, and interviewed IRS officials to clarify our understanding of these materials. In addition, we obtained available estimates on the financial value of tax-exemptions for hospitals that qualified for these exemptions under federal tax laws.⁷

To assess the basis for determining hospital uncompensated care payments made under Medicaid and Medicare, we reviewed federal laws, regulations, and CMS policy and guidance documents that detailed the formulas—including the methodologies, definitions, and data sources—used for determining payments that help offset hospital uncompensated care. For Medicaid payment types we reviewed the formulas for the federal payment limits that apply to payments made by the states. Under Medicaid, states have discretion to make payments in amounts up to hospital-specific payment limits and state-wide DSH allotments. We did not review the actual Medicaid payments that states made to individual hospitals or the basis for payments they made. For Medicare payments we reviewed federal formulas used to determine hospital payments that help offset uncompensated care costs. We did not analyze actual Medicare payments made to individual hospitals. In addition, we interviewed Medicaid and Medicare officials at CMS to understand each program's policies for determining hospital uncompensated care. We also interviewed experts, including officials from the Medicaid and CHIP Payment and Access Commission (MACPAC), the Medicare Payment Advisory Commission (MedPAC), and industry stakeholders including the American Hospital Association and Healthcare Financial Management Association, to obtain their views on CMS's policies to determine hospital uncompensated care payments under Medicaid and Medicare.

To determine the extent to which Medicare UC payments align with hospital uncompensated care costs, we examined CMS's Impact File for the 2014 Final Rule that implements Medicare payment policies for fiscal

⁷Although federal tax law provides tax exemptions to non-profit hospitals and does not—as Medicaid and Medicare programs do—provide payments to hospitals for uncompensated care, we included federal tax laws in our review because the provision of uncompensated care is a measure by which nonprofit hospitals may qualify for tax exemptions.

year 2014—the first year Medicare UC payments were made.⁸ We reviewed studies on the relationship between the factors on which Medicare UC payments were based and hospital uncompensated care costs, including a CMS contractor study and MedPAC studies.⁹ We also interviewed CMS officials regarding implementation of the Medicare UC payments, and MedPAC officials and the contractor hired by CMS to provide technical assistance about the implementation of the Medicare UC payment. We did not compare actual Medicare UC payments made to individual hospitals with those hospitals' uncompensated care costs.

We determined that the data we obtained from CMS on Medicaid and Medicare payment amounts and from the CMS Impact file were reliable for purposes of our review by checking the data for discrepancies, comparing the data to other publicly available data, and communicating with officials to resolve any identified discrepancies. We conducted this performance audit from April 2015 to June 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.¹⁰

⁸CMS annually implements Medicare payment policies through the federal regulatory rulemaking process, including seeking public comment on notices of proposed rulemaking. In conjunction with this process, CMS develops payment models to estimate the effect policy changes will have on hospitals. The data from CMS's payment models are made available in CMS's impact files for review as part of the public comment process.

⁹See Dobson DaVanzo & Associates, LLC, *Improvements to Medicare Disproportionate Share Hospital (DSH) Payments, a Report Prepared at the Request of Centers for Medicare & Medicaid Services* (May 9, 2013); also see MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2014.

¹⁰A list of related GAO products appears at the end of this report.

Background

Hospitals are an important and significant provider of health care services to our nation. Nearly one-third of the total \$3 trillion in health care spending in 2014 was attributed to hospital services.¹¹ Three major payers comprise the bulk of our nation's hospital spending: Medicare, Medicaid, and private health insurance companies:

- Medicare is a federal health program administered by CMS that provides health insurance coverage for seniors aged 65 and over, individuals with end-stage renal disease, and certain disabled persons.
- Medicaid is a joint federal-state health care program that provides health insurance coverage to low income and medically needy individuals. Medicaid is administered and operated by each state Medicaid program under CMS oversight. Within broad federal requirements, each state establishes provider payment rates, pays providers for services rendered, and determines the optional populations and benefits its Medicaid programs will cover beyond the mandatory populations and benefits states are required to cover. The federal government matches each state's Medicaid expenditures for services according to the state's federal medical assistance percentage.
- Private health insurance includes employer-sponsored coverage and coverage purchased by individuals from a private insurance carrier.

Medicare, Medicaid, and private insurance covered over 80 percent of spending on hospital services in 2014. The remainder of the spending came from various other sources including other third party payers and programs and out-of-pocket spending by patients.¹² Patient out-of-pocket

¹¹Centers for Medicare & Medicaid Services, National Health Expenditure Data, *Table 7: Hospital Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2014*, accessed on Jan. 6, 2016, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

¹²Other third party payers include workers' compensation and local indigent care programs.

spending includes deductibles, coinsurance, copayments, or payments for services not covered by insurance or that exceed coverage limits.¹³

Some patients receiving hospital services do not have health insurance coverage through public programs or private insurance; as a result, hospitals may provide care to these uninsured individuals for which the hospital may not receive compensation. Although the federal government has multiple funding streams to help offset these and other hospital uncompensated care costs, no standard definition of uncompensated care costs exists across federal programs. As a result, no standard federal estimate of total hospital uncompensated care costs is available. On the basis of its annual survey of hospitals, the American Hospital Association estimated that hospital uncompensated care costs totaled over \$46 billion in 2013.¹⁴ Any estimate of these costs would vary depending upon the definition of uncompensated care used for the estimate. Definitions of uncompensated care costs may include the following:

- **Uninsured patient costs.** These include the costs of services provided to patients who do not have health insurance coverage and are unable to pay for the services they receive; these services are sometimes referred to as charity care and can include the cost of care provided to privately insured patients whose insurance did not cover the services provided.
- **Bad debt.** This includes cost-sharing for which patients are responsible for paying but have not paid—for example, deductible and coinsurance amounts.

¹³A deductible is a set amount of spending that is the responsibility of the insured patient before the patient's insurance begins paying. Co-insurance is the amount of a provider's bill that is the responsibility of the insured patient; it is generally a percentage of the allowable charges for covered services. Copayments are a fixed amount paid for a covered service. In addition, services received that are not covered by a patient's health insurance coverage—such as an individual with basic hospitalization coverage that has an exclusion for organ transplant services—or services that exceed coverage limits—for example, hospital days that exceed specified limits on the number of covered inpatient days—are also the responsibility of the patient.

¹⁴See American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet* (Washington, D.C.: January 2015.)

-
- **Public payer payment shortfalls.** These include the differences between payments from public payers such as Medicaid, and hospitals' costs for the services provided to these payers' beneficiaries.¹⁵

Multiple Sources of Federal Support for Hospital Uncompensated Care Totaled Nearly \$50 Billion Annually in 2013 and 2014

In fiscal years 2013 and 2014, the federal government made multiple types of payments to hospitals to help offset uncompensated care costs mainly through two programs—Medicare and Medicaid—totaling nearly \$50 billion each year. Medicaid payments accounted for almost three-quarters of these payments in each year. Federal tax laws provided other benefits to qualifying non-profit hospitals through tax exemptions.

Three Types of Payments Are Made in the Medicaid Program That Help Offset Hospital Uncompensated Care Costs, with Payments of over \$35 Billion Annually in 2013 and 2014

In fiscal years 2013 and 2014, state Medicaid programs spent over \$35 billion in each year for payments that helped hospitals offset their uncompensated care costs. Medicaid spending comprised three types of payments: disproportionate share hospital (DSH) payments, upper payment limit (UPL) payments, and uncompensated care payments made under section 1115 demonstrations. All three payment types are, for purposes of this report, considered to be supplemental payments, which are payments generally made separately from, and in addition to, states' regular, claims-based payments to hospitals for Medicaid services provided to Medicaid beneficiaries. Supplemental payments are generally made as lump sum payments on a monthly, quarterly, or annual basis. Specifically

- **Medicaid DSH payments.** These are Medicaid payments that Congress established for hospitals serving large numbers of Medicaid and low-income individuals to help offset their uncompensated costs. Federal law requires states to make DSH payments to certain eligible

¹⁵Payment shortfalls from Medicare are generally not included in definitions of uncompensated care, since Medicare's inpatient prospective payment system, which pays a fixed amount for each type of inpatient admission, is intended to encourage efficiency in the delivery of care. Private payer shortfalls are also typically not considered in definitions of uncompensated care because hospitals have the ability to negotiate payment rates with private insurers.

hospitals and also limits DSH payment amounts to each hospital's costs of providing uncompensated care, as defined under federal law and regulations governing Medicaid DSH payments.¹⁶ States have broad flexibility in deciding how to allocate these payments among eligible hospitals as long as any payment to an individual hospital does not exceed that hospital's uncompensated costs of providing care to Medicaid beneficiaries and individuals without health insurance or other sources of third-party coverage for the service provided. State-specific limits also exist on the amount of federal funds available for Medicaid DSH payments.¹⁷

- **Medicaid UPL payments to hospitals.** These are supplemental payments states make per the Medicaid UPL regulations. The UPL is a limit or ceiling on the amount of a state's Medicaid payments for certain fee-for-service Medicaid services the federal government will match and is based on an estimate of what Medicare would pay for comparable services. States' regular payments to hospitals for services rendered to Medicaid beneficiaries are often below the UPL. Consequently, most states make UPL supplemental payments to some hospitals that are in addition to the hospitals' regular payments but do not exceed the UPL. Medicaid payments to individual hospitals are not limited to the hospitals' costs of providing services, and UPL payments that states make have resulted in Medicaid payments that exceed hospital costs for Medicaid services, making funds available to the recipient hospitals for uncompensated care purposes.¹⁸ The UPL is not a hospital-specific limit but is applied in the aggregate across certain categories of providers, and states have some flexibility in

¹⁶States are required to make DSH payments to hospitals treating large numbers of Medicaid or low-income patients. 42 U.S.C. §§ 1396a(a)(13), 1396r-4(d). Congress first required states to make Medicaid DSH payments to hospitals in 1981 when it eliminated the requirement that states pay hospitals on a reasonable cost basis. Recognizing that hospitals that serve a large Medicaid and low-income population are particularly dependent on Medicaid reimbursement, Congress directed states to adjust payment rates to account for the atypical costs experienced by these hospitals in treating this population. See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808-809 (1981) (codified, as amended, at 42 U.S.C. § 1396a(a)-(13)); H. R. Rep. No. 97-208, at 962 (1981) (Conf. Rep.).

¹⁷PPACA included provisions to reduce Medicaid DSH payments nationally. Under current law, these payments are scheduled to be reduced by \$43 billion between fiscal years 2018 and 2025. 42 U.S.C. § 1396r-4(f)(7).

¹⁸See GAO, *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed*, [GAO-13-48](#) (Washington, D.C.: Nov. 2012)

deciding which hospitals will receive a UPL payment, and how to allocate UPL payments among hospitals.¹⁹ While UPL supplemental payments to providers are associated with particular types of services, whether the payments are intended to offset uncompensated care costs related to the provision of those services is generally not reported.²⁰

- **Section 1115 demonstration uncompensated care payments.** These are payments that some states make to hospitals specifically for uncompensated care costs in conjunction with demonstration and pilot projects for which they have received approval from the Secretary of Health and Human Services.²¹ Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal matching funds for experimental, pilot, or demonstration programs that, in the Secretary's judgement, are likely to assist in promoting Medicaid objectives.²² Certain states have received approval to make supplemental payments for hospital uncompensated care in their Medicaid

¹⁹Federal regulations establish separate UPLs for certain services provided by three categories of hospitals based on ownership: local (nonstate) government-owned or government-operated hospitals, state-government-owned or state-government-operated hospitals, and privately owned and operated hospitals. See 42 C.F.R. §§ 447.272, 447.321 (2015). Also see GAO, Medicaid: *Federal Guidance Needed to Address Concerns about Distribution of Supplemental Payments*, [GAO-16-108](#) (Washington, D.C.: Feb. 2016).

²⁰Although federal requirements do not permit Medicaid UPL payments for any purpose other than to pay for Medicaid services, for purposes of this report, we considered UPL payments as payments that can help offset uncompensated care costs because UPL payments that exceed Medicaid costs may be available for hospital uncompensated care costs for uninsured patients. In addition, Medicaid rules require that payments in excess of costs must be applied to hospital uncompensated care for purposes of DSH payment limits.

²¹States have been approved to make two types of supplemental payments under Medicaid demonstrations: uncompensated care payments and incentive payments for delivery system reforms and improvements. Supplemental incentive payments—referred to as Delivery System Reform Incentive Payments—are not for medical services rendered and not for hospital uncompensated care.

²²42 U.S.C. § 1315(a).

demonstrations.²³ Supplemental payments states make under demonstrations are made according to the terms and conditions approved by the Secretary of HHS for each demonstration.

In fiscal years 2013 and 2014, total Medicaid spending—state and federal funds—through the three types of payments exceeded \$35 billion each year based on state Medicaid expenditure reports submitted to CMS. In fiscal year 2013, Medicaid DSH payments totaled \$16.4 billion and combined UPL and section 1115 demonstration payments totaled \$19 billion.²⁴ In fiscal year 2014, Medicaid DSH payments totaled \$18.1 billion and combined UPL and section 1115 payments totaled \$17.5 billion. These payments could comprise a large proportion of payments that hospitals receive. For example, total Medicaid payments for hospital inpatient and outpatient services totaled over \$88 billion in fiscal year 2013 and about \$84 billion in fiscal year 2014. All of these Medicaid payments were eligible for federal matching funds; that is, the federal government provided funds for half or more of the payments, depending on the state.²⁵

²³In 2013 and 2014, 10 states made supplemental payments to hospitals for hospital uncompensated care under approved section 1115 demonstrations: Arizona, California, Florida, Hawaii, Kansas, Massachusetts, New Mexico, New Jersey, Tennessee, and Texas. Some of these states' demonstrations also included supplemental incentive payments for delivery system reforms and improvements and did not offset hospital uncompensated care costs.

²⁴States are required to separately report DSH payments and hospital supplemental payments on supplemental payment reporting lines on the CMS expenditure reports. However, according to CMS officials, UPL supplemental payments and uncompensated care payments made under section 1115 demonstrations are reported together on the same line of the CMS expenditure report. As a result, we were unable to separately report payment amounts for each of these payment types. Our analysis does not include all Medicaid supplemental payments that states make. We did not include incentive payments for delivery system reforms in the total Medicaid supplemental payments for purposes of this analysis. In addition, some states may make supplemental payments but not report them on the supplemental payment lines on the CMS expenditure reports, in which case they would not be captured in this analysis.

²⁵The federal government matches state Medicaid expenditures based on a statutory formula—the Federal Medical Assistance Percentage (FMAP). Under the FMAP, the federal government pays a share of Medicaid expenditures based on each state's per capita income (PCI) relative to the national average. Federal law specifies that the regular FMAP will be no lower than 50 percent and no higher than 83 percent.

Two Types of Payments Are Made in the Medicare Program That Help Offset Hospital Uncompensated Care Costs, with Payments of over \$14 Billion Annually in 2013 and 2014

Medicare provided two types of payments that helped offset hospital uncompensated care costs in fiscal year 2013: DSH payments and bad debt payments. As required by PPACA starting in fiscal year 2014, Medicare DSH payments were reduced and a third type of payment—the Medicare UC payment—was established. Specifically

- **Medicare DSH payments:** These Medicare payments are required to be made to hospitals that serve a significantly disproportionate number of low-income patients. Congress established these payments to address concerns that these hospitals would have unreimbursed costs that would not be recognized under Medicare’s prospective payment system.²⁶ Although these payments do not directly reimburse hospital uncompensated care costs, they are intended to help offset eligible hospitals’ unreimbursed cost of treating low-income patients. DSH payments are added on to Medicare’s base payment to hospitals for each Medicare patient discharge. In general, there are no national or hospital-specific limits on Medicare DSH payments.²⁷ Under PPACA, starting in fiscal year 2014, Medicare DSH payments were reduced to 25 percent of the amount that would have been paid under prior law. PPACA requires that the remaining 75 percent of the amount that would have been paid as DSH payments is used to make a new type of payment, Medicare UC payments, discussed below.²⁸
- **Bad debt payments:** Hospitals are eligible to receive Medicare reimbursement for a portion of Medicare beneficiaries’ unpaid copayments and deductibles—known as bad debt—as long as the hospital makes a reasonable effort to collect the unpaid amounts.²⁹ In

²⁶As Medicare moved to a prospective payment system in the 1980s, whereby predetermined rates were set for each Medicare hospital discharge, concerns were raised that hospitals with substantial low-income patient loads would likely experience higher costs than otherwise similar institutions because low-income patients may be more severely ill than average, and these higher costs would not be adequately recognized under the prospective payment rates. DSH payments were enacted to help offset these higher costs. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, tit. IX, § 9105, 100 Stat. 82, 158-160 (1986) (codified, as amended, at 42 U.S.C. § 1395ww(d)(5)(F)).

²⁷The Medicare DSH adjustment is capped at 12 percent for certain hospitals, including urban hospitals with under 100 beds. See 42 C.F.R. § 412.106(d)(2)(iii)(C)(3)(2015).

²⁸42 U.S.C. § 1395ww(r).

²⁹The criteria for allowable bad debt appear at 42 C.F.R. § 413.89(e) (2015).

general, Medicare bad debt payments to individual hospitals are limited to 65 percent of a hospital's bad debt costs. The total amount of payments made by Medicare for bad debt is not capped and fluctuates as hospital bad debt increases or decreases. Bad debt payments are made as lump-sum supplemental payments and are not added on to Medicare base payments.

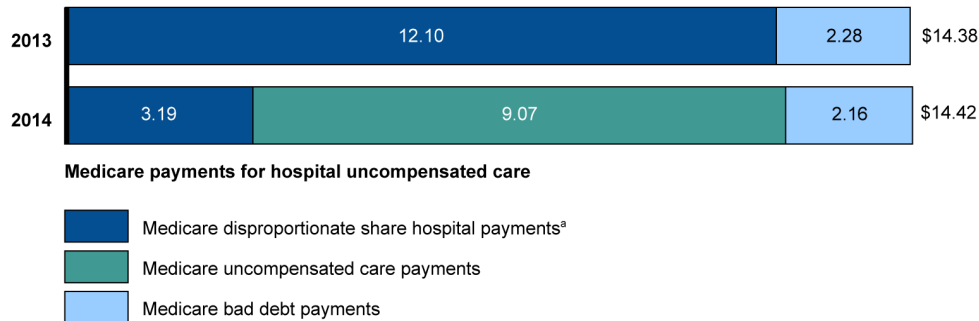
- **Medicare UC payments:** These payments, which were established under PPACA and required to be made starting in fiscal year 2014, are intended to help offset hospitals' uncompensated care costs and are added on to Medicare's base payment for each Medicare patient discharge.³⁰ Hospitals that are eligible to receive Medicare DSH payments are automatically eligible to receive Medicare UC payments. These payments are made from an amount equal to 75 percent of what otherwise would have been paid as Medicare DSH after reducing this amount for changes in the percentage of individuals that are uninsured.

In fiscal years 2013 and 2014, total Medicare spending through these payment types was over \$14 billion each year. In comparison to Medicaid, Medicare spending through these payment types is a lower proportion of payments the program made to hospitals for services. Medicare payments to hospitals for inpatient and outpatient services totaled about \$179 billion in 2013 and about \$183 billion in 2014. As illustrated in figure 1, of the different types of Medicare payments that help offset hospital uncompensated care costs, DSH payments were the largest in fiscal year 2013 (over \$12 billion); Medicare UC payments were the largest in fiscal year 2014 (over \$9 billion); and bad debt payments were the smallest and relatively unchanged from one year to the next.

³⁰42 U.S.C. § 1395ww(r)(2). Medicare's base payments are determined under a prospective payment system. Under this system, Medicare pays hospitals a flat fee per patient stay for the procedure provided or condition treated, set in advance, with different amounts for each type of condition. These payment rates are also influenced by such factors as the relative hourly wage in the area where the hospital is located and whether the hospital qualifies for additional payments. Medicare also pays hospitals for services provided to beneficiaries in outpatient departments under the hospital outpatient prospective payment system.

Figure 1: Medicare Payments That Help Offset Hospital Uncompensated Care by Type, 2013 and 2014

Dollars in billions (fiscal year)



Source: GAO analysis of CMS data. | GAO-16-568

Federal Tax Law Provides Additional Financial Benefits for Tax-Exempt Non-Profit Hospitals Incurring Uncompensated Care Costs with Benefits Estimated in the Billions Annually

In addition to payments from Medicaid and Medicare that offset hospital uncompensated care costs, federal tax law provides additional financial benefits to hospitals that qualify for tax-exempt status. Financial benefits for these qualifying nonprofit hospitals include exemptions from federal income taxes, eligibility for tax-exempt bond financing of capital projects, and tax-deductible contributions from donors (both individuals and corporations).³¹ To qualify for federal tax-exempt status, nonprofit hospitals must be organized and operated exclusively for charitable purposes. To meet this requirement, IRS requires that nonprofit hospitals meet its community benefit standard, a measure of which may include provision of uncompensated care.³² Hospitals are required to report the value of the community benefits they provide, including uncompensated care costs, in Schedule H of IRS Form 990. In tax year 2011, of the approximately 4,900 total hospitals nationwide, about half qualified for tax

³¹In addition to federal tax exemptions, hospitals also may receive various tax exemptions at the state and local level, including exemptions from state and local income, property, and sales taxes. State and local benefits vary by jurisdiction.

³²In 2010, PPACA added new requirements for tax-exempt hospital organizations that included the adoption of written financial assistance and emergency medical care policies, limits on the amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy, and a community health needs assessment and adoption of an implementation strategy at least once every 3 years. See. PPACA, § 9007, 124 Stat. at 855 (adding subsection (r) to section 501 of the Internal Revenue Code, 26 U.S.C. § 501(r)).

exempt status, and hospital uncompensated care accounted for about 56 percent of their total reported community benefit expenses.³³

The exact amount of the financial benefits nonprofit hospitals receive from tax exemptions is not regularly tracked, but reported benefits are in the billions of dollars.³⁴ For tax year 2002, the latest data available, the Joint Committee on Taxation (JCT) estimated that the financial benefits of federal tax exemption for nonprofit hospitals nationwide totaled about \$6.1 billion.³⁵ Using JCT's methodology for estimating nonprofit hospital tax exemption, researchers estimated that for tax year 2011 the financial benefits of the federal tax exemption totaled about \$13 billion.³⁶

³³IRS, *Report to Congress on Private Tax-Exempt, Taxable, and Government-Owned Hospitals* (Washington, D.C.: January 2015).

³⁴The JCT, (a nonpartisan committee that assists Congress with tax legislation), does not classify tax-exempt status as a tax expenditure and therefore, the tax-exempt status benefits that non-profit hospitals receive are not included in annual estimates of federal tax expenditures. See Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2014-2018*, (Washington, D.C.: Aug. 5, 2014).

³⁵Of the total \$6.1 billion in federal tax expenditures, exemptions from federal income taxes accounted for about \$2.5 billion; federal bond financing \$1.8 billion, and federal charitable contributions accounted for another \$1.8 billion. In addition to federal tax exemptions, JCT estimated that nonprofit hospitals received exemptions from state and local taxes, the value of which was estimated to be \$6.4 billion. The largest categories were the exemption from local property taxes (\$3.1 billion) and the exemption from state and local sales taxes (\$2.8 billion). See Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits* (Washington, D.C.: December 2006).

³⁶Of the total \$13 billion in federal tax expenditures, exemption from federal income taxes accounted for about \$6.3 billion; federal bond financing \$3.3 billion, and federal charitable contributions accounted for another \$3.4 billion. In addition to federal tax exemptions, researchers estimated that nonprofit hospitals received exemptions from state and local taxes, the value of which was estimated to be \$11.6 billion. The largest categories were the exemption from state and local sales taxes (\$6.1 billion) and the exemption from local property taxes (\$4.3 billion). See Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes and Colin O'Laughlin, "The Value of The Nonprofit Tax Exemption Was \$24.6 billion in 2011," *Health Affairs*, vol. 34, no.7 (2015).

Medicaid and Medicare Payments That Help Offset Hospital Uncompensated Care Costs Are Generally Based on Similar Factors

The basis for determining the different types of Medicaid and Medicare payments that help offset hospital uncompensated care costs varies somewhat by type of payment. However, the majority of the different payment types are based on similar factors—generally hospitals’ costs or workloads related to providing services to Medicaid, uninsured, or low-income Medicare patients, or some combination of these patients.

Medicaid Payments That Help Offset Uncompensated Care Are Generally Based on Services Hospitals Provide to Medicaid and Uninsured Patients

Federal law and policy limit the amounts states may pay under the three types of payments that help offset hospitals’ uncompensated care costs. Within these limits, however, states generally may determine the hospitals that will receive these payments and the payment amounts. For example, Medicaid DSH payment limits are statutorily based on a calculation of a hospital’s uncompensated care costs of treating Medicaid and uninsured patients. Although this statutory formula does not apply to section 1115 demonstrations, CMS officials stated that they generally use the Medicaid DSH methodology in determining payment limits for Section 1115 uncompensated care payments. As such, DSH payments and uncompensated care demonstration payments are based, in part, on the cost of services provided to Medicaid and uninsured patients. The third payment type—UPL payments—is based on the difference between what the state Medicaid program pays for Medicaid services and the federal upper payment limit for payments for such services. Specifically

- **Medicaid DSH payments.** Federal law requires that states make Medicaid DSH payments to certain eligible hospitals but limits the amount of Medicaid DSH payments that states may make to individual hospitals.³⁷ These limits are based on a hospital’s uncompensated care costs, which are defined by federal law and regulation to be the hospital’s uncompensated costs of providing care to Medicaid patients

³⁷42 U.S.C. § 1396r-4(g).

and uninsured patients.³⁸ CMS relies on states and hospitals to calculate these uncompensated care costs using data from Hospital Cost Reports, their financial records, and state Medicaid agency data. In calculating their uncompensated care costs for Medicaid patients and uninsured patients, hospitals are required to include all payments received from Medicaid, including supplemental payments that are related to Medicaid services provided, as revenues that offset the costs of care. Since 2010, states have been required to submit independently certified audited reports annually on any hospital receiving Medicaid DSH payments.³⁹

- **Medicaid section 1115 uncompensated care payments.** Limits on the amount of these payments to individual hospitals are established based on a hospital's uncompensated care costs, which are determined under the approved terms and conditions of a state's demonstration. According to CMS officials, the agency requires that section 1115 hospital uncompensated care payments generally use similar methods to those used for Medicaid DSH payments to calculate hospital uncompensated care costs. States may include in their calculations additional costs typically not allowed for Medicaid DSH payments, subject to CMS approval. For example, some states include hospital uncompensated costs of physician services provided in a hospital.
- **Medicaid UPL payments.** Limits on the amount of these payments are established in the aggregate based on the difference between state Medicaid payments to hospitals for services rendered to Medicaid patients and the amount Medicare would have paid for similar services. Thus, the total amount of Medicaid UPL payments a state can make is based on services provided to Medicaid patients. The UPL is not a hospital-specific limit and states have flexibility in determining which hospitals to pay and the payment amounts. In fiscal

³⁸Under federal Medicaid DSH regulations, uninsured patients include privately insured patients who lack coverage for specific services—for example, patients who have exhausted their lifetime benefits or an individual with basic hospitalization coverage that has an exclusion for organ transplant services—as long as those services are covered by the state's Medicaid plan. 42 C.F.R. § 447.295 (2015). Medicaid DSH payments are available only for inpatient and outpatient hospital costs. Unreimbursed physician costs associated with inpatient or outpatient hospital services are not eligible costs under the Medicare DSH program. See 79 Fed. Reg. 71679, 71687 (Dec. 3, 2014).

³⁹42 U.S.C. § 1396r-4(j).

year 2014, the bulk of state UPL payments were made to hospitals for inpatient and outpatient services.

Medicare Payments That Help Offset Uncompensated Care Are Generally Based on the Number of Days Hospitals Spend Treating Medicaid and Low-Income Medicare Patients

CMS makes Medicare DSH and Medicare UC payments to hospitals based on their workload, expressed as the number of days a hospital spends treating Medicaid and low-income Medicare patients (referred to as Medicaid patient days and low-income Medicare patient days, respectively).⁴⁰ CMS also makes Medicare bad debt payments based on a certain percentage of the unpaid copayments and deductibles for Medicare beneficiaries. Specifically

- **Medicare DSH payments.** As required by statute, CMS determines Medicare DSH payments based on each hospital's disproportionate patient percentage, which is calculated as the sum of two ratios: (Medicare low-income patient days / total Medicare days) + (Medicaid days / total hospital days). Hospitals qualify for Medicare DSH payments if their disproportionate patient percentage is above 15 percent, but actual Medicare DSH payments vary based upon hospitals' characteristics, including their size and geographic location.⁴¹ The resulting payment amount is a percentage of the Medicare base payment calculated using a statutory formula that is then added to the base payment the hospital receives for each Medicare patient discharge. In fiscal year 2014, as required by PPACA, Medicare DSH payments were reduced to 25 percent of the amount that would have been paid under prior law. Overall, the number of Medicaid patient days was the largest factor in determining Medicare DSH payments in fiscal year 2014. Generally, the ratio that included Medicaid patient days accounted for about 70 percent of Medicare DSH payments in fiscal year 2014 while the ratio that

⁴⁰Low-income Medicare patients may also be eligible for Medicaid. For Medicare DSH purposes, their utilization is counted only once, as part of the Medicare low-income patient days ratio.

⁴¹The actual amount of a hospital's DSH payments is calculated as a percentage add-on to Medicare's base payment for the service. The percentage used to calculate the DSH add-on varies by hospital because it is determined by the hospital's exact proportion of low-income patient days, its location, and its size. For example, a large urban hospital with 100 or more beds and a disproportionate patient percentage (DPP) exceeding 20.2 percent receives a larger percentage add-on than a smaller urban hospital with a lower DPP. A small number of hospitals—10 in fiscal year 2014—qualify for a specific Medicare adjustment using an alternative method.

included low-income Medicare beneficiaries treated accounted for the remaining 30 percent.

- **Medicare UC payments.** PPACA directed CMS to base these payments on hospital uncompensated care costs, including the costs of treating uninsured patients.⁴² However, CMS has discretion to choose the methods and data sources it uses to calculate these costs, and CMS has to date used data related to Medicaid and Medicare workload as a proxy for uncompensated care costs. For fiscal years 2014, 2015, and 2016, Medicare UC payments made to individual hospitals are based on a hospital's days spent treating Medicaid patients and low-income Medicare beneficiaries rather than on a hospital's actual uncompensated care costs.⁴³ Specifically, an individual hospital's Medicare UC payment is based on the hospital's relative proportion of days spent treating Medicaid patients and low-income Medicare patients across all hospitals receiving UC payments nationally. Our analysis indicates that, under this formula, Medicaid patient days accounted for about 85 percent of Medicare UC payments, and low-income Medicare patient days accounted for the remaining 15 percent in fiscal year 2014.⁴⁴ In other words, we found that the amount of a hospital's Medicare UC payment is largely based on the hospital's Medicaid patient workload.
- **Medicare bad debt payments.** CMS pays hospitals a certain percentage of the actual unpaid copayments and deductibles that hospitals expected to receive, but were unable to collect, from Medicare beneficiaries. In general, hospitals must demonstrate that they have made reasonable attempts to collect the bad debt—that is,

⁴²See 42 U.S.C. § 1395ww(r)(2)(C).

⁴³CMS has also proposed basing fiscal year 2017 Medicare UC payments on a hospital's days spent treating Medicaid patients and low-income Medicare beneficiaries. See CMS, *Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates*, 81 Fed. Reg. 24946, 25087 (Apr. 27, 2016).

⁴⁴The proportion of Medicare UC payments that is based on Medicaid patients treated is different from the proportion of Medicare DSH payments that are also based on this factor because the methodologies for calculating payments are slightly different. Specifically, Medicare DSH is based on the sum of two ratios, and actual payments also vary based on the exact DPP, size and location. Medicare UC payments, on the other hand, are based on a hospital's relative proportion of total Medicaid and low-income beneficiary days and not the sum of two ratios.

the same type of efforts that they would make for non-Medicare patients.⁴⁵

Medicare UC Payments Are Not Well Aligned with Hospitals' Uncompensated Care Costs

Medicare UC payments are not well aligned with hospital uncompensated care costs for two key reasons. First, Medicare UC payments are distributed to hospitals based largely on Medicaid patients treated and not on hospitals' actual uncompensated care costs, which include the costs of treating uninsured patients. Second, CMS does not account for Medicaid payments made to hospitals that help offset uncompensated care costs, even though the bulk of Medicare UC payments are based on Medicaid patients treated.

Medicare UC Payments Are Not Well Aligned with Hospitals' Uncompensated Care Costs As CMS Does Not Base Payments on the Costs of Treating Uninsured Patients

Medicare UC payments are not aligned with hospitals' uncompensated care costs because CMS bases these payments mainly on hospitals' historical Medicaid patient days rather than actual costs hospitals incurred treating uninsured patients. A 2015 report by HHS's Office of the Assistant Secretary of Planning and Evaluation (ASPE) found that an increase in Medicaid coverage (which would result in a corresponding increase in Medicaid hospital patient days) was associated with a reduction in hospital uncompensated care costs.⁴⁶ Distributing UC payments on the basis of Medicaid patient days will likely result in larger shares of Medicare UC payments directed towards hospitals where

⁴⁵However, if a hospital, using its customary methods, can document that a Medicare patient is indigent, or medically indigent, the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts.

⁴⁶Specifically, ASPE estimated that hospital uncompensated care costs in 2014 were 26 percent lower as a result of Medicaid expansion, based on an analysis of 28 states and the District of Columbia that had expanded Medicaid under PPACA. See Office of the Assistant Secretary of Planning and Evaluation, *Insurance Expansion, Hospital Uncompensated Care and the Affordable Care Act* (Washington D.C.: March 23, 2015.) In addition, a report from the Robert Wood Johnson Foundation examining statewide data published by a number of hospital associations and hospital systems in Medicaid expansion states showed decreases in hospital uncompensated care costs ranging from about 18 percent to about 60 percent in nine states that had expanded their Medicaid programs. While the methods for measuring uncompensated care and the time periods varied across systems and states, hospital systems consistently reported higher declines in uncompensated care costs in Medicaid expansion states compared to other states. See Robert Wood Johnson Foundation, State Health Reform Assistance Network, *The Impact of Medicaid Expansion*.

uncompensated care costs have likely declined. This is because hospitals located in states that expanded their Medicaid programs have higher proportions of Medicaid patient days and would therefore receive a larger share of Medicare UC payments. At the same time, uncompensated care costs in these hospitals may be declining due to a reduction in the number of uninsured individuals in the state. Conversely, hospitals in states that have not expanded Medicaid will continue to have relatively higher levels of uninsured individuals and thus higher uncompensated care costs, but these hospitals will likely have fewer Medicaid patient days and will thus receive a smaller share of Medicare UC payments under CMS's current calculation.

CMS officials acknowledged that using Medicaid patient days as a basis for Medicare UC payments could result in hospitals located in Medicaid expansion states receiving disproportionately higher payments. Officials stated that the effect of using Medicaid patient days rather than actual uncompensated care costs was somewhat mitigated because CMS had, for purposes of fiscal year 2014 Medicare UC payments, used data from fiscal years 2010 or 2011 to estimate hospitals' proportions of Medicaid patient days—a time period before when most states expanded their Medicaid programs in response to PPACA. However, hospitals in states that had broader Medicaid eligibility requirements in 2010 or 2011 (and therefore higher numbers of Medicaid patient days) would receive higher payments than those in states with more restrictive requirements in those same years, despite potentially having to provide less uncompensated care. In addition, the hospitals in seven states that had expanded their Medicaid programs prior to 2014 may have also received higher Medicare UC payments through CMS's use of Medicaid patient days to calculate Medicare UC payments.⁴⁷ Directing a larger portion of the Medicare UC payments, which are intended to reimburse hospital uncompensated care costs, to hospitals where hospital uncompensated care is declining is not consistent with CMS's role as an efficient payer of health care services.

CMS has for several years considered options for defining and using hospital uncompensated care costs to make Medicare UC payments, but has not yet implemented plans to do so. In a May 2013 notice of

⁴⁷PPACA permitted states to expand their Medicaid programs by covering certain low-income adults not historically eligible for Medicaid coverage and beginning on January 1, 2014, provided states enhanced federal matching funds for costs incurred in covering this population.

proposed rulemaking, CMS stated that the definition of hospital uncompensated care costs for purposes of making Medicare UC payments could comprise charity care and bad debt costs (for both Medicare and non-Medicare patients), since these were commonly identified as sources of hospital uncompensated care by various stakeholders, including federal and state programs, and provider associations.⁴⁸ CMS also identified a potential data source for actual hospital uncompensated care costs—an uncompensated care worksheet in the Hospital Cost Report—that is the only national data source for charity care and bad debt costs.⁴⁹ CMS did not propose at the time to use this definition or the data in the uncompensated care worksheet because of concerns by certain stakeholders about the worksheet’s reliability.⁵⁰ In an April 2016 proposed rule, CMS proposed transitioning away from using Medicaid days as the basis for UC payments, and instead using hospital uncompensated care costs from the uncompensated worksheet.⁵¹ Under the proposed rule, Medicare UC payments made in

⁴⁸78 Fed. Reg. 27486, 27585 (May 10, 2013). Medicare bad debt for Medicare UC payment purposes represents a hospital’s Medicare bad debt costs not covered by Medicare bad debt payments. Medicare bad debt payments are limited to 65 percent of a hospital’s total allowable bad debt costs. Non-Medicare bad debt represents hospital costs that a patient is responsible for paying and has the financial capacity to pay, but is unwilling to pay.

⁴⁹The data source is called the S-10 Hospital Uncompensated and Indigent Care Data worksheet.

⁵⁰Multiple studies conducted by a CMS contractor and MedPAC in recent years show that concerns about completeness and reliability of the data in the uncompensated care worksheet should not prevent its use for determining uncompensated care costs. See Dobson DaVanzo & Associates, LLC, *Improvements to Medicare Disproportionate Share Hospital (DSH) Payments*, and *Improvements to Medicare Disproportionate Share Hospital (DSH) Payments, Benchmarking S-10 Data Using IRS Form 990 Data and Worksheet S-10 Trend Analyses* (Apr. 13, 2016); also see MedPAC’s June 2013 Letter to CMS commenting on the proposed rule entitled *Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates*, 78 Fed. Reg. 27582 (May 10, 2013); also see MedPAC’s June 2015 letter to CMS commenting on the proposed rule, *Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions to Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program*, 80 Fed. Reg. 24324 (Apr. 30, 2015).

⁵¹CMS, *Medicare Program: Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates*, 81 Fed. Reg. 25091, 25092 (Apr. 27, 2016).

fiscal year 2020 would be entirely based on hospital uncompensated care costs, which CMS proposes to define as charity care and non-Medicare bad debt.⁵² In its proposed rule, CMS requested public comments on its proposed definition of hospital uncompensated care costs and use of the uncompensated care worksheet to determine these costs, among other things.

In Determining Medicare UC Payments, CMS Does Not Consider Medicaid Payments That Offset Uncompensated Care Costs

Although the majority of Medicare UC payments to individual hospitals are based on Medicaid patient days, CMS does not adjust these payments to reflect payments hospitals receive from Medicaid. Hospitals could potentially receive significant amounts of payments that help offset uncompensated care costs from both the Medicare and Medicaid programs. A relatively large portion of the Medicare UC payments are determined in the Medicare UC formula by hospitals' Medicaid patient days; similarly, a large portion of the Medicaid payments that help offset hospital uncompensated care costs are distributed, in part, on the basis of payment limits determined by those hospitals' Medicaid workloads. We estimate, for example, that in fiscal year 2014 about \$7.7 billion of Medicare UC payments to hospitals were based on Medicaid patient days and about \$14.1 billion of Medicaid payments to hospitals were based on services provided to Medicaid patients.⁵³

CMS officials told us that Medicare and Medicaid are separate programs administered under different statutory and regulatory rules under which hospitals can qualify for, and receive, both Medicare UC payments and Medicaid payments that help offset hospital uncompensated care costs.

⁵²For payments made in fiscal years 2018 and 2019, CMS proposed blending Medicaid and Medicare low-income patient days with hospital uncompensated care costs to make the payments. Medicare UC payments made in fiscal year 2017 will be based on hospitals' days spent treating Medicaid patients and low-income Medicare patients.

⁵³The \$7.7 billion of Medicare UC payments was estimated by determining each hospital's percentage of total low-income days (Medicaid and SSI) that were based on Medicaid days, multiplying the hospital's total Medicare UC payments by that percentage, then summing the total Medicaid-based UC payments across all hospitals. Overall, 85 percent of hospitals' total Medicare UC payments was based on Medicaid days. The \$14.1 billion in Medicaid payments represents 25 percent of the Medicaid DSH payments attributed to services provided to Medicaid patients (\$4.5 billion) and all of the Medicaid UPL payments that are based on the volume of services provided to Medicaid patients (\$9.6 billion). We did not include section 1115 demonstration supplemental payments because we were unable to determine the extent that these payments were made for uncompensated care for Medicaid patients.

When determining hospital uncompensated care costs for purposes of Medicaid DSH payments, states are required to consider Medicare payments made on behalf of patients covered by both Medicare and Medicaid.⁵⁴ While the law does not require CMS to take into account Medicaid payments that offset uninsured costs when calculating Medicare UC payments, CMS officials confirmed they have authority to consider such payments but have not taken steps to do so.

Transitioning away from using Medicaid patient days and instead basing Medicare UC payments on data showing actual hospital uncompensated care costs, would result in a better alignment of Medicare UC payments with actual hospital uncompensated care costs. However, this change on its own would not be sufficient to account for the fact that hospitals eligible to receive UC payments may also be eligible for Medicaid DSH payments to offset these same costs. Although the Medicare and Medicaid programs define uncompensated care costs somewhat differently, a common and significant cost in their definitions is the uncompensated care costs for uninsured individuals.⁵⁵ As a result, in determining Medicare UC payments, it is important that CMS, in fulfilling its role as an efficient payer of health care services, take into account the Medicaid payments eligible hospitals have received for these costs to ensure that Medicare UC payments are most effectively aligned with hospitals' actual uncompensated care costs.

Conclusions

Hospital uncompensated care costs are a longstanding concern that have the potential to weaken some hospitals' financial stability and undermine their ability to provide care and serve their community. Recognizing the importance of financially stable hospitals, certain Medicare and Medicaid payments and federal tax laws were established to support hospitals providing uncompensated care. The amount of uncompensated care incurred by individual hospitals varies across the thousands of hospitals

⁵⁴Medicaid payments that offset uninsured patient costs include Medicaid DSH payments, Medicaid payments in excess of a hospital's Medicaid costs, and section 1115 demonstration supplemental payments for uninsured patient costs.

⁵⁵For Medicaid DSH payments, the unreimbursed cost of uninsured patients represents about, on average, 75 percent of total uncompensated care costs. For Medicare UC payment purposes, CMS has indicated that it plans to include hospital charity care—which largely represents hospital care to uninsured patients—when it defines hospital uncompensated care costs.

in our nation, including private for-profit, private nonprofit, and state and local government hospitals. The expansion of health insurance coverage as a result of PPACA has and will continue to alter the amount of uncompensated care incurred by hospitals. Hospitals in states and communities where the number of uninsured individuals has declined are likely to incur lower uncompensated care costs.

In view of the changing landscape of hospital uncompensated care, Congress reduced the amount of federal support to offset hospital uncompensated care costs and also required federal spending to be aligned with hospitals' uncompensated care costs. In particular, a large amount of existing federal funding was redirected to establish Medicare UC payments, which will decline as the number of uninsured individuals declines nationally. CMS was directed to distribute these payments on the basis of each hospital's uncompensated care costs. While CMS was given flexibility to identify appropriate data for determining such costs, the agency's use of Medicaid patient days as the basis for distributing Medicare UC payments to hospitals results in poor alignment of payments to hospital uncompensated care costs. Poor alignment results because relatively large shares of Medicare UC payment amounts will be distributed to hospitals where Medicaid expansion has lowered their uncompensated care costs. Particularly in view of the changing landscape of health care coverage, including some but not all states expanding Medicaid and the impact of such choices on hospital uncompensated care costs in different states, CMS has the responsibility to use the best data available to allocate payments based on hospitals' actual uncompensated costs of providing care. In an April 2016 proposed rule, the agency announced that it is considering using hospitals' actual uncompensated care costs as the sole basis for making Medicare UC payments by fiscal year 2020.

Additional steps will be needed to ensure that Medicare UC payments are aligned with hospital uncompensated care costs, including taking into account Medicaid payments that hospitals receive for treating the uninsured. Neither the current poor alignment of Medicare UC payments with hospital uncompensated care costs nor the lack of accounting for reductions in hospital uncompensated care costs for uninsured patients resulting from Medicaid payments are consistent with Medicare's role as a prudent payer of health care.

Recommendations for Executive Action

To ensure efficient use of federal resources, we recommend that the Administrator of CMS take the following two actions:

1. Improve alignment of Medicare UC payments with hospital uncompensated care costs by basing these payments on hospital uncompensated care costs; and
2. Account for Medicaid payments a hospital has received that offset uncompensated care costs when determining hospital uncompensated care costs for the purposes of making Medicare UC payments to individual hospitals.

Agency Comments and Our Evaluation

We provided a draft of this report to the Secretary of Health and Human Services and the Commissioner of the Internal Revenue Service. We received written comments from HHS, which are reprinted in appendix I. In addition, HHS and IRS provided technical comments that we incorporated as appropriate.

In its written comments, HHS concurred with both our recommendations. HHS concurred with our first recommendation to better align Medicare UC payments with hospitals' actual uncompensated care costs, noting the April 2016 proposed rule that outlines a proposal to do so. HHS stated it would consider all stakeholder comments before issuing a final rule later this year. HHS also concurred with our second recommendation to account for hospitals' Medicaid payments that offset uncompensated care costs when determining these costs for purposes of making Medicare UC payments. HHS agreed that it is important to align uncompensated care payments with actual uncompensated care costs and that doing so would help ensure that HHS is directing the payments to hospitals appropriately. HHS stated that the Department would continue to review the definition of uncompensated care as appropriate, particularly in the event it finalizes the proposal to begin using uncompensated care cost data to determine the distribution of these payments. Taking steps to better align these payments is important to improving the distribution of significant amounts of federal funds for hospital uncompensated care.

As agreed with your offices, unless you publicly announce the contents of the report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff that made key contributions to this report is listed in appendix II.

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive style with a large, prominent initial "K".

Katherine M. Iritani
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUN 03 2016

Ms. Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *HOSPITAL UNCOMPENSATED CARE: Federal Action Needed to Better Align Payments with Costs* (GAO-16-568).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HOSPITAL UNCOMPENSATED CARE: FEDERAL ACTION NEEDED TO BETTER ALIGN PAYMENTS WITH COSTS (JOB CODE 291251/GAO-16-568).

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this report. HHS is committed to using reliable and complete data for payment purposes to act as an efficient payer of health care services.

Some people receiving hospital services do not have health insurance coverage through public programs or private insurance; as a result, hospitals may provide care to these uninsured individuals for which the hospital may not receive compensation. With the passage of the Affordable Care Act (ACA), the number of people with health insurance has increased through expansion of Medicaid and Health Insurance Exchanges. Consistent with the increasing number of people with health insurance, the ACA made changes to the Medicare disproportionate share (DSH) program to make a portion of these payments explicitly as DSH and the remainder as an additional payment distributed on the basis of each hospital's share of national uncompensated care costs. Beginning in Fiscal Year (FY) 2014, Medicare DSH payments were reduced to 25 percent of the amount that would have been paid under prior law. The ACA also required that the remaining 75 percent, be adjusted downward based on increases in the percent of uninsured individuals. Each hospital eligible for Medicare DSH payments receives a payment based on its share of the total amount of aggregate uncompensated care costs reported. However, as the General Accountability Office (GAO) notes, HHS has discretion to choose the methods and data sources used to calculate these costs. As such, HHS has been using insured low-income days (the sum of Medicaid days and Medicare Supplemental Security Income (SSI) days) as a proxy for uncompensated care costs.

To better align payments with actual uncompensated care costs, in the FY 2017 Hospital Inpatient Prospective Payment Systems (IPPS) proposed rule¹, HHS proposed to transition to a new data source to allocate the statutory amount of uncompensated care payments. HHS has proposed that, starting in FY 2018, it will begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report into the methodology for distributing these payments. Specifically, HHS proposes to define uncompensated care costs as the costs of charity care and non-Medicare bad debt and to incorporate Worksheet S-10 data over a three-year period. Beginning in FY 2018, HHS has proposed to use Worksheet S-10 data from FY 2014 cost reports in combination with insured low income days from the two preceding cost reporting periods to determine the distribution of these payments. These changes, if finalized, will help to better align Medicare payments to each hospital based on its share of national aggregate uncompensated care costs. The comment period for the proposal ends June 17, 2016, and we will carefully consider all comments before developing a final policy in the IPPS final rule.

HHS continues to evaluate and improve upon the Medicare and Medicaid programs that make supplemental payments to hospitals in accordance with statutory requirements.

¹ <https://www.gpo.gov/fdsys/pkg/FR-2016-04-27/pdf/2016-09120.pdf>

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HOSPITAL UNCOMPENSATED CARE: FEDERAL ACTION NEEDED TO BETTER ALIGN PAYMENTS WITH COSTS (JOB CODE 291251/GAO-16-568).

GAO Recommendation#1:

The GAO recommends that HHS improve alignment of Medicare UC payments with hospital uncompensated care costs by basing these payments on hospital uncompensated care costs.

HHS Response

HHS concurs with GAO's recommendation. To better align payments with actual uncompensated care costs, in the FY 2017 IPPS proposed rule, HHS proposed to transition to a new data source to determine hospitals' uncompensated care costs. HHS has proposed that, starting in FY 2018, it will begin incorporating uncompensated care cost data from Worksheet S-10 of the Medicare cost report into the methodology to distribute these payments. Specifically, HHS proposes to define uncompensated care costs as the costs of charity care and non-Medicare bad debt and to incorporate Worksheet S-10 data over a three-year period. Beginning in FY 2018, HHS has proposed to use Worksheet S-10 data from FY 2014 cost reports in combination with insured low income days from the two preceding cost reporting periods to determine the distribution of Medicare payments to each hospital based on its share of national uncompensated care costs. The comment period for the proposal ends June 17, 2016, and we will carefully consider all the comments before establishing a final policy in the IPPS final rule.

GAO Recommendation#2:

GAO recommends that HHS account for Medicaid payments a hospital has received that offset uncompensated care costs when determining hospital uncompensated care costs for the purposes of making Medicare UC payments to individual hospitals.

HHS Response

HHS concurs with GAO's recommendation. We agree that aligning uncompensated care payments to actual uncompensated care costs is important and helps make sure that HHS is directing these payments to hospitals appropriately. Medicare's and Medicaid's payments have different statutory requirements. Definitions of uncompensated care vary across programs, and as a result, do not represent specific uncompensated care costs of individual hospitals, making it difficult for Medicare to offset Medicaid payments that are made to the hospital but not designated for specific patients as payment for uncompensated care costs when determining how to distribute these payments. In the event HHS finalizes its proposal to begin using uncompensated care cost data from the Medicare cost report to determine the distribution of these Medicare payments, we intend to continue to review the definition of uncompensated care as appropriate, including evaluating how to identify different payment streams intended to compensate hospitals for providing uncompensated care and the degree to which to incorporate these into the definition.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine Iritani, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tim Bushfield, Assistant Director; Leonard Brown; Christine Davis; Iola D'Souza; Carolyn Fitzgerald, Sandra George; Peter Mann-King; and Laurie Pachter made key contributions to this report.

Related GAO Products

Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments. [GAO-16-108](#). Washington D.C.: February 5, 2016.

Medicaid: Improving Transparency and Accountability of Supplemental Payments and State Financing Methods. [GAO-16-195T](#). Washington D.C.: November 3, 2015.

Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds. [GAO-16-53](#). Washington D.C.: October 16, 2015.

Medicaid: Key Issues Facing the Program. [GAO-15-667](#). Washington, D.C.: July 30, 2015

Medicare: Legislative Modifications Have Resulted in Payment Adjustments for Most Hospitals. [GAO-13-334](#). Washington, D.C.: April 17, 2013.

High-Risk Series: An Update. [GAO-13-283](#). Washington, D.C.: February 2013.

Medicaid: States Reported Billions More in Supplemental Payments in Recent Years. [GAO-12-694](#). Washington, D.C.: July 20, 2012.

High-Risk Series: An Update. [GAO-11-278](#). Washington, D.C.: February 2011.

Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted. [GAO-10-69](#). Washington, D.C.: November 20, 2009.

Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements. [GAO-08-880](#). Washington, D.C.: September 12, 2008.

Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. [GAO-08-614](#). Washington, D.C.: May 30, 2008.

Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight. [GAO-05-836T](#). Washington, D.C.: June 28, 2005.

Related GAO Products

Nonprofit, For-Profit and Government Hospitals: Uncompensated Care and Other Community Benefits. [GAO-05-743T](#). Washington, D.C.: May 26, 2005.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [E-mail Updates](#).
Listen to our [Podcasts](#) and read [The Watchblog](#).
Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548



Please Print on Recycled Paper.