Methodology: Analysis of Low-Income Patient Loads and Uncompensated Care and Unreimbursed Costs Provided by 340B DSH Hospitals

The analysis used data from the 2012 Medicare Hospital Cost Report for short-term acute care hospitals in the U.S., which were identified as hospitals that were reported in the most recent Medicare Inpatient Prospective Payment System (IPPS) Impact file (FY2014). This method provided information on 3,298 acute care hospitals and excludes Critical Access Hospitals (CAHs).

Identifying 340B DSH Hospitals – Disproportionate share (DSH) hospitals participating in the 340B program were identified using the HRSA Office of Pharmacy Affairs (OPA) Covered Entity Daily Report as of 5/20/2014 which contains hospitals that participated in the program at some time during federal fiscal year 2012 (Oct. 1, 2011 – Sep 30, 2012). This method identified 1,099 participating hospitals. DSH hospitals refers to one of the categories of hospitals permitted to participate in the 340B program. To qualify, these hospitals must have a DSH adjustment percentage greater than 11.75%, as determined under Medicare law. This requirement can only be met by demonstrating that a hospital has a high level of Medicaid and/or low-income Medicare patients.

Removing Statistical Outliers - The analysis focused on hospital uncompensated care and unreimbursed costs in total and as a percent of total patient care costs as well as case load of low-income patients. Therefore, hospitals with extreme values or statistical outliers on uncompensated care and unreimbursed costs were excluded from the analysis. Removing statistical outliers is consistent with standard practice and results in a more accurate estimation of the variables of interest.

First, hospitals with a total patient care cost per bed\(^1\) value that was above or below two standard deviations from the log of the mean value were excluded from the analysis. Costs reported in Worksheet A of the Medicare Cost Report were used for this analysis because these costs form the basis for Medicare cost finding, which is the primary purpose of the Medicare Cost Reports. Worksheet A provides for recording the trial balance of expense accounts from hospital’s accounting records and also provides for the necessary reclassifications and adjustments to certain accounts. (Only patient-related costs are pertinent to this analysis.)

Second, hospitals not reporting total uncompensated care or unreimbursed costs\(^2\) were excluded. Finally, hospitals with implausible Worksheet S-10 data were excluded.\(^3\) A total of 295 acute care hospitals, including 51 hospitals participating in 340B program, were removed due to extreme values.

From this dataset, we included only 340B participating hospitals that were categorized as disproportionate share hospitals (DSH) in the OPA database, which resulted in 939 hospitals being included in our final analysis file. This final process eliminated 109 hospitals that were categorized as RRC or SCH covered entity types in the OPA database.

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1 Total patient care costs were defined from Medicare cost report (Wkst A, line 118, col 7). Patient care costs exclude costs for Medicare non-reimbursable cost centers (i.e., gift shop, research, physician private offices and non-paid workers) from hospital operating costs since these are not related to patient care. Number of beds was defined as total facility beds (Wkst S-3, line 27, col 2).

2 Total uncompensated care or unreimbursed costs were obtained from (Wkst S-10, line 31).

3 Hospitals with total costs reported on Wkst S-10 (lines 7, 11, 15, 21 and 29) plus Medicare costs greater than total hospital costs (Wkst C, Part I, line 202, col 3) were excluded.
Identifying Non-340B DSH Hospitals – Comparison Group – To be consistent, for hospitals not participating in the 340B program, we excluded hospitals with a RRC or SCH provider type from the Medicare IPPS Impact file and also excluded for-profit hospitals since they are ineligible for the 340B program. This process resulted in a total of 1,027 non-participating hospitals in the comparison group. We then examined the excluded RRCs and SCHs and found 16 hospitals for which the DSH adjustment percentage was over 11.75 percent. These hospitals were added back to the file making a total of 1,043 hospitals in the comparison group (non-340B).

Performing the Analysis - For the analysis, we obtained charity care costs, public program payment shortfalls, and bad debt costs for each 340B and non-340B hospital. We also examined total uncompensated care and unreimbursed costs.

In addition, 340B participating hospitals were categorized into quartiles (four groups of about 236 hospitals each) based on their patient care costs (largest to smallest). Average patient care costs, charity care costs, public program payment shortfalls, and bad debt costs per facility were computed for each quartile group. We then examined average charity care costs, public program payment shortfalls, and bad debt costs as a percent of average facility patient care costs within quartile. The combination of charity care costs, bad debt costs and public payer shortfalls provides a more complete measure of uncompensated care and unreimbursed costs. The American Hospital Association’s (AHA) standard definition of uncompensated care combines the hospital’s bad debt and charity care costs. In terms of accounting, bad debt consists of services for which hospitals anticipated but did not receive payment. Charity care consists of services for which hospitals neither received, nor expected to receive, payment because they had determined the patient’s inability to pay. In practice, however, hospitals often have difficulty in distinguishing bad debt from charity care. This difficulty is due to a number of factors, including the length of time that it takes for a patient to self-identify as medically indigent or underinsured. Patients who generate bad debt can be both medically indigent and/or uninsured, leading to the difficulty in distinguishing between bad debt and charity care. Thus, AHA combines the two.

The analysis also includes public payer shortfalls, which are payments by Medicaid, CHIP and other state and local government indigent care programs that pay less than the hospital’s cost to treat these patients. Although hospitals receive some reimbursement for these patients, this care represents a loss that hospitals incur in treating low-income patients. It is important to include all forms of uncompensated care provided by hospitals in order to understand the complete picture of the financial pressures on hospitals from all forms of the unreimbursed care they provide.

The analysis also examines Medicaid caseload and caseload of low-income patients who qualify for both the Medicare and Supplemental Security Income (SSI) programs of 340B and non-340B hospitals. We analyzed Medicaid inpatient days as a percent of total inpatient days as well as SSI days as a percent of Medicare days and compared the two hospital groups. The sum of these two ratios represents a

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4 Charity care and bad debt costs were obtained from Medicare Cost Reports (Wkst S-10, lines 23 and 29), public payer shortfalls were obtained from (Wkst S-10, lines 8, 12 and 16).

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6 American Hospital Association: “Uncompensated Care Fact Sheet”, January 2014

7 Medicaid inpatient days as a percent of total inpatient days were obtained from Medicare Cost Reports and reported as a weighted average across hospitals in each quartile. Total inpatient days are reported on Wkst S-3, Part I, column 8, line 14 plus line 32, minus the sum of lines 5 and 6, plus employee discount days reported on line 30. Medicaid inpatient ratio was reported on Wkst E, Part A, line 31. SSI Days as a percent of Medicare Days were obtained from Medicare Cost Reports and reported as a
hospital’s Disproportionate Patient Percentage that is used to determine Medicare Disproportionate Share Hospital (DSH) payments to hospitals as well as eligibility for the 340B program.

Issues with the Medicare Cost Report Form S-10 - This analysis relies on data from Medicare Cost Report Worksheet S-10. The S-10 is the only data on hospital uncompensated care that is publicly-available for all 340B DSH hospitals. Other studies regarding 340B DSH hospitals have also relied on this data. However, the S-10 form has been criticized as being problematic as a data source for determining the components of DSH. In the public comments to the 2014 Notice of Proposed Rulemaking (NPRM), many commenters voiced concern about the instructions leading to inaccuracies, or being misleading. Although our analysis excludes hospitals with unreasonable values reported in the S-10, the following comments were made in the 2014 NPRM demonstrating the impact of the problematic aspects of the S-10.

- On line 20, hospitals are instructed to record gross charges for charity care for the entire facility. These charges are then adjusted to costs by applying the hospitals RCC. However, to the extent that non-hospital charges (e.g., SNF charges) are included on line 20, charity care costs will be reported inaccurately as mark-ups on acute care hospital services differ from other services included on the entire cost report.

- Charity care reported on line 20 includes coinsurance and deductible amounts for insured patients written off pursuant to a hospital’s charity care policy. The hospitals RCC is then applied to this amount to estimate costs. However, this is misleading as copayment amounts are not similar to gross charges. Therefore, applying the RCC to this amount will greatly understate charity care costs associated with forgiven co-payments.

- On line 22, hospitals are instructed to include payments “expected.” There are no instructions as to how these estimates should be made. It may be better to focus solely on the cash received in partial payments from patients, and eliminate estimations of “expected” payments for this line.

- Line 20 includes gross charges for Medicaid and other indigent care program patients for "days exceeding a length of stay limit" which are subject to the hospital’s charity care policy. Line 25 requires additional information on these patients, specifically the specific charges relating to the date of services exceeding the length of stay covered. The only way to find this information is to review individual hospital bills, which is burdensome. It would be less burdensome to include shortfall amounts as part of the shortfalls in payment below cost incurred for public programs that are reported on the top half of the form.

- Presumptive charity care should be included in the charity care definition on the S-10. Publically available data can be used to determine a patient’s likelihood for qualifying for charity care under the provider’s policy based on a historical analysis of the provider’s documented charity approvals. The ability of hospitals to use presumptive charity care enables hospitals to realize cost reductions and efficiencies in relation to uncooperative patients and allows for consistency in reporting community benefits.

- Worksheet S-10 lines 20 – 23 column 2 are for charity care awarded to insured patients, for their patient responsibility amount (coinsurance and deductible). There is inconsistency due to confusion in the instructions for this form. The lead paragraph for these lines indicates amounts to be reported at gross charges, then second and third paragraphs specify uninsured weighted average across hospitals in each quartile. Medicare days were reported on Wkst S-3, Part I, column 6, line 14 plus line 2. SSI ratio was reported on Wkst E, Part A, line 30.
patients in column 1 and insured patients in column 2. Some Providers are including gross charges in column 2 for insured patients, where we believe CMS intended column 2 to be populated with the patient responsibility amount, to which charity care was awarded, not gross charges.

• The recent IRS proposed rule related to §501(r) requires tax-exempt Providers to offer uninsured patients who qualify under the financial assistance policy (FAP) a discount from gross charges. This is enforced through reporting on the 990. For the patients awarded charity care after discharge, therefore after uninsured discount has already been applied, would they be reported on S-10 under uninsured (column 1) at their gross charges or at their net patient responsibility after the uninsured discount, or should the uninsured discount be reversed upon award of charity? We believe the uninsured patient receiving the §501(r) mandated discount should still be reported at gross charges on S-10.