Texas Hospital Association

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Via electronic submission to pfd_hospitals@hhsc.state.tx.us

Texas Hospital Association Comments on Article IX Draft Report

Dear Mr. Wood:

On behalf of 460 member hospitals including acute care, rural, children's and teaching, the Texas Hospital Association (THA) appreciates the opportunity to comment as a contributor to the Article IX Charity Care Report developed by Myers and Stauffer, LC for the Texas Health and Human Services Commission (HHSC), pursuant to Article IX, Sec. 17.34 of the General Appropriations Act, 88th Texas Legislature.

Summary

Texas hospitals are delivering extraordinary benefits to their communities. This report provides ample evidence that Texas hospitals are going above and beyond to deliver extraordinary benefits to their communities, adding to other publicly available evidence illustrating the same conclusions. Billions of dollars in charity care and other community benefits are clearly documented across hundreds of hospital-specific profiles. Tax-exempt hospitals are providing benefits exceeding the value of their tax exemptions many times over, doing exactly what federal and state law require to demonstrate fulfillment of their charitable missions and reinvest in the communities they serve. Communities across Texas – rich, poor and everywhere in between – are benefiting from the free and discounted care hospitals deliver 24/7 to anyone who needs it, regardless of the patient's ability to pay. Further, the data reinforces that hospitals are underpaid in the safety net health care system, documenting billions in unreimbursed government-sponsored indigent care.

Report data are missing context. Any effort to describe the finances of an industry as large and varied as Texas hospitals requires context around the data. In this report, data is ample but context is missing. Myers and Stauffer chose to report on fiscal years (FYs) 2021 and 2022, two pandemic-affected years that were financially and operationally irregular. THA's comments intend to supply needed context around the financial experience of hospitals who delivered care to low-income patients during the COVID-19 pandemic. The remainder of our letter aims to guide the appropriate use of data in this report, and avoid its misuse. ***We encourage all policymakers to reference THA's comments to support appropriate uses of the data in this report.*** Relevant context issues are described in the Financial Context section of this letter.

This report has multiple limitations and methodological flaws. Regardless of what the report data conveys, the process used to generate the report is not one we would endorse or suggest repeating. To produce the required analyses, Myers and Stauffer hybridized many public sources of hospital data, each with different purposes, availabilities, definitions,

instructions for reporting, bases of accounting and audit standards. Each data source has strengths and limitations for this project. These differences, strengths and limitations are not thoroughly discussed in the report. Certain data elements required by the Article IX rider had no known standardized data source. In some such cases, Myers and Stauffer imputed novel values. In others, they requested non-publicly available data from hospitals with short response windows, few instructions, and minimal controls to promote uniformity. Ultimately, these inconsistent and non-standardized methods govern whether the final product can be deemed useful, and THA holds deep reservations about the methods used here.

Hospitals have identified specific errors and omissions in their data. In several cases, Myers and Stauffer's methods generated fact errors and omissions. We are concerned these could lead to improper conclusions about the financial position of certain hospitals or segments of the industry. We explain in the Disputed Methods and Calculations section errors and omissions that appear to have been common to all hospitals or classes of hospital. We are grateful HHSC has given contributors the opportunity to review their data and comment on errors and omissions that pertain to individual facilities. However, the burden should not fall on readers to piece together corrections from comments appended to an erroneous report. Rather, we call on HHSC to direct Myers and Stauffer to revise the report itself to correct these errors and omissions before it is delivered to the Legislature.

Financial Context

Context Issue 1. Data years

FYs 2021 and 2022 were financially irregular due to the COVID-19 pandemic and resulting public health emergency. Hospital revenues, costs and payer mixes were uncharacteristic of normal operations. Relying exclusively on COVID-19-affected data could lead to misleading portrayals of hospital finances and uncompensated care amounts.

In January 2021, the state of Texas also received a 10-year extension of the state's Medicaid 1115 waiver, which set into motion a major transition of Medicaid supplemental payments.

FYs 2021 and 2022 charity care and financial data were influenced by:

- Medicaid continuous coverage, leading to statewide Medicaid caseload growth of over 2 million between September 2020 and August 2022.[1] Of these, a large portion might have otherwise been uninsured and charity care-eligible.
- Patient avoidance or delay of non-emergency procedures. Hospitals treated higher-acuity patients during this time and delivered higher-cost care.[2]
- Abnormally high contract labor costs.[3]
- Receipt of one-time federal and state relief payments, including reimbursement specific to COVID-19 testing, treatment and vaccination of uninsured patients.[4]
- Discontinuation of Texas' longstanding Delivery System Reform Incentive Payment (DSRIP) program in FY 2021 and replacement with directed payment programs in FY 2022. This led to a major redistribution in Medicaid and uninsured supplemental payments by hospital class between FY 2021 and FY 2022.[5]

[1] End of Continuous Coverage (Texas HHSC, July 2022) and End of Continuous Medicaid Coverage Dashboard (Texas HHSC, Feb. 2024)
[2] Pandemic-Driven Deferred Care Has Led to Increased Patient Acuity in America's Hospitals. (AHA, Aug. 2022)
[3] Hospital Vitals: Financial and Operational Trends (Syntellis, Feb. 2023)
[4] COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured. (HRSA, 2024)
[5] Funding Impacts of the DSRIP Transition. (Texas HHSC, Oct. 2022)

Any use of Article IX report data should caveat the pandemic-related financial effects of FYs 2021 and 2022. It should establish that costs and payments related to Medicaid and uninsured care during these years are not typical for Texas hospitals, and treat data from these two years as point-in-time snapshots.

Context Issue 2. Data sources

Multiple sources of hospital and health system financial data exist. Each have different purposes, definitions, instructions for hospital reporting, basis of accounting, completeness, public accessibility, and audit standards. Each data source has strengths and limitations for this project. Certain data elements in this report had no known standardized source of data and were either imputed using novel methods or relied on hospital self-report.

For more information, reference Kaiser Family Foundation's Strengths and Weaknesses of Existing Hospital and Health System Financial Data.

Any use of the Myers and Stauffer report data should clearly identify the source of financial data used, including the definitions of measures, and identify whether the data does or does not come from a standardized, publicly available source.

Context Issue 3. Variation arising from hospital charity care policies and payer mixes

Each hospital's approach to recognizing charity care is different. Hospitals establish their own charity care and financial assistance policies according to their mission, ability to levy tax, financial condition, patient social and economic status, array of specialized services and charitable duties under law. All hospitals will also have processes to differentiate charity care from other unpaid dollar amounts including courtesy discounts and bad debt.

Charity care charges, costs, and payments vary according to underlying variation in charity care policies. Patient accounts classified as charity care in one hospital could be recorded as bad debt expense in another hospital. Patients eligible for free or discounted care in one hospital would not be expected to be eligible in all hospitals. Hospitals serving communities with comparable social and economic profiles may deliver different amounts of charity care, and systems comprised of multiple hospitals may also report an overall valuation of charity care that is not uniformly distributed between component facilities.

The insurance status of a hospital's patient population is the prevailing factor governing eligibility for charity care. Hospitals serving more insured patients will have a more limited pool of patients potentially eligible for charity care.

- Children's hospitals are one example, because the uninsured rate of children in Texas is lower than adults and eligibility for public programs is more generous. The community benefits delivered by pediatric hospitals are largely weighted toward government-sponsored indigent care shortfalls (i.e., the Medicaid shortfall) relative to charity care. This context is necessary when comparing the Article IX report's representation of charity care volumes at children's hospitals to adult hospitals.
- Similarly, rural hospitals in areas with large populations of older low-income residents (i.e., who are dually covered by Medicare and Medicaid) may see fewer uninsured patients that would qualify under the hospitals' charity care policies. This context is necessary when comparing the Article IX report's representation of charity care volumes at rural hospitals to non-rural hospitals.

A hospital's charity care policy may also state whether charity discounts only apply to uninsured patients, or if charity discounts apply to insured self-pay amounts (like deductibles or copays) or insured non-covered charges if other financial assistance criteria are met.

Any use of Article IX report uncompensated care data should recognize that variation in charity care and bad debt amounts derive from normal and expected variation in charity care policies and payer mixes. To the extent Myers and Stauffer's data conveys such variance, it should be considered a normal output intrinsic to charity care delivery and recordkeeping.

Context Issue 4. Payment incentives related to charity care

In Texas, the high uninsured rate and restrictive eligibility criteria for Medicaid and other public programs mean that many uninsured or underinsured patients will qualify for and receive free or discounted care under hospital charity care policies.

Any hospital receiving supplemental reimbursement from the state's Medicaid 1115 waiver uncompensated care (UC) pool must maintain a financial assistance policy adhering to the charity care principles of the Healthcare Financial Management Association (HFMA).[6] This includes investor-owned hospitals not required by law to maintain a charity care policy. Texas hospitals must be able to identify charity-eligible patient accounts for UC pool payment. Texas Medicaid computes the 1115 waiver UC pool payment based only on uninsured charity care cost; bad debt cannot be claimed for UC pool reimbursement. Non-duplicated uninsured charity care costs can also be reimbursed through Texas' Medicaid disproportionate share hospital (DSH) payment formula.

There is little incentive to forego charity discounts to patients in financial hardship. When a patient owes a balance they cannot pay, hospitals either incur expenses related to pursuit of the debt or bear the full cost of an uncollectible debt. Conversely, a hospital incurs no collection costs on the discounted portion of a charity care patient's bill.

Therefore, Texas hospitals *with and without* explicitly charitable missions are incentivized to set charity care policies that allow patients who demonstrate financial hardship to qualify, correctly identify those patients, ensure patients receive the full discount available under the policy, and record charity costs comprehensively.

Any use of Article IX report charity care data should acknowledge that the payment environment in Texas supports charity care delivery from all hospital types (governmental, investor-owned, nonprofit). Proper recording of charity care limits the cost of collection activities, reduces bad debt and increases available reimbursement remedies under Medicaid. For nonprofits, these benefits also encompass tax exemptions maintained by delivering legally required charity care.

Context Issue 5. Exclusion of non-allowable costs from Medicare cost reports

Medicare's exclusion of non-reimbursable (non-allowable) costs underestimates hospitals' true costs on Medicare cost reports, including Medicaid, charity and uncompensated care costs. These include physician professional fees and overhead related to non-reimbursable cost centers, such as administrative & general expenses, capital costs and employee benefits.

In the case of public hospital districts, non-allowable costs incurred may include jail care, mental health, public health, patient transportation and indigent care provided in other settings but paid by the hospital district. These are non-hospital patient care expenses disallowed by Medicare but incurred to fulfill the hospital districts' constitutional indigent care obligation.

[6] HFMA Principles & Practices Board Statement 15. (HFMA, 2019).

CMS excludes Medicare-disallowed costs for reimbursement but this does not mean those costs are insignificant to hospitals or that they should be discounted. The magnitude of cost underreporting in each non-reimbursable cost center can vary at the individual hospital level. For more information, see THA's Worksheet S-10 Reference Guide for Texas Hospitals.

Any use of Article IX report data should acknowledge costs derived from hospitals' Medicare cost report exclude non-allowable costs, which are real and significant to the safe delivery of care. The magnitude of cost underreporting for each non-reimbursable cost center can vary between hospitals.

Context Issue 6. Establishment of eligibility for charity care

It is unclear how the Article IX rider or Myers and Stauffer report define a "rejected charity care application." This imprecise term is not standard in the hospital industry to characterize patient accounts not receiving financial assistance. It resulted in confusion and inconsistency in responding to Myers and Stauffer's data requests. Such circumstances are better described as: *patient accounts evaluated for financial assistance but whose eligibility under the hospital's charity care policy could not be established.*

A hospital has discretion over which data it will use to support an eligibility determination for charity care. Such data may include but are not limited to: individual or family income, net worth, employment status, credit scores, amount and frequency of health care bills, and eligibility for public assistance. A hospital may determine that charity-eligible patients can qualify according to whether they are financially indigent, medically indigent or both. Hospitals also vary in the sophistication of administrative tasks they can support in validating eligibility for charity care. Data may be self-reported by the patient or patient's representative, or queried from external sources. Some hospitals use a presumptive process for certain eligibility categories.

Hospitals may require a patient to demonstrate charity eligibility at time of service, or – recognizing patients' circumstances and ability to pay may change – allow a patient to demonstrate eligibility during a defined time frame tied to the time of service. Timing of an eligibility determination depends on these factors. Some charity care policies allow for the possibility that a patient's eligibility can change.

In all cases, discrete and measurable criteria are used to determine charity care eligibility. The hospital's charity care policy transparently describes which criteria are used.

The following examples are a non-exhaustive list of reasons a patient account could be evaluated for financial assistance and not receive it[7]:

- Patient income is verified to be too high to qualify for the hospital's charity care policy.
- Patient seeks financial assistance but is found to be eligible for another public program.
- Information supplied by the patient and/or queried from external sources is insufficient to evaluate eligibility. Ability to pay cannot be reliably determined.
- Preliminary information relied upon at time of service is later found to be in error. The determination of eligibility is modified.
- Patient eligibility for financial assistance is evaluated at time of service and not established. The patient later experiences a change in financial circumstances within the time frame allowed by the charity care policy. The patient's new circumstances are not known to the hospital.

[7] Hospital charity care policies may differ in addressing eligibility for charity care when there is insufficient information, when information relied upon is found to be in error, or how determinations are modified based on changes over time in patients' ability to pay.

Any use of Article IX report data should make clear that "rejected charity care applications" are not a reliable or standard recordkeeping category. To the extent hospitals' profiles feature this data, the profiles should not be compared.

Any use of Article IX report data should acknowledge wide variation in methods used to evaluate patient eligibility for charity care discounts, and varied circumstances that can affect a determination. Hospitals' individual charity care policies offer transparency in the methods a hospital will use. Patients' eligibility for charity care may not be established for numerous reasons.

Disputed Methods and Calculations

In this section, we document Article IX report errors and omissions that appear to have been common to all hospitals or classes of hospitals. In general, the report's sparse methodology descriptions made it challenging for hospitals to verify and reproduce Myers and Stauffer's results. In some instances, hospitals were unable to validate their data. Others noted that the figures presented in the report do not match information submitted to Myers and Stauffer by the hospital in the provider survey.

Operating expense-to-revenue ratio

Myers and Stauffer's operating expense, revenues and operating expense-to-revenue ratios omit material costs and do not match operating expenses to revenues in accordance with Generally Accepted Accounting Principles (GAAP). This is partially attributable to use of Medicare Cost Report Worksheet G-3 revenues, whose instructions have not been updated to match GAAP. Worksheet G-3 data used in this manner will fail to correctly match expenses and revenues, and leads us to recommend against use of the operating expense-to-revenue ratios in this report. Specifically:

- The cost side of the calculation used allowable costs and excluded non-reimbursable expenses.
- Physician costs are excluded, but physician revenues are counted.
- Non-operating revenues are included.
- For one public hospital that operates a Medicaid managed care organization (MCO), MCO costs are excluded but revenues included.

The methods used to tabulate operating expenses and revenues in this report are particularly misleading for governmental hospitals. On the cost side, public hospital districts bear a constitutional indigent care obligation for their entire jurisdiction (usually, a county). For this reason, they incur costs that are not related directly to hospital patient care. Excluding these costs materially understates the cost side of the calculation. On the revenue side, the full balance of public hospitals' property tax revenues appears to have been included. It is not correct to represent hospitals' property tax revenues as a full offset for hospital expenses. These revenues are used for other obligations like maintenance and operations of hospital districts, debt service or non-hospital community investments. As a result, the operating expense-to-revenue ratio of governmental hospitals overstates their financial position.

Financing of hospital supplemental funding

In Texas, Medicaid supplemental payments are self-financed by hospitals. About 40% of the gross payment amount is comprised of hospitals' own money. Public hospitals finance the nonfederal share of Medicaid supplemental payments with intergovernmental transfers (IGTs) while private hospitals fund the nonfederal share with local assessments. Public hospital IGT is not recorded as an expense on the cost report, while private hospital assessments are recorded as an expense in the cost report offset by related revenue. Medicare cost report Worksheet S-10 instructions do state that

supplemental revenue should be recorded net of expense, but that instruction does not apply to the allowable expense lines used in Myers and Stauffer's calculations. Furthermore, hospital methods for recording provider assessment expense on the cost report are varied and there can be no assumption of uniformity between providers.

Public hospital supplemental payments were recorded as gross payments, which include the IGTs used to finance them. This overstates the supplemental revenue public hospitals appear to have received relative to their private counterparts and means public and private hospitals' supplemental payment amounts should not be compared. The distortion is especially pronounced for the five large public hospital districts who fund Medicaid DSH, a $2 billion program that relies on these five public hospitals alone to supply nearly all the nonfederal share.

For private hospitals, Myers and Stauffer appears to have included local assessments as a general expense with no netting from supplemental amounts. Since local assessment expense is offset on the cost report to determine allowable expense, this counts only supplemental revenue and not the expense. The Percentage of Operating Cost and Unreimbursed Cost of Health Services data items on each profile, therefore, fail to match revenue against expenses. Myers and Stauffer ought to have explained these differences in accounting standards and reporting practices.

Unreimbursed cost of health services

In each hospital profile, Myers and Stauffer provides the unreimbursed cost of health services. The report does not describe how this figure was derived.

After working to reproduce the calculation, it appears that for each of FY 2021 and FY 2022, Myers and Stauffer subtracted net patient revenue on Medicare Cost Report Worksheet G-3, Line 3, Col. 1 from allowable patient costs on Worksheet B, Part I, Col. 24, Line 118, then deducted state supplemental payment amounts reported by HHSC and federal supplemental payments reported by hospitals.

As with the operating expense-to-revenue ratio, material costs are omitted. The cost side of the calculation used allowable costs and excluded non-reimbursable expenses. Physician costs were also excluded.

To the extent net patient revenue reported on Worksheet G-3 already includes federal and state supplemental payments, supplemental payment revenue is being double-counted. If so, this calculation is erroneous and misstates the magnitude and potentially the direction of hospitals' unreimbursed costs.

The data is also ripe for misunderstanding because the direction of the figure is presented in reverse. When payments exceed costs, positive values are represented without parentheses as a longfall or credit. When costs exceed payments, negative values are represented in parentheses as a shortfall or debit. Myers and Stauffer appears to represent shortfalls with parentheses, but the data label 'unreimbursed costs' already implies a shortfall before applying a directional sign. Like using a double-negative, labeling unreimbursed costs in parentheses as a negative value muddies the data presentation and could lead to mischaracterizations.

Property tax exemption values

On p. 25, Myers and Stauffer describes the process used to estimate the tax benefits of nonprofits. One of the steps taken was to request parcel numbers from each hospital on the Myers and Stauffer Provider Survey. However, the report states, "After review of the provided [parcel number] data, it was determined the data was not sufficient enough to complete the review; therefore, Myers and Stauffer began researching each hospital system name and address at the county level." Myers and Stauffer did not explain what was insufficient about the data that hospitals submitted.

It is disappointing that Myers and Stauffer did not rely on data hospitals took time to gather and report and resorted to manual methods. After reviewing individual profiles, many hospitals determined the property values Myers and Stauffer included do not match the parcel numbers of their properties. In some cases, the property values (and tax exemption values derived from them) appear understated or overstated by orders of magnitude and are misleading. Some do not meet a basic plausibility test. For example, one hospital system observed that the listed property value of its smallest hospital in a rural town is 23 times higher than that of its 400-bed flagship hospital in a large urban area.

Myers and Stauffer describes the methods it used to impute property and tax exemption values that were not available in all appraisal districts. Its approach hybridizes many sources of information that are not necessarily comparable. These values should be regarded as estimates only, and should be revised as needed based on hospital validation.

Finally, under any legal definition, public hospital districts are units of government, not nonprofit organizations. However, public hospitals appear to have been included in the nonprofit medical exempt properties analysis. Myers and Stauffer avoided explaining to public hospitals why they are regarded as nonprofits in this analysis. During the provider survey, public hospitals were told: "The [Article IX] rider does not explicitly exclude governmental entities from this reporting requirement. ... If your hospital benefits from the exemption from property tax on the parcels it operates and maintains (which are owned by the hospital's owner - the county), these parcels should be reported."[8] It is circular to declare that governmental entities 'benefit' from tax exemptions when governments *are* taxing entities, as if to imply that governments forgo revenue by not collecting tax from themselves. The Myers and Stauffer report states "only hospitals identified as 'Non-Profit' on HHSC *(sic)* hospital listing will be included in the property tax exemption analysis, and included on the final report, unless that designation of non-profit is disproven during hospital analysis." Myers and Stauffer does not provide the HHSC hospital listing, but we are not aware of any hospital classification or legal opinion currently used by HHSC that regards governmental hospitals as nonprofit organizations.

Myers and Stauffer Provider Survey

Myers and Stauffer distributed provider surveys to obtain required information from licensed Texas hospitals. Most hospitals received two data requests – one in February 2024 and one in April 2024. Hospitals not governed by or licensed under Health and Safety Code Ch. 241 appear to have been excluded from initial survey distribution and received both data requests in May 2024.

THA and partner hospital associations supported survey efforts by notifying hospitals of the survey distribution, purpose and deadlines; supplementing hospital contact lists to HHSC to ensure survey notifications reached the correct hospital personnel; and convening a workgroup to consolidate questions on behalf of the industry, promote consistency in responses and provide feedback to HHSC and Myers and Stauffer upon request.

The data request process was labor- and time-intensive for hospitals, adding to an expanding burden of uncompensated and legally mandated reporting to the state of Texas. The surveys were submitted to hospitals with tight response windows and limited time offered for extensions. Identical data requests were made of all licensed hospitals regardless of whether the item(s) applied to those hospitals. The surveys requested copies of publicly retrievable information such as Forms 990 Schedule H, audited financial statements, and charity care policies. The surveys also requested certain elements that hospitals do not report publicly, or do not report at all in any standardized way. Requests for novel data featured considerable ambiguity in instructions and question intent, and minimal controls to promote uniformity.

[8] Survey 2 Questions Responses. Texas Article IX Hospital Charity Care and Transparency Report. (Myers and Stauffer, 2024).

We hold deep reservations about the reliability of the data collection methods in the provider survey. We are also disappointed that our members' review of the draft report reveals that several data elements submitted through the provider survey were discarded or not correctly reflected in the hospital profiles. These factors together resulted in a process that we do not endorse and would not want to see repeated.

Reducing Duplicate Hospital Reporting

The provider survey solicited hospitals' open-ended feedback on the Annual Statement of Community Benefit Standard (ASCBS) survey and reduction of duplicative reporting. Hospitals found this item difficult to return thorough and constructive comments on, given the short time frame for survey responses. The open-ended nature of the question was not similar to the other survey items, which were discrete document and information requests. We appreciate the intent and direction of the conversation this question was intended to generate. Efforts to reduce reporting and re-imagine longstanding data collection tools will require a collaborative, multi-stakeholder effort over a broader time frame and outside the context of the Myers and Stauffer report.

Using the feedback Myers and Stauffer collected as a starting place, we recommend HHSC and DSHS undertake – in collaboration with the hospital industry – a strategic effort to revise the ASCBS and reduce duplicative reporting.

Thank you for the opportunity to comment. If you have any questions, please contact me at (512) 465-1000.

Sincerely,

/s/

John Hawkins
President and CEO
Texas Hospital Association