Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: October 27, 2015

Uncompensated Care in New Mexico After the Affordable Care Act

AT A GLANCE

The Affordable Care Act (ACA) was designed to expand health care coverage to nearly all Americans. States like New Mexico that chose to expand their Medicaid program anticipated especially significant reductions to the number of uninsured people. One of the expected benefits of increased coverage was a decrease in the cost of uncompensated care, 60 percent of which is incurred by hospitals when they provide care to people who lack insurance and/or who cannot pay for their care.

House Memorial 33 (2015) requested the Legislative Finance Committee and the Department of Health study the effects of the Patient Protection and Affordable Care Act on uncompensated care and other health care costs in New Mexico hospitals.

As more Americans obtain insurance, uncompensated care costs have indeed declined. Nationally, the rate of uninsured persons dropped from 16.7 percent to 13.5 percent between 2013 and 2014. As expected, uncompensated care costs dropped as well, by 21 percent across all states, and a 26 percent reduction in Medicaid expansion states.

In New Mexico, the rate of uninsured adults declined from over 18 percent in 2013 to 13.1 percent as of the second quarter of 2015. Uncompensated care has diminished significantly. The state's Safety Net Care Pool hospitals submitted applications for $122.5 million in uncompensated care reimbursement in CY15, more than a 30 percent drop from CY14. Hospital CMS cost reports, which use a broader definition of uncompensated care, show a 3.6 percent reduction from 2013 to 2014. New Mexico's hospitals in the aggregate have seen increased net income as uncompensated care now accounts for less than 7 percent of their expenses.

All indications are that uncompensated care costs will continue to decline, but they will not disappear altogether. Some populations and some services cannot be covered by Medicaid or the New Mexico Health Insurance Exchange, and some people who are insured will continue to struggle with out of pocket healthcare costs.

Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

New Mexico Legislative Finance Committee

Policy Context for Uncompensated Care

Understanding uncompensated care is important for policy makers for several reasons. Federal and state funding for uncompensated care has been reduced in anticipation of declining costs. Policy makers need to know what the new costs are, how much funding is available, and whether existing policy should be changed to reflect the new situation.

With the implementation of Centennial Care and Medicaid expansion about 236 thousand newly eligible New Mexicans are now covered by Medicaid.

- The ACA assumes a reduction in uncompensated care costs, and therefore requires phased reductions in supplemental federal Medicare and Medicaid funding to hospitals that serve a disproportionate share of low income patients and thereby incur high uncompensated care costs.
- New Mexico's Safety Net Care Pool (SNCP) caps hospital reimbursements for uncompensated care costs at a total of $68.9 million per year, significantly less than the $92.4 million the SNCP hospitals (excluding UNMH) requested reimbursement for in 2015.
- The Centennial Care waiver includes a higher Medicaid inpatient reimbursement rate for SNCP hospitals and UNM hospital to reduce the discrepancy between actual costs of care and Medicaid payment rates. In CY14 hospitals received $142.5 million in enhanced rates, and HSD is considering whether to maintain the higher rates for CY16.

Another 44,307 New Mexicans obtained insurance coverage through the New Mexico Health Exchange (NMHIX) during the second open enrollment period.

- Counties use dedicated GRT increments to support the Safety Net Care Pool (SNCP), and their own county indigent care programs. Unaudited county budget reports for FY14 and FY15 show a 5 percent decrease in county indigent fund spending, although some counties report that the new SNCP structure has not left them with enough funds to cover their local needs and priorities.
- Less expensive insurance plans often selected by consumers trying to save money typically have higher out-of-pocket costs, which several national studies have shown may deter or delay individuals from seeking needed care from their providers or filling medically necessary prescriptions.

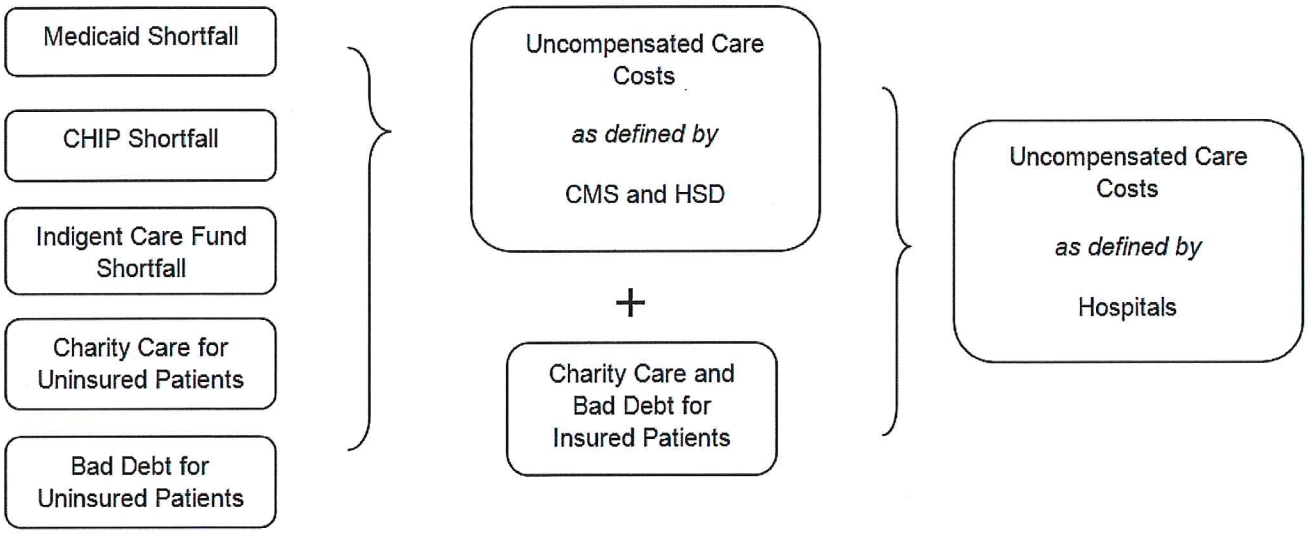
Defining Uncompensated Care

Hospitals provide approximately 60 percent of all uncompensated care and hospital-based costs are the focus of this brief. Uncompensated care is most broadly defined as the cost of any medical care delivered by a hospital to any patient for which the hospital does not receive payment. That is the definition used by hospitals. The Centers for Medicare and Medicaid Services (CMS) and the Centennial Care waiver use a more narrow definition that includes only the costs of care provided to Medicaid eligible or uninsured individuals; this is the definition of uncompensated care that is used to determine hospital reimbursements from the safety net care pool.

The different definitions are significant. In 2014 New Mexico's 28 Safety Net Care Pool hospitals and UNM Hospital submitted uncompensated care applications for $175.9 million; the Medicare cost reports for those same hospitals reported $293.2 million in uncompensated care. The higher amount is the result of including the costs of charity care and bad debts for insured individuals, primarily for insurance deductibles and/or co-pays which can often amount to substantial out-of-pocket expenses.

There are five component parts to the uncompensated care equation. The *Medicaid and CHIP shortfalls* are the difference between what hospitals say care costs and what Medicaid pays. Similarly, the *indigent care fund shortfall* is the difference between hospitals' cost of care for a patient and the payment the hospital receives from the county indigent care fund. *Charity care* is care provided to a patient for which the hospital never expected payment, and *bad debt* is care for which the hospital expected, but did not receive, payment.

Figure 1. Uncompensated Care Cost Components



Reimbursement Sources for Uncompensated Care Costs

Uncompensated care is not entirely "uncompensated." In 2013 an estimated $84.9 billion of uncompensated health care was provided, the bulk of which, approximately $44.6 billion, was hospital-based. The rest was provided by public health clinics, federally-qualified health centers (FQHCs), office-based physicians, and other community-based providers.

An estimated $53.3 billion of that uncompensated care was ultimately reimbursed from publicly-financed sources. The largest payers were Medicaid (25.7 percent), Medicare (15 percent), the Veteran's Administration (15.2 per-

cent), state and local indigent health programs (18.4 percent), and state and local public assistance programs (13.7 percent).

In New Mexico, hospitals are reimbursed for uncompensated care costs in both direct and indirect ways.

Safety Net Care Pool. The Centennial Care waiver replaced the Sole Community Provider (SCP) fund with the Safety Net Care Pool (SNCP). Like the SCP fund, the SNCP is a federal/state payment program administered by the Human Services Department (HSD), with county funds supporting the state share of expenditures. 2014 updates to the Indigent Hospital and County Health Care Act make county contributions of the equivalent of a 1/12th GRT increment to the SNCP mandatory (Bernalillo and Sandoval counties are exempt). Safety Net Care Pool (SNCP) uncompensated care reimbursements to hospitals are capped at a maximum of $68.9 million per year for the five years of the Centennial Care waiver, and are allocated according to hospital size, as seen in Table 1. The Safety Net Care Pool is in turn divided into two sub-pools:

Table 1. Safety Net Care Pool Uncompensated Care Allocations

Smallest hospitals	13 hospitals with 30 or fewer beds receive 60 percent of available funding.
Small hospitals	Seven hospitals with between 31and100 beds receive 30 percent of available funding, plus any amount not used by the smallest hospitals.
Medium hospitals	Six hospitals with between 101 and 200 beds receive 10 percent of available funding, plus any amount not used by the small hospitals.
Large hospitals	Two hospitals with between 201 and 300 beds are not allocated any funding directly. Instead, they can receive any funds not used by the medium hospitals.
Largest hospital	UNM Hospital, with more than 301 beds, is the only hospital in this category. It is not eligible for SNC pool funds and instead receives funds from the Bernalillo property tax mill levy.

Source: HSD

- The uncompensated care pool receives 92 percent of SNCP pool funding, or a total of $344 million over the five years of the waiver. The annual payment limit is $68.9 million. These funds are used to reimburse the 28 safety net qualified hospitals for their actual uncompensated care costs. In CY15, SNCP hospitals applied for $92.4 million in uncompensated care reimbursements from the pool. Of the 28 SNCP hospitals, the 20 smallest and small hospitals were reimbursed for 100 percent of their reported costs. The medium hospitals received approximately 47 percent of their reported costs, and the large hospitals and UNMH did not receive any reimbursement from the SNCP.

- The hospital improvement incentive (HQII) pool receives 8 percent of Safety Net Care Pool funding, or a total of $29.4 million over the five years of the waiver. The HQII pool aims to incentivize health care improvements at safety net hospitals along 25 hospital quality improvement measures listed in the Centennial Care waiver. Distributions will begin with a total of $2.8 million in the second year of the waiver (CY15) and rise to $12 million by the fifth year (CY18). In CY15, 25 percent of the HQII pool will be divided equally among participating hospitals. In CY15, the other 75 percent will be distributed based on each participating hospital's volume of Medicaid patients and their submission of baseline performance measure data. In CY16, allocations will be based on meeting minimum state performance levels for those measures, and in CY17 and CY18, allocations will be based on hospitals meeting (or exceeding) their improvement targets.

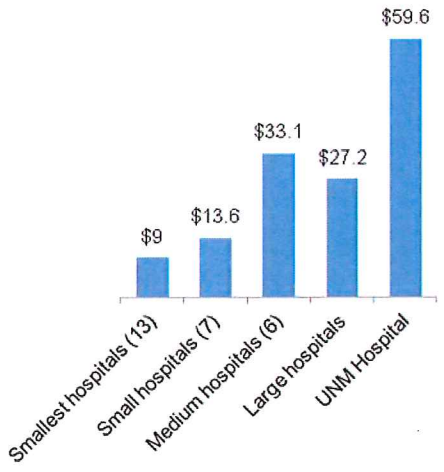
County Indigent Fund (CIF). The Indigent Hospital and County Health Care Act authorizes counties to pay for indigent health care claims by dedicating

revenue from a second 1/8th increment to the GRT. This is an optional tax, and 31 counties have created CIFs using this funding method. Bernalillo County is a statutory exception, and contributes a flat $1 million per year to its indigent care fund, which is directly distributed to University of New Mexico Hospital. Socorro and Harding counties do not have county indigent funds.

In FY14, the counties spent $62.8 million on uncompensated care through their CIFs. In FY15, the counties projected that amount would drop by 5 percent to $59.7 million. County indigent funds are not matched by federal dollars, and each county makes independent decisions about how to manage their fund, including eligibility, covered services and administration, and commonly cover services that are not Medicaid-reimbursable such as preventive care clinics, detox and sobering centers, and county inmate health care. Funds from the CIF may be transferred to meet the county's responsibilities to either or both of the County-Supported Medicaid Fund and the Safety Net Care Pool. (The County-Supported Medicaid Fund is a mandatory program in which counties provide funding to the state to support the state share of Medicaid expenditures. Nineteen counties have elected to impose a separate 1/16th GRT increment for this purpose; the other counties transfer the equivalent amount from their existing CIF.)

Enhanced Medicaid rates for inpatient hospital stays are available only to Safety Net Care Pool (SNCP) hospitals and UNM hospital. These enhanced rates were built into the Centennial Care waiver to close some of the gap between Medicaid rates and actual cost of hospital-based care (the Medicaid shortfall), in turn reducing the source of a significant portion of uncompensated care costs. In CY14, the rate increase totaled over $142.5 million, $59.6 million for UNM hospital alone and $82.9 million divided among the SNCP hospitals. As anticipated in an earlier LFC hearing brief, larger hospitals with more Medicaid patients benefitted proportionately more from the Medicaid rate increase.

Chart 3. Hospital Inpatient Rate Increase
CY2014



Source: HSD

As the number of New Mexicans covered by Medicaid expansion has soared, hospital cost reports appear to confirm the rate increase has made a significant impact on holding down commensurate increases in Medicaid shortfalls. The SNCP hospitals and UNM Hospital reported an aggregate 21.9 percent increase in Medicaid shortfall, while the five non-SNCP hospitals reported an aggregate 382 percent increase, largely the result of the $6.7 million shortfall reported by UNM Sandoval Regional Medical Center and the $18.9 million shortfall reported by Presbyterian Hospital.

Disproportionate share hospitals (DSH) have greater than 25 percent of low income and Medicaid patients. Prior to implementation of the ACA, the DSH program ensured a higher Medicaid reimbursement rate for DSH hospitals. In FY14, NM hospitals received $31.4 million in DSH payments, and as of the third quarter of FY15 were on track to receive a projected $31.7 million for the year.

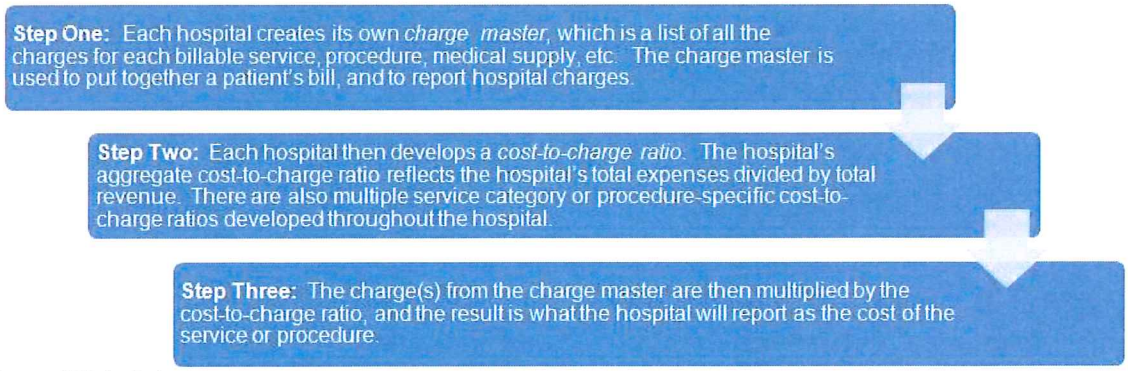
On the premise that the ACA would significantly reduce the cost of uncompensated care, the federal government began phasing out Medicare DSH payments in 2014, with Medicaid DSH reductions due to begin in 2016. HSD estimates that DSH payments will drop to $17.3 million by FY20. HSD's enhanced Medicaid rates for inpatient hospitalization are also intended to balance the loss of DSH funding.

Graduate medical education (GME) funding and indirect medical education (IME) funding, available only to major teaching hospitals such as UNMH, are another relevant source of funding. These programs are not directly connected to uncompensated care, but they are included here because the funding is a combination of Medicare, Medicaid and state monies; federal dollars are based on the proportion of services to Medicare and Medicaid patients and the ratio of residents to hospital beds. In FY14, UNM hospital received $39.3 million in graduate education subsidies.

Calculating Uncompensated Care Costs

Hospitals report uncompensated care costs as the *cost* of services, as distinct from the amount the hospital *charges* for those services. However, few hospitals have a precise calculation of the current cost of every service. So costs are generally determined by beginning with what the hospital charges for a service or procedure, and then using the *cost-to-charge ratio* to work backwards to figure out the cost. While this process has been the common business practice for hospitals around the country for decades, it nonetheless casts some doubt on the accuracy of uncompensated care cost reports. Because the eventual reported costs are determined by working backwards from charges that may have limited connection to actual costs, it is effectively

Figure 2. Hospital Cost-to-Charge Ratio



Source: LFC Analysis

impossible to establish whether the reported uncompensated care costs that are reimbursed by public funds equal or possibly exceed actual costs.

When costs are calculated from charges, there can be significant consequences for the overall cost of health care. Hospital charges have no uniform basis and the methods hospitals use to determine their charges are not transparent to the public or to policymakers. There is little governmental oversight of the process; Maryland and West Virginia are the only two states that regulate hospital charges.

In theory, hospitals charge all patients the same; in reality, private health insurance plans negotiate prices and discounts, and Medicare and Medicaid set their own prices for covered services. Different payors will all pay a different percentage of the hospital's charges, and hospitals generally set their charges high enough to take these differences into account.

Uninsured patients may end up paying the full hospital charges if they are not eligible for the hospital's charity or indigent care programs, leading to the large debts, home foreclosures and other financial difficulties that provided the impetus and context for the ACA. On the other hand, even when a health plan negotiates, for example, a 30 percent reduction to hospital charges, it may still be paying substantially above the true cost of services provided, which in turn factors into how the plan sets its premiums, deductibles and co-pays.

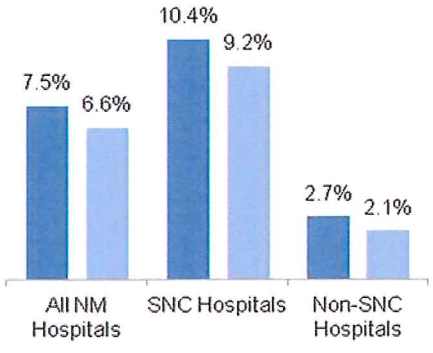
Cost-to-charge ratios reflect hospital mark-ups. The cost-to-charge ratio is another way of referring to the amount of mark-up over cost the hospital will charge. In 2012, US hospitals charged on average 3.4 times the Medicare-allowable costs; a recent study of the 50 hospitals with the highest mark-ups found charges as high as twelve times the Medicare-allowable costs. In FY14, the national average cost-to-charge ratio of urban acute care hospitals was 0.32, and the average cost-to-charge ratio for rural hospitals was 0.35, meaning that urban hospitals charge approximately 212 percent above costs and rural hospitals charge approximately 185 percent above costs.

In New Mexico, the average cost-to-charge ratio for the 44 member hospitals of the NM Hospital Association – which include general, acute, specialty and rehab facilities – was 0.25, meaning that on average these hospitals charge 300 percent over cost. The average cost-to-charge ratio for the 29 Safety Net Care Pool (SNCP) hospitals (including UNMH) was 0.36, or 177 percent over cost.

The average can be misleading, however, as hospitals in NM have a wide range of cost-to-charge ratios. Among the SNCP hospitals, the range is from 0.158 – or 532 percent over cost – at Eastern New Mexico Medical Center (ENMMC), to 0.962 – or 3.9 percent over cost – at Miner's Colfax Medical Center (MCMC).

Uncompensated Care and Hospital Profitability

Chart 1. Uncompensated Care Costs as a Percentage of Hospital Expenses



Source: CMS Cost Reports

The dollar amounts of uncompensated care costs are significant, and it is important to note the costs are not spread evenly over all types and sizes of hospitals. However, nationally uncompensated care costs make up a relatively small proportion of hospital revenues. The American Hospital Association estimates that in 2013, uncompensated care costs accounted for 5.9 percent of hospitals' total expenses. (Note: the AHA does not include the Medicaid shortfall in its definition of uncompensated care.)

The figures for New Mexico hospitals are notably higher than the national average: 7.5 percent in 2013, dropping to 6.6 percent in 2014. In this, as in other areas, the Safety Net Care Pool (SNCP) hospitals have a markedly different experience than the non-SNCP hospitals, as Chart 1 illustrates.

Even though uncompensated care costs are a higher share of hospital expenses in New Mexico than the national average, the overall decline in total uncompensated care costs has contributed to improved net income for most New Mexico hospitals. Across all New Mexico hospitals, net income as a percent of net revenue grew from an average of 5.4 percent in 2013 to an average of 7.84 percent in 2014. In this area, SNCP hospitals performed better than the state average: from 4.6 percent in 2013 to 9.4 percent in 2014.

Federally-qualified health centers (FQHCs) have also seen their financial stability improve since Medicaid expansion. Federally-qualified health centers (FQHCs) are non-profit entities that have long been the foundation of preventive and primary health care for low income and uninsured individuals. Funded by federal grants, Medicare and Medicaid, FQHCs are mandated to serve designated medically underserved populations or areas, and provide services at nominal or low cost. New Mexico has sixteen FQHCs, with a total of 95 medical sites, 40 dental locations, and 17 school-based clinics.

Table 2. FQHC Payor and Patient Mix

	FY13	FY14	Change
Medicaid billed charges	$60.6 million	$95.6 million	↑ 57.7%
Uninsured/self pay billed charges	$56 million	$46.3 million	17.3% ↓
Medicaid patients	26.2%	37.9%	↑ 11.7%
Uninsured patients	42.3%	31.1%	11.2% ↓

Sources: HRSA, NMPCA

The ACA recognized the critical role of health centers and included $11 billion over a five year period, delivered through a variety of new grants, awards and direct funding, to fund the operation, expansion and construction of health centers across the country. In FY14, the Health Resources and Services Administration (HRSA) awarded $82.8 million in 74 grants to New Mexican FQHCs; 59 grants worth $78.4 million have been awarded to date in FY15.

Despite substantial federal funding, FQHCs have historically operated under deficit budgets due largely to the costs of uncompensated care. In FY13, total uncompensated care costs for NM FQHCs was $91.4 million; that amount rose to $98.9 million in FY14. However, with total patient revenues of $127.4 million and combined federal, state and lo-

cal grants of $100.7 million, the FQHCs collectively had a net income of $1.8 million.

According to the New Mexico Primary Care Association, this improved financial picture allowed the centers to offer pay raises to providers and build capacity around the state. That change in economic fortunes can be seen clearly by looking at the payor and patient mix, as shown in Table 2.

By all measures, the costs of uncompensated care have dropped in New Mexico, as shown in Table 3:

- CY15 applications for reimbursement from the state's Safety Net Care Pool (SNCP) hospitals are down by over 30 percent;
- CMS Cost reports from all New Mexico hospitals show an aggregate uncompensated care decline of over 3 percent; and
- County Indigent Fund expenditures are projected to drop by 5 percent.

At the same time, other measures demonstrate the relative strength of reimbursement mechanisms:

- In CY15, the twenty 'smallest' and 'small' SNCP hospitals were reimbursed for 100 percent of their reported costs, and the six 'medium' hospitals were reimbursed for over 47 percent of their reported costs;
- In CY14, increased Medicaid rates for inpatient hospital stays totaled over $142.5 million, and CY15 payments are on track to increase by over 10 percent to $157.7 million; and
- County Indigent Fund balances increased by 1.6 percent from 2014 to 2015.

In short, more New Mexicans have health insurance coverage, hospitals have lower uncompensated care costs, and available reimbursements for those costs appear sufficient.

Table 3. Factors Related to Uncompensated Care Costs in New Mexico
(dollar amounts are in millions)

	2013	2014	2015	Change
Uninsured New Mexicans	18.6%	14.5%	--	↓ 4.1%
SNCP Applications	--	$175.9	$122.5	↓ 30.4%
CMS Hospital Cost Reports UCC	$376.6	$362.8	--	↓ 3.6%
UCC as Percent of Hospital Expenses	7.51%	6.57%	--	↓ 12.5%
County Indigent Fund Expenses	--	$62.8*	$59.7*	↓ 5%
County Indigent Fund Balances	--	$30.5	$31	↑ 1.6%
Enhanced Medicaid Inpatient Rates	--	$142.5	$157.7*	↑ 10.7%
DSH Payments	$30.7	$31.4	$31.7	↑ 1.3%
Hospital Net Income as Percent of Revenue	5.4%	7.84%	--	↑ 45.2%

*CIF expenditures as projected on unaudited county budgets; Medicaid rates as projected by HSD
Source: LFC Analysis

Uncompensated Care Costs Will Not Disappear Altogether

Some populations, and some services, cannot be covered by Medicaid or the New Mexico Health Insurance Exchange (NM HIX). According to the US Census, approximately 298,000 New Mexicans were still uninsured at the end of 2014. Some, like Native Americans, are not required to enroll. Others – an estimated 42,200 – are not eligible for Medicaid or health exchange insurance coverage due to their immigration status. Uncompensated care costs

for this population will continue to be borne by providers, hospitals and county health care assistance funds, although at least five New Mexico counties also have U.S. citizenship or legal permanent resident status requirements.

Medicaid's Emergency Medical Services for Aliens (EMSA) program covers emergency-only care costs for undocumented residents who would otherwise be Medicaid eligible. The EMSA program is relatively small, serving just 2,406 unique clients in 2014. Lastly, some undocumented immigrants are enrolled in the New Mexico Medical Insurance Pool (NMMIP). The NMMIP was created in 1987 to provide coverage to New Mexicans otherwise considered uninsurable, with a primary focus on individuals not eligible for Medicaid who were denied other coverage due to preexisting conditions. Since passage of the ACA and expansion of Medicaid, many NMMIP enrollees have found coverage elsewhere, but the pool remains a source of coverage for undocumented immigrants.

In addition, some of the services counties use their indigent funds for are not Medicaid reimbursable and therefore not responsive to increases in the Medicaid population. These services include types of care counties have long provided, such as preventive care clinics, detox and sobering centers, and county inmate health care, as well as newer programs such as Santa Fe County's mobile crisis response team.

Table 4. Choice of plan level for consumers enrolled through NM Health Insurance Exchange

Plan Level	2014 NM enrollment	2015 NM enrollment	2015 national
Bronze level plan (on average pays 60% of costs)	23%	25%	21%
Silver level plan (on average pays 70% of costs)	62%	61%	68%
Gold level plan (on average pays 80% of costs)	14 %	13%	7%
Platinum level plan (on average pays 90% of costs)	0 %	0.2%	3%
Catastrophic (on average pays less than 60% of costs; limited eligibility)	1 %	0.3%	1%

Sources: CMS, ASPE/HHS

Some people who are insured will continue to struggle with healthcare costs. There is also a sizeable population of New Mexicans who are 'underinsured,' meaning that although they have health insurance, they cannot afford the associated out-of-pocket expenses (deductibles, co-pays, co-insurance, etc.). These costs can be an economic barrier that may lead some individuals to put off seeking medical care; other individuals may continue to seek care and simply be unable to pay for it.

Insurance premiums and deductibles are key drivers of health-related financial difficulties: 44 percent of newly insured adults report difficulty affording their premiums, and research shows that 73.8 percent of people struggling with paying their medical bills forego needed medical care. Many people who have high out of pocket expenses do not apply for, or do not qualify for, charity care programs, a factor that may be contributing to the reports from New Mexico hospitals that they are seeing increases in patient bad debt. County indigent funds are prohibited by statute from covering out-of-pocket expenses.

ACA financial subsidies can help make insurance purchased through the health exchange affordable. The ACA includes two financial subsidies meant to off-set individual expenses and help make insurance more affordable, the

premium tax credit and cost-sharing subsidies. A majority of NM HIX enrollees, 74 percent, qualified for premium tax credits, and 47 percent qualified for cost-sharing subsidies.

Understanding health exchange plans and options can be difficult. The ACA only sets maximum out-of-pocket spending limits and allows plans to use any combination of deductibles, copayments and coinsurance to meet that limit. Consumers who select what appears to be an affordable plan based on only the premium may later find themselves faced with more than they can handle in other expenses. The tax credit can also be challenging to understand.

New Mexicans are not alone in this regard. Nationally, over 30 percent of newly-insured adults reported they had difficulty comparing services and providers networks. This data points to the possibility that some of the individual financial burden contributing to uncompensated care costs could be reduced with better education, and more assistance and more experience with shopping on NM HIX and understanding available financial subsidies.

Looking Forward

Continuing uncompensated care costs have policy and financial ramifications for New Mexico.

Reduced uncompensated care costs are not likely to result in lower insurance premiums, for example, for New Mexico's public employee health benefit plans. If hospitals currently shift the costs of uncompensated care to privately-insured patients by charging them higher prices, then reductions in uncompensated care costs should lead to less cost-shifting and help to stabilize, if not lower, health insurance premiums for the private sector, including the IBAC agencies.

However, whether this cost-shifting occurs, and to what extent, is not a settled issue. Although some cost-shifting may occur, there is no strong evidence to support the position that hospitals routinely handle uncompensated care costs by shifting significant amounts of those costs to privately insured patients by negotiating higher charges and payments with insurance companies. As noted above, uncompensated care costs are ultimately a small portion of overall hospital expenses. That said, even though relatively small, uncompensated care costs represent a lost opportunity for additional revenue for hospitals even when those costs are partially reimbursed. Lost revenue in one area can place additional pressure to get a higher percentage of charges from other payor sources, a dynamic that may also factor in to higher charges to MCOs and privately insured patients. Higher charges to MCOs may in turn factor into higher premiums and other costs.

The role of NM counties in sharing the burden of uncompensated care has changed. Counties have experienced the last year and a half quite differently since Medicaid expansion and NM HIX numbers are different for each county, as are proportional populations of undocumented immigrants. Because county indigent funds are based on GRT revenues, counties are also differentially able to support both the Safety Net Care Pool (SNCP) and their own indigent programs. Counties report they are struggling with the new SNCP structure, although better-than-expected revenues from the 1/12th GRT should improve that picture.

At the same time, the Indigent Hospital and County Health Care Act currently places limits on how counties can use their indigent funds, including prohibiting them from assisting their residents with out-of-pocket costs. Out-of-pocket costs are a growing concern, as seen by the fact that charity care for people who have insurance has dropped at a far slower rate than for people without insurance, and by the slight but noticeable rise for some hospitals in bad debt.

Table 5. Uncompensated Care Component Amounts

	Medicaid shortfall	CHIP shortfall	Indigent UCC shortfall	Charity care – uninsured	Charity care – insured	Charity care – total	Bad debt	Total UC cost
2013	$29,516,332	$1,702,140	$37,527,247	$144,318,513	$31,902,472	$158,030,329	$140,160,049	$376,560,191
2014	$61,012,706	$51,670	$16,626,920	$113,650,337	$27,836,555	$141,486,892	$143,668,809	$362,846,997
All Hosp	↑ 106.6%	↓ 97%	↓ 56%	↓ 21.3%	↓ 12.7%	↓ 10.6%	↑ 2.5%	↓ 3.6%
SNCP Hosp	↑ 21.9%	↓ 96%	↓ 54.7%	↓ 18.6%	↓ 18.7%	↓ 8.3%	↑ 6.6%	↓ 9.4%
Non-SNCP Hosp	↑ 382%	*None reported*	↓ 92%	↓ 48.5%	↑ 84%	↓ 31.7%	↓ 12.8%	↑ 31.8%

Source: CMS Cost Reports

Uncompensated care costs have gone down, but understanding how those costs have shifted between the component parts and among New Mexico's hospitals is critical to developing effective on-going policy. Medicaid enhanced inpatient rates have been effective at slowing the otherwise rapid increase of the Medicaid shortfall. For CY14, hospital inpatient rates were increased by 62 percent. Anticipating that county revenues would underfund the Safety Net Care Pool, HSD recently submitted a proposed state plan amendment to CMS, indicating plans to roll back the rate increase.

However, since submitting the proposal to CMS, HSD has indicated that county revenues have been better than expected and the rate reduction may be correspondingly smaller. No final figure has been announced, and HSD's most current projection is that, if unchanged, the rate increase for CY15 will total $157.7 million, a $15.2 million increase from CY14.

As shown by the increase in the Medicaid shortfall, the 62 percent rate increase was only partially successful at balancing the cost of providing care to Medicaid patients, particularly since it was only offered to Safety Net Care Pool hospitals. Any new rate reduction may shift even more of the cost onto hospitals, increasing the risk of cost shifting to private health plans. In New Mexico, the agencies of the Interagency Benefits Advisory Council (IBAC) are the largest participants in private health plans, and spent $890 million in FY14 to provide health care to over 196 thousand members.

Hospital charges are not transparent or comparable, and this blocks policy makers and consumers from gauging the true extent and consequences of uncompensated care costs. Hospital charges can be compared to the manufacturer's suggested retail price (MSRP) for a new car, or the asking price for a new house: it is unlikely anyone will ever end up paying the exact listed charge, and equally unlikely two patients, or two insurance companies, will end paying the same charge. In all cases, the higher the hospital sets the charge, the more room it will have to negotiate with potential purchasers.

Medicare and Medicaid are generally the exception to this cycle because they set their own fixed payments for hospital services. But as long as hospitals use charges and cost-to-charge ratios to determine the costs of goods and services, the cost-to-charge process will remain at the root of uncompensated care costs. Medicaid and CHIP shortfalls are based on the difference between what the hospital determines the cost of a procedure to be and what Medicaid will pay for that procedure or service – in other words, driven not by the fixed payment set by Medicaid but by the variable cost calculated by the hospital. Further, when applying for safety net care pool reimbursement, hospitals report their charity care and bad debt as lump sums, multiplied by the cost-to-charge ratio to get the resulting cost.

Given the wide variance of cost-to-charge ratios in New Mexico, one hospital may charge up to five times more than another for a service or procedure that costs exactly the same. With hundreds of millions of public dollars at stake for direct Medicaid payments, enhanced in-patient rates, and uncompensated care reimbursements, greater transparency in hospital charges is a sensible goal, as recognized by the legislature with a 2015 amendment to the Health Information Systems Act that directed the Department of Health to develop a public website that will include information about hospital cost, availability, utilization and revenues. The website is to be available to the public by January 1, 2018.