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DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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December 29, 2010

The Honorable Martin O'Malley
State House, 100 State Circle
Annapolis, MD 21401

The Honorable Thomas V. Mike Miller, Jr.
H-107, State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
H-101, State House
Annapolis, MD 21401-1991

RE: Legislative Report:
Health General Article
Section 19-214(e)

Dear Governor O'Malley, President Miller, and Speaker Busch;

I am writing in response to the provisions set forth in Section 19-214(e) of the Health General Article (as enacted in Chapter 245 of the 2008 Laws of Maryland, House Bill 1587), which requires the Health Services Cost Review Commission ("HSCRC," or "Commission") to report to the Governor and, in accordance with Section 2-1246 of the State Government Article, the General Assembly, the following information:

- The aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7, Acts of the General Assembly, 2007 Special Session; and

- The number of individuals who enrolled in Medicaid as a result of the change in

eligibility standards under Section 15-103(A)(2)(ix) and (x) of the Health General Article, and the expenses associated with the utilization of hospital inpatient care by these individuals.

Introduction

Over the past several years, the General Assembly has considered various ways to reduce the number of uninsured individuals in the State, which has been estimated roughly to be 800,000. For example, legislation has been introduced to create a health care exchange, increase the eligibility age of dependents for health care coverage purposes, require citizens to obtain coverage or pay a tax penalty, require businesses to provide coverage to employees or pay a subsidy, provide a subsidy for small businesses that have not provided health care coverage to their employees, and expand eligibility for the Medicaid Program.

Senate Bill 6 (Chapter 7) was enacted during the 2007 Special Session, and SB974/HB 1587 (Chapter 244/245) was enacted in 2008 to address several of these issues.

Background

Chapter 7 of the 2007 Special Session enacted the "Working Families and Small Business Health Coverage Act," which expands access to health care in the following ways:

- Expands Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent (currently 46%) of federal poverty guidelines (FPG), to be implemented in fiscal 2009 (116% for family of 4 = $24,000);

- Contingent on available funding, incrementally expands the Primary Adult Care program benefits over three years to childless adults with household income up to 116 percent FPG (currently 46%), to be phased in from fiscal 2010 through 2013; and

- Establishes a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission (MHCC) and funded with $15 million in fiscal 2009.

Special funds, including savings from averted uncompensated care and matching federal funds, will cover a portion of the costs of the expansion. Chapters 244/245 from 2008 requires the Commission to implement a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of health care coverage under Chapter 7. The assessment is to be broad-based, prospective, and uniform and will reflect averted uncompensated care realized from the expansion of the Medicaid Program under Chapter 7. The legislation authorizes the Commission to implement the assessment, provided that it does not exceed the actual averted uncompensated care.

The federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

require that in order for provider taxes to access federal matching funds, they may not exceed 25% of a state's share of Medicaid expenditures; they must be broad-based and uniform; and they may not hold providers harmless. A uniform tax is one that is imposed at the same rate on all providers.

In addition to altering the funding of health care expansion efforts, Senate Bill 974/House Bill 1587 made the Maryland Health Insurance Plan ("MHIP") assessment more responsive to the current needs of the program. Under this provision, regulations were adopted by the HSCRC to increase the assessment from the previous requirement of 0.81% to 1.0% of net patient revenue. The combined assessment (averted uncompensated care and MHIP) may not exceed 3% of total net patient revenue at Maryland hospitals.

FY 2009 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

Eligible individuals do not become enrolled in the Medicaid program until many months after care has been provided. Once enrolled, coverage is provided retroactively to the date of the service. In addition, it takes at least 3-6 months after care is provided for all relevant data to be accessed by Medicaid and the HSCRC on the associated costs. Therefore, the amount of averted bad debt is not fully known until many months after the conclusion of the applicable fiscal year. As a result, Medicaid and the HSCRC estimate the aggregate reduction in hospital uncompensated care based on Medicaid's expected enrollment and per member/per month costs. During FY 2008, the Medicaid Program and HSCRC calculated the estimated total Medicaid expenditures for FY 2009 by multiplying the total number of expected member months by the expected monthly Medicaid costs ($462.58). The result, $95.2 million, was adjusted to account for the following:

- The percentage of expenditures that will be spent in-state, 94%, calculated using a three year average of Medicaid claims data;
- Medicaid pays 94% of charges;
- The percentage of expenditures that would go to hospitals (61%) calculated based on the Medicaid HealthChoice reimbursement process that breaks out payment rates into hospital, drug, and other components;
- The estimated share of the spending that was directed to individuals who had coverage previously (known as "crowd out") was 28% based on available literature and confirmed by surveys issued through Medicaid; and
- The lower use rate of the uninsured, approximately 82%, based on the available literature.

Using these adjustments, the original estimated hospital averted bad debt from Medicaid expansion in FY 2009 was calculated to be $34.3 million (See Row 11, Column A of Appendix I for calculations).

The legislation states that a portion of averted bad debt shall be utilized to reduce costs to

purchasers of hospital care, through a reduction in hospital rates. For FY 2009, the Commission determined that 75% of the averted bad debt is to be passed on as reductions in hospital payments related to uncompensated care. Therefore, $24.2 million of the expected averted bad debt was remitted from hospitals to support the Medicaid expansion program (See Row 17, Column A of Appendix I for calculations). Once remitted and utilized for health care purposes by Medicaid, the State is able to access the federal match on this amount – more than doubling this amount (the federal match in FYs 2009 and 2010 is 61.59%).

As reported by the Department of Health and Mental Hygiene ("DHMH"), the average enrollment in Medicaid as a result of Medicaid expansion in FY 2009 was actually 29,273 – an amount higher than expected when the uniform assessment was originally calculated for FY 2009. Moreover, Medicaid found that the per member/per month cost was also higher than originally expected, since a higher proportion of the new enrollees was older than age 44. Typically, an older population requires more health care services, which means higher costs to the program. As a result, the original FY 2009 per member/per month cost estimate was increased from $462.58 to $510.61 – a 10.3% increase.

Factoring in these increases and making adjustments based on experience (such as the hospital portion from 61% to 54%) to date, it has been estimated preliminarily that the amount of averted bad debt in FY 2009 was $16.5 million greater than originally expected (See Row 18, Column B of Appendix I for calculations). This amount has been included in the uniform assessment calculation for FY 2010.

FY 2010 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

The FY 2010 assessment was based on an anticipated average enrollment of 55,000 and a per member/per month cost of $539. The total expected Medicaid expenditures for this population is $324.4 million. After making the same adjustments made for FY 2009, the total expected hospital averted bad debt in FY 2010 is $103.4 million, and the uniform assessment for FY 2010 is $90 million – providing a savings to purchasers of hospital care of about 7.4% or $13 million (See Column C of Appendix I for calculations).

The aforementioned $16.5 million from the underestimation in FY 2009 has been added to this amount so that the total assessment amount for the parents/caretakers expansion in FY 2010 is $106.5 million (See line 19 in Column C in Appendix I).

Expansion to Emergency Care under the Primary Adult Care Program

As described above, Chapter 7 of the 2007 legislation expands services to childless adults with incomes up to 116 percent of the federal poverty level. Currently, the childless adult population receives primary care, pharmacy, and certain office and clinic-based mental health services (the Primary Adult Care Program, or PAC). The Working Families and Small Business Health Coverage Act phases in specialty physician, emergency, and hospital services over a three-year period, if available funding exists. In accordance with Board of Public Works action in July of 2009, emergency services have been added to the PAC program beginning January 1, 2010. This expansion will also require an adjustment to the FY 2010 uniform assessment. This program

required an additional $8.7 million in resources between January 1, 2010 and June 30, 2010. Therefore, this amount has been added to the uniform assessment for a total FY 2010 uniform assessment of $115.2 million.

FY 2011 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

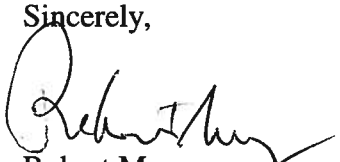
The FY 2011 assessment was based on an anticipated average enrollment of 69,773 and a per member/per month cost of $546. The total expected Medicaid expenditures for this population is $457.6 million. After making the same adjustments made in FY 2009 and 2010, the total expected hospital averted bad debt in FY 2011 is $155.4 million, which includes $128.6 million for the Medicaid Expansion, plus $26.8 million for the PAC program. The uniform assessment for FY 2011 is $146.1 million (adjusted for the conversion of hospital charges to Medicaid payments). There will be no savings to purchasers of hospital care in FY 20011(See Column D of Appendix I for calculations).

Conclusion

Thank you for this opportunity to share data on the impact that the provisions of Chapter 7 from 2007 and Chapter 244/245 from 2008 have had to date on hospital uncompensated care. In a short period of time, these provisions have begun to demonstrate the desired effect of increasing access to health care and reducing hospital uncompensated care. HSCRC policy dictates that since the uniform assessment represents an estimate of bad debt experience, once actual experience is known, the Commission will make "settle-up" adjustments in rates to correct for any error in forecasting.

Future reports will allow for a more comprehensive analysis by utilizing a full year of actual data. The HSCRC will continue to coordinate with DHMH to establish a more efficient and effective means of estimating averted bad debt resulting from the Medicaid expansion legislation, as well as determining the actual amount to be reconciled in hospital rates.

Sincerely,



Robert Murray
Executive Director

cc: Department of Legislative Services Library and Information Services (5 copies)
Senator Thomas Mac Middleton
Delegate Peter Hammen
Secretary John Colmers
Mr. Joseph Bryce (Governor's Legislative Office)
Ms. Marie Grant (DLS)
Ms. Linda Stahr (DLS)
Ms. Wynee Hawk (DHMH)

Appendix I

Estimate vs Actual Averted Bad Debt

Estimated for FY 2009, FY 2010, and FY 2011

		A Original Estimate FY 2009	B Revised Estimate FY 2009	C Revised Estimate FY 2010	D Revised Estimate FY 2011
1	Medicaid Total Expenditures	$95,170,624	$160,119,126	$324,422,100	$457,646,689
2	In State Payment Percent	94.00%	94.00%	94.00%	94.00%
3	In State Payments	$89,460,386	$150,511,978	$304,956,774	$430,187,888
4	Medicaid Payment Percent	94.00%	94.00%	94.00%	94.00%
5	Charges @ Hosp Payment Rate	$95,170,624	$160,119,126	$324,422,100	$457,646,689
6	Hospital Portion	61.00%	61.00%	54.00%	47.61%
7	Hospital Charges Reported	$58,054,080	$97,672,667	$175,187,934	$217,879,100
8	Crowd Out (28%)	72.00%	72.00%	72.00%	72.00%
9	Hospital Charges after Crowd	$41,798,938	$70,324,320	$126,135,312	$156,872,952
10	Lower Use Rate	82.00%	82.00%	82.00%	82.00%
11	**Averted Bad Debt**	**$34,275,129**	**$57,665,943**	**$103,430,956**	**$128,635,821**
12	Medicaid Expenditures for PAC	$0.00	$0.00	$0.00	$26,787,574
13	Hospital Charges after PAC				$155,423,395
14	Medicaid Payment Percent	94.00%	94.00%	94.00%	94.00%
15	Net Medicaid Payments	$32,218,621	$54,205,986	$97,225,099	$146,097,991
16	Percent Returned to Medicaid	75.00%	75.00%	92.61%	100.00%
17	Hospital Payments to Medicaid	$24,163,966	$40,654,489	$90,039,771	$146,097,991
18	**Difference**		**$16,490,523**		
19	Settle up Payment			**$16,490,523**	
20	Total Payments to Medicaid			$106,530,295	

Estimated Enrollees	29,273	55,000	69,773
Cost per Enrollee per member month	$511	$539	$546