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February 28, 2012

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 require 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.

Background

In 2007, the General Assembly enacted Chapter 7 of the Laws of Maryland, The Working Families and Small Business Health Coverage Act (The 2007 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 of the federal poverty guidelines (FPG), an increase from 46 percent FPG, to be implemented beginning in FY 2009;

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

- Establishes a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission.

Special funds, including savings from averted uncompensated care and federal matching funds, will cover a portion of the costs of the expansion. Chapters 244/245 of the Laws of Maryland were adopted in 2008 to require the Commission to implement a uniform assessment on hospital rates that reflects the aggregate reduction in hospital uncompensated care realized from the expansion of the Medicaid Program under The 2007 Act. To qualify for federal matching funds, Chapters 244/245 require the assessment to be broad-based, prospective, and uniform.[1] The 2008 legislation also requires the Commission to ensure that the assessment amount does not exceed the savings realized in averted uncompensated care from the health coverage expansion.

In conformance with The 2007 Act, Medicaid enrolled approximately 29,273 expansion population individuals in FY 2009. In FY 2010, expected enrollment in the Medicaid expansion grew to 50,500.

As described above, The 2007 Act also expands services to childless adults, contingent on available funding. Prior to implementation of this provision, the childless adult population received only primary care, pharmacy, and certain office and clinic-based mental health services through the PAC program. The Act intended to phase in specialty physician, emergency, and hospital services over a three-year period, to the extent that available funding exists. In accordance with Board of Public Works action in July of 2009, Medicaid added emergency services to the PAC benefit beginning January 1, 2010.

1 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 percent 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.

Hospital Uncompensated Care

Hospital Uncompensated Care (UCC) provisions in Maryland hospital rates are specific to each hospital and based on formulas and historical data. Thus, the amount a hospital receives in its rate base varies year by year based on the Commission's UCC policy and formula. Commission staff calculate and release the UCC policy results every year, usually in May or June. The prospective amount established for each hospital for the upcoming year is a blend of a hospital's three year average actual UCC and a predicted amount calculated by means of a linear regression model. In a final UCC calculation step, Commission staff applies a revenue neutrality adjustment to adjust each hospital's calculated UCC percentage to align with the last year's statewide average UCC percentage. See Table 1 for an example of the UCC policy calculation.

Table 1: Example of the HSCRC's Uncompensated Care Policy with Results

Policy Steps		**Example of FY 2008 UCC for a Hospital**	
Step 1	For each hospital, calculate the three year moving average of actual UCC	*Actual UCC* 2005: 6.25% 2006: 6.72% 2007: 7.15%	*Moving average* $\frac{(6.25\% + 6.72\% + 7.15\%)}{3} = 6.71\%$
Step 2	For each hospital, use a linear regression model to determine the predicted UCC	*Regression predicted UCC value for hospital:* 7.05%	
Step 3	50/50 blend the results from Step 1 and Step 2	*50/50 blend of past actual and regression prediction:* $(6.71\% + 7.05\%)/2 = 6.88\%$	
Step 4	Apply revenue neutrality adjustment to align each hospital with the most recent year's statewide actual UCC	*Statewide UCC 2007: 7.30%* *Statewide Step 3 blended (all hospitals): 7.15%* *Statewide revenue neutrality adjustment percentage:* $7.30\% / 7.15\% = 1.02\%$ *Hospital UCC adjusted for revenue neutrality:* $6.88\% * 1.02\% = 7.02\%$	
Result	**HSCRC applies the hospital-specific FY 2008 UCC policy result of 7.02% to FY 2009 rates for that hospital.**		

Because Commission staff calculate the policy result (UCC provision for each hospital) prospectively based partially on historical data, there is always a slight discrepancy (by design) between actual UCC experienced by hospitals and the UCC provision in rates per HSCRC policy. This lag, which stabilizes the UCC across time, also results in UCC being slightly underfunded when the actual number of uninsured is increasing over time, and UCC being overfunded when the actual number of uninsured is decreasing over time (e.g., during periods of economic prosperity, systematic changes to increase coverage such as small group health insurance reform or implementation of the Maryland Children's Health Insurance Program).

Determination of the Averted Bad Debt Assessment Amount

As discussed in the Background section above, Chapters 244/245 from 2008 require the Commission to implement a uniform assessment on hospital rates. The assessment is required to reflect the aggregate reduction in hospital uncompensated care that will be realized from the expansion of the Medicaid Program under The 2007 Act.

Beginning in FY 2009, each year, the Commission works with the Department of Health and Mental Hygiene ("DHMH") to arrive at a total amount of bad debt that is expected to be averted during the upcoming fiscal year as a result of the Medicaid expansion. DHMH provides the HSCRC with expected enrollment, per member/per month costs, and total expenditures. Commission staff then adjusts the expected total Medicaid expansion expenditure amount to reflect:

- Out-of-State Admissions – This represents the percentage of expenditures expected to be made at hospitals in Maryland versus out of state. Using a three-year average from Medicaid claims data, the percentage applied to the estimated total Medicaid expansion expenditure is 94 percent;
- The Hospital Portion – This is the estimated percentage of Medicaid expansion expenditures that would accrue to hospitals (as opposed to other providers or service components). This percentage was calculated based on Medicaid HealthChoice reimbursement data which categorizes payment rates by hospital, drug, and other components;
- Crowd out – This estimates the share of Medicaid expansion spending that is directed to individuals who previously had private health care coverage. Based on available literature at the time, the Commission and the Department agreed to 28 percent as a reasonable crowd out adjustment for the FY 2010 prospective calculation of the assessment amount.
- Lower Use Rate - Literature indicates that uninsured enrollees tend to use hospital services at a lower rate than newly enrolled individuals. Individuals moving from having no insurance to having Medicaid coverage have a "pent up demand" that is evidenced by increased use of hospital services. Based on the literature review at the initiation of this policy, HSCRC and Department staff determined that 82 percent is a reasonable estimate for a lower use rate.

The product of this calculation results in a total amount that is differentially removed from the uncompensated care amounts across all hospitals for that year. The amount removed for each hospital is based on the proportion of Medicaid's expenditures for this type of population at each hospital. In FY 2009, HSCRC staff used Medicaid claims and encounter data for specific Medicaid populations by hospital as proxy for the expansion experience.

Since the assessment is required to be uniform and broad-based, the Commission adds back to the rates of all hospitals an equal percentage that represents the total estimated averted bad debt amount. Any portion that is not added back to rates will reduce rates overall, resulting in savings to purchasers/payers of hospital care.

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

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 out-of state admissions, the hospital portion, crowd out, and lower use rate. After these adjustments, the estimated hospital averted bad debt from Medicaid expansion in FY 2009 was calculated to be $34.3 million (See Appendix I).

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 Appendix I). 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 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 was estimated that the amount of averted bad debt in FY 2009 was $16.5 million greater than originally expected (See Appendix I). This amount was 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 50,500 and a per member/per month cost of $535.35. The total expected Medicaid expenditures for this population is $324.4 million. After making the aforementioned adjustments, 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. Table 2 illustrates the calculations used for establishing the expected averted bad debt and assessment amount for FY 2010.

Table 2: Medicaid Expansion FY 2010 Expected Averted Bad Debt Calculations

Calculation of Estimated Reduction to Hospital Uncompensated Care	
DHMH Estimated Expansion Expenditures	
Amount per Enrollee per Month	$535.35
Estimated Number of Enrollees	50,500
DHMH Estimated Total Expansion Expenditures	$324.4 million
Less: Payments Made Outside of Maryland (-6%)	-$19.5 million
Payments Made Inside of Maryland	$305.0 million
Percent Paid to Maryland Hospitals (54%)	$164.7 million
Hospital Gross Charges (Medicaid pays 94% of Charges)	$175.2 million
Crowd Out (-28%) and Lower Use Rate (-18%)	-$71.8 million
*Estimated Reduction to Hospital Rates for Uncompensated Care**	$103.4 million
Calculation of Payment Made to DHMH	
Estimated Reduction to Hospital Rates for Uncompensated Care	$103.4 million
Savings Provided to Payer (-7.39%)	$95.8 million
*Amount Paid to Medicaid (94%)***	**$90.0 million**

Notes: *Numbers in table may not sum due to rounding*

* A portion of this amount was allocated to each hospital based on the percentage of current Medicaid payments made to the hospital for this type of population. The allocated amount for each hospital was used to calculate a percent of revenue which was then used to reduce each hospital's approved UCC. The reduced UCC was used in each hospital's calculation of approved markup, and Approved Revenue was reduced accordingly.

** A portion of this amount was uniformly allocated to each hospital based on its estimated Approved Revenue for FY 2010. Each hospital made monthly payments to DHMH throughout the year.

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. The PAC expansion for emergency services required a $8.7 million adjustment to the initial FY 2010 uniform assessment. However, HSCRC staff made no additional reduction to hospital UCC in rates for PAC for FY 2010.

Additionally, the $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

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 were no savings to purchasers of hospital care in FY 20011 (See Appendix I).

FY 12 Averted Bad Debt Assessment and FY 2010 Reconciliation

The FY 12 averted bad debt assessment includes two components: (1) the expected FY 12 averted bad debt amount, and (2) an adjustment for the reconciliation of FY 2010 averted bad debt amounts.

FY 2010 Reconciliation

In the fall of 2011, the Commission conducted a study to reconcile FY 2010 averted bad debt amounts and to consider changes to the adjustments. The reconciliation process is designed to determine the amount that hospitals actually received in payments for the Medicaid expansion population and to calculate the resulting reduction to UCC from the Medicaid expansion. HSCRC staff compared this UCC reduction to the amount that the HSCRC prospectively removed from the UCC component of each hospital's rate, minus any expected savings to purchasers/payers of care, to determine any discrepancies between the estimated and actual amounts.

Ideally, HSCRC staff could rapidly ascertain the actual payments for the Medicaid expansion population using one data source. Unfortunately, no one data source provides all information needed for this calculation. Instead, DHMH, HSCRC, and hospital staff worked together to supply, compare, and merge data from three major sources. This merging process has proven challenging for all involved.

Once HSCRC staff finalized the encounter data reconciliation process, Commission staff summed total charges for the Medicaid expansion population for each hospital. HSCRC staff then calculated the actual UCC by applying the crowd out and lower use rate estimates to these total charges. In practice, however, there is a continued amount of estimation involved in the calculation as the crowd out and lower use rates applied to the total charges are themselves estimates.

Crowd Out and Lower Use Rate Factors

In 2009, when DHMH and Commission staffs were considering the averted bad debt methodology, there was significant discussion regarding the most appropriate crowd out assumption. While all agreed that the HSCRC should apply crowd out and lower use rate factors, the most appropriate magnitude of the factors was not clear. DHMH and the Commission reviewed available literature regarding crowd out and determined that 28 percent was reasonable

and appropriate. The group also agreed to an 18 percent lower use rate. HSCRC staff prospectively applied these adjustment factors to calculate projected averted bad debt.

In September of 2011, HSCRC staff further engaged in discussions with DHMH, hospital, and payer representatives to discuss averted bad debt for FY 2010. When applied to the total hospital charges to Medicaid due to the expansion, the crowd out and lower use rate estimates significantly impact the final calculation of overpayments/underpayments to DHMH. To determine the most appropriate crowd out and lower use rate adjustment factors, HSCRC staff engaged stakeholders in a process which included discussions with the individual parties, independent literature research, review of research provided by DHMH, and the facilitation of two in-person meetings among the interested parties.

Based on the review of MHA data provided to HSCRC staff by DHMH, HSCRC staff recommended lowering the crowd out rate in the FY 2010 actual averted bad debt calculation from 28 percent to 18.22 percent. The MHA data from FY 2009 demonstrated that 10.65 percent of a large sample of the Medicaid expansion population receiving hospital services had commercial insurance in the previous year. While this does not completely address crowd out, in the absence of other data, the HSCRC staff accept this number as a proxy for commercial crowd out among the expansion population.

However, HSCRC staff also recognized that a portion of the population enrolled in Medicaid the previous year is eligible for Medicaid only due to their falling into what is known as the "spend-down" eligibility category. Individuals in a spend-down eligibility category may or may not qualify for Medicaid outside of the limited spend-down period. Therefore, HSCRC staff allocated a portion of the Medicaid spend-down population as "crowd out" for purposes of calculating actual averted bad debt. Including the spend-down population with the commercial crowd out proxy increases the crowd out rate to 18.22 percent.

HSCRC staff also discussed the lower use rate with the participating parties. However, HSCRC recommended maintaining the lower use rate at 18 percent. DHMH staff made a logical argument that the lower use rate should decrease based on overall expenditure trends. However, the supporting data provided by DHMH did not provide HSCRC staff a reduction amount to apply to our calculations. The Commission suggested that DHMH continue to refine data extracts to better quantify the most appropriate lower use rate for FY 2011.

As shown in Table 3, for FY 2010, the encounter data reconciliation process identified $125.5 million in total hospital charges associated with the Medicaid expansion. Appling the crowd out rate (18.22 percent) and lower use rate (18 percent), HSCRC staff calculated the actual reduction to bad debt as $84.2 million. The net aggregate difference in what was paid by hospitals to DHMH in the form of a uniform assessment, and the amount paid by DHMH to hospitals for this population was $10.9 million.

Since the assessment was applied as a uniform percentage of revenue, the Commission also calculated the difference in the assessment amount and the actual amount of Medicaid payments for the expansion population. The Commission then adjusted the uncompensated care provision of hospitals to reflect this difference.

Table 3: Medicaid Expansion FY 2010 Reconciliation of Actual Averted Bad Debt

Calculation of Actual Averted Bad Debt	
Actual Reduction to Hospital Rates for Uncompensated Care*	$104.7 million
Total Hospital Charges to Medicaid Due to Expansion	$125.5 million
Reduced for Crowd Out (-18.22%) and Lower Use Rate (-18%)	
Actual Reduction to Uncompensated Care Due to Expansion	*$84.2 million*
Calculation of Overpayment/Underpayment to DHMH	
Actual Reduction to Uncompensated Care Due to Expansion	$84.2 million
Amount Paid by Medicaid to Hospitals (94%)	$79.1 million
Amount Paid to Medicaid by Hospitals	$90.0 million
Difference	***$10.9 million***

Notes: *Numbers in table may not sum due to rounding*

* The actual reduction to hospital rates for UCC ($104.7 million), calculated retrospectively, differs from the estimated reduction to hospital rates for UCC in Table 2 ($103.4 million), calculated prospectively.

During its October 2011 Commission meeting, the Commission chose to include the expected averted bad debt amount in FY 2012 rates, but required hospitals to pay a reduced assessment amount to DHMH to reconcile the calculated overpayment of $10.9 million.

FY 12 Expected Averted Bad Debt Assessment

During the 2011 Session of the General Assembly, Chapter 397 (the Budget Reconciliation and Financing Act of 2011) was enacted and included a provision to establish the averted bad debt assessment at 1.25% of projected regulated net patient revenue. This would keep the Commission from having to continue to conduct the averted bad debt assessment calculation as done over the past few years. The projected regulated net patient revenue for FY 2012 is $12.6 billion. Therefore, the averted bad debt assessment for FY is $157.7 million. The amount was almost identical to the expected averted bad debt amount after applying the calculation used in prior fiscal years.

Table 4: Averted Bad Debt Assessment Amounts, FY 2009 - FY 2011
(Dollars in Millions)

	Original Estimate FY 2009	Revised Estimate FY 2009	Estimate FY 2010	Estimate FY 2011
Estimated Medicaid Total Expenditures	$95.2	$160.1	$324.4	$457.6
In State Payment Percent In State Payments	94% $89.5	94% $150.5	94% $305.0	94% $430.2
Medicaid Payment Percent Charges at Payment Rate	94% $95.2	94% $160.1	94% $324.4	94% $457.6
Hospital Portion Hospital Charges Reported	61% $58.1	61% $97.7	54% $175.2	47.61% $217.9
Crowd Out (28%) Charges after Crowd Out	72% $41.8	72% $70.3	72% $126.1	72% $156.9
Lower Use Rate Estimated Medicaid Averted Bad Debt	82% $34.3	82% $57.7	82% $103.4	82% $128.6
Estimated PAC Averted Bad Debt	$0	$0	$0	$26.8
Hospital Charges including Medicaid Expansion and PAC	$34.3	$57.7	$103.4	$155.4
Medicaid Payment Percent Net Medicaid Payments	94% $32.2	94% $54.2	94% $97.2	94% $146.1
% Returned to Medicaid Hospital Payments to Medicaid	75% $24.2	75% $40.7	92.61% $90.0	100% $146.1
Total Payments to Medicaid		**$40.7**	**$90.0**	**$146. 1**

Estimate Enrollees	29,273	55,000	69,773
Cost Per Member per Month	$511	$539	$546

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. Table 4 above illustrates the amount of averted bad debt that has occurred since the program began.

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. Settle-ups have been made for both FY 2009 and FY 2010. The Commission will use the process outlined in this report to determine whether a settle-up is necessary for FY 2011. Beyond 2011, aggregate settle-ups will no longer be necessary since the averted bad debt amount will be based on 1.25% of expected net patient revenue rather than actual (or calculated) averted bad debt.

Sincerely,

D. Patrick Redmon, Ph.D.
Executive Director

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