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January 1, 2015

The Honorable Martin O'Malley
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-101 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-107 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, 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 resulting from the health coverage expansion.

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.

In conformance with The 2007 Act, Medicaid enrolled approximately 29,273 expansion population individuals in FY 2009. In FY 2014, enrollment under the Medicaid parent expansion is expected to grow to over 107,000, while PAC is expected to grow to over 90,000.

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

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.

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 existed. In accordance with Board of Public Works action in July of 2009, Medicaid added emergency services to the PAC benefit beginning January 1, 2010. Beginning January 1, 2014, under the Patient Protection and Affordable Care Act of 2010, PAC enrollees will be eligible for both inpatient and outpatient services under the Medicaid 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 was 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.

During FYs 2009 through 2011, the Commission worked with the Department of Health and Mental Hygiene ("DHMH") to arrive at a total amount of bad debt that was expected to be averted during the upcoming fiscal year as a result of the Medicaid expansion. DHMH provided the HSCRC with expected enrollment, per member/per month costs, and total expenditures. Commission staff then adjusted the expected total Medicaid expansion expenditure amount to reflect:

- Out-of-State Admissions
- The Hospital Portion
- Crowd-out
- Lower Use Rate

The product of this calculation resulted in a total amount that was differentially removed from the uncompensated care amounts across all hospitals for that year. The amount removed for each hospital was 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 added 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.

A reconciliation process was designed to determine the amount that hospitals actually received in payments for the Medicaid expansion population and PAC emergency department service coverage expansion, and to calculate the resulting reduction to UCC from these programs. HSCRC staff compares this UCC reduction to the amount that the HSCRC prospectively removed from the UCC component of each hospital's rates to determine any discrepancies between the estimated and actual amounts.

FY 2009 - 2011 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

In 2009 and 2010, this methodology resulted in an averted bad debt amount of $34.3 million and $115.3 million, respectively. This was based on enrollment increasing from 29,000 to 50,000 during that time period.

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 was $457.6 million. After making the same adjustments made in FY 2009 and 2010, the total expected hospital averted bad debt in FY 2011 was $155.4 million, which included $128.6 million for the Medicaid Expansion, plus $26.8 million for the PAC program. The uniform assessment for FY 2011 was $146.1 million (adjusted for the conversion of hospital charges to Medicaid payments). There were no savings to purchasers of hospital care in FY 2011.

FY 12 Averted Bad Debt Assessment and FY 2010 Reconciliation

FY 2012 was the first year in which the assessment was a fixed percentage (1.25%) built into rates. The FY 2012 averted bad debt assessment includes two components: (1) the expected FY 2012 averted bad debt amount; and (2) an adjustment for the reconciliation of FY 2010 averted bad debt amounts.

The total assessment amount for the combined Medicaid/PAC expansion for FY2012 was $157.7 million. However, the Commission determined that hospitals overpaid Medicaid in FY 2010 by $10.9 million. That amount was applied to reduce the FY 2012 assessments.

The average monthly enrollment for the adult expansion population for FY12 was 89,964 and for PAC was 63,453. The per member per month costs for the adult expansion population were $494.71, and $337.27 for the PAC population.

FY 13 Averted Bad Debt Assessment and FY 2011 Reconciliation

In FY 20113, the 1.25% assessment resulted in an averted bad debt amount of $154.8 million. However, after making adjustments to the “crowd out” and “lower use rate” calculations, it was determined that Medicaid was overpaid in FY 2011 by $18.1 million.

In FY 2013, there was a monthly average of 101,448 enrollees under the traditional expansion population and 75,886 PAC enrollees. The per-member per-month costs for the expansion population were $465.35 and $320.18 for the PAC population.

FY 2014 and FY 2015 Averted Bad Debt

The total net patient revenue that was projected in FY 2014 was $12.7 billion. As a result, the amount distributed to the Health Care Coverage Fund in FY 2014 was $158.6 million. The expected NPR for FY 2015 is $13.1 million yielding $164.3 million to fund from hospital rates.

In FY 2014 there were 108,743 individuals enrolled under the parent expansion as a result of the 2008 legislation. The per-member per-month cost of these individuals was $471.22, and those

costs for the PAC population were $268.83 (from July through December 2013 since PAC ended on December 31, 2013).

Summary of Averted Bad Debt and Enrollment – 2009-2015

The table below summarizes the averted bed debt amounts and the enrollment growth in the expansion population from 2009 through 2015.

Averted Bad Debt Amounts and (Non-PAC) Expansion Enrollment – FY 2009-2015

Fiscal Year	Averted Bad Debt Amount	Average Enrollment	Notes
2009	$34.3 million	29,273	
2010	$115.3 million	50,000	Includes $25.2 million for Primary Adult Care Program enrollees
2011	$146.1 million	69,773	$26.8M for the PAC expansion
2012	$157.7 million	89,964	1.25% was set in statute and the $157.7M was reduced by $10.9M due to overpayment in FY10
2013	$154.8 million	101,448	$154M was reduced by $18Min overpayment from FY11 ($1.7M was added for budget purposes)
2014	$158.6 million	108,058	
2015	$164.3 million	108,000*	

*estimated

Conclusion

The Commission appreciates 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.

Beginning January 1, 2014, the Affordable Care Act expanded coverage to approximately, 300,000 individuals. The Commission conducted an analysis, within the confines of available data, to determine the impact that this may have on hospital uncompensated care. We focused our initial effort on quantifying the projected impact of expanded coverage for the PAC enrollees. As a result, the Commission reduced hospital rates in FY 2015by about 1% or $160 million to reflect this shift from uncompensated care to full coverage. The Commission is expanding its analysis to determine the impact that expanded coverage for other newly eligible Medicaid enrollees will have on uncompensated care including any increases in uncompensated care that may result from higher copays and deductibles, and shifts from inpatient to outpatient services.

Sincerely,

Donna Kinzer

Donna Kinzer
Executive Director