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January 1, 2017

The Honorable Lawrence J. Hogan, Jr.
Governor of Maryland
State House
Annapolis, Maryland 21401

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

The Honorable Michael E. Busch
Speaker of the House
State House
Annapolis, MD 21401-1991

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

Dear Governor Hogan, President Miller, and Speaker Busch:

Pursuant to Section 19-214(e) of the Health General Article (as enacted in Chapter 245 of the 2008 Laws of Maryland, House Bill 1587), the Maryland Health Services Cost Review Commission submits this report on (1) the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 General Assembly Special Session; and (2) 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 their hospital inpatient care.

If you have any questions regarding this report, please contact Katie Wunderlich at 410-764-2591 or at Katie.Wunderlich@maryland.gov.

Sincerely,

Donna Kinzer
Executive Director

Averted Bad Debt Legislative Report

January 1, 2017

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This report is hereby submitted to Governor Lawrence J. Hogan, Jr.,
President of the Senate Thomas V. Mike Miller, Jr., and Speaker of the House Michael E. Busch.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
Commission	Health Services Cost Review Commission
DHMH	Maryland Department of Health and Mental Hygiene
FPL	Federal poverty level
FY	Fiscal year
HB	House bill
HSCRC	Health Services Cost Review Commission
NPR	Net patient revenue
PAC	Primary adult care
PMPM	Per member per month
SB	Senate bill

INTRODUCTION

Section 19-214(e) of the Health-General Article (as enacted in Chapter 245 of the Acts of 2008, House Bill (HB) 1587) requires the Maryland Health Services Cost Review Commission (HSCRC or Commission) to submit an annual report on the following information:

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

In accordance with this requirement, the HSCRC submits this report to the Governor and the Maryland General Assembly.

BACKGROUND

In 2007, the Maryland General Assembly enacted Chapter 7 of the Acts of 2007 (Senate Bill (SB) 6), The Working Families and Small Business Health Coverage Act (the 2007 Act), which expanded access to health care coverage for Maryland residents in the following ways:

- Beginning in fiscal year (FY) 2009, expanded Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent of the federal poverty level (FPL), an increase from approximately 46 percent of the FPL.
- Contingent on available funding, incrementally expanded the Primary Adult Care (PAC) program benefit over three years, to be phased in from FY 2010 through FY 2013. PAC offered limited benefits to childless adults with household income up to 116 percent of the FPL.
- Established 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 these expansions. Chapters 244 and 245 of the Acts of 2008 (SB 974 and HB 1587) 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/PAC programs under the 2007 Act. To qualify for federal matching funds, Chapters 244 and 245 require the assessment to be broad-based, prospective, and uniform.[1] The 2008 legislation requires the Commission to ensure that the assessment amount does not exceed

[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, must be broad-based and uniform, and may not hold providers harmless. A uniform tax is one that is imposed at the same rate on all providers.

the savings realized in averted uncompensated care resulting from the health coverage expansion.

In conformance with the 2007 Act, Medicaid enrolled approximately 29,273 participants in the expansion in FY 2009. Enrollment in both the Medicaid parent expansion and PAC grew steadily since that time.

During the 2011 session, the Maryland General Assembly enacted Chapter 397 (HB 72), the Budget Reconciliation and Financing Act of 2011, which established an averted bad debt assessment at 1.25 percent of projected regulated net patient revenue (NPR).

The 2007 Act also expanded services covered under the PAC program for childless adults, contingent on available funding. Prior to implementation of this provision, PAC only covered primary care, pharmacy, and certain office and clinic-based mental health services. The 2007 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 outpatient emergency department services to the PAC benefit beginning on January 1, 2010. Beginning on January 1, 2014, PAC enrollees became eligible for full Medicaid benefits—including both hospital inpatient and outpatient services—under the Affordable Care Act (ACA) Medicaid expansion. In FY 2014, enrollment under the pre-ACA Medicaid parent expansion grew to over 107,000, while PAC enrollment grew to over 90,000. Below is a historical account of how the averted bad debt amount was implemented through hospital rates, as well as an explanation of the calculation of the averted bad debt amount and the number of enrollees in each year.

ASSESSMENT

Determination of the Averted Bad Debt Assessment Amount

As discussed above, Chapters 244 and 245 of the Acts of 2008 require the Commission to implement a uniform assessment on hospital rates. The assessment must reflect the aggregate reduction in hospital uncompensated care realized from the expansion of the Medicaid/PAC programs under the 2007 Act.

During FYs 2009 through 2011, the Commission worked with the Maryland 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 parent/PAC expansion. DHMH provided the HSCRC with expected enrollment, per member per month (PMPM) costs, and total expenditures. Commission staff then adjusted the expected total Medicaid expansion expenditure amount to reflect:

- Out-of-State Admissions – This represents the percentage of Medicaid expenditures expected to be made at hospitals in Maryland compared to those made 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 literature available at the time, the Commission and the DHMH agreed that 28 percent was a reasonable adjustment for crowd-out during the FY 2010 prospective calculation of the assessment amount.
- Lower Use Rate – Literature indicates that uninsured individuals tend to use hospital services at a lower rate than newly enrolled participants. When uninsured individuals newly gain Medicaid coverage, they may 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 DHMH staff determined that 82 percent is a reasonable estimate for a lower use rate.

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

Because 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.

The HSCRC reconciles the amount that hospitals actually received in payments for the Medicaid parent expansion population and the PAC emergency department service coverage expansion with the resulting reduction to uncompensated care from these programs. HSCRC staff compared this uncompensated care reduction to the amount that the HSCRC prospectively removed from the uncompensated care component of each hospital's rates in order to determine any discrepancies between the estimated and actual amounts.

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

In FYs 2009 and 2010, the above-described methodology resulted in averted bad debt amounts of $34.3 million and $115.3 million, respectively. This was based on PAC and parent expansion enrollment increasing from 29,000 to 50,000 during that time period.

The FY 2011 assessment was based on an anticipated average parent/ PAC enrollment of 69,773 and a PMPM cost of $546. The total expected Medicaid expenditures for this population were $457.6 million. After making the same adjustments made in FYs 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 parent 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 payers/purchasers of hospital care in FY 2011.

FY 2012 Averted Bad Debt Assessment and FY 2010 Reconciliation

FY 2012 was the first year in which the assessment was a fixed percentage (1.25 percent) built into rates. The FY 2012 averted bad debt assessment included 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 parent/PAC expansion for FY 2012 was $157.7 million. However, the Commission determined that hospitals overpaid Medicaid in FY 2010 by $10.9 million; this amount was applied to reduce the FY 2012 assessments.

The average monthly enrollment for the Medicaid parent expansion population for FY 2012 was 89,964; the average monthly PAC enrollment was 63,453. The PMPM cost was $494.71 for the Medicaid parent expansion population and $337.27 for the PAC population.

FY 2013 Averted Bad Debt Assessment and FY 2011 Reconciliation

In FY 2013, the 1.25 percent 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 by $18.1 million in FY 2011.

In FY 2013, the average Medicaid parent expansion enrollment was 101,448, and the average PAC enrollment was 75,886. The PMPM cost was $465.35 for the Medicaid parent expansion population and $320.18 for the PAC population.

FY 2014 – 2017 Averted Bad Debt

The total projected NPR for 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 was $13.1 billion, yielding $164.3 million for averted bad debt from hospital rates. The FY 2016 NPR is projected to be $13.2 billion, so the averted bad debt amount included in rates was $165.2 million. In FY 2014, 108,743 individuals were enrolled under the Medicaid parent expansion as a result of the 2008 legislation. The PMPM cost of these individuals was $471.22, and the PMPM cost for the PAC population was $268.83 (calculated from July through December 2013 because PAC ended on December 31, 2013). In FY 2015, the PMPM cost for the 112,822 Medicaid parent expansion enrollees increased to $475.81. In FY 2016, the average enrollment was 108,863 with a PMPM cost of $500.62. The expected average enrollment for FY 2017 is 117,463.

Summary of Averted Bad Debt and Enrollment: FY 2009 – 2017

The table below summarizes the averted bad debt amounts and the enrollment growth in the Medicaid parent expansion population from FY 2009 through 2017.

Table 1. Averted Bad Debt Amounts and (Non-PAC) Medicaid Parent Expansion Enrollment: FY 2009 – 2017

Fiscal Year	Averted Bad Debt Amount (in Millions)	Average Medicaid Parent Expansion Enrollment	Notes
2009	$34.3	29,273	
2010	$115.3	50,000*	Includes $25.2 million for PAC enrollees
2011	$146.1	69,773	$26.8 million for the PAC expansion
2012	$157.7	89,964	1.25% was set in statute, and the $157.7 million was reduced by $10.9 million due to overpayment in FY 2010
2013	$154.8	101,448	$154 million was reduced by $18 million in overpayment from FY 2011 ($1.7 million was added for budget purposes)
2014	$158.6	108,058	
2015	$164.3	112,822	
2016	$165.2	108,863	
2017	$176.6	117,463*	

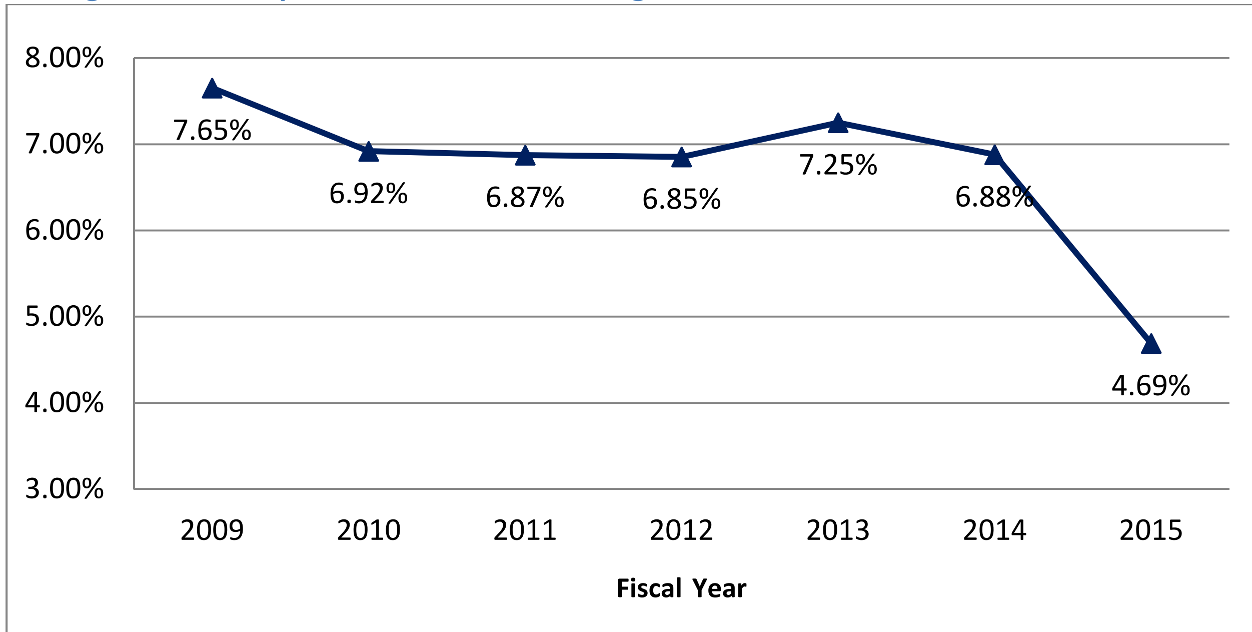
*estimated

CONCLUSION

As a result of the 2007 Act, more than 100,000 individuals enrolled in the parent expansion, and more than $175 million was distributed to the Medicaid program from hospital rates to reflect the resulting reductions in hospital uncompensated care. With the implementation of the ACA, there were additional reductions to uncompensated care beginning in FY 2015. As a result, there has been a significant decline in the amount of uncompensated care at hospitals.

Figure 1 shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2009 and FY 2015. Over the past three fiscal years, hospitals' uncompensated care costs declined by 2.55 percentage points, a reduction of approximately $311 million in unpaid hospital charges. The declines ranged from -0.42 to -14.16 percentage points across Maryland hospitals. Hospital specific trends are provided in Appendix I.

Figure 1. Uncompensated Care as Percentage of Gross Patient Revenue, FY 2009-2015



Source: Hospital Annual Financial Audited Cost Reports, RE Schedule

The HSCRC will continue to monitor how various Medicaid expansion and other ACA provisions impact the amount of uncompensated care paid by purchasers through hospital rates.

APPENDIX I. HOSPITAL UNCOMPENSATED CARE TRENDS (HOSPITAL AUDITED FINANCIAL COST REPORTS RE SCHEDULE)

Appendix I. UCC Trends by Hospital, FY 2013-2015

	% Bad Debt and Charity (% UCC)			The Difference from FY 2013	
Hospital Name	FY 2013	FY 2014	FY 2015	FY 2014	FY 2015
ANNE ARUNDEL	5.21%	5.06%	3.04%	-0.15%	-2.17%
ATLANTIC GENERAL	7.68%	6.98%	4.58%	-0.70%	-3.10%
BON SECOURS	18.12%	14.58%	3.96%	-3.54%	-14.16%
CALVERT	6.16%	6.53%	3.34%	0.37%	-2.82%
CARROLL COUNTY	4.70%	4.44%	2.15%	-0.26%	-2.54%
DOCTORS COMMUNITY	9.29%	9.49%	7.28%	0.20%	-2.01%
FORT WASHINGTON	13.63%	10.85%	8.73%	-2.77%	-4.90%
FREDERICK MEMORIAL	6.03%	6.72%	3.39%	0.69%	-2.64%
GARRETT COUNTY	10.86%	9.27%	8.25%	-1.58%	-2.61%
GBMC	3.12%	3.38%	2.48%	0.26%	-0.64%
HOLY CROSS	9.26%	8.78%	8.05%	-0.48%	-1.21%
HOLY CROSS GERMANTOWN			9.57%		
HOWARD COUNTY	5.99%	5.66%	4.14%	-0.33%	-1.85%
JOHNS HOPKINS	4.27%	4.16%	2.25%	-0.10%	-2.02%
JOHNS HOPKINS BAYVIEW	9.28%	8.82%	6.49%	-0.46%	-2.80%
LAUREL REGIONAL	14.23%	11.16%	8.81%	-3.07%	-5.43%
LEVINDALE			4.11%		
MCCREADY	8.32%	8.49%	7.62%	0.17%	-0.70%
MEDSTAR FRANKLIN SQUARE	7.06%	5.93%	4.10%	-1.13%	-2.96%
MEDSTAR GOOD SAMARITAN	6.60%	6.12%	4.02%	-0.48%	-2.59%
MEDSTAR HARBOR HOSPITAL	8.59%	6.04%	5.00%	-2.55%	-3.59%
MEDSTAR MONTGOMERY GENERAL	6.59%	5.44%	4.76%	-1.15%	-1.83%
MEDSTAR SOUTHERN MARYLAND	6.84%	8.25%	5.72%	1.41%	-1.12%
MEDSTAR ST. MARY'S	8.47%	5.49%	5.35%	-2.98%	-3.12%
MEDSTAR UNION MEMORIAL	8.13%	5.58%	3.53%	-2.56%	-4.60%
MERCY	8.29%	8.07%	6.44%	-0.22%	-1.85%
MERITUS	7.20%	7.39%	4.59%	0.20%	-2.61%
NORTHWEST	8.41%	7.76%	6.39%	-0.65%	-2.02%
PENINSULA REGIONAL	6.87%	5.94%	3.72%	-0.92%	-3.15%
PRINCE GEORGE	15.51%	13.05%	9.24%	-2.46%	-6.26%
SHADY GROVE	6.76%	7.68%	4.79%	0.92%	-1.97%
SINAI	5.41%	6.09%	4.20%	0.67%	-1.22%

	% Bad Debt and Charity (% UCC)			The Difference from FY 2013		
Hospital Name	**FY 2013**	**FY 2014**	**FY 2015**		**FY 2014**	**FY 2015**
ST. AGNES	7.96%	6.17%	4.99%		-1.78%	-2.97%
SUBURBAN	5.07%	4.35%	3.97%		-0.72%	-1.10%
UM-BWMC	9.78%	10.63%	5.82%		0.85%	-3.96%
UM-CHARLES REGIONAL	7.46%	7.52%	6.81%		0.06%	-0.65%
UM-CHESTERTOWN	10.13%	10.16%	6.62%		0.02%	-3.52%
UM-DORCHESTER	6.99%	9.33%	6.57%		2.34%	-0.42%
UM-EASTON	5.86%	6.32%	5.34%		0.47%	-0.52%
UM-HARFORD MEMORIAL	12.44%	9.76%	8.94%		-2.68%	-3.50%
UMMC	5.40%	5.49%	2.75%		0.09%	-2.65%
UM-MIDTOWN	15.22%	15.08%	10.51%		-0.15%	-4.71%
UMROI	5.20%	7.13%	4.69%		1.94%	-0.51%
UM-ST. JOSEPH	5.13%	6.30%	4.09%		1.18%	-1.04%
UM-UPPER CHESAPEAKE	6.08%	5.23%	5.25%		-0.85%	-0.84%
UNION OF CECIL COUNTY	8.69%	7.73%	4.74%		-0.96%	-3.95%
WASHINGTON ADVENTIST	14.08%	12.20%	10.20%		-1.89%	-3.88%
WESTERN MARYLAND	6.89%	6.50%	4.83%		-0.39%	-2.06%
SHOCK TRAUMA	22.32%	20.06%	12.62%		-2.26%	-9.70%
GRAND TOTAL	**7.25%**	**6.88%**	**4.69%**		**-0.36%**	**-2.55%**