Health Services Cost Review Commission
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January 1, 2016

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 Steve Ports at 410-764-2591 or at steve.ports@maryland.gov.

Sincerely,

Donna Kinzer

Donna Kinzer
Executive Director

Averted Bad Debt Legislative Report

January 1, 2016

Health Services Cost Review Commission
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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.

INTRODUCTION

Section 19-214(e) of the Health General Article (as enacted in Chapter 245 of the 2008 Laws of Maryland, House Bill 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; 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."

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 Laws of Maryland, 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 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/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 also requires the Commission to ensure that the assessment

[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.

amount does not exceed the savings realized in averted uncompensated care resulting from the health coverage expansion.

During the 2011 session, the Maryland General Assembly enacted Chapter 397 (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).

In conformance with The 2007 Act, Medicaid enrolled approximately 29,273 expansion population individuals in FY 2009. Enrollment in both the Medicaid parent expansion and PAC grew steadily since that time. In FY 2014, enrollment under the Medicaid parent expansion grew to over 107,000, while PAC enrollment grew to over 90,000.

As described above, The 2007 Act also expanded services covered under the PAC program for 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 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, under the Affordable Care Act of 2010 (ACA), PAC enrollees became eligible for full Medicaid benefits, including both hospital inpatient and outpatient services.

Below is a historical account of how the averted bad debt amount was handled through hospital rates, as well as an explanation 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 in the Background section above, Chapters 244 and 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 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/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 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 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 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.

HSCRC designed a reconciliation process to determine the amount that hospitals actually received in payments for the Medicaid parent expansion population and the PAC emergency department service coverage expansion, and to calculate 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 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 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/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 – 2016 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 (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.

Summary of Averted Bad Debt and Enrollment: FY 2009 – 2016

The table below summarizes the averted bad debt amounts and the enrollment growth in the Medicaid parent expansion population from FY 2009 through 2016.

Table 1. Averted Bad Debt Amounts and (Non-PAC) Medicaid Parent Expansion Enrollment: FY 2009 – 2016

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	113,500*	

*estimated

CONCLUSION

As a result of the 2007 legislation more than 100,000 individuals were enrolled under the parent expansion and more than $150 million has been distributed to the Medicaid program from hospital rates to reflect reductions in hospital uncompensated care as a result of this expansion. With the implementation of the ACA, there were additional reductions to uncompensated care beginning in FY 2015

For FY 2015, the HSCRC adjusted the methodology discussed in this report to incorporate a prospective yet conservative adjustment for the expected impact of the ACA's Medicaid expansion on uncompensated care. The results of the historic trend and regression model were adjusted down from 7.23 percent to 6.14 percent to capture the expected impact of the State extending full Medicaid benefits to people previously enrolled in the PAC program. PAC offered limited health care coverage, including primary care, family planning, prescriptions, mental health care and addiction services, and outpatient hospital emergency department services. However, PAC did not reimburse hospitals for inpatient or outpatient care beyond the emergency department. In FY 2016, the uncompensated care provision was lowered again to 5.25 percent. Over these two years, approximately $300 million was removed from hospital rates as a result of the increase in coverage.