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January 17, 2014

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, 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 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 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

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.

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 – 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 categorize 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 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.

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, Maryland Medicaid, HSCRC, and hospital staff worked together in an iterative process to supply, compare, and merge data from three major sources.

As indicated above, Chapter 397 from 2011 included a provision to establish the averted bad debt assessment at 1.25% of projected regulated net patient revenue. With a fixed percentage built into rates, HSCRC staff is no longer required to reconcile expected to actual averted bad debt between the hospitals and Maryland Medicaid. However, the Maryland Hospital Association (MHA) and hospital representatives have expressed interest in continuing the claim-specific reconciliation for use in calculating the HSCRC's uncompensated care provision.

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 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 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 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 Assesment and FY 2011 Reconciliation

The assessment to be applied to FY 13 rates was determined by using 1.25% of projected net patient revenue for that year. Based on this calculation, the base assessment was determined to be $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 Averted Bad Debt

The Commission expects net patient revenue to be $12.7 billion in FY 2014. As a result, the amount distributed to the Health Care Coverage Fund over the course of FY 2014 will be $158.6 million.

Medicaid estimates that in FY 2014 there will be approximately 107,743 individuals enrolled under the parent expansion as a result of the 2008 legislation. The per-member per-month cost of these individuals is projected to be approximately $476.75, and those costs for the PAC population are projected to be $557.67.

Summary of Averted Bad Debt and Enrollment – 2009-2014

The table below summarizes the averted bed debt amounts and the enrollment growth in the expansion population from 2009 through 2014.

Averted Bad Debt Amounts and (Non-PAC) Expansion Enrollment – FY 2009-2014

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	107,743*	

*projected

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.

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 FY 2009, 2010, and 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,

Donna Kinzer
Executive Director

cc: Department of Legislative Services Library and Information Services (5 copies)
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Delegate Peter Hammen
Patrick Dooley, DHMH
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