STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Stephen Ports
Acting Executive Director

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

481st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 14, 2011

EXECUTIVE SESSION
9:30 a.m.

1. **Personnel and Waiver Issues**

2. **Comfort Order – Upper Chesapeake Medical Center**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:15 A.M.

1. **Review of the Executive Session and Public Meeting Minutes of August 11, 2011 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2114N – Adventist Behavioral Health
   2116N – Germantown Emergency Center
   2118N – Bowie Emergency Center
   2124A – Johns Hopkins Health System
   2126A – University of Maryland Medical Center
   2127A – University of Maryland Medical Center

4. **Docket Status – Cases Open**

   2128A – MedStar Health
   2129A – Johns Hopkins Health System
   2130N – Suburban Hospital

2131A – St. Agnes Health Care, Maryland General Hospital, Meritus Health, and Western Maryland Health System
2132A – University of Maryland Medical Center
2133A – MedStar Health
2134A – MedStar Health
2135A – Johns Hopkins Health System
2136A – University of Maryland Medical Center

5. **Final Recommendation on Residual Outlier Policy for Update Factor Scaling Based on Reasonableness of Charges (ROC) report beginning in FY 2013**

6. **Options for Reconciliation of FY 2010 Averted Bad Debt Estimates to Actual**

7. **Summary of the FY 2010 Disclosure of Financial and Statistical Data**

8. **Hearing and Meeting Schedule**

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2011**
	*****	**FOLIO:**	**1938**
COLUMBIA, MARYLAND	*****	**PROCEEDING:**	**2128A**

Draft Recommendation

September 14, 2011

I. Introduction

On July 26, 2011, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2080A for the period from January 1, 2011 through December 31, 2011. The Hospitals are requesting to renew this contract for one year beginning January 1, 2012.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. MedStar Family Choice pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MedStar Family Choice provides services to about 4% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2080A).

Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2010 and 2011 and preliminary projections for CY 2012. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY2010 was positive, and is expected to remain positive in CY 2011. Projections for CY 2012 will be available once Medicaid's rate setting process is finalized, and the final recommendation proposed to the Commission in October will reflect these projections.

IV. Recommendation

With the exception of FY 2009, MFC has continued to achieve favorable financial performance in recent years. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy, in that the MCO has been able to sustain reasonable profit margins. However, Staff will reevaluate MFC's projected CY 2012 financial status when Medicaid rates are finalized, and present final recommendations at the October Commission meeting.

Therefore:

(1) At the October Commission meeting, Staff will recommend approval of this alternative rate application for a one-year period beginning January 1, 2012, provided staff believes the arrangement will not result in sustained losses to the MCO.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to

monitor financial performance to determine whether favorable financial performance is achieved in CY 2012 and expected to be sustained into CY 2013. Staff recommends that MedStar Family Choice report to Commission staff (on or before the August 2012 meeting of the Commission) on the actual CY 2011 experience and preliminary CY 2012 financial performance (adjusted for seasonality) of the MCO as well as projections for CY 2013.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1939**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2129A**

Staff Recommendation

September 14, 2011

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on August 3, 2011 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2011.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System, DHMH, and CMS. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF EVALUATION

Staff found that the experience under this arrangement for FY 2011 was unfavorable. According to the program administrator, losses in FY 2011 were associated with several exceedingly complex cases, as well as the increased cost of providing assisted living services. However, in order to constrain costs, HEP has decided that beginning in September 2011 it will close its own assisted living facility and will utilize other assisted living facilities on a contractual basis.

III. STAFF RECOMMENDATION

Based on the initiatives being taken by HEP, staff recommends that the Commission: 1)

waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's renewal application for an alternative method of rate determination for one year beginning September 1, 2011. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document formalizes the understanding between the Commission and the Hospital, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*****	**COST REVIEW COMMISSION**
SUBURBAN HOSPITAL	*****	**DOCKET: 2011**
BETHESDA, MARYLAND	*****	**FOLIO: 1940**
	*****	**PROCEEDING: 2130N**

Staff Recommendation

September 14, 2011

Introduction

On August 8, 2011, Suburban Hospital (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Operating Room Clinic (ORC) services. The Hospital is requesting the lower of a per minute rate based on its costs and volumes, or a per minute rate based on the statewide median for this service.

Staff Evaluation

To determine if the Hospital's ORC rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all cost and statistical data for ORC services for FY 2011. Based on information received, it was determined that the ORC rate based on the Hospital's actual data would be $15.64 per minute, while the statewide median rate for ORC services is $12.51 per minute.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an ORC rate of $12.51 per minute be approved effective September 1, 2011;
3. That no change be made to the Hospital s charge per case standard for ORC services; and
4. That the ORC rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
MARYLAND GENERAL HOSPITAL	*****	**COMMISSION**	
SAINT AGNES HEALTH	*****	**DOCKET:**	**2011**
WESTERN MARYLAND HEALTH SYSTEM	*****	**FOLIO:**	**1941**
MERITUS HEALTH	*****	**PROCEEDING:**	**2131A**

Draft Recommendation

September 14, 2011

I. Introduction

On August 17, 2011, Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, and Meritus Health (the "Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2089A for the period January 1, 2011 through December 31, 2011. The Hospitals are requesting to renew this contract for one year beginning January 1, 2012.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, in return for a State-determined capitation payment. Maryland Physicians Care pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Maryland Physicians Care is a major participant in the Medicaid Health Choice program, and provides services to about 19.6% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2089A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2010 and 2011, and preliminary projections for CY 2012. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2010 was positive, and is expected to remain positive in CY 2011. Projections for CY 2012 will be available once Medicaid's rate setting process is finalized, and the final recommendation proposed to the Commission in October will reflect these projections.

IV. Recommendation

MPC has continued to maintain consistent favorable performance in recent years. Based on past performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission policy, in that the MCO has been able to sustain reasonable profit margins. However, Staff will reevaluate MPC's projected CY 2012 financial status when Medicaid rates are finalized, and present final recommendations at the October Commission meeting.

Therefore:

(1) At the October Commission meeting, Staff will recommend approval of this alternative rate application for a one-year period beginning January 1, 2012, provided staff believes the arrangement will not result in sustained losses to the MCO.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to

monitor financial performance to determine whether favorable financial performance is achieved in CY 2012 and expected to be sustained into CY 2013. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the August 2012 meeting of the Commission) on the actual CY 2011 experience and preliminary CY 2012 financial performance (adjusted for seasonality) of the MCO as well as projections for CY 2013.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2011**
MEDICAL CENTER	*****	**FOLIO:**	**1942**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2132A**

Staff Recommendation

September 14, 2011

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on August 22, 2011 requesting approval to continue participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2011.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; 2) approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2011. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2011**
	*	**FOLIO: 1943**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2133A**

Staff Recommendation

September 14, 2011

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on August 22, 2011 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning October 1, 2011.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing October 1, 2011. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2011**
	*	**FOLIO: 1944**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2134A**

Staff Recommendation

September 14, 2011

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on August 22, 2011 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2011.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; 2) approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2011. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2011**
	*	**FOLIO:**	**1945**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2135A**

Draft Recommendation

September 14, 2011

I. Introduction

On August 30, 2011 Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2081A for the period from January 1, 2011 through December 31, 2011. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2012.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services on a statewide basis and serving 27% of the State's MCO population.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2081A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff has analyzed Priority Partner's financial history, net income projections for CY 2011, and initial projections for CY 2012. The statements provided by Priority Partners to staff represent both a stand-alone and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under one entity.

In recent years, the financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2010 was positive, and is expected to remain positive in CY 2011. Projections for CY 2012 will be available once Medicaid's rate setting process is finalized, and the final recommendation proposed to the Commission in October will

reflect these projections.

IV. Recommendation

With the exception of FY 2009, Priority Partners has continued to achieve favorable financial performance in recent years. Based on past performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission policy, in that the MCO has been able to sustain reasonable profit margins. However, Staff will reevaluate Priority Partners' projected CY 2012 financial status when Medicaid rates are finalized, and present final recommendations at the October Commission meeting.

Therefore:

1) **At the October Commission meeting, Staff will recommend approval of this alternative rate application for a one-year period beginning January 1, 2012 provided staff believes the arrangement will not result in sustained losses to the MCO.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance is achieved in CY 2012 and expected to be sustained into CY 2013. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the August 2012 meeting of the Commission) on the actual CY 2011 experience and preliminary CY 2012 financial performance (adjusted for seasonality) of the MCO as well as projections for CY 2013.**

3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2011**
MEDICAL CENTER	*	**FOLIO: 1946**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2136A**

Staff Recommendation

September 14, 2011

I. INTRODUCTION

University of Maryland Medical Center (“the Hospital”) filed an application with the HSCRC on August 30, 2011 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning July 1, 2011.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by University Physicians, Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; 2) approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2011. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Technical Report on Reasonableness of Charges (ROC) Regression Analysis and Final Recommendation to Routinely Review Regression Results for Outliers

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

September 14, 2011

This is a final recommendation, which requires Commission action.

Introduction

The purpose of this report is to review technical findings regarding the Reasonableness of Charges (ROC) regression analysis in the fiscal year (FY) 2012 ROC and recommend routine review of regression results for outliers in future ROC calculations.

After adjusting each hospital's charges through a series of hospital-specific cost factors (e.g., markup, direct strip, labor market adjustor, case mix index, and capital), HSCRC staff conducts a regression analysis on the adjusted cost per equivalent discharge. The goal of the regression is to quantify in a regression coefficient the impact of IME and DSH on the adjusted cost per equivalent discharge. Staff then applies the statewide coefficient to each hospital to produce the ROC Comparison Cost used by the HSCRC to compare hospitals within their ROC peer group.

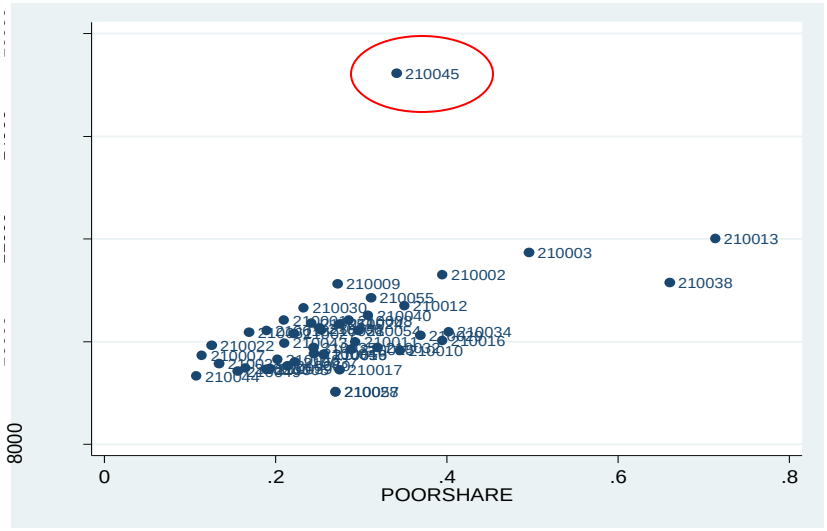
Regression Diagnostics, Outliers, and the FY 2012 ROC

In investigating preliminary ROC results for FY 2012, HSCRC staff ran multiple tests to determine the factors most influential in the ROC. In doing so, HSCRC staff conducted a regression diagnostic.

A regression diagnostic is a statistical tool that provides an understanding of potential data influencers and outliers among the observations. In the case of the ROC regression, each hospital is an equally weighted observation. If a single observation (i.e., a single hospital) is substantially different for the other observations, this one observation can greatly influence the overall regression analysis results.

The regression diagnostic, Chart 1, determined that one hospital, McCready Memorial Hospital (210045), was significantly different than the other observations in the regression.

Chart 1
Regression Diagnostic for the FY 2012 ROC IME and DHS Regression Analysis



While the regression diagnostic is an important tool in identifying potentially influential observations and outliers, HSCRC staff conducted further analysis to better understand the significance of McCready in the regression. Some examples of analysis include reviewing several years of data to understand trends and observing the overall differences of regression results both with and without McCready.

Based on our analysis, HSCRC staff concluded that McCready Memorial Hospital was an outlier in the ROC regressions. For the FY 2012 ROC, HSCRC staff recommended that the Commission remove the outlier from the regression analysis.[1] Staff then applied the resulting regression coefficient to all acute hospitals, including to McCready Memorial Hospital.

Staff Recommends a Routine Practice of Reviewing Regression Results for Outliers

HSCRC staff recommends that the Commission direct staff to routinely conduct regression diagnostics on preliminary regression results. When warranted, staff will remove significant outliers from the ROC regression analysis. HSCRC staff will apply coefficients resulting from the final regression analysis to all hospitals scaled by the ROC methodology, including those hospitals removed as outliers in the regression analysis.

HSCRC staff will clearly document any observation removed from a ROC regression analysis.

HSCRC staff received one comment on the draft recommendation from August 11, 2011. This letter from the MHA, available in Attachment 1, supports the adoption of this recommendation.

[1] Final Recommendation on the FY 2012 Reasonableness of Charges (ROC) Methodology and Scaling of the ROC, QBR, and MHACs. Commission approved the recommendation at the July 6, 2011 meeting.

Attachment 1

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

August 12, 2011

Mary Beth Pohl
Deputy Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Ms. Pohl:

On behalf of our 66 member organizations, the Maryland Hospital Association (MHA) supports the Health Services Cost Review Commission (HSCRC) staff's August 11 *Technical Report on Reasonableness of Charges (ROC) Regression Analysis and Draft Recommendation to Routinely Review Regression Results for* Outliers.

The decision to routinely review regression results and take appropriate action based on the findings will help to ensure rates set by the HSCRC, and hospital charges based on those rates, are reasonable. MHA affirms HSCRC's role to make certain hospital charges reflect each hospital's cost to provide care according to their mission. Furthermore, we appreciate the staff's intent to document these types of technical decisions that can have substantial effects on individual hospital revenue.

Thank you for the opportunity to comment on this recommendation.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Vice President, Financial Policy

cc: Commissioners, HSCRC
Stephen Ports, Acting Executive Director, HSCRC

Options for Reconciliation of FY 2010 Averted Bad Debt Estimates to Actual

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

September 14, 2011

These options are for final Commission consideration at the September 14, 2011 Public Commission Meeting.

Purpose

The purpose of the this paper is to illustrate how the Health Services Cost Review Commission (the Commission or HSCRC) estimates hospital averted bad debt resulting from the Medicaid expansion; to show how the Commission determines the actual amount of averted bad debt in that year; and to propose a series of options for the Commission to consider for reconciling estimates to the actual results. Commission staff is seeking guidance on how to reconcile the estimated averted to actual for state fiscal year (FY) 2010.

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 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.

[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.

As described above, The 2007 Act also expands services to childless adults, contingent on available funding. Prior 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.

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 Act.

Beginning in FY 2009, each year, the Commission works with the Department of Health and Mental Hygiene (the Department, or 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. The Department 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. 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 estimate (see Crowd Out section below).

- Lower Use Rate - Literature indicates that Medicaid enrollees tend to use hospital services at a lower rate than uninsured individuals. Based on the literature, 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 over all, resulting in savings to purchasers/payers of hospital care. For FY 2010, the intended savings to purchasers/payers of care was 7.39 percent of the averted bad debt amount.

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.

Additionally, 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.

Reconciliation of Hospital Estimated to Actual Averted Bad Debt

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 compare 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 devise 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, Department, HSCRC, and hospital staff work together to supply, compare, and merge data from three majors sources. This merging process has proven challenging for all involved. Table 3 provides a description of the data sources.

Table 3: Data Sources for Determining Actual Medicaid Expansion Populations

Data Source	Data Elements Used in Determining Actual Charges	Data Restrictions
Medicaid MCO Encounter Data	Patient Name, Hospital Name, SSN, Dates of Service	MCO encounter data do not include charges associated with the encounter
HSCRC inpatient and outpatient discharge data	Hospital ID, Patient Account Number, Medical Record Number, Dates of Service, Charges	Data do not distinguish Medicaid expansion population from other Medicaid coverage groups; until FY 2012 did not require Medicaid ID
Hospital data sources	Patient Name, Hospital ID, SSN, Patient Account Number, Medical Record Number, Dates of Service, Charges	Data do not routinely distinguish Medicaid expansion population from other Medicaid coverage groups

Approximately one year after the end of the fiscal year for which averted bad debt had been estimated (e.g., end of FY 2011 for all FY 2010 data), the Commission receives complete reimbursement data from the hospitals and the Department.[2] During the reconciliation process, the Department sends encounter data with patient identifiers to the hospitals; the hospitals send claims with patient identifiers and charges to the HSCRC; and the HSCRC sends results of the matching protocol back to hospitals and the Department. The process iterates until all Medicaid encounter data are populated with the hospital charges associated with the encounter.

Table 4 shows the resulting matched and unmatched claims from this process for FY 2010.

[2] One year is required to account for the claims "run-out," a period that includes the time providers have to submit claims after providing a service, the time MCOs have to pay the claims, and the time established for MCOs to submit encounter data to the Department.

Table 4: FY 2010 Medicaid Expansion Claims Reconciliation

Data Source Matching Process	**Count of Claims**	**Percentage of Total**
Total claims submitted from hospitals in FY 2010	121,126	
Additional claims submitted in FY 2009 with FY 2010 DOS	2,020	
Total initial claims in reconciliation process	***123,146***	**100%**
Excluded claims:		
Reported with FY 2010 with FY 2011 DOS	508	
Reported in both FY 2009 and FY 2010	10	
PAC (not reconciled in FY 2010)	34	
Unregulated claims	1,964	
Duplicate claims	1,413	
Pregnancy-related services (not expansion population)	7,212	
Total excluded claims	***11,141***	**9.0%**
Total claims with charges identified	**110,428**	**89.7%**
Imputed charges:		
Claims not found by hospitals	**1,439**	**1.2%**
Claims with charges not provided by hospitals	**138**	**0.1%**
Result: Total charges for Medicaid expansion population in FY 2010:	***$125.5 million***	

Once the encounter data reconciliation process is finalized the Commission sums total charges for the Medicaid expansion population for each hospital. HSCRC staff then calculates the actual UCC by applying the crowd out and lower use rate estimates to these total charges. Note that for purposes of this options paper, we refer to this amount as the "actual" reduction to UCC resulting from the Medicaid expansion. 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 (see the Crowd Out section, below).

As shown in Table 5, for FY 2010, the encounter data reconciliation process identified $125.5 million total hospital charges associated with the Medicaid expansion. Appling the crowd out and lower use rates, HSCRC staff found the actual reduction to bad debt as $74.1 million. After applying the desired savings that were to accrue to purchasers/payers of care, the net aggregate difference in what was paid by hospitals to the Department in the form of a uniform assessment, and the amount paid by the Department to hospitals for this population was $25.5 million.

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

Table 5: 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 (-28%) and Lower Use Rate (-18%)	-$51.4 million
Actual Reduction to Uncompensated Care Due to Expansion	*$74.1 million*
Calculation of Overpayment/Underpayment to DHMH - With Savings to Providers	
Actual Reduction to Uncompensated Care Due to Expansion	$74.1 million
Reduced for Savings Provided to Payers (-7.39%)	$68.6 million
Amount Paid by Medicaid to Hospitals (94%)	$64.5 million
Amount Paid to Medicaid by Hospitals	$90.0 million
Difference	***$25.5 million***
Calculation of Overpayment/Underpayment to DHMH - With No Savings to Providers	
Actual Reduction to Uncompensated Care Due to Expansion	$74.1 million
Amount Paid by Medicaid to Hospitals (94%)	$69.7 million
Amount Paid to Medicaid by Hospitals	$90.0 million
Difference	***$20.4 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.

Crowd Out

Both the initial averted bad debt estimate and the reconciliation formulas are adjusted for an expected percentage of crowd out. Crowd out is the substitution of public insurance coverage for private insurance coverage, such as, the explicit dropping of an employer policy when one is made eligible for Medicaid. Crowd out cannot be determined simply by looking at an individual's coverage in a prior period. For example, if an individual loses employment and employer sponsored health coverage and then enrolls in Medicaid, this is not considered crowd out. Likewise, if an individual's employer chooses to no longer offer employer sponsored health coverage and then the individual then enrolls in Medicaid, this is not considered crowd out.

In 2009, when the Department and Commission staff 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 a crowd out factor, the most appropriate magnitude of the crowd out factor was not clear. The Department and the Commission reviewed available literature regarding crowd out and determined that 28 percent was reasonable and appropriate.

When applied to the total hospital charges to Medicaid due to the expansion, the crowd out estimates impact the final calculation of overpayments/underpayments to DHMH. Commission

staff conducted sensitivity testing and determined that each percent change in the crowd out estimate produces a $896,000 increase or decrease to the overpayment/underpayment.[3]

Acknowledging the impact that crowd has on this calculation, and based on Commission interest in crowd out as discussed at the August 2011 Public meeting, staff conducted a new search of available literature on the topic. We also reviewed a letter prepared by the Department to the Commission Chairman (see Attachment A). Based on these data sources, Commission staff finds no compelling evidence substantial enough to alter the existing assumption for FY 2010. However, Commission staff will remain open to altering the crowd out assumption for future years, if there is convincing evidence to warrant such a change.

Averted Bad Debt Estimates FY 2009 – FY 2012

Table 6 shows the averted bad debt assessment amounts for FY 2009 through FY 2012. The assessment amount has increased from $24.2 million in FY 2009 to $157.7 million in FY 2012. This increase is primarily due to the ramp-up in enrollment during that period. The FY 2011 and 2012 estimates include the PAC costs.

Table 6: Averted Bad Debt Assessment Amounts, FY 2009 - FY 2012
(Dollars in Millions)

	Original Estimate FY 2009	Revised Estimate FY 2009	Estimate FY 2010	Estimate FY 2011	Estimate FY 2012
Estimated Medicaid Total Expenditures	$95.2	$160.1	$324.4	$457.6	$535.0
In State Payment Percent In State Payments	94% $89.5	94% $150.5	94% $305.0	94% $430.2	94% $502.9
Medicaid Payment Percent Charges at Payment Rate	94% $95.2	94% $160.1	94% $324.4	94% $457.6	94% $535.0
Hospital Portion Hospital Charges Reported	61% $58.1	61% $97.7	54% $175.2	47.61% $217.9	43% $230.1
Crowd Out (28%) Charges after Crowd Out	72% $41.8	72% $70.3	72% $126.1	72% $156.9	72% $165.6
Lower Use Rate Estimated Medicaid Averted Bad Debt	82% $34.3	82% $57.7	82% $103.4	82% $128.6	82% $135.8
Estimated PAC Averted Bad Debt	$0	$0	$0	$26.8	$31.9
Hospital Charges including Medicaid Expansion and PAC	$34.3	$57.7	$103.4	$155.4	$167.7
Medicaid Payment Percent Net Medicaid Payments	94% $32.2	94% $54.2	94% $97.2	94% $146.1	94% $157.7
% Returned to Medicaid Hospital Payments to Medicaid	75% $24.2	75% $40.7	92.61% $90.0	100% $146.1	100% $157.7
Total Payments to Medicaid		**$40.7**	**$90.0**	**$146. 1**	**$157. 7**

[3] Likewise, each percent change in the lower use rate, another estimate, produces a $797,000 increase or decrease to the overpayment/underpayment.

HSCRC and the Department staff have refined the assumptions used to estimate the expected hospital averted bad debt in FY 2011 and FY 2012. For example, HSCRC staff have considerably reduced the assumption regarding the portion of total Medicaid expansion dollar associated with hospital charges. In FY 2009, the Department estimated and HSCRC staff applied a 61 percent hospital portion. For FY 2012, HSCRC assumes a hospital portion of 43 percent.

It is also notable that prior to the FY 2009 reconciliation, the Department argued that enrollment had grown at a greater rate than initially expected. The Department provided evidence to show that this growth in enrollment would result in a $16.9 million underpayment in FY 2009. The Commission increased the FY 2010 assessment by that amount to address the projected underpayment (see the Revised Estimate FY 2009 column in Table 6).

Options for FY 2010 Reconciliation

Based on the hospital claims reconciliations, HSCRC staff calculated a $25.5 million difference in the FY 2010 actual and assessment amounts associated with averted bad debt. Below are a series of the options for Commission consideration to address the discrepancy.

Option 1 – Reduce Future Assessment Payments to the Department

Under this option, the Commission would include the expected averted bad debt amount in rates for a given year (FY 2012 for example), but require hospitals to pay a reduced assessment amount to the Department. The reduced assessment amount ($157.7 million - $25.5 million = $132.2 million) could be applied in one year (FY 2012), or phased in over a 2 or 3 year period.

> **Implication:** This option would result in increasing Medicaid deficits in the year(s) that the assessment is reduced. As a result, the Department may choose to increase the deficit assessment amount in future years to reflect the reduction in the averted bad debt assessment. The Department could also resort to other administrative or benefit restrictions, such as the Medicaid day limits that were imposed in prior fiscal years.

Option 2 – Increase Hospital Rates in FY 2012 to Reflect the Overpayment Amount

The Commission could increase rates above the estimated averted bad debt assessment in a given year but keep the amount of the assessment at the expected amount. This strategy would add $183.2 million ($157.7 million + $25.5 million) to hospital rates, but hospitals would only pay $157.7 million to the Department for the averted bad debt assessment in FY 2012.

> **Implication:** This option would make the hospitals whole for the FY 2010 overpayment, but purchaser/payers of care would then have paid the assessment twice--once in FY 2010, and again in FY 2012.

Option 3 – Reduce or Eliminate the Savings Designed to Accrue to Purchasers/Payers of Care

In FY 2010, the Commission intended to reduce rates overall by 7.39 percent (or approximately $5.5 million) to provide saving to purchasers/payers of care. During the reconciliation for FY 2009, the Commission reduced the expected savings to payers to zero percent. If the Commission were to impose the same policy for the FY 2010 reconciliation process, the overpayment would in essence decline from $25.5 million to $20.4 million.

> **Implication:** During the legislative process that created the averted bad debt assessment, it was anticipated that the averted bad debt policy would result in overall savings to the public. However, the amount of savings was not written into the statute. This option would not provide savings to the purchasers/payers of hospital care as anticipated through the legislative process.

Option 4 – Take No Action to Alter the Averted Bad Debt Estimated or Assessment Amounts in Future Years (FY 2012 or beyond)

If no action is taken, hospitals would have overpaid the Department for averted bad debt in FY 2010 in the amount of $25.5 million. This amount would have been reflected in the hospitals' operating budgets and profit margins for that year. The overall hospital operating profit margin in FY 2010 was $329.5 million (2.61 percent). The overpayment represents 0.2 percent of the total profit margin in FY 2010. However, there would be a differential impact on individual hospital margins based on the amount of total payments that the Department made to a hospital for the expansion population in FY 2010.

> **Implication:** Under this option, hospitals would not be permitted to recover any of the FY 2010 overpayment amount which negatively impacted their profit margins in that year.

Option 5 – Adopt a Combination of Any of Options 1 through 4

If it is the desire of the Commission to disperse the impact of the overpayment among hospitals, payers, and the Department, the Commission could share those costs using a combination of the options described above.

Attachment 1

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

August 19, 2011

John M. Colmers
Chairman
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers,

I am following up on my comments at last week's Commission meeting. The Commissioners asked if the 28 percent point crowd out factor was prepared prior to the economic downturn and, if so, whether it was revised to reflect the current economic climate. The answers are that: (1) the factor was prepared before the downturn; and, (2) it has not been revised, meaning changed. But the Department and the Health Services Cost Review Commission (HSCRC), with FY 2009 data supplied by the hospitals, conducted an analysis last year concerning the crowd out factor. Based on that analysis, the data suggest that the crowd out factor is overstated by perhaps 10 percentage points or higher. Additional details are included, below.

As you know, "crowd out" refers to the substitution of public programs for private arrangements. In the health care context, it means those abandoning private insurance to take advantage of public health care initiatives. When investigating this issue, the Maryland Hospital Association (MHA) identified a sample of Medicaid expansion claims from FY 2009. (*See* attached.) MHA's analysis suggests that the original crowd out figure of 28 percent may be understated and actually closer to 55 percent. In generating this figure, however, the hospitals examined their records to identify those who had health insurance in the prior year and, by so doing, included data of those who do not meet the crowd out definition.

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.state.md.us

Crowd-out takes into consideration only those who elect to drop insurance and enroll in a public benefit program. It does not include those who lose insurance coverage. Many individuals lose coverage for reasons beyond their control, *e.g.*, loss of employment. Similarly, the MHA crowd-out estimates includes those individuals whom the hospitals identify as having had Medicaid coverage in the prior year – this accounts for roughly 44 percent of their 55 percent crowd out estimate. Including all of the Medicaid individuals is an incorrect assumption that artificially inflates the ultimate crowd out number.

Individuals lose Medicaid coverage all the time. The reasons for such loss of coverage vary. For example, some may have incomes that increase beyond the income threshold guidelines. Others may have been granted coverage because of a pregnancy and lost coverage because eligibility for such person extends only up to two months post-partum. These types of churning on and off Medicaid will continue with the Medicaid expansion anticipated by the Affordable Care Act (ACA). National estimates show that within six months after the start of the expansion, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse. That estimate increases to 50 percent within one year after the start of the expansion.[1] Whether individuals have Medicaid coverage in the prior year does not equate to crowd-out.

To ensure that the Department's system for identifying expansion enrollees is accurate, the Department sampled 61 claims provided by Maryland hospitals. In our analysis of these claims, the Department determined:

- 31 percent were parents whose income increased beyond the prior income thresholds (39 percent of the federal poverty level).
- 28 percent were pregnant and would have lost coverage two months after giving birth if the state had not raised parent income thresholds.
- Five percent of the sample included dependent children who aged out of the Maryland Children's Health Program (MCHP). Under the family coverage group, Maryland is able to cover dependent children up to age 21, which is two years beyond what is allowed under MCHP.
- Two percent were covered under the Primary Adult Care program - likely the individual had a baby and was now eligible for full Medicaid benefits.
- 34 percent were individuals who had medical expenses in the previous year and were able to spend-down their income in order to qualify. To qualify for coverage in the next year, these individuals would again need medical bills that would permit them to spend-down to a level sufficient to qualify for again for coverage.

[1] "Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, February 2011.

The only individuals who may have been covered under Medicaid are those who qualified by spending down their income. There is no guarantee these individuals would have been covered in the following year.[2] Even assuming conservatively that half of the spend-down population now covered under the parent expansion would have been able to qualify under the spend-down requirements, the total crowd out factor using the MHA data would have been around 18 percent – less than the 28 percent factor used by HSCRC and the Department (and far less than the 55 percent estimate of the MHA).

As it appears that the crowd out issue is of interest to the Commission, I am providing this data to further inform your deliberations. Please let me know if you have any questions.

Sincerely,

Tricia Roddy

Tricia Roddy
Director
Planning Administration

cc: Charles J. Milligan, Jr.

[2] The Department compared the average enrollment in FY 08 to the average enrollment in FY 09 for the medical spend-down population. The average enrollment in FY 08 was 2,172 and in FY 09 it was 2,339.

FY 2009 Medicaid Expansion Charges

	FY 09 Expansion	FY 09 Medicaid Secondary Payor		FY 08 Medicaid FFS and MCO "crowd out"		FY 08 Commercial "crowd out"		Combined Medicaid and Commercial "crowd out"
1 Union of Cecil	1,790,925	208,816	11.66%	734,093	40.99%	419,895	23.45%	64.44%
2 Harford Memorial	335,573	58,903	17.55%	248,864	74.16%	27,806	8.29%	82.45%
3 St. Agnes	1,991,624	121,882	6.12%	688,360	34.56%	205,200	10.30%	44.87%
4 Suburban Hospital	170,909	4,075	2.38%	-	0.00%	-	0.00%	0.00%
5 Carroll Hospital Center	1,250,851	108,952	8.71%	457,266	36.56%	179,745	14.37%	50.93%
6 Western Maryland	2,073,266	-	0.00%	361,850	17.45%	233,557	11.27%	28.72%
7 Anne Arundel	880,019	64,803	7.36%	463,766	52.70%	260,772	29.63%	82.33%
8 Johns Hopkins Bayview	3,609,381	282,521	7.83%	1,551,521	42.99%	23,309	0.65%	43.63%
9 Washington County	337,303	69,340	20.56%	131,729	39.05%	69,682	20.66%	59.71%
10 Johns Hopkins Hospital	6,837,698	407,139	5.95%	4,821,968	70.52%	322,992	4.72%	75.24%
11 Howard County	1,034,051	103,734	10.03%	490,054	47.39%	30,494	2.95%	50.34%
12 Garrett County	595,128	10,320	1.73%	372,814	62.64%	89,480	15.04%	77.68%
13 St. Mary's	773,700	10,754	1.39%		0.00%		0.00%	0.00%
14 Franklin Square	3,109,294	287,131	9.23%	2,044,319	65.75%	542,723	17.45%	83.20%
15 Good Samaratin	1,504,122	97,790	6.50%	399,546	26.56%	70,371	4.68%	31.24%
16 Harbor	1,753,741	39,395	2.25%	1,132,596	64.58%	259,669	14.81%	79.39%
17 Union Memorial	2,140,995	59,357	2.77%	581,534	27.16%	151,533	7.08%	34.24%
18 Montgomery General	340,045	5,433	1.60%	76,508	22.50%	50,338	14.80%	37.30%
19 Bon Secours	181,797	9,309	5.12%	29,411	16.18%	78,182	43.01%	59.18%
20 Doctors	194,039	58,312	30.05%	25,805	13.30%	37,725	19.44%	32.74%
21 Mercy	2,203,028	209,007	9.49%	1,194,487	54.22%	281,203	12.76%	66.98%
22 Peninsula	3,092,152	792,139	25.62%	761,716	24.63%	478,414	15.47%	40.11%
23 Frederick Memorial	1,200,543	114,861	9.57%	83,795	6.98%	170,237	14.18%	21.16%
	$37,400,184	$3,123,973	8.35%	$16,652,002	44.52%	$3,983,327	10.65%	55.17%

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

September 9, 2011

John M. Colmers
Chairman, HSCRC
Vice President, Health Care Transformation and Strategic Planning
Johns Hopkins Medicine
3910 Keswick Road, Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

On behalf of our 66 member organizations, I am following up on comments made at the August public meeting on averted uncompensated care (UCC) estimates related to Medicaid expansion and to provide our recommendations on how to handle the Fiscal Year (FY) 2010 overestimate of averted UCC and resulting $25.5 million overpayment to Medicaid.

MHA Supports Medicaid Expansion

In July 2008, the Maryland Hospital Association (MHA) supported the expansion of Medicaid and the mechanism by which the expansion was funded. Expanded Medicaid coverage reduces UCC and builds on a founding concept of the Maryland all-payor system--ensuring access to care. The Medicaid expansion funding mechanism as envisioned in July 2008, provided advantages for all the major stakeholders: commercial payors contributed funding and in exchange saw an equivalent reduction in hospital rates in anticipation of reduced uncompensated care; the public benefitted from a reduction in the uninsured; hospitals benefitted by having a greater share of their patients covered by insurance. However, the finely balanced movement of funds from payors through hospitals to Medicaid and back to hospitals was moved out-of-balance by overestimating the magnitude of averted UCC and resulted in overpayments to the Medicaid program, as shown in Figure 1 below.

Figure 1: **FY 2010 Net Averted UCC Funding** (in millions)

Estimated Averted UCC

	Rate Increase (Assessment)	**Rate Reduction** (Prospective)	**Payment to Medicaid** (Net of mark-up)	**Payment for Hospital Services**	**Net** Favorable (Unfavorable)
Payors	$(104.7)	$104.7			$ -
Hospitals	$104.7	$(104.7)	$(90)	$64.5*	$(25.5)
Medicaid			$90	$(64.5*)	$25.5

*$64.5M does not equal the $74.1M actual averted UCC because of the 7.39 percent savings to payors

- more -

Averted UCC Estimate Likely Overstated in FY 2011 and FY 2012

The FY 2010 estimate of averted UCC was $104.7 million, but actual averted UCC is $74.1 million. FY 2011 and FY 2012 estimates of averted UCC are also likely higher than actual averted UCC. From FY 2009 to FY 2010--the years in which newly eligible individuals were rapidly enrolling--actual averted UCC grew 64 percent. Beginning in FY 2011, the pace of new enrollment was expected to have slowed significantly. However, FY 2011 estimated averted UCC is significantly greater than FY 2010 actual averted UCC. As demonstrated in Figures 2 and 3 below, FY 2011 actual averted UCC will need to increase 92 percent beyond FY 2010 actual averted UCC to reach the level of FY 2011 estimated averted UCC. Further, FY 2012 actual averted UCC will have to grow by 103 percent compared to FY 2010 to meet the current FY 2012 estimates. Trends in expected enrollment and per member per month (PMPM) cost do not support dramatic increases in actual averted UCC.

Figure 2: **Actual UCC Increases Necessary to Meet Projections**

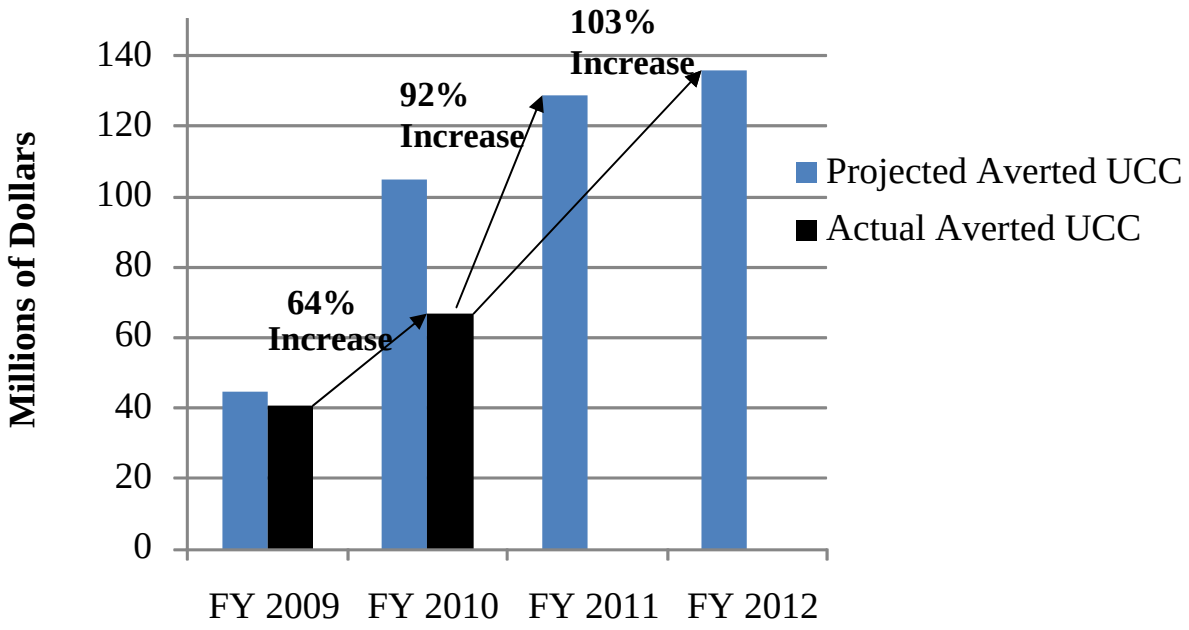


Figure 3: **Medicaid Enrollment and Cost Trends**

	FY 2009	FY 2010	FY 2011	FY 2012
Number of Enrollees	29,273	55,000	69,773	82,000
PMPM Cost Estimate	$511	$539	$546	$570

Recommendation: To reconcile the FY 2010 overpayment to Medicaid, MHA recommends the Health Services Cost Review Commission (HSCRC) reduce hospitals' FY 2012 planned payments to the Maryland Medicaid program by the amount of the overpayment, calculated at $25.5 million. Withholding the $25.5 million FY 2010 overpayment from payments hospitals are scheduled to make to Medicaid in FY 2012 resolves the funding imbalance between hospitals and Medicaid, holds payors harmless, and is consistent with HSCRC policy to reconcile

estimates of averted UCC once actual experience is known.[1,2] In addition, due to higher than anticipated state revenues of $344 million at the end of FY 2011, the state would be in a position to fund the repayment of hospitals' overpayments to the Medicaid program.[3]

Estimating the Amount of Averted Uncompensated Care is a Challenge

Estimating the amount of averted UCC is inexact and relies on assumptions. Medicaid and HSCRC must estimate averted UCC because actual data is not available until at least 15 months after the end of each fiscal year.[4] The estimate of averted UCC is calculated by adjusting expected Medicaid costs for "crowd-out" (28 percent) and the lower use rate of health services by the uninsured (82 percent). **In the process of truing up the original estimates to actual experience it is important to use the same assumptions as those on which the original estimates were made**. The purpose of the reconciliation process is to settle any over or under-estimates of original adjustments. It is not appropriate to retroactively change assumptions during the reconciliation process to meet a fiscal target.

Defining Crowd-Out

In the Maryland Medicaid expansion and averted UCC context, crowd-out is one adjustment used to derive an estimate of averted UCC from the cost Medicaid expects to pay for expansion coverage. The purpose of the crowd-out adjustment is to estimate averted UCC, and should therefore include everyone who had prior coverage--including Medicaid--and would have lost that coverage had the expansion not occurred. HSCRC and Medicaid consider crowd-out to include only those whose private coverage was displaced by the expansion of public coverage. While this more limited definition is an important public policy question to consider when policy makers are deciding whether to expand coverage, excluding individuals who would have retained eligibility for Medicaid under existing requirements substantially understates the amount of UCC averted by Medicaid expansion.

Literature Review on Crowd-Out Estimates Hugely Variable

The Robert Wood Johnson Foundation (RWJF) in its Synthesis Report on Crowd-Out[5] concludes, *there will always be some level of crowd-out with any public program expansion and measuring it with precision will always be difficult. A general midpoint of the studies reviewed indicated an overall substitution effect of 25 to 50 percent with lower rates of substitution for*

[1] Legislative Report: Health General Article Section 19-214 (e) to Governor O'Malley, President Miller, and Speaker Busch on aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage. January, 2010

[2] Legislative Report: Health General Article Section 19-214 (e) to Governor O'Malley, President Miller, and Speaker Busch on aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage. December, 2010

[3] As reported in the *Baltimore Sun*, September 1, 201, Maryland FY 2011 revenues exceeded estimated revenues by nearly $1 billion, although the state plans to use $590 million to balance the current budget.

[4] Managed Care Organizations have 18 months after the date of service to report encounter data to Medicaid. Medicaid uses this encounter data to identify expansion patients that have received hospital services.

[5] *Revisiting Crowd Out*, The Synthesis Project: New Insights from Research Results. The Robert Wood Johnson Foundation. September, 2007.

low-income children (0-15 percent) and higher rates for higher-income children and longer-term enrollees (35 to 50 percent). Appendix 1 represents a literature review from the RWJF report as well as published studies gathered by MHA staff. The literature review shows a crowd-out range between 0 and 68 percent. A number of limitations are cited by the published studies, most notably the difficulty in establishing a counterfactual or comparison group. A study by Long et al (2006) uses multiple control groups and gets different outcomes depending on the control group.[6]

Verifying the Magnitude of Crowd-Out

It is not feasible to unequivocally verify the amount of crowd-out--individuals who had and would have retained coverage had the expansion not occurred. However, data collected by MHA cast doubt on the 28 percent crowd-out assumption used to estimate averted UCC and may indicate a substantial overstatement of averted UCC. MHA believes that a large percentage of patients who had Medicaid coverage in the prior year are being counted in the expansion population even though they would have retained coverage in the absence of the expansion.

MHA collected data from a representative sample of hospitals, including about half of Maryland's acute care hospitals. Each hospital matched FY 2009 expansion patients, as identified by the Medicaid program, with the hospital's prior year patient list. In the aggregate, *more than 50 percent of the expansion patients were provided services and covered by insurance at that hospital in the prior year*. In the prior year, approximately 11 percent were covered by commercial insurance and 44 percent by Medicaid fee-for-service or a Medicaid Managed Care Organization (MCO). (See Appendix 2 for detailed results.) One would not expect patients already covered by Medicaid or an MCO to be included in the expansion category. Patients covered by insurance in the prior year cannot be considered averted UCC in the current year unless we are certain they would have lost that coverage in the current year.

MHA collected a second sample of FY 2009 expansion patients to understand why more than 50 percent of the expansion population included patients covered by Medicaid fee-for-service and Medicaid MCOs in the prior year. MHA provided Medicaid with a sample of 100 expansion patients from a representative group of hospitals and asked for documentation demonstrating that the person would have lost Medicaid coverage had the expansion not occurred. The sample was provided on July 7, 2010. On October 2, 2010, Medicaid provided information on 61 of the 100 patients. Medicaid representatives reported the prior year's eligibility category, but no information on individuals' income levels that would have confirmed that all patients in the sample would have lost coverage had the expansion not occurred. The following table demonstrates the results returned by Medicaid.

[6] Are Adults Benefiting from State Coverage Expansions?, *Health Affairs* vol 25., no 2, 2006, Long S., Zuckerman S., Graves JA

Eligibility Category	Number	Cumulative Percent
*Families	19	19%
Pregnant/Family Planning	17	36%
Aged out of MCHP	3	39%
In PAC Program	1	40%
In Spenddown Program	21	61%
Undetermined	39	100%

*The individual's income in 2009 would have had to be between 40-116 percent of Federal Poverty Level to have lost coverage without the expansion.

The Maryland Children's Health Program (MCHP)
Primary Adult Care (PAC) Program

Recommendation: HSCRC and Medicaid should continue to assume crowd-out at 28 percent, and not retroactively change the assumption to meet a fiscal target. The amount of crowd-out is an assumption that cannot be precisely verified. Twenty-eight percent is within the mid-range of studies that show wide variation in crowd-out depending on the population studied and other external factors.

MHA Recommendations

1. **To reconcile the FY 2010 overpayment to Medicaid, MHA recommends the HSCRC reduce hospitals' FY 2012 planned payments to the Maryland Medicaid program by the amount of the overpayment, currently calculated at $25.5 million**. Withholding the $25.5 million FY 2010 overpayment from payments hospitals are scheduled to make to Medicaid in FY 2012 resolves the funding imbalance between hospitals and Medicaid, holds payors harmless, and is consistent with the HSCRC policy. Higher than anticipated state revenues of $344 million put the state in a position to refund hospitals' overpayments to the Medicaid program.

2. **HSCRC and Medicaid should continue to assume crowd-out at 28 percent, and not retroactively change the assumption to meet a fiscal target**. The amount of crowd-out is an assumption that cannot be precisely verified. Twenty-eight percent is within the mid-range of studies that show wide variation in crowd-out depending on the population studied and other external factors. In the process of truing up the original estimates to actual experience it is important to use the same assumptions as those on which the original estimates were made.

MHA appreciates the opportunity to participate in the discussion of this issue. If you have any questions, concerns or would like additional information, please contact me at 410-540-5087.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Vice President, Financial Policy

cc: Stephen Ports, Acting Executive Director, HSCRC

Attachments
Murray's 2009 and 2010 Legislative Reports
Appendix 1 Crowd-out literature summary
Appendix 2 MHA data on prior coverage of expansion patients

Study	Findings	Population studied/Data source	Comments
"Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" by Jonathan Gruber and Kosali Simon (2007)	Estimates **crowd-out between 61 and 68 percent** when an entire family is eligible for public programs; about twice that estimated for individuals.	Adults and children	This study focuses on the impact of families enrolling in coverage. The authors estimate that the **crowd out rate for families is about twice that of individuals.**
"Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States" by Anna Sommers, Stephen Zuckerman, Lisa Dubay, and Genevieve Kenney (2007)	**Crowd out** rate for **newly enrolled children in CHIP** in 2002 was between **7- 14%** depending on whether affordability is included as a reason to voluntarily substitute public coverage for private.	Ten states were selected to include a large proportion of all low-income uninsured children, geographic diversity, and a variety of SCHIP structures. Data was taken from a survey of 16,700 CHIP enrollees in 2002 and state administrative data reporting enrollment history.	The authors found that 28% of new enrollees had private coverage at some point in the six months prior to enrollment. However, half of those lost private coverage involuntarily. Voluntary substitution accounted for only 14% of newly enrolled children in the ten states. Of those that voluntarily substituted, half of parents reported that prior coverage was unaffordable.
"Insuring Low-Income Adults: Does Private Coverage Crowd Out Private?" by Richard Kronick and Todd Gilmer	The study found that **crowd out rate was between 0 and 45 percent**, depending on income level of enrollee.	Current Population Survey (CPS) data from 1998 to 1999 for adults in MN, WA, OR, and TN. Also state administrative data reporting total enrollment among adults each year.	The authors found that among enrollees below 100% of FPL, there was no evidence of crowd out due to expansion. Among enrollees between 100 and 200% of FPL, crowd out accounted for as much as 45%.

Study	Findings	Population studied/Data source	Comments
"Are Adults Benefiting from State Coverage Expansions" by Sharon Long, Stephen Zuckerman, and John Graves (2006)	Lack of uniformity across states makes it **difficult to generalize crowd out estimates** from one state to another. Authors conclude that crowd-out may be small or non-existent in some states.	Used data from the National Survey of American Families (NASF) between 1997 and 2002 for adults in CA, MA, NJ, and WI.	The authors found significant variation in estimates of crowd out both within and across the states that expanded coverage to parents and childless adults. Parents in Wisconsin and parents and childless adults in Massachusetts experienced the largest increase in public coverage, with little offsetting reduction to private coverage. In contrast, expansion to parents in California and New Jersey led to increased enrollment but at the expense of private coverage.
"SCHIP's Impact on Dependent Coverage in the Small Group Market" by Eric Seiber and Curtis Florence (2010)	The study found **crowd out of 8.7 percent** for children with parents employed by a small busines with less than 25 employees and **41.6 percent** for children with parents employed at businesses up to 500 employees.	1996-2007 Annual Demographic Survey of the Current Population Survey (CPS) for children in households with at least one worker.	The authors found that crowd out rate increased with business size.
"Family Coverage Expansions: Impact on Insurance Coverage and Health Care Utilization of Parents" by Susan Busch and Noelia Duchovny (2005)	The study found **crowd out rate for eligible parents was 23.6%.**	Used data from the Current Population Survey (CPS) from 1996 to 2002 for non-disabled parents.	
"The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program" by Bansak and Raphael (2006)	The study estimated **crowd out of 25 to 33 percent for SCHIP-eligible children.**	Used data from 1998 and 2002 CPS nationally for low-income children	**Crowd out for low-income children tends to be lowest of all categories.**

Crowd Out Literature Review

Study	Findings	Population studied/Data source	Comments
"Congressionally-Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress" by Woolridge et al (2005)	The study estimated **crowd out of 7 to 14% for newly enrolled children.**	Used case studies and surveys of SCHIP enrollees and disenrollees in 10 states-CA, CO, FL, IL, LA, MO, NC, NJ, NY, and TX	This study finds a **low crowd out rate for children**. Specific rate varies based on affordability and how long a child has been enrolled in SCHIP.
"The Impact of SCHIP on Insurance Coverage of Children" by Hudson JL, Selden TM, Banthin JS (2005)	Estimates of **crowd out for children under 18 was between 42 and 49 percent**	Used Medical Expenditure Survey	The authors suggested that the findings were not conclusive, as some model specifications resulted in no significant crowd-out effects while others showed a significant impact on private coverage
"Does Public Insurance Crowd Out Private Insurance?" by Gruber and Cutler (1996)	Study found **crowd out rate to be between 15 and 50 percent depending on the definition** used for crowd out.	Used CPS data from 1988 to 1993; multi-state.	Results depended on the definitition used for crowd out: 1) the decrease in private coverage as a share of newly eligible Medicaid enrollees (50 percent); 2) the decrease in private coverage as a share of all Medicaid enrollment increases (22 percent); and 3) the percentage decline of private coverage over a period of time attributed to Medicaid enrollment (15 percent).

FY 2009 Medicaid Expansion Charges

		FY 09 Expansion	FY 09 Medicaid Secondary Payor		FY 08 Medicaid FFS and MCO "crowd out"		FY 08 Commercial "crowd out"		Combined Medicaid and Commercial "crowd out"
1	Union of Cecil	1,790,925	208,816	11.66%	734,093	40.99%	419,895	23.45%	64.44%
2	Harford Memorial	335,573	58,903	17.55%	248,864	74.16%	27,806	8.29%	82.45%
3	St. Agnes	1,991,624	121,882	6.12%	688,360	34.56%	205,200	10.30%	44.87%
4	Suburban Hospital	170,909	4,075	2.38%	-	0.00%	-	0.00%	0.00%
5	Carroll Hospital Center	1,250,851	108,952	8.71%	457,266	36.56%	179,745	14.37%	50.93%
6	Western Maryland	2,073,266	-	0.00%	361,850	17.45%	233,557	11.27%	28.72%
7	Anne Arundel	880,019	64,803	7.36%	463,766	52.70%	260,772	29.63%	82.33%
8	Johns Hopkins Bayview	3,609,381	282,521	7.83%	1,551,521	42.99%	23,309	0.65%	43.63%
9	Washington County	337,303	69,340	20.56%	131,729	39.05%	69,682	20.66%	59.71%
10	Johns Hopkins Hospital	6,837,698	407,139	5.95%	4,821,968	70.52%	322,992	4.72%	75.24%
11	Howard County	1,034,051	103,734	10.03%	490,054	47.39%	30,494	2.95%	50.34%
12	Garrett County	595,128	10,320	1.73%	372,814	62.64%	89,480	15.04%	77.68%
13	St. Mary's	773,700	10,754	1.39%		0.00%		0.00%	0.00%
14	Franklin Square	3,109,294	287,131	9.23%	2,044,319	65.75%	542,723	17.45%	83.20%
15	Good Samaratin	1,504,122	97,790	6.50%	399,546	26.56%	70,371	4.68%	31.24%
16	Harbor	1,753,741	39,395	2.25%	1,132,596	64.58%	259,669	14.81%	79.39%
17	Union Memorial	2,140,995	59,357	2.77%	581,534	27.16%	151,533	7.08%	34.24%
18	Montgomery General	340,045	5,433	1.60%	76,508	22.50%	50,338	14.80%	37.30%
19	Bon Secours	181,797	9,309	5.12%	29,411	16.18%	78,182	43.01%	59.18%
20	Doctors	194,039	58,312	30.05%	25,805	13.30%	37,725	19.44%	32.74%
21	Peninsula	3,092,152	792,139	25.62%	761,716	24.63%	478,414	15.47%	40.11%
22	Frederick Memorial	1,200,543	114,861	9.57%	83,795	6.98%	170,237	14.18%	21.16%
		$35,197,156	$2,914,966	8.28%	$15,457,515	43.92%	$3,702,124	10.52%	54.44%

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE, BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

December 29, 2010

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 requires 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.

Introduction

Over the past several years, the General Assembly has considered various ways to reduce the number of uninsured individuals in the State, which has been estimated roughly to be 800,000. For example, legislation has been introduced to create a health care exchange, increase the eligibility age of dependents for health care coverage purposes, require citizens to obtain coverage or pay a tax penalty, require businesses to provide coverage to employees or pay a subsidy, provide a subsidy for small businesses that have not provided health care coverage to their employees, and expand eligibility for the Medicaid Program.

Senate Bill 6 (Chapter 7) was enacted during the 2007 Special Session, and SB974/HB 1587 (Chapter 244/245) was enacted in 2008 to address several of these issues.

Background

Chapter 7 of the 2007 Special Session enacted the "Working Families and Small Business Health Coverage 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 (currently 46%) of federal poverty guidelines (FPG), to be implemented in fiscal 2009 (116% for family of 4 = $24,000);

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

- Establishes a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission (MHCC) and funded with $15 million in fiscal 2009.

Special funds, including savings from averted uncompensated care and matching federal funds, will cover a portion of the costs of the expansion. Chapters 244/245 from 2008 requires the Commission to implement a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of health care coverage under Chapter 7. The assessment is to be broad-based, prospective, and uniform and will reflect averted uncompensated care realized from the expansion of the Medicaid Program under Chapter 7. The legislation authorizes the Commission to implement the assessment, provided that it does not exceed the actual averted uncompensated care.

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% 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.

In addition to altering the funding of health care expansion efforts, Senate Bill 974/House Bill 1587 made the Maryland Health Insurance Plan ("MHIP") assessment more responsive to the current needs of the program. Under this provision, regulations were adopted by the HSCRC to increase the assessment from the previous requirement of 0.81% to 1.0% of net patient revenue. The combined assessment (averted uncompensated care and MHIP) may not exceed 3% of total net patient revenue at Maryland hospitals.

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

Eligible individuals do not become enrolled in the Medicaid program until many months after care has been provided. Once enrolled, coverage is provided retroactively to the date of the service. In addition, it takes at least 3-6 months after care is provided for all relevant data to be accessed by Medicaid and the HSCRC on the associated costs. Therefore, the amount of averted bad debt is not fully known until many months after the conclusion of the applicable fiscal year. As a result, Medicaid and the HSCRC estimate the aggregate reduction in hospital uncompensated care based on Medicaid's expected enrollment and per member/per month costs. 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 the following:

- The percentage of expenditures that will be spent in-state, 94%, calculated using a three year average of Medicaid claims data;
- Medicaid pays 94% of charges;
- The percentage of expenditures that would go to hospitals (61%) calculated based on the Medicaid HealthChoice reimbursement process that breaks out payment rates into hospital, drug, and other components;
- The estimated share of the spending that was directed to individuals who had coverage previously (known as "crowd out") was 28% based on available literature and confirmed by surveys issued through Medicaid; and
- The lower use rate of the uninsured, approximately 82%, based on the available literature.

Using these adjustments, the original estimated hospital averted bad debt from Medicaid expansion in FY 2009 was calculated to be $34.3 million (See Row 11, Column A of Appendix I for calculations).

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 Row 17, Column A of Appendix I for calculations). 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 Department of Health and Mental Hygiene ("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 has been estimated preliminarily that the amount of averted bad debt in FY 2009 was $16.5 million greater than originally expected (See Row 18, Column B of Appendix I for calculations). This amount has been 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 55,000 and a per member/per month cost of $539. The total expected Medicaid expenditures for this population is $324.4 million. After making the same adjustments made for FY 2009, 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 (See Column C of Appendix I for calculations).

The aforementioned $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 (See line 19 in Column C in Appendix I).

Expansion to Emergency Care under the Primary Adult Care Program

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. This expansion will also require an adjustment to the FY 2010 uniform assessment. This program

required an additional $8.7 million in resources between January 1, 2010 and June 30, 2010. Therefore, this amount has been added to the uniform assessment for a total FY 2010 uniform assessment of $115.2 million.

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

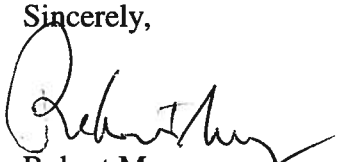
The FY 2011 assessment was based on an anticipated average enrollment of 69,773 and a per member/per month cost of $546. The total expected Medicaid expenditures for this population is $457.6 million. After making the same adjustments made in FY 2009 and 2010, the total expected hospital averted bad 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 will be no savings to purchasers of hospital care in FY 20011(See Column D of Appendix I for calculations).

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. 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.

Future reports will allow for a more comprehensive analysis by utilizing a full year of actual data. The HSCRC will continue to coordinate with DHMH to establish a more efficient and effective means of estimating averted bad debt resulting from the Medicaid expansion legislation, as well as determining the actual amount to be reconciled in hospital rates.

Sincerely,



Robert Murray
Executive Director

cc: Department of Legislative Services Library and Information Services (5 copies)
Senator Thomas Mac Middleton
Delegate Peter Hammen
Secretary John Colmers
Mr. Joseph Bryce (Governor's Legislative Office)
Ms. Marie Grant (DLS)
Ms. Linda Stahr (DLS)
Ms. Wynee Hawk (DHMH)

Appendix I

Estimate vs Actual Averted Bad Debt

Estimated for FY 2009, FY 2010, and FY 2011

		A Original Estimate FY 2009	B Revised Estimate FY 2009	C Revised Estimate FY 2010	D Revised Estimate FY 2011
1	Medicaid Total Expenditures	$95,170,624	$160,119,126	$324,422,100	$457,646,689
2	In State Payment Percent	94.00%	94.00%	94.00%	94.00%
3	In State Payments	$89,460,386	$150,511,978	$304,956,774	$430,187,888
4	Medicaid Payment Percent	94.00%	94.00%	94.00%	94.00%
5	Charges @ Hosp Payment Rate	$95,170,624	$160,119,126	$324,422,100	$457,646,689
6	Hospital Portion	61.00%	61.00%	54.00%	47.61%
7	Hospital Charges Reported	$58,054,080	$97,672,667	$175,187,934	$217,879,100
8	Crowd Out (28%)	72.00%	72.00%	72.00%	72.00%
9	Hospital Charges after Crowd	$41,798,938	$70,324,320	$126,135,312	$156,872,952
10	Lower Use Rate	82.00%	82.00%	82.00%	82.00%
11	**Averted Bad Debt**	**$34,275,129**	**$57,665,943**	**$103,430,956**	**$128,635,821**
12	Medicaid Expenditures for PAC	$0.00	$0.00	$0.00	$26,787,574
13	Hospital Charges after PAC				$155,423,395
14	Medicaid Payment Percent	94.00%	94.00%	94.00%	94.00%
15	Net Medicaid Payments	$32,218,621	$54,205,986	$97,225,099	$146,097,991
16	Percent Returned to Medicaid	75.00%	75.00%	92.61%	100.00%
17	Hospital Payments to Medicaid	$24,163,966	$40,654,489	$90,039,771	$146,097,991
18	**Difference**		**$16,490,523**		
19	Settle up Payment			**$16,490,523**	
20	Total Payments to Medicaid			$106,530,295	

Estimated Enrollees	29,273	55,000	69,773
Cost per Enrollee per member month	$511	$539	$546

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
Chairman

Kevin J. Sexton
Vice Chairman

Joseph R. Antos, Ph.D.

Trudy R. Hall, M.D.

Steven B. Larsen, J.D.

C. James Lowthers

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Charlotte Thompson
Deputy Director
Research and Methodology

January 1, 2010

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 requires 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 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.

Introduction

Over the past several years, the General Assembly has considered various ways to reduce the number of uninsured individuals in the State, which has been estimated roughly to be 800,000. For example, legislation has been introduced to create a health care exchange, increase the eligible age of dependents for health care coverage purposes, require citizens to obtain coverage or pay a tax penalty, require businesses to provide coverage to employees or pay a subsidy, provide a subsidy for small businesses that have not provided health care coverage to their employees, and expand eligibility for the Medicaid Program.

Senate Bill 6 (Chapter 7) was enacted during the 2007 Special Session, and SB974/HB 1587 (Chapter 244/245) was enacted in 2008 to address several of these issues.

Background

Chapter 7 of the 2007 Special Session enacted the "Working Families and Small Business Health Coverage 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 (currently 46%) of federal poverty guidelines (FPG), which will be implemented in fiscal 2009 (116% for family of 4 = $24,000);

- Contingent on available funding, incrementally expands the Primary Adult Care program benefits over three years to childless adults with household income up to 116 percent FPG (currently 46%), which will phase in from fiscal 2010 through 2013; and

- Establishes a Small Employer Health Insurance Premium Subsidy Program, which will be administered by the Maryland Health Care Commission (MHCC) and funded with $15 million in fiscal 2009.

Special funds, including savings from averted uncompensated care and matching federal funds, will cover a portion of the costs of the expansion. Chapters 244/245 from 2008 requires the Commission to implement a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of health care coverage under Chapter 7. The assessment is to be broad-based, prospective, and uniform and will reflect averted uncompensated care realized from the expansion of the Medicaid Program under Chapter

7. The legislation authorizes the Commission to implement the assessment provided that it does not exceed the actual averted uncompensated care.

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% 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.

In addition to altering the funding of health care expansion efforts, Senate Bill 974/House Bill 1587 made the Maryland Health Insurance Plan ("MHIP") assessment more responsive to the current needs of the program. Under this provision, regulations were adopted to increase the assessment from the previous requirement of 0.81% to 1.0% of net patient revenue. The combined assessment (averted uncompensated care and MHIP) may not exceed 3% of total net patient revenue at Maryland hospitals.

FY 2009 Uniform Assessment and Estimate of Averted Bad Debt

Frequently, eligible individuals do not become enrolled in the Medicaid program until many months after care had been provided. Once enrolled, coverage is provided retroactively to the date of the service. In addition, it takes at least 3-6 months after care is provided for all relevant data to be accessed by Medicaid and the HSCRC on the associated costs. Therefore, the amount of averted bad debt is not fully known until many months after the conclusion of the applicable fiscal year. As a result, Medicaid and the HSCRC estimate the aggregate reduction in hospital uncompensated care based on Medicaid's expected enrollment and per member/per month costs. 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 the following:

- The percentage of expenditures that will be spent in-state, 94%, calculated using a three year average of Medicaid claims data;
- Medicaid pays 94% of charges;
- The percentage of expenditures that would go to hospitals (61%) calculated based on the Medicaid HealthChoice reimbursement process that breaks out payment rates into hospital, drug, and other components;
- The estimated share of the spending that went to individuals who had coverage previously (known as "crowd out") was 28% based on available literature and confirmed by surveys issued through Medicaid; and

- The lower use rate of the uninsured, approximately 82%, based on the available literature.

Using these adjustments, the original estimated hospital averted bad debt from Medicaid expansion in FY 2009 was calculated to be $34.3 million (See Row 11, Column A of Appendix I for calculations).

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 Row 15, Column A of Appendix I for calculations). 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 Department of Health and Mental Hygiene ("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 has been estimated preliminarily that the amount of averted bad debt in FY 2009 was $16.5 million greater than originally expected (See Row 16, Column B of Appendix I for calculations). This amount has been included in the uniform assessment calculation for FY 2010.

FY 2010 Uniform Assessment and Estimated Averted Bad Debt

The FY 2010 assessment was based on an anticipated average enrollment of 55,000 and a per member/per month cost of $539. The total expected Medicaid expenditures for this population is $324.4 million. After making the same adjustments made for FY 2009, 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 (See Column C of Appendix I for calculations).

The aforementioned $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 (See line 18 in Column C in Appendix I).

Expansion to Emergency Care under the Primary Adult Care Program

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 Act phases-in specialty physician, emergency services, and hospital services over a three-year period, if available funding exists. Pursuant to Board of Public Works action in July of 2009, emergency services will be added to the PAC program beginning January 1, 2010. This expansion will also require an adjustment to the FY 2010 uniform assessment. This program is expected to require an additional $8.7 million in resources between January 1, 2010 and June 30, 2010. Therefore, this amount has been added to the uniform assessment for a total FY 2010 uniform assessment of $115.2 million.

Administrative Difficulties

Estimating averted bad debt has been more tedious than expected due to data lags, the inability of Medicaid to identify distinctly the individuals enrolled under the expansion legislation, the inadequacy of the enrollment and data systems at DHMH, the fact that uncompensated care is increasing overall due to other economic factors, and the time burden on staff at Medicaid and HSCRC.

Hospitals have claimed that they are not seeing the same level of averted bad debt that is being estimated. Medicaid, on the other hand, has been finding enrollment higher and more costly than initially estimated. Adding to the dichotomy is inability to provide- patient level information to hospitals in a timely manner to confirm such levels. As we note that uncompensated care continues to increase due to various economic factors, it will be difficult to determine averted bad debt accurately until all relevant data on Medicaid expansion enrollment and costs become available.

Over the past 18 months, HSCRC staff has invested approximately 800 hours in attempting to arrive at the most accurate estimates possible. Since this has not been an efficient use of staff time, the HSCRC, Medicaid, and the hospital industry representatives have been working to find a more efficient and accurate means of identifying the Medicaid expansion population within the HSCRC data.

Conclusion

Thank you for this opportunity to share preliminary data and an estimate of 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. 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.

Future reports will allow for a more comprehensive analysis by utilizing a full year of actual data. The HSCRC will continue to coordinate with DHMH to establish a more efficient and effective means of estimating averted bad debt resulting from the Medicaid expansion legislation, as well as determining the actual amount to be reconciled in hospital rates.

Sincerely,

Robert Murray, Executive Director
HSCRC

cc: Department of Legislative Services Library and Information Services (5 copies)
Senator Thomas Mac Middleton
Delegate Peter Hammen
Secretary John Colmers
Mr. Joseph Bryce (Governor's Legislative Office)
Ms. Marie Grant (DLS)
Ms. Linda Stahr (DLS)
Ms. Wynee Hawk (DHMH)

Appendix I

Estimate vs Actual Averted Bad Debt

Estimated for FY 2009 and FY 2010

		A Original Estimate FY 2009	B Revised Estimate FY 2009	C Revised Estimate FY 2010
1	Medicaid Total Expenditures	$95,170,624	$160,119,126	$324,422,100
2	In State Payment Percent	94.00%	94.00%	94.00%
3	In State Payments	$89,460,386	$150,511,978	$304,956,774
4	Medicaid Payment Percent	94.00%	94.00%	94.00%
5	Charges @ Hosp Payment Rate	$95,170,624	$160,119,126	$324,422,100
6	Hospital Portion	61.00%	61.00%	54.00%
7	Hospital Charges Reported	$58,054,080	$97,672,667	$175,187,934
8	Crowd Out (28%)	72.00%	72.00%	72.00%
9	Hospital Charges after Crowd	$41,798,938	$70,324,320	$126,135,312
10	Lower Use Rate	82.00%	82.00%	82.00%
11	**Averted Bad Debt**	**$34,275,129**	**$57,665,943**	**$103,430,956**
12	Medicaid Payment Percent	94.00%	94.00%	94.00%
13	Net Medicaid Payments	$32,218,621	$54,205,986	$97,225,099
14	Percent Returned to Medicaid	75.00%	75.00%	92.61%
15	Hospital Payments to Medicaid	$24,163,966	$40,654,489	$90,039,771
16	**Difference**		**$16,490,523**	
17	Settle up Payment			**$16,490,523**
18	Total Payments to Medicaid			$106,530,295

Estimated Enrollees	29,273	55,000
Cost per Enrollee per member month	$511	$539

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Stephen Ports
Acting Executive Director

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: September 7, 2011

RE: Hearing and Meeting Schedule

Public Session:

October 12, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

November 2, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

The Agenda for the Executive and Public Sessions will be available for your review on the Commission's website on the Thursday before the Commission meeting. To review the Agenda, visit the Commission's website at:
http://www.hscrc.state.md.us/CommissionMeetingSchedule.cfm

Post-meeting documents will be available on the Commission's website, on the afternoon, following the Commission meeting.