Final Recommendations on Uncompensated Care Policy for 2016

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

April 15, 2015

This document contains the final Staff recommendations the Uncompensated Care policy for 2016.

Finals Recommendations on Uncompensated Care Policy for 2016

INTRODUCTION

Overview

Since it first began setting rates, the HSCRC has recognized the cost of uncompensated care (charity care and bad debt) within Maryland's unique hospital rate setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of uncompensated care provided to those patients.

Under the current HSCRC policy, uncompensated care is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater-than-average level of uncompensated care and pay into the pool if they experience a less-than-average level of uncompensated care. This ensures that the cost of uncompensated care is shared equally across all of the hospitals within the system.

The HSCRC must determine the total amount of uncompensated care that will be placed in hospital rates for FY 2016 and the amount of funding that will be made available for the uncompensated care pool. Additionally, HSCRC must review the methodology for distributing these funds among hospitals.

Traditionally the HSCRC prospectively calculates the rate of uncompensated care at each regulated Maryland hospital by combining historical uncompensated care rates with predictions from a regression model. For fiscal 2015, the HSCRC adjusted this methodology to incorporate a prospective yet conservative adjustment for the expected impact of the Affordable Care Act's (ACA) Medicaid expansion on uncompensated care. The results of the historic trend and regression model were adjusted down from 7.23% to 6.14% to capture the expected impact of the State extending the full Medicaid benefits to people previously enrolled in the Primary Adult Care (PAC) program. PAC offered limited health care coverage including the cost of primary care, family planning, prescriptions, mental health care and addiction services, and outpatient hospital emergency room services. However, PAC did not reimburse hospitals for inpatient or outpatient care beyond the emergency room.

ACA implementation will influence the FY 2016 update as the variables underlying regression model include Medicaid coverage and the actual Medicaid expansion enrollment far exceeded the participants in the PAC program.

This report discusses the factors influencing uncompensated care rates in Maryland and makes recommendations to adjust the total funds available in the uncompensated care pool, to again use the results of last year's regression model for allocation of those funds in lieu of updating the regression analysis, and to update last's year prospective ACA adjustment to capture the full impact of the Medicaid expansion on uncompensated care.

The changes recommended are necessary to recognize an appropriate level of uncompensated care at hospitals in the State and to share the cost of that care equally across all regulated Maryland hospitals.

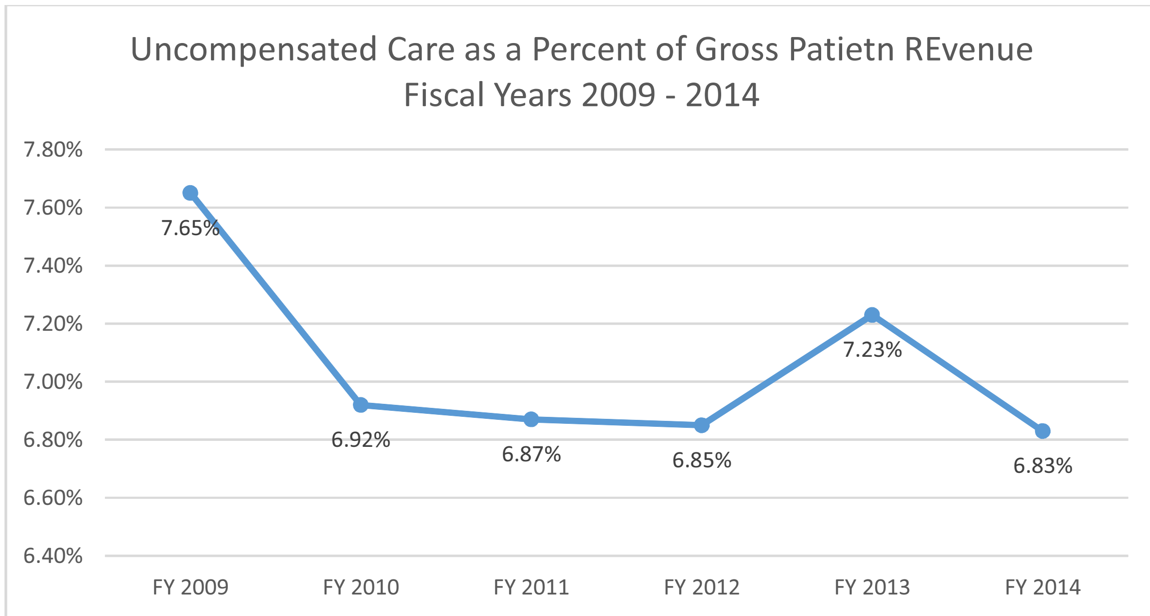
STAKEHOLDER INPUT

The conclusions in this report were reviewed with the Payment Models Workgroup and the Maryland Hospital Association's Financial Technical Issues workgroup. Several comments from the workgroups are incorporated in this staff report. Multiple iterations of hospital specific trends in self-pay and charity care were shared with each Maryland hospital. The overall analytic approach and figures for some hospitals were adjusted based on hospital feedback and additional analysis.

BACKGROUND

Recent Trends in Uncompensated Care

The chart below shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2009 and FY 2014. Uncompensated care levels dropped between FY 2009 and FY 2012, before climbing slightly in FY 2013. Implementation of the ACA in mid-FY 2014 resulted in a decline in an overall uncompensated care for the year.



Current Uncompensated Care Policy

The Commission adopted the current uncompensated care policies between 2007 and 2014. The policies create a statewide pool built into the rate structure of Maryland hospitals. Hospitals either pay into or withdraw from the pool depending on each hospital's prospectively calculated rate of uncompensated care. Each year, the total amount of funds available in the pool is determined by the total percent of gross patient revenue due to uncompensated care experienced in regulated Maryland hospitals during the previous year. For example, if in 2014 the actual total cost of uncompensated care were 6 percent, then in 2014 the pool would prospectively be set at 6 percent of the 2014 gross patient revenue.

For FY 2015, the prospective uncompensated care percentage for each hospital was computed by taking the average actual percent of uncompensated care experienced by the hospital over the past two years and combining that "actual" value with a predicted value of uncompensated care determined by a regression model. The annual uncompensated care percentage for each hospital was weighted equally between the two-year average and the predicted regression value as shown in the formula below.

$$\frac{Average\ UCC\ Rate\ for\ Past\ 2\ Years + Regression\ Value}{2} = Annual\ UCC\ Percentage$$

Once the annual uncompensated care percentages were calculated for each hospital, they were adjusted so that the pooling system will remain revenue neutral. Appendix I illustrates this calculation.

The regression model used to determine the FY 2015 predicted uncompensated care percentage for each hospital relied upon five explanatory variables:

- The proportion of a hospital's total charges from inpatient Medicaid admissions through the emergency room
- The proportion of a hospital's total charges from inpatient commercial insurance cases
- The proportion of a hospital's total charges from inpatient self-pay and charity cases
- The proportion of hospital's total charges from outpatient self-pay and charity emergency department charges
- The proportion of a hospital's total charges from inpatient self-pay and charity admission through the emergency room from the 80th percentile of Medicaid undocumented immigrant enrollment zip codes

This model was applied to data from the two-year historical period used to generate the average actual uncompensated care percentage described above. Three hospitals, Levindale Hospital, the University of Maryland Rehabilitation & Orthopedic Institute (formerly Kernan Hospital), and the Shock Trauma Center were excluded from the regression calculation. Under the current model, the HSCRC set the annual uncompensated care percentages for these hospitals at their actual average uncompensated care percentage for the previous three years.

Enrollment under the Affordable Care Act (ACA)

A primary goal of the ACA was to expand coverage to uninsured or underinsured individuals. Counting both individuals who have obtained Medicaid coverage and those who have selected a private health plan through Maryland's insurance exchange, more than 370,000 Marylanders enrolled in coverage through February 2015. This includes coverage of about 254,000 Marylanders through new Medicaid eligibility categories (including people previously covered under PAC) and about 120,000 through private health plans.

HSCRC staff is focusing its efforts on the new categories of Medicaid enrollees who account for about 70% of people covered through ACA related expansions. A wealth of information on this populations' utilization of hospital services before and after ACA

implementation is available due to the collaborative efforts of Medicaid and the Chesapeake Regional Information System for our Patients (CRISP).

ANALYSIS

Determining Appropriate Level of Uncompensated Care Funding in Rates

The HSCRC must determine the percentage of uncompensated care to recognize in hospitals' rates to enable funding of the uncompensated care pool.

Normally staff would begin by updating the regression model and examining the actual UCC rate for the last two or three years. Updating the regression model or the historical uncompensated care experience to include FY 2014 data is not recommended. Only six months of experience with the ACA expansion is captured in the FY 2014 data. This short a period is inadequate for assessing the impact of the Medicaid expansion on uncompensated care. Staff, instead, recommend continuing to use the historical experience from FY 12 and FY 13 and the results of last year's regression model.

The only recommended change to the FY 2015 uncompensated care analysis is to update the prospective adjustment for the impact of Medicaid expansion for an analysis of the actual calendar 2014 impact of the Medicaid coverage expansion. The prospective adjustment made for FY 2015 was limited to an estimate of the impact of the PAC population gaining full Medicaid coverage. The adjustment for FY 2016 captures the actual calendar 2014 impact on uncompensated care from extending Medicaid coverage to the entire expansion population covered by Medicaid (PAC and non-PAC).

Changes in Self-Pay and Charity Charges

HSCRC staff has focused on quantifying the impact of the ACA's Medicaid expansion on uncompensated care. To evaluate the impact, staff initially compared the charges identified in the Commission's case mix data with a primary expected payer of self-pay or charity before and after the ACA expansion. Self-pay and charity were the focus of the analysis as they are the best indicators of charges incurred by the uninsured population. This assumption is supported by an analysis of write-off data that shows about 80% of self-pay/charity charges are written off at most hospitals.

The staff analysis compared total charges with a primary expected payer of self-pay/charity for the first six months of calendar 2013 (pre-Medicaid expansion) and calendar 2014 (post- Medicaid expansion). Only six months of data for each year were used as Medicaid enrollment files were required to verify the accuracy of some of the

data (see discussion below). Because Medicaid allows retroactive eligibility, incomplete enrollment data was available at the time of the analysis for the 2nd half of calendar 2014.

Hospitals advised that the trends from 2013 to 2014 were distorted by a lack of uniformity in the classification of charges identified as Medicaid pending (charges associated with cases where the patient was not already enrolled in Medicaid but may qualify for coverage). Until July 2014 when the Commission staff established a uniform policy, some hospitals reported Medicaid pending cases as self-pay while others reported these cases as Medicaid. To resolve this data issue, staff collaborated with Medicaid and CRISP. CRISP's master patient index was used to identify all the hospital charges associated with people with Medicaid coverage for the time of service. Commission staff used the results of the CRISP analysis to reassign charges between Medicaid and self-pay/charity:

- Charges identified in the case mix data as self-pay or charity but associated with a patient enrolled in Medicaid were re-assigned to the Medicaid category.

- Charges identified in the case mix data as Medicaid but associated with a patient who was not identified as CRISP as enrolled in Medicaid were re-assigned to the self-pay category.

The results of the revised analysis are provided in the table below. Combined self-pay/charity charges dropped by $150 million from the first half of calendar 2013 to the first half of calendar 2014. Annualizing the six-month trend produces a $299 million decline in self-pay/charity charges. This amount is $133 million more than the prospective adjustment of the Medicaid expansion to the PAC population incorporated into the HSCRC's FY 2015 uncompensated care policy.

Analysis of Self-Pay/Charity Charges First Half of 2013 to First Half of 2014
($ in Millons)

	CY 2013	CY 2014	$ Change	% Change
Self-Pay/Charity Charges in Case Mix Data	$357	$183		
Remove Self-pay/Charity in CRISP Medicaid	-75	-27		
Add MA as Payer Not in CRISP	165	140		
	$446	**$296**	**-$150**	-34%
Annualized Change			**-$299**	

The annualized $299 million change was then adjusted for:

- Increases in Out-of-State Medicaid charges that were reported with in-State Medicaid charges at certain hospitals. The analysis treated out-of-State Medicaid as self-pay/charity. As a result, calendar 2014 self-pay/charity charges at border hospitals with significant growth in out-of-State Medicaid charges were overstated.

- An overstatement of calendar 2014 self-pay/charity charges at one hospital that appears to have incorrectly classified expected payers in the case mix data.

- Price changes at five hospitals that experienced significant swings in prices from calendar 2013 to calendar 2014.

The net impact of the adjustments is to reduce self-pay/charity charges by $10 million in calendar 2014. As shown in the table below, the revised annualized change in self-pay charity charges from calendar 2013 to calendar 2014 is $310 million. Staff recommends using the CY 2014 decline in self-pay/charity charges, converted to a percentage to reduce the provision for UCC in hospitals' rates for FY 2016.

Adjustments to Analysis of Self-Pay /Charity Charges

$ in Millions

	CY 2013 1st 6 Months	CY 2014 1st 6 Months	$ Change
Self-Pay Charity Charges for First Half of Year	$446	$296	-$150
Out-of-State Medicaid	-14	-16	-2
Correct Data issue at one hospital		-4	-4
Price Leveling		1	1
Revised Totals	$432	$278	-$155
Annualized Change			-$310

The estimate for the reduction in UCC without any offsets for collections is 1.98 percent. It should be noted that Medicaid receives a differential of 6 percent; therefore, approximately 94 percent of the reduction of the uncompensated care will be recognized in hospital rates due to a corresponding increase that will occur in the mark up relative to the increase in the differential that will result from the higher proportion of Medicaid revenues. This mark-up change is a separate provision in the rate update process.

Based on these recommendations, the UCC in hospitals' rates would be set at 5.25 percent as shown below. This percent is nearly identical to the FY 2015 year-to-date figure of 5.23% reported by hospitals through February 2015.

	FY 15 UCC	FY 16 UCC
FY 15 Policy Before ACA Adjustment	7.23%	7.23%
ACA Impact*	-1.09%	-1.98%
Net	**6.14%**	**5.25%**

*FY 2015 Adjustment limited to PAC population.

Continuing Suspension of Charity Care Multiplier

HSCRC staff recommends continuing the suspension of the charity care multiplier indefinitely. The data have not improved and, furthermore, the expansion of coverage under the ACA will likely reduce charity care. This policy can be reevaluated in two to three years after the expansion and implementation of ACA have been completed.

Evaluation of Continuing Sources of Uncompensated Care

Last year the Commission directed staff to begin collecting data on write-offs to guide future development of uncompensated care regression models and uncompensated care policies. Hospitals have submitted information on write-offs and recoveries that occurred during calendar 2014. The data submitted cover claims for services incurred in calendar 2014 and prior years. The data, which are still being scrubbed, are summarized in the table below.

Write-off and Recovery Data Submitted During CY 2014

$ in Millions

	Write-Off Amount	Payer Share of Write-offs	Total Billed Amount	Write-off as % of Bill
Self-Pay/Charity/Medicaid	$586	58%	$1,229	48%*
Commercial	265	26%	1,630	16%
Medicare	116	11%	1,264	9%
Workers' Comp	14	1%	53	26%
Other	31	3%	84	37%
Total	**$1,012**		**$4,260**	

	Recovery	Recovery as % of Writeoff
Self-Pay/Charity/Medicaid	$104	18%
Commercial	128	48%
Medicare	44	38%
Workers' Comp	7	50%
Other	11	35%
Total	**$294**	29%

	Write-off Net of Recovery	Payer Share of Net	Total Billed Amount	Write-off as % of Bill
Self-Pay/Charity/Medicaid	$482	67%	$1,229	39%*
Commercial	$137	19%	1,630	8%
Medicare	$72	10%	1,264	6%
Workers' Comp	$7	1%	53	13%
Other	$20	3%	84	24%
Total	**$718**		**$4,260**	

*Most hospitals report write-offs as share of Medicaid, self-pay, charity bills at 75% to 80%. The state average is pulled down by a couple of outliers who report a substantial volume of charges and write-offs of about 20%. Staff are working with those hospitals to determine if there is a data reporting issue.

The majority (58%) of the write-offs were for charges with a primary expected payer of self-pay, charity, or Medicaid. Since Medicaid does not require enrollee cost sharing,

Medicaid write-offs are most likely cases where the person ultimately failed to qualify for Medicaid and lacked insurance.

About 26% of the write-offs are associated with a commercial payer with the average write-off representing 16% of total charges. With only one year of data available, it is too soon to determine the extent to which increasing deductibles are contributing to increases in uncompensated care. Continued collection of the data is recommended to enable analysis of multi-year trends and guide future development of uncompensated care regression models and policies.

Impact of Denials on All-Payer Model

In response to direction from the Commission during development of the FY 2015 uncompensated care policy, hospitals have begun submitting data on outpatient denials. Due to the uneven quality of initial submissions, insufficient data are available at this point to perform a meaningful analysis. Staff are working with hospitals to improve the uniformity of the data submissions and expect to release an initial analysis in September.

HSCRC staff recommend continued collection of this data to support development of trends analysis and a better understanding of the impact denials have on individual hospital revenues.

Future Uncompensated Care Policy

HSCRC staff notes that the changes to the uncompensated care policy laid out in this report should only be applied for FY 2016. Development of the FY 2017 uncompensated policy will occur in a less dynamic insurance market place and a more data rich environment. Almost two years of post-ACA implementation data including audited financial statements for FY 2015 will be available to update the regression model. With two years of data on write-offs also available, staff may be able to incorporate new variables into the regression model that better capture the continuing sources of uncompensated care.

RECOMMENDATIONS

Based on the preceding analysis, the HSCRC staff recommends that:

1. The uncompensated care provision in rates be reduced from 6.14% to 5.25%, effective July 1, 2015;

2. The combined results of the regression model and two years of historical data underpinning the FY 2015 uncompensated care policy be re-used for FY 2016:
    a. No update to the regression results.
    b. Combine the regression results with the same two years of actual data (FY 2012 and FY 2013) incorporated into the FY 2015 policy.
    c. Subtract the ACA driven decline in self-pay/charity charges from CY 2013 to CY 2014 from the modeled uncompensated care result for each hospital to derive its final percentage for determining its contribution or withdrawal from the uncompensated care pool. Appendix II shows the result of this calculation.
3. The Charity Care Adjustment be suspended indefinitely and not be reinstituted in FY 2016 rates;
4. Data continued to be collected on write-offs to guide future development of uncompensated care regression models and uncompensated care policies;
5. Data continued to be collected on outpatient denials, in addition to data already collected on inpatient denials, to understand the continuing trends in denials under the new All-Payer model; and
6. A new uncompensated care policy be developed for FY 2017 that reflects the patterns in uncompensated care experience, which are observed in FY 2015 and projected for FY 2016.

Appendix I: Calculation to Achieve a Revenue Neutral Policy

The HSCRC calculated the annual UCC percentage for each hospital by combining the average actual UCC percentage for each hospital for the past two years with a predicted UCC percentage from the regression model. The HSCRC then adjusted the annual UCC percentage for each hospital so that the total statewide UCC percentage was equal to the actual total statewide UCC percentage for 2013. This was done to achieve a revenue neutral system of pooling across all hospitals. This adjustment was done before any policy adjustments were made, such as the PAC reduction.

Revenue neutral adjustment factor:

$$= \frac{Total\ actual\ 2013\ UCC\ \% - Total\ calculated\ UCC\%\ for\ 2015}{Total\ actual\ \ 2013\ UCC\%} + 1$$

Adjusted UCC percentage for each hospital:

$$= revenue\ neutral\ adjustment\ factor * 2015\ UCC\%\ calculated\ for\ hospital\ 1$$

Appendix II: Proposed Uncompensated Care Levels by Hospital for FY 2016

	A	B	C	D	E
			C = A - B		E = A -D
	FY 2015 Policy Results Without PAC	FY 15 PAC Adjustment	FY 2015 Policy	FY 2016 ACA Expansion Adjustment	FY 2016 Policy
Meritus Medical Center	7.83%	1.66%	6.17%	3.08%	4.76%
Univ. of Maryland Medical Center	6.50%	1.85%	4.65%	3.69%	2.81%
Prince Georges Hospital	16.07%	1.09%	14.98%	1.09%	14.98%
Holy Cross Hospital of Silver Spring	8.84%	0.31%	8.53%	1.46%	7.39%
Frederick Memorial Hospital	6.33%	0.90%	5.43%	2.32%	4.02%
Harford Memorial Hospital	10.75%	1.51%	9.24%	2.00%	8.75%
Mercy Medical Center, Inc.	6.74%	1.34%	5.40%	1.02%	5.72%
Johns Hopkins Hospital	4.31%	0.78%	3.53%	1.21%	3.10%
UM Dorchester	8.25%	2.67%	5.58%	4.16%	4.09%
St. Agnes Hospital	8.13%	1.45%	6.69%	2.81%	5.33%
Sinai Hospital	5.83%	1.10%	4.73%	1.33%	4.50%
Bon Secours Hospital	17.59%	5.80%	11.79%	7.12%	10.47%
Franklin Square Hospital	7.74%	0.95%	6.80%	2.82%	4.92%
Washington Adventist Hospital	13.36%	0.59%	12.78%	1.16%	12.20%
Garrett County Memorial Hospital	10.10%	0.75%	9.36%	3.24%	6.86%
Montgomery General Hospital	7.02%	0.78%	6.25%	1.55%	5.47%
Peninsula Regional Medical Center	6.71%	1.30%	5.41%	1.84%	4.87%
Suburban Hospital Association,Inc	5.33%	0.28%	5.05%	1.25%	4.08%
Anne Arundel General Hospital	4.82%	0.54%	4.29%	1.45%	3.38%
Union Memorial Hospital	7.49%	1.45%	6.03%	2.39%	5.10%
Western Maryland	6.49%	1.06%	5.43%	2.88%	3.61%
St. Marys Hospital	7.41%	1.09%	6.32%	3.09%	4.32%
Johns Hopkins Bayview Med. Center	8.71%	1.73%	6.98%	3.22%	5.49%
UM Chestertown	9.01%	0.77%	8.24%	2.50%	6.51%
Union Hospital of Cecil County	8.25%	1.82%	6.43%	2.61%	5.64%
Carroll County General Hospital	5.23%	0.69%	4.53%	1.23%	3.99%
Harbor Hospital Center	9.12%	1.47%	7.65%	2.55%	6.57%
UM Charles Regional	8.15%	0.80%	7.35%	2.36%	5.79%
UM Easton	6.40%	0.83%	5.56%	1.58%	4.82%
UM Midtown	12.65%	3.52%	9.14%	4.14%	8.51%
Calvert Memorial Hospital	6.55%	1.05%	5.51%	2.17%	4.39%
Northwest Hospital Center, Inc.	8.47%	0.93%	7.54%	2.75%	5.73%
UM Baltimore Washington	8.82%	1.02%	7.80%	2.01%	6.81%
Greater Baltimore Medical Center	3.79%	0.38%	3.42%	0.41%	3.39%
McCready Foundation, Inc.	9.57%	2.76%	6.81%	3.54%	6.04%
Howard County General Hospital	6.33%	0.61%	5.72%	2.18%	4.15%
Upper Chesepeake Medical Center	5.71%	0.59%	5.12%	0.61%	5.10%
Doctors Community Hospital	9.10%	0.61%	8.49%	2.09%	7.01%
Laurel Regional Hospital	13.24%	0.94%	12.30%	1.74%	11.51%
Good Samaritan Hospital	7.33%	0.90%	6.43%	1.93%	5.40%
Shady Grove Adventist Hospital	7.24%	0.53%	6.71%	1.06%	6.17%
Fort Washington Medical Center	13.09%	0.86%	12.23%	1.34%	11.76%
Atlantic General Hospital	7.86%	1.42%	6.43%	1.26%	6.60%
Southern Maryland Hospital	7.54%	0.94%	6.60%	2.65%	4.89%
UM St. Joseph's	4.63%	0.72%	3.90%	0.68%	3.95%
UM Rehab and Ortho	5.80%	1.13%	4.67%	1.61%	4.19%
Univ. of Maryland (MIEMSS)	21.36%	0.25%	21.11%	-0.73%	22.09%
Levindale	1.83%	0.00%	1.83%	0.00%	1.83%
Statewide	**7.23%**	**1.09%**	**6.14%**	**1.98%**	**5.25%**

*University of Maryland and MIEMSS will have a combined rate of 5.35%