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cost review commission

December 14, 2020

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

The Honorable Bill Ferguson
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

Dear Governor Hogan, President Ferguson, and Speaker Jones:

House Bill 1420 – Hospitals - Financial Assistance Policies and Bill Collections, enacted under Enacted under Article II, Section 17(c) of the Maryland Constitution - Chapter 470, mandates that the Health Services Cost Review Commission (HSCRC), to the extent practicable, evaluate the impact that the changes listed under subsection (b) would have on:

(1) the amount of hospital uncompensated care included in hospital rates; and
(2) the total cost of care for:
    (i) Medicare;
    (ii) the Maryland Medical Assistance Program;
    (iii) commercial insurers; and
    (iv) self–pay individuals.

Subsection (b) states:

(b) To the extent practicable, the Commission shall evaluate the impact that the following changes to § 19–214.1 of the Health – General Article would have:
    (1) increasing the maximum free care threshold and minimum reduced–cost care threshold from 200% to:
        (i) 250%;
        (ii) 300%; and
        (iii) 350%;
    (2) increasing the reduced–cost care with financial hardship threshold from 500%
    (3) reducing the financial hardship threshold for medical debt as a percentage of family income from 25%
    (4) including copays, coinsurance, and deductibles in the definition of medical debt; and
    (5) in consultation with Maryland Department of Health and the Department of Human Services, expanding presumptive eligibility for reduced–cost care determination to patients who:

(i) are homeless;
(ii) receive benefits through the State Family Investment Program;
(iii) receive benefits through the Emergency Assistance to Families with Children Program;
(iv) receive benefits through the Maryland Medical Assistance Program under Title XIX of the Social Security Act;
(v) receive benefits through any federal Medicare savings program, including the Qualified Medicare Beneficiary program, and the specified low–income Medicare Beneficiary Program;
(vi) receive benefits through the Public Assistance to Adults Program;
receive benefits through the Temporary Disability Assistance Program;
(vii) receive benefits through any other public assistance activities financed wholly or partly by the Family Investment Administration in the Department of Human Services; or
(viii) receive benefits from any other federal, State, or local public assistance program.

The HSCRC is required to report its findings and any recommendations to the Governor's office and the General Assembly on or before January 1, 2021.

The HSCRC understands the importance of this report and has worked assiduously over the several months to compile the data required for this report with the state's designated health information exchange Chesapeake Regional Information System for our Patients (CRISP), the Maryland Office of the Comptroller, the Maryland Department of Health, and the Maryland Department of Human Services. However, as the HSCRC noted during a briefing to the Health and Government Operations Committee on November 17, 2020, due to several factors, including the unforeseen COVID-19 pandemic, there has been a delay in our ability to complete the required analysis. We anticipate that we can perform a thorough analysis in the way contemplated by HB 1420 by January 29, 2021. The HSCRC is therefore writing this letter as a notice of delayed submission to the Governor's office and the General Assembly.

If you have any questions, please do not hesitate to contact me at tequila.terry1@maryland.gov.

Sincerely,

Tequila Terry
Director

Cc:
Sarah Albert, Department of Legislative Services
Diane Croghan, Office of the Governor
Jake Whitaker, Office of the Governor
The Honorable Melony Griffith
The Honorable Nancy J. King
The Honorable Susan C. Lee
The Honorable Sheree Sample-Hughes
The Honorable Eric G. Luedtke

The Honorable Talmadge Branch
The Honorable J. B. Jennings
The Honorable Stephen S. Hershey, Jr.
The Honorable Nicholaus R. Kipke
The Honorable Kathy Szeliga
The Honorable Delores G. Kelley
The Honorable Brian J. Feldman
The Honorable Shane E. Pendergrass
The Honorable Peña-Melnyk
The Honorable Guy Guzzone
The Honorable Jim Rosapepe
The Honorable Maggie McIntosh
The Honorable Michael A. Jackson

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January 26, 2021

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

The Honorable Bill Ferguson
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

Re: Submission Date for Required Report under Section 2 of Chapter 410, 2020 Laws of Maryland

Dear Governor Hogan, President Ferguson, and Speaker Jones:

Section 2 of Chapter 470, 2020 Laws of Maryland, (Hospitals - Financial Assistance Policies and Bill Collections) requires the Health Services Cost Review Commission (HSCRC) to model the impact of different financial assistance policies and submit a report to the Governor and the Legislature. This letter serves as notice of delayed submission. The HSCRC plans to submit this report by Friday, February 19, 2021.

The HSCRC has worked with the state's designated health information exchange Chesapeake Regional Information System for our Patients (CRISP), the Maryland Office of the Comptroller, the Maryland Department of Health, and the Maryland Department of Human Services to compile the data required for this report. In the process of collecting and analyzing the data, HSCRC has faced several unforeseen delays but expects this new submission date will provide the necessary additional time to ensure the accuracy of the report.

If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 443.462.8632 or tequila.terry1@maryland.gov or Megan Renfrew, Associate Director of External Affairs, at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Tequila Terry
Director

Cc:
Sarah Albert, Department of Legislative Services
Diane Croghan, Office of the Governor

Jake Whitaker, Office of the Governor
The Honorable Robbyn Lewis
The Honorable Lorig Charkoudian

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

The Honorable Bill Ferguson
President of the Senate
H-101 State House
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
H-107 State House
Annapolis, MD 21401-1991

Re: House Bill 1420 (Ch. 470, 2020 Md. Laws) _ MSAR# 12823 _ Analysis of the Impact of Hospital Financial Assistance Policy Options on Uncompensated Care and Costs to Payers.

Dear Governor Hogan, President Ferguson, and Speaker Jones,

The Health Services Cost Review Commission (HSCRC) is submitting the report, *Analysis of the Impact of Hospital Financial Assistance Policy Options on Uncompensated Care and Costs to Payers*. House Bill 1420 (Chapter 470 , 2020) requires HSCRC, to the extent practicable, to evaluate the impact of different financial assistance policies on the amount of hospital uncompensated care and the total cost of care for all payers in Maryland. The attached report contains this analysis.

If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 443-621-2244 or katie.wunderlich@maryland.gov or contact Megan Renfrew, Associate Director of External Affairs, at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Katie Wunderlich
Executive Director

cc:
Jake Whitaker, Deputy Legislative Officer, Office of the Governor
Webster Ye, Assistant Secretary, Maryland Department of Health
Sarah Albert, Department of Legislative Services (5 copies)

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Analysis of the Impact of Hospital Financial Assistance Policy Options on Uncompensated Care and Costs to Payers

Mandated by House Bill 1420 (Ch. 470, 2020 Md. Laws)

MSAR# 12823

February 2021

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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I. Executive Summary

Chapter 470, 2020 Laws of Maryland, (Hospitals - Financial Assistance Policies and Bill Collections) requires the Health Services Cost Review Commission (HSCRC or Commission), to the extent practicable, to evaluate the impact of different financial assistance policies on the amount of hospital Uncompensated Care included in hospital rates and the total cost of care for Medicare, the Medicaid; commercial insurers; and self–pay individuals. Chapter 470 requests modeling of changes to the maximum free care threshold and minimum reduced–cost care threshold; increasing the reduced–cost care with financial hardship threshold; reducing the financial hardship threshold for medical debt as a percentage of household income; including copays, coinsurance, and deductibles in the definition of medical debt; and expanding presumptive eligibility for a reduced–cost care determination to patients who are homeless or receive benefits from other federal, State, or local public assistance programs.

HSCRC analyzed hospital performance on the provision of statutorily-required free care to individuals under 200% of the federal poverty level (FPL); the impact of the possible changes to eligibility thresholds for free care on statewide uncompensated care and the total cost of care for Medicare, Medicaid, commercial insurers, and self-pay patients; and the impact of a potential presumptive eligibility program for reduced-cost care policy. Due to data limitations, the HSCRC was not able to complete an analysis of the financial impact of the changes eligibility thresholds to reduced-cost care or reduced-cost care with financial hardship stipulations on uncompensated care (UCC) and payers.

To conduct the analysis in this report, HSCRC used data from the Commission's hospital case mix data set, data from Maryland tax filings from the Maryland Office of the Comptroller, and commercial insurance claims data from Maryland Medical Care Database (MCDB), maintained by the Maryland Health Care Commission. The data used in this study are subject to a number of limitations due to issues associated with combining these separate data sources. Further, the analysis in this report relies on a number of assumptions, which are described in the body of this report. Finally, the analysis in this report may also be impacted by data limitations related to data completeness and accuracy.

HSCRC determined that approximately 60% of UCC (i.e. unpaid charges) attributable to individuals with a household income under 200% of the federal poverty level (FPL) is reported by hospitals as bad debt, rather than free care. Hospitals are required by statute to provide free care to patients below this income level. The analysis in this report suggests that hospitals attempted (and failed) to collect this debt from a sizable number of patients likely eligible for free care. In addition, approximately 1% of total hospital charges to individuals who likely qualify for free care are paid by those individuals (this amounts to approximately $60 million statewide). Commercial insurance benefit design appears to contribute to the amount of cost sharing paid by patients with incomes under 200% of FPL.

HSCRC's analysis of the estimated impact of increasing FPL thresholds for eligibility for hospital free care shows that every increase of 50 percentage points in FPL will increase UCC (and all payer costs) by $40 to $42 million, paid by patients that utilize the hospital. Specifically, increasing the FPL to 250% would increase costs by approximately $15 million for commercially insured patients, $9 million for Medicaid enrollees, and $16 million for Medicare FFS beneficiaries. Furthermore, if the FPL threshold was increased up to 350%, the additional costs to Medicare FFS would total approximately $48 million, which represents 16% of the required annual savings under the Total Cost of Care Model contract with the federal Centers for Medicare and Medicaid Services (CMS). Increasing the FPL threshold increases the total cost of care for Medicare, thereby making it more difficult to achieve the savings requirements under the contract. Staff did not analyze the financial impact of increasing FPL thresholds for reduced-cost care in UCC or payers due to data limitations.

HSCRC analyzed the potential for creating a presumptive eligibility policy for reduced-cost care. Neither the statute nor HSCRC regulations specify how much of a discount hospitals must provide to patients who qualify for reduced-cost care. Health General § 19-214.1(b)(5), Maryland Code, states that "the hospital shall apply the reduction that is most favorable to the patient." Because of the resulting variability in the amount of discounts offered by hospitals to patients eligible for reduced-cost care and other data limitations, HSCRC staff were not able to analyze the financial impact on UCC and payers of creating a presumptive eligibility program for reduced-cost care. The General Assembly should carefully consider the purpose of creating a presumptive eligibility for reduced-cost care policy, as reduced-cost care discounts are generally offered on a sliding scale based on income. As a result, it is not clear that a presumptive eligibility program for reduced-cost care would speed access to reduced-cost care discounts for patients compared to existing application processes. The General Assembly may wish to consider adding programs and populations in which most individuals are below 200% FPL to the eligibility criteria for free care in Health General 19-214.1(b)(7).

II. Introduction

This report contains the Health Services Cost Review Commission's analysis of hospital provision of statutorily-required free care to individuals under 200% of the federal poverty level (FPL). This report also contains an analysis of the impact of the possible changes to eligibility thresholds for free care and reduced-cost care on statewide uncompensated care and the total cost of care for Medicare, Medicaid, commercial insurers, and self-pay patients. Finally the report contains analysis of the impact of a potential presumptive eligibility for reduced-cost care policy.

House Bill 1420 (Ch. 470, 2020 Laws of Maryland) - Mandated Study

House Bill 1420[1], *Hospitals - Financial Assistance Policies and Bill Collections*, requires the HSCRC, to the extent practicable, to evaluate the impact of different possible changes to § 19–214.1 of the Health General Article on the amount of hospital uncompensated care (UCC) included in hospital rates and the total cost of care for Medicare, Medicaid; commercial insurers; and self–pay individuals.

The changes to § 19–214.1 of the Health General Article detailed in the bill include the following:

1. increasing the minimum maximum free care policy threshold and minimum reduced–cost care threshold from 200% to 250%, 300%, and 350%;
2. increasing the reduced–cost care policy from 300% to 350%, 400%, and 450%;
3. increasing the medical hardship policy from reduced–cost care with financial hardship threshold from 500% to 550%, 600%, and 650%;
4. reducing the financial hardship threshold for medical debt as a percentage of household income from 25% of household income to 20%, 15%, and 10%;
5. including copays, coinsurance, and deductibles in the definition of medical debt; and
6. in consultation with Maryland Department of Health and the Department of Human Services, expanding presumptive eligibility for reduced–cost care determination to patients who are homeless or receive benefits from federal, State, or local public assistance programs.[2]

[1] Ch. 470, 2020 Laws of Maryland

[2] The bill specifically mentions the following receive benefits from the following public assistance programs: the State Family Investment Program; the Emergency Assistance to Families with Children Program; the Maryland Medical Assistance Program under Title XIX of the Social Security Act (Medicaid); any federal Medicare savings program, including the Qualified Medicare Beneficiary program, and the specified low–income Medicare Beneficiary Program; the Public Assistance to Adults Program; the Temporary Disability Assistance Program; any other public assistance activities financed wholly or partly by the Family Investment Administration in the Department of Human Services; and any other federal, State, or local public assistance program.

Background on Uncompensated Care

Uncompensated Care is hospital care provided for which no compensation is received. Hospital UCC includes *charity care* and *bad debt*.

Charity Care

Charity care services are "those Commission regulated services rendered for which payment is not anticipated".[3] Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. There are two types of charity care that may occur across all payers:

1. **Free care** is care for which the patient is not responsible for any out-of-pocket expenses for hospital care. Hospitals are required statutorily to provide free care to patients with a household income less than 200% of the FPL.[4]

2. **Reduced-cost care** is care for which the patient is only responsible for a portion of out-of-pocket expenses and is required for patients with household income between 200 and 300% of the FPL.[5] Reduced-cost care is also required for patients that have a financial hardship[6] and have household income below 500% of the FPL. Financial hardship is defined by statute as medical debt, incurred by a household over a 12-month period, that exceeds 25% of household income.[7] There is no prescribed discount that hospitals must provide to patients between 200% and 500% of the FPL. Per statute "if a patient is eligible for reduced-cost medically necessary care, the hospital shall apply the reduction that is most favorable to the patient."[8] The lack of clarity in the statute results in a lack of uniformity in hospitals' financial assistance policies. See Appendix A for examples of individual reduced-cost care policies.

3. **Bad Debt:** The other type of Hospital UCC is bad debt, which is for "Commission regulated services rendered for which payment is anticipated and credit is extended to the patient" but the payment is not made. Hospitals follow their debt collection policies, and, if debt collection is

[3] HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at: https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf
[4] Md. Code, § 19-214.1(b)(2) (i) of the Health General Article
[5] COMAR 10.37.10.26 A-2 (2)(a)(ii)
[6] Md. Code, § 19-214.1(a)(2) of the Health General Article
[7] Md. Code, § 19-214.1(b)(4) of the Health General Article
[8] Md. Code, § 19-214.1(b)(5) of the Health General Article

unsuccessful, their write off policies. Bad debt is the amount written off due to non-collection of amounts from patients. Unpaid cost share for patients that do not meet the free thresholds can be charged as bad debt after the hospital makes a reasonable attempt to collect those charges.[9] However, there are several reasons that a hospital may not include bad debts into uncompensated care, most notably denials.[10]

Uncompensated Care and Hospital Rates

Recognizing the financial burden hospitals take on when providing quality care to patients who cannot pay for it, the HSCRC factors in the cost of UCC into the rates the Commission sets for hospitals.[11] HSCRC's UCC policy assures access to hospital services in the State for those patients who cannot readily pay for them and equitably distributes the burden of uncompensated care costs across all hospitals and all payers. This approach ensures that hospitals with high volumes of low-income patients are not at a financial disadvantage.

It is important to note that state-wide UCC funding for hospitals comes from increases to hospital charges for hospital services that apply to all payers (including Medicaid). Under this system, payers subsidize a share of uncompensated care that is equal to the payer's share of the market. These rate increases ultimately impact consumers and, for Medicaid, the state budget.

The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated Maryland hospital using a four-step process:

1. **Statewide UCC:** HSCRC determines the statewide actual UCC based on the prior year's charity care and bad debt as a percentage of gross patient revenue as reported on the Hospitals' Revenue

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[9] Bad debt includes unpaid cost share expenses reduced by a reduced-cost care discount for patients eligible for reduced-cost care. The HSCRC requires hospitals to make "a reasonable collection effort" before writing-off bad debt. HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at: https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[10] These include: a) Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.; b) Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers; c) Charges for medically unnecessary hospital services;). Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort - 08/01/08 SECTION 100 ACCOUNTING PRINCIPLES AND CONCEPTS I

[11] Maryland has a unique all-payer rate setting system for hospitals, administered by the HSCRC. Acute general hospitals in Maryland must charge patients (and insurers) the rate set by the HSCRC for health care services.

and Expense (RE) Schedules[12] (e.g. rate year (RY) 2021 UCC rates are based on the UCC percentage from the RY 2019 RE Schedules). The results from this computation determines the statewide UCC rate that will be built into the all-payer hospital rate structures. Only acute care hospitals are considered when determining the statewide UCC level.[13]

2. **Hospital-Specific UCC:** Determine the hospital-specific actual UCC for each hospital based on the prior year's charity care and bad debt as a percentage of gross patient revenue as reported on the Revenue and Expense (RE) Schedules.[14] (e.g. RY 2021 UCC uses the UCC percentage from the RY 2019 RE Schedules).

3. **Predicted Future UCC:** Use data from past years to predict the UCC for the upcoming rate year for each hospital. The HSCRC's model for predicting future UCC takes into account area deprivation Index[15], payer type, and site of care. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and then are divided by hospital total charges to establish the hospital's estimated UCC level.[16] Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.

4. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step 2 above) and the predicted UCC (described in step 3). This calculation serves to balance policy goals of reimbursing hospitals for UCC provided to low-income patients through the hospital's financial assistance policy while also incentivizing hospitals to minimize bad debt by encouraging reasonable activities to collect debt from patients who can afford to pay.

[12] Aggregation of hospital financial data due to the Commission 120 days after the end of the hospital's fiscal year.

[13] Freestanding medical facilities (i.e. freestanding emergency centers), behavioral health, and specialty hospitals are not considered in the determination of how much to fund UCC statewide. These facilities do have their hospital-specific UCC built into their rates.

[14] RY 2021 UCC rates are based on the UCC percentage from the RY 2019 RE Schedules.

[15] "The Area Deprivation Index ...allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest …. includ[ing] factors for...income, education, employment, and housing quality." https://www.neighborhoodatlas.medicine.wisc.edu/

[16] The logistic regression is limited to just acute care hospitals. UMROI, Levindale and University of Maryland Shock Trauma are also excluded from the regression due to the fact that these hospitals do not incorporate all of the input variables necessary to perform the regression as listed earlier in this Section.

5. **Hospital Payments or Contributions to the UCC fund.** The 50/50 blend from step four for each hospital is subtracted from the amount of UCC funding provided in rates (calculated in step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into a statewide UCC Fund. The UCC fund is the funding mechanism to ensure the burden of uncompensated care is shared equitably across all hospitals. Specifically, if a hospital has a UCC rate computed from the 50/50 blend that is less than the statewide average UCC rate from the prior fiscal year that was provided in rates to all hospitals, the hospital will pay into the UCC fund equal to the variance between the two statistics. Conversely, if a hospital has a 50/50 blend that is greater than the statewide average UCC rate, the hospital will receive funding equal to the variance between the two statistics.

Exhibit 1: UCC Methodology Example ($ Millions)

		Step 1		Step 2	Step 3	Step 4	Step 5
	A	**B**	**C = A X B**	**D**	**E**	**F = Avg D & E**	**G = (F-B) X A**
	GBR	**Prior Year Statewide UCC Rate**	**UCC Funding Provided in Rates**	**Prior Year Hospital-Specific UCC Rate**	**Predicted Hospital-Specific UCC Rate**	**Hospital-Specific 50/50 Blend[17]**	**(Payment) or Withdrawal from UCC Fund**
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

This UCC methodology is a cornerstone of the HSCRC's all payer system. In addition to equitably supporting financial assistance for low income patients, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.[18]

[17] Following the 50/50 blending of hospital actual UCC and predicted UCC, all individual hospital values for payment or withdrawal from the UCC fund are normalized such that the statewide 50/50 blend equals the prior year actual UCC rate. This ensures that the UCC Fund is redistributive in nature.

[18] Other states have struggled to maintain sustainable uncompensated care funds. One example is New Jersey. H S Berliner, S Delgado, "The rise and fall of New Jersey's uncompensated care fund", J Am Health Policy. Sep-Oct 1991;1(2):47-50. https://pubmed.ncbi.nlm.nih.gov/10112731/.

Data Sources

To conduct the analysis in this report, HSCRC used data from the Commission's hospital case mix dataset as well as data from Maryland tax filing from the Maryland Office of the Comptroller. The HSCRC's case mix data includes demographic, financial and clinical information on patient inpatient and outpatient hospital visits. The case mix data includes approximately two million unique patients in calendar years (CY) 2017 and 2018. The Office of the Comptroller provided HSCRC with over 1.2 million tax data points for CY 2017 and CY 2018. Given the sensitivity of this dataset and analysis, all data points provided to the HSCRC were expressed as federal adjusted gross income ranges, e.g. 150% - 200%, as opposed to distinct income levels. This approach allowed the Commission to conduct the analysis while ensuring that the Commission did not access or retain sensitive tax data at a granular level.

Data from the Maryland Medical Care Database (MCDB), maintained by the Maryland Health Care Commission, was also used in this analysis. The MCDB contains enrollment and claims data from private insurers operating in Maryland.[19]

Data Limitations and Assumptions

The Maryland tax data includes federally adjusted gross income.[20] Eligibility for Maryland's public assistance programs and hospital financial assistance provisions is based on modified adjusted gross income (MAGI), which is not available in tax data.[21]

This analysis requires several modelling assumptions and therefore should not be regarded as one hundred percent reliable. This is due to both the nature of modeling potential policies that are not currently in effect, as well as due to limitations in the dataset with respect to the type of available variables and the completeness of available data.

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[19] "The Maryland Health Care Commission (MHCC) collects privately insured data (claims and membership), known as the Medical Care Database (MCDB), on a quarterly basis from life and health insurance carriers, health maintenance organizations (HMOs), third party administrators (TPAs), and pharmacy benefits managers (PBMs) who are licensed to do business in Maryland. The MDCB is the main component of Maryland's All Payer Claims Database."
https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_mcdb.aspx

[20] Federal adjusted gross income is gross income, minus certain deductions. Federal adjusted gross income is calculated on federal personal income tax forms and reported on Maryland personal income tax forms.

[21] MAGI is federal adjusted gross income plus untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. For many people, MAGI is very similar to federal adjusted gross income. MAGI does not appear on federal or state tax returns. https://www.healthcare.gov/glossary/modified-adjusted-gross-income-magi/

III. Methodology

The HSCRC matched CY 2017 and CY 2018 tax data with the Commission's patient casemix dataset. This allowed HSCRC to determine the distribution of patient visits by income range.

Exhibit 2 summarizes the distribution of patient visits by patient income ranges for CY 2017 and 2018. Income is expressed as a percent of the FPL.[22] As demonstrated in Exhibit 2, only about 60% of the patient case mix data matched with federal income level data.

To increase the sample size, HSCRC staff evaluated additional variables provided in the hospital patient dataset, including payer status and the indication of homelessness, to make assumptions about the FPL of a patient. Exhibit 3 details these assumptions and the impact on the study's sample size for 2018. The same assumptions were made for 2017.

Using these assumptions, HSCRC staff were able to increase the sample size of the evaluation such that the percentage of unique patients in 2017 and 2018 with a federal income data point increased from 60% to 79%. This sample size is likely sufficient because it incorporates all payer classes associated with patients with lower socioeconomic status (e.g. Medicaid, Medicare, and patients that do not prepare tax filings), who are more likely to qualify for financial assistance or contribute to bad debt. In addition, the most significant, singular group unaccounted for is out-of-state residents, which have a similar payer mix to Maryland residents. Based on this similarity in payer mix, HSCRC staff assumed that out-of-state residents likely have a similar income distribution to the Maryland residents already identified in the analysis.

Because the Maryland tax data does not include MAGI data, HSCRC staff constructed an approximate measure of MAGI using data available in the tax data. MAGI income is determined by adding untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest to federal adjusted gross income (all of which are deductions that are taken to compute adjusted gross income). HSCRC staff did not have data on untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest but did have total deductions. Staff assessed the matching rate between federally adjusted gross income (FAGI) and federally adjusted gross income plus all deducted income. The federally adjusted gross income plus all deducted income is higher than the modified adjusted gross income measure used for hospital financial assistance (which only includes federal adjusted gross income plus untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest).

[22] The federal poverty level is a term used to refer to the federal poverty guidelines developed annually by the federal Department of Health and Human services to determine eligibility for federal subsidies and benefit programs. The FPL differs by household size. For example, in 2018, the FPL for a one person household was $12,140, while the FPL for a 8 person household was $42,380. https://aspe.hhs.gov/2018-poverty-guidelines

Exhibit 2: Distribution of Patients with Hospital Visits by Federal Adjusted Gross Income Range, CY 2017 and 2018 Patient Data

	Calendar Year 17		Calendar Year 18	
FPL Range	**Unique Patient Counts**	**% Distribution**	**Unique Patient Counts**	**% Distribution**
0 to 50% FPL	87,711	4.21%	87,647	4.27%
50 to 100% FPL	154,110	7.39%	148,215	7.22%
100 to 138% FPL	103,596	4.97%	101,495	4.95%
138 to 150% FPL	29,882	1.43%	29,391	1.43%
150 to 200% FPL	108,412	5.20%	106,959	5.21%
200 to 250% FPL	84,448	4.05%	83,825	4.08%
250 to 300% FPL	74,175	3.56%	73,590	3.59%
300 to 350% FPL	68,051	3.26%	66,905	3.26%
350 to 400% FPL	62,953	3.02%	61,938	3.02%
400 to 450% FPL	57,663	2.76%	56,683	2.76%
450 to 500% FPL	51,076	2.45%	50,524	2.46%
500 to 550% FPL	45,000	2.16%	44,368	2.16%
550 to 600% FPL	38,495	1.85%	38,618	1.88%
600 to 650% FPL	33,502	1.61%	33,214	1.62%
No FPL match	844,548	40.49%	824,865	40.19%
Not in FPL range	242,036	11.60%	244,104	11.89%
Total	2,085,658	100.00%	2,052,341	100.00%
Match Rate		**59.51%**		**59.81%**

Exhibit 3: Federal Adjusted Gross Income Distribution for CY 2018 Patient Data

Additional Characteristic of Patient Dataset to Determine FPL	Number of Patients without a Federal Income Data Point	Percentage of Total Sample	Assumption to Ascertain FPL	Notes
Homeless Patients, Missing ZIPs, and Invalid ZIPs	5,758	0.28%	Assumed all patients were between 0%-50% FPL.	All patients with a FPL beneath 200% FPL can be considered in one block since all patients under this threshold qualify for charity care.
Maryland Medicaid Patients	211,685	10.31%	Assumed all patients were 100%-138%.	With the exception of the enhanced FPL level for pregnant women (264% FPL)[23] and Maryland Children's Health Program, which consists mostly of children that are less likely to use the hospital, most all Medicaid beneficiaries are below 138% FPL and would not require bad debt write offs, and therefore would not affect UCC adherence reviews or threshold modelling, as both use 200% FPL as a starting point.
Maryland Medicare Patients	173,696	8.46%	Assumed these patients fell within the 150%-400% FPL thresholds. Thus the total patient population was split into five FPL thresholds; 150%-200%, 200%-250%, 250%-300% 300%-350% and 350%-400%	Assumptions were based on Kaiser Family Foundation's estimates of state level distribution of Medicare beneficiaries by FPL. [24] KFF's FPL threshold ratios for the under 100% to 399% range were summed and normalized to 1. Then the ratios were redistributed according to HSCRC's FPL thresholds and applied to the proportion of patients deemed to be non-tax filing Medicare patients.
Out-of-State Residents	168,452	8.21%	Did not make assumption	Distribution of income is likely similar to Maryland patients with a known FPL data point.
Miscellaneous	265,274	12.93%	Did not make assumption	

[23] https://mmcp.health.maryland.gov/Documents/Medicaid%20Income%20Limits/2020%20MONTHLY_INCOME_AND_ASSET_GUIDELINES_4%20on%201.27.2020%20(1).pdf
[24] https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-by-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Exhibit 4: Federally Adjustment Gross Income and Federally Adjusted Gross Income Plus All Deducted Income Match Rate for CY 2017 and 2018 Patient Data[25]

Federal Income Statistic Ranges	CY17 Matching Rate	CY18 Matching Rate
0 to 50%	99.0%	99.1%
50 to 100%	99.3%	99.3%
100 to 138%	98.6%	98.5%
138 to 150%	95.8%	96.3%
150 to 200%	97.8%	98.0%
200 to 250%	97.0%	97.3%
250 to 300%	96.4%	96.5%
300 to 350%	95.4%	95.7%
350 to 400%	94.8%	95.0%
400 to 450%	94.0%	94.4%
450 to 500%	93.4%	94.0%
500 to 550%	93.0%	92.6%
550 to 600%	91.5%	91.9%
600 to 650%	91.5%	92.2%
Total	**96.6%**	**96.8%**

Exhibit 4 shows that there is a 97% matching rate between federal adjusted gross income and federal adjusted gross income plus all deducted income. The matching rate is highest at the lowest income ranges (suggesting that MAGI and federal adjusted gross income are likely identical for most people in these income ranges). The matching rate is lower at higher income ranges, but still over 90%. This high rate of matching suggests the federally adjusted gross income is appropriate to assess a patient's MAGI.

[25] FAGI and FAGI plus Deducted Income are both federal income statistics.

HSCRC staff also sought to determine patient cost share for hospital services. Cost share expenses for insured patients include coinsurance, and copayments, or similar cost,[26] while cost share for uninsured patients would include the whole charge for the care provided, reduced by any hospital financial assistance received by the patient. Hospital charity care is provided to patients for the patient's cost share. If a patient is insured, the charity care only applies to the portion of the charge that is not paid by the insurer. As a result, determining an individual's cost share amount would allow for more accurate modeling of the impact of different potential financial assistance policies on the total cost of care and the UCC fund.

HSCRC hospital case mix data does not indicate what share of each bill is attributable to the patient's cost share. To impute cost share across all payers, HSCRC staff used UCC write off data (i.e. charity care and bad debt data), cost share values provided in the MCDB, and known benefit design elements, e.g. Medicaid has no cost share in Maryland. These cost share computations are listed in Exhibit 5 below.

Exhibit 5: Imputed Cost Shares by Payer and Site of Care

Payer Type	Site of Care	Cost Share	Basis	Notes
Self-Pay	IP, OP,ED	100%	Self-pay is by definition not a payer type whereby a third party defrays costs.	Self-pay designation is provided in hospital dataset. Staff's analysis of UCC write-off data, which indicates patient cost share for individuals classified as UCC, corroborated 100% cost share value
Medicaid with an imputed cost share more than 80%	IP, OP, ED	100%	There are no cost share provisions in Maryland's Medicaid program, so if a patient had calculated cost share greater than 80% in the UCC write off data, staff determined the payer flag should actually be self-pay. HSCRC made this determination because in the hospital charge data the payer variable represents the initial assumption of the payer made by the hospital, and it is therefore not surprising that the reported payer may not reflect the final patient circumstances in some cases.	Before HSCRC staff reclassified Medicaid patients with an imputed cost share of 80% or greater from the UCC write off data to self-pay, Medicaid statewide had an imputed cost share of 20%, which is prima facie implausible. Once these patients were reclassified to self-pay, the statewide imputed cost share dropped below 1% for all FPL thresholds, suggesting some patients deemed UCC were presumed eligible for Medicaid but were actually self-pay.

[26] https://www.healthcare.gov/glossary/cost-sharing/

Payer Type	Site of Care	Cost Share	Basis	Notes
Medicaid with an imputed cost share less than 80% and Medicaid without an imputed cost share	IP,OP.ED	0%	There are no cost share provisions in Maryland's Medicaid program.	Evaluations of UCC write off data substantiate that Medicaid does not have patient cost share.
Commercial	IP	3%-4%[27]	HSCRC staff utilized the MCDB to derive cost share percentages by FPL thresholds (outlined in exhibit 1).	As income or FPL increased cost share percentages decreased, suggesting wealthier individuals can afford and/or may have access to more generous health plans. IP evaluation from MCDB represented 47% of commercial claims in hospital dataset.
Commercial	OP	9%-14%[28]	HSCRC staff utilized the MCDB to derive OP cost share percentages by FPL thresholds (outlined in exhibit 1).	Again, as income or FPL increased cost share percentages decreased, suggesting wealthier individuals can afford and/or may have access to more generous health plans.
Commercial	ED	18%-26%	HSCRC staff utilized the MCDB to derive OP cost share percentages by FPL thresholds (outlined in exhibit 1) and then used Milliman data to increase each cost share percentage by 2.08 to reflect higher cost share values for emergency room services.	Analysis of the MCDB dataset could not yield cost share values exclusively for ED. Analysis of UCC write off data also suggests there is a 2:1 ratio of cost share percentages for ED:OP.

[27] See Appendix B Table 1 for breakdown of cost share by FPL.
[28] See Appendix B Table 2 for breakdown of cost share by FPL.

Payer Type	Site of Care	Cost Share	Basis	Notes
Medicare	IP	0% coinsurance, $1,316 deductible for CY 2017, $1,340 deductible for CY 2018	**For days 1-60: $0 Medicare coinsurance for each benefit period.** Days 61-90: $371 coinsurance per day of each benefit period. Days 91 and beyond: $742 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs. All initial Medicare Part A expenses (hospital and skilled nursing facility) require a deductible unless they are covered by a third party payer (e.g. Medigap coverage)	Given that 0.20% of inpatient admissions have a length of stay greater than 60, staff concluded that 0% for Medicare IP was appropriate. Staff did account for the required deductible if a patient did not have a commercial, Medicaid or Medicare Advantage secondary payer status under the supposition that al deductibles would otherwise be covered by a third party payer. While staff could not account for skilled nursing facility expenditures where a deductible could be realized, staff did adhere to the rolling 60 day Medicare benefit design so as not to account for required deductibles twice.
Medicare with commercial and Medicaid secondary payer	OP & ED	0%	Approximately 23%[29] of Maryland beneficiaries have Medigap insurance coverage, which HSCRC staff assumed defrays 100% of the cost of hospital OP out-of-pocket expenses. Staff also assumed that dually eligible patients, i.e. eligible for Medicare and Medicaid and total approximately 90,000 individuals statewide, had no cost sharing.	While staff cannot ascertain exactly the cost sharing of Medigap beneficiaries, because there is not access to patient's benefit design, staff do believe it is reasonable to assume 100% of the costs are defrayed. For dual eligibles, the assumption that there is 0% cost share is based on the fact that full benefit dual eligibles do not have out-of-pocket expenses and represent 64% of the dual eligible population in 2012.[30]
Medicare without commercial secondary payer, or with self-pay/other	OP & ED	20%	Approximately 77%[31] of Maryland beneficiaries have Medigap insurance coverage, thus for the vast majority of cases HSCRC staff assumed the typical copayment of 20% was incurred.	

[29] Figure 3 https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/
[30] Page 4, https://hilltopinstitute.org/wp-content/uploads/publications/MDDualEligibleBeneficiaries-CY2010-CY2012-ChartBook-Feb2016.pdf
[31] Ibid Figure 3

IV. Uncompensated Care Modeling Results

Hospital Performance in Providing Free Care

Before modelling potential impacts to UCC using the changes to FPL thresholds listed in the proposed legislation, staff first evaluated how hospitals' provision of uncompensated care aligned with the current requirements in law. Hospitals are required by law to provide free care to all patients with income at or below 200% of FPL. We would theoretically expect to see 100% of patient cost share for charges for patients with income at or below 200% of FPL written off to free care.[32]

In practice, the process of determining financial assistance eligibility can be challenging. Common challenges faced by hospitals in determining patient eligibility for financial assistance include the following:

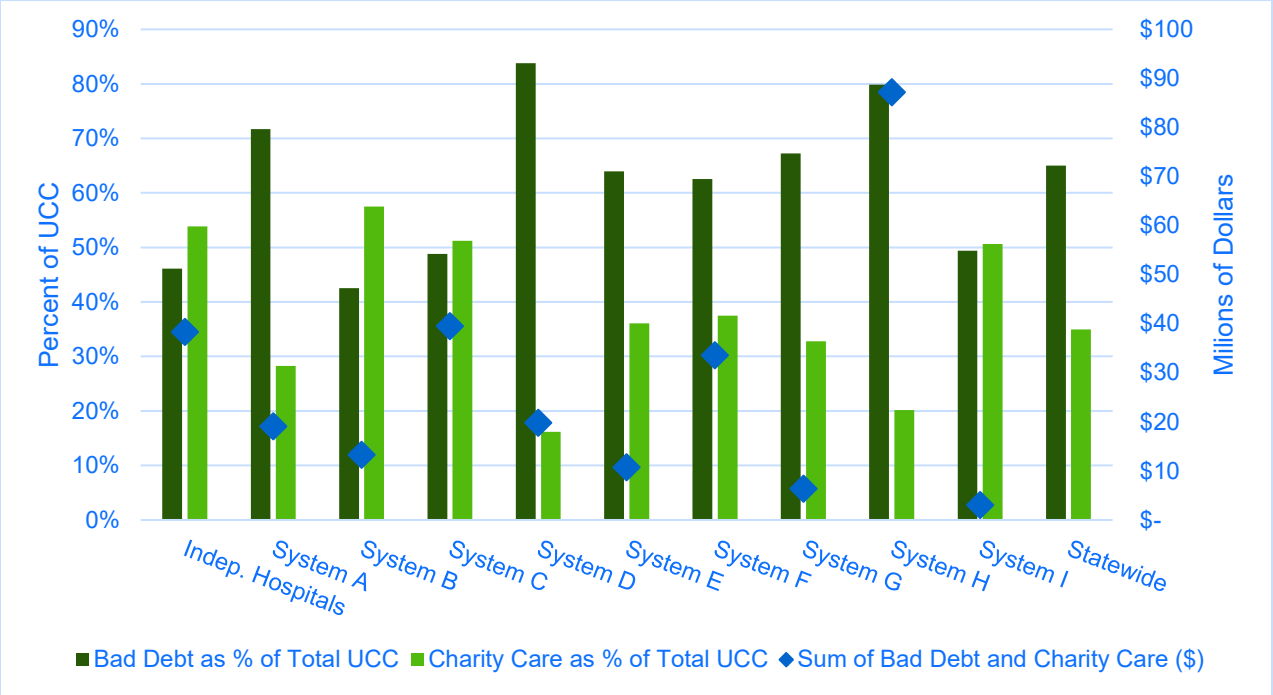
- For insured patients, covered benefits and payment rates vary by plan. This variation makes it difficult for hospitals to determine the patient's cost share. This consideration becomes particularly important as high-deductible commercial plans become more common. Patients with income between 138% and 200% FPL are often covered, at least partially, by commercial insurance. Lower income commercially insured individuals often have less generous insurance plans than higher income individuals (see Exhibit 5).
- Despite efforts to publicize financial assistance policies, patients may not know they will need financial assistance at the time they receive a hospital service. These patients may only realize they need financial assistance once they have received their bill, at which point communication and education about financial assistance is more difficult than it would have been when the patient was at the hospital.
- Gathering the necessary documentation to qualify the patient for financial assistance can be difficult. Financial assistance eligibility is based on income and lack of other payment options (such as insurance). Documentation is required to verify the patient's income and lack of payment options. Some patients do not respond to requests for documentation or may refuse to provide documentation.
- Hospitals, particularly smaller ones, have limited resources to expend on aiding patients (particularly patients who are non-responsive or non-cooperative) with the financial assistance eligibility process.

These challenges may affect the percent of charges written off to charity care.

[32] Only patient cost share is subject to the hospital free and reduced care policies, not the portion of the charges covered by insurance.

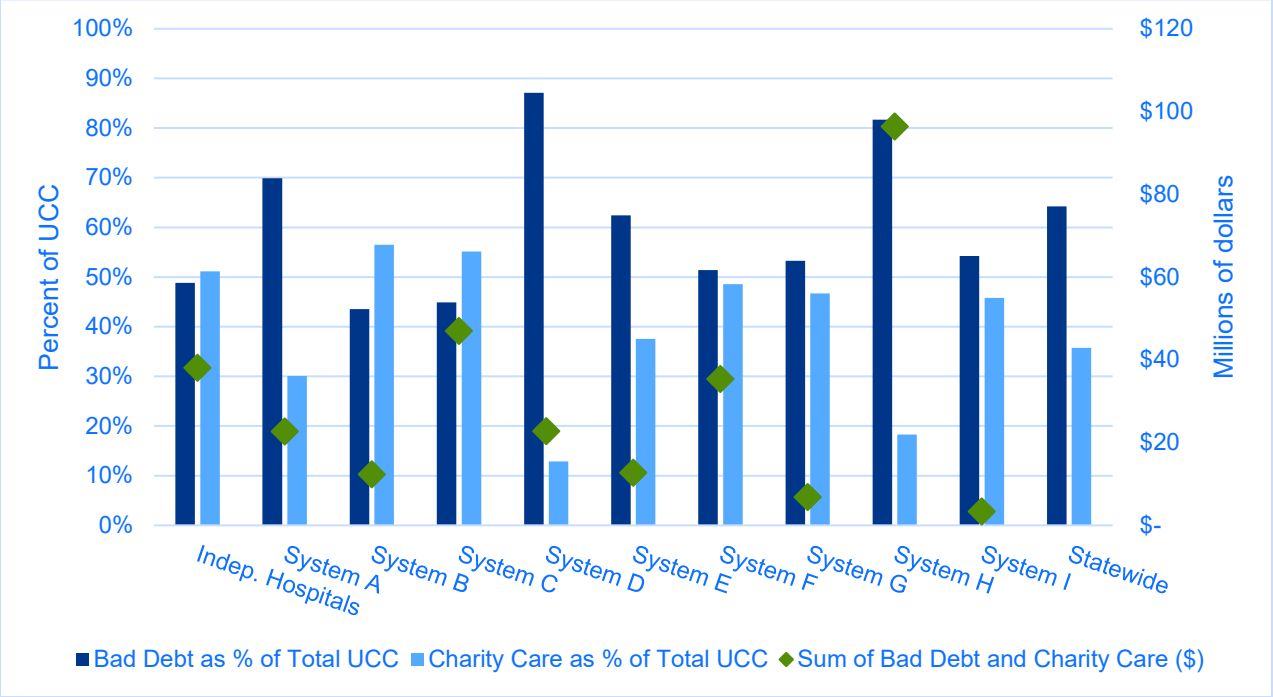
All patients with household incomes under 200% FPL qualify for hospital free care for their out-of-pocket expenses.[33] To evaluate the performance of hospitals at providing free care to patients with incomes under 200% FPL, staff looked at the percent of free care charged to UCC for this population and the percent of bad debt charged to UCC for this population. Staff assume that bad debt was billed to the patient, the hospital engaged in collection efforts, and the debt went unpaid before the hospital wrote it off as bad debt. Exhibits 6a and 6b show the percent of free care and the percent of bad debt attributable to the population with incomes under 200% FPL. The sum of the percentages of free care and bad debt is 100 percent in these exhibits, representing the amount of UCC written off by the hospital for this population.[34] To provide scale, the exhibits also show the total dollar amount of UCC for the population with household incomes under 200% FPL. Results were reported as anonymized hospital systems including one manufactured system for independent hospitals, so that rates were not skewed by small volume facilities.[35]

Exhibit 6a: CY 2017 Hospital UCC Attributable to Patients under 200% FPL, including Charity Care and Bad Debt Offs



[33] Md. Code, § 19-214.1(b)(2) (i) of the Health General Article
[34] Total UCC includes other adjustments not included in the explanation above, and not relevant to interpreting exhibits 7a and 7b.
[35] The data in these tables is reported by hospitals. HSCRC staff believe that the total amount of UCC per hospital system is reliable. The amount of UCC attributable to bad debt or free care may be less reliable.

Exhibit 6b: CY 2018 Hospital UCC Attributable to Patients under 200% FPL, including Charity Care and Bad Debt



Exhibits 6a and 6b show that only 40% of total amounts written off to UCC for patients under 200% FPL are attributed to charity care in hospital reporting, while 60% of UCC amounts were written off for bad debt. Statewide, UCC attributable to individuals with incomes below 200% FPL amounts to $245 million.

Staff also analyzed charges attributable to patients under 200% FPL that had a cost share that was likely paid by the patient (exhibits 7a and 7b below). To calculate, HSCRC staff assumed that all patients (and their insurer or other third party payer) that meet the following conditions were likely charged for hospital services and paid their cost share (if any):

- Patients with income below 200 percent FPL; and
- An imputed patient cost share for hospital services that was not written off to UCC.

Exhibits 7a and 7b show the dollar amount of the imputed cost share attributable to Medicare and commercially insured patients for each hospital system (Medicaid and CHIP patients were assumed to have zero cost share) that was paid by the patients. This amounts to approximately $60 million statewide. The exhibits also show the percent of total charges to patients below 200% of the FPL that appear to have been paid by patients with imputed cost share (and thus do not seem to align with the statutory requirement that hospitals provide free care to individuals in this income bracket). Most of these charges are paid by either a 3rd party (such as an insurer) or the patient.

The analysis in these exhibits is impacted by data limitations and assumptions (including those described in Section II of this report). For example, the data set only represents 79% of all hospital charges in each year, and the cost sharing was imputed based on statewide norms (described in Section III above). Staff could also not ascertain if charges deemed to be compensated were in fact denied (denials make up approximately 2% of all hospital charges), which could result in staff incorrectly suggesting that hospitals should have provided free care when in fact the care was deemed medically unnecessary. As in exhibits 6a and 6b, the data in exhibits 7a and 7b is shown by anonymized hospital systems including one manufactured system for independent hospitals, so that rates were not skewed by small volume facilities.

Exhibit 7a: CY 2017 Hospital Charges Attributable to Patients under 200% FPL, including Estimated Cost Share Paid by Patients in Medicare and Commercial Insurance.

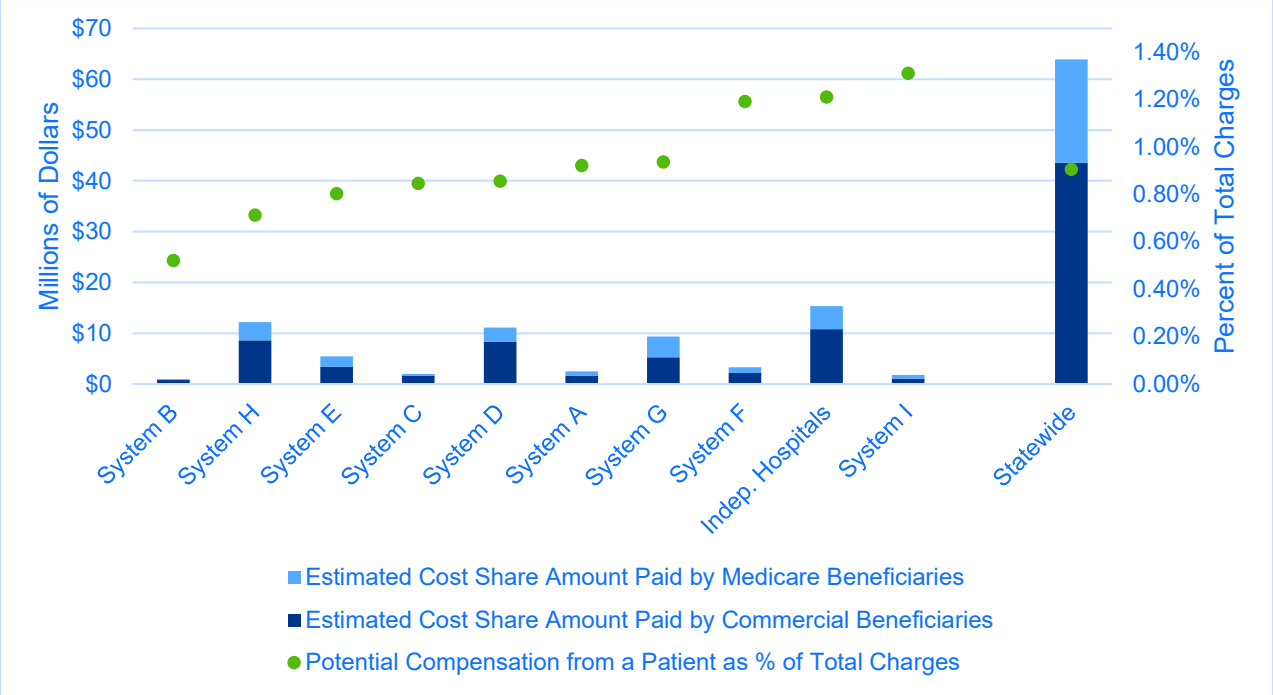
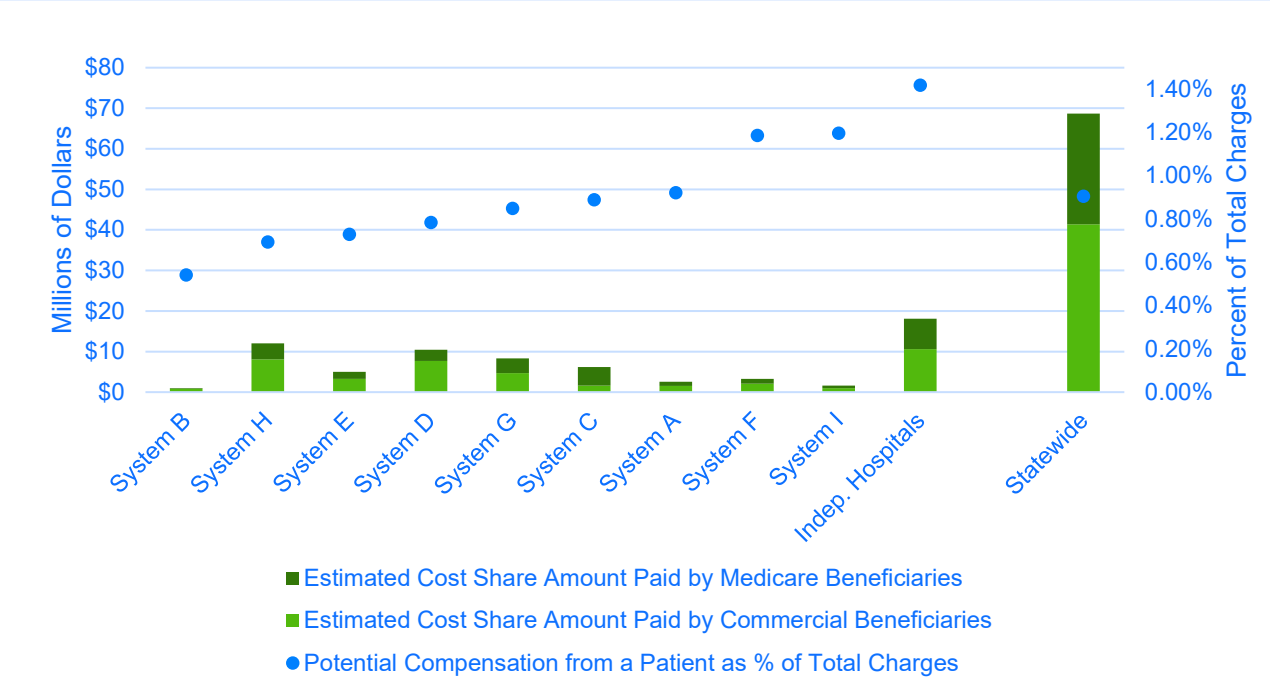


Exhibit 7b: CY 2018 Hospital Charges Attributable to Patients under 200% FPL, including Estimated Cost Share Paid by Patients in Medicare and Commercial Insurance.



Exhibits 7a and 7b demonstrate that, if HSCRC staff modeling is accurate, the amount of cost sharing likely paid by patients with household incomes under 200% FPL amounts to $60 million. It is important to note that the percent of cost sharing charged to, and likely paid by, patients with incomes under 200% of the poverty level was low (under 1% of total charges to this population) and consistent over the two-year period. No hospital system had a rate of cost sharing paid by patients over total charges that was greater than 1.5%.[36]

Finally, HSCRC staff sought to determine if there were underlying characteristics of a hospital that could potentially explain variation in how hospitals performed with respect to patients paying for cost shares that likely should have been covered by free care. Staff explored correlations between the percentage of total charges paid by patients (as shown in exhibits 7a and 7b) and the following variables: hospital size, percentage of services provided to patients below 200% FPL, percentage of services written off to UCC, and payer share. The purpose of this analysis was to answer to the following questions:

[36] The variation between hospitals on the percent of charges paid is limited, as evidenced by a variance from the mean ranging from -0.36% to 0.51% in CY 2018 and a coefficient of variation of 0.28. The coefficient of variation is a measure of the ratio of the standard deviation to the average. Less than 1 indicates limited variation.

1. Do larger hospital systems have additional resources to help determine FPL for patients?
2. Are hospitals that serve a more disadvantaged population based on the amount of UCC or proportion of patients beneath 200% FPL more likely to have greater non-adherence with the free care policy?

This analysis was completed at the hospital level (rather than the system level) to improve sample size.

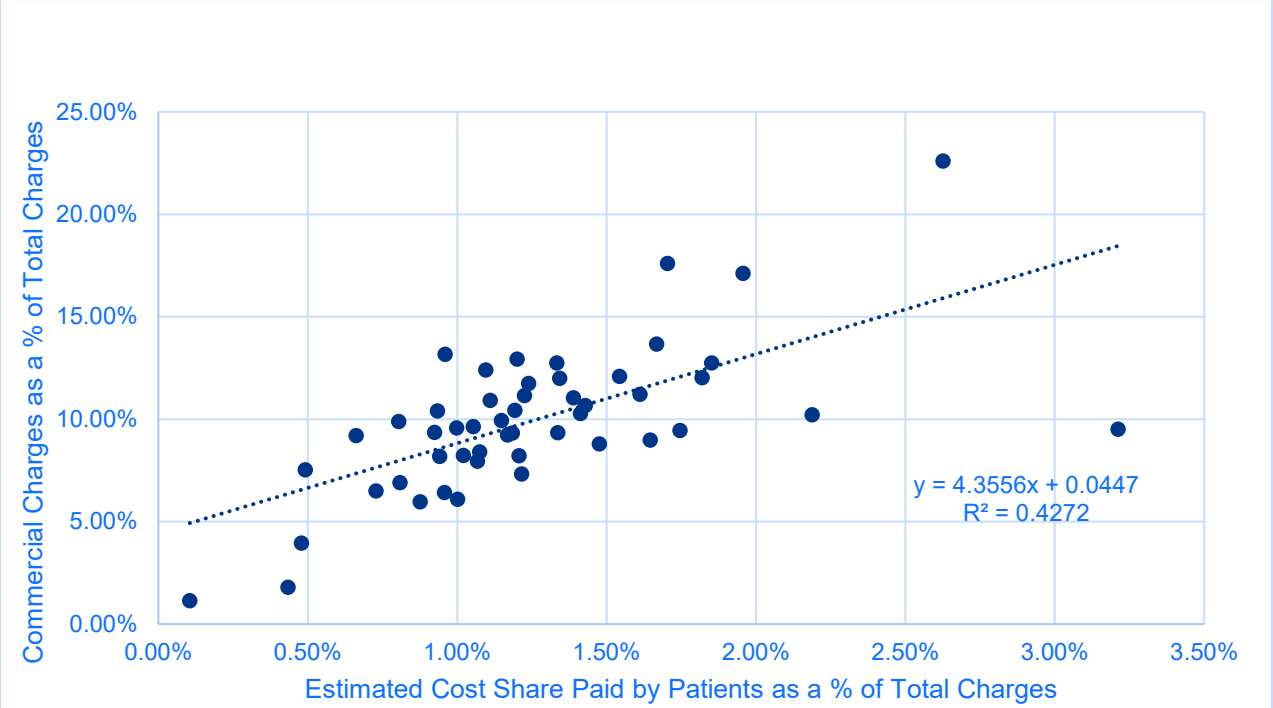
Exhibit 8a: CY 2018 Correlation between Hospital Performance Measured by Cost Sharing Likely Paid by Patients Eligible for Free Care & Various Hospital Characteristics

Hospital Characteristic	Correlation Coefficient[37]
Total Cases	(0.1406)
Total Charges for Patients Below 200% FPL	(0.1595)
UCC Rate for Entire Patient Population	0.0707
UCC Rate for Patients below 200% FPL	0.0551
Commercial Charges as a Share of Care Provided to Patients below 200% FPL	0.6062

As demonstrated in Exhibit 8a, all but one of the variables studied had limited correlation with the performance of hospitals measured by cost sharing likely paid by patients eligible for free care. The exception was the share of services provided to commercial beneficiaries with incomes below 200% FPL. Exhibit 8b, below, shows, for each hospital, the relationship between the percentage of cost sharing likely paid by patients eligible for free care and commercial charges as a share of care provided to patients with incomes below 200% FPL.

[37] Correlation coefficients range between -1 and 1. A correlation coefficient of -1 shows a negative relationship between the variables (i.e. if variable A goes up, variable B goes down). A correlation coefficient of 0 shows no relationship between the variables. A correlation coefficient of 1 shows a positive correlation between the variables (i.e. if variable A goes up, variable B goes up).

Exhibit 8b: CY 2018 Correlation between Hospital Performance Measured by Estimated Cost Share as a Percent of Total Charges Paid by Patients below 200% FPL and Commercial Charges as a Percent of Total Charges to Patients below 200% FPL



Exhibits 8a and 8b do not suggest there is an underlying hospital characteristic that differentiates hospital performance measured by the percentage of cost sharing likely paid by patients eligible for free care. However, there may be a relationship between commercial benefit design and charges levied on individuals under 200 percent FPL. Staff performed a regression model to look at UCC by hospital and found that the highest probability of a patient being deemed eligible for UCC occurred for patients with commercial insurance whose encounter with the hospital included an emergency room charge.

Staff also considered evaluating how hospitals performed with respect with their own financial assistance policies for reduced-cost care. Reduced-cost care is required by regulation for patients with a household income between 200 and 300% of the FPL.[38] Reduced-cost care is also required for patients that have a financial hardship[39] and have household income below 500% of the FPL.

HSCRC staff determined that an analysis of hospital performance in applying the reduced-cost care requirements (including reduced-cost care based on financial hardship) would not be accurate enough to make substantive conclusions. This determination was based on three concerns. First, staff were

[38] COMAR 10.37.10.26 A-2 (2)(a)(ii)
[39] Md. Code, § 19-214.1(a)(2) of the Health General Article

concerned that the data limitations described in Section II of this report were a barrier to conducting a reasonably reliable analysis. Second, the reduced-cost care discounts offered by hospitals by patient income level differ between hospitals, complicating the potential analysis.[40] Third, HSCRC staff would need more precise income level data to determine patients experiencing a financial hardship then was available for this report.

Financial Implications of Policy Changes to UCC Policy

HB 1420 requested that, to the extent practicable, the HSCRC model several changes to the current UCC policy, including changing FPL thresholds for guaranteed free care, changing the FPL thresholds for reduced-cost care (with and without a financial hardship), changing the financial hardship threshold (medical debt as a percentage of household income), and changing the definition of medical debt used to calculate the financial hardship threshold to include several types of cost sharing. HSCRC staff modeled the impact of increasing FPL thresholds to increase patient eligibility for free care. HSCRC staff were not able to model, with reasonable precision, the impact of changing the FPL thresholds for reduced-cost care (with and without a financial hardship), changing the financial hardship threshold (medical debt as a percentage of household income), and changing the definition of medical debt used to calculate the financial hardship threshold to include several types of patient cost sharing.[41]

Due to these modelling challenges, HSCRC staff focused their analysis on the impact of increasing income eligibility thresholds for free care from 200% FPL to 250%, 300%, and 350% on UCC. UCC costs are passed on to patients and payers through hospital rates. Thus, changes in the income eligibility threshold for free care affect Medicaid, Medicare, and other payers (including commercial insurance).[42] Changes in

[40] Neither statute nor regulations specify how much of a discount hospitals must provide to patients who qualify for reduced-cost care. § 19-214.1(b)(5) of the Health General Article, Maryland Code, states that "the hospital shall apply the reduction that is most favorable to the patient."

[41] Modeling the impact of changing the FPL thresholds for reduced-cost care (with and without a financial hardship) would be complex for several reasons. First, the amount of reduced-cost care discounts is not prescribed in statute and varies by hospital system. As a result, it is difficult to model how hospitals would modify their reduced-cost policies if reduced-cost care thresholds were increased. Second, for reduced-cost care with financial hardship, HSCRC staff cannot precisely ascertain financial hardship due to lack of precise income data. Finally, the eligibility requirement for reduced-cost care without financial hardship (household income as a percent of FPL) and reduced-cost care with financial hardship (medical debt as a percent of income) interact in a manner that confounds the analysis, e.g. if a patient meets the FPL qualification for reduced-cost care, the reduced-cost care discount provided by the hospital could reduce the patient's medical debt below the threshold for reduced-cost care with financial hardship. Similarly, staff do not have the necessary data on exact patient income and medical expenditures outside the hospital setting to model changes to the financial hardship threshold (medical debt as a percent of household income).

[42] As noted in section II, one feature of Maryland's all-payer rate setting system is the equitable distribution of hospital UCC costs to all payer types through rates set by the HSCRC.

hospital rates due to increased UCC also impacts patients with premiums, co-insurance and/or deductibles and uninsured/self-pay patients.

Exhibit 9: Impact of Increasing the Income Eligibility Threshold (as a Percent of FPL) for Free Care on Uncompensated Care and Payers, CY 2018

	Policy Change - Increase in Threshold for Free Care		
	From 200% FPL to 250% FPL	From 200% FPL to 300% FPL	From 200% FPL to 350% FPL
Total Charges (CY 2018)	$17,293,092,020		
UCC Rate (CY 2018)	4.07%		
Additional UCC (After Policy Change)	$33,624,231	$66,733,460	$98,634,906
Additional UCC (After Policy Change, Extrapolated to Entire Hospital Population)	$42,562,318	$84,472,734	$124,854,311
UCC Rate (After Policy Change, Extrapolated)	4.31%	4.56%	4.79%
Commercial/Other Dissavings As a Result of Policy Change (36% of Market)	$15,507,264	$30,777,013	$45,489,741
Medicaid Dissavings As a Result of Policy Change (21% of Market)	$9,078,179	$18,017,313	$26,630,358
Medicare FFS Dissavings As a Result of Policy Change (38% of Market)	$16,328,519	$32,406,944	$47,898,848
Medicare MA Dissavings As a Result of Policy Change (4% of Market)	$1,648,356	$3,271,465	$4,835,365
All-Payer Dissavings As a Result of Policy Change	$42,562,318	$84,472,734	$124,854,311

Exhibit 9 shows current hospital charges for patients with specified income levels, the percent of UCC (compared to total charges) for those patients, the estimated amount UCC would be expected to increase for the 79% of hospital patients for which income data is available or imputed for purposes of this study, an extrapolated amount of UCC increase expected for all hospital patients, and the amount of this estimated

increase that would be attributable to each payer type (Commercial/other, Medicaid, Medicare fee-for-service (FFS), and Medicare Advantage (MA)). The extrapolated amount of UCC increase expected for 100% of the hospital patients is based on an assumption that 21% of patients with unknown income have the same income distribution as the 79% of patients with a known income level. HSCRC staff believe this assumption is reasonable because half of the unknown population is out-of-state residents and the out-of-state resident population has a similar payer mix to the in-state resident population and likely a similar distribution of income.

Increasing the free care eligibility threshold from the current level (200% of FPL) to 250% of the FPL would increase UCC by approximately $33.6 million in CY 2018. For payers, the increase ranges from $1.6 million for Medicare Advantage to approximately $16 million for Medicare fee-for-service. These additional costs to payers increase in a relatively linear fashion as the income eligibility threshold increases, i.e. Medicare fee-for-service would experience an additional increase approximately $15 to $16 million for each 50% increase in the FPL.

If the income eligibility threshold for free care increased to the maximum amount contemplated in HB 1420 (350% FPL), the additional cost to Medicaid totals approximately $27 million and fee-for-service Medicare would experience additional costs of $48 million in CY 2018. Under the Total Cost of Care contract between CMS and Maryland, the State is required to generate $300 million in annual Medicare savings. An increase in Medicare hospital costs of $48 million represents 16% of the required annual savings under the contract. The cost to all payers of this policy would have been $108 million in CY 18.

Eligibility for Free or Reduced-Cost Care based on Eligibility for Other Public Assistance Programs

HB 1420 requested that, to the extent practicable, the HSCRC, in consultation with Maryland Department of Health and the Department of Human Services, model the impact on UCC and payers of expanding presumptive eligibility for reduced–cost care to patients who are homeless or receive benefits from federal, State, or local public assistance programs. Due to data limitations and variability in the amount in hospital reduced-care programs, HSCRC staff were unable to approximate changes to costs if all patients in the categories listed in HB 1420 were provided reduced-cost care. The HSCRC has provided analysis of the potential implications of implementing the new presumptive eligibility requirements as described in HB 1420. This analysis assumes the public benefit programs listed in the bill were included because these programs have similar eligibility criteria as the criteria listed in statute for reduced-cost care. Since reduced-cost care is provided on a sliding scale basis, a hospital would still need to determine the income of an individual who was determined presumptively eligible for reduced-cost care in order to determine the size of the discount provided to the patient.

Exhibit 10. Analysis of Populations and Programs for Potential Presumptive Eligibility for Reduced-Cost Care Policy

Group/program	Eligibility threshold(s)	Commentary
Homeless	N/A	Based on the limited data available, the majority of individuals affected by homelessness are eligible for free care. However, a sizable minority of patients who are homeless are above the statutory income threshold for reduced-cost care.[43]
State Family Investment Program	50% FPL[44]	Recipients of the State Family Investment Program likely have incomes below the 200% of FPL threshold for free care. HSCRC staff recommend against using eligibility for this program as a criteria for presumptive eligibility for reduced-cost care. Eligibility for this program could be considered as a possible addition to the criteria for presumptive eligibility for free hospital care in Health General 19-214.1(b)(7).
Emergency Assistance to Families with Children Program	N/A[45]	Income limits are not an eligibility requirement for this program. Thus, patients who receive benefits from EAFC may fall outside of the current 200%-300% of FPL threshold for reduced-cost care.
Maryland Medical Assistance Program	For adult expansion population: 138% FPL For pregnant individuals: 264% of FPL. Categorical Eligible groups[46]	Medicaid provides benefits to cover the hospital bills of eligible patients. Thus, Medicaid eligible individuals should not need hospital free care or hospital reduced-cost care.

[43] This analysis is based on a code in clinical data that indicates homelessness. HSCRC data from 2017 and 2018 indicates that approximately 60% of homeless individuals have income at or below 200% of FPL. HSCRC staff are not sure how accurately this data reflects the homeless population receiving hospital services due to variations in coding practices.
[44] TCA income thresholds are the maximum benefit amount which, combined with SNAP, must equal 61% of the Maryland Minimum Living Level.
[45] Income limits is not an explicit eligibility requirement for this program. Family resources are assessed to meet an emergency need.
[46] There is not always an income/asset test for categorically eligible (i.e. "'medically-needy') Medicaid populations.

Group/program	Eligibility threshold(s)	Commentary
Any federal Medicare savings program, including the Qualified Medicare Beneficiary program, and the specified low–income Medicare Beneficiary Program;	Income eligibility thresholds for these programs differ.	Some of the Medicare savings programs, including the Qualified Medicare Beneficiary program and the specified low–income Medicare Beneficiary Program have income eligibility thresholds low enough to allow individuals to qualify for free hospital care. Individuals enrolled in Medicare savings programs are enrolled in Medicare and receive assistance from the State to pay Medicare premiums. At least one of the Medicare savings programs also covers some Medicare cost sharing. Income eligible individuals in these programs could benefit from free or reduced hospital care for cost sharing that is not covered by the Medicare savings program.
Public Assistance for Adults Program	<100% FPL	DHS noted that this group is eligible for Medicaid. Medicaid provides benefits to cover the hospital bills of eligible patients. Thus, Medicaid eligible individuals should not need hospital free care or hospital reduced-cost care.
Temporary Disability Assistance Program	<50% FPL[47]	Recipients of this Program would most likely be below the 200% of FPL and thus should be considered for free care rather than reduced-cost care.

In conclusion, it is not clear that any programs identified in HB 1420 should be used as criteria for presumptive eligibility for reduced-cost hospital care. Public health insurance programs (e.g. Medicare and Medicaid) and benefit programs that are categorically eligible for Medicaid should not be used as a criteria for either free or reduced hospital care, because individuals in these programs have health insurance. The General Assembly may wish to consider adding programs and populations in which most individuals are below 200% FPL to the eligibility criteria for free care in Health General 19-214.1(b)(7).

In addition, the General Assembly should carefully consider the purpose of creating a presumptive eligibility for reduced-cost care policy. If such a program was created, hospitals would still need to determine a patient's income to determine the size of the reduced-cost discount that the hospital would provide to the patient. As a result, it is not clear that a presumptive eligibility program for reduced-cost care would speed access to reduced-cost care discounts for patients compared to existing application processes.

[47] Resources (assets) are also considered when determining eligibility for this program.

V. Conclusion

HB 1420 required the HSCRC, to the extent practicable, to evaluate the impact of different possible changes to § 19–214.1 of the Health General Article on the amount of hospital uncompensated care (UCC) included in hospital rates and the total cost of care for Medicare, Medicaid; commercial insurers; and self–pay individuals. HSCRC analyzed hospital performance on the provision of statutorily-required free care to individuals under 200% of the federal poverty level (FPL); the impact of the possible changes to eligibility thresholds for free care and reduced-cost care on statewide uncompensated care and the total cost of care for Medicare, Medicaid, commercial insurers, and self-pay patients; and the impact of a potential presumptive eligibility program for reduced-cost care policy.

HSCRC determined that approximately 60% of UCC attributable to the population eligible for hospital fee care[48] is reported by hospitals as bad debt, rather than charity care, suggesting that hospitals attempted (and failed) to collect this debt from patients likely eligible for free care. In addition approximately 1% of total hospital charges to individuals who likely qualify for free care are paid by those individuals (this amounts to approximately $60 million statewide). Commercial insurance benefit design appears to contribute to the amount of cost sharing paid by patients with incomes under 200% of FPL.

HSCRC's analysis of the estimated impact of increasing FPL thresholds for eligibility for hospital free care shows that every increase of 50 percentage points in FPL will increase UCC (paid by patients that utilize hospital services) by $40 to $42 million. Specifically, costs would increase by approximately $15 million for commercially insured patients, $9 million for Medicaid enrollees, and $16 million for Medicare FFS beneficiaries. Increasing the FPL threshold also increases the total cost of care for Medicare, thereby making it more difficult to achieve the savings requirements under the Total Cost of Care contract with CMS. Furthermore, if the FPL threshold was increased up to 350%, the additional costs to Medicare FFS would total approximately $48 million, which represents 16% of the required annual savings under the contract. Staff did not analyze the financial impact of increasing FPL thresholds for reduced-cost care in UCC or payers due to data limitations.

HSCRC analyzed the potential for creating a presumptive eligibility policy for reduced-cost care. Neither statute nor regulations specify how much of a discount hospitals must provide to patients who qualify for reduced-cost care. Health General § 19-214.1(b)(5), Maryland Code, states that "the hospital shall apply the reduction that is most favorable to the patient." Because of the resulting variability in the amount of discounts offered by hospitals to patients eligible for reduced-cost care and other data limitations, HSCRC staff were not able to analyze the financial impact on UCC and payers of creating a presumptive eligibility program for reduced-cost care. The General Assembly should carefully consider the purpose of creating a

[48] Individuals with household incomes below 200% FPL.

presumptive eligibility for reduced-cost care policy, as reduced-cost care discounts are generally offered on a sliding scale based on income. As a result, it is not clear that a presumptive eligibility program for reduced-cost care would speed access to reduced-cost care discounts for patients compared to existing application processes. The General Assembly may wish to consider adding some of the programs and populations in Exhibit 10 that have eligibility thresholds below 200% FPL to the presumptive eligibility for free care provision in Health General 19-214.1(b)(7).

Appendix A: Examples of Hospital Reduced-Cost Care Policies

Table 1. Example of reduced-cost care policy—Johns Hopkins Medicine

Income as a percentage of FPL	Adjustment to bill
Up to 200%	100% adjustment (patient responsible for 0% of the bill)
201 to 250%	75% adjustment (patient responsible for 25% of the bill)
251 to 300%	50% adjustment (patient responsible for 50% of the bill)
301 to 400%	35% adjustment (patient responsible for 65% of the bill)

Table 2. Example of reduced-cost care policy— Medstar Health (for HSCRC-Regulated Services)

Income as a percentage of FPL	Adjustment to bill
Up to 200%	100% adjustment (patient responsible for 0% of the bill)
201 to 250%	40% adjustment (patient responsible for 60% of the bill)
251 to 300%	30% adjustment (patient responsible for 70% of the bill)
301 to 350%	20% adjustment (patient responsible for 80% of the bill)
351 to 400%	10% adjustment (patient responsible for 90% of the bill)

Table 3. Example of reduced-cost care policy—Garrett Regional Medical Center

Income as a percentage of FPL	Adjustment to bill
Up to 200%	100% adjustment (patient responsible for 0% of the bill)
201 to 210%	95% adjustment (patient responsible for 0% of the bill)
211 to 220%	85% adjustment (patient responsible for 15% of the bill)
221 to 230%	75% adjustment (patient responsible for 25% of the bill)
231 to 240%	65% adjustment (patient responsible for 35% of the bill)
241 to 250%	55% adjustment (patient responsible for 45% of the bill)
251 to 260%	45% adjustment (patient responsible for 55% of the bill)
261 to 270%	35% adjustment (patient responsible for 65% of the bill)
271 to 280%	25% adjustment (patient responsible for 75% of the bill)
281 to 290%	15% adjustment (patient responsible for 85% of the bill)
291 to 300%	5% adjustment (patient responsible for 95% of the bill)

Appendix B: Cost Share Percentages for Commercially Insured Patients by Income Level

Table 1. Inpatient Commercial Patient Cost Share (From MCDB)

FPL Thresholds	Inpatient Commercial Cost Share (%)
0 to 50% FPL	4.02%
50 to 100% FPL	3.20%
100 to 138% FPL	3.96%
138 to 150% FPL	4.34%
150 to 200% FPL	4.48%
200 to 250% FPL	4.51%
250 to 300% FPL	4.41%
300 to 350% FPL	4.01%
350 to 400% FPL	4.37%
400 to 450% FPL	3.72%
450 to 500% FPL	3.29%
500 to 550% FPL	3.86%
550 to 600% FPL	2.60%
600 to 650% FPL	3.16%
0 to 50% FPL	3.11%
Unknown	3.47%
Grand Total	**3.56%**

Table 2. Outpatient Commercial Patients Cost Share (From MCDB)

FPL Thresholds	Outpatient Commercial Cost Share (%)
0 to 50% FPL	12.18%
50 to 100% FPL	10.04%
100 to 138% FPL	13.49%
138 to 150% FPL	11.91%
150 to 200% FPL	13.03%
200 to 250% FPL	13.90%
250 to 300% FPL	12.96%
300 to 350% FPL	12.30%
350 to 400% FPL	11.47%
400 to 450% FPL	11.37%
450 to 500% FPL	10.71%
500 to 550% FPL	10.97%
550 to 600% FPL	9.25%
600 to 650% FPL	8.94%
0 to 50% FPL	11.06%
Unknown	11.70%
Grand Total	**11.50%**