## Contributions to Changes in Total Levels of Uncompensated Care for FY 2015

## Situation

The HSCRC needs to examine the level of uncompensated care provided in hospitals' rates as well as the formula used to determine the amount of funds to be remitted or withdrawn from the uncompensated care fund by each hospital.

The HSCRC’s provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care (UCC) includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those patients who cannot pay for care. The uncompensated care methodology has undergone substantial changes over the years since it was initially established in 1983. The most recent version of the policy was adopted by the Commission on September 1, 2010.

Under the current policy, the statewide uncompensated care provision (now 6.86 percent) is placed in each hospital's rates. Each hospital remits funds or withdraws funds from an uncompensated care pool administered by HSCRC based on application of the formula contained in the UCC policy of the HSCRC. Hospitals with a result above 6.86 percent withdraw money from the funds to cover additional uncompensated care while hospitals with a result below 6.86 percent pay into the fund.

There are several factors contributing to the need for review of the level of uncompensated care provided for in rates overall as well as the formulation of hospital specific levels used to determine whether the hospital will receive money from the pool, or pay into the pool.

* Uncompensated care increased by approximately .5 percent between fiscal year 2012 and fiscal year 2013. This increase would be considered for rate formulation for FY2015 rates under current policies.
* Effective January 1, 2014 there was an increase in the number of Medicaid enrollees, including expansion of coverage to more than 90,000 limited enrollees who had limited benefits prior to January 1. Expansion of coverage to limited benefit enrollees is expected to begin to decrease bad debts in 2014.
* Historically, Medicaid enrollment has been used in the regression formulation to predict uncompensated care for individual hospitals. As Medicaid expands, its use in the formulation may need to be reexamined. Additionally, HSCRC staff have been informed that undocumented immigrants, who are not eligible for full Medicaid benefits, are producing unrecognized increases in uncompensated care levels for specific hospitals.
* For FY 2014, HSCRC suspended the charity care multiplier used in the formulation of the level of UCC recognized for individual hospitals in applying the policies due to inconsistencies in allocating uncompensated care between charity care and bad debt amounts. HSCRC staff will need to assess the consistency of allocations for FY 2015.

This paper focuses on the impact of the expansion of Medicaid to cover individuals who had only limited benefit coverage prior to January 1, 2014. Additional topics will be added as the related work is completed.

## Background

Maryland’s Primary Adult Care Program (PAC) served individuals aged 19 and over who had minimum incomes but did not qualify for full Medicaid benefits. PAC provided a limited benefit package covering 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 for inpatient or outpatient hospital care. When PAC-enrolled individuals did receive hospital care, hospitals would generally not be reimbursed for the services provided, and the hospitals would consider the cost of these services to be uncompensated care (UCC).

In January 2014, approximately 96,000 Marylanders transitioned from PAC to full-benefit Medicaid under the Medicaid expansion. Now that former PAC enrollees have access to full packages of services, including hospital care, Maryland hospitals will likely see resulting changes to UCC. When establishing hospital reimbursement rates, Maryland’s Health Services Cost Review Commission (HSCRC) accounts for UCC in rates. Therefore, State health officials, HSCRC and hospitals are interested in understanding potential reductions in UCC due to health reform and the resulting changes in coverage for former PAC enrollees.

## Analysis

#### Objectives of the Analysis

The objective of the analysis is to understand hospital utilization by PAC enrollees in the year prior to full benefit enrollment.

#### Description of the Analysis

Hospital data from the HSCRC are useful in understanding hospital utilization and costs. However, as PAC did not reimburse for hospital costs, we cannot reliably identify PAC individuals directly from HSCRC’s hospital data. Likewise, as Medicaid did not reimburse for hospital services for PAC enrollees, Medicaid claims/encounter files do not identify hospital utilization for PAC enrollees. Medicaid eligibility files do indicate individuals who were enrolled in PAC and the enrollment coverage dates.

To bridge these datasets, CRISP used its Master Patient Index to link HSCRC hospital data to Medicaid enrollment data to create an analysis file of PAC-enrolled individuals who obtained hospital care between January 1, 2012 and August 30, 2013. Figure 1 outlines the steps to create the analysis file.

The ability to link these data sets is only possible because of CRISP’s unique Master Patient Index and the partnership with hospitals to collect Administrative and Discharge data directly from Maryland hospitals.

**Figure 1: Process to Create the Analysis File of PAC Enrollees Who Received Hospital Care**

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**Findings of the Analysis**

##### Hospitals Provided PAC Enrollees with $127.2 Million in Hospital Inpatient Services in FY 2013.

Figure 2 provides the major findings from the analysis file. Analysis also found that the most frequent primary diagnosis for the PAC population’s inpatient stays in fiscal year (FY) 2013 were Psychiatric (23%), Substance Dependency (16%), Pulmonary (8%), GI (7%), Cardiology (6%), and Orthopedic (5%).

**Figure 2: PAC Enrollees Who Received Hospital Care, FY 2013**

|  |  |
| --- | --- |
|  | Total |
|  |  |
| *Hospital Inpatient* |
| Inpatient Stays | 14,008 |
| Unique Patients  | 11,784 |
| Charges for Inpatient Stays | $127.2 million |
| *Hospital Outpatient* |
| Outpatient Visits | 42,839 |
| Unique Patients | 19,110 |
| Charges for Outpatient Visits | $37.2 million |

Source: CRISP analysis of HSCRC case mix data (7/1/2012-6/30/2013) and Maryland Medicaid MMIS enrollment files (2011-2013) provided by the Hilltop Institute. March 2014.

Note: As PAC reimbursed for emergency department services, the analysis removed emergency department visits from the other outpatient services and totals provided above.

To understand the illness burden among the PAC population, CRISP combined enrollment data and hospital data to develop the hospital use rates displayed in Figure 3. Based on PAC annual enrollment counts, the PAC population--despite lack of inpatient insurance coverage--had 144 hospital inpatient stays per 1,000 enrollees. In comparison, Maryland’s population in 2011, the most recent year of available data, had 117 hospital inpatient stays per 1,000 residents. During 2012, Maryland did provide hospital emergency department (ED) coverage for PAC enrollees. CRISP analysis found that PAC enrollees used the hospital ED 92,083 times during calendar year (CY) 2012, for a use rate of 1,029 per 1,000 enrollees. The ED use rate for Maryland’s general population is 423 per 1,000 residents in 2011.[[1]](#footnote-1) While differences in time periods and data sources do not provide direct comparisons, they do allow us to conclude that PAC enrollees tend to use hospital services at a disproportionally high rate compared to Maryland’s general population.

**Figure 3: PAC Enrollees and Maryland Resident Hospital Use Rates, CY 2012**

|  |  |
| --- | --- |
|  | Use Rates |
| **PAC CY 2012** | **Maryland Population CY 2011** |
| Average PAC Enrollment | 89,605 | -- |
| Hospital Inpatient Stays Per 1,000 Individuals | 144 | 117 |
| ED Visits Per 1,000 Individuals | 1,029 | 423 |

Source: CRISP analysis of HSCRC case mix data (1/1/2012-12/31/2012, includes all hospitals) and information accessed from The Kaiser Family Foundation’s State Health Fact. March 2014.

#### Findings Inform the Understanding of Potential UCC Reductions

As with all analysis, it is important to understand the limitations of this analysis. Please note the following:

* **Not all hospital care provided to PAC enrollees was uncompensated**

This analysis uses HSCRC case mix data which indicate the expected payer for each inpatient discharge and outpatient visit. Of the 14,008 inpatient hospitalizations for PAC-enrolled individuals, HSCRC’s FY 2013 case mix data only denotes that about 62 percent with expected payers that clearly indicating a high likelihood that charges for the care will not be reimbursed (e.g., expected payer is self pay, expected payer is charity care or no charge). Note that hospitals coded another 31 percent of cases as Medicaid fee for service or Medicaid managed care and 7 percent from other sources. We cannot identify if these are coding misclassifications or if the hospital expected the PAC-enrolled individual to convert from PAC to Medicaid coverage due to the hospitalization. While this provides a good indication of uncompensated care, it is possible that there were payments from other sources.

* **Even among populations with hospital insurance, not all charges are reimbursed**

The dollar amounts discussed here are hospital charges. Even among insured populations, insurers do not reimburse 100 percent of charges. For example, Maryland Medicaid reimburses hospitals at 94 percent of charges. Based on accounting rules, the remaining 6 percent of charges above the reimbursed amount is not considered UCC.

* **Hospital usage changes across time.**

The data in this analysis do not provide an understanding of hospital use rates across a period of time. There may be increases or decreases in use rates in 2014, which would affect the level of UCC.

* **Coverage of Outpatient:** The PAC program does provide some coverage for outpatient services such as ED.

## Conclusion and Next Steps

HSCRC will share the hospital specific summaries of the data with hospitals. It is the intention of the HSCRC staff to include some portion of these charges in estimating an uncompensated care reduction that will occur from enrollment of these PAC individuals in Medicaid. While the coverage went into effect on January 1, 2014, a prospective reduction, net of any offset resulting from the increase in actual uncompensated care reported for 2013 over 2012 would be expected to take effect July 1, 2014.

1. <http://kff.org/statedata/> accessed March 2014. 2011 AHA Annual Survey Copyright 2013 by Health Forum LLC, an affiliate of the American Hospital Association, special data request, 2013. Available at [http://www.ahaonlinestore.](http://www.ahaonlinestore.com/ProductDisplay.asp?ProductID=637)
Population data from Annual Population Estimates by State, U.S. Census Bureau; available at <http://www.census.gov/popest/>. [↑](#footnote-ref-1)