Maryland
Hospital Association

June 3, 2016

Sule Gerovich, Ph.D.
Deputy Director, Research & Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Sule:

On behalf of the Maryland Hospital Association's (MHA) 64 member hospitals and health systems, we appreciate the opportunity to comment on HSCRC's Uncompensated Care (UCC) policy that will affect hospital rates beginning July 1, 2016. We also appreciate HSCRC staff's work on this important matter.

The rate year 2017 UCC policy reflects the most significant change in UCC funding since the policy was redesigned more than 10 years ago, and accounts for the massive expansion of insurance coverage mandated by the Affordable Care Act on January 1, 2014. Hospital actual UCC data and underlying statistics are from fiscal year 2015, the first full year since coverage expansion and the first full year for which hospital account level write-off information was collected by HSCRC.

After thorough discussion with our members, MHA has developed the following principles that should guide UCC policy:

1) The policy should include a blend of actual and predicted UCC; actual UCC should reflect regulated bad debts and charity care from each hospital's audited income statement
2) The statewide policy should agree with the most recently available audited data
3) HSCRC should not prospectively adjust the policy results
4) The actual data used to construct the policy should be at least one full year after the January 1, 2014, coverage expansion

Using these principles as guidance, Maryland's hospitals recommend that HSCRC staff consider the following when crafting its final recommendation:

1) **The statewide policy should continue to agree with the most recently available statewide audited UCC data**. The draft staff recommendation reflects the fiscal year 2015 statewide amount, the most recently available data. UCC is estimated to be about 4.7 percent of fiscal year 2015 revenues.
2) **Hospital rate funding should continue to reflect a blend of 50 percent actual UCC and 50 predicted UCC**. Using a blend of actual and predicted UCC creates incentives for efficient billing and collection practices.

3) **Use a logistic regression model to predict uncompensated care, reflecting the following variables**:
    a. Area Deprivation Index (ADI), a socioeconomic deprivation metric of a given area
    b. Primary payer: Medicare, Medicaid, self-pay, Blue Cross/commercial/HMO, and other
    c. Patient type: Inpatient, outpatient or emergency room

These recommendations reflect the consensus of the field. By setting the overall uncompensated care funding level at fiscal year 2015 actual, the statewide amount is guaranteed. MHA requests that the commission follow its Advisory Council's opinion and give deference to the consensus hospital position when there is no impact on the statewide total.

Hospital representatives discussed different approaches to predicting UCC, including a non-regression based approach, and three logistic regression alternatives. The work group considered including an emergency Medicaid regression variable as a proxy for identifying undocumented immigrant service use and UCC impact, but ultimately did not recommend including this variable due to considerations about the validity of the underlying data and its application. Hospital representatives would like to continue working with HSCRC staff, the Maryland Department of Health and Mental Hygiene and other stakeholders to explore alternative undocumented immigrant variables for future use; this work should be completed by December 2016.

The statewide funding level is an income statement measure, or uncompensated care as a percentage of revenues. The measure is audited and factored into each hospital's net income or net loss. The income statement allowance, or provision for uncompensated care, required by accounting principle, is an estimate of revenues the hospital will forego in a given period. The new account level write off data reflect balance sheet measures that may differ from the income statement measure for timing reasons. Hospitals and HSCRC staff should continue to analyze hospital UCC data over a longer period to validate the timing differences between the income statement provision and actual account write offs.

Before providing a summary data set to construct the logistic regression, HSCRC staff compared the write off data to the HSCRC medical record abstract data. A primary payer classification of self-pay in the write-off data was changed to match the primary payer in the abstract data if different than self-pay. Hospitals request that a report be created to identify these modifications by hospital, by account, to provide a greater level of transparency when data is modified.

Hospital representatives strongly support an overall limit, or phase-in, of significant rate setting policy changes to make the system more predictable, stable and manageable. The fiscal year 2017 UCC policy changes are large: ACA's dramatic insurance expansion, a new account level data set and a new logistic regression approach, all in a single year. In the future, including additional years of data to predict uncompensated care may mitigate this concern in the UCC policy, particularly as corresponding UCC expenses decline. However, the impact of multiple changes to rate setting methodologies, year in and year out, makes it difficult to predict revenues and plan operations accordingly.

The Uncompensated Care policy is an important component of Global Budget Revenues. We appreciate your time and attention to our input. Should you have any questions, please call me at (410) 540 5060.

Sincerely,

Brett McCone, Vice President

cc: Donna Kinzer, Executive Director
Nduka Udom, Associate Director, Research & Methodology