maryland
health services
cost review commission

February 14, 2024

The Honorable Josaline Peña-Melnyk
Chair, House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, MD 21401

RE: House Bill 328 - Hospitals - Financial Assistance Policies - Revisions – Letter of Support

Dear Chair Peña-Melnyk and Committee Members:

The Health Services Cost Review Commission (HSCRC) requests that the Committee favorably report House Bill 328, “Hospitals - Financial Assistance Policies - Revisions.” Hospitals differ in their current financial assistance eligibility policies related to geographic restrictions and the use of asset tests.This bill will benefit consumers by increasing access to hospital financial assistance and increase consistency in eligibility for patients regardless of the hospital they use.

Restricting Eligibility Based on Service Area Burdens Patients
Maryland law requires general acute care and chronic care hospitals to provide reduced-cost care to patients with family incomes between 200% and 300% of federal poverty level (FPL) and patients with family incomes below 500% of FPL who have a substantial amount of medical debt. Under current law, hospitals may restrict eligibility for reduced cost care to the hospital’s service area. Some hospitals have included this restriction to eligibility for reduced cost care in their financial assistance policies.

A hospital's service area is based on zip codes. A zip code is included in a hospital's service area if at least 50% of the residents of that zip code who had a hospital visit in the year visited that specific hospital. There are a number of reasons why a consumer that lives outside of a hospital’s service area may choose to use that hospital, including availability of specialty care, emergencies that occur during personal or business travel,

or simply personal preference. Whether or not a patient qualifies for reduced cost care should not be conditioned on their residence in a set of zip codes.

Maryland law requires hospitals to provide free care to patients with family incomes under 200% of the FPL. Hospitals may not, under current law, disqualify a patient for free care based on the hospital's service area. HSCRC believes that the policy for free care and for reduced cost care should be consistent. Whether you qualify for free care or reduced cost care, where you live should not determine your eligibility for financial help.

Asset Tests are Unequal and may Discourage Patients from Applying for Financial Assistance

Maryland law allows, but does not require, hospitals to use asset tests in determining eligibility for both free care (for patients with family incomes under 200% FPL) and reduced cost care. Twenty-seven of the forty-five hospitals that are required to provide financial assistance use asset tests. As noted in HSCRC's 2021 report on policy proposals related to reduced cost care "This leads to unequal results for consumers depending on the hospital they visit" (page 1). Particularly concerning is that only one motor vehicle is protected from the asset test. For most families in Maryland, vehicles are crucial to accessing work, groceries, health care, and other necessary services.

The use of asset tests also complicates the hospital financial assistance application and increases the burden on patients to apply. Patients are required to report their monetary assets, the worth of their home, and the value of their vehicles. This complexity may discourage patients from applying. Eliminating the asset tests will allow HSCRC and hospitals to simplify the hospital financial assistance application.

Maryland funds Uncompensated Care through Hospital Global Budgets

HSCRC funds hospital uncompensated care (UCC) through all-payer rates.This means that hospitals receive funding for the financial assistance they provide to patients and for "bad debt" (bills that patients have not paid). On a statewide basis, there is no gap between the UCC experienced by hospitals in a year and the increase in hospital rates to fund UCC in the next year. HSCRC expects that our existing uncompensated care funding policy can support the changes proposed by this bill and believes that this bill will benefit patients. This bill will likely increase the amount of financial assistance provided by hospitals to patients, relieving financial burdens for those patients. Some of

the increased financial assistance provided to patients will be offset by reductions in bad debt. Financial assistance and bad debt are the two components of uncompensated care. Bad debt negatively impacts patients who are being pursued for bills and potentially having a negative impact on their credit report. The substitution between bad debt and financial assistance will limit the increase in UCC due to this bill.

UCC Funding is not based on Geography or Asset Tests
HSCRC provides uncompensated care funding to a hospital regardless of whether the patient that received the financial assistance is a resident of the hospital's service area. HSCRC does not condition UCC funding on a hospital using an asset test. Hospitals that provide reduced cost care to patients outside of their service area already receive funding for all of the reduced cost care they provide to patients. Similarly, UCC funding is available for all of the financial assistance a hospital provides, whether or not that hospital applies an asset test.

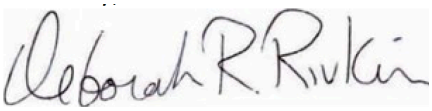
UCC is Fully Funded on a Statewide Basis
HSCRC builds funding for UCC into state-wide hospital rates each year. The amount of funding for UCC in rates equals the actual state-wide average UCC, as a percent of global budget revenue (GBR), that hospitals experienced in the prior year. On a state-wide basis, hospitals are compensated for the UCC they experienced in the prior year.

HSCRC's UCC Methodology is designed to Sustainably and Equitably Fund Hospital UCC
Because different hospitals experience different amounts of UCC relative to their individual GBRs, HSCRC redistributes funding between hospitals through the UCC pool. The purpose of the UCC pool is to provide additional financial support to hospitals with higher amounts of UCC relative to the statewide average, funded by the difference from hospitals that have lower amounts of UCC relative to the statewide average. The UCC pool does not add additional funding to state-wide hospital rates. Rather, the contributions to the pool are approximately equal to the distributions made from the pool. This redistribution of funds has an equity benefit: this additional support for hospitals with higher amounts of UCC helps maintain hospital access for communities that struggle to afford healthcare. It also results in lower prices in these hospitals (relative to if there were no UCC pool).

Each year, HSCRC determines the amount that each hospital will either contribute to the UCC pool or withdraw from the UCC pool. This amount is a blend of the actual amount of UCC the hospital experienced in the past year and the amount of UCC that HSCRC would expect the hospital to have based on a number of criteria (the "predicted UCC"). Hospitals with a higher blended UCC amount get a payment from the UCC pool and hospitals with a lower blended UCC amount must pay into the UCC pool. The use of "predicted UCC" in the formula helps to control UCC growth in the state by incentivizing hospitals to responsibly collect payments from patients 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. The use of "predicted" UCC in the formula means that some hospitals may not receive full reimbursement for the actual amount of UCC the hospital experienced in the prior year. This only occurs when that hospital's actual UCC is growing faster than the statewide average growth in UCC, which suggests that the hospital may not be doing enough to collect bad debt from patients who can pay their bills.

The Commission urges a favorable report on HB 328, to simplify financial assistance applications and to provide greater fairness for consumers. Thank you for your consideration of the information in this letter. If you have any questions or if I may provide you with any further information, please do not hesitate to contact me at 410-991-7422 or deborah.rivkin@maryland.gov, or Jon Kromm, Executive Director, at jon.kromm@maryland.gov.

Sincerely,



Deborah Rivkin
Director, Government Affairs

Attachments:

- **Appendix A: Hospital Financial Assistance Requirements in Maryland**

- **Appendix B: Hospital Financial Assistance: Use of Asset Tests by Maryland Hospitals**
- **Appendix C: UCC Funding Methodology**

Appendix A: Hospital Financial Assistance Requirements in Maryland
Each general acute and chronic care hospital in Maryland is required by law to provide financial assistance to the following patients:

1. *Free Care*: Hospitals must provide free care to patients with incomes at or below 200 percent of the federal poverty level (FPL) and to patients who receive benefits through the federal Supplemental Nutrition Assistance Program; Maryland's State Energy Assistance Program; the federal Special Supplemental Food Program for Women, Infants, and Children; or live in a household with a child enrolled in the free and reduced cost meal program.
2. *Reduced-Cost Care:* Hospitals must provide reduced-cost care to patients with income between 200 and 300 percent of FPL. Reduced-cost care is also available to patients with income below 500 percent of FPL who have a substantial amount of medical debt.[1]

Hospital financial assistance is available to both insured and uninsured patients for their out-of-pocket costs.[2] Financial assistance is available regardless of the patient's citizenship or immigration status. Hospital financial assistance is different from medical assistance (i.e. Medicaid). Patients who are eligible for medical assistance should apply for that coverage instead of using hospital financial assistance.

The law sets minimum standards. Hospitals are permitted to offer more generous financial assistance policies. This leads to variation between hospitals of the level of support provided to patients.

[1] For patients with a family income between 301% and 500% FPL, the family must have medical debt, incurred by the family over a 12–month period, that exceeds 25% of family income. Health General § 19-214.1.
[2] Hospital financial assistance is not available to patients in the Medicaid program as they have no out-of-pocket expenses.

Appendix B: Hospital Financial Assistance: Use of Asset Tests by Maryland Hospitals

Under Maryland law (Health General 19-214.1(b)(8) and COMAR 10.37.10.26) hospitals are allowed to include asset tests as a criteria for financial assistance eligibility. In total, 27 hospitals use asset tests or consider assets in determining eligibility for financial aid.

If a hospital includes an asset test in their financial assistance policy, the law prevents the hospital from considering the following assets when determining financial assistance eligibility as shown in HG 19-214.1(b)(8)(ii) and (iii):

"1. At a minimum, the first $10,000 of monetary assets;
2. A safe harbor equity of $150,000 in a primary residence;
3. Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans;
4. One motor vehicle used for the transportation needs of the patient or any family member of the patient;
5. Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and
6. Prepaid higher education funds in a Maryland 529 Program account.

(iii) Monetary assets excluded from the determination of eligibility for free and reduced–cost care under subparagraph (ii) of this paragraph shall be adjusted annually for inflation in accordance with the Consumer Price Index."

Hospitals that use asset tests differ in the components of those asset tests. The provisions of asset test policies may vary from hospital to hospital for those hospitals that use asset tests.

The following hospitals use asset tests in their financial assistance policies.

Table: Hospitals with Financial Assistance Policies that include Asset Tests

Health System	Hospital
Ascension	St. Agnes Hospital
ChristianaCare	Union Hospital of Cecil County
John Hopkins Medicine	Johns Hopkins Bayview Medical Center
	Johns Hopkins Hospital
	Johns Hopkins Howard County Medical Center
	Suburban Hospital
Lifebridge	Lifebridge Carroll County Hospital Center
	Lifebridge Levindale Hospital
	Lifebridge Northwest Hospital
	Lifebridge Sinai Hospital
Luminis Health	Anne Arundel Medical Center
	Doctors Community Medical Center
Medstar	MedStar Franklin Square Hospital
	MedStar Good Samaritan Hospital
	MedStar Harbor Hospital
	MedStar Montgomery General Hospital
	MedStar Southern Maryland Hospital Center
	MedStar St. Mary's Hospital
	MedStar Union Memorial Hospital Center
Independent Hospitals	Atlantic General Hospital
	Calvert Health
	Greater Baltimore Medical Center
	Mercy Medical
TidalHealth	Peninsula Regional
Trinity Health	Holy Cross
	Holy Cross Germantown
WVU Medicine	Garrett Regional Medical Center

Appendix C: UCC Funding Methodology

The 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.[3]

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

1. **Statewide Actual UCC in All-Payer Hospital Rates:** HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percent of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in RY 2024, HSCRC staff will use RY 2022 statewide UCC experience of 4.29 percent to determine the UCC amount built into all hospital rates.
2. **Hospital Payments or Contributions to the UCC Fund**
   The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
   i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital[4]. (See Appendix II).
   ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad

[3] 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/.

[4] Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts

debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),[5] payer type, and site of care as independent variables in the logistic regression. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. 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.

iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).

iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (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 the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

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

Exhibit 1: UCC Methodology Example ($ Millions)

		Step 1		Step 2 (i)	Step 2 (ii)	Step 2 (iii)	Step 2 (iv)
	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 Actual Hospital-Specific UCC Rate	Predicted Hospital-specific UCC Rate	Hospital-Specific 50/50 Blend	(Payment into) 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