Impact of Medicaid Expansion on Hospital Volumes

Executive Summary

- The Medicaid proportion of patient volume at hospitals in states that expanded Medicaid increased substantially in the first quarter of 2014. At the same time, the proportion of self-pay and overall charity care declined in expansion-state hospitals.
- Medicaid, self-pay and charity care showed no change outside normal variation for hospitals in non-expansion states in 2014.
- The increase in Medicaid volume, which occurred only in expansion states, is due to Medicaid expansion. The parallel decrease in self-pay and charity care shows that previously uninsured patients are now enrolled in Medicaid.

Introduction

Originally a required part of the Affordable Care Act (ACA), the U.S. Supreme Court ultimately ruled that Medicaid expansion should be voluntary, and allowed each state to choose independently whether to expand. This expansion, if fully implemented, would allow an estimated 21 million Americans to enroll in Medicaid by 2022 (Kaiser Family Foundation, 2013). On January 1, 2014, 26 states across the U.S. voluntarily expanded Medicaid eligibility. While the long-term effects on Americans' health and well-being will take more time to emerge, some immediate impacts of states' decisions to expand Medicaid are beginning to appear.

CHA DATABANK Analysis

Colorado Hospital Association (CHA) collects monthly reported financial and volume data for hospitals across the country in DATABANK (http://www.databank.org/). This analysis contains 465 hospitals from DATABANK across 30 different states[1], 15 of which expanded Medicaid and 15 that did not (seen in Fig. 1, data downloaded May 15, 2014). This CHA analysis reports the preliminary impact of the ACA Medicaid expansion on hospitals in both expansion and non-expansion states. Specifically, the report explores volume trends through changes in charges and payer mix.

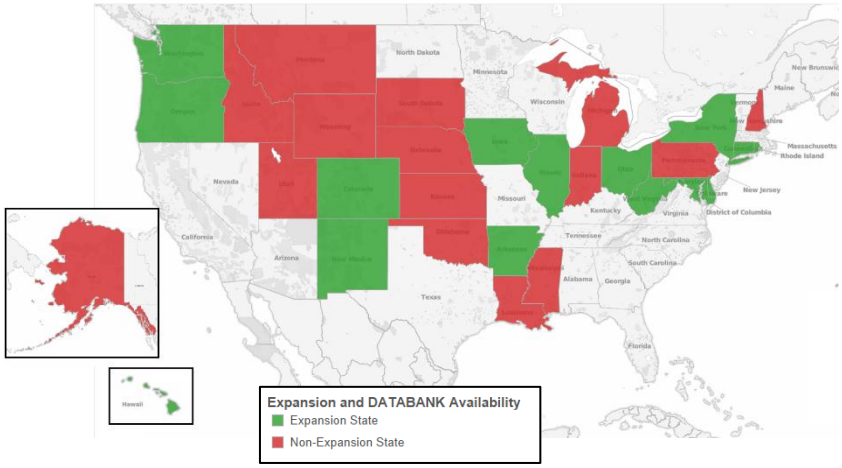

Figure 1. *Medicaid expansion status of states included in DATABANK (Medicaid.gov, 2014).*

[1] Twelve states comprise over 90 percent of the hospitals included in this survey; the remaining 18 states have fewer than 10 hospitals per state.

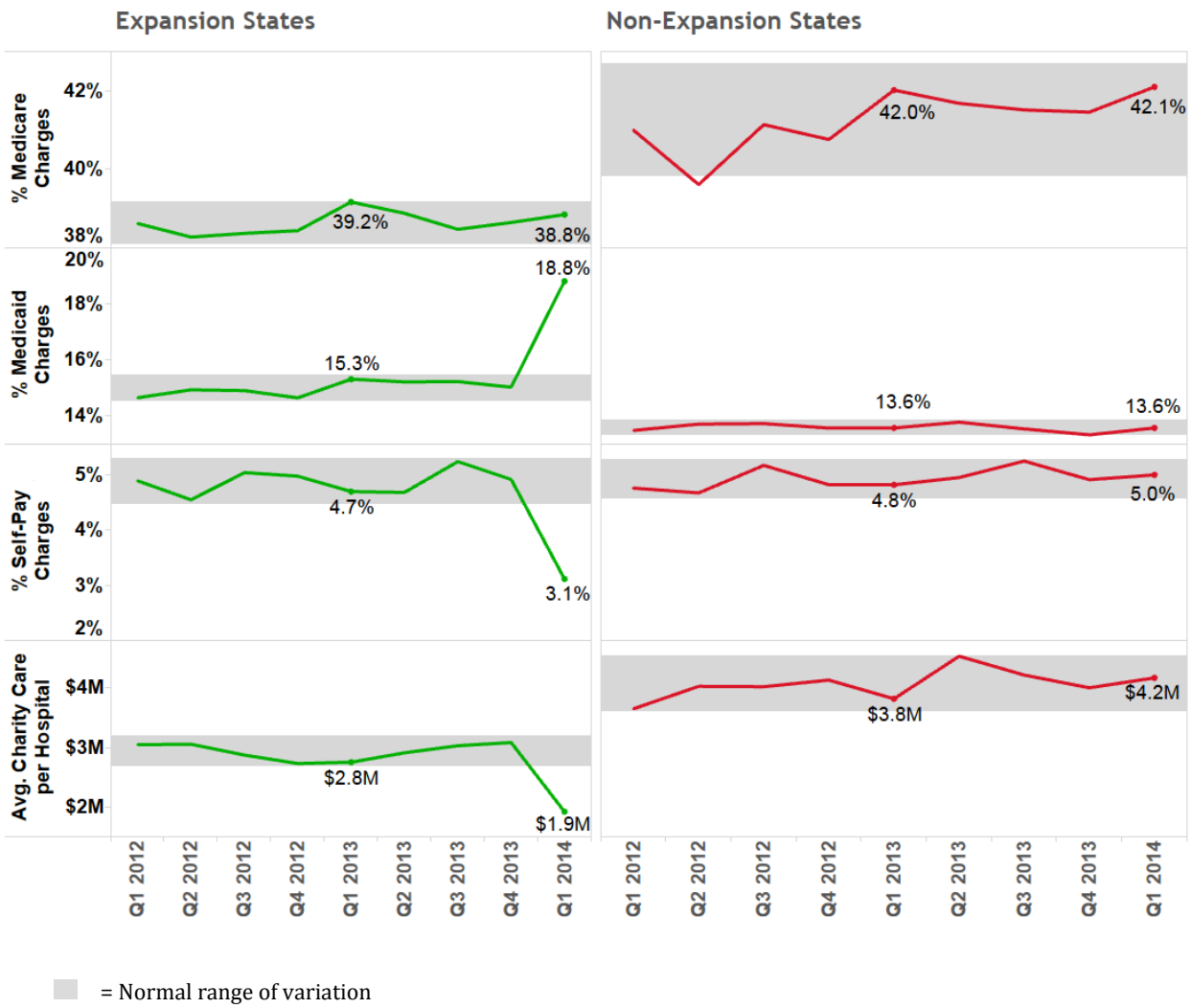

Figure 2. *Proportion of charges by payer per group and average charity care per hospital.*

Fig. 2 shows the proportion of Medicaid charges increasing for hospitals in expansion states for first quarter 2014. This shift cannot be explained by an overall rise in total volume of patients attending hospitals or overall costs of care due to other structural changes in the health care sector, as these changes would have resulted in the same proportions of each payer type—no one group would have increased its share. Instead, the Medicaid share grows in expansion states relative to Medicare, which held steady over the same time frame. The changes are thus due to something that effected Medicaid specifically: the Medicaid expansion. The distinct departure from previous patterns for these measures only occurs for hospitals in expansion states, not those in non-expansion states. Such a divide further supports the hypothesis that the new trends seen here are due to Medicaid expansion. Also, the changes appear in first quarter 2014, when Medicaid expansion began. Both groups show very similar patterns for Medicare charges, implying that the patient populations within these two groups and the external forces on hospitals, such as economic pressures, are reasonably similar; thus, the main variability arises from the status of their Medicaid programs.

Additionally, self-pay volumes and charity care experienced the *opposite* effect, with hospitals in expansion states recording significant reductions in these at the start of 2014. This decline in self-pay and charity care, occurring in parallel with the growth in numbers of Medicaid beneficiaries, shows that previously uninsured patients are now enrolled in Medicaid. Many hospitals provided on-site assistance to enroll eligible patients into Medicaid, promoting the recruitment of patients into Medicaid who otherwise would have self-paid or been provided with charity care.

The changes seen here are not only distinct, but also substantial. The Medicaid proportion of total charges increased over three percentage points to 18.8 percent in 2014 from 15.3 percent in 2013, representing a 29 percent growth in the volume of Medicaid charges. When compared to the first quarter of 2013, there was a 30 percent drop in average charity care per hospital across expansion states, to $1.9 million from $2.8 million. Similarly, total self-pay charges declined 25 percent in expansion states, bringing its proportion of total charges down to 3.1 percent from 4.7 percent. In contrast, the proportion of Medicare volume shows little variation through first quarter 2014.

This analysis, while preliminary, outlines noticeable changes occurring due to Medicaid expansion in certain states. Whether the future continues to magnify these impacts on payer shifts remains to be seen; CHA will continue to monitor these trends resulting from the expansion.

Colorado Hospitals

The changes reported by hospitals in expansion states nationally are also seen locally across Colorado. Urban, rural and critical access hospitals (CAHs) all demonstrate similar increases in Medicaid volume and decreases in self-pay volume and charity care. The magnitude of the changes in Colorado hospitals is greater than the national trend, as seen in Table 1. Furthermore, the values are outside the range of normal variation, indicating an influence beyond the typical month-to-month change. The proportion of Medicaid charges jumped almost five percentage points for urban hospitals and over three percentage points for CAHs and rural hospitals. Across the state, total Medicaid charges for Colorado grew 37 percent, while total self-pay charges dropped by 27 percent from first quarter 2013 to first quarter 2014.

	Hospital Peer Group	Jan—Mar 2013	Jan—Mar 2014	% Change
% Medicare Charges	Urban	31.6%	31.0%	-2.0%
	Rural	34.7%	35.4%	1.9%
	CAH	42.1%	39.7%	-5.6%
	All Colorado	32.0%	31.4%	-1.7%
% Medicaid Charges	Urban	15.7%	20.5%	31.2%
	Rural	12.4%	15.9%	27.8%
	CAH	13.5%	17.0%	25.4%
	All Colorado	15.4%	20.1%	30.8%
% Self-Pay Charges	Urban	4.8%	3.3%	-31.2%
	Rural	6.7%	4.8%	-29.0%
	CAH	7.8%	6.9%	-12.0%
	All Colorado	5.0%	3.5%	-30.3%
Average Charity Care per Hospital	Urban	$10.3 million	$6.6 million	-35.7%
	Rural	$1.5 million	$938,800	-38.3%
	CAH	$441,300	$210,400	-52.3%
	All Colorado	$4.6 million	$2.9 million	-36.2%

Red numbers represent values outside of normal variation (more than two standard deviations from the mean).

Table 1. *First quarter comparisons between 2013 and 2014 for Colorado hospital peer groups.*

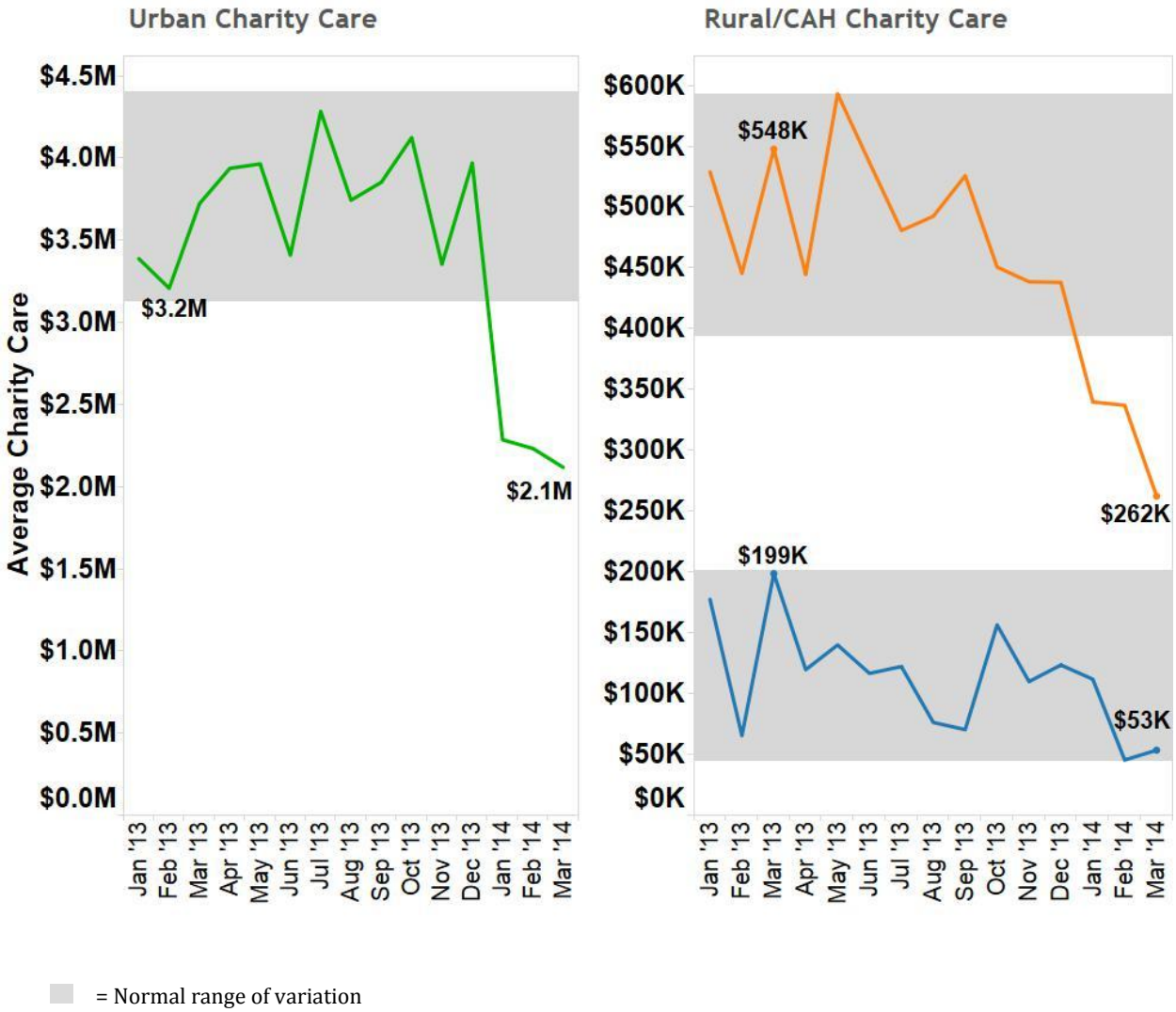

Figure 3. *Average charity care charges per hospital by peer group.*

Urban hospitals reported a drop of $3.6 million in charity care for the first quarter of 2014, as compared with the same quarter in 2013. For rural and urban hospitals, charity care was well outside the normal range (Fig. 3). While technically within an expected range of change, the 52 percent drop in charity care reported by CAHs between first quarter 2014 and first quarter 2013 is still substantial; charity care in February and March 2014 was also lower than any other months in 2012 or 2013. Charity care in CAHs varies considerably, causing a greater range of values to be considered within normal variation.

These results are preliminary. CHA will continue to update this analysis as more months pass to see whether the trends seen here persist or grow for Colorado hospitals.

About CHA

CHA represents 100 member hospitals and health systems throughout Colorado. The Association partners with its members to work towards health reform and performance improvement, and provides advocacy and representation at the state and federal level. Colorado hospitals and health systems are committed to providing coverage and access to safe, high-quality and affordable health care. In addition, Colorado hospitals have a tremendous impact on the state's economic stability and growth, contributing to nearly every community across the state with more than 71,000 employees statewide. For more information, visit www.cha.com.

About the Center for Health Information and Data Analytics

CHA is cognizant that data must be combined and analyzed quickly to derive meaningful and actionable information that will help hospitals continue to provide much-needed care and economic stability in their communities. To this end, CHA recently created a new center for health information and data analytics. A robust analytics function is crucial to informing CHA's advocacy on behalf of its members. The goal of the analytical function is to be proactive about changes and to use data to predict the effect of changes on hospital providers.

About DATABANK

The CHA DATABANK Program is an online hospital database available to licensed hospital associations, their members and other hospitals across the country willing to submit monthly data. Since 1985, DATABANK has served as a trusted source of hospital utilization and financial data, serving the needs of the hospital community. The DATABANK Program offers comparable data in a variety of useful reporting formats and graphs for many standard industry metrics including information on discharges, patient days, births, inpatient and outpatient surgeries, charges/cost, expenses, profitability and balance sheet ratios. Each month, hundreds of hospitals across the country upload their data into the database. In return, associations and hospitals can access useful, timely and accurate information online with a few clicks, or users can elect to have reports sent directly to their inboxes. Currently, there are hospitals in more than 25 states reporting monthly data.

References

2013. Kaiser Family Foundation. "Analysis of March 2013 Current Population Survey."

2014. Medicaid.gov. "State Medicaid & CHIP Policies for 2014." http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html. Accessed May 27, 2014.