Impact of Medicaid Expansion on Hospitals: Updated for Second-Quarter 2014

Executive Summary

- The Medicaid proportion of hospital volumes continued to increase in the second quarter, but at a slower rate than the first quarter of 2014.
- Unlike first-quarter 2014, second-quarter Medicaid volumes for hospitals in non-expansion states showed a small but noticeable increase; self-pay volumes decreased and charity care remained relatively stable.
- Expansion state hospitals reported a decrease in the volume of charges for total commercial and other payers.
- For Colorado hospitals, average case mix index and complexity increased for Medicaid patients in the first quarter of 2014 as compared to first quarter 2013.

Further CHA Analysis

In July 2014, the Colorado Hospital Association (CHA) released a preliminary analysis of first-quarter 2014 data regarding the impact of the Affordable Care Act (ACA) Medicaid Expansion. This updated analysis examines how the trends shown in the previous study progressed into the second quarter of the year, as well as additional information about the Medicaid population. It presents a national review; a regional comparison of Montana, Washington and Oregon; and a local, in-depth examination of Colorado trends using additional datasets. The national analysis is based on DATABANK data from 450 hospitals[1] across 25 states[2], 13 of which expanded and 12 of which did not (Fig. 1). Please see page 10 for more information on data sources.

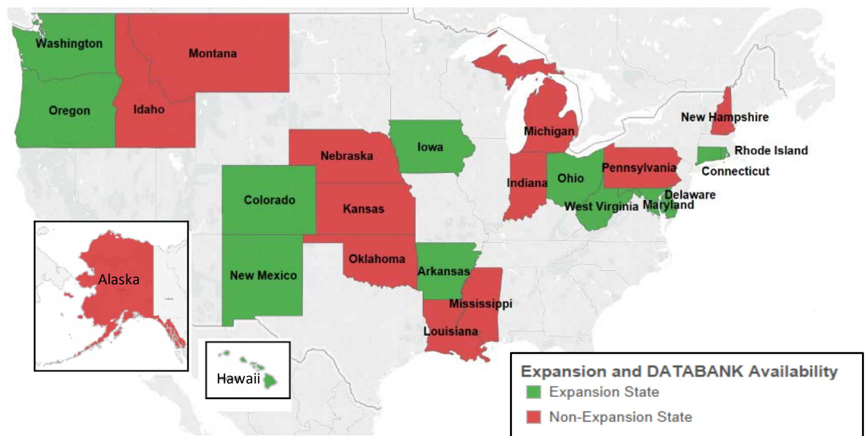


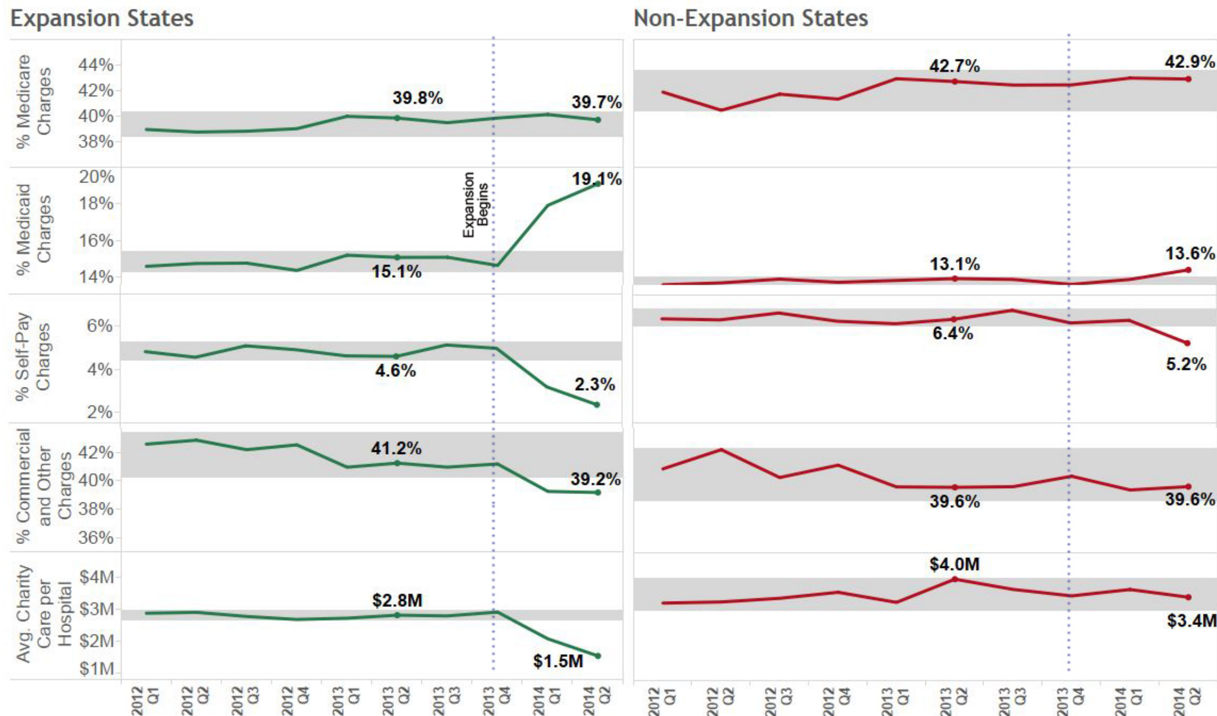
Figure 1. *Medicaid expansion status of states included in DATABANK (Medicaid.gov, 2014).* ***Note****: Michigan expanded Medicaid on April 1, 2014. Michigan hospitals' data are included in the expansion group from that time onward.*

[1] In order to release this report in a timely manner while preserving the integrity of the analysis, CHA excluded 37 hospitals from the original analysis due to incomplete second-quarter data. Twenty-two new hospitals were added to the analysis. As such, some baseline numbers may differ slightly from the previous report due to these changes.

[2] Only 12 states are represented by 10 or more hospitals.

National Trends

The proportion of Medicaid charges continued to increase and the proportion of self-pay charges continued to decrease for hospitals in expansion states for second-quarter 2014 (Fig 2).



= Normal range of variation for 2012-2013.

Figure 2. *Proportion of charges by payer[3] and average charity care per hospital by group. "All Other Charges" largely represents commercial/private payers. From DATABANK.*

A new development for second-quarter 2014 is the growth in the proportion of Medicaid charges and decline in the self-pay proportion seen in hospitals in non-expansion states. While far smaller than the rapid changes seen in hospitals in expansion states, these changes for hospitals in non-expansion states are noticeably greater than the expected normal variation from the previous year. The decrease in self-pay in hospitals in non-expansion states may be due, in part, to the increased Medicaid enrollment. This unexpected Medicaid growth in hospitals in non-expansion states is a likely result of the "woodwork effect," where previously unenrolled but eligible individuals discover

A new development for second-quarter 2014 is the growth in the proportion of Medicaid charges and decline in the self-pay proportion seen in hospitals in non-expansion states.

[3] Due to differences in hospital data reporting, 75 hospitals were held out from the self-pay proportion calculation, as these hospitals did not report self-pay as a separate category.

that they are eligible for Medicaid, whether due to the individual mandate, media coverage or attempts to sign up for health insurance through the exchanges. "There was no policy change that gave [the enrollees] new access to insurance," an August *New York Times* article explained. "What happened is that many people who were always eligible for the program have finally decided to sign up" (Sanger-Katz, 2014). The individual mandate may be a significant driver in overall enrollment, whether in commercial plans or Medicaid.

While the proportion of self-pay charges and charity care declined from second-quarter 2013 to second-quarter 2014 with the growth of Medicaid volumes, the proportion of total charges covered by commercial and other payers also declined in hospitals in expansion states during this time. Nationally, the proportion of charges covered by commercial payers and payers other than Medicaid, Medicare and self-pay declined by approximately 2 percentage points in hospitals in expansion states during the first and second quarter of 2014 when compared to the same time in 2013. This change exceeded the normal variation seen for commercial and other payer volumes, and pushed them to the lowest level yet reported by hospitals in expansion states. This decrease is not just due to a shrinking share from growth in the Medicaid proportion or total patient population; the number of discharges covered by commercial and other payers decreased 4.6 percent between second-quarter 2013 and second-quarter 2014.

The proportion of self-pay charges and charity care declined with the growth of Medicaid volumes; the proportion of total charges covered by commercial and other payers also declined.

The average number of emergency department (ED) visits to hospitals in expansion states increased 5.6 percent from second-quarter 2013 to second-quarter 2014. This change was greater than expected from the variation over the last two years, and resulted in the highest number of average visits over that time. In comparison, hospitals in non-expansion states reported a 1.8 percent increase in ED visits between the second quarters of 2013 and 2014.

Colorado Hospitals

Colorado trends continued to be more pronounced than the national pattern. Growth in Medicaid volumes and declines in self-pay persisted into the second quarter of 2014 (Fig. 3). The proportion of commercial and other charges for urban Colorado hospitals declined 5.4 percentage points, a 10.9 percent change, from second-quarter 2013 to the same quarter in 2014. This decline is not simply due to a relative decrease compared to growth in other payer groups; overall commercial charges across urban hospitals dropped 9 percent between second-quarter 2013 and second-quarter 2014. No such decline in the proportion of charges for commercial and other payers, outside normal variation, is seen for critical access or rural hospitals in Colorado.

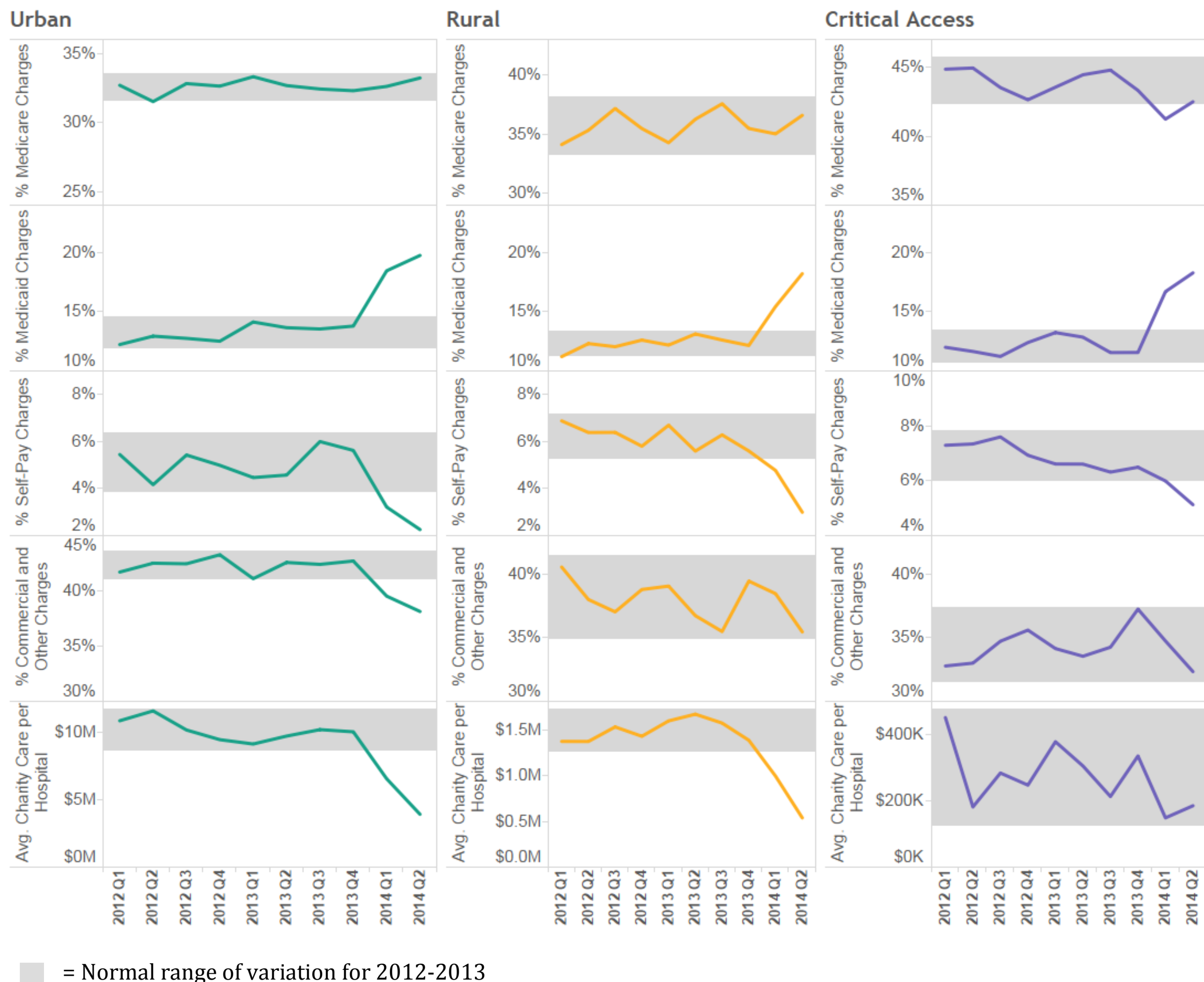


Figure 3. *Proportion of charges by payer and charity care by urban, rural and critical access hospitals in Colorado. From DATABANK, representing 45 Colorado hospitals.*

Emergency Departments

First-quarter 2014 data from the CHA Discharge Database Program showed similar patterns of payer mix changes occurring in EDs across Colorado hospitals (Table 1). Both proportionally and in terms of absolute numbers, the number of Medicaid-covered ED visits increased in first-quarter 2014 as compared to the previous year. Self-pay visits declined overall and proportionally; visits by Medicare and private insurance patients increased in absolute number in the first quarter as compared with previous quarters, but remained relatively stable proportionally. Across all payers, total ED visits increased 10.6 percent from first-quarter 2013 to first-quarter 2014.

The number of Medicaid-covered ED visits increased in first-quarter 2014 as compared to the previous year.

Table 1. *Total number and proportion of visits by payer for EDs across Colorado hospitals. From Discharge Database, across 62 Colorado hospitals. Note: For 2014, only first-quarter data are available for the Discharge Database (see page 10 for more information on the database).*

Payer		2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1
Medicare	# of Visits	58,478	60,002	59,436	63,626	63,903
	% of Visits	14.5%	15.5%	15.7%	15.5%	14.3%
Medicaid	# of Visits	114,221	104,459	106,447	109,713	157,829
	% of Visits	28.3%	27.0%	28.1%	26.8%	35.4%
Private	# of Visits	125,448	120,763	116,493	130,278	138,896
	% of Visits	31.1%	31.2%	30.7%	31.8%	31.1%
Self-Pay	# of Visits	57,609	55,655	56,465	58,542	49,839
	% of Visits	14.3%	14.4%	14.9%	14.3%	11.2%
Charity	# of Visits	9,877	9,853	9,124	10,953	6,670
	% of Visits	2.4%	2.5%	2.4%	2.7%	1.5%
Other	# of Visits	37,900	36,331	31,310	36,446	29,314
	% of Visits	9.4%	9.4%	8.3%	8.9%	6.6%
TOTAL	# of Visits	403,533	387,063	379,275	409,558	446,451

The New Medicaid Population

The data from the caseload report released by the Colorado Department of Health Care Policy and Financing (HPCF) make a clear case that the majority of individuals added after Medicaid expansion were adults under age 65 without dependent children (Fig. 4). Disabled adults and adults over age 65 showed little increase. While Colorado created "adults without dependents" as an eligible category in 2012, the enrollment was capped and the income eligibility level was 100 percent of federal poverty level (FPL). Medicaid expansion greatly increased the number of childless adults who could qualify in 2014 by raising the maximum income allowed to 133 percent of FPL and eliminating the cap on enrollment.

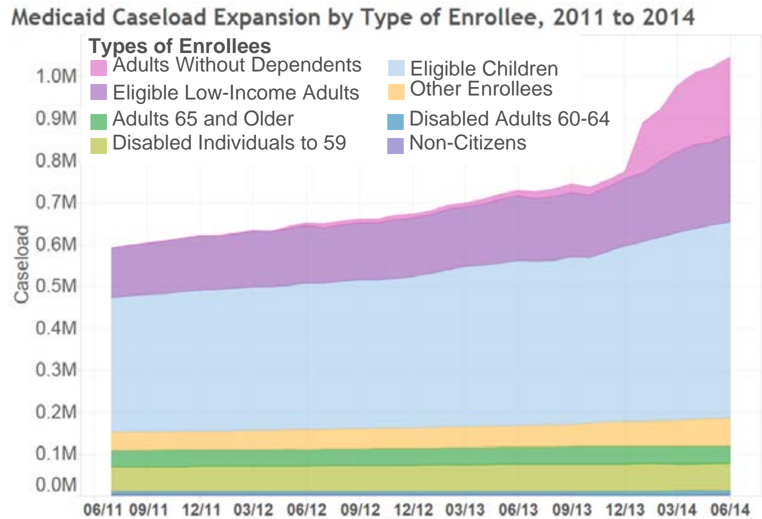


Figure 4. *Enrollment numbers for the different Colorado Medicaid eligibility categories. From HCPF Caseload Reports (HCPF, 2014).*

From first-quarter 2013 to first-quarter 2014, the case mix index, which measures intensity of resource needs and clinical complexity, increased 10 percent for Medicaid inpatients, compared to 2.6 percent for Medicare inpatients (Table 2). This increase indicates that the incoming Medicaid population has more complex needs and conditions on average than Medicaid patients seen previously.

This inference from case mix index is also substantiated by an increased average number of concurrent diagnoses seen in Medicaid inpatients between first-quarter 2013 and first-quarter 2014 (Table 2). A similar growth in concurrent diagnoses also appears for Medicaid patients seen in hospital-based ambulatory surgery centers (ASCs).

Incoming Medicaid patients have more complex conditions than the average Medicaid patient seen previously.

Table 2. *Average number of concurrent diagnoses for inpatients and outpatients, and inpatient case mix index for first-quarters 2013 and 2014 across 81 acute-care Colorado hospitals and 72 hospital-based ambulatory surgery centers. From Discharge Database.*

Hospital Setting		Concurrent Diagnoses			Case Mix Index (available only for Inpatients)		
	Payer Group	Q1 2013	Q1 2014	% Difference	Q1 2013	Q1 2014	% Difference
Inpatients	Medicare	14.64	14.98	2.3%	1.7087	1.7526	2.6%
	Medicaid	7.26	8.22	13.2%	1.1114	1.2227	10.0%
Outpatients (ASCs)	Medicare	5.56	5.70	2.5%			
	Medicaid	3.79	4.14	9.2%			

Regional Comparison

Figure 5 examines more closely three states included in the national data: the expansion states of Washington and Oregon, and the non-expansion state of Montana. The comparison demonstrates that the trends seen nationally are still visible at a state and regional level, and that the differences seen between hospitals in expansion states and those in non-expansion states are due to expansion status. In the northwest, Oregon and Washington reported trends very similar to the national expansion group, while Montana followed the non-expansion patterns.

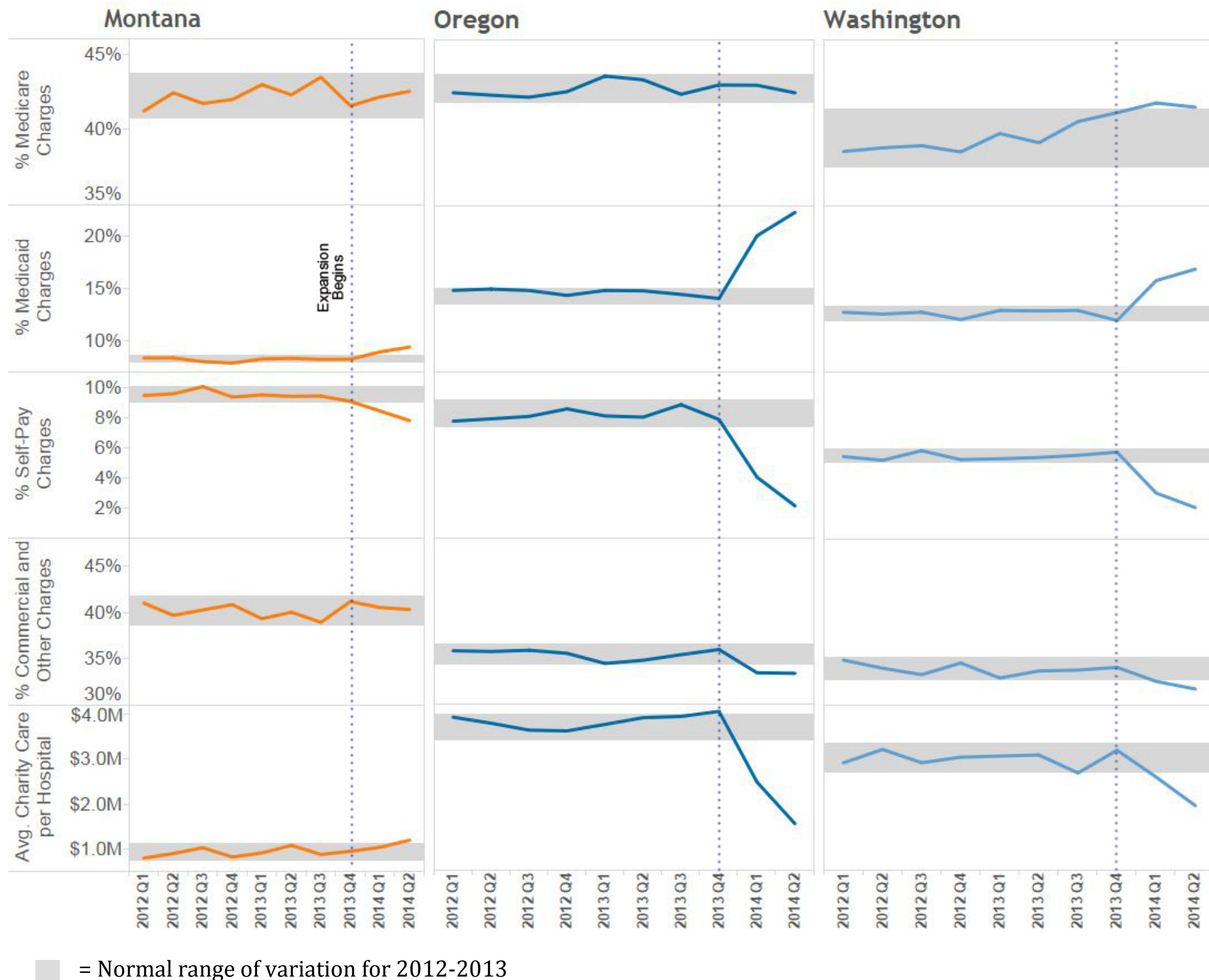


Figure 5. *Proportion of charges by payer[4] and average charity care per hospital for the states of Montana, Oregon and Washington. From DATABANK, representing 20 Montana hospitals, 54 Oregon hospitals and 46 Washington hospitals.*

Oregon in particular shows some of the greatest changes, with its statewide proportion of Medicaid charges growing 53 percent and the self-pay proportion decreasing by 75 percent from January to June this year. Montana hospitals reported trends similar to other hospitals in non-expansion

[4] Due to differences in reporting, 35 Washington hospitals were excluded from the calculation for self-pay proportion, as these hospitals did not report self-pay as a separate category.

states, with a 7 percent relative increase in the proportion of Medicaid charges and a 17 percent relative reduction in the proportion of self-pay charges from second-quarter 2013 to second-quarter 2014—likely due to the woodwork effect. “Some of that increase [in Medicaid] is natural growth in the program,” explained a July article in the *Billings Gazette*. “But 5,500 of those people are beyond what the state expected” (Dennison, 2014).

Washington and Oregon followed the national expansion state trend for commercial and other charges as well, with Washington hospitals reporting an approximately three percentage point drop in the proportion of commercial and other charges. Unlike Washington and Oregon, Montana hospitals did not report any significant change in the proportion of commercial and other charges.

Overall, ED visits have increased from second-quarter 2013 to second-quarter 2014 in Washington and Oregon, while remaining steady in Montana. Washington reported an 8.5 percent increase in the average number of ED visits per hospital, and Oregon, 6.5 percent, while Montana reported only 0.8 percent growth over the same time period.

Emergency department visits have increased from second quarter 2013 to second quarter 2014 in Washington and Oregon, while remaining steady in Montana.

Montana also reported an increase in charity care for the second quarter of 2014, although it is not clear why. On average across the nation, hospitals in non-expansion states did not see a similar increase.

This regional comparison demonstrates that national expansion trends in reduction of self-pay volumes and charity care, along with increases in Medicaid volumes, hold true in a closer examination of two expansion states individually. The similarity of the Northwest region to the national patterns supports the inference that the changes are due to expansion status of a state.

Conclusions

After a strong surge in the first quarter of this year, Medicaid expansion has continued to bring more enrollees into the Medicaid program across the United States. Hospitals in states that chose to expand Medicaid eligibility reported sustained growth in the proportion of Medicaid volume, as compared with a stable Medicare proportion over the same time period. Self-pay proportions in these hospitals also continued their decline from the first quarter of 2014. Hospitals in non-expansion states reported a small but notable increase in their proportion of Medicaid patients in the second quarter of 2014. This new trend is likely a result of the woodwork effect, where previously unenrolled individuals discover that they are eligible for Medicaid—probably due to the individual mandate requirement or from outreach and media coverage of health reform.

In addition to the first-quarter changes continuing their trends into the second quarter, the proportion and total volume of charges from commercial and other payers in hospitals in expansion states declined in the second quarter.

This analysis also highlighted how the Medicaid population is changing in Colorado. The vast majority of new Medicaid enrollees are adults without dependent children. Additionally, Medicaid patients being seen in Colorado hospitals are presenting with more complicated conditions and needing more resources.

CHA will closely watch how this new Medicaid population continues to develop, and monitor the impacts of Medicaid expansion on hospitals and health care both locally and across the nation.

About CHA

The Colorado Hospital Association (CHA) represents 100 member hospitals and health systems throughout Colorado. CHA 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 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.

Data Sources

This analysis used DATABANK data to continue the nationwide analysis. The analysis of Colorado trends utilized two additional data sources: the Colorado Discharge Database, a collection of the electronic claims records for all discharges across Colorado hospitals (described below), and the Colorado Department of Health Care Policy and Financing (HCPF) Premiums, Expenditures and Caseload Report for Medicaid. Due to the adjudication process for Discharge Database, only first-quarter 2014 data are available at the time of this document's release. HCPF reports were downloaded in July, 2014, and are available at:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1209635766663

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. Data for this study were accessed in July, 2014.

About the CHA Discharge Data Program

The CHA Discharge Data Program (DDP) database consists of administrative claims data derived from hospital billing information for all patients discharged from Colorado hospitals and patients who have hospital-based outpatient surgery. Beginning in 1978, the discharge data come from all general acute care hospitals in Colorado. Data can be aggregated into many different categories including hospital, DRG, severity level, payer type, age group or ZIP code. Data also can be used to create computed variables such as average length of stay, average charges or median age. These data categories and data elements can be used for patient origin studies, market share analysis, disease-specific volume reports, understanding health care capacity in response to local community needs, severity-adjusted death rate analysis, length-of-stay analysis and patient access analysis. These claims are adjudicated and released quarterly with approximately a three-month delay.

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