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CAH Medicaid Payer Mix in Expansion vs. Non-Expansion States

Savannah Stallings, George Pink, PhD and Kristin Reiter, PhD

KEY FINDINGS:

- The 10 states with the greatest increases in median CAH Medicaid payer mix from 2013 to 2018 are all expansion states.
- Among the 17 states with a decrease in median CAH Medicaid payer mix from 2013 to 2018, 12 were non-expansion states.

BACKGROUND

Since the Affordable Care Act's (ACA) enactment of Medicaid expansion in 2014, 36 states have decided to expand Medicaid – 21% of the population is now covered by Medicaid or Children's Health Insurance Program (CHIP).[1] The larger number of Medicaid patients has resulted in a substantial increase in Medicaid payer mix (the proportion of a hospital's net patient revenue provided by Medicaid). In August 2019, the Kaiser Family Foundation (KFF) issued a brief that summarized the extensive research on the effects of Medicaid expansion.[2] They state that numerous studies have found an association between expansion and payer mix (decreases in uninsured patients and increases in Medicaid patients) among patients hospitalized for certain conditions, including a range of cardiovascular conditions and operations; diabetes-related conditions; traumatic injury (among adults in one study and young adults in another); cancer surgery; and operative intervention for benign gallbladder disease. However, no study has specifically looked at Medicaid payer mix of Critical Access Hospitals (CAHs) in expansion versus non-expansion states.

Why is this important? The KFF states that previous studies have found that Medicaid expansion has significantly improved hospital operating margins and financial performance. One study found that Medicaid expansion was associated with improved hospital financial performance and significant reductions in the probability of hospital closure, especially in rural areas and areas with higher pre-ACA uninsured rates.[3] Another analysis found that expansion's effects on margins were strongest for small hospitals, for-profit and non-federal-government-operated hospitals, and hospitals located in non-metropolitan areas.[4] A third study found larger expansion-related improvements in operating

margins for public (compared to nonprofit or for-profit) hospitals and rural (compared to non-rural) hospitals.[5] Finally, a study found that the ACA was associated with substantial changes in hospitals' payer mix, with larger effects for hospitals in states that expanded Medicaid. Through FY 2015, hospitals in expansion states experienced reductions in uncompensated care costs and increases in Medicaid revenue and financial margins, compared with hospitals in non-expansion states.[6]

For these reasons, change in Medicaid payer mix could have material financial consequences for CAHs. Therefore, the purpose of this brief is to compare Medicaid payer mix in 2018 versus 2013 for CAHs in states that have and have not expanded Medicaid.

METHOD

2013 and 2018 data were obtained from the Centers for Medicare & Medicaid Services (CMS) Healthcare Cost Report Information System (HCRIS), hereafter Medicare Cost Report (MCR). Medicaid Payer Mix was defined as Medicaid charges / Total patient charges (Worksheet S-10, line 6 / Worksheet C Pt. 1 Line 200 column 8). A MCR was excluded if it had a reporting period less than 360 days, resulting in a total of 1,317 in 2013 and 1,322 in 2018 CAH MCRs. Medians were calculated across the CAHs in each state. Medians for Connecticut, Rhode Island, New Jersey, Delaware, and Maryland were not included because they do not currently have Critical Access Hospitals.

Each state was designated as either an "expansion" or "non-expansion" state, based on whether a state had adopted and implemented Medicaid expansion before May 2018.[7] After May 2018, Idaho, Utah, Maine, and Virginia adopted and implemented, and Nebraska adopted but has not implemented Medicaid expansion. In this study, these five states are designated as non-expansion states because Medicaid expansion occurred after the 2018 financial data used to calculate Medicaid payer mix.

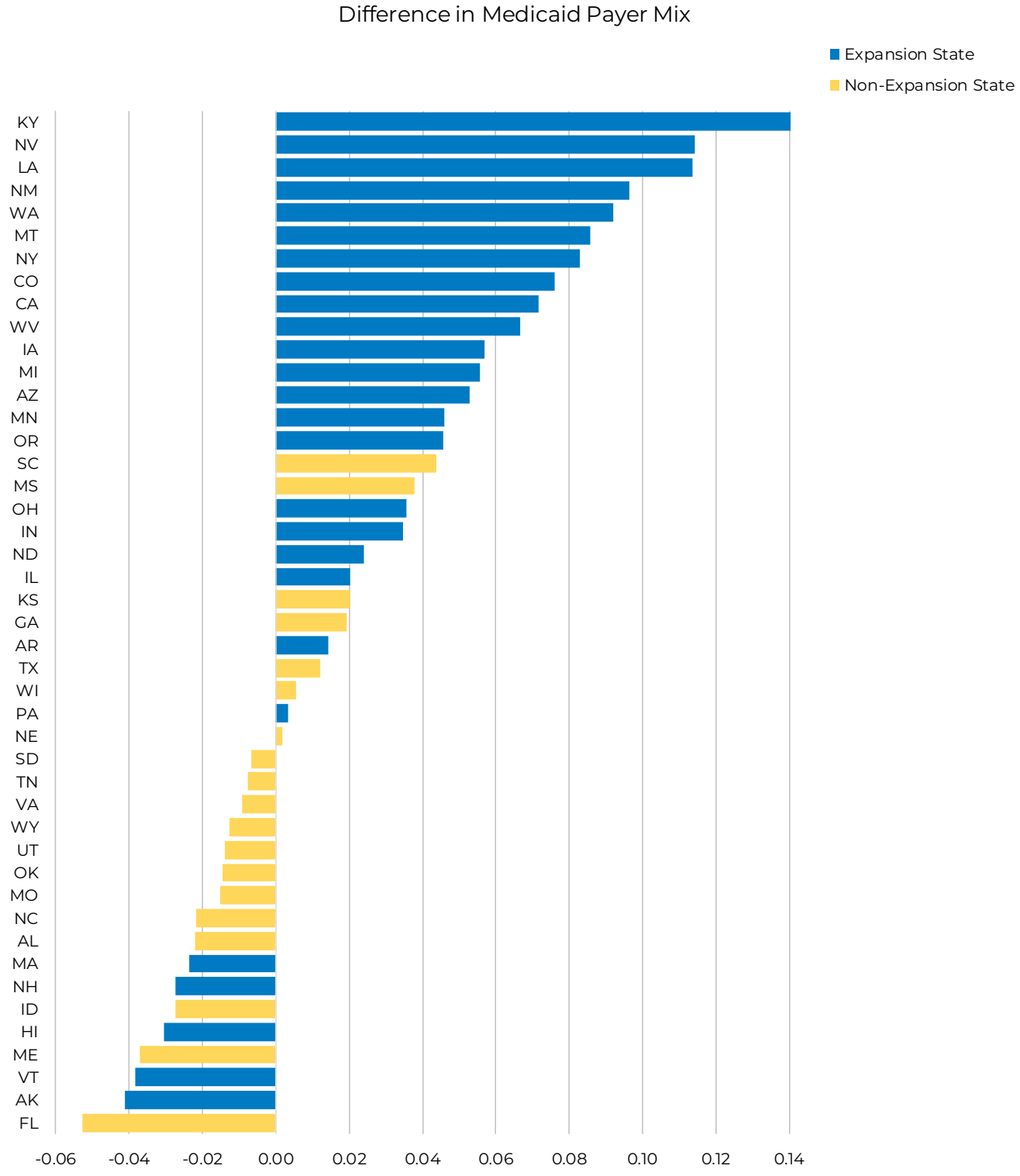
MEDICAID PAYER MIX IN STATES THAT HAVE AND HAVE NOT EXPANDED MEDICAID

The figure on the following page shows the percentage point difference in median Medicaid payer mix in 2013 versus 2018 among CAHs in expansion states (shaded blue) versus non-expansion states (shaded yellow).

The figure shows more blue bars at the top and more yellow bars at the bottom: states with the greatest change in median CAH Medicaid payer mix tend to be expansion states. States with smaller changes or negative changes tend to be non-expansion states. For example, in Kentucky, between 2013 and 2018, median Medicaid payer mix among CAHs in the state increased by 14 percentage points (from 15.6% to 29.7%), while in Florida, median Medicaid payer mix decreased by almost six percentage points (from 20.1% to 14.8%). The 10 states with the greatest positive change in median CAH Medicaid payer mix are all expansion states. Among the 17 states that had a decrease in median CAH Medicaid payer mix, 12 are non-expansion states.

The figure also shows that there were increases in median Medicaid payer mix in a few states that have not expanded Medicaid, and conversely decreases in median Medicaid payer mix in a few states that expanded Medicaid. Possible reasons for this result could be changes in state Medicaid eligibility requirements as well as changes in the number of CAHs in a state due to openings, closures, and loss of CAH status.

FIGURE 1: MEDICAID PAYER MIX CHANGE: EXPANSION VERSUS NON-EXPANSION STATES



CONCLUSION

Previous studies have found an association between Medicaid expansion and payer mix among patients hospitalized for certain conditions. This study finds a similar relationship among CAHs in expansion versus non-expansion states. CAHs with the greatest positive changes in Medicaid payer mix are located in expansion states. CAHs with the smallest or negative changes in Medicaid payer mix tend to be located in non-expansion states.

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