ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

IMPACT OF MEDICAID EXPANSION ON HOSPITAL UNCOMPENSATED CARE

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.[1]

ASHNHA has data representing 17 acute care hospitals for cost reporting period Oct 1, 2012 – Sept 30, 2013. **For 2013, 17 Alaska hospitals provided over $100 million in uncompensated care.**

To ensure accuracy, uncompensated care numbers are taken from hospital's cost reports that are required to be submitted annually to Medicare and Medicaid.[2] Many tribal hospitals are not included in this data because of differences in cost reporting requirements.[3] Tribal hospitals do have uncompensated care, but because of the difference in reporting requirements it is difficult to compare their data to the non-tribal facilities. Tribal facilities report data from patient accounting and general ledger systems and the uncompensated care represents the total amount of gross charges written off for care provided to patients who have no payer source.

This summary seeks to quantify the potential impact of Medicaid expansion on hospital uncompensated care.

- Early evidence shows a dramatic drop in uncompensated care for hospitals in states that have expanded Medicaid, due to an increase in Medicaid patient volume. At the same time, the proportion of self-pay and overall charity care has declined in expansion-state hospitals.[4]
- A Colorado study analyzed data from 465 hospitals in 30 states in the first four months of Medicaid expansion. It found that unpaid care decreased by 30 percent in expansion states and remained essentially unchanged in non-expansion states. The report links an enrollment surge in expansion states to not only the reduction in uncompensated care but also the 25-percent decrease in people paying out of pocket.[5]
- In Alaska, if Medicaid is expanded a decrease in uncompensated care is anticipated. Based on the experience in other states a 20%-30% reduction of uncompensated care could be achieved. This could amount to decrease of between $20 and $30 million in uncompensated care at Alaska hospitals.
- A decrease in uncompensated care could result in improved financial sustainability for Alaska's small/rural hospitals that are currently operating at a deficit. Additional resources will allow Alaska hospitals to better respond to community health needs and provide community benefits.
- Hospitals face looming uncertainty as federal cuts authorized by the ACA increase. These cuts amount to more than $591 million over fifteen years for Alaska hospitals.[6] Hospitals agreed to payment reductions based on the assumption that expanding Medicaid would be mandatory for all states and would make up for losses.

What would a reduction in uncompensated care mean for Alaska's health care system?

Small and large hospitals are under increasing regulatory and financial pressure to adapt to a rapidly changing business model and declining reimbursement. For small, rural hospitals, a reduction in uncompensated care could have a huge impact on future sustainability. Across the country, Critical Access Hospitals (CAH) with under 25 beds are shutting their doors. Across the country, 43 CAHs have closed since 2010.[7] In Iowa, if a CAH closes it means you might have to drive 20 miles more down the road. In Alaska, if a CAH closes it means an expensive Medevac and delayed treatment.

The health care industry is faced with significant financial pressure and at the same time being asked to transform health care, from a system that rewards volume to one that rewards value. Incentives within the current system are not aligned. Hospitals get paid when people are sick – not for keeping them well or for delivering high-quality, cost-effective care. Health care is undergoing radical transformation, away from a system that pays for volume to a system that pays for value. The reduction in uncompensated care can give hospitals the capital needed to support transformation.

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[1] American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet

[2] Hospital cost report data, schedule S-10 includes the uncompensated care cost numbers - non-Medicare bad debt on line 23 and charity care to uninsured patients line 29.

[3] Hospitals operated by Native health organizations are required to file a Schedule E cost report. The Schedule E cost report is an abbreviated form of cost reporting. As a result they are not obligated by CMS to report charity care or bad debt, simply because this is not a component of Schedule E cost report. Schedule S-10 is not a part of their cost report.

[4] Colorado Hospital Association, Center for Health Information and Data Analytics, June 2014

[5] Ibid.

[6] Medicare Payments Cuts in Alaska, February 2015, DataGen Medicare Cut Analysis report

[7] USA Today, Nov. 11, 2014 http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicaid-aca/18532471/