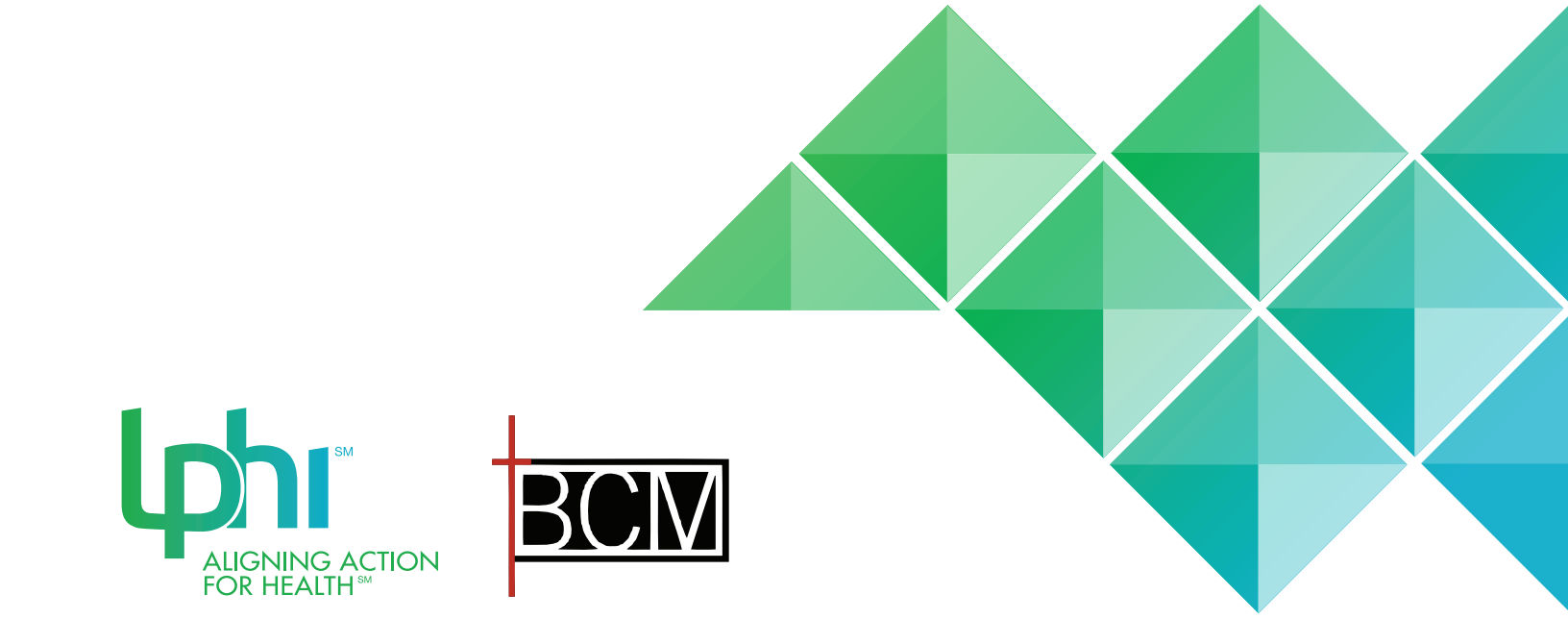
Medicaid Expansion, Budgetary Projections, and Impact on Hospitals

Prepared for the Louisiana Public Health Institute

James A. Richardson
Alumni Professor
Economics and Public Administration
Louisiana State University

Jared J. Llorens
Director and Associate Professor
Public Administration
Louisiana State University

Roy L. Heidelberg
Assistant Professor
Public Administration
Louisiana State University



This study was completed by Drs. James A. Richardson, Jared J. Llorens, and Roy L. Heidelberg, professors in the Public Administration Institute at Louisiana State University. The authors are solely responsible for the analysis and findings. This study was conducted as part of larger study implemented by the Louisiana Public Health Institute (LPHI) with funding from Baptist Community Ministries (BCM) that seeks to examine to impact of the Affordable Care Act on Louisiana residents.

Table of Contents

Executive Summary

Medicaid Expansion, Budgetary Projections, and Impact on Hospitals

The decision to expand Medicaid in Louisiana will have extensive effects on the budget of the state, on the quality of life for residents, on the services of healthcare providers, and on the operations of hospitals. In this report we focus on the impacts on the state budget, providers and rural hospitals.

Much of the discussion over the expansion of coverage has concerned the impact on the budget given the new financial obligations that the state will have. These analyses tend to neglect the fact that there will be effects if the state does not expand Medicaid as well. The ACA includes a gradual cutback on disproportionate share (DSH) payments to states, and Louisiana depends upon these dollars to fund uncompensated care expenses for uninsured residents. In this report we analyze the expected impact of this scheduled cut in federal dollars on rural hospitals.

We begin with a review of the forecast models produced by the state Department of Health and Hospitals (DHH) and the Louisiana Fiscal Office (LFO). These models are relatively simple as they evaluate two main variables: how many people will qualify for Medicaid and how many dollars, on average, a Medicaid patient requires. The federal government's contribution for the so-called Medicaid expansion population is far more favorable than the federal match for either existing Medicaid or for existing DSH payments. Nevertheless, with the state eventually assuming responsibility for ten percent of the new costs, it is a matter of simple arithmetic that the costs to the state will go up. But the decision requires not only consideration of how much expansion will cost the state but also how the state will continue to care for non-elderly patients who cannot afford the costs of health care.

The question of expansion, then, depends upon what the improved quality of care provided will cost and the potential loss of existing funding for the existing level of care. Presently, uninsured, poor residents rely on emergency care for all health needs, a system that is mainly funded through DSH payments, of which the state is a major beneficiary relative to other states. The ACA schedules these payments to reduce substantially, and so it is imperative that any analysis of the decision to expand Medicaid includes the inevitable loss of these dollars. The state must choose between improved care at ten percent of the cost (under expanded Medicaid) and existing care at roughly forty percent of the cost (DSH and uncompensated care system) with the added risk that the dollars for DSH-based care will likely not be available in the near future. The loss of these dollars will be especially important to the operations of critical access hospitals in rural communities as well as the state's public-private partnerships.

Introduction

On March 23, 2010 President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). The legislation promoted two major goals: to reduce the number of uninsured Americans and to lower the overall cost of healthcare. As of 2010, an estimated 47 million persons in the U.S., about 15% of the population, were uninsured. This included almost 900,000 Louisiana residents, approximately 20% of the state's population, according to the U.S. Census Bureau. Given the overall structure of healthcare provision in the United States, achieving the goal of expanded coverage necessitates both the expansion of employer sponsored insurance (ESI) and subsidizing, where needed, policies provided on the private market for certain income categories. Additionally, the ACA is structured to operate within the framework of existing public health programs, particularly the federal programs Medicare and Medicaid. A primary mechanism for expanding coverage under the ACA is through the expansion of Medicaid eligibility.

Medicaid expansion is a crucial part of the goal to achieve universal coverage as it provides health coverage for all individuals, including non-elderly adults, with incomes below the federal poverty level (FPL). In Louisiana, individual adults without children and parents with incomes above 19% of FPL do not qualify for Medicaid coverage. Children are accommodated by the expansion of CHIP, the Children's health Insurance Program. Expanded Medicaid access under the ACA would qualify all individuals below 138% FPL, eliminating the affordability coverage gap. As part of the ACA, the federal government is responsible for the entire cost of the newly eligible parents and childless adults through 2016, 95% of such costs in 2017, and gradually down to 90% of new costs in 2020.

As originally passed by the U.S. Congress, state level Medicaid expansion was a required component of the ACA. The legality of various components of the ACA was challenged immediately following its passage, and in June of 2012, in *National Federation of Independent Businesses (NFIB) v. Sebellius*, the U.S. Supreme Court ruled on two major provisions of the ACA: the individual health insurance mandate and Medicaid expansion. The Court upheld the constitutionality of the individual mandate, the provision of the law requiring individuals to maintain a minimum level of healthcare coverage beginning in 2014. The Court did, however, alter the ACA's provision for Medicaid expansion. Ultimately reversing a major component of the original legislation, the Court ruled that states were not legally mandated to expand Medicaid access as specified in the ACA, and were ultimately given the discretion to decide whether or not to provide expanded Medicaid eligibility to their residents.

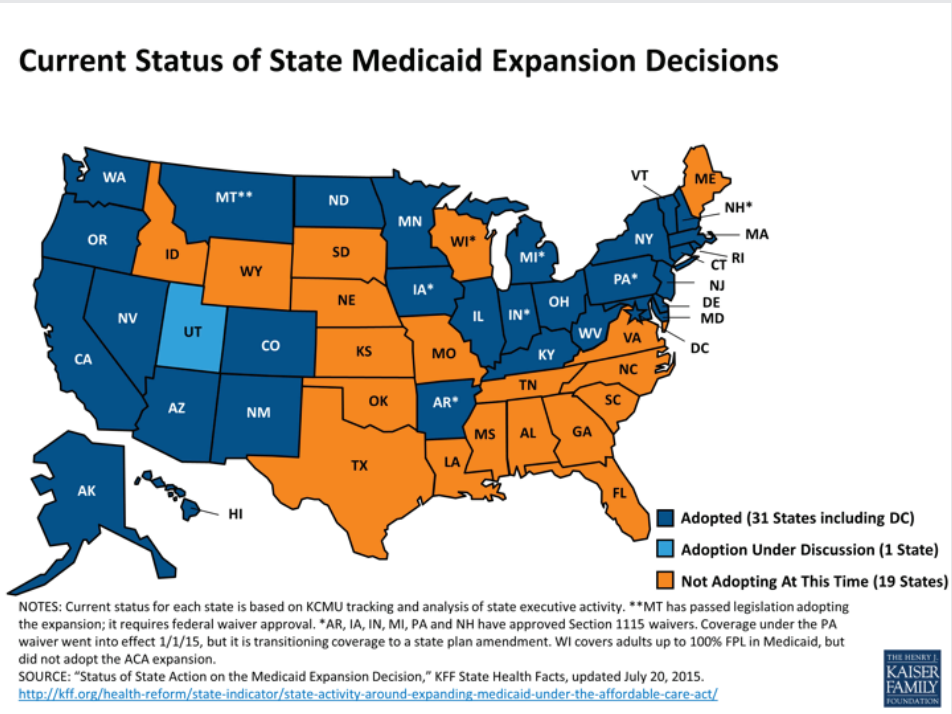
This report seeks to address the broad impact of Louisiana's ongoing decision whether or not to expand Medicaid access upon the state's fiscal health, its existing hospital infrastructure, and the broader Louisiana economy. The report pays particular attention to the impact of the ACA on the state's rural hospital network. It is important to note that that there are very tangible healthcare and financial consequences associated with both the decision to expand Medicaid access and the decision to continue on the non-expansion path under the ACA.

First, we overview the expansion of Medicaid at the state level, paying particular attention to the use of the Centers for Medicare and Medicaid Services (CMS) Section 1115 waiver process by select states to construct experimental approaches to Medicaid expansion. Second, we assess the potential fiscal impact of Medicaid expansion and non-expansion on the state budget. Third, we address the long-term impact of Louisiana's decision not to expand Medicaid access upon hospitals in the state, with a special focus on the state's rural hospital network. Last, throughout this discussion we emphasize the importance of the decision made by the state to healthcare opportunities for individuals who are included in the income ranges addressed by expansion of Medicaid and briefly note the broader economic impact of a decision to expand Medicaid in the state.

Options for Medicaid Expansion at the State Level

The result of the Supreme Court's ruling has been the uneven implementation of Medicaid expansion at the state level. At this time, 31 states (including the District of Columbia) have authorized Medicaid expansion as structured under the ACA and 20 states have not (see Map 1) though Utah is now working with CMS on its proposed waiver. Additionally, a number of states have chosen revised approaches to expanding Medicaid access through the CMS Section 1115 waiver process, which has allowed them to experiment with unique approaches to Medicaid expansion not originally specified in the ACA.

Map 1. Medicaid Expansion in the U.S. (Kaiser Family Foundation)



Use of Section 1115 Waivers and Medicaid Expansion

Prior to ACA, states could expand Medicaid coverage to childless adults using Section 1115 waivers, but any arrangement must be budget neutral to the federal government. The implementation of ACA would provide for a substantial federal outlay to the states to cover those in the "coverage gap", particularly childless adults and parents over a defined fraction of FPL. With ACA in force, though, at issue are the federal ACA matching funds now available to states that provide expanded coverage to childless adults. States that do not expand coverage will forego those funds, but some states are proposing Section 1115 waivers to expand coverage differently from ACA law *and* to receive the federal matching funds. The ACA has changed the role of waivers substantially because it eliminates the exclusion of adults without dependent children and provides initial federal covering 100% of such costs, phasing down to 90% starting in 2020.

Arkansas and Iowa both have approved waivers, and each relies upon premium assistance to implement Medicaid expansion. Under such a waiver, the state allows newly qualified residents to acquire health

insurance on the Marketplace by using the federal funds to purchase private health plans. Enrollees are still Medicaid beneficiaries, so state Medicaid agencies must ensure that the enrollees receive all services and benefits available through Medicaid. This requires states to provide "wrap-around" benefits so that enrollees seamlessly access all the benefits that are provided through the Medicaid program.

The CMS authorized states to provide premium assistance for a state plan option without acquiring a waiver, but both Arkansas and Iowa have opted for a Section 1115 waiver, which means that the arrangement is temporary. Waivers are typically used for pilot or demonstration projects, and this is no exception. However, premium assistance for state plan options has no time limit. It is unclear at this time how CMS will attend to this distinction, but for now the Section 1115 waivers are time-limited and are not the same as the premium assistance for state plan options. The Section 1115 waivers allow states to use private insurance plans in providing health insurance to those in the coverage gap.

Indiana has an existing waiver under Section 1115 known as the "Healthy Indiana Plan" (HIP). This waiver, however, does not include provisions for Medicaid expansion. The proposed waiver from Indiana, HIP 2.0, will include the population covered through Medicaid expansion by building upon the existing waiver. In January, 2015 the CMS approved the waiver to Indiana.

The Indiana plan is different than the other waivers because it allows for a qualified prevention of coverage. The HIP 2.0 plan will cover non-disabled adults (age 19-64) with annual incomes up to 138% FPL ($16,104 for an individual / $32,913 for a family of four based on 2014 federal poverty guidelines). To be eligible, however, all non-disabled adults must make contributions to a Personal Wellness and Responsibility (POWER) Account, which is similar to a Health Savings Plan. Those who make such contributions will qualify for the HIP Plus Plan, a plan that includes expanded benefits and no cost-sharing for the enrollee.

The POWER Account contributions are income-based, ranging from a monthly contribution of $3 for those making less than 22% FPL to $25 for those making 101-138% FPL.[1]

The plan deals differently with those who do not make contributions to the POWER Account. Individuals with annual incomes 100-138% FPL will be dis-enrolled from coverage and will not be able to re-enroll for six months if they fail to contribute to the Account. Those with incomes below the federal poverty level who do not contribute to the Account will be automatically enrolled in the HIP Basic Plan, which requires cost-sharing and has more limited benefit coverage.

The Indiana waiver also requests that the HIP Plus and Basic Plans not include non-emergency medical transportation. Also, for all non-disabled adults who apply for HIP coverage working fewer than 20 hours per week, the plan established a work referral required program (full-time students are excepted). For adults with employer-sponsored insurance (ESI) plans, the Indiana waiver request includes an optional premium assistance program through the HIP Link Plan.

The Indiana waiver request went into effect on February 1, 2015 and will be in effect through the end of 2019.

Medicaid Expansion Through Marketplace Premium Assistance without 1115 Waiver

CMS has issued regulations allowing states to implement Medicaid expansion by using Medicaid funds

1 The limit for premiums on plans offered through the Marketplace is 2% for households making less than 138% FPL. The Indiana plan would violate this rule for households making between 100% and 125% FPL.

to pay private health plan premiums without seeking a Section 1115 waiver.[2] This allows states some flexibility in implementing Medicaid Expansion depending on the healthcare market in the state.

There are several similarities between the state plan for premium assistance and the requested waivers. States must provide "wrap-around" benefits if the private plan does not cover all of the benefits contained in the state's Medicaid benefits package. A state must provide "wrap-around" cost sharing if the private plans requires cost sharing that exceeds Medicaid limits. And, a plan must be budget neutral for the federal government.

These requirements assure that the state-level implementation of Medicaid Expansion does not interfere with the core principles of ACA in terms of health care access and affordability for lower income citizens.

Marketplace premium assistance does, however, have some differences from the Section 1115 waivers. These differences include the following features:

- Enrollment is voluntary under the premium assistance while under waiver it can be mandatory
- Premium assistance can be offered to any Medicaid beneficiary while waivers are limited to those beneficiaries aligned with the QHP benefits package
- Premium assistance programs are not time-limited while 1115 waivers have limited duration
- 1115 waivers will be subject to evaluation to determine if the experiment is working while state premium assistance programs do not have to be evaluated
- Premium assistance programs do not have to place a public notice and solicit public comments.

The premium assistance program differs from typical Medicaid Expansion since participants are being asked to make choices about what plan best fits their needs and the users of this program must have sufficient information to make good decisions. Certain groups, such as the medically frail, must be ensured that they have access to packages that will meet their needs. Participants also must have access to "wrap-around" benefits and "cost-sharing" programs that allow participants the same benefits associated with traditional administration, financing, and providing of Medicaid benefits.

Choices for the State

Currently, Louisiana has declined to expand Medicaid given the ruling of the U.S. Supreme Court in NFIB v. Sebellius. As we evaluate the potential for Medicaid expansion in the state, we envision the following four options available to state policymakers.

1. Louisiana can remain steadfast in its decision not to expand Medicaid access.
2. Louisiana can expand Medicaid as Kentucky has done, without a premium assistance program or without a waiver seeking a special design of the Medicaid program consistent with Louisiana's healthcare assistance program.
3. Louisiana can expand Medicaid through a premium assistance program as allowed by CMS.
4. Louisiana can seek a Section 1115 waiver as Arkansas and Iowa have done.

2 **Medicaid Expansion Through Marketplace Premium Assistance**, The Henry J. Kaiser Family Foundation, Mary Beth Musumeci, September 17, 2013.

In order to sufficiently evaluate each of the options available to state policymakers, it is imperative that we consider both the consequences and outcomes associated with each of these options. To provide a framework for our analysis, we divide the potential consequences of the options outlined above into the following five impact groups, though we focus on the budgetary impact and the hospital impact.

1. **Individual impact,** namely those who qualify for assistance under Medicaid Expansion or who will receive alternative healthcare assistance if Medicaid Expansion is not selected.
2. **Budgetary impact**, since the state will have responsibilities to provide healthcare for the uninsured and the indigent if the state accepts Medicaid Expansion or does not accept it. Budgetary choices will have an impact on the individual impact since the type of healthcare available to individuals will be decided. This budgetary impact is also related to changes defined in the ACA regarding DSH payments.
3. **Healthcare provider impact**, since providers are primarily responsible for providing services to the uninsured and indigent and will continue to be.
4. **Hospital impact**, since hospitals depend on federal and state assistance in dealing with uncompensated care costs (costs related to providing medical assistance to those without insurance or the ability to pay out of pocket) and the ACA proposes to gradually reduce disproportionate share hospital (DSH) payments, the payment process by which uncompensated care costs are currently provided to hospitals serving uninsured individuals is being substantially altered.
5. **Economic impact**, since Medicaid Expansion involves an influx of federal dollars coming to the state that will not be spent in Louisiana if the state does not accept some form of Medicaid Expansion. This is a side effect of Medicaid Expansion and certainly not the reason for the development and passage of the ACA.

This report does not directly focus on the individual impact of the expansion of healthcare opportunities. Providing healthcare opportunities for low-income persons and families and those who are indigent was one of the major reasons for developing the ACA. We do not want to neglect the importance of adequate, reliable healthcare options for all individuals, but this report focuses on the delivery process of the healthcare services centered on the budgetary impacts of the state, healthcare providers, and, especially, hospitals. Hospitals are especially important in our analysis since the present healthcare system in Louisiana for low-income and indigent citizens depends upon access to hospitals. However, whatever choice made by the state will impact and influence the healthcare available to individual state residents.

Assessing the Budgetary Impact of Medicaid Expansion in Louisiana

The Present Medicaid Program and Medicaid Expansion

Medicaid is a federal policy program to provide healthcare insurance to children and eligible adults who cannot afford coverage in the private insurance marketplace. The program was instituted in 1965 along with Medicare, an exclusively federal program. In the case of Medicaid, each state oversees its Medicaid program, with the oversight and support of the CMS, and shares in the cost of providing coverage to its eligible population. The extent of current Medicaid coverage in Louisiana is shown in Table 1. In the New Orleans region almost 38% of the population is enrolled in a Medicaid program, while in north-

Table 1. Uninsured Rates and Medicaid Enrollment by Louisiana Health Districts

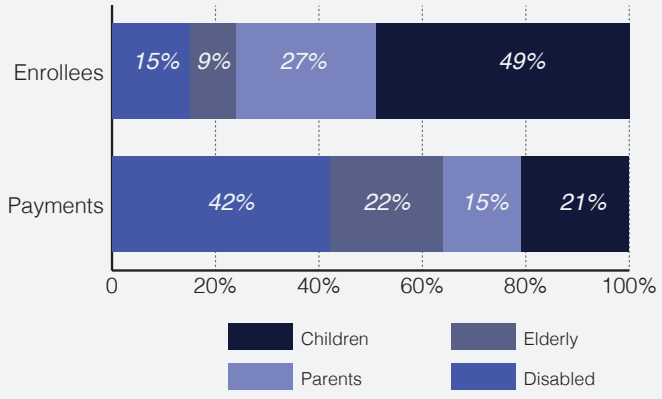
Health Districts	Medicaid Enrollment as % of Total Population	Estimated uninsured adults below 138% FPL	Uninsured adults below 138% FPL as percentage of adult population
Greater New Orleans	37.70%	60,280	10.60%
Capital Area	28.00%	42,674	9.80%
South Central Louisiana	30.80%	25,834	10.20%
Acadiana	32.70%	37,848	10.30%
Southwest Louisiana	30.40%	20,273	11.20%
Central Louisiana	33.80%	22,015	11.50%
Northwest Louisiana	31.70%	38,774	11.40%
Northeast Louisiana	36.30%	29,212	13.30%
Northshore Area	28.40%	30,083	8.80%

east Louisiana Medicaid enrollees represent just over 36% of the population. Overall, about 31% of the state's population is enrolled in Medicaid.

The state has contracted with five private companies to administer a managed care program to oversee Medicaid. This program (Bayou Health) accommodates over two-thirds of the Medicaid enrollees in the state. Medicaid accounts for approximately 17% of inpatient stays at hospitals around the state with several hospitals having more than 50% of their inpatient stays at hospitals being Medicaid-related. Just over 13% of the state's hospitals, representing about 2.4% of all hospital beds, have no Medicaid inpatient days. The largest of the hospitals with no Medicaid inpatient days is the V.A. Hospital in New Orleans, representing almost 30% of the beds in this group of hospitals. Medicaid, as it is in other states, is an integral part of the healthcare model in Louisiana.

Prior to the expansion of Medicaid under the ACA, the Medicaid program focused on lower income persons with disabilities, as well as the elderly, children, and parents. The make-up of Medicaid enrollees nationwide and the division of expenditures are shown in Figure 1. Presently, persons with disabilities and the elderly account for 24% of Medicaid enrollees and 64% of all payments; children account for 49% of total Medicaid enrollees and 21% of all payments; parents account for 27% of Medicaid enrollees and 15% of payments. Louisiana's breakdown of Medicaid enrollees and expenditures is slightly different from the national breakdown. Children make up a larger fraction of the enrollees and, conse-

Figure 1.Medicaid Enrollees and Payments



Louisiana Medicaid Enrollees and Payments

	Enrollees	Expenditures
Elderly	9%	17%
Disabled	18%	45%
Adults	15%	9%
Children	58%	29%

quently, a larger fraction of expenditures. On average Medicaid pays approximately $4,141 per enrollee for the adults now covered by Medicaid.[3] Based on an estimated cost growth of 5.9% per year, the average payment in 2015 for non-elderly adult enrollees will be $5,208.

In a March 2013 report *Understanding the Impact of a Medicaid Expansion in Louisiana: Considerations, Assumptions, and Uncertainties*, the Louisiana Department of Health and Hospitals (DHH) expressed general concern with the Medicaid program, calling it a 1960s-era entitlement program that limited choice and failed to integrate its recipients into the broader health care system.[4] Partly due to this generalization, which reflects Governor Bobby Jindal's belief that Medicaid is an outdated entitlement program and partly due to concerns about the future cost of Medicaid under expansion, the State of Louisiana has chosen not to expand Medicaid under the ACA. This decision was made despite the fact the federal government covers the entire cost of the program in 2014, 2015, and 2016.

The commitment by the federal government to fund 100% of Medicaid costs in the first three years of the ACA assists states in the transition to providing medical care access to a population that has historically lacked access to adequate healthcare coverage. The 2013 Louisiana Health Insurance Survey (see Table 1) reported estimates of uninsured non-elderly adults by income category and region. According to those estimates, approximately 10.6% of non-elderly adults in the state are uninsured and earn less than 138% of the FPL. This translates to approximately 307,000 state residents that would potentially be eligible for Medicaid coverage under the ACA should the state decide to expand access.[5]

As previously mentioned, the ACA was designed with the assumption that the early stages of its implementation would result in higher costs to states. For instance, those lacking insurance prior to the ACA might have put off care for chronic afflictions, and so the provision of insurance would entail opportunities for such individuals to treat such afflictions, which are typically more costly that preventative care. The higher costs anticipated for newly eligible Medicaid patients have been witnessed in recent Medicaid expense data. It has been reported that adults who became eligible for Medicaid in 2014 had an average medical cost of $5,517, while the average medical cost for non-newly eligible adults was $4,650, a difference of almost $900 per person.[6] Projecting whether this differential will disappear once a person has been insured for a period of time is difficult. Nevertheless, federal support for Medicaid will gradually diminish after 2016 to 90% by the year 2020. Put simply, the ACA was designed to minimize the burden on states for enrolling this new population into Medicaid services by having the federal government cover the first three years of expansion. This 100% coverage was designed to absorb the expected high marginal cost of entry for a population that has been deprived of health care on a cost basis. States that declined this coverage effectively declined this federal assistance. Louisiana cannot recover the full 100% federal support should it decide to expand Medicaid at a later date, and consequently, the state will have to cover a portion of the entry cost that it would otherwise not have had to cover if it decides to expand Medicaid at a future date.

Louisiana has operated a state run, charity hospital system for decades and in recent years, this system has transitioned to a network of public-private partnerships serving the same population that was once served by such state institutions as Charity Hospital in New Orleans, Earl K. Long Hospital in Baton Rouge, and other state-run facilities throughout the state. These private providers of healthcare for the poor are suppose to provide healthcare that is more efficient and of higher quality than that provided by

3 Based on 2011 information from the Henry J. Kaiser Family Foundation.

4 **Understanding the Impact of a Medicaid Expansion in Louisiana: Considerations, Assumptions, and Uncertainties**, Louisiana Department of Health and Hospitals, March 2013

5 All estimates based on 2012 Census population and the estimates of uninsured from the 2013 Louisiana Health Insurance Survey.

6 "Budget Woes Continue for Medicaid Expansion States", Dori Zweig, July 20, 2015, http://www.fiercehealthpayer.com/story/budget-woes-continue-medicaid-expansion-states/2015-07-20.

state institutions in the past, but payments to these private and nonprofit hospitals will still be public dollars. The federal government supplements the state's dollars with Disproportionate Share Hospital payments but at a much less favorable FMAP than under Medicaid expansion. The ACA also entails gradually reducing DSH payments since uncompensated care will diminish because of the expansion of Medicaid.

The Budget, Healthcare Choices, and the Economy

Evaluating Louisiana's budgetary outlook for healthcare obligations requires *comparing the cost to the state of expanding Medicaid under the ACA to the continued cost of the state's future financial obligations in the absence of Medicaid expansion*. Ultimately, both choices involve major financial commitments by the state and by individuals, and comparisons must address the different levels of federal support with and without Medicaid expansion, different levels of participation in the healthcare program by citizens who may qualify for assistance, and the extent of healthcare support available. This involves comparing the cost of Medicaid expansion to the status quo and, especially, to how the status quo will inevitably change. Even in the years 2017 through 2019 when the most the state has to contribute is 5% of the cost of Medicaid, the state should be better off financially unless there is an overwhelming and immediate increase in Medicaid enrollees and/or a substantial increase in available healthcare services thereby increasing the cost. As previously noted, the FMAP will eventually drop to 90%, which is still more generous than the approximate 62% match for the state's existing Medicaid enrollees and slightly higher than the 60% federal match for DSH payments. However, the added cost of expanded Medicaid could place an additional burden on the state relative to the status quo programs if the growth in Medicaid enrollment is substantial. As a result, one essential question is whether this financial burden associated with accepting Medicaid expansion will exceed the burden that the state will inevitably have for providing care, albeit reduced care, to this same population.

In the long-term, the comparison should be the budgetary impact for the state of expanding Medicaid for non-elderly adults to the budgetary impact of not doing so. The challenge is that the status quo itself will be impacted by changes designed in the ACA; the law has allowed some persons to receive subsidized insurance and other provisions within the ACA will affect funding sources for the state, particularly the scheduled reduction in DSH payments. A major adjustment connected to Medicaid expansion is the gradual reduction in DSH payments, a method by which the federal government shares with the states the payment to hospitals for uncompensated care. The design of the ACA anticipates that much of the uncompensated care expense, derived from the population to be covered by Medicaid expansion, will be unnecessary. Thus, if a state does not expand Medicaid, its uncompensated care payments owned to hospitals may not decline and there will be fewer federal dollars to cover such costs.

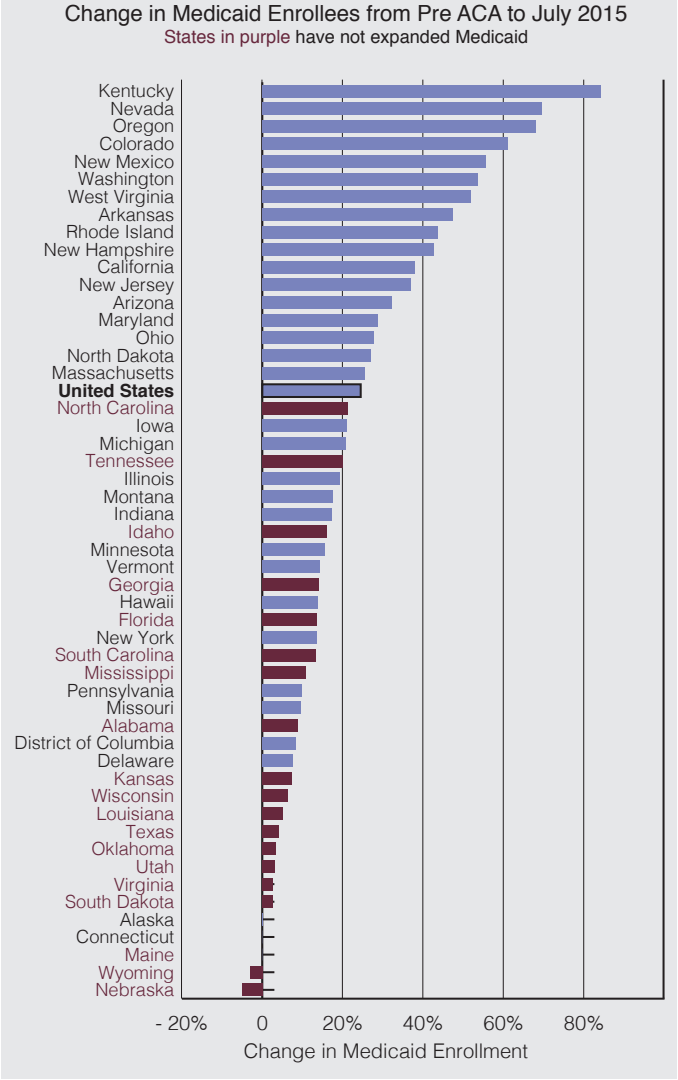
Projecting cost, enrollment, and behavior is a sensitive endeavor. Any analysis of general fund spending by the state has to be carefully considered with respect to the underlying assumptions. For example, recent events in Kentucky highlight the fallibility of enrollment projections.[7] Kentucky originally projected new Medicaid enrollment of just over 300,000 by 2021, but 311,000 enrollees signed up in 2014 alone. In fourteen states enrollment in the Medicaid expansion program has exceeded projections.[8] Enrollment is an important consideration in estimating future costs to the state. Overall, according to the Henry J. Kaiser Family Foundation, Medicaid enrollees in states that have expanded Medicaid have grown by 27.3%, while in states that have not expanded Medicaid the growth rate is 11.2% from just before the ACA was passed through June 2015. This growth differential is to be expected. The growth rates vary from state to state, as shown in the Figure 2. Kentucky had the largest growth in Medicaid enrollees with

7 Christina A. Cassidy, "Medicaid enrollment surges, stirs worry about state budgets." July 19, 2015, http://bigstory.ap.org/urn:publicid:ap.org:c158e3b3ad50458b8d6f8f9228d02948)

8 ibid.

a growth of 84%. Oregon had a growth of 68% from pre-ACA to June 2015. Some states that have not accepted Medicaid expansion, such as North Carolina, had a higher rate of growth of new Medicaid enrollees than several states that did accept Medicaid expansion, such as Iowa, Michigan, Illinois, Montana, and Indiana. It is a fact that all of states that did not expand Medicaid had a growth in Medicaid enrollees below the national average. This is not a surprising outcome. What is surprising is the variation in the increase in enrollment among the states that did accept Medicaid expansion.

Figure 2. Changes in Medicaid Enrollees



As has been mentioned, the state will still be obligated to provide some services to persons who fall into the <100% FPL category, as well as others who do not have insurance and are not able to pay for their healthcare costs. The *cost of not expanding Medicaid* needs to be evaluated just as carefully as the cost of expansion. The federal government's contribution to the state to provide coverage to non-elderly adults under 138% FPL will be 90% for the foreseeable future. On the other hand, the federal contribution to the existing method of providing coverage, the uncompensated care assistance through DSH payments, is only 60% and could potentially be reduced. According to the ACA, there will be a gradual reduction in federal DSH payments to cover uncompensated care.[9]

Choosing Medicaid expansion means that almost all of the state's population, excluding migrant workers and a few other exceptions, will have a healthcare insurance program in which check-ups and early medical testing will be available. This is a significant change in the healthcare system and in line with one of the overriding reasons for the passage of the ACA: to reduce the number of persons who did not have health insurance and to provide avenues to better care. This better care comes with a higher cost, but the question is how we properly compare this cost.[10]

The shift to health insurance coverage under Medicaid represents a significant change in the delivery of healthcare for the persons who have not been able to purchase healthcare insurance on the private marketplace. Due to this change towards a more proactive healthcare delivery system, there may be reductions in healthcare costs over the long run if persons

9 The FMAP for Louisiana was 61.24% in 2013; 60.98% in 2014; 62.05% in 2015; and 62.21% in 2016 according to the Kaiser Family Foundation. The FMAP is computed from a formula that takes into account the average per capita income for each state compared to the national average.

10 There was a study completed, **Insuring the Uninsured**, by Katherine Baicker and Amy Finkelstein in J-PAL Policy Briefcase (January 2014) on Medicaid recipients in Oregon with these findings: (1) increased use of healthcare services, (2) decreased financial strain on participants, (3) improved self-reported health and depression but no statistical improvement in physical health outcomes, and (4) no statistically significant impact on employment and earnings.

have earlier access to preventative healthcare before an illness becomes severe and more costly to treat. This is a potential long-term benefit of Medicaid expansion, a benefit that could be substantial but whose projection is beyond the scope of this report.

Projections for Impact of Medicaid Expansion from 2016 to 2020

DHH and the Louisiana Legislative Fiscal Office (LFO) have offered analyses of the expected cost or savings to be incurred if Louisiana accepts Medicaid Expansion. The DHH analysis was published in March 2013 with a timeframe extending from fiscal year 2014 through fiscal year 2023. LFO provided an analysis of a proposed constitutional amendment, HB 517, during the 2015 Legislative Session with a timeframe beginning in fiscal year 2016 through fiscal 2020, the year in which the FMAP for Medicaid Expansion becomes 90%.[11]

The main focus of the DHH report Understanding the Impact is a consideration of the potential cost of expanding the Medicaid program in Louisiana in accordance with ACA. This is a core issue that needs to be thoroughly examined. Ultimately, Louisiana will continue to contribute resources in providing healthcare to the non-elderly adult population targeted by this expansion, a population not officially covered by Medicaid at this time but one that will receive service through the state's remaining charity hospital and contracted providers. Holding all other factors constant, this would arithmetically add to the cost burden of the state simply because more coverage is being provided, although the state's share for covering this population is substantially less than the existing cost-sharing associated with DSH payments. But, all other factors will not remain constant. The projections and comparisons are complicated but quite important to providing a meaningful understanding of the impact on the State General Fund Budget if the state accepts Medicaid Expansion.

Whether the state accepts Medicaid expansion or not, there will be an impact on the state budget. Projections extend over a long period of time (in terms of forecasting) and depend on various economic and social conditions. Projections must consider the implications of Medicaid expansion on aspects of the overall healthcare system in Louisiana.

Current DHH projections are based on a five to ten-year period and consider the following variables:

(1) The number of adults eligible to be covered by expanded Medicaid and the number who actually sign up for Medicaid

(2) Cost per enrollee

(3) Number of persons already receiving Medicaid subject to reclassification to qualify for a more favorable Federal Medical Assistance Percentage (FMAP)

(4) Number of persons currently eligible for Medicaid who might be encouraged to sign up for Medicaid but at a less favorable FMAP offered under Medicaid Expansion

(5) Number of persons currently with insurance who would seek coverage under the ACA Medicaid expansion

(6) Potential cost increases for medical services,

(7) Reduction in DSH payments to hospitals given that these patients are now insured,

(8) Cost of treatment for inmates and their status under Medicaid expansion

Other possible financial implications include revenues gained from insurance premium taxes and pos-

11 HB 517 did not get sufficient votes to be put on the ballot.

sible contributions by hospitals as noted in House Concurrent Resolution 75.

DHH and LFO cost estimates begin with projections of how many persons will be covered by expanded Medicaid access and, without expansion, the number of persons for whom the state will be responsible to provide appropriate healthcare. The underlying assumptions of the projection models are presented in Table 2 with respect to enrollment in the Medicaid program and overall reductions in cost.

The estimates differ because of differences in key variables, particularly cost and the number of enrollees. Determining the number of enrollees requires three considerations: persons who are now uninsured and fall in the income classification less than 138% of the FPL, persons who are now currently insured but whose income is less than 138% of the FPL (i.e., those that may potentially switch to Medicaid coverage), and persons who are now eligible for Medicaid but who are not currently enrolled. According to the survey administered by the LSU Division of Economic Development and the LSU Public Policy Research Lab there about 300,000 non-elderly adults who are uninsured and have an income less than 138% FPL.[12] According to this survey there are 50,186 persons in this income category who have private insurance and 173,826 persons who are in this income category and have an employer sponsored insurance. In total, there are an estimated 224,012 non-elderly adults in the less than 138% FPL with healthcare insurance. This means that, according to the LSU Public Policy Research Lab survey, there are potentially 522,012 non-elderly adults that could apply for Medicaid if the state expands the program.

Table 2. Model Assumptions and Inputs

Significant Inputs in Projecting Cost to State of Louisiana for Accepting Medicaid Expansion	Louisiana Department of Health and Hospitals 2013		Louisiana Legislative Fiscal Office, 2015 (Fiscal Note for House Bill 517)	
	Low Forecast	*High Forecast*	*Low Forecast*	*High Forecast*
Estimated Eligible from 0 to 138% FPL	577,329 including estimated eligible from income categories and crowding out effect	653,305 including estimated eligible from income categories and crowding out effect	298,000	298,000
Crowding Out (newly eligible adults who drop private insurance)			67,000	89,600
Do You Include Persons who are now eligible for Medicaid but have not enrolled	Yes, up to as many as 27,606		Estimates up to 36,000 but do not include any because less than 0.5% have signed up since 2013	
Estimated New Medicaid Participants	577,329	653,305	365,000	387,600
Estimated Increased or (Decreased) Cost to SGF from Fiscal 2016 through Fiscal 2020	($242.5 million)	$585.8 million	($103.0 million)	($165.5 million)
Estimated total Cost to SGF through Fiscal 2023	($196.6 million)	$1,593.4 million	No estimates	No estimates

12 **Louisiana's Uninsured Population: A Report from the 2013 Louisiana Health Insurance Survey, 2013**, sponsored by the Louisiana Department of Health and Hospitals. Information also taken from Fiscal Note developed by the Louisiana Legislative Fiscal Office, Medicaid Expansion, April 24, 2015 for Constitutional Amendment providing for expansion of Medicaid eligibility.

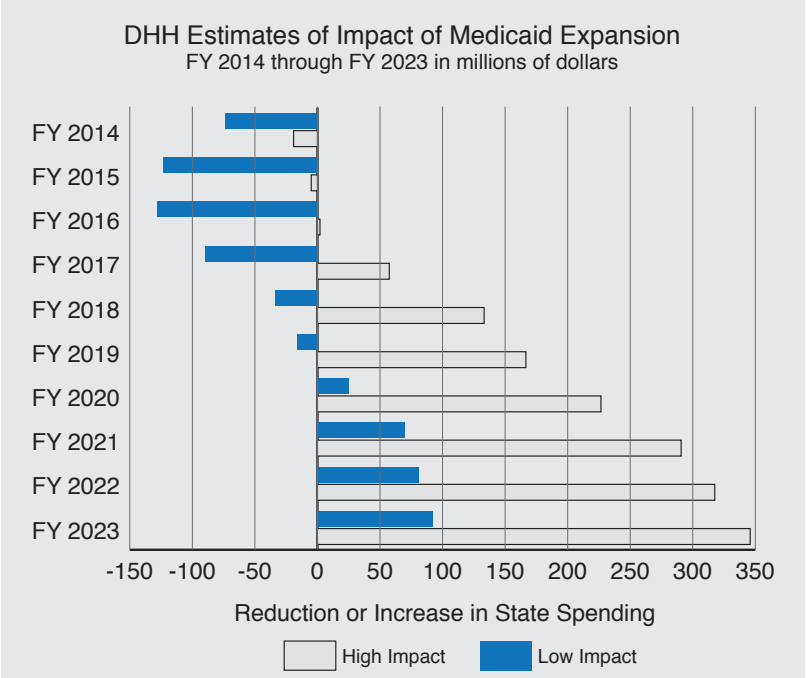
DHH, in its analysis, projected between 577,329 to over 653,305 non-elderly adults gaining coverage through expanded Medicaid access. LFO estimated 365,000 to 387,600 as gaining access to Medicaid under Medicaid expansion. In the low end estimates DHH projects a larger number of non-elderly adults entering the Medicaid program than LFO by over 212,000, while with respect to the high range, DHH projects almost 268,000 more non-elderly adults entering the Medicaid program than the LFO.

The cost differences in DHH and LFO projections are also substantial. DHH projects a reduction in the State's general fund (SGF) spending on healthcare due to an expansion of the Medicaid program in their *low enrollment model* from 2016 through 2020. This savings for the State is projected to be slightly over $242.5 million, for fiscal year 2016 through fiscal year 2020. DHH's *high enrollment model* projects that the State will spend an additional $585.8 million on expanded Medicaid access for this time period through 2020 though this increase in spending is related to significant cost assumptions included in the analysis. In contrast, the LFO forecast projects a savings to the State General Fund over the period of fiscal 2016 through fiscal 2020 of $103.0 million to $165.5 million. Both DHH and LFO project that in fiscal 2020 the State will incur an increase in State General Fund spending on healthcare under Medicaid expansion. This is the year in which the state picks up 10% of the cost of funding the Medicaid Expansion program.

While the number of persons projected to participate in the Medicaid Expansion program differs substantially between DHH and LFO, the ultimate impact on the SGF in these two scenarios is not determined or shaped entirely by these differences. After all, DHH projects an aggregate reduction in State spending over its time period of analysis with its low projection of participants in Medicaid. The number of participants increases by 10% from its low projection scenario to its high projection scenario, but its cost estimates changed from almost a $245 million reduction in State spending over the time period of fiscal 2016 through 2020 in the low projection scenario to a $545 million increase in state spending on Medicaid in the high projection scenario from 2014 through 2020.

The differences between DHH and LFO with respect to cost differences and other revenue sources are shown in Table 2. There are several differences between DHH and LFO cost estimates; however, one estimate should draw increased attention. DHH projects a $1.7 billion cost due to possible rate and utilization adjustments, which include possible increases in physician Medicaid rates to 100% of Medicare rates and hospital payments to 90% of actual cost. The significant differences in the low and high scenarios are shown in Figure 3 for fiscal years 2014 through 2023. However, it should be noted that there is no supporting justification for this cost increase due to rate and utilization adjustments.

Figure 3. Estimates by DHH



DHH and LFO also differ on savings with regards to DSH payments, the cost of administering the expanded Medicaid program, and the savings from Corrections patients being treated under the expanded Medicaid program with the improved FMAP. However, these differences

are minor compared to DHH's inclusion of the rate and utilization adjustments. Without the inclusion of the rate and utilization adjustments, LFO and DHH both conclude that the Medicaid expansion program would be financially beneficial from 2016 through 2020 or, in the case of the longer time period examined by DHH, 2014 through 2023. Both studies agree that in the later fiscal years Medicaid expansion will negatively impact the State General Fund.

Finally, DHH concludes that by not expanding Medicaid, there will be only 216,000 persons who might require public healthcare assistance to be provided from the State. This estimate is based on the Louisiana Survey of Uninsured Population with the assumption that every person eligible for the federal subsidy to buy insurance on the health insurance marketplace (those with incomes greater 100% FPL) would apply for the federally subsidized insurance. DHH's assumption represents the least number of persons that would possibly require public healthcare assistance; however, this may be an overly optimistic assumption given that some people who are eligible to apply for federally subsidized insurance and who have an income between 100% and 138% FPL may not apply. Just as there could be an unexpected number of non-elderly adults applying for Medicaid if the state accepted Medicaid expansion, there could be a number of persons that will be dependent on the state for healthcare above and beyond the persons who make less than 100% FPL. Additionally, the number of people making less than 100% FPL should be expected to grow over time.

DHH and LFO conclude that from 2016 through 2020 the state would be better off financially accepting Medicaid expansion. Financial issues may arise in 2020 when the FMAP match drops to 90% from the federal government and 10% for the state government. In the next section we consider the period after 2020 in order to understand the longer-term impact of Medicaid expansion.

Projections for Medicaid Expansion and Non-Expansion under the ACA, 2020 and beyond

Any estimation of projected impacts upon state spending must be thoroughly considered since it will be difficult to reverse the decision to expand Medicaid under the ACA. However, each year that the state refuses Medicaid expansion results in the state being subject to a less favorable FMAP, itself a cost, should it decide to expand Medicaid at a later date. Both DHH and the LFO agree that, from 2016 through 2020, it is in the state's financial best interest to expand Medicaid. However, after 2020 both DHH and LFO suggest that the state might be better off financially not expanding Medicaid based upon their models. This is important because, as stated earlier, the state cannot expect to expand Medicaid in the short-term and then pull back expanded Medicaid access in later years.

To appreciate the post-2020 condition for the state, it is crucial to depict accurately not only the cost of expanding Medicaid, but also the cost of *not* expanding. How many individuals will remain uninsured and require the kind of care that is currently provided by Louisiana without expansion? We assume that by 2020, if the state has not expanded Medicaid, a percentage of individuals who qualify for the federal subsidy will choose not to buy insurance and pay the concomitant tax.[13] In this case, a percentage of individuals making more than the FPL but less than 138% of FPL (a population that conceivably qualifies for Medicaid coverage under expansion) will still be uninsured and require care, which will be a continued cost to the state.

LFO estimates that by 2020 almost 390,000 persons could be eligible to enroll in the Medicaid program, including those who are uninsured and eligible by income and those who are eligible according to income but are presently insured. DHH estimates that approximately 577,000 would be eligible for

13 This may not be the most cost-effective decision to be made by the individual.

coverage, an estimate which does not include those persons currently covered but not enrolled in Medicaid. If the state continues its refusal to expand Medicaid, it will still be responsible for providing care to between 216,000 and 298,000 persons – a group which includes those without insurance whose income is below 100% FPL and those persons who may qualify for federal insurance subsidies but do not avail themselves of the insurance option. Further, this estimate does not account for any growth in the number of persons in the less than 100% FPL as of 2020.

Medicaid coverage is significantly more expensive, on a per capita basis, than the current cost of care for this uninsured population, but this is because healthcare coverage provided under Medicaid coverage is much more comprehensive than the reactive care of the status quo. In terms of patient costs, the LFO estimates that the 2016 cost per participant under an expanded Medicaid program would be $5,436 growing to $6,836 per year if the healthcare inflation rate of 5.9% is applied to the 2016 cost per participant. These estimates are very close to the national average of non-elderly adult Medicaid enrollees. Using this is as a base, the estimated total cost of Medicaid for 387,000–577,000 enrollees amounts to $2.65–3.9 billion, with the Federal government paying almost $2.4–3.5 billion and Louisiana's match at $265–390 million (based on the 90/10 ratio that goes into effect in 2020). Should the state maintain its decision not to expand Medicaid, it is estimated that the cost for providing health care for uninsured non-elderly adults less than 65 years of age will grow from $2,084 to $3,471 per person using the same inflation rate.[14]

The range in estimates between the DHH forecast and the LFO forecast depends almost entirely on the expected number of enrollees under an expanded Medicaid program. This is because the state already provides a certain level of care through emergency services, and both forecasts assume that this care will continue. The policy decision that must be made concerns the level of care that is provided. Through Medicaid expansion, the state will practically double the care provided to the uninsured and poor population (from $3,471 per person to $6,836) at a maximum of ten percent of the total cost. It is impossible to say with certainty the dynamic effects this could have on long term health care costs as individuals are able to access and use better routine care, preventative care, and mental health care. The individual impact of Medicaid expansion is profound, and it is reasonable to expect that providing such care could have unforeseen positive long-term effects.

Another simple way of comparing the relative cost to the state for expanding or not expanding Medicaid is the cost per enrollee in either Medicaid or the state's healthcare program if the state decides not to expand Medicaid:

- Expand Medicaid: estimated cost in 2020, $6,836 per enrollee with state's share being $684.
- Do Not Expand Medicaid: estimated cost in 2020, $3,471 per enrollee with state's share being $1,388

This focuses the discussion on the number of persons being cared for and the quality of the healthcare being available, both important issues. But the forecasts around which this decision is made exclude other difficult-to-quantify effects. The assessment of this impact is profoundly simple: A linear consideration of future costs where the main variable is the number of people who receive care. The bottom line is that the decision in the state seems to be exclusively focused on one of the impacts we discussed above: budgetary impact.

But there are important dynamic effects to this decision that are built in to the enabling legislation, par-

14 The estimate of $3,471 is derived from Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel, 2010 and then adjusted for healthcare inflation since 2015. The estimate of $2,084 is derived from estimate of expenditures as of 2014 given an estimated 298,000 persons uninsured.

ticularly the long-term treatment of DSH payments. At the present, the State relies heavily upon DSH payments to fund the program of care for the uninsured population, but whether the state expands Medicaid and accepts the federal FMAP of 90% or does not, DSH payments to the state are likely to decrease substantially. In addition, the DSH payments require a state match that is less favorable than the federal match under expanded Medicaid, a match in which the state must cover roughly 40% of the costs. The federal match under expanded Medicaid is far more generous than any other program for providing health care to the poor. At the same time, it increases the number of people accessing affordable care. This could be viewed as a burden to the state; using the DHH numbers, which seem to provide the max on the number of expected Medicaid enrollees and the minimum on the expected number of uninsured patients that will require care, it is plainly obvious that $395 million (the State's expected share for Medicaid if 577,000 persons are really eligible and the cost is $6,836 per enrollee as of 2020) is more than $300 million (the expected share for the status quo based on a 60% FMAP and the 2,16,000 enrollees in the state healthcare program is $3,471 per enrollee). Alternatively, this could be seen as quite a bargain for the state: for an additional $95 million, Louisiana can provide comprehensive health care to more than half a million residents of the state or about $164 per enrollee.

But this is not the full account of the decision that must be made. Indeed, the possibility that DSH payments will be reduced requires any consideration of not accepting Medicaid expansion to include a change to the status quo. Put simply, there is not status quo in this scenario because the present scheme is being deliberately changed in accordance to national law. In the next section, we consider what it could mean to the state if it does not expand Medicaid and continues to rely on DSH payments to provide support to the uninsured population.

DSH Payment Reductions, Louisiana's Rural Hospitals and Medicaid Expansion

The federal government is scheduled to reduce DSH payments through the ACA under the calculation that Medicaid expansion will partially eliminate the need the federal and state governments to reimburse hospitals for uncompensated care. Many individuals who, in the past, may have gone to the hospital having no insurance will now have insurance provided through Medicaid. In Louisiana, DSH payments have traditionally been used to support the charity hospital system and now help finance the public-private hospitals that are carrying out the responsibilities historically associated with the charity hospital system. These dollars allow hospitals to recover their uncompensated care costs but with reductions in the uninsured population following passage of the ACA, federal DSH dollars are scheduled for an incremental reduction beginning in 2018.[15]

The scheduled DSH reductions are as follows:

- 2018 $2 billion
- 2019 $3 billion
- 2020 $4 billion
- 2021 $5 billion
- 2022 $6 billion
- 2023 $7 billion
- 2024/25 $8 billion

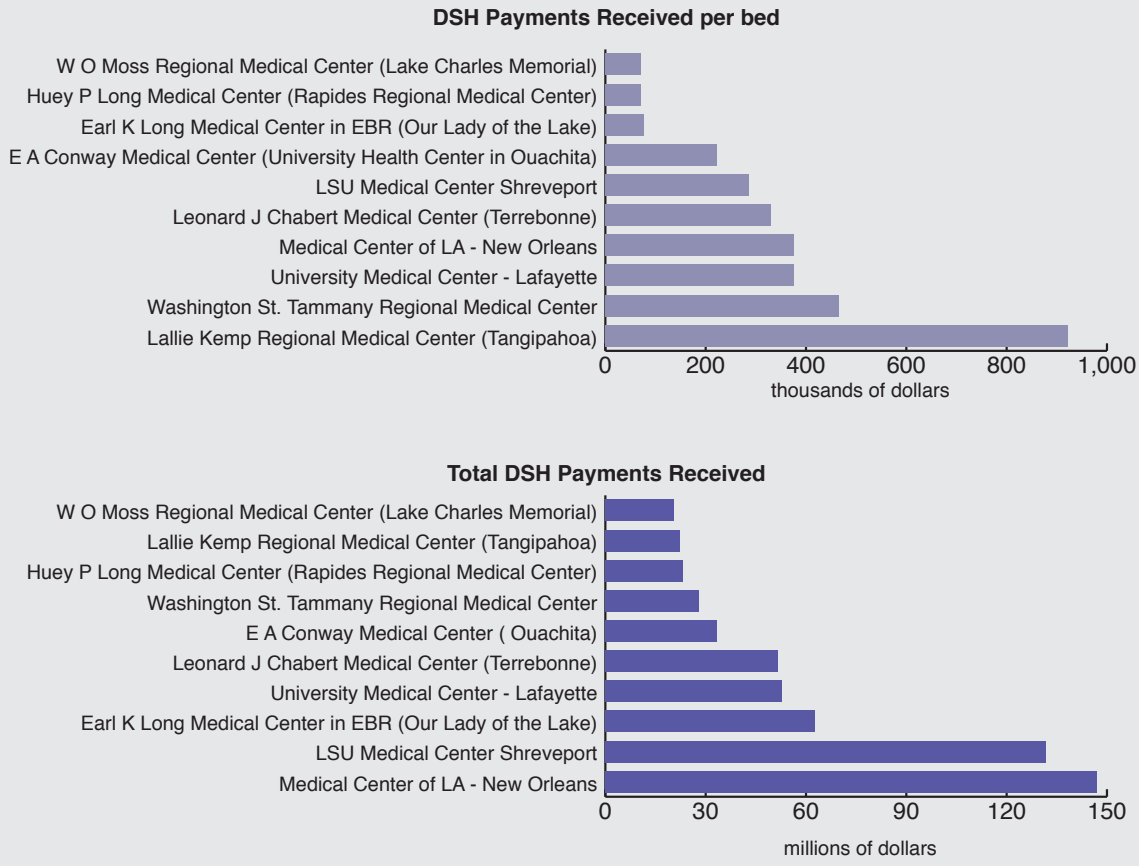
15 It should be noted that this reduction was scheduled to being in 2014 but was postponed to 2018.

Overall, Louisiana is a high DSH state, and its payments, in absolute terms, are in the same category as California, New York, and Texas. To place this in perspective, Louisiana receives over 6% of national DSH payments while only representing 1.5% of the nation's population. In Louisiana it is estimated that approximately 88% of DSH payments go to the private and nonprofit hospitals contracted with the state to care for the poor, non-elderly adults in the state.

The Medical Center in New Orleans received almost $150 million in DSH payments and the LSU Medical Center in Shreveport approximately $130 million. Five state hospitals received between $20 and $30 million in DSH payments, with those being Washington St. Tammany Regional Medical Center, the Central LA State Hospital, the Huey P. Long Center in Rapides Parish, the Lallie Kemp Medical Center in Tangipahoa Parish, and the W. O. Moss Regional Medical Center in Calcasieu parish. The Lallie Kemp facility received almost $1 million per bed and the Washington St. Tammany Medical Center received just over $400,000 per bed (see Figure 4).[16]

Overall, hospitals in the state, both public and private, received approximately $732 million in DSH payments in 2010. If the federal government follows through with scheduled reductions in DSH payments, there will be a negative impact on the state's financing of its public-private hospitals and its rural hospitals, forcing the state to find alternative means of financing these endeavors, especially if the

Figure 4. DSH payments to former Charity Hospitals, 2010



16 Medicaid Disproportionate Share Hospital (DSH) Payments; http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-disproportionate-share-hospital-dsh-payments.html

state continues to reject Medicaid expansion. The public-private partners have received special attention given the nature of their responsibilities and influence on the state's healthcare mission. However, other private hospitals will also be affected substantially by any reduction in DSH payments and this includes the rural hospitals. Ultimately, DSH payments are a significant component of financial support for hospitals serving the uninsured and indigent residents of Louisiana.

Taking a Closer Look at Louisiana's Rural Hospitals

A number of broad, interrelated factors must be taken into account when attempting to address the impact of the ACA on rural hospitals both nationally and in the State of Louisiana. Rural and urban hospitals rely upon revenue streams from patients with private health insurance, patients covered by publicly funded insurance plans (e.g., Medicare and Medicaid), self-pay, and federal and state reimbursements for the care of the uninsured and indigent. These uncompensated care payments are now at risk through ACA.

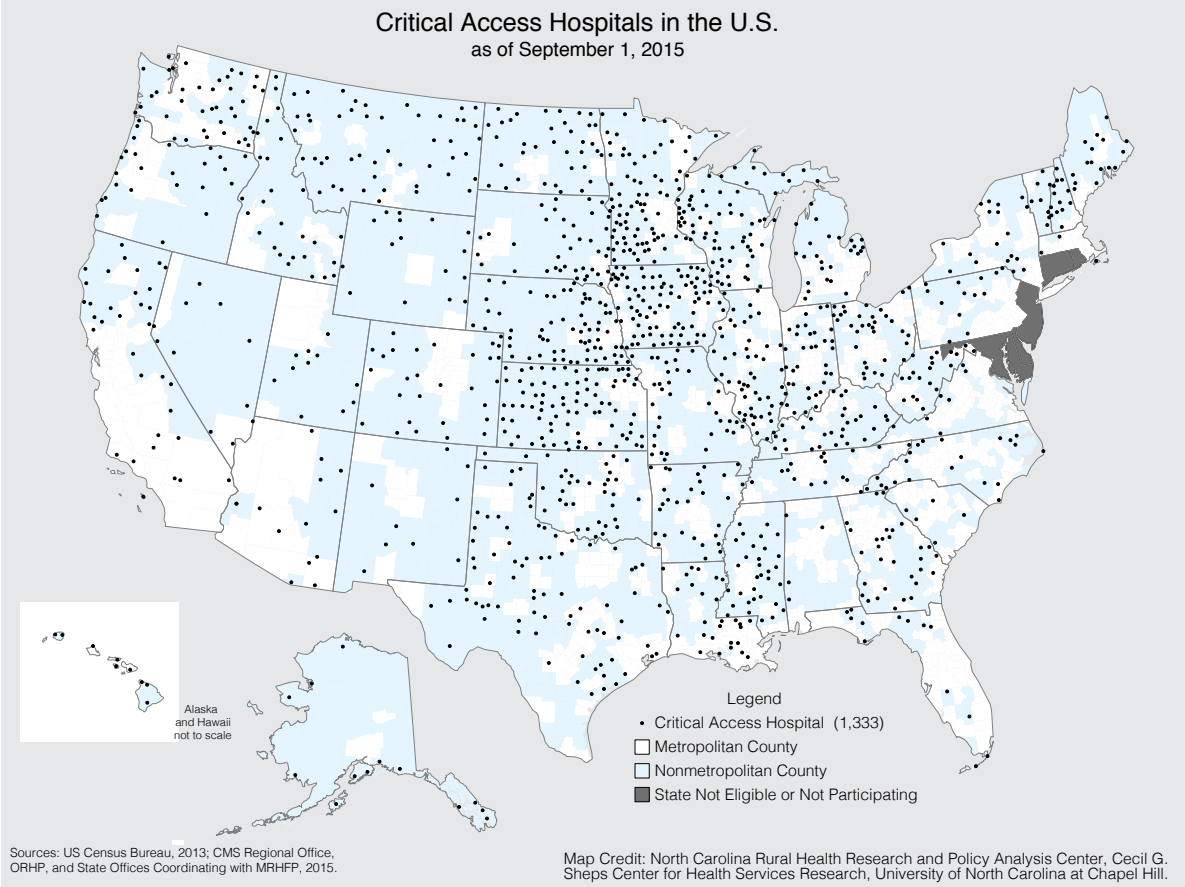
From the perspective of hospitals, each of the above revenue streams has been or will be impacted, to varying degrees, by the ACA. First, state health insurance marketplaces created by the ACA, along with federal subsidies for lower-income individuals and families to obtain insurance in the marketplace, has significantly increased the percentage of insured patients utilizing hospital services, regardless of a particular state's decision whether or not to expand Medicaid access under the ACA. Access to this new population of insured clients will ultimately benefit hospitals in those cases where the newly insured were previously receiving hospital services that they were not able to pay for. Second, the provision of the ACA allowing for expanded Medicaid eligibility has also increased the percentage of hospital patients whose hospital care can now be reimbursed through Medicaid. Much like the newly insured from the private health insurance marketplace, access to this new population should directly benefit hospitals. Third, and most germane to this study, the ACA's reliance upon expanded Medicaid coverage for the poor is also coupled with future reductions in DSH payments. As highlighted above, these payments are currently relied upon to reimburse hospitals for the care of the uninsured and indigent, and, as a result, represent a critical source of funding for hospitals, especially those located in states that have made the decision not to expand Medicaid under the ACA.[17]

While the expansion of Medicaid under the ACA has received a great deal of attention both nationally and within the State of Louisiana, the potential impact of Louisiana's choice not to expand Medicaid upon rural hospitals in the state should also be of concern for state lawmakers. At the present, there are approximately 54 smaller hospitals in the state, those with 60 beds or fewer, serving state residents and these hospitals range from political subdivision hospitals to private non-profit and for-profit hospitals. Further, there are 27 hospitals (see Map 2) in the state that have been designated by the CMS to be Critical Access Hospitals (CAH). To be designated as a CAH, these hospitals must be located at least 35 miles from another hospital or at least 15 miles in extremely remote areas.

Much like their larger, urban counterparts these rural hospitals are able to operate in the marketplace based upon a revenue stream that includes payments from private insurance providers, as well as public payments to cover services for the poor and elderly. The latter revenue stream is critical for Louisiana's rural hospitals given the high concentration of rural poverty in the state and the rapidly aging population of many of the state's rural parishes. While each of the state's rural hospitals has a unique revenue stream based upon its local characteristics, there are three primary revenue streams related to the care of the

17 Other factors impacting these hospitals include declining Medicare reimbursement rates and an increasing percentage of elderly patients.

Map 2. Critical Access Hospitals in the U.S.



elderly, poor and uninsured which significantly impact their long-term health and viability.[18]

First, these hospitals rely heavily upon payments from Medicare which covers medical services for the elderly and disabled. In 2013, revenue from Medicare represented approximately 34 percent of net revenue for hospitals in Louisiana.[19] Further, rural hospitals in the state directly benefit from the Louisiana Rural Hospital Preservation Act & Rural Hospital Flexibility Plan which allows the state's rural hospitals to receive 'critical access' status.[20] Certification as a critical access hospital allows hospitals "to receive cost-based reimbursement from Medicare, instead of standard fixed reimbursement rates. This reimbursement has been shown to enhance the financial performance of small rural hospitals that were losing money prior to CAH conversion and thus reduce hospital closures."[21]

Second, rural hospitals also rely heavily on payments from Medicaid which cover the cost of care for the poor. In 2013, revenue from Medicaid payments represented approximately 18 percent of net revenue for hospitals in Louisiana. Third, for hospitals providing care for the uninsured and indigent, the federal government provides DSH payments, on a matching basis, directly to the State of Louisiana to be distributed to hospitals within the state. While revenue from this source represents less than 7 percent of all hospital revenue within the state, the total dollar amount received by the state, as highlighted earlier, is

18 **Uncompensated Care for Uninsured in 2013: A Detailed Examination**; https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf

19 **Hospitals and the Louisiana Economy, 2014**; http://c.ymcdn.com/sites/www.lhaonline.org/resource/resmgr/Files/HospitalsandtheLouisianaEcon.pdf?hhSearchTerms=%22rural%22

20 C**ritical Access Hospital, Rural Health Fact Sheet Series**; http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf

21 **What are Critical Access Hospitals (CAH)?** http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/critical.html

quite high. Louisiana received approximately $732 million in federal DSH payments in the 2014 federal fiscal year.[22] As illustrated previously, while DSH payments are primarily used to fund the state's charity hospital system, a share of the state's DSH proceeds are also allocated to rural hospitals on the basis of their identified needs. For instance, in the 2010 fiscal year, Bunkie General, a 25 bed critical access hospital located in rural Avoyelles parish, received approximately $650,000 in DSH funding, and West Carroll Memorial Hospital, a 33 bed hospital located in rural West Carroll parish received approximately $872,000 in DSH funding.

The Impact DSH Payments Reductions on Rural Hospitals

Rural hospitals in Louisiana currently face two competing, long-term scenarios with respect to the continued implementation of the Affordable Care Act. First, should state policy makers remain steadfast in their decision not to expand Medicaid under the ACA, those hospitals currently receiving DSH payments, which include hospitals under contract to deliver services to the state's uninsured as part of the privatization of the state's charity hospital system, face the prospect of significant decreases in DSH funding. As previously highlighted, the ACA mandates reductions in federal DSH payments due to anticipated reductions in the nation's uninsured population as a result of expanded health care access under the ACA.[23] Presently, federal legislation calls for a $43 billion, roughly 67%, decrease in nationwide DSH payments from FY 2018 to FY 2024.[24]

For rural hospitals, this anticipated loss in DSH funding could substantially impact their overall financial health. In 2010, hospitals in Louisiana received approximately $790 million in federal DSH payments that were disbursed to hospitals across the state to cover uncompensated care costs. As illustrated, a large share of these payments was directed to hospitals under the state's charity hospital system. For instance, of the total amount disbursed to hospitals in the state, the Central Louisiana State Hospital received approximately $24 million, the Earl K. Long Medical Center received approximately $62 million and the state's medical centers in Shreveport and New Orleans received approximately $279 million combined.

While not as large, the state's 27 critical access hospitals, those serving the needs of the many of the state's rural uninsured, received approximately $52 million in DSH payments. Payments in 2010, shown in Table 5 below, ranged from a high of $22 million allocated to the Louisiana State University System's 25 bed Lallie Kemp Regional Medical Center in Independence to a low of $298,000 allocated to the 25 bed Prevost Memorial Hospital in Donaldsonville. Even in the rural hospitals the emphasis of the DSH dollars is to fund the state hospital system. While it is difficult to estimate the share of total rural hospital revenues represented by DSH payments, hospital level data on state DSH payments and uncompensated care costs highlight the fact that for the vast majority of Louisiana's rural, critical access hospitals, DSH payments actually exceed their total reported uncompensated care costs. As a result, it is plausible that for many of these hospitals, DSH payments represent a source of revenue that can be utilized to provide services to rural communities beyond simply the coverage of uncompensated care costs. Specifically, of the 27 critical access hospitals receiving DSH payments in 2010, only 8 hospitals did not receive payments matching their uncompensated care costs. The remaining 19 hospitals received payments either matching or exceeding their reported uncompensated care costs. For example, West Feliciana Parish Hospital in Saint Francisville received approximately $1.35 million in DSH payments to cover $1.33 million in uncompensated care costs. However, in a more extreme example, Assumption Community Hospital in Napoleonville received approximately $2.1 million to cover only $545,000 in uncompensated

22 **Federal Medicaid Disproportionate Share Hospital (DSH) Allotments**; http://kff.org/medicaid/state-indicator/federal-dsh-allotments/#

23 Medicaid.gov, Provider Payments; http://www.medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html

24 Disproportionate Share hospital payments, macpac.gov/subtopic/disproportionate-share-hospital-payments

Table 4. Critical Access Hospitals in Louisiana

Hospital	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year (Including RHCs) *	DSH Payments as a % of Uncompensated Care Costs	Beds
Hood Memorial Hospital	$ 301,448.00	$ 568,165.00	53%	25
Prevost Memorial Hospital	$ 297,957.00	$ 514,263.00	58%	25
Triward General Hospital	$ 326,546.00	$ 486,893.00	67%	11
Acadia-St. Landry Hospital	$ 430,333.00	$ 572,391.00	75%	23
Ochsner St. Anne	$ 2,401,116.00	$ 3,165,137.00	76%	25
Richland Parish Hospital	$ 476,678.00	$ 599,422.00	80%	25
St. Martin Hospital	$ 823,035.00	$ 973,245.00	85%	25
Jackson Parish Hospital	$ 1,079,201.00	$ 1,111,667.00	97%	25
West Feliciana Parish Hospital	$ 1,355,283.00	$ 1,337,883.00	101%	22
Riverland Medical Center	$ 1,014,489.00	$ 985,138.00	103%	25
DeQuincy Memorial Hospital	$ 452,819.00	$ 436,669.00	104%	19
Union General Hospital	$ 557,200.00	$ 518,054.00	108%	25
Riverside Medical Center	$ 1,207,110.00	$ 1,091,124.00	111%	25
St. James Parish Hospital	$ 1,725,860.00	$ 1,552,533.00	111%	25
Lallie Kemp Regional Medical Center	$ 22,144,046.00	$ 19,718,855.00	112%	25
Pointe Coupee General Hospital	$ 1,810,993.00	$ 1,584,272.00	114%	25
Coushatta Health Care Center	$ 696,680.00	$ 581,369.00	120%	25
Bienville Medical Center	$ 571,142.00	$ 460,287.00	124%	21
Madison Parish Hospital	$ 2,796,130.00	$ 2,120,039.00	132%	25
Franklin Foundation Hospital	$ 2,622,163.00	$ 1,808,318.00	145%	25
Bunkie General Hospital	$ 670,593.00	$ 427,709.00	157%	25
St. Helena Parish Hospital	$ 1,202,477.00	$ 694,009.00	173%	25
Lady of the Sea	$ 1,929,041.00	$ 1,016,045.00	190%	25
Abrom Kaplan Memorial Hospital	$ 1,147,671.00	$ 449,276.00	255%	23
North Caddo Memorial Hospital	$ 1,045,247.00	$ 303,053.00	345%	25
Hardtner Medical Center	$ 726,486.00	$ 199,047.00	365%	25
Assumption Community Hospital	$ 2,167,407.00	$ 545,814.00	397%	15
Totals	$ 51,979,151.00	$ 43,820,677.00	119%	634

care costs. Overall, the state's 27 rural, critical access hospitals received $52 million in DSH payments to cover approximately $44 million in uncompensated care costs.

While we are unable to characterize the financial health of each of the state's rural, critical access hospitals, it is relatively straightforward that the planned 67% reduction in federal DSH payments under the ACA, combined with unexpanded Medicaid access for poorer state residents, will force many of these smaller hospitals to seek alternative means of either reducing or paying for their uncompensated care costs or it may force the state to find other sources of funding to provide for healthcare for the uninsured and indigent. Using 2010 payment rates as a base of comparison, the federal government's eventual reduction in DSH payments would drop coverage of uncompensated care at critical access hospitals from approximately 119% of reported costs to approximately 39% of reported costs.

Should state policymakers decide to expand Medicaid access under the ACA, rural hospitals would face a second, and equally complex, scenario in terms of funding for their uncompensated care costs. As previously stated, the ACA intentionally called for reductions in DSH payments under the logic that uncompensated care costs for hospitals would be reduced significantly due to both expanded health care access in the private insurance market and expanded Medicaid access. Under ideal conditions, reductions in federal DSH payments would be equally matched by increases in patients receiving care through private insurance and Medicaid. While it is relatively clear that, all things being equal, both rural and urban hospitals in the state would stand to benefit from the offset that expanded Medicaid access would provide, what is not certain is the extent to which certain rural, critical access hospitals will be disproportionately impacted due to the current structure of their DSH payments and uncompensated care costs. More specifically, the majority of rural critical access hospitals receive DSH payments that far exceed their reported uncompensated care costs. Under a best case scenario, expanded Medicaid access could only match existing uncompensated care costs but would do nothing to address reductions beyond those costs.

Unless the U.S. Congress postpones or pulls back from scheduled reductions, DSH payments available to both urban and rural hospitals in the state will be drastically reduced. Further, as the ACA evolves over time, there should be less need for DSH payments as the number of uninsured persons decreases, but the reduction in the uninsured will be greater in states that accepted Medicaid expansion and lower in states that did not accept Medicaid expansion. Louisiana has yet to expand Medicaid and is a high DSH state, both absolutely and proportionately. Hence, any reduction in DSH payments will substantially affect the state's payment to hospitals with contracts with the state to provide care for the uninsured and the indigent, which represent approximately 90% of DSH payments, and will affect those hospitals that are identified as rural, critical access hospitals.

Conclusions and Summary Remarks

The Patient Protection and Affordable Care Act (ACA) promoted two major goals: (1) reduce the number of uninsured Americans and (2) lower the overall cost of healthcare. An estimated 47 million persons in the U.S., about 15% of the population, were uninsured as of 2010, including close to 900,000 Louisiana residents or 20% of the state's population. Achieving expanded coverage necessitated the expansion of employer sponsored insurance, federal subsidization of policies provided on the private market, and expansion of Medicaid coverage.

Medicaid expansion is a crucial part of the goal to achieve universal coverage as it extends health coverage for non-elderly adults with incomes below 138% of the federal poverty level. In Louisiana presently, non-elderly adults without children with incomes above 19% of FPL, or about 300,000 persons, do not qualify for Medicaid coverage. As part of the ACA, the federal government is responsible for the entire cost of the newly eligible parents and childless adults through 2016, 95% of such costs in 2017, and gradually down to 90% of new costs in 2020.

Medicaid expansion was a required component of the ACA, but given that it is a federal/state program, its legality was challenged. The U.S. Supreme Court ruled that states were not legally mandated to expand Medicaid as specified in the ACA, and were ultimately given the discretion to decide whether or not to provide expanded Medicaid eligibility to their residents. Thirty-one states (including the District of Columbia) have authorized Medicaid expansion as structured under the ACA or with CMS Section 1115 waivers. Louisiana has chosen not to expand its Medicaid program citing that it is an outdated program and that it will be a financial burden to the state in the long-run.

Presently, about 31% of the state's population is enrolled in Medicaid, including children, parents, the disabled, and the elderly. In the New Orleans region almost 38% of the population is enrolled in a Medicaid program, while in northeast Louisiana Medicaid enrollees represent over 36% of the population. The state has contracted with five private companies to administer a managed care program to oversee Medicaid. This program (Bayou Health) accommodates over two-thirds of the Medicaid enrollees in the state. Medicaid accounts for approximately 17% of inpatient stays at hospitals around the state with several hospitals having more than 50% of their inpatient stays at hospitals being Medicaid-related. Just over 13% of the state's hospitals, representing about 2.4% of all hospital beds, have no Medicaid inpatient days. The largest of the hospitals with no Medicaid inpatient days is the V.A. Hospital in New Orleans, representing almost 30% of the beds in this group of hospitals. Medicaid, as it is in other states, is an integral part of the healthcare model in Louisiana and the state's decision to either accept or reject Medicaid expansion affects (1) individuals who would qualify for assistance under Medicaid expansion, (2) the state budget given the state's role in caring for the uninsured and indigent, (3) healthcare providers given their role in the delivery of healthcare services, and (4) hospitals given their role as major providers of healthcare services.

Accepting or rejecting Medicaid expansion involves long-term financial commitments by the state so it is imperative that the comparison between accepting or rejecting Medicaid expansion be carefully analyzed. This estimation of projected impacts upon state spending must be thoroughly considered since it will be difficult to reverse the decision to expand Medicaid under the ACA. Each year that the state refuses Medicaid expansion results in the state being subject to a less favorable FMAP, itself a cost, should it decide to expand Medicaid. The state, if chooses to expand Medicaid, should decide as quickly as possible to avoid any further cost due to the decline in federal matching support from 100% to 90%. Overall, the state's fiscal outlook relating to the decision to expand Medicaid is fundamentally affected by (1) the number of uninsured persons who would qualify for Medicaid under the extended participation rules to non-elderly adults earning less than 138% FPL, (2) the number of state residents who are presently insured but who would fit this income characteristic, and (3) the cost of the healthcare and the state's share which, by 2020, would be 90% of costs. Other factors will also affect financial estimates, such as how inmates are treated presently and under ACA for overnight healthcare, the possible transfer of some patients presently covered by Medicaid with a lower federal FMAP to the expanded Medicaid program with a higher federal FMAP, and possible revenue increases due to insurance premium tax increases.

Another important factor is the upcoming reduction in federal DSH payments, scheduled to be reduced incrementally by approximately 67% starting in 2018. DSH payments are directed to hospitals for uncompensated care and must be matched by the state. This is especially important in Louisiana since the state is a major DSH recipient. Louisiana is one of the top 4 states in the country in terms of the absolute size of DSH payments received. with the other high DSH states being New York, California, and Texas. Louisiana receives over 6% of the federal DSH payments with less than 2% of the country's population. Taking all of these factors into account, the Louisiana Department of Health and Hospitals and the Louisiana Legislative Fiscal Office have determined that accepting Medicaid expansion would be fiscally prudent from 2016 through 2020. However, both DHH and LFO have concerns about the fiscal outcomes once the FMAP becomes 90%.

Accurately estimating and comparing the healthcare costs to the state under both Medicaid expansion and non-expansion is complex and difficult. Costs associated with either decision are dependent upon (1) the number of uninsured persons who would qualify for state support under either system, with these estimates including persons who might be able to drop out of their private policies and switch to Medicaid if the state expands Medicaid and the number of persons who would be eligible for federally subsidized insurance if the state does not expand Medicaid but who just do not sign up and (2) the cost of the healthcare under both the expand Medicaid scenario or the reject Medicaid scenario. The cost of healthcare under non-expansion also brings into question the quality of healthcare that the state will provide for the uninsured and indigent. In both cases, it is also necessary to assess the role of DSH payments and the impact of any reduction in DSH payments on the financial ability of the state to maintain a viable healthcare system.

Assuming the highest estimate of Medicaid enrollees in 2020 under Medicaid expansion and the lowest possible number of persons who will need state assistance if the state chooses not to expand Medicaid, we estimate that, given the impact of scheduled DSH payment reductions upon both urban and rural hospitals in the state and the secondary effects associated with Medicaid expansion that will reduce its cost, it would be financially prudent for the state to expand Medicaid eligibility under the ACA. Additionally, continued rejection of Medicaid expansion will cost the state in additional ways. The state will receive no federal assistance for the medical treatment of inmates. The state will not be able to transfer certain eligible Medicaid recipients to a more favorable FMAP, and the state will not gain any additional revenues from excise taxes on insurance premiums or any contributions by hospitals. Finally, the longer the state delays Medicaid expansion, the more it will cost the state to support the inclusion of persons into the healthcare system that have not had that opportunity before.