Hospital Community Benefit after the Affordable Care Act:

An Assessment of the Effects of Medicaid Expansion in a National Sample of Non-Profit Hospitals 2010-2018

Kim DiGioia, DrPH, MS

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Non-Profit Hospital Community Benefit

- Expenditures of 8-9% of total operating expenses on community benefit (average $20M)
- ~85% on **charity care at cost**, **unreimbursed Medicaid**, and other unreimbursed means-tested government programs
- ~15% on community health improvement, health professions education, subsidized health services, research, and cash and in-kind contributions to community organizations

After the ACA:

More insured Americans = less uncompensated care, more revenue, more investments in population health?

Coverage Expansion and Community Benefit

- **Coverage increased**: 41% decrease in uninsured nonelderly adults from 2010-2016 (ASPE, 2021)
- **Hospitals reported change in payer mix:** Increased Medicaid discharges and decreased uninsured discharges (Bachrach et al., 2015; Nikpay et al., 2016; Rudowitz and Garfield, 2015)
- **Uncompensated care decreased in expansion states**: But it was offset by an increase in Medicaid shortfall (Dranove et al., 2016; Kanter et al., 2020; Stoecker et al., 2020)
  - **No change in community health improvement spending**
  - Uncompensated care -0.85 percentage points; increase in Medicaid shortfall +0.85 percentage points
- ***What is still unknown*:** What underlies the tradeoff between financial assistance and Medicaid shortfall? Is there evidence that hospitals capitalized on Medicaid expansion to inflate the appearance of community benefit expenditures?

Research Questions

(1) Did hospitals with higher revenue report a lower decrease in spending on financial assistance compared to the increase in Medicaid shortfall following Medicaid expansion?

(2) Are there other hospital or community characteristics associated with a smaller reduction in financial assistance compared to the increase in Medicaid shortfall?

Data Sources and Variables

IRS Form 990

- Financial assistance
- Medicaid shortfall
- Total community benefit
- Total revenue
- Total expenses

CMS Providers of Services (POS)

- Children's hospital
- Church affiliation
- Teaching hospital
- Sole community provider
- Urban location
- Bed count

Area Health Resource Files (AHRF)

- Unemployment rate
- % Persons <65 years with no insurance
- % Persons in poverty

Kaiser Family Foundation

- Medicaid expansion

Hilltop Institute

- State community benefit reporting requirement

Data provided by Community Benefit Insight

Study Design and Statistical Analyses

- N=3,287 unique hospitals, 23,088 observations
- Difference-in-differences approach to estimate the effect of Medicaid expansion
- Regression models control for hospital- and state-level fixed effects as well as:
  - Bed count
  - Percent of persons in poverty
  - Percent of persons <65 with no insurance
  - Unemployment rate
  - State community benefit reporting requirement
- Outcomes: Financial assistance and Medicaid shortfall
- Stratified analyses by hospital-level and community-level characteristics

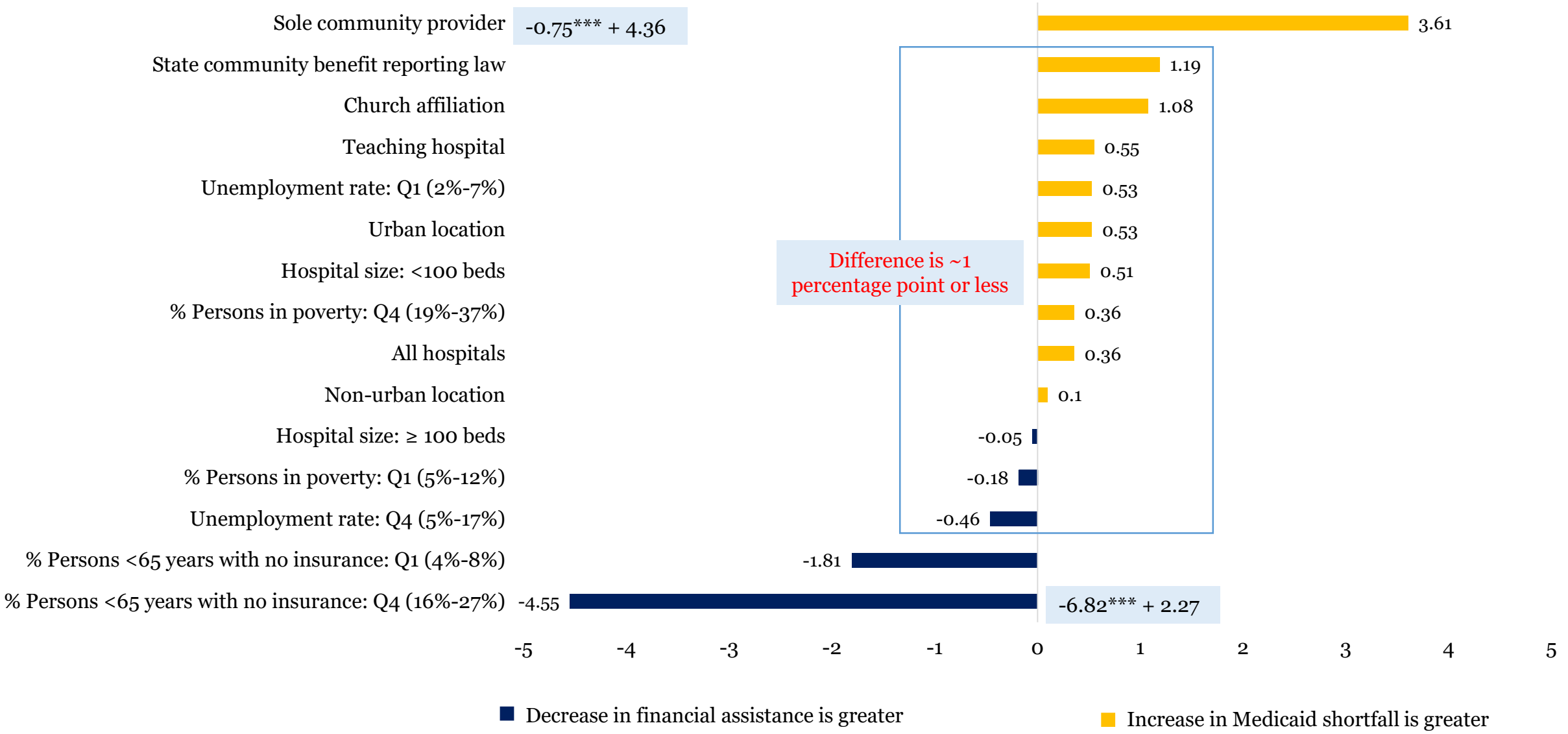
Key Findings

Table 1. Change in Financial Assistance and Medicaid Shortfall Associated with Medicaid Expansion, 2010-2018 (Key Findings)

	Financial Assistance	Medicaid Shortfall
All hospitals (n=3,287)	-6.83***	7.19***
Hospital revenue: Q1 (<$67.4M) (n=924)	-6.85***	6.69***
Hospital revenue: Q4 (>$1.08B) (n=879)	-4.36***	7.34***

*p<0.05; **p<0.01; ***p<0.001

Figure 1. Difference between Decrease in Financial Assistance and Increase in Medicaid Shortfall Associated with Medicaid Expansion as a Proportion of Total Community Benefit



Discussion

- No change in total community benefit expenditures after the ACA
- Spending on financial assistance decreased, but was offset by spending on Medicaid shortfall; **this tradeoff held true across many different types of hospitals and settings**
- Potential explanations for the observed tradeoff:
  - Hospitals inflated Medicaid shortfall
  - Shift from private payer to Medicaid
- Also consider these findings in the context of other hospital behavior, e.g., predatory billing practices

Policy Implications

- Including Medicaid shortfall in community benefit reporting *may have* provided the opportunity for hospitals to inflate total community benefit spending
- Revising the definition of community benefit to remove Medicaid shortfall would help to clarify the actual value of community benefit expenditures
- Alternatively, revise Schedule H to require clear reporting on the shortfall calculation

Limitations

- Quasi-experimental design
- Unbalanced panel
- Expansion as a binary variable
- No data on payer mix
- Did not examine spending in other CB categories

Thank you!

Contact:
Kim DiGioia, DrPH, MS
Program Officer, Evaluation & Analysis
Patient-Centered Outcomes Research Institute (PCORI)
kdigioia@pcori.org

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