Medicaid’s Evolving Delivery Systems

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Editor in Chief
National Press Club
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Health Affairs
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Panel 1: Primary Care
Health Center Expansion Over Time

- Office of Economic Opportunity/Department of Health, Education, and Welfare
- 1975, 151 health centers serving 1 million patients
- In 2013, 1,202 health centers serving 21.7 million patients
  - Plus 100 look-alikes serve 1 million patients
Patients Served At Community Health Centers (In Millions), 1975-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured patients</th>
<th>Medicaid/CHIP patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>1980</td>
<td>2.5</td>
<td>2.5</td>
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<tr>
<td>1985</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>1990</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>1996</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>2000</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td>2003</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>2005</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>2010</td>
<td>7.3</td>
<td>7.3</td>
</tr>
<tr>
<td>2013</td>
<td>7.6</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Totals:
- Uninsured patients: 21.7 millions
- Medicaid/CHIP patients: 21.7 millions
Key Program Requirements:

- MUA/P (e.g., mobile populations, schools, housing)
- Serve all regardless of ability to pay, coverage, or residence (Sliding scale fee)
- Patient majority board
- Comprehensive primary care including enabling services
- Report UDS
Health Centers Are One Of The Primary Sources Of Care For Medicaid Patients

• In 2013, an estimated 15.9% of Medicaid patients in the US (excluding territories) were served by health centers
  – Two basic factors explain this high rate:
    • the purposeful location of health centers in medically underserved communities
    • the relatively limited participation in Medicaid among office-based physicians
• Four states and the District of Columbia, proportion was >=30%
• 13 states with <10%
Percentage Of Health Center Patients And Revenues By Funding Source, 1985-2013
Health Center Medicaid Revenues In Relation To Discretionary Appropriations: 1996-2013

Revenues (in millions) | Patients (in thousands)
--- | ---
8.1 million patients | $950 million
21.7 million patients | $3.1 billion
$6.3 billion | (563% increase)
(168% increase)
(309% increase)
Moving Forward

• Strengthening and Encouraging their Partnership
  – Payment reform
  – Population health

• Preserving CHC-Medicaid relationship
  – Low physician participation/capacity
  – CHC success: access, outcomes, cost
  – Fragile and complex health issues
Many Medicaid Beneficiaries Receive Care Consistent With Patient-Centered Medical Homes

Peter Cunningham, PhD
Virginia Commonwealth University
What Are Patient-Centered Medical Homes?

• Patients connected to personal physician
• Patient engagement in medical decision-making
• Coordination/integration of care
• Enhanced access
• Quality and safety
• Payment incentives
PCMH and Medicaid

• Improve access and quality of care
• Reduce costs and overuse of hospitals
• Almost all states have some type of PCMH initiative for Medicaid
• But programs vary considerably in terms of target population and organization
Objective Of Study

• Estimate national prevalence of aspects of PCMH care among Medicaid population

• Association of PCMH attributes with care experiences and costs
Overview Of Findings

• Majority of Medicaid beneficiaries have primary care provider with some aspects of PCMH

• Young and healthy more likely to have care source with all PCMH attributes

• PCMH attributes associated with better access and higher perceived quality of care, but not lower costs.
Data

• 2008-2012 Medical Expenditure Panel Survey

• Total combined sample of 166,000 persons

• 38,000 Medicaid beneficiaries
PCMH Measures

• Has a usual physician
• Usual physician serves multiple health needs
• Easy to contact by phone during and after normal business hours
• Office hours nights and weekends
• Coordination of prescriptions
• Shared decision-making
## Prevalence Of PCMH Attributes

<table>
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<tr>
<th></th>
<th>Medicaid</th>
<th>Privately Insured</th>
<th>Uninsured</th>
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<tbody>
<tr>
<td>Has a usual physician (%)</td>
<td>77</td>
<td>73*</td>
<td>41*</td>
</tr>
<tr>
<td>Usual physician addresses multiple needs (%)</td>
<td>95</td>
<td>95</td>
<td>93*</td>
</tr>
<tr>
<td>Easy to contact by phone (%)</td>
<td>32</td>
<td>38*</td>
<td>31</td>
</tr>
<tr>
<td>Has office hours on nights or weekends (%)</td>
<td>34</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td>Coordinates all prescriptions (%)</td>
<td>78</td>
<td>77</td>
<td>77</td>
</tr>
<tr>
<td>Shared decision-making (%)</td>
<td>52</td>
<td>51</td>
<td>55*</td>
</tr>
</tbody>
</table>

*Difference with Medicaid is statistically significant at .05 level

Source: 2008-2012 Medical Expenditure Panel Survey
Has Usual Physician And At Least 3 Other PCMH Attributes

*Difference with Medicaid is statistically significant at .05 level
Source: 2008-2012 Medical Expenditure Panel Survey
Has Usual Physician And All 5 PCMH Attributes

*Difference with Medicaid is statistically significant at .05 level
Source: 2008-2012 Medical Expenditure Panel Survey
Medicaid Beneficiaries With All 6 PCMH Attributes

- Younger, especially children
- White
- Income above poverty line
- Fewer chronic conditions
- Higher self-assessed health
What Difference Do PCMHs Make For Medicaid Adults?

<table>
<thead>
<tr>
<th></th>
<th>Higher overall rating of care</th>
<th>Fewer unmet medical needs</th>
<th>Easier access to specialists</th>
<th>Lower spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serves multiple health needs</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy to contact by phone</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Office hours at nights or weekends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinates prescriptions</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared decision-making</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Limitations

- PCMH measures subject to reporting error
- Prevalence of PCMH likely has increased since 2012
- Caution in inferring causality of PCMH and outcome measures
Implications

• Obstacle to PCMH is that ¼ do not have usual physician
• Need to target older and sicker beneficiaries
• Need more precise understanding of PCMH attributes that improve access and quality of care, and lower costs.
MetroHealth Care Plus: Effects Of A Prepared Safety Net On Quality Of Care In A Medicaid Expansion Population

Randall D. Cebul, Thomas E. Love, Douglas Einstadter, Alice S. Petrulis, and John R. Corlett

Center for Health Care Research & Policy
Better Health Partnership
www.betterhealthpartnership.org

Case Western Reserve University at MetroHealth Medical Center
Cleveland, Ohio
Medicaid Expansion In 2013

When Ohio approved Medicaid expansion in October 2013:

- An influential publication had reported that Medicaid coverage alone resulted in higher rates of ED visits and no changes in measures of physical health
  - Little attention to new ways of delivering care or incentives for behavior change
- Ohio’s largest county (Cuyahoga) already was in the midst of an expansion enabled by a federal waiver, to:
  - Enroll up to 30,000 uninsured poor adults in “MetroHealth Care Plus” (MHCP), a closed network of 3 unaffiliated safety net organizations; and
  - Accept financial risk if “expenditure cap” was exceeded

Characteristics in common among participating safety net organizations:

- EMRs and health information exchange
- NCQA-recognized patient-centered medical homes (16)
- 7 years’ participation in Better Health Partnership, a regional health improvement collaborative with 2x/year public reporting of performance on quality standards
  - including patients covered by Medicaid and the uninsured
- Commitment to disadvantaged populations
Objectives And Study Samples

Objectives - to compare:
1. Changes in quality among Care Plus enrollees vs. a continuously uninsured comparison group reported by Better Health in both 2012 and 2013; and
2. Total costs for all Care Plus enrollees vs. the federal expenditure cap

Study Samples:
1. Quality of care and outcomes for patients with diabetes and/or hypertension seen in 2012-2013:
   Care Plus: n = 3437; Uninsured: n = 1150.
2. All Care Plus enrollees between February 5th and December 31st 2013 – n = 28,295, median enrollment 9 months.
**Costs:** 28.7% below federal expenditure cap (lower by $167.36 per member-month), or $41M savings across all 28,295 enrollees.
Discussion And Conclusions

1. In Care Plus, a prepared safety net improved care and outcomes at total costs of care more than 28% lower than allowed – over a median 9 months’ enrollment.

2. Features that promoted success:
   - **Waiver characteristics**: “closed panel” network of safety net organizations; a requirement to accept financial risk if expenditure cap was exceeded; no co-pay for any covered services
   - **Organization characteristics**:
     - Long-term commitment to quality improvement and transparency
     - Meaningful use of EMRs and health information exchange
     - Delivery system transformation as patient-centered medical homes
     - Commitment to disadvantaged populations

3. Our results suggest that Medicaid expansion is more likely to be successful if it is accompanied by new ways of delivering care and incentives for behavior change
The authors thank:

• The leaders and providers of The MetroHealth System, Neighborhood Family Practice, and Care Alliance Health Center, in Cleveland, Ohio;
• Medical Mutual of Ohio, also in Cleveland; and
• CMS and Ohio’s Department of Medicaid, for making MetroHealth Care Plus possible.

Analyses and preparation of this manuscript were made possible by funding from the Robert Wood Johnson Foundation and other organizations that support Better Health Partnership.
In California, Primary Care Continuity Was Associated With Reduced Emergency Department Use And Fewer Hospitalizations

Nadereh Pourat, et al
UCLA Center for Health Policy Research
UCLA Fielding School of Public Health
Why Continuity Matters?

• Escalating health care costs
  – Duplication in care
  – Avoidable ED visits and hospitalizations

• Managing care for complex patients
  – Patient history and clinical information
  – Patient-provider rapport
  – Patient engagement in self-care
  – Compliance with treatment plans
  – Adherence to treatment guidelines

• Triple Aim
  – Increased emphasis on primary care and Patient-Centered Medical Home
  – Newly insured and previously uninsured
Early Medicaid Expansion

- California, Section 1115 Medicaid Waiver
  - 49K enrolled in Orange County (OC)

- Insurance-like product
  - County-based, defined provider network, defined benefit package, PCP assignment

- OC policy change to reduce costs
  - Required adherence to PCP in third year
  - Declined payment to non-PCP for non-urgent visits
  - Added minimal copays for primary and ED visits
Framework & Methods

Policy to Enforce Adherence to a Usual Source of Primary Care

Path A

Continuity of Primary Care

Path B

Path C

Policy Implementation

Month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Study Year

Pre-Period

Post-Period

Level of Adherence to the Usual Source of Primary Care

ED Visits and Hospitalizations

ED Visits and Hospitalizations

ED Visits Hospitalizations
Enforcement → Continuity

- 35.5% lower likelihood of never adhering post period
- 6.3% lower likelihood of sometimes adhering post period
- 41.8% higher likelihood of always adhering post period
Continuity → Less Acute Care

- 2.1% higher likelihood of no ED visits, if always adhered
- 1-1.2% lower likelihood of any ED visits, if always adhered
- 1.7% higher likelihood of no hospitalizations, if adhered
- 0.5% lower likelihood of any hospitalizations, if adhered
Implications

• Provider and patient behaviors can be modified for better care outcomes

• Continuity provides the opportunity for better care management

• Small reductions in ED visits and hospitalizations translate into significant savings

• Connecting newly insured Medicaid enrollees to primary care providers is crucial
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California Healthcare Foundation

For Its Support Of The July 2015 Issue Of Health Affairs And This Important Briefing
Panel 2: Complex Populations
Lessons From Medicaid's Divergent Path On Mental Health And Addiction Services

Christina Andrews, Colleen Grogan, Marianne Brennen and Harold Pollack

National Institute on Drug Abuse (Grant No. R01 DA034634-01) for its project, “The impact of health reform on outpatient substance abuse treatment programs”
Medicaid’s Divergent Path

- Medicaid has become the dominant payer for Mental Health

- Much more modest role in Addiction Treatment
EXHIBIT 1: Medicaid Expenditures for Services for Selected Populations, 1984-2009*

Sources: Report on National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2009, Substance Abuse and Mental Health Services Administration

*Estimates are inflation-adjusted (2009)
ACA Creates Dramatic Change For Addiction Services

• Dramatically expand Medicaid’s role in financing addiction services
• Will obtain principal market power over addiction services
Strategic Lessons

1. Regulatory Flexibility to Leverage Optional Coverage Categories
2. Providing Incentives to Create and Deliver High Quality Alternatives to Inpatient Treatment
3. Targeted Medicaid Licensure Standards
Lesson #1: Regulatory Flexibility

Mental Health Experience

• Optional Coverage Categories
  – targeted case management ($2.9 billion) and rehabilitation ($6.4 billion)
Lesson #1: Regulatory Flexibility

- Leverage the flexibility built into Medicaid’s optional benefit policies
- Advocate for coverage across the service continuum—from intensive outpatient treatment and crisis management to recovery-oriented services—to effectively manage addiction as a chronic illness.
Lesson #2: Alternatives To Inpatient Treatment

Mental Health Experience

• Medicaid 1915 Waivers
  – Money Follows the Person Demonstration Programs
  – Four states—Colorado, Connecticut, Montana, and Wisconsin—currently have HCBS waivers for adults with severe mental illnesses.
Lesson #2: Alternatives To Inpatient Treatment

Lessons for Addiction

• 45 percent of people receiving services are in a residential or inpatient settings

• Inpatient addiction treatment is no more effective than outpatient treatment for many patients.

• Inpatient treatment is more costly, restrictive, and stigmatizing
Lesson #3: Targeted Medicaid Licensure Standards

Mental Health Experience

• Medicaid dollars for Mental Health Centers provided reimbursement to a whole new cadre of mental health professionals who pushed for state licensing laws.

• By 1990, 42 states had passed licensure and mandates
Lesson #3: Targeted Medicaid Licensure Standards

Addiction Lessons

• Less than 50% of addiction treatment providers have any formal training or credentialing in addiction treatment.

• In 2012, 6 states required addiction treatment providers to possess a bachelor’s degree, and only one state required a master’s degree.

• 14 states had no educational attainment requirements for licensure.
Lesson #3: Targeted Medicaid Licensure Standards

• Use Market power to have an impact
• Licensure could also help speed implementation of evidence-based addiction therapies
• Many existing addiction treatment providers will need technical assistance
Integrated Services

- Medical Health Homes
- Primary care providers have made greater strides in integrating mental health treatment into their repertoire of services.
- Assessment and treatment of addiction treatment has been less well integrated into primary care.
Conclusion

• Medicaid agencies must develop strategies to
  – support a continuum of care that effectively responds to people with diverse addiction-related needs
  – create regulatory policies that set clear rules to improve quality while remaining flexible and nimble to adjust to different patient needs
Deficiencies In Care At Nursing Homes And Racial & Ethnic Disparities Across Homes Declined, 2006–11

Yue Li, PhD, Dept. of Public Health Sciences, University of Rochester Medical Center
Charlene Harrington, University of California, San Francisco
Helena Temkin-Greener, University of Rochester Medical Center
Kai You, University of Rochester Medical Center
Xueya Cai, University of Rochester Medical Center
Xi Cen, University of Rochester Medical Center
Dana B. Mukamel, University of California, Irvine
Background

• Over 1.3 million older and disabled Americans receive care in 15,000 nursing homes.
• State Medicaid programs are the dominant payer.
• Quality of care issues have existed for several decades, but may have improved more recently (stronger regulations, improved Medicaid payments, CMS public reporting).
• Racial/ethnic minority residents tend to be cared for in facilities with limited resources, low nurse staffing levels, and high numbers of deficiency citations.
Impact Of Medicaid Payment Policies

• Increased Medicaid payment rates were associated with reduced number of healthcare–related deficiencies for all nursing homes, and with slightly reduced across-site disparities.

• State adoptions of case-mix payment methods were associated with increased healthcare–related deficiencies for all nursing homes, and slightly increased site-of-care disparities.
Federally Qualified Health Center Use Among Dual Eligibles: Rates of Hospital Utilization

Andrew Potter
PhD Candidate
University of Iowa

Health Affairs
Thank You...

• Co-Authors: Brad Wright (bradwright@uiowa.edu), Amal Trivedi
• Support: Fred Ullrich, Jeff Hiris
• Funding: Retirement Research Foundation

andrew-j-potter@uiowa.edu
Dual Eligibles

Medicare and Medicaid enrollees

– Non-financial barriers to care

– Elderly Blacks and Hispanics 6 times as likely to be dual eligible as Whites

– 2 times more likely than Medicare-only beneficiaries to be hospitalized for ambulatory care-sensitive conditions:
  • Diabetes
  • Hypertension
Federally Qualified Health Centers

• Enabling services:
  – Transportation
  – Child care
  – Interpreting/translation

• 69% of patients are racial/ethnic minorities

• 542,000 dual eligibles visited health centers in 2010, up 22% from 2008
### Adjusted Relative Rates Of Hospital-based Care For Health Center Users Vs. Non Users Among Elderly Dual Eligibles

<table>
<thead>
<tr>
<th>FQHC Users vs. Non-Users</th>
<th>Hospitalizations for Ambulatory Care-Sensitive Conditions</th>
<th>Emergency Visits for Ambulatory Care-Sensitive Conditions</th>
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<tbody>
<tr>
<td>Black</td>
<td>0.84*</td>
<td>1.03*</td>
</tr>
<tr>
<td>White</td>
<td>1.01*</td>
<td>1.20*</td>
</tr>
<tr>
<td>Asian</td>
<td>1.13*</td>
<td>1.27*</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0.87*</td>
<td>1.10*</td>
</tr>
<tr>
<td>All Other Races</td>
<td>1.06*</td>
<td>1.36*</td>
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</table>

* p < 0.01
### Adjusted Relative Rates Of Hospital-based Care For Non-whites Vs. Whites

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<th>Versus White</th>
<th>ACS Hospitalization (Non-Users)</th>
<th>ACS Hospitalization (Users)</th>
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</thead>
<tbody>
<tr>
<td>Black</td>
<td>1.16*</td>
<td>0.96*</td>
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<tr>
<td>Hispanic</td>
<td>0.84*</td>
<td>0.72*</td>
</tr>
<tr>
<td>Asian</td>
<td>0.49*</td>
<td>0.54*</td>
</tr>
<tr>
<td>Other</td>
<td>0.78*</td>
<td>0.82*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Versus White</th>
<th>ACS ED Visits (Non-Users)</th>
<th>ACS ED Visit (Users)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>1.18*</td>
<td>1.01*</td>
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<tr>
<td>Hispanic</td>
<td>0.82*</td>
<td>0.76*</td>
</tr>
<tr>
<td>Asian</td>
<td>0.46*</td>
<td>0.49*</td>
</tr>
<tr>
<td>Other</td>
<td>0.72*</td>
<td>0.82*</td>
</tr>
</tbody>
</table>

* p< 0.01
Conclusions

• Health center users had:
  – Lower disparities in hospitalizations
  – More emergency department visits

• 8.6% of dual eligibles visited health centers in 2008-2010

• Advance Primary Care Practice demonstration

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Panel 3: Payment and Coverage
Medicaid At 50
Remarkable Growth Fueled by Unexpected Politics

Michael Sparer, JD, PhD
Columbia University
The Medicaid Miracle

• Medicaid eligibility continues to become more generous

• Under both Republican and Democratic Administrations

• What is the Political Explanation for this Policy Outcome?
Medicaid Politics

• Interest Groups?

• Political Culture?

• Institutional Dynamics?
Medicaid History: Five Eras

• State Discretion and Welfare Medicine (1965-1985)

• Federal Mandates, Rising Costs, and Eligibility Expansions (1986-1992)

• CHIP, Managed Care Waivers and Eligibility Expansions (1993-2000)
Medicaid History: Five Eras

- Crowd-out, Cost Containment and Continued Growth (2001-08)

- ACA, Eligibility Expansions and the New Medicaid Model (2009-15)
Unexpected Medicaid Politics

- Interest Groups (some surprise supporters)
- Political Culture (the lure of state administration)
- Catalytic Federalism (the inter-governmental financing)
Medicaid Going Forward

• The Transforming Health System
• The ACA Expansions
• Medicaid and the Exchanges
• DSRIP and Delivery System Reform
• Medicaid Purchasing Power
• Ongoing Challenges
An Examination Of Medicaid Delivery System Reform Incentive Payment Initiatives Underway In Six States

Michael K. Gusmano, PhD
Research Scholar
The Hastings Center
Medicaid Waivers For Delivery System Reform Incentive Payment (DSRIP)

• DSRIP waivers in six states
  – Incorporated into larger Medicaid demonstrations that seek to transform health services
  – Link Medicaid funds to hospitals and other providers to performance
Pay-for-Performance

- History P4P in the US
  - Private Sector
  - CMS
    - Medicare P4P initiative
    - CMS Hospital Readmissions Reduction Program
- Mixed Evidence; Policy Enthusiasm
Hospital Oriented vs. Regional Network Approaches

- Hospital-Oriented Approach (CA, KS, MA, NJ)
  - Performance payments to hospitals will promote integration

- Regional Network Approach (NY and TX)
  - Integration requires formal partnerships among hospitals and community providers
The Supreme Court Ruling That Blocked Providers From Seeking Higher Medicaid Payments Also Undercut The Entire Program

Nicole Huberfeld, JD
Ashland-Spears Distinguished Research Professor
University of Kentucky College of Law
71 million
Equal Access Provision [30(A)]

A State plan for medical assistance must... assure that payments are ...sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.
Supremacy Clause

This Constitution, and the laws of the United States which shall be made in pursuance thereof... shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.
Early Medicaid Expansion In Connecticut Stemmed The Growth In Hospital Uncompensated Care

Sayeh Nikpay, PhD
Postdoctoral Researcher
University of Michigan

Health Affairs
The ACA Is Expected To Cut Cost Of Uncompensated Care, $74B In 2013

(Coughlin et al. 2014)
These Cuts Are Expected To Be Driven By Medicaid Expansions

‘14 Projected Reduction

$Billions

-5

-2.4

Expansion
Non-Expansion

(DeLeire, Joynt, and MacDonald 2014)
Estimating The Effect Of ACA Medicaid Expansions On Hospital Uncompensated Care Is Difficult

- Data are unavailable
- No obvious control group
- Multiple confounding factors

- Alternative strategy: study the impact of an “early” ACA expansion
We Estimated The Effect Of Connecticut’s 2010 Medicaid Expansion On Hospital Uncompensated Care

• Large gains in coverage
  o 46,000 new enrollees
  o 3p.p. ↓ in uninsured rate
• Compare to the rest of Northeast
• 2007-2013 Medicare cost reports

(Sommers, Kenney, and Epstein 2014)
Medicaid Volume In Connecticut Increased Relative To The Northeast

**EXHIBIT 2**

Unadjusted Trends in Medicaid Discharges As a Share of Total Discharges for Hospitals in Connecticut and Other Northeastern States, 2007-13

Source: Authors’ analysis of 2007-2013 Medicare hospital cost reports
Uncompensated Care In Connecticut Fell Relative To The Northeast

Unadjusted Trends in Uncompensated Care As A Share Of Total Expenditures For Hospitals In Connecticut And Other Northeastern States, 2007–13

Source: Authors’ analysis of 2007-2013 Medicare hospital cost reports
In Summary, Connecticut’s 2010 Medicaid Expansion ...

• Nearly doubled Medicaid volume
  – Medicaid share of discharges +7-9p.p.
  – Medicaid share of revenues +7p.p.

• Reduced uncompensated care by a third
Works Cited


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