

How Would Medicaid Losses in Approved Section 1115 Medicaid Work Experiment States Affect Community Health Centers?

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at <https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> or at www.rchnfoundation.org.

Executive Summary

This brief estimates the potential effects of Medicaid work experiments on community health centers and their patients. Our analysis focuses on seven states with approved experiments and uses data from the federal government's 2017 Uniform Data System. We find that across the seven states, between 120,000 and 169,000 adult health center patients could be expected to lose Medicaid coverage during the initial experimental year. As a result of declining Medicaid enrollment, health centers in these states would lose between \$89 and \$125 million in Medicaid revenue in the first year alone, which in turn could be expected to result in an overall drop in patient care capacity of between 104,000 and 147,000 and staffing reductions of between 815 and 1,145 FTE staff members.

Background

Recently, a number of states have sought to make Medicaid eligibility for adults conditional on proof of employment or other forms of community engagement. As of June 2019, the Trump administration has approved § 1115 Medicaid work experiments in nine states: Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, Ohio, Utah and Wisconsin. A tenth approved state (Maine) has decided not to proceed with its approved demonstration.

Previously, we have used analyses prepared by Leighton Ku and Erin Brantley estimating projected reductions to Medicaid coverage in three approved states ([Arkansas](#), [Kentucky](#), and [New Hampshire](#)) to project the potential impact of these losses on community health centers and their patients. In order to calculate impact, we used data from the 2017 Uniform Data System (UDS), a nationwide data-reporting system containing detailed information on community health center patients, services, staffing and other information.

In this blog, we update our work to apply [newly-reported estimates by Ku and Brantley](#) on Medicaid enrollment losses across multiple approved states. Specifically, we broaden our analysis to include Arizona, Ohio, and

Michigan; we also provide updated estimates for Arkansas. (Because Ku and Brantley conclude that projected losses for Utah and Wisconsin are uncertain, estimates of health center patient impact cannot be determined for these two approved states).

Table 1 shows selected characteristics for community health centers in the seven states. In 2017 (the latest year for which UDS data are available), the 179 health centers in these states served 3,263,935 patients, of whom nearly 60 percent (1,934,685) were adults age 18 to 64. Among the 1,655,431 health center patients enrolled in Medicaid, 906,787 (55 percent) were adults age 18 and older. Total patient visits to all health centers in these seven states surpassed 12.5 million in 2017, and the health centers employed more than 26,000 full-time equivalent staff.

Methods

Based on the latest Ku and Brantley estimates, we show in Table 2 the estimated population of adult Medicaid health center patients who would be subject to work requirements in each of these states, along with the estimated decrease in Medicaid enrollment for those enrollees targeted for participation in the experiment. In Arizona, Michigan and Ohio, Medicaid coverage losses are projected among

Table 1. Selected Health Center Characteristics in Seven States with Approved Medicaid Work Requirement Programs

State	Number of health centers	Total patients	Non-elderly adult patients	Total Medicaid patients	Total adult Medicaid patients	Total staff (FTEs)	Total visits
Arizona	21	587,459	334,922	283,167	151,445	5,508	2,250,893
Arkansas	12	210,380	128,773	83,794	43,544	1,659	793,064
Indiana	25	479,409	258,627	260,676	115,409	3,532	1,669,554
Kentucky	24	461,552	277,623	215,773	119,892	3,134	1,772,101
Michigan	38	695,224	417,601	370,936	213,457	5,833	2,697,514
New Hampshire	11	91,440	56,570	27,414	13,316	1,004	398,090
Ohio	48	738,471	460,569	413,671	249,724	5,460	2,966,433
Total	179	3,263,935	1,934,685	1,655,431	906,787	26,128	12,547,649

Source: GW analysis of 2017 UDS data

patients who are members of the ACA expansion population, since the experiment is limited to ACA expansion adults. In Indiana, all non-elderly adult beneficiaries, both ACA expansion and traditional, must participate unless exempt.

To estimate the number of Medicaid expansion adults served by health centers in these states, we applied the state-specific percentage of Medicaid expansion adults from the most recent Medicaid enrollment data available (2017, 3rd quarter) for [Arizona](#) (22 percent), [Michigan](#) (42 percent) and [Ohio](#) (22 percent) to total regular (non-CHIP) health center Medicaid enrollees in 2017. In [Indiana](#), where projected losses occur among both expansion and traditional adult populations (as is also the case in Kentucky), the estimated target population of 102,734 was based on the number of regular Medicaid adult health-

center patients (115,026), adjusted for age.

For all four states, the figures were adjusted to account for the age range of adults subject to work requirements by calculating the age distribution of non-elderly adult health-center patients in each state (ages 19-64 in Arizona, Michigan, and Ohio, to match the Medicaid expansion age range, and 18-64 for Indiana) and excluding the percentage of adults outside the work requirement age range (age 50-64 for Arizona and Ohio, age 60-64 for Michigan, and age 18 and 60-64 for Indiana). (It was assumed that elderly patients with Medicaid coverage are dually eligible for Medicare and would thus be reported under Medicare, as the UDS requires).

Table 2. Projected Number of Health Center Medicaid Patients Subject to Work Requirements

State	Age range subject to work requirements	Medicaid adult population subject to the work requirements	Estimated population of health center Medicaid patients subject to work requirements	Estimated percent reduction in Medicaid coverage for targeted Medicaid enrollees
Arizona	19-49	Expansion	42,347	26%-35%
Arkansas	19-49	Expansion	12,910	26%-30%
Indiana	19-59	Expansion and traditional	102,734	15%-25%
Kentucky	19-64	Expansion and traditional	119,892	26%-41%
Michigan	19-62	Expansion	142,471	28%-35%
New Hampshire	19-64	Expansion	8,398	30%-45%
Ohio	19-49	Expansion	63,306	26%-35%

Source: GW analysis of 2017 UDS data for [Arizona](#), [Indiana](#), [Michigan](#), and [Ohio](#); Medicaid.gov enrollment numbers for [2017, 3rd quarter](#); previously reported figures for [Arkansas](#), [Kentucky](#), and [New Hampshire](#); Ku & Brantley, 2019

Results

Table 3 below presents the projected first-year Medicaid coverage losses among health center patients subject to work requirements in the seven states. New estimates are provided for Arizona, Arkansas, Indiana, Michigan and Ohio, and previously-reported estimates are provided for Kentucky and New Hampshire. The losses in Table 3 shown for Arkansas differ from those in our prior Arkansas estimate, since Ku and Brantley revised their initial projections of Medicaid enrollment declines, from its previous range of 19 percent to 30 percent (on which our original estimates were based), to an updated range of [26 percent to 30 percent](#). The target population size for

Arkansas (Table 2) remains the same as it was in our [earlier analysis](#), but health-center impact (Table 3) differs from our earlier projections as a result of the updated enrollment loss estimates.

Applying the projected declines in Medicaid enrollment overall, we then estimate the projected drop in the number and percent of health center Medicaid patients in the first year of the experiment (Table 3). Assuming a proportional loss of Medicaid enrollment to Medicaid revenue, the estimated loss of Medicaid revenue (shown in Table 4) is then applied to determine the loss of total revenue (Table 3) and the resulting loss of total patients and staff (Table 4).

Across seven states, the number of health center patients

expected to lose Medicaid coverage ranges from 2,520 in New Hampshire to 39,892 in Michigan. Low-end total losses of coverage among health center patients stand at 119,820. At the high-end of the estimate range, 169,335 patients could lose coverage, and the state range jumps to between 3,779 (New Hampshire) and 49,865 (Michigan). Decreases in total Medicaid enrollment could reach as high as 23 percent (Kentucky).

As patients lose coverage, health centers lose Medicaid revenue, and as revenue declines, so does patient care capacity (Table 4). At the high end, health center Medicaid

revenue losses could reach a total of \$125 million across all seven states, surpassing \$37 million in Kentucky and \$38 million in Michigan. Across all seven states, we estimate a total reduction in health center patient capacity of between 103,991 and 147,217 patients and a total staffing reduction ranging between 815 to 1,145 health center FTE staff.

Table 3. Projected Loss of Health Center Patients with Medicaid Coverage and Total Revenue Losses

Projected losses	Arizona	Arkansas	Indiana	Kentucky	Michigan	New Hampshire	Ohio
Projected drop in Medicaid enrollees, low estimate	11,010	3,356	15,410	31,172	39,892	2,520	16,460
Projected drop in Medicaid enrollees, high estimate	14,821	3,873	25,683	49,156	49,865	3,779	22,157
Decrease in total Medicaid enrollment, low estimate	4%	4%	6%	14%	11%	9%	4%
Decrease in total Medicaid enrollment, high estimate	5%	5%	10%	23%	13%	14%	5%
Decrease in total revenue, low estimate	2%	1.2%	3%	6%	5%	2%	1.7%
Decrease in total revenue, high estimate	3%	1.4%	4%	10%	6%	3%	2.3%

Source: GW analysis of 2017 UDS; previously reported figures for [Kentucky](#), and [New Hampshire](#); Ku & Brantley, 2019

Table 4. Projected Medicaid Revenue, Patient, and Staffing Losses at Health Centers in Seven States

State	Decrease in Medicaid revenue, low estimate	Decrease in Medicaid revenue, high estimate	Reduced patient capacity, low estimate	Reduced patient capacity, high estimate	Reduced staff (FTEs) capacity, low estimate	Reduced staff (FTEs) capacity, high estimate
Arizona	\$10,906,915	\$14,682,385	11,728	15,787	110	148
Arkansas	\$1,990,116	\$2,296,288	2,478	2,859	20	23
Indiana	\$9,628,627	\$16,047,712	12,621	21,036	93	155
Kentucky	\$23,662,029	\$37,313,199	28,842	45,481	196	309
Michigan	\$30,493,098	\$38,116,373	33,810	42,262	284	355
New Hampshire	\$1,871,868	\$2,807,802	1,674	2,510	18	28
Ohio	\$10,274,016	\$13,830,406	12,838	17,282	95	128
Total	\$88,826,669	\$125,094,165	103,991	147,217	815	1,145

Source: GW analysis of 2017 UDS data; previously reported estimates for [Kentucky](#) and [New Hampshire](#); Ku & Brantley, 2019

Conclusion

The Institute of Medicine, in a landmark study of health insurance and its effect, concludes that health insurance coverage patterns can have a [community-wide impact](#). In communities with more limited access to coverage at the individual level, services can be affected community-wide since health care providers located in these communities lack the financial means to maintain strong systems of care. Just as the expansion of health insurance led to overall economic strengthening that benefits all patients, coverage losses can adversely affect access to care for all patients, not just those immediately losing coverage. As coverage declines, economic losses mount; providers must treat

growing numbers of uninsured patients, and uncompensated care and bad debt grow. Staffing and services get scaled back, which can take several forms—layoffs, reduced hours, shuttered locations, and elimination of services that may be more costly to provide but generate little in the way of revenue.

It is also important to note that this issue of community-wide impact is one that typically is systematically overlooked, both in federal guidance governing § 1115 evaluations and in the evaluations themselves. Evaluation of the impact of coverage loss for community-wide access should be viewed as a basic element of any § 1115 experiment designed to achieve large-scale shifts in coverage.