ISSUE BRIEF
MARCH 2019

How Will Medicaid Work Requirements Affect Hospitals' Finances?

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ABSTRACT

ISSUE: The recent debate regarding Section 1115 demonstration waivers that include work requirements has focused on potential loss of coverage for Medicaid beneficiaries, but little has been discussed about the potential impact on providers that serve Medicaid patients.

GOAL: To assess the potential financial impact on hospitals in states that have approved or pending Section 1115 demonstration waiver applications for implementing work requirements in their Medicaid programs.

METHODS: Our analysis extrapolates the early results of Medicaid coverage loss from Arkansas's implementation of work requirements and information from other recent studies to estimate the financial impact that work requirements may have on hospitals using our Hospital Finance Simulation Model.

FINDINGS AND CONCLUSION: The results show that Medicaid work requirements could weaken hospitals' financial positions in states that implement these requirements as a condition of coverage. However, the design of states' Medicaid work requirement programs will play a key role in how many beneficiaries lose coverage and the resulting financial impact on hospitals.

TOPLINES

- In states that impose work requirements, fewer covered Medicaid beneficiaries means hospitals will see reduced revenues, increased uncompensated care costs, and smaller operating margins.
- Implementing Medicaid work requirements will impact hospitals differently across states, depending on factors like payer mix, program design issues like age limits, and the portion of enrollees who become uninsured.

The Commonwealth Fund

BACKGROUND

Much of the recent debate regarding Section 1115 Medicaid waivers that impose work requirements as a condition for eligibility has focused on potential loss of coverage for beneficiaries, but there has been little discussion about the impact on providers. In states that impose work requirements, Medicaid beneficiaries will lose health insurance coverage if they cannot find work, are unable to document the required number of hours of work activity, or cannot document an exemption. Their loss of coverage will impact hospitals by reducing revenue and increasing uncompensated care costs. These adverse effects will not only affect the hospitals and Medicaid patients, but the entire community served by these hospitals if hospitals must reduce staff or eliminate important services because of lower revenues and increased uncompensated care.

In this brief, we examine the potential impact on hospitals in states that have approved or pending Section 1115 waiver applications for implementing work requirements in their Medicaid programs. Our analysis uses the early results from Arkansas's implementation of work requirements in Medicaid as well as other recent studies to estimate the financial impact that work requirements may have on hospitals.

At the time of publication, seven states have received approval and another eight have submitted applications that would require nondisabled adults to work a certain number of hours per week or month to receive Medicaid coverage.[1] Exhibit 1 shows the status of these applications.

Arkansas was the first state to implement work requirements in Medicaid, targeting enrollees that became eligible through the ACA Medicaid expansion. The state began gradually rolling out the work requirement program in June 2018, starting with enrollees ages 30 to 49 and expanding to enrollees ages 19 to 29 in January 2019.

Exhibit 1. Medicaid Work Requirement Waivers: Application Status and Targeted Populations

State	Application status	Targeted population
Alabama	Pending	Traditional adults up to age 59
Arizona*	Approved	Expansion adults up to age 49
Arkansas*	Approved	Expansion adults up to age 49
Indiana*	Approved	Traditional and expansion adults up to age 59
Kentucky*	Approved	Traditional and expansion adults up to age 64
Michigan*	Approved	Expansion adults up to age 62
Mississippi	Pending	Traditional adults up to age 64
New Hampshire*	Approved	Expansion adults up to age 64
Ohio*	Pending	Expansion adults up to age 49
Oklahoma	Pending	Traditional adults up to age 50
South Dakota	Pending	Traditional adults up to age 59
Tennessee	Pending	Traditional adults up to age 64
Utah	Pending	If expansion is implemented, work requirements will apply to expansion adults up to age 59
Virginia*	Pending	Traditional and expansion adults up to age 64
Wisconsin	Approved	Childless adults up to age 49

* States that expanded Medicaid under the Affordable Care Act.

Data: Commonwealth Fund, "Status of Medicaid Expansion and Work Requirement Waivers"; and Henry J. Kaiser Family Foundation, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State."

Early results from Arkansas have been striking. The state used an automated exemption process based on other known state data about enrollees and also issued letters, phone calls, and emails from the Arkansas Department of Human Services to affected Medicaid enrollees to inform them of the new policy. Despite these efforts, nearly 8,500 people lost their Medicaid coverage within the first four months of the program.[2] Data show that between 23 percent and 29 percent of the targeted population either did not meet the work requirement or failed to report their work activities each month. Assuming these rates continue, nearly 50,000 (29%) of the state's estimated 167,000 Medicaid enrollees targeted for the program may lose their coverage.[3] Simply failing to report work activities for three months during the year for enrollees who would otherwise meet the requirement would result in loss of coverage.

Reductions in Medicaid coverage will have an impact on hospitals by reducing Medicaid payments and increasing uncompensated care costs, which will result in lower hospital operating margins. How the work requirements are designed will play a key role in how many beneficiaries lose coverage and the resulting financial impact on hospitals.

The following analysis estimates the impact of Medicaid coverage loss on revenues, uncompensated care costs, and operating margins for hospitals in the affected states. The analysis excludes hospitals in Utah and Virginia because their work requirements would be applied to the expansion populations, and Virginia has only recently expanded Medicaid and Utah has not yet expanded the program. Thus, data are not yet available on the impact of Medicaid expansion on coverage and hospital financial status. We present impact estimates under two scenarios: a low coverage loss assumption and a high coverage loss assumption. See How We Conducted This Study for details.

IMPACT ON MEDICAID REVENUES

The loss of Medicaid coverage because of implementing work requirements will have a significant impact on Medicaid revenues for hospitals in all the study states. However, the impact will vary across states because of the design of the work requirement programs. Five states (Arizona, Arkansas, Michigan, New Hampshire, and Ohio) target work requirements only to adult enrollees who obtained eligibility through the ACA expansion. Indiana and Kentucky will apply work requirements to both the traditional Medicaid and expansion populations. Six states that did not expand Medicaid (Alabama, Mississippi, Oklahoma, South Dakota, Tennessee, and Wisconsin) will apply work requirements to adults in the traditional Medicaid program. All states have a maximum age limit that ranges from 49 to 64. Exemptions from the work requirements vary significantly by state, but typically focus on enrollees that are medically frail, full-time students, or caregivers.

Exhibit 2 shows the estimated reductions in Medicaid revenues in acute care hospitals.[4] We estimate that Medicaid revenues will decline by 18 percent to 20 percent on average for hospitals in Indiana and by 20 percent to 22 percent for hospitals in Kentucky (Exhibits 2 and 3). These two states apply work requirements to both traditional and expansion eligible beneficiaries up to age 59 and 64, respectively. In contrast, Arizona, Arkansas, and Ohio will apply work requirements only to the expansion population up to age 49. We estimate that Medicaid revenues will decline by a lesser degree (10% to 14%) for hospitals in these states.

IMPACT ON UNCOMPENSATED CARE COSTS

Most of the individuals losing Medicaid coverage will be ineligible for premium subsidies in the health insurance marketplaces because their incomes will be below the poverty level (or below 138% of poverty for those in expansion states).[5] Many will be unemployed or have jobs that do not offer employer-sponsored insurance. Therefore, many beneficiaries losing Medicaid coverage will become uninsured and will contribute to rising hospital uncompensated care costs.

A recent study on insurance coverage "churning" among Medicaid beneficiaries nationally showed that nearly one-third of nonelderly Medicaid beneficiaries churned off Medicaid over a two-year period for various reasons.[6]

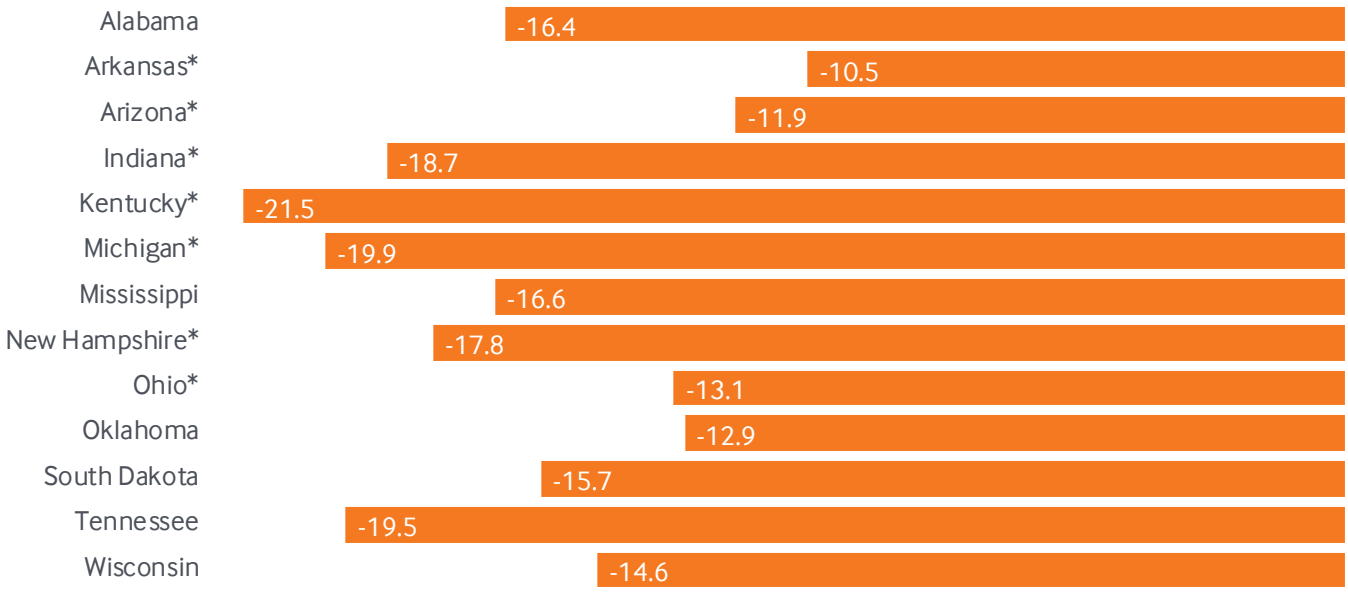
Exhibit 2. Changes in Hospitals' Medicaid Revenue in States Implementing Medicaid Work Requirements

			Change in Medicaid revenue per hospital after implementation of Medicaid work requirements		Percent change in Medicaid revenue per hospital	
State	Hospitals included in the analysis	Average Medicaid revenue per hospital	Low coverage loss estimate	High coverage loss estimate	Low coverage loss estimate	High coverage loss estimate
Alabama	82	$8,424,462	–$1,324,364	–$1,446,205	–15.7%	–17.2%
Arkansas*	70	$9,510,734	–$955,841	–$1,043,778	–10.1%	–11.0%
Arizona*	59	$33,269,017	–$3,791,076	–$4,139,854	–11.4%	–12.4%
Indiana*	107	$15,612,700	–$2,784,654	–$3,040,842	–17.8%	–19.5%
Kentucky*	88	$30,229,315	–$6,201,818	–$6,772,385	–20.5%	–22.4%
Michigan*	121	$35,060,639	–$6,672,540	–$7,286,414	–19.0%	–20.8%
Mississippi	86	$15,566,115	–$2,476,391	–$2,704,218	–15.9%	–17.4%
New Hampshire*	26	$14,135,553	–$2,407,125	–$2,628,580	–17.0%	–18.6%
Ohio*	157	$28,498,465	–$3,567,928	–$3,896,177	–12.5%	–13.7%
Oklahoma	97	$12,933,367	–$1,598,913	–$1,746,013	–12.4%	–13.5%
South Dakota	45	$5,288,206	–$791,657	–$864,490	–15.0%	–16.3%
Tennessee	98	$23,161,337	–$4,323,311	–$4,721,056	–18.7%	–20.4%
Wisconsin	119	$14,487,746	–$2,023,478	–$2,209,639	–14.0%	–15.3%

* States that expanded Medicaid under the Affordable Care Act.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

Exhibit 3. Percent Changes in Hospitals' Medicaid Revenue in States Implementing Medicaid Work Requirements (midpoint of high and low coverage loss estimates)



* States that expanded Medicaid under the Affordable Care Act.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

Of those that left, about 74 percent became permanently or temporarily uninsured. Many individuals that experienced a temporary spell of uninsurance later reenrolled in Medicaid. However, Medicaid beneficiaries in some states, like Arkansas, who lose coverage because of work requirements may be "locked out" of reenrolling for a certain time period. Even after the lock-out period, these individuals will need to prove they are working the required number of hours to regain coverage. As a result, many will be permanently uninsured and others will have extended gaps in coverage. This increases hospital uncompensated care costs.[7]

Exhibits 4 and 5 show the estimated increase in uncompensated care costs per hospital from implementing Medicaid work requirements. Hospitals in states that expanded Medicaid will experience the largest increases in uncompensated care in both dollar amounts per hospital and in terms of percentage increases. This is because there will be a larger proportion of Medicaid beneficiaries losing coverage in expansion states. In addition, hospitals in expansion states have benefited from reduced uncompensated care costs, which will now be undone. Hospitals in Kentucky could see the largest uncompensated care increases from implementing work requirements, as the condition will apply to both traditional and expansion populations up to age 64.

IMPACT ON HOSPITAL OPERATING MARGINS

The reduction in Medicaid revenues and increases in uncompensated care costs will lead to reduced operating margins[8] for hospitals in states that implement Medicaid work requirements. Exhibits 6 and 7 show the estimated changes in hospital operating margins by state. For example, we estimate that hospital operating margins for Alabama hospitals will be –2.3 percent in 2019, without Medicaid work requirements. Implementing work requirements in the state would reduce margins by an additional 0.2 to 0.6 percentage points, resulting in margins of –2.5 to –2.9 percent.

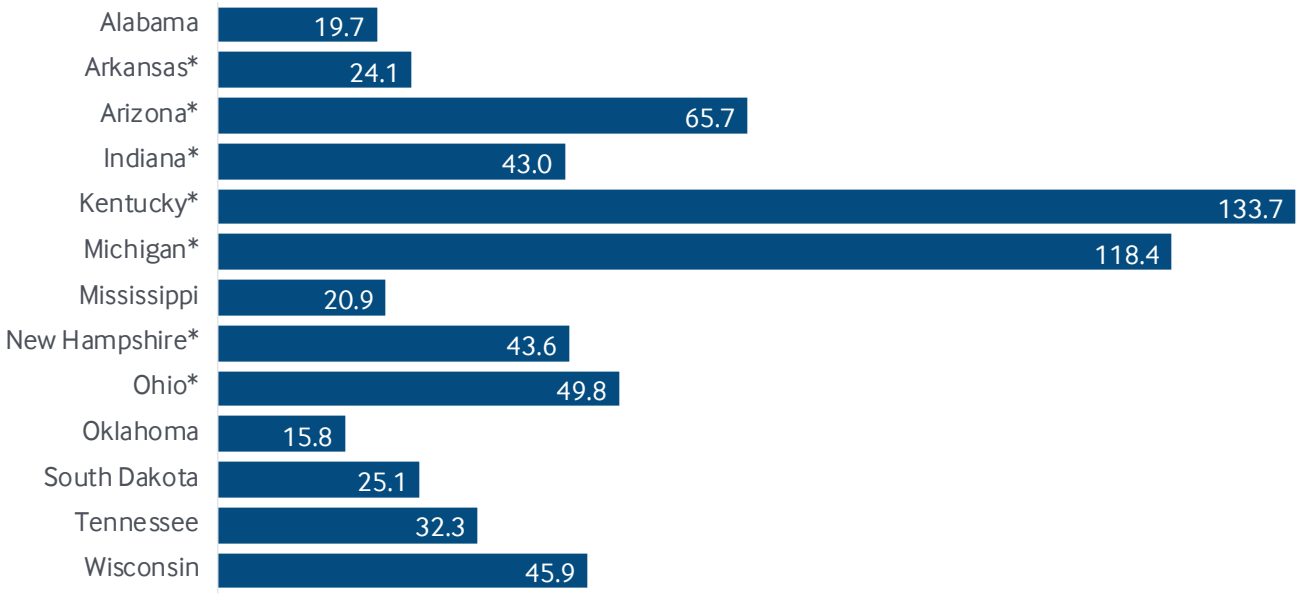
Exhibit 4. Changes in Hospitals' Uncompensated Care Costs in States Implementing Medicaid Work Requirements

			Change in uncompensated care cost per hospital after implementation of Medicaid work requirements		Percent change in uncompensated care cost per hospital	
State	Hospitals included in the analysis	Average uncompensated care cost per hospital	Low coverage loss estimate	High coverage loss estimate	Low coverage loss estimate	High coverage loss estimate
Alabama	82	$7,185,674	$1,155,905	$1,677,388	16%	23%
Arkansas*	70	$3,238,468	$638,113	$925,995	20%	29%
Arizona*	59	$5,920,702	$3,172,976	$4,604,454	54%	78%
Indiana*	107	$6,208,860	$2,179,297	$3,162,480	35%	51%
Kentucky*	88	$3,646,751	$3,978,386	$5,773,222	109%	158%
Michigan*	121	$4,513,836	$4,361,502	$6,329,179	97%	140%
Mississippi	86	$7,060,445	$1,201,599	$1,743,696	17%	25%
New Hampshire*	26	$5,046,195	$1,796,836	$2,607,472	36%	52%
Ohio*	157	$6,684,118	$2,713,432	$3,937,588	41%	59%
Oklahoma	97	$6,680,415	$860,733	$1,249,050	13%	19%
South Dakota	45	$2,487,137	$509,862	$739,885	20%	30%
Tennessee	98	$10,233,881	$2,696,819	$3,913,481	26%	38%
Wisconsin	119	$3,988,100	$1,492,081	$2,165,228	37%	54%

* States that expanded Medicaid under the Affordable Care Act.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

Exhibit 5. Percent Changes in Hospitals' Uncompensated Care Cost in States Implementing Medicaid Work Requirements (midpoint of high and low coverage loss estimates)



* States that expanded Medicaid under the Affordable Care Act.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

As the data show, implementing work requirements will impact hospitals differently across states. Several factors help to explain these differences:

- **Hospital payer mix.** Hospitals in states that have a high Medicaid payer mix are more dependent on Medicaid revenues and will be adversely affected more than hospitals in states with a lower Medicaid payer mix.
- **Portion of Medicaid enrollees subject to work requirements and the number that lose coverage.** States that subject a large portion of enrollees to work requirements, by setting higher age limits and applying work requirements to both traditional and expansion groups, will experience a larger negative impact than other states.
- **Portion of Medicaid enrollees that become uninsured.** If a large portion of enrollees that lose Medicaid coverage are unable to obtain private coverage, hospital uncompensated care costs will increase and operating margins will decline.

Hospitals in Kentucky, for instance, will be adversely impacted because of the design of the program, which applies work requirements to both traditional and expansion eligible beneficiaries up to age 64. Hospitals in rural areas of states that implement Medicaid work requirements will be hardest hit by the loss of Medicaid coverage.[9] Rural hospitals are projected to have negative operating margins, on average, in most of these states prior to work requirements, meaning they are already operating at a loss on patient care (Exhibit 8). Implementing work requirements will further reduce operating margins for these already struggling hospitals. Hospitals in rural communities have recently been closing at an alarming rate; a reduction in operating margins may intensify the issue.

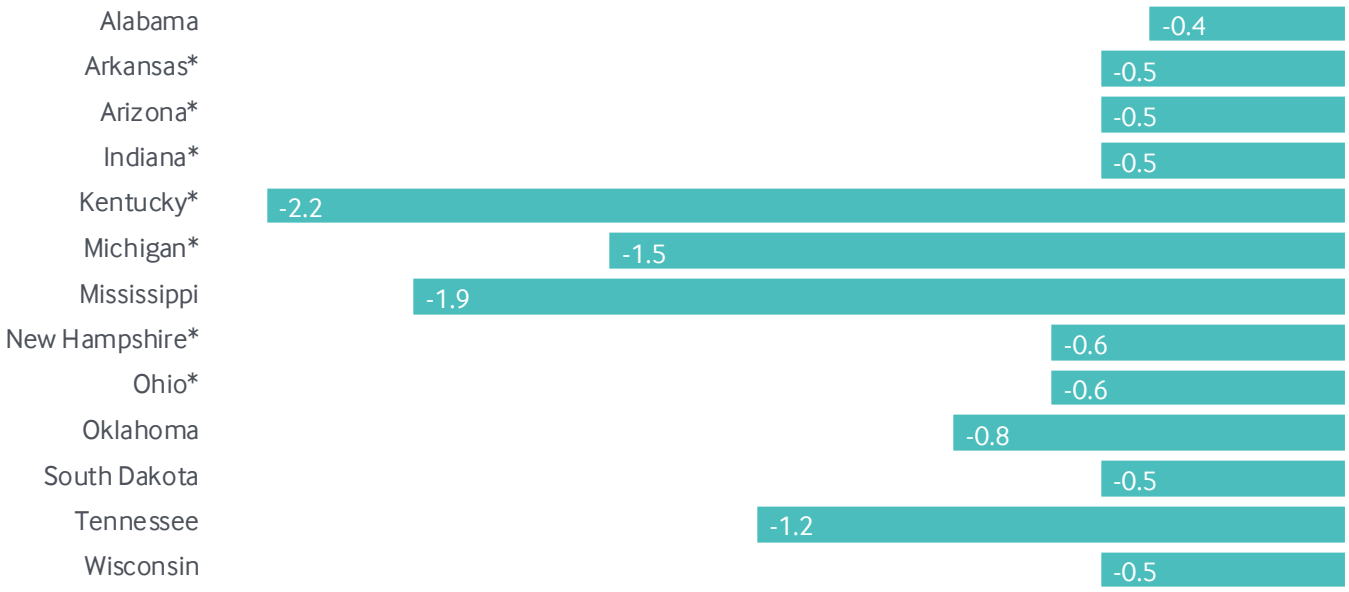
Exhibit 6. Changes in Hospitals' Operating Margins in States Implementing Medicaid Work Requirements

			Change in operating margins after implementation of Medicaid work requirements	
State	Hospitals included in the analysis	Average hospital operating margin	Low coverage loss estimate	High coverage loss estimate
Alabama	82	–2.3%	–0.2%	–0.6%
Arkansas*	70	0.2%	–0.3%	–0.6%
Arizona*	59	1.3%	–0.2%	–0.8%
Indiana*	107	6.0%	–0.2%	–0.8%
Kentucky*	88	–3.9%	–1.6%	–2.9%
Michigan*	121	–2.0%	–1.1%	–1.8%
Mississippi	86	–2.5%	–1.6%	–2.2%
New Hampshire*	26	–1.0%	–0.3%	–0.8%
Ohio*	157	–0.8%	–0.3%	–0.9%
Oklahoma	97	1.5%	–0.6%	–1.0%
South Dakota	45	0.2%	–0.3%	–0.6%
Tennessee	98	1.4%	–0.9%	–1.5%
Wisconsin	119	2.4%	–0.3%	–0.7%

* States that expanded Medicaid under the Affordable Care Act.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

Exhibit 7. Percent Changes in Hospitals' Operating Margins in States Implementing Medicaid Work Requirements (midpoint of high and low coverage loss estimates)



* States that expanded Medicaid under the Affordable Care Act.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

Exhibit 8. Changes in Rural Hospitals' Operating Margins in States Implementing Medicaid Work Requirements

			Change in operating margins after implementation of Medicaid work requirements	
State	Rural hospitals included in the analysis	Average hospital operating margin	Low coverage loss estimate	High coverage loss estimate
Alabama	42	–8.1%	–0.2%	–0.6%
Arkansas*	46	–4.5%	–0.6%	–0.9%
Arizona*	15	–8.2%	–0.5%	–1.1%
Indiana*	41	–3.2%	–0.1%	–0.7%
Kentucky*	65	–4.0%	–1.7%	–3.1%
Michigan*	59	–2.8%	–0.7%	–1.4%
Mississippi	64	–1.8%	–1.5%	–2.1%
New Hampshire*	18	–7.7%	–0.2%	–0.7%
Ohio*	61	2.6%	0.5%	–0.7%
Oklahoma	54	–7.0%	–0.5%	–1.0%
South Dakota	36	–3.6%	–0.4%	–0.6%
Tennessee	51	–2.1%	–0.7%	–1.4%
Wisconsin	70	0.3%	–0.2%	–0.6%

* States that expanded Medicaid under the Affordable Care Act.

Note: Rural hospitals are defined as hospitals physically located in a state and county that is not designated as a Core Based Statistical Area by the Office of Management and Budget at the beginning of the hospitals' 2016 Medicare cost-reporting period.

Data: Dobson DaVanzo simulation of the impact of Medicaid work requirements on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; includes acute care hospitals that reported required Medicare hospital cost report data in 2016.

DISCUSSION

The results of this analysis, which is based on the early impact of a work requirement on Medicaid coverage loss in Arkansas, show that Medicaid work requirements could weaken hospitals' financial positions.

While the data provided by the Arkansas Department of Human Services have been extremely helpful for understanding the program's impact on Medicaid coverage, more research is needed to understand the risk profile of Medicaid beneficiaries who lose coverage. Enrollees with disabilities or with health conditions that keep them from working have substantially higher costs than the average Medicaid beneficiary. If even some of these individuals fall through the cracks, it could have a significant impact on hospital uncompensated care. While most states plan to exempt people deemed "medically frail," it's likely that many people with disabilities won't qualify for an exemption or will be unable to prove that they do.

Additional research also is needed to explore whether Medicaid enrollees that lose coverage will be able to obtain other insurance coverage or will become uninsured. Much of the current research regarding churning in Medicaid indicates that most people who lose coverage experience permanent coverage loss or significant gaps in coverage. If a high percentage of Medicaid enrollees that lose coverage because of work requirements are unable to obtain private insurance coverage, this will also increase the uncompensated care burden for hospitals.

The improved financial stability experienced by many hospitals following the ACA coverage expansion has allowed them to hire new staff and maintain or offer new services to their communities. The improvements in hospital finances may be jeopardized if the Medicaid coverage losses experienced by Arkansas are seen in other states. This adverse financial impact will not only affect the hospitals and Medicaid patients but their entire surrounding communities.

HOW WE CONDUCTED THIS STUDY

This analysis uses the Dobson DaVanzo Hospital Finance Simulation Model (HFSM) to produce estimates of the financial impact of Medicaid work requirements on hospitals. The model is built using 2016 Medicare Hospital Cost Reports (MCRs) as the primary data source. This data source allows us to determine revenues and expenses by payer (i.e., Medicare, Medicaid, other government payers, and all other payers) for each U.S. hospital. Hospital revenues and costs for each payer category were projected from 2016 through 2026 based on trends in population growth, utilization, service intensity, and medical inflation.

HFSM uses these data and applies assumptions about the impact of Medicaid work requirements on coverage loss within each state. The model then incorporates dynamics of how the assumptions impact hospital utilization, costs, and revenues. Coverage loss assumptions were developed using the following steps:

1. We first estimated the number of Medicaid enrollees in each state that would be subject to work requirements using data from the March Supplement of the Current Population Survey (CPS) for 2016 through 2018 by identifying survey respondents that meet each state's criteria for who would be subject to Medicaid work requirements.

2. We next estimated the number of Medicaid enrollees subject to work requirements that would lose Medicaid coverage in each state based on the rate of Medicaid coverage loss experienced in Arkansas during the early phases of their work requirement program. We assume that about 24 percent of enrollees that reported meeting the hours worked requirement in the CPS survey or potentially qualifying for an exemption will lose coverage because of not reporting work activities or documenting an exemption. We also assume 72.5 percent of nonworking enrollees not qualifying for an exemption will lose coverage.

3. An important factor for providers will be the health care utilization or risk profile of Medicaid beneficiaries that lose coverage. Our analysis of the national Medical Expenditure Panel Survey (MEPS) data for 2015 found that hospital spending for working Medicaid nonelderly adults is about 16 percent less costly than the average Medicaid enrollee, and nonworking adults that would not meet the criteria for a potential exemption are 52 percent less costly. However, enrollees that could potentially meet one of the exemptions are substantially more costly than the average Medicaid enrollee. While most states plan to exempt people deemed "medically frail," it's likely that many people with disabilities won't qualify for an exemption or will be unable to prove that they do.

4. Finally, we estimated the number of individuals losing Medicaid coverage that will become uninsured. A recent study on insurance coverage "churning" among Medicaid beneficiaries nationally found that about 63 percent of people losing Medicaid coverage would become permanently uninsured and the remaining 37 percent would experience a gap in insurance coverage of about four months over the 24-month study period. This would result in about 69 percent (63% + 37% x (4/24)) of people who lose Medicaid coverage because of work requirements would be uninsured at any given point in time. We use this assumption as a low-range coverage loss estimate.

5. Another recent study of the impact on enrollees of the suspension of the Tennessee adult Medicaid expansion found no evidence that adults who lost Medicaid coverage gained private insurance. Therefore, as a high-range coverage loss estimate, we assume that nearly all people who lose their Medicaid coverage because of work requirements would become uninsured.

NOTES

1. "Status of Medicaid Expansion and Work Requirement Waivers," Interactive, Commonwealth Fund, last updated Feb. 22, 2019; and "Work Requirement Waivers: Approved and Pending as of March 1, 2019," Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, Henry J. Kaiser Family Foundation, Mar. 1, 2019.

2. Benjamin Hardy, "Work Requirement Bars over 4,000 from Receiving Medicaid Coverage," *Arkansas Times,* Sept. 13, 2018.

3. Arkansas Department of Human Services, "Reports, Toolkits, and Infographics" (DHS, n.d.).

4. Medicaid revenues includes payment received for all covered inpatient and outpatient services except physician or other professional services, also includes payments received from Medicaid managed care plans and disproportionate share hospital and supplemental payments, net of associated provider taxes or assessments.

5. Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (KFF, Nov. 2018).

6. Sara R. Collins, Sherry A. Glied, and Adlan Jackson, *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky* (Commonwealth Fund, Oct. 2018).

7. Uncompensated care costs were defined as charity care costs net of partial payments by patients plus non-Medicare and Medicare nonreimbursable bad debt costs.

8. Hospitals operating margins were calculated as (net patient revenues – operating expenses) / net patient revenues. Operating margin measures hospitals' profitability on the income or losses derived from patient care. An operating margin of 2 percent means that each dollar of patient revenues generates two cents in profits. Operating margin is often a better measure of a hospital's sustainable profitability than total hospital margins because it focuses on revenue from patient care as opposed to income from other less dependable sources, such as investment income.

9. Rural hospitals are defined as hospitals physically located in a state and county that is not designated as a Core Based Statistical Area by the Office of Management and Budget at the beginning of the hospitals' 2016 Medicare cost-reporting period.

ABOUT THE AUTHORS

Randy Haught is a senior data manager at Dobson DaVanzo and brings more than 25 years of experience performing analysis of Medicare and Medicaid payment policies and major health care reform legislation. While at Dobson | DaVanzo, Mr. Haught has worked for a range of organizations to assist them with their Health Care Innovation applications to the Centers for Medicare and Medicaid Services (CMS) by providing financial analysis and consulting on payment models and innovations. He also worked on a project with the CMS Center for Medicaid and CHIP Services to review Medicaid DSH and UPL submissions from each state to identify gaps in the methodologies used by states, as well as gaps in the data submission and review process.

Allen Dobson, Ph.D., is cofounder and president of Dobson DaVanzo & Associates, LLC. Over the past several years, Dr. Dobson has studied Medicare's Prospective Payment Systems (PPS) and Physician Payment System and has led efforts to model the impact of physician and hospital payment policies upon stakeholders using microsimulation and econometric techniques. He also led a series of state Medicaid studies. Dr. Dobson developed estimates for the Institute of Medicine Committee on Medicare Benefit Extensions of the likely cost to Medicare of expanding preventive benefits. Before cofounding Dobson | DaVanzo, Dr. Dobson was a senior vice president at The Lewin Group. Prior to that, he was director of the Office of Research at the Health Care Financing Administration during the period that Medicare PPS was developed and implemented. Dr. Dobson earned his Ph.D. in Economics from Washington University in St. Louis.

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Editorial support was provided by Deborah Lorber.

ACKNOWLEDGMENTS

The authors thank Melinda Abrams and Sara Collins of the Commonwealth Fund for their support of this project.

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