

Background on Rural Hospital Struggles

According to Kaiser Health News, “Many of the problems plaguing rural hospitals date to 1983, when Medicare began paying hospitals a set fee for medical services and procedures rather than reimbursing them for the actual costs of providing care. From 1983 to 1998, 440 rural hospitals closed in the US...

The recession hit rural hospitals especially hard, as did federal budget cuts that reduced Medicare payments by 2 percent. Because the rural population tends to be older, rural hospitals rely heavily on Medicare payments. The pressure increased in 2012, when the federal government reduced by 30 to 35 percent its reimbursements to hospitals for Medicare patients who don’t cover their share of the bill.” ([“Rural Hospitals Team Up To Survive,”](#) August 19, 2015).

Exacerbating the struggles, the last five years have been a tumultuous time for the healthcare industry in the U.S. Since the passage of Obamacare, healthcare providers have been thrown into the turmoil of changing reimbursement rates, overly complicated regulations, and changing court interpretations.

The closure of the Mercy Hospital in Independence is being used as the poster child for expanding Medicaid in Kansas. However, there are a few pieces of information to keep in mind:

- Montgomery County has a population of 35,000 and had two hospitals; the County still has one.
- Hospital officials said they are not sure that expanded Medicaid would have kept Mercy open.
- All of the rural hospitals combined only receive \$19 million, or 2%, of the funding from expanding Medicaid.
- The vast majority of Medicaid expansion funding would go to Johnson, Wyandotte, Shawnee and Sedgwick hospitals.

How KanCare Fits

At the state level, Kansas Republican leadership has strived to insulate providers, the state budget, and most importantly, Kansans who rely on Medicaid services, from the unwieldy effects of Obamacare and its ensuing court decisions. Additionally, Kansas Republicans implemented reforms of the antiquated Medicaid system that hadn’t changed much since its inception in 1965. These changes provided Kansans who rely on its services access to increased coverage and better customer service than they received in the past. The state has been able to provide services to clients while simultaneously restraining the costs that can be controlled.

Currently, the biggest variable in regard to the Medicaid portion of the state budget (approximately 20 percent of the State General Fund) is caseloads. Caseload estimates represent the number of people who meet current eligibility requirements entering the system, in relation to the people who leave the system. Caseloads generally trend upwards, which means a bigger financial obligation for the state.

This is why the implementation of KanCare was such a vital reform. By reorganizing and modernizing the way disadvantaged Kansans receive services, we have imparted as much stability and predictability as we can into the system. We continue to fulfill the responsibility of caring for Kansans with limited incomes and resources, as the program was designed to do when enacted. Medicaid was designed to be a safety net, not a long-term health insurance option to compete with market-based insurance.

The Question of Expanding Medicaid

When Obamacare passed, mandatory Medicaid expansion was a critical piece of the plan. With the June 2012 Supreme Court ruling, states were left with the decision of whether or not to expand this element of additional federal spending and government intrusion. In Kansas, Medicaid expansion would cost \$100 million per year to raise eligibility to individuals up to 138 percent of federal poverty guidelines ("[KDHE: Medicaid Expansion Could Cost More Than \\$100 Million Per Year](#)," March 19, 2015). Despite these numbers, there is really no way to know what the long-term costs for Kansas will end up being. There are two facts we do know that should be important elements in anyone's evaluation of the situation.

1) Costs will definitely go up by 2017 when 5 percent of the expansion expenses shift to states. The costs will continue to shift until Kansas has to pick up 10 percent of the cost beginning in 2020 ([HHS.gov, "HHS Finalizes Rule Guaranteeing 100 Percent Funding for New Medicaid Beneficiaries,"](#) March 29, 2013). The 90% federal funding has been a priority of the Obama administration but is far from a certainty with the next administration.

2) Other states that have expanded have seen costs skyrocketing above estimates – Oregon enrollment came in 73% higher than anticipated with the cost being 70% higher than original estimates ("[Oregon Underestimated Medicaid expansion price Tag](#)," July 20, 2015). Even other states that have expanded in a "red state" model have seen costs that far exceeded estimates.

Arkansas – "When Arkansas expanded Medicaid through its private option earlier this year, the Department of Health and Human Services estimated that the first-of-its-kind program would be budget-neutral. But now federal auditors are blaming HHS for flawed estimates and say it will actually cost taxpayers an extra \$778 million over the next three years ("[Arkansas Expanded Medicaid Program Will Cost \\$778 Million More Than Expected](#)," September 10, 2014).

Ohio – "Medicaid expansion ran \$1.5 billion over budget in its first 18 months ("[Obamacare's Medicaid Enrollment Fiscal Nightmare for States](#)," July 30, 2015).

Michigan – The state "projected 323,000 enrollees in the first year and 477,000 by 2020. But more than 15 months after the launch of 'Healthy Michigan,' 600,000 have signed up — 25 percent above the peak estimate in 2020" ("[Rise in Medicaid Enrollment May Squeeze Michigan Budget](#)," July 19, 2015). The program is \$120 million over budget according to the same source.

Iowa – "The program has seen double-digit premium hikes, one carrier becoming insolvent, both carriers eventually leaving the program, skyrocketing enrollment, cost overruns, and changes that make Medicaid enrollees less accountable. With that unfolding, it's no wonder state officials announced in July 2015 that they were [closing the Medicaid expansion waiver](#) ("[Iowa Scraps Waiver for Obamacare Medicaid Expansion](#)," September 14, 2015). Additionally, the enrollment estimates have gone from 81,000 to over 121,000 enrollees – or roughly 50% over estimates according to the same source.

New Hampshire – The state estimated 34,000 new enrollees but received 41,000 or 20% over projections. "New Hampshire's Gov. Maggie Hassan included \$12 million for Medicaid in her

state budget for fiscal years 2016 and 2017, assuming the expansion would be reauthorized once the federal government, now paying 100 percent of the costs, starts lowering its share. But after lawmakers said they would rather wait until next year to debate whether to continue the program, Hassan vetoed the Legislature's \$11.3 billion budget proposal, and the state is now operating under a six-month temporary spending plan that keeps funding at existing levels" (["N.H. Medicaid Enrollment Surging,"](#) July 20, 2015).

The population Medicaid expansion would cover mostly consists of healthy adults without children, who could receive private coverage for free if they work 33 hours a week at the minimum wage. According to the Fiscal Times, "In Illinois, for example, the state originally expected to cover about 199,000 people in 2014. Now, that number is at about 634,000—[with most enrollees](#) tending to be younger, white childless adults" ("[Soaring Medicaid Enrollment Could Hit State Budgets,](#)" May 19, 2015). Medicaid expansion would increase costs to the state, and would be detrimental to our overriding goal—providing health coverage for the poor, disabled, and elderly. Expanding Medicaid would not only put strain on the rest of the Medicaid system by increasing the load on providers, it would also increase the strain on the state budget's other vital responsibilities.

The reality is, rural hospitals face many long-term challenges that far outsize what Obamacare can fix. It is critical that state officials continue to work for innovative ways to help rural hospitals meet the challenges they face, without resorting to expanding an unpredictable federal program that will send the vast majority of funding to urban areas while not addressing the real needs of rural hospitals.