American Hospital Association

Ensuring Adequate Resources for Patients and Communities

Medicaid

Issue

For more than 40 years, Medicaid has served as the nation's health care safety net, providing access to health services for millions who cannot afford private insurance in a dynamic and changing economy. Today, more than 57 million children, poor, disabled and elderly individuals rely on Medicaid for care. The program now serves more people than Medicare, and with the ranks of the uninsured growing, and the threat of an economic recession, the Medicaid program is more important than ever.

Hospitals are the backbone of America's health care safety net, providing care to all patients who come through their doors, regardless of ability to pay. But, hospitals experience severe payment shortfalls when treating Medicaid patients. For example, in 2006, Medicaid paid only 86 cents for every dollar spent treating Medicaid patients. And that same year, hospitals provided care at a cost of more than $31 billion for which no payment was received. Despite these financial pressures, the Administration continues to call for further cuts in federal funds for the Medicaid program that will affect hospitals and the patients they serve.

The Federal Budget and CMS Regulations. Since early 2007, the Centers for Medicare & Medicaid Services (CMS) has issued over a half dozen regulations, in either proposed or final form, that will, if implemented, significantly affect the Medicaid program's financial support for hospitals and impact the patients they serve. The Administration estimates these rules would reduce spending by at least $15 billion over five years. However, a House Committee on Oversight and Government Reform March report estimated the fiscal impact of these rules at nearly $50 billion over five years. CMS asserts that the majority of these regulations are necessary to address problems, particularly with the financing of the program. But, in the written justification for these regulations, CMS failed to identify any significant or widespread problems.

Despite concerns raised by Congress, the states and the provider and advocacy communities, CMS continues to take steps to implement these regulations. These rules range from limiting payments for public hospitals and hospital outpatient services to reducing school-based services for children and case management for the disabled. The AHA has joined a broad-based coalition of 131 organizations including advocates, educational organizations, hospitals and physicians opposing these regulations. The National Governors' Association also has called for a moratorium on these rules. The following are the regulations that directly affect hospitals.

Regulations under Congressional Moratorium

Last year, Congress imposed a year-long moratorium (P.L. 110-28) on two regulations — the proposed and final cost-limit rule and the proposed graduate medical education (GME) rule. The moratorium on implementation of these rules expires May 25.

Cost-limit Rule. This regulation would restrict payments to financially strapped government-operated hospitals, narrow the definition of "public" hospitals, and restrict state Medicaid financing through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). It would limit reimbursement for government-operated hospitals to the cost of providing Medicaid services to Medicaid recipients. In addition, the rule would restrict states' ability to make supplemental payments to providers with financial need by setting the Medicaid Upper Payment Limit (UPL) for government-operated hospitals at the individual facility's cost.

The rule's restrictive definition of government-operated hospitals would have significant practical implications for public hospitals, particularly those that have restructured to achieve gains in efficiency. This regulation effectively amounts to a cut in funding for those public and safety-net providers that – as CMS recognized – are in stressed financial circumstances and are most in need of enhanced payments. CMS estimates that the rules would result in $5 billion over five years in reduced federal Medicaid spending. These cuts would undermine the ability of states and hospitals to ensure quality of care and access to services for Medicaid beneficiaries, as well as to continue their substantial investments in health care initiatives to promote the Department of Health and Human Services' policy goals, including adoption of electronic health records, reducing disparities in care provided to minority populations, and enhancing access to primary and preventative care.

GME Rule. This proposed rule would eliminate any federal Medicaid support for GME. CMS claims this rule is a clarification, when, in fact, it is a reversal of more than 40 years of agency policy and practice recognizing GME as medical assistance. This rule will result in a cut of nearly $2 billion in federal funds from the Medicaid program. The finalization of this new policy would put many safety-net hospitals in financial jeopardy, ultimately harming the most vulnerable of our citizens covered by the Medicaid program and served by these hospitals.

Regulations That Should be Under a Moratorium

The AHA believes two other CMS proposed rules should be placed under moratoria —the proposed outpatient rule and final provider tax rule.

Outpatient Rule. This proposed rule substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services and how costs for such services are treated for the purposes of calculating the hospital outpatient UPL. Under the proposed rule, the types of services that are at risk for not being reimbursed through hospital outpatient programs include: early and periodic screening and diagnostic treatment dental services for children; physician emergency department services; physical, occupational and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services.

CMS justifies its dramatic shift in policy on the need to align Medicaid outpatient policies with Medicare outpatient polices. However, these programs serve very

different populations. Medicaid serves a largely pediatric population, while Medicare serves an elderly population. Yet despite these differences, CMS proposes to narrowly define Medicaid hospital outpatient services to align Medicaid with Medicare. The effect of aligning the hospital outpatient policies for these two programs would be to limit Medicaid federal spending for hospital outpatient programs and state Medicaid programs overall and ultimately the number of patients served by Medicaid.

Provider Tax Rule. This final rule would make changes to Medicaid policy on health care-related taxes used by the states to help support their share of Medicaid expenditures. The AHA specifically objects to CMS' changes to the standards for determining whether an impermissible hold-harmless arrangement exists within a health care-related tax. The rule represents a substantial departure from long-standing Medicaid policy by imposing largely subjective, overly broad standards for determining the existence of hold-harmless arrangements. These policy changes would create great uncertainty for state governments and providers, making it difficult for them to adopt or implement Medicaid health care-related tax programs with reasonable assurance that they are compliant, and leaving them unreasonably open to after-the-fact challenges. In addition, the vaguer and broader standards CMS proposes would unduly limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

AHA View

Hospital and state Medicaid programs are reeling under the weight of these new regulatory policy decisions, and Congress and the general public have been largely excluded from the decision making process. CMS' regulatory budget-cutting policies will have a devastating effect on state Medicaid programs, along with the hospitals and physicians serving our nation's most vulnerable population – poor children and mothers, the disabled and elderly individuals. The current fiscal crisis faced by states demands immediate attention and should include extension of the current moratorium, as well as the application of additional moratoria to rules resulting in deep reductions in Medicaid spending and an increase in the federal Medicaid matching percentage.

On Capitol Hill. Much of Congress has expressed opposition to these rules. Legislation to extend the moratorium for an additional year on these Medicaid cuts has strong bipartisan support in the House and Senate. We applaud those leaders in Congress who have supported our efforts to date.

- *The Protecting the Medicaid Safety Net Act* (H.R. 5613) would extend until March 31, 2009 the moratorium on several Medicaid regulations that would strip an estimated $20 billion over five years from the program. Introduced by Reps. John Dingell (D-MI), chairman of the House Committee on Energy and Commerce, and Tim Murphy (R-PA), also a member of the committee, the bill delays implementation of regulations affecting: CPEs; IGTs; GME; coverage of rehab services for people with disabilities; outreach and enrollment in schools,

in addition to specialized medical transportation to school for children covered by Medicaid; coverage of hospital outpatient services; case management services that allow people with disabilities to remain in the community; and state provider tax laws.

- Additional legislation (S. 2460/H.R. 3533), introduced by Sens. Jeff Bingaman (D-NM) and Elizabeth Dole (R-NC) and Reps. Eliot Engel (D-NY) and Sue Myrick (R-NC), would extend the current moratorium preventing CMS from moving forward with some of the pending Medicaid regulations, specifically those affecting IGTs, CPEs and GME payments.

In the Courts. On March 11, the AHA, National Association of Public Hospitals, the Association of American Medical Colleges and the Alameda County (CA) Medical Center, along with the support of several other hospitals and the National Association of Children's Hospitals, filed suit in the U.S. District Court for the District of Columbia to prevent the Bush administration from putting in effect the Medicaid regulation that would cut some $5 billion in funding by restricting how states fund their Medicaid programs and pay public hospitals. The grounds of the suit are: CMS has overstepped its authority in dictating to states the governmental status of entities within their jurisdiction; Congress has barred the agency from imposing a cost limit on Medicaid payments to governmental providers; and CMS improperly issued the rule on the very day – May 25, 2007 – that a congressional moratorium took effect blocking the rule for one year.

The AHA will continue its efforts to have Congress and the federal court stop CMS' harmful rules.