

Medicaid

Background

For nearly 45 years, Medicaid has served as the nation's health care safety net, providing access to health services for millions who cannot afford private insurance. Today, more than 59 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, 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. On a national level, the Medicaid payment shortfall amounted to \$10.4 billion in 2007. That means Medicaid paid only 88 cents for every dollar spent treating Medicaid patients. In addition, hospitals, in 2007, provided care at a cost of \$34 billion for which no payment was received.

The demand for Medicaid services only will increase as the nation struggles under the weight of the current economic recession. State governments face increased enrollment and funding pressures at a time when budgets are stretched thin. Forty-seven states have reported budget shortfalls for the current fiscal year (FY) or projected budget shortfalls for FY 2010. Policy experts estimate that a one percentage point increase in unemployment increases enrollment in Medicaid and the Children's Health Insurance Program (CHIP) by one million lives. According to many economists, unemployment could reach 10 percent by the year 2010, putting more pressure on America's hospitals as they struggle to serve the growing numbers of uninsured.

ECONOMIC RECOVERY

Medicaid Funding. Among the top priorities for President Obama and Congress is tackling the complex issues of economic recovery. On February 17, President Obama signed into law the *American Recovery and Reinvestment Act of 2009* (ARRA). The \$787 billion legislation included \$87 billion for state Medicaid programs through a temporary increase in the Medicaid matching funds, known as the Federal Medical Assistance Percentage (FMAP). This temporary FMAP increase is available to states for nine fiscal quarters beginning on October 1, 2008, through December 31, 2010. All states will receive an increase in their current federal matching rate of 6.2 percent. States will receive additional federal funds (bonus funds) through the matching rate based on the state's rate of increase in unemployment. These bonus funds are approximately 35 percent of the \$87 billion. State eligibility for these temporary Medicaid funds is tied to several requirements. States:

- Must maintain Medicaid eligibility criteria as of July 1, 2008;
- Must meet prompt pay requirement for hospitals and nursing homes;
- Cannot spend ARRA funds on new populations with eligibility criteria above July 1, 2008 levels; and
- Cannot bank ARRA funds in state rainy day funds.

According to the ARRA, states are required to report to the Secretary of Health and Human Services (HHS) on how the temporary FMAP funds are spent. The Office of the Inspector General also will monitor state FMAP spending. Finally, the Government Accountability Office will report to Congress their findings and policy recommendations by April 1, 2011. This report will examine the health care needs and pressures experienced by state Medicaid programs during periods of economic downturn.

In addition to the temporary increases in FMAP, the ARRA will increase federal funds to the state Medicaid disproportionate share hospitals (DSH) allotments by 2.5 percent for FY 2009 and FY 2010. Eligibility for the temporary increase in DSH allotments funds will depend on whether the state has fully expended its current DSH allotment.

Medicaid 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 the patients they serve. The AHA, working with a broad-based coalition of 131 organizations including advocates, educational groups, hospitals and physicians, succeeded delaying implementation of these rules through congressionally imposed moratoria. In 2008, the AHA expanded its advocacy to include litigation. In collaboration with Alameda County (CA) Medical Center, the National Association of Public Hospitals, the Association of American Medical Colleges, the National Association of Children's Hospitals, and several other hospitals, the AHA brought suit in federal court to challenge the Bush Administration's plans to implement new Medicaid regulations that would limit how states fund their Medicaid programs and pay public hospitals, and HHS' surreptitious effort to avoid the congressionally enacted moratorium on the Medicaid rules. The federal court ruled in favor of the AHA, the hospitals and hospital associations in agreeing that HHS had violated the congressionally-imposed moratoria.

Concerns over these rules continue. The ARRA did address these rules in part. The bill extends moratoria for three of the original six Medicaid regulations – provider taxes, targeted case management and school-based transportation services – from March 31 through June 30. The bill also places a moratorium on the Medicaid regulation for hospital outpatient services through June 30. These provisions are estimated to cost \$105 million. For the remaining three rules that were part of the original moratoria, the ARRA includes a *Sense of the Congress* that the Secretary of HHS should not promulgate, as final, rules concerning cost-limits for public hospitals, elimination of graduate medical education payments and coverage of rehabilitation services.

If finalized, these rules will disrupt existing funding systems on which hospitals depend to provide care to Medicaid and uninsured patients, to provide access to

specialty services to all members of their communities, and to train our future physicians and nurses. As a result, the hospital community, along with states and beneficiaries, has opposed these regulations, as expressed in the numerous comment letters CMS received. Congress has shared these concerns by passing several delays in the implementation of these rules. A more complete explanation of the hospital-related rules follows:

- **Medicaid Outpatient Rule:** This final rule substantially departs from long-standing Medicaid policy regarding the definition of Medicaid outpatient hospital services. Under the rule, the types of services that are at risk for not being reimbursed through hospital outpatient programs include Medicaid's 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 stated that it based its dramatic shift in policy on the need to align Medicaid outpatient policies with Medicare outpatient policies. However, these programs serve different populations; Medicaid serves a largely pediatric population while Medicare serves an elderly population. Yet despite these differences, CMS would 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 patients served by Medicaid.

- **Medicaid Cost-limit Rule:** The cost-limit rule 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 also would limit reimbursement for government-operated hospitals and restrict the ability of states to make supplemental payments to providers through the Medicaid upper payment limit (UPL). It would cut funding for public and safety-net providers that are in stressed financial circumstances and are most in need of adequate payments.
- **Medicaid Graduate Medical Education (GME) Rule:** This proposed rule would eliminate any federal Medicaid support for GME. While CMS claims that this rule is a clarification, it is in fact a reversal of more than 40 years of agency policy and practice, would cut nearly \$2 billion in federal support for training physicians when the demand for health care professionals is high and puts safety-net hospitals in financial jeopardy.
- **Medicaid Provider Tax Rule:** The Medicaid provider tax final rule would change Medicaid policy on health care-related taxes. Specifically, the rule's

hold-harmless changes would make it difficult for states to adopt or implement health care-related tax programs with reasonable assurance that they are compliant with federal rules. The vaguer and broader standards CMS proposes would limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent.

- **Medicaid DSH Reporting and Auditing Regulation:** On December 19, 2008, CMS issued the final rule for implementing the Medicaid DSH reporting and auditing requirements in the *Medicare Modernization Act of 2003* (MMA). The rule took effect January 19. While the AHA advocates for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the final rule fails to achieve these goals and makes substantive policy changes that exceed congressional intent. The rule alters the definition of uncompensated care to largely exclude both bad debt and physician services, despite the fact that the MMA left the underlying law governing DSH limits in place, and that Congress expressed no concern about the calculation of uncompensated care costs. The policy changes to the Medicaid DSH program, which is a lifeline to many safety-net hospitals across the country, will have a significant negative impact on these institutions. The rule should be withdrawn.

AHA View

The ARRA responded, in part, to the current fiscal crisis faced by state Medicaid programs with a temporary infusion of federal funds through FMAP and DSH. The bill also responded by putting on a temporary brake to the CMS's harmful rules. More advocacy, however, is necessary.

Holding States Accountable. States must be held accountable for how they spend the additional federal funds provided by the ARRA. The AHA will work with state hospital associations and our members to make certain those funds are spent on health care-related services for the Medicaid population. Further, the AHA will monitor state spending to advocate for important changes in the future such as maintenance of effort for provider payments when the federal government provides states with additional funds during periods of economic downturns.

Reversing Course on Bad Regulations. CMS Medicaid 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 populations – poor children and mothers, the disabled and elderly individuals. We must ensure continued access for those most in need. **The AHA will continue to urge the Obama Administration to withdraw the following five Medicaid rules:**

- The rule to limit Medicaid reimbursement for hospital outpatient services;
- The rule to eliminate graduate medical education funding;
- The rule to limit payment to public providers to cost and restrictions on IGTs; CPE and UPL;
- The rule to restrict provider tax programs; and
- The rule to implement changes to the Medicaid DSH auditing and reporting.