American Hospital Association

Protecting the Promise of Care

Medicaid

Background

For 45 years, Medicaid has provided health coverage for millions of the nations' poor and vulnerable population. Today, more than 59 million children, poor, disabled and elderly individuals rely on Medicaid for care. The recently passed *Patient Protection and Affordability Act* (PPACA) will add 16 million more to its rolls by 2019.

Enormous changes face the Medicaid program in the years ahead including expansions in the number of people served and pressures to reform payment systems and care delivery. As these transformations take place, it is important not to overlook the key role hospitals play in serving Medicaid and other vulnerable populations. 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 have long been 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 2008. That means Medicaid paid only 89 cents for every dollar spent treating Medicaid patients. In addition, hospitals, in 2008, provided care at a cost of $36.4 billion for which no payment was received. And while hospitals' uncompensated care burdens will fall as coverage – both public and private – expands, the issues around Medicaid payment shortfalls are not solved by coverage expansions alone.

The Medicaid caseload increased by 3.3 million people between June 2008 and June 2009 demonstrating the increased demand for Medicaid services as a result of the nation's economic recession. And while national economic indicators are beginning to point to an end of the recession, economists project that states will not feel the effects of the recovery for one to two more years. State governments face increasing enrollment and declining state revenues in addition to other funding pressures at a time when Medicaid budgets are stretched thin.

Forty-seven states have reported current budget shortfalls for fiscal year (FY) 2010. Twenty-nine states reported that cuts to provider payments and benefits top their list of reductions. The state budget forecasts for FY 2011 look even more challenging. According to White House economists, unemployment is expected to average 10 percent in 2010, adding more people to the rolls of the uninsured and putting more pressure on America's hospitals.

AHA View

Medicaid Funding. Among the top priorities for President Obama and Congress is promoting economic recovery. President Obama signed the *American Recovery and Reinvestment Act of 2009* (ARRA) into law last year. The $787 billion legislation included $87 billion for state Medicaid programs through a temporary increase in 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. By all accounts, the ARRA funds have helped to shore up state budgets, but the fiscal pressures continue along with projected high unemployment rates. Extending ARRA FMAP for an additional six months, until June 30, 2011, is critically important. On March 1, Senate Finance Committee Chairman Max Baucus (D-MT) offered a substitute amendment to the *American Workers, State and Business Act of 2010* (H.R. 4213) – one of the Senate's "jobs" bills – which included this essential FMAP language. The Senate passed this legislation on March 10. The House included a similar FMAP extension as part of its version of H.R. 4213, which passed in December 2009. The AHA urges Congress to finish work on H.R. 4213 to support these important programs.

Medicaid and CHIP Payment and Access Commission. The 2009 Children's Health Insurance Program (CHIP) reauthorization legislation established a new commission to review payment policies under Medicaid and CHIP and how they affect access to services. This new federal commission, known as the Medicaid and CHIP Payment and Access Commission (MACPAC), will function in a capacity similar to the way in which the Medicare Payment Advisory Commission (MedPAC) provides recommendations to Congress on the Medicare program. This marks the first time that Congress will have an independent body to review Medicaid and CHIP provider payments. The PPACA expands the mission of MACPAC to look at payment for all Medicaid services provided to adults as well as children.

Medicaid Disproportionate Share Hospital Program. The Medicaid disproportionate share (DSH) program provides payments to hospitals that serve disproportionate numbers of poor Medicaid and uninsured patients. Since the PPACA will expand coverage to 32 million uninsured, Medicaid DSH payments have been a target for payment reductions. The President's 2011 budget called for a 90 percent reduction in DSH payments and the Senate health reform bill reduced payments by $18 billion. The final PPACA provision reduces DSH payments by $14 billion from 2014 through 2019. The Secretary of Health and Human Services (HHS) is instructed to look at the percentage of a state's reduction in the uninsured, and whether a state targets DSH funds to hospitals with high Medicaid volumes or uncompensated care when making DSH allocation decisions.

Medicaid DSH Auditing Regulation. On December 19, 2008, the Centers for Medicare & Medicaid Services (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, 2009. While the AHA advocates for greater transparency in the operation of the Medicaid DSH program and more consistent federal standards, the final rule not

only fails to achieve these goals but also makes substantive policy changes that exceed congressional intent. The rule alters the definition of uncompensated care to largely exclude traditionally counted elements, such as bad debt and physician services. 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 by reducing the amount of DSH payments to these hospitals. The AHA supports the *Medicaid DSH Integrity Act* (H.R. 4250/S.2984), sponsored by Rep. Charlie Melancon (D-LA) and Sen. Mary Landrieu (D-LA), which directs CMS to not implement the portions of the rule that would change the definition of DSH-allowable costs and narrow the scope of DSH payments made to hospitals.

Medicaid Integrity Program. Congress, through the *Deficit Reduction Act* (DRA) of 2005, directed CMS to establish the Medicaid Integrity Program (MIP). Congress specifically directed CMS to perform the following key program integrity activities: review provider actions; audit claims; identify overpayments; and educate providers, managed care entities, beneficiaries and others with respect to payment integrity and quality of care.

CMS has awarded umbrella contracts with several contractors to perform these functions. These contractors are known as the Medicaid Integrity Contractors (MICs); there are three types of MICs: Review MICs, Audit MICs and Education MICs. CMS' overall approach is to build on existing state law and regulation regarding provider audits. The audit contractors that have direct contact with hospitals and other providers are the audit MICs which perform field and desk audits using Generally Accepted Government Auditing Standards.

The first audits began in 2008 and there are currently 31 state programs that are subject to review. This year, the rollout will expand to the remaining states and U.S. territories. A number of problems have been raised since the MIP began, such as:

- No limit on the number of medical records that can be requested;
- Poor communication between the Audit MIC and the provider; and,
- No provider education in advance of the audits.

The PPACA expands the Medicare Recovery Audit Contractor (RAC) program and its contingency fee-based approach to the current MIP program. Concerns raised by the AHA were noted in a recent Government Accountability Office report on the RAC program. The report concluded that CMS has failed to take the appropriate steps to prevent improper Medicare payments, one of the program's primary objectives. Also noted were problems related to the program's

contingency fee payment structure, poor oversight of RAC determinations and administrative burden. The AHA will work to address the implementation of RACs in the Medicaid program, along with hospital concerns about the operation of the MIP.