



American Hospital  
Association

## Medicaid

### Background

Today, more than 59 million children, poor, disabled and elderly individuals rely on the Medicaid program for their health care. By 2019, the Medicaid program will add 16 million more to its rolls as a result of the expansions included in the *Patient Protection and Affordable Care Act (ACA)*.

Hospitals provide 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 average, Medicaid covers only 89 cents for every dollar spent treating Medicaid patients. In addition, hospitals, in 2009, provided care to patients at a cost of \$39.1 billion for which no payment was received. And while hospitals' uncompensated care burdens should partially decline as coverage – both public and private – expands, Medicaid payment shortfalls will not.

Moreover, with state governments facing budget shortfalls, governors and state legislatures are turning to Medicaid spending reductions to address looming deficits, while others are seeking greater flexibility in managing their programs. In addition, President Obama, in his fiscal year (FY) 2012 budget, proposes cutting federal Medicaid spending by \$33 billion.

### AHA View

To meet the challenges of the future, the Medicaid program will have to undergo a transformation. But reducing eligibility and provider payments, while adding burdensome oversight, are short-term budget savings tools that may impede this change. The AHA is pursuing the following key initiatives to protect hospitals.

**Coverage.** The ACA expands Medicaid eligibility to all legal residents earning up to 133 percent of the federal poverty level (FPL), about \$14,404 for a single adult or \$29,327 for a family of four. The federal government will largely finance this expansion. The Congressional Budget Office estimates that half of the 32 million newly insured under the ACA will get their coverage through the Medicaid expansion. States are required to maintain levels of Medicaid eligibility in place as of March 23, 2010. States that have already expanded coverage to 133 percent of the FPL and beyond can seek a waiver from this requirement if they can demonstrate hardship. Many governors say they lack sufficient funds to maintain current levels of Medicaid eligibility, and are seeking relief as they prepare for a significant expansion in the program slated for 2014. In addition, several governors and members of Congress are looking to repeal or modify the Medicaid Maintenance of Effort provision.

**The AHA has urged Congress not to reduce Medicaid coverage**, as this would push some low-income Americans off the Medicaid rolls and into the ranks of the uninsured.

**Provider Tax Programs.** The Medicaid provider tax program over the years, has allowed state governments to expand coverage, fill budget gaps and maintain access to health services by reducing proposed payment cuts. The President's budget proposal to cut \$18.4 billion over 10 years by lowering the tax rate cap from its current level to 3.5 percent will put enormous pressure on already stretched state Medicaid budgets and could potentially jeopardize this critical safety-net program, just as states prepare to expand eligibility to comply with the ACA. The AHA has strongly urged Congress not to restrict this important funding mechanism for the states.

**Medicaid DSH Program.** The Medicaid Disproportionate Share Hospital (DSH) program provides payments to hospitals that serve disproportionate numbers of Medicaid and uninsured patients. The ACA reduces DSH payments by \$14 billion from 2014 through 2019, when its coverage expansions take effect. When making DSH allocation decisions, the HHS Secretary 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. The AHA will carefully monitor this process. At the same time, the AHA believes Congress should revisit the DSH cuts included in the ACA.

**Medicaid DSH Auditing Regulation.** On December 19, 2008, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for implementing the Medicaid DSH reporting and auditing requirements in the *Medicare Modernization Act of 2003*. While the AHA supports 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 makes substantive policy changes that exceed congressional intent. Specifically, the rule alters the definition of uncompensated care to largely exclude traditionally counted elements, such as bad debt and physician services. These policy changes will reduce DSH payments to many hospitals that rely on these funds to provide services to the uninsured. The AHA continues to advocate for additional changes including how uninsured and under-insured, and physician costs are counted, as well as bad debt. CMS has committed to addressing the definition of underinsured costs and will be announcing this policy change sometime in 2011. **The AHA continues to advocate for flexibility and further policy changes in the definition of allowable costs.**

**Medicaid RAC Program.** The ACA expands Medicare's Recovery Audit Contractor (RAC) program and its contingency fee-based approach to the Medicaid program. The program will run alongside the established audit-based Medicaid Integrity Program (MIP). While there are differences between the Medicare and Medicaid programs, many Medicare RAC policies, such as a new audit issue review process and medical record request limits, are applicable to the Medicaid RAC program. The AHA has raised concerns about Medicaid RACs engaging in the same overzealous and aggressive payment denial patterns

seen when RACs were first introduced to Medicare, and recommends that the proposed Medicaid RAC rule be revised to require CMS, state Medicaid agencies and the RACs to use program findings to educate providers and implement payment system fixes to avoid billing mistakes before they are made. CMS has delayed the April 1, 2011 implementation date for the RAC program. The AHA will continue to work to address hospitals' concerns with implementation of RACs in Medicaid, as well as the operation of the MIP. The AHA will also urge CMS to allow states to use an existing RAC-like auditing program instead of adding a new RAC process.

**340B Drug Discount Program.** Safety-net hospitals depend on the 340B drug discount program to provide pharmacy services to some of their most vulnerable patients. The program is available only for outpatient services provided at DSH hospitals – it is not available for pharmacy services provided to inpatients at these hospitals, which often have poor financial health. While the AHA is pleased that, under the ACA, Congress expanded eligibility for the discount drug prices available under the program to critical access hospitals and certain sole community hospitals (SCHs) and rural referral centers (RRCs) for outpatient services, the ACA expansion did not go far enough. The AHA is working to ensure that the 340B program is expanded to inpatient drugs, for all hospitals, including Medicare-dependent hospitals and all SCHs and RRCs. The AHA successfully advocated for the 340B technical correction that passed last year that restores the ability of children's hospitals to receive 340B discounts on orphan drugs, retroactive to the date of enactment of the health care reform law.