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 enrollees 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 a little over 92 cents for every dollar spent treating Medicaid patients. In addition, hospitals, in 2010, provided care to patients at a cost of $39.3 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. Some other governors are seeking greater flexibility in managing their programs. In addition, President Obama, in his fiscal year (FY) 2013 budget, seeks to cut federal Medicaid spending by $51 billion, with proposals to reduce spending on provider assessments, limit spending on durable medical equipment, institute a federal medical assistance percentage (FMAP) blend, and implement fraud and abuse initiatives.

AHA View

To meet the challenges of the future, the Medicaid program must undergo a transformation. But reducing eligibility and provider payments, while adding burdensome oversight, are short-term budget savings tools that may impede 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 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 have expressed concerns that they lack sufficient funds to maintain current levels of Medicaid eligibility, and continue to argue for greater flexibility as they prepare for a significant expansion in the program slated for 2014. In addition, several governors and members of Congress are looking to make significant changes in the Medicaid program, such as converting it into a block grant program to give states greater flexibility to manage their own programs.

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

Blended Federal Medicaid Matching Rate. President Obama's FY 2013 budget includes a provision that would replace the various Medicaid federal matching percentages applied to spending for different populations (such as traditional Medicaid, Children's Health Insurance Program (CHIP) and the expansion population) with a single matching rate specific to each state to reduce administrative complexity and federal spending.

The Medicaid program and CHIP are jointly financed by the federal and state governments using a formula that matches state dollars spent with federal dollars. Under current law, states face a patchwork of different matching formula rates for individuals eligible for Medicaid and CHIP. Specifically, state Medicaid expenditures are generally matched by the federal government using FMAP; CHIP expenditures are matched with enhanced FMAP (eFMAP); and the ACA provides an increased FMAP for newly eligible individuals and certain childless adults beginning in 2014. Under the president's budget, beginning in 2017, these formulas would be replaced with a single matching rate specific to each state that automatically increases if a recession forces enrollment and state costs to rise. This proposal saves $17.9 billion over 10 years.

To achieve savings, the president's proposal would set the blended rate below the combined effect of the various federal matching rates a state would otherwise receive. One area of concern with this proposal is that it would shift more and more of the financing of the Medicaid and CHIP programs to states. Also, in order to develop a blended FMAP for each state, the federal government would have to make assumptions about a state's future enrollment in Medicaid and CHIP, including the ACA-expanded population. Such assumptions would be estimates and not based on a state's actual experience. Thus, this proposal becomes another way for the federal government to achieve savings and shift costs to the states.

Provider Tax Programs. The Medicaid provider tax program has allowed state governments to expand coverage, fill budget gaps and maintain access to health services by reducing proposed provider payment cuts. The president's budget proposal cuts $22.8 billion over 10 years by lowering the tax rate cap from its current level of 6 percent to 3.5 percent in 2017 and beyond. This change would 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 Health and Human Services 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, particularly if the coverage expansions envisioned in the ACA are not achieved.

Medicaid DSH Auditing Regulation. Earlier this year, the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Medicaid DSH reporting and auditing requirements that have governed the program since 2009. The AHA supports greater transparency and accountability in how the state Medicaid DSH programs function and believes the Medicaid DSH audit program could be a useful tool toward that end. However, the AHA has repeatedly expressed concern about CMS's implementation of the audit program, particularly with respect to how unreimbursed costs are defined. The AHA is pleased that in this proposed rule, CMS begins to address some of those concerns through changes in the definition of uninsured and the clarification that all costs incurred in providing hospital services to Medicaid patients should be counted. In particular, the AHA strongly supports the agency's proposal to allow unreimbursed costs for those individuals with minimal health care coverage in the determination of the hospital-specific DSH limit. T**he AHA continues to urge CMS to make further clarifications and modifications to the definition of uninsured and uncompensated care costs specifically with respect to the unreimbursed cost of hospital-based physician services and unpaid high-deductible copayments.**

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 these hospitals – it is not available for pharmacy services provided to inpatients who 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 (CAHs) and certain sole community hospitals (SCHs) and rural referral centers (RRCs) for outpatient services, the ACA expansion did not go far enough.

The AHA supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays and opposes any attempts to scale back this vital program. Reps. Cathy McMorris Rodgers (R-WA), Bobby Rush (D-IL) and Jo Ann Emerson (R-MO) have introduced the *340B Improvement Act* (H.R. 2674), which would extend the 340B drug discount program to the

inpatient setting for safety-net hospitals, CAHs, SCHs, RRCs and Medicare-dependent hospitals. Importantly, this legislation also would repeal the orphan drug exclusion and allow rural and free-standing cancer hospitals access to discounted pharmaceuticals through the 340B program.

340B eligible hospitals are the safety net for their communities. Expanding the program would allow these hospitals to further stretch their limited resources and relieve them of the burden of carrying two separate inventories and pricing structures for inpatient and outpatient drugs.

In addition, expansion of the program would be a "win-win" for taxpayers, as well as for hospitals. Expanding the 340B program would generate savings for the Medicaid program by requiring hospitals to rebate Medicaid a percentage of their savings on inpatient drugs administered to Medicaid patients. This change also would reduce Medicare costs, as CAHs are paid 101 percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism will lower CAHs' drug costs. According to the Congressional Budget Office, expanding the program to cover inpatient services would save the federal government upwards of $1.2 billion.