



Medicaid

Background

Today, more than 69 million children, and poor, disabled and elderly individuals rely on the Medicaid program for their health care. By 2022, the Medicaid program is expected to add 12 million more enrollees as a result of the expansions included in the *Patient Protection and Affordable Care Act (ACA)*. This is 4 million fewer Medicaid beneficiaries than originally projected by the Congressional Budget Office (CBO) due to the U.S. Supreme Court's 2012 ruling that the federal government could not require states to expand their programs or risk losing all of their Medicaid funding.

Hospitals provide care to all patients who come through their emergency departments, regardless of ability to pay. But hospitals experience severe payment shortfalls when treating Medicaid patients. In 2011, on average, hospitals were paid 95 cents for every dollar spent treating Medicaid patients. In addition to this payment shortfall, hospitals in 2011 also shouldered the burden of providing \$41.1 billion in care for the poor and uninsured for which no payment was received (uncompensated care). And while hospitals' uncompensated care burdens should partially decline as insurance coverage – both public and private – expands, Medicaid payment shortfalls will persist.

Moreover, the sluggish economy has many governors and state legislatures considering additional Medicaid spending reductions to address looming deficits. Many governors also are seeking greater flexibility in managing their programs to rein in costs. In addition, the administration and some in Congress have proposed cuts to federal Medicaid spending. These include proposals to reduce spending on provider assessments, limit spending on durable medical equipment, implement fraud and abuse initiatives and convert the basic program to a block grant program.

AHA View

To meet the challenges of the future, the Medicaid program must be transformed. But reducing provider payments and limiting states' ability to finance their share of the Medicaid program, 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 required that states expand Medicaid eligibility to all legal residents earning up to 133 percent of the federal poverty level (FPL) (138 percent of FPL with a 5 percent income disregard), or about \$15,282 for a single adult and \$31,322 for a family of four, with the federal government largely financing this expansion. CBO, shortly after the passage of the ACA, projected that up to 16 million people would receive coverage through the Medicaid program, or about half of the estimated 32 million individuals gaining health care coverage through the ACA. The Supreme Court's decision, however, changed that trajectory

by giving states the option to expand their Medicaid program. As a result, CBO's coverage estimates fell to 12 million individuals who will receive their coverage through the Medicaid expansion. As of March 2013, 25 governors support expanding their Medicaid programs to take advantage of the federal government fully financing the first three years of coverage for the expansion population.

Medicaid Disproportionate Share Hospital (DSH) Program. The Medicaid DSH payment program provides supplemental payments to hospitals that serve a disproportionate number of low-income patients. The ACA reduces DSH payments, starting in 2014, to reflect the expected decrease in uncompensated care as reform increases the number of patients with health insurance. The reduction for fiscal year (FY) 2014 is \$500 million. Since the ACA, Congress has passed two additional laws impacting Medicaid DSH. *The Middle Class Tax Relief and Job Creation Act of 2012* included reducing DSH allotments for FY 2021 for a savings of \$4.1 billion over 10 years. And, the *American Taxpayer Relief Act of 2012* extended the ACA Medicaid DSH payment reductions through FY 2022 for a savings of \$4.2 billion over 10 years.

CMS is expected to issue a proposed rule in spring 2013 outlining how to implement the DSH reductions. In distributing the DSH reduction, the secretary of Health and Human Services must give consideration to states based on three existing categories: High-DSH States; Low-DSH States; and 1115 Waiver Expansion States. The secretary also must take into consideration two factors: a state's percentage of remaining uninsured; or whether a state targets DSH payments to hospitals serving a high volume of Medicaid inpatients and hospitals that have high levels of uncompensated care.

Working closely with the state hospital associations, the AHA has adopted principles for implementing the ACA's Medicaid DSH payment provision. The AHA will urge CMS to implement the DSH reduction in a fair and equitable manner, consistent with our principles.

The reductions in Medicaid DSH payments required by the ACA and subsequent legislation were premised on a reduction in the number of uninsured patients as a result of coverage expansion. When the ACA was enacted into law, CBO projected that in 2014, the first year of DSH cuts, the number of uninsured would fall from about 51 million to 31 million. As of February 2013, CBO projects that 44 million will remain uninsured in 2014, a 42 percent increase compared to the 31 million estimated at time of enactment. **Given continued uncertainty regarding whether states will expand Medicaid, as well as questions about how the new exchange marketplace will work and how significant the decline in the uninsured will be, the AHA is urging Congress to delay implementation of the Medicaid DSH reductions for three years, through 2017.**

Medicaid DSH Auditing Regulation. In early 2012, 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 the proposed rule, CMS begins to address some of those concerns through changes in the definition of the 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.

The AHA continues to urge CMS to issue a final rule that includes 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.

Provider Assessment Program. The Medicaid provider assessment program has allowed state governments to expand coverage, fill budget gaps and maintain access to health services by reducing proposed provider payment cuts. Despite its importance to financing state Medicaid programs, there have been recent proposals to scale back the use of provider assessments. The president's FY 2013 budget would have cut \$22.8 billion over 10 years by lowering the assessment rate cap from its current level of 6 percent to 3.5 percent in 2017 and beyond. Last year, House Republicans twice passed legislation that contained a reduction in the allowable assessment from 6 percent to 5.5 percent, which would result in \$11.2 billion in cuts to the Medicaid program. Any loss of funding from provider assessments 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 strongly urges Congress not to restrict the use of provider assessments by the states.**

340B Drug Discount Program. Section 340B of the *Public Health Service Act* requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. Covered entities include community health centers, children's hospitals, hemophilia treatment centers, and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations. Safety-net and rural hospitals act as the health care safety net for their communities and depend on the 340B drug discount program to provide pharmacy services to their most vulnerable patients. The 340B program allows these hospitals to stretch their limited resources.

Currently, 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), certain sole community hospitals (SCHs) and rural referral centers (RRCs) for outpatient services, the ACA expansion did not go far enough. In addition, expanding the program would relieve 340B hospitals from the burden of carrying two separate pharmaceutical inventories and pricing structures for inpatient and outpatient drugs.

The expansion of the program also is good for taxpayers. 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 CBO, expanding the program to cover inpatient services would save the federal government upwards of \$1.2 billion.

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. In addition, while AHA supports 340B program integrity efforts to make sure that covered entities comply with the program requirements, we urge the Health Resources and Services Administration (the agency with oversight of the 340B program) to work with hospitals on any compliance issues identified.