

## Medicaid

### Background

Today, nearly 70 million children, poor, disabled and elderly individuals rely on the Medicaid program for their health care. By 2022, the Medicaid program is expected to add 13 million more enrollees as a result of the expansions included in the Affordable Care Act (ACA). This is 4 million fewer Medicaid individuals 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 doors, regardless of ability to pay; however, hospitals experience severe payment shortfalls when treating Medicaid patients. In 2012, on average, hospitals were paid 89 cents for every dollar spent treating Medicaid patients, according to AHA survey data. In addition to this payment shortfall, hospitals also shouldered the burden of providing \$45.9 billion in care for the poor and uninsured for which no payment was received (uncompensated care). And while hospitals' uncompensated care burdens may partially decline as insurance coverage – both public and private – expands, Medicaid payment shortfalls will persist.

Moreover, with many state governments continuing to face budget shortfalls during a slowly recovering economy, governors and state legislatures often make Medicaid spending reductions to address looming deficits. Many governors also are seeking greater flexibility in managing their programs in order to rein in costs. In addition, cuts to federal Medicaid spending are being discussed by Congress. Some proposals being discussed would reduce spending on provider assessments, limit spending on durable medical equipment, rebase Medicaid Disproportionate Share Hospital (DSH) allotments, implement fraud and abuse initiatives and change the basic program to a per-capita-cap system.

### AHA View

To meet the challenges of the future, the Medicaid program must be transformed. However, 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 initiatives, among others, to improve coverage and prevent funding cuts to these programs.

**Coverage through Hospital-based Presumptive Eligibility.** The ACA provides hospitals with a new opportunity to help potentially eligible Medicaid patients gain health coverage. This new opportunity, called presumptive eligibility determination, allows hospitals to temporarily enroll patients into Medicaid coverage with a few basic pieces of information, such as income and household size, at the point of service. For patients, it means they will have Medicaid coverage in the hospital, as well as after they are discharged. The AHA has been actively educating members on presumptive eligibility through tools and resources that can be found at [www.aha.org/GetEnrolled.org](http://www.aha.org/GetEnrolled.org). The AHA also has been working with our members and state hospital associations to address implementation

issues with the Centers for Medicare & Medicaid Services (CMS) regulations, such as hospitals' ability to use enrollment and eligibility service vendors to assist in presumptive eligibility determinations. At the AHA's request, in early 2014 CMS issued clarification of the eligibility service vendor issue, allowing hospitals to continue to use service vendors to assist them in making Medicaid presumptive eligibility determinations.

**Medicaid DSH Payment Cuts.** The Medicaid DSH payment program provides supplemental payments to hospitals that serve a disproportionate number of low-income patients. In the ACA, the DSH payment reductions were scheduled to start in FY 2014 and reflected the assumption that there would be a decrease in hospital uncompensated care as reform increased the number of patients with health insurance. However, the coverage expansions envisioned in the ACA are projected to be lower than what was expected. As a result, the AHA successfully urged Congress to delay the start of the Medicaid DSH cuts for three years, until FY 2017.

**Medicaid DSH Rebasing – Extending DSH Cuts.** The ACA Medicaid DSH cuts were scheduled to end in FY 2020. However, over the past few years, Congress repeatedly has extended these Medicaid DSH reductions to offset short-term legislative fixes for the Medicare physician payment formula. In fact, the Protect Medicare Access Act of 2014 extended the ACA Medicaid DSH payment reductions through FY 2024 for a savings of \$4.4 billion. **The AHA opposes using cuts to the Medicaid DSH program to pay for other Medicare spending.**

**Medicaid DSH Auditing Regulation.** In 2012, CMS issued 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 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 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 to be included 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 avoiding proposed provider payment cuts. Despite its importance to financing state Medicaid programs, there have been proposals, in recent years, to scale back the use of provider assessments. 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 as states work to expand Medicaid eligibility.

**The AHA continues to strongly urge Congress and the administration not to restrict states' use of provider assessments.**