

State Cutbacks to Medicaid May Hit Hospitals Hard

New Federal Reductions Might Compound the Stress

Stephen Barlas

Illinois hospitals swallowed a bitter pill on June 14 when Democratic Governor Pat Quinn signed the Saving Medicaid Access and Resources Together (SMART) Act. That bill and four other associated pieces of legislation aimed to cure what ails the state Medicaid program, which has been on the financial critical list with a \$2 billion a year structural deficit. In order to do so, the bill lasered \$1.6 billion per year off state Medicaid costs. Some of that was in the form of 62 benefit reductions, and some of that was in the form of reduced payments to for-profit hospitals (3.5%) as well as safety-net hospitals and critical access rural hospitals (2.7%).

The SMART Act left pharmacies smarting. The pharmacy industry agreed to some reductions back in April 2012, when Governor Quinn first announced his package. Negotiations with medical providers continued through the spring. Danny Chun, Vice President of Communications for the Illinois Hospital Association, says that pharmacies had then agreed to a second round of reductions, much to the industry's dismay. The final bill restricts Medicaid recipients to four prescriptions per month; terminates Illinois Cares Rx; and increases copays to the federal maximum for pharmaceuticals, among other new restrictions.

The cancellation of Illinois Cares Rx underlines the ripple effect of the Medicaid benefit reductions being announced by many states. This program subsidized prescription costs for some seniors through Medicare Part D.

Illinois' Medicaid program may be more financially troubled than programs in some other states, although other states have also been whacking away at payments to hospitals and cutting pharmacy and other benefits. Florida reduced Medicaid payments to its hospitals by 12% in July 2011 and instituted an additional 5.6% cut in July 2012.

Cuts in state Medicaid payments to Florida hospitals have forced Sarasota Memorial Hospital to squeeze its nickels and dimes, if not its pennies. Sarasota treats 90% of the Medicaid recipients in its area, and these individuals constitute about 9.5% of the hospital's payer mix. The nearly 20% reduction in Florida's Medicaid payments over the previous 2 years comes out to about \$2 million each year in lost revenue for the hospital, according to Bill Woeltjen, Chief Financial Officer (CFO) at Sarasota Memorial. When all direct and indirect costs are thrown into the equation, the hospital is losing \$9 million each year on its Medicaid patients.

"That \$2 million is really critical when you think of the fully absorbed costs," says Mr. Woeltjen. "So far it has not cut into muscle. But we are continuing to look for ways to do more with less."

Maybe the Medicaid payment cuts have not busted the hospital's biceps, but the reductions have led to heavier lifting for fewer people at the hospital's in-patient pharmacy. David

Jungst, RPh, PharmD, BCPS, Director of Pharmaceutical Care Services at Sarasota Memorial, says:

We have definitely had to give up salary dollars and not fill open positions. We took those positions off the books. All my positions are critical. That loss won't affect patient care, but I am worried about anything getting through the cracks, especially when one dose can cost \$10,000 or \$20,000. We cannot take our eyes off the ball.

The financial pressures on the hospitals have forced Dr. Jungst to make some changes, some minor and some major, in the way the pharmacy department handles Medicaid patients.

"Particularly with regard to expensive drugs such as chemotherapy, which today account for about 50% of our drug budget, up from 25% a few years ago, we are trying to provide that drug therapy outpatient, if appropriate, where the Medicaid payment is much better," he notes.

Not only is a lot at stake for hospitals; there is a lot at stake, too, for the 60 million individuals and families who currently qualify for Medicaid. The program provides health coverage for low-income families who lack access to other affordable coverage options; individuals with disabilities for whom private coverage is often not available or adequate; and the elderly, who need long-term-care services and support or assistance in affording Medicare coverage. Total spending for Medicaid was about \$276 billion in 2011. The federal government pays about 57% of the program's costs, and the states pay the remaining 43%. Children and their parents account for 75% of all enrollees, whereas the elderly and disabled account for two-thirds of total spending on the program.

The outcome of the 2012 presidential and congressional elections could complicate hospital finances even more if there are significant Republican gains and if Mitt Romney wins the White House. So far, there have not been deep cuts in federal support for Medicaid; only the states have cut back their support. However, Republicans want to convert Medicaid into a block grant program. That would have the effect—based on Vice Presidential candidate Representative Paul Ryan's (R-Wisc.) plan—of reducing federal outlays to the states for Medicaid by nearly \$800 billion over a period of 10 years, according to various media outlets. Regardless of who wins the election, Medicaid will be on the chopping block because of the need to reduce the federal deficit.

Despite more state and imminent federal funding reductions, the Medicaid program will grow in 2014 if the Patient Protection and Affordable Care Act (PPACA) is still in place. A study from the Kaiser Family Foundation projects that Medicaid enrollment will climb by 15.9 million more people by 2019 than it otherwise would have, and the number of uninsured will fall by more than 11 million. California and Texas, for example, two states with considerable numbers of uninsured residents, are



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each projected to see 1.4 million fewer uninsured adults in 2019 because of the Medicaid expansion, with the federal government covering 95% of the cost in Texas and 94% in California. The cost of the Medicaid expansion between 2014 and 2019 would be jointly financed; the federal government would pay \$443.5 billion (or 95.4% of the total cost), and the states would contribute \$21.2 billion. (Federal matches start at 100% in 2014 and decrease to 93% in 2019.) That is what the PPACA says; whether those federal funds will actually be there and will be appropriated by Congress is a different story.

On its face, the expansion is a boon to hospitals, which will be reimbursed 100% for uninsured patients whose bills are today being written off as charity care. The PPACA allows a state to expand Medicaid coverage to families up to 133% of the federal poverty level. The federal government now pays about 57% (the percentage varies among the states) for current Medicaid recipients. However, hospitals with high Medicaid populations today, called Disproportionate Share Hospitals (DSHs), will be badly hurt if their states authorize expansion. Although these DSHs will be paid 100% for new Medicaid recipients who were previously uninsured, at the same time they will lose federal DSH payments they had previously received. DSH payments generally go to large hospitals in urban areas to compensate them for charity care of uninsured patients.

In 2011, federal DSH payments to hospitals totaled \$8.1 billion, which was 26% of the total federal Medicaid payments to hospitals. Those DSH payments went to safety-net hospitals in the U.S., such as Sarasota Memorial. Bill Woeltjen, the hospital's CFO, says that the Medicaid "enhancement" (i.e., the infusion of new Medicaid patients whose costs are being paid for by the federal government at 100%) results in a net financial gain for the hospital in 2014, but just slightly. However, 5 years later, as the loss of DSH payments mounts, the Medicaid expansion becomes "significantly negative" financially for Sarasota Memorial.

Expansion of the PPACA also threatens *all* hospitals—not just DSHs—from a second angle. Danny Chun of the Illinois Hospital Association points out that significant numbers of individuals in all states *already* qualify for Medicaid but have not signed up. Come 2014, they will have to join Medicaid or pay a penalty for not having health insurance. If they join Medicaid, the federal government will reimburse Illinois Medicaid 57% (not 100%) for those previously eligible individuals, which could complicate the state's Medicaid shortfall even more.

Of course, many governors have indicated that they will opt out of the Medicaid expansion if the PPACA itself survives political execution at the hands of Republicans, a possibility only if they win the White House and the Senate in 2012. Even if the Medicaid expansion does survive, Republicans in Congress will try to restructure the program to reduce its costs to the federal government. Some Democrats are likely to be sympathetic to structural changes because of the larger political imperative to reduce federal spending imposed by the Budget Control Act of 2011. That law requires Congress to reduce the federal deficit further starting January 1, 2013. If Congress fails to do that, deep automatic budget cuts, including to defense, will go into effect. Thus, there will be strong pressure after the November elections for both Democrats and Republicans to look for substantial cuts in federal spending, and Medicaid is

likely to top the targets.

Although Republican Vice Presidential candidate Paul Ryan's plan to restructure Medicare has received extensive coverage, he also wants to restructure Medicaid. The budget for fiscal 2013, approved by the House last May, reduces federal spending on all programs by \$5.8 trillion over 10 years (while losing some \$4 trillion in federal revenues via new tax cuts). Of that \$5.8 trillion, Medicaid accounts for \$771 billion. The Ryan plan would achieve this by capping federal payments to the states at 2012 levels plus the rate of inflation.

Mitt Romney endorses the same approach; his Web site advocates block grants that would grow at the rate of (non-medical) inflation plus 1% per year. Of course, the rate of medical inflation would be much higher, meaning states would have to either restrict the number of new participants or reduce payments to health care providers. The Congressional Budget Office estimates that federal payments to the states would be 35% lower in 2022 under the Ryan plan than currently projected and 49% lower in 2030.

So far, Democratic opposition has stymied Paul Ryan's proposed Medicaid block grant proposal. But should Mitt Romney win the White House and Republicans win control of the Senate, federal spending on Medicaid, one way or another, is certain to fall faster than a Zeppelin with a leak.

Not that Democrats don't have their own Medicaid cost-deflation program; they do. President Barack Obama made a number of cost reduction proposals as part of his fiscal 2013 budget proposal. According to Bruce Siegel, MD, MPH, President and Chief Executive Officer of the National Association of Public Hospitals and Health Systems, Mr. Obama's proposal to limit state imposition of Medicaid provider taxes "would reduce states' flexibility in financing their Medicaid programs, leading states to make harmful cuts or pass the cost burden on to providers and beneficiaries."

The President's proposal would have combined, into a single blended payment, a number of separate Federal Medical Assistance Percentages (FMAP) payments, which cover different populations or provide various services. This proposal would have the effect of cutting the federal match, including the 100% for newly eligible Medicaid recipients in 2014.

Dr. Siegel says, "We oppose the overall idea of combining FMAP payments because it does nothing to reduce the cost of care or make the program more efficient. It simply shifts Medicaid costs onto states by reducing federal spending, leaving the states to make up the difference."

According to one Washington public hospital lobbyist, the blended FMAP doesn't seem to have a lot of traction right now, although it still comes up in policy discussions. The provider tax cut has been included in various legislative vehicles, but it hasn't made it to the President's desk.

"We're hopeful that [the cuts] will not be included in the next budget and are keeping an eye out for future action," says Dr. Siegel.

Budget realities, however, are sure to stymie that hope. Report after report, written by substantial, credible, nonpolitical commissions of one sort or another, has buttressed the "cut Medicaid" political imperative. Former Federal Reserve Chairman Paul Volcker and former New York Lieutenant Governor Richard Ravitch co-chaired a task force that published

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the *Report of the State Budget Crisis*.¹ The task force included such prominent figures of Republican administrations as Nicholas Brady and George P. Shultz. The report said that Medicaid programs are growing rapidly because of increasing enrollments, escalating health care costs, and difficulty in implementing cost reduction proposals. At recent rates of growth, state Medicaid costs will outstrip revenue growth by a wide margin and the gap will continue to expand. The report points out that structural Medicaid deficits are not peculiar to Illinois. They affect most states, and they “can no longer be absorbed without significant cuts to other essential state programs like education or unpopular tax increases or both.”

Matt Salo, Executive Director of the National Association of Medicaid Directors, suggests that Medicaid programs have only three alternatives for reducing costs: (1) reducing the number of recipients, (2) cutting services, or (3) reducing payments to providers. He explains:

But those three options are not sustainable in the long run (especially two of the three), that is, cutting services and people. Medicaid directors are starting to think outside the box. It is acknowledged that the system, which depends on fee-for-service, is broke. It rewards volume and is ignorant around quality and outcomes. There are also dysfunctional payment incentives, which is particularly true for hospitals.

So states are beginning to experiment with payment reforms, such as reducing fees to hospitals based on hospital-acquired infection rates and unnecessary cesarean sections. Illinois, for example, has begun to reduce payments to hospitals when Medicaid patients have a higher than normal number of hospital-acquired illnesses such as urinary tract infections, bed sores, and fall-related bone fractures. This change is over and above the changes mandated in the SMART Act, which Governor Quinn signed in June and beyond what federal Medicaid requires.

The Illinois Hospital Association estimates that state hospitals will lose at least \$30 million in Medicaid reimbursements in fiscal 2013, according to an article in the *State Journal-Register*.² Illinois hospitals receive about \$2 billion per year for inpatient services to state residents covered by Medicaid.

Mike Claffey, spokesman for the Illinois Department of Healthcare and Family Services, told the newspaper that the department has tried to negotiate a compromise with the hospital association, but talks broke down. He said the department's new payment policies are within the law.

Matt Salo said, “The key to this is doing it in a way that doesn't penalize the hospital.”

But it is not easy to change the health care model, in the context of Medicaid or in any other application. Health care constitutes 18% of gross domestic product. Mr. Salo says:

There are a lot of people with money invested in the status quo. Another impediment is that dollar savings from long term, structural reforms don't show up on the short-term ledger. That sends a real mixed message to hospitals. It is hard for them to believe state directors when they say ‘trust us, we are doing the right thing’ when they are doing a lot of stuff that looks awful.

States also face federal rules that result in higher spending. Dual-eligible beneficiaries, for example, are eligible for both Medicare and Medicaid benefits; these are particularly sick and costly individuals. In 2010, they accounted for about 15% of Medicaid enrollment and 40% of Medicaid spending. About 26 states have begun efforts to move 3 million dual eligibles into managed care programs in an effort to decrease costs, according to The Senior Citizens League. More than half of dual eligibles also have annual incomes of less than \$10,000, and they are more likely to receive nursing home care. Chairman Larry Hyland says:³

But the time is coming when the states and federal government will be under urgent pressure to cut Medicaid and Medicare costs. The Senior Citizens League is concerned that if states and the federal government don't design and implement the changes the right way, beneficiaries may lose access to medically necessary care and quality.

In other instances, there may be obvious ways to reduce Medicaid costs. Medication adherence is a good example. A study released in July by Langone Medical Center at New York University looked at 2008 and 2009 data from more than 150,000 Medicaid patients in New York City.⁴ Of those patients 20 to 64 years of age, only 63% of those with the three chronic conditions studied were taking their prescribed medications.

Lead author Kelly Kyanko, MD, MHS, an instructor in the Department of Population Health at Langone, says:⁴

The outcome of this study is concerning, as it shows a large number of people with chronic conditions that lead to cardiovascular disease aren't taking prescribed medications, which could prevent a potential stroke or heart attack. ... We believe that patients and their doctors can work to improve medication adherence through simple measures such as switching to once-a-day or combination pills, keeping a pillbox and obtaining 90-day refills instead of 30-day refills for medications they take on a regular basis.

Hospital pharmacies that become active in areas like medication reconciliation and follow-up will have a chance to buffer the effect on their institutions of the stormy winds blowing up around Medicaid. They will also have an opportunity to reduce the program's costs, \$17.4 billion of which is attributed to prescribed drugs. No one expects pharmacists to start pulling rabbits out of their hats, but if they can start making Medicaid drug dollars disappear, that would help.

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