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HEALTH CARE PROVIDERS WOULD FACE DEEP CUTS IN PAYMENTS AND HIGHER UNCOMPENSATED CARE COSTS UNDER MEDICAID BLOCK GRANT

by Jesse Cross-Call

The proposal in the House-passed budget plan to convert Medicaid to a block grant would weaken the nation's health care infrastructure by making it difficult for a multitude of providers — including hospitals, nursing homes, doctors, and pharmacies — to remain economically viable and to continue to deliver health and long-term care services, particularly in underserved areas. These disruptions would be in addition to the proposal's adverse consequences for Medicaid beneficiaries — millions of whom could lose health coverage — and for states, which would face greatly increased costs.¹

The House proposal, crafted by Budget Committee Chairman Paul Ryan, would reduce federal Medicaid funding to states by 35 percent in 2022 and 49 percent in 2030, relative to current law, according to the Congressional Budget Office. To compensate for funding cuts of this magnitude, states would likely have to sharply reduce payment rates for providers, rates that already are low and have been cut further in many areas as states act to close budget deficits. Providers also would face heavy revenue losses resulting from the Medicaid enrollment caps, eligibility restrictions, and benefit reductions that states would likely have to impose to cope with the federal funding cut. The Urban Institute estimates that Medicaid spending on hospitals and nursing homes would each be cut by *31 percent* under the Ryan plan, for example.

Even as providers' revenues declined, their uncompensated care costs would rise significantly. Many of these providers would still have to treat Medicaid beneficiaries who had lost coverage for health care services they could not afford on their own, as well as people who had lost Medicaid coverage altogether because of eligibility cuts and had become uninsured. (Urban Institute researchers estimate that Medicaid enrollment would decline by between 14 million and 27 million by 2021 under the Ryan plan.) But they would no longer be compensated for the care provided.

¹ For analysis of the block grant's likely effect on beneficiaries, see January Angeles, "Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities, and Children," Center on Budget and Policy Priorities, May 3, 2011. For the likely effect on states, see Edwin Park and Matt Broaddus, "Medicaid Block Grant Would Shift Financial Risks and Costs to States," Center on Budget and Policy Priorities, February 23, 2011.

The Ryan plan would increase providers' uncompensated care burden in another way, as well. Over the next 10 years, the Affordable Care Act reduces federal Disproportionate Share Hospital (DSH) payments to hospitals with high uncompensated care costs to reflect the fact that those costs will shrink considerably due to the law's expansion of health coverage to 34 million uninsured people. The Ryan plan would repeal the law's coverage expansions while leaving its DSH cuts in place. Providers thus would have less DSH funding but higher uncompensated care costs than at present, due to state Medicaid cutbacks.

Ryan Plan Would Lead to Sharp Reductions in Provider Payment Rates

Under current law, the federal government pays a fixed percentage of a state's Medicaid costs. In contrast, under a block grant, the federal government would pay only a fixed dollar amount each year. The state would be responsible for all costs that exceed the cap.²

The Ryan plan would convert Medicaid from an entitlement program to a block grant starting in 2013.³ States would receive a fixed allotment of federal funding that would increase annually based on population growth and general inflation, as measured by the Consumer Price Index. As a result, over the next ten years, federal Medicaid funding would rise about 3.5 percentage points per year less than under the current program (and roughly 4 percentage points per year less over the long run). This change would reduce federal funding for state Medicaid programs by \$750 billion over the next ten years, relative to current law.⁴ The Congressional Budget Office (CBO) estimates that the Ryan plan would cut federal Medicaid funding by 35 percent in 2022 and by 49 percent in 2030.⁵

These federal funding reductions could be even larger in certain years because the Ryan plan, unlike the current Medicaid structure, would not provide for automatic increases in federal funding to respond to recessions, epidemics, or medical breakthroughs that improve health or save lives but at greater expense.⁶ According to CBO, the Ryan plan would "make funding for Medicaid more

² For background on proposals to convert Medicaid to a block grant, see Edwin Park, "Medicaid Block Grant or Funding Caps Would Shift Costs to States, Beneficiaries, and Providers," Center on Budget and Policy Priorities, January 6, 2011.

³ The Ryan plan would apparently base the first year's block grant amount (for 2013) on actual spending in fiscal year 2010 (excluding the temporary increases in federal Medicaid funding under the 2009 Recovery Act) plus adjustments to reflect population growth and inflation, as described in the text.

⁴ The House budget plan includes a reduction in Medicaid spending of \$771 billion over the next ten years, of which \$750 billion would come from the block grant. The remainder is likely due in part to the Ryan plan's cap on liability for medical malpractice and the elimination of some modest Medicaid spending increases included in the Affordable Care Act that are not related to that law's coverage expansions. The Ryan budget would also repeal the health reform law's Medicaid expansion (and the \$627 billion in additional federal funding to cover nearly all of the expansion's costs), for a total cut to Medicaid of \$1.4 trillion over ten years.

⁵ These reductions are relative to what states would otherwise receive, exclusive of the additional federal Medicaid funds they would receive under the health reform law. Under the Ryan plan, states will receive far less federal Medicaid funding than they would receive under current law. Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," April 5, 2011.

⁶ Park and Broaddus, *op. cit.*

predictable from a federal perspective, but it would lead to greater uncertainty for states as to whether the federal contribution would be sufficient during periods of economic weakness.”⁷

As CBO notes, to compensate for such massive federal Medicaid funding cuts, states would likely have to make significant cuts to reimbursement rates for providers that furnish health and long-term care services to Medicaid beneficiaries, even though those payments already are considerably lower, in most cases, than what Medicare and private insurance pay. As a result, according to CBO, if states further lowered their payment rates, fewer providers would be willing to treat Medicaid beneficiaries, some of whom would in turn lose access to needed care. A substantial number of Medicaid beneficiaries already encounter limits on access to physician care, particularly from specialists, due largely to Medicaid’s already-low reimbursement rates. The block grant would significantly exacerbate that problem.⁸

Ryan Plan Would Significantly Increase Incidence of Uncompensated Care

Under current law, state Medicaid programs must meet certain requirements in order to receive federal funding. For example, states generally cannot impose enrollment caps or waiting lists and must serve all eligible people who apply. States must also cover certain “mandatory” populations, including children up to age 6 in families with incomes up to 133 percent of the poverty line and older children in families with incomes up to 100 percent of the poverty line. Federal law also requires states to cover certain “mandatory” benefits, including hospital, nursing home, physician, and home health care and the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, a comprehensive program of preventive care, screenings, and treatment for low-income children. States generally cannot charge premiums and can require only modest co-payments, since most beneficiaries have very low incomes.

Consistent with past block-grant proposals, the Ryan plan would likely give states far greater flexibility to bypass many or all federal minimum standards concerning eligibility and benefits. For example, it would likely permit states to limit income eligibility for various populations to very low levels, such as 50 percent of the poverty line, or eliminate coverage for certain beneficiary groups altogether. States could also be allowed to cap enrollment. States also likely would be allowed to charge beneficiaries much higher premiums and co-payments or eliminate coverage for certain mandatory health services and treatments.

As CBO notes, “if states reduced benefits or eligibility levels [to help close the federal funding shortfalls they would experience under a block grant], beneficiaries could face higher out-of-pocket costs, and providers could face more uncompensated care as beneficiaries lost coverage for certain benefits or lost coverage altogether.” According to an Urban Institute study for the Kaiser Commission on Medicaid and the Uninsured, the enrollment cuts alone would be draconian. Depending on how they were distributed across the beneficiary population and whether states could glean some modest efficiencies in spending per beneficiary, enrollment would decline by between 14

⁷ Congressional Budget Office, *op. cit.*

⁸ Joanna Bisgaier and Karin V. Rhodes, “Auditing Access to Specialty Care for Children with Public Insurance,” *The New England Journal of Medicine*, June 16, 2011.

million and 27 million by 2021 under the Ryan block grant, relative to the current Medicaid program.⁹ (These figures do not include the effects of repealing the Medicaid expansion in the Affordable Care Act.)

Health care providers would thus face not only reductions in their payment rates for current beneficiaries but also large increases in their uncompensated care burdens. Some Medicaid beneficiaries would end up wholly uninsured. Others would lack Medicaid coverage for certain critical services and supports that they could not afford on an out-of-pocket basis.

Impact on Hospitals

The Urban Institute estimates that total Medicaid spending on hospitals would be cut by 31 percent under the Ryan block-grant proposal in 2021, relative to current law (excluding the effects of the Medicaid expansion in the Affordable Care Act). That would greatly weaken a major source of hospital revenue: Medicaid accounted for 18 percent of all hospital revenue in 2008, though this percentage varies significantly among individual hospitals.

Safety-net hospitals, which disproportionately serve Medicaid beneficiaries and other low-income people, would likely bear a considerable share of the reductions:

- **Public hospitals.** Public hospitals provide a vital safety net to underserved areas, including communities of color and communities with high rates of poverty and high percentages of people who are uninsured. They provide inpatient care as well as primary and specialty care and training for physicians and nurses. In addition, public hospitals are the only Level I trauma care centers — that is, facilities with the capability to treat the range of trauma patients — in many of the counties in which they are located.

Demand for services at public hospitals has increased steadily over the past decade, from roughly 400,000 outpatient visits in 1997 to 580,000 visits in 2009. Average admissions are 43 percent higher for public hospitals than for non-public hospitals in the same market.¹⁰

Public hospitals are also in a much more precarious financial situation than non-public hospitals: they have long operated with lower profit margins than the rest of the hospital industry¹¹ and are highly dependent on Medicaid payments for their financing. Public hospitals receive 35 percent of their revenue from Medicaid, nearly double the 18 percent rate for all hospitals.

As federal funding sharply declined under a block grant and states cut their Medicaid programs

⁹ John Holahan *et al.*, “House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing,” Kaiser Commission on Medicaid and the Uninsured, May 2011.

¹⁰ National Association of Public Hospitals and Health Systems, “America’s Public Hospitals and Health Systems, 2009,” December 2010.

¹¹ According to the National Association of Public Hospitals and Health Systems, its members had an operating margin of 2.5 percent, as compared to 5 percent for all hospitals. Without DSH and other supplemental Medicaid payments, that margin would drop to -11.7 percent.

Ryan Budget Would Repeal Health Reform's Medicaid Expansion and Health Care Infrastructure Investments

In addition to converting Medicaid to a block grant, the Ryan plan would repeal health reform's Medicaid expansion, which CBO estimates will enable 17 million more people to enroll in the program (and CHIP) by 2021. The large majority of these 17 million would end up uninsured under the Ryan plan, which would significantly enlarge the uncompensated care burden on hospitals and other providers.

The Ryan plan would also eliminate many of the Affordable Care Act's investments in health infrastructure. For example, it would repeal \$11 billion in additional mandatory funding over five years for the establishment or expansion of community health centers in medically underserved areas and cancel \$1.5 billion over five years for the National Health Service Corps to place 15,000 new physicians and other primary care providers in underserved communities. Eliminating these funds would be an additional economic blow to providers such as safety-net hospitals and community health centers located in underserved areas.

(including reimbursement rates), an offsetting increase in state and local funding for public hospitals would be highly unlikely, since states would already be facing considerable budget pressures due to the loss of federal Medicaid funding. Offsetting increases would be particularly unlikely during recessions since, unlike the federal government, most state and local governments are required to balance their budgets even in lean times. As a result, public hospitals would face particular strain during recessions, when the number of uninsured patients whom these hospitals serve tends to increase. In contrast, under current law, federal Medicaid funding automatically increases as enrollment rises during a recession.

- **Children's hospitals.** Children's hospitals also rely heavily on Medicaid for their patient revenues. For example, in fiscal year 2009, Medicaid beneficiaries accounted for 56 percent of all inpatient days of care provided by freestanding children's hospitals and 46 percent of the outpatient visits.¹² As states cut hospital payment rates and capped or cut children's Medicaid eligibility, children's hospitals would face substantial revenue reductions that could threaten their long-term financial viability.
- **Other safety-net hospitals.** The House budget plan's likely adverse impact on other safety-net hospitals would be similar to its impact on public hospitals. For example, many Catholic hospitals are located in underserved areas with large numbers of Medicaid beneficiaries. These hospitals provide important services such as treatment for HIV/AIDS, alcohol and drug abuse treatment, child wellness programs, and other social work services. Catholic health facilities also furnish other services Medicaid covers, including assisted living and home health care services.

Adding to the harmful impact of the block grant are the Affordable Care Act's scheduled reductions in Medicaid Disproportionate Share Hospital (DSH) payments, which compensate public and private hospitals that disproportionately serve Medicaid and uninsured patients for the large amount of uncompensated care they provide. In fiscal year 2009, DSH payments to hospitals totaled \$11.3 billion. The Affordable Care Act reduces federal DSH funding by \$14 billion over the next ten years, because hospitals' uncompensated care costs will fall significantly under that law, due

¹² National Association of Children's Hospitals, "Medicaid Fact Sheet," February 2011.

to the large reduction in the number of the uninsured. (Under the Affordable Care Act, the number of uninsured will decline by about 34 million by 2021, relative to prior law.)

The Ryan plan would repeal the Affordable Care Act's coverage expansions, so those 34 million people would remain uninsured and the decline in uncompensated care costs would not occur. But the Ryan plan would *not* repeal the Affordable Care Act's Medicaid DSH reductions (or the similar reductions the law would make to Medicare DSH payments). As a result, over the next 10 years, hospitals would face a potentially catastrophic combination of lower Medicaid payment rates, lower DSH funding, and continued high costs for uncompensated care. That, in turn, would threaten the long-term viability of many hospitals, particularly those located in underserved communities, and their continued ability to serve patients — those with public or private insurance as well as the uninsured.

Impact on Nursing Homes and Other Providers of Long-Term Care Services and Supports

Long-term care services and supports include nursing home care for seniors and a variety of home- and community-based services. Medicaid is central to the provision of nursing home care for seniors, acting as the primary payer for 64 percent of nursing home residents in the country.¹³ Overall, Medicaid finances 43 percent of all long-term care services and supports nationwide.¹⁴

Thus, the sharp reductions in reimbursement rates and likely eligibility restrictions that states would have to make under a Medicaid block grant would severely affect nursing homes. Total Medicaid spending on nursing homes would fall by about 31 percent, according to the Urban Institute.

A prime target for a state looking to cut Medicaid costs under a block grant would likely be those Medicaid-eligible seniors and people with disabilities who make more than the cutoff for Supplemental Security Income benefits (76 percent of the poverty line, or \$8,328 in 2011 for an elderly or disabled individual). Currently, every state provides coverage that allows some of this population to receive long-term care services. While seniors with incomes slightly above the SSI limit would still receive *Medicare* coverage, long-term care providers would take a serious financial hit if Medicaid coverage for this population's long-term care services were scaled back or eliminated.¹⁵

In recent decades, states have made a significant shift toward emphasizing home- and community-based care that allows people with long-term care needs to continue to live in the community. Under a block grant with funding levels significantly below what states would receive under the current program, states would likely have to slash payment rates to the providers of these services, many of whom — such as home health attendants, drivers, and nurses — already receive only

¹³ American Health Care Association, "LTC Stats: Nursing Facility Patient Characteristics Report," March 2011.

¹⁴ Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long-Term Care Services and Supports," March 2011.

¹⁵ For a discussion of how states could use flexibility to limit benefits for seniors requiring long-term care services, see Judith Solomon, "Repealing Health Reform's Maintenance of Effort Provision Could Cause Millions of Children, Parents, Seniors, and People with Disabilities to Lose Coverage," Center on Budget and Policy Priorities, February 24, 2011.

modest reimbursements. States' progress in expanding community-based care could come to a halt, since such expansions require additional investments. (The Affordable Care Act includes financial incentives for states to increase the use of home- and community-based care, but the Ryan plan would apparently repeal these as well.)

Medicaid is also a critical payer for long-term care services and supports for *children and young adults*, such as those with traumatic brain injuries, or children with developmental disabilities who require intensive speech therapy services. Under the block grant, states would likely cut these services, eliminate eligibility for those who require them, or scale back payments to physical therapists, speech therapists, providers of mental health services, and others who furnish such critical services.

Impact on Pharmacies

While Medicare Part D has replaced Medicaid as the primary payer for prescription drug coverage for low-income seniors, Medicaid remains an important revenue source for pharmacies.¹⁶ Medicaid spent \$20 billion on prescription drugs in 2008, accounting for 8 percent of all prescription drug spending.

Under the Ryan plan, states would likely further reduce pharmacy reimbursement rates (which many of them have previously lowered to produce savings), while also shifting a greater share of drug costs to Medicaid beneficiaries through higher co-payments and more restrictive drug formularies and utilization limits. These policy changes would have a significant impact on pharmacies. Cuts in reimbursement rates would reduce pharmacy revenues directly, and shifting drug costs to Medicaid beneficiaries would do so indirectly, as some beneficiaries with the greatest drug costs (like people with disabilities) would likely forgo purchasing some needed drugs.

Scaling back Medicaid eligibility or capping enrollment to cope with a block grant would also reduce drug utilization. An analysis from the Center for Studying Health System Change found that 58 percent of uninsured low-income individuals skipped needed drug treatments because of cost, a much higher rate than among comparable individuals covered by Medicaid or private insurance (39 percent and 34 percent, respectively).¹⁷

Impact on Providers in Rural Areas

Rural residents are more likely than their urban counterparts to be uninsured (24 percent of people living in rural areas lack insurance, compared to 18 percent in urban areas)¹⁸ and also are more likely to rely on Medicaid for health coverage (16 percent compared to 11 percent). This is largely because small businesses and agricultural employers, which often do not offer private

¹⁶ Since Part D took effect in 2006, Medicare's share of public funding for prescription drugs has increased from 7 percent to 60 percent, while Medicaid's share has dropped from 70 percent to 24 percent. For more information see Kaiser Family Foundation, "Prescription Drug Trends," May 2010.

¹⁷ Marie Reed, "An Update on Americans' Access to Prescription Drugs," Center for Studying Health System Change, May 2005.

¹⁸ Kaiser Commission on Medicaid and the Uninsured, "The Uninsured in Rural America," April 2003.

insurance to their employees, make up a bigger share of the economy in rural areas and because rural areas have higher rates of poverty.

Rural areas are also underserved by certain types of providers — particularly internists, pediatricians, OB/GYNs, and general surgeons. (Rural and urban areas have similar ratios of general practitioners and family specialists.) Additionally, rural hospitals have a lower patient volume, with 55 percent occupancy compared to 63 percent at their urban counterparts.¹⁹

The low patient volume combined with lower levels of insurance coverage requires many rural providers to walk a financial tightrope that would only become more precarious under the Ryan plan. Many of the adverse impacts from a block grant, such as a rise in uncompensated care, expensive complications from forgone care due to lack of coverage, and less access to long-term care services and supports, would be sharpest in rural areas, where Medicaid plays an outsized role as a payer for services.

Moreover, the long-standing challenge of attracting health professionals to rural areas is somewhat mitigated by the revenue certainty that Medicaid now provides them. If Medicaid reimbursement rates were cut substantially and coverage restricted under a block grant, many physicians in rural areas likely would find it nearly impossible to keep their practices economically viable.²⁰ If these professionals were to leave for urban settings, the tax base and the overall economy of rural areas would suffer as well.

Impact on Community Health Centers

Federally Qualified Health Centers (FQHCs) are non-profit health centers that provide a range of primary and preventive services, including dental, mental health, and pharmacy services. These centers serve approximately 20 million Americans a year in poor and medically underserved communities and are required by law to provide care regardless of a client's ability to pay. As a result, they serve a unique demographic: 37 percent of their patients are covered by Medicaid (compared to 16 percent of the overall U.S. population) and 38 percent of their patients do not have insurance (compared to 17 percent of the U.S. population).

The Ryan plan poses several risks to community health centers. While the centers would continue to treat the same populations, more of their patients likely would go from being covered by Medicaid to being uninsured over time as states scaled back their Medicaid programs. Yet they would continue to have to serve all clients, regardless of ability to pay.

A designation as a FQHC or Rural Health Clinic (RHC) allows an institution to be paid under a special Medicaid prospective payment system, which ensures that these facilities receive adequate reimbursement for the health services they provide to Medicaid beneficiaries. These Medicaid dollars enable the health centers to provide care to people who lack *both* Medicaid *and* private insurance coverage but whom the clinics are nevertheless required by law to treat; the clinics are able

¹⁹ Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in Rural America," September 2003.

²⁰ For more information about Medicaid's place in the delivery of care in rural areas, see Rural Policy Research Institute, "Medicaid and Its Importance to Rural Health," 2006.

to use the funds they receive from *other* revenue streams, such as federal grants, to provide care to uninsured individuals. Under a block grant, however, states likely would no longer be required to follow the prospective payment system requirements for FQHCs and RHCs, with the result that states often would pay those centers a considerably smaller share of the cost of serving Medicaid beneficiaries than they do today. That would pose a threat to the centers' overall finances.

State cuts in financial support for community health centers during the current economic downturn, when states have faced significant budget pressures, underscore the risks to which a block grant would expose these centers. Twenty-three states reduced funding for community health centers in state fiscal year 2011, and four states eliminated such funding altogether, according to the National Association of Community Health Centers.²¹ Nationally, state appropriations for community health centers in state fiscal year 2011 are 20 percent lower (in nominal dollars) than state fiscal year 2010 levels, and 42 percent below state fiscal year 2008 levels. If the decisions that states have made during the current downturn are any indication, community health centers would be in particular jeopardy under a block grant, given the fiscal pressures that a state would face as a result of the loss of substantial federal Medicaid funding.

Impact on Managed Care Plans

Beginning in the 1990s, state Medicaid programs shifted more of their beneficiaries to managed care. By 2009, nearly half of all Medicaid enrollees received some or all of their services through a risk-based managed care program. In federal fiscal year 2010, Medicaid directed \$92 billion to managed care plans and premium assistance.²²

The primary populations enrolled in Medicaid managed care — children, pregnant women, and parents — would likely be among the first to see their eligibility scaled back under a block grant. States have already indicated that they would like the flexibility to roll back coverage for these groups (which constitute the largest share of Medicaid beneficiaries) where it exceeds federal minimum eligibility levels.

A block grant would likely be most damaging to managed care organizations that primarily serve Medicaid beneficiaries. A number of these organizations are operated by safety-net hospital or community center systems, which would face a double hit under a block grant: the number of Medicaid beneficiaries that their managed care organizations serve would decline if Medicaid eligibility were cut back, while they would likely face an increase in uncompensated care costs in the hospitals and clinics that make up these systems.

²¹ Dawn McKinney *et al.*, "Entering the Era of Reform: The Future of State Funding for Health Centers," National Association of Community Health Centers, October 2010.

²² Medicaid and CHIP Payment and Access Commission, "MACPAC March 2011 Report to the Congress on Medicaid and CHIP," March 2011.

Conclusion

To compensate for the very large federal Medicaid funding cuts under the block grant the Ryan budget plan includes, states would likely reduce provider payment rates substantially over time. States likely also would scale back eligibility and cap enrollment for certain populations. As a result, providers such as hospitals and community health centers would experience a large surge in the volume of uncompensated care they provide. Other providers, such as pharmacists and managed care plans, would have fewer clients with the means to pay for services, which would decrease their revenues and could, in some cases, threaten their long-term viability. Finally, the Ryan plan would repeal the Affordable Care Act's expansion of Medicaid coverage, causing millions of Americans with limited incomes to continue to lack the means to pay for needed health services.