ISSUE SUMMARY

Medicaid, administered by states and jointly funded by states and the federal government, is the largest health insurance program in the United States, providing coverage to more than one in five Americans—more than 65 million beneficiaries. The Children's Health Insurance Program (CHIP) covers another 8.3 million children at any point in the year. Teaching hospitals are core institutions in the health care safety net and serve a disproportionate number of Medicaid and CHIP beneficiaries. This means teaching hospitals support efforts to ensure that Medicaid patients have access to care, and they are all too aware when Medicaid policies threaten that access. State Medicaid programs vary considerably; the federal government can do more to ensure that this variation is used to innovate and improve health outcomes—not to short-change providers and beneficiaries through payment rates that are too low and networks that exclude key providers.

Issue

Medicaid is a cornerstone of the health care landscape, affecting nearly every hospital in every community nationwide. Unfortunately, this vital program has been perennially and increasingly underfunded due to state budget crises and inadequate federal oversight and investment. Overall, states are reducing their contributions to Medicaid and relying increasingly on health care providers themselves to finance the program. The federal government has scheduled a $9 billion cut, beginning in fiscal year (FY) 2018, in Disproportionate Share Hospital (DSH) payments to hospitals serving the most Medicaid beneficiaries. Unless Congress acts, funding for CHIP will expire on September 30, 2017. The financial instability of the program hinders thoughtful long-term policymaking at both the federal and state levels, leaves provider payments notoriously insufficient, and jeopardizes Medicaid beneficiaries' access to high-quality care.

Academic medical centers serve a disproportionate number of Medicaid and CHIP beneficiaries and have pioneered ways to meet both the medical and psychosocial needs of underserved communities despite low Medicaid reimbursements. As the Medicaid program continues to grow, the federal government must champion new investments in Medicaid access, sustainability, and quality.

Background

Major teaching hospitals, medical schools, and their clinical physician faculties are fundamental components of the nation's health care safety net. While representing just 5 percent of the nation's hospitals, major teaching hospitals account for 25 percent of all Medicaid hospital care and provide 35 percent of total hospital charity care in this country. Additionally, major teaching hospitals have large ambulatory clinics that often become surrogate medical homes for individuals living in neighborhoods without access to other sources of care.

The Affordable Care Act (ACA) and the subsequent U.S. Supreme Court ruling provided states the option to expand Medicaid eligibility to nearly all low-income adults with incomes at or below 138 percent of the federal poverty level with full federal financing for the first three years, gradually decreasing to 90 percent federal funding. As of October 2016, 32 states (including the District of Columbia) have expanded their Medicaid programs to include this new population, providing Medicaid coverage to more than 15 million previously uninsured Americans.

Coverage expansion alone, however, is insufficient to create a sustainable, high-quality Medicaid program. Medicaid reimbursements to hospitals and physicians are unsustainably low. The Government Accountability Office (GAO) has found them to be 65 percent lower than median commercial insurance payments in various markets, and many studies have found providers of all types and specialties to be less likely to accept new Medicaid patients than patients with other forms of insurance. Academic medical centers proudly take on the mission of serving Medicaid beneficiaries, but cross-subsidizing from other missions to make up for Medicaid shortfalls is unsustainable as a long-term strategy and puts training, research, and other priorities at risk.

The Medicaid statute acknowledges the additional burden facing hospitals caring for large numbers of Medicaid beneficiaries and uninsured patients. Supplemental payments—Medicaid DSH payments—support these hospitals. Federal spending on Medicaid DSH is capped, and within that cap, each state

has a specific "allotment" or limit up to which it can draw down matching funds. The combination of state and federal Medicaid DSH funding was approximately $18 billion in FY 2016.

Anticipating a nationwide expansion in Medicaid coverage and a reduction in uninsured patients, the ACA included more than $9 billion in cuts to the federal contributions to DSH, to be phased in beginning in FY 2014. These cuts were subsequently delayed by Congress and are currently scheduled to begin in FY 2018. Cuts of this magnitude would devastate the health care safety net, especially in states that have not yet expanded Medicaid, but also in teaching hospitals around the country because 24 million Americans remain uninsured, and Medicaid reimbursement to providers is unsustainably low without supplemental payments like DSH.

In addition to their safety net missions, teaching hospitals also rely on funding from Medicaid to further their academic, training, and research missions. Though not mandatory, 42 states currently contribute to Medicaid graduate medical education (GME) to help offset the higher costs associated with training residents in teaching hospitals. These supplemental payments allow more physicians to be trained in safety net institutions, which improves cultural competence, coordination between health care and community organizations, and access for Medicaid beneficiaries. The federal government collects scant data on Medicaid GME programs, but the AAMC conducts regular surveys and makes its findings public. Issues on the horizon include the maintenance of these funding streams, particularly as states increasingly move their Medicaid programs toward managed care.

Created in 1997, CHIP provides coverage to uninsured children who are not eligible for Medicaid but cannot afford private coverage. Like Medicaid, CHIP is jointly funded by states and the federal government, and states retain considerable flexibility to set eligibility and benefits. Unlike Medicaid, however, CHIP is not a permanent program and requires periodic reauthorization and appropriations to continue. The current authorization and funding expire on September 30, 2017.

Though the ACA Marketplaces now allow families ineligible for Medicaid to purchase affordable insurance, letting CHIP lapse would have devastating, unintended consequences. A feature of the ACA, known as the "family glitch," misaligns the affordability test for low-income working parents and could leave more than 2 million children uninsured, according to the Center on Budget and Policy Priorities. Further, CHIP provides a more generous benefit package for children than many plans offered through the Marketplaces, making it an important safety net for the most vulnerable low-income children.

AAMC Policy Recommendations

- Congress should maintain the federal government's commitment to match state spending on medically necessary care for Medicaid beneficiaries, without limits, caps, or block grants.
- The federal government should ensure that Medicaid beneficiaries have meaningful access to high-quality care by enforcing network adequacy requirements and mandating sufficient payments to providers.
- Congress should delay scheduled cuts to Medicaid DSH.
- The federal government should encourage states to continue to provide Medicaid GME funding for the training of future physicians, particularly as the nation faces a physician shortage.
- Congress should permanently reauthorize CHIP funding and make such funding permanent rather than subjecting it to the regular appropriations process.

Related Issues

- Medicare Mission Payments to Teaching Hospitals
- Medicare Physician Payment and Quality

AAMC Contacts

Jason Kleinman
Senior Legislative Analyst, Government Relations
202-803-0806
jkleinman@aamc.org

Mary Mullaney
Director, Hospital Payment Policies
202-909-2084
mmullaney@aamc.org

Web Resource

AAMC Information on Medicaid
www.aamc.org/advocacy/medicaid