

Federal Medicaid Reform: A Rural Perspective

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National Rural Health Association

Problem Statement

Medicaid is a joint state and federal health care entitlement program currently facing a number of challenges. Rural community members and providers are dependent on Medicaid, and the NRHA is committed to assuring that proposed changes in Medicaid address the unique needs of rural and frontier communities.

Background

Many economic factors have contributed to a fiscal crisis for state Medicaid plans. The economic recession, the ongoing effects of September 11, 2001, and the war in Iraq have combined to cause many state economies to change from budget surpluses to substantial budget deficits.

In addition, many states are constitutionally required to operate under a balanced budget. Medicaid is the second largest expenditure in most state budgets. As health care and prescription drug costs grow, Medicaid takes a larger share of state budgets. With limited additional help from the federal government on the horizon, many states are considering cutting their Medicaid programs through one or more of the following actions:

- Reducing the number of eligible beneficiaries
- Reducing the number and nature of covered services
- Reducing the reimbursement levels for providers

President Bush and many leaders in Congress have expressed the need for federal reform of Medicaid. Block granting of Medicaid to the states has been discussed as a mechanism to improve state flexibility to deal with program expansions and contractions.

In addition, as Medicare coverage for prescription drugs is phased in, Medicare will provide a comprehensive prescription drug benefit to individuals covered by both Medicare and Medicaid. With all things being equal, this will automatically lower a state's Medicaid spending because Medicare will bear the prescription drug costs of dual eligibles.

The Medicare Prescription Drug Improvement and Modernization Act contains a provision, known as the "clawback" provision, which requires that states provide payment into the Medicare Prescription Drug Account equal to 90% of the state effort in 2006 and phased down to 75% over 10 years. The annual amount is adjusted by the growth factor of annual increases in prescription drug expenditures. Thus, states will not realize 100% of the savings from Medicare assuming what had been a state expense. Given many rural areas' disproportionate reliance on Medicaid, any reform measures must take into account the unique needs of rural and frontier areas.

Rural Concerns

Residents of rural areas tend to be older and poorer than urban residents. Rural health care facilities serve a disproportionately high proportion of Medicare and Medicaid (dual eligibles) eligible patients. Approximately two-thirds of total State Medicaid expenditures are for services to the aged or disabled. Many of the latter also qualify for Medicare (dual eligibles). The financial burden for dual eligibles has fallen to state Medicaid plans specifically, costs associated with long term care and prescription drugs. That burden was one factor that exacerbated the Medicaid crisis and made it more difficult for states to continue providing essential benefits to the Medicaid population.

Medicaid reimbursements already fail to cover the costs of providing services and any change in these programs would have a unique and dramatic consequence on the rural health care system. The shift of financial responsibility from the federal to state governments has made (will make) it difficult for rural providers to provide consistent quality care to rural Medicaid beneficiaries. Many rural providers now find themselves unable to serve the existing Medicaid population and others are considering not accepting new Medicaid patients.

NRHA Recommendations

NRHA understands any change in federal Medicaid policy will directly affect a state's ability to provide appropriate, adequate, and quality care through the Medicaid program. NRHA further understands that state budget deficits are leading state legislatures to cut their Medicaid budgets, resulting in the loss of essential services, the loss of essential providers, and the elimination of beneficiaries for whom this program is critical. Accordingly, the NRHA offers the following recommendations for federal Medicaid reform.

- The federal Medicaid definition of “mandatory populations” must include elderly and disabled and long-term care.
 - NRHA recognizes that many states currently include long-term care under their optional services. While NRHA appreciates these efforts, we are concerned a continuing financial strain will force states to cut back on these essential services.
- A federal long-term care and non-emergency medical transportation (NEMT) benefit for Medicare would relieve tremendous pressure on state budgets, allowing states to better fund the medical aspects of Medicaid.
- In rural areas, patients often must travel long distances to visit qualified specialists, a cost paid for solely by Medicaid. This travel creates additional mental and financial burdens on the patient and their families. The NRHA recognizes the increased use of telemedicine technology is one promising method for reducing this transportation burden.
 - Specialist and long-term care under Medicaid should emphasize local treatment to the highest extent possible.
 - Adequate reimbursement is needed for telemedicine services.
- NRHA supports state flexibility in principle; however, turning Medicaid into a block grant program is likely to have a disproportionate impact on rural beneficiaries and on

NRHA Policy Brief

rural providers. Any federal Medicaid reform proposals should include provisions for a rural impact study, prior to any full scale implementation, including a study of state practices with block granted programs in the past.

- Federal Medicaid policy should seek better coordination between Medicaid and the State Children's Health Insurance Program (S-CHIP).
- Federal Medicaid reform should seek better coordination of enrollment and benefits for dual-eligible beneficiaries.
- Federal Medicaid reform should restore some type of "Boren Amendment" protections for rural providers, requiring state Medicaid plans to set payment rates that would reimburse the allowable cost of an "economically and efficiently operated" provider as defined by the states subject to approval by the Centers for Medicare and Medicaid Services.
- The clawback provisions in the MPDIMA should be repealed.

Questions in regard to this policy brief should be directed to the NRHA Government Affairs Office at 703/519-7910

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