WRITING SAMPLE

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Medicaid Rule Stresses Hospitals During COVID-19, Unifies Response

Hospital executives are united in opposing a proposed Medicaid rule, warning it could force more closures

By Mary Ann Roser

At a Washington, D.C. conference in February, Ted Matthews cornered a federal agency chief proposing a Medicaid rule that Matthews says would doom his small hospital.

"I said, 'Before you close my hospital, you need to come to Eastland and see the quality of care we provide,'" said Matthews, CEO of Eastland Memorial Hospital, which stands about 55 miles east of Abilene and serves a rural area hugging Interstate-20. "Honestly, this is not something she wanted to discuss with me."

His encounter with Centers for Medicare & Medicaid Services Administrator Seema Verma lasted all of a minute. But Matthews and executives at hospitals of all sizes in Texas and across the country have spent countless hours writing letters, making phone calls and visiting state and federal leaders. They, along with their advocacy organizations, are all trying to persuade CMS to withdraw the rule, known as MFAR.

Until recently, many hospital executives considered the Medicaid Fiscal Accountability Regulation one of the gravest threats on the health care horizon. But the last few months have been unprecedented.

The COVID-19 pandemic is consuming hospitals and communities reeling from jobs losses and economic upheaval. Hospitals have made significant changes to their business practices, including canceling elective surgeries and other revenue-generating services, to preserve scarce resources, increase bed capacity and focus on saving the lives of those infected with the virus.

For some Texas hospitals on the brink, the pandemic's financial stress alone could be fatal.

"I worry that the coronavirus situation will push more hospitals over the edge," said John Henderson, president and CEO of the Texas Organization of Rural & Community Hospitals. "We wonder how many cuts and punches rural hospitals can take."

For hospitals that survive COVID-19, "MFAR would likely be the last straw," said Tim Ottinger, government relations division director for CHI St. Luke's Health in Houston. "With unemployment skyrocketing, more people who had insurance through their work will apply for Medicaid, which means the new policies that would come with MFAR would be more catastrophic to state budgets and access to hospital services."

"The Impact Would Be Widespread"

The Texas Hospital Association, which represents 470 hospitals, estimates that the rule would risk $11 billion a year in supplemental Medicaid payments. Those payments keep Eastland afloat, and many other hospitals rely on them to alleviate some of the costs of uncompensated care, underpayments in Medicaid and care for vulnerable people in their communities.

"To take $11 billion out of the Texas health care system at a time when we're stretched to the limit with COVID-19 is unimaginable," Ottinger said.

His system includes four rural hospitals in Texas, which has seen 27 rural hospitals close in the last 10 years, the most of any state. At the same time, Texas has the largest number of uninsured residents, more than 5 million people, or 17.7% of its population. Another 4 million are on Medicaid, which covers over half of the state's births.

With MFAR, St. Luke's could lose $65 million to $70 million annually, Ottinger said. "That's a big chunk of our annual revenue. And in some rural hospitals, half a million dollars can be the difference in closing or keeping the doors open. The impact would be widespread."

TORCH estimates losses at $900 million annually for Texas rural hospitals.

Because MFAR would touch hospitals small and large, urban and rural, and because Texas cannot afford to lose any more rural hospitals, Matthews said he sees "universal" opposition to the rule.

A key reason is that MFAR would redefine public money eligible for a federal match by limiting it to local and state tax dollars. That means Texas state leaders would have to approve a massive tax increase to make up for lost funds. "When you talk about raising taxes in Texas, that's a non-starter and expanding Medicaid is also a non-starter in Texas," Henderson said.

Hospitals and CMS

THA has rallied hospitals to fight back to preserve an increasingly crucial funding stream. Advocates of rural, children's and teaching hospitals worked with THA on a letter to CMS. Many hospitals also sent letters to decision makers objecting to the rule. They've collaborated with business leaders in their communities, and, before most parts of the country were locked down to control the pandemic, some traveled to meet elected officials to press their case.

When Matthews went to Washington, D.C., in February, he was accompanied by other rural hospital and business leaders, as well as Henderson from TORCH. The group visited the congressional offices of all 36 Texas representatives to enlist their help.

In a rare show of unity, all 36 signed a letter to CMS, voicing their concerns about MFAR.

Then, in the midst of working on a $200 trillion stimulus package to mitigate the economic strain from COVID-19, including $100 billion for hospitals and other health care providers, the U.S. House inserted language in the bill to put a moratorium on MFAR. That effort failed, and President Trump signed the CARES Act into law on March 27.

But Texans in Congress continued the push to delay MFAR. On March 31, Reps. Michael Burgess (R-Lewisville), Pete Olson (R-Sugar Land) and Bill Flores (R-Bryan) sent a letter, asking CMS to not finalize the rule during the COVID-19 pandemic.

On April 17, U.S. Rep. Lizzie Pannill Fletcher (D-Houston) and a Democratic colleague, Rep. Nanette Diaz Barragán from California went a step further, filing a bill to prevent CMS from implementing MFAR or anything similar for two years after the end of the emergency declaration. THA expects lawmakers to request similar language in Congress' fourth COVID-19 relief bill and propose a standalone MFAR bill so they can publicly record their support for a delay of MFAR.

"CMS has reportedly told a group of state Medicaid directors that MFAR will not be 'implemented' during the COVID-19 crisis," Henderson said. "While this is encouraging news, an express moratorium remains important. CMS has not withdrawn the rule or committed to backing away from the claimed policy 'clarifications' announced in the rule."

Matthews said that he was disappointed that the same day he approached Verma after her speech to National Rural Health Association conferees, she issued a series of tweets extolling the rule's virtues. They included one that said, "Over the years, a chorus of oversight agencies have called on CMS to strengthen our oversight of Medicaid supplemental payments. The Trump administration is finally taking action through the proposed Medicaid Fiscal Accountability Regulation."

Verma has repeatedly said that, despite comments to the contrary, MFAR is not an attempt to reduce Medicaid funding but a way to strengthen accountability and transparency. She pointed out that states are relying more heavily on supplemental payments to finance their programs. They've risen from 9.4% of provider reimbursements in fiscal year 2010 to 17.5% in 2017.

When Verma unveiled the rule in November, she said: "We have seen a proliferation of payment arrangements that mask or circumvent the rules where shady recycling schemes drive up taxpayer costs and pervert the system. Today's rule proposal will shine a light on these practices, allowing CMS to better protect taxpayer dollars and ensure that Medicaid spending is directed toward high-value services that benefit patient needs."

More Repercussions

Opposition to MFAR, has extended beyond hospital walls. The U.S. Chamber of Commerce warned that if the rule causes struggling hospitals to close, communities will see job losses, tax increases and other economic pain, not to mention losing the essential services of a hospital.

In rural areas, the hospital often is one of the largest employers. Eastland Memorial is the second largest employer in the county, just behind the school district. If the hospital is shuttered, 150 full-time-equivalent workers would lose their jobs, Matthews said, causing a ripple effect on the local economy.

"Who's going to even move to your community if your hospital is closed?" he asked.

Matthews and other MFAR opponents argue that the supplemental payment system works well in Texas, is fully transparent and was blessed by CMS.

"I think there's a misunderstanding on the federal level that we're not spending funds appropriately," said Katherine Yoder, vice president of government relations at Parkland Health & Hospital System in Dallas. "Because each state is different, they believe there's not transparency, not oversight, not checks and balances. Maybe that's true in certain areas, but Texas is really the model of transparency and reporting."

Parkland hasn't put a figure on its losses under MFAR, and Yoder said that wouldn't provide a true a picture anyway. Health care is a team sport, she said, because services extend across institutions. For example, supplemental payments are used as an incentive to improve nursing home quality. Parkland, like Eastland and other hospitals, supports Medicaid payments for nursing homes under the Quality Incentive Payment Program.

"That program going away is detrimental and is a problem for Parkland because we use our nursing homes for continuity of care," Yoder said. "The effect of MFAR will be devastating to Parkland and other safety-net hospitals."

Parkland also provides the highest level of trauma care, an expensive service that some hospital officials worry MFAR would make cost-prohibitive.

The federal government needs to make Medicaid "more flexible, not less so," Yoder said.

Texas leaders have embraced new approaches to Medicaid. They are using the 1115 Medicaid waiver to draw down billions in federal dollars to improve the effectiveness and efficiency of Medicaid managed care delivery. "That funding, which makes up more than half of the $11 billion in MFAR losses, is at risk because Texas's share of the match is made up of local provider participation funds and public hospital district dollars, both of which are severely limited under the proposed rule," said Jennifer Banda, the THA's vice president for advocacy and public policy.

The Texas Health and Human Services Commission worked "hand in hand with CMS" to develop the current the payment system so it complied with federal rules, Banda said. Now CMS wants to change those arrangements by unilaterally issuing a vague, ambiguous rule, she said.

MFAR "extends miles beyond transparency," THA said in a Jan. 30 to CMS, and would "devastate the state's health care infrastructure."

Already, the proposal is having "a chilling effect by curbing transformational thinking in states like Texas," said Geronimo Rodriguez, chief advocacy officer of Ascension Texas.

For example, he said, earlier this year HHSC took steps to put on hold its State Plan Amendment to use supplemental Medicaid funding for Graduate Medical Education programs at private hospitals. That hurts physician recruitment in communities across Texas, he said.

Ascension, which has worked with other organizations to communicate its concerns to the Texas Congressional delegation and the federal administration, is still assessing MFAR but believes at least $120 million a year would be jeopardized, Rodriguez said.

Although the $100 billion in federal aid for health care providers will help hospitals fight COVID-19, "it will not be nearly enough in the long run to make up for lost revenue and ensure that we have the resources to care for the most vulnerable in our community," Rodriguez said.

For now, fighting the pandemic is all-consuming, leaving hospitals with little choice but to cast a wary eye at MFAR.

"This MFAR issue is still out there," Matthews said. But right now, "we're taking care of our patients and wondering how we're going to survive COVID-19."

For hospitals, it's one crisis at a time.