Washington Healthcare News

wahcnews.com

Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 4, ISSUE 12 DECEMBER 2009

State Medicaid Rate Cuts: Legal Challenges and Possible Solutions

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The largest recession in recent history has forced many states to drastically cut payments for health care services provided to Medicaid enrollees. Medicaid, which provides coverage to indigent patients, is a jointly funded state/federal program in which the federal government matches a percentage of the funds expended by a state on Medicaid services. Washington's 2009-11 operating budget included an overall 4% reduction in inpatient and outpatient hospital rates, as well as numerous other cuts.[1] Other states have made similar rate reductions. As a result, health care providers in several states have resorted to litigation, seeking to reverse what providers assert are illegal Medicaid rate cuts. Where these challenges have succeeded, however, the question remains: where will the money come from in order to maintain adequate Medicaid payments? In California, as in other states, the answer has been to enact an assessment or tax on providers, funds from which are used to draw down additional federal matching dollars. Such an assessment has the added benefit of allowing the state to take advantage of provisions of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), which provides for enhanced federal matching rates through December 2010.

Federal Law Restricts Medicaid Cuts

The federal Ninth Circuit Court of Appeals, which covers the west coast states, has permitted health care providers to sue states in order to enforce certain requirements of the federal Medicaid Act.[2] Among these requirements are that states must set reimbursement rates at levels "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that such care and services are available under the [Medicaid state] plan at least to the extent that such care and services are available to the general population in the geographic area."[3] These "quality of care" and "access" requirements, as interpreted and applied by the Ninth Circuit, prohibit states from enacting rate cuts that are purely budget-driven or that fail to consider their impact on Medicaid patients' access to and quality of care.[4] And in setting rates, states must rely on cost studies and establish that the rates they set bear a reasonable relationship to the costs

incurred by an efficient provider.

Legal Challenges to Rate Cuts

In a series of recent cases, federal courts have enjoined California's attempts to enact Medicaid cuts.[5] In each of these cases, the courts have found that the state failed to conduct a rate study or to otherwise show that reduced rates were sufficient to meet the requirements of federal law. In Washington, limited, but successful, legal actions have been brought to challenge pharmacy and nursing home rate cuts.[6] As in California, Washington failed to conduct a rate study or make findings concerning whether reduced rates would cover providers' costs and afford Medicaid beneficiaries with adequate access to quality care.

Washington's hospital rate cuts have yet to be challenged. If those cuts are challenged, the state is likely to try to distinguish earlier cases on the basis of a legislative "finding" that was included in the 2009 budget, which states that the rates to be set by the Department of Social and Health Services (DSHS) will comply with the "quality of care" and "access" requirements of the Medicaid Act. This finding was added to the bill on the day after the Ninth Circuit had enjoined California's hospital rate cuts, apparently at the behest of the state Attorney General. It was added *after* the state had determined the gross amount of the cuts, but *before* DSHS had actually determined the methodologies by which the cuts would be implemented. And neither the Legislature nor DSHS conducted an actual study of the impact of the rate cuts.

Finding Solutions

Even when successful, legal challenges to Medicaid cuts do not provide the funds necessary to maintain adequate rates. And in these times when state revenues are diminished and the ability to raise general taxes is politically or legally constrained, additional funding for Medicaid is extremely problematic. One solution that has emerged, however, is an assessment on providers that is used exclusively to obtain additional federal matching dollars for Medicaid services. In the wake of its litigation, California adopted an annual provider fee in October 2009, which is expected to generate an additional $2.3 billion in matching federal funds annually.[7] In May 2009, Oregon expanded its existing taxes on hospitals and health insurers, which are expected to generate an additional $700 million annually and will be used to cover nearly all of Oregon's uninsured children and 60,000 low-income adults.[8]

These types of measures must meet certain federal requirements. Generally, such taxes (1) cannot exceed 25% of the state share of Medicaid expenditures, (2) must be broad based and uniformly applied to all providers in a given category (e.g., all hospitals), and (3) states may not directly or indirectly guarantee that providers will be "held harmless" or reimbursed for the exact amount of taxes paid.[9] The hold harmless restriction only applies where the tax rate paid exceeds 5.5% of the revenue received by the taxpayer.[10]

In 2007, at least 43 states and the District of Columbia were using some form of an industry assessment, and approximately 25 states currently have a hospital provider assessment.[11] As we bid farewell to 2009, only time will tell if Washington will join the ranks of a growing number of states using a provider assessment to mitigate the impact of state budget shortfalls on Medicaid services in the upcoming biennium.

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Notes:

[1] 2009 Wash. Laws Ch. 564.

[2] *Independent Living Ctr. v. Maxwell-Jolly,* 543 F.3d 1050 (9th Cir. 2008), *cert denied* --- U.S. --- (No. 08-1223 June 22, 2009).

[3] 42 U.S.C. § 1396a(a)(30)(A).

[4] *Orthopaedic Hosp. v. Belshe,* 103 F.3d 1491, 1496 (9th Cir. 1997).

[5] *California Pharmacists Assoc. v. Maxwell-Jolly,* 563 F.3d 847 (9th Cir. 2009); *Independent Living Ctr. v. Shewry,* 543 F.3d 1050 (9th Cir. 2008); *Managed Pharmacy Care v. Maxwell-Jolly,* 603 F.Supp.2d 1230 (C.D. Cal. 2009).

[6] *Washington State Pharmacy Ass'n v. Gregoire,* 2009 WL 1259632 (W.D. Wash. 2009); *Washington Health Care Ass'n v. Dreyfus,* 2009 WL 2432005 (W.D. Wash. 2009).

[7] Press Release, California Hospital Association, *Golden State Hospitals to Gain $2.3B in Matching Medi-Cal Funds* (Oct. 15, 2009).

[8] Diane Lund-Muzikant, *Provider Tax is Settled for Good*, The Lund Report, May 28, 2009.

[9] 42 U.S.C. § 1396b(w); 42 C.F.R. § 433.68. Despite numerous efforts, the Centers for Medicare & Medicaid Services (CMS) has had little success in establishing brightline tests for determining when state payments to taxed providers equate to holding those providers harmless. *See e.g., In the Case of Hawaii Department of Human Services, et al.,* Department of Health and Human Services, Departmental Appeals Board, Appellate Decision, No. 2006-1 (Feb. 22, 2006).

[10] 42 C.F.R. 433.68(f)(3)(i)(A). The applicable percentage increases to 6% after September 30, 2011. Earlier this year, CMS delayed a regulation that would have reduced this requirement to 3%, such that provider taxes that totaled more than 3% facility's revenues would no longer count toward a state's matching contribution. *See* 74 Fed. Reg. 31196 (Jun. 30, 2009).

[11] National Conference of State Legislatures, *Health Care Provider, Industry and Tobacco Taxes and Fees* (2009).