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Reform Update: HHS rule allows hospitals to bill state for some presumed-eligible Medicaid patients

By Rich Daly

Hospitals girding for an influx of Medicaid patients in 2014 under the healthcare reform law's Medicaid coverage expansion recently were given some new regulatory tools to deal with the financial fallout.

A final HHS rule (PDF) issued the morning after Independence Day implemented provisions of the Patient Protection and Affordable Care Act that allow hospitals to presume some uninsured patients are eligible for Medicaid and then bill their state program for the cost of their care. The rule specified that states cannot hold hospitals liable for the cost of care for patients they incorrectly assumed were Medicaid-eligible.

“This provision is vitally important for covering the uninsured, because it ensures that if any person who is uninsured but eligible for Medicaid shows up at a hospital needing care, he or she can immediately be enrolled in Medicaid,” Tim Jost, a law professor at Washington and Lee University, recently wrote about the new regulation in a Health Affairs blog post.

The rule will allow hospital to make presumptive eligibility decisions for Medicaid categories where eligibility is income-based. In addition, states have the option of authorizing hospitals to make eligibility determinations based on other qualifying characteristics, such as eligibility stemming from a disability.

The hospital enrollment initiative was backed by the American Hospital Association, although Richard Pollack, the hospital group's senior lobbyist, raised some concerns when the rule was first proposed.

Hospitals may not participate “because they may lack the necessary information on state eligibility and enrollment policies and procedures and because of the uncertainty over whether they could even meet the yet-to-be-established performance standards,” Pollack warned in a Feb. 21 letter to the CMS.

The final details on hospitals' expanded Medicaid enrollment role came amid new evidence of the primary role those facilities serve for low-income residents.

A recent article in Health Affairs by University of Pennsylvania researchers concluded that many low-income patients rely on hospital care over physician offices for a variety of reasons, including perceptions of it as less expensive, more accessible, and of higher quality than ambulatory care.

The authors of the report blamed those preferences for higher-cost hospital-based care on the inaccessibility of office-based primary care. “What we learned is it's not just about insurance,” Dr. Shreya Kangovi, one of the report's authors, said in an interview.

A separate article in Health Affairs reported that two-thirds of primary-care physicians accepted new Medicaid patients in 2011 to 2012. But Kangovi, who is a primary-care provider, noted that the low-income patients in her study reported having physicians who referred them to hospital emergency departments for routine care.

“There's a lot of ways to put up barriers besides not accepting your insurance,” Kangovi said.

Another financial tool included in the new HHS rule allowed states to impose cost-sharing for non-emergency use of a hospital emergency department—up to \$8 for those earning up to 150% of the federal poverty level and no dollar limit on patients with higher incomes. That's strongly opposed by advocates for low-income patients.

“Reducing non-emergency use of hospital emergency departments continues to be a challenge for hospitals and state Medicaid agencies,” Pollack said.

The extent of that challenge was illustrated in a recent AHA report concluding that the growth in emergency department use was driven by low-income patients. Specifically, ED visits from 2004 to 2009 rose 23%, compared with a 42% increase in visits by the uninsured and Medicaid beneficiaries in the same time frame.