Medicaid Financing: Good, Bad and Ugly

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Future Medicaid Challenges

- Limited state match (General Revenue and provider tax) in state budget
  - Support for transitional payments and stop-loss payments (GME)
- Slow revenue growth and increasing spending demands may cause administration and legislative conversations to restrict Medicaid provider reimbursement rates, benefits, or eligibility
- Managing DSH liabilities and potential repayments
- Significant federal changes as a result of OBBBA enactment

Medicaid Pressures: Issues at Play

- Who and what services are covered? Will the state reconsider optional services? Will the state reconsider the expansion population?
- How do we pay providers reasonable rates when state budgets are restricted? What resources are available?
- In Missouri, the managed care contracts are up for rebid effective July 1, 2027. What impact do the new contracts have on hospitals?
- How does the state manage federal policy changes?
- Are local participation levels sustainable?

Federal Hospital Watch List – Short-term

- Expiration of the enhanced premium tax credits for ACA
- Medicaid Eligibility
  - Implementation of work requirements
  - Redeterminations every six months for expansion population
  - Cost-sharing for certain enrollees
  - Retroactive eligibility changes
- Efforts to control drug prices

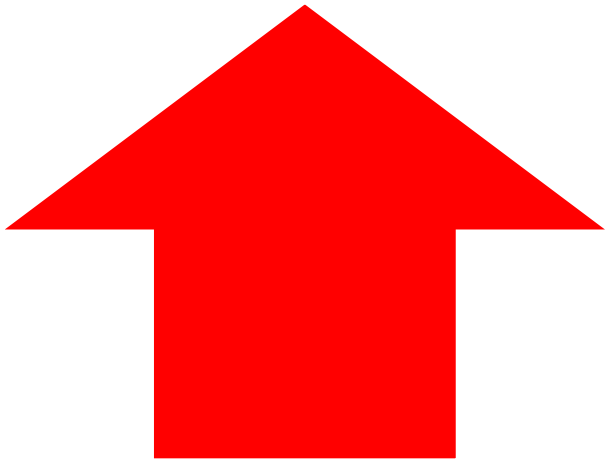
Federal Hospital Watch List – Long-term

- Medicaid payment limits to Medicare
    - Impacts Medicaid managed care rates because of state directed payment changes
- Beginning in 2028, grandfathered payments must be reduced 10% points per year (new guidance)
- Provider Tax Reductions
    - Expansion state phase down begins in 2028
    - .5% annual reduction to 3.5%; current rate is 5%

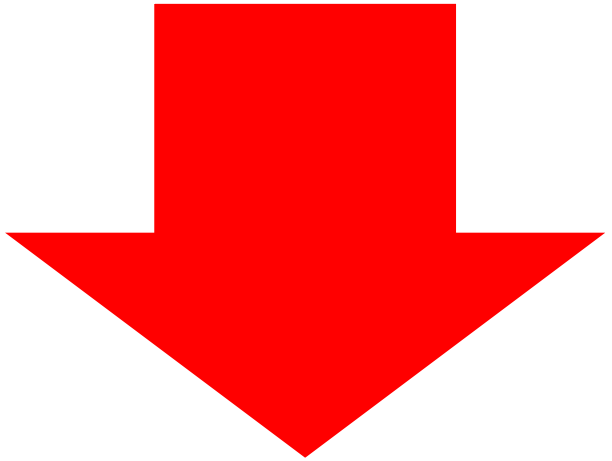
OBBBA: State Directed Payment Changes

- Prior to enactment of H.R. 1 (OBBBA) and presidential memo guidance, CMS allowed states to require Medicaid managed care plans to pay hospitals and other providers up to average commercial rates.
- These state directed payments were targeted by Congress as a mechanism to fund H.R. 1 providing $149.4 billion reduction in federal spending over ten years.
- After bill negotiations, the final H.R. 1 did allow states with preprints submitted before enactment to be grandfathered allowing a window of opportunity for enhanced rates until FY 29.
- In July 2, 2025, MHD filed a preprint for public hospitals (state-owned and non-state governmental) to receive Medicaid managed care payments up to the average commercial rates for inpatient and outpatient services.

What does this mean for hospitals?



- Uninsured costs
- Increased administrative burden
- Internal pressure on finance teams



- Days cash-on-hand
- Reduced margins

When all new provisions are fully implemented without future interventions, it will result in an estimated impact of **$1.2 billion** reduction to Missouri's hospitals.

What Have We Learned

- What history has taught us…
  - The only thing certain in Medicaid reimbursement is that it constantly changes.
- Hospitals are often asked to prepare without final written guidance and governmental direction.
- Hospitals are expected to pivot and manage quickly.
- Challenges have brought opportunity for payment innovation.

Examples of Medicaid Key Policy Changes

Upper Payment Limit

Provider Tax

Out-of-State Payments

Pooling Restrictions

Implementation of Managed Care (1995)

Proposed Limits on Intergovernmental Transfers (IGTs)

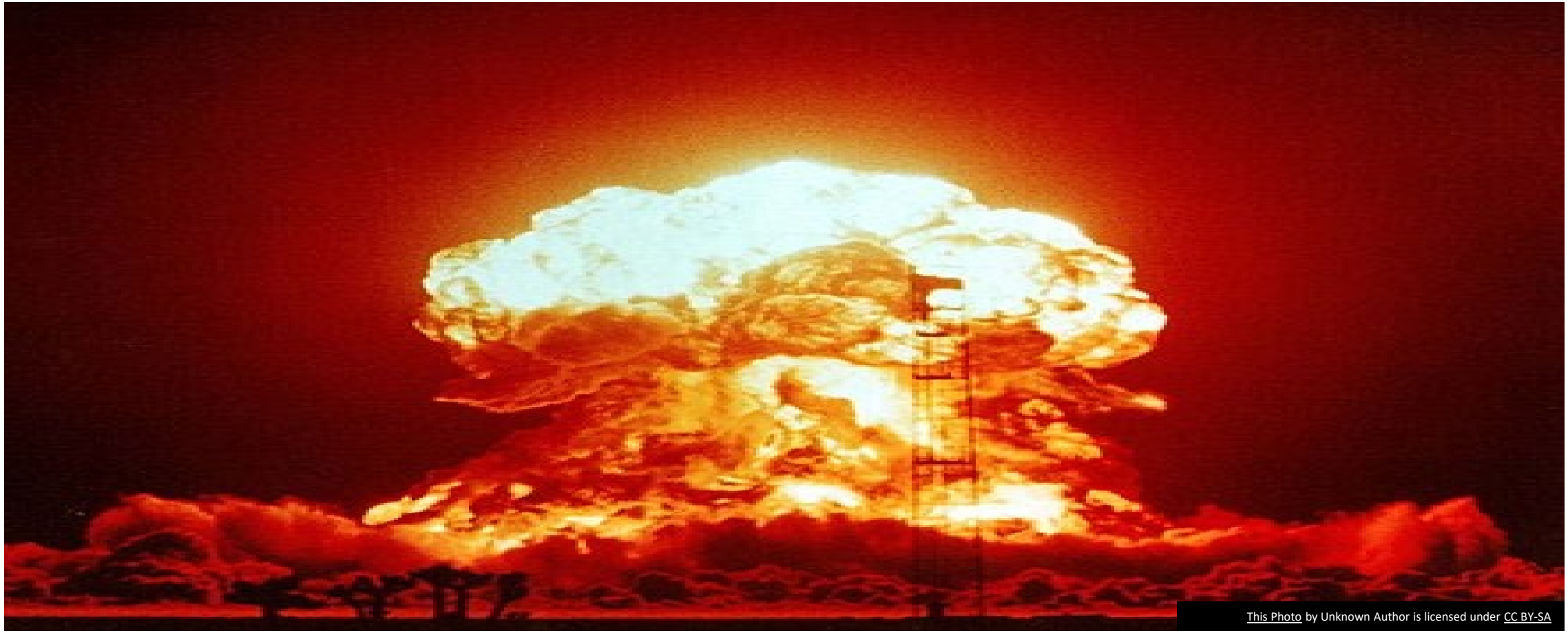
Rebasing from 1995 Costs to 2003

Cost-Based Reimbursement to DRG Methodology

Implementation of Hospital-Specific DSH Limits

Outpatient Services to a Fee Schedule

What we thought would happen!



Medicaid Upper Payment Limit Payments – Hospitals

SFY 2010 – The gap was $54,225,626
- Actually paid out $33 million
  - Worked with a public hospital for intergovernmental transfer (NKC)

SFY 2011 – The gap was $115,845,954
- Actually paid out $73.6 million
  - Worked with a public hospital for intergovernmental transfer (UMC)

SFY 2012 – The gap was $105,744,571
- Actually paid out $67.1 million
  - Worked with a public hospital for intergovernmental transfer (UMC)

SFY 2013 – The gap was $156,195,995
- Never paid out

Medicaid Upper Payment Limit – Nursing Homes

August 2000 – December 2000
- 7 Nursing Homes
- IGT Transfer Amount
  $85,227,273

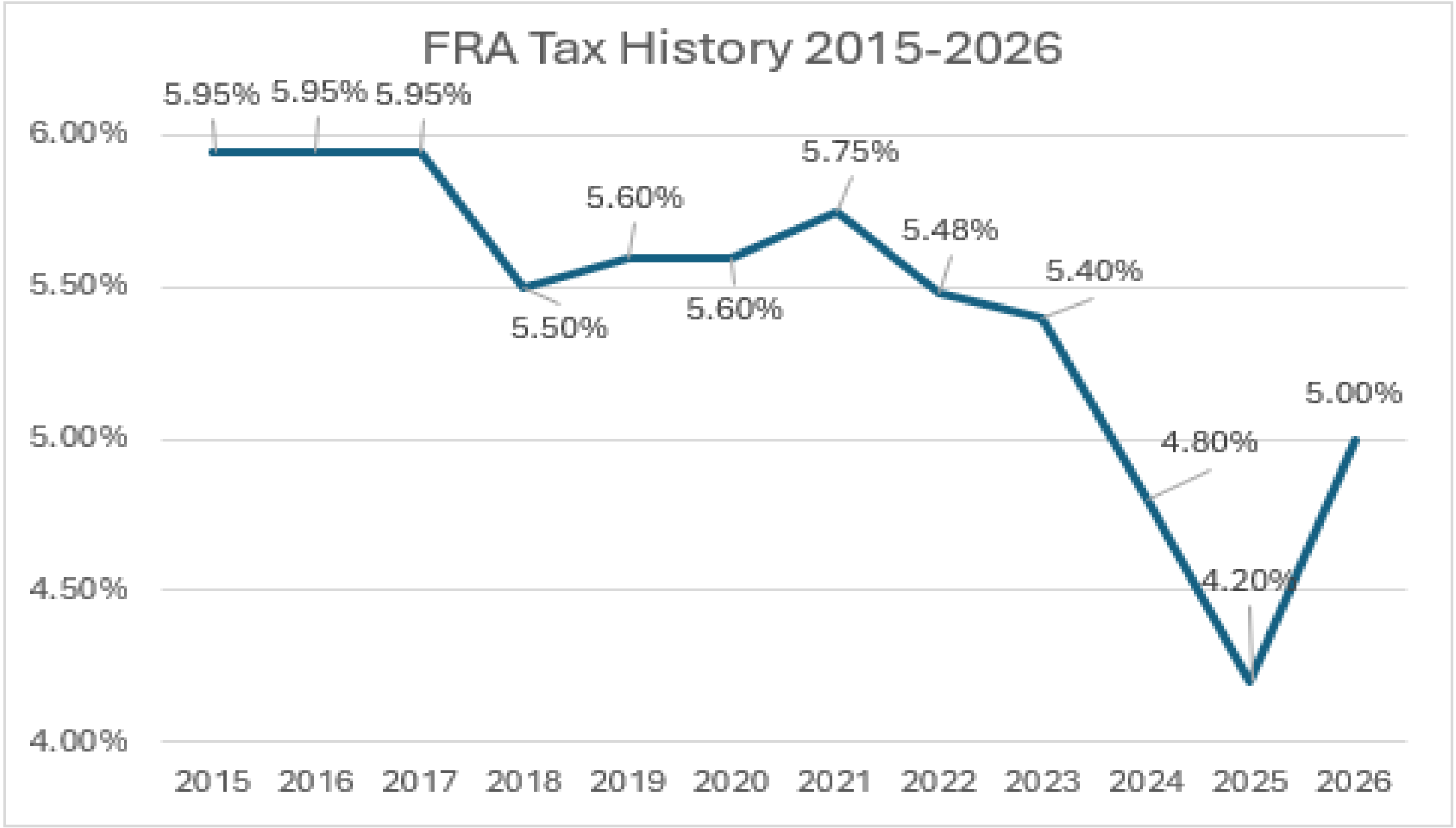
September 2000 – June 2001
- 10 Nursing Homes
- IGT Transfer Amount
  $11,295,039

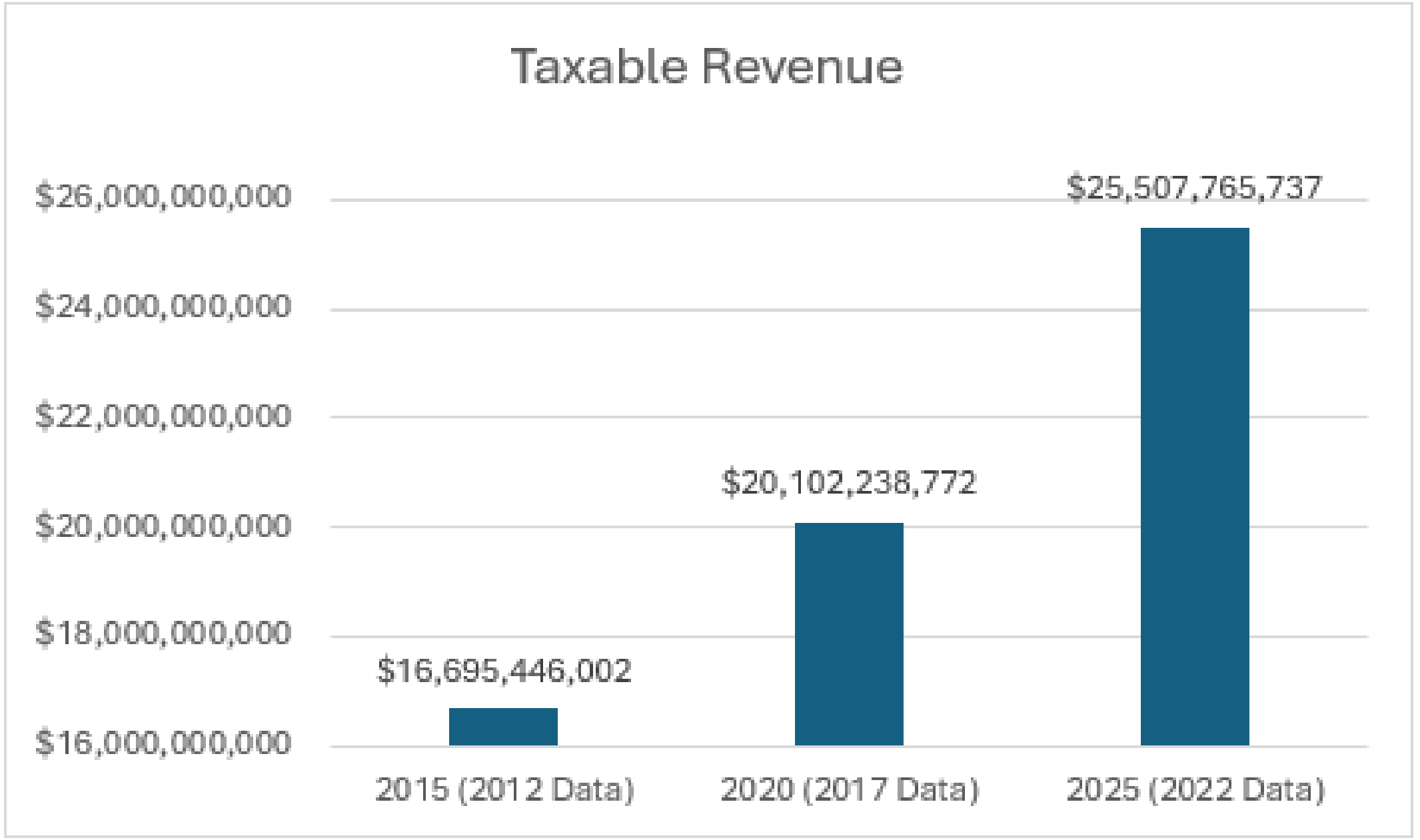
January 28, 2002
- 7 Nursing Homes
- IGT Transfer Amount
  $81,750,000

September 25, 2002
- 7 Nursing Homes
- IGT Transfer Amount
  $119,600,000

January 15, 2003
- 5 Nursing Homes
- IGT Transfer Amount
  $8,217,000

January 13, 2004
- 5 Nursing Homes
- IGT Transfer Amount
  $22,234,978


FRA Tax History 2015-2026
5.95%
5.95%
5.95%
5.50%
5.60%
5.60%
5.75%
5.48%
5.40%
4.80%
4.20%
5.00%
6.00%
5.50%
5.00%
4.50%
4.00%
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026


Taxable Revenue
$26,000,000,000
$24,000,000,000
$22,000,000,000
$20,000,000,000
$18,000,000,000
$16,000,000,000
$16,695,446,002
$20,102,238,772
$25,507,765,737
2015 (2012 Data)
2020 (2017 Data)
2025 (2022 Data)

Out-of-State Payments

Out-of-State Payments for SFY 2002: $14,105,039

Out-of-State Payments for SFY 2022: $215,203,568

**This payment reimbursed a hospital for the difference between its cost-per-day and its per-diem times its out-of-state days*

Highest Record Pooling

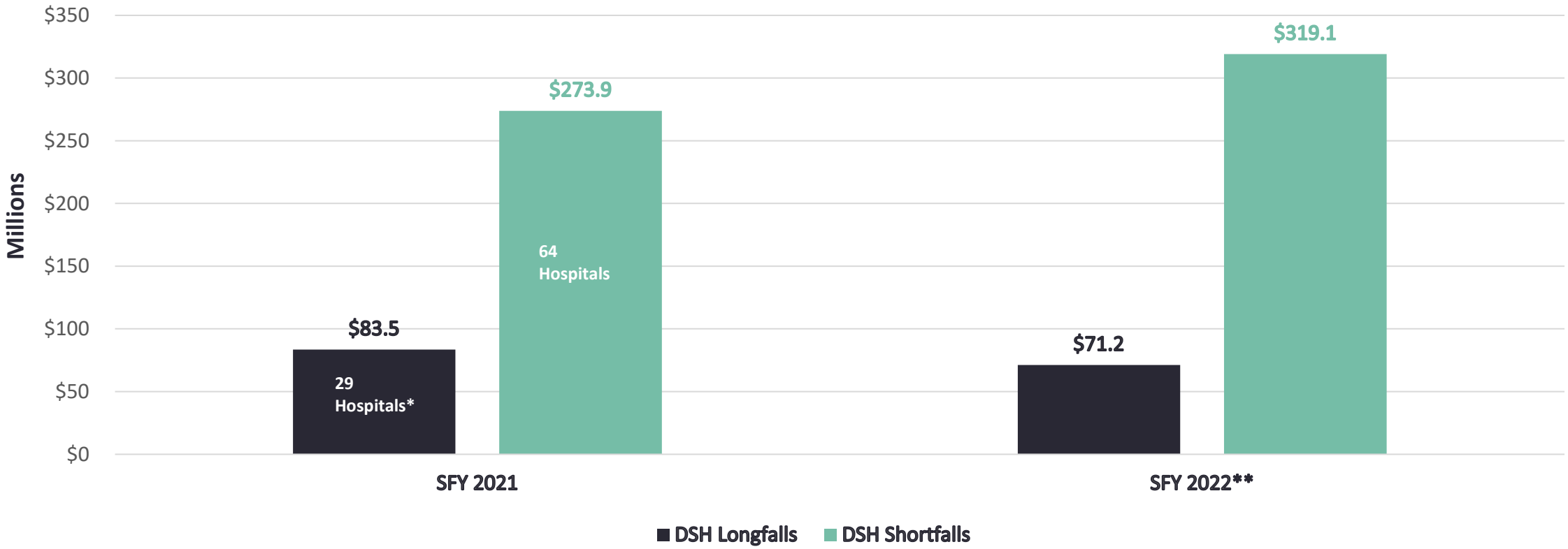
SFY 2022 (beginning of year)

- $83,111,853 Pool
- $16,030,000 B1/B2

SFY 2026

- $26,038,784 Pool
- $3,889,000 B1/B2

DSH Longfalls and Shortfalls SFY 2021 and SFY 2022



*Two bankruptcy hospitals with DSH longfalls (totaling $604,038) have been excluded.
**Two bankruptcy hospitals with DSH longfalls (totaling $1,773,163) have been excluded. One closed hospital with a DSH shortfall (totaling $5,703,235) has been excluded as well.
Note: The State Institutions of Mental Disease (IMDs) have been excluded from the above figures.

What happened!

Is the Medicaid Sky Falling?

- In our opinion, no - just dark and somewhat gloomy, but the sky will clear.
- There are strong supporters of hospitals at each level of government – local, state and federal.
- Our industry is too important to fail.
- As we've thought about our 40+ year careers, what seems impossible to overcome becomes possible when we work together.

What Can Hospitals Do to Help?

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- Work to understand Medicaid reimbursement – read regulations, review provider bulletins, help MHA understand how a change may impact your hospital
- Support advocacy efforts
- Share problems with state's Medicaid leadership and MHA team
- Be specific and have data when possible, to support your position
- Be aware of the new Medicaid Managed Care contract (RFP) process

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- Yes