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Issues for Medicaid Nursing Facilities Under the American Recovery and Reinvestment Act

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The American Recovery and Reinvestment Act of 2009 (ARRA)[1] represents a landmark effort to revive a flagging national economy in the throes of a deep recession. The ARRA contains approximately $787 billion of federal spending aimed at stimulating the economy through an array of projects and initiatives. Of this amount, more than 11% ($87 billion) is targeted to Medicaid and to furnishing states with increased federal assistance to maintain and administer their Medicaid programs.

The Medicaid stimulus provisions are incorporated into Title V of the ARRA (State Fiscal Relief).[2] Section 5000(a) explains that the purposes of this particular title of the ARRA are:

(1) To provide fiscal relief to States in a period of economic downturn.

(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.

A number of ARRA provisions under Title V directly or indirectly affect nursing facilities (NFs) that participate in Medicaid; understanding the terms and limits of these provisions will be crucial for NFs to address Medicaid program actions, including rate restrictions and cuts. This article examines four particular ARRA provisions and their implications for Medicaid NFs:

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—from a declaration of the American Bar Association

- Temporary enhancements to the rates of federal financial participation (FFP);[3]
- Constraints on the use of the enhanced FFP by states with respect to Medicaid eligibility but not with regard to Medicaid benefits or provider rates;[4]
- Prompt-pay requirements;[5] and
- Prohibition on diversion of monies to state reserve or rainy-day funds.[6]

Enhanced FFP Rates

Under ARRA Section 5001, the states' FFP rates for the period October 1, 2008, through December 31, 2010, are or may be increased in three different ways:

(1) FFP Grandfathering Maintenance—If a state's FFP rate would ordinarily have declined during any portion of this time, the state is permitted to stay at the higher or highest FFP rate applicable to any preceding period from federal fiscal years (FYs) 2008, 2009, or 2010. Specifically, if a state's FFP rate would have declined in FY 2009, it reverts to the FY 2008 FFP rate; if that rate would have declined in FY 2010, it will be set at the higher of the FFP rates for FYs 2008 or 2009; if that rate would have declined for FY 2011, it will be established at the highest rate of the FFP rates for FYs 2008, 2009, or 2010, but only for the first quarter of FY 2011.[7]

(2) Across-the-Board Increase—Each state receives a FFP boost of 6.2% for this period.[8]

(3) High-Unemployed-States Adjustments—States with high unemployment rates receive additional 5.5%, 8.5%, or 11.5% increases in their FFP match levels depending upon the degree of job losses within the state.[9]

These increases in the FFP rates give states additional federal monies that may enable them to bridge their own budget shortfalls because of recessionary-driven declines in state tax revenues. A useful table showing the FY 2009 FFP rates of the individual states with the various ARRA adjustments is available at the Henry J. Kaiser Family Foundation website.[10] Interestingly, under the adjustments, for FY 2009, Mississippi has the highest FFP rate (83.6%); New Hampshire and Wyoming have the lowest (56.2%) rates. Nevada (13.9%) and Florida (12.2%) received the highest FFP increases; Iowa, Kansas, Nebraska, New Hampshire, South Dakota, Wisconsin, and Wyoming received the lowest (6.2%) increases.

The sections that follow detail the various strings attached to the federal ARRA purse.

Eligibility Maintenance

The previously quoted language from the ARRA Section 5000 purposes provision suggests that the legislation is designed to help avoid Medicaid rate cuts for providers as well as reductions in benefits or services. The legislation also aims to prevent "constrictions in income eligibility requirements."[11] A careful examination of the ARRA and its legislative history, however,

reflects that Medicaid rate and benefit cuts are not barred, but that states are only required to maintain their efforts with respect to Medicaid eligibility.

In particular, under the ARRA, states must have Medicaid eligibility standards that are no more stringent than those that were in effect on July 1, 2008.[12] If a state fails to do this (i.e., if it keeps in place any tightening of Medicaid eligibility standards imposed after July 1, 2008), the state is ineligible for any of the increases in its FFP rate.[13] This maintenance-of-effort provision applies only to Medicaid eligibility standards. Proposed amendments to the ARRA to have similar maintenance-of-effort requirements as to Medicaid benefits and Medicaid payment rates for providers were rejected and, as such, were not included in the final legislation. In essence, this means that under the ARRA itself, states may be sanctioned for imposing tougher Medicaid eligibility criteria but they cannot be penalized for cutting back on Medicaid benefits or provider rates.

It should be emphasized that, although Medicaid benefit or rate cuts may be permissible under the ARRA, beneficiaries and providers may still have legal claims against such cuts based upon other provisions of the federal Medicaid Act or perhaps even state law. These include but are not limited to procedural and substantive requirements such as:

- *Public notice*;[14]
- *The Medicaid state plan amendment approval process*;[15]

- *The "equal access" provision* requiring that Medicaid payment rates be consistent with efficiency, economy, and quality of care, and sufficient to enlist enough providers that services are as available to Medicaid beneficiaries as to the general population in the geographic area;[16]
- *The "reasonable promptness" requirement* that medical assistance under the state plan must be furnished with reasonable promptness;[17] and
- *The "comparability of services" and "amount, duration, and scope" mandates* that Medicaid services for certain eligible individuals be comparable to Medicaid services provided to similarly situated individuals.[18]

To date, anecdotal evidence suggests that many states use the savings in state funds from enhanced FFP under the ARRA to plug other holes in their state budgets, rather than maintaining or restoring Medicaid rates or benefits. Beneficiaries and providers have had some success recently in challenging such cuts, particularly in the Ninth Circuit, whether they came before or after the ARRA's enactment.[19]

Prompt Pay

Prior to the ARRA's enactment, 42 U.S.C. § 1396a(a)(37)(A) required state Medicaid programs to have claims payment procedures to ensure that: (1) 90% of claims for payment for which no further written information or substantiation is necessary (i.e., clean claims) for Medicaid-covered services of "health care practitioners through individual or group practices or through shared health facilities" are paid within thirty days of receipt; and (2) 99% of such claims are paid within ninety days of receipt.

The ARRA extends the prompt-pay provisions beyond physicians to include NFs and hospitals.[20] It should be emphasized, however, that this extension is limited in a number of respects.

First, it applies only to claims made for covered services *after* the ARRA's enactment (February 17, 2009).[21] As such, this provision does not encompass claims for covered services prior to February 18, 2009.

Second, as to NFs and hospitals, state Medicaid programs are given a prompt-payment grace period. Specifically, no period of ineligibility for the enhanced FFP rates—the statutory sanction for failure to comply—is to be imposed against state Medicaid programs prior to June 1, 2009.[22] In essence, this means that for periods through May 31, 2009, the prompt-pay provisions as to NFs and hospitals are not to be enforced. In other words, states have until June 1, 2009, to get their Medicaid payment mechanisms for NFs and hospitals in order. Notably, it appears that the Secretary will read the grace-period provision to apply only to claims made on and after June 1, 2009, and measured thereafter by the thirty-day and ninety-day deadlines.[23] Thus, for example, 90% of claims filed on June 1, 2009, will have to be paid by July 1, 2009, and 99% will have to be paid by August 29, 2009. Claims prior to June 1, 2009, would be covered by the grace period even if the prompt-payment provisions are not met with respect to them and even though non-compliance would occur on and after June 1, 2009. An alternative reading would have interpreted the grace period to end June 1, 2009 and, by that time, states would have had to have paid 90% of clean claims filed thirty days previously (May 2, 2009), and 99% of clean claims filed ninety days previously (March 3, 2009). Obviously, the Secretary's reading is much more favorable to the states.

Third, the Secretary is authorized to waive the prompt-payment provisions or related reporting requirements for states when "there are exigent circumstances, including natural disasters, that prevent the timely processing of claims or the submission of a report."[24] It is unclear how broadly or narrowly the Secretary will interpret this authority. Assumedly, it should be confined to truly extraordinary circumstances that are entirely beyond states' control—i.e., acts of God such as natural disasters (like fires, earthquakes, hurricanes, tornadoes, or floods), war, riot, or strikes, *and* that directly preclude a state's ability to meet the prompt-pay or reporting requirements.[25] It should not include neglect or administrative inadequacy on the state's part.[26]

Fourth, because the prompt-pay provisions apply to clean claims, there is a legitimate concern that some states could drastically narrow their definitions of such claims to evade or avoid these requirements.

Finally, the prompt-pay requirements for NFs and hospitals sunset after the end of the "recession adjustment period" (December 31, 2010).[27]

Anti-Diversion Provisions

Under the ARRA, states are ineligible for portions of the increased FFP (i.e., the 6.2% across-the-board increase and the high unemployment increase but *not* any grandfathering maintenance increase) if any sums that are directly or indirectly attributable to those increases are deposited in or credited to any state reserve or rainy-day fund.[28] This provision's purpose is relatively clear—Congress wanted states to spend the state dollars saved by the enhanced FFP on something to revive the economy. Those expenditures do not necessarily have to be related to Medicaid or healthcare. But, the state cannot squirrel the state savings away in an emergency or contingency fund.

The issue is: how carefully or stringently will this prohibition be interpreted? By its terms, it does not seem to foreclose any and all additions to a state's reserve or rainy-day fund—only those "directly" or "indirectly" related to the enhanced FFP. Certainly, most states are sufficiently sophisticated that they could engage in enough budgetary legerdemain to make any money trail relatively opaque. The Secretary has not yet furnished enforcement guidelines. One conceivable approach would be to presume that any such additions are impermissible and impose the burden of proof on states to demonstrate otherwise and to rebut this presumption.

Conclusions

Although enhanced FFP under the ARRA is a measure widely welcomed by Medicaid NFs, there is no guarantee that states will use the additional monies to ensure rate stability. Indeed, many states have openly expressed concerns that if Medicaid rates

are not curtailed now, they will have to take even more drastic measures when the enhanced FFP rates disappear and states have to use their own monies to make up the difference. As a consequence, it will be imperative for NFs, their associations, and their attorneys to educate state Medicaid agencies and state legislatures that the use of stimulus and state monies for this purpose not only is consistent with the overall objectives of the ARRA and represents the highest and best use of those funds, but also comports with ensuring quality of care for program beneficiaries. Likewise, they will need to work with Congress and the Secretary to assure that adequate enforcement policies result in careful monitoring of state compliance with the ARRA's requirements as to enhanced FFP, maintenance of effort as to eligibility standards, prompt payment, and anti-diversion.[29] If such efforts are unsuccessful, however, many providers and beneficiaries will likely seek redress in the courts. Of course, all of this may eventually be overshadowed by the imminent healthcare reform debate, the results of which may be even more consequential for Medicaid NFs.

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1 P.L. No. 111-5 (Feb. 17, 2009).
2 ARRA, Sections 5000-5008.
3 ARRA, Section 5001(a)-(e).
4 *Id*. at Sections 5000 and 5001(f)(1).
5 *Id*. at Section 5001(f)(2)(B).
6 *Id*. at Section 5001(f)(3).
7 *Id*. at Section 5001(a).
8 *Id*. at Section 5001(b). It should be noted that such FFP increases have occurred before. For example, Section 401 of Title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003, P.L. No. 108-27 (May 28, 2003), granted a 2.95% FFP increase across the board for the period April 1, 2003, through June 30, 2004.
9 ARRA, Section 5001(c).
10 *See* www.statehealthfacts.org/comparemaptable.jsp?ind=695&cat=4.
11 ARRA, Section 5000(a)(2).
12 *Id*. at Section 5001(f)(1).
13 *Id*. at Section 5001(f)(1)(A).
14 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. § 447.205 (governing content, publication, and timing requirements).
15 42 C.F.R. §§ 430.12(c), 430.20(b)(2), and 447.256(c) (detailing when proposed plan amendments are required and the timing for such submissions and their effective dates).
16 42 U.S.C. § 1396a(a)(30)(A).
17 42 U.S.C. § 1396a(a)(8).
18 42 U.S.C. § 1396a(a)(10)(B).
19 E.g., *California Pharmacists Ass'n v. Maxwell-Jolly*, No. 09-55365 (9th Cir. Apr. 6, 2009), *reported in* Medicare & Medicaid Guide (CCH) ¶ 302,863 (preliminary injunction against legislatively mandated rate cuts in California due to non-compliance with the "equal access" provision); *Independent Living Center of Southern California v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (reversing and remanding the district court's denial of a preliminary injunction as to Medicaid rate cuts in California); *Washington State Pharmacy Ass'n v. Gregoire*, No. C09-5174-BHS (W.D. Wash. Mar. 31, 2009), *reported in* Medicare & Medicaid Guide (CCH) ¶ 302,859 (temporary restraining order against 6% Medicaid rate cut in Washington; based on likely "equal access" violation); *Managed Pharmacy Care v. Jolly*, No. CV 09-382 CAS (MANx) (C.D. Cal. Feb. 27, 2009) *reported in* Medicare & Medicaid Guide (CCH) ¶ 302,772 (preliminary injunction against legislatively required 5% Medicaid rate cut in California; premised on likely "equal access" violation); *Independent Living Center of Southern California v. Shewry*, CV 09-3315 CAS (MANx) (C.D. Cal. Aug. 18, 2008), reported in Medicare & Medicaid Guide (CCH) ¶ 302,604 (preliminary injunction issued under "equal access" provision following remand from Ninth Circuit).
20 ARRA, Section 5001(f)(2)(B)(i).
21 *Id*. at Sections 5001(f)(2)(A)(iv) and (B)(i).
22 *Id*. at Section 5001(f)(2)(B)(ii).
23 Comments of Richard Strauss, acting deputy director of the Financial Management Group, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, during the June 2, 2009, teleconference of the American Health Lawyers Association on "Implementing the Medicare and Medicaid Provisions in the American Recovery and Reinvestment Act of 2009."
24 ARRA, Section 5001(f)(2)(A)(iii).
25 *See* 42 C.F.R. § 413.40(g)(2) (Medicare rate adjustments for unusual costs incurred due to "extraordinary circumstances".)
26 *See* 45 C.F.R. § 95.22(c) (defining "good cause" for late filling of state claim).
27 ARRA, Sections 5001(h)(3) and (i).
28 *Id*. at Section 5001(f)(3).
29 Developments concerning the ARRA may be followed *at* www.hhs.gov/recovery/ (the portion of the website of the United States Department of Health and Human Services devoted to the ARRA).

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