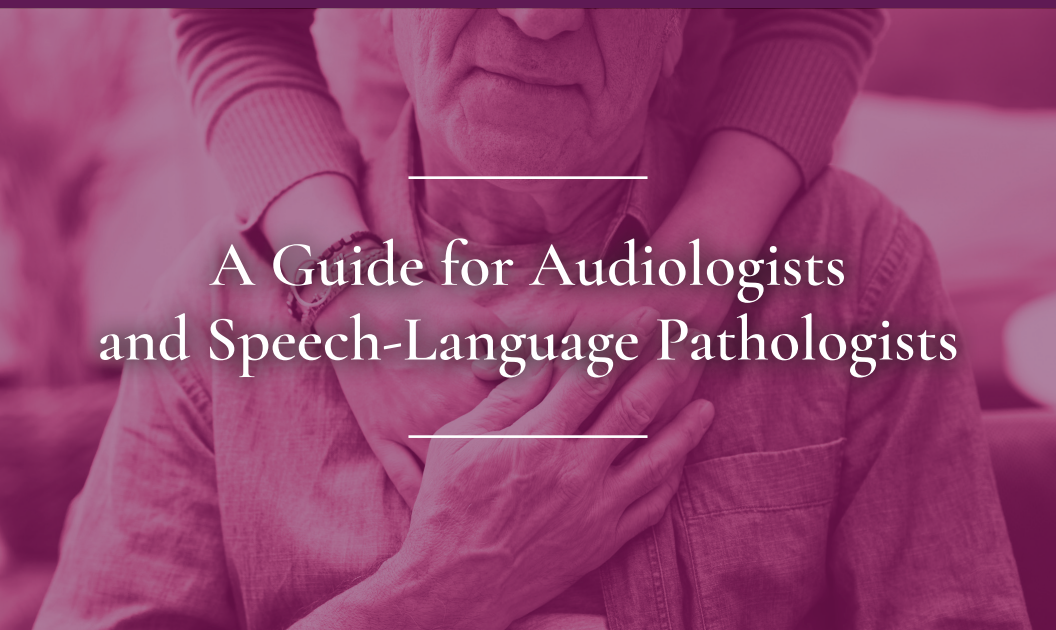
MEDICARE VS MEDICAID



A Guide for Audiologists and Speech-Language Pathologists

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GOVERNMENT-FUNDED HEALTH CARE IN TWO PARTS

Both Medicare and Medicaid are health insurance programs that the government provides to specific populations who might not otherwise be covered or have the ability to pay privately for health care services. It's important for audiologists and speech-language pathologists (SLPs) to understand who these programs serve, how they're funded, and who oversees and administers them.

MEDICAID

- Jointly funded by the state and federal government.
- Most policies, including reimbursement rates, are developed at the state level. Each Medicaid agency acts on its own with some parameters set by the federal government.
- Medicaid covers inpatient and outpatient services, prescription drugs, and some services offered in the schools.

MEDICARE

A federally funded and managed health insurance program comprised of four parts:

- **Part A:** Inpatient services such as hospitals and skilled nursing facilities
- **Part B:** Outpatient services such as private practices and university clinics
- **Part C:** Medicare Advantage, private plan replacements for traditional Medicare
- **Part D:** Prescription drugs.

Who Is Eligible?

MEDICAID

- Low-income children and families
- Qualified pregnant women and children
- Individuals receiving Supplemental Security Income (SSI)
- States have additional flexibility and can choose to cover more people, including medically needy individuals, children in foster care, and, as a result of the Affordable Care Act, low-income adults.

BOTH

Medicare and Medicaid both cover services provided in:

- Private practice
- Care facilities like hospitals, home health, long-term care hospitals, rehabilitation agencies, and outpatient hospital departments, as well as inpatient rehabilitation facilities and skilled nursing facilities
- Physician offices
- University clinics

MEDICARE

- People 65 and older
- People who are permanently disabled

Billing and Cash Pay

MEDICAID

- There is no **federal requirement** to enroll in Medicaid.
- **Each state Medicaid program has its own policies for cash pay.** Providers must consult with the state Medicaid program before accepting cash pay to ensure they are complying with any program requirements. Even if a provider is out of network with a Medicaid program, Medicaid beneficiaries themselves are required to comply with the contracts they have with their insurance companies.

MEDICARE

- **Federal law** requires that audiologists and SLPs enroll in and bill Medicare for covered services.
- **There is no option to "opt out"** (although physicians are legally allowed to do this), and you can't charge the patient even if they are willing to pay out of pocket. Failure to comply with this could result in a determination that you must reimburse the Medicare patient for every cent you took from them plus the application of civil monetary penalties.

BUT WHY?

Policymakers view mandatory enrollment and claim submission as a patient protection for Medicare and Medicaid beneficiaries.

Medicare is predicated on the idea that we pay into the system our whole working lives so if we're lucky enough to make it to 65, or if we unfortunately become disabled, Medicare will be there to help cover our costs. Paying out of pocket almost seems like paying twice. Most Medicare patients are retired and on fixed incomes, so they can't afford to pay out of pocket. Given that we pay into the system during our working lives, we will likely not appreciate having to pay out of pocket for services we thought would be covered when we qualify for Medicare.

The same is true for Medicaid: We pay into those benefits so that they're available to us if we need them. Medicaid beneficiaries are often low income and/or have multiple complex, costly medical conditions that make it challenging to pay for services on their own. The expectation is that if people are in need of Medicaid benefits, they likely cannot afford to pay out of pocket for covered services.

Different State, Different Rules

- **In State A**, you could be required to enroll in Medicaid if you are enrolled in Medicare.
- **In State B**, if you practice in the schools, you could be required to enroll in Medicaid.
- **In State C**, you could be required to enroll across plans.

You **must** verify enrollment requirements if you provide services in your state.

How Are Medicaid Payment Rates Set? Who Decides How Much You Get Paid?

MEDICAID

- **Rates are set by each state Medicaid program**, not by the federal government.
- **State Medicaid programs develop a fee schedule, which includes a list of all procedure codes that are eligible for payment across all professions**, including audiology and speech-language pathology.
- Payment rates in the fee schedule are based on money that is appropriated to the state Medicaid program as part of the **state budget** AND money appropriated at the federal level in the form of the **Federal Medical Assistance Percentage (FMAP)**.
- The FMAP is the part of the money that the federal government pays to state Medicaid programs. It's calculated via a specific formula that results in a different FMAP for each state. Each state's FMAP is based on how much the state spends on Medicaid, so states with a higher Medicaid population (and thus a bigger Medicaid budget) get more money from the federal government.

EXAMPLE STATE BUDGET

Federal funds that are contributed to a state's unique Medicaid budget. Additional federal matching funds as part of Medicaid expansion can be rejected for political reasons by a state, which would decrease available resources.

DID YOU KNOW?

State legislators and Medicaid program staff are the major decision makers around Medicaid. **Legislators' political agenda directly sets the level of funding** that Medicaid providers (you) and beneficiaries receive. Those who set the fee schedule decide how much you should be paid.

Some state governments have chosen not to expand Medicaid and are therefore leaving valuable federal Medicaid money on the table for political reasons, even though it would be available for their use if they decided they wanted it.

How Are Medicare Payment Rates Set? Who Decides How Much You Get Paid?

MEDICARE

- **Rates are set by the federal government.**
- You are paid based on the value of the CPT code multiplied by a set dollar amount, minus any budget neutrality adjustments that are applied.
- **Part B does not have an annual inflationary update, and the system is required to remain budget neutral.** That means if program spending increases in one area—like primary care—spending must be cut in another area—like surgical or therapy services.
- **All providers—regardless of specialty—who bill Part B have not had a positive annual payment adjustment from 2020 to 2025.** Beginning in 2026, clinicians participating in alternative payment models will receive an annual 0.75% payment update. Clinicians participating in the payment/reimbursement code will receive an annual 0.25% payment update.

REALITY CHECK

Inpatient services: Part A systems have written into law annual inflationary updates known as the market basket.

Outpatient services: *Five years is a long time to go without a rate update!* Normally there would be a small increase, but in 2015 all clinicians paid under Part B accepted a five-year pause on annual updates to pay for the elimination of the sustainable growth rate (SGR) formula. The SGR was a flawed methodology that led to payment reductions that Congress had to fix annually for nearly 20 years. Payment policy is a slowly developing process that involves tough tradeoffs because to fix it, you need to pay for the fix and identify where the money to do that will come from.

MEDICARE PART B PAYMENT FORMULA

CPT CODE VALUE × **FEDERAL $ AMOUNT** − **BUDGET NEUTRALITY ADJUSTMENTS** = **PROVIDER PAYMENT**

What Is "Managed Care" and How Does It Affect Medicare and Medicaid Programs?

MANAGED CARE WHAT?

Managed care happens when a state Medicaid agency or a federal program, like Medicare, contracts with outside entities to cover Medicare and Medicaid beneficiaries.

DID YOU KNOW?

Managed care is called lots of things in different states. For Medicaid, managed care health plans can be called **"managed care organizations"** (MCOs), **"health plans," "prepaid health plans,"** or **"care management organizations."** Check your state Medicaid program's website to see what they're called in your state.

People refer to Medicare managed care as Medicare Part C, Medicare Advantage, and Medicare replacement plans. Medicare Advantage plans are different from Medicare supplemental insurance that is primarily designed to help Medicare beneficiaries pay cost-sharing obligations like co-pays and deductibles.

MEDICAID

- **MCOs** contract with state Medicaid agencies to provide health care to Medicaid beneficiaries. **Most Medicaid beneficiaries in the U.S. receive their health care through an MCO**. In addition to contracting with the state Medicaid agency, audiologists and SLPs may also need to contract with MCOs—which differ from state to state—to deliver services to Medicaid beneficiaries.
- Just like the Medicaid state programs, MCOs have a wide degree of flexibility when covering services and can set up their own administrative protocols like prior authorization. **MCOs can also decide to pay the same, more, or less than the Medicaid fee schedule.**

MEDICARE

- Medicare Advantage plans (Part C) are private health plans that contract with the federal government to provide Parts A, B, and, in some cases, D of the Medicare benefit.
- While they are required to cover "traditional" Medicare benefits, they can use a variety of utilization management techniques. They can also cover additional services not traditionally covered by Medicare such as meal delivery, gym memberships, or hearing aids. **They can also set different reimbursement rates than traditional Medicare.**

Why Managed Care?

74%

OF MEDICAID BENEFICIARIES **USE AN MCO**

51%

OF MEDICARE BENEFICIARIES **USE MEDICARE ADVANTAGE**

State and federal governments contract with MCOs to provide care to Medicare and Medicaid beneficiaries in a more cost-effective way than paying for them on a straight fee-for-service basis. State and federal budgets are often financially strained, so while they are bound to cover health care for enrolled beneficiaries, state and federal governments often aim to save money while they do so. Sometimes that will look like utilization management techniques–like prior authorization–to ensure that all covered care has met certain medical necessity criteria.

What Are the Major Roadblocks to Better Pay?

MEDICAID

- There is insufficient health care funding across the U.S.
- There is a lack of political will to fund health care programs for low-income and medically needy individuals.
- State legislators can leave additional federal matching funds on the table as a symbolic gesture of their opposition to Medicaid.
- Medicaid is usually one of the biggest expenses that a state budget has, so it is often one of the first elements cut in the case of budget shortfalls.
- MCOs can pay lower rates than Medicaid.

MEDICARE

- Budget neutrality requirements arbitrarily and inappropriately reduce payments for many services under the Medicare fee schedule, including audiology and speech-language pathology services. **The budget neutrality requirement is set at the Congressional level.**
- **The budget neutrality requirement has reduced payments** to 37 clinical specialties, including audiology and speech-language pathology, in order to pay more for primary care services for the last several years.
- **There is currently no fundamental or permanent solution to inadequacies in the payment system,** even though Congress has temporarily mitigated annual reductions on several occasions.

UNDERFUNDING MEDICAID AND MEDICARE MEANS...

- Longer wait times for patients
- Longer travel times to reach providers who accept Medicare or Medicaid
- Practices closing their doors because they cannot afford to stay in business
- Provider unemployment, which jeopardizes access to care and increases the financial strain on unemployed individuals and their communities
- Increased healthcare costs (including hospitalization) for conditions that could have been effectively managed but became more serious due to lack of care.

Impact on Patients and Clinicians

CASE STUDIES

Jane (she/her/hers) was discharged from a hospital to a skilled nursing facility to home after a stroke. Unfortunately, despite complaining that swallowing was tough, Jane could not find an SLP within a 30-mile radius of her home that was in network with Medicare or Medicaid. Within a week of discharge, Jane aspirated and was re-hospitalized with pneumonia. With timely access to care, Jane's extremely costly hospitalization could have been avoided.

Marcus (he/him/his) had been having dizzy spells for almost two weeks. He called his primary care physician, who recommended an evaluation by an audiologist. Marcus called multiple audiologists with wait lists of three or more weeks. Unfortunately, Marcus fell due to his dizziness and broke his shoulder. After a short stay in acute care, Marcus was discharged to an inpatient rehabilitation facility for three weeks to rehab his shoulder. Timely access to an audiologist could have prevented Marcus's fall, broken shoulder, and time away from family and friends.

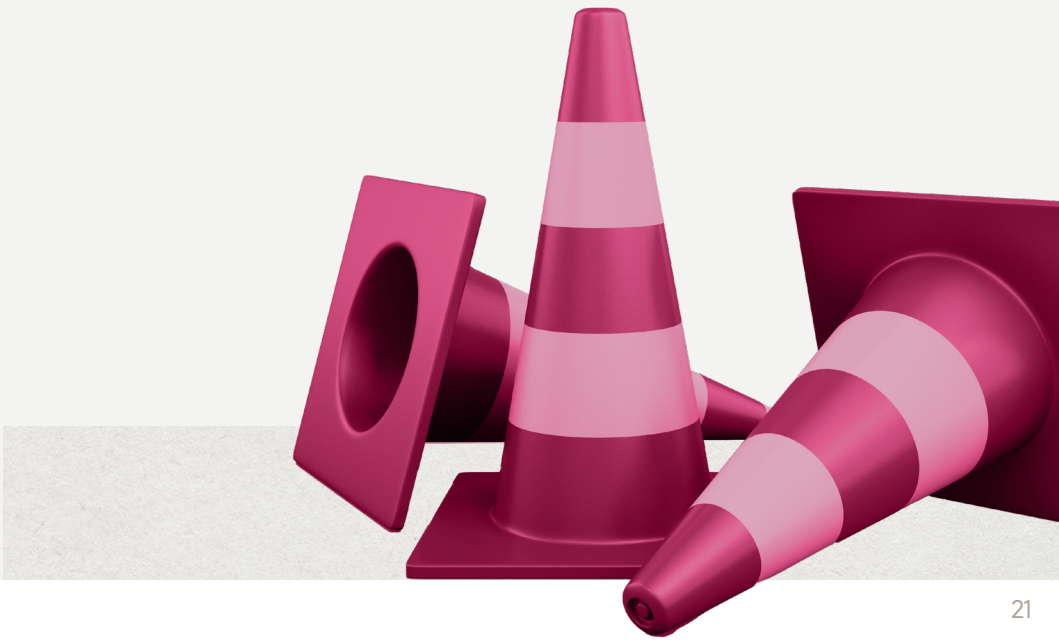
REALITY CHECK

37 clinical specialties–working collaboratively and independently–**have not been able to eliminate or permanently fix the Medicare budget neutrality cuts** our members have experienced for the last several years.

The previous payment reductions, associated with the sustainable growth rate, took **18 years of consistent engagement with Congress to repeal** (1997-2015).

CHANGE ISN'T EASY

It costs money to expand budgets–but where does that money come from? What other programs need/want it? When demanding better reimbursement or better funding for these programs, it's important to **focus on who makes the decisions and why**. They're the people we all have to convince.



Who Are the Major Players in Payment Decisions?

MEDICAID

- State governments
- State Medicaid programs
- Federal government
- Managed care plans

MEDICARE

- Congress
- Specialty societies, like ASHA, working through the code development process to recommend values to the Centers for Medicare & Medicaid Services (CMS)
- Private payers administering the plan (for Medicare Advantage plans)
- CMS

FACT CHECK

Your state licensing board has nothing to do with Medicaid funding levels in your state. A licensing board is a regulatory agency that handles state licensure only. CMS does not decide rates for Medicaid programs. When ASHA meets with CMS, we discuss overall policy—not payment rates.

Where Do You Have Power in the System?

THE POWER OF VOTING AND FORMING RELATIONSHIPS WITH YOUR REPRESENTATIVES

Your state and federal elected officials want to hear from you. **It's literally their job to represent you!**

So, what specific steps can **you** take?

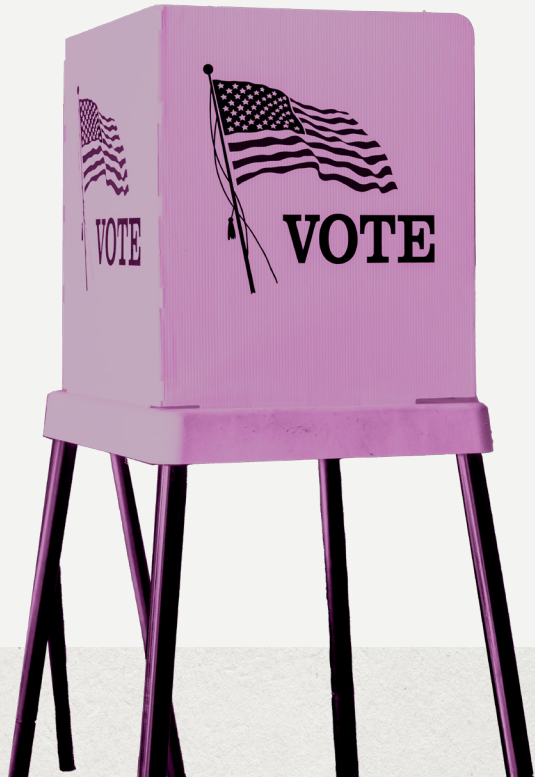
- **Contact your representatives.** When you meet with or write to your representatives, your voice carries much more weight than any statement from ASHA or a state association.
- **Research your candidates and legislators.** Know where they stand on the issues! If you want better funding and coverage from Medicaid or Medicare, then you need politicians in power who support funding these programs. And how do you get those politicians in power? You research their stances on the issues and their voting histories and **you show up at the polls and vote** for the ones who can make the biggest difference! Remember: If your state votes for people who want to defund these programs, it is much harder for ASHA and your state association **to address low payment rates**.
- **Mobilize your network.** Ask your patients, co-workers, friends, and family to join you in advocating and voting for candidates—at both the federal and state level—who support reimbursement rate increases for the audiologists and SLPs who serve Medicare and Medicaid beneficiaries.

MEDICAID

- **Get involved in group advocacy efforts.** An excellent way to do so is by **joining your state speech-language-hearing association**. ASHA and state advocates need to work together.
- **Reach out to reimbursement@asha.org** to **partner with us** in advocating to improve rates in your state. We need you!
- **Vote for state and federal legislators who will appropriately fund the Medicaid program in your state.**

MEDICARE

- **Contact your members of Congress!** Encourage them to eliminate the cuts and fix the underlying flaws of the payment system that requires budget neutrality.
- **Vote for legislators who will appropriately fund Medicare.**



How Do ASHA and Your State Association Work for (and With) You?

MEDICAID

- Meet with state elected officials
- Write comment letters in response to proposed rules and pending legislation at both the state and federal level
- Meet with state Medicaid agency policy staff and Medicaid managed care plan representatives
- Engage with other stakeholders, including other professional and trade organizations in joint advocacy
- State associations can hire a state lobbyist to work on priorities, like payment rates, that are identified by the association membership

CONNECTING THE DOTS. Remember, Medicaid funding is set at your state level. That's why you and ASHA rely so heavily on your state association.

MEDICAID CASE STUDY (WHERE IT WENT WRONG)

In State A, the state association and ASHA determined that Medicaid payment rates were too low for SLP provider participation. They met with the Medicaid agency staff and state legislators. They got state-level legislation introduced to increase reimbursement rates by appropriating more money in the state budget for audiology and speech-language pathology Medicaid providers. The legislation passed both houses and just needed the governor's signature to be enacted.

Unfortunately, the **governor wanted to better fund a different program unrelated to health care, and thus line-item vetoed this increase** that would result in better access to care for Medicaid beneficiaries. In this scenario, despite incredible coordination and dedication by all interested parties, political whim outweighed a well-supported priority for some of the state's most vulnerable residents.

How Does ASHA Work for (and With) You?

MEDICARE

- Meet with members of Congress
- Write comment letters in response to proposed rules
- Meet with Medicare payment staff
- Identify and support audiologists and SLPs to participate in technical expert panels that inform Medicare's decision making
- Engage with other stakeholders, including other professional and trade organizations in joint advocacy

MEDICARE CASE STUDY (WHERE IT WENT RIGHT)

As a member of a coalition representing 37 clinical specialties and as an independent organization, ASHA has worked hard since 2021 to push Congress to eliminate or mitigate the Medicare Part B cuts and fundamentally revamp the payment system. Each year ASHA has helped to secure partial relief to the Part B payment reductions through a mix of regulatory and legislative advocacy, including:

- Writing comments in response to proposed rules and meeting with CMS staff
- Meeting with members of Congress
- Tracking proposed legislation to address the cuts
- Writing to Congress in response to requests for information on ways to reform the Medicare payment system
- Developing resources for our members to help them advocate directly with policymakers.

ASHA **Advocacy**

Learn more at on.asha.org/medicarevsmedicaid

reimbursement@asha.org