The Disproportionate Impact of Medicare Cuts and Health Care Reform on Urban Safety-Net Hospitals

A Study
by the National Association of Urban Hospitals
December 2014

NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

The Affordable Care Act has increased the number of Americans with health insurance. Depending on the source you consult, somewhere between 10 million and 13 million previously uninsured Americans have obtained health insurance through health insurance exchanges, expanded Medicaid eligibility in 28 states and the District of Columbia, and the ability of young adults to obtain insurance through their parents' health plans.

The National Association of Urban Hospitals (NAUH) welcomes enhanced access to health insurance because it means better access to care, and better health, for the residents of the low-income communities served by private, non-profit urban safety-net hospitals.

An urban safety-net hospital in Massachusetts recently began seeing a decline in its provision of uncompensated care as the state's Medicaid expansion took effect but is still providing the same $33 million a year in uncompensated care it provided nine years ago. Meanwhile, it will suffer approximately $26 million in Medicare payment cuts in FY 2014 and FY 2015 in addition to sequestration cuts.

At the same time, NAUH has observed that enhanced access to health insurance has not occurred uniformly across the country. The residents of some states have embraced the use of insurance exchanges more readily than others, for example, while some states have expanded eligibility for Medicaid but many others have not. As a result, while there is a growing perception that enhanced access to health insurance is addressing or even has already successfully addressed the financial challenges that have long plagued safety-net providers and others that deliver care to large numbers of low-income and uninsured patients, the reality today that enhanced access to health insurance *is* helping – but that it is not yet helping all of those providers in all states.

Medicare Payment Cuts

This poses a challenge for hospitals that are not receiving significant relief from the cost of serving low-income, uninsured patients because in anticipation of safety-net hospitals receiving that relief, the Affordable Care Act and other legislation have made significant cuts in Medicare payments, including:

An urban safety-net hospital in Maine, which has not expanded its Medicaid program, is not seeing many newly insured patients, and most of its patients with exchange plans were insured in the past and have only changed insurers in the past year. Its Medicare payment losses in FY 2014 and FY 2015 are estimated to be approximately $4 million.

- reduced Medicare disproportionate share hospital payments (Medicare DSH)
- reduced Medicare bad debt reimbursement
- "productivity adjustments" and "documentation and coding adjustments" that are *de facto* payment cuts
- reduced payments as a result of Medicare's hospital readmissions reduction program
- the sequestration law that reduces all Medicare payments to hospitals by two percent well into the 2020s

In addition, the Affordable Care Act calls for significant cuts in Medicaid DSH payments made to eligible hospitals; those payments have long been an importance source of funding for care for low-income patients. Medicaid DSH cuts were supposed to begin in FY 2014 but were delayed by Congress until FY 2017.

The Impact of Medicare Cuts on Urban Safety-Net Hospitals

Except for Medicaid DSH, these cuts have already gone into effect – even before the benefits of enhanced access to health insurance have been felt, or felt fully, in many parts of the country. Among the providers suffering the steepest payment cuts before experiencing the full benefits of enhanced access to health insurance are many urban safety-net hospitals.

An academic medical center in Pennsylvania, which has not expanded its Medicaid program, reports that its charity care and bad debt were greater in FY 2014 than in FY 2013. Many of its patients with health exchange plans were previously insured by other insurers. It expects to see a loss of $12.5 million in Medicare payments, plus sequestration cuts, in FY 2014 and FY 2015 combined.

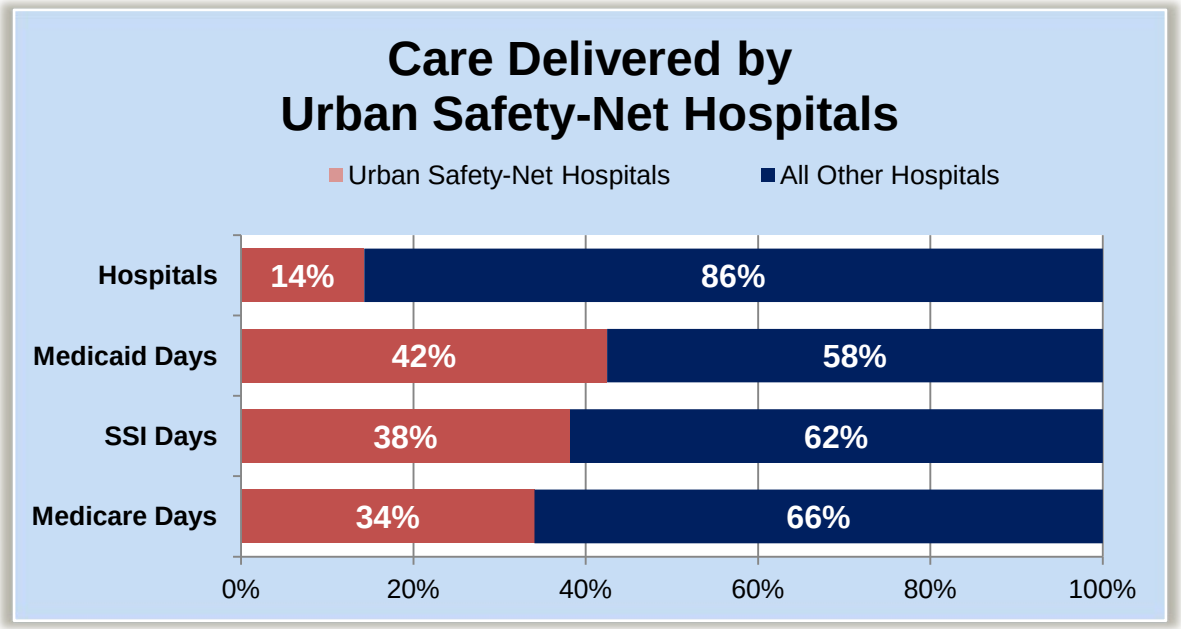
Urban Safety-Net Hospitals: What They Are and the Role They Play

By definition, urban safety-net hospitals:

- are private and non-profit
- are located in urban areas, as defined by Medicare
- have at least 15 percent of their patients insured by Medicaid
- have at least 200 beds

Currently, 496 hospitals across the U.S. meet these criteria – 14 percent of the 3424 acute-care hospitals in the country.

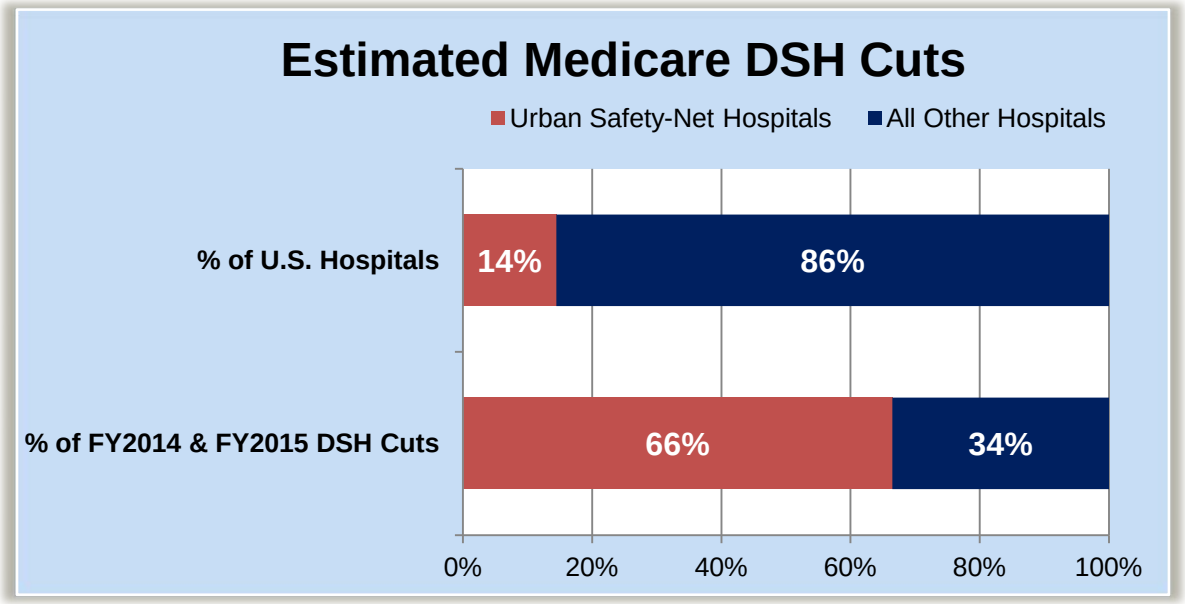
But as this graph shows, this 14 percent provides an outsized proportion of care to the nation's Medicare, Medicaid, and Supplemental Security Income (SSI) patients.



Bearing a Disproportionate Share of the Cost of Reform

The cuts noted above are considerable, and the biggest among them is a reduction of ***Medicare DSH payments*****.** These supplemental Medicare payments are made to selected hospitals that care for especially large numbers of low-income patients. The Affordable Care Act calls for major reductions in Medicare DSH payments based on the expectation that the hospitals that receive these payments will need them less in the future because many of those low-income patients will become eligible for Medicaid under the reform law's Medicaid expansion and others will obtain partially subsidized insurance through a health insurance exchange.

As this graph illustrates, urban safety-net hospitals are bearing a disproportionate share of Medicare DSH cuts.



In all, urban safety-net hospitals, just 14 percent of acute-care hospitals, will suffer $1.7 billion of the estimated $2.5 billion in Medicare DSH cuts in FY 2014 and FY 2015 – 66 percent of the cuts – and those cuts will grow greater in future years. Nearly half of those private, non-profit urban safety-net hospitals, moreover, are located in states that have not expanded their Medicaid programs. That means they are benefiting only partially from the Affordable Care Act's insurance expansions. Together, these 223 hospitals in non-Medicaid expansion states will suffer approximately $400 million in Medicare DSH payment cuts in FY 2014 and FY 2015 – and the size of these cuts is scheduled to grow in the coming years.

A California urban safety-net hospital, located not far from the Mexican border, reports no decline in charity care from 2013 to 2014, no decline in uninsured inpatients, and a $4.9 million increase in bad debt from the first six months of 2013 to the first six months of 2014.

The Affordable Care Act imposes other major Medicare cuts on hospitals as well. Among them are ***"documentation and coding adjustments"*** and ***"productivity adjustments" in Medicare payments*** – both of which reduce those payments – and the ***two percent sequestration cut in all Medicare payments*** imposed by the Budget Control Act of 2011.

13% of acute-care hospitals in Virginia are urban safety-net hospitals, yet they absorbed 82% of the state's Medicare DSH cuts in FY 2014 and FY 2015. Virginia has not expanded its Medicaid program, so these hospitals will see neither a major benefit from Medicaid expansion nor relief from Medicare cuts.

In addition, Medicare's ***hospital readmissions reduction program*** imposes financial penalties on those that struggle most with this challenge. When the program was introduced, many believed it would be biased against providers like private, non-profit urban safety-net hospitals that care for especially large numbers of low-income patients who pose special challenges to caregivers, and both academic research and the numbers have proven this anticipated bias to be real. Despite these concerns, FY 2015's maximum penalty has been raised 50 percent over FY 2014's maximum penalty.

Between them, three of these four payment cuts – the documentation and coding adjustment, the productivity adjustment, and hospital readmissions reduction program penalties – will cost urban safety-net hospitals a combined and estimated $1.2 billion in FY 2014 and FY 2015. (Modeling the extent of sequestration cuts is beyond the scope of this analysis, which focuses on Medicare payments for inpatient hospital services, but those sequestration cuts are considerable, amounting to a two percent reduction of all Medicare payments to hospitals on top of all other cuts.)

Added to the $2.5 billion in Medicare DSH cuts during that same period of time, these urban safety-net hospitals face an estimated loss of $3.7 billion in Medicare revenue in FY 2014 and FY 2015 – plus the sequestration cut of two percent of all Medicare payments.

Potential Challenges on the Horizon

At the same time they are dealing with these issues, private, non-profit urban safety-net hospitals (and other safety-net providers) face three additional challenges in the coming months.

- Surveys show that many people who obtained health insurance for the first time through health insurance exchanges do not realize they now need to renew that insurance or select a new plan. If they allow their policies to expire without acting and then turn to providers for care, those providers could face a surge in uninsured patients and care for which they will not be paid.

- Growing numbers of people appear to be turning to low-cost health plans, unaware that those plans often carry high deductibles and steep co-pays. If meaningful numbers of such low- and middle-income policy-holders require hospitalization, they may leave those hospitals with large, unpaid deductibles that will have to be written off as uncom- uncompensated care.

- A new session of Congress will begin in Washington in January and with it will come new ideas for improving, reforming, and even reshaping Medicare, Medicaid, and the Affordable Care Act. Such an environment will be marked by both opportunities and threats.

Insurance plans with high deductibles are leaving many patients unable to pay their medical bills in Rhode Island, so hospitals there have seen unpaid bills rise 20 percent in the last three years – and many patients are choosing not to seek care they know they cannot afford.

Conclusion

In light of these challenging circumstances, it is not surprising that Congress stepped in to stop at least some of these losses, delaying the introduction of another major cut that would have hurt urban safety-net hospitals: major, Affordable Care Act-mandated cuts in their Medicaid DSH payments. Those cuts, scheduled to take effect in FY 2014, will not take effect until FY 2017.

The National Association of Urban Hospitals appreciates Congress's action on the Medicaid DSH cuts but respectfully asks Congress to do more: it asks Congress to recognize that the Affordable Care Act has not extended health insurance to everyone and has not relieved all hospitals of the financial challenge of providing uncompensated care to the low-income residents of the communities they serve. This makes additional Medicare cuts – and as noted, some of the cuts described above are getting bigger by the year – both premature and a problem, and NAUH looks forward to working with Congress to ensure that all Americans, regardless of their means, have access to high-quality health services from mission-driven providers like the private, non-profit urban safety-net hospitals that serve low-income patients throughout the country.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit urban safety-net hospitals that serve America's needy urban communities. These urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more dependent on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to help underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

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For further information about the data presented and views expressed in this paper, please contact Ellen Kugler, Esq., NAUH's executive director, at ellen@nauh.org or 703-444-0989.

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