ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

MEDICARE PAYMENT CUTS IN ALASKA

Since 2010, Congress and the Centers for Medicare and Medicaid Services (CMS) have enacted a series of Medicare payment cuts for hospital services in their effort to address the federal deficit and offset other program costs, including the cost of expanding insurance coverage under the ACA.

This summary is intended to support an understanding of existing Medicare provider cuts that Alaska hospitals are facing now and in the future. This analysis includes estimated Medicare fee-for-service payments and payment changes from 2010-2024 based on legislative payment changes adopted by Congress and regulatory payment changes adopted CMS and additional cuts under consideration.

These cuts will cost Alaska hospitals $591 million over 15 years.[1]
Cuts under consideration could reduce revenue by an additional $320 million if enacted.

Enacted Cuts as a Percent of Total FFS Medicare Revenue[2] 15 year summary value	-10.0%

Cuts Enacted (2010-2024): Legislative	
ACA Marketbasket Cuts	($266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
Total Legislative Cuts	**($458,675,800)**

Cuts Enacted (2010-2024): Regulatory	
Coding Cuts	($127,744,400)
2-Midnight Offset	(4,769,600)
Total Regulatory Cuts	**($132,514,000)**
Total Cuts Enacted	**($591,189,800)**

Cuts Under Consideration (2015-2024)	
Rural Cuts	($228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
Total Cuts Under Consideration	**($319,764,800)**

ANCHORAGE 1049 W 5th Ave., Suite 100, Anchorage AK 99501 *tel* 907.646.1444 JUNEAU 426 Main St., Juneau, AK 99801 *tel* 907.586.1790
ashnha.com

Over the past few years, law makers have repeatedly turned to cutting Medicare payments to providers to address federal budget shortfalls and/or offset the costs associated with implementing new programs including the expansion of insurance coverage provided by the Affordable Care Act (ACA). As Congress looks for ways to further reduce federal spending, address the debt ceiling, and offset costs associated with fixing the sustainable growth rate, Medicare payments to hospitals remain vulnerable. This prospect is particularly troubling in light of uncertainty surrounding implementation of the ACA, including the lack of Medicaid expansion in Alaska and the uncertainty of the subsidies received through the federal marketplace.

ASHNHA opposes additional Medicare payment cuts without full implementation of the expanded coverage promised through the ACA. ASHNHA also opposes poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead we support the development of more rational long-term payment methodologies that reward quality and promote better health outcomes, such as value-based purchasing and accountable care models.

Cuts enacted – Summary of 15 year impact

- **ACA Marketbasket Cuts: $266,013,300**
  The impact shown reflects the Affordable Care Act (ACA) of 2010 authorized hospital/health system payment cuts,
- **Sequestration Cuts: $93,961,800**
  The impact reflects the 2% sequester reduction on total Medicare payments currently in effect for years 2013-2024.
- **Medicare DSH Cuts: $79,884,200**
  Impacts reflect the estimated reductions to the national uncompensated care payment pool amount based on projected changes to the national uninsured rate provided by the CBO.
- **Quality Cuts: $6,743,300**
  Reflect payment adjustments related to ACA-mandated Quality Based Payment Reform including value based purchasing, readmissions, and hospital acquired conditions.
- **Bad Debt Payment Cuts: $2,180,700**
  The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65%.
- **ATRA Coding: $9,932,500**
  The impact reflects the American Taxpayer Relief (ATRA) of 2012-authorized retrospective (one-time) coding adjustment cuts totaling at least -9.3% that CMS must implement over a 4 year period.

Total Legislative Cuts = $458,675,800

- **Regulatory Coding Adjustments $ 127,744,400**
  The impact shown reflect annual adjustments made to the standard amount/federal rate in order to recoup for increases in gross payments due solely to the transition to new DRGs and/or DRG weights.
- **2-Midnight Rule Offset: $4,769,600**
  The impact reflects the -0.2% adjustment to the IPPS federal rate established by CMS in order to offset grown in IPPS expenditures as a result of increased inpatient admissions associated with the "2-Midnight Rule".

Total Regulatory Cuts =$132,514,000

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[1] 15-Year Medicare Cut Analysis, DataGen, February 2015.

[2] This value is calculated by first estimating and aggregating Medicare Fee-for-Service (FFS) revenue overall a 15 year period (2010-2024) without the effect of existing legislative or regulatory payment cuts. Then the estimated impact of the existing cuts over the same 15 year period are aggregated and divided by the aggregated revenue calculated in the first step. The result is a 15 year summary value of cuts as a percent of total Medicare FFS revenue. This does not include any of the cuts under consideration.