

**03/05/15**

**PRESENTATION:  
IMPACT OF  
UNCOMPENSATED  
CARE**

<TARGET><BILL></BILL><SUBJECT>03-05-15 PRESENTATION  
IMPACT OF UNCOMPENSATED  
CARE</SUBJECT><COMM>HHSS29</COMM></TARGET>



## 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.<sup>1</sup>***  
***Cuts under consideration could reduce revenue by an additional \$320 million if enacted.***

Enacted Cuts as a Percent of Total FFS Medicare Revenue <sup>2</sup> 15 year summary value	-10.0%
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### 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)
<b>Total Legislative Cuts</b>	<b>(\$458,675,800)</b>

### Cuts Enacted (2010-2024): Regulatory

Coding Cuts	(\$127,744,400)
2-Midnight Offset	(4,769,600)
<b>Total Regulatory Cuts</b>	<b>(\$132,514,000)</b>
<b>Total Cuts Enacted</b>	<b>(\$591,189,800)</b>

### 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)
<b>Total Cuts Under Consideration</b>	<b>(\$319,764,800)</b>

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 growth in IPPS expenditures as a result of increased inpatient admissions associated with the "2-Midnight Rule".

#### Total Regulatory Cuts = \$132,514,000

<sup>1</sup> 15-Year Medicare Cut Analysis, DataGen, February 2015.

<sup>2</sup> 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.



## IMPACT OF MEDICAID EXPANSION ON HOSPITAL UNCOMPENSATED CARE

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided. In practice, however, hospitals often have difficulty in distinguishing bad debt from charity care.<sup>1</sup>

In 2011, non-tribal Alaska hospitals provided \$91 million in uncompensated care.<sup>2</sup> Because of difference in cost reporting requirements, data is not available from most tribal hospitals. This summary seeks to quantify the potential impact of Medicaid expansion on hospital uncompensated care.

- Early evidence shows a dramatic drop in uncompensated care for hospitals in states that have expanded Medicaid, due to an increase in Medicaid patient volume. At the same time, the proportion of self-pay and overall charity care has declined in expansion-state hospitals.<sup>3</sup>
- A Colorado study analyzed data from 465 hospitals in 30 states in the first four months of Medicaid expansion. It found that unpaid care decreased by 30 percent in expansion states and remained essentially unchanged in non-expansion states. The report links an enrollment surge in expansion states to not only the reduction in uncompensated care but also the 25-percent decrease in people paying out of pocket.<sup>4</sup>
- In Alaska, if Medicaid is expanded a decrease in uncompensated care is anticipated. Based on the experience in other states a 20%-30% reduction of uncompensated care could be achieved. This could amount to decrease of between \$18 and \$27 million in uncompensated care at non-tribal hospitals.
- A decrease in uncompensated care could result in improved financial sustainability for Alaska's small/rural hospitals that are currently operating at a deficit. Additional resources will allow Alaska hospitals to better respond to community health needs and provide community benefits.
- Hospitals face looming uncertainty as federal cuts authorized by the ACA increase. These cuts amount to more than \$320 million over ten years for Alaska hospitals.<sup>5</sup> Hospitals agreed to payment reductions based on the assumption that expanding Medicaid would be mandatory for all states and would make up for losses.
- Pending federal cuts may result in severe financial hardship for hospitals, meaning that they will increase costs to paying patients or provide less uncompensated care to uninsured residents.

<sup>1</sup> American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet

<sup>2</sup> 2011 Hospital Cost Report data, S-10 worksheet Non-Medicare bad debt line 23 and Charity care to uninsured patients line 29. Data represents 16 non-tribal hospitals for cost reporting period Oct 1, 2010 – Sept 30, 2011.

<sup>3</sup> Colorado Hospital Association, Center for Health Information and Data Analytics, June 2014

<sup>4</sup> Ibid.

<sup>5</sup> Impact of Existing Medicare Provider Payment Cuts in Alaska, DataGen report, October 2013