

# BILLIONS IN FUNDING CUTS THREATEN CARE AT NATION'S ESSENTIAL HOSPITALS

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## ESSENTIAL HOSPITALS TARGETED

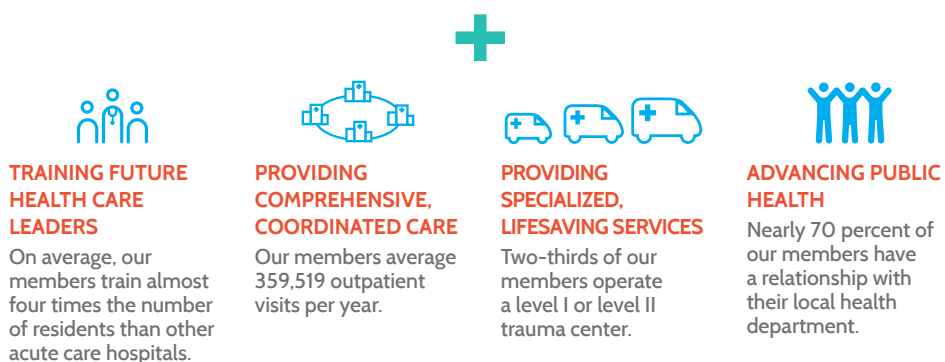
The U.S. health care system is evolving to meet the demands of the Affordable Care Act (ACA), a large aging population, and economic challenges, among other factors. Essential hospitals across the country find themselves caught in a delicate balance as they adopt innovative care delivery models while facing increasing cuts to the funding streams that help make those innovations possible—cuts that will total billions of dollars over the next decade.

These cuts touch upon all aspects of health care delivery. In fiscal years 2014 to 2016, more than \$1 billion in estimated cuts are targeted at essential hospitals through existing and proposed reductions to Medicaid and Medicare disproportionate share hospital (DSH) payments, Medicare payments for inpatient and outpatient services, and payments based on quality incentive programs. Essential hospitals, which already operate on some of the lowest margins nationwide, cannot afford to lose this much crucial funding (see Figure 2). If they do, all patients' access to health care will suffer.

## FIGURE 1: WHAT IS AN ESSENTIAL HOSPITAL?

### CARING FOR THE MOST VULNERABLE

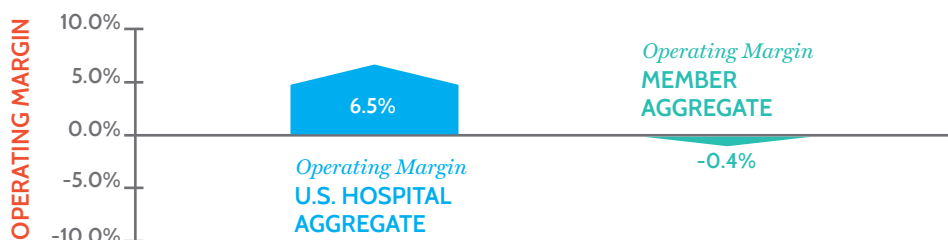
Members of America's Essential Hospitals serve a disproportionate share of low-income patients. Their patients are generally sicker and more complex than those served at other hospitals, and roughly half of patients discharged by members are racial or ethnic minorities.



Sources: American Hospital Association. Annual Survey of Hospitals, FY 2012; Essential Hospitals Vital Data (See full source below).

## FIGURE 2: NATIONAL OPERATING MARGINS

Members of America's Essential Hospitals Versus All Hospitals Nationwide, FY 2012



Source: Reid K, Roberson B, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012. America's Essential Hospitals. July 2014. <http://2c4xez132caw2w3cpr1il98fssfwengine.netdna-cdn.com/wp-content/uploads/2014/08/VitalData-FullReport-20140804.pdf>. Accessed August 2014.

## ESSENTIAL HOSPITALS BEAR THE BRUNT OF DSH CUTS

The Medicaid and Medicare DSH payment programs were created in the 1980s to support hospitals serving a disproportionate number of low-income patients, including those covered by Medicaid, Medicare, and the uninsured. But lawmakers assumed the ACA would decrease the number of uninsured, thus lessening this disproportionate burden. So they targeted DSH in the law for major cuts, and essential hospitals, which provided \$7.7 billion of uncompensated care in fiscal year (FY) 2012, are feeling the brunt of these cuts.

### MEDICAID DSH

#### \$17 billion+

The amount of Medicaid DSH cuts included in the ACA

#### ~\$230 million

The amount of federal and state Medicaid DSH cuts essential hospitals would have seen in FY 2014 (cuts were ultimately delayed)<sup>1</sup>

#### \$1.8 billion

The amount all hospitals stand to lose in just federal Medicaid DSH support in FY 2017 (DSH cuts having been delayed until then)

#### \$30 billion

The total amount of Medicaid DSH cuts now in law, since Congress has extended these cuts through FY 2023

For essential hospitals, these cuts are clearly disproportionate—on average they risk losing almost **9 times more** in funding than other U.S. hospitals.

### MEDICARE DSH

#### \$22 billion+

The amount of Medicare DSH cuts included in the ACA

#### \$55 million

The amount by which essential hospitals' Medicare DSH payments were reduced in FY 2014

#### \$122 million

The amount by which essential hospitals' Medicare DSH payments are reduced in FY 2015

Again, these cuts strike essential hospitals much more deeply than other U.S. hospitals—among hospitals losing Medicare DSH, essential hospitals on average have seen their share cut by **73 percent more** than other hospitals. And, this funding will continue to decrease as the overall amount of Medicare DSH funding decreases, per the ACA.

## REGULATORY CUTS TARGET MEDICARE PAYMENTS FOR PATIENT CARE

### Inpatient Care

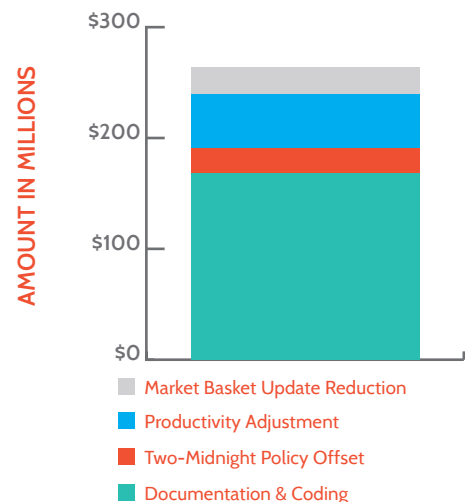
The Inpatient Prospective Payment System (IPPS) covers Medicare payments for inpatient hospital stays. The ACA cut funding to hospitals via the yearly IPPS rulemaking process. Mandates include an annual reduction to the market basket update and a hospital productivity adjustment, both of which result in a lower payment rate each year (see Figure 3).

The American Taxpayer Relief Act of 2012 also cut funding to hospitals for inpatient stays. The Act included cuts to recoup previous payments for documentation and coding changes.

In FY 2008, the Centers for Medicare & Medicaid Services (CMS) refined the method it uses to categorize patients for payment purposes. The agency claimed that the new method would improve documentation and coding for patient severity of illness. The change resulted in higher payments to hospitals, without, as CMS claims, a corresponding change in the complexity of patients hospitals see.

CMS also put in place for FY 2014 a Medicare payment policy for short inpatient hospital stays, known as the two-midnight policy. To make this a budget-neutral policy, CMS reduced overall hospital payments by \$200 million. Although this policy has now been delayed, the \$200 million offset continues for FY 2014 and beyond.

**FIGURE 3: INPATIENT PAYMENT REDUCTIONS TO ESSENTIAL HOSPITALS, FYs 2014 AND 2015**



Source: America's Essential Hospitals. Analysis of the FY 2014 and FY 2015 IPPS final rules. November 2014.

## Outpatient Care

In addition to inpatient care cuts, many policymakers are looking to cut funding for care provided in outpatient settings (see Table 1). Essential hospitals operate extensive outpatient networks. In FY 2012, they provided non-emergency outpatient care to **4.1 million patients** and treated **more than 7.2 million patients** in their emergency departments.<sup>2</sup> Their on-campus clinics, satellite clinics, and mobile units provide access to primary and specialty care in low-income communities where health care access is scarce.

It is these robust networks that make outpatient care cuts so detrimental to essential hospitals. The more extensive their outpatient service offerings, the higher the cuts are for the hospital. CMS has begun to target cuts to the outpatient setting through the Outpatient Prospective Payment System (OPPS), which covers payment for outpatient visits for Medicare patients. During the calendar year 2015 rulemaking process, the agency instituted a policy that packages all services related to a primary service—including all of the supporting services such as lab tests and supplies—into one payment amount. This will result in a reduction of payments overall.

Policymakers are also debating whether to equalize payments for evaluation and management (E&M) and other services provided in hospital outpatient departments with those provided in standalone physician offices. Such a policy would yield savings to the federal government, but could negatively impact patient continuity of care. Further, policymakers have also looked at equalizing payments for additional ambulatory payment classifications (APCs) in a similar manner.

**TABLE 1**

## OUTPATIENT PAYMENT REDUCTIONS TO ESSENTIAL HOSPITALS, FYs 2014 AND 2015

Cuts such as the ones detailed here would force essential hospitals to consider decreasing their outpatient services, leaving many in their communities with nowhere else to turn.

SOURCE OF CUT	COST TO ESSENTIAL HOSPITALS	DISPROPORTIONATE IMPACT	YEAR
Proposed reduction to hospital E&M payments*	\$277 million*	These cuts would be almost <b>4.5 times more</b> on average for essential hospitals than other U.S. hospitals.	FY 2015
Proposed additional payment equalization for ambulatory services*	\$150 million*	These cuts would be more than <b>2 times greater</b> on average for essential hospitals than other U.S. hospitals.	FY 2014
OPPS rule combining all related services for a primary, device-dependent service into a single payment	\$3.8 million	This cut is <b>24 percent higher</b> on average for essential hospitals than other U.S. hospitals.	FY 2015

\* This decision is currently under consideration and is not finalized.

Source: America's Essential Hospitals. Analysis of calendar years 2014–2015 OPPS final rules and 2009–2014 OPPS cost statistic files. November 2014.

## Quality Incentive Programs

Efforts to promote quality improvement within hospitals is a move in the right direction for the U.S. health care system. However, these efforts come with funding reductions for hospitals unable to meet milestones set by policymakers in Washington (see Table 2). These milestones are set for all hospitals through comparisons that do not always compare like hospitals, often leading to inaccurate portrayal of a hospital's quality level.

For example, the Hospital Readmissions Reduction Program

does not incorporate factors relating to a patient's background—socioeconomic status, language, and postdischarge support structure—in its risk-adjustment methodology. These underlying factors, as opposed to the quality of care provided, frequently drive readmissions to essential hospitals. By failing to take into consideration the full range of differences in patients' backgrounds that may affect readmission rates, readmission measure calculations will inevitably be skewed against hospitals providing essential care to racial and socioeconomic minorities, as well as the uninsured.

TABLE 2

QUALITY INCENTIVE PROGRAM REDUCTIONS TO ESSENTIAL HOSPITALS, FYs 2014, 2015, AND 2016

Three main quality incentive programs included in the ACA are coupled with serious fiscal implications that disproportionately and unfairly target essential hospitals.

QUALITY INCENTIVE PROGRAM	WHAT'S MEASURED	COST TO ESSENTIAL HOSPITALS	YEAR	DISPROPORTIONATE IMPACT
Value-Based Purchasing Program	Performance on health care quality measures and patient satisfaction	\$15 million	FY 2015	These cuts are, on average, <b>more than 50 percent higher</b> for essential hospitals than for other U.S. hospitals.
		\$17.5 million	FY 2016	
Hospital Readmissions Reduction Program	Preventable inpatient readmissions	\$11 million	FY 2014	This program unduly penalizes essential hospitals that serve the nation's most vulnerable populations because external factors that explain higher readmission rates are not taken into account.
		\$24 million	FY 2015	
Hospital Acquired Conditions Reduction Program	Hospital-acquired infections and other patient injuries	\$49 million	FY 2015	These cuts are, on average, <b>86 percent higher</b> for essential hospitals than for other U.S. hospitals

CHALLENGES AT THE STATE LEVEL

Cuts to federal funding are not the only source of worry for essential hospitals. Many states, faced with a mandate to balance their budget, have targeted hospitals for savings. Particularly, during the onset of the recession that began in late 2007, many states instituted cuts in funding to hospitals.<sup>3</sup> Few states have returned to prerecession funding levels due to continued pressure for fiscal austerity. Essential hospitals have had to absorb these cuts all while continuing to provide vital services to their communities. And, because of the large amount of uncompensated care essential hospitals provide, these cuts have been especially damaging to them.

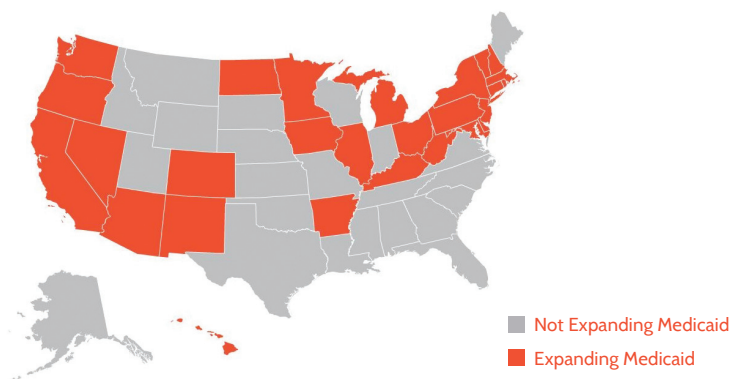
The ACA has also added to the state-level funding pressures. Because the U.S. Supreme Court ruled that the ACA's Medicaid expansion is optional for states, numerous states have chosen not to expand Medicaid (see Figure 4).

The resulting uneven nationwide picture of Medicaid coverage has led to almost 5 million Americans falling into the coverage gap in 2014. These individuals earn too much to qualify for Medicaid under the ACA's expanded eligibility but not enough to be eligible for tax credits to buy insurance in the health insurance marketplaces (exchanges).<sup>4</sup> Without these subsidies, many patients simply cannot afford needed insurance coverage. These patients will still seek medical care regardless of their coverage status, and essential hospitals will continue to provide that care.

What's more, many of those patients who are obtaining coverage for the first time through the marketplaces are essential hospital patients. And while the opportunity for coverage is a great achievement,

Source: America's Essential Hospitals. Analysis of IPPS policies and rates. November 2014.

FIGURE 4: ACA MEDICAID EXPANSION ACROSS THE UNITED STATES, 2014



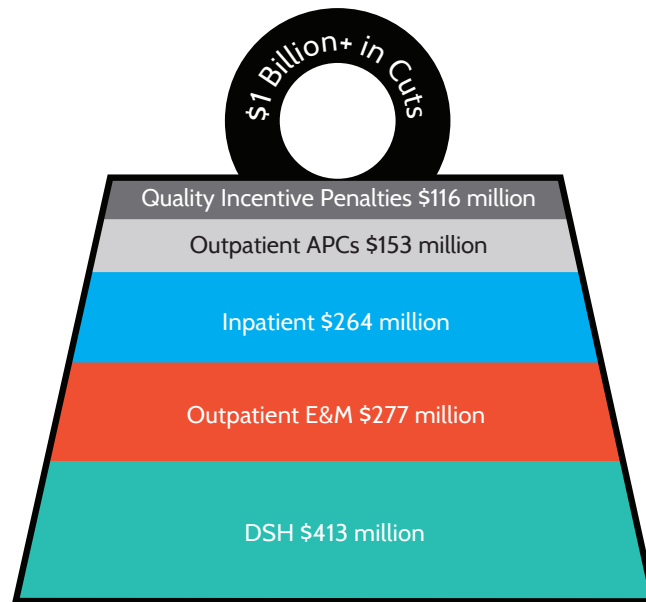
Source: Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. August 2014. <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>. Accessed November 2014.

these patients are unfamiliar with the details and nuances of cost-sharing responsibilities. They may see an increase in their medical bills, and essential hospitals may see a corresponding increase in bad debt or unpaid bills. As we close out the first year of ACA coverage expansion, essential hospitals will begin to have a clearer picture of the fiscal challenges they will face with these patients.

### ESSENTIAL HOSPITALS NEED PROTECTION

These existing and potential funding reductions severely threaten essential hospitals' sustainability. As Figure 5 demonstrates, the combination of cuts adds up to a more than \$1 billion weight that sits heavy atop essential hospitals. And the threats stem from other areas as well. For example, lawmakers may be considering scaling back the 340B Drug Pricing Program, which offers eligible hospitals access to low-cost medications for their vulnerable patients. Congress and the administration must be cognizant of the multiple missions essential hospitals support in the interest of their communities or risk losing the services relied on by all patients across the country.

**FIGURE 5: THE WEIGHT OF FUNDING CUTS ON ESSENTIAL HOSPITALS**



Note: Numbers rounded to nearest million.

Source: America's Essential Hospitals. Analysis of hospital funding streams. November 2014.

## Notes

1. America's Essential Hospitals. Analysis of 2008 Medicaid DSH audit data and state allotments. November 2014.
2. Reid K, Roberson B, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012. America's Essential Hospitals. July 2014. <http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/08/VitalData-FullReport-20140804.pdf>. Accessed August 2014.
3. Johnson N, Oliff P, Williams E. An Update on State Budget Cuts. Center for Budget and Policy Priorities. February 9, 2011. <http://www.cbpp.org/cms/?fa=view&id=1214>. Accessed October 27, 2014.
4. The Henry J. Kaiser Family Foundation. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. April 2, 2014. <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>. Accessed October 27, 2014.