IMPACT OF EXISTING MEDICARE PROVIDER CUTS
AND ADDITIONAL CUTS UNDER CONSIDERATION

Statement by Gwen Combs

MHA, Vice President for Policy

The Affordable Care Act changes the way Medicare pays for inpatient acute care services. The concept of reimbursement shifts from paying for volume to paying for quality of care. Part of this emphasis requires reductions in reimbursement to hospitals across the board in order to pay for quality improvements down the road.

What conceptually drives these reimbursement reductions is the Affordable Care Act’s foundational premise that having more people covered with some sort of health care coverage reduces the amount Medicare will have to spend on paying hospitals to take care of people who cannot pay. The original intent of the Affordable Care Act was for 95% of the population to be covered by a combination of Medicaid expansion and the ability by buy affordable health care on the state health insurance exchange. In other words, the federal government would rather pay for people to be able to pay for their health care than to pay hospitals for uncompensated care. Thus, the Affordable Act placed its emphasis on driving quality through Medicare payments, as well as using Medicare reductions to help balance the federal budget.

For example, beginning this past January, hospital acute care reimbursement was reduced by 1% across the board under a program called Value-Based Purchasing. In addition, under a program called Readmission Reduction, hospitals with readmissions within 30 days of discharge for three conditions, heart attacks, heart failure, and pneumonia, will receive a reduction in acute care payments. By 2015, hospitals will see no Medicare reimbursement for what CMS considers to be hospital acquired conditions, and by 2015, hospitals will see reduced reimbursement for failure to meaningfully use electronic health records and other information technology to transmit patient information.

Also under the Affordable Care Act, hospitals will see a reduction in their Medicare Disproportionate Share Payments (DSH), which they now receive for taking care of people who have no means to pay for their health care. Those payments, beginning October 1, 2013, will be reduced by 75%. This reduction will create a pool of Medicare DSH funds which CMS will reduce by the reduction of the number of uninsured across the nation, and then redistribute to some hospitals who still see some patients with way to pay for their health care. CMS has yet to promulgate regulations about how this additional redistribution of Medicare DSH funds will be achieved.
The 10 year financial impact on Mississippi hospitals of the ACA Reimbursement Reductions described above is estimated at $2,254,653,500 - $663,650,800 of this amount are Medicare DSH funds.

But that’s not all! The Budget Control Act of 2011 authorized a 2% sequestration reduction to total Medicare payments for a 9-year period. Having “gone over the cliff,” the sequestration reduction will go into effect April 1, 2013. The 9-year impact to Mississippi hospitals should sequestration reduction go into effect will be $426,128,800.

But still that’s not all! 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%. The financial impact on Mississippi hospitals over 10 years is $37,001,400. The American Taxpayer Relief Act of 2012 authorized coding adjustment cuts for inpatient and for outpatient radiosurgery. The financial impact on Mississippi hospitals over 10 years is $123,512,800.

For Mississippi hospitals, there is a potential $3,088,048,900 Medicare financial impact to Mississippi hospitals from ACA, BCA, MCTRJCA, and ATRA reductions over the next 10 years.

There are additional Medicare cuts under consideration by the federal government. These potential reductions, along with the sequestration across-the-board reductions, are driven by federal budget concerns. Several of these potential cuts will affect the financial viability of our Critical Access Hospitals and our Sole Community Hospital programs. These are safety-net hospitals in our rural communities that often provide the only medical care available in that region. The additional impact on Mississippi hospitals, should these reductions go into effect, could be an additional $464,582,000.
## Impact of Existing Medicare Provider Payment Cuts and Additional Cuts Under Consideration

### Mississippi

#### Existing Legislative Medicare Cuts (1)

**Two-Year Impact (2012-2013)**

<table>
<thead>
<tr>
<th>Year</th>
<th>ACA Cuts (all provider settings)</th>
<th>Sequestration Cuts (all provider settings)</th>
<th>Bad Debt Payment Cuts (all provider settings)</th>
<th>Coding Adjustment Cuts (inpatient and Radiosurgery Payment Cut outpatient hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($2,254,653,500)</td>
<td>($426,128,900)</td>
<td>($37,001,400)</td>
<td>($133,512,800)</td>
</tr>
<tr>
<td>2014</td>
<td>($2,249,752,400)</td>
<td>($421,240,400)</td>
<td>($36,120,300)</td>
<td>($132,800,400)</td>
</tr>
</tbody>
</table>

#### Existing Regulatory Medicare Cuts (2)

**Two-Year Impact (2012-2013)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Coding Adjustment Cuts (inpatient/home health)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($246,752,400)</td>
</tr>
<tr>
<td>2014</td>
<td>($246,752,400)</td>
</tr>
</tbody>
</table>

**Total Impact of Existing Cuts**

($3,088,048,900)

**Existing Cuts as a Percent of Total Medicare FFS Revenue** *(10-year summary value)*

-11.5%

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#### Additional Medicare Cuts Under Consideration (3)

**Ten-Year Impact (2013-2022)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Outpatient E/M Cuts (outpatient hospital)</th>
<th>Indirect Medical Education Cuts (inpatient hospital)</th>
<th>Direct Medical Education Cuts (inpatient hospital)</th>
<th>Bad Debt Payment Cuts (all provider settings)</th>
<th>SCH Program Elimination (inpatient hospital)</th>
<th>CAH Payment Cuts (inpatient/outpatient hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($41,577,400)</td>
<td>($113,311,200)</td>
<td>($5,677,400)</td>
<td>($257,921,500)</td>
<td>($22,380,000)</td>
<td>($20,713,600)</td>
</tr>
<tr>
<td>2014</td>
<td>($41,577,400)</td>
<td>($113,311,200)</td>
<td>($5,677,400)</td>
<td>($257,921,500)</td>
<td>($22,380,000)</td>
<td>($20,713,600)</td>
</tr>
</tbody>
</table>

**Total Impact of Cuts Under Consideration**

($646,582,000)

#### DSH Payment Reductions

**Five-Year Impact (2014-2019)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare DSH - Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>($663,650,800)</td>
</tr>
</tbody>
</table>

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**Notes:**

1. Existing Legislative Medicare Cuts include:
   - **ACA Cuts:** The impact shown reflects the Affordable Care Act (ACA) of 2010's mandated hospital/health system payment cuts and include update factor cuts (all provider settings). Payment cuts and changes related to the mandatory quality-based performance reforms of value-based purchasing, the readmissions reduction program, and the hospital-acquired conditions payment policy (inpatient hospitals) and Medicare disproportionate share hospital (DSH) payment cuts (inpatient hospitals). The impact shown does not capture ACA update factor cuts implemented prior to 2013 that carry forward additional time impacts in the budget window analyzed.
   - **Sequestration Cuts:** The impact shown reflects the Budget Control Act (BCA) of 2011's mandated 2.0% sequester reduction on total Medicare payments for a 5-year period (2013-2017), the two-month delay in sequestration cuts legislated under the ATRA is accounted for in this analysis. CMS has not released guidance on how sequestration will be implemented. It is believed that the 2.0% adjustment will be applied to all Medicare levels of payment, including those outside of the PPS rates and not included in this impact estimate, i.e., direct graduate medical education. Payment for Medicare Advantage plans will also be reduced, but the potential effect on providers will depend on the terms of each individual contract.
   - **Bad Debt Payment Cuts:** The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012's 2.0% reduction to Medicare payments for reimbursable bad debts for all provider settings to 45%. Coding Adjustment Cuts and Radiosurgery Payment Cut: The impact shown reflects the American Taxpayer Relief Act (ATRA) of 2012's mandated retrospective (one-time) coding adjustment cuts totaling at least -0.1% that CMS must implement over a 4-year window (FY 2018-2021). The impact of the ATRA revision that reduces the sequester amount for certain nontoxicology radiology services baseline Act 5. 2013 and thereafter is also shown.

2. Existing Regulatory Medicare Cuts include:
   - **Coding Adjustment Cuts:** The impact shown reflects the CMS-imposed prospective (permanent) coding adjustment cuts of 1.96% (0.55%) for hospitals paid at the hospital-specific rate in 2013 (inpatient hospitals) and a 3.25% in 2013 (inpatient providers). The impact shown does not capture CMS coding adjustment cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

3. Additional Medicare Cuts Under Consideration Include:
   - **Outpatient E/M Cuts (source: HHS: Planning):** The impact shown reflects the U.S. House-approved policy from 2011 to cap payment to hospitals for outpatient evaluation and management (E/M) services at the payment level provided to physicians under the Medicare physician fee schedule. Due to data limitations, impacts for free-standing and specialty hospitals are subject to this cut and are not shown in this analysis.
   - **MED Cuts (source: Simpson-Bowles Commission):** The impact shown reflects the recommendation to cut inpatient indirect medical education (IME) payments in half by reducing the IME reimbursement percentage of 5.47% to 2.5%. DSH Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to limit teaching hospitals' direct graduate medical education (DGME) reimbursement to 125% of the national average salary paid to residents in 2010, updated annually thereafter.
   - **Bad Debt Payment Cuts (source: Simpson-Bowles Commission):** The impact shown reflects the recommendation to eliminate payment for reimbursable bad debts for all provider settings.
   - **SCH Program Elimination (source: Congressional Budget Office):** The impact shown reflects the recommendation to eliminate special inpatient status for sole community hospital (SCHs).
   - **CAH Payment Cuts (source: Congressional Budget Office):** The impact shown reflects a reduction in reasonable costs based reimbursement to Critical Access Hospitals (CAHs) from 105.4% to 103.6% for inpatient, outpatient, and census-based services.

*This value is calculated by first estimating and aggregating Medicare Fee-For-Service (FFS) revenue over a 10-year period (2013-2022) without the effect of existing legislative or regulatory payment cuts. Then, the estimated impact of the existing legislative and regulatory payment cuts (shown on the left side of the report) over the same 10-year period are aggregated and divided by the aggregate revenue calculated in the first step. The result is a 10-year summary value of the existing legislative and regulatory Medicare FFS payment cuts as a percent of total Medicare FFS revenue. This number does not include any of the additional cuts or consideration shown on the right side of the report.

- Medicare payment data used to estimate payment changes from CMS' 2013 payment rule impacts for hospital inpatient and outpatient services, inpatient rehabilitation facilities, and long-term care hospitals. Medicare cost report data (FY09 to FY13) is used for all nursing facilities and home health providers, to calculate the bad debt payment cuts for all provider settings, and to estimate the sequestration cuts for SCHs, cancer, and children's hospitals. Medicare outpatient data from FY10 is used to estimate the E/M payment cut.

- This analysis omits Medicare FFS payments only, and dollar impacts shown in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods. Dollar impacts have been rounded to the nearest hundred dollar; hence, totals may not sum and dollar amounts less than $500 will appear as zero due to rounding.