URBAN Safety-Net Hospitals in the U.S. Today

# The Potential Impact of Affordable Care Act-Mandated Medicare DSH Cuts on Urban Safety-Net Hospitals

The National Association of Urban Hospitals

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# Introduction

The reduction of Medicare disproportionate share hospital payments by as much as 75 percent, mandated by the Affordable Care Act to take effect in 2014, will have a damaging impact on private, non-profit urban safety-net hospitals and may be great enough to jeopardize access to care in the low-income urban communities these hospitals serve.

# Background

The Affordable Care Act, the health care reform law passed in March of 2010, calls for reducing Medicare disproportionate share hospital (DSH) payments by as much as 75 percent beginning in 2014. Medicare DSH payments are supplemental payments made to selected hospitals that care for large numbers of low-income patients. These hospitals suffer considerable financial losses caring for these patients, and the purpose of Medicare DSH payments is to help compensate them for those losses.

The Affordable Care Act's 75 percent reduction of Medicare DSH payments is predicated on the belief that health care reform will result in many more people having health insurance, thereby relieving hospitals of much of their responsibility for caring for patients for whom they are paid poorly or not paid at all. It is not clear that this assumption adequately recognizes three conditions that hospitals will continue to face even after reform is implemented:

- Approximately 23 million people will remain uninsured despite reform, including 12 million undocumented residents, and hospitals will continue to serve them without reimbursement. These figures, moreover, could be overly optimistic about how many people will obtain health insurance.

- Reform will shift 15 to 20 million Americans into Medicaid, which in most states pays hospitals less than the cost of the care they provide. This is commonly referred to as a Medicaid shortfall – the difference between what hospitals spend to care for their Medicaid patients and what their state Medicaid programs pay them for that care.

- Hospitals that care for large numbers of low-income Medicare patients will be paid less than other hospitals because so many of those low-income Medicare beneficiaries cannot afford their Medicare co-pays and deductibles and do not pay them.

These challenges are more likely to arise in the low-income communities in which urban safety-net hospitals are located. Together, they raise important questions about the impact of the 2014 Medicare DSH cut on hospitals.[1]

[1] The Affordable Care Act will impose other cuts that could have a disproportionate impact on urban safety-net hospitals, such as a major reduction in Medicaid DSH payments and denial of Medicare payments for some patients admitted to hospitals shortly after they are discharged. This study addresses only the potential implications of the Medicare DSH cut; it does not cover any other anticipated changes or cuts.

# Urban Safety-Net Hospitals and Their Financial Performance Today

As of 2008, there were 6005 hospitals in the U.S. Among them, 448 – 7.5 percent of the total – are considered urban safety-net hospitals. This means they are private and non-profit; they have at least 200 beds; they are located in urban areas; they provide at least 15 percent of their services to Medicaid patients; and they are paid by Medicare under its inpatient prospective payment system.

Of those 448 urban safety-net hospitals, 245 – 54.7 percent – lost money in 2008. This means that more than half of the country's urban safety-net hospitals spent more on patient care that year than they received in payment for that care.

## Operating Margins

A more in-depth means of evaluating the financial performance of hospitals, aside from the simple question of whether they made or lost money, is to look at their margins. Margins are ratios of hospitals' expenses to their revenue, and two types of margins are commonly used: operating margins measure revenue only from patient care while total margins encompass patient care revenue as well as revenue from hospitals' non-patient-care activities such as contributions, government appropriations, investments, parking, gift shops, and other sources. While some hospitals are fortunate enough to have other revenue, many do not; this makes operating margins the more useful measure.

**In 2008, the median operating margin of the country's 448 urban safety-net hospitals was -0.82 percent. This means that as a group, urban safety-net hospitals lost money.**

## Consequences of Unhealthy Margins

Positive margins are important even for non-profit hospitals because such positive margins – excess revenue over expenses – are the only thing that sustains them. All hospitals need positive operating margins. If a hospital only covers its operating expenses – that is, has an operating margin of 0.0 percent – it might have difficulty finding cash to pay its bills and would have no resources with which to fund capital improvements such as new buildings, major facility maintenance and improvements, and the purchase of new equipment and technology. It would be unable to service any debt, which probably would not matter because it would not be able to borrow, nor would it have any money to invest in training and professional development for staff. The importance of a positive operating margin has given rise to the expression "No margin, no mission."

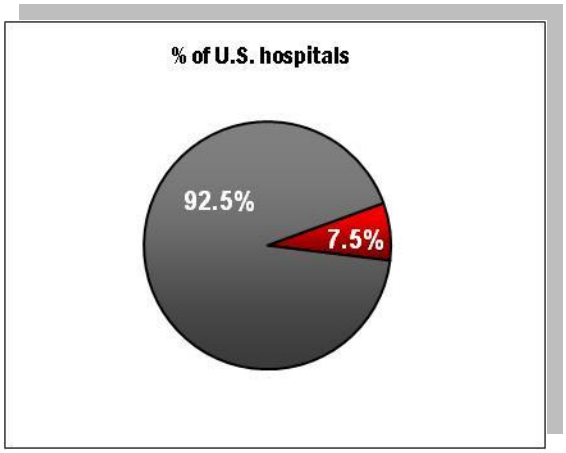
In general, hospitals are thought to need a positive operating margin of four percent to operate effectively. Hospitals often can get by with smaller positive margins for limited periods of time. When a hospital has a negative operating margin, this means it is losing money, and like any commercial enterprise, negative operating margins over a prolonged period of time are financially unsustainable. Just as businesses that cannot make money and that consistently lose money end up going out of business, hospitals that cannot find a way to make money eventually go out of business and close their doors as well.

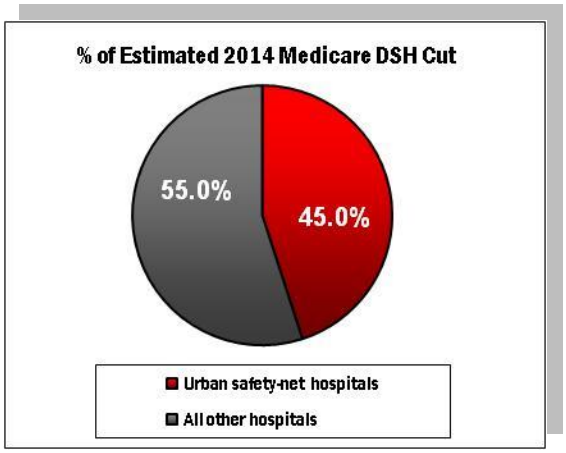
This is the very situation that the nation's 448 urban safety-net hospitals face today: more than half of them are losing money and together, they have a negative median operating margin.

# Urban Safety-Net Hospitals Would Shoulder a Huge Proportion of the 2014 Medicare DSH Cut

Based on 2008 federal Medicare DSH disbursements and 2008 hospital financial performance, the 2014 Medicare DSH cut of up to 75 percent would reduce Medicare DSH payments to American hospitals by as much as $8 billion.[2] As the following figures show, the brunt of this cut would be borne by urban safety-net hospitals.

**Private, non-profit urban safety-net hospitals – just 7.5 percent of hospitals in the U.S. – would bear 45 percent of the Affordable Care Act-mandated cut in Medicare DSH payments to hospitals in 2014.**




[2] The Affordable Care Act calls for cutting Medicare DSH payments by 75 percent in 2014 but will return some portion of that cut to some hospitals based on the documented care they provide to uninsured patients (excluding non-legal residents). Thus, it is fair to say that most, if not all hospitals, will receive some money back and therefore not sustain the full 75 percent cut. Because the federal government has never successfully collected uniform, reliable data on hospitals' uncompensated care, it is very difficult to estimate with confidence the degree to which the provision of uncompensated care will offset some of the 75 percent Medicare DSH cut.

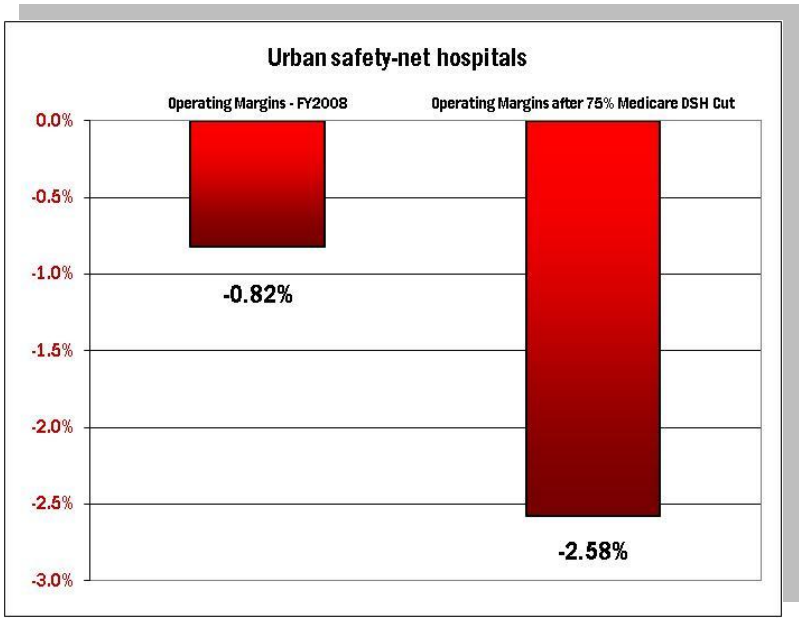
# The DSH Cut Would Cause More Urban Safety-Net Hospitals to Lose Money

This mandated reduction in Medicare DSH payments would push even greater numbers of urban safety-net hospitals into the money-losing category.

| | Hospitals Losing Money, 2008 | Hospitals Losing Money After 75% Medicare DSH Cut (estimated) |
|---|---|---|
| **Urban safety-net hospitals** | **245 (54.7%)** | **289 (64.5%)** |

In other words, the anticipated reduction of Medicare DSH payments by as much as 75 percent beginning in 2014 could turn another 9.8 percent of urban safety-net hospitals into money-losing institutions.

The 75 percent Medicare DSH cut would have a similarly damaging impact on the operating margins of urban safety-net hospitals as a group.




Thus, as a result of the anticipated 75 percent DSH cut, **the proportion of urban safety-net hospitals losing money would rise from a little more than one-half to nearly two-thirds** and their median operating margin would plunge from -0.82 percent to -2.58 percent.

# The Dollars-and-Cents Impact of the 75% Medicare DSH Cut

As noted, urban safety-net hospitals would lose $3.6 billion under the 75 percent reduction in DSH payments scheduled to take effect in 2014; that would amount to 45 percent of the $8 billion in DSH cuts that could take place at that time. Over the first six years of the 75 percent Medicare DSH cut, this would add up to a loss of $23.8 billion in Medicare DSH revenue for urban safety-net hospitals.

This translates into large, dramatic losses of revenue for individual hospitals. The average urban safety-net hospital would lose $8.5 million in Medicare DSH revenue in the first year under the Affordable Care Act's 75 percent Medicare DSH reduction. That, in turn, would amount to an average loss of $53.1 million for each urban safety-net hospital during the first six years of the 75 percent Medicare DSH cut.

## Conclusion

If implemented as passed, the mandatory health insurance requirement in the Affordable Care Act and the financial assistance that supports that requirement should result in millions of Americans joining the ranks of the insured. The 75 percent reduction in Medicare DSH payments scheduled to take place in 2014 reflects the expectation that hospitals across the country will see significant decreases in the number of uninsured patients they treat. Some hospitals, however, depending on where they are located, may continue to care for very large numbers of uninsured patients, and those same hospitals, again because of where they are located, also are likely to experience greater Medicaid shortfalls than ever as their states' Medicaid rolls rise to unprecedented levels.

Many of the communities that will still experience high levels of uninsured people and will also have larger-than-ever numbers of Medicaid recipients, even after reform is implemented, are served by private, non-profit urban safety-net hospitals. For years these hospitals have had their service to low-income patients subsidized in part by Medicare DSH revenue. When that subsidy is cut by as much as 75 percent in 2014, these safety-net hospitals will lose an important part of their own financial safety net – an average of $53.1 million for each urban safety-net hospital over six years, from 2014 through 2019. When they do, and when their financial health declines as a result, their ability to keep their doors open and ensure continued access to care for the low-income residents of their communities – and others as well – may be jeopardized.

## A Note About Methodology

This study employed the Centers for Medicare & Medicaid Services' (CMS) Medicare August 2010 Impact File (available for downloading at http://goo.gl/6k6ZB) and Medicare July 2010 Provider Specific Files (available for downloading at http://goo.gl/owLX2) to determine whether hospitals meet the criteria, outlined above, for designation as "urban safety-net hospitals."

This study derived hospital operating margins from FY 2008 Medicare cost reports (Hospital 2552-96, Cost Report Data files, released October 13, 2010) that are filed by hospitals with CMS.

This study estimated hospitals' FY 2011 Medicare DSH payments by using the Medicare August 2010 Impact File and FY 2011 standardized amounts; the latter can be found in the final FY 2011 Medicare inpatient prospective payment system regulation, CFR parts 412, 413, 415, et al., *Federal Register*, Vol. 75, No. 157, August 16, 2010, pp. 50042-50677.

This study inflated estimated hospital FY 2011 Medicare DSH payments for each year using the estimated market basket update, estimated productivity reductions, and market basket reductions described in section 3401 of the Patient Protection and Affordable Care Act of 2010; these adjustments are developed by IHS Global Insight, Inc. and employed by CMS/Medicare. These estimates were multiplied by 75 percent – the potential reduction in Medicare DSH payments established in the Affordable Care Act – to yield the potential Medicare DSH cut in FYs 2014-2019 when this cut will be implemented. This final calculation estimates the Medicare DSH reduction described in section 3133 of the Affordable Care Act but does not reflect the impact of the uncompensated care portion of the payment.

# 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 reliant 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 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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