The Potential Impact
of the
Affordable Care Act
on
Urban Safety-Net Hospitals

A Study
by the National Association of Urban Hospitals
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NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

Introduction

One by one and provision by provision, the federal government is implementing parts of the 2010 Affordable Care Act health care reform law that change how the government pays for health care services.

- In FY 2010, Medicare began reducing annual cost-of-living increases in hospital payments.
- In FY 2012, Medicare began making productivity adjustments to hospital payments.
- In FY 2013, Medicare will begin penalizing hospitals for readmitting large numbers of patients.
- In FY 2013, Medicare will introduce a value-based purchasing program that rewards some hospitals and penalizes others based on the outcomes of selected quality measures.

More changes are coming soon, too.

- In FY 2014, Medicare will reduce by up to 75 percent the disproportionate share hospital payments (Medicare DSH) it makes to qualified hospitals.
- In FY 2014, Medicaid will introduce significant reductions in Medicaid DSH payments to qualified hospitals.

Together, these new policies will result in significant reductions in government payments to urban safety-net hospitals.

Urban safety-net hospitals are providers that are both private and non-profit; have at least 200 beds; are located in urban areas; provide at least 15 percent of their services to Medicaid patients; and are paid by the federal government under its Medicare inpatient prospective payment system. Today, 498 of the 3448 U.S. hospitals paid by Medicare under its inpatient prospective payment system – 14.5 percent – meet these criteria.

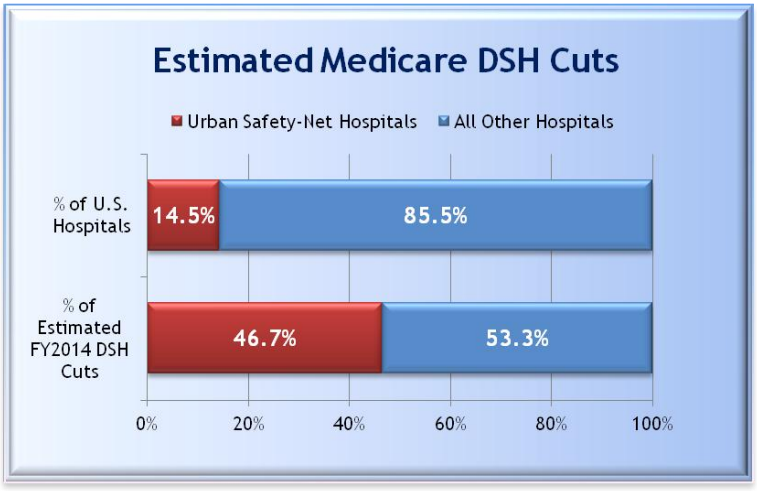
Of these 498 urban safety-net hospitals, slightly more than half lost money in 2009. These hospitals, and many of the others that managed not to lose money, are already struggling financially and face further challenges in the near future because of additional changes in Medicare payment practices that will take effect on October 1, 2013. The following is a look at all of these changes and their current and projected impact on private urban safety-net hospitals.

Cuts in Medicare DSH Payments

The Affordable Care Act calls for reducing Medicare disproportionate share hospital payments, commonly referred to as Medicare DSH, by as much as 75 percent beginning in October of 2013.[1] Medicare DSH payments are supplemental payments made to selected hospitals that care for especially 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.

[1] The Affordable Care Act calls for cutting Medicare DSH payments 75 percent in FY 2014 but will return some portion of that cut based on the documented care hospitals provide to uninsured patients (excluding non-legal residents). Thus, it is reasonable to assume 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 and, as of this writing, still has not decided how it will collect data for the purpose of restoring some Medicare DSH revenue to hospitals or how it will define "uncompensated care," it is very difficult to estimate the degree to which the provision of uncompensated care will offset some of the 75 percent Medicare DSH cut.

In FY 2014, the federal government's outlay for Medicare DSH is expected to decline by more than $9 billion; over five years, this cut will exceed $56 billion. Some of these reduced payments will be restored to hospitals based on how much uncompensated care they provide, but Medicare has not yet determined how it will define that uncompensated care, how it will collect uncompensated care, and what formula it will use to determine how much of the reduced Medicare DSH payments will be restored. Private, non-profit urban safety-net hospitals, just 14.5 percent of the acute-care hospitals covered by Medicare's inpatient prospective payment system, will absorb nearly half of that cut.



The average private urban safety-net hospital will lose more than $8 million in Medicare DSH revenue in FY 2014 alone. Over five years, this will amount to a loss of more than $53 million in Medicare DSH revenue for the average private urban safety-net hospital. This is by far the largest and most damaging of all of the government payment changes mandated by the Affordable Care Act and will have an extremely damaging effect on the urban health care safety net.

This plan to reduce Medicare DSH payments is predicated on the belief that health care reform will enable many more people to obtain health insurance, thereby relieving hospitals of much of their current responsibility for caring for patients for whom they are poorly paid or not paid at all. This assumption, however, does not adequately reflect four circumstances that all hospitals – especially private urban safety-net hospitals – will continue to face even after the full Affordable Care Act takes effect.

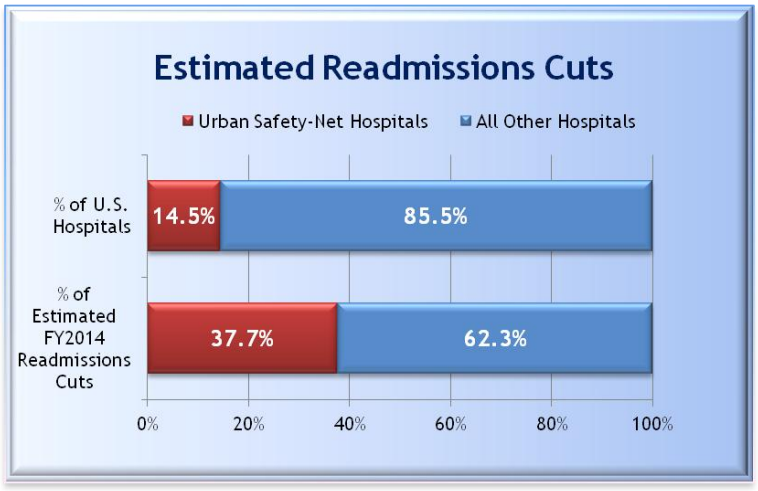
- Reform was expected to shift 15 to 20 million Americans into Medicaid, which in most states pays hospitals less than the cost of the care they provide. This creates a Medicaid shortfall – the difference between what hospitals spend to care for their Medicaid patients and what their state Medicaid programs pay for that care. The expansion of Medicaid enrollment under the Affordable Care Act will increase hospitals' Medicaid shortfalls, not decrease them.
- That figure of 15 to 20 million Americans moving into Medicaid is now in great doubt. In the wake of the Supreme Court decision that ruled unconstitutional the Affordable Care Act's mandate that states expand their Medicaid programs, the governors of several states have already declared their intention not to expand their Medicaid programs and some other governors are expected to follow suit after the November election. Thus, some uninsured people who were expected to enroll in Medicaid will undoubtedly remain uninsured.
- Approximately 23 million people were originally expected to remain uninsured despite reform, including 12 million undocumented residents, and hospitals will continue to serve them without reimbursement. These figures have long been considered optimistic, and now, with Medicaid unlikely to cover as many people as originally anticipated, the 23 million figure almost certainly is much too low.
- 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.

All of these challenges are more likely to arise in the low-income communities that urban safety-net hospitals serve. Together, they raise important questions about the impact of the October 2013 Medicare DSH cut on hospitals.[2]

The Medicare Hospital Readmissions Reduction Program

Medicare launches a new Affordable Care Act-mandated hospital readmissions reduction program in October of 2012. This program penalizes hospitals when the rate at which they readmit Medicare patients within 30 days of discharge significantly exceeds that of other hospitals for patients who suffered from heart attacks, heart failure, and pneumonia.

This program should cost hospitals about $300 million in FY 2014 alone. Of that amount, private urban safety-net hospitals, again just 14.5 percent of hospitals, are absorbing more than one-third of those revenue losses, as the following graph shows.



Medicare's hospital readmissions reduction program poses a particular challenge for private urban safety-net hospitals. Many of the Medicare patients they serve are low-income individuals who have had only sporadic contact with the health care system throughout their lives, so they have numerous medical problems beyond those that resulted in their admission that sometimes require readmission to treat.

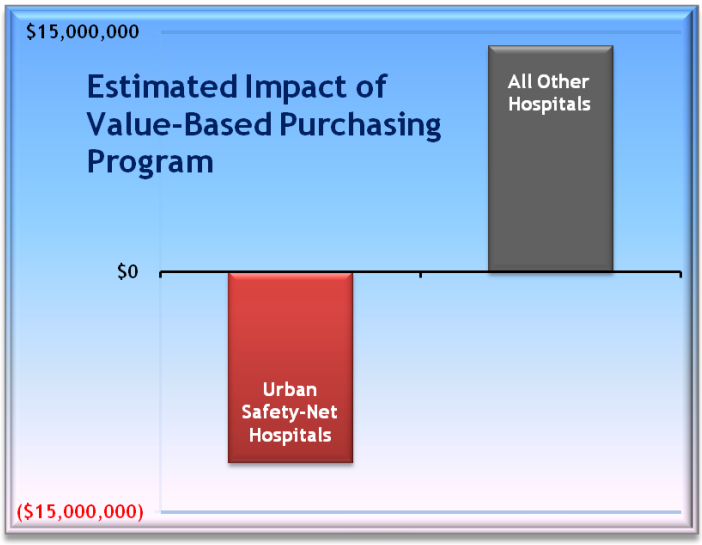
In addition, these patients often lack a combination of the resources and access to supplemental community-based services needed to comply with their discharge instructions. According to a report by Harvard researchers presented to the American Heart Association in May of 2012, differences in regional hospital readmission rates are more closely tied to socioeconomic factors and access problems than they are to hospitals' performance. An analysis by Kaiser Health News, a report in the Journal of the American Medical Association, and others echo these views and the Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment policy, is now looking closely at this issue as well.

Value-Based Purchasing Program

Beginning in October of 2013, Medicare's new value-based purchasing program started rewarding or punishing hospitals based on their performance according to quality measures that hospitals report to the federal government. This program places urban safety-net hospitals at a decided disadvantage because it does not include sufficient risk adjustment for the additional medical challenges that the patients or urban safety-net hospitals often present. The result is that while urban safety-net hospitals collectively lose money under this program, all other acute-care hospitals gain additional revenue.

[2] The Affordable Care Act will impose a major cut in Medicaid DSH payments as well beginning in FY 2014 but that cut is not addressed in this paper. These cuts will be based on states hitting certain federal "triggers" in their uninsured rates, but this approach makes it impossible to project the extent of these Medicaid DSH cuts on a hospital-by-hospital basis – assuming individual states even hit those triggers.

Another of the program's flaws is that it employs the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey of Medicare patients to evaluate hospital quality. Both the survey's questions and the manner in which they are weighted appear to be biased against large urban hospitals. In addition, studies have found that more seriously ill, low-income patients are more likely to respond with negative observations when completing such surveys, and private urban safety-net hospitals care for such seriously ill patients in far greater numbers than other hospitals. Even Medicare's own data shows significantly lower survey scores in more urbanized areas.



At the same time that hospitals struggle with all of these Affordable Care Act-mandated cuts, they also are dealing with a payment cut not related to the 2010 health reform law: a reduction in their Medicare bad debt reimbursement. Recognizing that low-income Medicare patients often cannot afford their co-pays and deductibles, Medicare has long reimbursed hospitals for the bad debt they incur when such patients fail to make those payments.

Other Medicare Payment Cuts

Reduced Cost-of-Living Adjustments and Productivity Adjustments

Every year, Medicare adjusts hospital payments based on an index of health care costs. Beginning in FY 2010, Medicare began intentionally paying less than the annual cost-of-living increases indicated by that index. In FY 2013, its annual increase will be 0.1 percentage points less than the true rise in health care costs; in FY 2014, 0.3 percentage points less; in FY 2015 and FY 2016 it will be 0.2 percentage points less; and in FY 2017, FY 2018, and FY 2019 it will be 0.75 percentage points less.

Medicare also believes hospitals are continually becoming more efficient in how they provide certain services, so in FY 2012 it began imposing productivity adjustments that decrease Medicare payments; those cuts will amount to 0.8 percentage points in FY 2013.

Together, the market basket cuts and productivity adjustments will cost hospitals more than $1 billion in FY 2014 alone – this is considered a conservative figure – with private urban safety-net hospitals absorbing more than 36 percent of this cut.

Reduced Medicare Bad Debt Reimbursement

As of February of 2012, Medicare reduced its bad debt reimbursement from 70 to 65 percent. Based on hospitals' FY 2009 Medicare cost reports, this will likely cost hospitals more than $115 million in FY 2014, and private urban safety-net hospitals, just 14.5 percent of those hospitals, will suffer nearly one-third of those losses, as the following chart shows.

Sequestration Cuts

Unless Congress intervenes, the Budget Control Act of 2011 will require $2 billion in Medicare payment cuts. As of this writing, Medicare has not indicated how it will make such cuts so it is impossible to calculate their potential impact on individual hospitals.

Impact on Hospital Operating Margins

As noted previously, of the 498 private urban safety-net hospitals in the U.S. today, more than one-half lost money in 2009. A more in-depth means of evaluating hospitals' financial performance is to look at their margins. Margins are ratios of hospitals' expenses to their revenue, and the most telling is a hospital's operating margin, which includes only revenue derived from patient care and excludes non-patient care revenue from sources such as contributions, government appropriations, investments, parking, gift shops, and other sources that not all hospitals have.

In 2009, the median operating margins of the country's 498 private urban safety-net hospitals and all other acute-care hospitals were virtually identical. Once the cuts mandated by the Affordable Care Act are all implemented, however, the balance of hospitals with positive and negative operating margins will shift significantly, as this chart shows. The anticipated reductions will turn 10 percent more urban safety-net hospitals into money-losing institutions and send their median operating margin plunging from -0.06 percent to -2.02 percent.

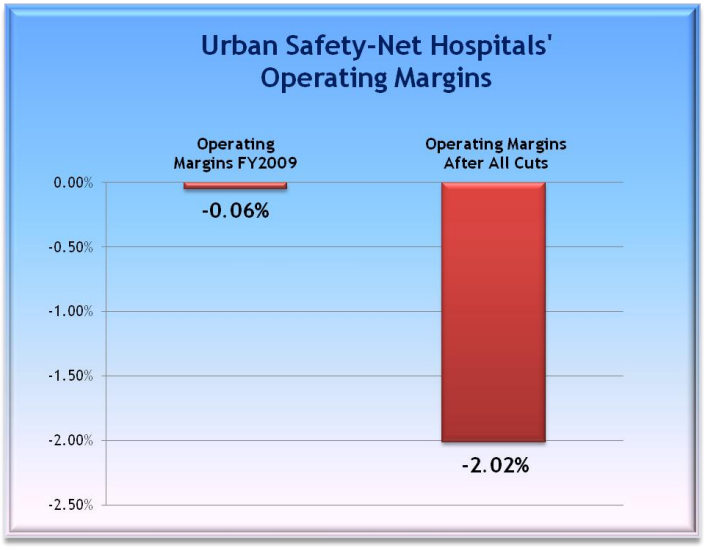
Urban Safety-Net Hospitals That Lose Money

Number Losing Money in FY2009	Number Losing Money After Cuts*
248 (50.2%)	297 (60.1%)

**After 75% Medicare DSH, Bad Debt, Market Basket, Productivity, Value-Based Purchasing, and Readmissions Cuts (Estimated)*

Without question, the biggest influence on this dramatic fall in urban safety-net hospitals' financial health will be the huge Medicare DSH cuts coming in FY 2014.

Positive operating margins are important for all hospitals. If a hospital only covers its operating expenses – that is, has an operating margin of 0.0 percent – it will have difficulty finding cash to pay its bills and have no resources to fund needed capital investments such as new buildings and major facility maintenance and improvements. It also will find it difficult to purchase new equipment and technology, to service debt, and 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. When a hospital has a negative operating margin, this means it is losing money, and just as businesses that consistently lose money go out of business, hospitals – even non-profit hospitals – that cannot find a way to bring in more money than they spend eventually must reduce their services and accessibility and the staff that makes those services and accessibility possible.

Conclusion

Private, non-profit, mission-driven urban safety-net hospitals find themselves in a very difficult position today. Their already-precarious financial health is being subjected to the eroding effect of new Medicare payment policies mandated by the Affordable Care Act. The two biggest of those policies have yet to be implemented: the major reductions in Medicare DSH and Medicaid DSH payments that await these hospitals beginning in FY 2014. Both of these reductions will be especially harmful to urban safety-net hospitals.

Together these losses of Medicare revenue – especially the Medicare DSH cut – threaten to turn some hospitals experiencing modest financial good health into money-losing institutions and to turn hospitals that already lose money into even bigger losers. It is conceivable that some of these losses will be so great that in the not-too-distant future, they will affect services, accessibility, and staffing at many urban safety-net hospitals.

This, in turn, would create even bigger losers: the residents of the communities these hospitals serve. Those urban communities, which generally have especially large proportions of low-income and low-income elderly residents, have come to rely on private urban safety-net hospitals as their primary provider of health care services – and in some places, their only provider of such services. If, as the cuts required by the Affordable Care Act suggest, Medicare payments to hospitals are inadequate and some of those hospitals struggle financially, entire communities could feel their loss in a very tangible way. With the Medicare DSH, Medicaid DSH, and value-based purchasing cuts specifically and disproportionately targeting private urban safety-net hospitals, this appears very possible. Such circumstances suggest that it would be appropriate for policy-makers to reassess these cuts in light of the damage they might do and consider other possible means of achieving their desired ends.

Methodology

This study employed the Centers for Medicare & Medicaid Services' (CMS) Medicare August 2012 Impact File and Medicare January 2012 Provider Specific Files to determine whether hospitals meet the criteria, outlined above, for designation as "urban safety-net hospitals."

This study derived hospital operating margins from FY 2009 Medicare cost reports (Hospital 2552-96, Cost Report Data files, released August 13, 2012) that are filed by hospitals with CMS.

This study estimated hospitals' FY 2013 Medicare DSH payments by using the Medicare August 2012 Impact File and FY 2013 standardized amounts; the latter can be found in the final FY 2013 Medicare inpatient prospective payment system regulation, Federal Register, Vol. 77, August 31, 2012, pp. 53257 -53750.

This study inflated estimated hospital FY 2013 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 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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