

Estimate of Federal Payment Reductions to Hospitals Following the ACA 2010-2026

Estimates and Methodology

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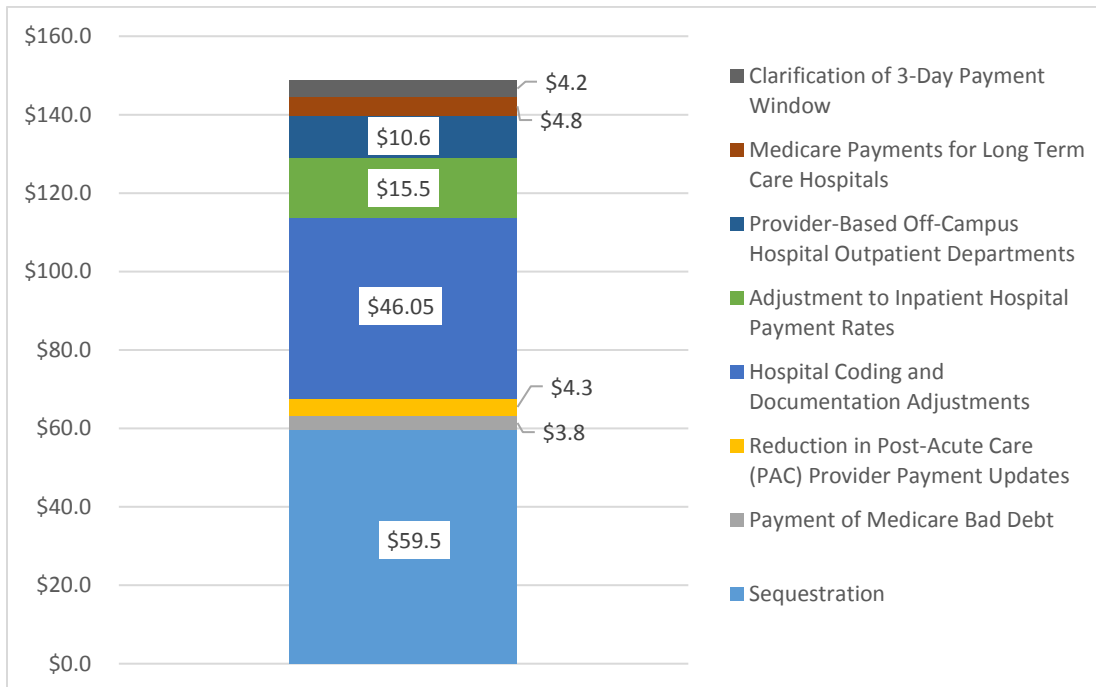
Table of Contents

<i>Executive Summary</i>	1
<i>Sources and Methodology</i>	2
Sequestration	2
Medicare Payments for Bad Debt	3
Reduction in Post-Acute Care (PAC) Provider Payment Updates.....	3
Hospital Coding and Documentation Adjustments	4
Adjustment to Inpatient Hospital Payment Rates.....	4
Provider-Based Off-Campus Hospital Outpatient Departments.....	5
Medicare Payments for Long Term Care Hospitals	5
Clarification of 3-Day Payment Window	5
Total Impact of Reductions on Federal Payments to Hospitals	6

Executive Summary

Dobson DaVanzo & Associates was commissioned by the Federation of American Hospitals (FAH) and the American Hospital Association (AHA) to estimate the cumulative federal payment reductions to hospitals from 2010 through 2026 in addition to those that were enacted under the Affordable Care Act (ACA).¹ Nine legislative Acts were identified as well as regulatory changes by the Centers for Medicare and Medicaid Services (CMS) that are estimated to reduce federal payments to hospitals by \$148.75 billion over this period. *Exhibit ES-1* shows the level of reductions by type.

Exhibit ES-1: Federal Payment Reductions to Hospitals 2010-2026 In Addition to ACA (in billions)



Source: Dobson|DaVanzo estimates – sources and methodology described below.

The following sections describe the sources for each of these federal payment reductions.

¹ For this analysis, we included acute care (inpatient and outpatient services), free-standing inpatient rehabilitation, long-term care hospitals and hospital-based providers (inpatient rehabilitation, skilled nursing and home health) where relevant.

Sources and Methodology

This section describes each of the types of hospital payment reductions and describes the sources and methods used for estimating the impacts.

Sequestration

The Budget Control Act of 2011 imposed mandatory across-the-board reductions in Federal spending to achieve \$1.2 trillion in budget savings over a 10-year period. Under the Act, Medicare FFS discharges on or after April 1, 2013 incur a 2 percent reduction in Medicare payment.² The sequestration adjustment is applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. Medicare beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment.³

The Bipartisan Budget Act of 2013/Pathway for SGR Reform Act of 2013 extended sequestration for an additional two years (2022 and 2023) beyond the period specified in the Budget Control Act of 2011 at the same percentage of spending.⁴

The Military Retiree COLA Restoration Bill (S. 25) of 2014 repealed the cost-of-living reduction for most working-age military retirees under the age of 62. To offset those costs, the Bill extended for one additional year, 2024, the requirement under the Budget Control Act that certain mandatory spending be sequestered each year, including Medicare.

Subsection 101(c) of the Bipartisan Budget Act of 2015 requires the President to sequester the same percentage of direct spending in 2025 as will be sequestered in 2021. It also replaced the arbitrary dips and increases in the Medicare sequester percentages in 2023 and 2024 with a flat two-percent rate as applies under current law in fiscal years 2016 through 2022.⁵

The impact on Medicare payments to hospitals due to sequestration was estimated by calculating 2 percent of Medicare fee-for-service baseline spending as projected by CBO for April 2013 through March 2026 for hospital inpatient and outpatient services, as well as

² The American Taxpayer Relief Act of 2012 postponed implementation of sequestration for 2 months

³ <https://www.congress.gov/bill/112th-congress/senate-bill/365>

⁴ http://www.rpc.senate.gov/imo/media/doc/RPC%20Legislative%20Notice_HJRes59_BBAandSGR.pdf

⁵ docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf

Sources and Methodology

hospital-based skilled nursing and home health, which results in a hospital payment reduction of \$59.5 billion over this period *Exhibit 1*.

Exhibit 1: Reduction in Medicare Hospital Payments Due to Sequestration 2010-2026 (in billions)

Act	Reduction in Medicare Hospital Payments (billions)
Budget Control Act of 2011	\$37.3
Bipartisan Budget Act of 2013	\$10.5
Military Retiree COLA Restoration Bill of 2014	\$5.7
Bipartisan Budget Act of 2015	\$6.0
Total	\$59.5

Source: Dobson|DaVanzo estimates – sources and methodology described above.

Medicare Payments for Bad Debt

Prior to 2013, Medicare reimbursed providers between 70 and 100 percent (depending on the type of provider) of beneficiary bad debt (beneficiaries' unpaid coinsurance and deductible amounts after reasonable collection efforts). The Middle Class Tax Relief and Job Creation Act of 2012 (section 3201) phased down bad debt reimbursement for all providers to 65 percent. Providers had a three-year transition period to 65 percent in 2013.⁶

The CBO estimated this provision to generate \$6.9 billion in savings from all providers over the 2013 to 2022 period. An analysis of Medicare hospital cost report data was used to estimate the impact of reducing payments for bad debts for hospitals to 65 percent for the 2013 through 2026 period. Based on this analysis, we estimate the impact on hospitals to be \$3.8 billion over this period.

Reduction in Post-Acute Care (PAC) Provider Payment Updates

The Medicare Access and CHIP Reauthorization Act of 2015 (Section 411) requires that Medicare reimbursements to post-acute care providers will increase by no more than 1.0 percent in fiscal year 2018. CBO estimated this provision would reduce Medicare payment to PAC providers by \$15.4 billion from 2018 to 2025.⁷ For this analysis, we extended the estimate to 2026 assuming the same level of savings for both 2025 and 2026, which results in an impact on all PAC providers of \$17.9 billion. We also estimated that Medicare payments to free-standing inpatient rehabilitation and long-term care hospitals as well as hospital-based providers (inpatient rehabilitation, skilled nursing and home health) account for around 24

⁶ <http://www.finance.senate.gov/news/press-releases/summary-of-the-middle-class-tax-relief-and-job-creation-act-of-2012>

⁷ CBO letter to John Boehner, March 25, 2015

Sources and Methodology

percent of all Medicare PAC spending.⁸ Thus, the impact on Medicare payments to hospitals under this provision would be \$4.3 billion.

Hospital Coding and Documentation Adjustments

CMS implemented Medicare Severity diagnosis-related groups (MS-DRGs) in FY 2008 for the inpatient prospective payment system (PPS), which refined the classification of patients based on severity of illness and in turn refined payments made for those patients. CMS asserted that implementation of the MS-DRGs eventually resulted in a 5.4 percent increase in the base payment rate due to improvements in coding and documentation (DCI) that were unrelated to increases in patient severity of illness, and reduced the base payment rate accordingly to prevent overpayments. An analysis conducted by the hospital industry, however, estimated that the DCI increase was 3.5 percent. The American Hospital Association estimates that this difference inappropriately reduces Medicare payments to hospitals by \$34.3 billion over the 2013 through 2026 period.

In addition, the Transitional Medical Assistance, Abstinence Education, and QI Programs Extension Act of 2007 required, among other things, that CMS recoup any overpayments that occurred in FY 2008 and FY 2009 as MS-DRGs were being implemented. As a result of its analysis, CMS applied a one-time 2.9 percent reduction in FY 2011 and again in FY 2012. AHA's analysis concluded that CMS overstated the recoupment by \$0.8 billion.

Finally, the American Taxpayer Relief Act of 2012 (ATRA) (Section 631) mandated that between FY 2014 and FY 2017 CMS recoup an additional \$11 billion related to MS-DRG implementation and documentation and coding improvements through FY 2013 that had not been recovered through previous adjustments to payment rates. The Medicare Actuary estimated the reduction amounts for each of the 4 years totaled 10.95 billion.⁹

Adjustment to Inpatient Hospital Payment Rates

Under the ATRA, hospitals were scheduled to receive a one-time 3.2 percentage point payment increase in FY 2018 to restore the reductions already imposed to recover the \$11 billion described above. The Medicare Access and CHIP Reauthorization Act of 2015 (Section 414), however, provides that the hospital payment increase total 3.0 percentage points to be phased in at 0.5 percentage points per year over 6 years beginning in fiscal year 2018. CBO estimated this provision would reduce Medicare payment to hospitals by \$15.1 billion from 2018 to 2025.¹⁰ For this analysis, we extended the estimate to 2026 assuming the

⁸ Based on Medicare spending by provider type over a 5-year period. MedPAC, A data Book: Health Care Spending and the Medicare Program, June 2016

⁹ CMS Office of the Actuary Memo, "Estimate of Medicare Documentation and Coding Adjustments", July 15, 2016

¹⁰ CBO letter to John Boehner, March 25, 2015

Sources and Methodology

same level of savings for both 2025 and 2026, which results in a reduction in Medicare payments to hospitals of \$15.5 billion through 2026.

Provider-Based Off-Campus Hospital Outpatient Departments

Section 603 of the Bipartisan Budget Act of 2015 modified the CMS definition of provider-based off-campus hospital outpatient departments (off-campus PBDs) such that only off-campus PBDs that were billing under CMS’s Outpatient Prospective Payment System (OPPS) prior to November 2, 2015 could continue to bill under OPPS as of January 1, 2017. Off-campus PBDs that did not satisfy this condition would likely only be eligible for reimbursements from either the Ambulatory Surgical Center, the Medicare Physician Fee Schedule, or perhaps some other payment schedule.¹¹

CBO estimated this provision would save \$9.3 billion from 2017 to 2025. For this analysis, we extended the estimate to 2026 assuming the same level of savings for both 2025 and 2026, which results in an impact on hospital payments of \$10.6 billion over the 2017 to 2026 period.

Medicare Payments for Long Term Care Hospitals

The Bipartisan Budget Act of 2013/Pathway for SGR Reform Act of 2013 (Section 1206) created new criteria for Medicare Long Term Care Hospital (LTCH) PPS payments. This provision of the Act clarifies that only patients admitted directly from an inpatient PPS hospital who stayed at least three days in an intensive care unit (ICU) or coronary care unit (CCU) and not having been assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH, or who receive at least 96 hours of ventilator services in the LTCH qualify for the traditional LTCH PPS payment rate. All other cases are reimbursed at the same level as an acute care hospital paid under the inpatient PPS (with a few minor exceptions). The provision also delayed implementation of the “25 percent rule” for three years and reinstates the moratorium on new LTCHs and the expansion of existing LTCHs.

CBO estimated that this provision would save \$3.0 billion over the 2014 to 2023 period.¹² For this analysis, we extended the estimate to 2026 assuming the same level of savings for the years 2023 through 2026, which results in a reduction in Medicare payments to LTCH hospitals of \$4.8 billion over the 2014 to 2026 period.

Clarification of 3-Day Payment Window

The American Jobs and Closing Tax Loopholes Act of 2010 (H.R. 4213, Section 523) provided clarification of the 3-day payment window. This provision would prevent future

¹¹ docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf

¹² CBO, “Estimate for Amendment to Pathway for SGR Reform Act of 2013”, December 11, 2013

Sources and Methodology

unbundling of related services within 3 days of an inpatient admission and submission of adjustment claims seeking separate and additional Medicare payments. CBO estimated that this provision would result in a reduction in Medicare payments to hospitals of \$4.2 billion in 2010 and 2011.¹³

Total Impact of Reductions on Federal Payments to Hospitals

In total, we estimate that there were \$148.75 billion in federal payment reductions to hospitals from 2010 through 2026 in addition to those that were enacted under the ACA. *Exhibit 2* provides a summary of the reductions and the corresponding legislation.

¹³ CBO, "Estimate of Effects on Direct Spending for H.R. 4213", June 7, 2010

Sources and Methodology

Exhibit 2: Summary of Reduction in Federal Payments to Hospitals in Addition to the ACA Reductions 2010-2026 (in billions)

Act	Impact on Federal Government Payments to Hospitals
Sequestration	
Budget Control Act of 2011	\$37.3
Bipartisan Budget Act of 2013	\$10.5
Military Retiree COLA Restoration Bill of 2014	\$5.7
Bipartisan Budget Act of 2015	\$6.0
Payment of Medicare Bad Debt	
Middle Class Tax Relief and Job Creation Act of 2012	\$3.8
Reduction in Post-Acute Care (PAC) Provider Payment Updates	
Medicare Access and CHIP Reauthorization Act of 2015	\$4.3
Hospital Coding and Documentation Adjustments	
American Taxpayer Relief Act of 2012	\$10.95
Regulatory	\$35.1
Adjustment to Inpatient Hospital Payment Rates	
Medicare Access and CHIP Reauthorization Act of 2015	\$15.5
Provider-Based Off-Campus Hospital Outpatient Departments	
Bipartisan Budget Act of 2015	\$10.6
Medicare Payments for Long Term Care Hospitals	
Bipartisan Budget Act of 2013	\$4.8
Clarification of 3-Day Payment Window	
American Jobs and Closing Tax Loopholes Act of 2010	\$4.2
Total Federal Reductions to Hospitals	\$148.75

Source: Dobson|DaVanzo estimates – sources and methodology described above.