Estimate of Federal Payment Reductions to Hospitals Following the ACA: 2010-2029

Estimates and Methodology

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Submitted to:
The Federation of American Hospitals (FAH)
The American Hospital Association (AHA)

Submitted by:

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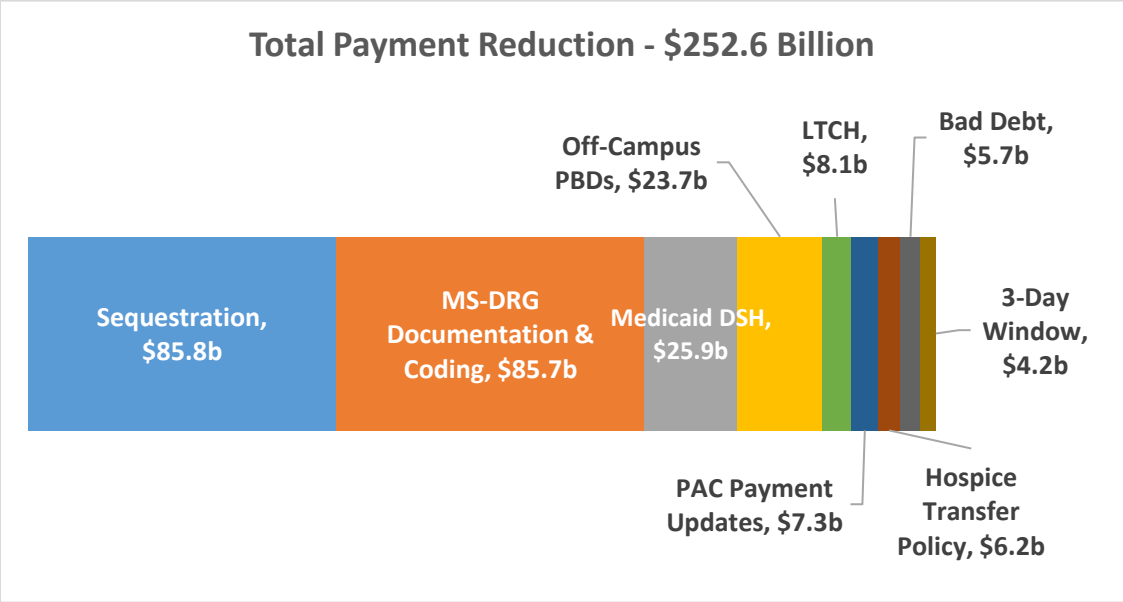
Table of Contents

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 2029 that were beyond those enacted under the Affordable Care Act (ACA).[1] Twelve 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 $252.6 billion over this period. ***Exhibit ES-1*** shows the level of reductions by type.

Exhibit ES-1: Federal Payment Reductions to Hospitals 2010-2029 In Addition to ACA



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

[1] For this analysis, we included acute care (inpatient and outpatient services), free-standing inpatient rehabilitation, long-term care hospitals, inpatient psychiatric, and hospital-based post-acute care units (inpatient rehabilitation, skilled nursing and home health).

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 deductibles, and any applicable Medicare Secondary Payment adjustments. Medicare beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction.[3]

The Bipartisan Budget Act of 2013/Pathway for SGR Reform Act of 2013 expanded 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 expanded 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

[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.

2023 and 2024 with a flat two-percent rate as applies under current law in fiscal years 2016 through 2022.[5]

The Bipartisan Budget Act of 2018 maintains the sequestration of mandatory spending for 2018 and 2019, including the two-percent cut to Medicare providers, and extends mandatory sequestration for an additional two years, through FY 2027.[6] The Act specifies Medicare payment reductions of 4 percent for the first 6 months of fiscal year 2027.

Finally, the Bipartisan Budget Act of 2019 extends mandatory sequestration for an additional two years, through FY 2029. Relative to current law, the Act would increase spending for most Medicare benefits by 2 percent for April through September 2027, reduce spending by 2 percent for October 2027 through March 2029, and reduce spending by 4 percent for April through September 2029.[7]

The impact on Medicare payments to hospitals due to sequestration was estimated by calculating two percent of Medicare fee-for-service baseline spending as projected by CBO for April 2013 through March 2029 and four percent for April through September 2029[8] for hospital inpatient and outpatient services, as well as hospital-based skilled nursing and home health[9], which results in a hospital payment reduction of $85.8 billion over this period (***Exhibit 1)***.

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

[6] https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-signs-h-r-1892-law.

[7] CBO Estimate for the Bipartisan Budget Act of 2019

[8] Actual Medicare program spending for federal fiscal years 2013-2018 by type of service was obtained from CBO Medicare baseline spending reports from April 2014, March 2015, March 2016, June 2017, April 2018, and May 2019 respectively. Projected Medicare spending for 2019-2029 was obtained from the CBO Medicare baseline spending report from May 2019. These spending amounts include only payments made by the Medicare program and exclude beneficiary cost sharing.

[9] Our analysis assumes 3% of Medicare skilled nursing facility payments were made to hospital-based facilities (MedPAC, "A Data Book: Health care spending and the Medicare program", June 2018). We estimated that Medicare payments to hospital-based home health agencies accounted for 9.9% of total Medicare home health payments in 2013 which decreased to 9.6% in 2016 based on our analysis of Medicare claims data. We assumed 9.6% for 2017 through 2029.

Exhibit 1: Reduction in Medicare Hospital Payments Due to Sequestration FY 2013-2029 (in billions)

Act	Reduction in Medicare Hospital Payments (billions)
Budget Control Act of 2011	$37.1
Bipartisan Budget Act of 2013	$10.3
Military Retiree COLA Restoration Bill of 2014	$5.6
Bipartisan Budget Act of 2015	$5.8
Bipartisan Budget Act of 2018	$12.7
Bipartisan Budget Act of 2019	$14.3
Total	**$85.8**

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. Critical Access Hospitals had a three-year transition period in which Medicare reimbursement was reduced from 100 percent to 88 percent in 2013, 76 percent in 2014 and 65 percent beginning in 2015.[10]

The CBO estimated this provision to generate $6.9 billion in savings from all providers over the 2013 to 2022 period. To estimate the impact on hospitals, we performed an analysis of Medicare hospital cost report data from 2013 to 2017 to obtain total Medicare bad debt costs for Critical Access Hospitals and all other hospitals separately. We assumed that total Medicare bad debt costs would increase from 2017 to 2029 at the same rate as Medicare spending for hospital care over that period as projected by CBO in their May 2019 Medicare Baseline spending reports.

The impact of the bad debt reimbursement reduction for hospitals other than Critical Access Hospitals was calculated as the difference between 70 percent of actual and projected Medicare bad debt costs and 65 percent of these costs. For Critical Access Hospitals, the impact of the bad debt reimbursement reduction was calculated as the difference between 100 percent of actual and projected Medicare bad debt costs and 88 percent in 2013, 76

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

percent in 2014 and 65 percent for 2015 and later. Based on this analysis, we estimate the impact on hospitals to be $5.7 billion over the 2013 to 2029 period.

Reductions 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 (PAC) providers will increase by no more than 1.0 percent in fiscal year 2018. CBO estimated this provision would reduce Medicare payment to all PAC providers by $15.4 billion from 2018 to 2025.[11] For this analysis, we expanded the estimate to 2029 assuming CBO's rate of growth in Medicare payments to SNFs and HHAs for 2025 through 2028, which results in an impact on all PAC providers of $27.1 billion. We also estimated that Medicare payments to free-standing inpatient rehabilitation and long-term care hospitals as well as hospital-based post-acute care units (inpatient rehabilitation, skilled nursing and home health) account for 25.0 percent of all Medicare PAC spending.[12] Thus, the impact on Medicare payments to hospitals under this provision would be $6.8 billion over the 2018 to 2029 period.

The Bipartisan Budget Act of 2018 (sec. 53110) continues a policy of restricting inflation-based payment increases for home health services to a statutorily specified amount. For federal fiscal year 2020, the home health payment update will be set at 1.4 percent but will not be subject to the productivity adjustment. Also, section 53111 of the Act reduces the SNF market basket update to 2.4% in federal fiscal year 2019. CBO estimates that these two provisions will save $5.4 billion over the 2018 to 2027 period. For this analysis, we expanded the estimate to 2029 assuming CBO's rate of growth in Medicare payments to SNFs and HHAs for 2028 and 2029.

As described above, we estimate that Medicare payments to hospital-based skilled nursing facilities accounts for about 3 percent of total Medicare spending for skilled nursing facilities, and Medicare payments to hospital-based home health agencies accounts for about 9.6 percent of total Medicare spending for home health. Therefore, the reduction in payment updates will result in reduced Medicare payments to hospital-based providers of $540 million over the 2018 to 2029 period. Taken together, the total impact of the reductions in PAC payment updates is $7.3 billion.

[11] CBO letter to John Boehner, March 25, 2015.

[12] Based on Medicare spending by provider type over a 6-year period 2011-2016. MedPAC, A Data Book: Health Care Spending and the Medicare Program, June 2018.

Hospital Documentation and Coding Adjustments

CMS implemented Medicare Severity diagnosis-related groups (MS-DRGs) in FY 2008 for the inpatient prospective payment system (IPPS), 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 documentation and coding (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. This difference of 1.9 percent represents a permanent payment reduction to hospitals. By applying this 1.9 percent reduction to total IPPS payments (including operating and capital payments), the hospital industry estimates that this difference inappropriately reduces Medicare payments to hospitals by $46.2 billion over the 2013 through 2029 period. [13]

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. An analysis performed by the hospital industry concluded that CMS overstated the recoupment by $0.9 billion.

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 that the reduction amounts for each of the 4 years totaled 10.95 billion.[14] In order to achieve this reduction, CMS intended to reduce the IPPS standard amount by 0.8 percentage points in each fiscal year 2014 through 2017, for a total 3.2 percentage point reduction.

The payment reduction under ATRA section 631 was to be a one-time reduction in order to recoup overpayment in prior years and not a permanent reduction in payment rates. Therefore, hospitals were scheduled to receive a one-time percentage point payment

[13] The 2014-2017 IPPS operating and capital payments were obtained from a July 15, 2016 memo from CMS's Office of the Actuary (FY2017-CMS-1655-FR-Actuary-Estimate-of-Medicare-Documentation.pdf) that was released with the FY 2017 IPPS final rule. These payments were inflated from 2017 to 2029 using IPPS update factors assumed by CBO in their May 2019 Medicare Baseline Spending Report.

[14] CMS Office of the Actuary Memo, "Estimate of Medicare Documentation and Coding Adjustments", July 15, 2016.

increase in fiscal year 2018 to restore the reductions already imposed to recover the approximately $11 billion overpayment described above.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided that the hospital payment increase total 3.0 percentage points to cover what was anticipated at the time of the Act to be a 3.2 percentage point reduction required under ATRA. However after MACRA was enacted, the CMS actuaries estimated that a 1.5 percentage point reduction in fiscal year 2017 (the last year of the ATRA reductions) instead of the scheduled 0.8 percentage point reduction was necessary to recover the full $11 billion required under ATRA. This resulted in an additional 0.7 percentage point reduction in 2017 that was not originally anticipated, for a total reduction of 3.9 percentage points from 2014 to 2017.[15]

Due to not fully restoring the payment reductions made under ATRA, hospital IPPS operating payment rates will permanently be reduced by 0.7 percentage points. We estimated the impact this will have on Medicare payments to hospitals for each year from 2018 through 2029, which results in a $9.8 billion payment reduction over this period.[16]

In addition, the MACRA (section 414) scheduled the 3.0 percentage point payment increase to be phased in at 0.5 percentage points per year over six years beginning in fiscal year 2018 instead of applying the full increase in 2018. CBO estimated this provision would reduce Medicare payment to hospitals by $15.1 billion from 2018 to 2025.[17] For this analysis, we expanded the estimate to 2029 assuming the same level of savings for each year from 2025 through 2029, which results in savings to the Medicare program of $16.8 billion from 2018 to 2029.

The 21st Century Cures Act modified the Medicare Access and CHIP Reauthorization Act phase in of the 3.0 percentage point increase for hospital payment rates by reducing the scheduled 0.5 percentage point increase in fiscal year 2018 with an increase of 0.4588 percentage points.[18] The CBO estimated that this modification would result in $760 million in savings to the program over the 2018 through 2026 period.[19] For this analysis, we expanded the estimate to 2029 assuming an average annual rate of savings growth

[15] Federal Register / Vol. 82 , No. 155 / Monday, August 14, 2017 / Rules and Regulations.

[16] IPPS operating payments excluding hospital-specific payments for 2018 and 2019 were calculated by the hospital industry. These payments were inflated from 2019 to 2029 using IPPS update factors assumed by CBO from their May 2019 Medicare Baseline Spending Report.

[17] CBO letter to John Boehner, March 25, 2015.

[18] https://www.congress.gov/bill/114th-congress/house-bill/34/text.

[19] CBO, "Direct Spending and Revenue Effects for H.R. 34, The 21st Century Cures Act", November 28, 2016.

estimated by CBO for 2019 through 2026, which results in savings to the Medicare program of $1.1 billion from 2018 to 2029.

In total, we estimate that documentation and coding adjustments will reduce Medicare payments to hospitals by $85.7 billion over the 2012 to 2029 period.

Off-Campus Provider Based 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.[20] CBO estimated this provision would save $9.3 billion from 2017 to 2025. For this analysis, we expanded the estimate to 2029 assuming the average annual rate of savings growth estimated by CBO for 2017 through 2025, which results in an impact on Medicare payments to hospitals of $15.4 billion over the 2017 to 2029 period.

The OPPS final rule for CY 2019 expanded the site-neutral payment policy to all off-campus PBDs.[21] CMS will pay off-campus PBDs that were exempted under Section 603 of the Bipartisan Budget Act of 2015 the site-specific physician fee schedule (PFS) rate for clinic visit services (HCPCS code G0463) instead of the current OPPS payment rate and implemented the change in a non-budget neutral manner.[22] CMS estimates savings to Medicare of $300 million in CY 2019 and $610 million in CY 2020. For this analysis, we converted these savings to federal fiscal year estimates and expanded the estimate to 2029 assuming the same average annual rate of savings growth estimated by CBO for Section 603 of BBA 2015, which results in an impact on Medicare payments to hospitals of $8.3 billion over the 2019 to 2029 period.

In total, we estimate that implementing a site-neutral payment policy for off-campus PBDs will reduce Medicare payments to hospitals by $23.7 billion over the 2017 to 2029 period.

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[20] docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf.

[21] On September 17, 2019 the U.S. District Court for the District of Columbia ruled that CMS exceeded its statutory authority in the CY 2019 OPPS final rule when it cut the payment rate for clinic services at excepted off-campus provider-based clinics. The proceedings will continue while the court considers a number of issues related to potential remedies for the impacted hospitals.

[22] Federal Register / Vol. 83, No. 225/ Wednesday, November 21, 2018 / Rules and Regulations.

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 clarified 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 were not 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 standard (traditional) LTCH PPS payment rate. All other cases are reimbursed at a site-neutral rate that is at the same level as an acute care hospital paid under the IPPS (with a few minor exceptions). The provision also delayed implementation of the "25 percent rule" for three years and reinstated 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.[23] For this analysis, we expanded the estimate to 2029 assuming the average annual rate of savings growth estimated by CBO for 2018 through 2023, which results in a reduction in Medicare payments to LTCH hospitals of $7.8 billion over the 2014 to 2029 period.

Section 112 of the Protecting Access to Medicare Act of 2014 makes technical and other changes to the treatment of LTCHs. As described above, the Bipartisan Budget Act and the Pathway to SGR Reform Act of 2013 expanded a moratorium on the establishment of an increase in beds for LTCHs through fiscal year 2017. The Protecting Access to Medicare Act creates exceptions from this moratorium for certain LTCHs.[24] The technical amendments become effective on the date of enactment and CBO estimated this amendment to increase Medicare spending by $100 million in fiscal year 2016.[25]

The site neutral payment rates are applicable for LTCHs with cost reporting periods beginning on or after October 1, 2015 and are phased in over a 2-year period. LTCH site neutral cases receive a blended payment rate that consists of one-half of the standard LTCH payment and one-half of the site neutral payment. The Bipartisan Budget Act of 2018 (sec. 51005) extends the 50/50 payment blend for two additional years, through 2018 and 2019, but reduces LTCH site-neutral payments for years 2018 through 2026 by 4.6 percent to

[23] CBO, "Estimate for Amendment to Pathway for SGR Reform Act of 2013", December 11, 2013.

[24] Exceptions are made for LTCHs that began their qualifying periods for payment as a long-term care hospital before the date of enactment; have a binding written agreement with an outside party for the construction or demolition for a long-term care hospital and have expended at least 10 percent of the cost of the project; or have obtained an approved certificate of need in a state where one is required.

[25] Congressional Budget Office, Cost Estimate for the Protecting Access to Medicare Act of 2014, March 26, 2014

offset the costs of extending the transition period. CBO estimated this provision to reduce Medicare spending by $45 million over the 2018 to 2026 period.

The FY 2019 IPPS/LTCH final rule eliminated the "25-percent rule" and CMS estimated that this would increase aggregate LTCH PPS payments by approximately $35 million in FY 2019, $33 million in FY 2020, and $28 million in FY 2021 and subsequent years.[26] In order to account for the projected increase in payments, the agency finalized the following budget neutrality factors to be applied to the LTCH PPS standard Federal payment rate:

- FY 2019 - a temporary, one-time factor of 0.990884;
- FY 2020 - a temporary, one-time factor of 0.990741; and
- FY 2021 and subsequent years - a permanent, one-time factor of 0.991249.

The hospital industry believes that CMS is inappropriately reducing payments to LTCHs by these amounts from FY 2019 and beyond. Using CMS's estimates, we project that this provision will result in a reduction of $320 million from FY 2019-2029.

Based on these analyses, we estimate the impact of all provisions on LTCHs to be $8.1 billion over the 2015 to 2029 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 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.[27]

Hospital Transfer Policy Expanded to Hospice

For Medicare patients that are transferred early (prior to the geometric mean length of stay minus 1 day for the MS-DRG) from an IPPS hospital to a hospital or unit that is excluded from IPPS (i.e., long-term care hospitals, rehabilitation hospitals and units, psychiatric hospitals and units, Children's hospitals, cancer hospitals, skilled nursing facilities, or home health agencies) within one of 278 MS-DRGs that are subject to the post-acute care transfer

[26] Federal Register/Vol. 83, No. 160/Friday, August 17, 2018/Rules and Regulations

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

policy, the transferring IPPS hospital is paid based upon a per diem rate not to exceed the full IPPS payment rate for the MS-DRG.

The Bipartisan Budget Act of 2018 (sec. 53109) extends the definition of post-acute care provider to include hospice, so that patients who are discharged early from an IPPS hospital to hospice will now result in a reduced payment to the IPPS hospital beginning in federal fiscal year 2019. CBO estimated that this provision would save $4.9 billion over the 2019 to 2027 period. For this analysis, we expanded the estimate to 2029 assuming CBO's rate of growth in Medicare inpatient spending from its May 2019 Medicare Baseline projection, which results in a reduction in Medicare payments to hospitals of $6.2 billion over the 2019 to 2029 period.

Federal Medicaid DSH Allotment Reductions

The ACA required reduction in federal Medicaid Disproportionate Share Hospital (DSH) allotments of $18.1 billion beginning in 2014, to account for the decrease in uncompensated care anticipated under health insurance coverage expansion. However, numerous pieces of legislation have been enacted since 2010 that reduced Medicaid DSH funds even more and delayed the ACA's Medicaid DSH reduction schedule, which will take effect in fiscal year 2020 and continue through 2025.[28] For example, Congress expanded DSH allotment reductions for fiscal years 2021 and 2022, adding $4 billion in cuts each year to offset other health provisions. This legislative activity has increased the amount of the Medicaid DSH reductions to $44.0 billion. ***Exhibit 2*** shows the ACA's original federal Medicaid DSH reduction schedule and the current schedule, which increases the original ACA reductions by $25.9 billion.

[28] https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments.

Exhibit 2: Federal Medicaid DSH Reduction Schedule under the ACA and Current Law

Federal Fiscal Year	Original ACA DSH reduction schedule		Federal Fiscal Year	Current DSH reduction schedule
2014	$0.5			
2015	$0.6			
2016	$0.6			
2017	$1.8			
2018	$5.0			
2019	$5.6			
2020	$4.0		2020	$4.0
			2021	$8.0
			2022	$8.0
			2023	$8.0
			2024	$8.0
			2025	$8.0
Total	**$18.1**		**Total**	**$44.0**

The Medicaid DSH reduction factors in only the additional cut resulting from the legislative delays of $25.9 billion ($44.0 - $18.1), for the period 2020-2025

Source: https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments

Total Impact of Reductions on Federal Payments to Hospitals

In total, we estimate that $252.6 billion in federal payment reductions have been imposed on hospitals from 2010 through 2029 in addition to those that were enacted under the ACA. ***Exhibit 3*** provides a summary of the reductions and the corresponding legislation.

Exhibit 3: Summary of Reduction in Federal Payments to Hospitals in Addition to the ACA Reductions: 2010-2029 (in billions)

Act	Impact on Federal Payments to Hospitals
Sequestration	**$85.8**
Budget Control Act of 2011	$37.1
Bipartisan Budget Act of 2013	$10.3
Military Retiree COLA Restoration Bill of 2014	$5.6
Bipartisan Budget Act of 2015	$5.8
Bipartisan Budget Act of 2018	$12.7
Bipartisan Budget Act of 2019	$14.3
Payment of Medicare Bad Debt	**$5.7**
Middle Class Tax Relief and Job Creation Act of 2012	
Reduction in Post-Acute Care (PAC) Provider Payment Updates	**$7.3**
Medicare Access and CHIP Reauthorization Act of 2015	$6.8
Bipartisan Budget Act of 2018	$0.5
Hospital Documentation and Coding Adjustments	**$85.7**
American Taxpayer Relief Act of 2012	$10.95
Regulatory	$56.9
Medicare Access and CHIP Reauthorization Act of 2015	$16.8
21st Century Cures Act	$1.1
Off-Campus Provider Based Hospital Outpatient Departments	**$23.7**
Bipartisan Budget Act of 2015	$15.4
Regulatory	$8.3
Medicare Payments for Long Term Care Hospitals	**$8.1**
Bipartisan Budget Act of 2013	$7.8
Protecting Access to Medicare Act 2014	-$0.1
Bipartisan Budget Act 2018	$0.1
Regulatory	$0.3
Clarification of 3-Day Payment Window	**$4.2**
American Jobs and Closing Tax Loopholes Act of 2010	
Hospital Transfer Policy Expanded to Hospice	**$6.2**
Bipartisan Budget Act of 2018	
Federal Medicaid DSH Allotment Reductions [1]	**$25.9**
Multiple pieces of legislation	
Total Federal Reductions to Hospitals	**$252.6**

1/ The Medicaid DSH reduction factors in only the additional cut resulting from the legislative delays, for the period 2020 through 2025.

Source: Dobson | DaVanzo estimates – sources and methodology described above. Totals may not add due to rounding.