

## Safety Net Hospitals May 2010

*Non-profit hospitals play a critical role in caring for uninsured, Medicaid, and other vulnerable populations. Whether publicly or privately run, these “safety net” hospitals often care for a disproportionate number of un- and under-insured individuals, putting their financial stability at risk without additional sources of revenue. The health reform legislation impacts these hospitals through changes in payment sources and community-benefit requirements, among other reforms. Below is a summary of key provisions related to non-profit and disproportionate share hospitals and the potential impact of these changes on these hospitals in Illinois.*

**Disproportionate Share Hospital (DSH) Payment Reductions:** The bill reduces national Medicaid DSH allotments by \$0.5 billion in 2014, \$0.6 billion in 2015, \$0.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The Secretary of HHS is required to develop the way in which Medicaid DSH reductions will be distributed, imposing the largest reductions in states with the lowest percentage of uninsured and smaller reductions for low-DSH states. Also accounts for DSH allotments used for 1115 waivers.<sup>1</sup> The bill also reduces national Medicare DSH allotments initially by 75% and then increases the payments based on the percent of the population uninsured and the amount of uncompensated care provided.<sup>2</sup>

- In 2009, with the implementation of the American Recovery and Reinvestment Act, IL received \$215,878,645 in Medicaid DSH payments.<sup>3</sup> Nationally in 2009, \$11.3 billion was allotted for Medicaid DSH<sup>4</sup> and \$9.8 billion for Medicare DSH<sup>5</sup>.
- The Congressional Budget Office estimates that there will be no change in DSH allotments from 2010 to 2013.<sup>6</sup> A \$0.5 billion reduction in 2014 represents a 4.4% change from the 2010 allotments. If a 4.4% reduction occurred in IL, based on the 2009 allotment, IL would receive an estimated \$206,326,493 in 2014. Following the reduction pattern, IL might receive \$204,416,062 in 2015, \$204,416,062 in 2016, \$181,490,896 in 2017, \$120,357,121 in 2018, \$108,894,538 in 2019, and \$139,461,425 in 2020.
- In Illinois, there were 71 hospitals in over 30 cities that received Medicaid DSH payments in 2010.<sup>7</sup>
- While it is expected that the reductions in Medicaid DSH allotments will be off-set by increases in Medicaid reimbursements, the impact of this transfer of revenue on hospitals is unknown.
- Since the 2006 health reform in Massachusetts, safety net hospitals have been seeing the same number or more of low-income patients but are getting paid less for the care they provide, mainly due to low Medicaid and public coverage reimbursement rates. The State DSH payments were redirected to help pay for the reform and the safety net hospitals have lost revenue to care for low-income and uninsured patients (it is estimated that 2.6% of the population remains uninsured). Covering the uninsured with funds used by safety net hospitals has not been found to be a one-to-one funding transfer.<sup>8</sup>

**Non-Profit Hospital Requirements:** Non-profit hospitals will be required to conduct community needs assessments every 3 years and adopt an implementation strategy to meet the identified needs. Hospitals must also adopt and widely publicize a financial assistance policy that helps patients understand what assistance is available and how to apply. Those receiving financial assistance cannot be charged more than those who are insured, and reasonable attempts to determine eligibility for assistance must be made before extraordinary collection actions are taken. A \$50,000 tax per year after enactment is imposed for failure to meet these requirements.<sup>2</sup>

- Most of the over 200 hospitals in Illinois are non-profit hospitals and will have to meet these new requirements.
- With the recent Illinois Supreme Court ruling that Provena Covenant Medical Center be denied property tax exemption, this provision helps us define what is required of non-profit hospitals. Illinois needs to clarify state-wide charity care and community benefit requirements for tax-exemption status in light of these recent changes.

**Reform of the Medicare hospital wage index system:** Requires the HHS secretary to submit a plan for reform of the Medicare hospital wage index system no later than the end of 2011. Hospitals will have to adhere to this new plan once enacted.<sup>10</sup>

- The Medicare hospital wage index system is a way to adjust for geographical differences in labor costs when reimbursing for pre-discharge services.<sup>11</sup> Changes in the system could lead to increases or decreases in revenue for various hospitals.

**Hospital Value-Based Purchasing Program:** A hospital value-based purchasing program will provide acute care hospitals with incentives to enhance quality outcomes. By 2012, the HHS secretary must submit a plan to Congress that identifies how to move home health and nursing home providers into a value-based purchasing payment system.<sup>10</sup>

- Moving to value-based purchasing payment systems will produce major cost-savings for health systems
- Depending on how much flexibility is provided in the Secretary's plan, groups may want to develop criteria beyond cost when making decisions about these systems so that benefits to the local communities are maximized.

#### **Quality Improvements:**

- Effective 2010, market basket updates to provider payments under Medicare will be modified to account for productivity improvements in inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, and outpatient hospitals.<sup>10</sup>
  - Forecasts of the market basket index approximate how much providers' costs would rise in the coming year if the quality and mix of inputs they use to provide care remain the same. Making adjustments based on productivity (improvements in productivity are required in a competitive market environment) will put pressure on providers to deliver services more efficiently while maintaining quality outcomes.<sup>12</sup>
  - For providers who may not have the resources to increase productivity while maintaining quality outcomes (i.e.: safety net providers who struggle to maintain sufficient revenue), these productivity adjustments may hurt their ability to be adequately reimbursed for Medicare services.
- Effective in 2011, prohibits Medicaid payments for services related to hospital-acquired conditions. Emphasizes patient safety and quality care.

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