

Sustaining Health Care: Protect Medicaid and Medicare against Further Cuts

Illinois hospitals are the cornerstone of the state's health care delivery system – now and in the years to come – as they and other key stakeholders work together to transform health care to ensure access to high-quality, cost effective and efficient care for all Illinoisans. Illinois hospitals are also critical to the health of local and state economies, providing more than 425,000 direct and indirect jobs, and generating an economic impact on the state of more than \$75 billion annually.

But the ability of Illinois hospitals to continue serving their patients and communities is jeopardized by many challenges and pressures. Hospitals are operating on thin margins resulting from inadequate state and federal revenues, high labor and medical liability costs, and increased expenses for compliance with a multitude of regulatory requirements. Hospitals in Illinois absorb the costs of government-sponsored health care not covered by payments, receiving only 75% of cost for Medicaid (without the Hospital Assessment Program) and 91% of cost for Medicare. Illinois hospitals are absorbing \$8 billion in federal payment reductions over 10 years under health care reform, which began in 2010.

Enough is enough – no more cuts to hospital care

The Illinois Hospital Association and hospital community oppose any cuts to Medicare and Medicaid in the FY2012 federal budget process as well as cuts and drastic changes to Medicare and Medicaid in future years. We respectfully urge you and your colleagues in Congress to oppose such cuts and changes that would undermine the sustainability of Illinois hospitals and the state's health care system in the short-term and the transformation of health care in the longer-term. **Specifically, cuts and changes that we oppose include:**

- **Reductions or elimination of Medicaid provider assessments;**
- **“Blended” Medicaid/CHIP rate for states;**
- **Block granting of the Medicaid program;**
- **Global caps/deficit triggers on spending, requiring deep Medicare and Medicaid cuts;**
- **Reductions of Medicare payments for graduate medical education; and**
- **Reductions of Disproportionate Share Hospital (DSH) payments.**

We also urge Congress to:

- Continue pressing the Centers for Medicare and Medicaid Services (CMS) to re-evaluate and **revise its proposed FY2012 Inpatient Prospective Payment System (IPPS) rule regarding coding offsets;** and
- Pass the **Rural Hospital Protection Act (H.R. 1398)** authorizing provider taxes to be allowable expenses under Medicare for Critical Access Hospitals.

Illinois hospitals support rational, workable alternatives, including:

- Medical liability reform, including caps on non-economic damages;
- Enhancing revenues, such as taxes on junk food;
- Coordinated care for dual eligibles;
- Increased Medicare beneficiary cost sharing; and
- Increased use of generic drugs.

Hospitals across Illinois are working to make the health care system as cost efficient and effective as possible, while improving quality and ensuring the best outcomes for patients. However, further and deep cuts to Medicaid and Medicare will only stymie those efforts.

Key Health Care Issues for Congress

Medicaid Provider Assessments – Oppose Attempts to Reduce or Eliminate

The Illinois Hospital Assessment program generates \$900 million annually in critical federal support for health care for children, the elderly and the disabled. Since Illinois has the lowest federal Medicaid matching rate of 50%, this is one way for the state to increase the return of our federal tax dollars to support health care and health care jobs. Illinois serves 4% of the nation's Medicaid population, but receives only 3.3% of total federal Medicaid funding.

More than one-third of Medicaid payments to Illinois hospitals are directly funded by the Hospital Assessment Program. Without this program, Illinois hospitals, on average, would be reimbursed only 75% of cost for providing health care services to Medicaid patients. Reducing or eliminating this important program will not only put enormous pressure on Illinois' already stretched Medicaid budget but jeopardize patients' access to hospital services.

Blended Medicaid Rate for States – Oppose

Under this proposal, the various matching rates at which the federal government reimburses states for their costs for Medicaid and the Children's Health Insurance Program (CHIP) would be replaced with a single, "blended" rate for each state. Illinois' rates are already at the nation's lowest level for both programs – 50% for Medicaid and 65% for CHIP. Estimates indicate that moving to a blended rate would result in federal Medicaid funding reductions of \$60 billion to \$110 billion over 10 years, shifting those costs to the states.

Illinois' blended rate would be set at a level providing LESS federal funding than under current law, when the state already is receiving less than its fair share of federal Medicaid funding. Such an approach will shift costs to the states and will only exacerbate Illinois' challenges in supporting Medicaid and CHIP, likely resulting in reduced access, service reductions, and cuts to providers. In addition, calculating the new "blended" rates will be extremely difficult to do accurately because it would require numerous assumptions and estimates for which solid data are not yet available.

Block Granting Medicaid – Oppose

Under the budget passed by the U.S. House, Medicaid would be turned into a block grant program, with the federal contribution to Medicaid reduced by nearly \$800 billion over the next decade (cuts of 5% in 2013, 15% in 2014, and 33% in 2021). This would shift an increasing financial burden to Illinois and the states, at a time when Illinois is already struggling with budget challenges and its support of the Medicaid program. Illinois and other states would be forced to dramatically cut Medicaid eligibility, benefits and services, and the rates paid to providers who serve Medicaid patients.

According to a new Families USA study, under the Medicaid cuts called for in the House budget, **in 2013, Illinois would lose \$1.2 billion in business activity, 9,280 jobs, and \$493 million in health care funding. In 2021, Illinois would lose more than \$7.83 billion in business activity, more than 61,000 jobs, and \$3.25 billion in health care funding.** Illinois would be among the top 10 states most affected by the cuts.

Global Caps/Deficit Triggers – Oppose

The adoption of global caps or deficit triggers on federal spending would require deep cuts to Medicare and Medicaid expenditures without Congressional approvals. Such mechanisms would impose arbitrary across-the-board cuts to health care and hospital programs that will jeopardize Illinois patients' access to needed health care.

For example, one proposal, the Commitment to American Prosperity (CAP) Act, would make automatic cuts to federal programs, including Medicaid and Medicare, if projections show spending will exceed a cap (21% of GDP) in any year. An analysis by the Lewin Group found that such a cap and trigger would cut Medicare by \$859 billion and Medicaid by \$575 billion from 2013 to 2021, including payment reductions of more than \$700 billion to hospitals alone. In addition, more than 5 million individuals could lose their health insurance as a result.

Graduate Medical Education – Oppose Reductions

By virtue of their mission to educate tomorrow's physicians, Illinois' teaching hospitals fill a vital need, especially as the demand for physicians will continue to increase with the aging of Baby Boomers and the implementation of health care reform. The costs of training tomorrow's physicians includes the actual salaries and fringe benefits paid for each resident slot (direct medical education costs) as well as the costs of training in the use of an increasingly wide range of various complex patient services and technology (indirect costs). Medicare's payments for these direct and indirect costs of training physicians are vital to teaching hospitals, and we object to any reductions in such funding.

The President's National Commission on Fiscal Responsibility and Reform recommended that federal Medicare funding for Graduate Medical Education be reduced by about \$6 billion in FY2012 and by nearly \$60 billion over 10 years. These cuts would have a devastating impact on the ability of Illinois' teaching hospitals to train tomorrow's physician workforce, on patient access to care, and on the state's economy. **A recent economic impact study conducted for the Association of American Medical Colleges found that cutting GME funding under the commission's proposal would result in the loss of 3,500 jobs throughout Illinois, \$525 million in state economic activity, and \$31.4 million to the regional tax base.**

IPPS Rule on Coding Offsets – CMS Should Revise

CMS is seeking to offset increases in hospital payments that it attributes to changes in coding or classification of a patient rather than the actual treatment of more complex and severely ill patients. In addition to ignoring research studies that validated the increased acuity in the case mix calculation over the past few years, CMS is not taking into consideration whether hospitals are caring for more patients on an outpatient basis – and therefore admitting only the sickest and most expensive to treat patients. This flawed approach understates the true increase in costs related to the admission of more severely ill patients. **The rule includes a proposed 3.15% cut to hospital payments in FY 2012 that would cost hospitals an estimated \$3.2 billion nationally and \$159 million in Illinois, and continues a past cut of 2.9%. We urge our House members to sign the letter being circulated by U.S. Representatives Pete Sessions (R-TX) and Joe Crowley (D-NY), and our U.S. Senators to sign the letter being circulated by U.S. Senators Debbie Stabenow (D-MI) and Lisa Murkowski (R-AK), which both ask CMS to revise the rule.**

Disproportionate Share Hospital (DSH) Payments – Revisit and Lower the ACA Reductions

The Medicaid Disproportionate Share Hospital Program provides payments to hospitals that serve disproportionate numbers of Medicaid and uninsured patients. The Accountable Care Act calls for cuts in these important DSH payments by \$14 billion from 2014 through 2019, when coverage expansions take effect. To support hospitals and preserve the health care safety net as hospitals work to improve the quality and cost effectiveness of the health care system, these cuts should be reduced.

Rural Hospital Protection Act (H.R. 1398) – Support its Passage

H.R. 1398, the Rural Hospital Protection Act, sponsored by U.S. Representatives Ron Kind (D-WI) and Sam Graves (R-MO) would override CMS' negative interpretation concerning the cost reporting treatment of provider taxes as allowable costs for Critical Access Hospitals (CAHs) under Medicare. In June, the U.S. District Court in the Central District of Illinois ruled in favor of CMS' position that while provider taxes are allowable costs for Medicare, increased revenues received from the state must be offset to the extent of those costs. Twenty-six hospitals in Illinois had challenged CMS in court after the CMS Administrator reversed a ruling in favor of hospitals by the Provider Reimbursement Review Board. With this adverse court decision, it is more critical than ever that Congress take action on a legislative remedy, **H.R. 1398**.

Provider taxes are required to be paid by hospitals, they do constitute real costs to hospitals, and they have long been considered a regular business operating cost for hospitals. Critical Access Hospitals tend to have lower operating margins and serve particularly vulnerable and elderly populations. If Medicare does not reimburse Critical Access Hospitals for the cost of provider taxes, they will find themselves with fewer resources to deliver quality care, weakening the rural health care safety net.