Supporting Medicare safety-net hospitals

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MEDPAC

Motivations for examining safety-net hospitals

- In 2020, the House Committee on Ways and Means requested that MedPAC study access to health care for vulnerable beneficiaries. We found:
  - Rural and urban beneficiaries use similar amounts of care
  - Beneficiaries dually eligible for Medicare and Medicaid used more services than non-dual-eligible beneficiaries
  - Beneficiaries with multiple chronic conditions used more services than those with fewer reported conditions
- Ongoing concerns about the financial stability of safety-net providers
- Need to balance support for providers with fiscal responsibility
  - Large, across-the-board Medicare payment updates would be costly
  - Targeting new funding to Medicare safety-net providers may be more efficient

Summary of MedPAC's June 2022 safety-net chapter

- Step 1: Identification of Medicare safety-net providers
  - Common framework for all sectors
  - Sector-specific characteristics will affect which types of patients are used to identify safety-net providers
- Step 2: Determine if additional Medicare safety-net funds are needed
- Applied steps one and two to the hospital sector

Classifying Medicare beneficiaries as low-income

- Low-income includes all dual-eligible beneficiaries plus non-dual eligible beneficiaries who receive a low-income Part D subsidy (LIS)
- LIS beneficiaries are:
  - Three times as likely to be disabled (40% vs. 13%)
  - Twice as likely to be Black (17% vs. 9%)
  - Twice as likely to be Hispanic (13% vs. 6%)
  - Nearly three times as likely to have ESRD (3% vs. 1%)
  - Slightly more likely to be female or live in a rural area

Note: LIS (low-income subsidy), ESRD (end-stage renal disease). Results are preliminary and subject to change.
Source: MedPAC analysis of 2020 enrollment data.

Applying our safety-net framework to hospitals

Framework (step 1): Identifying Medicare safety-net hospitals

- Hospitals with higher shares of low-income beneficiaries tend to have higher risk-adjusted costs per discharge
- Hospitals with high shares of Medicare LIS patients are less likely to receive full cost sharing
- For hospitals, patients with public insurance are usually not materially profitable
- Therefore, hospitals with high shares of low-income Medicare beneficiaries and/or high shares of uninsured and patients with public insurance (including Medicare) would be deemed Medicare safety-net hospitals

Note: LIS (low-income subsidy).

Framework (step 2): Deciding whether additional Medicare funding is needed to support Medicare safety-net hospitals

- Hospital sector may merit additional safety-net funding
  - Risk of negative effects: For example, elevated rate of closures among safety-net hospitals
  - Medicare is not a materially profitable payer in the sector: Medicare margins are negative, on average
  - Even with improved design of how funds are distributed, additional funds may be needed

Source: MedPAC analysis of hospital claims and cost report data.

Results are preliminary and subject to change

Current Medicare safety-net payments to disproportionate share hospitals (DSH)

- Substantial payments (~6% of Medicare hospital payments)
  - $3.1 billion in DSH payments in 2019
  - $8.3 billion in uncompensated care payments to DSH hospitals in 2019
- Concerns
  - Medicare indirectly subsidizes Medicaid
  - DSH shares are negatively correlated with Medicare shares, meaning high Medicare share hospitals tend to get lower DSH payments
  - DSH payments are inpatient-only
  - Should Medicare be paying uncompensated care costs?
  - Current uncompensated care payments are distorted providing higher payments to hospitals with high Medicare Advantage shares

Uncompensated care payments biased against hospitals with high share of FFS patients

	High FFS share hospital	High MA share hospital
Historical uncompensated care costs	$2 million	$2 million
FFS discharges	750	250
MA discharges	250	750
FFS uncompensated care payments (20% of uncompensated care costs)	$0.4 million (0.4/750 or $533 per discharge)	$0.4 million (0.4/250 or $1,600 per discharge)
MA uncompensated care payments	$0.13 million 250*($533)	$1.2 million 750*($1,600)
Total uncompensated care payments	$0.53 million	$1.6 million
Share of uncompensated care costs paid	27%	80%

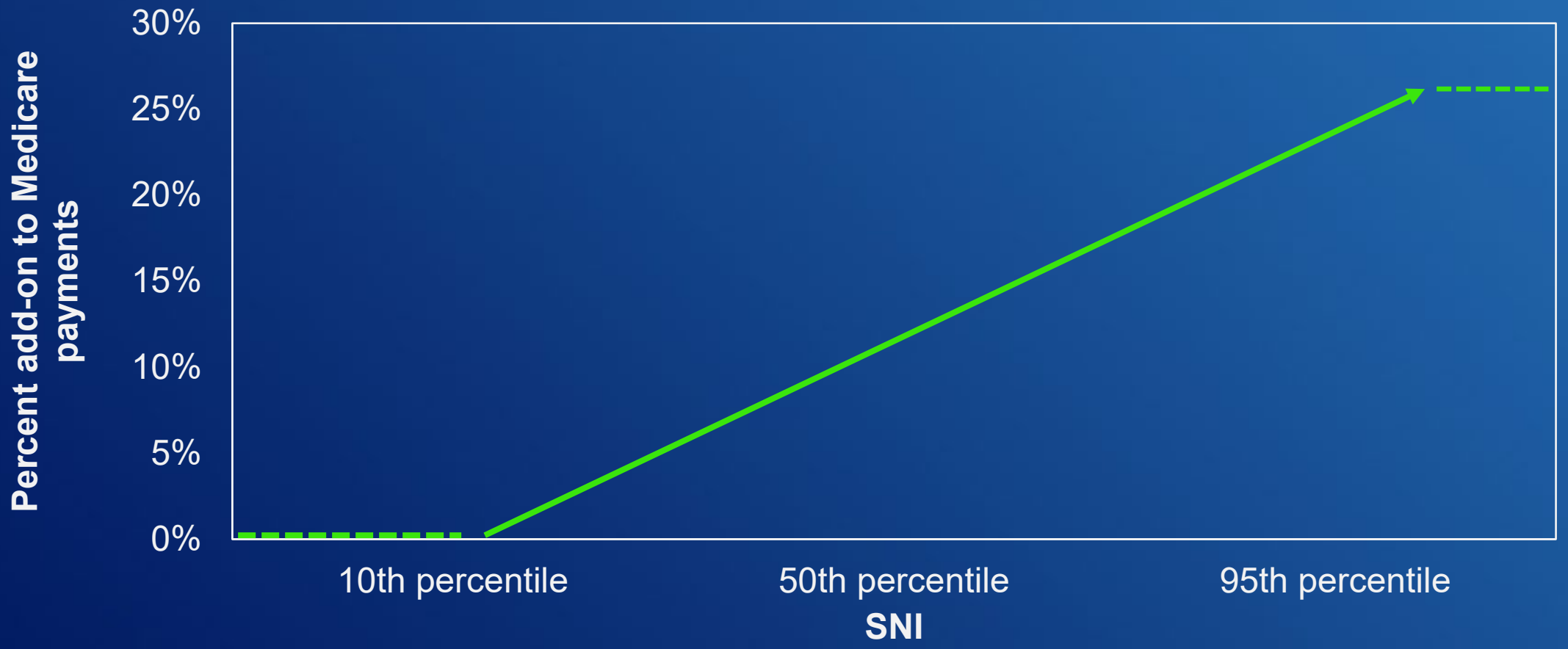
Note: FFS (Fee-for-service); MA (Medicare Advantage). In 2023, DSH hospitals will receive FFS uncompensated care payments equal to approximately 20% of their historic uncompensated care costs. Based on the literature and staff discussions with insurers and hospital systems, we assume MA plans pay hospitals rates approximately equal to FFS rates.

Safety-Net Index: An alternative mechanism for supporting Medicare safety-net hospitals

- SNI computed as:
  - LIS share of Medicare beneficiaries, plus
  - Uncompensated care costs as a share of revenue, plus
  - One half the Medicare share of inpatient days
- Why use SNI to distribute safety-net funds?
  - Includes Medicare shares to recognize the reduced profitability of Medicare since DSH was enacted
  - Eliminates direct subsidy of Medicaid and uncompensated care
  - Aligns Medicare funds more directly with hospitals serving low-income Medicare beneficiaries

Note: DSH (disproportionate share hospital), LIS (low-income subsidy), SNI (safety-net index).

Illustrative example of how Medicare add-on payments could increase as SNI increases



Note: SNI (Safety-Net Index).

Results are preliminary and subject to change

Comparing 2019 safety-net payments to the SNI

	DSH	Uncompensated care	SNI (Redirects DSH and uncompensated care)
Spending (2019)	$3.1 billion	$8.3 billion	$11.4 billion
Driving factors	Medicaid days, SSI share	Uncompensated care costs*, MA share	LIS share, Medicare share of days, uncompensated care costs
Percentage add-on to Medicare payments?	Yes. Inpatient only	No	Yes. Inpatient and outpatient
Higher add-ons as low-income share increases?	Yes	No	Yes

*Hospitals must meet a minimum DSH percentage, but over 80% of hospitals meet this threshold.
Note: DSH (disproportionate share hospital), LIS (low-income subsidy), SSI (Supplemental Security Income), MA (Medicare Advantage).

Results are preliminary and subject to change

What did the over $8 billion in Medicare uncompensated care payments cover?

- Uncompensated care costs consist of:
  - Charity care for the uninsured (about 53% of the total)
  - Charity care for cost-sharing for the insured (about 15% of the total)
  - Bad debts (about 32% of the total)
- Medicare treats all uncompensated care equally
- In 2019, fee-for-service Medicare paid for about 20% of all DSH hospitals' uncompensated care costs
- About $3 to $4 billion is added onto MA benchmarks

Source: MedPAC analysis of 2018 cost report data.

Hospital SNI add-on implementation

- The SNI add-on would be applied to:
  - Hospital inpatient and outpatient payments
  - Services for FFS and MA patients
- CMS would pay safety-net payments for MA patients served by safety-net hospitals directly to the hospitals (not to MA plans)
  - SNI payments would be excluded from MA benchmarks
  - MA plans would not be expected to pay higher rates to safety-net hospitals
  - Paying hospitals directly would assure funds go to safety-net hospitals
  - The precedent for this is indirect medical education payments. CMS generally makes these payments directly to hospitals for their MA patients.

Note: SNI (safety-net index), FFS (fee-for-service), MA (Medicare Advantage).

Illustrative example: SNI would increase high-SNI hospitals' low all-payer margin

Margin (2019)	Lowest SNI quartile	2nd SNI quartile	3rd SNI quartile	Highest SNI quartile
Medicare margin	−12.4%	−9.5%	−5.5%	−0.9%
Simulated Medicare margin if SNI replaced DSH/uncompensated care	−15.8	−9.8	−3.1	3.0
Simulated Medicare margin if an additional $1 billion was distributed via the SNI	−15.7	−9.4	−2.3	4.2
All-payer (total) margin	10.0	8.3	6.0	3.1
Simulated all-payer margin if SNI replaced DSH/uncompensated care	9.2	8.2	6.7	4.2
Simulated all-payer margin if an additional $1 billion was distributed via the SNI	9.2	8.3	6.9	4.4

Note: SNI (safety-net index) DSH (disproportionate share hospital).
Source: MedPAC analysis of cost-report data
Results are preliminary and subject to change

Hospitals that gain and lose payments if DSH and uncompensated care payments were redistributed via the SNI

- Hospitals with high Medicare shares and high shares of low-income beneficiaries would tend to see payment increases (Slightly more likely to be rural)
- Hospitals with low Medicare shares and high levels of uncompensated care would tend to see payment reductions (Slightly more likely to be large public hospitals)
- Across all categories of hospitals (rural, urban, teaching, non-teaching, for-profit, government, non-profit) some hospitals would gain and others would see reductions.
  - About five percent of hospitals in all categories would lose 1 to 2 percent of revenue
  - About five percent of hospitals in all categories would gain 3 to 5 percent of revenue

Note: DSH (disproportionate share hospital), SNI (safety-net index).

Results are preliminary and subject to change

Key implications

- The SNI metric can better identify Medicare safety-net hospitals than the DSH and uncompensated care metrics
- Using the SNI to distribute Medicare safety-net funds would cause:
  - Medicare funding to be more focused on hospitals serving high shares of low-income Medicare patients
  - Medicare funding to be less focused on hospitals with high uncompensated care costs and relatively few Medicare patients
- Medicare would provide equal support to Medicare safety-net hospitals for their care of FFS and MA beneficiaries

Note: DSH (disproportionate share hospital), SNI (safety-net index) FFS (fee-for-service) MA (Medicare Advantage).

Commission discussion

- Any clarifying questions?
- Is there support for moving toward an SNI recommendation as part of the December meeting's update process?