Developing a new Medicare framework for safety-net providers

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Today's discussion

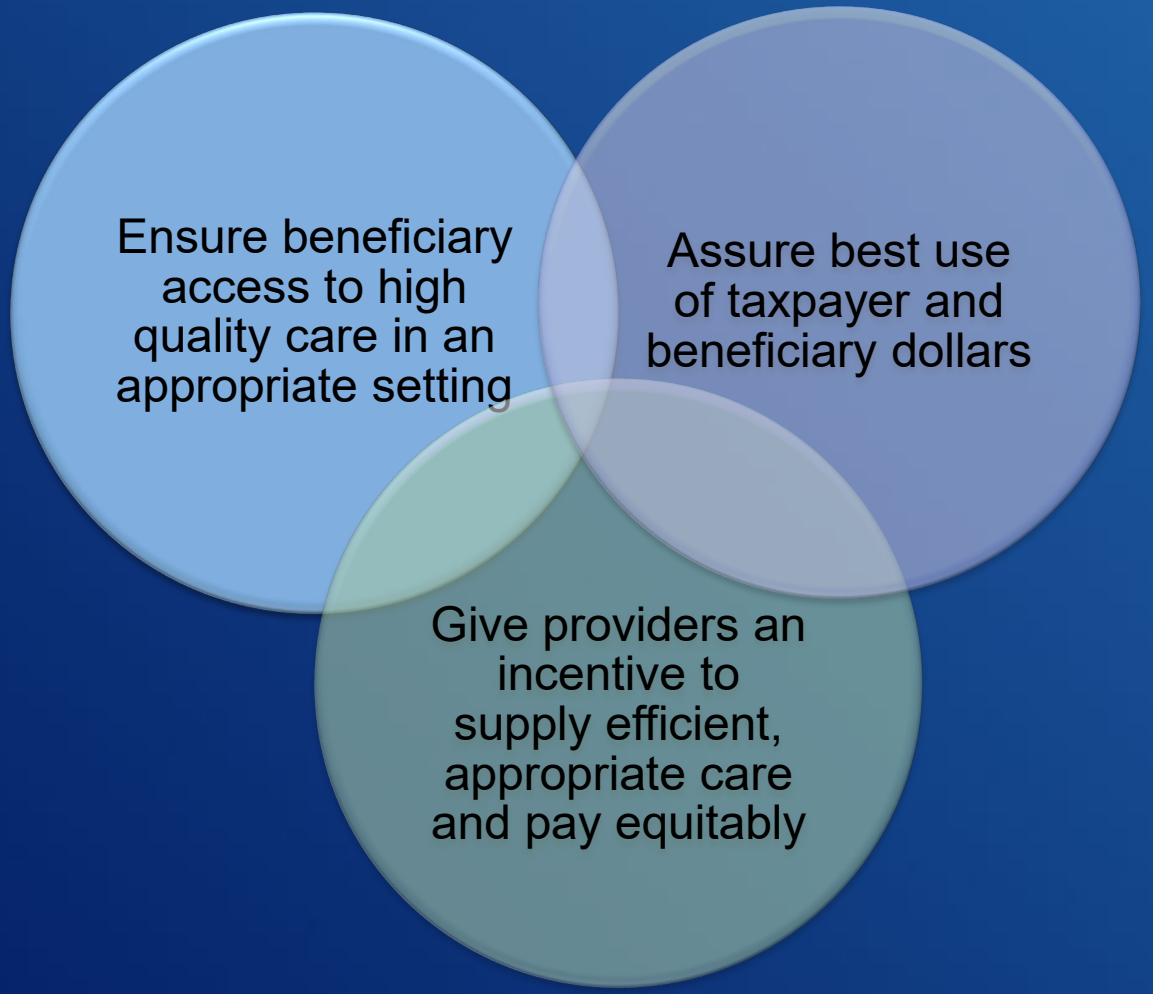
- Overview of MedPAC
- Developing a Medicare framework for safety-net providers
- Applying the safety-net framework to hospitals
- Questions / discussion

MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by Comptroller General (GAO) for experience and subject matter expertise
  - Includes providers, payers, researchers, beneficiary-focused individuals
  - Serve 3-year terms, can be reappointed
  - Meet in public 7x a year
- Commissioners supported by 25-30 analysts

Note: GAO (Government Accountability Office).

MedPAC's principles of Medicare payment



Motivations for examining safety-net providers

- In 2020, the House Committee on Ways and Means requested that MedPAC study access to health care for vulnerable beneficiaries. We found:
  - Defining “vulnerable beneficiaries” using MUAs is imprecise and poorly targets Medicare’s financial resources
  - Beneficiaries dually eligible for Medicare and Medicaid used more services than non-dual eligible beneficiaries
  - Beneficiaries with multiple chronic conditions use 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 payment updates would be costly
  - Targeting new funding to safety-net providers may be more efficient

Note: MUAs (medically underserved area).

Current Medicare policies to support safety-net providers vary by sector

- Clinician safety net policies include:
  - Health professional shortage area (HPSA) incentive payment available to physicians
  - Enhanced payment rates for FQHCs and RHCs
- Hospital safety net policies include:
  - Disproportionate share hospital and uncompensated care payments
  - The Medicare Dependent Hospital (MDH) program
- Safety net policies do not exist in outpatient dialysis facilities, skilled nursing facilities, home health agencies, and others

Note: FQHCs (federally qualified health centers), RHCs (rural health clinics).

Focus on safety-net providers and the beneficiaries they serve

- Beneficiaries with the highest health care needs often have the fewest personal resources to address those needs
- Low-income beneficiaries report difficulties accessing care compared with higher-income beneficiaries
- Providers treating low-income beneficiaries may:
  - Incur extra costs
  - Generate relatively lower revenues
- In some health care sectors, public payers have relatively lower payment rates making it more difficult for providers who are substantially dependent on public payers to compete with other providers for labor and technology

Source: MedPAC analysis of the Medicare Current Beneficiary Survey (MCBS).

The concentration of low-income beneficiaries may create undue financial strain on providers

- Financial strain could lead to diminished access to and quality of care for beneficiaries
- Goals of new safety-net programs / adjustments:
  - Mitigate potential negative outcomes for beneficiaries (e.g., access issues, lower quality)
  - Address ongoing concerns about the financial stability of safety-net providers that serve Medicare beneficiaries
  - Balance support for providers with fiscal responsibility
- Consistent framework that would be applied to all providers

MedPAC's two-step safety-net framework

- Step 1: Identifying safety-net providers
  - Providers that treat a disproportionate share of Medicare beneficiaries who have low incomes and are less profitable than the average beneficiary, the uninsured, or those with public insurance that is not materially profitable
- Step 2: Deciding whether new Medicare funding is warranted to support safety-net providers. Medicare should spend additional funds only if:
  - There is a risk of negative effects on beneficiaries without new funding
  - Medicare is not a materially profitable payer in the sector, and
  - Current Medicare payment policies cannot be redesigned to adequately support safety-net providers

Dual eligibility for Medicaid and Medicare may not be the best metric to identify low-income beneficiaries

- Reflects variation in state Medicaid eligibility policies
- Alternative approach: Broaden definition of "low-income beneficiaries"

Beneficiaries eligible for:
full Medicaid benefits,
partial Medicaid benefits, or
the Part D LIS

Collectively, this population is referred to as:
"LIS beneficiaries"

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Note: LIS (low-income subsidy).

Advantages of using the LIS to define low-income beneficiaries

- Reduces variation across states related to Medicaid eligibility
  - Some variation across states is appropriate and driven by differences in the rates of beneficiaries living at or near the federal poverty level
- Providers would have an incentive to make their patients aware of and help them enroll in Medicaid, MSPs, and the Part D LIS program

Note: LIS (low-income subsidy), MSPs (Medicare Savings Programs).

LIS is correlated with other characteristics that have traditionally defined vulnerable populations

- In addition to having relatively low incomes, LIS beneficiaries differed from the full Medicare FFS population in other regards, including being:
  - Three times as likely to be currently disabled (40% vs. 13%)
  - Twice as likely to be Black (17% vs. 9%) or 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), FFS (fee-for-service), ESRD (end-stage renal disease). MedPAC publications are the definitive reference source for all analyses and results.

Source: MedPAC analysis of 2020 enrollment data.

Applying the new framework to the hospital sector

Step 1: Apply the framework to identify safety-net hospitals

- Hospitals that treat a disproportionate share of low-income beneficiaries:
  - Have lower total margins
  - Are more likely to close
- The gap between commercial payment rates and Medicare payment rates to hospitals has grown
  - Profit margins on commercial patients continue to diverge from margins on Medicare patients
  - Safety-net hospitals may not have sufficient resources to compete with hospitals that treat a higher share of commercial patients for labor and services
- Hospitals' Medicare profit margins have decreased over the last two decades
  - In 1999, hospitals' average Medicare margin was 10 percent, and declined to -8.7 percent in 2019

Note: LIS (low-income subsidy). MedPAC publications are the definitive reference source for all analyses and results.
Source: MedPAC analysis of hospital claims and cost report data.

Step 2: Apply the framework to determine whether new Medicare funding is needed to support safety-net hospitals

- The hospital sector may merit additional safety-net funding
  - Risk of negative outcomes: Elevated rate of closures among safety-net hospitals
  - Medicare is not a materially profitable payer in the sector: Medicare margins are negative, on average
  - Design of current adjustments could be improved to provide greater support to safety-net hospitals at risk of closure

Note: MedPAC publications are the definitive reference source for all analyses and results.

Current Medicare safety-net payments to hospitals total over $10 billion but are not well targeted

- DSH payments: $3.5 billion in 2022
  - Calculated as a percentage of IPPS payments, based on each hospital's DSH patient percentage (Medicaid + SSI)
  - DSH payments are inpatient-centric
  - DSH patient percentages are driven by Medicaid shares and are negatively correlated with Medicare shares; high Medicare share hospitals are at a disadvantage
- Uncompensated care (UC) payments: $7.2 billion in 2022
  - Calculated as an add-on to IPPS payments, set at a fixed percent of DSH hospitals' prior year UC costs (Medicare FFS pays about 20% in 2022)
  - UC payments are a fixed percent of UC costs; percent does not vary by hospitals' DSH patient percentage or share of total costs that are uncompensated

Note: DSH (disproportionate share hospital), IPPS (inpatient prospective payment system), SSI (Supplemental Security Income), FFS (fee-for-service). MedPAC publications are the definitive reference source for all analyses and results.

An alternative mechanism for supporting safety-net hospitals: Safety-net index

- Computed as:
  - LIS share of beneficiaries, plus
  - Uncompensated care costs as a share of revenue, plus
  - One half the Medicare share of inpatient days
- Includes Medicare shares to focus Medicare spending on hospitals that are providing care to Medicare beneficiaries

Note: DSH (disproportionate share hospital), LIS (low-income subsidy), SNI (Safety-Net Index). MedPAC publications are the definitive reference source for all analyses and results.

Comparing current safety-net payments to the illustrative SNI

	DSH	UC payments	Illustrative SNI (redirects current DSH and UC payments)
Spending	$3.5 billion	$7.2 billion	$10.7 billion
Driving factors	Medicaid days, SSI share	Uncompensated care costs*	LIS share, Medicare share of days, cost of uncompensated care
Add-on to Medicare payments	Yes, inpatient only	No	Yes, inpatient and outpatient
Higher add-ons as low-income share increases?	Yes	No	Yes

Note: SNI (safety-net index), DSH (disproportionate share hospital), UC (uncompensated care), LIS (low-income subsidy), SSI (Supplemental Security Income). MedPAC publications are the definitive reference source for all analyses and results. *Hospitals must meet a minimum DSH percentage, but over 80% of hospitals meet this threshold.

SNI redirects funds toward hospitals that have larger Medicare shares and a higher risk of closure

	Lowest DSH quartile	2nd DSH quartile	3rd DSH quartile	Highest DSH quartile
Share closed 2016-2019	1.7	1.0	1.3	2.1
Medicare share of inpatient days	64%	62%	57%	47%

	Lowest SNI quartile	2nd SNI quartile	3rd SNI quartile	Highest SNI quartile
Share closed 2016-2019	0.1	0.4	2.3	3.3
Medicare share of inpatient days	51%	58%	61%	58%

Note: SNI (Safety-Net Index), DSH (disproportionate share hospital). MedPAC publications are the definitive reference source for all analyses and results.
Source: MedPAC analysis of 2016 cost report data and 2016 to 2020 closure data.

Illustrative example: SNI should improve support for hospitals that treat large shares of low-income Medicare beneficiaries

	Lowest SNI quartile	2nd SNI quartile	3rd SNI quartile	Highest SNI quartile
Medicare margin 2016	-13	-10	-6	-2
Simulated Medicare margin if SNI replaced DSH/uncompensated care	-15	-10	-4	0

Note: SNI (Safety-Net Index), DSH (disproportionate share hospital). MedPAC publications are the definitive reference source for all analyses and results.
Source: MedPAC analysis of cost report data.

Conclusions

- Consistency in Medicare payment policies to support providers serving vulnerable populations
- Using LIS eligibility to define low-income beneficiaries:
  - Helps address variation due to states' Medicaid polices
  - Could encourage greater enrollment in MSPs and the LIS
- Targeting additional payment to safety-net hospitals balances fiscal responsibility and ensuring beneficiary access to quality health care
- Current Medicare DSH and uncompensated care payments are an imperfect way to support safety-net hospitals
- SNI should better support safety-net hospitals with high Medicare shares

Note: LIS (low-income subsidy), MSPs (Medicare Savings Programs), DSH (disproportionate share hospital), SNI (Safety-Net Index).