Modernizing the Medicare-Dependent Hospital program

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Background on the Medicare-Dependent Hospital (MDH) program

- The MDH program was enacted to help hospitals with high shares of Medicare patients
  - Limited to those with fewer than 100 beds
  - Mostly a program for rural hospitals
- Currently includes 155 hospitals
- Extended through 2022
Magnitude of the MDH add-on payment

- MDH hospitals receive the higher of:
  - Inpatient Prospective Payment System (IPPS) rate
  - Prospective payment rates plus 75% of the difference between the hospital’s historic costs (trended forward) and the IPPS rate
    - Historic costs based on higher of 1982, 1987, or 2002
- 60 percent of MDHs get higher payments
- Increases fee-for-service (FFS) payments by an average of $1.2 million per hospital (over IPPS rates) at an annual cost of $125 million
Why should Medicare modernize the MDH program?

- Eligibility criteria fail to measure Medicare dependence
  - Eligibility is based only on inpatient days and discharges
  - Does not account for outpatient services
  - Does not account for difference in rates paid by commercial patients, Medicaid patients, and the uninsured

- Magnitude of payment determined by costs, not need
  - Uses cost data from up to 37 years ago
  - Costs are not a good mechanism for scaling the amount of the add-on payment

- Lacks geographic equity
Why is it the right time to modernize the MDH program?

- Medicare hospital margins have declined for several years and are now negative.
- Lower Medicare margins mean it is harder for hospitals with high Medicare shares to remain open.
- High Medicare shares can be an issue in both rural and urban areas.
Medicare days and discharges are not good measures of Medicare dependence

<table>
<thead>
<tr>
<th>Decile</th>
<th>Medicare share of patient-care revenue 2014-2016, Median</th>
<th>Medicare share of days, 2016, 10th:90th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>51%</td>
<td>51% to 77%</td>
</tr>
<tr>
<td>9</td>
<td>43%</td>
<td>45% to 67%</td>
</tr>
<tr>
<td>8</td>
<td>39%</td>
<td>44% to 68%</td>
</tr>
<tr>
<td>7</td>
<td>36%</td>
<td>42% to 65%</td>
</tr>
<tr>
<td>4</td>
<td>29%</td>
<td>36% to 60%</td>
</tr>
<tr>
<td>1</td>
<td>17%</td>
<td>16% to 50%</td>
</tr>
</tbody>
</table>

Note: Excludes critical access hospitals. Total Medicare share of patient-care revenue includes imputed Medicare Advantage payments based on inpatient days attributed to MA. Results are preliminary and subject to change.

Source: MedPAC analysis of Medicare cost report data from CMS.
Hospitals with the highest share of Medicare revenue have lower standardized cost per discharge

<table>
<thead>
<tr>
<th>Decile</th>
<th>Total Medicare share (FFS+ estimated MA) of patient-care revenue 2014-2016 (median)</th>
<th>Standard Medicare FFS cost per discharge 2014-2016 (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>51%</td>
<td>$10,690</td>
</tr>
<tr>
<td>9</td>
<td>43</td>
<td>10,884</td>
</tr>
<tr>
<td>8</td>
<td>39</td>
<td>11,312</td>
</tr>
<tr>
<td>7</td>
<td>36</td>
<td>11,526</td>
</tr>
<tr>
<td>6</td>
<td>33</td>
<td>11,711</td>
</tr>
<tr>
<td>5</td>
<td>31</td>
<td>11,991</td>
</tr>
<tr>
<td>4</td>
<td>29</td>
<td>12,417</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>12,650</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>13,068</td>
</tr>
<tr>
<td>1</td>
<td>17</td>
<td>13,192</td>
</tr>
</tbody>
</table>

Note: Excludes critical access hospitals. Total Medicare share of patient-care revenue includes imputed Medicare Advantage payments based on inpatient days attributed to MA. Results are preliminary and subject to change.

Source: MedPAC analysis of Medicare cost report data from CMS.
Ways to modernize the MDH program

- Focus on hospitals that are dependent on Medicare revenues
  - Include inpatient and outpatient Medicare (FFS and Medicare Advantage) revenues
- Scale the amount of the MDH add-on payment to a hospital’s Medicare share of revenue, not costs
- Expand the program to allow both rural and urban hospitals to qualify
- Eliminate the bed size requirement
- Require qualifying hospitals to be either:
  - Geographically isolated, or
  - In markets with above-average occupancy
## Illustrative policy parameters

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Metric</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicare share</td>
<td>Patient-care revenues</td>
<td>&gt;35%</td>
</tr>
<tr>
<td>2. Add-on amount</td>
<td>Based on Medicare’s share of patient-care revenues</td>
<td>Up to 5% on a sliding scale</td>
</tr>
<tr>
<td>3. Geographic isolation</td>
<td>Mileage to the next closest PPS facility</td>
<td>&gt;15 miles</td>
</tr>
<tr>
<td>or</td>
<td>Market or facility occupancy rate</td>
<td>&gt;62%</td>
</tr>
</tbody>
</table>
Illustrative example: The sliding scale payment would range from 0% to 5% based on Medicare’s share of hospital revenue.

Note: Excludes critical access hospitals. Medicare share of patient-care revenue includes imputed Medicare Advantage payments based on inpatient days attributed to MA. Results are preliminary and subject to change.

Source: MedPAC analysis of Medicare cost report data from CMS.
Expected impacts based on illustrative policy parameters

- Number of MDHs would expand to over 600
  - Facilities across each hospital category (e.g. urban/rural, teaching/non-teaching) would qualify for the program
  - A larger share of major teaching and relatively efficient providers would receive an add-on payment
- Average add-on payment would equal 2.7 percent of inpatient and outpatient Medicare revenue
- One-quarter of the qualifying hospitals would receive the maximum 5 percent add-on
- Payments would no longer be dependent on data from the 1980s

Preliminary; subject to change
Financial impacts of illustrative policy parameters

- Using 2016 data:
  - Medicare (and total) profitability would increase slightly
  - Hospitals that are relatively efficient and Medicare dependent would be expected to have positive Medicare margins
  - FFS payments to qualifying hospitals would increase by about $900 million, based on 2016 data

Preliminary; subject to change
Discussion questions

- Should eligibility criteria shift from inpatient days/discharges to the Medicare share of revenue (inpatient and outpatient)?
  - Is a 35 percent threshold reasonable?
- Should the program include measures of geographic isolation or occupancy for eligibility?
- Is the scale of the adjustment appropriate?
- Should the program be funded with new money or a reduction in the update?