Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: hospital inpatient and outpatient services

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Summary of payment adequacy

- Access to care is good
- Access to capital is strong
- Quality is improving
- Medicare margins 2014
  - Aggregate margin: -5.8%
  - Marginal profit: +10%
  - Efficient provider: + 1%
  - Projected 2016 aggregate margin: -9%
  - Marginal revenue expected to continue to be higher than marginal cost in 2016

Medicare payments for Medicaid and uncompensated care

- Medicare support for hospitals with high DSH shares, primarily meaning high Medicaid shares*
  - $3.3 billion in traditional DSH (an add-on to Medicare payment rates based on Medicaid and SSI shares)
  - $6.4 billion in “uncompensated care” payments. Medicare currently uses Medicaid inpatient days and Medicare SSI days as a proxy for uncompensated care.
  - $1.2 billion in Medicare payments above 340B drug acquisition costs
  - $1.1 billion in “bad debt” payments for dual-eligible beneficiaries in cases where Medicaid declines to pay their hospital coinsurance
- No payments are directly tied to uncompensated care

* DSH days include Medicaid days plus days of Medicare patients on supplemental security income (SSI). Medicaid days represent 85% of the total.

Problems with Medicare subsidizing Medicaid

- The Medicaid program has supplemental payments to pay for Medicaid "shortfalls." Medicare payments for the same shortfalls are duplicative
- If Medicare pays for Medicaid shortfalls, it encourages states to reduce Medicaid rates
- Medicaid "shortfalls" may be due to low payment rates or due to high costs
- At some hospitals there may be no Medicaid shortfall after supplemental payments are considered

Many DSH and 340B hospitals have below-average levels of uncompensated care

Category of hospital	Criteria	Share of PPS hospitals	Median share of uncompensated care	Share with below the median level of uncompensated care (<3.6%)
DSH	15% DSH percentage*	80%	3.8%	46%
340B	High DSH* & non-profit/government	35%	4.3	40
All hospitals	All	100	3.6	50

*The DSH percentage is the share of days that are Medicaid plus the share of Medicare patient days that are for patients on SSI. To be a 340B PPS hospital the DSH percentage must meet certain thresholds.

Note: Computed for hospitals with S-10 cost report information. Critical Access Hospitals are excluded.
Source: MedPAC analysis of Medicare claims and HRSA file on hospital 340B participation, 2014

Share the 340B discounts with beneficiaries and hospitals providing uncompensated care

- Issue: 340B hospitals' acquisition costs for Part B drugs are much lower than Medicare rates (OIG estimate: discount was 34% of ASP)
- Change: Allow beneficiaries and hospitals providing the most uncompensated care to share in the savings
  - Reduce Medicare rates by 10% of ASP (lowers cost sharing by 10%)
  - Redistribute program savings to the hospitals providing the most uncompensated care
- The 340B program and the mandated discounts from pharmaceutical companies would not change

Using the S-10 to distribute the Medicare-funded uncompensated care pool dollars

- $6.4 billion in uncompensated care payments in 2016
- CMS uses Medicaid days as the primary proxy for uncompensated care costs*
- Data from hospitals' cost reports (worksheet S-10)
  - S-10 directly measures uncompensated care costs
  - A better indicator of uncompensated care (charity care and bad debts) than the current proxy
  - Using the S-10 would increase payments to public hospitals

*In 2016, a fixed payment of $174 per day is paid to DSH hospitals for each Medicaid day and each Medicare-SSI patient day. Medicaid days represent 85 percent of Medicare funded "uncompensated care" payments, and Medicare-SSI days represent 15 percent.

Phasing in the use of the S-10

- Hospitals report their uncompensated care costs on worksheet S-10 of their cost report
- We have shown it is a closer match to audited uncompensated care data than the Medicaid proxy
- However, the data are not perfect. There can be errors in reporting charity care charges and bad debts.
  - CMS should be auditing aberrant data
  - CMS should audit the hospitals reporting the largest amounts of uncompensated care
- The three-year phase in will provide an incentive for improved reporting and auditing of the data