

Medicare payment policies to support safety-net providers

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Today's session

- Focuses on safety-net clinician groups and hospitals
 - Motivations for examining
 - Current policies
 - Possible definitions of safety-net providers
 - Characteristics compared with other providers
- Commissioner discussion of next steps

Beneficiary access to clinician care is good overall, but some concerns exist

- The Commission has concluded that beneficiaries have good access to clinician care overall
 - Surveys (high satisfaction and access similar to privately insured)
 - Claims analyses (volume of care and number of billing clinicians increasing)
 - Focus groups with providers and beneficiaries
- Some stakeholders have concerns
 - Future updates under PFS are low, while private payer rates are increasing
 - Accessing care might be more challenging for certain subgroups of beneficiaries (e.g., dual-eligible beneficiaries)

Some dual-eligible beneficiaries might face difficulties accessing clinician care

- Dual-eligible beneficiaries receive more care than other beneficiaries
- Survey data suggest dual-eligible beneficiaries may experience more difficulties accessing care
- Medicaid increasingly does not pay full cost-sharing
 - Results in clinicians often being paid 20% less for treating dual-eligible beneficiaries compared with other beneficiaries
 - Research suggests this is associated with modest decrease in access to care
- Other populations could also face access challenges (e.g., low-income beneficiaries who do not qualify for Medicaid)

Current Medicare policies to support safety-net clinician groups

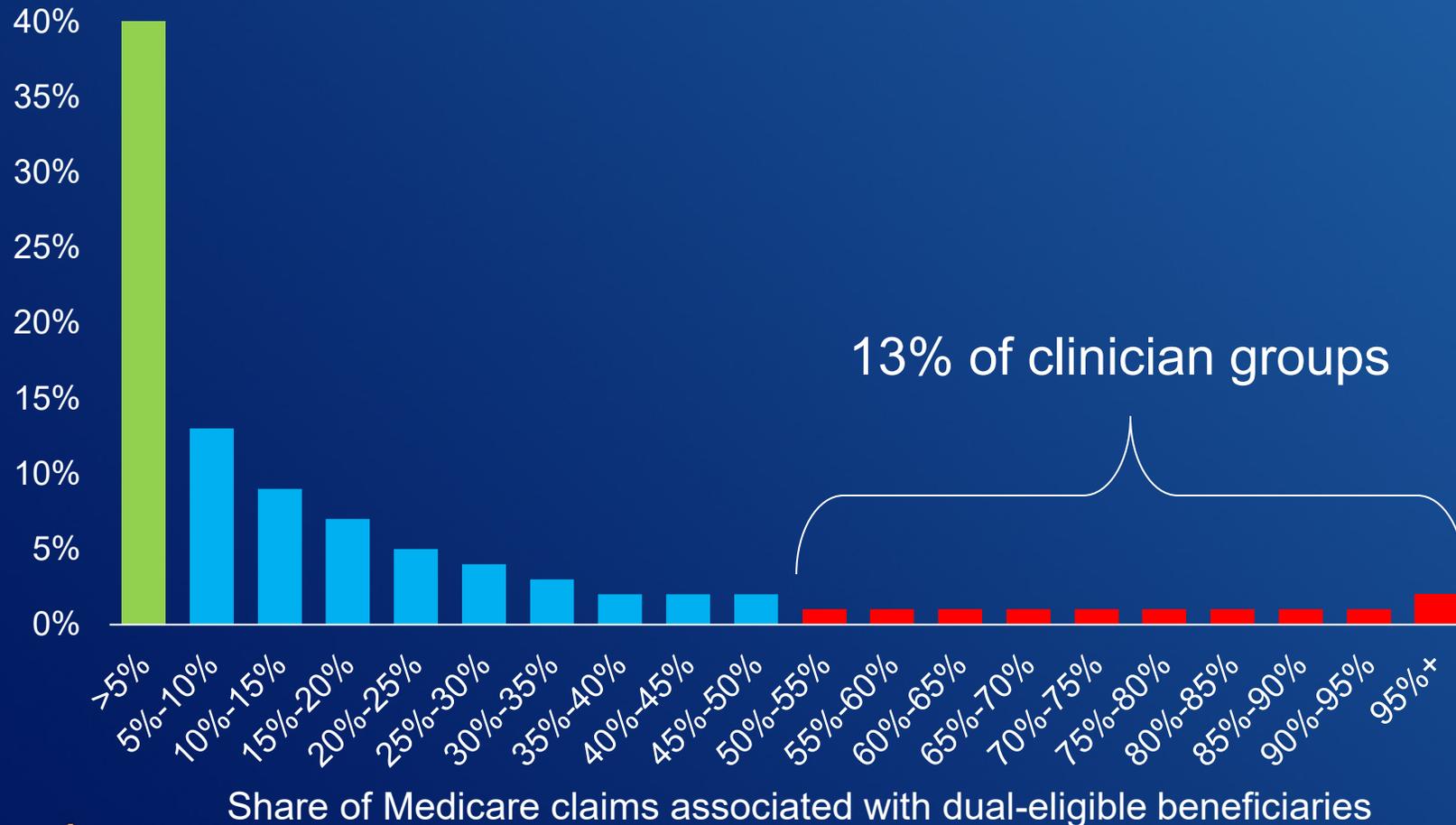
- Health professional shortage area (HPSA) incentive payment
 - 10% bonus to fee schedule services furnished in geographic primary care and mental health HPSAs
 - Available to physicians, not other types of clinicians
- FQHCs and RHCs
 - Separate payment systems with enhanced payment rates
 - Largely focused on primary care

Defining safety-net providers

- Working definition: Providers that treat a disproportionate share of low-income patients or are substantially dependent on public payers
 - Treating low-income beneficiaries might entail extra costs and result in lower revenue for providers
 - Providers who are dependent on public payers might have difficulty competing with other providers who are not
- We operationalize this definition differently across sectors
 - Clinician groups: Share of Medicare patients who are dual-eligible
 - Hospitals: Dual-eligible beneficiary measure and other alternatives

Many clinician groups billing the physician fee schedule had a low share of their Medicare claims associated with dual-eligible beneficiaries, 2019

Share of groups



Implications

- Across-the-board payment updates are not well-targeted at safety-net groups
- Establishing a threshold to be considered a safety-net provider is difficult because distribution is continuous

Motivations for safety-net hospital policies

- Access to hospital care is generally good
- Over time, rates paid by commercial insurers and public payers have diverged
- As rates diverge, safety-net hospitals may increasingly have trouble competing for labor and technology with hospitals that have more commercially insured patients

History of safety-net hospital policies

- ProPAC (a predecessor to MedPAC) recommended that Congress enact higher payment rates for hospitals with high shares of poor patients
- Disproportionate Share Hospital (DSH) payments were enacted in 1986
- The Affordable Care Act (2010) redistributed a majority of DSH payments to partially fund uncompensated care in DSH hospitals
- In 1989, Congress enacted the Medicare Dependent Hospital program to assist small rural hospitals with large Medicare shares

Current payments to disproportionate share hospitals (DSH)

- **DSH eligibility**
 - Medicaid share of patient days (excluding dual-eligible beneficiaries) plus SSI share of Medicare patient days must exceed 15%
 - Over 80% of hospitals meet the threshold
- **Substantial payments (~6% of Medicare hospital payments)**
 - \$3.5 billion in DSH payments
 - \$7.2 billion in uncompensated care payments to DSH hospitals
- **Possible 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 target low-margin hospitals

- Despite DSH payments, DSH hospitals have:
 - Moderately lower total (all-payer) margins
 - Moderately higher risk of closure

	Lowest DSH quartile	2 nd DSH quartile	3 rd DSH quartile	Highest DSH quartile
Total (all-payer) margin (2016)	6.1%	4.8%	4.8%	3.2%
Percent closed 2016-April 2020	1.7	1.4	1.4	2.9

Source: MedPAC analysis of cost report data and closure data.

Note: Quartiles are based on DSH patient percentages from 2015. We sort hospitals into quartiles using 2015 data and examine outcomes (margins and closures) from subsequent years to determine the extent to which DSH patient percentages can predict these future outcomes.

Alternative safety-net provider definition: Hospitals with high shares of dual-eligible beneficiaries

- Despite DSH payments, hospitals with high shares of Medicare patients who are dual-eligible beneficiaries have:
 - Materially lower total (all-payer) margins
 - Higher risk of closure

	Lowest dual eligible quartile	2 nd quartile	3 rd quartile	Highest dual eligible quartile
Total (all-payer) margin (2016)	8.5%	5.6%	3.4%	1.7%
Percent closed 2016-April 2020	0.6	0.8	1.5	3.7

Source: MedPAC analysis of cost report data and closure data.

Note: Quartiles are based on the share of Medicare claims that were for dual-eligible beneficiaries in 2015. We sort hospitals into quartiles using 2015 data and examine outcomes (margins and closures) from subsequent years to determine the extent to which the share of claims that were for dual-eligible beneficiaries can predict these future outcomes. Alternative measures are included in your mailing materials.

Medicare Dependent Hospital (MDH) program

- Eligibility
 - Rural
 - Fewer than 100 beds
 - 60% inpatient care was Medicare
- Modest payments: Less than \$200 million per year
- Policy concerns
 - Rural only
 - Inpatient only
 - Cost-based payments

Conclusions

- Access to clinician and hospital care is good but some concerns exist
- Certain providers serve a disproportionate share of poor patients
 - Access may weaken if commercial prices continue to grow faster than Medicare prices
 - An across-the-board increase in payments will not remedy the disparity between safety-net and other providers. It also may exacerbate the Medicare program's financial difficulties.

Conclusions (continued)

- Medicare provides relatively limited support to safety-net clinicians
- Medicare provides substantial support to DSH hospitals
 - DSH payments target hospitals with low-income patients
 - But hospitals with high shares of dual-eligible beneficiaries still have lower profitability and are more likely to close
 - DSH percentages are negatively correlated with Medicare shares

Discussion questions

- Given the deficiencies discussed, what type of changes are needed to safety-net policies?
 - Replace current policies
 - Add to existing policies
- Do we need new metrics to identify safety-net providers?
 - Preferred metrics for clinician groups
 - Preferred metrics for hospitals
- For sectors where Medicare pays relatively low rates, should there be a separate Medicare-dependent program, or should high Medicare shares be woven into a composite safety-net metric?