Medicare payment policies to support safety-net providers

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Motivations for examining safety-net providers

- House Committee on Ways and Means request to study access for vulnerable beneficiaries
- Ongoing concerns about the financial stability of safety-net providers
- Need to balance support of providers with fiscal responsibility
  - Large, across-the-board payment updates would be costly
  - Targeting new funding to safety-net providers may be more efficient

Today's session

- Revised framework for identifying safety-net providers and deciding whether new Medicare funding is warranted
- Expanded definition of low-income beneficiaries
- Updated analyses of safety-net hospitals
- Commissioner feedback and discussion of next steps

Framework for identifying safety-net providers and deciding whether new Medicare funding is warranted

Overview of safety-net provider framework

- Based on commissioner feedback, we define safety-net providers based on the characteristics of their patients
- Revised framework has two distinct steps
  - Identifying safety-net providers
  - Deciding whether new Medicare funding is warranted
- Framework allows us to broadly identify safety-net providers while recognizing that new Medicare funding is not warranted in all situations

Framework (step 1): Identifying safety-net providers

- Safety-net providers are those who treat a disproportionate share of:
  - Medicare beneficiaries who have low incomes and are less profitable than the average beneficiary, or
  - the uninsured or those with public insurance that is not materially profitable
- Providers who treat a disproportionate share of such patients could be financially challenged, which could lead to negative outcomes for beneficiaries (e.g., access issues, lower quality)

Framework (step 2): Deciding whether new Medicare funding is warranted to support safety-net providers

- Because Medicare faces substantial financial challenges, Medicare should only spend additional funds to support safety-net providers if:
  - There is a risk of negative effects on beneficiaries without new funding (e.g., access issues due to provider closures)
  - Medicare is not a materially profitable payer in the sector
  - Current Medicare payment adjustments cannot be redesigned to better support safety-net providers

Defining low-income beneficiaries

Expanding definition of low-income beneficiaries to include all LIS beneficiaries

- In November, we defined low-income Medicare beneficiaries as those eligible for full Medicaid benefits
- In response to commissioner feedback, we expanded our definition to include beneficiaries eligible for:
  - Full Medicaid benefits,
  - Partial Medicaid benefits, or
  - The Part D LIS
- Collectively, we refer to this population as “LIS beneficiaries”

Note: LIS (low-income subsidy).
Results preliminary and subject to change.

LIS beneficiaries are more likely to be disabled and a racial minority compared with the full FFS population

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

Using the LIS to define low-income beneficiaries narrows state variation and has additional benefits

- Expanding our low-income beneficiary definition reduced but did not eliminate variation across states
- Some variation across states is appropriate and driven by differences in the rates of beneficiaries living at or near the federal poverty level
- Identifying low-income beneficiaries using LIS eligibility has additional benefits
  - Less administrative burden
  - If funds are allocated based on treating LIS beneficiaries, providers would have an incentive to make their patients aware of and help them enroll in Medicaid, MSPs, and the LIS

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

Illustrative example of applying our safety-net framework to hospitals

Safety-net framework (step 1): Identifying safety-net hospitals

- Certain hospitals serve a disproportionate share of LIS beneficiaries:
  - Lowest ¼ of hospitals: less than 25% of Medicare volume was for LIS beneficiaries
  - Highest ¼ of hospitals: more than 40% of Medicare volume was for LIS beneficiaries
- Low-income Medicare beneficiaries: Hospitals with higher shares of low-income beneficiaries tended to have higher risk-adjusted costs per discharge
- Payer mix: Hospitals with more uncompensated care and larger Medicare shares tend to have low non-Medicare margins

Note: DSH (disproportionate share hospital), LIS (low-income subsidy).
Source: MedPAC analysis of hospital claims and cost report data. Data are preliminary and subject to change.

Safety-net framework (step 2): Deciding whether new Medicare funding is needed to support safety-net providers

- Hospital sector may merit additional safety-net funding, but reforms to current adjustments may be needed
  - 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

Current safety-net payments to hospitals: DSH and uncompensated care payments

- 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 FFS Medicare hospital payments)
  - $3.5 billion in DSH payments
  - $7.2 billion in uncompensated care payments to DSH hospitals
    - FFS Medicare pays about 20% of DSH hospitals' uncompensated care costs

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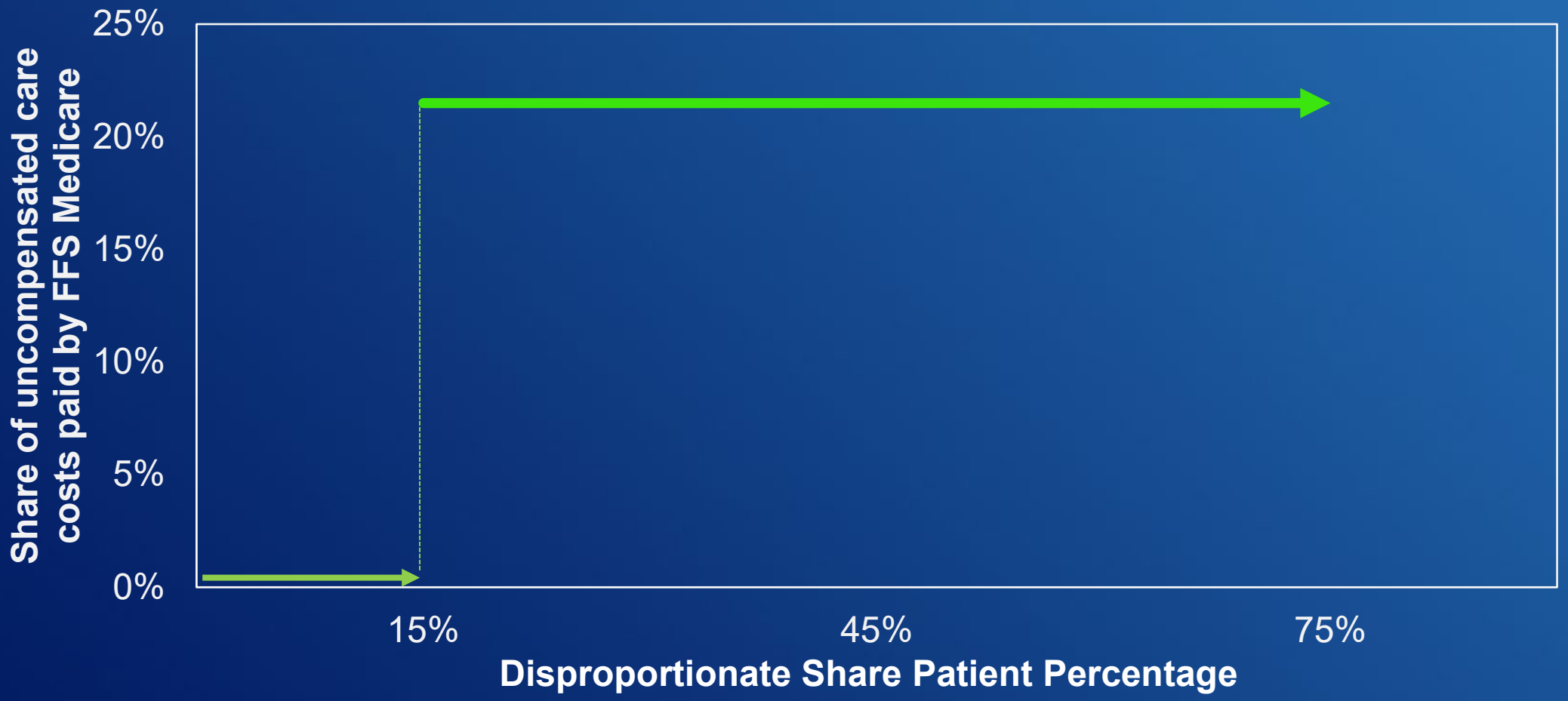
Note: DSH (disproportionate share hospital), FFS (fee-for-service), SSI (Supplemental Security Income).
Data are preliminary and subject to change.

Concerns with current DSH payments

- DSH patient percentages are driven by Medicaid shares and are negatively correlated with Medicare shares
  - Medicare indirectly subsidizes Medicaid
  - High Medicare share hospitals at a disadvantage
- DSH payments are inpatient-centric

Note: DSH (disproportionate share hospital).

Concern with current uncompensated care payments: Lack of focus on safety-net hospitals



Source: MedPAC analysis of CMS supplemental DSH files.

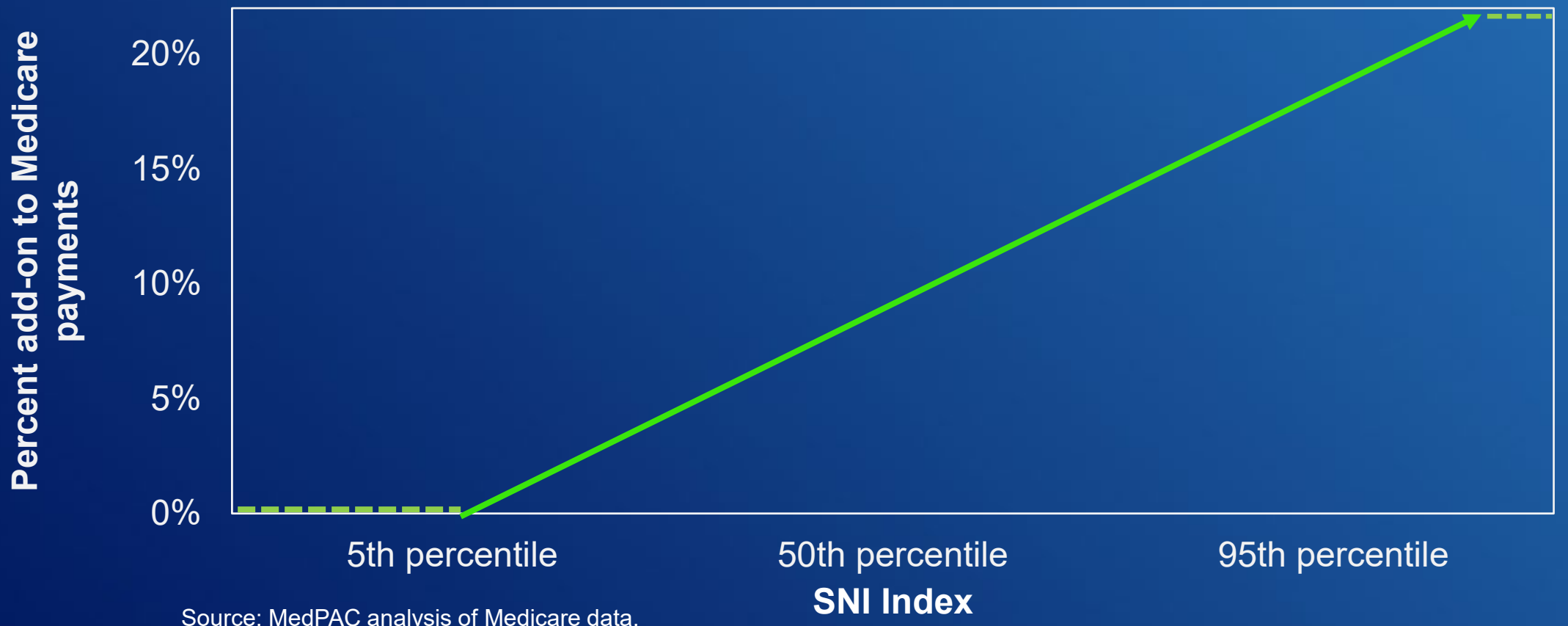
Note: DSH (disproportionate share hospital).
Data are preliminary and subject to change.

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

- Computed in this illustrative example 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 recognize the reduced profitability of Medicare since DSH was enacted
- Illustrative example of an SNI that increases SNI payment adjustments from the 5th percentile of the SNI distribution to the 99th percentile

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



Source: MedPAC analysis of Medicare data.

Note: DSH (disproportionate share hospital), (SNI) Safety-Net Index.
Data are preliminary and subject to change.

Comparing current safety-net payments to the SNI

	DSH	Uncompensated care payments	SNI
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

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

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
Percent closed 2016-April 2020	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
Percent closed 2016-April 2020	0.1	0.4	2.3	3.3
Medicare share of inpatient days	51%	58%	61%	58%

Note: DSH (disproportionate share hospital), SNI (Safety-Net Index).
Source: MedPAC analysis of 2016 cost report data and 2016 to 2020 closure data. Data are preliminary and subject to change.

Illustrative example: SNI may improve support for low-margin hospitals

	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
All-payer (total) margin (2016)	8	6	3	1
Simulated total margin if SNI replaced DSH/uncompensated care	8	6	4	2

Source: MedPAC analysis of cost report and closure data.
Note: DSH (disproportionate share hospital), SNI (Safety-Net Index). 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.

Conclusions

- Using LIS eligibility to define low-income beneficiaries helps address variation due to states' Medicaid polices and could encourage greater enrollment in MSPs and the LIS
- Current Medicare DSH and uncompensated care payments are an imperfect way to support safety-net hospitals
  - DSH patient percentages are negatively correlated with Medicare shares
  - DSH is inpatient-centric
  - Uncompensated care payments are not highly focused on safety-net hospitals
- SNI may better support safety-net hospitals with high Medicare shares

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

Commission feedback and discussion

- Feedback on safety-net framework
  - Identifying safety-net providers
  - Deciding whether new Medicare funding is warranted
- Feedback on applying safety-net framework to hospitals
  - Medicare shares should influence the identification of and level of payment for safety-net hospitals
  - Reforming or replacing current safety-net policies should be part of our safety-net hospital work
  - An SNI-type metric is our preferred hospital safety-net metric

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