

CHAPTER

3

**Supporting
safety-net providers**

Supporting safety-net providers

Chapter summary

The Medicare program strives to ensure access to care for all beneficiaries and to adequately compensate providers for providing that access. The beneficiaries with the greatest health care needs are often low-income Medicare beneficiaries with the fewest personal resources to address those needs, making it critical to ensure that these beneficiaries have access to a safety net of health care providers. However, treating low-income beneficiaries might entail extra costs that are not sufficiently reflected in Medicare's standard payment systems and can generate lower revenues for providers. In addition, public payers (including Medicare and Medicaid) in certain sectors have lower payment rates than commercial insurance, making it more difficult for providers who are substantially dependent on public payers to compete with other providers for labor. The Commission is concerned that the concentration of low-income beneficiaries or patients with public insurance among certain providers may create an undue financial strain on these providers and could result in diminished access to or quality of care for beneficiaries. But implementing large, across-the-board payment rate increases to support this subset of providers would be an inefficient use of scarce Medicare resources. For these reasons, the Commission has begun a body of work examining safety-net providers, including exploring how they should

In this chapter

- A conceptual framework for identifying safety-net providers
- A conceptual framework for determining the need for new Medicare safety-net funding
- Identifying low-income Medicare beneficiaries
- Safety-net hospitals' greater financial challenges and risk of closure suggest need for revisions to Medicare safety-net funding

be defined and how the Medicare program can best support their critical missions.

To identify safety-net providers and evaluate whether new Medicare safety-net funding might be warranted in a health care sector, we developed a conceptual framework intended to be applicable across multiple sectors. We identify safety-net providers as those that disproportionately serve (1) low-income Medicare beneficiaries who are less profitable to care for than the average beneficiary or (2) uninsured patients or patients with public insurance who are not materially profitable. A provider that serves a disproportionate share of patients with above-average profitability (even if those patients are low-income Medicare patients) would not meet our criteria for being a safety-net provider.

We also developed a conceptual framework for determining whether the Medicare program should allocate new funding to support identified safety-net providers. Medicare should spend additional funds to support safety-net providers only if:

- low-income beneficiaries are at risk of negative outcomes (e.g., access problems due to provider closures) without additional funding;
- Medicare is not a materially profitable payer in the sector; and
- current payment adjustments cannot be redesigned to adequately support safety-net providers.

By separating the identification of safety-net providers and the determination of whether new Medicare funds should be allocated to support them, these frameworks allow the Commission to broadly identify safety-net providers while recognizing that new Medicare funding is not warranted in all instances.

Our definition of low-income beneficiaries includes all those who are eligible for full or partial Medicaid benefits and those who do not qualify for Medicaid benefits in their states but who receive the Part D low-income subsidy (LIS) because they have limited assets and an income below 150 percent of the federal poverty level. Collectively, we refer to this population as “LIS beneficiaries” because those who receive full or partial Medicaid benefits are automatically eligible to receive the LIS. To identify hospitals’ low-income populations, we use the LIS as the definition of “low income” because it reduces the impact of variation in state Medicaid policies. Our analysis found that, compared with the full Medicare population, LIS beneficiaries are three times as likely to be disabled and are twice as likely to be Black or Hispanic. Given the demographic mix of the LIS population, directing safety-net funds

to LIS patients' providers could promote greater equity in access to care and quality across demographic groups.

Applying our framework to safety-net hospitals

In acute care hospitals, Medicare patients, and in particular low-income Medicare patients, would generate lower levels of profitability than commercial patients without additional safety-net payments. Therefore, hospitals with high shares of Medicare patients, low-income Medicare patients, and uninsured patients may have insufficient resources to compete for labor and technology with hospitals that treat a higher share of commercial patients. This disparity can be problematic if certain hospitals treat a disproportionate share of LIS beneficiaries. In 2019, for the quarter of hospitals that treated the highest share of LIS beneficiaries, these beneficiaries made up 43 percent or more of the hospitals' Medicare inpatient and outpatient volume. In contrast, for the quarter of hospitals that treated the lowest share of LIS beneficiaries, these beneficiaries made up 23 percent or less of the hospitals' total Medicare volume.

The Commission's analyses have shown that, on average, Medicare beneficiaries have good access to hospital care. However, in this analysis of safety-net hospitals, we found that hospitals with high shares of LIS Medicare beneficiaries tend to have lower levels of profitability and a higher risk of closure (that is, the rate of closure increased as the share of total volume associated with LIS beneficiaries increased). For example, the quarter of hospitals with the highest shares of total Medicare volume associated with LIS beneficiaries had a median non-Medicare margin of 2 percent, compared with 15 percent among the quarter of hospitals with the lowest shares of such beneficiaries.

Medicare already provides substantial safety-net funding to hospitals in three ways—via disproportionate share hospital (DSH) payments, uncompensated care payments, and payments through the Medicare-dependent hospital program. Medicare also provides enhanced funding to isolated providers, such as critical access hospitals. These additional payments help maintain access to care in isolated areas. However, in this work, we do not consider them safety-net adjustments because they are targeted solely based on isolation metrics and not based on treating certain types of patients, such as low-income patients.

Because of the continuing association between patient income and hospital profitability, in this chapter we analyze how hospitals' current safety-net payments under the DSH program address the financial difficulties of hospitals treating high shares of Medicare and low-income patients. We compare the existing DSH policies using a metric we developed called the Safety-Net Index (SNI). Each hospital's SNI is computed as the sum of (1) the share of its Medicare volume associated with LIS beneficiaries (including those beneficiaries who are eligible for full or partial Medicaid benefits), (2) the share of its revenue the hospital spends on uncompensated care, and (3) an indicator of how dependent the hospital is on Medicare. Under this computation, hospitals with high SNI scores will have either a high Medicare share of services, low incomes among a high share of its Medicare patients, and/or a high share of its revenue spent on uncompensated care.

Our results suggest that the SNI measure is a better predictor of financial strain (as measured by predicted non-Medicare margins and risk of closure) than the current DSH measure. In addition, the DSH measure is negatively correlated with the share of hospitals' patients who are enrolled in Medicare, and using the measure leads to Medicare indirectly subsidizing Medicaid. The results of our analysis suggest that the new SNI metric could do a better job of targeting Medicare funds to safety-net hospitals than simply expanding the funds allocated to the existing DSH program would.

We also simulated a model that redistributed current DSH and uncompensated care payments using the SNI metric. By shifting from the current DSH system of payments to an SNI system of payments, a slightly larger share of safety-net payments would go to hospitals with high Medicare shares and a greater risk of closure. While these results should be considered illustrative, providing a sense of how distributing safety-net dollars using a metric that considers hospitals' Medicare shares and low-income Medicare beneficiaries would alter the distribution of Medicare funds. The magnitude of the pool of safety-net funds and whether additional safety-net funds are needed will be addressed in future work. ■

The Medicare program strives to ensure access to care for all beneficiaries and to adequately compensate providers for providing that access. The beneficiaries with the greatest health care needs are often low-income Medicare beneficiaries with the fewest personal resources to address those needs, making it critical to ensure that these beneficiaries have access to a safety net of health care providers. However, treating low-income beneficiaries can entail extra costs that are not adequately reflected in Medicare's standard payment systems and can generate lower revenue for providers. In addition, public payers (including Medicare and Medicaid) in certain sectors have lower payment rates than commercial insurance, making it more difficult for providers who are substantially dependent on public payers to compete with other providers for labor and technology. The Commission is concerned that the concentration of low-income beneficiaries or patients with public insurance among certain providers may create an undue financial strain on these providers and could result in diminished access to or quality of care for beneficiaries. But implementing large, across-the-board payment rate increases to all providers to support this subset of safety-net providers would be an inefficient use of scarce Medicare resources.

Medicare's role in preserving safety-net providers has a long history. Over three decades ago, in 1985, the Prospective Payment Assessment Commission (ProPAC) (a predecessor of the current Medicare Payment Advisory Commission) recommended that special payments be given to hospitals with high shares of low-income patients. In line with this recommendation, the Congress enacted the disproportionate share hospital (DSH) program, which began in 1986. The metrics chosen in 1985 to identify hospitals meriting DSH payments have been used in that program for the past 35 years. In addition, the DSH measure has become an off-the-shelf measure used to qualify hospitals for other benefits, including eligibility for the 340B program (starting in 1992) and for uncompensated care payments (starting in 2014).¹ However, the DSH formula omits two categories of patients who can be financially challenging: the uninsured and Medicare beneficiaries. These omissions may result in hospitals that serve high shares of uninsured or Medicare patients being disadvantaged by the current DSH formula.

The Commission has begun a new body of work examining safety-net providers, including how they should be defined and how the Medicare program can best support their critical missions. Our initial examination of safety-net providers focuses on hospitals for a few reasons. First, Medicare's payment rates for hospital services are substantially below average commercial insurer rates. Therefore, having a high share of patients enrolled in Medicare can present financial challenges for hospitals, which is not necessarily the case in other sectors. (For example, Medicare's payment rates for skilled nursing facility services are relatively generous and often subsidize losses generated by patients insured by Medicaid.) Second, hospitals play an important role in preserving access to emergency services, which is a critical part of the safety-net system. While we begin with hospitals, the principles discussed in this chapter have implications for identifying safety-net providers in other sectors.

This chapter begins with conceptual frameworks for identifying safety-net providers and deciding the extent to which new Medicare funding is warranted for all safety-net providers. The intent of developing these frameworks is to be able to apply them across multiple payment sectors to determine whether new safety-net funding is needed. Second, we provide an example of how these frameworks apply to the hospital sector. We start by demonstrating that certain hospitals disproportionately serve low-income beneficiaries and that these hospitals face significant financial challenges. We then examine how different hospital safety-net metrics predict a hospital's profitability and risk of closure, presenting an illustrative example of how hospital payments would change if one of these alternative safety-net metrics were used to reallocate current safety-net funding (i.e., DSH and uncompensated care payments).

In future work, we will consider whether the current level of funding for safety-net hospitals is sufficient or whether the pool of safety-net dollars for hospitals should be expanded. We will also investigate the application of these safety-net principles to other sectors, along with methods for distributing safety-net dollars in those sectors and the appropriate magnitude of those distributions.

A conceptual framework for identifying safety-net providers

Researchers, policymakers, and other stakeholders have defined the term *safety-net provider* in a multitude of ways. Some definitions employ area-based classifications (e.g., clinicians located in medically underserved areas) or facility-type designations (e.g., 340B hospitals). Still others use the term to mean providers situated in isolated locations (see the text box, p. 60, regarding isolation metrics). We did not use any of these criteria to define safety-net providers; instead, we based this designation on a provider's shares of certain patients who are typically less profitable. Defining safety-net providers based on their shares of patients who are typically less profitable is rooted in the premise that providers with comparatively high shares of unprofitable patients are financially disadvantaged relative to their competitors. This financial disadvantage, in turn, could lead to negative outcomes for Medicare beneficiaries, such as limited access (e.g., if providers close or choose not to treat certain beneficiaries) or lower quality (e.g., if financial stress limits capital investments or puts providers at a disadvantage when competing for labor).

As shown in Figure 3-1, under the Commission's framework, determining a provider's safety-net status depends in part on the availability of information on a provider's non-Medicare patients. Where such data are available, the share of uninsured patients and Medicaid patients can be considered. If such data are not available, safety-net status is determined based only on the characteristics of Medicare patients.

Identifying safety-net providers when information on providers' non-Medicare patients is available

When information on providers' non-Medicare patients is available, the relevant question in determining safety-net status is: Are low-income beneficiaries less profitable to care for than the average Medicare patient, or are certain public payers less profitable than average? Low-income beneficiaries can be less profitable to care for than other beneficiaries because treating them could generate higher costs (e.g., patients with fewer resources at home or no home at all may require longer lengths of stay) or lower revenues (e.g., lack of cost-sharing payments). Some payers might

be less profitable because their payment rates are set lower than those of other payers. For example, Medicare's payment rates for hospital and clinician services are substantially lower than commercial payers' rates for similar services.

If there is no reason to believe that low-income Medicare beneficiaries are less profitable to care for than the average Medicare beneficiary or that certain public payers are less profitable, on average, then we conclude that safety-net providers cannot be identified in the sector.

If there is reason to believe that low-income Medicare beneficiaries are less profitable to care for than the average Medicare patient or certain public payers are less profitable than average, then safety-net status should be based on a provider's share of patients who are less profitable: those without insurance or with public insurance that is not materially profitable or, alternatively, the share of Medicare patients with low incomes. (See pp. 58–61 for a discussion of how we identify Medicare patients with low incomes.) Defining “materially profitable” in some sectors is straightforward if the sector's providers have large negative or positive margins. In other sectors, judgments would need to be made regarding material profitability based on the sector's unique circumstances. One key decision to make when analyzing a provider's payer mix is deciding how to treat Medicare. In many sectors, Medicare is materially profitable; in others, it is not.

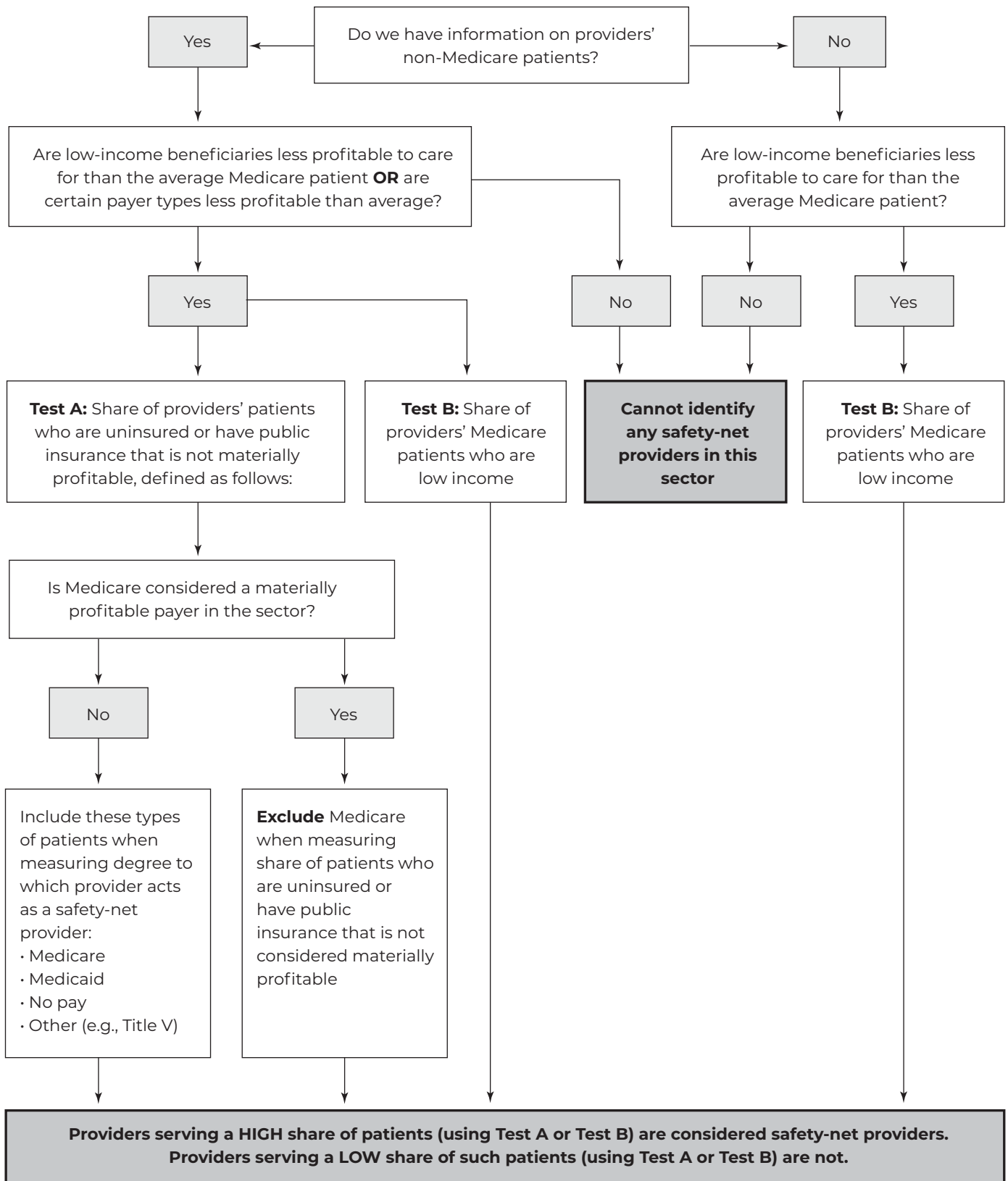
Identifying safety-net providers when no information on providers' non-Medicare patients is available

When information on providers' non-Medicare patients is unavailable, no consideration of providers' uninsured patients or patients with public (non-Medicare) insurance can be made. In this circumstance, the relevant question in determining safety-net status is: Are low-income beneficiaries less profitable to care for than the average Medicare patient?

In sectors where information on providers' non-Medicare patients is not available, if there is no reason to believe that low-income Medicare beneficiaries are less profitable to care for than the average Medicare beneficiary, then we conclude that safety-net providers cannot be identified in the sector. For example, certain

FIGURE 3-1

The Commission's framework to identify safety-net providers



clinical laboratories might disproportionately serve low-income beneficiaries. However, such beneficiaries are likely no less profitable than the average beneficiary because the cost per laboratory test is relatively fixed across beneficiaries (i.e., laboratory tests are relatively commoditized) and laboratories almost always collect full payment for their tests (i.e., the Medicare program pays the full rate with no beneficiary cost sharing, so there is little concern that low-income beneficiaries might be less likely to satisfy their cost-sharing requirements).

In sectors where no information is available on providers' non-Medicare patients, if low-income Medicare beneficiaries are typically less profitable to care for than the average Medicare patient, then safety-net status should be based on a provider's share of Medicare patients who have low incomes.

A conceptual framework for determining the need for new Medicare safety-net funding

After a health care sector's safety-net providers have been identified, the next step is to consider whether the Medicare program should allocate new funding to support these providers (Figure 3-2) based on the following criteria.

- **Lack of additional funding would place beneficiaries at risk:** While safety-net providers may be financially disadvantaged relative to other providers, new Medicare funding should be allocated only if failing to do so could lead to negative outcomes for low-income beneficiaries. For example, in the hospital sector, a substantially higher closure rate among safety-net hospitals could compromise beneficiaries' access to care, thereby necessitating new funding.
- **Medicare is not a materially profitable payer in the sector:** If Medicare is a materially profitable payer, on average, within a sector, then new Medicare safety-net funding is not warranted. However, a sector's failure to meet this criterion for new safety-net funding does not preclude providers in the sector that serve low-income beneficiaries from being disadvantaged or from experiencing

other financial concerns (e.g., difficulties among low-volume, isolated providers). Instead, it means that other solutions, beyond adding new Medicare funding to support safety-net providers, are likely more appropriate. For example, a sector's providers could average 15 percent Medicare margins while a substantial share of providers who serve low-income patients are at risk of closure. Under these circumstances, new Medicare safety-net funding would not be warranted because Medicare already subsidizes the sector's other payers. However, policymakers could explore other solutions, such as redistributing existing Medicare funding within the sector or addressing the problems through the payers that are more directly responsible for poor all-payer financial performance (e.g., Medicaid).

- **Current payment adjustments cannot be redesigned to address the issue:** In some sectors, Medicare already makes special payments to help support safety-net providers, some of which may be poorly targeted. Policymakers should reform these adjustments or redirect their funding before considering adding new funding to support safety-net providers.

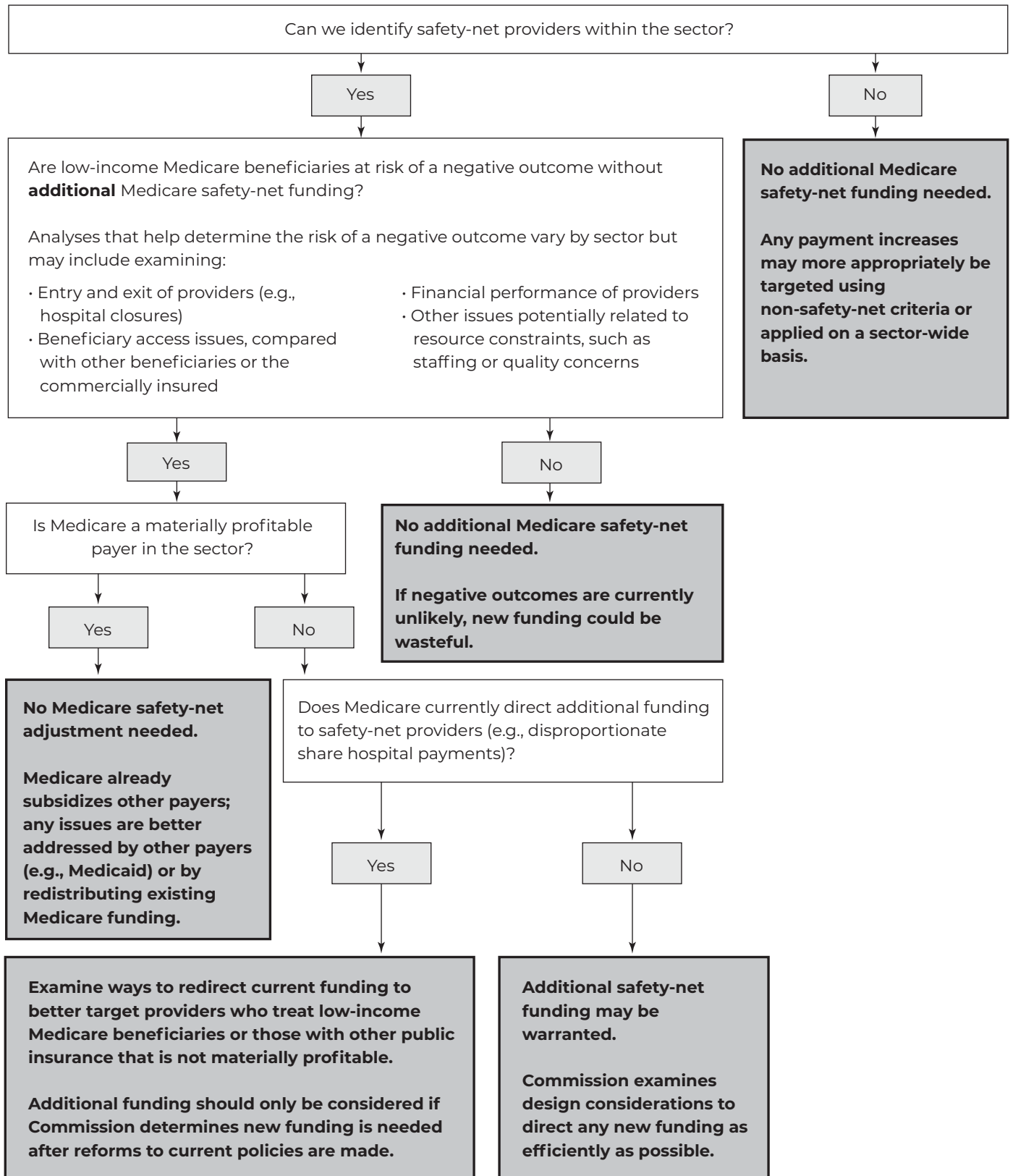
By separating the identification of safety-net providers from the determination of whether new Medicare funds should be allocated to support them, policymakers can broadly identify safety-net providers while recognizing that new Medicare funding is not warranted in all situations. These conceptual frameworks allow for identification of situations in which new funding is critical to maintaining access to care; targeting safety-net providers is the most appropriate way to distribute the funds (e.g., as opposed to across-the-board updates); and Medicare is the most appropriate payer to address the issue (i.e., Medicare does not already cross-subsidize other payers in the sector).

Identifying low-income Medicare beneficiaries

Instead of relying solely on eligibility for full Medicaid benefits as a measure of low-income status, our definition includes (1) those who receive full Medicaid benefits, (2) those who receive partial Medicaid

**FIGURE
3-2**

The Commission's framework for deciding if new Medicare safety-net funding is needed



Providers' isolation not considered when defining safety-net providers

Proximity to other providers is not incorporated into our framework for identifying safety-net providers. Instead, our definition relies on the extent to which providers treat low-income beneficiaries or patients who are uninsured or have other public insurance with rates that make their covered population not materially profitable to treat.

Under our definition, isolation is not among the criteria for defining a safety-net provider. Requiring a provider to be isolated would result in excluding urban providers that are important sources of access for many low-income patients and beneficiaries enrolled in Medicare or Medicaid. The lack of an isolation criterion means that a hospital serving a largely low-income population in Chicago, for example, could be deemed a safety-net hospital even though there are several other hospitals in the Chicago metro area. Stroger (Cook County) Hospital in Chicago is only a nine-minute walk from the Rush University Medical Center, but that would not preclude the Cook County facility from being categorized as a safety-net hospital if the hospital met the Commission's safety-net criteria.

Isolation is not a sufficient condition for being deemed a safety-net provider for additional

reasons. Allowing hospitals to qualify as safety-net providers solely on the basis of isolation could result in providers that predominantly serve a wealthy clientele or that have a relatively large share of patients with materially profitable commercial insurance being considered safety-net providers. For example, the Mayo Clinic Health System is a near monopolist in southeast Minnesota (meaning it is not located near other large hospitals); it would not automatically meet the criteria for a safety-net provider needing special assistance. Similarly, the critical access hospital located in the ski resort community of Snoqualmie, Washington, would likely not qualify for safety-net status due to its high shares of commercially insured patients, even if its rural location qualifies it for a critical access hospital designation.

While we don't consider proximity to other providers in our safety-net definition, Medicare has several programs designed to preserve access to care in isolated rural areas. The Commission has supported many of these programs, and we compare these programs with programs designed to help providers serving low-income patients in Table 3-3 (pp. 66-67). ■

benefits through one of four Medicare Savings Programs, and (3) those who do not qualify for Medicaid benefits in their states of residence but who receive the Part D low-income subsidy (LIS), which provides assistance with Part D premiums and cost sharing.² Collectively, we refer to this population as "LIS beneficiaries" because those who receive full or partial Medicaid benefits automatically receive the LIS. In addition, beneficiaries may receive the LIS even if they are not eligible for Medicaid coverage in their states of residence if they have limited assets and incomes below 150 percent of the federal poverty level (about \$19,300 for an individual and \$26,100 for a

couple in 2021).³ (We refer to LIS beneficiaries who do not receive full or partial Medicaid benefits as "LIS-only beneficiaries.")

The intent of defining low-income beneficiaries in this manner is to reduce the effect of variation in states' Medicaid policies on the share of beneficiaries whom we consider low income, but to allow for appropriate variation across states based on the share of beneficiaries who are at or near the federal poverty level. This definition reduces variation related to state Medicaid policies by allowing all beneficiaries with limited assets and incomes below 150 percent of

the federal poverty level to qualify as a low-income beneficiary in our analyses (Table 3-1, pp. 62–63). Some of the remaining variation is due to differences across states in beneficiary income levels.⁴ For example, the poverty rate in New Hampshire (7.3 percent) is much lower than it is in Mississippi (19.6 percent), so even if the two states' Medicaid eligibility criteria were equally generous, we would expect substantial variation in the share of beneficiaries we consider to have low incomes (Census Bureau 2020).

Even using our expanded definition, low-income beneficiaries as a group are markedly distinct from all Medicare beneficiaries. As shown in Table 3-2 (p. 64), in addition to having lower incomes than the full Medicare population, LIS beneficiaries in 2020 were:

- three times as likely to be disabled;
- nearly three times as likely to have end-stage renal disease;
- more than twice as likely to be under age 64, less likely to be 65 to 84, and equally as likely to be 85 or older;
- twice as likely to be Black or Hispanic;
- more likely to be female; and
- slightly more likely to live in a rural area.

Identifying low-income beneficiaries using LIS eligibility has substantial benefits. Compared with other measures (such as those eligible for full Medicaid benefits), the LIS measure is less directly correlated with state Medicaid eligibility policies because all beneficiaries with limited assets and incomes below 150 percent are eligible for the LIS; that is, the LIS creates a national “floor” of 150 percent of the federal poverty level. For our low-income identification purposes, relying on the existing LIS measure would also be less administratively burdensome than creating a new measure. For additional payment purposes, paying an add-on to providers who treat LIS beneficiaries could encourage providers to make their patients aware of and help them enroll in Medicaid, the Medicare Savings Programs, or the LIS. Such a “woodwork effect,” whereby previously eligible but unenrolled beneficiaries gain access to these programs' benefits, could improve access to care beyond any positive

effects of financially supporting safety-net providers. Increasing enrollment in these programs could be an important second-order effect of a safety-net provider add-on, as researchers have consistently found low participation rates in these programs (Medicaid and CHIP Payment and Access Commission 2020, Shoemaker et al. 2012). For example, the Medicaid and CHIP Payment and Access Commission has found that only 53 percent of individuals eligible for the Qualified Medicare Beneficiary Program were actually enrolled, and the participation rates for other Medicare Savings Programs were even lower (Medicaid and CHIP Payment and Access Commission 2020).

Safety-net hospitals' greater financial challenges and risk of closure suggest need for revisions to Medicare safety-net funding

The concentration of low-income beneficiaries or patients with relatively unprofitable types of insurance in certain hospitals has led policymakers to enact provisions to financially support these hospitals to maintain access to care. For example, in 1985, the Congress enacted safety-net payments in the form of DSH payments to hospitals serving high shares of Medicaid and very low-income Medicare patients. While DSH payments were an improvement to Medicare payment policy when enacted 37 years ago, there have been substantial changes in the delivery of hospital care and in the profitability of different types of payers over the past four decades. Therefore, the Commission is now revisiting the issue of how to identify safety-net hospitals and how Medicare should make supplemental payments to safety-net providers.

Identifying safety-net hospitals

The elements involved in identifying safety-net hospitals include examining a hospital's payer mix (share of Medicare and uninsured patients) and the income of the hospital's Medicare patients. Payer mix is important because public payers tend to pay hospitals far lower rates than commercial payers (Medicare Payment Advisory Commission 2020). The income of Medicare patients is important because costs of care tend to be higher for low-income patients (Nguyen and

**TABLE
3-1****Share of state Medicare populations who were full-benefit dual-eligible beneficiaries or LIS beneficiaries, 2020**

Beneficiary state	Full-benefit dual-eligible beneficiaries	All LIS beneficiaries
District of Columbia	23.8%	32.9%
Maine	19.2	29.8
California	27.2	29.2
Kentucky	15.3	26.6
Mississippi	12.9	25.7
West Virginia	12.4	25.7
Louisiana	16.1	25.4
Connecticut	13.5	25.3
New York	19.9	23.2
Massachusetts	19.4	22.8
New Mexico	13.1	22.0
Vermont	14.8	21.9
Michigan	15.7	21.5
Alaska	18.2	21.2
Alabama	8.7	19.6
Arkansas	11.1	19.4
North Carolina	13.2	19.0
Oregon	10.2	19.0
Illinois	14.5	18.6
Wisconsin	16.3	18.6
Georgia	9.1	18.3
Oklahoma	13.0	18.1
Indiana	12.9	18.0
Maryland	9.0	17.4
Minnesota	13.6	17.4
Missouri	12.8	17.2
Rhode Island	12.7	17.0
Pennsylvania	12.6	16.6
Colorado	10.7	16.5
Nevada	7.5	16.1
Montana	9.7	16.0
Idaho	8.2	15.5
New Jersey	11.9	15.4
Ohio	9.7	15.4
Texas	7.6	15.3
Washington	10.2	15.3
Delaware	7.3	15.1

**TABLE
3-1**

Share of state Medicare populations who were full-benefit dual-eligible beneficiaries or LIS beneficiaries, 2020 (cont.)

Beneficiary state	Full-benefit dual-eligible beneficiaries	All LIS beneficiaries
Tennessee	7.9	15.0
North Dakota	11.1	14.9
New Hampshire	8.7	14.8
South Dakota	8.6	14.6
Florida	8.2	13.8
Iowa	10.0	13.4
Kansas	7.4	13.3
Virginia	7.3	12.9
Wyoming	7.1	12.9
Nebraska	9.4	12.2
South Carolina	8.3	12.2
Arizona	7.9	11.6
Utah	8.3	11.2
Hawaii	7.7	10.9
Ratio of the highest to the lowest state	3.8	3.0

Note: LIS (low-income subsidy). Beneficiaries are included in the table if they had at least one month of Part A or Part B coverage and no Medicare Advantage coverage.

Source: MedPAC analysis of enrollment data.

Sheingold 2011). Moreover, if low-income patients are less likely to pay cost sharing, revenue may be lower.

Certain hospitals treat disproportionate shares of low-income Medicare beneficiaries or have a relatively unprofitable payer mix. In 2015, we found that, for a quarter of inpatient prospective payment system (IPPS) hospitals, LIS beneficiaries made up over 43 percent of their Medicare volume (averaging inpatient and outpatient claims). In contrast, another quarter of hospitals treated the lowest share of LIS beneficiaries, whose claims made up 23 percent or less of these hospitals' Medicare claims. We found similar distributions in later years of data as well, and previous research has demonstrated that certain hospitals treat more relatively low-margin patients (e.g., uninsured patients and those with public insurance).

Certain hospitals serving higher shares of patients with public insurance and/or higher shares of low-income Medicare patients may have difficulty competing for labor and new technologies against neighboring hospitals with a more profitable payer mix. This disadvantage, in turn, could lead to difficulty maintaining quality of care and even to hospital closure. Therefore, the Medicare program may want to examine whether current Medicare payments are sufficient to preserve access at these facilities.

Current Medicare policies supporting safety-net hospitals

Medicare makes three main types of payments for hospitals commonly considered safety-net providers—DSH payments, uncompensated care payments (which

**TABLE
3-2**

Compared with all Medicare beneficiaries, those who received the low-income subsidy had substantially different characteristics, 2020

	Type of beneficiary				
	All FFS	Full-benefit dual eligible	Partial-benefit dual eligible	LIS only	All LIS
Total	100.0%	12.9%	3.3%	2.2%	18.4%
Race					
White	77.3	55.3	64.5	64.4	58.0
Black	8.9	17.1	18.9	17.0	17.4
Hispanic	6.4	13.9	10.8	11.5	13.0
Other	7.4	13.7	5.9	7.1	11.5
Geographic location					
Urban	79.9	79.6	69.4	73.6	77.1
Rural micropolitan	11.2	11.3	16.3	13.9	12.5
Rural adjacent	5.4	5.4	8.6	7.4	6.2
Rural nonadjacent	3.5	3.7	5.8	5.1	4.2
Frontier status					
Frontier	1.3	1.1	1.7	1.6	1.2
Not frontier	98.7	98.9	98.3	98.4	98.8
Sex					
Male	47.2	42.6	43.9	45.1	43.2
Female	52.8	57.4	56.1	54.9	56.8
Disability status					
Disabled	12.8	40.1	40.7	36.0	39.8
Not disabled	87.2	59.9	59.3	64.0	60.2
ESRD status					
ESRD	1.2	3.2	3.3	3.2	3.2
No ESRD	98.8	96.8	96.7	96.8	96.8
Age					
64 or younger	16.2	43.7	42.5	38.4	42.9
65 to 74	49.6	27.5	33.8	35.1	29.6
75 to 84	23.6	16.7	16.6	17.6	16.8
85+	10.6	12.0	7.1	8.9	10.8

Note: FFS (fee-for-service), LIS (low-income subsidy), ESRD (end-stage renal disease). Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, rural micropolitan counties contain a cluster of 10,000 to 50,000 people, rural adjacent counties are adjacent to urban areas and without a city of at least 10,000 people, rural nonadjacent counties are not adjacent to urban areas and do not have a city with at least 10,000 people, and frontier counties have 6 or fewer people per square mile. Components may not sum to totals due to rounding.

Source: MedPAC analysis of enrollment data.

are tied to DSH payments), and payments through the Medicare-dependent hospital (MDH) program. (See Table 3-3, pp. 66–67, for a comparison of these and other special hospital payment policies.)

DSH and uncompensated care payments

DSH payments are supplementary inpatient payments that Medicare makes to hospitals that serve high shares of low-income patients. Hospitals are eligible to receive DSH payments if their share of low-income patients, referred to as the DSH patient percentage, meets or exceeds 15 percent. Hospitals' DSH payment adjustments generally increase as their DSH patient percentages increase, with certain limitations.⁵ The DSH patient percentage is defined as the sum of two percentages:

- the number of inpatient days for Medicare beneficiaries eligible for Supplemental Security Income (SSI) divided by the total number of Medicare inpatient days,⁶ and
- the number of inpatient days for Medicaid beneficiaries (who are not dually eligible for Medicare) divided by the total number of inpatient days for all patients.

Medicare DSH payments were established in the Consolidated Omnibus Budget Reconciliation Act of 1985 and became effective for discharges occurring on or after May 1, 1986. The original rationale for Medicare DSH payments was that low-income Medicare patients were typically more costly to care for in ways that were not accounted for by the original diagnosis related group system. However, subsequent research by the Commission and others concluded that, at most, 25 percent of DSH payments were empirically justified by the higher costs associated with treating low-income Medicare patients (Medicare Payment Advisory Commission 2007, Sheingold et al. 2016).

Despite the limited empirical justification for the established level of DSH payments, some stakeholders argued that full DSH payments should continue to assist hospitals with uncompensated care costs for non-Medicare patients.⁷ However, in 2007, the Commission found that DSH payments were not well targeted to hospitals with high uncompensated care costs (Medicare Payment Advisory Commission 2007).

Subsequently, the Congress made several changes to the magnitude and structure of DSH payments as part of Affordable Care Act of 2010. Beginning in 2014, hospitals that qualify for DSH payments may receive two different payment adjustments: a revised DSH payment and an uncompensated care payment.

- First, hospitals receive 25 percent of the DSH payments they would have received under the traditional DSH formula. This lower DSH payment is referred to as the “empirically justified” Medicare DSH payment.
- Second, hospitals that qualify for the empirically justified Medicare DSH payment may also receive a share of a fixed pool of dollars referred to as the “uncompensated care pool.” Hospitals each receive uncompensated care payments that are equal to the product of three values—75 percent of all hospitals' aggregate traditional DSH payments, 1 minus the percent change in the national uninsured rate since 2013 for individuals under the age of 65, and the hospital's share of uncompensated care relative to the amount of uncompensated care costs for all DSH hospitals.⁸

In 2022, Medicare expects to pay roughly \$3.5 billion in empirically justified DSH payments and \$7.2 billion in uncompensated care payments to IPPS hospitals, which together represent 6 percent of all Medicare payments to short-term acute care hospitals (Centers for Medicare & Medicaid Services 2021b).⁹ Nearly all hospitals will receive at least some of this funding since the share of hospitals qualifying for DSH payments has expanded over time. (See the text box on maintaining targeting of special payments, pp. 68–69, for more information on this topic.)

The DSH patient percentage has frequently been used to identify safety-net hospitals. However, the DSH formula omits two categories of patients who can be financially challenging for hospitals: the uninsured and Medicare beneficiaries. These omissions may result in hospitals that serve high shares of uninsured or Medicare patients being disadvantaged by the current DSH formula.

The DSH patient percentage does not include a measure of uncompensated care. For example, a hospital stay furnished to an uninsured, low-income

**TABLE
3-3**

Descriptions of special hospital payment policies (cont. next page)

Payment policy	Current primary eligibility requirements	Payment adjustment methods	Annual cost (billions)	Share of urban hospitals	Share of rural hospitals
Disproportionate share hospital	Medicaid share plus SSI share of Medicare beneficiaries generally has to exceed 15%	Inpatient add-on ranging from 0.6% to 19%	\$3.5	82%	92% (of IPPS)
Uncompensated care	Must be a DSH hospital	Pays approximately 21% of uncompensated care costs	7.2	82%	92% (of IPPS)
Critical access hospital program	Must have 25 or fewer beds, have been designated as a “necessary provider” by the state prior to 2006, or meet certain criteria for being isolated from other hospitals (e.g., be 35+ miles by primary road from other hospitals)	Pays approximately cost for inpatient, outpatient, post-acute swing services, lab, therapy services, and on-call costs; add-on for physician payments	3–4 ^a	Must be rural or classified as rural by the state	64%
Sole community hospital program	Must be 35+ miles from non-CAH hospital or be 15 miles from non-CAH hospitals and meet other criteria	Inpatient operating payments based on the higher of prospective rates or historical costs trended forward from 1982, 1987, 1996, or 2006; outpatient add-on of 7.1%	0.8 ^b	4%	48% of IPPS hospitals
Medicare-dependent hospital program	Rural or reclassified as rural, 100 or fewer beds, and 60% of days or discharges were Medicare beneficiaries	Inpatient operating payments equal to the higher of prospective rates or 25% of prospective rate plus 75% of historical costs trended forward; historical costs based on 1982, 1987, or 2002 cost reports	0.1	0	18% of rural IPPS

patient who cannot afford to pay for their care is not counted in the calculation of a hospital’s DSH patient percentage.¹⁰ In contrast, the stay would count toward the DSH patient percentage if that same patient were eligible for Medicare and SSI or Medicaid. This difference means that a hospital that treats a high share of patients without insurance could be doubly disadvantaged: It would not receive payment for some of the care it provides (other than through Medicare uncompensated care payments), and it might receive lower Medicare DSH payments because fewer of its

patients count toward the DSH patient percentage. Uncompensated care burden may have been excluded from the original DSH patient percentage because data on uncompensated care data were not available at the time it was implemented. However, such data are now available on Medicare hospital cost reports.

The DSH patient percentage also does not account for the share of patients who are Medicare beneficiaries. Instead, it includes only the ratio of Medicare patients who qualify for SSI to all Medicare patients. This metric

**TABLE
3-3**

Descriptions of special hospital payment policies (cont.)

Payment policy	Current primary eligibility requirements	Payment adjustment methods	Annual cost (billions)	Share of urban hospitals	Share of rural hospitals
340B program	Must be a nonprofit or government-owned hospital; also must be either a CAH or meet a minimum DSH adjustment percentage (usually 11.75%); approximately half of all hospitals meet this DSH threshold	Receive discount prices on drugs from pharmaceutical companies	Generates slight savings for the Medicare program due to lowering CAH costs ^c	About 55% of IPPS nonprofit/government hospitals	About 87% of CAHs
Low-volume hospital program	Must have under 3,800 discharges and be more than 15 miles from another IPPS hospital (can be next to a CAH)	Increases payments for inpatient care by up to 25% (linear decline between 500 and 3,799 discharges)	0.4	6%	61% of rural IPPS
Rural emergency hospital program	Rural hospital that ceases inpatient services	Pays a fixed monthly payment plus 105% of PPS rates for outpatient care	Not yet started ^d		

Note: DSH (disproportionate share hospital), SSI (Supplemental Security Income), IPPS (inpatient prospective payment system), CAH (critical access hospital).
^a This amount represents an estimate of the difference between cost-based payments and what payments (including cost sharing) would have been if CAHs were paid PPS rates. About half of the increase is due to increased program payments (primarily on post-acute swing care) and about half is higher outpatient cost sharing paid by beneficiaries or their supplemental insurers on outpatient care. The last time we formally estimated this amount was for 2011, when the estimate was \$2 million per CAH or approximately \$2.6 billion dollars in additional payments. Given growth in CAH payments since that time, the net additional payments are estimated to be in the \$3 billion to \$4 billion range.
^b The cost of sole community hospital (SCH) special payments is about \$250 million from the 7.1% outpatient add-on program payments in addition to \$600 million of the combined value of low-volume and SCH hospital-specific payments.
^c The CAH program makes cost-based payments for Part B drugs and other services. To the extent that the 340B program reduces drug acquisition costs, the cost-to-charge ratio for the CAH's pharmacy will be reduced and cost-based payments will be reduced. There may also be indirect effects of the 340B program on Medicare spending and other payer spending due to increased incentives for 340B hospitals to acquire certain providers, such as oncologists. We have not attempted to quantify those secondary effects.
^d The rural emergency hospital program is scheduled to begin on January 1, 2023.

Source: MedPAC analysis of IPPS final rules (Centers for Medicare & Medicaid Services 2021a, Health Resources and Services Administration 2021, Medicare Payment Advisory Commission 2005a).

is a measure of the income of Medicare patients served by the hospital rather than a measure of the share of patient days attributed to Medicare patients. Medicare was a relatively profitable payer when the original DSH patient percentage was conceived, so policymakers likely never considered a hospital's share of Medicare patients as an indicator of a provider's need. For example, the average hospital Medicare inpatient margin was about 13 percent in 1985 (Prospective Payment Assessment Commission 1997). However, hospitals' average Medicare margins are now negative,

and aggregate hospital payment rates across Medicare and Medicaid are similar (Selden et al. 2015, Stensland et al. 2016). Therefore, including a hospital's Medicare share in the DSH patient percentage may now be warranted.

A third issue with the current DSH formula is that it is based purely on inpatient payments. As the practice of medicine shifts toward outpatient settings, the mix of inpatients may become less reflective of the hospitals' overall patient mix.

Maintaining targeted payment adjustments is often difficult

Many special payments to safety-net or isolated providers are initially targeted narrowly to provide financial support to those providers that are most critical for ensuring beneficiary access to care. However, over time, some of Medicare's special payment programs have been expanded to include a broader array of providers, many of which do not function as safety-net providers or ensure access in isolated areas. For example, in 1988, 35 percent of urban hospitals qualified for payment under the disproportionate share hospital (DSH) program; this figure had increased to 82 percent by 2020 (Table 3-4).

Historically, policymakers face particular pressure to expand programs that have discrete cutoff points in order to qualify. Such programs create a benefit “cliff” whereby providers who qualify receive substantial financial benefits and providers who fall just short of qualifying receive no benefits. Providers who fall just short of qualifying (and their advocates) then often argue that the qualifying criteria should be expanded to maintain equal treatment for similar providers. Over time, this process can lead to broadly expanding what was initially a narrowly targeted program.

Given this history, policymakers may want to design future special payments to allow almost all providers to qualify, with the magnitude of special payments determined on an incremental basis using recent data, so that providers earn higher payments by increasing beneficiary access to care (as opposed to earning higher payments through activities such as reclassifying urban hospitals as rural). As an example, if policymakers wanted to direct additional funding to hospitals or clinicians who treat low-income beneficiaries, instead of requiring providers to treat a certain share of low-income beneficiaries, be located in areas where low-income beneficiaries live, or be a certain type of facility, policymakers could consider:

- determining the magnitude of special payments on an incremental basis using recent data, removing the “cliffs,” and allowing most providers who treat some low-income beneficiaries to qualify for special payments; and
- increasing the magnitude of the special payments as the low-income share of safety-net-type patients increases. ■

(continued next page)

Medicare-dependent hospital program

The Medicare-dependent hospital (MDH) program provides small, rural hospitals with enhanced inpatient payments. Specifically, MDH hospitals receive 75 percent of the difference between standard IPPS rates and a hospital-specific rate, which is based on each hospital's historic inpatient operating costs from 1982, 1987, or 2002 (trended forward to account for annual market basket updates and changes in case mix). If IPPS rates are higher than a hospital's updated costs, then the hospital receives standard IPPS rates. To qualify for the MDH program, a hospital must:

- be located in a rural area (with certain exceptions);
- have fewer than 100 beds; and

- have at least 60 percent of its inpatient days or discharges attributable to Medicare beneficiaries using two of the three most recently settled cost reports or using cost reports from 1987 or 1988.

The Government Accountability Office found that, in 2017, 138 hospitals qualified for the MDH program, 78 hospitals received additional payments through the program (the remaining hospitals' updated costs were lower than standard IPPS rates), and the median additional payment per hospital was about \$800,000, although additional payments per hospital ranged from \$1,000 to \$10.4 million (Government Accountability Office 2020).

Maintaining targeted payment adjustments is often difficult (cont.)

**TABLE
3-4**

Targeted policies for hospitals have generally expanded over time

Program	Expanded over time?	Degree of expansion
Medicare disproportionate share hospital program	Yes; criteria were lowered and Medicaid was expanded, which increased the number of providers that qualified ^a	In 1988, 35% of urban hospitals qualified; this rose to 42% in 1991, 52 percent in 1997, and 82% in 2020 ^a
Uncompensated care payments for disproportionate share hospitals	All disproportionate share hospitals qualify	The pool of dollars has declined as more hospital patients become insured
340B program (limited to critical access hospitals and nonprofit or government hospitals with moderate or high low-income shares (i.e., Medicaid patients and Medicare patients on SSI))	Special rules for rural hospitals were enacted in 2010, and Medicaid expansion increased the number of eligible hospitals	Hospitals participating in the program increased over 70% from 2011 to 2019, from 1,465 (33% of hospitals) to 2,574 (57% of hospitals) ^b
Medicare-dependent hospital program	Increased the share of payments that can be cost based, but little change in eligibility	Little change
Low-volume and low-provider-density programs		
Sole community hospital program	Expanded due to looser criteria for entering, somewhat offset by critical access hospital expansion ^c	In 1987, 12 percent of rural hospitals were sole community hospitals; this rose to 16 percent of rural hospitals by 2020 ^c
Critical access hospitals (formerly medical assistance facilities or rural primary care hospital demonstrations)	Allowed states to waive distance requirements, expanded size to 25 beds, expanded length of stay up to a limit of 4 days, expanded cost-based payments to include post-acute care, and other expansions ^d	Increased from 16 hospitals in 1994 (under demonstrations) to 916 in 2004 to 1,353 in 2021, representing 65% of all rural hospitals ^d
Low-volume hospital program for hospitals more than 15 miles from other providers	Expanded due to legislation changing eligibility criteria from 200 annual discharges to 3,800 annual discharges	Expanded from 3 hospitals in 2010 to 626 hospitals in 2019; by 2019, 61% of rural IPPS hospitals received a low-volume adjustment ^e

Note: SSI (Supplementary Security Income), IPPS (inpatient prospective payment system). Critical access hospitals do not qualify for DSH payments.

Source: ^a Centers for Medicare & Medicaid Services 2021a, Prospective Payment Assessment Commission 1998, Prospective Payment Assessment Commission 1997.

^b Government Accountability Office 2018, Health Resources and Services Administration 2021.

^c Centers for Medicare & Medicaid Services 2021a, Freiman and Cromwell 1987, U.S. House of Representatives 1985.

^d Flex Monitoring Team 2021, Medicare Payment Advisory Commission 2005a, Medicare Payment Advisory Commission 2005b, Wright et al. 1995.

^e Centers for Medicare & Medicaid Services 2021a, Centers for Medicare & Medicaid Services 2009.

The additional Medicare spending distributed through the MDH program is not well targeted to those hospitals most in need for a few key reasons:

- **Inpatient services are no longer the dominant service lines for many hospitals:** When the MDH program was enacted, hospitals' primary source of Medicare revenue was inpatient services. In contrast, outpatient services now represent about half of MDHs' Medicare revenues. Therefore, any measure of "Medicare dependence" should consider outpatient as well as inpatient revenue.
- **Supplemental payments do not reflect current costs:** The hospital-specific rate used to calculate extra payments is based on data from 1982, 1987, or 2002. Allowing hospitals to pick their highest-cost year from data that is up to 40 years old results in hospital-specific rates that are unlikely to reflect current costs.
- **Hospitals with the highest costs may not be those in the most need:** The Commission's prior work has shown that hospitals under financial pressure tend to have lower costs, while hospitals that are in better shape financially tend to have higher costs (Medicare Payment Advisory Commission 2020). Therefore, cost-based payments that pay more to hospitals with higher costs may not be directing funds to hospitals most in need. In fact, hospitals that are under enough financial pressure to keep their costs below current IPPS rates would not receive any benefit from the MDH program.

The MDH program is premised on the idea that financial viability can be challenging for hospitals when Medicare is their dominant payer. In recent years, the decline in Medicare profit margins has resulted in even greater financial challenges for hospitals dependent on Medicare in both rural and urban areas.

Beneficiaries' access to hospital care is good in the aggregate, but safety-net hospitals are more likely to face financial challenges

Our analyses have shown, on average, that Medicare beneficiaries have good access to hospital care, and hospitals' total (all-payer) margins are near record highs as a result of rapidly increasing rates paid by commercial insurers. However, hospitals' Medicare margins are negative, have decreased over time, and

are near zero even for relatively efficient hospitals. These trends suggest a growing disparity between hospitals that predominantly rely on Medicare (and other public payers) and hospitals with a substantial volume of commercially insured patients.

Our analyses confirmed that safety-net hospitals face significant financial challenges, even with the special payments these hospitals already receive from Medicare. We found that hospitals that treated higher shares of low-income beneficiaries had lower total margins and were more likely to close than other hospitals.

The gap between commercial and Medicare payment rates to hospitals has grown, underscoring the importance of payer mix in hospital profitability

Each year the Commission examines trends in the capacity and supply of hospitals, the volume of services per beneficiary, hospitals' financial performance, and other metrics to assess the adequacy of Medicare's hospital payment rates. The Commission has consistently found that hospitals have a financial incentive to treat Medicare beneficiaries (i.e., a positive Medicare marginal profit margin), adequate capacity prior to the coronavirus pandemic (e.g., aggregate occupancy rate of 64 percent in 2019), and strong overall financial performance. For example, from 2005 to 2019, hospitals' average total margin climbed from 4.7 percent to 7.6 percent, a record high.

While hospitals' total (all-payer) margins have reached record highs, their Medicare profit margins have decreased over the last two decades. From 1999 to 2008, the Commission found that hospitals' average Medicare margins fell steadily from 10 percent to -7.6 percent (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2008). Since 2008, hospitals' Medicare margins have varied somewhat but have remained substantially negative. In 2019, hospitals' average Medicare margin was -8.7 percent, and it remained below -8 percent in 2020.

Because profit margins on commercial patients continue to diverge from profit margins on Medicare and Medicaid patients, safety-net hospitals may not have sufficient resources to compete for labor and amenities with hospitals that treat a higher share of

commercial patients. The concern is that eventually this disparity could negatively affect access to high-quality care for certain Medicare beneficiaries. In the extreme, hospitals whose patients consist nearly entirely of those on Medicare or Medicaid or patients who are uninsured could have to reduce unprofitable service lines or even be forced to close.

Hospitals with higher shares of low-income patients had lower margins and were more likely to close than other hospitals

Using our proposed definition of low-income beneficiaries (those who receive the Part D LIS), we found that the share of hospitals' Medicare claims associated with low-income beneficiaries was negatively correlated with hospitals' non-Medicare and total margins—that is, both non-Medicare and total margins were lower for hospitals serving higher shares of LIS beneficiaries.¹¹ For example, the quarter of hospitals with the lowest shares of LIS beneficiaries in 2015 had a median non-Medicare profit margin of 15 percent, suggesting that they did not need to break even on Medicare to remain profitable. In contrast, the quartile of hospitals with the highest LIS shares had a median non-Medicare margin of 2 percent, suggesting that they needed to almost break even on Medicare to remain profitable. Similarly, we found that hospitals with the lowest LIS shares of beneficiaries had a total margin (including investment income) of 8 percent, compared with 2 percent for the hospitals with the highest shares of LIS beneficiaries (Table 3-5, p. 72). These findings are not unique to the years shown in the table. We found similar results when looking at 2019 margins.

It is important to note that the LIS beneficiary variable considers only Medicare beneficiaries. But it is strongly negatively correlated with non-Medicare margins, suggesting that the LIS beneficiary variable is acting as a proxy for other factors at the hospital. For example, hospitals whose Medicare patients tend to have low incomes may be more likely to have a large share of low-income patients among their non-Medicare patients as well, which could result in lower levels of non-Medicare profitability.

In contrast to our findings for total margins, we found that hospitals with higher shares of low-income beneficiaries tended to have higher Medicare margins. The quarter of hospitals with the highest

shares of their Medicare volume associated with LIS beneficiaries had a median Medicare profit margin of 0 percent, compared with -13 percent among the quarter of hospitals with the lowest shares (Table 3-5, p. 72). Higher Medicare margins among hospitals with higher shares of LIS beneficiaries in part reflects the fact that these hospitals already receive higher special payments from Medicare in the form of higher DSH and uncompensated care payments.

Hospitals with a high share of volume associated with LIS beneficiaries have a higher risk of closure. Among the quarter of hospitals with the highest shares of LIS beneficiaries in 2015, 3.0 percent closed over the next four years, compared with 0.3 percent among the quarter of hospitals with the lowest shares (Table 3-5, p. 72). This finding suggests that Medicare's current safety-net payments (DSH and uncompensated care) do not fully offset the lower level of profits associated with treating high shares of LIS beneficiaries.

A new safety-net index may be a better way to identify safety-net providers

On average, our relatively simple measure of the share of hospitals' Medicare volume associated with LIS beneficiaries is a strong predictor of total margins and risk of closure, suggesting that the measure might be useful in future analyses of safety-net hospitals. As a comparison, we ran our analyses again using two different measures of hospitals' low-income shares—the DSH patient percentage (which Medicare uses to distribute DSH and uncompensated care funding) and a Safety-Net Index (SNI), which is computed as the sum of (1) the share of a hospital's total patient population associated with LIS beneficiaries, (2) the share of its revenue spent on uncompensated care, and (3) one-half of its Medicare share of total days.¹²

Both the LIS and SNI measures appear to have stronger associations with non-Medicare margins and closures than the current DSH metric. These two safety-net metrics are also closely correlated with each other (correlation coefficient of 0.91). This correlation should not be surprising, given that a key variable in both metrics is the share of Medicare volume associated with LIS beneficiaries.

The SNI was our strongest measure in terms of predicting closures. Among the quarter of hospitals with the lowest SNI, 0.1 percent closed over a four-

**TABLE
3-5**

High SNI hospitals had lower margins and were more likely to close

Hospital characteristic	DSH percentage, by hospital quartile				LIS, by hospital quartile				Safety-Net Index, by hospital quartile			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2015 characteristics												
LIS share of Medicare patients	22%	30%	36%	48%	20%	29%	38%	53%	21%	29%	37%	53%
Medicare share	64	62	57	47	57	58	59	54	51	58	61	58
Uncompensated care cost/revenue	2.3	3.2	3.3	3.3	2.1	2.8	3.3	4.2	1.9	2.7	3.3	5.1
Medicaid share	10	19	25	39	14	21	23	31	17	21	23	26
Share teaching hospitals	22	31	37	47	28	41	34	33	35	40	33	30
Share rural hospitals	18	29	30	22	9	20	31	39	10	18	29	42
2016 financial performance (actual 2016 data)												
Non-Medicare margin	13%	9%	7%	5%	15%	9%	6%	2%	14%	10%	6%	2%
Medicare margin	-13	-10	-5	-3	-13	-10	-7	0	-13	-10	-6	-2
Total margin	6	5	5	3	8	6	3	2	8	6	3	1
Share closed 2016-2019	1.7	1.0	1.3	2.1	0.3	0.6	2.3	3.0	0.1	0.4	2.3	3.3

Note: SNI (Safety-Net Index), DSH (disproportionate share hospital), LIS (low-income subsidy), Q (quartile). The unit of analysis is the hospital, with 704 hospitals in each quartile. The full sample of 2,816 hospitals represents all inpatient prospective payment system hospitals with more than 200 Medicare discharges and complete data. The margins presented are the median margin for the quartile. The LIS shares in this table are the average of inpatient and outpatient LIS shares. Medicare shares are presented as a share of adult and pediatric inpatient days, including Medicare Advantage days. Medicare patients tend to have longer lengths of stay and thus a large share of inpatient days. The non-Medicare margin excludes fee-for-service Medicare revenue and costs from the margin computation. "DSH percentage" refers to the disproportionate share patient percentage. The SNI consists of adding the share of Medicare patients who are LIS, the share of revenue spent on uncompensated care, and one-half of the hospital's Medicare share. The half weight of Medicare shares reflects its lower effect on non-Medicare margins as tested in series regression analyses. The redistribution of safety-net dollars (DSH and uncompensated care dollars) was computed as a percentage add-on to each hospital's inpatient and outpatient Medicare payments; it was approximately equal to a 0.3 percent add-on for each 1 percentage point increase in the SNI. The mean add-on is 7 percent in the illustrative example.

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

year period compared with 3.3 percent among the quarter of hospitals with the highest SNI (Table 3-5).¹³ In addition, the SNI predicted total margins as well as the LIS beneficiary metric did. A potential benefit of the SNI metric over the DSH and LIS measures is that it is positively correlated with the share of hospitals' patients who are enrolled in Medicare (due to Medicare shares being part of the metric). Therefore, the SNI metric combines the positive predictive attributes of the LIS beneficiary metric while avoiding the negative correlation with the share of patients who are enrolled in Medicare observed in both the DSH and LIS metrics. The current DSH metric has a high negative correlation

with the Medicare share, and the LIS beneficiary metric has a moderately negative correlation with the Medicare share (data not shown).

We have shown that the SNI is a slightly better predictor of hospitals' non-Medicare margins and closures than the current DSH patient percentage. The SNI can be used to identify safety-net status. Using the SNI metric to determine the distribution of safety-net payments also may be more appropriate than using DSH and uncompensated care payments, given the limitations of the current DSH payments and what appear to be reasonable results if payments were distributed via the SNI.

Limitations of the DSH percentage as an indicator of safety-net status

While the current DSH patient percentage used to qualify for DSH and uncompensated care payments tends to direct more dollars to safety-net hospitals than other hospitals, the DSH patient percentage has three potential shortcomings:

- The DSH measure includes the share of inpatient days that are associated with non-dual-eligible Medicaid beneficiaries. While the original intent of using Medicaid days was as a proxy for a hospital serving low-income patients, incorporating these days into the formula means that Medicare is indirectly subsidizing Medicaid. The Commission has historically asserted that, as a matter of policy, Medicare should not subsidize Medicaid (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2016). When Medicare shifted 75 percent of DSH funds to paying for uncompensated care, the magnitude of the subsidy was reduced. However, the Medicaid share remains the primary factor in determining which hospitals receive DSH funds.
- The DSH metric is an inpatient-only metric. As the practice of medicine shifts toward outpatient settings, the mix of inpatients may be less reflective of the hospitals' overall patient mix.
- The DSH patient percentage is negatively correlated with the hospitals' share of Medicare patient days. For example, the typical hospital in the quartile of hospitals with the lowest DSH patient percentages had a patient mix that was 64 percent Medicare, compared with 47 percent Medicare at a typical high-DSH hospital (Table 3-5). The shift of special payments away from hospitals with high shares of Medicare patients may not have been a concern in 1985, when the DSH formula was established, because Medicare was a relatively profitable payer. However, because Medicare margins have declined over time, policymakers may want to consider targeting a larger share of Medicare's special payments to hospitals with higher shares of Medicare beneficiaries in the future. Much of the shift in safety-net payments shown in Table 3-5 stems from bringing Medicare shares into the safety-net formula.

Using the Safety-Net Index to better target Medicare payments for safety-net hospitals

Given the flaws in the current DSH metric, simply adding additional dollars to the DSH program does not appear to be a good way of targeting Medicare dollars. However, reasonable options exist for altering the distribution of Medicare's current safety-net payments.

We illustrate one such approach, which is designed to accomplish three objectives:

- **Target payments to safety-net hospitals, using the SNI.**¹⁴
- **Avoid a "cliff" effect, under which add-on payments increase dramatically if the provider meets a predetermined threshold.** To avoid the cliff effect, we modeled the adjustment so that it starts at zero for all those below the 5th percentile of the SNI distribution and increases in a linear fashion up to the 99th percentile of the distribution. The 5th and 99th percentiles were used to limit the influence of tails or potential errors in data while still allowing for higher payments to hospitals at the highest SNI level. The result was that the new SNI adjustment would eliminate current DSH and uncompensated care payments and redirect current DSH dollars by increasing inpatient and outpatient payments by approximately 0.3 percent for every 1 percentage point increase in the hospital's SNI.¹⁵ Under this approach, the magnitude of the payment would be targeted, but almost all providers would receive some safety-net payment. For example, hospitals at the 10th percentile of the LIS beneficiary share distribution would receive about a 2 percent add-on to their Medicare rates, while providers at the 95th percentile of the distribution would receive a 17 percent add-on to their inpatient and outpatient rates.
- **Fully expend the dollars currently being spent on DSH and uncompensated care payments.** In future work, we can evaluate whether additional funds are needed in the safety-net pool.

In our illustrative example, we model SNI payments as a pure budget-neutral redistribution of existing DSH and uncompensated care payments. Policymakers could decide whether additional funds are needed in the pool of SNI dollars to create a pool of safety-net payments

that is larger than the current DSH/uncompensated care pool of funds. The Congress could set the size of the initial pool of dollars and then have the pool increase annually by some factor, such as the expected percentage increase in IPPS hospital spending. That would keep the SNI pool of dollars proportionate to the Medicare program's overall hospital spending.

The SNI for hospitals in this chapter was created with a combination of data on hospitals' fee-for-service (FFS) and Medicare Advantage (MA) Medicare patients. While we only illustrate the effect of SNI payments on FFS Medicare payments, an equal percentage add-on could be made to MA hospital claims. Because of the encounter data provided by MA plans, CMS will have the data to make payments directly to safety-net providers for MA patients. CMS should make SNI payments directly to providers serving low-income MA patients rather than simply increasing MA plans' capitated payments. Making payments directly to providers would ensure that the SNI payments are received by providers serving low-income Medicare beneficiaries rather than being used by MA plans for other purposes. In addition, beneficiary cost sharing should not increase with SNI payments, as increasing cost sharing for low-income beneficiaries could have a negative effect on access to care. The result would support safety-net providers serving both FFS and MA patients without an increase in cost-sharing burdens on low-income beneficiaries.

Illustrative effect on hospital revenue of redistributing safety-net payments

Under current DSH policies, hospitals with high SNI values tend to have above-average Medicare margins and below-average total margins. The higher Medicare margins reflect the DSH and uncompensated care payments these hospitals receive, and the lower total margins suggest that these hospitals have fewer profitable commercial patients.

In the illustrative model shown in Table 3-6, replacing current DSH payments with a new SNI add-on would raise Medicare payments to high-SNI hospitals and thus slightly increase their Medicare margins and total margins relative to the current DSH model (Table 3-5, p. 72). For example, the hospitals in the quartile with the highest SNI values would see their Medicare payments increase by an average of 1.8 percent and their total revenue increase by 0.4 percent. In contrast,

hospitals with the lowest SNI values would see their total revenue decline by 0.4 percent (Table 3-6).

One concern would be the financial impact on hospitals with high DSH shares that currently benefit from the DSH and uncompensated care policies. On average, the quartile of hospitals with the highest DSH patient percentage (primarily due to high Medicaid patient loads) would see a decline of 2.3 percent of their Medicare payments, equivalent to a decline of 0.4 percent of total revenue. But the effects within the high-DSH group would vary. About 21 percent of the high-DSH hospitals would experience a decline of more than 1 percent in revenue, and about 13 percent of high-DSH hospitals would receive more than a 1 percent increase in total revenue. Because Medicare shares are a factor in the SNI metric but not in current DSH or uncompensated care metrics, hospitals that tend to have high Medicare shares would tend to benefit from the change and those with low Medicare shares would tend to lose under the SNI model. While high-DSH hospitals would tend to receive a reduction in Medicare payments under a policy of using the SNI rather than the DSH percentage to measure safety-net status, high-DSH hospitals would still receive an above-average share of safety-net payments (SNI adjustments equal to 8 percent of Medicare revenue, on average, in the top DSH quartile), and high-DSH hospitals would disproportionately benefit from any increase in the pool of safety-net dollars, even if those dollars were distributed through the SNI.

In this illustrative redistribution of DSH and uncompensated care funds, both teaching and nonteaching hospitals would see little change in total revenue (shifting by less than 0.3 percent; data not shown). Rural IPPS hospitals would see their Medicare revenue increase by about 3 percent and their total revenue increase by about 0.7 percent.¹⁶ Urban hospitals would see a decline of Medicare revenue of about 0.3 percent, on average, and total revenue would decline by about 0.1 percent, on average. Rural hospitals tend to receive more money under the SNI metric than under the DSH and uncompensated care policies due to having relatively high Medicare shares (which are included in the SNI metric) and receiving lower payments under current DSH regulations. The change would not affect critical access hospitals, which receive cost-based payment and are not eligible for DSH or

**TABLE
3-6**

Illustrative example: Redistributing existing DSH and uncompensated care dollars based on the SNI would slightly increase margins of hospitals with large shares of low-income Medicare beneficiaries

Hospital characteristic	DSH percentage, by hospital quartile				LIS, by hospital quartile				Safety-Net Index, by hospital quartile			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Medicare FFS payment change (in millions)	1.0	0.5	0.1	-1.6	-0.3	-0.3	0.5	0.2	-1.4	-0.1	0.8	0.7
Mean DSH payments as a share of total Medicare payments	1.4%	4.9%	5.6%	10.3%	2.7%	5.0%	6.3%	10.9%	3.8%	5.2%	5.8%	10.4%
Mean simulated SNI payments as a share of total Medicare payments	3.4%	4.0%	5.8%	8.0%	2.4%	4.5%	7.0%	11.4%	2.0%	5.0%	7.7%	12.2%
2016 margins given current DSH policy												
Medicare margin	-13%	-10%	-5%	-3%	-13%	-10%	-7%	0%	-13%	-10%	-6%	-2%
Total margin	6	5	5	3	8	6	3	2	8	6	3	1
Simulated changes in margins caused by a shift to using the SNI to distribute safety-net dollars												
Percent change in Medicare payments	2.0%	0.9%	0.2%	-2.3%	-0.4%	-0.5%	0.7%	0.4%	-1.7%	-0.2%	1.5%	1.8%
Percent change in total payments	0.5%	0.2%	0.0%	-0.4%	-0.1%	-0.1%	0.2%	0.1%	-0.4%	0.0%	0.3%	0.4%
Simulated Medicare margin under SNI	-11%	-9%	-5%	-5%	-14%	-10%	-6%	0%	-15%	-10%	-4%	0%
Simulated total margin under SNI	7%	5%	5%	3%	8%	5%	4%	2%	8%	6%	4%	2%

Note: DSH (disproportionate share hospital), SNI (Safety-Net Index), LIS (low-income subsidy), FFS (fee-for-service). The unit of analysis is the hospital, with 704 hospitals in each quartile. The full sample of 2,816 hospitals represents all inpatient prospective payment system hospitals with more than 200 Medicare discharges and complete data. The margins presented are the median margin for the quartile. The LIS shares in this table are the average of inpatient and outpatient LIS shares. Medicare shares are presented as a share of adult and pediatric inpatient days, including Medicare Advantage days. Medicare patients tend to have longer lengths of stay and thus a large share of inpatient days. The non-Medicare margin excludes FFS Medicare revenue and costs from the margin computation. "DSH percentage" refers to the disproportionate share patient percentage. The SNI consists of adding the share of Medicare patients who are LIS, the share of revenue spent on uncompensated care, and one-half of the hospital's Medicare share. The half weight on Medicare shares reflects its lower effect on non-Medicare margins, as tested in series regression analyses. The redistribution of safety-net dollars (DSH and uncompensated care dollars) was computed as a percentage add-on to each hospital's inpatient and outpatient Medicare payments; it was approximately equal to a 0.3 percent add-on for each 1 percentage point increase in the SNI. The mean add-on is 7 percent in the illustrative example.

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

uncompensated care dollars. While the ownership of hospitals that gain under the redistribution would vary, hospitals benefiting from the redistribution are more likely to be government-owned hospitals. About 17 percent of the hospitals that would gain 1 percent or more due to the SNI redistribution are government

hospitals, while only about 10 percent of the hospitals that would lose 1 percent or more of revenue would be government hospitals. For-profit hospitals would represent 28 percent of the hospitals gaining at least 1 percent and 39 percent of hospitals with revenue declines of 1 percent or more. Nonprofit hospitals

would represent 54 percent of the hospitals gaining at least 1 percent and 51 percent of hospitals with revenue declines of 1 percent or more. These results are based on assumptions included in the model and are used to illustrate how margins could change with a shift from a DSH and uncompensated care framework to an SNI

framework. While these figures provide a sense of the magnitude of the changes in a budget-neutral model, actual changes would depend on both the size of the SNI pool of funds and on regulations governing the SNI model. ■

Endnotes

- 1 The 340B Drug Pricing Program allows certain hospitals to obtain discounted prices from drug manufacturers. The 340B program could continue in its current form, using existing DSH thresholds, even if the Medicare DSH program was reformed and DSH was no longer used as the basis for distributing Medicare payments to hospitals. Because the 340B program does not distribute Medicare dollars to providers, it differs from the Medicare safety-net policies discussed in this chapter.
- 2 Full-benefit dual-eligible beneficiaries are enrolled in Medicare and also receive the full range of Medicaid benefits offered in a given state. In 2019, about half of full-benefit dual-eligible beneficiaries qualified for Medicaid because they received Supplemental Security Income (SSI) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2022). In 2021, beneficiaries were eligible for SSI if they had limited assets and their income was \$794 or less per month for an individual (\$1,191 for a couple), which equates to about 74 percent of the federal poverty level. Partial-benefit dual-eligible beneficiaries do not receive full Medicaid benefits but qualify for assistance with Medicare costs through one of four Medicare Savings Programs: the Qualified Medicare Beneficiary Program, which pays for Part A and Part B premiums, coinsurance, and deductibles; the Specified Low-Income Medicare Beneficiary Program, which pays for Part B premiums; the Qualifying Individual Program, which pays for Part B premiums; or the Qualified Disabled and Working Individuals Program, which pays for Part A premiums.
- 3 The federal poverty level is the same for the 48 contiguous states, meaning it is not adjusted for cost of living. Alaska and Hawaii have separate, higher federal poverty levels.
- 4 Some variation may also be due to differences in take-up rates of Medicaid, the Medicare Savings Programs, and the LIS across states and because some states set income limits for Medicaid eligibility higher than 150 percent of the federal poverty level. For example, the federal government sets income and asset standards to qualify for the Medicare Savings Programs; states may set their income and asset limits higher than federal standards but may not use more stringent criteria. The federal income limit to qualify for the Qualified Medicare Beneficiary Program is 100 percent of the federal poverty level, but in 2020, Connecticut set the income limit at 211 percent of the federal poverty level (Medicaid and CHIP Payment and Access Commission 2020). In 2020, a total of 14 states and the District of Columbia set more generous income or asset limits for one or more of the Medicare Savings Programs (Medicaid and CHIP Payment and Access Commission 2020). Many of the 14 states increase or eliminate the asset test but keep the income standards at or near the federal standard.
- 5 Medicare's DSH payments are operationalized as a percentage adjustment to diagnosis related group rates. While the magnitude of the adjustment generally increases as a hospital's DSH patient percentage increases, the amount varies based on formulas that differ depending on hospital characteristics (e.g., urban or rural, number of beds, share of low-income patients). We discuss the primary method for qualifying for DSH payments here. Hospitals may also qualify under an alternate special exception. In this report, "DSH payments" refers to operating DSH payments; Medicare has separate rules for capital DSH payments.
- 6 In 2021, SSI payments are made to individuals with basic income below \$794 per month. Not all income is counted toward the limit (e.g., the first \$20 of Social Security income is not counted). About 10 percent of Medicare discharges are for beneficiaries receiving SSI, while over 20 percent of discharges are for dual-eligible beneficiaries. In most states, all Medicare beneficiaries who receive SSI benefits are eligible for full Medicaid benefits.
- 7 "Non-Medicare" refers to all payments and costs other than for fee-for-service Medicare. Medicare Advantage revenue and costs are still included in the "non-Medicare" margin due to our lack of data on Medicare Advantage payments to hospitals.
- 8 The Affordable Care Act of 2010 stipulated the formula by which the available DSH funds will decline in proportion to the decline in the share of the uninsured population from the 2013 baseline. The rationale is that as the rate of uninsurance declines, hospitals' uncompensated care burdens should also decline.
- 9 For 2022, the DSH pool under the original formula would have been approximately \$14 billion. Therefore, empirically justified DSH payments are equal to \$3.5 billion ($\$14 \text{ billion} \times 0.25$). Because CMS actuaries predict that the uninsured rate will be 68.57 percent as high in 2022 as it was in 2013, uncompensated care payments are \$7.2 billion ($\$14 \text{ billion} \times 0.75 \times 0.6857$).
- 10 While the patient would not count in terms of the hospital's DSH patient percentage, a hospital would receive some additional funding through the uncompensated care pool if the hospital qualified as a DSH hospital.

- 11 For this analysis, the LIS share measure is an average of LIS shares from inpatient and outpatient claims. We divided IPPS hospitals into quartiles based on the share of their total Medicare volume associated with LIS beneficiaries in 2015. We then analyzed how well this measure predicted hospitals' 2016 margins and closures from 2016 until April 2020. We stop the analysis with the onset of the coronavirus pandemic to avoid confounding factors. However, as a robustness check, we also ran the same analysis using more recent data and found similar results. Specifically, we examined how our various safety-net metrics from 2018 predicted 2019 profit margins and closures from 2019 through fiscal year 2021.
- 12 Using one-half of the Medicare share of total days was determined based on regression models that attempt to explain differences in non-Medicare margins based on the characteristics of hospitals' patients. We found that Medicare shares, uncompensated care shares, and LIS shares were all predictors of hospital margins. Medicaid shares and characteristics of the ZIP codes where the patients lived added little to the explanatory models and were excluded for empirical reasons and to avoid having Medicare directly subsidize Medicaid.
- 13 We measured closures as counts of hospitals. We also measured closures in terms of closed beds to adjust for size of closures and found similar results. The number of closed beds was 10 times larger among hospitals in the highest SNI quartile compared with hospitals in the lowest SNI quartile.
- 14 We also tested redistributing the funds using the LIS variable as the safety-net indicator and achieved results similar to the SNI redistribution.
- 15 This example is oversimplified, and several policy decisions would have to be made in any redistribution. For example, in this model, we allow the new safety-net payments go to all hospitals, including Medicare-dependent hospitals, even if those hospitals receive cost-based payments based on historical costs.
- 16 Under current regulations, sole community hospitals can choose to receive traditional IPPS rates plus DSH and uncompensated care payments or a hospital-specific rate based on their historical costs. In this model, we assumed hospitals that choose the hospital-specific payment rate would continue to do so. However, a few hospitals could switch to the IPPS rates if they were allowed to obtain SNI payments, which could result in slightly higher increases in rural payments than those indicated in this simulation.

References

- Census Bureau. 2020. 2019 poverty rate in the United States. <https://www.census.gov/library/visualizations/interactive/2019-poverty-rate.html>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021a. Final rule impact file. <https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipp-pps-final-rule-home-page#Data>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021b. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2022 rates; quality programs and Medicare Promoting Interoperability Programs requirements for eligible hospitals and critical access hospitals; changes to Medicaid provider enrollment; and changes to the Medicare Shared Savings Program. Final rule. *Federal Register* 86, no. 154 (August 13): 44774-45615.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2009. Medicare program; changes to the hospitals inpatient prospective payment system and updates to certain IPPS-excluded hospitals. *Federal Register* 74, no. 165 (August 27): 43768.
- Flex Monitoring Team, Rural Research Centers. 2021. Historical CAH data. <https://www.flexmonitoring.org/historical-cah-data-0>.
- Freiman, M. P., and J. Cromwell. 1987. Reimbursement of sole community hospitals under Medicare's prospective payment system. *Health Care Financing Review* 9, no. 2 (Winter): 39-54.
- Government Accountability Office. 2020. *Rural hospital closures: Affected residents had reduced access to health care services*. GAO-21-93. Washington, DC: GAO.
- Government Accountability Office. 2018. *Federal oversight of compliance at 340B contract pharmacies needs improvement*. Washington, DC: GAO.
- Health Resources and Services Administration, Department of Health and Human Services. 2021. Covered entity search. <https://340bopais.hrsa.gov/CoveredEntitySearch/000020143>.
- Medicaid and CHIP Payment and Access Commission. 2020. *Report to the Congress on Medicaid and CHIP*. Washington, DC: MACPAC.
- Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2016. MedPAC comment letter on CMS's proposed rule on hospital inpatient prospective payment system, May 31.
- Medicare Payment Advisory Commission. 2008. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2005a. *Report to the Congress: Issues in a modernized Medicare program*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2005b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. 2022. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MedPAC/MACPAC.
- Nguyen, N. X., and S. H. Sheingold. 2011. Indirect medical education and disproportionate share adjustments to Medicare inpatient payment rates. *Medicare & Medicaid Research Review* 1, no. 4: E1-E19.
- Prospective Payment Assessment Commission. 1998. *Report to the Congress: Context for a changing Medicare program*. Intramural report June. Washington, DC: ProPAC.
- Prospective Payment Assessment Commission. 1997. *Medicare and the American health care system: Report to the Congress*. Intramural report June. Washington, DC: ProPAC.
- Selden, T. M., Z. Karaca, P. Keenan, et al. 2015. The growing difference between public and private payment rates for inpatient hospital care. *Health Affairs* 34, no. 12 (December 1): 2147-2150.
- Sheingold, S. H., R. Zuckerman, and A. Shartzter. 2016. Understanding Medicare hospital readmission rates and differing penalties between safety-net and other hospitals. *Health Affairs* 35, no. 1 (January): 124-131.

Shoemaker, J. S., A. J. Davidoff, B. Stuart, et al. 2012. Eligibility and take-up of the Medicare Part D low-income subsidy. *Inquiry* 49, no. 3 (Fall): 214-230.

Stensland, J., Z. R. Gaumer, and M. E. Miller. 2016. Contrary to popular belief, Medicaid hospital admissions are often profitable because of additional Medicare payments. *Health Affairs* 35, no. 12 (December 1): 2282-2288.

U.S. House of Representatives. 1985. Omnibus Budget Reconciliation Act of 1985. 99th Cong., 2nd sess., H.R. 3128.

Wright, G., S. Felt, A. Wellever, et al. 1995. *Limited-service hospital pioneers: Challenges and successes of the Essential Access Community Hospital/Rural Primary Care Hospital (EACH-RPCH) Program and Medical Assistance Facility (MAF) Demonstration*. Report prepared by Mathematica Policy Research for the Health Care Financing Administration. Washington, DC: Mathematica Policy Research.