Modernizing the Medicare-Dependent Hospital program

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Background on the Medicare-Dependent Hospital (MDH) program

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

Magnitude of the MDH add-on payment

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

Why should Medicare modernize the MDH program?

- Eligibility criteria fail to measure Medicare dependence
  - Eligibility is based only on inpatient days and discharges
  - Does not account for outpatient services
  - Does not account for difference in rates paid by commercial patients, Medicaid patients, and the uninsured
- Magnitude of payment determined by costs, not need
  - Uses cost data from up to 37 years ago
  - Costs are not a good mechanism for scaling the amount of the add-on payment
- Lacks geographic equity

Why is it the right time to modernize the MDH program?

- Medicare hospital margins have declined for several years and are now negative
- Lower Medicare margins mean it is harder for hospitals with high Medicare shares to remain open
- High Medicare shares can be an issue in both rural and urban areas

Medicare days and discharges are not good measures of Medicare dependence

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

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

Source: MedPAC analysis of Medicare cost report data from CMS.

Hospitals with the highest share of Medicare revenue have lower standardized cost per discharge

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

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

Source: MedPAC analysis of Medicare cost report data from CMS.

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Ways to modernize the MDH program

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

Illustrative policy parameters

Parameter	Metric	Threshold
1. Medicare share	Patient-care revenues	>35%
2. Add-on amount	Based on Medicare's share of patient-care revenues	Up to 5% on a sliding scale
3. Geographic isolation	Mileage to the next closest PPS facility	>15 miles
or		
Occupancy	Market or facility occupancy rate	>62%

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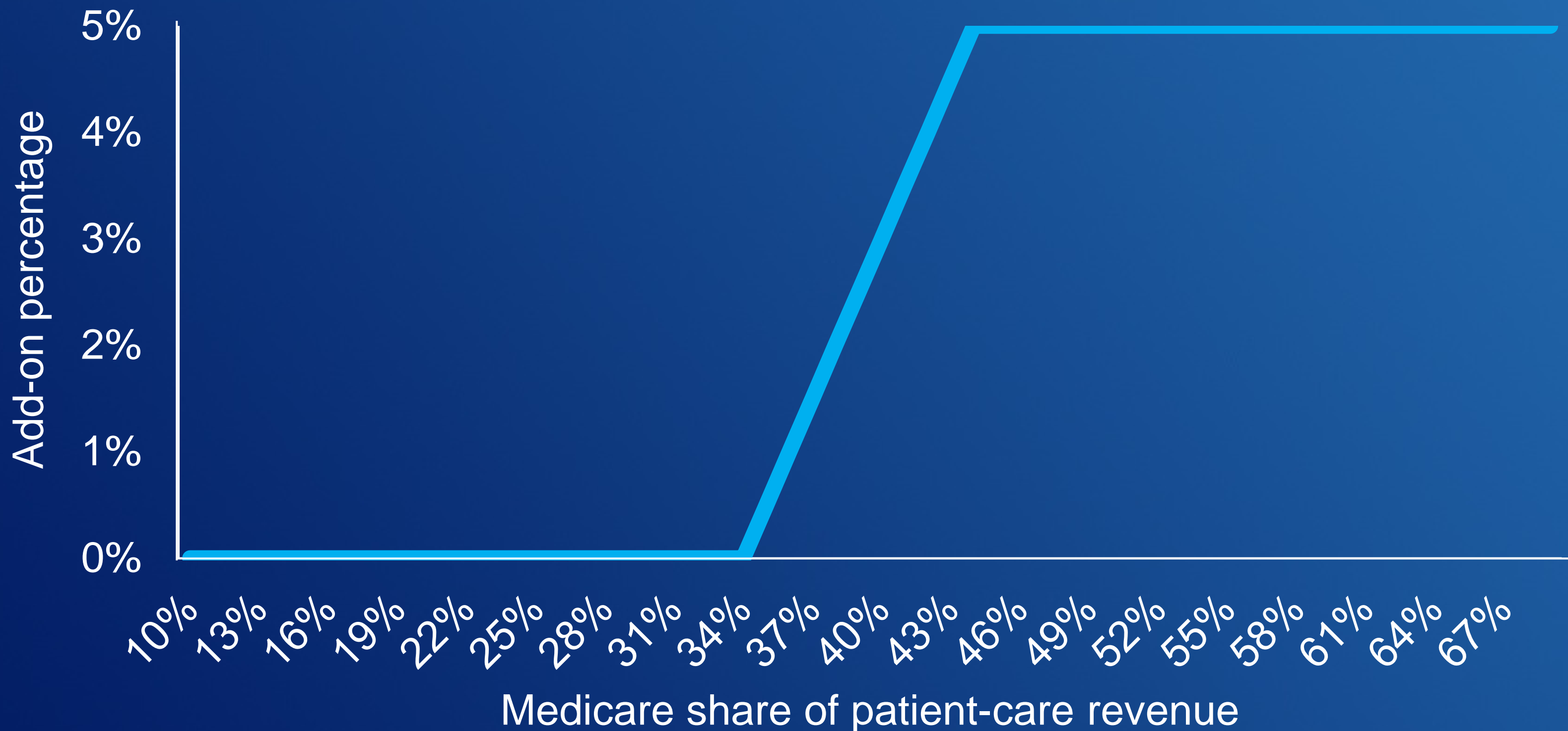
Illustrative example: The sliding scale payment would range from 0% to 5% based on Medicare's share of hospital revenue



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Expected impacts based on illustrative policy parameters

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

Financial impacts of illustrative policy parameters

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

Discussion questions

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