APPENDIX A

Impact of MedPAC's recommendations for reforming the disproportionate share hospital adjustment

APPENDIX A

Impact of MedPAC's recommendations for reforming the disproportionate share hospital adjustment

In previous years, MedPAC proposed a minimum value, or threshold, for the low-income share a hospital must have before payment is made and suggested that a reasonable range for this threshold would allow between 50 percent and 60 percent of hospitals to be eligible for a payment. However, based on MedPAC's most recent analysis, the Commission has revised its recommendation to a level that makes 60 percent of hospitals eligible to receive a disproportionate share (DSH) payment. Below are additional tables to supplement our Chapter 3 analysis of the impact of this change.

Under MedPAC's proposal, when the minimum low-income share for eligibility is reduced from the level that makes 50 percent of hospitals eligible to the level that makes 60 percent eligible, there is a negligible change in total PPS payments (Table A-1). Most noteworthy is that hospitals with the lowest current total margins would experience a slight decline in the degree to which they are helped by MedPAC's proposal—from 1.3 percent to 1.1 percent.

Table A-2 reveals no change in the overall shift of PPS payments from urban to rural hospitals when the minimum low-income share for eligibility is reduced, although there are some changes among urban and rural subgroups. Under both threshold options, the decline in total PPS payments is generally lower for large urban hospitals than for other urban hospitals. Hospitals designated as small rural Medicare dependent hospitals, rural referral centers or sole community providers would have somewhat smaller increases in total PPS payments, compared with other rural hospitals. Because of their special designation, these hospitals currently receive a higher percentage add-on under existing policy and thus would not gain as much from the change in policy.

When eligibility is expanded from 50 percent to 60 percent of hospitals, academic medical centers (AMCs) drop

TABLE A-1

Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and total margin quartile

Total margin quartile	Threshold making 50% eligible	Threshold making 60% eligible
1st quartile (lowest margins)	1.3	1.1
2nd quartile	−0.2	−0.2
3rd quartile	−0.4	−0.3
4th quartile (highest margins)	−0.4	−0.4

Source: MedPAC analysis of 1997 data from Medicare cost reports and the American Hospital Association Annual Survey of Hospitals.

from a 0.2 percent increase to a -0.4 percent decrease (Table A-3). At the same time, major teaching hospitals other than AMCs drop from no change to a -0.5 percent decline in total PPS payments. Although many of these hospitals provide a disproportionate amount of uncompensated care, the modest decline in total PPS payments is not unexpected, given the shift in payments from urban to rural hospitals under MedPAC's proposal.

A 60-percent eligibility threshold would minimize the shift in total PPS payments away from private urban hospitals with 60 percent to 75 percent combined Medicare and Medicaid patient shares (Table A-4). This group was highlighted in MedPAC's report on urban critical access hospitals (MedPAC 1997).

Much of the aggregate shift in DSH payments to public hospitals under our proposal is due to the inclusion of a greater number of public hospitals in rural areas, which are currently left out of the DSH system. Although major public teaching hospitals tend to have less Medicare business, our analysis suggests that the amount of uncompensated care they provide is large enough to produce a shift in DSH monies from private hospitals (Table A-5). Among non-teaching hospitals, many of which are located in rural areas, the share of Medicare business is virtually the same for public and private hospitals. Moreover, even among non-teaching hospitals, which tend to fare best under our proposal, the share of total Medicare dollars going to public hospitals is considerably less than that going to private hospitals (Table A-6). For example, Medicare's cost share among public non-teaching hospitals is approximately 8 percent, compared with 39 percent among private non-teaching hospitals. Even more striking is the difference between other public and private teaching hospitals—2 percent versus 33 percent, respectively. ■

TABLE A-2

Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and hospital location

Hospital location	Threshold making 50% eligible	Threshold making 60% eligible
Urban	−1.0	−1.0
Large urban (1 million+ population)	−0.6	−0.8
Other urban	−1.5	−1.3
Rural	6.5	6.5
Sole community	6.7	6.6
Rural referral center	4.0	4.3
Other rural, 50 beds or more	9.8	9.7
Other rural, less than 50 beds	10.0	9.5
Small rural Medicare dependent	6.0	6.2

Source: MedPAC analysis of 1997 data from Medicare cost reports and the American Hospital Association Annual Survey of Hospitals.

TABLE A-3

Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and teaching status

Teaching status	Threshold making 50% eligible	Threshold making 60% eligible
Academic medical centers	0.2	−0.4
Other major teaching hospitals (not AMCs)	0.0	−0.5

Note: AMC (Academic medical center).

Source: MedPAC analysis of 1997 data from Medicare cost reports and the American Hospital Association Annual Survey of Hospitals.

TABLE A-4

Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and proportion of Medicare and Medicaid patient shares

Hospitals proportion of Medicare and Medicaid	Threshold making 50% eligible	Threshold making 60% eligible
Public urban: 100+ beds		
60–75% Medicare and Medicaid	0.8	−0.4
75% or more Medicare and Medicaid	5.5	3.1
Private urban: 100+ beds		
60–75% Medicare and Medicaid	−1.2	−1.0
75% or more Medicare and Medicaid	0.7	−0.1

Source: MedPAC analysis of 1997 data from Medicare cost reports and the American Hospital Association Annual Survey of Hospitals.

TABLE A-5

Selected payer cost shares by public/private teaching status

Teaching status	Medicare costs	Key components of low-income patient share: Uncompensated care costs	Low-income Medicare costs	Medicaid costs	All components of low-income share
Major teaching					
Public	25.0%	12.0%	3.0%	22.0%	39.0%
Private	34.3	5.5	3.2	15.5	24.3
Other teaching					
Public	35.4	8.0	4.4	15.4	28.2
Private	41.5	4.3	3.0	9.4	16.7
Nonteaching					
Public	43.7	5.9	4.3	11.0	21.3
Private	43.8	4.5	3.4	9.1	17.0

Note: "All components" includes uncompensated care costs, low-income Medicare costs, Medicaid costs, and a proxy measure of the costs of other indigent care programs. Data assume a threshold allowing 60 percent of hospitals to be eligible for a disproportionate share payment.

Source: MedPAC analysis of 1997 data from Medicare cost reports and the American Hospital Association Annual Survey of Hospitals.

TABLE A-6

Proportion of total Medicare costs, by public/private teaching status

Teaching status	Proportion of total Medicare costs
Major teaching	
Public	3.7%
Private	15.3
Other teaching	
Public	2.1
Private	32.9
Nonteaching	
Public	7.5
Private	38.5
Total	100

Source: MedPAC analysis of 1997 data from Medicare cost reports and the American Hospital Association Annual Survey of Hospitals.