ONLINE APPENDIXES 3

Hospital inpatient and outpatient services

ONLINE APPENDIX 3-A

Changes to disproportionate share payments

In 2012, Medicare paid roughly $11 billion in disproportionate share hospital (DSH) payments to inpatient prospective payment system (IPPS) hospitals, which represent 7 percent of all Medicare payments to short-term acute care hospitals. DSH payments are supplementary inpatient payments given to hospitals with high shares of low-income patients. For purposes of computing DSH payments, the low-income patient share is defined as the sum of two ratios: the share of Medicare patients on Supplemental Security Income (SSI) plus the share of Medicaid days over all inpatient days.

The original justification for Medicare DSH payments was that low-income Medicare patients were thought to be more expensive in ways that were not accounted for by the original diagnosis related group (DRG) system. However, by 2011, both the Commission and other researchers concluded that, at most, 25 percent of the DSH payments were empirically justified by the higher Medicare costs at hospitals treating low-income patients (Medicare Payment Advisory Commission 2007, Nguyen and Sheingold 2011).

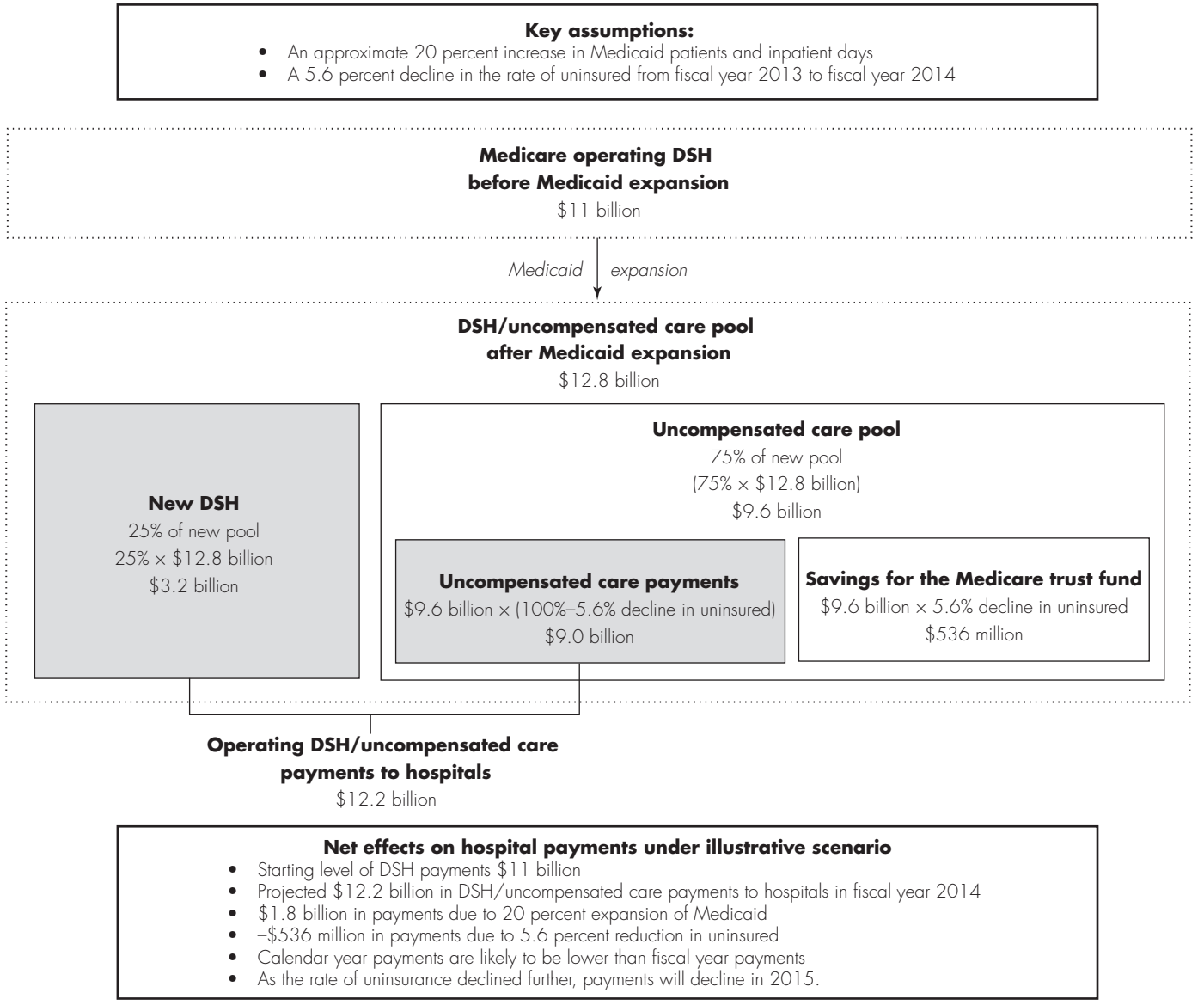
Some have argued that DSH payments should continue in order to assist hospitals that serve low-income patients because of their higher non-Medicare uncompensated care burdens. However, in 2007 the Commission noted that DSH payments were not well targeted at hospitals with high uncompensated care costs (Medicare Payment Advisory Commission 2007). Because at most 25 percent of DSH payments could be justified as covering higher Medicare costs, and because DSH payments were poorly targeted at uncompensated care, the Congress made several changes in the DSH payments as part of the Patient Protection and Affordable Care Act of 2010 (PPACA). Beginning in 2014, hospitals that treat a disproportionate share of low-income patients may qualify for two different payment adjustments (Figure 3-A1 p. 5).

- First, hospitals will receive 25 percent of the operating DSH payments they received under the traditional DSH formula, according to which any hospital with a low-income share exceeding 15 percent is eligible to receive operating DSH payments. The low-income patient share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days provided to Medicaid patients. This 25 percent of payments is referred to as the empirically justified Medicare DSH payment, and CMS expects to make $3.2 billion of these payments in 2014.
- 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. In fiscal year 2014, the uncompensated care pool will be equal to approximately $9 billion. CMS calculates the uncompensated care pool as 75 percent of aggregated operating DSH payments under the traditional DSH formula multiplied by the percent change in the national uninsured rate for individuals under the age of 65 from 2013 to 2014. For fiscal year 2014, CMS projects a 5.6 percent decline in the rate of uninsurance from 18 percent to 17 percent (18 – 17 / 18 = 0.056). CMS's projection for fiscal year 2014 reflects a weighted average of conditions in the start of fiscal year 2014 (which is prior to the January 1, 2014, Medicaid expansion), and part of the year is after the expansion and the insurance mandate take effect. The share of the pool each hospital receives will be based on the share of Medicaid and Medicare SSI days they provided in a given year relative to all other DSH-qualifying hospitals. CMS is using this measure of low-income patients as a temporary proxy for a measure of uncompensated care. Its metric is similar to past DSH formulas but will skew the uncompensated care payments more directly toward hospitals with high Medicaid days relative to Medicare discharges than did past DSH policies.

The net result is as follows: In the absence of the new PPACA Medicaid expansion and DSH policies, the traditional DSH policy would have yielded approximately $11 billion in Medicare operating DSH payments to hospitals in fiscal year 2014 (Figure 3-A1, p. 4). Accounting for the new PPACA Medicaid expansion and DSH policies, the full potential DSH/uncompensated care pool for fiscal year 2014 is approximately $12.8 billion. Among this $12.8 billion, the new DSH policy (empirically justified Medicare DSH amount) accounts for approximately $3.2 billion, uncompensated care payments account for $9 billion, and savings for the Medicare trust fund will account for the remaining $536 million. These savings result from the adjustment built into the calculation of the uncompensated care pool for the annual change in the rate of uninsured. This adjustment means that for every 1 percent decline in the rate of uninsurance among those under 65 years of age, the share of the DSH pool allocated to uncompensated care will decline by 1 percent.

FIGURE 3A–1

Illustration of DSH payment changes under new 2014 payment policy



Note: DSH (disproportionate share hospital). Computations were made using 2012 Medicare payment rates and 2012 cases to isolate the effect of policy changes.

Source: MedPAC simulation using Congressional Budget Office estimates of the rate of uninsurance.

In fiscal year 2014, in aggregate, hospitals are projected to receive $12.2 billion in combined DSH and uncompensated care payments. This will exceed the prior year's DSH payments of approximately $11 billion. The complexity in projecting fiscal year 2014 total DSH/uncompensated care payments lies in assumptions that are made about Medicaid expansion and the rate of uninsurance. The Congressional Budget Office (CBO) has estimated that Medicaid enrollment will expand by roughly 20 percent under PPACA.[1] If this estimate holds, we expect Medicaid inpatient days to expand by roughly 20 percent.[2] The expansion of Medicaid days will result in a larger pool of DSH dollars because DSH is based on the share of Medicare patients on SSI plus the share of overall inpatient days that are Medicaid days. In addition, CMS projects a 5.6 percent decline in the rate of uninsured, a more conservative estimate than the originally expected decline. Given a 20 percent increase in Medicaid

TABLE 3–A1

Computation of add-ons per Medicare discharge

Example of three hospitals receiving 2014 DSH payments	Medicaid days	"Uncompensated" care payment for Medicaid days (Medicaid days x $248)	Total Medicare discharges	Medicaid add-on per Medicare discharge (payment/discharges)
Medicaid days per Medicare discharge				
High	101,407	$25,148,936	1,341	$18,753
Medium	10,654	$2,642,192	4,384	$602
Low	1,368	$339,264	777	$437

Note: DSH (disproportionate share hospital).

Source: MedPAC analysis of Medicare 2014 inpatient prospective payment system final rule files. The three hospitals represent roughly 5th, 50th, and 99th percentile on the distribution of payments per case reported in the final rule by CMS.

enrollment and a 5.6 percent decline in the rate of the uninsured, we estimate that the net amount of payments to hospitals under the DSH and uncompensated care policies will increase by about $1.2 billion in 2014.[3]

Beyond 2014, the change in aggregate Medicare payments to hospitals from new DSH payments and uncompensated care pool payments will continue to depend on two key factors. First, the amount of uncompensated care is expected to decline as the subsidized insurance exchanges become increasingly operational and the availability of health insurance increases in general. Second, further expansion of Medicaid eligibility will also reduce the number of uninsured individuals under the age of 65.

In the future, if the insurance exchanges are successful and more people become insured, payments will decline significantly. For example, if Medicaid enrollment expanded by 25 percent and the number of uninsured individuals fell by 50 percent (as CBO estimated for 2017), the pool of dollars going to hospitals would decline by roughly $2.3 billion below the level of fiscal year 2013, or 1.5 percent of all Medicare payments. In general, as the rate of the uninsured declines, Medicare payments for uncompensated care will decline. We expect hospitals' uncompensated care costs to decline as Medicaid expands, the new insurance exchanges are established, and the penalties for being uninsured go into effect. While the expansion of those with insurance will reduce Medicare payments to hospitals, those newly insured individuals are expected to significantly increase private payer payments to hospitals.

Implementation of the uncompensated care policy

In 2014, the full $12 billion of DSH payments are from the Medicare trust fund, but $9 billion will be distributed as a flat payment of $248 per Medicaid day and $248 per Medicare SSI patient day. The $248 per diem rate was computed by dividing the $9 billion pool of available funds by the number of Medicaid and SSI days at DSH hospitals. Because Medicaid days outnumber Medicare SSI days three to one, about $7 billion of the $9 billion in uncompensated care payments will be distributed as a fixed Medicaid per diem. This results in a large number of Medicare trust fund dollars being used to pay directly for Medicaid days.[4]

A related issue involves the mechanics of how the uncompensated care payment regulations interact with prices paid by Medicare Advantage (MA) plans to hospitals. Most MA plans have contracts that are based on Medicare rates (Centers for Medicare & Medicaid Services 2013). Medicare rates in turn are affected by the uncompensated care payments that are based on Medicaid days. The fixed $248 per Medicaid day uncompensated care payment is distributed as a hospital-specific add-on payment spread across fee-for-service (FFS) Medicare discharges. The add-on is equal to the following formula: Medicaid days × 248 / Medicare FFS discharges. The net result is a per Medicare discharge add-on as low as $50 to as high as more than $10,000 per Medicare claim, with high payments per claim going to hospitals with far more Medicaid days than Medicare discharges (Table 3-A1).

When MA contracts have language that bases the price on the Medicare price—including the "uncompensated" care

TABLE 3–A2

Illustrative examples of how Medicare Advantage shares affect Medicare payments (MA plus FFS) per Medicaid day

Payment variables	Hospital A: 2,000 FFS discharges, 0 MA discharges	Hospital B: 1,000 FFS discharges, 1,000 MA discharges
Medicaid days	4,000	4,000
FFS payment per day	$248	$248
Total FFS "uncompensated" care payment for Medicaid days	$992,000 (days x 248)	$992,000 (days x 248)
Medicare FFS discharges	2,000 FFS	1,000 FFS
Add-on payment per Medicare discharge* (This is determined by FFS discharges only)	$496 (payment/FFS discharges)	$992 (payment/FFS discharges)
Total FFS uncompensated care payments (add on × cases)	$992,000 ($496 x discharges)	$992,000 ($992 x discharges)
Add-on payment per discharge paid by MA plans (This is usually the same as for FFS discharges)	$496	$992
Total MA discharges	0	1,000
Total add-on payments paid by MA plans	$0	$992,000
Total payments for "uncompensated" care using Medicaid days as a proxy for uncompensated care	$992,000	$1,984,000

Note: MA (Medicare Advantage), FFS (fee-for-service).
*This example assumes that MA plans pay FFS rates. Hospital associations asserted this is common.

Source: Centers for Medicare & Medicaid Services 2013.

add-on per discharge—MA payment rates would increase the Medicare subsidy of Medicaid days beyond the $248 subsidy paid by FFS Medicare. We compare two hospitals as an illustration (Table 3-A2). For simplicity, we assume they both have zero SSI days and 4,000 Medicaid days. The only difference is one hospital has 2,000 Medicare FFS discharges and no Medicare MA discharges and the other hospital has 1,000 Medicare FFS discharges and 1,000 MA discharges. The net effect in this hypothetical example is that the hospital with MA days will receive twice as much in Medicaid per diem payments ($496) to pay for uncompensated care. If a hospital has more MA days than FFS days, the subsidy will increase further. The magnitude of the payments—including uncompensated care payments made by MA plans— makes the question of whether Medicare dollars should be tied to Medicaid days important.

In summary, payments for uncompensated care can be disconnected from the actual costs of uncompensated care for two reasons. First, the law states that Medicare FFS add-on payments should pay the same share of each DSH hospital's uncompensated care costs. This means the computation of the add-on payment per Medicare discharge ignores the effect of MA discharges on overall uncompensated care payments that will be received. Second, Medicaid and SSI days were used as a proxy for uncompensated care rather than using estimates of the cost of uncompensated care reported on Schedule S-10 of the cost reports. CMS declined to use this cost-report data on uncompensated care for 2014 "uncompensated" care payments due to concerns that the schedule is new and the data may not be accurate.

CMS stated in the 2014 inpatient final rule that it plans to eventually use uncompensated care data from the S-10 to distribute uncompensated care payments. In using S-10 data, there is a need to consider the effect of uncompensated care payment methodology on the FFS Medicare and the Medicare Advantage payments to hospitals. ■

Endnotes

1 This 20 percent estimate takes into account the Supreme Court ruling of 2012, which allows states to choose not to expand their Medicaid rolls without losing their other Medicaid dollars.

2 We expect the newly insured to have a roughly similar number of inpatient days per capita compared with those currently on Medicaid. In survey data from the Massachusetts expansion of health care coverage, the health status reported by newly covered individuals was similar to that of individuals on Medicaid. In the lottery-based expansion of Medicaid in Oregon, the initial number of Medicaid days per capita for the newly insured was less than 1 standard deviation point higher than for the existing Medicaid population (Finkelstein et al. 2011).

3 The 20 percent increase in Medicaid enrollment reflects CBO estimates for 2014, taking into consideration the Supreme Court decision in the summer of 2012. Earlier estimates by CBO and others projected a greater expansion of Medicaid. CBO projected a 25 percent decline in uninsured in 2014 and 50 percent by 2017. The administration has projected greater reductions in the number of uninsured. CMS has set the pool of uncompensated care dollars at $9.6 billion, but the amount of traditional DSH dollars will depend on actual levels of Medicaid and SSI days. Currently, CMS projects DSH payments and then reconciles after actual Medicaid and SSI share data for the year become available.

4 The same issue of Medicare paying DSH payments based on Medicaid days existed under the old formula, but the magnitude of the add-on to Medicare payments was more limited by the structure of the DSH formula. Due to the structure of the formula, DSH add-on payments were always under 60 percent of base payments and were more dependent on the income level of Medicare patients. Under the new formula, the add-on is over 100 percent of base payments in some cases and is more dependent on Medicaid days than the old formula. The new formula is more distorting than the old formula because hospitals can now receive add-ons that can be 100 percent of base Medicare payments.

References

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long term care; hospital prospective payment system and fiscal year 2014 rates; quality reporting requirements for specific providers; hospital conditions of participation; payment policies related to patient status. Final rule. *Federal Register* 78, no. 160 (August 19): 50495–51040.

Finkelstein, A., S. Taubman, B. Wright, et al. 2011. *The Oregon health insurance experiment: Evidence from the first year.* Cambridge, MA: National Bureau of Economic Research.

Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

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.