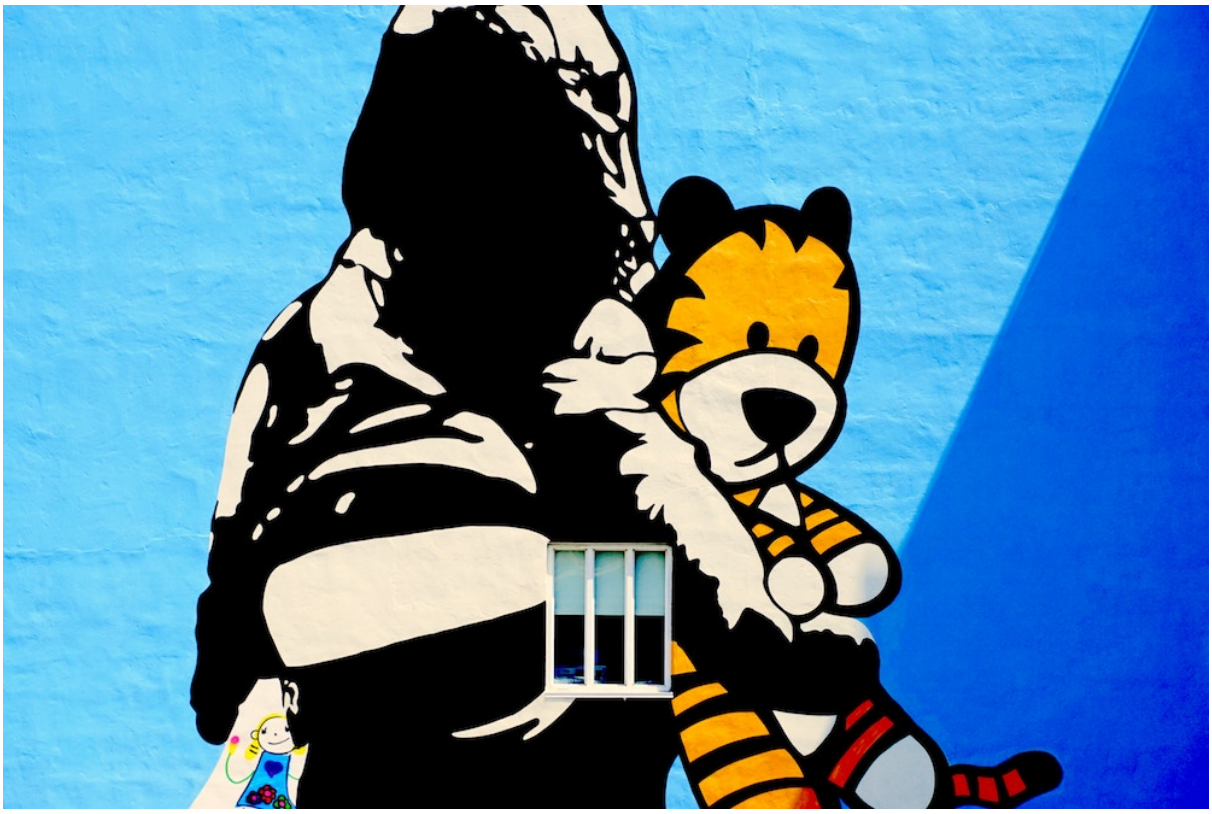
How Safe is Medicare? What To Know About White House Budget Proposals

written by Theresa Hush | February 22, 2018



Health care providers may be lulled into believing that Medicare budget cuts proposed by the White House last week won't happen. Media reports have repeatedly emphasized that the budget is simply a policy proposal. Congress alone has the authority to determine spending limits and allocate funds.

But labeling this budget—and the Medicare proposals in it—as "dead on arrival" is a mistake. For one, the proposal includes efforts aimed at reducing drug prices and fighting the opioid epidemic. But these are minor political enticements, compared to the proposed Medicare cuts labeled as "Reducing Wasteful Federal Spending." Those are the most significant ideas in the document, which have real potential for passage:

> Politically, these proposals align with other efforts to trim federal spending. Passing them could be seen as an important victory in an otherwise contentious budget process. Cutting $266 billion is worth the effort to risk Medicare reductions, especially if the cuts are not perceived as eliminating beneficiary services.

> Those who would like to breach the wall protecting entitlements—and not just Medicaid—will likely support Medicare cuts.

White House Budget Proposals Predominantly Affect Provider Reimbursements—and Probably Also Reduce Access

The impact of these programs, if adopted, would be significant for providers. Notably, the proposals are said to reduce costs "without harming beneficiaries' access to care or altering covered items and services." However, changing reimbursements will cause long-term effects that, together with other proposed measures—such as capping Medicaid expenditures and turning the program over to the states—will affect beneficiaries as well as providers.

These effects will not fall evenly across all health care. The largest impact will likely be felt by inpatient rehabilitation facilities and long term care hospitals, as well as by large health networks and academic systems—especially those in urban areas that serve lower income patients. Here are the top five proposed changes with aggregate savings of $266 billion over 10 years, in order of estimated cost reductions:

1. Establish Uniform Payment System for Post-Acute Services (Fiscal 2019, $0.8 Billion; 10-Year Projected Savings, $80.2 Billion)

The White House Budget proposes to construct a uniform payment schedule for nursing homes, home health agencies, rehab institutions and other post-acute providers, as recommended by the Medicare Payment Advisory Commission (MedPAC) in 2016. Just as for past reimbursement changes for hospitals and outpatient facilities, this intends to correct the incentives of reimbursement systems that pay by type of service and do not always correlate with patients' clinical needs. Note that in unifying rates, the plan is also to lower the average payment for care, resulting in the savings estimate. MedPAC additionally recommended a patient share for such costs, which may also be an unspecified element in the projected savings.

There is support for a uniform post-acute payment program on a relatively short timetable, but it is controversial in the hospital industry. Nevertheless, given significant MedPAC spadework in research and testing on a uniform post-acute payment system, plus the search for budget cuts, this proposal may well go forward.

2. Modify Payments to Hospitals for Uncompensated or Charity Care (Fiscal 2019, $0; 10-Year Savings Projection, $69.5 Billion)

Medicare is one vehicle for supporting the health care system to serve patients who cannot afford care. Although it does not directly pay the bills of charity care patients, there are payments, such as Medicaid's Disproportionate Share Hospital payments, that are included in the Medicare budget. The White House Budget proposes to remove this from the Medicare budget altogether and create a separate program.

There is no doubt that "calling out" the program separately will make it vulnerable to cuts and perhaps elimination, much like other distinct programs on the list of proposed cuts. And while it may appear to be an accounting shift, with zero cuts in Fiscal 2019, there is little question that such a shift would affect access to care by threatening vulnerable facilities.

There are legitimate policy questions here: how to support the medical infrastructure for the poor, and whether it should be part of an insurance program. But since there is no entitlement for health care through any other means, arguments for making the Medicare system totally aligned with payments for Medicare services has larger implications. It means that the federal government woud no longer play a role to support the health care system accessed by lower income Medicare and dual-eligible Medicare-Medicaid beneficiaries (as well as low income ineligibles, like the working poor).

3. Reduce and Redirect Funds to Providers for Graduate Medical Education (Fiscal 2019, $.4 billion; 10-year savings, $48 billion)

A less-understood part of Medicare payments is support for Graduate Medical Education (GME), or payment for residents. Many also do not realize that this is included in most Medicaid programs.

The payments are substantial and meant to support the patient care delivered by residency programs, many of which operate clinics or provide care for Medicare beneficiaries. But as pointed out by the budget, there is no accounting for the relationship between payment levels and how much care is actually rendered to Medicare or Medicaid beneficiaries.

It is not an easy formula to fix, and any adjustments will have ripple effects throughout areas where academic centers are concentrated. Many hospitals dedicated to serving inner city

populations have affiliated with institutions having residency programs. They view it as vital to providing care at lower cost by extending their workforce, as well as offering specialized services that these patients cannot access elsewhere.

The proposal also raises questions about residency program size and placement. Will institutions with large residency programs get credit if they rotate those residents to community providers?

But the larger issue is how Medicare or any other insurance program should support the physician supply. This is a valid policy question: How should we support the education and training of physicians, and how does the supply of physicians drive costs? However, it is less a question of wasteful federal spending than of public policy, encompassing the role of government support for education and training for our workforce, in general, and for physicians, in particular.

Again, cuts to providers may have significant impacts on beneficiaries. Since Medicare support for GME is so interwoven with care to lower income populations, there is little question that cuts could, indeed, affect access to care for individuals who cannot afford the prices charged by many academic institutions.

4. Reduce Medicare Coverage for Bad Debts (Fiscal 2019, $0.4 Billion; 10-year savings, $37 Billion)

This proposed cut would reduce Medicare's contribution to unpaid deductibles and copayments owed by beneficiaries, from 65 percent to 25 percent over time. The budget says this is in keeping with private sector levels of reimbursements.

According to a report sponsored by the American Hospital Association, hospitals must make diligent efforts to collect debt owed by beneficiaries, a substantial number of whom are dual Medicare-Medicaid beneficiaries with Medicaid copayments that fail to cover the full amount of care. Hospitals may indeed be diligent in collections, but the fact that health care costs are too high for fixed income or impoverished patients to bear is illuminated by the projected savings figure of $37 billion. And that situation is not only unlikely to change; if cuts in Medicaid also take place, bad debts will only get worse.

It could well be inappropriate for Medicare to pay a higher level than the private sector for failure of some patients to pay their bills. That is a public policy—not budget—determination to make with regards to the overall affects of the Medicare reimbursement system. Hospitals, on the other hand, argue that lower Medicare payments shift costs to private sector payers now,

so that coverage of more beneficiary charity care is reasonable. In any case, however, this proposal would result in a flat-out payment reduction for hospitals, most affecting those hospitals with the highest volume of lower-income Medicare patients and dual-eligibles. In particularly vulnerable hospitals, it could tip the balance of survival and affect beneficiaries' access to services.

5. Pay Hospital-employed Physicians Practicing Off-site the Same Scale as Non-employed Physicians (Fiscal 2019, $1.2 billion; 10-year savings, $34 billion)

It's no secret that hospitals have been acquiring and expanding physician practices and outpatient facilities. By expanding their networks to communities, they have also enjoyed higher hospital-related reimbursement for those physicians. The Bipartisan Budget Act of 2015, however, changed that rate prospectively, while allowing existing physicians in off-site facilities to continue at higher fee levels. The White House proposal removes the grandfathering provision and effectively creates a uniform fee schedule for physicians, regardless of practice location.

This appears to be a parity maneuver. On its surface, the proposal seems not only fair, but also an effort to equalize physicians across the system. As usual, however, health care is more complex. Like the charity care proposal, there are historical reasons for the higher payments, involving community infrastructure for care.

Some "off-site" facilities—not all, certainly—were created before hospital acquisition of practices peaked, and represented community investments that provided necessary off-site care and services to populations that could not otherwise access them. While we can debate whether higher fees are the right or wrong vehicle, we still may need another method to improve beneficiary access to services in their communities—or risk the demise of these facilities and the health of those who need them for treatment.

The Medicare Budget Is Not Simple Because Medicare Is More than a Payment System

These are just five of the major provisions in the proposed White House budget. There are other provisions that don't affect provider rates, but, if adopted, could affect the speed and scope of Medicare's transition to a financial risk program.

I have focused on these five cuts to show how Medicare has never been just a “payment system.” Proposals to correct imbalance, shift sources of payment, create uniformity, eliminate higher costs—all have a ripple effect throughout the system. Some may be appropriate and overdue. Some may affect vulnerable providers and will therefore change access to services.

Medicare is not the same as an insurance program, although the current policy debate tends to characterize it that way. The Medicare payment system, along with Medicaid, has always been, in part, a placeholder for supporting access to health care as a larger initiative. That’s why we have support for the infrastructure of health care in community facilities, for providers who serve poorer and uncompensated patients, and for the physician supply. These functions are not one-to-one benefit-to-cost for Medicare beneficiaries, and if we viewed Medicare only as an insurance program, the proposed cuts seem appropriate. But the effect on access to care is an entirely different story.

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