Assessing payment adequacy and updating payments: hospital inpatient and outpatient services

Craig Lisk, Dan Zabinski, Dana Kelley and Jeff Stensland

December 12, 2013
Payment adequacy indicators

- Beneficiaries’ access to care
  - Capacity and supply of providers
  - Volume of services
- Access to capital
- Quality of care
- Payments and costs
  - For average providers
  - For relatively efficient providers
Access to care remains strong

- Excess supply of beds in most markets
- Overall Medicare volume down 2 percent
  - Inpatient down 4.5 percent
  - Outpatient up 4.3 percent
  - Decline in volume due to less demand, not capacity constraints
- Access to capital is adequate
  - Equity markets: hospital stocks up 30 to 70% in 2013
  - Bond markets: Mostly stable, some downgrades due to patient volume and future liquidity needs
Quality of care generally improving

- 30-day mortality measures improved
- Patient safety measures mostly improved
- Readmission rates improved slightly
Medicare hospital spending in 2012

- Inpatient (PPS and CAH) — $120 billion
- Outpatient (PPS and CAH) — $46 billion
- Spending growth per capita 2011-2012
  - Inpatient −2.3%
  - Outpatient +7.0%
  - Total 0.3% (weighted average of inpatient and outpatient)

Source: Medicare cost reports

Preliminary data subject to change
Hospital cost growth per case came down close to input price inflation

Percent change

Costs per case
Input price inflation

Source: Medicare cost reports

Preliminary data subject to change
Margins are steady through 2012

<table>
<thead>
<tr>
<th>Medicare margin</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Medicare</td>
<td>– 7.3%</td>
<td>– 5.4%</td>
<td>– 4.7%</td>
<td>– 5.5%</td>
<td>– 5.4%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>– 4.7</td>
<td>– 2.4</td>
<td>– 1.7</td>
<td>– 3.6</td>
<td>– 4.4</td>
</tr>
<tr>
<td>Outpatient</td>
<td>–13.6</td>
<td>–11.4</td>
<td>–10.5</td>
<td>–10.5</td>
<td>–11.2</td>
</tr>
</tbody>
</table>

Note: Margins = (payments – costs) / payments; excludes critical access hospitals. The overall Medicare margin, covers inpatient, outpatient, hospital-based post-acute care in IPPS hospitals, GME, and other payments such as HIT payments.

Source: Medicare cost reports.
## Overall Medicare margin by hospital group

<table>
<thead>
<tr>
<th>Hospital group</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td>−5.4%</td>
</tr>
<tr>
<td>Urban</td>
<td>−5.8</td>
</tr>
<tr>
<td>Rural PPS</td>
<td>−1.9</td>
</tr>
<tr>
<td>Rural with CAH*</td>
<td>−0.3*</td>
</tr>
<tr>
<td>Major teaching</td>
<td>−2.6</td>
</tr>
<tr>
<td>Other teaching</td>
<td>−5.2</td>
</tr>
<tr>
<td>Non-teaching</td>
<td>−7.3</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>−7.1</td>
</tr>
<tr>
<td>For-profit</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Note: *CAHs are paid cost plus 1% and are only included in this line
Source: Medicare cost reports

Preliminary data subject to change
Medicare margins are expected to decline slightly by 2014

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare margin</td>
<td>–5.4%</td>
<td>–6.0%</td>
</tr>
</tbody>
</table>

Why do we expect margins to decline slightly by 2014?

- Payment rate updates and case mix growth will increase revenue
- Cost growth is expected to be slightly larger than updates
- Expiration of certain special payments will offset increases in HIT payments

Source: Medicare cost reports, claims files, and FY 2013 impact file.
All-payer margins reach a record high

Preliminary data subject to change

Source: Medicare cost reports.
Relatively efficient hospitals

- Must be in the best third on either risk-adjusted mortality or inpatient costs per case every year (2009, 2010, 2011), and
- Cannot be in the worst third in any year for risk-adjusted mortality, inpatient costs per case, or readmission rates
Comparing 2012 performance of relatively efficient hospitals to others

<table>
<thead>
<tr>
<th>Measure</th>
<th>Relatively efficient hospitals</th>
<th>Other hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospitals</td>
<td>302</td>
<td>1,831</td>
</tr>
<tr>
<td>30-day mortality (rel. to avg.)</td>
<td>13% lower</td>
<td>3% above</td>
</tr>
<tr>
<td>Standardized costs (rel. to avg.)</td>
<td>10% lower</td>
<td>2% above</td>
</tr>
<tr>
<td>Overall Medicare margin</td>
<td>2%</td>
<td>-6%</td>
</tr>
<tr>
<td>Share of patients rating the hospital highly</td>
<td>69%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Note: Hospitals are classified as efficient based on 2009 to 2011 performance. In this slide, 2012 medians for each group are compared to the national median.

Source: Medicare cost reports, claims data, and hospital compare.

Preliminary data subject to change.
Summary of payment adequacy

- Access to care is strong
- Access to capital is adequate
- Quality is improving
- Medicare Margins are low for average providers
- Relatively efficient providers have been able to make a small profit on Medicare while providing relatively good quality care
- As discussed in November, revenues would fall in 2015 due to policies in current law
Reducing incentives to shift care to higher-cost settings

- **Problem:** current payment rates encourage providers to shift care to higher-cost sites without any evidence of improved outcomes
- **Solution:** remove the pricing distortions
  - **OPPS:** Pay hospitals rates that are comparable to physician office rates for services that can safely be provided in physician offices
  - **LTCH / IPPS:** Pay LTCHs acute care hospital inpatient rates for less-severely ill LTCH patients. Pay acute care hospital higher payments for the most-costly “LTCH-type” patients
## Services shifting from offices to outpatient departments (OPDs)

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Change in freestanding office</th>
<th>Change in OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;M office visits</td>
<td>-1%</td>
<td>8%</td>
</tr>
<tr>
<td>Echocardiogram</td>
<td>-7</td>
<td>18</td>
</tr>
<tr>
<td>Nuclear cardiology</td>
<td>-13</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: Medicare claims data

Preliminary data subject to change
Aligning payment rates in OPDs and freestanding offices

- Medicare and beneficiaries pay $2.1 billion more annually for E&M and other services than if OPD rates aligned with office rates.
- Criteria for service to have equal rates across settings:
  - More than 50% of volume in offices
  - Minimal packaging differences between settings
  - Infrequently provided with ED visit
  - Patient severity no greater in OPDs
  - Not a 90-day global code in the physician fee schedule
Services where payment rates could be equal or differences narrowed

- Group 1: 24 APCs where payment rates across settings could be equal
- Group 2: 42 APCs where payment rate differences could be narrowed; rates higher in OPDs because of more packaging in OPPS
Impact on hospitals of payment changes for 66 APCs

- Adjusting payment rates in these 66 APCs
  - Reduce hospital program spending and cost sharing by $1.1 billion per year
  - Reduce hospitals’ Medicare revenue by 0.6%
- Rural and small hospitals affected more
- Mitigating impact of payment rate changes
  - Illustrative example: Limit losses to 2% of overall revenue for hospitals that have DSH > median
  - 2% of hospitals qualify; $10 million returned
  - Little mitigation effect, many of the most affected hospitals have low DSH or are specialty hospitals
Reforming LTCH payment methods

- Maintain separate LTCH payment system with higher rates only for chronically critically ill (CCI) cases
  - CCI cases (with 8+ ICU days in preceding IPPS stay) paid LTCH rates
  - Non-CCI would be paid IPPS-equivalent rates
  - All LTCH cases (CCI and non-CCI) eligible for LTCH outlier payments (8% outlier pool)
  - 25+ day ALOS requirement applied only to CCI cases
- Savings would be transferred to IPPS outlier pool to boost payments for IPPS CCI cases
Effects on LTCHs

- 36% of LTCH cases would receive higher LTCH CCI rates—aggregate payments for these cases unchanged (budget neutral)
- 64% would get IPPS base rates (reduced payments)
- All cases eligible for LTCH outlier payments
- Total payments would fall more than average for:
  - LTCHs with a high share of non-CCI cases
  - Proprietary LTCHs
  - LTCHs in markets with high LTCH supply
- Expect reduced length of stay—and reduced costs—for non-CCI cases in LTCHs

Source: MedPAC preliminary analysis of Medicare claims data
Effects on IPPS hospitals

- No payment reductions for IPPS hospitals
- Increased payments for IPPS hospitals with high CCI shares
- CCI shares (average = 6.1%) higher for:
  - Hospitals in large urban areas (MSAs with pop. > 1 million)
  - Major teaching hospitals
  - Hospitals with > 300 beds located in urban areas
  - Hospitals in areas with moderate LTCH bed ratios

Source: MedPAC preliminary analysis of Medicare claims data
How will fixing incentives affect Medicare hospital payments?

- Aligning payment rates for 66 APCs with physician office rates will reduce acute hospital payments by $1.1 billion
  - $920 million less from taxpayers
  - $190 million less in beneficiary cost sharing
- LTCH and outlier reform would increase acute hospital payments by $2 billion

Note: Prior recommendation to make E&M payments site neutral would reduce outpatient payments by $1 billion in addition to the reductions for the 66 APCs.

Preliminary data subject to change.