

Assessing payment adequacy and updating payments:  
Hospital inpatient and outpatient services;  
and  
Mandated report: Expanding the post-acute care  
transfer policy to hospice

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# MedPAC's payment adequacy framework – hospitals

## Beneficiaries' access to care

- Capacity and supply of hospitals
- Volume of services
- Marginal profit

## Quality of care

- Mortality and readmission rates
- Patient experience

## Hospitals' access to capital

- All payer profitability
- Bonds and construction
- Mergers and acquisitions
- Employment

## Medicare payments and hospitals' costs

- Payments and costs
- Overall Medicare margins among all and efficient hospitals
- Projected overall Medicare margins

Update recommendation for IPPS and OPPS base rates

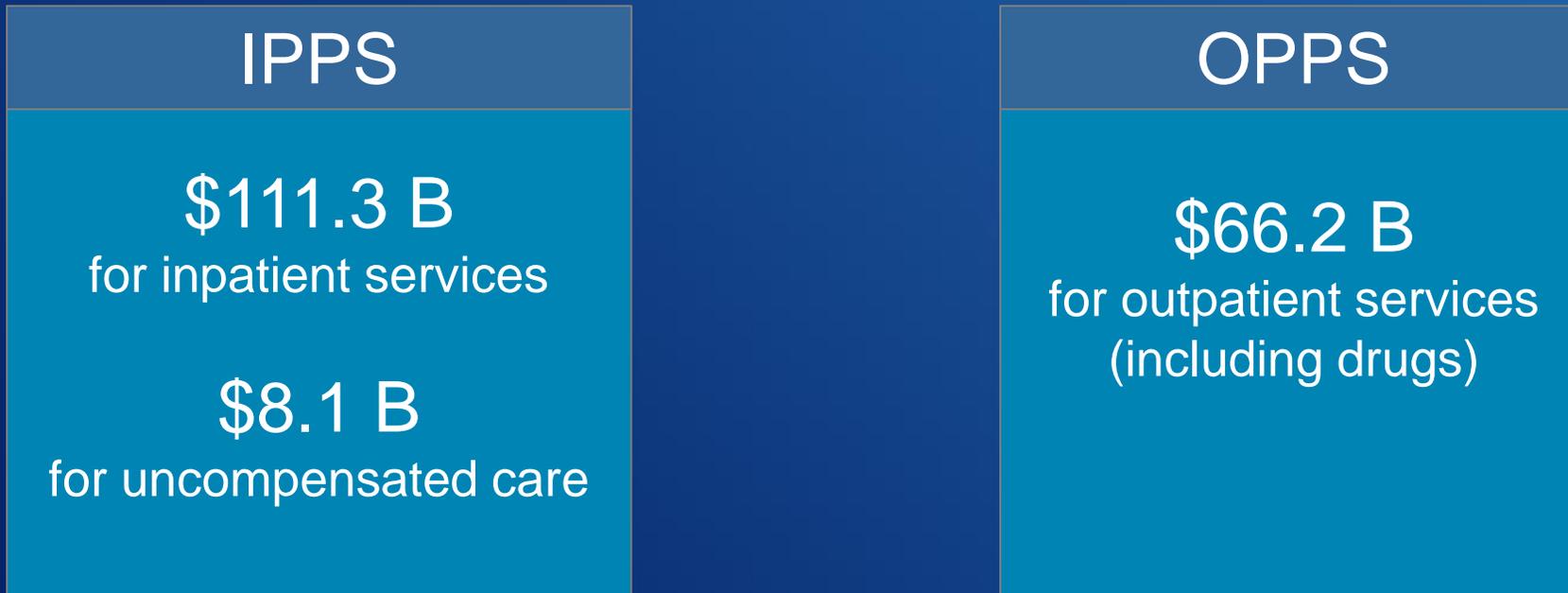
# Payment adequacy framework and the coronavirus public health emergency

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- The coronavirus has had tragic effects on beneficiaries and the health care workforce and material effects on providers
- We start with 2019 data; consider information gained in 2020; and evaluate current law for 2020, 2021 and 2022
- Temporary or highly variable coronavirus effects are best addressed through targeted, short-term funding policies rather than permanent changes to all providers' payment rates in 2022 and future years

# Context: FFS Medicare payments for hospital inpatient and outpatient services in 2019

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Note: FFS (fee-for-service). IPPS (inpatient prospective payment system). OPSS (outpatient prospective payment system). Payments reflect Medicare payment rates and include payments from the Medicare program and from beneficiaries or their supplemental insurance. Payments exclude those made outside these systems. Year is fiscal year for inpatient services and calendar year for outpatient services.

# Access to care: Excess capacity and incentive to see FFS Medicare beneficiaries continued in 2019

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**64%**  
occupancy rate

→ *About two-thirds of all inpatient beds were occupied in 2019, consistent with prior years*

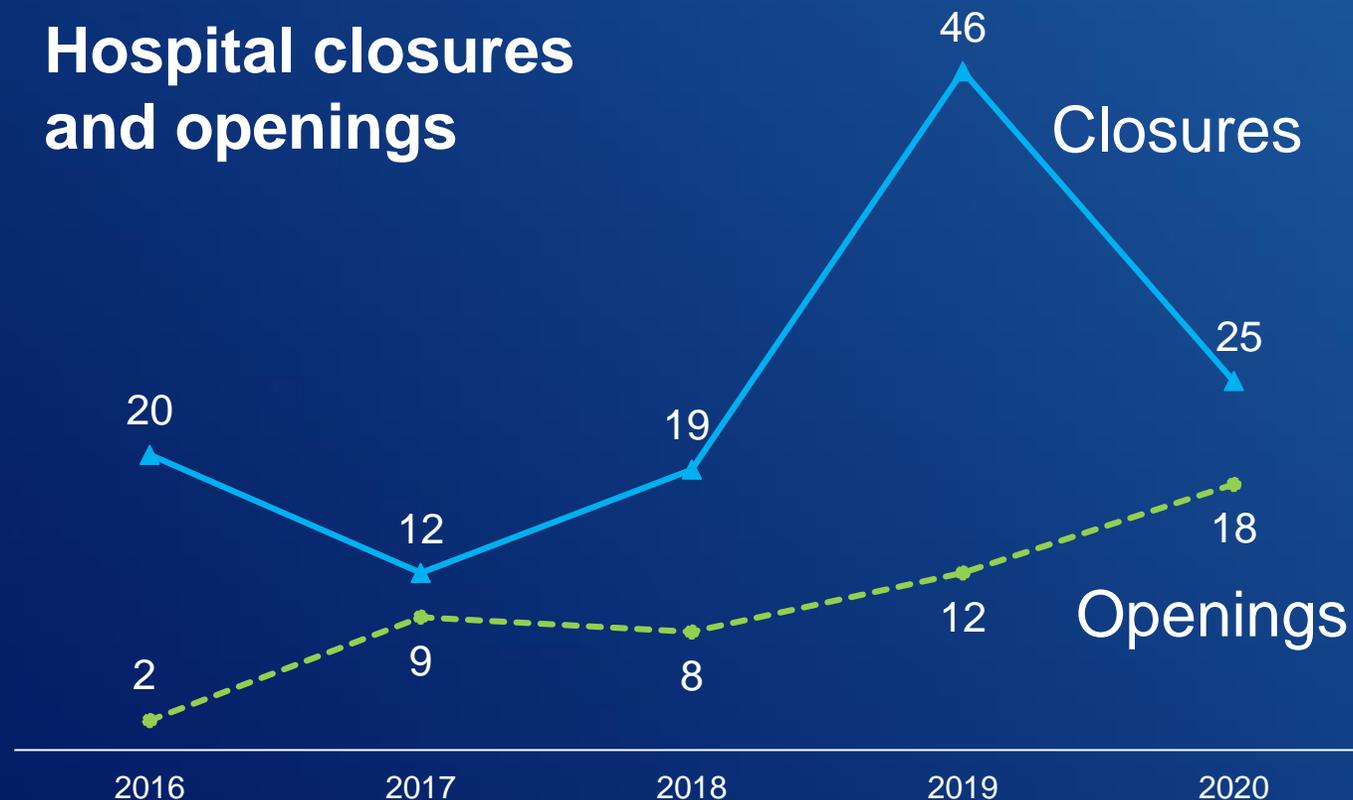
**8%+**  
marginal profit

→ *Hospitals with excess capacity have financial incentive to serve FFS Medicare beneficiaries*

Note: FFS (fee-for-service). Occupancy rate is across all short-term acute care hospitals in the United States. If we approximate marginal cost as total Medicare costs minus fixed building and capital costs, then marginal profit can be calculated as follows:  $\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and capital costs})) / \text{payments for Medicare services}$ . This comparison is a lower bound on the marginal profit. Marginal profit is calculated on inpatient stays and outpatient services.

# Access to care: Fewer hospital closures in 2020 after 2019 peak, but continued to exceed openings

## Hospital closures and openings



### 2020 closures

- Average occupancy: 35%
- Average beds: 102
- Average distance to nearest hospital: 11.6 miles

Notes: Hospital closures defined as cessation of Medicare beneficiaries' access to inpatient services at a short-term acute care hospital or critical access hospital. The figure does not include the relocation of inpatient services from one hospital to another under common ownership within ten miles, nor does it include hospitals that both opened and closed within a five-year time period. The number of hospital closures and openings in a given year can change over time as hospitals re-open or dates of closure are updated. Year is fiscal year.

# Access to care: Shift from inpatient to outpatient services continued in 2019

**-1.9%**

**inpatient stays per capita**

- Continuation of a long-term trend of decreasing inpatient stays per capita

**+0.7%**

**outpatient services per capita**

- Continued shift of complex surgical procedures from inpatient to outpatient
- Continued, but slowed, hospital acquisitions of physician practices

Note: Inpatient stays per capita refers to per fee-for-service (FFS) Medicare Part A beneficiaries, and outpatient services per capita refers to per FFS Medicare Part B beneficiaries. Year is fiscal year for inpatient stays and calendar year for outpatient services.

# Quality of care: Key indicators improved modestly or remained stable in 2019

Risk-adjusted mortality rate continued to decline



Risk-adjusted readmission rate continued to decline



Patient experience remained stable

73% of patients rated overall hospital experience a 9 or 10 out of 10

→ *MedPAC has a standing recommendation for a single, outcomes-focused quality incentive program based on our principles for quality measurement*

Note: Mortality rate is percent of beneficiary deaths during an inpatient stay or within 30 days of discharge. Readmission rate is percent of inpatient stays where the beneficiaries are readmitted for an unplanned inpatient stay within 30 days from initial discharge. Risk-adjusted values differ from the March 2020 Report to the Congress because of a change in the baseline years and version of grouper used to calculate expected results. Readmission rate also differs because of an update to the definition of unplanned admissions. Year is fiscal year.

# Access to capital: Hospitals' all-payer margin reached record highs in 2019

## All-payer margin (%)



## Other indicators remained strong

\$26B construction

\$23B bonds

71 acquisitions

Steady employment

# Medicare payments and costs: Increased profitability on IPPS services and UC payments in 2019

IPPS	IPPS: UC	OPPS
+3.3% payments per stay	+22% uncompensated care payments (+\$1.5 B)	+5.4% payments
+3.2% costs per stay		+5.7% costs

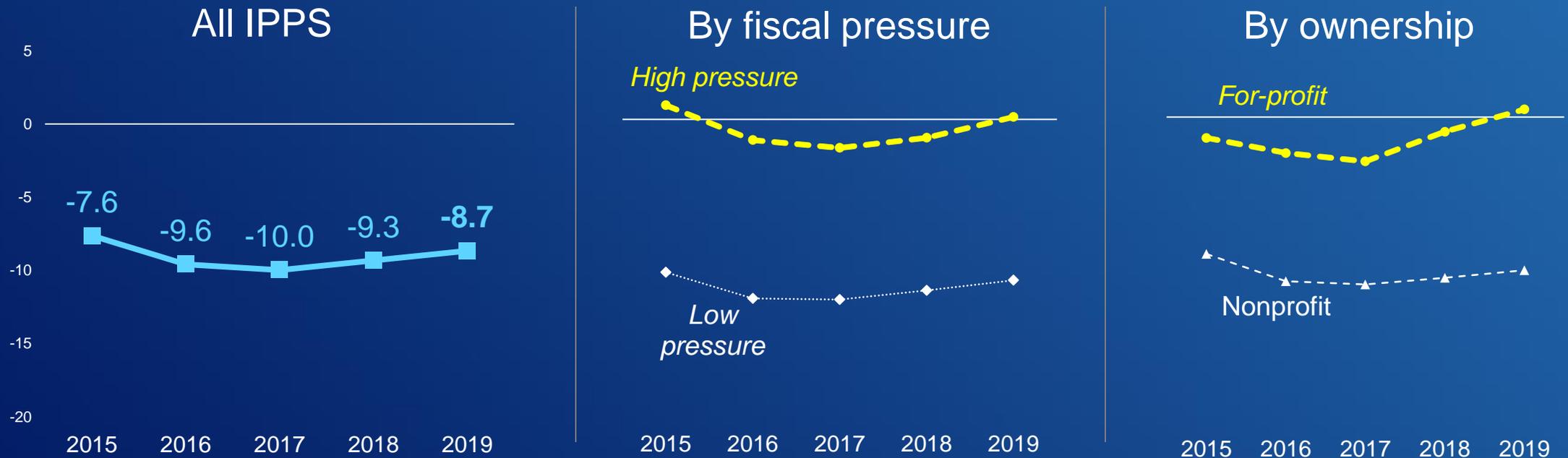
→ *Faster growth in payments than costs primarily from overestimate of input price inflation (2.9% vs. 2.4%)*

→ *Increase driven by 16% increase in uninsured rate*

→ *Slower growth than prior years from slowed conversion of ASCs and physician offices to HOPDs, and the number of drugs with expiring pass-through status*

# Medicare payments and costs: Overall Medicare margin at IPPS hospitals increased in 2019

## Overall Medicare margin increased, and variation continued



Note: IPPS (inpatient prospective payment system). A margin is calculated as payments minus costs, divided by payments; a margin is based on Medicare-allowable costs. Analysis includes IPPS hospitals in the United States with complete cost reports and non-outlier cost per stay data. Overall Medicare margin covers acute inpatient, outpatient, hospital-based home health and skilled nursing facility (including swing beds), and inpatient psychiatric and rehabilitation services, plus graduate medical education.

# Medicare payments and costs: Relatively efficient hospitals had better performance and margin in 2019

	Hospital group	
	Relatively efficient (N=224)	Other (N=1,249)
<b>Performance relative to national median (2016-2018)</b>		
Mortality rate (risk-adjusted, 30 day)	10% lower	1% higher
Readmission rate (risk-adjusted, 30 day)	8% lower	1% higher
Medicare costs per discharge (standardized)	9% lower	3% higher
<b>Median margin (2019)</b>		
Overall Medicare margin	<b>-1%</b>	-7%
Non-Medicare margin	9%	9%
Total (all-payer) margin	7%	6%

Note: Relative values are the median for the group as a share of the median of all hospitals. Per case costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the 3M methodology to compute risk-adjusted mortality for all conditions. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) due to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and risk-adjusted quality metrics.

# Starting in 2020, current law updates to IPPS and OPPS rates increase substantially

	2019	2020	2021	2022*
Inpatient operating market basket	2.9%	3.0%	2.4%	2.8%*
Productivity offset	-0.8	-0.4	0	-0.1*
Budgetary reduction	-0.75	0	0	0
<b>Annual update</b>	<b>1.35%</b>	<b>2.6%</b>	<b>2.4%</b>	<b>2.7%*</b>
Additional statutory increase (IPPS only)	0.5	0.5	0.5	0.5

*\*2022 estimate based on CMS Q2-2020 forecasts from CMS; forecasts used to set actual update will be revised to reflect most recent economic data at the time the final rule is published in summer 2021.*

Note: IPPS (inpatient prospective payment system). OPPS (outpatient prospective payment system). Final net update to base rates will also reflect budget neutrality adjustments. Separate updates to inpatient capital base rate not shown.

# Effect of pandemic on hospital services

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- Inpatient and outpatient volume declined in April 2020, followed by partial Summer rebounds, and then a spike in coronavirus cases this Fall; 2021 uncertain
  - Quality uncertain, as collection of data suspended
  - Hospitals access to capital remained strong in aggregate in part due to federal support
  - Medicare payments and costs per stay increased
- We do not anticipate any long-term changes that will persist past the end of the public health emergency*

# Mandated report: Expanding the post-acute care transfer policy to hospice

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- The post-acute care (PAC) transfer policy reduces IPPS payments for short stays followed by transfer to PAC
- Starting in 2019, hospice was added to list of PAC settings to which transfer policy applies
- Final results:
  - Savings to Medicare program (about \$300M in FY 2019)
  - No evidence of discernable changes in timely access to hospice care

Note: IPPS (inpatient prospective payment system).

Source: MedPAC analysis. Results are preliminary and subject to change.

# Considerations for the Chair's draft recommendation

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- Maintain payments high enough to ensure beneficiaries' access to care
- Maintain payments close to hospitals' cost of efficiently providing high-quality care
- Maintain fiscal pressure on hospitals to constrain costs
- Minimize differences in payment rates for similar services across sites of care

*→ To the extent coronavirus public health emergency continues, any needed additional financial support should be separate from annual update and targeted to affected hospitals that are necessary for access*