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

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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
Medicare hospital spending in 2013

- Inpatient (PPS and CAH) — $118 billion
- Outpatient (PPS and CAH) — $49 billion
- Spending growth per capita 2012-2013
  - Inpatient −1.3%
  - Outpatient +5.5%
  - Total 0.8% (weighted average of inpatient and outpatient)

Source: Medicare cost reports

Preliminary data subject to change
Access to care remains good

- Overall demand for hospital services is stable
  - Inpatient use falling (-4%)
  - Outpatient use rising (+4%)
- Excess inpatient capacity growing
  - Occupancy down to 60 percent
  - Occupancy varies by market
Bond and equity markets see hospitals as attractive investments

- Access to bond markets is good for most hospitals
  - Interest rates down to 3.6 percent for AA 30-year municipal bond
  - Most bond ratings stable
    - 319 remained unchanged
    - 37 downgrades
    - 27 upgrades

- Access to equity markets is good
Quality of care improving

- In-hospital and 30-day mortality rates declined or were stable from 2010 to 2013 for five prevalent conditions
  - AMI, CHF, stroke, hip fracture, pneumonia
- Patient safety indicators improved or stable
  - Lower rates of central catheter-related infections, post-operative pulmonary embolisms
- Readmission rates decreased, concurrent with start of readmissions payment penalty
Hospital cost growth down from historical averages

- Hospital input price inflation has slowed
  - 2004 to 2008 averaged 3.7%
  - 2010 to 2013 averaged 2.2%
  - No longer growing faster than economy-wide inflation

- Hospital cost increases closer to hospital input price inflation
  - 2004 to 2008 cost growth more than a percentage point higher than input price inflation
  - 2010 to 2013 cost growth close to input price inflation
## Overall Medicare margins steady through 2013

<table>
<thead>
<tr>
<th>Medicare Margin</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Medicare</td>
<td>–5.3%</td>
<td>–4.8%</td>
<td>–5.4%</td>
<td>–5.4%</td>
<td>–5.4%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>–2.3</td>
<td>–1.8</td>
<td>–3.4</td>
<td>–4.4</td>
<td>–5.3</td>
</tr>
<tr>
<td>Outpatient</td>
<td>–11.4</td>
<td>–10.7</td>
<td>–10.6</td>
<td>–11.1</td>
<td>–12.4</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>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td>-5.4%</td>
</tr>
<tr>
<td>Urban</td>
<td>-5.9</td>
</tr>
<tr>
<td>Rural PPS</td>
<td>0.2</td>
</tr>
<tr>
<td>Rural with CAH</td>
<td>1.2</td>
</tr>
<tr>
<td>Major teaching</td>
<td>-3.0</td>
</tr>
<tr>
<td>Other teaching</td>
<td>-5.3</td>
</tr>
<tr>
<td>Non-teaching</td>
<td>-6.8</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>-6.9</td>
</tr>
<tr>
<td>For-profit</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Source: Medicare cost reports

Preliminary data subject to change
All-payer margins reach a record high

Margin

2005 2006 2007 2008 2009 2010 2011 2012 2013

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 (2010, 2011, 2012), and
- Cannot be in the worst third in any year for risk-adjusted mortality, inpatient costs per case, or readmission rates
## Comparing 2013 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>266</td>
<td>1,866</td>
</tr>
<tr>
<td>30-day mortality (rel. to avg.)</td>
<td>16% lower</td>
<td>2% 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>Readmissions</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Note: Hospitals are classified as efficient based on 2010 to 2012 performance. In this slide, 2013 medians for each group are compared to the national median.

Source: Medicare cost reports, claims data, and hospital compare.
Last year’s payment adequacy discussion

- Payment adequacy indicators were very similar
- Recommendation package
  - Update of +3.25 percent
  - Reduce or eliminate differences between hospitals and physician offices for selected outpatient services
  - Long-term care hospital (LTCH) payments reduced with savings redistributed to increase outlier payments to IPPS hospitals
Outpatient growth reflects distortions in the hospital payment system

- Hospitals paid more than physician offices for many services that can safely be performed in physician offices.
- Market share is shifting to hospitals (the higher-cost setting). For example, in 2013 hospitals billed for 7% more echocardiograms while volume in physician offices fell by 8%.
- For the set of 66 APCs discussed last year (e.g., echocardiograms), payments were $1.44 billion higher.
  - Medicare program paid $1.2 billion more
  - Beneficiaries paid $240 million more in coinsurance
Reforming Long-term care hospital (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