

Assessing payment adequacy: hospital inpatient and outpatient services

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Three hospital payment questions

- Payment adequacy – what should the update be in 2013 to make aggregate payments adequate?
- Are rural payments adequate relative to urban payments?
- Are hospital payment rates for E&M outpatient office visits in OPDs appropriate given the rates paid for visits in free-standing offices?

Payment adequacy indicators

- Beneficiaries' access to care
 - Capacity and supply of providers
 - Volume of services
- Quality of care
- Access to capital
- Payments and costs
 - For average providers
 - For relatively efficient providers
 - For rural providers (PPACA mandate)

Background

- Update recommendations for hospital acute inpatient and outpatient services in 2013
- Medicare spending in 2010:
 - Inpatient FFS —\$116 billion
 - Outpatient FFS —\$37 billion
 - Total spending per FFS beneficiary grew 3.5 percent from 2009 to 2010
 - Inpatient grew 2 percent
 - Outpatient grew 8 percent

Capacity, capital, and service volume

- Capacity and supply are growing
- Access to capital is adequate
- Medicare outpatient volume increased by 4 percent per year from 2004 to 2010
- Medicare inpatient volume declined by 1 percent per year from 2004 to 2010

Quality of care metrics are either improving or remain steady

- 30-day mortality and patient safety measures generally improved (2007 to 2010)
- Patient satisfaction improved slightly
- However, readmission rates have not changed significantly, readmission penalties will start in 2013

Why are payments up and cost growth down in 2010?

- Payments per discharge rose 2.5 percent
 - 2.1 percent operating update
 - Documentation and coding changes
- Growth in cost per discharge slowed to 2 percent (lowest since 1998)
 - Low inflation in input prices
 - Increased financial pressure at the start of 2009

Margins improved due to documentation changes and slower cost growth

Medicare margin	2006	2007	2008	2009	2010
Overall Medicare	- 4.6%	- 6.0%	- 7.1%	- 5.1%	- 4.5%
Inpatient	- 2.2	- 3.7	- 4.7	- 2.3	- 1.7
Outpatient	-11.0	-11.5	-12.7	-10.7	-9.6

Note: Margins = (payments – costs) / payments; excludes critical access hospitals.

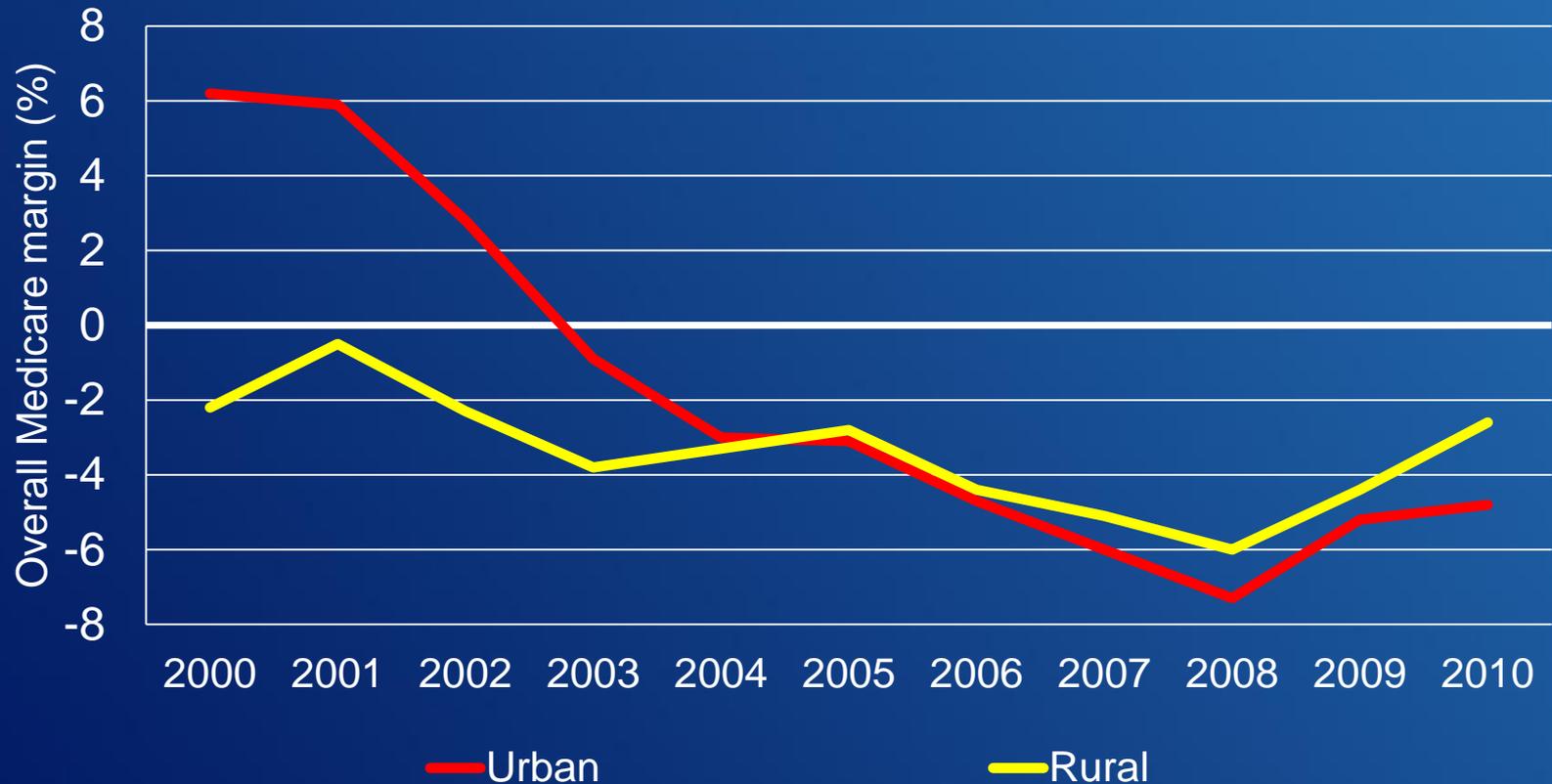
Source: Medicare cost reports.

Overall Medicare margin by hospital group

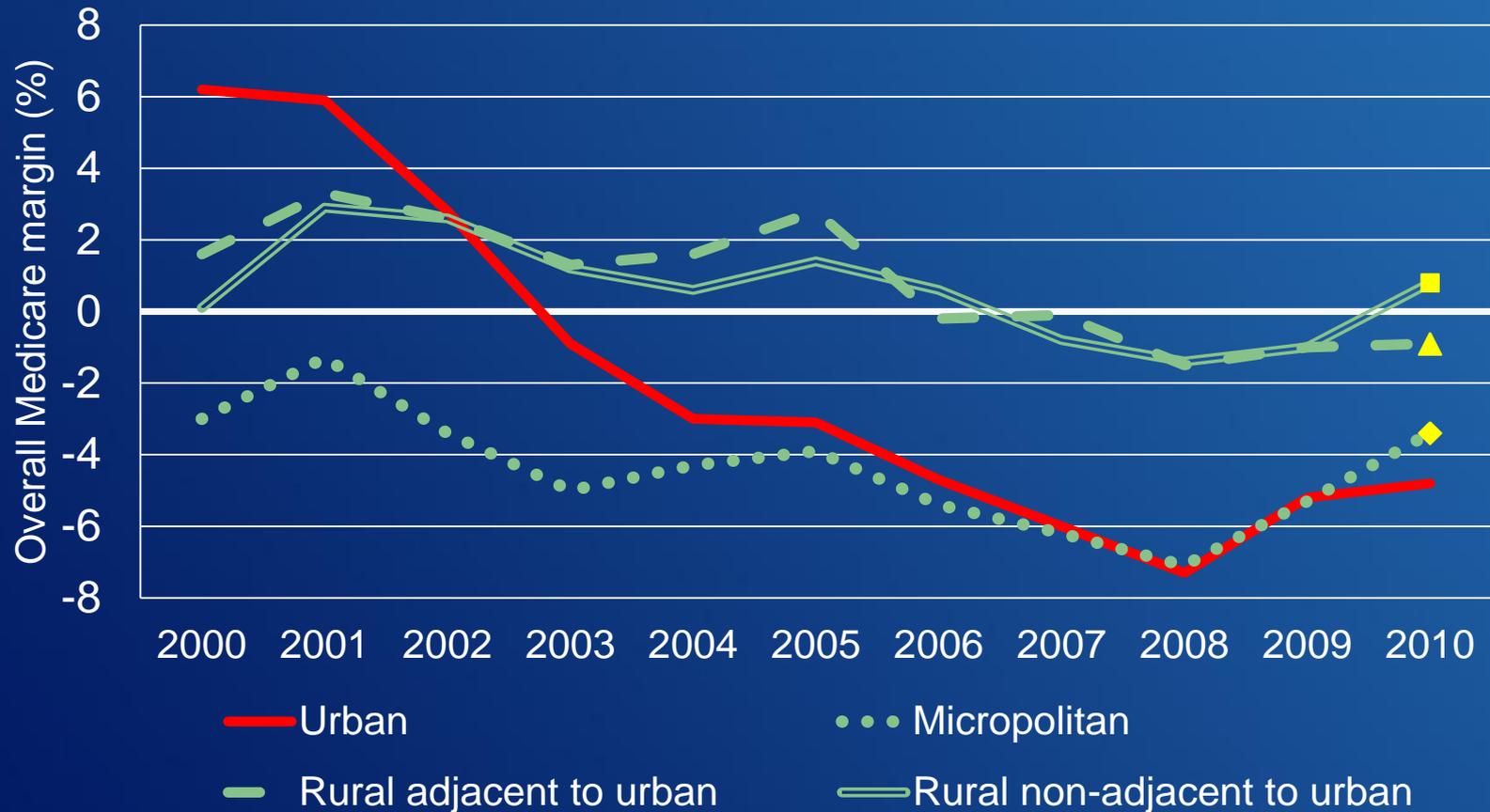
Hospital group	Share of facilities	2010
All hospitals	100%	-4.5%
Urban	71	-4.8
Rural*	29	-2.6*
Major teaching	9	-0.2
Other teaching	21	-4.5
Non-teaching	69	-7.0
Nonprofit	59	-5.7
For profit	24	0.1

* An additional 1,300 rural facilities are paid costs plus 1 percent as critical access hospitals. Rural margin including these providers is -1.7 percent.

Rural-urban overall Medicare margin gap reversed



Overall Medicare margins differ by urban and rural location



New low-volume adjustment program poorly-targeted

- Concerns with program design
 - Not all isolated, can be close to CAH
 - Not empirically based and uses only Medicare discharges
 - Duplicates SCH and MDH program payments
- Low-volume rural hospitals already have higher Medicare margins than other hospitals
 - Average inpatient margin -1.7 percent
 - Smallest 20 percent of rural hospitals average inpatient margin is 0.8 percent due to SCH/MDH add-ons
 - Low-volume adjustment would raise inpatient margin to 14.0 percent for the smallest rural hospitals

We expect cost growth to increase due to improved financial performance



Relatively efficient hospitals

- Must be in the best third on either risk-adjusted mortality **or** inpatient costs per case **every** year (2007, 2008, 2009), and
- Cannot be in the worst third in **any** year for risk-adjusted mortality, readmission rates, or costs per case

Comparing 2010 performance of relatively efficient providers to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	188	1,943
30-day mortality	17% lower	1% above
Readmission rates (3M)	5% lower	1% above
Standardized costs	11% lower	2% above
Overall Medicare margin	4%	-5%
Share of patients rating the hospital highly	69%	66%

Correcting for documentation and coding changes

- After MS-DRGs were introduced in 2008, documentation and coding changes led to increased payments without any real change in patient complexity or the cost of care
- CMS has authority to recover \$7 billion in overpayments that occurred in 2008 and 2009
- CMS needs new authority to recover \$11+ billion in overpayments from 2010 through 2012
- The commission has recommended that payment rates should be adjusted to recover all overpayments

Shift of services from free-standing practices to OPDs

- Hospitals have been increasing employment of physicians
- Many factors causing this trend
- Likely to cause billing of services to shift from free-standing practices to OPDs
- Result: Increase program spending and beneficiary cost sharing; may not change clinical aspects of care

Shift of services to OPDs is a concern because of higher payment rates

	Visit in OPD			
	Visit in freestanding practice	PFS facility rate	OPPS rate	Total payment
Program payment	\$55.18	\$39.42	\$60.10	\$99.52
Beneficiary cost sharing	13.79	9.85	15.03	24.88
Total payment	68.97	49.27	75.13	124.40

Note: Payment rates for mid-level E&M outpatient office visit (CPT code 99213) from 2011 outpatient PPS and physician fee schedule.

Equalizing total payment rates for mid-level E&M outpatient office visits across settings

	Visit in office	Visit in OPD	
		Current rates	Limit on OPPS rate
Fee schedule rate	\$68.97	\$49.27	\$49.27
OPPS rate	N/A	75.13	\$19.70
Total payment	68.97	124.40	68.97

Effect on Medicare revenue of equalizing payment for E&M outpatient office visits

Hospital group	Percent reduction in Medicare revenue
All hospitals	0.60%
Urban	0.58
Rural	0.75
Major teaching	1.21
Other teaching	0.44
Non-teaching	0.41
Nonprofit*	0.60
For-profit*	0.20
10 th percentile	0.00
90 th percentile	1.29