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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Context: Number of hospitals, payments, and volume, 2018

~4,700
short-term acute care hospitals
participating in Medicare program

~$201b
Medicare FFS payments
(+3.6% from 2017-2018)

$121b inpatient stays (+1.1%)
$69b outpatient services (+7.2%)
$11b supplemental payments (+10.4%)

~9.5m
inpatient stays
by Medicare FFS beneficiaries

~171m
outpatient services

Note: Medicare FFS payments reflect Medicare payment rates, and include payments from the Medicare program and from beneficiaries or their supplemental insurance.

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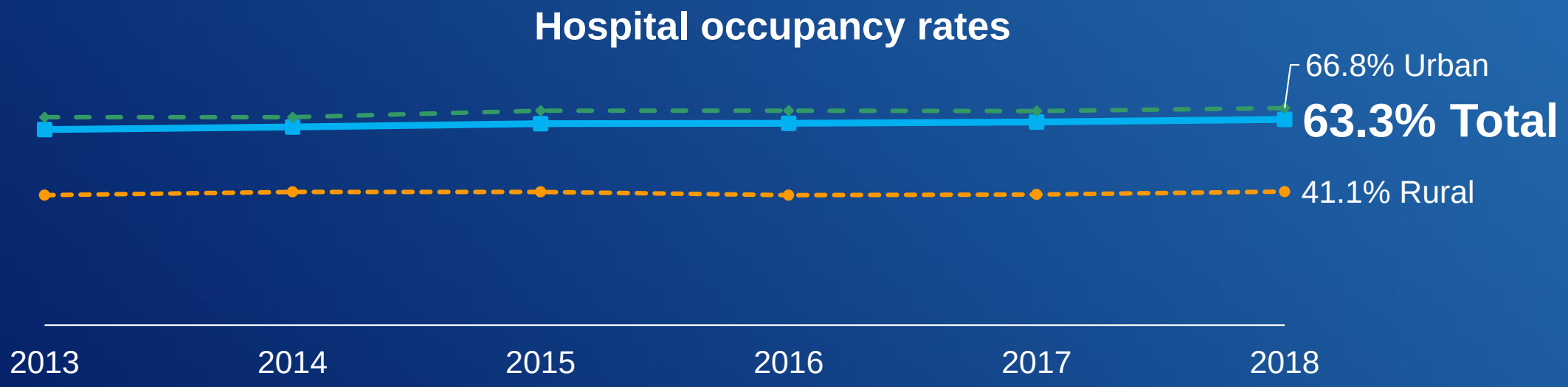
Source: MedPAC analysis of MedPAR and outpatient claims. Results are preliminary and subject to change.

Hospital payment adequacy framework

Beneficiaries' access to care	Quality of care	Hospitals' access to capital	Medicare payments and hospitals' costs
• Capacity and supply of hospitals • Volume of services • Marginal profit	• Mortality and readmission rates • Patient experience	• All payer profitability • Bonds and construction • Mergers and acquisitions • Employment	• Payments and costs • Overall Medicare margins among all and efficient hospitals • Projected overall Medicare margins

Update recommendation for IPPS and OPPS base rates

Access to care: Excess inpatient capacity persisted in 2018, especially in rural areas



Given excess inpatient capacity, some hospitals have sought to reduce inpatient capacity and replace it with outpatient capacity

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

Access to care: Decrease in inpatient stays per capita and increase in outpatient services in 2018

-1.6%
inpatient stays per capita

+0.7%
outpatient services per capita

-0.3%
FFS beneficiaries

➔ 3.6% increase in hospital payments not driven by increases in volume of hospital services, but rather from increases in:

- prices (including higher-cost sites of care),
- intensity of services (e.g. higher reported case mix), and
- supplemental payments

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Source: MedPAC analysis of MedPAR and outpatient claims. Results are preliminary and subject to change.

Access to care: Hospital closures increased in 2018 and 2019, as some struggle with low occupancy

Hospital closures and openings

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.

2018 and 2019 closures:

- Average occupancy: 26%
- Average beds: 106
- Average distance to nearest hospital: 12 miles

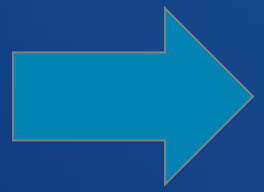
➔ The Commission previously recommended allowing isolated rural hospitals with low inpatient volume to convert to rural stand-alone emergency departments (June 2018)

Source: MedPAC analysis of the CMS Provider of Services file, internet searches, and personal communication with the Department of Health and Human Services Office of Rural Health Policy. Results are preliminary and subject to change.

Access to care: Medicare marginal profit continued to be positive in 2018

8%+

marginal profit across hospital service lines in 2018, on average



Incentive for hospitals with excess capacity to serve more Medicare beneficiaries

Note: If we approximate marginal cost as total Medicare costs minus fixed building and capital costs (interest, depreciation, insurance, equipment, plant maintenance, utilities and operating costs) then marginal profit can be calculated as follows: Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and capital costs)) / payments for Medicare services. This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.

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Source: MedPAC analysis of cost report data from CMS. Results are preliminary and subject to change.

Quality of care: Key indicators improved modestly or remained stable, 2016-2018

Between 2016 and 2018:

Risk-adjusted mortality declined modestly
All condition 30-day mortality rate: 6.7% to 6.1%

Risk-adjusted readmissions declined modestly
All condition 30-day readmission rate: 14.0% to 13.7%

Patient experience remained high
73% rated overall hospital experience 9 or 10 out of 10

➔ The Commission recommended a single, outcome-focused quality incentive program (HVIP) based on our principles for quality measurement (March 2019)

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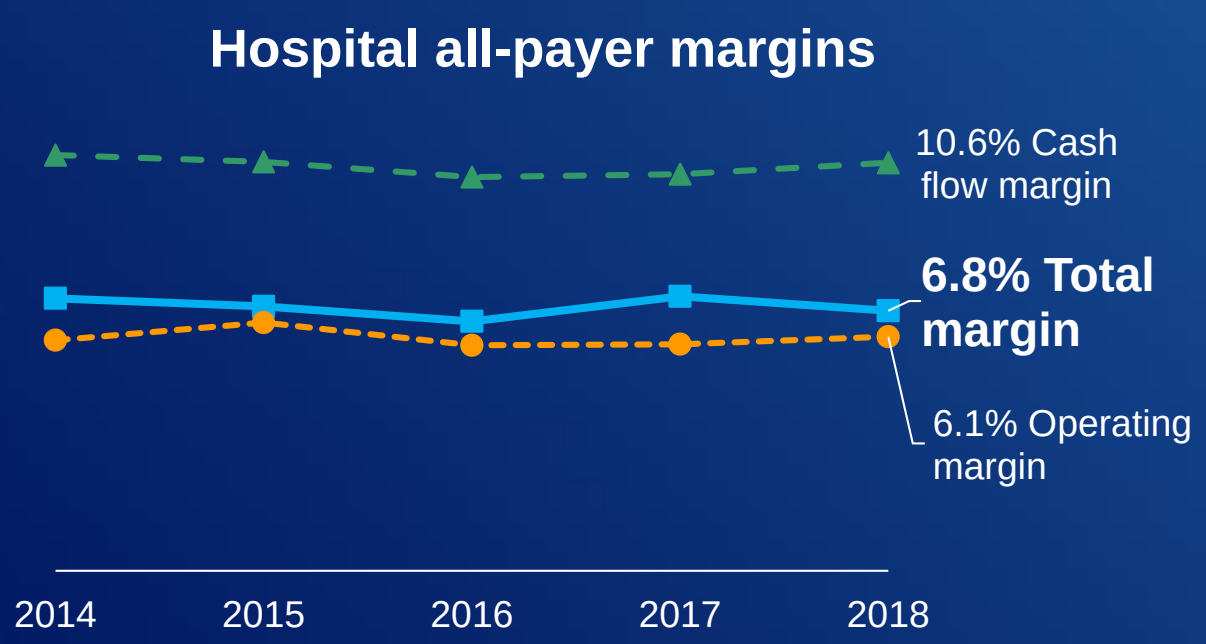
Source: MedPAC analysis of Medicare claims and Hospital Compare data. Results are preliminary and subject to change

Access to capital: Hospitals' all-payer profitability remained strong in 2018, as did other indicators

All-payer margins remained strong

- For-profit all-payer margin at all-time high of 11.3%



Note: Analysis includes IPPS hospitals in the United States with complete cost reports and non-outlier cost per stay data.

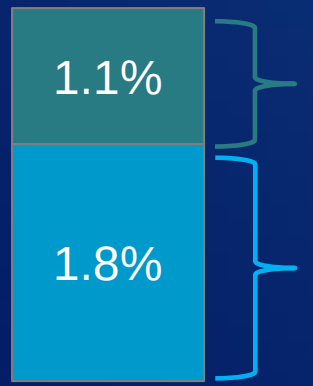
Other indicators of access to capital remained strong

- $23b bonds
- $25b construction
- 79 acquisitions
- +8.1% employment

Source: MedPAC analysis of cost report data from CMS. Results are preliminary and subject to change.

Medicare payments and costs: IPPS payments per stay grew faster than costs per stay in 2018

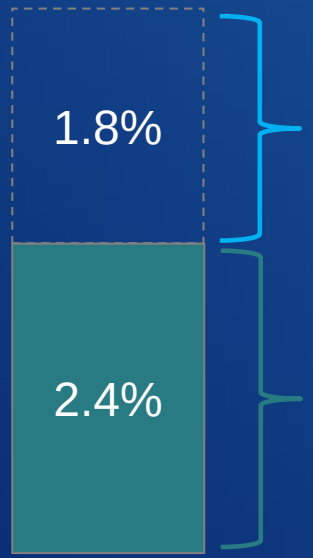
2.9% growth in IPPS payments per stay



growth in IPPS base rates

growth in reported case mix

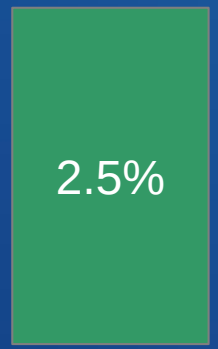
4.2% growth in reported case mix and input prices



growth in reported case mix

growth in input prices

2.5% growth in IPPS costs per stay



≈ input price inflation, despite growth in reported case-mix

➔ Suggests combination of more extensive coding of diagnoses and/or improvements in productivity

Source: MedPAC analysis of IPPS final rules, MedPAR claims, and cost reports for IPPS hospitals. Results are preliminary and subject to change.

Medicare payments and costs: OPPS payments grew in 2018, driven by drugs and shift to HOPDs

7.2% growth in OPPS payments in 2018, driven by

- Part B drug price increases and new, expensive drugs
- Shift of services from physician offices to HOPDs, as hospitals continue to acquire physician practices
- Shift of some complex services from inpatient to outpatient

➔ The Commission previously recommended reducing or eliminating differences in payments rates between HOPDs and physician offices (March 2012, 2014)

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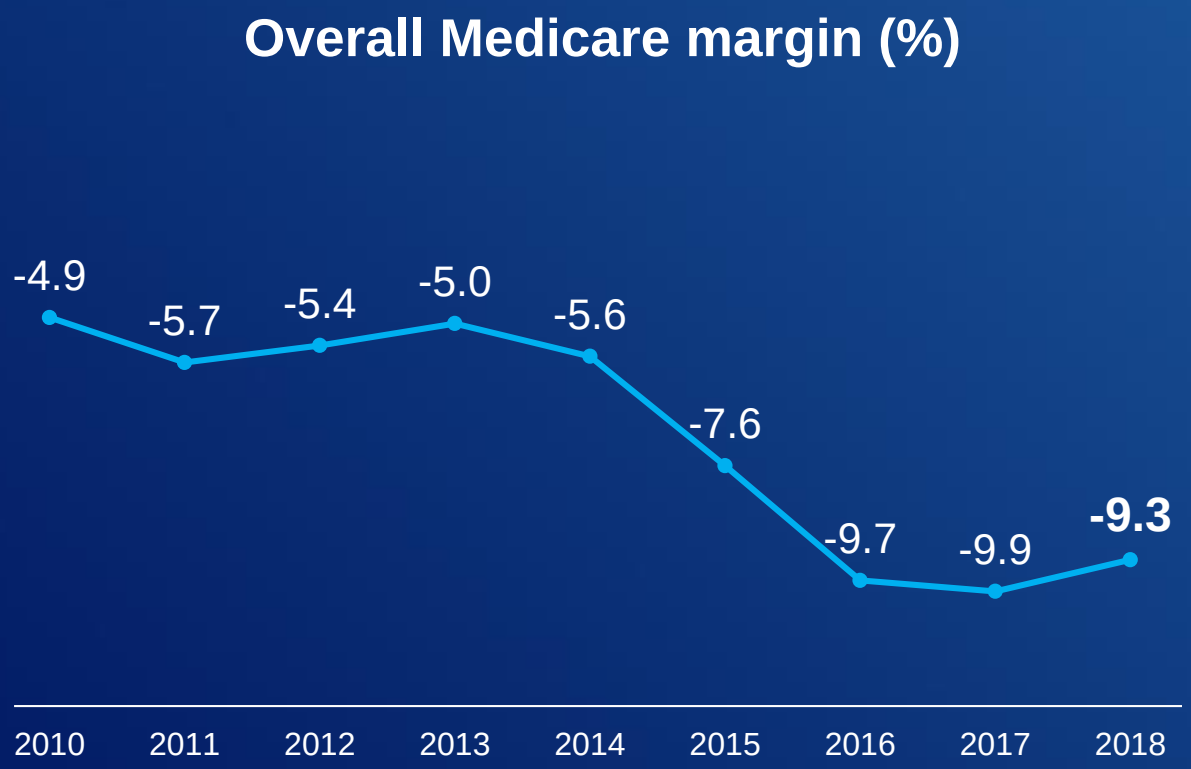
Source: MedPAC analysis of outpatient claims for OPPS hospitals. Results are preliminary and subject to change.

Medicare payments and costs: Overall Medicare margin at IPPS hospitals increased in 2018



- 2017-2018 increase in Medicare margin likely due to:
  - CMS overestimate of input price inflation
  - More extensive coding of diagnoses and improvements in efficiency
  - Increased revenue from Part B drugs

Note: A margin is calculated as payments minus costs, divided by payments; margins are 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.

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Source: MedPAC analysis of cost report data from CMS. Results are preliminary and subject to change.

Medicare payments and costs: Medicare margins varied but increased for most hospital groups in 2018

	Overall Medicare margin (%)	
	2017	2018
All	-9.9	-9.3
Urban	-10.0	-9.6
Rural	**-8.2**	**-6.6**
Nonprofit	-11.0	-10.6
For-profit	**-2.6**	**-0.9**

- Rural hospitals had higher Medicare margins and a larger increase than urban hospitals
- For-profit hospitals continued to have highest Medicare margins of all groups

Note: A margin is calculated as payments minus costs, divided by payments; margins are 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.

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Source: MedPAC analysis of cost report data from CMS. Results are preliminary and subject to change.

Medicare payments and costs: Relatively efficient hospitals had better performance and margins

	Hospital group	
	Relatively efficient (N=266)	Other (N=1,612)
Performance relative to national median (2015-2017)		
Mortality rate (risk-adjusted, 30 day)	10% lower	1% higher
Readmissions rate (risk-adjusted, 30 day)	7% lower	1% higher
Medicare costs per discharge (standardized)	9% lower	3% higher
Median margins (2018)		
Overall Medicare margin	**-2%**	-8%
Non-Medicare margin	9%	9%
Total (all-payer) margin	7%	5%

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.

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Source: MedPAC analysis of cost report and claims-based quality data from CMS. Results are preliminary and subject to change.

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

	2019	2020	2021*
Inpatient operating market basket	2.9%	3.0%	**3.2%**
Adjustment for productivity	-0.8	-0.4	**-0.4**
Other statutory adjustments	-0.75	0	**0**
Annual update	1.35%	2.6%	**2.8%**

**2021 estimate based on CMS Q2-2019 forecast from CMS; forecast used to set actual update will be revised to reflect most recent economic data at the time the final rule is published in August 2020.*

Note: Final net update to base rates will also reflect budget neutrality adjustments and other statutory updates (e.g. coding). Updates to inpatient capital base rate not shown.

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Source: MedPAC analysis of IPPS final rules and market basket forecasts from the Office of the Actuary. Results are preliminary and subject to change.

Summary: Hospital payment adequacy indicators generally positive

Beneficiaries' access to care	Quality of care	Hospitals' access to capital	Medicare payments and hospitals' costs
• Excess capacity, but increase in closures • Slowing change in volume • Positive marginal profits	• Risk-adjusted mortality and readmissions improved modestly • Patient experience stable	• Strong all-payer profit margins, near all-time high • Construction, bonds, mergers, and employment all strong	• Medicare margins improved but still negative • Efficient provider margins still negative (-2%)
Generally positive	Positive	Positive	Mixed

MEDPAC

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

Mandated report: Expanding the post-acute care transfer policy to hospice, preliminary results

- 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
- Preliminary results: Small savings without significant changes in timely access to hospice care
- Final evaluation due in March 2021

MEDPAC

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

Considerations for the Chairman's draft recommendation

- Maintain payments high enough to maintain access to care
- Maintain a level of financial pressure on hospitals to limit cost growth
- Minimize differential in payment rates across sites of care (e.g., on-campus versus off-campus provider payments)
- Reward high-performing hospitals
- Move Medicare payments toward the cost of efficiently providing high-quality care