Advising the Congress on Medicare issues

Assessing payment adequacy: hospital inpatient and outpatient services

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December 15, 2011

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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

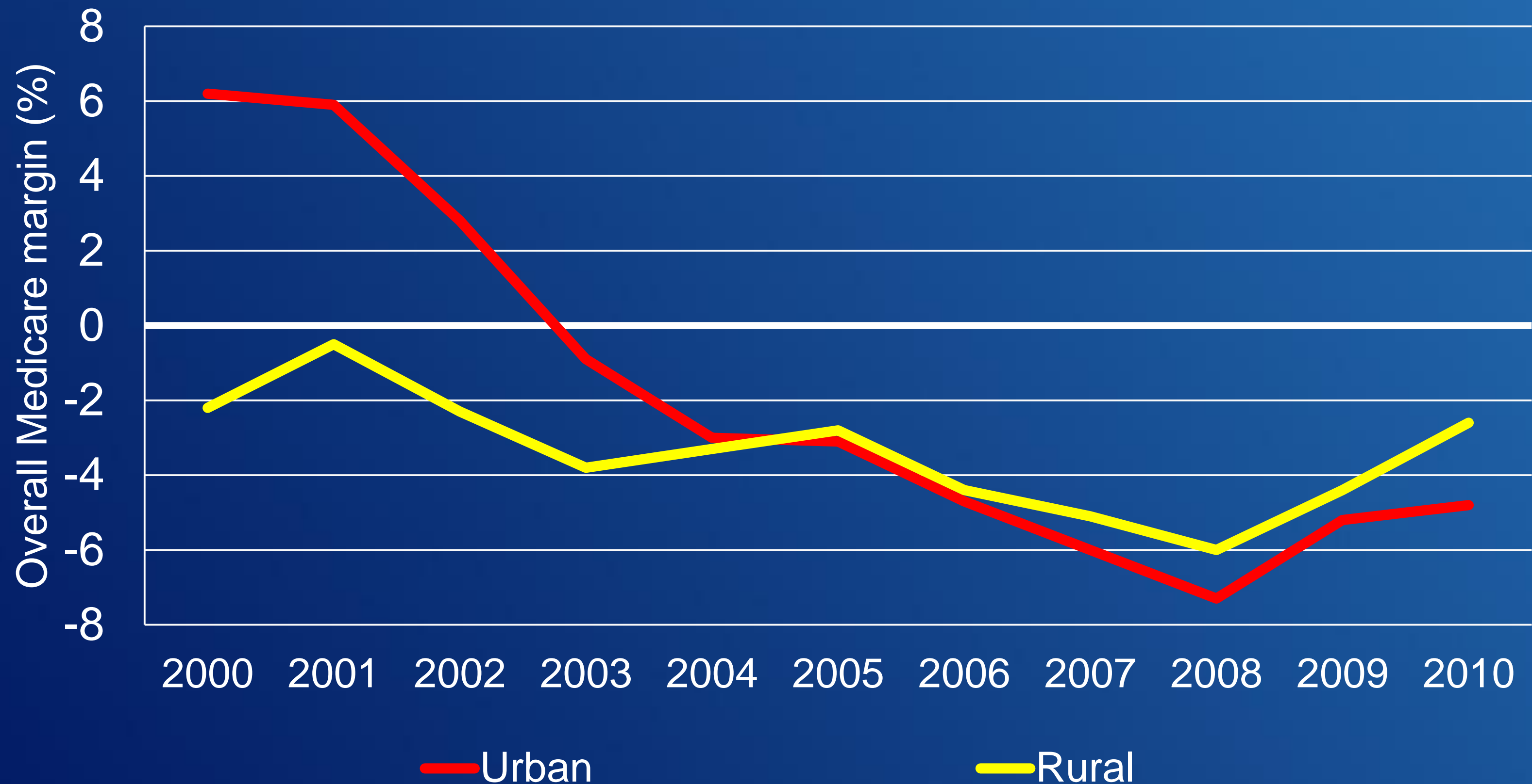
Note: Margins = (payments – costs) / payments; excludes critical access hospitals.
Source: Medicare cost reports.

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

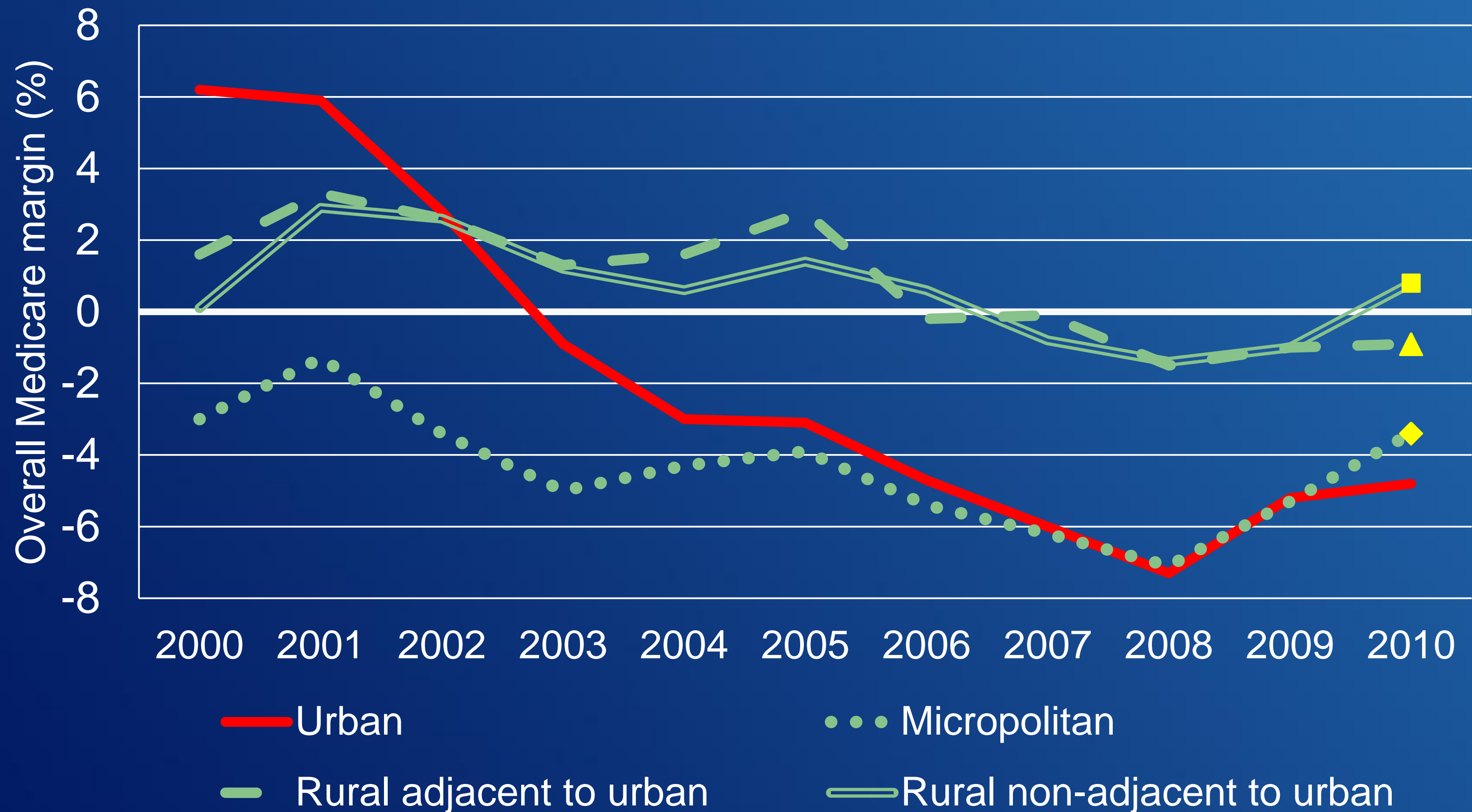
* An additional 1,300 rural facilities are paid costs plus 1 percent as critical access hospitals. Rural margin including these providers is -1.7 percent.

Rural-urban overall Medicare margin gap reversed



Preliminary data subject to change

Overall Medicare margins differ by urban and rural location



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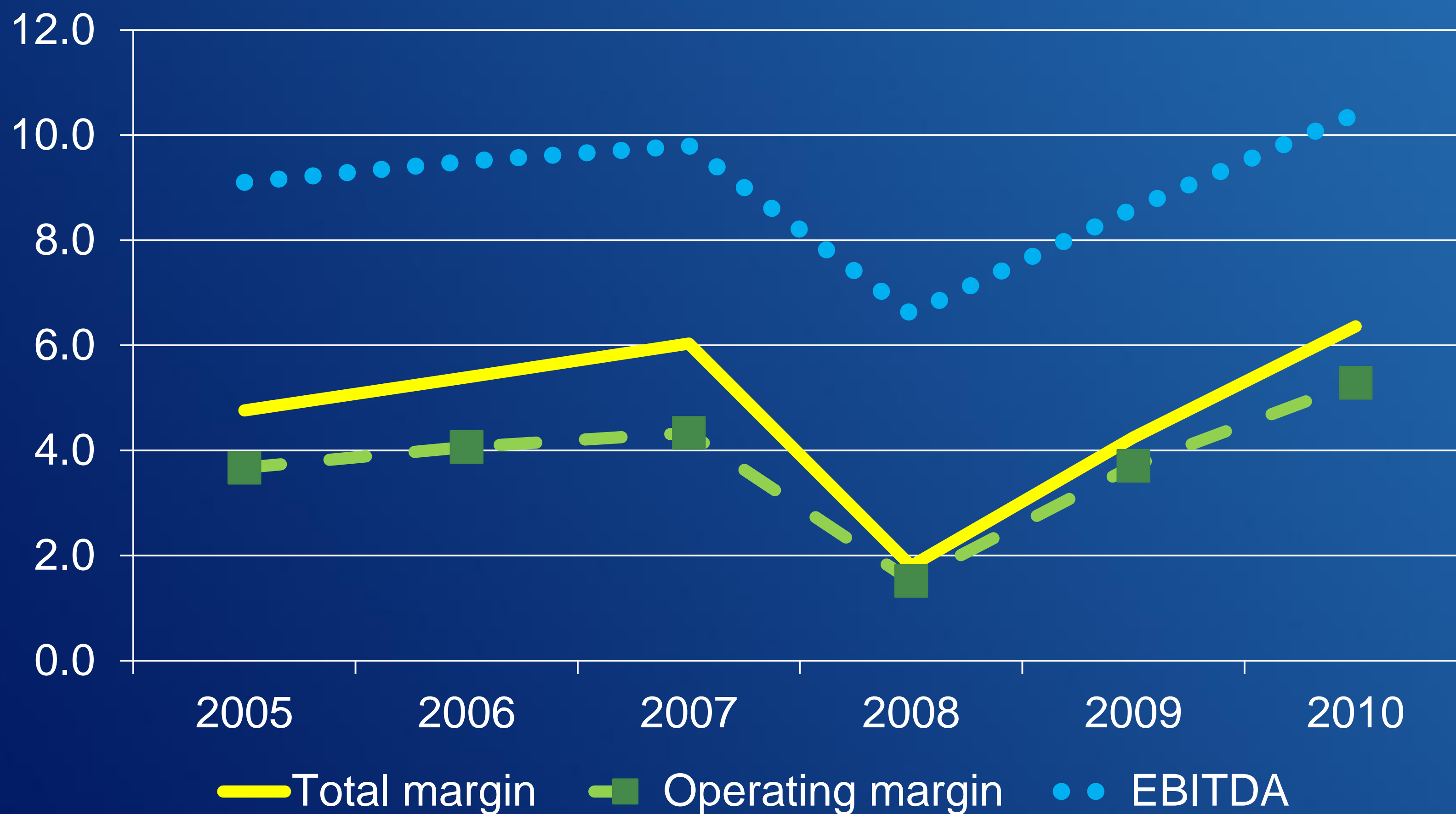
New low-volume adjustment program poorly-targeted

- 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



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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%

Note: medians for each group are compared to the national median

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 freestanding practice	Visit in OPD		
		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.

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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**

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Note: Payment rates are for CPT 99213 from 2011 outpatient PPS and physician fee schedule.

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
10th percentile	0.00
90th percentile	1.29

* The ownership grouping excludes government hospitals.

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