Advising the Congress on Medicare issues

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

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MEDPAC

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

Access to care remains strong

- Excess supply of beds in most markets
- Overall Medicare volume down 2 percent
  - Inpatient down 4.5 percent
  - Outpatient up 4.3 percent
  - Decline in volume due to less demand, not capacity constraints
- Access to capital is adequate
  - Equity markets: hospital stocks up 30 to 70% in 2013
  - Bond markets: Mostly stable, some downgrades due to patient volume and future liquidity needs

Quality of care generally improving

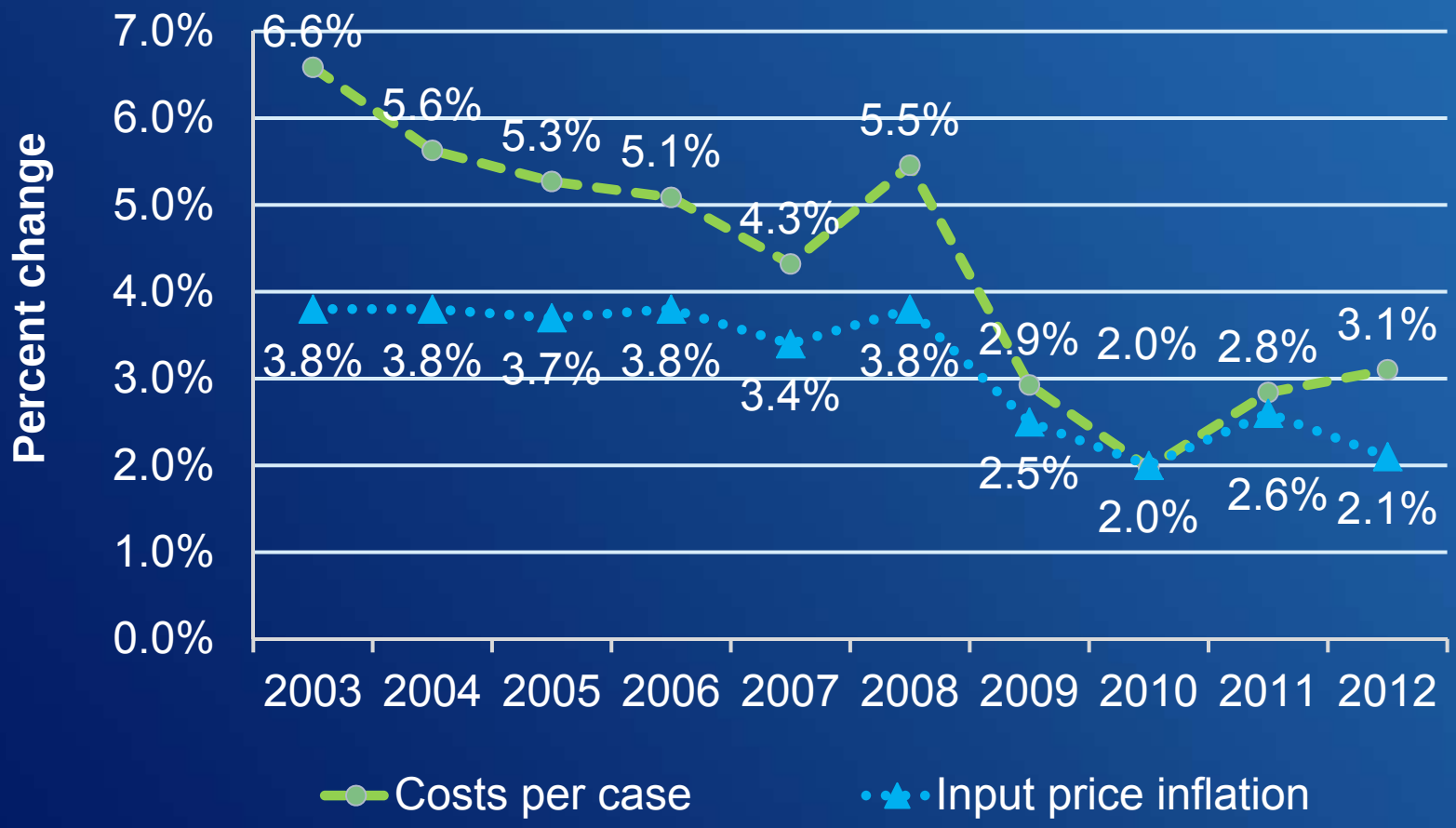
- 30-day mortality measures improved
- Patient safety measures mostly improved
- Readmission rates improved slightly

Medicare hospital spending in 2012

- Inpatient (PPS and CAH) —$120 billion
- Outpatient (PPS and CAH) —$46 billion
- Spending growth per capita 2011-2012
  - Inpatient −2.3%
  - Outpatient +7.0%
  - Total 0.3% (weighted average of inpatient and outpatient)

Source: Medicare cost reports

Hospital cost growth per case came down close to input price inflation



Source: Medicare cost reports

Margins are steady through 2012

Medicare margin	2008	2009	2010	2011	2012
Overall Medicare	– 7.3%	– 5.4%	– 4.7%	– 5.5%	– 5.4%
Inpatient	– 4.7	– 2.4	– 1.7	– 3.6	– 4.4
Outpatient	–13.6	–11.4	–10.5	–10.5	–11.2

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

Hospital group	2012
All hospitals	–5.4%
Urban	–5.8
Rural PPS	–1.9
Rural with CAH*	–0.3*
Major teaching	–2.6
Other teaching	–5.2
Non-teaching	–7.3
Nonprofit	–7.1
For-profit	1.5

Note: *CAHs are paid cost plus 1% and are only included in this line
Source: Medicare cost reports

Medicare margins are expected to decline slightly by 2014

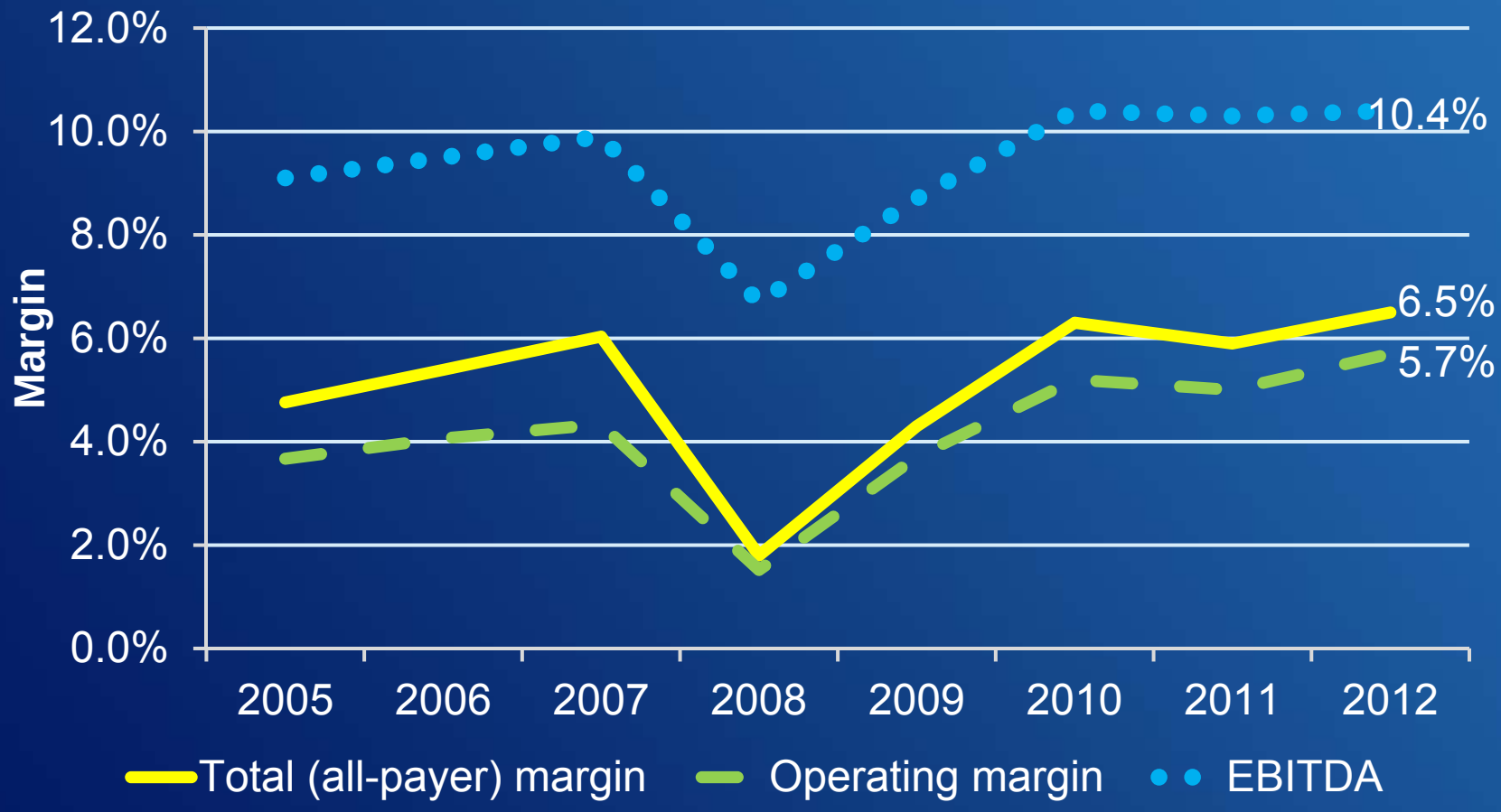
	2012	2014
Aggregate overall Medicare margin	–5.4%	–6.0%

Why do we expect margins to decline slightly by 2014?

- Payment rate updates and case mix growth will increase revenue
- Cost growth is expected to be slightly larger than updates
- Expiration of certain special payments will offset increases in HIT payments

Source: Medicare cost reports, claims files, and FY 2013 impact file.

All-payer margins reach a record high



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 (2009, 2010, 2011), and
- Cannot be in the worst third in **any** year for risk-adjusted mortality, inpatient costs per case, or readmission rates

Comparing 2012 performance of relatively efficient hospitals to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	302	1,831
30-day mortality (rel. to avg.)	13% lower	3% above
Standardized costs (rel. to avg.)	10% lower	2% above
Overall Medicare margin	2%	-6%
Share of patients rating the hospital highly	69%	68%

Note: Hospitals are classified as efficient based on 2009 to 2011 performance. In this slide, 2012 medians for each group are compared to the national median
Source: Medicare cost reports, claims data, and hospital compare

Summary of payment adequacy

- Access to care is strong
- Access to capital is adequate
- Quality is improving
- Medicare Margins are low for average providers
- Relatively efficient providers have been able to make a small profit on Medicare while providing relatively good quality care
- As discussed in November, revenues would fall in 2015 due to policies in current law

Reducing incentives to shift care to higher-cost settings

- Problem: current payment rates encourage providers to shift care to higher-cost sites without any evidence of improved outcomes
- Solution: remove the pricing distortions
  - OPPS: Pay hospitals rates that are comparable to physician office rates for services that can safely be provided in physician offices
  - LTCH / IPPS: Pay LTCHs acute care hospital inpatient rates for less-severely ill LTCH patients. Pay acute care hospital higher payments for the most-costly “LTCH-type” patients

Services shifting from offices to outpatient departments (OPDs)

	Change in freestanding office		Change in OPD	
Type of service	2011	2012	2011	2012
E&M office visits	-1%	-1%	8%	9%
Echocardiogram	-7	-9	18	13
Nuclear cardiology	-13	-16	14	9

Source: Medicare claims data

Preliminary data subject to change

Aligning payment rates in OPDs and freestanding offices

- Medicare and beneficiaries pay $2.1 billion more annually for E&M and other services than if OPD rates aligned with office rates
- Criteria for service to have equal rates across settings
  - More than 50% of volume in offices
  - Minimal packaging differences between settings
  - Infrequently provided with ED visit
  - Patient severity no greater in OPDs
  - Not a 90-day global code in the physician fee schedule

Services where payment rates could be equal or differences narrowed

- Group 1: 24 APCs where payment rates across settings could be equal
- Group 2: 42 APCs where payment rate differences could be narrowed; rates higher in OPDs because of more packaging in OPPS

Preliminary data subject to change

Impact on hospitals of payment changes for 66 APCs

- Adjusting payment rates in these 66 APCs
  - Reduce hospital program spending and cost sharing by $1.1 billion per year
  - Reduce hospitals' Medicare revenue by 0.6%
- Rural and small hospitals affected more
- Mitigating impact of payment rate changes
  - Illustrative example: Limit losses to 2% of overall revenue for hospitals that have DSH > median
  - 2% of hospitals qualify; $10 million returned
  - Little mitigation effect, many of the most affected hospitals have low DSH or are specialty hospitals

Reforming 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

Effects on LTCHs

- 36% of LTCH cases would receive higher LTCH CCI rates—aggregate payments for these cases unchanged (budget neutral)
- 64% would get IPPS base rates (reduced payments)
- All cases eligible for LTCH outlier payments
- Total payments would fall more than average for:
  - LTCHs with a high share of non-CCI cases
  - Proprietary LTCHs
  - LTCHs in markets with high LTCH supply
- Expect reduced length of stay—and reduced costs—for non-CCI cases in LTCHs

MEDPAC Source: MedPAC preliminary analysis of Medicare claims data

Effects on IPPS hospitals

- No payment reductions for IPPS hospitals
- Increased payments for IPPS hospitals with high CCI shares
- CCI shares (average = 6.1%) higher for:
  - Hospitals in large urban areas (MSAs with pop. ≥ 1 million)
  - Major teaching hospitals
  - Hospitals with > 300 beds located in urban areas
  - Hospitals in areas with moderate LTCH bed ratios

Source: MedPAC preliminary analysis of Medicare claims data

How will fixing incentives affect Medicare hospital payments?

- Aligning payment rates for 66 APCs with physician office rates will reduce acute hospital payments by $1.1 billion
  - $920 million less from taxpayers
  - $190 million less in beneficiary cost sharing
- LTCH and outlier reform would increase acute hospital payments by $2 billion

Note: Prior recommendation to make E&M payments site neutral would reduce outpatient payments by $1 billion in addition to the reductions for the 66 APCs.