

*Advising the Congress on Medicare issues*

# Assessing payment adequacy: hospital inpatient and outpatient services

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# Payment adequacy indicators

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- 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

# Most payment adequacy indicators are positive

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- Supply of hospital beds is at least adequate in most markets
- Breadth of services is growing
- Access to capital is adequate
- Quality of care is generally improving

# Medicare hospital spending in 2011

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- Inpatient (PPS and CAH) —\$117 billion
- Outpatient (PPS and CAH) —\$41 billion
- Spending growth per capita 2010-2011
  - Inpatient -1%
  - Outpatient +9%
  - Overall +2%
    - PPS hospitals +2%
    - CAHs +6%

Source: Medicare cost reports

# Medicare margins are expected to stay steady through 2013

	2011	2013
Aggregate overall Medicare margin	-5.8%	-6.0%

## Why do we expect margins to stay steady through 2013?

- Payment rate updates will increase revenue
- Cost growth is expected to exceed updates
- HIT payments will offset difference between payment updates and cost growth
- Other payment policy changes

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

# Comparing 2011 performance of relatively efficient hospitals to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	297	1,864
30-day mortality	13% lower	3% above
Readmission rates (3M)	5% lower	1% above
Standardized costs	10% lower	2% above
Overall Medicare margin	2%	-6%
Share of patients rating the hospital highly	69%	67%

Note: medians for each group are compared to the national median  
 Source: Medicare cost reports and claims data

# Characteristics of efficient providers

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- Higher occupancy (63% v. 56% for others)
- Better outpatient margins (-1% v. -11%)
- Between 9% and 21% of hospitals in each of our categories are in the efficient group
  - 14% of all hospitals
  - 21% of “other teaching” hospitals -- more likely to score well on quality metrics
  - 10% of for-profit hospitals -- less likely to score well on quality metrics

# Payment policy changes 2011 to 2014

Payment change	Percent change in Medicare payments (2014 relative to 2011)	Affected years
EHR incentive payments increase	+1 to 2%	2012 to 2015
Readmission penalty started	-0.2%	2013 onward
Low spending county expired	-0.2%	2013 onward
Reduction in bad debt payments	-0.1%	2013 onward
MDH adjustment through 2013	-0.1%	2014 onward
Low volume through 2013	-0.2%	2014 onward
Documentation and coding adjustment	Discussed on following slides	2014 to 2017

Note: EHR, electronic health record; MDH, Medicare-dependent hospital

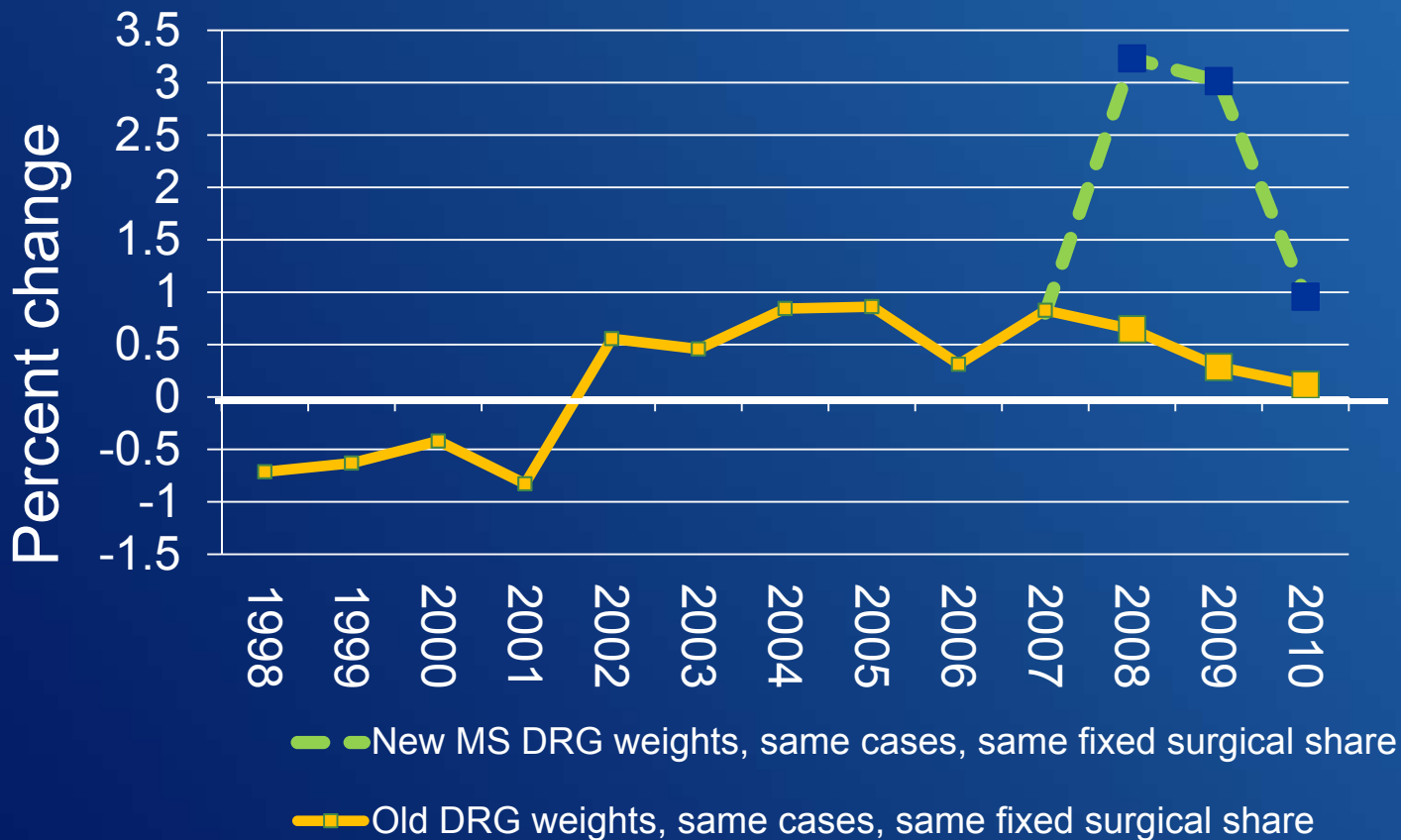


# Correcting for documentation and coding changes

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- MS-DRGs were needed to improve payment accuracy
  - Driven by the MedPAC specialty hospital report
  - Reduced opportunities to specialize in profitable patients and services
- MS-DRGs also gave hospitals an opportunity to increase payments by changing documentation and coding – an offset is needed to maintain budget neutrality
- MedPAC, CMS, and current law generally agree on the dollar value of overpayments that need to be recovered to keep transition to MS-DRGs budget neutral
- Draft recommendation differs from current law in the timing for recovering the overpayments

# Annual changes in case mix spiked in 2008 to 2010



# Current law updates for 2014

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Statutory update = market basket – productivity adjustment – budget adjustment

- October 1: Inpatient update = 1.8% (2.6% – 0.5% – 0.3%)
  - Secretary must also reduce inpatient rates to recover \$11 billion in overpayments during the next four years (2014-2017)
  - Secretary must also reduce payments by 0.6 % to 0.8% to prevent further overpayments
  - Secretary has discretion over timing of these two actions
- January 1: Outpatient update = 2.0% (2.7% – 0.4% – 0.3%)