Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: hospital inpatient, outpatient and LTCH payment policy

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MEDPAC

Most payment adequacy indicators are positive

- Access to care is good
  - Excess capacity in most markets
  - Inpatient volumes declining
  - Outpatient growing
- Access to capital is adequate
- Quality of care is generally improving
  - 30-day mortality is declining
  - Readmissions are declining

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
- Policy changes from 2012 to 2014 largely offset each other

Note: the projected margin does not include the effect of the sequester. If it remains in effect, margins will be almost 2 percent lower in 2014.

Source: Medicare cost reports, claims files, and FY 2013 impact file.
Preliminary data subject to change

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
30-day readmissions	4% lower	1% 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

Expected 2015 payment changes under current law

	Current law
Payment change estimates (2014 to 2015)	
DSH/uncompensated care payment	-2.0%
Other policy changes in current law	-1.5
Update (current law, draft recommendation)	2.2
Effect on hospital payments	**-1.3%**

Note: These projections are presented as changes in overall hospital Medicare fee-for-service revenue (not just inpatient revenue) which is about $170 billion per year. The measures do not factor in any changes in volume of service. The DSH / uncompensated care changes could vary depending on the expansion of the insurance coverage under the exchanges and the degree of Medicaid expansion.

Reducing incentives to shift care to higher-cost settings

- Problem: Price distortions 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

Billing of services shifting from offices to outpatient departments

	Volume change freestanding office		Volume change 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
Note: OPD (hospital outpatient department).

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: APCs meet 5 criteria; payment rates across settings could be equal
- Group 2: APCs where payment rate differences could be narrowed; rates higher in OPDs because of more packaging in OPPS
- For 2010, 24 APCs in Group 1; 42 in Group 2

Preliminary data subject to change

Impact on hospitals of payment rate 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

Reforming the LTCH PPS

- Maintain separate LTCH payment system with higher rates only for chronically critically ill (CCI) cases
- Non-CCI paid IPPS-based 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

MedPAC definition of chronically critically ill (CCI)

- 8+ ICU days during preceding ACH stay; OR
- Prolonged mechanical ventilation services during preceding ACH stay
- 41% of current LTCH cases
- 6% of current IPPS cases

Why this definition of CCI?

- Literature describes CCI cases as having long hospital stays with heavy use of ICU services
- Participants in CMS panel discussions defined appropriate LTCH cases as “stable post-ICU patients”
- PAC Demonstration found that ICU LOS was the most important predictor of resource intensity in the LTCH
- Fewer ICU days allows less-complex patients to qualify

Impact of LTCH payment reform (assumes no behavioral change)

LTCH

- –$2 billion
- 41% of cases = CCI

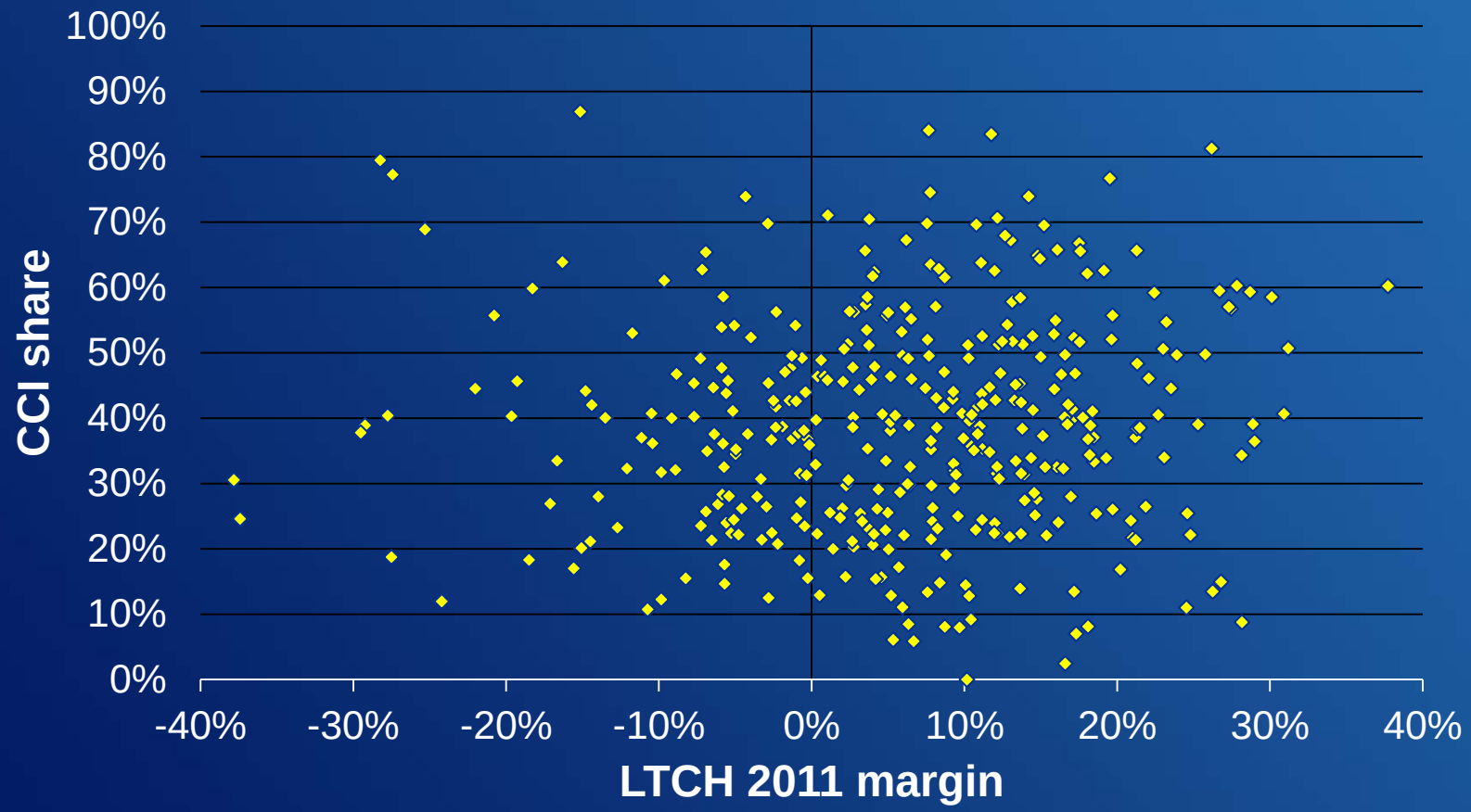
  59% paid IPPS rates
- Avg. impact: –36.5% in year 3. Greater for LTCHs that are:
  - For-profit
  - In LTCH-saturated areas
  - Low CCI

IPPS

- +$2 billion (outlier pmts)
- 6% of cases eligible
- Avg. impact: 1.8% in year 3. Greater for hospitals that are:
  - Major teaching
  - Low margin
  - In areas with fewer LTCHs

Preliminary data subject to change

LTCH margins by share of CCI cases



Preliminary data subject to change

Source: MedPAC analysis of Medicare cost report and MedPAR data from CMS.

Historically, LTCHs have been responsive to payment incentives

- Behavior changes expected
  - Admission of more CCI cases
  - More selective admission of non-CCI cases
  - Reduced LOS for non-CCI cases

Hypothetical example:

Non-CCI case, current policy	Non-CCI case, 1st year of transition to new policy
Payment = $40,000	Payment = $30,360
Cost/day = $1,500	Cost/day = $1,500
LOS = 25 days	LOS = 20 days
Cost/discharge = $37,500	Cost/discharge = $30,000

Preliminary data subject to change