Advising the Congress on Medicare issues

Assessing payment adequacy: 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
- Quality of care
- Access to capital
- Payments and costs
  - For average providers
  - For relatively efficient providers

Most payment adequacy indicators are positive

- 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

- 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

Preliminary data subject to change

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

- 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

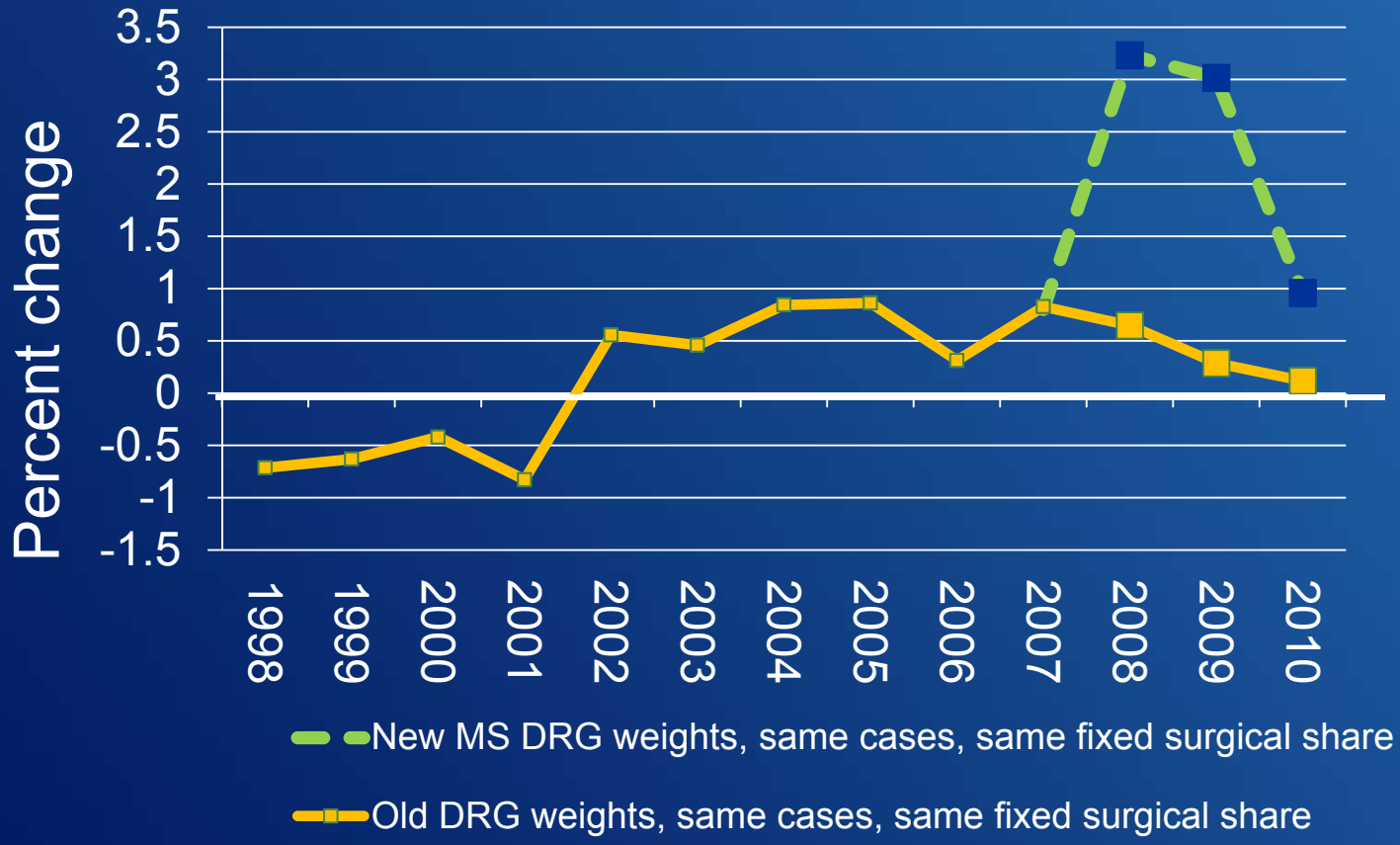
Payment change	Percent change in Medicare payments (2014 relative to 2011)	Affected years
EHR incentive payments increase	+1 to 2%	2012 to 2015
Readmission penalty started	-0.2%	2013 onward
Low spending county expired	-0.2%	2013 onward
Reduction in bad debt payments	-0.1%	2013 onward
MDH adjustment through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

- 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

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%)

Preliminary data subject to change