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

Craig Lisk, Jeff Stensland, and Zach Gaumer

December 18, 2014

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

Medicare hospital spending in 2013

- Inpatient (PPS and CAH) —$118 billion
- Outpatient (PPS and CAH) —$49 billion
- Spending growth per capita 2012-2013
  - Inpatient −1.3%
  - Outpatient +5.5%
  - Total 0.8% (weighted average of inpatient and outpatient)

Source: Medicare cost reports

Access to care remains good

- Overall demand for hospital services is stable
  - Inpatient use falling (-4%)
  - Outpatient use rising (+4%)
- Excess inpatient capacity growing
  - Occupancy down to 60 percent
  - Occupancy varies by market

Bond and equity markets see hospitals as attractive investments

- Access to bond markets is good for most hospitals
  - Interest rates down to 3.6 percent for AA 30-year municipal bond
  - Most bond ratings stable
    - 319 remained unchanged
    - 37 downgrades
    - 27 upgrades
- Access to equity markets is good

Quality of care improving

- In-hospital and 30-day mortality rates declined or were stable from 2010 to 2013 for five prevalent conditions
  - AMI, CHF, stroke, hip fracture, pneumonia
- Patient safety indicators improved or stable
  - Lower rates of central catheter-related infections, post-operative pulmonary embolisms
- Readmission rates decreased, concurrent with start of readmissions payment penalty

Hospital cost growth down from historical averages

- Hospital input price inflation has slowed
  - 2004 to 2008 averaged 3.7%
  - 2010 to 2013 averaged 2.2%
  - No longer growing faster than economy-wide inflation
- Hospital cost increases closer to hospital input price inflation
  - 2004 to 2008 cost growth more than a percentage point higher than input price inflation
  - 2010 to 2013 cost growth close to input price inflation

Overall Medicare margins steady through 2013

Medicare margin	2009	2010	2011	2012	2013
Overall Medicare	– 5.3%	– 4.8%	– 5.4%	– 5.4%	– 5.4%
Inpatient	– 2.3	– 1.8	– 3.4	– 4.4	– 5.3
Outpatient	–11.4	–10.7	–10.6	–11.1	–12.4

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.

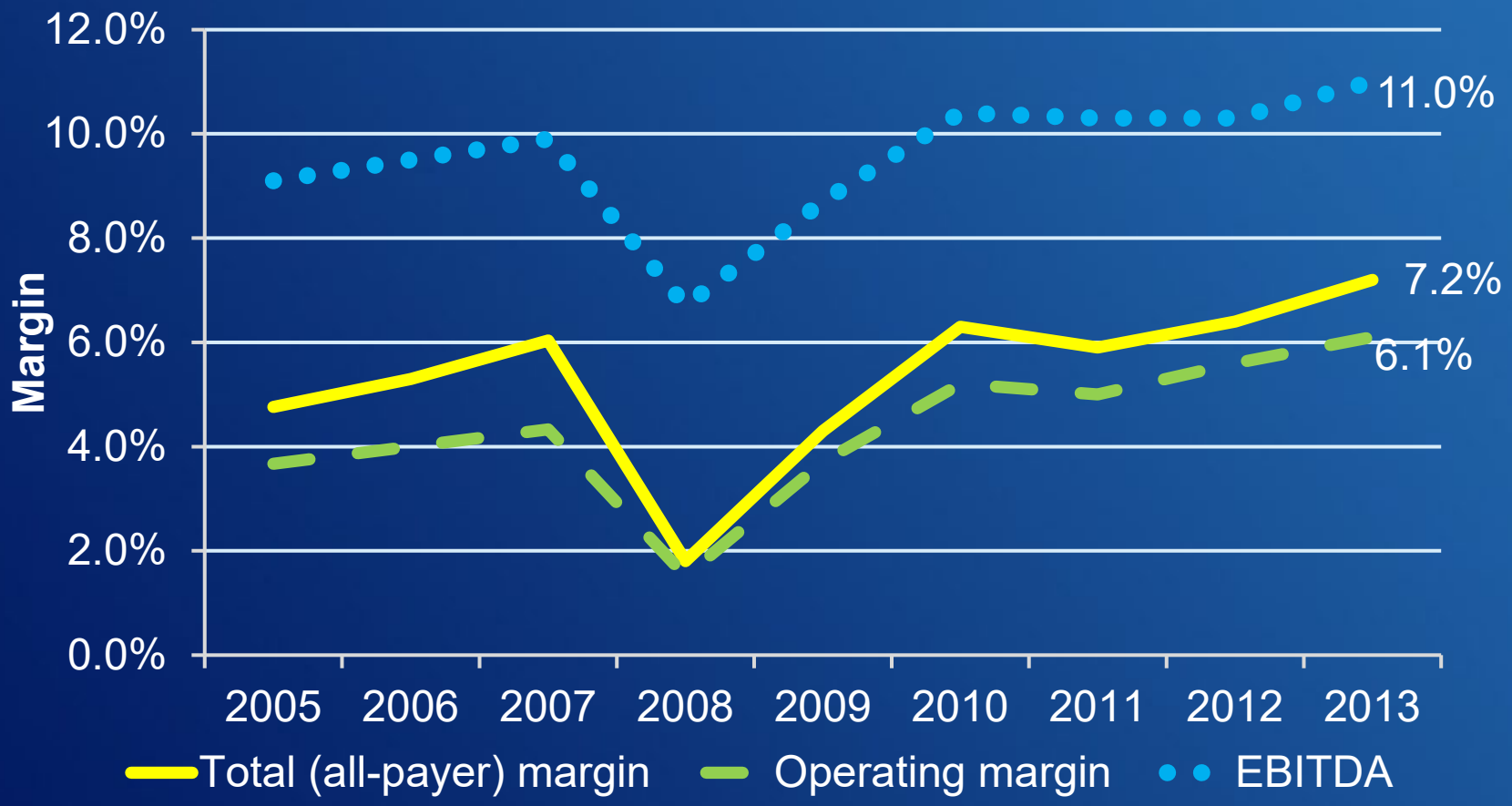
Source: Medicare cost reports.

Overall Medicare margin by hospital group

Hospital group	2013
All hospitals	–5.4%
Urban	–5.9
Rural PPS	0.2
Rural with CAH	1.2
Major teaching	–3.0
Other teaching	–5.3
Non-teaching	–6.8
Nonprofit	–6.9
For-profit	1.2

Source: Medicare cost reports

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 (2010, 2011, 2012), and
- Cannot be in the worst third in **any** year for risk-adjusted mortality, inpatient costs per case, or readmission rates

Comparing 2013 performance of relatively efficient hospitals to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	266	1,866
30-day mortality (rel. to avg.)	16% lower	2% above
Standardized costs (rel. to avg.)	10% lower	2% above
Overall Medicare margin	2%	-6%
Readmissions	NA	NA

Note: Hospitals are classified as efficient based on 2010 to 2012 performance. In this slide, 2013 medians for each group are compared to the national median
Source: Medicare cost reports, claims data, and hospital compare

Last year's payment adequacy discussion

- Payment adequacy indicators were very similar
- Recommendation package
  - Update of +3.25 percent
  - Reduce or eliminate differences between hospitals and physician offices for selected outpatient services
  - Long-term care hospital (LTCH) payments reduced with savings redistributed to increase outlier payments to IPPS hospitals

Outpatient growth reflects distortions in the hospital payment system

- Hospitals paid more than physician offices for many services that can safely be performed in physician offices
- Market share is shifting to hospitals (the higher-cost setting). For example, in 2013 hospitals billed for 7% more echocardiograms while volume in physician offices fell by 8%.
- For the set of 66 APCs discussed last year (e.g., echocardiograms), payments were $1.44 billion higher
  - Medicare program paid $1.2 billion more
  - Beneficiaries paid $240 million more in coinsurance

Reforming Long-term care hospital (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