Assessing payment adequacy and updating payments: Ambulatory surgical center services

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Summary of key facts and payment adequacy measures

- Facts from 2013
  - Medicare payments to ASCs: $3.7 billion
  - Number of ASCs: 5,364
  - Beneficiaries served: 3.4 million
- Access to ASC services continued to increase
- Medicare payments per beneficiary increased
- Access to capital has been adequate
- Limitations of analysis
  - Insufficient data to assess quality
  - Lack cost data: Commission has recommended that ASCs be required to submit cost data

Numbers are preliminary and subject to change

Draft recommendation

The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

Implications

Spending: Decrease of less than $50 million in 1st year and less than $1 billion over 5 years, relative to statutory update

Beneficiaries and providers: Would not diminish beneficiaries' access to services or providers' willingness or ability to furnish services; ASCs would incur some administrative costs to submit cost data

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Assessing payment adequacy and updating payments: outpatient dialysis services

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Summary of outpatient dialysis payment adequacy

- Medicare paid $11 billion to 6,000 dialysis facilities for care furnished to about 376,000 beneficiaries
- Access to care indicators are favorable
- Dialysis quality improving for some measures
- Access to capital indicators are favorable
- 2013 Medicare margin: 4.3%
- 2015 projected Medicare margin: 2.4%

Data are preliminary and subject to change.

Draft recommendation

The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2016.

Implications

Spending: Decrease of between $50 million and $250 million over 1 year, and less than $1 billion over 5 years relative to statutory update.

Implications for beneficiaries and providers: Increased financial pressure on some providers, but overall a minimal effect on providers' willingness and ability to care for Medicare beneficiaries expected. No adverse impact on beneficiaries expected.

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Assessing payment adequacy and updating payments: hospice services

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Hospice payment adequacy indicators

- Medicare paid ~$15.1 B to >3,900 hospices for care furnished to >1.3 M beneficiaries in 2013
- Indicators of access to care are favorable
  - Supply of providers continues to grow, driven by for-profit hospices
  - Hospice users increased; ALOS held steady
- Quality data are unavailable
- Access to capital appears adequate
- 2012 margin is 10.1%
- 2015 projected margin is 6.6%

Results are preliminary and subject to change.

Draft recommendation

The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

Implications

Spending: decrease in spending relative of between $250 million and $750 million over 1 year, and between $1 billion and $5 billion over 5 years relative to statutory update

Beneficiaries and providers: No adverse impact on beneficiaries expected. Not expected to affect providers' willingness and ability to care for Medicare beneficiaries.

Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services

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Inpatient rehabilitation facilities: Summary

- 1,160 IRFs treated 373,000 FFS cases in 2013
- Medicare FFS spending = $6.8B
- Access: Supply and volume stable
  - Average occupancy rate = 63 percent
- Quality: Small improvement from 2011–2013
- Access to capital very good for many facilities
- 2013 margin = 11.4 percent
- Projected margin for 2015: 12.6 percent

Results are preliminary and subject to change.

Draft recommendation

The Congress should eliminate the update to the payment rates for inpatient rehabilitation facilities in fiscal year 2016.

Implications

Spending: Decrease relative to statutory update by between $50M and $250M in 2016; between $1B and $5B over 5 years

Beneficiary and provider: Minimal impact on providers' willingness and ability to care for Medicare beneficiaries. No adverse impact on beneficiaries expected

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Assessing payment adequacy and updating payments: Long-term care hospital services

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Long-term care hospital payment adequacy indicators

- Medicare FFS spending totaled $5.5 billion for ~138,000 cases in 2013
- Indicators of access to care are favorable
  - Growth in payment per case between 2012 and 2013
  - Volume decreases similar to other inpatient settings
  - Many beneficiaries receive similar services in other settings
- Quality data are stable for limited available measures
- Access to capital adequate with limited activity from prior and current moratoria
- 2013 margin is 6.6%
- 2015 projected margin is 4.6%

Data are preliminary and subject to change.

Draft recommendation

The Secretary should eliminate the update to payment rates for long-term care hospitals for fiscal year 2016.

Implications

Spending: Decrease relative to expected regulatory update by between $50M and $250M in 2016; less than $1B over 5 years

Beneficiaries and providers: Not expected to affect providers' willingness and ability to care for Medicare beneficiaries. No adverse impact on beneficiaries expected.

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IRF Medicare margins, 2013

	% of IRFs	% of cases	Margin
All IRFs	100%	100%	11.4%
Freestanding	21%	47%	24.1%
Hospital-based	79%	53%	0.3%
Nonprofit	58%	50%	1.5%
For-profit	28%	41%	23.4%

Government-owned IRFs are not shown but are reflected in the aggregate margin. Results are preliminary and subject to change.

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

Factors that affect the margins of hospital-based IRFs

- Higher routine, ancillary & indirect costs than freestanding IRFs
  - Hospital-based IRFs' routine costs were 70% higher
- Much more likely to be not-for-profit
- Tend to be smaller with lower occupancy
  - 67% have fewer than 25 beds
- *One-fourth of hospital-based IRFs had Medicare margins > 10%*
- *Acute care hospitals with an IRF unit have an average Medicare margin that is almost 1 percentage point higher than acute care hospitals without an IRF unit*

Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report data from CMS.

High margins for hospital-based and freestanding IRFs with low costs, 2013

Median	Lowest-cost IRFs	Highest-cost IRFs
Standardized cost per discharge	$11,227	$21,934
Hospital-based	12,127	21,848
Freestanding	10,632	22,514
Medicare margin	26.2%	-26.0%
Number of beds	44	17
Occupancy rate	70%	47%
% hospital-based	41%	95%
% nonprofit	31%	63%

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Costs are standardized for differences in the price of inputs across geographic areas and in case mix. Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report and claims data from CMS.

Medicare margins are expected to increase in 2015

	2013	2015
Aggregate overall Medicare margin	11.4%	12.6%

Why do we expect margins to increase in 2015?

- Sequester will decrease revenue
- Update to payment rate and change to high-cost outlier fixed-loss amount will increase revenue, more than offsetting effect of sequester
- Based on historical trends, cost growth expected to be lower than updates

Source: MedPAC analysis of Medicare cost report and MedPAR data from CMS. Results are preliminary and subject to change.

Recent changes to LTCH payment policy

- The Pathway for SGR Reform Act of 2013 establishes "site-neutral" payments for LTCHs, beginning FY 2016
  - Higher LTCH payments allowed for cases with immediately preceding ACH discharge and either:
    - 3+ ICU days in referring ACH; or
    - principal LTCH diagnosis of prolonged mechanical ventilation
  - All other LTCH cases paid lower of IPPS-based rate or costs
- LTCHs cannot have more 50% of discharges paid at the site-neutral rate, beginning FY 2020
- Required ALOS of 25+ days excludes:
  - Cases paid based on the site-neutral rate
  - MA cases
- Moratorium on new LTCHs from April 2014 through September 2017

Previous MedPAC recommendation on LTCH reform

- Establishes criteria for chronically critically ill (CCI) patients, beginning FY 2016
  - Higher LTCH payments for cases with 8+ ICU days in ACH;
    - Exception: Cases with prolonged mechanical ventilation in IPPS
  - All other LTCH cases paid IPPS-based rate
- Redistribute savings to increase inpatient outlier payments for CCI cases in IPPS hospitals