
# Medicare outlier payments and hospital charging practices

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# Overview

- The policy rationale for outlier payments
- How Medicare pays for outlier cases
- Two outlier policy issues:
  - Influence of charge markups
  - Calculation of outlier costs
- Potential changes to Medicare outlier policies

# Policy rationale for outlier payments

- Medicare pays hospitals fixed payment rate for each MS-DRG
- Some patients are very high cost
- Outlier policy acts as a stop-loss insurance

# Outlier payment formula

Outlier payment =

0.80 x

(Total covered charges x Medicare CCR*) –

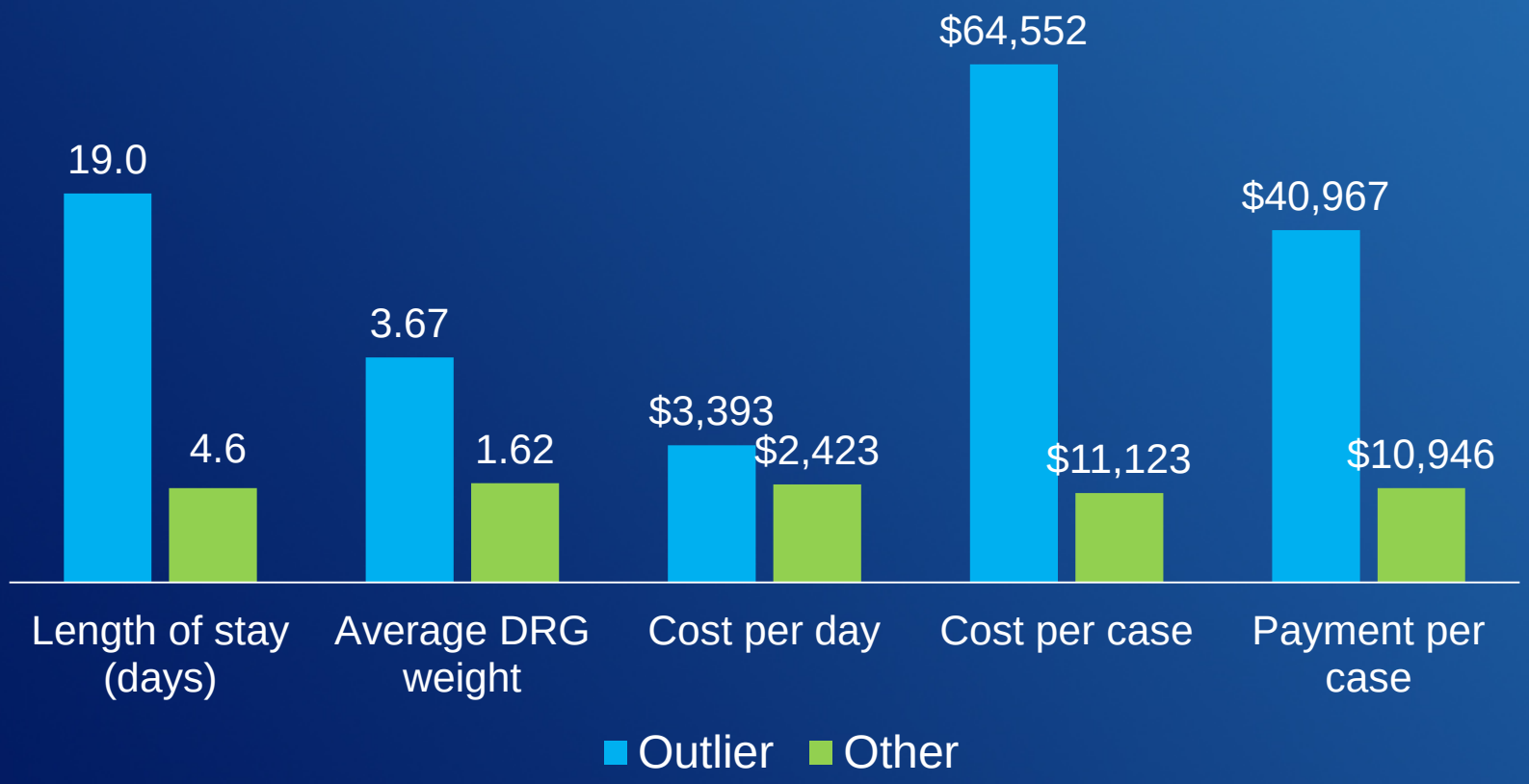
(DRG payment + fixed-loss cost threshold)

Fixed-loss cost threshold in 2017 = $23,573**

*CCCR (cost-to-charge ratio)

**Adjusted by area wage index and COLA

# What do outlier cases look like?

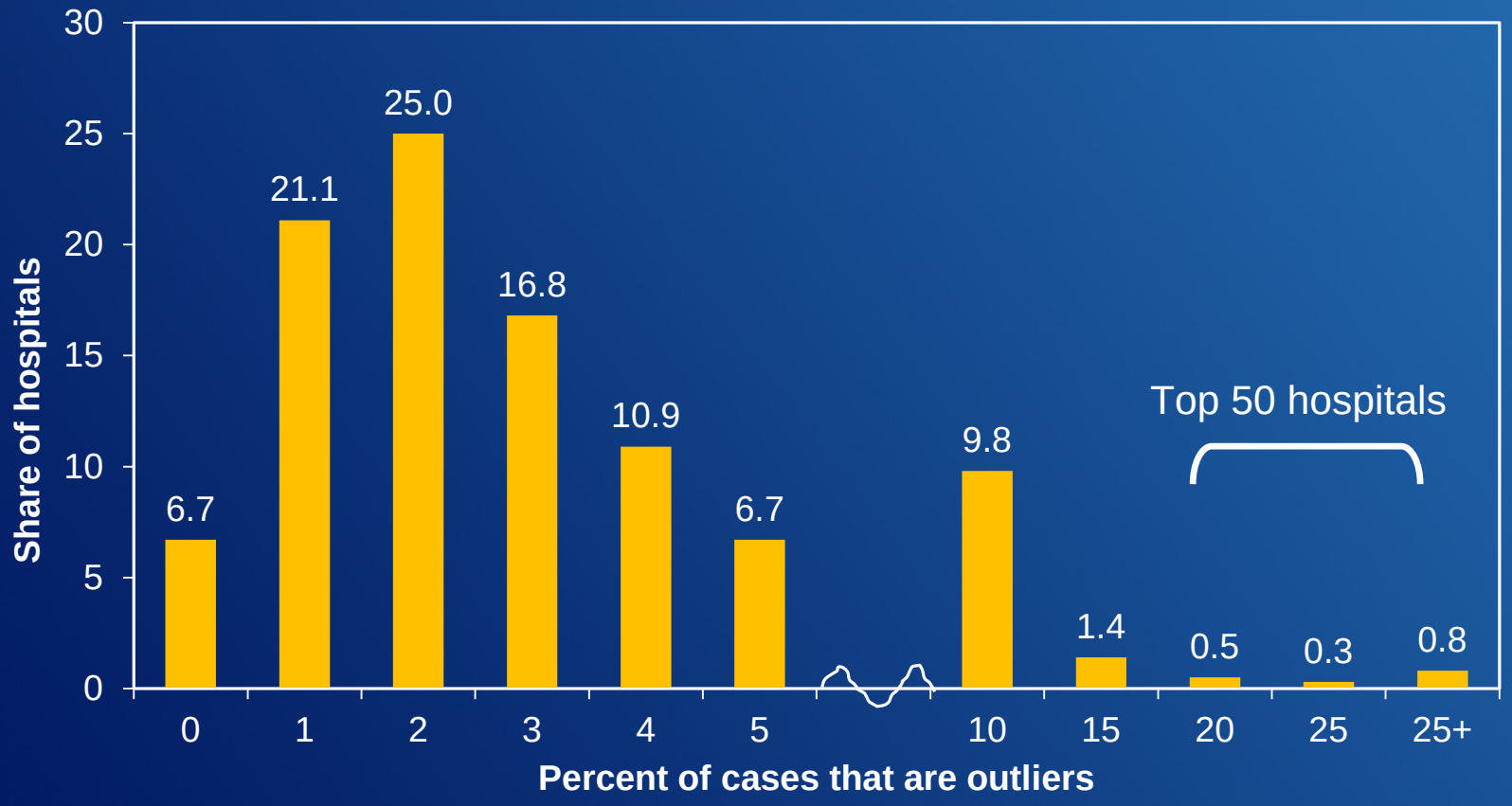



Data are preliminary and subject to change

# Share of cases that become outliers varies by MS-DRG

- Higher incidence in MS-DRGs with high weights, long average lengths of stay, and MCCs
  - Transplants
  - Major cardiac procedures
  - Major spinal procedures
- Lower incidence in low-weighted DRGs with short average lengths of stay, and no MCCs
  - Common medical conditions: e.g., COPD, heart failure, simple pneumonia
  - Major joint replacements

# Share of cases that become outliers varies across hospitals




Source: MedPAC analysis of 2014 Medicare inpatient claims.

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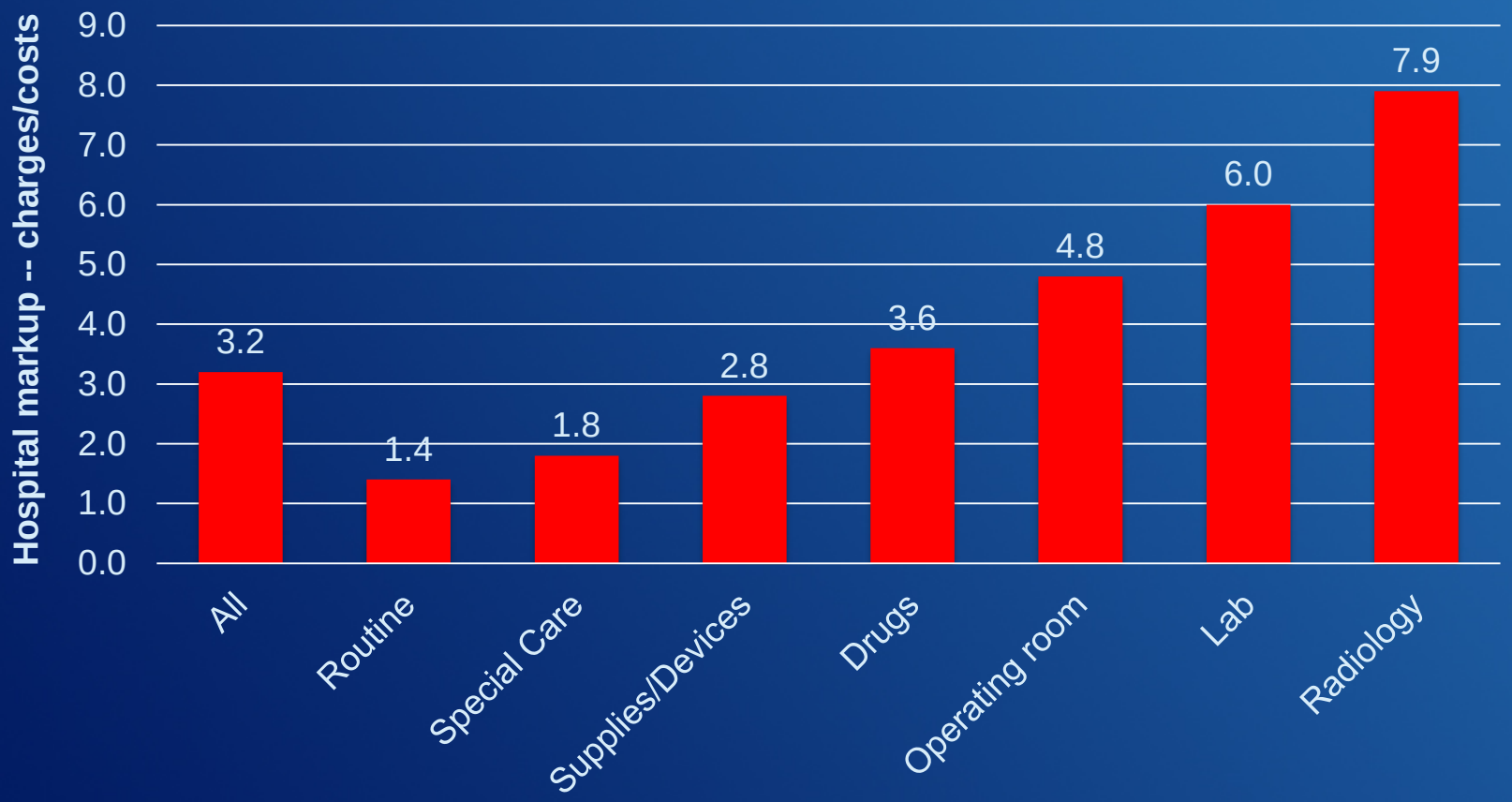
# Characteristics of 50 hospitals with highest share of outlier cases

- Most are small hospitals
- Majority are for-profit surgical subspecialty hospitals
  - Short length of stay for outliers (5.2 days)
  - High charge markups in operating room
  - High device costs

# How can hospital charge markups affect outlier payments?

- Mix of services – More service use from departments with higher markups will result in higher outlier cost estimates and vice versa
- Differential markups – Services with a higher than average markup within a department will also results in higher outlier cost estimates

# Average markups across cost centers




Source: MedPAC analysis of 2014 Medicare claims and cost reports.

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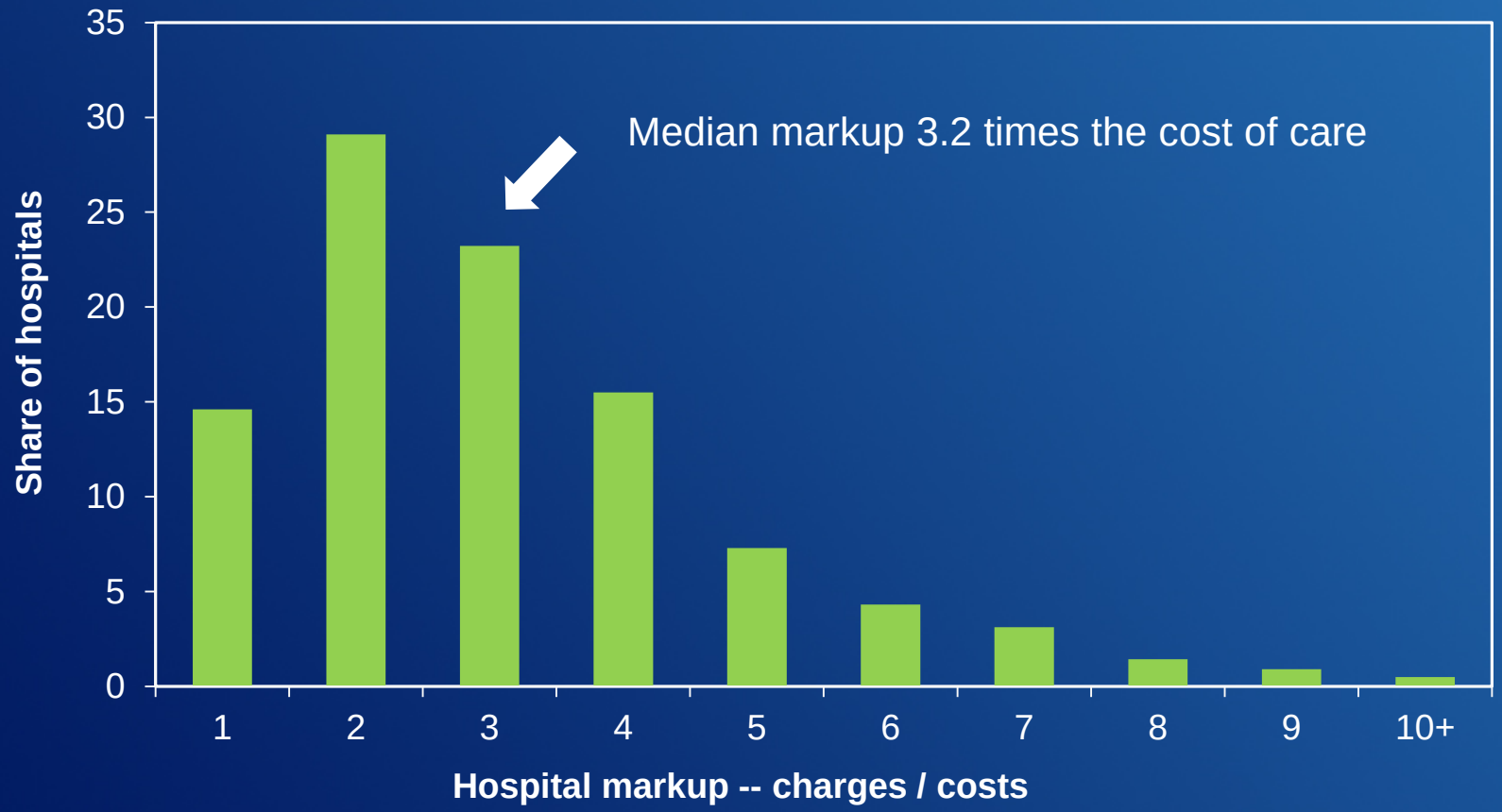
# Markups vary across hospitals




Source: MedPAC analysis of 2014 Medicare claims and cost reports.

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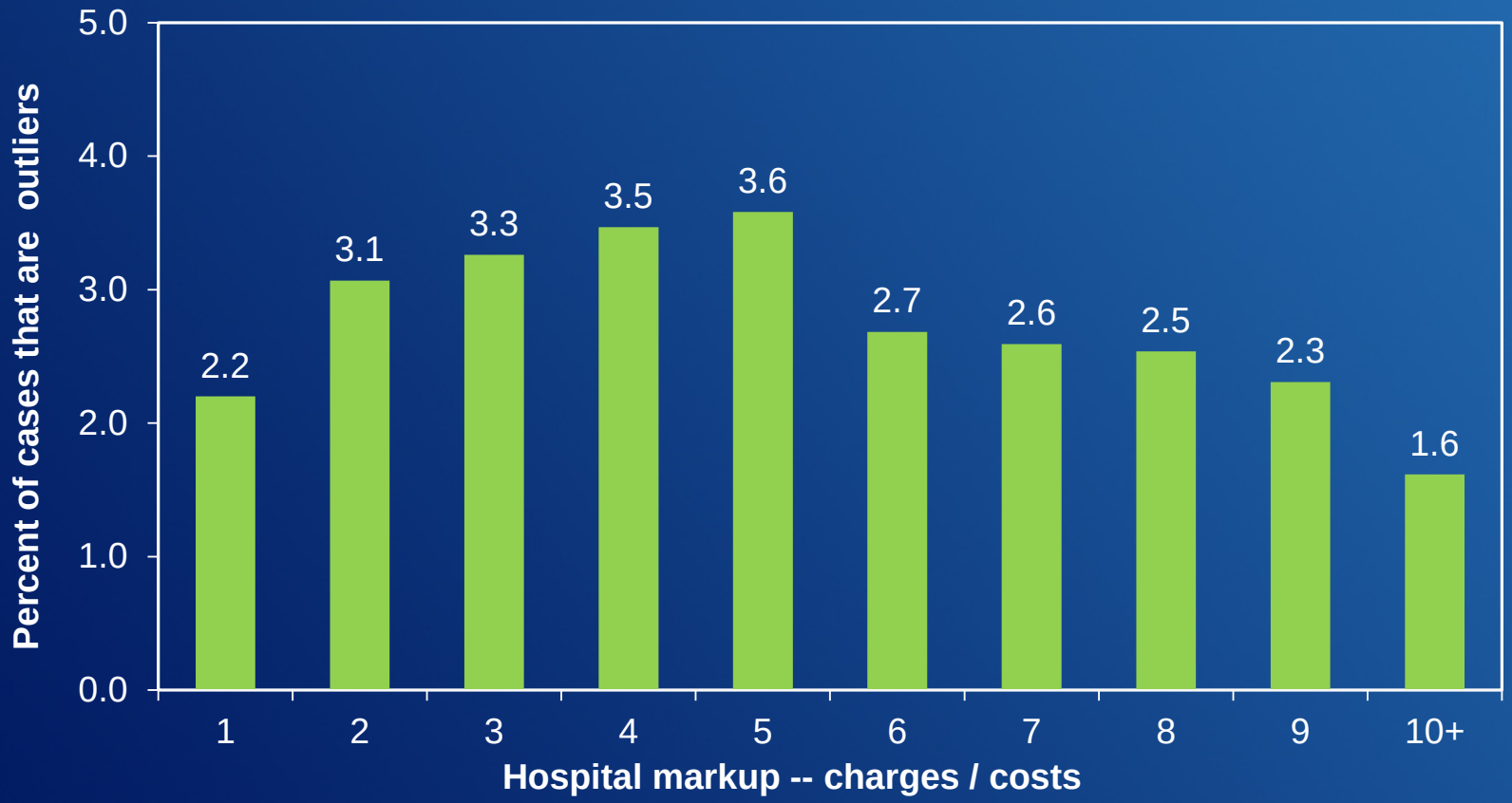
# Weak relationship between markups and share of cases that are outliers




Source: MedPAC analysis of 2014 Medicare claims and cost reports.

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# How well does the total CCR work in estimating costs for outlier cases?

- Compare costs using total CCR and departmental CCRs
  - Departmental CCRs should provide a more accurate picture of hospital claim costs
  - Neither method will capture differential markups within a department
- In aggregate both give similar estimates of total outlier costs….

# …but at the case level the mix of services used will affect calculation of costs

| | Routine | Operating room | Supplies | Total |
|---|---|---|---|---|
| CCR | 0.5 | 0.1 | 0.3 | 0.32 |
| Charges | $40,000 | $80,000 | $30,000 | $150,000 |
| Estimated Costs: | | | | |
| Departmental CCR | $20,000 | $8,000 | $9,000 | $37,000 |
| Total CCR | $12,800 | $25,600 | $9,600 | $48,000 |

- If a case has a high share of services with higher markups, total CCR will give higher estimate of costs
- If a case has a high share of routine services—such as for patients with long stays—total CCR will underestimate costs

# Potential changes to Medicare outlier policy

- Use hospital specific departmental CCRs to calculate case costs
  - Provides a more accurate estimate of case costs at the DRG and hospital level
  - Increases complexity of calculating outlier payments
- Establish a length-of-stay threshold for outlier claims
  - Reduces potential for gaming
  - Would eliminate many outlier claims for small surgical specialty hospitals
  - Should be relatively straightforward to implement
- Both policies would be budget neutral

# Discussion

- Questions on analysis
- Discussion of policy options