

Assessing payment adequacy and updating payments:
Hospital inpatient and outpatient services;
and
Mandated report on Bipartisan Budget Act of 2018
changes to the low-volume hospital payment adjustment

Alison Binkowski, Jeff Stensland, Dan Zabinski, Ledia Tabor, Brian O'Donnell
December 9, 2021

MedPAC's payment adequacy framework: Acute care hospitals

Beneficiaries' access to care

- Capacity and supply of hospitals
- Volume of services
- Marginal profit

Quality of care

- Mortality and readmission rates
- Patient experience

Hospitals' access to capital

- All-payer profitability
- Employment
- Bonds and construction

Medicare payments and hospitals' costs

- Payments and costs per service
- Overall Medicare margin among all and efficient hospitals
- Projected margin

Update recommendation for base payment rates

Payment adequacy framework and the coronavirus public health emergency (PHE)

- COVID-19 has had tragic and disproportionate effects on Medicare beneficiaries and the health care workforce
- PHE has also had material effects on payment adequacy indicators, making them more difficult to interpret
- Temporary or highly variable coronavirus effects are best addressed through targeted, short-term funding policies rather than permanent changes to all providers' payment rates in 2023 and future years

Federal support to health care providers during the public health emergency

All-payer





- Provider Relief Funds: \$178 billion
 - General distributions
 - Targeted distributions
- Paycheck Protection Program loans: ≈\$100 billion

Medicare-specific

- Suspension of 2 percent Medicare sequestration
- Sector-specific payment changes
- Sector-specific waivers to increase access

➔ Collectively, federal support to date has generally maintained—if not improved—providers' financial performance in 2020; and more funds remain to be distributed

Context: FFS Medicare payment systems for hospital inpatient and outpatient services (2020)

	Inpatient PPS	Outpatient PPS
 Prospective payment unit	Inpatient stay	Primary service and ancillary items; some drugs
 Hospitals	3,150	3,600
 FFS Medicare volume	7.5 million stays	78.1 million visits
 FFS Medicare payments	\$104.1 billion	\$60.2 billion

Note: FFS (fee-for-service); PPS (prospective payment system). Payments reflect Medicare payment rates and include payments from the Medicare program and from beneficiaries or their supplemental insurance. Inpatient PPS payments exclude \$8.3 billion in uncompensated care payments. Year is fiscal year for inpatient services and calendar year for outpatient services. Source: MedPAC analysis of MedPAR and outpatient claims.

Access to care: Excess inpatient capacity in aggregate across 2020, but stressed at times

62%

aggregate occupancy rate

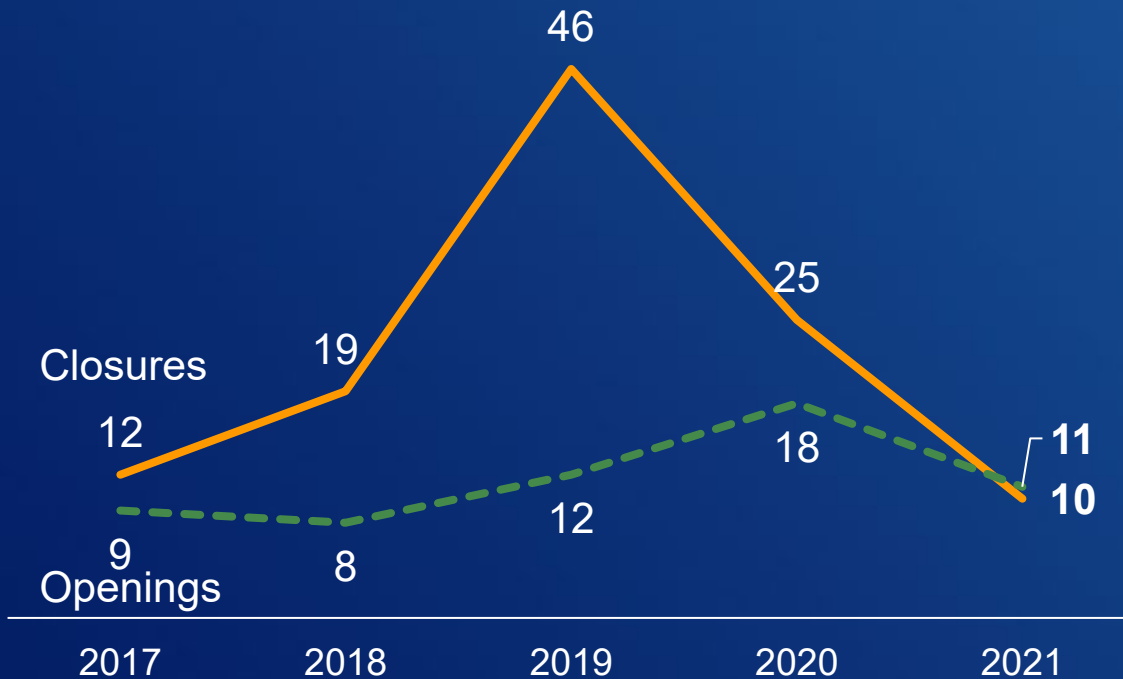
- About two-thirds of all inpatient beds were occupied in 2020, consistent with prior years...
- ... but certain states neared inpatient or intensive care unit capacity limits at times

→ To help address temporary hospital capacity constraints, CMS enacted numerous waivers, including allowing hospitals to provide care in temporary expansion locations

Source: MedPAC analysis of cost report data from CMS and hospital capacity by state data from HealthData.gov.

Access to care: Fewer hospital closures in fiscal years 2020 and 2021 after a peak in 2019

Hospital closures and openings



➔ Federal support provided to hospitals during the pandemic may have contributed to significant decline in closures

Notes: Hospital closures defined as cessation of Medicare beneficiaries' access to inpatient services at a general short-term acute care hospital or critical access hospital. The figure does not include the relocation of inpatient services from one hospital to another under common ownership within ten miles, nor does it include hospitals that both opened and closed within a five-year time period. The number of hospital closures and openings in a given year can change over time as hospitals re-open or dates of closure are updated. Year is fiscal year.

Source: MedPAC analysis of the CMS Provider of Services file, internet searches, and personal communication with the Department of Health and Human Services Office of Rural Health Policy.

Access to care: Hospital services per capita declined, driven by a large drop in Spring 2020

	Inpatient services per capita	Outpatient services per capita
Volume relative to 2019		
April 2020	-40%	-50%
June 2020	-15%	-20%
December 2020	-15%	-20%
June 2021	-15%	-10%

Note: Inpatient stays per capita refers to per fee-for-service (FFS) Medicare Part A beneficiaries, and outpatient services per capita refers to per FFS Medicare Part B beneficiaries.
Source: MedPAC analysis of MedPAR, outpatient claims, Common Medicare Environment Data, and preliminary 2021 claims data.

Access to care: Incentive to serve FFS Medicare beneficiaries continued in 2020

≈ 5%
marginal profit

- Hospitals with excess capacity have financial incentive to serve FFS Medicare beneficiaries

→ The rapid response to the coronavirus pandemic has demonstrated that at least some hospitals can substantially decrease their costs when volume declines

Note: FFS (fee-for-service). If we approximate marginal cost as total Medicare costs minus fixed building and capital costs, then marginal profit can be calculated as follows: $\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and capital costs})) / \text{payments for Medicare services}$. This comparison is a lower bound on the marginal profit. Marginal profit is calculated on inpatient stays and outpatient services.

Source: MedPAC analysis of cost report data from CMS.

Quality of care: Difficult to assess in 2020

- Change in measures reflect temporary changes in the delivery of care and data limitations unique to the PHE rather than trends in the quality of care provided to beneficiaries, and risk-adjustment models do not include COVID-19 diagnosis information
 - Mortality increased
 - Readmissions declined slightly
 - Most patient experience measures declined slightly

Source: MedPAC analysis of Medicare claims and Hospital Compare data.

Access to capital: IPPS hospitals' all-payer total margin remained strong but declined in 2020

Aggregate all-payer total margin (%)



- IPPS hospitals reported receiving over \$32 billion in federal support, primarily through the Provider Relief Fund
- Without relief funds, net income would have declined \$50 billion—substantially less than AHA's estimate of \$320 billion

Note: Inpatient prospective payment systems (IPPS); American Hospital Association (AHA). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer total" margin includes payments from all payers and from investments, and in 2020, reported federal relief funds.

Source: MedPAC analysis of cost report data from CMS and the AHA's "Hospitals and health systems face unprecedented financial pressures due to COVID-19" June 2020 update.

Access to capital: Rural hospitals' all-payer total margins reached a near record high in 2020

Aggregate all-payer total margin (%)



→ Rural hospitals received targeted provider relief funds

→ Rural IPPS margin highest in over 20 years; CAH margin a record high

Note: Inpatient prospective payment systems (IPPS); critical access hospital (CAH). Hospitals' aggregate margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer total" margin includes payments from all payers and from investments, and in 2020, reported federal relief funds.

Source: MedPAC analysis of cost report data from CMS.

Access to capital: Preliminary data suggest hospitals' all-payer margins strengthened in 2021

- 2020 was a particularly anomalous year
- Among the six largest hospital systems (over 20% of IPPS hospitals), 2021 operating profits reported to date exceed pre-pandemic levels

➔ No evidence of negative effect on hospitals' long-term access to capital

Note: Inpatient prospective payment systems (IPPS).

Source: Financial statements from Ascension, Common Spirit, and the Trinity health system for fiscal years ending June 30, 2019 and June 30, 2021. Earnings releases from HCA, Community Health Systems and Tenet for the third quarter of 2019 and 2021.

Medicare payments and costs: Costs per service grew faster than payments per service in 2020

	IPPS	OPPS
Payments per service	8.7%	13.5%
Costs per service	12.6%	24.4%

- Faster growth in costs per service primarily reflects:
 - Spreading fixed costs over fewer services
 - Increase in complexity of services and needed supplies
- Higher outpatient growth reflects continued growth in separately payable drugs

Notes: IPPS (inpatient prospective payment systems); OPSS (outpatient prospective payment system). Source: MedPAC analysis of MedPAR, outpatient claims, and hospital cost reports.

Medicare payments and costs: Overall Medicare margin at IPPS hospitals improved slightly in 2020

Aggregate overall Medicare margin (%)



- ➔ Based on FFS Medicare's share of all-payer revenue, allocated \$6.4 billion of the \$32 billion in relief funds to Medicare
- ➔ With these funds, overall Medicare margin improved slightly

Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Funds and Paycheck Protection Program loans recorded on hospitals' cost reports, with the Medicare share calculated using FFS Medicare's share of 2019 all-payer operating revenue; the line "excluding relief funds" assumes hospitals' costs remained the same. Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Overall margin refers to the aggregate margin across multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as direct graduate medical education and uncompensated care payments.

Source: MedPAC analysis of cost report data from CMS.

Medicare payments and costs: Relatively efficient hospitals broke even in 2020

	Relatively efficient (15%)	Other (85%)
Performance in 2020		
Share rating hospital a 9 or 10 (out of 10)	72%	69%
Risk-adjusted percent of national median		
Mortality rate (30-day)	92	101
Readmission rate	96	102
Medicare costs per stay (standardized)	91	104
Median margin in 2020		
Overall Medicare margin	1	-6
All-payer total margin	7	5

Note: Relative values are the median for the group as a share of the median of all hospitals. Per stay costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the 3M methodology to compute risk-adjusted mortality for all conditions. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) due to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and risk-adjusted quality metrics.

Source: MedPAC analysis of cost report and claims-based quality data from CMS.

Current law updates to IPPS and OPPS rates

	2018	2019	2020	2021	2022	2023*
Market basket	2.7%	2.9%	3.0%	2.4%	2.7%	2.6%
Productivity offset	-0.6	-0.8	-0.4	0	-0.7	-0.6
Budgetary reduction	-0.65	-0.75	0	0	0	0
Annual update	1.35	1.35	2.6	2.4	2.0	2.0*
Statutory increase (IPPS only)	0.46	0.5	0.5	0.5	0.5	0.5

**2023 estimate based on 2021 3rd quarter forecasts from CMS, including an estimated 3.1% growth in hospital wages and benefits; forecasts used to set actual update will be revised to reflect most recent economic data at the time the final rule is published in summer 2022.*

Note: IPPS (inpatient prospective payment systems); OPPS (outpatient prospective payment system). Final net update to base rates will also reflect budget neutrality adjustments. Separate updates to inpatient capital base rate not shown.

Source: MedPAC analysis of IPPS final rules and market basket forecasts from the Office of the Actuary.

Summary: COVID-19 affected hospital adequacy indicators, but they remained generally positive

Beneficiaries' access to care

- Excess capacity in aggregate
- Fewer closures
- Decline in volume reflects PHE
- Positive marginal profit

Quality of care

- Measure changes not indicative of changes in quality or payment adequacy

Hospitals' access to capital

- All-payer total margin remained strong, due to substantial federal support
- Near record high margin for rural hospitals

Medicare payments and hospitals' costs

- Medicare margin still negative but remained steady
- Relatively efficient hospital margin 1%

Note: Provider Relief Funds (PRF).

Mandated report: BBA of 2018 changes to the low-volume hospital payment adjustment

- The Bipartisan Budget Act (BBA) of 2018 temporarily extended and modified the low-volume hospital (LVH) payment adjustment in the IPPS for 2019 through 2022
- The BBA of 2018 also mandated that MedPAC report on the effects of the LVH changes on:
 - Medicare inpatient stays
 - Medicare spending
 - LVH's financial status
 - Other matters

Mandated report: Low-volume hospital (LVH) payment adjustment history

- In 2001 the Commission recommended creating a graduated adjustment to the IPPS for low-volume, isolated hospitals
- Congress created and then modified an LVH adjustment:

Effective fiscal years	LVH volume criterion	LVH isolation criterion	LVH payment adjustment
2005-2010	< 800 all-payer stays	> 25 miles	Empirically set by CMS
2011-2018	< 1,600 Medicare stays	> 15 miles	Set in statute
2019-2022	< 3,800 all-payer stays	> 15 miles	Set in statute
2023 and beyond	Revert to 2005 criteria		

Source: MedPAC analysis of 42 USC 1395ww(d)(12) and cited laws, regulations (42 CFR 412.101), and CMS final rules.

Mandated report: Effects of BBA of 2018 modifications to low-volume hospital (LVH) policy

- BBA of 2018 modifications to LVH policy:
 - Modestly increased number of LVHs, the average number of FFS Medicare inpatient stays per LVH, and average LVH adjustment
 - Shifted LVH adjustment towards hospitals with lower all-payer volume
- ➔ The change to LVH eligibility based on all-payer volume is consistent with MedPAC's prior recommendation, but concerns remain about expanded eligibility and statutorily set adjustment
- ➔ Allowing the LVH modifications to expire and revert to original 2005 criteria would preserve BBA's basing the adjustment on all-payer volume and allow CMS to calibrate the adjustment to an empirically-justified amount

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

Considerations for the Chair's draft recommendation

- Maintain payments high enough to ensure beneficiaries' access to care
- Maintain payments close to hospitals' cost of efficiently providing high-quality care
- Maintain fiscal pressure on hospitals to constrain costs
- Minimize differences in payment rates for similar services across sites of care

→ To the extent coronavirus public health emergency continues, any needed additional financial support should be separate from annual update and targeted to affected hospitals that are necessary for access