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
Jan 13, 2021
MedPAC’s payment adequacy framework: Acute care hospitals

<table>
<thead>
<tr>
<th>Beneficiaries’ access to care</th>
<th>Quality of care</th>
<th>Hospitals’ access to capital</th>
<th>Medicare payments and hospitals’ costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity and supply of hospitals</td>
<td>Mortality and readmission rates</td>
<td>All-payer total margin</td>
<td>Payments and costs per service</td>
</tr>
<tr>
<td>Volume of services</td>
<td>Patient experience</td>
<td>Employment</td>
<td>Aggregate Medicare margin</td>
</tr>
<tr>
<td>Medicare marginal profit</td>
<td></td>
<td>Bonds and construction</td>
<td>Projected Medicare margin</td>
</tr>
</tbody>
</table>

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, including recent increases from omicron variant
- 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
Summary: COVID-19 affected hospital adequacy indicators, but they remained generally positive

<table>
<thead>
<tr>
<th>Beneficiaries’ access to care</th>
<th>Quality of care</th>
<th>Hospitals’ access to capital</th>
<th>Medicare payments and hospitals’ costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Excess capacity</td>
<td>• Measure changes not indicative of changes in quality or payment adequacy</td>
<td>• All-payer total margin remained strong, due to substantial federal support</td>
<td>• Aggregate Medicare margin still negative but remained steady</td>
</tr>
<tr>
<td>• Fewer closures</td>
<td></td>
<td>• Near record high margin for rural hospitals</td>
<td>• Relatively efficient hospitals’ median Medicare margin 1%</td>
</tr>
<tr>
<td>• Decline in volume reflects PHE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicare marginal profit positive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Provider Relief Funds (PRF).

Results are preliminary and subject to change.
Policy changes since December meeting

- Congress extended the suspension of the 2% sequester
  - Full suspension through March 31, 2022
  - 1% suspension through June 30, 2022
- HHS began distributing $9 billion in PRF Phase 4 payments

➤ Our projected 2022 Medicare margins were unchanged:
  ➤ Without relief funds: -10% for IPPS hospitals, 0% for relatively efficient hospitals
  ➤ With relief funds: -9% for IPPS hospitals, 1% for relatively efficient hospitals

Note: Provider Relief Funds (PRF).
Results are preliminary and subject to change
Considerations for the 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
BBA of 2018 required LVH eligibility be based on all-payer volume and modified the statutorily set adjustment for 2019 through 2022.

In 2019, the number of LVHs rose, as did the average number of FFS Medicare inpatient stays per LVH, and average LVH adjustment.

The requirement to base LVH eligibility on all-payer volume is consistent with MedPAC’s prior recommendation, and LVH policy will become more consistent beginning in 2023 when CMS’s authority to determine an empirically justified LVH adjustment is restored.

Still, concerns remain that LVH policy is not well-targeted to isolated hospitals and is duplicative for the subset of LVHs that already receive cost-based payments.

Note: Bipartisan Budget Act (BBA).
Source: MedPAC analysis MedPAR and cost report data from CMS.

Results are preliminary and subject to change.