Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and Supporting Medicare safety-net hospitals

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MEDPAC

MedPAC's payment adequacy framework: General acute care hospitals

Access to care

- Hospital closures
- Capacity and staffing
- Medicare marginal profit
- Inpatient and outpatient volume

Quality of care

- Risk-adjusted mortality and readmission rates
- Patient experience

Access to capital

- All-payer profitability
- Access to bonds

Medicare payments and hospitals' costs

- Medicare margin among all and relatively efficient hospitals
- Projected margin

Update recommendation for payment system base rates

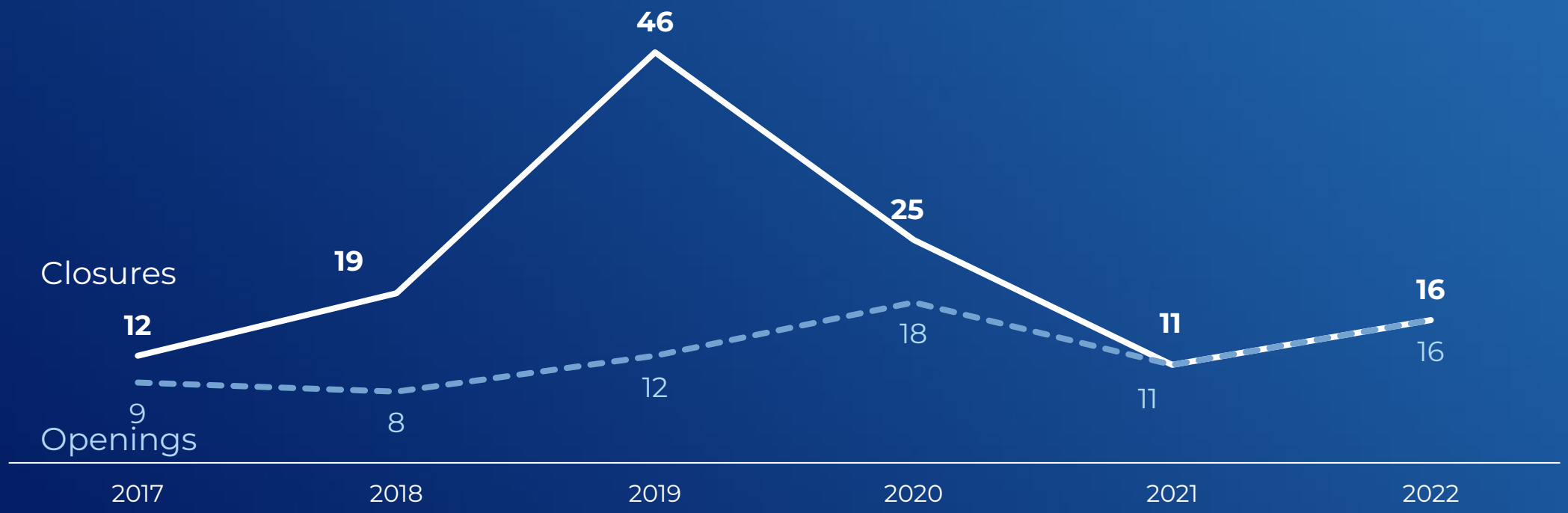
FFS Medicare pays for most general acute care hospital services under the IPPS and OPPS

2021	IPPS	OPPS
Prospective payment unit	Inpatient stay	Primary service and ancillary items
Hospitals	3,170	3,370
FFS volume	7.1 million stays	135.7 million services
FFS PPS payments	$107.9 billion	$49.9 billion
Separate payments	$8.3 billion for uncompensated care	$16.4 billion for separately payable drugs

Note: FFS (fee-for-service); IPPS (inpatient prospective payment systems); OPPS (outpatient prospective payment system). Payments reflect Medicare payment rates and include payments from the Medicare program and from beneficiaries or their supplemental insurance. Year is fiscal year for inpatient services and calendar year for outpatient services. The number of general acute care hospitals that provided OPPS services is higher than the number that provided IPPS services primarily because about 200 facilities gained hospital provider numbers during the public health emergency but did not provide any inpatient services to FFS beneficiaries.
Source: MedPAC analysis of Medicare Provider Analysis and Review data, IPPS final rule, and outpatient claims.

Access to care: General acute care hospital closures equaled openings in fiscal years 2021 and 2022

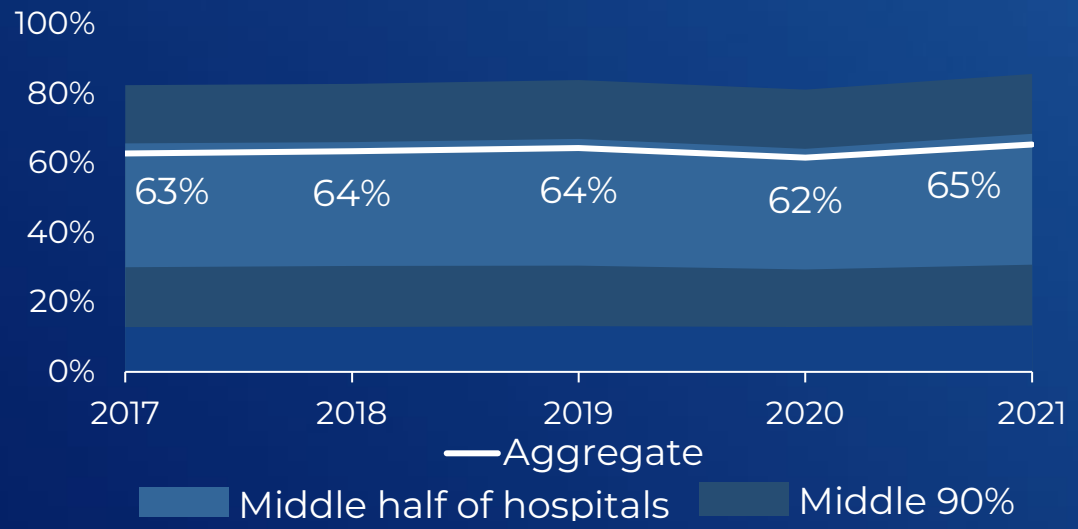
Hospital closures and openings



Notes: Hospital closures defined as cessation of Medicare beneficiaries' access to inpatient services at a general acute care 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: Hospitals had excess inpatient capacity in aggregate but some experienced constraints at times

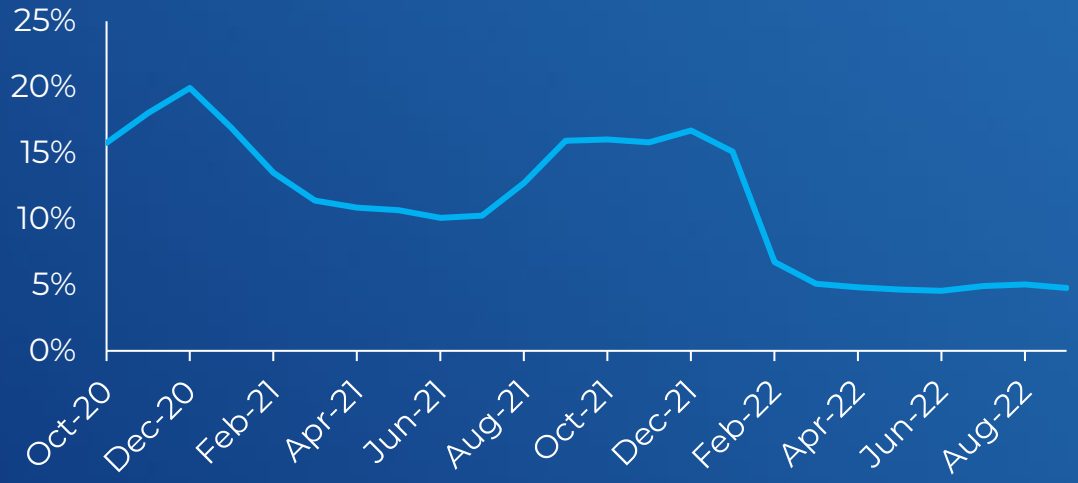
Occupancy rate



- In aggregate, 65 percent of inpatient bed-days were occupied in 2021; but some hospitals neared capacity at times

Source: MedPAC analysis of cost report data from CMS.

Percent of hospital days for which hospitals reported a critical staffing shortage



- Hospitals reported critical staffing shortages at times despite modest increase in employment in 2021; but improved in 2022

Source: MedPAC analysis of healthdata.gov data.

Access to care: Hospitals' incentive to serve FFS Medicare beneficiaries continued in 2021

≈ 8%
Medicare marginal profit

- Hospitals with excess capacity continued to have a financial incentive to provide inpatient and outpatient services to FFS beneficiaries

➔ The rapid response to the coronavirus pandemic has demonstrated that many hospitals can substantially lower their costs in response to declining volume over a matter of months

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: Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and capital costs)) / payments for Medicare services. This comparison is a lower bound on the marginal profit. Marginal profit is calculated on inpatient stays and outpatient services. Data includes hospitals paid under the inpatient prospective payment systems with complete cost report data with a midpoint in fiscal year 2021.
Source: MedPAC analysis of cost report data from CMS.

Access to care: Inpatient stays per FFS beneficiary declined but outpatient services increased

Inpatient stays per 1,000 FFS beneficiaries

- Inpatient stays per beneficiary declined, but average length of stay increased

Hospital outpatient services per FFS beneficiary

- Growth in outpatient services per beneficiary driven by COVID-19-related services and clinic services

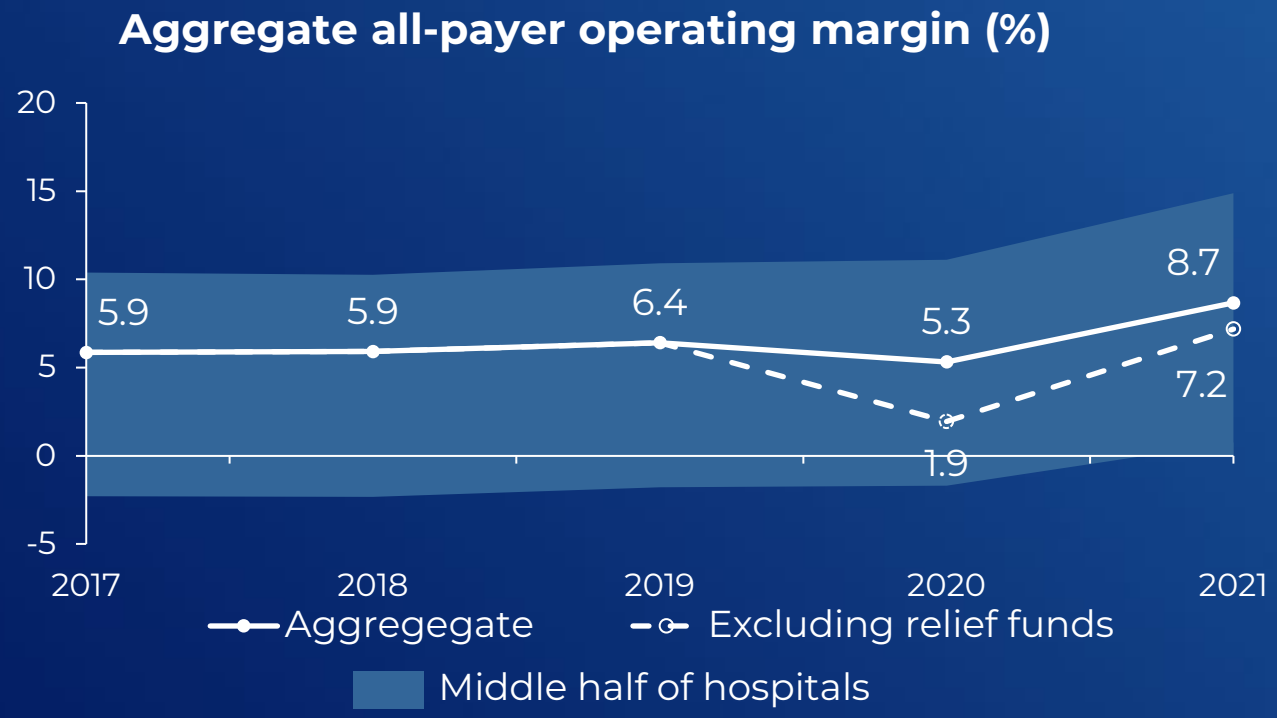
Note: FFS (fee-for-service).
Source: MedPAC analysis of Medicare Provider Analysis and Review data, outpatient claims, and the Medicare trustees report. Year is fiscal year for inpatient services and calendar year for outpatient services.

Quality of care: Mixed in 2021 relative to 2019

- Comparing 2021 quality indicators to 2019, due to data limitations in 2020
- Relative to 2019, FFS beneficiaries':
  - Risk-adjusted hospital mortality rate increased slightly
  - Risk-adjusted hospital readmission rate improved; and
  - Patient experience remained high, but the share of patients rating their hospital highly declined slightly

Source: MedPAC analysis of Medicare Provider Analysis and Review data and CMS summary of Hospital Consumer Assessment of Healthcare Providers and Systems public report of survey results tables.

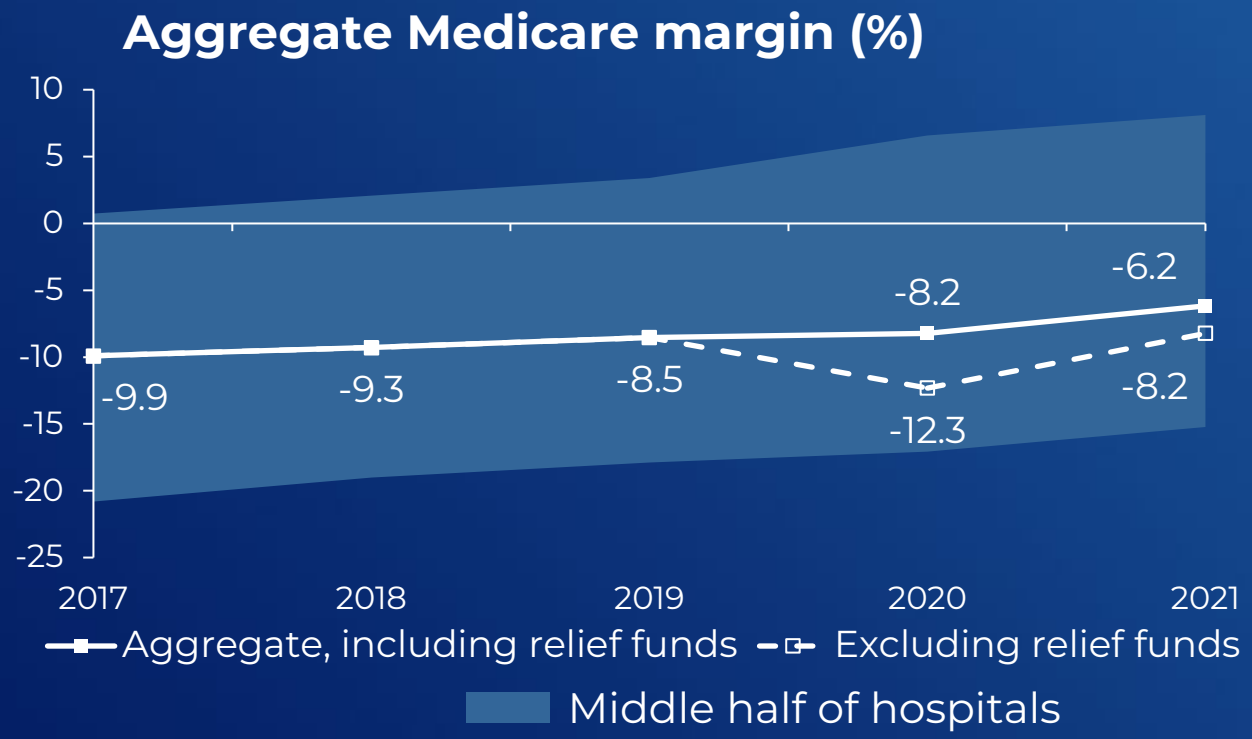
Access to capital: Hospitals' access strengthened, including record high all-payer margin in 2021



- Hospitals also continued to have strong access to bond markets
  - Risk premium decreased, falling to 1 percentage point above the yield on 10-year treasury bonds by end of fiscal year 2022

Note: Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer operating" margin includes payments from all payers and is limited to patient care revenue. "Relief funds" refers to Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program, as recorded on hospitals' cost reports. Data are for inpatient prospective payment systems hospitals that had a cost report with a midpoint in the fiscal year and was complete as of our analysis.
Source: MedPAC analysis of cost report data from CMS.

Medicare payments and costs: IPPS hospitals' Medicare margin increased in 2021



- IPPS payments per stay increased 10.3% and OPPS payments per beneficiary increased 16.5%
- Payments grew faster than costs in part due to Medicare payment changes, such as suspension of 2% sequestration

Note: IPPS (inpatient prospective payment systems). Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include 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. "Relief funds" refers to Provider Relief Fund payments and forgiven loans from the Paycheck Protection Program, as recorded on hospitals' cost reports; Medicare's share of these funds was calculated using fee-for-service Medicare's share of 2019 all-payer operating revenue. Data are for IPPS hospitals that had a cost report with a midpoint in the fiscal year and was complete as of our analysis.
Source: MedPAC analysis of cost report data from CMS.

Medicare payments and costs: Relatively efficient hospitals' Medicare payments were near costs in 2021

2021	Relatively efficient (15%)	Other (85%)
Median margin		
Medicare margin with relief funds	1%	-4%
Medicare margin excluding relief funds	0	-7
All-payer total margin	11	9
Performance		
Risk-adjusted percent of national median		
Mortality rate (within stay plus 30 days)	93	101
Readmission rate	96	101
Medicare costs per stay (standardized)	91	102
Share rating hospital a 9 or 10 (out of 10)	71	68

Note: "Relatively efficient hospitals" and "other hospitals" were identified based on their mean performance during 2017-2019 relative to the median hospital's performance during those years. We removed hospitals with a low share of Medicaid patient days reported on cost reports (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.

Summary: Hospitals' payment adequacy indicators remained generally positive in 2021

Access to care

- Closures same as openings
- Excess capacity in aggregate, but some stressed at times
- Positive marginal Medicare profit
- Continued shift from inpatient to outpatient settings

Quality of care

- While risk-adjusted hospital mortality rate increased slightly from 2019, readmission rate improved
- Patient experience remain high, but most measures declined slightly

Access to capital

- All-payer operating margin reached a record high
- Hospitals maintained strong access to bond markets

Medicare payments and hospitals' costs

- Aggregate Medicare margin increased
- Relatively efficient hospitals' median Medicare margin near break even

Results are preliminary and subject to change

Considerations for the Chair's draft recommendation

- Maintain Medicare 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; and
- Avoid implementing large, across-the-board payment rate increases to support a subset of hospitals with specific needs

Changes to safety-net payments are warranted for hospitals serving low-income Medicare beneficiaries

- Hospitals with high shares of low-income Medicare patients have additional challenges
- Current Medicare safety-net payments do not address these challenges effectively
- A new Medicare safety-net payment system could improve financial security for hospitals with challenging payer mixes

Caring for low-income Medicare patients may create financial challenges for hospitals

- Hospitals with higher shares of low-income Medicare patients tend to receive less cost sharing (e.g., Medicaid may not pay cost sharing for dual-eligible beneficiaries)
- Studies have found certain low-income beneficiaries cost more to treat than other patients with the same principal diagnosis
- Hospitals with a large share of Medicare patients and few commercial patients have a smaller financial cushion

Concerns with current Medicare safety-net payments

- Substantial payments (~6% of IPPS hospital payments)
  - Approximately $11.7 billion in DSH and uncompensated care payments to IPPS hospitals in 2019
- Concerns
  - Medicare indirectly subsidizes Medicaid
  - DSH shares are negatively correlated with Medicare shares, meaning high Medicare share hospitals tend to get lower DSH payments
  - DSH payments are inpatient-only
  - Uncompensated care payments are not focused on Medicare beneficiaries
  - Current uncompensated care payments are distorted providing higher payments to hospitals with high Medicare Advantage shares

Note: DSH (disproportionate share hospital); IPPS (inpatient prospective payment systems).
Source: MedPAC analysis of Medicare Provider Analysis and Review data and IPPS final rule.

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Safety-Net Index (SNI): An alternative mechanism for supporting Medicare safety-net hospitals

- SNI computed as:
  - LIS share of Medicare beneficiaries, plus
  - Uncompensated care costs as a share of revenue, plus
  - One half the Medicare share of inpatient days
- Why use SNI to distribute safety-net funds?
  - Includes Medicare shares to recognize the reduced profitability of Medicare since DSH was enacted
  - Eliminates direct subsidy of Medicaid and reduces uncompensated care subsidy
  - Aligns Medicare funds more directly with hospitals serving low-income Medicare beneficiaries

Note: DSH (disproportionate share hospital); LIS (low-income subsidy).

Hospital SNI add-on would be applied to both FFS and MA services

- SNI add-on would be applied to inpatient and outpatient payments
- Safety-net payments for MA patients would be paid directly to hospitals
  - SNI payments would be excluded from MA benchmarks
  - MA plans would not be expected to pay higher rates to safety-net hospitals
  - Would assure funds go to safety-net hospitals

Note: FFS (fee-for-service); MA (Medicare Advantage); SNI (safety-net index).

Example: SNI would increase margins for hospitals serving high shares of low-income Medicare beneficiaries

2019	Lowest SNI quartile	2nd SNI quartile	3rd SNI quartile	Highest SNI quartile
Medicare margin	−12.4%	−9.5%	−5.5%	−0.9%
Simulated FFS Medicare margin if an additional $1 billion was distributed via the SNI for FFS discharges	−15.7	−9.4	−2.3	4.2
All-payer (total) margin	10.0	8.3	6.0	3.1
Simulated all-payer margin if an additional $1 billion FFS payments (and $0.5 billion in MA payments)	9.2	8.3	6.9	4.4

Note: DSH (disproportionate share hospital); FFS (fee-for-service); MA (Medicare Advantage); SNI (safety-net index).
Source: MedPAC analysis of cost report data.

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Discussion

- Hospital update recommendation
- Hospital safety-net recommendation

Note: DSH (disproportionate share hospital); SNI (safety-net index).