



*Advising the Congress on Medicare issues*

# Medicare outlier payments and hospital charging practices

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# Overview

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- 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

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- 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

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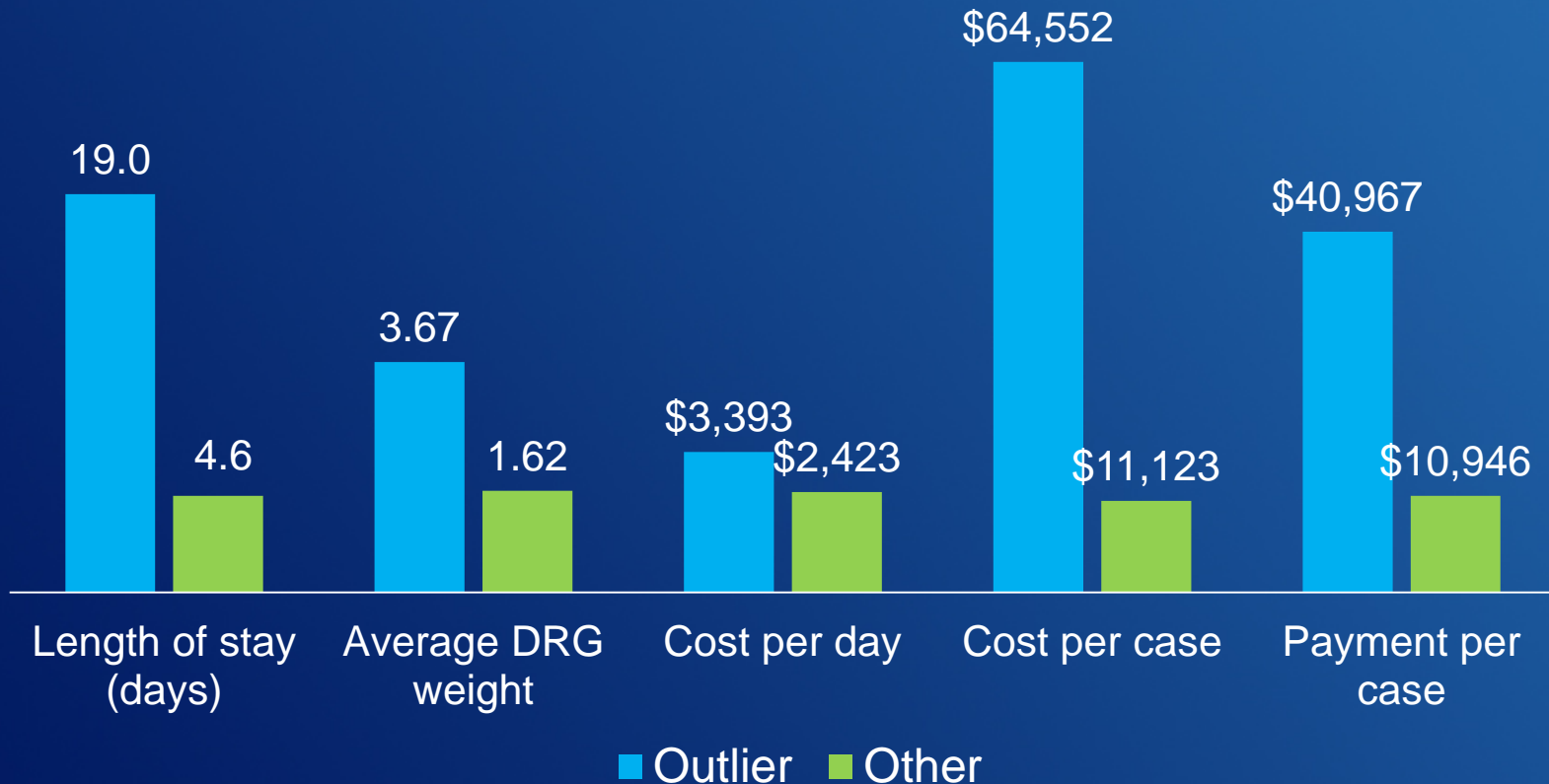
$$\begin{aligned} \text{Outlier payment} = & \\ & 0.80 \times \\ & (\text{Total covered charges} \times \text{Medicare CCR}^*) - \\ & (\text{DRG payment} + \text{fixed-loss cost threshold}) \end{aligned}$$

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?

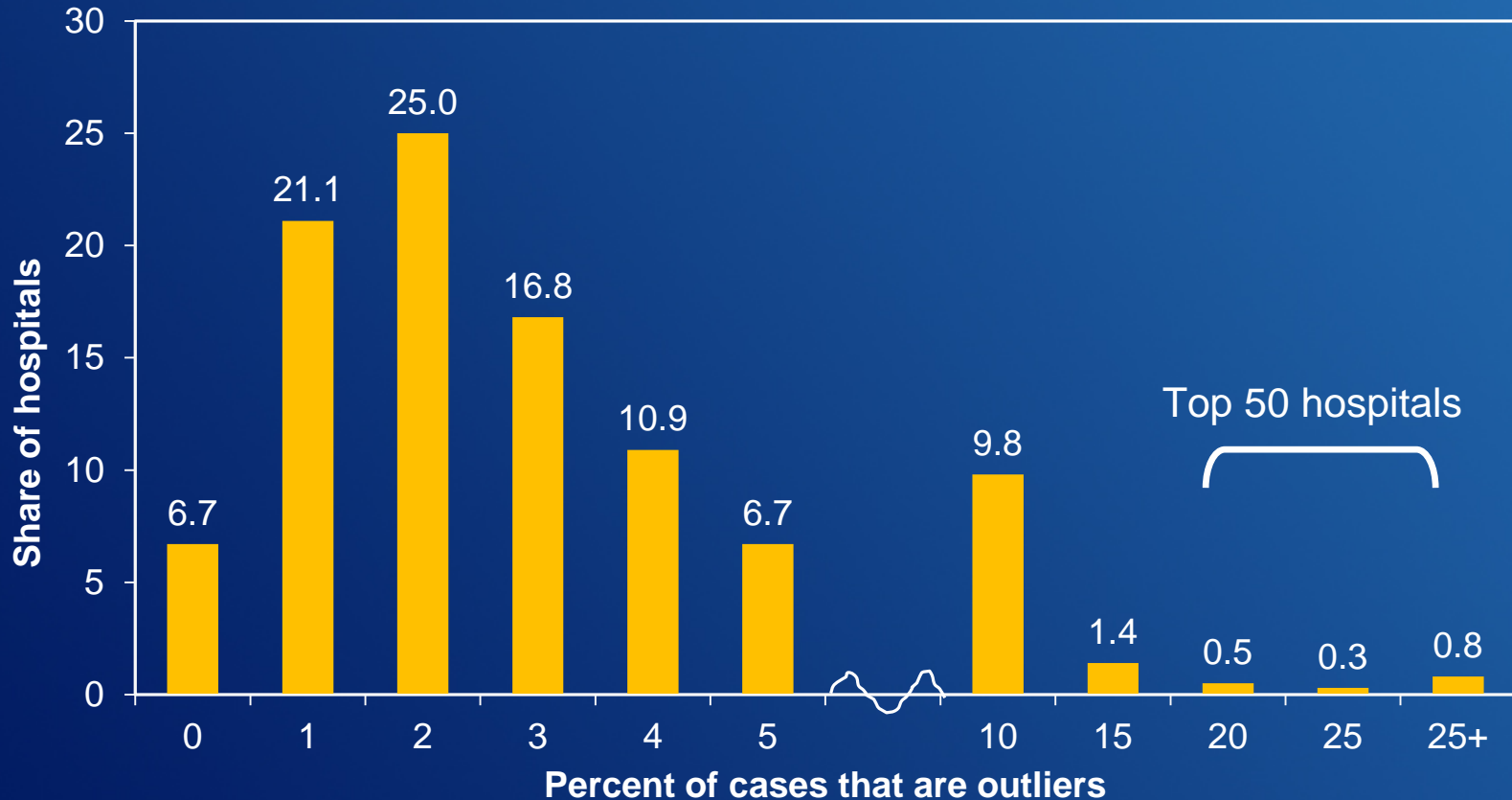


# Share of cases that become outliers varies by MS-DRG

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- 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.

# Characteristics of 50 hospitals with highest share of outlier cases

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- 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

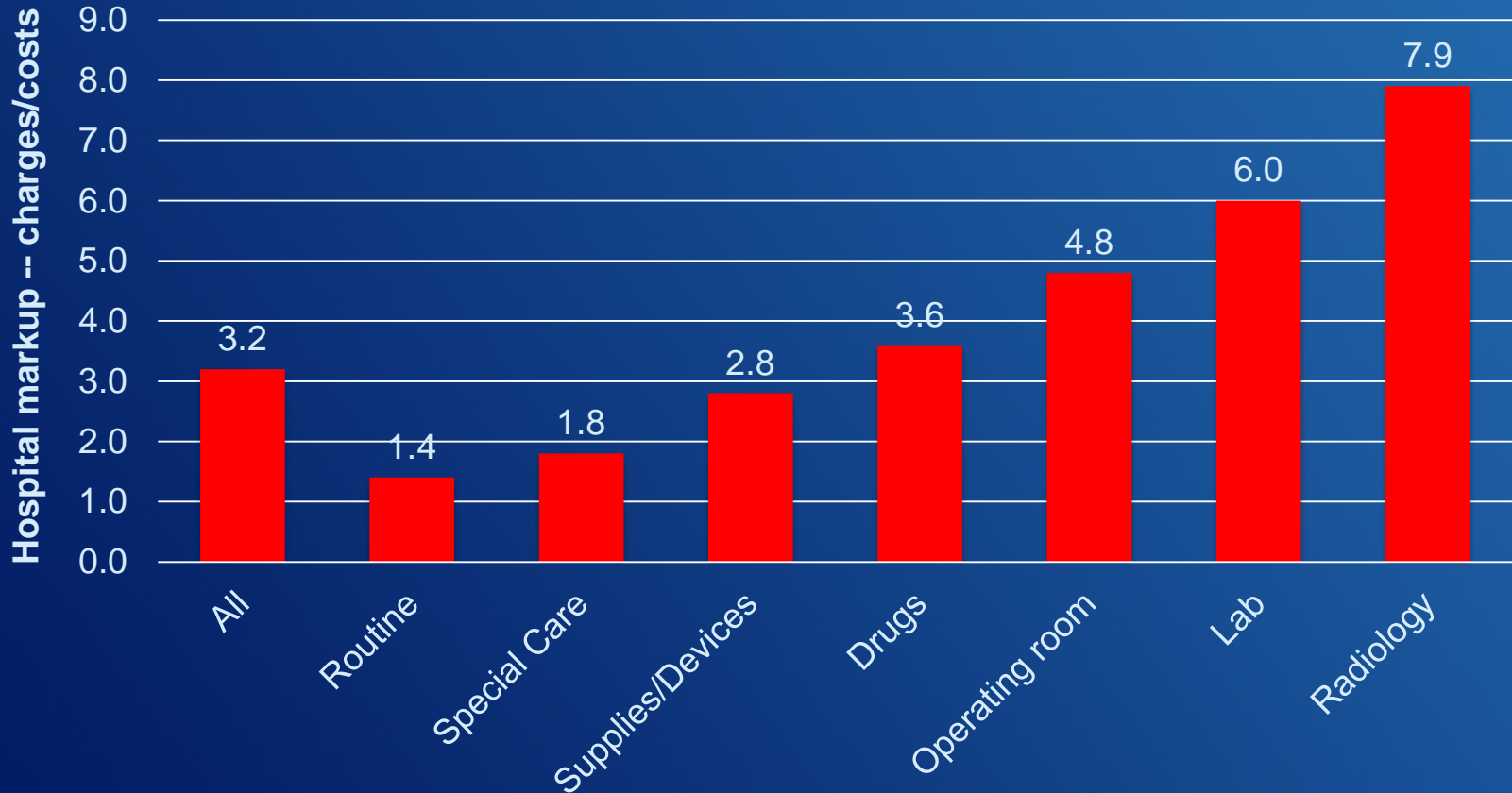


# How can hospital charge markups affect outlier payments?

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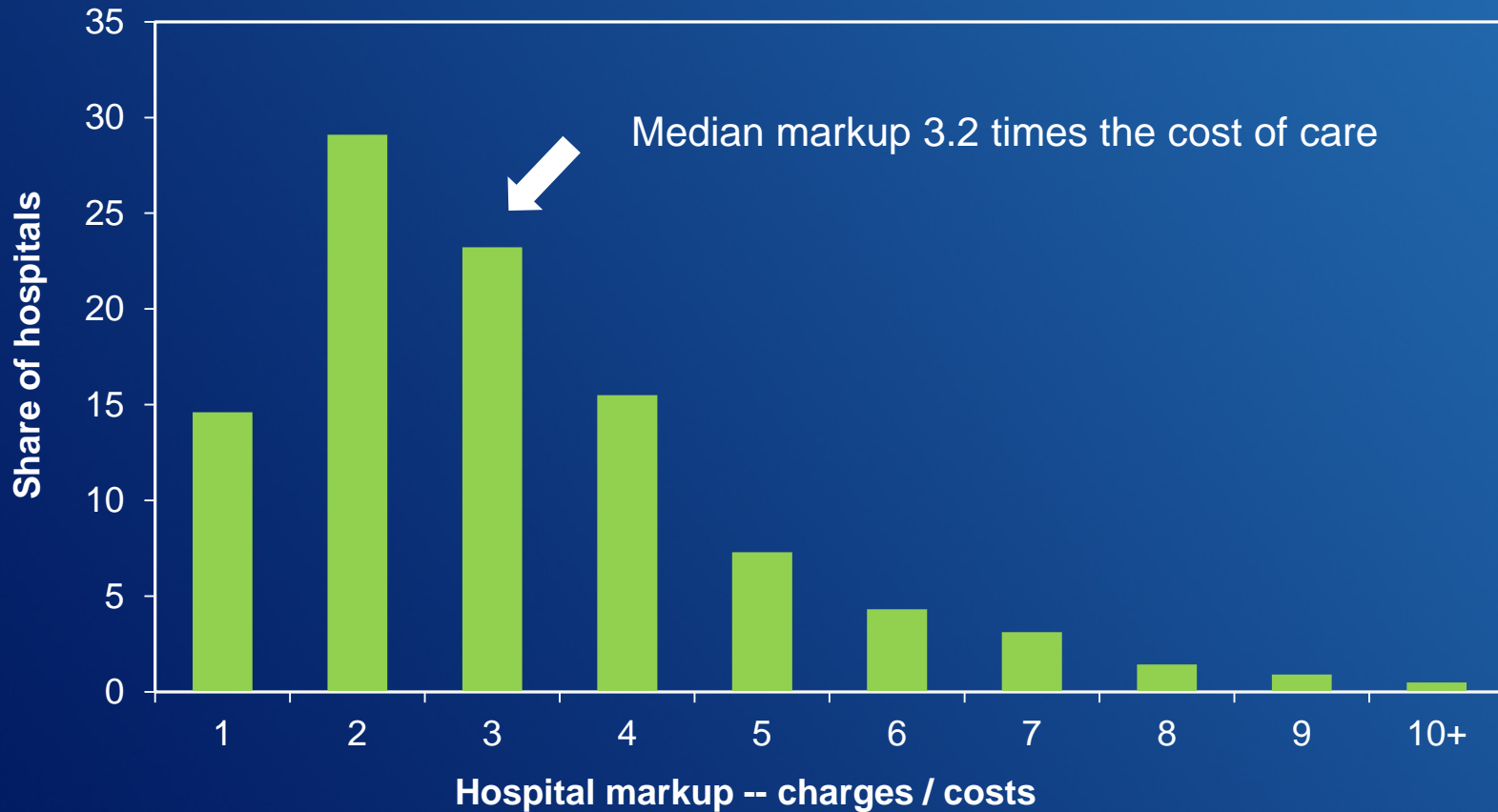
- Mix of services – More service use from departments with higher markups will result in higher outlier cost estimates and vice versa
- Differential markups – Services with a higher than average markup within a department will also result in higher outlier cost estimates

# Average markups across cost centers



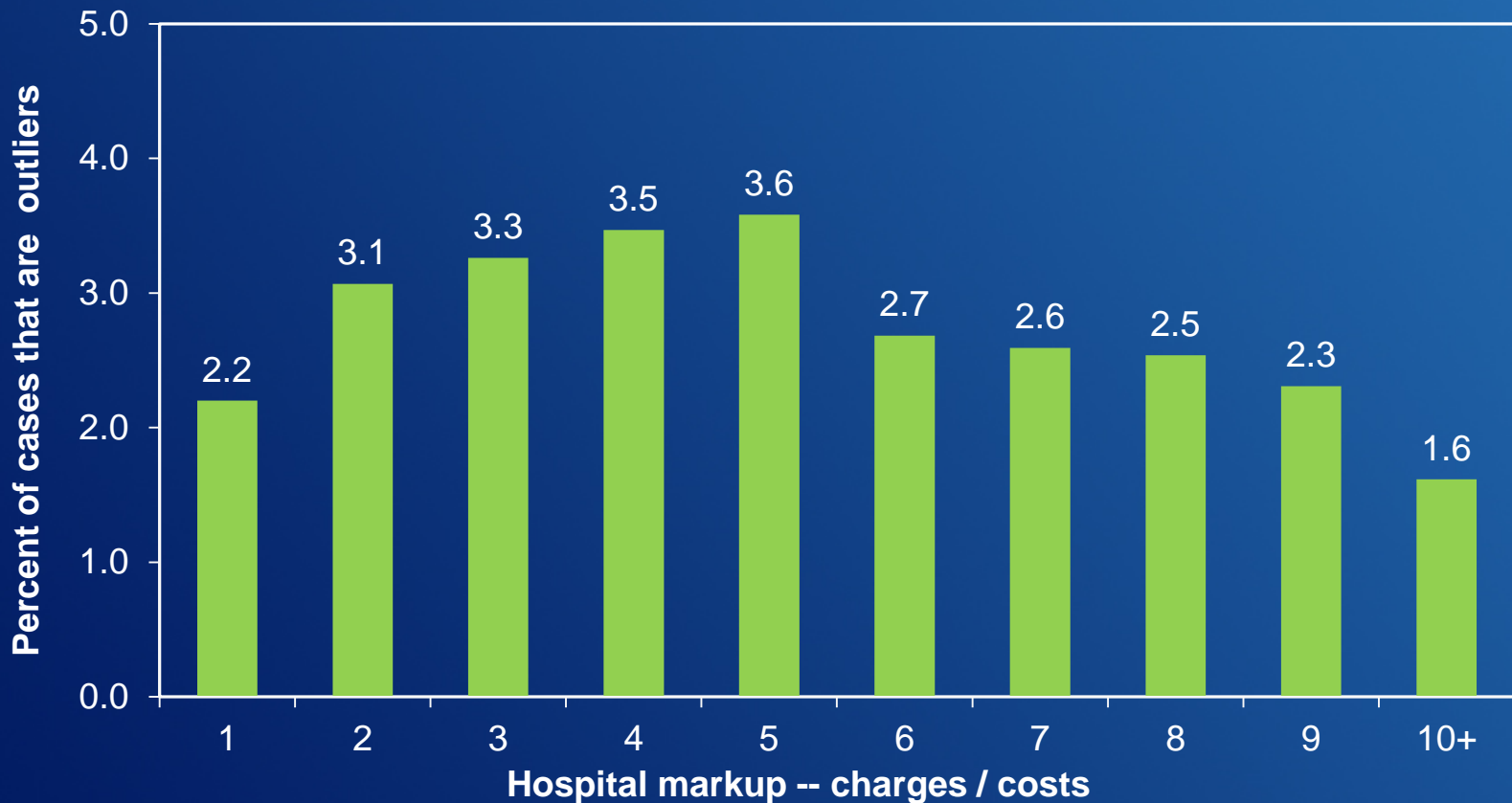
Source: MedPAC analysis of 2014 Medicare claims and cost reports.

# Markups vary across hospitals



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

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



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

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

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- 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

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- 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

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- Questions on analysis
- Discussion of policy options