MEDPAC

Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and mandated report on rural emergency hospitals

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Presentation roadmap

1. Overview of hospital use and spending under FFS Medicare
2. Beneficiaries' access to hospital care
3. Quality of hospital care
4. Hospitals' access to capital
5. FFS Medicare payments and hospitals' costs
6. Chair's draft recommendation

Presentation roadmap, continued

7 Mandated report on rural emergency hospitals

8 Discussion

Overview of hospital use and spending under FFS Medicare, 2023

		IPPS	OPPS
	Hospitals	3,145	3,110
	Users	4.2 million	15.9 million
	Services	6.6 million stays	123.8 million services
	Payments for services	$102.6 billion	$49.6 billion
	Other payments	$6.7 billion for uncompensated care	$20.4 billion for separately payable items

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), OPPS (outpatient prospective payment system). OPPS services provided at post-acute care and other specialty hospitals are not included.

Source: MedPAC analysis of Medicare Provider Analysis and Review data, IPPS final rule, and outpatient claims data.

Payment adequacy framework: Hospitals

Beneficiaries' access to care

- Hospital capacity and supply
- Volume of FFS Medicare inpatient and hospital outpatient services
- FFS Medicare marginal profit

Quality of care

- FFS Medicare risk-adjusted mortality rate and readmission rate
- Patient experience

Access to capital

- All-payer operating margin
- All-payer total margin
- Borrowing costs
- Financial statements
- Rating agency outlooks

FFS Medicare payments and costs

- FFS Medicare margin
- Median FFS Medicare margin among relatively efficient hospitals
- Projected FFS Medicare margin

Update recommendation for hospital base payment rates

Note: FFS (fee-for-service).

Access: Hospital capacity increased and hospitals maintained available capacity in 2023

Employment increased

- 4.7 million employees (+3% from 2022)

Inpatient capacity increased

- 674,000 inpatient beds (+1%)

Available inpatient capacity

- 69% aggregate occupancy rate (stable)

Available ED capacity

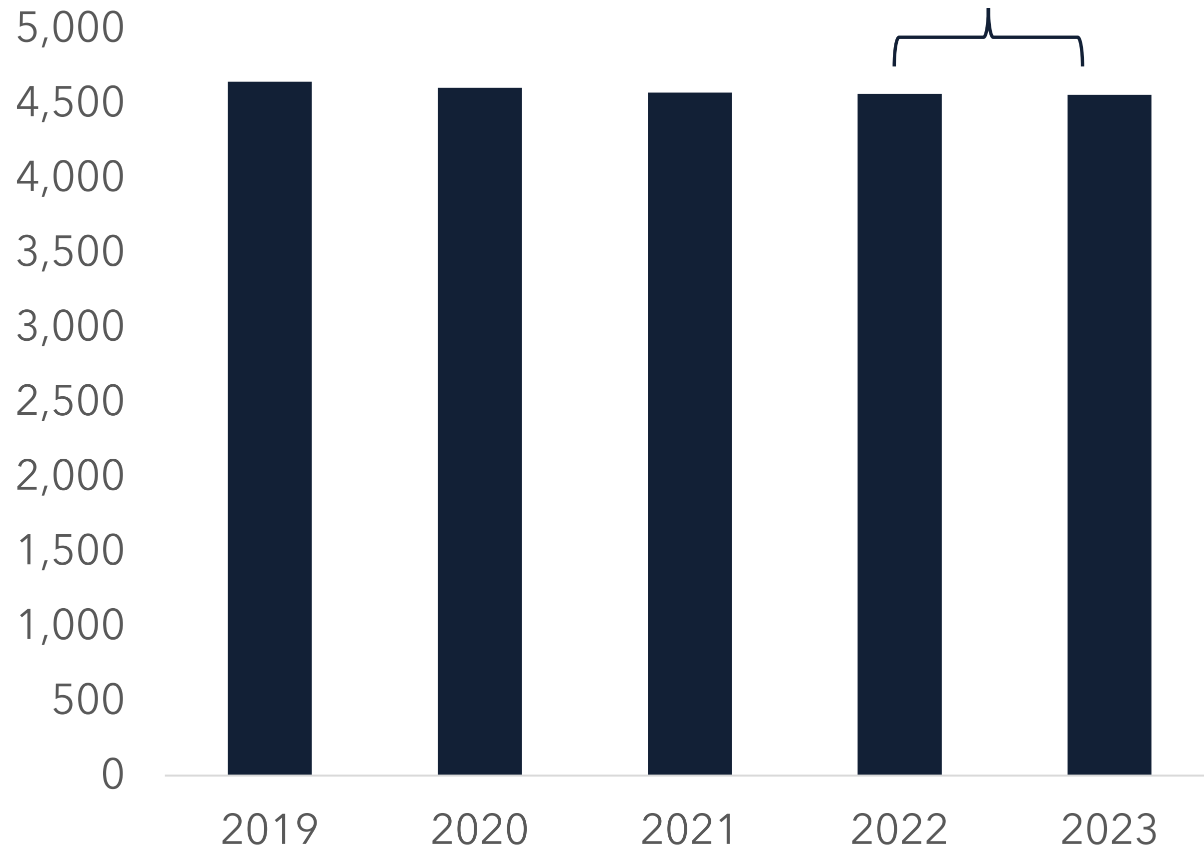
- 2% of patients left ED without being seen (median) (stable)

Within these aggregates, there continued to be substantial variation in hospitals' available capacity

Note: ED (emergency department). Data include all Subsection (d) and critical access hospitals that provided inpatient services to at least one fee-for-service Medicare beneficiary. Years are fiscal year 2023 except for ED data, for which the most recent are from calendar year 2022.

Source: MedPAC analysis of hospital cost reports, inpatient provider-specific files, and CMS timely and effective care data.

Access: Supply of hospitals relatively steady in 2023



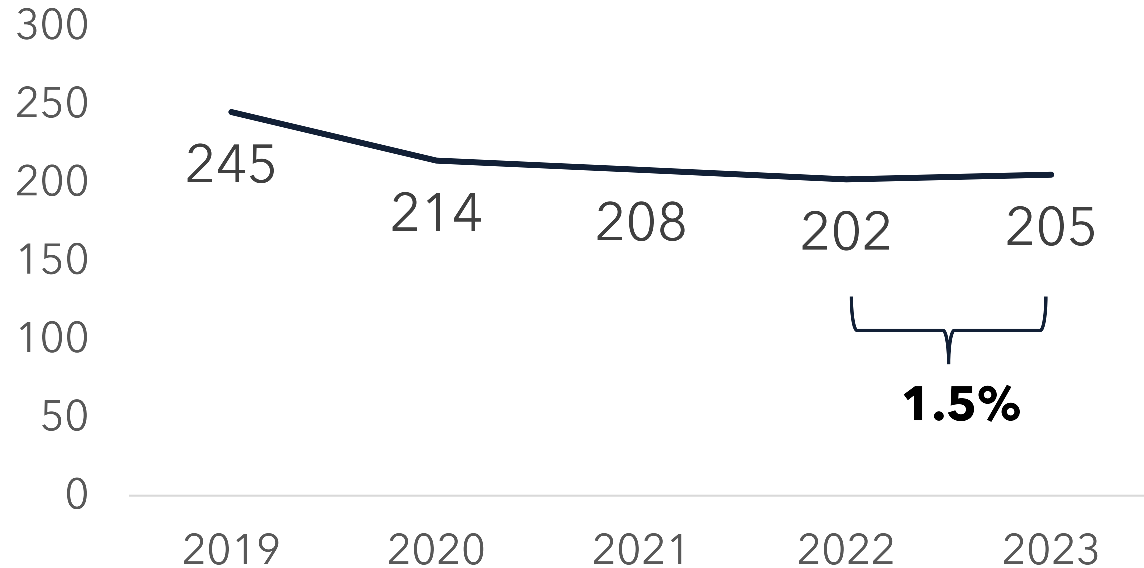
- In both FY 2023 and 2024:
  - About 10 more hospitals closed than opened; low volume most common cited reason for closure
  - About 15 hospitals converted to rural emergency hospitals

Note:. FY (fiscal year). Data include all Subsection (d) and critical access hospitals that provided inpatient services to at least one fee-for-service Medicare beneficiary.

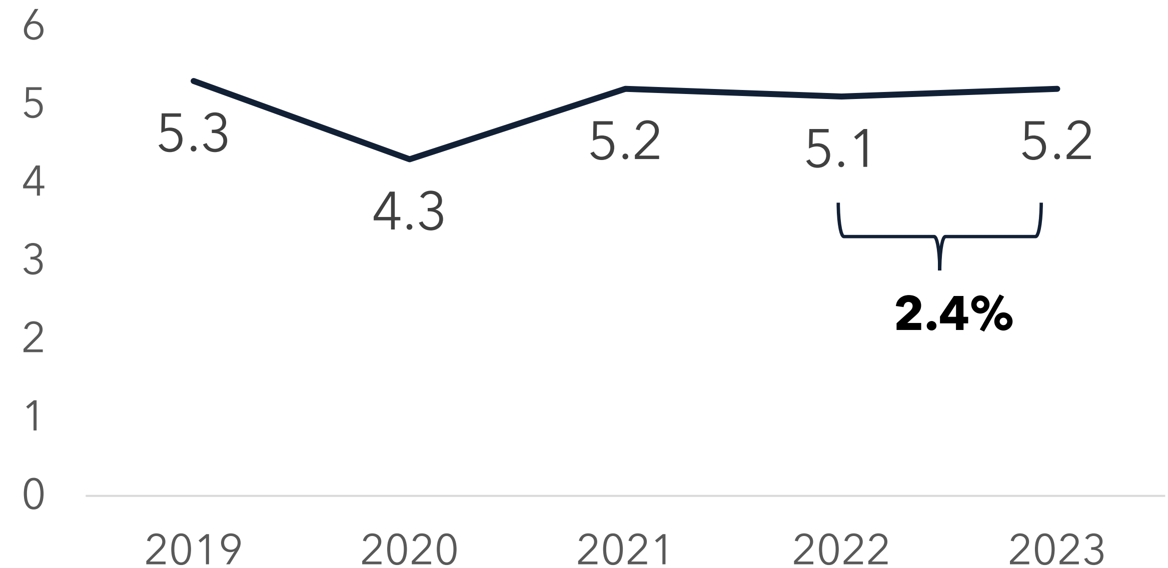
Source: MedPAC analysis of Medicare Provider Analysis and Review files.

Access: FFS Medicare inpatient stays and outpatient services per capita increased in 2023

Inpatient stays per 1,000 FFS Medicare beneficiaries



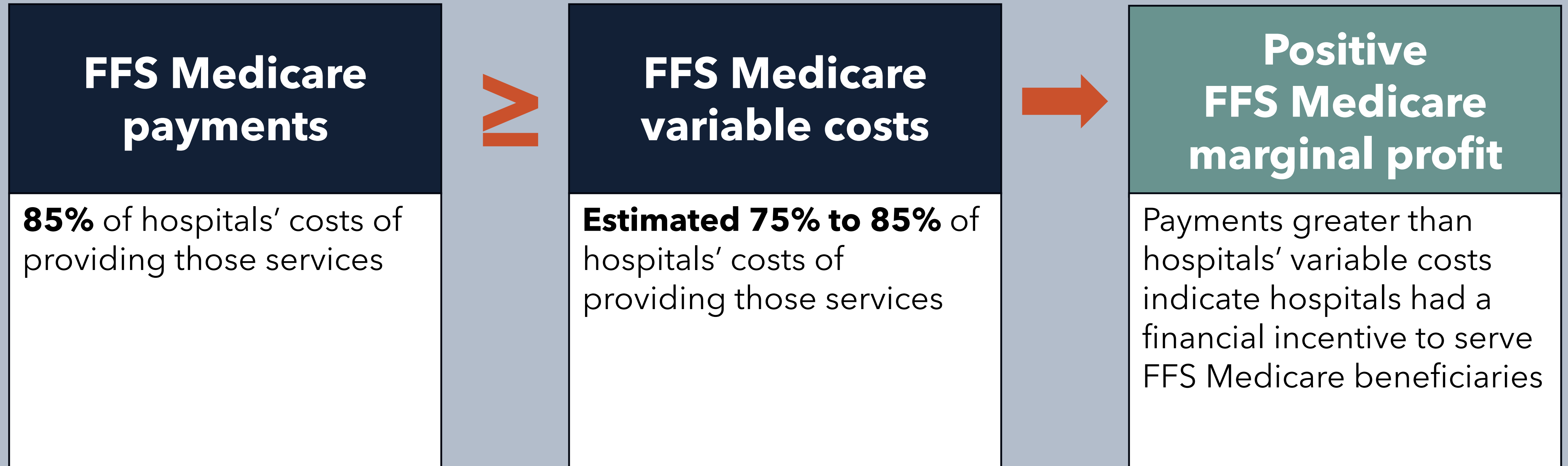
Hospital outpatient services per FFS Medicare beneficiary



Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. FFS Medicare beneficiary enrollment limited to those residing in the U.S. who have Part A coverage for inpatient and Part B coverage for outpatient services. Years are fiscal for inpatient and calendar for outpatient; those are the years used by CMS in rate setting. Outpatient results differ slightly from the results previously published because we modified the way we capture changes in policies for packaging ancillary items under the outpatient prospective payment system and the effects of expanded uses of comprehensive ambulatory payment classifications that occur over time.

Source: MedPAC analysis of Medicare Provider Analysis and Review files, hospital outpatient claims, and Common Medicare Environment files.

Access: Hospitals had a financial incentive to serve FFS Medicare beneficiaries in 2023



Note: FFS (fee-for-service). Payments and costs limited to services paid under the inpatient or outpatient prospective payment systems. "FFS Medicare payments" excludes uncompensated care payments, which do not vary with hospitals' volume of services provided. "Variable costs" estimated as the share of hospitals' costs that varied with annual changes in volume; the range is from the confidence interval of our regressions.

Source: MedPAC analysis of hospital cost reports.

Quality: 2023 indicators mixed

FFS mortality rate improved

- 7.6% risk-adjusted mortality rate
- Improvement from 2022 (+0.3 percentage points)
- Improvement from 2019 (+0.3 percentage points)

FFS readmission rate mixed

- 15.0% risk-adjusted readmission rate
- Worse than 2022 (–0.4 percentage points)
- Improvement from 2019 (+0.5 percentage points)

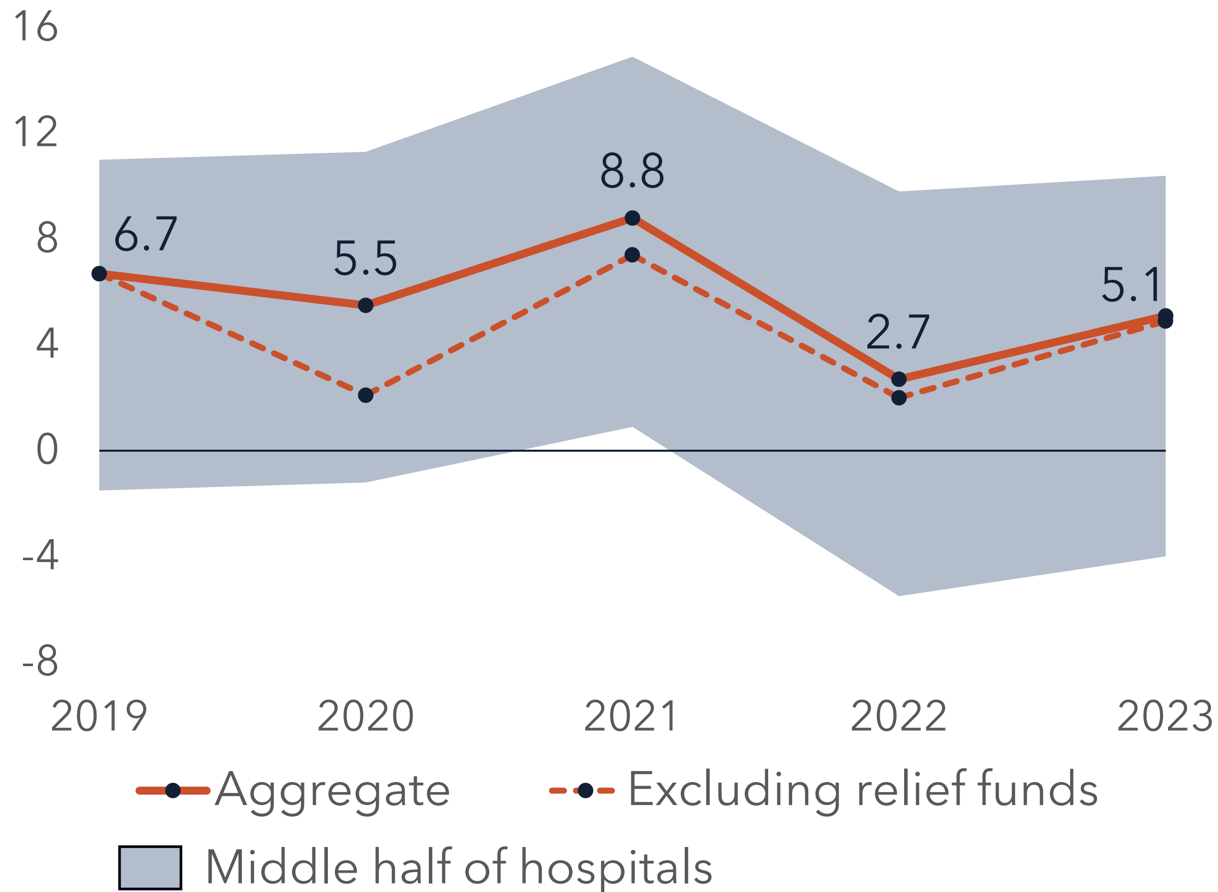
Patient experience mixed

- Most measures improved relative to 2022
- Almost all are at least 1 percentage point worse than 2019

Note: FFS (fee-for-service). "Mortality rate" refers to the share of inpatient stays that resulted in a death during or within 30 days after the stay. "Readmission rate" refers to the share of inpatient stays that resulted in a readmission during or within 30 days after the initial stay. Results differ from those published in prior years because of methodological updates, including removing critical access hospital stays.

Source: MedPAC analysis of Medicare Provider Analysis and Review data and CMS summary of H-CAHPS public report of survey results tables.

Capital: Hospitals' all-payer operating margin increased in 2023



- 2.4 percentage point improvement driven by growth in operating revenues
- Varied across hospitals
  - For profit: 12.9%
  - Nonprofit: 4.4%
  - Urban: 5.3%
  - Rural nonmicropolitan: –0.5%

Note: Data are for hospitals paid under the inpatient prospective payment systems that had a complete cost report with a midpoint in the fiscal year and had nonoutlier data as of our analysis. The all-payer operating margin excludes investment and donation income and, for 2020 to 2023, is reported with and without federal or other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers and inclusion of other coronavirus relief funds.

Source: MedPAC analysis of hospital cost reports and census geographic files.

Capital: Other measures positive; preliminary data suggest continued gradual improvement in 2024

All-payer total margin increased

- Hospitals' all-payer total margin increased to 6.4 percent, driven by investment income

Borrowing costs increased

- Hospital bonds yield increased to 4.4% in 2023
- But lower increase than in the general market

Financial statements suggest improvement

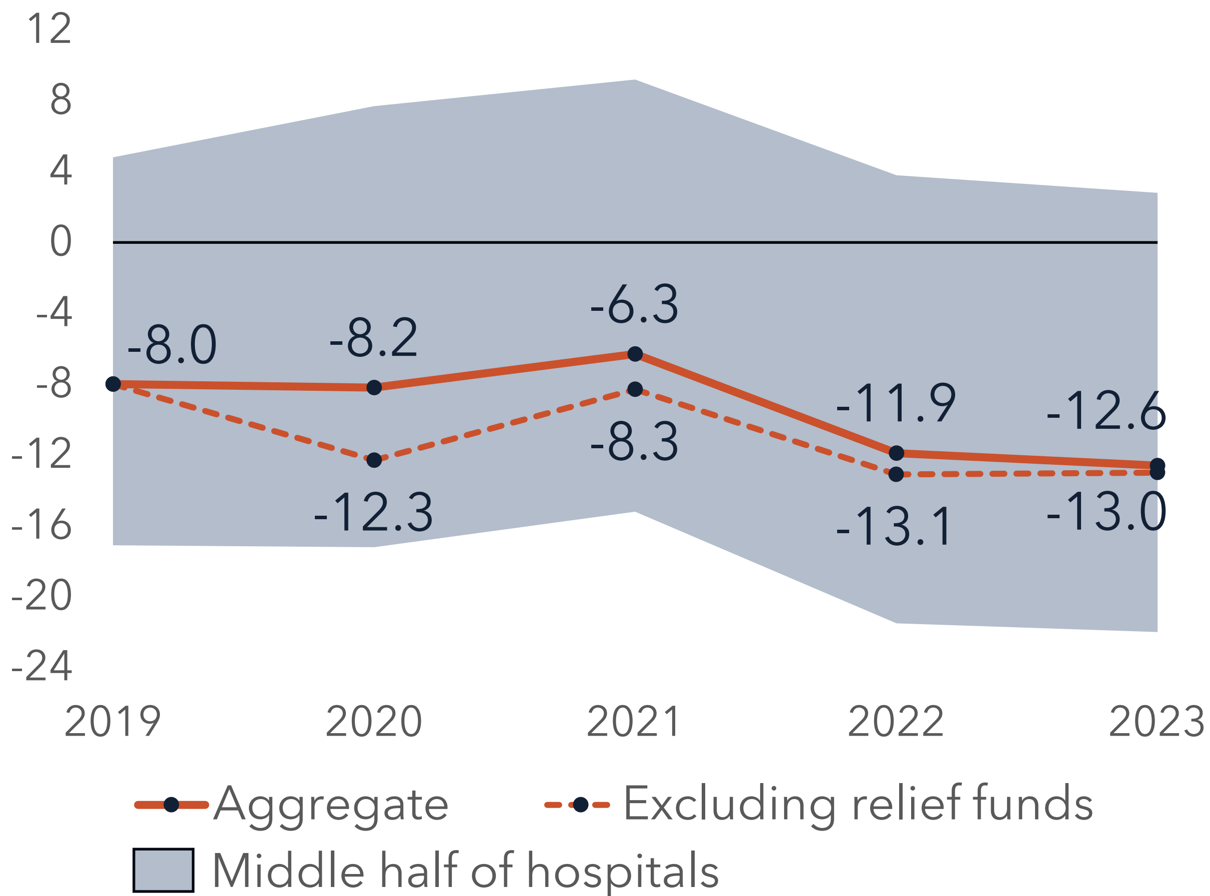
- Large hospital systems show ~1 percentage point increase in all-payer operating margin in 2024

Rating agencies predict gradual improvement

- Rating agencies project gradual improvement in nonprofit hospitals' access to capital

Source: MedPAC analysis of hospital costs reports, S&P global bond data, 2024 financial statements from six large hospital systems, and rating agency reports.

Payments and costs: Hospitals' aggregate FFS Medicare margin remained low in 2023



- Stable FFS Medicare margin exclusive of relief funds reflects offsetting pressures from 2022 to 2023
- Varied across hospitals:
  - For profit: 0.1%
  - Nonprofit: −14.3%
  - Urban: −13.2%
  - Rural nonmicropolitan: −3.9%

Note: FFS (fee-for-service). Data are for hospitals paid under the inpatient prospective payment systems that had a complete cost report with a midpoint in the fiscal year and had nonoutlier data as of our analysis. Results differ from those published last year because of newer data and methodological updates, such as limiting the set of included services paid under the inpatient or outpatient prospective payment systems.

Source: MedPAC analysis of hospital cost reports.

Payments and costs: Relatively efficient hospitals' median FFS margin improved in 2023 but remained negative

- Identified a subset of hospitals that historically performed relatively well on quality metrics while keeping costs relatively low

Median margin	Relatively efficient (6%)	Other (94%)
FFS Medicare margin with relief funds	–1%	–9%
FFS Medicare margin excluding relief funds	–2	–10
All-payer operating margin with relief funds	7	2

Note: FFS (fee-for-service). In 2023, "relatively efficient" and "other" hospitals were identified based on performance during 2019, 2021, and 2022. Medicare cost per unit combines standardized costs per inpatient stay and per outpatient service (relative to their respective national medians) using two-thirds and one-third weighting. Costs are standardized for area wages, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity.

Source: MedPAC analysis of CMS cost reports, claims data, and CMS's summary of Hospital Consumer Assessment of Healthcare Providers and Systems® public reports of survey results tables.

Summary: Hospital payment adequacy indicators

Beneficiaries' access to care

- Employment and beds increased
- Occupancy rate stable
- Supply relatively stable
- FFS Medicare volume per capita increased
- FFS Medicare marginal profit: Positive

Positive

Quality of care

- Mortality rate improved
- Readmission rate worsened but still improved from 2019
- Most patient experience measures improved but still below 2019 levels

Mixed

Access to capital

- All-payer operating margin increased
- All-payer total margin increased
- Borrowing costs increased but by less than general market
- Preliminary data suggest gradual improvement in 2024

Positive

FFS Medicare payments and costs

- FFS Medicare margin exclusive of relief funds:
  - −13% in aggregate
  - −2% median among relatively efficient hospitals

Negative

Chair's draft recommendation involves balancing objectives

- Maintain payments high enough to ensure beneficiaries' access to care
- Maintain payments close to hospitals' cost of providing high-quality care efficiently to ensure value for taxpayers
- Maintain fiscal pressure on hospitals to constrain costs
- Limit the need for large, across-the-board payment rate increases by directing a portion of the increase in Medicare payments to Medicare safety-net hospitals treating higher shares of vulnerable Medicare patients

In June 2023, the Commission recommended using the MSNI to target hospitals that serve more low-income Medicare patients

MSNI components

Medicare low-income share

- Share of Medicare hospital volume for beneficiaries with low income

Uncompensated care costs share of all-payer revenue

- Uncompensated care costs as a share of total revenue

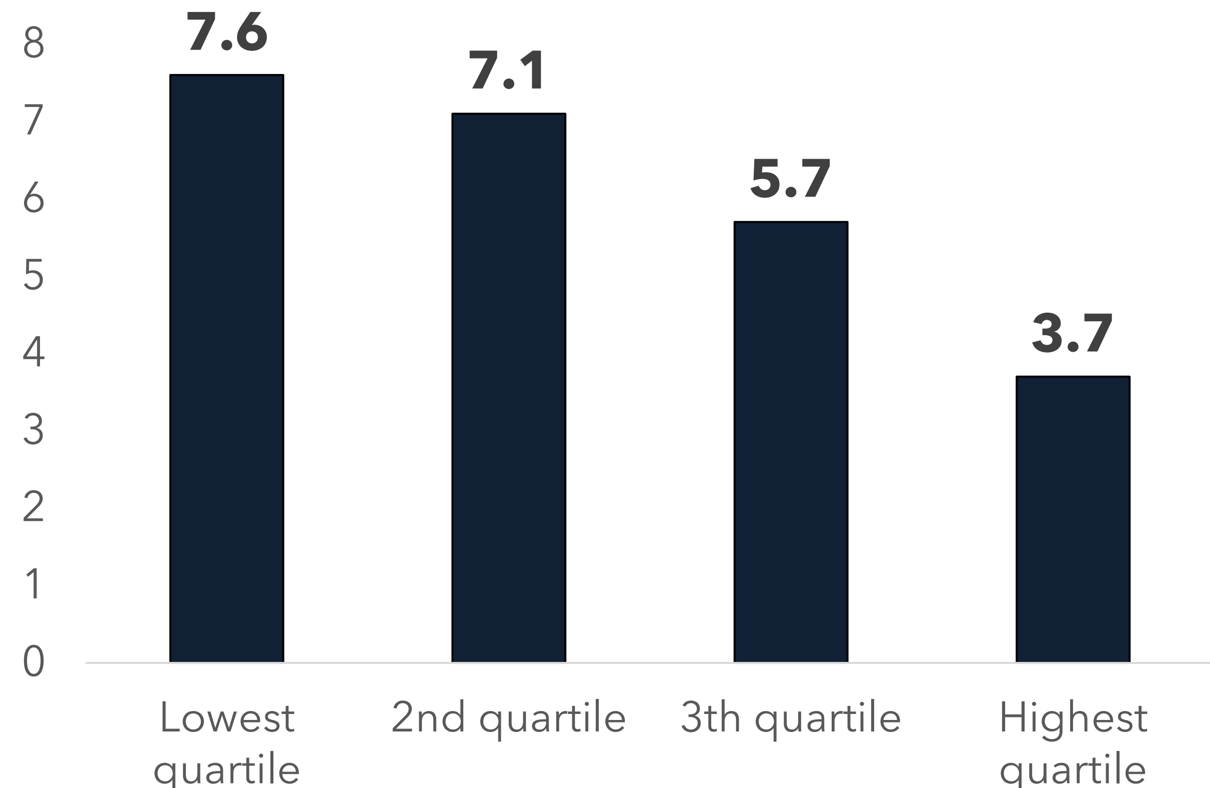
Medicare share of all-payer volume

- Medicare's share of inpatient and outpatient volume (divided by 2)

Note: MSNI (Medicare Safety-Net Index). "Medicare low-income share" is calculated as the percentage of fee-for-service (FFS) and Medicare Advantage (MA) inpatient stays and outpatient services that were for low-income beneficiaries. On the inpatient side, we used the Medicare Provider Analysis and Review and inpatient encounter data; on the outpatient side, we used the percentage of FFS Medicare outpatient volume that was for low-income FFS beneficiaries, but we plan to incorporate MA outpatient data in the future. "Uncompensated care costs as a share of all-payer revenue" is calculated from Medicare cost reports. "Medicare share of all-payer volume" incorporates both FFS- and MA-covered inpatient and outpatient volume using data on inpatient days and charges from the Medicare cost reports.

Hospitals with a higher MSNI have lower all-payer operating margins

- MSNI is better predictor of all-payer margin and risk of closure than those used for current Medicare safety-net payments
- Since 2023, the Commission has recommended moving to the MSNI, which would better target funds to hospitals most in need of additional Medicare funds



Note: MSNI (Medicare Safety-Net Index). Current Medicare safety-net payments are disproportionate share hospital and uncompensated care payments.

Source: MedPAC analysis of cost reports and MSNI data sources. Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Mandated report: Rural emergency hospitals

MedPAC recommended the creation of an outpatient-only hospital in 2018

- Inpatient volumes at some rural hospitals had declined substantially
- Isolated, rural towns still need local emergency care
- An outpatient-only hospital could accommodate markets that need emergency care but have little inpatient volume
- Fixed monthly payments would help cover fixed costs
- FFS payments would help cover marginal costs

Note: FFS (fee-for-service).

Consolidated Appropriations Act, 2021, created new REH designation

- REHs must have an ED staffed 24/7 and offer hospital observation care services
- REHs cannot maintain acute inpatient beds or swing beds
- REHs have the option to furnish other services
  - Distinct-part SNF services
  - Other outpatient care
- In 2025, REHs will receive fixed payments of about $286,000 per month ($3.4 million annually)
- REHs also receive 105% of OPPS rates for all OPPS services and standard rates for other services (e.g., laboratory tests)

Note: REH (rural emergency hospital), ED (emergency department), SNF (skilled nursing facility), OPPS (outpatient prospective payment system).

Mandated report: Rural emergency hospitals

Consolidated Appropriations Act, 2021:

- Mandated that MedPAC annually report on payments to REHs
- In our March 2024 report, we discussed the REH program in detail
- This year we analyze calendar year 2023 data, which show:

21	~$10 million	~$30 million
Hospitals converted to REHs	**FFS Medicare outpatient payments**	**FFS Medicare fixed payments**

Note: REH (rural emergency hospital), FFS (fee-for-service).
Source: MedPAC analysis of calendar year 2023 outpatient claims data.

Discussion

- Questions
- Feedback

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