MEDPAC

Advising the Congress on Medicare issues

Differences in Hospital Use Between Medicare Advantage and Fee-For-Service Patients: Implications for Hospitals' Costs

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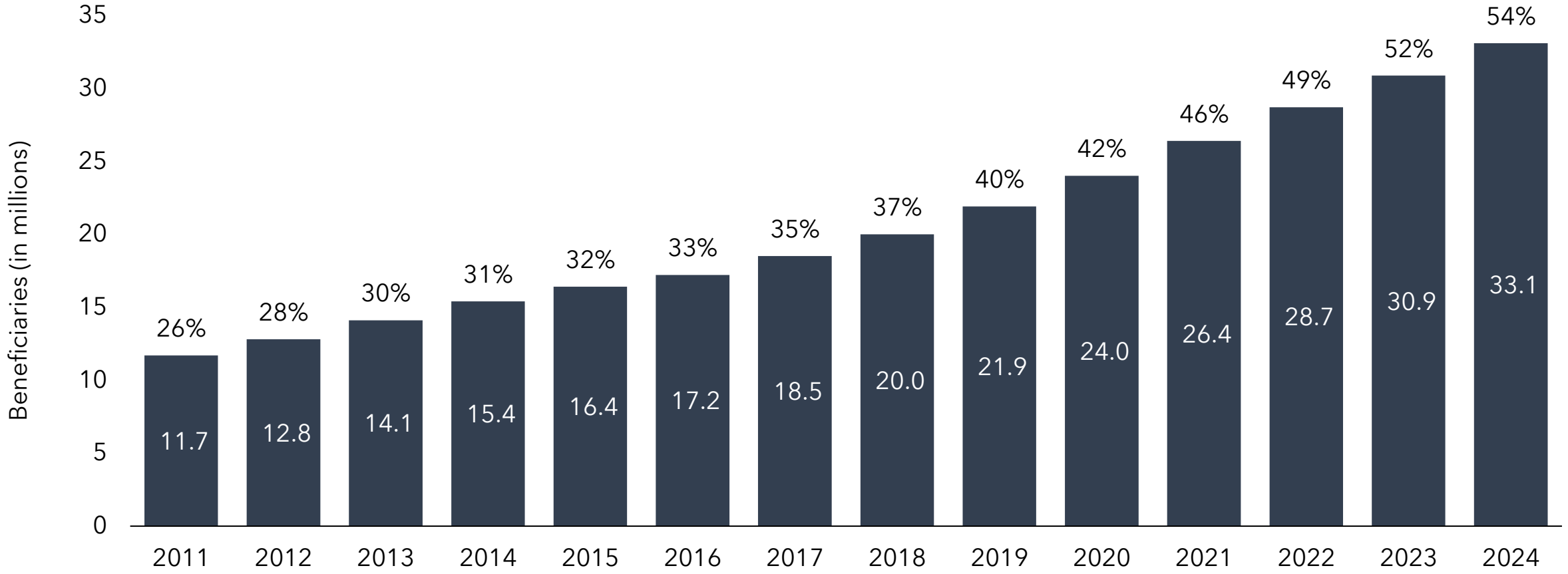
MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by the Comptroller General of the Government Accountability Office (GAO) for experience and subject matter expertise
  - Include providers, payers, researchers, beneficiary-focused individuals
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields
- Seven public meetings during the year
  - Staff present analyses informed by site visits, focus groups with beneficiaries and providers, expert panels, input from stakeholders, quantitative analyses
- Guiding principles strive to ensure that beneficiaries have access to high-quality care, providers have incentives to supply appropriate and equitable care in an efficient manner, and that the program's financial burden on taxpayers and beneficiaries is not greater than necessary

Transparency in MedPAC's work

- Commission meetings are open to the public and webcast
- Full meeting transcript publicly available on MedPAC's website
- Presentations are available through webcast and MedPAC's website
- Public comments are disseminated to commissioners and available on MedPAC's website
- Other publications on MedPAC's website include reports, comment letters, testimony, press releases, data books, payment basics, contractor reports, and recommendations
- Publish analytic agenda for the upcoming year

More than half of eligible Medicare beneficiaries are enrolled in a Medicare Advantage plan



Note: MA (Medicare Advantage).
Source: CMS enrollment data, February 2011–2024.

Prior analysis of Medicare Advantage

- MedPAC assesses trends in the MA program annually
- Recent work covers MA plan provider networks and prior authorization
- Our work adds to a large body of research comparing MA and FFS
- All comparisons of MA and FFS face 3 challenges that limit the reliability of findings:
  - Data comparability and completeness
  - Differences in coding intensity (both within MA and between MA and FFS)
  - Favorable selection in MA

Source: Medicare Payment Advisory Commission. 2024. Report to the Congress: Medicare payment policy.

Interviews with stakeholders about Medicare Advantage

Providers expressed concerns about MA during MedPAC site visits:

- Challenges around getting prior authorization for hospital admission and discharge to post-acute care
  - Challenges include denials, requests for additional documentation, and delays
  - Longer length of stay for MA patients associated with higher costs to the hospital
- Lower effective payment rates for MA patients than for FFS patients
  - "Down-tiering" of inpatient hospital stays to observation stays

We looked at Medicare claims and MA encounter data to explore these assertions.

Note: MA (Medicare Advantage), FFS (fee-for-service)
Source: MedPAC site visits and interviews with providers.

Financial incentives may affect plan and provider behavior

- MA plans have an incentive to keep people healthy and avoid unnecessary or inappropriate hospitalizations
- When an enrollee receives care at the hospital:
  - Extending inpatient length of stay (usually paid on a MS-DRG basis)
    - Can reduce price paid by MA plan due to per diem copayments
    - Can reduce use of post-acute SNF care (which generally does not have cost sharing)
  - Shift inpatient to observation stays
    - Lower payment rate for observation
- SNFs may have an incentive to prioritize admission of FFS patients
  - It has been reported that rates paid by MA plans for SNF care are often 20 percent or more below FFS rates

Analytical approach

- Used MedPAR and MA encounter data
- Comparing length of stay for MA and FFS patients
  - Compared average length of stay for MA and FFS patients with same MS-DRG at same facility
  - Stratified by discharge destination
- Exploring use of observation care in MA and FFS patients
  - Will assess effect of MA enrollment on length and likelihood of observation stay, controlling for facility and patient characteristics

MA patients have longer lengths of stay, particularly when discharged to post-acute setting

	MA beneficiaries' length of stay minus FFS beneficiaries' length of stay, 2019-2021 (difference in days)
Total (All discharge destinations)	0.5*
Discharged to SNF	1.2*
Discharged to home	0.2*

*Indicates statistically significant at the P<.01 level of significance after adjusting for clustering of standard errors at the hospital level.

Potential impacts of longer lengths of stay

- Could increase hospital costs (without an increase in revenue if paid on a DRG basis)
- Could lower plan costs
- Could increase beneficiary cost-sharing

Note: MA (Medicare Advantage), FFS (fee-for-service), SNF (skilled nursing facility), DRG (diagnosis-related group). Length of stay is measured within severity adjusted DRGs within the same hospital. For the length of stay analysis, each combination of hospital and MS-DRG is considered an observation.
Source: MedPAC analysis of Medicare claims and encounter data.

Assessing factors that may contribute to differences in length of stay

- We considered whether the differences in length of stay are driven by differential use of observation stays
  - Billing short MA stays as observation could increase average length of stay
  - Unlikely to drive results, given differences for individuals discharged to SNFs
- We have consistently heard about difficulties discharging MA patients
  - Hospital administrators indicating delays in MA plan authorization
  - Discharge planners indicating that even with authorization it is harder to place MA patient than FFS patients

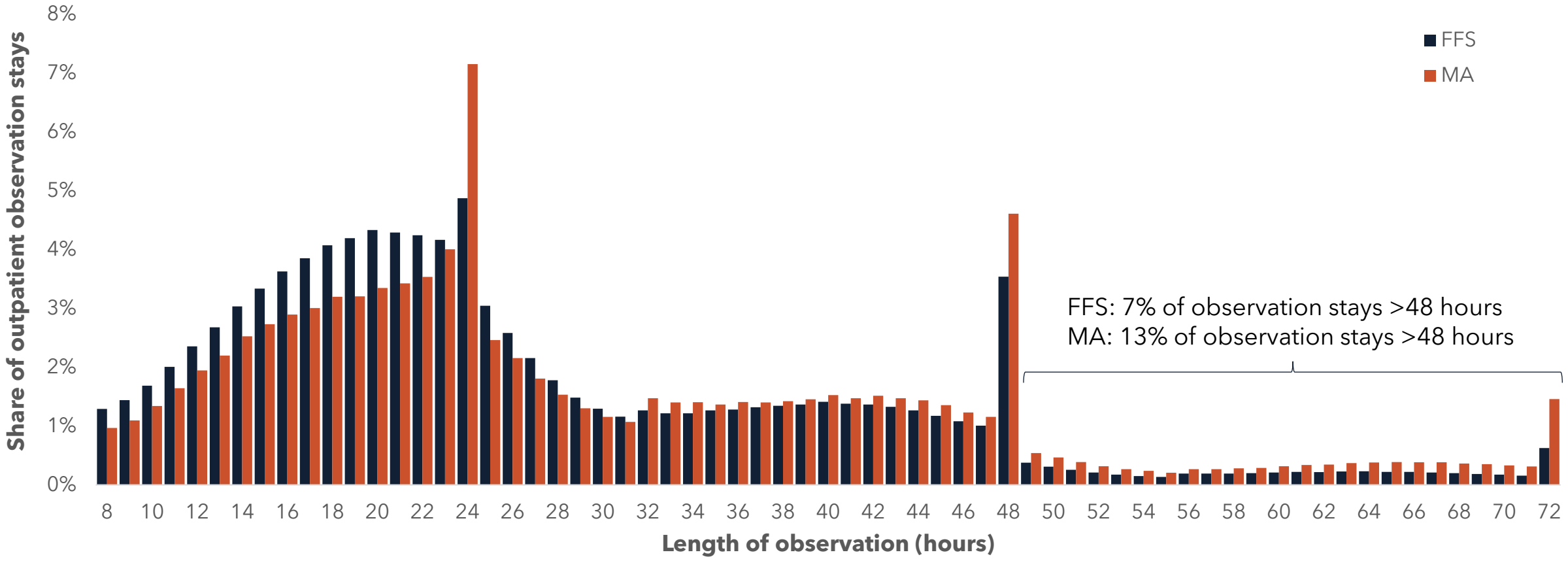
Source: MedPAC structured interviews, MedPAC March 2024 report to Congress.

Looking forward

- The **"two-midnight" rule** states that hospitalizations in FFS are generally appropriate for payment as inpatient admissions when the admitting physician expects the patient to require hospital care crossing two-midnights
- Hospitals have asserted that MA plans are using other coverage criteria that result in some stays being paid as observation care
- In 2023, CMS issued a final rule stating that MA plans must also follow the two-midnight rule

Source: Centers for Medicare and Medicaid Services. Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program.

MA patients are more likely to have observation stays exceeding 48 hours



Note: MA (Medicare Advantage), FFS (fee-for-service)
Source: MedPAC analysis of MedPAR (Medicare Provider Assessment and Review) file and MA encounter data, 2019

Recent MA plan and hospital statements

Humana (April 24, 2024 investor call):

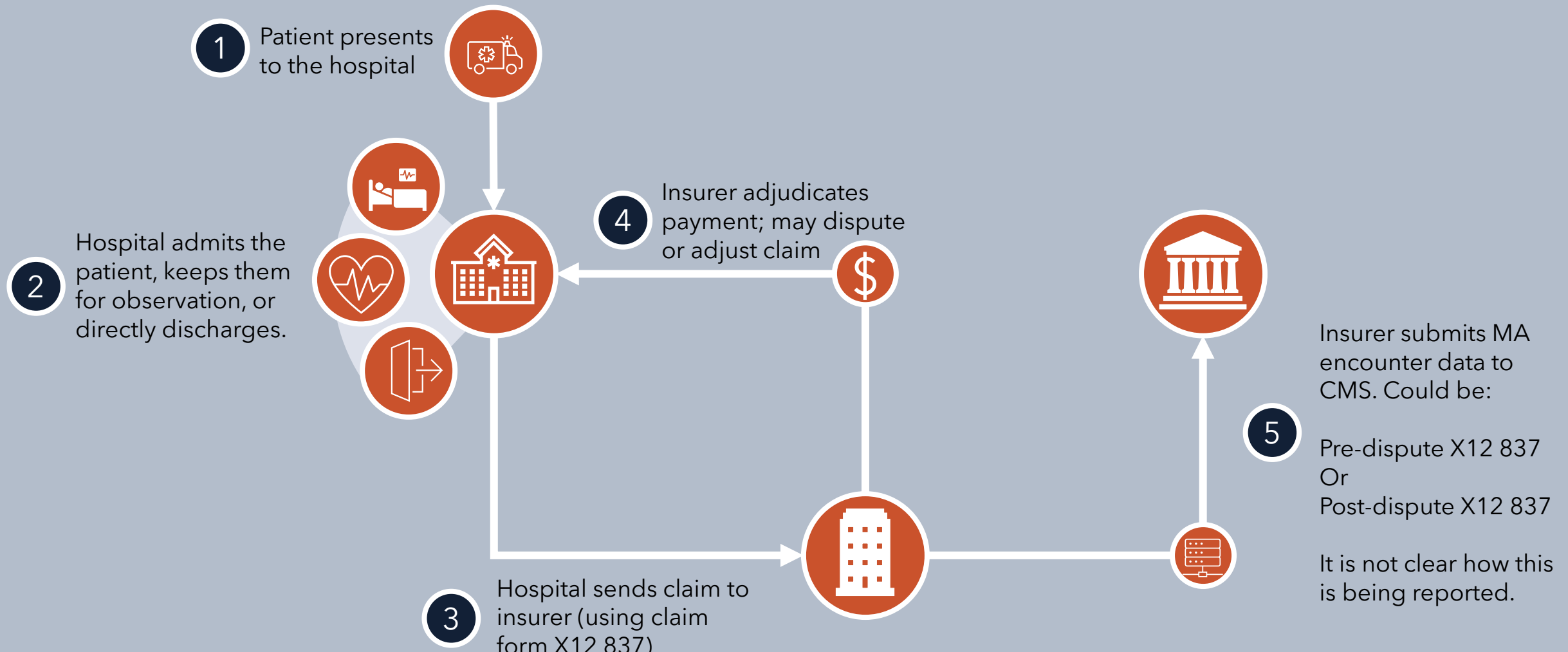
"[As] you might remember from our fourth quarter commentary, one of the things we did experience was an unexpected uptick in inpatient utilization, which we did believe was in some way related to the expected 2-midnight rule changes that went into effect in January. . . *[As] we said on our fourth quarter call, we were anticipating, in light of the 2-midnight rule changes, that we would see an increase in short stays and things that under the old rules were billed as an observation, they would now flip to an inpatient's stay. And we saw that in the fourth quarter start to emerge and did continue to see that in the quarter incrementally."*

HCA (April 26, 2024 investor call):

"On the two-midnight rule, I'd say it's still early. We are starting to see some encouraging signs. We do believe it's providing a modest benefit. **We're seeing some of our two-midnight inpatient volume grow. And we think that's due to status in accordance with the new rules.** But I'll emphasize it's still early and not all claims have completed the adjudication processes. But at this point, we still believe there's going to be a modest benefit from the two-midnight rule."

Sources: Humana: Susan Diamond, CFO, on Human's first quarter conference call.
HCA: Bill Rutherford,CFO, on HCA's first quarter conference call

Unclear if MA encounter data can be used to assess re-categorization of inpatient stays



Limitations

- Encounter data
  - Prior analysis has showed MA encounter data to be incomplete
- Risk adjustment & selection
- Cross sectional analysis

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