

# **Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services**

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# Presentation roadmap

- 1 Overview of hospital use and spending under FFS Medicare
- 2 Review of payment-adequacy indicators
- 3 Site-neutral payments
- 4 Draft recommendation

# Overview of hospital use and spending under FFS Medicare, 2023



**Hospitals**

IPPS

3,145

OPPS

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), OPSS (outpatient prospective payment system). OPSS services provided in 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.

# Beneficiary access to hospital care was positive in 2023



## Relatively steady supply

- Number of hospitals relatively steady at about 4,500
- About 10 more hospitals closed than opened, and 15 others converted to rural emergency hospitals



## Available capacity in aggregate

- Employment increased 3% to 4.7 million
- Beds increased 1% to 674,000
- Occupancy rate steady at 69%
- Median share of patients leaving ED without being seen steady at 2%



## FFS volume increased

- Inpatient stays per capita increased 1.5% to 205 stays per 1,000 FFS Medicare beneficiaries
- Outpatient services per capita increased 2.4% to 5.2 services



## Financial incentive to treat FFS

- FFS Medicare payments remained greater than hospitals' variable costs

**Note:** ED (emergency department), FFS (fee-for-service). Most access indicators include critical access hospitals. See December presentation for more notes.

**Source:** MedPAC analysis of hospital cost reports, Provider of services file, internet searches, claims data, and Common Medicare Environment files.

# Quality of hospital care was mixed in 2023



## FFS mortality rate improved

- 7.6% risk-adjusted mortality rate (-0.3% percentage points)



## FFS readmission rate worsened

- 15.0% risk-adjusted readmission rate (+0.4 percentage points)



## Patient-experience results improved

- Most measures improved, but many remained low

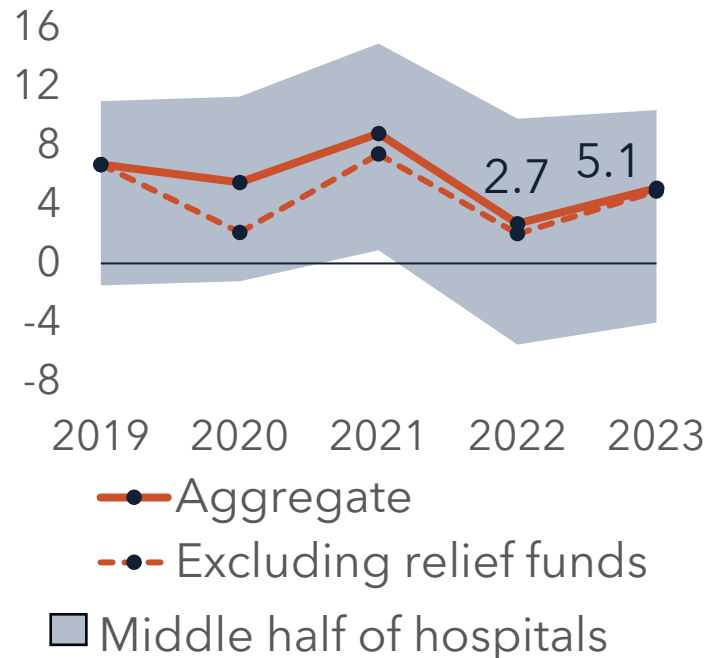
**Note:** FFS (fee-for-service). "Mortality rate" refers to the share of inpatient stays that resulted in a death during or within 30 days after the stay. "Readmission rate" refers to the share of inpatient stays that resulted in a readmission during or within 30 days after the initial stay. Results 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 Hospital Consumer Assessment of Healthcare Providers and Systems public report of survey-results tables.

# Hospitals' access to capital was positive in 2023; gradual improvement projected



## All-payer operating margin positive, increased



**Note:** The all-payer operating margin excludes investment and donation income. See December presentation for additional notes.

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



## Bond and other measures positive

- Hospital-bond yield increased but by less than general market
- All-payer total margin increased to 6.4%
- Mergers and acquisitions continued



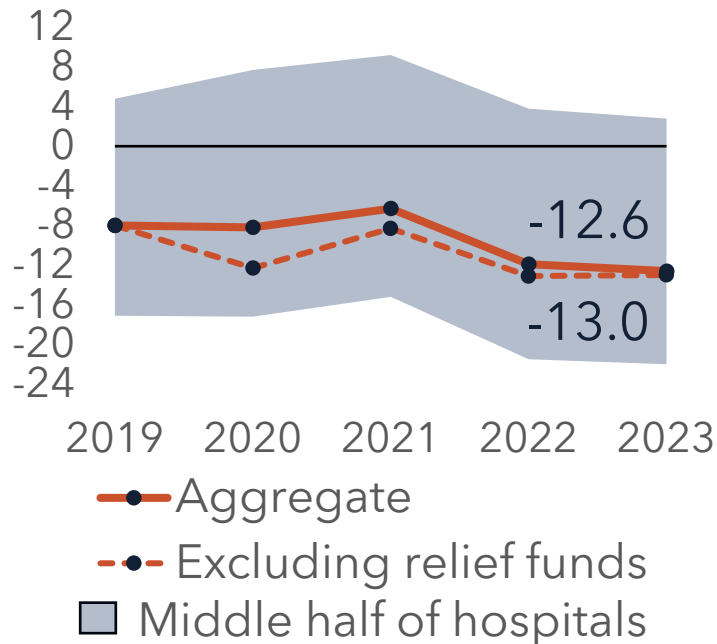
## Preliminary data suggest gradual improvement

- Large hospital systems' statements suggest slight improvement in operating margin in 2024
- Relative borrowing costs decreased in 2024
- Rating agencies project gradual improvement among nonprofit hospitals in 2025

# Hospitals' FFS Medicare margin was negative in 2023



## FFS Medicare margin negative, steady



## Negative margin for relatively efficient hospitals

- Identified 6% of hospitals as “relatively efficient”: consistently performed relatively well on quality while keeping costs relatively low
- Median FFS Medicare margin:
  - -1% with relief funds
  - -2% without relief funds



## Project margin to remain low

- Project similar margins in 2025:
  - -13% in aggregate
  - -2% for median relatively efficient hospital

**Note:** FFS (fee-for-service). See December presentation for additional notes.

**Source:** MedPAC analysis of hospital costs reports, claims data, survey results from the Hospital Consumer Assessment of Healthcare Providers and Systems, and market basket data.

# Draft recommendation involves balancing objectives

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- 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 incomes



### 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.

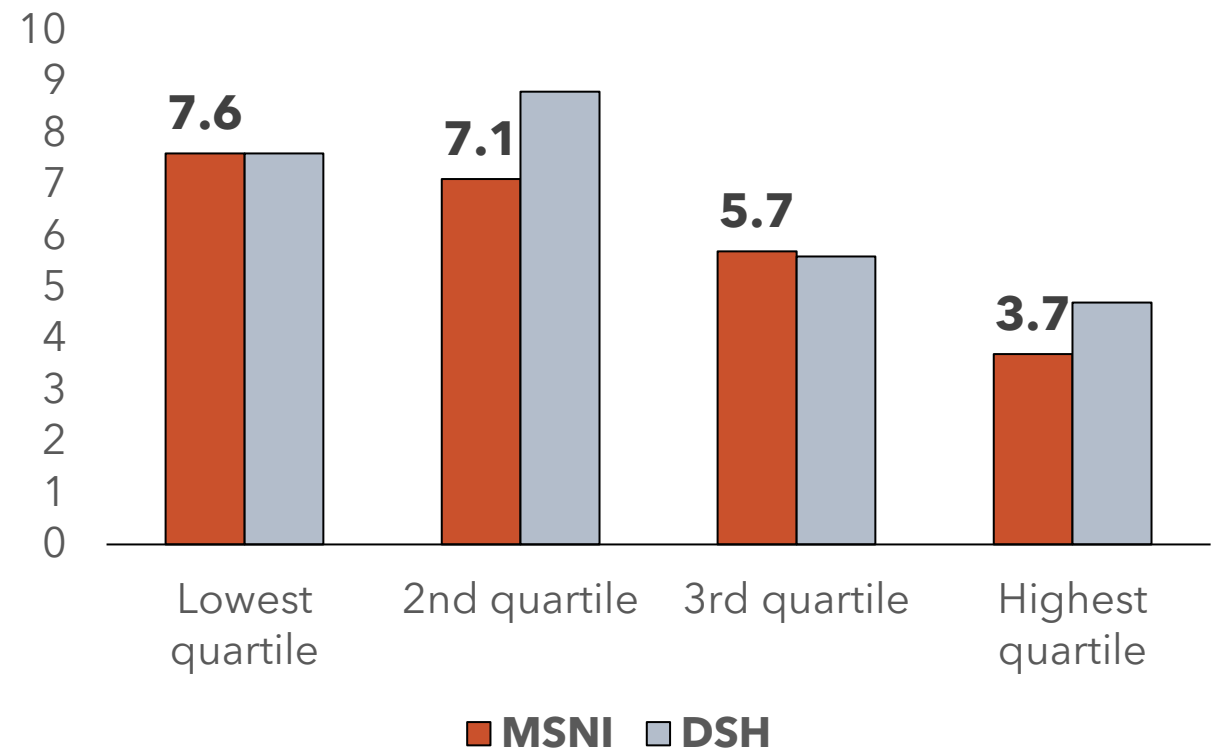
# Hospitals with a higher MSNI have lower all-payer operating margins

- MSNI is better predictor of all-payer margin 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), DSH (disproportionate share). Current Medicare safety-net payments are DSH 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.

**Hospitals' 2023 all-payer operating margin (in percent), by MSNI and DSH quartiles**





# Site-neutral payments

# Effects of expanding the Bipartisan Budget Act (BBA) of 2015's site-neutral payment policy

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- Site-neutral payments improve incentives to provide care in the lowest-cost setting in which it is safe and appropriate
- Commission recommendations: Align payment rates for select services in all HOPDs (March 2014 and June 2023)
- BBA of 2015: Aligns payment rates for all services in new off-campus PBDs
- Expanding the BBA of 2015 policy to include OPPS services provided in all off-campus PBDs would have lowered Medicare OPPS payments in 2023 by \$1.3 billion and beneficiary cost sharing by \$0.3 billion (before the application of budget neutrality)

**Note:** HOPD (hospital outpatient department), PBD (provider-based department), OPPS (outpatient prospective payment system).

**Source:** MedPAC analysis of hospital outpatient claims.



# Draft recommendation

## Draft recommendation

The Congress should:

- for 2026, update the 2025 Medicare base payment rates for general acute care hospitals by the amount specified in current law plus 1% and
- redistribute existing disproportionate share hospital and uncompensated-care payments through the Medicare Safety-Net Index (MSNI)—using the mechanism described in our March 2023 report—and add \$4 billion to the MSNI pool

# Implications

*Spending:* Relative to current law, spending would increase by \$5 billion to \$10 billion in one year and by \$25 billion to \$50 billion over five years ( $\approx 2.2\%$  above current law)

*Beneficiary and provider:* Will help ensure fee-for-service Medicare beneficiaries' access to care by increasing hospitals' willingness and ability to treat beneficiaries, especially those with low incomes

# Medicare Payment Advisory Commission

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