Advising the Congress on Medicare issues

Medicare
Hospital Payment Policy

Jeff Stensland, Principal Policy Analyst, MedPAC

Patient Classification Systems International

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Today's presentation

- Overview of MedPAC
- The Medicare cost challenge in the United States
- The challenges in setting payment weights
  - Bundling and coding tradeoffs
  - Technical issues in setting weights
- Questions / discussion

Medicare Payment Advisory Commission

- Provide nonpartisan policy and technical advice to the Congress on Medicare, which is the insurance for the aged and disabled
- 17 Commissioners selected for experience and subject matter expertise
  - Includes providers, payers, researchers, beneficiary-focused individuals (non-partisan)
  - Deliberate and vote in public
- Commissioners supported by about 25 analysts

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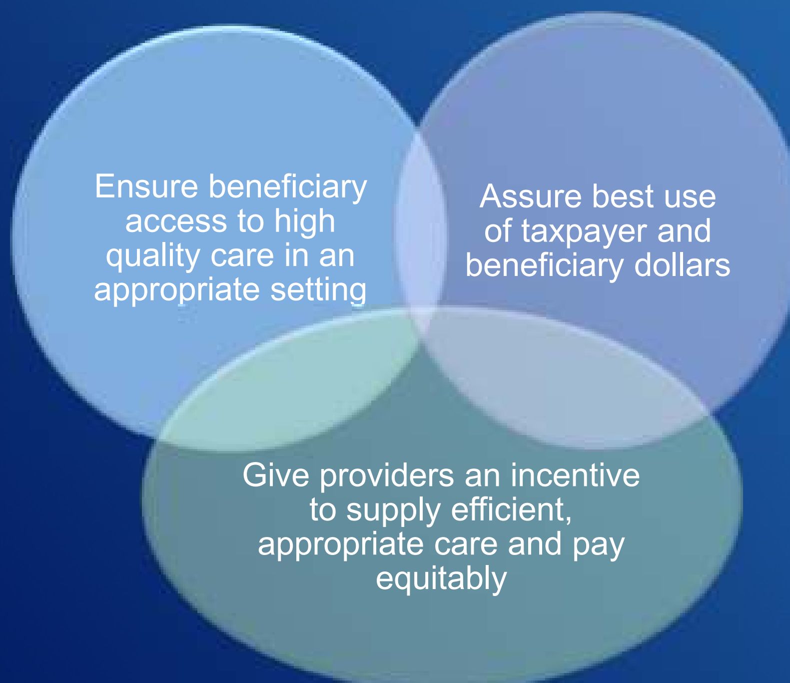
MedPAC's principles of Medicare payment



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The Big Picture

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The American insurance system

- Categories of hospital admissions
  - 43% Medicare (aged and disabled)
  - 24% Medicaid/other (low income/births)
  - 33% Commercial/other (including employees)
- 4% of care is uncompensated (in part due to a lack of insurance)
- Providers
  - Non-profit and for-profit profividers
  - High market power / High commercial prices
  - Vertically integrated physicians/hospitals

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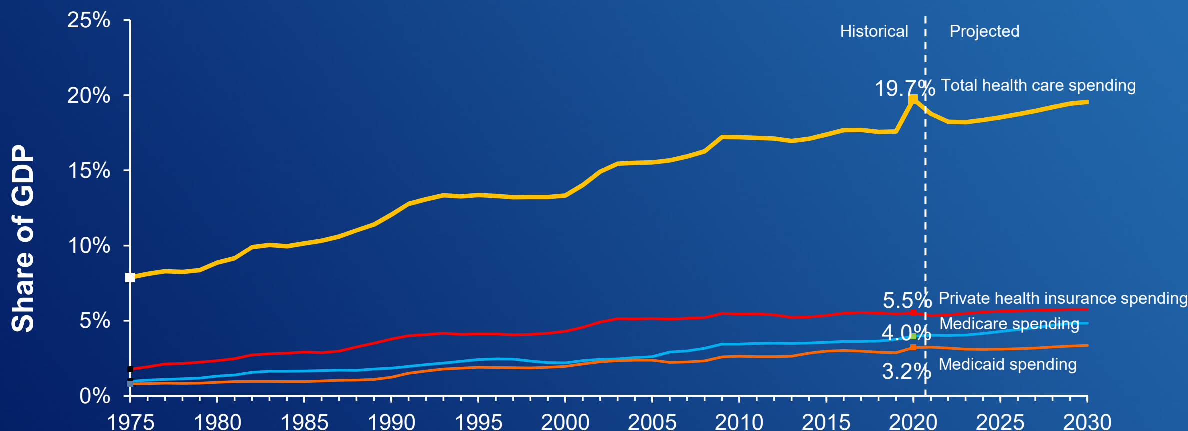
National health care spending consumes a growing share of the country's GDP



Note: GDP (gross domestic product). Beginning in 2014, private health insurance spending includes federal subsidies for both premiums and cost sharing for the health insurance marketplaces created by the Affordable Care Act of 2010. Health care spending also includes the following expenditures (not shown): out-of-pocket spending; spending by other health insurance programs (the Children's Health Insurance Program, the Department of Veterans Affairs, and the Department of Defense); and other third-party payers and programs and public health activity (including Indian Health Service; Substance Abuse and Mental Health Services Administration; maternal and child health; school health; workers' compensation; worksite health care; vocational rehabilitation; other federal, state, and local programs; other private revenues; and general assistance). Data are preliminary and subject to change.
Source: MedPAC analysis of CMS's National Health Expenditure Data.

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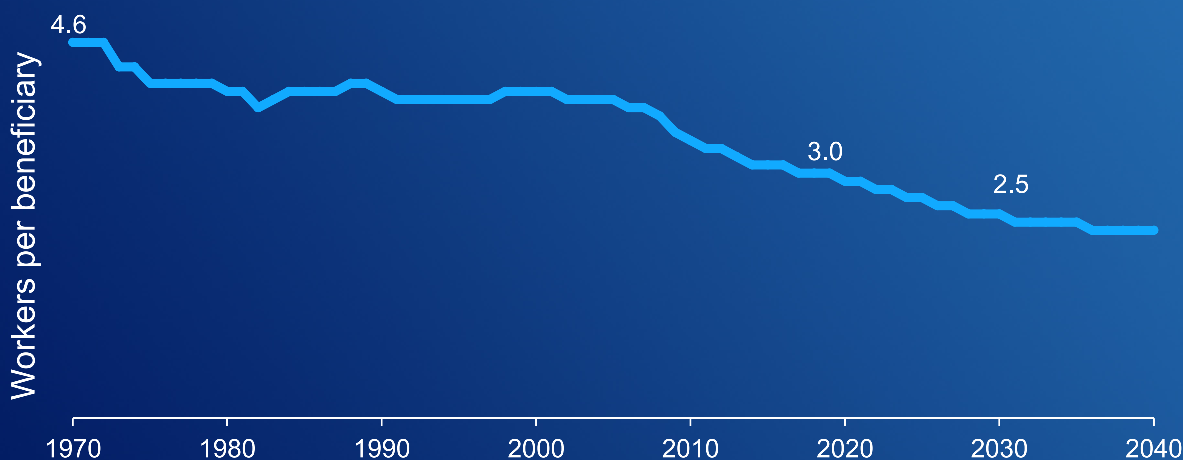
The demographic problem in financing Medicare: Ratio of workers per Medicare beneficiary



Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is financed in part by Medicare's Hospital Insurance Trust Fund. The potential effects of the COVID-19 pandemic are not included in these projections.

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

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Potential solutions for slowing spending growth

Healthcare spend equals

Volume of services x Intensity (type) of services x Provider cost per Service bundle x Price / provider cost ratio

Volume of services

Interventions
- Readmissions
- ACO / HMOs
- Self referral
- Prices (controversial)

Intensity (type) of services

Interventions
- Balancing innovation and costs of drugs
- Adjusting for coding intensity changes

Provider cost per Service bundle

Interventions
- DRGs/bundling
- Site neutral pricing
- Financial pressure
  - Private sector
  - Medicare

Price / provider cost ratio

Interventions
- Restrain prices growth

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Volume growth – slight decline in volume per capita from 2009 to 2019

- Inpatient volume decline
- Skilled nursing facility volume decline
- Long-term care hospital payment decline (driven by payment policy)
- Physician-owned specialty hospital decline (driven by payment policy)

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Intensity: Increasingly expensive types of service are being purchased

- Across all services, intensity grew moderately
- However, drug costs rising more rapidly due to “intensity” shift associated with higher cost biologics
- Higher patient needs—real or coding?

Source: Medicare claims data 2009 to 2019

Reducing provider costs per service bundle

- Success of DRGs, outpatient bundles
- Provider cost per unit of service—after case mix adjustment — has been below general inflation
- Allows price increases that were below general inflation from 2009 to 2019

Taxpayer savings via reducing provider costs

1st Payment reform (DRGs). Payments are budget neutral to earlier models

2nd Provider costs reduced

3rd Provider profits increased

4th Medicare rate growth slowed

5th Taxpayers see savings

Key: Payments are never increased to achieve care transformation

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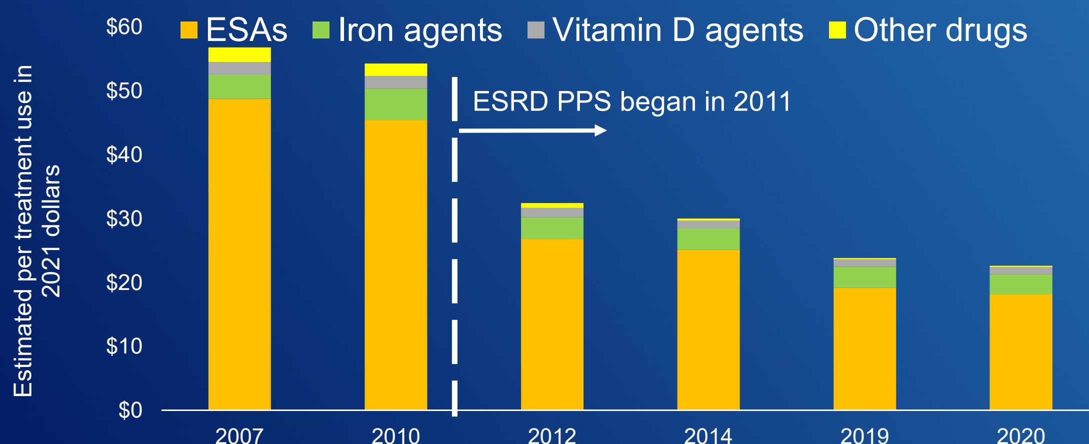
Use of ESRD drugs in the PPS bundle continues to decline, with no adverse effect on beneficiaries' health status



Note: All drugs included in this analysis are paid under the ESRD PPS base rate. Use of drugs is estimated by multiplying drugs units reported on claims by 2021 average sales price. Drugs included are: epoetin alfa, epoetin beta, darbepoetin (ESAs); iron sucrose, sodium ferric gluconate, ferumoxytol, ferric carboxymaltose (iron agents); calcitriol, doxercalciferol, paricalcitol (vitamin D agents); daptomycin, vancomycin, alteplase, and levocarnitine (all other drugs). ESAs (erythropoietin stimulating agents).

Source: MedPAC analysis of 100 percent claims submitted by dialysis facilities to CMS. Data are preliminary and subject to change.

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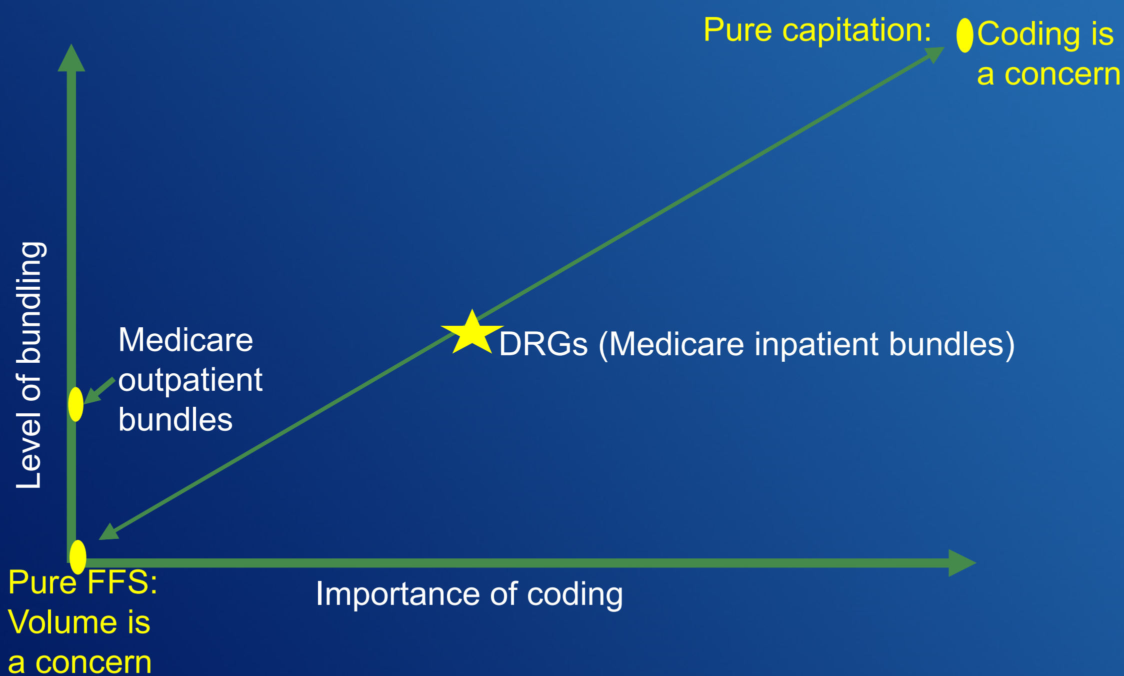
The fee-for-service (FFS) / fee-for-coding (FFC) tradeoff



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Changes in hospital spending

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Medicare hospital spending in 2020

- Inpatient —$119 billion
- Outpatient—$66 billion
- Volume per capita growth 2009 to 2019
  - Inpatient −2.2%
  - Outpatient +3.1%
- Spending growth per year 2009 to 2019
  - Inpatient 0.5%
  - Outpatient 6.9%

Source: Medicare cost reports

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Reductions in inpatient volume

- Primarily technological change
- Secondary reason Accountable Care Organizations
- Minor reason: Spillover from managed care
- Pricing?

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The details:
Medicare payment
for inpatient bundles

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Hospital payment goals

- Incentive for low-cost and high-quality care
- Adjust payments to account for input prices
- Adjust payments to account for patient resource use
- Adjust payments for other products (e.g., teaching, uncompensated care)
- Increase payment to “safety-net” hospitals to preserve access to care for low-income individuals

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How are inpatient payment weights set?

- Traditional hospitals
  - Aggregate costs across all patients within specific DRG/severity level category
  - Set weights based on national relative costs
- Rehabilitation hospitals
  - Uses hospital-specific relative values
  - Sets weights based on an average of hospital relative values
    - Accounts for differences in hospitals' efficiency
    - May pick up differences in hospitals' coding if aggressive coders have different types of cases

Preserving a rural "safety-net"

- Cost-based payments (started 1997)
  - Reduced incentive to constrain costs
  - Volume may be too low for high-quality care
  - May try to do more than should be done
- Fixed payment for stand-by capacity
  - Starts in 2023
  - Eliminate most inpatient care
  - Required to staff emergency room 24/7
  - Stabilize and transfer

How much real and illusory savings can we expect from bundling care into DRGs?

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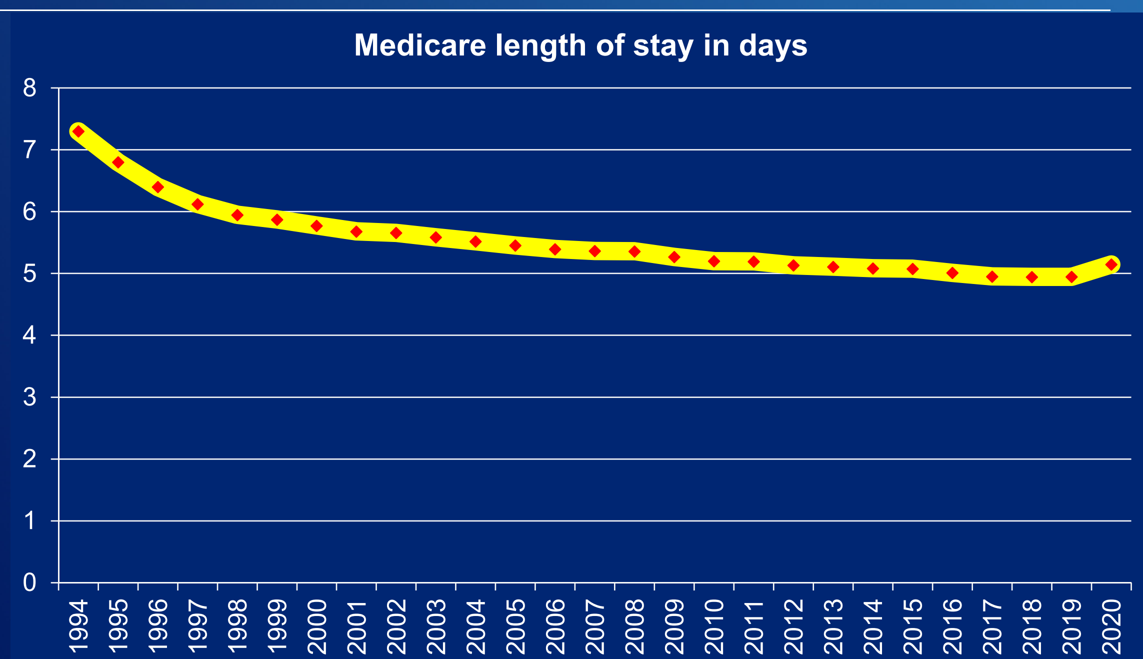
Declines in length of stay has slowed, making reductions in unit cost more difficult



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Data are preliminary and subject to change

Some efficiency gains still possible

- "Relatively efficient" hospitals have costs 10% below average
- For-profit hospital costs more than 10% lower than non-profit hospital costs
- Non-profit hospitals under financial pressure have costs that are 8% lower than highly profitable non-profits

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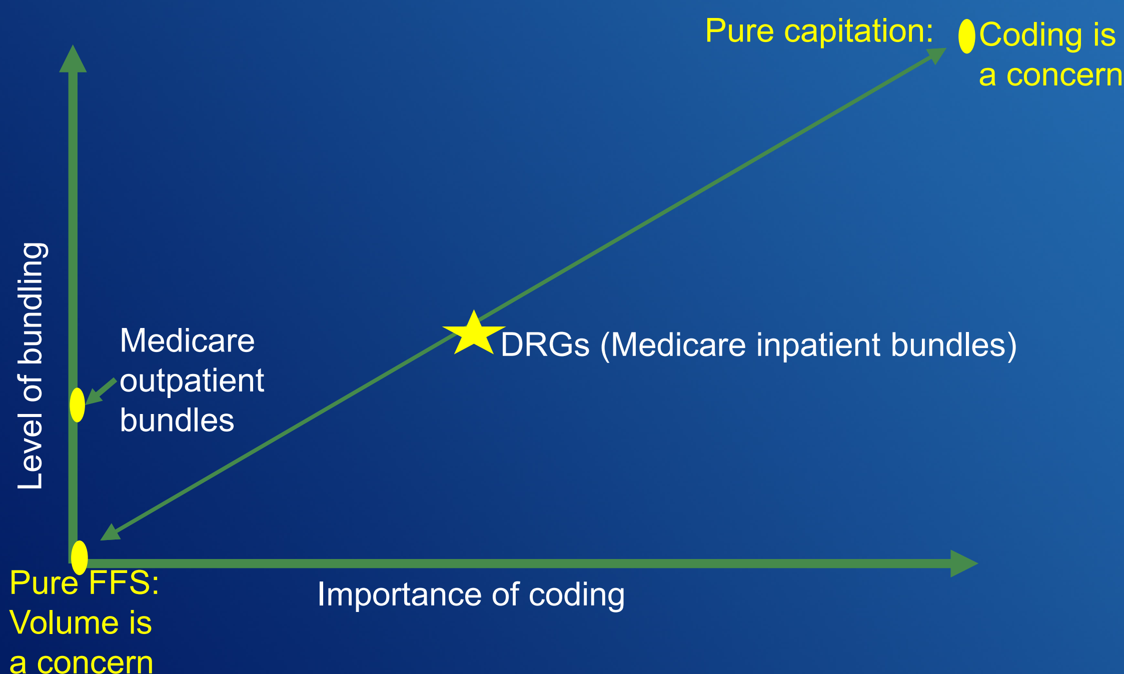

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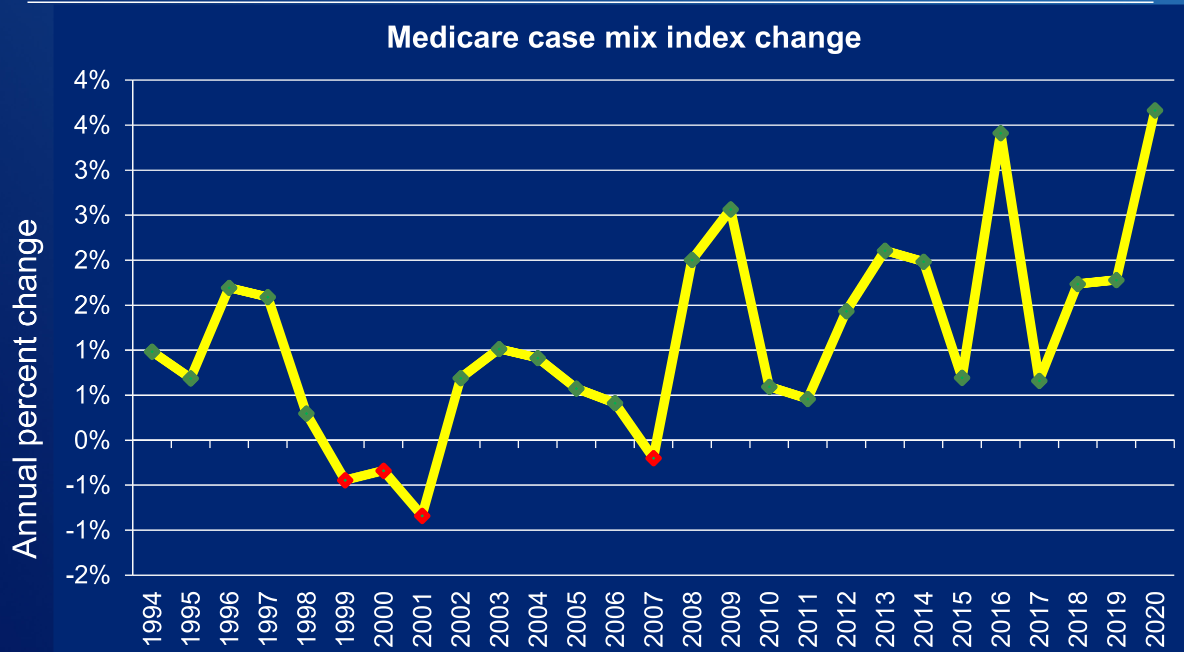
Reported inpatient case mix change by year may in part reflect illusory efficiency gains



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How much of the coded severity growth is real severity growth?

- New DRG payment model in 2008
  - See how coding shifts when models change
- Consistent DRG payment models
  - Shift across types of care
    - Increase in surgeries – not coding
  - Shift of severity within principal DRG – may be coding
  - COVID effects
- Capitated models
  - How much faster do patients in capitated models appear to get sicker than patients outside of capitated models?

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What is my job?

- Ensure access to high-quality care
- Protect the taxpayer from excessive costs
- How? Make the return for investing in good patient care higher than the return on investing in coding and patient selection

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