Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and Supporting Medicare safety-net hospitals

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FFS Medicare pays for most general acute care hospital services under the IPPS and OPPS

2021	IPPS	OPPS
Prospective payment unit	Inpatient stay	Primary service and ancillary items
Hospitals	3,170	3,370
FFS volume	7.1 million stays	135.7 million services
FFS PPS payments	$107.9 billion	$49.9 billion
Separate payments	$8.3 billion for uncompensated care	$16.4 billion for separately payable drugs

Note: FFS (fee-for-service); IPPS (inpatient prospective payment systems); OPPS (outpatient prospective payment system). Payments reflect Medicare payment rates and include payments from the Medicare program and from beneficiaries or their supplemental insurance. Year is fiscal year for inpatient services and calendar year for outpatient services. The number of general acute care hospitals that provided OPPS services is higher than the number that provided IPPS services primarily because about 200 facilities gained hospital provider numbers during the public health emergency but did not provide any inpatient services to FFS beneficiaries.
Source: MedPAC analysis of Medicare Provider Analysis and Review data, IPPS final rule, and outpatient claims.

Hospitals' payment adequacy indicators remained generally positive in 2021, but some declined in 2022

Access to care

- Supply: 11 closures and openings
- Occupancy: 65%, but some hospitals stressed at times
- Medicare marginal profit: ≈ 8%
- Volume: Continued shift from inpatient to outpatient settings

Quality of care

- Risk-adjusted hospital mortality rate: Increased slightly vs. 2019
- Readmission rate: improved
- Patient experience measures: remain high, but most measures declined

Access to capital

- All-payer operating margin: 8.7% (record high), but declining in 2022 closer to 2019 level
- Bond access: Minority of bonds downgraded in 2022, but bond market access maintained

Medicare payments and hospitals' costs

- Aggregate Medicare margin: −6.2% (increase)
- Relatively efficient hospitals' median Medicare margin: near break even
- Projected 2023 Medicare margin: ≈ −10%

Results are preliminary and subject to change

Considerations for the draft recommendation

- Maintain Medicare payments high enough to ensure beneficiaries' access to care;
- Maintain payments close to hospitals' cost of efficiently providing high-quality care;
- Maintain fiscal pressure on hospitals to constrain costs;
- Minimize differences in payment rates for similar services across sites of care; and
- Avoid implementing large, across-the-board payment rate increases to support a subset of hospitals with specific needs

Changes to safety-net payments are warranted for hospitals serving low-income Medicare beneficiaries

- The draft update recommendation applies to all general acute care hospitals
- Hospitals with high shares of low-income Medicare patients have additional challenges
- Current Medicare safety-net payments do not address these challenges effectively
- A new Medicare safety-net payment system could improve financial security for hospitals with challenging payer mixes

Concerns with current Medicare safety-net payments

- Medicare indirectly subsidizes Medicaid
- DSH shares are negatively correlated with Medicare shares, so high Medicare share hospitals tend to get lower DSH payments
- DSH payments are inpatient-only
- Uncompensated care payments are not focused on Medicare beneficiaries
- Current uncompensated care payments are distorted, providing higher payments to hospitals with high Medicare Advantage shares

Note: DSH (disproportionate share hospital).

Medicare Safety-Net Index (MSNI) would address these concerns

- MSNI computed as:
  - LIS share of Medicare beneficiaries, plus
  - Uncompensated care costs as a share of revenue, plus
  - One half the Medicare share of inpatient days
- Includes Medicare shares to recognize the reduced profitability of Medicare since DSH was enacted
- Eliminates direct subsidy of Medicaid and reduces uncompensated care subsidy
- Aligns Medicare funds more directly with hospitals serving low-income Medicare beneficiaries

Note: DSH (disproportionate share hospital); LIS (low-income subsidy).

Transition to the new MSNI policy

- The additional $2 billion of MSNI funding would occur in year one of the transition
- The shift of existing DSH and uncompensated care to MSNI funding could:
  - Occur slowly over several years; or
  - Be implemented with a stop-loss policy
- Hospitals with revenue reductions would have time to:
  - Try to augment revenues from existing sources
  - Request additional state or local support, as warranted
  - Some hospitals may also be able to improve cost efficiencies

Note: MSNI (Medicare safety-net index); DSH (disproportionate share hospital).