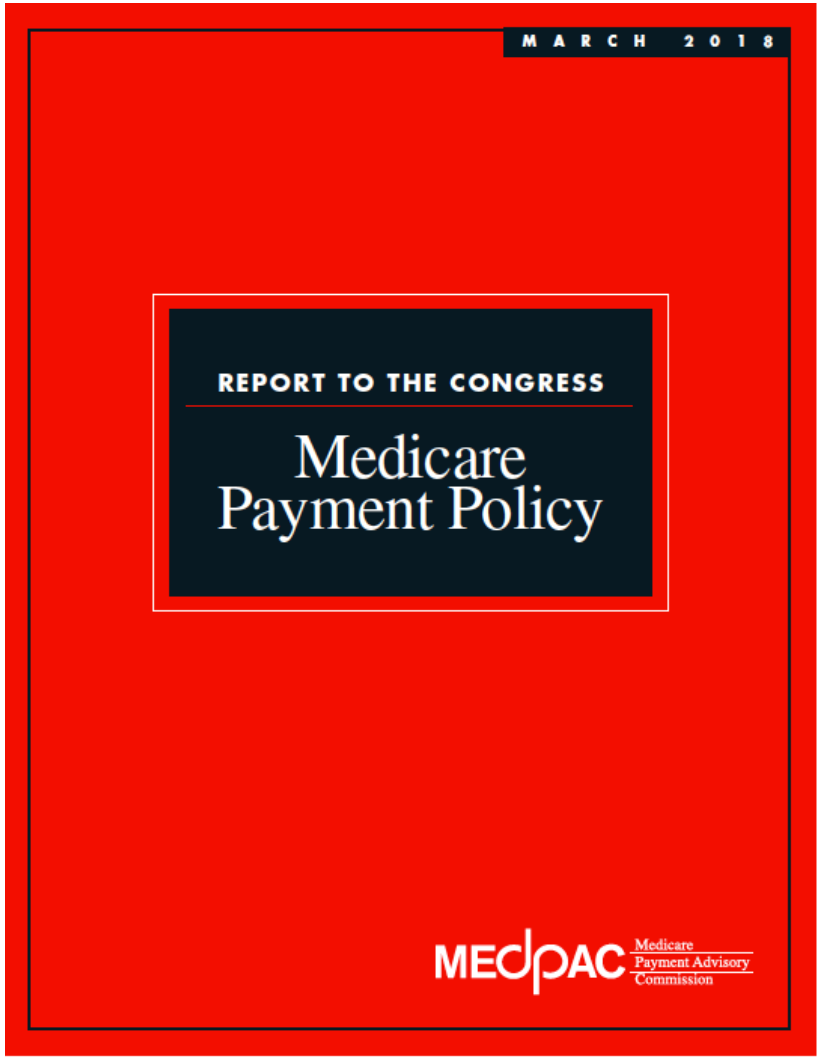
# Determining Medical Pricing Reasonableness:

## Using Medicare payment as a benchmark/reference point.

Colorado Business Group on Health
*Working Together to Improve Health Care Value*

**Robert Smith**
Executive Director
June 14th, 2018



# About MedPAC
## (Medicare Payment Advisory Commission)


- Independent US federal body established by the Balanced Budget Act of 1997.
- Composition: 17 members with expertise in health care financing and delivery.
- Primary roles:
  - To advise Congress on issues affecting Medicare payment, particularly it effects…
  - Beneficiaries' **access to care** and the **quality of care** received.
- MedPAC produces reports to Congress with recommendations to improve Medicare access, quality, cost and ***payment adequacy***.

# Medicare's IPPS: Inpatient Prospective **Payment System**

- Based on 335 Diagnostic Related Groups or DRG's
- Each split into 2 or 3 based on resource use
- Result: 752 severity adjusted "MS-DRGs"
- A series of adjustments the applied to separate operating and capital base payment rates
  - New technology
  - Teaching
  - Bad debt
  - etc

**Figure 1 Acute inpatient prospective payment system for fiscal year 2018**

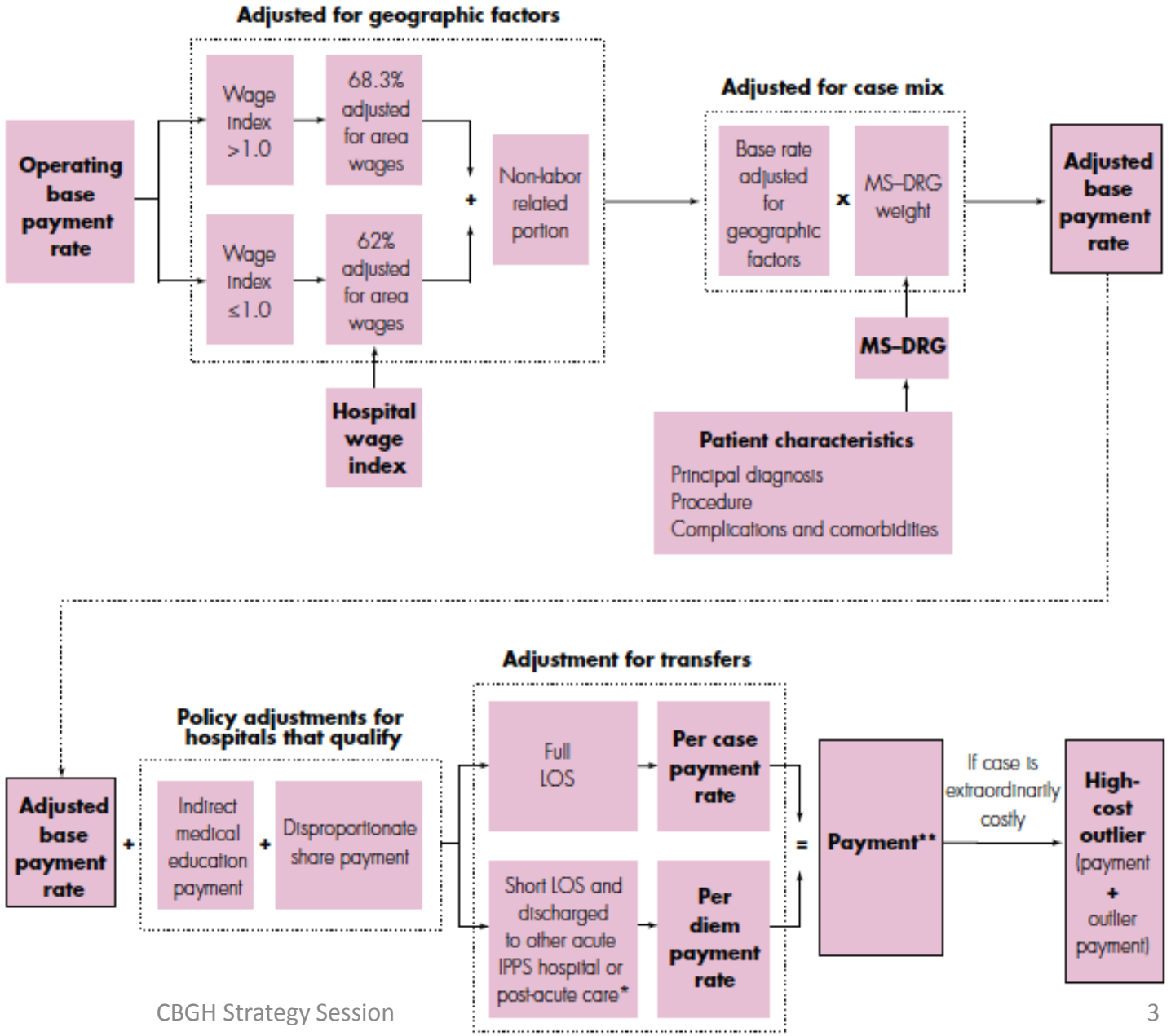
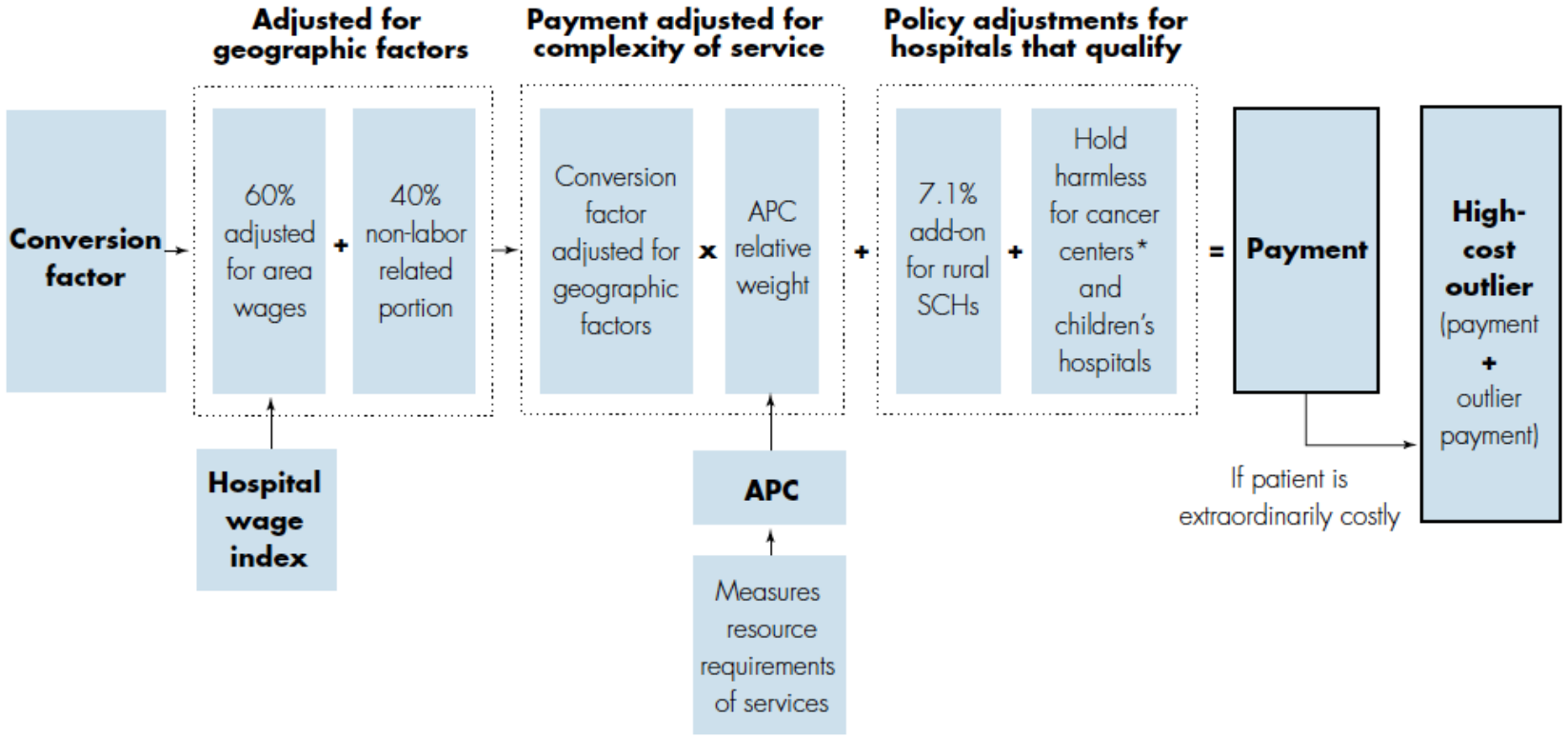


**Figure 1 Hospital outpatient services prospective payment system**




Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system. *Medicare adjusts outpatient prospective payment system payment rates for 11 cancer centers so that the payment-to-cost ratio (PCR) for each cancer center is equal to the average PCR for all hospitals.

# Medicare **OutPatient Payments**

# About “Relatively Efficient” hospitals

Hospitals were identified as relatively efficient if they met four ***risk-adjusted*** criteria in each year from 2013 to 2015:

- Mortality rates were among the best 2/3$^{rds}$ of all hospitals.
- Readmission rates were among the best 2/3$^{rds}$ of all hospitals.
- Standardized costs per discharge were among the best 2/3$^{rds}$ of all hospitals.
- Mortality or standardized costs per discharge were among the best one-third of all hospitals.

## MedPAC's March 2018 Report:

# Assessment of hospital payment adequacy

- **Adequacy Indicators Include:** Beneficiary access to care, changes in the quality of care, hospitals' access to capital, and the relationship of Medicare's payments to hospitals' costs for both *average and relatively efficient hospitals* (for Medicare patients).

- **Adequacy Conclusions:**
  - Payment rates 8% higher than ***variable costs*** associated with M'care patients.
  - In 2016, hospital's aggregate Medicare margin was -9.6 percent.
    - - 11.0% for non-profit hospitals
    - - 2.4 for profit hospitals
  - **Overall margins were approximately zero for *relatively efficient providers*.**

# Other Relevant Observations

- Hospitals' all-payer operating ***margins reached a record high*** in 2015; slightly lower in 2016 but still near 30 year high.
  - All-payer margins remain strong "***because the growth of private-payer rates continues to rise faster than costs.***"
  - "Hospitals with strong profits on non-Medicare services and investments are under ***relatively little pressure to constrain their costs***."

  ***Note:*** In 2014, MedPAC report that the Medicare rate was 50% higher than payments to OCED countries' hospitals.

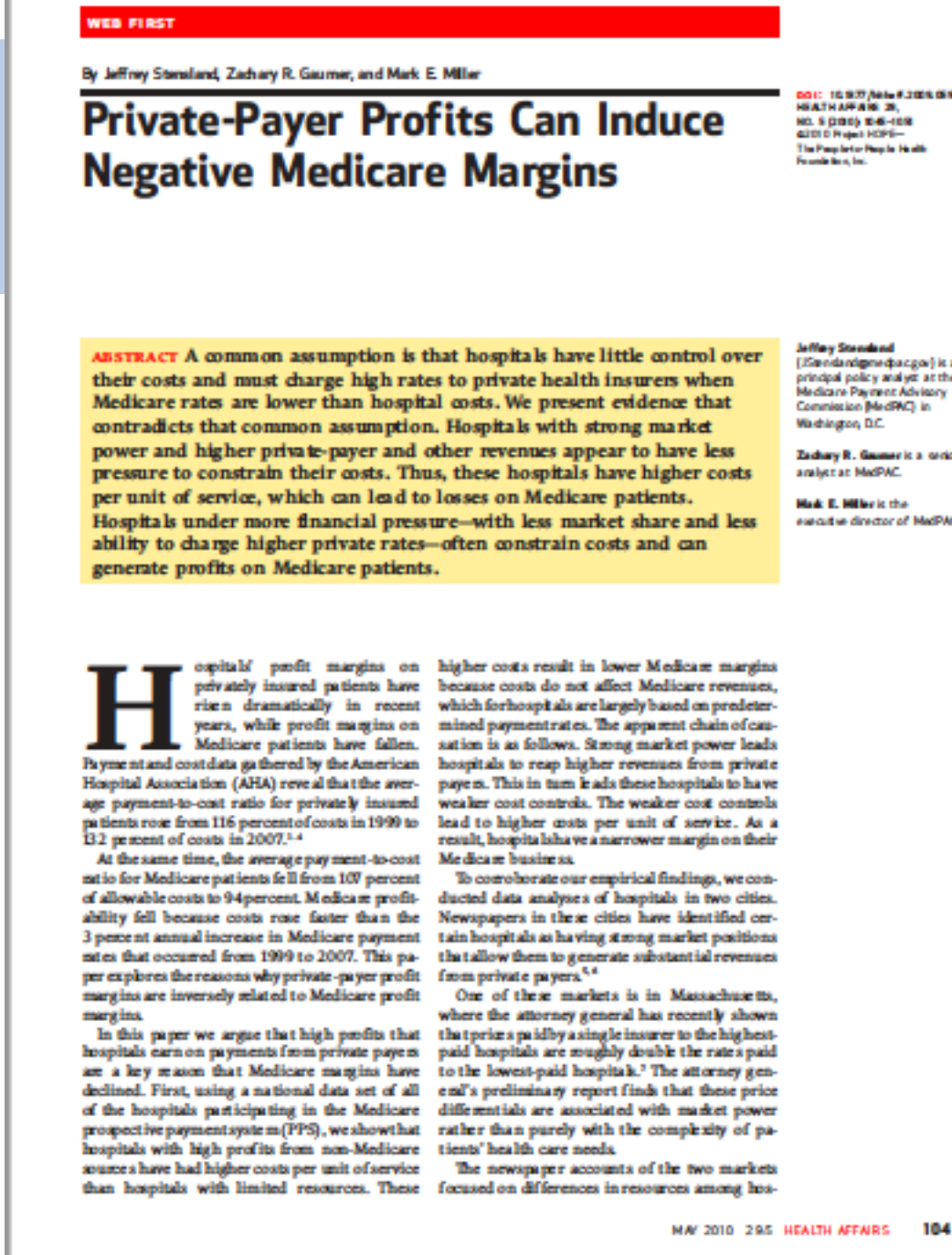
- "When providers receive high payment rates from insurers, they face no particular need to keep their costs low, and so, all other things being equal, ***Medicare margins are low because [hospital] costs are high.***"

# Why are so many hospitals Losing Money on M'care?"

"Strong market power leads hospitals to reap higher revenues from private payers. This in turn leads these hospitals to have weaker cost controls. The weaker cost controls lead to higher costs per unit of service. As a result, hospitals have a narrower margin on their Medicare business."

Jeffrey Stensland

Principal Policy Analyst MedPAC)



WEB FIRST

By Jeffrey Stensland, Zachary R. Gaumer, and Mark E. Miller

## Private-Payer Profits Can Induce Negative Medicare Margins

ABSTRACT A common assumption is that hospitals have little control over their costs and must charge high rates to private health insurers when Medicare rates are lower than hospital costs. We present evidence that contradicts that common assumption. Hospitals with strong market power and higher private-payer and other revenues appear to have less pressure to constrain their costs. Thus, these hospitals have higher costs per unit of service, which can lead to losses on Medicare patients. Hospitals under more financial pressure—with less market share and less ability to charge higher private rates—often constrain costs and can generate profits on Medicare patients.

Jeffrey Stensland [JStensland@medpac.gov] is a principal policy analyst at the Medicare Payment Advisory Commission (MedPAC) in Washington, D.C.

Zachary R. Gaumer is a senior analyst at MedPAC.

Mark E. Miller is the executive director of MedPAC.

Hospitals' profit margins on privately insured patients have risen dramatically in recent years, while profit margins on Medicare patients have fallen. Payment and cost data gathered by the American Hospital Association (AHA) reveal that the average payment-to-cost ratio for privately insured patients rose from 116 percent of costs in 1999 to 132 percent of costs in 2007.[1-4]

At the same time, the average payment-to-cost ratio for Medicare patients fell from 107 percent of allowable costs to 94 percent. Medicare profitability fell because costs rose faster than the 3 percent annual increase in Medicare payment rates that occurred from 1999 to 2007. This paper explores the reasons why private-payer profit margins are inversely related to Medicare profit margins.

In this paper we argue that high profits that hospitals earn on payments from private payers are a key reason that Medicare margins have declined. First, using a national data set of all of the hospitals participating in the Medicare prospective payment system (PPS), we show that hospitals with high profits from non-Medicare sources have had higher costs per unit of service than hospitals with limited resources. These higher costs result in lower Medicare margins because costs do not affect Medicare revenues, which for hospitals are largely based on predetermined payment rates. The apparent chain of causation is as follows. Strong market power leads hospitals to reap higher revenues from private payers. This in turn leads these hospitals to have weaker cost controls. The weaker cost controls lead to higher costs per unit of service. As a result, hospitals have a narrower margin on their Medicare business.

To corroborate our empirical findings, we conducted data analyses of hospitals in two cities. Newspapers in these cities have identified certain hospitals as having strong market positions that allow them to generate substantial revenues from private payers.[5,6]

One of these markets is in Massachusetts, where the attorney general has recently shown that prices paid by a single insurer to the highest-paid hospitals are roughly double the rates paid to the lowest-paid hospitals.[7] The attorney general's preliminary report finds that these price differentials are associated with market power rather than purely with the complexity of patients' health care needs.

The newspaper accounts of the two markets focused on differences in resources among hos-

# Observations – Cont'd.

- OP payments rose because of volume increases, price increases, and ***the continued shift of services from lower cost physician offices to higher cost hospital outpatient settings*.**

- **Hospital consolidation** contributed to commercial spending growth from 2010 to 2015 of **3.2 percent annually**.

- **Meanwhile (back at the family ranch), from 2006 to 2016**
  - Household incomes increased **22%**
  - Average premium for family coverage increased **58%** (2.6 x incomes)

# So, for your consideration…

- Medicare rates, although adjusted for hospital-specific variables (eg., indigent care load) are not, *per se*, being recommended for commercial payers.  We would suggest, however…

- Medicare payment provides a tangible, ***empirically-based point of reference*** at which an "efficient" hospital, with adequate volumes, can break-even, which then begs the question…..

- ***So the question will be:  What percent of Medicare payment do you, as a buyer, find reasonable and fair?  What will you do?***

## To quote John Oliver…

# ”And now, this….”

If the first rule of medicine is *“Do no harm*,” then we would be wise to consider this:

**Financial harm IS harm**.