MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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10:11 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Hospital margins and their uses
-- Jack Ashby

MR. HACKBARTH: The last item for today, hospital margins and their uses.

MR. ASHBY: In this presentation we are going to review two types of hospital margins that we routinely in our payment policy work; that is the overall Medicare margin and margins for components of that overall Medicare margin. Then we'll talk briefly about one other margin used for context; the total margin.

The overall Medicare margin includes costs and payments for the largest six Medicare services that hospitals provide plus costs and payments for graduate medical education. You see the six services listed here. Its primary use is in assessing payment adequacy for the acute inpatient and outpatient payment. Specifically, this margin, or the cost and payment components of it, forms the basis for estimating our current payments and costs, which is one of several factors that we examine in drawing conclusions about the adequacy of payments.

We assess payment adequacy for the hospital as a whole because we suspect that the allocation of costs is biased in the Medicare cost report. Prior to the late 1990s hospitals had the incentive to allocate as much of their costs as possible to services other than acute inpatient because all of these other services were paid at the time on the basis of cost. As a result of that phenomenon we believe that the inpatient margin is overstated and all of the other margins are probably understated. Unfortunately, we don't know how much difference this bias makes, and we also don't know whether it has been reduced over time as the other services have come into their own respective PPSs.

Turning to the component margins, we have calculated margins for all six of the components of the overall Medicare margin, but we make primary use of the inpatient and outpatient margin. Their use is, for the most part, analyzing the distribution of payments within a specific PPS, including estimating the impact of policy options that the Commission has considered at various points along the way.

The overall Medicare margin does not work well for that purpose because it reflects payments and costs outside the PPS under consideration, which confounds the analysis. If we assess the analysis the impact of an outpatient option, for example, with this measure with outpatient comprising only 15 percent of hospital payments, large changes in outpatient payments would appear as small changes in the overall payments, and the distribution of changes would be different as well.

When it comes to comparing hospital margins to those of other sectors we have to remember that because all six hospital component margins are likely over- or understated, none of them can be compared with any confidence to margins in other sectors. The overall Medicare margin provides a much better comparison to

other sectors, and by other sectors I'm referring to freestanding SNF, home health, rehab, dialysis. The overall Medicare margin provides a better comparison to those sectors because it is netting out the overstatement and understatement of its components.

Comparing the margins of a hospital-based and a freestanding service with the same sector, like freestanding and hospital-based SNF is also difficult. If a margin for a hospital-based service is thought to be understated then a weighted average of the hospital-based and the freestanding is still going to be understated, but obviously to a less degree.

The last margin is the total margin. This covers revenue from all payers as well as non-patient sources. Non-patient sources include non-patient services like cafeteria, parking lot, that sort of thing, and also donations and investment income. The total margin does not play a direct role in MedPAC's policy decisions primarily because the Commission concluded that Medicare payments should relate to the cost of treating Medicare patients. To the extent that beneficiary access to care is an issue we would like to develop direct measures of access to care rather than relying on overall financial condition as an indirect indicator.

There's also some question as to whether total margin even provides an accurate indicator of overall financial condition in larger organizations given that it is limited to the hospital corporation and does not encompass all components of complex corporate structures that have become commonplace in the field.

The difficulty of attempting to affect total margins through Medicare policy is exhibited in this scatterplot by the lack of any consistent relationship between overall Medicare and total margins. Hospitals with negative and positive overall Medicare margins are roughly equally likely to have positive total margins.

DR. ROWE: Is there an R value for that?

MR. ASHBY: It's 0.06 which is roughly like nothing.

MS. BURKE: Jack, just for illustrative purposes, can you give me an example of an institution at the extreme, one that might have an overall Medicare margin of plus-40, or some variation, and a negative overall margin? Give me an example of what would end up in that kind of an array.

MR. ASHBY: More than anything else there are a number of academic medical centers, major teaching hospitals in that category--

MS. BURKE: Because of GME.

MR. ASHBY: --that do have very high Medicare margins because of the policy adjustments that Medicare gives them but don't fare as well in other payers and uncompensated care.

MS. BURKE: What about the reverse?

MR. ASHBY: But I want to point out that there are major teaching hospitals that are on the other side of this matrix as well, that have very high Medicare margins and still have high total margins as well.

DR. NEWHOUSE: The big public teaching hospital would be--

MS. BURKE: That would make sense to me. What about the

reverse?

DR. NELSON: InterMountain Healthcare.

DR. ROWE: Pediatric hospitals where the overall Medicare margin was negative but a very small portion of the patients were Medicare--

MS. BURKE: Let me ask that question. Tell me what's included in this array. Would it include, for example, pediatric hospitals?

MR. ASHBY: No, it actually would not include pediatric hospitals, because these are PPS hospitals.

MS. BURKE: These are all PPS hospitals.

MR. ASHBY: That in the group, right.

DR. ROWE: How about the disabled patient who's a Medicare beneficiary who goes to a pediatric hospital?

MR. ASHBY: It certainly counts as Medicare but it's not a hospital that's under the prospective payment system so we don't include it in this.

MS. BURKE: Jack, give me an example of the other extreme, which is a very high overall margin and a very low Medicare margin.

MR. ASHBY: This would be a community hospital that has a large private payer business and has negotiated well in that private payer business, has limited uncompensated care and fills out nicely in its revenue.

DR. REISCHAUER: I think, Jack, you've already answered my question in that you knew the answers to these questions. But I was wondering if you had ever run a simple regression of overall Medicare margins as a function of the relative importance of these various other types, inpatient, outpatient, Medicare, nursing home, et cetera?

MR. ASHBY: As a function of their mix of other services?

DR. REISCHAUER: Yes, the mix of other Medicare services. The overall as a function of the mix excluding inpatient. And then maybe adding onto that, percent of total revenue from Medicare and percent from Medicaid as two other--

MR. ASHBY: Right. We have not run that precise analysis. However, we did put together a similar scatterplot of the proportion of Medicare business covered by this and the total margin and it is a very similar blob, if you will. That varies all over the map too. So one of the key variants here is the amount of Medicare of all types they have. We have not really looked at it by those service components as you suggest, so we would have to go back and take a look.

DR. NEWHOUSE: I had three comments. The first was actually quite similar to Bob's. I thought we should try to explain variation in the total Medicare margin with the product mix to tell us something about--which would give us an estimate of Medicare margin by service. Also, the second point is, if there is variation there, it doesn't make sense to compare hospitals with different product mixes in their total margin because it's comparing apples and oranges.

MR. ASHBY: When you say product mix, do you mean Medicare product mix now or the mix of Medicare and other--

DR. NEWHOUSE: Yes, I mean a mix of product lines. Do they

have an IRF? Do they have a SNF? Do they have a home health agency, et cetera? So what are the product lines that are contributing to this margin?

My second question really goes also to the component margins, which is at some point in the past you were talking about trying to get a handle on these margins by using certain hospitals' cost allocation mechanisms. Where does that stand? Is that still going forward?

MR. ASHBY: That project is absolutely going forward. We have awarded a contract and the project just started just in the last couple weeks.

DR. NEWHOUSE: When will we hear something of what it found?

MR. ASHBY: That's always a risky question. We're shooting for next spring for the spring meetings, but there are a lot of unknowns in the meantime and it's a little bit hard to make any promise on that.

DR. NEWHOUSE: I understand.

DR. MILLER: We're not even sure how much hospital participation we're going to get in it.

MR. ASHBY: That's one of the biggest unknowns is how well we're going to be able to recruit hospitals, let alone the right mix of hospitals that we'd like to have, into this study.

DR. NEWHOUSE: Then a third question is, you've made the point several times in the past that the level of margins depends on what costs count as cost for the purpose of calculating the margin, and specifically the disallowed costs. I wondered if you have any plans to go into that.

MR. ASHBY: No, we don't. All of the hospitals in this scatterplot are treated equally in the sense that we're looking Medicare-allowable costs, as we always do, in our financial performance analysis. So all of them have some level of non-allowables and we're not looking at that.

DR. REISCHAUER: When we do the total margin do we include those unallowable costs?

MR. ASHBY: Yes.

DR. REISCHAUER: That's interesting.

DR. NEWHOUSE: That is interesting.

MR. ASHBY: The total margin, you're using the financial data that the hospital generates, and they have no interest in dealing in allowable or non-allowable costs. Obviously we're on their platform when we do this measure.

DR. MILLER: It's not identified. It's just a total number.

DR. NEWHOUSE: For purposes of trying to translate, shouldn't we try to do some kind of crosswalk then?

MS. DePARLE: I think we should because that's something that they always raise, not only with respect to hospitals but others always raise, but you haven't counted the costs that you won't allow. Sitting here, I'm not even sure I could tick them off, so at least I think we ought to be clear about what they are.

DR. REISCHAUER: Do we have the ability to look at the ratio of unallowed to allowed Medicare costs by hospital and do a scatter diagram of that? And relate that to how much Medicare business they do relative to all business? Because the ones that

are most upset about it, it could be a relatively minor thing in their overall book of business.

MR. ASHBY: The amount of non-allowables is not a readily available number actually. There's a very complex set of reporting and calculation that backs that up, so it's not something we could easily run and do.

MS. BURKE: Jack, what's the biggest category of non-allowables?

MR. ASHBY: We don't have complete data on that but we're told that one of the most major, if not the major category, has to do with home office costs with chain operations, because the chains are doing a variety of different things and some of their costs are not necessarily applicable to providing inpatient and outpatient care and the like.

MR. MULLER: This is along those themes. Since we know from our prior years' work that not the DSH, where we put in the whole revenue but don't put in the whole costs, therefore overstates the Medicare margin considerably. In the calculation we don't have the Medicaid costs in that, if you follow me. So the DSH hospitals always have a higher Medicare margin just by definition, but probably have, because they're DSH hospitals, a lower total margin. It would be good to break that one out without the DSH payments because I think you might see a different plot, given how much the DSH payments affect those base. I seem to remember--I'm trying to remember now from our books in the last couple years, I think of the overall--the 14 or 15 that we show for inpatient doesn't about four to six of that come from DSH or so, some fairly high number?

MR. ASHBY: Right, it does. We have all of the cost of treating Medicare patients in the numerator or denominator here, depending how you--

MR. MULLER: We have the costs in. But we have DSH revenues in that therefore make the margin look bigger because some of the DSH revenues are for Medicaid patients.

MR. ASHBY: They're really not for Medicaid patients, per se. This is a Medicare payment. It's in the Medicare program as it stands now. The distribution of those DSH payments is determined heavily by the hospital's Medicaid penetration. But it's never really been offered as payment for Medicaid. There is a Medicaid DSH separate from--

MR. MULLER: No, I'm talking about the Medicare DSH which is calculated on Medicare and Medicaid. Therefore, in a sense, you get payment for your Medicaid patients even though you don't have the cost of those Medicaid patients in there. Am I accurate in that?

MR. ASHBY: The Medicaid costs are definitely not in there as it stands now.

MR. MULLER: But the payment is.

MR. HACKBARTH: Jack, correct me if I'm wrong, or Sheila, somebody correct me if I'm wrong. My understanding was that originally the notion behind DSH was that Medicare patients that were low income patients might have higher costs and we were trying to find an adjustment that would reflect the higher cost of treating low income Medicare patients. Over time, however,

the rationale for the DSH adjustment and the amount of money involved in the DSH adjustment has changed. So now we've got a sum that is actually, I think, quite a bit larger than the amount that would be required to pay for the higher cost of low-income--

DR. NEWHOUSE: The higher costs were based on a study of Massachusetts only and didn't hold up a couple years later when you went to the nation. They aren't higher cost.

MR. HACKBARTH: So now we have a payment adjustment that increases payments for Medicare admissions based on Medicaid and SSI volume without a clearly defined rationale of what we're compensating for. Is it the higher cost of Medicare patients? Is it for uncompensated care patients? It's, frankly, I think murky at this point.

MR. MULLER: I'm just saying, by definition it overstates the Medicare inpatient margin because in a sense you get credit for patients that aren't in the cost base. So in the ratio you get credit in the numerator for costs that aren't in the denominator.

DR. MILLER: But you can also say that the adjustment is supposed to be for a more expensive Medicare patient. This was the best proxy at the time. That relationship didn't show up, but the money is still flowing through. You're technically right about the Medicaid cost is not in there, but there's a whole different way to look at this transaction in terms of the dollars hitting the hospital.

DR. REISCHAUER: If you really want to be tough you could say this is just the same thing as the excess payment in IME, over and above the justifiable payment.

DR. WOLTER: One other clarification on total margin that might be useful, at least as many institutions use that phrase includes investments, unrelated business income, subsidiaries that might not be really related to the operation of health care. I don't know whether we're using it that way here or not, but that would be important to know, because I think that really then muddies the picture. Some people use the phrase operating margin to refer to the operations of direct health care services.

MR. ASHBY: No, an operating margin is not necessarily restricted to health care services either.

DR. WOLTER: Not necessarily, but it's closer than the phrase total margin. That's all I'm saying. Total margin might include activities that are really quite separate, and it certainly would include your investments, for example, Jack.

MR. ASHBY: The main thing that a total margin includes that's an operation margin doesn't is investment income and donations. But all of the services, even if they have virtually nothing to do with health care--they could be operating a restaurant or a senior citizen living arrangement, would still be in an operation margin.

DR. WOLTER: That may be true for some institutions, Jack, but I'm not sure that's universally so. The point I'm making is, total margin in any way is a less-good comparison to overall Medicare margin than something that's a little bit narrower than that. Maybe we can't get to that, but when you include investment income and donations--and many places would some of

these other things you just mentioned in their total margin but not in their operating margin. But maybe not all. Maybe there's some imprecision there.

One other thing I just wanted to mention that's in the body of the paper, I'm not sure I would say that the overall Medicare margin is a good comparator to some of the component margins. It may give us some comfort when we look at--

MR. ASHBY: To margins in other sectors.

DR. WOLTER: Yes, but it's perhaps not a good comparator because it does lump many things together, whereas, in the other sectors we're just looking at one set of services. So that might be a slight overstatement.

MR. ASHBY: Right. Nick, that was a reference primarily to the problem I was trying to explicate about the upward and downward bias in the component margin.

DR. WOLTER: I understand where it's coming from, but it's probably not a good comparator.

MR. ASHBY: So I used the word, better measure, in that sense because it's not hit by this bias problem. But that doesn't make it a good measure on all fronts, as you say.

DR. WOLTER: A minor point.

The thing I've wondered about this, I think this presentation describes fairly well what a cloudy lens we look through when we make update recommendations about individual component sectors, at least I think it describes that pretty well. I've wondered, if you were to say, where would the Commission want to be in three or four years, what course would we get on? Do we think that the individual sectors should have reimbursement that covers the cost of an efficient provider? Because we've talked about that framework. If we thought that, we would clean up the cost reports, we would get information that we don't currently have, and we would have a system that would do that.

Although we have gravitated to using the overall Medicare margin to give us some comfort, the fact of the matter is that at times we dip to the level of the individual DRG to try to create reimbursement that covers the cost of an efficient provider. When we get into bundling conversations we're looking at another level of reimbursement that might or might not cover overall cost.

So I think it would be helpful for the Commission to decide what principles it would like to have, and then see if we could design a course to get there, recognizing that it would take several years. Because covering the cost of an efficient provider for each of the component sectors is different than having this somewhat cloudy feeling that at the end of the day that overall Medicare margin at least seems to be in whatever shape it's in. I'm not really sure what our goals are on this. I've thought about it a lot over the past year.

DR. NEWHOUSE: Nick, I think that's a great question and at the end of the day it's probably impossible because the reason these costs--one reason the costs differ is that the hospitals are allocating their joint costs. So in terms of how Ralph's salary is getting allocated at Penn is ultimately arbitrary. I

mean, it follows accounting conventions, but the conventions are arbitrary.

But beyond that, what that implies is that to cover the cost of adding a SNF unit, if you did the incremental cost of everything, you wouldn't cover the joint costs, unless you want to say something like, there's always going to be an inpatient unit so I'll put them there. But then I'm paying more than the operating cost of the inpatient unit. So we're stuck with that inherent issue in operating a hospital that does several different things.

DR. WOLTER: I haven't really presumed an answer to my question because I know these are difficult things, but we have said that our goal is to cover the cost of an efficient provider, and we have applied it to things like DRGs as well as component sectors as well as total margin. But then sometimes we go into other reasons for not getting there, such as the reasons you just gave.

I think some clarity about how we might want to look at all these things would be useful. The achievement of getting to something better would be very difficult. It seems to me we've moved to a great deal of PPS in recent years. There's much less in terms of reimbursement that's currently dependent on the cost reports. I don't know how that is or isn't changing behavior around cost reports.

I also know that in our case our staffs spend so much time on filling those cost reports out, and there are some very specific requirements, so in theory you could imagine a cost report that tries to answer some of the questions you just outlined.

I just don't know whether it would be worth our while to define where we'd like to be and then decide whether it's worth the effort to try to get there. But we do have a pretty cloudy lens that we look through when we make specific payment updates, I think.

MR. MULLER: We do use basically the inpatient margin to cover the other five sectors over and over again, and our data has shown that what we'll call the product mix of these services does, first of all, it varies quite a bit in terms of scale; there's quite a bit of distribution, so not everybody has the same proportions of inpatient to outpatient to rehab, et cetera, and so forth. So a hospital that, in a sense, in theory had only an inpatient program could have a significantly high margin, and those that do a lot of outreach, do a lot of rehab, have broader needs to--have a broader role in the community, whether it's a rural community or urban community and so forth, in a sense one could argue have a broader social role, get dragged down because we don't give them as much money in those other sectors and so forth, financially. So in a sense, one is punished financially for playing a broader role.

So I understand the discussion between Joe and Nick, but I do think understanding exactly, or trying to better understand--not exactly. I concede Joe's point, it can't be exact, but trying to better understand the components make a lot of sense. Because I remember when we went through the SNF discussion last

year or the year before and we had margins of minus 70 and minus 30, and so forth, and we just said, oh well, it gets covered by inpatient and so forth. That's a lot to cover through inpatient. So I'm just hesitant to keep saying that the inpatient margin will cover all these other components for the foreseeable future.

MR. HACKBARTH: To the extent that the inpatient margins are inflated because of allocation of costs, the hospitals that haven't had the other lines of business never went through the practice of allocating the costs out. So presumably, I guess, all other things being equal, they would have lower inpatient margins.

MR. MULLER: I think that's what we want to know.

DR. NEWHOUSE: My regression is going to get the incremental costs.

MS. DePARLE: My question went to the same kind of issue that Nick was raising that we were just discussing, which is the quality of the data that we're relying on. I just wanted to be clear, am I correct that none of what we're looking at when we establish Medicare margins relies upon, or is influenced by, hospital charges? We had a discussion in July about charges and how that was something that did obviously affect--

MR. ASHBY: No, it very definitely is influenced by charges.

MS. DePARLE: Then it seems like we should have some discussion of that, because we had a long discussion in July, or fairly long, about the extent to which that had affected outlier payments in the notable case, and just what a house of cards it might all be. I wasn't clear that it was part of what you were relying on here. It affects the cost reports.

MR. ASHBY: It is part of what we're relying on here because charges are used in the cost report process for allocating costs among services for ancillary costs. So we are at the mercy of hospital's charge-setting practices and the consistency of their markups.

MS. DePARLE: In the cost-to-charge ratio?

MR. ASHBY: Exactly. So we are affected by that, by all means. Now the study that we are undertaking is going to examine the charge-setting practices of hospitals to try and better understand what they take into account in setting their charges and what implications that has for the allocations that we do. In addition to, for a sample of hospitals, measuring the allocation of costs that they with their sophisticated cost accounting systems think is correct, which is not based on charges, or to a very small degree. So we'll have a comparison in that way of how much difference all of this charge problem has.

DR. REISCHAUER: How about a regression that related overall Medicare margins to the fraction of Medicare payments that were represented by outlier cost payments. It could be that a subgroup is doing quite well because it's gaming--

MR. ASHBY: I think CMS has pretty well announced that there is a subgroup that has been doing well.