Hospital–physician site of service payment neutrality

Policy description

Payment rates for Medicare hospital outpatient services are set at the same level as physician office services every year beginning in 2022.

Assessment

Financial, 2022–2031

10-year budget net impact	Δ HI Trust Fund insolvency date	Δ Medicare spending per benef. (2031)	Δ Part B revenue contribution
–$127B	**No change**	**–1%**	**–$127B**

Δ % HI revenue as share of HI spend (2031)	% of HI revenue gap closed (2031)	Δ % spending funded by gen. rev. (2031)	Δ Medicaid payments for Part B
0% (80%)	**0%**	**0% (48%)**	**–$4B**

Beneficiary Δ average OOP burden (without supplemental coverage), 2027

Total OOP burden	Over 85	Low income (<150% FPL)	Multiple chronic conditions
–$39 (–0.5%)	**–$36 (–0.4%)**	**–$28 (–0.5%)**	**–$35 (–1.2%)**

High OOP cost and an inpatient stay	Beneficiary self-reported health = poor	Change in monthly Part B premium	Δ Medicare Advantage enrollment
–$112 (–0.4%)	–$40 (–0.8%)	**–$4.82 (–2.3%)**	**0%**

Health system impacts, 2027

Δ avg. hospital margin	Δ avg. margin high DSH hospitals	Δ avg. margin major teaching hospitals	Δ avg. margin small rural hospitals	Δ avg. margin low-volume hospitals	Δ avg. margin high Medicare share hospitals	Δ share of hospitals with negative margin	Δ accountable care org. attribution
–0.9%	**–0.4%**	**–0.3%**	**–0.9%**	**–0.9%**	**–1.2%**	**+3%**	**Down**

Key assumptions

- Hospital outpatient department payments reduced 1.1% in 2022 to levels equivalent to physician fee schedule payments.
- Annual payment updates for hospital outpatient departments from 2022 to 2031 set at the same rate as physician fee schedule annual updates.
- Hospitals slightly increase outpatient services per visit to recoup some of the lost revenue.
- Hospitals reduce costs per service to offset 90% of lost revenue per service.

Discussion

- Reducing annual hospital outpatient payment updates to physician fee schedule levels (0%–0.75%) reduces hospitals' Medicare margins.
- Hospitals with a larger relative proportion of outpatient (versus inpatient) cases will experience larger reductions in margins, such as small rural hospitals.
- Hospitals may choose to protect themselves from the payment reduction by increasing their volume of outpatient services per case.
- This policy will result in a slight decline in ACO attribution of patients (less participation).

Notes: HI = hospital insurance. Δ = change in. OOP = out-of-pocket. Beneficiary OOP cost results include the approximately 6 million beneficiaries without supplemental coverage. FPL = federal poverty level. B = $ billion. DSH = disproportionate share hospital.

Postacute care payment reductions

Policy description

Annual payment updates to postacute care (PAC) providers — home health, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities — reduced. For 2022, industry-specific updates reduced by amounts recommended by MedPAC (2021). For subsequent years, annual payment updates capped at 1 percent until industry-specific Medicare margins reach approximately 1 percent.

Assessment

Financial, 2022–2031

10-year budget net impact	Δ HI Trust Fund insolvency date	Δ Medicare spending per benef. (2031)	Δ Part B revenue contribution
–$122B	**No change**	**–1%**	**–$31B**

Δ % HI revenue as share of HI spend (2031)	% of HI revenue gap closed (2031)	Δ % spending funded by gen. rev. (2031)	Δ Medicaid outlays
+3% (83%)	**20%**	**–1% (47%)**	**–$0.5B**

Beneficiary Δ average OOP burden (without supplemental coverage), 2027

Total OOP burden	Over 85	Low income (<150% FPL)	Multiple chronic conditions
+$4 (+0.1%)	**+$19 (+0.0%)**	**+$1 (+0.0%)**	**+$4 (+0.2%)**

High OOP cost and an inpatient stay	Beneficiary self-reported health = poor	Change in monthly Part B premium	Δ Medicare Advantage enrollment
+$38 (+0.1%)	**+$8 (+0.2%)**	**–$1.31 (–0.6%)**	**0%**

Health system impacts, 2027

Δ avg. hospital margin	Δ avg. margin high DSH hospitals	Δ avg. margin major teaching hospitals	Δ avg. margin small rural hospitals	Δ avg. margin low-volume hospitals	Δ avg. margin high Medicare share hospitals	Δ share of hospitals with negative margin	Δ accountable care org. attribution
0%	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**None**

Key assumptions

- Payment reductions: 2022 payment rates reduced consistent with MedPAC's 2021 recommendations, from 2023–2031 payment updates capped at 1 percent annually until industry-specific margins reach approximately 1 percent.
- Utilization: Payment rate cuts will cause PAC utilization declines across all PAC industries. Home health will experience the largest utilization reductions. IRFs and LTCHs will have slight utilization reductions. SNFs will have slight reductions, but these will be partially offset by longer lengths of stay for remaining patients.

Discussion

- Hospitals are not significantly impacted by payment cuts to PAC providers. Although some hospitals in markets where LTCHs close could experience slight temporary cost increases as a result of being forced to hold patients longer, hospitals will continue to have adequate access to PAC providers to discharge patients.
- Beneficiary access to PAC services might be slightly reduced in some markets, requiring more travel to receive care.
- A subset of SNF beneficiaries will face higher OOP costs because of longer stays and the SNF coinsurance that starts on the 21st day of their stay.

Notes: HI = hospital insurance. Δ = change in. OOP = out-of-pocket. Beneficiary OOP cost results include the approximately 6 million beneficiaries without supplemental coverage. FPL = federal poverty level. B = $ billion. DSH = disproportionate share hospital.

Medicare Advantage competitive bidding

Policy description

Medicare Advantage (MA) payment adjusted to set benchmarks at average of all bids submitted in each county. Plans below the average bid receive a rebate that varies based on quality (Star) performance of plan. Traditional Medicare fee-for-service costs not included when determining average MA bid.

Assessment

Financial, 2022–2031

10-year budget net impact	Δ HI Trust Fund insolvency date	Δ Medicare spending per benef. (2031)	Δ Part B revenue contribution
–$471B	**+2 years (2028)**	**–5%**	**–$232B**

Δ % HI revenue as share of HI spend (2031)	% of HI revenue gap closed	Δ % spending funded by gen. rev. (2031)	Δ Medicaid payments for Part B
+4% (84%)	**48%**	**+2% (50%)**	**–$5B**

Beneficiary Δ average OOP burden (without supplemental coverage), 2027

Total OOP burden	Over 85	Low income (<150% FPL)	Multiple chronic conditions
+$1,200 (+16%)	**+$6,300 (+16%)**	**+$900 (+16%)**	**+$446 (+15%)**

High OOP cost and an inpatient stay	Beneficiary self-reported health = poor	Change in monthly Part B premium	Δ Medicare Advantage enrollment
+$4,000 (+15%)	**+$700 (+14%)**	**–$8.61 (–4.1%)**	**–14%**

Health system impacts, 2027

Δ avg. hospital margin	Δ avg. margin high DSH hospitals	Δ avg. margin major teaching hospitals	Δ avg. margin small rural hospitals
0%	**0%**	**0%**	**0%**

Δ avg. margin low-volume hospitals	Δ avg. margin high Medicare share hospitals	Δ share of hospitals with negative margin	Δ accountable care org. attribution
0%	**0%**	**0%**	**Up**

Key assumptions

- Plans reduce supplemental benefits and increase cost sharing in response to lower payments.
- MA enrollment declines among plans that no longer receive rebates, partially offset by increased enrollment in plans that continue to receive rebates.
- Medicaid (dual) enrollment in MA plans generally unaffected due to state policies covering cost sharing.
- Non-Medicaid (non-dual) individuals with higher expected costs more likely to switch to traditional fee-for-service.

Discussion

- The anticipated increase in average spend and OOP costs for individuals without supplemental coverage is due to higher-cost individuals leaving MA and enrolling in FFS, and not due to increased payments in traditional fee-for-service.
- An estimated 62% of MA enrollment is currently in plans that have below-average bids in the local county.

Notes: HI = hospital insurance. Δ = change in. OOP = out-of-pocket. Beneficiary OOP cost results include the approximately 6 million beneficiaries without supplemental coverage. FPL = federal poverty level. B = $ billion. DSH = disproportionate share hospital.