

GAO Releases Report on Payment Methods for Certain Cancer Hospitals

To control costs and reward efficiency, Medicare pays the majority of hospitals under a prospective payment system (PPS), which make payments on the basis of the clinical classification of each service. In response to concerns that cancer hospitals would experience payment reductions under a PPS, Congress required the establishment of criteria under which 11 PPS-exempt cancer hospitals (PCHs) are currently exempted from the inpatient PPS and are receiving payment adjustments under the hospital outpatient PPS. As such, PCHs are paid largely on the basis of their reported costs. The Government Accountability Office (GAO) was asked to examine PCHs in terms of their characteristics and Medicare payments.

Compared with how PPS teaching and community-based hospitals are paid, the methodologies for paying PCHs provide little incentive for efficiency. Under a PPS, Medicare pays hospitals a predetermined amount based on the clinical classification of each service they provide. PPS hospitals can retain any cost savings relative to their Medicare payments. In contrast, as required by the exemption, Medicare pays PCHs for inpatient services based on their reported costs, subject to an upper limit, as well as potential add-on payments. For outpatient care, Medicare pays PCHs at service-specific rates with an upward payment adjustment based on reported costs.

In 2012, Medicare payments—both inpatient and outpatient—were substantially higher at PCHs than at PPS teaching hospitals in the same geographic area for beneficiaries with the same diagnoses or services. GAO estimated that PCHs received, on average, about 42 percent more in Medicare inpatient payments per discharge than what Medicare would have paid a local PPS teaching hospital to treat cancer beneficiaries with the same

level of complexity. Similarly, Medicare outpatient payment adjustments to PCHs resulted in overall payments that were about 37 percent higher, on average, than payments Medicare would have made to PPS teaching hospitals for the same set of services. The estimated differences in Medicare payments varied greatly across the 11 PCHs. Furthermore, GAO found no association between the proportion of Medicare payments for cancer patient care and Medicare profit margins at PPS teaching hospitals, indicating that the PPS or an alternative payment methodology may be reasonable for cancer care.

Because Medicare's payment methodology for PCHs lacks strong incentives for cost containment, it has the potential to result in substantially higher total Medicare expenditures. If, in 2012, PCH beneficiaries had received inpatient and outpatient services at nearby PPS teaching hospitals—and the forgone outpatient adjustments were returned to the Supplementary Medical Insurance Trust Fund—Medicare may have realized annual savings of almost \$0.5 billion. Until Medicare pays PCHs to at least, in part, encourage efficiency, Medicare remains at risk for overspending.

The GAO recommended that Congress should consider requiring Medicare to pay the 11 PCHs as it pays PPS teaching and community-based hospitals, or provide the Secretary of Health and Human Services (HHS) with the authority to otherwise modify how Medicare pays PCHs. In doing so, Congress should provide that all forgone outpatient payments be returned to the Trust Fund. HHS had no general comments.

To review the GAO report, go to:

<http://www.gao.gov/products/GAO-15-199>