Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services

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Payment adequacy indicators

- Beneficiaries' access to care
- Providers' access to capital
- Quality of care
- Provider payments and costs
  - Medicare margins (2017)
  - Efficient provider margins (2017)
  - Projected Medicare margins (2019)

Background: Medicare fee-for-service hospital spending increased in 2017

Type of service	2016 (billions)	2017 (billions)	Percent change per beneficiary (2016-2017)
Inpatient	$116.0	$118.6	+2.5%
Outpatient	$60.6	$65.5	+8.4
Uncompensated care*	$6.4	$6.0	-6.4
Total	**$183.0**	**$190.1**	**+4.3**

Note: Spending includes FFS payments received by hospitals from the Medicare program and Medicare beneficiaries. Hospitals in this analysis include those paid under the Medicare prospective payment system and critical access hospitals.
* Uncompensated care payments are supplemental payments made to cover a portion of hospitals' uncompensated care costs and are not regarded as fee-for-service payments.
Source: MedPAC analysis of Medicare hospital cost report dataset

Access to hospital care is good: Service use increased

- Inpatient service use per capita increased slightly
  - Volume increased +0.7% (2016 to 2017)
  - Follows -2.6% average annual change (2007 to 2016)
  - Increased due to growth in short-stay inpatient cases
- Outpatient service use per capita increased slightly
  - Volume increased +0.7% (2016 to 2017)
  - Follows +3.4% average annual change (2007 to 2016)
  - Slow down due to flattening of ED and observation growth
  - Clinic visit cases increased
  - Part B drug administration increased

Outpatient spending growth largely driven by Part B drugs

- Outpatient spending increased 8.4% per beneficiary (2016 to 2017), or $4.9 billion
- Spending on separately payable drugs:
  - Increased $2 billion (2016 to 2017), or 40% of the growth in outpatient spending
  - Increased $6 billion (2012 to 2017)
- Drug spending driven by:
  - Higher prices for existing drugs (e.g., cancer drugs)
  - Growth in spending for pass-through drugs increased $1 billion (2016 to 2017)
- Medicare payments for outpatient Part B drugs exceeded costs at 340B hospitals, resulting in hospital profits

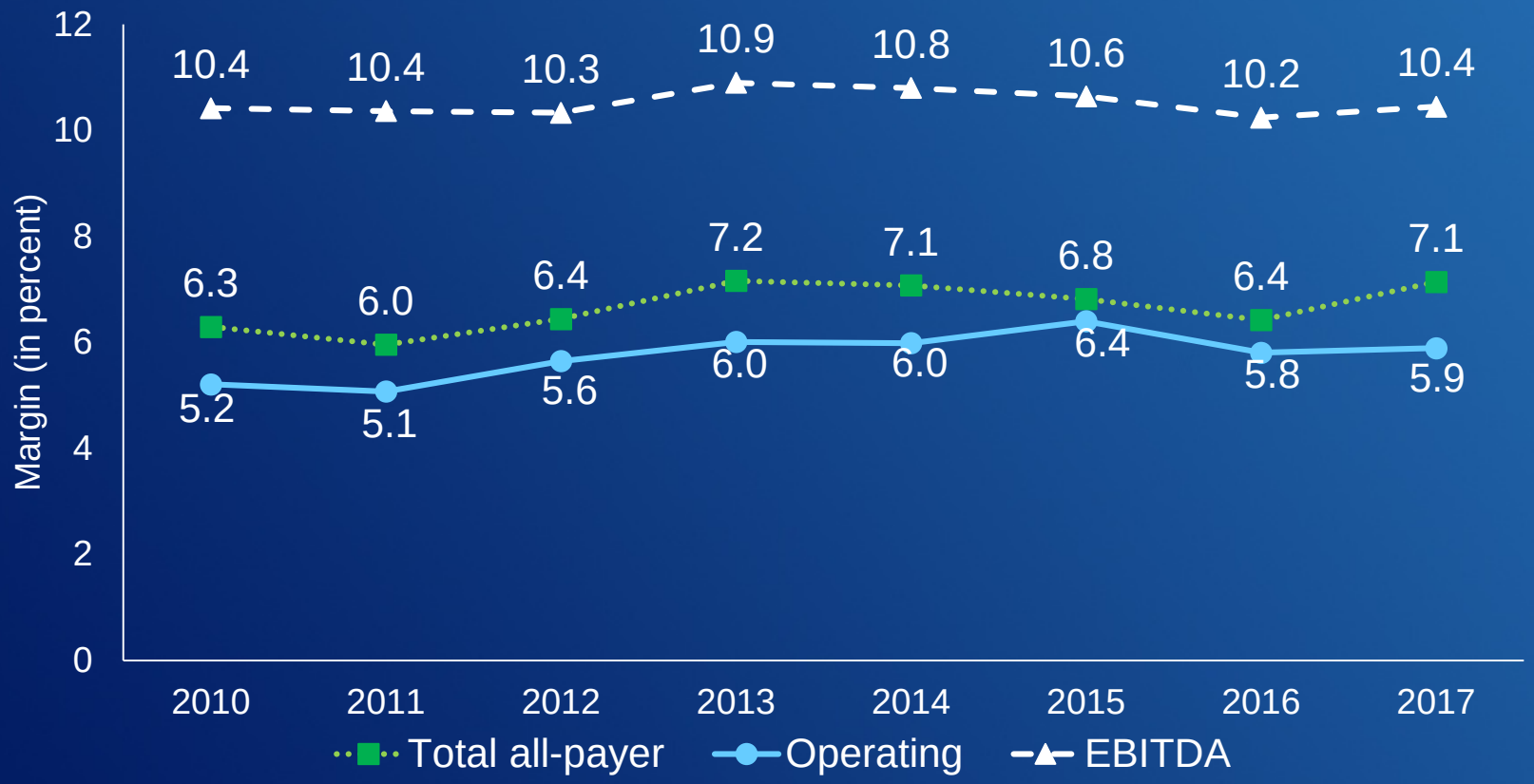
Access to hospital care is good

- Fewer of hospital closures and openings in 2017
  - 2017: 18 closures and 5 openings
  - 2013: 30 closures and 14 openings
  - More urban closures than rural in 2017
- Occupancy rates remain low, up slightly in 2017
  - Overall: 62.5%
  - Rural: 40.2%
- Average marginal Medicare profit = 8% in 2017, hospitals have financial incentive to serve Medicare beneficiaries

Access to capital remains strong

- Bond issuances totaled to $35 billion in 2017, consistent with 2016
- Industry construction spending totaled to $24 billion in 2017, consistent with 2016 and remains focused on outpatient capacity
- Merger and acquisition activity strong
- Hospital profitability remains strong
  - All-payer margins = 7.1% in 2017
  - Operating margins and cash-flow measures increased (2016 to 2017)

Hospitals' all-payer margins remain high



Note: EBITDA (earnings before interest, taxes, depreciation, and amortization). A margin is calculated as revenues minus costs, divided by payments. Excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data.

Quality of care improved

- Patient experience improving (percent of patients rating overall hospital experience a 9 or 10):
  - 2012: 71 percent
  - 2017: 73 percent
- Readmission rates declining (all-condition, 30-day, not risk adjusted):
  - 2012: 16.4 percent
  - 2017: 15.8 percent
- Mortality rates declining (all-condition, 30-day, risk adjusted):
  - 2012: 7.7 percent
  - 2017: 6.4 percent

Source: MedPAC analysis of Medicare claims and Hospital Compare data.

Overall Medicare margin dropped slightly from 2016 to 2017

Note: Margins = (payments – costs) / payments; excludes critical access hospitals. The overall Medicare margin, covers inpatient, outpatient, hospital-based post-acute care in IPPS hospitals, graduate medical education, and other payments such as payments for the adoption of electronic medical records.

Source: MedPAC analysis of Medicare Cost Reports from CMS.

Overall Medicare margins vary across hospital groups

Hospital group	2017 Margin
All hospitals	–9.9%
Urban	–10.0
Rural (excluding CAHs)	–8.2
Rural (including CAHs)	–5.9
Major teaching	–9.0
Other teaching	–8.2
Non-teaching	–12.2
Nonprofit	–11.0
For-profit	–2.6

Note: CAHs (critical access hospitals). Margins = (payments – costs) / payments; excludes critical access hospitals. The overall Medicare margin, covers inpatient, outpatient, hospital-based post-acute care in IPPS hospitals, graduate medical education, and other payments such as payments for the adoption of electronic medical records.

Source: MedPAC analysis of Medicare Cost Report files, MedPAR, and impact files from CMS.

Comparing performance of relatively efficient hospitals to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	291 (14%)	1,860 (86%)
30-day mortality (rel. to median)	7% lower	2% above
30-day readmissions (rel. to median)	7% lower	2% above
Standardized costs (rel. to median)	9% lower	1% above
Median overall Medicare margin	-2%	-9%

Note: Hospitals are classified as efficient based on 2014 to 2016 performance. In this slide, 2017 medians for each group are compared to the national median, except for the 30-day readmissions measure, which is from 2014 to 2016.

Source: Medicare cost reports and claims data

Summary of payment adequacy

- Access to care is good
- Access to capital is strong
- Quality is improving
- Medicare margins 2017
  - Aggregate margin: -9.9%
  - Efficient provider: -2%

Estimated current law 2020 update

Market basket*	3.3%
Productivity*	-0.5
Net update	2.8%

**Based on CMS Q3-2018 forecast from CMS, forecast used to set actual update will be revised to reflect most recent economic data at the time the final rule is published in August 2019.*

Considerations for the Chairman's draft recommendation

- Maintain a level of financial pressure on hospitals to limit cost growth
- Minimize differential in payment rates across sites of care (e.g., on-campus versus off-campus provider payments)
- Reward high-performing hospitals
- Move Medicare payments toward the cost of efficiently providing high quality care