

CHAPTER

3

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**Hospital inpatient and  
outpatient services**

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## R E C O M M E N D A T I O N

- 3** The Congress should direct the Secretary of Health and Human Services to:
- reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory payment classifications.
  - set long-term care hospital base payment rates for non-chronically critically ill (CCI) cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for CCI cases in inpatient prospective payment system hospitals. The change should be phased in over a three-year period from 2015 to 2017.
  - increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

**COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0**

# Hospital inpatient and outpatient services

## Chapter summary

The 4,700 acute care hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received \$166 billion for 10.4 million Medicare inpatient admissions and 190 million outpatient services in 2012. These amounts compare with \$163 billion for 10.8 million inpatient admissions and 181 million outpatient services in 2011. Net payments per beneficiary were essentially constant from 2011 to 2012 due to roughly equal growth in total payments and the number of fee-for-service beneficiaries with Part A and Part B Medicare coverage.

This year, we recommend a package of changes to Medicare's hospital payment systems. The recommendation consists of aligning payment rates for certain outpatient hospital services with rates paid in physician offices, creating greater equity in rates paid to acute care hospitals and long-term care hospitals (LTCHs), and changing inpatient and outpatient payment rates for fiscal year 2015 based on our assessment of payment adequacy and the impact of the outpatient and LTCH changes. This package of changes is designed to improve financial incentives in these payment systems while maintaining adequate overall payments.

## Assessment of payment adequacy

To evaluate whether aggregate payments are adequate, we consider beneficiaries' access to care, changes in the volume of services provided,

## In this chapter

- Are Medicare payments adequate in 2014?
- Joint recommendation on how to change hospital payment policies and payment rates in 2015

hospitals' access to capital, quality of care, and the relationship of Medicare's payments to the average cost of caring for Medicare patients. In addition to examining the costs of the average provider, we compare Medicare payments with the costs of relatively efficient hospitals.

Most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. However, on average, overall Medicare margins continue to be negative, and under current law they are expected to fall further in 2015.

***Beneficiaries' access to care***—Access measures include the capacity of providers and volumes of services provided.

- ***Capacity and supply of providers***—We expect Medicare beneficiaries' access to hospital services to remain strong due to excess hospital capacity in most markets. The excess capacity stems from a decline in admissions per capita coupled with few hospital closures. While we eventually expect bed supply to more closely meet demand, there have been only modest reductions in bed supply in recent years.
- ***Volume of services***—Medicare inpatient volume declined by 4.5 percent and outpatient service volume grew by 4.3 percent. When inpatient and outpatient volumes are combined into a measure of adjusted admissions (which converts outpatient services to inpatient equivalents), overall service use shows a decline of over 2 percent per capita. Because there is excess capacity (occupancy rates averaged 61 percent in 2012), the decline in service volume appears to reflect a decline in demand for services.

***Quality of care***—Across all inpatient prospective payment system (IPPS) hospitals, most indicators of quality are improving.

***Providers' access to capital***—Most hospitals continue to have adequate access to capital markets. However, in 2013, some hospitals have faced downgrades by credit rating agencies associated with weak demand for inpatient care.

***Medicare payments and providers' costs***—From 2007 through 2012, Medicare IPPS hospital payments were 5 percent to 7 percent below allowable Medicare costs, with an industry-wide Medicare margin of –5.4 percent in 2012. We identify a set of relatively efficient hospitals that have historically done well on a set of cost and quality metrics. These relatively efficient hospitals generated a positive overall Medicare margin of about 2 percent in 2011 and 2012. Their margins are expected to remain at 2 percent through 2014. However, under current law, payments are

projected to decline in 2015; this decline would result in lower margins for all hospitals, including the relatively efficient providers.

### **Addressing differences in payment rates across sites of care for outpatient care**

To move toward paying equivalent rates for the same service across different sites of care, we recommend adjusting the rates paid for certain services when they are provided in hospital outpatient departments (HOPDs) so they more closely align with the rates paid in freestanding physician offices. Under current policy, Medicare usually pays more for services in outpatient departments even when those services are performed safely in physician offices. For example, Medicare pays more than twice as much for a level II echocardiogram in an outpatient facility (\$453) as it does in a freestanding physician office (\$189). This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix. For example, from 2010 to 2012, echocardiograms provided in HOPDs increased 33 percent, while those in physician offices declined 10 percent. When echocardiograms shifted from being billed as physician services to being billed as HOPD services, the higher Medicare rates resulted in beneficiary cost sharing increasing from \$38 to \$91 for level II echocardiograms, and program cost increasing from \$151 to \$362. To remove this distortion in the payment system, the Commission recommends aligning outpatient prospective payment rates with physician office rates for certain services that meet the Commission's criteria. This approach will reduce Medicare program spending, reduce beneficiary cost sharing, and create an incentive to improve efficiency by caring for patients in the most efficient site for their condition.

### **Addressing differences in payment rates across sites of care for inpatient care**

Payment rates also differ for similar patients in acute care hospitals and LTCHs. As explained in greater detail in Chapter 11, LTCHs are currently paid much higher rates than traditional acute care hospitals, even for patients who do not require an LTCH's specialized services. To correct this problem, we propose a new criterion for admissions to receive higher level LTCH payments. Chronically critically ill (CCI) patients would still qualify for the relatively high LTCH standard diagnosis related group (DRG) payment rates because they often need LTCH type care. LTCHs' average standard DRG rate for CCI patients would remain at roughly \$50,000. In contrast, most non-CCI patients at LTCHs (who often do not need LTCH type care) would receive IPPS standard DRG payment rates. Equalizing non-CCI base rates would reduce LTCHs' average DRG payment for non-CCI cases from about \$40,000 to \$12,000 (the IPPS average for these types of non-CCI cases).

The reduction in LTCH DRG rates for non-CCI cases would generate savings that would be transferred to acute care hospitals in the form of higher outlier payments for the most costly CCI cases. In the end, the differences in IPPS and LTCH rates would be reduced. The rates paid for services in the two payment systems would be more aligned with patients' needs and less dependent on the payment system under which the provider operates.

### **Recommendation**

To improve financial incentives in the Medicare hospital payment systems while maintaining adequate payments, the Commission recommends adjusting the relative payment rates in the outpatient prospective payment system, the long-term care hospital payment system, and the acute care inpatient outlier payment system. Specifically, the Congress should direct the Secretary of Health and Human Services to:

- adjust payment rates for services provided in HOPDs so that they more closely align with the rates paid in physician offices for selected ambulatory payment classifications.
- set LTCH base payment rates for non-CCI cases equal to acute care hospital base rates and redistribute the resulting savings to create additional inpatient outlier payments for CCI cases that are treated in IPPS hospitals. The change should be phased in over three years.
- increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

This package of changes should be considered as a whole; together the changes will improve incentives in the system to care for patients in the most appropriate setting and ensure that funding in the acute care hospital system is adequate to provide high-quality care for Medicare beneficiaries. These changes can be accomplished by reducing payment rates for services that can safely be provided in lower cost settings and, concurrently, increasing base payment rates for other hospital services by 3.25 percent so that overall Medicare payments are adequate for efficient providers. ■

**TABLE  
3-1**

**Growth in Medicare inpatient and outpatient spending**

Hospital services	2006	2011	2012	Average annual change 2006-2011	Change 2011-2012
<b>Inpatient services</b>					
Total FFS payments (in billions)	\$110	\$121	\$120	1.8%	-0.8%
Payments per FFS beneficiary	3,084	3,341	3,263	1.6	-2.3
<b>Outpatient services</b>					
Total FFS payments (in billions)	29	42	46	7.8	8.0
Payments per FFS beneficiary	845	1,305	1,397	8.1	7.0
<b>Inpatient and outpatient services</b>					
Total FFS payments (in billions)	140	163	166	3.2	1.5
Payments per FFS beneficiary	3,967	4,646	4,660	3.2	0.3

Note: FFS (fee-for-service). Reported hospital spending includes all hospitals covered by Medicare’s inpatient prospective payment system along with critical access hospitals. Maryland hospitals are excluded. Fiscal year 2012 payments include partial imputation to account for hospitals that typically do not submit their cost reports to CMS before CMS makes the most recent year available to the public. Although the number of Medicare beneficiaries grew significantly from 2006 to 2011, the number of Part A FFS beneficiaries only increased slightly and Part B beneficiaries declined slightly due to the shift of beneficiaries to the Medicare Advantage program. From 2011 to 2012, the number of Part A beneficiaries grew by 1.6 percent, while the number of Part B enrollees grew by 0.9 percent, presumably because many 65-year-olds declined Part B because they continued to have employer-based insurance. For the purposes of calculating payments per beneficiary, we identified populations of beneficiaries eligible for inpatient (Part A) and outpatient (Part B) coverage. The combined inpatient and outpatient services per capita are based on a weighted average of the Part A and Part B beneficiaries.

Source: MedPAC analysis of CMS Medicare hospital cost reports and Medicare Provider Analysis and Review files.

**Background**

Acute care hospitals provide Medicare beneficiaries with inpatient care for the treatment of acute conditions and manifestations of chronic conditions. They also provide ambulatory care through hospital outpatient departments (HOPDs) and emergency rooms. In addition, many hospitals provide home health, skilled nursing facility, psychiatric, and rehabilitation services. To be eligible for Medicare payment, short-term general and specialty hospitals must meet the program’s conditions of participation and agree to accept Medicare rates as payment in full.

**Medicare spending on hospitals**

In 2012, Medicare paid acute care hospitals nearly \$120 billion for fee-for-service (FFS) inpatient care and nearly \$46 billion for FFS outpatient care (Table 3-1). Acute inpatient and outpatient services represented 92 percent of Medicare FFS spending on acute care hospitals. From 2011 to 2012, Medicare inpatient spending per FFS beneficiary decreased by 2.3 percent, and outpatient spending per FFS beneficiary grew by 7 percent.<sup>1</sup> The 2.3 percent decline in inpatient payments reflects a 4.5 percent drop in admissions per capita, which was partially offset

by increases in case complexity and Medicare payment rates. The 7 percent outpatient increase in spending reflects a 4.3 percent increase in service volume and an increase in Medicare payment rates. On a combined basis, total payments per beneficiary were roughly flat (a 0.3 percent increase) due to decreases in payments for inpatient care offsetting increases in outpatient payments.

**Medicare’s payment systems for inpatient and outpatient services**

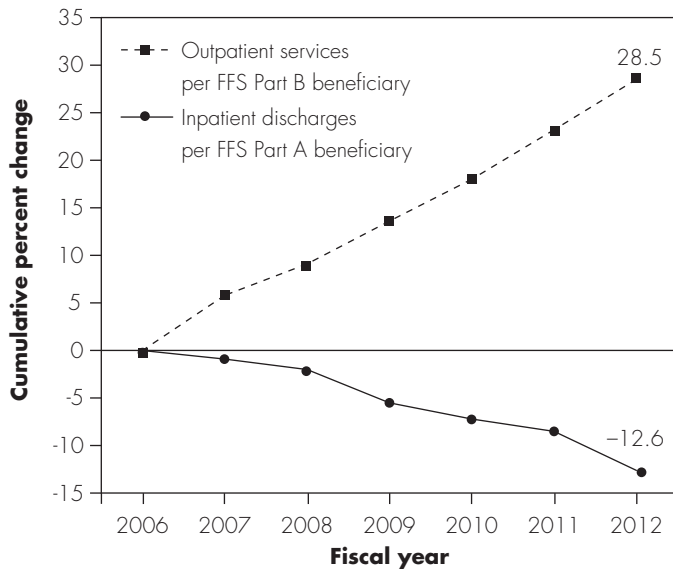
Medicare’s inpatient and outpatient prospective payment systems (PPSs) have a similar basic structure. Each has a base rate modified for the differences in type of case or service as well as geographic differences in input prices. However, each PPS has different units of service and a different set of payment adjustments.

**Acute inpatient payment system**

Medicare’s acute inpatient prospective payment system (IPPS) pays hospitals a predetermined amount for most discharges. The payment rate is the product of a base payment rate and a relative weight that reflects the expected costliness of cases in a particular clinical category compared with the average of all cases. The labor-related portion of the base payment rate is adjusted by a hospital geographic wage index to account for

**FIGURE  
3-1**

**Medicare inpatient discharges per beneficiary declined as outpatient visits per beneficiary increased**



Note: FFS (fee-for-service). Data include general and surgical, critical access, and children's hospitals.

Source: Medicare hospital cost reports and Medicare outpatient claims data.

differences in hospital input prices among market areas. Payment rates are updated annually.

To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system classifies patient cases in 1 of 749 groups, which reflect similar principal diagnoses, procedures, and severity levels. The severity levels are determined according to whether patients have a complication or comorbidity (CC) associated with the base MS–DRG (no CC, a nonmajor CC, or a major CC). A more detailed description of the acute IPPS, including payment adjustments, can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_13\\_hospital.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_hospital.pdf).

**Hospital outpatient payment system**

The outpatient prospective payment system (OPPS) pays hospitals a predetermined amount per service. CMS assigns each outpatient service to 1 of approximately 800 ambulatory payment classification (APC) groups. Each APC has a relative weight based on its geometric mean cost of service compared with the geometric mean cost of a clinic visit. A conversion factor translates relative weights into dollar payment amounts. A more detailed description

of the OPPS can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_13\\_OPD.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_OPD.pdf).

**Are Medicare payments adequate in 2014?**

To judge whether payments for 2014 are adequate to cover the costs relatively efficient hospitals incur, we examine several indicators of payment adequacy. We consider beneficiaries' access to care, hospitals' access to capital, changes in the quality of care, and the relationship of Medicare's payments to hospitals' costs for both average and relatively efficient hospitals. Most of our payment adequacy indicators for hospitals are positive, but on average, margins for treating Medicare patients remain negative for most hospitals.

**Beneficiaries' access to care: Access remains positive, while excess inpatient capacity increased**

We expect Medicare beneficiaries' access to hospital services to remain strong because of excess hospital capacity in most markets. The excess stems from a decline in admissions per capita coupled with few hospital closures. While we would expect bed supply to more closely meet demand eventually, hospitals have reduced bed supply only modestly in recent years.

**Volume of services: Inpatient volume declines as outpatient volume grows**

Medicare inpatient discharge volume declined 4.5 percent per Medicare FFS Part A beneficiary between 2011 and 2012 and by a total of 12.6 percent over the past six years (Figure 3-1). The decline is only partially explained by the shift to outpatient care. From 2011 to 2012, outpatient services increased 4.3 percent per Medicare Part B beneficiary; from 2006 to 2012, service volume increased by 28.5 percent. On a weighted average basis (where outpatient services are converted to inpatient equivalents), the total volume of Medicare hospital services per beneficiary declined from 2011 to 2012 by over 2 percent.

Declines in admissions are widespread across groups of patients. From 2011 to 2012, the volume of inpatient services declined approximately 4 percent to 6 percent across all Medicare age groups. Among privately insured individuals under age 65, inpatient admissions per capita declined by 1.5 percent in 2011 and then by another 3.1 percent in 2012 (Health Care Cost Institute 2013). This



**TABLE  
3-2**

**Growth in observation stays only partially explains decrease in admissions**

	Number of discharges/visits per 1,000 beneficiaries			Change in volume per 1,000 beneficiaries			
	2006	2011	2012	2006-2012		2011-2012	
				Number	Percent	Number	Percent
Inpatient and observation stays per 1,000 beneficiaries							
Inpatient discharges	334	306	289	-45		-17	
Outpatient observation visits	28	47	53	25		6	
Total	362	353	342	-20	-6%	-11	-3%
Inpatient and observation days per 1,000 beneficiaries							
Inpatient days	2,218	2,136	2,063	-155		-73	
Outpatient observation days	30	56	65	35		9	
Total	2,248	2,192	2,128	-120	-5%	-64	-3%

Source: MedPAC analysis of claims data.

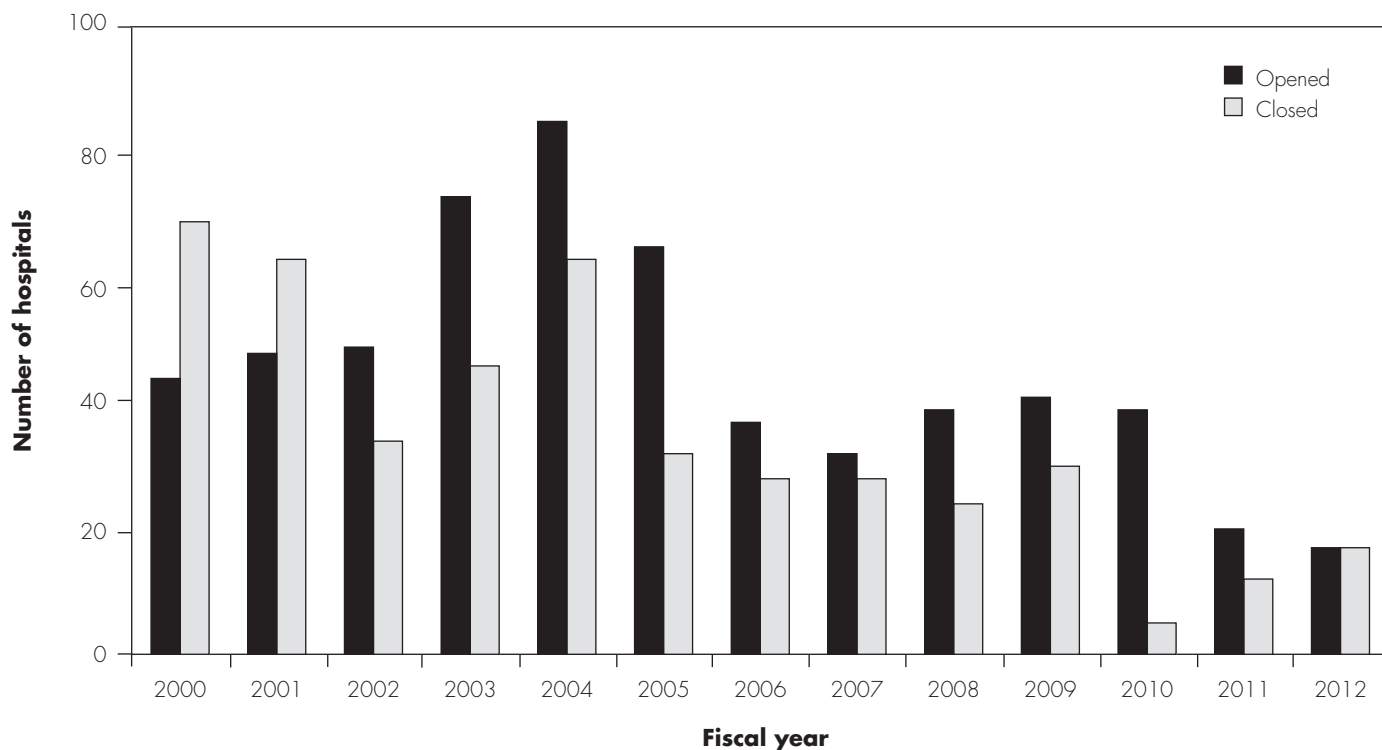
decline suggests that care patterns are changing for all insured patients, not just Medicare beneficiaries.

In 2012, there were slightly more than 10 million Medicare FFS inpatient discharges, and the rate of decline in discharges differed depending on the type, geographic location, and size of the hospital. For the same cohort of hospitals from 2006 to 2012, inpatient discharges declined 8 percent in urban hospitals and 21 percent in rural hospitals. The drop in inpatient discharges was most pronounced for the smallest rural hospitals (those with fewer than 100 beds), declining approximately 25 percent. This more rapid decline in discharges at the smallest rural hospitals is attributable in part to the movement of patient care from relatively isolated rural facilities to more centralized facilities. For example, large shifts in market share from rural hospitals to urban hospitals occurred for cardiac diagnosis related groups (DRGs) and nervous system DRGs (including stroke), which could reflect cases being directed to more specialized facilities that offer cardiac catheterization facilities and specialized stroke care centers (Jauch et al. 2013). Use of hospital inpatient care also varies among states and regions. In 2012, for example, approximately 15 percent of Medicare beneficiaries in Oregon and Vermont had an inpatient stay, compared with 21 percent in Ohio and Kentucky.

**Observation stays are growing but only partially explain the decline in inpatient stays** If a Medicare patient does not initially meet the criteria for inpatient admission but

the attending physician concludes the patient should be observed in the hospital for a period of time before being sent home, the patient can remain in the hospital in observation status.<sup>2</sup> Observation stays are billed as outpatient services rather than inpatient admissions. Over the last several years, outpatient observation claims have risen rapidly, but these stays alone do not account for the decline in inpatient discharges. From 2006 to 2012, the number of outpatient observation claims per 1,000 Part B beneficiaries increased from approximately 28 to 53 visits (Table 3-2). Inpatient discharges declined by 45 discharges per 1,000 beneficiaries (from 334 to 289). The net result is that the combined number of inpatient and observation stays declined by 20 stays from 2006 to 2012 (a 6 percent decline) and by 11 stays from 2011 to 2012 (a 3 percent decline). When we used days spent in the hospital as the unit of analysis, we similarly found a 3 percent reduction in combined observation and inpatient days, indicating that the growth in observation days does not fully explain the decline in inpatient days and occupancy.

Hospitals increased their use of observation status in 2012. CMS processed 1.8 million outpatient observation claims in 2012; another 700,000 observation stays did not result in observation claims because the patient was admitted for inpatient care and the observation care was bundled into the inpatient stay. From 2006 to 2012, the number of outpatient observation claims increased 88 percent and the

**FIGURE  
3-2****Hospital openings and closures were equal in 2012**

Note: "Hospital" refers to general short-term acute care hospitals. MedPAC's reported number of open and closed hospitals can change from year to year based on hospitals that enter Medicare as an acute care facility and later convert to a more specialized type of facility, such as a long-term care hospital or critical access hospital.

Source: MedPAC analysis of Medicare Provider of Service file, inpatient prospective payment system final rule impact file, and hospital cost reports.

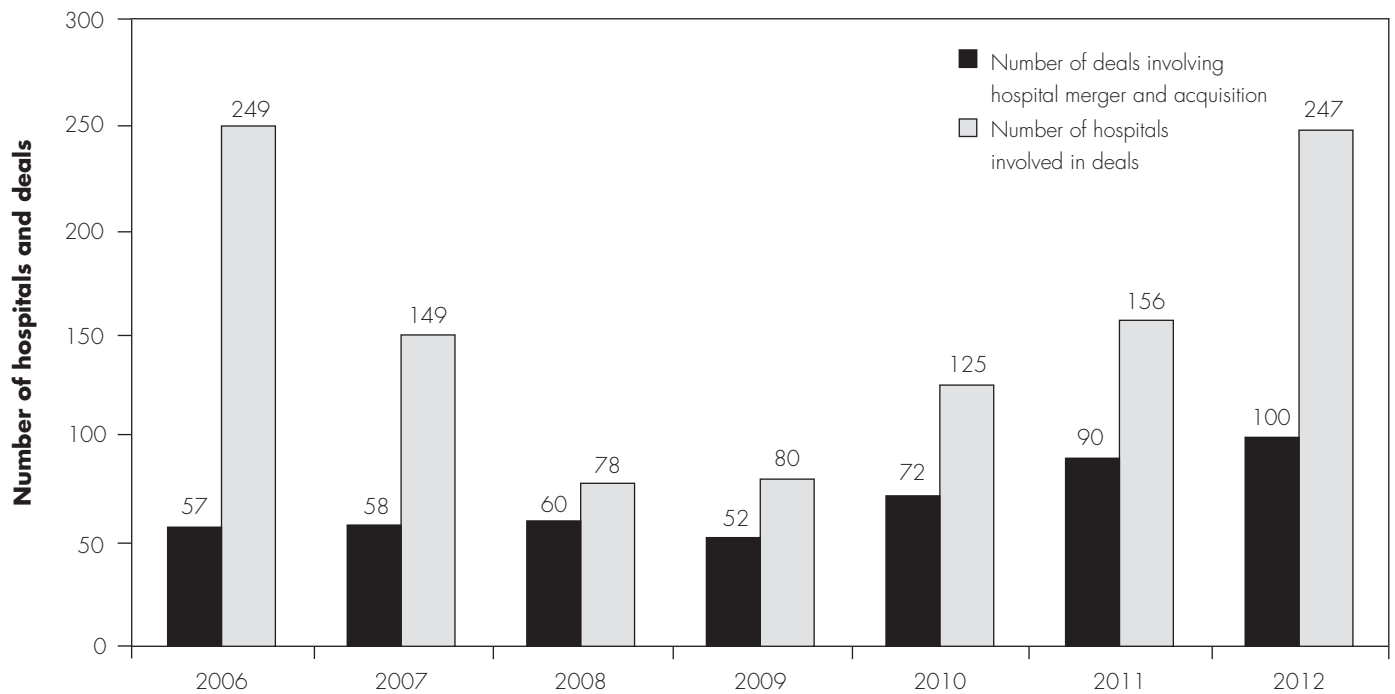
average length of observation stays also increased from 26 hours per stay to 29 hours per stay.

In 2012, Medicare paid \$2.5 billion for outpatient observation visits. The average payment per visit that included packaged outpatient observation care was about \$1,400, and the average out-of-pocket cost for Medicare beneficiaries was about \$360. Both volume and spending associated with outpatient observation visits in 2012 were concentrated among a small group of diagnoses. Six diagnoses accounted for about one-third of volume and one-third of spending: two different chest pain diagnoses, syncope, coronary atherosclerosis, dizziness, and dehydration. Chest pain alone accounted for 23 percent of observation stays.

**Excess capacity varies by region** From 2006 to 2012, the national average hospital bed occupancy rate for beds that were available to be staffed declined from 64 percent

to 61 percent, despite a decrease during this period in the number of available beds, from 2.8 beds to 2.6 beds per 1,000 people. Occupancy rates for urban hospitals declined from 67 percent to 64 percent on average. Occupancy rates for rural hospitals declined from 48 percent to 43 percent on average. Inpatient capacity is expected to remain in excess in most markets even after accounting for increases in demand expected from the 2014 expansion of Medicaid and introduction of the new mandate to purchase insurance.<sup>3</sup>

On a market level, the extent of excess inpatient capacity varied widely in 2012. Among the 382 metropolitan statistical areas with available data, 17 markets had average hospital occupancy rates of more than 75 percent, 243 markets had rates between 50 and 74 percent, 121 markets had rates between 25 and 49 percent, and 1 market had an average occupancy rate below 25 percent.<sup>4</sup>

**FIGURE  
3-3****Hospital merger and acquisition activity increased**

Source: MedPAC analysis of data from Irving Levin Associates, Inc. (Irving Levin Associates Inc. 2013).

**Despite declining demand for inpatient services, few hospitals closed in 2012**

In 2012, approximately 4,700 short-term acute care hospitals participated in the Medicare program, of which approximately 1,300 were critical access hospitals (CAHs) (Flex Monitoring Team 2012). In that year, 17 acute care hospitals closed and 17 new hospitals opened (Figure 3-2).<sup>5</sup> In light of changes in the practice of medicine, reductions in inpatient discharges, and declining occupancy rates, we may see more than 17 closures per year in the future.

The 17 hospital openings added 1,200 new acute care beds and the closures eliminated about 2,000 beds, a net reduction of 800 beds. This amount represents a 0.1 percent reduction in existing bed capacity. The majority of closures occurred in urban locations, with only four occurring in rural locations. Among the 17 closed facilities, most appear to have closed completely, but 5 were converted to outpatient care facilities.

**Closed hospitals had low occupancy and lower average quality scores**

Hospitals that closed in 2012 had an average occupancy rate of 27 percent in 2011, considerably lower than the 57

percent average occupancy rate of the competing nearby hospitals.<sup>6</sup> For most of the closed facilities, low occupancy was associated with poor financial performance. (Poor performers are discussed in the text box, pp. 60–61.) The average all-payer 2011 profit margin for the hospitals that closed in 2012 was –10.5 percent, considerably lower than the average of 6 percent for all hospitals. On average, closed hospitals had slightly higher readmission and mortality rates, but the differences were not statistically significant. In terms of patient satisfaction, 6 of the 17 hospitals had among the lowest scores in the nation, based on the share of their patients who would “definitely not recommend” their hospital to others. The 17 hospitals also had lower average quality scores on three process measures for cardiac care.<sup>7</sup>

**Hospital industry consolidation increased**

In 2012, at least 247 individual hospitals were acquired in over 100 transactions (Irving Levin Associates Inc. 2013).<sup>8</sup> Both the number of merger and acquisition deals in 2012 and the number of hospitals involved in the deals represent a marked increase from 2009 to 2012 (Figure 3-3).

Large acquisitions continued in 2013, with the Tenet system’s acquisition of Vanguard Health Systems and Community Health Systems’ (CHS’s) acquisition of

## Characteristics of poorly performing hospitals

As discussed, inpatient volume and occupancy rates have been declining for the past several years. Eventually, these trends may result in hospitals closing or merging to reduce unneeded capacity. Some recently closed hospitals had low occupancy and low patient satisfaction. If more such hospitals closed, that could improve the quality of care as long as neighboring hospitals have excess capacity. We analyzed the characteristics of low-occupancy, low-performing hospitals to understand what role they play in their markets and whether other hospitals (with better quality metrics) could absorb some or all of these hospitals' patients.

We defined hospitals as low occupancy, high readmission, and poor satisfaction if they met all three of the following criteria:

- an occupancy rate for beds available to be staffed of under 50 percent
- risk-adjusted hospital-wide readmissions rates in the worst decile
- patient experience survey (Hospital Consumer Assessment of Healthcare Providers and Systems®) scores in the worst decile as indicated by either:
  - a high (worst decile) share of patients rating the hospital 6 or lower on a 10-point scale
  - a high share of patients who would not recommend the hospital
  - a low share of patients who would recommend the hospital

We identified 112 hospitals with this combination of low occupancy, high readmission rates, and low patient satisfaction. Of these, about half were urban hospitals and half were rural hospitals.

- *Urban poor-performing hospitals.* Most of the poor-performing hospitals are near another hospital—half have another hospital less than five miles away. However, a quarter of these urban hospitals are more than 15 miles away from the nearest hospital, so they do not have a direct competitor in their immediate vicinity. On average, urban low-performing hospitals have an average of 138 beds, an average daily census of 50 patients, and are disproportionately for profit (70 percent compared with 27 percent of all urban hospitals). Chicago, Los Angeles, and Miami all have multiple hospitals identified as low performing and low occupancy.
- *Rural poor-performing hospitals.* In most cases, these hospitals are the only hospital in the immediate market; median distance to the next nearest hospital is almost 25 miles. However, 8 of these rural hospitals have a neighboring hospital within 15 miles and 3 have a competing hospital of similar size in the same town. The low-occupancy, low-quality rural hospitals have an average of 78 beds and an average daily census of 23 patients. Alabama, Arkansas, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas all have at least four rural hospitals classified as low performing and low occupancy.

The financial situation of many of these hospitals is tenuous. In general, these hospitals have falling

*(continued next page)*

Health Management Associates. These two deals made CHS the second largest chain (\$19 billion in revenues) and Tenet the third largest (\$15 billion in revenues). Hospital Corporation of America remains the largest chain (\$33 billion in revenues) and has also acquired hospitals in recent years. These three chains now collectively own nearly 450 hospitals (Moody's Investors Service 2013a). Los Angeles-based Prime Healthcare Services also

expanded its portfolio by acquiring six additional hospitals in New Jersey, Rhode Island, and Texas.

There has also been an increase in vertical integration—hospital systems merging with insurers or other hospital systems that have an insurance product. We have been told by some hospital executives that they are pursuing this strategy to prepare for taking on greater risk-based contracts. Some recent acquisitions include Pittsburgh's

## Characteristics of poorly performing hospitals (cont.)

occupancy rates and lower than average total all-payer margins in 2011 as compared with other hospitals, with 43 percent facing negative total margins. Moreover, their non-Medicare margins were much lower than average, with the median at only 2.2 percent, 5 percentage points below the median for all hospitals. In contrast, these hospitals have higher Medicare inpatient and overall Medicare margins relative to other facilities. This situation is likely due to Medicare disproportionate share payments since most of these hospitals have above average shares of low-income Medicare patients.

In addition to poor readmission rates, most of these hospitals also perform poorly on mortality metrics. Their median all-condition mortality rate (as measured by an Agency for Healthcare Research and Quality metric) was 20 percentage points higher than average.

To better understand what might be happening to this set of hospitals, we examined whether the hospital was still operating in 2013 or may have merged or had other major organizational changes. Our analysis found that:

- 8 of the 112 hospitals closed.
- 3 hospitals were involved in bankruptcy proceedings.
- 22 hospitals were or are undergoing a change in ownership.
- 8 were undergoing substantial renovations of their facilities; 2 were replacing their entire facility.

- 10 were either eliminating specific services such as the emergency department, intensive care unit, or pediatrics department, or were making substantial cuts in staffing without any specific departments targeted.
- 6 had a specialty focus, generally a surgical specialty, which may also explain their low occupancy rates. (The services of these specialty hospitals may not be crucial for access.)
- 3 were likely unavailable to the general public since 2 were hospitals located within retirement communities that provide all levels of care to their residents and the other was a state hospital that provides surgical and medical care to residents of state mental health facilities.

Poor performance on patient surveys and other quality metrics may signal a hospital that is in trouble; in fact, five of the urban hospitals we identified closed, and competing hospitals absorbed their patient loads. In situations where a low-performing hospital is the only facility in the immediate market, other interventions may be necessary if that facility is to remain open. In some cases, larger systems purchase these poor-performing providers. In other cases, the hospitals or communities have committed resources to improving the facilities, through either major renovations or curtailing underperforming services. ■

health insurer, Highmark Inc., recently acquiring Saint Vincent Health System in Erie, Pennsylvania. HealthPartners, a nonprofit insurer in Minnesota with an existing network of hospitals and clinics, merged with Park Nicollet, a nonprofit physician group practice with a hospital of its own. Both of these deals vertically integrated regional payers and regional providers to create integrated payer/provider health care systems with a broad geographic base within their markets. In addition, Baylor Health Care System of northern Texas merged with Scott & White Healthcare of central Texas to form the state's largest nonprofit health system. The merger will not only create a system encompassing 43 hospitals, 500 patient care sites,

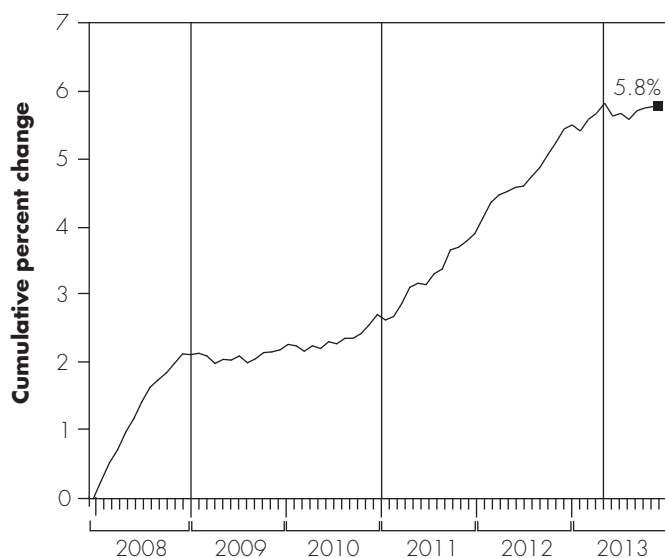
and more than 6,000 affiliated physicians, but also will include a health plan originating from Scott & White.

The presence of accountable care organizations (ACOs) in a particular market does not appear to be directly correlated with hospital merger and acquisition activity since half of mergers and acquisitions occur in markets with an ACO and half in markets without a significant ACO presence. This observation is not surprising since hospitals can benefit from enhanced market power through consolidation in markets with and without ACOs. Greater provider consolidation can lead to higher prices for commercially insured patients (Gaynor and Town 2012). The additional commercial revenue can reduce financial



**FIGURE  
3-4**

### Hospital employment growth since 2008



Source: Bureau of Labor Statistics.

pressure to constrain costs, resulting in higher costs for Medicare and privately insured patients, as well as reduced Medicare margins. The result could be an increase in the discrepancy between Medicare and private payer payment rates.

### Access to capital and employment remains steady

Overall, hospitals maintained reasonable access to capital markets in 2012 and 2013. Hospital construction spending has been consistent over the last three years, with more construction now focused on building outpatient capacity than inpatient capacity. Hospital employment grew significantly in 2012 but remained flat in 2013.

### Hospital borrowing

Overall, the hospital industry maintains reasonable access to capital markets. Through the end of 2012, hospital tax-exempt municipal bond offerings amounted to \$27 billion, including refinancing. Bonds involving only new financing remained relatively flat at \$18 billion in 2012. We expect refinancing to decline since interest rates increased between November 2012 and November 2013 from 3.5 percent to 5.13 percent for the average double-A tax-exempt 30-year hospital bond (Brothers 2013). While most hospitals continue to have access to bond markets,

some hospitals have had their credit ratings downgraded. Moody's cites the decline in hospitals' volumes as one reason why the number of downgrades (30) exceeded upgrades (18) through the first three quarters of 2013 (Moody's Investors Service 2013b). In addition to the traditional capital bond markets and use of cash flows from operations, hospitals have increasingly sought out alternative sources of capital, for instance, by partnering with real estate entities that possess both capital and expertise in developing health care facilities (Zismer 2013).

### Hospital construction

The dollar value of hospital construction projects in the United States remained steady in 2012 and the first half of 2013. Hospital construction spending was consistently in the \$26 billion to \$28 billion range in 2010, 2011, and 2012 (Census Bureau 2013). Based on data from the first half of the year, the Census Bureau projects that 2013 hospital construction spending also exceeded \$26 billion. These findings are consistent with Moody's Investment Service's observation concerning a steady median capital-spending ratio—1.2 times annual depreciation in 2011 and 2012—and hospitals spending more than necessary to replace existing facilities (Moody's Investors Service 2013c). Additionally, in *Modern Healthcare's* 2013 Construction & Design Survey, respondents indicated that the balance of hospital construction spending has tilted away from inpatient- and toward outpatient-based projects, such as building new medical office buildings (Robeznieks 2013).

### Hospital employment

Over the past six years, hospital employment has grown by a total of 5.8 percent, but employment has alternated between periods of growth and stability (Figure 3-4). Before the recession of 2009, employment grew by 2 percent per year. But during the recession (January 2009 to January 2011), hospital employment growth slowed to less than 0.5 percent per year. As the economy started to recover, hospital employment increased more than 1 percent per year (January 2011 to August 2012). Finally, in the most recent 12 months (November 2012 to November 2013), hospital employment was flat, reflecting a lack of growth in patient volume. Over the same six-year period, employment for the rest of the health care sector grew by 14.8 percent.<sup>9</sup> Employment trends appear strong in the health care sector and the hospital industry compared with the rest of the economy, which declined 2.6 percent over the same period. While the hospital industry has added jobs in recent years, an increase in the number of individuals employed by a given industry may not indicate

## Hospital Readmissions Reduction Program: Options for refinement

In its June 2013 report to the Congress, the Commission included a chapter on options for refining the Hospital Readmissions Reduction Program. The chapter focused on three primary changes:

- provide a fixed target for readmission rates so penalties disappear if a hospital reduces its readmission rates below the target,
- use an all-condition readmission measure to increase the number of observations and reduce the random variation compared with single readmission measures, and
- evaluate each hospital's readmission rate against the rate for a group of its peers with similar shares of low-income Medicare beneficiaries as a way to

adjust the readmission penalties for socioeconomic status.

These refinements would help overcome issues with current policy, maintain or increase the average hospital's incentive to reduce readmissions, and increase the share of hospitals that has an incentive to reduce readmissions. The changes could be structured so that the Medicare program savings from either future reductions in readmissions or future penalties are equal to the expected savings under current law. The three readmission program changes would require new legislation because the current formula to compute the readmission penalty is set in current law. The goal of the refinements would be a decline in readmissions, a decline in penalties paid by hospitals, and a decline in Medicare spending on readmissions. ■

an improvement in economic efficiency (Baicker and Chandra 2012).

### Quality of care: Overall, indicators show improvement

We use mortality rates and patient safety indicators (PSIs) developed by the Agency for Healthcare Research and Quality (AHRQ) to evaluate trends in the quality of inpatient care. Our analysis for the period 2009 to 2012 shows generally positive trends in quality. We observed statistically significant improvements in 8 out of 10 risk-adjusted mortality rates, including in-hospital and 30-day postdischarge, for 5 prevalent clinical conditions.<sup>10</sup> We also found statistically significant improvements from 2009 to 2012 in seven out of the eight risk-adjusted PSIs analyzed.<sup>11</sup>

### Readmission rates have improved, but refinements in the Medicare Hospital Readmissions Reduction Program are warranted

The Congress enacted a Medicare Hospital Readmissions Reduction Program in 2010. Starting in fiscal year 2013, hospitals face a penalty if they have above-average readmission rates (from a prior three-year period) in one of three clinical conditions (heart failure, acute myocardial infarction, or pneumonia). The penalty is capped at 1 percent of base inpatient payments in 2013, 2 percent

in 2014, and 3 percent in 2015 and after. CMS plans to add two more sets of conditions (acute exacerbation of chronic obstructive pulmonary disease and hip and knee replacements) to the measure in 2015.

Commission analysis has found some small declines in risk-adjusted readmission rates since public reporting began in 2009 and hospitals became aware of the Hospital Readmissions Reduction Program (Medicare Payment Advisory Commission 2013c). From 2009 through 2011, all-cause readmission rates for the three conditions covered by the current readmissions reduction program dropped between 0.5 and 0.7 percentage point, with a slightly larger drop if we focused only on potentially preventable readmissions. In 2012, readmission rates continued to decline for these conditions, with the average rate dropping an additional 0.5 percentage point across all conditions. Analysis from CMS also shows a decline in all-cause readmission rates between 2011 and 2013, from an average of 19 percent to below 18 percent by the start of 2013 (Council of Economic Advisers 2013). The readmissions reduction payment policy and other efforts such as the Partnership for Patients have encouraged hospitals to look beyond their walls and improve care coordination across providers to reduce readmissions (Naylor et al. 2012). The Commission finds that the policy should be refined and continued (see text box).

## **Value-based purchasing program**

The Congress mandated a value-based purchasing (VBP) program for IPPS hospitals beginning in fiscal year 2013. For fiscal year 2014, CMS reduced all IPPS hospitals' base operating DRG payment amounts by 1.25 percent to create a pool of funds from which the performance-based incentive payments will be distributed. As required by law, the total amount of withheld payments, which CMS projected at \$1.1 billion for fiscal year 2014, must be redistributed to hospitals participating in the VBP program.

The Commission has expressed concerns regarding the relatively large number of clinical process measures and low weight (25 percent) given to the outcome measures in the first year of the program (Medicare Payment Advisory Commission 2012a). CMS is moving to address this concern. By 2016, CMS will use an almost equal number of outcome and process measures and will increase the outcome measures' weight (to 40 percent) in the calculation of a hospital's total performance score, while reducing the weight for process measures (to 10 percent).

## **Hospital-Acquired Condition Reduction Program**

In 2010, the Congress enacted a Hospital-Acquired Condition (HAC) Reduction Program that will take effect in fiscal year 2015. Medicare will reduce payments by 1 percent to IPPS hospitals that rank in the lowest national quartile on a set of hospital-acquired conditions defined by CMS. For fiscal year 2015, CMS has decided to use a composite of AHRQ PSIs and two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention (CDC).

The Commission has expressed its concerns that the current statutory design of the HAC Reduction Program penalizes 25 percent of hospitals every year, even if all hospitals significantly reduce HAC rates (Medicare Payment Advisory Commission 2013a). As with the current readmissions penalty program, it may be more effective to use a fixed performance target, to create an incentive for all hospitals to decrease HACs at least to the benchmark rate to avoid the payment penalty.

## **Medicare payments and providers' costs**

In assessing payment adequacy, the Commission also considers the estimated relationship between Medicare payments for and hospitals' costs of providing care

to Medicare patients as one of the five key indicators of payment adequacy. We assess the adequacy of Medicare payments for the hospital as a whole (all Medicare services), and thus our primary indicator of the relationship between payments and costs is the overall Medicare margin. This margin includes all payments and Medicare-allowable costs attributable to Medicare patients for the six largest covered services, plus graduate medical education payments and costs.

We report the overall Medicare margin across service lines because no hospital service is a purely independent business. For example, we find that operating a skilled nursing facility (SNF) improves the profitability of acute inpatient care services because an in-hospital SNF allows hospitals to safely discharge patients sooner from their acute care beds, thus reducing the cost of the inpatient stay. In addition, the precise allocation of overhead and administrative costs among services presents many challenges. By combining data for all major covered services, we can estimate Medicare margins without the influence of how overhead costs are allocated.

To measure the pressure hospitals are under to control costs, we also examine hospital total (all-payer) profit margins and hospital cash flows. When total margins and cash flows are strong, hospitals are under less pressure to control their costs.

## **Medicare payment changes**

Growth in Medicare hospital payments per discharge under the IPPS depends primarily on three factors: (1) annual updates to base payment rates, (2) changes in reported case mix, and (3) policy changes that are not implemented in a budget-neutral manner. In 2012, the base inpatient payment rate increased by approximately 1 percent.<sup>12</sup> Our analysis also shows that inpatient case mix increased approximately 1.4 percent between 2011 and 2012, which is larger than the 0.5 percent increase in 2011. The 2012 case-mix growth may be the result of real changes in the mix of patients rather than continued documentation and coding changes that we observed for several years after the implementation of the MS-DRGs in 2008.<sup>13</sup> The additional payments hospitals receive for health information technology (HIT) significantly affected payments. Between 2011 and 2012, Medicare HIT payments rose from \$0.8 billion to \$2.4 billion.<sup>14</sup> These payments increased hospitals' FFS Medicare revenue by more than 1 percent.



**TABLE  
3-3**

**Cost growth close to input price inflation since 2009**

Cost measure	Annual cost growth				Average annual cost growth 2009-2012
	2009	2010	2011	2012	
Inpatient costs per discharge	3.5%	1.6%	2.5%	3.1%	2.7%
Outpatient costs per service	4.8	0.1*	2.7	3.2	2.7
Weighted average	3.9	1.1	2.5	3.1	2.7
Input price inflation	2.6	2.1	2.7	2.2	2.4

Note: Cost growth numbers are not adjusted for reported changes in case mix. Analysis excludes critical access hospitals and Maryland hospitals. The weighted average is based on services provided to Medicare patients in hospitals, including costs for inpatient, outpatient, skilled nursing facility, inpatient rehabilitation, and home health services.

\*Outpatient cost growth was 1.7 percent if adjusted for complexity of services provided. Input price inflation reflects a weighted average of changes in the hospital operating and capital market basket indexes.

Source: MedPAC analysis of Medicare cost reports and claims files from CMS.

**Rate of cost growth remains close to rate of input price inflation**

From 2009 through 2012, hospitals’ Medicare inpatient and outpatient costs per case grew an average of 2.7 percent, only about 0.3 percent faster than input price inflation (the hospital market basket index) (Table 3-3). This growth is much slower than that experienced through most of the 2000s, when costs increased one or more percentage points faster than input price inflation.

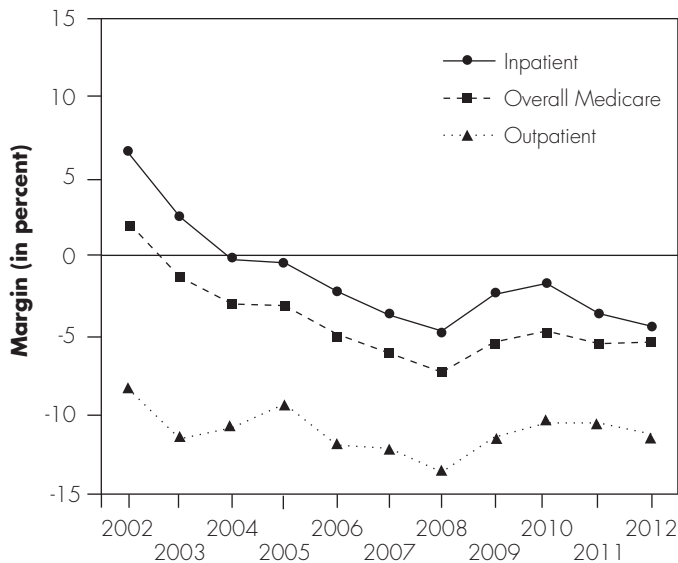
The lower cost growth from 2009 through 2012 was partly due to lower input price inflation facing hospitals, reflecting lower economy-wide inflation for goods and services and slower wage growth. Compensation costs for hospital workers, for example, grew by less than 2.5 percent in each year from 2009 through 2012. These increases are the smallest in hospital compensation costs in more than a decade (Bureau of Labor Statistics 2013b). Hospitals may also have worked to control cost growth in response to the recession and difficult year they had financially in 2008, when the industry experienced historically low total all-payer margins (1.8 percent) and had declines in hospitals’ investment portfolios, including those that fund hospital workers’ retirement plans.

Lower cost growth, however, was not uniform across provider groups. We see higher cost growth for smaller rural hospitals in 2011 and 2012, which could be due to higher revenues associated with the low-volume adjustment. Rural hospitals with less than 50 beds, for example, saw Medicare inpatient payments per case

increase by 8.8 percent in 2011, but they also had much higher growth in cost per case, at 6.5 percent in 2011 and 5.1 percent in 2012. This trend compares with an average cost increase of 2.7 percent for hospitals that did not receive this adjustment. For-profit hospitals’ Medicare costs per case rose by just 1.6 percent in 2012, the lowest of any hospital group. For-profit hospitals tend to control their costs to increase profits, even when they are not under financial pressure to do so. Nonprofit hospitals’ costs tend to be more related to financial pressure.

**Trend in the overall Medicare margin**

We define Medicare margins as Medicare payments minus the allowable costs of treating Medicare patients, divided by Medicare payments. In analyzing hospital margins, we compute margins with and without CAHs, which are 1,300 rural hospitals paid based on their incurred costs. We also exclude hospitals in Maryland, which are excluded from the IPPS and paid under a state-wide all-payer prospective payment system. The overall Medicare margin trended downward from 2002 through 2008 (Figure 3-5, p. 66).<sup>15</sup> However, from 2008 to 2010, the overall Medicare margin went up from -7.3 percent to -4.7 percent, largely due to documentation and coding changes and lower cost growth. In 2011, it declined to -5.5 percent as CMS started to recover past coding-related overpayments. In 2012, it held at -5.4 percent. The overall Medicare margin is dominated by inpatient and outpatient services, which account for 92 percent of hospitals’ Medicare revenues.

**FIGURE  
3-5****Hospital Medicare margins:  
Inpatient, outpatient, and overall**

Note: A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Analysis excludes critical access and Maryland hospitals. Medicare inpatient margins include services covered by the acute inpatient prospective payment system. Overall Medicare margin covers acute inpatient, outpatient, hospital-based home health and skilled nursing facility (including swing bed), inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments.

Source: MedPAC analysis of Medicare cost reports from CMS.

### 2012 Medicare margins by hospital type

We further examined overall aggregate Medicare margins by hospital type. In 2012, the -1.9 percent overall Medicare margin for rural PPS hospitals was higher than the -5.8 percent margin for urban hospitals (Table 3-4). Smaller rural hospitals saw the greatest improvement in their overall Medicare margins. Between 2010 and 2012, rural hospitals in the bottom quintile of inpatient volume saw their overall margins increase from -2.1 percent to 7.1 percent (not shown in Table 3-4). This improvement is likely temporary, however, because many of these hospitals received a combination of low-volume and other temporary payments that are scheduled to expire before 2015.

In 2012, the overall Medicare margin was -2.6 percent for major teaching hospitals, which is 2.8 percentage points higher than the average for all hospitals. Major

teaching hospitals have higher overall Medicare margins than the average IPPS hospital in large part due to the extra inpatient payments they receive through the indirect medical education (IME) and disproportionate share (DSH) adjustments in the IPPS. Past Commission analysis has shown that the IME and DSH adjustments have provided payments that substantially exceed the estimated effects that teaching intensity and service to low-income patients have on hospitals' average costs per discharge. In June 2010, the Commission made recommendations to use teaching hospital payments as incentives to train physicians for the skill sets needed by future Medicare beneficiaries (Medicare Payment Advisory Commission 2010a). Nonteaching hospitals, most of which are in urban areas, have lower overall Medicare margins on average (-7.2 percent in 2012).

In aggregate, overall Medicare margins at for-profit hospitals were positive in 2012, well above aggregate margins for nonprofit hospitals. In 2012, the aggregate overall Medicare margin for for-profit hospitals was 1.5 percent compared with -7.1 percent for nonprofit hospitals, an 8.6 percentage point differential. In aggregate, for-profit hospitals have higher inpatient margins (6.4 points higher) and higher outpatient margins (11.2 points higher) than nonprofits. Our analysis of data in recent years shows that most of the differential in margins can be explained by lower cost structures for inpatient and outpatient care at for-profit hospitals. However, a detailed analysis of 2009 outpatient services indicates that for-profit hospitals' outpatient margins also benefit somewhat from a more favorable service mix and from being less likely to incur outpatient teaching costs (see text box, p. 68)

### Total (all-payer) profitability reaches a 20-year high in 2012

Hospitals' total (all-payer) profit margins are an indicator of how much financial pressure hospitals are under to control costs. In 2012, total margins for hospitals increased to 6.5 percent, the highest level recorded since we started tracking all-payer margins (Figure 3-6). The growth in these margins was caused by average payment rates rising slightly faster than average cost growth, which was in the 2 percent to 3 percent range during this period. While Medicaid and Medicare payment rate increases have been modest in recent years, all-payer average price increases have exceeded cost growth due to strong average increases in private-payer prices. The Health Care Cost Institute and the Bureau of Labor Statistics report that payment

**TABLE  
3-4**

**Overall Medicare margins by hospital group**

Hospital group	2007	2008	2009	2010	2011	2012
All hospitals	-6.1%	-7.3%	-5.4%	-4.7%	-5.5%	-5.4%
Urban	-6.3	-7.5	-5.5	-4.9	-5.8	-5.8
Rural						
Excluding CAHs	-5.2	-6.1	-4.6	-2.8	-2.9	-1.9
Including CAHs	-3.7	-4.3	-3.2	-1.8	-1.6	-0.3
Nonprofit	-7.0	-8.5	-6.7	-6.0	-6.8	-7.1
For profit	-3.5	-2.9	-0.3	0.0	-0.3	1.5
Government*	N/A	N/A	N/A	N/A	N/A	N/A
Major teaching	-0.5	-2.4	-1.1	-0.5	-2.0	-2.6
Other teaching	-6.5	-7.3	-5.3	-4.8	-5.1	-5.2
Nonteaching	-9.4	-10.2	-8.2	-7.3	-7.9	-7.2

Note: CAH (critical access hospital), N/A (not applicable). Data are for all hospitals covered by the Medicare acute inpatient prospective payment system in 2010 and for CAHs where indicated. A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Overall Medicare margin covers acute inpatient, outpatient, hospital-based skilled nursing facility (including swing beds), home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments. The rural margins are shown with and without 1,300 CAHs that are paid 101 percent of costs for inpatient and outpatient services. The margins without CAHs illustrate the profitability of rural inpatient prospective payment system hospitals; the rural margins with CAHs give a fuller picture of rural hospital profitability.  
\*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

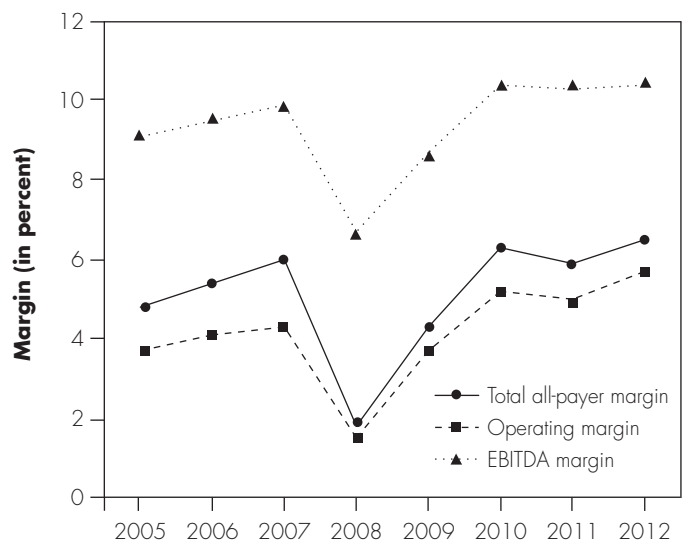
Source: MedPAC analysis of Medicare cost reports, Medicare Provider Analysis and Review files, and impact files from CMS.

rates from private insurers have grown at rates averaging 5 percent to 6 percent annually from 2011 through 2013 (Bureau of Labor Statistics 2013a, Health Care Cost Institute 2012).

While annual cost growth has remained at 3 percent or less in recent years, it may start to increase in response to the strong total all-payer margin (Figure 3-6). In addition, cash flow, as measured by earnings before interest, taxes, depreciation, and amortization (EBITDA), held steady at 10.4 percent in 2012, showing hospitals maintained a relatively strong cash flow position. It is unclear whether cost growth will remain at current levels or rebound to levels above input price inflation due to strong all-payer profits. In the past, the Commission has shown that the hospital industry's level of cost growth has been responsive to changes in all-payer profitability (Medicare Payment Advisory Commission 2012). In general, in periods when the hospitals were under pressure due to managed care cost constraints or contractions in the economy, costs per discharge grew slowly. In periods when profit margins were high, costs per discharge grew more rapidly.

**FIGURE  
3-6**

**Hospitals' financial performance has rebounded strongly after poor performance in 2008**



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

Source: MedPAC analysis of Medicare hospital cost reports.

## For-profit outpatient hospital margins

To examine the degree to which service mix contributes to better outpatient margins among for-profit hospitals, we examined 2009 Medicare data, which was the most recent available detailed data at the time this study was conducted. As was also the case in 2012, 2009 outpatient margins varied widely among hospitals and hospital groups. The average outpatient margin was –2.5 percent among for-profit hospitals and –12.6 percent among nonprofit hospitals on average, while major teaching hospitals had an outpatient margin of –21 percent.

It is possible that these discrepancies among hospital categories are due to the most profitable hospitals focusing on services that have the lowest cost relative to payment (most profitable) in the outpatient prospective payment system (OPPS), while the least profitable hospitals disproportionately provide services that are less profitable. Alternatively, it could be that the more profitable hospitals use fewer inputs per service than less profitable hospitals, meaning that their cost per unit of outpatient service is lower, after adjusting for differences in their mix of services.

We examined hospitals' 2009 outpatient cost and service mix data to determine which of these factors contributes

more to the differences in outpatient margins among hospital groups. We found that differences in hospitals' basic cost structures have a larger effect on hospitals' outpatient Medicare margins than differences in service mix. In particular, underlying cost-structure differences increase the outpatient cost per unit of service in major teaching hospitals by 10.4 percent above the national average and decrease the cost per unit in for-profit hospitals by 5.2 percent below the national average. In contrast, service mix differences increase cost per unit for major teaching hospitals by 1.2 percent and decrease cost per unit in for-profit hospitals by 0.8 percent (Table 3-5). This finding suggests that differences in average relative profitability among services under the OPPS are small, while cost differences across hospital categories are large among services grouped together in each ambulatory payment classification.

We suspect that a part of the higher outpatient costs for major teaching hospitals is due to the teaching costs they incur. Medicare makes extra payments for teaching costs under the inpatient prospective payment system but not under the OPPS. However, for-profit hospitals still have roughly a 6 percent lower cost structure on average than other hospitals after controlling for the effect of teaching status (not shown). ■

**TABLE  
3-5**

**Cost structure has larger effect than service mix on outpatient costs**

Hospital group	Effect on cost relative to national average		
	Medicare margin	Effect of cost structure	Effect of service mix
Urban	-12.6%	0.4%	0.1%
Rural	-7.2	-2.5	-0.5
Major teaching	-21.0	10.4	1.2
Other teaching	-8.4	-0.5	-0.4
Nonteaching	-7.8	-3.9	-0.7
Nonprofit	-12.6	1.0	0.0
For profit	-2.5	-5.2	-0.8
Government	-14.2	2.1	0.8

Note: This analysis examines how hospital cost structure and service mix affect cost per unit in hospital outpatient departments for the hospital groups listed in this table. The second column indicates how much hospital cost structure causes per unit cost in a hospital group to be above or below the national average per unit cost. The third column indicates how much service mix causes per unit cost in a hospital group to be above or below national average per unit cost. The difference in Medicare margins is not completely explained by cost structure and service mix given that we have excluded outliers and separately payable drugs in this analysis. Major teaching hospitals have resident-to-bed ratios above 0.25. This analysis excludes critical access hospitals.

Source: MedPAC analysis 2009 hospital claims from their outpatient departments.

## **Profit margins and financial pressure to constrain costs vary by hospital**

The effect of financial pressure on hospitals' costs is not only evident over time; it is also evident when comparing hospitals facing different levels of financial pressure to constrain costs. Some hospitals have strong profits on non-Medicare services and investments and are under relatively little pressure to constrain their costs. Other hospitals, with thin profits on non-Medicare services, face overall losses (and possibly closure) if they do not constrain costs and generate profits on Medicare patients. To determine the effect of financial pressure on costs, we grouped hospitals into three levels of financial pressure from private payers: high, medium, and low, based on their median non-Medicare profit margins and other factors from 2007 to 2011. For these years, the hospitals under high pressure had non-Medicare profits of less than 1 percent, while the low-pressure hospitals had non-Medicare margins of more than 5 percent. We found that hospitals under high pressure from 2007 to 2011 ended up with lower standardized Medicare costs per discharge in 2012 than hospitals under low levels of financial pressure during the same five-year period. For more details on our analytic methods, see our prior year's analysis of payment adequacy (Medicare Payment Advisory Commission 2011).

Key findings from our analysis of financial pressure on hospitals are:

- **High pressure = low cost:** The 26 percent of hospitals under the most financial pressure had median standardized Medicare costs per case that were roughly 9 percent lower than the national median for all 2,822 IPPS hospitals with available data. Because of their lower Medicare costs, hospitals under pressure generated a median overall Medicare profit margin of 2 percent, which is 7 percentage points above the national median.
- **Low pressure = high cost:** The 59 percent of hospitals that were under a low level of financial pressure had median standardized Medicare costs per case that were 3 percent above the national median. Because of higher costs, they generated a median Medicare profit margin of -10 percent, which is 4 percentage points below the national median.
- While the high-pressure hospitals' costs are significantly lower than low-pressure hospitals' costs, the cost differential between these groups remained

constant in recent years. Both low-pressure and high-pressure hospitals have constrained cost growth to about 2 percent per year from 2011 to 2012, which is roughly the rate of input price inflation. The similar rate of cost growth for the two groups suggests that financial pressure may cause a one-time shift in cost structure rather than allowing perpetually lower cost growth.

- **For-profit hospitals have different incentives:** For-profit hospitals tended to keep their median standardized Medicare costs per case at the national median even when they were under little financial pressure. This finding suggests that if both types of hospitals receive high payment rates from private payers, the higher revenues tend to result in higher costs in nonprofit hospitals, whereas in for-profit hospitals, a larger share of the revenue is retained as operating profit for shareholders.

The overarching conclusion is that costs are at least partially under hospitals' control, and those hospitals with the strongest cost control can generate profits treating Medicare patients. The next question is whether some set of hospitals can have both low costs and high-quality outcomes.

## **Relatively efficient hospitals**

The goal of our analysis of relatively efficient hospitals is to examine payment adequacy for the group of hospitals that perform relatively well on both cost and quality metrics while serving a broad spectrum of patients. The variables we use to identify relatively efficient hospitals are hospital-level mortality rates (AHRQ Inpatient Quality Indicators), readmission rates (3M<sup>TM</sup> potentially preventable readmissions), standardized inpatient Medicare costs per case, providers' payer mix, and the annual level of total FFS Medicare service use per beneficiary in the county where the hospital is located. As data and risk-adjustment methodologies improve, our measures of efficiency will continue to evolve. Our assessment of efficiency is not in absolute terms but rather is relative to other IPPS hospitals.

Ideally, we would limit our set of efficient hospitals to those that not only had high in-hospital quality and low unit costs but also low overall costs to the Medicare program during the year. To avoid having hospitals from high-use areas in our analysis, we removed hospitals from the population studied if they were in counties in the top 10 percent of annual Medicare FFS service use per FFS beneficiary. This method reduces the chance that a hospital



will appear to have low unit costs of service simply because it is in an area with a high volume of low-cost admissions that could have been treated on an outpatient basis.

We further restricted the population of hospitals that we evaluated for efficiency by removing the 10 percent of hospitals with the smallest shares of Medicaid patients. This process reduces the likelihood that hospitals in our efficient group got there simply because they had a favorable selection of patients. Our goal in this screening process is to improve our ability to identify hospitals that can provide good outcomes at a reasonable cost while serving a broad spectrum of patients (including Medicaid) without driving up the overall volume of hospital and nonhospital services provided.

**Categorizing hospitals as relatively efficient** We assigned hospitals to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and quality metrics for the period 2009 to 2011.<sup>16</sup> We then examined the performance of the two hospital groups in fiscal year 2012.

Hospitals were identified as relatively efficient if they met four criteria every year of the 2009 to 2011 period:

- Risk-adjusted mortality rates were in the best two-thirds of all hospitals.
- Risk-adjusted readmission rates were in the best two-thirds of all hospitals.
- Standardized costs per discharge were in the best two-thirds of all hospitals.
- Risk-adjusted mortality or standardized costs per discharge were in the best one-third.

The objective was to identify hospitals that consistently performed at an above-average level on at least one measure (cost or quality) and that always performed reasonably well on all measures. The rationale for this methodology is discussed in detail in our March 2010 report (Medicare Payment Advisory Commission 2010b).

**Examining performance of relatively efficient and other hospitals from 2009 to 2011** Of the 2,133 hospitals that met our screening criteria, 302 (14 percent) were found to be relatively efficient during the 2009 to 2011 period.<sup>17</sup> The set of relatively efficient providers was a diverse array of hospitals, including large teaching hospitals and

smaller rural hospitals. CAHs were excluded from the analysis because they are not paid under the IPPS and have different cost-accounting rules.

We examined the performance of relatively efficient hospitals on three measures from 2009 to 2011 by reporting the group's median performance divided by the median for the set of hospitals in our analysis (Table 3-6). The median efficient hospital's relative risk-adjusted 30-day mortality rate from 2009 through 2011 was 83 percent of the national median, meaning that the 30-day mortality rate for the efficient group was 17 percent below the national median. The median readmission rate for the efficient group was 6 percent below the national median. Standardized Medicare cost per discharge for the efficient group was 11 percent below the national median. Relatively efficient hospitals tended to be larger than average but otherwise had diverse characteristics. For a more complete description of the methodology and other characteristics of relatively efficient providers, see our March 2011 report (Medicare Payment Advisory Commission 2011).

**Historically strong performers had lower mortality rates and readmissions in 2012** The composite mortality rate for the efficient group was 13 percent below the national median in 2012, and the readmission rate was 4 percent below the national median. The share of patients who gave the median hospital a top rating in 2012 was similar for the efficient group, with 69 percent of patients treated at hospitals in the efficient group being highly satisfied and 68 percent in the comparison group being highly satisfied.

**Historically strong performers continue to have lower costs in 2012** Hospitals that were low-cost and low-mortality providers from 2009 through 2011 continued to have lower costs in 2012. The median standardized Medicare cost per discharge in the efficient group was 10 percent lower than the national median, compared with 2 percent higher for the other group. The lower costs allowed the relatively efficient hospitals to generate higher overall Medicare margins. The median hospital in the efficient group had an overall Medicare margin of 2 percent, while the median hospital in the comparison group had an overall Medicare margin of -5 percent. Among the relatively efficient hospitals, 59 percent had positive Medicare margins compared with 37 percent for the comparison hospitals. The distribution for the efficient hospitals ranged from -5 percent to 9 percent at the 25th and 75th percentiles, respectively. For the comparison group, the distribution of Medicare margins was -15 percent and 4 percent at the 25th and 75th percentiles,

**TABLE  
3-6**

**Performance of relatively efficient hospitals**

Relative performance measure	Type of hospital	
	Relatively efficient during 2009-2011	Other hospitals
Number of hospitals	302	1,831
Share of hospitals	14%	86%
<b>Historical performance, 2009-2011 (percent of national median)</b>		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	83%	103%
Readmission rates (3M™)	94	101
Standardized Medicare costs per discharge	89	102
<b>Performance metrics, 2012 (percent of national median)</b>		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	87%	103%
Composite 30-day readmission (3M)	96	101
Standardized Medicare costs per discharge	90	102
Percent of patients highly satisfied, 2012 (H-CAHPS®)	69	68
Median:		
Overall Medicare margin, 2012	2%	-5%
Non-Medicare margin, 2012	5	8
Total (all payer) margin, 2012	5	5

Note: AHRQ (Agency for Healthcare Research and Quality), H-CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems). Relative measures are the median for the group as a percentage of the median of all hospitals. Per case costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the AHRQ methodology to compute risk-adjusted mortality for six conditions (acute myocardial infarction, congestive heart failure, pneumonia, gastrointestinal hemorrhage, stroke, and hip fracture). We then weighted the scores for each type of discharge by the share of discharges in that particular hospital. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) due to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and outcomes. H-CAHPS scores are the most recently available scores.

Source: MedPAC analysis of impact file, Medicare Provider Analysis and Review file, Medicare hospital cost reports, and CMS hospital compare data.

respectively. Among the relatively efficient hospitals, 47 percent were under high or medium financial pressure to constrain their costs, compared with 38 percent for the other hospitals. This result suggests that some of the efficient hospitals may have been pressured to constrain their inpatient costs, while those who were not under pressure still restrained their unit costs in order to expand services or build financial reserves.

**How would current law changes for 2014 and 2015 affect hospitals' Medicare payments and access?**

Certain changes to Medicare payment policy have increased payments to hospitals in 2014 and are expected to decrease payments to hospitals in 2015. The largest change stems

from changes to Medicare DSH/uncompensated care payments, which are expected to increase slightly in 2014 because of the expansion of the Medicaid program, but they are projected to decline in 2015 and future years because of reductions in the number of uninsured people. The Patient Protection and Affordable Care Act of 2010 (PPACA) mandated that uncompensated care payments would decline as the rate of uninsurance declines. Given Congressional Budget Office estimates of annual changes in rates of uninsurance, we project that DSH/uncompensated care payments will increase from roughly \$11 billion in 2013 to \$12 billion in 2014 (a 0.7 percent increase in overall Medicare payments) and then decline to \$9 billion by 2015. Hospitals are expected to offset these losses in DSH/uncompensated care payments with increases in payments

from Medicaid and private insurers as rates of uninsurance decline. (A further discussion of the changes to Medicare DSH/uncompensated care policy is available in the online Appendix 3-A, available at <http://www.medpac.gov>).

A group of smaller payment rate changes will reduce Medicare payments by 0.9 percent from 2012 to 2014, and another set of changes will reduce rates by another 1.5 percent in 2015. The two sets of changes are discussed below.

### **Expected changes in payments from 2012 to 2014**

In addition to changes in DSH payments and payment updates, a group of smaller payment rate changes are expected, on net, to reduce Medicare payments by 0.9 percent from 2012 to 2014. The group of other permanent policy changes includes:

#### **Policies designed to address or change hospital practice patterns**

- Most hospitals receive additional Medicare bonus payments for adopting electronic health records (EHRs). As more hospitals adopt EHRs between 2012 and 2014, these bonus payments will increase overall Medicare payments by roughly 0.5 percent.
- The American Taxpayer Relief Act of 2012 requires that CMS recover \$11 billion of past overpayments with temporary adjustments from 2014 through 2017. The \$11 billion in recoveries is equivalent to reducing inpatient payments by roughly 0.8 percent for four straight years. In the context of overall Medicare hospital payments, this reduction is equivalent to a 0.6 percent reduction in 2014.
- Penalties for high readmission rates in 2013 and 2014 have reduced payments by 0.2 percent.
- Medicare program payments for bad debts associated with beneficiary cost sharing were reduced in 2013, thereby reducing payments by approximately 0.1 percent.

#### **Expiration of special add-on payments**

- The expiration of the temporary Medicare low-volume payment adjustment in 2014 reduced payments by approximately 0.2 percent.
- The expiration of outpatient hold-harmless payments at the end of 2012, eliminating additional payments to some sole-community hospitals and rural hospitals

with 100 or fewer beds, on net reduced payments by approximately 0.1 percent.

- The expiration of a temporary add-on adjustment for hospitals in counties with low overall Medicare spending at the end of 2012 reduced payments by roughly 0.1 percent.
- The expiration of a temporary wage index add-on payment (called the Section 508 adjustment) at the end of 2013 reduced payments by less than 0.1 percent.
- The expiration of the Medicare Dependent Hospital Program in 2014 will reduce payments by less than 0.1 percent.

(See the text box about further regulatory changes).

### **Medicare margins are expected to decline slightly in 2014**

We expect that the overall Medicare margin will decline slightly to –6 percent in 2014. The slight margin decline from 2012 is projected as a result of hospitals' costs increasing faster than payment rates under current law. From 2012 to 2014, we expect hospitals' Medicare revenues will increase a little over 4 percent due to payment rate updates and other policy changes. We also expect a small increase in payments from a continued rise in inpatient case mix as measured by the MS–DRGs. At the same time, we expect that hospital costs will increase about 6 percent—roughly 3 percent per year. This cost increase is similar to what we observed from 2011 to 2012 and what also has been reported by for-profit hospitals through the first nine months of 2013 (Community Health Systems 2013, Hospital Corporation of America 2013, LifePoint Hospitals 2013, Tenet Health 2013, Universal Health Services 2013). Finally, we expect that Medicare payments for hospitals' purchase of HIT will increase from about \$2.4 billion in cost reporting year 2012 for FFS enrollees to \$3 billion in the 2014 cost reporting year. We also expect some case-mix growth. Together these changes will offset much of the 2 percentage point difference between the growth in costs and payment rates we expect to see between 2012 and 2014.

The projection of a –6 percent overall Medicare margin is dependent on hospitals maintaining their rate of cost growth at around 3 percent. There is uncertainty, however, as to whether hospitals will be under sufficient pressure to maintain that level of cost growth given the strong growth in all-payer profitability that has occurred in recent years. In the past, we have seen cost growth accelerate when



## Regulatory policy changes in 2014

Several regulatory changes that took place in 2014 affect Medicare payments to hospitals. These changes are as follows:

- **Changes in inpatient admission and medical review criteria (“2-midnight policy”)**—In the fiscal year 2014 inpatient prospective payment system final rule, CMS finalized the 2-midnight policy. This regulation clarifies for Medicare’s external reviewers that they must presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing two midnights) in the hospital receiving medically necessary services.<sup>18</sup> If a patient does not stay two days, they are presumed to be appropriately served on an outpatient basis unless a physician documents the need for a one-day inpatient stay. CMS estimates that the 2-midnight policy will result in changes in hospital admitting practices that will amount to a \$220 million increase in inpatient payments in fiscal year 2014. As a result, CMS reduced the fiscal year 2014 inpatient update by 0.2 percent to keep this change budget neutral.
  - **Changes to Part B inpatient payment policy (“rebilling policy”)**—An increasing number of successful appeals of decisions made by administrative law judges and the Medicare Appeals Council required Medicare, under Part B, to pay for inpatient services attached to denied Part A inpatient claims. In response, CMS issued regulations that permit hospitals to rebill the Medicare program for these inpatient services, which would have been payable under Part B if the beneficiary initially had been treated as an outpatient rather than admitted as an inpatient and subsequently had the inpatient claim denied by a Medicare external contractor. Rebilling for these services must be done within 12 months of the original date of service. CMS estimates that this policy will increase Part B inpatient payments by \$850 million in fiscal year 2013 and by \$120 million or less in each year from fiscal year 2014 to fiscal year 2017. CMS’s estimated impact for
- fiscal year 2013 is considerably higher because the 12-month rebilling restriction was added midyear. In subsequent years, the 12-month timeliness restriction blunts the extent of hospital rebilling (Centers for Medicare & Medicaid Services 2013).
- **Changes to outpatient payment weights:**
    - CMS substantially increased the items that can be packaged with a primary service to create a single payment unit. This change will increase the size of payment units in the outpatient prospective payment system (OPPS). Items in this category include certain drugs, biologics, and laboratory tests.
    - CMS will use new standard cost centers for computed tomography (CT), MRI, and cardiac catheterization in setting OPPS payment rates for those services. This change will result in lower rates for CT, MRI, and cardiac catheterization and higher rates for other imaging services. Lower OPPS payment rates for CT and MRI services will affect the Medicare physician fee schedule (PFS). The PFS payment rate for the technical component of CT and MRI services is the lesser of the standard PFS method for setting those rates or the OPPS payment rate.
    - CMS created a single ambulatory payment classification (APC) (and payment rate) for clinic visits. There had been five APCs and five payment rates for clinic visits. This change will result in higher payment rates for some of these services and lower rates for others.
  - **Separately paid drugs**—For 2014, CMS has decided to pay for drugs and biologics separately at a rate equal to each drug’s average sales price (ASP) plus 6 percent. In 2012, CMS had paid for such drugs at a rate of ASP plus 4 percent. To maintain budget neutrality in the OPPS, the increased rates for separately paid drugs will be offset by lower rates for all other services. ■

**TABLE  
3-7**

**Medicare payment growth slows from 2012 to 2015**

**Approximate change in payments  
under current law**

<b>Payment change</b>	<b>2012-2014</b>	<b>2014-2015</b>
DSH/uncompensated care payment changes	+0.7%	-2.0%*
Other permanent policy changes	-0.9	-1.5
Projected weighted average of inpatient and outpatient updates to payment rates	+4.2	+2.2**
Approximate change in projected payments, not including any case-mix change	+4.0 (2 years)	-1.3*

Note: DSH (disproportionate share). These projections are preliminary and subject to change and are presented as changes in overall hospital Medicare fee-for-service revenue (not just inpatient revenue), which is roughly \$170 billion per year. The projections do not factor in the 2 percent sequester, and they do not factor in a 0.4 percent permanent documentation and coding adjustment that will eventually have to be made. Projected updates are net of adjustments for productivity, budget adjustments, and certain other factors.

\* The impact of the DSH/uncompensated care changes could be less to the extent that expansion of insurance coverage through the exchanges and Medicaid expansion is less than the Congressional Budget Office forecast.

\*\* The 2015 update is projected to be approximately 2.2 percent, but this update could change as CMS changes its forecasts of the market basket between now and the start of fiscal year 2015.

Source: MedPAC analysis of CMS claims data and scheduled legislative changes.

hospitals are under less pressure to constrain costs. The -6 percent margin also does not factor in the effect of the sequester, which is currently reducing Medicare program payments to hospitals by 2 percent. Therefore, if the sequester remains in place, margins would be expected to be almost 2 percentage points lower. The reduction in payments is slightly less than 2 percent because the sequester affects Medicare program payments but not beneficiary cost sharing.

**Medicare margins are expected to fall further in 2015 if current law holds**

A series of policy changes in current law will decrease payments to hospitals in 2015. Under current law, the base payment rate update is projected to be 2.2 percent; however, because of a scheduled reduction in DSH payments and other policy changes, we expect payments to decline by roughly 1.3 percent in 2015 (Table 3-7). These changes may cause Medicare revenues to fall below the costs of relatively efficient providers in 2015.<sup>19</sup>

The other policy changes that will affect payments in 2015 are the following:

- Readmission penalties are expected to increase when additional conditions are added. This increase is expected to reduce payments by an additional 0.1 percent in 2015.
- The 25 percent of hospitals with the lowest performance on hospital-acquired conditions will face

a 1 percent reduction in their IPPS payments (equal to roughly 0.2 percent of all Medicare hospital payments in 2015).

- Payments for EHRs will start phasing out, causing a decline in EHR payments equivalent to 0.7 percent of overall Medicare payments from 2014 to 2015.
- Mandated recoveries of \$11 billion will continue, resulting in an expected 0.8 percent adjustment to inpatient rates, 0.5 percent of overall 2015 payments.

**Despite the potential for declining margins, access is expected to remain strong**

After PPACA was passed, some argued that the slow growth of Medicare payments and continued rapid growth in private-payer rates would create a large divergence that could put pressure on Medicare patients' access to care (Foster 2010, Newhouse 2010, Shatto and Clemens 2011). They suggested either private insurers will have to slow the growth in their payment rates or the Medicare program will have to increase its rates of payment growth to maintain beneficiaries' access to care. In 2011, private insurer payment rates were 47 percent above costs, and Medicare rates were 6 percent below costs; we expect this gap to grow. Despite the gap in payer rates, we do not expect to see any near-term material reductions in Medicare beneficiaries' access to care for several reasons:

- Most hospitals have excess capacity; occupancy fell from 64 percent to 61 percent in recent years.
- Medicare payment rates, while less than the total cost of care, are still greater than the marginal cost of care for most hospitals.
- Some hospitals currently accept discounts to Medicare rates from Medicare Select medigap plans to gain Medicare market share. These hospitals want more Medicare patients even at rates lower than standard Medicare rates.
- Medicare's share of hospitals' revenue (excluding critical access hospitals) is rarely more than 50 percent, and hospitals' overall financial condition is expected to remain strong because of the expansion of profits from private payers' patients.

Given these considerations, the current law reductions in Medicare payments in 2015 are not expected to be large enough to induce hospitals to restrict access for Medicare patients.

### **Addressing differences in payment rates across sites of care for outpatient and inpatient care**

As part of our annual March report on payment adequacy, the Commission has traditionally had two objectives. One is to recommend an appropriate aggregate level of payments using the update. The second objective is to make adjustments in payment policies when necessary to have appropriate relative prices across services and across sites of care. One problem with the current system of relative prices is that differences in prices across care settings are causing distortions in provider incentives. For example, HOPD rates are not aligned with rates paid for the same services in a physicians' office, which gives hospitals an incentive to acquire physician practices and start billing for the same services as outpatient services. To remove this incentive, we are proposing to move outpatient rates closer to physician office rates for services that are often performed in both locations.

A similar problem exists for hospital inpatient services. Long-term care hospitals (LTCHs) are currently paid much higher rates than traditional acute care hospitals, even for patients who do not require the specialized services of an LTCH. To correct this problem, we propose a new criterion for patients receiving standard LTCH payments. Chronically critically ill (CCI) patients would still qualify

for the relatively high LTCH standard DRG payment rates because they often need LTCH-type care. LTCHs' average standard DRG rate for CCI patients would remain at roughly \$50,000.<sup>20</sup> In contrast, non-CCI patients (other than patients who receive prolonged mechanical ventilation) would receive IPPS standard DRG payment rates. Equalizing rates for non-CCI patients would reduce the average standard DRG rate for LTCHs' non-CCI cases from roughly \$40,000 to about \$12,000 (the IPPS average standard DRG rate for the same LTCH non-CCI cases). The reduction in LTCH standard DRG rates for non-CCI cases would generate savings that would be transferred to acute care hospitals in the form of higher outlier payments for the most costly CCI cases in acute care hospitals. In the end, the differences in IPPS and LTCH rates would be reduced. The rates paid for services in the two payment systems would be more aligned with the patients' needs and less dependent on the payment system under which the provider operates.

### **Aligning payment rates across hospital outpatient departments and physician offices**

Medicare payment rates often differ for the same (or similar) ambulatory services provided in physicians' offices and HOPDs. CMS sets payment rates for physician and other practitioner services in the fee schedule for physicians and other health professionals, also known as the PFS. Payment rates for most HOPD services are set by the OPDS. For services provided in physicians' offices, Medicare makes a single payment under the PFS. For services provided in HOPDs, Medicare makes two payments: one for the physician's professional fee under the PFS and one for the HOPD under the OPDS. For most services, the combined OPDS and PFS payments for services provided in HOPDs are higher than the single PFS payment for services provided in freestanding offices.

The Commission's position is that Medicare should ensure that patients have access to settings that provide the appropriate level of care. From this perspective, if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than another. These payment differences between settings may cause Medicare and beneficiaries to pay more than necessary. Therefore, Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient (i.e., highest quality, lowest cost) setting, adjusting for differences in patient severity to the extent that severity differences affect costs.

**TABLE  
3-8**

**E&M office visits and cardiac imaging services migrated from freestanding offices to HOPDs, where payment rates are higher**

Type of service	Share of ambulatory services performed in HOPDs, 2012	Per beneficiary volume growth, 2010-2012	
		Freestanding office	HOPD
E&M office visits (CPT codes 99201-99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), HOPD (hospital outpatient department), CPT (Current Procedural Terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of standard analytic claims files from 2010, 2011, and 2012.

In previous work, the Commission recommended that Medicare reduce payment rates for evaluation and management (E&M) office visits provided in HOPDs so that total payment rates would be equal whether these visits were provided in an HOPD or in a freestanding physician’s office (Medicare Payment Advisory Commission 2012). We also identified groups of services provided in HOPDs and physicians’ offices that meet the Commission’s principles for aligning payment rates across settings (Medicare Payment Advisory Commission 2013b). In this chapter, we recommend that the Congress direct the Secretary to adjust HOPD rates so that they align more closely with physician office rates for all service groups that meet these five principles (discussed on p. 77).

Payment variations across settings should be addressed because the billing of many ambulatory services has been shifting from physicians’ offices to the usually higher paid HOPD setting. Among E&M office visits, echocardiograms, and nuclear cardiology services, for example, the volume of services decreased in freestanding offices and increased in HOPDs from 2010 to 2012 (Table 3-8). As billing of services shifts from physicians’ offices to HOPDs, program spending and beneficiary cost sharing increase without significant changes in patient care (Dutton 2012, Kowalczyk 2013, Mathews 2012, Schulte 2012). To limit the incentive to shift cases to higher cost sites of care, there is a need to align HOPD rates with physician office rates.

Some stakeholders have argued that Medicare should pay HOPDs higher rates purely because hospitals could use the higher payments to subsidize standby capacity, access to care for low-income patients, efforts to improve care coordination, and community outreach (Medicare Payment

Advisory Commission 2013b). However, building indirect subsidies for these activities into the payment rates for all services does not directly target resources to these activities and can distort prices, which could have unintended consequences. For example, paying much more for cardiac tests in HOPDs than freestanding offices may encourage hospitals to purchase cardiology practices and bill for cardiac testing as a hospital outpatient service. In addition, paying higher rates for services provided in HOPDs is an inefficient way to reward hospitals for improving care (such as reducing readmissions) because it does not distinguish between hospitals that improve care and those that do not.

Higher rates for HOPD services should be limited to a select set of services. For example, some services have costs associated with maintaining standby emergency capacity. HOPDs on the main campus of a hospital with an emergency department are subject to the Emergency Medical Treatment and Active Labor Act of 1986, which requires them to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay. Medicare payments for emergency department services include these standby costs, and therefore they will not be equal to freestanding office rates for similar services. For certain other services, patients treated in HOPDs are often more medically complex than patients receiving those services in a freestanding office. The higher complexity patients in HOPDs may require more resources than the lower complexity patients in freestanding offices.

Stakeholders have further argued that Medicare should not align any HOPD rates with physician office rates because hospitals incur higher overhead costs than freestanding



physician offices. For example, hospitals must comply with more stringent building codes, life-safety codes, and hospital-level staffing requirements. In addition, hospitals must incur the cost of financially integrating the HOPD into the hospital and billing patients a separate facility fee (in addition to the physician's fee). However, we believe that if patient severity is similar and a service can be provided in a lower cost setting without a reduction in quality or safety, Medicare should pay a rate based on the cost of the more efficient setting. If Medicare paid a higher rate to the less efficient setting, services would shift to being billed by the higher cost site of care, the cost of care could increase, and beneficiary costs would increase without any evidence that care would improve.

### **Aligning HOPD payment rates with physician office rates for some ambulatory services**

We evaluated about 450 APCs that represent service categories and found 66 that do not require emergency standby capacity, do not have extra costs associated with higher patient complexity in the hospital, and do not need the additional overhead associated with services that must be provided in a hospital setting. These are candidates for having their HOPD payment rates aligned with the PFS rates. We classify these services into two categories:

- Group 1 includes services for which HOPD payment rates could equal physician office payment rates.
- Group 2 includes services for which the HOPD rate could be higher than the physician office rate but the difference should be reduced from the current level (see online Appendix 2-A to the Commission's June 2013 report for the list of services in Group 1 and Group 2, available at <http://www.medpac.gov>) (Medicare Payment Advisory Commission 2013b). The additional cost in HOPDs would reflect the cost of ancillary items that are packaged into the unit of payment in the OPSS but are paid separately in the PFS.<sup>21</sup>

We organized the services in Group 1 and Group 2 into APCs because that is how the OPSS classifies services for the purpose of payment. APCs comprise Current Procedural Terminology (CPT) codes that are similar both clinically and in terms of resource costs, and all CPT codes in the same APC have the same payment rate.

Services that meet the following five criteria are good candidates for adjusting HOPD payment rates so that payment rates are the same in HOPDs and freestanding offices:

- Services are frequently performed in physicians' offices (more than 50 percent of the time). This fact indicates these services are likely safe and appropriate to provide in a freestanding physician's office. Also, the PFS payment rates for these services are sufficient to ensure access to care.
- Services entail minimal packaging differences across payment systems (i.e., the payment rate includes a similar set of services).
- The services are infrequently provided with an emergency department (ED) visit when furnished in an HOPD (such services are unlikely to have costs that are directly associated with operating an ED).
- Patient severity is no greater in HOPDs than freestanding offices.
- The services do not have a 90-day global surgical code (CMS assumes that physicians' costs for these codes are higher when performed in a hospital than a freestanding office).<sup>22</sup>

Each of the criteria must be met at the APC level rather than at the level of each CPT code. For more details on how we applied the criteria, see online Appendix 2-B to the Commission's June 2013 report, available at <http://www.medpac.gov> (Medicare Payment Advisory Commission 2013b).

We identified 24 APCs that met the five criteria for adjusting HOPD payment rates so that payment rates are equal in HOPDs and freestanding offices. Group 1 includes these 24 APCs. We also identified 42 APCs that meet four of the five criteria for equal payments across settings, but they have greater packaging of ancillary items in the OPSS than the PFS (the cost of packaged ancillaries was more than 5 percent of their total cost). These 42 APCs make up Group 2. OPSS payment rates for these services should be allowed to exceed the PFS rates by an amount equal to the cost of the additional packaging in the OPSS.<sup>23</sup>

### **Effects of aligning payment rates between physicians' offices and HOPDs**

For APCs in Group 1, we estimated OPSS payment rates that would produce equal payment rates in offices and HOPDs. For APCs in Group 2, we estimated OPSS payment rates that account for the cost of additional packaged services in the OPSS but would otherwise produce equal payment rates across settings. We modeled

the effect of these changes on program spending and beneficiary cost sharing for each of the 66 APCs in Group 1 and Group 2. Changing OPSS payment rates for APCs in the two groups would, on net, reduce program spending and beneficiary cost sharing by a total of \$1.1 billion in one year.<sup>24</sup> Assuming current law, beneficiaries would save about \$180 million in cost sharing.<sup>25</sup> (See the text box on pp. 80–81 for an example of how beneficiary cost sharing and Medicare program spending decline when we adjust OPSS payment rates so that payment rates are equal in offices and HOPDs.<sup>26</sup>)

### **Impact on hospitals' Medicare revenue**

For all OPSS hospitals (excluding CAHs), changing the OPSS payment rates for the 66 APCs in Group 1 and Group 2 would reduce overall Medicare revenue by 0.6 percent and aggregate Medicare HOPD revenue by 2.7 percent. Although the effect of this policy would vary widely among individual hospitals, the effect on overall Medicare revenue for most hospital categories is about equal to the overall average of 0.6 percent (see the Commission's June 2013 report for more details on the impact by hospital category). Exceptions are rural hospitals, which would lose 0.9 percent of aggregate Medicare revenue, and hospitals that have 100 or fewer beds, which would lose 1.2 percent. Rural and small hospitals would lose more revenue than urban hospitals because they receive a larger share of their overall Medicare revenue from outpatient care than do urban and larger hospitals.

We also examined the characteristics of the 100 hospitals that would have the largest percentage reductions in overall Medicare revenue from changing OPSS payment rates for APCs in Group 1 and Group 2. We found the following differences between the 100 hospitals that would be most affected and all other hospitals:

- On average, the 100 most affected hospitals are smaller, with an average of 44 beds, compared with an average 198 beds at all other hospitals.
- The 100 most affected hospitals are less likely to serve low-income patients—the median DSH percentage is 14 percent for these hospitals versus 25.8 percent among all other hospitals.
- The 100 most affected hospitals are less likely to have major teaching status than all other hospitals.
- Over half of the 100 most affected hospitals are specialty hospitals.

Some hospitals that are primary sources of access to ambulatory services for low-income patients might experience significant reductions in Medicare revenue as a result of the policies discussed, which could reduce access for these patients. Therefore, policymakers may wish to consider a stop-loss policy that would limit the loss of Medicare revenue for these hospitals.

We evaluated the effects of the same illustrative stop-loss policy that we examined in our June 2012 report (Medicare Payment Advisory Commission 2012). In this case, we estimate that the stop-loss would return only \$10 million to the hospitals that qualify. The effect would be small because many of the hospitals with the highest revenue losses under this policy serve a relatively small percentage of low-income patients, and the hospitals that would qualify for the stop-loss are relatively small, on average.

### **Addressing differences in payment rates across sites of care for inpatient care in LTCHs and acute care hospitals**

The Commission has been considering for some time whether Medicare is paying accurately for services furnished in LTCHs (Medicare Payment Advisory Commission 2013c, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2008, Medicare Payment Advisory Commission 2004). LTCHs have positioned themselves as providers of hospital-level care for long-stay CCI patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care—but nationwide most CCI patients are cared for in acute care hospitals, and most LTCH patients are not CCI (Medicare Payment Advisory Commission 2013c).

As described in Chapter 11, Medicare pays LTCHs under a separate PPS, with higher payment rates—for both CCI and non-CCI cases—than those made for similar patients in other settings (Gage et al. 2007, Kahn et al. 2013, Kandilov and Dalton 2011, Koenig et al. 2013, Medicare Payment Advisory Commission 2004). There are few criteria defining LTCHs, the level of care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for appropriately in less-expensive settings. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by

patients who are not CCI (Medicare Payment Advisory Commission 2013c).

The effect of the disparity in Medicare’s payments across settings for the most medically complex patients is exacerbated because such cases often are unprofitable in acute care hospitals paid under the IPPS (Gage et al. 2007). Further, the relative profitability of more complex cases—whether CCI or non-CCI—may differ across acute care hospitals due to the uneven geographic distribution of LTCHs. In areas with LTCHs, acute care hospitals may be able to reduce the costs of caring for some types of cases by transferring them earlier in the course of illness.<sup>27</sup> In areas without LTCHs, acute care hospitals may have to keep these cases longer—and therefore accrue additional costs—until the patients are stable enough to be transferred to a lower level of post-acute care.

As discussed in Chapter 11, what Medicare is purchasing with its higher LTCH payments remains unclear. Studies comparing LTCH care with that provided in acute care hospitals have failed to find a clear advantage in outcomes for LTCH users (Gage et al. 2011, Kahn et al. 2013, Kennell and Associates Inc. 2010, Koenig et al. 2013, Medicare Payment Advisory Commission 2013c, Medicare Payment Advisory Commission 2004, Morley et al. 2011). At the same time, some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. In addition, some studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill (Kahn et al. 2013, Kandilov and Dalton 2011, Kennell and Associates Inc. 2010, Medicare Payment Advisory Commission 2004).

As a prudent payer, Medicare must ensure that its payments to providers are properly aligned with the resource needs of beneficiaries. In addition, the Commission has held that payment for the same set of services should be comparable regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.

The Commission’s approach to reforming the LTCH PPS and aligning payment for CCI cases across settings is based on the premise that the most medically complex patients have always been a small share of the total population of hospital inpatients (Medicare Payment Advisory Commission 2013c). As discussed in Chapter 11, although hospital case mix has increased over time, the explosive growth in the number of LTCHs that followed

implementation of the IPPS was not driven by a need for these services but rather by payment policies that created opportunities for financial gain.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommends that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an acute care hospital. LTCH cases that are not CCI (non-CCI) should be paid IPPS rates approximately the same as MS–DRG payment rates they would have been paid if the patient had been treated in an IPPS hospital in the same local market.<sup>28</sup> The Commission recommends that the Congress use the savings achieved from improving the appropriateness of LTCH payments to improve the accuracy of payments for CCI cases in ACHs paid under the IPPS. Funds that would have been used to make payments under the LTCH payment system instead should be allocated to the IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in acute care hospitals. Outlier payments for IPPS CCI cases could be calculated using a lower fixed loss amount, and Medicare could pay 90 percent of hospitals’ costs above the CCI outlier threshold. The outlier policy for non-CCI cases in IPPS hospitals would remain unchanged.

As discussed in Chapter 11, the Commission recommends that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize the CCI condition—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding acute care hospital stay. This definition is more restrictive than the three-day ICU stay threshold that is mandated by the Pathway for SGR Reform Act of 2013, scheduled to be implemented in 2016 (see text box, p. 82). The Commission also recommends that an exception to the eight-day ICU threshold be made for LTCH cases that received mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. These types of cases are generally considered appropriate for admission to LTCHs and generally viewed as warranting higher, LTCH-level payment rates.

Similarly, the Commission recommends that the cases in IPPS hospitals that will be eligible for higher outlier payments should be those in which the IPPS stay includes eight or more days in an ICU, with an exception to the eight-day ICU requirement made for patients receiving prolonged mechanical ventilation.

## How to adjust the outpatient prospective payment system payment rates to produce equal rates across settings

When a physician provides a service in a freestanding office or a hospital outpatient department (HOPD), the physician's payment under the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS), has three components: physician work, practice expense (PE), and professional liability insurance (PLI). The work and PLI payments are the same regardless of setting. However, the PE payment for a service provided in an office (the nonfacility PE) is usually higher than the PE payment for a service provided in an HOPD (the facility PE). The higher nonfacility PE payment reflects the cost of the clinical staff, medical equipment, medical supplies, and additional overhead incurred by physicians. Therefore, the PFS payment is higher in a freestanding office than in an HOPD for most services. However, when a service is provided in an HOPD, Medicare makes an additional payment to the hospital under the outpatient prospective payment system (OPPS). In most cases,

the PFS payment for a service that is provided in a freestanding office is lower than the combined OPPS and PFS payments for a service delivered in an HOPD.

For example, in 2014, when a level II echocardiogram without contrast is provided in a freestanding office, the payment to the physician (the combined physician work, PLI, and nonfacility PE) totals \$228.02 (Table 3-9). If the service is provided in an HOPD, the total payment equals the sum of the work, PLI, facility PE, and OPPS payment for a total of \$492.22.

In our analysis, we adjust the OPPS payment rate for a service to create an equal payment rate across sites of care by setting the OPPS rate equal to the difference between the nonfacility PE rate and facility PE rate. For level II echocardiograms, the nonfacility PE is \$179.56 and the facility PE is \$16.48. Taking the difference produces an adjusted OPPS rate of \$163.07. The total payment for level II echocardiograms

(continued next page)

**TABLE  
3-9**

**Differences in payment rates for level II echocardiogram without contrast provided in physicians' offices and HOPDs, 2014**

	Payment amount	Calculation
<b>2014 payment rates</b>		
<i>Service in physician's office</i>		
Payment to physician	\$228.02	Work (\$) + PLI (\$) + nonfacility PE (\$)
<i>Service in HOPD</i>		
Payment to physician	\$64.95	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	<u>\$427.27</u>	HOPD rate (\$)
Total payment	\$492.22	
<b>Policy that aligns rates across settings</b>		
<i>Service in HOPD</i>		
Payment to physician	\$64.95	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	<u>\$163.07</u>	Nonfacility PE (\$) – facility PE (\$)
Total payment	\$228.02	

Note: HOPD (hospital outpatient department), PLI (professional liability insurance), PE (practice expense). Payments include both program spending and beneficiary cost sharing. The services in this table are in ambulatory payment classification (APC) group 269. When the services in this APC are provided in a physician's office, the average physician work amount is \$46.65, the PLI amount is \$1.81, and the nonfacility PE amount is \$179.56. When the services in this APC are provided in an HOPD, the average physician work amount is \$44.31, the PLI amount is \$1.72, and the facility PE amount is \$16.48.

Source: MedPAC analysis of physician fee schedule and outpatient prospective payment system payment rates for 2014.



## How to adjust the outpatient prospective payment system payment rates to produce equal rates across settings (cont.)

provided in HOPDs would fall to \$228.02, which is the same rate that is paid in a freestanding office.

The lower OPSS rates that would result from aligning OPSS payment rates to PFS rates would also produce lower beneficiary copayments in most ambulatory payment classifications (APCs). For level II echocardiograms, the copayment is \$45.60 if they are provided in freestanding offices and \$98.45 if they are provided in HOPDs. Adjusting the OPSS rate so the total payment rate is the same in HOPDs as freestanding offices would reduce the total copayment in HOPDs to \$45.60 (Table 3-10).

However, reducing payment rates in the OPSS would lower beneficiaries' copayments only for APCs where the copayment is currently 20 percent of the payment rate. Current law requires that in APCs where the copayment is more than 20 percent of the payment rate, the copayment must stay at a constant dollar amount over time until the payment rate has risen high enough that the copayment is 20 percent of the payment rate. Because the copayment for level II echocardiograms is currently 20 percent of the payment rate, reducing the payment rate for that service category reduces the copayment amount. However, other service categories—such as level II extended electroencephalography, sleep, and cardiovascular studies—have copayments that exceed 20 percent of the payment rate. For those services, current law does not allow the copayment amount

**TABLE  
3-10**

### Differences in beneficiary copayments for level II echocardiograms without contrast provided in physicians' offices and HOPDs, 2014

	Copayment amount
<b>Copayments in 2014</b>	
<i>Service in physician's office</i>	
Payment to physician	\$45.60
<i>Service in HOPD</i>	
Payment to physician	\$12.99
Payment to hospital	<u>\$85.46</u>
Total payment	\$98.45
<b>Policy that aligns rates across settings</b>	
<i>Service in HOPD</i>	
Payment to physician	\$12.99
Payment to hospital	<u>\$32.61</u>
Total payment	\$45.60

Note: HOPD (hospital outpatient department). The services in this table are in ambulatory payment classification group 269.

Source: MedPAC analysis of physician fee schedule and outpatient prospective payment system payment rates for 2014.

to decrease when the payment rate decreases. We discussed three options for allowing beneficiary coinsurance to decline along with rates for these services in our June 2013 report to the Congress (Medicare Payment Advisory Commission 2013b). ■

In concert with the payment changes for LTCHs, the Congress should change the length-of-stay requirement for LTCHs. Currently, to qualify as an LTCH, a facility must maintain an average length of stay of more than 25 days. When non-CCI cases are paid IPSS-based rates, this requirement would only apply for CCI cases and no longer apply for non-CCI cases. This change would remove the financial incentives LTCHs currently have to keep non-CCI patients in the LTCH longer than necessary. Therefore, we would expect the average length of stay and the cost for non-CCI cases at LTCHs to decline. We also expect LTCHs to admit fewer non-CCI cases and to be more selective in choosing which non-CCI cases they do admit.

Without behavioral changes, aggregate payments to LTCHs would decline by about \$2 billion. However, due to the expected efficiency gains described above, the net effect on LTCH profits is expected to be far less than \$2 billion. Chapter 11 discusses these effects in detail.

Fully implementing these recommendations would shift approximately \$2 billion from LTCH PPS payments for non-CCI cases to an expanded IPSS outlier pool. IPSS hospitals would receive roughly \$2 billion in additional outlier payments. As described more fully in Chapter 11, the Commission recommends using these additional outlier funds to make higher outlier payments for IPSS CCI cases, which generally are substantially more costly

## Current-law chronically critically ill definition

As discussed in Chapter 11 of this report, the Commission has maintained that long-term care hospitals (LTCHs) should serve only the most medically complex patients—the chronically critically ill (CCI)—and has determined that the best available proxy for intensive resource needs in LTCH patients is intensive care unit (ICU) length of stay during an immediately preceding acute care hospital stay. The research literature consistently describes CCI patients as having long acute care hospital stays with heavy use of intensive care services (Carson et al. 2008, Donahoe 2012, Macintyre 2012, Nelson et al. 2010, Wiencek and Winkelman 2010, Zilberberg et al. 2012, Zilberberg et al. 2008). Further, in site visits and technical expert panel discussions conducted by Kennell and Associates, Inc. and RTI under contract with CMS, LTCH representatives and acute care hospital critical care physicians agreed that medically stable post-ICU patients are appropriate candidates for LTCH care (Centers for Medicare & Medicaid Services 2013, Dalton et al. 2012). In CMS’s Post-Acute Care Payment Reform Demonstration, length of stay in the ICU was significantly associated with post-acute care case complexity, and long ICU stays were a distinguishing characteristic of LTCH patients (Gage et al. 2011).

The Pathway to SGR Reform Act of 2013 mandated changes to the LTCH prospective payment system (PPS), including limiting standard LTCH payments to cases that spent at least three days in an ICU during an immediately preceding acute care hospital stay. The Commission’s analysis of IPPS claims data from 2012 found that 22.8 percent of inpatient prospective payment system (IPPS) discharges spent three or more days in an ICU. The Commission is concerned that this threshold is too low to distinguish the truly CCI patients and thus will allow Medicare to continue to

pay too much for many cases that could be cared for appropriately in other settings at a lower cost to the program.

The Commission maintains that CCI cases are a small share of Medicare acute care hospital cases and that the ICU length-of-stay threshold identifying CCI cases should be set accordingly. The Commission therefore recommends that the Congress limit standard LTCH payments to cases that spent eight or more days in an ICU during an immediately preceding acute care hospital stay. Our analysis of IPPS claims data found that cases with eight or more days in an ICU accounted for about 6 percent of all Medicare discharges and had a geometric mean cost per discharge that was four times as large as other IPPS cases. Further, these cases were concentrated in a small number of MS–DRGs that correspond with the “ideal” LTCH patients typically described by LTCH representatives and critical care clinicians (Dalton et al. 2012). Previous studies have found such severely ill patients more likely to benefit from LTCH care (Kennell and Associates Inc. 2010, Medicare Payment Advisory Commission 2004).

Setting the ICU length-of-stay threshold for CCI cases at eight days captures a large share of LTCH cases requiring prolonged mechanical ventilation. The Commission’s analysis of 2012 LTCH claims data found that 69.7 percent of discharges receiving mechanical ventilation for more than 96 hours had had an immediately preceding acute care hospital stay that included at least eight days in the ICU.<sup>29</sup> Nevertheless, to ensure that patients requiring prolonged mechanical ventilation have appropriate access to the specialty weaning services offered by many LTCHs, the Commission recommends an exception to the eight-day ICU threshold for LTCH cases that receive mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. ■

than IPPS non-CCI cases in the same MS–DRG. To accomplish this goal, the Congress should give CMS the authority to hold the IPPS outlier policy—both the national fixed loss amount and the marginal cost factor (80 percent)—unchanged for IPPS non-CCI cases, while using the LTCH savings to set a separate national fixed loss amount and marginal cost factor (e.g., 90 percent)

for IPPS CCI cases. The Commission’s estimates suggest that adding approximately \$2 billion to the IPPS outlier pool while keeping the outlier policy unchanged for non-CCI cases would produce a much lower national fixed loss amount for CCI cases (about \$13,300 compared with about \$21,500 under current policy). Therefore, if an IPPS hospital treats a CCI patient, the Medicare program

could cover 90 percent of the additional losses after the hospital's loss once the case reaches \$13,300. The lower fixed loss amount (\$13,300) and the higher share of losses paid (90 percent rather than 80 percent) would reduce the large disparities in payments for similar CCI patients between those treated in IPPS hospitals and those treated in LTCHs.

In 2011, about 600,000 cases in IPPS hospitals met our CCI definition because they had eight or more days in the ICU. Under the proposed policy, these cases in acute care hospitals would qualify for higher outlier payments (than under current Medicare law) if the hospital incurred a loss greater than \$13,300 (the estimated fixed loss amount). The higher outlier payments would increase payments for high-cost CCI cases in acute care hospitals by almost 11 percent, causing a significant reduction in hospital losses on these cases and an overall increase in inpatient payments of almost 2 percent. The hospitals benefiting from these patients will be those that take the most CCI cases, which are disproportionately major teaching hospitals and hospitals with below-average Medicare margins.

About 20 percent of IPPS CCI cases were treated in the 1,051 IPPS hospitals located in market areas that have no LTCHs. On average, outlier payments under the current outlier policy accounted for a higher share of total DRG payments for CCI cases in hospitals in these markets compared with hospitals in markets that have LTCHs. These IPPS hospitals may be keeping their CCI patients for longer stays in the ICU or a step-down unit because of a lack of local LTCHs. The higher outlier payments under the proposed policy for IPPS hospitals taking CCI cases will make Medicare payments more equitable between markets with and without LTCHs.

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## **Joint recommendation on how to change hospital payment policies and payment rates in 2015**

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This year, we are presenting a joint recommendation (covering acute care and LTCH non-CCI rates) that is designed to improve the incentives in the hospital payment systems and provide an adequate aggregate level of payments. The recommendation will improve alignment of acute hospital and physician office payment rates, improve alignment of acute care hospital and long-term care hospital rates, and increase acute care hospital rates through an update. The update portion of

the recommendation will apply to services paid under the acute care inpatient and outpatient payment systems, including non-CCI patients in LTCHs. Updates for other services provided in hospital-owned rehabilitation, home health, and skilled nursing units are based on separate recommendations for those types of Medicare services.

### **Current law: Projected update of 2.2 percent in 2015**

For both the acute IPPS and the OPSS, the update in current law for fiscal year 2015 equals the projected increase in the hospital operating market basket index minus an adjustment equal to the Secretary's forecast of the 10-year average productivity growth nationwide, and a -0.2 percent budgetary adjustment. The operating market basket index is a projection of input price inflation for the goods and services hospitals use in producing inpatient and outpatient services. CMS's latest forecast of the market basket for October 2014 when the inpatient update takes place is 2.7 percent, and the productivity forecast is 0.3 percent. The resulting projected statutory inpatient update on October 2014 is 2.2 percent (2.7 percent - 0.3 percent - 0.2 percent). The final update may differ because input prices and productivity estimates will change twice before the final updates are published in August 2014. Given the payment adequacy indicators discussed and given the proposals to better align acute care hospital payments with payments in physician offices and long-term care hospitals, a base payment update larger than current law is warranted.

### **RECOMMENDATION 3**

**The Congress should direct the Secretary of Health and Human Services to:**

- **reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory payment classifications.**
- **set long-term care hospital base payment rates for non-chronically critically ill (CCI) cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for CCI cases in inpatient prospective payment system hospitals. The change should be phased in over a three-year period from 2015 to 2017.**
- **increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.**

The Commission balanced several factors in reaching its recommendation. First, incentives must be reduced to shift care to higher cost sites. The recommendation would reduce the incentive to shift patient billing to hospital-owned outpatient facilities when the patient does not need hospital-level care. The recommendation would also eliminate the incentive to direct non-CCI patients to LTCHs when LTCH-level care is not needed. The savings from this policy would be used to increase payments for CCI patients in acute care hospitals. This policy of reducing payment rates for non-CCI cases in LTCHs and increasing payments for CCI cases in IPSS hospitals would make the system more equitable and reduce incentives to shift non-CCI cases to the more costly LTCH setting.

The update recommendation is higher than current law because of a balance of several factors. First, most payment adequacy indicators are positive, but Medicare margins are negative. Second, several current law policy changes are scheduled to reduce payments in 2015. The update recommendation reflects the assumption that the Congress will not override these reductions. Given the changes in current Medicare law that are expected to reduce payments in 2015, and given the proposed changes to outpatient payments and outlier payments for CCI cases, an update of 3.25 percent in the base payment is warranted. The Commission maintains that Medicare payment rates should be determined by analysis of payment adequacy rather than an across-the-board sequester reduction. Therefore, the Commission recommends that hospitals receive base payment rates that are 3.25 percent higher than the 2014 base payment rates and there should be no sequester adjustment. However, if the Congress increases hospital payments by reinstating expiring special payments, the full 3.25 percent update to base payment rates would not be warranted.

We also realize that the proposed changes to the long-term care payment system and the acute care hospital outlier payments for CCI cases would be large. For that reason, we propose that these changes be phased in over a three-year period.

### Spending

- If the reform of LTCH and acute care hospital CCI outlier payments were phased in over three years, roughly \$700 million per year would be transferred from the LTCH payment system to the acute care payment system. Aligning certain outpatient ambulatory payment classifications with physician office rates would reduce payments to hospitals by approximately \$1.1 billion, and increasing the update over current law would increase payments by approximately \$1.6 billion over current law. The three factors together would increase acute care hospital payments by roughly \$1.2 billion in 2015, or about 0.7 percent. After including the reductions in LTCH payments and other factors, the net effect on Medicare program spending is an increase of between \$250 million and \$750 million in 2015 and between \$5 billion and \$10 billion over five years. The annual cost of the Commission's recommendation—relative to current law—increases materially from 2015 to 2016 because the law governing LTCH payments is scheduled to change. Starting in 2016, a recently enacted reform of the LTCH system is scheduled to generate budgetary savings. Our proposal is to replace this scheduled LTCH reform (see text box, p. 82). Because we are replacing an LTCH policy that is scheduled to generate savings with one that transfers any savings to acute care hospitals, the net cost of our policy increases in 2016.

### Beneficiaries and providers

- Beneficiaries would see roughly \$200 million in lower cost sharing due to the alignment of selected outpatient payment rates with the physician fee schedule and an increase in cost sharing of roughly \$100 million due to the higher update. Thus the net reduction in cost sharing is expected to be \$100 million per year. The recommendation may also slow or stop the shift of services from freestanding practices to HOPDs. Payments to LTCHs would decline for the non-CCI cases, and payments to acute care hospitals would increase for high-cost CCI cases. In addition, the higher update would increase payments for all cases in acute care hospitals. ■



## Endnotes

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- 1 Payments per beneficiary include roughly \$7 billion of inpatient and outpatient payments to critical access hospitals, which are paid 1 percent over their costs of inpatient, outpatient, and post-acute services in swing beds. While PPS payments per beneficiary were roughly flat in 2013, critical access hospital payments per beneficiary grew by 4 percent, primarily because of growth in payments for outpatient care and post-acute care in swing beds.
- 2 As a condition of payment for hospital inpatient services under Medicare Part A, Section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis (42 CFR Part 424 subpart B and 42 CFR 412.3).
- 3 Some evidence suggests that when individuals gain insurance, they increase their inpatient use; in the Oregon Medicaid expansion, newly insured individuals increased their chance of being hospitalized by 2.1 percentage points (Finkelstein et al. 2011). The Congressional Budget Office projects that roughly 30 million people will gain insurance over the next few years; even if their chance of being admitted increased by 2 percentage points, that would only yield roughly 600,000 more admissions or less than a 2 percent increase in admissions.
- 4 Nonmetropolitan markets generally have lower average hospital occupancy rates, and had they been included in this market-level analysis, we would have seen far more markets with occupancy below 50 percent.
- 5 From 2002 to 2012, 497 hospitals entered the Medicare program and 319 closed as inpatient facilities. These numbers reflect the raw count of hospitals beginning or ending participation in the Medicare program. Changes in hospital ownership, Medicare provider number, or conversion to a different type of hospital are not considered openings or closures.
- 6 Hospitals that closed were located an average of eight miles from the nearest competitor.
- 7 Seventy-five percent of patients at closed hospitals received percutaneous coronary intervention within 90 minutes of arrival, compared with a national average of 87 percent. Seventy-six percent of heart failure patients at closed hospitals received discharge instructions, compared with a national average of 84 percent. Chest pain patients received an electrocardiogram within an average of 50 minutes of arrival at closed hospitals, compared with an average of 11 minutes nationally.
- 8 Merger and acquisition (M&A) data from Irving Levin Associates are gathered through media and government (state and federal) reports documenting merger or acquisition agreements reached between the interested parties. These data are likely to underestimate the total volume in M&A deals that occur each year because of the decentralized nature of market activity in this field. We also believe that Irving Levin's dataset is somewhat biased toward larger deals. Therefore, deals involving entities with a smaller net worth, such as the acquisition of physician group practices, are less likely to be captured by Irving Levin's data collection.
- 9 Within the health sector, employment increases were among the fastest in home health care services and outpatient care centers, which grew approximately 38 percent and 34 percent, respectively, from 2008 to 2013. The employer category "home health care services" includes home health providers, visiting nurse associations, hospital agencies, and other providers specializing in the delivery of health care services in the patient's home. In addition, the count of individuals employed within the category of home health care services includes home health aides as well as higher skilled employees such as registered nurses. The employer category outpatient care centers includes mental health centers, dialysis facilities, freestanding surgical and emergency centers, family planning centers, and other outpatient care facilities.
- 10 Inpatient mortality for all five conditions (acute myocardial infarction, congestive heart failure (CHF), hip fracture, stroke, and pneumonia) improved. Thirty-day mortality improved for CHF, stroke, and pneumonia but was unchanged for the other two conditions.
- 11 The seven PSIs are death in low-mortality DRGs, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative respiratory failure, postoperative pulmonary embolism / deep-vein thrombosis, postoperative wound dehiscence, and accidental puncture or laceration.
- 12 This increase consists of a legislated update of 1.9 percent (market basket forecast of 3 percent, a multifactor productivity adjustment of -1 percentage point, and a statutory budget adjustment of -0.1 percentage point in accordance with Section 3404 of the Patient Protection and Affordable Care Act of 2010), plus a 1.1 percent increase related to settlement of a lawsuit (*Cape Cod v. Sebelius*), minus a 2 percent prospective case-mix coding adjustment, for a net increase of 1 percent.
- 13 It is plausible that the 4.5 percent reduction in discharges in 2012 was primarily due to a reduction in lower severity cases. Because lower severity cases are treated outside of the hospital or as observation cases, the average case mix

- remaining within the hospital could increase. In contrast, the case-mix changes in 2008 and 2009 were tied to changes in documentation and coding practices. Analyses by both CMS and the Commission have concluded that the increases in case mix reported from 2008 through 2010 (2 percent, 2.6 percent, and 0.5 percent, respectively) resulted from changes in hospitals' documentation and coding rather than from an actual shift toward patients whose care required greater resources (Medicare Payment Advisory Commission 2010a).
- 14 The \$2.4 billion amount comprises payments to hospitals for FFS patients; it does not include payments for managed care patients or benefits received by critical access hospitals under the program.
  - 15 The services included in the overall Medicare margin are Medicare acute inpatient, outpatient, graduate medical education, Medicare SNF (including swing beds), Medicare home health care, Medicare inpatient psychiatric, and Medicare inpatient rehabilitation, as well as special payments for health information technology and temporary extra payments to hospitals located in low-spending counties.
  - 16 We use medians rather than means to limit the influence of outliers on our set of efficient providers.
  - 17 Roughly 75 percent of the relatively efficient hospitals also met our criteria for being relatively efficient in the prior year. Combining this year's findings with prior years, we find that roughly 40 percent of the hospitals that were deemed relatively efficient in 2011 were also deemed relatively efficient in 2013, and roughly 6 percent of those that were not deemed relatively efficient three years ago have moved into the relatively efficient category. Thus there is a moderate level of consistency among the hospitals deemed relatively efficient each year. The share of hospitals meeting our criteria for being relatively efficient has remained between 9 percent and 14 percent in recent years.
  - 18 Medicare's external reviewers include Medicare administrative contractors and recovery audit contractors.
  - 19 Under current law, for hospitals to avoid a decline in Medicare overall margins, they have to reduce the number of inputs used per unit of output. Reducing prices paid for inputs (e.g., a wage freeze) would not halt the decline in margins because wages are linked to the market basket index, which governs updates under current law. A reduction in wages would cause a reduction in the update. In contrast, the Commission's update recommendations have not been directly tied to input price inflation in recent years. A fixed update (set independent of the market basket forecast) would allow the hospital industry to benefit from lower input prices (e.g., lower wage growth), and it would avoid the procyclical problem of Medicare payment rates increasing at times when hospitals can afford to increase wages and Medicare payment rates decreasing in times when hospitals constrain wages because of financial pressure.
  - 20 The standard DRG rate includes all adjustments except for high-cost outlier patients.
  - 21 There are a few services in Group 2 for which the office rate is currently higher than the HOPD rate. In these cases, the HOPD rate could be increased to the level of the office rate.
  - 22 The physician fee schedule payment for 90-day global surgical codes includes the surgical procedure itself and office visits that occur in a 90-day period after the procedure. CMS assumes that the physician's clinical staff spends additional time scheduling the procedure and coordinating presurgical services when the procedure is performed in an HOPD than in a physician's office. Therefore, these services are assumed to have a higher cost when delivered in an HOPD. However, we are unable to estimate the amount of this additional cost. Consequently, we excluded these procedures from the group of services that are candidates for equal payment rates across settings.
  - 23 For 2014, CMS has substantially expanded the extent to which ancillary items are packaged with primary services into single payment units in the OPPIs. For some APCs in Group 1, this additional packaging may cause them to be reclassified into Group 2. However, it would not change the total number of APCs in Group 1 and Group 2, nor do we think it would have a large effect on our estimate of the reduction in program spending and cost sharing that would result from adjusting the OPPI payment rates for the APCs in Group 1 and Group 2.
  - 24 The \$1.1 billion estimated impact on program spending and beneficiary cost sharing is greater than the \$900 million estimate reported in our June 2013 report to the Congress. Our current estimate is greater because the billing of services has continued to shift from freestanding offices to HOPDs, especially echocardiograms and nuclear cardiology. As this shift continues, the effect of aligning HOPD payment rates with the rates in freestanding offices will continue to increase.
  - 25 Current law requires that in APCs where the OPPI copayment amount is currently more than 20 percent of the payment rate, the copayment must stay at a constant dollar amount over time until the payment rate has risen enough that the copayment is 20 percent of the payment rate. In APCs where the copayment amount currently is 20 percent of the payment rate, any change to the payment rate must be accompanied by a change to the copayment amount so that the copayment amount remains at 20 percent of the payment rate.

- 26 For 2014, CMS reduced the practice expense portion of physician payment for all services in the physician fee schedule. Such adjustments have an effect on how much Medicare spending and beneficiary cost sharing would change by adjusting OPPS rates so that they more closely align with rates paid in freestanding offices.
- 27 The Commission and other researchers have found that patients who use LTCHs tend to have shorter acute care hospital stays than similar patients who do not use these facilities, suggesting that LTCHs substitute for at least part of the acute hospital stay (Kahn et al. 2013, Medicare Payment Advisory Commission 2004). Early transfers may distort the acute inpatient PPS relative weights by reducing the costs of acute care hospitals that routinely transfer patients to LTCHs. To the extent that such distortion occurs, even after recalibration acute care hospital payments may be too low for some patients in areas without LTCHs.
- 28 The proposed IPPS rates use the operating and capital base payment rates and MS-DRG relative weights from the IPPS. However, some payment adjustments (e.g., the LTCH geographic wage index) and the LTCH outlier policy differ from the comparable policies in the IPPS. Therefore, LTCH and IPPS payments, while similar, would not be exactly equal in all cases.
- 29 Of the remaining 30.3 percent of cases, almost half had no acute care hospital discharge within three days of admission to the LTCH.

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