



*Advising the Congress on Medicare issues*

# Hospitals: Assessment of payment adequacy

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# Background

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- Update recommendations for hospital outpatient and acute inpatient services
- We assess payment adequacy for all hospital services taken together
- Medicare spending in 2006:
  - Inpatient—\$104 billion (36% of FFS)
  - Outpatient—\$27 billion (9% of FFS)

# Framework for assessing payment adequacy

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- Beneficiaries' access to care
- Capacity and supply of providers
- Volume of services
- Quality of care
- Access to capital
- Payments and costs for 2008

# The share of hospitals offering select services is stable or rising

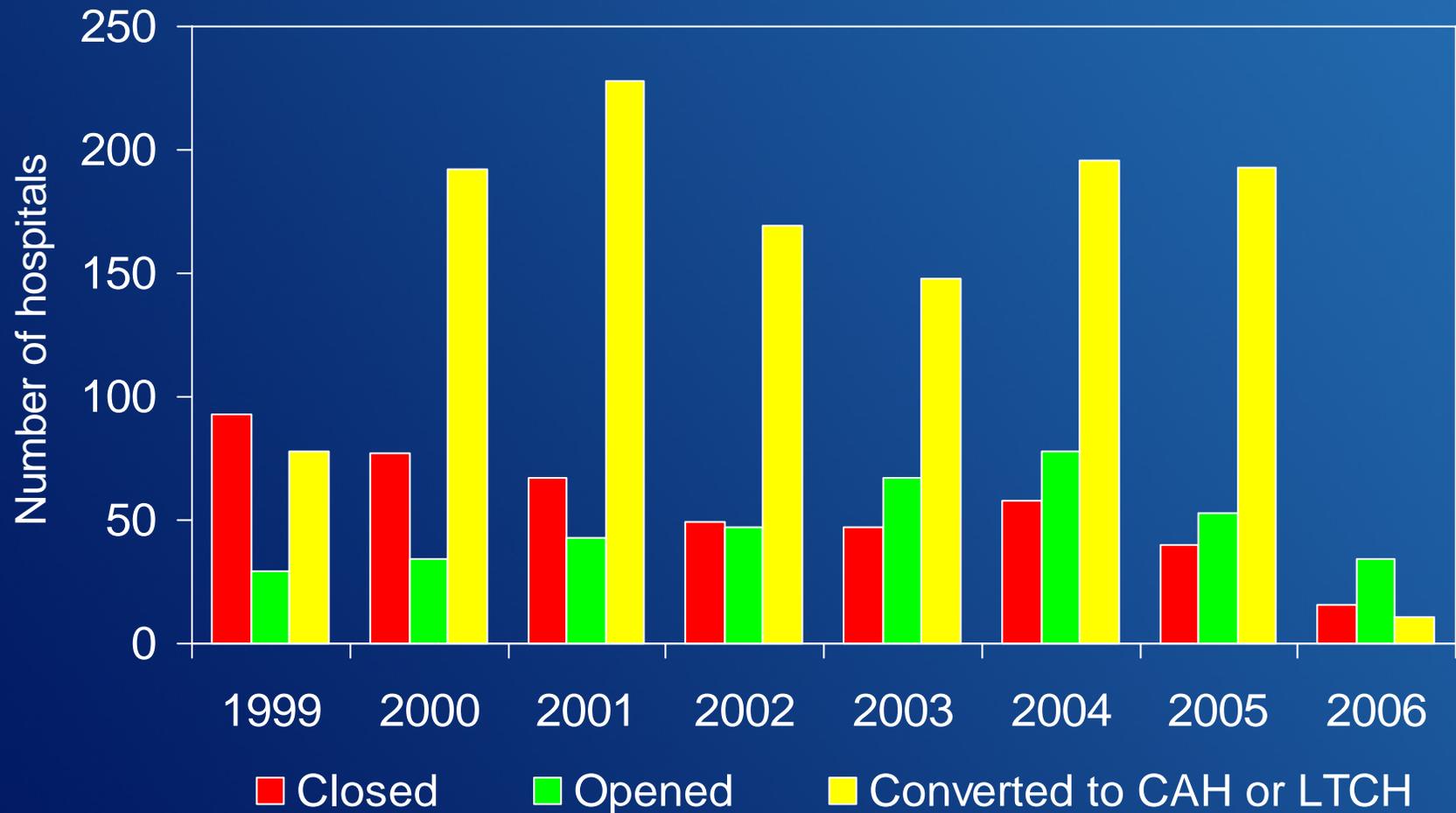
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- The share of hospitals offering most specialized services has grown—sizable increases in cardiac cath, radiation therapy, and MRI in 2005
- The share offering outpatient services (including ER) increased with introduction of the outpatient PPS and has remained stable since then

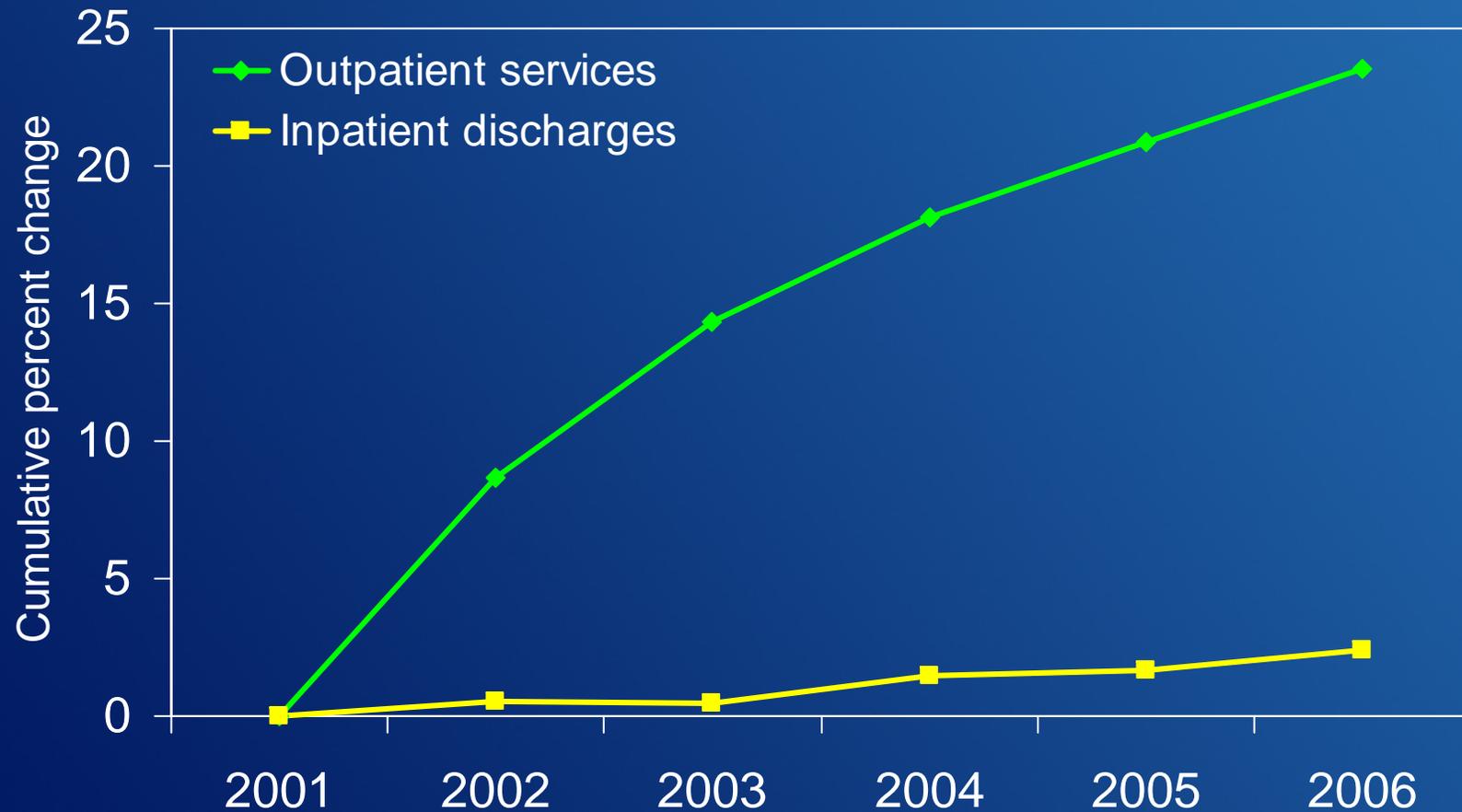
# More hospitals have opened than closed since 2002



# Many hospitals have converted to critical assess or long-term care hospitals



# Medicare volume per FFS beneficiary continues to increase



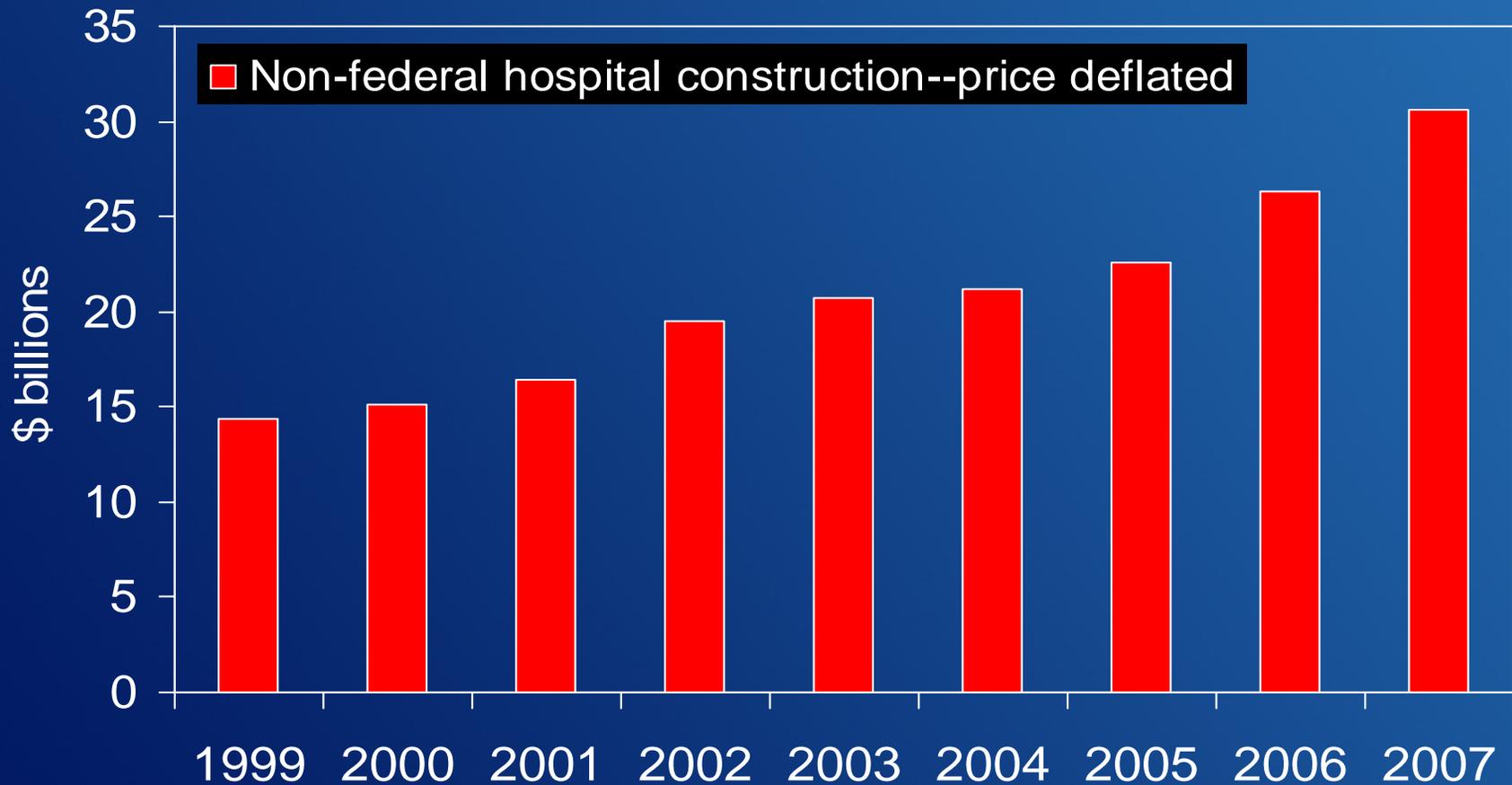
Note: Calendar years for outpatient, fiscal years for inpatient.

# Quality of care is generally improving

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- In-hospital and 30-day mortality declined for all 8 conditions or procedures measured (1998-2006)
- Based on process data from CMS Hospital Compare, care improved in 22 of 23 measures (2004-2006)
- Patient safety results were mixed—the rate of adverse events got worse in 5 of the 9 most common measures (1998-2006)

# Spending on hospital construction continues to grow



Note: 2007 estimate based on seasonally adjusted annual rate through August.

Source: Department of Census.

# Access to capital is good

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- Construction spending strong
- Debt for hospitals with upgraded credit ratings far exceeds debt for those with downgrades
- Many financial indicators continue at historic best
- Hospitals expect access to remain good

# Key factors in margin projection

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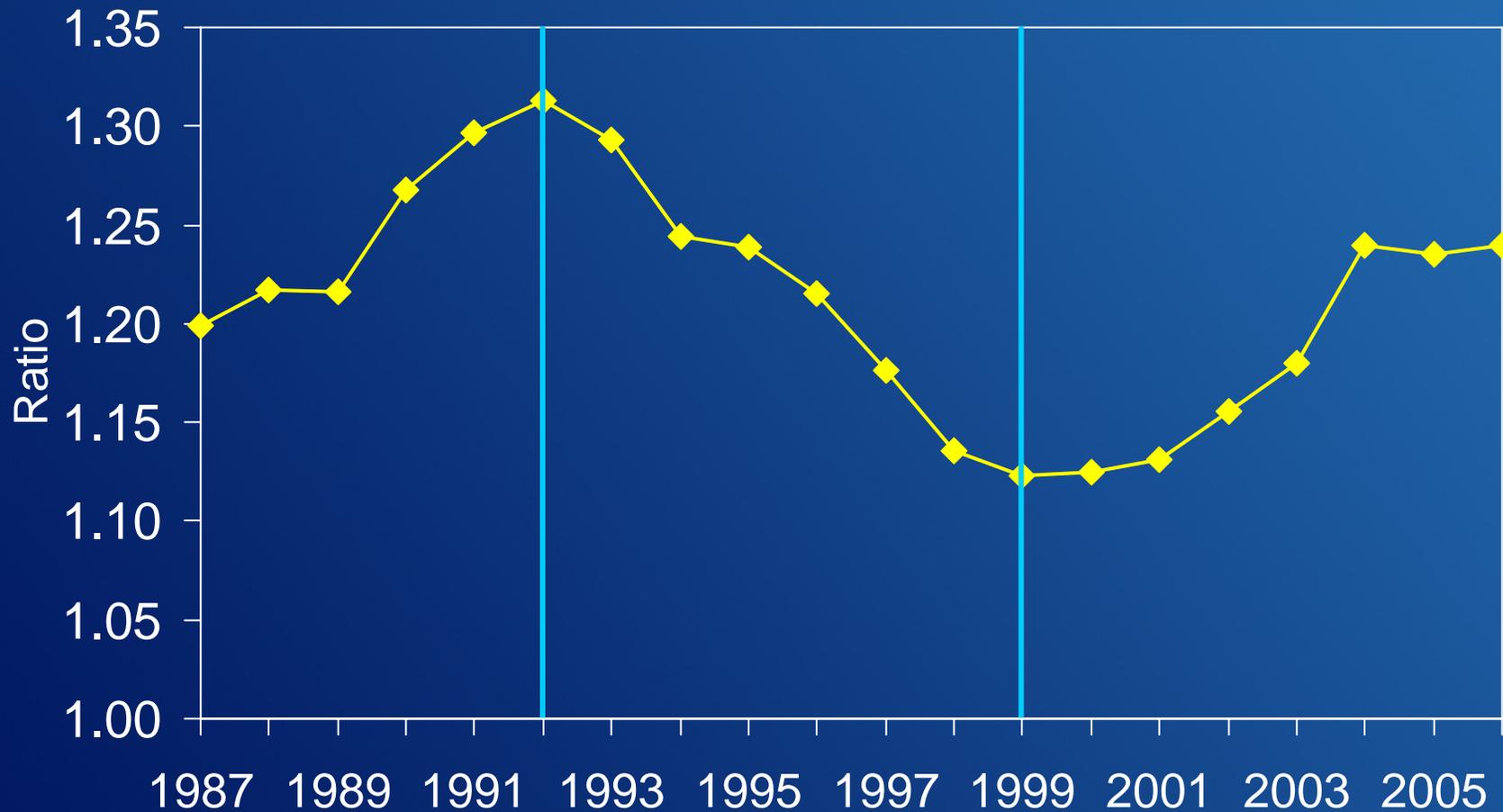
- Cost growth greater than market basket
- Payment reductions from capital payment cut and end of Section 508 reclassifications
- Payment increases for Medicare-dependent hospitals, fewer discharges affected by transfer policy under MS-DRGS, and rising low-income shares
- Payment increase from changes in coding practices and medical records documentation exceeding legislated coding offsets

# Congestive heart failure: An example of new CC definitions increasing payments

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- Indicating CHF not otherwise specified was all that was needed for CC designation under old DRGs
- Under MS DRGs, must have more specific code for CC (e.g., chronic diastolic heart failure)
- In 2005, 93% of CHF codes had sufficient detail for CC under old DRGs, but not MS-DRGs
- What share of cases will have detailed coding in 2008?

# Three distinct periods in the private payer payment-to-cost ratio



Source: AHA annual survey.

# Examples of low cost and high quality

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- MedPAC staff visited four low-cost cost hospitals with high quality scores
  - Low adjusted cost per discharge
  - High quality rankings on Hospital Compare etc.
- Three of the four were under financial pressure due to low non-Medicare margins
- Common characteristics:
  - Tended to have good physician relations
  - Often had staff that were highly focused on quality metrics