



Advising the Congress on Medicare issues

Updating payments for hospitals

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Background

- Update recommendations for hospital outpatient and acute inpatient services in 2010
- Medicare spending in 2007:
 - Inpatient FFS —\$107 billion
 - Outpatient FFS —\$29 billion

Payment adequacy indicators

- Beneficiaries' access to care
- Capacity and supply of providers
- Volume of services
- Quality of care
- Access to capital
- Payments and costs for 2009

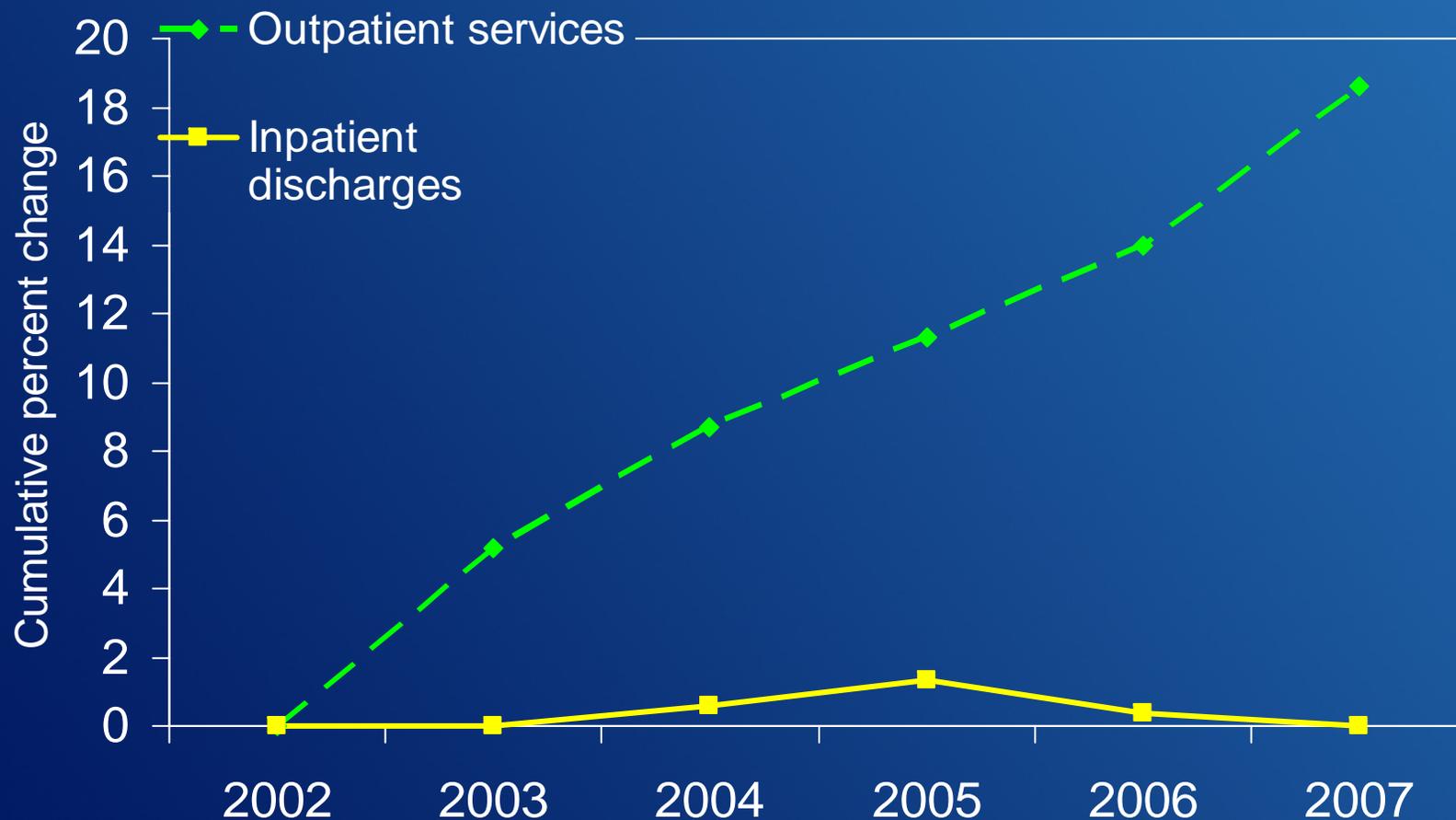
More general acute care hospitals have opened than closed since 2002



The share of hospitals offering select services is stable or rising

- The share of hospitals offering most specialized services has grown
 - 11% of hospitals added MRI services
 - 3% of hospitals added cardiac surgery
 - 3% of hospitals added trauma services
 - 2% of hospitals dropped psychiatric services
- Hospitals offering outpatient services (including ER) has remained stable

Medicare volume per FFS beneficiary

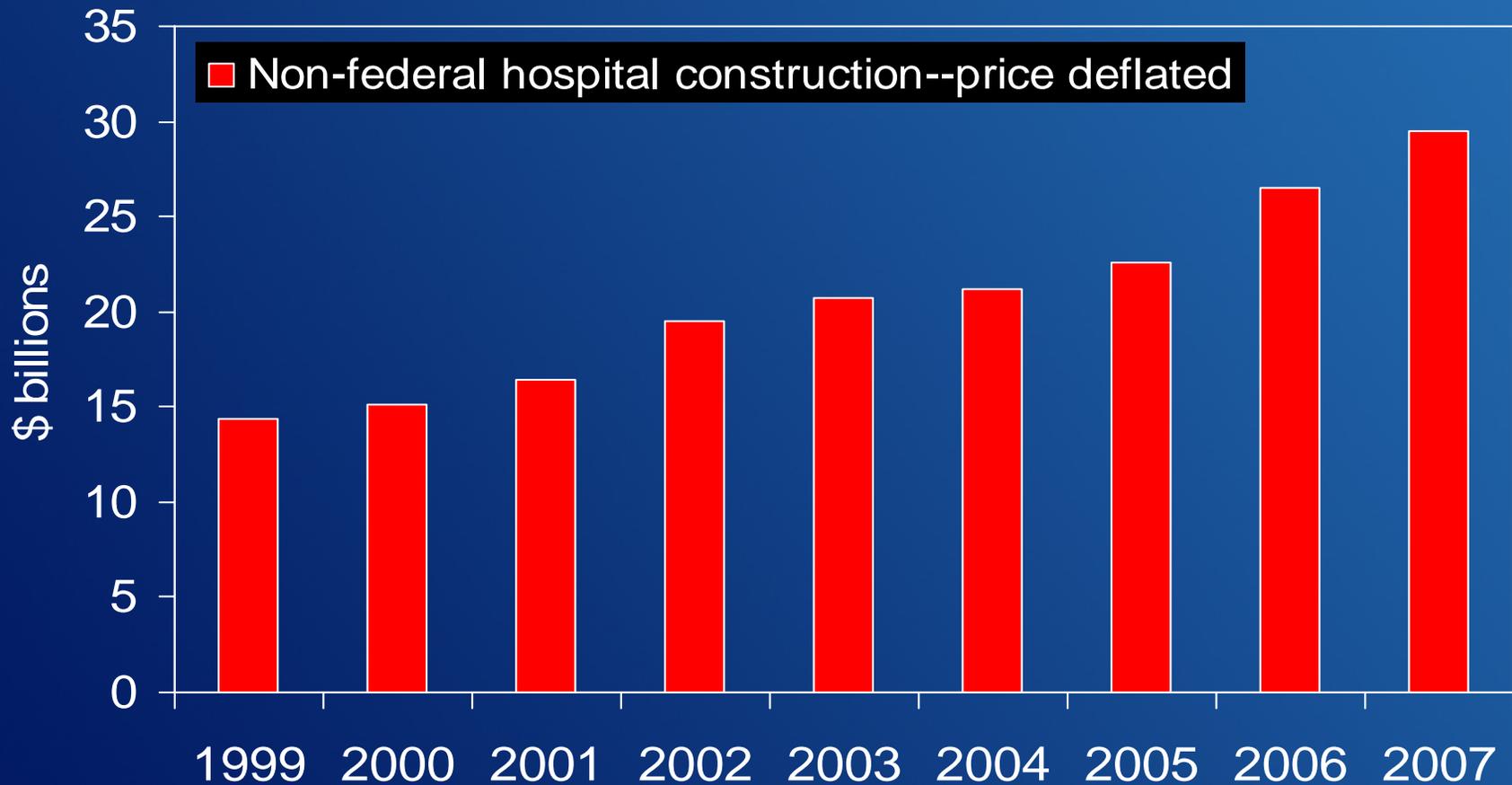


Note: Calendar years for outpatient, fiscal years for inpatient.

Quality of care is generally improving

- In-hospital and 30-day mortality declined for all 8 conditions or procedures measured (2004-2007)
- Patient safety results mostly improving—the rate of adverse events improved in 5 of the 8 most common measures (2004-2007)
- Joint Commission reports process measures are improving 2002-2007 (e.g. beta blocker)

Spending on hospital construction continued to grow through 2007



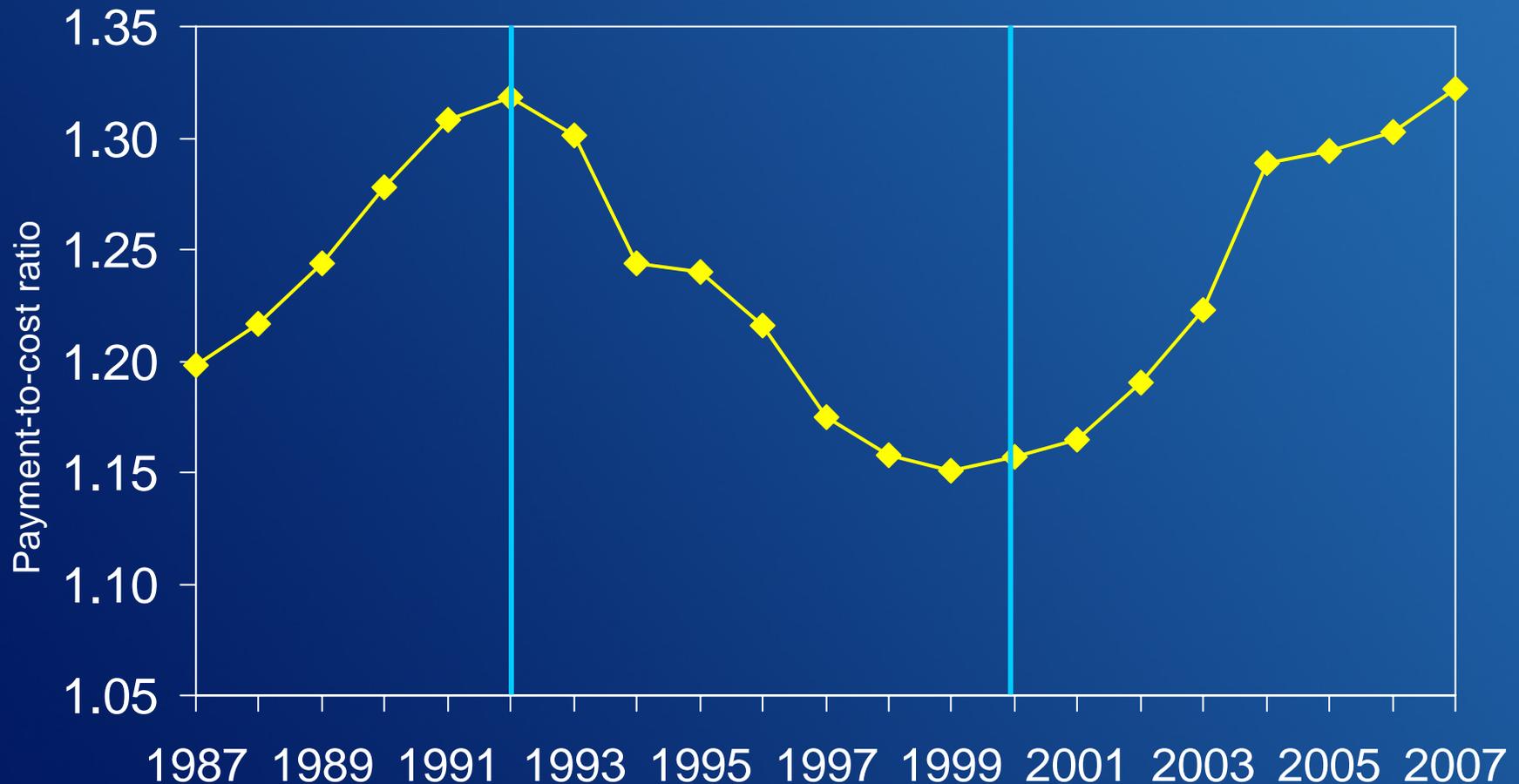
Source: Department of Census.

Access to capital tightened in 2008

- Record bond offerings in the spring
- Almost none in late September
- By November 2008, hospital bond offerings had resumed, but interest rates rose
- The temporary freeze in hospitals' access to capital should not be seen as a reflection of Medicare payment rates

Source: Cain brothers industry insights, November 2008

Private-payer payment to cost ratios are high in recent years



Note: Private-payer costs do not include Medicare and Medicaid managed care.

Source: AHA annual survey.

Exploring hospital efficiency

- Ideally we would look at annual cost per capita and outcomes
- Limited to exploring efficiency per unit of output
- Categorize hospitals as “relatively efficient” if they meet both criteria:
 - Either risk-adjusted mortality or risk-adjusted costs in the best one-third during every year (2004, 2005, and 2006), and
 - Middle third or better performance on all measures (risk-adjusted mortality, readmission rates, and costs)

Summary of payment adequacy indicators

- Most payment adequacy indicators are positive
- Medicare margins were low in 2007 and are expected to decline
- There is a set of hospitals that has been able to consistently maintain relatively low costs, low mortality, and break even treating Medicare patients

The indirect medical education adjustment

- In 2007, Medicare spent \$6.0 billion on IME payments
- IME adjustment of 5.5 percent per 10 percent increment in the resident-to-bed ratio is more than twice empirically justified amount
- Major teaching hospitals' overall Medicare margin is higher than nonteaching hospitals

Reducing the “margin gap”

- Overall Medicare margin of major teaching hospitals are 10 percentage points higher than non-teaching hospitals in 2007
- Gap will be reduced by:
 - 1 percentage point when the capital IME is eliminated
 - 2 percentage points if the IME adjustment were reduced to 4.5 percent and savings used for P4P
- However, a gap will remain because:
 - IME payments will still be larger than the empirical amount
 - Teaching hospitals still benefit from DSH payments