Advising the Congress on Medicare issues

Medicare beneficiaries' access to hospital care and near-term changes in Medicare payment policies

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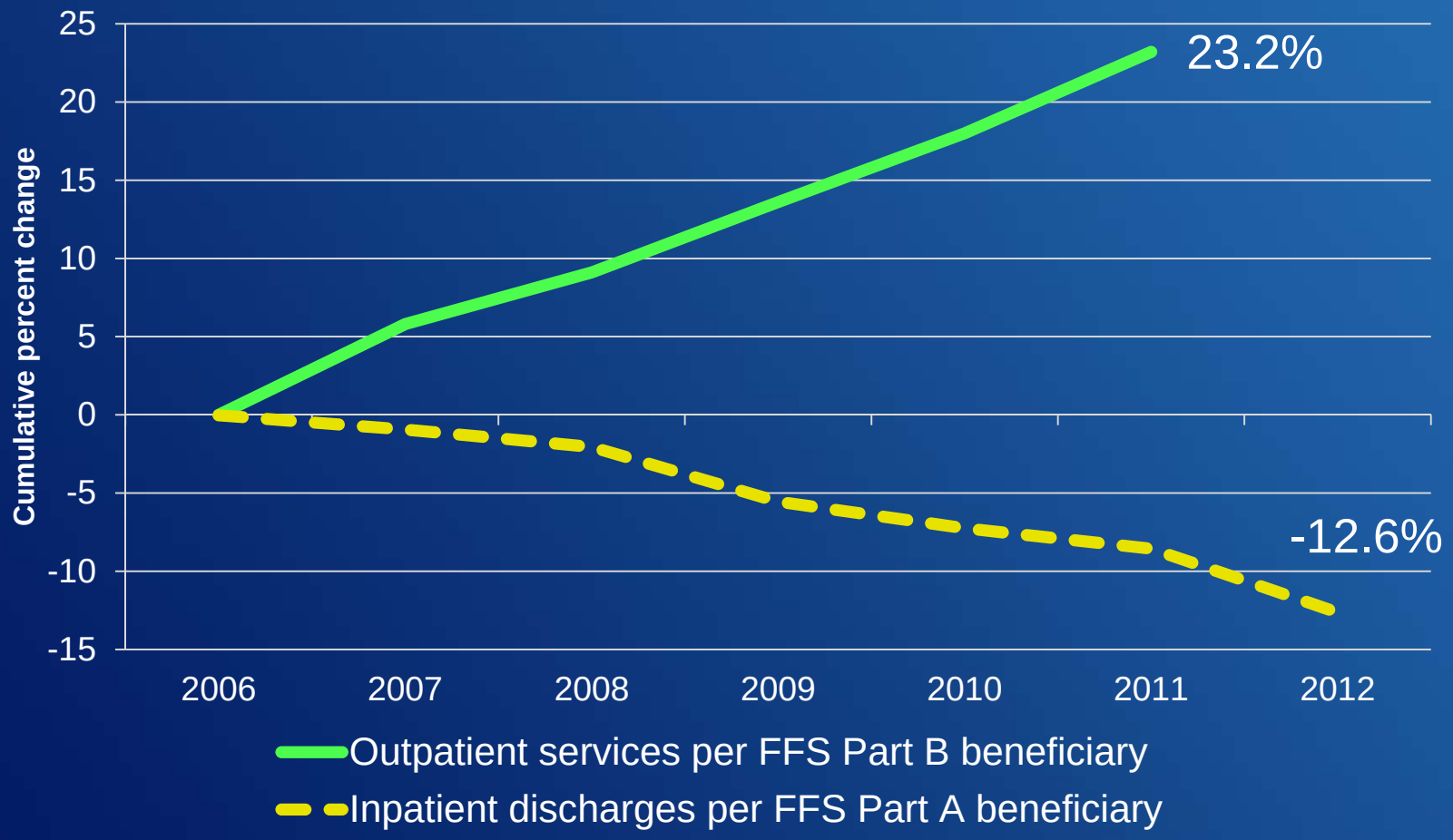
MEDPAC

Today's topics: Beneficiary access and payment policy changes

- Access is expected to remain strong
  - Inpatient use is falling
  - Occupancy is falling, creating more available beds
  - Despite excess inpatient capacity in many markets, closures are rare
- Under current law, payments expected to grow slower than costs in 2015
- Distribution of payments is changing

Medicare inpatient volume declined, outpatient volume increased



Source: Medicare claims

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Observation growth does not fully offset decline in inpatient volume

	Number of discharges/visits per 1,000 beneficiaries (2006)	Number of discharges/visits per 1,000 beneficiaries (2012)	Raw change in volume per 1,000 beneficiaries (2006 to 2012)
Outpatient observation visits	28	53	+25
Inpatient discharges	334	289	-45
Total (outpatient observation visits + inpatient discharges)	362	342	-20

Source: Medicare claims

Occupancy rates suggest excess capacity varies by market

National

- Occupancy rates declined from 64 to 61 percent (2006-2012)

Urban v. Rural

- Urban hospitals: Occupancy rates declined from 67 to 64 percent (2006-2012)
- Rural hospitals: Occupancy rates declined from 48 to 43 percent (2006-2012)

MSA Markets

- 17 MSAs with more than 75 percent occupancy (2012)
- 243 MSAs with 50 to 75 percent occupancy (2012)
- 121 MSAs with 25 to 50 percent occupancy (2012)
- 1 MSA with less than 25 percent occupancy (2012)

Source: CMS hospital cost reports
Note: MSA is a metropolitan statistical area with more than 50,000 people. Occupancy in micropolitan and rural areas tends to be lower than in the 382 MSAs shown above.

Hospital closures remained modest in the midst of growing excess capacity

- 17 hospitals confirmed opened in 2012
- 17 hospitals confirmed closed in 2012
  - Occupancy rates low (27 percent) relative to their nearest competitor (57 percent) and declined for several years
  - All-payer margins averaged -10.5 percent in final year
  - Lower average quality
    - Average readmission and mortality rates slightly worse than average
    - Patient satisfaction scores place 6 of the 17 hospitals in the bottom 10 percent of all hospitals
    - Worse than average on three heart condition-related metrics
- Net impact: 800 fewer hospital beds in 2012

Hospitals' capacity and capital availability is strong

- Employment: Positive growth in last 12 months (+1 percent)
- Service offerings: Expanding new technology and core services, but contracting post-acute services
- Construction spending: High at $27 billion per year (2011-13)
- Capital availability: Non-profit hospitals borrowed more in 2011 than 2012
- Mergers and acquisitions: 60 percent increase in activity from 2011 to 2012

Payment changes 2011 to 2016

	Percent change in payments	
Payment change estimates	2011 to 14	2014 to 15
DSH/uncompensated care payment	+0.7%	-2.0%
Other policy changes	-0.2	-1.5
Current law updates	+5%	+2%
Net change	+5.5%	-1.5%

Note: These projections are subject to change and have been presented as changes in overall hospital Medicare fee-for-service revenue (not just inpatient revenue), which is roughly $160 billion per year. The projections do not factor in the 2 percent sequester due to uncertainty surrounding whether this will be in effect in 2015, and do not factor in a 0.4 percent permanent documentation and coding adjustment that will eventually have to be taken that is not included given CMS discretion over when it is taken. Projected updates are net of adjustments for productivity, budget adjustments, permanent DCI adjustments, and certain other factors. The DSH/Uncompensated care changes could vary depending on the expansion of the insurance coverage under the exchanges and the degree of Medicaid expansion.

Current law update for 2015

Statutory update = market basket – productivity adjustment – budget adjustment

- Expected 2015 update = 2.1% (2.8-0.5-0.2)
- Policy changes = - 3.6% (roughly)
- Net change in payments = -1.5% (roughly)

Note: This is the approximate change in the hospital inpatient and outpatient operating updates. A separate inpatient capital update is made by CMS and is not determined by statute. The actual update will change due to changes in estimates of input price inflation (the market basket) and historical productivity that will occur between now and August 2014 when the final 2015 rates are set.

Preliminary data subject to change

Difference between private rates and Medicare rates will continue to grow

- 2011 rates:
  - Privately insured prices were almost 150 percent of costs
  - Medicare prices were roughly 95 percent of allowable costs
- Expected changes
  - Private prices have been growing at 5 to 6 percent
  - Costs have been growing by roughly 2 to 3 percent
  - Expect strong all-payer profits
  - Medicare revenues are expected to grow slower than costs
  - Hospital profits on privately-insured and Medicare patients are expected to diverge further

Preliminary data subject to change

Access is expected to be strong despite declines in margins

- Access is expected to remain strong because:
  - Most hospitals have excess capacity
  - Medicare payment rates exceed marginal costs
  - Some hospitals accept discounts off current standard Medicare rates to increase volume (Medicare Select plan discounts, ACE demonstration)
  - Non-profit hospitals could lose their tax exemption if they refuse Medicare patients
- Conclusion: very few hospitals will restrict access for Medicare patients

Uncompensated care payments will be tied to Medicaid days in 2014

- In 2014 CMS will distribute $3 billion of traditional DSH and $9 billion in uncompensated care payments
- CMS decided to use Medicaid days and SSI days as a proxy for uncompensated care
  - Poor proxy of uncompensated care
  - More directly ties DSH payments to Medicaid days than under the old formula
  - Does not target hospitals with high uncompensated care costs
- Medicare will pay a fixed $248 payment per historical Medicaid day to DSH hospitals in 2014
- Hospitals receive additional payments from MA plans

Alternatives to using Medicaid days as a proxy for uncompensated care

- In 2015 CMS could shift from a payment per Medicaid and SSI day to using cost report data (schedule S-10) where hospitals report uncompensated care
  - CMS stated it intends to use S-10 at some point in the future
  - Some concern on wording of S-10 instructions in 2014
  - Imperfect measure of uncompensated care may be better than using a proxy that does not measure uncompensated care
- Would shift funds toward safety-net hospitals serving large numbers of uninsured individuals

Discussion topics

- Excess capacity (declining inpatient volume)
- Declining margins
- Continued strong access
- Appropriate payment rates in this context
- Medicare payments for uncompensated care