Beneficiary access to hospital care, and how service volume affects hospital costs

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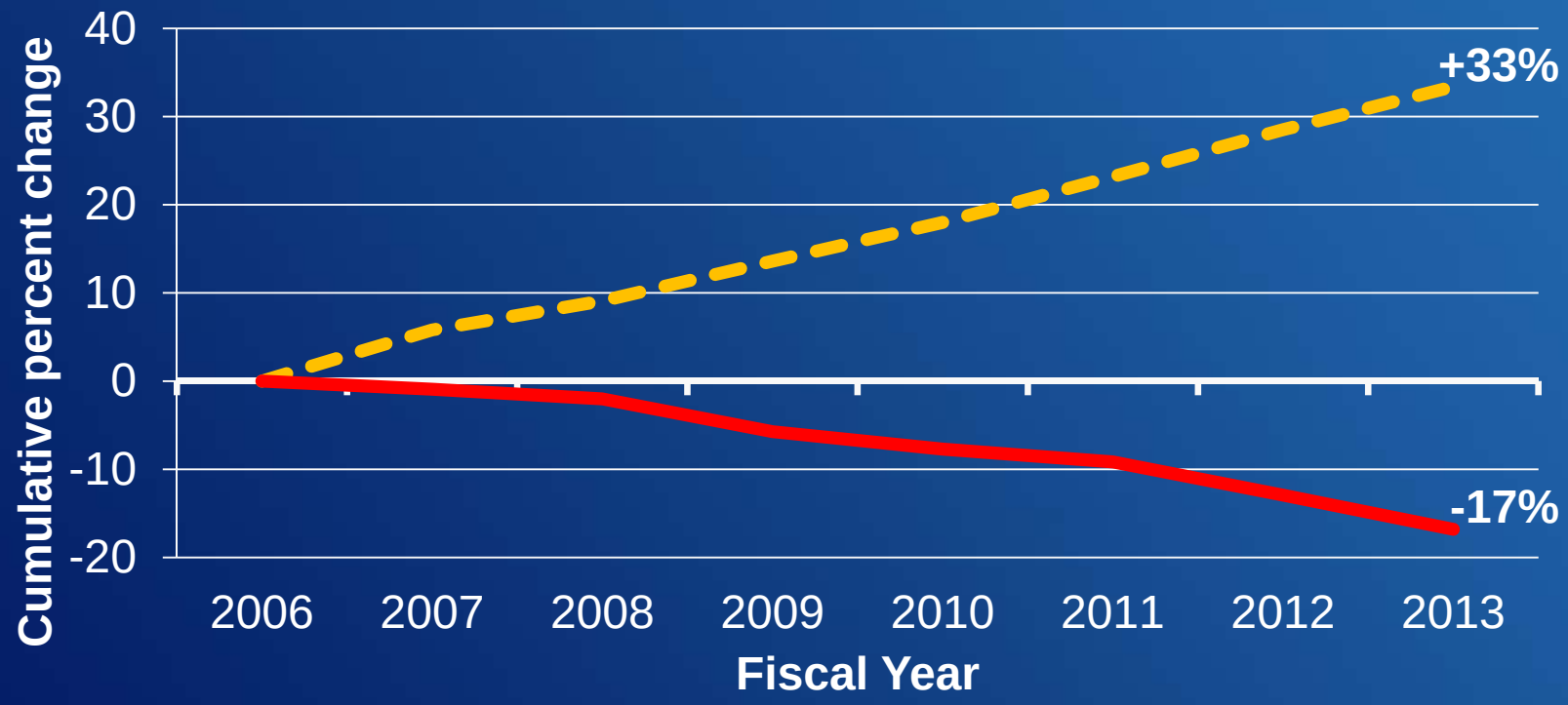
MEDPAC

Today's topics: Beneficiary access and the relationship between volume and cost

- Beneficiary access is good
  - Inpatient use is falling, outpatient use rising
  - Occupancy is falling, creating more available beds
  - Closures are in line with changes in volume
  - Hospitals' access to capital is reasonable
  - Hospital construction focused on outpatient capacity
- Relationship between occupancy and costs suggest most hospital costs are not fixed

Changes in Medicare hospital inpatient and outpatient utilization



Source: Medicare claims

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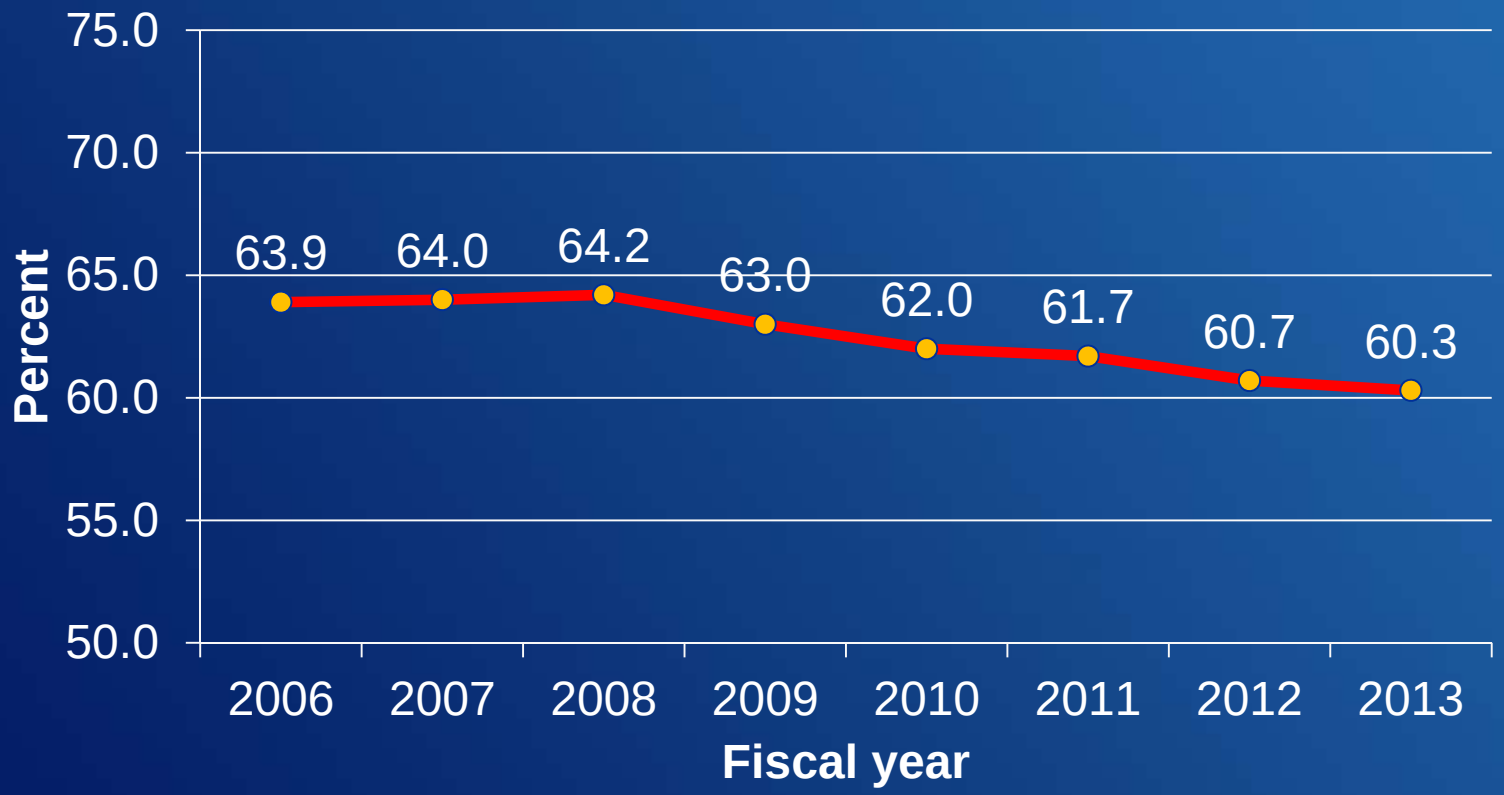
Data are preliminary and subject to change

Hospital occupancy rates suggest excess inpatient bed capacity



Source: CMS hospital cost reports

Data are preliminary and subject to change

Hospital closures exceeded openings in 2013 in midst of growing excess capacity

- Net impact: 9 fewer hospitals and 1,100 fewer beds
- 27 hospitals closed
  - Small hospitals (average number of beds = 68)
  - Occupancy rates low (32 percent) relative to the nearest hospital (51 percent)
  - All-payer margins low (-5.7 percent) relative to all-hospital average (+6.5 percent)
- 18 hospitals opened
  - Very small hospitals (average number of beds = 38)
  - Limited set of services offered

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Rural hospital occupancy and closures

- Occupancy rates declined 47 to 41 percent (2006 to 2013)
- Few closures annually from 2006 to 2012
- 13 rural hospitals closed in 2013
- Rural hospitals accounted for 48 percent of all hospitals and 48 percent of closures in 2013
- Some closed hospitals become outpatient facilities

Hospital industry indicators of accessing capital

- Capital availability maintained
  - For-profit hospitals: Equity markets see them as attractive investments – rapid increase in share prices in 2014
  - Non-profit hospitals:
    - Most have access to capital at low interest rates
    - Some struggling with volume declines face rating downgrades
- Mergers and acquisitions
  - 16 percent increase from 2012 to 2013 (283 hospitals)
  - Large acquisitions drove much of the deal-making
- Employment: Stable growth in last 18 months (+0.4 percent)

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Hospitals focused on outpatient capacity growth

- Hospital construction spending continued:
  - $27-$28 billion per year (2011 - 2012)
  - $23-$26 billion per year (2013 - 2014)
- Outpatient capacity the focus of hospital industry
- Other trends in the health care facilities marketplace:
  - Urgent care centers
  - Freestanding emergency departments

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How do hospital costs change with volume?

- Common perception: most costs are fixed
- We find: most costs are not fixed
  - Hospital cost per discharge should not grow materially due to small reductions in occupancy
  - We should expect modest (not large) savings from hospital closures
- Hospital-based ACOs do have a financial incentive to reduce unnecessary admissions

Occupancy and cost per discharge

	Four categories of occupancy (2012)			
	<40%	40 to 49%	50 to 64%	65+%
Number of hospitals	424	416	787	560
Average occupancy	33%	45%	57%	73%
Std. Medicare cost per discharge	$12,000	$12,030	$11,840	$11,560

Note: costs are standardized for input prices, case mix, teaching status and outliers.

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Changes in volume and changes in cost per discharge

	Change in all payer discharges 2011 to 2012		
	Reduction of over 10%	-10% to +10%	Increase of over 10%
Number of hospitals	137	1,783	111
Change in discharges	-16%	-1%	20%
Change in cost per discharge	4.3%	1.9%	0.7%

Note: costs are standardized for input prices, case mix, teaching status and outliers.

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Summary

- Excess capacity (declining inpatient volume)
- Beneficiary access is good
- Access to capital is maintained
- Most costs are not fixed. Hospitals can adjust most costs to lower volumes
- In December we will present margin data and discuss hospitals' ability to reduce costs when under fiscal pressure