Advising the Congress on Medicare issues

Assessing payment adequacy: hospital inpatient and outpatient services

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MEDPAC

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 average providers
  - For relatively efficient providers

Medicare hospital spending in 2011

- Inpatient (PPS and CAH) —$117 billion
- Outpatient (PPS and CAH) —$41 billion
- Spending growth per capita 2010-2011
  - Inpatient −1%
  - Outpatient +9%
  - Overall +2%
    - PPS hospitals +2%
    - CAHs +6%

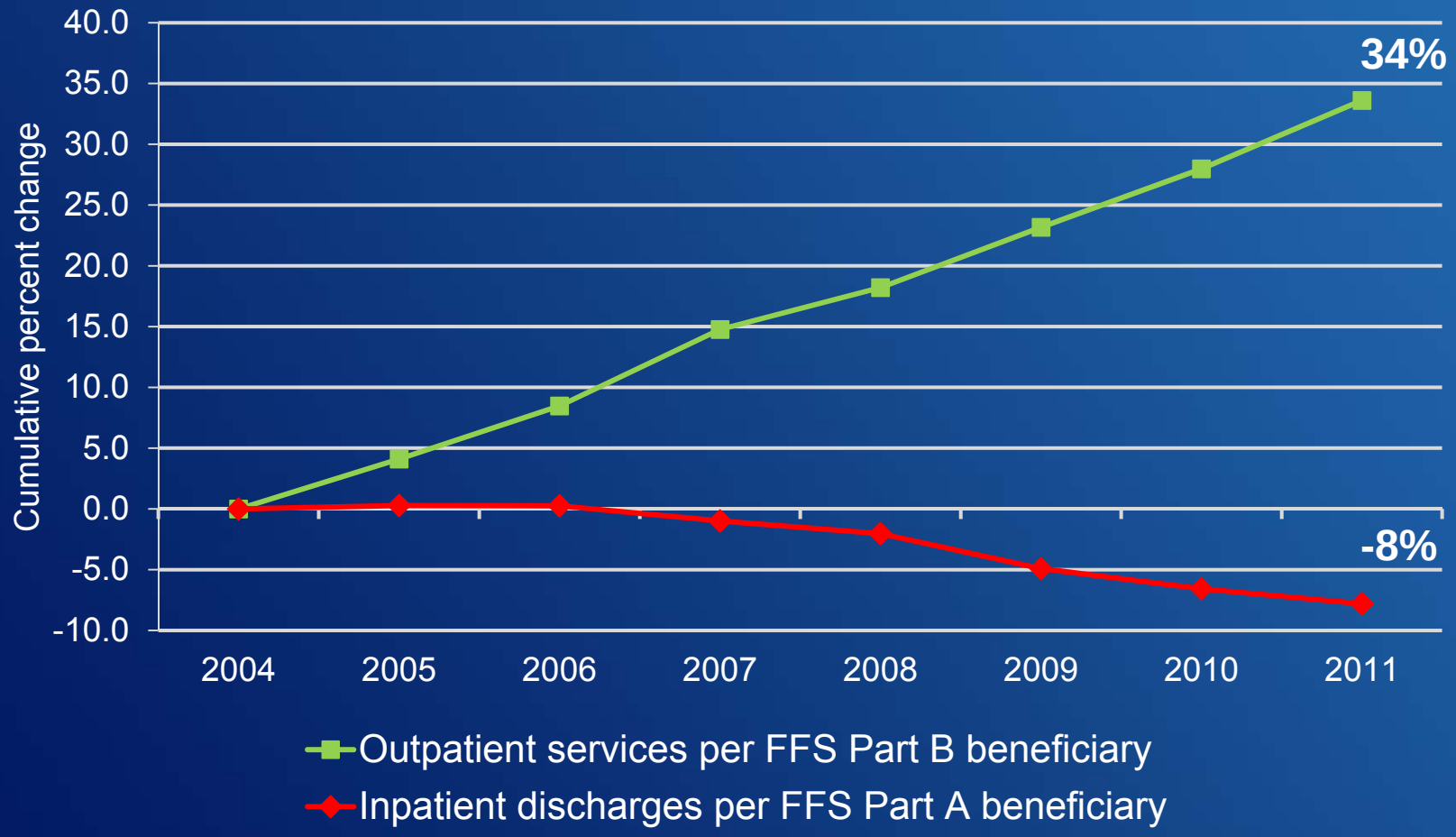
Source: Medicare cost reports

Preliminary data subject to change

Capacity and access to capital

- Supply of hospitals is growing
- Breadth of services is growing
- Access to capital is adequate
  - Construction steady at $26 billion
  - Interest rates low

Hospital inpatient and outpatient volume growth



Source: Medicare claims data

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Physician office services shift to hospital outpatient billing

- Growth in outpatient service billing in 2011
  - Outpatient E&M visits up 8%
  - Outpatient Echocardiograms up 18%
- Shifting away from physician offices in 2011
  - Office E&M down 1%
  - Office Echocardiograms down 7%
- Payments to hospitals for these two services were $1.5 billion above physician office rates in 2011, an increase of $200 million over 2010 due to the site of service shift

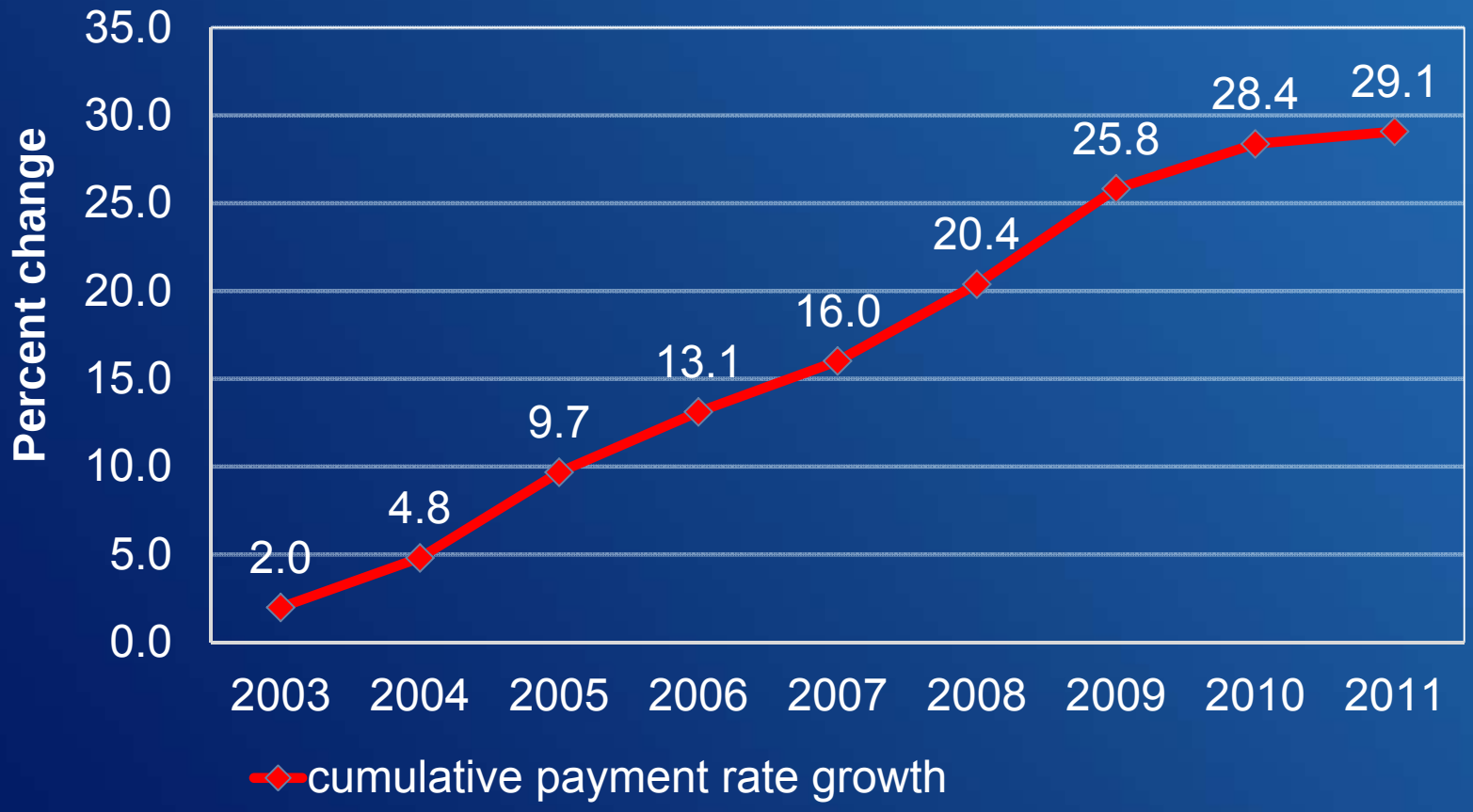
Source: Medicare claims data

Preliminary data subject to change

Quality of care generally improving

- 30-day mortality measures improved
- Patient safety measures mostly improved
- Patient satisfaction improved slightly
- Readmission rates improved slightly and readmission penalties will start in 2013

Payment rate growth faster in 2008 and 2009, slower in 2011 (in part due to documentation and coding)



Source: Medicare cost reports

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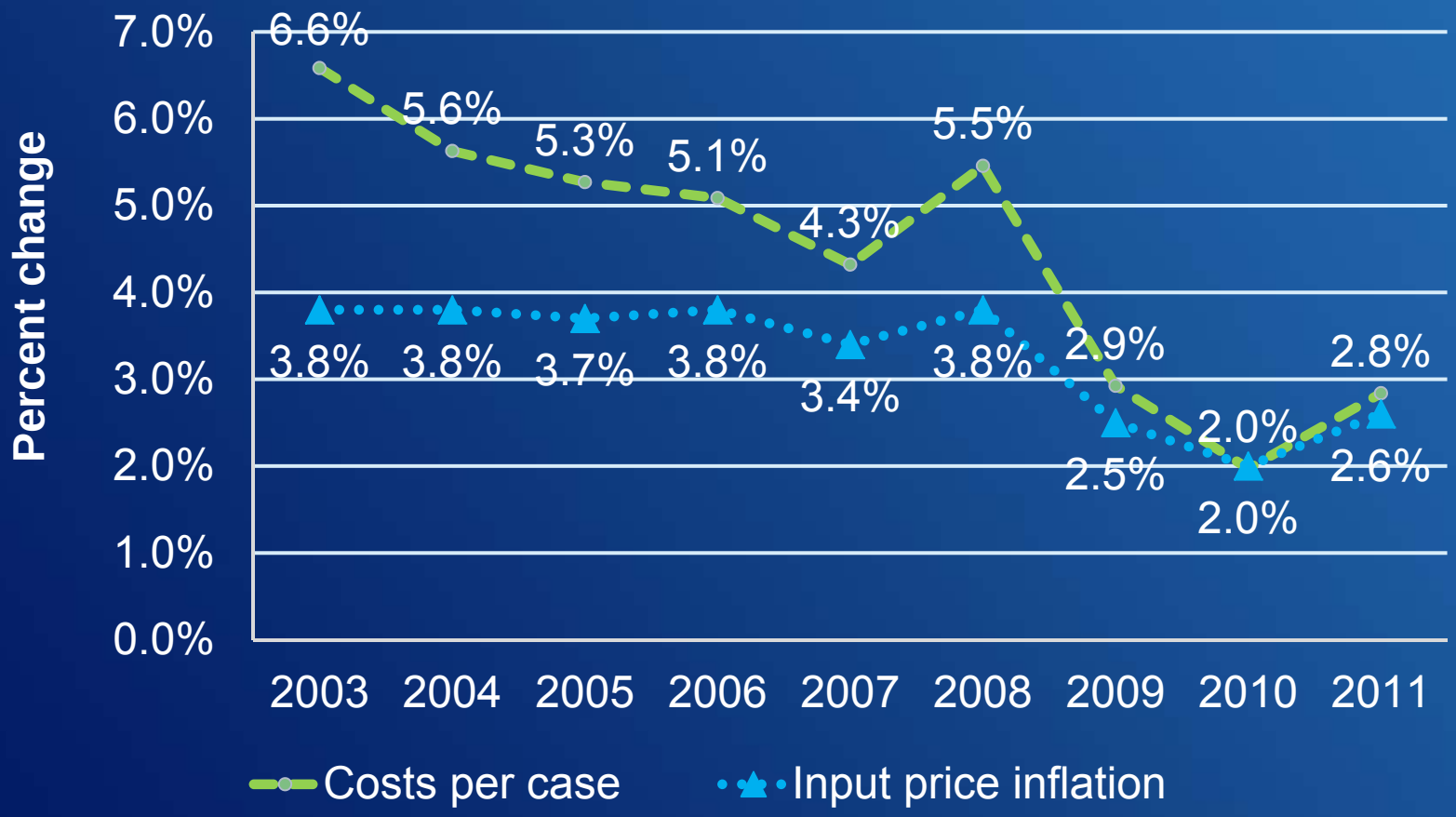
Correcting for documentation and coding changes

- After MS-DRGs were introduced in 2008, documentation and coding changes led to increased payments without any real change in patient complexity or the cost of care
- CMS reduced payments in 2011 and 2012 to offset the effects of documentation and coding that occurred in 2008 and 2009
- 2014 update needs to be adjusted to:
  - Prevent further overpayments due to documentation and coding changes that took place in 2010
  - Recover $11+ billion in overpayments ocurring in 2010 through 2013

Cost growth has come down close to input price inflation



Source: Medicare cost reports

Margins affected by documentation changes and slower cost growth

Medicare margin	2007	2008	2009	2010	2011
Overall Medicare	– 6.1%	– 7.3%	– 5.4%	– 4.7%	– 5.8%
Inpatient	– 3.6	– 4.7	– 2.3	– 1.7	– 4.0
Outpatient	–12.2	–13.7	–11.7	–10.5	–11.0

Note: Margins = (payments – costs) / payments; excludes critical access hospitals.
Source: Medicare cost reports.

Overall Medicare margin by hospital group

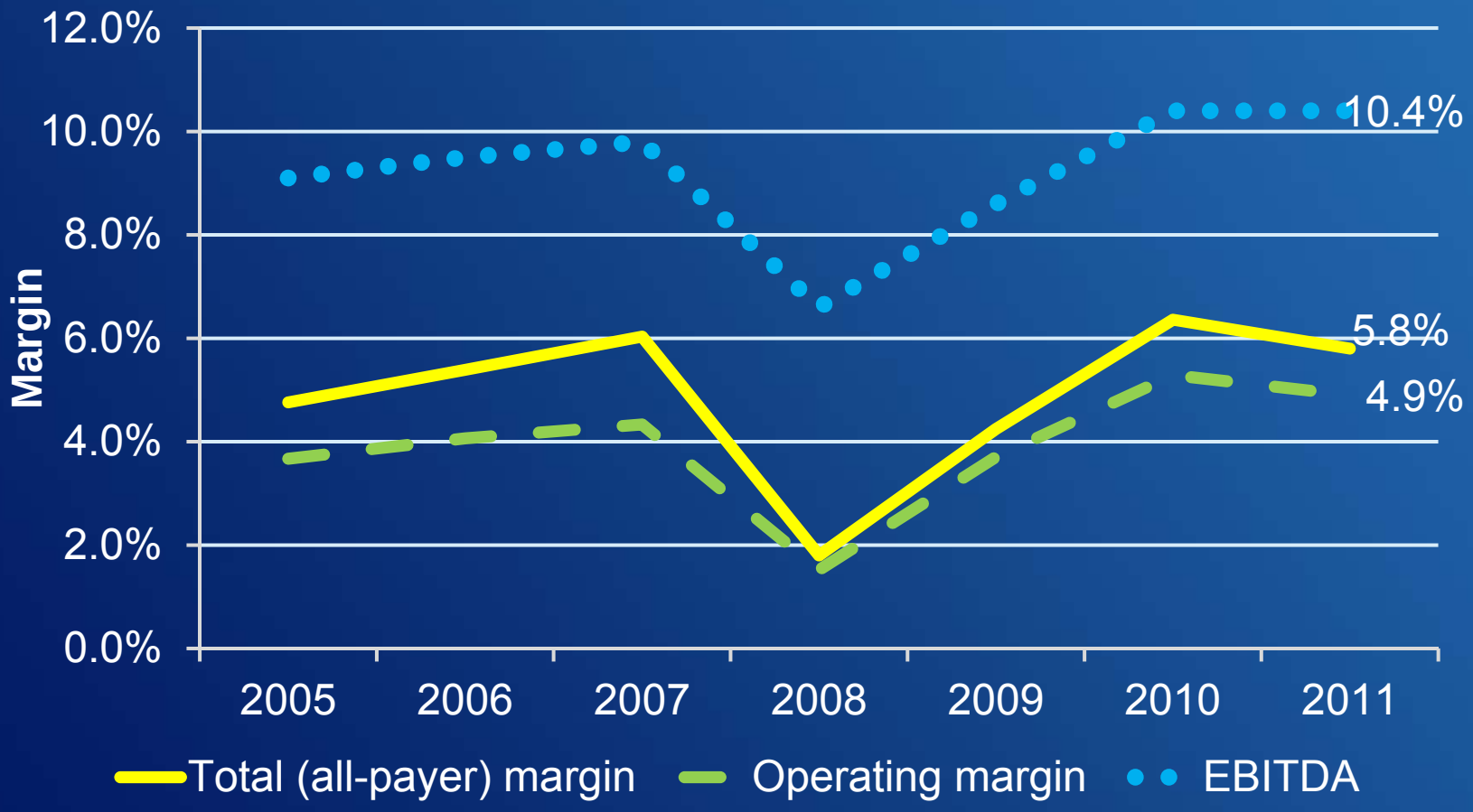
Hospital group	2011
All hospitals	–5.8%
Urban	–6.2
Rural PPS	–3.2
Rural with CAH*	–1.8*
Major teaching	–2.4
Other teaching	–5.4
Non-teaching	–8.3
Nonprofit	–7.2
For-profit	–1.0

Note: *CAHs are paid cost plus 1% and are only included in this line
Source: Medicare cost reports

Hospitals under financial pressure have lower costs

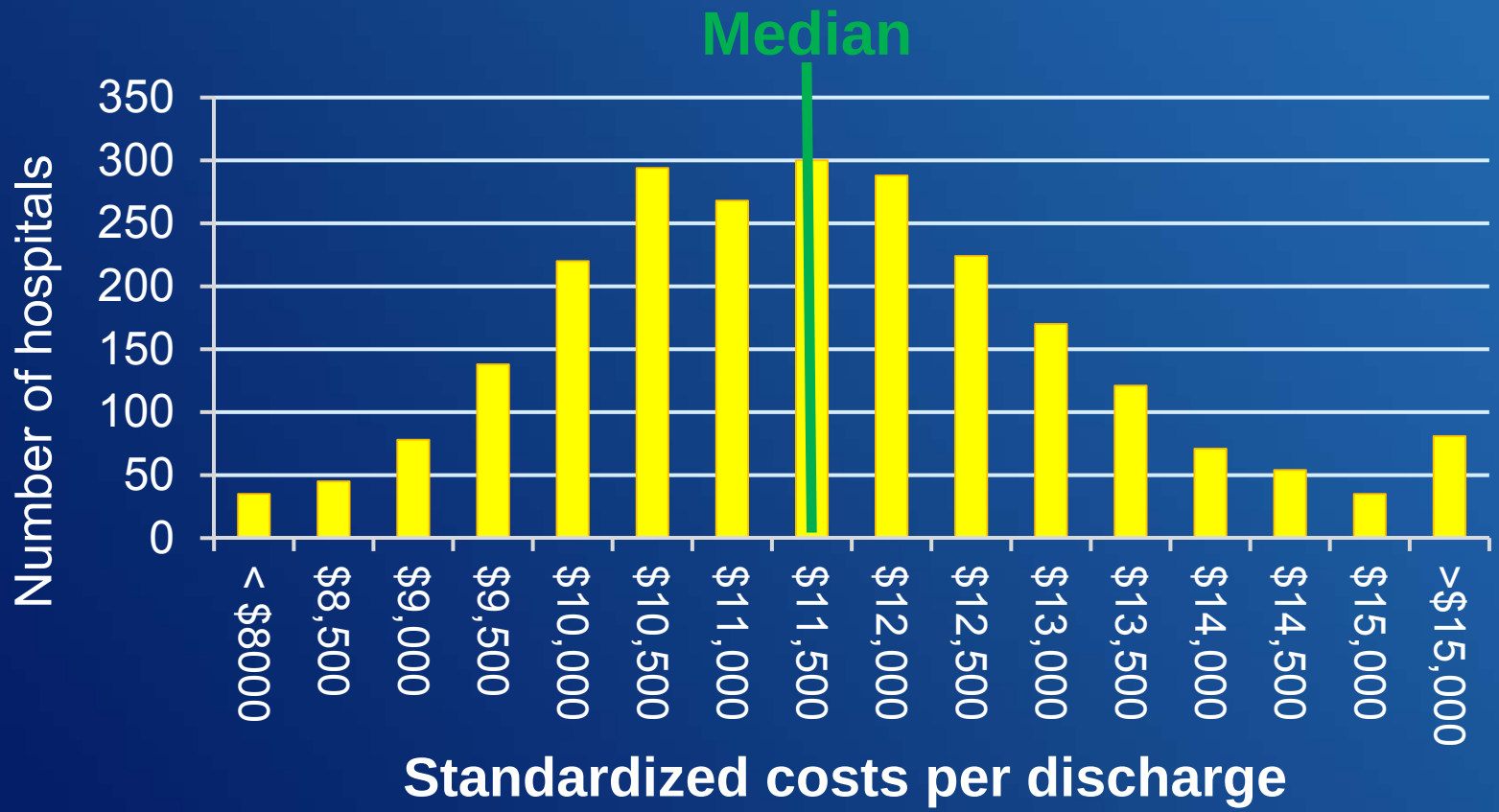
- Hospitals under high pressure tend to have lower costs (8% lower)
- Hospitals under low pressure tend to have higher costs (4% higher)
- Medicare payment rates and profits on non-Medicare patients affect cost growth
  - Higher cost growth at small rural hospitals after low-volume adjustment was enacted
  - Lower industry cost growth after recession

Strong all-payer margins could reduce pressure to constrain costs



Source: Medicare cost reports.

Standardized costs per discharge vary widely



Note: Costs are standardized for case mix, local wages, interest costs, outliers, teaching costs and disproportionate share costs. The sample is limited to hospitals with over 500 discharges
Source: Medicare cost reports

Relatively efficient hospitals

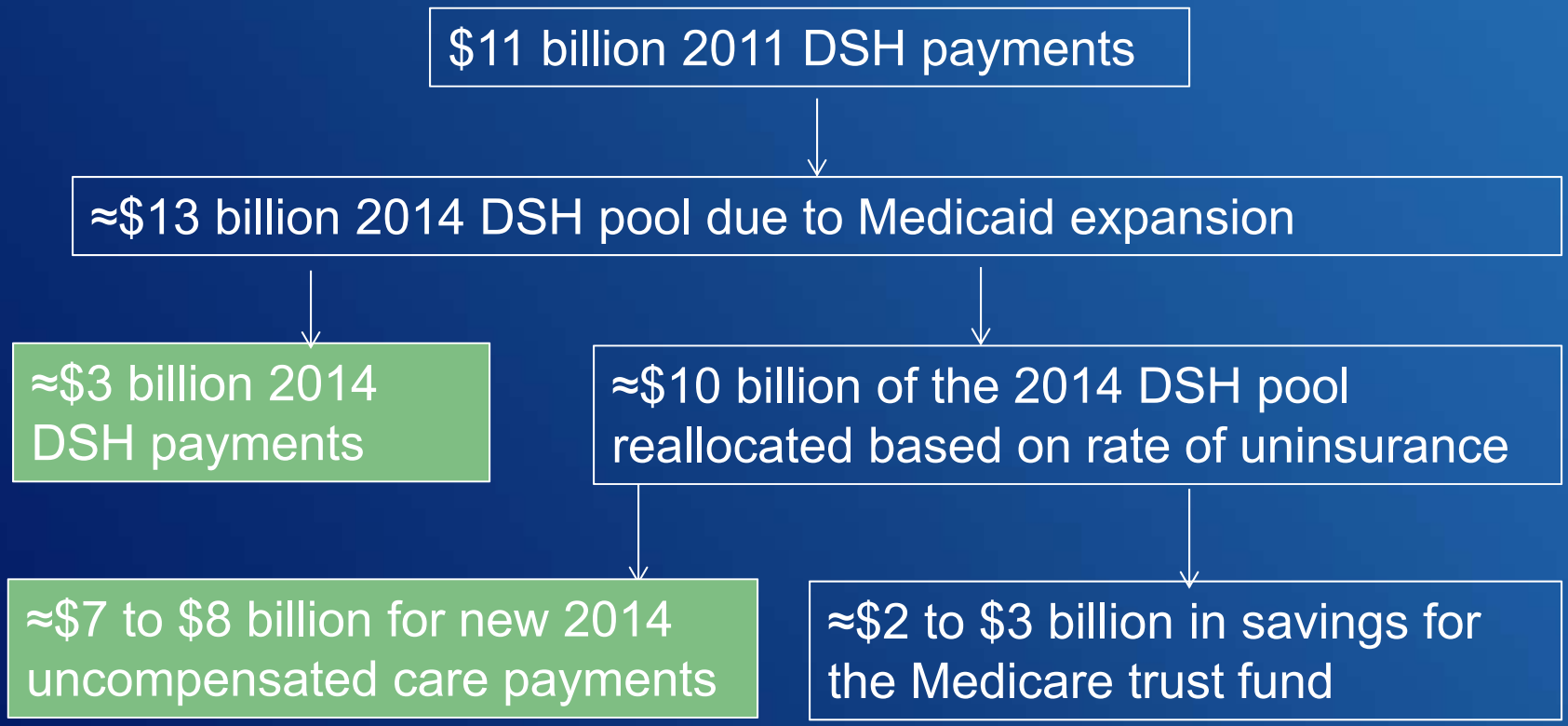
- Must be in the best third on either risk-adjusted mortality **or** inpatient costs per case **every** year (2008, 2009, 2010), and
- Cannot be in the worst third in **any** year for risk-adjusted mortality, readmission rates, or costs per case

Comparing 2011 performance of relatively efficient hospitals to others

Measure	Relatively efficient hospitals	Other hospitals
Number of hospitals	297	1,864
30-day mortality	13% lower	3% above
Readmission rates (3M)	5% lower	1% above
Standardized costs	10% lower	2% above
Overall Medicare margin	2%	-6%
Share of patients rating the hospital highly	69%	67%

Note: medians for each group are compared to the national median
Source: Medicare cost reports and claims data

Forecast changes in disproportionate share (DSH) payments



Note: The above analysis assumes a 25% reduction in uninsurance. If rates of uninsurance decline further, uncompensated payments will decline below 2014 levels in future years.
Source: MedPAC analysis based on CBO forecasts of uninsurance and Medicaid enrollment

Forecast updates for 2014 under current law

Statutory update = market basket – productivity adjustment – budget adjustment

- October 1: inpatient 1.8% (2.6% – 0.5% – 0.3%)
- January 1: outpatient 2.0% (2.7% – 0.4% – 0.3%)

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