

CHAPTER

3

**Hospital inpatient and
outpatient services**

R E C O M M E N D A T I O N

- 3** The Congress should direct the Secretary of the Department of Health and Human Services to:
- update inpatient and outpatient payments by the amount specified in current law,
 - reduce Medicare payment rates for 340B hospitals' separately payable 340B drugs by 10 percent of the average sales price (ASP),
 - direct the program savings from reducing Part B drug payment rates to the Medicare-funded uncompensated care pool, and
 - distribute all uncompensated care payments using data from the Medicare cost reports' Worksheet S-10. The use of S-10 uncompensated care data should be phased in over three years.

COMMISSIONER VOTES: YES 14 • NO 3 • NOT VOTING 0 • ABSENT 0

Hospital inpatient and outpatient services

Chapter summary

In 2014, the Medicare fee-for-service (FFS) program paid 4,700 hospitals a total of \$173 billion for 9.7 million Medicare inpatient admissions, 193 million outpatient services, and \$9.4 billion of uncompensated care costs. These sums represent a 4 percent increase in hospital spending from 2013. On net, Part A hospital payments increased by \$1 billion, and Part B outpatient payments increased by \$5 billion. Part A payments increased because the increase in prices and patient severity more than offset a decline in inpatient volume. In addition, \$9.4 billion of Part A trust fund dollars were reallocated from inpatient disproportionate share (DSH) payments to non-Medicare uncompensated care payments. Outpatient payments rose due to volume increases, price increases, and bundling of some laboratory services into the outpatient fee schedule. The \$6 billion increase between 2013 and 2014 in overall hospital payments is equivalent to payments per FFS beneficiary increasing from \$4,630 to \$4,820.

Assessment of payment adequacy

In brief, most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. However, average Medicare margins are negative, and under current law they are expected to decline in 2016. Despite negative average margins, hospitals with excess capacity still have an incentive to see more Medicare beneficiaries because Medicare

In this chapter

- Are Medicare payments adequate in 2016?
- How should Medicare payment rates change in 2017?

payment rates are still higher than the variable costs associated with Medicare patients. To judge whether payments are adequate, the Commission makes a collective judgment after discussing the payment adequacy indicators listed below.

Beneficiaries' access to care—Access measures include the capacity of providers and the volume of services.

- ***Capacity and supply of providers***—The average hospital occupancy rate was 61 percent in 2014, suggesting hospitals have excess inpatient capacity in most markets.
- ***Volume of services***—Inpatient use per beneficiary declined by 3.6 percent in 2014 and outpatient services increased by 3.7 percent. However, some systems reported increases in both inpatient and outpatient volumes in the first half of 2015.

Quality of care—Hospital quality metrics remained stable or improved in 2014.

Providers' access to capital—Access to bond and equity markets remains strong for most hospitals, in part reflecting hospitals' strong all-payer profitability from 2012 through 2014.

Medicare payments and providers' costs—In 2014, hospitals' aggregate Medicare margin was –5.8 percent. However, a set of relatively efficient hospitals were able to break even on Medicare while performing well on quality metrics. Under current law, payment rates are projected to decline from 2014 to 2016 because of a \$3 billion decline in uncompensated care payments and other policy changes. Uncompensated care payments declined due to an increase in the share of the population that was insured. The reduction in Medicare payment rates from 2014 to 2016 could lower Medicare margins for all hospitals, including the relatively efficient providers. We project hospitals' aggregate Medicare margin for 2016 to be about –9 percent. While Medicare payments are lower than overall costs (fixed and variable combined), Medicare payments continue to be about 10 percent higher than the variable costs of treating Medicare patients. Therefore, hospitals with excess capacity will still have a financial incentive to serve more Medicare patients in 2016.

Sharing 340B discounts with beneficiaries and hospitals serving the uninsured

Nonprofit hospitals with high shares of Medicaid and low-income Medicare patients (about one-third of all prospective payment system hospitals) qualify for the 340B Drug Pricing Program. These hospitals receive substantial discounts from drug companies for Part B drugs. The Office of Inspector General estimates that discounts across all 340B providers (hospitals and certain clinics) average 34

percent of the average sales price (ASP). Medicare sets payment rates for all Part B drugs that are separately payable under the outpatient prospective payment system (OPPS) at 106 percent of each drug's ASP. Medicare does not currently adjust the OPPS payment rates for the lower drug acquisition cost at 340B hospitals, resulting in substantial differences between Medicare payment rates and the acquisition costs of Part B drugs at these hospitals.

The Commission has discussed whether those savings should be shared with beneficiaries and taxpayers. The Commission decided that a portion of the discount that these hospitals receive should be shared with beneficiaries through lower cost sharing. However, the Commission did not want to reduce net program payments to hospitals providing the most uncompensated care. Instead, the Commission recommends redistributing part of the Medicare program's share of the discounts (\$300 million) to hospitals with the highest uncompensated care costs.

Helping hospitals that provide the most uncompensated care

In 2016, the Medicare program will distribute \$6.4 billion of uncompensated care payments to hospitals. The \$300 million in redirected Medicare payments (from 340B drug payments to uncompensated care payments) would increase the size of that pool to \$6.7 billion (if rates of uninsurance do not change). Since the start of the uncompensated care payment distributions in 2014, the Secretary of the Department of Health and Human Services has decided to distribute the funds using Medicaid days (and inpatient days of low-income Medicare patients) as a proxy for uncompensated care costs. In 2016, the Secretary expects to pay each DSH hospital a payment of \$174 per Medicaid day from this pool. In this chapter, we provide data on why Medicaid days are a poor proxy for uncompensated care, discuss problems with Medicare cross-subsidizing Medicaid, and explain why using cost report data (Worksheet S-10) would be a more effective way to target uncompensated care payments to hospitals that disproportionately serve the uninsured.

Recommendation

The Commission's multipart recommendation addresses the issues of updating Medicare hospital payments in view of mixed payment adequacy signals, allowing beneficiaries to share in 340B drug discounts, and directing additional program payments to hospitals that provide the most uncompensated care. Specifically, this multipart recommendation would increase providers' base payment rates by the amount stipulated in current law, currently projected to be a 1.75 percent increase. We also recommend reducing the price Medicare pays for separately payable 340B drugs by 10 percent. While the Commission decided that beneficiaries should share in discounts from the 340B program, we were concerned about the impact of

reducing the Medicare price for 340B drugs for hospitals that provide high levels of uncompensated care. Therefore, the \$300 million in program payments saved by reducing Medicare payment rates for 340B drugs would be redirected into the Medicare-funded uncompensated care pool. To better target all uncompensated care payments, CMS would be required to distribute the expanded uncompensated care pool based on reported uncompensated care costs on hospital cost reports.

Our recommendation does not change the 340B program: Pharmaceutical companies would still have to provide hospitals the same 340B discounts (estimated to be 34 percent) that they currently provide. One-third of the 34 percent spread between Medicare payment rates and hospitals' acquisition costs would be shared with the beneficiary (10 percent lower cost sharing) and with hospitals providing uncompensated care that would receive the savings from the 10 percent reduction (\$300 million) in uncompensated care payments.

While the uncompensated care pool would be directly tied to hospitals' uncompensated care costs, the \$3.3 billion in traditional DSH dollars would still be distributed to hospitals, based primarily on Medicaid days. Hospitals with high Medicaid shares would be disproportionately helped by the traditional DSH pool, and hospitals with high uncompensated care costs would be disproportionately helped by the uncompensated care pool. The expanded uncompensated care pool would be large enough to pay for roughly 20 percent of DSH hospitals' uncompensated care costs.

While all hospitals are expected to experience increases in base payment rates because of the update, DSH hospitals with high uncompensated care costs would see increases in payments that are above average, and DSH hospitals with below average uncompensated care costs would see smaller increases or reductions in Medicare payments. The net effect of reduced payment rates for 340B hospitals' Part B drugs and increases in uncompensated care payments would be a small increase in average payments to 340B hospitals, reflecting large increases in payment to 340B hospitals with high levels of uncompensated care (often public hospitals) and relatively smaller payment decreases to the 340B hospitals with lower than average levels of uncompensated care. ■

**TABLE
3-1**

Growth in Medicare inpatient and outpatient spending

| Hospital services | 2006 | 2013 | 2014 | Average annual change 2006-2013 | Change 2013-2014 |
|---|-------|-------|-------|---------------------------------|------------------|
| Inpatient services | | | | | |
| Total FFS payments (in billions) | \$110 | \$118 | \$110 | 1% | -7% |
| Payments per FFS beneficiary | 3,080 | 3,170 | 2,950 | 0 | -7 |
| Outpatient services | | | | | |
| Total FFS payments (in billions) | 29 | 49 | 54 | 8 | 11 |
| Payments per FFS beneficiary | 880 | 1,470 | 1,630 | 8 | 11 |
| Uncompensated care payments | | | | | |
| Total (in billions) | N/A | N/A | 9 | N/A | N/A |
| Payments per FFS beneficiary | N/A | N/A | 250 | N/A | N/A |
| Inpatient, outpatient, and uncompensated care payments | | | | | |
| Total FFS payments (in billions) | 139 | 167 | 173 | 3 | 4 |
| Payments per FFS beneficiary | 3,970 | 4,630 | 4,820 | 2 | 4 |

Note: FFS (fee-for-service), N/A (not applicable). Reported hospital FFS spending includes all hospitals covered by Medicare’s inpatient prospective payment system along with critical access hospitals and Maryland hospitals. Fiscal year 2014 payments include partial imputation to account for the hospitals that had not yet submitted 2014 cost reports covering fiscal year 2014. Combined inpatient and outpatient services per capita are based on a weighted average of the Part A and Part B services. A portion of the growth in outpatient payments is due to certain lab tests that had been paid separately under the laboratory fee schedule now being packaged into ambulatory payment classifications in the outpatient payment system. CMS estimates that this change accounts for over \$2 billion of the growth in outpatient payments (Centers for Medicare & Medicaid Services 2015b). Numbers may not sum to stated totals due to rounding.

Source: MedPAC analysis of CMS Medicare hospital cost reports and Medicare Provider Analysis and Review files.

Background

Medicare spending on hospitals

In 2014, the Medicare fee-for-service (FFS) program paid acute care hospitals \$110 billion for inpatient care, \$54 billion for outpatient care, and approximately \$9.4 billion in uncompensated care payments (Table 3-1). The \$9.4 billion represents a reallocation of Medicare trust fund dollars, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA). Under this change, approximately 2,500 disproportionate share (DSH) hospitals received 25 percent of the DSH payment they would have received under the older DSH formula and \$9.4 billion in uncompensated care payments in 2014. The result was that inpatient payments (which include traditional DSH payments but not uncompensated care payments) declined, but the overall sum of inpatient and uncompensated care payments was roughly flat from 2013 to 2014. Outpatient spending per FFS beneficiary grew

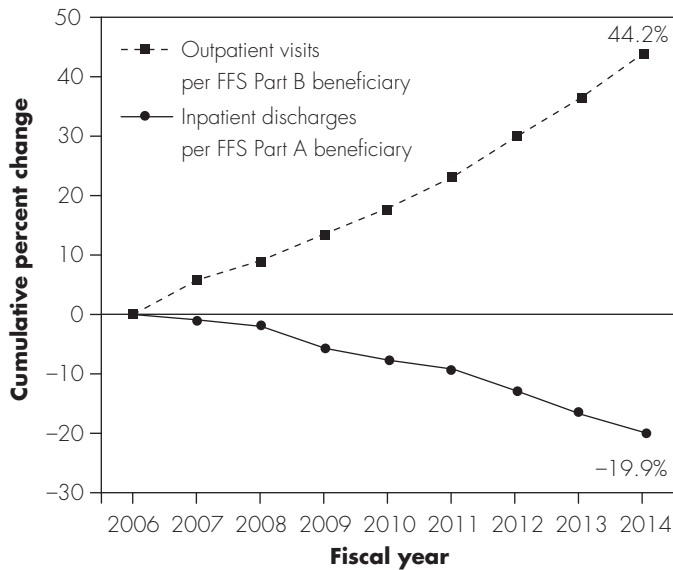
by 11 percent (Table 3-1), driving a 4 percent increase in overall Medicare inpatient and outpatient payments in 2014.¹ The \$5 billion increase in outpatient payments resulted from several changes, including the packaging of laboratory tests into outpatient payments (which shifted dollars from being paid under the laboratory fee schedule to the outpatient payment system), a 2 percent increase in payment rates, increasing volume, and a shift in some services from physician offices to higher paying hospital sites of care.

Medicare’s payment systems for inpatient and outpatient services

Medicare’s inpatient and outpatient prospective payment systems have a similar basic structure. Each has a base rate that is modified for the differences in type of case or service, as well as geographic differences in input prices. However, each prospective payment system (PPS) has different units of service and a different set of payment adjustments.

**FIGURE
3-1**

Medicare inpatient discharges per beneficiary continued to decline as outpatient visits per beneficiary continued to increase



Note: FFS (fee-for-service). Data include general and surgical, critical access, and children’s hospitals.

Source: MedPAC analysis of CMS’s inpatient and outpatient claims and enrollment data.

Acute inpatient prospective payment system

Medicare’s acute inpatient prospective payment system (IPPS) pays hospitals a predetermined amount for most discharges. The payment rate is the product of a base rate and a relative weight that reflects the expected costliness of cases in a particular clinical category compared with the average of all cases. The labor-related portion of the base payment rate is adjusted by a hospital geographic wage index to account for differences in hospital input prices among market areas. Payment rates are updated annually.

To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system classifies each patient case into 1 of 749 groups, which reflect similar principal diagnoses, procedures, and severity levels. The severity levels are determined according to whether patients have a complication or comorbidity (CC) associated with the base MS–DRG (the categories are no CC, a nonmajor CC, or a major CC). A more detailed description of the acute IPPS, including

payment adjustments, can be found at <http://www.medpac.gov/documents/payment-basics/hospital-acute-inpatient-services-payment-system-15.pdf?sfvrsn=0>.

Hospital outpatient prospective payment system

The outpatient prospective payment system (OPPS) pays hospitals a predetermined amount per service. CMS assigns each outpatient service to 1 of about 700 ambulatory payment classification (APC) groups. Each APC has a cost-based relative weight, and a conversion factor translates these relative weights into dollar payment amounts. In 2014, CMS started to package additional laboratory tests (previously paid separately under the clinical laboratory fee schedule) into the services covered under the OPSS. CMS estimated that this change shifted \$2.4 billion of payments from the laboratory fee schedule to the outpatient fee schedule. In 2015, CMS implemented comprehensive ambulatory payment classifications (C–APCs) in the OPSS and expanded packaging in some APCs. A more detailed description of the OPSS can be found at <http://www.medpac.gov/documents/payment-basics/outpatient-hospital-services-payment-system-15.pdf?sfvrsn=0>.

Are Medicare payments adequate in 2016?

To judge whether payments in 2016 are adequate for relatively efficient hospitals, we examine several indicators of payment adequacy. We consider beneficiaries’ access to care, changes in the quality of care, hospitals’ access to capital, and the relationship of Medicare’s payments to hospitals’ costs for both average and relatively efficient hospitals. Most of our payment adequacy indicators for hospitals are positive, but 2014 Medicare margins remained negative for most hospitals and were approximately zero for relatively efficient providers.

Beneficiaries’ access to care remained good as excess inpatient capacity increased

To evaluate access to care, we examine the availability of hospital services to Medicare beneficiaries by analyzing inpatient and outpatient utilization, hospital service offerings, hospital openings and closures, hospital occupancy rates, and other measures. Our framework also includes an evaluation of hospitals’ access to capital, which provides an outlook on the industry’s ability to sustain or expand its existing resources.

Medicare beneficiaries' access to hospital services remains good, in part because of excess hospital capacity in most markets. Between 2013 and 2014, inpatient discharges per Medicare beneficiary declined 3.6 percent; from 2006 to 2014, the drop in discharges totaled 19.9 percent (Figure 3-1). Inpatient volume declined more rapidly at rural hospitals than urban hospitals. Between 2013 and 2014, the number of inpatient discharges declined by 3.9 percent at urban hospitals and by 6.7 percent at rural hospitals. Rural hospitals with fewer than 50 beds had an 8.4 percent decline in discharges (data not shown).

From 2013 to 2014, the volume of inpatient services declined approximately 2 percent to 7 percent across all Medicare age groups. Among privately insured individuals under age 65, acute inpatient discharges per capita declined by 3.8 percent in 2012, 2.8 percent in 2013, and 2.7 percent in 2014 (Health Care Cost Institute 2015). This trend suggests that care patterns are changing for all insured patients, not just Medicare beneficiaries. On a combined basis (called adjusted discharges), total inpatient and outpatient volume across all payers was roughly flat from 2013 to 2014. In 2015, there are some reports of modest increases in inpatient volume for Medicare and non-Medicare services, suggesting that the decline in inpatient volume through 2014 may have paused (Census Bureau 2015, Moody's Investors Service 2015b, Morningstar Document Research 2015a, Morningstar Document Research 2015c).

The growth in outpatient hospital services in part reflects incentives to shift patients to higher cost sites of care

From 2013 to 2014, the use of outpatient services increased by 3.7 percent per Medicare FFS Part B beneficiary; over the past eight years, the cumulative increase was 44 percent. Approximately one-quarter of the growth in outpatient volume in 2014 was due to an increase in the number of evaluation and management (E&M) visits billed as outpatient services. This growth in part reflects hospitals purchasing freestanding physician practices and converting the billing from the physician fee schedule to higher paying hospital outpatient department (HOPD) visits. The conversions shift market share from freestanding physician offices to HOPDs (Table 3-2). From 2012 to 2014, hospital-based E&M visits per beneficiary grew by 16 percent, compared with a 1 percent decline in visits based in physicians' offices. Other categories of services, such as echocardiograms and nuclear cardiology, are also shifting to hospital-based

TABLE 3-2

E&M office visits and cardiac imaging services are migrating from freestanding offices to HOPDs, where payment rates are higher

| Type of service | Share of ambulatory services performed in HOPDs, 2012 | Per beneficiary volume growth, 2012-2014 | |
|--------------------|---|--|-------------------------------|
| | | HOPD | Freestanding physician office |
| E&M office visits | 11% | 16% | -1% |
| Echocardiography | 34 | 15 | -13 |
| Nuclear cardiology | 39 | 1 | -20 |

Note: E&M (evaluation and management), HOPD (hospital outpatient department). In 2012 and 2013, the E&M office visits had Current Procedural Terminology (CPT) codes 99201-99215. In 2014, all facility fees for E&M office visits were billed under a single CPT code, 60463. Echocardiography includes services in ambulatory payment classification (APC) 0269, APC 0270, and APC 0697. Nuclear cardiology includes services in APC 0377 and APC 0398.

Source: MedPAC analysis of standard analytic claims files from 2012-2014.

billing. Hospital-based echocardiograms per capita grew by 15 percent, compared with a 13 percent decline in physician-office echocardiograms. Nuclear cardiology grew by 1 percent in HOPDs, compared with a 20 percent decline in nuclear cardiology in physician offices.

We have documented how the billing for these services has shifted from physician offices to higher cost outpatient sites of care in previous reports (Medicare Payment Advisory Commission 2014d, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012). Among other effects, the shift in care setting increases Medicare program spending and beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in HOPDs than in freestanding offices. For example, we estimate that the Medicare program spent \$1.0 billion more in 2009 and \$1.3 billion more in 2014 than it would have if payment rates for E&M office visits in HOPDs were the same as freestanding office rates. Analogously, beneficiaries' cost sharing was \$260 million higher in 2009 and \$325 million higher in 2014 than it would have been because of the higher rates paid in HOPD settings.²

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission recommended adjusting OPSS payment rates so that Medicare payment for E&M office visits is equal in freestanding physician offices and HOPDs (Medicare Payment Advisory Commission 2012). The Commission also recommended adjusting OPSS payment rates for a set of other services so that payment rates are equal or more closely aligned across these two settings (Medicare Payment Advisory Commission 2014d). In 2015, the Congress moved partially toward the Commission's recommendations by equalizing rates between new off-campus HOPDs and physician offices. However, on-campus HOPDs as well as existing off-campus HOPDs will continue to receive the higher HOPD facility fees under the Bipartisan Budget Act of 2015.

Part of the decline in discharges and growth in outpatient services is due to increased use of observation services as a substitute for inpatient care

From 2006 to 2014, the number of outpatient observation stays increased by 30 stays per 1,000 beneficiaries. In contrast, the number of 1-day inpatient stays declined by 17 stays per 1,000 beneficiaries, and stays with 2 or more days declined by 55 stays per 1,000 beneficiaries. Given that observation stays increased by 30 stays and inpatient stays declined by 72 stays (17 + 55) per 1,000 beneficiaries, we conclude that about 40 percent of the decline in discharges over this period can be explained by the shift of some cases from inpatient stays to observation stays over the past 8 years.

Excess capacity varies by region

Between 2006 and 2013, hospital occupancy rates declined from approximately 64 percent to 61 percent nationwide. Between 2013 and 2014, occupancy rates were largely unchanged overall, as were rates of 64 percent for urban hospitals. However, between 2013 and 2014, rates at rural hospitals declined 1 percentage point, to 41 percent. Rural hospitals with fewer than 100 beds had the lowest occupancy rates in 2014, at 37 percent. Occupancy rates declined the most for small rural hospitals (9 percentage points from 2006 to 2014), suggesting that individuals from rural areas often bypass small rural hospitals and travel to urban hospitals for inpatient care.

Bed capacity and service use continues to vary by market. The 10 major metropolitan areas with the lowest number of beds per capita had an average occupancy rate of 68

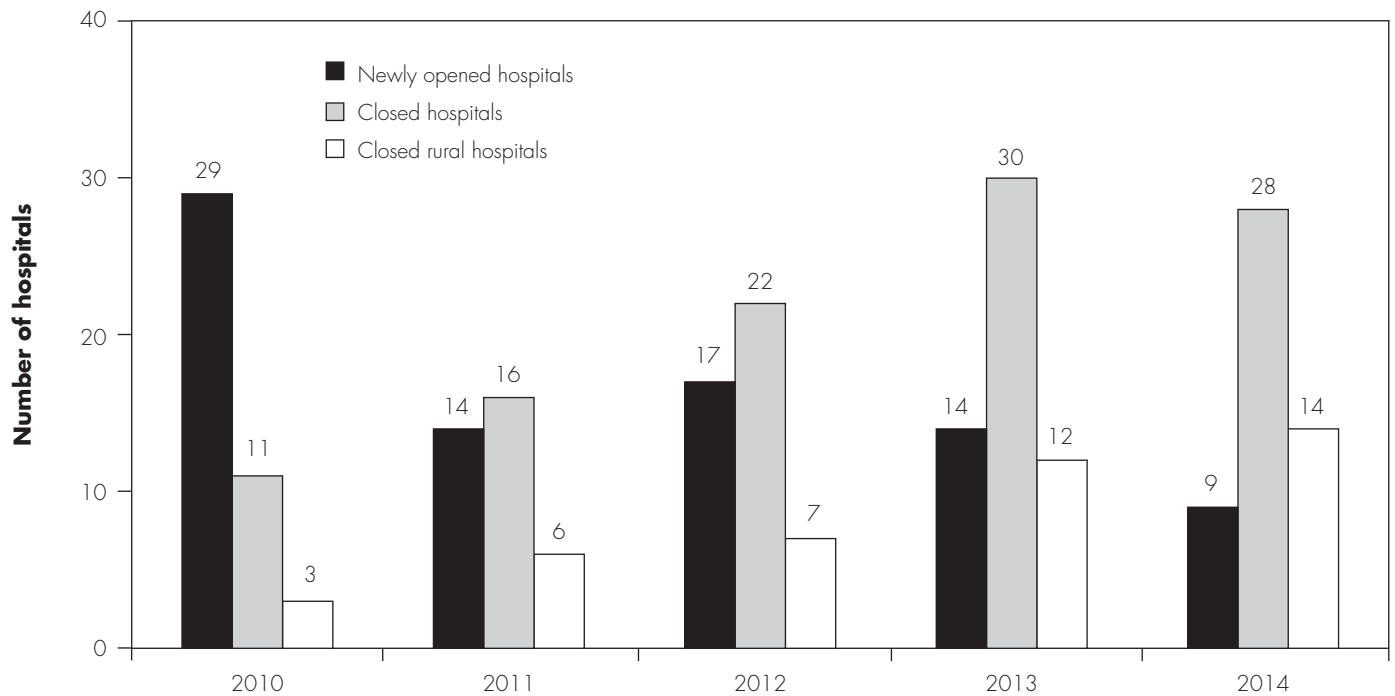
percent, and the 10 markets with the highest number of beds per capita had an average occupancy rate of 61 percent. For example, in 2014, the market-wide occupancy rate in Atlanta (with 1.8 beds per 1,000 people) was 72 percent compared with 55 percent in St. Louis, MO (with over 3.4 beds per 1,000 people). In 2013, there were 319 stays and 1,631 inpatient days per 1,000 beneficiaries in the St. Louis hospital referral region (HRR) compared with 260 stays and 1,451 days per 1,000 beneficiaries in the Atlanta HRR. The difference in inpatient volume per capita reflects a combination of differences in beneficiary health status and physician practice styles across the two markets.

As occupancy fell, hospital closures increased slightly

There have been slightly more hospital closures than hospital openings over the past four years. In 2014, we identified 28 closures and 9 openings (Figure 3-2). Among those that closed in 2014, 14 were in urban counties and 14 were in rural counties. All nine openings were urban.

Hospitals that closed in 2014 were smaller than average and had low occupancy and poor profitability; a large share were located in states that did not expand their Medicaid program in recent years. These 28 hospitals had an average of 55 inpatient beds. The urban hospitals that closed were an average of 9 miles from the nearest hospital, and the rural hospitals were an average of 18 miles from the nearest hospital. Twenty of the 28 hospitals (71 percent) that closed were in states that did not expand their Medicaid programs under PPACA. In addition, among all the hospitals that closed, 20 closed completely and 8 remained open as different types of facilities: 3 as outpatient centers with 24-hour per day emergency departments (2 rural and 1 urban), 2 as urgent care centers, 2 as outpatient facilities with long-term care capacity, and 1 as a clinic.

The hospitals that closed in 2014 had low occupancy rates and poor margins. The average occupancy rate of these 28 hospitals was 25 percent, and their average total all-payer margin in the most recent year available was -5.6 percent. Among the urban hospitals that closed, the average occupancy rate was 32 percent in the year before closure, and the average all-payer margin was -8.0 percent. Among the rural hospitals that closed in 2013, the average occupancy rate was 19 percent, and the average all-payer margin was -3.6 percent. The seven critical access hospitals that closed had average occupancy rates of 24 percent and an average total all-payer margin of -4.2 percent.

**FIGURE
3-2****Hospitals opened and closed, including rural, by year**

Note: Counts of closed hospitals include the rural hospital closures.

Source: MedPAC analysis of the CMS Provider of Services file, internet searches, and personal communication with Sara Young of the Office of Rural Health Policy.

To date, we have identified 10 hospitals that closed in 2015. Among these were six urban hospitals and four rural hospitals. While this count is preliminary, it appears that these 10 hospitals have characteristics similar to the hospitals that closed in 2014, including 2 that remained open as outpatient facilities with emergency departments.

Preserving emergency services as inpatient volumes decline in rural areas

From January 2013 through October 2015, there were 30 rural hospital closures, 41 if we include the hospitals located in rural portions of urban counties (Young 2015). These closures raise questions about whether there are more efficient and financially stable ways to ensure access to emergency services in these communities. One option for these types of communities could be payment models that are focused on outpatient access rather than maintaining inpatient services (Thompson 2015). In the fall of 2014, the Commission started to discuss alternative models for preserving access to care at rural hospitals, and we will continue to investigate new models. The objective is to create models that can do a better job preserving access

and do more to improve the efficiency of care delivered in rural areas. Meeting these objectives involves targeting communities that would otherwise lack emergency care and developing payment models to support emergency and primary care services in these communities.

Quality of care has been improving

The quality of hospital care has been improving in recent years, and at least part of this improvement appears to be due to financial incentives in the Medicare program. While the financial incentives are not perfect and the Commission has discussed refinements to the quality improvement programs, the data suggest that even imperfect incentives can lead to improved quality.

In 2016, hospitals' performance on quality metrics has the potential to increase base IPPS payment rates by as much as 3.0 percent and lower payments by as much as 5.75 percent. Three payment adjustments are responsible for these potential changes: the Hospital Readmissions Reduction Program (HRRP) (can account for up to a 3.0 percent reduction), the Hospital Value-Based Purchasing

**TABLE
3-3**

Potentially preventable readmission rates have declined

| Reason for initial admission | 2010 | 2011 | 2012 | 2013 | 2014 | Percentage point change, 2010-2014 |
|------------------------------|-------|-------|-------|-------|-------|------------------------------------|
| All | 12.9% | 12.4% | 11.9% | 11.3% | 11.0% | -1.9 |
| AMI | 17.3 | 16.9 | 16.1 | 15.0 | 14.3 | -3.0 |
| Heart failure | 19.5 | 19.2 | 18.4 | 17.6 | 17.0 | -2.5 |
| Pneumonia | 13.1 | 12.6 | 12.1 | 11.5 | 11.5 | -1.6 |
| COPD | 16.8 | 16.5 | 15.9 | 15.1 | 14.7 | -2.1 |

Note: AMI (acute myocardial infarction), COPD (congestive obstructive pulmonary disease). Rates are adjusted for changes in the mix of patients.

Source: MedPAC analysis of 2010 through 2014 Medicare claims data and 3M™ potentially preventable readmissions software.

(VBP) Program (between a 3.0 percent increase and a 1.75 percent reduction to payments), and the Hospital-Acquired Condition (HAC) Reduction Program (a 1.0 percent reduction to payments for 25 percent of hospitals). While these adjustments have the potential to change inpatient payments, they do not alter outpatient payments. In 2016, about a quarter of hospitals will see a net increase in payments (averaging about \$70,000) and two-thirds will see a net decrease in payments (averaging around \$380,000) under the combined effect of these programs. On net, these three programs lower Medicare payments by about \$780 million, or 0.5 percent of overall Medicare payments.³

Overall hospital quality metrics show improvement

To assess aggregate trends in quality of care across all IPPS hospitals, we use mortality rates and patient safety indicators (PSIs) that are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ). Our analysis of these measures from 2010 through 2014 shows significant improvements in 8 of 10 mortality rate measures, which include in-hospital and 30-day postdischarge mortality rates for 5 prevalent clinical conditions.⁴ We also found improvements in some of the AHRQ PSIs, but only one measure’s improvement was statistically significant. It is difficult to get statistically significant changes for rare patient safety events.

The quality improvements reflect the efforts hospitals have made to improve patient outcomes, but also reflect the closure or restructuring of some of the poorest performing hospitals. In 2014, we examined 112 hospitals that had a combination of low occupancy, high readmission rates,

and poor patient experience from 2009 through 2011 (Medicare Payment Advisory Commission 2014d). By 2015, 13 of the 112 hospitals closed, a quarter of the hospitals changed ownership, and others replaced their facilities. This finding is consistent with a recent study that suggests market share is flowing to higher quality hospitals (Chandra et al. 2015).

Readmission rates declining The Congress enacted a Medicare HRRP in 2010, and since that time the program has expanded to include more conditions. Penalties under the HRRP started in fiscal year 2013, based on three conditions, with the maximum penalty capped at 1 percent.⁵ In fiscal year 2016, hospitals are penalized if they have above-average readmission rates (from a prior three-year period (July 1, 2011, through June 30, 2014)) in one of five clinical conditions (acute myocardial infarction (AMI), heart failure, pneumonia, congestive obstructive pulmonary disease (COPD), or elective total hip or knee replacement). As stated earlier, HRRP is capped at a 3 percent reduction to base inpatient payments. In fiscal year 2017, readmission rates for coronary graft bypass surgery will be added to the program.

In 2016, 78 percent of hospitals will have payments reduced due to the HRRP, with 15 percent receiving a penalty of between 1 percent and 3 percent of base payments. While a larger share of major teaching hospitals (91 percent) and hospitals serving large shares of poor patients (86 percent) receive a readmission penalty, only 12 percent of these facilities are receiving a penalty of 1 percent or more. A large share of hospitals will receive an HRRP penalty in 2016 because a hospital needs to have an above-expected rate for only one of the five conditions to receive

Increase in observation stays is only a small factor contributing to decline in readmissions

Some have contended that the decline in readmissions can be largely attributed to the rapid increase in the use of observation stays (Himmelstein and Woolhandler 2015). However, the Commission analyzed the increase in observation stays and decline in readmissions; we found that readmission rates declined substantially even after adjusting for observation stays. For the three conditions covered by the Hospital Readmissions Reduction Program in 2013, readmission rates dropped by more than one percentage point from 2011 to 2013, even after counting observation stays as readmissions. In general, only 20

percent to 25 percent of the decline in readmissions can be accounted for by increased use of outpatient observation stays of one day or longer. Moreover, growth in use of 24-hour-plus observation stays occurring within 30 days of discharge from a hospital (22.2 percent) was essentially the same as the overall per capita growth rate in 24-hour-plus observation stays from 2011 to 2013 (22.1 percent). Thus the increased use of observations was not systematically higher for patients with a prior admission than for the Medicare population overall. ■

a penalty. While most hospitals face a penalty, the average penalty was a modest \$160,000 per hospital in 2016. Total penalties are expected to be \$420 million in 2016.⁶

In 2013, the Commission suggested several improvements to the HRRP. One called for setting a fixed target for readmission rates so aggregate penalties would go down when industry performance improves. We also suggested using an all-condition readmission measure to increase the number of observations and reduce the random variation that single-condition readmission rates face under current policy. A third improvement would be to evaluate hospitals' readmission rates against rates for peer hospitals with similar shares of poor patients as a way to adjust penalties for the possible effects of socioeconomic status on hospitals' readmission rates (Medicare Payment Advisory Commission 2013a).

The readmission reduction payment policy and other efforts, such as the Partnership for Patients, have encouraged hospitals to look beyond their walls to improve care coordination with providers outside of the hospital to reduce readmissions. The Commission has found that readmission rates continued to fall through 2014, including for the three conditions initially included in the HRRP (Table 3-3). From 2010 to 2014, potentially preventable readmissions declined by 1.9 percentage points across all cases, after adjusting for changes in the mix of patients. Potentially preventable readmission rates dropped 3.0 percentage points for AMI, 2.5 percentage points for heart failure, and 1.6 percentage points for pneumonia. Readmission rates for COPD (which was

added to the program in 2015) fell 2.1 percentage points between 2010 and 2014. Increases in the use of 24-hour-plus observation care account for only a small portion of the drop in readmission rates, meaning that care (not just coding) is improving (see text box).

Hospital value-based purchasing incentives are increasing

The Congress mandated a value-based purchasing (VBP) program for IPPS hospitals beginning in fiscal year 2013. Under the program, CMS reduces all IPPS hospitals' base operating diagnosis related group payment amounts by 1.75 percent in fiscal year 2016 (2.0 percent in 2017) to create a pool of funds from which the performance-based VBP incentive payments will be distributed.⁷ As required by law, the hospital VBP program is budget neutral; that is, the pool of withheld payments must be redistributed to hospitals based on their performance on the VBP program's quality measures.

In 2016, the VBP program will redistribute approximately \$1.5 billion in Medicare inpatient payments (Centers for Medicare & Medicaid Services 2015a). The program uses a combination of measures from 4 quality domains to develop hospital scores under the program:

- 10 percent based on clinical process-of-care measures using hospitals' reported patient safety indicators;
- 25 percent based on patient experience of care using 8 measures from the Hospital–Consumer Assessment of Healthcare Providers and Systems® (H–CAHPS®) survey;

- 40 percent based on patient outcomes, which are assessed using a combination of three 30-day mortality measures, a composite patient safety measure (AHRQ's PSI 90)⁸, and four health care associated infections; and
- 25 percent based on efficiency measures, which use a 30-day Medicare measure of spending per beneficiary.

The VBP program gives a hospital credit for achievement (relative to other hospitals) and improvement (relative to its own base-line performance). Some of the quality metrics included in the VBP program overlap with other quality programs, particularly the Hospital-Acquired Condition Reduction Program, which is discussed next.

In 2016, the VBP program will increase payments to 56 percent of IPPS hospitals (by an average of \$80,000) and will decrease payments to 37 percent of them (by an average of \$120,000). For roughly a third of these hospitals, the change in payments under the program will be small, less than 0.25 percent of base payments. However, 10 percent will see an increase of between 1 percent and 3 percent, and another 10 percent will see a decrease of more than 0.5 percent. Performance under the VBP program varies by hospital group, with 35 percent of major teaching hospitals receiving rewards compared with 63 percent of nonteaching hospitals. Further research is needed to evaluate reasons for the differences across hospital groups.

Hospital-Acquired Condition Reduction Program implemented in 2015 The Congress mandated the Hospital-Acquired Condition Reduction Program to begin in fiscal year 2015. Under this program, Medicare reduces hospitals' inpatient payments by 1 percent for hospitals whose performance on a set of hospital-acquired condition (HAC) measures defined by CMS ranks in the lowest performing quartile nationally. The 1 percent reduction applies to total inpatient payments, including indirect medical education (IME), DSH, and other quality payment adjustments (readmissions and hospital VBP). This program is not budget neutral because it reduces payments by 1 percent for 25 percent of all hospitals.

The HAC program measures hospitals in two domains. In the first domain, hospitals' overall performance is examined in terms of a blended set of eight patient safety indicators (AHRQ's PSI 90), including pressure ulcers, various postoperative complications, and certain hospital-acquired infections. The second domain includes four infection measures: central line-associated bloodstream

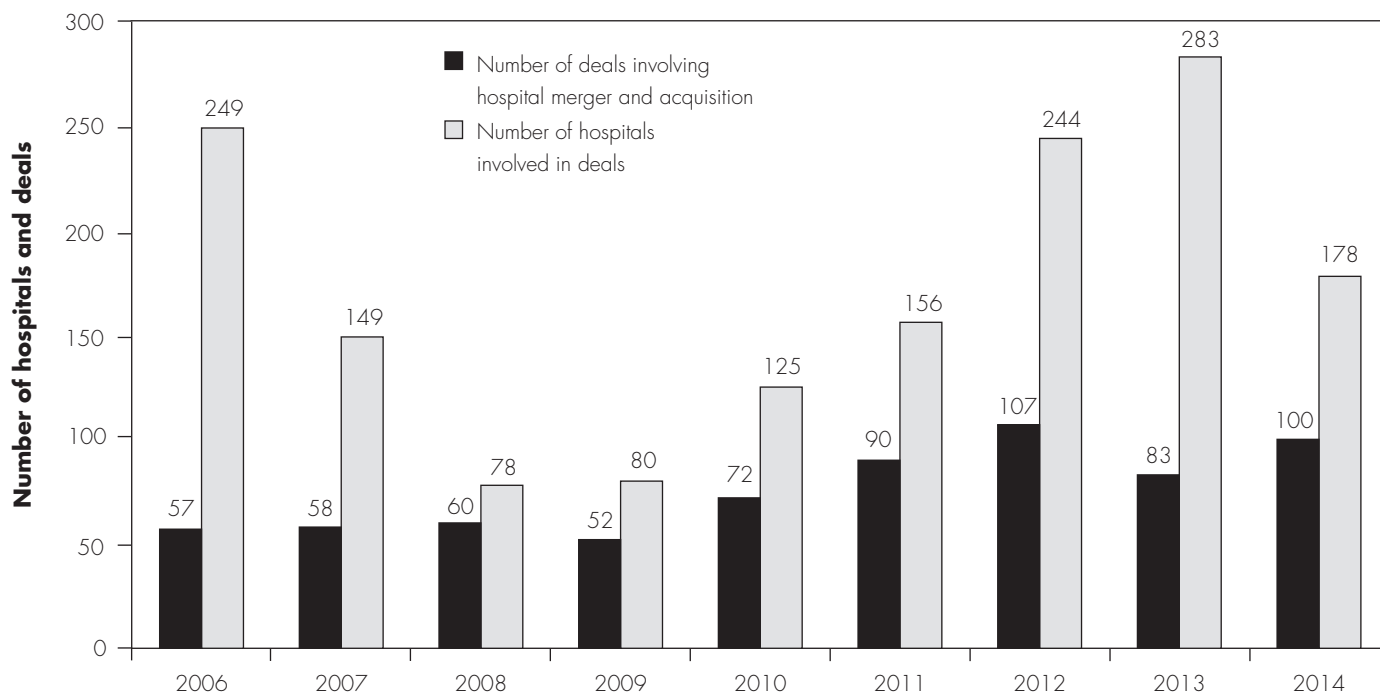
infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), and surgical site infections (SSIs) for colon and hysterectomy surgeries.⁹ The patient-safety domain is given a weight of 25 percent in fiscal year 2016, and the infection measures are given a weight of 75 percent.¹⁰ The HAC measures are also included in the patient outcome domain in the hospital VBP program. The fiscal year 2016 HAC penalty is based on performance data from 2012 to 2014. In 2016, the HAC program will reduce payments to 735 hospitals (25 percent), with penalties totaling around \$360 million, or an average of almost \$500,000 per penalized hospital. Penalties will vary by type of hospital, with 46 percent of major teaching hospitals receiving a penalty compared with an average of 25 percent across all hospitals. This variance may in part reflect types of cases (e.g., intensive care unit cases) and procedures (e.g., surgical cases) that occur more frequently in major teaching hospitals.

Hospitals have been successful in reducing the number of HACs. An AHRQ study found a 17 percent decline in HACs per 1,000 discharges from 2010 to 2013. This study also found that approximately 50,000 fewer patients died in the hospital as a result of the reduction in HACs, and approximately \$12 billion in health care costs were saved from 2010 to 2013 (Agency for Healthcare Research and Quality 2014). Similarly, data from the Centers for Disease Control and Prevention demonstrate substantial declines in hospital-associated infections from 2008 to 2013, including a 46 percent decline in CLABSIs and a 19 percent decline in SSIs for 10 procedures collectively (Centers for Disease Control and Prevention 2015).

The Commission has expressed concern that the current statutory design of the HAC Reduction Program penalizes 25 percent of hospitals every year, even if all hospitals significantly reduce HAC rates (Medicare Payment Advisory Commission 2013a). Similar to the Hospital Readmissions Reduction Program, a fixed performance target may improve the HAC program by creating an incentive for all hospitals to decrease HACs to at least the benchmark rate to avoid the payment penalty.

Access to capital and hospital employment strong

Hospitals' access to capital remained strong due to hospitals' unusually high levels of profitability and continued low interest rates in recent years. The three major bond rating agencies report improved financial measures such as days-cash-on-hand, the ratio of revenues to expenses, and the cash-to-debt ratio (Fitch Ratings

**FIGURE
3-3****Hospital merger and acquisition activity increased**

Source: MedPAC analysis of 2014 data from Irving Levin Associates Inc.

2015a, Moody's Investors Service 2015b, Standard & Poor's Ratings Services 2015). The agencies cite improvements in all-payer volumes due to pent-up demand, the aging population, and the general expansion of insurance coverage. In addition, Moody's reports the self-pay share of hospital patients declined from 7.7 percent in 2013 to 6.9 percent in 2014 (Moody's Investors Service 2015a).

Thomson Reuters found that, through the first three quarters of 2015, hospitals issued \$22 billion dollars in bonds, surpassing the \$17 billion of bond offerings in 2014 levels. The rebound of bond offerings in 2015 reflects hospitals' strong financial position and continuing low interest rates. The average interest rate for a double-A tax-exempt 30-year nonprofit hospital bonds remain low, at 3.63 percent in October 2015 (Cain Brothers 2015). This rate is approximately the same level as November 2014 (3.70).

The level of bond offerings may remain below the historic highs seen earlier in the decade (\$30+ billion) because nonprofit hospitals are focused on less expensive

capital investments such as outpatient and ambulatory capacity and information technology, as opposed to more costly inpatient capacity (Fitch Ratings 2015b). The shift from building inpatient capacity to outpatient and other ambulatory capacity reduces hospital debt and the need to borrow. As a result, measures of hospital capital expenditures from 2013 to 2014 show a decline (Fitch Ratings 2015b, Moody's Investors Service 2015b).

Capital continues to be available for acquisitions (Figure 3-3). In 2014, 178 individual hospitals were acquired in 100 transactions, sustaining the high level of transactions in recent years (Irving Levin Associates Inc. 2015). In general, many smaller community hospitals merged with or were acquired by larger health systems. For example, Duke LifePoint Healthcare acquired the three hospitals that were part of the Conemaugh Health System in central Pennsylvania for \$500 million, and University of Wisconsin Health acquired two hospitals that were part of the Swedish American Health System in Rockford, Illinois, for \$255 million (Irving Levin Associates Inc. 2015). The most active acquirer in 2014 was Prime Healthcare Services, which acquired eight hospitals with

1,609 beds in seven separate deals. These deals differed from those that occurred in 2013, which featured large corporations such as Tenet and Community Health System acquiring other large hospital companies in billion-dollar deals. The long-term trend is greater consolidation in the industry, with independent hospitals joining larger systems.

Construction spending steady and changing

Annualized hospital construction spending was \$26 billion through July 2015, a \$3 billion increase from 2014 but lower than the \$31 billion in average annual spending from 2008 to 2012. Spending declined because hospitals are now focused more on building outpatient capacity than on expensive inpatient capacity. Based on a survey of nonprofit hospital executives, Fitch reported that executives' top capital investment priorities are information technology, clinics, and outpatient capacity (Fitch Ratings 2015b).

Hospital employment increased

Between October 2010 and October 2015, the number of individuals employed by hospitals increased 6 percent, with more than half of this growth occurring in the last 12 months. Growth in hospital employment over the last 12 months (3.5 percent) was faster than the rest of the health care sector (3.3 percent) and the rest of the economy excluding health care (1.9 percent). In their third quarter 2015 financial statements, three of the largest hospital entities—HCA, Tenet, and Lifepoint—indicated that they have seen some volume increases and have increased hiring. HCA noted that those entities have increased use of higher cost contract nurses (Morningstar Document Research 2015a, Morningstar Document Research 2015b, Morningstar Document Research 2015c). This increased demand for nurses could start to push wages higher.

Based on data from a separate Bureau of Labor Statistics (BLS) survey that best corresponds to the period described above, we observed hospitals hiring individuals in certain high-skill occupational categories and reducing the number of individuals in certain lower skilled occupations. Occupations that experienced the largest increase in hospital employment from 2010 to 2014 were physicians (26 percent), computer specialists (18 percent), pharmacists (12 percent), business and financial occupations (11 percent), and diagnostic imaging technicians (5 percent). By contrast, BLS reported declines in hospital employment for licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) (–30

percent), food service employees (–5 percent), building and grounds employees (–5 percent), and clinical lab technicians (–2 percent). While the number of LPNs and LVNs employed by hospitals declined by 44,000 (–30 percent), the number of registered nurses increased by 39,000 (3 percent).

Medicare payments and providers' costs

In assessing payment adequacy, the Commission also considers the relationship between Medicare payments and the costs of providing care to Medicare patients. We assess the adequacy of Medicare payments for the hospital as a whole (across all Medicare services), thus measuring the relationship between payments and costs using an overall Medicare margin. This overall margin includes all Medicare payments and all Medicare-allowable costs for the six hospital departments covered by the inpatient, outpatient, and post-acute PPS systems as well as uncompensated care payments and graduate medical education payments and costs.¹¹

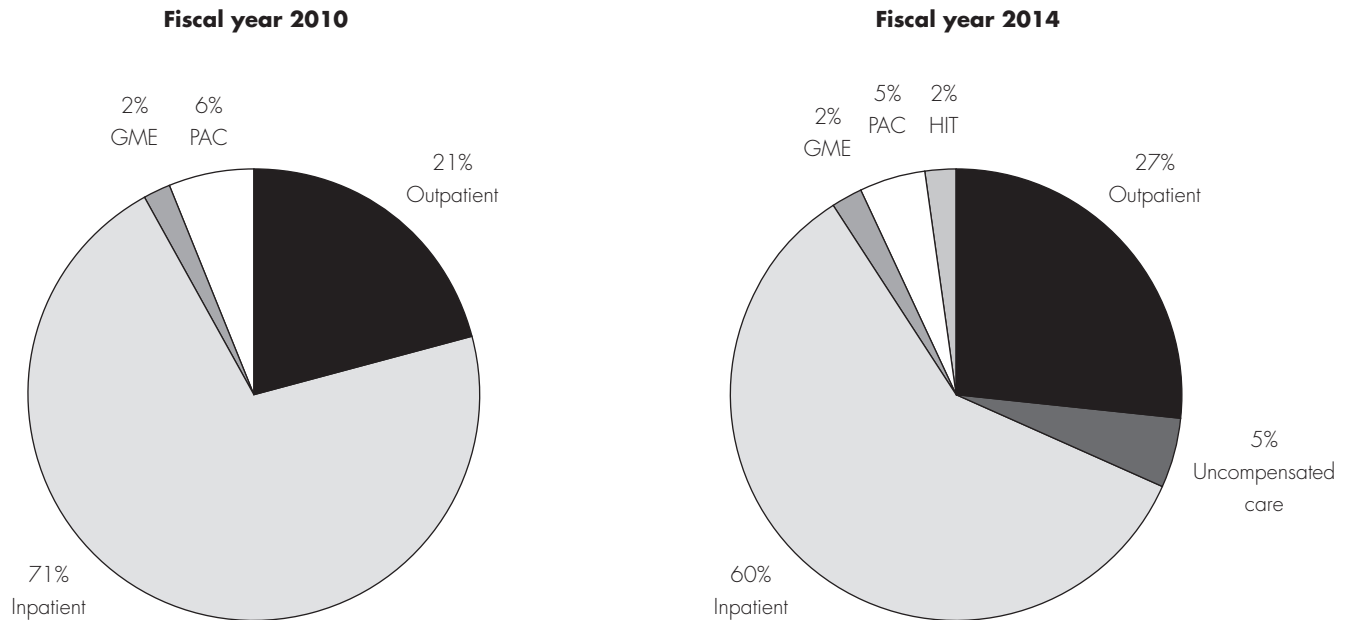
We report the overall Medicare margin across service lines because no hospital service is a purely independent business. For example, we find that operating a skilled nursing facility (SNF) improves the profitability of acute inpatient care services because an in-hospital SNF allows hospitals to safely discharge patients sooner from their acute care beds, thus reducing the cost of the inpatient stay. The overall Medicare margin also takes into account revenues that are not included in the service-line payments for inpatient and outpatient care. These revenues include Medicare payments for health information technology (beginning fiscal year 2011) and uncompensated care payments (beginning fiscal year 2014). Excluding these Medicare revenues would understate Medicare payments to hospitals.

Another benefit of focusing on overall margins is that we can avoid challenges of precisely allocating overhead and administrative costs among the different service lines. We also capture the additional Medicare revenues hospitals receive that are not included in Medicare payment rates for individual services (e.g., uncompensated care payments and electronic health records incentive payments).

To determine whether hospitals have an incentive to treat additional Medicare patients, we also examine the marginal profits for treating additional Medicare patients. This measure examines whether Medicare payments cover the variable cost of treating an additional Medicare patient. We find that, while Medicare payments do not cover all costs

**FIGURE
3-4**

Share of revenue from inpatient services has declined



Note: GME (graduate medical education), PAC (post-acute care), HIT (health information technology). The uncompensated care payments that were started in 2015 are payable only to hospitals serving a disproportionate share of poor patients. The uncompensated care payments are funded through a reduction in traditional disproportionate share payments to these hospitals. There were no HIT payments in 2010.

Source: MedPAC analysis of Medicare hospital payments using hospitals cost reports.

(fixed and variable), they are sufficient to cover the variable costs of treating additional Medicare patients. This measure is an indicator of whether hospitals with excess capacity have an incentive to see more Medicare patients.

To measure the overall pressure that hospitals are under to control costs, we also examine hospital total (all-payer) profit margins and hospital cash flows. When total margins and cash flows are strong, hospitals are under less pressure to control their costs, which in turn affects their Medicare margin.

The source of Medicare revenues to hospitals has shifted

Historically, 92 percent of Medicare revenues to hospitals have come from inpatient and outpatient services. Over time, however, the share of revenue coming from the outpatient setting has increased, and the share coming from the inpatient setting has decreased (Figure 3-4). From 2010 to 2014, the share of revenues coming from

the outpatient setting increased from 21 percent to 27 percent. The increase resulted from several changes: a shift in services from the inpatient to the outpatient setting, a general increase in beneficiary outpatient service use, a shift in the billing of physician office services from the physician fee schedule to the OPSS, and changes made to the outpatient payment system that packaged many lab services into outpatient payment rates that were previously paid on a fee schedule rather than the OPSS.¹²

The share of revenues coming from the inpatient side fell from 71 percent in 2010 to 60 percent in 2014. This decline results from (1) a shift in services from the inpatient setting to the outpatient setting, as just discussed, and (2) changes in Medicare DSH payments. Starting in fiscal year 2014, Medicare DSH payments (which are included in inpatient payments) are paid at 25 percent of the historical payment formula that uses the hospitals' current low-income patient share percentage. This decrease in inpatient DSH payments, however, is offset

**TABLE
3-4**

Cost growth slightly above input price inflation since 2010

| Cost measure | Annual cost growth | | | | | Average annual cost growth 2010-2014 |
|-------------------------------|--------------------|------|------|------|------|--------------------------------------|
| | 2010 | 2011 | 2012 | 2013 | 2014 | |
| Inpatient costs per discharge | 2.2% | 2.6% | 3.0% | 2.9% | 2.2% | 2.6% |
| Inpatient case-mix index | 0.6 | 0.5 | 1.4 | 2.0 | 2.0 | 1.3 |
| Input price inflation* | 2.0 | 2.6 | 2.1 | 1.9 | 1.7 | 2.1 |

Note: Cost growth numbers are not adjusted for reported changes in case mix. Analysis excludes critical access hospitals and Maryland hospitals.
*Input price inflation reflects a weighted average of changes in the hospital operating and capital market basket indexes.

Source: MedPAC analysis of Medicare cost reports, claims files, and input price estimates from CMS.

in large part by a new payment for uncompensated care costs (accounting for 5 percent of Medicare revenues in 2014) that goes to DSH hospitals. The uncompensated care payments, however, are not tied to hospitals' Medicare inpatient payment rates or case volume. They were intended to be allocated to DSH hospitals based on each hospital's share of total uncompensated care costs, but they are currently being distributed based on each DSH hospital's share of total Medicaid and low-income Medicare patient days (see text box on DSH payments, pp. 72-73).

The additional temporary payments that hospitals have received as a part of the Medicare Electronic Health Records (EHR) Incentive Program also increased total Medicare payments. Between 2011 and 2014, Medicare EHR payments rose from \$0.7 billion to \$3.2 billion, and in 2014 they totaled \$2.5 billion, accounting for almost 2 percent of total Medicare payments to IPPS hospitals in 2014.¹³ HIT payments (under the EHR Incentive Program), however, will gradually decline as this program phases out.

Medicare payment growth

Changes in Medicare inpatient hospital payments per discharge under the IPPS depend primarily on three factors: (1) annual updates to base payment rates, (2) changes in reported case mix, and (3) policy changes that are not implemented in a budget-neutral manner. In 2014, the average Medicare inpatient payment per case fell primarily because of reallocating \$9.4 billion of inpatient payments to uncompensated care payments. The key changes to inpatient payments were:

- a 75 percent reduction in the Medicare inpatient DSH payment adjustment, resulting in about a 7 percent reduction in inpatient payments (but with an offsetting increase in uncompensated care payments),
- a 0.7 percent increase in base payment rates,
- a 2 percent increase in case mix, and
- full implementation of the budget sequester, which reduced inpatient payments by 2 percent, 1 percentage point more than in 2013.¹⁴

On net, inpatient payments declined by 4.5 percent per case; however, the reduction in inpatient DSH payments was largely offset in aggregate by a new payment for uncompensated care.¹⁵ (For more details on DSH and uncompensated care payments, see the text box on pp. 72-73.)

Rate of cost growth remains close to rate of input price inflation

Hospitals' per case cost increases have been relatively low since 2010, averaging 2.6 percent over the period, about 0.5 percentage points faster than input price inflation (the hospital market basket index) (Table 3-4). This growth is much slower than that experienced through most of the 2000s, when costs per case increased at twice this rate, an average of 5.6 percent per year, or 1.4 percentage points faster than underlying input price inflation.

The lower cost growth from 2010 through 2014 was partly due to lower input price inflation facing hospitals, reflecting low economy-wide inflation and slow wage growth. Hospitals benefited from this low economy-

wide wage growth, with compensation costs for hospital workers growing by less than 2 percent in each year from 2010 through 2014 (Bureau of Labor Statistics 2014).

From 2012 through 2014, there was also a sizable increase in inpatient case mix, rising by 1.4 percent in 2012 and 2.0 percent in both 2013 and 2014. In examining this recent growth in case mix, we suspect that most of it is due to increases in the relative complexity of the cases seen rather than due to coding changes we saw after implementation of the MS-DRGs. If we control for this sizable increase in case mix, the hospital cost increase for the past three years would be substantially less than underlying input price inflation. The Commission believes it is imperative for hospitals to continue to maintain this lower cost growth in the coming years for the financial health of the Medicare program and the costs of the overall health care system.

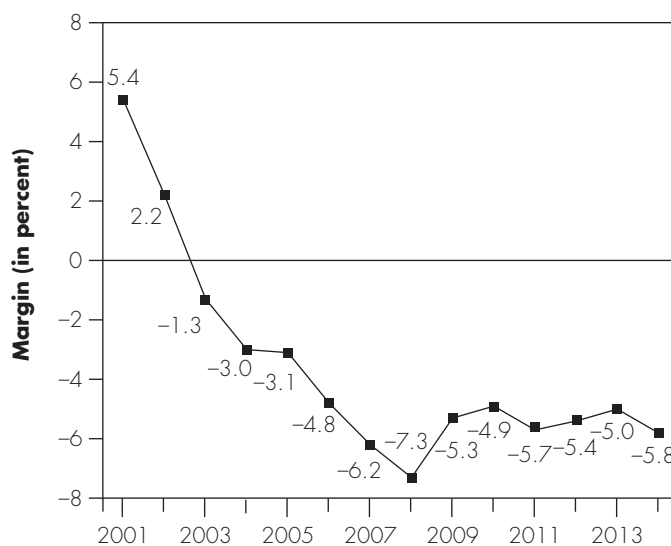
Lower cost growth, however, was not uniform across hospital types. Rural hospitals had much higher cost growth than urban hospitals; from 2010 through 2014, inpatient costs per case increased an average of 3.4 percent in rural hospitals compared with 2.4 percent in urban hospitals. Over the same period, smaller rural hospitals, those under 50 beds, saw even higher average cost increases, 5.4 percent. Some of the rural hospitals' higher cost growth may have been driven by the higher revenues associated with the low-volume adjustment, which provided rural hospitals with higher payments; these payments may have eased the financial pressure on some of these hospitals, resulting in higher cost growth. In addition, total inpatient volume in rural hospitals declined more than in urban hospitals, possibly contributing to higher cost growth because of reduced economies of scale. During this same period, urban hospitals with the fewest total discharges also saw much higher cost growth, averaging 4.2 percent, compared with the highest volume urban hospitals, for which cost growth averaged 2.3 percent. Hospitals with lower levels of uncompensated care also had higher average cost growth, at 3.4 percent.

Trend in the overall Medicare margin

We define Medicare margins as Medicare payments minus the allowable costs of treating Medicare patients divided by Medicare payments. In analyzing hospital margins, we compute margins with and without critical access hospitals (CAHs), which are 1,300 rural hospitals whose payments are based on their incurred costs. We also exclude hospitals in Maryland, which are excluded from the IPPS and paid under a statewide all-payer prospective payment system. The overall Medicare margin trended downward

FIGURE 3-5

Overall Medicare margin has held relatively steady since 2009



Note: A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Analysis excludes critical access and Maryland hospitals. "Overall Medicare margin" covers acute inpatient, outpatient, hospital-based skilled nursing facility (including swing beds), hospital-based home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments and Medicare payments for uncompensated care.

Source: MedPAC analysis of Medicare cost reports from CMS.

from 2001 through 2008 (Figure 3-5).¹⁶ However, from 2008 to 2010, the overall Medicare margin went up, from -7.3 percent to -4.9 percent, largely because of increases in reported case mix—the result of documentation and coding changes hospitals made with the introduction of MS-DRGs in 2008—and lower cost growth as a result of the downturn in the economy from the recession (Medicare Payment Advisory Commission 2013b). From 2009 to 2013, the overall Medicare margin has held relatively steady, varying from -4.9 to -5.7 percent. From 2013 to 2014, it dropped from -5.0 percent to -5.8, its lowest level since 2008 as the full effect of the 2.0 percent sequester took effect in fiscal year 2014.

Despite the budget sequester, Medicare margins have held relatively steady, in part, because CMS overestimated hospital wage inflation. Each year, the hospital update is based on forecast, not actual, input price inflation. In every year from 2012 to 2014, CMS overestimated the market basket, which added over 2 percentage points to hospital

DSH and uncompensated care payments

Disproportionate share (DSH) payments are supplementary inpatient payments given to hospitals with high shares of low-income patients. Uncompensated care payments are payments the Medicare program makes to DSH hospitals to pay for part of their non-Medicare charity care and non-Medicare bad debts. See our March 2014 report for a discussion of the history, literature, and mechanics of DSH and uncompensated care payments.

The Congress made several changes in the DSH payments as part of the Patient Protection and Affordable Care Act of 2010 (PPACA). Beginning in 2014, hospitals that treat a disproportionate share of low-income patients can qualify for two payment adjustments.

- First, hospitals will receive 25 percent of the operating DSH payments they received under the traditional DSH formula. Under the traditional DSH formula, any hospital with a share of low-income patients exceeding 15 percent is eligible to receive operating DSH payments. The low-income patient share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income (SSI) benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. This 25 percent is referred to as the empirically justified Medicare DSH payment, and CMS expects to make \$3.3 billion of these payments in 2016.
- Second, hospitals that qualify for the empirically justified Medicare DSH payment may also receive a share of a fixed pool of dollars referred to as the uncompensated care pool. PPACA stipulated the formula by which the available DSH funds will continue to decline in proportion to the decline in the share of the uninsured population. The rationale is that as the rate of uninsurance declines, hospitals' uncompensated care burdens should also decline.

Due to declines in the rate of uninsurance (resulting from the insurance exchanges and Medicaid expansion), the amount of uncompensated care dollars has been reduced from \$9.4 billion in 2014 to \$7.6

billion in 2015 and down to \$6.4 billion in 2016. This \$3 billion reduction in DSH payments is slightly less than 2 percent of annual Medicare payments to hospitals. We expect only modest reductions in the DSH pool, unless the rate of uninsurance falls more rapidly than is expected. The Congressional Budget Office's current projections for the rate of uninsurance for 2017 (10 percent for those under 65) are close to what the projections were for 2016 (11 percent) (Congressional Budget Office 2015).

For fiscal year 2016, CMS continues to use Medicaid and Medicare SSI days as a proxy for hospitals' uncompensated care costs. Therefore, a DSH hospital's uncompensated care payments will be purely a function of the number of Medicaid and Medicare SSI days at the hospital. About 85 percent of the payments are tied to Medicaid days and 15 percent to Medicare SSI days because Medicaid days are more common. Due to the dominance of Medicaid in the formula, we will emphasize the effect of Medicaid days on payments. In 2016, hospitals receive a fixed payment of \$174 per Medicaid day directly from the Medicare trust fund.¹⁷ In other words, Medicare is directly subsidizing Medicaid.

Medicare subsidizing Medicaid is problematic

Several problems arise when Medicare subsidizes Medicaid. First, if Medicare tells states that it will increase payments when states decrease Medicaid rates, it sends a signal for states to underpay for Medicaid. Second, the Medicaid program already has two special payment policies (upper payment limit payments and Medicaid DSH payments) that are in part designed to cover Medicaid patients' costs that exceed Medicaid fee-for-service (FFS) payment rates. The \$29 billion provided to hospitals under these supplemental payment policies was equivalent to more than 50 percent of base Medicaid FFS rates (Medicaid and CHIP Payment and Access Commission 2015). Having both Medicare and Medicaid cover Medicaid shortfalls could be duplicative. Third, state Medicaid rates vary widely, and in some cases, Medicaid base payments and Medicaid supplemental payments will more than fully fund all Medicaid costs. Fourth,

(continued next page)

DSH and uncompensated care payments (cont.)

costs vary widely across hospitals. Therefore, some “Medicaid shortfalls” may be due to high costs rather than low payment rates, especially after Medicaid supplemental payments are considered. Fifth, CMS sets Medicare FFS rates, and Medicare Advantage (MA) plans often follow these FFS rates; the result is that hospitals receive both \$174 per Medicaid day from the FFS program and additional payments from the MA program. Because MA payments per Medicaid day are not considered when setting Medicare uncompensated care payments, the combined FFS and MA payments per Medicaid day (\$174 + “uncompensated care” payments built into MA rates) are not proportionate to the hospitals’ number of Medicaid days or the Medicaid “shortfall.” (The changes made to Medicare DSH payments are explained in the online appendix to the hospital chapter in our March 2014 report to the Congress, available at <http://www.medpac.gov>.)

One cross subsidy that is expected to continue even with a reform of Medicare’s uncompensated care payments is that Medicare will continue to pay 65 percent of dual-eligible patients’ bad debts. These bad debts are incurred when state Medicaid agencies decline to pay Medicare coinsurance due to Medicare program payments exceeding the base Medicaid rate for a service. Nonpayment of cost sharing by Medicaid programs results in approximately \$1.1 billion of Medicare bad-debt payments to hospitals. In addition, there are over \$3 billion in traditional DSH payments that are tied to Medicaid shares of patients and paid out as a percentage add-on to inpatient payment rates. These traditional DSH payments will continue even if uncompensated care payments start to be distributed based on more accurate measures of uncompensated care.

Rather than have Medicare pay a per diem for each Medicaid day, a better way to fund uncompensated care costs would be to use data from Worksheet S-10 on the Medicare hospital cost reports. Representatives of the hospital industry have stated that CMS needs to move toward using Worksheet S-10 to compute charity care levels, but they have also expressed concerns that the data still need to be refined before they are used. However, we find that S-10 data

(even in their current imperfect state) are a better predictor of audited uncompensated care costs than the Medicaid/SSI proxy being used. We used 2009 audited data that the Medicaid program collects on the cost of caring for the uninsured for each hospital that receives Medicaid DSH payments. While the Medicaid audited uncompensated care data cannot be used for Medicare payment because it is available only for about one-third of Medicare hospitals, it can be used to determine how closely the S-10 data matches audited uncompensated care data. We used 2009 data because it was the most recent data we could obtain from the Medicaid and CHIP Payment and Access Commission, which has compiled CMS DSH audit information from publicly available files into a more readily analyzable format. The S-10 data on uncompensated cost of caring for the uninsured and the Medicaid/SSI days are from 2011.¹⁸ The correlation between audited uncompensated care data and S-10 data was over .80 compared with a correlation of .50 for the Medicaid/SSI measure currently being used.

There are two reasons why Medicaid days are a poor proxy for uncompensated care. First, the Medicaid/SSI proxy assumes hospitals’ relative Medicaid shares are proportional to their relative uncompensated care shares. In contrast, the data show that public hospitals tend to have more uncompensated care than would be predicted based purely on their Medicaid and SSI days. In addition, the Medicaid/SSI days proxy is purely an inpatient measure. It ignores uncompensated care that occurs in the emergency department, which is problematic for rural hospitals that may provide much of their uncompensated care in an outpatient setting and may have relatively few Medicaid inpatient days, especially if they do not offer obstetric care.

Given that the S-10 more closely tracks hospitals’ relative costs of caring for the uninsured, we have urged CMS to transition over three years to using S-10 data and simultaneously continue to revise the S-10 as needed. A three-year transition will prevent financial shocks to hospitals and will create an incentive for them to more accurately report uncompensated care on the S-10. ■

**TABLE
3-5****Overall Medicare margins by hospital type**

| Hospital group | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|--------------------------------|-------|-------|-------|-------|-------|-------|-------|
| All hospitals (excluding CAHs) | -7.3% | -5.3% | -4.9% | -5.7% | -5.4% | -5.0% | -5.8% |
| Urban | -7.4 | -5.4 | -5.2 | -6.0 | -5.8 | -5.7 | -6.0 |
| Rural | | | | | | | |
| Excluding CAHs | -5.9 | -4.2 | -2.8 | -2.7 | -1.3 | 1.4 | -3.6 |
| Including CAHs | -3.9 | -2.7 | -1.7 | -1.4 | 0.3 | 1.9 | -1.9 |
| Nonprofit | -8.5 | -6.6 | -6.3 | -7.2 | -7.0 | -6.5 | -7.4 |
| For profit | -2.7 | -0.2 | 0.0 | -0.3 | 1.1 | 1.3 | 1.0 |
| Major teaching | -2.0 | -0.7 | -0.4 | -1.8 | -2.4 | -3.1 | -4.0 |
| Other teaching | -7.4 | -5.1 | -5.0 | -5.5 | -5.3 | -4.8 | -5.7 |
| Nonteaching | -10.5 | -8.4 | -7.8 | -8.4 | -7.5 | -6.4 | -7.5 |

Note: CAH (critical access hospital). Data are for all hospitals covered by the Medicare acute inpatient prospective payment system in 2014 and for CAHs where indicated. A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. "Overall Medicare margin" covers acute inpatient, outpatient, hospital-based skilled nursing facility (including swing beds), hospital-based home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments. The rural margins are shown with and without 1,300 CAHs, which are paid 101 percent of costs for inpatient and outpatient services. The margins without CAHs illustrate the profitability of rural inpatient prospective payment system hospitals; the rural margins with CAHs give a fuller picture of rural hospital profitability. Government-owned providers operate in a different context from other providers and are not included in this table.

Source: MedPAC analysis of Medicare cost reports, Medicare Provider Analysis and Review files, and impact files from CMS.

payment rates. The overestimation more than offset the effects of the 2 percent sequester and allowed hospital margins to remain relatively constant.

2014 Medicare margins by hospital type

We further examined overall aggregate Medicare margins by hospital type. In 2014, rural PPS hospitals had a -3.6 percent overall Medicare margin, which was 2.4 percentage points higher than the -6.0 percent margin for urban hospitals (Table 3-5). In 2014, the overall Medicare margin for major teaching hospitals (i.e., hospitals with a high resident-to-bed ratio) was -4.0 percent. Major teaching hospitals have higher overall Medicare margins than the average IPPS hospital in large part because of the extra payments they receive through the IME and DSH adjustments and uncompensated care payments (see text box).

In 2014, for-profit hospitals had positive overall Medicare margins (1.0 percent), well above the -7.4 percent overall Medicare margin for nonprofit hospitals (Table 3-5). Most of this differential can be explained by lower costs at for-

profit hospitals; in particular, they have lower outpatient costs. A detailed analysis of 2009 outpatient services indicated that for-profit hospitals' outpatient margins also benefit somewhat from a more favorable service mix and from being less likely to incur outpatient teaching costs (Medicare Payment Advisory Commission 2014d).

Marginal profits

Another consideration in evaluating the adequacy of payments is to assess whether providers have a financial incentive to increase the number of Medicare beneficiaries they serve. In considering the financial incentive to treat more Medicare patients, the provider compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. On the other hand, if marginal payments do not cover the marginal costs, the provider may have a disincentive to admit Medicare beneficiaries.

Medicare indirect medical education adjustment

Past Commission analysis has shown that the inpatient indirect medical education (IME) and disproportionate share (DSH) hospital adjustments have provided payments that substantially exceed the estimated effects that teaching and providing service to low-income patients has on hospitals' average costs per discharge. Commission analysis of 2013 data regarding the relationship between teaching intensity and costs per case continues to show that the IME adjustment is set higher than can be empirically justified, with only about one-third of IME payments being necessary to account for the higher patient care costs associated with these training programs in the inpatient setting. In 2014, IME payments (for both fee-for-service beneficiaries and Medicare

Advantage enrollees) totaled approximately \$7.8 billion. In June 2010, the Commission recommended using teaching-hospital payments as incentives to train physicians in the skill sets needed to treat future Medicare beneficiaries (Medicare Payment Advisory Commission 2010).

As part of the Patient Protection and Affordable Care Act of 2010, starting in fiscal year 2014, the DSH adjustment has been reduced by 75 percent with funds redirected to an uncompensated care pool. Our analysis shows that the new level of DSH funding (set at 25 percent of the former adjustment) closely approximates the higher patient care costs associated with treating low-income patients in the inpatient setting. ■

To operationalize this concept, we compare payments for Medicare services with marginal costs, which is approximated as:

$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

On average, the marginal profit across hospital service lines was at least 10 percent in 2014.¹⁹ Because hospitals would be expected to generate at least a 10 percent profit on a marginal increase in Medicare volume, hospitals with excess capacity have a financial incentive to serve more Medicare beneficiaries.

Medicare Select

Some hospitals accept discounts off Medicare rates from medigap plans to increase their Medicare volume; this practice suggests they believe that Medicare payment rates are above their marginal costs. These hospitals accept discounted deductibles from certain medigap plans, and in exchange, these plans place the hospitals on the medigap plan's in-network list of hospitals. Beneficiaries with these medigap plans have lower cost sharing if they use these in-network hospitals. Medigap plans with these preferred provider networks are called "Medicare Select" plans. The Kaiser Family Foundation estimated that 9 percent of

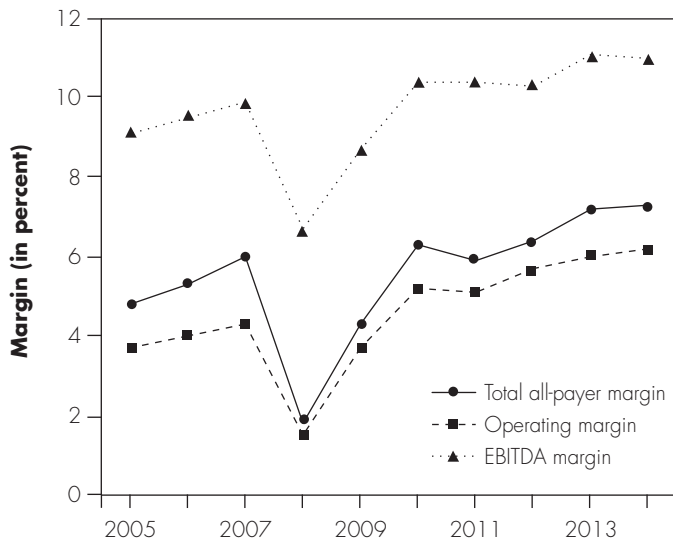
medigap plans were Medicare Select plans in 2010 (Huang et al. 2013). More recently, some traditional medigap plans (e.g., Type F plans) have been offering premium discounts to beneficiaries if they use network hospitals that accept discounts to Medicare's standard rates. For example, one insurer has proposed a system in which "[n]etwork hospitals would provide discounts of up to 100 percent on Medicare inpatient deductibles.... The [insurer] would return a portion of the savings resulting from the [discount] directly to any policyholder who has an inpatient stay at a network hospital. The savings would be shared with the policyholder in the form of a \$100 credit toward the policyholder's next renewal premium..." (Office of Inspector General 2015a). Our conversations with medigap-plan and hospital representatives suggest that hospitals are more likely to accept the discounts when they have excess capacity, commercial rates are relatively low, and their costs are relatively low.

Payments and costs for Part B drugs provided by 340B hospitals

Under the 340B Drug Pricing Program, approximately one-third of all PPS hospitals (primarily those with high Medicaid shares) receive steep discounts from pharmaceutical companies on the cost of the Part B drugs. Payment rates for all Part B drugs that are separately payable under the OPDS are set at 106 percent of each drug's average sales price (ASP).²⁰

**FIGURE
3-6**

**Hospitals' financial performance
has rebounded strongly after
poor performance in 2008**



Note: EBITDA (earnings before interest, taxes, depreciation, and amortization). A margin is calculated as revenues minus costs, divided by payments. Analysis excluded critical access hospitals.

Source: MedPAC analysis of Medicare hospital cost report data.

In aggregate, the Office of Inspector General (OIG) estimates that discounts across all 340B providers (hospitals and certain clinics) average 34 percent of ASP, allowing these providers to generate significant profits when they administer Part B drugs (Office of Inspector General 2015b). We propose reducing Medicare payment rates for separately payable 340B drugs by 10 percent of the ASP. This reduction would allow 340B hospitals to still make a profit on these drugs and accomplish two goals for Medicare. First, it will reduce beneficiary cost sharing by 10 percent, allowing beneficiaries to partially share in the discounts hospitals receive from pharmaceutical companies. Although in some cases, the savings will accrue to the beneficiaries' supplemental insurers (and would be expected to reduce supplemental policy premiums over time), about 19 percent of beneficiaries who received Part B drugs at 340B hospitals in 2014 did not have private or Medicaid supplemental coverage for Part B drugs.²¹ Reduced cost sharing may be material to these beneficiaries given that approximately 70 percent of beneficiaries without private or Medicaid supplemental coverage had incomes under \$30,000 per year in 2011 (Medicare Payment Advisory Commission 2015a).

Second, the 10 percent reduction in program payments would be redirected into the uncompensated care pool (see the text box on DSH payments, pp. 72–73). These uncompensated care dollars would be directed to hospitals with high uncompensated care costs.

Currently, the 340B program is not well targeted to hospitals with high levels of uncompensated care or to hospitals with financial difficulties. We find that 40 percent of 340B hospitals provide less than the median level of uncompensated care (3.6 percent) as reported on Worksheet S-10 of the Medicare cost reports. While the median all-payer margin is 3.8 percent for 340B hospitals compared with 5.3 percent at non-340B hospitals, there is wide variation in profitability among 340B hospitals: 25 percent of 340B hospitals reported all-payer margins of over 8.0 percent in 2014. Because of variation in the uncompensated care provided by 340B hospitals and variation in the profit margins of 340B hospitals, we are suggesting that a portion of the 340B discounts be redirected toward the hospitals providing the most uncompensated care. For more details on the 340B program, see the text box, pp. 78–79.

Total (all-payer) profitability reached a 30-year high in 2014

Hospitals' total (all-payer) profit margins are an indicator of how much financial pressure hospitals are under to control costs. In 2014, total margins for hospitals increased to 7.3 percent, the highest level recorded since the first year of the IPPS 30 years ago (Figure 3-6). All-payer margins grew because private-payer rate growth was strong (4 percent to 6 percent in recent years) and cost growth has been low (2 percent to 3 percent) (Bureau of Labor Statistics 2013, Health Care Cost Institute 2015, Health Care Cost Institute 2014, Health Care Cost Institute 2012). Other measures of all-payer profitability are also strong. Cash flow—as measured by earnings before interest, taxes, depreciation, and amortization (EBITDA)—increased from 10.3 percent in 2012 to 11.0 percent in 2013 and 2014, indicating hospitals maintained a relatively strong cash flow.

In 2014, total margins varied across types of hospitals. For-profit hospitals had the highest total (all-payer) margin, reaching a record 10.5 percent, more than 4 percentage points higher than in 2007, before the recession; nonprofit hospitals' total margin stood at 7.3 percent, 1 percentage point higher than in 2007; and major teaching hospitals' total margin stood at 5.2

percent, similar to the 5.1 percent margin they had in 2007. Substantial diversity also existed in the financial condition of rural hospitals. Some isolated rural hospitals closed, raising concerns about access to emergency care. In addition, rural hospitals adjacent to urban areas had low total margins (–1.2 percent in aggregate). On the other hand, the 21 frontier PPS hospitals (those in low population-density counties) had an average total margin of 10.9 percent, the highest of any group, which suggests that isolated hospitals can do well in frontier areas when they have sufficient volumes of insured individuals. The total margin for critical access hospitals was 3.4 percent.

A key question is whether the high total margins and strong cash flows the industry has enjoyed in recent years will result in increased cost growth. As we discussed earlier, there are signs of increasing wage pressure in 2015.

Profit margins and financial pressure to constrain costs vary by hospital

In aggregate, all-payer profit margins are at record highs. However, among individual hospitals, their market power, charges, and prices negotiated with insurers vary widely. An analysis of Truven Health MarketScan[®] data shows that negotiated rates commercial insurers paid to hospitals vary widely (Medicare Payment Advisory Commission 2011a). For example, in 2013, 10 percent of hospital commercial claims were paid less than \$236 for a head computed tomography scan (CPT 70450), but another 10 percent of hospital commercial claims were paid over \$1,472 for the same service (see online Appendix 3-A, available at <http://www.medpac.gov>). Given the variability in market power, charges, and the discounts hospitals negotiate with private insurers, we expect to see a wide variation both in hospital profits and in pressure to constrain costs.

Hospitals with strong profits on non-Medicare services and investments are under relatively little pressure to constrain their costs. Other hospitals, with losses on non-Medicare services, face overall losses (and possibly closure) if they do not constrain costs and generate profits on Medicare patients. To determine the effect of financial pressure on costs, we grouped hospitals into three levels of financial pressure from private payers: high, medium, and low, based on their median non-Medicare profit margins and other factors from 2009 to 2013. For these years, the hospitals under high pressure had non-Medicare profits of less than 1 percent, while the low-pressure hospitals had non-Medicare margins of more than 5 percent. We

found that hospitals under high pressure from 2009 to 2013 ended up with lower standardized Medicare costs per discharge in 2014 than hospitals under low levels of financial pressure during the same five-year period. For more details on our analytic methods, see our earlier analysis of payment adequacy (Medicare Payment Advisory Commission 2011b).

The following are key findings from our analysis of financial pressure on hospitals:

- **High pressure = low cost:** The 25 percent of hospitals under the most financial pressure had median standardized Medicare costs per case that were 8 percent lower than the national median for all 2,776 IPPS hospitals with available data. Because of their lower Medicare costs, hospitals under pressure generated a median overall Medicare profit margin of 6 percent, which is 10 percentage points above the national median.
- **Low pressure = high cost:** The 59 percent of hospitals that were under a low level of financial pressure had median standardized Medicare costs per case that were 2 percent above the national median. Because of higher costs, they generated a median Medicare profit margin of –8 percent, which is 4 percentage points below the national median.
- **For-profit hospitals have different incentives:** For-profit hospitals tended to keep their median standardized Medicare costs per case at the national median even when they were under little financial pressure. This finding suggests that if nonprofit and for-profit hospitals receive high payment rates from private payers, the higher revenues tend to result in higher costs in nonprofit hospitals, whereas in for-profit hospitals, a larger share of the revenue is retained as operating profit for shareholders.

Relatively efficient hospitals

The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over the past three years. The Commission's approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (say, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

The 340B Drug Pricing Program

The 340B Drug Pricing Program (“340B program”) allows certain hospitals and other health care providers (“covered entities”) to obtain discounted prices on covered outpatient drugs (prescription drugs and biologics other than vaccines) from drug manufacturers for drugs provided to eligible patients.²² This text box provides an overview of the program; for more information, see the Commission’s *Overview of the 340B Drug Pricing Program*, available at <http://www.medpac.gov>.

The 340B program was created in 1992 following the adoption of the Medicaid Drug Rebate Program and is named for the provision in the Public Health Service Act that authorizes it. To have their drugs covered under Medicaid, manufacturers must offer 340B discounts to “covered entities.” In fiscal year 2013, covered entities saved about \$3.8 billion on outpatient drugs through the program (Health Resources and Services Administration 2015). Medicare Part B pays for certain 340B drugs that covered entities provide to beneficiaries, such as drugs used to treat cancer and rheumatoid arthritis.

The Health Resources and Services Administration (HRSA) calculates a 340B ceiling price for each covered outpatient drug using a statutory formula that is based on the formula used to calculate Medicaid drug rebates. According to statute, HRSA is allowed to share these prices with covered entities but not with the general public. The 340B ceiling price represents the maximum price a manufacturer can charge for a 340B drug. However, covered entities that participate in HRSA’s Prime Vendor Program may pay less than the ceiling price. By pooling the purchasing power of entities, the prime vendor (Apexus) negotiates subceiling prices on 340B drugs with manufacturers; the average savings was 10 percent below the ceiling price in fiscal year 2013 (Department of Health and Human Services 2014, Health Resources and Services Administration 2014).

The statute specifies which types of providers are eligible to participate in the 340B program. Several types of hospitals and certain clinics that receive grants from the Department of Health and Human Services (e.g., Federally Qualified Health Centers and family

planning clinics) are eligible for the program. There are six types of eligible hospitals: disproportionate share (DSH) hospitals, critical access hospitals (CAHs), rural referral centers (RRCs), sole community hospitals (SCHs), children’s hospitals, and freestanding cancer hospitals. Each eligible hospital must be owned by a state or local government, be a public or nonprofit hospital that is formally delegated governmental powers by a state or local government, or be a nonprofit hospital under contract with a state or local government to provide services to low-income patients who are not eligible for Medicare or Medicaid. Each type of eligible hospital except for CAHs must have a minimum DSH adjustment percentage (which is based on the share of a hospital’s inpatients who are Medicaid and low-income Medicare patients) to qualify for the program.²³

The 340B program has grown substantially during the past decade. Covered entities and their affiliated sites spent over \$7 billion to purchase 340B drugs in 2013, three times the amount spent in 2005. This figure includes both oral and physician-administered drugs and refers to the amount spent by covered entities to purchase 340B drugs for all patients, not the payments received by entities from public and private payers and patients for these drugs. Despite substantial growth in the number of covered entities, much of the growth in what is paid for drugs provided in the covered entities has occurred in covered entities that have been in the 340B program for a number of years. For example, Medicare spending on separately payable Part B drugs at hospitals that were in the 340B program in both 2008 and 2013 rose from \$1.2 billion in 2008 to \$2.8 billion in 2013, an increase of 145 percent. Although total drug spending in the United States has had strong growth, the rate of growth is much slower than the rate of growth in the 340B program. Total drug spending in the United States grew by 33 percent from 2005 to 2013 (IMS Institute for Healthcare Informatics 2014, IMS Institute for Healthcare Informatics 2012). During that period, spending by covered entities on 340B drugs increased from 1.0 percent to 2.2 percent of total drug spending in the United States.

From 2005 to 2010, the number of hospital organizations in the 340B program grew from 583 to

(continued next page)

The 340B Drug Pricing Program (cont.)

1,365 (134 percent).²⁴ Most of this increase reflects growth in the number of DSH hospitals during that period, from 583 to 1,001. From 2010 to 2014, the number of 340B hospitals grew by 57 percent to 2,140. This increase was driven by growth in the number of CAHs and other types of hospitals (e.g., RRCs and SCHs) that became eligible for 340B through the Patient Protection and Affordable Care Act of 2010 (PPACA).

From 2004 to 2013, Medicare spending for separately payable Part B drugs at hospitals that participate in 340B grew from \$0.5 billion to \$3.5 billion, or 543 percent.²⁵ Hospitals in the 340B program accounted for 22 percent of Medicare spending for Part B drugs at all Medicare acute care hospitals in 2004, growing to 48 percent in 2013. Some of the growth in Medicare spending at 340B hospitals during this period was due to an increase in the number of participating hospitals after the passage of PPACA. However, most of the growth in Medicare spending occurred among hospitals that were in the 340B program before the PPACA expansion. For example, 733 hospitals in the 340B program received Medicare payments for separately payable Part B drugs in both 2008 and 2013. These hospitals accounted for 73 percent of the growth in Medicare spending for separately payable Part B drugs at all 340B hospitals from 2008 to 2013.

Covered entities can use 340B drugs for all eligible patients, including patients with Medicare or private insurance, and can generate revenue if the reimbursements from payers exceed the discounted prices they pay for the drugs. The 340B statute does not restrict how covered entities can use revenue generated through the program. Therefore, entities can use these funds to expand the number of patients served, increase the scope of services offered to low-income and other patients, invest in capital, cover administrative costs, or

accomplish any other purpose.²⁶ HRSA does not have statutory authority to track how entities use this revenue.

Even though hospitals (except for CAHs) are required to have a minimum share of Medicaid and low-income Medicare patients to qualify for the 340B program, we found that many 340B hospitals do not provide high levels of uncompensated care (charity care and bad-debt costs).²⁷ Forty percent of 340B hospitals provided less than the national median share (3.6 percent) of uncompensated care in 2014. However, the median 340B hospital had uncompensated care costs equal to 4.3 percent of expenditures in 2014.

In a recent report, the Department of Health and Human Services Office of Inspector General (OIG) estimated that the aggregate discount on Part B drugs received by covered entities equaled 33.6 percent of the average sales price (ASP) in 2013 (Office of Inspector General 2015b).²⁸ In other words, entities paid 33.6 percent less than ASP to acquire Part B drugs. Medicare's payment rates for these drugs are based on ASP plus 6 percent (ASP + 6 percent). OIG's estimate of the aggregate discount was based on all covered entities (hospitals and certain clinics). Because 340B hospitals accounted for 91 percent of Part B drug spending for all covered entities in 2013, it is reasonable to assume that 340B hospitals received a discount similar to 33.6 percent of ASP.

Under the outpatient prospective payment system, Medicare pays 340B hospitals and non-340B hospitals the same payment rates for Part B drugs, even though 340B hospitals are able to purchase these drugs at steep discounts. Similarly, beneficiaries have a cost-sharing liability of up to 20 percent of Medicare's payment rate for outpatient drugs received at both types of hospitals.²⁹ By contrast, many state Medicaid programs pay 340B hospitals their actual cost of acquiring outpatient drugs.³⁰ ■

This year, we reviewed the set of criteria used to define efficient providers and evaluate potential improvements in our methodology. Specifically, we tested the effect of using different selection criteria such as adjusting the threshold of minimum acceptable quality or relaxing the consistency requirement. The Commission concluded

that alternative methods could change the number of efficient providers by varying degrees, but these methods did not result in greater distinction between the efficient and average providers, and in some cases, the differences were reduced. Most fundamentally, the clarity of the information provided for assessing payment adequacy

would not have improved significantly with any of the new methods tested. Therefore, the Commission will use its previous definition of an efficient provider in this year's report, but we will continue to look for improvements in our methods, including using new quality metrics as better indicators of patient outcomes are developed.

In the hospital sector, the variables we use to identify relatively efficient hospitals are hospital-level mortality rates (AHRQ Inpatient Quality Indicators), readmission rates (3M[®] potentially preventable readmissions), and standardized inpatient Medicare costs per case. Our assessment of efficiency is not in absolute terms, but rather, relative to other IPPS hospitals.

Categorizing hospitals as relatively efficient We assigned hospitals to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and quality metrics for the period 2011 to 2013.³¹ We then examined the performance of the two hospital groups in fiscal year 2014.

Hospitals were identified as relatively efficient if they met four criteria in each year from 2011 to 2013:

- Risk-adjusted mortality rates were among the best two-thirds of all hospitals.
- Risk-adjusted readmission rates were among the best two-thirds of all hospitals.
- Standardized costs per discharge were among the best two-thirds of all hospitals.
- Risk-adjusted mortality or standardized costs per discharge were among the best one-third of all hospitals.

The objective was to identify hospitals that consistently performed at an above-average level on at least one measure (cost or quality) and that always performed reasonably well on all measures. The rationale for this methodology and the details of computing the various measures is discussed in detail in our March 2011 report (Medicare Payment Advisory Commission 2011b). As a secondary check on hospital quality, we also require that at least 60 percent of the hospital's patients rated the hospital a 9 or 10 on a 10-point scale.³²

Examining performance of relatively efficient and other hospitals from 2011 to 2013 Of the 1,953 hospitals that met our screening criteria, 302 (15 percent) were found to

be relatively efficient during the 2011 to 2013 period. We examined the performance of relatively efficient hospitals on three measures from 2011 to 2013 by reporting the group's median performance divided by the median for the set of hospitals in our analysis (Table 3-6). The median efficient hospital's relative risk-adjusted 30-day mortality rate from 2011 through 2013 was 86 percent of the national median, meaning that the 30-day mortality rate for the efficient group was 14 percent below (that is, better than) the national median. The median readmission rate for the efficient group was 6 percent below the national median. The standardized Medicare cost per discharge for the efficient group was 9 percent lower than the national median. These relatively efficient hospitals were spread across the country and had a diverse set of characteristics, but they were more likely to be larger nonprofit hospitals because those hospitals tend to have better performance on the quality metrics we analyzed. For a more complete description of the methodology and other characteristics of relatively efficient providers, see the online Appendix 3-B, available at <http://www.medpac.gov>.

Historically strong performers had lower mortality and costs in 2014 In 2014, the efficient group's median composite mortality rate was 12 percent below the national median, and its median standardized Medicare cost per discharge was 9 percent lower than the national median. The lower costs allowed the relatively efficient hospitals to generate higher overall Medicare margins. The median hospital in the efficient group had an overall Medicare margin of 1 percent, while the median hospital in the comparison group had an overall Medicare margin of -5 percent. The marginal profits (which ignore the approximately 20 percent of costs that are fixed) were about 15 percent for the relatively efficient provider. As shown in past years, it is possible to deliver relatively good quality care that patients value at a cost roughly equal to Medicare payment rates.

Summary of hospitals' financial performance

The financial measures presented for 2014 present a mixed picture. All-payer margins were at a 30-year high of 7.3 percent, but Medicare margins were at a relative low, -5.8 percent in aggregate and 1 percent for the relatively efficient providers. While Medicare payments do not cover the full costs (fixed and variable) of the average hospital, they are at least 10 percent higher than the marginal cost of adding additional Medicare patients. Therefore, hospitals with excess capacity have an incentive to serve more Medicare patients.

**TABLE
3-6**

Performance of relatively efficient hospitals

| Relative performance measure | Type of hospital | |
|---|---------------------------------------|-----------------|
| | Relatively efficient during 2011-2013 | Other hospitals |
| Number of hospitals | 302 | 1,651 |
| Share of hospitals | 15% | 85% |
| Historical performance, 2011-2013 (percent of national median) | | |
| Risk-adjusted: | | |
| Composite 30-day mortality (AHRQ) | 86% | 102% |
| Readmission rates (3M™) | 94 | 102 |
| Standardized Medicare costs per discharge | 91 | 102 |
| Performance metrics, 2014 (percent of national median) | | |
| Risk-adjusted: | | |
| Composite 30-day mortality (AHRQ) | 88% | 101% |
| Composite 30-day readmission (3M) | 95 | 102 |
| Standardized Medicare costs per discharge | 91 | 102 |
| Median: | | |
| Overall Medicare margin, 2014 | 1% | -5% |
| Non-Medicare margin, 2014 | 10 | 8 |
| Total (all-payer) margin, 2014 | 7 | 5 |

Note: AHRQ (Agency for Healthcare Research and Quality). Relative measures are the median for the group as a percentage of the median of all hospitals. Per case costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the AHRQ methodology to compute risk-adjusted mortality for six conditions (acute myocardial infarction, congestive heart failure, pneumonia, gastrointestinal hemorrhage, stroke, and hip fracture). We then weighted the scores for each type of discharge by the share of discharges in that particular hospital. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) because of concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and risk-adjusted quality metrics.

Source: MedPAC analysis of 2011 to 2014 Medicare cost report and claims-based quality data.

How would current law changes for 2015, 2016, and 2017 affect hospitals' Medicare payments and beneficiaries' access?

We project Medicare margins for 2016 based on margins in 2014 and policy changes that take place in 2015 and 2016. The 2015 update for inpatient and outpatient payments was 2.2 percent. In 2016, the update is 1.7 percent for inpatient services, but outpatient payment rates are projected to decline by -0.4 percent. This reduction in outpatient rates reflects a correction for overestimating the number of services that were packaged into new APCs.³³ On net, the average update (across inpatient and outpatient services) is about 3 percent over the two-year period. However, as we discussed in our March 2015 report to the Congress, several policy changes in current law are expected to fully offset that increase in payment rates from 2014 to 2016.

First, Medicare uncompensated care payments will fall from \$9.4 billion in 2014 to \$6.4 billion in 2016 due to a sizable drop in the number of uninsured, which the Congressional Budget Office (CBO) estimated will decline from 16 percent in 2014 to 11 percent in 2016. CBO projects modest reductions in rates of uninsurance for 2017, meaning we do not expect to see a significant additional reduction in uncompensated care payments in 2017.

Second, payments from Medicare's EHR Incentive Program will sunset in 2016, declining by almost \$1.8 billion from 2014 to 2016, which is about 1 percent of overall Medicare payments.

Third, expansion of quality incentive payment programs will also reduce payments to hospitals with poor performance on quality metrics. This expansion includes the start of HAC payment penalties in fiscal year 2015,

which reduced by 1 percent per year the inpatient payments to 25 percent of hospitals. In fiscal year 2016, penalties under this program will total about \$360 million, or 0.2 percent of overall Medicare payments. In addition, the Hospital Readmissions Reduction Program added two additional conditions to the program and increased the maximum penalty from 2 percent to 3 percent of base payments in 2015, increasing total penalties under the program by about \$200 million, or 0.1 percent of overall Medicare payments.

Finally, mandated recovery of past overpayments due to documentation and coding changes following implementation of MS-DRGs resulted in a 0.8 percent adjustment to inpatient rates, equivalent to 0.5 percent of overall payments in 2015 and 2016. This reduction is expected to occur again in 2017.

We expect cost growth per discharge to remain around 2.5 percent per year in 2015 and 2016, similar to what we have seen for the past several years. We expect case mix to increase about 1 percent per year. On net, payment updates and case-mix increases in 2015 and 2016 will offset expected cost growth. However, the above-mentioned payment policy changes will reduce payments by about 3 percent between 2014 and 2016. With this decline in payments and continued modest cost growth, we expect the overall Medicare margin to decline from -5.8 percent in 2014 to around -9 percent in 2016. We also expect that the median overall Medicare margin for relatively efficient hospitals will be slightly negative in 2016.

There is some interest in understanding what margins would be without penalties from the quality incentive programs. Hospitals with above-average readmission rates and hospitals with HAC rates in the top 25 percent both receive penalties. In aggregate, penalties from these two programs are relatively small (less than 0.5 percent of overall Medicare revenues), and thus excluding them from our margin calculation would not materially change our projected overall Medicare margin. We would still expect the aggregate overall margin in 2016 to be around -9 percent. However, it is important to understand that the magnitude of these penalties does not reflect industry-wide quality performance. Because these are “tournament model” penalties, industry-wide improvement or declines in performance will not affect the industry-wide level of these penalties. The Commission has suggested changing the penalty structure so that industry-wide penalties decline when performance improves (Medicare Payment Advisory Commission 2014a).

Current law payment changes in 2017

Under current law, the hospital update is projected to be 1.75 percent. This share is the result of a 3.0 percent projected market basket increase, a 0.5 percent reduction for productivity, and a 0.75 percent reduction mandated by PPACA. We expect CMS to make its final temporary adjustment for documentation and coding and a further reduction in payments for health information technology in 2017. We do not expect substantial further declines in uncompensated care payments coming from the Medicare trust fund in 2017. Readmission penalties may increase slightly when cardiac bypass surgery is added to the Hospital Readmissions Reduction Program in 2017, but aggregate penalties and rewards from the other quality incentive programs should hold relatively steady. The net result would be an expected increase in payment rates of slightly less than 1 percent under current law in 2017. Depending on cost growth, Medicare margins could decline between 2016 and 2017.

Hospitals will continue to have a financial incentive to see Medicare patients

Despite Medicare margins of -5 percent to -6 percent in recent years, hospitals’ all-payer margins (which include Medicare) in 2014 rose to a record high of over 7 percent. The all-payer margins are at historic highs due to rate increases from private insurers that are well above cost growth, resulting in high margins for patients with commercial insurance (Health Care Cost Institute 2014, Medicare Payment Advisory Commission 2014b). While commercial rates vary wildly from hospital to hospital and insurer to insurer, on average, commercial rates are about 50 percent higher than hospital costs and often far more than 50 percent above Medicare rates (Cooper et al. 2015, Health Care Cost Institute 2014, Medicare Payment Advisory Commission 2014b, Selden et al. 2015). For example, Selden and colleagues found that average private rates were 75 percent higher than Medicare rates in 2012; Aetna and Blue Cross of California paid hospitals rates that were often 200 percent of Medicare’s rate for inpatient care and 300 percent of Medicare’s rate for outpatient services in California in 2014 (California Department of Insurance 2014a, California Department of Insurance 2014b).

Despite this growing gap, we do not expect to see any near-term material reductions in Medicare beneficiaries’ access to care for several reasons:

- Most hospitals have excess inpatient capacity.

- Medicare payment rates, while less than the total cost of care, are still sufficient to generate a marginal profit of approximately 10 percent on each additional Medicare patient. Therefore, it is still profitable for the average hospital to fill its empty beds with Medicare patients.
- Some hospitals currently accept discounts on Medicare rates from Medicare Select medigap plans to gain Medicare market share (Huang et al. 2013, Lee et al. 1997, Office of Inspector General 2015a). These hospitals want more Medicare patients, even at rates lower than standard Medicare rates.

Because hospitals have a financial incentive and the capacity to serve Medicare patients, we do not believe beneficiaries' access to care is at risk in the near term. However, in the long run, the growing disparity between Medicare rates and commercial rates (rates that continue to grow at roughly 4 percent to 5 percent per year) will have to be addressed. The gap cannot be closed by increasing Medicare rates by 4 percent to 5 percent or more per year; the Medicare trust fund would not be able to absorb those price increases. Therefore, commercial payment rate growth will have to decline, or eventually the difference between commercial rates and Medicare rates will grow so large that more hospitals would have an incentive to focus primarily on patients with commercial insurance. Thus, in the long term, Medicare beneficiaries' access to care may in part depend on commercial payers restraining rates paid to hospitals.

How should Medicare payment rates change in 2017?

RECOMMENDATION 3

The Commission's multipart recommendation addresses the issues of updating Medicare hospital payments in view of mixed payment adequacy signals, allowing beneficiaries to share in 340B drug savings, and directing additional payments to hospitals that provide the most uncompensated care. Specifically, the Commission recommends:

The Congress should direct the Secretary of the Department of Health and Human Services to:

- **update inpatient and outpatient payments by the amount specified in current law,**

- **reduce Medicare payment rates for 340B hospitals' separately payable 340B drugs by 10 percent of the average sales price (ASP),**
- **direct the program savings from reducing Part B drug payment rates to the Medicare-funded uncompensated care pool, and**
- **distribute all uncompensated care payments using data from the Medicare cost reports' Worksheet S-10. The use of S-10 uncompensated care data should be phased in over three years.**

This recommendation will increase providers' base payment rates by the amount stipulated in current law. It will also change Medicare payment rates for 340B hospitals' Part B drugs. While pharmaceutical companies will still have to provide hospitals the same 340B discounts that they currently provide, the discount will be shared with beneficiaries (10 percent lower cost sharing) and hospitals that provide high levels of uncompensated care. Reducing Medicare payment rates for 340B drugs will generate approximately \$300 million in additional funds for uncompensated care payments to hospitals. To better target all uncompensated care payments, CMS will be required to distribute uncompensated care payments based on uncompensated care costs reported in hospital cost reports.

RATIONALE 3

We recommend a base payment rate update equal to current law (projected to be 1.75 percent) to maintain beneficiaries' access to care. While our recommendation does not change the 340B program or the discounts pharmaceutical companies must provide to hospitals, we do recommend a reduction in Medicare payment rates for separately payable 340B drugs. One objective of the rate reduction is to allow beneficiaries to share in the discounts 340B hospitals receive from drug companies. While the Commission decided that beneficiaries should share in the benefit of 340B discounts, it does not want to reduce program payments to hospitals providing the most care to the uninsured. Therefore, the Commission recommends that the program savings from reducing Medicare payment rates for 340B drugs be redirected to the uncompensated care pool. In addition, to make sure that dollars in the uncompensated care pool actually go to the DSH hospitals providing the most uncompensated care, we recommend payments be distributed in proportion to the amount of uncompensated care that hospitals provide. This distribution can be done by using S-10 data to measure hospitals' uncompensated care costs.

These changes would maintain beneficiaries' access to care and improve the targeting of Medicare dollars toward hospitals providing the most uncompensated care. However, in the long term, given the Medicare trust fund's funding challenges, policymakers will need to deal with the larger question of how society in general should fund hospitals' non-Medicare charity care and bad debt costs.

IMPLICATIONS 3

Spending

- The recommendation would not change the update and is budget neutral.

Beneficiaries and providers

- The recommendation would maintain the projected 1.75 percent increase in base payment rates to all hospitals. It would also reduce beneficiary cost sharing on separately payable Part B drugs at 340B hospitals by 10 percent. This would reduce aggregate hospital revenue by about \$70 million, or \$30,000 per DSH hospital on average. The recommendation would also reduce program payments for 340B drugs by \$300 million and increase program payments for uncompensated care by \$300 million. Across all categories of DSH hospitals (e.g., 340B, non-340B, for profit, nonprofit), those with high uncompensated care shares would experience an increase in payments, and those with low levels of uncompensated care costs would experience a decline in payments relative to

current law. On average, the 340B hospitals' revenue from Part B drugs would decline, but their total Medicare revenues would increase slightly because of the expanded pool of dollars for uncompensated care and allocating the full uncompensated care pool on the basis of S-10 data.³⁴ On average, we estimate that payments per 340B hospital would increase by \$170,000 over current law, and payments per non-340B hospital would decline by \$190,000. We estimate average Medicare payments to public hospitals would increase by \$2.7 million per hospital relative to current law, while payment to nonprofit and for-profit hospitals would decline by \$500,000 and \$800,000 per hospital, respectively. To prevent large one-year swings in payments, these changes would be phased in over three years. The policy would not affect non-DSH hospitals or CAHs.

While the uncompensated care pool would be directed to help fund uncompensated care cost, as better measured by the S-10 worksheet, the \$3.3 billion in traditional DSH dollars would still be distributed to hospitals primarily based on Medicaid days. Hospitals with high Medicaid shares would be disproportionately helped by the traditional DSH pool, and hospitals with high uncompensated care costs would be disproportionately helped by the uncompensated care pool. ■

Endnotes

- 1 A portion of the growth in outpatient payments is due to certain lab tests that were paid separately under the laboratory fee schedule being packaged into APCs. CMS estimates that this growth accounts for over \$2 billion of the growth in outpatient payments (Centers for Medicare & Medicaid Services 2015b). Payments include roughly \$7 billion of inpatient and outpatient payments to critical access hospitals (CAHs), which are paid 1 percent over their costs of inpatient, outpatient, and post-acute services in swing beds. CAHs do not receive disproportionate share payments or uncompensated care payments.
- 2 To obtain these results, we used the volume of E&M visits in outpatient PPS hospitals, OPSS payment rates in 2014, and physician fee schedule payment rates in 2014.
- 3 CMS reports on hospital quality performance on Hospital Compare, a website that allows consumers to view an array of quality information on individual hospitals and compare their performance to other hospitals in the community and state and throughout the nation.
- 4 In-hospital mortality rates for all five conditions that we analyze—acute myocardial infarction (AMI), congestive heart failure, hip fracture, stroke, and pneumonia—improved (i.e., went down) by statistically significant percentages from 2010 to 2014. Over the same period, 30-day postdischarge mortality rates demonstrated statistically significant declines (i.e., improved) for AMI, hip fracture, and stroke.
- 5 The initial three conditions included in the Hospital Readmissions Reduction Program were acute myocardial infarction, heart failure, and pneumonia.
- 6 Twenty-two percent of hospitals avoided a penalty for one of two reasons. Seven percent were exempted because they did not have the minimum number of cases (25) over three years in any of the five conditions covered by the program. The remaining 15 percent of hospitals avoided penalties because they had better than average performance for all conditions for which they had the minimum 25 cases.
- 7 The program began in fiscal year 2013 with 1 percent of base payments at risk, phasing in to a maximum of 2 percent starting in fiscal year 2017.
- 8 The PSI 90 measure used is a composite of eight patient safety measures: PSI 03 (pressure ulcers); PSI 06 (iatrogenic pneumothorax); PSI 07 (central venous catheter-related bloodstream infections); PSI 08 (postoperative hip fracture); PSI 12 (perioperative pulmonary embolism or deep vein thrombosis); PSI 13 (post-operative sepsis); PSI 14 (post-operative wound dehiscence); and PSI 15 (accidental puncture or laceration).
- 9 SSI measures were added in fiscal year 2016. The HAC program will include two additional HAC infection measures in fiscal year 2017: methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile.
- 10 The domain weight for the patient safety indicators will be reduced to 15 percent and the weight for infections increased to 85 percent.
- 11 In 2014, the six largest services in order of Medicare patient revenues were inpatient acute care, outpatient care, inpatient rehabilitation, inpatient psychiatric, home health care, and skilled nursing services.
- 12 In 2014, many lab services were packaged into outpatient service rates, which shifted revenues and costs from the lab fee schedule to the outpatient payment system. CMS estimates that this change added approximately \$2.4 billion in covered services to the outpatient payment system, services that were previously paid on a separate fee schedule (Centers for Medicare & Medicaid Services 2015b). This change makes it difficult for us to assess underlying outpatient cost growth.
- 13 The \$3.2 billion consists of payments to IPPS hospitals for FFS patients; it does not include payments for managed care patients or payments received by critical access hospitals under the program.
- 14 Total payments in fiscal year 2013 were reduced by about 1 percent because the budget sequester was in effect for approximately one-half of the fiscal year. The sequester reduces payments from the Medicare program. It does not reduce payments from beneficiaries.
- 15 While CMS currently uses the inpatient payment system to distribute uncompensated care payments, the total payments hospitals will receive from the program are not affected by Medicare inpatient case volume or patient mix.
- 16 The services included in the overall Medicare margin are Medicare acute inpatient, outpatient, graduate medical education, Medicare SNF (including swing beds), Medicare home health care, Medicare inpatient psychiatric, and Medicare inpatient rehabilitation, as well as special payments for health information technology, temporary extra payments to hospitals located in low-spending counties, and (starting October 1, 2014) uncompensated care payments.

- 17 These DSH hospitals will also receive uncompensated care payments for each Medicaid day from Medicare Advantage plans, which generally follow Medicare FFS pricing (Berenson et al. 2015, Medicare Payment Advisory Commission 2014c).
- 18 We used the 2011 Worksheet S–10 Line 23, Column 1, which reports the uncompensated cost of caring for the uninsured because it most closely matches data on the audited Medicaid DSH financial statements. In addition, the more comprehensive definition of uncompensated care (Line 30, Column 1, which includes charity care and bad debts) was not of sufficient quality to be accurate in 2011. In 2011 and 2012, there was some confusion as to whether bad debts incurred in prior years and written off in the current year should be reported as bad debt. This confusion may have made bad-debt reporting inconsistent in 2011. In 2013, CMS clarified that the S–10 should match the hospital’s financial statements, and all bad debts written off during the fiscal year qualify as bad debts on the Worksheet S–10. Therefore, the comprehensive computation of uncompensated care on Line 30 of the S–10 is now of sufficient quality to be used to distribute uncompensated care payments.
- 19 Using a cost-accounting approach, we find that approximately 20 percent of hospital costs are fixed, resulting in a marginal profit of approximately 10 percent. This estimate of 20 percent is conservative because it ignores any potential managerial or clinical labor costs that are fixed. In last year’s report, we took an econometric approach to estimating hospitals’ marginal costs and also found that fixed costs were approximately 20 percent of overall costs. This figure also matches the 20 percent figure used in the Medicare outlier policy. For a discussion of our econometric results and the literature on hospital marginal costs, see online Appendix 3-A from the March 2015 report, available at <http://www.medpac.gov> (Medicare Payment Advisory Commission 2015b).
- 20 For most Part B drugs that are separately payable under the OPSS, Medicare pays 80 percent of the payment rate, and beneficiaries’ cost sharing is the remaining 20 percent. The sequester reduces the program payment by 2 percent. Therefore, the payment rate in the OPSS for most separately payable Part B drugs in 2016 is: $0.98 \times 0.8 \times 1.06 \times \text{ASP} + 0.2 \times 1.06 \times \text{ASP} = 1.043 \times \text{ASP}$, or 104.3 percent of ASP.
- 21 We determined this finding through the Commission’s analysis of claims data for 340B separately payable drugs and CMS data on beneficiaries’ supplemental insurance.
- 22 Covered entities are allowed to provide 340B drugs only to individuals who are eligible patients of the entity, but the statute does not define who should be considered “a patient of the entity.” HRSA’s current guidance, released in 1996, lists the criteria for individuals to be considered eligible patients.
- For example, the covered entity must have a relationship with the individual, which is defined as maintaining the individual’s health care records.
- 23 The minimum DSH adjustment percentage is generally 11.75 percent, with some lower levels allowed for certain hospitals. The formula for the DSH adjustment percentage is complicated, but the part that is relevant for 340B hospitals equals $5.88 \text{ percent} + [0.825 \times (\text{DSH patient percentage} - 20.2 \text{ percent})]$. The DSH patient percentage is the sum of the percentage of Medicare inpatient days for patients who are eligible for Supplemental Security Income and the percentage of total inpatient days for patients on Medicaid.
- 24 A hospital and all of its affiliated sites count as one hospital organization. Each hospital that files its own Medicare cost report must register separately with HRSA and counts as a unique organization.
- 25 Because some 340B hospitals do not provide 340B drugs to Medicaid beneficiaries, we excluded spending for drugs provided to patients of these hospitals who are eligible for both Medicare and Medicaid (dual eligible). We also excluded spending on vaccines (because they are excluded from the 340B program) and spending for all orphan drugs used by hospitals that are subject to the orphan drug exclusion.
- 26 Although there are no requirements under the 340B statute for how 340B revenue can be used, covered entities that are federal grantees may be required to use 340B revenue in ways that are consistent with their grant requirements. In addition, nonprofit hospitals are required to conduct a community needs assessment and document their community benefits in Internal Revenue Service tax filings.
- 27 Uncompensated care was measured as the cost of charity care and the cost of bad debts as reported on line 30 of the Medicare cost report Worksheet S–10.
- 28 OIG used data on ceiling prices and Medicare spending for Part B drugs to estimate the discount.
- 29 Although cost sharing equals 20 percent of the payment rate for most drugs, cost sharing is less than 20 percent for some high-cost drugs because cost sharing is capped at the level of the hospital inpatient deductible (\$1,216 in 2014). On average, cost sharing accounts for about 18 percent of the payment rate. In 2014, about 81 percent of beneficiaries who received Part B drugs at 340B hospitals had supplemental coverage that covered their cost-sharing for Part B drugs. About 19 percent of these beneficiaries lacked supplemental coverage.
- 30 In 2011, the Department of Health and Human Services Office of Inspector General found that about half of states had policies that required covered entities to bill Medicaid at

- their actual acquisition cost (AAC) for 340B drugs (Office of Inspector General 2011). According to interviews conducted by the Government Accountability Office (GAO) with 18 covered entities in 2011, most of these entities that used 340B drugs for Medicaid patients reported that Medicaid reimbursement for 340B drugs was based on the AAC plus a dispensing fee (Government Accountability Office 2011). According to GAO, state Medicaid agencies may reimburse covered entities at AAC because states cannot claim Medicaid rebates for drugs when entities decide to use drugs purchased at 340B prices for Medicaid patients.
- 31 We use medians rather than means to limit the influence of outliers on our set of efficient providers.
- 32 While H-CAHPS and similar patient satisfaction surveys have the limitation of being subjective, we add it as another way to screen out low-value providers because it has the advantage of not being dependent on coding. It is possible that overly aggressive coding by some providers could artificially lower their risk-adjusted cost and risk-adjusted mortality metrics.
- 33 CMS started to package some clinical lab tests into APCs in 2014. However, CMS overestimated the number of lab services that would be provided as part of each APC, resulting in payment rates for these services being too high. Starting in 2016, CMS will reduce conversion factors for all APCs to correct this overestimate. The reductions will more than fully offset the update for 2016, resulting in a net reduction in payment rates for outpatient services between 2015 and 2016.
- 34 We used data from line 30 of the 2014 Medicare cost reports, data on current uncompensated care payments for 2016, and data from 2014 Part B drug claims to estimate how the two policies would redistribute payments to hospitals in 2017. To check the robustness of our estimates, we also estimated how payments would be redistributed based on a sample of hospitals with audited data pertaining to their costs of caring for the uninsured. We took this extra step because CMS may choose to distribute dollars based only on charity care costs for the uninsured (line 23 of Worksheet S-10), rather than on the combination of charity care and bad debts (line 30 of Worksheet S-10). The results across hospital groups were similar, indicating an increase in payments to public hospitals. The policy materially redistributes payments, but overall Medicare payments would not change by using the S-10 data.

References

- Agency for Healthcare Research and Quality, Department of Health and Human Services. 2014. *Saving lives and saving money: Hospital-acquired conditions update*. Rockville, MD: AHRQ.
- Berenson, R. A., J. H. Sunshine, D. Helms, et al. 2015. Why Medicare Advantage plans pay hospitals traditional Medicare prices. *Health Affairs* 34, no. 8 (August): 1289–1295.
- Bureau of Labor Statistics. 2014. Employment cost index historical listing—volume III. Current dollar, March 2001–September 2014 (December 2005=100). October. <http://www.bls.gov/web/eci/echistrynaics.pdf>.
- Bureau of Labor Statistics, Department of Labor. 2013. Consumer Price Index—All Urban Consumers. Data for Los Angeles-Riverside-Orange County, CA. http://data.bls.gov/pdq/SurveyOutputServlet?series_id=CUURA421SA0,CUUSA421SA0.
- Cain Brothers. 2015. *Industry Insights* no. 886. November 2.
- California Department of Insurance. 2014a. Aetna Life Insurance Company rate filing. https://interactive.web.insurance.ca.gov/apex/f?p=102:9:0::NO::P9_RATE_FILINGS_ID,P9_COMPANY_NAME,P9_REFERRING_PAGE_NUM:8347,%5CAetna%20Life%20Insurance%20Company%5C,4&cs=1EC2866C2258A4653FBF2AB75773F8514.
- California Department of Insurance. 2014b. Blue Shield of California Life & Health Insurance Company rate filing. https://interactive.web.insurance.ca.gov/apex/f?p=102:9:0::NO::P9_RATE_FILINGS_ID,P9_COMPANY_NAME,P9_REFERRING_PAGE_NUM:8948,%5CBlue%20Shield%20of%20California%20Life%20%26%20Health%20Insurance%20Company%5C,4&cs=19EB00AA77FC6C786F771ED7A07590A6F.
- Census Bureau. 2015. Quarterly Services Survey, 2Q. <http://www2.census.gov/services/qss/2015/>.
- Centers for Disease Control and Prevention. 2015. *National and state healthcare associated infections progress report*. Atlanta, GA: CDC. <http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015a. Fiscal year (FY) 2016 results for the CMS Hospital Value-Based Purchasing Program. Press release. October 26. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-26.html>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015b. Medicare program; hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; short inpatient hospital stays; transition for certain Medicare-dependent, small rural hospitals under the hospital inpatient prospective payment system. Final rule. *Federal Register* 80, no. 219 (November 13): 70298–70607.
- Chandra, A., A. Finkelstein, A. Sacarny, et al. 2015. *Healthcare exceptionalism? Performance and allocation in the U.S. healthcare sector*. Working paper 21603. Cambridge, MA: National Bureau of Economic Research.
- Congressional Budget Office. 2015. *Updated budget projections: 2015 to 2025*. Washington, DC: CBO.
- Cooper, Z., S. V. Craig, M. Gaynor, et al. 2015. *That price ain't right? Hospital prices and health spending on the privately insured*. NBER working paper no. 21815. Cambridge, MA: National Bureau of Economic Research.
- Department of Health and Human Services. 2014. *Fiscal year 2015 Health Resources and Services Administration justification of estimates for appropriations committees*. Washington, DC: HHS.
- Fitch Ratings. 2015a. 2015 median ratios for nonprofit hospitals and healthcare systems. August 10.
- Fitch Ratings. 2015b. Cap Ex rising. September 24.
- Government Accountability Office. 2011. *Drug pricing: Manufacturer discounts in the 340B Program offer benefits, but federal oversight needs improvement*. GAO-11-836. Washington, DC: GAO.
- Health Care Cost Institute. 2015. *2014 health care cost and utilization report*. Washington, DC: HCCI.
- Health Care Cost Institute. 2014. *2013 health care cost and utilization report*. Washington, DC: HCCI.
- Health Care Cost Institute. 2012. *Health care cost and utilization report: 2010*. Washington, DC: HCCI.
- Health Resources and Services Administration. 2015. Statement of Diana Espinosa, Deputy Administrator, Health Resources and Services Administration, before the Subcommittee on Health, Committee on Energy and Commerce, U. S. House of Representatives. March 5.

- Health Resources and Services Administration, Department of Health and Human Services. 2014. FAQs: 340B Drug Pricing Program. <http://www.hrsa.gov/opa/faqs/index.html>.
- Himmelstein, D., and S. Woolhandler. 2015. Quality improvement: ‘Become good at cheating and you never need to become good at anything else’. *Health Affairs* blog, August 27. <http://healthaffairs.org/blog/2015/08/27/quality-improvement-become-good-at-cheating-and-you-never-need-to-become-good-at-anything-else/>.
- Huang, J., G. Jacobson, T. Neuman, et al. 2013. *Medigap: Spotlight on enrollment, premiums, and recent trends*. Menlo Park, CA: Kaiser Family Foundation.
- IMS Institute for Healthcare Informatics. 2014. IMS health study: Spending growth returns for U.S. medicines. News release. April 15.
- IMS Institute for Healthcare Informatics. 2012. *The use of medicines in the United States: Review of 2011*. Parsippany, NJ: IMS Institute for Healthcare Informatics.
- Irving Levin Associates Inc. 2015. *The health care services acquisition report: 21st edition*. Norwalk, CT: Irving Levin Associates Inc.
- Irving Levin Associates Inc. 2013. *The health care services acquisition report: 19th edition*. Norwalk, CT: Irving Levin Associates Inc.
- Lee, A. J., S. A. Garfinkel, R. K. Khandker, et al. 1997. Impact of Medicare SELECT on cost and utilization in 11 states. *Health Care Financing Review* 19, no. 1 (Fall): 19–40.
- Medicaid and CHIP Payment and Access Commission. 2015. *MACStats: Medicaid and CHIP data book*. Washington, DC: MACPAC.
- Medicare Payment Advisory Commission. 2015a. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2015b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2014a. Comment letter to CMS on the acute and long-term hospitals proposed rule, June 13. <http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms's-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0>.
- Medicare Payment Advisory Commission. 2014b. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2014c. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2014d. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2013a. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2013b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011a. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2010. *Report to the Congress: Aligning incentives in Medicare*. Washington, DC: MedPAC.
- Moody’s Investors Service. 2015a. Not-for-profit healthcare outlook stabilizes; cash flow buffers long-term pressures. August 26.
- Moody’s Investors Service. 2015b. Strong business conditions bolster profitability and growth, moderating fundamental sector risks. September 10.
- Morningstar Document Research. 2015a. HCA Holdings, for 10–Q. October 29.
- Morningstar Document Research. 2015b. Lifepoint Health Inc., for 10–Q. September 30.
- Morningstar Document Research. 2015c. Tenet Healthcare Corp., for 10–Q. November 2.
- Office of Inspector General, Department of Health and Human Services. 2015a. OIG advisory opinion no. 15–05. <http://oig.hhs.gov/fraud/docs/advisoryopinions/2015/advopn15-05.pdf>.
- Office of Inspector General, Department of Health and Human Services. 2015b. *Part B payments for 340B-purchased drugs*. Washington, DC: OIG.

Office of Inspector General, Department of Health and Human Services. 2011. *State Medicaid policies and oversight activities related to 340B-purchased drugs*. Washington, DC: OIG.

Selden, T. M., Z. Karaca, P. Keenan, et al. 2015. The growing difference between public and private payment rates for inpatient hospital care. *Health Affairs* 34, no. 12 (December 1): 2147–2150.

Standard & Poor's Ratings Services. 2015. U.S. not-for-profit health care sector outlook revised to stable from negative, though uncertainties persist. September 9.

Thompson, B. 2015. Rural Kansas hospitals search for ways to survive. KHI News Service/Heartland Health Monitor, June 29. <http://kcur.org/post/rural-kansas-hospitals-search-ways-survive>.

Young, S. 2015. Personal communication with Sarah Young, Office of Rural Health Policy.