



Advising the Congress on Medicare issues

Fiscal pressure and Medicare payments to hospitals

Presentation to the Brookings Institution
Hospital Productivity Trends: Implications for Medicare Payment Policy

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June 25, 2019

Outline of brief comments

- Efficient hospitals – cost and quality
- Readmissions
- Overall cost growth trends – Medicare vs. commercial payers

Indicators of Medicare hospital payment adequacy are mostly positive

- Access to care: Good
 - Inpatient and outpatient hospital use increased
 - Excess capacity with overall 62.5% occupancy
 - Marginal profit: +8% in 2017
- Access to capital: Strong access to capital markets
 - All-payer margin: +7%
- Quality: Improving (lower mortality, improved patient experience)
- 2017 Medicare margins: Declining
 - Aggregate margin: -9.9%
 - Efficient provider : -2%
- 2019 projected aggregate Medicare margin: -11%

Defining relatively efficient providers

- MedPAC required by statute to assess “factors affecting expenditures for the efficient provision” of Medicare services
- Principles for identifying relatively efficient providers:
 1. Providers must do well on cost and quality metrics
 2. Performance must be consistent over the past three years
- *Broad definition of “efficiency” in order to capture sufficient number of hospitals*
- Metrics used to identify relatively efficient hospitals:
 1. Hospital-level mortality rates
 2. Readmission rates
 3. Standardized inpatient Medicare cost per case

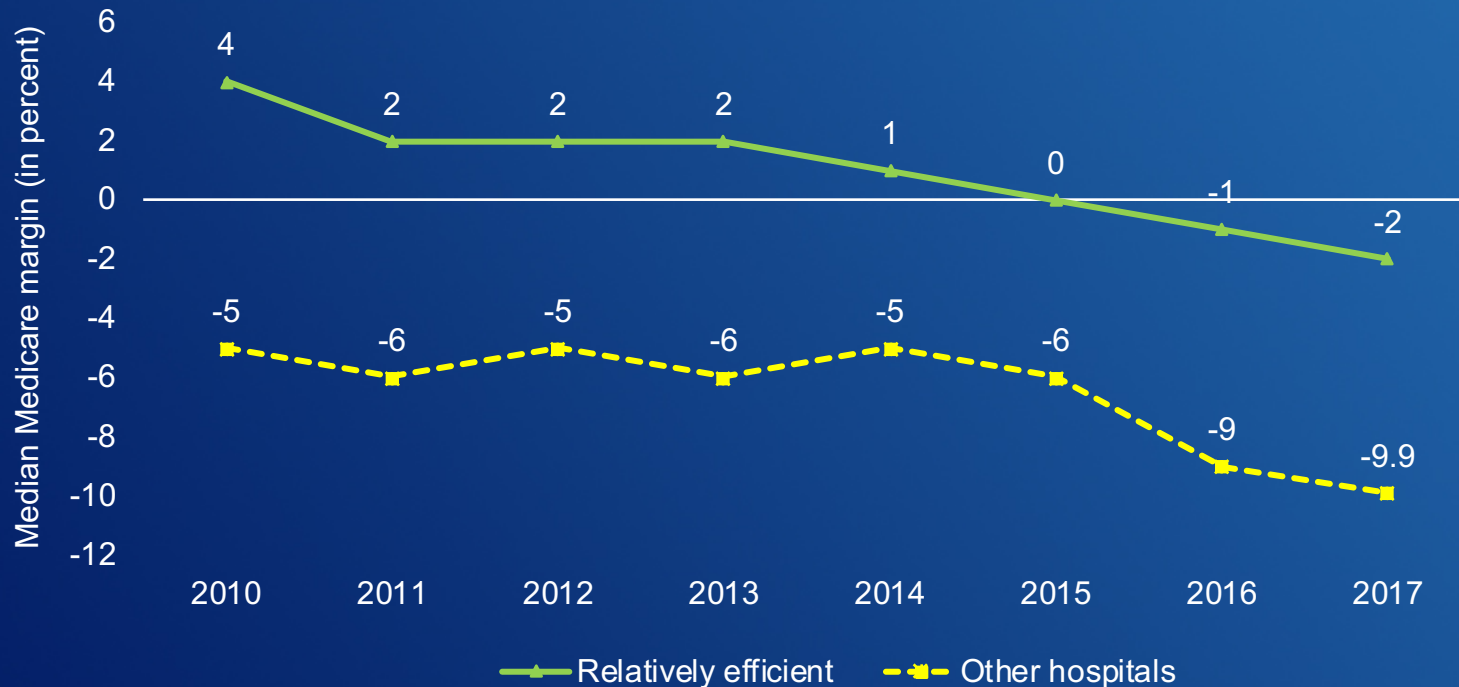
Comparing performance of relatively efficient hospitals to others, 2017

| Measure | Relatively efficient hospitals | Other hospitals |
|--------------------------------------|---------------------------------------|------------------------|
| Number of hospitals | 291 (14%) | 1,860 (86%) |
| 30-day mortality (rel. to median) | 7% lower | 2% above |
| 30-day readmissions (rel. to median) | 5% lower | 3% above |
| Standardized costs (rel. to median) | 9% lower | 1% above |
| Overall Medicare margin | -2% | -9% |

Note: Hospitals are classified as efficient based on 2014 to 2016 performance. In this slide, 2017 medians for each group are compared to the national median.

Source: Medicare cost reports and claims data

Financial performance of relatively efficient hospitals under Medicare's inpatient prospective payment system



Note: Margins = (payments – costs) / payments. Excludes critical access hospitals and Maryland hospitals. The overall Medicare margin covers inpatient, outpatient, hospital-based post-acute care in IPPS hospitals, graduate medical education, and other payments such as payments for the adoption of electronic medical records. Efficient hospitals exclude hospitals with Medicaid shares in the lowest 10% percent and hospitals in the 10% of markets with the highest service use due to concerns that socioeconomic status and aggressive treatment patterns can influence unit costs.

Source: MedPAC analysis of Medicare cost reports from CMS.

Hospital Readmissions Reduction Program has been largely successful

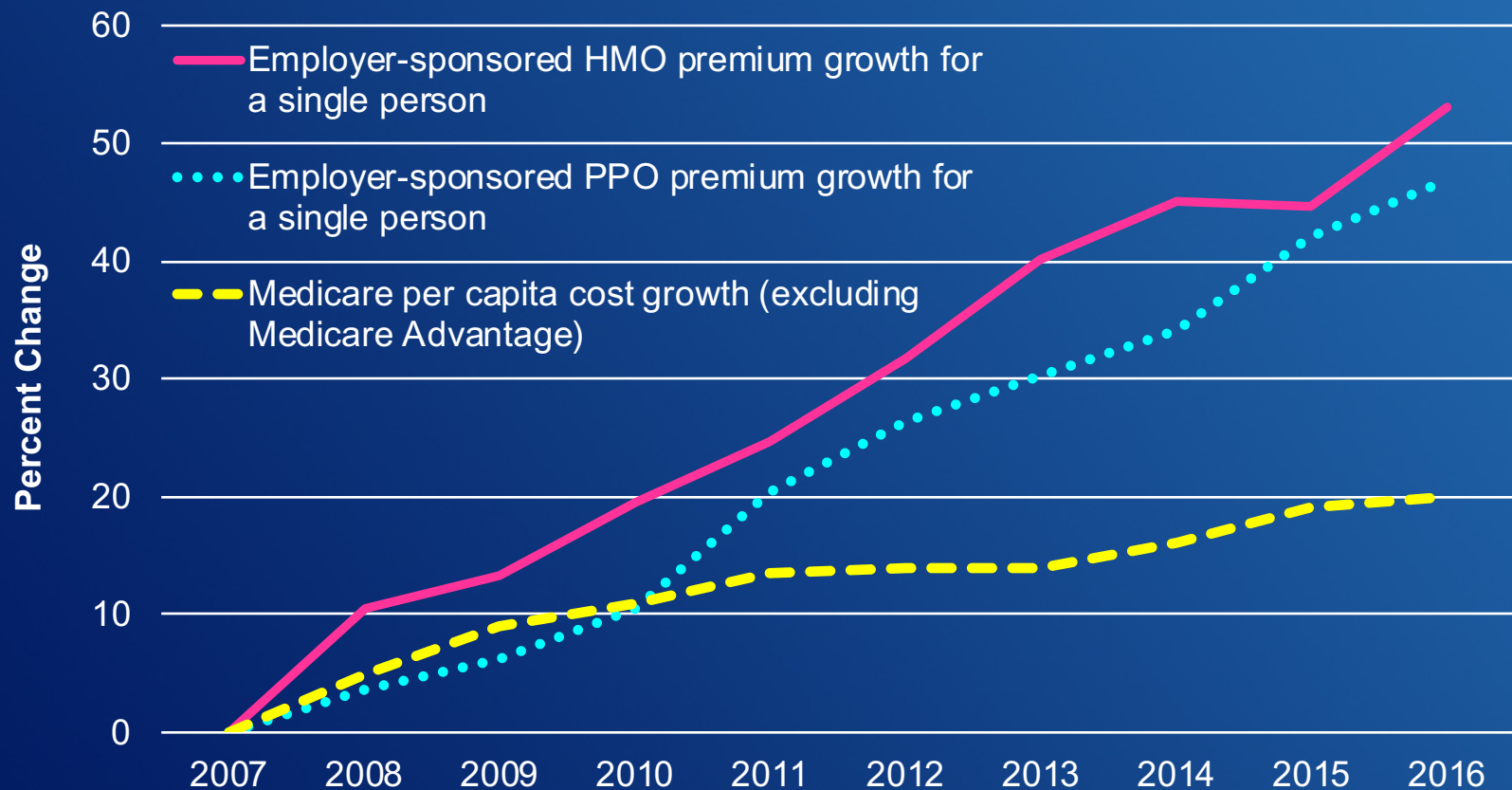
- The Hospital Readmissions Reduction Program (HRRP) created an incentive to reduce readmissions
- Readmissions declined (at least partially due to the HRRP)
- Observation and emergency visits increased, but may be largely due to reasons other than the HRRP
- HRRP did not appear to negatively affect mortality rates

Effect of lower readmission rates on Medicare payments from 2010 to 2016

| Type of care (post-discharge) | Change in payments (in billions) |
|----------------------------------|-------------------------------------|
| Readmissions | \$ -2.28 |
| Observation stays | 0.17 |
| ED visits | <u>0.07</u> |
| Annual change in spending | -2.04 |

Note: Change in the annual payments for readmissions, observation stays, and ED visits post-discharge includes the cost of all changes, even if they did not stem from the HRRP. The \$2 billion in reduced trust fund expenditures does not include reductions due to the penalties.

Over the last decade, cost of commercial insurance has grown twice as fast as Medicare costs



Data are preliminary and subject to change.

Note: HMO (health maintenance organization), PPO (preferred provider organization), FFS (fee-for-service).

Source: Employer-sponsored premium data from Kaiser Family Foundation surveys, 2007 through 2016. Medicare spending figures from Part A and Part B spending data from CMS actuaries; Part D spending per capita figures through 2015 from MedPAC analysis of claims and reinsurance data for individuals with Part D coverage. Part D spending for 2016 is a projection based on MedPAC analysis.

Discussion / questions

- More info at www.medpac.gov