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Health, Education and Human Services Division

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May 25, 1995

The Honorable John R. Kasich
Chairman, Committee on the Budget
House of Representatives

Dear Mr. Chairman:

As you know, the Medicare program covers hospital inpatient as well as outpatient services for eligible beneficiaries. Hospital inpatient services constitute the single largest category of Medicare spending. In fiscal year 1984, the prospective payment system (PPS), a system of standardized payments per discharge based on patient diagnosis, was put in place to control the growth of this spending category; however, payments per discharge have continued to grow faster than the general inflation rate. While payments to all types of hospitals have increased faster than inflation, they have not increased at the same rate. To examine the trends in payment growth, you asked us to provide you with the annual growth rates in payments per discharge by type of hospital. To provide this information, we examined data from the Prospective Payment Assessment Commission (ProPAC).

In summary, these data show that

-- hospital payments per discharge grew at an annual rate of 5.4 percent from 1984 through 1992, while general prices grew about 3.5 percent annually over the same period;[1]

-- by teaching status, major teaching hospitals experienced the largest growth in payments per discharge, averaging 5.7 percent annually from 1984 through 1992; nonteaching hospitals' payment growth averaged 5.3 percent annually;

[1]We measured the growth in general price levels using the gross domestic product implicit price deflator, adjusted for the fiscal year.

-- hospitals receiving disproportionate share (DSH) payments for treating large numbers of low-income patients experienced higher per discharge payment growth than hospitals not receiving these payment adjustments;

-- for both urban and rural hospitals, average annual payment growth rates were higher for larger hospitals; and

-- for ownership types, government-owned facilities had higher growth in payments per discharge than voluntary or proprietary facilities.

Table 1 contains a detailed breakdown of these growth rates by hospital category and by fiscal year.

Table 1: Changes in PPS Operating Payments per Discharge, by Hospital Group (Fiscal Years 1984-92)

	Percent Change During Fiscal Year									
Hospital Group	1984	1985	1986	1987	1988	1989	1990	1991	1992	Average 1984 through 1992
Annual inflation rate	3.89	2.92	3.06	3.72	4.30	4.42	3.95	3.05	2.31	3.51
All hospitals	10.30	3.20	5.00	5.40	5.70	5.30	5.50	4.72	3.74	5.43
Urban	10.10	3.00	4.80	5.10	5.80	4.70	5.10	4.43	3.92	5.22
Rural	9.20	3.20	5.70	7.10	5.70	7.50	7.70	6.08	2.96	6.13
Large urban	8.80	2.90	3.60	4.60	5.80	4.30	5.10	3.91	4.45	4.83
Other urban	11.70	3.20	6.40	5.90	5.80	5.20	5.00	5.25	3.15	5.73
Rural referral	14.20	4.30	6.40	6.90	6.30	5.80	7.40	6.74	2.80	6.76
Sole community	6.60	2.20	4.90	5.60	4.10	10.30	9.00	4.27	3.29	5.58
Other rural	6.60	2.20	5.00	7.30	5.70	7.60	7.40	6.02	3.00	5.65
Teaching										
Major teaching	12.90	0.90	4.80	5.80	5.10	5.70	7.40	3.88	5.18	5.74
Other teaching	10.00	3.00	4.40	4.70	6.10	5.50	5.40	4.54	3.65	5.25
Nonteaching	9.30	3.50	5.40	6.00	5.60	4.90	5.00	4.66	3.13	5.28
Disproportionate share (DSH)										
Large urban	9.00	3.80	4.50	5.20	6.00	5.60	5.80	3.94	4.60	5.38
Other urban	11.90	3.90	7.40	6.20	6.00	5.50	5.40	5.60	3.83	6.19
Rural	9.20	3.50	6.90	8.00	8.10	9.20	8.40	8.03	3.08	7.16
Nondisproportionate share	10.10	2.80	4.30	5.10	5.60	4.80	5.30	4.48	3.19	5.07
Payment adjustments for indirect medical education (IME) and DSH										
IME and DSH	11.10	3.50	5.60	5.40	5.70	6.00	6.20	4.56	4.33	5.82
IME only	10.70	1.80	3.30	4.30	6.10	5.10	5.60	4.53	3.84	5.03
DSH only	9.10	4.20	6.50	6.60	6.60	5.70	5.20	5.18	3.55	5.85
No IME or DSH	9.40	3.20	5.00	5.80	5.20	4.60	4.90	4.27	2.82	5.02
Urban <100 beds	10.00	2.60	4.90	4.30	5.00	0.30	1.60	3.11	2.75	3.84
Urban 100-199 beds	8.70	3.70	5.30	5.10	5.90	4.10	3.90	4.27	3.72	4.97
Urban 200-299 beds	8.70	3.10	4.40	4.60	5.80	4.50	4.40	4.59	4.35	4.94
Urban 300-399 beds	9.60	3.10	4.40	5.50	5.30	5.40	5.40	4.28	3.99	5.22
Urban 400-499 beds	11.20	2.50	5.40	5.60	5.00	4.90	5.80	4.09	3.18	5.30
Urban 500+ beds	11.80	1.90	4.30	5.10	6.60	5.40	6.40	4.01	3.99	5.50
Rural <50 beds	6.90	2.00	6.10	8.20	3.40	7.00	6.10	2.81	2.88	5.04
Rural 50-99 beds	7.40	1.90	4.10	6.90	5.60	8.70	7.40	5.13	2.76	5.54
Rural 100-149 beds	7.20	3.00	5.80	6.50	7.40	7.70	7.60	7.35	2.28	6.09
Rural 150-199 beds	10.60	4.00	6.50	6.70	4.30	5.10	8.50	6.61	3.31	6.18
Rural 200+ beds	13.40	3.90	6.00	6.70	6.60	7.10	8.20	7.74	3.85	7.05
Voluntary	10.00	2.90	4.60	5.20	5.60	5.00	5.30	4.64	3.75	5.22
Proprietary	8.70	4.00	5.80	5.40	6.30	6.20	5.60	4.73	4.18	5.66
Urban government	12.40	3.80	6.60	6.50	6.30	4.10	6.20	4.69	3.94	6.06
Rural government	9.30	2.80	5.80	8.20	5.80	8.20	7.10	5.43	2.42	6.12

Source: ProPAC.

Note that the numbers in table 1 show only the revenue side of the equation without addressing issues of cost per discharge. Payment increases, therefore, do not necessarily translate into earnings increases. In particular, these revenue growth rates do not account for differences in case complexity across hospital types and regional differences in wage rates. For example, if hospitals with high payment growth rates also receive cases of increasing complexity, relatively high payment growth rates may offset corresponding cost increases.

Table 2 shows the average annual growth rate in case mix (a measure of case complexity) by hospital type.

Table 2: Changes in Hospital Case Mix, by Hospital Group (Fiscal Years 1984-92)

Hospital Group	Average annual growth rate, 1984 through 1992
All hospitals	2.78
Urban	2.98
Rural	1.85
Large urban	2.95
Other urban	2.99
Rural referral	2.41
Sole community	1.48
Other rural	1.54
Teaching	
Major teaching	3.55
Other teaching	3.10
Nonteaching	2.42
Disproportionate share	
Large urban	3.05
Other urban	3.01
Rural	1.96
Nondisproportionate share	2.68
Payment adjustments	
IME and DSH	3.27
IME only	3.14
DSH only	2.49
No IME or DSH	2.39
Urban <100 beds	1.88
Urban 100-199 beds	2.37
Urban 200-299 beds	2.75
Urban 300-399 beds	3.08
Urban 400-499 beds	3.27
Urban 500+ beds	3.58
Rural <50 beds	0.80
Rural 50-99 beds	1.49
Rural 100-149 beds	2.04
Rural 150-199 beds	2.00
Rural 200+ beds	2.56
Voluntary	2.76
Proprietary	3.30
Urban government	2.91
Rural government	1.51

Source: ProPAC.

Note that case complexity grew more rapidly for large hospitals in both rural and urban areas, partially accounting for higher payment growth in those categories.

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If you or your staff have any questions, please call me or Patrick Redmon at (202) 512-7107.

Sincerely yours,

Jonathan Ratner

Jonathan Ratner
Associate Director
Health Financing and Policy Issues

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