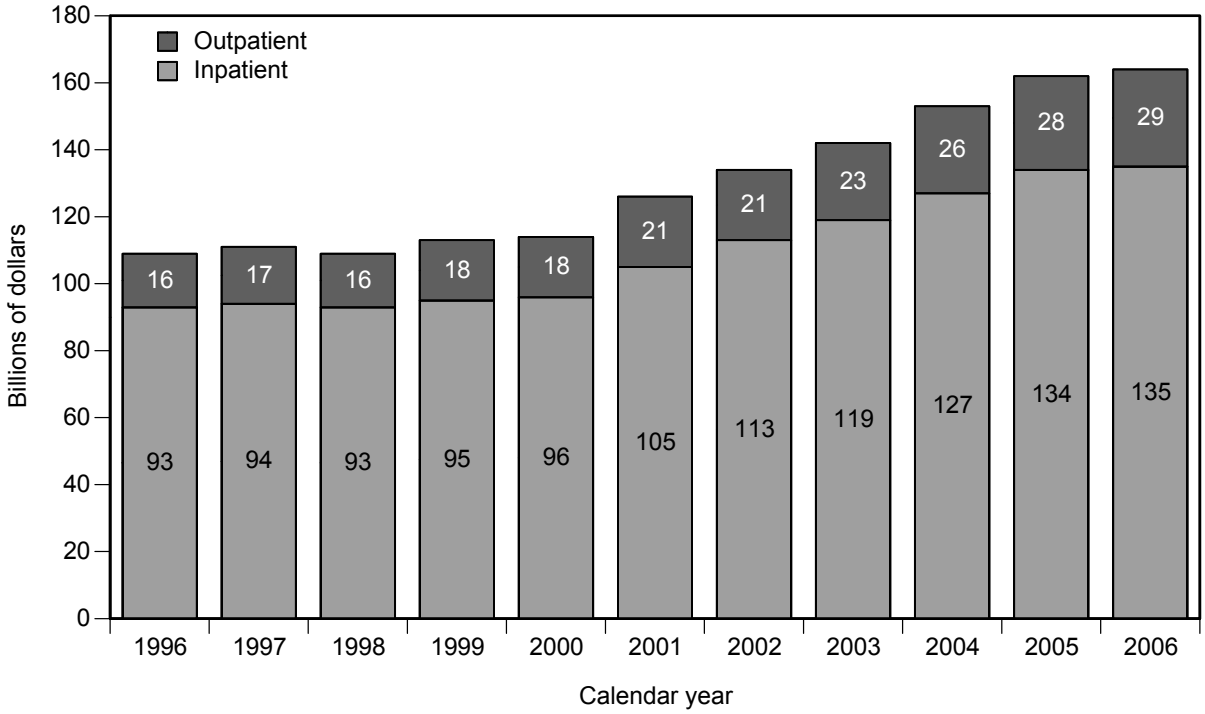
SECTION 7

Acute inpatient services

Short-term hospitals
Specialty psychiatric facilities

Chart 7-1. Growth in Medicare's payments for hospital inpatient and outpatient services, 1996–2006



Note: Analysis includes inpatient services covered by the acute inpatient prospective payment system (IPPS); psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; outpatient services covered by the outpatient PPS; and other outpatient services. Payments include program outlays and beneficiary cost sharing. The growth in spending was slowed in 2006 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

Source: CMS, Office of the Actuary.

- Aggregate Medicare fee-for-service (FFS) inpatient spending was $135 billion and outpatient spending was $29 billion in 2006.
- Medicare hospital FFS inpatient spending increased 46 percent (3.9 percent per year) and outpatient spending increased 77 percent (6.0 percent per year) from 1996 to 2006.
- A freeze in inpatient payment rates in the Balanced Budget Act of 1997 (BBA) reduced inpatient spending growth in 1998. Spending increased substantially in 2001 through 2004. Payment growth was relatively slow from 2005 to 2006 because a large number of beneficiaries switched from traditional fee-for-service Medicare to the Medicare Advantage (MA) program.
- Outpatient spending fell in 1998, reflecting the BBA's elimination of inadvertent overpayments. Transitional corridor and new technology payments in the outpatient prospective payment system, along with volume increase, increased outpatient spending in 2001. Payment for certain outpatient drugs on an average wholesale price basis and extension of hold-harmless payments to small rural and sole community hospitals were the key factors in higher growth rates in 2004 and 2005.

Chart 7-2. Major diagnostic categories with highest volume, fiscal year 2006

MDC number	MDC name	Share of all discharges	Share of medical discharges	Share of surgical discharges
5	Circulatory system	27%	25%	31%
4	Respiratory system	14	19	3
8	Musculoskeletal system and connective tissue	12	4	31
6	Digestive system	11	12	9
1	Nervous system	8	9	5
11	Kidney and urinary tract	6	7	4
10	Endocrine, nutritional, and metabolic diseases and disorders	4	5	2
18	Infectious and parasitic diseases	4	5	2
7	Hepatobiliary system and pancreas	3	3	4
9	Skin, subcutaneous tissue, and breast	3	3	2
Total		92	92	92

Note: MDC (major diagnostic category).

Source: MedPAC analysis of MedPAR data from CMS.

- In fiscal year 2006, 10 major diagnostic categories accounted for 92 percent of all discharges at hospitals paid under the acute inpatient prospective payment system.
- Circulatory system cases accounted for almost one-third of surgical discharges and one-quarter of medical discharges.
- Musculoskeletal system cases accounted for 31 percent of surgical discharges.
- Respiratory system cases accounted for 19 percent of medical discharges.

Chart 7-3. Number of acute care hospitals and Medicare discharges, by hospital group, 2006

Hospital group	Hospitals		Medicare discharges	
	Number	Share of total	Number (thousands)	Share of total
All PPS and critical access hospitals	4,643	100.0%	11,608	100.0%
PPS hospitals	3,375	72.7	11,148	96.0
Urban	2,400	51.7	9,484	81.7
Rural	975	21.0	1,663	14.3
Large urban	1,311	28.2	5,130	44.2
Other urban	1,089	23.5	4,354	37.5
Rural referral	141	3.0	481	4.1
Sole community	410	8.8	655	5.6
Medicare dependent	142	3.1	164	1.4
Other rural <50 beds	95	2.0	60	0.5
Other rural ≥50 beds	187	4.0	303	2.6
Voluntary	2,008	43.2	8,048	69.3
Proprietary	781	16.8	1,743	15.0
Government*	586	12.6	1,357	11.7
Major teaching	281	6.1	1,681	14.5
Other teaching	761	16.4	3,964	34.1
Nonteaching	2,333	50.2	5,503	47.4
Critical access hospitals	1,268	27.3	461	4.0

Note: PPS (prospective payment system). Analysis includes all hospitals covered by Medicare's inpatient PPS along with critical access hospitals. Maryland hospitals are excluded. Large urban areas have populations of more than 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least 0.25. Other teaching hospitals have a ratio of below 0.25. Data are limited to providers with complete cost reports in the CMS database.
*The results for government-owned providers are not necessarily comparable to other providers because they operate in a different context.

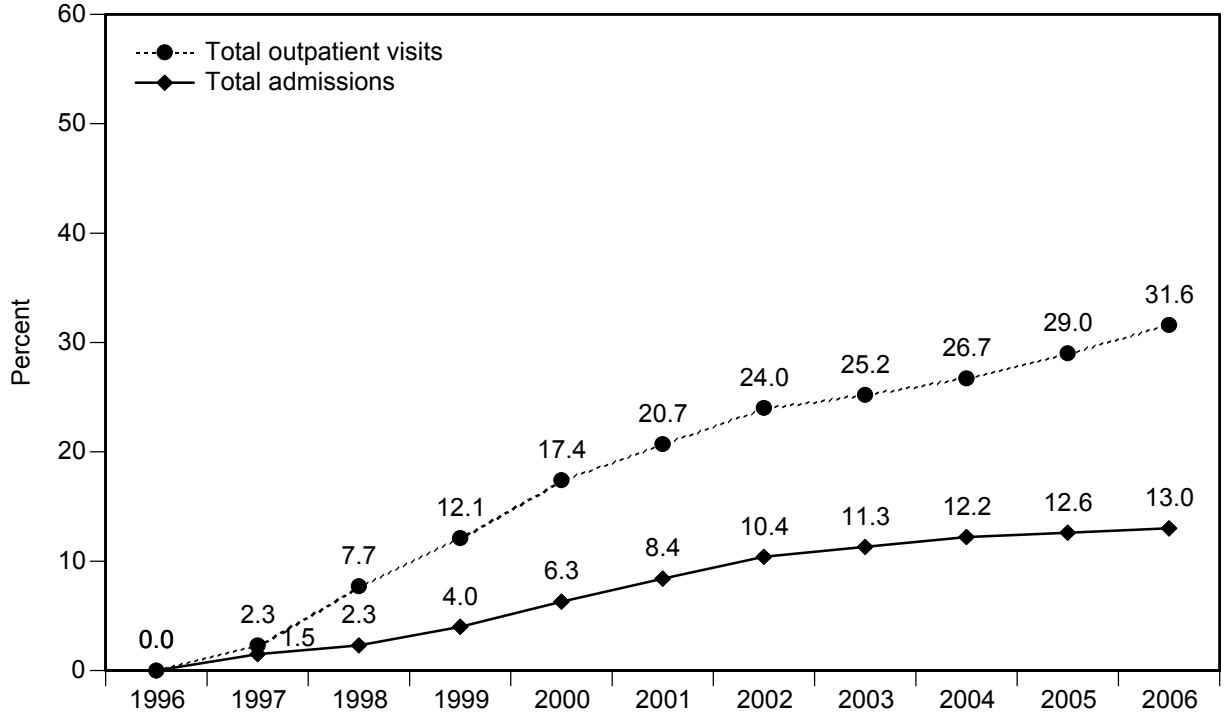
Source: MedPAC analysis of PPS impact files and Medicare cost report data from CMS.

- In 2006, 3,375 hospitals provided 11.1 million discharges under Medicare's acute inpatient prospective payment system (PPS) and 1,268 critical access hospitals provided almost 0.5 million discharges. The number of PPS discharges declined primarily due to a shift in Medicare beneficiaries from fee-for-service Medicare to Medicare Advantage plans.

- About 15 percent of acute care hospitals (20 percent of PPS hospitals) are covered by three special payment provisions intended to help rural facilities that do not become critical access hospitals (rural referral, sole community, and small rural Medicare-dependent hospitals); these facilities provide about 11 percent of all discharges.

- See Chart 7-22 for more information about critical access hospitals.

Chart 7-4. Cumulative change in total admissions and total outpatient visits, 1996–2006



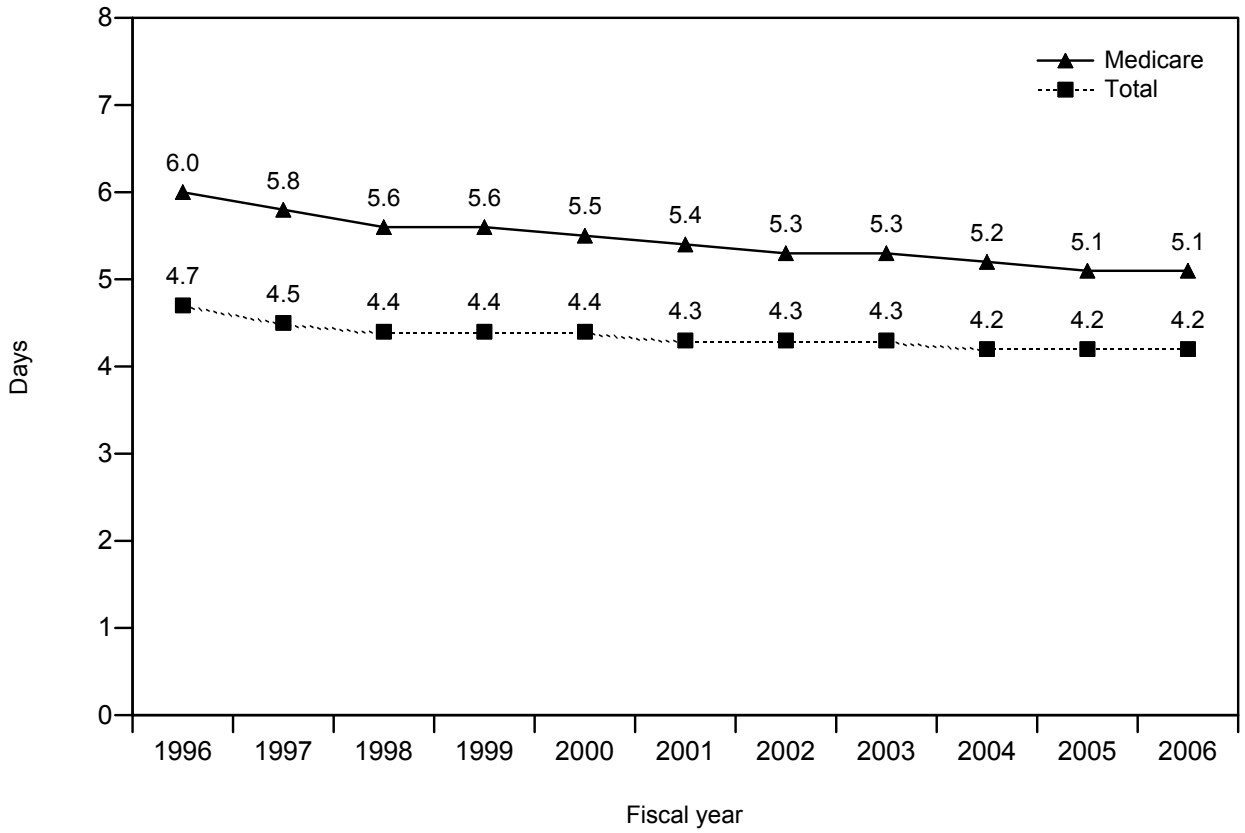
Note: Cumulative change is the total percent increase from 1996 through 2006. Data are admissions (all payers) to and outpatient visits at approximately 5,000 community hospitals.

Source: American Hospital Association, AHA Hospital Statistics.

- Hospital outpatient service use has grown much more rapidly than inpatient service use. Total hospital outpatient visits increased approximately 32 percent from 1996 to 2006, while total admissions grew just 13 percent.

- There were nearly 600 million outpatient visits and over 35 million admissions to community hospitals in 2006.

Chart 7-5. Trends in Medicare and total hospital length of stay, 1996–2006

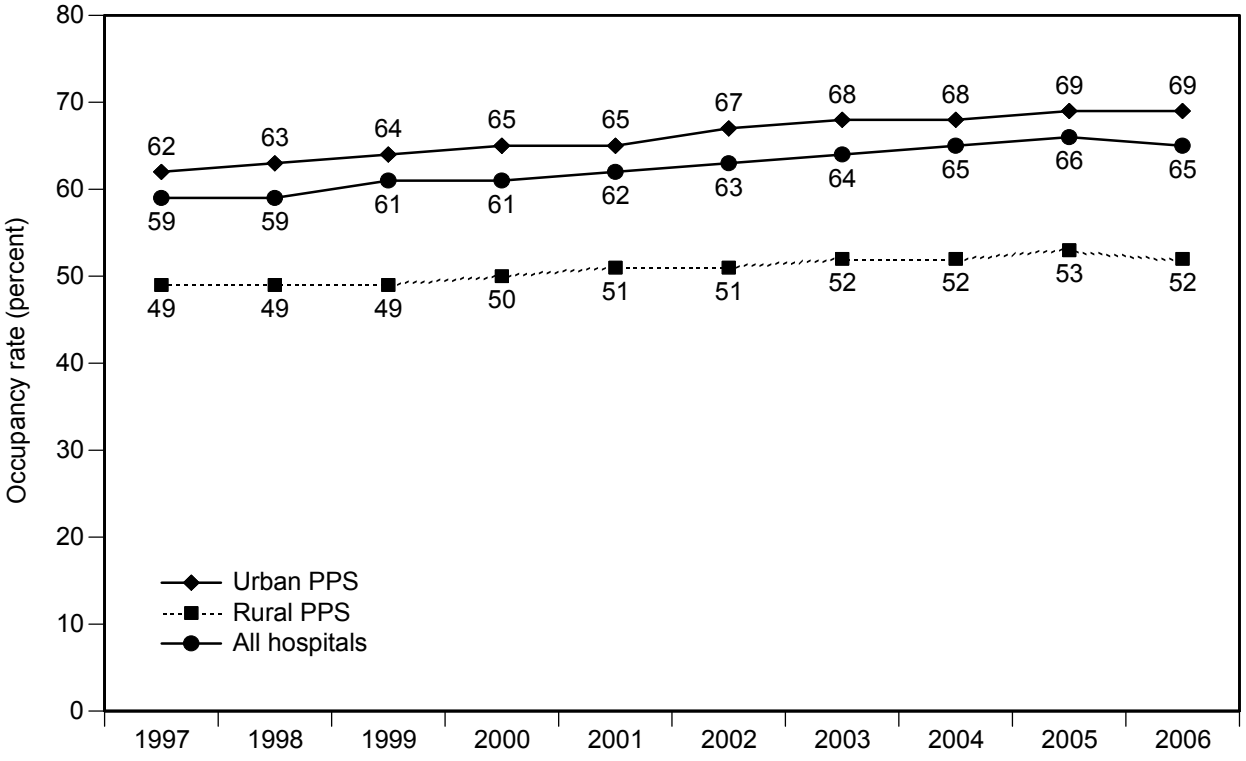


Note: Length of stay is calculated from discharges and patient days for approximately 3,300 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Length of stay for Medicare inpatients was nearly 1 day longer than for all hospital discharges in 2006.
- Length of stay for all hospital discharges fell 10 percent, from 4.7 days in 1996 to 4.2 days in 2006, dropping at an average annual rate of 1.1 percent from 1996 to 2001 and 0.3 percent from 2001 to 2006.
- Length of stay for Medicare inpatients fell 15 percent, from 6.0 days in 1996 to 5.1 days in 2006, dropping at an average annual rate of 2.3 percent from 1996 to 2001 and 0.9 percent from 2001 to 2006.

Chart 7-6. Hospital occupancy rates, 1997–2006

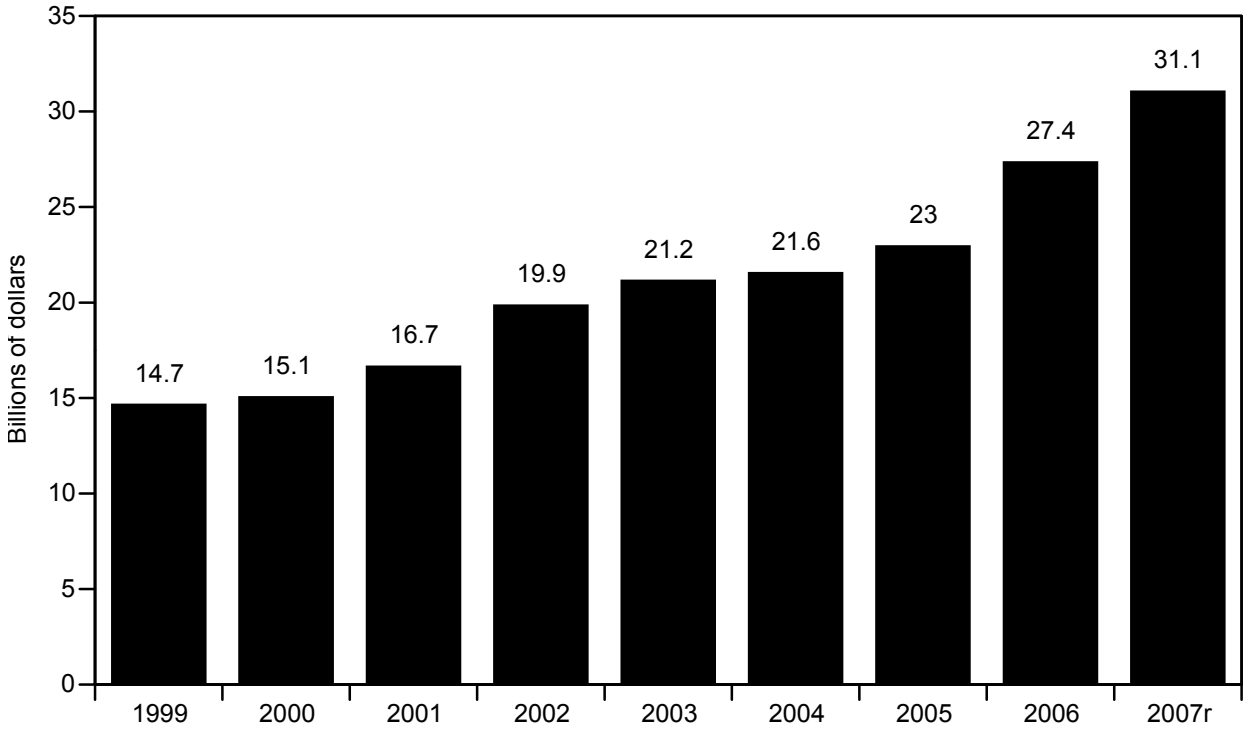


Note: PPS (prospective payment system). Hospital occupancy rate is measured as total inpatient days as a percent of total available bed days in the hospital over the reporting period. Bed days available are based on beds that are set up and staffed for inpatient service (i.e., the units are open and operating), but the beds may not be staffed for a full patient load in each unit on any given day. Hospitals' group designations for the entire 1997–2006 period are based on their status at the end of 2006.

Source: MedPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

- Hospitals' occupancy rates have been rising, with the aggregate occupancy rate climbing from 59 percent in 1997 to 65 percent in 2006.
- Occupancy rates are higher in urban than in rural hospitals; in 2006, occupancy rates stood at 69 percent for urban hospitals and 52 percent for rural hospitals, a 17 percentage point difference.

Chart 7-7. Nonfederal hospital construction spending, 1999–2007

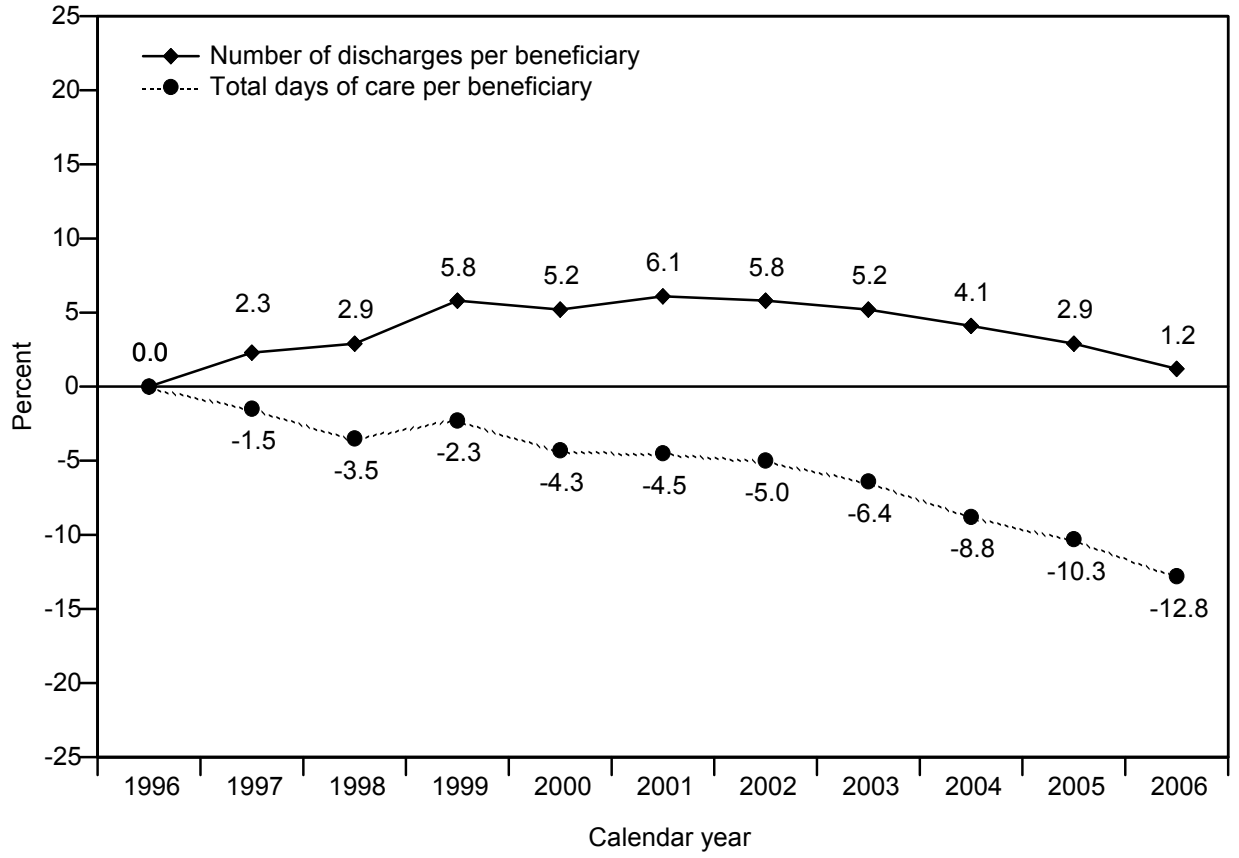


Note: Spending is for nonfederal hospital construction. Data for 2007 is revised by Census Bureau in May 2008. Data are inflated to 2007 dollars using the McGraw-Hill construction cost index. r = revised.

Source: Census Bureau. http://www.census.gov/const/www/c30index.html. May 2008.

- Hospital construction has increased substantially since 1999, expanding almost 35 percent (in real terms) in the past two years alone to $31 billion.

Chart 7-8. Cumulative change in Medicare discharges and days of care per beneficiary, 1996–2006



Note: Cumulative change is the total percent change from 1996 through 2006. Data are short-stay hospital Medicare patient days and discharges. Rate is per beneficiary enrolled in Part A. The statistics do not reflect managed care enrollment.

Source: MedPAC analysis of claims files and enrollment data from CMS.

- From 1996 to 2006 short-stay hospital discharges per beneficiary increased slightly and total days of care per beneficiary declined. Medicare discharge rates increased between 1996 and 2006, to a peak of approximately 6 percent more discharges per enrollee in 2001. However, by the end of the period discharges returned close to 1996 levels. In addition, declining length of stay led to 12.8 percent fewer days of inpatient care per enrollee in 2006, relative to 1996.

- There were 349 Medicare hospital discharges and 1,981 patient days per 1,000 beneficiaries enrolled in Part A in calendar year 2006.

Chart 7-9. Medicare inpatient payments, by source and hospital group, 2006

Hospital group	Percent of total payments					Total payments (millions)
	Base	IME	DSH	Outlier	Additional rural hospital*	
All hospitals	82.5%	5.1%	7.8%	4.2%	0.5%	$104,992
Urban	81.8	5.6	8.1	4.5	0.2	93,645
Rural	88.8	0.7	5.5	1.8	3.1	11,277
Large urban	79.9	6.8	8.6	4.7	0.0	53,150
Other urban	84.2	3.9	7.4	4.1	0.3	40,445
Rural referral	88.4	2.3	5.5	2.7	2.3	5,793
Sole community	87.3	0.0	4.0	0.9	7.8	2,436
Medicare dependent	90.2	0.0	5.7	0.8	3.2	830
Other rural <50 beds	91.6	0.0	7.7	0.7	0.0	315
Other rural ≥50 beds	91.0	0.3	6.6	1.8	0.4	1,953
Voluntary	83.1	5.4	6.9	4.1	0.5	77,289
Proprietary	85.1	1.5	9.5	3.6	0.3	14,231
Government**	76.2	6.7	11.4	4.9	0.7	13,106
Major teaching	67.0	16.4	10.7	5.8	0.1	23,634
Other teaching	84.6	3.7	7.4	4.0	0.3	37,915
Nonteaching	89.2	0.0	6.5	3.5	0.8	43,374

Note: IME (indirect medical education), DSH (disproportionate share). Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Includes both operating and capital payments but excludes graduate medical education payments. Excludes critical access hospitals. Simulated payments reflect 2006 payment rules applied to actual number of cases in 2006. Medicare fee-for-service inpatient payments did not grow from 2005 to 2006 due to enrollment shifting from fee-for-service to Medicare Advantage (MA). Due to changes in MA enrollment and in our reporting methodology, this year's table is not exactly comparable to last year's table.

*Payments received by sole community and Medicare-dependent hospitals beyond what would have been received under PPS. A few sole community hospitals are located in urban areas.

** The results for government-owned providers are not necessarily comparable to other providers because they operate in a different context.

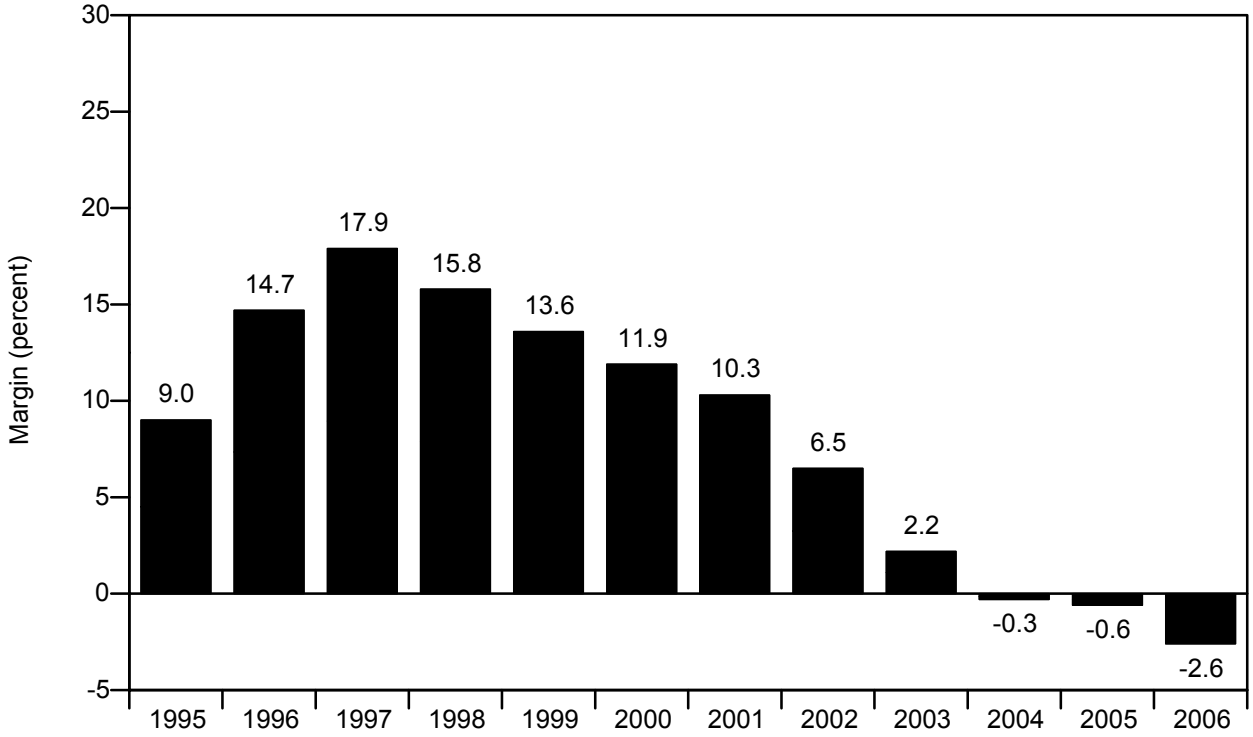
Source: MedPAC analysis of claims and impact file data from CMS.

- Medicare payments in 2006 to hospitals covered by the acute inpatient prospective payment system totaled about $105 billion. About $94 billion (89 percent) was paid to hospitals located in urban areas. The other $11 billion went to rural hospitals, although this figure does not reflect payments to critical access hospitals.

- Special payments—which include disproportionate share, indirect medical education, and outlier payments, as well as additional payments to rural hospitals through the sole community and Medicare-dependent programs—account for about 17 percent of all inpatient payments. This proportion is higher for urban than for rural hospitals.

- Outlier payments were 4.2 percent of total inpatient payments in 2006. The legislative mandate for the level of outlier payments uses a different measure—outlier payments as a percent of base plus outlier payments. Measured in this way, CMS's goal is 5.1 percent and the agency reports that outlier payments were 4.0 percent in 2005 and 4.7 percent in 2006.

Chart 7-10. Medicare acute inpatient PPS margin, 1995–2006



Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

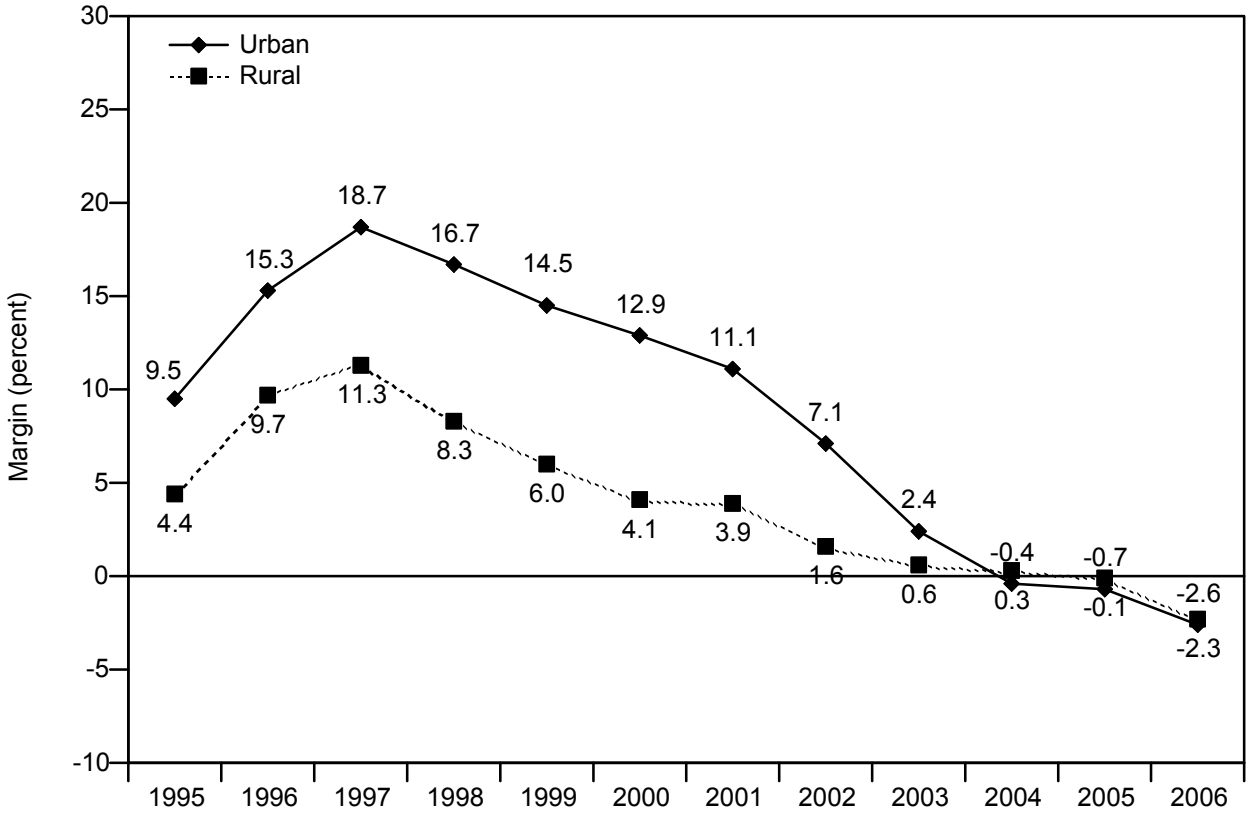
Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- Medicare's acute inpatient margin reflects payments and costs for services covered by Medicare's inpatient hospital prospective payment system (PPS). The inpatient margin may be influenced by how hospitals allocate overhead costs across service lines. Only by combining data for all major services can we estimate Medicare costs without the influence of how overhead costs are allocated (see Chart 7-12).

- The Medicare inpatient margin reached a record high of 17.9 percent in 1997. After implementation of the Balanced Budget Act of 1997, however, inpatient margins fell. In 2006, the margin was –2.6 percent, the lowest level since the beginning of the inpatient PPS.

- Medicare inpatient margins vary widely. In 2006, one-quarter of hospitals had Medicare inpatient margins that were 8.0 percent or higher, and another quarter had margins that were –16.8 percent or lower. About 42 percent of hospitals treating 42 percent of Medicare cases had positive inpatient Medicare margins in 2006.

Chart 7-11. Medicare acute inpatient PPS margin, by urban and rural location, 1995–2006

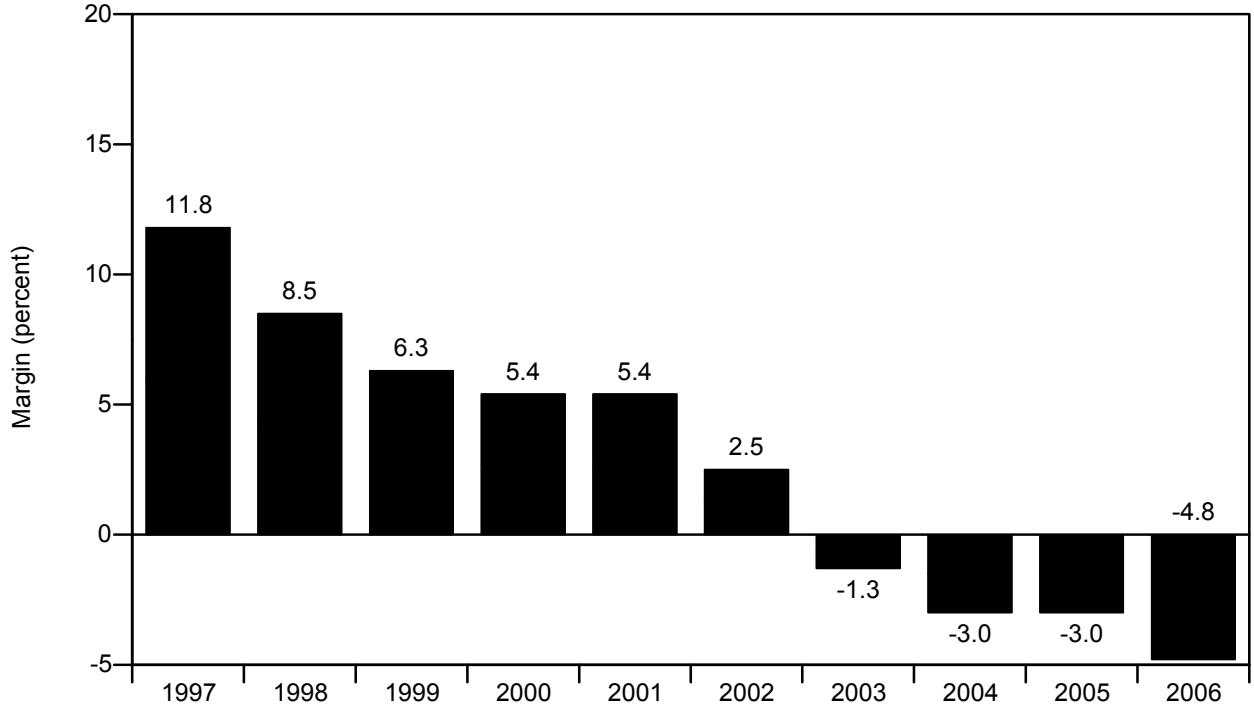


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- Urban hospitals tend to have higher Medicare inpatient margins than rural hospitals.
- The gap between urban and rural hospitals' inpatient margins grew between 1995 and 2000. One factor in this divergence is that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. From 2001 through 2004, these differences narrowed and from 2004 to 2006 rural hospitals' inpatient margins were slightly higher than those of urban hospitals. This change is the result of payment policies targeted at raising rural hospital payments, and growth in the number of critical access hospitals, which removed many rural hospitals with low margins from the prospective payment system.

Chart 7-12. Overall Medicare margin, 1997–2006



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

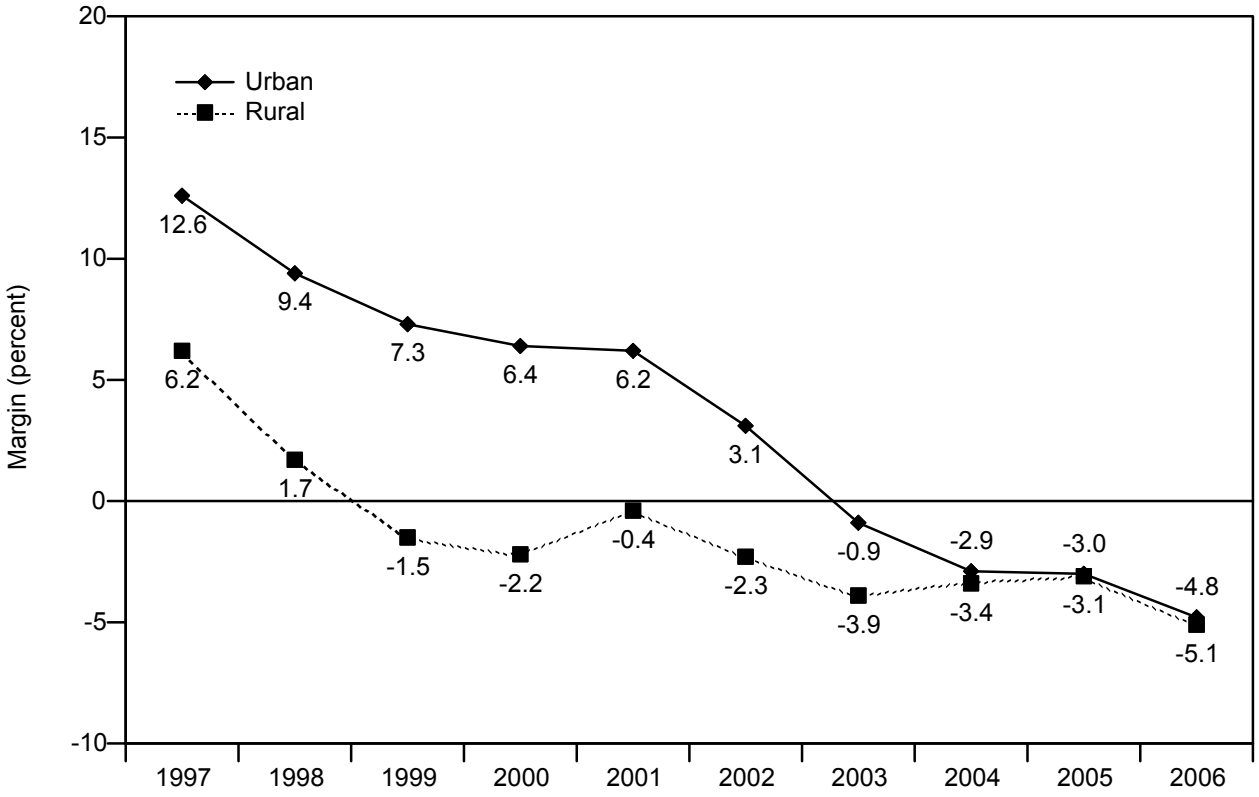
Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health, and inpatient psychiatric and rehabilitative services, as well as graduate medical education and bad debts. The overall margin is available only since 1997, but it follows a trend similar to that of the inpatient margin.

- The overall Medicare margin in 1997 was 11.8 percent. In fiscal year 2006, it was –4.8 percent.

- In 2006, one-quarter of hospitals had overall Medicare margins of 3.6 percent or higher, and another quarter had margins of –16.3 percent or lower. Between 1997 and 2006, the difference in performance between the top and bottom quartile widened from 14 percent to 20 percent. About 35 percent of hospitals had positive overall Medicare margins in 2006, accounting for 36 percent of Medicare inpatient discharges.

Chart 7-13. Overall Medicare margin, by urban and rural location, 1997–2006



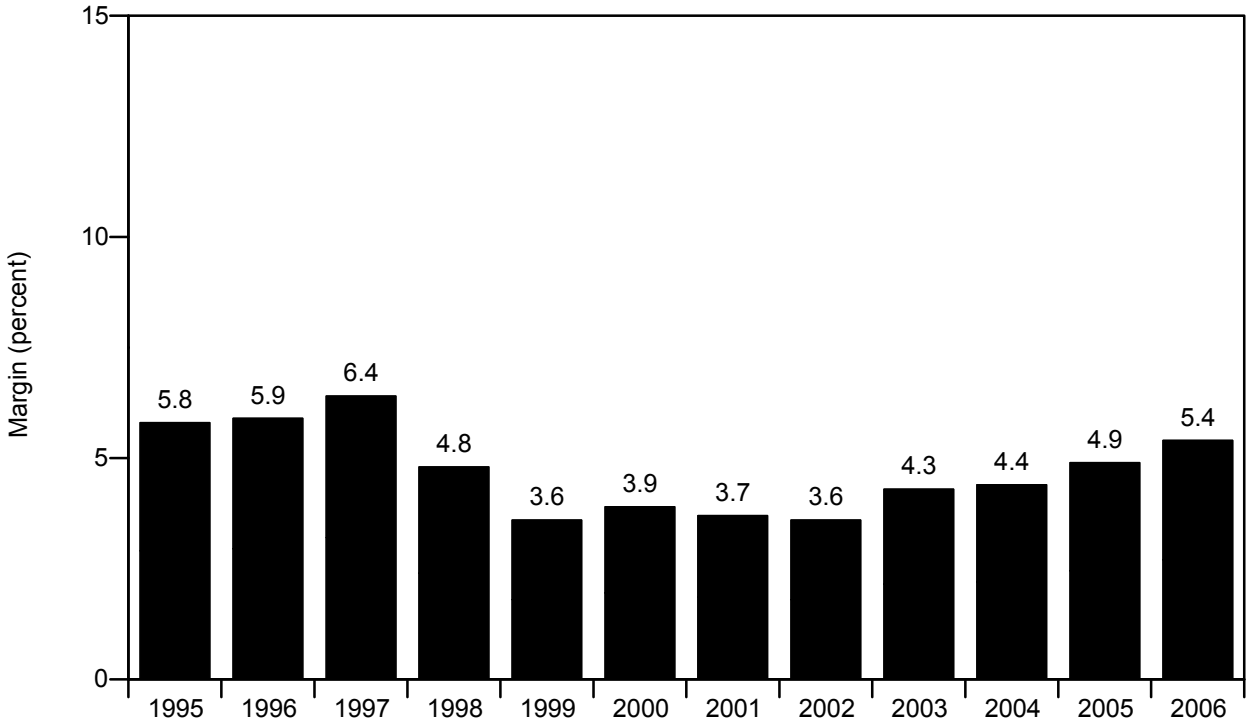
Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- As with inpatient margins, overall Medicare margins have historically been higher for urban hospitals than for rural hospitals.

- The difference in margins between the two groups grew between 1997 and 2000 but has since narrowed, with rural hospital margins similar to those of urban hospitals in each of the past three years. In 1997, the overall margin for urban hospitals was 12.6 percent, compared with 6.2 percent for rural hospitals. In 2006, the overall margin for urban hospitals was –4.8 percent, compared with –5.1 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals helped to narrow the difference in overall Medicare margins between urban and rural hospitals.

Chart 7-14. Hospital total margin, 1995–2006



Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, other government and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services.

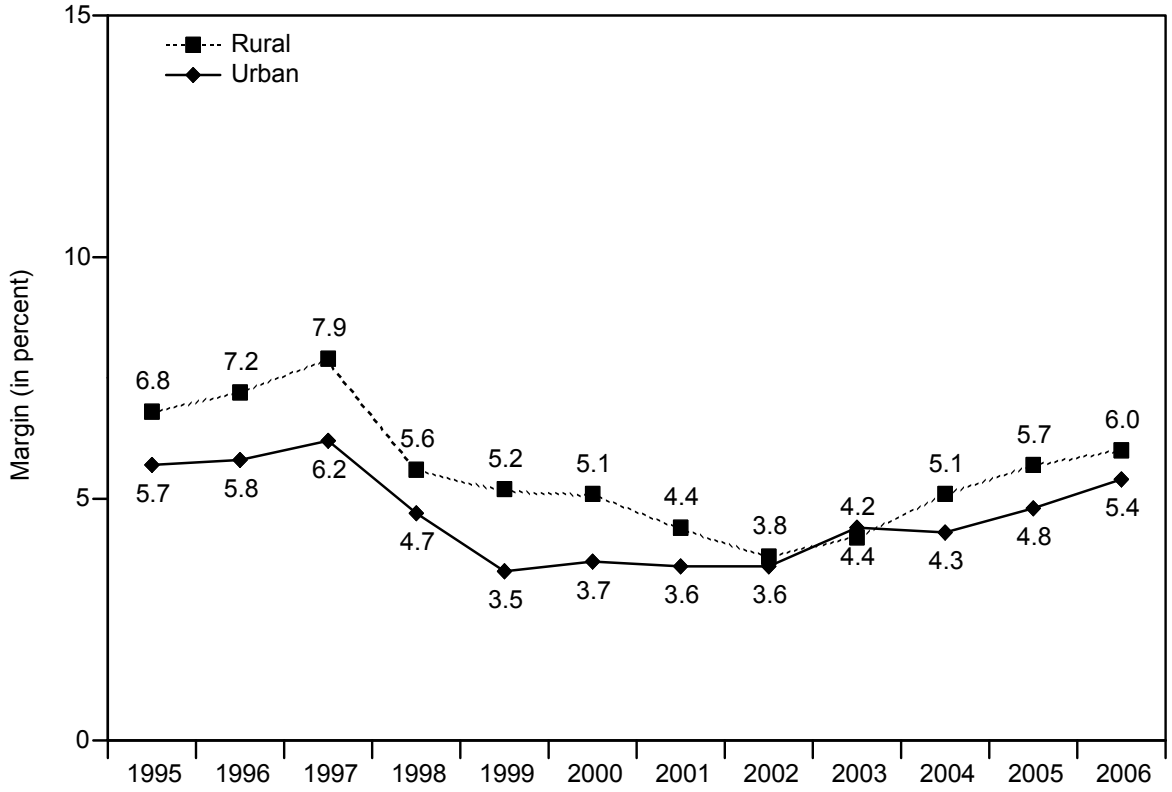
- The total hospital margin peaked in 1997 at 6.4 percent, before declining to under 4 percent in the 1999 to 2002 period. In 2005, the total margin climbed to 4.9 percent and again rose to 5.4 percent in 2006, its highest level in nine years. Total margins rose despite declines in Medicare overall margins over this same period.

- The decline in total margins from 1997 to 1999 reflected a drop in both Medicare and private payer margins. Medicare overall margins from 1997 through 2001 were higher than the corresponding total margins.

- In 2006, 75 percent of hospitals had positive total margins. These hospitals accounted for 82 percent of all hospital discharges and 83 percent of Medicare discharges.

- The total margin varies much less than the Medicare inpatient or overall Medicare margin. In 2006, one-quarter of prospective payment system hospitals had total margins that were 8.6 percent or higher, while another quarter had margins that were -0.1 percent or lower, a spread of just 9 percentage points compared to a 20 percentage point spread for overall Medicare margins and a 25 percentage point spread for Medicare inpatient margins.

Chart 7-15. Hospital total margin, by urban and rural location, 1995–2006

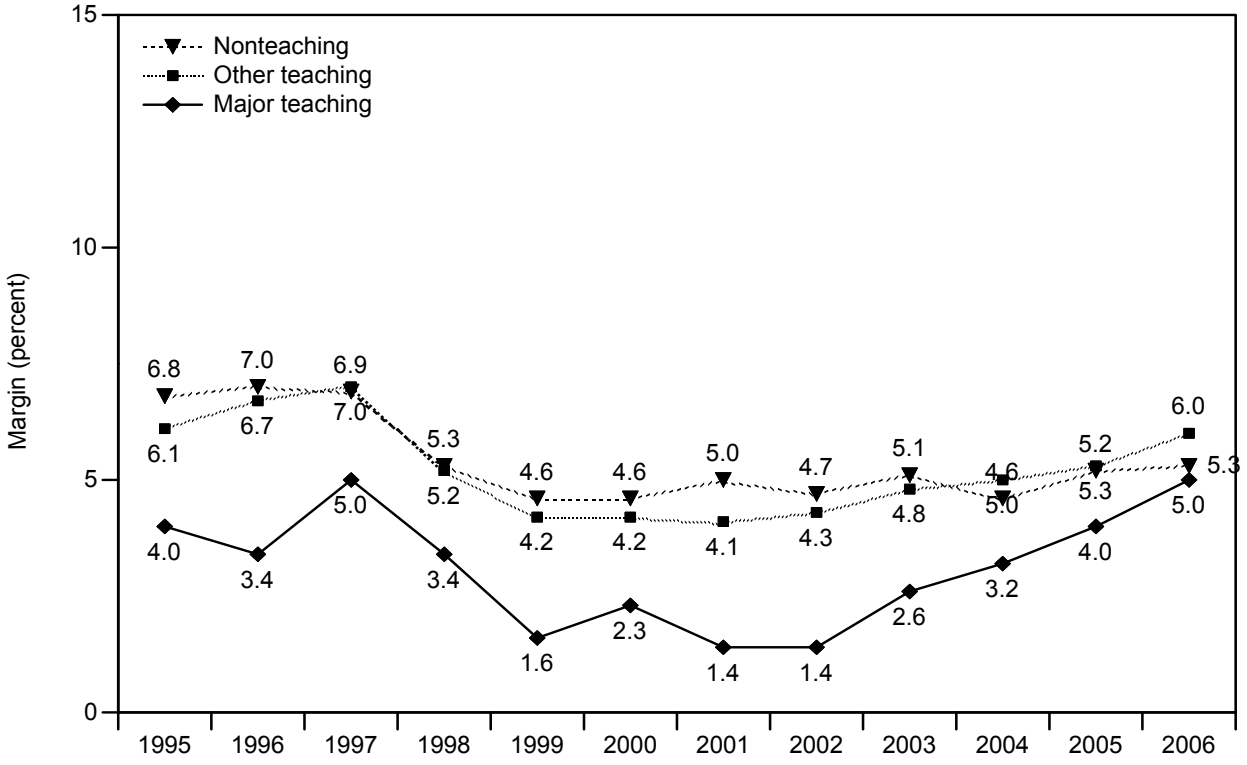


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- With the exception of 2002 and 2003, total (all payer) margins for rural hospitals have been about 1 percentage point higher than those of urban hospitals.
- In 2006, total margins were 6.0 percent for rural and 5.4 percent for urban hospitals, the highest they have been for either group since 1997.

Chart 7-16. Hospital total margin, by teaching status, 1995–2006



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of greater than zero and less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2007) from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for the Medicare inpatient and overall Medicare margins. The total margins of major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals. In 2006, the total margin of nonteaching hospitals stood at 5.3 percent compared with 5.0 percent for major teaching hospitals.

- The difference in margins between major teaching and nonteaching hospitals narrowed to only 0.3 percentage points in 2006, the smallest difference recorded since the start of the inpatient prospective payment system. In 2006, major teaching hospitals' total margins reached their highest level since 1997.

Chart 7-17. Financial pressure leads to lower costs

	Level of financial pressure 2002 to 2005		
	High pressure (non-Medicare margin <1%)	Medium pressure	Low pressure (non-Medicare margins >5%)
Number of hospitals	911	427	1,529
Financial characteristics, 2006			
Non-Medicare margin (private, Medicaid, uninsured)	–1.1%	6.3%	13.6%
Standardized cost per discharge			
Median of for profit and nonprofit	$5,500*	$5,800	$6,200
Nonprofit hospital	5,500*	5,800	6,200
For-profit hospital	5,600*	5,600	5,800
Annual growth in cost per discharge 2003 to 2006	4.6%*	5.4%	5.5%
Overall 2006 Medicare margin	3.7*	–3.3	–10.8
Patient characteristics (medians)			
Total hospital discharges in 2006	5,495*	7,350	7,130
Medicare share of inpatient days	47%	45%	49%
Medicaid share of inpatient days	13%*	12%	12%
Medicare case mix index	1.26*	1.35	1.36

Note: Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on hospital costs. The sample includes all hospitals that had complete cost reports on file with CMS by August 31, 2007.
* Indicates significantly different from low-pressure hospitals using $p = 0.01$ and a Wilcoxon rank test. A Wilcoxon rank test is used to limit the influence of the few hospitals that report very large costs per discharge.

Source: MedPAC analysis of Medicare cost report and claims files from CMS.

- Higher financial pressure tends to lead to lower cost growth and lower costs per discharge.
- Hospitals with lower volume, lower case mix, and higher Medicaid charges are more likely to be under financial pressure.

Chart 7-18. Medicare margins by teaching and disproportionate share status, 2006

Hospital group	Share of hospitals	Share of inpatient payments	Medicare inpatient margin	Overall Medicare margin
All hospitals	100%	100%	–2.6%	–4.8%
Major teaching	8	23	9.2	2.8
Other teaching	23	35	–3.9	–5.4
Nonteaching	69	42	–8.0	–8.5
Both IME and DSH	25	49	3.3	0.7
IME only	6	10	–9.7	–9.9
DSH only	51	30	–4.9	–6.2
Neither IME nor DSH	18	11	–16.7	–15.1

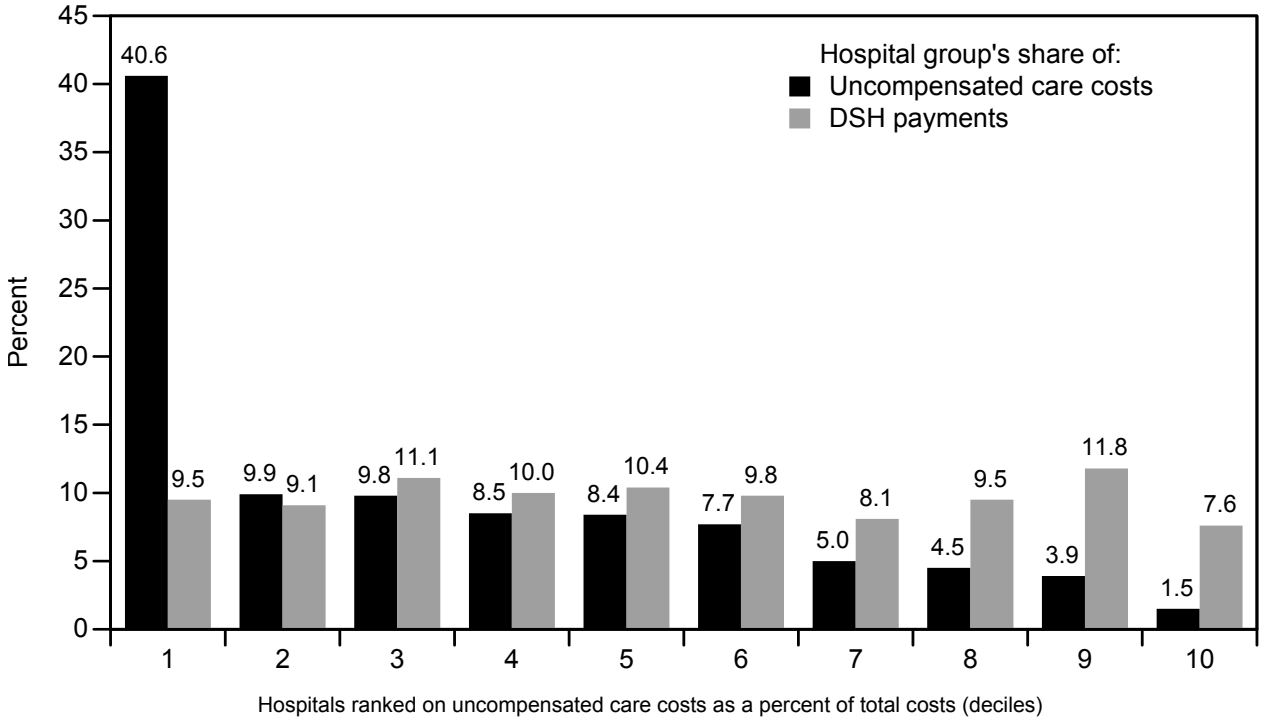
Note: IME (indirect medical education), DSH (disproportionate share).

Source: MedPAC analysis of 2007 Medicare cost report data from CMS.

- Major teaching hospitals have the highest Medicare inpatient and overall Medicare margins. Their better financial performance is due largely to the additional payments they receive from the indirect medical education (IME) and disproportionate share (DSH) adjustments.

- Hospitals that receive neither IME nor DSH payments have the lowest Medicare margins. In 2006, the Medicare inpatient margins of these hospitals were more than 25 percentage points below those of major teaching hospitals and overall Medicare margins were about 18 percentage points lower.

Chart 7-19. Relationship between hospitals' uncompensated care costs and disproportionate share payments, 2003



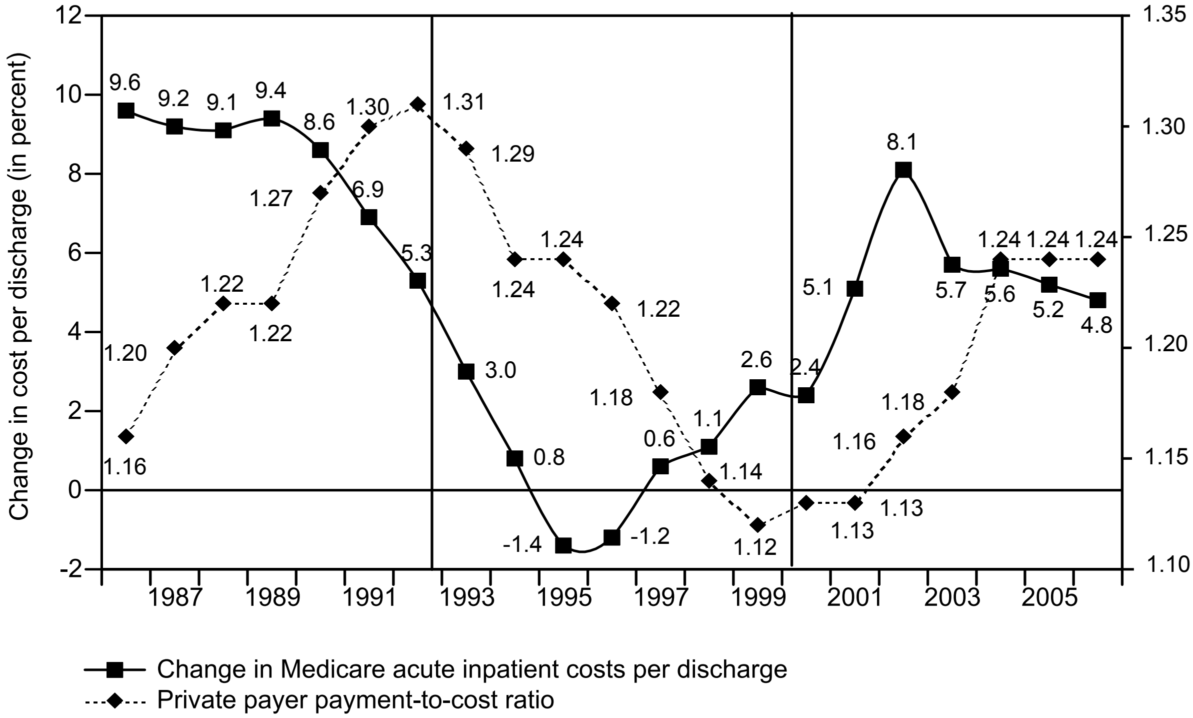
Note: DSH (disproportionate share). The first group includes the 10 percent of hospitals with the highest ratio of uncompensated care costs to total costs. The last group includes the 10 percent of hospitals with the lowest such ratio.

Source: State-mandated reporting systems in California, Florida, Georgia, Indiana, and Texas (2002 and 2003 data, N=848) and Medicare cost report data from CMS. State-level data compiled by the Government Accountability Office.

- The original rationale for the Medicare disproportionate share (DSH) adjustment was that poor patients are more costly to treat, so that hospitals with substantial low-income patient loads would likely experience higher costs for their Medicare patients than otherwise similar institutions. Over the last decade, however, many observers have shifted to arguing that the adjustment subsidizes uncompensated care provided to the uninsured and underinsured.

- Uncompensated care is highly concentrated. The top 10 percent of hospitals in terms of the share of resources they devote to furnishing uncompensated care provided 41 percent of all unpaid care. But DSH payments are poorly targeted to hospitals' uncompensated care. This top group of uncompensated care providers receives only about 10 percent of DSH payments. The bottom 10 percent, in contrast, provides less than 2 percent of all uncompensated care but receives almost 8 percent of DSH payments.

Chart 7-20. Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1986–2006



Note: Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about one-third of observations). Most Medicare and Medicaid managed care patients are included in this private insurer category.

Source: MedPAC analysis of Medicare Cost Report files from CMS and CMS's rules for the acute inpatient prospective payment system and American Hospital Association Annual Survey of Hospitals.

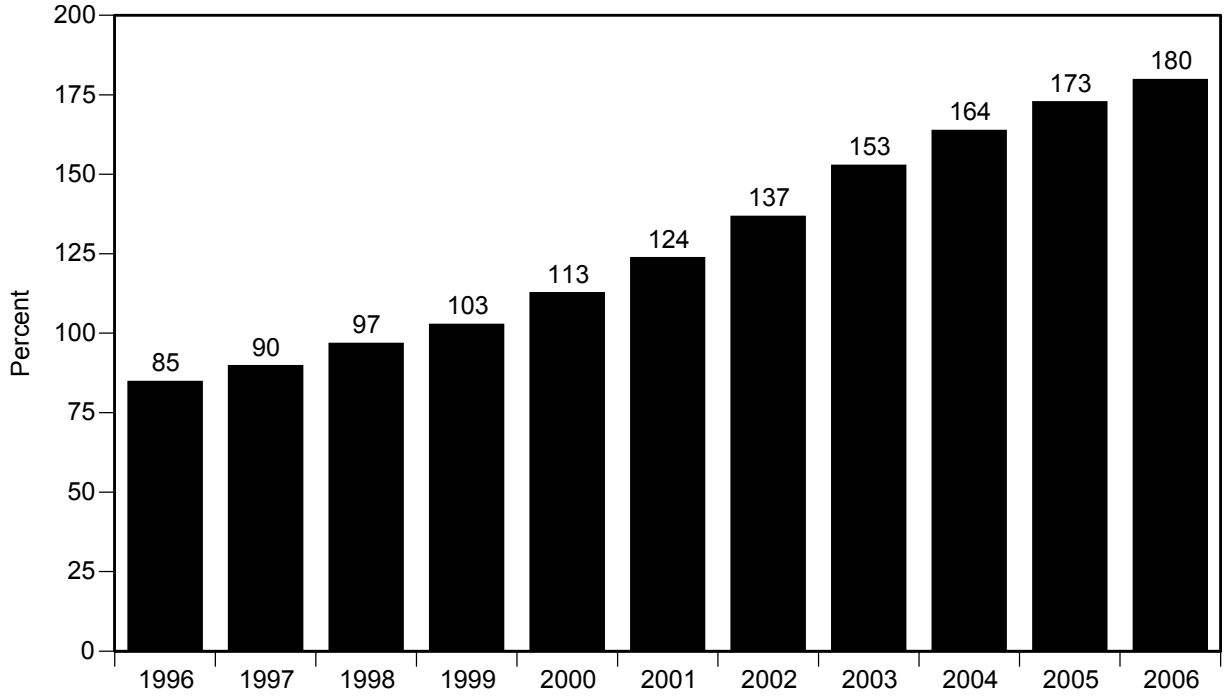
- The pattern of growth in Medicare costs per discharge makes it clear that hospitals have responded strongly to the incentives posed by the rise and fall of financial pressure from private payers over three periods.

- During the first period, 1986 through 1992, private payers' payments rose much faster than the cost of treating their patients (seen in the chart as a steep increase in the payment-to-cost ratio). This suggests an almost complete lack of pressure from private payers. Medicare costs per discharge rose 8.3 percent per year through these years, more than 3 percentage points a year above the increase in Medicare's market basket index.

- As HMOs and other private insurers exerted more pressure during the second period, 1993 through 1999, the private payer payment-to-cost ratio dropped substantially. The rate of cost growth plummeted to only 0.8 percent per year, which was more than 2 percentage points below the average increase in the market basket.

- As pressure from private payers waned after 1999, the private payer payment-to-cost ratio has again risen sharply, and hospital cost growth has once again exceeded growth in the market basket by 2 percentage points a year. In 2005 and 2006, the trend in private payer profit margins begins to level off, and cost growth more closely matches market basket.

Chart 7-21. Markup of charges over costs for all patient care services, 1996–2006



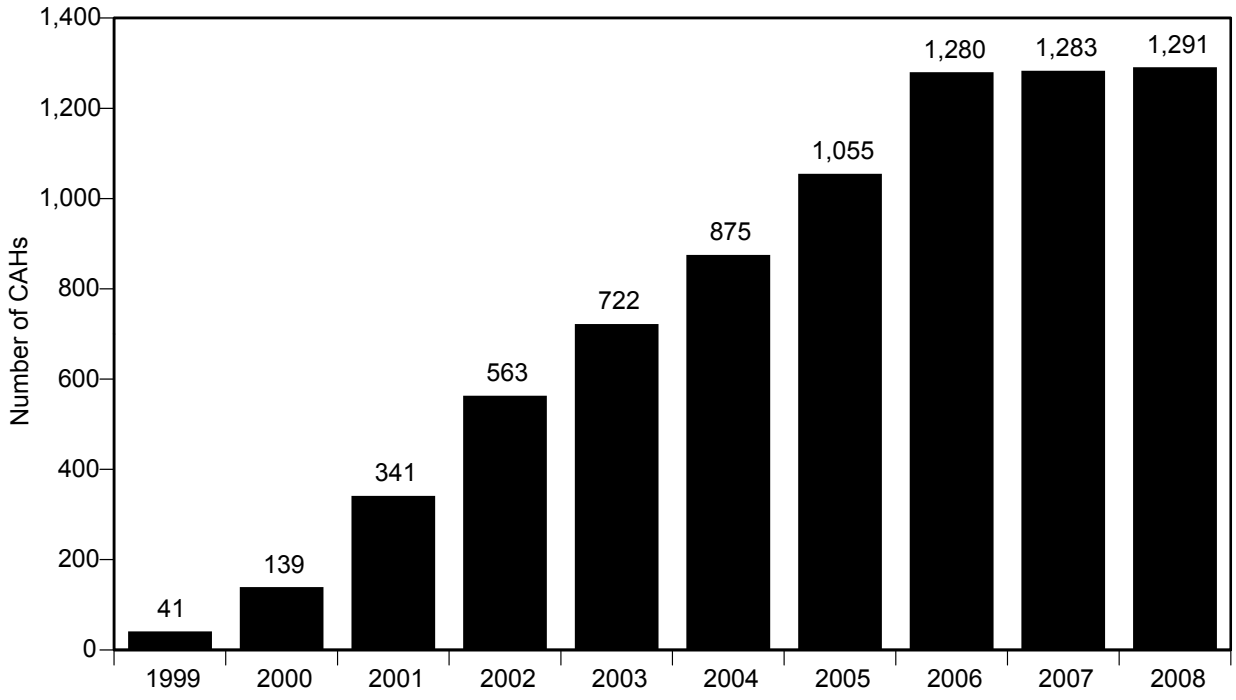
Note: Analysis includes all community hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

- From 1996 through 2006, hospitals' patient care costs (covering all services and all payers) increased 6.5 percent per year but their charges went up by 11 percent per year. Consequently, the markup of charges over costs rose from about 85 percent in 1996 to about 180 percent in 2006. Charges are now almost three times costs.

- Since few patients pay full charges, rapid charge growth may have little impact on hospital financial performance. However, this growth may significantly impact uninsured patients, who may pay full charges. More rapid growth in charges than costs may reflect hospital attempts to maximize revenue from private payers (who often structure their payments as a discount off charges). The unusually large increases in charges in 2002 and 2003 may have resulted from some hospitals manipulating Medicare outlier payments. In 2003, Medicare revised its outlier policy in an attempt to curb hospitals' opportunity to increase their outlier payments through excessive increases in their charges.

Chart 7-22. Number of critical access hospitals, 1999–2008

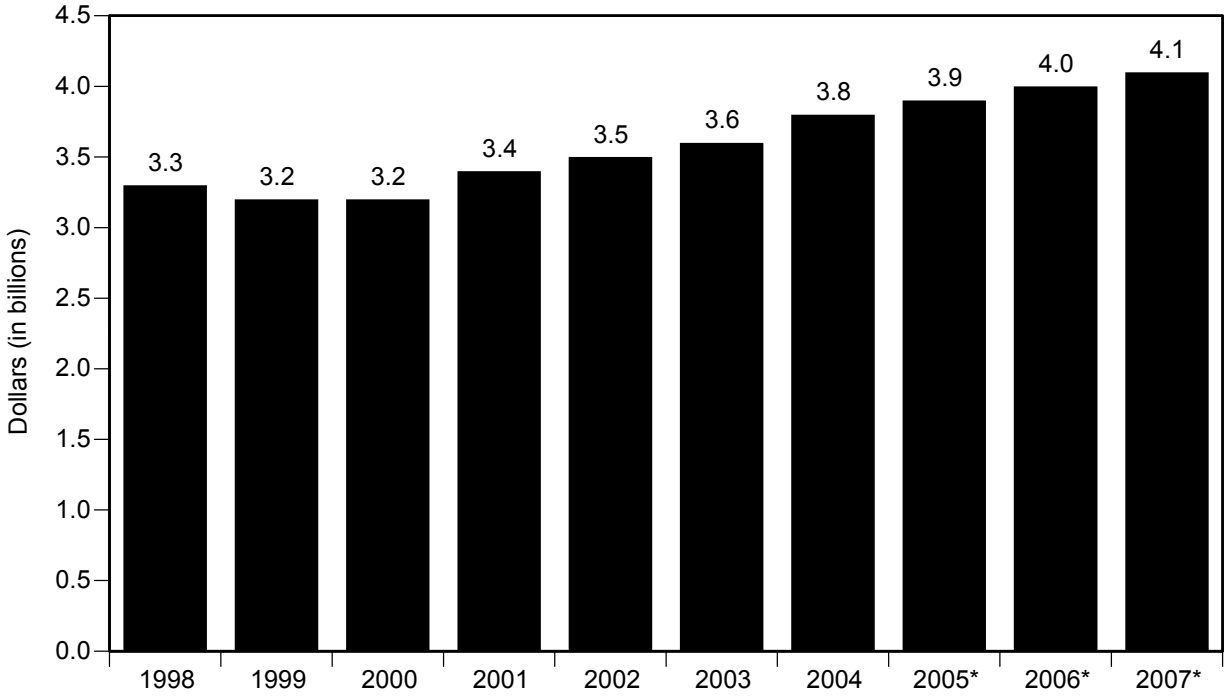


Note: CAH (critical access hospital).

Source: The Medicare Rural Hospital Flexibility Program and CMS.

- The number of critical access hospitals (CAHs) has grown steadily over the last nine years, from 41 in 1999 to approximately 1,291 as of March 2008.
- The increase in CAHs is in part due to a series of legislative changes that made conversion to CAH status easier and expanded the services that qualify for cost-based reimbursement. Currently, CAHs are paid their Medicare costs plus 1 percent for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.
- Prior to 2006, a hospital could convert to CAH status if it was (1) 35 miles by primary road or 15 miles by secondary road from the nearest hospital, or (2) their state waived the distance requirement by declaring the hospital a "necessary provider." Starting in 2006, states could no longer waive the distance requirement. While most existing CAHs fail the distance test, they are grandfathered into the program. Among small rural hospitals that have not converted, most would not meet the distance requirement. Therefore, we expect the number of CAHs to remain fairly constant.

Chart 7-23. Medicare payments to inpatient psychiatric facilities (in billions), 1998–2007



Note: *Estimated spending. The rate of growth in spending was slowed somewhat in 2006 and 2007 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

Source: CMS, Office of the Actuary.

- The inpatient psychiatric facility prospective payment system started January 1, 2005.
- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities grew an estimated 2.4 percent per year between 1998 and 2007.

Chart 7-24. Inpatient psychiatric facilities, 2000–2007

	2000	2001	2002	2003	2004	2005	2006	2007
Freestanding hospitals	491	477	473	466	463	477	481	490
Hospital-based units								
PPS hospital units	1,848	1,821	1,794	1,769	1,732	1,688	1,657	1,643
CAH units	1	3	6	10	27	70	75	77
Total	2,340	2,301	2,273	2,245	2,222	2,235	2,213	2,210

Note: PPS (prospective payment system), CAH (critical access hospital).

Source: CASPER reports from CMS, as of December each year.

- Inpatient psychiatric facilities—both freestanding and hospital-based facilities—provide acute hospital care to beneficiaries with mental illnesses and alcohol- or drug-related problems.

- In recent years, the number of critical access hospitals with Medicare-certified psychiatric units has grown substantially because of new authority granted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. After declining from 2000 to 2004, the number of freestanding psychiatric hospitals has grown as well. The number of psychiatric units in hospitals covered by the acute inpatient prospective payment system has declined, however. Overall, the total number of certified psychiatric facilities has fallen 5.6 percent since 2000.

Web links. Acute inpatient services

Short-term hospitals

- Chapter 2A of the MedPAC March 2008 Report to the Congress provides additional detailed information on hospital margins.

  http://www.medpac.gov/chapters/Mar08_Ch02a.pdf

- MedPAC provides basic information about the acute inpatient prospective payment system in its Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_ 07_hospital.pdf

- MedPAC provides information on the outlier payment issue in Medicare Hospital Outlier Payment Policy.

  http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf

- CMS provides information on the hospital market basket.

  http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf

- CMS published the proposed acute inpatient PPS rule in the May 3, 2007 *Federal Register*.

  http://edocket.access.gpo.gov/2008/pdf/08-1135.pdf

Inpatient psychiatric facilities

- MedPAC provides basic information about the inpatient psychiatric facility (IPF) prospective payment system in its Payment Basics series.

  http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_psych.pdf

- CMS provides information on the inpatient psychiatric facility prospective payment system.

  http://www.cms.hhs.gov/InpatientPsychFacilPPS/

- CMS describes updates to the inpatient psychiatric facility prospective payment system for the rate year beginning July 1, 2008 in the May 7, 2008 *Federal Register.*

  http://www.access.gpo.gov/su_docs/fedreg/a080507c.html

  http://edocket.access.gpo.gov/2008/pdf/08-1213.pdf