

Assessing payment adequacy and updating payments for hospital inpatient and outpatient services

ISSUE: Do we believe that payments for all services hospitals provide to Medicare beneficiaries are adequate? What is the appropriate adjustment to account for efficient hospitals' cost increases next year? What changes in the distribution of inpatient payments are needed along with next year's update?

KEY POINTS: Preliminary data show that the overall margin for the Medicare services hospitals provide remained constant in 2000 at 5.1 percent. (This figure does not reflect imputed values for hospitals that have not yet reported. A revised figure including imputations will be presented at the meeting.) Our estimate of the overall Medicare margin in fiscal year 2003 has not yet been finalized, but we know that the 2003 value will be somewhat below the 2000 value due primarily to payment policy changes implemented in 2003 and scheduled for 2004. Staff find that our broad market indicators (particularly trends in volume, provider entry and exit, and providers' access to capital) are generally consistent with a conclusion that payments are at least adequate.

For the coming year, we begin with CMS' forecast of the hospital market basket. With consideration of other factors that may affect cost increases in the coming year, staff proposes an update of market basket minus 0.4 percent. For outpatient payments, where technological advancements often result in additional payments through new technology payment groups, staff proposes an update of market basket minus 0.9 percent.

Staff have developed six draft recommendations for change in the distribution of payments:

- An extension of the expanded transfer policy to all DRGs, phased in over three years;
- A reduction in the indirect medical education adjustment to a level close to the empirically justified level, phased in over five years;
- Implementing a low-volume adjustment. Two options are offered: limiting the adjustment to (1) hospitals more than 15 miles from a like facility, and (2) hospitals located in a rural area;
- Reevaluating (with a view toward reducing) the labor share used in geographic adjustment of rates;
- Raising the base rate for hospitals in other urban and rural areas to the level for hospitals in large urban areas, phased in over two years.
- Raising the cap on disproportionate share payments to 10 percent. Two options are offered: phasing this change in (1) over five years or (2) over two years.

ACTION: The Commission needs to make policy decisions for the inpatient and outpatient updates, as well as the six distributional issues. In addition, Commissioners will have an opportunity to comment on the hospital section of the draft chapter on payment adequacy and updates for the March Report.

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