



*Advising the Congress on Medicare issues*

# Updating payments for hospitals

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# Background

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- Update recommendations for hospital outpatient and acute inpatient services in 2011
- Medicare spending in 2008:
  - Inpatient FFS —\$109 billion
  - Outpatient FFS —\$30 billion
  - Spending growth of 3.7% per FFS beneficiary from 2007-2008

# Payment adequacy indicators

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- Beneficiaries' access to care
  - Capacity and supply of providers
  - Volume of services
- Quality of care
- Access to capital
- Payments and costs for 2010

# Capacity, service volume, and capital

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- Capacity and supply is growing
- Medicare outpatient volume is increasing
- Medicare inpatient volume is stable
- Access to capital has mixed signals
  - Lower interest rates
  - Monthly volume of bond issues in 2009 equal to 2007
  - But bond ratings fell in 2009

# On balance, quality of care is improving

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- In-hospital and 30-day mortality declined for all 6 conditions or procedures measured (2006-2008)
- Process metrics reported by CMS are improving (e.g. beta blocker)
- However, patient safety measures are mixed and readmission rates have been stagnant

# Why did margins fall in 2008?

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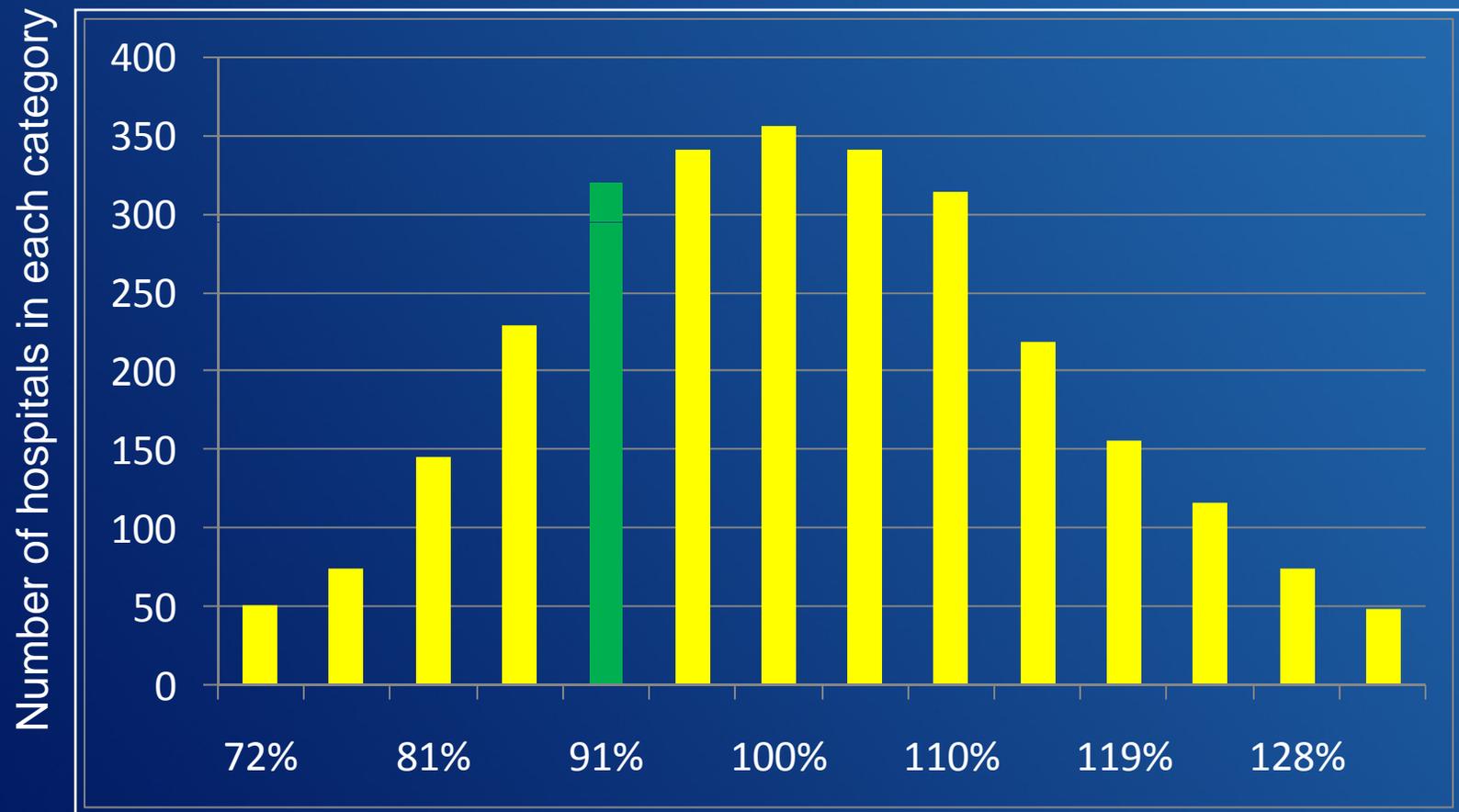
- Payments rose by 4.5% per discharge
  - Update of roughly 3%
  - Documentation and coding improvement
- Cost rose by 5.5% per discharge
  - Costs vary widely by hospital

# Exploring hospital efficiency

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- To be categorized as “relatively efficient” hospitals:
  - Must be in the best third in either risk-adjusted mortality or inpatient costs during every year (2005, 2006, 2007), and
  - Can not be in the worst third in any year for risk-adjusted mortality, readmission rates, or costs
- New screens this year:
  - Removed the 10% of hospitals in counties with the highest service use per beneficiary from our sample
  - Removed the 10% of hospitals with the lowest Medicaid share of patients from our sample

# The median efficient provider's costs are below the national average



Standardized cost per discharge as a share of the national average

# Summary of payment adequacy indicators

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- Most payment adequacy indicators are positive
- Medicare margins were low in 2008 and are expected to remain negative through 2010
- Some hospitals have been able to consistently maintain relatively low costs and relatively high quality. In aggregate these hospitals break even treating Medicare patients.

# Current IME adjustment formula

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- Percentage add-on to Medicare inpatient operating and capital PPS rates
- Adjustment increases operating payments by about 5.5 percent per 10 percent increment in the resident to bed ratio
- Medicare IME payments totaled \$6.5 billion in FY 2008

# Empirical level of IME

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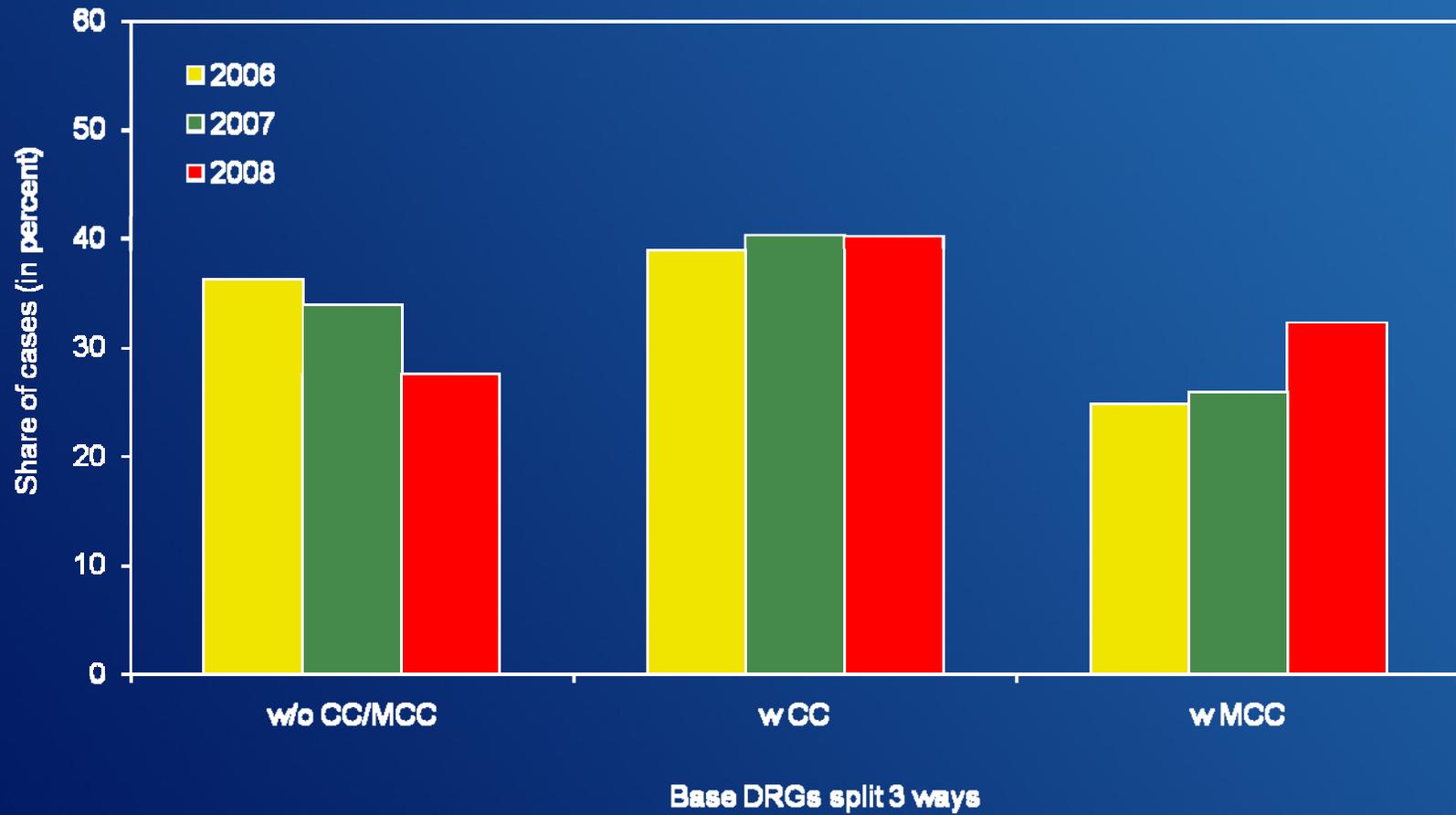
- Measure of teaching hospitals' patient care costs (operating and capital) relative to other hospitals
- Recalculated relationship using 2008 cost report data:
  - Account for use of MS-DRGs
  - Account for other payment factors
- Find costs increase about 2 percent for each 10 percent increment in teaching intensity
  - Subsidy approximately 60 percent

# MS-DRGs changed coding incentives

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- CMS adopted Medicare severity diagnosis related groups (MS-DRGs) in fiscal year 2008
- MS-DRGs created incentives to better document and code secondary diagnoses
- Documentation and coding improvements (DCI) result in higher payments, without any change in patient complexity or the cost of care

# A larger share of cases report Major CCs in 2008



# Legislative background

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- CMS expected DCI to raise IPPS payments by 4.8% and planned to reduce payment rates by that amount over 3 years.
- The hospital industry objected and the law now reflects the following agreement:
  - The law limits prospective downward adjustments to 0.6% in 2008 plus 0.9% in 2009 (1.5% in total).
  - The law requires CMS to recover the difference in 2010-2012 if a retrospective study finds that the 0.6% and 0.9% adjustments were too small.
  - The law also requires CMS to make a separate adjustment to prevent further overpayments.

# Current law: large adjustments may be required

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- Current law requires a temporary adjustment to recover 2008 and 2009 overpayments plus an additional adjustment to prevent future overpayments. The total adjustments could be 5.9 percent and be in place during 2011 and 2012.
- In 2013, the base rate could increase by 2.6 percent because the temporary recovery adjustment ends.

Note: adjustments assume that CMS Office of the Actuary estimate of DCI in 2009 (4.8%) is correct.

# Alternative to current law

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- Principle: maintain budget neutrality
- Limit adjustment to 1% per year
  - More manageable adjustment
- Would increase the number of years required to fully recover overpayments
  - Could be 8 years of 1 percentage point reductions to the rate of payment increase
  - Would result in an increase in inpatient payment rates as long as the update is more than 1 percent
- Could also consider a larger adjustment for fewer years (e.g. 2% for 4 years).