



Advising the Congress on Medicare issues

Assessing payment adequacy: inpatient and outpatient hospital services

Jeff Stensland, Julian Pettengill and Craig Lisk

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Agenda

- Payment adequacy and update for acute inpatient and outpatient services
- Timing of budget neutrality adjustments to offset the impact of documentation and coding improvement (DCI)
- IME will be addressed at future meetings in our broader evaluation of graduate medical education policies

Background on hospital payment updates

A single update recommendation for hospital outpatient and acute inpatient services in 2011

- Affects 92% of all hospital Medicare revenues
 - \$109 billion of inpatient payments (10 million discharges)
 - \$30 billion of outpatient payments (70 million claims)
- 3,400 IPPS hospitals

Payment adequacy indicators

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

Review of December findings

- Capacity and supply is growing
- Medicare outpatient volume is increasing
- Quality of care is improving
- Access to capital is returning to normal
- Margins are low and expected to remain negative

Hospital Medicare margins by service

Hospital margin	2004	2005	2006	2007	2008
Medicare Inpatient and outpatient	- 2.3%	- 2.1%	- 3.8%	- 5.1%	- 6.4%
Medicare Overall	- 3.1	- 3.1	- 4.7	- 6.0	- 7.2

Projected Medicare overall margin in 2010 = -5.9%

Note: Margins = (Medicare payments – Medicare costs) / Medicare payments.
Excludes critical access hospitals.
Source: Medicare cost reports.

Comparing 2008 performance of relatively efficient providers to others

2008 measure	Top performers during 2005-2007	Other hospitals
Number of hospitals	218	1,991
30-day mortality (CMS measures) (relative to national median)	5% below	1 to 2% above
Readmission rates (3M) (relative to national median)	5% below	3% above
Standardized costs (relative to national median)	9% below	2% above
2008 Medicare margin	0.2%	-8.3%
Share of patients rating the hospital highly	64%	63%

Note: medians for each group are compared to the national median

MS-DRGs budget neutrality adjustment

- CMS adopted MS-DRGs in fiscal year 2008 to improve payment accuracy
 - MS-DRGs created incentives to better document and code secondary diagnoses
 - Documentation and coding improvements (DCI) increased payments, without any real change in average patient complexity or the cost of care
 - By law changes in DRGs and weights must be budget neutral
- Issue: to counterbalance the effect of DCI, current law requires a payment reduction in 2011 that is larger than the expected update

Legislative background

- 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:
 - Limits prospective downward adjustments to 0.6% in 2008 plus 0.9% in 2009 (1.5% in total by 2009).
 - 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.
 - Requires CMS to make a separate adjustment to prevent further overpayments.

Current law: large adjustments will be required

- Current law requires a temporary adjustment to recover 2008 and 2009 overpayments plus an adjustment to prevent future overpayments. The total 2011 adjustment could be 5.9 percent and remain in place through 2012.
- In 2013, rates could increase by 2.6 percent when the recovery adjustment ends.
- Result:
 - Inpatient rates would decline in 2011
 - Does not recover 2010 overpayments

Note: adjustment assumes CMS Actuary's 2009 DCI estimate (4.8%) is correct.