Assessing payment adequacy: hospital inpatient and outpatient services

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Background

- Update recommendations for hospital acute inpatient and outpatient services in 2012
- Medicare spending in 2009:
  - Inpatient FFS —$114 billion
  - Outpatient FFS —$34 billion
  - Spending growth of 6% per FFS beneficiary from the prior year
    - Inpatient grew by 4.2 percent
    - Outpatient grew by 11.7 percent

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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

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Capacity, service volume, and capital

- Capacity and supply is growing
- Medicare outpatient volume increased by 4 percent per year from 2004 to 2009
- Medicare inpatient volume declined by 1 percent per year from 2004 to 2009
- Access to capital has rebounded from the fall of 2008

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Quality of care metrics are either improving or remain steady

- In-hospital and 30-day mortality declined for all 6 conditions or procedures measured (2006-2009)
- Patient satisfaction has improved slightly
- However, patient safety and readmission metrics have not changed significantly
  - There is room for improvement on both of these measures

Why are payments up and cost growth down in 2009?

- Payments rose by 5.3 percent per discharge
  - Update of roughly 2.5% (after .9% adjustment for DCI)
  - Reported case mix grew by 2.6%
    - Growth is due to documentation and coding improvement, not higher resource needs of patients
    - Highest reported case mix growth in 20 years
- Cost growth slowed to 3% per discharge
  - Lowest since 2000
  - Increased financial pressure at the start of 2009

Margins improved due to DCI and slower cost growth

Medicare margin	2005	2006	2007	2008	2009
Overall Medicare	– 3.0%	– 4.6%	– 6.0%	– 7.1%	– 5.2%
Inpatient	– 0.5	– 2.2	– 3.7	– 4.7	– 2.4
Outpatient	– 9.1	–11.0	–11.5	–12.7	–10.8

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

Overall Medicare margin by hospital group

Hospital group	Share of facilities	2009
All hospitals	100%	–5.2%
Urban	71	–5.2
Rural*	29	–4.9*
Major teaching	8	–0.6
Other teaching	22	–5.2
Non-teaching	69	–7.9

* An additional 1,300 rural facilities are paid costs plus 1 percent as critical access hospitals. Rural margin including these providers is -3.3 percent.

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Preliminary data subject to change

Hospitals under financial pressure tend to keep their costs down

	Financial pressure 2004 to 2008		
	High pressure*	Medium	Low pressure**
Number of hospitals	756	390	1,747
Relative 2009 standardized cost per discharge	92%	96%	104%
2009 overall Medicare margin	4.7%	-1.1%	-10.2%

* High pressure hospitals have a non-Medicare margin <1% and stagnant or falling net worth.

**Low pressure hospitals have a non-Medicare margin>5% and growing net worth.

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Relatively efficient hospitals

- Must be in the best third in either risk-adjusted mortality or inpatient costs during every year (2006, 2007, 2008), and
- Can not be in the worst third in any year for risk-adjusted mortality, readmission rates, or costs

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Comparing 2009 performance of relatively efficient providers to others

2009 measure	Top performers during 2006-2008	Other hospitals
Number of hospitals	219	1,952
30-day mortality (CMS measures) (relative to national median)	3 to 7% below	1 to 2% above
Readmission rates (3M) (relative to national median)	4% below	Average
Standardized costs (relative to national median)	10% below	2% above
2009 Medicare margin	2.7%	-5.9%
Share of patients rating the hospital highly	66%	64%

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

Characteristics of relatively efficient hospitals

- Wide variety of hospitals in the efficient and comparison groups (e.g. location, service offerings, level of financial pressure)
- However some characteristics are associated with greater likelihood of being in the efficient group
  - Large size
  - Financial pressure
  - Physician-hospital integration

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Documentation and coding adjustments are required to restore budget neutrality

- In 2007-2009, CMS phased-in MS-DRGs and cost-based weights to improve payment accuracy
- MS-DRGs created financial 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

Current law

- Limits prospective downward adjustments to 0.6% in 2008 plus 0.9% in 2009 (cumulative 1.5% in 2009).
- Requires CMS to **recover** the difference between actual DCI and adjustments taken in 2008 and 2009. Recoveries must take place in 2011 and 2012. (5.8% over two years)
- Requires CMS to make a separate 3.9% adjustment to **prevent** further overpayments.

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How DCI adjustments affect IPPS payment rates in FY 2011

	2011
Market basket forecast	2.60%
Temporary recovery adjustment (must total -5.8% over 2011 and 2012)	-2.90
DCI adjustment to prevent further overpayments (must total -3.9% eventually)	0.00
Productivity and budget adjustments under current law	-0.25
Net increase in payment rates	-0.55

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DCI adjustment principles (from March 2010 recommendation)

- Treat providers and taxpayers fairly by making the transition to MS-DRGs fully budget neutral
  - First, adjustments should be made to prevent future overpayments
  - Second, adjustments should be made to recover all past overpayments
- Avoid a large financial shock to hospitals that would occur if all the necessary adjustments were made in a single year