

Medicare's payments for inpatient hospital services

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Key points

- Inpatient PPS is entering its 20th year
- How it works
- Issues
 - Payment adequacy
 - Payment adjustments
 - Variation in financial performance

Overview of sector in 2001

- 11 million discharges
- 4,600 acute care hospitals providing services
- Program spending of \$100 billion
 - 40% of Medicare total
- Growth rate in spending
 - 6.1% 1993-1997
 - 0.1% 1998-2000
 - 6.7% 2001-2002
 - 6.1% 2002-2007 (CBO)
- Payment system: DRG per case payments

How Medicare paid hospitals before 1984

- Reasonable cost reimbursement
- TEFRA: Reasonable costs with rate of increase limits
- Problems
 - Budget deficits
 - Medicare spending growth
 - Cost based payments provided no incentive for efficiency gains

Medicare's inpatient hospital PPS payment system

- Prospective per case payment system started in FY 1984
- System components
 - Base rates (standardized amounts)
 - Patient classification (DRGs)
 - Payment adjustments (wage index)
 - Policy adjustments (IME, DSH)
 - Updates

Initial objectives of inpatient PPS for hospitals

- Ease of understanding and simplicity of administration and implementation
- Predictability of payment
- Establish federal government as a prudent purchaser
- Rewards for efficient operation
- Reduce administrative burdens

Base rates (standardized amounts)

- Separate payment amounts for operating and capital payments
 - Operating rates based on 1982 costs updated for inflation and payment updates
 - Capital rates (PPS started in 1992) based on 1989 capital costs reduced 15 percent and updated for inflation and updates
 - Direct costs of graduate medical education programs excluded and paid separately
- Operating rates for hospitals in large urban areas 1.6 percent higher than for other hospitals
 - For last half of FY 2003 base rate is the same for all hospitals

Patient classification (DRGs)

- Patients classified into one of 508 active diagnosis related groups
- DRG assignment based on the patient's principal diagnosis or procedure
- DRGs given a weight reflecting the relative resource costs for cases in a DRG
- Resource costs determined based on billed charges

Cost related payment adjustments

- Hospital wage index
- Cost of living adjustment (Alaska and Hawaii)
- Outlier cases
 - Additional payments made for cases with costs over a fixed loss threshold
 - Medicare pays 80 percent of costs above above this threshold
- Transfer policy
 - Cases transferred paid a per diem

Area wage index

- Compares average hourly wage for market area to nationwide average
- Market areas based on MSAs and statewide rural areas
- Applied to 71.1 percent of base rate
- Reclassification
 - Hospital wages above own market market area average (106% rural, 108% urban)
 - Hospital wages comparable to average in area to which it is seeking reclassification (82% rural, 84% urban)
 - Relative proximity to market area

Policy adjustment

- Indirect medical education adjustment
- Disproportionate share adjustment
- Hospital specific rates
 - Sole community hospitals
 - Medicare dependent hospitals

Percent increase in payment rates under IME adjustment

IME adjustment	Resident-to-bed ratio				
	.05	.10	.25	.50	.75
6.5	3.2%	6.3%	15.1%	28.6%	40.7%
5.5	2.7	5.3	12.8	24.7	34.3
2.7	1.3	2.6	6.2	11.6	16.3

Disproportionate share adjustment

- Adjustment for hospitals that treat disproportionate share of low income patients
- Nine different formulas based on hospital location, number of beds, and other characteristics
- Hospital's low-income patient share based on:
 - Share of all patients that are Medicaid eligible
 - Share of Medicare patients that are eligible for SSI benefits
- CMS collecting uncompensated care data

Hospital specific rates

- Policy applies to sole community and Medicare dependent hospitals
- Payment based on higher of PPS rate or updated hospital specific costs from one of three base years 1982, 1987, 1996
- Medicare dependent hospitals receive blended payment (50 percent PPS rate and 50 percent hospital specific rate)

Example case

Operating payment for simple pneumonia with CC
at Vanderbilt University Hospital, Nashville Tennessee

$$((0.711 \times \text{large urban standardized amount} \times \text{area wage index}) + (0.289 \times \text{large urban standardized amount} \times \text{cola})) \times (\text{DRG weight}) \times (1 + \text{IME adjustment} + \text{DSH Adjustment})$$

Standardized amount:	\$4,251.20	Payment = \$ 8,000
Wage index:	0.9578	
DRG weight:	1.042	
IME adjustment:	0.70	
DSH adjustment:	0.24	

Updates

- Payment rates updated annually
 - Operating update set in law (for 2004 and beyond update is set at market basket)
 - Secretary of HHS sets annual update to capital rates
- Market basket
 - Measures national average price levels for labor and other inputs, weighted to reflect relative importance of each input category
 - Market basket used in update is a forecast

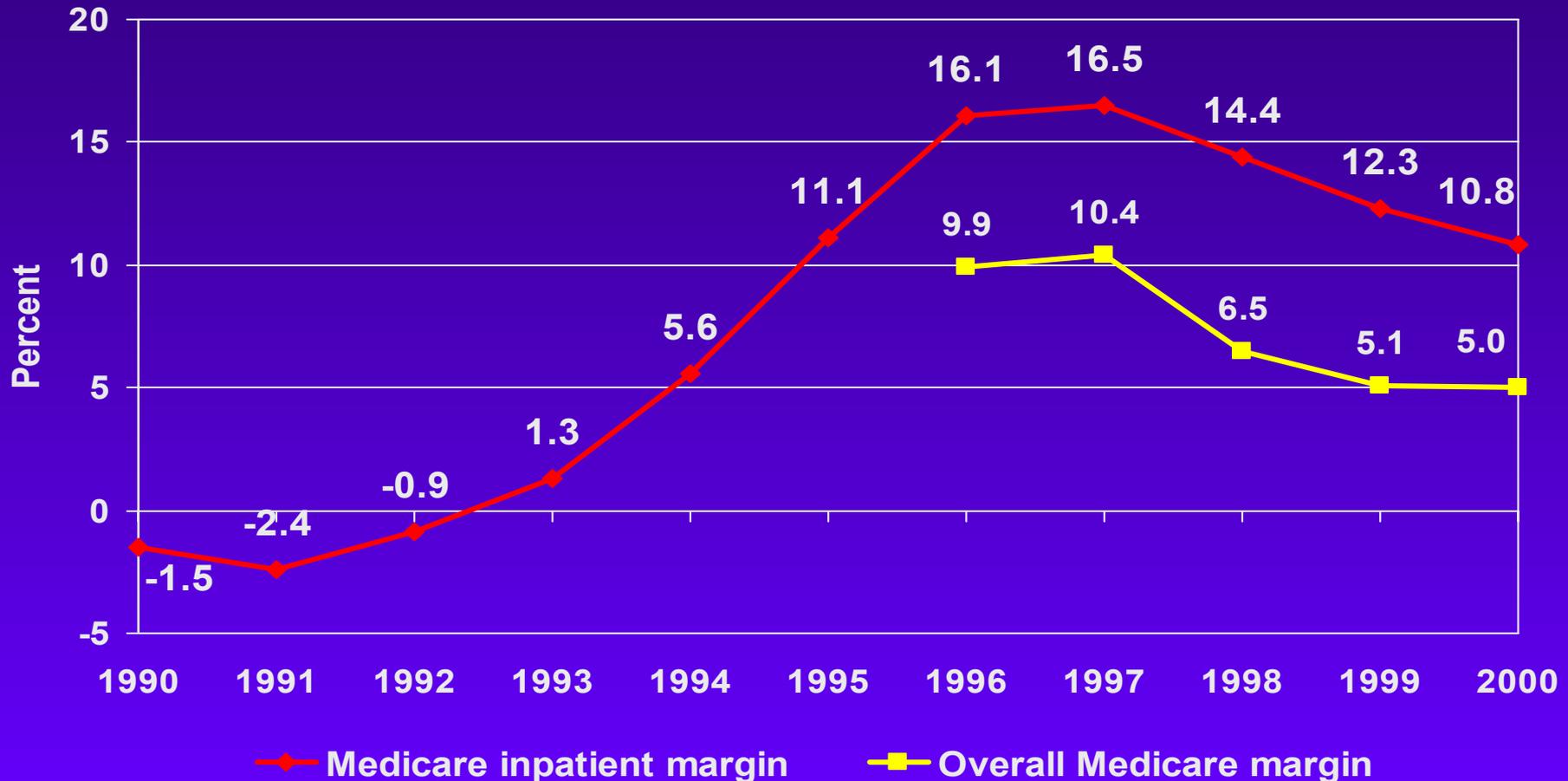
Critical access hospitals

- Paid based on reasonable costs
- Qualifications:
 - Located more than 35 miles from nearest similar hospital or governor may designate
 - Average length of stay not exceeding 4 days
 - Provide 24-hour emergency care
 - No more than 15 acute care beds and 10 swing beds
- Currently over 700 hospitals designated

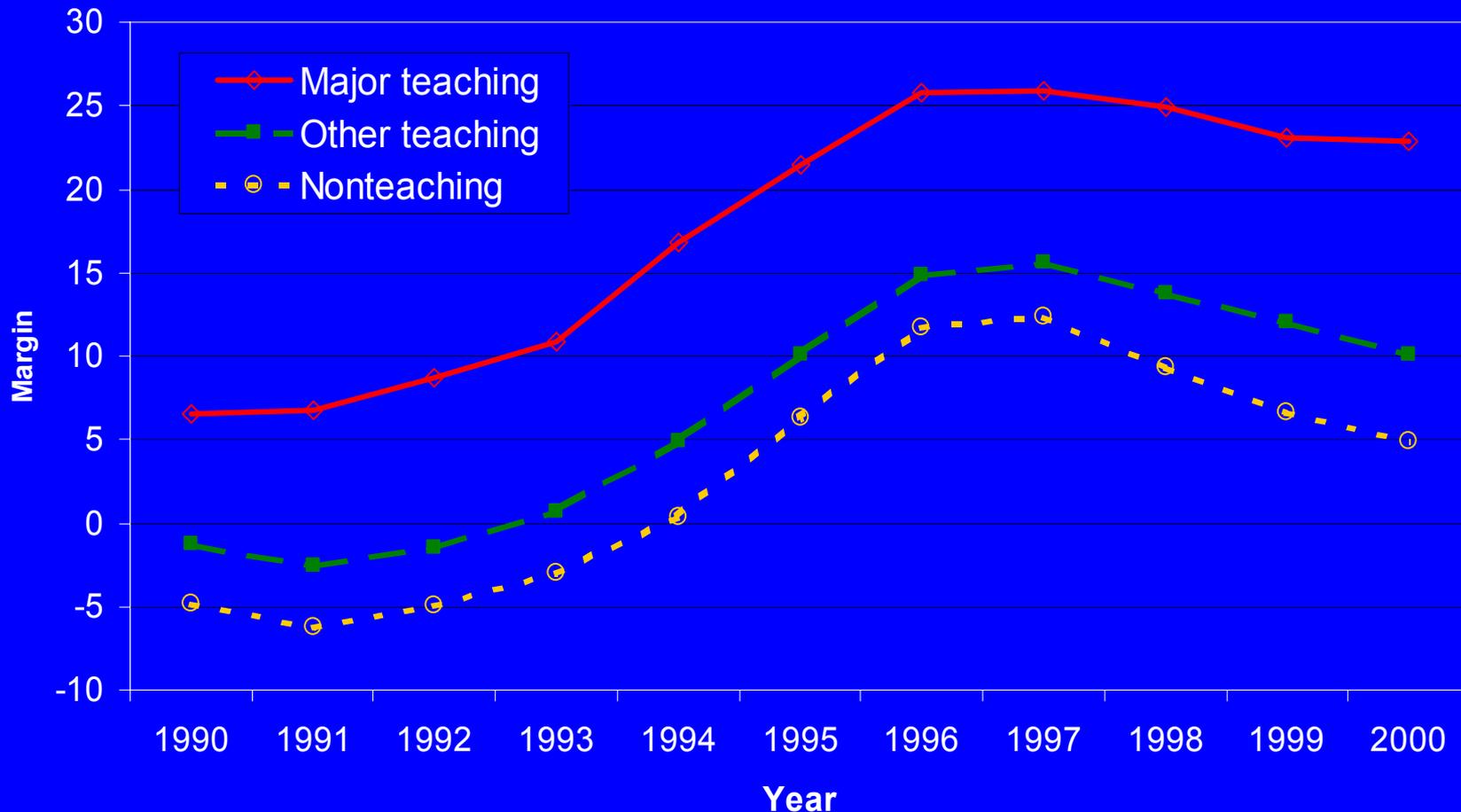
Changes in length of stay

Change in costs

Medicare overall and inpatient margins



Trend in Medicare inpatient margins, by teaching hospital group, 1990 to 2000



Overall Medicare margin by group

Hospitals	1999	2000	2003 (est.)
All	5.1%	5.0%	3.9%
Large urban	8.4	8.4	6.9
Other urban	3.3	2.9	1.7
Rural	-2.5	-2.9	-1.9
Major teaching	13.7	14.9	12.7
Other teaching	5.7	5.0	3.8
Non-teaching	0.1	-0.2	-0.6

Payment-to-cost ratios by payer, 1991-2001

