



Medicare and Hospitals

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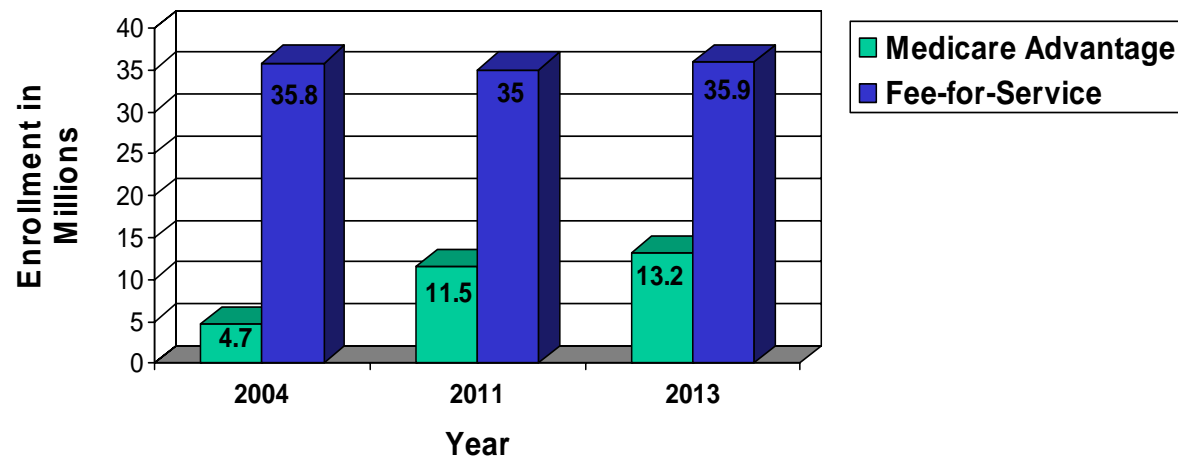
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Original Medicare

- Now covers 88% of Medicare caseload
- Uses fee-for-service payment methodology

Comparison of Overall Medicare Enrollment by Fiscal Year



Existing FFS Payment Systems

- Largely completed conversion from cost or charges to pre-set rates
 - Twenty + year process
 - Twelve different systems
 - Latest: Inpatient psychiatric facility PPS
- Now need to revise and modernize

MedPAC Recommendations for Potential Revisions to IPPS

- **Better capture severity of illness.**
- **Cost-based instead of charge-based weights.**
 - Reduce bias from differential markups
- **Use hospital-specific relative values.**
- **Account for outliers in setting DRG relative weights.**

CMS Has Improved Inpatient Payment Accuracy

In FY 2006, replaced 9 cardiovascular DRGs with 12 new ones that better recognize severity of illness

For FY 2007:

- **Move to “cost-based” weights**
 - 3-year transition
- **Other DRG changes**
 - 20 new DRGs in 13 clinical areas
 - 32 DRGs modified; 8 deleted

More Plans Afoot

- Now reviewing severity adjusted DRGs
- RAND will test several alternative systems
- Expect proposal for FY 2008

► ***Budget neutral*** ◀

Specialty Hospitals – Next Steps

- New specialty hospitals can be certified.
- All hospitals must report investment and ownership periodically.
- DHHS will enforce against disproportionate returns and non *bona fide* investments.
- Physicians must disclose their ownership of hospitals to referred patients.
- DHHS will continue improvements in IPPS and ASC payment systems.

CMS Proposes Changes for Outpatient Payments

- Projected 9.2 percent increase in total expenditures for CY 2007
- Step toward value based-purchasing: smaller update for OPPS if no IPPS data.
- Revised coding & payment structure for clinic and emergency services
- Revised APC structure for drug administration

MMA Requires Reform of Ambulatory Surgical Center Payment System

- **Dated and crude**
 - **Weights not changed since 1990**
 - **Only nine payment cells**
- **CMS proposed linking to outpatient PPS**
- **Implement January 1, 2008**
- **Also updating the ASC list**
 - **For 2008, add 750 procedures; 2/3 from MD offices**

Why Pay for Performance?

- **Improve Quality**
 - Quality of our healthcare system is inadequate
 - Wennberg's Dartmouth Atlas
 - IOM's "Crossing the Quality Chasm"
- **Avoid Unnecessary Costs**
 - Medicare's various fee-for-service payment systems are based on resource consumption and quantity of care, **NOT** quality or unnecessary costs avoided

Pay for Performance Elements

- **Measures**
 - Quality, cost, patient experience
 - Valid and reliable
 - Evidence based
 - Consensus
- **Data Infrastructure**
 - Collection
 - Analysis
 - Validation
 - Appeals
- **Payment Methodology**
 - Individual measures or composite
 - Attainment and improvement
 - Bonus or differential
 - Funding source
- **Public Reporting**
 - Providers and professionals
 - Consumers
 - Researchers

CMS' P4P Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Gainsharing Demonstration (DRA section 5007)
- Nursing Home P4P Demonstration
- ESRD Bundled Payment Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration (MMA section 649)
- Oncology Demonstration
- Medicare Health Care Quality Demonstration (MMA section 646)
- Medicare Health Support Pilots
- Other Care Coordination/Disease Management Demonstrations

Hospital Quality Initiative

- **P4R: FY 2005 – 2006**
 - Payment differential of 0.4% for reporting
 - Starter set of 10 measures
- **More P4R: FY 2007 and subsequent years**
 - Payment differential 2.0%; expanded set of measures
- **Reports made public: Hospital Compare website**
- **Plan for hospital P4P beginning with FY 2009**
 - Plan must consider: quality and cost measure development and refinement, data infrastructure, payment methodology, and public reporting

Medicare recognizes advances in medical technology

- Most new technology fits in existing payment system without special provisions
- May need decisions on benefit category, coding, coverage, payment
- Additional payments for new technology
 - Inpatient PPS
 - Outpatient PPS

Activities in Health IT

- New rules recently published to facilitate involvement of hospitals and physicians in e-prescribing and electronic health records.
- Emphasize interoperability and flexibility.
- CMS interested in paying for outcomes, not technology.
- Preparing for implementation of new coding system – ICD-10

CMS Announces Gainsharing Demonstrations

- Promote better quality, improved efficiency
- General strategy: align incentives between physicians and hospitals
- One demo will focus on in-hospital care, in six sites.
- The second: broader concept, interested in affecting system redesign.
 - Up to 72 sites; emphasis on consortium models
 - Involves long-term tracking