

## **Challenges Associated with Setting Hospital Rates at a Percentage of Medicare**

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## 1. Introduction

This paper is intended to identify and discuss the key challenges associated with the use of some multiple of Medicare Fee-for-Service (FFS) hospital rates as the basis for the establishment of private payer payment rates. While it may be feasible to make use of Medicare FFS inpatient and outpatient payment levels to determine a reasonable payment level for small numbers of individual payments (as has been proposed in a number of states for patients with high out-of-network bills by hospitals), using Medicare's Inpatient and Outpatient Prospective Payment System (IPPS and OPSS) methodologies to establish regulated payment rates for hospitals services to privately insured patients (at some multiple of Medicare rates) is likely to be administratively infeasible and undesirable for the following reasons:

- 1) The enormous administrative complexity involved in pricing out all private payer claims at IPPS and OPSS rates (particularly in the case of duplicating Medicare's outpatient payment rules which require quarterly updates);
- 2) The inapplicability of Medicare IPPS and OPSS to a younger privately insured population;
- 3) The "Fee-for-Service" character of Medicare IPPS and OPSS which provides financial incentives for hospitals to treat more cases and perform more procedures;
- 4) Medicare's declining payment levels relative to hospital costs over time; and
- 5) Solvency issues associated with the use of prospective payment for the State's small and rural hospitals which are currently reimbursed under a cost-based payment system for Medicare.

## 2. Background – Description of How Medicare Sets Hospital Rates

The federal Medicare program establishes payment rates for a defined set of both inpatient and outpatient hospital services. The Medicare Inpatient Prospective Payment System (IPPS) is a "Case-Rate" payment system that sets an average payment amount for each inpatient case admitted to a hospital. Medicare sets average Case Rates for 756 different types of cases based on each patient's illness diagnosis and treatment category (e.g., pneumonia, cardiac surgery, etc.). Medicare uses a diagnosis-based classification system called Medicare Severity-adjusted Diagnosis Related Group system (MS-DRGs) to categorize elderly Medicare patients based on their type of disease and the relatively costliness of their treatment. The Medicare Outpatient Prospective Payment System uses a similar system, the Ambulatory Patient Classification system (APCs) to establish average payment levels for services based on the most costly procedure or treatment applied to a patient during his or her outpatient visit. The assignment of an inpatient MS-DRG or an outpatient APC to a particular patient is based on a treating hospital's documentation of that patient's illness diagnoses and the various services required for treatment.

Average payment rates are assigned to Medicare's 756 MS-DRGs and approximately 700 APCs are based on national experience of the relative costliness of each MS-DRG and APC. MS-DRG and APC categories that are more difficult to treat have higher average payment levels (e.g., an inpatient getting cardiac surgery is more expensive to treat than a patient admitted for pneumonia and an outpatient receiving ambulatory surgery is more expensive than a patient in for a primary care visit).

These average payment levels per MS-DRG and APC are further adjusted for a myriad of factors that are specific to each hospital to account for differences in hospital "input costs" (e.g., variations in area wages, capital costs). In the case of IPPS, MS-DRG payment levels are also adjusted based on whether the hospital is a "Teaching" hospital and/or whether the hospital serves a "Disproportionately large number of poor patients. Hospitals are also paid on a separate basis for "outlier" cases (i.e., unusual cases that are much more expensive to treat than an average case) for the cost of "Direct Medical Education" (i.e., the subsidy for

Medical Resident salaries). On a quarterly basis Medicare updates the “mapping” of specific medical codes and procedures to individual APCs and APC payment levels for OPSS. For certain services including outpatient therapy services, Medicare pays for these services under Medicare’s physician fee schedule, which is updated on an annual basis. Medicare also tacks on an extra “facility” fee for many outpatient services that are provided at a hospital (versus a physician’s office).

The average payment levels for both IPPS and OPSS are increased each year based on policy and Medicare budgetary considerations. In addition, Medicare constantly modifies particular aspects of its payment methodology to reflect changes in medical technology, counteract undesirable coding and operational practices of hospitals and implement desired policy changes.<sup>1</sup>

### **3. Problems Associated with Setting Private Payer Rates Based on Medicare**

**Problem 1: Administrative Complexity:** The primary issue associated with using Medicare payment levels as a benchmark for either establishing both inpatient and outpatient payment levels for private payers or setting relates to the enormous administrative complexity involved in pricing out large numbers of claims based on Medicare payment rules on a “real-time” basis (i.e., as the patients are treated and the hospital bills are produced). While many private payers have adopted the core Medicare MS-DRG inpatient per case payment structure as the basis for paying hospitals, these private payment systems are administratively difficult to establish and they omit many features and various adjustments of the Medicare IPPS because they are too complicated to implement and administer.

Moreover, Medicare’s OPSS is an extremely complicated and dynamic system that changes quarterly. This along with the many Medicare-specific coding/billing requirements incorporated into the system have been key obstacles in the ability of private payers to replicate and operate versions of Medicare OPSS. With Medicare constantly striving to improve the system, no one has had the time or resources to become an expert in its workings. Private payers that attempted to adopt some version of the OPSS for outpatient pricing and payment found that the complexity of the system and the frequent updates to the various rules and methods made the system far too administratively complex to operate. A related problem was that complexity of this system often led to frequent disputes by hospitals as to whether the payer’s APC based system was providing accurate payments.<sup>2</sup>

Given the inability of sophisticated private payers to replicate even the general components of OPSS and the complexities and frequent changes in Medicare IPPS rules and policies, it is unlikely that the State of Oregon could develop and adequately maintain a rate setting system for private payers that was benchmarked off of Medicare IPPS and OPSS.

**Problem 2: Inapplicability of the Medicare Payment System to Younger Patient Populations:** In addition, Medicare IPPS and OPSS were developed to pay for services provided to an elderly population and in many cases these systems are not directly applicable to a younger privately insured population, particularly pediatric cases. Thus, a myriad of modifications will need to be made to the core Medicare payment methods

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<sup>1</sup> This is a highly simplified description of IPPS, OPSS and the Medicare Therapy payment systems. For a more complete description of these systems see the following Medicare publications: The Acute Care Hospital Inpatient Prospective Payment System. Centers for Medicare and Medicaid Services. Medicare Learning Network. December 2016; The Outpatient Hospital Services Payment System. Centers for Medicare and Medicaid Services. October 2016; The Outpatient Therapy Services Payment System. Centers for Medicare and Medicaid Services. October 2016

<sup>2</sup> This information is based on personal communications with representatives from larger Blue Cross plans in Maryland and Pennsylvania and various industry assessments of the OPSS such as: <https://www.managedcaremag.com/archives/2005/1/health-plans-slow-adopt-outpatient-prospective-payment>

to accommodate payment for services rendered to younger populations (e.g., to establish appropriate per case payment levels for obstetric, maternity and pediatric cases and adjust payment weights per case for a younger patient population with a lower severity of illness profile.

**Problem 3: Financial Incentives Implicit in the Fee-for-Service Medicare IPPS and OPSS:** Another disadvantage to basing private payer payment off of Medicare IPPS and OPSS is that these systems are quintessential “Fee-for-Service” (FFS) payment systems. FFS payment systems are generally regarded as “pay for volume” systems, because under per Case or per APC payment (of IPPS and OPSS respectively), hospitals can generate marginal revenues for each case or each procedure that exceed their average costs (which are largely fixed costs and don’t vary 100% with volume increases). Thus, under FFS payments, hospitals have financial incentives to increase the number of inpatient cases they treat and the number for outpatient procedures and services they provide. These incentives to perform more volume of service, contributes greatly to the overall costliness of our health care system. Accordingly, it would not be in the State’s interest to adopt IPPS and OPSS from an overall cost containment standpoint.

**Problem 4: Medicare Payment Updates Don’t Keep up with Cost Inflation:** As noted, Medicare IPPS and OPSS payment levels are updated each year based on various policy and budgetary priorities of the federal government. Based on these factors, Medicare annual payment updates have lagged far behind estimates of the increase in hospital operating costs over the years. Recently, Medicare hospital payment levels were reported to be about 87% of hospital costs. The inability of Medicare payment levels to keep up with hospital cost increases will necessitate adjustments to the multiple used in any payment formula that links private payer rate setting by the State to Medicare payments.<sup>3</sup> The State of course could decide to increase this payment multiple over time. However, it would likely find itself in heated negotiations with hospitals about what the payment multiple should be, year-in and year-out, as Medicare payments continued to drop relative to private sector payments.

**Problem 5: Small Hospitals are Unable to Operate on a Solvent Basis under Prospective Payment:** A final consideration relates to the State’s small and rural hospitals. A subset of these hospitals, the so-called Critical Access Hospitals (CAHs), are currently reimbursed by Medicare on a “cost basis” (i.e., Medicare pays on the basis of these hospitals’ reported costs). This is because Medicare learned early on that small hospitals could not handle the additional financial risk imposed on them by IPPS’s average Care-Rate payment structure and instead decided to pay these hospitals based on their actual incurred costs. Indeed, in the mid-to late-1980s when Medicare’s IPPS was applied to all hospitals, a large number of small and rural hospitals became insolvent because of not being able to absorb the large swings in their per case costs due to fluctuations in patient morbidity that was beyond these hospitals’ control.<sup>4</sup>

If a State hospital payment system used the Medicare payment system as a benchmark for setting payment rates for non-Medicare patients or to establish upper charge limits, a different system would need to apply to the State’s small and rural hospitals.

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<sup>3</sup> For instance, if the State started out setting rates at 150% of Medicare say, it would likely have to increase that multiple over time as Medicare payments continued to drop relative to hospital costs, in order to maintain adequate private payer payment levels for hospitals.

<sup>4</sup> These small hospitals are subject to large swings in the average morbidity and costliness of the relatively few number of patients they treat in any given MS-DRG category. When a small hospital is paid an average amount per case for a given MS-DRG, and in one year the cost profile of the small number of patients they see is far more costly than that average payment, they can be vulnerable to generating large losses on their Medicare patients.

#### About the author:

Robert Murray is President of Global Health Payment LLC, a management consulting firm specializing in the design of health care reimbursement systems, including population-based payment, global budget, patient-centric medical home and pay-for-performance methodologies. He currently assists CareFirst Blue Cross of Maryland in their payment policy development process. He has previously worked as a consultant to a number of clients assisting in payment reform efforts, including the State of Vermont, Vermont Blue Cross and Blue Shield, the University of Iowa Health Alliance, The World Bank and The Chinese Ministry of Health. In addition to his consulting responsibilities, Mr. Murray is a writer and health service researcher. Previously, Mr. Murray served as Executive Director of the Health Services Cost Review Commission (HSCRC), Maryland's all-payer hospital rate-setting agency for 17 years. He received his B.A., M.A. in Economics and M.B.A. degrees from Stanford University.