

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/jval

Patient-Reported Outcomes

Where Does the Money Go? Analyzing the Patient Experience in Safety-Net Hospitals

Allison Marier, PhD*

Abt Associates, Inc., Cambridge, MA, USA

ABSTRACT

Background: Low-income, publicly insured admissions historically cost more to treat than does the average patient. To ensure that hospitals are reimbursed an adequate amount for care of indigent populations, Medicare reimburses hospitals an additional percentage amount according to federally set financial schedule. At 15% of a disproportionate patient percentage, a hospital is reimbursed an extra 2.5% of the standard prospective payment rate. **Objective:** This research seeks to determine whether hospital qualification as a Medicare Disproportionate Share Hospital results in higher patient experience ratings. **Methods:** A regression discontinuity method was used to determine the effect of lagged Disproportionate Share Hospital (DSH) status on next year patient experience ratings. The Hospital Consumer Assessment of Healthcare Providers and Systems data provide publicly available patient ratings. **Results:** On average, hospital ratings increase by 6% as a result of DSH status. Hospital ratings increase by an average of 6.5% when nonprofit hospitals are analyzed.

This finding is primarily driven by patient facility cleanliness and medical provider communication ratings. **Conclusions:** The federal mandate that individuals purchase health insurance in the United States coupled with the state expansion of Medicaid coverage will theoretically eliminate the need for Medicare DSH payments. It is calculated, however, that hospitals will need increased Medicaid reimbursements of more than \$300 per patient to make up for the loss of Medicare DSH reimbursements. Hospitals will likely suffer financially as a direct result of reduced Medicare reimbursements through the DSH program.

Keywords: Consumer Assessment of Healthcare Providers and Systems, Disproportionate Share Hospital, Hospital Compare, hospital reimbursement.

Copyright © 2014, International Society for Pharmacoeconomics and Outcomes Research (ISPOR). Published by Elsevier Inc.

Introduction

For the same illness, low-income patients are more costly to treat than those who are not indigent. To compensate hospitals for the difference in the cost of care between patients, Medicare reimburses hospitals with more than 15% low-income patient admissions an additional percentage of the prospective payment rate [1,2]. This research analyzes patient-reported hospital experience ratings to determine whether funds that should be allocated toward patient care are being used for this purpose.

Determination as a low-income patient requires enrollment in either Medicare combined with the receipt of federal financial assistance or a state's Medicaid health insurance program. These programs require asset or income tests to qualify for public assistance eligibility, and are used by hospitals, states, and the federal government to distinguish low-income patients from the rest of the population [3,4].

Twenty-six percent of a hospital's admissions, on average, are low-income. This percentage is called a hospital's "disproportionate share," and a hospital's Medicare reimbursement rate directly depends on this percentage.

Hospitals that qualify for the Disproportionate Share Hospital (DSH) reimbursement can expect to receive an additional \$2 to \$3 million yearly from Medicare. Federal Medicare DSH spending reached \$9.1 billion in 2009 [5]; more than 75% of acute-care hospitals in the United States qualified for these funds. Of debate in the literature is whether the money is used for patient care: most disproportionate share research examines the effect of additional reimbursement on hospital mortality rates. By using patient satisfaction scores instead of mortality rates, this research determines whether patients treated at hospitals that qualify for Medicare's DSH program receive different care than do those who do not.

This study differs from previous work in two important ways. The first is that only the Medicare DSH program is evaluated instead of jointly with a state's Medicaid DSH program. The second is that hospital patient experience data are used instead of hospital mortality ratings or staffing ratios to determine the extent of hospital care. Hospital quality and effective use of funds are typically measured by using patient clinical outcome data. Until recently, this measure has been the best available data for hospital quality research despite the fact that patients who are severely ill may choose different hospitals than do the less ill [6].

* Address correspondence to: Allison Marier, Abt Associates, Inc., 55 Wheeler Street, Cambridge, MA 02139.

E-mail: Allison_Marier@abtassoc.com.

1098-3015/\$36.00 – see front matter Copyright © 2014, International Society for Pharmacoeconomics and Outcomes Research (ISPOR).

Published by Elsevier Inc.

<http://dx.doi.org/10.1016/j.jval.2013.12.001>

By using patient mortality and hospital financial data from California, Duggan [7] found that nonpublic hospitals that qualified for Medicaid's DSH program saw no drop in infant mortality rates, but instead increased their financial holdings dollar for dollar. Baicker and Staiger [8] found that public hospitals that receive Medicaid's DSH program funds see a slight decrease in infant and heart attack mortality rates. Lindrooth et al. [9] examined staffing decisions in a study of the effects of the Balanced Budget Act on safety-net hospitals. When hospital revenues were adversely affected by a change in reimbursement rates, non-safety-net (non-DSH) hospitals reduced nursed staffing by approximately 6% and no significant effect was found for DSH hospitals.

Health services research articles often use data from the recent U.S. Center for Medicaid & Medicare Services (CMS) Physician, Nursing Home, and Hospital Compare programs. Lehrman et al. [10] described the correlations between hospital characteristics and hospital performance on clinical process scores and patient experience measures. They found that small (fewer than 100 beds) and large (more than 200 beds) hospitals, nonprofit hospitals, and northeastern and midwestern hospitals perform in the top quartile of both patient experience and clinical process measures. Werner et al. [11] used the first 3 years of the Hospital Compare clinical process data to determine how DSH payments affect hospital performance on clinical process quality measures. The authors separated hospitals with high and low Medicaid patient percentages (40% and 5%, respectively) and simulated the effect of a change in reimbursement on the hospital process quality measures. They found that from 2004 to 2006, safety-net hospitals showed a smaller performance increase than did non-safety-net hospitals. Werner et al. [12] found a small, causal, and positive relationship between nursing home "report cards" and the market share of nursing homes. Dafny and Dranove [13] used Medicare enrollee health management organization plan assessments to determine the effect of health management organization patient experience scores and Healthcare Effectiveness Data and Information Set on future changes of plan enrollees.

This analysis used hospital ratings from the Consumer Assessment of Healthcare Providers and Systems. These patient-provided data rate aspects of the hospital experience. The analysis was carried out by using patient ratings from the full sample as well as from a subsample of nonprofit hospitals just above and below the 15% disproportionate patient percentage (DPP) cutoff to determine the effect of DSH status on hospital ratings. Hospital fixed effects were included to control for unobserved time-invariant hospital heterogeneity. The effect of DSH hospital status was identified by hospitals switching over the 15% boundary.

This study found that DSH reimbursement increases hospital ratings by 8% (6 percentage points) for all owners, and modestly increases to 10% (6.5 percentage points) for nonprofit hospitals. DSH status increases ratings for nonprofit hospitals in all individual categories, and the effects are statistically significant (approximately a 10% point increase) in the hospital cleanliness and medical staff communication categories. This finding is in line with a recent opinion article published by Pardes and Miller [14] who argue against a proposed cut in Medicare graduate medical education expenditures. The article states that a cut in graduate medical education funding would affect all the services offered by hospitals; it is reasonable to expect that Medicare funding cuts through the DSH reimbursement would similarly affect all hospital services.

Disproportionate Share Hospitals

The disproportionate share reimbursement was established in 1985 through the Consolidated Omnibus Reconciliation Act. This act actualized a switch from cost-based reimbursement to a prospective payment scheme. To compensate hospitals for treating low-income patients, Congress created an upward adjustment to traditional Medicare reimbursement for hospitals that treat a higher share of the needy. Without additional financial incentive, the shift from a cost-based reimbursement scheme (pre-1986) would not necessarily ensure that those who most need intensive care would receive it [15].

The current federal minimum qualifications for DSH status are detailed in Table 1. Qualification as a DSH hospital is dependent on the number of low-income patients admitted into a hospital: additional reimbursement is a function of this number. The current minimum DPP necessary for qualification as a DSH hospital is 15%. The calculation of the disproportionate share percentage is as follows:

$$DPP = \frac{\text{Medicare supplemental security income Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}} \quad (1)$$

Equation 1 adds the hospital's percentage of dually eligible Medicare and supplemental security income patient-days to the hospital's percentage of Medicaid (and non-Medicare) patient-days [15].

Mathematically, the DSH adjustment for hospitals with a specific DPP can be expressed as follows:

$$DSH \text{ Adjustment} = \begin{cases} 0 & \text{if } DPP < 0.15 \\ 0.025 + [.65 * (DPP - .15)] & \text{if } 0.15 \leq DPP \leq 0.202 \\ 0.0588 + [.825 * (DPP - .202)] & \text{if } 0.202 < DPP \end{cases} \quad (2)$$

Table 1 – Reimbursement rules for disproportionate share hospitals.

Hospital type	Beds	DPP Threshold	Adjustment	Note
Urban	0–99	$\geq .15, \leq .202$	$.025 + [.65 \times (DPP - .15)]$	Cannot exceed .12
		$> .202$	$.0588 + [.825 \times (DPP - .202)]$	Cannot exceed .12
Urban	≥ 100	$\geq .15, \leq .202$	$.025 + [.65 \times (DPP - .15)]$	No cap
		$> .202$	$.0588 + [.825 \times (DPP - .202)]$	No cap
Rural referral center	All	$\geq .15, \leq .202$	$.025 + [.65 \times (DPP - .15)]$	No cap
		$> .202$	$.0588 + [.825 \times (DPP - .202)]$	No cap
Medicare-dependent hospital	All	$\geq .15, \leq .202$	$.025 + [.65 \times (DPP - .15)]$	No cap
		$> .202$	$.0588 + [.825 \times (DPP - .202)]$	No cap
Other rural	0–499	$\geq .15, \leq .202$	$.025 + [.65 \times (DPP - .15)]$	Cannot exceed .12
		$> .202$	$.0588 + [.825 \times (DPP - .202)]$	Cannot exceed .12
	≥ 500	$\geq .15, \leq .202$	$.025 + [.65 \times (DPP - .15)]$	No cap
		$> .202$	$.0588 + [.825 \times (DPP - .202)]$	No cap

DPP, disproportionate patient percentage.

Download English Version:

<https://daneshyari.com/en/article/10485010>

Download Persian Version:

<https://daneshyari.com/article/10485010>

[Daneshyari.com](https://daneshyari.com)