

proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years during which output growth is relatively low and larger in years during which output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Normally, the expected FY 2004 hospital output growth would be simply the sum of the expected change in intensity (1.0 percent), projected admissions change (1.6 percent), and projected real case-mix growth (1.0 percent—a definition of real case mix growth appears below), or 3.6 percent. However, as discussed below and in relation to the proposed capital update, we believe our intensity estimate is skewed by hospitals' charge data. Therefore, we are including only the projected changes in admissions and real case-mix in our calculation of productivity gains. This results in an estimate of 2.6 percent.

The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.6 percent. Multiplying the expected change in total hospital service output (2.6 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage of 61.6 provides our productivity standard of -0.6 to -0.5 percent. Because productivity gains hold down the rate of increase in hospitals' costs, this factor is applied as a negative offset to the market basket increase.

B. Intensity

The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove non-cost-effective services. Under the capital IPPS framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that are used in the framework for the operating IPPS.

We calculate case-mix constant intensity as the change in total Medicare charges per admission, adjusted for price level changes (the Consumer Price Index (CPI) for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor.

However, as discussed above in relation to the proposed capital update, because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately inflated due to manipulation of charges to maximize outlier payments, we are proposing a 0.0 percent adjustment for intensity in FY 2004. In past fiscal years (1996 through 2000) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2004 until we determine that any increase in charges can be tied to intensity, rather than to attempts to maximize outlier payments.

C. Change in Case-Mix

Our analysis takes into account projected changes in real case-mix, less the changes attributable to improved coding practices. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients, as opposed to changes in

coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. For our FY 2004 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We do not believe changes in coding behavior will impact the overall case-mix in FY 2004. As such, for FY 2004, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 percent adjustment for case-mix.

D. Effect of FY 2002 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2002 (GROUPE version 19.0) resulted in a 0 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPE (version 18.0). Therefore, we are recommending a 0 percent adjustment for the effect of FY 2002 DRG reclassification and recalibration.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. The estimated market basket percentage increase used to update the FY 2002 payment rates was 3.3 percent. Our most recent data indicates the actual FY 2002 increase was 2.9 percent. The resulting forecast error in the FY 2002 market basket rate of increase is (-0.4) percentage points. This overestimate was due largely to a lower-than-expected increase in energy costs that impacted natural gas and chemical prices. This follows consecutive years where the market basket was under-forecast by 0.7 percentage points each year.

The following is a summary of the update range supported by our analyses:

HHS'S FY 2004 UPDATE RECOMMENDATION

Market basket	MB
Policy Adjustment Factors:	
Productivity	- 0.6 to - 0.5
Intensity	0.0
Subtotal	- 0.6 to - 0.5
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	1.0
Real Across DRG Change	- 1.0
Subtotal	0.0
Effect of FY 2002 DRG Reclassification and Recalibration	0.0
Forecast Error Correction	- 0.4
Total Recommendation Update	- 1.0 to - 0.9

IV. MedPAC Recommendations for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In the past, MedPAC recommended specific adjustments to its update recommendation for each of the factors discussed under section III. of this Appendix.

In its March 2003 Report to Congress, MedPAC assesses the adequacy of current payments and costs and the relationship between payments and an appropriate cost base. MedPAC stresses that the issue at hand is whether payments are too high or too low, and not how they became such.

In the first portion of MedPAC's analysis on the assessment of payment adequacy, the Commission reviews the relationship between costs and payments (typically represented as a margin). Based on the latest cost report data available, MedPAC estimated an inpatient Medicare operating margin for