



Office of External Affairs

FACT SHEET

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IMPROVING MEDICARE'S HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM TO MAKE MORE ACCURATE AND BETTER RECOGNIZE THE COSTS OF CARE

On August 1, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2008. In FY 2008, payments to all hospitals are expected to increase by an average of 3.5 percent, or by more than \$3.8 billion, taking into account all changes in the final rule.

The reforms to the payment system included in this rule continue efforts, for the third consecutive year, to better recognize patient severity of illness in Medicare's inpatient hospital rates.

- They continue changes begun last year to improve the accuracy of Medicare's inpatient hospital payments by using hospital costs rather than charges to set rates.
- They adjust payment under the IPPS to better recognize severity of illness and the cost of treating Medicare patients by increasing payment for some services and decreasing payment for others.
- They will help to eliminate biases in the current system that have provided incentives for physician-owned specialty hospitals to treat the healthiest and most profitable cases, leaving the sickest and least profitable patients to general acute care hospitals.
- The policies in this year's final rule reflect CMS' continued commitment to refine the current payment system to ensure hospitals are provided with incentives to invest in service areas based on the clinical needs of their patients rather than financial incentives.
- The changes are responsive to MedPAC Recommendations made in its March 2005 Report to Congress on Physician-Owned Specialty Hospitals to adopt cost weights, better recognize severity of illness, and adopt changes over a transition period.

Key Actions Taken by CMS in the FY 2006 Final Rule

In the final rule to update the IPPS for FY 2006, CMS performed an extensive review of the cardiovascular DRGs in MDC 5 (Diseases and Disorders of the Circulatory System), particularly those DRGs that are commonly billed by specialty hospitals. In doing so, CMS identified conditions that would lead to a more complicated patient stay requiring greater resource use. These conditions are called Major Cardiovascular Conditions (MCV). Using the MCV approach, CMS found a sound analytical basis for revising 9 cardiovascular DRGs that account for nearly 700,000 cases. CMS replaced these 9 DRGs that are commonly billed by specialty hospitals with 12 new DRGs that better recognize severity of illness.

Key Actions Taken by CMS in FY 2007

Improving the Accuracy of Payments by Adopting Cost-Based Weights

- CMS set the DRG relative weights based on costs instead of charges improving the accuracy of payments, leading to better incentives for hospital quality and efficiency and ensuring that payment rates relate more closely to patient resource needs. More specifically, these changes are expected to reduce incentives for hospitals to cherry pick the healthiest and most profitable patients.
- CMS implemented the cost weights over a 3-year transition period from FY 2007 to FY 2009 period. As a result of these changes to the relative weights, between FY 2006 and FY 2009, payments to cardiac specialty hospitals are projected to decline by over 5 percent.
- CMS contracted with RTI International to study further improvement to the cost methodology to address charge compression (the practice of marking up low cost items more than high cost items) to ensure that Medicare's cost weights do not underpay high cost devices.

Revising the Payment System to Better Account for Severity

- CMS identified 20 new DRGs involving 13 different clinical areas and modified 32 others to significantly improve the CMS DRG system's recognition of severity of illness. The new and revised DRGs were selected from 40 current DRGs which contain 1,666,476 cases and represent a number of body systems. In creating these 20 new DRGs, CMS deleted 8 and modified 32 existing DRGs.
- Shortly after the final rule, CMS contracted with RAND Corporation to conduct an evaluation of alternative severity DRG systems. Further, CMS indicated our plans to update our own prior research, to achieve further improvements in payment accuracy by FY 2008.

Key Actions Taken by CMS in the FY 2008 IPPS Final Rule

Revising the Payment System to Better Account for Severity

- CMS is adopting MS-DRGs that replace 538 DRGs with 745 new ones that better recognize severity of illness. The changes do not result in any savings to Medicare but will increase payments to hospitals treating more severely ill and costlier patients. Payments to hospitals for treating less severely ill patients will decline.
- Cardiac specialty hospitals generally treat the healthiest and least costly patients and their payments are projected to decline by nearly 3 percent due to the new MS-DRGs and the continuing adoption of cost weights in FY 2008. These changes are in addition to reductions of over 5 percent that we estimated last year occurring from FY 2006 to FY 2009.
- By better recognizing severity of illness, fewer cases would be paid as outliers if we did not reduce the fixed loss amount. Reducing the fixed loss amount will help assure that hospitals that do treat these extremely costly cases will have an easier time qualifying for outlier payments. The outlier threshold for FY 2008 will be \$22,650, a reduction of 7.5 percent from the FY 2007 outlier threshold of \$24,485.
- RAND Corporation evaluated five commercially available DRG products and the MS-DRGs to determine whether they could be used by Medicare to better recognize severity of illness in its inpatient hospital payments. Consistent with RAND's findings, CMS is adopting the MS-DRG system for Medicare in FY 2008. There will be an opportunity for the public to comment on RAND's findings.

Ensuring Reforms Do Not Increase Medicare Spending

- Substantial evidence supports the conclusion that the adoption of new payment systems leads to an increase in aggregate payments without any corresponding growth in actual patient severity. MedPAC has noted that past prospective adjustments to reduce the effect of expected coding improvements have been consistently lower than the increase in payments that actually occurred.
 - Inpatient Rehabilitation Facility (IRF). Two retrospective adjustments were made several years after the start of the IRF prospective payment system to ensure that IRF payments going forward would not reflect increases in case mix that were not due to real increases in severity of illness. However, for the intervening years, Medicare paid more than it should have and there was a permanent cost to the Trust Fund.
 - Long Term Care Hospital (LTCH) Prospective Payment System. A retrospective review of LTCH case mix after its implementation suggested large increases in payment due to improvements in documentation and coding.

- Absent an adjustment to account for this factor, both the Actuary and MedPAC conclude that aggregate payments for inpatient hospital services would increase significantly from adoption of MS-DRGs.
 - Maryland recently adopted a system similar to the MS-DRGs. MedPAC and the Actuary compared how much coding improvements increase payments in Maryland under the MS-DRGs and nationally under Medicare.
 - MedPAC recommend an adjustment of -1.6 to -1.8% the first year for adoption of the MS-DRGs. CMS is adopting a -1.2 percent adjustment for FY 2008. Both MedPAC and the Actuary see a need for additional adjustments in future years to maintain budget neutrality.
 - The Actuary estimates that the Medicare Part A Trust Fund would be exhausted 18 months earlier than previously forecast if CMS did not make this adjustment.

High Praise for the MS-DRGs in Public Comments

- “Your proposal showcases the best of CMS, evidenced, for example, by an elegant and reasonable framework for severity-adjusted DRGs.”
- “CMS dedicated an extensive amount of thought, planning, and resources toward the development of the MS-DRGs.”
- “The MS-DRGs represent a reasonable approach to DRG refinement. They are, in principle, a positive advancement and will create a more equitable and accurate payment system.”
- “Making adjustments in the rates to restore balance to the entire inpatient payment system is a needed step.”

Improving the Accuracy of Payments by Adopting Cost-Based Weights

- CMS is continuing the 3-year transition to adopt cost weights.
- RTI completed a report on charge compression suggesting that CMS could expand from 13 to 19 hospital departments to improve payment accuracy.
- Although CMS was unable to model the changes to address charge compression for the proposed rule, it asked for public comments on whether to adopt these changes in the final rule without providing the specific payment impacts.
- The device industry supported going to 19 hospital departments. National hospital associations had specific concerns about using statistical techniques to adjust for charge compression without making improvements to how hospital report costs and charges. CMS decided to expand from 13 to 15 hospital departments in the final rule.

Other Important FY 2008 Changes

- The rule also changes the way Medicare pays for hospital capital-related costs based on an analysis that showed substantial positive margins experienced by some hospitals. In response to comments from MedPAC and other parties, the rule does not finalize the proposal to provide a zero payment update for urban hospitals and instead provides a full update for all hospitals. However, the final rule does eliminate the large urban add-on payment, and adopts a policy of discontinuing the teaching adjustments to capital payments over a three-year period.

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