

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201



Public Affairs Office

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Contact: CMS Public Affairs

(202) 690-6145

CMS ANNOUNCES PAYMENT REFORMS FOR INPATIENT HOSPITAL SERVICES IN 2008

REFORMS CONTINUE TRANSITION TO MORE ACCURATE PAYMENT SYSTEM; PROMOTE QUALITY CARE FOR ALL HOSPITALIZED PATIENTS

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule that takes significant steps to improve the accuracy of Medicare's payment under the acute care hospital inpatient prospective payment system (IPPS), while providing additional incentives for hospitals to engage in quality improvement efforts.

“The IPPS payment reforms we are making today finalize the changes we proposed in April and build upon three years of consistent, incremental improvements to Medicare inpatient hospital payments,” CMS Acting Deputy Administrator Herb Kuhn said. “With these changes – first proposed by the Medicare Payment Advisory Commission in 2005 – Medicare payments for inpatient services will be more accurate and better reflect the severity of the patient's condition.”

“Moreover, combined with payment system rules we released this week on inpatient rehabilitation facilities and skilled nursing facilities, we are demonstrating our commitment to ensure that the Medicare program is sustained for future generations by paying accurately and efficiently,” added Kuhn.

The IPPS payment reforms would restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient's condition. In addition, the rule includes important provisions to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. The rule also expands the list of publicly reported quality measures and reduces Medicare's payment when a hospital replaces a device that is supplied to the hospital at no or reduced cost.

Payments to all hospitals will increase by an estimated average of 3.5 percent for FY 2008 when all provisions of the rule are taken into account, primarily as a result of the 3.3 percent market basket increase. Payments to specific hospitals may increase more or less than this amount depending on the patients they serve. For instance, urban hospitals generally treat more severely ill patients and are estimated to receive a 3.8 percent increase in payments.

“The good news is that hospitals across the Nation, the District of Columbia, and Puerto Rico will see their payments increase under this final rule by nearly \$4 billion. This three year effort to reform Medicare’s hospital payment system will ensure predictability, reliability, and fairness of Medicare payments well into the future,” said Kuhn.

In the previous two years, Medicare made important, incremental changes while it studied comprehensive reform of the inpatient hospital payment system. This year, the rule creates 745 new severity-adjusted diagnosis-related groups (Medicare Severity DRGs or MS-DRGs) to replace the current 538 DRGs. Projected aggregate spending will not change as a result of the reforms. However, payments will increase for hospitals serving more severely ill patients and decrease for those serving patients who are less severely ill.

The changes Medicare is adopting are consistent with public comments on how the reforms should occur and were widely praised in the public comments. Based on these public comments, the new severity-adjusted DRGs will be phased in over two years, rather than one year, as detailed in April’s proposed rule. In addition, important first steps are taken in response to an extensive study of “charge compression.” CMS is making some initial changes this year and is further studying how to better recognize the cost of expensive devices as it considers other improvements to its payments for FY 2009.

The Medicare Actuary estimates that without an adjustment to account for changes in how hospitals document and code patient severity of illness, the new system would increase payments.

“In keeping with the law, the new basis for DRGs is not intended to reduce overall Medicare costs or to increase them. Based on more than 20 years of program experience with such changes, a documentation and coding adjustment is needed to make sure the new system is budget neutral,” said CMS Chief Actuary Richard Foster. “Substantial evidence supports our conclusion that, absent such an adjustment, aggregate payments for inpatient hospital services would increase significantly under the new system—without any corresponding growth in actual patient severity. If we didn’t make this adjustment, the Medicare Part A Trust Fund would be exhausted an estimated 18 months earlier than previously forecast.”

The changes reflect recommendations from the Medicare Payment Advisory Commission (MedPAC). CMS took its initial steps toward implementing the new system when it created new DRGs for cardiac procedures performed in FY 2006. An additional set of DRGs reflecting severity of illness was introduced for more procedures in FY 2007.

By more accurately recognizing the costs of caring for a patient, the new MS-DRGs should help reduce the potential for abusive practices. Under the old DRG system (with payments based on broad averages) incentives could lead hospitals to “cherry pick” – the practice of treating only the healthiest and most profitable patients. The new MS-DRGs help address the concerns that certain specialty hospitals – hospitals that provide a limited range of services and typically are owned in whole or in significant part by physicians who serve as referral sources – may selectively provide such profitable services. Finally, by paying more accurately for inpatient services, MS-DRG’s will minimize the cost shifting hospitals now say they have to make to account for variation in payment among Medicare inpatient procedures.

In addition to the base payment for the DRGs, the law requires Medicare to make a supplemental payment to a hospital if its costs for treating a particular case exceed the usual Medicare payment for that case by a set threshold. Medicare sets the threshold for high cost cases at an amount that is projected to make total “outlier payments” equal to 5.1 percent of total inpatient payments. For FY 2008, CMS is adopting a high cost outlier threshold of \$22,650, down from \$24,485 in FY 2007. By better recognizing severity of illness in the DRG reforms that are part of this final rule, fewer cases would be paid as outliers if CMS 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 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.

The rule implements a provision of the Deficit Reduction Act of 2005 (DRA) that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient who acquires a condition (including an infection) during a hospital stay. Already the feature of many state health care programs, the DRA requires hospitals to begin reporting secondary diagnoses that are present on the admission of patients, beginning with discharges on or after October 1, 2007. Beginning in FY 2009, cases with these conditions would not be paid at a higher rate unless they were present on admission. In order to improve the reliability of care in the nation’s hospitals, the rule identifies eight conditions, including three serious preventable events (sometimes called “never events”) that meet the statutory criteria. CMS will work to add an additional 3 conditions to the list next year.

The final rule adds new quality measures that hospitals would need to report in calendar year (CY) 2008 in order to qualify for the full market basket update in FY 2009.

CMS will measure 30-day mortality for Medicare patients with pneumonia and plans to adopt two measures relating to surgical care improvement in the CY 2008 outpatient prospective payment system final rule. In addition, CMS will finalize two additional surgical care improvement measures by program notice after they receive NQF endorsement.

The provision of the law specifies that Medicare payments for inpatient hospital services be adjusted if hospitals fail to report this quality information. Hospitals that report quality information will receive the full market basket update. For those that do not report, the market basket update will be reduced by 2.0 percentage points.

“Taken together, these two initiatives will significantly improve the quality and reliability of care delivered in the nation’s hospitals,” said Kuhn. “These reforms not only represent CMS’s continued push to create more transparency in our health care system, they also put us on more secure footing as we strive to become a more active purchaser of high quality care for Medicare beneficiaries.”

CMS will also change the way it pays for medical devices that are recalled or replaced at no or reduced cost to the hospital. The policy is consistent with the policy CMS adopted for outpatient payments beginning January 1, 2007. Under the IPPS, payment for these devices is included in the payment for the DRG. Currently, Medicare pays the same for the second procedure even if the hospital acquires the device for free or at reduced cost, as it did for the initial procedure when the hospital had to purchase the device. The rule reduces payment when hospitals use a recalled or replacement device at no cost or with partial credit.

In keeping with the plan contained in CMS’s August 2006 final Report to Congress on specialty hospitals, the rule creates new disclosure requirements for these hospitals. The rule requires physician-owned hospitals to disclose such ownership to patients and provide the names of the physician owners upon request. The rule also requires physician-owned hospitals to require physician owners who are members of the hospital’s medical staff to disclose their ownership to the patients they refer to the hospital. Disclosure would be required at the time of referral. In addition, the rule requires a hospital to notify all patients in writing if a doctor of medicine or doctor of osteopathy is not present in the hospital 24 hours a day, seven days per week, and describe how the hospital will meet the medical needs of a patient who develops an emergency condition while no doctor is on site. CMS now has the authority to terminate a provider agreement for noncompliance with these disclosure requirements.

The rule continues to phase in a change introduced in FY 2007 which would better align payment with the costs of care by using estimated hospital costs, rather than list charges, to establish relative weights for the DRGs. Under the rule, hospitals will be paid during 2008 based on a blend of one-third charge-based weights and two-thirds

hospital cost-based weights for the DRGs. In 2009, hospitals will be paid 100 percent based on cost-based DRG weights.

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