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CMS Announces Payment Reforms For Inpatient Hospital Services In 2007; Delays Major Reform Until FY 2008

On August 1, 2006, the Centers for Medicare & Medicaid Services ("CMS") issued the hospital Inpatient Prospective Payment System ("IPPS") final rule for federal fiscal year 2007 ("FY 2007"). While the rule does take steps to improve the accuracy of Medicare's payment for inpatient stays, the rule also delays any significant reform in FY 2007. The final rule implements the first year of a three-year transition to change the relative weights of Diagnosis Related Groups ("DRGs") from charge-based to cost-based weights, including significant technical improvements for FY 2008 based on a contractor analysis of issues raised in public comments. Further, the final rule makes refinements to the current CMS classification system to increase recognition of severity of illness, including 20 specific Diagnosis DRG changes. Additionally, the rule notes that CMS will evaluate, with public comment, alternative severity adjustment systems for implementation in FY 2008.

Background

On April 12, 2006, CMS announced proposed payment and policy changes for acute care hospital services to patients. At that time, CMS proposed a plan to significantly reform the IPPS over the next two federal fiscal years, with the general goal of refining the DRG system to better recognize the severity of illness among patients.

CMS proposed to adopt cost-based DRG payments based on accounting for the differential mark-ups between costs and charges for 10 individual hospital departments. Further, CMS proposed to adopt refinements in accounting for patient disease severity, in order to prevent underpayments for caring for the most severely ill patients. The proposed options included adopting CS-DRGs which would replace the current system of 526 DRGs with 861 refined DRGs, and other options for timing and content of a refined severity adjusted system.

Detailed Analysis

The final rule implements initial payment reforms in two parts. First, CMS begins a transition to using estimated hospital costs, rather than list charges, to set payment. According to CMS, the reform is aimed at eliminating biases in the current system arising from the hospital practice of having list charges that disproportionately exceed costs for some services. CMS has refined the methods used to determine average costs per case at the DRG level. CMS expanded the number of distinct hospital departments used in calculations from 10 to 13; included more hospital data in the final calculations by applying less stringent criteria for eliminating statistical outliers and accounted for hospital size when evaluating the mark-up of charges over costs. The

changes will go into effect October 1, 2006 and will be phased in over a three-year period.

Second, CMS's reform involves more accurate accounting for severity of a patient's illness, which has a significant impact on the costs of care. As part of the final rule, CMS identified 20 new DRGs involving 13 different clinical areas that strive to improve the CMS DRG system's recognition of severity of illness. The final rule also modifies 32 DRGs to better capture differences in severity. In creating these 20 new DRGs, CMS is deleting 8 and modifying 32 existing DRGs. CMS is taking these interim steps in FY 2007 as a prelude to making more comprehensive changes to better account for severity in the DRG system by FY 2008.

Additionally, CMS plans to conduct an evaluation of alternative DRG severity systems, with opportunity for public comment. According to CMS, an interim report comparing severity-adjusted DRG systems will be completed by the end of 2006 and will be released for public comment. A Technical Advisory Panel to consider the interim report will be convened in January 2007. CMS indicates that results of the evaluation research will be used to inform deliberations about the IPPS rule for FY 2008.

Impact on Specialty Hospitals

A number of the changes in the proposed rule reflected recommendations to CMS from the Medicare Payment Advisory Commission ("MedPAC"). These recommendations focused on reducing incentives for hospitals to invest in certain service areas because payment rates significantly exceed costs. The recommendations also addressed concerns that specialty hospitals are selectively only providing profitable services. Under the payment methodology in the proposed rule, payments to specialty hospitals (and more specifically cardiac specialty hospitals) were expected to significantly decline. As a result of the payment reforms implemented in 2006 (cardiac DRG reform) and now for 2007, payments to cardiac specialty hospitals are expected to decline by over 5 percent between 2005 and 2007. However, cardiac specialty hospitals are expected to see an average increase of 1.2 percent in FY 2007 because of the phased-in implementation.

Additionally, under the proposed rule, CMS considered how the provisions of the Emergency Medical Treatment and Labor Act ("EMTALA") should apply to specialty hospitals. CMS convened a Technical Advisory Group ("TAG") to further study the issue. As part of this work, EMTALA TAG considered whether there should be a Federal requirement that all hospitals must have an emergency department. In the final rule, CMS states that the agency does not intend to recommend to Congress that all hospitals must have an emergency department. However, CMS is requiring that all Medicare-participating hospitals with specialized capabilities, including specialty hospitals, accept appropriate transfers of unstable individuals, regardless of whether the hospital with specialized capabilities has an emergency department.



CMS has indicated that additional reforms are likely in FY 2008. To review the final rule, visit <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488f.pdf>

Please note that the final rule is 1468 pages in length currently. The version that will appear in the Federal Register in the coming days will be a more compact format.

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