CMS proposes major DRG revisions

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In the May 3, 2007, **Federal Register**, CMS proposes the most dramatic restructuring of the diagnosis-related groups (DRGs) used in the inpatient prospective payment system (IPPS) since its inception. The restructuring (adjusting DRG weights based on the severity of a patient's condition) would take effect October 1, 2007. Access the proposed rule at **bkd.com/docs/industry/050307proposedrule.pdf**.

MS-DRGs

The proposal would replace the current 538 DRGs with 745 Medicare Severity DRGs (MS-DRGs). First, current DRGs would be consolidated to 335 base MS-DRGs. Of these, 106 would be split into two subgroups and 152 would be split into three subgroups, arriving at 745 total MS-DRGs.

Subgroups would be determined based on the presence of complications or comorbidities (CCs) or major CCs (MCCs). Table 6J in the proposed rule lists 1,389 secondary diagnoses designated as MCCs. Table 6K lists 2,913 secondary diagnoses designated as CCs.

An example of the MS-DRG restructuring would be current DRG 127, Heart Failure & Shock, which would be split into the following three MS-DRGs:

- DRG 291 – with MCC
- DRG 292 – with CC
- DRG 293 – without CC/MCC

The following compares the total standard operating and capital payment for the old DRG in fiscal year 2007 and the new MS-DRGs in fiscal year 2008:

DRG Number	Weight	Payment Amount
DRG 127	1.0490	$5,561.29
MS-DRG 291	1.4850	$7,923.02
MS-DRG 292	1.0216	$5,450.61
MS-DRG 293	0.7317	$3,903.89

The wide variation between the weights for the MS-DRGs demonstrates the significant impact the proposed MS-DRG system could have on hospitals. While the overall impact is intended to be budget neutral, CMS estimates urban hospitals will experience a 0.2% increase in payments because of the MS-DRG system and the transition to cost-based DRG weights, with a 1.8% decrease expected for rural hospitals.

The impact table by individual hospital is available at **bkd.com/docs/industry/ippsimpact.xls**. A crosswalk between the old DRG system and the new MS-DRG system is available at **bkd.com/docs/industry/crosswalk.xls**.

In a controversial proposal, CMS plans to reduce the standardized payment amount by 2.4% in fiscal year 2008 and again in 2009 because of anticipated improvements in hospital documentation and coding under the new system.

The overall estimated 4.8% reduction is based on observations CMS made about the change in coding experienced by Maryland hospitals when they implemented a severity-adjusted DRG system several years ago.

While CMS proposes to move forward with the MS-DRG system, it notes the Rand Corporation has been evaluating five alternative systems for recognizing severity of illness. CMS has requested the MS-DRG system also be evaluated in Rand's final report, due September 1, 2007.

Additional payment & cost report changes proposed

Before considering the impact of the MS-DRG system, CMS proposes an overall 3.3% market basket inflation update to operating DRG rates.

In another controversial move, CMS proposes to freeze capital DRG rates for urban hospitals, eliminate the 3.0% large urban add-on and allow only a 0.8% update for rural hospital capital DRG rates.

Because CMS believes the MS-DRG system will improve the accuracy of coding and reduce the number of outlier cases, it proposes to reduce the outlier fixed-loss threshold from $24,485 to $23,015. CMS estimates this will keep total outlier payments close to its goal of 5.1% of overall IPPS payments.

CMS does propose to continue the three-year transition to cost-based DRG

About BKD Health Care Group

Understanding the documentation, coding and billing requirements under Medicare's various prospective payment systems (PPS) is an ongoing challenge. The complexity of DRGs and PPS make it difficult to know if you are properly billing for the payment you are entitled to and remaining compliant. BKD Health Care Group offers various techniques for gaining proper payment under Medicare PPS. Contact your BKD advisor or **healthcare@bkd.com** for more information. ❖❖❖

weights it began last year. CMS commissioned RTI International (RTI) to study ways of improving the accuracy of cost information by DRG.

Based on the study and CMS's analysis, CMS plans to revise the hospital Medicare cost report, which may include additional cost centers, *e.g.*, devices, implants and prosthetics; computed tomography (CT) scanning; magnetic resonance imaging (MRI); and intermediate nursing units that provide care above basic acute care but below intensive care.

Hospital-acquired conditions

The *Deficit Reduction Act of 2006* (DRA) required CMS to identify at least two hospital-acquired conditions that result in higher DRG payments. By October 1, 2007, hospitals will have to document whether these conditions are present on admission. By October 1, 2008, CMS must provide that hospitals' DRG payments cannot be increased if the condition occurred after admission.

CMS describes 13 different hospital-acquired conditions and proposes six be implemented to comply with this DRA provision:

- Catheter-associated urinary tract infections
- Pressure ulcers
- Object left in surgery
- Air embolism
- Blood incompatibility
- Staphylococcus aureus septicemia

Wage index issues

The fiscal 2008 wage index will include data from both occupational mix surveys hospitals completed for the first six months of 2006. The three-year transition to a rural wage index provided to hospitals that became rural under the new census definitions implemented in 2004 expires on September 30, 2007.

CMS briefly addresses the wage index provision of the *Tax Relief and Health Care Act of 2006* (TRHCA) that requires the Medicare Payment Advisory Commission (MedPAC) to issue a report by June 30, 2007, about the current wage index system and proposed revisions.

CMS is expected to publish "one or more" proposed revisions to the hospital wage index next year as part of its fiscal 2009 IPPS proposed rule. Testimony at recent MedPAC meetings has centered on the possibility of using employer data from the Bureau of Labor Statistics to develop county-level wage index factors.

Specialty hospitals

The proposed moves to MS-DRGs and cost-based DRG weights are both partially intended to address concerns raised by industry groups and others about the impact specialty hospitals have on community hospitals.

CMS proposes additional disclosure requirements that, while applicable to all hospitals, may primarily affect specialty hospitals. First, CMS proposes all patients be notified on admission of any physician ownership of the hospital. The physician owners must disclose in writing their ownership interest to all patients they refer to the hospital. Second, hospitals that do not have physicians present around the clock must notify all patients on admission about plans to address emergency medical needs at a time when no physician is present.

Other issues

Six new quality reporting measures have been adopted for fiscal 2008, including the Hospital Consumer Assessment of Health Providers and Systems Hospital Survey (HCAHPS).

Hospitals must file notification of intent by August 15, 2007, to participate in the fiscal 2008 quality reporting and must collect HCAHPS data starting with July 2007 discharges.

CMS proposes to revise the computation of full-time equivalent interns and residents to exclude vacation and sick leave from both the numerator and denominator, effective with cost reporting periods beginning on or after October 1, 2007.

Under certain circumstances, urban hospitals can elect to be treated as rural hospitals. Current regulations state such hospitals can revoke their rural election, effective at the start of their next cost reporting period; they must provide notice to the CMS regional office not less than 120 days before the end of the current cost reporting period.

For PPS hospitals, CMS proposes such notice be required not less than 120 days before the end of the federal fiscal year and after being paid as rural for at least one 12-month cost reporting period. The revocation would be effective October 1, the start of the next federal fiscal year.

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The proposed rule contains numerous other provisions not recapped here. Contact your BKD Health Care Group advisor for information on how the proposed rule will affect your operations and Medicare reimbursement. ❖❖❖

About Tim Wolters

Tim Wolters, a member of BKD Health Care Group, was one of 11 participants in the Technical Expert Panel convened to advise RTI about its study approach concerning cost-based DRG weights. He also participated in a follow-up workgroup convened by the American Hospital Association and other organizations to study this issue. ❖❖❖