



Office of External Affairs

FACT SHEET

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FY 2007 HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE

On April 12, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the hospital inpatient prospective payment system (IPPS) proposed rule for fiscal year (FY) 2007. In this rule, CMS estimates FY 2007 operating and capital payments for hospitals under the Medicare program will increase \$3.33 billion.

- The proposed rule includes revisions to the hospital payment system that implement a number of changes made by the Deficit Reduction Act of 2005 (DRA). The changes being proposed by CMS will promote higher quality and more efficient care in our nation's hospitals.
- More specifically, CMS is proposing to refine the diagnosis-related group (DRG) system under the IPPS to better recognize severity of illness among patients for implementation in FY 2008 (if not earlier); and for FY 2007 to use hospital-specific cost weights (rather than charge-based data) to adjust DRG relative weights.

Discussed below in more detail are proposals to enhance Medicare payments and promote high quality care, including provisions related to the submission of hospital quality data; data transparency for consumers; applications for new technologies and medical services add-on payments; provisions governing emergency services under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA); and payments to sole community hospitals and Medicare-dependent, small rural hospitals. These proposed changes would be applicable to discharges occurring on or after October 1, 2006.

Hospital Quality Data

The proposed rule discusses implementation of section 5001(a) of the DRA, which sets out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program. Building on the Department of Health and Human Services' ongoing voluntary Hospital Quality Initiative, the RHQDAPU program was established to implement section 501(b) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA).

- Section 5001(a) of the DRA revises the mechanism used to update the standardized amount for payment of hospital inpatient operating costs. The payment update for FY 2007 and each

subsequent fiscal year will be reduced by 2.0 percentage points for any “subsection (d) hospital” that does not submit certain quality data in the form and manner, and at a time, specified by the Secretary.

- Hospitals will continue to be required to submit quality data for the 10 starter measures included in the MMA. In addition, hospitals will be required to pledge to submit data on a set of expanded quality measures (the 21 Hospital Quality Alliance clinical quality measures), starting with discharges that occur in CY 2006. Hospitals will be required to submit data on the expanded measures into the QIO Clinical Data Warehouse beginning for discharges that occur in the first calendar quarter of 2006 (January through March discharges). The deadline for hospitals to submit their data for the first quarter of 2006 is August 15, 2006. Hospitals must also continue to meet CMS’ chart audit validation requirements.
- Hospitals that wish to withdraw from the RHQDAPU program may do so by August, 1, 2006.

Hospital Quality

The proposed rule discusses the issues that must be considered in developing a plan to implement a value-based purchasing plan under section 5001(b) of the DRA beginning with FY 2009.

- For each of the required pieces of the value-based purchasing plan (measure development and refinement, data infrastructure, incentives, and public reporting), the proposed rule discusses CMS’ activities to date and solicits comments.
- The proposed rule also discusses options for implementation of section 5001(c) of the DRA, which authorizes quality adjustments for certain conditions that were not present on hospital admission.

Transparency of Pricing and Quality Information

The proposed rule lays out several potential options for making pricing and quality information available to the public in order to foster comment on possible options to promote the aims of transparency of pricing and quality information.

- The proposed options include publishing hospital charges in every region of the country or in selected regions of the country; publishing the rates that CMS pays to individual hospitals for every DRG or for selected DRGs, adjusted to take into account the hospital’s labor market area, teaching hospital status, and disproportionate share hospital status; establishing hospital conditions of participation that require hospitals to post their prices and/or post their policies regarding discounts or other assistance for uninsured patients; and publishing the total cost for an episode of care.

New Medical Services and Technologies

The Social Security Act establishes a process for identifying and ensuring adequate payment for new medical services and technologies (“new technologies”) under the IPPS. Applicants for new technology add-on payments must meet three general criteria in order to receive additional reimbursement: (1) the product is new (less than 2-3 years old); (2) the product meets a defined cost threshold (the cost of the patient including the new technology must be a specified amount greater than the DRG payment for the case); and (3) the product must offer substantial clinical improvement for the Medicare patient population.

- For FY 2007, CMS received three applications for new technology add-on payments. The proposed rule solicits comments from the public on whether the technologies meet the criteria above.
- In addition, CMS is proposing to continue add-on payments for two of the three technologies that were approved for new technology add-on payments in FY 2006. The third technology does not qualify for new technology add-on payments in FY 2007 because it is no longer new.

Emergency Medical Treatment and Labor Act (EMTALA) Requirements

Section 945 of the MMA directed the Secretary to convene a Technical Advisory Group (TAG) to review issues related to EMTALA and its implementation. In this rule, CMS proposes to revise current regulations to adopt two recommendations of the EMTALA TAG.

- CMS proposes to state explicitly the current policy that hospitals with specialized capabilities must accept appropriate transfers of individuals from other hospitals' emergency departments if the hospitals at which the individuals first present for emergency treatment are not capable of stabilizing them, regardless of whether they have their own emergency departments, and if the hospital with specialized capabilities has the capacity to treat the individual.
- CMS also proposes to modify the current requirement under which only a physician is authorized to determine that a pregnant woman having contractions is in false labor. As recommended by the TAG, CMS would allow hospitals the flexibility to use certified nurse-midwives or other qualified non-physicians acting within their scope of practice, as defined in hospital medical staff bylaws and State law.

Hospitals within Hospitals (HwHs)

CMS is proposing to revise the regulations for grandfathered HwHs, grandfathered hospital satellites, and grandfathered satellite units to allow these facilities to reduce their square footage or number of beds without jeopardizing their grandfathered status. CMS is also proposing to revise the HwH provision at §412.22(f) (3) that would allow for increases or decreases in square footage, or decreases in the number of beds of the HwH if these changes are made necessary by relocation of a hospital to permit construction or renovation necessary to comply with Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

Medicare Dependent Hospital Program Payments

The Medicare Dependent Hospital (MDH) Program payment methodology was set to expire at the end of FY 2006. Under the DRA, the program was extended until 2011. Specifically, the DRA removes the 12 percent cap on Disproportionate Share Hospital (DSH) payments to MDHs effective for FY 2007 and allows MDHs to use their FY 2002 cost reporting periods to determine their hospital-specific rate if such use results in higher payment. The DRA also increases the adjustment to MDH payments from 50 to 75 percent of the difference between their hospital-specific rate and the federal rate. This proposed rule implements these DRA provisions. As a result of the provisions in this rule, including the implementation of the DRA provisions, MDHs are projected to experience a 14 percent increase in payments in FY 2007.

Payment for Services Furnished Outside the United States

The Social Security Act generally prohibits, with some exceptions, payment under Medicare for items and services furnished outside the United States. Services that fall under these exceptions typically are furnished in Canada or Mexico. However, under the “outside of the United States” language and the definition of the term “United States,” it is permissible for Medicare to pay for services furnished in foreign countries other than Canada and Mexico. Therefore, CMS proposes to amend the regulations that refer to Canada and Mexico, and to make some related technical changes.