Cardiovascular Surgery Hardest Hit by New IPPS Regulations

Changes to the Medicare inpatient prospective payment system (IPPS) by the Centers for Medicare and Medicaid Services (CMS) will significantly affect how hospitals are reimbursed for FY 2008. These changes include the continued phase-in of relative weights based on hospital-specific costs and new Medicare severity-adjusted DRGs (MS-DRGs). The regulations redistribute revenues among medical services and may profoundly affect the bottom line for many hospitals.

The Medicare IPPS pays hospitals on the basis of pre-determined rates. The system includes numerous technical adjustments based on factors such as local area wage differences, a hospital's indigent caseload, and whether a hospital has a teaching program. The system also allows additional payment for cases that are unusually costly, referred to as "outlier" cases.

The complexity of the IPPS makes it difficult to gauge the effects of changes to a particular component of the payment system. Some components are patient-specific, some are hospital-specific, and some are interrelated with other components. It is also difficult to measure effects on specific hospital operations such as shifts in reimbursement among medical services, major diagnostic categories, etc.

This analysis is based on the FY 2006 MedPAR file that CMS used in promulgating the final regulations for FY 2008. More than 3,400 short term acute care hospitals were included representing more than $100 billion in IPPS payments per year. IPPS payment was computed on a patient-by-patient basis according to detailed payment regulations for respective fiscal years. Each component of reimbursement was included in calculating payment: the respective DRG definitions, relative weights, hospital blended rates, capital payments, outlier payments, DSH adjustments, IME adjustments, transfer adjustments, etc.

The resulting computations of IPPS payment were then summarized by medical service. These medical services were defined by groupings of DRGs and were refined for each fiscal year's DRG definitions. It is important to note that the new MS-DRGs for fiscal year 2008 actually cause shifts in utilization among some medical services because of increased specificity among DRGs.

Results shown in the accompanying table were ranked according to changes in total IPPS reimbursement. A projected 1.0% decrease in payments for cardiovascular surgery will shift almost $169 million to other medical services nationwide. On the other hand, a 6.0% increase in payments for orthopedic surgery will shift more than $711 million to that service. These shifts are the result of the new MS-DRGs that are intended to account more precisely for differences in severity among individual cases and the continued phase-in of relative weights calibrated according to reported hospital costs.

These shifts in reimbursement among medical services mean that a hospital may need to anticipate changes among its medical services even though the net effect on its bottom line may remain relatively unchanged.

Projected Change in Total IPPS Reimbursement by Medical Service

Medical Service	FY2006 Number Disch	FY2006 Reimb / Disch	FY2007 Number Disch	FY2007 Reimb / Disch	FY2007 $ Chg ($ mil)	FY2008 Number Disch	FY2008 Reimb / Disch	FY2008 $ Chg ($ mil)	FY2008 % Chg
Cardiovasc Surg	828,031	$21,047	828,030	$20,929	-$97.6	828,030	$20,725	-$168.9	-1.0%
Surg for Malig	114,396	$10,742	110,097	$10,411	-$82.7	94,950	$11,147	-$87.8	-7.7%
Oncology	244,049	$9,551	244,095	$9,840	$70.8	243,922	$9,915	$16.7	0.7%
Neurosurgery	73,544	$18,208	73,545	$18,590	$28.1	73,620	$18,873	$22.2	1.6%
Gynecology	90,786	$5,414	90,593	$5,638	$19.2	92,356	$5,838	$28.4	5.6%
Cardiology	2,029,938	$5,660	2,029,936	$5,867	$420.3	2,029,979	$5,881	$28.5	0.2%
Vascular Surg	264,145	$12,364	264,160	$12,678	$83.0	264,085	$12,892	$55.7	1.7%
Orthopedics	325,889	$4,818	325,888	$5,124	$99.7	325,891	$5,316	$62.7	3.8%
Neurology	691,286	$6,264	691,287	$6,438	$120.1	691,298	$6,531	$64.2	1.4%
Psychiatry	169,758	$3,904	169,758	$4,393	$83.1	169,763	$4,819	$72.3	9.7%
Urology	725,280	$6,552	729,769	$6,902	$284.8	730,178	$7,056	$115.5	2.3%
Pulmonology	1,479,413	$7,399	1,479,441	$7,516	$173.4	1,479,465	$7,623	$158.8	1.4%
Surgery	888,420	$21,029	888,230	$21,202	$149.8	901,010	$21,210	$277.9	1.5%
Medicine	2,424,470	$5,997	2,424,584	$6,306	$749.7	2,424,856	$6,479	$422.3	2.8%
Orthopedic Surg	1,052,986	$9,523	1,052,965	$11,253	$1,821.2	1,052,965	$11,928	$711.4	6.0%
TOTAL	11,423,559	$9,036	11,423,559	$9,380	$3,928.0	11,423,559	$9,537	$1,793.4	1.7%

TECHNICAL NOTES:

Data are based on the FY 2006 MedPAR, March file. This is a file of 100% of all Medicare fee-for-service claims representing discharges during the 12 months ending September 30, 2006 and billed as of 2/28/2007. This is the same file used by CMS in promulgating final IPPS regulations for FY 2008. Only short-term acute care hospitals were included and hospitals were excluded if they did not have sufficient data to project IPPS for the periods studied. No adjustments were made to the data to account for inflation among the periods and no adjustments were made to disregard the "behavioral offset" proposed by CMS for FY 2008.

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