



Nonpayment for Performance? Medicare's New Reimbursement Rule

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To defuse physicians' and hospitals' opposition to the creation of Medicare back in 1965, the program's congressional architects selected payment mechanisms designed to preserve the status

quo.¹ But as Medicare has expanded and problems of affordability and quality of care have grown, such an approach has become untenable. Recently, the Centers for Medicare and Medicaid Services (CMS) announced its decision to cease paying hospitals for some of the care made necessary by "preventable complications" — conditions that result from medical errors or improper care and that can reasonably be expected to be averted. This rule, which implements a congressionally mandated change in hospital reimbursement, is the latest in a series of steps that have rendered Medicare's payment policy far less passive than it once was.²

The starting point for current

Medicare payments for inpatient care is the system based on diagnosis-related groups (DRGs) that was adopted in 1983 by CMS's predecessor, the Health Care Financing Administration. That system is considered prospective, in that the amount paid to a hospital for a patient is fixed in advance and depends only on the diagnoses and major procedures reported at discharge (which, in turn, map to a specific DRG).

In reality, payments under this system have never been completely prospective, being influenced to some degree by what happens to an individual patient during a hospitalization. For example, higher payments are made on behalf of patients in whom clinically sig-

nificant complications develop after admission than for those with the same diagnosis who have no such complications. There are also so-called outlier payments that partially compensate hospitals for the additional expenses incurred for very-high-cost cases. With regard to preventable complications, these retrospective features of the DRG payment system have harbored a perverse incentive: hospitals that improved patient safety and ameliorated problems such as nosocomial infections saw their Medicare revenues — and sometimes their profits — reduced.

Believing that this counterproductive incentive should be eliminated, Congress instructed the Secretary of Health and Human Services in 2005 to "select at least 2 conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary di-

agnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.²² After issuing a proposed set of measures and considering comments from stakeholders and experts, CMS decided to disallow incremental payments associated with eight secondary conditions that it sees as preventable complications of medical care (see table).² These conditions, if not present at the time of admission, will no longer be taken into account in calculating payments to hospitals after October 1, 2008.

The new rule will result in hospitals seeing substantial reductions in payment for the care of individual patients with preventable complications. For example, if a patient were admitted to a Boston-area hospital with pneumonia and developed a urinary tract infection or bed sores during the hospitalization, the hospital would currently be paid \$6,253.58, under DRG 89 (“pneumonia with com-

plications”); under the new rule, if there were no other complications, the hospital would be paid only \$3,705.38, under DRG 90 (“simple pneumonia”) — a difference of \$2,548.20 (a reduction of approximately 40%). The policy, however, is unlikely to change the total Medicare payments to hospitals substantially, because the payment will be “reduced” only for instances in which preventable complications were the only factors causing a case to be reclassified under a more expensive DRG.

Medicare will continue to make outlier payments for cases with costs substantially exceeding the average for the appropriate DRG, even when these costs are the consequence of preventable complications — and the likelihood of incurring such outlier payments will actually be increased by the new policy, because cases in which there are complications will more easily exceed the threshold associated with the lower-paying DRG. Moreover, preventable complica-

tions including the eight that CMS identified for exclusion may continue to result in higher Medicare payments to hospitals, because their downstream consequences may place cases in entirely different and very-high-cost DRGs, such as DRG 483 (tracheostomy with mechanical ventilation for 96 hours or more). The new approach does not attempt to unravel these more complex clinical scenarios.

Although in the near term, the amount of money withheld may be small, in terms of the percentage of all payments to hospitals, it can be expected to have a disproportionate effect on their behavior. One reason is that this change represents the leading edge of a series of anticipated CMS reforms of provider payment, which include a shift toward pay for performance. Hospitals may therefore view the new policy as a harbinger of things to come and act in anticipation of more substantial reimbursement changes. In addition, nonreimbursement for costs associated with perceived quality failings may be a more powerful motivator than an equal reward for eliminating complications.³ Finally, because hospitals will be obliged to ascertain and code infections and other conditions as “present on admission” to avoid reductions in their revenues, the policy may lead to more widespread adoption of quality measurement and reporting or to improved targeting of prophylaxis against or treatment of community-acquired infections.

During its development, the new rule was criticized both for going too far and for not going far enough. Some stakeholders argued that it will penalize hospitals for treating frail or otherwise high-risk patients, encouraging

Conditions for Which Medicare Will No Longer Pay More If Acquired during an Inpatient Stay.*		
Condition	No. of Medicare Cases in Fiscal Year 2006	Average Medicare Payment for Admissions in Which Condition Was Present
Object left in patient during surgery	764	\$61,962
Air embolism	45	\$66,007
Blood incompatibility	33	\$46,492
Catheter-associated urinary tract infection	11,780	\$40,347
Pressure ulcer	322,946	\$40,381
Vascular-catheter-associated infection†	Unknown	Unknown
Mediastinitis after coronary-artery bypass grafting	108	\$304,747
Fall from bed	2,591	\$24,962

* Data are from the *Federal Register*.²

† Data are unknown because a unique code for this condition was introduced for fiscal year 2008.

them to avoid such patients. Although this concern may be valid, the new rule only exacerbates an inherent side effect of prospective payment in the absence of perfect risk adjustment: to the extent that certain observable patient characteristics are associated with higher costs and are not accounted for in the payment formula, the DRG system already rewards hospitals for avoiding patients with these risk factors. On the other side of the issue, some stakeholders proposed substantial expansions of the list of nonreimbursable conditions, given the extent of injuries, the number of deaths, and the magnitude of the expense associated with patient-safety problems in hospitals; the approval of a much larger set of conditions would have ratcheted up the financial implications and made a more compelling case for more fundamental and comprehensive reform of inpatient care. In the end, however, CMS ruled out a number of candidate conditions,

either because they could not be identified through existing DRG codes or because of a lack of proven strategies for preventing them.

In the same regulatory ruling, Medicare has also refined the DRG system to increase the extent of payment differentiation according to the severity of illness. Thus, along with emerging pay-for-performance initiatives, the new policy appears to be part of a larger reform of the Medicare payment scheme. The current reform rests on the following three principles: payers should pay more for the treatment of conditions that require more resources and that the provider could not reasonably have prevented; they should pay more when evidence-based or consensus-based best practices are followed; and they should pay less or not at all for low-quality care. Naturally, the last will be the most controversial.

The conditions for which Medicare will cease to pay hospitals as of next October have been shown

to be within the control of hospitals, so there is a relatively compelling case that their costs should fall on the provider rather than the purchaser. It is unclear how Medicare will generalize the principle of refusal to pay for poor-quality care beyond this initial and largely symbolic effort. As inadequate as the store of evidence-based beneficial practices appears to advocate of pay for performance, there is even less empirical support or consensus for the identification of inappropriate or clearly contraindicated services and care patterns.

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3. Kahneman D, Tversky A. Prospect theory: an analysis of decision under risk. *Econometrica* 1979;47:263-92.

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Satisfaction Guaranteed — “Payment by Results” for Biologic Agents

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As increasing numbers of promising but expensive biologic agents are introduced for use as medical treatments, drug pricing has become a high-profile issue. Earlier this year, pricing practices took a new turn in Britain, when the National Institute for Health and Clinical Excellence (NICE), the evaluative agency that applies cost-effectiveness analysis in making recommendations concerning drug coverage, declined to support coverage of the proteasome inhibi-

tor bortezomib (Velcade) by the British National Health Service (NHS) for the treatment of multiple myeloma. It concluded that the price was too high relative to NICE's estimates of its average benefits for the population to be covered. Rather than reducing bortezomib's price, its manufacturer, Johnson & Johnson, offered to forgo charges for patients who do not have an adequate response to the drug. Although many details remained to be negotiated

— including the criteria defining a response — the proposal reflected the recognition that the time has come to consider new approaches to drug pricing.

Payment based on results, including “pay for performance,” has been touted as a way to avoid waste and increase value in health care.¹ In a conventional pay-for-performance contract, a small part (typically, 1 to 10%) of the reimbursement to providers is tied to measures of the quality and cost