MEDPAC Medicare Payment Advisory Commission

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Glenn M. Hackbarth, J.D., Chairman
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May 27, 2010

Marilyn Tavenner, Principal Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1498-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: file Code CMS-1498-P

Dear Ms Tavenner:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMSôs proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals under Age 21*, Federal Register Vol. 75, No. 85, pages 23851-24362 (May 4, 2010). We appreciate your staffôs ongoing efforts to administer and improve the payment systems for acute inpatient hospital services and long-term care hospital services, especially considering the agencyôs many competing demands and limited resources.

In this letter, we comment on CMS actions to address unintended increases in Medicare payments within the hospital inpatient prospective payment systems (IPPS) and the long-term care hospital payment system due to the adoption of Medicare severity diagnosis related groups (MS-DRGs) and hospitalsô responses in the form of improved medical record documentation and diagnosis coding. Our comments focus on five key points:

- CMS adopted MS-DRGs to improve the distribution of payments among hospitals by shifting payments toward hospitals that treat more costly types of cases.
- Adopting MS-DRGs should not increase or decrease aggregate hospital payments.
- CMS Actuaries were correct in estimating that the new MS-DRGs coupled with improved coding increased payments by $6.9 billion over 2008 and 2009. We expect an additional $4.8 billion in overpayments in 2010 and overpayments will continue until CMS makes a prospective offsetting adjustment to the IPPS payment rates.

- MedPAC has recommended two actions:
    - CMS should act to prevent future overpayments.
    - Congress should require CMS to recover all overpayments, not just the $6.9 billion that occurred in 2008 and 2009. It should also authorize CMS to make the recoveries gradually rather than force CMS to make all recoveries in 2011 and 2012.
- We support CMSõs proposal to reduce long term care hospital payments by 2.5 percent to offset the effect of improved coding and the change to MS-LTC-DRGs.

CMS adopted MS-DRGs to improve the distribution of payments

In our March 2005 report to the Congress on physician-owned specialty hospitals we noted that under the policies then in effect, hospitals had financial incentives to specialize in treating patients in certain relatively profitable DRGs and to avoid treating high-severity patients within all DRGs because of their higher than average costs. Under the DRG definitions then in use, high-severity cases often were not paid more than cases with low or moderate severity. CMS adopted MS-DRGs and other payment refinements in fiscal year 2008 to ensure that the relative payment rates IPPS hospitals receive for Medicare patients reasonably match their relative costs of furnishing care. However, the shift to MS-DRGs was taken to improve the distribution of payments, not change the aggregate level of payments.

Adopting MS-DRGs should not increase or decrease aggregate payments

As expected, implementation of MS-DRGs in 2008 gave hospitals a financial incentive to improve medical record documentation and diagnosis coding to more fully account for each patientõs severity of illness. While documentation and coding improvements (DCI) help hospitals measure patient severity more accurately, they also increase payments without a real increase in patient severity or the resources hospitals must use to furnish inpatient care. (For more on how DCI affects case-mix, analysis of its effects on IPPS payments, and the law governing DCI adjustments, see the attachment to this letter.)

To prevent inappropriate increases in payments, CMS has long been required by law to ensure that changes in the DRGs and relative weights are made in a budget neutral mannerð that is, they do not increase or decrease aggregate IPPS payments to hospitals compared with the payments that would have been made without the changes. However, section 7 of the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Quality Improvement] Programs Extension Act of 2007 (TMA) limited the prospective adjustments that CMS could apply to offset DCI in 2008 and 2009. But if overpayments occurred because actual DCI exceeded those adjustments, CMS is required to recover the overpayments, with interest, and also further reduce IPPS payment rates to fully prevent overpayments from continuing in subsequent years. When the TMA was enacted, CMS was expected to implement these provisions in a manner that would achieve budget neutrality, and this expectation was reflected in the budget scoring provided by the Congressional Budget Office.

CMS correctly estimated the effect of DCI on case mix and payments

CMS analysis of 2008 Medicare hospital inpatient claims found that DCI increased reported case mix by 2.5 percent, which resulted in overpayments equal to 1.9 percent of total IPPS payments in 2008 (the statutory DCI adjustment was -0.6 percent). Using 2009 claims, CMS found a cumulative increase in case mix of 5.4 percent due to DCI, which resulted in overpayments of 3.9 percent in 2009 (the cumulative statutory offset was -1.5 percent). In our judgment, CMSôs analytic methods are valid. Using similar methods, our analysis of Medicare hospital inpatient claims for 2007-2009 confirms all of CMSôs findings. Like CMS, we expect that overpayments equal to 3.9 percent of annual IPPS payments will continue through 2010, 2011, and future years until CMS makes a prospective offsetting adjustment (-3.9 percent) to the IPPS payments rates.

CMS has proposed an adjustment of -2.9 percent in 2011 and a future adjustment of -3.9 percent for an undetermined date. These adjustments are insufficient because cumulative overpayments would continue to increase in 2010 and 2011 (Table 1). The first two columns of Table 1 show our estimates of how much coding changes increased case mix and payments in 2008 and 2009, as well as the cumulative effects on overpayments to hospitals. The last two columns show what the projected effects of coding changes and CMSôs proposed policies would be in 2010 and 2011 if no further coding changes occur after 2009. As the last line shows, cumulative overpayments are increasing by about 3.9 percent of annual payments in 2010 and by 1 percent of annual payments in 2011 after CMSôs proposed recovery adjustment is adopted. According to the CMS actuaries, the 3.9 percent overpayment in 2009 alone amounts to about $4.5 billion. Thus, the reductions in payment rates that CMS has proposed to offset the effects of coding changes do not represent payment cuts, but rather offset unintended overpayments to hospitals.

Table 1: Cumulative overpayments continue to rise despite the recoveries proposed by CMS

	2008	2009	2010 (projection)	2011 (projection)
Cumulative effect of coding changes	2.5%	5.4%	5.4%	5.4%
Prospective adjustment in law	-0.6	-1.5	-1.5	-1.5
Annual overpayments	1.9	3.9	3.9	3.9
CMS Proposed Recoveries	0.0	0.0	0.0	-2.9
Net change in payments	1.9	3.9	3.9	1.0
Cumulative Overpayments	1.9	5.8	9.7	10.7

Note: Overpayments and recoveries are expressed as a share of annual inpatient payments. Proposed recoveries reflect recoveries of estimated overpayments in 2008 and 2009. Claims for 2010 and 2011 have not been evaluated, and estimates of the effects of coding changes for those years assume no further coding improvements past 2009.

CMS actuaries estimate that the 1.9 percent overpayment in 2008 plus the 3.9 percent overpayment in 2009 are equivalent to $6.9 billion. CMS has proposed to reduce IPPS payment rates by 2.9 percent in 2011 to recover about $3.5 billion of those overpayments. Depending on how and when CMS applies additional adjustments needed to recover the remaining overpayments from 2008 and 2009 and to prevent further overpayments, we estimate that total overpayments could reach as high as $19 billion by the end of 2012.[1] As much as $12 billion of that total would not be recovered. To put this number in perspective, $12 billion is roughly equal to giving hospitals an additional 3.2 percent of annual IPPS payments for three years.

MedPAC's positions on DCI

Overpayments should be stopped

CMS has concluded that it is required by law to permanently reduce payment rates by 3.9 percent to prevent further overpayments. We concur. CMS has also concluded that it has discretion to delay implementing this payment adjustment. We recognize that CMSôs reason to delay making a -3.9 percent adjustment to prevent further overpayments is two-fold. Under current law, CMS must recover overpayments from 2008 and 2009 by the end of 2012. Further, the combination of CMSôs proposed recovery adjustment for 2011 (-2.9 percent) and a -3.9 percent adjustment to prevent further overpayments would total 6.8 percent. CMS is concerned that a 6.8 percent reduction in the rates, if taken, may be financially disruptive to many hospitals. Delaying prevention of overpayments, however, also creates a problem because overpayments will continue to accumulate in 2010 and later years until the effect of DCI is fully offset in the payment rates. Thus CMS will not achieve budget neutrality unless Congress directs it to recover all overpayments.

All overpayments should be recovered

In response to these problems, in our March 2010 report to the Congress, MedPAC recommended that Congress change the law to require CMS to recover all overpayments (with interest), including those that occur in 2010 and 2011. Our recommendation, if implemented, would result in a smaller accumulation of overpayments because CMS would first focus on preventing further overpayments. Our recommendation also would achieve budget neutrality because all overpayments eventually would be recovered. To prevent a financial shock to hospitals, the Commission recommended that reductions in payment rates should be made gradually over three years, with a maximum annual reduction of 2 percent per year and a maximum cumulative offset of 6 percent by the third year. Payment reductions in the first two years would lower payments by the -3.9 percent needed to prevent future overpayments. The remainder of the adjustments would

[1] For example, if CMS did not fully prevent overpayments until 2013, overpayments would be roughly $2.2 billion in 2008, $4.7 billion in 2009, $4.8 billion in 2010, $4.9 billion in 2011, and $2.4 billion in 2012, for a total of approximately $19 billion..

be temporary adjustments used to recover all overpayments and restore budget neutrality in the implementation of MS-DRGs and cost-based relative weights. The temporary part of the reductions would cease when overpayments were fully recovered.

The net results of the commissionôs recommendation are:

- MedPACôs approach would reduce payments in increments of no more than 2 percent for three years.
- Hospitals would continue to receive their scheduled updates, which would offset much of these reductions.
- After three years, hospitals would receive their scheduled updates without any additional offsets.
- After roughly six years, overpayments would be fully recovered, and hospitals would see an increase in payments of roughly 2 percent in addition to their scheduled update.

The Commissionôs recommendation encompasses preventive and recovery adjustments to offset the effects of DCI on all paymentsð including both operating and capital paymentsð and for all hospitals paid under the IPPS. However, CMS is unable to follow this path without a change in the law.

What should CMS do if Congress does not change the law to permit full recovery?

Current law creates a difficult situation for CMS, hospitals, and taxpayers. To minimize the accumulation of overpayments, CMS must recover the 2008 and 2009 overpayments as quickly as possible so that adjustments to prevent further overpayments can be put in place as soon as is practicable. In 2012, CMS could replace the 2011 recovery adjustment with a recovery adjustment that is sufficient to recover the remainder of the overpayments that occurred in 2008 and 2009 (plus interest). CMS could also make downward adjustments in IPPS rates in 2012 and 2013 of -2.0 percent and -1.9 percent to offset the effect of coding changes going forward. These adjustments would be consistent with the Commissionôs recommendation and would moderate the impact on hospitals of preventing further overpayments. In 2012, the net effect would be to reduce payment rates by about 2 percent. In 2013, however, the decrease in rates due to a -1.9 percent adjustment would be more than offset by the expiration of the temporary recovery adjustment for 2012. This would result in an increase in payment rates in 2013 of roughly 1 percent. In all of these years hospitals will also continue to receive the annual update (estimated at 2.4 percent for 2011).

All IPPS hospitals should be treated the same

In the proposed rule, CMS specifically requested comments on its proposed DCI adjustments for special categories of hospitals. Payments to all IPPS hospitals reflect changes in their case-mix indexes based on the MS-DRGs and cost-based relative weights for the current year. Thus, all hospitals have the same financial incentives for DCI and the same capacity to benefit from case-mix change due to DCI. In our view, the

same principles should apply for all IPPS hospitals. To fully ensure budget neutrality in the adoption of MS-DRGs, the Congress should change the law to require CMS to prevent further overpayments to all IPPS hospitals and to recover all overpayments from all IPPS hospitals.

Long-term care hospitals

As with acute care hospitals, implementation of MS-LTC-DRGs in 2008 gave long-term care hospitals (LTCHs) a financial incentive to improve medical record documentation and diagnosis coding to more fully account for each patientôs severity of illness. We concur with CMSôs conclusions about the need for, and application of, counterbalancing adjustments to LTCH payments to offset the effects of case-mix increases due to changes in documentation and coding practice. We also concur with the methods CMS proposes to determine the effects of documentation and coding improvements on LTCH case mix and payments. Using this methodology, CMS found that documentation and coding improvements increased reported case mix by 2.5 percent in 2008 and 2009 combined. This increase is smaller than that found for acute care hospitals, which is what we would expect given that a larger share of LTCH cases are already coded at the highest severity levels. MedPAC concurs with CMSôs proposal to reduce LTCH payment rates by 2.5 percent to prevent further overpayments.

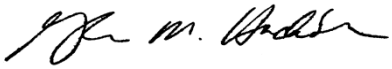
Conclusion on documentation and coding

Prior to the introduction of the MS-DRGs, CMS and MedPAC both predicted that hospitals would improve their medical record documentation and coding, and both organizations recommended prospective adjustments to correct for the expected effect of these improvements on Medicare payments to hospitals. These adjustments were limited by law, but CMS must recover overpayments that occurred in 2008 and 2009 (with interest) and prevent further overpayments. Now that the 2009 claims data are available, we can see that hospitals received a total overpayment of about $6.9 billion through 2009. Moreover, overpayments are continuing in 2010 and cumulative overpayments are increasing each year. All overpayments need to be recovered, but current law only provides for recovery of overpayments that occurred in 2008 and 2009 (plus accumulated interest), ignoring ongoing overpayments in 2010 through 2012.

In our view, the most important priorities are for CMS to stop further overpayments from occurring and then restore budget neutrality. To do this, the Congress needs to change the law to permit CMS to recover <u>all</u> overpayments due to coding changes in response to MS-DRGs.

If you have questions about any of the issues raised in our comments, please contact Mark Miller, MedPACôs Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

Attachment on Documentation and Coding Improvement

Background on the introduction of MS-DRGs

We commend CMS for its substantial efforts to develop the MS-DRGs and refine the IPPS payment rates. In our March 2005 report to the Congress on physician-owned specialty hospitals we noted that under the policies then in effect, hospitals had financial incentives to specialize in treating patients in certain relatively profitable DRGs and to avoid treating high-severity patients within all DRGs because of their higher than average costs. Under the DRG definitions then in use, high-severity cases often were not paid more than cases with low or moderate severity. The MS-DRGs and other payment refinements have moved a long way toward ensuring that the relative payment rates IPPS hospitals receive for Medicare patients reasonably match their relative costs of furnishing care.

However, as we have seen in the past, these major changes in the DRG classification system created opportunities and incentives for hospitals to improve their medical record documentation and diagnosis coding. Hospitals improve documentation and coding to ensure that they get full credit for the highest level of patient severity. The result is that hospitals report a higher case mix under the new MS-DRG system than they would have reported for the same patients under the prior DRG system. But this change in reported case mix due to documentation and coding improvement (DCI) is not real; the severity level is not higher, but under the new system, it looks higher.

Ordinarilyð if the DRG changes were relatively minor and did not create incentives for more specific reporting of diagnosesð CMSôs annual recalibration of the DRG relative weights would prevent any change in the national average case mix index (CMI) and aggregate hospital payments. However, when CMS makes major changes in the DRG definitions, as it did with the MS-DRGs in 2008, the recalibration process can not prevent an increase in the CMI that is due to DCI. The recalibration must use claims that are available at the time. When the 2008 recalibration took place, the latest available claims were from 2006, which preceded hospitalsô incentives for DCI in response to MS-DRGs.

Compared with the prior DRGs, the MS-DRGs distinguish very costly cases with major complications or comorbidities. Many of the 326 base DRGsð types of conditions or proceduresð are split into 3 MS-DRGs instead of 2 DRGs under the old system. In addition, CMS thoroughly revised the lists of secondary diagnoses that qualify as a complication or comorbidity (CC) or major CC (MCC).

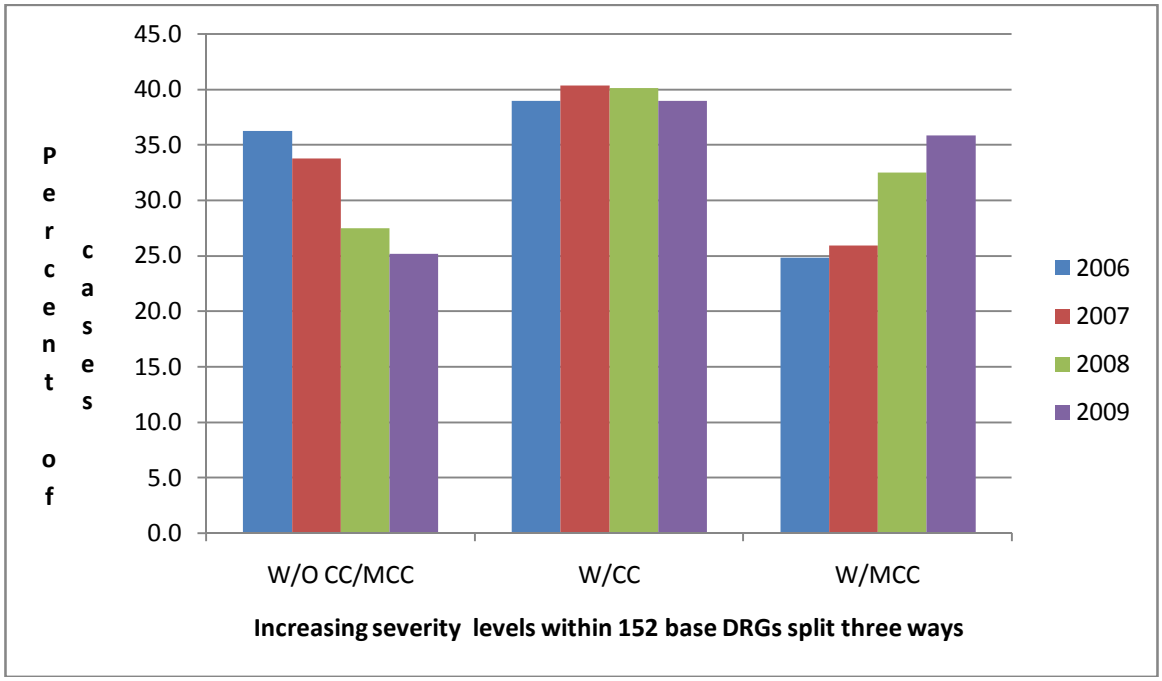
These changes created more patient categories and greater differentiation in the relative weights and payment rates among cases with and without CCs or MCCs. These changes also created financial incentives and opportunities to document and code diagnoses more carefully and completely because hospitals would receive higher payments if their cases with qualifying CCs and MCCs were reported accurately.

Changes in documentation and coding resulted in more cases with CCs and MCCs

Generally, hospitalsô changes in documentation and coding of diagnoses shift cases from lower severity and cost MS-DRGs to higher severity and cost groups within the same base DRG. We conducted an analysis to see how cases within each base DRG shifted among the two or three component MS-DRGs between 2006 and 2009. Our objective was to understand how DCI affects case mix and also whether the effect was focused in a few common base DRGs or was widespread and consistent across all base DRGs.

Figure 1 shows the pattern for all base DRGs that are split 3 ways. The share of cases without a CC or MCC declined more than 6 percentage points in 2008 and an additional 2 percentage points in 2009, while the shares of cases with a MCC increased by more than 6 and 3 percentage points, respectively. This figure includes 152 base DRGs that accounted for more than 54 percent of all cases in 2009. When we looked at all 259 base DRGs that are split in some fashion based on secondary diagnoses, we found that all but one had essentially the same pattern of shifts in 2008 and 2009 toward the highest severity and cost MS-DRG and away from the lowest severity or cost MS-DRG. **In 68 of these base DRGs, the cumulative shift from 2007 to 2009 in the share of cases toward the highest-weighted MS-DRG was at least 10 percentage points.**

Figure 1. Shares of cases with major complications jumped in 2008 and 2009



Source: MedPAC analysis of Medicare fee-for-service claims from IPPS hospitals in proposed rule MedPAR files (December updates) for fiscal years 2006-2009 from CMS.

How much did DCI increase IPPS hospitals' Medicare inpatient case mix and payments in 2008 and 2009?

CMS analyzed hospital inpatient claims for fiscal year 2008 and concluded that DCI increased case mix and payments by 2.5 percent. Hospitalsô overpayments due to DCI in 2008 amounted to 1.9 percent because the DCI effect was 2.5 percent and the statutory prospective adjustment applied that year was -0.6 percent. CMS also examined hospital claims for fiscal year 2009 and found that the cumulative effect of DCI in 2008 and 2009 was 5.4 percent (slightly higher than the CMS actuariesô original projection of 4.8 percent). Hospitalsô overpayments due to DCI in 2009 were 3.9 percent because the cumulative statutory DCI adjustment in 2009 was -1.5 percent. CMS concluded that under the law the total overpayments of 5.8 percent (1.9 + 3.9) from 2008 and 2009 must be recovered in 2011 and 2012.

Our analysis of hospital claims for fiscal years 2007-2009 confirms CMSô findings. For example, to measure the cumulative effect of DCI on the aggregate CMI and payments for 2009, we used fiscal year 2009 claimsð from the December 2009 update of the 2009 MedPAR fileð to calculate the national aggregate CMI based on the 2009 MS-DRGs and weights. **Using the same claims,** we also calculated the aggregate CMI based on the 2007 DRGs and weights. The difference between the two CMIs is 5.6 percent. By definition, this change in reported case mix is not real because the cases are the same. The difference is that the 2009 MS-DRGs and weights recognize more detailed coding of diagnoses while the 2007 DRGs and weights do not. Under MS-DRGs, more detailed documentation and coding can result in a larger increase in case mix and payments than under the prior DRG system.

We also know, however, that even if incentives for DCI were small or nonexistent, the two CMIs would always differ by some small amount. For example, the difference was 0.2 percent when we calculated the same two CMIs using claims for the December 2007 update of the 2007 MedPAR file, which do not reflect hospitalsô DCI response to the new MS-DRGs because they preceded the policy change. To avoid attributing this difference to hospitalsô DCI, we reduced our cumulative 2009 DCI estimate of 5.6 percent accordingly (1.056/1.002 = 1.054). Thus our net cumulative DCI estimate for fiscal year 2009 is 5.4 percent, which matches CMSô estimate. Our DCI estimate for fiscal year 2008 (2.6 percent) also confirmed CMSô estimate.

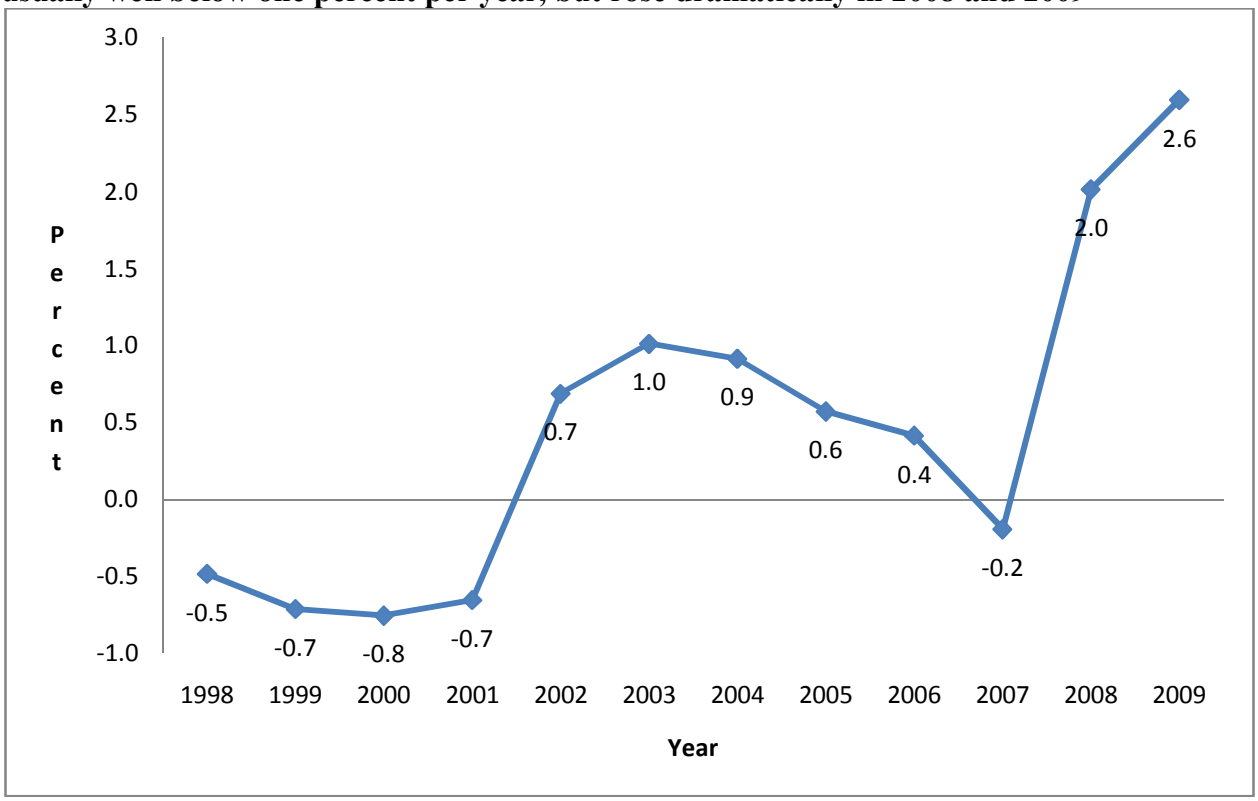
Substantial DCI in 2008 and 2009 implies a recent slight decline in real case mix

The percent change in actual case mix is equal to the sum of the percent change in real case mix plus the percent change in actual case mix due to DCI. Actual case mix increased 2.0 percent in 2008 and 2.6 percent in 2009. Therefore, the implication of our findings on DCI is that real case mix declined approximately 0.6 percent between 2007 and 2008 and was virtually flat (-0.1 percent) from 2008 to 2009. Some people question our findings on DCI because they assume that real case mix has increased historically by more than one percent per year. This assumption is somewhat difficult to test because a valid direct measure of real case mix does not exist. However, the percent change in real case mix can be inferred by rearranging the equation above; the percent change in real case mix is equal to the percent change in actual case mix minus the percent DCI. As

long as the percent DCI is positive, the percent change in real case mix can never be larger than the percent change in actual case mix.

We calculated the annual percent change in the national aggregate case-mix index (CMI) for the period from 1997 to 2009. These actual CMI values are based on the DRG version, relative weights, and transfer policies that were in effect for each year. To calculate the percent change for each year, we used national aggregate average CMIs for the cohort of hospitals paid under the IPPS in each pair of adjacent years. We also excluded all hospitals that had converted to critical access hospital status (CAH) by the end of 2009.

Figure 2: Before implementation of MS-DRGs, the change in actual case mix was usually well below one percent per year, but rose dramatically in 2008 and 2009



Note: Percent change values are based on national aggregate average case-mix indexes (CMI) calculated for cohorts of hospitals paid under the Medicare hospital inpatient prospective payment system in each pair of years (1997-2009). Hospitals that converted to critical access hospital status by the end of 2009 are excluded from the analysis. The CMI for each year (except 2009) is based on valid Medicare hospital inpatient claims in the March update (final rule) MedPAR file and the DRG version, relative weights, and transfer policies in effect for that year. The CMI for 2009 is a preliminary value based on the December 2009 update (proposed rule) MedPAR file for 2009.

As Figure 2 shows, over the 10 years preceding the adoption of MS-DRGs in 2008, the change in actual case mix has been negative in some years and positive in others, but never exceeded 1 percent or fell below -1 percent. Therefore findings of -0.6 and -0.1 percent real change in 2008 and 2009 are within the range of historical experience and those that assume the average change in real case mix has consistently been one percent

or more per year are not supported by the data. Given the large jumps in the actual case-mix in 2008 (2 percent) and 2009 (2.6 percent), it is clear that very substantial DCI occurred following implementation of MS-DRGs.

Legislative background on required adjustments to IPPS payment rates to offset the effects of DCI

When we recommended severity refinements to the DRGs in our 2005 report to the Congress, we expected a DCI response and we knew that it would lead to unwarranted increases in IPPS payments if CMS did not make commensurate adjustments in the base payment rates. We recommended that CMS make prospective adjustments in advance to prevent overpayments from occurring.

CMS actuaries expected hospitalsô DCI to eventually raise the CMI and aggregate IPPS payments by 4.8 percent. In the final IPPS rule for fiscal year 2008, CMS said it would reduce payment rates by 4.8 percent over three years to offset the expected increase. Following publication of the final rule, the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Quality Improvement] Programs Extension Act of 2007 (TMA) limited the prospective downward adjustments to 0.6 percent in 2008 and 0.9 percent in 2009, or 1.5 percent in total. However, the TMA also required CMS to analyze the appropriateness of these adjustments. If CMSôs retrospective study of discharges during fiscal years 2008 and 2009 finds that the 0.6 and 0.9 percent adjustments were too small (or too large), the law requires CMS to recover (or restore) the difference, with interest. If needed, these adjustments must be temporary and they can be applied only in 2010, 2011, or 2012 and will cease when recoveries of 2008 and 2009 overpayments are complete. To prevent further overpayments, the law also requires CMS to make an appropriate permanent adjustment to the rates to offset the 3.9 percent ongoing effect of DCI, which is not accounted for by the .6 percent and .9 percent adjustments taken in 2008 and 2009.

As reflected in the budget scoring by the Congressional Budget Office, the understanding at the time was that payments would be adjusted so that the transition to MS-DRGs would be completed in a budget neutral manner. To achieve budget neutrality, significant ongoing overpayments to hospitals during 2010 through 2012 would have to be recovered, but current law only provides for recovery of overpayments that occurred in 2008 and 2009 (plus accumulated interest). Thus, further legislation is needed to allow CMS to recover all overpayments stemming from DCI.