MEDPAC Medicare Payment Advisory Commission

FACT SHEET

MedPAC on CMS's Inpatient Hospital Rule and Coding

Today, MedPAC submitted comments on the documentation and coding changes proposed in CMS's most recent proposed rule on the inpatient hospital prospective payment system. Below we have included a summary of our principles and recommendations.

Background

In March 2005, the Commission recommended that CMS refine the DRGs to improve payment accuracy and fairness within the hospital inpatient prospective payment system. To do this CMS adopted the thoroughly revised MS-DRGs in 2008. Since, historically, changes like this had the unintended effect of increasing total payments by creating opportunities to code differently, we recommended adjustments to make the introduction of MS-DRGs budget neutral.

CMS estimates are correct

Consistent with CMS's estimates, our analysis shows that the implementation of MS-DRGs resulted in substantial overpayments to hospitals in 2008 and 2009. Additionally, we find that overpayments continue for 2010 and will continue into the future. We estimate that total overpayments could reach $19 billion for the period of 2008 through 2012.

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. The 2010 and 2011 claims have not been evaluated, and estimates of coding changes in those years assume no further documentation and coding improvements past 2009.

The first two columns of Table 1 show our estimates of how much coding changes increased payments in 2008 and 2009, as well as the cumulative overpayments to hospitals. The last two columns show the projected effects of coding changes and CMS's proposed policies in 2010 and 2011 if no further coding changes occur after 2009. As the last line shows, cumulative overpayments are increasing about 3.9 percent per year in 2010 and will increase 1 percent in 2011 after CMS's 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.

MedPAC recommends all overpayments should be recaptured

Current law has two flaws and should be changed. First, it does not allow for CMS to fully recover overpayments accruing in 2010 through 2012. Second, it requires deep short-run reductions in payments to recapture 2008 and 2009 overpayments.

Under current law, CMS must take large reductions in the short-term and still cannot recover all overpayments. In contrast, MedPAC recommended a change in law that allows CMS to reduce payments less sharply – by up to 2 percent – for a longer period of time, in order that all overpayments are recovered and future overpayments are prevented. The Commission's approach allows for a process that provides hospitals with a more predictable repayment schedule, while also protecting the Medicare Trust Fund.

MedPAC's approach would reduce payments in increments of no more than 2 percent for 3 years. It is important to keep in mind that hospitals would continue to get scheduled payment updates during these 3 years so they would not experience the full impact of these reductions. For the next 3 years (starting in 2014), hospitals would receive their scheduled payment update with no additional offset. Finally, when payments are fully recovered, hospitals would get an increase in payments of about 2 percent above their scheduled payment update.

Patient changes vs. coding changes

Some have argued that steady increases in real patient case-mix – rather than changes in coding – explain the increases in payments. For the last decade, case-mix has both increased and decreased and has never changed by more than 1 percent. However, when the MS-DRGs were implemented, we saw an increase in case-mix of 2 percent in 2008 and another increase of 2.6 percent in 2009. This abrupt growth in case-mix scores indicates that in order to receive higher payments, hospitals have changed their coding in response to the new MS-DRGs.

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