



July 20, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Dr. Berwick:

As the Centers for Medicare & Medicaid Services (CMS) prepares its fiscal year (FY) 2011 final rule on the hospital inpatient prospective payment system (PPS), we would like to present two additional independent studies for your consideration. The first examines issues around measuring documentation and coding, while the second examines Medicare case-mix trends. They highlight significant concerns with CMS' approach to measuring documentation and coding change. **We bring these independent studies to your attention ahead of publication of the final rule and urge you to change the agency's methodology for determining documentation and coding change to better account for increasing patient severity, as documented by historical trends, and reduce the proposed cut to inpatient PPS payments for FY 2011.**

ISSUES IN MEASURING DOCUMENTATION AND CODING CHANGE

In its July 2010 report titled "Issues in Measuring Documentation and Coding Change," The Moran Company examined CMS' approach to measuring documentation and coding change to determine whether it appropriately isolates documentation and coding from the other factors that could affect case-mix index (CMI), including historical trends reflecting changes in the beneficiaries' needs and corresponding treatment. The report concludes that CMS' methodology does *not* adequately isolate documentation and coding from other factors when calculating changes in CMI. The Moran Company's analyses included:

- Examination of trends in CMI over a 10-year period. After converting the data to a common grouping system, The Moran Company found that there were increases in CMI prior to the implementation of Medicare Severity diagnosis-related groups (MS-DRGs). This raises questions as to why CMS did not test or attempt to account for this historical trend of increasing CMI for reasons other than documentation and coding in response to the introduction of MS-DRGs.
- Examination of "Within versus Across DRG Change." DRGs can be collapsed into what are known as "Base DRGs," which measure underlying conditions, and then can often be split by severity level. CMS found that the change in CMI is due primarily to changes in measured

levels of severity within base DRGs and not underlying conditions. However, CMS assumes that this change in severity is due solely to changes in documentation and coding, which The Moran Company study shows is not a reasonable assumption given the historic trends. There is no reason why there cannot be changes in measured levels of severity without changes in underlying conditions. This is not accounted for by CMS in its analysis.

- Examination of Intensive Care Usage. Over time, there has been an increasing proportion of discharges that include time in intensive care. Intensive care can be a proxy for severity; more use of intensive care implies greater severity, which should lead to greater CMI. However, CMS' methodology finds no increase in severity, which is inconsistent with these results. Thus, these results also raise questions about the adequacy of CMS' methodology.

These different analyses suggest that there may be factors responsible for CMI changes other than documentation and coding. For these reasons, The Moran Company believes that CMS' methodology fails to adequately isolate documentation and coding change due to the implementation of MS-DRGs from historical trends and other treatment shifts.

TRENDS IN CASE-MIX IN THE MEDICARE POPULATION

In his July 2010 report entitled "Trends in Case-Mix in the Medicare Population," Partha Deb, Ph.D, Professor of Economics, Hunter College and the Graduate Center, City University of New York, analyzed changes in Medicare case-mix over time. His findings were inconsistent with CMS' assertion that case mix has declined in the recent past. Multiple data sets and different measurement tools indicate that the Medicare population is indeed getting sicker.

Dr. Deb's main findings were:

- Based on data from the Medical Expenditure Panel Survey, case-mix based on overall disease prevalence in the Medicare population steadily increased from 2000 through 2007.
- Using measures of disease severity from the Agency for Healthcare Research and Quality's Clinical Classification System applied to data from the Healthcare Cost and Utilization Project, in-hospital case-mix in the Medicare population steadily increased from 2000 through 2007.
- Based on indicators from the Disease Staging system developed by Thomson-Reuters applied to data from the Healthcare Cost and Utilization Project database, in-hospital case-mix in the Medicare population also steadily increased from 2002 through 2007.

There is no reason to believe that these trends would not continue in 2008, 2009 and 2010.

We ask that you consider the above independent studies when preparing the inpatient PPS final rule for FY 2011, and reduce the cuts from what was included in the proposed rule. We appreciate the opportunity to share this information and look forward to working together to ensure that CMS' documentation and coding policy is appropriate and workable.

Sincerely,

American Hospital Association
Association of American Medical Colleges
Federation of American Hospitals

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cc: Ms. Marilyn Tavenner, Principal Deputy Administrator
Mr. Jonathan Blum, Deputy Administrator and Director, Center for Medicare

Enclosure