

Medicare Documentation and Coding

THE ISSUE

Beginning in fiscal year (FY) 2008, the Centers for Medicare & Medicaid Services (CMS) refined the method it uses to categorize patients for purposes of payment under the inpatient prospective payment system (PPS). The agency claimed that there would be improved documentation and coding for patient severity of illness as hospitals moved to the new system, which would result in higher payments. In response,

Congress required CMS to make retrospective cuts to recoup overpayments from FYs 2008 and 2009. The agency has since done so, resulting in \$6.9 billion in retrospective coding cuts. However, some policymakers have proposed to require CMS to make even more retrospective cuts to recoup what they claim are overpayments that occurred in FYs 2010, 2011 and 2012. Such a proposal would result in about \$10 billion in cuts to hospital payments.

AHA POSITION

Reject further retrospective documentation and coding cuts to hospital payments.

WHY?

- **For America's already financially constrained hospitals, such a reduction in Medicare payments could result in the loss of health services and programs that are essential for Medicare beneficiaries, as well as other patients.**
- **The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.**
- **CMS's estimate of the effect of documentation and coding, and therefore the cuts the agency has already made, are overstated. Making further cuts based on this overstated estimate is inappropriate.**
- **Medicare pays hospitals under a PPS, which allows providers to reasonably estimate payments in advance. Instituting further retrospective cuts flies in the face of the purpose of a PPS.**

KEY FACTS

Under the inpatient PPS, each patient's case is categorized into a diagnosis-related group (DRG) that has a set payment rate. Beginning in FY 2008, CMS began a transition to a more refined DRG system, known as Medicare Severity DRGs (MS-DRGs) because the prior system was found to inadequately account for differences in patient acuity. However, the agency claimed that changes in hospital documentation and coding practices in response to the new system would lead to increases in case-mix – and associated payments – that did not reflect real changes in patient acuity. Therefore, it planned to adjust payments to remove what it estimated to be the documentation and coding effect.

In response, Congress required CMS to apply an adjustment of negative 0.6 percent in FY 2008 and negative 0.9 percent in FY 2009 to inpatient payments. The law also specified that, to the extent that these two adjustments were over- or under-stated relative to the actual amount of documentation and coding-related change, CMS should make additional retrospective cuts to recoup the remaining overpayments. The agency has since completed making these additional retrospective cuts.

However, the AHA conducted analyses that found that much smaller documentation and coding adjustments were necessary than what CMS implemented. These analyses indicate that much of the change CMS found is actually the continuation of historical increases in patient severity, not the effect of documentation and coding changes due to the implementation of the MS-DRGs. In light of these trends, CMS's cuts were excessive. If policymakers were to allow additional cuts based on these overstated estimates, it would compound the over-recoupment that CMS has already made and remove further valuable resources from hospitals.

Medicare pays for inpatient hospital services under a PPS, which should be simple, transparent and predictable over time. Congress already has required CMS to make one set of retrospective recoupments. Requiring further recoupments from past and current payment years flies in the face of the purpose of a PPS – to give providers the ability to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions.