

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 initially required CMS to make prospective cuts to hospital payments to account for these higher payments, as well as to make retrospective cuts, if necessary, to recoup overpayments

from FYs 2008 and 2009. In the American Taxpayer Relief Act of 2012 (ATRA), Congress required CMS to recoup alleged overpayments made in FYs 2008-2013, an additional cut to hospitals of \$11 billion. The law also clarified that the Secretary of Health and Human Services (HHS) has the authority to make an additional prospective documentation and coding cut of 0.8 percent to remove what it claimed were increased FY 2010 payments from the system. Although this cut was proposed by CMS but subsequently withdrawn, some policymakers are interested in this additional cut as part of deficit reduction.

AHA POSITION

Reject any further documentation and coding cuts to hospital payments.

WHY?

- **For America's already financially strained hospitals, an additional 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.** The Medicare Payment Advisory Commission (MedPAC) found that overall Medicare margins declined from negative 4.5 percent in 2010 to negative 5.4 percent in 2013 and continue to fall well below the cost of caring for America's seniors. MedPAC estimates that overall Medicare hospital margins in FY 2015 will be negative 9.0 percent. Additional cuts are not warranted.
- **CMS's estimate of the effect of documentation and coding and, therefore, the cuts the agency has already made, are overstated. CMS asserted that a total prospective cut of 5.4 percent was necessary.** However, AHA's analysis indicates that this prospective adjustment should have totaled 3.5 percent and that no further cuts were warranted related to case-mix change in 2010. This 1.9 percent difference will inappropriately reduce hospital payments and amounts to a cut of \$22.6 billion over the next 10 years. Congress then added another cut of \$11 billion, bringing the total value of excess cuts to hospitals to nearly \$34 billion.
- **It is inappropriate to consider even more cuts to hospitals based on a flawed methodology.** CMS continues to compare hospital documentation and coding in FY 2010 to documentation and coding under a diagnosis-related group (DRG) system that was discarded in FY 2007. The inpatient PPS changed substantially from FY 2007 to FY 2010. For example, the 2010 system utilized cost-based (rather than charge-based) data, allowed up to 25 (rather than nine) diagnosis codes per claim, and used a completely reformed list to document patient complications and comorbidities. Yet, CMS continues to believe that the case-mix index should be the same when using the new versus old system to measure patient severity levels in 2010. It is time to fully embrace the new improved system and to stop comparing it to the prior, obsolete system.

Continued on reverse

- **Medicare pays hospitals under a PPS, which allows providers to reasonably estimate payments in advance.** A PPS should be simple, transparent and predictable over time. Congress already has required CMS to make one set of prospective cuts and retrospective recoupments. Instituting further cuts 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.

KEY FACTS

Under the inpatient PPS, each patient's case is categorized into a 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 DRG 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. They 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 prospective cuts, as well as retrospective cuts to recoup the remaining overpayments. The agency implemented a prospective cut of 2.0 percent in FY 2012 and 1.9 percent in FY 2013, for a total prospective cut of 5.4 percent. In addition, it implemented a retrospective cut of 2.9 percent in both FYs 2011 and 2012, for a total recoupment of 5.8 percent. CMS's recoupment of overpayments in FYs 2008 and 2009 was completed as of the end of FY 2013.

The ATRA requires the HHS secretary to make a temporary adjustment to the standardized amount in FYs 2014, 2015, 2016 and 2017 to recoup overpayments that occurred in FYs 2008 through 2013 during the transition to MS-DRGs. These overpayments, estimated to be \$11 billion, allegedly occurred because the prospective adjustments made in each year did not fully offset the additional payments made because of documentation and coding change. The AHA does not agree with this analysis.

In addition, for FY 2013, CMS proposed a new cut of 0.8 percent to permanently remove what it claims were increased FY 2010 payments from the system. An AHA analysis 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. Specifically, AHA data indicate that CMS's prospective adjustment should have totaled 3.5 percent, not 5.4 percent. CMS's current cuts are excessive and the additional cuts added by ATRA are even more so. It is inappropriate for the agency to continue to compare hospital documentation and coding in FY 2010 and beyond to documentation and coding under a DRG system that was discarded in FY 2007. CMS withdrew its proposal for the new 0.8 percent cut in its FY 2013 inpatient PPS final rule. CMS agreed with AHA's position that a smaller cut would be appropriate in its FY 2014 proposed and final rules. CMS has not implemented this cut at this time.