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June 17, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1518-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: file Code CMS-1518-P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's 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 2012 Rates*, Federal Register Vol. 76, No. 87, pages 25788-26084 (May 5, 2011). We appreciate your staff's ongoing efforts to administer and improve the payment systems for acute inpatient hospital services and long-term care hospital services, especially considering the agency's many competing demands and limited resources.

In this letter, we comment on a series of CMS actions that are designed to address unintended effects of hospitals' changes in medical record documentation and coding and other policy changes that could improve fairness within the inpatient prospective payment systems for acute care hospitals (IPPS). Specifically we address the following issues in the IPPS:

- Adjusting IPPS payment rates to offset extra payments resulting from hospitals' changes in diagnosis documentation and coding, and phasing in the adjustments to allow for a 1 percent update to the payment rates in fiscal year 2012;
- Reducing the administrative burden of the inpatient hospital quality reporting program; and
- Ending the excessive number of exceptions to the hospital wage index and developing a new wage index system as we recommended in our June 2007 Report to Congress.

Offsetting extra payments resulting from hospitals' changes in diagnosis documentation and coding

In this section, we comment on CMS actions to offset unintended increases in Medicare payments within the hospital inpatient prospective payment systems (IPPS) due to the adoption of Medicare severity diagnosis related groups (MS-DRGs) and hospitals' responses in the form of changes in medical record diagnosis documentation and coding. Our comments focus on five key points:

- CMS adopted MS-DRGs and cost-based relative weights to improve the distribution of payments among hospitals. Under long-standing law and policy, CMS is required to implement changes in the DRGs and weights in a budget neutral manner—that is, to ensure that aggregate IPPS payments to hospitals neither increase nor decrease compared with what they would have been without the changes;
- CMS actuaries estimated (and we concurred) that hospitals' changes in documentation and coding of patients' diagnoses in response to MS-DRGs increased IPPS payments by $6.9 billion over 2008 and 2009. Further overpayments continued in 2010 and will continue in 2011 and later years, until CMS makes a prospective offsetting adjustment to the IPPS payment rates;
- Hospital representatives have argued that our estimate of overpayments may be too high because changes in documentation and coding may have caused CMS and MedPAC to underestimate what aggregate hospital payments would have been under the prior DRG system if MS-DRGs had not been adopted. We examined the issues they raised, and found that these issues could cause only a small change in the estimated effect of documentation changes. Taking into account a reasonable range for the effect of changes in documentation and coding on payments under the old DRG system, we estimate that total overpayments in 2008 and 2009 amounted to between $6.0 and $6.9 billion. This means that CMS should recover at least $6 billion of overpayments;
- Using the latest available hospital claims, we find that hospitals continued to change documentation and coding in fiscal year 2010. As expected, the incremental effect on payments was smaller than in previous years. Allowing for uncertainty, we estimate that IPPS payments in 2010 were 4.5 to 4.7 percent ($5.5 - $5.8 billion) higher than they otherwise would have been due to changes in documentation and coding; and
- Current law requires CMS to adjust IPPS payment rates to prevent further overpayments from continuing, but it does not authorize CMS to recover overpayments that occur after fiscal year 2009. To fully restore budget neutrality, we reiterate the recommendations we made in our March 2011 Report to the Congress:
    - CMS should act to prevent future overpayments, but it should phase in the required adjustment to allow hospital payments in fiscal year 2012 to increase by 1 percent.
    - Congress should require CMS to recover all overpayments, not just the $6.0 - $6.9 billion that occurred in 2008 and 2009. It should also authorize CMS to make the recoveries gradually over a period of years.

CMS adopted MS-DRGs to improve the distribution of payments without changing aggregate payments to hospitals

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 more accurately match their relative costs of furnishing care. However, MS-DRGs were adopted to improve the distribution of payments, not change the aggregate level of payments.

As expected, implementation of MS-DRGs in 2008 gave hospitals a financial incentive to change diagnosis documentation and coding to more fully account for each patient's severity of illness. While documentation and coding changes 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.

To prevent inappropriate increases in payments, CMS has long been required by law to make changes in the DRGs and relative weights in a budget neutral manner—that is, to ensure that aggregate IPPS payments to hospitals neither increase nor decrease 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 the payment effects of documentation and coding changes in 2008 and 2009. If overpayments occurred because the actual effects of documentation changes exceeded the allowed adjustments, however, 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.

Last year, CMS actuaries estimated that documentation and coding changes increased IPPS payments beyond what they should have been by $6.9 billion in 2008 and 2009

CMS analysis of 2008 Medicare hospital inpatient claims found that documentation changes increased reported case mix by 2.5 percent. This resulted in overpayments equal to 1.9 percent of total IPPS payments in 2008 because the statutory adjustment was -0.6 percent. Using 2009 claims, CMS found a cumulative increase in case mix of 5.4 percent due to documentation and coding changes, which resulted in overpayments of 3.9 percent in 2009 (the cumulative statutory offset was -1.5 percent). Together, these overpayments amounted to 5.8 percent of IPPS payments or about $6.9 billion over 2008 and 2009.

Using similar methods, our analysis of Medicare hospital inpatient claims for 2007-2009 reached similar conclusions: CMS would need to reduce IPPS payments temporarily by 5.8 percent to recover overpayments that occurred in 2008 and 2009. We also expected that overpayments equal to 3.9 percent of annual IPPS payments would continue through 2010, 2011, and future years until CMS makes a prospective offsetting adjustment (-3.9 percent) to the IPPS payments rates. However, any overpayments occurring in fiscal year 2010 or later years could not be recovered under current law.

These estimates rest on a comparison of two case-mix indexes (CMI) for each year, both calculated using the IPPS inpatient claims for the year (the same set of cases). For 2009, for example, we compared (took the ratio of):

1. The CMI calculated by applying the fiscal year 2009 MS-DRG grouper and relative weights to the 2009 claims (the numerator), and
2. The CMI calculated by applying the fiscal year 2007 CMS-DRG grouper and relative weights to the same 2009 claims (the denominator).

Essentially, this is akin to comparing two sets of payments: what payments actually were in fiscal year 2009 under the 2009 MS-DRGs and relative weights; and what payments would have been in 2009 if MS-DRGs had not been adopted and CMS had continued to use the prior (2007) CMS-DRGs and weights.

Why are the two CMIs different? Both CMIs are based on the same claims, which reflect both real changes in case mix and the effects of hospitals' documentation and coding changes in response to the adoption of MS-DRGs. As is discussed more fully below, the difference between the two CMIs reflects the new grouper's interaction with how hospitals changed their documentation and coding. After the adoption of MS-DRGs in 2008, hospitals switched from recording general descriptions of patients' chronic conditions—which no longer affect payments under MS-DRGs—to recording the specific acute manifestations of patients' chronic conditions, which trigger higher payments under MS-DRGs. However, the same changes in diagnosis documentation and coding have little or no effect on the CMI measured using the 2007 CMS-DRGs and weights. This is because in that grouper, **both** acute manifestations of chronic conditions and general descriptions of chronic conditions trigger higher payments. In contrast, when hospitals had little incentive to change documentation and coding—in 2007, for example—the two CMIs are approximately equal.

In its final rule for fiscal year 2011, CMS adopted a temporary adjustment of -2.9 percent in 2011 to recover approximately one-half of the total overpayments that occurred in 2008 and 2009. CMS also recognized the need to make an additional adjustment of -3.9 percent to forestall further overpayments. However, CMS deferred this adjustment on the grounds that a downward adjustment of -6.8 percent in a single year would be financially disruptive to many hospitals.

In its proposed rule for fiscal year 2012, CMS has proposed to extend the -2.9 percent temporary adjustment made in 2011 for one more year to recover the remaining half of the overpayments that occurred in 2008 and 2009. (Extending the -2.9 percent adjustment would have no effect on the

level of the IPPS payment rates in 2012 because the adjustment would be exactly offset by the expiration of the -2.9 percent adjustment for 2011.) CMS proposes to apply a further adjustment of -3.15 percent to reduce the amount of the ongoing overpayments that would otherwise occur in 2012, based on its estimate of overpayments in 2009. This adjustment would account for all but 0.75 percent of the -3.9 percent adjustment needed to fully prevent further overpayments—if the 2009 estimate is accurate and no further documentation and coding changes occurred after 2009.

Hospital associations raised concerns that CMS's estimates of overpayments were too high

National hospital associations raised concerns that CMS's estimates of overpayments in 2008 and 2009 were too high. The associations' major concern was that the estimated effects of documentation and coding changes were larger than the increases in reported case-mix, implying that real case mix must have declined in 2008 and 2009. (Changes in reported case mix are equal to the sum of real changes in case mix plus changes due to shifts in documentation and coding; if the change due to documentation exceeds the increase in reported case mix, real change must be negative.) As shown in Table 1, the estimates we made last year for cumulative changes in case mix and the effect of documentation changes suggest that real case mix declined -0.6 percent in 2008 and cumulative -0.8 percent by 2009.

Table 1: Given changes in reported case mix, the estimated effects of documentation and coding changes imply that real case mix fell in 2008 and 2009

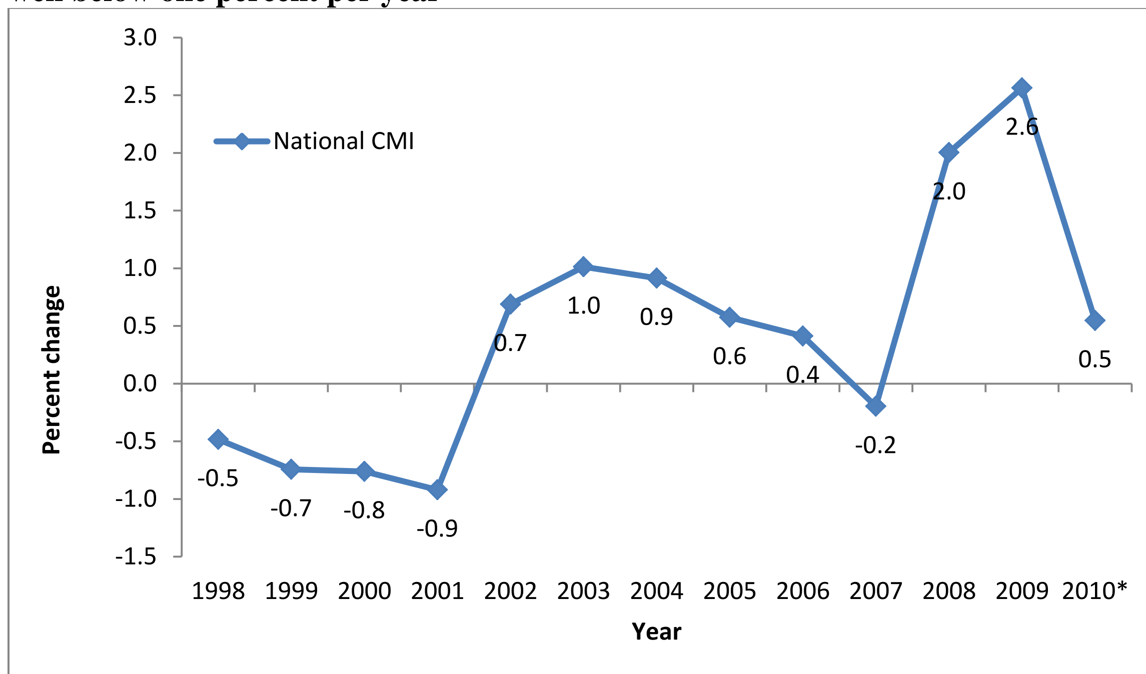
Year	Cumulative percent change over 2007		
	Reported national case mix	Documentation and coding changes	Implied real case mix
2008	1.9	2.5	-0.6
2009	4.5	5.4	-0.8

Source: MedPAC estimates based on IPPS claims from final rule MedPAR claims files for fiscal years 2007-2009 from CMS.

The associations argued that declines in real case mix are implausible because the case-mix trend over the long term has been positive. They cited improvements in medical technology—new antibiotics, minimally-invasive surgical procedures, improved anesthetics, and the like—that have enabled successful treatment in ambulatory care settings for many kinds of patients that once required more intensive inpatient care. They asserted that as relatively less-costly types of patients have migrated away from inpatient care, the average relative costliness (the case mix) of the patients who receive inpatient care must have increased.

However, annual growth in the reported national CMI does not support their argument. CMI growth was quite modest during the decade preceding the adoption of MS-DRGs in 2008. As Figure 1 shows, annual changes in the reported CMI from 1998 to 2007 never exceeded plus or minus 1 percent and the changes were negative in 5 of the 10 years and positive in the other 5 years. Over the decade, the average annual growth rate was just 0.1 percent per year.

Figure 1: Before implementation of MS-DRGs, the change in reported case mix was usually well below one percent per year



Note: * indicates preliminary data from the proposed rule MedPAR file for fiscal year 2010.
Source: MedPAC analysis of IPPS hospital inpatient claims in the final rule MedPAR files for fiscal years 1997-2009 and the proposed rule MedPAR file for fiscal year 2010, from CMS. CMIs are based on the DRG grouper, relative weights, and transfer policies in effect for each fiscal year. Claims for hospitals designated as critical access hospitals as of 12/31/2010 were excluded from the CMIs for all years.

Some have argued that simply comparing CMIs as CMS and MedPAC have done cannot separate real case-mix change from the effects of changes in documentation and coding.[1] Instead, they have suggested that real case-mix change can be measured by having a group of high-quality coders (gold-standard coders) re-abstract and code random samples of medical records for each year from 2007 to 2010. One could then compare changes in the CMI based on the gold-standard codes for the sample records with the changes in the CMI based on the same sample records as they were coded by the hospitals' coders. They assert that the change in the CMI based on the gold-standard codes would be the real change in case mix; the change due to hospital coding changes would be measured as the difference between the change in the gold-standard CMI and the change in the CMI based on the hospital-coded records.

In our view, this approach does not work. The reason is that hospitals had an incentive to persuade attending physicians to be more specific in describing patients' acute manifestations of chronic conditions in their medical records. Some hospitals hired documentation specialists with the goal of changing physicians' medical record documentation, not simply to do a better job of coding

[1] American Hospital Association, Association of American Medical Colleges, and Federation of American Hospitals letter to Donald Berwick, dated April 13, 2011.

what they wrote in the record (Hahey 2008).[2] Gold-standard coders, however, only see the diagnoses written in the record and therefore are not able to distinguish changes in documentation from real changes in patients' diagnoses. This method of recoding existing documentation only works in situations where hospitals have no incentive to change documentation. That is clearly not the case with the transition to MS-DRGs. Thus, a very important part of the effect of changes in documentation and coding cannot be detected by the proposed method.

Index number theory has been used to argue that, absent the gold-standard re-abstract method, the best one can do is estimate lower and upper bounds on the combination of real case-mix change and the effect of changes in documentation and coding. However, in this instance at least, the estimated range between the lower and upper bounds based on this approach is so wide that the estimates are useless for policy making. While we agree that there is some uncertainty surrounding any estimate of the documentation and coding effect, we think we can greatly narrow the range of uncertainty by using our knowledge of the 2007 DRG grouper, the new MS-DRG grouper, historical documentation of patients' diagnoses, and the changes CMS made when it created the MS-DRGs.

Along a similar line, the hospital associations suggested that the estimated effects of changes in documentation and coding for 2008 and 2009 could be overstated if hospitals' changes tended to lower the CMI based on the 2007 CMS-DRG grouper and weights (the denominator of the documentation change estimate). The associations argued that this effect could happen as follows. A key distinction in both the MS-DRG and CMS-DRG groupers is whether or not a patient has a secondary diagnosis that qualifies as a comorbidity or complication (CC). About one-half of all claims are assigned to base DRGs where the presence of a CC triggers a higher payment rate. In creating the MS-DRGs, however, CMS thoroughly revised the list of diagnoses that qualify as a CC, primarily by excluding diagnoses that are general descriptions of chronic diseases or conditions.

In response to the new MS-DRGs, hospitals had an incentive to report diagnoses that count as CCs in the new system. The associations' argument is that hospitals' may also have stopped reporting diagnoses that counted as CCs in the old system, but do not count in the new one. In short, the associations argued that the disappearance of the general chronic condition codes could have caused the CMIs based on the old 2007 grouper and weights to be understated in 2008 and 2009. Thus, because CMIs based on the 2007 grouper and weights are the denominators of the documentation change estimates, understatement would bias the estimates upward. Understatement would occur, however, only to the extent that hospitals (1) did not replace such general chronic condition codes with corresponding acute manifestation codes and (2) the patient had no other secondary diagnosis code that qualified as a CC in the old grouper.

The national CMIs based on the 2007 grouper and weights declined each year from 2008 to 2010, reaching a cumulative -1.3 percent in 2010. To better understand this decline, we re-examined Medicare IPPS claims data for 2007–2010. Our goal was to see whether changes in the proportions

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[2] Hahey J. and M. Tulley. 2008 "Case Study: The Rewards of Accurate Clinical Documentation" Health Care Financial Management Association. Available at: http://www.hfma.org/Templates/InteriorMaster.aspx?id=2789.

of claims with a CC and/or a surgical procedure could explain the -1.3 percent drop in case mix measured with the 2007 grouper and weights.

From 2007 to 2010, a stable 48 percent of all claims were assigned to base DRGs in the 2007 grouper where the presence or absence of a CC affects payment. Among these DRG pairs, DRGs with a CC carry higher relative weights than DRGs without a CC. The share of claims assigned to DRGs with a CC fell by -2.9 percentage points in 2008, but then bounced back 0.8 and 0.9 percentage points in 2009 and 2010. These changes could be attributable to (1) documentation and coding changes that hospitals made in response to MS-DRGs, (2) real changes in the mix of cases admitted for care, or (3) some of both.

The share of claims assigned to surgical DRGs declined -0.8, -0.3, and -0.5 percentage points in 2008, 2009, and 2010, respectively. Surgical DRGs carry much higher relative weights than medical DRGs. In our view, declines in the share of surgical claims represent real changes in case mix due to changes in the site of care or in the incidence of inpatient surgical procedures. Adoption of MS-DRGs did not change hospitals' incentives to report surgical procedures.

To evaluate the effects on the CMIs of the declines in the shares of claims with a CC or a surgical procedure, we calculated what the overall CMI (based on the 2007 DRGs and weights) would have been each year if (1) the share of claims in surgical DRGs remained constant and (2) the shares of claims in surgical and medical DRGs with a CC remained constant at their 2007 levels.

As Table 2 shows, most of the decline in reported case mix—when using the 2007 grouper and weights—is due to a decline in surgical cases as a share of all Medicare discharges. A smaller part of the decline (-0.36 percentage points in 2008 and 2009) is due to fewer cases reporting a CC that is counted by the 2007 grouper. Therefore, it is possible that changes in documentation and coding to optimize payments under the 2009 grouper would have resulted in less than optimal payments under the 2007 grouper. However, the magnitude of this effect was small, possibly as much as 0.36 percent. If we adjust for the declines in the shares of surgical cases and cases with CCs, we would have seen cumulative case-mix growth of 0.68 percent from 2007 to 2010. This is consistent with recent historical case-mix growth rates when hospitals lacked strong incentives for documentation changes.[3]

[3] Note that the share of claims assigned to a surgical DRG also declined -0.5 percentage points in 2007, which is consistent with the decline that year of -0.2 percent in the reported CMI based on the 2007 DRGs and weights.

Table 2: Case mix as measured in 2007 DRGs declined primarily due to a shift from surgical to medical DRGs

Year	Cumulative change in CMIs based on 2007 DRGs and weights	Cumulative effect of correcting for changes in shares of claims assigned to:		Cumulative change in CMI if surgical and CC shares had not changed
		Surgical DRGs	DRG with CCs	
2008	-0.82	0.94	0.36	0.48
2009	-1.00	1.27	0.36	0.63
2010	-1.27	1.70	0.25	0.68

Source: MedPAC analysis of IPPS inpatient claims in the final rule MedPAR files for fiscal years 2007 – 2009 and in the proposed rule MedPAR file for fiscal year 2010 from CMS. CMIs are calculated using the CMS-DRG grouper, weights, and transfer policies in effect in fiscal year 2007.

These findings mean that CMS's (and MedPAC's) documentation change estimates for each year could only have been overstated by as much as 0.36 percentage points. Whether the overstatement is closer to zero or 0.36 percentage points depends on how much of the changes in the shares of claims with a CC are due to hospitals' documentation changes and how much they are due to real changes in the mix of patients admitted for care. However, most of the -1.27 percent cumulative decline in the CMI by 2010 is due to a real shift in the relative shares of cases away from surgical and toward medical DRGs. The declines in the shares of claims with surgical procedures reduce the CMIs because surgical DRGs carry much higher relative weights than medical DRGs.

We have considered the associations' criticisms of the methods CMS and MedPAC used to estimate the documentation and coding effect in prior analyses. We have concluded that if the documentation effect is overstated, the magnitude of the overstatement is small—between 0.0 and 0.36 percent. Accordingly, we estimate that total overpayments due to documentation changes in 2008 and 2009 may have ranged from 5.1 to 5.8 percent of IPPS payments ($6.0 to $6.9 billion). Therefore, CMS should recover at least $6.0 billion dollars of 2008 and 2009 overpayments made to hospitals.

Hospitals' continued to change documentation and coding in fiscal year 2010

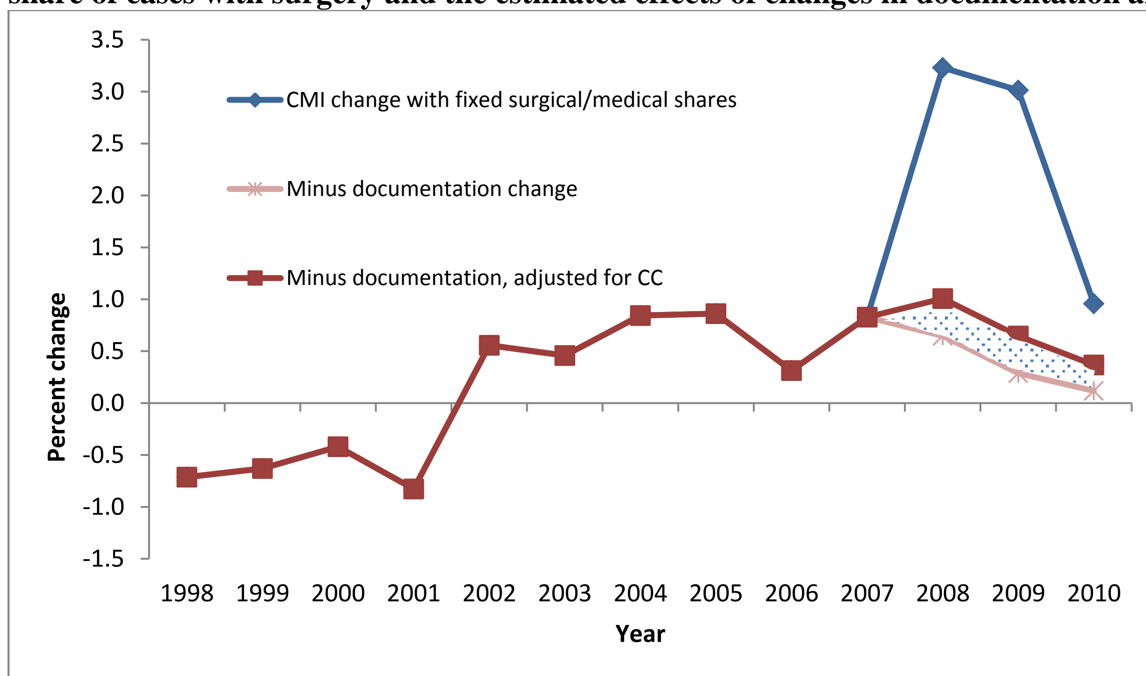
We used the latest available claims for fiscal year 2010 (in the December 2010 update of the fiscal year 2010 MedPAR file) and the same methods we have used previously to estimate the effect of documentation and coding changes in 2010. The cumulative estimate for 2010 is 6.25 percent. Allowing for a potential contribution to the 2010 documentation change estimate of as much as 0.25 percentage points from the decline in the share of claims with a CC (from Table 2), our estimate for 2010 ranges from 6.00 to 6.25 percent. Given the cumulative permanent documentation change adjustment of -1.5 percent in 2010, this estimate implies that overpayments in 2010 and later years range from 4.50 to 4.75 percent (assuming that no further documentation change occurs after 2010).

This estimate also suggests that the incremental effects of documentation changes have been declining—as we would expect if hospitals were still working in 2010 to get attending physicians

to fully document acute manifestations of patients' chronic conditions in their medical records. If we use a CMI for 2008 that is based on the 2008 MS-DRGs and the fully-implemented cost-based weights for 2009, we get a clearer picture of changes in case mix that are solely due to changes in documentation and coding. These estimates suggest that documentation and coding changes had their biggest effect in 2008 at 3.5 percent, followed by 2.7 percent in 2009 and 0.8 percent in 2010. The implied real change in case mix for 2010 is still negative, but this is consistent with the further decline of -0.5 percentage points that year in the share of claims assigned to surgical DRGs.

To summarize the effects of documentation changes and shifts in the proportions of cases with surgical procedures and CCs, Figure 2 shows annual changes in the reported CMI from 1997 to 2010, adjusted for the impact of each factor. After adjusting for the shift away from surgical cases and documentation changes, the implied real annual changes in the CMI from 2008 to 2010 lie in the shaded area. The point of the figure is that, absent changes in documentation and coding and the shift away from inpatient surgeries, real changes in the CMI in 2008 through 2010 would be completely consistent with historical CMI changes since 2001.

Figure 2: Annual changes in the CMI look quite ordinary after we adjust for changes in the share of cases with surgery and the estimated effects of changes in documentation and coding



Source: MedPAC analysis of IPPS hospital inpatient claims in the final rule MedPAR files for fiscal years 1997-2009 and the proposed rule MedPAR file for fiscal year 2010, from CMS. CMIs are based on the DRG grouper, relative weights, and transfer policies in effect for each fiscal year. Trends are based on CMIs calculated with fixed medical/surgical shares of 70.5 and 29.5 percent (the averages for the whole period). Percent changes for the other two series reflect the documentation change and CC adjustments described earlier for each year 2008-2010.

Phasing in documentation and coding adjustments to allow a 1 percent increase in payment rates in fiscal year 2012

Our recommendation in our March 2011 Report to the Congress stated that the Congress should increase hospital inpatient payment rates in the IPPS by 1 percent for fiscal year 2012, which would incorporate a permanent adjustment to partially offset ongoing overpayments due to documentation and coding changes. We reiterated our previous recommendation that to fully restore budget neutrality with respect to the implementation of MS-DRGs, the Congress should also require the Secretary of Health and Human Services to make adjustments to inpatient payment rates in future years to fully recover all overpayments due to documentation and coding changes.

We recognize, however, that CMS is constrained by provisions of current law that require it to start with the projected increase in the hospital market basket index and then deduct statutory productivity and budget adjustments enacted in PPACA. In addition, under a court ruling, CMS must provide an adjustment to reflect the outcome of recent litigation regarding budget neutrality adjustments related to the wage index rural floor policy.

In this context, CMS has proposed a -3.15 percent permanent adjustment for fiscal year 2012 to partially forestall ongoing overpayments due to documentation changes (see Table 3 below). To be consistent with our recommended update of 1 percent, however, CMS would have to make a smaller adjustment to reduce further overpayments due to documentation and coding changes.

The range of documentation and coding estimates shown above suggests that overpayments in 2008 and 2009 amounted to between 5.1 and 5.8 percent of IPPS payments. Given the -2.9 percent temporary adjustment that CMS made in fiscal year 2011, the remaining amount to be recovered ranges from 2.2 to 2.9 percent of IPPS payments. At the lower estimate, CMS would need to recover 2.2 percent rather than the expected 2.9 percent that would result from its proposed extension through 2012 of the temporary -2.9 percent adjustment from 2011. The range of required 2012 temporary adjustments from -2.9 to -2.2 percent would free up an additional 0.0 to 0.7 percent that could be used to permanently forestall further overpayments due to documentation changes.

Table 3: Effect on the 2012 update and documentation change adjustments of allowing for potential declines in the share of claims with CCs that are counted in the 2007 grouper

Item	CMS proposed rule	Range of adjustments for documentation changes given our recommended 1 percent update and other required adjustments
Market basket index	2.80%	2.80%
Productivity adjustment	-1.20%	-1.20%
PPACA adjustment	-0.10%	-0.10%
Rural floor adjustment	1.10%	1.10%
Change in 2008/2009 recovery adjustment	0.00%	0.00 to 0.70%*
Prospective documentation adjustment	-3.15%	-1.60 to -2.3%
Net update for 2012	-0.55%	1.00%

*Under the lower bound documentation change estimate, total overpayments in 2008 and 2009 equaled 5.1 percent of IPPS payments. In 2011, CMS recovered 2.9 percent of payments and would therefore only need to recover 2.2 percent in 2012 to complete the recovery of all 2008 and 2009 overpayments. The result would be a 0.7 percentage point reduction in the recovery adjustment for 2012. This would allow a larger prospective adjustment while maintaining a 1 percent update.

Given the range of required recovery adjustments of -2.9 to -2.2 percent to complete the recovery of all 2008 and 2009 overpayments, and a 1 percent net update, the amount left for a permanent adjustment to offset ongoing overpayments in 2012 would range from -1.6 to -2.3 percent. If CMS follows our recommendation, a prospective adjustment of -1.6 to -2.3 percent would replace its proposed -3.15 percent adjustment.

Looking forward, two changes will be needed to fully restore budget neutrality with respect to the adoption of MS-DRGs and cost-based weights. First, CMS will have to make a further adjustment in fiscal year 2013 to fully prevent continuing overpayments due to documentation changes. Using the lower-end estimates for the net cumulative effects of documentation and coding changes in 2008 through 2010—and assuming that no further documentation change occurs in 2011—the required 2013 adjustment would be -2.2 percent (4.5 percent ongoing overpayments minus a 2.3 percent permanent preventive adjustment in 2012). This adjustment would be exactly offset by the expiration of the revised temporary recovery adjustment of -2.2 percent for fiscal year 2012. As a result, CMS could fully prevent further overpayments due to documentation changes in fiscal year 2013 without a further reduction in the payment rates. Using the higher-end estimates for the net effects of documentation change, the required adjustment would be -3.1 percent (4.7 percent ongoing overpayments minus a 1.6 percent permanent preventive adjustment in 2012). Even in this case, however, the net effect on the payment rates in 2013 would be only -0.2 percent (-3.1 percent offset by the expiration of the -2.9 percent temporary adjustment for 2012).

Second, as we recommended in our March 2011 Report to the Congress, the Congress should enact legislation to require the Secretary of Health and Human Services to adjust payments further to recover all overpayments that have occurred or will occur in 2010, 2011, and 2012. This further adjustment could be set at 1 or 2 percent (or some other level), depending on how rapidly the Secretary would want to recover the accumulated overpayments. Under the range of estimates laid out above, total accumulated overpayments amount to at least 11.2 percent of IPPS payments (4.5 percent per year in 2010 and 2011, plus 2.2 percent in 2012). However, a small reduction in the payment rates (e.g., -1 percent) could be made in 2013 and then left in place over a longer period. This would recover overpayments over a period of years without reducing payment updates after 2013.

Conclusion on documentation and coding adjustments

We concur with CMS on the approximate magnitudes of the documentation and coding effects on IPPS payments, and that the payment rates need to be corrected to offset these effects. We recommend slowing the pace of the corrections so hospitals would receive a net 1 percent update in 2012.

However, the commission also recommended that the principle of budget neutrality should be preserved with respect to implementation of MS-DRGs. Therefore, even after ongoing overpayments are stopped, a further reduction in IPPS payment rates will be needed to recover the overpayments that have occurred in 2010 and 2011 and will occur in 2012. To allow payments to increase due to documentation and coding changes would undermine Congressional policy on updates. If Congress wants more money to flow into the hospital sector, a higher update is the appropriate mechanism, not cumulative changes in documentation and coding. Indeed, allowing those changes to increase hospital payments through the back door could eventually discourage needed refinements to the case-mix system in a tight budget era. In other words, if more money inevitably leaks into the system every time case mix is refined, then there may be pressure to stop refining. That would lead to inequities for both providers and patients.

Hospital Inpatient Quality Reporting (IQR) program

Under the Hospital Inpatient Quality Reporting (IQR) program, CMS is authorized to reduce the annual market basket update by 2 percentage points for any IPPS hospital that fails to successfully report on a specified set of quality measures. The FY 2012 IPPS proposed rule proposes changes in the performance measures that would be used to determine hospitals' FY 2014 and FY 2015 payment updates. For the IQR program measures that require hospitals to collect and report data (as opposed to those calculated by CMS from Medicare claims data), the impact on hospitals would begin in calendar year 2012 (for measures affecting the FY 2014 update) or 2013 (for FY 2015 update measures).

Table 4 shows that the number of measures required under the IQR program has grown steadily since its implementation for the FY 2003 payment update determination. The program began with 10 measures and currently includes 57 measures that will affect hospitals' FY 2013 payment update. In the current proposed rule, CMS proposes to increase the number of measures to 73 for the FY 2015 payment update. The sources of data used for the measures also have evolved, from measures being based exclusively on data abstracted by hospitals from a sample of patients' clinical records, to the current program where roughly half the measures are calculated by CMS from Medicare claims data and roughly half are based on hospital-reported data.

Table 4. Number of Inpatient Quality Reporting program measures by data source, 2003-2015

FY payment update determination	Number of measures by data source				
	Total	Chart-abstracted	Claims-based	Patient survey (HCAHPS)	Other (Registry/NHSN)
2003–2006	10	10	0	0	0
2007	21	21	0	0	0
2008	27	24	2	1	0
2009	30	26	3	1	0
2010	44	26	16	1	1 (1/0)
2011	45	27	14	1	3 (3/0)
2012	55	27	24	1	3 (3/0)
2013	57	28	24	1	4 (3/1)
2014 (proposed)	56	22	25	1	8 (4/4)
2015 (proposed)	73	36	25	1	11 (4/7)

Note: FY (fiscal year), HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), NHSN (National Healthcare Safety Network).

Source: FY 2011 IPPS final rule (*Federal Register* 75, no. 157: 50181-50214) and FY 2012 IPPS proposed rule (display copy): 343-396.

For the FY 2014 update, CMS proposes to retire eight chart-abstracted measures that are currently in use, but would add seven other measures, with the end result that next year's IQR program would include 56 measures, or one less than this year. Of the 56 proposed measures for the FY 2014 payment update, hospitals would be required to collect and report data for 31 of them: 22 measures based on data abstracted from clinical charts; Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results; four measures of participation in certain kinds of clinical registries; and four measures of healthcare-associated infection (HAI) rates based on data reported by the hospital through the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). The other 25 measures would be calculated by CMS from Medicare claims data.

For the FY 2015 payment update, CMS proposes to increase the total number of measures to 73 by adding 14 chart-abstracted process of care measures and three new HAI measures, for which hospitals would have to report data through the NHSN. This would bring the total number of

hospital-reported measures to 48 (with 36 measures using data extracted by hospitals from random samples of patient charts).

MedPAC comments on proposed quality measures

The Commission has recommended and continued to support hospital quality measurement, public reporting, and pay-for-performance (or VBP) for several years. We are concerned, however, about the steadily increasing number of measures required by the Hospital IQR program, and in particular the growing number of clinical process measures that require hospitals to incur substantial costs for the abstraction and collection of data from samples of patient clinical records. We also noted in our recent comment letter on the Hospital VBP program proposed rule a growing body of literature that suggests at least some of the clinical process measures Medicare currently uses to measure hospital quality capture only a small proportion of the variation in hospital mortality rates or have little or no association with aggregate mortality or readmission rates.[4] These findings suggest that the benefits from continuing to measure these processes may be outweighed by the costs of doing so and deflects attention from potentially more productive quality improvement activities. We encourage CMS to consider a moratorium on adding any new process measures to the IQR program until the agency critically evaluates the contribution of each current process measure for measuring meaningful differences in health outcomes among IPPS hospitals and over time.

Another option CMS could consider would be to delete any process measures for which the Hospital IQR program also includes outcome measures such as mortality and readmission rates. For example, since the IQR program currently includes both 30-day mortality rate and 30-day readmission rate measures for AMI, heart failure, and pneumonia, CMS could drop the nine chart-abstracted process measures currently used for these three conditions, since the program's primary concern appropriately should be improving outcomes (mortality and readmission rates) across all IPPS hospitals and over time. This step would reduce the administrative burden of the IQR program for hospitals, but they would still have the incentive to focus their efforts on improving quality of care.

Concerning CMS's proposal to continue reporting eight hospital-acquired condition (HAC) measures in the IQR program, we agree with CMS's proposal to use Medicare claims data to calculate the five HAC measures for which there is no alternative data source at this time. These five HACs—foreign object retained after surgery; air embolism; blood incompatibility; pressure ulcers stages III and IV; and patient falls and trauma—are very rare, but clinically serious and avoidable iatrogenic events (formerly called never events, they are now referred to as "serious reportable events"). We believe CMS should continue calculating and reporting these measures using claims data to focus attention on the reduction of these avoidable patient safety events.

However, two of the other three proposed claims-based HAC measures should be dropped because they duplicate measures that will be calculated from data IPPS hospitals must report through the CDC's National Healthcare Safety Network (NHSN):

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[4] MedPAC comment letter on proposed rule for Medicare Hospital Value-Based Purchasing Program, March 4, 2011.

- The vascular catheter-associated infections measure is similar, but not identical to, an NHSN-based measure that CMS has already implemented in the IQR program: central line-associated bloodstream infection (CLABSI) rates. Beginning with discharges in January 2011, all IPPS hospitals are reporting CLABSIs through the NHSN infrastructure in order to qualify for a full FY 2013 payment update. The proposed claims-based vascular catheter-associated infections HAC measure would not impose additional data collection and reporting burden on hospitals, but it is unnecessary and potentially confusing and inefficient to have two similar but technically different measures in use at the same time.

- CMS proposes to include a claims-based catheter-associated urinary tract infection (CAUTI) measure as a HAC in the IQR program, but also proposes to require IPPS hospitals to start reporting CAUTIs in 2012 measure via the NHSN in order to qualify for a full payment update in FY 2014. As with the CLABSI measure, this proposed duplication seems unnecessary and potentially counter-productive to the goal of focusing on accurately measuring and focusing hospitals on reducing or eliminating these infections. CMS should rely on the NHSN reporting infrastructure for the collection of data on CAUTIs and drop the claims-based CAUTI measure.

Proposed per-beneficiary spending measure

The Commission agrees that hospital performance should be evaluated both on the quality of care and the cost of care. CMS has proposed to measure costs during an episode that starts three days prior to a hospital admission. If CMS follows this path, it should consider reducing the length of the episode to 30 days following discharge to focus on care that is more directly influenced by the hospital and to maintain consistency with the 30-day readmission and mortality rate measures already in use. CMS could also tighten its focus on a subset of episode costs associated with a hospital stay, such as costs during the stay and the costs of post-acute care services delivered during the 30 days following discharge.

Both CMS and MedPAC should focus on creating parallel incentives for hospitals and post-acute care providers to work to reduce readmissions. The end goal is to align incentives across the sectors to encourage cooperation among providers to improve the quality of the episode of care, reduce the cost of the episode of care, and reduce the number of unnecessary inpatient episodes.

Proposed changes to the hospital wage index for acute care hospitals

The FY 2012 IPPS Proposed Rule requests comment on a variety of detailed hospital wage index issues. We wish to reiterate our recommendations on wage index reform, included in the Commission's 2007 Report to Congress, which were to repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary the authority to establish a new wage index system. Our 2007 recommendations specified that the new hospital compensation index should be established so that it:

- Uses wage data from all employers and industry-specific occupational weights;
- Is adjusted for geographic differences in the ratio of benefits to wages;
- Is adjusted at the county level and smoothes large differences between counties; and
- Is implemented so that large changes in wage index values are phased in over a transition period.

The Institute of Medicine (IOM) has reached a similar conclusion in its recent report which recommends a new wage index system based on Bureau of Labor Statistics data with a method for smoothing differences in wage indexes across adjacent payment areas. The new system "is intended to replace the system of geographic reclassification and exceptions that is currently in place." [5] We encourage CMS to consider the MedPAC and IOM recommendations when developing changes to the current wage index system.

The flaws of the existing hospital wage index system continue to erode the accuracy of Medicare's hospital payment system and remain evident in the FY 2012 IPPS Proposed Rule. For example, according to data in the FY 2012 Proposed Rule, over one-third of IPPS hospitals (over 1,200 hospitals) will receive either a reclassification to a different geographic area with a higher wage index or a specific exception to their original FY2012 geographic wage index.

Among the proposed wage index reclassifications or exceptions granted to hospitals for FY2012, the rural floor exception triggered in the state of Massachusetts will have a large impact on hospital payments. Beginning in FY 2012, the conversion of Nantucket Cottage Hospital from a critical access hospital to an IPPS hospital will trigger the rural floor wage index exception for the 60 urban hospitals in the state of Massachusetts, increasing wage indexes for these hospitals from an average of 1.16 in FY2011 to 1.35 in FY2012. Nantucket Cottage Hospital is a rural island hospital, which has 15 inpatient beds and serves approximately 150 Medicare inpatients per year. This hospital will become the only rural IPPS hospital in the state of Massachusetts. As a result of this change in one small hospital's status, and the subsequent change in the wage index, payment rates for urban hospitals in Massachusetts will increase by 8 percent, or by more than $200 million in FY 2012. These extra payments will be made budget neutral at the national level, and therefore all hospitals—including rural hospitals—will absorb the financial loss. This is a clear example of

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[5] Institute of Medicine, 2011. *Geographic Adjustment in Medicare Payment: Phase I: Improving Accuracy*. The National Academy Press, Washington DC. See Appendix E for a comparison of MedPAC and IOM recommendations.

how the current system of exceptions is not an equitable method of adjusting for input prices. A new wage index system is needed.

Conclusion

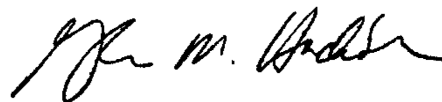
We support the direction CMS is moving with respect to correcting for overpayments from documentation and coding changes and creating incentives for improved quality of care. While all overpayments should eventually be recovered, the recoveries should be made gradually. In addition, we are concerned that proposed expansion of quality reporting requirements could generate excess administrative burdens. Therefore, we have made two comments with respect to the 2012 IPPS rule:

- Consistent with our March 2011 recommendation, recover all overpayments from documentation and coding changes, but do it at a slower pace allowing for a 1 percent increase in payment rates in 2012.

- Slow the growth in the number of quality metrics to relieve the growing quality reporting burden that hospitals face.

If you have questions about any of the issues raised in our comments, please contact Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth
Chairman