



601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Francis J. Crosson, M.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

June 15, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1406-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: file Code CMS-1406-P

Dear Ms. Frizzera:

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 Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates*, Federal Register Vol. 74, No. 98, pages 24079-24686 (May 22, 2009). 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, particularly considering the agency's 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' improvements in medical record documentation and diagnosis coding and other changes that could improve fairness within the inpatient prospective payment systems for acute care and long-term care hospitals. Specifically we address the following issues in the acute care hospital inpatient prospective payment system (IPPS):

- Adjusting the level of payments to offset the effects of hospitals' documentation and coding improvements;
- Improving accuracy of payments by addressing charge compression within hospital revenue centers in calculating MS-DRG relative weights;
- Improving accuracy of payments by revising the charge standardization process used in constructing MS-DRG relative weights;
- Improving accuracy of payments by revising the basis and calculation of the hospital area wage index; and
- Expanding incentives to improve the quality of care.

We also discuss adjusting payments for documentation and coding improvements as well as payment accuracy improvements in the long-term care hospital prospective payment system (LTCH PPS).

Proposed FY2010 MS-DRG Documentation and Coding Adjustment to Payments in the IPPS

As expected, implementation of Medicare severity diagnosis related groups (MS-DRGs) in 2008 gave hospitals a financial incentive to improve medical record documentation and diagnosis coding to more fully account for each patient's severity of illness. (For an explanation of how DCI occurs see the attachment to this letter). Documentation and coding improvements (DCI) improve documentation of patient severity, but they also increase reported case mix and payments without a real increase in patient severity or the resources hospitals must use to furnish inpatient care. Based on our analysis of hospital claims for fiscal year 2008, we concur with CMS's conclusions that DCI occurred in 2008, and that under current law IPPS payment rates must be adjusted to offset its effects on reported case mix and payments. Our analysis indicates that downward payment adjustments will have to be taken over several years to recover past overpayments and to prevent overpayments from continuing in the future.

As we discuss more fully below, three key questions need to be answered regarding the magnitude and timing of the required adjustments:

- 1. How much did DCI increase case mix and payments in 2008?** CMS found that documentation and coding improvements increased case mix by 2.5 percent in 2008, which resulted in overpayments of 1.9 percent. Our analysis of 2008 claims confirms CMS's findings.
- 2. How much will DCI increase case mix and payments in 2009?** CMS projects that by the end of 2009, hospitals' documentation and coding improvements will have increased casemix by a cumulative total of 4.8 percent. While all DCI projections are subject to uncertainty, 4.8 percent appears to be a reasonable estimate, given our examination of recent experience in Maryland.
- 3. When should CMS reduce payment rates to prevent further overpayments and to recover overpayments occurring in 2008 and 2009?** We support CMS's proposal to reduce IPPS payments in 2010 by 1.9 percent to prevent further overpayments. While we and the CMS actuaries believe that a 1.9 percent reduction will not fully prevent overpayments from continuing in 2010, this is a reasonable first step toward reducing overpayments. In addition, it would be desirable for CMS to minimize year-to-year changes in payment adjustments it must make to recover overpayments that were made in 2008 and 2009. To achieve this goal, CMS should consider spreading the recovery of 2008 overpayments over three years, beginning in 2010.

Background on the introduction of MS-DRGs

We commend CMS for the substantial effort it has made to develop the MS-DRGs and refine the IPPS payment rates. In our March 2005 report to the Congress on physician-owned specialty hospitals we noted that under the policies then in effect, hospitals had an incentive 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 in use at the time, high-severity cases often were not paid more than cases with low or moderate severity. The MS-DRGs and other payment refinements have moved a long way toward ensuring that the relative payment rates IPPS hospitals receive for Medicare patients reasonably match their relative costs of furnishing care.

However, as we have seen in the past, these major changes in the DRG classification system created opportunities and incentives for hospitals to improve their medical record documentation and diagnosis coding. Hospitals improve documentation and coding to ensure that they get full credit for the highest level of patient severity to which they are legitimately entitled under the new system. The result is that hospitals report a higher case mix under the new MS-DRG system than they would have reported for the same patients under the prior DRG system. But this change in reported case mix due to DCI is not real; the severity level is not higher, but under the new system, it looks higher. Ordinarily—if the DRG changes were relatively minor and did not create incentives for more specific reporting of diagnoses—CMS’s annual recalibration of the DRG relative weights would prevent any change in the national average case mix index (CMI) and aggregate hospital payments. However, when CMS makes major changes in the DRG definitions, as it did with the MS-DRGs in 2008, the recalibration process can not prevent an increase in the CMI that is due solely to DCI. This is because CMS uses the latest available claims to recalibrate the relative weights (for example, CMS used 2006 claims to recalibrate the weights for the new MS-DRGs in 2008), and those claims do not reflect hospitals’ response to the new DRGs because they were prepared by hospitals before the new system was adopted.

Legislative background

When we recommended severity refinements to the DRGs in our 2005 report to the Congress, we expected a DCI response and we knew that it would lead to unwarranted increases in IPPS payments if CMS did not make commensurate adjustments in the base payment rates. We recommended that CMS make prospective adjustments in advance to prevent overpayments from occurring.

Based on their analysis of historical experience with earlier major changes in the DRGs and Maryland’s recent experience in implementing all-patient refined DRGs (APR-DRGs), CMS actuaries expected hospitals’ DCI to eventually raise the CMI and aggregate IPPS payments by 4.8 percent. In the final IPPS rule for fiscal year 2008, CMS said it would reduce payment rates by 4.8 percent over three years to offset the expected increase. Following publication of the final rule, the Congress passed legislation to limit the prospective downward adjustments to 0.6 percent in 2008 and 0.9 percent in 2009, or 1.5 percent in total. Congress also required CMS to analyze the appropriateness of these adjustments. If CMS’s retrospective study of discharges during fiscal years 2008 and 2009 finds that the 0.6 and 0.9 percent adjustments were too small (or too large), the law requires CMS to recover (or restore) the difference, with interest. If needed, these adjustments must be temporary and they can be applied only in 2010, 2011, or 2012. The law also requires CMS to make a permanent adjustment equal to the difference between the adjustments taken in 2008 and/or 2009 and the actual DCI effect to prevent further over (or under) payments going forward.

How much did DCI increase provider case mix in 2008?

CMS analyzed hospital claims for fiscal year 2008 and concluded that DCI increased payments by 2.5 percent. Hospitals' overpayments due to DCI in 2008 amounted to 1.9 percent because the DCI effect was 2.5 percent and the statutory prospective adjustment applied that year was -0.6 percent. CMS concluded that under the law these overpayments will have to be recovered.

Our analysis of hospital claims for fiscal year 2008 confirms CMS's findings. To see how much the aggregate CMI and payments increased in 2008 due solely to hospitals' DCI, we used fiscal year 2008 claims—from the December 2008 update of the 2008 MedPAR file—to calculate the national aggregate CMI based on the 2008 MS-DRGs and weights. **Using the same claims**, we also calculated the aggregate CMI based on the 2007 DRGs and weights. The difference between the two CMIs is 2.8 percent. By definition, this change in reported case mix is not real because the cases are the same; the difference is that the new MS-DRGs recognize more detailed coding of diagnose while the prior DRGs do not. Under MS-DRGs, more detailed documentation and coding can result in a larger increase in case mix and payments than under the prior DRG system.

In its recalibration of the relative weights for the MS-DRGs for fiscal year 2008, CMS calculated and compared the same two national CMIs (using the 2008 MS-DRGs and weights and the prior 2007 DRGs and weights) with 2006 claims. CMS then adjusted the 2008 MS-DRG weights so that the two CMIs would be equal. If hospitals had not changed their documentation and coding of diagnoses between 2006 and 2008 in response to the new MS-DRGs, we would expect the two CMIs based on the 2008 data to be nearly equal. Instead, the difference is 2.8 percent.

We also know, however, that the two CMIs will always differ by a small amount whenever they are calculated using a different claims data set than CMS used for recalibration. For example, the difference was 0.3 percent when we calculated the same two CMIs using claims for fiscal year 2007, which do not reflect hospitals' DCI response to the new MS-DRGs because they preceded the policy change. To avoid attributing this difference to hospitals' DCI, we subtracted the 0.3 percent from our 2008 DCI estimate of 2.8 percent. Thus our net DCI estimate for fiscal year 2008 is 2.5 percent.

In addition, we estimated the 2008 DCI effect using the same methods for various subgroups of hospitals. Although the DCI estimates varied somewhat among the groups, the variation was generally small. Thus, the DCI response appears to be widely consistent among all types of hospitals.

What will be the effect of DCI in 2009?

To estimate the effects of DCI in 2009, we looked at what the DCI effect would have been in 2008 if we had used the fiscal year 2009 MS-DRGs and weights instead of the 2008 MS-DRGs and weights. The MS-DRGs and cost-based weights are fully-implemented in fiscal year 2009. We made similar comparisons of CMIs based on the 2009 MS-DRGs and weights and the 2007 DRGs and weights calculated using first the claims for fiscal year 2008, and then again the claims for fiscal year 2007. Our estimate of the cumulative DCI effect for fiscal year 2009 (using 2008 claims) was 3.2 percent.

We think that this finding provides a lower bound on what the cumulative DCI effect will be in 2009. If hospitals have not fully completed their planned improvements by the end of 2008, the cumulative DCI effect in fiscal year 2009 will be at least as large as our 3.2 percent estimate. Because CMS's cumulative downward payment adjustment for DCI was limited to -1.5 percent in 2009, the 3.2 percent DCI estimate implies that payments in fiscal year 2009 are at least 1.7 percent too high (i.e., $3.2 - 1.5 = 1.7$). This means that if hospitals do not improve their documentation and coding at all from 2008 to 2009, payments will still be roughly 1.7 percent too high. If hospitals are continuing to make improvements in 2009, as seems likely, we expect that the DCI estimate for fiscal year 2009 will turn out to be higher than 3.2 percent.

CMS actuaries project that the aggregate CMI will eventually increase 4.8 percent due to better documentation and coding and that nearly all of the increase will have occurred by the end of fiscal year 2009. They project higher DCI in 2009 for two reasons. One reason is that the MS-DRGs were not fully phased in until 2009. The other reason is that they expect documentation and coding to improve from 2008 to 2009. The 4.8 percent estimate implicitly assumes that improvements in coding from 2008 to 2009 will result in an additional 1.6 percent increase in case mix. This assumption is reasonable given our examination of recent experience in Maryland.

Table 1 shows how the DCI effect and related adjustments could play out, if the actuaries' projection of 4.8 percent (the first line) turns out to be correct. The second line shows the cumulative effect of the counterbalancing adjustments that Congress included in the law. The third line shows the 1.9 percent proposed adjustment for 2010 and the additional counterbalancing adjustments that CMS will have to adopt to prevent further overpayments going forward, if the CMS projection of 4.8 percent is correct.^a With these adjustments, the DCI effect is fully offset beginning in 2011, as indicated in the fourth line. The fifth line shows the temporary adjustment CMS will have to make if, as proposed, it waits until 2011 to begin recovering overpayments made in 2008 and 2009. The sixth line is the sum of lines 4 and 5; it shows the net effect of DCI and the related adjustments on the level of payments.

The seventh line of the table illustrates the effect that DCI and the adjustments will have on annual changes in payments per case. In 2009, for example, line 7 shows that the changes in DCI and adjustments are expected to increase payments by 1.4 percent. This reflects the increase in the "net effect of DCI and counterbalancing adjustments" from 1.9 percent in 2008 to a projected 3.3 percent in 2009 ($3.3 - 1.9 = 1.4$). The eighth line shows the actual and projected market basket updates under current law. The ninth line shows the annual increase in payments per case resulting from the combination of the net impact of DCI and the update (the sum of lines 7 and 8). Note that the change in per case payments turns negative in 2011 as CMS begins to recover overpayments that occurred in 2008 and 2009, but rebounds immediately in 2012. The last line shows the cumulative level of hospitals' financial benefit from DCI coupled with the cost of returning the prior overpayments. This is equal to a running sum of the changes shown in line 7. As indicated, payments are returned to where they should be in 2013.

^a The 3.3 percent that we show in line 3 for 2011 assumes that if CMS' estimate of a 4.8 percent DCI effect is correct, additional prospective adjustments will need to be taken to prevent further overpayments.

Table 1: Achieving balance in DCI and payment adjustments by 2013

	2008	2009	2010	2011	2012	2013
Impact on levels of payments						
1. Increased payments due to DCI (cumulative)	2.5	4.8*	4.8*	4.8*	4.8*	4.8*
2. Counter-balancing DCI adjustments in law (cumulative)	-0.6	-1.5	-1.5	-1.5	-1.5	-1.5
3. Expected additional counter-balancing adjustments (cumulative)			-1.9	-3.3	-3.3	-3.3
4. Net effect of DCI and counter-balancing adjustments (annual effect)	1.9	3.3	1.4	0.0	0.0	0.0
5. Recovery of past overpayments	-	-	-	-2.6**	-2.6**	**
6. Net effect of DCI, counterbalancing adjustments and recovery of past overpayments (annual effect)	1.9	3.3	1.4	-2.6	-2.6	0.0
Year-to-year changes in payments						
7. Change in sum of DCI, counter-balancing adjustments, and recoveries from the preceding year	1.9	1.4	-1.9	-4.0	0.0	2.6
8. Market basket update***	3.3	3.6	2.1	2.8	3.0	3.0
9. Annual change in payments per case due to change in DCI, adjustments, and update	5.2	5.0	0.2	-2.2	3.0	5.6
Cumulative change above the market basket	1.9	3.3	1.4	-2.6	-2.6	0.0

Note: * Indicates the CMS actuaries' projection. Actual findings may differ.

** Recoveries begin in 2011 and continue in 2012; payment levels are restored in 2013 when overpayments have been repaid.

*** Market basket updates for 2010 to 2013 reflect current law and projections of input prices. Actual updates may differ.

When should CMS start to recover the 2008 overpayments?

CMS has proposed to defer recovery of 2008 overpayments until 2011. CMS has the authority to do this, but as Table 1 illustrates, this raises the risk of having to reduce payment rates significantly in 2011 (-4 percent). Payments would then bounce up significantly in 2013. To reduce potential volatility in the payment rates, CMS could start to recover 2008 overpayments in 2010. This would result in a somewhat larger downward adjustment to the payment rates in 2010, followed by less volatility in following years.

Conclusions on documentation and coding

Prior to the introduction of the MS-DRGs, CMS and MedPAC both predicted that hospitals would improve their medical record documentation and coding, and both organizations recommended prospective adjustments to correct for the expected effect of these improvements on Medicare payments to hospitals. These adjustments were limited by the Congress, but Congress also provided that any overpayments would have to be recovered by CMS. Now that the 2008 claims data is available, we can see that hospitals' DCI in 2008 resulted in a 2.5 percent increase in case mix and a net increase in payments of 1.9 percent. These overpayments have to be recovered and payment rates need to be corrected to prevent future overpayments. The CMS proposal to reduce payments in 2010 by 1.9 percent to prevent further overpayments is reasonable but conservative given the magnitude of the recoveries that are expected to be necessary from 2010 to 2012. It would be equally reasonable for CMS to make a larger adjustment in 2010 in order to smooth out payment rate volatility.

Refinement of the MS-DRG Relative Weight Calculation

RTI Study of Charge Compression and CCR Refinement

When hospitals use different mark-ups among the services included in the same revenue center, CMS's cost estimates for those services—derived by multiplying hospitals' charges for the services by the overall average cost-to-charge ratio (CCR) for the revenue center—overstate costs for services with high mark-ups and understate costs for services with low mark-ups. The main problem is that the current cost report—the source for the national CCRs that CMS uses to estimate costs for different services—does not break out all of the groups of services for which hospitals use different mark-ups. The way to correct this problem is to have hospitals break out services with high and low mark-ups into separate categories on their annual cost reports.

In a CMS sponsored report, RTI International recommended improving the computation of cost-to-charge ratios by breaking the radiology, drugs, and supplies revenue centers into smaller revenue centers. We agree with the RTI recommendations on charge compression. CMS has suggested separating supplies into two subcategories: implantable devices that tend to have low mark-ups and other supplies that tend to have high mark-ups. To be equitable, CMS should not make this change only for devices and other supplies. CMS needs to have more detailed reporting on the cost report and MedPAR claims file for all three revenue centers recommended by RTI: radiology

(disaggregating services and costs into five categories), drugs (three categories) and supplies (two categories). We provided detail on the need for additional revenue centers in our June 2009 comment letter on last year's proposed rule.

RAND Corporation Study of Alternative Methods for Setting Relative Weights

Among other recommendations for improving payment accuracy in our March 2005 report to the Congress on physician-owned specialty hospitals, we recommended that CMS adopt the hospital-specific relative value (HSRV) method for calculating cost-based relative weights for DRGs. We argued that adoption of this method would have obviated the need to standardize hospitals' charges (or case-level cost estimates based on charges) for factors that affect hospitals' costs but are largely beyond their control. The goal of either method (HSRV or standardization) is to make the cost estimates included in calculating the relative weights reflect comparable costs across hospitals.

Amid expressed concerns that the HSRV method might compress the relative weights (resulting in overpayment of relatively low-cost types of patients and underpayment of relatively high-cost types of patients) CMS commissioned the RAND Corporation to compare and evaluate alternative methods for calculating DRG relative weights. The RAND researchers concluded that no method, including HSRV, appeared to provide a clear advantage over other methods.

Based on the RAND findings, CMS has stated that it does not plan to use the HSRV method for determining cost-based relative weights for MS-DRGs. Instead, CMS tries to make the underlying cost estimates more comparable across hospitals by standardizing hospitals' claim service charges for three factors: differences in local input prices, as measured by the area wage index and cost of living adjustment (COLA); the indirect costs of medical education programs (IME) operated by teaching hospitals; and the cost of serving a disproportionate share (DSH) of low income patients. Historically CMS has used hospitals' IME and DSH payment adjustment percentages to adjust for the effects of the latter two factors. This approach entails implicitly assuming that the IME and DSH payment adjustment percentages accurately reflect the impact that teaching intensity and serving poor patients have on hospitals' Medicare inpatient costs per discharge. We and RAND have both found that the IME and DSH payment percentages substantially exceed the empirically estimated effects of teaching activity and serving low income patients on costs per discharge. Therefore, we support the option CMS has raised of standardizing hospitals' service charges using the empirically estimated effects of IME and DSH rather than the payment adjustment percentages.

Proposed changes to the hospital wage index for acute care hospitals

CMS has contracted with Acumen LLC to study the wage index recommendations in our June 2007 report to the Congress. We recommended that the Congress repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems. 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 smooths large differences between counties, and
- is implemented so that large changes in wage index values are phased in over a transition period.

In part 1 of their final report, Acumen finds that "...the methods recommended by MedPAC for constructing the hospital compensation index represent an improvement over existing methods and that the BLS data should be adopted so that the MedPAC approach can be implemented." We look forward to Part 2 of Acumen's report and to working with your staff on improving the hospital wage index.

RHQDAPU: Incentives to improve the quality of care

The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program requires CMS to penalize hospitals with a 2 percentage point reduction in the market basket update to their payments if they fail to successfully report designated quality measures. This year, CMS has proposed changes that will require hospitals to successfully report 46 quality measures for the fiscal year 2011 payment update.

The Commission supports CMS's efforts to move Medicare toward value-based purchasing for hospital services, and in that spirit we support the proposed additional quality data collection. The Commission also supports several of the goals that CMS considers when it evaluates candidate measures in updating the RHQDAPU program. The Commission specifically emphasizes that:

- The measures set should evolve as the clinical evidence base evolves, including greater understanding of the benefit-cost trade-offs of particular services and treatments. Ideally, the program should only use measures where clinical evidence indicates that the benefit of the service measured exceeds its cost.
- To ensure that Medicare's quality measures do not add unnecessarily to the administrative costs that hospitals incur in gathering and reporting quality data, we encourage CMS to leverage quality data reports that hospitals already submit to state health agencies or hospital associations.
- Measures should be selected that will promote providers' clinical and financial accountability across care settings. This can be done by aligning measures and incentives across providers and settings, such as through the application of care coordination measures and measures of quality across episodes of care.
- The measure set should encourage effective management of beneficiaries with chronic conditions by focusing on evidence-based measures of quality that include ambulatory care-sensitive and preventable hospital admissions and readmissions.
- The measures used should not allow hospitals to be rewarded for providing marginally effective care or care that is already routinely furnished.

Proposed Changes to the Long-Term Care Hospital Prospective Payment System

Documentation and coding improvement

As with IPPS hospitals, we concur with CMS's conclusions about the need for, and application of, counterbalancing adjustments to LTCH payments to offset the effects of case-mix increases due to changes in coding practice. Such adjustments are needed because the implementation of MS-LTC-DRGs in 2008 gives LTCHs a financial incentive to improve medical record documentation and coding to more fully account for each patient's severity of illness. As discussed above, MedPAC analyzed the increase in case mix and payments for acute care hospitals; our findings confirmed those of CMS. We support the use of this same methodology to determine the effects of documentation and coding improvements on LTCH case mix and payment. Using this methodology, CMS found that documentation and coding improvements increased reported case mix by 0.5 percent in 2007 and 1.3 percent in 2008. These increases are lower than those found among acute care hospitals because LTCH cases are often already coded at the highest severity levels, and thus there is less opportunity for DCI.

Because adoption of the MS-LTC-DRG grouper and weights increased average payment rates by 1.8 percent, MedPAC supports CMS's proposal to reduce payment rates by 1.8 percent to prevent further overpayments.

Ensuring providers have adequate experience treating medically complex patients

CMS notes that members of its technical expert panels agreed that the most medically complex cases need specialized treatment requiring higher level nursing and physician oversight and interdisciplinary teams to monitor infections and other complications. Further, adequate numbers of cases are needed to ensure appropriate experience treating these conditions. The Commission has pointed out in previous reports and comment letters that if a critical mass of medically complex patients is needed to ensure quality of care, then the proliferation of LTCHs in some markets might be cause for concern. Last year we suggested in our comment letter to the Secretary (March 24, 2008) that, to ensure providers have an adequate level of experience caring for medically complex patients, CMS might appropriately view LTCHs (and other providers of medically complex care) as regional referral centers, serving wider catchment areas. Similarly, some TEP participants suggested that Medicare establish Centers of Excellence for treating the medically complex population. These centers could be LTCHs, acute care hospitals, or other settings that have the requisite staffing, resources, and volume of patients. We urge CMS to consider policies that encourage this model of care for medically complex patients. Providers with adequate experience may be able to provide more value for the Medicare program by achieving better outcomes with greater efficiency. The development of facility and patient criteria, which MedPAC has long advocated, is an important step in implementing a Centers of Excellence model. Such criteria would define the desired level of care—whether furnished in an LTCH, acute-care hospital, specialized skilled nursing facility (SNF), or inpatient rehabilitation facility (IRF)—and the staff credentials, service capabilities, and volume levels needed to furnish this level of care.

Improving the accuracy of payment

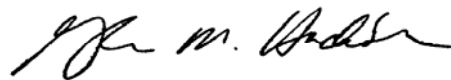
In its work for CMS, RTI analyzed trends in profitability for some of the more common conditions treated in LTCHs. RTI found substantial differences in aggregate facility Medicare margins by ownership. The Commission reported a similar observation in our March 2009 Report to the Congress. RTI also found that these differences in facility margins were explained by differences in case mix. Indeed, at the case level, margins varied substantially, indicating differences in relative profitability across LTC-DRGs. Such differences send inappropriate signals to LTCHs and reward or penalize individual providers based on the mix of patients they treat rather than their efficiency of treatment. Medicare must address this situation as quickly as possible. MedPAC looks forward to working with CMS to find ways to improve the accuracy of Medicare's payments to LTCHs.

Conclusion

We commend CMS for its outstanding efforts in working through a wide range of difficult but important issues. As we have discussed in this letter, several additional opportunities exist to improve payment accuracy in the prospective payment systems for acute care and long term care hospital services. We will be pleased to work with your staff to make the most of these opportunities.

If you have questions about any of the issues raised in our comments, please contact Mark Miller, MedPAC's Executive Director.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth", is written over a thin red horizontal line.

Glenn M. Hackbarth, J.D.
Chairman

Attachment on Documentation and Coding Improvement

Background

In 2008, to better capture differences in patients' severity of illness and improve payment accuracy, CMS began a two-year phase-in of Medicare severity DRGs (MS-DRGs). Compared with the prior DRGs, the MS-DRGs distinguish very costly cases with major complications or comorbidities. Many base DRGs—types of conditions or procedures—are split into 3 MS-DRGs instead of two DRGs under the old system. In addition, CMS thoroughly revised the lists of secondary diagnoses that qualify as a complication or comorbidity (CC) or major CC (MCC).

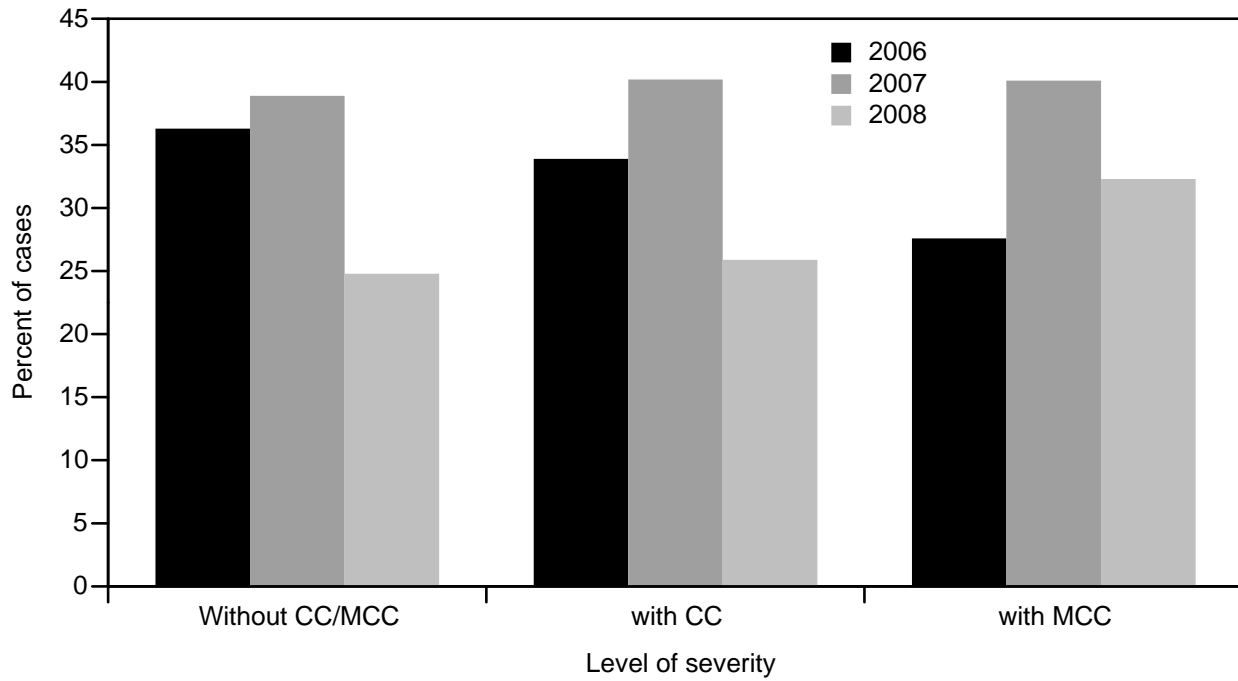
These changes created more patient categories and greater differentiation in the relative weights and payment rates among cases with and without CCs or MCCs. These changes also created financial incentives and opportunities to document and code diagnoses more carefully and completely because hospitals would receive higher payments if their cases with qualifying CCs and MCCs were reported accurately.

Changes in documentation and coding result in more patients with CCs and MCCs

When hospitals respond to the incentives for documentation and coding improvement (DCI) in the new MS-DRGs, they change the way they document and code diagnoses. Generally, these changes shift cases from lower severity and cost MS-DRGs to higher severity and cost groups within the same base DRG. We conducted an analysis to see how cases within each base DRG shifted among the two or three component MS-DRGs between 2006 and 2008. The objective was to understand how DCI affects case mix and also whether the effect was focused in a few common base DRGs or was widespread and consistent across all base DRGs.

Figure 1 shows the pattern for all base DRGs that are split 3 ways. The share of cases without a CC or MCC declined more than 6 percentage points in 2008, while the share of cases with a MCC increased by more than 6 percentage points. This figure includes 152 base DRGs that accounted for 54 percent of all cases in 2008. When we looked at all 289 base DRGs that are split in some fashion based on secondary diagnoses, we found that all but three reflect essentially the same pattern of large shifts in 2008 toward the highest severity and cost MS-DRG and away from the lowest severity or cost MS-DRG. In 124 of these base DRGs, the shift in the share of cases toward the highest weighted MS-DRG was at least 5 percentage points.

Figure 1. Increased coding of major complications in 2008



Source: MedPAC analysis of Medicare fee-for-service claims from IPPS hospitals in proposed rule MedPAR files (December updates) for fiscal years 2006-2008 from CMS.