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MEDICARE FACT SHEET

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MEDICARE'S FY 2012 HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE

UNDERSTANDING THE DOCUMENTATION AND CODING ADJUSTMENT

OVERVIEW: On April 19, 2011, the Centers for Medicare & Medicaid Services (CMS) announced a proposed rule that would update Medicare policies and payment rates for inpatient services furnished by both acute care hospitals and long-term care hospitals in fiscal year (FY) 2012. Under the proposed rule, CMS projects that Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 would decrease by a projected $498 million or 0.5 percent in FY 2012 relative to FY 2011. This reflects a hospital update of 1.5 percent (based on a projected increase of 2.8 percent for inflation in hospital costs, reduced a multi-factor productivity adjustment of 1.2 percent and an additional 0.1 percent in accordance with the Affordable Care Act), increased by 1.1 percent in response to litigation, as well as a -3.15 percent documentation and coding adjustment. This documentation and coding adjustment is intended to remove the effect of increased aggregate payments in FY 2008 and 2009 due to changes in hospital coding practices that did not reflect increases in patients' severity of illness. Under legislation passed in 2007, CMS is required to prospectively adjust hospital rates so that they do not continue to reflect the excess FY 2008 and FY 2009 payments. In addition, the legislation requires CMS to recoup the entire amount of FY 2008 and 2009 excess payments no later than FY 2012. CMS is requesting public comment on the proposed rule.

BACKGROUND: Since FY 1983, Medicare Part A has paid acute care hospitals for inpatient stays under the IPPS, which provides for a single prospectively-determined payment for each case based on the patient's diagnosis, or, in a few instances, the technology used in treating the patient. In FY 2003, Medicare began paying LTCHs under the LTCH PPS, which used the same patient classifications as the IPPS, but weighted them differently to reflect the different resources

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and higher treatment costs typically associated with long-term care hospital stays.

Under both the IPPS and the LTCH PPS, the payment amount is based on the average costs incurred by the hospital in treating a patient with a specific diagnosis. In rare cases, where the costs of treatment greatly exceed Medicare's payment rate, the hospital may be entitled to an additional payment, called an outlier payment. Medicare pays separately under the Part B Medicare Physician Fee Schedule for services of physicians and non-physician practitioners

From FY 1983 through FY 2007, payments to acute care hospitals were made using the Diagnosis Related Group (DRG) classifications, but over time, CMS discovered that the classification structure needed greater specificity to ensure that hospitals were paid more for more severely ill patients who are more costly to treat relative to less severely ill patients with the same principal diagnosis. In FY 2008, CMS replaced the 538 DRGs with 745 new Medicare Severity DRGs (MS-DRGs) that reflected not just the patient's diagnosis, but also the severity of the patient's illness.

BUDGET NEUTRALITY AND THE NEW CLASSIFICATIONS: As explained in the final IPPS rule for FY 2008, CMS anticipated the effect of documentation and coding practices resulting in higher payments that do not reflect real changes in case mix by finalizing adjustments to inpatient rates by -1.2 percent in FY 2009 and -1.8 percent in FY 2009 and 2010. These adjustments were intended to maintain budget neutrality, as permitted under the Medicare statute. As explained in the FY 2008 and FY 2009 IPPS final rules, CMS planned to revise the FY 2010 adjustment if a review of actual data for FY 2008 indicated that the effect of documentation and coding were differed from the documentation and coding adjustments applied in FY 2008 and FY 2009.

Hospitals believed that the adjustments CMS made in the FY 2008 IPPS final rule overestimated the impact of the documentation and coding effect. In the Transitional Medical Assistance, Abstinence Education, and QI Programs Extension Act of 2007 (TMA), Congress required CMS to reduce the adjustments to -0.6 percent for FY 2008 and -0.9 percent for FY 2009. The TMA required that, if CMS determines that implementation of the MS-DRG system resulted in changes in documentation and coding during FY 2008 and FY 2009 that are different than the adjustments required by the TMA, additional adjustments must be made to reconcile the difference in payment for these years. These recoupment adjustments are required to be made by FY 2012. The Medicare Actuary determined that a total adjustment of -5.8 percent was required to recoup total excess spending due to documentation and coding in FYs 2008 and 2009. In FY 2011, CMS applied an adjustment of -2.9 percent to recoup one-half of the 5.8 percent increase in FY 2008 and 2009 aggregate payment due to changes in hospital coding practices that did not reflect increases in patients' severity of illness.

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Further, the TMA required adjustments to IPPS rates going forward—called prospective adjustments—so that these excess payments are not permanently incorporated into future inpatient payment rates. The Medicare Actuary estimates that the cumulative effect of documentation and coding increased spending by 5.4 percent. CMS has already applied a -0.6 percent adjustment in FY 2008 and a -0.9 percent adjustment in FY 2009 (for a total -1.5 percent adjustment). Therefore, a prospective adjustment of -3.9 percent is required to ensure that future rates do not continue to incorporate past overpayments due to documentation and coding.

PROPOSED ADJUSTMENT FOR FY 2012: CMS is now proposing to complete the recoupment of the excess FY 2008 and FY 2009 spending that was initiated in FY 2011. As explained above, CMS applied an adjustment of -2.9 percent in FY 2011 to recoup one-half of the 5.8 percent increase in FY 2008 and 2009 aggregate payment due to changes in hospital coding practices that did not reflect increases in patients' severity of illness. The recoupment adjustments are not permanent adjustments to hospital rates; therefore, the FY 2011 adjustment must be restored to FY 2012 IPPS rates to prevent this recoupment from continuing. Thus, CMS is proposing to complete the recoupment adjustment by implementing the remaining -2.9 percent adjustment, in addition to removing the effect of the -2.9 percent adjustment finalized for FY 2011. Because these adjustments will, in effect, balance out, there will be no year-to-year change in the standardized amount due to this recoupment adjustment.

Additionally, CMS is now proposing to make a prospective adjustment of -3.15 percent for FY 2012 to remove much of the effect of increased aggregate payments in FY 2008 and 2009 due to changes in hospital coding practices that did not reflect increases in patients' severity of illness. Although CMS has the authority to make the full prospective adjustment of -3.9 percent to the FY 2012 rates, CMS believes it is prudent to phase-in the prospective adjustment in order to mitigate the effects of significant downward adjustments on hospital. CMS is requesting public comment on its proposal.

CMS is also proposing to make a prospective documentation and coding adjustment of -2.5 percent to the hospital specific rates for Medicare Dependent Hospitals and Sole Community Hospitals and -1 percent to the capital Federal rate applicable to all hospitals for FY 2012 to account for the estimated increase in payments that has occurred due to the adoption of the MS-DRGs. These complete the prospective adjustments for documentation and coding due to the MS-DRGs for hospital specific rates and the capital Federal rates. CMS is not proposing a documentation and coding adjustment for LTCHs because based on an analysis of most recent available data, it does not appear that an adjustment for the effect of documentation and coding in FY 2010 is warranted.

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The proposed rule was placed on display at the Federal Register today, and can be found under Special Filings at:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

CMS will accept comments on the proposed rule until June 20, and will respond to comments in a final rule to be issued no later Aug. 1, 2011.

For more information, please see:

www.cms.gov/AcuteInpatientPPS/01_overview.asp.

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