SAMPLE COMMENT LETTER

[DATE – DUE BY APRIL 4, 2003]

The Honorable Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS –1243-P; P.O. Box 8010
Baltimore, MD 21244-8010

Re: CMS-1243-P — Medicare Program; Proposed Changes in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System; Proposed Rule *(68 Federal Register 10420*).

Dear Administrator Scully:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule with changes to the methodology for determining Medicare outlier payments, published March 5, 2003 in the *Federal Register*. I am the [TITLE] of [Hospital/Health System Name and brief description of hospital/system.]

We are concerned by significant revisions to the outlier policy, and the potential negative impact they will have on the entire hospital community. While we agree with your recommendations to eliminate use of the statewide average and to use more updated cost-to-charge ratios, your proposal to reconcile outlier payments through settled cost reports for all hospitals is duplicative and unnecessary. Additionally, we are troubled that the outlier threshold has not been appropriately lowered, and that a transition has not been provided for those hospitals adversely affected by the regulation.

Outlier payments are a critical and necessary component of any prospective payment system (PPS) based on averages. They were created by Congress to limit hospitals' financial risk while ensuring that elderly patients with especially serious illnesses receive appropriate care. The outlier payment provision is tremendously complex, based on historical data and facility-specific cost-to-charge ratios. While we support changes to the current system in order to ensure the accuracy of outlier payments, we are concerned that certain elements of CMS' proposal will have negative consequences on the overall payment system.

Updating Cost-to-Charge Ratios

The proposed rule would implement a number of provisions to ensure that more accurate and timely data is used to calculate hospitals' cost-to-charge ratio, and thus outlier payments. Most importantly, CMS proposes to use cost-to-charge ratios from hospitals' most recent *tentatively* settled cost report, rather than wait to obtain it from hospitals' *final* settled audited cost report. This should decrease the lag time of cost-to-charge ratios from approximately three to five years, to approximately eight to 20 months. In addition, CMS is proposing to allow hospitals and fiscal intermediaries to alter even the tentatively settled cost-to-charge ratio if data show reason to do so. Using more recent cost-to-charge ratios will dramatically improve the accuracy of outlier payments in the inpatient prospective payment system. We are concerned, however, that the immediate change from using hospitals' final settled cost-to-charge ratios to more current, tentatively settled cost-to-charge ratios may create dramatic and unanticipated changes in outlier payments for providers, and thus we recommend a transition period (see below).

Cost-Settlement

We strongly believe that use of more recent cost-to-charge ratios is sufficient to determine appropriate outlier payments, and that a retrospective, cost settlement process for all hospitals as proposed by CMS is not necessary.

Outlier payments are made on a claim-by-claim basis, and are determined based on the estimated costs and charges for each bill processed. The proposed rule would require individual claims to be processed twice over several years as the Medicare cost reports are settled. Given that a hospital's cost-to-charge ratio is likely to increase or decrease upon final settlement of the Medicare cost report, each claim would need to be reprocessed to determine *if* it still qualifies for an outlier payment (or if a new claim now qualifies), and *how much* the payment should be. This would lead to further unpredictability and volatility in the Medicare payment system, and would have serious implications for cost-report simplification. It would mean that outlier payments would no longer be part of a *prospective* payment system but rather would be *retrospective* and cost-based – the direct opposite of the intent of Medicare legislation.

Reconciling outlier payments through settled cost reports is a fundamental policy change, and it is unclear whether CMS will be able to adopt the procedural changes necessary to implement this provision. **Therefore, we urge CMS to use the mechanisms outlined above to ensure appropriate accountability of the payment system and not require cost settlement for the purpose of making outlier payments.**

Statewide Average

The proposed rule would also eliminate use of the statewide average cost-to-charge ratio floor. Currently, hospitals with cost-to-charge ratios that fall outside of an acceptable range have their hospital-specific cost-to-charge ratio changed to the average urban or rural cost-to-charge ratio for their state. This policy, adopted in 1989, resulted in

significant adjustments to the cost-to-charge ratios for certain hospitals. We agree that the statewide average should be eliminated. However, we are concerned about the potential impact this adjustment could have on some providers, as it could result in significant reductions in Medicare payments to hospitals that have budgeted for, and are operating under the current rules of the Medicare program, and thus recommend a transition period (see below).

Threshold

We are disappointed that CMS has chosen to ignore the premise that using more updated cost-to-charge ratios and eliminating the use of the statewide average should result in a lowering of the outlier threshold. In 2003, the threshold increased approximately 60 percent, from $21,025 to $33,650. This steep rise makes it extremely difficult for hospitals to qualify for outlier payments and puts them at greater risk when treating high-cost cases. Given that the 2003 threshold was calculated to equal 5.1 percent of total DRG payments based on policies in place at the beginning of the year, major mid-year changes suggested by CMS should, by definition, result in a new threshold amount. **We strongly urge CMS to lower the outlier threshold to ensure that all hospitals have access to these special payments to cover extremely high-cost Medicare patients.**

Transition

The policy changes in the outlier proposed rule are of such magnitude that they require a transition for those hospitals adversely effected. Historically, CMS has provided a transition period for major changes – such as transitioning towards the capital PPS, removing graduate medical education salaries in the calculation of the inpatient PPS wage index, and implementing transitional corridor payments and hold harmless payments under outpatient PPS. A steep drop in expected payments for outlier cases could be financially devastating to providers, especially given increased pressures of workforce shortages, skyrocketing labor costs, rising pharmaceutical and technology costs, and soaring medical liability premiums. Additionally, these policies would be mid-year changes, without any information provided regarding financial impact and without a full 60-day comment period for providers to respond. **We encourage CMS to implement a transition period to protect those providers harmed by such significant changes in the regulation.**

Thank you for your review and consideration of these comments. If you have any questions, please feel free to contact [insert contact information].

Sincerely,