

Regulatory Advisory



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Proposed Changes to Medicare Inpatient PPS: Outlier Payments

A Message to AHA Members:

The Centers for Medicare & Medicaid Services (CMS) published in the March 5 *Federal Register* a proposed rule with changes to the methodology for determining payment for extraordinarily high-cost cases (outliers) under the hospital inpatient prospective payment system (PPS). **The regulation proposes major revisions to outlier payment policy, and some changes, if adopted, would hurt every hospital that receives outlier payments, not just those with significant outlier experience.** The AHA is working hard to significantly change this proposed rule. We will be submitting a detailed comment letter to CMS Administrator Thomas Scully by the April 4 deadline. We strongly urge you do the same. To help you, the AHA developed a sample comment letter for you to tailor to your organization. It is available at www.aha.org, under "Advocacy and Representation," then click on "Comment Letters 2003." You may e-mail your letter to us at outliers@aha.org, and we will hand-deliver it directly to CMS before the deadline. If you e-mail us your letter for delivery, be sure to insert your electronic signature.

Key Aspects of the Proposed Rule

- **CMS proposes using more recent hospital cost-to-charge ratios to calculate outlier payments.** Rather than using information from a hospital's final settled cost report, CMS would use data from a hospital's tentatively settled cost report. Given that many hospitals' final settled cost reports are from 1999 or even earlier, the change in cost-to-charge ratios could be substantial. While we support using more recent data to improve the accuracy of outlier payments, we are concerned that an immediate change in cost-to-charge ratios would create significant and unanticipated reductions in outlier payments to providers.
- **The rule would eliminate the use of the statewide average cost-to-charge ratio floor.** The statewide average ratio is used for those hospitals whose cost-to-charge ratio falls outside of an acceptable range, mainly because of poor data. While we support changes in use of the statewide average, this provision also would result in a steep drop in expected payments for outlier cases.

These two proposed changes, if adopted, could be financially devastating to providers, especially given increased pressures of skyrocketing labor costs, rising pharmaceutical and technology costs, soaring medical liability premiums, state budget crises, and increases in the number of uninsured Americans. **The AHA will strongly urge CMS to implement a transition period for hospitals adversely affected by these policy changes.**

- **We are troubled that CMS did not lower the outlier threshold, which would allow more hospitals to qualify for outlier payments.** Last year, the threshold increased approximately 60 percent, from \$21,025 to \$33,650, placing hospitals at even greater risk when treating high-cost cases by making it more difficult for them to qualify for outlier payments. Given that the 2003

threshold was calculated to equal 5.1 percent of total inpatient PPS payments based on policies in place at the beginning of the year, major mid-year changes, such as updating the cost-to-charge ratios and eliminating the use of the statewide average floor, should, by definition, result in a lower threshold amount. **The AHA will push for CMS to lower the outlier threshold.** We are working to determine what the correct level should be, and we will provide this information to CMS in our detailed comments.

- **In a fundamental policy change, CMS is proposing that outlier payments be subject to a new cost settlement process on a retrospective basis for ALL hospitals.** This policy would require that inpatient claims be reprocessed upon final settlement of the Medicare cost report to determine if each claim still qualifies for an outlier payment and how much the payment should be. Hospitals would be required to pay back any excess payments - and this may be three to five years after the time of service.

Outlier payments help mitigate the financial burden hospitals incur in caring for the most costly cases. At the same time, it is important to remember that hospitals still lose money treating Medicare's sickest, outlier patients. Under this proposed policy, all hospitals would still receive less than the cost of care for outlier patients

CMS' other proposed provisions to use more current cost-to-charge ratios will ensure the accuracy and integrity of Medicare payments. The proposed adjustment of outlier payments upon final settlement of the cost report is duplicative and undermines the PPS - jeopardizing the predictability and stability of the system. While we support an accurate accounting of costs, CMS' proposal goes far beyond an acceptable policy option. It imposes more red tape and is a duplicative accountability process that would divert resources away from patient care to unproductive paperwork. The AHA is adamantly opposed to this proposal.

After reviewing this advisory, check off the following items from your to-do list:

- ✓ Share this advisory with your chief financial officer.
- ✓ Determine how changes in the rule will impact your organization's ability to qualify for outlier payments and its corresponding impact on your FY 2003 Medicare revenue.
- ✓ Compare your cost-to-charge ratios from your most recent final settled cost report to your most recent tentatively settled cost report. A substantial change in this number would result in substantial changes in your outlier payments.
- ✓ **Submit comments to CMS before the April 4 deadline.** Feel free to use the AHA's sample comment letter as a guide.

Outlier payments are a critical and necessary component of a prospective payment system based on averages. The AHA will continue to work to obtain adequate Medicare payment for hospitals so that you have the resources you need to care for your communities.

Sincerely,

Rick Pollack
Executive Vice President

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Background

On March 5, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule with changes to the methodology for determining payment for extraordinarily high-cost cases (outliers) under the Medicare hospital inpatient prospective payment system (PPS). The revisions will not just affect a small number of hospitals with significant outlier experience, but rather, every hospital that receives outlier payments.

The regulation is available at:

www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/register/afedregister.html.

We urge all hospitals to weigh-in with CMS on this proposed rule. Comments are due by Friday, April 4, at 5 p.m. ET. If you prefer, you may e-mail your letter to us at outliers@aha.org, and we will hand-carry it directly to CMS before the deadline. The AHA also has developed a sample comment letter for members to use. It is at:

http://www.hospitalconnect.com/authorize?page=/aha/members_only/member/030312samcommentlet.html. If you e-mail us your letter for delivery, be sure to insert your electronic signature.

Outlier Payment Methodology

When the Medicare program moved from a cost-based reimbursement to a PPS, Congress created additional payments to protect hospitals from large financial losses due to unusually expensive cases. Given that a hospital's actual cost may vary significantly from the average diagnosis-related group (DRG) payment, outlier payments were established to limit hospitals' financial risk while ensuring that elderly patients with especially serious illnesses received appropriate care¹. These payments are budget neutral, and are funded by reducing the base inpatient PPS payment amount by between 5 percent and 6 percent. Yet despite this target amount, actual outlier payments in any given year may be higher or lower than anticipated.

Currently, hospitals qualify for outlier payments when the cost of a case exceeds Medicare payments by a certain threshold. Because hospitals are unable to calculate per-case costs, fiscal intermediaries (FIs) use Medicare charges reported on a claim to estimate the cost of a patient's stay. These charges are converted to costs using a hospital-specific cost-to-charge ratio.

Currently, FIs annually compute each hospital's cost-to-charge ratio based on charges from the Provider Statistical and Reimbursement Report (PS&R) and costs from the hospital's latest

¹ In addition to DRG payments, hospitals may receive Medicare payments for indirect medical education (IME), disproportionate share hospital (DSH) and new technology.

available final settled cost report. If this cost-to-charge ratio falls outside of a set range – plus or minus three standard deviations from the geometric mean of cost-to-charge ratios for all hospitals – then the hospital is assigned the urban or rural average cost-to-charge ratio for that state.

The amount of the outlier payment is based on a marginal costs factor, which is a percentage of hospital costs above a threshold. This factor is currently set at 80 percent. In general, outlier payments equal²:

$$[(\text{Charges} \times \text{Cost/Charges}) - (\text{DRG Payment} + \text{IME} + \text{DSH} + \text{New Technology}) + \text{Fixed-Loss Threshold}] \times .80$$

The fixed loss threshold amount is calculated annually by CMS, and is prospectively set to equal the target amount for outlier payments. The target amount has historically been 5.1 percent of total operating PPS payments. For fiscal year (FY) 2003, the operating fixed-loss threshold is \$33,560, an increase of almost 60 percent from \$21,025 in FY 2002. The main reason for this dramatic increase was a change in the methodology CMS used to calculate the threshold. Rather than measure the rate of increase in costs, CMS determined that it would measure the rate of increase in charges.

This change also was made to account for the fact that the agency has underestimated the threshold amount over the past several years and thus payments exceeded the 5.1 percent target. For example, in FY 2002, CMS exceeded the targeted amount by \$1.6 billion. Payments over the target are made from the Medicare Trust Fund and represent additional money to the inpatient PPS. Since the Balanced Budget Act of 1997, outlier payments have exceeded the target by \$8.4 billion. However, it is important to note that CMS also has over estimated the fixed-loss threshold, resulting in program underpayment. Analysis over a longer time period demonstrates that the years in which CMS has paid more than projected are offset by years in which CMS has paid less than projected.

Updating Cost-to-Charge Ratios

The current outlier methodology uses old cost report data, and thus old cost-to-charge ratios, to assess current charges on a bill. Yet hospitals' costs and charges change from year-to-year. If a hospital's charges have increased faster than costs since its final settled cost report then its cost-to-charge ratio used to calculate outlier payments may be higher than actual costs. This will cause some patients to become outliers who would not otherwise be outliers, and it increases payment for those patients who are outliers.

To correct the time lag between current charges submitted on a bill and the cost-to-charge ratio taken from the most recent settled cost report, CMS proposes to allow FIs to use more up-to-date data when determining the cost-to-charge ratio for each hospital. Specifically, FIs would be permitted to use either the most recent settled cost report or the most recent *tentative* settled cost report, whichever is from the latest cost reporting period. This would potentially decrease the time lag from its current level of approximately three-to-five years using final settled cost reports to approximately eight-to-20 months using tentatively settled cost reports.

² This formula is somewhat simplified as outlier payments are determined through use of both an operating cost-to-charge ratio and a capital cost-to-charge ratio.

The AHA supports the use of more recent data in calculating hospital's cost-to-charge ratios, as it would result in more accurate outlier payments. However, initial data analysis suggests that the majority of hospitals will experience a steep decline in outlier payments due to this policy change. The AHA will strongly urge CMS to protect these hospitals by phasing in use of the new ratios (see last section, *Impact and Need for a Transition*).

In addition, the rule proposes to allow hospitals to request a change to its cost-to-charge ratio if it is able to present "substantial evidence" that the ratio used is inaccurate. The rule also would allow CMS to direct an FI to change a hospital's cost-to-charge ratio if more recent charge data indicate that a hospital's charges have been increasing at "an excessive rate" relative to the rate of increase among other hospitals. The AHA is concerned that this later provision gives CMS too much authority. We will push for parameters and guidelines to be established. At the very least, hospitals should have the opportunity to review and appeal any changes to their cost-to-charge ratios.

Statewide Averages

If a hospital's cost-to-charge ratio is very unusual, then the statewide average urban or rural cost-to-charge ratio is substituted to calculate costs, and thus outlier payments. This policy may raise or lower outlier payments substantially for hospitals. If a hospital's cost-to-charge ratio is below the determined range, then it would be raised to the statewide average and its outlier payments would increase. If its cost-to-charge ratio was above the acceptable range, then it would be lowered to the statewide average and its payments would decrease. The statewide average was adopted by CMS in FY 1989 to address its concern at the time that "ratios falling outside this range are unreasonable and are probably due to faulty data reporting or entry. Therefore, they should not be used to identify and pay cost outliers" (*Federal Register*, September 30, 1989).

CMS proposes to eliminate assigning the statewide average when a hospital has a cost-to-charge ratio that falls below the floor. Rather, outlier payments for these providers would be calculated using a hospital's actual cost-to-charge ratio. The agency maintains, however, that hospitals with cost-to-charge ratios exceeding the ceiling would continue to have their cost-to-charge ratios adjusted to the statewide average, as CMS indicates that cost-to-charge ratios at the high end are likely still due to faulty data reporting or entry. Use of statewide average cost-to-charge ratios would also be used for hospitals that have not yet filed their first Medicare cost report.

The AHA supports revisions to the use of the statewide average, but is concerned about CMS' approach to eliminating the floor but not the ceiling. More importantly, we remain concerned that this small group of hospitals will undergo an immediate and dramatic reduction in their outlier payments. The AHA will strongly urge CMS to protect these hospitals by phasing in use of the new ratios (see last section, *Impact and Need for a Transition*).

Reconciling Outlier Payments Through Settled Cost Reports

CMS is proposing to make outlier payments subject to adjustment when hospitals' cost reports are settled. This is a significant change in policy, as outlier payment determinations are currently made based on the best information available at the time a claim is processed, and the payment is not revised, upward or downward, based on updated data. It is important to note that CMS' proposal to cost settle outlier payments does not mean hospitals will receive the full cost of an outlier case. Hospitals will continue to experience substantial losses for these patients. The AHA adamantly opposes CMS' proposal to reconcile outlier payments through settled cost reports. Given the proposed changes to use more current cost-to-charge ratios, the cost

settlement proposal imposes more red tape and is a duplicative accountability process that would divert resources away from patient care to unproductive paperwork.

Under CMS' proposal, payments would need to be processed throughout the year using cost-to-charge ratios based on the best information available at the time. Many years later, when a hospital's cost report is settled, outlier payments would need to be processed once again to reconcile outlier payments based on a hospital's actual cost-to-charge ratio.

Given that a hospital's cost-to-charge ratio is likely to slightly 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. Unlike payments under IME and DSH, both of which are routinely adjusted when hospitals' cost reports are settled to reflect updated data such as the number of residents or patient days during the actual cost reporting period, outlier payments would need to be recalculated on a claim-by-claim basis – as it is not possible to determine how much outlier payments would change on an aggregate basis. The proposed rule does not provide any information on how this provision would work, except to say that it is still “assessing the procedural changes that would be necessary to implement this change.”

The AHA strongly believes that use of more recent cost-to-charge ratios and elimination of the statewide average ratio is sufficient to determine appropriate outlier payments. A retrospective, cost settlement process for all hospitals is not necessary given CMS' other proposed changes. This misguided policy would lead to further unpredictability and volatility in the Medicare payment system, and would have serious implications for cost-report simplification. 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. The AHA will strongly oppose this policy in our detailed comment letter to CMS Administrator Thomas Scully.

Fixed-loss Outlier Threshold

As indicated above, the fixed-loss threshold is set prospectively so that outlier payments equal 5.1 percent of total operating DRG payments plus outlier payments. The threshold for discharges in FY 2003 is set at \$33,560. Given CMS' proposal to use more recent cost-to-charge ratios and eliminate the statewide average floor, outlier payments would be dramatically reduced, and the threshold amount, by definition, must be lowered to reflect these re-calculations. The AHA will push CMS to lower the outlier threshold, which would allow more hospitals to qualify for outlier payments.

In the preamble of the proposed rule, CMS expresses concern that “unrestrained charge increases” may continue to occur during FY 2003, and thus may result in payments in excess of the 5.1 percent offset. It claims that public attention on this issue may have lead providers to aggressively change their charging practices. However, the preamble fails to reference the agency's December 2002 initiative directing FIs to carefully scrutinize hospital billing practices and refer those in question to the CMS Program Integrity Unit for further investigation and, if warranted, to the Office of Inspector General – a move that would halt any unjustified initiative to change one's charging practices.

CMS does indicate that it will examine the threshold once claims data for the current fiscal year become available to determine whether outlier payments to date appear to be approximately 5.1 percent of total DRG payment. The AHA will also conduct an analysis to determine the new,

appropriate threshold amount, and will strongly urge CMS to lower the threshold to this amount to ensure that all hospitals have access to these special payments to cover extremely high-cost patients.

Implementation

The agency proposes implementing the rule's changes beginning with discharges on or after the effective date of the final rule. CMS has not indicated when it anticipates issuing a final rule. The AHA will notify the field once the final rule is released.

Impact and Need for a Transition

The policy changes described above would have a significant impact on hospital outlier revenue. Although CMS fails to quantify the likely impact of the proposed changes on hospitals, it does indicate that the regulation is a major rule with economically significant effects – more than \$100 million in any one year. 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. Moreover, when hospitals moved from length of stay outliers to cost outliers, they were granted a three-year transition. Given the substantial changes contained in the proposed outlier rule and the negative impact it will have on more than half of hospitals across the nation, the AHA will insist that a transition period be implemented to protect those providers harmed.