

HEALTH CARE COMPLIANCE ADVISER

Medicare Outlier Payments

A number of Medicare reimbursement consultants are reportedly advising hospitals to increase routine inpatient charges (*i.e.*, charges for room, board, and nursing) as a means of obtaining increased Medicare “outlier” reimbursement. Under the current regulatory system for inpatient outlier payments, a hospital can unilaterally affect the amount of outlier payments it receives by adjusting its charges. A hospital that increases its charges from one year to the next will also increase the outlier payments it receives. Hospitals should carefully consider a number of issues before pursuing such a reimbursement strategy.

Medicare Outlier Payment System

In general, Medicare reimburses hospital inpatient services under a prospective payment system (“PPS”), paying a predetermined amount for each inpatient discharge. The amount varies according to the diagnosis-related group (“DRG”) to which the inpatient is assigned, as well as certain characteristics of the hospital (*e.g.*, teaching hospitals receive certain medical education payments; hospitals that admit a large percentage of low-income patients receive disproportionate share payments). When it created inpatient PPS, Congress was concerned about reimbursement of cases whose costs far exceed the costs of typical cases within that DRG. As a result, Congress created a system for “outlier” payments (in addition to the prospective payments) to defray some of the expenses in caring for the most costly cases.

Currently, hospitals qualify for outlier payments when the hospital’s charges (adjusted by the hospital’s

cost-to-charge ratio) exceed a certain threshold amount. The outlier payment for a given inpatient equals 80 percent of difference between the hospital’s charges, adjusted by the hospital’s cost-to-charge ratio, and the sum of the DRG, IME, and DSH payments plus a threshold amount set annually by the Centers for Medicare and Medicaid Services (“CMS”). The outlier payment regulation can be expressed by the following algebraic formula:

$$\text{Outlier Payment} = (.80) \times [(\text{charges} \times \text{cost/charge ratio}) - (\text{DRG} + \text{IME} + \text{DSH} + \text{threshold})].^1$$

Where:

Charges = Hospital’s actual charges for services provided to the patient

Cost/Charge ratio = Cost-to-charge ratio derived from most recent settled Medicare cost report

DRG = Standard DRG payment

IME = Indirect medical education payment

DSH = Disproportionate share payment

Threshold = Annual threshold set by CMS (\$33,560 in fiscal year 2003)

Raising Charges Leads to Increased Outlier Payments

As noted, the purpose behind outlier reimbursement is to defray a portion of the expenses incurred in caring for the most costly patients to treat. To derive the costs of treatment, the outlier formula multiplies the hospital’s actual charges by the hospital’s cost-to-charge ratio. The cost-to-charge ratio used to calculate outlier reimbursement, however, is taken from the most recent settled cost report. Accordingly, if a hospital abruptly increases its charges by a substantial amount,

¹ See 42 C.F.R. §§ 412.80 & 412.84. The formula is somewhat simplified, as the outlier payment amount actually involves application of separate cost-to-charge ratios for operating costs and capital costs.

the charge structure used to derive the hospital's cost-to-charge ratio would lag behind the current charge structure. Therefore, since the cost-to-charge ratio is based on cost reports that are typically three years old, rather than up-to-date cost-to-charge ratio data, a hospital can obtain increased outlier payments merely by increasing charges.² A charge increase will cause some patients to become outliers who would not otherwise be outliers; it will also increase the payment for patients who would have been outliers anyway.

Very substantial increases in charges can increase outlier payments in another way. According to CMS' outlier regulation, if a hospital's cost-to-charge ratio falls very low (more than three standard deviations below the mean of the log distribution of cost-to-charge ratios for all hospitals in the country), then the statewide average cost-to-charge ratio is used to calculate outlier payments instead of the hospital-specific ratio. In these circumstances, the statewide average cost-to-charge ratio will be considerably higher than the hospital-specific cost-to-charge ratio and will lead to dramatically increased outlier payments.³ HCFA's rationale for having the statewide average cost-to-charge ratio apply is that a hospital's cost and charge data must be flawed if its cost-to-charge ratio turns out to be so far above or below the national norm.⁴ We understand that some consultants have encouraged hospitals to increase their charges so much that the hospital's cost-to-charge ratio will drop low enough that the statewide cost-to-charge ratio will be used, resulting in increased outlier payments.

The fact that hospitals have an incentive to increase charges solely to generate additional outlier payments

has repeatedly been brought to the attention of HCFA/CMS. In 1988, HCFA received comments that its proposed regulation on outlier reimbursement would give hospitals the incentive to increase charges to obtain additional outlier payments. HCFA responded that a number of factors would mitigate those incentives, including: (1) private market forces would constrain increases in charges, (2) outlier reimbursement considerations would induce hospitals to want to have a higher cost-to-charge ratio and therefore serve as a disincentive to increase charges, and (3) some states' laws limit a hospital's ability to raise charges.⁵ HCFA's 1988 response also reflected the agency's understanding that there are no federal regulations limiting what a hospital can charge. The concern that the outlier reimbursement system gave hospitals incentives to increase charges was again considered and rejected by CMS at times since 1988, most recently in connection with the annual updates to Medicare inpatient reimbursement for fiscal year 2003.⁶

CMS has noted, however, that hospital charges have increased over the past several years more rapidly than CMS expected, and outlier payments have been substantially higher than CMS had expected. In response, CMS has dramatically boosted the outlier threshold since fiscal year 2000, including a 59.6 percent increase for fiscal year 2003.⁷ Even these increases in the outlier threshold were not enough to counteract increases in hospital charges. Because CMS did not anticipate sufficiently annual increases in hospital charges, CMS paid \$1.5 billion more in outlier payments in 2002 than it had projected, and \$8.5 billion more in outlier payments since 1997 than it had projected.⁸

2 Fiscal intermediaries are supposed to update cost-to-charge ratios as they settle cost reports "... to ensure that the ratios used to calculate cost outlier payments are as up to date as possible." 42 C.F.R. §§ 412.80(a)(2) & 412.84(h); 53 Fed. Reg. at 38507 (Sept. 30, 1988).

3 See *OIG, Review of Hospital Outlier Payments Under the Medicare Program— Blue Cross of Rhode Island*, No. A-01-94-00519 (March 1995) (analyzing reimbursement consequences where fiscal intermediary erroneously applied statewide cost-to-charge ratio to every hospital in the state).

4 See 53 Fed. Reg. at 38507-08 (Sept. 30, 1988).

5 See 53 Fed. Reg. at 38509 (Sept. 30, 1988).

6 See 59 Fed. Reg. at 45,407 (Sept. 1, 1994); 67 Fed. Reg. at 50,123 (Aug. 1, 2002).

7 The outlier thresholds set by CMS since fiscal year 2000 reflect CMS' response to increases in hospital charges, and are as follows: \$14,050 in 2000; \$17,550 in 2001; \$21,025 in 2002; \$33,560 in 2003. See 67 Fed. Reg. at 50,124 (Aug. 1, 2002).

8 See 67 Fed. Reg. at 50,123 (Aug. 1, 2002).

Increased Attention of Regulators Expected

The government can be expected to intensify its examination of reimbursement policies related to outliers and to review payments to hospitals. In fact, the Office of Inspector General of the U.S. Department of Health and Human Services (“OIG”) has included audits of inpatient outlier payments in its 2000, 2001, and 2002 Work Plans. Additionally, since December 2001, the OIG has released three audits of different hospitals’ outlier payments.⁹ These audits have concerned whether hospitals possessed physicians’ orders and other documentation to support the various services included on inpatient claims. The OIG’s audits have not concerned the issue of whether the amount of charges were themselves appropriate, possibly due to a lack of legal standards concerning how hospitals are to set charges. The issue of outlier payments has recently also drawn the attention of the press and private investors concerned about hospital reliance on outlier payments as a source of revenue.¹⁰

Conclusions

The Medicare outlier payment system contains recognized weaknesses. Although HCFA/CMS has been put on notice of these regulatory flaws since it promulgated the outlier regulations in 1988, it has not taken any action to revise outlier payment policies. Hospitals should exercise caution, however, before following the advice of consultants to increase charges to obtain greater outlier payments. Experience over the past decade has shown that the government often treats providers who benefit from defects in the Medicare program as having defrauded Medicare. The government all too often fails to implement a regulatory

solution at the time that problems with the Medicare regulations are raised, and then later accuses providers of fraud. This history could repeat itself in the context of Medicare outliers.

Further Information

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⁹ See OIG, *Review of Medicare Outlier Payments at Brigham & Women’s Hospital for Fiscal Year 1999*, No. A-01-01-00516 (Dec. 7, 2001); OIG, *Review of Medicare Outlier Payments at Rhode Island Hospital for Fiscal Year 1999*, No. A-01-01-00527 (Feb. 27, 2002); OIG, *Review of Medicare Outlier Payments at Bridgeport Hospital for Fiscal Year 1999*, No. A-01-01-00515 (Mar. 14, 2002).

¹⁰ See “Tenet Healthcare Shares Drop Amid Investigation of Doctors,” *The Wall Street Journal* (Nov. 1, 2002).