CMS Issues Revised Outlier Payment Policy

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The Centers for Medicare & Medicaid Services (CMS) published a final rule in the June 9, 2003 Federal Register as expected, revising the methodology for determining outlier payments under the Medicare program. This final rule applies to both acute care hospitals subject to the Inpatient Prospective Payment System (IPPS) and also long-term care hospitals subject to the Long-Term Care Hospital Prospective Payment System (LTCH PPS). This article will focus on the impact related to the IPPS due to the limited number of hospitals subject to the LTCH PPS as well as the fact that the revised outlier payment methodology is pretty similar when the two PPS outlier methodologies are compared.

CMS first began considering revising the outlier payment policy in November 2002 after determining that a large publicly traded hospital company was receiving what CMS considered to be an inappropriately high level of outlier payments. This led to an investigation of a number of hospitals that had been receiving very high outlier payments. In December 2002, CMS issued two Program Memorandums (PMs) that instructed fiscal intermediaries (FIs) to analyze Medicare outlier payments for the purpose of identifying hospitals with high outlier payments. CMS also provided instructions for the FIs to perform field audits and medical reviews of the hospitals that had been identified. This process is currently ongoing.

Looking back, it’s interesting to note that CMS first provided some evidence that there was concern regarding Medicare outlier payments under the IPPS in the Federal Fiscal Year (FFY) 2003 IPPS final rule that was published in the Federal Register on August 1, 2002. Within that final rule, CMS noted that there was a change in determining the fixed-loss outlier threshold, which is used to determine the amount of an outlier payment.
This change, while subtle, was quite significant. CMS changed how the fixed-loss outlier threshold was computed for FFY 2003 by updating the FFY 2002 fixed-loss outlier threshold by the increase in the rate of charges per case submitted by hospitals from FFY 1999 to FFY 2001. Previously, CMS had computed this update based on the increase in costs from submitted Medicare cost reports.

The fixed-loss outlier threshold had increased from $9,700 in FFY 1997 to $21,025 in FFY 2002. Then in FFY 2003, it jumped to $33,560 and is $50,645 in the proposed FFY 2004 IPPS. This analysis started the ball rolling and led to the situation hospitals currently have to deal with today.

**Concerns regarding outlier payment policy**

CMS was concerned with what they considered to be two major vulnerabilities in the outlier payment policy:

1. There was a significant time lag between the Cost-to-Charge Ratios (CCRs) from the latest settled Medicare cost report, which are used to determine current outlier payments, and current charges, which are also used to determine outlier payments. The concern was that since charges were on average increasing much faster than costs, the CCR used to determine outlier payments was overstated in many cases, and therefore, inaccurate.

2. The use of statewide average CCRs, as opposed to hospital specific CCRs, provided hospitals with an opportunity to receive very high levels of outlier payments by significantly increasing charges so that the hospital qualified for use of the statewide average CCR. The statewide average CCRs are significantly higher in these cases than the hospital specific CCR, which had fallen below the CMS floor of 0.194. This also resulted in overstated and inaccurate outlier payments.

With this, CMS began moving towards revising the Medicare program’s IPPS outlier payment methodology. Some additional analysis of the data seems to support
CMS’ contentions. Outlier payments are defined under Section 1886 of the Social Security Act (SSA) and are to be not less than five percent and not more than 6 percent of total estimated operating DRG payments plus outlier payments. However, the last year that actual outlier payments fell within this range was in 1997 when they came in at 5.5 percent. In 1998, actual outlier payments were equal to 6.5 percent and steadily increased through 2002 to a level of 7.9 percent.

June 9, 2003 final rule
The final rule revising CMS outlier payment policy was published in the June 9, 2003 Federal Register. This followed the proposed rule which was published in the March 5, 2003 Federal Register and provided for a 30 day comment period. Thomas Scully, CMS Administrator, had originally indicated that the revised outlier policy would be implemented immediately upon publication in the Federal Register, without going through the required notice and comment rulemaking process. This wound up not being the case, presumably to eliminate the likelihood that hospitals would attempt to invalidate the final rule through a legal challenge.

CMS noted in the final rule that they had received 582 comments on the IPPS proposed rule, which they addressed in the final rule. The effective date of the final rule is 60 days after publication, or August 8, 2003. However, there is still a significant amount of uncertainty regarding the implementation of the final rule’s provisions as evidenced by numerous referrals within the final rule to upcoming PMs that will instruct FIs on how to implement these provisions of the final rule.

There were three significant revisions to the CMS outlier payment policy that are discussed in great detail in the final rule:

1. CMS may direct the FI to change a hospital’s operating and capital CCR if evidence indicates that a hospital’s charges have been increasing at an excessive rate. Also, CCRs used to compute outlier payments will be based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the
latest cost reporting period.

2. CMS will remove the existing requirement that a FI will assign a hospital the statewide average CCR when the hospital specific CCR falls below the established floor.

3. Outlier payments will become subject to FI reconciliation based on an updated CCR using the settled cost report for the year which coincides with the discharge for which the outlier payment was computed. Additionally, for hospitals undergoing the reconciliation process, an adjustment to account for the time value of money will also be applied.

CMS also stated in the final rule that they will maintain the current fixed-loss outlier threshold of $33,560 for the remainder of 2003, as well as the marginal cost factor at the current 80 percent, even though CMS believes it does have the authority to change these amounts.

**Analysis of the final rule**
The first significant revision to the outlier payment policy will result in a more accurately computed outlier payment by matching the discharges resulting in outlier payments with the CCRs from the same cost reporting period through the use of tentative settled cost reports instead of solely relying on the most recent settled cost report. Due to the fact that many hospitals file their cost reports within the required time period, five months after the end of the hospital’s fiscal year, but do not receive final settlement on these cost reports until sometimes three or four years later, a much more current CCR will be used to compute outlier payments. This provision will become effective for discharges occurring on or after October 1, 2003.

The fact that CMS may direct an FI to change the CCR used to compute outlier payments if evidence indicates that charges have been increasing at an excessive rate appears to be somewhat subjective absent the final instructions regarding how this will be evaluated. In addition, there also appears to be a significant burden placed on the hospital to support any request from the hospital for the FI to update the CCR in the hospital’s favor. CMS is requiring the hospital to provide
“substantial evidence” to the FI, without any further guidance as to what that may include. Additionally, before any change can go into effect, the CMS Regional Office must also approve any request forwarded by a FI.

The second significant revision which relates to the elimination of the assignment of statewide average CCRs for hospitals whose CCR falls below three standard deviations from the mean as computed by CMS will result in a more level playing field as all hospitals will now have their outlier payments computed using a hospital specific CCR, whatever that may be.

Based on CMS data, there are 43 hospitals that were assigned the statewide average operating CCR and 14 hospitals that were assigned the statewide average capital CCR, with 3 hospitals being on both lists. These hospitals will be almost immediately affected as this revision will go into effect 60 days after the date of publication of the final rule, or August 8, 2003 with no transition period. On the other hand though, CMS is not eliminating the ceiling for cases in which a hospital's CCR exceeds the mean by over three standard deviations.

It would seem fair to eliminate both the provisions for the floor and the ceiling, however, CMS is probably correct in stating that any hospital with a CCR exceeding the ceiling may be using faulty data. Additionally, there will probably be very few hospitals that fall into this bucket. New hospitals will continue to be assigned the statewide average until they have sufficient data to determine an accurate CCR, which may be their first tentative settled cost report.

The most contentious of the revisions to the outlier payment policy relates to the reconciliation requirement because as several commenters on the final rule argued, CMS is incorporating retroactive provisions into the IPPS, which is in direct conflict with the premise of a prospective payment system. This new CMS position also is in conflict with recent litigation regarding outliers, during which CMS argued that outliers should not include any retroactive provisions because that conflicts with the purpose of the IPPS. It must be nice to be able to change policy positions solely when it is convenient to do so.
The reconciliation provision will require re-computing outlier payments by FIs during the cost report settlement process using the CCR from the settled cost report to compute outlier cases from this cost report year.

Additionally, CMS feels that it is necessary to include an adjustment to estimate an interest charge, or what CMS refers to as an adjustment to reflect the time value of money, to offset the interest free loan that a hospital is receiving when charges are increased dramatically resulting in excessive outlier payments. This adjustment will be based on both under and overpayments and will reflect the use of a widely available index to estimate the interest rate that will be provided by CMS and applied from the mid-point of a cost reporting period.

**Conclusion**

As expected, a final rule will soon be effective, revising Medicare’s outlier payment policy. There will be a number of hospitals across the country that will suffer a significant decrease to their Medicare reimbursement due to the implementation of this final rule. That impact will be felt almost immediately as CMS has not provided for any transition period for the implementation of the revised outlier policy despite some fairly strong protests from the hospital industry.

Also remaining to be seen, are the final instructions from CMS to FIs detailing how the revised policy will be implemented and enforced. CMS has promised to issue several new PMs accomplishing this in the very near future. It will be interesting to see if the revised outlier policy can be effectively and efficiently implemented by the FIs across the country as the revised policy appears to result in a significant increase in the workload for the FIs.

Hospitals across the country are hoping that the implementation instructions will be clear and relatively painless, apart from the obvious pain that will be caused by the significant reduction in Medicare reimbursement for the affected hospitals.
Compliance officers will need to take note of this revised outlier policy and ensure that hospital finance and reimbursement policies are updated to reflect the changes to outlier payments, including those related to financial reporting, budgeting and cost reporting. CMS continues previously started investigations, cost report audits and medical reviews stemming from the initial outlier issues identified by CMS and Compliance Officers will also need to stay on top of developments related to these issues.

Hospital charges will also now be under scrutiny as CMS attempts to determine whether the revised policy ultimately has the intended effect of reducing the “inappropriate” levels of outlier payments made to certain hospitals as well as achieving a more accurate computation of outlier payments made to hospitals. Although there may be some legal challenges from the hospital industry, it does not appear that any significant aspects of the revised policy will be overturned based on the initial analysis, so hospitals will have to accept another area of potential Medicare reimbursement reductions and either find alternative revenues or devise new cost cutting measures.