Hospital Payment Monitoring Program and Cost Outlier Issues

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- TMF is contracted with the CMS during the 7th Scope of Work (SoW) as the support Quality Improvement Organization (QIO) for the Hospital Payment Monitoring Program (HPMP)
- TMF was contracted with CMS during the 6th SOW as the support QIO for the Payment Error Prevention Program (PEPP)
Payment Error Prevention Program (PEPP)

• CMS 6th SoW initiative to protect Medicare trust fund and reduce inappropriate Medicare payments by monitoring inpatient hospital PPS claims and educating hospitals regarding payment errors

• Focused primarily on payment errors due to incorrect DRG assignment and unnecessary admissions
PEPP

• Implemented by the QIOs during the 6th SoW
  – QIOs were responsible for identifying payment errors and developing and implementing projects aimed at preventing payment errors
  – QIO’s goal: to reduce payment error rate
  – Collaborative, educational effort between QIOs and hospitals to identify and prevent payment errors
  – Hospitals were required to participate if requested by QIO
PEPP Accomplishments

- QIOs developed tools, education, comparative data to share with hospitals to assist in prevention of payment errors.
- Produced a payment error rate specifically for acute care IP hospitals. The Net Payment Error Rate, as identified by case review conducted by QIOs for PEPP is estimated as follows:
  - FY 1998: 2.43%
  - FY 2000: 2.56%
  - FY 2001: 2.78%
PEPP Findings

• Data from case review activities conducted by QIOs (FY 2000) to monitor the payment error rate indicate:
  – 81% of the net dollars in error were the result of unnecessary admissions
  – Coding errors were both undercoding and overcoding
  – 10% of the net dollars in error were due to billing errors, i.e. outpatient billed as inpatient, or billing to the wrong provider number
Hospital Payment Monitoring Program (HPMP)

- PEPP transitioned into the HPMP in the 7th SoW
- QIOs are responsible for implementing HPMP
  - QIO resources for HPMP were reduced from resources available for PEPP
  - Goal continues to be reduction in payment error rate
  - Focus continues to be collaborative
  - Hospital participation continues to be mandatory
HPMP

- Projects directed from CMS; however, QIOs may develop projects based on identified need with CMS approval
- HPMP is more focused on admission necessity; however, will continue to monitor DRGs with a history of coding errors
HPMP

- CMS will emphasize reducing variation related to medical necessity of admission
- QIOs will continue to collaborate with provider and practitioner groups and other agencies (state, licensure/accreditation, Medicaid, intermediaries, etc.) to support HPMP
HPMP

- CMS has centralized data processing and pattern monitoring (hospital-specific); QIOs receive quarterly administrative data reports
  - FATHOM: First-look Analysis Tool for Hospital Outlier Monitoring
FATHOM

- Developed by TMF for CMS
- FATHOM is an Excel program for QIO use to identify outliers in focused areas
  - Provides comparative, hospital-specific data that identifies outliers, QIOs can set criteria for hospital inclusion/exclusion
  - QIOs may conduct case review to confirm presence of payment errors
  - QIOs may use FATHOM to support a HPMP project proposal
Payment Error Rate Trending

- CMS will continue to randomly sample medical records to monitor the payment error rate on a national and state-specific basis.
- QIOs will continue to conduct case review activities on this sample to track and trend payment errors in their states.
Cost Outlier Issues

- CMS has instructed the FI’s to determine if hospitals are abusing the Medicare Cost Outlier Supplemental Payment.
- CMS Program Memorandum requires FI’s to conduct data analysis to identify providers:
  - Tier I - Outlier Payments of 80% or more of their operating and capital DRG payments; or,
  - Tier II - Meet both estimated outlier payments >20 % of their operating and capital DRG payments, and an increase in the average charges of 20% or more.
  - Tier III - Other issues the FI may determine should be reviewed.
Cost Outlier Review

• Responsibilities of the FI:
  • Notify CMS and QIO’s which providers require a sample of Cost Outliers be reviewed,
  • Conduct outpatient reviews of a sample of Cost Outliers,
  • Report to CMS the results of the audits, and
  • Collect overpayments and take appropriate remedial action.

• Role of the QIO:
  • Conduct Inpatient Reviews of a sample of Cost Outlier cases in accordance with CMS guidelines;
  • Take appropriate follow up action; and
  • Report review results to CMS.
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QUESTIONS AND ANSWERS ???