Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-122 **Date: DECEMBER 3, 2002**

CHANGE REQUEST 2500

SUBJECT: Notice Regarding Cost-to-Charge Ratios and Inpatient Outlier Payments

I. Introduction and Background

To determine whether a case qualifies for outlier payments under the hospital inpatient prospective payment system (IPPS), hospital-specific cost-to-charge ratios are applied to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios and combining these costs to compare them with the fixed-loss outlier threshold.

In the August 1, 2002, **Federal Register**, CMS stated that for Federal fiscal year (FY) 2003, those hospitals for which operating cost-to-charge ratios (CCR) are lower than 0.194 or greater than 1.258, or capital cost-to-charge ratios lower than 0.012 or greater than 0.163, fiscal intermediaries (FIs) will use statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments. These ranges represent 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals.

The CCRs are also used in determining outpatient hospital outlier payments, payments for pass-through devices and monthly interim transitional corridor payments under the outpatient prospective payment system (OPPS). The CCRs for OPPS will be addressed in a separate Program Memorandum (PM).

II. Cost-to-Charge Ratios for IPPS

Analysis of hospital charges since 1999 reveals that some hospitals' charges have grown at a much higher rate than the national average. Although these extraordinary increases will eventually result in lower CCRs, the lag between when charges are increased and the availability of cost reports results in higher outlier payments than is the case if the CCRs were updated more timely. Additionally, the ratio will eventually fall below the national threshold and cause the higher statewide average CCR to be assigned to the hospital.

The CMS believes that some hospitals may be attempting to "game" the current payment systems for the purposes of maximizing payment. The CMS is instructing you to take two steps to mitigate any potential vulnerability.

1. Data Analysis. Fiscal intermediaries' audit areas should immediately begin data analysis for the purpose of identifying high outlier payment hospitals. This analysis should be conducted using the latest available and accessible data (e.g., PS&Rs, claims data files, or cost reports). The purpose of this analysis is to identify hospitals that will be subject to further compliance review (as described below). Initiate this process to identify those hospitals that received outlier payments that totaled more than 10 percent of their operating and capital diagnosis-related group (DRG) payments for discharges during FY 2002 (excluding outlier, indirect medical education, and disproportionate share payments). FIs should limit this identification to those hospitals with at least 200 Medicare discharges in FY 2002, absent other reasons to include them.

The FIs should also identify, at their discretion, other hospitals with outlier payments that may be problematic. In order to do this, FIs should consider the following criteria:

1. The hospital has an outlier payment of 80 percent or more of their operating and capital DRG payments for discharges during October and November 2002 (excluding outlier, indirect medical education, and disproportionate share payments), or;

2. The hospital meets both of the following criteria:

   - Estimated outlier payments greater than 10 percent of their operating and capital DRG payments for discharges during October and November 2002 (excluding outlier, indirect medical education, and disproportionate share payments) and,
   - An increase in average charges per case (calculated including all Medicare discharges) of 20 percent or more from 2000 to 2001 and 2001 to 2002. This comparison may be performed using either hospitals' cost reporting periods or Federal fiscal years.

This analysis should be completed no later than December 10. Inform your contract manager immediately if you will not be able to meet this deadline. Because the Medicare Quality Improvement Organizations (QIOs) will be assisting in the compliance phase of this initiative, at the conclusion of your analysis, inform your contract manager of the states where the hospitals identified above are located.

Finally, identify all hospitals whose operating or capital cost-to-charge ratios are set equal to the statewide average ratio for the state where the hospital is located because the hospital's actual calculated ratio falls below the 3 standard deviation range described above. For these hospitals, e-mail the following information to: sphillips1@cms.hhs.gov by December 15, 2002.

- Hospital Provider Number
- Actual Operating or Capital Cost-to-Charge Ratio (only send the actual value for whichever ratio is equal the statewide average ratio).

2. *Compliance Actions.* By December 15, 2002, CMS will issue further instructions on actions with respect to hospitals that may be abusing the outlier system. These actions may include onsite visits, review of hospital chargemaster data, audit of cost-reimbursed expenses and review of inpatient and outpatient outlier stays/services and nonoutlier stays/services. Hospitals found to have engaged in strategies to obtain excessive outlier payments will be referred to the CMS Program Integrity Unit for further investigation and, if warranted, to the Office of Inspector General. Compliance actions will be tailored to individual hospitals based on your analysis utilizing CMS criteria. You will be expected to coordinate your efforts with the QIO in your state.

III. Changes in Regulation

The CMS expects to issue a regulation as soon as possible to revise the current rules for determining outlier payments. Any changes made by this regulation will take effect prospectively.

The *effective date* for this PM is December 3, 2002.

The *implementation date* for this PM is December 3, 2002.

These instructions contained in this PM should be implemented within your current operating budget.

This PM may be discarded after September 30, 2003.