PUBLICATION

Outliers: CMS Explains its Reasoning for FY2004 Fixed Loss Threshold Calculation [Ober|Kaler]

2016

In accordance with the order issued by the D.C. Circuit in *District Hospital Partners, LP v. Burwell* and related cases, on January 22, CMS issued an explanation of the methodology it used to calculate the fixed-loss threshold used to determine outlier payments to hospitals under the IPPS for FY2004.

CMS described its publication as a "clarification" and indicated that it would not recalculate the fixed loss threshold promulgated in the 2004 IPPS rule. The clarification, which details the rationale for changes in the number of hospitals determined to be "turbocharging" between the 2003 proposed rule [PDF] and the final rule [PDF] related to the calculation of outlier payments, likely indicates a new phase of the ongoing litigation on the outlier issue.

History of the Issue

Hospitals receive outlier payments when the costs of providing care to a particular patient exceed the amount associated with the DRG for the patient's condition by a specific margin, known as the fixed loss threshold. The fixed loss threshold is calculated annually by the Secretary. The outlier threshold is the amount of payment associated with a DRG plus the fixed loss threshold.

In the early 2000s, CMS identified a practice it labeled as fraudulent, known as turbocharging, whereby hospitals would increase their charges at a faster rate than the underlying costs were rising. Because CMS used the cost-to-charge ratio from a hospital's most recent settled cost report, which could reflect data that were several years old, this practice meant that hospitals could obtain outlier payments more frequently. By 2003, CMS had proposed changes to the methodology for calculating the fixed loss threshold and the general process for making outlier payments. In its 2003 proposed rule, CMS identified 123 hospitals that appeared to have engaged in the practice of turbocharging.

The final rule tied outlier payments to the cost-to-charge ratio identified in each hospital's most recent tentatively settled cost report—a figure that would be much more up to date than the figure from a finalized cost report. It also established that reconciliation of outlier costs would occur based on the settled cost report, meaning that changes to the cost-to-charge ratio occurring during the settlement process would be reflected in the final outlier payments received if (i) the cost-to-charge ratio changed more than 10 percentage points between the time the claim was paid and the settlement of the final cost report, and (ii) the hospital received more than $500,000 in outlier payments during the cost reporting period. CMS indicated in the 2004 IPPS rule that, based on its calculations, 50 hospitals would be subject to reconciliation.

District Hospital Partners, LP was one of several hospital organizations to challenge the new rule based on alleged violations of the Administrative Procedures Act (APA). On appeal of the district court's grant of summary judgment to CMS, the D.C. Circuit Court of Appeals held that CMS had not adequately explained why its proposed rule identified 123 hospitals engaged in turbocharging but indicated that only 50 would be subject to reconciliation of outlier payments.

CMS' Clarification in Response to the Court's Decision

CMS stated that when it estimated that 123 hospitals were engaged in turbocharging, it based the estimate on an analysis of MedPAR file data that identified hospitals whose percentage of outlier payments relative to total DRG patients increased by 5 percentage points or more between FY 1999 and FY 2001, and whose case mix-adjusted charges increased at a rate at or above the 95th percentile rate of charge increase over the same period. These changes were not reflected in the cost-to-charge ratios in place at the time, CMS noted.

In contrast, CMS stated that in determining the number of hospitals that would potentially be subject to reconciliation of outlier payments for FY2004, it used data on cost-to charge ratios taken from the most recent tentatively settled cost reports for each hospital in accordance with the methodology it set out in the 2003 rule. Based on the new methodology, reconciliation could apply to 50 hospitals. In using the new methodology to arrive at this figure, CMS explained, it ensured that its estimate reflected the payment policies that were actually in place for FY 2004. In addition to mitigating any distortion that could arise from the use of historical cost-to-charge data, CMS anticipated that the use of more current cost report data in calculating cost-to-charge ratios would curb the practice of turbocharging in general, further mitigating potential distortions in payments that could arise from the practice.

Ober|Kaler's Comments

Because CMS has declined to reconsider its overall approach to outlier payments, it is likely that litigation on the question will continue. However, CMS has articulated a detailed rationale for its approach, and such litigation in the future will have to articulate a convincing rationale for overturning the rule.