



April 4, 2003

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Ave, SW
Washington, DC 20201

Attention: **CMS-1243-P**

Dear Administrator Scully:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicare Program; Proposed Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System*" 68 Fed. Reg. 10420 (March 5, 2003). The AAMC represents approximately 400 major teaching hospitals and health systems; all 126 accredited U.S. medical schools; 96 professional and academic societies; and the nation's medical students and residents.

We applaud the Agency's intent to ensure the integrity of the Medicare outlier payment system. These payments are critical to the many teaching hospitals that treat the sickest and most complex patients. These cases frequently involve the level of extraordinary costs that outlier payments are intended to ameliorate. It is worth noting that even with these payments, teaching hospitals sustain significant losses treating these patients because outlier payments reimburse only 80 percent of hospitals' costs *beyond* the cost threshold level.

While we appreciate CMS' effort to address flaws in the outlier methodology, we believe several key changes are necessary before the rule is finalized. Chief among these are:

- Lowering the cost threshold,
- Providing for a reasonable transition period, and
- Rescinding the reconciliation process proposal.

We believe several other provisions also should be in the final rule, including a commitment by the Agency to implement refined diagnosis-related groups (DRGs), and an October 1 effective date.

A. BACKGROUND: THE OUTLIER PAYMENT CALCULATION

Under Medicare outlier policy, if the costs of a particular Medicare case exceed the relevant DRG operating and capital payment (including any DSH, indirect medical education (IME), or new technology add-on payments) plus a fixed-loss cost threshold (\$33,560 in Federal fiscal year (FFY) 2003), the hospital will receive an outlier payment. This payment equals 80 percent of the case's costs above the threshold calculation.

Because the claim submitted by a hospital for a particular case contains only the hospital's charge amount for that case, CMS uses a hospital-wide inpatient cost-to-charge ratio (CCR or ratio) to obtain the corresponding cost. Under current policy, the CCRs are obtained from a hospital's most recently settled cost report. Because the CCRs are at least two years old, and often are older than that, they may not reflect the cost/charge relationship in a current year, which can result in a cost calculation that does not reflect current year costs.

Outlier payments are budget-neutral and, according to law, must be between five and six percent of total estimated operating DRG payments plus outlier payments. Under CMS policy, the Agency reduces the PPS standardized amount by 5.1 percent and each year estimates a cost threshold that will result in outlier payments that equal 5.1 percent.

B. CMS MUST REDUCE THE OUTLIER COST THRESHOLD

The proposed rule would make a number of significant changes to the outlier methodology, including using CCRs from more recent cost reports and eliminating the use of state-wide averages for hospitals with extremely low CCRs (see below). Because these changes will significantly reduce outlier outlays, the outlier threshold must be reduced.

We recognize that over the past several years, aggregate outlier payments have exceeded the five to six percent outlier payment corridor. CMS addressed this issue aggressively in last year's inpatient prospective payment system (PPS) rulemaking when the Agency increased the cost threshold by 60 percent, from \$21,025 to \$33,560. This extraordinary threshold increase was decided upon after careful analysis by CMS staff (as reflected by the in-depth discussion in the final rule preamble at 67 Fed. Reg. at 50122 (Aug 1, 2002)). In fact, despite objections from many commenters, in the final rule CMS increased the threshold above what the Agency had originally proposed.

The steep increase in the threshold has resulted in significant and painful reductions in Medicare payments to teaching hospitals. However, teaching hospitals recognized that

such an increase was necessary if outlier payments were to be within statutory limits using the current methodology.

Given that current threshold of \$33,560 was contemplated and implemented on the basis that the outlier methodology would not be changed, it is axiomatic that if changes are made to that methodology that will reduce outlier payments, the outlier threshold also must be reduced.

Prior to the issuance of the proposed regulation, the CMS Administrator publicly reported that the changes that would be included in the proposed rule would be accompanied by a significant cost threshold reduction. However, no such reduction was included when the proposed rule was ultimately published in the *Federal Register*.

Our data analysis confirms the Administrator's initial pronouncements.¹ Without a reconciliation process, if tentatively settled CCRs are used, and the state-wide average is eliminated, the cost threshold can be reduced significantly -- to around \$22,000 if not lower -- and still ensure that total outlier payments are in the five to six percent range legislated by Congress. This threshold would be even lower if a reconciliation process were implemented.

We believe that if the outlier changes are finalized without a substantial reduction in the cost threshold, outlier payments will fall significantly below the statutorily mandated levels. To avoid this scenario, CMS must lower the cost threshold in the final rule.

C. THE FINAL RULE SHOULD INCLUDE A TRANSITION PERIOD

Given the significance of the changes to the outlier payment methodology that are being proposed, we believe a transition period should be included as part of the final rule.

If finalized, the changes contained in the proposed rule will significantly reduce outlier payments. These reductions will be imposed while hospitals are still trying to adjust to the major payment reductions that are occurring as a result of the 60 percent increase in the outlier cost threshold that went into effect this year. The impact of these current reductions should not be underestimated. Individual teaching hospitals are receiving millions of dollars less in revenue because of the threshold increase. These reductions have placed significant stress on major teaching hospitals' already fragile financial situations.

The proposed rule was not anticipated at the beginning of the current FFY, nor most hospitals' fiscal years. The issue for hospitals adversely affected by the rule is not

¹ It should be noted, however, that our analysis involves only projections because we do not have access to 2003 Medicare claims, as does CMS. In a letter to CMS dated March 26, 2003, the AAMC, along with the American Hospital Association and Federation of American Hospitals, requested data relating to the impact of the proposed rule provisions.

whether outlier payments must be reduced, but rather the timing of these reductions. Because of their slim total margins, major teaching hospitals, by necessity, have eliminated many excess costs. Thus, it is not easy for them to find further reductions to offset an outlier payment shortfall. This is particularly true when that shortfall is unpredicted, is coming right on the heels of current year outlier and other Medicare payment reductions (such as the FFY 2003 IME payment cut), and is occurring amidst other financial stresses such as Medicaid and private payer reductions.

While we support the key provisions in the proposed rule, we believe the desire to implement these changes expeditiously must be compromised to some extent because of the grave financial consequences that could occur for many hospitals if a transition period is not provided. Such an outcome is not in the best interests of hospitals, the Medicare program, or the health care system.

We would like to emphasize that implementing a transition period does not affect the requirement that the outlier threshold be reduced. The cost threshold should be reduced in accordance with the changes to the outlier methodology contained in the proposed rule. A transition mechanism could then be developed based on the outlier payment implications associated with the reduced threshold.

D. THE USE OF STATE-WIDE CCR AVERAGES MUST BE ELIMINATED

We support CMS' proposal to eliminate the policy of replacing a hospital's outlier CCR with the state-wide average when that CCR is significantly below the national average CCR. However, we believe the state-wide average substitution also should be eliminated for hospitals that have unusually high CCRs.

CMS' rationale for its proposed rule change is sound: hospitals should receive outlier payments based on their actual CCRs, no matter how low they fall. We believe this rationale applies equally to hospitals with high CCRs. If the CCRs are correct, they are the most accurate way of determining a case's cost and consequently whether it qualifies for outlier payments. If there is a question about a potential data error related to the CCR, it should be resolved with the hospital, rather than by making a unilateral CCR substitution

E. COST-TO-CHARGE RATIOS AND A RECONCILIATION PROCESS

A principle component in the proposed rule involves using more current cost-to-charge ratios and introducing a reconciliation process. While we support the use of more current data, we strongly object to a reconciliation process.

1. More Recent CCRs Should Be Used in the Outlier Calculation

We fully agree and endorse the concept of using hospitals' most recent tentatively settled cost reports to obtain CCRs for purposes of calculating outlier payments. This change will help ensure that the costs used to determine outlier payments are as accurate as reasonably possible to determine outlier payments.

2. There Should Not Be A Reconciliation Process

We disagree with the proposal to implement a reconciliation process for outlier payments. As the proposed rule acknowledges, a reconciliation process would involve a case-by-case recalculation of outlier payments at the time of final settlement of the cost report, which would not occur until a number of years after the care has been delivered and an outlier payment had been made. Such a process would impose significant administrative burdens on both hospitals and fiscal intermediaries. This is especially true for teaching hospitals, particularly if the reconciliation process includes reexamining not only CCRs, but also the IME and DSH payment calculations that help determine the level of an outlier payment.

We would also point out that another provision in the proposed rule would give CMS the authority to change a hospital's CCR at the time a claim is submitted if the Agency determines that the current year ratio is significantly different than the tentatively settled CCR. This authority would eliminate the need for a reconciliation process.

More importantly, however, we believe a reconciliation process would be at odds with the fundamental principles of prospective payment, which is to have payment rates set in advance so that payments are predictable for both hospitals and the Medicare program. Of necessity, historical data are used to set current rates. This is the case with other important inpatient PPS policies, such as DRG assignment changes, DRG weight recalibration, and the wage index. Outlier policy should be treated no differently.

Finally, a reconciliation process could result in outlier payments falling below the statutorily mandated levels. Each year, the outlier cost threshold is calculated such that outlier payments will be between five and six percent of total PPS operating payments.² Consequently, if a reconciliation process occurs that results in hospitals returning outlier payments to the program it will result in outlier outlays that are less than statutorily mandated amounts. This outcome would be particularly unwarranted because the outlier payment system is budget-neutral; that is, the PPS standardized payment is reduced in exchange for hospitals, in aggregate, receiving an equivalent amount in outlier payments.

² This calculation will become even more precise when tentatively settled CCRs are implemented since they will more closely estimate hospital costs.

In sum, for the reasons stated above, we urge the Agency to rescind its proposal to implement a reconciliation process for outlier payments. Such an action would not preclude CMS from proposing reconciliation at a later date if analysis of the impact of the other changes dictates that such a process is necessary.

3. If the Reconciliation Proposal is Not Rescinded, It Should Be Limited

While the proposed rule language can be interpreted to mean that the reconciliation process would apply to all hospitals, we have been told by CMS staff that the process would be used only in those situations in which CMS believes hospitals have received significant outlier overpayments. If, in the final rule, CMS decides to retain some form of reconciliation process, we believe the Agency must clearly state that the process is going to be applied only in select situations as well as establish and publish clear criteria and thresholds the Agency would use when deciding when reconciliation would occur. These criteria should be set such that only those hospitals that would otherwise receive substantial outlier overpayments would be subject to the reconciliation process.

4. The Application of Interest Payments Should be Clarified

The proposed rule states that if reconciliation occurs, hospitals that are determined to have been overpaid will be assessed an interest payment for the time they have possessed the excess outlier payments. We have strong reservations about this proposal because it runs counter to the policy applied in other reconciliation processes. For example, the IME and DSH payment reconciliation processes do not involve interest payments if an underpayment or overpayment occurs.

We recognize, however, that the outlier payment calculation is distinguishable from these other payments. The primary reason for a difference in outlier payments as calculated between tentatively settled and final cost reports is a difference in the CCR, which is readily apparent to both the hospital and fiscal intermediary (FI) and does not involve policy interpretation. By contrast, IME and DSH payment discrepancies can result from a number of factors that are subject to reasonable differences in interpretation, such as number of beds and resident counts for IME payments, and Medicaid days for DSH payments.

Thus, while we have reservations, we understand if CMS decides to retain the interest policy as it relates to outlier payments. However, we believe it is important for the Agency to clarify that the outlier interest payment provision is necessary because of its unique situation and that its premise is not applicable to reconciliation of other Medicare PPS payments, particularly IME and DSH payments.

F. CMS SHOULD IMPLEMENT REFINED DRGs

It is generally acknowledged that the current DRG-based payment system does not adequately recognize patient severity and thus under-reimburses the higher resource costs associated with complex patients. As a result of this under-reimbursement, cases assigned to higher-weighted DRGs are more likely to receive outlier payments.

Fundamentally, the purpose of outlier payments is to provide some financial relief for cases that have costs that are “extraordinary” and not as a means to redress deficiencies in the DRG system. CMS has the authority to implement changes to the DRG system (often referred to as “refined” DRGs) that would better target DRG payment rates for complex cases. Such a change would have the added impact of making more outlier payments available for the extraordinarily high cost cases. We urge CMS to use its regulatory authority to implement refined DRGs as soon as possible.

G. THE RULE SHOULD BE EFFECTIVE OCTOBER 1, 2003

The timing of this proposed rule is unusual since these changes would normally be proposed as part of the annual inpatient PPS proposed rulemaking process, by which changes are proposed in May, finalized in August, and implemented October 1.

Because this is a major rulemaking, and thus is subject to a 60 day Congressional review period, we understand that the earliest date the rule could be effective would be around July 1. Given that this date is already three-quarters into the current fiscal year, it seems prudent to wait until the beginning of next fiscal year, October 1, to implement these changes. This would give CMS additional time to do the analyses necessary to lower the threshold and do an adequate quantitative analysis of the impact of the changes. An October 1 effective date would also eliminate the administrative burden and difficulties that would occur for both FIs and hospitals in managing a major mid-year change in Medicare policy.

Thank you for this opportunity to present our views. Outlier payments are a critical component of the Medicare inpatient PPS and we believe strongly that it is important that the outlier methodology reflects its intended purpose -- to help offset the large financial losses that occur when hospitals treat high cost, complex patients. We would be happy to work with CMS on this important policy.

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If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President of the Association or Karen Fisher, Associate Vice President. They may be reached at (202) 828-0490.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC