DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 19 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Impact of Not Retroactively Adjusting Outpatient Outlier Payments (A-07-06-04059)

Attached is our final report on the impact of not retroactively adjusting outpatient outlier payments. Under the Medicare prospective payment system (PPS), the Centers for Medicare & Medicaid Services (CMS) reimburses outpatient providers, including hospital outpatient departments and community mental health centers (CMHC), based on predetermined, fixed payment amounts. CMS may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses.

In a series of reviews, we identified significant outpatient outlier overpayments to CMHCs. In response to our recommendations, the fiscal intermediaries stated that CMS had not authorized them to collect the overpayments because CMS considered outpatient outlier payments to be final payments not subject to retroactive adjustments. In contrast, in 2003, CMS modified its policy under the inpatient PPS to require retroactive adjustments of outlier payments in certain circumstances.

Our objective was to assess the impact that CMS's practice of not retroactively adjusting outpatient outlier payments has on the integrity of the outpatient outlier program.

CMS's practice of not retroactively adjusting outpatient outlier payments creates significant vulnerabilities in the outpatient outlier program. The practice is also inconsistent with CMS's policy of retroactively adjusting inpatient PPS outlier payments.

Our prior audits showed that some CMHCs received significant outpatient outlier overpayments as a result of fiscal intermediaries' and CMHCs' mathematical and clerical errors and CMHCs' manipulation of charge data to their advantage. Other CMHCs received underpayments as a result of fiscal intermediaries' errors. Following its current practice, CMS did not adjust these

erroneous payments, resulting in substantial net losses to the Medicare trust fund and payment inequities among CMHCs. CMS's practice also does not allow for retroactive adjustments when a fiscal intermediary's final cost report settlement identifies errors that caused previous erroneous outlier payments. Although our work was specific to CMHCs, similar vulnerabilities may exist in the entire outpatient outlier program.

We recommend that CMS issue regulations to require retroactive adjustments of outpatient outlier payments within appropriately established thresholds. Specifically, we recommend that CMS require:

- adjustments of outpatient outlier payments at final cost report settlement, retroactive to the beginning of the cost report period, and

- retroactive adjustments of outpatient outlier payments when an error caused by the fiscal intermediary or provider is identified after the cost report is settled.

In written comments on our draft report, CMS stated that it would explore the feasibility and cost effectiveness of implementing our recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-07-06-04059 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPACT OF NOT RETROACTIVELY ADJUSTING OUTPATIENT OUTLIER PAYMENTS

Daniel R. Levinson
Inspector General

June 2007
A-07-06-04059

Office of Inspector General

http://oig.hhs.gov

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Effective August 2000, the Centers for Medicare & Medicaid Services (CMS) implemented a Medicare prospective payment system (PPS) for hospital outpatient services. Under this system, CMS reimburses outpatient providers, including hospital outpatient departments and community mental health centers (CMHC), based on predetermined, fixed payment amounts.

CMS may make additional payments, called outlier payments, if the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. CMS's fiscal intermediaries determine whether claims qualify for outlier payments after reviewing the cost and charge data in providers' annual cost reports. To qualify for outlier payments, a provider's charges for services, adjusted to cost, must exceed a given threshold established by CMS. For calendar years 2001 through 2007, CMS estimates that outpatient outlier payments will amount to approximately $2.73 billion.

During the first several years of the outpatient PPS, CMHCs received a disproportionate amount of outlier payments compared with other types of outpatient providers. We therefore initiated a series of reviews of outlier payments to CMHCs. Our reports identified significant outpatient outlier overpayments. In response to the recommendations in those reports, the fiscal intermediaries stated that CMS had not authorized them to collect the overpayments because CMS considered outpatient outlier payments to be final payments not subject to retroactive adjustments. In contrast, in 2003, CMS modified its policy under the inpatient outlier PPS to require retroactive adjustments of outlier payments in certain circumstances.

OBJECTIVE

Our objective was to assess the impact that CMS's practice of not retroactively adjusting outpatient outlier payments has on the integrity of the outpatient outlier program.

SUMMARY OF FINDINGS

CMS's practice of not retroactively adjusting outpatient outlier payments creates significant vulnerabilities in the outpatient outlier program. The practice is also inconsistent with CMS's policy of retroactively adjusting inpatient PPS outlier payments.

Our prior audits showed that some CMHCs received significant outpatient outlier overpayments as a result of fiscal intermediaries' and CMHCs' mathematical and clerical errors and CMHCs' manipulation of charge data to their advantage. Other CMHCs received underpayments as a result of fiscal intermediaries' errors. Following its current practice, CMS did not adjust these erroneous payments, resulting in substantial net losses to the Medicare trust fund and payment inequities among CMHCs. CMS's practice also does not allow for retroactive adjustments when a fiscal intermediary's final cost report settlement identifies errors that caused previous erroneous outlier payments. Although our work was specific to CMHCs, similar vulnerabilities may exist in the entire outpatient outlier program.

RECOMMENDATIONS

We recommend that CMS issue regulations to require retroactive adjustments of outpatient outlier payments within appropriately established thresholds. Specifically, we recommend that CMS require:

- adjustments of outpatient outlier payments at final cost report settlement, retroactive to the beginning of the cost report period, and

- retroactive adjustments of outpatient outlier payments when an error caused by the fiscal intermediary or provider is identified after the cost report is settled.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, which are included as Appendix B, CMS stated that it would explore the feasibility and cost effectiveness of implementing our recommendations.

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INTRODUCTION

BACKGROUND

Medicare Outpatient Prospective Payment System

The Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 authorized the Centers for Medicare & Medicaid Services (CMS) to implement a Medicare prospective payment system (PPS) for hospital outpatient services. Effective August 2000, CMS began reimbursing outpatient providers, including hospital outpatient departments and community mental health centers (CMHC), based on predetermined, fixed payment amounts. CMS established the payment amounts by classifying services into standard groups that were similar clinically and used similar levels of resources. Since the program's inception, total outpatient PPS payments have steadily increased each calendar year, as shown below:

Total Outpatient PPS Program Payments (in billions)

2001	2002	2003	2004	2005	2006[1]	2007[1]
$17.7	$19.2	$20.8	$23.7	$26.5	$29.8	$32.5

Under the PPS, hospitals could have a financial incentive to avoid extremely costly cases because they would be reimbursed only the standard fixed payment for each case, not the actual cost of the case. To counter this incentive and promote access to hospital care for extremely costly patients, section 1833(t)(5) of the Social Security Act requires that CMS make additional payments called outlier payments. CMS makes outlier payments for situations in which the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. To qualify for outlier payments, a provider's charges for services, converted to estimated costs through a provider-specific cost-to-charge ratio, must exceed a given threshold established by CMS.

Each year, CMS sets an outlier payment target at a specified percentage of total outpatient PPS payments. From 2001, the first full year of the outpatient PPS, through 2007, CMS estimates that outlier payments will amount to approximately $2.73 billion.

Outpatient Outlier Payment Calculations

CMS contracts with fiscal intermediaries for such services as processing and paying claims from outpatient providers, calculating and updating cost-to-charge ratios, computing outlier payment amounts, and conducting cost report audits.

Providers submit Medicare claims containing data on patient charges. To determine whether a claim qualifies for an outlier payment, the intermediary must convert billed charges to estimated costs by computing a cost-to-charge ratio. The use of a properly computed, provider-specific

[1]Payments for 2006 and 2007 are projected.

cost-to-charge ratio is essential to ensure that Medicare makes outlier payments only for cases that have extraordinarily high costs, not merely high charges. The intermediary calculates each ratio by dividing total patient-related costs by total charges as shown on the provider's Medicare cost report.

Each outpatient provider is required to file a Medicare cost report each year. The intermediary reviews the cost report and performs a tentative settlement to ensure that the provider is reimbursed expeditiously. The intermediary may perform a detailed audit after the tentative settlement. If the intermediary does not perform a detailed audit, the intermediary determines final settlement by performing a limited desk audit. After auditing the cost report, the intermediary issues a notice of program reimbursement. As the final settlement document, this notice shows whether payment is owed to the provider or to the Medicare program.

Outpatient Outlier Overpayments

During the first several years of the outpatient PPS, CMHCs received a disproportionate amount of outlier payments compared with other types of outpatient providers. We therefore initiated a series of reviews of outlier payments to CMHCs. Appendix A lists the audit reports in which we reported overpayments due to both miscalculation of outlier payments on the part of fiscal intermediaries and cost report errors on the part of CMHCs.

We also found that some CMHCs took advantage of vulnerabilities in the outpatient outlier payment methodology by dramatically increasing their billed charges, without a comparable increase in costs, after their cost-to-charge ratios were established. Consequently, their charges were not appropriately reduced to cost, and inflated outlier payments resulted. To remedy this situation, in 2003, CMS directed the intermediaries to use more current cost reports to compute cost-to-charge ratios, established separate outlier payment thresholds for CMHCs apart from hospital outpatient department thresholds, and began adjusting the outlier thresholds annually. These actions significantly reduced outpatient outlier payments in 2004. However, some providers continued to manipulate their cost-to-charge ratios by significantly increasing their charges. In July 2004, we advised CMS of this ongoing abuse. In its 2004 final rule (68 FR 63470) and its 2007 final rule (71 FR 67998), which updated the payment methodologies for PPS outpatient services, CMS acknowledged that some CMHCs had manipulated their charges to receive inappropriate outpatient outlier payments.

Medicare Practices and Policies on Retroactively Adjusting Outlier Payments

Our prior reports recommended that the fiscal intermediaries adjust erroneous outpatient outlier payments and recover the overpayments. The fiscal intermediaries responded that CMS had not authorized them to collect the overpayments because CMS considered outpatient outlier payments to be final payments. However, neither the Social Security Act nor Medicare regulations specifically state that outlier payments are final payments.

Prior to 2003, CMS's longstanding practice, under both the inpatient PPS and the outpatient PPS, was to consider all outlier payments as final payments not subject to retroactive adjustments. In 2003, CMS modified its policy under the inpatient PPS by promulgating regulations requiring

retroactive adjustments of outlier payments in certain circumstances (42 CFR § 412.84, published June 9, 2003 (68 FR 34515)). CMS took this action to curtail excessive inpatient outlier payments that some hospitals received by taking advantage of vulnerabilities in the inpatient outlier payment methodology. On July 3, 2003, CMS issued Program Memorandum A-03-058 to implement 42 CFR § 412.84. The program memorandum states that, for discharges in cost-reporting periods beginning on or after October 1, 2003, fiscal intermediaries must retroactively adjust inpatient outlier payments if:

- actual cost-to-charge ratios are at least 10 percentage points higher or lower than the cost-to-charge ratios used to calculate outlier payments during the cost-reporting period and

- total outlier payments in the cost-reporting period exceed $500,000.

However, CMS has not similarly modified its practice to allow retroactive adjustments of outlier payments under the outpatient PPS.

Other Requirements on Overpayments

The "Medicare Financial Management Manual," Chapter 3, section 10, defines an overpayment as a Medicare payment that a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Chapter 3, section 90.1, of the manual states that providers are liable for overpayments due to clerical or mathematical errors by the fiscal intermediary in calculating reimbursement or by the provider in calculating charges.

The Federal Claims Collection Act of 1966 (31 U.S.C. § 3711), as implemented by 31 CFR § 901.1, requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor where necessary, demand repayment, and effect recoupment.

CMS regulations (42 CFR §§ 405.370–405.378) state that CMS or its Medicare contractors may suspend, offset, or recoup payments if the provider was overpaid.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to assess the impact that CMS's practice of not retroactively adjusting outpatient outlier payments has on the integrity of the outpatient outlier program.

Scope

This report addresses a vulnerability we identified in prior audits of outlier payments to CMHCs. We limited this review to examining CMS's practice with respect to retroactive adjustments of outpatient outlier payments. We did not review the internal controls of CMS, CMHCs, or fiscal intermediaries because our audit objective did not require us to do so. We performed fieldwork at CMS headquarters in Baltimore, Maryland, from February to November 2006.

Methodology

We analyzed the results of our prior audit work and interviewed officials of CMS and fiscal intermediaries regarding CMS's practice of not retroactively adjusting outpatient outlier payments. We also reviewed CMS's policy of retroactively adjusting inpatient outlier payments. We reviewed the applicable provisions of the Federal Claims Collection Act, the Code of Federal Regulations, the Federal Register, the "Provider Reimbursement Manual," the "Medicare Financial Management Manual," and CMS program memorandums. We also reviewed the Social Security Act to determine whether any provisions apply to retroactive adjustments of outlier payments.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

CMS's practice of not retroactively adjusting outpatient outlier payments creates significant vulnerabilities in the outpatient outlier program. The practice is also inconsistent with CMS's policy of retroactively adjusting inpatient PPS outlier payments.

Our prior audits showed that some CMHCs received significant outpatient outlier overpayments as a result of fiscal intermediaries' and CMHCs' mathematical and clerical errors and CMHCs' manipulation of charge data to their advantage. Other CMHCs received underpayments as a result of fiscal intermediaries' errors. Following its current practice, CMS did not adjust these erroneous payments, resulting in substantial net losses to the Medicare trust fund and payment inequities among CMHCs. CMS's practice also does not allow for retroactive adjustments when a fiscal intermediary's final cost report settlement identifies errors that caused previous erroneous outlier payments. Although our work was specific to CMHCs, similar vulnerabilities may exist in the entire outpatient outlier program.

ERRONEOUS OUTLIER PAYMENTS TO COMMUNITY MENTAL HEALTH CENTERS

The CMHCs we reviewed received significant erroneous outpatient outlier payments. Two fiscal intermediaries made errors in calculating outlier payments when settling cost reports, and some CMHCs made errors when preparing their cost reports. These errors resulted in net overpayments totaling $24,437,784.

- Intermediaries made mathematical and clerical errors by failing to adhere to CMS guidance when calculating outlier payments. For example, intermediaries failed to follow Program Memorandum A-00-63, which instructs them to use full-year cost reports to calculate cost-to-charge ratios. One intermediary also used incorrect cost report figures to calculate cost-to-charge ratios, contrary to the instructions in Program Memorandum A-00-63. In other cases, the intermediary failed to use the latest available cost reports, whether tentatively settled or final, to update cost-to-charge ratios and failed to timely update the ratios after cost report settlement as required by Program Memorandum A-03-004.

- CMHCs made mathematical and clerical errors in their cost reports by failing to comply with CMS guidance. For example, some CMHCs excluded non-Medicare charges, even though the "Provider Reimbursement Manual," Part 2, section 1809, instructs providers to enter gross total patient charges (Medicare and non-Medicare) in their cost reports. Other CMHCs included excessive owners' compensation in their cost reports. This practice was contrary to the "Provider Reimbursement Manual," Part 1, section 900, which states that "a reasonable compensation for owners' services is an allowable cost." The intermediaries failed to identify these cost report inaccuracies.

- CMHCs made errors by not uniformly charging all patients the same amount for services, contrary to instructions in the "Provider Reimbursement Manual." Part I, section 2202.4, of the manual states that charges must be uniformly applied to all patients, and Part 1, section 2204, states that the Medicare charge for a specific service must be the same as the charge to a non-Medicare patient.

CMHCs also received erroneous outlier payments by dramatically raising billed charges without a comparable increase in costs. This practice was contrary to the "Provider Reimbursement Manual," Part 1, section 2204, which states that the Medicare charge for a specific service must be related to the cost of the service. By raising billed charges, CMHCs were able to take advantage of vulnerabilities in the outlier payment methodology and receive higher outlier payments. These CMHCs significantly increased their charges after their cost-to-charge ratios were established. Consequently, their charges were not appropriately reduced to cost, and inflated outlier payments resulted. For example, one CMHC increased its group therapy charge from $560 to $3,200 per unit, a 571-percent increase, after its cost-to-charge ratio was established. As a result, this CMHC received an outlier payment on every claim between April and October 2003.

In response to our recommendations to collect these outpatient outlier overpayments, the fiscal intermediaries stated that CMS had not authorized them to do so. CMS's longstanding practice has been to regard outpatient outlier payments as final payments not subject to retroactive adjustments. This practice is inconsistent with the policy on inpatient outlier payments, which CMS made subject to retroactive adjustment in 2003. It is also inconsistent with Medicare guidance on liability for overpayments found in section 90.1 of the "Medicare Financial Management Manual," as well as CMS's guidance in the "Provider Reimbursement Manual," described above, addressing the allowability of charges that are unreasonable or unrelated to costs. Under these provisions, excessive outlier payments should be considered overpayments. As such, the Federal Claims Collection Act, its implementing regulations, and Medicare regulations regarding recoupment of overpayments obligate CMS to collect excessive outlier payments.

CONTINUING VULNERABILITIES

Unless CMS modifies its practice to allow retroactive adjustments of outpatient outlier payments, the following types of vulnerabilities and erroneous payments will continue:

- Inadvertent mathematical or clerical errors made by intermediaries may result in millions of dollars in outlier overpayments that providers will not be required to repay to the Medicare trust fund.

- Intermediaries' errors may result in providers' being underpaid through no fault of their own and unable to recoup the legitimate payments to which they are entitled.

- Intermediaries that do not settle the latest available cost reports in a timely manner may make erroneous outlier payments based on outdated cost-to-charge ratios that cannot be retroactively adjusted.

- Providers that do not comply with CMS guidance may prepare cost reports containing mathematical or clerical errors, which may result in erroneous outlier payments that cannot be adjusted.

- Providers that do not uniformly charge all patients the same amount for a particular service may skew their cost-to-charge ratios, which may result in outlier overpayments that cannot be recovered.

- Providers that do not include all costs in their cost reports may skew their cost-to-charge ratios, which may result in outlier overpayments that cannot be recovered.

- Providers may continue to take advantage of the outlier payment methodology by increasing their charges for services faster than intermediaries can adjust the cost-to-charge ratios.

- Providers that comply with CMS guidance and do not significantly raise billed charges may be disadvantaged if CMS raises the threshold to qualify for outlier payments in order to stay within its annual outlier payment target.

CONCLUSION

CMS's corrective actions in 2003 helped reduce outpatient outlier payments. However, CMS's current practice, which considers outpatient outlier payments as final payments not subject to retroactive adjustments, creates significant vulnerabilities and is inconsistent with CMS's policy of retroactively adjusting inpatient PPS outlier payments.

Currently, providers are liable for inpatient outlier overpayments that they receive. Also, providers that receive inpatient outlier underpayments may collect the amount due. However, providers are not liable for outpatient outlier overpayments, nor can they collect the outpatient outlier payments to which they are entitled if they are underpaid. Such inconsistencies are particularly evident for providers that submit both inpatient and outpatient claims. Furthermore, CMS's practice of not adjusting erroneous outpatient outlier payments results in losses to the Medicare trust fund; creates payment inequities among CMHCs; and may, as described above, penalize providers that comply with Medicare requirements. Although our work was specific to

CMHCs, similar vulnerabilities may exist in the outpatient outlier programs for other types of providers.

CMS reduced vulnerabilities in the inpatient outlier PPS by allowing, in certain circumstances, retroactive adjustments of outlier payments. Outpatient outlier programs warrant a similar policy.

RECOMMENDATIONS

We recommend that CMS issue regulations to require retroactive adjustments of outpatient outlier payments within appropriate thresholds. Specifically, we recommend that CMS require:

- adjustments of outpatient outlier payments at final cost report settlement, retroactive to the beginning of the cost report period, and

- retroactive adjustments of outpatient outlier payments when an error caused by the fiscal intermediary or provider is identified after the cost report is settled.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS stated that it would explore the feasibility and cost effectiveness of implementing our recommendations. CMS pointed out that financial risk is much more likely in the inpatient PPS than in the outpatient PPS. Accordingly, in the past, CMS had to balance retroactive adjustments for overpayments and underpayments against the administrative costs of identifying and reconciling erroneous cost reports and reprocessing claims.

CMS also provided information on several measures it had taken to restrain CMHC outlier payments. Specifically, CMS stated that it had been proactive in addressing inflated charges by designating a unique outlier threshold for CMHCs. CMS added that until the implementation of the threshold, it did not believe that pursuing retroactive adjustments of outpatient outlier payments would be cost effective. With respect to Medicare contractor and provider errors, CMS stated that it had taken several steps to improve the accuracy and frequency of the fiscal intermediaries' cost-to-charge ratio calculations, including updating its instructions and conducting an annual review of CMHC cost-to-charge ratios.

Appendix B presents the full text of CMS's comments.

APPENDIXES

SUMMARY OF REPORTS ON OUTPATIENT OUTLIER PAYMENTS TO COMMUNITY MENTAL HEALTH CENTERS[1]

"Review of TrailBlazer Health Enterprises Outlier Payments to Clinic Resources Management, Inc., for Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2003" (A-07-04-04045, issued September 14, 2005).

> *Summary of finding*: The fiscal intermediary incorrectly used a tentatively settled cost report, instead of an available final cost report, to establish the cost-to-charge ratio.

"Review of TrailBlazer Health Enterprises' Outlier Payments to Foundation Behavioral Health Center for Partial Hospitalization Services for the Period August 1, 2000, Through December 31, 2003" (A-07-04-04035, issued April 26, 2005).

> *Summary of finding*: The fiscal intermediary incorrectly used a short-period cost report to establish the cost-to-charge ratio.

"Review of TriSpan Health Services's Payments to Synergy Behavioral Health for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003" (A-06-04-00032, issued September 18, 2006).

> *Summary of findings*: The fiscal intermediary used the incorrect cost report worksheet to calculate the cost-to-charge ratio, and the provider entered incorrect data in its cost report.

"Review of TriSpan Health Services's Payments to Community Mental Health Centers for Partial Hospitalization Services for the Period August 1, 2000, Through June 30, 2003" (A-06-04-00065, issued September 18, 2006).

> *Summary of findings*: The fiscal intermediary incorrectly used short-period cost reports and used incorrect worksheets to calculate outlier payments, and providers entered incorrect data in their cost reports.

[1]These reports are available on the Internet at http://oig.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 12 2007

TO: Daniel R. Levinson
Inspector General

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Impact of Not Retroactively Adjusting Outpatient Outlier Payments" (A-07-06-04059)

Thank you for the opportunity to review and comment on the OIG draft report entitled: "Impact of Not Retroactively Adjusting Outpatient Outlier Payments." The report describes the OIG's research into sources of error in community mental health center (CMHC) outlier payments and recommends that the Centers for Medicare & Medicaid Services (CMS) engage in rulemaking to require (1) adjustment of outpatient prospective payment system (OPPS) outlier payments at cost report settlement, retroactive to the beginning of the cost report period, and (2) retroactive adjustments of OPPS outlier payments when an error caused by the Medicare contractor or provider is identified after the cost report is settled. As the report notes, these are the key provisions of CMS' policy for retroactive adjustment of outlier payments in the Inpatient Prospective Payment System (IPPS), which CMS pursues in certain circumstances. As always, we find the OIG's investigations, and this review of outlier payments for CMHCs in particular, informative and helpful in our continued effort to protect the Medicare Trust Fund.

The OPPS and IPPS outlier policies have a great deal in common. Both systems set aside some portion of anticipated payments to provide extra payment for extraordinarily expensive, outlier cases that pose hospitals with financial risk. Under both systems, Medicare contractors estimate costs from charges on submitted claims using cost-to-charge ratios (CCRs) estimated from each provider's most recently submitted cost report to determine whether the cost of a service or case exceeds predetermined thresholds and to determine the payment amount.

Extreme financial risk is much more likely in the IPPS, which pays for large bundles of services associated with diagnoses. The IPPS allocates 5.1 percent of total payments, roughly $6 billion, to outlier payments each fiscal year. IPPS payments are concentrated in fewer claims than the OPPS. Financial risk is more moderate under the OPPS because the OPPS makes separate payment for many individual services. The OPPS sets aside only 1 percent of all anticipated OPPS payments for outlier payments, roughly $320 million for calendar year (CY) 2007. Until CY 2005, CMS made many modest outlier payments for individual services. For CY 2005 non-CMHC services, CMS established a fixed dollar outlier threshold in addition to the historical multiple threshold, which requires that a hospital's cost for a service exceed the base payment

rate by a specified multiple of the base rate, to concentrate outlier payments in costly services that pose providers with the greatest financial risk under the OPPS (69 FR 65844). While CMHC outlier payments are subject to a multiple threshold, they are not to subject to a separate fixed dollar threshold because they are paid for a single service under the OPPS, partial hospitalization. Provisions for a separate CMHC outlier threshold are discussed below.

Until 2003, it was CMS' long-standing policy that any outlier payments made under a prospective payment system (PPS) be considered final payment because a PPS makes prospective payment that is not settled through a cost report process. However, for fiscal year (FY) 2004, we engaged in rulemaking to allow retroactive adjustments of outlier payments for the IPPS when the actual, operating CCRs in a hospital's cost report are plus or minus 10 percentage points from the CCR used to calculate outlier payments, and the hospital's total outlier payments in the cost reporting period exceed $500,000 (68 FR 34494). Medicare contractors make this assessment at cost report settlement. The CMS and Medicare contractors also have discretion to reconcile outlier claims of any IPPS hospital even if they do not meet the criteria above. These steps largely were undertaken to ensure that hospitals not take advantage of the time difference between the costs and charges on the cost report used by the Medicare contractor to calculate a CCR and current year charges by excessively inflating current charges. CMS specifically identified the above qualifying criteria to balance retroactive adjustments for extreme over or under payment against the administrative costs of identifying and reconciling erroneous reports and the associated costs of reprocessing claims to identify an adjustment to the cost report.

At the time that we instituted this policy for the IPPS, it would not have been cost effective to implement the same policy for the OPPS. For all of the OPPS, prior to the implementation of the fixed dollar outlier threshold for CY 2005, the administrative cost of reprocessing claims would have quickly overwhelmed the dollar value of the adjustments themselves. Because hospitals use the same charging structure for both inpatient and outpatient services, we believe that OPPS benefited from any change in hospital charging practices prompted by the institution of retroactive adjustment of IPPS outlier payments through cost report reconciliation.

The CMS also made changes in 2003 to improve the accuracy of prospective IPPS outlier payment and instituted the same changes for the OPPS. In January 2003, CMS began requiring Medicare contractors to continuously update the CCRs from each provider's most recently submitted full year cost report, whether tentatively settled or final. The CMS also requires Medicare contractors to report new CCRs within 30 days. Both payment systems removed the lower bound for replacing calculated CCRs with the statewide CCR. Statewide CCRs and thresholds for replacement are updated and reviewed annually. The CMS also has improved the accuracy of its prospective outlier threshold estimates for the OPPS by building in anticipated increases in charge inflation. The IPPS added an off-setting increase in cost inflation for FY 2007, and we plan to consider this adjustment for the OPPS in future calendar years.

The specific circumstances of CMHC outlier payments have posed a significant challenge to CMS. [1]As referenced in this report, in 2004, the OIG found specific evidence of CMHCs inflating charges to benefit from outlier payments. CMHC claims data also demonstrate excessive increases in charges for some CMHCs. We have addressed this concern by designating a unique outlier threshold for CMHCs beginning in CY 2004, and we maintained the current threshold of 3.4 times the ambulatory payment classification rate from CY 2006 to CY 2007. Differences in total CMHC outlier payments between CY 2004 and CY 2005 demonstrate that designating a separate threshold has successfully restrained CMHC outlier payments (71 FR 68003).

The OIG also has documented several examples of provider error in completing the cost report and Medicare contractor error in calculating CCRs between CY 2000 and CY 2003. In the first OPPS program memorandum on CCRs (A-00-63, issued in August 2000), we provided instructions for calculating CCRs for CMHCs from their cost reports but did not require that this number be updated, except in certain circumstances. Like the IPPS, we have improved this process. Beginning in 2003, we require the Medicare contractor to update CCRs when a new cost report, whether tentatively or finally settled, becomes available (PM A-03-004 and transmittal 1030, issued August 11, 2006). We believe that greater frequency of and experience with the CCR calculation has greatly improved the Medicare contractors' accuracy. Further, CMS reviews all CMHC CCRs for consistency as part of our calculation of partial hospitalization APC payment during the annual rate-setting process for the OPPS.

OIG Recommendation

Require adjustments of outpatient outlier payments at final cost report settlement, retroactive to the beginning of the cost report period.

CMS Response

We are concerned about the inappropriate payments to CMHCs created by excessive charge inflation specifically designed to garner greater outlier payments. We have been proactive in addressing this issue for prospective payment by designating a unique outlier threshold for CMHCs beginning in CY 2004. Differences in total CMHC outlier payments between CY 2004 and CY 2005 demonstrate that designating a separate threshold has successfully restrained CMHC outlier payments (71 FR 68003). Until the recent implementation of a fixed dollar threshold that concentrates outlier payments on costly and complex services, we did not believe it would be cost effective to pursue retroactive adjustments of outlier payments for all of the OPPS. Having changed the distribution of outlier payments, we will explore the feasibility of implementing this recommendation.

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[1] CMS notes that inflating charges in order to take advantage of increased outlier payments may subject a provider to sanction under the False Claims Act.

OIG Recommendation

Require retroactive adjustments of outpatient outlier payments when an error caused by the Medicare contractor or provider is identified after the cost report is settled.

CMS Response

We also are concerned about improper payments resulting from calculation errors by the Medicare contractor or providers. We note that the OIG's findings largely draw from OPPS' early implementation period, between 2000 and 2003. We believe we have taken several steps since that time in order to improve the accuracy and frequency of the Medicare contractors' CCR calculations, including updating our instructions, increasing the frequency of calculation, and conducting an annual review of CMHC CCRs. In light of this OIG recommendation, we will explore the feasibility and cost effectiveness of pursuing retroactive adjustments of outlier payments in the OPPS in cases of Medicare contractor or provider error, considering the most current CCR calculation practices in the OPPS.

We conclude by offering our thanks to the OIG for this report. As always, we find the OIG's investigations, and this review of outlier payments for CMHCs in particular, informative and helpful in our continued effort to protect the Medicare Trust Fund.