

IN THE WAKE OF THE TENET INVESTIGATION, CMS ISSUES PROGRAM MEMORANDUM ON DRG OUTLIERS

By Robert Homchick

Published by [Davis Wright Tremaine LLP](#)

Last month, federal regulators launched a review of Medicare "outlier" payments to Tenet hospitals. An outlier is an inpatient case that is so expensive it exceeds the anticipated cost thresholds established by the Medicare Program. As a consequence, instead of paying the hospital on the diagnostic related group (DRG), the Medicare Program pays the hospital at a higher or outlier rate. Outlier payments are intended to encourage hospitals to treat acutely ill patients where the cost of care exceeds the normal payment levels by a wide margin.

The formula used to calculate outlier payments is complex. The formula, which is defined by Medicare, includes among its components a facility-specific cost-to-charge ratio; that ratio is necessarily based on historical data. The formula also uses the hospital's current aggregate charges for the services the outlier patient has received. (Although patients and insurance companies rarely pay the prices listed in the charge master, it is one of the components used by Medicare to calculate a hospital's outlier payments.) The basic idea is to calculate a higher payment that bears some relationship to the costs the hospital incurred in the particular case. Some observers have commented that outlier payments might be increased if a hospital aggressively marks up current charges and the Medicare Program applies an historical cost-to-charge ratio to those higher charges to determine reimbursement.

Last week, The New York Times reported that the investigation of hospital outlier payments has moved beyond Tenet to a number of other institutions. Tom Scully, the administrator of CMS, commented that many hospitals deserve their outlier payments but some hospitals have been receiving payments inappropriately. "If they are gaming the system, they'd better look out...Tenet wasn't the only one doing this."

Reinforcing the Program's level of concern, on Dec. 3, 2002, the Centers for Medicare and Medicaid Services (CMS) issued a program memorandum to fiscal intermediaries (Transmittal A-02-122) regarding cost-to-charge ratios and inpatient outlier payments. In discussing cost-to-charge ratios, CMS noted that hospital charges since 1999 have grown at a much higher rate than the national average. Although these increases will eventually result in lower cost-to-charge ratios, the lag between when charges are increased and the availability of final cost reports results in higher outlier payments than would be the case if the cost-to-charge ratios were updated more timely. CMS echoed Mr. Scully's comments, stating that it believes some hospitals may be attempting to "game" the current payment system for purposes of maximizing payments.

The Program Memorandum (PM) instructs the fiscal intermediaries to review the available data to identify high outlier payment hospitals. The PM provides the following guidelines for identifying such hospitals:

1. The hospital has an outlier payment of 80 percent or more of its operating and capital and DRG payments for discharges during October and November 2002; or
2. The hospital's estimated outlier payments are greater than 10% of the operating capital and DRG payments for discharges during October and November and the hospital has had an increase of average charges per case of 20 percent or more from 2000 to 2001 and 2001 to 2002.

Fiscal intermediaries are to complete the outlier analysis no later than Dec. 10. By Dec. 15, CMS will issue further instructions with respect to hospitals that may be abusing the outlier system. Hospitals found to have engaged in strategies to obtain excessive outlier payments will be referred to CMS Program Integrity Unit for further investigation and, if warranted, to the Office of the Inspector General.

CMS expects to issue a regulation as soon as possible to revise the current rules for determining outlier payments. These changes, however, will be applied prospectively.

ABOUT THE AUTHOR

[Robert G. Homchick](#) is a partner in the Seattle office of the Davis Wright Tremaine law firm. His practice focus is on health law, regulatory compliance and litigation and he represents hospitals, physicians, health plans, skilled nursing facilities, home health agencies and other providers. Bob has a broad range of experience in investigations, administrative proceedings and litigation, including conducting internal investigations of regulatory compliance issues and other matters and defending health plans, providers and individuals in qui tam False Claims Act lawsuits.

Any questions about this Advisory should be directed to:

Robert Homchick, Seattle, (206) 628-7676, roberthomchick@dwt.com

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