Information Collection Requirements for
Requests by Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital Prospective Payment System (LTCH PPS) for an Alternative Cost-to-Charge Ratio and Supporting Regulations in 42 CFR 412.84(i)(2), 412.525(a)(4)(ii), 412.525(a)(4)(iv)(A), 412.529(c)(3)(ii) and 412.529(c)(3)(iv)(A)

A. Background for IPPS Outliers

Section 1886(d)(5)(A) of the Act provides for additional Medicare payments to Medicare-participating hospitals for cases incurring extraordinarily high costs. To qualify for outlier payments, a case must have costs above a threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers).

Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine the costs of the case exceed. Payments for eligible cases are then made based on a marginal cost factor of 80 percent, i.e. a percentage of the costs above the threshold. For Federal fiscal year (FY) 2007, the existing fixed-loss outlier threshold is $24,485. Therefore, for FY 2007 if the cost per case exceeds the Medicare payment for that discharge plus $24,485, Medicare will pay the hospital 80 percent of the excess amount.

The actual determination of whether a case qualifies for outlier payments takes into account both operating and capital costs and DRG payments. That is, the combined operating and capital costs of a case must exceed the fixed-loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital cost is compared with the threshold after dividing that threshold into an operating portion and a capital portion (by first adding the operating and capital ratios and then determining the ratios of the operating and capital ratios to the total and applying these percentages to the threshold). The thresholds are also adjusted by the area wage index (and for capital by the geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor which is equal to 80 percent of the combined operating and capital costs in excess of the threshold (90 percent for burn DRGs).

Prior to October 1, 2003, cost-to-charge ratios were determined using the most recent settled cost report for each hospital. At the end of the cost reporting period, Medicare charges from all claims during that period are accumulated through the Provider Statistical and Reimbursement Report (PS&R). The PS&R contains data on the number of discharges and the actual charges from each hospital. The hospital also submits a cost report

to its fiscal intermediary (FI), which is used to determine total allowable inpatient Medicare costs. The FI determines the cost-to-charge ratio for the hospital by using charges from the PS&R and costs from the cost report. For example, the covered charges on bills submitted for payment during FY 2003 are converted to costs by applying a cost-to-charge ratio from the most recent final settled or tentatively settled cost report (whichever is from the later cost reporting period) that began in FY 2000 or, in some cases, FY 1999 or even earlier. These covered charges reflect all of a hospital's charge increases to date, in particular those that have occurred since FY 2000 and are not reflected in the FY 2000 cost-to-charge ratios. If a hospital's rate-of-charge increases since FY 2000 exceeds the rate of the hospital's cost increases during that time, the hospital's cost-to-charge ratio based on its FY 2000 cost report will be too high, and applying it to current charges will overestimate the hospital's costs per case during FY 2003. Overestimating costs may result in some cases receiving outlier payments when these cases, in actuality, are not high-cost cases.

The Congress intended that outlier payments would be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. We conducted analysis in 2003 that indicated that some hospitals were taking advantage of two vulnerabilities in our methodology to maximize their outlier payments. One vulnerability is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. The second vulnerability, is that hospitals in some cases, may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied.

Because of these vulnerabilities in the June 9, 2003 IPPS outlier payment final rule, beginning October 1, 2003 we implemented new regulations at §412.84(i)(1) that allow fiscal intermediaries (FIs) to use more up-to-date data when applying the cost-to-charge ratio for each hospital. As mentioned above, before October 1, 2003, FIs used data from the hospital's most recent settled cost report. We revised our regulations to specify that FIs will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period.

Hospitals must submit their cost reports within 5 months after the end of their fiscal year. CMS makes a decision to accept a cost report within 30 days. Once the cost report is accepted, CMS makes a tentative settlement of the cost report within 60 days. The tentative settlement is

based on a basic review of the as filed cost report to determine the amount of payment to be paid to the hospital. After the cost report is tentatively settled, it can take 12 to 24 months, depending on the type of review or audit, before the cost report is final-settled. Thus, using cost-to-charge ratios from tentative settled cost reports, as we implemented in the June 6, 2003 final rule, reduces the time lag for updating cost-to-charge ratios by a year or more.

However, even the cost-to-charge ratios calculated based on data from the tentative settled cost reports could overestimate costs for hospitals that have continued to increase charges faster than costs during the time between the tentative settled cost report period and the time when the claim is processed. That is, even though we proposed to reduce the lag in time by revising the regulations to use the latest tentative settled cost report rather than the latest settled cost report, there would still be a lag of 1 to 2 years during which a hospital's charges may still increase faster than costs. Therefore, we also implemented new regulations that provide that, in the event more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate-of-increase among other hospitals), CMS has the authority to direct the FI to change the hospital's operating and capital cost-to-charge ratios to reflect the high charge increases evidenced by the later data.

In addition, we implemented new regulations to allow a hospital to contact its FI to request that its cost-to-charge ratios, otherwise applicable, be changed if the hospital presents substantial evidence that the ratios are inaccurate. Any such requests would have to be approved by the CMS regional office (RO) with jurisdiction over that FI.

B. Background for LTCH Outliers

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, when we implemented the LTCH PPS (for cost reporting periods beginning on or after October 1, 2002)), we established an adjustment for additional payments for outlier cases that have extraordinarily high-costs relative to the costs of most discharges at §412.525(a). Providing additional payments for high cost outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient level and hospital level. Specifically, under §412.525(a), we make high cost outlier payments to LTCHs for any discharge if the estimated cost of the case exceeds the adjusted LTCH PPS payment for the LTC-DRG plus a fixed-loss amount. Under the LTCH PPS high-cost outlier policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold. We calculate the estimated cost of a LTCH case by multiplying the Medicare allowable covered charge by the overall hospital CCR. In accordance with §412.525(a)(3), we pay outlier cases additional payment if 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount).

Additionally, when we implemented the LTCH PPS, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA at §412.529, we established a special payment policy for short-stay outlier cases. LTCH PPS cases with a length of stay that is less than or equal to five-sixths of the geometric average length of stay for each LTC-DRG are short stay outliers. Generally, LTCHs are defined by statute as having an average Medicare length of stay of greater than 25 days. We believe that a short-stay outlier payment adjustment results in more appropriate payments, because these cases most likely would not receive a full course of a typical LTCH stay in such a short period of time and a full LTC-DRG payment may not be appropriate. Under the short-stay outlier policy at §412.529(c)(1), for LTCH PPS short-stay outlier discharges occurring before July 1, 2006, in general, we adjust the LTCH PPS per discharge payment for a short stay outlier by the least of 120 percent of the estimated cost of the case, 120 percent of the LTC-DRG specific per diem amount, or the full LTC-DRG payment. Under the short-stay outlier policy at §412.529(c)(2), for LTCH PPS short-stay outlier discharges occurring on or after July 1, 2006, in general, we adjust the LTCH PPS per discharge payment for a short stay outlier by the least of 100 percent of the estimated cost of the case, 120 percent of the LTC-DRG specific per diem amount, the full LTC-DRG payment, or a blend of an amount comparable to the IPPS per diem amount (capped at the full IPPS comparable amount) and the 120 percent of the LTC-DRG specific per diem amount. Consistent with the LTCH PPS high-cost outlier policy, under the short-stay outlier policy at §412.529, we calculate the estimated cost of a case by multiplying the Medicare allowable covered charges by the overall hospital CCR.

Because the LTCH PPS high cost and short stay outlier policies are modeled after the IPPS outlier policy, and CCRs are used to determine payments, we believe they are susceptible to the same payment vulnerabilities as described above. Therefore, we implemented changes to the regulations for both high cost and short stay outliers to mitigate these vulnerabilities for the LTCH PPS. The regulations for the LTCH PPS are similiar to the IPPS outlier regulations at in §412.84 (i) . Specifically, in the June 9, 2003 IPPS outlier payment final rule, beginning October 1, 2003 we implemented new regulations at §412.525((a)(4)(iii) and §412.529(c)(5)(iii) that would allow FIs to use more up-to-date data when determining the cost-to-charge ratio for each hospital (similiar to that at §412.84(i)(2). In that same final rule, effective August 8, 2003, we implemented new regulations at §412.525((a)(4)(ii) and §412.529(c)(5)(ii) to allow a LTCH to contact its FI to request that its cost-to-charge ratio, otherwise applicable, be changed if the LTCH presents substantial evidence that the ratios are inaccurate (as set forth under 412.84(i)(1). Any such requests would have to be approved by the CMS RO with jurisdiction over that FI.

We specified at §§412.525(a)(4)(iv)(A) and 412.529(c)(3)(iv)(A) that for discharges occurring on or after October 1, 2006 a hospital may request that its fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. A request must be approved by the CMS regional office. For a full discussion on the remaining regulations that we codified in subpart O of part 42 of the CFR, please refer to the FY 2007 IPPS final rule.

C Justification

1. Need and Legal Basis

Because of the extensive gaming of outlier payments, we implemented regulations in §412.84 (i)(2) of the Code of Federal Regulations for IPPS hospitals and §§412.525(a)(4)(ii), 412.525(a)(4)(iv)(A), 412.529(c)(3)(ii) and 412.529(c)(3)(iv)(A) of the Code of Federal Regulations for LTCHs to allow a hospital to contact its FI to request that its cost-to-charge ratio (operating and/or capital CCR for IPPS hospitals or the total (combined operating and capital) CCR for LTCHs), otherwise applicable, be changed if the hospital presents substantial evidence that the ratios are inaccurate for IPPS hospitals. Any such requests would have to be approved by the CMS RO with jurisdiction over that FI.

We note that in this document any instance of the word “hospitals” includes hospitals subject to the IPPS and LTCH PPS, respectively.

2. Information Users

Interested parties include hospitals, contractors and consultants.

3. Use of Information Technology

Depending on the type of evidence presented, some hospitals will be submitting evidence in paper and/or in electronic form. Some hospitals may request an update to their CCR based on financial data that can be presented in electronic form while other hospitals may submit evidence on paper that explains why an update to their CCR is necessary.

Hospitals making a request for an update to their CCR must make a formal submission to the FI, which must be approved by the RO. This usually requires a signature from the requestor. Assuming an FI accepts electronic correspondence, this collection should be made available electronically with an electronic signature.

4. Duplication of Efforts

Hospitals may submit data that the FI has already reviewed to calculate a hospital's CCR. It is possible that hospitals may also submit other data to justify their claim for a new CCR. However, any duplication of data submitted by the hospital is in all probability in order to ensure accuracy by the FI.

5. Small Business

The information being reviewed is requested by the hospital and therefore has no effect on small businesses.

6. Less Frequent Collection

This information is collected upon request by the hospitals in order to comply with regulatory requirements. Rreducing or eliminating this collection would contradict the current regulation.

7. Special Circumstances
There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice for this information collection published on July 21, 2006. Please see the attached copy.

In addition to the 60-day Federal Register notice, the June 9, 2003 Federal Register final rule implements the new regulations. For IPPS hospitals, the new regulation was assigned to §412.84 (i)(1) and for LTCHs the new regulations were originally assigned to §412.525(a)(4)(ii) for high cost outliers and §412.529(c)(5)(ii) for short stay outliers. The FY 2007 IPPS final rule codified those provision of the regulations in subpart O of 42 CFR for discharges on or after October 1, 2006 at §412.525(a)(4)(iv) for high cost outliers and §412.529(c)(3)(iv) for short stay outliers. Under the current regulations, this policy for discharges on or after October 1, 2003 and before October 1, 2006, can now be found at §412.525(a)(4)(ii) for high cost outliers and §412.529(c)(3)(ii) for short stay outliers.

Comments were made in the Federal Register asking what constitutes "substantial evidence". We explained we would issue further guidance on this in a program memorandum. We have left this issue as a local decision for the FI and RO.

The public was invited to comment on all inpatient issues as part of our annual final rule. In addition, concerns from hospitals were expressed to the FI and RO.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

Because it is possible that this information can be made public, any confidential information that is disclosed to CMS must be marked as such in any submission of data.

11. Sensitive Questions

There are no questions of a sensitive nature.

12. Burden Estimates (Hours and Wages)

We anticipate approximately 10 hospitals paid under the IPPS and 8 hospitals paid under the LTCH PPS will request that their CCR be updated based on substantial evidence presented to CMS. Based on the complexity of the request, some requests may take longer than others. Therefore, we estimate that it will take approximately 8 hours on average for the hospitals to compile such a request.

The information for various items may be compiled by personnel at different levels of pay (clerk, lawyer, medical staff, etc.). Based on this we are using an average salary of $34/hour to calculate the cost.

$34 x 144 hours (8 hours (average estimated time) x 18 (number of hospitals making this request)) = $4,896

13. Capital Costs

Not applicable to this collection.

14. Cost to Federal Government

The FI will be responsible for the initial review of data received from the hospitals. The FI review of each hospital's request should take approximately 2 hours. In addition, the RO must review the work and approve the FI's determination in this matter. We estimate it will take approximately 2 hours for the RO to review this request. The breakdown for the total cost is:

18 hospitals x 2 hours FI review per hospital x $25 per hour plus 20 percent for fringe benefits (Auditor/Financial Analyst AHW based on annual salary of $45,000 [estimated from OES survey]), = $1,080

$35.29/hr (average salary GS 9/11/12/13/14/15) x 2 hours/ request x 18 requests = $1270.44

The total Federal cost is: $2,350.44

15. Changes to Burden

This is a new information collection.

16. Publication/Tabulation Dates

This data is submitted by the hospital to the FI when a hospital feels a adjustment is necessary to its CCR and therefore there are no specific publication or tabulation dates.

17. Expiration Date

This information collection will remain in effect as long as the regulation is in place.

18. Certification Statement

There are no exceptions to the certification statement.

Collections of Information Employing Statistical Methods

1. There are currently approximately 3,824 hospitals that are being paid under the IPPS and 363 hospitals being paid under the LTCH PPS. Because this is still a new regulation, it is very difficult to accurately predict how many hospitals will make this request. As stated in the June 9, 2003 Federal Register final rule, we expected 120 hospitals to request a change to their CCR by presenting substantial evidence. However, since that time we have had approximately 10 requests.

2. Hospitals can submit an array of data and information when requesting an update to their CCR. The data submitted by the hospitals should be accurate and justify the necessity for an adjustment to the hospitals CCR.

3. As stated above, hospitals will submit this data when they feel an adjustment is necessary and therefore this does not apply.

4. No testing will apply. The FI and RO must approve the data and reasoning submitted by the hospitals for an adjustment to its CCR.

5. Any FI or ROs can be part of this process.