Information Collection Requirements for
Requests by Hospitals Paid Under the Inpatient Prospective Payment System (IPPS) and the 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)(1), 412.525(a)(4)(iv)(A), and 412.529(f)(4)(i)

A. Background for IPPS Outliers

Section 1886(d)(5)(A) of the Act provides for additional Medicare payments to Inpatient Prospective Payment System (IPPS) hospitals for cases that incur extraordinarily high costs. To qualify for outlier payments, a case must have costs above a predetermined threshold amount (a dollar amount by which the estimated cost of a case must exceed the Medicare payment).

Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine the estimated cost of the case. In general, additional outlier payments for eligible cases are made based on a marginal cost factor of 80 percent, i.e. a fixed percentage of the costs above the outlier threshold. Therefore, if the estimated cost of the case exceeds the Medicare payment for that discharge plus the outlier threshold, generally Medicare will pay the hospital 80 percent of the excess amount. The outlier threshold is updated annually at the beginning of the Federal Fiscal Year.

Prior to October 1, 2003, cost-to-charge ratios were determined using the most recent final 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 for each hospital. The hospital also submits a cost report to its fiscal intermediary (FI) or A/B Medicare Administrative Contractor (MAC), which is used to determine total allowable inpatient Medicare costs. The FI or A/B MAC 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 2002 are converted to costs by applying a cost-to-charge ratio from the most recent final settled cost report 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. However, those charge increases that have occurred since FY 2000 are not reflected in the FY 2000 cost-to-charge ratios. For example, if a hospital's rate of charge increase since FY 2000 exceeds the rate of the hospital's cost increase during that time, the hospital's cost-to-charge ratio based on its FY 2000 cost report data will

be too high, and applying it to current charges overestimates the hospital's costs for each case during FY 2002. Overestimating costs may result in some cases receiving outlier payments when these cases, in actuality, are not unusually high cost cases. Additionally, prior to 10/1/2003, if a hospital's cost-to-charge ratio determined from the latest settled cost report was above or below 3 standard deviations from the geometric mean of cost-to-charge ratios, the hospitals was assigned the applicable state-wide average cost-to-charge ratios instead of the cost-to-charge ratios determined from the cost report.

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 was 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 was that hospitals, in some cases, may have increased their charges so far above their costs that their cost-to-charge ratios fell below 3 standard deviations from the geometric mean of cost-to-charge ratios, and a higher statewide average cost-to-charge ratio was applied instead of the cost-to-charge ratio determined from the latest settled cost report..

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 FIs or A/B MACs to use more up-to-date data when determining the cost-to-charge ratio for each hospital. Specifically, we revised our regulations to specify that FIs or A/B MACs will use either the most recent final settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period, instead of only using data from the hospital's most recent final-settled cost report.

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 implemented in the June 9, 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 reduced the lag in time by revising the regulations to use the latest tentative settled cost report rather than the latest settled cost report, there is 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 or A/B MAC 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 or A/B MAC to request that its cost-to-charge ratios, otherwise applicable, be changed if the hospital presents substantial evidence that its cost-to-charge ratios currently being used for payment are inaccurate. Any such requests would have to be approved by the CMS regional office (RO) with jurisdiction over that FI or A/B MAC.

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 the LTCH PPS was implemented (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 case 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 cost-to-charge ratio. In accordance with §412.525(a)(3), we pay outlier cases additional payment 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 case and the fixed-loss amount).

Additionally, when we implemented the LTCH PPS, 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 LTCH PPS payment may not be appropriate. Under the current short-stay outlier policy at §412.529(c), the adjusted payment for the case is the least of several payment options, one of which is 100 percent of the estimated cost of the case (prior to July 1, 2006, the short-stay outlier payment formula included 120 percent of the estimated cost of the case as one of the payment options). 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 cost-to-charge ratio.

Because the LTCH PPS high cost and short stay outlier policies are modeled after the IPPS outlier policy, and cost-to-charge ratios are used to determine payments, we believed they are susceptible to the same payment vulnerabilities as the IPPS (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 similar 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 initially at §412.525(a)(4)(iii) (which is now codified in the regulations at §412.525(a)(4)(iv)(B) for discharges occurring on or after October 1, 2006) and §412.529(c)(5)(iii) (which is now codified in the regulations at §412.529(f)(3) and §412.529(f)(4)(ii)) that allows FIs or A/B MACs to use more up-to-date data (that is, data from the most recent tentative settled cost report, whichever is from the later cost reporting period) when determining the cost-to-charge ratio for each hospital (similar to the IPPS policy at §412.84(i)(2)).

In the June 9, 2003 final rule, effective August 8, 2003, we also implemented new regulations initially at §412.525(a)(4)(ii) (which is now codified in the regulations at §412.525(a)(4)(iv)(A) for discharges occurring on or after October 1, 2006) and §412.529(c)(5)(ii) (which is now codified in the regulations in §412.529(f)(2) and §412.529(f)(4)(i)) to allow a LTCH to contact its FI or A/B MAC to request that its cost-to-charge ratio, otherwise applicable, be changed if the LTCH presents substantial evidence that the ratios are inaccurate (similar to the IPPS policy set forth under 412.84(i)(1). Any such requests must be approved by the CMS RO with jurisdiction over that FI or A/B MAC.

C Justification

1. Need and Legal Basis

To improve the accuracy of outlier payments, the current regulations at §412.84 (i)(2) of part 42 of the Code of Federal Regulations for IPPS hospitals and §§412.525(a)(4)(ii), 412.525(a)(4)(iv)(A), 412.529(f)(2) and 412.529(f)(4)(i) of part 42 of the Code of Federal Regulations for LTCHs allow a hospital to contact its FI or A/B MAC to request that its cost-to-charge ratio (operating and/or capital cost-to-charge ratio for IPPS hospitals or the total (combined operating and capital) cost-to-charge ratio 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 or A/B MAC.

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 cost-to-charge ratio 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 cost-to-charge ratio is necessary.

Hospitals making a request for an update to their cost-to-charge ratio must make a formal submission to the FI or A/B MAC, which must be approved by the RO. This usually requires a signature from the requestor. Assuming an FI or A/B MAC 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 or A/B MAC has already reviewed to calculate a hospital's cost-to-charge ratio. It is possible that hospitals may also submit other data to justify their request for a change to their cost-to-charge ratio. However, any duplication of data submitted by the hospital is in all probability necessary to ensure accuracy by the FI or A/B MAC.

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 current regulatory requirements. Reducing 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 the current submission was published March 29, 2010.

In addition to the 60-day Federal Register notice, the June 9, 2003 Federal Register final rule implements the regulations allowing hospitals to request and alternative cost-to-charge ratio. For IPPS hospitals, the regulation was assigned to §412.84 (i)(1) and for LTCHs the regulations

were originally assigned to §412.525(a)(4)(ii) for high cost outliers (which for discharges on or after October 1, 2006, is now codified in the regulations at §412.525(a)(4)(iv)(A)) and §412.529(c)(5)(ii) for short stay outliers (which is codified in the regulations at §412.529(f)(2) and §412.529(f)(4)(i)).

Public comments responded to in the June 9, 2003 Federal Register asked what constitutes “substantial evidence”. In our response 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 or A/B MAC and the RO.

The public was also invited to comment on all inpatient issues as part of our annual final rule. In addition, concerns from hospitals were expressed to the FI OR A/B MAC 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 cost-to-charge ratio 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 or A/B MAC is responsible for the initial review of data received from the hospitals. The review of each hospital's request by the FI or A/B MAC should take approximately 2 hours. In addition, the RO must review the work and approve the FI or A/B MAC'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 or A/B MAC review per hospital x $25 per hour plus 20 percent for fringe benefits (Auditor/Financial Analyst Average Hourly Wage based on annual salary of $45,000 [estimated from OES survey]), = $1,080

$40.48/hr (average salary GS 9/11/12/13/14/15) x 2 hours/ request x 18 requests = $1,457.28

The total Federal cost is: $2,537.28

15. Changes to Burden

Adjustments were accounted for due to the rise of salaries under the GS salary schedule.

16. Publication/Tabulation Dates

This data is submitted by the hospital to the FI or A/B MAC when a hospital feels an adjustment is necessary to its cost-to-charge ratio 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.